London Ambulance Service NHS
NHS Trust

TRUST BOARD

Meeting to be held at 10.00am on Tuesday 24th January 2012
Conference Room, 220 Waterloo Road London SE1 8SD

Peter Bradley
Chief Executive Officer

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AGENDA

			TAB
1.	**Welcome and apologies for absence** Apologies received from:		
2.	**Declarations of Interest** To request and record any notifications of declarations of interest in relation to today's agenda or gifts and hospitality received	RH	TAB 1
3.	**Minutes of the Part I meeting held on 13th December 2011** To approve the minutes of the meeting held on 13th December 2011	RH	TAB 2
4.	**Matters arising** Actions from previous meetings	RH	TAB 3
5.	**Report from Sub-Committees** To receive a report from the following Committee: Finance and Investment Committee on 17th January 2012	 RH	Oral
6.	**Chairman's Report** To receive a report from the Trust Chairman on key activities	RH	TAB 4
7.	**Update from executive directors** To receive reports from Executive Directors on any additional key matters		
	7.1 Chief Executive Officer, including balanced scorecard and performance reports	PB	TAB 5
	7.2 Director of Finance, to receive a report on financial performance for month 9	MD	TAB 6
	7.3 Director of Finance, to receive a report on progress against the Cost Improvement Programme	MD	
8.	**Clinical quality and patient safety report** To receive the monthly report on clinical quality and patient safety to month 9	FM/SL	TAB 7
STRATEGIC AND BUSINESS PLANNING			
9.	**CommandPoint Update** To receive an update on CommandPoint	PS	TAB 8

FOUNDATION TRUST PROCESS

10.	**Foundation Trust Update** To receive a report on the current position with the application including timeline and assurance and preparation for Monitor's assessment stage	SA	TAB 9

GOVERNANCE

11.	**Annual Equality Report 2010/11** To note the Annual Equality Report for 2010/11	CH	TAB 10
12.	**Risk Management Strategy and Policy** To approve the Risk Management Strategy and Policy	SA	TAB 11
13.	**Board Assurance Framework and Corporate Risk Register** To note the quarter 3 documents	SA	TAB 12
14.	**Report from Trust Secretary** To receive the report from the Trust Secretary on tenders received and the use of the Trust Seal	SA	TAB 13
15.	**Forward Planner** To note the Trust Board forward planner	SA	TAB 14
16.	**Any other business**		
17.	**Questions from members of the public**		
18.	**Date of next meeting** The next meeting of the Trust Board is on Tuesday 27th March 2012		

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	28/11/2011		✓	Koodu Ltd - Property services start-up. Altain Partners Ltd - Executive coaching company.					
Jessica Cecil	05/12/2011		✓				On the advisory board on IntoUniversity, an educational charity.	Sister, Antonia Hearn, is an NHS physiotherapist, who also sees patients privately.	
Roy Griffin	29/11/2011		✓	Non-executive Director and Chairman of Docklands Aviation Group, operators of London City Airport. Non-executive Director of NHS Blood and Transplant (NHSBT).					
Brian Huckett	02/12/2011	✓							
Beryl Magrath	24/11/2011		✓					Ceased being a Trustee of Harris HospicCare in 2009.	
Caroline Silver	25/11/2011	✓							
Peter Bradley	05/12/2011	✓							
Martin Flaherty	24/11/2011	✓							
Sandra Adams	24/11/2011	✓							
Lizzy Bovill	25/11/2011	✓							
Caron Hitchen	24/11/2011	✓							
Steve Lennox	25/11/2011	✓							
Fionna Moore	27/11/2011		✓	Medical Director Location Medical Services.			Executive member Resuscitation Council (UK) Member London BASICS (British Association for Immediate Care) Honorary Consultant London's Air Ambulance		
Peter Suter	12/01/2012	✓							

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING
Part I

DRAFT Minutes of the meeting held on Tuesday 13th December 2011 at 10:00 a.m.
in the Conference Room, 220 Waterloo Road, London SE1 8SD

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Present:	
Richard Hunt	Chairman
Peter Bradley	Chief Executive Officer
Jessica Cecil	Non-Executive Director
Mike Dinan	Director of Finance
Martin Flaherty	Deputy Chief Executive
Roy Griffins	Non-Executive Director
Caron Hitchen	Director of Human Resources and Organisation Development
Brian Huckett	Non-Executive Director
Steve Lennox	Director of Health Promotion and Quality
Murziline Parchment	Non-Executive Director
Beryl Magrath	Non-Executive Director
Fionna Moore	Medical Director
In Attendance:	
Sandra Adams	Director of Corporate Services
Lizzy Bovill	Deputy Director of Strategic Development
Francesca Guy	Committee Secretary (minutes)
Angie Patton	Head of Communications
Peter Suter	Director of Information Management and Technology
Members of the Public:	
Lynne Strother	Patients Forum
Julian Williams	LAS Commissioning Team
Minute 160 only:	
Russ Obert	Northrop Grumman
Ed Sturms	Northrop Grumman

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142. Welcome and Apologies

142.1 Apologies had been received from Caroline Silver.

143. Declarations of Interest

143.1 There were no declarations of interest.

144. Minutes of the Part I meeting held on 29th November 2011

144.1 The minutes of the Part I meeting held on 29th November 2011 were approved subject to two minor amendments.

155. Matters Arising

155.1 The following matters arising were discussed:

155.2 **112.5:** The Chair confirmed that he and Peter Bradley had met to discuss the recommendations made in the NAO report. This would be an ongoing discussion and would be considered in the context of the Trust's objectives for 2012/13. The Public Accounts Committee report and the report by the London Assembly would also need to be considered as part of this discussion.

155.3 **126.9:** The action for Steve Lennox to look into options for presenting patient stories at Trust Board meetings was ongoing.

155.4 **126.11:** Francesca Guy agreed to circulate the minutes of the Quality Committee on 15th November by the end of the week.

155.5 **126.13:** The Trust Board development session on quality governance was arranged for 19th December. This action was complete.

155.6 **128.5:** Martin Flaherty agreed to provide the Trust Board with a graph which showed hours produced against use of the DMP at the next meeting on 24th January 2012.

155.7 **128.6:** The action regarding the use of the balanced scorecard was ongoing. It was agreed that the new reporting format would be implemented from the start of the new financial year.

156. Report from Sub- Committees

156.1 The Trust Board noted the report from the Finance and Investment Committee meeting held on 28th November 2011.

157. Chairman's Report

157.1 The Trust Board noted the report from the Chairman.

157.2 The Trust Board agreed that it would be useful to hold a discussion on the strategy and marketing for the 111 non-emergency contact number. It was agreed that this would be discussed at a future Strategy Review and Planning meeting.

ACTION: FG to add 111 strategy and marketing to the forward planner for the Strategy Review and Planning Committee.

DATE OF COMPLETION: 24th January 2012

158. Update from Executive Directors

Chief Executive Officer

158.1 Peter Bradley reported the following:

- Performance had been above trajectory for November and December 2011 and Category A demand remained high with an increase of 3% on last year. The recent cold weather had contributed to an increase in calls and this was likely to be sustained throughout December. Staffing was robust although it was likely that the service would experience some difficulties on Christmas day and Boxing day;
- The day of industrial action on 30th November was a difficult day for the Trust and other

ambulance services nationally. Demand was higher than usual with only half of staff attending incidents, which resulted in a drop of 0.25% performance for the year to date. Acknowledgement was given to staff in the Control Room who responded well on the day, despite the difficult circumstances. The Trust would now be looking to identify any lessons learnt, particularly given that additional days of industrial action were planned for January 2012;

- Hospital handovers remained difficult and generally worsened at this time of year. The LAS was working with the commissioners to address this but it continued to be a difficult issue, with London being the worst area in the country for hospital handovers.

158.2 Lizzy Bovill reported that there was a permanent member of staff who was seconded to work on the improving hospital handover times. Action plans were in place and yet there had been as many breaches this year as there had been last year. The Trust lost approximately 6000 hours in November with staff waiting at hospitals to handover patients.

158.3 The Chair commented that, in his opinion, this was indicative of the problems associated with having a non-integrated demand chain, as every service provider in the chain focussed just on their individual part of the whole. Brian Huckett commented that current commissioning arrangements did not recognise the inefficiencies of third parties and asked whether this would change this year. Lizzy Bovill responded that currently there was a caveat for Category A performance with regards to delays at hospital of over one hour. This year's negotiations would recommend that this was brought down to 30 minutes. Steve Lennox noted that the LAS also had its part to play in reducing the number of patients inappropriately conveyed to an A&E department.

158.4 Martin Flaherty gave an update on the day of industrial action on 30th November. He stated that it was a very difficult day for the Trust and staffing had been very constrained. Planning assumptions had not been out of step with the national view and other ambulance trusts had experienced similar difficulties. Control Room staff had performed well although there was disappointment that staff had not responded to the appeal to return to work. Lessons learnt would need to be identified prior to the potential further industrial action that was planned for mid-January 2012.

158.5 Peter Bradley commented that initially Hayden Newton, Chief Executive of East of England Ambulance Trust, had been asked to undertake an external review of the events on the day, however, this was now being jointly undertaken with the SHA.

158.6 The Chair commented that he would have expected an immediate internal review to have taken place, with an analysis and lessons learnt. Peter Bradley agreed to take this forward and to share the report with the Trust Board.

ACTION: PB to undertake internal review of the day of strike action on 30th November 2011.

DATE OF COMPLETION: 24th January 2012.

158.7 Murziline Parchment commented that the key point was the fact that staff refused to respond to the appeal to return to work and the reasons for this needed to be fully understood as this is in conflict with what should be the instinct of a caring professional.

158.8 Beryl Magrath commented that the Trust Board should acknowledge the role of Control Services on the day and the part that they played. Beryl also supported the proposal to undertake an internal review.

Director of Finance

158.9 Mike Dinan reported that the financial risks remained the same as in previous months. The Trust had achieved 96.2% of its Cost Improvement Programme, which was an improved position.

158.10 The Chair asked whether there was any significant change in position from last year. Mike responded that the financial risks were similar this year to that of last year's.

158.11 The Chair asked whether the increase in Category A volume had had an impact on the financial position. Mike responded that attending Category A patients was more resource intensive. The full impact of the strike action on 30th November had also not been reflected in the financial position for the month.

158.12 Roy Griffins commented that it would be useful to have a profile of demand on 30th November. Martin Flaherty agreed to follow this up.

ACTION: MF to provide the Trust Board with a profile of demand on 30th November.

DATE OF COMPLETION: 24th January 2012

158.13 The Chair commented that the Strategy Review and Planning Committee should consider, at its next meeting, how best to use the balanced scorecard. The Trust Board should consider what action should be taken to recover any red rated Key Performance Indicators.

159. Clinical Quality and Patient Safety Report

159.1 Fionna Moore reported the following:

- The National Directors of Clinical Care discussed on a monthly basis the learning from Serious Incidents and any Rule 43 reports made to their services;
- The Demand Management Plan had been deployed much less in November than in previous months, which was indicative of the fact that the measures put in place to improve staffing had had an impact;
- A summary of findings from cycle six of the National Clinical Performance Indicators had been provided to the Trust Board;
- No controlled drugs incidents had been declared in the period.

159.2 Murziline Parchment noted that the summary of the findings from cycle six of the CPIs stated that there were some worrying trends and asked how much of a concern this should be to the Trust Board and what actions were in place to address this. Fionna Moore responded that the cycle 7 results were already showing some improvements.

159.3 Fionna Moore agreed to circulate the key messages from the recent consultation meetings. These messages would be incorporated into the training for training officers.

ACTION: FM to circulate the key messages from the recent consultation meetings to members of the Trust Board.

DATE OF COMPLETION: 24th January 2012

160. CommandPoint Update

160.1 Peter Suter reported that two successful technical cutovers had been undertaken which was encouraging, although these tests could only provide limited assurance as they could not reflect perfectly the live environment. In order to provide additional assurance, the LAS team would be provided with remote access to the Northrop Grumman development systems to undertake basic functional testing. In addition, an LAS team would travel to Chantilly in the first week of January 2012 to run scenario based testing in the factory prior to the software being delivered to the UK.

160.2 Peter reported that there were two key risks associated with the current proposed go-live date of 14th March. The first was that there was no contingency within the current plan, which was made more significant given that additional industrial action was proposed for January 2012. The second was that pressure to achieve operational performance targets might delay the final go-live on 14th March 2012. In order to mitigate both these risks, Peter recommended to the Trust Board an additional live run on 27th/28th March 2012, which would be the final stay-live date. This date would be three weeks ahead of the London Marathon, nine weeks in advance of the Queen's Diamond Jubilee celebrations and 17 weeks ahead of the London Olympics.

160.3 Ed Sturms commented that Northrop Grumman had reviewed the schedule and understood the prudence behind going forward with a final stay-live date of 28th March, although this did not mean that a go-live date of 14th March was not possible.

160.4 Murziline Parchment asked whether, if the Trust Board agreed to an additional live run on 27th/28th March, it would still be possible to have the final stay live on 14th March if everything went well. Peter responded that it would not be possible hence the final date of end March 2012.

160.5 Jessica Cecil asked whether, if the proposed industrial action went ahead in January and resulted in a day's worth of training being lost, this would result in a delay to the first live date of 14th March. Peter confirmed that, as there was no contingency in the current plan, it would result in a delay to final go-live.

160.6 Brian Huckett was supportive of the proposal of a final go-live of 27th/28th March, particularly in light of potential further industrial action and to mitigate the risks to achieving operational performance targets.

160.7 The Chair was supportive of this proposal but expressed the opinion that he would not like to think that there was any element of doubt remaining regarding the go live date of 14th March, but that the date of 27th/28th March was to allow 30 days of support to be properly planned.

160.8 There followed a discussion about how long it would take for users to become familiar with the new system. NG stated that users should be fully-functional in 2 to 4 weeks and Peter Suter stated that at the most, users should be comfortable in 10 to 12 weeks, which was 5 weeks ahead of the start of the Olympics.

160.9 Mike Dinan commented that this timetable was dependent on Northrop Grumman delivering a product that was of sufficient quality. Peter Bradley agreed and commented that so far the LAS had not received a product that had been fit for purpose and that the LAS would need assurance that faults would not continue to be found.

160.10 The Trust Board agreed the proposal to treat 14th March as an additional live run and that the final stay-live date would be 27th/28th March 2012.

160.11 The Trust Board agreed that it would need to hold an additional meeting in the week commencing 14th February to make a final decision on go live.

ACTION: FG to arrange additional Trust Board meeting for the week commencing 13th February 2012.

DATE OF COMPLETION: 24th January 2012

160.12 Peter Bradley commented that the recommendations from the serious incident relating to the first go live needed to be actioned before the second go live.

161. Foundation Trust Update

161.1 Sandra Adams reported that the Trust's Foundation Trust (FT) application had been discussed and agreed by the SHA's Capital Management Group and she had received confirmation that the application was now with the SHA's Capital Investment Committee. The Integrated Business Plan and Long Term Financial Model were currently being updated and the deadline for all application documents was 21st December in readiness to submit to the Department of Health on 1st January 2012.

161.2 Sandra reported that the Trust would be required to submit the Board memorandum and the quality governance assurance to the SHA in early January. She suggested that the Trust Board would benefit from holding an additional session to work through the Board memorandum. Sandra added that, following this timetable, the Trust could receive FT authorisation by September 2012, given that the Monitor stage could take up to 4 months.

161.3 The Chair stated that this was good news. Peter Bradley expressed his gratitude to Sandra Adams, Mike Dinan and Amanda Cant for their contribution and acknowledged that this was a big step forward.

162. Charitable Funds Annual Accounts 2010/11

162.1 Mike Dinan reported that the Charitable Funds Annual Accounts had received a clean external audit report and had been reviewed by the Charitable Funds Committee and the Audit Committee. The intention was to run down the fund and continue to use the fund for staff welfare and amenities.

162.2 The Trust Board approved the Charitable Funds Annual Accounts for 2010/11.

163. 7th July 2005 London Bombings Progress Update

163.1 Martin Flaherty gave an update on progress against the action plan arising from the 7th July 2005 London Bombings. He reported that 20 out of 29 actions were signed off as compete and of the remaining actions, five were related to technical changes that could only be brought live following the implementation of CommandPoint. A further two actions would be completed when the Major Incident Plan was published in January 2012. The expectation was that all actions would be complete once CommandPoint was implemented.

163.2 The Chair asked whether the fact that some of the actions had not been completed would have an impact should a similar incident occur. Martin Flaherty responded that the outstanding actions should not have a significant impact and that workarounds were in place in the Control Room for those actions which could not be completed until CommandPoint was implemented.

163.3 The Trust Board noted the progress made against the 7th July 2005 London Bombings action plan.

164. Standing Orders and Standing Financial Instructions

164.1 Sandra noted that the Trust Board had reviewed the Standing Orders and Standing Financial Instructions last year. The documents had been subsequently updated to reflect changes to the governance structure and the updates had been highlighted in yellow. An internal audit recommendation had been made to update the Standing Financial Instructions to include the Government Banking System and to reflect the terms of reference for the Remuneration and Nominations Committee. The anti-bribery section of the Standing Financial Instructions had also been strengthened.

164.2 Sandra noted that since the papers had been circulated, notification had been received of changes to the thresholds for contracts for supplies, services and works which would come into play in January 2012. These would be updated in the Standing Orders.

164.3 The Trust Board agreed the proposal to remove section 10.3 on 'Patient Led NHS and Practice Based Commissioning'.

164.4 Murziline Parchment asked whether there was an intention to appoint a senior independent non-executive director. The Chair agreed that this was the intention and he would follow this up.

ACTION: RH to follow up action to appoint a senior independent non-executive director.

DATE OF COMPLETION: 24th January 2012

164.5 Sandra Adams confirmed that paragraph 12.2.7b (all leases for property over £3 million in value over the life of the lease must be referred to the SHA for approval prior to commitment) would be removed once the Trust became authorised as a Foundation Trust.

164.3 Subject to these comments, the Trust Board approved the revised Standing Orders and Standing Financial Instructions.

165. Report from the Trust Secretary

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

166. Any other business

166.1 There were no items of other business.

167. Questions from members of the Public

167.1 Lynne Strother asked whether the 22 new ambulances that were due to be purchased would be built in the new design that won an award from the Design Council. Mike Dinan responded that this was still in the design phase and would need to be manufactured and tested before it was implemented. The new vehicles would therefore follow the existing design.

167.2 Lynne Strother asked whether there was any penalty attached to failure to implement CommandPoint. Peter Suter responded that if CommandPoint failed to go live in March 2012 then the contract with Northrop Grumman would need to be reconsidered.

167.3 Lynne commented that the Trust did not advertise how patients could write in to express their appreciation. Jessica Cecil commented that she ran the complaints system at BBC and that it was useful to run these side by side as it gave a good indication about how people felt about the service.

Angie Patton commented that there was an option on the website for patients to submit letters of thanks and this had increased the number of letters of thanks received. However, it was acknowledged that this would not be accessible to all our patients and therefore Angie suggested advertising this in Ambulance News.

141. Date of next meeting

141.1 The next formal meeting of the Trust Board is on 29th January 2011. An additional Trust Board development session would take place in the week commencing 13th February 2011.

142. Forward Planner

142.1 The Trust Board noted the forward planner.

142.2 Roy Griffins commented that it would be useful to circulate as soon as possible the suggested dates for the Trust Board development sessions.

DRAFT

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Signed by Chairman

ACTIONS
from the Meeting of the Trust Board of Directors of
LONDON AMBULANCE SERVICE NHS TRUST
held on 13th December 2012

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
03/02/11	**19.1**	**Questions from members of the public** AP to look into publicising case studies of patients who had received better clinical care as a result of being referred to an appropriate care pathway.	**AP**	**Angie Patton reported that it had been difficult to access case studies of patients who had received better clinical care as a result of being referred to an appropriate care pathway, but that it was still on her agenda. It was suggested that she contact Gary Bassett and report back at the next SRP. Outstanding.**
28/06/11	**67.3**	**Chairman's Report** RH to discuss world cities benchmarking with FM.	**RH/FM**	**RH and FPM reported that they would develop a plan to develop a small number of appropriate measures.**
27/09/11	**109.9**	MD to circulate the CQUINs and their worth to members of the Trust Board.	**MD**	**Complete via Finance and Investment Committee.**

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
27/09/11	**112.5**	RH/PB to meet to discuss whether there was anything further the Trust could be doing to meet the recommendations made by the NAO report.	**RH/PB**	**The Chair confirmed that he and Peter Bradley had met to discuss the recommendations made in the NAO report. This would be an ongoing discussion and would be considered in the context of the Trust's objectives for 2012/13. The Public Accounts Committee report and the report by the London Assembly would also need to be considered as part of this discussion.**
29/30/11	**126.9**	SL to look into options for presenting patient stories at Trust Board meetings.	**SL**	**Ongoing.**
29/30/11	**126.11**	FG to circulate the minutes of the Quality Committee meeting on 15th November to members of the Trust Board and to ensure that they are included in the Trust Board packs in future.	**FG**	**Complete.**
29/30/11	**126.13**	CH to finalise date for the Trust Board development session on quality governance.	**CH**	**Complete.**
29/30/11	**128.5**	MF to provide the Trust Board with a graph which showed hours produced against use of the DMP.	**MF**	
29/30/11	**128.6**	RH to discuss with Peter Bradley the decision to use the balanced scorecard as the primary review document for the organisation and how this would be taken forward in practice.	**RH**	**New reporting format would commence at the start of the financial year.**
29/30/11	**128.10**	MD to circulate the appendix on CQUIN risks to member of the Trust Board.	**MD**	**Complete via Finance and Investment Committee.**
29/30/11	**313.8**	PS to discuss with Beryl Magrath the cost of additional training.	**PS**	**Complete.**

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
13/12/11	**157.2**	FG to add 111 strategy and marketing to the forward planner for the Strategy Review and Planning Committee.	**FG**	**Complete.**
13/12/11	**158.6**	PB to undertake internal review of the day of strike action on 30th November 2011.	**PB**	**Complete.**
13/12/11	**158.12**	MF to provide the Trust Board with a profile of demand on 30th November.	**MF**	
13/12/11	**159.3**	FM to circulate the key messages from the recent consultation meetings to members of the Trust Board.	**FM**	**December edition of the Clinical Update emphasises the important messages from the meetings. Action complete.**
13/12/11	**160.11**	FG to arrange additional Trust Board meeting for the week commencing 13th February 2012.	**FG**	**Complete.**
13/12/11	**164.4**	RH to follow up action to appoint a senior independent non-executive director.	**RH**	

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 24TH JANUARY 2012

PAPER FOR NOTING

Document Title:	**Chairman's report**
Report Author(s):	**Trust Chairman**
Lead Director:	**-**
Contact Details:	
Why is this coming to the Trust Board?	**A standing Agenda item for the Trust Board – a summary of key meetings and activity in the month**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ 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:	**To note the report**

Executive Summary

Due to Christmas/New Year holidays, there is little to report since the last Trust Board meeting. A meeting due with Labour MPs was attended only by the Chief Executive as only two MPs were at the meeting.

Meeting with representative from RSM Tenon on the External Quality Governance

I had a long telephone call with Jim Myers, the Vice President, Civil Systems, Northrop Grumman after the resignation of Sir Nigel Essenhigh from NG UK.

I had a meeting with Professor Mike Spyer, NHS London Chairman.

Key issues for the Trust Board

Attachments

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Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

☒ To have staff who are skilled, confident, motivated and feel valued and work in a safe environment
☒ To improve our delivery of safe and high quality patient care using all available pathways
☒ To be efficient and productive in delivering our commitments and to continually improve

Risk Implications

This paper supports the mitigation of 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

NHS Constitution

This paper supports the following principles that guide the NHS:

☐ 1. The NHS provides a comprehensive service, available to all
☐ 2. Access to NHS services is based on clinical need, not an individual's ability to pay
☐ 3. The NHS aspires to the highest standards of excellence and professionalism
☐ 4. NHS services must reflect the needs and preferences of patients, their families and their carers
☒ 5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
☐ 6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
☐ 7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☒ No

Key issues from the assessment:

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 24 JANUARY 2012

PAPER FOR NOTING

Document Title:	**Chief Executive's report**
Report Author(s):	**Peter Bradley & SMG colleagues**
Lead Director:	**Chief Executive Officer**
Contact Details:	
Why is this coming to the Trust Board?	**For information and noting**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ 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:	**To note the report**

Executive Summary (PLEASE NOTE SOME ASPECTS OF THIS SUMMARY ARE REFERRED TO IN OTHER BOARD REPORTS AND NOT IN THE CEO REPORT)

- Members of the senior management team are now working on 2012/2013 business plan, budget setting and commissioning discussions for next year have also begun
- Further industrial action regarding pension reform has been deferred pending national talks and lessons learned from November 30th have been incorporated into LAS planning. An external review is currently underway and the LAS awaits any further findings and recommendations.
- The LAS FT application has been lodged with the Department of Health and we are now dealing with the issues they raise as they arise.
- The LAS remains on track to deliver its financial control total of £2.7m and at month 9 is reporting a surplus of £1.86m, with a surplus of £205k for December.
- Cat A performance for December was below target at 71.7% but above the agreed trajectory and 9% higher than last year. Overall Category A YTD performance remains strong at 75.8% at the time of writing and the Trust is aiming to stay above 75% now for the remainder of 2011/2012
- Utilisation remains unacceptably high and Hospital delays have caused significant problems over December and early January
- The LAS remains on track to go live and then stay live with Commandpoint on 28 March 2012.
- A Vehicle based equipment bag has been rolled out across the service reducing incidences of missing kit and the New Make Ready contractor has started the transition phase and will be fully operational by 1st March

- Sickness absence remains stable but slightly over target
- Proactive media work throughout December highlighted the issues of alcohol related calls with very positive coverage.
- Social Media coverage with the BBC on #crash24 produced excellent exposure for their service

Attachments

- Performance data pack
- HR data pack

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Strategic Goals 2010 – 13

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Risk Implications

This paper supports the mitigation of the following strategic risks:

☒ That we fail to effectively fulfil care/safety responsibilities
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☒ 5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
☒ 6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
☒ 7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☒ No

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING 24 JANUARY 2012
CHIEF EXECUTIVE'S REPORT

1. COMMISSIONING AND BUSINESS DEVELOPMENT

2012/13 contract negotiations have started with our NWL commissioners. We are looking to agree the cost, activity levels and expected quality by mid February. The key performance indicators have been set out in the DH Operating Framework and continue as 75% of Cat A calls attended in 8mins and 95% Cat A attended in 19mins by a vehicle which can convey the patient if necessary. CQUIN (Commissioning for Quality and Innovation monies) areas have been broadly agreed as reduced conveyance to emergency departments; increase Hear and Treat; increase our communications with GPs regarding patients with early signs of diabetes or hypertension and use of the NHS number and learning from patient experience.

With reference to our performance against the 11/12 contract we are performing well against the Key Performance Indicators and the CQUINs. Of particular interest is the continued reduction in conveyance to A & E Departments and increased use of appropriate care pathways. In addition, LAS now hold over 2500 end of life care plans on our systems which support crews to ensure that where possible a patient's wishes are carried out at the end of their lives.

2. INTEGRATED BUSINESS PLAN (IBP) DELIVERY PROGRAMME

The three programmes which make up the IBP Delivery Programme (Patient Care [SRO Steve Lennox]; Value for Money [SRO Mike Dinan]; Workforce and OD [SRO Caron Hitchen]) are progressing according to plan. Clinical leads are engaged in providing clinical quality assurance of CIP projects. Work to map interdependencies between projects looking out to 2016/17 will be finalised when the outcomes of the budget review process are known. Points of note are:

- **Patient Care Programme** –

- *Implementation of ACPs*: Falls referrals to GPs have increased to 943 for November 2011.
- *Implementation of NHS Pathways*: NHS Pathways will not be implemented into CTA by February. There are two main reasons for this. Firstly there is no link with AMPDS, therefore the triage algorithm would be re-started once a call is passed from EOC call handling, a situation that is clinically undesirable. Secondly NHS Pathways is not the stand alone system and has to be integrated into another system, preferably the CAD. This was not made clear when this objective was first agreed. An option has been investigated for an alternative product, however, due to the inability to fully link to the DOS, this is unlikely to be a viable solution.
- *CommandPoint*: Next steps are to test the latest release of software from NG and recover the shortfall in the training schedule to maintain the March go live.
- *Control Rooms (Bow as a 'hot' control)*: It has been agreed that Bow will be made technically ready (excluding geographical call routing) by the end of March 2012 and operationally live at the end of October 2012 when the control staff relocate into Bow.
- *FT Application*: The Trust and SHA submitted the FT application to the DH on 23 December. Additional information on CIPs and SIs was submitted w/c 28 December.

- **Value for Money Programme** –

- *Roster Optimisation Phase 1 project, Manage Unsocial Hours payments project and Review Management Overtime project*: All three now completed.
- *Incident Reporting*: Suspended as it is unclear on the future direction following a failed tender exercise.

- **Workforce and OD Programme –**

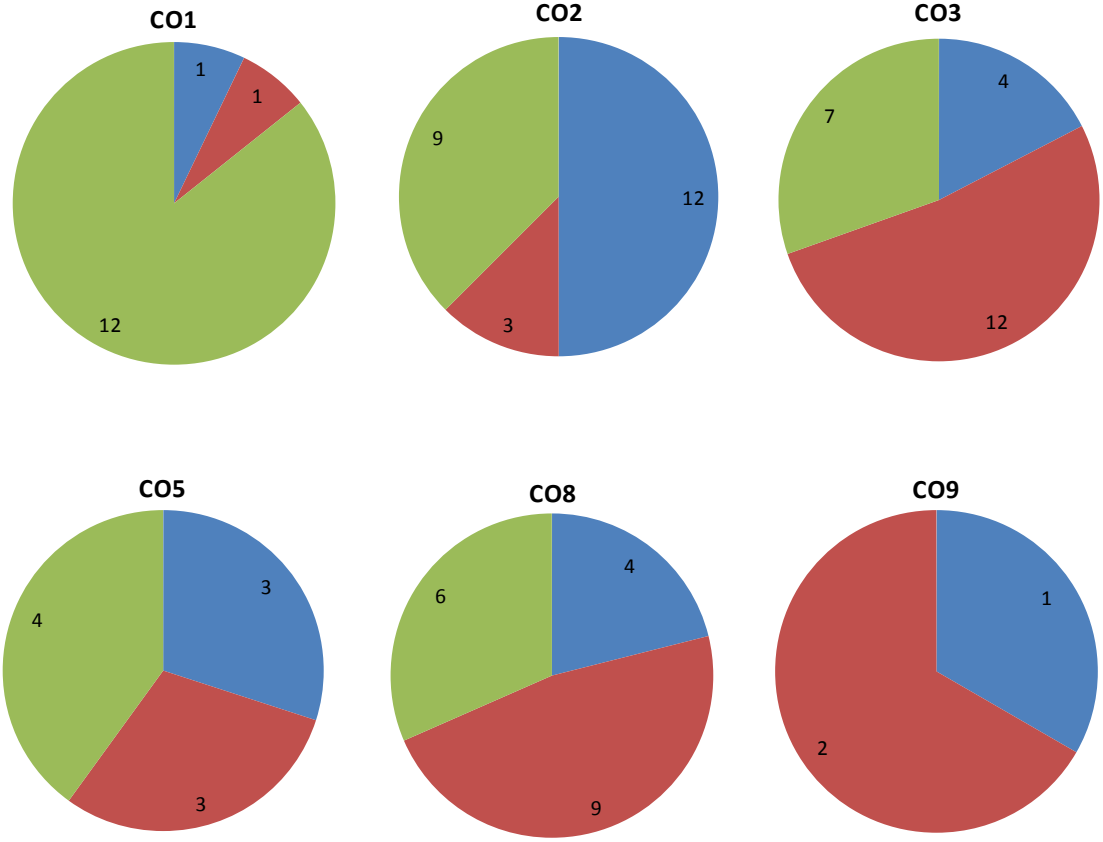
- *Estates Project:* two workshops have taken place to develop the Isleworth business case which should be complete by April 2012 to be approved by the relevant internal committees before going to the SHA.
- *NWoW:* the cluster proposal for the clinical tutors went live on the 5th of December with 14 further training officers covering all complexes across London (32 in total). The next step will be the completion of the Training Needs Analysis for all staff and development of their PDPs.
- *Clinical Career Structure*: a business case for the advanced paramedic role has been developed and included in the commissioning round. A working group is developing the scope of practice and tasking for the role in order to understand the intended benefits of introducing it.
- *Learning Management Systems*: The revised project plan was approved at project board.
- *Annual Leave Project*: The financial accruals can now be accurately predicted / forecast, however there are a couple of dummy reconciliations runs planned to test this.
- *Team Briefings*: Team briefings have been rolled out across the majority of non-operational directorates and an update has been requested regarding its status. The next steps are to roll out to the remaining directorates, as well as looking into ways to simplify and support the process (e.g. potentially establishing a central store of questions and answers following each month's briefing period).

3. BALANCED SCORECARD

Dashboard

The dashboard below shows the status distribution of performance indicators underlying the 6 'main' Corporate Objectives (CO) as at December 2011.

Green – target met; Red – target not met; Blue – information not provided[1]

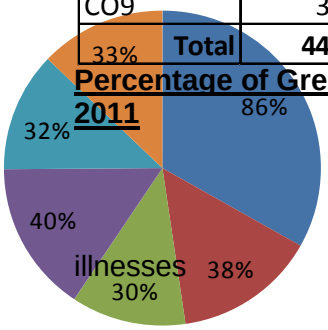


Comparison with previous month

November	Green	Red	Incomplete	Total
CO1	10	2	2	14
CO2	9	2	13	24
CO3	12	7	4	23
CO5	1	6	3	10
CO8	9	8	2	19
CO9	3	0	0	3
Total	**44**	**25**	**24**	**93**

December	Green	Red	Incomplete	Total
CO1	12	1	1	14
CO2	9	3	12	24
CO3	7	12	4	23
CO5	4	3	3	10
CO8	6	9	4	19
CO9	1	2	0	3
Total	**39**	**30**	**24**	**93**

Percentage of Green Status Performance Indicators per Corporate Objective – December 2011



To improve outcomes for critically ill or injured patients
To provide more appropriate care for patients with less serious illnesses
To meet response times routinely
To develop staff to have the skills and confidence they need
To use resources more efficiently and effectively
To maintain service during Major events

1. Except for the CO9 graph, which shows Blue – Target Met; Red – Target Not Met. Constraint of MS Excel

Care for Patients

CO1: % of patients with STEMI who receive an appropriate care bundle has returned to green status from a dip into the red last month. In total, 66% of patients were provided with the full care bundle or met the criteria for having valid exceptions to its provision against the target of 63%

CO2: % of patients not conveyed to ED has moved from green to red (marginal) this month

CO3: The Trust did not achieve the National Key Standard for Category A8 for the month of December ending on 71.7%, which was due to high demand; overall, December's Category A growth increased by 1.05% against that of last year. It would also be prudent to note that last year the Trust had experienced the worst adverse weather conditions seen for many years. YTD Category A8 performance April to December currently sits at 75.5%

Category C1 (72%) and C2 (74%) 20 minute response times are significantly below the 90% target. Information on C3 and C4 targets has not been provided.

FRU mobilisation from Station was just above 27% (target 25%) and shows signs of improvement as this is the lowest percentage in the last three months. FRU utilisation 45% (target 40%) and Ambulance utilisation 83% (target 55%) are both over target as a result of increased demand. Staffing hours for AEU and FRU are both below the 100% target, AEU at 92% and FRU at 96%.

The job cycle time has an upward trend over target from 66 minutes in August (on target) to 67.8 minutes in December. Similarly, the vehicle of the road percentage is gradually increasing from 4.1% (just over target) in August to 5.39% in December.

CO4: Incident reporting remains below target, with no figures available for December 2011, this will be followed up and reported back to the Board.

Good for Staff

CO5: December shows an improvement in the number of green performance indicators; where targets for operational staff receiving two CPI feedback sessions per year were met for the first time this financial year and CPI completion and compliance continues to meet target.

The % of staff attending training courses is reported as status Red. The number of student paramedics who have completed their training is reported as status Amber due to Student Paramedic deferment. 310 staff in total have now completed their 3 year programme.

The proportion of annual priority training commitments (CSR1 & 2) delivered was less than optimally attended due to numbers of staff unavailable on rostered training days. In January 2012, the Cluster model takes over CSR delivery and we expect to see an improvement in population of CSR courses.

Value for Money

CO8: December shows an improvement in value for money performance indicators, due to meeting the YTD CIP target, which had been below target for the previous three months and information provided by IM&T on CAD Performance, which was incomplete for the previous month.

Improve Engagement – Service Experience

The Learning from Experience group reviewed the Q2 integrated report on complaints, incidents, PALS and claims at the November meeting and a further review of themes and trends is planned for January 2012.

The Director of Clinical Quality will be taking forward some work on staff attitude and behaviour as this has the most common complaint from the public in the past.

Work is ongoing in monitoring progress with SI investigations, recommendations and actions and the LfE group will monitor the impact/outcome of these on the patient experience.

4. SERVICE DELIVERY

Accident &Emergency service performance and activity (see attached information pack)

Performance Overview

The table below sets out the A&E performance against the key standards for Category A for October and November and the first 17 days of November 2011

	Cat A8	Cat A19
Key Standard	**75%**	**95%**
October	75.4%	99.2%
November	76.3%	98.7%
*December (Data to be validated for end of month)	71.7%	98.9%

Please note that some data is still being inputted for December which means that some areas of the information pack are not showing full data for December.

Overall incident activity levels remain at circa 3% lower than last year however it should be noted that this masks an increase in 999 Call volumes of circa 7% and an increase in Cat A volumes of circa 11%.

The overall reduction in incidents is of course driven in the main by our much increased focus on 'hear and treat' during this year. Of particular concern is the increase in Cat A volumes which is also being experienced to varying levels in other ambulance trusts. It is difficult as yet to be clear on what is driving this increase and whilst we accept that a small amount is driven by coding changes in April 2011 and by changes to the management of Met Police Calls, more work needs to be done to fully understand the drivers for the increase.

It is pleasing to note that the service continues to reach more Cat A patients in 8 minutes than ever before this year but it remains our most expensive and resource intensive type of response.

The Trust maintained above trajectory performance and achieved the National Key Standard for Category A performance for the months of October and November.

December was of course more difficult given increased workload and problematic staffing over the holiday period. I am pleased to report however that we achieved 71.7% Cat A performance which was above the trajectory of 70% set with our commissioners and indeed over 9% better than that achieved last year. Overall activity in December was down on the same period last year largely because we have not experienced the heavy snowfall of last year. It should be noted though that we still attended more Cat A calls than last year despite the improved weather which indicates that the overall upward trend is being maintained.

January has also started well with the Trust performing above trajectory for the first 12 days at 78.2%

The year to date CAT A performance at time of writing is 75.65%.

The Board should note that it is our intention to ask NHSL and our Commissioners to support us in advising DH that it is our intention to exclude the performance figures associated with the Industrial Action on the 30th November. Our Commissioners have already accepted that a Force Majeure clause in our contract will be applied locally omitting the day from any calculations made against local trajectories. If this is accepted by DH our year to date performance will improve by circa 0.2% to 75.85%

Call answering performance held up well in December at just over 95% in 5 secs and is at 95.3% ytd. This represents an excellent achievement and is a fundamental quality measure within the control room ensuring that patients do not experience delays in answering their 999 call.

As mentioned earlier, operational staffing has always proved difficult in December and particularly over the Christmas holiday period which this year fell across a weekend. There is more work to do to improve the current annual leave arrangements to maximise the numbers of staff available to operations at weekends. This increased pressure on resources led to delays and increased use of DMP in December following a general reduction through October and November.

Utilisation of both ambulance resources and FRU resources remains unacceptably high at 85% and 42% in December and is a reflection of both high base utilisation together with increased workload and reduced staffing during the holiday period. These high levels need to be addressed in 2012/13 if we are to be successful in reducing the numbers of staff who do not get breaks and who do not finish on time.

Hospital delays caused very significant problems throughout December and continue to do so in early January. The numbers of 60 minute breeches in December was at 306 down from 483 last year but still absolutely unacceptable and leading to significant lost hours to the LAS. January has started very poorly with 172 breeches in the first 11days. Extensive discussions are underway with commissioners to ensure that appropriate measures are taken with the Acute Trusts that regularly exceed the agreed thresholds. In overall terms the promises made that there would be significant improvements made this year have not been realised. This issue will now be the subject of increased focus in this years commissioning round as the LAS can no longer accept the clinical and operational risks associated with these long delays.

Fleet & Logistics

The Fleet and logistics restructure is proceeding and staff are progressively being assimilated into the new posts. The lead post of Assistant Director of Operations Fleet and Logistics has also now been advertised.

Overall VOR increased to its highest level in 18 months during December and there is also an increasing incidence of no available vehicle in January associated with significantly improved staffing and the related increase in peak vehicle requirement.

The situation will be eased by the provision of new vehicles through the final quarter and the overall fleet replacement programme is currently being reviewed by operations and finance.

Personal issue fuel cards have now been rolled out in the East Area and this work will continue through the remaining two operational areas with completion expected by end February.

The change of contract for Make Ready has now moved into the 'Transition Phase' with a confirmed start date of 1st March 2012. The steering group has been created and has begun work to ensure delivery against these timeframes. The contract provider has also now put in place a contract manager and general manager based at Cody road.

The roll out of the new equipment bags for each front line vehicle containing Airwave Radios and medical equipment for patient assessment has been completed and is bedding down. It has been well received and will resolve some of the issues associated with the unavailability of this equipment.

Emergency Preparedness

New Years Eve

Following the normal extensive planning in cooperation with the Metropolitan Police (MPS), St John Ambulance and the British Red Cross, the Trust had a successful New Years Eve Night into New Years Day.

ADO John Hopson was Trust Gold for the event this year. Incoming call demand was slightly down from last year to 7208 mainly due to a reduction in demand from the MPS. It should be noted however that incoming call demand was above 500 calls per hour for the first 4 hrs of New Years Day peaking at 638 in the 2am hour. It is a credit to all staff who were working but in particular EOC staff and the provision of a well staffed clinical hub led by Deputy Medical Director Fenella Wrigley that allowed us to manage this incredible workload in a clinically safe manner.

500,000 people attended the central London events on NYE and our operational staff and managers did an exceptional job in difficult circumstances. Treatment Centres were established within the event footprint and some 275 patients were treated on site with only 55 requiring transport to hospital.

A series of exercises have taken place during December including:

- A live exercise to test the response to a major road traffic collisions in the Blackwall tunnel,
- A live Urban Search and Rescue exercise at the Lincolnshire Fire and Rescue Training Centre
- Several Olympic Test events..

The revised Major Incident Plan will be presented to ADG during January for final consideration subject to approval by the SMG. It will then be published and disseminated across the Trust and key partners.

5. PATIENT TRANSPORT SERVICE

Commercial

The London Ambulance Service has submitted a tender for managed service provision of transport as part of the London Procurement Programme on 6 January 2012. The purpose of this tender is around management of all transport requirements including, non-emergency PTS, couriers, taxis and shuttle buses for the following NHS Trusts;

- Barnet, Enfield & Haringay Mental Health Trust (existing business);
- Camden & Islington NHS Foundation Trust (new business)
- Central & North West London NHS Foundation Trust (new business);
- East London Foundation Trust (new business); and
- Homerton University Hospital NHS Foundation Trust (new business).

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If successful in winning these tenders, over the lifetime of the contract, there will be a shift away from direct delivery of some of these services. The LAS will become responsible for ensuring the quality of delivery and the distribution of work although this may be to other transport providers especially in the area of couriers, taxi and shuttle bus, if this is more cost effective.

A Preliminary Qualifying Questionnaire (PQQ) has been accepted and we are considering submitting a tender for PTS for Surrey. This work is currently undertaken by G4S. The tender is split into 2 lots with the 2nd lot containing journeys from South West London some of which are completed by the LAS.

North West London Hospitals NHS Trust, which consists of Northwick Park, Central Middlesex and Ealing Hospitals have advertised a new tender and a PQQ has been submitted. We are currently investigating with other providers whether a joint bid would be advantageous with the LAS managing the contract and providing ambulance cover. The other party would deliver the taxi services and walking patients.

Activity and Performance

Activity in December fell sharply to 13,395 journeys which has had an effect on expected income for the month.

The quality indicators for December were maintained at the levels recorded for November in all 3 areas and were:

• Arrival Time: 91%
• Departure Time: 92%
• Time on Vehicle: 95%

6. Information Management and Technology

Power Issues in the main Data Centre

There have been two issues relating to power in the main data centre, each causing the Control Room to have to revert to paper operations. By way of explanation, the Data Centre is protected in its entirety by the main building UPS (Uninterruptable Power Supply), this provides resilience in terms of a power cut to the building. Each equipment rack in the data centre is then fitted with its own individual UPS to allow local power work to be undertaken without effecting services. There is also an

additional benefit of providing reliance should the main building UPS ever fail (as it did when it previously caught fire in November 2010). However, there have been several occasions where individual UPS failures have caused loss of service.

On Friday 23 December at 11:30 one of the rack UPS's failed causing a partial loss of equipment in one rack. This resulted in a large number of Control Room workstations losing connection to the system. The control Room immediately reverted to paper operations. The fault was diagnosed, the faulty rack UPS was bypassed and removed from circuit and full service was restored at 13:00hrs. An assessment was undertaken as to the best course of action over the impending Christmas period. Given that the rack UPS is designed to provide support when power work is undertaken and not required for normal operations it was decided to leave the rack without a rack UPS in circuit. Additional checks were carried out overnight and into Christmas Eve, no further problems arose.

On Friday 30 December at approximately 10:00 the faulty rack UPS was replaced with a new unit that had been previously on test for several hours including full load testing. This was done without service interruption which is a feature of the design. At 13:55, the new rack UPS failed, however, on this occasion the failure caused a complete loss of the HQ CAD service. The Control Room reverted to paper. The rack UPS indicated a failure condition. It was bypassed and taken out of circuit. It was found that the main supply to that rack had also tripped causing the complete failure of the rack. Full service was restored to the Control room at 15:55. Once again additional checks were put into place to ensure that the environment remained stable.

Based on investigations from the supplier and the manufacturer, engineering information suggests that this second failure was more likely to have been caused by faulty components within the new UPS, rather than an external problem causing the UPS to fail. A plan is currently being developed to replace the rack UPS, also an electrical engineering review will be undertaken to ascertain the current suitability of the overall electrical design of having the secondary rack UPS's in circuit.

Airwave

There has been excellent progress with regard to the Airwave radio communications system. During the New Years Eve celebrations 2010/11 there were problems with the system that caused concern over its ability to cope during times of peak loading. Meetings took place with Senior Executives from Airwave in January 2011 and a wide-ranging plan was developed to improve the overall service. This was lead by Airwave's Chief Technical Officer and a steering group that included Airwave's CEO was established to oversee the necessary sequence of activities. This included a review of all services, system and network upgrades and a review of our operating practices. Airwave also provided a stand at all of the CEO's consultation meetings at Complexes and EOC to meet staff and assist with general problems and queries. The London Marathon, Royal Wedding, Notting Hill Carnival and the Civil Disorder in August were all significant events that were milestone achievements in the improved use of Airwave. The ultimate test was across the New Years Eve celebrations 2011/12, and it is pleasing to report that the use of the system was successful with no problems reported.

MDT Maintenance

In December 2011, a new maintenance contract was signed with Telent to provide hardware maintenance and support for MDT's. All faults are now reported online by the LAS Vehicle Resource Centre to Telent, who then despatch mobile engineers to

meet Ambulances /FRU's at pre-determined locations to effect the initial repair. If the fault is more complex then there is a fixed workshop location available. There are clear SLAs in place and to date the service is working effectively. By April, the service will move to full 24 hour operation. This new approach of mobile support and extended hours of operation rather than a single fixed location will provide significant benefit in reducing VOR.

7. HUMAN RESOURCES

Workforce information

Highlights from the attached workforce information report are:

Sickness absence

Sickness absence for the Trust as a whole has remained largely static from August (5.11%) through to November (5.15%). The YTD figure at 5.12% remains just above the target for 2011/12 of 5% or below. As reported previously, many of the long term absences are attributable to serious illness, so we cannot expect rapid improvements. The RAG rated audits continue to show that, in the main, all absence is being managed appropriately and in accordance with the Managing Attendance Policy (MAP).

Sickness in the Areas fell slightly October to November, and at 5.15% matched the Trust total for the month and at 5.17% just above the Trust YTD figure. There was again some disparity between the Areas (October's figures in brackets); East at 5.9% (5.72%), South at 5.34% (5.53%) and West at 4.27% (4.52%).

In November sickness fell in Control Services 5.27% (6.06%), YTD 5.86%. An increase was seen in long-term sickness but a marked decrease in short term absence.

Although a reduction was seen October to November PTS sickness remained high 9.15% (9.52) Short-term absence decreased slightly and long-term absence increased. The detailed report overleaf shows that December's figures are expected to show an improvement. All cases are being managed appropriately through the MAP.

Unauthorised Absences

Unauthorised absences fell dramatically in December to the lowest figure for the year. At present no explanation can be found for this improvement. Management action in Control Services, including overtime bans for repeat offenders, continues.

Vacancies and Turnover

As at 31.12.11, the vacancy level of frontline staff was 99 wte. If turnover remains at current levels we would anticipate an end of year vacancy level of c135 wte.

Turnover in December was within normal range. Year to date levels are also within normal range.

PDR completion

A manual reconciliation of PDR completion rates is currently being undertaken. Early indications show an increase in completion rates in some areas from those reported previously. A full report will be provided following year end.

Health Safety and Risk – incident reporting

Manual Handling Update

The number of reported incidents has risen against the same period last year with the East consistently reporting more incidents - East 23, South 8 and West 14.

The pilot of the chair transporter will conclude at the end of March.

Abusive Behaviour Update

The numbers of incidents where staff are verbally abused or threatened is consistently lower than this period last financial year with the overall trend decreasing.

Physical Assault and Security Update

The numbers of reported physical abuse has decreased compared to the same period in the last financial year with an overall downward trend.

An abusive frequent caller (whose habit is to call from public spaces and usually to have members of the public call the service on his behalf and who abuses and threatens the crews who attend) was reported previously as having been given an eight week custodial sentence for homophobic abuse on 19/09/11 and has assaulted another crew member following his release. He was arrested and charged with common assault. We are also working with the Croydon police to apply for an "on-conviction" Anti-Social Behaviour Order to strengthen the future management of this individual.

A member of staff was assaulted on 2nd January 2012. The assailant was arrested by police but following interview was released with no further action as it was deemed not to be in the public interest to pursue a prosecution. Understandably the member of staff is upset and the Local Security Management Specialist is gathering evidence to seek advice on the possibility of pursuing a private prosecution.

There are a number of cases of assault against crews which are currently being investigated by the police or are awaiting court hearings. A man received a 4 month community order for a verbal abuse 28th October 2011 on a member of staff. He was prosecuted under the Public Order Act.

Stonewall

The London Ambulance Service is celebrating being named among the country's most gay-friendly workplaces.

It is the first time that the organisation has made Stonewall's Top 100 Employers list and was this year the only ambulance service and the only London emergency service to do so.

The Service took 94th place in the 2012 list, which was announced earlier this week.

Training and Education

The interim cluster arrangements went live on 6 December 2011with18.5 WTE training officers working alongside the clinical tutors to deliver cluster based education at Complex. The programme includes the NWoW training programme, Core Skills Refresher (CSR) and EMT 4 training. The cluster AOM's became accountable for these elements of clinical education from January 2011. The aim of the clusters is to deliver more training and education (especially CSR) locally thus improving access and attendance.

Possibility of future industrial action

Following the national public sector day of action on 30 November, joint discussions on pensions reform between the Government and the Trade Unions recommenced. In terms of the NHS Pension scheme, this resulted in "Heads of Agreement" being accepted by the majority of health unions as being the best that could be achieved by negotiation. In view of this, these unions agreed to discuss within the individual national executive groups whether the Heads of Agreement formed the basis of further and more detailed discussions about the proposed reforms.

Unison and GMB have now announced that they will engage in further national discussions, and that industrial action will be deferred pending those talks. This removes the possibility of industrial action by those unions in January. Unite did not accept the Heads of Agreement as forming the basis for discussion and did not take them to its Executive. There has been no announcement as to any plans for further industrial action by Unite.

Planning for future action, drawing upon the experience of 30 November, had commenced and continues regardless of the current "pause". The existing ballots conducted by the unions remain "live" whilst the Trade Dispute (pension reform) remains. In addition, Unison's ambulance sector nationally has conducted a further ballot, of ambulance members only, asking whether they would be willing to take action short of strike action. The majority is in favour so this remains a possibility, for Unison only, should further action follow.

The Trust continues to attend and support the NHS London IR reference group, and all formal joint consultative arrangements will continue.

8. SERIOUS INCIDENTS

We continue to make good progress with SI governance and management. Reports are investigated and finalised in a more timely and thorough manner and the review process is much more robust. Analysis of the time taken to investigate and report an SI shows that, in April 2011 we were taking approximately 6 months to complete an SI, however this had improved to 2 months by October. There are currently 11 serious incidents under investigation, with a further 2 declared in January 2012. The recently declared serious incidents concern an error in triage of a call resulting in a delayed response; and the loss of two patient record forms. Two serious incidents are included in Coroners' cases and are likely to attract external stakeholder and media interest.

9. COMMUNICATIONS AND ENGAGEMENT

Stakeholder relations

Publication of London Assembly's review: The Health and Public Services Committee published its review into the London Ambulance Service. It made a number of recommendations having considered the operational, financial and organisational challenges facing the Service.

The committee accepts that the London Ambulance Service should remain part of the NHS; however, it has recommended that the Service develops closer working relations with the Mayor, the London Assembly and other emergency services to find efficiencies. The Service will now consider the recommendations in detail and respond to them in the next few months.

Media coverage of the report focused on the Service combining premises with the fire service, and the unnecessary number of requests for assistance made by the police to the Service.

Visit of Health Minister: Minister of State for Health, Simon Burns, visited the Service to hear about its planning for the 2012 Games. Mr Burns had a tour of the event control room in Bow which will be used to manage the day-to-day response to the Games.

Reputation and issues management

Alcohol-related incidents: A proactive programme of media relations activity took place from the end of November and throughout December to highlight how the Service deals with the increase in alcohol-related incidents over Christmas, and to highlight the health risks to people who drink too much.

Approximately 60 minutes of radio and TV airtime was given to this issue – up from 20 minutes last year. And the Service was given over 65 name checks (last year 40) in 55 media items (up from 35 last year). Coverage was overwhelmingly positive.

The media work was supported through social media activity, and the Service Twitter page gained 735 new followers between 7 December and 1 Jan, largely as a result of the alcohol-related messages that were posted.

Media

Handover of patients at hospital: The BBC used data obtained under Freedom of Information to highlight the delays that ambulance staff across the country face when attempting to hand patients over at hospital. A key aspect of the reporting was that the London Ambulance Service experiences more delays in handing patients over at hospital than other ambulance trusts, and almost half of patients taken to hospitals in the capital wait longer than 15 minutes to be assessed. See coverage in table below.

Inquest verdict into death of Shannon Powell: The tragic death of 14-year-old Shannon Powell who died following a running race at Trent Park was widely reported following the inquest verdict.
While the coroner stated that the significant delay in getting her to hospital caused her death, he said that the ambulance could not have arrived any earlier given the information available to the crew, the fact that the gates were locked, and that the event organisers had given 'little or no thought' to what would happen if an

ambulance was needed. Ambulance staff were at the park within nine minutes of the 999 call being received, but had difficult getting access. The Service has contacted LBC radio and the Daily Mail following their unbalanced reporting from the inquest, specifically in relation to issues regarding health and safety.

Social media

#crash24: The Service worked with the BBC on an innovative social media initiative looking at the scale of road collisions in the UK. As part of #crash24, the BBC joined the Service on 6 December to get an insight into a typical day on London's roads and the dozens of collisions staff attend.

Over a 24-hour period the BBC ran a live feed on its website, which was updated with reports from journalists who attended crashes with our staff, as well as advice, facts and figures, and messages from the public. This was supported through radio and TV interviews.

Outcome:

- Feature on main BBC homepage (5th most visited website in world)
- Main story on BBC News Online homepage (14m users a week)
- Most read story on BBC news online between 1-3pm on 6 December
- Almost 700,000 visitors to live feed
- #crash24 trended on Twitter – ie it was on one of the most talked about topics on Twitter in the London area
- 280 tweets made by Service, and 400 followers gained
- 64% increase in visitors to Service website

PPI & Public Education Activity

Activity for the calendar year (2011) showed that there were 894 PPI and Public Education activities recorded on the database; of these, the Service attended 708.

This represents a wide range of activities, but 84 were knife crime talks and 134 were basic life support/ CPR sessions. The Trust took part in 29 Junior Citizen schemes across London over the year (aimed at 10 and 11 year olds) and 21 events involving people with learning disabilities.

A number of events focused on road safety, including five "Safe Drive, Stay Alive" events, which are hard-hitting participative theatre events for 16-18 year olds about the risks involved with driving.

Staff involved in public education work

Approximately 600 members of staff have registered their interest in taking part or organising public education activities on behalf of the Service. Of these, 45 did over 25 hours of public education work during 2011, mainly in their own time. They have received certificates in recognition of this commitment. Five members of staff did over 100 hours' public education work over the year, and have been presented with a gift.

Key initiatives for 2012

- The PPI & Public Education team now has a Public Education Officer (John Wright) focusing particularly on knife crime prevention initiatives. Over the last year he has built up key relationships across London with Youth Offending Teams, Pupil Referral Units, youth services, schools and colleges. During 2012

he will focus on other vulnerable groups such as young people leaving care, and children in primary schools.

- The next Community Event (replacing the Patient Care Conference) will be held in the Camden & Islington area in the spring.

- Picker Europe are conducting a national patient experience survey of non-life threatening callers. The pilot was carried out in December (of calls from October) and the results will be available from mid-January. Feedback from the pilot will be used to finalise the design for the full survey, to be conducted in the spring.

- A plan is being developed for stakeholder engagement around some of the Trust's key developments, e.g. the Clinical Response Model and Estates Strategy. This is to include wide-ranging patient and public engagement activities.

Peter Bradley CBE
Chief Executive Officer
16 January 2012

London Ambulance Service
NHS Trust

Information Pack for Trust Board

December 2011

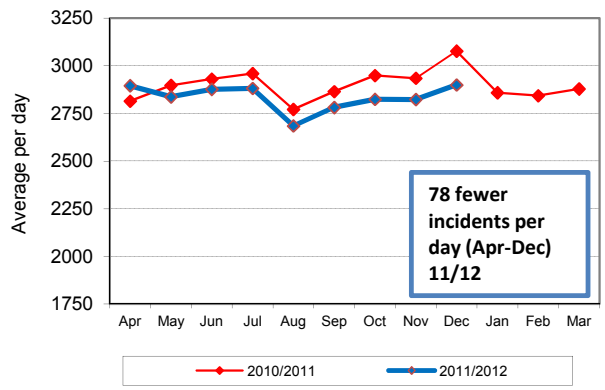
PRF's not complete

No conveyance to non A&E

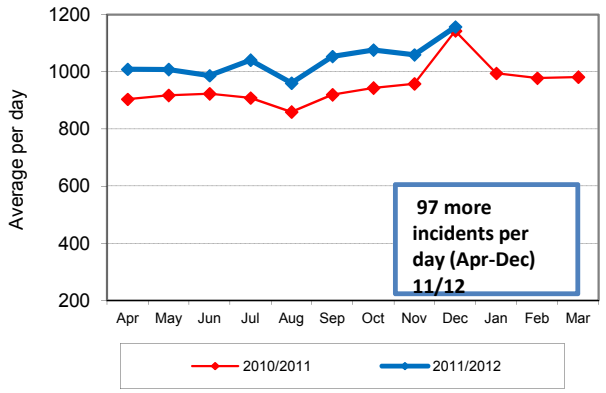
Patients Conveyed to Non A&E Hospital
Handover times based on 1st to 25th December

London Ambulance Service NHS Trust
Accident and Emergency Service
Activity / Call Process -
December 2011

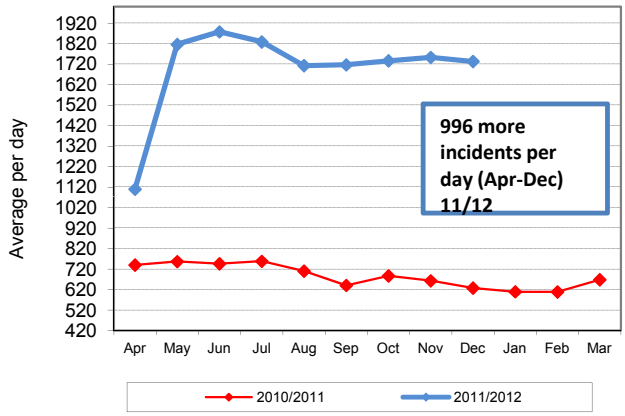
Graph 1
Average number of Total incidents per day



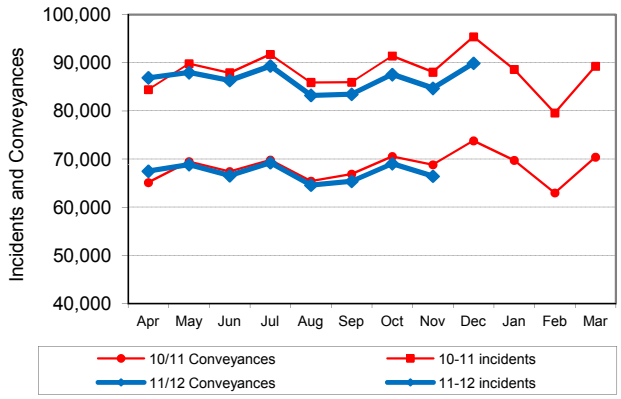
Graph 2
Average number of Cat A incidents per day



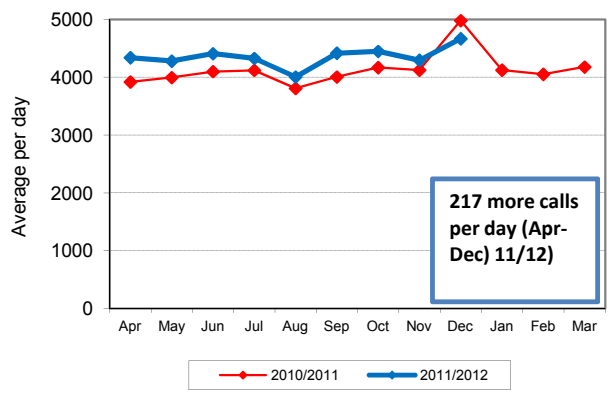
Graph 3
Average number of Cat C incidents per day



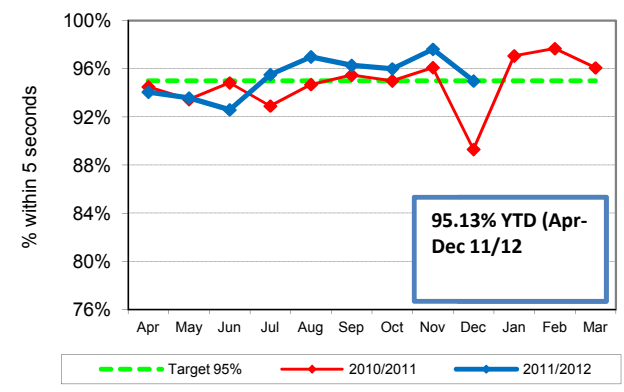
Graph 4
No of incidents conveyed



Graph 5
Average number of 999 (+ MPS) calls received per day

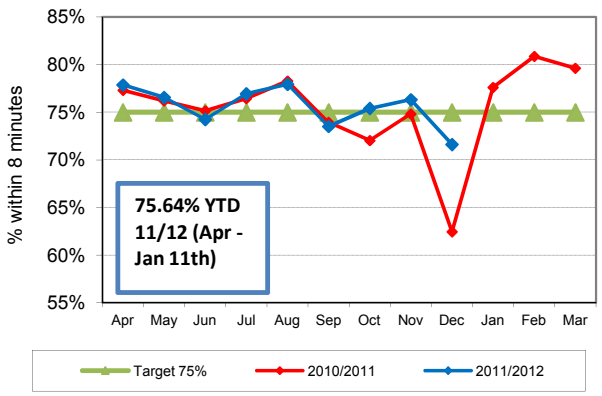


Graph 6
Percentage of calls answered within 5 seconds

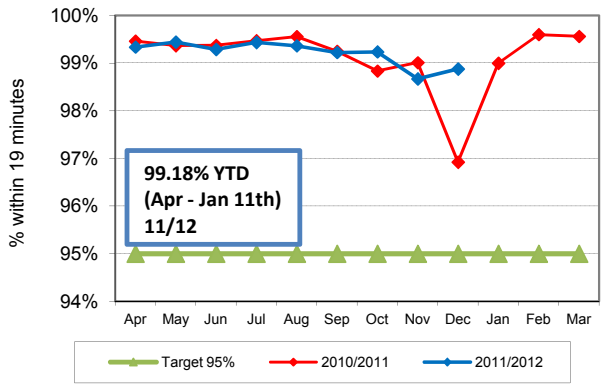


London Ambulance Service NHS Trust
Accident and Emergency Service
Performance - December 2011

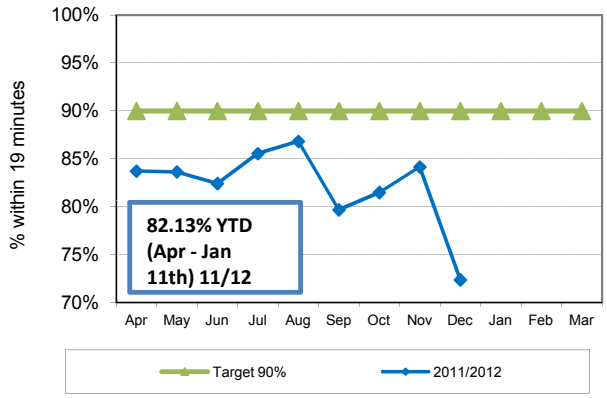
Graph 7
Category A 8 minute performance



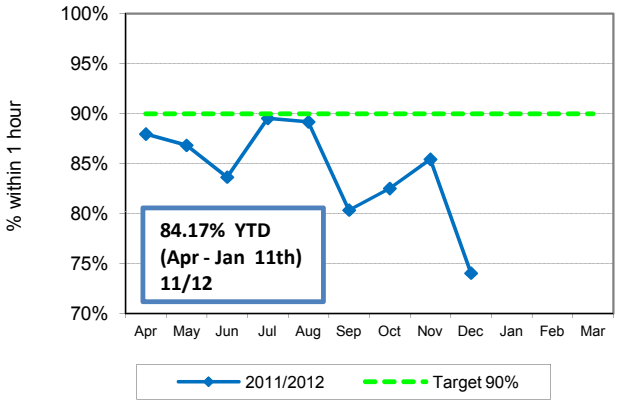
Graph 8
Category A 19 minute performance



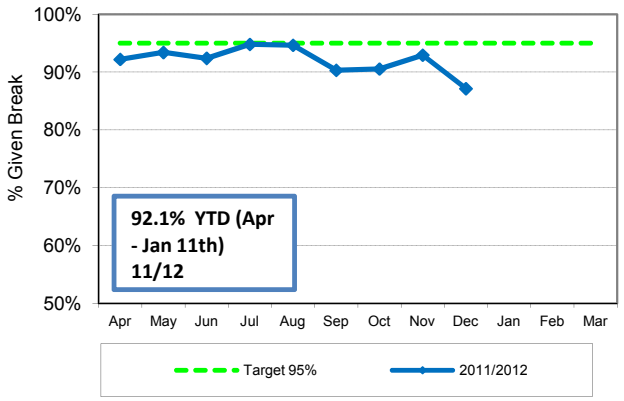
Graph 9
Category C1 20 minute performance
(Incidents responded to only)



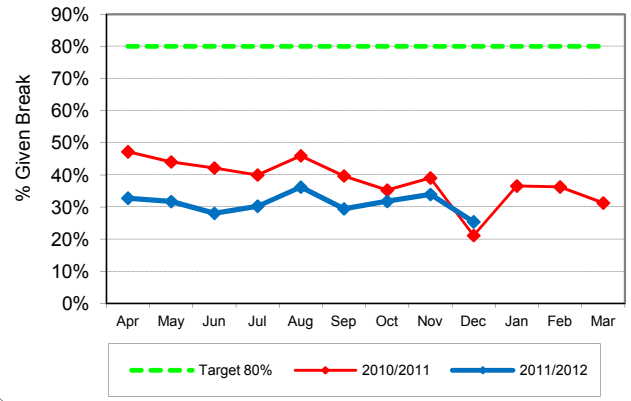
Graph 10
Category C2 30 minute performance
(Incidents responded to only)



Graph 11
Cat C incidents 60 Minute Performance
(Incidents responded to only)

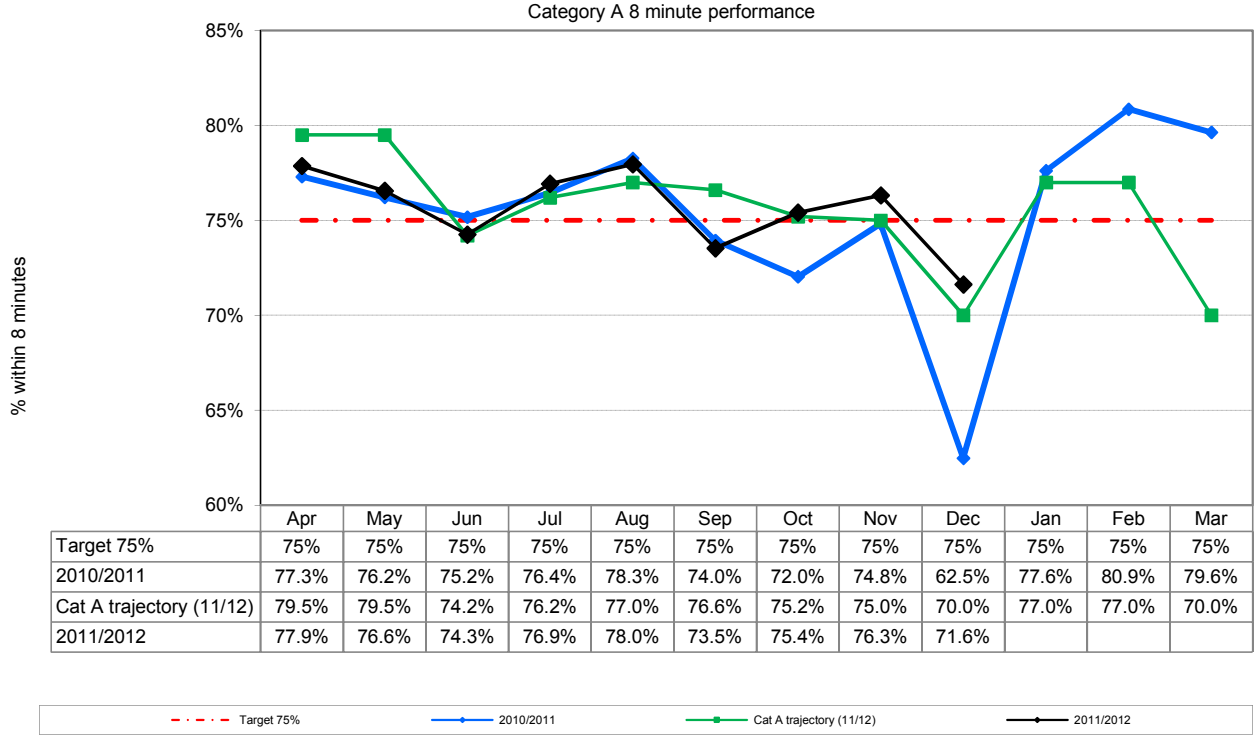


Graph 12
Rest Breaks Given



London Ambulance Service NHS Trust
Accident and Emergency Service
Performance - December 2011

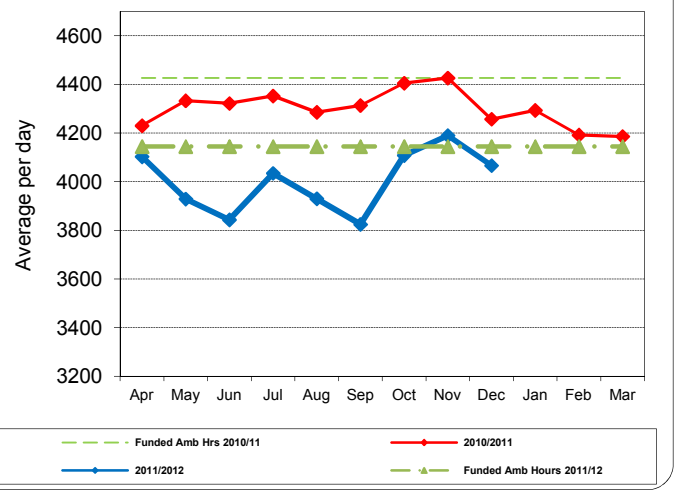
Graph 13
Category A 8 minute performance



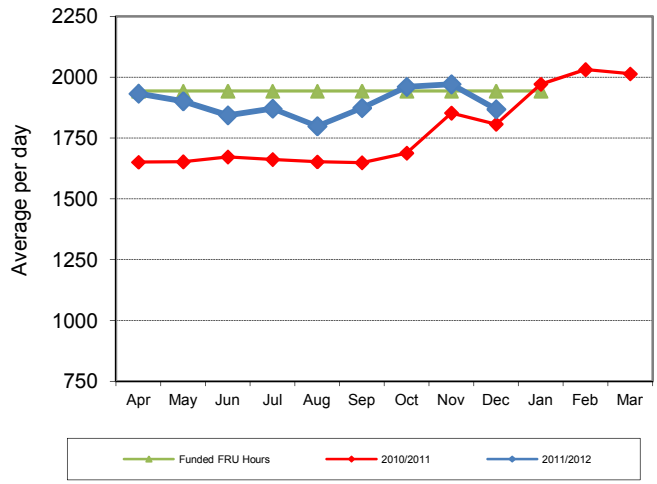
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target 75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
2010/2011	77.3%	76.2%	75.2%	76.4%	78.3%	74.0%	72.0%	74.8%	62.5%	77.6%	80.9%	79.6%
Cat A trajectory (11/12)	79.5%	79.5%	74.2%	76.2%	77.0%	76.6%	75.2%	75.0%	70.0%	77.0%	77.0%	70.0%
2011/2012	77.9%	76.6%	74.3%	76.9%	78.0%	73.5%	75.4%	76.3%	71.6%			

London Ambulance Service NHS Trust
Accident and Emergency Service
Efficiency and Effectiveness - December 2011

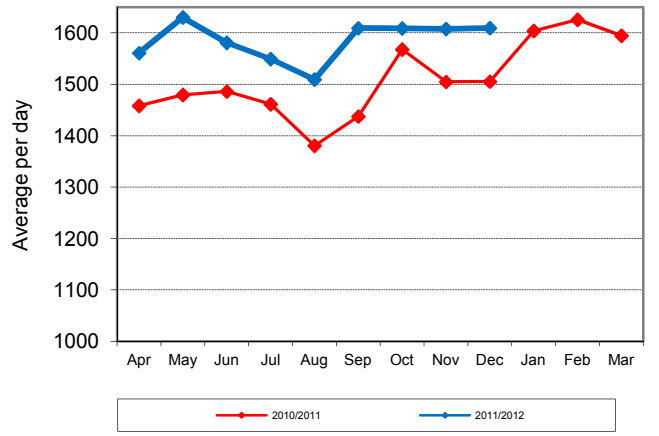
Graph 14
Ambulance Hours average available per day



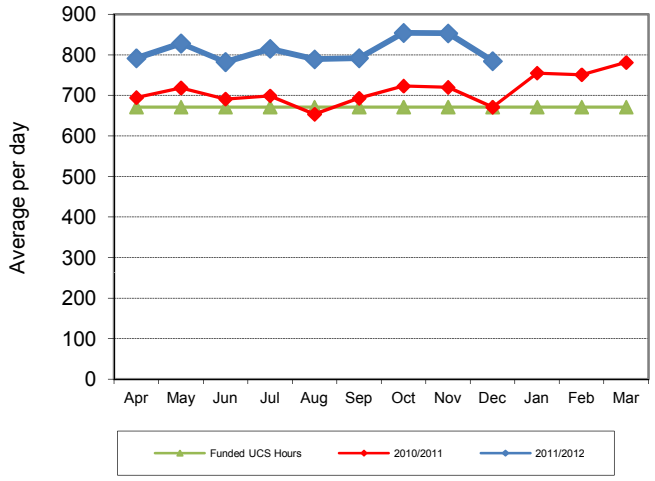
Graph 15
FRU hours average available per day



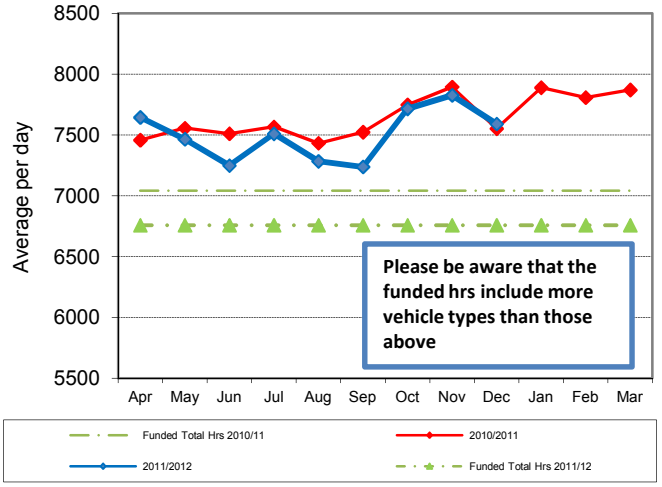
Graph 16
EOC hours staffed per day



Graph 17
UOC Hours average available per day



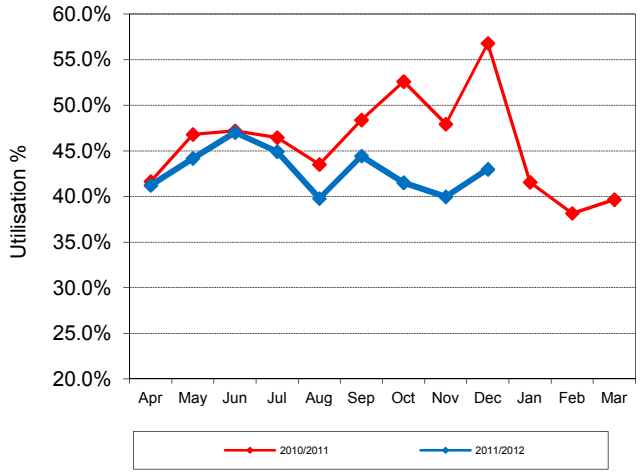
Graph 18
All Vehicle Hours average available per day



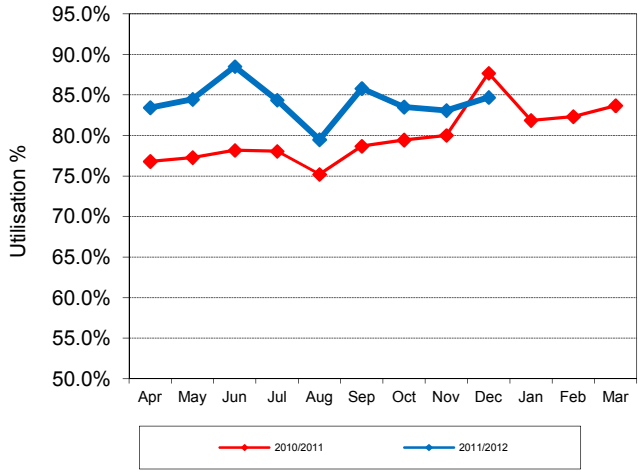
includes other vehicle types other than those above

London Ambulance Service NHS Trust
Accident and Emergency Service
Efficiency and Effectiveness - December 2011

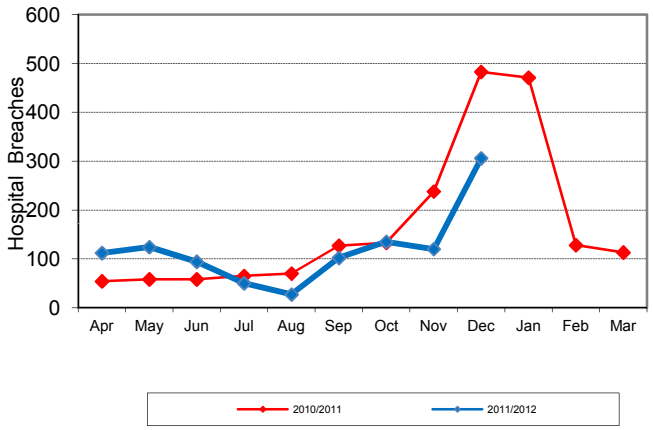
Graph 19
FRU Utilisation



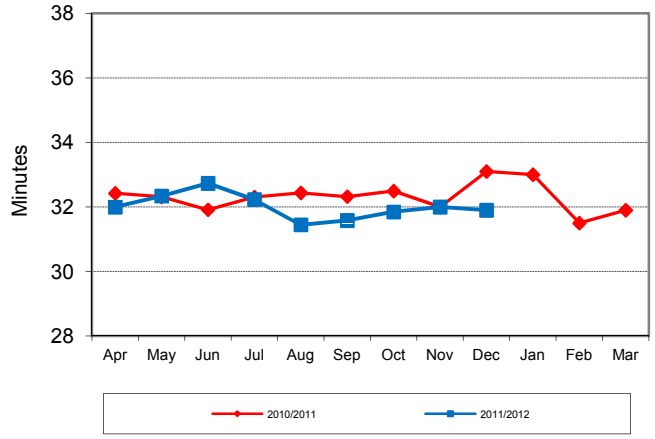
Graph 20
Ambulance Utilisation



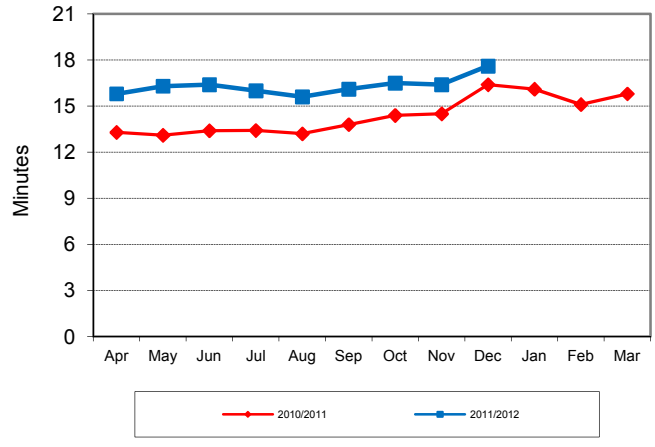
Graph 21
Hospital breaches over 60 minutes investigated



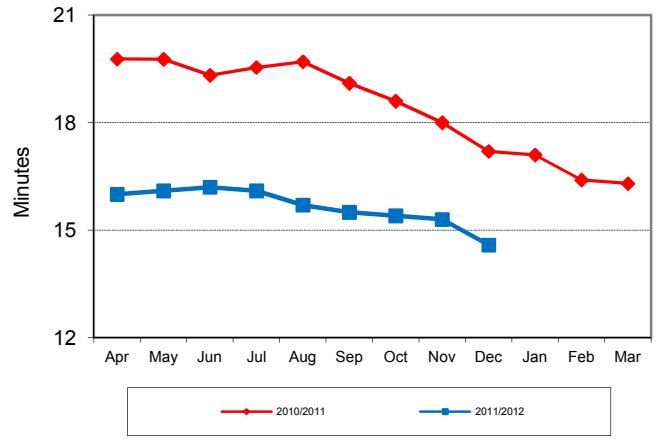
Graph 22
Average hospital turnaround time



Graph 23
Average Arrival at Hospital to Handover (Mins)

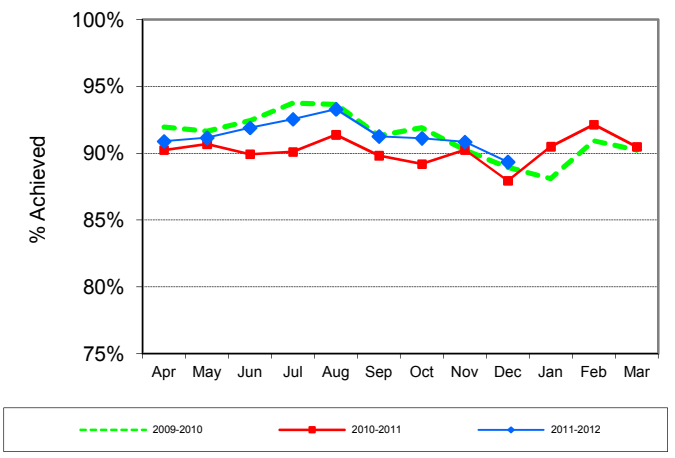


Graph 24
Average Handover to Green (Mins)

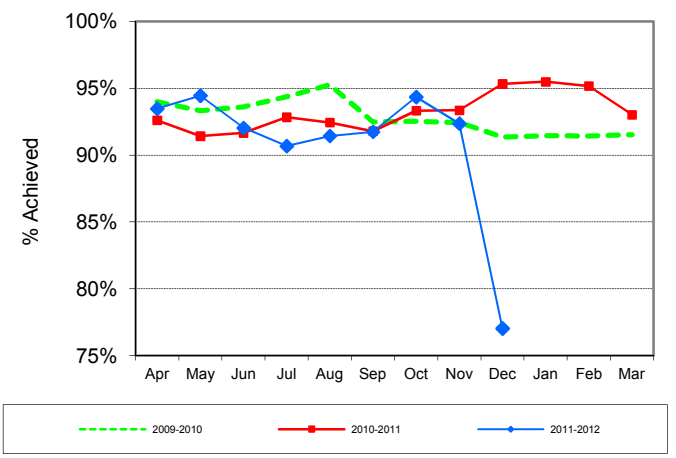


London Ambulance Service NHS Trust
Patient Transport Service
Activity and Performance - December 2011

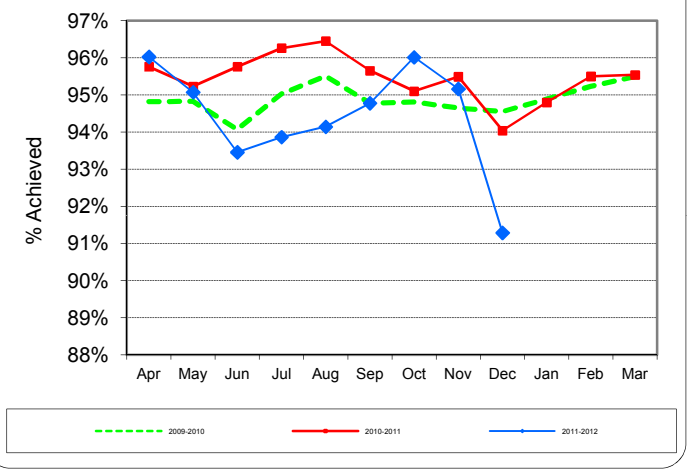
Graph 25
Arrival at Hospital Against Appointment Time



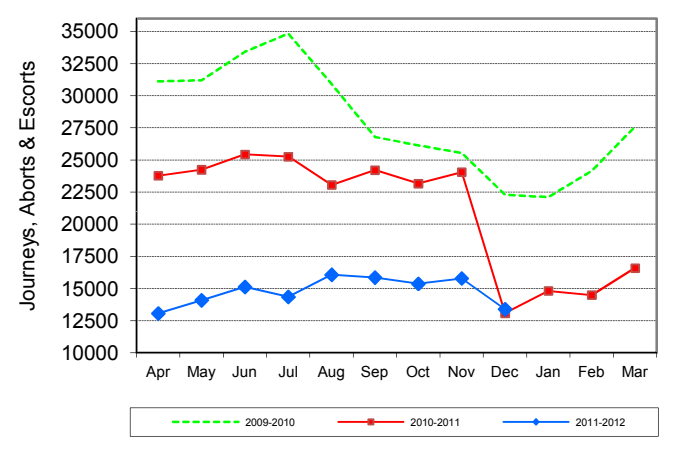
Graph 26
Departure Against Ready Time



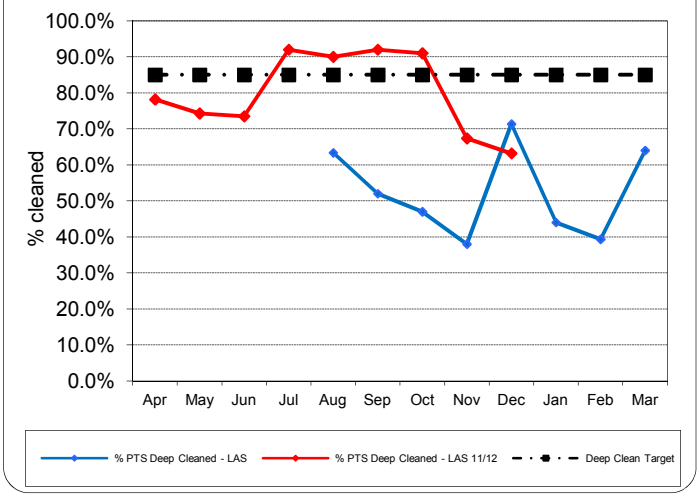
Graph 27
Time spent on Vehicle



Graph 28
PTS Total Activity



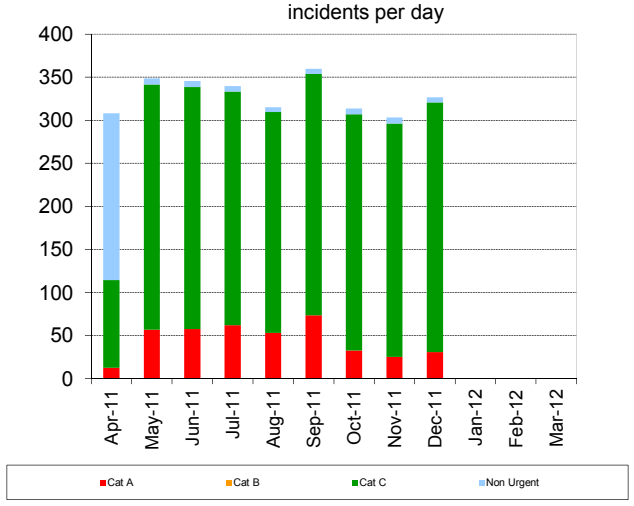
Graph 29
Deep Clean - PTS (17 weeks) - LAS



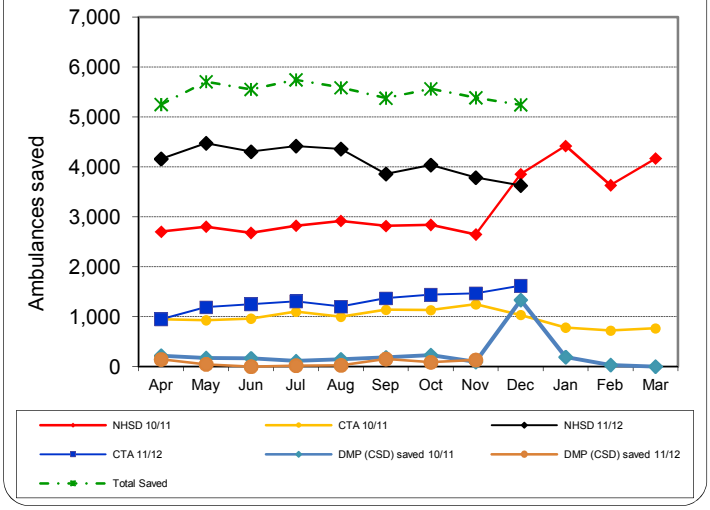
London Ambulance Service NHS Trust
Accident and Emergency Service
UOC Effectiveness - December 2011

Incident information is based on responses where a vehicle has arrived on scene for dispatches occuring during UOC operational hours (0700 -02259)

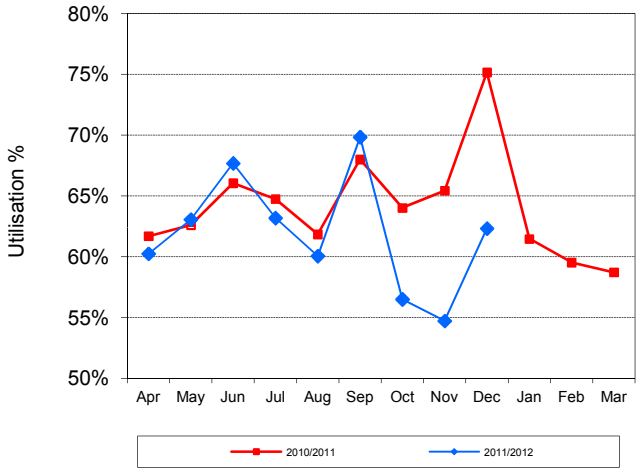
Graph 30
CAT A, B & C Workload by Urgent Care Vehicles average incidents per day



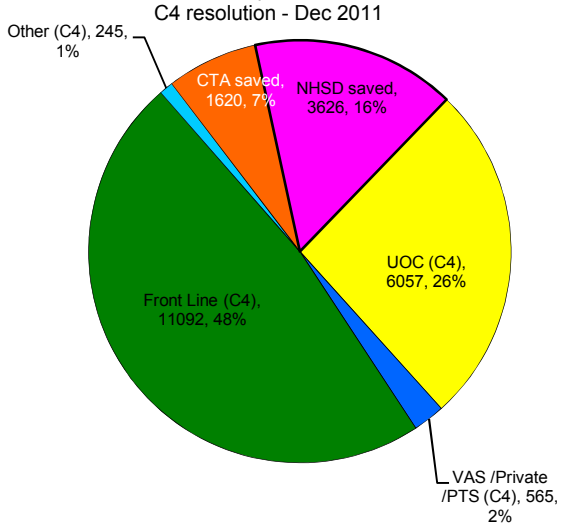
Graph 31
CTA/NHSD/DMP Ambulances saved



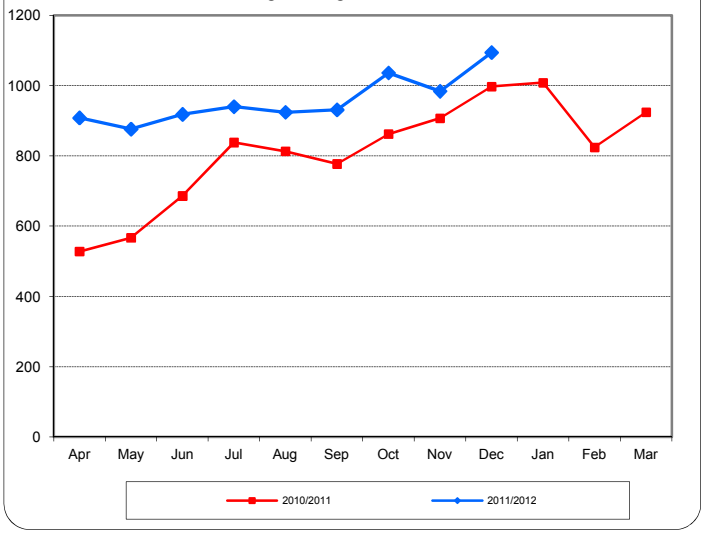
Graph 32
UOC Utilisation



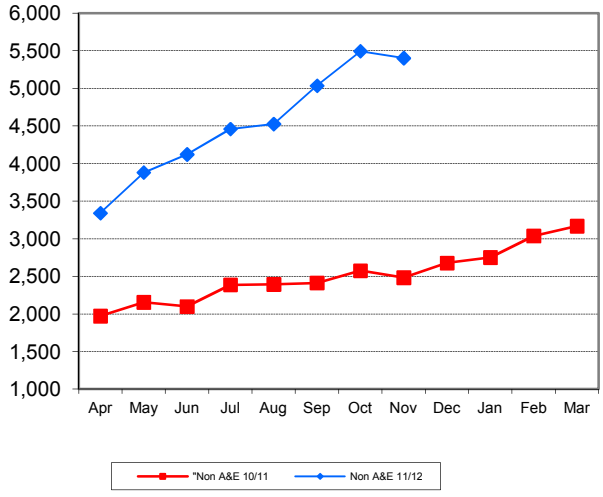
Graph 33
C4 resolution - Dec 2011



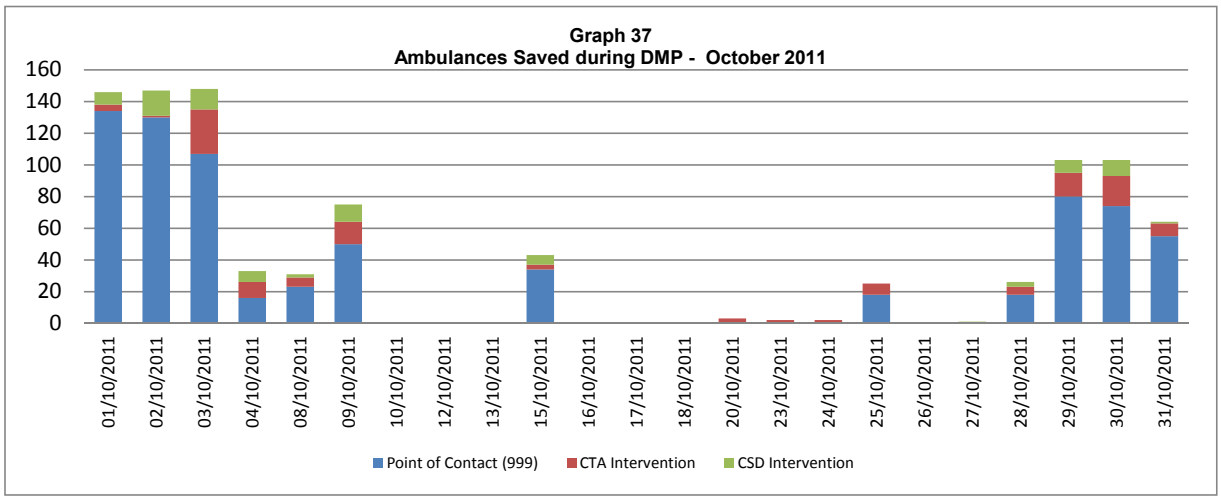
Graph 34
Safeguarding children and adults

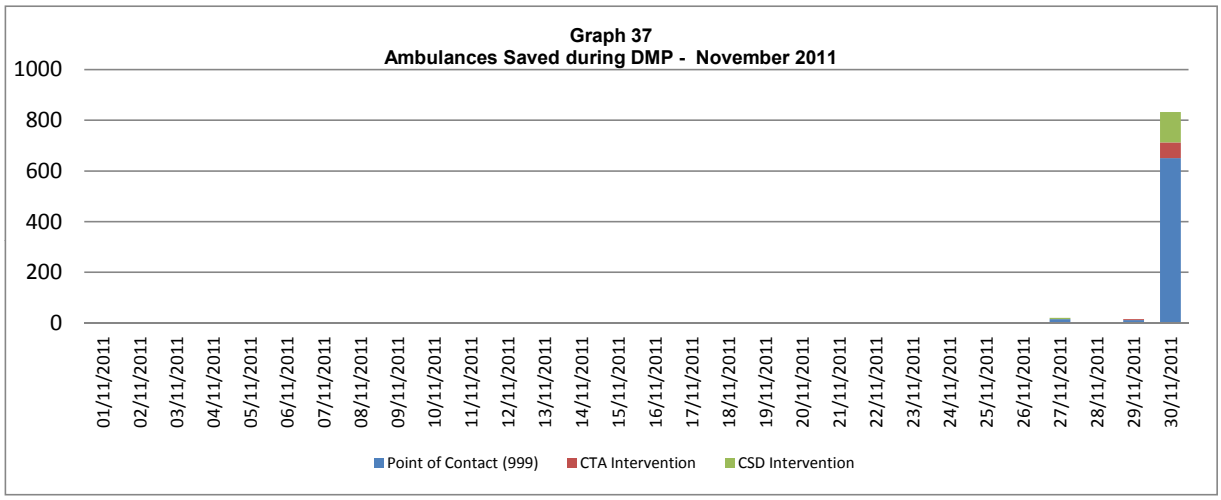


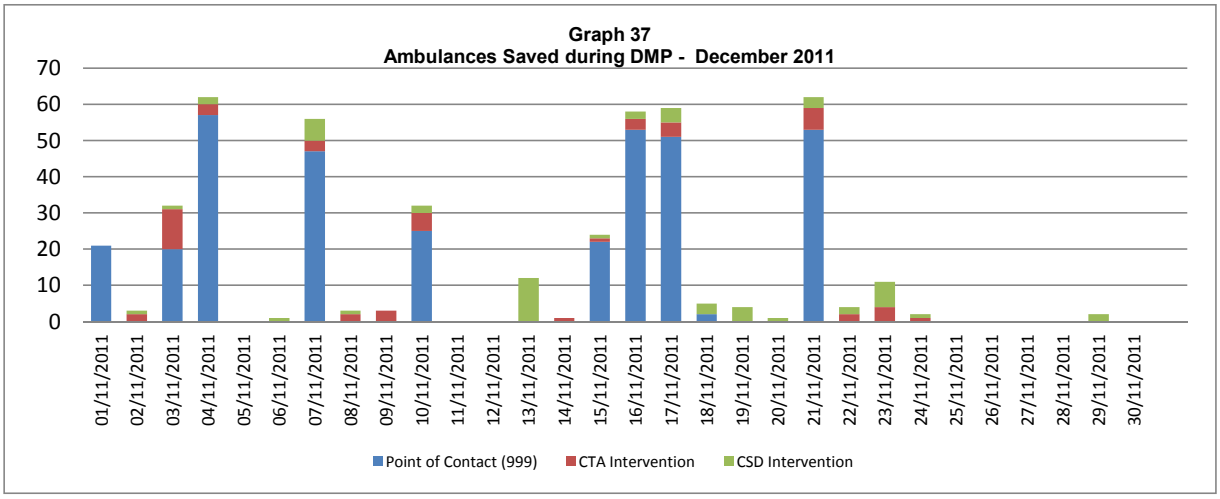
Graph 35
Patients conveyed to Non A&E Departments - LAS



London Ambulance Service NHS Trust
Accident and Emergency Service
DMP Ambulance saves -
December 2011







London Ambulance Service NHS Trust
Accident and Emergency Service
DMP Ambulance saves -
December 2011

DMP Stages by hour by day including number of saves from CSD - October - Table 39

Date	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	Total
01/10/11	1												1			1				2	3				8
02/10/11	1	1	1	2	2								1	3						2	1	1	1		16
03/10/11																	1	1	2	2	6		1		13
04/10/11	6		1																						7
08/10/11																						1		1	2
09/10/11	1	2		3	2																1		2		11
10/10/11																									0
12/10/11																									0
13/10/11																									0
15/10/11																			2	2	1			1	6
16/10/11																									0
17/10/11																									0
18/10/11																									0
20/10/11																									0
23/10/11																									0
24/10/11																									0
25/10/11																									0
26/10/11																									0
27/10/11	1																								1
28/10/11																									3
29/10/11	1		1		1																		2	3	8
30/10/11	2	7		1																					10
31/10/11																					1				1

Key

Not Recorded
Stage B
Stage C
Stage D
Stage E
Stage F
Stage G
Stage H

DMP Stages by hour by day including number of saves from CSD - November

Date	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	aily Tot
03/11/11																						1			1
04/11/11																									
06/11/11																									
12/11/11																									
13/11/11																						1			1
14/11/11																									
17/11/11																						1			1
18/11/11																									
21/11/11																									
22/11/11																									
23/11/11																				1					1
24/11/11																									
25/11/11																									
26/11/11												1						1	1						3
27/11/11													2		2	1									5
28/11/11																									
29/11/11																									
30/11/11	4	3	1		1	1	2	3	2	4	5	7	5	2	7	11	12	9	12	13	8	6	1	1	120

Key

Stage B
Stage C
Stage D
Stage E
Stage F
Stage G
Stage H

DMP Stages by hour by day including number of saves from CSD - December

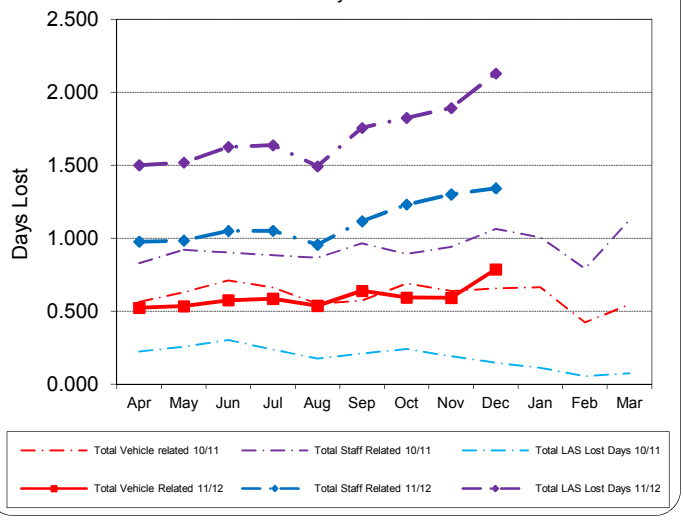
Date	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	aily Tot
01/12/11																									
02/12/11																							1		1
03/12/11																			1						1
04/12/11				1	1																				2
05/12/11																									
07/12/11																			1						1
08/12/11																			3	1		1	1		6
09/12/11	1																								1
10/12/11																									
12/12/11																			2						2
13/12/11																									
14/12/11																									
15/12/11																			1	6		1	1	3	12
16/12/11																									
17/12/11																						1			1
18/12/11														1	1										2
19/12/11																2	1				1				4
20/12/11																								3	3
21/12/11																				1		3			4
22/12/11																					1				1
23/12/11			1																		2				3
24/12/11																							1	1	2
25/12/11	1	1		1																			2	2	7
26/12/11																							1		1
27/12/11																									
28/12/11																									
29/12/11																									
30/12/11																									
31/12/11																								2	2

Key

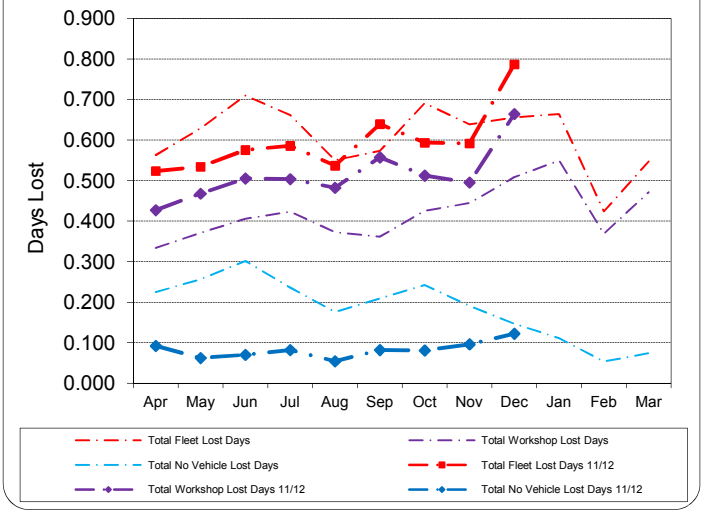
Not Recorded
Stage B
Stage C
Stage D
Stage E
Stage F
Stage G
Stage H

London Ambulance Service NHS Trust
Accident and Emergency Service
SMG Pack - Fleet and Logistics - December 2011

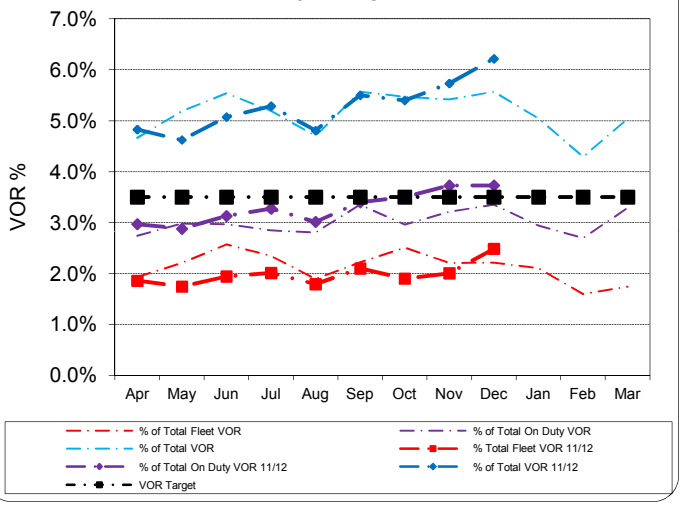
Graph 51
AEU Lost Days - LAS



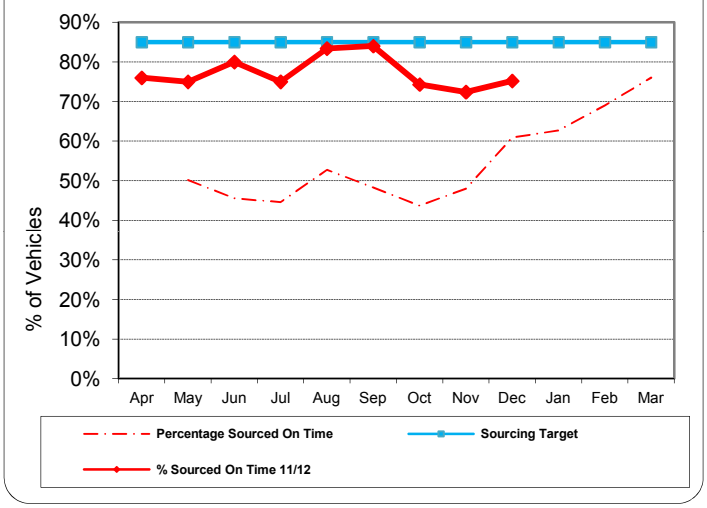
Graph 52
AEU Lost Days - Fleet Breakdown



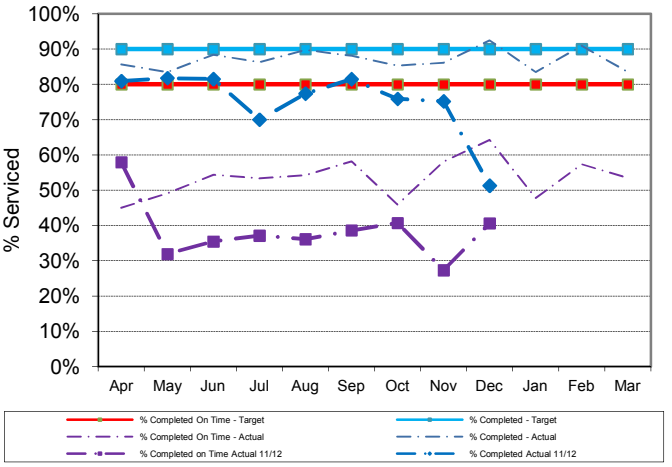
Graph 53
VOR - LAS



Graph 54
Vehicles Sourced -% within 30mins of shift start

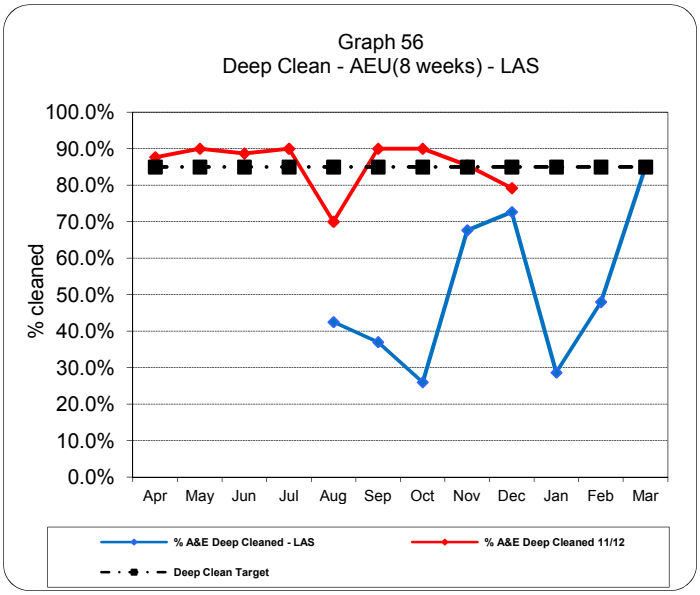


Graph 55
Servicing Performance - LAS

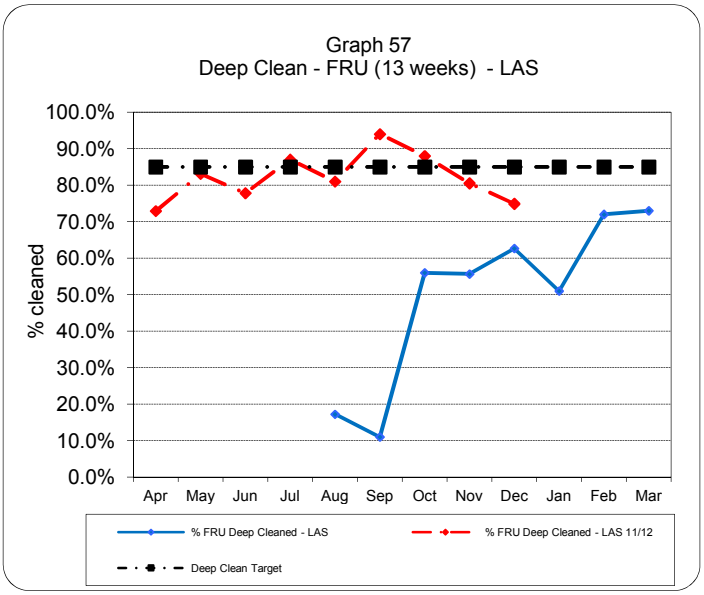


London Ambulance Service NHS Trust
Accident and Emergency Service
SMG Pack - Fleet and Logistics - December 2011

Graph 56
Deep Clean - AEU(8 weeks) - LAS

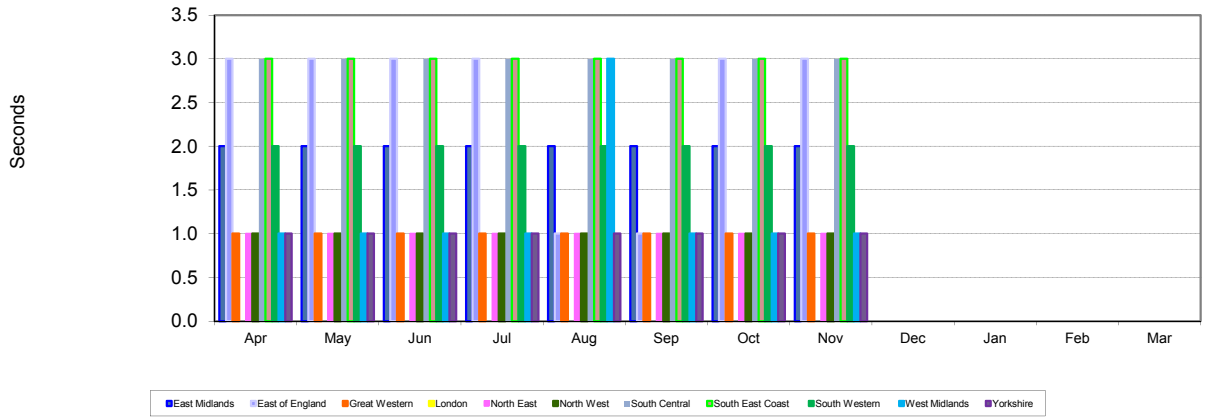


Graph 57
Deep Clean - FRU (13 weeks) - LAS

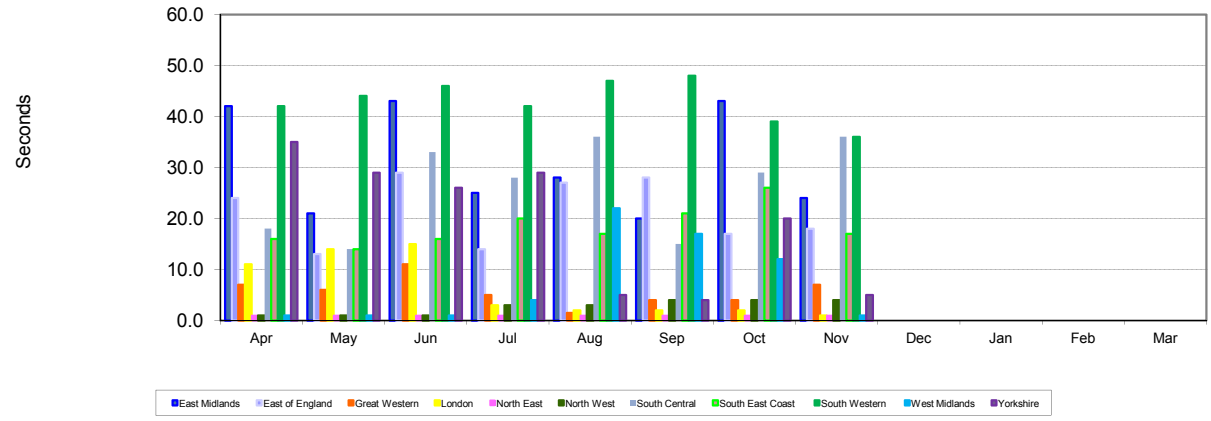


London Ambulance Service NHS Trust
Accident and Emergency Service
Ambulance Quality Indicators -
December 2011

Graph 58
Median - Time to answer calls (in seconds) by Ambulance Trust

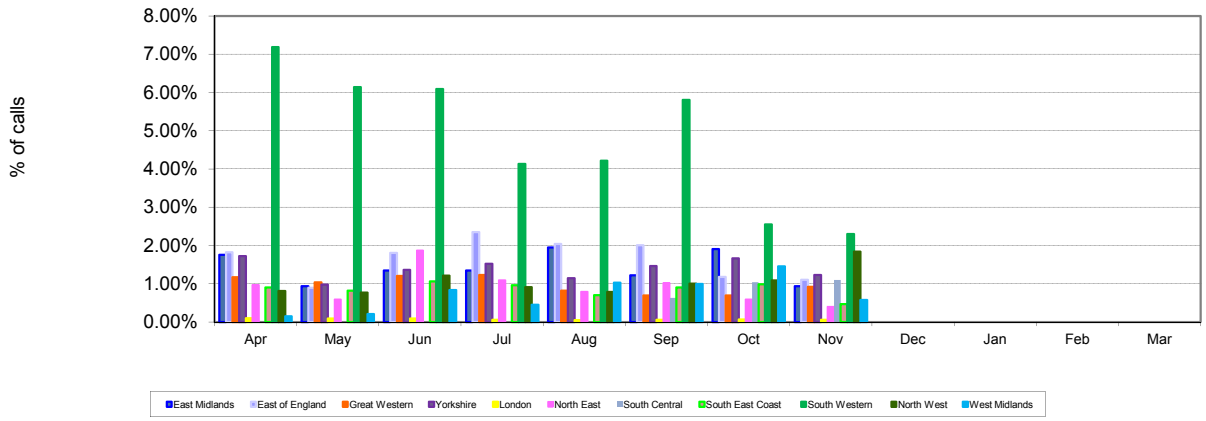


Graph 59
95th percentile - Time to answer calls (in seconds) by Ambulance Trust

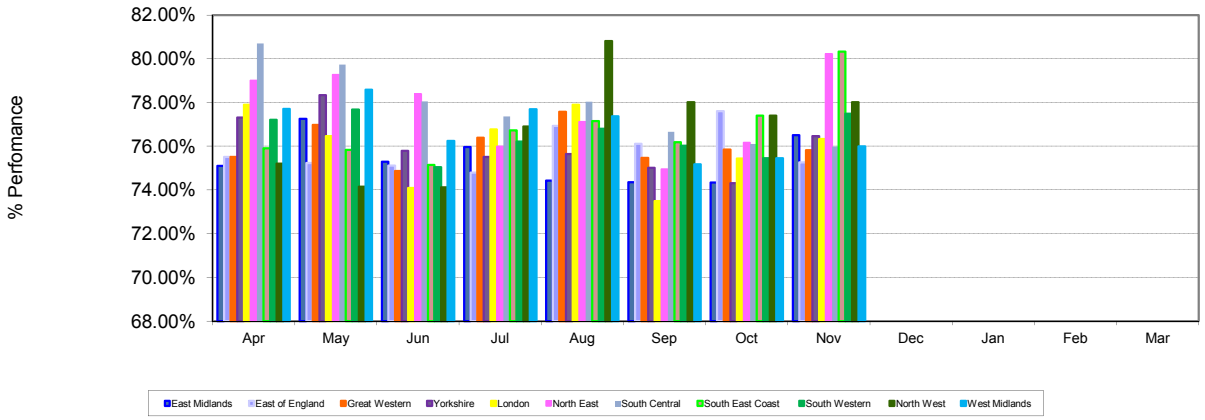


London Ambulance Service NHS Trust
Accident and Emergency Service
Ambulance Quality Indicators -
December 2011

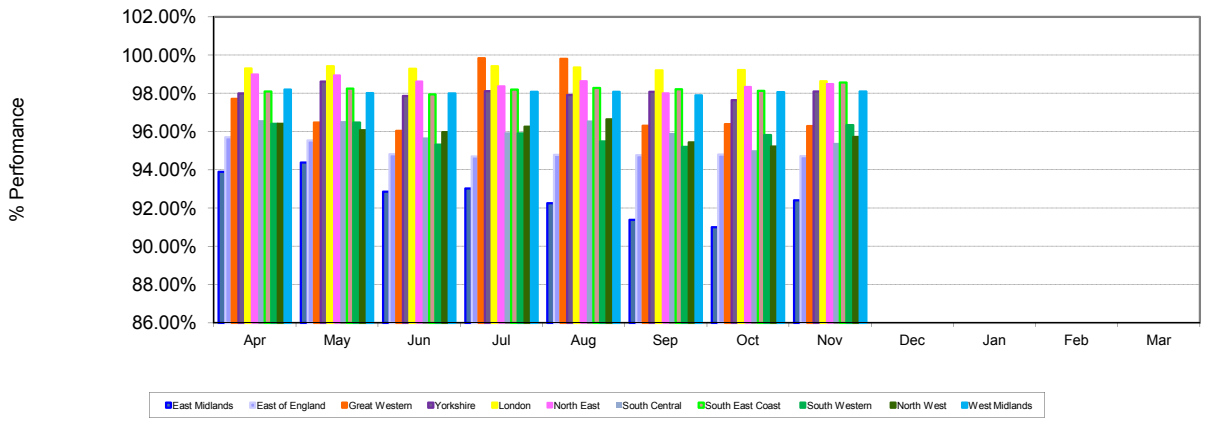
Graph 60
Proportion of calls abandoned before being answered by Ambulance Trust



Graph 61
Proportion of calls responded to within 8 minutes by Ambulance Trust

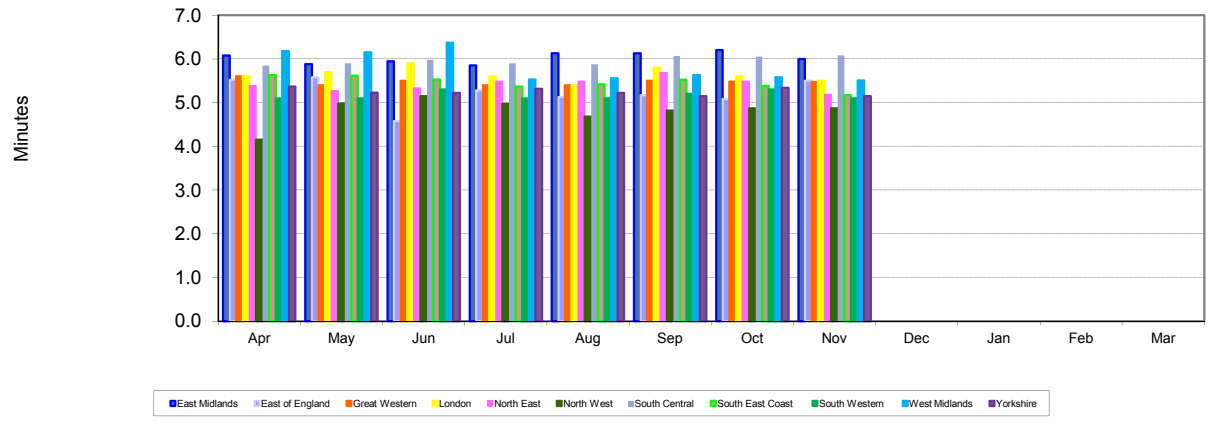


Graph 62
Proportion of calls responded to within 19 minutesby Ambulance Trust

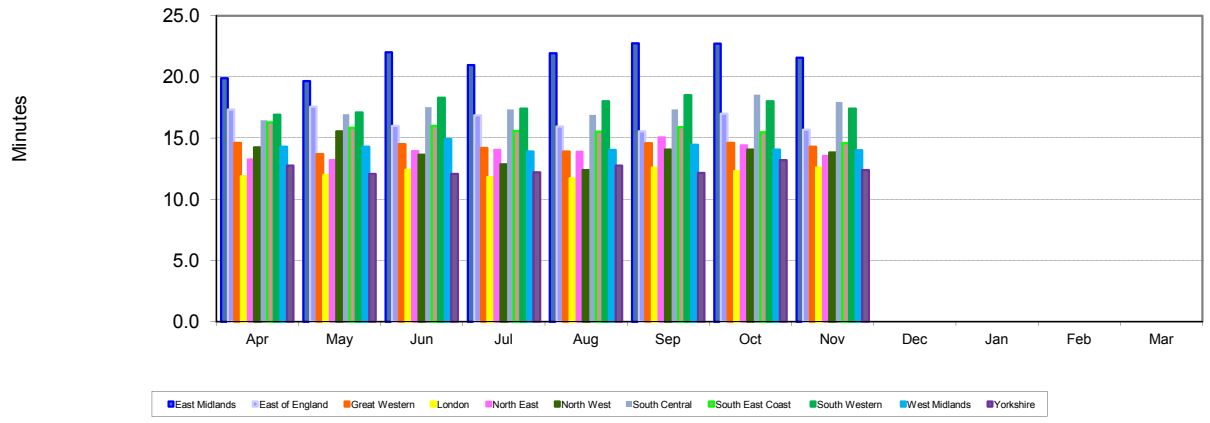


London Ambulance Service NHS Trust
Accident and Emergency Service
Ambulance Quality Indicators -
December 2011

Graph 63
Median - Time to treatment for Cat A calls (in minutes) by Ambulance Trust

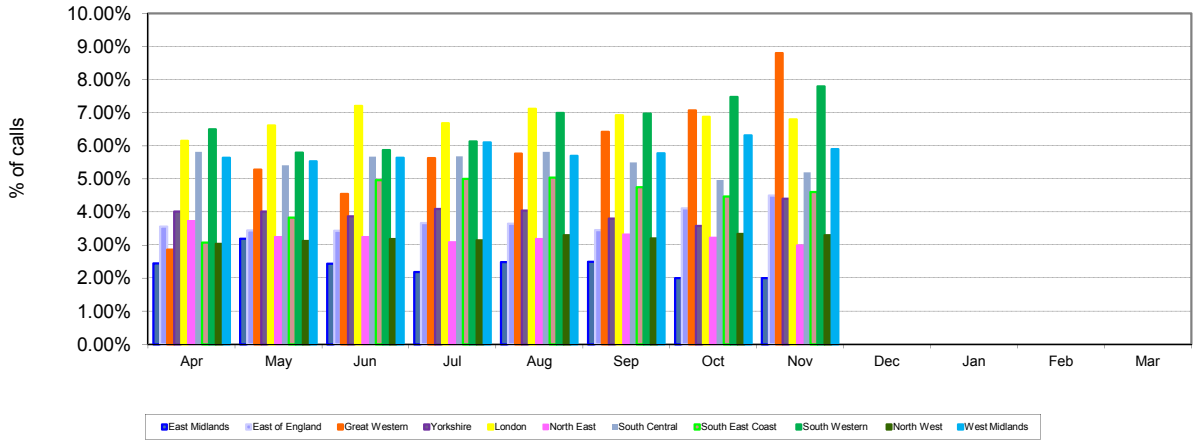


Graph 64
95th percentile - Time to treatment for Cat A calls (in minutes) by Ambulance Trust

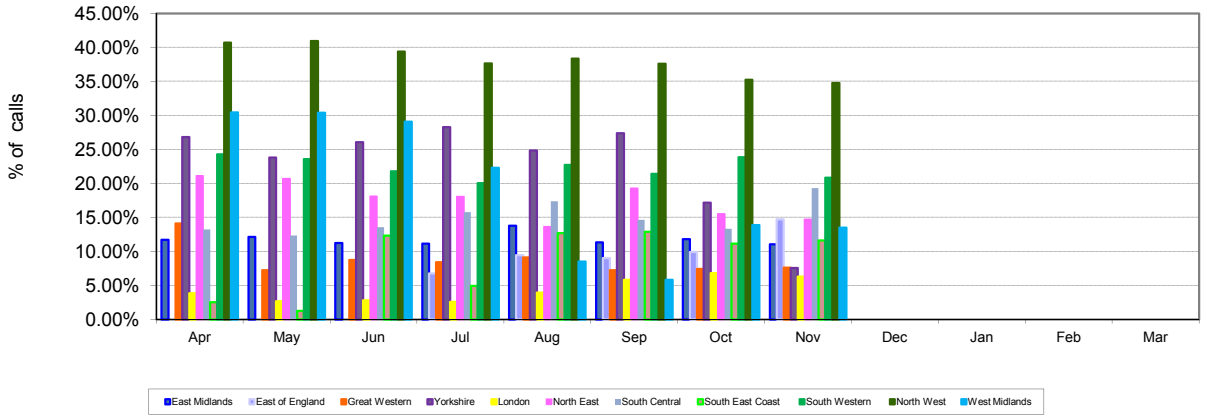


London Ambulance Service NHS Trust
Accident and Emergency Service
Ambulance Quality Indicators -
December 2011

Graph 65
Proportion of calls closed by Telephone Advice by Ambulance Trust

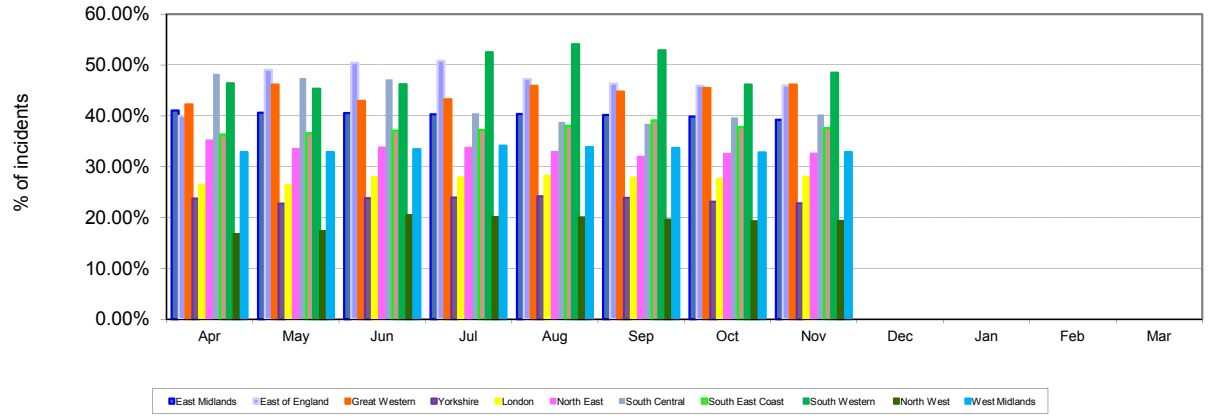


Graph 66
Proportion of patients who re-contacted following dischange of care, by telephone within 24 hours by Ambulance Trust

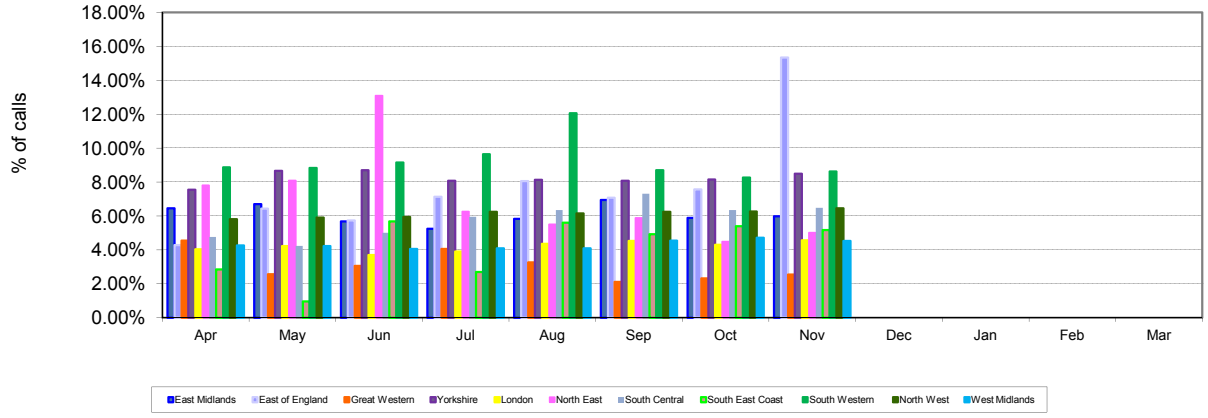


London Ambulance Service NHS Trust
Accident and Emergency Service
Ambulance Quality Indicators -
December 2011

Graph 67
Proportion of incidents managed without need for transport to Accident and Emergency department by Ambulance Trust



Graph 68
Proportion of patients who re-contacted following treatment and discharge at the scene, within 24 hours by Ambulance Trust



London Ambulance Service
NHS Trust

HR Summary for Trust Board

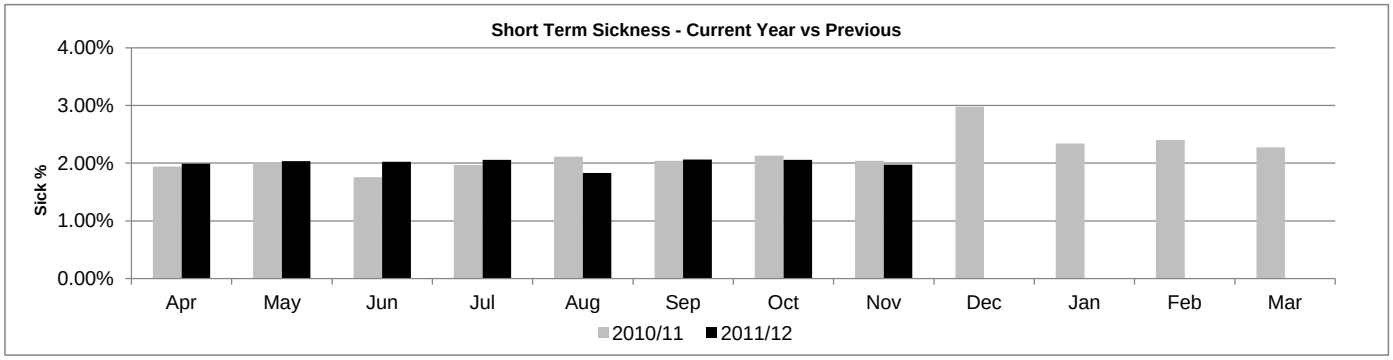
January 2012

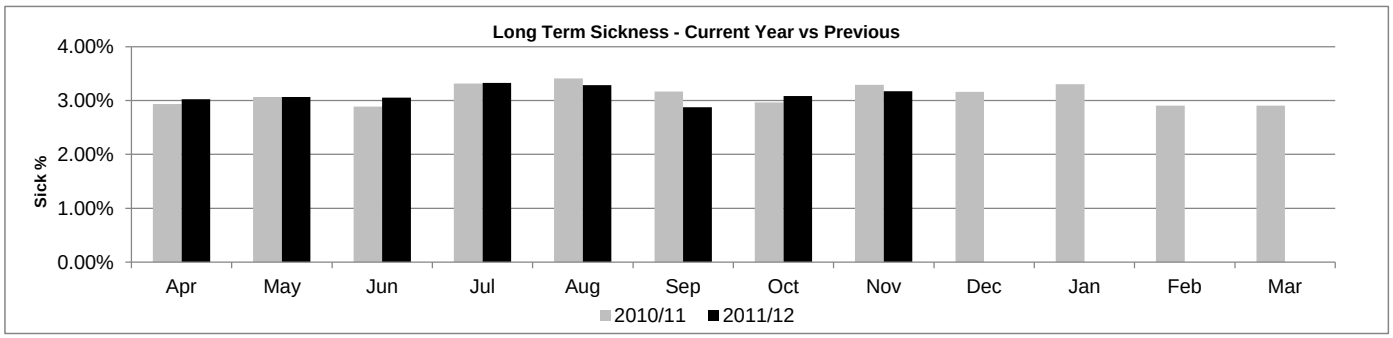
Workforce Report

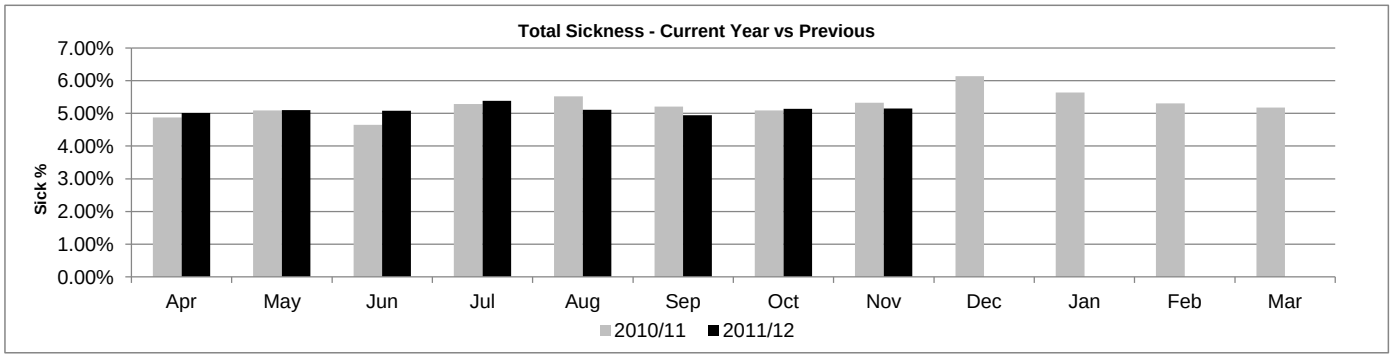
Current Month Jan-12 **Sickness Month** Nov-11

Trust Summary

Sickness Absence







Sickness 2010/11	5.28%	**Current WTE**	4604.59
YTD Sickness	5.12%	**Current Headcount**	4833.00

NB Secondments and Acting Up Included in Totals

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	4.87%	5.09%	4.65%	5.29%	5.52%	5.20%	5.09%	5.33%	6.13%	5.64%	5.30%	5.18%
2011/12	5.01%	5.10%	5.08%	5.39%	5.11%	4.94%	5.14%	5.15%	0.00%	0.00%	0.00%	0.00%

Unauthorised Absence	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	263.00	210.00	167.00	178.00	136.00	197.00	169.00	197.00	388.00	190.00	142.00	175.00
2011/12	163.00	167.00	161.00	192.00	171.00	164.00	161.00	312.00	98.00	0.00	0.00	0.00

Narrative

Sickness

Sickness levels for the Trust as a whole remained largely static from August through to November. Within the overall figure, short term absence fell slightly and long term rose. The YTD figure also remained static, just above the target for 2011/12 of 5% or below. As reported previously, many of the long term absences are attributable to serious illness, so we cannot expect to see rapid significant improvement. The RAG rated audits continue to show that, in the main, all absence is being managed appropriately and in accordance with the Managing Attendance Policy (MAP).

Unauthorised Absences

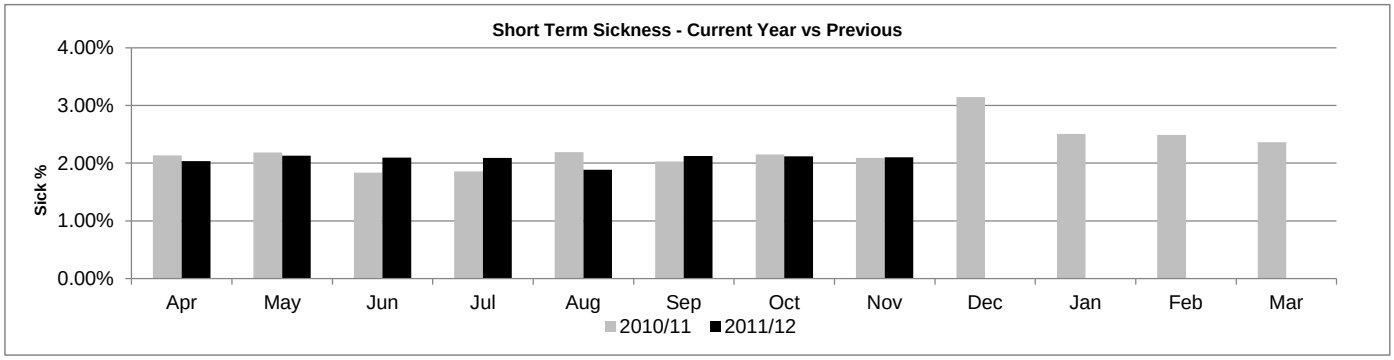
This figure shows the number of instances when staff have reported unable to attend work at short notice for reasons other than their own sickness or when they have not reported for work. Depending on the reason, the absence may be converted into annual leave or un/paid special leave or remain an unpaid unauthorised absence. Disciplinary action may result. The figure for December shows the lowest figure for the year and much reduced on December last year, when the figure was affected by the adverse weather. It should be remembered that the November figure includes the day of industrial action.

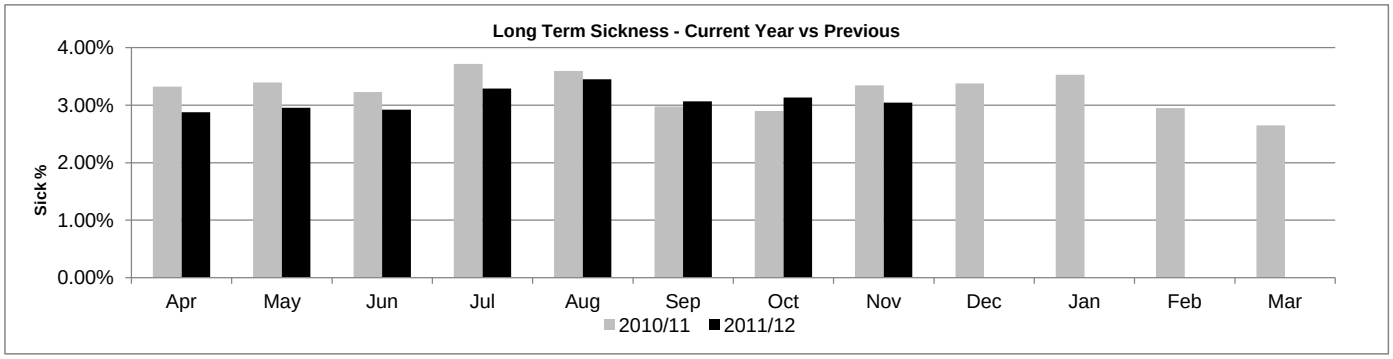
Workforce Report

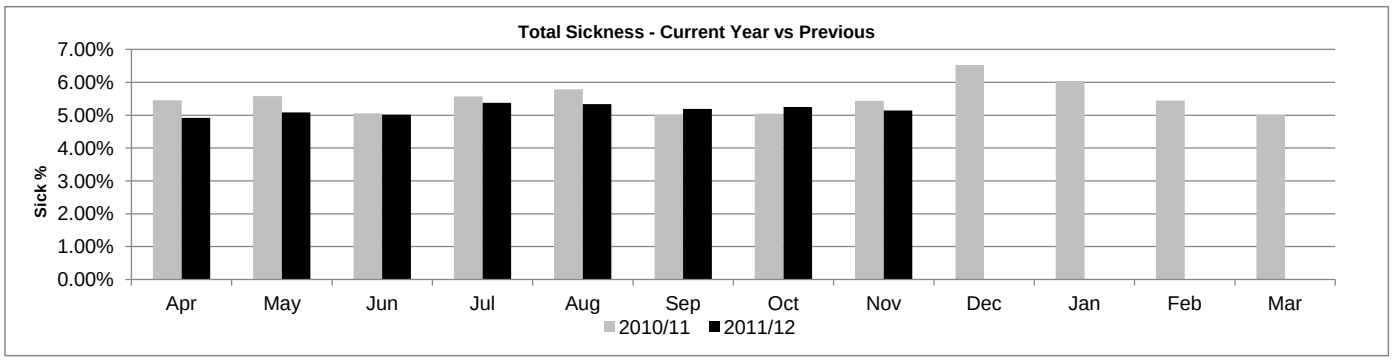
Current Month **Jan-12** **Sickness Month** **Nov-11**

A&E Operations Areas

Sickness Absence







Sickness 2010/11	5.50%	**Current WTE**	3261.00	**NB Secondments and Acting Up Included in Totals**	
YTD Sickness	5.17%	**Current Headcount**	3421.00		

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	5.45%	5.58%	5.06%	5.58%	5.79%	5.00%	5.05%	5.44%	6.52%	6.04%	5.44%	5.01%
2011/12	4.91%	5.08%	5.02%	5.38%	5.34%	5.19%	5.25%	5.15%	0.00%	0.00%	0.00%	0.00%

Unauthorised Absence	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	247.00	193.00	148.00	163.00	115.00	167.00	141.00	174.00	340.00	148.00	108.00	147.00
2011/12	141.00	144.00	136.00	162.00	137.00	150.00	133.00	292.00	80.00	0.00	0.00	0.00

Narrative

Sickness

Sickness in the Areas fell slightly October to November and matched the Trust total for the month and was slightly above the Trust YTD figure. During November 27people reached the four week long-term sickness trigger ; five people were referred for hearings; one person on long-term sickness resigned; a total of 95 long-term sickness cases were active; 24 people returned to work following long-term absences; 70 members of staff were subject to formal warnings under the Managing Attendance Policy (MAP). On the last day of November a total of 171 members of staff were absent due to sickness, compared with 174 on the last day of October.

Audits of application of the MAP have raised no cause for concern. Only two Complexes received amber audits in November due to actions not being undertaken within agreed timeframes.

Unauthorised Absences

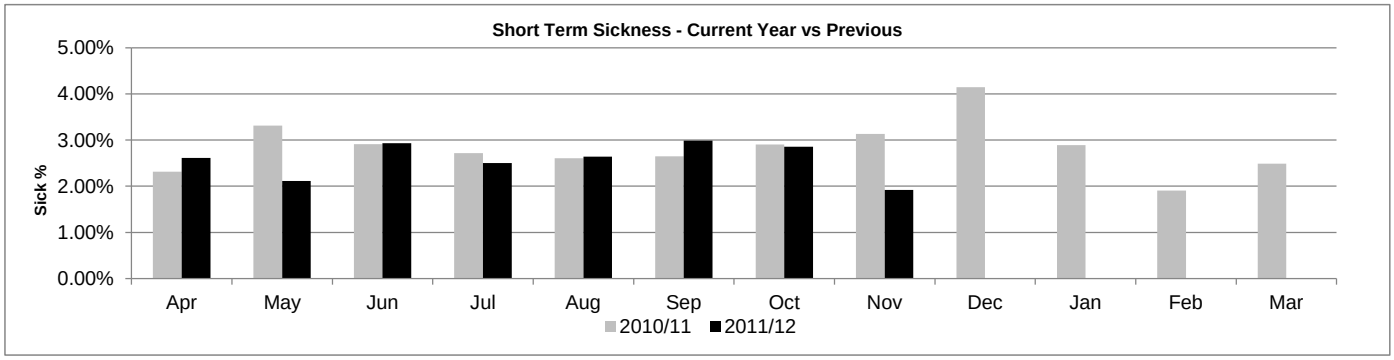
The total figure for U/As for October decreased; East 21 from 65; South 42 from 143; West 17 from 84.

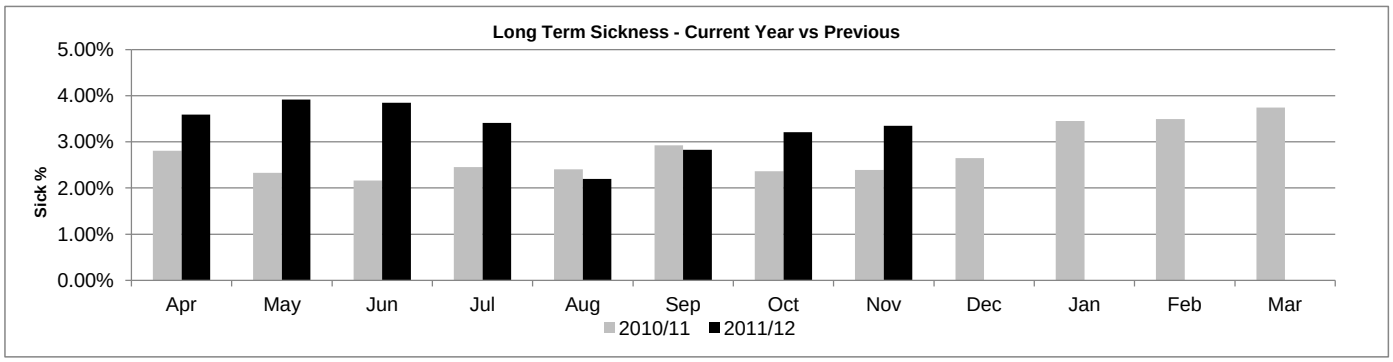
Workforce Report

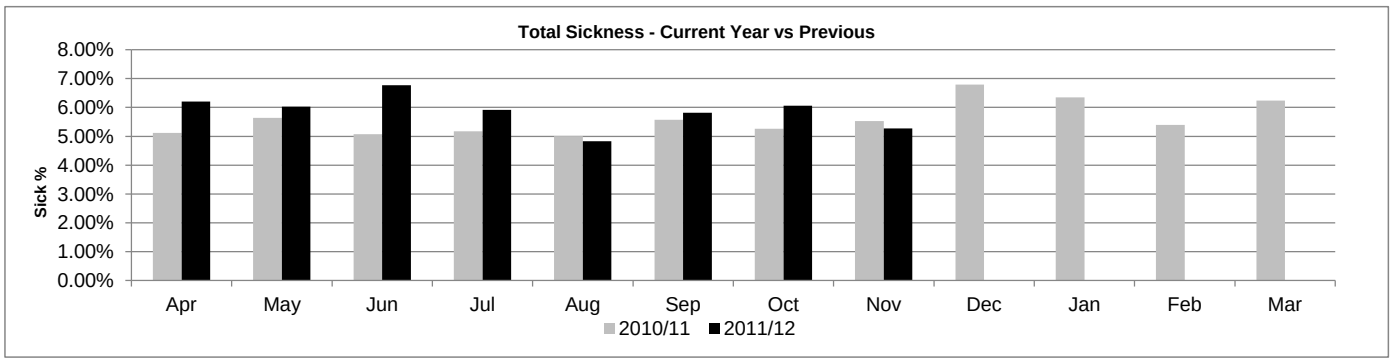
Current Month **Jan-12** **Sickness Month** **Nov-11**

Control Services

Sickness Absence







Sickness 2010/11	5.60%	**Current WTE**	424.07
YTD Sickness	5.86%	**Current Headcount**	451.00

NB Secondments and Acting Up Included in Totals

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	5.12%	5.64%	5.07%	5.17%	5.01%	5.57%	5.27%	5.52%	6.79%	6.35%	5.40%	6.23%
2011/12	6.20%	6.03%	6.77%	5.91%	4.83%	5.82%	6.06%	5.27%	0.00%	0.00%	0.00%	0.00%

Unauthorised Absence	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	16.00	17.00	19.00	15.00	21.00	30.00	28.00	23.00	48.00	42.00	34.00	28.00
2011/12	22.00	23.00	25.00	30.00	34.00	14.00	28.00	20.00	18.00	0.00	0.00	0.00

Narrative

Sickness

In November there was fall of 0.8% in sickness in Control Services. The fall was due to a marked decrease in short-term absence , with a slight increase in long-term sickness. Six members of staff returned to work following long term absence. In November we had 21 active long term sickness cases. We had nine cases reach the four week trigger. A total of 20 staff were subject to formal warnings under the MAP. The total number of staff off due to sickness on the last day of September was 23 (October 31).

Efforts continue to be made to reduce sickness absence in Control Services. Four Watches received a Green rating in the November audits; D Watch received a Red rating as did CTA, but all outstanding actions are now completed.

Unauthorised absence

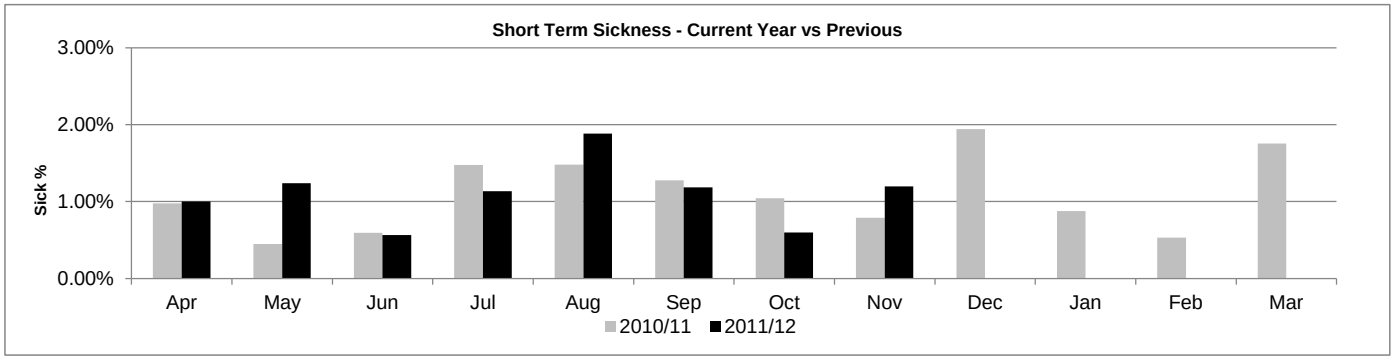
Management attention to U/As, including overtime bans for repeat offenders , continues.

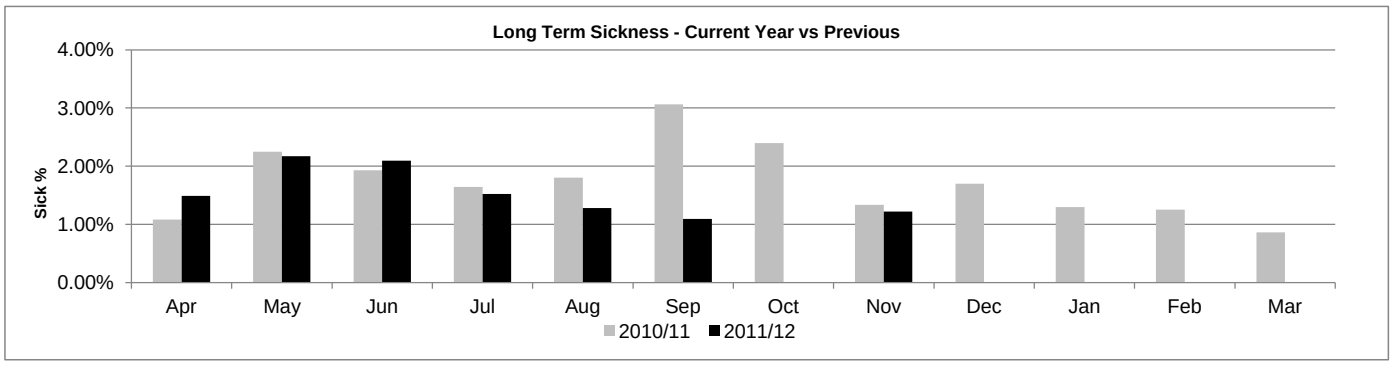
Workforce Report

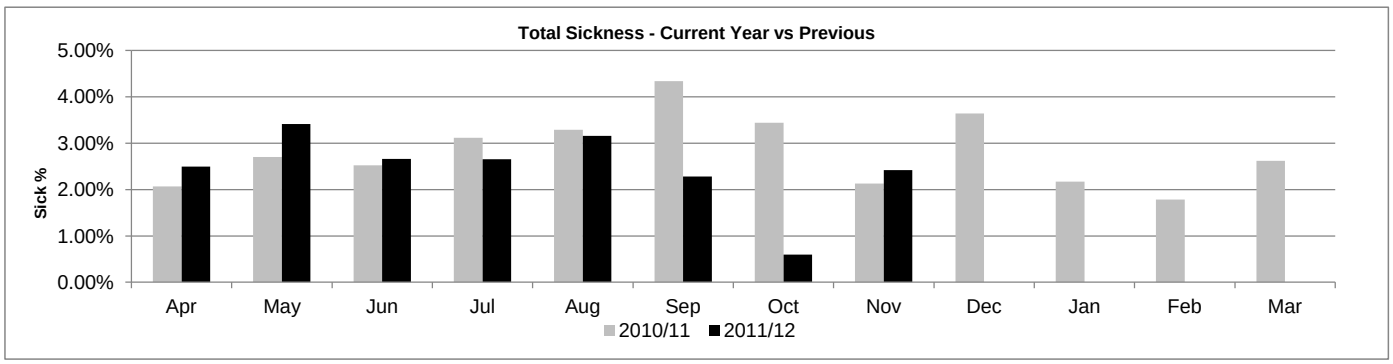
Current Month **Jan-12** **Sickness Month** **Nov-11**

Human Resources & Organisation Dev Directorate

Sickness Absence







Sickness 2010/11	2.77%	**Current WTE**	164.17
YTD Sickness	2.48%	**Current Headcount**	175.00

NB Secondments and Acting Up Included in Totals

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	2.06%	2.70%	2.52%	3.12%	3.29%	4.34%	3.44%	2.13%	3.64%	2.17%	1.79%	2.62%
2011/12	2.49%	3.41%	2.66%	2.66%	3.16%	2.28%	0.60%	2.42%	0.00%	0.00%	0.00%	0.00%

Narrative

Short term

20 employees had a total of 22 episodes of short term absence during November .

Long term

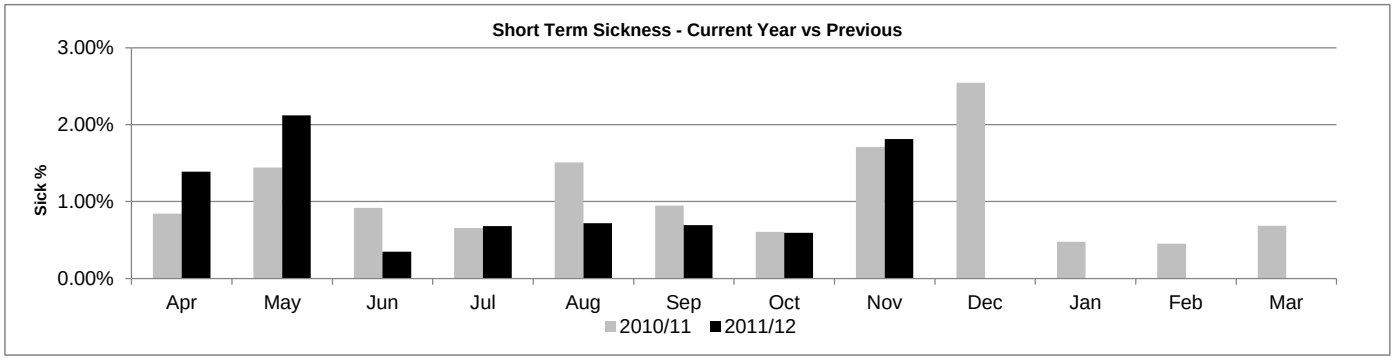
Two employees reached the four week trigger and moved into long term absence.

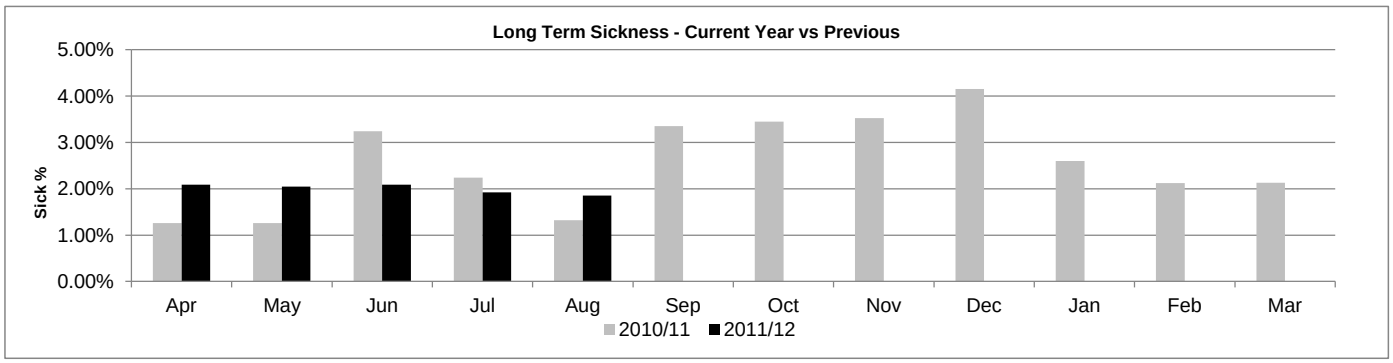
Workforce Report

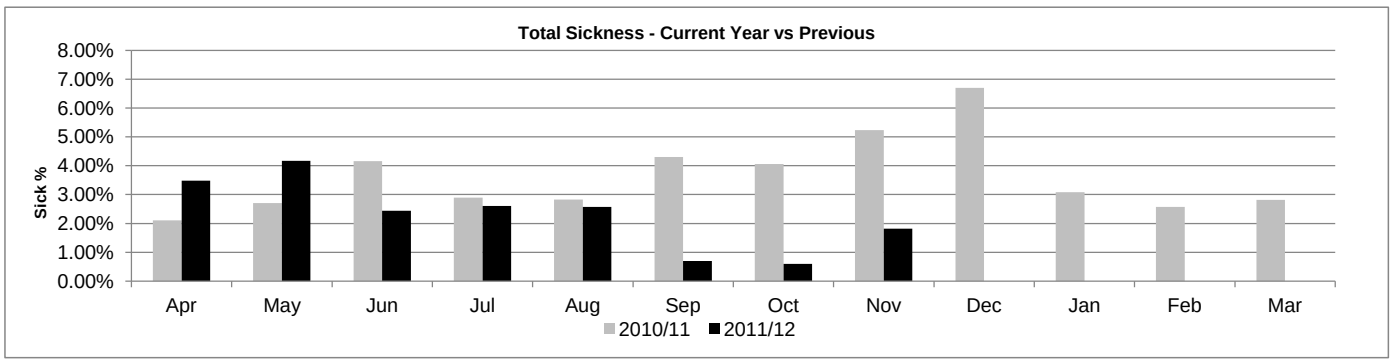
Current Month **Jan-12** **Sickness Month** **Nov-11**

Finance & Business Planning Directorate

Sickness Absence







Sickness 2010/11	3.61%	**Current WTE**	52.93	**NB Secondments and Acting Up Included in Totals**
YTD Sickness	2.28%	**Current Headcount**	55.00	

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	2.10%	2.70%	4.16%	2.89%	2.83%	4.30%	4.06%	5.23%	6.70%	3.08%	2.58%	2.82%
2011/12	3.48%	4.17%	2.43%	2.61%	2.57%	0.69%	0.59%	1.81%	0.00%	0.00%	0.00%	0.00%

Narrative

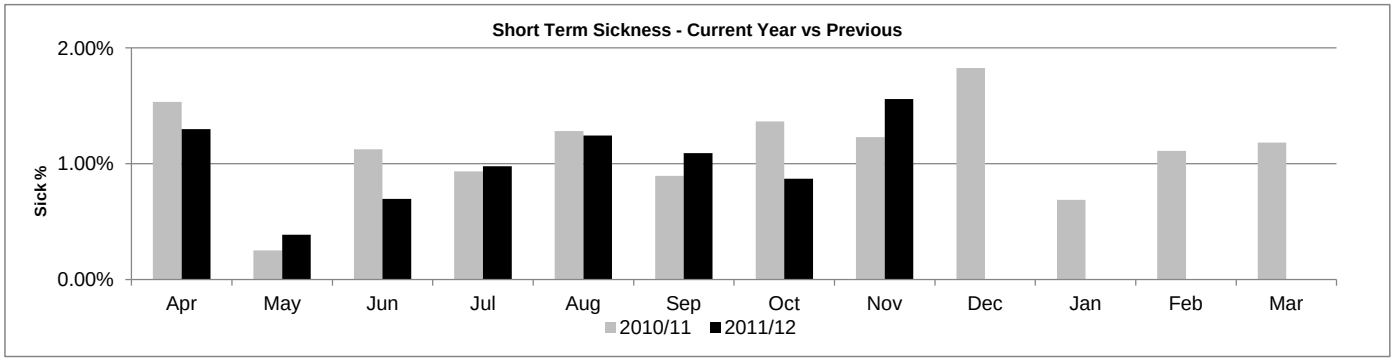
Short term
Five employees had a total of six episodes of short term absence during November.

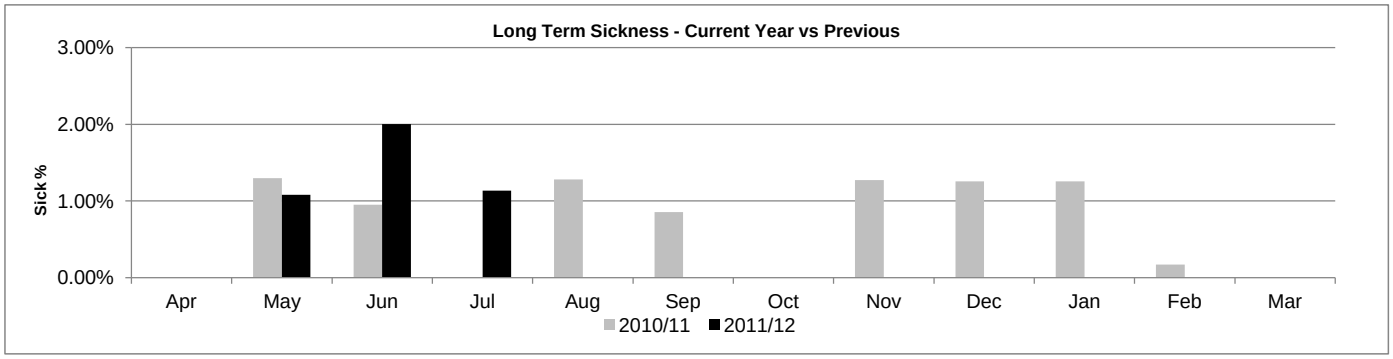
Workforce Report

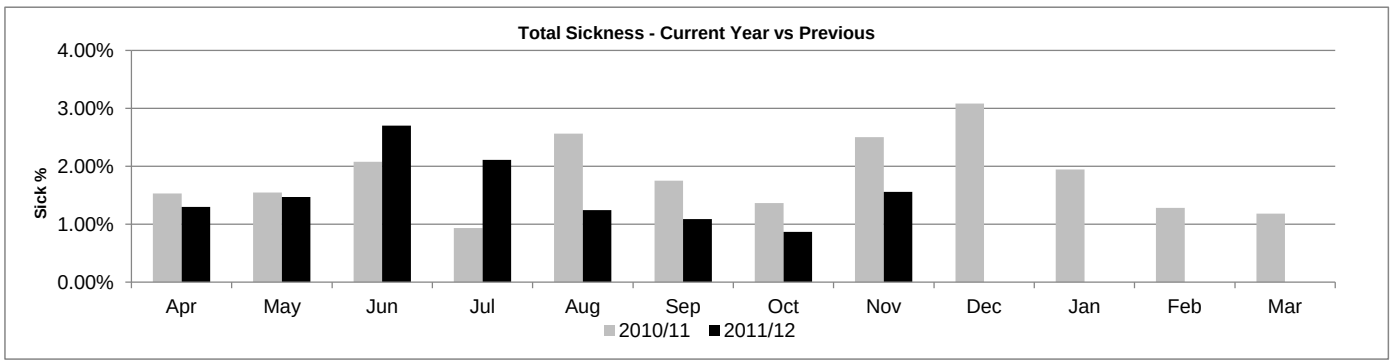
Current Month **Jan-12** **Sickness Month** **Nov-11**

Information Management & Technology Directorate

Sickness Absence







Sickness 2010/11	1.81%	**Current WTE**	84.46
YTD Sickness	1.54%	**Current Headcount**	86.00

NB Secondments and Acting Up Included in Totals

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	1.53%	1.55%	2.08%	0.93%	2.56%	1.75%	1.36%	2.50%	3.08%	1.95%	1.28%	1.18%
2011/12	1.30%	1.47%	2.70%	2.11%	1.24%	1.09%	0.87%	1.56%	0.00%	0.00%	0.00%	0.00%

Narrative

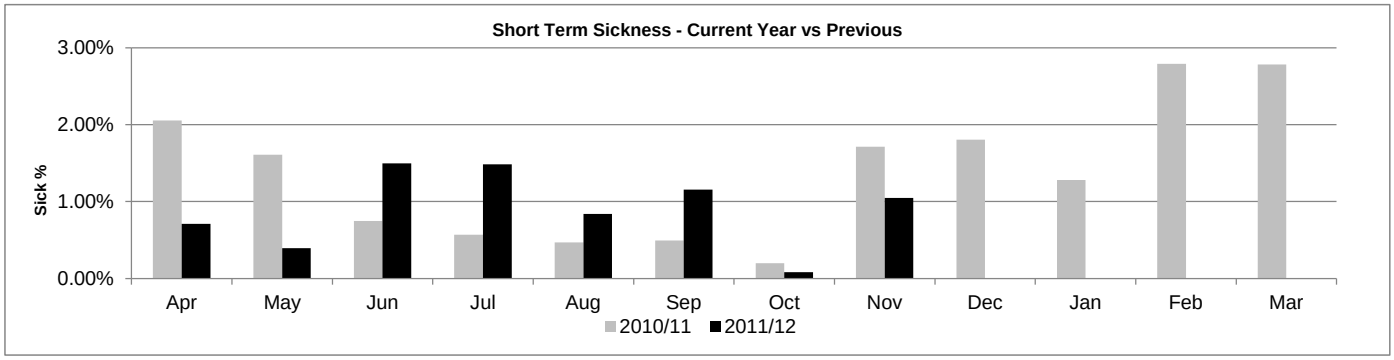
Short term
14 employees had a total of 15 periods of short term absence during November

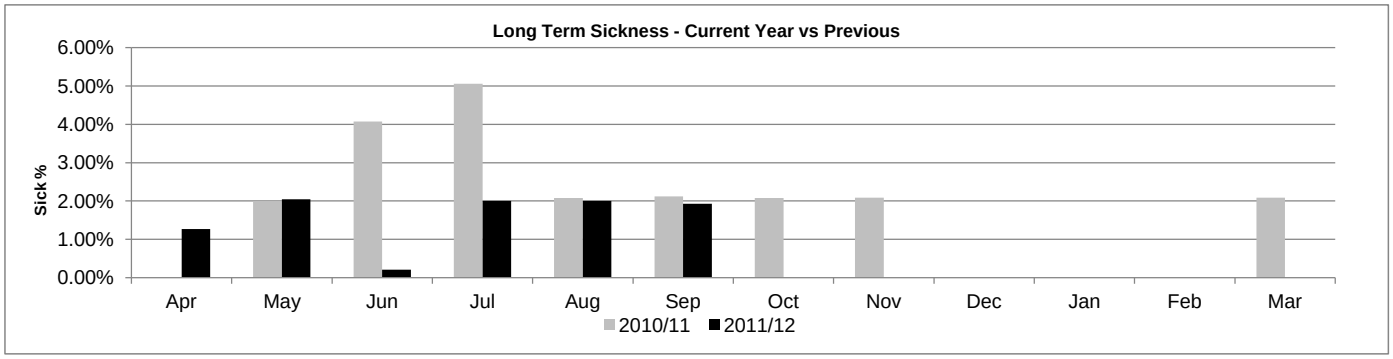
Workforce Report

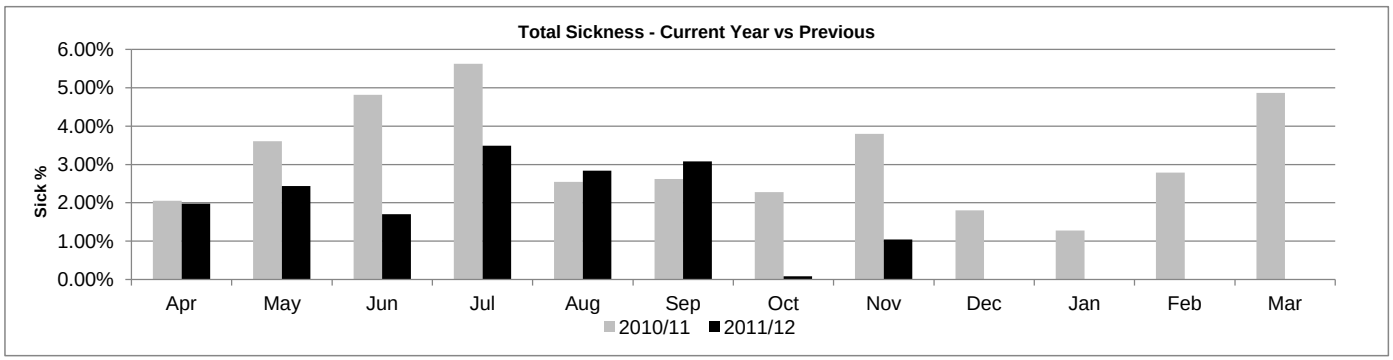
Current Month **Jan-12** **Sickness Month** **Nov-11**

Corporate Services Directorate

Sickness Absence







Sickness 2010/11	3.19%	**Current WTE**	50.93
YTD Sickness	2.08%	**Current Headcount**	52.00

NB Secondments and Acting Up Included in Totals

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	2.05%	3.61%	4.82%	5.63%	2.55%	2.62%	2.28%	3.80%	1.80%	1.28%	2.79%	4.87%
2011/12	1.98%	2.44%	1.70%	3.49%	2.84%	3.08%	0.08%	1.05%	0.00%	0.00%	0.00%	0.00%

Narrative

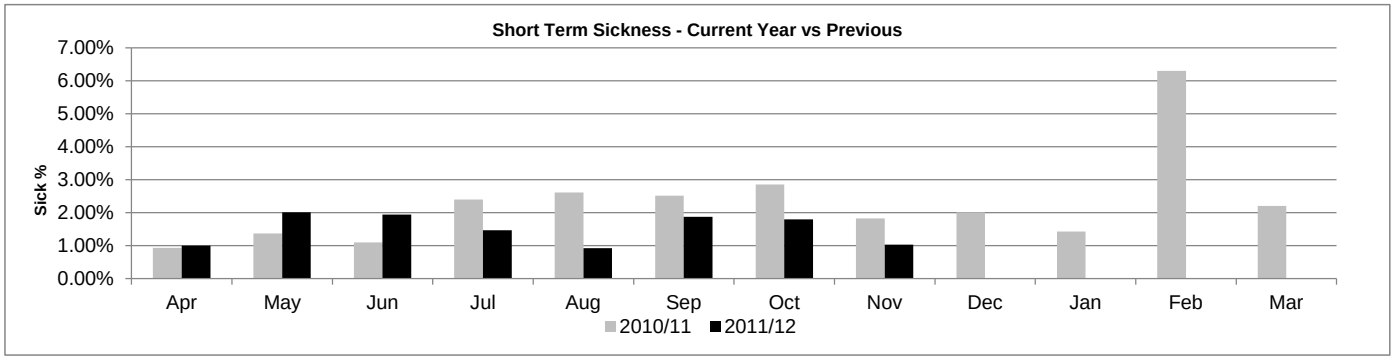
Short term
Five employees had a total of six periods of short term absence during November.

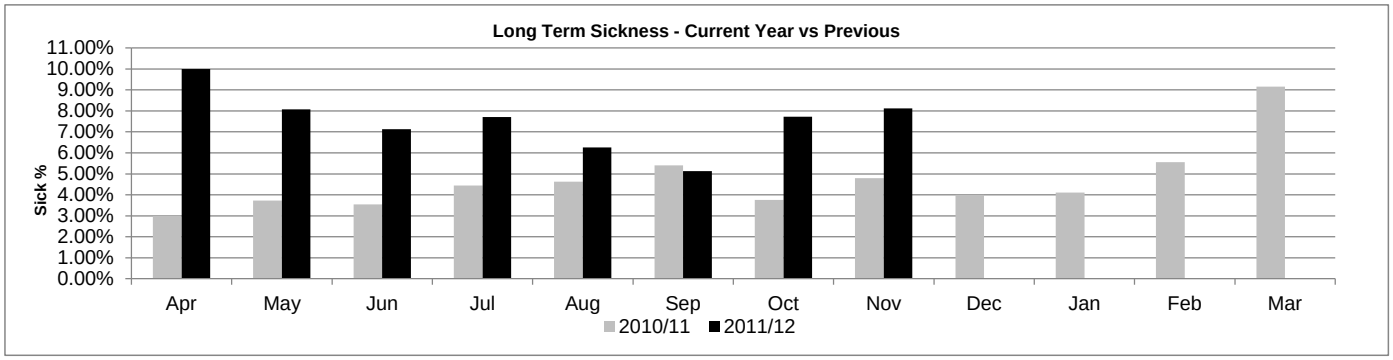
Workforce Report

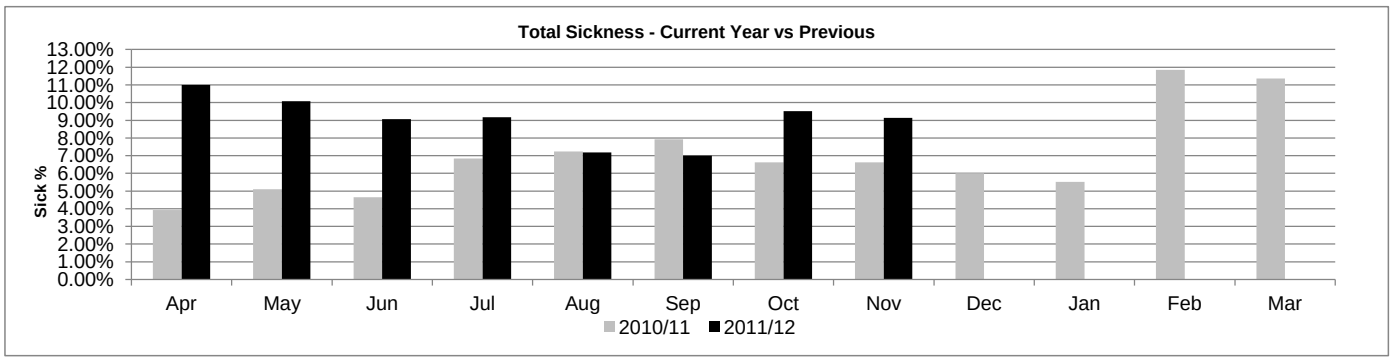
Current Month **Jan-12** **Sickness Month** **Nov-11**

Patient Transport Service

Sickness Absence







Sickness 2010/11	6.78%	**Current WTE**	153.54	**NB Secondments and Acting Up Included in Totals**	
YTD Sickness	9.02%	**Current Headcount**	162.00		

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	3.92%	5.10%	4.64%	6.84%	7.23%	7.93%	6.62%	6.61%	6.00%	5.52%	11.86%	11.36%
2011/12	11.00%	10.08%	9.06%	9.18%	7.18%	7.00%	9.52%	9.15%	0.00%	0.00%	0.00%	0.00%

Narrative

Sickness remains high within PTS due to a high number of long term sick absences. All sickness absence is being closely managed in accordance with the MAP. The breakdown in the two operational areas are:

East: 2 x long term (remains static); 1 has been given notice following a capability hearing; 1 is awaiting appointment with OHD and a (phased) return to work meeting with POM. 6 x short term (up from 3 last month); 1 member of staff placed on a formal warning.

West: 12 x long term of which 6 returned during November; 1 is awaiting capability hearing date; 2 retiring in November; 1 being considered for a capability hearing. 12 x Short Term (down from 17 in October). Again all being closely managed.

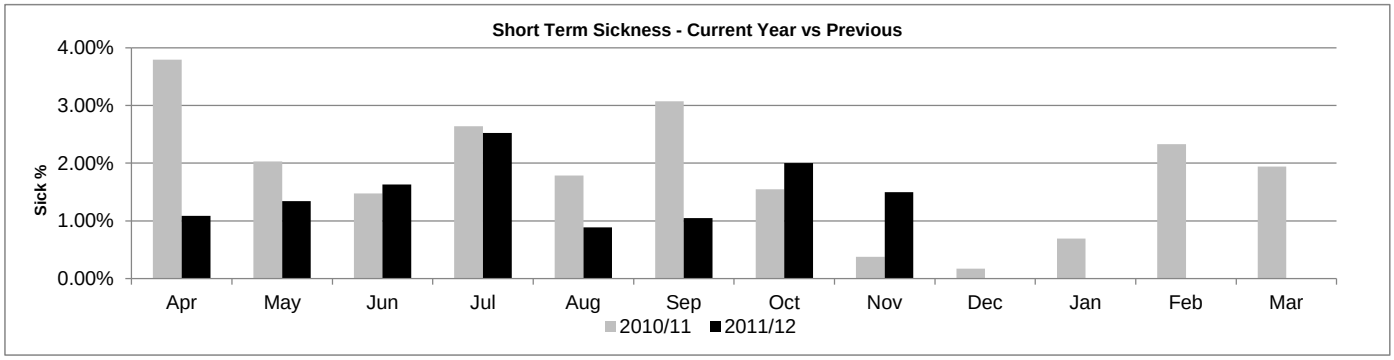
Managers: 1 x Long Term 0 x Short Term (moved from short term to long)

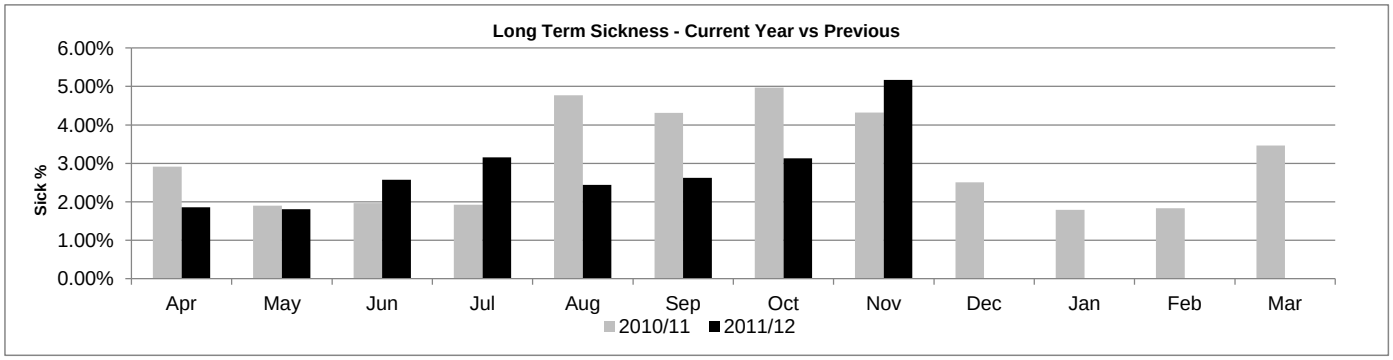
Workforce Report

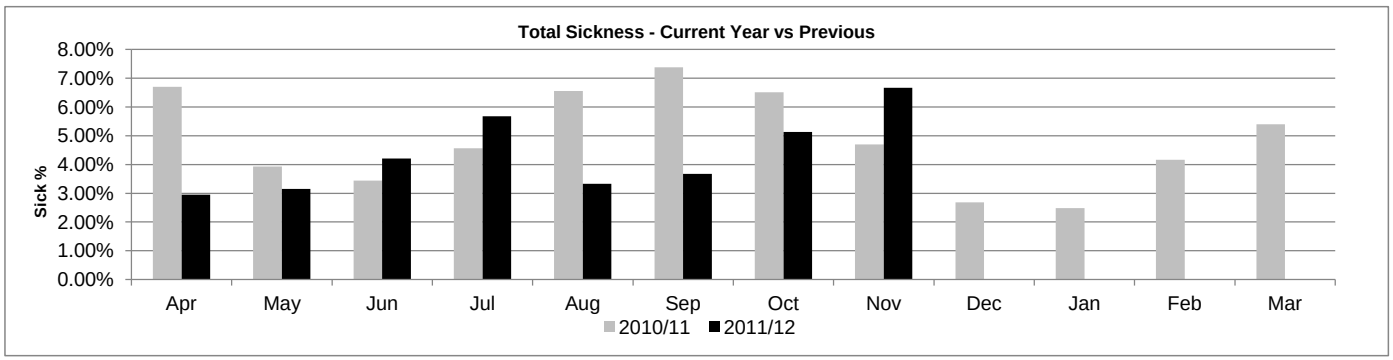
Current Month **Jan-12** **Sickness Month** **Nov-11**

Operational Support

Sickness Absence







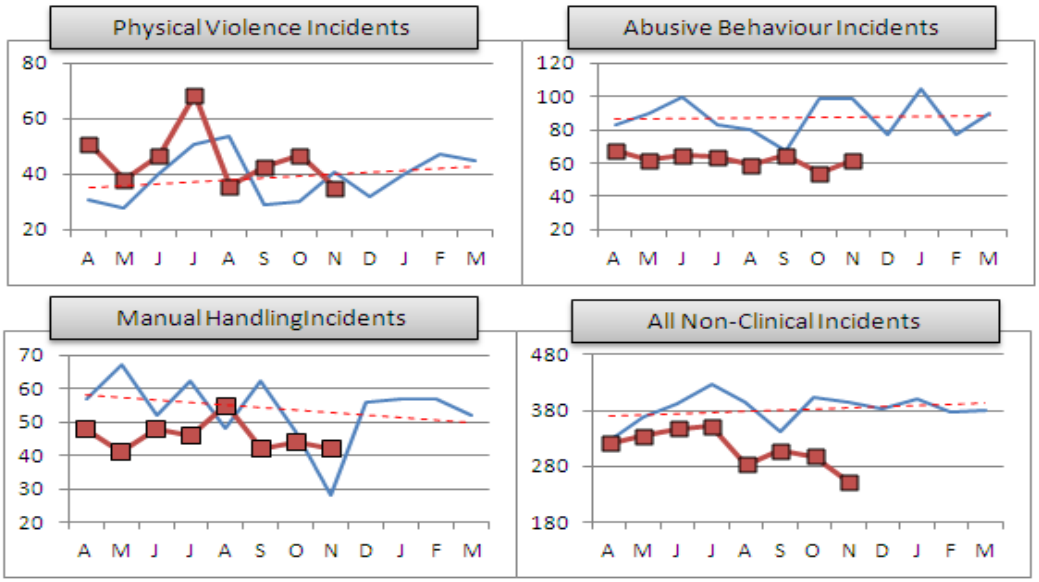
Sickness 2010/11	4.88%	**Current WTE**	113.43	**NB Secondments and Acting Up Included in Totals**
YTD Sickness	4.36%	**Current Headcount**	114.00	

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	6.70%	3.93%	3.44%	4.57%	6.55%	7.38%	6.52%	4.70%	2.68%	2.48%	4.17%	5.40%
2011/12	2.95%	3.15%	4.21%	5.68%	3.32%	3.67%	5.13%	6.67%	0.00%	0.00%	0.00%	0.00%

Narrative

Short term
11 employees had a total of 13 peisodes of short term absence in November .

Long term
Five employees are on long term sickness absence. These are being managed in accordance with the MAP.



Note: Due to the delay in receiving incidents, the figures for November are artificially low by an expected 11%. Due to this figure, the commentary will centre around November 2011, but this reduction should be considered.

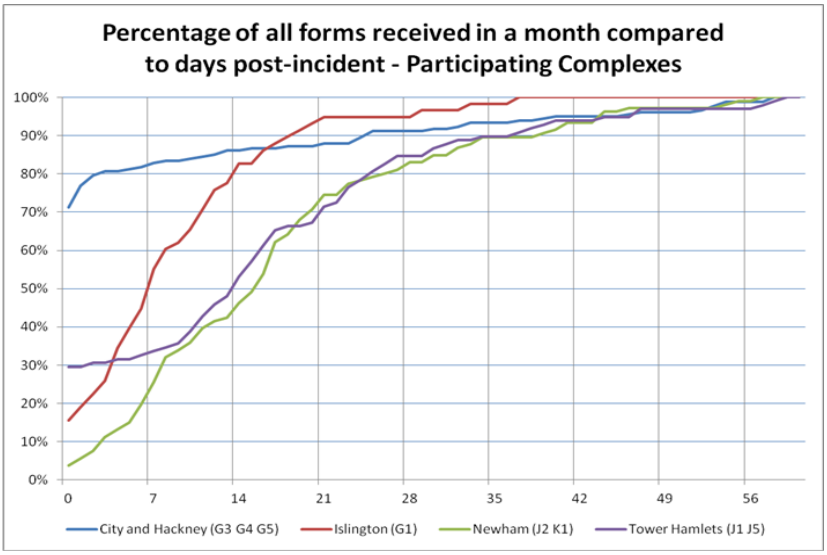
Manual Handling Update
Manual handling incidents have begun to level out in the previous three months but are up from the corresponding period last year. The East continues to report significantly larger numbers of incidents with 23 compared to the West 11 and the South 8.
Due to the onset of Winter Pressures, it has been decided to extend the chair transporter trial at the Oval; this takes away the need to train new crews at this busy time.

Abusive Behaviour Update
The number of Abusive Behaviour Incidents has risen slightly from the previous month, but again below the level reported for the same period in 2010. East 23, West 11 and South 8.

Physical Assault and Security Update
The number of Physical Assaults has decreased from the previous month East 13, West 7 and South 15.
There have been a number of successful prosecutions since the last update, two receiving prison sentences the other a community order, there are several more at various stages ongoing.

Health and Safety Training Update
There was one Managing Safety and Risk Course the ran on the 23rd of November with 7 delegates, the other course was cancelled due to insufficient delegate numbers.

EBS Reporting Trial
The pilot is still ongoing in the participating complexes. An interim report has been produced; the data within the report indicates the need for Web based incident reporting, a sample graph from the report is shown below.



This chart shows the participating complexes. It is reasonable to assume the starting point for each Complex in the chart are the Electronic forms, the subsequent rise in percentage are the Paper LA52's being received by Safety and Risk. It must be noted that those received the same day do not have

Workforce Report

Current Month **Jan-12**

Trust Summary

Vacancies & Turnover

	Funded WTE	Inpost WTE	Variance
Trust Total	4706.72	4597.08	-109.64
Directorate			
A&E Operations	3425.95	3410.92	-15.03
Chief Executive	16.61	15.61	-1.00
Control Services	437.28	423.83	-13.45
Corporate Services Directorate	52.93	50.93	-2.00
Finance & Business Planning Directorate	58.20	51.93	-6.27
Health Promotion & Quality	3.60	2.00	-1.60
Human Resources & Organisation Dev Directorate	183.12	166.17	-16.95
Information Management & Technology Directorate	91.53	84.46	-7.07
Medical Directorate	24.20	18.87	-5.33
Operational Support	130.86	114.43	-16.43
Patient Transport Service	166.44	150.54	-15.90
Trust Board	6.00	6.00	+0.00

	Est.	In Post	Var.
T/L Paramedic	193.19	199.67	+6.48
Paramedic	1143.67	1235.91	+92.24
Student Paramedic 4	4.00	76.00	+72.00
Student Paramedic 3	304.00	375.00	+71.00
Student Paramedic 2	348.00	26.00	-322.00
Student Paramedic 1	0.00	0.00	+0.00
EMT 2-4	796.18	877.35	+81.17
EMT 1	19.62	18.61	-1.01
A&E Support	355.00	343.84	-11.16
CTA	54.43	49.37	-5.06

Turnover

2010/11	7.1%	Apr-10 to Mar-11
2011/12	6.9%	12 Months up to Dec-11

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No. Leavers (Headcount)												
2010/11	44.00	32.00	11.00	27.00	28.00	34.00	22.00	52.00	18.00	26.00	24.00	34.00
2011/12	22.00	36.00	33.00	28.00	34.00	30.00	23.00	21.00	25.00	0.00	0.00	0.00
No. Starters (Headcount)												
2010/11	10.00	6.00	28.00	21.00	13.00	70.00	37.00	62.00	6.00	24.00	25.00	23.00
2011/12	6.00	7.00	7.00	21.00	7.00	32.00	50.00	8.00	15.00	0.00	0.00	0.00

NB: Inpost figures are based on individuals substantive post not their seconded/acting up post.

Workforce Report

Current Month **Jan-12**

Trust Summary

Employee Relations Data

	Attendance	Grievances	Capabilities	Discipliary (Clinical)	Discipliary (Non Clinical)
Current Case Total	867 (631)	25 (20)	2 (2)	2 (4)	10 (35)

Current Employment Tribual Cases	10 (11)

Current Suspensions	13 (5)

Narrative

* The figure for **October** appears in brackets.

Attendance
The figures and the audit results mentioned previously continue to demonstrate the focus on attendance management has been sustained.
Grievances
As reported previously , it must be expected that as managers increase the focus on all facets of performance this figure will be higher than previously seen. Nevertheless, given the number of employees, this number still remains low.
Disciplinaries
The ratio of clinical to non-clinical cases continues to show that clincial issues are rarely dealt with under the disciplinary procedure.
Employment Tribunals
We received the judgement for one case, which the Trust won. We have settled another. One new case has been lodged.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

M09 December

PAPER FOR REVIEW

Document Title:	**M09 December - Financial Review**
Report Author(s):	Maria Faroque
Lead Director:	Mike Dinan
Contact Details:	Michael.Dinan@lond-amb.nhs.uk
Why is this coming to the Trust Board?	Monthly Trust Financial Review
This paper has been previously presented to:	Senior Management Group
Recommendation for the Trust Board:	• The committee is asked to comment on the information included within the month 9 report and the actions being taken to safeguard the trusts' position against plan.

Executive Summary/key issues for the Trust Board

The Trust reported a surplus of £205k for the month against a plan surplus of £139k. The Cash position remains on track, however the Capital position is underspent £4.7m in month and requires attention. Financial risk of £3.73m has been identified at Month 9.

YTD the Trust is reporting a £1,862k surplus against plan of £2,970k. This is £1,108k behind plan and a Financial Recovery Plan has been developed in Month 4 to ensure that the planned control total of £2.7m was achieved. The Trust has delivered on this FRP through Month 9.

EBITDA in Month 9 is £397k behind plan mainly due to overspend on A&E and Control services Overtime, and reduction in PTS income.

CIP is £696k behind the year to date plan. Specific actions are being taken by SMG to recover the position by year end.

The Department of Health has set the CRL for 2011/12 at £9,112k. The Trust is planning to under spend on its allocated capital funding by £370k. The YTD position is a favourable variance of £4m mainly due to sale and leaseback of ambulances and delay in its Fleet Programme and CommandPoint.

The Year end cash position is forecast to be £5.25m.

Result

The LAS made a surplus of £205k for the month.

Ytd, the surplus is £1,862k compared to budget of £2,970k.

The forecast for the year is a surplus of £2,736. This is in line with the budgeted control total.

Forecast EBITDA is £3.6m below budget at 6.6% of income or £13.8m. This compares to £12.1m for 2010/11.

- Income shortfalls in A&E penalty (2010/11), RTA and PTS are primary drivers
- Non pay and depreciation gains offset an overspend in pay

The CIP is forecast to deliver savings of £15.5m.

The Trust is on track to achieve a Financial Risk Rating of 2.

Income

For the month, overall income was £23,448k. This was £75k up on m8 and £21k ahead of forecast.

- Q1 income impacted by application of £800k penalty for 2010/11 (£267k per month)
- Ytd income also reduced by 87k per month for a reduction in expected RTA income

Ytd, total income is down £1,359k vs budget.

- Impact of A&E penalty (£806k) and RTA income (£783k)
- PTS income down £406k vs budget

For 2011/12, the forecast income is £281,176k which is £1,803k below budget

- 2010/11 penalty £806k
- RTA £783k
- PTS £406k
- Run rate of £23.2m per month is expected to be reasonably consistent. The increase forecast in m12 relates to the final CQUIN payment of £1.8m. A related provision of £1m for underachievement of the CQUIN is included in forecast expense. See **Appendix A**.
- No penalties forecast for A&E income

Expense

For the month, total operating expense was £21,927k (m8 £21,863k) and total expense was £23,448k (m8 £23,373k).

- Payroll expense have fallen by £2k and was £127k below forecast at £16.8m
- A&E overtime is 38k less than m8 and broadly in line with forecast
- Agency expense has fallen by £31k.
- Corporate Support expense are broadly in line with last month.

Ytd, total operating expense was £394k above budget.

- Pay cost is £1,830k over budget but £3,372k below the same period in 2010/11.
- Overtime spend of £5,414k over budget. This is driven both higher than planned abstractions for training in the first half of the year and continued slippage in hospital handover times by London Acute hospitals.
- The LAS has reduced its element of time at hospital by 0.6 minutes to a current average of 15.5 minutes in the same period as at the end of November 2011.
- Another driver of increased pay expense is increase in key activity
    - Call volume is up 5.9% over the same period in 2010/11 compared to plan of 2.8%.
    - Cat A activity is 10.2% over the same period last year (plan 3.5%)
    - Overall incident activity is down 2.4% (Planned increase 1.8%)
    - Cat A activity is a disproportionate driver of cost, given the higher clinical risk. At present the LAS is absorbing this additional clinical activity.
- Non pay is £394k above budget as a result of operating lease costs of vehicles.
- Depreciation, Dividend and Interest expense is £2,476k below budget mainly due to slippage in the capital plan.
- Average monthly operating expense is £21,927k and total expense £23,448k

For 2011/12, the forecast total operating expense is £278.4m which is in line with budget and £3.8m below 2010/11.

- Forecast average payroll expense is £17m per month for the remaining 3 months of 2011/12. This is line with the current run rate.
- Overtime spend has been re-profiled in line with the updated workforce plan.
- Forecast total payroll expense is £2.8m below payroll cost for 2010/11.
- Non Pay expense is forecast to be in line with budget and adjusting for income provisions £1.0m below 2010/11
- Forecast monthly average non pay cost for rest of the year is at £5.1m

Depreciation, Dividend & Interest expense is forecast to be £3.0m below budget.

- Depreciation is forecast to be £1.8m below budget due to the delay in implementing CommandPoint
- Slippage in the rest of the capital plan (Estates and Fleet) is also included in the forecast.

Cost Improvement Programme (CIP)

Ytd, the CIP delivered is £10.6m which is £696k below plan.

- Slippages in rest breaks (£257k), Agency (£176k) and Unidentified (£705k)
- Non Pay Savings (£670k) ahead of plan and IM&T Savings (£295k) behind plan

Forecast CIP is expected to exceed the plan by £683k.

- Rest break slippage of £348k caused by current operating pressures
- Agency under plan by £138k with further SMG attention to attempt to recover position
- PTS CIP plan critical to turnaround plan
- Support Service pay on track to deliver planned savings underpinned by vacancy freeze
- Annual Leave accrual monitored by senior finance team to ensure delivery of required CIP

The Director of Finance has implemented a continuous review of all of the existing CIP projects.

Balance Sheet & Cash flow

Capital Employed by the LAS of £114.4m is unchanged from m8. Forecast capital employed is £115.4m.

Trust on track to deliver a return on assets of 6.5% for the year in line with plan of 6.6%

The capital plan is under spent by £4,712k on its capital plan by m9. This is caused by a delay in CommandPoint, IT hardware replacement, and the sale and leaseback on ambulances.

Forecast capital expenditure of £8.7m is projected to be below the plan or CRL of £9.1m.

The Finance & Investment Committee and SMG continue to closely monitor capital spend.

Cash balances were £8.9m at the end of m9. The forecast cash balance for m12 remains £5.3m. Key elements of the forecast include:

- Delivery of forecast EBITDA (£18.8m)
- Capital plan delivered
- Completion of Sale & Leaseback transactions for existing leased vehicles

Better Payment Practice Code (BPPC)

Ytd performance for supplier payments is Non NHS (90%) and NHS (82%) which is behind the required 95%. This metric is being tracked by the department to improve performance.

Financial Risks

Key financial risks remain

- Unachieved CQUIN – **see appendix A**
- Failure to deliver the CIP
- Overtime control
- VAT reclaim

A worse case scenario has been developed identifying a £3.7m risk to the current forecast.

Existing controls plus the application of the Financial Recovery Plan are expected to mitigate this risk.

Financial Recovery Plan (FRP)

Additional Income

- CQUIN delivery reviewed by SMG
- RTA review underway by senior finance team
- No additional income included in current forecast.

Forecast Pay (£17.0m) expense was delivered in m9.

Further analysis is being completed for the non forecast items in the FRP.

Conclusion

The trust is on track to deliver a surplus of £2.7m

- No performance penalties
- CIP delivered
- Overall pay controlled at £17m per month
- Non pay controlled at average £5.1 per month

CRL will be achieved.

Cash flow forecast of £5m for m12 will be achieved.

Mike Dinan

Director of Finance

January 2012

London Ambulance Service NHS Trust

Trust Board - Financial Review

Month Ending 31st December 2011 - (Month 9)

Report Contents

LAS Financial Review - Financial Snapshot

APPENDIX 1

Month Ending 31st December 2011 - (Month 9)

NHS Trust Statutory Financial Duties	Forecast	Commentary
Income & Expenditure against plan	↓	Assessment based on achievement of the YTD financial plan
External Financing Limit (EFL)	↔	Assessment based on achievement of the YTD financial plan
Capital Resource Limit (CRL)	↓	Assessment based on achievement of the YTD financial plan
Return on Assets	↑	Assessment based on achievement of the YTD financial plan
CIP	↓	The Trust is expected to deliver a CIP of £15.5m for the year. At month 9 the trust is behind plan.

Income and Expenditure

The year to date I&E position is a surplus of £1,862k, behind plan by £1.1m mainly due to overspend on A&E Overtime and reduction in RTA and PTS Income. Recovery plan has been developed to ensure the Trust remains on track financially for the rest of the year.

Capital

The Trust is forecasting to meet its Capital Resource Limit (CRL) for the year.

Cash

The Trust is forecasting to meet the External Financing Limit (EFL) for the year.

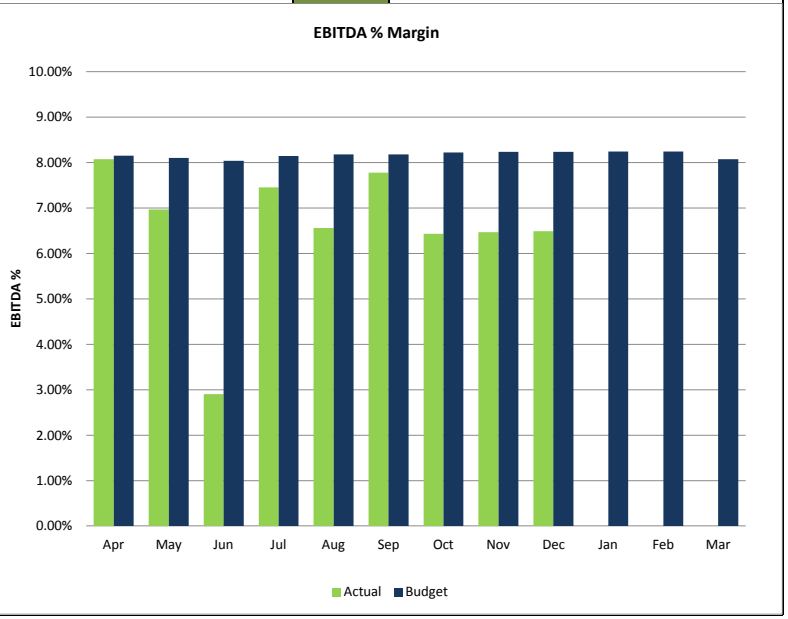
Financial Risk Rating

Monitor Financial Risk Rating forecast is for performance equivalent to a rating of 2. Monitor assesses financial risk on a scale from 1 (high risk) to 5 (low risk).

NHS Financial Performance Framework	Forecast Score	Status	Commentary
Initial Planning (Planned I&E Surplus Margin)	3	G	The planned I&E surplus is in line with SHA expectations
Year to Date Performance (YTD I&E Surplus Margin)	3	G	Year to date Operating Surplus is at variance to plan less than 3% of Income (0.5%)
Forecast Outturn Performance (Forecast I&E Surplus Margin)	3	G	Forecast surplus with variance from plan of less than 3% of Forecast Income (0.001%)
Underlying Financial Position (Underlying I&E Surplus Margin)	3	G	Underlying breakeven or surplus position is on track
Better Payment Practice Code (95% bills paid within 30 days)	2	A	Bills paid within 30 days for the year to date to 82% of NHS suppliers and 90% non NHS suppliers
Balance Sheet Efficiency (Liquidity)	2	A	Current assets (stocks, debtors and cash) over current liabilities (amount owing < one year) less than 1 but greater than 0.5
LAS Trust Management Costs (% of Total LAS Income (Excl. MPET))	N/A	G	Management costs (excluding MPET) is 6.73% of Income
Overall	3	G	**Trust is rated as Performing**

Monitor Financial Risk Rating	Forecast Score	Status	Commentary
Achievement of plan (EBITDA achieved compared to plan)	3	A	Better than 70% achievement against planned EBITDA margin
Underlying Performance (EBITDA margin)	3	A	The EBITDA margin required is 5% for 3 and 9% for 4 (current forecast is 6.7%)
Financial Efficiency (Return on assets and I&E margin)	4	G	Return on Assets is forecast at 6.5% and I&E surplus margin is forecast at 1%
Liquidity (Liquid assets / operating expenditure)	1	R	Liquid asset cover less than15 days, assumes 30 day working facility
Overall	2	G	**The Trust is targeting a score of 4 for 2011/12**

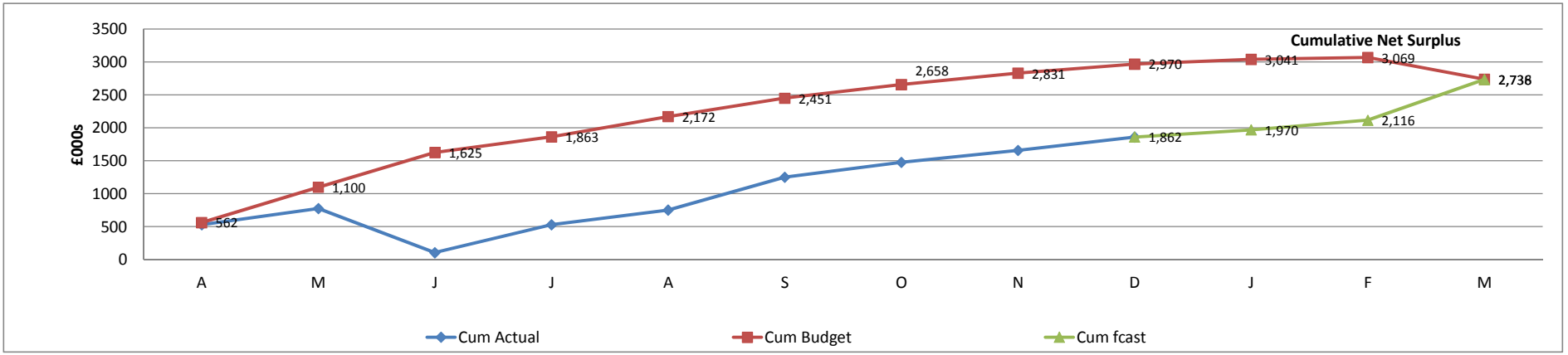
Income & Expenditure	Current Month Actual £000	Current Month Budget £000	Current Month Variance £000	Year to Date Actual £000	Year to Date Budget £000	Year to Date Variance £000	Annual Forecast £000	Annual Budget £000
Income								
A&E	(20,852)	(20,853)	(1)	(186,872)	(187,679)	(806)	(251,282)	(252,088)
HART/CBRN	(1,234)	(1,234)	0	(11,144)	(11,102)	41	(14,844)	(14,803)
Olympics	(114)	(114)	0	(1,024)	(1,024)	0	(1,365)	(1,365)
PTS	(517)	(568)	(51)	(4,705)	(5,111)	(406)	(6,332)	(6,815)
Other	(731)	(659)	72	(5,743)	(5,931)	(187)	(7,352)	(7,908)
Total Income	**(23,448)**	**(23,427)**	**21**	**(209,488)**	**(210,847)**	**(1,359)**	**(281,176)**	**(282,979)**
Pay Expenditure								
Frontline	10,413	11,058	645	95,481	98,119	2,639	127,150	131,513
Other	5,286	5,488	202	47,427	49,446	2,018	63,873	65,923
Overtime	991	395	(596)	9,347	4,369	(4,979)	12,043	5,337
Agency	142	19	(124)	1,698	189	(1,509)	2,124	250
Total Pay	**16,833**	**16,960**	**127**	**153,953**	**152,123**	**(1,830)**	**205,191**	**203,023**
Medical Consumables	605	497	(108)	4,530	4,473	(57)	5,922	5,964
Vehicle	797	893	96	9,537	8,034	(1,503)	12,246	10,712
Fuel & Oil	556	496	(61)	4,445	4,462	17	5,986	5,949
Accommodation and Estates	1,059	1,062	3	9,216	9,770	554	12,411	12,934
Other	2,077	1,601	(476)	14,038	14,634	596	20,612	21,563
Finance Costs	352	451	99	3,335	4,059	725	4,447	5,412
Depreciation	965	1,329	364	8,572	10,323	1,751	11,625	14,684
Total Non Pay	**6,411**	**6,329**	**(82)**	**53,672**	**55,754**	**2,082**	**73,249**	**77,218**
Total Expenditure	**23,244**	**23,289**	**45**	**207,626**	**207,877**	**252**	**278,440**	**280,241**
EBITDA	**(1,522)**	**(1,919)**	**(397)**	**(13,769)**	**(17,352)**	**(3,584)**	**(18,808)**	**(22,834)**
(Surplus) / Deficit	**(205)**	**(139)**	**66**	**(1,862)**	**(2,970)**	**(1,108)**	**(2,736)**	**(2,738)**



LAS Financial Review - Financial Summary

APPENDIX 2

Month Ending 31st December 2011 - (Month 9)



	Month Act	Month Budget	Month Variance	%	Ytd Act	Ytd Budget	Diff	%	Ytd 1011	Diff	%	2011/12 Fcast	2011/12 Budget	Diff	%
Income															
A&E	21,636	21,671	(35)	-0.2%	193,428	195,038	(1,610)	-0.8%	193,330	98	0.1%	259,934	261,901	(1,967)	-0.8%
Other	1,813	1,757	56	3.2%	16,060	15,809	251	1.6%	18,574	(2,514)	-13.5%	21,242	21,078	163	0.8%
Total	23,448	23,427	21	0.1%	209,488	210,847	(1,359)	-0.6%	211,904	(2,416)	-1.1%	281,176	282,979	(1,803)	-0.6%
Operating Expense															
Pay	16,833	16,960	127	0.8%	153,953	152,123	(1,830)	-1.2%	157,325	3,371	2.1%	205,191	203,023	(2,168)	-1.1%
Non Pay	5,094	4,548	(546)	-12.0%	41,766	41,372	(394)	-1.0%	42,422	656	1.5%	57,177	57,122	(55)	-0.1%
Total	21,927	21,509	(418)	-1.9%	195,719	193,495	(2,224)	-1.1%	199,746	4,027	2.0%	262,368	260,145	(2,223)	-0.9%
EBITDA	1,522	1,919	(397)	-20.7%	13,769	17,352	(3,584)	-20.7%	12,158	1,611	13.2%	18,808	22,834	(4,026)	-17.6%
EBITDA %	6.5%	8.2%	-1.7%		6.6%	8.2%	-1.7%		5.7%	0.8%		6.7%	8.1%	-1.4%	
Depreciation, Dividend & Interest	1,317	1,780	463	26.0%	11,907	14,383	2,476	17.2%	12,158	251	2.1%	16,072	20,096	4,024	20.0%
Net Surplus/(Deficit)	205	139	66	47.7%	1,862	2,970	(1,108)	-37.3%	0	1,862	2779019.3%	2,736	2,738	(2)	-0.1%
Net Margin	0.9%	0.6%	0.3%		0.9%	1.4%	-0.5%		0.0%	0.0%		1.0%	1.0%	0.0%	
Impairments	0	0	0	#DIV/0!	0	0	0	#DIV/0!	0	0	#DIV/0!	0	0	0	#DIV/0!
Net Surplus after Impairment	205	139	66	47.7%	1,862	2,970	(1,108)	-37.3%	0	1,862	2779019.3%	2,736	2,738	(2)	-0.1%
Income															
Non Current Assets					142,576	143,882	(1,306)	-0.9%	140,717	1,859	1.3%	143,544	143,882	(338)	-0.2%
Cash					8,852	8,152	700	8.6%	4,209	4,643	110.3%	5,250	5,250	0	0.0%
Working Capital					(14,853)	(5,383)	(9,470)	175.9%	5,529	(20,382)	-368.6%	(13,773)	(5,383)	(8,390)	155.9%
Non Current Liabilities					(22,094)	(28,403)	6,309	-22.2%	(41,811)	19,717	-47.2%	(19,665)	(28,403)	8,738	-30.8%
Capital Employed					114,481	118,248	(3,767)	-3%	108,644	5,837	5.4%	115,356	115,346	10	0%
Average Capital Employed					114,481	118,248	(3,767)	-3.2%	108,486	5,996	5.5%	115,356	118,248	(2,892)	-2.4%
Return on Assets												6.49%	6.50%	0.0%	-0.1%

LAS Financial Review - Income & Expense Trend

APPENDIX 3

Month Ending 31st December 2011 - (Month 9)

	Apr-11 Actual	May-11 Actual	Jun-11 Actual	Jul-11 Actual	Aug-11 Actual	Sep-11 Actual	Oct-11 Actual	Nov-11 Actual	Dec-11 Actual	Jan-12 Fcast	Feb-12 Fcast	Mar-12 Fcast	2011/2012 Fcast	2011/2012 Budget	Diff	%
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	
Income	**(23,354)**	**(22,690)**	**(23,060)**	**(23,479)**	**(23,403)**	**(23,331)**	**(23,349)**	**(23,373)**	**(23,448)**	**(23,275)**	**(23,285)**	**(25,129)**	**(281,176)**	**(282,979)**	**(1,803)**	**-0.6%**
Payroll (£k)																
A&E Frontline	10,733	10,675	10,640	10,584	10,628	10,539	10,652	10,617	10,413	10,547	10,580	10,542	127,150	131,513	4,363	3.3%
A&E Overtime	857	648	1,075	1,062	972	862	831	914	876	830	608	837	10,372	4,957	(5,414)	-109.2%
A&E Management	1,240	1,257	1,205	1,204	1,209	1,211	1,237	1,234	1,188	1,232	1,233	1,233	14,682	14,301	(380)	-2.7%
EOC	975	977	959	947	956	948	919	935	965	1,001	989	977	11,549	12,053	505	4.2%
Operational Support	288	296	311	315	332	316	317	316	320	320	320	320	3,770	4,210	440	10.5%
PTS	390	388	388	381	389	378	356	367	361	362	362	362	4,483	4,611	128	2.8%
Corporate Support	2,286	2,369	2,399	2,390	2,466	2,470	2,424	2,396	2,453	2,575	2,597	2,566	29,390	30,747	1,357	4.4%
Other Overtime	130	146	193	136	147	141	114	128	116	132	122	168	1,672	380	(1,292)	-339.9%
Agency	217	237	308	174	128	203	177	111	142	145	140	140	2,124	250	(1,874)	-749.6%
Total	**17,115**	**16,993**	**17,477**	**17,193**	**17,228**	**17,068**	**17,026**	**17,020**	**16,833**	**17,143**	**16,950**	**17,145**	**205,191**	**203,023**	**(2,168)**	**-1.1%**
Non Pay																
Staff Related	441	630	578	546	511	512	597	603	507	547	630	551	6,654	5,956	(699)	-11.7%
Consumables, Medical Equip & Drugs	479	430	548	491	423	491	509	554	605	461	461	470	5,922	5,964	42	0.7%
Vehicle Leasing	123	253	328	241	259	261	262	263	272	273	273	273	3,081	1,480	(1,601)	-108.2%
Fuel & Oil	504	492	476	550	470	417	497	482	556	522	497	522	5,986	5,949	(38)	-0.6%
Vehicle Maintenance	619	647	702	483	571	775	623	607	490	613	613	613	7,357	7,609	252	3.3%
Vehicle Insurance	179	138	370	322	378	189	13	134	34	17	17	17	1,808	1,623	(185)	-11.4%
3rd Party Transport	42	70	61	98	72	114	67	90	105	82	82	82	964	585	(379)	-64.8%
Accommodation & Estates	1,080	913	1,011	1,009	991	1,059	1,010	1,083	1,059	1,059	1,059	1,078	12,411	12,934	523	4.0%
IT & Telecoms	564	628	609	530	579	495	744	784	756	672	682	687	7,731	7,918	187	2.4%
Finance & Legal	152	(270)	(10)	87	243	190	163	84	261	246	287	1,422	2,856	4,545	1,689	37.2%
Consultancy	58	69	86	41	43	33	61	56	88	52	34	4	625	672	47	7.0%
Other	112	115	153	139	100	(89)	276	103	359	91	164	257	1,781	1,887	105	5.6%
Subtotal	**4,354**	**4,116**	**4,913**	**4,537**	**4,639**	**4,448**	**4,821**	**4,843**	**5,094**	**4,634**	**4,801**	**5,976**	**57,177**	**57,122**	**(55)**	**-0.1%**
Depreciation																
Fleet	476	477	475	454	443	451	397	425	424	450	450	450	5,368	6,658	1,290	19.4%
IT	140	140	140	140	140	140	150	150	150	155	155	155	1,760	3,528	1,769	50.1%
Other	347	348	348	348	348	348	391	391	391	413	413	413	4,497	4,497	0	0.0%
Subtotal	**962**	**965**	**963**	**943**	**931**	**939**	**938**	**966**	**965**	**1,018**	**1,018**	**1,018**	**11,625**	**14,684**	**3,058**	**20.8%**
Financial																
Dividend	319	319	319	319	319	319	319	319	319	319	319	319	3,832	3,832	0	0.0%
Interest	72	51	59	63	61	59	18	44	33	52	51	51	615	1,580	966	61.1%
Subtotal	**392**	**370**	**378**	**383**	**380**	**378**	**337**	**364**	**352**	**371**	**370**	**371**	**4,447**	**5,412**	**966**	**17.8%**
Total Expense	**22,823**	**22,445**	**23,732**	**23,054**	**23,179**	**22,833**	**23,123**	**23,193**	**23,244**	**23,166**	**23,139**	**24,509**	**278,440**	**280,241**	**1,801**	**0.6%**
Net Surplus	**(531)**	**(245)**	**671**	**(424)**	**(223)**	**(498)**	**(226)**	**(181)**	**(205)**	**(108)**	**(146)**	**(620)**	**(2,736)**	**(2,738)**	**(2)**	**0**
Cumulative Surplus	**(531)**	**(776)**	**(105)**	**(529)**	**(753)**	**(1,250)**	**(1,477)**	**(1,657)**	**(1,862)**	**(1,970)**	**(2,116)**	**(2,736)**	**(2,736)**	**(2,738)**		

LAS Financial Review - Worst Case Scenario

APPENDIX 4

Month Ending 31st December 2011 - (Month 9)

	2011/2012 Base Case Fcast	2011/2012 Worst Case Fcast	Diff	%	2011/2012 Budget
	£000	£000	£000		£000
Income	**(281,176)**	**(279,768)**	**(1,408)**	**0.5%**	**(282,979)**
Payroll (£k)					
A&E Frontline	127,150	127,150	0	0.0%	131,513
A&E Overtime	10,372	10,797	(425)	-4.1%	4,957
A&E Management	14,682	14,682	0	0.0%	14,301
EOC	11,549	11,549	0	0.0%	12,053
Operational Support	3,770	3,770	0	0.0%	4,210
PTS	4,483	4,483	0	0.0%	4,611
Corporate Support	29,390	29,390	0	0.0%	30,747
Other Overtime	1,672	1,672	0	0.0%	380
Agency	2,124	2,124	0	0.0%	250
Total	**205,191**	**205,616**	**(425)**	**-0.2%**	**203,023**
Non Pay					
Staff Related	6,654	6,992	(338)	-5.1%	5,956
Consumables, Medical Equip & Drugs	5,922	5,922	0	0.0%	5,964
Fuel & Oil	5,986	5,986	0	0.0%	5,949
Vehicle Maintenance	7,357	7,357	0	0.0%	7,609
Vehicle Insurance	1,808	1,808	0	0.0%	1,623
3rd Party Transport	964	964	0	0.0%	585
Accommodation & Estates	12,411	12,411	0	0.0%	12,934
IT & Telecoms	7,731	7,781	(50)	-0.6%	7,918
Finance & Legal	2,856	4,366	(1,510)	-52.9%	4,545
Consultancy	625	625	0	0.0%	672
Other	1,781	1,781	0	0.0%	1,887
Subtotal	**57,177**	**59,075**	**(1,898)**	**-3.3%**	**57,122**
Depreciation					
Fleet	5,368	5,368	0	0.0%	0
IT	1,760	1,760	0	0.0%	0
Other	4,497	4,497	0	0.0%	14,684
Subtotal	**11,625**	**11,625**	**0**	**0.0%**	**14,684**
Financial					
Dividend	3,832	3,832	0	0.0%	3,832
Interest	615	615	0	0.0%	1,580
Subtotal	**4,447**	**4,447**	**0**	**0.0%**	**5,412**
Total Expense	**278,440**	**280,763**	**(2,323)**	**-0.8%**	**280,241**
Net (Surplus)/ Deficit	**(2,736)**	**995**	**(3,731)**	**(0)**	**(2,738)**

* The net value of the financial risks listed in Appendix 11 has been used in developing the Worst Case scenario forecast in this Appendix

LAS Financial Review - CIP Summary

APPENDIX 5

Month Ending 31st December 2011 - (Month 9)

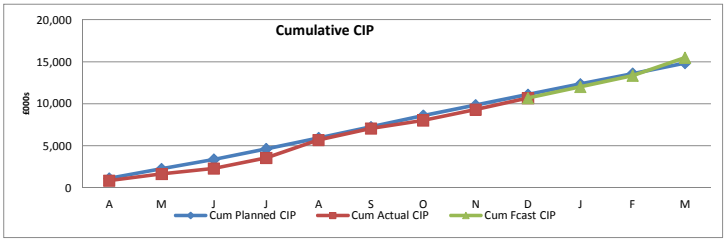
Key CIP Programs	Performance Ytd Position Act £000	Plan £000	Diff £000	%	Forecast 2011/12 Fcast £000	Plan £000	Diff £000	%	Status Current	Forecast
Front Line staffing - Process Management	3,890	3,890	0	100.0%	5,187	5,187	0	100.0%	↔	↔
Front Line staffing - Resource Management	276	533	(257)	51.8%	452	800	(348)	56.5%	↓	↓
Fleet optimisation	112	167	(55)	67.1%	245	251	(6)	97.6%	↓	↓
Support Services - Pay	537	463	74	116.0%	734	617	117	119.0%	↑	↑
Support Services - Agency	1,610	1,786	(176)	90.1%	2,243	2,381	(138)	94.2%	↓	↓
Support Services - Non Pay	3,216	2,546	670	126.3%	4,474	3,740	734	119.6%	↑	↑
Support Services - IM&T	401	696	(295)	57.6%	535	895	(360)	59.8%	↓	↓
PTS	187	139	48	134.5%	303	268	35	113.1%	↑	↑
Subtotal	**10,229**	**10,220**	**9**	**100.1%**	**14,173**	**14,139**	**34**	**100.2%**	↑	↑
Unidentified	398	1,103	(705)	36.1%	550	669	(119)	82.2%	↓	↓
Other - Annual Leave Policy	0	0	0	0.0%	800	32	768	2500.0%	↔	↑
Total	**10,627**	**11,323**	**(696)**	**93.9%**	**15,523**	**14,840**	**683**	**104.6%**	↓	↑

KEY:

CIP Target being exceeded by more than 5%	↑
CIP Target not being achieved by more than 5%	↓
CIP on Target +/- 5% of plan	↔

Front Line Staffing - Process Management :
- CIP identified in this line only include the reduction of Frontline posts by 132wte. It does not include overspend on Overtime and over establishment of A&E Management.

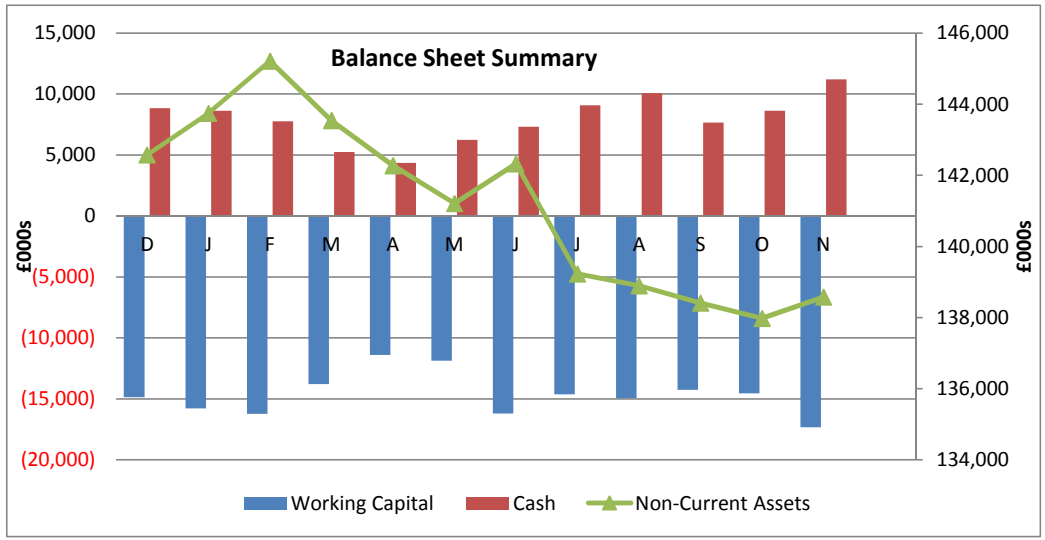
Other :
- Included in Other is £800k further CIP to be identified relating to Year-End Agreement with PCT. This is expected to be achieved in Month 12 through amendments in annual leave policy.

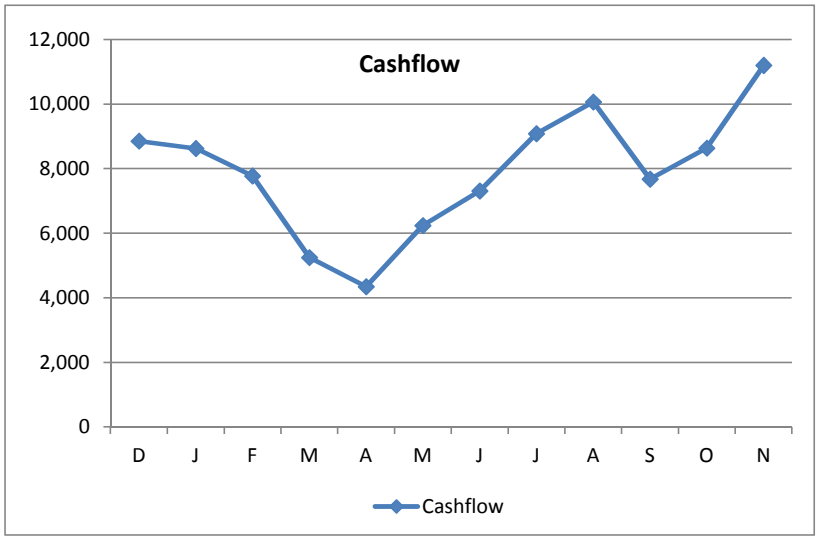


LAS Financial Review - Balance Sheet & Cashflow

APPENDIX 6

Month Ending 31st December 2011 - (Month 9)





Trade Debtors	A&E £-96k > 60 days (-4.15%),November £-265k > 60 days (-18.24%)
	PTS £498k > 60 days (21.51%), November £423k > 60 days (29.15%)
Trade Creditors	NHS PSPP - This month (92%), November (92%), Ytd (82%)
	Non NHS PSPP - This month (93%), November (92%), Ytd (90%)

Key Balance Sheet Items	Current £000s		Year End £000s	
Cash	8,852		5,250	
Working Capital	(14,853)		(13,773)	

	Dec-11 £'000s Actual	Jan-12 £'000s Fcast	Feb-12 £'000s Fcast	Mar-12 £'000s Fcast	Apr-12 £'000s Fcast	May-12 £'000s Fcast	Jun-12 £'000s Fcast	Jul-12 £'000s Fcast	Aug-12 £'000s Fcast	Sep-12 £'000s Fcast	Oct-12 £'000s Fcast	Nov-12 £'000s Fcast
Non-Current Assets	142,576	143,745	145,212	143,544	142,275	141,207	142,323	139,228	138,895	138,410	137,977	138,579
Current Assets	20,570	19,241	18,256	19,173	18,284	20,176	19,308	21,082	22,064	17,791	18,751	21,316
Total Assets	**163,146**	**162,986**	**163,468**	**162,717**	**160,559**	**161,383**	**161,631**	**160,310**	**160,959**	**156,201**	**156,728**	**159,895**
Current Liabilities	(26,571)	(26,393)	(26,699)	(27,696)	(25,323)	(25,796)	(28,201)	(26,627)	(26,933)	(24,361)	(24,652)	(27,443)
Net Current Assets/(Liabilities)	**(6,001)**	**(7,152)**	**(8,443)**	**(8,523)**	**(7,039)**	**(5,620)**	**(8,893)**	**(5,545)**	**(4,869)**	**(6,570)**	**(5,901)**	**(6,127)**
Total Assets less Current Liabilities	**136,575**	**136,593**	**136,769**	**135,021**	**135,236**	**135,587**	**133,430**	**133,683**	**134,026**	**131,840**	**132,076**	**132,452**
Total Non-Current Liabilities	22,094	22,003	22,033	19,665	19,575	19,621	17,159	17,107	17,145	14,654	14,585	14,656
Total Assets Employed	**114,481**	**114,590**	**114,736**	**115,356**	**115,661**	**115,966**	**116,271**	**116,576**	**116,881**	**117,186**	**117,491**	**117,796**
Total Taxpayers' Equity	**114,481**	**114,590**	**114,736**	**115,356**	**115,661**	**115,966**	**116,271**	**116,576**	**116,881**	**117,186**	**117,491**	**117,796**
Cashflow	**8,852**	**8,624**	**7,772**	**5,250**	**4,349**	**6,241**	**7,311**	**9,085**	**10,067**	**7,674**	**8,634**	**11,199**

LAS Financial Review - Capital Summary

APPENDIX 7

Month Ending 31st December 2011 - (Month 9)

Projects	Ytd Position Month 9				Capital plan 2011/12				Status
	Act £000	Plan £000	Diff £000	%	Act £000	Plan £000	Diff £000	%	2011/12
Capital programme - Information Technology	3,052	3,163	111	4%	4,336	3,845	(491)	-13%	↓
Capital programme - Estates	1,100	1,141	41	4%	1,730	1,500	(230)	-15%	↓
Capital programme - Fleet	2,907	5,352	2,445	46%	6,890	8,265	1,375	17%	↑
Capital programme - Equipment	0	0	0	0%	2,466	0	(2,466)	0%	↓
Capital programme - Disposals NBV	(9,503)	(6,738)	2,765	41%	(9,503)	(6,738)	2,765	41%	↑
Capital programme - Unallocated funds	2,374	1,724	(650)	-38%	2,374	2,240	(134)	-6%	↓
Total	(70)	4,642	4,712	102%	8,293	9,112	819	9%	↑

> Information Technology - slippage in Command Point delivery plan will lead to overspend by year end
> Fleet - Slippage on the purchase of new FRU vehicles means only 10 will be delivered before year end. A Business Case is currently in progress for DSO replacement vehicles.
> Equipment - Finance & Investment Committee has recently approved the purchase of defiblirators to offset against the underspend on the Trust's Fleet programme. Invoices are due for payment starting on 1st April 2012.
> The Trust will terminate two of the Bank of Scotland finance leases in October 2011 and December 2011 and purchase the ambulances outright

KEY:

Capital Program on Target	↔
Capital Program Overspend - Requires attention	↓
Capital Program Underspend - Requires attention	↑

LAS Financial Review - Income Summary

APPENDIX 8

Month Ending 31st December 2011 - (Month 9)

Month Act	Month Budget	%		Ytd Act	Ytd Budget	Diff	%	2011/2012 Fcast	2011/2012 Budget	Diff	%
£000	£000			£000	£000	£000		£000	£000	£000	
			Emergency Delivery								
20,852	20,853	0.0%	PCT Commissioned	186,872	187,679	(806)	-0.4%	251,282	252,088	(806)	-0.3%
642	642	0.0%	CBRN	5,758	5,780	(21)	-0.4%	7,685	7,706	(21)	-0.3%
141	176	-19.6%	RTA	797	1,580	(783)	-49.6%	967	2,106	(1,139)	-54.1%
21,636	**21,671**	-0.2%	**Subtotal**	**193,428**	**195,038**	**(1,610)**	-0.8%	**259,934**	**261,901**	**(1,967)**	-0.8%
			Specialised Services								
592	591	0.0%	HART	5,385	5,323	62	1.2%	7,159	7,097	62	0.9%
3	3	3.3%	HEMS	31	30	1	3.3%	41	39	1	3.3%
595	**595**	0.0%	**Subtotal**	**5,416**	**5,352**	**63**	1.2%	**7,200**	**7,137**	**64**	0.9%
			Information Services & Research								
92	92	0.3%	EBS	832	829	3	0.3%	1,108	1,106	1	0.2%
29	18	59.8%	Research	52	162	(110)	-67.7%	72	216	(144)	-66.7%
121	**110**	10.0%	**Subtotal**	**884**	**991**	**(107)**	-10.8%	**1,180**	**1,322**	**(143)**	-10.7%
			Patient Transport Services								
517	568	-8.9%	PTS	4,705	5,111	(406)	-8.0%	6,332	6,815	(483)	-7.1%
104	66	58.2%	BETS & SCBU	620	592	28	4.8%	818	789	28	3.6%
7	20	-67.3%	A&E Long Distance	152	180	(28)	-15.6%	220	240	(20)	-8.3%
			NHS London								
102	104	-2.0%	MPET	919	937	(18)	-2.0%	1,225	1,250	(25)	-2.0%
0	0	0.0%	Other Education	0	0	0	0.0%	0	0	0	0.0%
114	114	0.0%	Olympics 2012	1,024	1,024	0	0.0%	1,365	1,365	0	0.0%
216	**218**	-0.9%	**Subtotal**	**1,943**	**1,961**	**(18)**	-0.9%	**2,590**	**2,615**	**(25)**	-0.9%
			Commercial								
91	83	9.3%	Stadia	760	750	10	1.3%	1,010	1,000	10	1.0%
55	52	6.1%	BAA	497	469	29	6.1%	663	625	38	6.1%
4	1	320.8%	Training	32	9	24	279.3%	34	11	23	202.0%
150	**136**	10.3%	**Subtotal**	**1,290**	**1,227**	**62**	5.1%	**1,707**	**1,636**	**71**	4.3%
103	44	134.4%	**Other**	1,051	394	657	167.0%	1,194	525	669	127.5%
23,448	**23,427**	0.1%	**Total**	**209,488**	**210,847**	**(1,359)**	-0.6%	**281,176**	**282,979**	**(1,805)**	-0.6%

LAS Financial Review - Rolling Balance Sheet

APPENDIX 9

Opening — Closing

Month Ending 31st December 2011 - (Month 9)

	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
	Actual	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	
Non-Current Assets													
Intangible assets	15,981	15,981	15,981	15,981	15,981	15,981	15,981	15,981	15,981	15,981	15,981	15,981	
Property, Plant and Equipment	118,558	120,034	121,808	123,867	122,633	121,549	122,650	121,815	121,466	121,017	120,568	121,154	
Trade and Other Receivables	8,037	7,730	7,423	3,696	3,661	3,677	3,692	1,432	1,448	1,412	1,428	1,444	
Total Non-Current Assets	142,576	143,745	145,212	143,544	142,275	141,207	142,323	139,228	138,895	138,410	137,977	138,579	
Current Assets													
Inventories	2,644	2,644	2,644	2,644	2,644	2,644	2,644	2,644	2,644	2,644	2,644	2,644	Trade Debtors
NHS Trade Receivables	3,648	2,831	2,732	2,716	2,728	2,728	2,728	2,728	2,728	2,728	2,728	2,728	A&E £-96k > 60 days (-4.15%),November £-265k > 60 days (-18.24%)
Non NHS Trade Receivables	0	0	0	0	0	0	0	0	0	0	0	0	PTS £498k > 60 days (21.51%), November £423k > 60 days (29.15%)
Other Receivables	2,426	2,226	2,276	5,815	5,815	5,815	3,877	3,877	3,877	1,997	1,997	1,997	
Accrued Income	186	182	178	174	174	174	174	174	174	174	174	174	
Prepayments	2,814	2,734	2,654	2,574	2,574	2,574	2,574	2,574	2,574	2,574	2,574	2,574	
Investments	0	0	0	0	0	0	0	0	0	0	0	0	
Cash and Cash Equivalents	8,852	8,624	7,772	5,250	4,349	6,241	7,311	9,085	10,067	7,674	8,634	11,199	
Current Assets	20,570	19,241	18,256	19,173	18,284	20,176	19,308	21,082	22,064	17,791	18,751	21,316	
Non-Current Assets Held for Sale	0	0	0	0	0	0	0	0	0	0	0	0	
Total Current Assets	20,570	19,241	18,256	19,173	18,284	20,176	19,308	21,082	22,064	17,791	18,751	21,316	
Total Assets	163,146	162,986	163,468	162,717	160,559	161,383	161,631	160,310	160,959	156,201	156,728	159,895	
Current Liabilities													
Bank Overdraft	0	0	0	0	0	0	0	0	0	0	0	0	Trade Creditors
Non NHS Trade Payables	488	478	468	458	1,787	1,890	1,890	1,890	1,890	1,890	1,890	1,890	NHS PSPP - This month (92%), November (92%), Ytd (82%)
NHS Trade Payables	6,234	5,841	5,967	6,689	6,689	6,689	6,689	6,689	6,689	6,689	6,689	6,689	Non NHS PSPP - This month (93%), November (92%), Ytd (90%)
Other Payables	8,798	8,829	8,648	8,649	8,531	8,531	8,531	8,531	8,531	8,531	8,531	8,531	
PDC Dividend Liabilities	957	1,276	1,595	0	316	632	948	1,264	1,580	0	316	632	
Capital Liabilities	194	1,555	3,093	3,828	24	174	2,359	859	909	809	809	3,309	
Accruals	4,237	4,087	3,937	4,687	4,687	4,687	4,687	4,687	4,687	4,687	4,687	4,687	
Deferred Income	3,801	2,637	1,473	263	263	263	263	263	263	263	263	263	
DH Capital Loan Principal Repayment	622	622	622	1,244	1,244	1,244	1,244	1,244	1,244	622	622	622	
Borrowings	440	268	96	1,078	982	886	790	400	340	70	45	20	
Provisions for Liabilities & Charges	800	800	800	800	800	800	800	800	800	800	800	800	
Total Current Liabilities	26,571	26,393	26,699	27,696	25,323	25,796	28,201	26,627	26,933	24,361	24,652	27,443	
Net Current Assets/(Liabilities)	(6,001)	(7,152)	(8,443)	(8,523)	(7,039)	(5,620)	(8,893)	(5,545)	(4,869)	(6,570)	(5,901)	(6,127)	
Total Assets less Current Liabilities	136,575	136,593	136,769	135,021	135,236	135,587	133,430	133,683	134,026	131,840	132,076	132,452	
Non-Current Liabilities													
DH Capital Loan Principal Repayment	6,831	6,831	6,831	5,587	5,587	5,587	5,587	5,587	5,587	5,587	5,587	5,587	
Borrowings	7,135	7,135	7,135	5,981	5,981	5,981	3,468	3,468	3,468	927	927	927	
Other Financial Liabilities	0	0	0	0	0	0	0	0	0	0	0	0	
Provisions for Liabilities & Charges	8,128	8,037	8,067	8,097	8,007	8,053	8,104	8,052	8,090	8,140	8,071	8,142	
Total Non-Current Liabilities	22,094	22,003	22,033	19,665	19,575	19,621	17,159	17,107	17,145	14,654	14,585	14,656	
Total Assets Employed	114,481	114,590	114,736	115,356	115,661	115,966	116,271	116,576	116,881	117,186	117,491	117,796	
Financed By Taxpayers' Equity													
Public Dividend Capital	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	
Revaluation Reserve	34,927	34,927	34,927	34,927	34,927	34,927	34,927	34,927	34,927	34,927	34,927	34,927	
Donated Asset Reserve	0	0	0	0	0	0	0	0	0	0	0	0	
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	
Retained Earnings	17,457	17,566	17,712	18,332	18,637	18,942	19,247	19,552	19,857	20,162	20,467	20,772	
Total Taxpayers' Equity	114,481	114,590	114,736	115,356	115,661	115,966	116,271	116,576	116,881	117,186	117,491	117,796	

LAS Financial Review - Rolling Cashflow

Cashflow Statement

Month Ending 31st December 2011 - (Month 9)

APPENDIX 10

	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
	Actual	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	
Operating Activities													
Operating surplus/(deficit)	605	480	516	990	654	654	654	654	654	654	654	654	7,823
Depreciation and amortisation	965	1,018	1,018	1,018	1,258	1,258	1,258	1,258	1,258	1,258	1,258	1,258	14,083
Impairments and reversals	0	0	0	0	0	0	0	0	0	0	0	0	0
Transfer from the donated asset reserve	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest Paid	(29)	(47)	(46)	(47)	(27)	(27)	(27)	(27)	(27)	(27)	(27)	(27)	(385)
Dividend Paid	0	0	0	(1,914)	0	0	0	0	0	(1,896)	0	0	(3,810)
(Increase)/Decrease in Inventories	4	0	0	0	0	0	0	0	0	0	0	0	4
(Increase)/Decrease in NHS Trade Receivables	(433)	817	99	16	(12)	0	0	0	0	0	0	0	487
(Increase)/Decrease in Long Term Receivables	494	400	400	555	35	(16)	(15)	(16)	(16)	36	(16)	(16)	1,825
(Increase)/Decrease in Non NHS Trade Receivables	(168)	(93)	(93)	3,172	0	0	0	2,276	0	0	0	0	5,094
(Increase)/Decrease in Other Receivables	1,574	200	(50)	(3,539)	0	0	1,938	0	0	1,880	0	0	2,003
(Increase)/Decrease in Accrued Income	(11)	4	4	4	0	0	0	0	0	0	0	0	1
(Increase)/Decrease in Prepayments	53	80	80	80	0	0	0	0	0	0	0	0	293
Increase/(Decrease) in Trade Payables	199	(10)	(10)	(10)	1,329	103	0	0	0	0	0	0	1,601
Increase/(Decrease) in Other Payables	52	(379)	(72)	707	(128)	(10)	(10)	(10)	(10)	(10)	(10)	(10)	110
Increase/(Decrease) in Payments on Account	0	0	0	0	0	0	0	0	0	0	0	0	0
Increase/(Decrease) in Accruals	557	(150)	(150)	750	0	0	0	0	0	0	0	0	1,007
Increase/(Decrease) in Deferred Income	(901)	(1,164)	(1,164)	(1,210)	0	0	0	0	0	0	0	0	(4,439)
Increase/(Decrease) in Provisions & Liabilities	(79)	(91)	30	30	(90)	46	51	(52)	38	50	(69)	71	(65)
Net Cash inflow/outflow from operating activities	2,882	1,065	562	602	3,019	2,008	3,849	4,083	1,897	1,945	1,790	1,930	25,632
Cashflows from Investing Activites													
Interest received	11	12	12	12	4	4	4	4	4	4	4	4	79
(Payments) for property, plant & equipment	(1,245)	(1,133)	(1,254)	(2,342)	(3,828)	(24)	(174)	(2,359)	(859)	(909)	(809)	(809)	(15,745)
Proceeds from disposal of property, plant & equipment	1,152	0	0	0	0	0	0	436	0	0	0	1,465	3,053
(Payments) for intangible assets	(490)	0	0	0	0	0	0	0	0	0	0	0	(490)
Proceeds from disposal of intangible assets	0	0	0	0	0	0	0	0	0	0	0	0	0
(Payments) for investment with DH	0	0	0	0	0	0	0	0	0	0	0	0	0
(Payments) for other financial assets	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Cash inflow/outflow from investing activities	(572)	(1,121)	(1,242)	(2,330)	(3,824)	(20)	(170)	(1,919)	(855)	(905)	(805)	660	(13,103)
Net Cash inflow/outflow before financing	2,310	(56)	(680)	(1,728)	(805)	1,988	3,679	2,164	1,042	1,040	985	2,590	12,529
Cashflows from Financing Activites													
Public Dividend Capital Received	0	0	0	0	0	0	0	0	0	0	0	0	0
Public Dividend Capital Repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
Loans received from DH	0	0	0	0	0	0	0	0	0	0	0	0	0
Loans principal repaid to DH	0	0	0	(622)	0	0	0	0	0	(622)	0	0	(1,244)
Loans received from Salix Finance	0	0	0	0	0	0	0	0	0	0	0	0	0
Capital element of finance lease	(2,944)	(172)	(172)	(172)	(96)	(96)	(2,609)	(390)	(60)	(2,811)	(25)	(25)	(9,572)
Net Cashflow inflow/(outflow) from financing	(2,944)	(172)	(172)	(794)	(96)	(96)	(2,609)	(390)	(60)	(3,433)	(25)	(25)	(10,816)
Increase/(decrease) in cash & cash equivalents	(634)	(228)	(852)	(2,522)	(901)	1,892	1,070	1,774	982	(2,393)	960	2,565	1,713
Cash, cash equivalents and bank overdrafts at 301011	9,486												9,486
Cash, cash equivalents and bank overdrafts at 301012	8,852	8,624	7,772	5,250	4,349	6,241	7,311	9,085	10,067	7,674	8,634	11,199	11,199

LAS Financial Review - Financial Risks

APPENDIX 11

Month Ending 31st December 2011 - (Month 9)

Key Financial Risks	Gross Risk				Net Value £000	Status	Comment
	Value £000	Impact	Likelihood	Rating			
1. Penalty Charge - Category A Target	10,104	5	2	10	0	G	For December, we were below target but above monthly trajectory (71.62%). Overall demand was significantly lower than November (-6.48%), however CAT A demand continues to be significantly higher than last year (10.27% YTD). Cat A8 Cluster level quarterly performance is on track and does not present significant exposure especially as a number of Clusters are already exceeding the 60 minute breach threshold (7 x number of EDs in the Cluster per quarter) which provides mitigation against potential penalties. There is no risk associated with Cat A19
2. CQUIN	3,730	4	4	16	1,258	A	M9 highlights slippage on A1 ACP conveyance, 3 CPI non-conveyed and 5a EOLC. The overall risk remains the same as M8
6. CIP Delivery	14,840	5	3	15	920	A	M9 CIP is behind plan
7. Economic Cost Pressures (Fuel, Rates, etc)	250	1	3	3	0	G	M9 ytd on track
8. Low Emmission Zone	1,200	3	4	12	0	G	The implementation of LEZ will happen in FY2012/13 and therefore no cost will be incurred in this financial year
9. EOC	542	2	4	8	0	G	Risk arising from increased EOC Overtime. M9 forecast included full value of expected EOC Overtime spend for the rest of the year
12. A&E Operational	3,028	4	4	16	425	A	Operational financial risk arising from increased A&E overtime
13. PTS Profitability	1,000	2	3	6	150	G	Contract have been tendered and the outcome remains uncertain. Non contract income targets are not being met
14. VAT	850	2	4	8	590	A	HMRC have rejected the Vat reclaim on our recent transaction on Sale and Lease back of Ambulances. The Trust has filed an appeal and HMRC has agreed to review their decision
15. CBRN Equipment	225	1	5	5	100	G	The Trust needs to extend the warranty of its CBRN equipment which is expiring this financial year.
16. MPS Call Charges	80	1	4	4	50	G	It is probable that the Trust will be charged £1,000 per call by the MPS for handling 999 emergency calls during the 30th Nov strike. However, this is still in negotiation
17. Occupational Health Fees	357	2	5	10	238	A	It is likely that the Trust will be invoiced for £238k for the services rendered by Guy's and St Thomas on Occupational Health
Total	59,923				3,731		

* The net value of the financial risks listed in this Appendix has been used in developing the Worst Case scenario forecast in Appendix 4

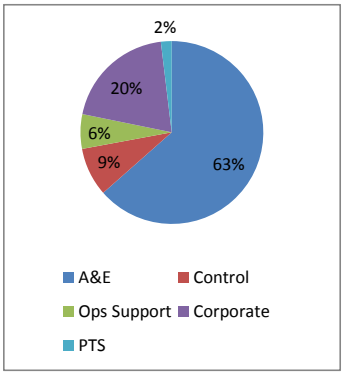
KEY:	
G	**Green - Minimal or No Financial Risk at Present**
A	**Amber - Moderate level of risk requiring attention**
R	**Red - Significant Level of risk requiring corrective action**

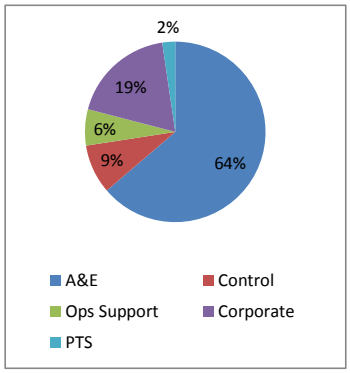
LAS Financial Review - Divisional Summary

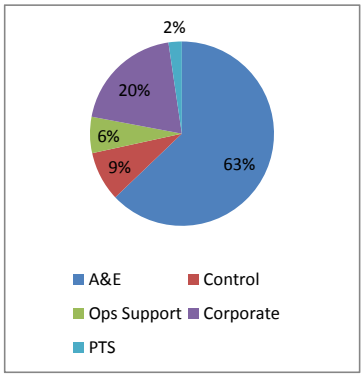
APPENDIX 12

Month Ending 31st December 2011 - (Month 9)

Month Act	Month Budget	Diff	%		Ytd Act	Ytd Budget	Diff	%	2011/2012 Fcast	2011/2012 Budget	Diff	%
£000	£000	£000			£000	£000	£000		£000	£000	£000	







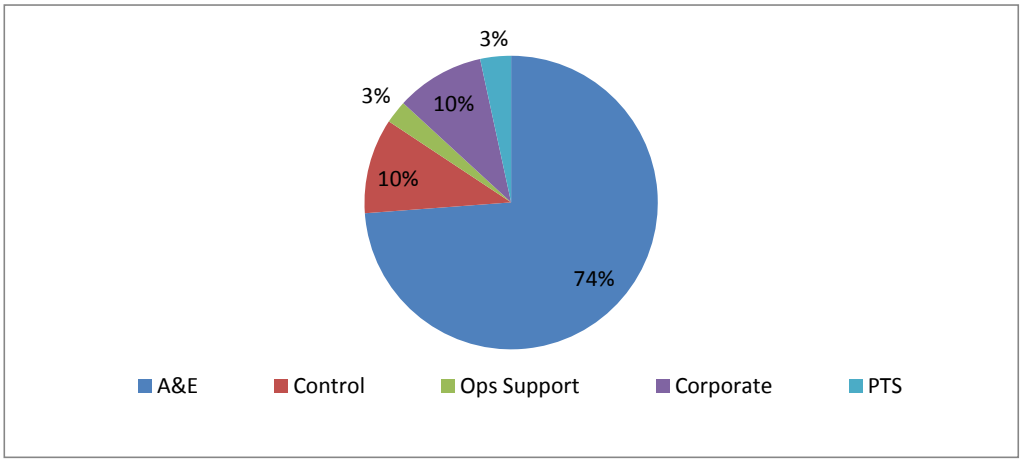
14,760	14,531	(228)	-1.6%	A&E Sector Services	132,317	129,063	(3,254)	-2.5%	175,029	172,984	(2,044)	-1.2%
2,003	1,871	(131)	-7.0%	Control Services	18,328	17,214	(1,114)	-6.5%	24,287	22,801	(1,486)	-6.5%
1,418	1,424	6	0.4%	Operational Support	13,462	12,875	(587)	-4.6%	17,725	17,148	(577)	-3.4%
18,181	17,827	(354)	-2.0%	Total Operations	164,107	159,152	(4,956)	-3.1%	217,041	212,934	(4,107)	-1.9%
450	515	65	12.6%	Patient Transport Services (PTS)	4,854	4,873	19	0.4%	6,602	6,418	(184)	-2.9%
				Corporate Directorates								
274	342	69	20.1%	Chief Executive	2,727	3,070	343	11.2%	4,147	4,098	(49)	-1.2%
424	485	60	12.4%	Corporate Services	3,716	4,344	627	14.4%	5,313	5,798	485	8.4%
168	194	26	13.4%	Strategic Development	1,651	1,727	76	4.4%	2,246	2,310	64	2.8%
1,504	1,497	(6)	-0.4%	Finance & Estates	11,671	13,410	1,739	13.0%	17,152	20,017	2,865	14.3%
912	966	54	5.6%	Human Resources & Training	7,826	8,755	929	10.6%	10,444	11,657	1,213	10.4%
1,201	1,326	125	9.4%	IM & T	10,032	11,314	1,282	11.3%	14,056	15,363	1,307	8.5%
18	18	(0)	-0.6%	Healthcare Promotion & Quality	161	164	3	1.9%	214	219	5	2.1%
113	120	7	5.8%	Medical	879	1,069	190	17.7%	1,226	1,428	202	14.1%
4,613	4,948	334	6.8%	Total Corporate Directorates	38,664	43,852	5,188	11.8%	54,797	60,889	6,092	10.0%
23,244	23,289	45	0.2%	Total LAS	207,626	207,877	252	0.1%	278,440	280,241	1,801	0.6%
1,522	1,919	(397)		EBITDA	13,769	17,352	(3,584)		18,808	22,834	(4,026)	

LAS Financial Review - Establishment Summary

APPENDIX 13

Month Ending 31st December 2011 - (Month 9)

	Month 9 Actual WTE	Month 9 Budget WTE	Diff WTE	%	Month 8 Budget WTE	Month 9 Budget WTE	Diff WTE	%
A&E Sector Services	3,387.02	3,462.98	75.96	2.2%	3,463.01	3,462.98	(0.03)	0.0%
Control Services	480.59	501.59	21.00	4.2%	504.69	501.59	(3.10)	-0.6%
Operational Support	115.43	130.86	15.43	11.8%	130.84	130.86	0.02	0.0%
Total Operations	3,983.04	4,095.43	112.39	2.7%	4,098.54	4,095.43	(3.11)	-0.1%
Patient Transport Services (PTS)	155.54	166.34	10.80	6.5%	166.33	166.34	0.01	0.0%
Corporate Directorates								
Chief Executive	45.08	50.61	5.53	10.9%	50.60	50.61	0.01	0.0%
Corporate Services	44.93	47.93	3.00	6.3%	47.93	47.93	0.00	0.0%
Strategic Development	42.66	43.67	1.01	2.3%	43.67	43.67	0.00	0.0%
Finance & Estates	53.13	57.20	4.07	7.1%	57.20	57.20	0.00	0.0%
Human Resources & Training	160.49	179.87	19.38	10.8%	179.85	179.87	0.02	0.0%
IM & T	78.98	94.03	15.05	16.0%	94.02	94.03	0.01	0.0%
Healthcare Promotion & Quality	2.00	2.00	0.00	0.0%	2.00	2.00	0.00	0.0%
Medical	20.47	25.20	4.73	18.8%	25.20	25.20	0.00	0.0%
Total Corporate Directorates	447.74	500.51	52.77	10.5%	500.47	500.51	0.04	0.0%
Total LAS	4,586.32	4,762.28	175.96	3.7%	4,765.34	4,762.28	(3.06)	-0.1%



* Paid and Worked WTE as at Month 9 are 4,972.08 wte and 4,817.92 wte respectively

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 24TH JANUARY 2012

PAPER FOR NOTING

Document Title:	**Clinical Quality and Patient Safety report**
Report Author(s):	**Dr Fionna Moore / Steve Lennox**
Lead Director:	**Dr Fionna Moore / Steve Lennox**
Contact Details:	
Why is this coming to the Trust Board?	**For information and noting**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☒ Other **Elements of this report have been discussed at CQSEC, Quality Committee CARSG and SMG**
Recommendation for the Trust Board:	**That the Board considers and notes this report**

Executive Summary/key issues for the Trust Board

Safety:

1. Ten CAS alerts since the December report. All assessed; none requiring action.

Clinical and cost effectiveness:

1. The use of the Demand Management Plan (DMP) in December is presented. Considerably greater use than in November (excluding use on 30th November), however this fails to accurately reflect the demand on the LAS, as over the Christmas period clinical staffing did not permit the use of the plan.
2. Overall CPI completion rate for November was the highest in 2011, at 93%.
3. Executive summary of cycle 6 of the National Clinical Performance indicators reported.

Governance:

1. Limited assurance provided on the management of medicines, including both Controlled and General Drug issues. No incidents relating either to Controlled Drugs or General Drugs to report. Update on the introduction of oral paracetamol and ibuprofen; tranexamic acid planned for paramedics, as part of improved major haemorrhage control.
2. Complaints portfolio has now moved to the Director of Health Promotion and Quality.
3. Continued progress with Quality Improvement Priorities, including mental health, end-of-life care and falls.
4. A Clinical Advisor for mental health has now been appointed and takes up post in February 2012.

Care Environment and Amenities

1. Infection prevention and control scorecard allocated red RAG rating, due to Governance and Compliance lead returning to operations as a result of operational pressures. This has led to audit work not being undertaken and consequently evidence for the scorecard not being available. Plans are now in place to recover audit gap.
2. To-date, 1,663 staff have received the influenza vaccination. This is higher than in 2010 and vaccination clinics are due to run until March 2012.

Attachments

Cardiac circular (007)
Clinical Audit & Research ASCQI Report

****

Strategic Goals 2010 – 13
This paper supports the achievement of the following corporate objectives:

☒ To have staff who are skilled, confident, motivated and feel valued and work in a safe environment
☒ To improve our delivery of safe and high quality patient care using all available pathways
☒ To be efficient and productive in delivering our commitments and to continually improve

Risk Implications
This paper supports the mitigation of 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

NHS Constitution
This paper supports the following principles that guide the NHS:

☒ 1. The NHS provides a comprehensive service, available to all
☒ 2. Access to NHS services is based on clinical need, not an individual's ability to pay
☒ 3. The NHS aspires to the highest standards of excellence and professionalism
☒ 4. NHS services must reflect the needs and preferences of patients, their families and their carers
☒ 5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
☒ 6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
☒ 7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

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

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board 24th January 2012

Clinical Quality and Patient Safety Report

1. Safety

1.1 Update on Serious Incidents (SIs)

Information on SIs is now provided within the Chief Executive's report. The National Directors of Clinical Care (DOCC) Group share the learning from SIs as well as discussing any Rule 43 requests made to their services at their monthly meetings.

1.2 Central Alerting System (CAS) formerly the Safety Alert Broadcasting System (SABS)

10 Alerts have been received from the MHRA for the period 2nd December 2011 – 10th January 2012. All were acknowledged and none required further action. The alert referred to in the December report, relating to the potential failure of the Merlin Gerin Ring Main Unit (the high voltage switch gear of the type used in sub stations, such as those found in large hospitals) does not apply to the LAS.

1.3 High Risk Register (HRR)

Work is continuing to review existing addresses on the High Risk Address Register. There are now a total of **693** addresses on the Register (an increase of 35 from the previous report in November 2011).

Category 1: 153
Category 2: 298
Category 3: 161
Category 4: 81

2. Clinical and Cost Effectiveness

2.1 Demand Management Plan

During December 2011, the use of DMP was significantly increased, compared to previous months; most notably the use of stage B. In total, DMP was in place for **323** hours at stages B, C and D. There was no escalation higher than stage D. In January, a meeting was held with NHS London, to inform Commissioners about DMP and its use.

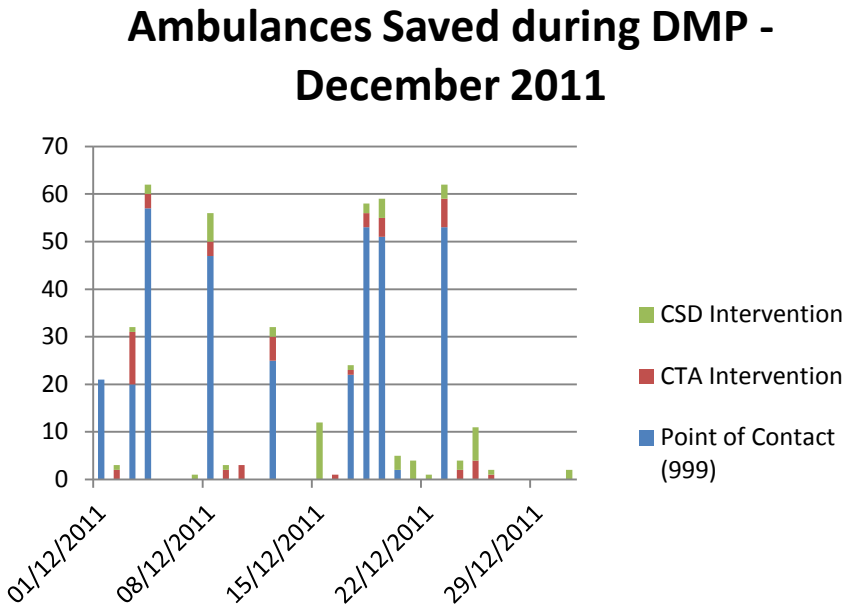
Stage **B** was invoked 42 times for a total duration of 273.75 hours (versus 18 times / 74.75 hours in November)

Stage **C** was invoked 10 times for a total duration of 42.25 hours (versus 3 times / 5.5 hours in November)
Stage **D** was invoked once in the early hours of New Years Day, for a duration of 7 hours (versus twice / 14.5 hours in November)

New Year's Eve and New Year's Day, DMP did not escalate beyond stage D. This is in contrast to last year, where DMP stage F was invoked in the early hours of New Years Day. The limited use of DMP over the Christmas period reflected poor clinical staffing in EOC that DMP could not be implemented.

When staffing over the Christmas and New Year period is planned for 2012 there will need to be a greater emphasis on ensuring adequate levels of cover for Christmas Day and Boxing Day.

Total Saves	
Unknown Stage	0
Total B Saves	82
Total C Saves	376
Total D Saves	0
Total E Saves	0
Total F Saves	0
Total G Saves	0
Total H Saves	0
TOTAL SAVES	**458**



2.2 Clinical Performance Indicator completion and compliance

The overall Team Leader CPI completion rate for November was the highest for 2011, at 93%. 18 out of 27 Complexes had a CPI completion rate of between 95% and 100%. Overall compliance against all clinical care standards, in November 2011, was 95% or higher. The Trust target is 100%.

Diagram 1. CPI completion March to November 2011

Area	June	July	August	Sept.	Oct.	Nov.
East	89%	81%	72%	79%	84%	96%
South	73%	80%	83%	90%	84%	87%
West	71%	94%	77%	82%	90%	95%
LAS	**77%**	**85%**	**78%**	**84%**	**86%**	**93%**

Diagram 2. CPI Compliance October 2011

	Cardiac Arrest	Difficulty in Breathing	ACS (Including MI)	Stroke	Glycaemic Emergencies	Non-Conveyed	1 in 20 PRF
East	98%	95%	95%	97%	98%	96%	97%
South	98%	94%	96%	97%	98%	94%	96%
West	97%	95%	96%	97%	97%	96%	97%
LAS Total	**98%**	**95%**	**96%**	**97%**	**98%**	**95%**	**97%**

Diagram 3. CPI Compliance November 2011

	Cardiac Arrest	Difficulty in Breathing	ACS (Including MI)	Stroke	Glycaemic Emergencies	Non-Conveyed	1 in 20 PRF
East	98%	95%	94%	98%	98%	95%	97%
South	97%	95%	96%	96%	97%	94%	97%
West	98%	94%	96%	96%	97%	95%	97%
LAS Total	**97%**	**95%**	**95%**	**97%**	**97%**	**95%**	**97%**

2.3 Cardiac Care

A Cardiac Care Information Circular (007) was released in January, providing an update on adult basic and advanced life support guidelines (Appendix 1). Key points include the importance of high quality chest compressions, using all defibrillators in manual mode and post resuscitation care. Review of defibrillator data downloads from cardiac arrests highlights that defibrillators are still being used in automatic mode and this causes significant interruption to chest compressions during rhythm analysis.

The use of intra-venous morphine in acute coronary syndrome (ACS) pain management, has now been revised after seeking expert opinion from leading Cardiologists at London's heart attack centres. This consultation was the result of the national clinical performance indicator (CPI) for ACS stating that for any pain score greater than zero, IV morphine was indicated for use (if other analgesia had not been effective). The consensus of all Cardiologists was that morphine should be administered for pain scores of greater than three, after the use of GTN and entonox.

2.4 LAS News Clinical Update

The latest edition of the Clinical Update was published in December. It includes articles explaining DH Ambulance Clinical Quality Indicators, the new A&E Support dispatch model and crew action on locality information for high risk addresses.

2.5 Equipment

Following a trial of a new supra-glottic airway (SGA) device, the Medical Directorate will be meeting with the manufacturers of the i-Gel device in January, with the intention of moving to this device (including paediatric sizes). A review of disposable equipment has lead to current re-usable laryngoscope handles, used by paramedics, being replaced by a disposable version.

The roll-out of new LifePak 15 machines continues and a reminder has been sent to all complexes/training centres to return any old LifePak 12 machines that are not being used, to Logistics.

2.6 Update for Clinical Tutors

A series of one day clinical update sessions for Clinical Tutors was delivered in December. The update covered End of Life Care (EoLC), which continues to prove a challenging area of practice for clinical staff and has been supported by an article in the December Clinical Update. Clinical issues that were identified during the Consultation meetings have been discussed with Clinical Tutors, so that key learning points can be incorporated into practice education.

2.7 Neutropenic Sepsis Patient Specific Protocol Trial

On the 9th January, a trial will start in collaboration with the Whittington Hospital NHS Trust, for patients receiving chemotherapy who are at risk of neutropenic sepsis. PSPs will be created for patients at risk and will include diagnostic features of neutropenic sepsis and instructions for ambulance staff to pre-alert the Emergency Department. The trial has been designed by a Student Paramedic on the talent management programme.

2.8 Summaries of clinical audit or research projects that are currently being undertaken by the Clinical Audit & Research Unit

A report from CARU on Ambulance Service Cardiovascular Quality Initiative (ASCQI) is included as Appendix 2.

3. Governance

3.1 Update on Medicines Management

No reportable Controlled Drugs incidents have occurred since the last report to the Board. There have been no further Unannounced Visits by the Metropolitan Police.

There have been no CAS Alerts for medicines that affect the Trust since last report to the Board.

No reported general drug incidents reported since my last report.

From February 2012 both oral paracetamol and ibuprofen tablets will be introduced into the general drug packs for administration by staff of EMT 3 level and above. This will improve the availability of analgesia for adults (paracetamol); and an anti-inflammatory agent (ibuprofen for adults) and alternative analgesic and antipyretic for children over 7 years.

In the light of the Medicines and Healthcare products Regulatory Agency (MHRA) revised dosing instructions for oral paracetamol liquid suspension (Calpol®), new

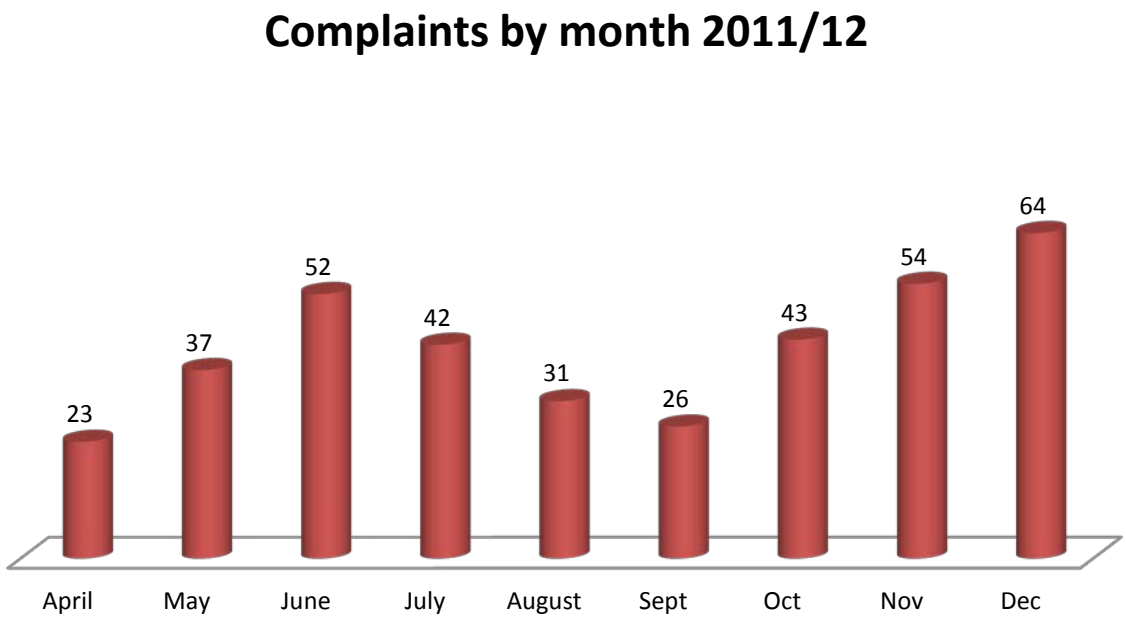
formulations for children under and over the age of 6 years will replace the existing products in the general drug bags. This allows for the dose to be calculated on the child's age rather than weight. The new dosing guide will also be placed in the general drug bags.

The Trust will look to introduce tranexamic acid and haemorrhage control dressings into the paramedic drug pack following the publication of the updated JRCALC Clinical Practice Guidelines.

4. Patient Experience

4.1 Complaints

The complaint portfolio moved to the Director of Health Promotion and Quality in December 2011. As part of this move a change in procedure was implemented that reinstated a "Director review" as part of the complaint management process. Therefore, since December the Director of Health Promotion & Quality has read all of the complaint letters and their subsequent responses. The intention is that this will allow an informed discussion at the Senior Management Committee and Quality Committee and also facilitate the identification of patient stories for sharing at Trust Board. In December there were 64 complaints and the primary issue appears to be the attitude of clinical staff. This is consistent with the reporting within the Integrated Report that is received by the Quality Committee.
The following graph illustrates the number of complaints received in December against other months in the year.



One complaint that made uncomfortable reading was received in December and was regarding a patient in mental health crisis. The complaint contained the following paragraph;

"A second time our brother was assured by the female crew member that the male would not come near him so again he got on the stretcher and was strapped on with two lower body straps. At this point the male crew member stepped forward, grinning, and saying, I'm in charge now, so our brother could do nothing, as he was trapped, but stated again that he had been lied to".

(complaint ref 06544)

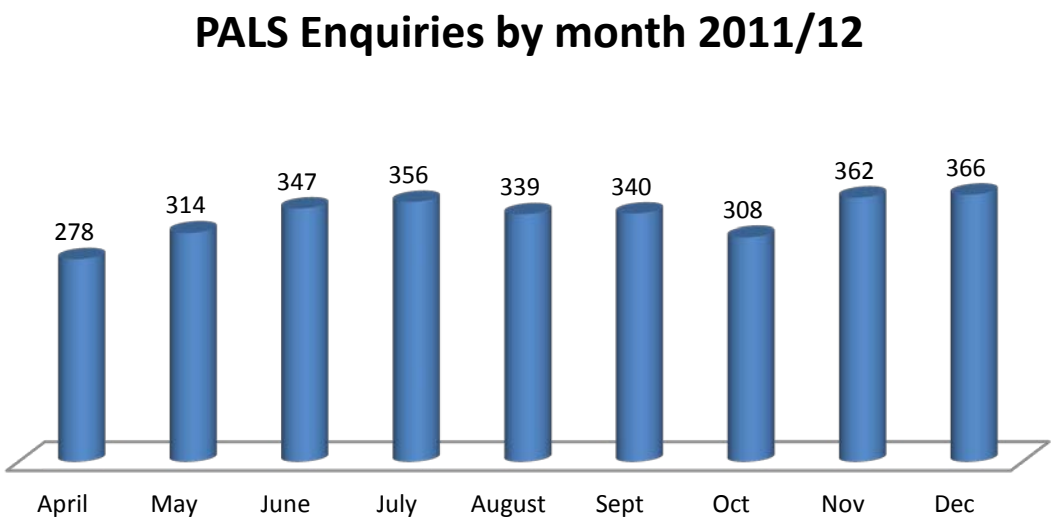
This complaint is still being investigated but SMG has previously asked the Director of Health Promotion & Quality to pull an action plan together that helps address staff attitude. This is being assembled.
The table below lists the numbers of complaints received during October - December and the time frame within which the target response was achieved. The overall closure rate for the period within the allocated time frame was 65%. As at 13 January a total of 93 complaints remain open or re-opened following a further approach from the complainant.

Response time allocated October to December 2011	**No. of complaints**	**Closed within time frame**
Complaint 25 days	126	85
Complaint 30 days	12	8
Complaint 40 days	23	12
Total:	161	105

A true reflection of response times to include December cannot be calculated until the furthest timescale (i.e. 40 days have) elapsed, which will be 26 February 2012.

4.2 PALS

PALS remains the most accessed point for patients with 366 cases. The following graph illustrates the number of PALS enquiries received in December against other months in the year.



The following table illustrates the types of PALS enquiries made during the month of December.

PALS Specific	Total	PALS Specific	Total
Information/Enquiries	226	Non-physical abuse	3
Lost Property	52	Policy/ Procedure	3
Incident Report - Other	15	Incident Report EOC	2
Appreciation	12	Incident Report - LAS Equipment	2
Explanation of Events	8	Access	1
Clinical	7	Clinical Equipment	1
Communication	7	External Incident Report - LAS Crew	1
Delay	7	Incident Report - MPS	1
Incident Report - A&E	6	Incident Report - Hospital Midwife	1
Other	6	Non-conveyance	1
Incident Report - GP Surgery	4	TOTAL	366

One case involved the acceptance of a patient transfer presenting with a low GCS (Glasgow Coma Score).
The outcome was that the local Practice Learning Manager will undertake a reflective practice exercise with the crew concerned, particularly as regards to the assessment and recording of GCS. The Medical Directorate have also agreed to produce guidance about when a patient transfer should be declined by the attending ambulance staff, citing this case in anonymised terms.

5. Quality Improvement Priorities 2011-2012 (Quality Account)

5.1 Mental Health

The mental health work stream is progressing well. The Director of Health Promotion & Quality has met with a Director level representative from all 10 of the Mental Health Trusts that provide acute mental health care.
This has been primarily to serve as an introduction but to also act as a first stage towards reaching an agreement on how we can improve the service we provide to mental health patients in crisis. This is detailed within the mental health action plan.
The London Mental Health Directors of Nursing have invited the Director of Health Promotion & Quality to become a regular member of their forum. This recognises the role the Trust plays in mental health care.
The Clinical Advisor for Mental health commences in post in February 2012.

5.2 End of Life Care

During 2011/12 the Trust has been working to increase the numbers of end of life care records held to support clinical staff with clinical decision making, when they attend patients reaching the end of life. The aim is to improve the experience of patients by preventing unnecessary conveyance to Emergency Departments at this critical time of life.

Currently multiple systems, both paper and IT based, are used across London. The Trust now has access to all records held both on Co-Ordinate my Care and Gold Standard Framework systems. In addition, the Trust hold copies of paper records and have created address flags to alert crews that the Clinical Support Desk holds information about a patient at the address. The Trust now holds over 2500 records on end of life care.

5.3 Falls

On average per month, we are now referring 950 non-conveyed elderly patients who have fallen to their GP. This new initiative for 2011 has involved staff passing information about patients who have fallen, but are uninjured and not be conveyed, to their GP. Clinical staff pass the information on to the referral support team in the Emergency Bed Service who then ensure that the information is passed in a timely fashion to the GP whilst leaving the clinical staff to attend the next patient. Feedback from GPs has been that they do act on this information and that being made aware that the LAS have attended is useful.

5.4 Implementation of the Quality Dashboard

The quality dashboard is now being presented at every quality committee and is embedding into the quality governance structures. The next stage is to consider how best to use this with external stakeholders. The dashboard has been presented on one occasion to the Clinical Quality group (GP Commissioners) and this was well received.

6. Care Environment and Amenities

6.1 Infection Prevention and Control

An update on infection prevention and control is now provided in the Chief Executive's Report.

In December the operational pressures required the temporary Governance and Compliance lead to return to his substantive post as a Paramedic. In reality he had been undertaking a considerable number of the audits. Consequently, his return has weakened the evidence on the infection control scorecard. Therefore, the infection control indicator has been given a RED rag rating.
However, the Deputy Chief Executive and the Director of Health Promotion and Quality (DIPC) have met to discuss a way of quickly recovering the audit gap. Plans will be implemented to ensure a full dashboard for January.
Conversely the Trust is able to demonstrate extremely strong compliance for the uptake of the flu vaccine. 1,663 staff members have been vaccinated (around 40% of the workforce). This is the highest number except for the pandemic flu year (1800 staff vaccinated). Interestingly this is the first year that ambulance staff have been used at a national level in the awareness raising work. Vaccination clinics are due to run until March or until vaccine stores are depleted. In view of REAP being lowered to level one on 16th January 2012, complex AOMs are going to be prompted to run vaccination clinics, if demand exists.

A number a Norovirus outbreaks in London hospitals has lead to a Medical Directorate Bulletin (MD101) being released, reminding staff of the importance of robust infection prevention and control measures.

7. Public Health

Nothing further to report.

Recommendation

That the Board notes the report.

Fionna Moore
Medical Director
16th January 2012

Appendix 2

London Ambulance Service NHS Trust
Trust Board Meeting –January 2012

Clinical Audit & Research Summary Reports for the Trust Board

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Ambulance Service Cardiovascular Quality Initiative

Introduction

The Ambulance Service Cardiovascular Quality Initiative (ASCQI) is a national project run by East Midlands Ambulance Service NHS Trust and funded by the Health Foundation's closing the gap initiative. The primary aim of the project is to improve pre-hospital care for cardiovascular disease by using a care bundle approach to ensure that every patient presenting with heart attack or stroke receives each element of optimal care and to improve outcomes in these patient groups. The secondary aim is to increase the diffusion of quality improvement methods to front line staff in ambulance services.

In January 2011, the Clinical Audit and Research Unit (CARU) appointed a Quality Improvement Fellow (QIF) to work on this project one day a week.

LAS Quality Initiatives

Over the last year the QIF has been supported by a core group of volunteers based at the host complex, Pinner, who have helped develop quality improvement initiatives, through the learnt quality improvement methods.

The project has been promoted in service publications such as the CARU bulletin, Clinical Update and LAS News and at the LAS Research Conference, as well as several related LAS groups and committees. It has also been promoted externally via public information leaflets at the LAS Stroke Evening and the LAS website.

ASCQI Display Boards were created at the host complex to raise awareness of the project aims and current care bundle figures, and the project was launched by the QIF and CARU in September 2011 at Pinner Complex. This was in conjunction with the Chief Executive Officer's consultation meeting and included a discussion by the LAS Medical Director, an ECG training session for staff and stroke presentation by team from the local Hyper Acute Stroke Unit (HASU).

Three editions of the ASCQI News have been created and distributed to all staff at Pinner Complex which act as a reminder of the key ASCQI messages and provide updates on the project and advertise upcoming events. ASCQI pages were developed for the LAS intranet, the Pulse, which went live in October to act as a point of reference for further information for all staff.

Heart Attack

The core ASCQI team investigated the LAS journey for heart attack patients through a series of workshops and as a result determined areas for improvement. The main area for improvement for this patient group was pain assessment and management, which has therefore formed the basis for many of the quality improvement initiatives.

Questions raised at the ASCQI launch at Pinner Complex led to further examination of the administration of morphine for heart attack patients and discussion with Consultants from the Heart Attack Centres across London. A final decision was reached as to at what pain score it is appropriate to administer morphine and this will be fed back to staff via Team Leaders and Training Officers through a heart attack training slides.

An ASCQI pen has been created for every front line member of staff which will act as a reminder to crews regarding pain management in heart attack patients, these were distributed at Pinner Complex as part of the launch. An audio podcast was also published on the Pulse at the beginning of the month which features the care bundle for heart attack patients emphasizing the importance of pain assessment and management and a pocket book sized pain tool has also been developed, again to act as a aid and reminder for staff regarding pain scoring. The tool provides staff with consistant questioning for patients regarding their level of pain and provides three different visual scales should patients have trouble understanding and using a verbal pain score. The pain tool can be used for all patient groups but contains a reminder of the care bundle for heart attack patients. This has been agreed at the LAS Pain Management Development Group and 6,000 copies will be printed in the coming weeks to be distributed service wide. The QIF joined the LAS Pain Management Development Group to develop a pain training session and to ensure the key elements of the care bundle are emphasised. This powerpoint training will be delivered to all front line staff and outlines how to assess pain using the pain tool, as well as a slide and case study on heart attack patients. The training session will be accompanied by a poster for ambulance stations regarding pain assessment and management which will explain how to use the pain tool, and a booklet about pain will be given to all front line staff. A heart attack flowchart is also being developed for use by staff which will act as a checklist when attending a patient.

Stroke

As with heart attacks, the team investigated the LAS journey for stroke patients. Several of the areas for development related to training, therefore a Consultant led stroke/neurological training session was held for 20 people at the Pinner Complex and the opportunity for staff to visit the nearest HASU was provided. A multimedia Stroke training session is also being developed, which may involve collaboration with Imperial College. A film has been made with a stroke survivor which may form part of this training following the successful pilot at the training session at Pinner.

Discussions regarding a proposal for direct to CT scanner trial continue with the Hyper Acute Stroke Unit that works most closely with the Pinner Complex, the LAS Medical Directorate and the LAS Equality and Diversity Team.

The future of ASCQI

A spread plan has been developed which will involve recruiting ASCQI Champions at each complex to launch and promote the project complex wide, and to facilitate the initiatives which have been successful at Pinner Complex. The first three launches, one in each area, will take place at the end of January and beginning of February. As the project spreads across the Service, we will encourage staff at individual complexes to develop their own initiatives to improve patient care.

Due to the restrictions of external funding and subsequent time limitations there are several initiatives which are in the early development stages but may not reach completion. These include: providing feedback to staff through a heart attack patient survey and reviewing Team Leader CPI feedback to staff, a patient information leaflet, a review of entonox vehicle equipment and creating a PRF completion guide. Further investigation will continue to allow us to continue with this work. There are also plans to develop posters and leaflets which will advertise the vast amount of work front line staff have invested in developing the quality improvement initiatives for patient care. This will also be communicated at public events in the summer.

London Ambulance Service NHS
NHS Trust

Cardiac Care Information

Cardiac Care Information Circular **007**

For all operational (clinical) staff Updated: **Jan 2012**

Update on **ADULT** basic/advanced life support guidelines

IMPORTANT:
The most highly qualified member of staff MUST take the lead in the management of the cardiac arrest: in most cases this will be the first Registered Paramedic on scene.

Chest compressions hold the key to survival where definitive treatment cannot be given within four to five minutes**. Every effort MUST be made to ensure chest compressions are carried out correctly and effectively**

Basic Life Support

- The ratio of compressions to ventilations is **30:2** for all adult victims of cardiac arrest. Compression rate is recommended at **100-120** per minute and compression depth has increased slightly to 5-6cm.

- Chest compression should be started **IMMEDIATELY** after cardiac arrest is diagnosed while the defib is made ready.

- In an **UNWITNESSED** cardiac arrest 2 minutes of **good quality CPR** should be started **BEFORE** the first shock is delivered.

- Subsequent rescue breaths should be given over 1 sec rather than 2 sec

- No more than 12 ventilations per minute should be delivered

Use of FR2/LP1000

- One shock should be delivered followed by 2 minutes of **good quality CPR** without a check for termination of pulseless VT/V Fib or for a check for signs of life or a pulse.

- Chest compressions should now be carried out throughout the 'charging phase' of the AED to minimise the pre-shock pause. In order to do this defibrillation will need to be carried out in **MANUAL MODE** (just as with treatment of pulseless VT). The clinician carrying out chest compressions should be the person delivering the shock, therefore the AED should be on the same side of the patient as the clinician carrying out chest compressions.
  The interval between the last compression and the shock should be as brief as possible.

- If the patient is still in pulseless VT/VF after the 4th shock from an FR2 then switch to the LP12/15 and use an energy level of **360J** (this will require increasing the energy on the LP12/15 manually).

- Emergency Medical Technicians/Student Paramedics: If no registered paramedic is present or en route, up to **6 shocks** may be delivered on scene and then transportation to hospital should be undertaken continuing to defibrillate as appropriate en route.

- Following use of the FR2/LP1000 in cardiac arrest, the data should be downloaded as soon as possible by the duty Team Leader

- The roll out of defibrillators in public places will continue pan London

Adult Advanced Life Support

- In a witnessed cardiac arrest (by the clinician) with a presenting rhythm of pulseless VT/VF, a single shock should be delivered, followed immediately by 2 minutes of good quality CPR (approximately 5 cycles of 30:2).

- In an **UNWITNESSED** cardiac arrest (by the clinician) 2 minutes of **good quality CPR** should be started **BEFORE** the first shock is delivered. **Remember to compress during charging.**

- Following 2 minutes of CPR, check the rhythm/pulse (if rhythm compatible with life) and give another shock if indicated.

- If using the LP12/15 ensure energy levels are set to **200J** for first shock, second shock at **300J** and all further shocks at **360J** unless ROSC is achieved (the LP12/15 are configured to these setting, therefore no adjustment is usually required).

- If there is doubt about whether the rhythm is asystole or fine VF, do NOT attempt defibrillation; instead, continue chest compressions and ventilations at 30:2

- Registered Paramedics are reminded that while the patient remains in a shockable rhythm they **should remain on scene** (unless there is a clear reason not to e.g. crew safety) and deliver up to **18 shocks** – on approaching the 18th shock the **Clinical Coordination Desk should be contacted** for further advice on patient treatment/management.

- On the very rare occasion where hypothermia is believed to be the cause of the cardiac arrest and the patient presents in a shockable rhythm, 3 shocks should be delivered while on scene and the patient removed to the vehicle and transported. Shocks may be continued en route to hospital as appropriate

- For hypothermic patients with a tympanic temperature less than 30, **no drugs** should be administered

- Give **adrenaline** (registered paramedics only) 1mg 1:10,000 IV/EZIO if pulseless VT/VF persists. Give the adrenaline straight AFTER the 3rd shock followed by at least 20ml saline flush WHILST CHEST COMPRESSIONS ARE ONGOING.

- **Amiodarone** (registered paramedics only) 300mg bolus IV/EZIO (into a LARGE VEIN – i.e. ACF/EJV) should be given straight AFTER the first dose of adrenaline (i.e. after the third shock) once only, followed by another 20ml flush, WHILST CHEST COMPRESSIONS ARE ONGOING

- Repeat adrenaline 1mg IV every 3-5 minutes.

- For PEA /asystole give adrenaline 1mg IV **as soon as intravenous/EZIO access is obtained**, and repeat every 3-5 minutes thereafter until ROSC is achieved.

- Drugs must NOT be administered via the endotracheal/ supraglottic (LMA/iGEL) route.

- Atropine should no longer be administered in cardiac arrest.

- **Following ET intubation/placement of supraglottic airway, confirmation of correct placement using end-tidal $C0_2$ MUST be carried out ASAP**

- During ALS the $ETCO_2$ should be above 10mmHg as this is associated with an increase in ROSC. A drop in $ETCO_2$ should alert to the lead paramedic that chest compressions may be becoming ineffective.

- A sudden and sustained rise in $ETC0_2$ should alert the paramedic that ROSC may have been achieved. If it is sustained at the next patient/rhythm assessment check carefully for signs of circulation.

- An $ETCO_2$ reading may still be achieved if the right main bronchus is inadvertently intubated. Therefore, ensure the length of the tube at the lips is checked and auscultate both sides of the chest to ensure bilateral air entry.

- The ET tube/LMA/igel should be secured using the Thomas Tube Holder

- A bougie **SHOULD** be available for **ALL** intubations

- A correctly sited supra-glottic airway (LMA/igel) can be considered a ‘definitive’ airway in terms of recognition of life extinct (ROLE)

- Ventilation during cardiac arrest is best achieved using the bag-valve-mask with oxygen attached

- When defibrillating and with a definitive airway in situ, the ventilation bag and connected oxygen may remain attached to the tracheal tube/supraglottic airway when the command ‘oxygen away’ is given. If using the microvent this should be disconnected.

- Every effort will be made by EOC to dispatch two vehicles to all cardiac arrests.

Post Resuscitation Care

- Once ROSC is achieved crews should remain on scene for at least 10 mins before attempting removal as the recurrence rate of a shockable rhythm is at its highest during this period.

- Every effort **MUST** be made to remove a patient with ROSC to the vehicle in a supine position i.e. back board or carry sheet

- Before moving the patient correct tube placement must be confirmed (see above)

- Full vital signs should be recorded (BP, ECG, HR, 12 lead ECG, $Sp0_2$, and $ETC0_2$)

- Should the patient with a ROSC be hypotensive (systolic <90mmHg) a fluid bolus of 250mls may be given (registered paramedics only) followed by a check of vital signs (provided there are no obvious signs of severe heart failure present).

- If a symptomatic bradycardia is present atropine should be administered as per current clinical guidelines.

- Should the patient remain hypotensive (systolic <90mmHg AND NO palpable RADIAL pulse) then a dose of adrenaline 1ml (0.1mg) of 1 in 10,000 may be given IV/EZIO (registered paramedics only) up to a total of 5ml (provided the heart rate is LESS than 100bpm). A check of vital signs should be carried out after each dose. Note the small dose (i.e. only one tenth of the 10ml adrenaline syringe).

- Should the patient still remain hypotensive, transport to hospital should be undertaken with full monitoring of vital signs without delay.

- Patients with **ROSC** in whom the post arrest 12 lead ECG shows **ST ELEVATION**, (STEMI) should be conveyed to the **nearest cardiac cath lab** regardless of GCS (see Medical Directors Bulletin no. 87 for full guidance). Should the airway become compromised/ unmanageable then consider diverting to the nearest Emergency Department.

- There is now substantial emerging evidence that high levels of oxygen (hyperoxia) may be harmful in the **post cardiac arrest phase**. Inspired oxygen should therefore be titrated to achieve a SpO2 of 94-98%.

- Every effort should be made to remove the patient in a stable condition.

For further advice contact the Clinical Coordination Desk

This guidance has been approved by the Medical Director

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD (pt 1)

24 JANUARY 2012

PAPER FOR DECISION

Document Title:	**CommandPoint Update**
Report Author(s):	**Peter Suter, Director of Information Management and Technology**
Lead Director:	**Peter Suter, Director of Information Management and Technology**
Contact Details:	**Peter.suter@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To provide an update of progress on the CommandPoint project.**
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
Recommendation for the Trust Board:	• **Note the progress of the project** • **Supports the recommendation, to be made verbally at the Trust Board meeting, to either change the date of the 13/14 Live Run to16/17 March or to leave it as originally planned.**

Executive Summary: The objective of this paper is to provide an update of progress on the CommandPoint Project. It currently remains on track for a series of live runs that will enable the system to stay live on 28 March 2012. There are four appendices to this paper providing details on CTAK sustainability, Risks and two Serious Incident Reports.

Key issues for the Trust Board

Recommendations as detailed.

Attachments

1. CommandPoint Project Update, January 2012
2. Serious Incident Report
3. Serious Incident Report

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Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

☒ To have staff who are skilled, confident, motivated and feel valued and work in a safe environment
☒ To improve our delivery of safe and high quality patient care using all available pathways
☒ To be efficient and productive in delivering our commitments and to continually improve

Risk Implications

This paper links to the following strategic risks:

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

NHS Constitution

This paper supports the following principles that guide the NHS:

☐ 1. The NHS provides a comprehensive service, available to all
☐ 2. Access to NHS services is based on clinical need, not an individual's ability to pay
☒ 3. The NHS aspires to the highest standards of excellence and professionalism
☐ 4. NHS services must reflect the needs and preferences of patients, their families and their carers
☐ 5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
☐ 6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
☒ 7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☒ Yes
☐ No

Key issues from the assessment:
None.

COMMANDPOINT PROJECT UPDATE: JANAURY 2012

1. INTRODUCTION

1.1 The objective of this paper is to provide an update of progress on the CommandPoint Project. It currently remains on track for a series of live runs that will enable the system to stay live on 28 March 2012. There are four appendices to this paper providing details on CTAK sustainability, Risks and two Serious Incident Reports.

2. SUMMARY OF PROGRESS SINCE LAST REPORT

2.1 Prior to Christmas, testing was completed on V1.2 of the CommandPoint software in relation to fitness for use in training. This was successful and training commenced as planned on 2 January. Initial feedback from staff and trainers has been positive.

2.2 As planned, during the week of 19 December, the project team successfully undertook basic functionality testing of V1.3 via a remote link. This was followed up with a visit to Chantilly during the first week of January. Six members of LAS staff travelled to Chantilly to participate in pre-release software testing. The team included one of the Senior Users, User experts and the LAS Test Manager. It was a productive week, enhancements and bug fixes checked, some issues were identified that NG will address ahead of final testing here in the UK. As with previous trips of this nature, the exercise has proved extremely helpful and the view of the team is that is was positive. However, this cannot pre-empt the results of the full testing that will take place once the system is delivered to the UK.

2.3 There are currently four live runs planned in the go live schedule. All are planned for the actual transition to take place in the early hours of a Wednesday morning, with each staying live for progressively longer periods of time. An option is currently being considered to identify if there is benefit (verses the risk) in changing the third live run from Wednesday 14 March to Friday 16 March. This would provide a final live run of the system during a traditional busy period. A verbal update of this assessment and proposed plan will be given at the Trust Board meeting.

3. RISKS

3.1 Risk management remains a key focus of project controls, the risk register being dynamically updated on a weekly basis. Appendix 1 details the most significant risks that the project is currently managing. Three of the top four risks relate to quality, suitability and acceptance of the product. Given the background of 8 June, this is understandable. Completion of testing, training and success of the dry and live runs will support mitigation of these risks.

4. CONTINGENCY

4.1 The contingency to not be able to go live safely with CommandPoint before the Olympics is to stay live with the existing CTAK system. In order to provide assurance as to the systems viability, a technical assessment has been undertaken; it is attached at Appendix 2. In the opinion of the CAD Support specialists, the overall conclusion is that the capacity and performance of the current hardware is adequate to meet the increased demand through the Games period.

5. SERIOUS INCIDENT REPORTS

5.1 As a result of the CommandPoint failure on 8 June, two Serious Incidents were declared. STEIS 10487 deals with the actual failure and given the length of the document, the executive summary and recommendations are attached at Appendix 3. STEIS 10648 deals with a specific clinical incident, given its relative length; the entire report is attached at Appendix 4. The recommendations of both reports are being managed by the CommandPoint Project. All are well advanced and there are none that would warrant a delay of the current timetable. A full update of actions against each recommendation will be given in the next Trust Board report.

6. HIGH LEVEL TIMETABLE

6.1 At the December Trust Board, it was agreed that an additional live run would be added to the schedule. The high level high level timetable has been amended to both reflect this additional date and update progress.

DATE	EVENT	INDICATORS
24 January	Trust Board Meeting	• Training commenced on 2 January.√ • Update from remote testing and pre-delivery visit to Chantilly (described above) √ • Verbal confirmation V1.3 delivered to site and initial installation commenced. √ • Report on CTAK sustainability through the Olympics √
14 February	Trust Board review	• Full testing completed on V1.3 • Technical rehearsal with V1.3 • Seek authority for first Live Run.
21/22 February	First Live Run	• First Live run event where CommandPoint will be used to take live calls for a limited period.
28 February	Trust Board Meeting	• Results from first Live Run scheduled to take place on 21/22 February (verbal). • Seek Trust Board approval to continue live run process and ultimately go live.
6/7 March	Second Live Run	• Second Live Run event where CommandPoint will be used to take live calls for a limited period.
13/14 March or 16/17 March	Third Live Run	• Third Live Run event where CommandPoint will be used to take live calls for a limited period.
27 March	Trust Board Meeting	• Update before final live run.
27/28 March	Fourth Live Run	• Final live run. Plan is to stay live at this point.

7. RECOMMENDATIONS

That the Trust Board;

7.1 Note the progress of the project.

7.2 Supports the recommendation, to be made verbally at the Trust Board meeting, to either change the date of the 13/14 Live Run to 16/17 March or to leave it as originally planned.

Peter Suter
Project Executive
Director of Information Management & Technology

Appendix 1

COMMANDPOINT PROJECT

CTAK SUBSTAINABILITY ANALYSIS (PROJECT RISK 140)

8. INTRODUCTION

.1 CommandPoint Project Risk 140 describes the potential for a further delayed implementation of CommandPoint™ requiring extended use of the current CTAK Computer Aided Dispatch (CAD) system though the 2012 Olympics/Paralympics Games period (27/7 to 12/8 and 28/8 to 10/9 respectively).

.2 This paper seeks to assure, that should this circumstance arise, that CTAK has sufficient capacity to provide an acceptable level of performance throughout the period.

9. FACTORS

.3 The LAS Olympics Project has commissioned analysis of the likely activity increase from ORH Ltd, the estimate is an average increase of 5.6% to 8.9%; on top of the usual volume for this time of year. It is predicted that there will be an additional 600,000 people per day in London. These values take into account many factors including: the opening/closing ceremonies, local stadia responded incidents (estimated at 0.34 incidents per 1000 attendees), night time festivities, visitors staying vs commuting, etc.

.4 Anecdotal comments such as “the Games will be the equivalent of New Years Eve (NYE) each day for the period” have been rumoured. NYE causes an increase in activity of c15% and is focused on a few hours; the demand profile for games days is likely to be distributed over each full day.

.5 The current CTAK hardware (servers) was implemented in Oct 2009. In specifying the servers, consideration was given to future loading and expected life. The solution comprises two high specification R900 servers at HQ and further server at FBC. The warranty period for the hardware is the standard 3 years (from time of delivery) and expires on the 30/3/12; extension to cover the period in question will be required.

.6 CTAK does not retain (on line) historical incident data (it is regularly archived); so there is not a problem of reducing storage capacity. The system has easily coped with the significantly increased demand over two successive NYE periods (see Appendix A).

.7 However, user perception vs technical performance reports is acknowledged and users did and do at other times report ‘CTAK delays’ (pauses of a few seconds) at times of increased EOC/Fleet activity. CAD is a complex conjunction of CTAK and numerous interfaced sub systems and data flows, this phenomena cannot be easily mitigated, see para .20 below

.8 The disk storage subsystem has: 20GB for the operating (24% used); 40GB for application files (60% used); and is proactively house kept.

.9 The Informix database has a large amount of pre-allocated space (of which less than 20% is used) and operates effectively within it.

.10 It is not considered that system performance would not be greatly improved by purchasing additional hardware components.

10. SPECIFIC ACTIONS THAT WOULD BE UNDERTAKEN:

.11 • Extend warranty (ongoing maintenance & support) on Dell hardware.

.12 • Over and above normal housekeeping, a planned period of downtime to be negotiated for system administration activities to be carried out (that require exclusive use of the system); to improve efficiency:

.13 • Check database table ‘extents’ and defragment any considered to have an excess.

.14 • Review and optimise memory allocation.

.15 • Clear down and refresh all directories.

.16 • Review the impact of scheduled housekeeping processes and adjust as necessary.

.17 • Immediately before the Games period, carry out additional archive of closed incidents to minimise the data retained in the system.

.18 • Increase the frequency of system checks/monitoring over the period.

.19 • Prepare the necessary boundary polygons and Complex records for: CTAK, XC and all other applications (DIBA, GeoTracker, etc.).

11. CHANGE FREEZE.

.20 Once the actions defined above have been completed, we would invoke a change freeze on CTAK.

.21 The items described below are largely aspects of CTAK software (re)development that have been under consideration. It is well known that CTAK is bespoke software, that has been incrementally developed. The fact that it has served the Trust for 15 years is tribute to the ingenuity and diligence of a small number of highly technical support engineers. Notwithstanding the improvements to the system that have been developed over the years, any change to it has the potential to introduce instability (as has been previously witnessed) and is to be avoided. Some of the issues identified below would entail fundamental revisions to how CTAK works and are difficult to justify from the point of view of benefit vs risk and the short life expectancy of the system. Whilst they may improve underlying system efficiency I do not recommend undertaking such development and the list is included here in demonstration of due diligence.

.22 • Investigations aimed at addressing those issues which are recorded in log files and in

the users “errorsql” files and reorganisation of the system so that the number of lengthy transactions are reduced.

.23 • Analysis of database indexes and stored procedures, in conjunction to make sure they are performing efficiently.

.24 • Heavily used functions, such as those behind the “1” screen and “U” screen should be looked at closely and redesigned if appropriate.

.25 • Examine table usage and identify heavily used (contended) tables - log entry is an obvious example as many new record types have been added over the years – this could be split so that reads/writes can be performed more efficiently, or perhaps a new (smaller) table put in place to hold the last 30 minutes of data.

.26 • Consider supplier recommended upgrades of Linux operating system and Informix database software.

12. CONCLUSION

.27 It is the opinion of the CAD Support specialists that the capacity and performance of the current CTAK hardware is adequate to meet the increased demand through the Games period.

John Downard
Head of IM&T Software and Development Support

Appendix A

Chart 1 below shows the increase in CTAK users through the NYE period.

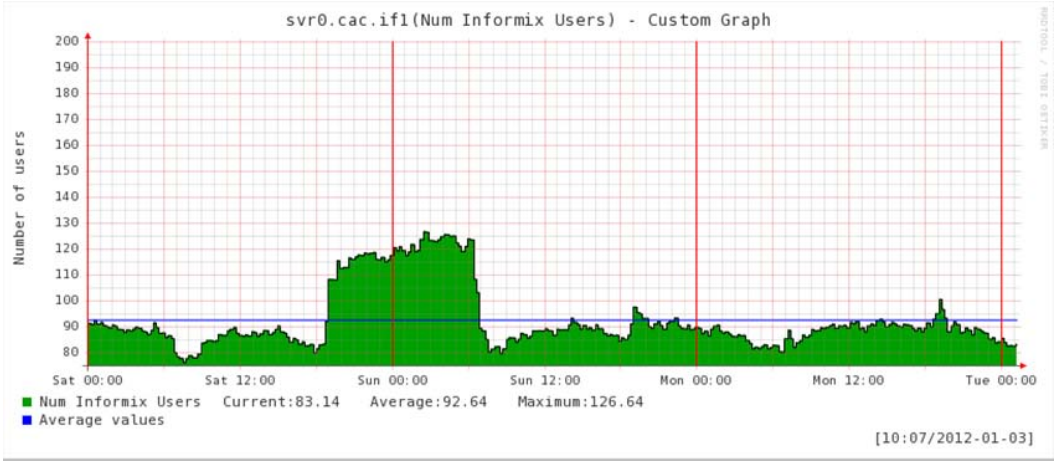


Chart 2 below shows indicative system load during the latest NYE period (several factors taken into consideration).

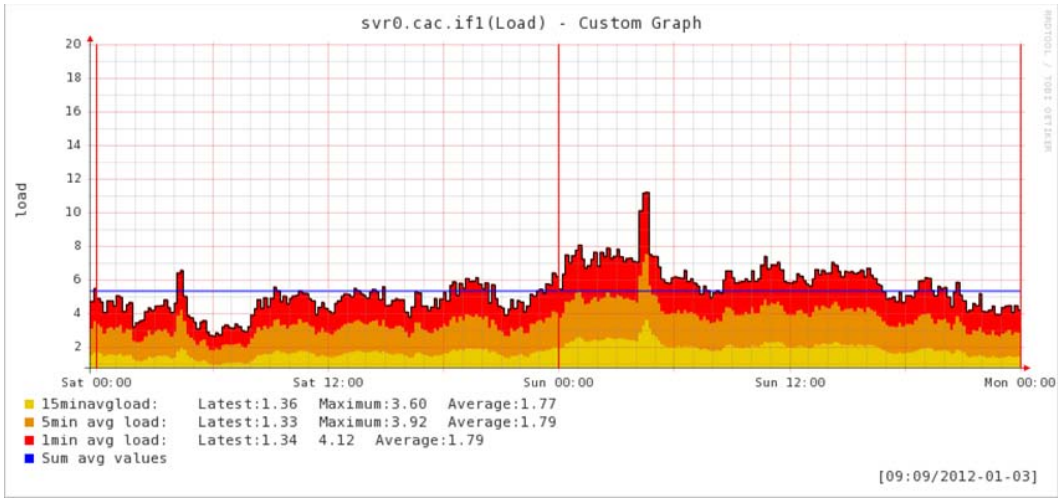
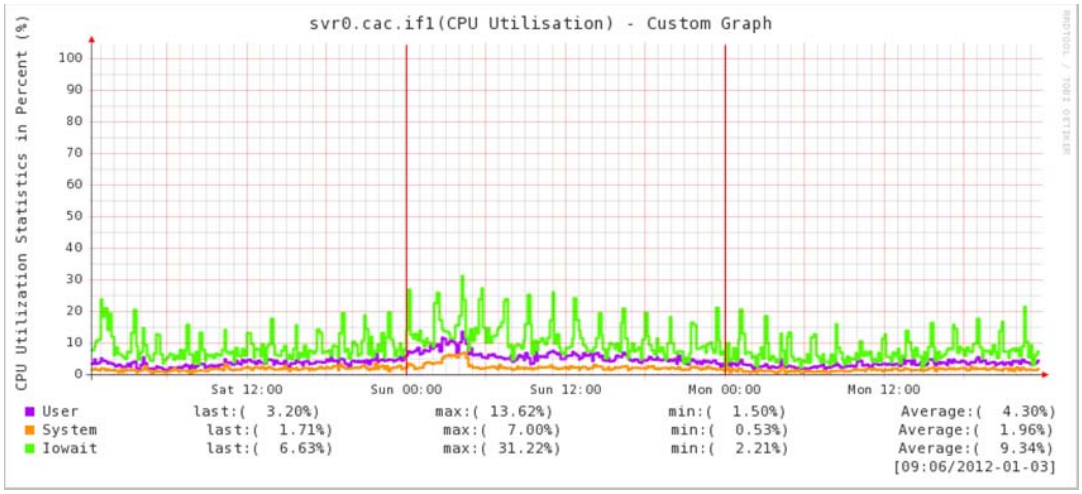


Chart 3 below shows specific CPU loading, again a corresponding slight increase through the early hours of the morning. The purple and orange lines show that the CPUs (16 in total) were not significantly stressed. The green line indicates the interaction with the database.



Appendix 2 Most Significant Risks

Risk Id P / I	Title	Score	Owner	Description
144 4 / 5	Poor Quality of supplied product	20	John Downard	There is a risk that poor development and coding by the supplier and final quality of the NG supplied product leads to an unacceptable number of bugs / workarounds for the users, undermining confidence leading to a cost and time overrun
44 4 / 5	LAS Industrial Action	20	John Hopson	There is a risk that industrial action amongst LAS staff will delay full or partial implementation leading to delays in Go Live 2, causing unexpected cost/time overruns. In particular, industrial action in January 2012 will cause a delay in training which will impact Go Live on 28th March.
70 5 / 4	Lack of user confidence in solution	20	John Hopson	There is a risk that lack of confidence in the reliability of the functionality of the system and data by operational users will alienate staff, undermine confidence and/or create suspicion leading to confused expectations, hesitant decisions and/or obstructive actions resulting in delay to (or during) implementation or performance degradation to service delivery, necessitating an extension to the implementation period or a rollback to CTAK causing a cost and/or time overrun.
135 4 / 5	Dry run results unsatisfactory for proceeding to Cut over and Go Live	20	Jonathan Nevison	There is a risk that unexpected technical or operational issues impact on the results from the Dry run events for the 2nd Cut over and Go Live such that the project does not have sufficient confidence to authorise further events without some re-planning or re-work causing unexpected cost/time overruns delays in the Cut Over and Go Live.
69 4 / 4	Negative Publicity for LAS	16	Peter Suter	There is a risk that the service will receive negative publicity over the plans to introduce a new CAD solution in its control rooms, particularly given the previous 1992 project, and failed attempt on 8th June 2011, leading to a lack of confidence in the proposed solution amongst stakeholders including service staff and the general public and consequent time / cost overrun.

Risk Id P / I	Title	Score	Owner	Description
48 3 / 5	System performance does not meet user expectations	15	John Downard	There is a risk that the performance of the system (including Graphical User Interface (GUI) response times) will not meet user expectations, leading to a lack of acceptance by users and a need for further development, causing a time overrun.
71 3 / 5	Inadequate testing of system	15	John Downard	There is a risk that the quality or totality of testing or analysis of the testing results will be reduced in scope or detail due to timescale in analysis and or time pressures leading to compromises and resilience of the software leading to bugs being revealed post Cut Over resulting in a need to roll back, causing a cost and time overrun or failure to achieve a key objective.
111 3 / 5	ProQA Interface	15	John Downard	There is a risk that Northrop Grumman encounters unforeseen difficulties during the development and testing of the ProQA interface, resulting in a need for additional unplanned development work, causing time and/or cost overrun.
149 3 / 5	Inability to authorise Go Live 2 due to Trust's Year To Date Performance Submission	15	Peter Suter	There is a risk that the Trust's Year To Date Performance Submission level will not be adequate for the Trust Board to authorise the Go Live 2 event to start as planned leading to delay of the event, incurring additional costs for the project team, Go Live event, etc. resulting in a time and cost overrun

London Ambulance Service NHS Trust

Appendix 3

Serious Incident Investigation

STEIS - 10487

Incident date: June 8th 2011

Executive Summary

1. Introduction

The London Ambulance Service NHS Trust receives on average in excess of 1.5 million emergency calls per year, and is the busiest ambulance service in the UK. The number of calls received by the LAS has steadily increased year on year. The management of a call and the dispatch of an appropriate resource is a complex process which involves the skilful interaction of the call taker with the caller and the highly specified software. To maintain the most efficient evaluation of a call it is essential that the Trust has an electronic dispatch software system that is reliable and consistent. The in-house system CTAK had been unstable and required replacement.

The Computer Aided Dispatch system (CAD) replacement project commenced in 2005. A recognised project structure based on PRINCE2 principles was established and project leads appointed. A formal procurement process was undertaken and Northrop Grumman were selected with CommandPoint, a large bespoke development to suit LAS requirements as the preferred choice. The Outline Business case was approved by the Trust Board on 30th January 2007. Following an assessment of various systems a Full Business Case was submitted and approved at the Trust Board on 29th July 2008. The CAD system contract was signed on the 15th December 2008.

This was a large and highly complex technical project. The project governance has been robust throughout with the Project Executive chairing regular Project Board meetings and providing regular project updates to the Trust Board.

The planned 'cut over' from the existing CTAK system to CommandPoint on June 8th 2011 was not successful. It was subsequently agreed that an investigation was required to determine the sequence of events, what contributed to the failure and what lessons can be learnt to support any future implementation. It will not apportion individual blame but look, in hindsight, to identify improvements to process that can be widely shared both internally and externally to the Trust. It is evident this was a large and complex project and that all the staff involved were completely dedicated and professional in their approach.

2. Incident Description

On 8th June 2011 London Ambulance Service NHS Trust implemented a replacement Computer Aided Dispatch (CAD) IT system within the Control Room, however following the technical cut over the system initially operated for a few hours before slowing and ultimately failing. The Control Room reverted to operating on paper until transferring back to the old CAD system some hours later. This failure delayed responses to patients representing a serious risk.

3. Incident type	IT infrastructure with operational impact on response times for patients
4. Effect on patient:	Delay in response and treatment

5. Severity level:	Major
6. Level of Investigation	RCA level 3 external investigation
7. Investigation team	Steve West, External Director Association of Ambulance Chief Executives supported by the LAS Governance and Compliance Team
8. Terms of Reference	1. To understand the impact of the changes to call taking and dispatch during the implementation of CommandPoint and the fallback operations, on patient care and safety. 2. To assess whether the fallback arrangements operated effectively and minimised the impact on patient care and safety. 3. To assess whether the operational command structure and performance cells worked effectively. 4. To learn and implement any lessons arising from these events

9. Root Causes

- The product (CommandPoint) failed to deliver the system, technical and operational functionality expected.
- Critical configuration issues were not identified in the testing phase.
- There were no operational procedures in place in the event of a critical system failure
- The project was not fully integrated into business as usual.

10. Contributory Factors

- Project Management – the project was not integrated into business as usual, the focus being placed on the technical aspects.
- Project Risk Management – the lack of visibility of significant risks and effective contingency planning was not available to the wider project team.
- Go-Live Option – the decision to 'cut-over' and not run both systems in tandem
- Testing regime – the failure to identify the weaknesses of the core product
- Technical Hub – LAS IT staff did not have visibility of server performance. LAS and Northrop Grumman staff did not have clear parameters set for CPU usage.
- Performance Management – late planning and unsuccessful implementation with no clear parameters for performance.
- Gold Command Structure – Experience and understanding of the senior members. The availability of appropriate staff on shift at critical points in transition
- Operating on Paper – Lack of documented procedures and risk assessments for operating on paper.
- Failure of Northrop Grumman to understand the full implications of the response profile rules on the testing regime and ultimately functionality.

11. Conclusions

The following conclusions have been reached about the evidence to support the terms of reference for this serious incident investigation.

12. Terms of reference:

1. To understand the impact of the changes to call taking and dispatch during the implementation of CP and the fallback operations, on patient care and safety.

There was an impact on patient care and safety.

- Whilst ambulance call categorisation allows for non life threatening calls to receive a response in slower time, in some cases some responses were delayed by over 3 hours.
- Of the sample audit undertaken by the Assistant Medical Director, of calls taken from the period when call centre operations were paper-based, 10 were identified where the delay may have had an impact on clinical outcome however this not been confirmed as there is no outcome data available as yet.
- One patient died from a cardiac arrest during the period and this is being investigated as a serious incident (outcome yet to be reported). It should be noted that, based on evidence for survival of out-of-hospital cardiac arrests, the outcome for this patient was unlikely to have been different.
- One patient has placed a legal claim for the delay he experienced on the day and this is being investigated.
- Four complaints have been received, three of which have been responded to with an

apology for the delay. The 4th is still being investigated.

- Four incidents were reported by crews concerning failures in electronic communication systems and delays.

2. To assess whether the fallback arrangements operated effectively and minimised the impact on patient care and safety.

Fallback arrangements did not operate as effectively as they could have done:

- Contingency plans were not detailed or tested prior to go live; the approach to risk management was not as effective as it could have been.
- The PC logger contingency failed and staff were unfamiliar with its operation.
- The paper-based system was implemented quickly however there were no documented procedures for operating on paper and not all staff were fully familiar with operating in this manner.
- A decision to return to CTAK could have been taken earlier if all facts had been available to senior managers and planning had recognised the risks of elongated paper operations.
- An early decision to declare an internal major incident may well have helped the response and in particular communications with other Trusts.

3. To assess whether the operational command structure and performance cells worked effectively.

Neither worked as effectively as they could have done. The command structure should be reviewed to ensure that there is clarity over roles and responsibilities and with key individuals with the right knowledge for critical points during the day. The performance cell was planned late in the project and was not fully successful when implemented. There were no clear parameters set for what might be deemed acceptable levels of performance or contingencies identified if they were not maintained.

4. To learn and implement any lessons arising from these events.

Five lessons have been identified that can support the next phases for the implementation of CommandPoint, these link to 11 recommendations that, if accepted, will also enhance the quality of preparation and planning for the next stages.

- All projects must link effectively with business as usual delivery and ideally led by the Executive (the Customer) who commissioned the project. *(Prince2 methodology)*
- Risk management and contingency planning are critical for successful project governance and delivery.
- External assurance did not identify the gaps in testing or contingency planning despite formally reviewing previous CAD implementation lessons.
- Operating on paper is only acceptable for short periods in extreme circumstances
- The lack of performance reporting whilst operating on paper and links to clinical audit systems hampered analysis and patient impact assessment.

13. Recommendations:

1. All projects should be managed under the overall programme of change to ensure interdependencies are fully understood. A greater role for the Director of Operations as part of the Project Executive role should be considered to ensure the transition from project to business as usual is enhanced.
2. The handover from the IT project to Operations business as usual is a critical point of success. The leadership of the operations director is crucial in leading the planning and delivery of this stage. Acceptance criteria should be agreed, confirmed and signed off by IT and Operations before 'go-live'.
3. Review of risk management training for managers involved in this and future projects.
4. A full and detailed review of the risk and issue logs relating to the project undertaken with clear, tested and approved contingency plans approved by the Project Board where required. Consideration to utilising internal audit as part of such large project teams may be valuable in giving greater assurance around detailed project and risk/issue management.
5. A full review should be undertaken of the options for an alternative approach to go live with a view to identifying a more resilient technological solution and less reliance on paper based operations. This review should include a full risk assessment of the technical, operational and clinical risks and include senior managers from all these disciplines.
6. Before any future go live event full load testing of the final system should be undertaken and any issues identified should then be resolved. Ideally an external peer review of the testing should be undertaken to give added assurance to the Trust Board.
7. The plans for the Technical hub should be reviewed to ensure sufficient capacity at periods of identified high risk and individuals with the greatest knowledge available at such times. LAS IM &T managers must have visibility of all key system performance measures at all times and there should be clearly identified triggers for unacceptable performance with associated actions.
8. The plans should be reviewed identifying modelled performance impacts and thus levels of acceptable risk for the Trust Board to approve. Any performance below these agreed levels should have clearly identified associated actions that should be exercised before go live.
9. A review of the command structure for the implementation should be undertaken, identifying clear roles and individuals with the right knowledge for each critical point of the day.
10. The use of paper operations as part of the go live planning should be reviewed, in particular the length of time it is acceptable to do so without compromising patient safety. Documented procedures should be developed involving Control staff and the Medical directorate reflecting the learning identified. All staff in the Control room should be trained and assessed for competence in operating in such a manner.
11. The Call Receipt Forms need amending to ensure vital information is captured and a CAD number can be passed to the crew to enable the CRFs and PRFs to be linked thereby improving the quality of the data contained in paper records.

14. Arrangements for sharing the learning

- The Senior Management Group will monitor progress.
- The Trust Board will receive regular reports and assurance from the Project Board.

London Ambulance Service NHS Trust

Appendix 4

Serious Incident Investigation

STEIS- 10648

Incident date: 8th June 2011

Report date: November 2011

Introduction and Background

The London Ambulance Trust receives on average in excess of 1.5 million emergency calls per year, and is the busiest ambulance service in the UK. The number of calls received by the LAS has steadily increased year on year. The management of a call and the dispatch of an appropriate resource is a complex process which involves the skilful interaction of the call taker with the caller, and the highly specified software. To maintain the most efficient evaluation of a call it is essential that the Trust has an electronic dispatch software system that is reliable and consistent. On 8th June 2011 London Ambulance Service NHS Trust implemented a replacement Computer Aided Dispatch (CAD) IT system within the Control Room. Following the technical cut over the system initially operated for a few hours before slowing and ultimately failing. The Control Room reverted to operating on paper until transferring back to the old CAD system some hours later. This failure delayed responses to patients representing a serious risk. An investigation into the management and technical events of 8th June has been undertaken, this report focuses on an individual case where a significant delay in dispatching a resource to a patient took place.

Incident description and consequences

At 10.00hrs the CAD system failed and the control room reverted to a paper-based dispatch system.

At 14.38hrs an emergency call was received into the control room for a 55 year-old male patient with sudden onset of shortness of breath. During the call the patient collapsed and went into cardiac arrest. Bystander cardio-pulmonary resuscitation commenced under direction of the call-taker in EOC.

From the EOC paper call log the call is initially coded as 6C (respiratory/breathing problems) but this was overwritten to 9D1 (cardiac arrest) as the patient's condition deteriorated. The call-taker recognised the change in the patient's condition and altered the call determinant and category appropriately and provided pre-arrival cardio-pulmonary resuscitation instructions.

There was a delay in the dispatch of a resource to this call.
A general broadcast to all crews in the vicinity was made on the local channel radio approximately 15 minutes after the start of the 999 call.

An officer from the local complex had heard the call but could not get through to the sector desk due to radio traffic and he self-activated to the call. He was the first responder on scene followed quickly by another fast response vehicle.

At 14.51hrs a fast response vehicle was dispatched to the call arriving on scene with the patient at 14.57. At 14.52hrs an emergency ambulance was dispatched to the call from Barnet General Hospital arriving on scene with the patient at 14.58. On arrival the LAS crews confirmed the patient was in cardiac arrest and commenced full advanced life support. This included placing an endotracheal tube into the patient's trachea and an intravenous cannula into a vein order to give drugs to try to restart the heart. At no point did the patient have a cardiac rhythm that was amenable to a DC shock to try to restart it.

The patient was in pulseless electrical activity (PEA). This refers to a cardiac arrest situation

in which a heart rhythm is observed on the electrocardiogram that should be producing a pulse but the heart muscle is not contracting sufficiently to produce a palpable pulse so there is no cardiac output.

Despite a full advanced life support resuscitation attempt, no sustained return of circulation was achieved although there were brief periods where a pulse could be felt indicating that the heart was intermittently beating without chest compressions.

The patient was conveyed to Barnet General Hospital, arriving at 15:57 hours, a priority call having been placed. The resuscitation attempt was continued in hospital, but was terminated at approximately 16:30 hours and the patient declared dead by the attending medical personnel.

The LAS Gold Command Point team were notified of the incident by a DSO immediately afterwards and the SI team were notified.

Although the delay in reaching the patient is regrettable and falls below the expected standards, the probability of death in out-of-hospital cardiac arrest remains greater than 50%, regardless of the time before ambulance resuscitation is commenced.

Incident date	08/06/2011
Incident type	Delay in care
Specialty	Clinical and Quality
Effect on patient	Death
Severity of incident	Catastrophic

Detection of incident

The incident was highlighted during a review of all category A calls that followed the failure of the CommandPoint system on 8th June 2011. The deputy medical director and senior manager reviewed all category A calls to determine if there was any risk to patients as a result of the system failure. This call was a Red 1 call and was considered to have been complicated by the delay in dispatch.

Clinical opinion

The patient was a known asthmatic patient who had 3 day history of a productive cough and had, according to one PRF, also used recreational drugs. The patient had run out of inhalers one day earlier. The patient had experienced a sudden onset of shortness of breath which prompted a friend / relative to call 999 for an ambulance. During the time this call was being made it appears the patient acutely deteriorated and collapsed.

On arrival of the LAS crews full advanced life support resuscitation was undertaken including placing an endotracheal tube into his trachea and an intravenous cannula into a vein order to give drugs to try to restart the heart. At no point did the patient have a cardiac rhythm that was amenable to a DC shock to try to restart it.

The resuscitation attempt appears to be in line with LAS guidelines, and included placing an endotracheal tube and establishing intravenous access. Eight doses of adrenaline 1:10000 were given, together with two 250 ml boluses 500ml bolus of saline. Nebulised salbutamol and atrovent were given in addition via the endotracheal tube in recognition of the history of asthma. Hypoglycaemia was considered, but the patient had a blood glucose level of 5.2 mmol/L. The end tidal carbon dioxide measurements confirmed that the endotracheal tube was correctly positioned in the trachea and indicate that good quality chest compressions were being provided.

It is apparent that at the time of the 999 call that the patient was already in respiratory extremis and he went into cardiac arrest during the initial call. Although survival from out of hospital cardiac arrest has improved over the past decade, it remains low. The LAS reports an overall cardiac arrest survival rate of 8%. Using the Utstein template (patients where the cardiac arrest is of cardiac origin, was witnessed and in a shockable rhythm on arrival of the ambulance crew) the survival rate increases to 22.8%.[1] Survival rates from non-cardiac causes, or if the patient is in a non-shockable rhythm is much lower, and approaches zero in patients who have suffered massive blood loss or severe trauma.

It is well documented that the chance of survival (and particularly survival to discharge with no residual disability) decreases with time. Although bystander CPR does improve the chance of survival, and the crew have commented that the CPR being done appeared “effective”, it is still unlikely that survival was possible under the circumstances.

The cause of cardiac arrest is not known although there is no documentation to suggest any trauma so the assumption is that the cause was medical. This is supported by the patient’s recent medical history.

[1] X:\Clinical Audit & Research Unit\Cardiac Reports\Annual Reports\Cardiac Arrest Annual Reports

Support offered to patient/family

An LAS officer was on scene with the family at the time of the incident and offered his apology for the delay in the response of the crews. The author is unaware if the family have made any formal approach to the Trust or if the Trust has made any contact or offered support to the family following the incident.

Care and Service Delivery Problems

- As a result of the failure of the control system, control services were running on a paper system.
- Allocators were unable to clearly see where there were vehicles available.
- Failure to respond to a Category A call within 8 minutes, however the response to what was initially a Red 2 call was within the A19 minute target parameter of having an ambulance on scene.

Contributory factors

- The dispatchers had no view of available resources and the room was dispatching by radio. As a direct result, radio communication was much higher than normal and there were delays in radio operatives answering calls.
- The call to the patient was delayed as a result of the inability to identify a resource to attend despite regular general broadcasts.
- This was impacted by the lack of visual data available to the sector desk, the amount of radio traffic and the call demand.
- The fall back systems in place in the EOC are tested and had been in place for some hours so at the time of the incident were considered normal practice by EOC staff.

Root Cause

With the uncertainty around the actual cause of death it is difficult to determine if the delay in response to the call had an impact on the overall outcome for the patient.

Lessons Learned

No contact has been made with the family following the incident and they are unaware of this investigation so consideration should be given to whether it is now appropriate to contact the family. In cases of potential harm to a patient early consideration should be made of the appointment of a family liaison officer in line with Trust policy.

Notable practice

The actions of the call-taker in recognising the change in the patient's condition and altering the call determinant and category; and in providing pre-arrival cardio-pulmonary resuscitation instructions.

Conclusion –

1. The delay in responding to the call was caused by the failure of the IT system which prevented EOC staff from visualising available resources and dispatching. It also created a backlog of radio traffic above the normal demand and prevented available resources from contacting the desk. This, combined with the time of day normally associated with an increase in call demand, delayed the response to the call.

2. The patient had suffered a cardiac arrest but it cannot be determined if the prognosis of the patient was affected by the delay in response to the call.

3. It cannot be determined if the outcome of the patient would have been any different even with an earlier response. No information from a post mortem result is available to the Trust.

Recommendation

1. Clinical Support from CSD should be provided to the sector desks when red calls are being held enabling a review of those calls to ensure that resources coming available are assigned to the most appropriate call based on clinical need.

2. When on paper the red calls are identifiable on the AS1 for easier identification and review and a system is in place to start the review process much earlier with a clinical team as part of the implementation process.

Action Plan and Implementation

(To be included in the Command Point Investigation recommendations)

Arrangements for sharing learning

Face to face briefing of Clinical support desk

Executive sign – off

SMG

7th December 2011

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 24TH JANUARY 2012

PAPER FOR NOTING and APPROVAL

Document Title:	**Update on the LAS Foundation Trust application**
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?	**To advise the Trust Board of progress with the LAS FT application** **To seek approval for the Short Form Standing Orders for the Foundation Trust Board of Directors**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ 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:	**To approve the Short Form Standing Orders**

Executive Summary

The LAS submitted its foundation trust application to NHS London (the SHA) and the Department of Health (DH) on 23rd December 2011 and, during the course of the following week, further submissions were made to NHS London to respond to the questions from their Capital Investment Committee.

The Department of Health submitted, via the SHA, a series of finance and non-finance questions for submission by 16th January 2012. This was a joint submission by the SHA and LAS and the timeline and requests were met. We are likely to receive the outcome of the DH Technical Committee discussions in early February after which the next steps and timeline for our FT application will be known.

Work is ongoing to update key documents supporting the application and the Short Form Standing Orders are attached for approval. These will replace Appendix N of the Integrated Business Plan and be appended to Appendix C – draft Constitution. This is recommended good practice for foundation trusts as they contain the relevant amount of detail and have previously been accepted by Monitor. The document attached reflects the current Trust Standing Orders and has some additional information within SO 4 (i) and (v), both of which will be reflected in the long form Standing Orders and associated Trust policies for the LAS NHS foundation trust. Board members will also note the reference to the Council of Governors in SO 1.1. SO 6.0 is not included within our current Standing Orders however it seems reasonable to include it here.

The independent assessment of the quality governance framework was completed on 12th January following desk top review and a series of interviews. The outcome of the assessment will be

presented in Part II of the Trust Board.

The Department of Health published the new board governance assurance framework requirement in December 2011 for which there are two key stages to the assessment:

1. Board governance memorandum (BGM) – for the Board to self-assess current capacity and capability, supported by appropriate evidence and then externally validated by an independent supplier, the cost of which is to be met by the Trust;
2. Development modules – where the Board can opt to seek a deeper level of assurance into Strategy, Quality or Finance. Or, where the independent supplier recommends deeper levels of assurance.

We have had confirmation from the Department of Health that, as our application is now at DH stage, we are not required to undertake the formal assessment process. It is recommended however that we follow the framework for our own assessment and board development purposes. An initial gap analysis has been prepared and will be discussed by the Trust Board at its meeting of the Strategy Review and Planning Group in February.

Key issues for the Trust Board

What action does the Trust Board need to take with the information provided?
To be assured that the executive team are progressing with the FT application and meeting required deadlines.

Are there any areas which are a cause for concern?
We will not know the timeline until the DH Technical Committee has met. This will identify whether there are any significant issues that need to be resolved before the application can progress to Monitor.

What are the key actions to mitigate any concerns?
None known at this stage.

How does the Trust Board draw assurance?
From the submission of the FT application to the DH on 23rd December 2011; the submission of key documents and evidence to the SHA to respond to any remaining CIC queries; and the joint submission of responses and evidence to the DH.

Attachments
Short Form Standing Orders for the London Ambulance Service NHS Foundation Trust Board of Directors

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Strategic Goals 2010 – 13
This paper supports the achievement of the following corporate objectives:

☐ To have staff who are skilled, confident, motivated and feel valued and work in a safe environment
☐ To improve our delivery of safe and high quality patient care using all available pathways
☒ To be efficient and productive in delivering our commitments and to continually improve

Risk Implications
This paper supports the mitigation of 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

NHS Constitution

This paper supports the following principles that guide the NHS:

☒ 1. The NHS provides a comprehensive service, available to all
☐ 2. Access to NHS services is based on clinical need, not an individual's ability to pay
☒ 3. The NHS aspires to the highest standards of excellence and professionalism
☐ 4. NHS services must reflect the needs and preferences of patients, their families and their carers
☐ 5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
☒ 6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
☒ 7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☒ No

Key issues from the assessment:

ANNEX [ ]

STANDING ORDERS – BOARD OF DIRECTORS

1. Appointments to the Board of Directors

1.1 Appointment of the Chairman and Non-Executive Directors

The governors at a general meeting of the Council of Governors shall, subject to the other provisions of the Constitution, appoint or remove the Chairman of the Trust and the other non-executive directors. Any re-appointment of a non-executive director by the Council of Governors[1] shall be subject to a satisfactory appraisal carried out in accordance with any procedures the Board of Directors may approve from time to time.

1.2 Appointment of the Chief Executive and other Executive Directors

The Chief Executive is appointed by the non-executive directors subject to the approval of the Council of Governors. A committee consisting of the Chairman, the Chief Executive and the other non-executive directors shall appoint the other executive directors.

1.3 Appointment and Powers of the Deputy Chairman

The governors at a general meeting of the Council of Governors shall appoint one of the non-executive directors to be Deputy Chairman of the Board of Directors. If the Chairman is unable to discharge his/her office as Chairman of the Trust for whatever reason, the Deputy Chairman of the Board of Directors shall be acting Chairman of the Trust.

2. Meetings of the Board of Directors

2.1 Calling and Notice of Meetings

(i) Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least three days written notice of the date and place of every meeting of the Board of Directors to all directors.

(ii) Meetings of the Board of Directors may be called by the Secretary, the Chairman, or by four or more Directors who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all directors as soon as possible after receipt of such a request and shall call a meeting at least three clear days before the meeting.

2.2 Chair of the Meeting

(i) At any meeting of the Board of Directors, the Chairman of the Board of Directors, if present, shall preside. If the Chairman is absent from the meeting the Deputy Chairman, if there is one and he/she is present, shall preside. If the Chairman and Deputy Chairman are absent, then the non-executive

[1] Not stated within draft constitution or governance rationale but fits within Monitor's Code of Governance

Directors present shall choose which non-executive director present shall preside.

2.3 Quorum

No business shall be transacted at a meeting unless at least four of the whole number of directors are present two of whom shall be executive and two non-executive directors.

2.4 Voting

All questions arising at a meeting of the Board of Directors and put to the vote shall, at the discretion of the Chairman, be determined by oral expression or by show of hands provided that, upon any question the Chairman may direct, or it be proposed, seconded and carried that a vote be taken by paper ballot. In the case of an equality of votes the person presiding at or chairing the meeting shall have a casting vote.

3. Committees and Delegation

3.1 The Board of Directors may delegate any of its powers to a committee whose membership is composed entirely of such Directors or to an Executive Director, in each case subject to such restrictions and conditions as the Board of Directors thinks fit from time to time.

3.2 The Board of Directors shall have various committees which will advise it, including an audit committee and a Board of Directors' remuneration and nominations committee.

3.3 Each such committee, and any sub-committee, shall have such terms of reference and powers as the Board of Directors shall determine from time to time.

4. Disclosure of interests

Directors shall declare any pecuniary, personal or family interest, whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Board of Directors. A family interest will include those of a director's spouse or partner.

Such interests include:

(i) Directorships, including non-executive directorships held in private companies, public limited companies (PLCs) or *public benefit corporations (with the exception of those dormant companies).*

(ii) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

(iii) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.

(iv) A position of authority in a charity or voluntary organisation in the field of health care or social services.

(v) Any connection[2] with a voluntary or other body contracting for services with NHS organisations.

(vi) Any other commercial interest in a decision before the meeting of the Trust Board.

5. Declaring interests

5.1 At the time directors' interests are declared, they should be recorded in the Board of Directors' minutes and entered on a register of interests of directors to be maintained by the Secretary. Any changes in interests should be declared at the next Board of Directors' meeting following the change occurring.

5.2 During the course of a Board of Directors' meeting, if a conflict of interest is established, the director concerned shall disclose the fact, and withdraw from the meeting and play no part in the relevant discussion or decision.

5.3 If a director has any doubt about the relevance of an interest, he should discuss it with the Chairman or Secretary who shall advise him on whether or not to disclose the interest.

6. Additional Provisions

The Board of Directors may establish[3] additional protocols and procedures for the operation of the Board of Directors, and the economic, effective and efficient operation and good governance of the Trust generally from time to time as appropriate.

[2] Current Standing Orders state 'any material connections'. This may lead to confusion about what is meant be material although if in doubt, SO 5.3 would apply.
[3] Not included within current Standing Orders but reasonable to include them here.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 24 JANUARY 2012

PAPER FOR NOTING

Document Title:	**Annual Equality Report**
Report Author(s):	**Janice Markey, Equality and Inclusion Manager**
Lead Director:	**Caron Hitchen**
Contact Details:	**Caron.hitchen@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Requirement under the Equality Act 2010**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Senior Management Group ☐ 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:	**To note the contents and support the SMG in agreeing future actions and objectives**

Executive Summary:

This comprehensive report provides detail on progress on equality and inclusion issues in the Trust for the year 2010/11, highlighting any key areas of under representation for the Trust, improvements required in the collection and provision of management information on the workforce, service delivery and patient profiling and suggested initiatives to be considered to address any gaps in line with the requirements of the Equality Act 2010 and the new public sector duty.

The report also updates the Trust Board on action taken since submission of the last Annual Equality report (09/10).

The timing of this report is later than normally anticipated due to the late publication of the specific public sector duty guidance. A report for the period 2010/11 will be presented to the Trust Board in May 2012 which will re-establish the regular reporting cycle.

It is timely to announce (whilst not within the time period of this report) that the LAS has been awarded a position within the Stonewall top 100 employers in recognition of its equality policies, practices and experience of staff with regard to employment of gay, lesbian and bisexual staff. It should be noted that these policies also reflect our general approach to the broader diversity arena and serves as validation to the Trust's approach to equality and inclusion across the board.

In addition, the LAS will be adopting the national NHS Equality Delivery System to both strengthen our existing practices and measure and monitor our progress against our stated objectives.

Key issues for the Trust Board

The Trust Board should recognise that representation overall in the workforce of BME staff remains low compared to the London census at 9%. It is not anticipated that the report for 2011/12 will show a different picture and at a time of workforce reduction there is little/no opportunity to impact on this. That said, of the BME staff employed, the majority are in pay band 5 and 10.2% of BME staff hold senior management positions (compared to 9.9% of other staff).

The Trust Board are asked to note the contents of this report and await the report for 2011/12 together with its recommendations from which it can draw up to date assurance that areas for action have been identified with intended actions clearly stated. These actions will be monitored and managed through the Equality and Inclusion Steering group and strengthened by the adoption of the national Equality Delivery System.

Attachments

Annual Equality Report 2010/11

****

Strategic Goals 2010 – 13
This paper supports the achievement of the following corporate objectives:

☒ To have staff who are skilled, confident, motivated and feel valued and work in a safe environment
☐ To improve our delivery of safe and high quality patient care using all available pathways
☐ To be efficient and productive in delivering our commitments and to continually improve

Risk Implications
This paper supports the mitigation of 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

NHS Constitution
This paper supports the following principles that guide the NHS:

☒ 1. The NHS provides a comprehensive service, available to all
☐ 2. Access to NHS services is based on clinical need, not an individual's ability to pay
☐ 3. The NHS aspires to the highest standards of excellence and professionalism
☒ 4. NHS services must reflect the needs and preferences of patients, their families and their carers
☐ 5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
☐ 6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
☐ 7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?
☐ Yes
☐ No – N/A

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board Date of Meeting: 24 January 2012

ANNUAL EQUALITY REPORT 2010- 11

1 INTRODUCTION

1.1 The 2010-11 Annual Equality Report provides equalities information on the Trust's workforce and access to services for the year April 1 – March 31 2010.

1.2 A Staff Data Refresh, to update employee staff records, will be undertaken at regular intervals, to ensure information is accurate and as comprehensive as possible, to assist the Trust with identifying and combating any areas of disadvantage.

1.3 The Annual Equality Report will continue to be published on the Trust's website and be made available on request in community languages and alternative formats to our patients, service users and stakeholders.

1.4 In line with the Trust's standard reporting timescales, the next Annual Equality Report will cover the period from April 1 2011 to March 31 2012.

2. PROGRESS SINCE ANNUAL EQUALITY REPORT 09-10

2.1 The current report provides the workforce profiling & access to key services statistics for the period from April 1 2010 to March 31 2011.

2.2 The impending Staff Data Refresh across all protected characteristic groups should enable all managers and function holders to more comprehensively analyse performance in regard to employment and training in their respective service areas across all protected characteristic groups. The analysis from this will inform future Annual Equality reports.

2.3. Following the Equality Act 2010 Public Sector Duty Specific Regulations and forthcoming equalities monitoring guidance from the Department of Health, consideration will be given to how best and appropriately to monitor take- up and satisfaction with the services provided by the Trust in relation to their protected characteristic groups.

2.4. A number of recommendations were made in the previous report, which have been progressed as follows:

- A Staff Data Refresh across all protected characteristic groups has been actioned, which should provide more robust, comprehensive data in regard to the workforce.
- Resourcing has been provided for actions identified in the Equality & Inclusion Action Plan.

- Work is planned to embed equality and inclusion objectives within staff Performance Development Reviews.
- A new Positive Action Strategy has been produced, to encourage the recruitment and development of people from under-represented and protected characteristic groups.
- The delivery of new Equality Act 2010 training was actioned, with an additional focus on disability, targeted at specific groups of Trust staff, including HR Managers and Assistants, with presentations planned to the Trust Board, Senior Managers', Managers' and Admin Conferences and additional face to face workshops for managers and staff. Briefings on the new Equality Act 2010 are planned for the HR Directorate Team and the All-in-one Refresher training. New Equalities Induction Training material has been produced.
- The Chairs of the new Staff Diversity Forums, Enable (Disabled Staff & Carers Forum), LGB Staff Forum and the Deaf Awareness Forum have attended numerous meetings of the Trust's Equality and Inclusion Steering Group to discuss the forum terms of reference and activity plans, with a joint Staff Forum Day planned to raise staff awareness of the new forums and encourage an uptake in membership. Staff Forum members have also acted as critical friends in equality analysis .
- In September 2010 the Trust submitted its second application for inclusion in the Stonewall Workplace Equality Index. This time the Trust came 169th out of 378 organizations applying, with a score of 119 points, an increase of 130 places since the previous year, only 27 points less than the organization ranked 100th on the Workplace Equality Index.
- The Trust was commended for being the most improved Health organization in London and Ambulance Trust over the previous year and also for some of the answers in the confidential Staff Feedback Survey, including a 93% affirmative response to the question "Is your workplace inclusive?" (in comparison to an average for the Index of 73%) and "Do you feel loyal to your organization?" (affirmative response for Trust – 81%, as compared to an average of 70% across all organizations).
- Benchmarking with the National Ambulance Diversity Forum continues through Trust representation at this and the National Ambulance BME forum.
- The Trust has been profiled in a wide range of equality media, including annually in the Stonewall "Starting Out" recruitment guide, aimed at students and people leaving school and college; this guide goes out to all universities, secondary schools, career services and youth groups across the UK and is an important way to attract the best new talent into the service.
- The Trust was represented in October 2010 at the Stonewall-sponsored Diversity Recruitment Fair and attracted considerable interest from visitors to the Fair, both in regard to recruitment as well as in regard to membership queries.
- A new Equality Analysis procedure, incorporating a critical friend aspect, has been produced and briefings provided by the Equality and Inclusion Team on the new procedure and Equality Act 2010 implications to all teams undertaking equality analyses. All equality analyses continue to be published on the Trust's website.

- A six-monthly update on the new Equality and Inclusion Strategy was provided to SMG in September 2010, with an update on the first year scheduled for 2011.

3. GOVERNANCE

3.1 During 2010/11 the Trust continued to undertake Equality Analysis in line with the Policy and Procedure for the development and implementation of procedural documents (TP01). The governance & compliance team worked with the Equality & Inclusion Manager on the review of policy documents that were required for the NHSLA assessment in late 2010 and this contributed to a successful outcome.

3.2. Front sheets for Board and formal committees included the Equality Analyses for the relevant document under consideration and, although compliance levels are variable, the new Equality Analysis procedure simplifies the process for managers.

3.3. The Trust was awarded unconditional registration by the Care Quality Commission in April 2010 and continues to monitor progress against each of the outcomes. The requirements do not specify a standard for equality & inclusion but the application for registration included a section on equality, diversity & human rights asking how we ensure people's equality, diversity and human rights are actively promoted in our services and how these influence our service priorities and plans.

3.4. With effect from 1st April 2010 the committee has reported to the Senior Management Group under the revised governance structure. The following Directors are members of the steering group: Human Resources & Organisational Development, Finance, Corporate Services, and a non-executive director who is also the Chair of the Quality Committee reporting to the Trust Board.

4. FOUNDATION TRUST

4.1. Membership Strategy

The Membership Strategy sets out the Trust's approach for growing, maintaining and developing an engaged and active public and staff membership. The strategy defines the membership community and sets out actions to help the Trust achieve its membership objectives. These objectives include achieving a membership consisting of the range of diverse communities of London's population and workforce and focusing on the development of our membership base and member-relations activities in order to achieve a representative membership. The document outlines how the Trust will evaluate its success in delivering the strategy and how it will continue to develop and benefit from an active and involved membership. The Membership Strategy is an appendix to the Integrated Business Plan and as such forms part of the application for NHS foundation trust status. An Equality Analysis has been carried out on the strategy.

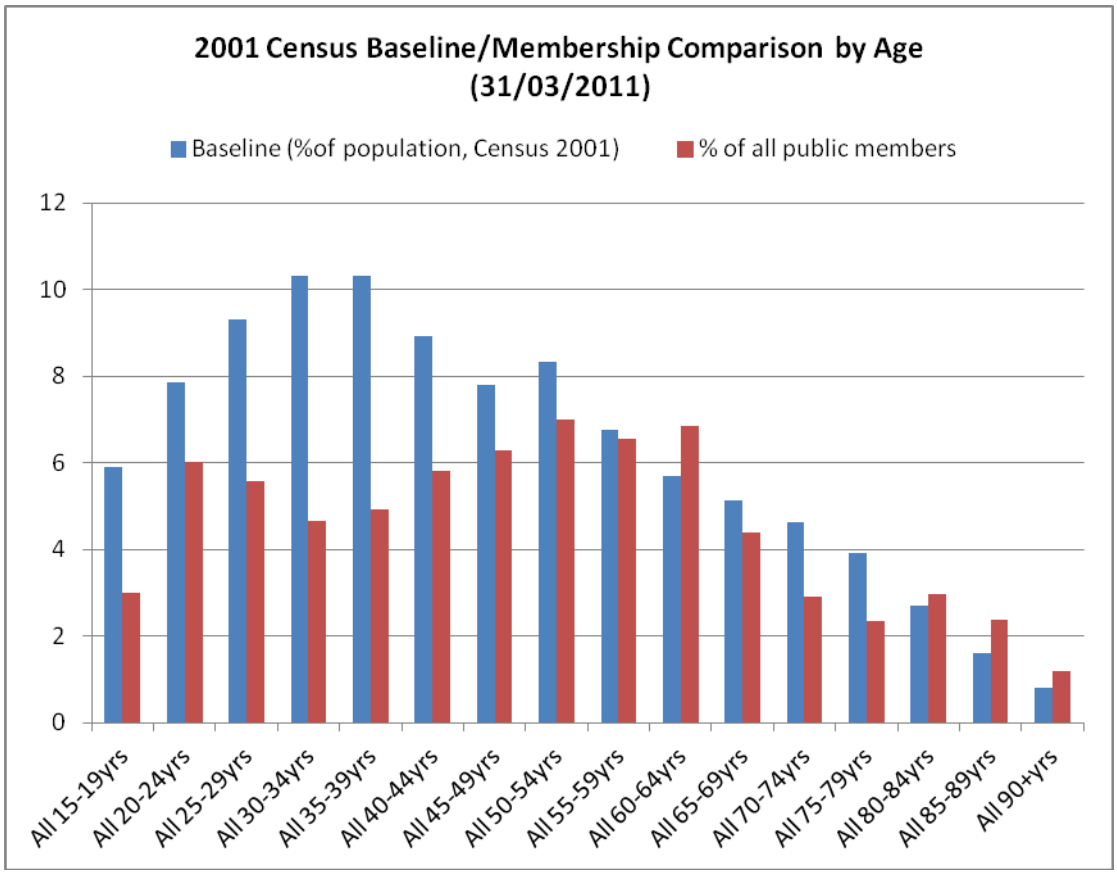
4.2 Analysis of Membership

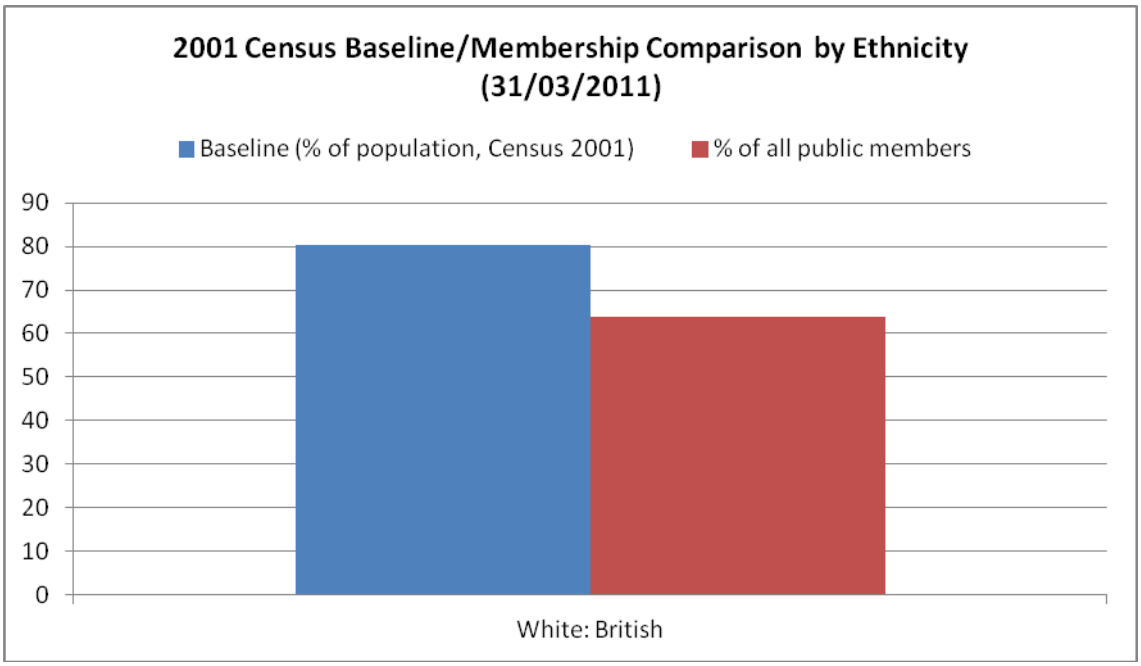
Section 3.5 of the Integrated Business Plan outlines the profile of our public membership in relation to age, ethnicity, social grade, gender and constituency. This is compared against the London census population baseline 2001. From the data collected from our members who have provided ethnicity details, almost 6% are Asian/Asian British: Pakistani, and just under 5% are White: Other White. The remaining data is spread evenly across ethnic groupings.

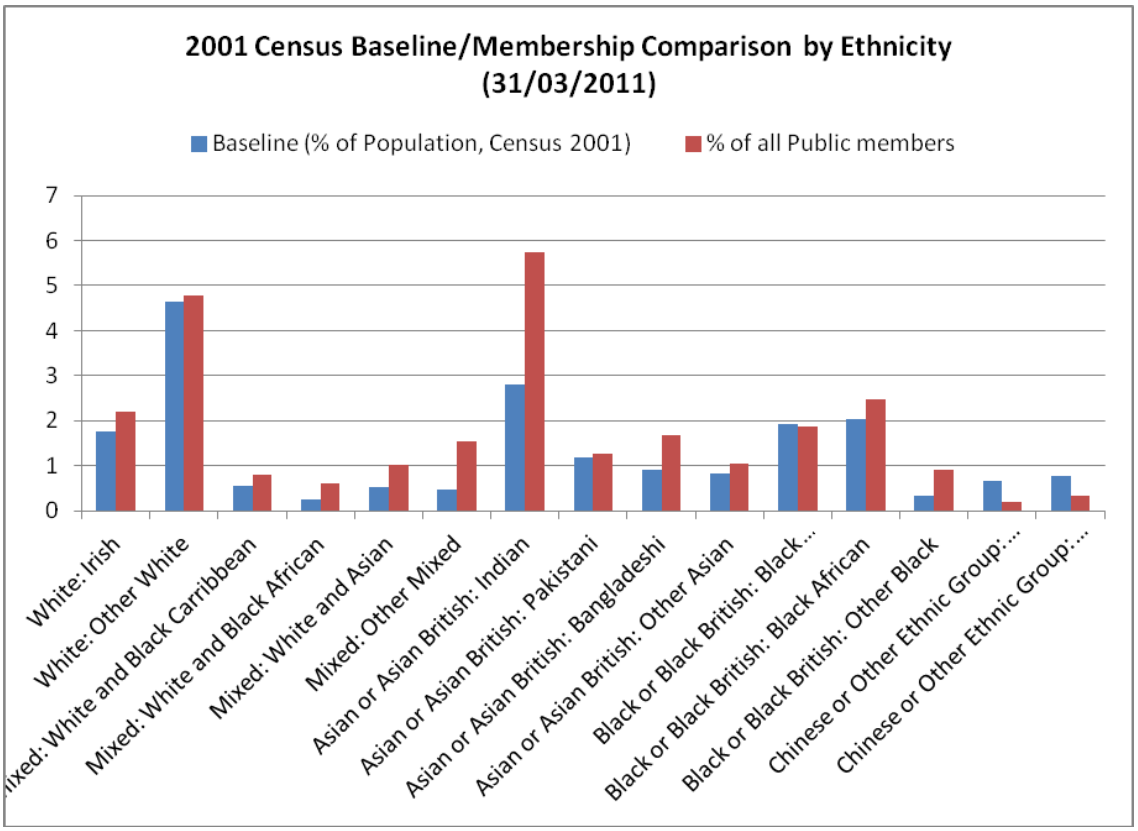
The majority of members (82%) state their socio-grade as ABC1 and we have identified that we need to focus on recruiting members from socio-grade C2, skilled manual workers.

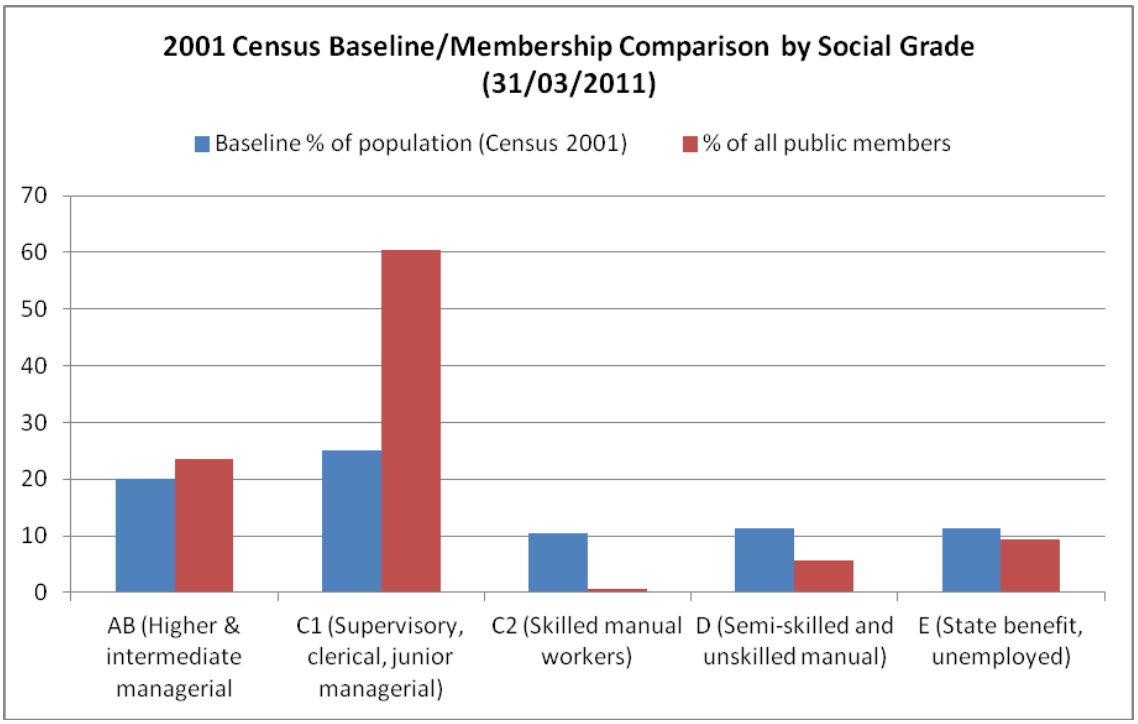
11% of our public members (5,781) have indicated that they consider themselves to have a disability.

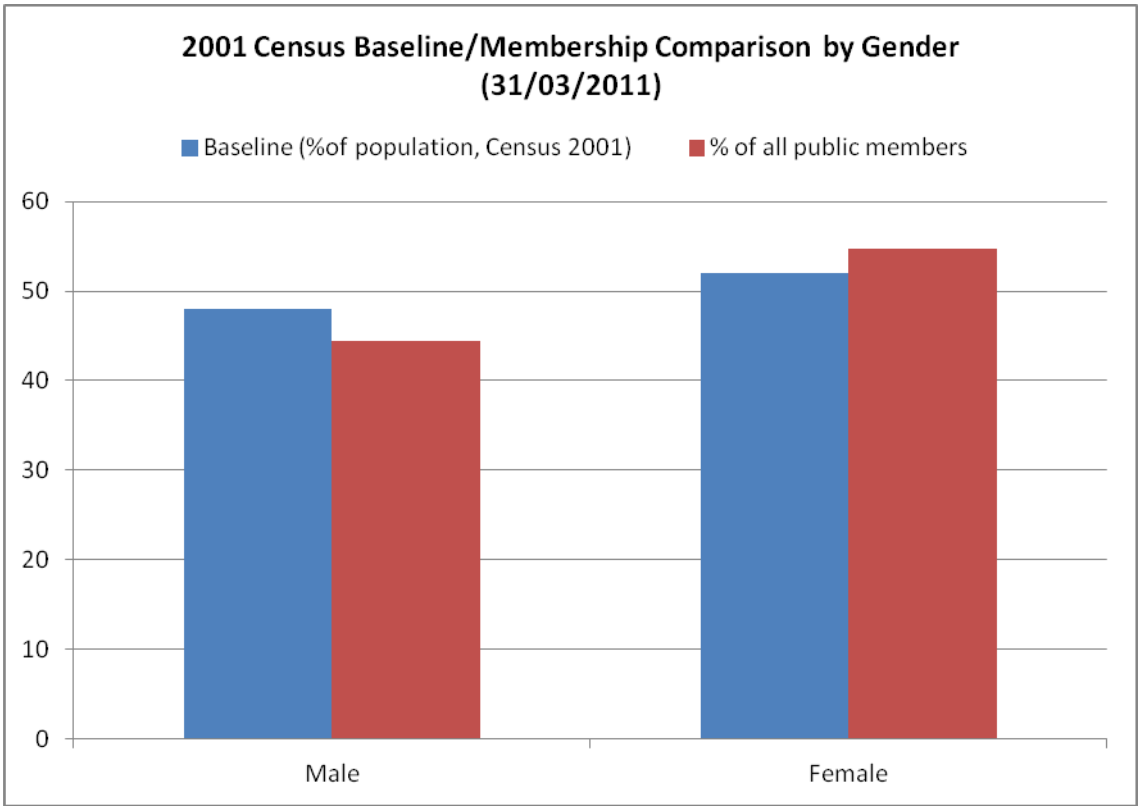
At 31 March 2011 the Trust had 5,060 public members. Members have been recruited through a variety of methods including through face-to-face contact, mailings, telephone recruitment and online. The Trust regularly and closely monitors the demographic profile of its public members to get a picture of how representative the membership is of the local population and to address any inequity through recruitment. The following graphs compare the public membership against the London population by age, ethnicity, socio-economic grade, gender and area.

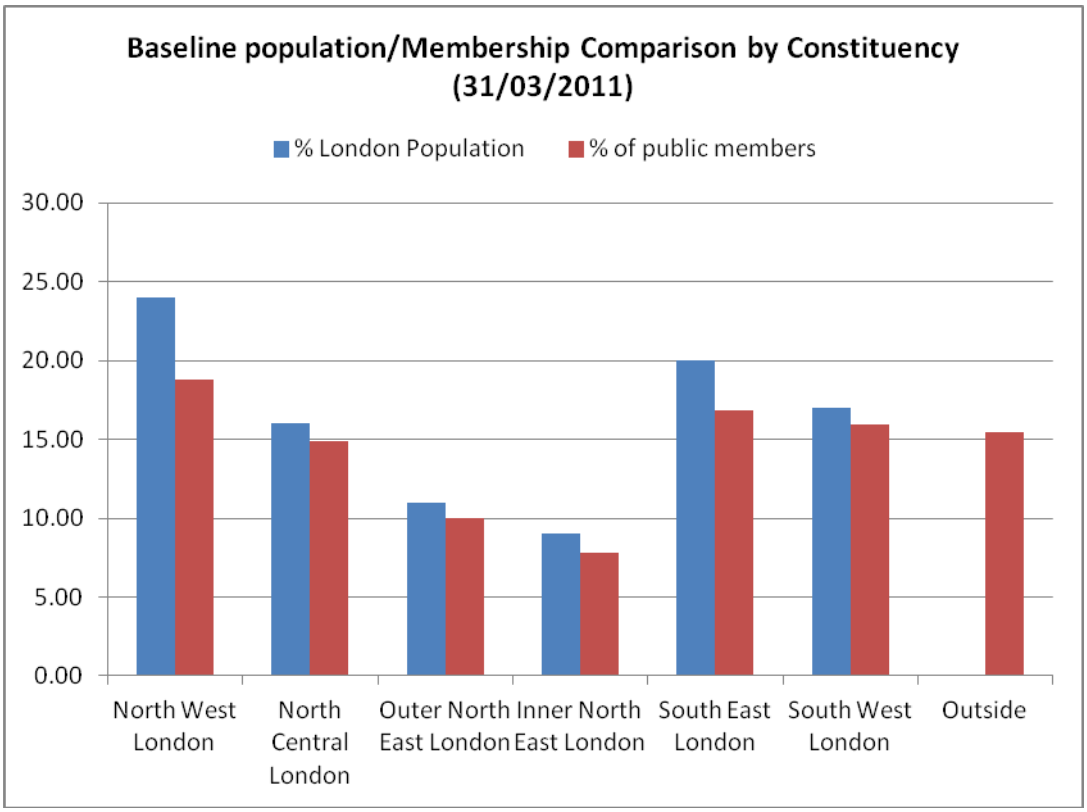



2001 Census Baseline/Membership Comparison by Ethnicity (31/03/2011)
Baseline (% of population, Census 2001)
% of all public members
90
80
70
60
50
40
30
20
10
0
White: British


2001 Census Baseline/Membership Comparison by Ethnicity (31/03/2011)
Baseline (% of Population, Census 2001)
% of all Public members
7
6
5
4
3
2
1
0
White: Irish
White: Other White
Mixed: White and Black Carribbean
Mixed: White and Black African
Mixed: White and Asian
Mixed: Other Mixed
Asian or Asian British: Indian
Asian or Asian British: Pakistani
Asian or Asian British: Bangladeshi
Asian or Asian British: Other Asian
Black or Black British: Black...
Black or Black British: Black African
Black or Black British: Other Black
Chinese or Other Ethnic Group:...
Chinese or Other Ethnic Group:...


2001 Census Baseline/Membership Comparison by Social Grade (31/03/2011)
Baseline % of population (Census 2001)
% of all public members
70
60
50
40
30
20
10
0
AB (Higher & intermediate managerial
C1 (Supervisory, clerical, junior managerial)
C2 (Skilled manual workers)
D (Semi-skilled and unskilled manual)
E (State benefit, unemployed)


2001 Census Baseline/Membership Comparison by Gender (31/03/2011)
Baseline (%of population, Census 2001)
% of all public members
60
50
40
30
20
10
0
Male
Female



4.3 Membership engagement and involvement

All Trust members receive the Trust's newsletter Ambulance News four times a year. This is a great opportunity for members to learn and understand more about the Service, how it works, key achievements and plans for the future.

We have commenced a programme of meetings and events for members with discussion groups on the Trust's corporate objectives and urgent care plans as well as an introduction to our clinical services: stroke and cardiac care and health education (anti-knife crime for example). By using different forms of social media and advertising membership on different sections of our website, we have started to attract a different profile of membership. We will monitor this as the year progresses.

More than 300 members have attended these events which have provided a fantastic opportunity for the Trust to showcase its work and gain a greater understanding of the views of the public.

4.4 Ambulance News

The membership newsletter is published quarterly and is available to members in hard copy, email and published on the website.

4.5 NHS foundation trust application

Due to a number of delays in the preparation stages the Trust did not apply to become an FT in 2010/11. It is now likely that we will achieve FT status in

2012/13.

5. LONDON AMBULANCE SERVICE NHS TRUST WORKFORCE DIVERSITY PROFILE

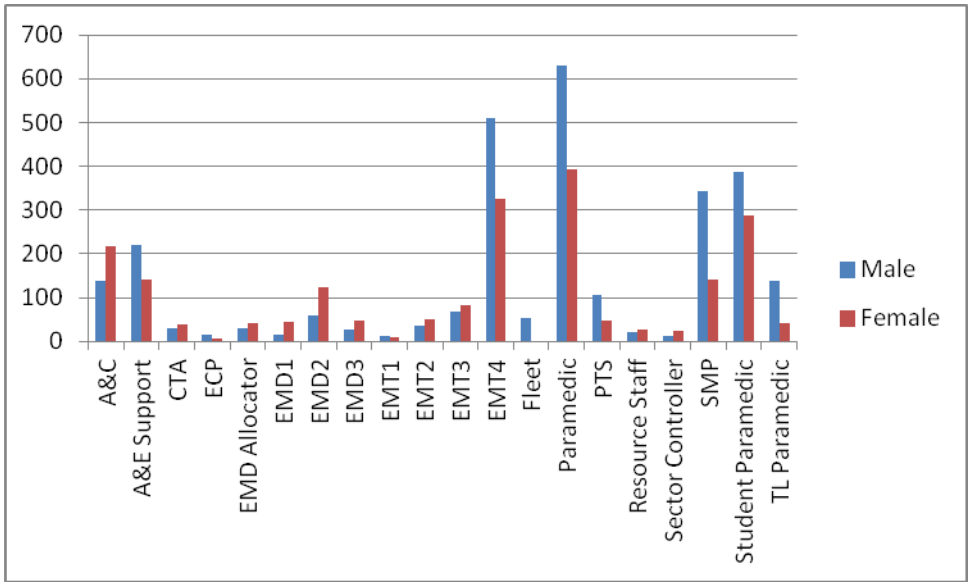
5.1. LONDON AMBULANCE SERVICE NHS TRUST WORKFORCE PROFILE 2009-10

In the last Annual Equality Report, presented to SMG and the Trust Board, covering the year April 1 2009 to March 31 2010, the Trust's workforce comprised 9% BME staff and 41% female. No statistics on disabled staff were available.

5.2.LONDON AMBULANCE SERVICE NHS TRUST WORKFORCE PROFILE 2010-11

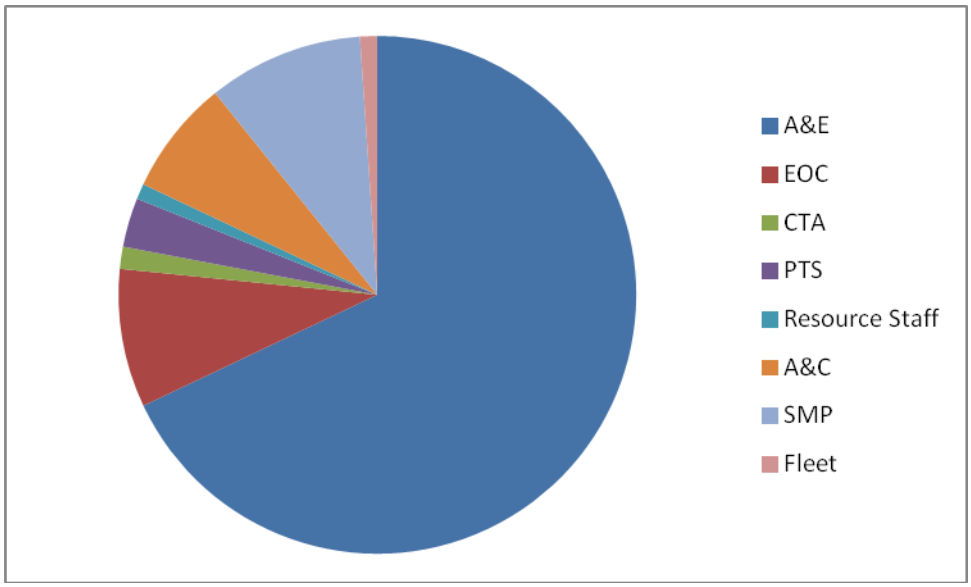
The charts below shows the representation of all staff within the Trust at grade and rank level, staff group and length of service.

ALL STAFF BY GRADE AND RANK



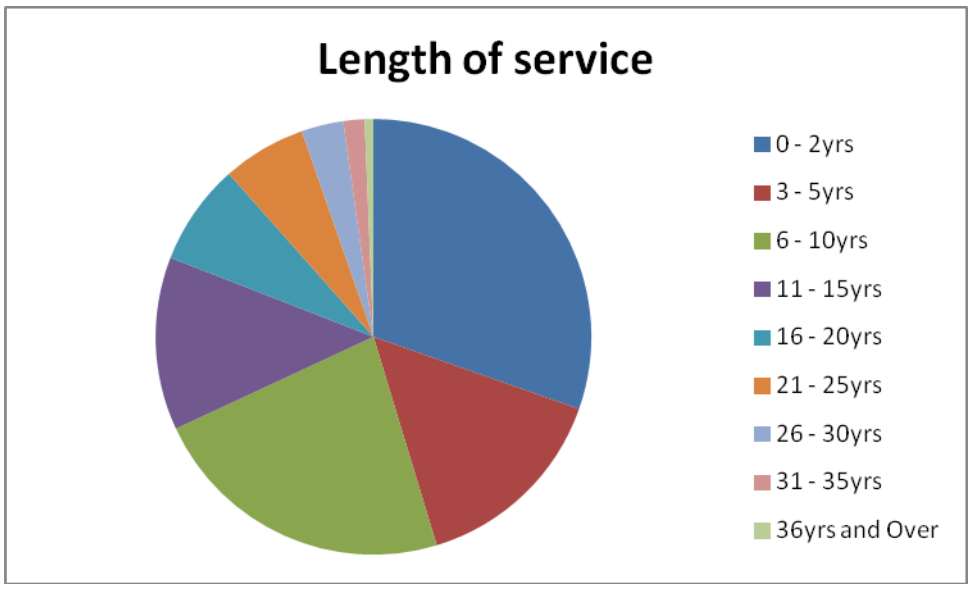
The highest number of Trust staff were, as expected, Paramedics (1025), followed by EMT4s (837) and Student Paramedics (674).

ALL STAFF BY STAFF GROUP



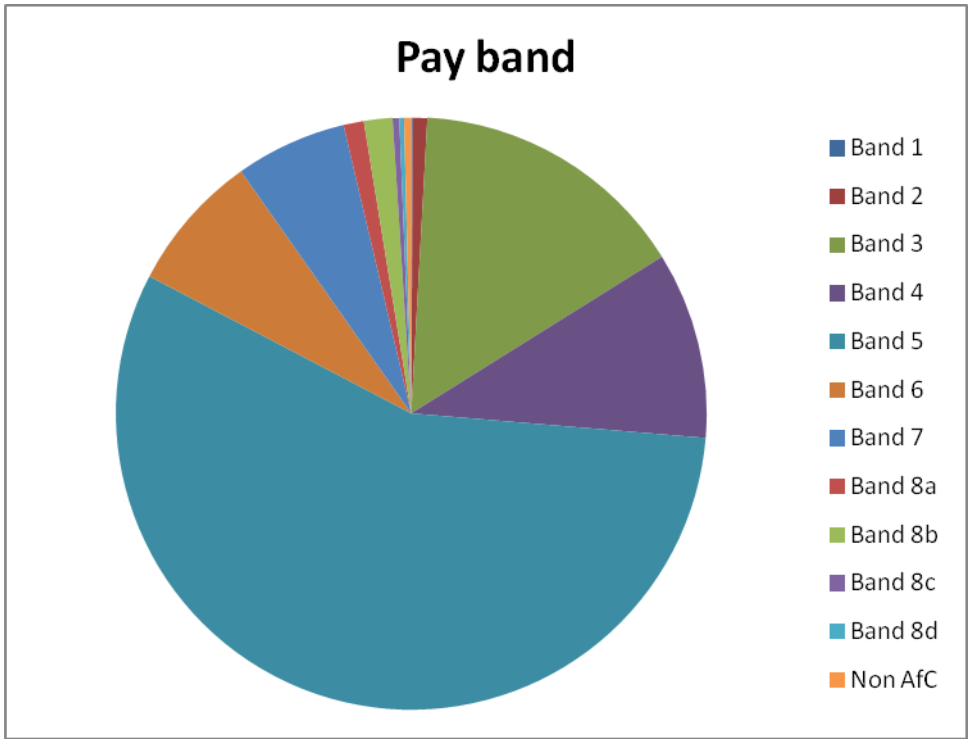
Again, as expected, the largest number of staff were employed in A&E (336), followed by SMP (480) and EOC (428).

ALL STAFF BY LENGTH OF SERVICE



This chart shows that the highest percentage of staff within the Trust have been here for between 0 to 2 years (30.4%), 6-10 years (22.8%), then 3 – 5 years (14.9%).

ALL STAFF BY PAY BAND



Staff in the Trust are predominantly at Band 5 level (56.3%), followed by Band 3 (15.2%), then Band 4 (10.2%), with 9.9% of staff at Senior Management level.

RECRUITMENT AND NEW STARTERS

325 people started with the Trust in 2010-11. The overwhelming majority of new starters were in A&E (206), with the most prevalent age range and pay band being 21-30 (157) and Bands 3 (151) and 4 (109) respectively. A breakdown of new starters by protected characteristic groups, where data is available, is provided later in this report.

The Recruitment Team made significant changes to the application process with updated guidance on how to complete an application form. This contains examples to aid potential recruits to complete a more detailed application form. The Trust's application system has also moved to the NHS jobs application form; previously candidates could apply using either the LAS application form from the Trust's website or the NHS jobs application form. Now all external applicants complete the same form in order to ensure a consistent and fair approach.

During this period of time external recruitment was significantly reduced with no student paramedic courses running and only a few EMD courses planned; therefore the recruitment team did not attend any careers events, due to the lack of available vacancies. For any vacancies the Trust had, for example IM&T, advertisements continued to be placed in a broad range of media in order to attract as wide a pool of applicants as possible but with the necessary skills.

Over 2010-11 the Trust's Recruitment Team amended the diversity reports completed and are now able to report and analyse recruitment figures for six of

the protected characteristic groups. For sexual orientation of applicants, for the whole of 2010-11, 56 % of applicants were heterosexual and with 41 % preferring not to answer or not completing this part of the form. Therefore, it would seems that we are attracting low numbers of applicants who are gay/ lesbian or bisexual, although this low figure could be attributed to the significant number failing to answer this question.

As well as being a Stonewall Diversity Champion, the Trust is regularly featured in Stonewall's Starting Out Guide, aimed at attracting people leaving school, college and university. Throughout the year the Trust has had profiles in a range of equalities media, including the disability, BME and LGB press, so this coverage should also assist with the recruitment of people from diverse backgrounds, wherever possible.

To ensure that people from a wide range of backgrounds, who from the recruitment analysis currently do not seem to be applying to the Trust (e.g. Chinese Disabled people, Gay, Lesbian and Bisexual applicants), consider this as a career option, it is recommended that the Trust looks at how we can engage actively with these sections of the community.

It is also recommended that the Trust looks into holding awareness events for certain sections of the community on how to complete an application form, but only in the circumstances when the Trust is able to have a large recruitment campaign so that the effectiveness of this initiative can be measured.
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LEAVER PROFILE

In 2010-11 a total of 352 staff left the Trust. The highest number of those leaving were from A&E (182), then Patient Transport Service (68), followed by A&C (31) with those staff having between 0 and 2 years (133), 3 and 5 years (62), then 6-10 years (56) the greatest numbers of those leaving. Exit questionnaires continue to be circulated and exit interviews held with staff leaving the Trust. Enhanced monitoring of leavers' details will assist the Trust in identifying any equalities-related issues.

PROMOTIONS

In the year 2010-11 there were a total of 172 promotions. Breakdown by protected characteristic groups is provided later.

Currently, Employee Staff Records do not have the facility to record a change of position as a promotion. The only way of identifying this is to look at all changes to positions which involved both a change of job title and an increase in pay band. However, this may not necessarily capture all promotions, as for example where staff are rebanded in the same job, e.g. through Agenda for Change.

The statistics by protected characteristics shown later in this report indicate that there is still work to be done in regard to promoting career development opportunities for women, black and ethnic minority staff and disabled staff. Training and development initiatives should help to address this, as should the Equality Act 2010/disability equality training to be provided by the Employers' forum on disability, as well as the emergence of the new Staff Diversity forums.

In September 2011 a system change is to be applied to the NHS-wide Electronic Staff Record System to prompt HR staff to give a reason why a change has been made to an employee's position/job title. This will be a great improvement on the current manual system of reporting, enabling more accurate reporting, also in regard to the protected characteristic groups.

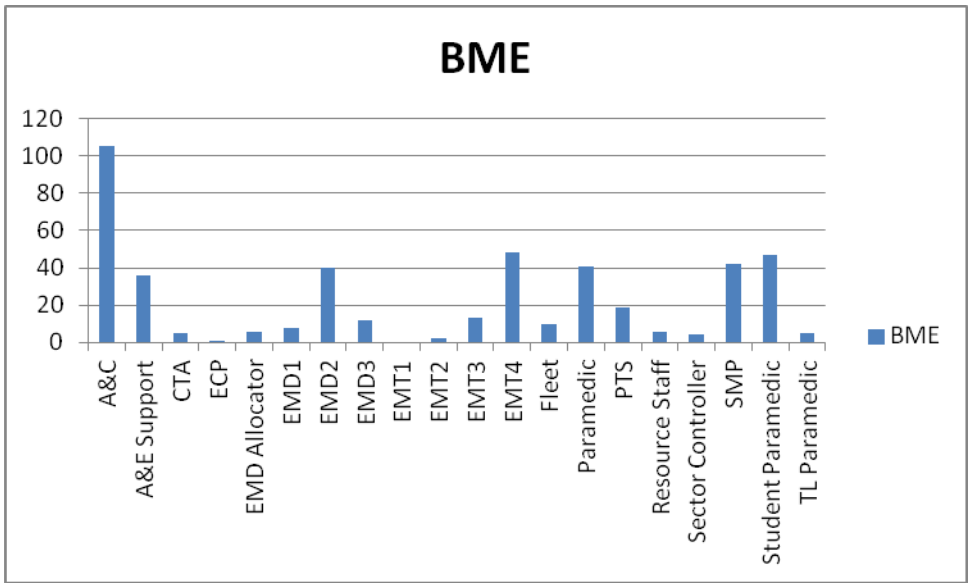
5.3.LAS PROFILE BY ETHNICITY

From April 1 2010 to March 31 2011 the Trust's workforce comprised 9% BME staff, almost the same as the workforce representation last year. Representation in the Trust is still some way below the Census 2001 estimate of 28% BME people in the capital.

REPRESENTATION BY STAFF GRADE/RANK

Most BME staff are in the following grades/ranks: A&C (105 – 29.5% of all staff), followed by EMT4 (48 – 5.7%) and Student Paramedic (47- 7%), as shown on the chart below. (Last year the highest representation was A&C, followed by Student Paramedic then EMT4.)

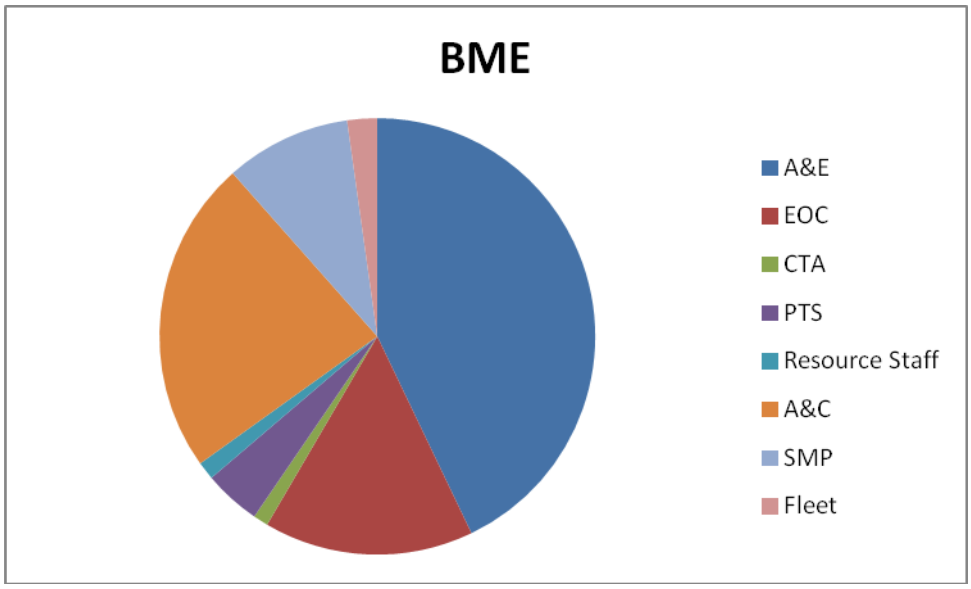
STAFF IN POST BY GRADE/RANK BY ETHNICITY



BME REPRESENTATION BY STAFF GROUP

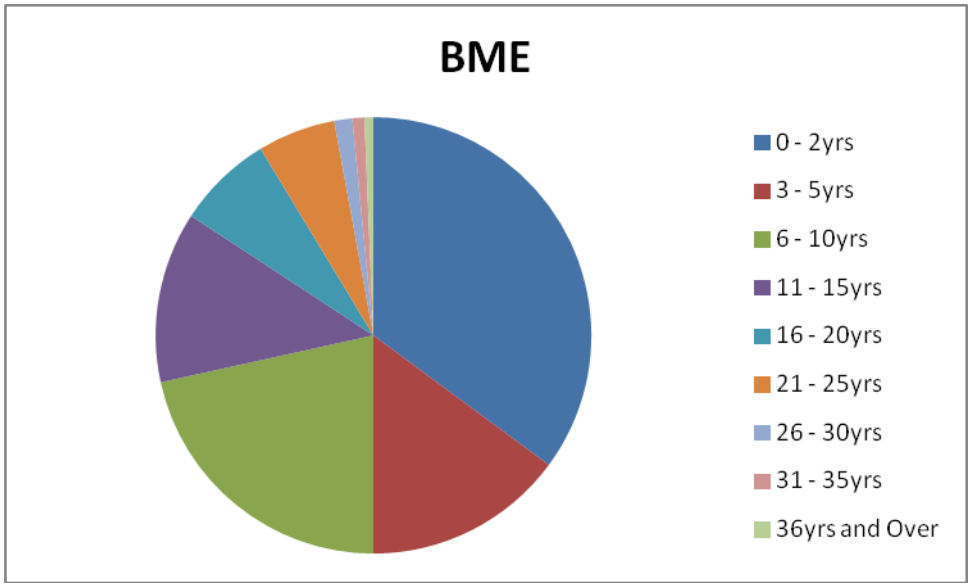
Overwhelmingly, A&E has the greatest representation of BME staff A&E (193 – 5.7% of all staff), followed by A&C (105 – 29.5%) and EOC (70 – 16.4%), as shown by the chart below. This was the same situation in 09/10.

Further work will need to be undertaken to ensure that the other service areas within the Trust attract and retain BME staff, wherever possible, in a t time of cuts, as the representation of BME staff across the service still falls far short of the Census 2001 estimate of 28.8% and seems very much concentrated in a small number of occupational groups.



LENGTH OF SERVICE OF BME STAFF

In the year 2010-2011 the highest number of BME staff (158 – 10.5% of all staff) had length of service between 0 and 2 years, (97 – 8.6%) between 6 and 10 years and 67 (9.1%) between 3 and 5 years, as indicated by the chart below. This is the same trend seen in the previous year and mirrors the profile of all staff in this last year.

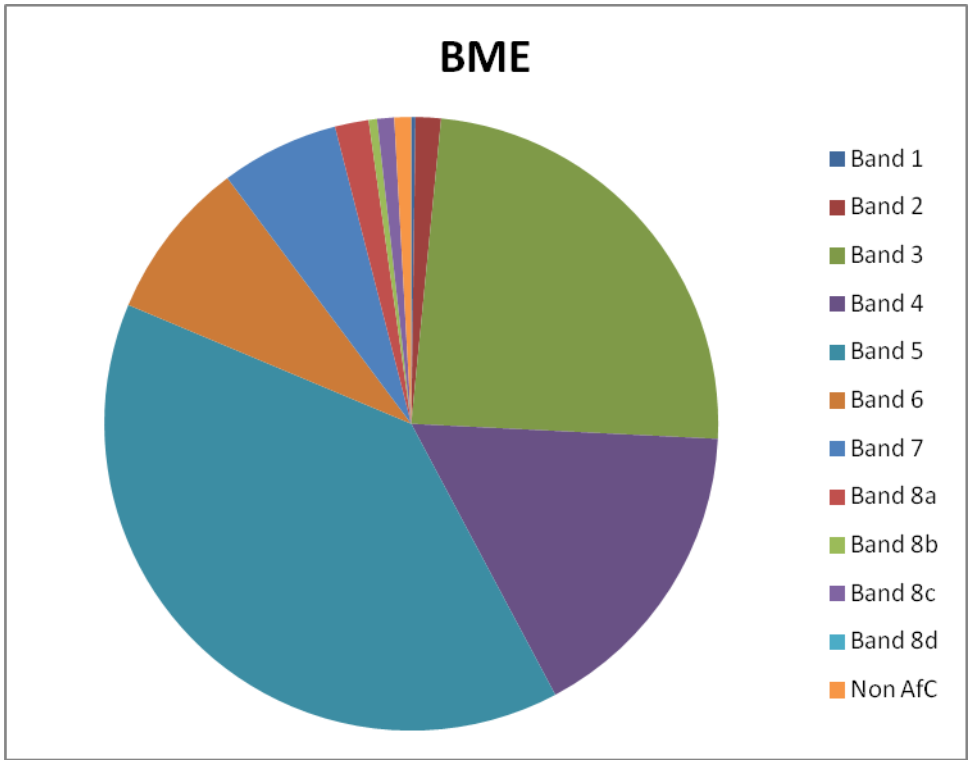


REPRESENTATION BY PAY BANDS

The Healthcare Commission's "Tackling the challenge – Promoting race equality in the NHS in England" report (March 2009) estimated that BME staff represented 16% of the total workforce, with fewer than 10% of senior managers being BME staff. In 09-10 there were 14% BME staff graded at Senior Management grades (Band 7 +) in the Trust, almost on a par with the NHS-wide representation.

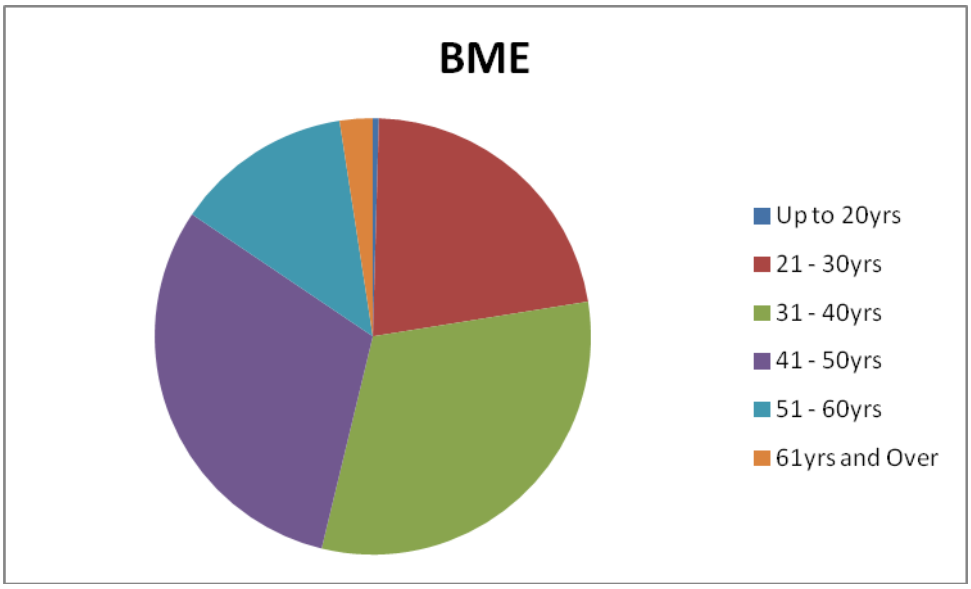
In 2010-11, as indicated by the chart below, the highest number of BME staff were at Band 5 (176 - 6.3% of all staff), followed by Band 3 (109 – 14.5%), then Band 4 (74 -14.7%). This mirrors the profile of all staff in the Trust. 10.2% of BME staff were at senior management grade; this is higher than the percentage of all staff at senior management grade (9.9%) and the representation within the Trust of BME staff (9%), although a decrease on the previous year; the total number of BME staff at senior management grade was 46, comprising 9.5% of all staff at that grade.
. However, there are a number of specific developments underway (including Talent Management & Mentoring) highlighted in the Training section of this report aimed at promoting career development for under-represented groups, which should assist with ensuring that the Trust can grow and retain its own talent, including staff from black and ethnic minority backgrounds. A new BME Staff Forum is planned, which will also assist the Trust with identifying new forms of support and development for our BME staff.

BME STAFF BY PAY BAND



STAFF AGE RANGE BY ETHNICITY

The majority of BME staff were in the age ranges 31 – 40 (9% of all staff), 41 – 50 (138 – 9.7% of all staff) and 21 – 30 (8.7%).



STARTER PROFILE

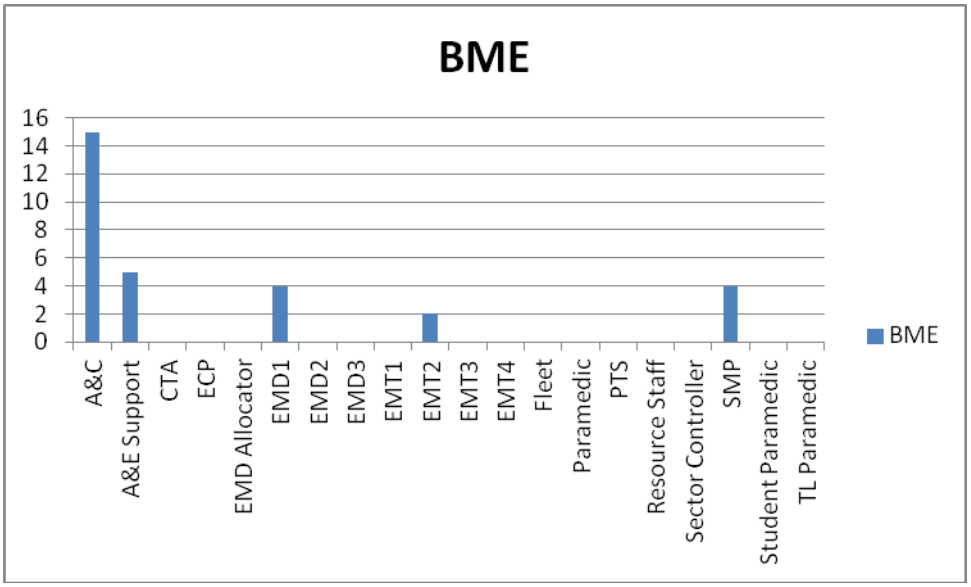
A review of the recruitment figures for the last quarter in 2011 demonstrated that the Trust is still attracting just over a third of applicants (35 %) from BME backgrounds which is close to the figure for the year before (39%). It is encouraging that the Trust continues to attract applicants for a wide range of roles from across varied ethnic backgrounds. However, it would appear that candidates from BME backgrounds are more likely to fail during the recruitment process, with only 1 out of 28 Indian applicants being appointed; applicants from BME backgrounds appearing more likely to fail the short listing stage than any other stage of the recruitment process.

It would also appear that certain ethnic groups are less likely to apply to the Trust for employment, for example, consistently over 2010-11, the lowest number of applications was from Chinese applicants. In contrast, the highest number of applications was from people from either African or Indian backgrounds.

In the year 2010-11 a total of 30 BME staff started with the Trust.

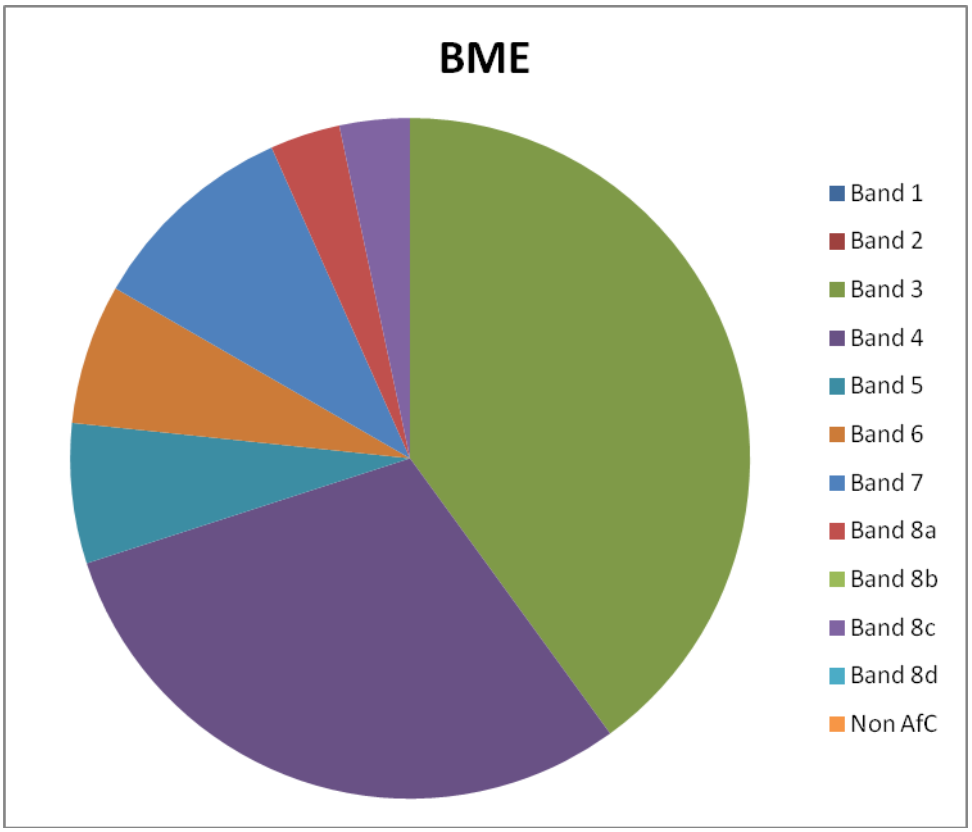
The majority of black and ethnic minority people starting with LAS started as A&C(15), followed by A&E Support (5), then EMD1 and SMP jointly (4) , as indicated by the chart below:

BME STARTERS BY GRADE/RANK



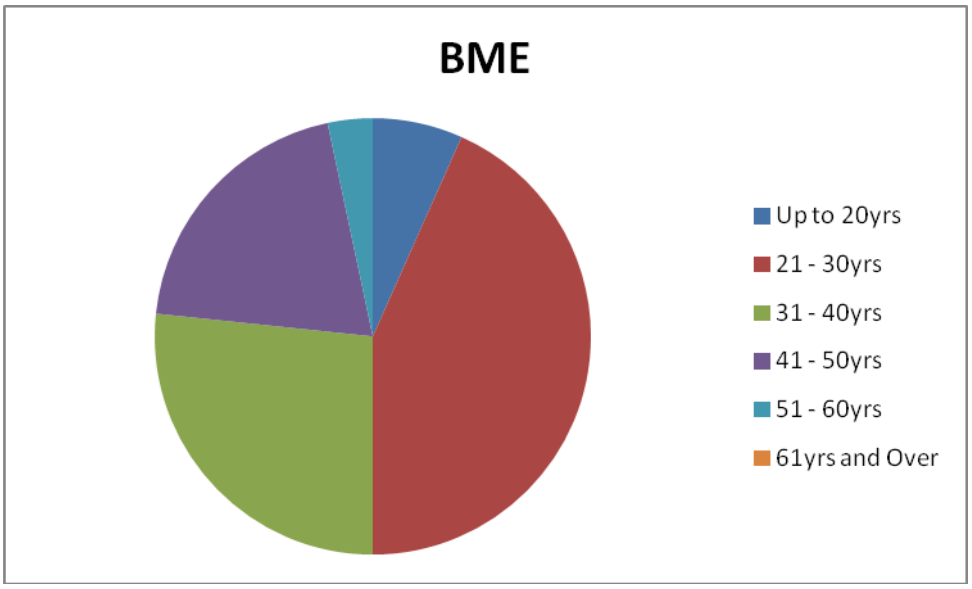
BME STARTERS BY PAY BAND

The majority of BME starters in 10-11 started on Band 3(12), followed by Band 4 (9), then Band 7(3).



BME STARTERS BY AGE

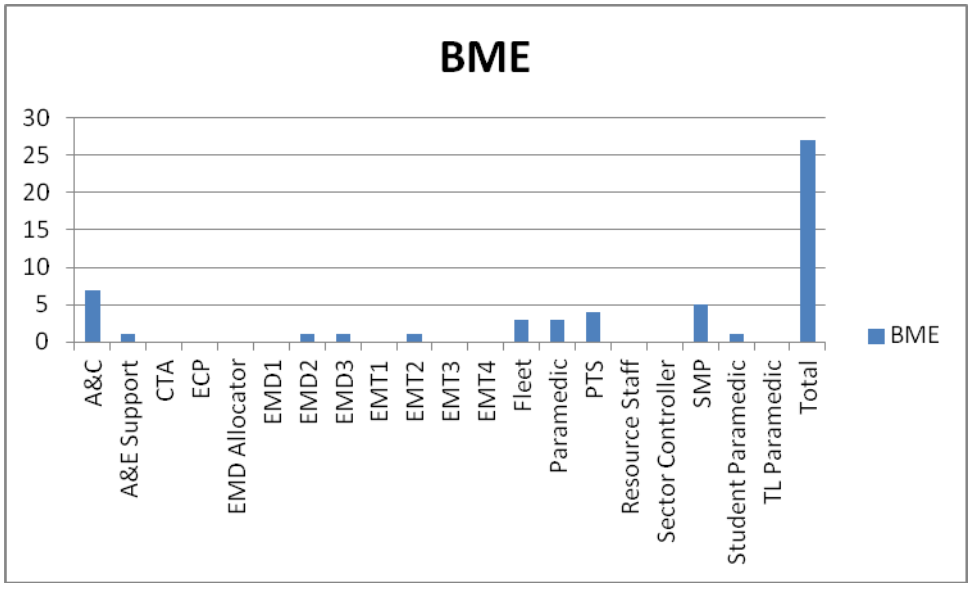
The most prevalent age range for BME Starters was 21-30 (13), followed by 31-40 (8) and 41-50 (6).



LEAVER PROFILE

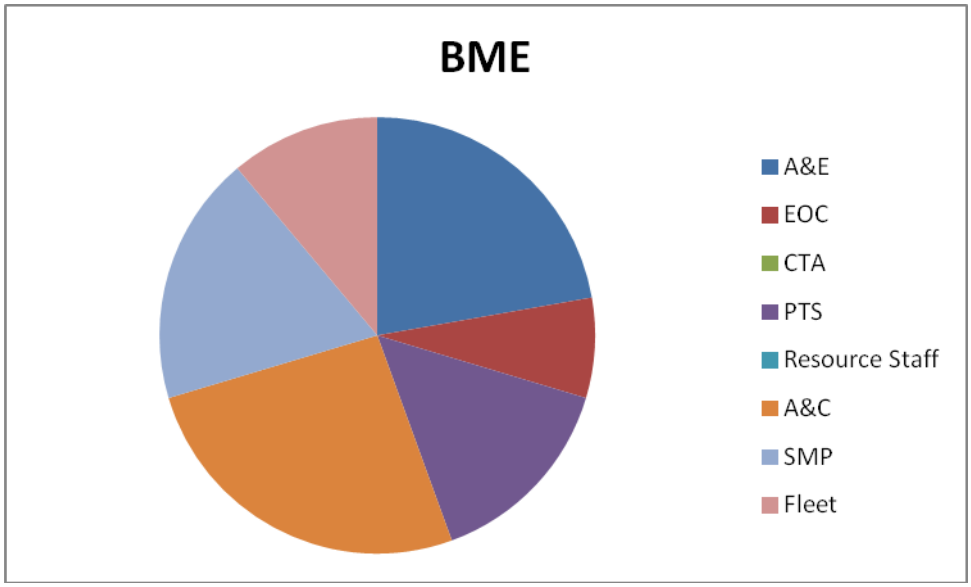
In the year 2010-11 a total of 27 BME staff left the Trust. As the chart below shows, the majority of BME staff leaving had been employed as A&C (7), followed by SMP (5) and PTS (4).

BME LEAVERS BY GRADE AND RANK



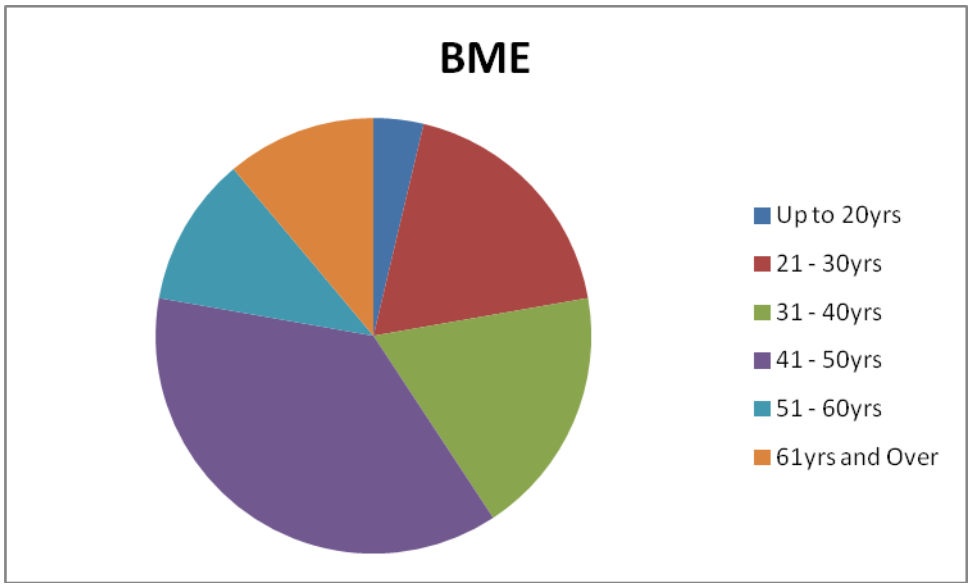
As the chart below shows, the majority of BME leavers were in the staff groups A&C, A&E, and SMP.

BME LEAVERS BY STAFF GROUP



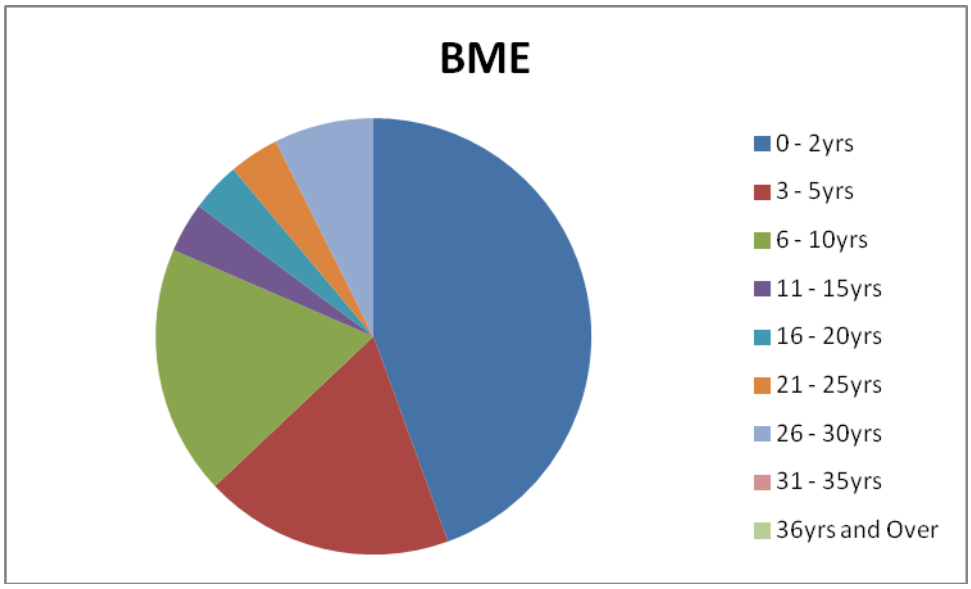
BME LEAVERS BY AGE

In 2010-11 the majority of BME leavers were in the age bands 41-50 (10), followed by 31-40 and 21-30 equally (5).



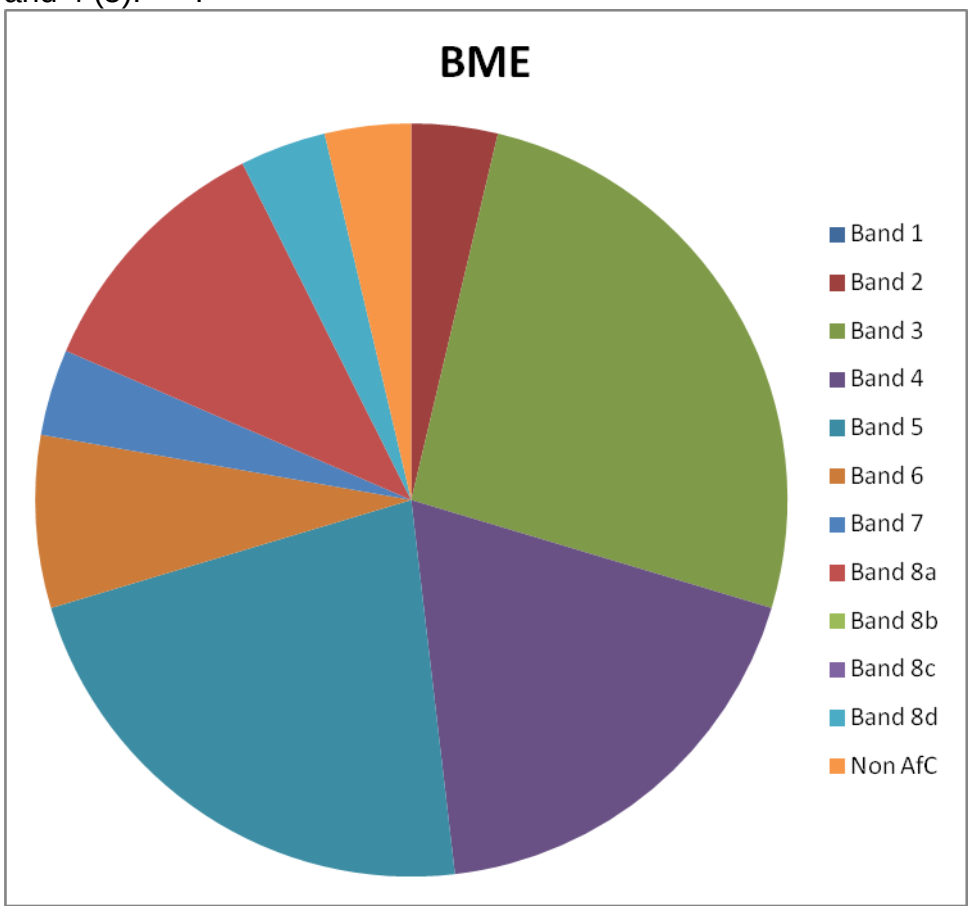
BME LEAVERS BY LENGTH OF SERVICE

In 2010-11 the majority of BME leavers, had a length of service of between 0 to 2 years (12), followed by 3-5 and 6-10 years equally (5).



BME LEAVERS BY PAY BAND

In 2010-11 the majority of BME staff were at Band 3 (7), followed by Band 5 (6) and 4 (5). .



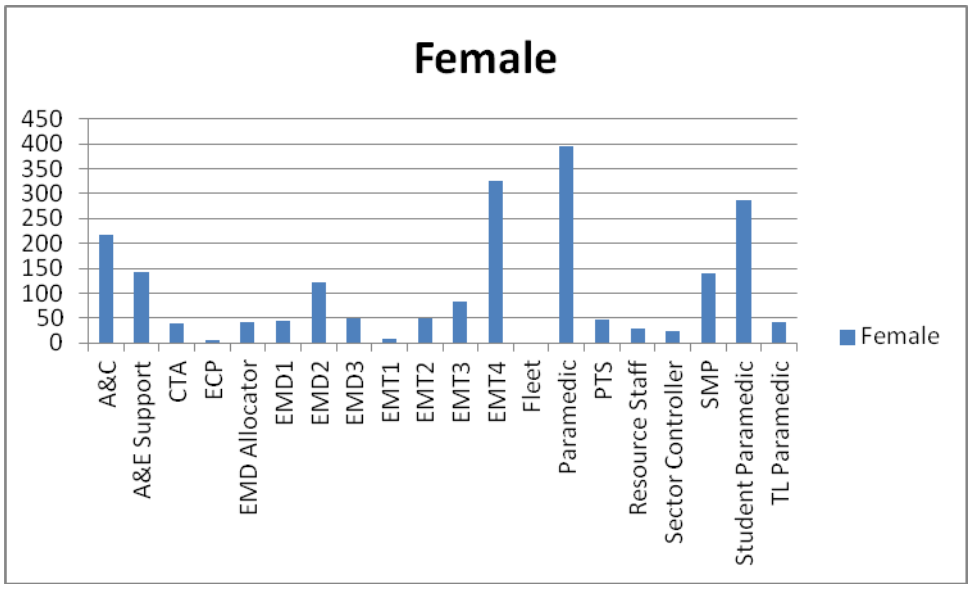
BME LEAVERS BY REASON
In 2010-11 the majority of BME staff leaving went by voluntary resignation (16 out of 27), similar to the previous year, followed by Retirement on the grounds of age (2), fixed term contract (2) and Dismissal Other Reasons (2).

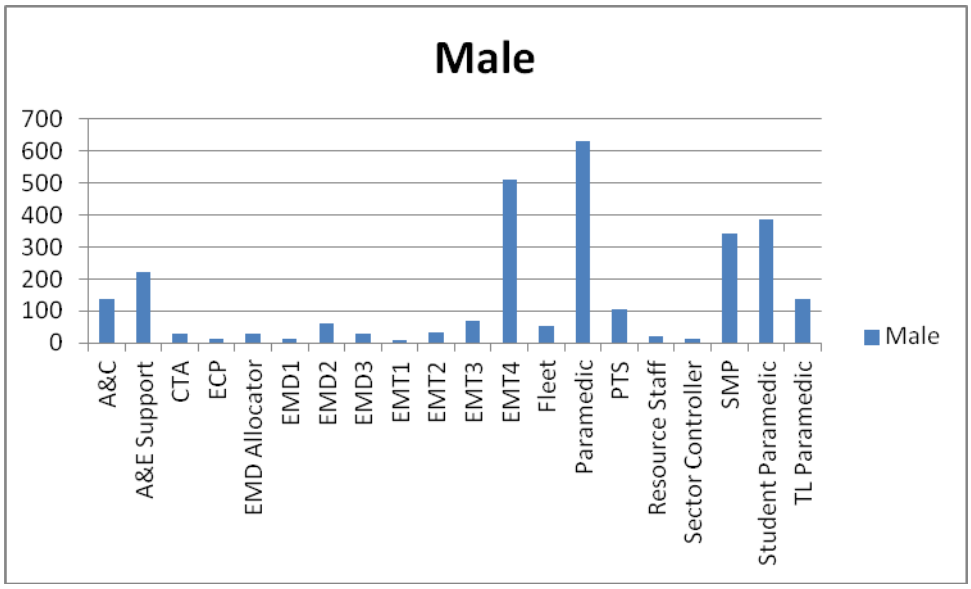
PROMOTIONS
9.9% were for Black and Ethnic Minority staff, which is marginally over the representation of Black and Ethnic minority staff in the Trust and an increase on last year's percentage of 6.33%.

5.4. LAS PROFILE BY SEX
PROFILE BY SEX
From April 1 2010 to March 31 2011 the Trust's workforce comprised 42 % female and 58% male, almost the same as the workforce representation last year. Representation in the Trust is still some way below the Census 2001 estimate respectively of 51% women in the capital.

REPRESENTATION BY STAFF GRADE/RANK
In 2009-10 the highest representation by staff grade/rank of women was at Paramedic (15.4% of all staff), followed by Student Paramedic (14.3%) and EMT4 (14.1%). In the year 2010-11 most women staff were again Paramedics (326 - 38.4% of all staff at that grade) followed by EMT4 (326 – 38.9% of all staff at that grade) and Student Paramedics (288 – 42.7 of all staff at that grade), as shown in the chart below.

STAFF GRADE/RANK BY SEX





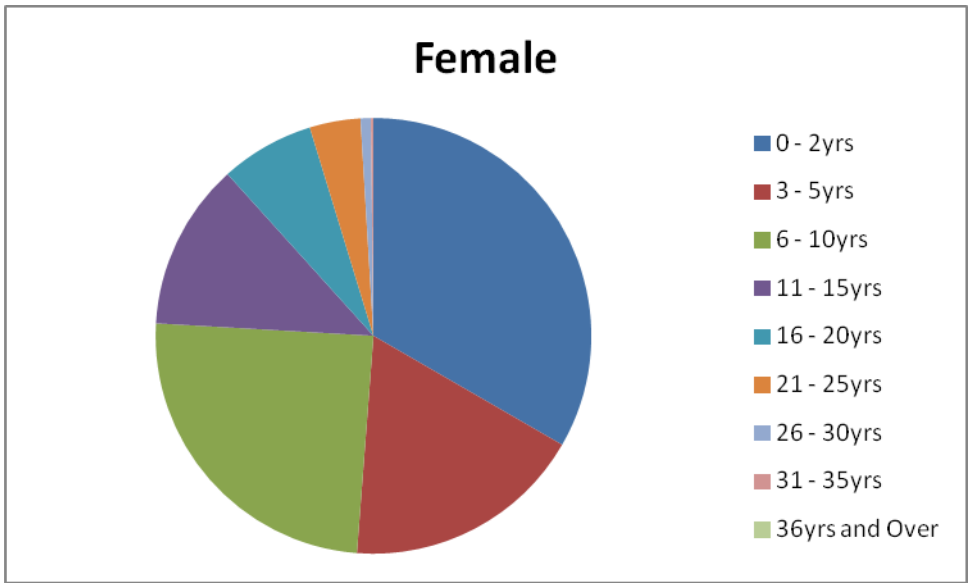
REPRESENTATION BY STAFF GROUP

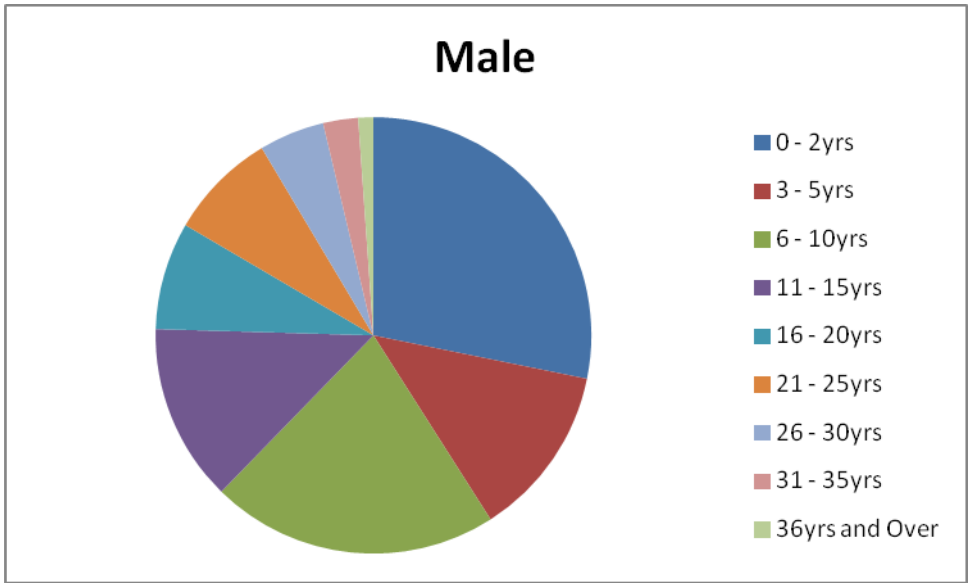
In 2009-10 the highest representation in the workforce by women was found to be overwhelmingly in A&E, followed by EOC and A&C, mirroring exactly the representation of men. In the year 10 -11 the staff groups in which there was the greatest representation of women were again A&E (1342 – 39.9% of all staff at that grade), followed by EOC (283 – 66.1%) and A&C (218 – 61.2%). Further action needs to be taken to improve recruitment of women in other parts of the service and in a wider range of occupations.

LENGTH OF SERVICE BY SEX

The chart below shows the length of service most prevalent for women staff in the Trust, with most women having between 0-2 years (699 – 46.5% of all staff), followed by between 6-10 years (518 - 46%) and 3-5 years (375 – 50.7%) (this was similar to male staff, with the exception that the third most prevalent length of service for them was between 11 and 15 years). This was exactly the same situation in 09- 10.

LENGTH OF SERVICE BY SEX



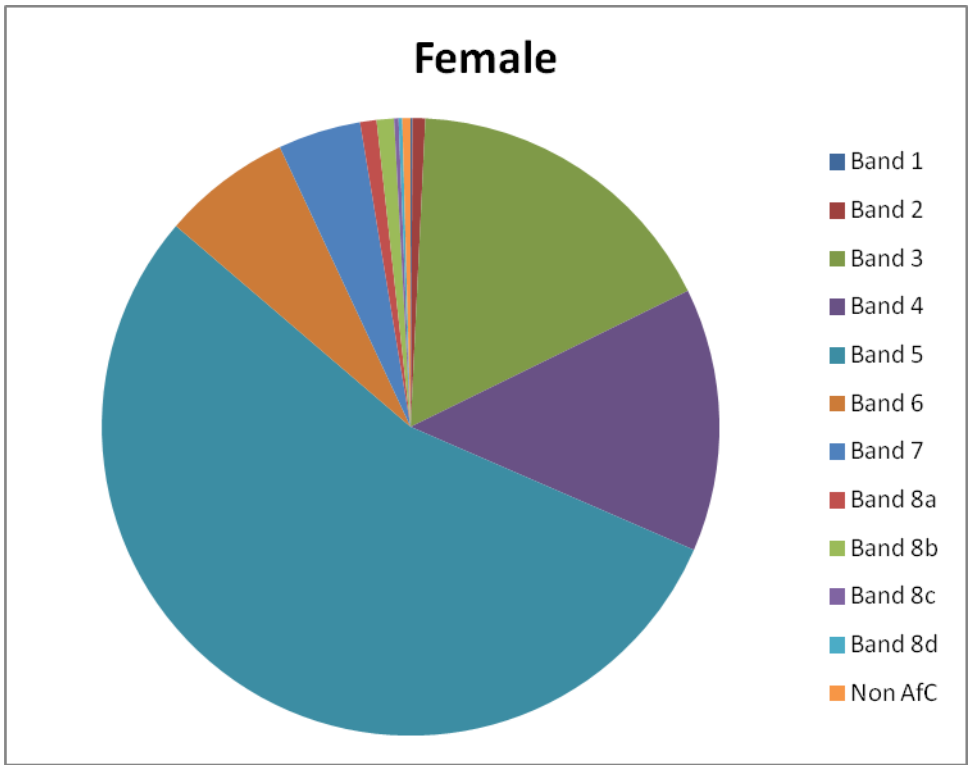


PAY BANDS BY SEX

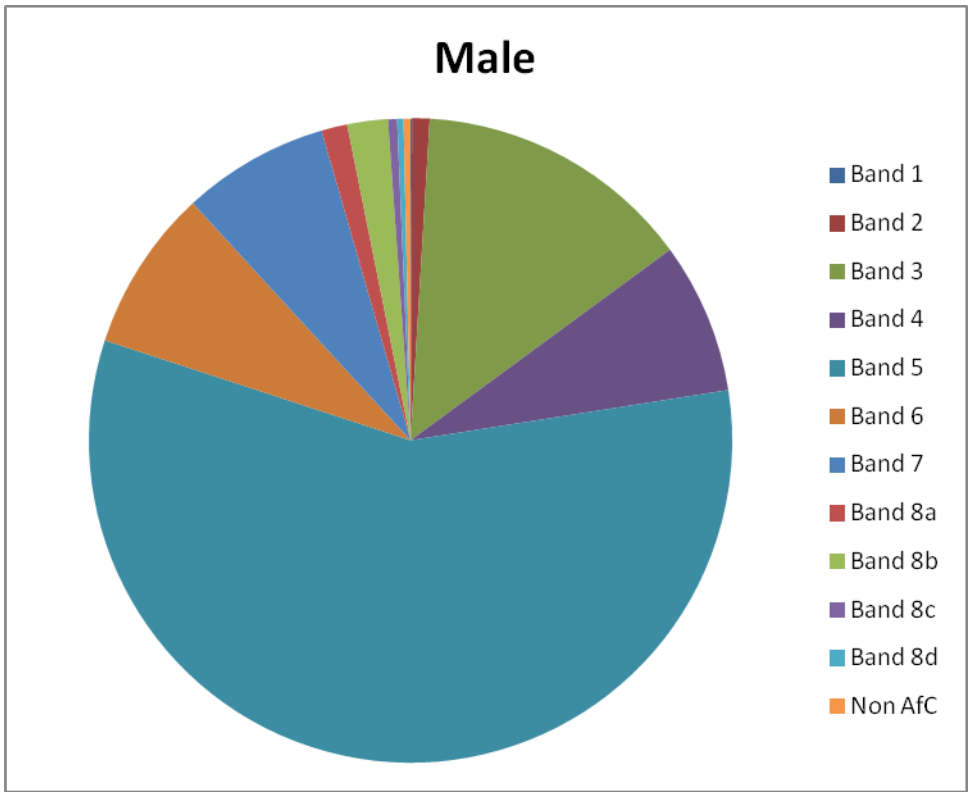
In the previous year 09-10 the overwhelming majority of women staff were paid at Band 5 (50.6%), followed by 17% at Band 4 and 15.9% at Band 3. Only 9.4% of women staff were at Band 7 plus. In the year 10-11, as the chart below illustrates, the overwhelming majority of women in the service were paid at Band 5 level (1148 – 41.2 of all staff at that grade%), followed by Band 3 (356 – 47.2%) and Band 4 (289 – 57.2), with only 6.9% of women being paid at senior grade level, which is less than the equivalent for BME staff and for male staff (11.9%); however, the total number of women at senior management grade comprised 146 out of a total of 483 staff (30.2%). The most prevalent pay bands for male staff in the Trust were similar: 57.5% of men were paid at Band 5, followed by 14.0 at Band 3, with the third most prevalent pay band being slightly higher than women – at Band 6 (8.1%).

Given that women make up 42% of the current LAS workforce, more work needs to be done to encourage women to apply for senior manager positions. Again, as with the under-representation of BME staff, specific targeted action is required to address this, which in a time of financial austerity will need to include some of the training initiatives referred to later in this report.

WOMEN STAFF BY PAY BAND



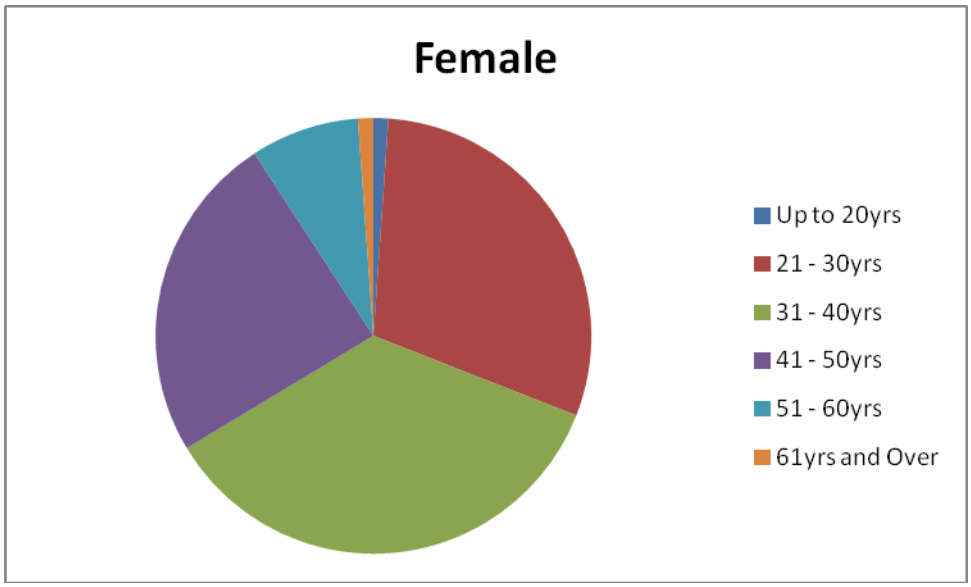
MALE STAFF BY PAY BAND

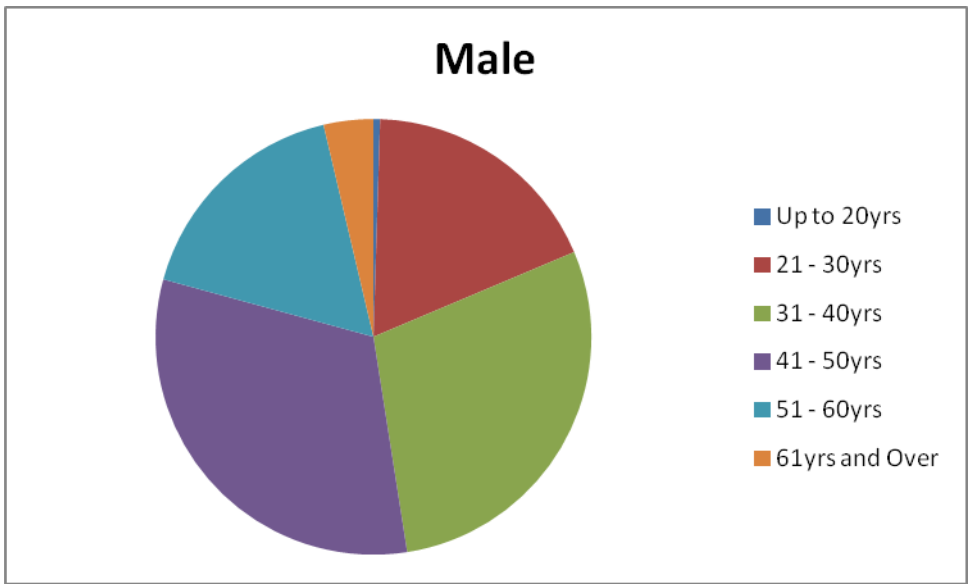


STAFF AGE RANGE BY SEX

The majority of women were in the age ranges 31 – 40 (743 – 47.4%), followed by 21 – 30 (626 – 54.8%), then 41 – 50 (512 – 36.2%), with men mostly in the

age ranges 41 – 50 (904 – 63.8% of all staff), 31 – 40 (823 – 52.6%), then 21 – 30 (517 – 45.2%).



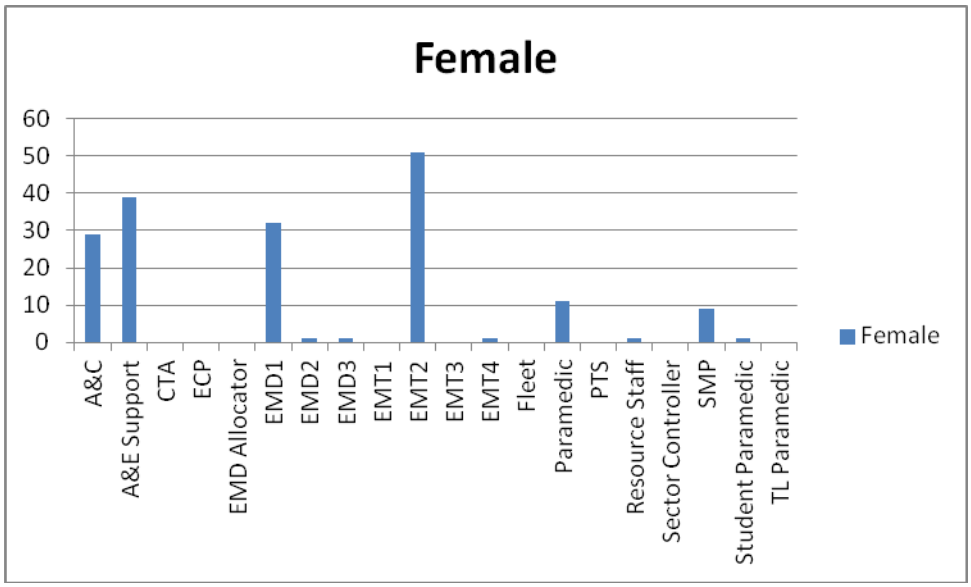


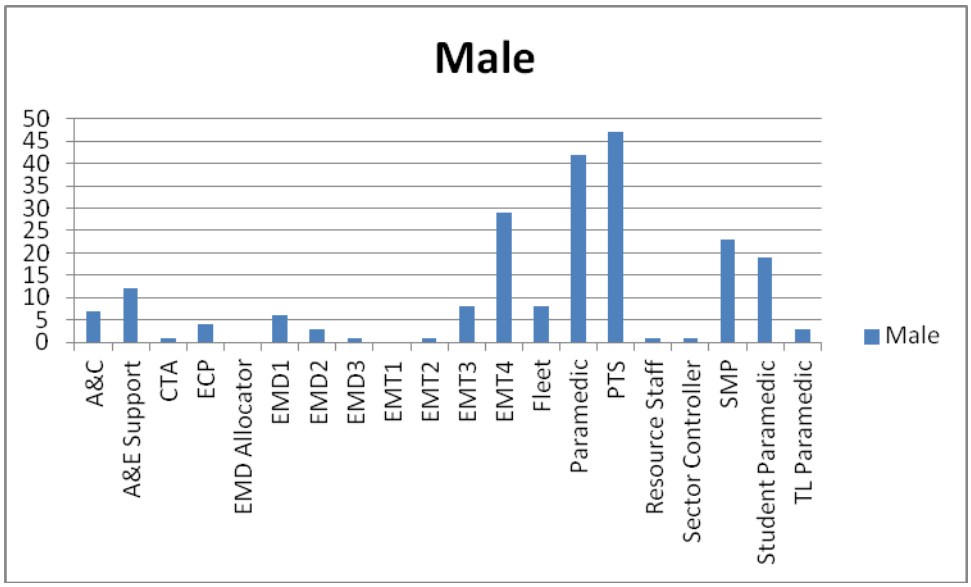
STARTER PROFILE

In 2010-11 47.1% of all applicants were women, 52% men (the remainder not stated); of all new starters to the Trust 176 were women and 149 men.

The percentage of women applying to the Trust was 47.1% and men 52% with the remaining unstated. As the charts below show, in 2010-11 the majority of women started as EMT2 (51), followed by A&E Support (39) and EMD1(32), with the majority of men starting as A&E Support (54), followed by EMT2 (34) and EMD1 (17).

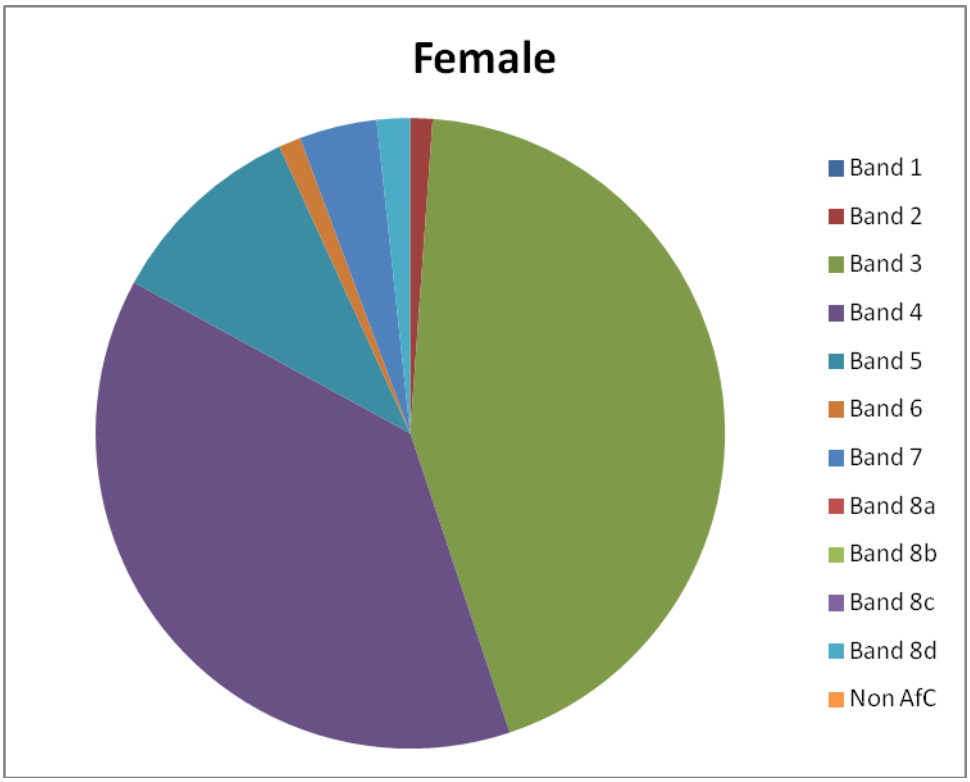
STARTER GRADE/RANK PROFILE BY SEX



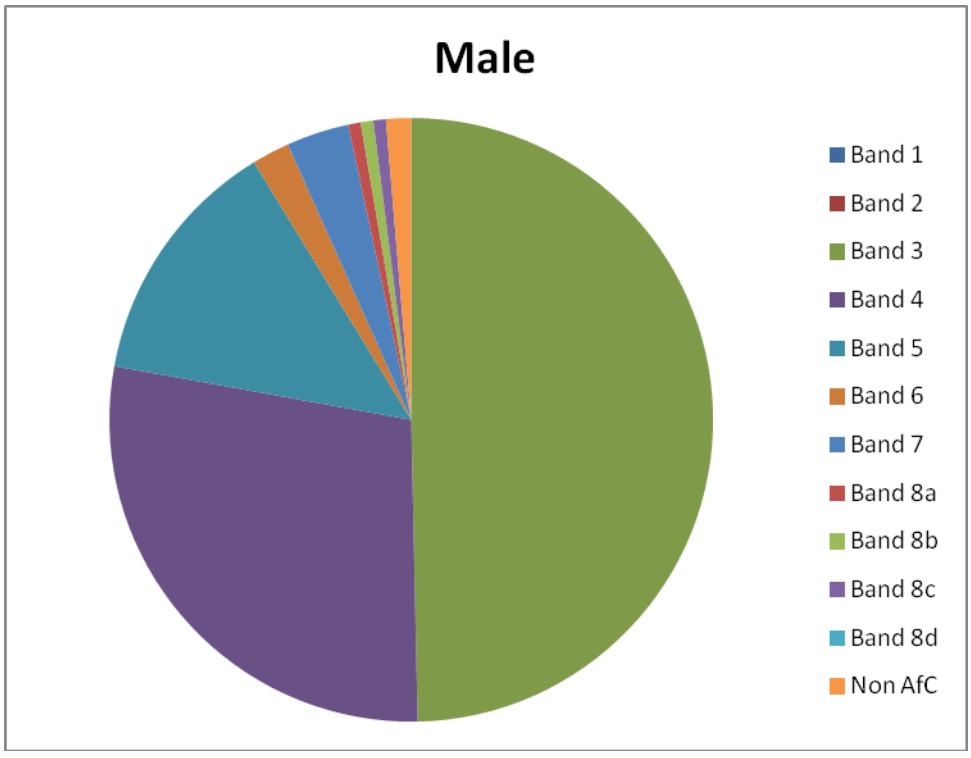


STARTERS BY PAY BAND BY SEX

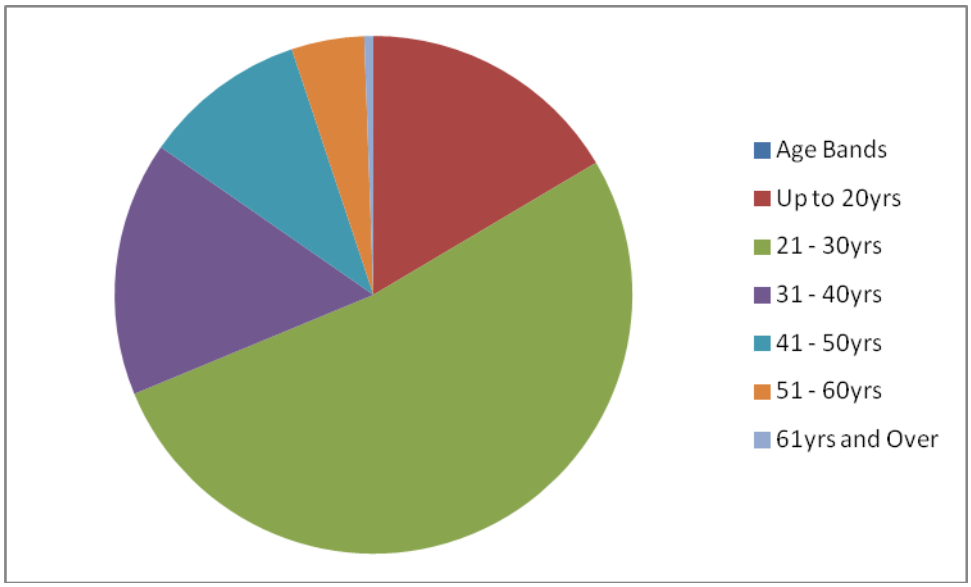
In terms of pay banding, the majority of women started in Band 3 (77) and Band 4 (67), followed by Band 5 (18), with 10 women starting in Senior Management positions. Men started predominantly in Band 3 (74), followed by Band 4 (42), then Band 5 (20), with the same number as women in Senior Management positions.


Female
Band 1
Band 2
Band 3
Band 4
Band 5
Band 6
Band 7
Band 8a
Band 8b
Band 8c
Band 8d
Non AfC

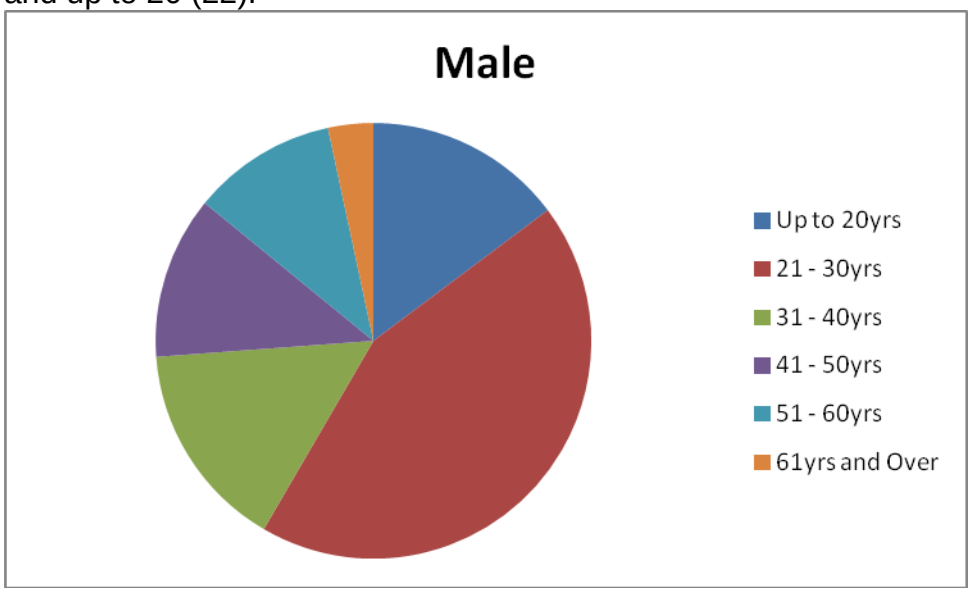
``


Male
Band 1
Band 2
Band 3
Band 4
Band 5
Band 6
Band 7
Band 8a
Band 8b
Band 8c
Band 8d
Non AfC

WOMENSTARTERS BY AGE RANGE
The most prevalent age ranges for women were 21-30 (92), followed by up to 20 (29) and 31-40 (28).

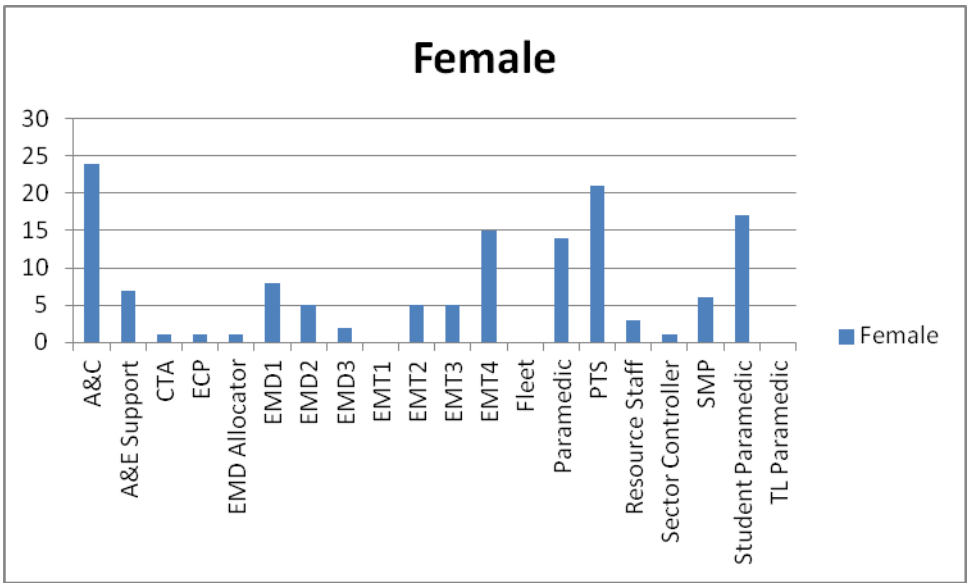


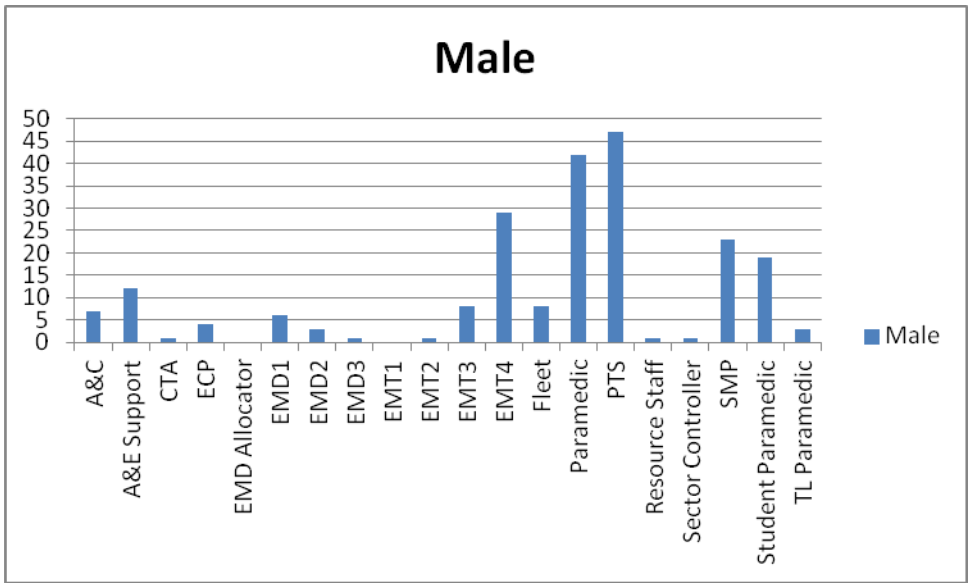
The most prevalent age ranges for men were 21-30 (65), followed by 31-40 (23) and up to 20 (22).



LEAVER PROFILE
In the year 2010-11 136 women and 216 men left the Trust. The majority of women leaving were from A&C (24), PTS (21) and Student Paramedics (17)., with the majority of men leaving from PTS (47), Fleet (42) and EMT4 (29).

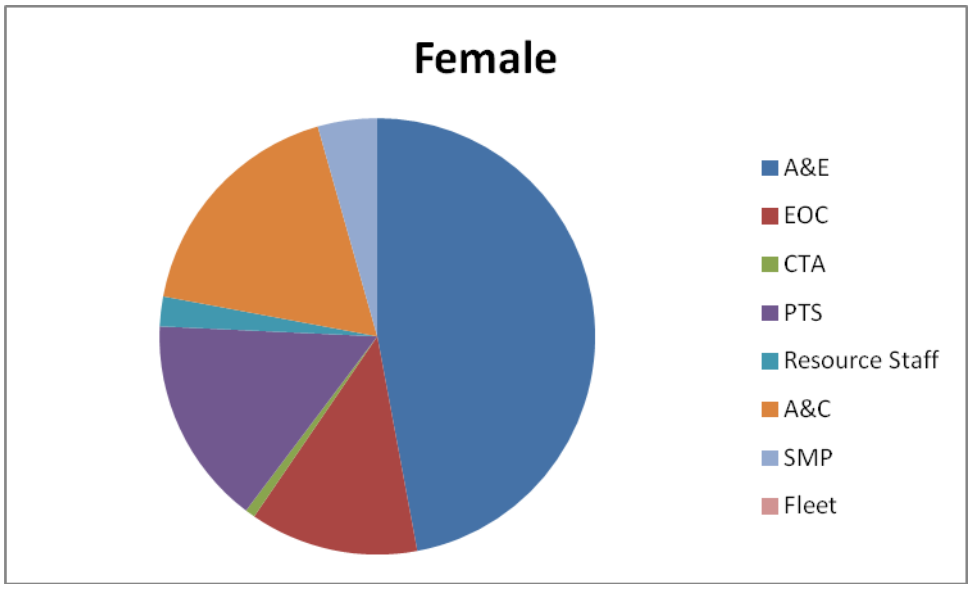
LEAVERS BY GRADE AND RANK BY SEX

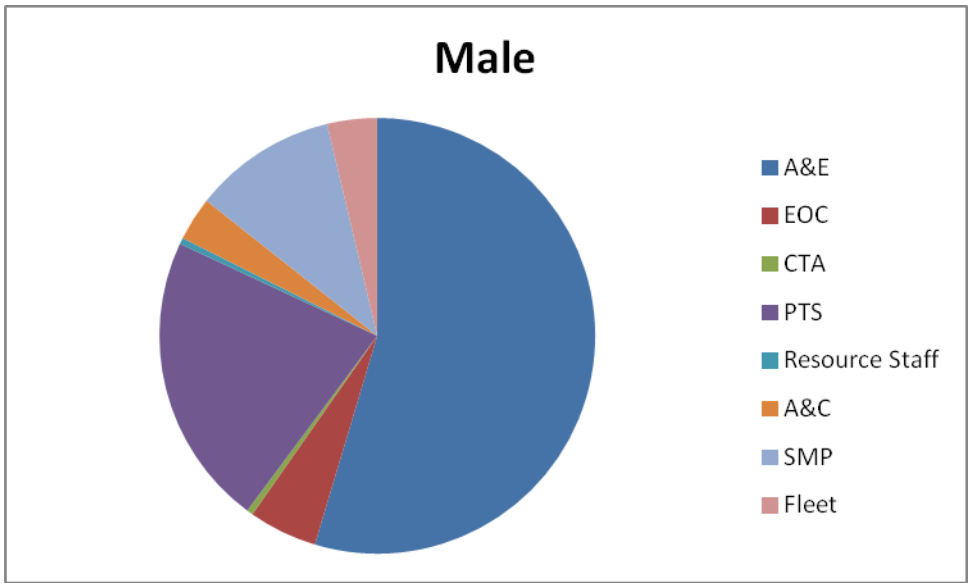




LEAVERS BY STAFF GROUP BY SEX

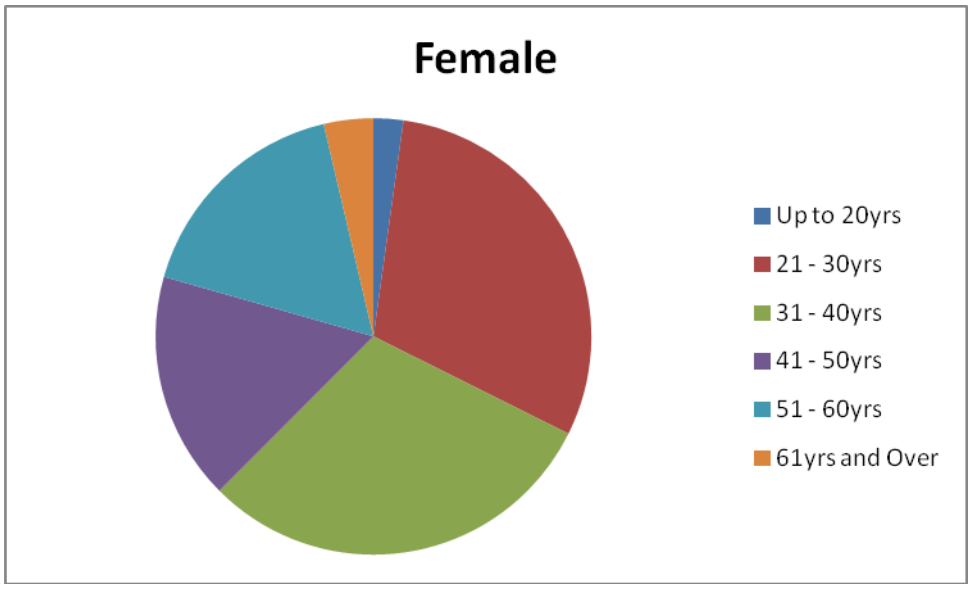
As the charts below show, the majority of women leaving were from A&E (64), followed by A&C (24) and PTS (21). The majority of men leaving were from A&E (118), followed by PTS (47) and SMP (23).



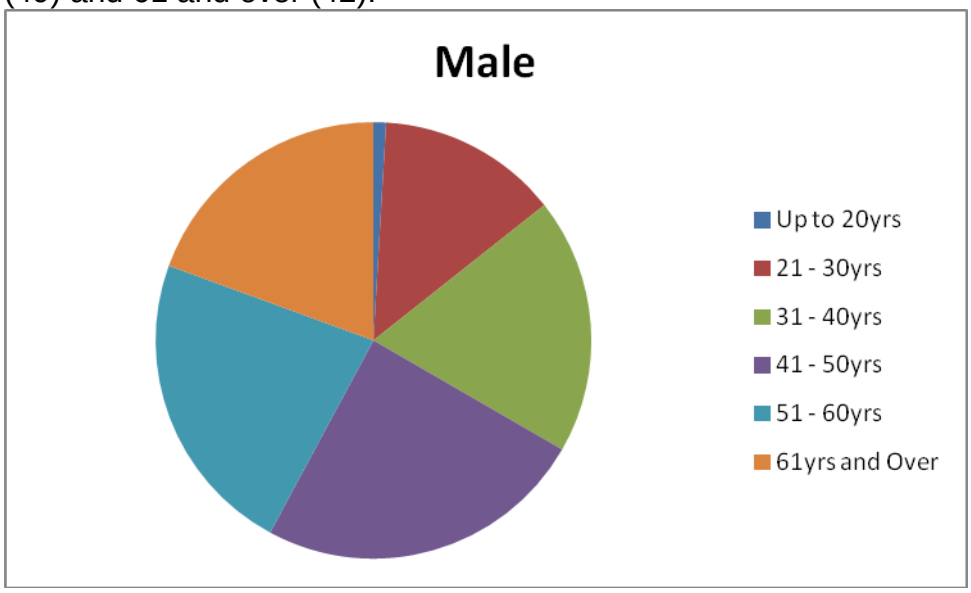


WOMEN AND MEN LEAVERS BY AGE BAND

The large majority of women leaving the Trust in 2010-11 were equally in the age bands 21-30 and 31-40 (41) followed by in equal measure 41-50 and 51-60 (23).

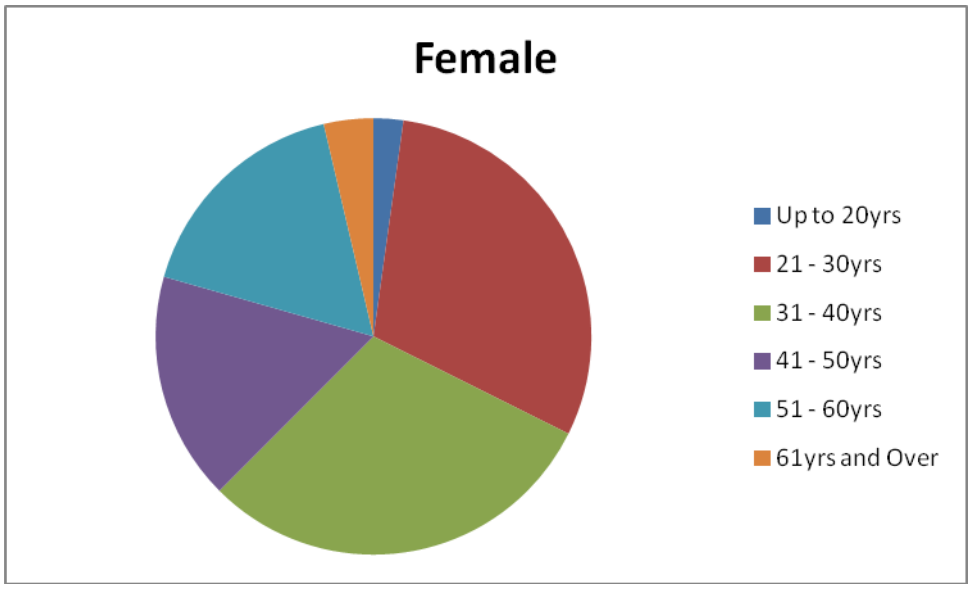


In contrast, the age profile of men leaving the Trust, as depicted below, shows that the majority leaving were in the age range 41 -50 (53), followed by 51-60 (49) and 61 and over (42).

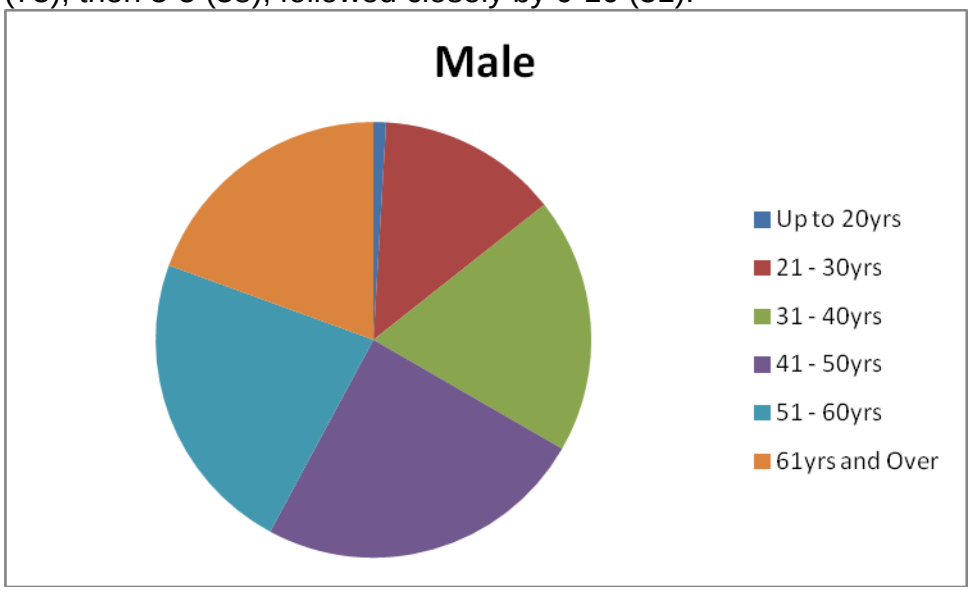


LEAVERS BY LENGTH OF SERVICE BY SEX

The majority of women leaving the Trust in 2010-11 had 0-2 years of service (60), then 6-10 (25), followed closely by 3-5 (24).

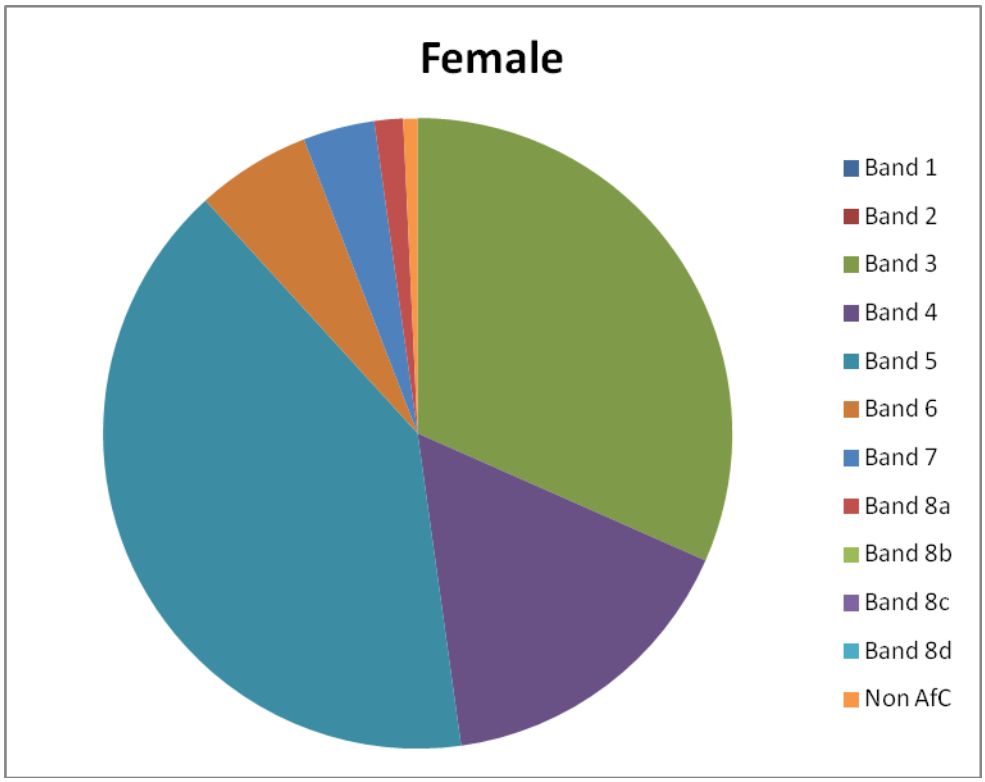


This compared to a length of service profile of men of predominantly 0-2, too (73), then 3-5 (38), followed closely by 6-10 (31).

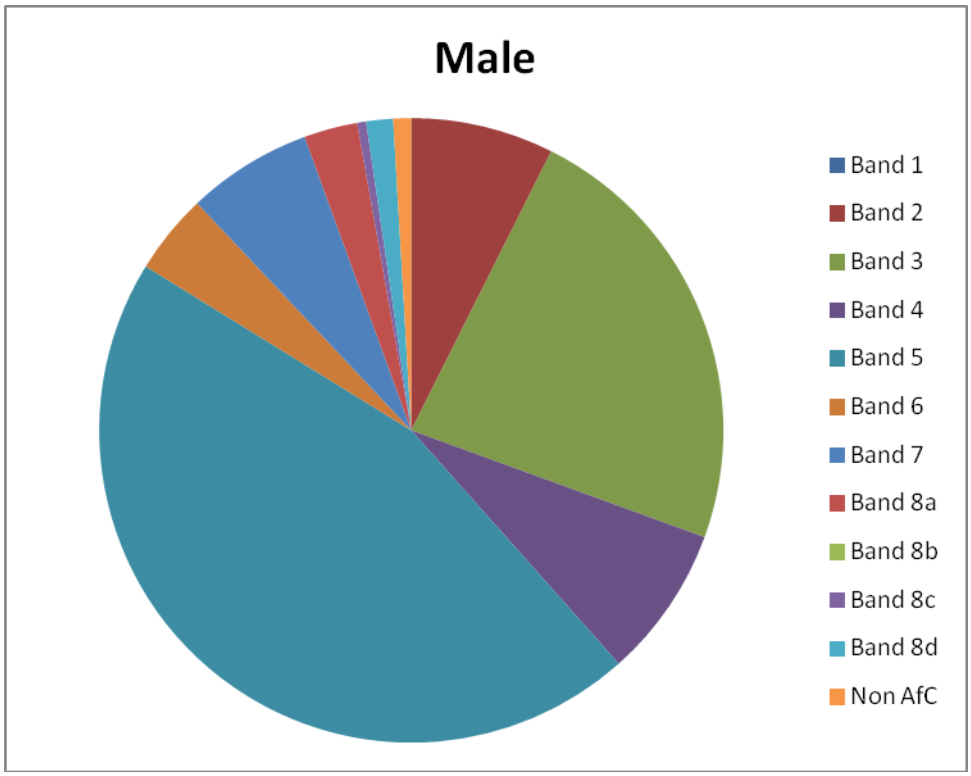


LEAVERS BY PAY BAND BY SEX

In 2010-11 the majority of women leaving the Trust were at Band 5 (55), followed by Band 3 (43), then Band 4 (22).



The majority of men were at Band 5 (98), followed by Band 3 (50), then Band 4 (17).



LEAVERS BY SEX – REASONS FOR LEAVING

In 2010-11 the majority of women (96 out of 136) left on voluntary resignation, followed by Inter Trust Transfer (28) and Retirement on the grounds of age (37).

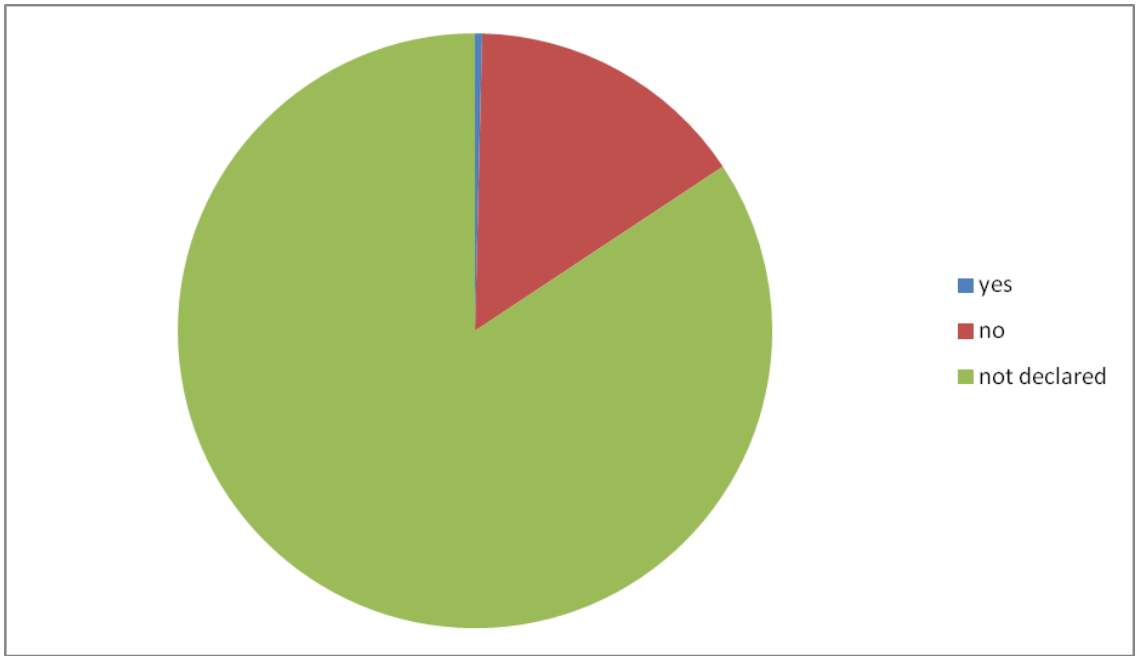
Most male staff retiring (102 out of 216) also went on voluntary resignation, followed by retirement on the grounds of age (37) then Inter Trust Transfer (28).

PROMOTIONS

Of all the promotions recorded for 2010-11 43% were for women, just above the representation of women in the workforce, 56.4% for men (0.6% unstated).

5.5. LAS PROFILE BY DISABILITY

As the chart below shows, the number of people declared that they were disabled was very low – 19 – with 757 stating that they were not disabled and 4169 not declaring either way. Due to issues related to the transfer of records across the Trust's legacy system to ESR, more comprehensive disability records were not available, which does not allow for any further breakdown of staff in terms of grade, length of service etc. This will be rectified through the Staff Data Refresh and in all future reporting from April 1 2012.



STARTER PROFILE

Only two people said that they were disabled; 130 said they were not and 193 did not declare. For the reasons highlighted earlier in this report, no further breakdown of disabled staff is available; this will be addressed through the Staff Data Refresh and through all future reporting from April 1 2012.

An analysis of applications received during this timescale from disabled people shows that for the whole of 2010-11, disabled applicants made up 4 % of all applications. This could be because applicants are not disclosing if they have a disability on the application form. Further work may be needed to engage with disabled communities in order to ensure that they are aware of our vacancies.

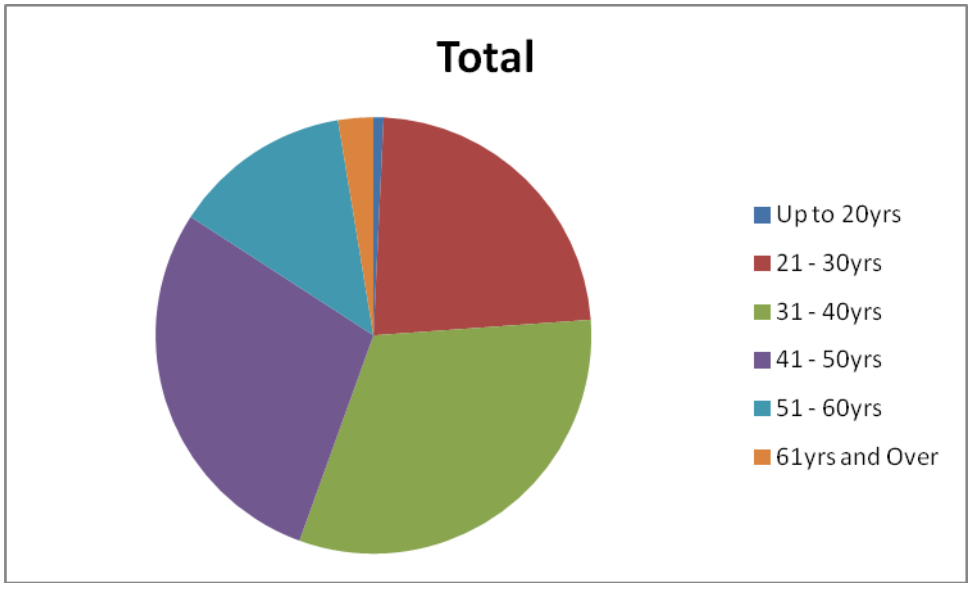
LEAVER PROFILE
Two leavers said they were disabled, 30 said they were not and 320 did not declare either way. For the reasons highlighted earlier in this report, no further breakdown of disabled staff is available; this will be addressed through the Staff Data Refresh and through all future reporting from April 1 2012.

PROMOTIONS
4.1% staff, who identified as disabled, were promoted; in the previous year no staff who were promoted had declared themselves to be disabled.

5.6.LAS PROFILE BY AGE
In the year 09-10 the majority of LAS staff were in the following age ranges: 31- 40, 41-50 and 21-30.

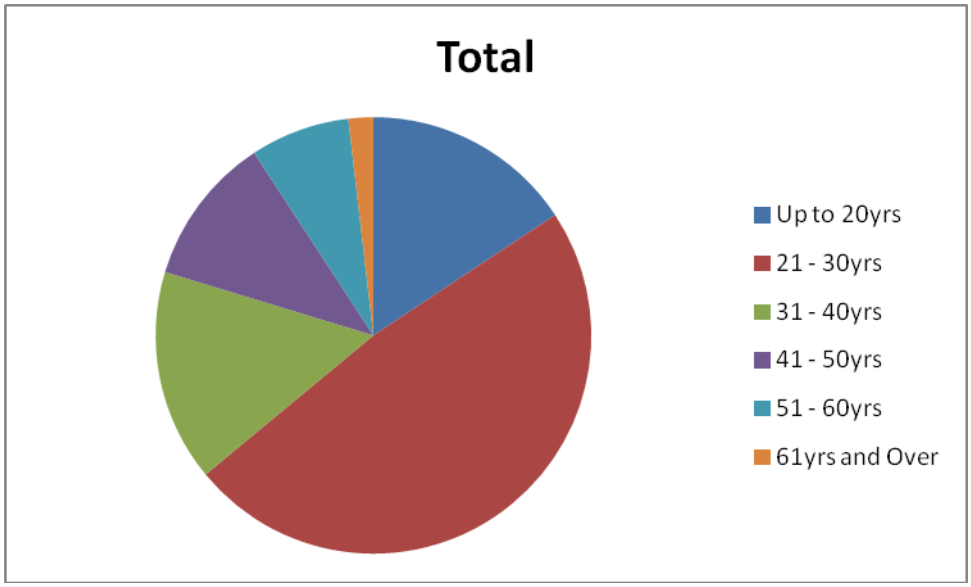
In 2010 – 11, as the charts below indicate, the majority of Trust staff were in the age ranges 31 – 40 (1566 – 31.7% of all staff), 41 – 50 (1416 – 28.6%), then 21 – 30 (1143 – 23.1%), the same profile as the previous year.

ALL STAFF BY AGE



STARTER PROFILE
The majority of new starters to LAS (325) were in the age ranges 21-30 (157), followed by the age ranges up to 20 and 31-40 equally (51).

ALL STARTERS BY AGE



LEAVER PROFILE

The most prevalent age range of those leaving was 31-40 (82), followed by 41-50 (76) then 51-60 (72),

PROMOTIONS

The age ranges in which most staff were promoted were 31-40 (28.5%), 21-30 (26.7%) and 41-50 (24.4%), which was similar to the previous year. The percentages for these age ranges are very close to each other, indicating that there appears to be equal opportunity for promotion, regardless of age range

5.7. EMPLOYEE RELATIONS ACTIVITY

Recording of employee relations activity has continued to improve and this will account for a proportion of the increase in activity. The incidences of gaps in completeness of information have fallen since the last report.

In total, records show that the Disciplinary procedure was instituted 64 times; Grievance 15 times; and Managing Attendance 613 times. The figure for Managing Attendance includes people for whom capability in terms of their health was the key issue.

Two cases were initiated during the period under the Capability Performance procedure.

The Disciplinary Procedure was instituted with a total of 64 staff, 34 men (53.1%) and 30 women (46.9%). Eight people (12.5%) were BME staff. One member of staff (1.6%) was in the age band 20 or under; eight (12.5%) in band 21-30; 25 (39.1%) in band 31-40; 19 (29.7%) in band 41-50; ten (15.6%) in band 51-60; and one (1.6%) over 60 years.

The Disciplinary Procedure was not instituted with any member of staff who self-identified as a disabled person.

In no instance did disciplinary allegations relate to bullying and/or harassment.

18 women (42.9 of a total of 42) and six BME staff (14.3%) received warnings or were dismissed as a result of the Disciplinary proceedings. One member of staff was in the age band 20 or under; four in band 21-30; 18 in age band 31-40; 14 in band 41-50; four in band 51-60; and one over 60 years.

The Grievance Procedure was instituted by a total of 34 staff, 13 women and 21 men, of whom three (8.8%) were BME staff. No member of staff self-identified as a disabled person.

Two members of staff were in age band 21-30; 12 were in age in band 31-40; eight in band 41-50; eight in band 51-60; and four over 60 years.

Ten grievances were related to bullying and/or harassment. Of this ten, seven were submitted by a single group of staff and were also related to TUPE issues

Of the grievances submitted, one was upheld. This was submitted by a white male in the age band 51-60. Six were upheld in part; all of these were submitted by men; one of these was submitted by a BME member of staff. Six cases were resolved through discussion; and one was withdrawn. 20 grievances were not upheld. Seven of these related to TUPE issues; two were submitted by BME members of staff and ten by women; one member of staff was in the age band 21-30;five in band 31-40; five in band 41-50; five in band 51-60 and four over 60 years.

The Managing Attendance Procedure (MAP) was formally instituted (i.e. the member of staff was issued with a warning or dismissed) with 613 members of staff in total; 274 (44.7%) women; 339 (55.3%) men; 16 (6.9%) BME staff.

Five members of staff (0.8%) either self-identified as a disabled person or were declared by the Occupational Health department to be treated as protected by legislation.

One member of staff (0.2%) was in age band 20 or under; 112 (18.3%) in band 21-30; 195 (31.8%) in band 31-40; 203 (33.1%) in band 41-50; 92 (15%) in band 51-50; ten (1.6%) were over 60.

The Capability Performance Procedure was instituted with two members of staff; one female; one in the age band 41-50; and one in band 51-60.

In the year 2010-11 there were a total of 20 claims lodged in the Employment Tribunal, eight of which were by women. One member of staff was in age band 21-30; 12 in band 31-40; three in band 41-50; and three in band 51-60.

Four claims were made by BME members of staff.

One claim for discrimination on the grounds of race (and unfair dismissal) was lodged by a BME member of staff; this claim was withdrawn.

Three claims were made for discrimination on the grounds of disability. One case included a claim for age discrimination and unfair dismissal as well. Following medical reports showing the claimant had no case for disability discrimination, this claim was settled. One case was withdrawn and the other is yet to be heard.

One claim for sex discrimination has been lodged by a woman. This has yet to be heard.

Analysis

As noted above, record keeping and reporting of employee relations activity continued to improve. Although it is reasonable to assume that this improvement accounts for some part of the increase in recorded activity, it is also the case, and particularly true for attendance management, that there has been increased organisational focus in ensuring that such issues receive appropriate management attention. A comparison of the data (where data is available) year-on-year is made in the table below.

		07/08		**08/09**		**09/10**		**10/11**
	No	%	No.	%	No.	%	No.	%
Disciplinary Procedure			**36**		**51**		**64**	
Male			22	61.2	36	70.6	34	53.1
Female			14	38.8	15	29.4	30	46.9
BME		8.33	0	0	7	13.7	8	12.5
Disabled			0	0	0	0	0	0
Grievances			**17**		**16**		**34**	
Male			13	76.5	8	50.0	21	61.8
Female			4	23.5	8	50.0	13	38.2
BME		12.24	3	17.6	4	25.0	3	8.8
Disabled			1	5.9	1	6.3	0	0
Managing Attendance			**48**		**403**		**613**	
Male			26	54.2	233	57.8	339	55.3
Female			22	45.8	170	42.2	274	44.7
BME			11	22.9	16	4.0	16	2.6
Disabled			0	0	7	1.7	5	0.8
Capability Performance					**2**			
Male			0	0	0	0	1	50.0
Female			0	0	2	100.0	1	50.0
BME			0	0	1	50.0	0	0
Disabled			0	0	0	0	0	0
Age (all activity)					**472**		**713**	
20 or under				0	5	1.1	2	0.3
21 - 30				9.6	58	12.3	122	17.1

31 - 40				41.2	166	35.3	231	32.4
41 - 50				33.3	183	38.7	232	32.5
51 - 60				14	60	12.6	111	15.6
Over 60				2.6	0	0	15	2.1

In 2010/11 women represented 42% of our total workforce. The figures disciplinary action show a gender split broadly similar to the workforce as a whole. Activity figures under the MAP also reflected this gender split, as they have done for the two previous years.

9% of our workforce is from BME groups. The figures show that the number of BME staff who were the subject of a disciplinary investigation remained almost unchanged, but the increase in the total number of cases resulted in a slight fall in percentage terms. The number of BME staff who received a warning or were dismissed under the Managing Attendance Procedure in 2010/11 (2.6%) was disproportionately low for the second year running.
Activity under the Grievance policy in 2010/11 reflected broadly the composition of the workforce.

The figures show an increase from the last reported period of over 50% in the number of people being managed under the MAP. Although the numbers are small, the number of disabled people within this caseload fell by a similar amount from seven to five. In terms of age, as with gender, activity under the MAP reflected broadly the composition of the workforce.

The activity under the Capability Performance procedure remains too low to allow meaningful conclusions to be drawn.

5.8. RETURN TO WORK FOLLOWING MATERNITY LEAVE
In the year April 1 2010 to March 31 2011 143 women took maternity leave, with the overwhelming majority (133) returning to work with the Trust afterwards.

5.9.ACCESS TO FLEXIBLE WORKING
In the last annual Staff Survey, completed in October to December each year, questions were asked around access to flexible working.

In response to the question “I can approach my immediate manager to talk openly about flexible working”, to which 49.2% of all respondents agreed or strongly agreed that they can approach their immediate manager to talk openly about flexible working, the following protected characteristic groups responded in the affirmative:

- 30.1% of staff who identified as having a “long-standing illness, health problem or disability”(from 226 responses) agreed; 7.1% strongly agreed
- 42.1% of staff aged 21-30 agreed and 11.3% strongly agreed; 35.4% of staff aged 31-40 agreed and 15.3% strongly agreed; 34.2% of staff aged

41-50 agreed and 11.3% strongly agreed; 37.8% of staff aged 51-65 agreed and 10.9% strongly agreed (from 1674 responses)

- 38.4% of women agreed and 12.7% strongly agreed (661 responses) and35.8% of men agreed with 12.4% strongly agreeing (991 responses)
- 33% of Mixed White and Black Caribbean/Africans agreed and 8.3% strongly agreed (from 12 responses)
- 21.4% of Mixed White and Asians agreed (from 14 responses)
- 30.8% of Mixed/any other background agreed and 15.4% strongly agreed (13 responses)
- 48% of Asian British/Indian agreed and 4% strongly agreed (25 responses)
- 37.5% of Asian/British Pakistani/Bangladeshi/any other Asian agreed and 4.2% strongly agreed (24 responses)
- 33.33% of Black British Caribbean agreed and 4.8% strongly agreed (42 responses)
- 35.7% of Black British African/any other black backgrounds agreed and 14.3% strongly agreed (14 responses)
- 19% of Chinese/ any other background agreed (21 responses)
- 31.1% of White Irish agreed and 8.9% strongly agreed (from 45 responses)
- 27.2% of White British agreed and 8.2% strongly agreed (from 1335 responses)
- 27.1% of White Other agreed and 5.9% strongly agreed (from 85 responses)

In response to the question “In your job at this Trust do any of the flexible working options apply to you?” the following protected characteristic groups responded with “yes” in regard to working flexitime (able to vary start and finish times):

- 24.3% of staff who said they had a long-standing illness, health problem or disability (from a total of 1674 responses)
- 17.2% of staff aged between 21-30 (337 responses); 20.2% of staff aged between 31-40 (509 responses); 21.7% of staff aged between 41-50 (497 responses); 26.2% of staff aged 51-65 (294 responses)
- 24.4% of women (661 responses); 19.2% of men (991 responses)
- 60% of Asian/British – Indian (15 responses)
- 33.3% of Asian/British – Pakistani/Bangladeshi/any other Asian (8 responses)
- 40.5% of Black/British – Caribbean (17 responses)
- 35.7% of Black/British – African/any other background (5 responses)
- 14.3% of Chinese/any other ethnic background (3 responses)
- 41.7% of Mixed White and Black Caribbean/African (5 responses)
- 14.3% of Mixed – white and Asian (2 responses)
- 38.5% of Mixed – any other background (5 responses)
- 20% of White Irish (9 responses)
- 21.2% of White – any other background (18 responses)
- 19.4% of White – British (259 responses)

This is the first year this is being monitored. This question will be repeated in the next year's survey and any trends identified.

5.10.STAFF ENGAGEMENT

A new staff engagement strategy and action plan was ratified in July 2010, following a period of extensive research and consultation. This was supported by the introduction of the permanent role of HR Manager- Staff Engagement, recruited to in August 2010.

In line with the strategy, many activities have been aimed at increasing opportunities for staff to share their thoughts and ideas. December 2010 saw the completion of a project sponsored by NHS London, to conduct focus groups with staff regarding the implementation and improvement of appropriate care pathways. This had included training 14 members of staff in facilitation skills, including a number of staff side representatives. The project resulted in the presentation of 8 recommendations to the Senior Managers' Group, which it was agreed would be taken forward. From February 2011, a new team briefing system was piloted to encourage the sharing of key messages via face-to-face meetings, and to provide an opportunity to provide feedback to managers and senior managers in the Service.

As usual, staff were given the opportunity to complete the national NHS Staff Survey. The results were announced in March 2011 and analysed at department and complex level. Managers in each area committed to 3-5 things they would work to improve as a result of the feedback from the staff survey. Examples include commitments to improve access to computer facilities and e-learning opportunities, to improve communication between senior managers and their teams and to increase the amount of positive feedback offered to staff. These commitments were published on the Pulse.

5.11. LINC WORKER SERVICE

The management information collected on how the Trust's LINC Worker Service has been operating over 2010-11 shows that LINC, in general, is very reflective of the demographics of the LAS. However, there is a need for more male LINC Workers.

The following activities were run:

1. 4 LINC Forums (2 cancelled due to REAP pressures)

   Usually, a minimum of 6 Forums run per year. They aim to address current issues, and those that have been identified by the LINC Workers. Between 20 – 30 LINC Workers attend each Forum, held in the Conference room at Headquarters.

   Open Forum (LINC Workers could discuss any LINC related topic, raise concerns, share experience, network)
   Understanding Self Harming (A Senior LINC Worker spoke and held a Q&A session as an insight into this area)
   Understanding LAS work roles (About 10 speakers explained their

job roles within the Trust)
Bullying and Harassment (The LINC Manager and Senior LINC Worker led this Forum – the first to invite written feedback. The feedback was excellent – all attendees enjoyed the Forum and found it relevant, relaxed and informative).

Two forums are planned on:

A personal experience of being a gay man and working for the LAS / Living with Cancer.
Understanding Mental health
T

2. The LINC Manager has held 1-2-1's with most of the LINC Workers, and the Senior Counsellor with the Senior LINC Workers.
   These ensure that concerns and issues can be discussed and clarified – ensuring that the LINC Worker is complying with the LINC framework. It also is a time to check their own wellbeing.

3. LINC Workers continue to attend regular Clinical Supervision with external Counsellors. These afford time for the LINC Worker to talk through their LINC experiences, seek expert guidance and support. LINC Workers are required to attend 3 group meetings and 1 individual meeting per year.

4. Senior LINC Workers maintained an appropriate and supportive presence at **all** 7 / 7 inquest hearings, if a member of LAS staff was attending court, which was greatly appreciated.

5. Recruitment - in excess of 150 people requested application packs to become a LINC Worker. From this, 50 were shortlisted to attend an assessment centre. There were 29 successful candidates who went on to complete the 5 day (part residential) LINC Training Course. This bought the overall number of LINC Worker to more than a hundred, for the first time. There is an excellent geographical spread of LINC Workers across the LAS, which enables more choice and ease of access for all staff.

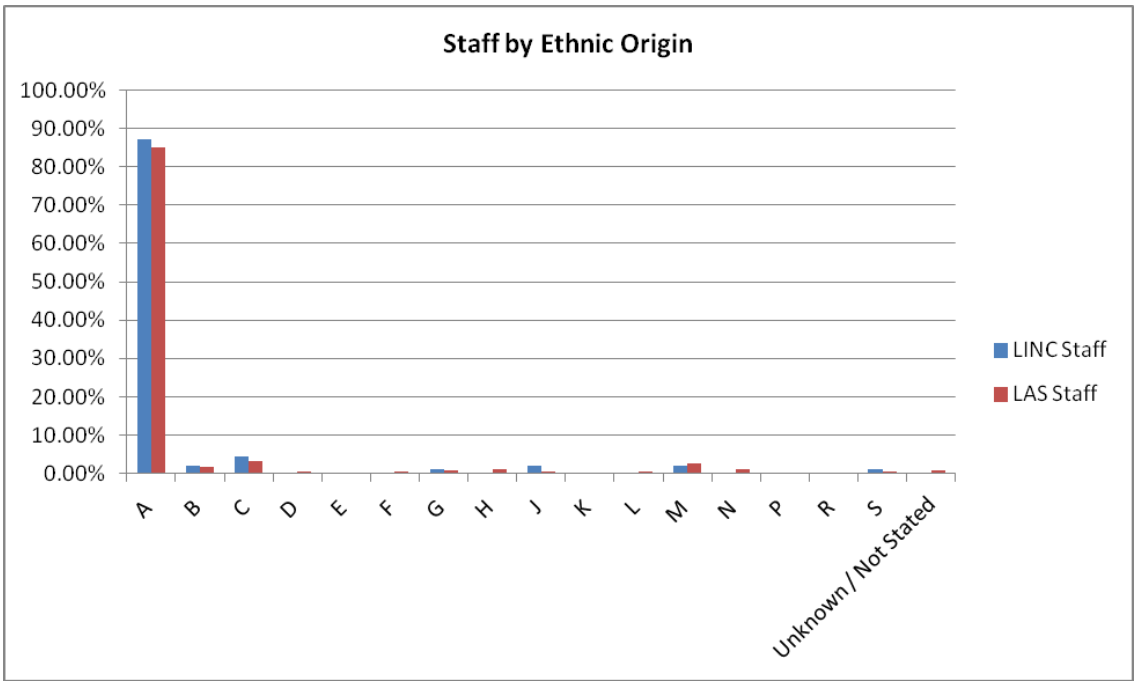
6. There has been a higher rate than ever of LINC Workers stepping down from the role, some because they are leaving the service; others, however, have fed back that it is due to having increasing demands and pressures to cope with.

7. The latest statistics show an increase of staff members accessing LINC, which is a continuing trend. The last financial year recorded 335 individuals who accessed the LINC Network. This should be taken as representative as a much greater number - the reporting rate from LINC Workers is currently quite low – a new reporting system is currently being developed. The main reasons people access LINC is due to *'Family and Relationship problems'* and *'Cumulative Stress'*.

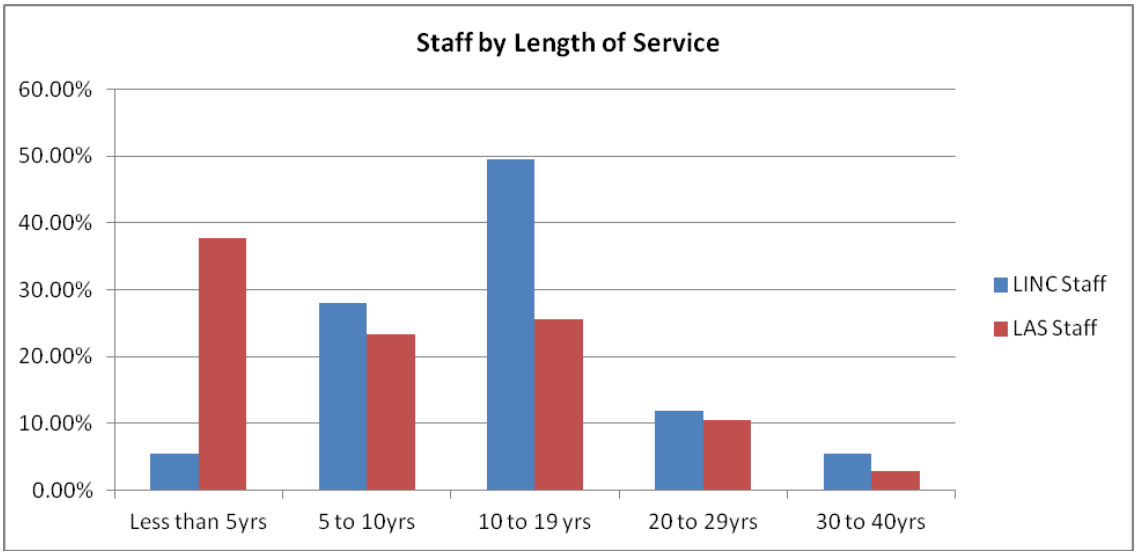
Equalities profiling questions were added to the statistical analysis of LINC; however these were introduced part way through the year, so not yet as widely recorded. However what has been highlighted about staff that have accessed LINC includes:

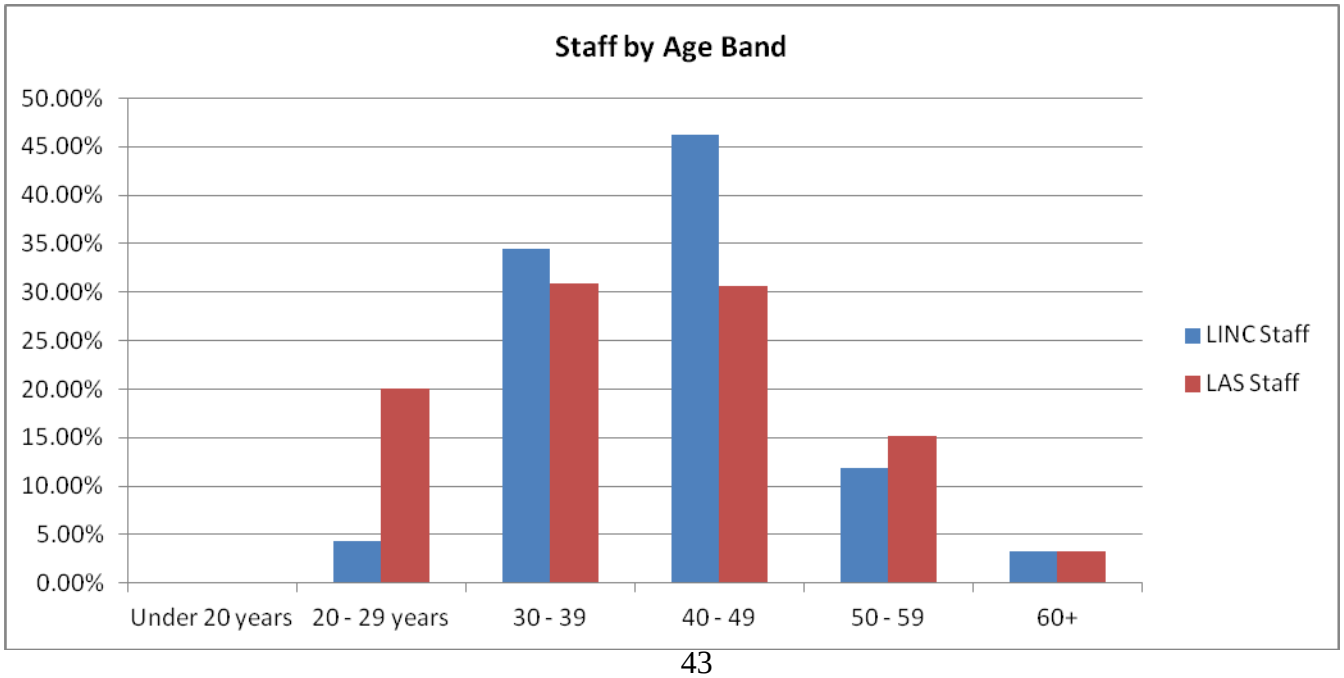
- there was an even spread across the age range from 19 – 62years old.
- LINC was accessed mainly by heterosexual people; however, take-up was recorded by Lesbian / Gay women and Gay men.
- The first language of all people accessing LINC was English (where recorded)
- Work locations that have more LINC Workers report much higher usage, for example Friern Barnet and Camden.
- Access by people from BME backgrounds has more than doubled.

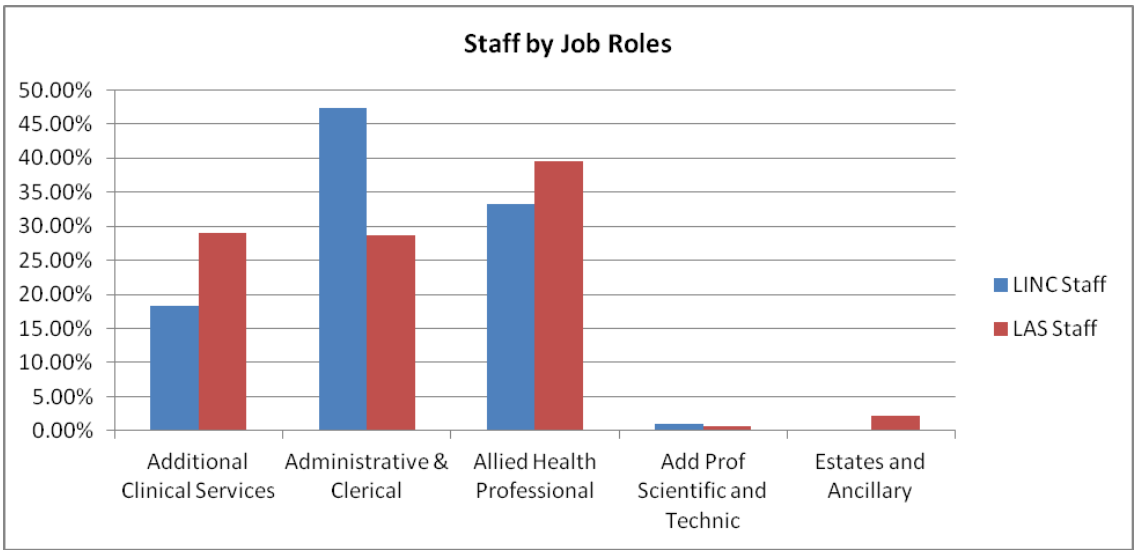
The make-up of Linc worker staff and clients is captured below:




Staff by Gender
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Female
Male
LINC Staff
LAS Staff


Staff by Length of Service
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Less than 5yrs
5 to 10yrs
10 to 19 yrs
20 to 29yrs
30 to 40yrs
LINC Staff
LAS Staff


Staff by Age Band
50.00%
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Under 20 years
20 - 29 years
30 - 39
40 - 49
50 - 59
60+
LINC Staff
LAS Staff



Regular monitoring of LINC, to ensure it is reflective of the workforce, continues to take place and any under-representation will be actively addressed, with applicants from any under-represented areas encouraged to apply. Analysis of the composition of LINC over this year has shown that more male workers are required. Six LINC Newsletters for the LINC Workers were distributed, which act as an update and to ensure LINC Workers remain included and aware of developments etc.

6. TRAINING & DEVELOPMENT

6.1. TRAINING ORGANISED BY LEARNING & ORGANISATIONAL DEVELOPMENT

E-learning Module on Equality & Inclusion

LAS LIVE (Learning in a Virtual Environment) was launched in 2009 and has over 4000 registered users who access the system 24 hours a day 7 days a week. In year 2010/11 232 staff completed the Equalities & Inclusion e-learning package. LAS LIVE, the Trust e-learning website, currently only tracks completion data and assessment score, not equality information of those that have completed E-learning or face to face training.

It is hoped that Learning & Development will be able to produce the required reports detailing the breakdown by protected characteristic groups when OLM (Oracle Learning Management) and NLMS (National Learning Management) are implemented. This project is expected to be delivered in 2012/13.

Talent Management Programme

The Talent Management Programme aimed at providing the Trust with a framework to identify and develop its most talented individuals and ensures that the service is able to respond to its leadership challenges for the future, went live in autumn 2010. The programme is available annually for all staff and in particular those who may not as yet have realised their potential. One of the Talent principles under which the programme operates, in line with all leadership development activity at the Trust, is that it seeks to promote positive

action with the objective of supporting and developing staff from under-represented groups.

In the first year of application, all four successful candidates were women. With the new Staff Data Refresh, more comprehensive analysis of successful applicants will be undertaken across all protected characteristic groups, with a view to being able to report on this from April 1 2012 on.

Learning & Development initiatives 10/11
Participants
In 2010/11 there were719 applicants of whom 119 cancelled (16%)
In 2009/10 there were 528 applicants of whom 114 cancelled (22%)
(an annual reduction of 6%)
In response to course and participant cancellations, key stakeholders were sent regular attendance and cancellation information. L&OD records identified all cancellations and the associated rationale and actions.

Sponsorship for Study (SFS)
This budget is designed to provide financial support to those staff pursuing academic course and/or attending conferences as part of their continual professional development.

2010/11 saw the introduction of a more robust, although administratively challenging, approach to SFS applications.
Applications were split into two pathways:

a) Academic/qualification led courses of study (e.g. Open University degree modules, Cert. Ed. PGCE, NVQ's etc
b) Courses, Conferences and workshops (non academic) route (e.g. professional seminars, short "one-off" 2 or 3 day courses etc. It must be noted that there was negligible interest in this latter route in 2010/11

The former saw the introduction of a panel approach to the consideration of applications. The panel met twice during the year, and consisted of 3 senior managers, ensuring a mix of both operational and non operational managers, reviewing applications, with the level of SFS funding awarded determined against a set of agreed criteria, with the process and outcomes managed by the L&OD Development Advisor.

Courses can involve considerable sums of money and this new panel approach has brought a corporate and rigorous approach to the level of awards made or in some circumstances rejected.

The panel process has confirmed to those seeking SFS funding that they must make clear what the benefits to the Service will be in supporting their application.

2 key factors have been highlighted in this year's round of applications and both are to be reviewed in terms of the administration/management of the SFS scheme in 2011/12:

i) Although managed by the L&OD team the vast majority of academic applications for SFS have been for ***clinically led*** qualifications, the reason being that bursary funding only supports courses up to a maximum of £300 and applies to a limited range of short courses only.

ii) The Services budgetary year and requisitioning/invoicing processes do not sit well with either the academic cycle or many institutions payment procedures which has led to a considerable administrative overhead for the L&OD administrators relative to the number of awards made.

Both of the above issues will be reviewed as part of a wide piece of work in hand regarding revision of both Sponsorship and Study leave policy and administration

Joint Initiative Framework (JIF)*
This initiative is funded jointly by the Learning Skills Council and the Department of Health. It is designed to allow trusts to fund activities which promote greater access to learning for staff occupying bands1-4 within AFC pay scales.

Funding was received via NHS London who in turn required us to return a detailed Band 1-4 “Strategic Workforce Development Template” outlining our intended use of funds; and thereafter a quarterly return breaking down this fund usage by activity type, job type and band.

L&OD put considerable effort into promotion of JIF with 2009/10 seeing encouraging take-up of by staff of short 1 day courses specifically designed for, and targeted at bands 1-4; however by the spring of 2010 it was clear that this approach had served its purpose with those needing to attend having done so.

For 2010/11 the L&OD team determined that a more strategic/corporate approach be used; with the JIF funding being employed to maximise benefit to both the individuals and the Service.

1. Departments and teams were invited to bid for JIF funding, identifying the proposed activities, who for and the amount of funding required. All bids were reviewed by the L&OD team and Assistant Director, Equality & Organisation Development
   Funding was then transferred to a designated “bid lead” who organised the delivery of the proposed development with guidance from the L&OD Development Advisor. Attendance details were provided to L&OD for reporting purposes.

   Supported JIF funding activities included:
   - A series of 1 day “Handling Change” workshops for staff in Control Services
   - “Professionalism in Communications” to PTS staff
   - Safe and Fuel efficient driving (ROSPA) for Logistics

- Funding development and build of an E:Learning infrastructure to support roll–out of on line development packages geared to bands 1-4

2. Funding via the above bid process for more significant development geared to individual development/career needs, e.g.:
   - PRINCE training for a support staff member in the Olympics Office
   - Certificate in Counselling Skills for and administrator in Human Resources & Organisational Development

3. Continuation of a suite of courses offered by external providers, notably MS Office suite training, funded via JIF and targeted specifically at bands 1-4 open courses

This approach worked well and the intention is to embed and build on this approach in 2011/2

In all some 150 staff in bands 1-4 have been able to secure personal development opportunities via the L&OD team JIF work.

Mentoring and Coaching
Driven by request or referral coming direct to the team, L&OD provided 50 days support to managers and staff from all areas in their personal or team development through coaching, mentoring and facilitation, at an overage rate of 30 hours per month.

Business Partnering
In addition to the team development within coaching and mentoring, L&OD made some further gains in employing the Business Partnering model within directorates.
One notable example of this was a series of short 2 day “Introduction to Management” workshops commissioned by Fleet and Logistics to develop their workshop technicians with 21 staff attending. The whole directorate are keen to build on this partnership model with a wider range of development activities planned for 2011/12.

Conclusions and Future Actions
Following its own review and subsequent changes the L&OD service have achieved the following:

- Improved attendance rates
- A reduction of participant cancellations
- Increased number of requests for type specific events.
- Increased take-up of “one to one” coaching sessions and “consultancy” with L&OD team members
- Introduction of a new FLM accredited programme
- Close working with Education and Development to support the A&E support staff.

The team will continue to:

- Sustain its focus on cost effectiveness in all area of its work – with particular reference to usage venues and third part providers and the longer term benefits accruing from OLM
- Ensure all our activities and their outcomes are aligned, and give support to the needs of the Service at individual, team and corporate level, in particular by promoting its business partner model to optimise focus in any activity.
- Act as a advocate of, and conduit for, key corporate messages and expectations – notably in the "people skills" arena
- Offer feedback and "intelligence" gained from its development interventions to other Service change agents – notably HR colleagues and SIP team and the wider NHS services.
- Focussed work needs to be undertaken to encourage more staff from BME backgrounds to access learning and review why the disability declaration remains a challenge for staff.

Dimension	**2009-10**	**2009-10 actual numbers**	**2010-2011**	**2010-2011 actual numbers**
Courses Offered	**74**	**74**	**146**	**146**
Courses cancelled	**27**	**27**	**36**	**36 (of which 17 was Managing Safety & Risk)**
Nos. who applied for training	**528**	**528**	**719**	**719**
Attendance	**69.32% (as a% of applied)**	**366**	**83.4 % As a % of applied**	**600**
Women attending	**43.56% (as % of attendees)**	**230**	**47.56% as a % of attendees**	**285**
BME attending	**35.24% (as % of attendees)**	**129**	**19.50% as a % of attendees**	**117**
Bands1-4 (JIF)	**46.45% (as % of attendees)**	**170**	**16.16% as a % of attendees (excluding JIF**	**97(excluding JIF bids etc)**

			bids et c)	
Disability	**None recorded**		**1 recorded**	**1 recorded**

(*information above gathered from completion of training application forms)

6.2.TRAINING ORGANISED BY EDUCATION AND DEVELOPMENT

Overview

The Department of Education and Development (Department) is the primary provider of clinical education and training within the LAS. It delivers its core services from seven Education Centres throughout the London area, either directly or in conjunction with its three Higher Education partners. The Department also provides a range of clinical training services at station complex level. These are either delivered directly by the Department, or in a support capacity to the New Ways of Working scheme currently being introduced throughout the LAS.

As an accredited provider of national ambulance training, the LAS has a duty to comply with the standards of its awarding body, the Institute of Healthcare and Development Ltd (IHCD), along with the requirements of the Health Professions Council (HPC) as the regulatory body. Both organisations require member services to meet a wide range of standards, which include various measures associated with equality and diversity and the support of students.

The Department ensures that all of its programmes are developed on student centred learning concepts, which are then firmly embedded in all clinical education and training practices delivered throughout the Trust. LAS clinical training programmes are designed specifically for the various staff grades/roles as required by the organisation. They contain the necessary skills and competencies set by the IHCD/HPC as a minimum, with additional and/or LAS specific skills authorised and approved by the LAS Clinical Steering Group and Training Strategy Group. The content of our clinical training programmes also reflect the NHS Knowledge & Skills Framework, which includes Equality and Diversity as one of the six core dimensions.

As part of the annual appraisal process, all clinical staff participate in an Operational Workplace Review (OWR) with their Team Leader, as well as a Personal Development Review (PDR) with their line manager. These provide the opportunity for each individual to demonstrate how they apply their knowledge and skills in the respective work area in order to fulfil their role. Where evidence demonstrates gaps between the level for the role and the level achieved, the remedial actions are reflected in a Personal Development Plan for ongoing monitoring and review.

The LAS utilises the outcomes from the PDR process, along with all statutory and mandatory training requirements etc, to inform the annual Training Needs Analysis. This is then reflected in the Clinical Training Plan which outlines all

clinical training and development opportunities within the LAS. This is publicised to staff via 'the pulse' intranet site and forms the basis of all subsequent planning and provision.

Uptake of Clinical Training Activities (2010-11)

Course Name	Training Type	Number of Planned Places	Number of Attendees	Number of DNA's	% Uptake
A&E Support	Pre Registration	69	65	1	94%
Clinical Tutors Development Programme	Post Registration	79	63	0	79%
Clinical Update Day for Clinical Leads	Post Registration	26	21	0	81%
Clinical Update Day for Training Officers	Post Registration	75	70	0	93%
Core Skills Refresher	Post Registration	2146	1647	113	77%
CSD	Clinical/Technical	12	5	0	42%
CTA MPDS	Clinical/Technical	48	28	0	58%
CTAK (20 days)	Clinical/Technical	67	60	0	89%
Control Services Train the Trainer	Project	21	20	0	95%
Command Point- Call Taking	Project	195	174	0	89%
Command Point-Dispatch	Project	207	182	0	88%
Command Point-Clinical Telephone Advice	Project	24	18	0	75%
Dispatch	Clinical/Technical	30	0	0	0%
EMT 4 - Patient Assessment	Post Registration	538	131	16	24%
EOC EOY	Clinical/Technical	51	50	0	98%
HEMS Training (EOC)	Clinical/Technical	5	5	0	100%
LARP	Clinical/Technical	53	55	0	104%
Module J - Clinical Audit	Pre Registration	444	343	15	77%
Module J - Clinical Decision Making	Pre Registration	696	494	26	71%
Module J - Health Promotion	Pre Registration	636	432	24	70%
Module J - Law & Ethics	Pre Registration	564	460	15	82%
Module J - Psychology	Pre Registration	372	292	15	78%
Module J - Sociology	Pre Registration	720	529	21	73%
MPDS Course	Clinical/Technical	54	48	0	89%
MPDS One Hour Recert	Clinical/Technical	2	2	0	100%
MPDS Recert Course	Clinical/Technical	116	113	0	97%
MPDS Re-certification Paper	Clinical/Technical	95	95	0	100%
Paramedic (Incl Student Paramedic and APL)	Qualifiers	168	114	0	68%
Practice Placement Educator - Module 1 & 2	Post Registration	128	117	10	91%
Practice Placement Educator - Module 2	Post Registration	132	111	18	84%
Practice Placement Educator - Module 3	Post Registration	156	97	6	62%
Radio Training	Clinical/Technical	115	115	0	100%
Student Paramedic	Pre Registration	204	194	0	95%
Student Paramedic	Post Registration	14	11	0	79%
Team Leader	Post Registration	14	12	0	86%
VRC CTAK Refresher	Clinical/Technical	6	6	0	100%
WBT	Clinical/Technical	32	27	0	84%
Work Based Trainer EMD/CTA	Project	36	22	0	61%
XC Map Training (1Day)	Clinical/Technical	31	31	0	100%
		8381	**6259**	**280**	**75.0%**

	Number of Students Attending	Number of Students Passed	Number of Students Failed	% Pass Rate
Student Paramedic (Gateway 1)	488	479	9	98%
Student Paramedic (Gateway 2)	84	81	3	96%
Student Paramedic (Mod G)	85	66	19	78%

Training Documentation

The format of all LAS training material is designed to be clear and specific. Each student is provided with a personal copy of the respective training programme, which includes a comprehensive set of Learner Outcome Plans that detail each individual area of learning. This is designed to be retained by the student, and allows for subsequent note taking etc. for personal record purposes. The Department also produces any such material in coloured paper format etc., in accordance with the individual needs of students.

All competencies are then mirrored within an Achievement Record booklet. These are subsequently 'signed off' as the course progresses and individual competencies are achieved. Recognition of achievement is specifically designed to operate on a partnership basis between the student and tutor. The booklet also allows for easy monitoring of student progress, as well as for final checking that all learning areas have been addressed.

The Department also provides individual 'Reflective Record' booklets that allow each student to reflect on their learning at the close of each day, and to seek assistance for any area causing concern. Entries are also monitored by the respective Course Tutor on a daily basis to ensure that any previously unidentified problems are highlighted and subsequently addressed. This is in addition to the student tutorial process which is conducted in accordance with the schedules outlined in the course programme.

Additional Student Support

In order to provide further support to students, the Department provided additional 'Study Day' events at various locations throughout the Service. These were primarily aimed at our Student Paramedic cohorts in preparation for the Gateway 1 & 2 assessments, as well as Module G Human Physiology prior to Paramedic course attendance. However, the Study Day events were open to all staff who wished to attend, which again were publicised via 'the pulse'.

During March 2011, the Department delivered three Area Clinical Development Courses for frontline staff. The topics included:

- 12 Lead ECG Review
- Consent & Capacity
- Patient Assessment Introduction / Review
- Focus Group Discussion

In June 2010, the Department facilitated two Tutors attending courses run by the British Dyslexia Association (BDA). The aim of this initiative was to enhance and develop more expertise of specific learning needs within the Department. Both Tutors attended two BDA modules i.e. Understanding Dyslexia & Screening for Dyslexia Workshops.

As a consequence, the LAS purchased the Lucid Adult Dyslexia Screening (LADS) software and agreed to a trial of screening students who demonstrated potential learning needs. These typically involved students who had failed to complete assessment papers in the allotted time, and/or who had indicated problems in reading the material.

In utilising the LADS tool throughout the remaining 2010-11 time period, a total of 23 students were identified as having specific learning needs. The support given is detailed in the table below:

Screening Undertaken	**Number of Students**
No. of students with previous diagnosis of Dyslexia / Special Learning Needs	6
British Dyslexia Association Adult Checklist completed	2
LADS+ screening tool completed	17
LADS+ Low probability identified	13
LADS+ Moderate probability identified	4
LADS+ High probability identified	0
Support Given in Education Centres	
Study / Revision advice given	23
Extra times in Exams	10
Reader provided in exams	1
Scribe provided in exams	1
Handouts given prior to any theory session	8
Exams and handouts printed on coloured paper	3
Referral to Educational Psychologist	1

Future Plans

In recognition of current difficulties in regard to staff capacity to capture

equalities monitoring information, the Department is pleased to be a key participant in the impending introduction of the Oracle Learning Management (OLM) system. This represents a key LAS development, with wide ranging benefits of having a centralised learning management provision that is integrated within the Electronic Staff Record (ESR). This should enable future reporting of application and take-up of clinical training across all the protected characteristic groups.

7 EQUALITIES INITIATIVES

EQUALITY ANALYSIS

In line with the requirements of the Equality Act 2010 and Public Sector Duty, an updated Equality Impact Assessment Procedure (now "Equality Analysis") was produced. Briefings on the use of the new tool have been provided to managers and teams carrying out equality analysis by the Equality and Inclusion Team. All equality analyses continue to be published on the Trust's website.

All equality analyses, as detailed in the Trust's Equality Analysis Schedule are being monitored by the Governance Team**.**

8.ACTIVITIES OF THE LONDON AMBULANCE SERVICE

8.1.PATIENT & PUBLIC INVOLVEMENT (PPI) AND PUBLIC EDUCATION

There are three main components of the PPI Action Plan for the period 2008-2012:

- Continuation of what has already been established, including ongoing projects.

- Developments to improve how PPI activity is co-ordinated, recorded, evaluated and supported within the LAS.

- Developments to ensure that the LAS is engaged with strategic changes in the external environment.

Listed below are a brief update and progress report against the activities set out in the action plan during the year 2010/11.

Update against action plan

Continuation of existing systems and current projects

- The Head of PPI & Public Education continues to report regularly to PPI Committee, Learning from Experience Group and Trust Board.
- The introduction of the role of PPI & Public Education Co-ordinator has ensured that all databases are maintained.
- The PPI & Public Education Co-ordinators continue to support LAS colleagues organising and taking part in public events, e.g. use of risk assessments / event plans, provision of display materials and resources. They have also created public education pages on the pulse and on the LAS website, with downloadable resources.

- Members of the Patients' Forum attend key Trust committees including the Trust Board, Learning from Experience Group, PPI Committee, Equality & Inclusion Steering Group, Clinical Audit and Research Steering Group, Mental Health Committee and Community Responder Steering Group.
- The Trust continues to work closely with the Patients' Forum Ambulance Services (London) Ltd., including the provision of meeting rooms and speakers, encouraging station visits, involvement in committees, projects and public events.
- PPI activity continues to be devised in line with the Trust's corporate objectives, e.g. access for deaf people, and that patients are involved in relevant projects.
- Six Community Involvement Officers are in post and meet monthly in a network, to share information and provide mutual support.
- Some PPI activity is still specifically focused on the Bangladeshi community in Tower Hamlets.
- The Public Education Staff Development Programme is now fully embedded in the Trust, providing staff involved in public education work with the skills and knowledge they need to be effective in this role.
- A series of Community Events is being held across London, with the aim of engaging with communities in different areas.

Developments to improve coordination, recording, evaluating and supporting PPI within the LAS

- Event planning forms are available to staff on the public education resource library on *the pulse*.
- Co-ordinators try to ensure local staff are involved in events and activities in their areas.
- Evaluation forms are provided for staff and organisers to give feedback following an event or activity.
- Trust-wide events (such as Know your Blood Pressure; community events; FT events) are managed by co-ordinating groups.
- A Non-Executive Director has joined the PPI Committee, providing Board-level support for this work.
- The Director of Corporate Services is also a PPI Committee member and has become actively involved in the Public Education Staff Development Programme.
- The findings of the Category C Service User survey, and the action plan arising from it, have been presented to various internal committees and to commissioners.
- Local management teams are supported by the central PPI and Public Education team.
- Community Involvement Officers take the lead on involvement activities in their areas.
- Quarterly newsletters are produced by the PPI & Public Education Co-ordinators.
- PPI and public education activities are also publicised through the public education resource library on the pulse.

- A prioritisation tool for PPI activity was written and agreed by PPI Committee and Public Education Strategy Group, for use at times when there are conflicting demands which cannot all be met.
- Two induction programmes have been held for Patients' Forum members wishing to engage with the Trust.
- The Foundation Trust membership strategy includes methods of engaging with members/governors and ensuring they contribute as fully as possible. Support and training will be available for FT governors.

Responding to the external environment and strategic changes

- Links have been formed with some of the Local Involvement Networks in London.
- There is now greater involvement and interest in PPI and public education by commissioners.
- FT membership and governor arrangements are being led by the FT team but with the involvement of others (PPI / Public Education team, HR, Communications).
- Additional methods of eliciting patient feedback are being introduced, e.g. the use of SNAP survey software, the website, FT members etc.
- Patient and public involvement forms part of most major service changes within the LAS.
- There are long-standing and robust patient involvement mechanisms for patients with long term conditions, cardiac problems etc.
- Patient involvement in plans for the Olympics has started in earnest, with a series of events being held in the Olympic boroughs.

8.2.EMERGENCY BED SERVICE

In the delivery of its services, EBS deals mostly with Health Care Professionals, dealing with patients at one remove. Often the patient's details are unclear or the patient to be moved may not have been decided upon at the time the enquiry is taken. For that reason it has been the view of EBS Managers historically that there was no benefit to recording either ethnicity or disability in the operation of these services.

The table below indicates total volumes for each service area for the year from April 1 2009 to March 31 2010 with diversity categories profiled where possible, illustrated by the charts.

The ex-utero service is provided to premature babies, and the in-utero to women in the later stages of pregnancy: gender and age profiling has not been thought relevant in these services.

EBS does have patient contact in the delivery of its services to District Nursing clients. The dataset collected for those patients has been agreed by the commissioners of those services (the provider wings of Lewisham, Newham and Southwark PCT's) and does not include age, gender or disability.

In provision of the Safeguarding service, whereby EBS collect and forward child protection and vulnerable adult referrals, no information on gender or ethnicity was collected, but this omission has recently been identified and EBS are piloting a new referral mechanism from Jan 2012, which will allow subsequent reporting on this.

EBS Service Summary 10 – 11 by Gender

	Total	Male	Female	Unknown
GP Referral Service	2227	897	1329	1
Adult Intensive Care Service	955	519	358	78
Paediatric Bed & Cubicle	1852	1004	811	
District Nursing	8433	no recorded	no recorded	

EBS Service Summary 10 – 11 by Age Range

	Total	0 - 9	10 - 19	20 - 29	30 - 39	40 - 49	50 - 59	60 - 69	70 - 79	80 - 89	90 >	Unknown
GP Referral Service	2227	29	47	51	145	184	232	303	488	500	153	0
Adult Intensive Care Service	955	15	20	60	62	122	141	176	171	57	6	125

8.3.THE PATIENT TRANSPORT SERVICE

Patient Transport Services is responsible for the transport of patients to their non-emergency appointments at a range of clinical care facilities.

Transport is provided to patients who are disabled, with mobility difficulties, where their medical condition may deteriorate on route or where failure to provide transport would restrict their ability access healthcare. The eligibility of patients to access this transport is assessed by a medical clinician at a GP's surgery or at a hospital or other NHS facility with an appropriate booking made with the London Ambulance Service.

In 2010-11 the LAS PTS service delivered 220,727 journeys the details of which are captured on the Services Meridian system. From this data we can determine the following equalities data.

PATIENT GENDER	JA	%
F	126390	57%
M	82653	37%
UNKNOWN	11684	5%

The unknown group is where the system has only registered a last name and initial and gender can not be ascertained.

Patient Age Profile	JA	%
0-20	1236	1%
21-30	1574	1%
31-40	3332	2%
41-50	6073	3%
51-60	10239	5%
61+	133938	61%
Unknown	64335	29%

The age profile shows that the largest group of patients using the service are aged 61 and over. This is expected as older patients, in general, require more assistance to access healthcare on a routine and ongoing basis.

Ethnicity Of Patient	JA	%
A - White British	10473	5%
B - White Irish	371	0%
C - Any other White Background	452	0%
D - Mixed White & Black Caribbean	39	0%
E - Mixed White & Black African	9	0%
F - Mixed White & Asian	16	0%
G - Mixed Any other White Background	49	0%
H - Asian or British Asian Indian	223	0%
J - Asian or British Asian Pakistani	82	0%
K - Asian or British Asian Bangladeshi	60	0%
L - Asian or British Asian Any other background	80	0%
M - Black or Black British Caribbean	685	0%
N - Black or Black British African	170	0%
P - Black or Black British Any Other Background	48	0%
R - Other Ethnic Groups Chinese	61	0%
S - Any other Ethnic Groups	224	0%
Z - No Information Available	207685	94%

Booking forms for transport provide for the capture of ethnic monitoring data, however, as the table above shows this continues to be largely left blank. This may be as a result of patients not wishing for this data to be collected although it is more likely that it is unknown at the time that the booking is made as this is completed by someone other than the clinician.

PTS has reminded commissioners for the requirement to provide this data.

To overcome these blockages PTS has introduced a system of e-booking which provides for ethnicity to be collected, however, take up of this system by commissioners has been slow.

Work has also been carried out to establish whether ethnicity data can be collected via the NHS number, which the service has had more success in collecting. It appears that this data is not recorded against this unique identifier and therefore this does not assist in this data collection.

Without a central resource (such as the data spine) with which to collect this data the service continues to encounter barriers to obtaining the data. As an interim we will continue to establish whether access to separate PAS and HIS systems is available to help identify data, however, this will remain sporadic and time consuming without a true link into the LAS system.

8.4. CLINICAL TELEPHONE ADVICE

CTA are referring a significant amount of patients to Alternative Care Pathways and more appropriately attending their individual clinical need and personal circumstances. The department is also reducing the number of inappropriate admissions to hospital by offering, for example, self care advice at home.

Collecting ethnic data places significant demands on those who collate such information locally. There are over one million staff in the health service, and a further one million in social services, of whom perhaps 30% are employed by Local Authorities. There are about eleven million Hospital Episode Statistics (HES) records each year, for inpatients alone (outpatients would at least double this). Getting ethnicity data for all these groups and activities (and where necessary, checking and updating records) is a major undertaking, on any examination of the facts.

To address future data collection requirements, CTA have been capturing ethnicity data since 16th September 2008 and this is a required field within their Clinical Decision Support Software PSIAM.

The benefits of capturing this information by the team has allowed the London Ambulance Service to provide even more appropriate patient care and outcomes for our patients.

Ethnicity Monitoring has become part of the Quality Assurance process for CTA and the Psiam Quality Improvement case evaluation form will allow the monitoring and measuring of the effectiveness of the data, and will be appropriately scored under the Pre-Triage phase of the audit form.

Although this information has been captured and CTA staff are able to see and search individual patient records to view ethnicity information, they are still not able to report on the data captures, and are awaiting IM&T installation of the latest version of PSIAM to facilitate this. The current IT system is not fit for purpose, and the electronic link between PSIAM and CTAK has not been implemented due to restrictions on technological development. The department has not been able to make any significant changes to the current system as a

new CAD system CommandPoint was due to be introduced into the Control Centres in June 2011. The CTA PSIAM links will not be introduced in March 2012 as the specifications have not been finalised. It is envisaged that the technological solutions will be realised Summer 2012 during the 2nd or 3rd phase/release. The LAS Management Information department is also currently unable to access this data for the same reasons.

The disability question exists within PSIAM, but is not currently being applied.Because of the difficulties in producing this data and the lack of data covering ethnicity, there is no basis for a sensible comparison with the figures, also incomplete, from the previous report.

Improvements to the I.T. systems used to obtain this data will be required for reporting across protected characteristic groups for future years, balanced against the need to ensure no adverse impact on performance.

8.5. PATIENT EXPERIENCES

Patient Experiences

There were regrettably a number of inhibitors which impacted on data collection during the period. The department experienced administration difficulties and budget restraints had the effect that return envelopes were no longer issued. A further challenge is that the case management system uses a complex data extrapolation process that does not easily enable accurate analyses or reporting.

PALS

A total of 6033 PALS cases were entered on the case management system during the period.

Ethnicity

Of the data, only 1.4% of actual ethnicity data was recorded.

Ethnicity data where recorded	**Number**
White British (1)	54
White Irish (2)	8
White other (3)	8
Mixed white black Caribbean (4)	2
Indian (8)	1
Pakistani (9)	3
Bangladeshi (10)	1
Other Asian (11)	2
Caribbean (12)	1
Black African (13)	6
Other black (14)	1
Other ethnicity (16)	1
Not stated (17)	1537
No details	4408
Total	**6033**

Gender
1168 enquiries received were from women (19%)
969 enquiries received from men (16%)
3896 where gender was not specified (65%).

Age Group
Less than 2% of ages were recorded in the case management system

Age bracket of enquirer	Number
Under 20	10
21-30	20
31-40	23
41-50	19
51-60	20
61-70	16
71-80	6
81 and over	5
Not stated	5914
Total	**6033**

Complaints
There were 460 complaints recorded during 2010/11.

Ethnicity
The data below reflects the ethnicity monitoring of complainant/patient where recorded (hence higher than actual number of complaints). 19% of complaints recorded ethnicity data.

Ethnicity data where recorded (patient and enquirer information)	Number
White British (1)	57
White Irish (2)	1
White other (3)	5
Mixed white black Caribbean (4)	4
Mixed white and black African	2
Mixed white and Asian	1
Indian (8)	2
Pakistani (9)	3
Bangladeshi (10)	3
Caribbean (12)	2
Black African (13)	5
Chinese (15)	1
Other ethnicity (16)	3
Not stated (17)	305
No details	86
Total	**480**

Gender

Gender recorded (complainant)	Number
Female (52%)	248
Male (28%)	139
Not recorded (20%)	93
Total	**480**

Age Group

Only 12% of age data was recorded in the case management system.

Age bracket of enquirer	Number
21-30	11
31-40	10
41-50	8
51-60	14
61-70	6
71-80	5
81 and over	2
Not stated	424
Total	**480**

On a more positive note, there is now have a permanent administrator in post and the service has designed a new process to improve data collection at source. Ethnicity monitoring was also included in a recent training workshop highlighting the importance of collecting this data. As a result improved returns are expected for the future.

8.6. PATIENT PROFILING

A total number of 1,062,233 (1,019,163 in 09-10) incidents were recorded from April 2010 to March 2011. Of these a total of 525,003 were from women (up from 500,412 in 09-10), 512649 from men (up from 487,961 in 09-10); for 24,581 no sex was stated (a considerable reduction on the previous year's figure of 30,790 in 09-10). The BME communities with the highest number of incidents raised were Black African (16,854) (down from 18,337 in 09-10), followed closely by Black Caribbean (14,392) (also down from 17,573 in 09-10) then Asian or British Asian – Indian (8544). The most prevalent age ranges were the same as last year – 21-30, 31-40 then 81-90.

8.7. OLYMPIC PROGRAMME OFFICE

Community engagement

This year the Service has taken part in community engagement events to promote the 2012 Games.

The events organised by the Met took place in the five Olympic boroughs with the aim to promote the 2012 Games and the opportunities it will generate. The team spoke to members of the public about Games-related issues including impact on services and Games Legacy. The majority of people were positive about the 2012 Games and more events will be planned for next year. The Olympic Programme Equality Analysis has been updated.

Safeguarding

A member of the team is working on a project dealing with issues around trafficking and domestic violence. There is evidence that the latter increases during some major sporting events.

This work is focused through LB Newham who have set up a Safeguarding Group for the Olympics in conjunction with the Met. The group looks at the full range of issues, including capacity to deal with increased referrals, how to manage workload under the increased pressure on resources from staff leave/transport etc. during the Games-time. It also focuses on how capacity and normal working practices will be affected where referrals involve foreign nationals.

9. CONCLUSION

The Trust has been very active over the past year, investigating areas requiring improvement in the collection of data and establishing a number of new initiatives directly intended to improve the representativeness of the Trust's workforce, and access to training and development of its staff**,** more targeted and enhanced services to its patients and service users and better engagement with all its stakeholders. These initiatives will enable the Trust to make real progress in the coming years.

However, there remains a large amount of work needing to be done in terms of collecting and expanding equalities information, as required by the Equality Act 2010, both in regard to the workforce and patients and service users. More work remains to be done in the areas of data collection and respective service managers have clearly identified in this report any barriers such as resourcing, IT difficulties or cross-organisational restrictions facing them in providing clear and comprehensive profiles of staff, patients or service users across the new protected characteristic groups.

Over the coming year the Trust should benefit from the impending Staff Data Refresh, which should enhance the protected characteristic information the Trust holds on its staff across all its employment and training functions. The Trust will need to consider how best to capture similar, proportionate information from its patients and service users. The Equality & Inclusion Team will work closely with respective service managers to devise the most sensible and effective approach, which will need to be tailored to the needs of the respective service.

The Trust continues its active engagement with its patients and service users through its work with the Patients' Forum and LINks and is taking this forward in a number of specific initiatives, highlighted in this report.

The Trust's Equality and Inclusion Steering Group, comprising Directors, Heads of Service, non-Executive Director, Patients' Forum/LINks and staff side representation, continues to meet regularly to oversee the progress of all equality and inclusion work in the Trust.

10. RECOMMENDATIONS.

To ensure that the Trust continues to be proactive in its equality & inclusion work and compliant with the requirements of the new Equality Act 2010, it is recommended that:

- Directors and Heads of Service encourage and facilitate access to the new Equality Act 2010 training planned for all staff across the Trust;
- To ensure the Trust meets its duties under the Equality Act 2010 Public Sector Duty, all Directors and Heads of Service urgently review their monitoring systems in regard to the protected characteristic groups and build in any necessary resourcing, wherever identified as necessary, to enhance the data collection and analysis of take-up of services, employment and training and access to decision making in the Trust, using the Staff Data Refresh planned;
- The Staff Data Refresh be carried out by IM&T on an annual basis, to ensure Employee Staff Records are full and accurate;
- Directors and Heads of Service support their staff in joining the Trust's new Staff Diversity Forums;
- Equality and inclusion objectives be included in all PDRs for Trust staff;
- Directors and Heads of Service continue to resource their actions in the Equality and Inclusion Strategy Action Plan;
- On the next available opportunity, when there is a new recruitment campaign, the Trust look at how it can engage actively with people from a wide range of backgrounds, who from the recruitment analysis currently do not seem to be applying to the Trust (e.g. Chinese, Disabled people, Gay, Lesbian and Bisexual applicants) to enable them to consider this as a career option for any future recruitment campaign and consider holding awareness events for certain sections of the community on how to complete an application form, in line with the Trust's new Positive Action Strategy.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 24TH JANUARY 2012

PAPER FOR APPROVAL

Document Title:	**Risk Management Strategy and Policy TP 005**
Report Author(s):	**Frances Wood, Carmel Dodson-Brown, Sandra Adams**
Lead Director:	**Sandra Adams, Director of Corporate Services**
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Why is this coming to the Trust Board?	**For approval**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Senior Management Group ☐ 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:	**To approve the revised Risk Management Strategy and Policy**

Executive Summary

The Risk Management Strategy and Policy is the overarching governance document for the Trust's risk management arrangements. It was last reviewed and approved by the Trust Board on 30th March 2010.

Over the past 18 months there has been substantial work undertaken to update supporting risk management procedures as well as a strengthening of governance arrangements from Trust Board down. The attached document has been fully reviewed and updated to take account of changes during that period. The Senior Management Group has approved the Risk Management Strategy and Policy at its meeting on 16th January 2012.

Changes have not been tracked or highlighted as they are substantial.

Key issues for the Trust Board

There is a risk that we fail to:

- maintain accountability and responsibility for the management of risk throughout the organisation;
- achieve NHSLA level 2 in October 2012 and therefore miss the additional financial discount
- delay elements of the Foundation Trust application as a key document for governance and IBP purposes is not up to date and approved by the Trust Board.

Attachments

TP005 Risk Management Strategy and Policy v7.0

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Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

☒ To have staff who are skilled, confident, motivated and feel valued and work in a safe environment
☒ To improve our delivery of safe and high quality patient care using all available pathways
☒ To be efficient and productive in delivering our commitments and to continually improve

Risk Implications

This paper supports the mitigation of 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

NHS Constitution

This paper supports the following principles that guide the NHS:

☐ 1. The NHS provides a comprehensive service, available to all
☐ 2. Access to NHS services is based on clinical need, not an individual's ability to pay
☒ 3. The NHS aspires to the highest standards of excellence and professionalism
☐ 4. NHS services must reflect the needs and preferences of patients, their families and their carers
☐ 5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
☐ 6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
☐ 7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☒ No

Key issues from the assessment:

London Ambulance Service NHS Trust

Risk Management Policy and Strategy

DOCUMENT PROFILE and CONTROL

Purpose of the document: To define the LAS approach to risk management.

Sponsor Department: Governance and Compliance

Author/Reviewer: Assistant Director of Corporate Services. To be reviewed by December 2013.

Document Status: Final

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
29/12/2011	7.0	Director of Corporate Services	Review and update for RCAG and the SMG approval in January 2012
20/12/11	6.3	Director of Corporate Services and Audit and Compliance Manager	Major review and revision
	6.2	Audit & Compliance Manager	Addition of monitoring table
20/09/10	6.1	Governance and Compliance Manager	Reformat and updated related documents
03/06/10	5.3	Head of RM & BC	Revised Appendix 2: CQSE & LfE TofR
02/06/10	5.2	Head of RM & BC	New Gov Committee chart added
20/05/10	5.1	Director of Corporate Services	Updated to include the final terms of reference for key committees
02/02/10	4.2	Director of Corporate Services	Updated to reflect changes to risk committee structure and responsibilities of committees.
01/10/09	4.1	Head of Governance	Updated to reflect role changes. Interim policy pending major revision by March 2010.
21/10/08	3.2	Head of Governance	Amendments to Risk Management Structure and Details of Committee Membership
20/10/08	3.1	Head of Governance	Amendments to ToR for SMG.
18/09/08	2.5	Chair of CGC, Chair of SBH group	Amendments to TofR for both
11/09/08	2.4	Head of RM & BC	Amendments from RCAG & new TofR details
28/08/08	2.3	Head of Governance(MB)	Include new ToR for Liability Claims Group Amendments to Audit Committee entries
13/08/08	2.2	Head of RM & BC	Revision incl. addition of T of R.
05//08	2.1	Head of Governance & Head of RM & BC	Revision
03/07	2	Head of Governance & Head of RM & BC	Major revision
12/06	1	Head of Governance	Replaced Risk Management Strategy

***Version Control Note:** All documents in development are indicated by minor versions i.e. 0.1; 0.2 etc. The first version of a document to be approved for release is given major version 1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until

the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

For Approval By:	Date Approved	Version
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TP/035	Risk Reporting and Assessment Procedure
H&S/011	Incident Reporting Procedure
TP/013	Claims Policy
TP/004	Complaints and Feedback Policy
TP/034	Being Open Policy
HR/07/22	Whistle Blowing Policy & Procedure
TP/006	Serious Incident Policy
TP/023	Driving and Care of Service Vehicles
H&S/001	Health and Safety Organisation – Policy Statement
TP/055	Learning from Untoward Incidents, PALS, Claims & Complaints Policy
TP/054	Investigation of Incidents, PALs, Complaints & Claims Policy

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are neither controlled nor substantive.

1. Introduction

The Board recognises that good risk management awareness and practice at all levels is a central part of the strategic management of the London Ambulance Service NHS Trust. It is the process whereby the Trust will methodically address the risks attached to its current and proposed activities with the goal of achieving sustained benefit within each activity and across the portfolio of all activities.

Led by the Board of Directors, the management of risk is integrated into the culture and internal control of the Trust through the application of effective evidence based governance, policies, procedures and training appropriate to the Trust business and circumstances. This will be translated into strategic, corporate and annual objectives, which are set out annually in the business plan, assigning responsibility throughout the organisation with each manager and employee responsible for the management of risk as an integral part of their work activities and forming a part of staff appraisal and personal development plans.

Equally important is the creation of an open and 'fair blame' culture so that staff feel confident to report incidents and near-misses openly and enable learning from mistakes to eliminate and/or reduce risks to the Trust's patients, staff and stakeholders.

The use of the appraisal process will enable the Trust to monitor and evaluate changes in financial, clinical, operational and management practice with KPIs at a staff level. This will encourage staff to review their performance and allow them to concentrate on addressing any risk and quality issues.

The fast changing nature of service development will require regular review of risk management arrangements.

2. Scope

This document applies to all Trust employees, contractors and third parties working within the Trust. Risk management is the responsibility of all staff, although managers at all levels are expected to take an active lead to ensure that risk management is a fundamental part of their operational area.

3. Objectives

The overall objectives of the policy and strategy are:

3.1 To ensure organisational wellbeing and make sure that both staff and others can perform their work in a safe and open environment and to raise the quality of care provided by the LAS to patients, through the identification, control and elimination or reduction of all risks to an acceptable level.

3.2 To inform the development of the Trust's clinical and non-clinical operations and support services to facilitate the implementation of the Trust's strategic and corporate objectives.

3.3 To understand the underlying causes of adverse incidents and ensure that lessons are learned from the experience.

3.4 To ensure that managers and staff at all levels in the organisation are clear about their personal responsibilities with regards to risk management and an effective Risk Reporting and Assessment Procedure is in place.

3.5 To understand the risks the Trust faces, their causes and cost and to transfer risks where unacceptable or unavoidable.

3.6 To allocate resources appropriately to reduce risks.

3.7 To ensure that the Trust meets its mandatory obligations in regard to national performance and quality targets

3.8 To identify and consult with stakeholders regarding the management of risk.

4. Responsibilities

4.1 Trust Board

- The Trust Board has corporate responsibility for the Trust's system of internal control and for robust risk management. The Trust Board is responsible for setting the strategic direction and corporate objectives for the Trust. It discharges its functions through a delegated structure (see page 26) designed to ensure effective risk management.

- The Trust Board is responsible for committing those financial, managerial, technological, and educational resources necessary to adequately control identified risks.

- The Trust Board will receive assurance, based on sufficient evidence and via quarterly review of the Trust's Assurance Framework, including assurance that internal controls are in place; that they are operating effectively; and that the objectives are being achieved.

- This assurance is provided through a system of monitoring and review by the Senior Management Group (SMG), Quality Committee, the Audit Committee and the Trust Board.

- The Quality and Audit Committees are chaired by non-executive directors who are responsible for reporting and providing assurance to the Trust Board.

- The Senior Management Group is chaired by the Chief Executive.

- Terms of reference, minutes and reports will be shared between the Audit and Quality committees.

- In particular the Board and its committees will receive external assurance through reports from external and internal audits, and assessments through the NHS Litigation Authority (NHSLA), the Care Quality Commission and the Health and Safety Executive.

- The Trust Board will receive regular updates on risk management and assurance as part of the board development programme. This will include updates on legislative or regulatory changes, for example the Anti-Bribery Act or CQC registration.

4.2 Chief Executive

- The Chief Executive, as Accountable Officer, has overall accountability for having a robust risk management system in place and an effective system of internal control, which is embedded within the Trust.

- The Chief Executive has delegated day to day responsibility for all aspects of risk management to nominated Executive Directors for their respective areas in line with this risk management policy and strategy.

4.3 Directors

Directors have responsibility for ensuring that:

- The risk management policy and strategy is implemented within their own directorate and that suitable and sufficient assessment of risk has taken place.

- Managers and staff apply this strategy and policy throughout their directorate.

- Steps are taken to secure resources for risk assessment, including the implementation of associated controls.

- Steps are taken to secure resources (financial and/or human) for risk management education and essential training.

- Risks held on the Corporate Risk Register are regularly reviewed; action plans are developed to mitigate the risks, and positive sources of assurance are identified.

- Specialist advice is available to the Trust as appropriate e.g. fire prevention; infection prevention and control; legal, and occupational health.

- An open and honest culture is developed where errors and adverse incidents are identified quickly and dealt with in a positive and constructive way.

4.4 Director of Corporate Services

- The Director of Corporate Services has delegated responsibility for managing the strategic development and implementation of corporate risk management (including any element of risk relating to governance, NHS Foundation Trust foundation status, legal matters, the corporate risk register, assurance framework, and compliance).

- The Director of Corporate Services has overall responsibility for ensuring that corporate risk processes and controls are in place.

- The Director of Corporate Services has overall responsibility for compliance with external risk requirements including the NHSLA and Care Quality Commission.

4.5 Director of Finance

- The Director of Finance has delegated responsibility for managing the strategic development and implementation of financial risk management (any element of risk containing financial implications in whole or in part).

4.6 Medical Director

- The Medical Director has delegated responsibility for managing the strategic development and implementation of clinical risk management and clinical governance (any element of risk relating to clinical issues including decontamination; medical equipment and devices; and medicines and research).

- The Medical Director is also responsible for the investigation of clinical incidents, in close liaison with the Medical Directorate.

4.7 Director of Health Promotion & Quality

- The Director of Health Promotion & Quality has delegated responsibility for managing the strategic development of risk management relating to infection control, safeguarding and disadvantaged and vulnerable groups.

- The Director of Health Promotion & Quality is responsible for ensuring implementation of the safeguarding policy and procedures.

4.8 Director of Human Resources and Organisation Development

- The Director of Human Resources & Organisation Development has delegated responsibility for managing the strategic development and implementation of operational risk management (any element of risk relating to human resources; occupational health; health & safety; training and personnel records management).

- The Director of Human Resources & Organisation Development has overall responsibility for health and safety within the Trust, although individual executive directors are responsible for and manage the health and safety risks that fall within their particular field of activity.

4.9 Chief Operating Officer

- The Chief Operating Officer has overall responsibility for managing the strategic development and implementation of operational risk management (any element of risk relating to the Accident and Emergency Service, including resourcing and control services, which may impact upon the ability of the Trust to provide the required level of patient care).

- The Chief Operating Officer has overall responsibility for emergency preparedness and business continuity.

- The Chief Operating Officer has responsibility for all logistical risks relating to vehicles, equipment and supplies which impact upon the ability of the Trust to provide the required level of patient care.

4.10 Deputy Director of Strategic Development

- The Deputy Director of Strategic Development has delegated responsibility for managing the strategic development and implementation of risk management relating to strategic development, any new business opportunities, and any element of risk relating to commissioning contracts.

4.11 Director of IM&T

- The Director of IM&T is the Senior Information Risk Owner (SIRO) and has delegated responsibility for managing the strategic development and implementation of IM&T and information risk management (including any element of risk relating to the provision, use, operation and maintenance of the Trust's technology, communications and information systems).

4.12 Other Members of the Trust

Other roles which have a specific risk management element include the following:

4.12.1 Assistant Director of Corporate Services – Governance and Compliance

- The Assistant Director of Corporate Services, is responsible for ensuring that risk management arrangements, including policy and strategy, Trust assurance framework, and the corporate risk register, are in place and being managed.

- The Assistant Director of Corporate Services is responsible for the Trust's compliance with external assessment requirements as defined by the Care Quality Commission, the NHS Litigation Authority and any other relevant bodies.

- The Assistant Director of Corporate Services is responsible for the co-ordination of serious incident investigations and Freedom of Information requests, the production of the integrated risk report and highlighting trends and learning points to the Learning from Experience Group.

4.12.2 Senior Health, Safety and Risk Advisor

- The Senior Health, Safety and Risk Adviser is responsible for advising on the development of all aspects of Health and Safety risk management and training and contributes to the integrated risk report, highlighting any trends and learning points to the Learning from Experience group.

4.12.3 Head of Patient Experiences

- The Head of Patient Experiences is responsible for the co-ordination of complaints investigation and management, including contributing to the integrated risk report and highlighting trends and learning points to the Learning from Experience group.

- The Head of Patient Experiences produces an annual report on complaints management in line with Regulations.

4.12.4 Head of Legal Services

- The Head of Legal Services is responsible for the co-ordination of litigation case management, inquests and Rule 43 Coroner reports, and contributes to the integrated risk report, highlighting any trends and learning points to the Learning from Experience group.

4.12.5 Managers

- All managers are responsible for the management of risk locally and for day to day implementation of the policy and strategy within their own area. Responsibilities include the following:

- Managing risk on a day to day basis, including patients, contractors, agency staff and visitors.

- Identifying and acting upon any significant risks, and reporting any risks that they cannot adequately control to the appropriate level for action or inclusion on the corporate risk register.

- Ensuring that risk assessment systems are in place and that these are regularly reviewed.

- Initiating and participating in any risk assessments as required.

- Ensuring accidents, incidents and near misses are reported in line with Trust policy, sufficiently investigated and action taken to prevent reoccurrences.

- Contributing to the identification of employees' risk management training needs through the Performance Development Review (PDR) process and training needs analysis.

- Ensure that employees receive and attend adequate risk management training.

- Issuing, raising awareness and ensuring compliance with Trust policies.

4.12.6 All Employees and Workers

- All employees, workers and contractors are responsible for:

- Being personally responsible for not undertaking any task or action which would knowingly cause risk to themselves, others, or to the Trust.

- Carrying out dynamic risk assessments as part of their everyday roles and responsibilities.

- Identifying and reporting actual /potential hazards in the work environment.

- Participating in briefing/training sessions and carrying out any agreed control measures and duties as instructed.

- Taking immediate action to minimise risks where it is reasonably practicable to do so.

5. Consultation and Communication with Stakeholders

5.1 The Trust recognises that effective governance requires a methodical approach to risk management which:

- Protects the interests of all its stakeholders.
- Ensures that the Board of Directors discharges their duties to direct strategy, build value and monitor the performance of the Trust.
- Ensures that management controls are in place and performing adequately.

5.2 To enable this to happen the Trust communicates its policy and strategy to a wide audience of its stakeholders through existing communications mechanisms, including staff training and induction programmes, internal/external newsletters and publication on the Trust's website.

6. Organisational Structure Relating to Risk Management

6.1 The Trust Board and Chief Executive require that consideration of risk and systems of internal control are fully embedded within the culture of the Trust, whilst ensuring a coordinated and holistic approach and maintaining clear lines of accountability. The Trust's organisational structure has been designed to reflect this and is detailed at Appendix 1. The terms of reference for all the groups detailed below can be found at Appendix 2.

6.2 **The Trust Board** takes ultimate corporate responsibility for the management of risk in the LAS. The Director of Corporate Services will ensure that the Trust Board reviews the corporate risk register quarterly together with the Board Assurance Framework. Board minutes will be routinely reviewed to ensure discussion has taken place of the principal risks that threaten the achievement of the Trust's corporate objectives. Decisions taken by the Board in respect of the risks presented to them will be reflected on either the Risk Register or the Assurance Framework.

6.3 **The Quality Committee** provides assurance to the Trust Board on clinical, corporate, information governance and compliance matters ensuring high quality care to patients. It will review the Board Assurance Framework and Corporate (Trust) Risk Register and ensure that risk management is on the governance agenda throughout the organisation. Key agenda items would include seeking assurance on the CQC regulatory outcomes and the preparation for the NHSLA risk management inspection; seeking assurance from within the organisation that patient safety was being managed effectively; and that effective processes are in place to manage and monitor hygiene/infection control and safeguarding.

6.4 **The Audit Committee** advises the Board upon the adequacy and effective operation of the Trust's overall system of internal control. The Audit Committee also monitors financial risk.

6.5 The Finance and Investment Committee
The Finance and Investment Committee has delegated authority from the Trust Board to consider the medium-term financial strategy and performance and this includes strategic financial risks.

6.6 The Clinical Quality Safety & Effectiveness Committee oversees the arrangements within the Trust for managing clinical safety and quality. This will include clinical governance and clinical risk, as well as reviewing evidence and outcomes and developing or improving clinical practice. It has particular responsibility for ensuring the provision of high quality clinical care within the LAS, and managing the risks associated with that. It works closely with the Risk Compliance and Assurance Group to ensure that the management of all significant risks is monitored through one or other of the committees. The committee will have delegated responsibility for a number of the CQC regulation outcomes.

6.7 The Risk Compliance and Assurance Group is responsible for the operation and monitoring of all risk management processes and activities within the Trust, and for ensuring that the objectives of the risk management policy and strategy are achieved. The RCAG will oversee the implementation of the Risk Assessment and Reporting Procedure (TP035) leading to the development of local risk registers supporting, and supported by, the corporate risk register and board assurance framework. The group will routinely review the corporate risk register and any proposed additions or deletions to this. The RCAG will also lead on the NHSLA risk management standards. The committee will have delegated responsibility for a number of the CQC regulation outcomes.

6.8 The Learning from Experience Group is responsible for the integrated review of incidents, complaints, and claims, in order to identify actual and emerging risk themes and to recommend changes to practice, and has a direct relationship with clinical audit and research. The committee will have delegated responsibility for a number of the CQC regulation outcomes.

6.9 Senior Management Group manages operational risk on behalf of the Trust Board and ensures that structures and management arrangements are in place together with systems and processes for monitoring and reviewing all forms of risk throughout the Trust.

7. Committees with Responsibility for Risk Management

Committee Name and Chair	Overview	Reports and provides Assurance to
Trust Board **Chair: Chair: Trust Chair (non-executive director)**	The Trust Board has corporate responsibility for the Trust's system of internal control and for robust risk management.	**NHS London Commissioners**
Quality Committee **Chair: Non-executive director**	Delegated by the Trust Board to provide assurance on clinical, corporate and information governance, compliance, risk and high quality patient care.	**Trust Board**
Audit Committee **Chair: Non-Executive Director**	Delegated by the Trust Board to review the operation of the risk management process and to oversee the system of internal control.	**Trust Board**
Finance and Investment Committee Chair: Trust Chair (non-executive director)	Delegated authority from the Trust Board to consider the medium-term financial strategy and performance including strategic financial risks.	**Trust Board**
Clinical Quality, Safety & Effectiveness Committee **Chair: Medical Director**	Delegated by the Quality Committee to oversee the arrangements within the Trust for managing clinical safety, quality and outcomes. This incorporates clinical risk and governance, and the review of evidence and outcomes to ensure the provision of high quality patient care.	**Quality Committee**
Risk Compliance and Assurance Group **Chair: Director of Finance**	Delegated by the Trust Board to take an overview of all risk management activities within the Trust.	**Quality Committee**
Learning from Experience Group **Chair: Director of Corporate Services**	To ensure that any necessary actions, arising from incidents, complaints, claims or concerns, are made for the benefit of patients, relatives and carers, and that any lessons arising are	**Quality Committee**

Committee Name and Chair	Overview	Reports and provides Assurance to
	disseminated for learning across the Trust.	
Senior Management Group **Chair: Chief Executive**	The SMG manages operational risk on behalf of the Trust Board and ensures that structures and management arrangements are in place together with systems and processes for monitoring and reviewing all forms of risk throughout the Trust.	**Trust Board**
Assistant Directors Group **Chair: Deputy Director of Operations or nominated senior manager**	The Assistant Directors Group has responsibility for monitoring the implementation of the action plans of Serious Incidents.	**Senior Management Group**
Corporate Health and Safety Group **Chair: Director of Human Resources and Organisation Development**	Responsible for the coordination and implementation of the Trust's Health and Safety Strategy	**Risk Compliance and Assurance Group**
Emergency Preparedness and Business Continuity Strategy Group **Chair: Deputy Director of Operations**	To determine, monitor and review the Trust's level of emergency preparedness and to ensure that the business continuity policy/plans are effectively reviewed, practiced and implemented.	**Risk Compliance and Assurance Group**
Safeguarding group **Chair: Director of Health Promotion & Quality**	To oversee and provide assurance on safeguarding arrangements for vulnerable children and adults.	**Clinical Quality, Safety & Effectiveness Committee**
Information Governance Group **Chair: Director of IM&T (SIRO)**	Provides a framework to combine the requirements, standards and best practice that apply to the handling of corporate and personal information.	**Risk Compliance and Assurance Group**

Committee Name and Chair	Overview	Reports and provides Assurance to
Area Governance Committees **Chairs: ADOs/PIMs**	To oversee and review, and provide assurance on, the operational arrangements for clinical quality, safety and risk management.	**Clinical Quality, Safety & Effectiveness Committee**
Patient & Public Involvement committee **Chair: Head of Patient and Public Involvement**	To oversee the effectiveness of PPI arrangements ensuring key messages are fed back through the risk and quality management processes.	**Learning from Experience Group**
Motor Risk Group **Chair: Director of Finance**	Review, monitor and report on all aspects of motor risk management.	**Risk Compliance and Assurance Group**
Training Strategy Group **Chair: Director of Human Resources & Organisational Development**	The management and development of clinical and educational governance within the Trust.	**Risk Compliance and Assurance Group**
Infection Control Steering Group **Chair: Director of Health Promotion**	Coordinates the development and implementation of infection prevention and control policy for the Trust.	**Clinical Quality, Safety & Effectiveness Committee**
Medicines Management Committee **Chair: Senior Clinical Advisor to the Medical Director**	Oversight of all aspects of any drug utilised by the Trust.	**Clinical Quality, Safety & Effectiveness Committee**
Clinical Audit and Research Steering Group **Chair: Medical Director**	To manage and progress both clinical audit and research and development within the Trust.	**Clinical Quality, Safety & Effectiveness Committee**

Committee Name and Chair	Overview	Reports and provides Assurance to
Clinical Equipment Group **Chair: Manager for Infection Prevention and Control**	The Clinical Equipment Group's prime purpose is to ensure that high quality patient care is being delivered by the Trust through effective use and management of clinical equipment.	**Clinical Quality, Safety & Effectiveness Committee**
Vehicle Equipment Working Group **Chair: Head of Operational Support**	The Vehicle Equipment Working Group's prime purpose is to develop and recommend to the Director of Operations a vehicle and equipment strategy for Emergency and Non Emergency services as well as Urgent Care Services.	**The Risk Compliance and Assurance Group**

8. Policy development

8.1 This policy and strategy will continue to be developed in line with the organisational and operational changes that take place within the Trust.

8.2 Work will be prioritised to ensure that proportionate action can be taken to direct appropriate levels of resource at controlling the risk or minimising the effect of potential loss.

8.3 The responsibility for the development of this document will reside with the Director of Corporate Services in conjunction with the Risk Compliance and Assurance Group. Any such developments will be taken in line with the direction set by the Trust Board and operational developments.

9. Key Objectives for Managing Risk

9.1 The Board, on an annual basis and through the relevant Committees, will ensure that a framework is in place that identifies risks associated with all its activities as an on-going process in the achievement of its strategic and operational objectives.

9.2 Risk Register

9.2.1 Core to this framework will be the provision and maintenance of a well founded risk register, maintained for all activities of the Trust. The business planning process will be used to identify key risks to the organisation and individual objectives will be set for all levels of staff to reflect this. The terms of reference of committees, project teams, area governance meetings, directorate meetings or working groups will include the provision of recording and notification of risks to ensure risks are captured at all levels within the organisation.

9.2.2 As a minimum requirement every two years, the Trust Board will undertake a review of the strategic risks facing the organisation, and will ensure that these are reflected in the Assurance Framework.

9.2.3 The risk register will be maintained on the Trust's risk reporting and management system in accordance with the Trust's Risk Assessment and Reporting Procedure (TP/035).

9.3 Risk Matrix

9.3.1 The LAS uses a risk matrix, based on the NPSA model, in its assessment of the severity of risks. The risk matrix will be reviewed annually (See Appendix 3).

9.4 Investigations

9.4.1 The purpose of the investigation of reported incidents, complaints, claims and systems is to ensure that individuals involved or the Trust as a whole can learn in a fair blame environment and thereby prevent recurrence. A key objective is therefore to ensure that all relevant employees receive appropriate training in the management of risk, including incident reporting and investigation.

9.5 Training

9.5.1 The development of learning for all levels of management is considered a key element to the management of risk and internal control. Core to this ethos will be the assessment of personal and organisational training requirements and the development of training systems to support these.

9.6 Reporting

9.6.1 The management of risks, mitigating actions and outcomes, and relevant learning from these, will be reporting on a quarterly basis through an integrated risk report.

9.6.2 As a minimum, the integrated risk report will include complaints, serious incidents, health and safety incidents, inquests and any Rule 43 Coroner reports, highlighting any trends or themes emerging that present a risk to the organisation if not mitigated and managed appropriately.

9.7 Measuring Risk Compliance

Method	Application	Performance Indicators	Monitoring	Independent Assessment
Care Quality Commission: Registration Requirements	Individual Directors accountable with lead responsibility delegated to key senior managers Performance managed through Board committees and the Board. Action plans feeding and linking into business plans (objectives) and risk register (assurance framework).	Robust assurance evidences compliance against Regulatory outcomes	Assurance from the **Quality Committee;** Compliance & action plans monitored by **RCAG, CQS&E and Learning from Experience.** Compliance monitored by Committee with updates at each meeting. Regular reports to the Trust Board **Senior management group (SMG)** Performance Accelerator	Internal Audit NHS London NHSLA Audit Commission
Risk Management Standards for Ambulance Services (NHSLA)	Individual Directors accountable with responsibility delegated to key senior managers. Actions required to meet relevant level of compliance.	Continuous improvement year on year.	Actions and compliance monitored by the **Quality Committee**, **the Risk Compliance and Assurance Group and the Assessment Steering Group** **SMG**	NHSLA assessment
Clinical Governance	Clinical Audit Plan.	Local and national clinical audits.	**Quality Committee**	CQC Internal Audit

Method	Application	Performance Indicators	Monitoring	Independent Assessment
	Clinical Performance Indicators Complaints and Serious Incidents JRCALC	PRF compliance audits against CPIs. Complaints audit	**Clinical Quality Safety & Effectiveness committee** **Clinical Audit and Research Group**	NHSLA
Risk Management Process	Applied on an ongoing basis through day to day working activities. Risks identified can be recorded onto the risk register. Working groups committees, business planning and project teams apply the risk management process and provide risk information to the relevant risk register.	Risks treated (i.e. reducing in risk level). Numbers of high and extreme risks.	Executive Directors Trust Board **Quality Committee** **Audit Committee** **RCAG** **CQS&E** **Information Governance Group** Individual project management groups Internal audit recommend-ations	Internal Audit HSE NHSLA
Information Governance	Senior Information Risk Owner (SIRO) and Director of Corporate Services accountable with responsibility delegated to key managers. Actions required to reach and	Number of Serious Information Incidents. IG Toolkit shows level of compliance.	Information Governance Group.	Connecting for Health and Internal Audit.

Method	Application	Performance Indicators	Monitoring	Independent Assessment
	aintain levels required by IG Toolkit.			
Internal Risk Assessment Process	The Senior Health, Safety and Risk Advisor and the Governance & Compliance team oversee an ongoing programme of formal risk assessment and reporting. Line managers carry out and/or request risk assessments. Controls in place via safe systems at work. Working groups, committees, business planning and project teams feed into the programme. Risks identified are placed on the relevant risk register.	Numbers, type and severity of patient safety incidents, serious incidents, staff accidents, complaints and claims. Progress against the Risk Assessment Programme. Examples of learning from incidents.	Trust Board Executive Directors **RCAG** **Corporate Health and Safety Group** Health and Safety Annual Report Annual patient experiences (complaints) report Quarterly integrated risk report	Internal Audit HSE NHSLA
Emergency Planning and Business Continuity	Major incident planning – in collaboration with other emergency services. Business continuity and internal disaster recovery planning.	Number of untoward incidents arising during a major incident or internal disaster. Compliance against emergency	Trust Board Executive Directors **Quality Committee** **RCAG** **Business Continuity &**	Internal Audit NHS London

Method	Application	Performance Indicators	Monitoring	Independent Assessment
	Testing of the above systems.	planning element of CQC standard. Benchmarking.	**Emergency Preparedness Group**	
Health and Safety Workplace Inspections	Carried out quarterly at each site to identify health and safety issues and hazards. Annual audit by the Safety and Risk Department. Outstanding issues are logged.	Number of premises inspected. Key issues identified (trends).	Executive Directors **RCAG** **Corporate Health and Safety Group**	Internal Audit Six Facet Appraisal Process

10. Implementation of Risk Management Policy and Strategy

10.1. The Trust recognises the value of the whole systems approach in preventing, analysing and learning from errors and will continually aim to implement the management of risk in a structured way. Risk registers are used to record and monitor risks at both a local and corporate level within the Trust. Interaction with the risk register occurs at all stages of the risk management process from risk identification, assessment, through to risk response development and monitoring.

10.2 The generic risk management process is detailed in the Trust's Risk Assessment and Reporting Procedure (TP035).

10.3 Owners of risks and further action will be identified on the Trust's Risk Reporting and Management System. Owners have responsibility to actively manage and prioritise risks in their areas, reviewing risk response actions and the critical risk areas wherever possible.

10.4 When risk owners cannot complete actions necessary to treat risks because they may not have the required level of authority, they need to escalate the risk to a higher level to ensure that the risk is allocated to the most appropriate person capable of handling. This process is set out in the Risk Assessment and Reporting Procedure (TP/035).

10.5 The level at which risks will be managed or assigned priorities for remedial action will be determined by the colour bandings and risk ratings as set out in the matrix below.

Risk Colour	Risk Level	Remedial Action	Decision to accept risk	Risk register level
Green 1 to 3	**Low**	Line Manager	Station/Department Manager	Area/ Department Manager
Yellow 4 to 6	**Moderate**	Station/Department Manager	Area/Department Manager	Assistant Director/ Head of Department
Orange 8 to 12	**Significant**	Assistant Director/ Head of Department	Director	Directorate/Senior Management Group
Red 15 to 25	**High**	Director	Senior Management Group	Trust Board

11. Learning

11.1 The Trust recognises that the proper management of risk is essential to the provision of quality health care within accepted standards of medical/professional care. It will also provide for safe delivery of this care to all who may be affected by the Trust activities, including the protection of its employees.

11.2 The Trust is committed to adopting:

- Unified mechanisms for reporting and analysis when things go wrong
- A more open "fair blame" culture, in which errors or service failures can be reported and discussed.
- Integrated risk reporting thereby identifying themes and trends that may indicate increasing levels of risk.
- Mechanisms for ensuring that, where lessons are identified, the necessary changes are put into practice.
- A much wider appreciation of the value of the system approach in preventing, analysing and learning from errors.

12. Acceptable Risk

12.1 The Trust recognises that it is impossible and not always desirable to eliminate all risks and that systems of controls should not be so rigid that they stifle innovation and imaginative use of limited resources in order to achieve health benefits. The Trust will continually aim to develop a system for identifying and categorising risks which clearly states under what circumstances and at what level the Trust would be willing to carry risk (risk tolerance). However, as a general principle the Trust will seek to eliminate and control all risks which have the potential to:

- harm its staff, patients, visitors and other stakeholders
- have a high potential for incidents to occur, would result in loss of public confidence in the Trust and/or its partner agencies
- have severe financial consequences which would prevent the Trust from carrying out its functions.

13. Monitoring Compliance with the Policy and Strategy

13.1 The Trust Board will receive regular performance reports in respect of all actions of risk considered high and significant until such actions reduce the level of risk below these levels. This reporting is undertaken by the Audit Committee and Quality Committee.

13.2 The Audit Committee will also receive reports from Internal Audit at each of its meetings and the Quality Committee will receive reports on a timely basis covering:

- incident reporting systems, including analysis and feedback
- complaints and PALS reporting systems, including analysis and feedback
- claims reporting systems, including analysis and feedback
- risk register / assessment reporting systems, including analysis and feedback
- compliance with CQC registration, NHSLA and other appropriate standards and audits
- risk management training initiatives
- sickness and absence statistics analysis
- clinical performance indicator checks
- number of road traffic collisions and cost of claims on vehicle damage.

13.3 The Clinical Quality, Safety & Effectiveness Committee and RCAG will help to provide central support and encourage the uptake of good practice. As the central points for the receipt of risk register information, they will compare the data and approaches being taken by individual groups for consistency across the organisation. They will keep the main risks under strategic review and share information on how to address these risks, as well as maintaining and disseminating up-to-date risk management guidance for managers and policy makers.

13.4 Trust committees will have a standing agenda item on risk, where the top risks from the corporate risk register will be discussed and escalated/communicated to the Board, as appropriate.

13.5 Changes in the Trust and the environment in which it operates will be identified and appropriate changes made to systems. Regular audits of policy and standards compliance will be carried out and standards of performance will be reviewed to identify opportunities for improvement. Any changes in guidance, best practice and legislation will be considered as the need arises and incorporated appropriately into the Risk Management Policy and Strategy, which will be reviewed every two years as a minimum and approved by the Trust Board.

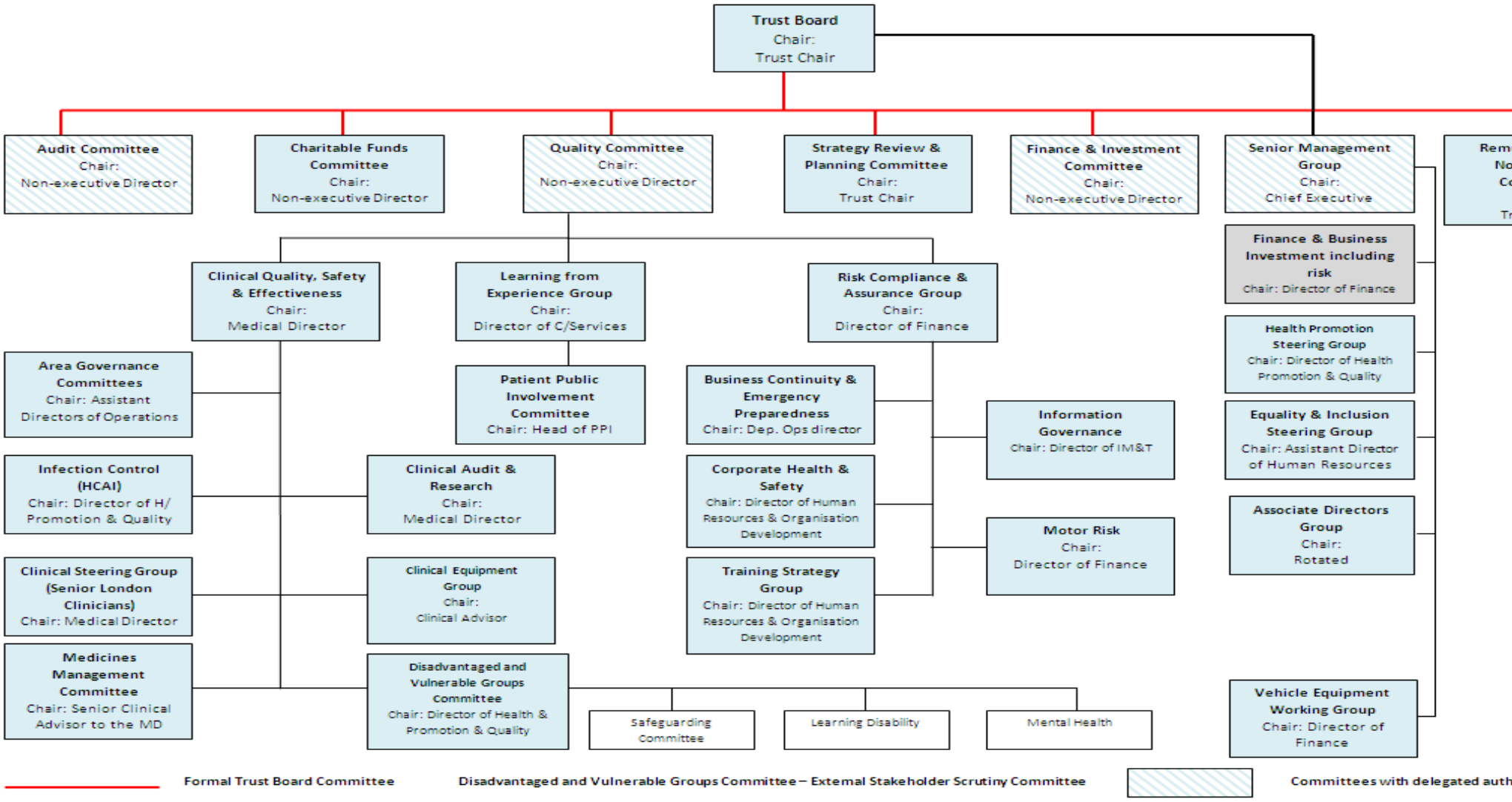
14. Standards/Key Performance Indicators

14.1 The content of this policy and strategy complies with best practice, NHS Litigation Authority and Department of Health requirements. Key Performance Indicators are used to monitor performance on a Trust-wide basis and follow the process as outlined in the Trust Policy for Organisational Learning and Improvement through Feedback, Complaints, Incidents and Claims (TP055).

Implementation Plan

IMPLEMENTATION PLAN	
Intended Audience	All LAS staff.
Dissemination	Available on Pulse to all staff and on the LAS Website for the public.
Communications	Revised policy to be announced in the RIB and a link to be provided to the document.
Training	Training will be provided to all relevant staff as part of the mandatory training programme.
Monitoring	This policy will be monitored through the Risk Compliance and Assurance Group (RCAG). The Group will receive regular reports and also directly review the Risk Register produced using the Trust's Risk Reporting and Management System. Trust compliance with the Policy will also be monitored on a regular basis by the Governance and Compliance department, who report to the RCAG via the Assistant Director, Corporate services. Directors/Managers/Staff will also be able to review and monitor compliance via the Trust's Risk Reporting and Management System. The Policy will also be reviewed annually by Internal Audit as part of their audit programme. The RCAG will also receive audit reports where they are relevant to their function. The Policy will also be monitored/reviewed by other external bodies, e.g., Audit Commission; CQC; NHSLA etc. All recommendations made to the Trust by external bodies and are reported as appropriate.

Governance Structure – October 2011



Appendix 2

Terms of Reference

A) Quality Committee

1. Authority

1.1 The Quality Committee is constituted as a Standing Committee of the Trust Board of Directors (the Board). Its constitution and terms of reference shall be set out below and subject to amendment when directed and agreed by the Board.

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

1.3 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of external representatives with relevant experience and expertise if it considers this necessary.

1.4 The Committee provides assurance to the Trust's Audit Committee on the effectiveness of the risk management framework.

2. Purpose

The primary focus of the Quality Committee will be to assure the Board on clinical, corporate, quality and information governance, and on compliance matters, leading to the provision of safe and effective services of the highest quality, within the framework of the Quality Strategy.

The Committee shall:

2.1 Be responsible for governance and risk management arrangements and processes, including risk strategy and policy development, and overseeing/being assured of implementation and effectiveness;

2.2 Oversee the systems and processes in place to ensure that the Trust's services deliver safe, high quality, patient-centred care;

2.3 Oversee the improvements to quality and safety within the framework of the Trust's Quality Strategy.

2.4 Review the Trust's performance against internal and external quality improvement targets and monitor action plans to address concerns;

2.5 Monitor the quality and safety aspects of the Cost Improvement Programme.

2.6 Oversee the Care Quality Commission registration process and the preparation for the NHSLA risk management standards assessment;

2.7 Seek assurance from the management team that effective management processes are in place for patient safety, hygiene/infection prevention and control, and safeguarding.

3. Quality and safety assurance

3.1 The Committee shall ensure that there are robust and effective mechanisms in place to manage and measure the quality and safety of services provided for patients.

3.2 To receive assurance on the ongoing compliance with the CQC's registration requirements for quality of services and the statutory requirements for infection prevention and control.

3.3 To receive reports on performance against quality initiatives commissioned by PCTs and to understand the risks in not meeting these.

3.4 To oversee and approve the development of the Trust's annual Quality Account.

3.5 To receive reports on outcomes and effectiveness of patient treatment, care and interventions with particular reference to clinical quality indicators.

3.6 To oversee the programme for patient involvement and experience and to seek assurance that this incorporates the CQC regulatory requirements and the development of the annual Quality Accounts.

4. Risk management

4.1 To seek assurance on the effectiveness of processes and systems for managing clinical, corporate, quality and information governance and risks.

4.2 To oversee the strategic assessment of organisational risk, and to review the corporate risk register and identify key strategic risks to the Trust and recommend action to alleviate or control such risks.

4.3 To oversee the risk management processes throughout the organisation including regular review of the corporate risk register and board assurance framework.

4.4 To hold senior managers to account for the effective implementation of risk assessments, action plans, risk registers and a culture of proactive risk and governance.

4.5 To oversee the assessment of compliance against the NHSLA Risk Management standards and the development and implementation of action plans to achieve this.

4.6 To annually review the Risk Management policy and strategy.

5. Monitoring and Reporting

5.1 To review the objectives and outcomes of each of the Clinical Quality, Safety & Effectiveness, Learning from Experience, and Risk Compliance and Assurance committees, to agree action plans and priorities for the coming year.

5.2 To receive regular reports from the Clinical Quality, Safety & Effectiveness, Learning from Experience, and Risk Compliance and Assurance committees.

5.3 To ensure that quality is a core part of Board meetings, both as a standing item and as a core element of key discussions and decisions.

5.4 To present the annual Quality Account to the Trust Board as the annual report on quality issues.

5.5 To report to external bodies (e.g. Monitor, Care Quality Commission, Health and Safety Executive, NHS London) in relation to risk as appropriate.

5.6 To be kept up to date on national and local policy changes relating to the management of risk.

5.7 To ensure there is a policy review programme in place and monitored and to review new or revised policies against this programme.

5.8 To review attendance records for statutory and mandatory training programmes.

5.9 To create, implement and monitor key performance indicators for risk management.

5.10 To complement the work of the Audit Committee and exchange information and reports on a regular basis.

5.11 To receive and review reports on Serious Incidents and associated action and outcomes from the Learning from Experience group.

5.12 To receive trend information on incidents, complaints and claims and other quality & safety data.

5.13 The Committee shall review the findings of other significant assurance functions, both internal and external to the Trust and consider the implications to the governance of the Trust. These will include but will not be limited to any reviews by the Care Quality Commission, NHS Litigation Authority, Health & Safety Executive or other regulators/inspectors etc; and professional bodies with responsibility for the performance of staff or functions (e.g. accreditation bodies etc).

5.14 The Quality Committee of the Trust is responsible for ensuring the Trust has effective risk management and governance systems and controls in place. The Director of Corporate Services (or another representative as authorised/delegated by the Chair of the Quality Committee) shall be the representative of the Quality Committee and the Audit Committee. In addition the Audit Committee receives minutes from the Quality Committee.

6 Membership

6.1 The Committee shall be appointed by the Board and shall comprise the four non-executive directors and the Chief Executive.

6.2 The chairmen of the following sub-committees will routinely attend the Quality Committee along with the Directors of Corporate Services, HR and Organisation Development, and Health Promotion and Quality:
- Clinical Safety, Quality and Effectiveness
- Learning from Experience
- Risk Compliance & Assurance.

6.3 All committee members shall have voting rights.

6.4 One non-executive director shall be appointed by the Board to be the Chair of the committee and, in their absence, another non-executive director shall chair the meeting.

6.5 At least one non-executive director shall be a full member of the Audit Committee.

6.6 The Director of Corporate Services shall act as the executive team's link between the Quality Committee and the Audit Committee.

6.7 Other senior managers should be invited to attend when the Committee is discussing areas of quality, safety and risk that are their responsibility.

6.8 At least once a year the appropriate Internal Auditor representative should attend the meeting.

6.9 Full membership shall be as follows:
Four non-executive directors
Chief Executive
Attending:
Medical Director & chair of Clinical safety, Quality & Effectiveness
Director of Corporate Services & chair of Learning from Experience
Director of Finance & chair of Risk Compliance & Assurance
Director of Human Resources and Organisation Development
Director of Health Promotion and Quality

6.10 As and when the LAS becomes an NHS foundation trust, an elected public governor will be invited to attend the meetings of the Quality Committee.

7 Accountability

The Quality Committee shall be accountable to the Board of Directors.

8 Responsibility

The Quality Committee is a formal sub-committee of the Board of Directors and has no executive powers other than those specifically delegated in these Terms of Reference.

9 Reporting

9.1 The minutes of the Quality Committee meetings shall be formally recorded by the Trust's Committee Secretary.

9.2 The approved minutes of every Quality Committee meeting will be submitted to the next meeting of the Trust Board and a written report will be given to the Trust Board by the Chair of the Committee. The emphasis of this will be to highlight the strategic

and corporate risks associated with items considered by the Quality Committee and provide assurance to the Trust Board relative to the mitigation. This report will be given to the Trust Board four to six times a year, depending on how often the Quality Committee meets throughout the year.

9.3 The Quality Committee will receive a report from each of its sub-committees (Clinical Quality, Safety and Effectiveness Committee, Learning from Experience Group and Risk Compliance and Assurance Group) at least four times a year. The reports will provide assurance on the areas covered within the terms of reference of the sub-committees and annual work programmes, including identifying areas of good practice and any gaps in assurance together with action being taken to address these.

9.4 The Chair of the Quality Committee shall draw the attention of the Board to any issues that require disclosure to the full Board or that require executive action;

9.5 The Quality Committee will annually monitor the effectiveness of the committee. A report will be prepared by the Chair and the Director of Health Promotion and Quality and submitted to the next meeting of the Audit Committee and then to the Trust Board, highlighting areas of good practice as well as any shortfall in assurance and the action to be taken to address this.

9.6 Responsibility for monitoring action to be taken rests with the Director of Health Promotion and Quality.

10 Administration

10.1 Secretarial support will be provided by the Trust's Committee Secretary and will include the agreement of the Agenda with the Chair of the Quality Committee and attendees and collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.

10.2 Agenda items shall be forwarded to the Committee Secretary six days before the date of the committee meeting.

10.3 The draft minutes and action points will be available to Committee members within 7 working days of the meeting.

10.4 Papers will be tabled at the discretion of the Chair of the Quality Committee.

11 Quorum

The quorate number of members shall be 50% non-executive directors and the Chief Executive or nominated senior executive to deputise in his absence.

12 Frequency

12.1 Meetings shall be held at least quarterly and initially bi-monthly.

12.2 The Chief Executive may request a meeting if they consider that one is necessary.

12.3 Committee members are required to attend at least 75% of the committee's meetings per financial year. Committee members' attendance will be recorded in the minutes of each meeting and reviewed at the end of each year to ensure that this requirement is met.

13 Terms of reference review

13.1 The Quality Committee will review these Terms of Reference annually.

13.2 The Chair or the nominated deputy shall ensure that these Terms of Reference are amended in light of any major changes in committee or Trust governance arrangements.

Terms of Reference
31st October 2011 (Chair's approval 01/11/11)

B) Audit Committee

1. Authority

- The Audit Committee is constituted as a Standing Committee of the Trust Board of Directors. Its constitution and terms of reference shall be set out below and subject to amendment when directed and agreed by the Board of Directors.
- The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.
- The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2. Purpose

The primary focus of the Audit Committee shall be the risks, controls and related assurances that underpin the achievement of the Trust's objectives.

- The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities;
- The Committee shall review the adequacy of risk and control related disclosure statements, in particular the Statement on Internal Control, Care Quality Commission regulations, Internal and External Audit reports, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
- The Committee shall review the adequacy of the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- The Committee shall review the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements; and
- The Committee shall review the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, within the context of the Board Assurance Framework, but will not be limited to these audit functions. It will also seek reports and assurances from the Quality and Finance & Investment Committees, and from directors and managers as appropriate, concentrating on the overarching systems of risk, controls and assurances, together with indicators of their effectiveness.

3. Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

- review and approval of the Internal Audit strategy, operational plan and a more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;

- consideration of the major findings of internal audit work (and management's response), ensuring co-ordination between the Internal and External Auditors to optimise audit resources;

- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;

- an annual review of the effectiveness of Internal Audit.

4. External Audit

The Committee shall review the work and findings of the External Auditor and consider the implications and management responses to their work. This will be achieved by:

- consideration of the performance of the External Auditor;

- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, the audit fee, and ensure coordination, as appropriate, with other External Auditors in the local health economy;

- discussion with the External Auditors of their local evaluation of audit risks;

- review of all External Audit reports, including agreement of the Annual Audit Letter before submission to the Board and any work carried outside the Annual Audit Plan, together with the appropriateness of management responses;

- discussion and agreement on the Trust's Statement on Internal Control.

5. Other Assurance Functions

The Audit Committee shall review other assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

- To review the effectiveness of the other committees in the management of risk and principally that of the Quality Committee and the Risk, Compliance and Assurance Group;
- To review the findings of any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc);
- In reviewing the work of the Quality Committee, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

6. Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. [1]

[1] From the NHS Audit Committee Handbook

7. Management[2]

- The committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
- The committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

8. Financial Reporting

The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the Statement on Internal Control;
- disclosures relevant to the Terms of Reference of the Audit Committee;
- changes in, and compliance with, accounting policies and practices;
- unadjusted mis-statements in the financial statements;
- significant judgments in preparation of the financial statements;
- significant adjustments resulting from the Audit;
- letter of representation; and
- qualitative aspects of financial reporting.

The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness, timeliness and accuracy of the information provided to the Board.

The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's performance.[3]

9. Membership

The Committee shall be appointed by the Board from amongst the Non-Executive directors of the Trust and shall consist of not less than three members, all of whom shall have voting rights.

One non-executive director member will be the Chair of the committee and, in their absence, another non-executive member will be nominated by the others present to deputise for the Chair.

The Director of Finance, Director of Corporate Services and the Director of Operations or their deputy should normally attend all Audit Committee meetings, with the Chief Executive invited to attend at least annually to discuss with the Audit Committee the process for assurance that supports the Statement on Internal Control.

[2] As above
[3] As above

The non-executive Chair of the Quality Committee should be invited to attend all Audit Committee meetings.

Other executive directors should be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that director.

The appropriate Internal and External Audit representatives and a Local Counter Fraud representative shall normally attend all meetings. At least once a year the Audit Committee should meet privately with the External and Internal Auditors.

10. Accountability

The Audit Committee shall be accountable to the Trust Board of Directors.

11. Responsibility

The Audit Committee is a non-executive committee of the Trust Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

12. Reporting

- The minutes of Audit Committee meetings shall be formally recorded by the Trust's Committee Secretary and the approved minutes submitted to the Trust Board;
- The Chair of the Audit Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Board or that require executive action;
- The Committee will report to the Board annually on its work in support of the Statement on Internal Control, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against the Care Quality Commission regulations and the processes behind the Quality Accounts.[4]

13. Administration

- Secretarial support will be provided by the Trust's Committee Secretary and will include the agreement of the Agenda with the Chair of the Audit Committee and attendees and collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward;
- The Agenda and papers will be distributed 5 working days before each meeting;
- The draft minutes and action points will be available to Committee members within 7 working days of the meeting;
- Members will ensure provision of agenda items, papers and update the commentary on action points at least 10 days prior to each meeting;
- Papers tabled will be at the discretion of the Chair of the Audit Committee.

14. Quorum

The quorate number of members shall be 2 which will include the following:

[4] The NHS Audit Committee handbook

- The Chair of the Audit Committee or the nominated deputy (who must also be a Non-Executive Director);
- In the absence of the Chair, committee members will nominate a deputy chair for the purposes of that meeting.

15. Frequency

- Meetings shall be held at least quarterly;
- The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

14. Review of Terms of Reference

- The Audit Committee will review these Terms of Reference at least annually from the date of agreement;
- The Chair or the nominated deputy shall ensure that these Terms of Reference are amended in light of any major changes in committee or Trust governance arrangements.

Terms of Reference
September 2011

C) Finance & Investment Committee

1. Authority

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

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

2. Purpose

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

3. Duties

3.1 Financial Policy, Management and Reporting

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

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

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

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

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

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

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

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

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

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

4. Investment Policy, Management and Reporting

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

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

5. Other

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

6. Membership

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

3 non-executive directors one of whom shall be a member of the Audit Committee and one a member of the Quality Committee;
Director of Finance (Executive director)
Director of Health Promotion and Quality
Deputy Director of Strategy
Director of Corporate Services
Director of Human Resources and Organisation Development (Executive director)
Deputy Director of Finance

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

7. Attendance

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

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

8. Accountability

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

8.2 The Senior Management Group will report on finance and investment issues to the Committee.

9. Reporting

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

10. Administration

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

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

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

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

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

11. Quorum

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

12. Frequency

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

13. Review of Terms of Reference

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

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

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

April 2011

D) Clinical Quality, Safety & Effectiveness Committee

1. Authority

1.1 The constitution and terms of reference for the Clinical Quality, Safety & Effectiveness Committee shall be set out below and subject to amendment when directed and agreed by the Quality Committee.

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

1.3 The Committee is authorised by the Quality Committee to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2. Purpose

2.1 The committee's prime purpose is to oversee the arrangements within the Trust for managing clinical safety and quality. This will include clinical governance and clinical risk, as well as reviewing evidence and outcomes and developing or improving clinical practice.

2.2 The committee will oversee the work of the clinical audit and research function ensuring that an audit programme is in place that supports the Trust's corporate objectives.

2.3 The area governance committees and those established for A&E support/Control, (and PTS) will report to this committee.

2.4 The agenda will routinely include a focus on a clinical issue/risk for discussion and recommendations for improving practice and this will be informed and led by the area committees.

2.5 The committee will also review compliance with the CQC registration requirements and relevant NHSLA risk management standards. Evidence of measured outcomes and changes to practice where required are key elements of both the CQC and NHSLA standards.

3. Objectives

3.1 The committee will collect and consider evidence which demonstrates that high quality, safe and effective care is being delivered throughout the London Ambulance Service NHS Trust. The committee will:

3.2 Oversee the clinical guidelines and protocols that members of staff are expected to follow during their working lives at LAS[5]. The Committee will consider any decision by the Medical Director, not to follow the JRCALC guidelines. This will be reported this to the Quality Committee, after reflecting on the alternative proposed by the Medical Director.

[5] NB: these are based principally on those published by the Joint Royal College Ambulance Liaison Committee (JRCALC)

3.3 Require evidence on an exceptional basis that procedures and protocols are reviewed and further training is given (where appropriate) in response to the reporting and investigation of clinical incidents and complaints.

3.4 Gain assurance from the committees accountable in all areas of clinical governance and risk demonstrating that high quality, safe and effective patient care is in place.

3.5 Ensuring that there is adherence to standards for good practice and making recommendations for remedial actions where necessary.

3.6 Work within the framework of the Care Quality Commission registration standards and the NHSLA risk management standards for ambulance trusts.

3.7 Work with the Learning from Experience and Risk Compliance & Assurance groups to ensure that all aspects of clinical governance are being managed, monitored and action taken to learn and improve.

3.8 Review integrated risk information reports (incidents, complaints, claims inquests, and PALs) and related trend analysis and identify action to be taken to improve and learn from these.

3.8 The Committee will review the risks associated with the LAS' clinical practice and will ensure that appropriate action plans have been put in hand to reduce the number of untoward clinical events.

3.9 Review the clinical risks on the corporate and overall risk register with a view to the controls and assurance in place and the action being taken to mitigate the risks.

3.10 Recommend changes to the risk register and risk severity gradings for referral to the RCAG.

3.11 Monitor the annual clinical audit programme and assessing the effectiveness of clinical intervention and practice.

3.12 Make recommendations for clinical audits to provide evidence of clinical practice, risks to this, and to monitor outcomes from changes to practice.

3.13 The Committee will review reports from the Clinical Audit and Research Steering Group to assure that day-to-day practice is evidence-based and is supported by research and development.

4. Membership and attendance

4.1 Membership of the committee is determined by the Senior Management Group and the Chair of the Committee.

4.2 The following core membership applies:

- Medical director (Chair of the committee)
- Deputy medical director (deputy chair)
- Assistant medical director
- Assistant directors of operations: Control/A&E, East, South, West
- Deputy director of operations
- Director of corporate services/assistant director
- Assistant director employee support services
- Head of patient experience (including safeguarding)
- Head of legal services
- Head of safety & risk
- Head of operational support
- Infection prevention & control manager

- Head of PTS Modernisation & Performance
- Head of CARU
- Governance & compliance manager
- Head of Education
- Director of Health Promotion & Quality
- Senior clinical advisor
- Non-executive director (observer status)
- LAS patient forum representative (observer status).

4.3 The members listed above are expected to attend every meeting or send a formally nominated deputy.

4.4 Other representatives may be invited to attend as relevant to the agenda and work programme.

4.5 Other agencies representatives will be asked to attend annually, including but not exclusively:
- HEMS
- Voluntary Aid Societies
- NHS Direct
- Community First Responder scheme.

5. Accountability

5.1 The committee reports to the Quality Committee which is a board committee.

5.2 The reporting structure is attached (Appendix 1).

6. Reporting

6.1 The minutes of the Clinical Quality, Safety & Effectiveness Committee meetings shall be formally recorded by the Trust's Committee Secretary.

6.2 The approved minutes of each Clinical Quality, Safety and Effectiveness Committee will be submitted to the next meeting of the Quality Committee together with a written report providing assurance on the areas covered within their terms of reference and annual work programmes, including identifying areas of good practice and any gaps in assurance together with action being taken to address these. This report will be submitted to the Quality Committee four times a year.

6.3 The Chair of the Clinical Quality, Safety & Effectiveness Committee shall draw the attention of the Quality Committee to any issues that require disclosure to the full Trust Board.

6.4 The Clinical Quality, Safety & Effectiveness Committee shall receive reports from the following groups:

- Area governance committees (four times a year)
- Infection control committee
- Safeguarding group
- Medicines management group (four times a year)
- Clinical audit & research group (at least twice a year)

6.5 The minutes and papers from the Clinical steering group of the senior London clinicians will be made available and key issues discussed.

6.6 Recommendations and feedback shall be made to these groups as appropriate. Responsibility for monitoring action taken rests with the Chair of the Clinical Quality, Safety and Effectiveness Committee.

7. Administration

7.1 Secretarial support shall be provided by the Trust's Committee Secretary and shall include the agreement of the agenda with the Chair of the Clinical Quality, Safety & Effectiveness Committee and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.

7.2 Agenda items shall be forwarded to the Committee Secretary six days before the date of the committee meeting.

7.3 The draft minutes and action points shall be available to Committee members within 7 working days of the meeting.

7.4 Papers shall be tabled at the discretion of the Chair of the Clinical Quality, Safety & Effectiveness Committee.

8. Quorum

8.1 The quorum shall be:

- Medical director or nominated deputy;
- At least two out of the 4 ADOs
- Director of corporate services or nominated deputy
- 30% of the remaining members.

8.2 Committee members' attendance will be recorded in the minutes of each meeting and reviewed at the end of the year to ensure that this requirement is met.

4 Frequency of meetings

9.1 The Clinical Quality, Safety & Effectiveness committee shall meet every two months and this will be scheduled at least one week prior to the Quality Committee.

9.2 The Chair of the committee or the Director of Corporate Services may request a meeting outside of these times if required.

10. Review of Terms of Reference

10.1 The Clinical Quality, Safety & Effectiveness committee shall review these Terms of Reference in six months time in the 1st year of operation and then annually thereafter.

10.2 The Chair or the nominated deputy shall ensure that these Terms of Reference are amended in light of any major changes in committee or Trust governance arrangements.

E) Learning from Experience Group

1 Authority

1.1 The Learning from Experience Group constitution and terms of reference shall be set out below and subject to amendment when directed and agreed by the Quality Committee.

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

1.3 The Group is authorised by the Quality Committee to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2 Purpose

2.1 The primary focus of the Learning from Experience group will be the integrated review of incidents including SUIs, PALs enquiries, complaints and claims, in order to identify actual and emerging risk themes and to recommend changes to practice and for ensuring that the objectives of the Learning from Untoward Incidents, PALs, Claims and Complaints Policy (TP055) are achieved.

2.2 Oversee the arrangements for investigation and action planning on incidents, claims and complaints.

2.3 Ensure that following investigations and serious case reviews, action plans to address root causes are drawn up and their implementation monitored and reported to the Quality Committee.

2.4 Ensuring arrangements for improvement in practice following serious incidents is implemented and evaluated.

2.5 Oversee and monitor arrangements for the dissemination of learning within the organisation and where appropriate, across the ambulance service network.

3 Objectives

3.1 Examine emerging themes and issues of significance from incidents including SUIs, complaints, claims, and PALs as a mechanism for service user and stakeholder feedback.

3.2 Seek assurance of action taken on, and implementation of, themes and issues and the lessons learnt and improvements made.

3.3 Seek assurance on the effectiveness and outcomes of lessons, improvements and changes to practice.

3.4 Consider ways of involving and engaging patients and the public in learning from issues and assessing the effectiveness of outcomes and improvements made.

3.5 Make recommendations to the Risk, Compliance and Assurance Group on any new risks emerging, or changes to existing risks.

3.6 Make recommendations to the Clinical Quality, Safety and Effectiveness Committee on action, monitoring or assurance required on emerging themes and risks.

3.7 Provide assurance to the Quality Committee.

3.8 Oversee the implementation and review of the following policies:

- Learning from Untoward Incidents, Claims and Complaints
- Investigating incidents, claims and complaints
- Complaints and user feedback policy
- Being Open.

4 Membership and attendance

4.1 The Learning from Experience Group shall comprise:

- Director of Corporate Services (Chair)
- Assistant Director, Corporate Services (Deputy Chair)
- Director of Health Promotion & Quality[6]
- Head of Patient Experience
- Head of Legal Services
- Senior Health, Safety and Risk Advisor
- Head of Patient & Public Involvement
- Deputy Director of Operations
- Assistant Medical Director
- Assistant Director, Employee Relations
- Assistant Director, Professional Education & Development
- Audit and Compliance Manager
- LAS Patient Forum representative.

Other members of staff may be required to attend for specific agenda items.

5 Accountability

5.1 The Learning from Experience Group shall be accountable to the Quality Committee.

6 Reporting

6.1 The minutes of the Learning from Experience Group meetings shall be formally recorded by the Trust's Committee Secretary.

6.2 The approved minutes of each Learning from Experience Group meeting will be submitted to the next meeting of the Quality Committee together with a written report providing assurance on the areas covered within their terms of reference and annual work programmes, including identifying areas of good practice and any gaps in assurance together with action being taken to address these This report will be given to the Quality Committee four times a year.

[6] Appointed to the committee in-year

6.3 The Learning from Experience Group shall receive reports from the Patient and Public Involvement Committee four times a year.

6.4 The Chair of the Learning from Experience Group shall draw the attention of the Quality Committee to any issues that require disclosure to the full Trust Board.

6.5 Recommendations and feedback shall be made to this group as appropriate. Responsibility for monitoring action to be taken rests with the Chair of the Learning from Experience Group.

7 Administration

7.1 Secretarial support shall be provided by the Trust's Committee Secretary and shall include the agreement of the agenda with the Chair of the Learning from Experience Group and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.

7.2 Agenda items shall be forwarded to the Committee Secretary six days before the date of the committee meeting.

7.3 The draft minutes and action points shall be made available to Committee members within seven working days of the meeting.

7.4 Papers shall be tabled at the discretion of the Chair of the Learning from Experience Group.

8 Quorum

8.1 The quorum shall be the Chair or Deputy Chair, and two other members. Learning from Experience Group members' attendance will be recorded in the minutes of each meeting and reviewed at the end of the year to ensure that this requirement is met.

9 Frequency of meetings

9.1 The Learning from Experience Group shall meet quarterly before the Senior Management Group and the Quality Committee.

9.2 The Director of Corporate Services may request an additional meeting if they consider that one is necessary.

10 Review of Terms of Reference

10.1 The Learning for Experience Group shall review these Terms of Reference annually.

10.2 The Chair or the nominated deputy shall ensure that these Terms of Reference are amended in light of any major changes in committee or Trust governance arrangements.

Terms of reference
12th November 2010

F) Risk Compliance and Assurance Group

1. Authority

1.1 The Risk Compliance and Assurance Group constitution and terms of reference shall be set out below and subject to amendment when directed and agreed by Quality Committee.

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

1.3 The Group is authorised by the Quality Committee to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2. Purpose

2.1 The committee's prime purpose is to oversee the operation and monitoring of all risk management processes and activities within the Trust, and for ensuring that the objectives of the Risk Management Policy and Strategy are achieved.

2.2 The Risk Compliance and Assurance Group is responsible for the provision of a systematic and focussed approach to the management of all foreseeable risks within the Trust.

2.3 The Committee will manage and routinely review the Assurance Framework ensuring that assurance and controls are up to date and appropriate to manage and minimise the risks to the Trust.

2.4 The RCAG will oversee the implementation of the risk register procedure leading to the development of local risk registers supporting, and supported by, the corporate risk register and board assurance framework.

2.5 The group will routinely review the corporate risk register and any proposed additions or deletions to this.

2.6 The RCAG will lead on the NHSLA risk management standards and Care Quality Commission requirements specified in attachment A.

2.7 The RCAG will oversee claims management and will monitor and review the Trust's exposure to litigation, ensuring there are effective processes in place for organisation and individual learning resulting from claims.

3. Responsibility

3.1 To review the Corporate Risk Register and Board Assurance Framework as a standing item;

3.2 To manage the trust-wide risk assessment exercise and make recommendations for changes to the corporate and trust-wide risk registers.

3.3 To agree the grading of risks before accepting them onto the Trust-wide risk register and onto the Corporate Risk Register (those scoring >15);

3.4 To ensure that action plans in place to reduce the likelihood and impact of risks;

3.5 To receive an annual progress report on trust-wide risk management arrangements;

3.6 To provide advice concerning the effectiveness of the risk management arrangements throughout the Trust, to the Quality and Audit Committees and the Trust Board;

3.7 To oversee the work programme necessary to achieve compliance with the NHSLA Risk Management Standards for ambulance trusts and to take a specific lead on those standards under the responsibility of the RCAG;

3.8 To monitor the implementation of the Risk Management Framework;

3.9 To receive a report on the effectiveness of training courses and management arrangements relating to clinical and non-clinical risk management as set out in the NHSLA Training Needs Analysis;

3.10 To receive a report on the level of manual handling, incidents and claims;

3.11 To ensure that external communication and consultation takes place with other NHS Ambulance trusts to promote sharing of good practice and lessons learned from effective risk management.

4. Membership

4.1 The Risk Compliance and Assurance Group shall comprise:

- Director of Finance (Chair)
- Chief Executive
- Deputy Chief Executive
- Director of Operations
- Director of Human Resources & Organisational Development
- Director of Information Management and Technology
- Medical Director
- Director of Health Promotion and Quality
- Director of Corporate Services
- Assistant director of corporate services
- Head of Emergency Preparedness
- Governance & compliance manager
- Audit & compliance manager.

4.2 The following members may be required to attend for specific agenda items:

- Medical director
- Head of legal services
- Head of patient experiences
- Head of safety & risk.

5. Accountability

5.1 The Risk Compliance and Assurance Group shall be accountable to the Quality Committee.

6. Reporting

6.1 The minutes of the Risk Compliance and Assurance Group meetings shall be formally recorded by the Trust's Committee Secretary.

6.2 The approved minutes of each Risk, Compliance and Assurance Group meeting will be submitted to the next meeting of the Quality Committee together with a written report providing assurance on the areas covered within their terms of reference and annual work programmes, including identifying areas of good practice and any gaps in assurance together with action being taken to address these. This report will be submitted to the Quality Committee four times a year.

6.3 The Chair of the Risk Compliance and Assurance Group shall draw the attention of the Quality Committee to any issues that require disclosure to the full Trust Board.

6.4 The Risk Compliance and Assurance Group shall receive regular reports from the following groups:

- Business Continuity and Emergency Preparedness
- Corporate Health and Safety
- Information Governance, Data and Quality Assurance
- Training Strategy Group
- Motor Risk Group.

6.5 Recommendations and feedback shall be made to these groups as appropriate. Responsibility for monitoring action to be taken rests with the Chair of the Risk, Compliance and Assurance Group.

7. Administration

7.1 Secretarial support shall be provided by the Trust's Committee Secretary and shall include the agreement of the agenda with the Chair of the RCAG and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.

7.2 Agenda items shall be forwarded to the Committee Secretary six days before the date of the committee meeting.

7.3 The draft minutes and action points shall be available to Committee members within 7 working days of the meeting.

7.4 Papers shall be tabled at the discretion of the Chair of the RCAG.

8. Quorum

8.1 The quorum for this group shall be one Executive Director and four Directors. Members' attendance will be recorded in the minutes of each meeting and reviewed at the end of the year to ensure that this requirement is met.

9. Frequency

9.1 The Risk Compliance and Assurance Group shall meet quarterly before the Senior Management Group and the Quality Committee.

9.2 The Director of Finance, the Chief Executive, or the Director of Corporate Services may request a meeting if they consider that one is necessary.

10. Review of Terms of Reference

10.1 The Risk Compliance and Assurance Group shall review these Terms of Reference annually.

10.2 The Chair or the nominated deputy shall ensure that these Terms of Reference are amended in light of any major changes in committee or Trust governance arrangements.

November 2010

G) Senior Management Group

1. Authority

1.1 The terms of reference of the Senior Management Group shall be set out below and subject to amendment when directed and agreed by the Trust Board.

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

1.3 The Senior Management Group is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2. Purpose

2.1 The purpose of the Senior Management Group is to manage the performance of the Trust within the strategic framework established by the Trust Board. This arrangement forms part of the overall Board Assurance Framework. The Senior Management Group shall advise the Trust Board on key policy and service issues and recommend policy proposals for Trust Board decision. The Senior Management Group is an Executive Team meeting and shall work within the parameters of the direction set through this team and the Trust Board.

3. Responsibility

3.1 To deliver the Integrated Business Plan as part of the Trust's strategy and to ensure the corporate and SMART objectives are achieved;

3.2 To recommend the Trust's annual business plan to the Trust Board, and manage its implementation and delivery;

3.3 To manage the performance of the Trust against its targets and other key deliverables;

3.4 To oversee the financial performance of the Trust and agree any actions to improve the Trust's position and mitigate risks of delivery, including monitoring the potential impact of the LTFM downside scenarios, associated risks and plans for mitigation;

3.5 To manage the delivery of actions to prevent and mitigate risk, focussing on high risk issues and those with immediate service quality, operational or governance implications;

3.6 To monitor progress against the corporate risk register and board assurance framework and referring any new or updated risks to the Risk Compliance and Assurance Group as appropriate;

3.7 To manage the Cost Improvement Programme;

3.8 To approve and ratify Trust policies and procedures and make recommendations to the Trust Board on policy direction and implementation plans, which enable the Trust Board to fulfill its corporate responsibilities;

3.9 To use the weekly diary meeting as an extended and formal SMG meeting at least once per month for key discussion and decision-making;

3.10 To delegate key business items to the Associate Directors' Group for action and reporting back;

3.11 To establish working groups to take forward the business of the Trust;

3.12 To oversee and contribute to other committees across the Trust;

3.13 To receive reports from and to support the Trust's Groups/Committees;

3.14 To oversee and contribute to communications and briefings across the Trust;

3.15 To support and advise the Chief Executive in his role as accountable officer.

4. Membership

4.1 The Senior Management Group membership shall comprise:

Chief Executive (chair)
Chief Operating Officer[7]
Director of Finance
Director of Human Resources and Organisation Development
Medical Director
Director of Health Promotion & Quality
Director of Information Management and Technology
Head of Communications
Director of Corporate Services
Deputy Director of Strategic Development
Chair of the Associate Directors' Group

4.2 Additional members of staff may be called to attend the Senior Management Group according to the agenda.

5. Accountability

5.1 The Senior Management Group shall be accountable to the Trust Board through the Chief Executive.

6. Reporting

6.1 The minutes of Senior Management Group meetings (including formal diary meetings) shall be formally recorded by the Trust's Committee Secretary;

6.2 The Chair of the Senior Management Group shall draw to the attention of the Trust Board any issues that require disclosure to the full Board or that require executive action;

6.3 The approved minutes of the Senior Management Group will be held by the Committee Secretary and will be available to any member of the Trust Board on request;

[7] Updated December 2011

6.4 The Trust Board will ask for an annual report on the effectiveness of the Senior Management Group. This report will be prepared by the Chief Executive and the Director of Corporate Services and agreed by members of the committee before being submitted to the Trust Board. This will highlight any areas of good practice as well as any shortfall in assurance and the action to be taken to address this;

6.5 Responsibility for monitoring action to be taken rests with the Director of Corporate Services and the Committee Secretary.

7. Administration

7.1 Secretarial support shall be provided by the Trust's Committee Secretary and shall include the agreement of the agenda with the Chair of the Senior Management Group and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward;

7.2 Agenda items shall be forwarded to the Committee Secretary six days before the date of the Senior Management Group meeting and papers will be sent out by close of play on the Friday before the next meeting;

7.3 The draft minutes and action points shall be available to Senior Management Group members within 7 working days of the meeting.

7.4 Papers shall be tabled at the discretion of the Chair of the Senior Management Group.

8. Quorum

8.1 The Senior Management Group quorum shall be five members of those entitled to attend (or deputy), a nominated director shall chair in the absence of the CEO.

9. Attendance

9.1 Members will be required to attend a minimum of ten meetings per annum unless otherwise agreed with the Chief Executive.

9.2 Deputies or representatives may attend in the absence of the SMG member but this must be agreed with the Chief Executive in advance.

10. Frequency

10.1 The Senior Management Group shall meet on a monthly basis, with a weekly diary meeting to complete outstanding work and additional business.

11. Review of Terms of Reference

11.1 The Senior Management Group shall review these Terms of Reference annually from the date of agreement.

5th August 2011
Approved October 2011

Appendix 3

RISK MATRIX

Table 1 Impact Score

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Impact score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood Score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood Score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency	Not expected to occur annually.	Expected to occur at least annually.	Expected to occur at least every 6 months.	Expected to occur at least monthly.	Expected to occur at least weekly.
Probability	< 1%	1-5%	6-25%	25-60%	>60%
	Will only occur in exceptional circumstances.	Unlikely to occur.	Reasonable chance of occurring.	Likely to occur.	More likely to occur than not.

Some organisations may want to use probability for scoring likelihood, especially for specific areas of risk which are time limited. For a detailed discussion about frequency and probability see the guidance notes.

Table 3 Risk Score = Impact x Likelihood (I x L)

	Likelihood Score				
Impact Score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

	1-3	Low risk
	4-6	Moderate risk
	8-12	Significant risk
	15-25	High risk

Instructions for Use

1. Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.
2. Use Table 1 to determine the impact score (I) for the potential adverse outcome(s) relevant to the risk being evaluated.
3. Use Table 2 to determine the likelihood score (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.
4. Use Table 3 to calculate: I (Impact) x L (Likelihood) = R (risk score)
5. Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 24TH JANUARY 2012

PAPER FOR NOTING

Document Title:	**Corporate risk register and Board Assurance Framework**
Report Author(s):	**Sandra Adams/Frances Wood/Jasjit Dhaliwal**
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 practice – the Board should routinely review and discuss the key corporate risks and the assurance framework**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ 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:	**To take assurance from the updates to the board assurance framework and corporate risk register that risks are being identified, assessed, and action taken to mitigate and reduce wherever possible**

Executive Summary

The risk register and board assurance framework are dynamic documents and are intended to provide assurance to the Trust Board that controls are in place to manage, mitigate and reduce risks facing the organisation. The register is reviewed and managed by the Risk Compliance and Assurance Group, reporting to the Quality Committee. The RCAG reviewed both documents on 9th January 2012 and the register and BAF have been updated accordingly.

The Trust Board reviews the assurance framework and risk register documents quarterly and should be able to take assurance from the movement across the risk register and the assurance framework on how risks are being managed, mitigated and reduced. Section C of the BAF identifies the key sources of assurance and has been updated from the previous quarter. It now includes the Finance & Investment committee.

As this is the report for Quarter 3 2011/12 the final column in the BAF has been updated to reflect the likely year end position for each of the risks against their target rating. Risks 327 (re-use of linen) and 22 (clinical assessment of patients not conveyed) appear, based on progress against the actions described on the corporate risk register, to be on target. The remaining 3 risks look likely to remain at their current high level.

The Trust Board will need to review the strategic risks in the 1st quarter of 2012/13 and the RCAG and Quality Committee may wish to review those risks that have been presented via the register for a number of years to determine whether these now represent business as usual. This will be factored into the forward planners for those committees.

Highlighted text in the BAF indicates new or updated information since September 2011.

Attachments
Corporate risk register – 28th December 2011 (updated January 2012)
Board Assurance Framework – January 2012

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Strategic Goals 2010 – 13
This paper supports the achievement of the following corporate objectives:

☒ To have staff who are skilled, confident, motivated and feel valued and work in a safe environment
☒ To improve our delivery of safe and high quality patient care using all available pathways
☒ To be efficient and productive in delivering our commitments and to continually improve

Risk Implications
This paper supports the mitigation of 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

NHS Constitution
This paper supports the following principles that guide the NHS:

☒ 1. The NHS provides a comprehensive service, available to all
☒ 2. Access to NHS services is based on clinical need, not an individual's ability to pay
☒ 3. The NHS aspires to the highest standards of excellence and professionalism
☒ 4. NHS services must reflect the needs and preferences of patients, their families and their carers
☒ 5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
☒ 6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
☒ 7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

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

Key issues from the assessment:

Board assurance framework
January 2012

The Board Assurance Framework (BAF) comprises the principal risks facing the Trust in 2011/12 and looking ahead within the strategic period 2011-16 thereby mirroring the integrated business plan. The BAF is structured as follows:
Section A: Trust Vision – strategic goals – corporate objectives – strategic risks
Section B: The key risks identified by the Trust Board for focus
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, and have been assessed with a net rating of, High/ >15 as at 28th December 2011. Amended risks and those new to the BAF this quarter are highlighted.

It should be noted that Risk 334 – that the implementation of CommandPoint will lead to a short-term reduction in performance targets has been accepted at its current level and the year end rating has changed to Red/High.

As this is the BAF for Quarter 3 2011/12, an assessment has been made of the likely year end position based on progress against mitigating actions described in the risk register. At this stage risks 327 (re-use of linen) and 22 (clinical assessment for patients not conveyed) appear to be on target.

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.

Sandra Adams 17th January 2012

Board assurance framework
January 2012

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 improve our delivery of safe and high quality patient care using all available pathways**
Strategic Goal 2	**To have staff who are skilled, confident, motivated and feel valued and 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 2010-2015.

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
	To provide more appropriate care for patients with less serious illness and injuries	CO2	1
	To meet response time targets routinely	CO3	1 & 2
	To meet all other regulatory and performance targets	CO4	2
Deliver care with a highly skilled and representative workforce	To develop staff so they have the skills and confidence they need to do their job	CO5	1
	To improve the diversity of our workforce	CO6	All

Board assurance framework
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Strategic Goal	Key Corporate Objectives	Abbrev.	Strategic risk
	To create a productive and supportive working environment where staff feel safe, valued and influential	CO7	1
Deliver value for money	To use resources more efficiently and effectively	CO8	3
	To maintain service performance during major events, both planned and unplanned, including the 2012 Games	CO9	1 & 2
	To improve engagement with key stakeholders	CO10	4

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During 2009/10 the Trust Board reviewed the strategic risks facing the London Ambulance Service NHS Trust with a further update in early 2010/11. These are shown below together with the key causes and the likelihood of the risk occurring. These are then mapped to the risk focus (Section B) and the mitigating actions which are reflected within the integrated business plan.

Strategic Risk	Causes	Likelihood of risk occurring	Risk focus	Mitigating actions
1. There is a risk that we fail to effectively fulfill care and safety responsibilities	Clinical training and development for frontline staff; failure of infrastructure such as fleet or equipment; compromising safety in our efforts to achieve performance targets	Unlikely to occur	Clinical effectiveness Key clinical skills training	Implementation of the clinical training and development strategy; adoption of reflective practice; Use of clinical performance indicators and benchmarking Fleet strategy New ways of working programme roll-out Electronic patient report form

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Strategic Risk	Causes	Likelihood of risk occurring	Risk focus	Mitigating actions
2. There is a risk that we cannot maintain and deliver the core service along with the performance expected	Funding levels within the local health economy and a focus on 'more for less'; continued increase in demand and expectations for the service; lack of capacity within the healthcare system.	Possible	Demand management Performance delivered against trajectories	Strong cost improvement programme and focus on gaining efficiencies and driving up productivity Clinical response model Partnership working within the local health economy to manage capacity and direct responses accordingly – Coordinating Healthcare in London Service Development Plan Implementation of the demand management plan CommandPoint implementation

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Strategic Risk	Causes	Likelihood of risk occurring	Risk focus	Mitigating actions
3. There is a risk that we are unable to match financial resources with priorities	Funding levels within the local health economy; an over-ambitious transformation plan across London – too many priorities	Possible	Cost improvement programme Key performance indicators	Clearly articulated strategic direction with planned developments across three-five years and using foundation trust freedoms to support these Strong cost improvement programme and focus on gaining efficiencies and driving up productivity Implementation of the estates strategy and clinical response model

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Strategic Risk	Causes	Likelihood of risk occurring	Risk focus	Mitigating actions
4. There is a risk that our strategic direction and the pace of innovation to achieve this are compromised	Lack of certainty within the local health economy on strategic direction or the transformation programme; we are unable to clearly articulate a strategy; management focus on delivering day to day performance; lack of space to release staff from core duties to undertake training and development/to transform the workforce.	Unlikely	Clinical response model Single point of access Health policy	Clearly articulated strategic direction with planned developments across three to five years Implementation of the clinical response model Implementation of stakeholder perceptions audit action plan Ensure that partnerships within London's health economy (LHE) are maintained to support the development of appropriate clinical pathways and utilisation of the LHE

Section B: Risk focus areas

Strategic Risks	Trust Board Risk Focus	Lead	Linked Risks
1) CARE AND SAFETY **There is a risk that we fail to effectively fulfil care/safety responsibilities**	A] CLINICAL EFFECTIVENESS The overall performance rating of an NHS trust is made up of a number of performance indicators, clinical audit, how we collect information and outcomes. (eg: 1:20 PRF checks, completion of paperwork and quality of clinical treatment, following protocols, non-conveyance, etc)	RICHARD WEBBER	Risk ID: **22** There is a risk that failure to undertake comprehensive clinical assessments may result in the inappropriate non-conveyance or treatment of patients. (See Board Assurance Framework section D)
2) CORE SERVICE DELIVERY AND PERFORMANCE **There is a risk that we cannot maintain and deliver the core service along with the performance expected**	A] DEMAND MANAGEMENT Utilising resources appropriately in relation to demand to ensure patients consistently get the right response (eg pressures include; unknown service charges, increased calls, major events, etc) [may need to engage in capacity review]	RICHARD WEBBER	Risk ID: **265** Service performance may be adversely affected by the inability to match resources to demand. (See Board Assurance Framework section D)
	B] PERFORMANCE DELIVERED AGAINST TRAJECTORIES Trajectories and standards help us identify where we are on track to deliver – connects policy goals with operations and tells us if we are succeeding	RICHARD WEBBER	Risk ID: **317** There is a risk that the Trust may not achieve its Category A target in 2011/11.

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Strategic Risks	Trust Board Risk Focus	Lead	Linked Risks
3) FINANCIAL RESOURCES **There is a risk that we are unable to match financial resources with priorities**	A] COST IMPROVEMENT PROGRAMME (CIP) Programme for containing and reducing costs without negatively impacting on performance.	MICHAEL DINAN	Risk ID: **272** There is a risk that the LAS may not achieve the full CIP.
	B] KEY PERFORMANCE INDICATORS (KPIs) Potential penalties that could be imposed on the trust if failure to meet the targets as agreed.	MICHAEL DINAN	Risk ID: **329** There is a risk that as a result of the non-achievement of the KPIs, contractual financial penalties will be levied on the Trust.
4) STRATEGIC DIRECTION **There is a risk that our strategic direction and the pace of innovation to achieve this are compromised**	A] CLINICAL RESPONSE MODEL As a primary response to a large majority of 999 calls, paramedics will carry out face to face patient assessments, to utilise the appropriate patient pathways and identify the most appropriate method of transport.	CARON HITCHEN	Risk ID: **337** There is a risk that there will be a delay in establishing the CRM due to changes that need to be made to interfacing other projects (CommandPoint/CTAK) Gross rating 16 Net rating 16 Target rating 1: Added to corporate register

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Strategic Risks	Trust Board Risk Focus	Lead	Linked Risks
	B] SINGLE POINT OF ACCESS The aim of the SPA is to; provide a proactive, timely response to triage and manage new referrals, provide an urgent assessment for people who need a same day response, manage referrals from GPs, hold up to date capacity information of the availability for community services, be the central point to collect information and monitor referrals.	LIZZY BOVILL	Risk ID to be confirmed. Rating given as 9 = moderate 3 x possible 3. There is a risk that, with the GP Consortia and reconfiguration of the SHA and PCTs, there will be a temporary reduction in stakeholder engagement and partnership working whilst these new organisations are established. This may lead to a temporary loss of drive to deliver demonstrable change in the urgent and emergency system.
	C] HEALTH POLICY We use the NHS operating framework (these priorities are also further emphasised within the commissioning intentions) as our main publications for informing our health priorities. The priorities for us within the operating framework are: - autism, dementia, support for carers, ambulance indicators, infection prevention & control, end of life, stroke, mental health, safeguarding, learning disability, children and young people, diabetes, violence, regional trauma networks, respiratory disease, public health, emergency preparedness and physical activity. All priority areas are represented in various work streams of the Trust.	STEVE LENNOX	Work underway to link the statement to risks on the risk register and to assess any new and emerging risks.

Section C – Key sources of assurance

Committee minutes and papers	External	Internal
Trust Board	Care Quality Commission NHS London London Assembly Externally commissioned reports eg National Audit Office – Transforming NHS Ambulance Services	Corporate risk register; Board assurance framework; Annual review of effectiveness of the Board and supporting committees; Statement on Internal Control; Annual reports – safeguarding/infection prevention and control/complaints management/corporate social responsibility; Monthly board reports from the CEO, Director of Finance, Medical director, Trust Secretary
Quality Committee	Care Quality Commission registration; DH Clinical Quality Indicators; NHS London safety and quality assurance gateway review; CQC quality risk profile.	Board assurance framework; Corporate risk register; Audit recommendations progress report; Minutes of RCAG, LfE, CQSEC; Quality indicators dashboard; Integrated risk management report; PEAG; 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; Statement on Internal Control; Report from Chair of the Quality Committee; ALE.
Risk Compliance & Assurance Group	Internal audit reports and recommendations;	Audit recommendations progress report

	CQC quality risk profile.	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).
Senior Management Group	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; Serious Incident reports.
Finance and Investment Committee	Historical due diligence report – received November 2011.	Cost Improvement Programme governance linked to IBP delivery programme board reporting;

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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. As shown in Section B, a number of the key risk areas for focus during 2010/11 are principal risks.

Principal risk and headline	Corporate objective	Risk score	CQC map	Key controls	Assurance on controls			Action plan	Responsible officer	Q3 RAG status	Year End f/cast
					Positive assurance	Gaps in controls	Gaps in assurance				
334 There is a risk that the implementation of CommandPoint will lead to a short term reduction in performance targets	C08 C03	20	**N/A**	CommandPoint Project Board; Reports to SMG and Trust Board; Planning assumption of the likely impact on performance and the plans in place to mitigate the level of impact. Board-level commitment. Fully resourced project.	Minutes of: CommandPoint Project Board; Independent assurance to Non-Executive directors; Reports and Minutes for SMG and Trust Board. Risk register for CommandPoint; Detailed training plan; Full user involvement; Thorough system testing; Detailed transition planning; Ability to switch back to CTAK on the event of catastrophic failure of CP; **New risk – 23/8/2010 &**	See actions	Assurance will be gained from the outputs of audit and the lessons learned from 8th June	1. Detailed audit arrangements of project and transition plan to ensure success e.g. a gateway review process. 2. Decision to go live will be made by the Trust Board ensuring they are satisfied that the system and transition plan are fit for purpose. 3.Key stakeholders briefed on plan, transition	PS	H	H

					reviewed 8/11/ 2010 and 11/11/2011 09/05/2011 11/7/2011			arrangement and anticipated reduction in performance.			
355 Staff not receiving clinical and non-clinical mandatory training	C05 C07		**12 14**	PDR/KSF agreed rostered training days; Dedicated tutors; Paramedic HPC registration; Weekly operational demand capacity meetings	**New risk: 23/11/2011**	NWoW not fully rolled out; TNA needs updating		1. NwoW roll-out; 2. Review the TNA with emphasis on statutory and mandatory training; 3. Develop a workbook approach to support CSR training 4. OLM implementation	**CH**	H	H Target is S - 8
327 Re-use of linen/infection prevention and control guidelines	C04	20	**8**	Increased availability of blankets for A&E crews; Improved collection of soiled blankets from hospitals and non-contract laundries; New laundry provider; Action plan ; IP&C lead; Audit and	HCAI registration; Medical director's report; IP&C minutes. Regular audit and reporting on the dashboard. Reduction in blanket loss; KPIs measuring blankets collected, allocated and		Audit results show compliance with single use is not consistent	To understand the scale of the problem and to develop a strategic solution to blanket usage: 1 a) Audit blanket usage as part of hand hygiene auditing.	**SL**	H	M

				monitoring via the dashboard	delivered; **Risk reviewed October 2010;** **4/2/2011** **30/03/2011** **15/06/2011** **28/06/2011** **Risk reviewed and downgraded on 23/11/11.**			1 b) Chris Vale developing options paper to agree strategic direction. 1 c) PIMS to address compliance of single use locally. DIPC to present at conferences. Continue to audit.			
265 Service performance affected by inability to match resource to demand	C03 C05 C08	20	16	NWoW in place at 2 sites and incorporating a more flexible rota system; DSO/Team leaders have cover within current rotas; Monitoring of resource allocation through ORH 168 Operational weekly demand and capacity review group. Completed recruitment.	Monitoring KPIs; Introduction of team based working which is monitored by the Operations team on a daily basis. **Risk reviewed** **8/11/2010** **9/12/2010** **24/03/2011** **29/06/2011** **25/10/2011**		Outcome of roster reviews and rest break allocation	Second round of roster reviews to be recommended to SMG; Modelling underway by the weekly OWDaCR group	**MF**	H	H Target is M - 6

22 Failure to clinically assess comprehensively may result in inappropriate conveyance or treatment	C01 C02 C05 C08	20	16 13 14	Enhanced patient assessment course for paramedics and reflective practice and includes a supervision element. Training Strategy Group monitor the level of training delivery; CPIs monitor level of assessment provided; LA52 reporting and review at CQSE; Operational workplace review includes rideouts; Closed round table reviews and reflective practice; Clinical updates from the Medical directorate; Development and monitoring of treat and refer pathways alongside NWoW. An enhanced patient	Incident reporting; Operational workplace reviews; CQSE papers and minutes; Reporting of incidents via EBS shows improved take-up with this on LA52s. **Risk reviewed** **8/11/2010** **28/03/2011** **01/09/2011**	Monitoring development of treat and refer pathways; Effectiveness of incident reporting system;	Review of effective-ess of incident reporting;	To monitor the development of treat and refer pathways. To review the effectiveness of the existing incident reporting system. Pilot scheme where crew staff from 4 identified complexes will contact EBU via their airways radio. EBU will record incidents directly onto an electronic version of the existing LA52.	**FM**	H	S

				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.							

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334	There is a risk that the implementation of CommandPoint will lead to a short-term reduction in performance targets	***		IM&T	12-Aug-10	Major	Certain	20	This has been fully discussed and accepted by SMG & Trust Board - actions defined and agreed. The planning assumption is that WILL happen - mitigaton is to reduce impact - not remove the risk.	Peter Suter	11-Jul-11	Major	Certain	20	1. Detailed audit arrangements of project and transition plan to ensure success e.g. a gateway review process. 2. Detailed thorough training plan for staff. 3. Full user involvement with project e.g. ADO and DCEO and senior users of project board. 4. Thorough system testing and planning that is auditable. 5. Detailed planning for actual transition subject to scrutiny and evaluation. 6. Decision to go live will be made by the Trust Board ensuring they are satisfied that the system and transition plan are fit for purpose. 7. Ability to switch back to old system in the event of catastrophic failure of new system. 8. Board level commitment and focus of supplier organisation (Northrop Grumman) to ensure full success. 9. Key stakeholders briefed on plan, transition arrangements and anticipated reduction in performance. 10. Fully resourced plan to ensure technical and user support following transition through to the point where the system is deemed to have reached optimum performance.	1. P.Suter 2. Keith Miller 3. P.Suter 4. J.Nevision 5. J.Nevision 6. P.Suter 7. P.Suter 8. P.Suter 9. J.Nevision / P.Suter 10. J.Nevision / P.Suter	1. Feb 2011 "Ready for Service" Gateway Review. 2. Jan 2011 - June 2011, plus continued training thereafter.	Assurance by CommandPoint Project Board reporting structure to SMG and Trust Board.	Major	Certain	20	This risk is accepted and expected to manifest. Operations are running a performance cell from the night of go live to root cause every 8 min breach that will support operations in recovery. Paul Gates is setting this up.
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)			Human Resources	23-Nov-11	Major	Almost Certain	20	1. PDR / KSF Agreed rostered training days. 2. Dedicated tutors. 3. Paramedic registration. 4. Weekly Operational demand capacity meetings.	Caron Hitchen		Major	Likely	16	1. NWOW roll out. 2. Review TNA with emphasis on Stautory / mandatory training. 3. Develop a work book approach to support CSR training. 4. OLM implemetation into the service.	1. BON 2. GH 3. KM 4. BON	1. Dec 2011 2. Sept 2011 3. TBC 4. TBC	Reporting to TSG Performance Accelerator	Major	Unlikely	8	
327	There is risk that the Trust does not follow Department of Health Guidelines for the re-use of linen.	***	6	Infection Control	12-Oct-09	Major	Certain	20	1. The Trust has an adequate supply of blankets, however these are not always available. 2. Increased availability of blankets for A&E crews - Additional linen and disposable blankets added to stocks and circulated. 3. Improved collection of soiled blankets from hospitals and non-contract laundries - New laundry provider appointed and increased activity being established to collect blankets. Reduction in blanket loss.	Steve Lennox	23-Nov-11	Major	Likely	16	1. To understand the scale of the problem and to develop a sstrategic solution ot blanket usage: 1 a) Audit blanket usage as part of hand hygiene auditing. 1 b) Chris Vale developing options paper to agree strategic direction. 1 c) PIMS to address compliance of single use locally. DIPC to present at conferences. Continue to audit.	1a. Trevor Hubbard 1b. Chris Vale 1c. Trevor Hubbard	1a. Ongoing 1b.Feb 2012 1c. Ongoing	1. KPI measuring blankets collected delivered. 2. KPI measuring blankets allocated/ delivered.	Minor	Possible	6	

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265	Service Performance may be adversely affected by the inability to match resources to demand.	***	17	Operational	31-Jul-06	Major	Certain	20	1.NWoW has been introduced at two pilot sites (Barnehurst and Chase Farm) and will incorporate a more flexible but robust rota system. 2. The option of weekend rotas has been advertised to all frontline staff, whilst Sector Support rotas are in place and concentrate on weekend cover. DSO's and Team Leaders now have cover installed in their current rotas. Improvements have been made to dual sending with adjustments to the distance an FRU would be expected to travel, whilst still dispatching the nearest AEU. This will have an impact on both resources available to EOC and will produce shorter job cycle times. 3. The ORH 168 plans now enable the monitoring of resource allocation. 4. 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. 5. Completion of recruitment exercise.	Martin Flaherty	25-Oct-11	Major	Likely	16	1. Monitor pilot sites for NWOW. 2. Roster reviews. 3. Review ORH implemented rosters Pan London 4. Modelling being undertaken by the Operational Weekly Demand and Capacity Review Group (OWDaCR) 5. Second round of roster reviews to take into account the current service requirements. Paper to be submitted to SMG with recommendations.	1. C.Hitchen 2. P.Gates 3. J. Killens 4. J. Killens 5. A. Khan	1. Complete 2. Nov 2011 3. Ongoing 4. Ongoing 5. April 2012	1. Monitoring of KPIs 2. Following the roster reviews, team based working is being introduced and is monitored by the Operations Team on a daily basis	Minor	Possible	6	
22	There is a risk that failure to undertake comprehensive clinical assessments may result in the inappropriate non-conveyance or treatment of patient.	***	4	Clinical	14-Nov-02	Major	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	01-Sep-11	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.	1. J.Selby 2. J. Selby	1. Nov 2011 2. May 2011	1. Incident reporting. 2. Operational workplace reviews. 3. Regular reports to CQSE.	Moderate	Possible	9	The Student Paramedic pathway contains a more robust assessment regime which focus's on holistic patient care and assessment.2. Student paramedics have acess to a practice placement educator to help them develop the requsite patient assessment skills and to provide real time feedback on clinical decision making. Action 3 - A tender evaluation of 2 providers has been under taken, with a decision expected asap Action 5 - The pilot has undergone a number of teething issuies , however in principle the proposal appears to be working well
269	At staff changeover times, LAS performance falls as it takes longer to reach patients.	***	17	Clinical	08-Dec-06	Major	Certain	20	1.New rosters are being implemented Pan London that match demand and provide overlap, all rosters are being vetted for compliance by the project manager and AOM of resourcing. 2. Team Leaders now provide additional area cover (ACR) working from 14.00 to 20.00 each day to bridge the evening changeover period. 3. Director of Operations has put together a 15 point Operational plan "Operations Workstream 2009/10" covering a number of resourcing issues which will, once implemented, impact on changeover times and patient care. All the workstream initiatives have a workstream lead at either Assistant Director Operations (ADO) Assistance Chief Ambulance Officer (ACAO) or nominated Ambulance Operations Manager (AOM) level. 4. Allocation plan for rest breaks to minimise losses at shift end	Martin Flaherty	25-Oct-11	Major	Possible	12	1. Roll out of NWOW across the Trust. 2. Introduction of new rest break allocation introduced to reduce losses at shift change over. 3. Rosters will be reviewed every 6 months to model against current demand capacity. 4. The Trust is meticulously analysing all missed Category A calls on a daily basis to aid and improve both patient care and Category A performance.	1. C.Hitchen 2. C.Hitchen 3. A.Khan 4. P.Cassidy	1. Jan 2012 2. Jan 2012 3. Ongoing 4. Ongoing	1. Monitoring of KPIs.	Major	Unlikely	8	A Roster Optimisation paper has been prepared by A.Khan and presented to Jason Killens for approval by SMG. Risk rating to be reviewed following the rest break agreement is complete (Sept 2011)

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31	There is a risk that the control and operational staff may fail to recognise serious maternity issues or fail to apply correct guidelines which may lead to serious adverse patient outcomes in maternity cases.	***	4	Clinical	14-Nov-02	Major	Certain	20	1. The Medical Director attends NPSA's Obstetric Pan London Forum. 2. Introduction of a flow chart to CTA to enable safe triage of women in early labour. 3. Consultant Midwife working with the LAS one day a week, providing advice to Control Services, Legal Services, Patient Experience, and Education and Development. 4. Reports on all the reported incidents concerning obstetric cases are presented to the Clinical Quality Safety and Effectiveness Committee. 5. A number of complexes have made local arrangements for midwives to deliver training sessions. 6. Articles on maternity care have been published in the Clinical Update in March and September 2009. 7. CTA now have maternity pathway to assist with triage. 8. Monitoring the delivery of the CPD obstetrics module. 9. Ongoing training through direct contact and articles in the Clinical Update. 10. Evaluated the flow chart used to enable the safe	Fionna Moore	25-Oct-11	Major	Possible	12	1. Modifications to the safe triage of women in early labour flow-chart in terms of maternity pathways. 2. Review incidents reported through LA52's, Patient Experiences and Legal Claims relating to problematic obstetric incidents.	1. A.Stallard / F.Sheraton 2. A. Stallard	1. Jan 2012 2. Ongoing	1. Monitor processes at CQSE and Corporate Health and Safety Group. 2. Incident reporting.	Major	Unlikely	8	Risk updated by Andrew Stallard, it is still current and applicable to the trust.
324	There is a risk that cleaning arrangements are insufficient to ensure that the environment for providing healthcare is suitable, clean and well maintained.	***	6	Infection Control	17-May-10	Major	Certain	20	1. Introduction of revised cleaning programme. 2. Infection control champions are in place. 3. Audits of vehicles and premises. 4. Swabbing of vehicles by LSS. 5. Processes now in place to triangulate audit information.. 6. Opportunities within the PEAG initiative have been identified to support the audit process.	Steve Lennox	11-Nov-11	Major	Possible	12	1. To ensure Trust is consistently compliant across the service: a) Make Ready tender awarded	1a. Trevor Hubbard	1a. Jan 2012	1a. Comprehensive dashboard	Minor	Unlikely	4	Risk not closed or changed due to the risks associated with change in provider.
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.	***	4	Health & Safety	13-Nov-02	Major	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. Electronic reporting has been approved in principle. 6. A review of incident reporting is underway and led by the PCMO. 7. Weekly SI control sheet and conference call updates. 8. Monthly reports to SMG. 9. Implemented policy on investigating and learning from incidents, complaint, PALs and claims.	Caron Hitchen	10-Nov-11	Moderate	Possible	9	1. Complete the review of incident reporting and make recommendations to Corporate H&S and RCAG. 2. Develop a plan of action and learning from the integrated reports following: - Comms update, - Risk Management Workshops (Nov 2011) - PIMs to incorporate session into training (core refresher) 3. Review and implement uniform coding within Datix for incidents, complaints, PALs and claims to facilitate integrated reporting. 4. Programme of rolling out local risks register accountability to Area and Directorates. 5. Pilot incident electronic reporting.	1. S.Sale 2. S.Adams 3. C.Dodson-Brown 4. .Dodson-Brown 5. S.Sale	1. April 2012 2. Jan 2012 3. April 2012 4. Nov 2011 5. April 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	

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343	There is a risk of staff not recognising safeguarding indicators and therefore failing to make a timely referral.			Clinical	12-Aug-10	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 Adults Gap Analysis.	Steve Lennox	17-Nov-11	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	1. P.McKenna, K.Millard, P.De Bruyn 2. Steve Lennox	1. Dec 2011 2. Nov 2011	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.	***	***	Operational	11-Jul-11	Major	Likely	16	1. Review of CCD role being undertaken by AOM Andy Fitzsimons. 2. Currently, where possible, the trained EMDs are working alongside the new EMD in order to rpovide support and guidance.	Martin Flaherty	18-Nov-11	Major	Likely	16	1. To identify a chort of EMDs from each watch and provide necessary training for them in order to fulfill the role. 2. Review of the role of CCD EMDs.	1. A.Fitzsimons 2. AOM Control Services	1. Ongoing 2. Ongoing		Major	Unlikely	8	Training is planned for the 2nd September 2011, which once completed will provide an additional 3 staff per watch to undertake the specialist role required to staff the CSD desk. On completion of the course/training it is perceived that staffing the CSD desk will be more robust and the risk reduced or mitigated. Four staff have been recruited to join theCSD desk. Training is due to commence on the 5th December, these staff will be filling the vacant lines on the core rota making the desk staffing more robust.
337	There is a risk that there will be a delay in establishing the Clinical Response Model due to changes that need to be made to interfacing other projects (CommandPoint/CTAK)			Clinical	11-Jan-11	Major	Likely	16	1. EOC Planning Group in place, reviewing options. 2. Review of changes to CTAK/parameters of CommandPoint. 3. CRM workshop took place to reaffirm the Trusts intentions in regard to the CRM.	Steve Sale	10-Nov-11	Major	Likely	16	1. Operational and Control Room planning for CRM restart 2. Review ORH (Oct 2011) report regarding potential impact on performance when implementing CRM	1. S.Sale 2. S.Sale	1. Nov 2011 2. Nov 2011	1. CommandPoint Project Group 2. Programme Delivery Board	Negligble	Rare	3	Options paper to be presented to delivery board in December, decision taken to defer CRM restart until 2012

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9	There is a risk of RTC injury to persons travelling in an LAS A&E vehicles.	***	19	Operational	13-Nov-02	Major	Likely	16	1. Authorisation to drive any service vehicle/lease car can only be provided by a qualified service trained driving instructor. 2. Introduction of advanced training for a number of DSO's in each Sector. 3. Team Leaders complete an Operation ride out report, within which is a section categorised as self driving demonstrated (G123). 4. The Trust displays notices internally stipulating safety features and the use of safety equipment when travelling; • A&E Op's and Health Safety bulletins • Motor Vehicle notices are displayed reminding staff and passengers to wear seat belts/harnesses at all times. • Improved visibility whilst Ambulance's reverses -	Martin Flaherty	23-Nov-11	Major	Possible	12	1. Review adequacy of driving course and include training for specific vehicles (i.e. FRUs). 2. Ensure refresher training is provided following RTA's. 3. Develop robust system for tracking individual accident rates, including lease car drivers. 4. Expand about benefits of regular reassessing of all service drivers that will be implemented early next year 5. Implementation of updated Operational Policies (TP065 and TP067)	1. K.Miller 2. K.Miller 3. Jason Killens 4. Jason Killens 5. Jason Killens	1. Complete 2. Complete 3. Ongoing 4. April 2012 5. Complete	1. Monitor processes at RCAG and Motor Risk Group. 2. Monitoring of RTA claims 3. ADO's to implement a robust system	Moderate	Possible	9	The Motor Risk Group will continue to monitor the actions for this risk
138	Failing to appreciate the significance of psychiatric illnesses will lead to mis-diagnosis.	***	8	Clinical	12-Nov-03	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 with the Trust in August 2009. 3. Mental health e-learning module has been developed - training package assessed by external assessors	Steve Lennox	27-Oct-11	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	1. S.Lennox 2. S.Lennox 3. S.Lennox 4. S.Lennox	1. Dec 2011 2. Dec 2011 3. Sept 2011 4. tbc - meeting with auditors has been arranged to review this	1. CPD completion records 2. Monitor processes at CQSE 3. Monitor package completion data on e-learmng site	Major	Unlikely	8	Mental Health Committee meeting to review risk description and actions. Module has now been signed off by subject matter experts, and roll-out of the e-learning facility has commenced
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.]	***	11	HR	01-Jun-05	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.	Caron Hitchen	11-Nov-11	Major	Possible	12	1. Review the process of archiving training records within the DoE&D (funding currently being sought for this) 2. The introduction of a Trust-wide project to establish a centralised Learning Management System	1. P.Billups 2. R. Habib	1. Dec 2011 2. Dec 2011	1. Part of organisation & development of people workstream. 2. Progress of project report to workstream board.	Major	Unlikely	8	1. New scanner ordered to enable the electronic capture of training records. Revised processes will be developed for integration within the new Oracle Learning Management (OLM) system, along with NWoW and other related service developments. 2. Project Board established to manage the introduction of OLM. The Project Initiation Document is currently being prepared.
211	There is a risk that drug errors and adverse events may not be reported.	***	4	Clinical	08-May-06	Major	Likely	16	1. CQSE suggest PIMs give some thought to how this be managed - JK to report new action plan 2. 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.	Fionna Moore	25-Oct-11	Major	Possible	12	1. Continue to encourage reporting of all clinical incidents using LA52's.		1. Ongoing	1. CPI checks 2. Incident Reporting	Major	Unlikely	8	Actions completed have been moved to controls - rating to be reviewed / new actions identified. All the current measures remain in place. In addition there is to be a reminder to all the Team Leaders on the forthcoming Team Leader Course about this issue

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305	There is a risk that the management of morphine at Station level is not in accordance with LAS procedure OP/30 Controlled Drugs.	***	24	Clinical	21-Oct-08	Major	Likely	16	1. Internal Audit carried out annually. 2. Procedure to be reinforced by bulletins from Director of Operations/Medical Director. 3. Independent audit to be carried out throughout the Trust - 1st visit took place in June 2010, 2nd visit took place Oct 2010 4. Initial peer review pilot audit carried out in the south area with results and process amendments discussed at a morphine audit meeting in October 2011.	Fionna Moore	25-Oct-11	Major	Possible	12	1. A second peer review audit to be carried out in the south area in November 2011 with results reported back to morphine audit meeting scheduled for January 2012 with a view to rolling the process out across all areas of the Trust.	1. D.Whitmore	1. Jan 2012	1. Internal Audit 2. Independent Audit 3. LIN oversight of system	Major	Unlikely	8	All the current measures remain in place. In addition there was a Medical Directors Bulletin issued re CDs on 4th January 2011. DSW has met with the Met Pol CDLO and the next round f unannounced visits are being planned. DSW will be attending the Area Business Meetings to raise awareness of CD issues, starting with the West Area Business Meeting on 28th June 2011.
326	There is a risk that the inadequate facilities and lack of policy for the decontamination of equipment may increase the risk of infection.	***	6	Infection Control	17-May-10	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.	Steve Lennox	10-Nov-11	Major	Possible	12	1. to have a decontamination policy that meets CQC expectations: a) Establish Equipment Decontamination Improvement Group at Logistics Support Unit with Terms of Reference. b) Monitor decontamination compliance	1a. C. Vale/ K. Merritt 1b. T. Hubbard	1a. Jan 2012 1b. Jan 2012	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. -Impact on patient care.			Health & Safety	23-Nov-11	Major	Likely	16	1. Manual handling policy (being reveiwed in line with best practice and NHSLA/CQC requirements) 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 core refresher training; all operational ambulance vehicles are fitted with tail lifts; all operational ambulances have hydraulic trolley beds and manual/patient handling aid kits; all 516 and 616 ambulances have pneumatic patient lifting cushions; PTS have 3 bariatric ambulance vehicles; alternative bariatric vehicle provision can be requested through EOC, 26x 'B' tech assessor have been trained. 3. Core Skills Refresher training is monitored via the quality dash board. 4. The Corporate Health and Safety Group monitor manual handling incidents and training activity,	Jason Killens		Major	Possible	12	1. (Pilot assessment being undertaken until Dec 2011) of an alternative chair transporter. 2. Pilot assessment of additional bariatric ambulances, or pod back up support vehicles. 3. Introduction of pneumatic air cushions (full body size)			Manual Handling Implementation Group Manual Handling Policy Central Health and Safety Group Incident Statistics Monitor and Audit Reviews	Minor	Unlikely	4	
316	The non-reporting of faults in accordance with service procedures may result in the loss of vehicle availability.	***	17	Logistics	17-Aug-09	Major	Likely	16	1. LA400 (defect reporting sheet) has been replaced by a vehicle specific defect book. 2. Vehicle Resource Centre is now operating 24/7 and managing some Vehicles Off Road (VOR). 3. Process mapping of VOR process in EOC to be undertaken to understand the impact of the removal of the logger's role. 4. TRANMAN, Statutory Checks and Make Ready tender for new contract 5. RAC checking stations at weekends for unreported faults. 6. Enhancement of fleet workshop hours of working will reduce the risk of occurrence. 7. Outputs from process mapping to inform changes in management of VOR.	Chris Vale	27-Sep-11	Major	Possible	12	1. Roll-out of new service procedure incorporating vehicle checks (OP68) - signed off at ADG, pending implementation 2. Roll-out of revised OP44 (VoR) replacing OP12, pending implementation	1. J.Killens 2. P.Tattum	1. Oct 2011 2. Oct 2011	1. Vehicle Equipment Working Group	Rare	Unlikely	2	TP/068 Statutory Vehicle Checks Incorporating Pre and Post Shift Arrangements highlight the legal responsibilities that drivers of vehicles have towards ensuring the vehicle complies with legal standards. The policy also provides guidance for undertaking checks to satisfy compliance and to provide protected time to individuals to undertake
153	There is a risk that fuel prices may be in excess of sums held in budgets which may lead to overspend	***	19	Finance	06-Jan-04	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 2011/12. The move to an all diesel fleet will further mitigate against fuel costs.	Michael Dinan	10-Nov-11	Moderate	Possible	9	1. Finance Review of billing data underway by Director of Finance	1. M.Dinan	1. Dec 2011	Monitored at SMG and Trust Board	Moderate	Possible	9	Risk at target rating but to remain visible on Risk Register

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20	Inappropriate use/completion of the LA4H Single Response Handover form may lead to the loss of patient information.	***	8	Operational	14-Nov-02	Major	Likely	16	1. Team Leaders audit PRFs to provide information for Clinical Performance Indicator (CPI) reviews. CPI reviews are carried out monthly and are published by Sectors. 2. 07/10/08 - 95% compliance was achieved for PRF completion. Feedback sessions were undertaken in July 2008 (expected target 1904/ achieved 1895). 3. Simplified PRF produced for completion by FRU staff. Team leaders advise staff on the importance of PRF completion. Team leaders are in turn monitored on the inspection of PRFs. Monthly CPI reports are sent out by CARU to all Complexes informing them of their PRF completion levels. These results are then discussed at area business meetings. 4. Presentation on Performance Indicators. 5. CPI database monitored to check team leaders quality assurance on PRF completion. 6. Presentation of PRFs on computer to simplify process.	Martin Flaherty	25-Oct-11	Moderate	Possible	9				1. Station audits. 2. Monitoring of completion rates.	Minor	Likely	8	
322	There is a risk that the Trust does not provide adequate infection prevention and control training to all staff which may lead to healthcare associated infections.	***	6	Infection Control	17-May-10	Major	Likely	16	1. Introduction of training programme for operational and non-operational staff. 3. Trust updates have been delivered to 1,600 staff including hand hygiene training 3. Use of Infection Control Communications Strategy to ensure that all staff are kept well-informed.	Steve Lennox	11-Nov-11	Moderate	Possible	9	1. To be fully compliant with CQC expectations and all staff to have up to date infection control training: a) Ensure all staff receive all in one training or alternative form of update (core skills refresher and induction training) b) Monitor and implement hand hygiene training. c) Need to capture the training of contracted staff on the scorecard.	1a Carmel Dodson-Brown / Ian Bullamore 1b Steve Lennox 1c Gill Heuchen	1a Nov 11 1b Nov 11 1c Nov 11 1c Nov 11	Reports from the central training register	Minor	Unlikely	4	General update. All in one training about to recommence. CSR to be over provided in the Winter to recover the numbers. Hand Hygiene not currently being delivered locally but is part of CSR. Need to consider contract staff
323	There is a risk that the audit programme is not sufficiently robust to identify to identify infection control issues across the Trust.	***	6	Infection Control	17-May-10	Major	Likely	16	1. Quarterly reports to Area Operations. 2. Further training of infection control champions. 3. Continued awareness training by use of Trust-wide communications.	Steve Lennox	23-Nov-11	Major	Unlikely	8	1. Strengthen current audit process (also introduce new audit measures - separate workstream) a) Audit needs adapting to make it more relevant locally. b) Create an Escalation Plan	1a. Trevor Hubbard 1b. Trevor Hubbard	1a. Complete 1b. Complete		Minor	Possible	6	1a The audit has been revised and tested and declared not fit. It has since been revised and now being tested again. 1b Not yet delivered. Date renegotiated. 1c Had meetings with RSM Tenon to discuss robustness of aud process rather than assist with audit. Meetings progressed and concluded.
173	There is a risk to staff, patients and the organisation of staff working excessive overtime/hours in breach of the Working Time Directive.	***	7	HR	05-Jan-05	Major	Likely	16	1. ProMis has a warning sign that is generated before the Coordinator continues to place a member of staff on a shift. The warning system highlights any contraventions of the Working Time Directive. 2. Regular ProMis reports are provided to operational managers and auditing is carried out by Station Management Teams who advise and take the appropriate measures with staff who try to compromise their own and patient safety. 3.The completion of the recruitment and training of student paramedics, coupled with the review of rosters due to compete in Summer 2010, should enable this risk to be revi=ewed and the rating reduced.	Caron Hitchen	11-Nov-11	Major	Unlikely	8	1. Continued monitoring and review of working hours via PROMIS. 2. Reissue WTD guidance. 3. Further enhancements are envisaged with the roll out of GRS in 2011.	1. G.Hughes 2. T.Crabtree 3. G.Hughes/A Khan	1. Ongoing 2. Dec 2011 3. July 2011		Major	Rare	4	The report has been run and those staff that have worked in excess of the WTR guidelines have been asked to slow down and improve their work life balance. AK 1/4/11 A service wide report was sent to all AOMs highlighting staff that had exceeded WTR hours for an average of 17 weeks.

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72	There is a risk that inconsistent action relating to the maintenance and repair of trolley beds, due to inadequate record keeping, may result in adverse clinical incidents.	***	24	Logistics	17-Mar-03	Major	Likely	16	1. A comprehensive paper based system for recording the servicing of trolley beds has been in use for the last 11 years and this includes filing the records in the individual vehicle file on which the bed was presented. 2. A new Fleet Management software system (TRANMAN) has been introduced.. 3. Electronic Fleet system has been roled out across the Trust. 4. TRANMAN has been introduced allowing the electronic monitoring of trolley beds. 5. Replacement of existing trolley beds with stryker trolley beds. 6. Continous monitoring of the systems to ensure they are being managed and incidents reported. 7. Enforcement of 8 weekly vehicle servicing schedulles required to ensure beds are serviced on time.	Chris Vale	01-Nov-11	Major	Unlikely	8	1. Comprehensive review of TRANMAN records to be undertaken. 2. A site auditor has been appointed to review and update all information on the TRANMAN system.	1. P.Mann 2. K.Trew	1. Complete 2. Jan 2012	1. Asset tracking system. 2. TRANMAN 3 Centralised Servicing Plan	Major	Rare	4	As a result of the recent TRANMAN review which showed that records were not up to date a site auditor was appointed to review and update the system.
325	There is a risk that the lack of displayed/available cleaning schedules may mean that the staff and public are not aware of cleaning protocols.	***	6	Infection Control	17-May-10	Major	Likely	16	1. Introduction of revised cleaning programme. 2. Infection control champions are in place. 3. Cleaning schedule is published in clinical update and are issued to individuals.	Steve Lennox	23-Nov-11	Moderate	Unlikely	6				1. Audits of sites by contractor and IPC lead	Minor	Unlikely	4	(All actions have been moved to controls) 1a Completed. Part of quarterly audit tool. 1b costing needs to be determined and where funds will be identified approximate costs are £4,500.
344	Unable to assure that the current taxi contract accommodates the guidelines for regulated activity (safeguarding)			Governance	16-May-11	Moderat e	Almost Certain	15	1) Current contract stipulates all drivers must have CRB checks	Steve Lennox	10-Nov-11	Moderate	Almost Certain	15	1) Registration with the Independent safeguarding Authority needs stipulating in the contract 2) Contract monitoring	1) Paul Webster 2) Paul Webster	1. 2011/12 2. 2011/12	1. Safeguarding Committee			#N/A	ISA remit currently under review - actions have been identified and risk will be further reviewed following the review of independent body.
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.	***		Finance	06-May-10	Catastr ophic	Possible	15	1. 2011/12 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 2011/12. 4. Communications with commissioners.	Michael Dinan	10-Nov-11	Catastrop hic	Possible	15	1. Review by Finance Investment Committee	1. A.Cant	1. 28 Nov 2011	1. Performance is tracked daily both centrally and by area. 2. Financial risks are reviewed by SMG and Trust Board.Diary meeting every Monday reporting where performance is reviewed and recover plans are discussed. 3. Monthly meetings with PCT commissioners were performance is reviewed against targets and agreement is reached and findings are documented. 4. Performance is reported to the SHA monthly	Catastrop hic	Unlikely	10	Communications have taken place with commissioners to identify financial offsets arising from higher than agreed levels of activity. Separate key financial risks as per LAS Financial Review top 15 risks schedule

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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			Finance	16-May-11	Catastr ophic	Possible	15	1. No agreement in place to ensure this funding to become recurrent funding. 2. 2011/12 contract reflects this work, if there is a shortfall PCTs are liable.	Michael Dinan	10-Nov-11	Catastrop hic	Possible	15	1. Trust to attempt to gain assurances from DH that this funding will continue	1. Lizzy Bovill	1. Feb 2012	1. Service Line Reporting	Catastrop hic	Unlikely	10	
357	There is a risk that LAS may receive a significant increase in call demand as a result of 111 pilot sites that we do not have the capacity for.			Operational	23-Nov-11	Moderat e	Almost Certain	15	1. SLA regarding clinical governance of 111 call management. 2. Agreed audit mechanisms during first month of implementation to ensure 111 calls are reviewed. 3. Agree to report back through 111 Clinical Governance meetings if calls are being passed inappropriately.	Lizzy Bovill		Moderate	Likely	12	1. We will negotiate as a clause in 2012/12 contract.	1. L. Bovill	1. 1 May 12	Reviewed through Control Service Clinical Governance Group Reviewed through Monthly commissioning reports Attendance at NHS London Clinical Governance Group Attendance at pilot site governance groups as required 5. Agreed process to manage incidents and complaints (through 111 governance teams)	Moderate	Unlikely	6	
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.	***	17	Business Continuity	17-Aug-09	Catastr ophic	Possible	15	1. In the event of a loss of HQ, call dispatch would take place from Emergency Control Vehicles until the Fall Back Centre (FBC) was fully operational.	Martin Flaherty	10-Nov-11	Catastrop hic	Unlikely	10	1. Scoping work to be carried out in terms of technology for Bow Control Room. 2. Consider having fall back control room at Bow operating as a warm site to aid a swift switchover when required.	1. Jason Killens 2. Jason Killens	1. June 2012 2. June 2012	1. Monthly Project Board meetings	Catastrop hic	Rare	5	Actions will be delayed until CommandPoint has been implemented. The Trust will now have two warm control rooms, one being at HQ and the other at Bow, Both each of the control rooms will mirror one another giving the Trust capacity to simultaneously run both rooms together if and when required.
353	There is a 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. This is compounded by a lack of up to date training or operational bulletins. There is a lack of awareness of track side safety equipment in use i.e. Short Circuit Device or Electrical Testers			Operational	23-Nov-11	Catastr ophic	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	Jason Killens		Catastrop hic	Unlikely	10	1. Communication campaign to raise awareness of issue. 2. Introduction of new section on The Pulse to provide reference point for material. 3. Creation of new operational policy to act as standard across organisation.	1. W.Kearns 2. W.Kearns 3. W.Kearns	In progress In progress In progress	.	Catastrop hic	Rare	5	

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207	Risk of staff not being able to download information from Defibrillators and 12 lead ECG monitors leading to incomplete patient records.	***	5	Clinical	04-Apr-06	Moderate	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	25-Oct-11	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	1. Monitor processes at Clinical Quality Saftey and Effectiveness Committee	Moderate	Unlikely	6	The last audit of defib downloads showed that only 6% were being done, Team Leader the issues were: - Not enough time i.e. being allocated vehicles etc, - Not enough FR2 data cards - IM&T issues including card reader(s) not working.
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.	***	17	Health & Safety	12-Jul-06	Moderate	Certain	15	1. The Lone Worker Policy has been reviewed. 2. The Trust received positive feedback from Bentley Jennison's 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; - FRU, MRU and ECP 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	14-Nov-11	Moderate	Possible	9	1. The Loneworker Policy is now to be incorporated within a Security Management Policy together with the Violence Prevention Procedure and Policy.	1. Martin Nicholas	1. Jan 2012	1. Incident Reporting.	Moderate	Unlikely	6	Security Management Policy is going to the Corporate Health and Safety Meeting on 24th November and then to ADG for approval in January 2012 subject to staff side response.
200	There is a risk of loss of physical assets due to the risk of fire.	***	21	Health & Safety	01-Jan-02	Catastrophic	Possible	15	1. Fire Marshall awareness training is undertaken as a module on a 1 day Safety and Awareness Course. 2. 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.	Martin Nelhams	10-Nov-11	Major	Unlikely	8	1. Health Safety and Risk team to take responsibility for delivering Fire Marshall Awareness Training.	1. J.Selby	1. Ongoing	1. Record of fire marshall training is kept by J Selby. 2. Update on premises inspection reported to Corporate Health and Safety Group Quarterly. 3. Annual return to DOH including a fire risk statement signed off by Peter Bradley. 4. Core skills refresher 2 includes vehicle fire precaution awareness training.	Minor	Rare	2	JS to review this risk with CV in terms of vehicles - currently only looks at buildings. Risk to be reviewed once the associated SI has been completed.
354	There is a risk of ongoing industrial action due to national ballots leading to disruption of service provision.			Human Resources	23-Nov-11	Major	Possible	12	1. Partnership agreement with staff side. 2. Intelligence gathering. 3. Business continuity plan.	Caron Hitchen		Major	Possible	12	1. Trust REAP & BCP. 2. More frequent communications. 3. Review partnership arrangements.	1. T.Crabtree	1.30 Sep 11		Major	Possible	12	

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282	General failure of personnel to adequately 'back-up' IT may lead to the loss of data.	***	25	Business Continuity	03-Jul-07	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.	Paul Williams	22-Sep-11	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.				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.	***	17	Clinical	18-Feb-08	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	25-Oct-11	Major	Possible	12	1. The introduction of Command Point		1. March 2012	1. Incident reporting. 2. Complaints monitoring. 3. Protocols and transfer procedure	Major	Unlikely	8	All the current measures remain in place. Command point goes live in June 2011 thus making the "Locality Information" flag more noticeable to the Call Taker. The EOC Training Department have been re-iterating to all Call Takers the importance of acting on "Locality Information" flags. The development of the End of Life
296	Exposure of staff to carbon monoxide fumes whilst in incident premises.	***	17	Clinical	21-May-08	Major	Possible	12	1. A steering group to manage this risk has been formed with Jason Killens to act as chair. 2. The recommendations made within a report prepared by a member of staff from the HART team have been considered viable in some cases. The group will further scope the recommendations and where necessary and appropriate will drive their implementation. 3. Steering group to develop management and monitoring procedure. To be managed through EP and BC steering group. 4. Action plan to be put in place following re-run of pilot in Dec 2010 with more strict controls around feedback and assessment of equipment.	Martin Flaherty	25-Oct-11	Major	Possible	12	1. The Trust will pilot a scheme in the winter months, carrying out robust monitoring of patients and the immediate environment for crew safety surrounding carbon monoxide poisoning.	1	1	1. Incident reporting.	Major	Unlikely	8	**RW is liaising with Marc Rainey to monitor carbon monoxide incidents over the winter period, to allow this risk to be evaluated.**
306	There is a risk that failure to undertake Vehicle Daily Inspections before driving vehicles in relation to roadworthiness checks, as required by Road Traffic Act, may result in adverse traffic incidents.	***	20	Logistics	21-Oct-08	Major	Possible	12	1. Staff required to complete roadworthiness checks on form LA1. 2. Percentage of LA1 forms audited by Team Leaders for compliance	Chris Vale	11-Nov-11	Major	Possible	12	1. Roll-out of new service procedure incorporating vehicle checks	1. J. Killens	1. Oct 2011	1. Vehicle Equipment Working Group	Major	Unlikely	8	Waiting for OP68 to be rolled

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348	There is a risk that the Clinical Coordination Desk may not be able to coordinate demand across London's specialist centres due to lack of information provided by neighbouring ambulance trusts when bringing patients to London Centres.	***	***	Operational	11-Jul-11	Major	Possible	12	1. Reporting back at clinical and oeprational network meetings to reinforce policy where it is not adhered to.	Martin Flaherty	07-Nov-11	Major	Possible	12	1.Liaison with neighbouring ambulance trusts both by LAS and network leads is on-going 2. Monitoring of information fed back to Trauma Office about number of patients from outside London brought in to London MTCs				Major	Unlikely	8	The major trauma networks are developed and implemented by South East Coast, South Central and East of England over the next 12 months.
339	The potential lack of technician drug packs for use by operational staff causes a risk to providing clinical care for patients due to vehicles being deficient of drugs for all or part of a shift.			Logistics	11-Jan-11	Moderat e	Likely	12	1. Bulletin from Director of Operations to all staff reinforcing drug protocols 2. Letter from Director of Operations to AOMs reinforcing local management responsibilities 3. Trial scheme at 3 sites as part of review of drug pack procedure where the signing out and in of packs is regularly checked 4. ADO for F&L carried out drug pack audit in May 5. 11. PVR's for indivudual stations now reassessed against audit results. 6. New drug lockers have been fitted on a number of sites to improve security	Chris Vale	01-Nov-11	Moderate	Likely	12	1. Additional packs to be rolled out over the summer to bring allocations to correct levels. 2. The new vehicle pack will be launched with the new LA1 on 6.12.11 trust wide and this includes a drug sign in / out process on the LA1 which will have an admin audit. 3. The 10 minute checks policy will be launched on 6.12.11 trust wide.	1. K.Merritt 2. K. Brown 3. K.Brown 4. TBC	1. Ongoing 2. Ongoing 3. Ongoing 4. Dec 2011	1. Regular auditing indicates corrects number of packs is being accounted for on stations. 2. Reduction in LA52 issues.	Major	Unlikely	8	The vehicle pack scheme will require monitoring and auditing by station Management for missing equipment. There have been recent improvements in the provision of packs through the issue of additional bags and the launch of the manager's drug packs
294	The Trust is unable to guarantee to provide a paramedic to attend every incident where one was requested.	***	17	Operational	18-Feb-08	Major	Possible	12	1. Skill levels of staff have been identified so EOC can task appropriately skilled staff to these calls. 2. The General Broadcast system will be used to identify an available paramedic.	Martin Flaherty	25-Oct-11	Major	Possible	12	1. Increase the number of paramedics employed by the Service. 2. Completion of paramedic education, arising form the recruitment campaign. 3. Report to SHA/LAS in terms of recruitment position. Delete as no longer applicable.	1. C.Hitchen 2. C.Hitchen 3. A.Bell	1. Ongoing 2. 2012 3. Ongoing	1. Monitoring the numbers of paramedics. 2. Monitoring of individual training.	Minor	Unlikely	4	The Trust over the last 18 months has recruited c700 staff to the student paramedic programme with c300 achieving the skill set of a paramedic each year. Within CommandPoint a set response profile rule identifies incidents that require a paramedic response which will further aid in reducing the risk where a paramedic was requested.
63	The risk of incurring liability through the re-use of "single use" equipment.	***	6	Infection Control	14-Nov-02	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	11-Nov-11	Major	Possible	12	1. To have a decontamination policy that meets CQC expectations: a) Establish Equipment Decontamination Improvement Group at Logistics Support Unit with Terms of Reference. b) Monitor decontamination compliance	1a C. Vale/ K. Merritt 1c Trevor Hubbard	1a Jan 2012 1b Sep 2012	1. Incident reporting. 2. Complaints/ claims monitoring.	Moderate	Rare	3	
272	There is a risk that the LAS may not achieve the full CIP due to new/unforseen cost pressures.	***	19	Finance	03-Jul-07	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. 5. Continued colaboration with wider health care services.	Michael Dinan	10-Nov-11	Moderate	Possible	9	1. Review as part of CIP monitoring 2. Review by Finance Investment Committee	1. M.Dinan 2. A.Cant	1. Ongoing 2. 28 Nov 2011	1. CIP reported monthly to SMG and the Trust Board. 2. Programme Governance Structure 3. Finance Investment Committee	Moderate	Possible	9	

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217	There is a risk that the Trust may not be able to contact a resource in a "Black Spot" area.	***	22	Operational	12-Jul-06	Moderate	Likely	12	1. Airwaves currently supplied to operational managers. Delete 2. Airwave radios have been introduced across the Trust.	Martin Flaherty	25-Oct-11	Moderate	Possible	9	1. Surveys now being carried out for remedial action, the only black spots that have been identified are for texting.	1. J.Hopson /P.Sykes	1. February 2011	1. Regular reporting on certain areas (eg. Victoria Station) 2. Information from EBS	Moderate	Possible	9	Phil Sykes - We have had a couple of coverage reports come through recently and I'm aware that the MPS reported significant issues in the Hanwell area which have now been rectified. There will always be black spots with any radio system but the levels of coverage with the Airwave network are far higher than the previous analogue system.
309	Risk of fraudulent activity from staff, patients and contractors.	***	19	Finance	16-Feb-09	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	Michael Dinan	10-Nov-11	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. M.Dinan (via Trust Counter Fraud Group)	1-5. As scheduled in the Local Counter Fraud Specialist Annual Work Plan for 2011 / 2012	1. Reported incidents. 2. Trust Counter Fraud Group	Moderate	Unlikely	6	Counter Fraud Group to review wording of this risk at their next meeting.
165	Delivery of sub-optimal care for patients with age-related needs and failure to meet NSF milestones.	***	17	Clinical	04-Jan-05	Major	Possible	12	1. Action Plan (section 5 - Older People's Strategy) is in place through which the delivery of "sub optimal care for patients with age-related illnesses" is being addressed. 2. Older People's Strategy has been updated. 3. Referral Pathways Project in progress and is now part of the Healthcare for London workstream.	Lizzy Bovill	08-Nov-11	Moderate	Possible	9	1. Development of referral pathways as our partnership work with commissioners. 2. Training for front-line staff on use of referral pathways (as part of 1.), is being developed. 3. Training for front line staff on use of referral pathways is being rolled out with particular focus on improving the management of people who have fallen, many of whom are older people.	1. Lizzy Bovill 2. Emma Williams 3. Emma Williams	1. Apr 2012 2. Apr 2011 3. Apr 2012	1. Annual report to the CQSE.	Moderate	Unlikely	6	LB and SL to review the risk and identify a new one. All 3 actions are currently being delivered and will be fully in place by April 2012.
247	There is a risk of not achieving the 3 strategic goals where there is non-delivery of project outcomes (to time cost and/or quality) in relation to the IBP.	***	19	Corporate	25-Jul-06	Moderate	Likely	12	1. Senior Managers have been trained through MSP and PRINCE2 courses and programme and project management methodologies are being used to deliver project outputs and realise programme benefits. 2. Progress reports made to programme boards and SMG monthly and Trust Board through the CEO report monthly. 3. Each Programme maintains a risk and issues log and any new and appropriately graded risks are added to the corporate ris register. 4. Governance arrangements have now been established for the IBP Delivery Programme.	Sandra Adams	10-Oct-11	Moderate	Possible	9	1. Governance arrangements to be established for the IBP Delivery Programme commencing 1st April 2011.	1. M.Brand	1. Complete	1. Progress reports to IPB Delivery Programme Board 2. SROs report monthly to SMG. 3. Reports toTrust Board. 4. Closure reports on the SIP to the Trust Board in May 2011 .	Moderate	Unlikely	6	Senior Responsible Owners (director level) appointed to lead Patient Care, Value for Money and Workforce and OD programmes with programme boards established to support them which have met several times over the past six months. Project boards set up where appropriate for larger projects within the programmes and smaller projects overseen by directors leading portfolios of projects within programmes. progress reporting taking place through Performance Accelerator fed through to monthly SMG meetings and section of CEO's update to Trust Board meetings.

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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.	***	4	Health & Safety	01-Apr-11	Moderate	Likely	12	1. The interim Local Security Management Specialist (LSMS) has developed a draft Trust Security Management Plan in accordance with Counter Fraud and Security Management guidance. 2. Trust 2010/11 Security Management plan submitted and approved by CFMS prior to implementation - This is a yearly requirement and will be an ongoing annual event. 3.The delivery of Conflict Management training undertaken in-house.	Steve Sale	11-Nov-11	Moderate	Possible	9	1. Serious Incident Reporting system will ensure information is regularly reported to NHS Protect. 2. Conflict Resolution Training update is included in 2nd day of core learning skills. 3. Introduction of violence prevention champions in all complexes.	1. S. Sale	1. Complete 2. Core Skills refresher 3 will include CRT April 2012. 3. Awaiting direction prior to implementation	1. Monitoring of Incident Reports.	Moderate	Unlikely	6	JS proposed this risk is split into two, one element to address physical violence and the second verbal abuse. M Nicolas submitted a LA167 - TC to review risk NOTE: This is the same as item 351.
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.	***	24	Logistics	10-Feb-04	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	Chris Vale	01-Nov-11	Moderate	Possible	9	1. Management of Medical Devices Policy being submitted to the ADO Group and ADG for approval - Chris Vale to chase up progress. 2. 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.	1. C.Vale 2. M.Salter/ G.Gifford	1. Dec 2011 2. March 2012	1. Monitoring of service records for medical devices.	Minor	Unlikely	4	MD now has involvement in the project for implementing an asset tracking system - there is potential for it to be included within the new make ready terms currently under review (Oct 2011)
164	Policies and Procedures not adhered to due to lack of staff awareness and robust implementation plans.	***		Corporate	04-Jan-05	Moderate	Likely	12	1. NHSLA level one achieved in October 2010 2. Ongoing review of policies and procedures linked to NHSLA . 3. Monitor incidents and serious incidents where policy has not been followed and action is required.	Sandra Adams	11-Nov-11	Moderate	Possible	9	1. Identify a system for managing the updates of policies and procedures and implementation of TP001. 2. Consider how we communicate policy updates, how compliance is monitored and where assurance is received.	1. S. Moore 2. S. Moore	1. Mar 2012 2. Dec 2011	NHSLA level 1 Review of incidents and comlaints to ascertain any breach of policy	Moderate	Rare	3	To note: Having reviewed the Serious Incident process it is clear that non compliance with policy is often the root cause.
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			Human Resources	23-Nov-11	Moderate	Likely	12	1. All tutors have recived a clinical update package. 2. All tutors have received major incident update training.	Caron Hitchen		Moderate	Possible	9	1. Further protected time to develop clinical tutors. 2. Establishment of adequate staffing levels to allow delivery of update programmes for tutors.	1. KM 2. GH	1. Dec 2011 2. Mar 2012	Course review and feedback by Education Governance Manager	Moderate	Rare	3	
222	The lack of frontline management at weekends may reduce the level of support/advice available to staff, and could result in a SUI.	***	1	Operational	13-Jun-06	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. 5. General broadcast to other vehicles where requirement for a manager is due to crew safety. 6. Clinical Support Desk is now in place and provides a route for staff to gain support and advice on a range of	Martin Flaherty	25-Oct-11	Major	Unlikely	8	1. Review new leave rules for DSOs. 2. Complex Management Review - consultations	1. J.Killens 2. J.Killens	1. Dec 2011 2. Dec 2011	1. Analysis of incident reporting	Moderate	Unlikely	6	Richard Webber Director of Operations tasked AOM Athar Khan to write a paper surrounding a Management review. The paper was submitted by Athar Khan at the end of February 2011, which is currently being considered by the Senior Management Team and work is ongoing. The review

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317	There is a risk that the Trust may not achieve its Category A target in the current financial year.	***	17	Operational	17-Aug-09	Major	Possible	12	1. The Trust has a comprehensive recovery plan in place. 2. The recruitment of c400 additional staff during 2009/10 is on track and has the aim of reducing utilisation and increasing performance. 3. Demand assumptions have already been breached this year and therefore a Demand Management Group has been set up. 4. Delivery completed against all recovery plan actions. 5. Delivery completed against Operational Model 2009/10 aims and objectives (the projects)	Martin Flaherty	25-Oct-11	Major	Unlikely	8	1. Roster changes are being made to meet increased demand. 2. Forecasting and Planning Group to provide a more accurate way of forecasting activity against demand. 3. Weekly Demand and Capacity Group review abstractions within there operational directorate.	1.-3. J.Killens	1.-3.Ongoing	1. The Business Continuity (BC) Plan has been tested and is fit for purpose. 2. A BC and Emergency Preparedness Steering Group has been set up which will continue to test the BC plans.	Major	Rare	4	Operational Directorate have indentified and implemented two specialised working groups. The forecasting and planning group is tasked to develop a more accurate way of forecasting and planning against activity rather than the static ORH 168 plan currently used within the Trust. The weekly demand and capacity group will look at expected demand whilst reviewing abstractions made within the operational directorate.
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.			Corporate	09-Jan-12	Major	Possible	12	1. NHSLA Level 1 compliance with 48/50 standards.	Sandra Adams		Major	Possible	12	1. Review of standards in which existing policies/procedures do not match practice. 2. Update relevant polocies/procedures to ensure current practice is captured correctly. 3. Collate and provide evidence on Performance Accelerator.	1. Governance and Compliance Team (GCT) 2. GCT 3. GCT	1. Oct 2012 2. Oct 2012 3. Oct 2012		Major	Unlikely	8	
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.	***	11	Operational	12-Jun-06	Moderate	Likely	12	1. NWoW is now in place at two complexes and incorporates a more robust rota allowing time for meetings. 2. PDR and CPI are also now in place, although these may be sidelined due to operational pressures. 3. New rostering arrangements under NWOW will allow time for meetings	Martin Flaherty	18-Nov-11	Moderate	Unlikely	6	1. Monitoring PDR	1. A. Khan			Minor	Unlikely	4	Since April 2011 the Trust has undertaken c508 PDR's Trust wide, this data has been abstracted from ProMis and will require further validation.
208	Risk of staff not knowing their accountabilities for internal control and the principles of the Code of Conduct.	***	7	Governance	22-Sep-11	Moderate	Likely	12	1. The Code of Conduct is included in the Non-Executive and Executive Directors induction. 2. Standing Orders revised and reviewed by Trust Board in March 2010 3. Annual review of effectiveness to Board 4. Annual appraisal of NEDs and EDs 5. Governance Structure reviewed 6. Annual review for 2010/11 7. Preparation for Board to Board 8. Training for the Board on Counter Fraud and Implications of the Bribery Act	Sandra Adams	22-Sep-11	Moderate	Unlikely	6				1. Minutes from SRP 2. Effectiveness reports for committees	Moderate	Rare	3	Completed actions moved to controls
181	There is a risk of injury to staff from slips, trips and falls on LAS premises during the course of their duties.	***	21	Health & Safety	09-Feb-03	Moderate	Likely	12	1. Premises inspections are undertaken every three months and are reviewed at meetings of the Corporate Health and Safety Group. 2. The one day Health & Safety Awareness course now covers premises inspections. 3. Slips, Trips and Falls Policy approved by CQSE June 2010	Tony Crabtree	11-Nov-11	Minor	Unlikely	4	1. Revised policy issued October 2010. 2. Training requirements are defined within the training Needs Analysis. Compliance in terms of conetnt of training for different staff groups through corporat ean dlocal induction and through "all in one" for non-clinical staff should be audited. 3. review H&S Premises inspection reports 4. Local risk assessment responsibility is being rolled out that will enhance the existing quartely premises inspection. 5 All senior and line managers attend madatory H&Safety awareness training. 6. Vehicle equipment working group review vehicle design that includes anti slip flooring.	1. Keith Miller/ Carmel Dodson-Brown 2. Carole Livett 3. John Selby 4. John Selby 5. John Selby 6. VEWG	1. Complete 2. on-going quarterly 3. Complete 4. TBA Governance 5. Ongoing 6. Ongoing	1. Health and Safety Inspection Reports.	Minor	Unlikely	4	

London Ambulance Service NHS Trust
Risk Register as at 28th December 2011

Risk ID	Risk Description	Assurance Framework Ref.	Corporate Objective	Risk Category	Date Opened	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
335	There is a risk that service delivery will be compromised in the event of flooding.	***	17	Business Continuity	16-Feb-09	Catastr ophic	Unlikely	10	1. London Strategic Flood Plan. 2. Environment Agency Flood Plan - Signed up to the Environment Agency early warning system. 3. RIB and exceptional bulletins to alert staff to dangers of entering floodwaters. 4. PPS -25 Development and Flood Risk (Government guidance on planning new development and making current buildings more flood resilient). 5. LAS Business Continuity Plans - individual stations have business continuity plans. 6. Mutual aid agreements with other service partners.	Paul Williams	22-Sep-11	Catastrop hic	Unlikely	10	1. LAS flood plan being written (inlc. Severe weather plan) 2. Station Business Continuity Plans to include flooding contingencies. 3. Staff training to include Water Awareness not planned at present. 4. Post Pitt report guidance due in Autumn.	1. L.Lehane 2. E.Potter 3. K.Miller 4. L.Lehane			Catastrop hic	Rare	5	EPBCSG to review risk at their next meeting
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.			IM&T	09-Jan-12	Minor	Almost Certain	10	1. Removal of duplicate Employee IDs	Peter Suter		Minor	Likely	8	1. Starters and leavers process documentation being created. 2. Complete and distribute 'Managers Guide to Administration' to Managers.	1. A.Honour 2. G.Masters	1. Feb 2012 2. Feb 2012	Starters and leavers meeting held every 2 weeks chaired by Robbie Cowan	Minor	Rare	2	
359	There is a risk that users may install unauthorised software which may compromise information security, service management and potentially breach software licencing agreements which would leave the Trust liable.			IM&T	09-Jab-12	Minor	Almost Certain	10	1. Only admin users can install software. 2. Password changes are forced every 90 days. 3. A list of authorised/unauthorised software is being developed and acted upon.	Peter Suter		Minor	Likely	8	1. Further locking down of desktops required. 2. Reduction of the number of Admin accounts. Instances of questionable software installs to be investigated and either removed or to be added to authorised list.	1. R.Clifford 2. R.Clifford	1. Jan 2012 2. Jan 2012	Startard reporting item of IGG	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)	***		HR	06-May-10	Moderat e	Possible	9	1 Salix match funding agreement, which has funded a number of works that will reduce energy usage, thereby carbon footprint. 2. Replacement of LDVs in fleet. The replacement Mercade4s vehicle is more fuel efficient and its bodywork is mostly recycable. 3. in addition there is a regular progress report to SMG/Trust Board on the implementation of the carbon reduction management action plan. 4. Draft KPIs relating to reducing Trust carbon footprint is in development. 5. implementation of CRM, web based processes to replace paper based processes will support the trust's carbon reduction objective.	Martyn Salter	11-Nov-11	Moderate	Possible	9	1. The LAS is part of the 2011/12 NHS Carbon Management Programme and the Carbon Management Project Team is working the with Carbon Trust to development a comprehensive quanitfied plan to deliver reductions in the Trust's carbon footprint which exceed the original target.	1.C.McMahon	1. March 2012	Regular reports to SMG	Moderate	Unlikely	6	There is a possibility that the workload of members of the CRWG will mean the implementation of the management action plan receives less support
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.	***	***	Clinical	11-Jul-11	Moderat e	Possible	9	1. Monthly monitoring of current care pathway usage. 2. Feedback mechanism in place of care pathways with commissioners.	Lizzy Bovill	23-Nov-11	Moderate	Possible	9	1. Creating an evidence base and continuing a dialogue with commissioners to maintain clinically appropriate pathways and reported bi monthly to Clinical Quality Group. 2. Membership and attendance at NHS London and cluster level unscheduled care boards. 3. Development of Clinical Quality Group to engage senior GPs from clusters in strategy and quality issues.	1. L.Bovill 2. L.Bovill 3. L.Bovill	1. April 2012 2. April 2012 3. April 2012	1. Established relationships with Senior Leads. 2. Quarterly meetings with Senior Leads and monthly meetings with Junior Leads	Moderate	Unlikely	6	

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199	Risk to staff safety / vandalism/theft due to inability to adequately secure premises.	***	21	Finance	01-Jan-03	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. Bulletin reminding staff to secure premises when leaving unattended.	Michael Dinan	11-Nov-11	Moderate	Possible	9	1. A Security Management Policy will be developed.	1. M. Nicolas / Chris Vale / John Selby	1. Oct 2011	1. Reported to SMG	Moderate	Unlikely	6	**10/11/11 MD - Health and Safety Group to review this risk at their next meeting. Recommendation made in a recent SI to be considered by SMG and the Trust Board**
303	There is a risk of unavailability of critical patient care equipment on vehicles.	***	24	Logistics	21-Oct-08	Moderate	Possible	9	1. Equipment amnesty - audits carried out, about 20 vehicles were unequipped, all the rest were fully equipped, and this will be resolved via purchasing of additional equipment. 2. Daily assessment of vehicle equipment by make-ready, and follow-up to locate spare eqiupment 3. 74 sets of new equipment have also been issued in the last year, with new Mercedes Ambulances 4. Purchase of 165 new vehicles and equipment. 5. Monthly defib audits - returns reported to VEWG (350 extra defibs)	Chris Vale	11-Nov-11	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	1. Kevin Brown 2. Kevin Brown	1. Ongoing 2. Dec 2011	1.Weekly audit returns to Logistics and Make Ready contractors. 2. Monitoring at Area Governance Groups.	Minor	Unlikely	4	This is part of the VDI policy being written. Update from Jason Killens. Roll out of vehicle packs and new LA1 will improve recording of equipment on vehicles. As risk 186 more focus has been placed on the introduction of an asset tracking system.
46	There is a risk of infection to staff due to sharps injury.	***	6	Infection Control	14-Nov-02	Moderate	Possible	9	1. Introduced the Safety Canulae trial in early 2009. Results to be monitored via Infection Control Steering Group. 2. In 2008 the overall number of LA52 reported needle stick incidents for Q3 (1st July - 30th Sept) was 9 near misses and 3 actual. This represents a reduction of reported incidents from Q2 of 12 actuals and 2 near misses. The new cannulae are now in use which should hopefully reduce the number of injuries. 3. H&S bulletin related to 'Disposal of Sharps' was issued in 2007/08. 4. This is part of the infection prevention and control action plan.	Steve Lennox	11-Nov-11	Moderate	Possible	9	1. Minimise the risk of sharps injury: a) Participate in national ambulance audit 2011. b) Undertake a programme of staff awareness (and to incorporate new guidance from POSSH conference)	1a.T.Hubbard 1b T.Hubbard	1a 2011/112 1b May 2012	1. Health and Safety Audits. 2. Clinical Quality Safety and Effectiveness Committee. 3. Incident reporting. 4. ICSG quarterly review 5. SUI of high risks cases.	Minor	Unlikely	4	

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328	There is a risk that paramedics are not trained in the use of aseptic no touch technique (ANTT).	***	6	Infection Control	17-May-10	Moderate	Possible	9	1. All Team Leaders have received ANTT training. 2. The principles of ANTT are now included in paramedic courses. 3. Training for all clinical staff for ANTT has now been completed.	Steve Lennox	11-Nov-11	Minor	Possible	6	1. To be fully compliant with CQC expectations and all staff to have up to date infection control training: a) Ensure all staff receive all in one training or alternative form of update (core skills refresher and induction training) b) Monitor and implement hand hygiene training. c) Need to capture the training of contracted staff on the scorecard.	1a Carmel Dodson-Brown / Ian Bullamore 1b Steve Lennox 1c Gill Heuchen	1a Nov 11 1b Nov 11 1c Nov 11		Minor	Unlikely	4	All in one training about to recommence. CSR to be over provided in the Winter to recover the numbers. Hand Hygiene not currently being delivered locally but is part of CSR. Need to consider contract staff.
275	Loss of access to the Deptford Logistics Store may result in drug supplies being disturbed.	***	24	Business Continuity	03-Jul-07	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 Williams	11-Nov-11	Moderate	Unlikely	6	1. Review of business continuity plan for the supply of drugs as there is no formal arrangement with Frimley Park.				Moderate	Rare	3	PW to add update from Medicines Management Group. SLA not in place with Frimley Park as this
278	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.	***	17	Business Continuity	03-Jul-07	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.	Paul Williams	10-Nov-11	Moderate	Unlikely	6	1. Training and awareness plan to be produced. 2. Tabletop testing of departmental plans to be scheduled, when new plan complete. 3. Gold and Silver training included in training scheduled under development.	1. Liam Lehane 2. Liam Lehane 3. Liam Lehane			Moderate	Rare	3	NHS London have produced a business continuity toolkit which the EP&BC will use todevelop and align their processes . 1. Gold and silver training is subject to operational pressures.
182	Not being able to escape from an LAS building in the case of fire or other emergencies.	***	21	Health & Safety	09-Feb-04	Moderate	Possible	9	1. Procedures are found on Pulse under Fire and Bomb Evacuation Procedure. 2. 'Statement of Fire Safety' is produced annually and is returned to NHS Estates. 3. Risk Action Plans have been produced from the Fire Risk Assessments. 4. Local Fire Marshals have been nominated. 5. Fire evacuation drills are undertaken twice yearly. 6. Fire alarm testing carried out on a weekly basis. 7. Estates department annual assurance of Trusts fire safety compliance. 8. All in one and senior line manager safety and risk awareness training includes fire awareness.	Martin Nelhams	11-Nov-11	Minor	Unlikely	4	1. Health Safety and Risk team to take responsibility for delivering Fire Marshall Awareness Training. 2. Core learning skills includes fire awareness training. 3. Continued undertaking of premises inspections.	1. J.Selby 2. K Miller 3. J Selby	1. Oct 2011 Ongoing 2. Ongoing 3. Ongoing	1. Incident Reporting.	Minor	Rare	2	
271	All staff may not be in possession of a valid driving licence for the category of vehicle they are required to drive.	***	17	Operational	14-Mar-07	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.	Michael Dinan	23-Nov-11	Moderate	Rare	3	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	Unlikely	6	Release (TP/063): Procedure for checking driving licences, to provide a process which ensures staff with driving duties and responsibilities maintain a current and updated driving licence.
346	The Trust is commited to having 2 full strenght HART's by April 2010. Due to recruitment difficulties, there is a risk that the West Team may not be at full strength by that date.			Finance	16-May-11	Major	Unlikely	8	1. Recruitment well under way with 33 out of the maximum 42 staff either in post, in training or recruited.	Michael Dinan	11-Nov-11	Major	Unlikely	8	1. Continued recruitment plan	1. C.Hitchen	1. Ongoing	1. Monitored at SMG and Trust Board	Major	Unlikely	8	To be updated by J. Killens and C. Hitchen. Currently there are no national Course available for the outstanding staff not yet recruited

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332	There is a risk that Trust and National infection control procedures may be compromised as ambulance mattress covers are not routinely changed after each patient.	***		Infection Control	01-Mar-10	Minor	Likely	8	1. The matress is disinfected between each patient.	Steve Lennox	30-Sep-11	Minor	Likely	8	1. Identify - procure suitable disposable mattress covers; finalise assessment and make recommendation. 2. Improve returns from laundry of sheets and covers; agree process for returning sheets with the provider. 3. Eliminate soft repairs being undertaken with tape: a) Establish the incidence of repairs being undertaken to soft furnishings with tape. b) Instruct workshops to ensure spare mattresses are available to swap.	1 Chris Vale 2. Chris Vale 3.a Chris Vale 3b Chris Vale	1. Aug 2011 2. Aug 2011 3a Aug 2011 3b Aug 2011		Minor	Unlikely	4	Risk to be reviewed at next IPCC 1. Chris reported that this had not be progressed due to costs. IPC Committee requested for this to be costed and presented to ADG. 2. New laundry provider identifying process to manage. This still needs management observation. improved but not able yet to close. 3a Chris reported that this had stopped but operationsl representatives stated
351	There is a risk that operational staff may be verbally abused. The consequences being an increase in staff absence through stress, and an adverse impact on staff moral/ service/ patient care.	***		Health & Safety	10-Oct-11	Minor	Likely	8	1. Conflict Resolution Training, Identification of trends through incident reporting statistics. 2. High risk address flagging, MDT updates from EOC; Airwave radio. 3. Obstructing Emergency Worker legislation. 4. Appointment of local security leads	Caron Hitchen	11-Nov-11	Minor	Possible	6	1. Run an additional "No Tolerance" campaign. 2. Public awareness posters.	1. M.Nicholas 2. M.Nicholas	1. 2.	1. CH&SG incidnet statistics review 2. Review local risk registers 3. Local security leads in all complexes 4. Period review of High Risk flagged addresses	Minor	Rare	2	NOTE: This is the same as item 308
281	HR Occupational Health has no formal fall back if contractors are unable to fulfil their contracts.	***	10	Business Continuity	03-Jul-07	Minor	Likely	8	1.	Paul Williams	11-Nov-11	Minor	Possible	6	1. Requirement identified at Staff Support Business Continuity test and to be pursued by Fatima Fernandes and Atos representative K.Woodcock.				Minor	Rare	2	
304	There is a risk of non-functioning critical patient care equipment on vehicles.	***	24	Clinical	21-Oct-08	Moderate	Unlikely	6	1. Continued review of LA52 data. 2. Routine vehicle maintenance checks. 3. Make Ready staff check equipment functionality when making vehicles ready. 4. Purchase of new 12 lead defibrillators and shock boxes	Fionna Moore	09-Nov-11	Moderate	Unlikely	6	1. Monitor details submitted on LA52's which are completed relating to equipment failure.	1.		1. Monitoring by CQSE.	Minor	Unlikely	4	A Health and Safety bulletin has been issued reminding staff to include information such as equipment type and serial number and a description of the faullt. Release OP/026 this procedure is to ensure that all vehicle equipment is in a safe and ready state of working order and used correctly in keeping with a professional ambulance service that provides pre-hospital care, treatment and appropriate ambulance

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341	There is a risk that the Trust will be unable to receive sufficient 'engineering information' from MDT devices, due to a delay in completing the roll out of MDT/2 to all necessary vehicles before CommandPoint Go Live, causing compromises to the capability to rectify any related faults that may occur.			IM&T	11-Jan-11	Minor	Unlikely	4	1)The Trust Board authorised a single tender Business Case in December 2010 and 570 MPC2s were ordered from Microbus, the first delivery has been receieved and further deliveries are scheduled during March, April and May. The roll out to the fleet continues and full deployment is expected by Summer 2011. 2) Conduct a business impact analysis on the CommandPoint project of not implementing the MDT2 ExpressQ software 3) Provide additional funds to procure the software and units. 4) Plan to design and test business process prior to implementation 5) Conduct a business impact analysis on the CommandPoint project of any MI related information contained in the engineering information that is critical for go-live of CommandPoint 6) Conduct a business impact analysis on the CommandPoint project of any other related Operational	Peter Suter	16-May-11	Minor	Unlikely	4	1) Upgrade the MDT1s at the same time as the implementation of MDT2s, to provide the CommandPoint project with a solution before Go Live.	1) John Downard	1) May 2011	CommandPoint project will provide the following assurances on the risk: 1) CommandPoint Project Board monthly reviews 2) Risk Manager weekly reports 3) Risk manager and risk owner regular reviews. 4) Risk manager and project manager regular reviews	Minor	Unlikely	4	
340	There is a risk to the CommandPoint Training schedule through travel disruption due to bad weather or industrial action by travel operatives, leading to reduced attendance or the cancellation or postponement of the training schedule.			IM&T	11-Jan-11	Moderate	Rare	3	1. Commenced investigations into considering offering the Tutors / WBT 1 the option of accommodation in London during periods of extreme weather. 2. Project Executive support requested.(From Peter Suter) 3. Project Finance approval requested (To Martyn Salter)	Peter Suter	16-May-11	Moderate	Rare	3	1. To mitigate against the risk to training of travel disruption, consider offering the Tutors / WBT 1 the option of accommodation in London during periods of extreme weather to ensure that we are able to deliver the entire programme. 2. Investigate costs of hotels in the Waterloo/Southwark area.	1. Peter Suter 2. Keith Miller	1. Complete 2. Complete	CommandPoint project will provide the following assurances on the risk: 1. CommandPoint Project Board monthly reviews 2. Risk Manager weekly reports 3. Risk manager and risk owner regular reviews. 4. Risk manager and project manager regular reviews 5. Operational Change Management procedure and working group	Minor	Unlikely	4	Training now over 60% through planned period. No travel disruption experienced. Weekend Underground upgrades have not affected the attendance. Contingency period only impacted by an additional course for non-attendance due to other factors and an additional Dispatcher refresher course.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

24TH JANUARY 2012

Compliance with Standing Orders and Standing Financial Instructions

Document Title:	**Trust Secretary Report**
Report Author(s):	**Sandra Adams**
Lead Director:	**Sandra Adams**
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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 22nd November and to be assured of compliance with Standing Orders and Standing Financial Instructions**

Executive Summary

One tender has been received, opened and entered into the tender book since 22nd November 2012:

- FRU conversion – Skoda Octavia Estate
  Tenders received an opened by Bravo Solutions 13th January 2012:
  Audit Electrical Services (Manchester) Ltd
  Bott Ltd
  J S Fraser Oxford Ltd
  Oughtred and Harrison (Facilities) Ltd
  S MacNeillie and Son Ltd
  Was Vehicles (UK) Ltd
  Wilker UK Ltd

A contract was signed between the London Ambulance Service and Lakethorne Ltd on 16th January 2012 for cleaning services.

There have been no new entries to the Register for the Use of the Trust Seal since 13th December 2011.

Key issues for the Trust Board

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

Attachments

None.

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Strategic Goals 2010 – 13
This paper supports the achievement of the following corporate objectives:

☐ To have staff who are skilled, confident, motivated and feel valued and work in a safe environment
☐ To improve our delivery of safe and high quality patient care using all available pathways
☒ To be efficient and productive in delivering our commitments and to continually improve

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 FORWARD PLANNER 2012

Date of meeting	Standing Reports to the Board	Safety and Quality (additional to standing reports)	Finance and Performance (additional to standing reports)	Strategic and Business Planning	Governance	Sub-Committee meetings during this period
28 February **Strategy, Review and Planning Committee**		Outcome Data Late finishes and rest break allocation Community First Responders/corporate and social responsibility SMG Effectiveness Review – progress against recommendations	2012/13 Financial Plan and Cost Improvement Programme	2012/13 Annual Business Plan 2012/13 Corporate Objectives FT Update including preparation for Monitor interviews and review Stakeholder Engagement Strategy 111 strategy and marketing	Equality Act 2010 Briefing	
27 March **Trust Board**	Report from the Trust Chairman Report from CEO including balanced Scorecard and performance reports Report from Director of Finance Report from Sub-committees Clinical Quality and Patient Safety Report		2012/13 Financial Plan and Cost Improvement Programme	2012/13 Annual Business Plan 2012/13 Corporate Objectives FT Progress Report 2012/13 Equality Objectives	Report from Trust Secretary Trust Board Forward Planner BAF and Corporate Risk Register – Quarter 4 documents Annual Review of Standing Orders and Standing Financial Instructions Risk Management Strategy and Policy review	28th Feb – Quality Committee 5th March – Audit Committee 13th March – Finance and Investment Committee

Date of meeting	Standing Reports to the Board	Safety and Quality (additional to standing reports)	Finance and Performance (additional to standing reports)	Strategic and Business Planning	Governance	Sub-Committee meetings during this period
24 April **Strategy, Review and Planning Committee**				FT Progress Report including draft Board Statements and Working Capital Review		
29 May **Trust Board**	Report from the Trust Chairman Report from CEO including balanced Scorecard and performance reports Report from Director of Finance Report from Sub-committees Clinical Quality and Patient Safety Report	Quality Account 2011/12	Annual Report and Accounts 2011/12	FT Progress Report and Board Statements Workforce/HR Strategy	Report from Trust Secretary Trust Board Forward Planner	25th April – Quality Committee 14th May – Audit Committee 15th May – Finance and Investment Committee

Date of meeting	Standing Reports to the Board	Safety and Quality (additional to standing reports)	Finance and Performance (additional to standing reports)	Strategic and Business Planning	Governance	Sub-Committee meetings during this period
26 June **Trust Board**	Report from the Trust Chairman Report from CEO including balanced Scorecard and performance reports Report from Director of Finance Report from Sub-committees Clinical Quality and Patient Safety Report	Annual Safeguarding Report 2011/12 Annual Infection Prevention and Control Report 2011/12		FT Progress Report	Report from Trust Secretary Trust Board Forward Planner BAF and Corporate Risk Register – Quarter 1 documents Equality Report	29th May – Remuneration Committee 1st June – Audit Committee 20th June – Quality Committee
24 July **Strategy, Review and Planning Committee**					Committee Effectiveness Review	10th July – Finance and Investment Committee

Date of meeting	Standing Reports to the Board	Safety and Quality (additional to standing reports)	Finance and Performance (additional to standing reports)	Strategic and Business Planning	Governance	Sub-Committee meetings during this period
21 August **Trust Board**	Report from the Trust Chairman Report from CEO including balanced Scorecard and performance reports Report from Director of Finance Report from Sub-committees Clinical Quality and Patient Safety Report				Report from Trust Secretary Trust Board Forward Planner Annual Trust Board Effectiveness Review 2011/12 Annual Equality Report 2011/12 Annual Corporate Social Responsibility Report 2011/12 Annual Patient Experiences Report 2011/12 KA34 Compliance Statement	15th August – Quality Committee
25 September **Trust Board**	Report from the Trust Chairman Report from CEO including balanced Scorecard and performance reports Report from Director of Finance Report from Sub-committees Clinical Quality and Patient Safety Report				Report from Trust Secretary Trust Board Forward Planner BAF and Corporate Risk Register – Quarter 2 documents Annual Report of the Audit Committee	21st August – Charitable Funds Committee 3rd September – Audit Committee 11th September – Finance and Investment Committee

Date of meeting	Standing Reports to the Board	Safety and Quality (additional to standing reports)	Finance and Performance (additional to standing reports)	Strategic and Business Planning	Governance	Sub-Committee meetings during this period
23 October **Strategy, Review and Planning Committee**						
27 November **Trust Board**	Report from the Trust Chairman Report from CEO including balanced Scorecard and performance reports Report from Director of Finance Report from Sub-committees Clinical Quality and Patient Safety Report		Charitable Funds Annual Accounts 2011/12		Report from Trust Secretary Trust Board Forward Planner	24th Oct – Quality Committee 5th November – Audit Committee

Date of meeting	Standing Reports to the Board	Safety and Quality (additional to standing reports)	Finance and Performance (additional to standing reports)	Strategic and Business Planning	Governance	Sub-Committee meetings during this period
11 December **Trust Board**	Report from the Trust Chairman Report from CEO including balanced Scorecard and performance reports Report from Director of Finance Report from Sub-committees Clinical Quality and Patient Safety Report				Report from Trust Secretary Trust Board Forward Planner BAF and Corporate Risk Register – Quarter 3 documents	11th December – Quality Committee