London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO BE HELD IN PUBLIC ON TUESDAY 26th JUNE 2012 AT 10.00 – 13.00 CONFERENCE ROOM, 220 WATERLOO ROAD, LONDON SE1 8SD

AGENDA: PUBLIC SESSION

ITEM	SUBJECT	LEAD	TAB
1.	**Welcome and apologies for absence** Apologies received from: Steve Lennox Jessica Cecil Angie Patton		
2.	**Declarations of Interest** To request and record any notifications of declarations of interest in relation to today's agenda	RG	
3.	**Minutes of the Part I meeting held on 29th May 2012** To approve the minutes of the meeting held on 29th May 2012	RG	TAB 1
4.	**Matters arising** To review the action schedule arising from previous meetings	RG	TAB 2
5.	**Patient Story** To hear an account of a patient experience	FM	Oral
6.	**Report from Chairman** To receive a report from the Trust Chairman on key activities since the last meeting	RH	TAB 3
QUALITY ASSURANCE			
7.	**Ambulance Services Clinical Quality Initiative** To receive a presentation from the Quality Improvement Fellow	FM	Presentation
8.	**Quality Dashboard and Action Plan** To receive the most recent Quality dashboard and progress against the Quality Action Plan	FM	TAB 4
9.	**Quality Account 2011/12** To approve the Quality Account 2011/12	FM	TAB 5
10.	**Annual Infection Prevention and Control Report 2011/12** To approve the annual report for infection prevention and control	TH	TAB 6
11.	**Clinical Quality and Patient Safety Report** To receive the monthly report on clinical quality and patient safety	FM	TAB 7
12.	**Quality Committee Assurance Report** To receive a report from the Chair of the Quality Committee	BM	Oral
13.	**Staff Survey Temperature Check** To receive an update on the Staff Survey Temperature Check	CH	TAB 8

STRATEGIC AND BUSINESS PLANNING			
14.	**Report from Chief Executive Officer** To receive a report from the Chief Executive Officer, to include an update on the development of the enabling strategies	PB	TAB 9
15.	**Foundation Trust Progress Report** To receive an update on progress made towards submitting a successful application in 2013	SA	TAB 10
EXECUTIVE REPORTS			
16.	**Performance reports** 16.1 Chief Operating Officer, to receive the performance report 16.2 Director of Finance, to receive the report on financial performance for month 2, including the cost improvement programme 16.3 Director of Human Resources and Organisation Development, to receive a report on workforce 16.4 To discuss the draft report and agree future format and content of the integrated performance report	MF/ MD/ CH/ PB	TAB 11
17.	**Update on Olympic Preparedness** To receive an update on Olympic Preparedness	MF	Presentation
18.	**CommandPoint Update** To receive an update on the CommandPoint project	PS	TAB 12
ASSURANCE AND RISK REPORTS			
19.	**Audit Committee Assurance Report** To receive a report from the Audit Committee meeting on 1st June 2012	CS	TAB 13
20.	**Board Assurance Framework and Corporate Risk Register** To receive the quarter 1 documents	SA	TAB 14
GOVERNANCE			
21.	**Annual Audit Committee Report 2011/12** To receive the Annual Audit Committee report for 2011/12	CS	TAB 15
22.	**Amendments to Standing Orders** To approve the proposed changes to Standing Orders and Standing Financial Instructions to reflect the new shared financial service arrangements that take effect from 1st July 2012	MD/SA	TAB 16
BUSINESS ITEMS			
23.	**Report from Trust Secretary** To receive the report from the Trust Secretary on tenders received and the use of the Trust Seal	SA	TAB 17
24.	**Forward Planner** To note the Trust Board forward planner	SA	TAB 18
25.	**Any other business**	RH	

26.	**Questions from members of the public**	RH	
27.	**Date of next meeting** The next meeting of the Trust Board will take place on Tuesday 21st August 2012		

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING
Part I

DRAFT Minutes of the meeting held on Tuesday 29th May 2012 at 10:00 a.m.
in the Conference Room, 220 Waterloo Road, London SE1 8SD

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Present:

Roy Griffins	Non-Executive Director (Chair)
Peter Bradley	Chief Executive Officer
Jessica Cecil	Non-Executive Director
Mike Dinan	Director of Finance
Martin Flaherty	Deputy Chief Executive
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)
Peter Suter	Director of Information Management and Technology

Members of the Public:

Neil Kennett-Brown	North West London Commissioning Partnership
Joseph Healy	LAS Patients' Forum
Carol Hunt	Northrop Grumman (minute 57 only)
Peter Thorpe	Head of London 2012 Olympic Planning

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42. Welcome and Apologies

42.1 Apologies had been received from Richard Hunt, Caroline Silver and Angie Patton.

43. Declarations of Interest

43.1 There were no declarations of interest.

44. Minutes of the Part I meeting held on 27th March 2012

44.1 The minutes of the Part I meeting held on 27th March 2012 were approved, subject to an amendment to paragraph 25.1

ACTION: FG to amend the minutes of the Part I meeting held on 27th March 2012.

DATE OF COMPLETION: 11th June 2013

45. Matters Arising

45.1 The following matters arising were discussed:

45.2 **67.3:** Peter Bradley reported that he would be meeting with the Heads of the Canadian and Australian emergency ambulance services in June 2012 and would update the Trust Board on the outcome of this meeting.

45.3 **112.5:** Peter Bradley reported that one of the key recommendations of the National Audit Office report was to introduce the clock start change. This had now been approved and would go live from 1st June 2012. The Trust Board would be kept updated on the impact of this.

45.4 **128.6:** Peter Bradley stated that the new format balanced scorecard would be presented to the June meeting of the Trust Board, as agreed at the Strategy Review and Planning Committee meeting in April 2012. Peter confirmed that the balanced scorecard would be presented in a workable format, although there might initially be some duplication with other board reports. The Chair suggested that the Trust Board might wish to consider a board development session on understanding the balanced scorecard.

45.5 **26.7:** Martin Flaherty reported that letters to the entrants on the High Risk Register were currently being sent out by area. The High Risk Register would be reviewed on an annual basis.

45.6 **28.5:** Caron Hitchen reported that an end of year outturn report on PDR completion had been included in the workforce report. This action was closed.

45.7 **28.7:** Peter Bradley reported that he had not yet discussed the attitude and behaviour action plan with the Trust Chair. This action was outstanding.

45.8 **20.3:** The deliverables and deadlines against each of the Trust priorities would be the subject of discussion at the next Strategy Review and Planning Committee in July.

45.9 **34.3:** Strategic risks would be discussed at the next meeting of the Strategy Review and Planning Committee in July.

46. Patient Story

46.1 Steve Lennox presented a case study of a frequent caller, who had made approximately 500 presentations to A&E in 2011, 155 of which involving the LAS. The LAS Community Involvement Officer called a multi-disciplinary team meeting to discuss the patient's needs and they had agreed for the patient to always be conveyed to the same hospital and for the hospital to always admit him as a patient. As a result, the patient's anxiety and overall physical health has shown an improvement and the patient has now not attended hospital in the last three months.

46.2 Trust Board members asked why the GP had not alerted the other services of the situation and asked whether this case study could be presented to other GPs. Lizzy Bovill responded that the CQUINS for 2012/13 included an action to produce frequent caller reports which would be fed into the clinical commissioning groups. The GPs would then have responsibility for calling multi-disciplinary teams to address particular patients' needs. Steve Lennox added that the LAS had a team dedicated to managing frequent callers.

46.3 The Chair asked whether there was any other way that this story could be highlighted to GPs. Lizzy Bovill agreed to publish the story in the GP newsletter.

ACTION: LB to publish patient story in the GP newsletter.

DATE OF COMPLETION: 26th June 2012

46.4 The Chair stated that the Trust Board should also consider any patient stories which highlighted lessons for the LAS. Steve responded that he expected that stories of this nature would come out of complaints, but that between this and the last Trust Board meeting, the majority of complaints received by the Trust had been about delays.

47. Quality Dashboard and Action Plan

47.1 Steve Lennox reported that the LAS was in the top quartile for 25% of the Department of Health measures, which was a strong position nationally. Steve added that there were no red flag issues to highlight to the Trust Board.

47.2 Beryl Magrath asked whether there had been any improvement in STEMI and stroke outcomes. Fionna Moore responded that the LAS Quality Improvement Fellow would give a presentation to the Trust Board on the Ambulance Services Cardio Vascular Quality Improvement project at its next meeting in June, which would outline the actions taken to improve STEMI outcomes. Steve Lennox added that he and Fionna Moore would also develop a clinical strategy as part of the Foundation Trust application, which would address some of these issues.

48. Quality Account 2011/12

48.1 Steve Lennox stated that this was the draft Quality Account for 2011/12 and the final report would be presented to the next Trust Board meeting in June, incorporating patient feedback.

48.2 Jessica Cecil commented that, as the intended readership of the Quality Account was patients, the wording should be reviewed to ensure accessibility and to remove any jargon.

ACTION: SL to review the wording of the Quality Account to ensure accessibility and remove any jargon.

DATE OF COMPLETION: 26th June 2012

48.3 Murziline Parchment commented that it was more likely that patient organisations would read the report, rather than the patients themselves and asked whether it would be possible to produce an abridged version which would be accessible to a wider audience. Peter Bradley suggested that the Communications Team could assist in developing this.

ACTION: PB/SL/AP to produce an abridged version of the Quality Account.

DATE OF COMPLETION: 26th June 2012

48.4 Peter Bradley added that this was a very good document and the information presented was very powerful. Jessica Cecil agreed that it was a very impressive story, which meant that it was even more important to make it accessible to a wider audience. Sandra Adams suggested that the abridged version should also be made available to staff.

49. Clinical Quality and Patient Safety Report

49.1 Fionna Moore reported the following:

- There had been some improvement in the completion rates for the Clinical Performance Indicators in March;
- There had been high utilisation rates over the period and the Demand Management Plan had been enacted to a significant extent;
- On scene times had shown a year on year increase. There were a number of conditions where this was not necessarily a problem, for example where a patient had suffered an epileptic fit and the crew remained on scene until they were recovered. However this was an issue for potentially time-critical stroke, heart attack and trauma patients. It was thought that this was partly due to a tendency for staff to complete the PRF on scene to reduce time at hospital. This issue had been highlighted at both the Senior Managers' and Managers' conferences;
- Three clinical audit summaries were included in the report. Overall, good progress had been made in the completion of the clinical audit work plan;
- Each area was currently sending out letters to entrants on the High Risk Register.

49.2 Steve Lennox noted that the mental health action plan, which had been in place for a year, had started to have a positive impact. The results of the mental health patients' survey demonstrated that, overall, patients were treated with dignity and received a response within an appropriate timeframe. The Mental Health Clinical Performance Indicator went live in April 2012 and would assess whether mental health patients received a physical assessment and whether there was anything additional that could be done to improve the experience for mental health patients.

49.3 Murziline Parchment noted that the LAS had shown a downward trend in the national CPI measure for asthma and asked what actions would be put in place to improve this position. Fionna Moore responded that messages around the importance of measuring the Peak Expiratory Flow Rate needed to be re-emphasised to staff. Beryl Magrath asked whether it would be worth publishing the results in every station. Fionna responded that currently these results were published in the Clinical Update, but she would consider also displaying these at stations.

49.4 Beryl Magrath noted the increase in the use of the Demand Management Plan and asked what the cost of this was in terms of complaints, serious incidents, LAS reputation and clinicians having to perform other roles in order to provide clinical support to the Control Room. Fionna responded that DMP level B had been deployed more frequently than the other levels, and at this level the time on call was reduced which lessened the impact on staff.

49.5 Jessica Cecil asked when the sustained increase in demand would become the new norm, what impact would this have on clinical innovation and whether the clock start change represented an opportunity to address this issue. Martin responded that the Trust Board was right to express its concern about the increase in demand and suggested that it was discussed in more detail under his report.

50. Quality Committee Assurance Report

50.1 Beryl Magrath highlighted the quality dashboard indicators that were currently rated red, a number of which had also been rated red in last month.

50.2 With regards to CSR training, Caron Hitchen reported that the Trust had delivered more training last year than in previous years and this was partly due to the introduction of cluster training in December. The Learning and Organisation Development team was also looking to introduce a learning passport which would allow staff to have a personal record of the training they had

completed.

50.3 Beryl Magrath noted that there had been an ongoing issue with regards to the sourcing of secure PRF boxes. Martin Flaherty responded that this had now been resolved.

50.4 Beryl noted that, in the Quality Risk Profile, work pressure felt by staff was rated as worse than expected and she suggested that this was not surprising given the reduction in staffing.

50.5 Beryl noted that there were a number of quality achievements, which were as follows:

- The LAS was ranked in the upper quartile in 12 out of 22 areas in the National CPI audit;
- There was a 97% pass rate for student paramedics on the internal programme;
- The Trust had successfully bid for funding to develop an application to keep patients informed of what had happened as a result of their call;
- The draft Quality Account underlined the work undertaken by the staff of the LAS to improve the quality of care given;
- The LAS had achieved 79% pass rate for the level 2 compliance for the IG Toolkit;
- The on-going overall improvement in the Quality Risk Profile;
- The improvement in the status of the action plans following recent internal audit final report recommendations.

50.6 The Trust Board noted the report from the Quality Committee.

51. <u>Report from Chief Executive Officer</u>

51.1 Peter Bradley noted the following:

- The hospital summit had been a success and other ambulance trusts were organising similar events. Peter had met with Monitor and the Department of Health to discuss what else could be done to improve hospital turnaround;
- The clock start change had been approved. Peter thanked everybody who had supported this change;
- Peter had announced his resignation and would be leaving the organisation in September 2012. He would also be resigning from his roles as Department of Health National Ambulance Director and Chair of the Association of Ambulance Chief Executives. The Trust would be advertising for a new Chief Executive in the next two to three weeks;
- Peter had met with the new London Assembly following the London elections;
- The recent Ambulance Leadership Forum had been a success;
- The cardiac arrest results were due to be published in the next six weeks and it was expected that the LAS would have a positive result;
- There had been some adverse publicity in the Sun newspaper regarding staff discussing LAS patients on Facebook. This was being taken very seriously and was currently being investigated to understand how widespread this was amongst staff. Staff would be reminded of their responsibilities towards patient confidentiality;
- There was currently significant focus on getting performance back on track in the context of unprecedented demand levels.

51.2 Peter noted that the Patients' Forum had submitted a number of questions prior to the meeting and it was suggested that the responsible officers discuss with Joseph Healy outside of the meeting those questions which were not dealt with today.

ACTION: LB/MF/PB to discuss with Joseph Healy outside of the meeting the questions he had submitted to the Trust Board, which had not been dealt with at the meeting.

DATE OF COMPLETION: 26th June 2012

51.3 In response to a question about training, Peter responded that the Trust had delivered more training last year than in previous two years combined, although acknowledged that this was not as much as had been planned. Training was a priority for the executive team and, in Peter's view, this did not constitute a risk.

51.4 Beryl Magrath asked what progress had been made in obtaining an agreement on CBRN funding. This would become more significant as the Trust moved towards Foundation Trust status. Mike Dinan acknowledged that this was one of the Trust's biggest financial risks and he was currently working with the Department of Health to reach an agreement.

51.5 Murziline Parchment noted that three members of staff had been suspended over the Facebook incident and asked whether any other action had been taken. Peter responded that this issue had only come to light yesterday, but that the Trust would be issuing a bulletin to all staff over the next 24 hours to emphasis staff's responsibility to patient confidentiality.

51.6 The Chair stated that hospital handover times were a continuing concern and asked whether more could be done to raise awareness of this issue in national newspapers. Lizzy Bovill responded that there had been some progress in this area and performance management at a local level was much higher.

51.7 The Chair congratulated Peter Bradley on the clock start change.

52. Annual Report and Accounts 2011/12

52.1 Mike Dinan explained that the Trust Board was asked to delegate authority to the Audit Committee to approve the Annual Report and Accounts for 2011/12. The draft Annual Report and Accounts had been reviewed by the Audit Committee, the Finance and Investment Committee and the Senior Management Group.

52.2 Mike asked Trust Board members to email any comments directly to him.

ACTION: Trust Board to email feedback on the Annual Report and Accounts to Mike Dinan.

DATE OF COMPLETION: 1st June 2012

52.3 Mike gave an update on the progress of the year end audit and noted that it had gone relatively smoothly and no significant issues had been identified.

52.4 The Trust Board agreed the proposal to delegate authority to the Audit Committee for the approval of the Annual Report and Accounts for 2011/12.

53. Foundation Trust Progress Report

53.1 Sandra Adams reported that the Foundation Trust (FT) timetable had been revised to align with the new process for aspirant Foundation Trusts. The key milestones were as follows:

- Board to Board meeting with the SHA on 25th June 2012. The SHA had requested an

update on CommandPoint, industrial relations, Olympic preparedness and the FT application;

- The Quality Governance Assurance Framework review would take place in July 2012. The Trust would need to receive a score of less than 3.5 in order to progress to the next stage;
- Trust Board sign-off of the Integrated Business Plan and enabling strategies on 21st August 2012;
- SHA assurance phase from September to December 2012 to include a refresh of Historical Due Diligence phases 1 and 2;
- Application submitted to the Department of Health on 1st March 2013.

53.2 Sandra reported that KPMG would be joining the Trust Board in its part II meeting to give an update on the findings of the board governance assurance framework review. One of the key actions arising from this review was for the Trust Board to establish a formal board development plan which was aligned with the corporate objectives.

53.3 Sandra added that CBRN funding had been identified as a risk to the Tripartite Formal Agreement, as was the control total, the Cost Improvement Programme and delivery of service for the Olympics.

54. 2012/13 Summary Budget

54.1 Mike Dinan reported that the 2012/13 budget had been agreed with the commissioners and had been discussed by the Finance and Investment Committee and the Senior Management Group. The Finance and Investment Committee would continue to monitor the budget going forward.

54.2 The Trust Board approved the 2012/13 summary budget.

55. Carbon Management Plan

55.1 Mike Dinan reported that the Carbon Management Plan had been produced by Christine McMahon and approved by the Carbon Trust. The Trust Board was asked for approval of the five year plan, which would not require any additional investment.

55.2 Murziline Parchment noted that there was a risk that the LAS might not fully implement the clinical response model and asked where this risk would be monitored. Mike responded that this was part of the Cost Improvement Programme and would be monitored monthly.

55.3 The Chair asked for confirmation that the plan was achievable. Mike responded that the majority of these actions would be undertaken anyway in order to manage demand and that the plan was quite conservative in comparison with other ambulance trusts.

55.4 The Trust Board approved the Carbon Management Plan.

56. Performance Report

Chief Operating Officer's Report

56.1 Martin Flaherty reported that, since writing the report to the Trust Board, the Trust had experienced one of the busiest weeks on record and Category A performance now stood at 69.8% year to date. There had been a 20% increase in incoming 999 calls and a 20% or more increase in Category A patients. The Demand Management Plan had been deployed throughout the period, with level C used to a significant extent. Overall, delays were managed well and although there were examples of some patients having to wait for 6 hours, there had been no adverse incidents. There was one case of a 107 year old patient having to wait for 4 hours for a response and this was currently being investigated.

56.2 Martin added that Tuesday 22nd June had been the busiest weekday that the Trust had ever experienced and the 5th busiest day overall, the top 4 busiest days all being New Year's Eve. The biggest increase had been seen in cardiac arrests and respiratory problems.

56.3 A number of actions had been identified to manage demand and these included:

- Reducing the volume of rostered training delivered. It was likely that this reduction in the level of training delivered would be in place until after the Olympics;
- Accelerating the recruitment of staff to recruit 180 additional members of staff;
- Increasing the use of private and voluntary ambulance providers;
- Incentivising overtime working;
- Clock start change, which would be in place from 1st June. It was predicted that reported performance would improve by 4 to 5%, and although it was acknowledged that this would not change waiting times, it would allow the Trust to work differently to reduce the number of cancellations and the volume of dispatch;
- Proactively working with media on hot weather messages to try to manage down demand;
- Formal Capacity Review with ORH.

56.4 Martin added that the increase in demand was a national trend, but was more acute in London. The Management Information team was looking into the possible drivers of demand and identifying any lessons learnt.

56.5 Martin acknowledged that performance was worse in the East area compared with the South and West and this was due to the workload increasing disproportionately in the East and there being more vacancies. Some of the worst hospital delays were also experienced in the East. The Deputy Director of Operations was therefore looking to develop a specific Performance Improvement Plan for the area.

56.6 Martin reported that the Trust had experienced some technical issues over the weekend and that this had been escalated to Cable and Wireless to be resolved.

56.7 Martin gave an update on plans for the Diamond Jubilee and stated that this would be a pre-runner for the Olympics. Mutual aid would be used, with 100 staff working in London from across the country.

56.8 Beryl Magrath asked when the results of the capacity review would be reported. Martin responded that this had not yet been finalised, but it was likely to be in the next 8 to 10 weeks.

56.9 Beryl stated that the recent Operation Amber exercise had been very impressive and she expressed her thanks to everyone who was involved. Martin responded that the plan was to hold a similar national exercise on an annual basis.

56.10 Caron Hitchen gave an update on the apprentice paramedic role and stated that apprentice paramedics would be available to work on ambulances from the beginning of July 2012. The course took four years in total to complete.

<u>Report from the Director of Finance</u>

56.11 Mike Dinan reported that in month 1, the Trust had achieved the planned targets for surplus and the Cost Improvement Programme. There had been some slippage on capital, but this was to a manageable degree. All other items were as expected.

56.12 Mike stated that he would circulate the revised board report format to members of the Trust Board

this week and would be grateful for any feedback.

ACTION: MD to circulate the month 1 finance report to member of the Trust Board.

DATE OF COMPLETION: 1st June 2012

56.13 The Chair asked whether the clinical leads for the Cost Improvement Programme had been content with the year end result and were satisfied that there had been no adverse impact on quality. Mike Dinan responded that a full report would be provided to the Quality Committee. Peter Bradley added that the impact of the reduction in staffing would need to be reviewed as this was having an impact on Category C patients.

Workforce

56.14 Caron Hitchen reported the following:

- The Trust did not achieve its year end target for sickness absence although there had been a lot of activity in managing sickness. The LAS was still in the top 3 nationally in managing sickness. A realistic target would need to be set for next year;
- There would be a focussed approach to improving PDR completion;
- 95.6% of GMB members had voted to reject the pension proposals. This was therefore a mandate for GMB to continue with industrial relations activity. A further update would be provided to the Trust Board in part II.

57. Presentation on Olympic Preparedness

57.1 Peter Thorpe joined the meeting for this agenda item and gave an update on Olympic preparedness.

57.2 Murziline Parchment asked what alignment there was between the Olympics and business as usual. Peter Thorpe responded that the programme board included Paul Woodrow who was the lead for maintaining service delivery. Martin added that there was equal focus on business as usual as there was on the service for the Olympics.

57.3 Francesca Guy was asked to circulate the presentation to members of the Trust Board.

ACTION: FG to circulate the Olympics Preparedness presentation to members of the Trust Board.

DATE OF COMPLETION: 26th June 2012

58. CommandPoint Update

58.1 Peter Suter introduced Carol Hunt from Northrop Grumman who was working with closely with the LAS team as the project progressed towards business as usual.

58.2 Peter noted the following:

- CommandPoint go live had been a success and the Trust had begun to recover its performance. The live runs had been key to this success;
- Overall, the system was performing well. A number of issues had been identified, but this was not unexpected given the size of the system. The team would continue to work with Northrop Grumman to resolve these issues;

- The project was on track to close as planned by the end of June 2012, at which point it would transition to business as usual and staff would transfer to their previous roles.

58.3 Peter Suter commended all staff involved in the project, particularly those staff in the Emergency Operations Centre.

58.4 Beryl Magrath congratulated Peter Suter and everyone involved in the project and noted that this was a significant achievement.

59. Audit Committee Assurance Report

59.1 Mike Dinan reported that the Audit Committee had last met on 14th May and noted the following:

- The Audit Committee had reviewed the draft Annual Accounts, which would be approved at the Audit Committee meeting on 1st June 2012;
- The Audit Committee noted that good progress had been made with the corporate risk register which meant that it was now a live and dynamic document, which accurately reflected the key issues facing the Trust;
- Updates from the Quality Committee and the Finance and Investment Committee;
- The External and Internal audit review. The year end audit was progressing to plan and no significant issues had been identified. External Audit Services would be transferred to Price Waterhouse Coopers in September 2012 and the Audit Committee requested assurance that this would not incur any additional costs;
- The Internal Audit Recommendations Progress Report. The Audit Committee noted that significant progress had been made in finalising internal audit reports.

60. Finance and Investment Committee Report

60.1 Mike Dinan reported that the Finance and Investment Committee had met the day after the last Audit Committee meeting on 15th May 2012. The Committee had discussed the following:

- An update on Olympic preparedness;
- Strategic Capital Plan and how this would be aligned with the Integrated Business Plan;
- Liquidity;
- Cost Improvement Programme;
- Business Case for the West Area Workshop.

61. Bank Mandates

61.1 Mike Dinan reported that Lloyds Banking Group was reducing its number of branches and the branch at which the LAS currently banked was closing. The Trust was therefore taking the opportunity to rationalise its banking arrangements.

61.1 The Chair recommended that the Audit Committee, which was meeting on Friday have delegated authority to review this.

62. Major Incident Plan

62.1 Martin Flaherty reported that the Major Incident Plan had been revised following the 7/7 London Bombings inquest. The key areas of change had been listed on the front sheet. Francesca Guy agreed to circulate the full version of the Major Incident Plan to members of the Trust Board via email.

ACTION: FG to circulate the full version of the Major Incident Plan via email.

DATE OF COMPLETION: 1st June 2012

62.2 Martin commented that the Major Incident Plan had been submitted to the Trust Board for information only and had been approved by the Senior Management Group.

63. Report from Trust Secretary

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

63.2 In response to a question from Beryl Magrath, Mike Dinan stated that approximately 200 vehicles would need converting in order to comply with the Lower Emission Zone requirements.

64. Forward Planner

64.1 Trust Board noted the forward planner and noted that the new version of the balanced scorecard would be presented to the June meeting. A review of the strategic risks would be added to the forward planner for the Strategy Review and Planning Committee in July.

65. Any other business

65.1 There were no items of other business.

66. Questions from members of the Public

66.1 Joseph Healy expressed his thanks to Peter Bradley, particularly for his contribution to the Patients' Forum. Joseph added that he had invited the Trust Chair to attend the next meeting of the Patients' Forum in July to discuss the future of LAS.

67. Date of next meeting

67.1 The next meeting of the Trust Board will take place on Tuesday 26th June 2012 at 10.00.

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Signed by the Chair

ACTIONS
from the Meeting of the Trust Board of Directors of
LONDON AMBULANCE SERVICE NHS TRUST
held on 24th January 2012

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
28/06/11	**67.3**	**Chairman's Report** RH to discuss world cities benchmarking with FM.	**RH/FM**	FM reported that she had attended a meeting of the 'Eagles', which comprised the medical directors of ambulance trusts in large cities across the world. The meeting provided a forum to discuss topics of interest and each of the attendees were asked to make a 10 minute presentation. This provided a good opportunity to showcase the work and innovative practice of the LAS. PB commented that he had strong links with the Canadian and Australasian ambulance services and would continue to share best practice. This action was ongoing.
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**	Peter Bradley reported that one of the key recommendations of the National Audit Office report was to introduce the clock start change. This had now been approved and would go live from 1st June 2012. The Trust Board would be kept updated on the impact of this.

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
29/11/11	**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 to be trialled at the June meeting of the Trust Board.
27/03/12	**26.7**	MF to follow up with John Pooley on the status of the letters to the entrants on the High Risk Register and the associated risks.	**MF**	Letters are being sent, from a number of stations, to entrants in categories 1 to 3 of the High Risk Register. An update is provided in the Clinical Quality and Patient Safety Report.
27/03/12	**28.7**	RH to discuss with PB his experiences of tackling attitude and behaviour issues.	**RH**	Action outstanding.
27/03/12	**20.3**	SMG to identify the specific deliverables and deadlines against each of Trust Priorities for presentation at the next Strategy Review and Planning Committee.	**SMG**	The deliverables and deadlines against each of the Trust priorities would be the subject of discussion at the next Strategy Review and Planning Committee in July.
27/03/12	**34.3**	FG to add review of strategic risks to the forward planner for the Strategy Review and Planning Committee.	**FG**	Action complete.
29/05/12	**44.1**	FG to amend the minutes of the Part I meeting held on 27th March 2012.	**FG**	Action complete.
29/05/12	**46.3**	LB to publish patient story in the GP newsletter.	**LB**	
29/05/12	**48.2**	SL to review the wording of the Quality Account to ensure accessibility and remove any jargon.	**SL**	
29/05/12	**48.3**	PB/SL/AP to produce an abridged version of the Quality Account.	**PB/SL/AP**	
29/05/12	**51.2**	LB/MF/PB to discuss with Joseph Healy outside of the meeting the questions he had submitted to the Trust Board, which had not been dealt with at the meeting.	**LB/MF/PB**	
29/05/12	**52.2**	Trust Board to email feedback on the Annual Report and Accounts to Mike Dinan.	**TB**	
29/05/12	**56.12**	MD to circulate the month 1 finance report to member of the Trust Board.	**MD**	
29/05/12	**57.3**	FG to circulate the Olympics Preparedness presentation to members of the Trust Board.	**FG**	Action complete.
29/05/12	**62.1**	FG to circulate the full version of the Major Incident Plan via email.	**FG**	Action complete.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH JUNE 2012

PAPER FOR INFORMATION

Document Title:	**Report from the Chairman**
Report Author(s):	**Trust Chair**
Lead Director:	**N/A**
Contact Details:	**marilyn.cameron@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To provide the Trust Board with an update from the Trust Chairman on key activities since the last meeting**
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 ☐ Finance and Investment Committee ☐ Other
Recommendation for the Trust Board:	**To note the report**

Key issues and risks arising from this paper

None.

Executive Summary

- Have completed 1:1s with all non exec colleagues
- Have held weekly review calls with Jim Myers of Northrop Grumman
- Communicated to selected external parties Peter's intended resignation later this year
- Attended Capstick's briefing on the health and social care bill.
- Attended King's Fund presentation on learning points from Mid Staffs story
- Attended Project Amber operation at the Olympic Deployment Centre
- Attended lunch hosted by the new London Assembly members at City Hall following the recent elections
- Met new head of Northrop Grumman in the UK, Danny Milligan
- Participated in ASN board meeting and prepared papers etc for Chairs Meeting before the ALF conference
- Met KPMG for final debrief on board governance review
- Attended dinner for selected NHS Chairs hosted by Saxton Bampfylde the majority of which were external LAS stakeholders
- Meeting with Dame Ruth Carnall, CEO of NHS London

Attachments

None.

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Quality Strategy

This paper supports the following domains of the quality strategy

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

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

Equality Analysis

Has an Equality Analysis been carried out?

- ☐ Yes
- ☒ No

Key issues from the assessment:

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26 JUNE 2012

PAPER FOR NOTING

Document Title:	**Quality Dashboard & Action Plan**
Report Author(s):	**Steve Lennox**
Lead Director:	**Steve Lennox**
Contact Details:	**Steve.lennox@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Inform Trust Board current position against quality measures**
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:	**Note the report**

Key issues and risks arising from this paper

This report identifies that the LAS remains one of the top performing Ambulance Trusts in the country.

Executive Summary

There are three components to the Quality Dashboard & Action Plan

1. **Quality Dashboard (April 2012)**

The dashboard illustrates the Trusts performance for April 2012 against the identified Quality Measures. The challenge and discussion for each indicator has been undertaken at SMG and Quality Committee where a Full Quality report supported the dashboard.

The Trust is Green for 11 of the indicators, Amber for 9 of the indicators and Red for 16 of the indicators. This position is similar to the previous month. 1 indicator (% of priority training commitments delivered) is not RAG rated as the Trust did not deliver mandatory training in April. This is a CQUIN for 2012-2013 and a trajectory will be developed for delivery later in the year.

2. **DH Quality Measures (Comparison)**

The DH mandatory quality measures have been lifted from the dashboard in order to offer a comparison across all other ambulance services. Some of the DH indicators appear Red on the dashboard as we have set ourselves tough SMART targets but appear more favourable when comparing against other services as there is no associated SMART target when making comparisons.

Some of the 11 DH measures (service experience has been excluded) are made up of a number of indicators. As this is the start of a new year the year to date comparisons have not been made for April.

The Trust is in the upper quartile for 19 of the 22 indicators.

Overall the Trust is still in the top 3 performing ambulance Trust for April 2012 even with CommandPoint implementation. The following table illustrates the number of top performing measures each Ambulance Trust has in the 22 information points (not all comparisons are drawn from statistically significant data therefore, this is merely a discussion point).

Isle of Wight 4 (18%)
South central 4 (18%)
London 3 (14%)
North West 3 (14%)
West Midlands 2 (9%)
Great Western 2 (9%)
North East 2 (9%)
South East Coast 2 (9%)
East of England 1 (4.5%)
South Western 1 (4.5%)
Yorkshire 1 (4.5%)
East Midlands 0 (0%)

3. Quality Action Plan

The supporting action plan identifies a number of actions that are in place to improve against the SMART targets of the quality dashboard. This will be superseded by the Clinical Strategy later in 2012.

Attachments

1. Quality dashboard
2. DH Quality Measures (Comparison)
3. Quality Action Plan

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Quality Strategy

This paper supports the following domains of the quality strategy

- ✓ Staff/Workforce
- ✓ Performance
- ✓ Clinical Intervention
- ✓ Safety
- ✓ Clinical Outcomes
- ✓ Dignity
- ✓ Satisfaction

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

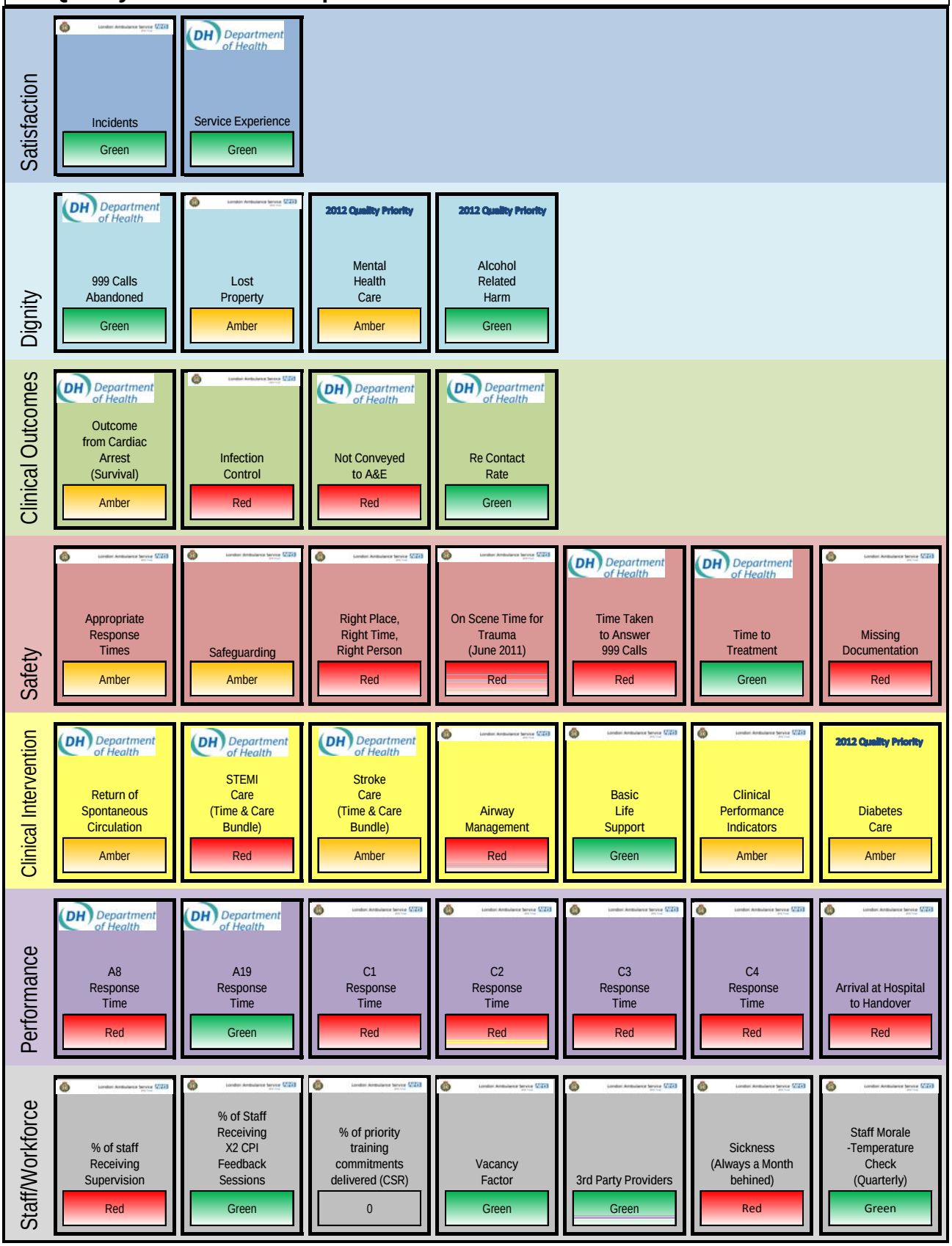
Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

- ☐ Yes
- ✓ No

Key issues from the assessment:

1. Quality Dashboard for April 2012



DH Measures Comparison Table

10.1 The following table identifies the Department of Health Indicators and our ranking against other Ambulance Trusts and our direction of travel.

10.2 The GREEN shading represents where the Trust is in the upper quartile when compared to other services. In April we were upper quartile in 9 out of 22 areas and the direction of travel is up in 11 of the indicators.

	March (December)			Year to Date	
	Compliance	Rank	Direction of Travel (Compliance)	Compliance	Rank
A8 Response Time	71.9%	11th	↓		
A19 Response Time	98.4%	1st	↔		
ROSC (all)	28.9%	2nd	↑		
ROSC (Utstein)	48%	3rd	↑		
Time Taken to Answer 50th Percentile	0 Seconds	1st	↔		
Time Taken to Answer 95th Percentile	21 Seconds	9th	↑		
Time Taken to Answer 99th Percentile	76 Seconds	10th	↑		
Time to Treatment 50th Percentile	336 Seconds	9th	↓		
Time to Treatment 95th Percentile	852 Seconds	3rd	↓		
Time to Treatment 99th Percentile	1365 Seconds	6th	↓		
Outcome from cardiac Arrest Survival	6.9%	4th	↑		
Outcome from cardiac Arrest Survival (Utstein)	28.9%	1st	↑		
STEMI Outcome 150 minutes	92.5%	5th	↑		
STEMI Outcome Care Bundle	63.5%	12th	↓		
Stroke Outcome 60 minutes	65.9%	6th	↑		
Stroke Care Outcome Bundle	95.6%	9th	↑		
Calls Closed with CTA	4.8%	10th	↓		
Non A&E	30.4%	10th	↓		
Re Contact rate CTA	3.6%	2nd	↑		
Re Contact rate See & Treat	4.4%	3rd	↓		
Re Contact rate Frequent callers	2.8%	5th	↑		
999 Calls Abandoned	0.1%	1st	↓		
Service Experience	No measure				

Quality Improvement Actions

Domain	Quality Measure	Action	Where Monitored	Who is Responsible	Impact	Progress (June 2012)
Staff/Worforce	% of staff receiving supervision	Director of Operations/Deputy Chief Executive clarifies the need to populate OWR data with the Assistant Directors of Operations. (added February 2012)	Operations meetings	Deputy Chief Executive; Martin Flaherty	↔	PPED numbers extremely high. Need to concentrate on OWR as numbers not as high as they need to be.
Staff/Worforce	% of Priority Training Commitments Delivered (CSR)	1) Training figures to be accurately reported by marrying corporate figures with new ways of working data capture. (added February 2012)	Training & Strategy Group	Director of Human Resources; Caron Hitchen		Awaiting for trajectory to be agreed.
Performance	**Added June 2012** All category C performance	Action plan to be developed for SMG approval and monitoring	SMG	Chief Operating Officer		Identified as SMG objective. Actions need identifying.
Performance	Average Arrival at Hospital to handover	Continue to champion with GPs and through commissioning and performance routes (added February 2012)	Clinical Quality Group	Deputy Director of Strategic Development Lizzy Bovill	↔	Continues to be addressed as a whole economy approach

Physiological	STEMI Outcome	Medical Director to continue to push for national agreement on analgesic intervention for STEMI care (added February 2012).	CQSEC	Medical Director, Fionna Moore	↔	This is a long term action point overall the measure is stable..
Physiological	Outcome from Stroke	Quality Improvement managers to reinforce the need for complete documentation and report back though area Governance to CQSE (added February 2012).	Area Governance Committees & CQSEC	PIMS	↑	Continue to monitor impact of ECG changes.
Physiological	Airway Management	Area Quality Leads to focus on local actions and report to CQSE (added February 2012)	Area Governance & CQSEC	Director of Health Promotion & Quality & Medical Director Fionna Moore & Steve Lennox	↔	Area Quality Committees asked to forward actions taken to CQSEC (too early in reporting cycle to report)
		Paramedic Consultant meeting with senior training staff to review training (added March 2012)	Clinical & Quality Directorate	Paramedic Consultant	↔	Too early to report.
Physiological	CPIs	Area leads to reinforce the need to undertake a full assessment prior to deciding not to convey (added February 2012)	Area Governance Committees & CQSEC	PIMS	↔	Reporting cycle too early to observe any real benefits.
		Asthma improvement is being addressed through the Area Governance Committees with each being asked to report actions being taken, In	Area Governance Committees & CQSEC	PIMs and Paramedic Consultant. Mark Whitbread.		Quarterly reporting and monitoring

		addition the training of the care bundle is being refreshed (added February 2012).				
Safety	Appropriate Response Times	Clinical Audit to recover the data and ensure a data set is available for the next report (added February 2012).	Quality & Clinical Directorate	Director of Health Promotion & Quality & Medical Director Fionna Moore & Steve Lennox		Completed March 2012
Safety	Appropriate Response Times	To be discussed at Senior Managers Conference and Area Quality Meetings (added May 2012)	SMG	Director of Health Promotion & Quality & Medical Director Fionna Moore & Steve Lennox	↑	Awaiting to see benefits from discussion at senior managers conference
Safety	Safeguarding	East area to focus on improving the timeliness of safeguarding referrals (added February 2012). Ensure maximum attendance at remaining CSR 1 sessions (added February 2012)..	East Area Governance Committee Training & Strategy Group	Assistant Director of Operations. Katy Millard Chief Operating Officer. Martin Flaherty		Completed May 2012
Safety	Right Time, Right Place, Right Person	Clinical Audit to recover the data and ensure a data set is available for the next report (added February 2012).	Quality & Clinical Directorate	Director of Health Promotion & Quality & Medical Director Fionna Moore & Steve Lennox		Completed May 2012
Safety	On scene time for Trauma	Area Governance Committee to report to CQSE the local action taken (added February 2012).	Area Governance Committees & CQSEC	PIMS		Too early in reporting cycle to report benefits. Not reported in March Quality Dashboard

Safety	Missing Documentation	Ensure Performance Improvement Managers are aware this is now monitored centrally and is seen as a fundamental part of safety and is to feature within area governance reports (added February 2012).	Area Governance Committees & CQSEC	PIMS	↓	Continue action to drive further improvement.
Clinical Outcomes	Outcome from Cardiac Arrest	This is a complex issue Paramedic Consultant is going to explore and feedback to Medical Directorate (added February 2012).	Medical Directorate	Paramedic Consultant. Mark Whitbread		Improved results. Action closed.
Clinical Outcomes	Infection Control	PIMS to recover the data capture system for the scorecard (added February 2012).	Area Governance Committees & CQSEC	PIMS		Scorecard now recovered and populated. Training compliance now hindering full green RAG rating
Esteem & Respect	Pain Relief	Clinical Audit to recover the data and ensure a data set is available for the next report (added February 2012).	Quality & Clinical Directorate	Director of Health Promotion & Quality & Medical Director Fionna Moore & Steve Lennox		Action Closed in May 2012
Satisfaction	Service Experience	Performance managers to report on actions being taken to improve attitude and behaviours (added February 2012).	Area Governance Committees & CQSEC	PIMS		Too early in reporting cycle.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH JUNE 2012

PAPER FOR APPROVAL

Document Title:	**2011-2012 Quality Account**
Report Author(s):	**Steve Lennox**
Lead Director:	**Steve Lennox**
Contact Details:	**02077832299**
Why is this coming to the Trust Board?	**Statutory requirement**
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 ☐ Finance and Investment Committee ✓ Other: Previous Trust Board
Recommendation for the Trust Board:	**Approval prior to publication on NHS Choices**

Key issues and risks arising from this paper

None

Executive Summary

Publication of the Quality Account is a legal requirement. The account informs the public on a number of quality issues. The DH provides a template and there are a number of mandatory statements within the template.

In addition, a fundamental part of the process is to ask key stakeholders to give an opinion on the account and it is mandated that that opinion is published as part of the account.

A draft version of the Quality Account was presented at the May Trust Board prior to circulation to key stakeholders. The report presented here is the final version, including stakeholder comments that is to be published on NHS choices.

This version has had a final grammatical check and a few modifications have been made to some of the jargon identified at the last Trust Board. A shorter summarised version will be prepared for the AGM in September that attendees will be able to take away from the meeting.

The quality reporting and success stories are as reported at the last Trust Board.

Attachments

To follow: Quality Account 2011/12

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Quality Strategy

This paper supports the following domains of the quality strategy

- ✓ Staff/Workforce
- ✓ Performance
- ✓ Clinical Intervention
- ✓ Safety
- ✓ Clinical Outcomes
- ✓ Dignity
- ✓ Satisfaction

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

- ☐ Yes
- ✓ No

Key issues from the assessment:

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH JUNE 2012

PAPER FOR APPROVAL

Document Title:	**Infection Prevention & Control Annual Report 2011/12**
Report Author(s):	**Trevor Hubbard, Shane Platt, Ian Bullamore & Steve Lennox**
Lead Director:	**Steve Lennox, Director of Quality and Health Promotion**
Contact Details:	**020 7783 2299**
Why is this coming to the Trust Board?	**Statutory requirement**
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 ☐ Finance and Investment Committee ☐ Other
Recommendation for the Trust Board:	**To approve the Infection Prevention and Control Annual Report for 2011/12**

Key issues & risks arising from this report

None.

Executive Summary

Key issues and risks arising from this paper.

This has been a successful year for Infection Prevention & Control where a number of initiatives have embedded across the organisation. These include;

- Embedded dashboard
- Improved compliance with hand hygiene
- Improved deep clean performance
- Improved reporting from the areas
- Revised Infection Prevention & Control Committee membership
- Revised action plan
- Improved CQC compliance
- Policies reviewed

It is a legal requirement for the Director of Infection Prevention and Control to produce a report for Trust Board.

Attachments

Infection Prevention & Control Report 2011/12

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Quality Strategy

This paper supports the following domains of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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- ☐ 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:

London Ambulance Service NHS
NHS Trust

Infection Prevention & Control

Annual Report 2011 / 2012

Contents

List of Appendices

1 Introduction

This is the annual report for Infection Prevention and Control (IPC) within the London Ambulance Service NHS Trust from the Director of Infection Prevention Control (DIPC). This report is to inform the Board of the progress made against the Care Quality Commission standards, and the Department of Health 'Health and Social Care Act 2008' during the last 12 months, and to outline the IPC programme for 2012 / 2013.

The report provides information of the ongoing commitment of the Trust to entrench IPC principles and practices throughout the service and shows the significant improvements the Trust has made in this respect.

2 Background

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

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

2.1 Health and Social Care Act 2008 (revised 2010): Code of Practice for Health and Social Care on the Prevention and Control of Infections and related guidance (Department of Health).

Section 21 of the Health and Social Care Act (2008) enables the Secretary of State for Health to issue a revised code of practice. The code contains statutory guidance about compliance with the registration requirement for cleanliness and infection control. The Act states that the code must be taken into account by the Care Quality Commission when decisions are made regarding the cleanliness and infection control standards required to achieve registration.

During December 2010 the Department of Health published a revised Code of Practice on the Prevention and Control of Infections and Related Guidance. The new code focuses on 10 areas as opposed to the previous 9, due to the addition of Criterion 4. The revised Criteria are detailed in Table 1 (below). Although the exact wording of the majority of requirements has been revised, the general meaning and purpose remain the same with no new requirements detailed.

Table 1 – Revised Code of Practice Criteria

Criterion	Requirement	Current LAS Standard (April 2012)
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.	Green
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Green
3	Provide suitable accurate information on infections to service users and their visitors.	Green
4	Provide suitable accurate information on infections to any person concerned with providing further support or nursing/ medical care in a timely fashion.	Green
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.	Green
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.	Green
7	Provide or secure adequate isolation facilities.	Not Applicable
8	Secure adequate access to laboratory support as appropriate.	Not Applicable
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	Green
10	Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.	Amber

We have achieved green in most criteria; the only exceptions are 7 & 8, which are not applicable to the Trust and Criteria 10, where the information for immunisation records was not made readily available to IPC.

2.2 The Operating Framework for the NHS in England 2011-2012

The NHS Operating Framework recognises that there is still scope to drive Healthcare Associated Infections down further and states: '*NHS organisations should aim for a zero tolerance approach to all healthcare associated infections and all organisations must identify and adjust plans so that they can operate at the level of the best'*. The Trust sees this as a priority and is currently working towards achieving this standard.

2.3 NHS Litigation Authority (NHSLA) Risk Management Standards for Ambulance Trusts (2011 – 2012)

The NHS Litigation Authority is a Special Health Authority, established in 1995 to administer the Clinical Negligence Scheme for Trusts and thereby provide a means for NHS organisations to fund the cost of clinical negligence claims. Infection Prevention and Control was removed from these standards as it was recognised that these were being addressed by the Care Quality Commission Regulations and the Health and Social Care Act 2008 (amended 2010).

3 Board Assurance

It is mandated that each NHS organization has a designated Director for Infection Prevention and Control (DIPC) and that the post reports directly to the Chief Executive Officer and the Trust Board. The Director of Health Promotion and Quality has been designated as the Trust's Director of Infection Prevention and Control with lead responsibility within the Trust for IPC. The Trust Board holds overall responsibility for ensuring that the Trust is compliant with IPC national guidance.

4 Performance Monitoring

4.1 Infection Prevention and Control Committee

The aim of the Infection Prevention and Control Committee is to provide assurance to the Trust Board that all services are provided in a clean and safe environment through the effective performance monitoring of key performance indicators. It provides a forum for the co-ordination of any IPC related projects ensuring a consistent approach to IPC throughout the Trust.

The group is responsible for providing assurance to the Director of Infection Prevention and Control. It monitors compliance with the Health and Social Care Act 2008 (amended 2010) via monthly updates from complexes relating to the IPC audits for

vehicles, premises and observed practice, deep clean status of vehicles and training attendance. The Infection Prevention and Control Committee receives recommendations from other key groups including the Clinical Equipment Group, Vehicle Working Group, Clinical Decontamination Group and Corporate Health and Safety, and plays a key role in performance managing and policy implementation.

4.2.1 Director of Infection Prevention and Control

It is the responsibility and role of the DIPC to:

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

4.2.2 Ambulance Operations Manager for Infection Prevention and Control

The Ambulance Operations Manager for IPC has delegated responsibility from the DIPC to provide infection control advice to all disciplines within the Ambulance Trust on a day to day basis.

- To produce written reports on compliance with the Health & Social Care Act 2008 for the Care Quality Commission registration requirements and ensure that accurate records are kept.
- To advise line managers within the Trust on the implementation of agreed policies in their areas.
- To report to the Trust Infection Control Steering Group and other appropriate committees within the trust's Governance structure as necessary.
- To undertake under the direction from the Head of Operational Support and Assistant Director of Corporate Services research for evidence based practice and clinical effectiveness and the planning of future services and training needs.

4.2.3 Practice Learning Manager West

The Practice Learning Manager for the West has been delegated as the Training Lead for IPC; this role encompasses the development of training packages, input into the content of policies regarding training and IPC, ensure IPC is embedded into training and practice of all staff and represents the training department in the various sub groups.

4.2.4 Infection Control Champions

The Infection Control Champion role has been introduced to provide all staff with a local link at complex or department level. Infection Control Champions have received additional training and have an increased awareness of IPC procedures. The Infection Control Champions also undertake audits to assist the entry of IPC statistics to the Trust X:/ drive. The role will be further developed to also build stronger relationships with local Trusts and organisations to increase the community awareness of IPC and its benefits.

4.3 Infection Prevention and Control Annual Programme Report / Work Programme

The Trust has shown that it has taken on board and implemented the IPC recommendations from both internal and external reviews such as the Department of Health / Care Quality Commission improvement visit. The Performance Accelerator governance table, which is in place to assure the DH/Care Quality Committee and NHSLA that the Trust is meeting all its required criteria. The Hygiene Code section of this governance tool indicates a significant increase in achieving the desired targets within the last 12 months.

4.4 Policy Review and Development

All IPC policies and procedures have been reviewed and updated as appropriate during 2011-2012 following national guidance and legislation. All policies and procedures are available both as a hard copy on every complex, and on The Pulse which has its own dedicated IPC section. The IPC team has also developed a new policy for the Transportation of Specimens, Decontamination Policy and a new Management of Sharps Policy. There has also been a review and revision of the IPC Policy to come into line with NHSLA Level 2.

4.5 Education

The Trust has ensured on-going training of all staff with a variety of IPC updates; these have been delivered face to face on Clinical Skills Refresher courses, bulletins via The Pulse and Routine Information Bulletin, communication briefings and the rollout of a new IPC Training Workbook.

There is also an e-learning module available on the Skills for Life website which has been redesigned with the assistance of West London University to incorporate ambulance work. Station notice boards have also been utilized to ensure that the key IPC information is easily accessible to all staff. The IPC team are responsible for ensuring that all IPC education material is up-to-date and reflects current best practice for the Trust in line with national guidance. Hand hygiene and 'bare below the elbow' has been a core theme throughout all training packages and compliance with this is monitored with an Audit Tool and recorded on the IPC area of the Trust X:/ drive.

The 'All-in-1' mandatory and refresher course for all non-clinical staff has been delivered successfully, being organised via the Learning and Development team.

Training Officers, Clinical Tutors and Team Leaders have been given the responsibility for the delivery of IPC training packages at station level, the record of this training has been entered on the Trust X:/ drive, summary details are listed in table 2 below. IPC education forms part of the Trust's mandatory education programme and also for the induction of new starters.

Table 2 – Complex Training Figures

Complex	Infection Control Training %
West	
Brent	1
Camden	88
Friern Barnet	51
Fulham	49
Hanwell	63
Hillingdon	92
Islington	93
Isleworth	54
Pinner	143
East	
Chase Farm	109
Edmonton	47
Homerton	0
Newham	104
Romford	0
Tower Hamlets	3
Whipps Cross	177
South	
Barnehurst	76
Bromley	96
Croydon	21
Deptford	61
Greenwich	0
New Malden	114
Oval	0
St Helier	42
Waterloo	0
Wimbledon	31
Total Avg%	58.3

4.6 Third Party Contractors

The Trust has also taken on two new contractors, Lakethorne (premises cleaning) and Rentokil-Initial (vehicle preparation) which also have responsibility, in part for infection prevention and control. The inspection of their IPC training and monitoring is assessed and reviewed by the Trust IPC team.

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

4.7 Annual Audit Programme

The IPC annual audit programme has been very successful in providing Board Assurance in order to declare compliance with the Health and Social Care Act 2008 (amended 2010).

The audit schedule is operated on a monthly basis, with each complex reporting compliance within a strict timeframe and populating the data on the infection control balance scorecard (this scorecard was directly presented to the board during an escalated phase in 2010-2011) .

This scorecard and audit programme has enabled the trust to identify key trends in non compliance and take any required action to address this in a swift and timely manner.

The monthly audit results are RAG rated and published on the Trust X: drive.

The RAG rated score is calculated below:

GREEN	≥ 95%	Compliant
AMBER	75.1 – 94.9%	Partially Compliant, action required
RED	≤ 75%	Minimal Compliance, Urgent action required

4.7.1 Mapping Improvement

There have been many vast improvements in the reporting of hygiene, cleaning and training in the last 12 months. The Audit Programme has ensured easier access to the reporting and sharing of information for IPC. A few comparisons that can be made are shown in the table below;

Area of Audit	March 2011	March 2012	Difference
Hand Hygiene (Compliance)	Avg 34.5%	Avg 85.6%	Increase of 51.1%
IPC Training (Compliance)	Avg 74.4%	Avg 58.3%	Decrease of 16.1%
Vehicle Audits (Received)	313	880	Increase of 281%
Premises Audits (Received)	233	209	Decrease of 11%

It has shown that the increases are a vast improvement, where the decreases are nominal.

4.8 Area IPC Audit Proforma

The area IPC audit proformas are presented to the Infection Prevention Control Committee in order to gain assurance of individual area and complex compliance. Any exceptions are notified and action plans developed to address any shortfalls.

4.9 Audit Tools

The IPC team has re-evaluated the audit tools with the result that there are now 4 audit tools. These are;

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

4.10 Deep Clean

The Trust has recognised that cleanliness in the patient environment is paramount for patient safety and reducing the likelihood of Healthcare Associated Infections. The Trust has ensured that every complex has access to staff that perform deep cleaning of all vehicles and equipment. The Trust implemented a 4 weekly deep clean schedule for vehicles. This proved to be very successful in maintaining a high level of cleanliness in our vehicles. During February 2012 a new 4 weekly deep cleaning schedule was introduced with all patient carrying vehicles being cleaned every 4 weeks. Each complex has responsibility for ensuring that 100% of its vehicles are cleaned within the timeframe. The results of the deep clean programme are presented to the IPCC where any exception is also reported. The deep clean compliance figures form part of the IPC Key Performance Indicators and are therefore key in attaining compliance with the Health and Social Care Act 2008 (amended 2010).

5 Decontamination

The Trust appointed Christopher Vale, Head of Operational Support as the nominated Decontamination Lead. The Decontamination Lead works in partnership with the Ambulance Operations Manager IPC to ensure a comprehensive approach to medical devices management, procurement of, and the suitability of cleaning products. A member of the IPC team sits on the Equipment Working Group.

6 Communications Strategy

An IPC communications strategy was launched to assist in embedding IPC Policies and Procedures into everyday practice throughout the Trust. The strategy has utilised a mix of communication formats to get the right messages across to staff in a timely manner. This has resulted in staff being able to access information both remotely and whilst on station. Key subject areas are;

- Hand Hygiene
- Appropriate Glove Usage
- Sharps Awareness
- Seasonal Flu Vaccinations
- Norovirus
- Audits
- Personal Protective Equipment
- Vehicle Cleanliness
- Category 4 Infections
- 3 Poster Presentations

7 Hand Hygiene

Effective hand hygiene continues to be promoted by the IPC team and is evidenced through the hand hygiene procedure which is available to all staff via the Infection Prevention and Control page on The Pulse, the IPC Toolkit, Induction and Essential Education programmes and hand hygiene posters. Monitoring of clinicians compliance takes place via the IPC Observed Practice Audit Tool and Clinical Supervision. The results from the Observed Practice audits for the year have shown a significant improvement. Work is ongoing to address the issue of appropriate glove usage and is part for the new IPC Training Workbook.

8 Occupational Health Department

Occupational Health is provided to the Trust by Guys and St Thomas' Occupational Health Department and is performance managed through the Human Resources department. Guys and St Thomas' Occupational Health Department are a contributing member of the Safety and Risk team providing quarterly data on needle stick injuries, vaccinations, post exposure prophylaxis and any skin allergies due to glove or alcohol gel usage. To support frontline staff and reduce the incidence and impact of vaccine preventable illness in the work place, Guys and St Thomas' Occupational Health Department has liaised with Human Resources to ensure that staff are appropriately immunised. This work is ongoing and is monitored through the IPC team.

9 Needlestick Injuries

The Safety and Risk Department has provided the figures for the type and total of needlestick injuries. The current procedure for the reporting of needlestick injuries has been updated and is found in the latest Management of Sharps Policy. The full procedure and process for the treatment and reporting of such injuries can be found on The Pulse, on complex or in the IPC Training Workbook.

There were a total of 62 (12 unused and 50 used) reported needlestick injuries during the year 2010/2011, this has increased to 87 (21unused and 66 used) in 2011/2012. The cause of needlestick injuries varies; the most common accidents are during the disposal process. The appropriate training has been identified and provided to the members of staff where necessary.

10 Seasonal Influenza

The 2011/12 flu season saw us achieve the highest vaccination rate amongst staff in a seasonal flu period. Nearly 1700 staff were vaccinated across the Trust, around 40% of the workforce.

This was acknowledged by the LAS being invited to present “Flu vaccination and healthcare workers; how to improve compliance” at a national conference in May 2012. This was undertaken by Paul Williams the pandemic flu lead at LAS.

Our success can be contributed to a number of factors including;

- Early preparation in 2011.
- The use for the first time of Ambulance service personnel in a national communications campaign. The staff involved were London Ambulance staff and came from Control services, Operations, Fleet and Logistics and Support Services.
- We were fortunate to be able to utilise a member of staff on restricted duties who was instrumental in maintaining the programme administration.
- A mild winter and low levels of flu activity contributed to more staff being able to access the vaccine, supported by a network of complex based vaccinator clinics.
- The work of the dedicated member of communications department staff was crucial in allowing us to access as many staff as possible through the widest range of media.

Work is underway to prepare for next season which will include providing more mobile vaccine clinics and building on the national communications provided this year from NHS Employers.

11 Serious Incidents and Complaints

During 2011/2012 there were 2 complaints passed to IPC, these were both regarding blood/body fluid spillages and clinical waste being left on scene, in a public place. No LAS action was required for either of these cases.

IPC carried out a Root Cause Analysis for a MRSA Bacterium case; this was found not to be the liability of the Trust.

One investigation was held for an outbreak of Hepatitis C in a central London hospital where the LAS were said to be a common link. The investigation concluded that the LAS could be excluded from the cause due to the many differentiating factors involved.

12 External Partnerships

The IPC team works with many external sources to assist in the smooth implementation of the latest IPC policies and procedures. Some of our IPC partners include;

- NASICN – National Ambulance Service Infection Control Network
- HPA – Health Protection Agency
- BCAS - British Columbia Ambulance Service
- IPS – Infection Prevention Society
- RCN – Royal College of Nursing
- NICE – National Institute for Clinical Excellence
- DH – Department of Health

13 Achievements in 2011-2012

The report has already identified a number of achievements in improving infection prevention and control within the Trust. However, the LAS have also played a part in shaping the national picture in infection prevention and control prevention. These are detailed below

- The Trust hosted the first infection prevention society conference for ambulance services. This was chaired by the Trust DIPC.
- Dixie Dean, paramedic, presented at national conference on designing a 21st century ambulance
- Trevor Hubbard chairs the national ambulance forum at the infection prevention society
- 3 posters were presented at IPC conferences in 2011 in the following subjects:
- Category 4 infection and the role of the London Ambulance Service (Health Protection 2011 Warwick University)
- Patient Environment Action Group in IPC within an Ambulance Trust (IPS Conference 2011 Bournemouth)
- The use of bacillus subtilis as a cleaning agent: a trial of its use at a London Ambulance Station (IPS Conference 2011 Bournemouth)Trust audit of Aseptic Non Touch Technique Development of pathway for ambulance trusts for patients with acute onset diarrhoea

14 Conclusion

Patient safety is a top priority for the Trust and IPC is an integral part in achieving this. The Trust has shown its commitment to IPC by the systems and processes implemented during 2011-2012. Trust staff has worked hard to achieve the IPC objectives for the year. This has now set the foundations for taking the IPC agenda forward. Making and sustaining improvements in the experience patients have whilst in our care through focusing on safety and quality will be the primary focus for the forthcoming year.

Appendix 1; 2012 Action Plan.

Delivery Plan

Summary of Workstreams and Status

Created 20 December 2010

Workstream	R.A.G February					
Workstream 1 (incorporating WS 9). There is risk that the Trust does not follow Department of Health Guidelines for the re-use of linen (Risk Register &CQC). 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 (Risk Register)	Amber					
Workstream 2. There is a risk that cleaning arrangements are insufficient to ensure that the environment for providing healthcare is suitable, clean and well maintained. (Risk Register & CQC).	Amber					
Workstream 4. There is a risk that the inadequate facilities and lack of policy for the decontamination of equipment may increase the risk of infection. (Risk Register & CQC) & The risk of incurring liability through the re-use of "single use" equipment.. (Risk Register &CQC)						
Workstream 6. 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.	Amber					
Workstream 8. There is a risk of infection to staff due to sharps injury (Risk Register).						
Workstream 12. Infection Control Champions (Previous Action Plan)	Amber					
Workstream 15. Improving Hand Hygiene Compliance (Balance Scorecard January 2011						

Developed: December 2010 Reviewed February 2012

Workstream 1. There is risk that the Trust does not follow Department of Health Guidelines for the re-use of linen. (Risk Register & CQC) **Supporting Documentation** **Risk 327**								
Objective	**Current State**	**Action**	**Imp' Lead**	**Operational Lead and involved individuals**	**Date of Completion**	**Current Risk**	**Measure of Success**	**Evidence**
1.1 Increase availability of blankets for A&E crews	Additional linen and disposable blankets added to stocks and circulated	Continue	David Hutton	Chris Vale	31/03/2011		Improved availability of blankets	KPI measuring blankets collected/ delivered
1.2 Improve collection of soiled blankets from hospitals and non-contract laundries	New laundry provider appointed and increased activity being established to collect blankets		David Hutton	Chris Vale	31/03/2011		Reduction in blanket loss	KPI measuring blankets allocated / delivered
1.3 To understand the scale of the problem and to develop a strategic solution to blanket usage	a) Unable to demonstrate compliance	Audit blanket usage as part of hand hygiene auditing	Steve Lennox	Trevor Hubbard	31/03/2011		Audits completed	Audit figures in place for compliance with guidelines
	b) Agreed strategic direction at recovery meeting and options paper to be written	Chris Vale developing options paper	Steve Lennox	Chris Vale	~~31/03/2011~~ ~~31/05/2011~~ ~~August 2011~~ February 2011		Solution in place	Strategic plan in place

	c) Audit results show compliance with single use is not consistent	1) PIMS to address locally. 2) DIPC to present at conferences 3) Continue to Audit	Steve Lennox	Trevor Hubbard	30/06/2011		Audit results	Compliance with blanket usage at audit
	d) Options paper presented to committee. Small sub group need to be formed	Karen/Chris to form small sub group to discuss options paper and endorse recommendations	Chris Vale	Karen Merritt	February 2012		Solution in place	Paper prepared for SMG
1.4 Ensure that the mattress has an adequate cover to protect the patient and trolley bed	a) That the process for sheets as a mattress cover is incorporated into the discussions about linen and its use	Karen / Chris to include as part of sub group discussion	Chris Vale	Karen Merritt	February 2012		Solution in place	Paper prepared for SMG

Updated April 18
1.1 Completed. Extra blankets bought for Winter 2010
1.2 No update
1.3 A) Auditing as part of Hand Hygiene Audits (continuing)
1.4 B) Options paper being developed. Deadline end of March missed. For reporting back at IPCC 8 May 2011

Updated May 5
1.2 Much improved. No reports of delayed collections. Item closed at Infection Control Committee.
1.3a Audits now being undertaken as part of Hand Hygiene Audits.
1.3b Options paper drafted. Deadline extended to end of May for refining the detail.
1.3c Added in May as audit results suggest poor compliance with policy

Update July 2011 (sub group meeting)
13.b Paper written but needs amending. Chris to ensure paper is written and suitable for SMG presentation

Update August 2011
1.3a & 1.3c Blanket usage now audited monthly at complex level. Although this may change and return during the winter months. Audit results demonstrate good compliance. Action Closed.

Update October 2011
1.3b 12,000 extra blankets ins system last year. 10,000 waiting to go into system this year.

Update November 9 2011
1.3b Options paper discussed. Chris Vale to nominate a lead to form a small working group that can "flesh" out the options in slightly more dteila nd re look at the

risks for further presentation at the next committee meeting.

Update February 2012
The decontamination meeting needs to happen in February. Work stream 9 to be incorporated in work stream 1 for future discussions on linen.

Developed: December 2010 Reviewed February 2012

Workstream 2. There is a risk that cleaning arrangements are insufficient to ensure that the environment for providing healthcare is suitable, clean and well maintained.. (Risk Register & CQC)

Supporting Documentation

Risk 324

Objective	Current State	Action	Imp' Lead	Operational Lead and involved individuals	Date of Completion	Current Risk	Measure of Success	Evidence
2.1 To ensure Trust is consistently compliant across the service	Compliant for the first quarter but inconsistent across the Trust	a) Find alternative processes to triangulate audit information	Steve Lennox	Trevor Hubbard	April '11		Alternative processes identified	Comprehensive dashboard
		b) Fully explore the opportunities within the PEAG initiative	Steve Lennox	Trevor Hubbard	~~April '11~~ August 2011		PEAG team fully involved in audit process	Comprehensive dashboard
		c) Make Ready tender ~~publicised~~ awarded	Richard Webber	David Hutton	~~March '11~~ ~~November '11~~ January 2012		Cleaning is fully compliant with CQC Outcomes	Cleaning audit results

Updated November 7 2011
2.1b This has been delivered and presented at national conferences. Now incorporated into usual infection control practice.
2.1c Down to 2 companies. Due to be finalised soon. Risk not closed or changed due to the risks associated with a change in provider.

Updated February 2012
Healthcare Initial appointed and go live from march 2012. Contract Manager to be appointed. That role will be key in performance and reporting.

Developed: December 2010 Reviewed February 2012

Workstream 4. There is a risk that the inadequate facilities and lack of policy for the decontamination of equipment may increase the risk of infection (Risk Register & CQC) and Workstream 7. The risk of incurring liability through the re-use of "single use" equipment.. (Risk Register &CQC)

Supporting Documentation

RISK 326 & RISK 63

Objective	Current State	Action	Imp' Lead	Operational Lead and involved individuals	Date of Completion	Current Risk	Measure of Success	Evidence
4.1 To have a decontamination policy that meets CQC expectations	a) No current policy in place	To have written policy submitted to IP&CC in February 2011.	David Hutton	Chris Vale	Draft Dec '10 Approved Feb '11		Decontamination policy in place	Fully compliant with CQC registration
	b) Establish Equipment Decontamination Improvement Group at Logistics Support Unit	Establish Group and Terms of Reference	Chris Vale	Karen Merritt	~~31/03/2011 May '11~~ January 2012		Improved processes in operation	Group minutes and actions
	c) Unknown compliance with decontamination guidance	Monitor decontamination compliance	Steve Lennox	Trevor Hubbard	~~Sept 11~~ January 2012		Audit results at 100%	Audit trail
4.2 All equipment to be used in adherence to manufacturers instructions	Single use equipment occasionally reused	**Actions will be delivered by above actions**	Steve Lennox	Trevor Hubbard				

Update November 7 2011
4.1b. Draft terms of reference to come to next committee meeting
4.1c This issue will sit with the new group and transfer to them once the group is established

Updated February 2012
Terms of reference created but to be approved by committee. Group to meet in February.

Workstream 6. 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. (Risk Register &CQC)

And There is a risk that paramedics are not trained in the use of aseptic no touch technique (ANTT).

Supporting Documentation

RISK 322 & 328

Objective	Current State	Action	Imp' Lead	Operational Lead and involved individuals	Date of Completion	Current Risk	Measure of Success	Evidence
6.1 To be fully compliant with CQC expectations and all staff to have up to date infection control training	All in One training and induction training available	Ensure all staff receive all in one training or alternative form of update	Caron Hitchen	Carmel Dodson-Brown	~~March 2011~~ February 2012		80% of non clinical staff trained in infection control annually	Training records
	Core Skills Refresher training and induction training available	Ensure all staff receive training or alternative form of update	Gill Heuchan	Ian Bullamore	~~March 2011~~ November '11		80% of clinical staff trained in infection control annually	Training records
	Basic training and assessment for clinical staff in Hand Hygiene and Aseptic Non Touch Techniques	Monitor and implement Hand Hygiene Training	Steve Lennox	Trevor Hubbard	~~March 2011~~ November '11		80% of clinical staff trained in hand hygiene annually	Training records
	Need to capture the training of contracted staff on the scorecard			TBD	~~? June 2011~~ November '11			

Update March 2011
ANTT IPC education and development bulletin issued. Some issues with wording need to be dealt with. Meeting on 30th March with IB to discuss

Update April 2011
6.1 a) No update but Carmel changed as the lead. For feedback at next IPCC 8 May 2011
6.1 b) No update. For feedback at next IPCC 8 May 2011

6.1 c) Ian and Trevor meeting 19 April for development of plan.
6.1 d) For feedback at next IPCC 8 May 2011

Update May 2011
General Update There was an over provision of training last year and all clinical staff have been trained in NTT. Consider closing this risk on the risk register. Need to have a separate discussion regarding training with central infection control team. Hand Hygiene training about to commence.

Update August 2011
General Update. This will improve from November with CSR restarted and embedded. There will be 96 places available per week. Hand hygiene training being improved week on week.
No update regarding all in 1.

Update November 7 2011
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.

Update February 2012
Training now being delivered across the Trust in CSR1 and evidence of good uptake. But, some gaps in the training data that is being recovered. For review at next meeting with a view to closing the action.

Developed: December 2010 Reviewed February 2012

Workstream 8. There is a risk of infection to staff due to sharps injury. (Risk Register)

Supporting Documentation

RISK 46

Objective	Current State	Action	Imp' Lead	Operational Lead and involved individuals	Date of Completion	Current Risk	Measure of Success	Evidence
8.1 Minimise the risk of sharps injury	Position reported within UKAP report (improving)	a) Participate in national ambulance audit 2011	Steve Lennox	Trevor Hubbard	2011-2012			
		b) Undertake a programme of staff awareness (and to incorporate new guidance from POSSH conference)	Steve Lennox	Trevor Hubbard	~~Sept' 2011~~ May 2013			

Update May 2011
8.1a) Meeting with UKAP end of May 2011
8.1b) Awaiting draft action plan from POSH conference.
This has also been added to the balance scorecard

Update August '11
8.1a Steve participated in discussion group at national conference. Closed.
8.1b. Awaiting guidance. Compliance not necessary until 11 May 2013

Update November 7 2011
8.1b Not due until 2013

Update February 2012
Head of IPC is setting up a sub group to ensure the Trust is ready to implement guidance in 2013. Gap analysis currently being completed.

Developed: February 2011 Updated February 2012

Workstream 12. Infection Control Champions (Previous Action Plan)

Supporting Documentation

Objective	Current State	Action	Imp' Lead	Operational Lead and involved individuals	Date of Completion	Current Risk	Measure of Success	Evidence
12. 1 For champions to be better engaged in infection prevention and control issues locally	Champions identified at all complexes and some departments	12.1a) Update training and focus for champion role to be re-enforced re: Hand Hygiene and auditing	Steve Lennox	Trevor Hubbard	~~May 2011~~ ~~September 2011~~ February 2012		Regular auditing of stations and departments Improved staff awareness and accountability of IPC issues	Monthly dashboard Audits
		12.1b) Agreement of stand down shifts for champions to undertake role	Steve Lennox	Steve Lennox / SMG	~~April 2011~~ ~~September 2011~~ February 2012		Agreed stand down for IPC champions to undertake audits	Improvements in completion and compliance of local audits

Update August 2011
Met with champion representatives from all three areas following IPC meeting. Champions need re-launching.

Update November 7 2011
Champions issue to be resolved.

Update January 2012 (IPC Sub Group)
Need to explore if the champion model has now been exhausted and if there is now the requirement to inform the team leaders that they are the leads for IPC. A view that IPC should now be embedded into practice and the requirement now is for audit and standards.

Update February 2012
Committee is divided about champion model. For further discussion at sub group meeting.

Developed: February 2011 Reviewed February 2012.

Workstream 15. Improving Hand Hygiene Compliance (Balance Scorecard) **Supporting Documentation**								
Objective	**Current State**	**Action**	**Imp' Lead**	**Operational Lead and involved individuals**	**Date of Completion**	**Current Risk**	**Measure of Success**	**Evidence**
15. 1 Improve knowledge and awareness	Basic training and assessment for clinical staff in Hand Hygiene and Aseptic Non Touch Techniques	a) Monitor and implement Hand Hygiene Training	Steve Lennox	Trevor Hubbard	**As detailed in Workstream 6**		Staff are aware of hand hygiene practices	Local audits / hand hygiene obs audit results
	Hand Hygiene campaign over 12 months old	b) Re-launch new Hand Hygiene campaign	Steve Lennox	Trevor Hubbard	April 2011		Improved awareness	Hand Hygiene Campaign & Visible Audits
15. 2 Establish base line audits and system for regular monitoring	No regular audit results	a) Roll out first round of infection control audits at Accident & Emergency departments	Steve Lennox	Trevor Hubbard	March 31st 2011		Every ED in London audited as baseline	Balance Scorecard

		b) Invite all Accident & Emergency Departments to join regular audit programme	Steve Lennox	Trevor Hubbard/ Steve Lennox	~~March 31st 2011~~ ~~May 2011~~ August 2011		Every ED in London to provide hand hygiene audits of LAS / Ambulance staff	Balance scorecard
		c) Train Executive and Non Executive directors who can support audits when undertaking observational visits	Steve Lennox	Trevor Hubbard/ Steve Lennox	~~June 2011~~ September 2011		Audits received from NEDs on operational shifts	Balance scorecard
		d) Use balance scorecard to drive improvements across the three areas (PIMs)	Jason Killens	Kevin Brown Paul gates Martin Cook	May 2011		Each area to provide regular reporting for the balance scorecard	Area Governance minutes IPCC minutes
		e) Devlop communications for world hand hygiene day in May	Steve Lennox	Angie Patton Trevor Hubbard	May 2011		Hand Hygiene awareness campaign	
		f) Second round of Hand Hygiene audits to incoproate correction of practice	Steve Lennox	Trevor Hubbard	April 2011			
15.3 Robust population of IPC dashboard	IPC dashboard not fully populated for January 2012	PIMs (&AOMS) to develop system by start of February	Trevor Hubbard	PIMS	February 2012		Fully populated dashboard	Fully populated dashboard

Update August 2011
15.1b. Completed and closed.
15.2b Steve to contact DIPCs.
15.2c Not yet completed.
15.2d PIMS actively using scorecard to drive improvements. Action Closed.

Update November 7 2011
15.2b Letter written. Action Closed.
15.2c Action outstanding

Update February 2012
Directors still need training. PIMS going to identify solution for updating the scorecard next week.

Completed Workstreams		
WS	Description	Date Reviwed/Completed
1	There is risk that the Trust does not follow Department of Health Guidelines for the re-use of linen. (Risk Register & CQC)	
2	There is a risk that cleaning arrangements are insufficient to ensure that the environment for providing healthcare is suitable, clean and well maintained.. (Risk Register & CQC)	
3	There is a risk that the audit programme is not sufficiently robust to identify to identify infection control issues across the Trust. (Risk Register)	Feb 2012
4	There is a risk that the inadequate facilities and lack of policy for the decontamination of equipment may increase the risk of infection (Risk Register & CQC) and Workstream 7. The risk of incurring liability through the re-use of "single use" equipment.. (Risk Register &CQC)	
5	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 (Risk Register &CQC).	Nov 2011
6	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. (Risk Register &CQC)	
7	The risk of incurring liability through the re-use of "single use" equipment.. (Risk Register &CQC)	May 2011 – now part of WS4
8	There is a risk of infection to staff due to sharps injury. (Risk Register)	
9	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. (Risk Register)	Feb 2012 – now part of WS1
10	Trust not currently aware of Hand Hygiene Compliance (CQC and DH)	Nov 2011
11	Improve Deep Clean Compliance (Dashboard)	Nov 2011
12	Infection Control Champions (Previous Action Plan)	
13	Flu Planning	Nov 2011
14	Patient Environment Action Group (Previous Action Plan)	Nov 2011
15	Improving Hand Hygiene Compliance (Balance Scorecard)	
16	Equipment Supply (following Staff Survey results)	Apr 2011

Appendix 2; Risk Register

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Corporate Objective	Risk Category	Gross Impact	Gross Like-lihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Like-lihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like-lihood	Target Rating	Comments
327	There is risk that the Trust does not follow Department of Health Guidelines for the re-use of linen.		12-Oct-09	4	Infection Control	Major	Certain	20	1. The Trust has an adequate supply of blankets, however these are not always available. 2. Increased availability of blankets for A&E crews - Additional linen and disposable blankets added to stocks and circulated. 3. Improved collection of soiled blankets from hospitals and non-contract laundries - New laundry provider appointed and increased activity being established to collect blankets. Reduction in blanket loss.	Steve Lennox	08-Feb-12	Major	Likely	16	1. To understand the scale of the problem and to develop a sstrategic solution ot blanket usage: 1 a) Audit blanket usage as part of hand hygiene auditing. 1 b) Chris Vale developing options paper to agree strategic direction. 1 c) PIMS to address compliance of single use locally. DIPC to present at conferences. Continue to audit. 1 d) Small sub group to be formed to discuss options paper and endorse recommendations	1a. Trevor Hubbard 1b. Chris Vale 1c. Trevor Hubbard 1d. Karen Merritt	1a. Mar 2012 1b.Feb 2012 1c. June 2012 1d. Feb 2012	1. KPI measuring blankets collected delivered. 2. KPI measuring blankets allocated/ delivered.	Minor	Possible	6	Infection Prevention & Control Committee 02/02/2012 proposed net rating revised to 20. A sub group is to be set up establish further actions to be taken. RCAG did not agree that the net rating is revised to 20 and felt it should remain at 16 as there was no evidence that to show that linen was currently being reused.
324	There is a risk that cleaning arrangements are insufficient to ensure that the environment for providing healthcare is suitable, clean and well maintained.		17-May-10	4	Infection Control	Major	Certain	20	1. Introduction of revised cleaning programme. 2. Infection control champions are in place. 3. Audits of vehicles and premises. 4. Swabbing of vehicles by LSS. 5. Processes now in place to triangulate audit information.. 6. Opportunities within the PEAG initiative have been identified to support the audit process.	Steve Lennox	08-Feb-12	Major	Possible	12	1. To ensure Trust is consistently compliant across the service: a) conduct audit following implementation of contract.	1a. Trevor Hubbard	1a.	1a. Comprehensive dashboard	Minor	Unlikely	4	Infection Prevention Control Committee 02/02/2012 - reviewed risk remains the same until an audit has been carried out following the aware of the new make ready contract.

326	There is a risk that the inadequate facilities and lack of policy for the decontamination of equipment may increase the risk of infection.		17-May-10	1,2	Infection Control	Major	Likely	16	1. Introduction of single-use items. 2. Introduction of more robust cleaning programme for vehicles and premises. 3. Introduction of detergent and disinfectant wipes for equipment in between patient use. 4. Decontamination policy is now in place. 5. Improved decontamination processs in operation.	Steve Lennox	02-Feb-12	Major	Possible	12	1. Decontamination sub group to review compliance with decontamination process.	1. Steve Lennox	1. Feb 2012	1. Area Governance Meetings 2. Incident reports.	Minor	Unlikely	4	Infection Prevention & Control Committee reviewed this risk 02/02/12. The risk score remains the same - the decontamination policy has gone to the ADG for sign off.
322	There is a risk that the Trust does not receive assurance that infection prevention and control training is taken up by staff.	Current workload within the department means that there is insufficient capacity to ensure that all tutors are developed in line with the departmental tutor development strategy. This includes time to incorporate information from bulletin into teaching strategies.	17-May-10	1,2,4,5	Infection Control	Major	Likely	16	1. Introduction of training programme for operational and non-operational staff. 3. Trust updates have been delivered to 1,600 staff including hand hygiene training 3. Use of Infection Control Communications Strategy to ensure that all staff are kept well-informed.	Steve Lennox	08-Feb-12	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 TBD	1a Feb 12 1b Feb 12 1c Feb 12	Reports from the central training register	Minor	Unlikely	4	Infection Prevention & Control Committee 02/02/2012 proposed new wording of risk to: There is a risk that the Trust does not receive assurance that infection prevention and control training is taken up by staff. Training now being delivered across the Trust in CSR1. Gaps in training data is being recovered. Review at next meeting. New wording agreed by the RCAG on 02/04/12.
323	There is a risk that the audit programme is not sufficiently robust to identify to identify infection control issues across the Trust.		17-May-10	1,2,4,5	Infection Control	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. 4. 7 Point Audit plan is being used as an audit tool. 5. An Escalation plan is in place.	Steve Lennox	08-Feb-12	Major	Unlikely	8	1. PIMS and AOMS to identify solution for updating the scorecard.	1a. PIMS	1. Feb 2012		Minor	Possible	6	The Infection Prevention & Control Committee 02/02/2012 reviewed this risk and the decided the net rating remains the same.

63	The risk of incurring liability through the re-use of "single use" equipment.		14-Nov-02	1,2,4, 5	Infection Control	Major	Possible	12	1. Make Ready has improved the controls over single use equipment. 2. The infection Control Policy covers "single use" equipment. 3. Staff awareness has been increased by the use of Training Bulletins, RIB, posters etc. 4. "Single use" items are in place. Risk of re-use rather than disposal is unlikely. 5. A decontamination policy is now in place.	Steve Lennox	08-Feb-12	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	The Infection Prevention & Control Committee 02/02/2012 reviewed this risk and decided the net rating remains the same.
46	There is a risk of infection to staff due to sharps injury.		14-Nov-02	4,7	Infection Control	Moderate	Possible	9	1. Introduced the Safety Canulae trial in early 2009. Results to be monitored via Infection Control Steering Group. 2. In 2008 the overall number of LA52 reported needle stick incidents for Q3 (1st July - 30th Sept) was 9 near misses and 3 actual. This represents a reduction of reported incidents from Q2 of 12 actuals and 2 near misses. The new cannulae are now in use which should hopefully reduce the number of injuries. 3. H&S bulletin related to 'Disposal of Sharps' was issued in 2007/08. 4. This is part of the infection prevention and control action plan.	Steve Lennox	08-Feb-12	Moderate	Possible	9	1. Minimise the risk of sharps injury: a) Participate in national ambulance audit 2011. b) Undertake a programme of staff awareness (and to incorporate new guidance from POSSH conference)	1a.T.Hubbard 1b T.Hubbard	1a May 2012 1b May 2013	1. Health and Safety Audits. 2. Clinical Quality Safety and Effectiveness Committee. 3. Incident reporting. 4. ICSG quarterly review 5. SUI of high risks cases.	Minor	Unlikely	4	The Infection Prevention & Control Committee 02/02/2012 reviewed this risk and decided the net rating remains the same. Head of IPC is setting up a sub group to ensure the Trust is ready to implement guidance in 2013. Gap analysis currently being completed.

332	There is a risk that Trust and National infection control procedures may be compromised as ambulance mattress covers are not routinely changed after each patient.		01-Mar-10	4	Infection Control	Minor	Likely	8	1. The matress is disinfected between each patient.	Steve Lennox	02-Feb-12	Minor	Likely	8	1. Identify - procure suitable disposable mattress covers; finalise assessment and make recommendation. 2. Improve returns from laundry of sheets and covers; agree process for returning sheets with the provider. 3. Eliminate soft repairs being undertaken with tape: a) Establish the incidence of repairs being undertaken to soft furnishings with tape. b) Instruct workshops to ensure spare mattresses are available to swap.	1 Chris Vale 2. Chris Vale 3.a Chris Vale 3b Chris Vale	1. Aug 2011 2. Mar 2012 3a Aug 2011 3b Aug 2011		Minor	Unlikely	4	The Infection Prevention & Control Committee reviewed this risk 02/02/12 and decided the net rating remains the same. Further actions are to be decided by a sub group which will also be discussing risk 327 around the reuse of linen.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH JUNE 2012

PAPER FOR INFORMATION

Document Title:	**Clinical Quality & Patient Safety Report**
Report Author(s):	**Joint Clinical Directors' Report**
Lead Director:	**Fionna Moore and Steve Lennox**
Contact Details:	
Why is this coming to the Trust Board?	**For information**
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 presented at SMG, Quality Committee, and CQSEC
Recommendation for the Trust Board:	**For information**

Executive Summary

This is the third edition of a revised clinical report. The report is structured around the quality domains of the quality dashboard but also reports on issues wider than the quality measures.

Key issues and risks arising from this paper

Overall this report provides assurance that a high quality and safe clinical service is provided.

Key issues and risks identified include:

- Overall reduction in completion rates of the Clinical Performance Indicators in April
- High utilisation rates which impact on our ability to introduce clinical innovations.
- Increasingly frequent use of the Demand Management Plan from January onwards. (Trust at REAP level 4 throughout the reported period)
- Continued progress in the delivery of the clinical audit work plan.
- Further reduction in the number of addresses held on the High Risk Register and progress in writing to the addresses. Clinical focus on category 4 addresses.
- No Controlled Drugs incidents to report
- Performance against STEMI and stroke ACQIs

Attachments

None

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Quality Strategy

This paper supports the following domains of the quality strategy

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

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☒ No

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST

Clinical Quality & Patient Safety Report – June 2012

Clinical Directors' Joint Report

1. Introduction

This is the third edition of a revised clinical report. The report is structured around the quality domains of the quality dashboard but also reports on issues wider than the quality measures.

2. Quality Domains

Quality Domain 3: Clinical Intervention

Clinical Performance Indicators (CPIs)

Team Leader CPI completion rate decreased to 86% in April. This decrease is seen in a month where REAP was escalated to 4 as a result of significantly higher than expected call demand, which has impacted on the ability of Team Leaders to undertake CPI audit. It is of note that the West area achieved a record 100% CPI completion rate during April. Team Leader feedback is below trajectory. Overall compliance against all clinical care standards remains consistently high. In April 2012, compliance was 95% or higher except the new mental health CPI; the Trust target is 100%.

The new mental health CPI was introduced on 1st April and the first data set is detailed in table 2. As expected with the introduction of a completely new CPI, compliance was lower than other clinical care standards. Low compliance was mainly due to crews not documenting if a safeguarding referral had been considered for patients presenting with a mental health problem. To allow for the introduction of the new mental health CPI, reporting of CPI compliance for Difficulty in Breathing and Glycaemic Emergencies is now alternated on a monthly basis.

Table 1. CPI completion September 2011 to April 2012

Area	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.
East	96%	94%	93%	86%	94%	95%
South	87%	78%	93%	83%	78%	67%
West	95%	95%	95%	84%	96%	100%
LAS	**93%**	**88%**	**94%**	**84%**	**89%**	**86%**

Table 2. CPI Compliance April 2012

	Cardiac Arrest	Difficulty in Breathing	ACS (Including MI)	Stroke	Mental Health	Non-Conveyed	1 in 20 PRF
East	98%	95%	95%	97%	89%	95%	97%
South	97%	95%	95%	97%	83%	95%	97%
West	97%	97%	98%	98%	84%	96%	97%
LAS Total	**98%**	**96%**	**96%**	**97%**	**85%**	**96%**	**97%**

Table 3. CPI Compliance March 2012

	Cardiac Arrest	Difficulty in Breathing	ACS (Including MI)	Stroke	Glycaemic Emergencies	Non-Conveyed	1 in 20 PRF
East	98%	95%	96%	97%	97%	95%	96%
South	97%	96%	96%	98%	99%	95%	97%
West	98%	96%	97%	98%	97%	96%	98%
LAS Total	**98%**	**96%**	**96%**	**98%**	**98%**	**96%**	**97%**

Cardiac Care

ParaSVT – This trial continues to go extremely well, recruiting on average three to four patients per month.

DANCE – Progression with this trial remains poor due to low patient numbers fitting inclusion criteria and the inability to stand crews down for training to facilitate wider recruitment of patients into the trial.

Defibrillators – A plan to purchase in excess of 200 LifePak 1000 defibrillators has received financial approval. The new machines will be placed on to ambulances to replace older FR2 AEDs.

RhinoChill – The planned feasibility trial of inducing therapeutic hypothermia in post cardiac arrest patients using the RhinoChill device has been postponed until after the Olympics.

Stroke

There has been a significant increase in the number of stroke patients over the last few months and this has impacted on stroke capacity across London. An issue for the Trust is the fact that North East London do not have an adequate number of HASU beds - this could be due to patient numbers, but also reflects the difficulty that the HASUs have accessing rehabilitation services in ONEL

Quality Domain 4: Safety

This section will report on the work of the Clinical and Quality Directorate to improve the safety of patients and also any concerns regarding safety.

NHS Central Alerting System (CAS)

7 Alerts have been received from the MHRA for the period 15th May – 15th June 2012. All have been acknowledged by the Trust and no alerts required any action.

High Risk Register

There are currently 581 addresses on the register broken down as follows:

CATEGORY 1: 130

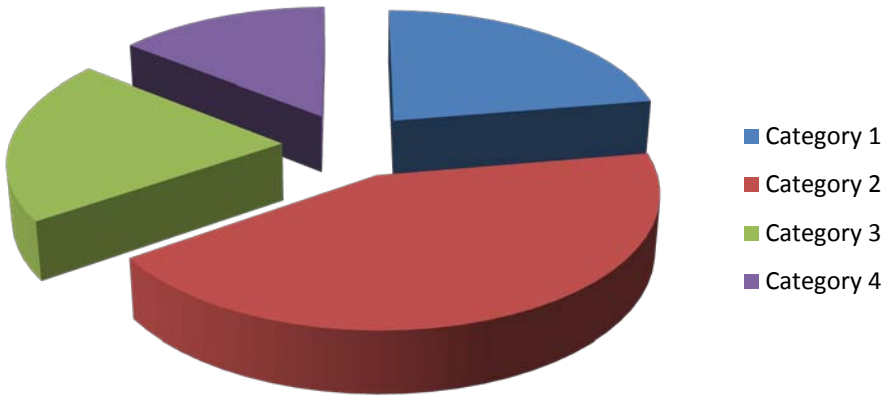
CAT EGORY 2: 250

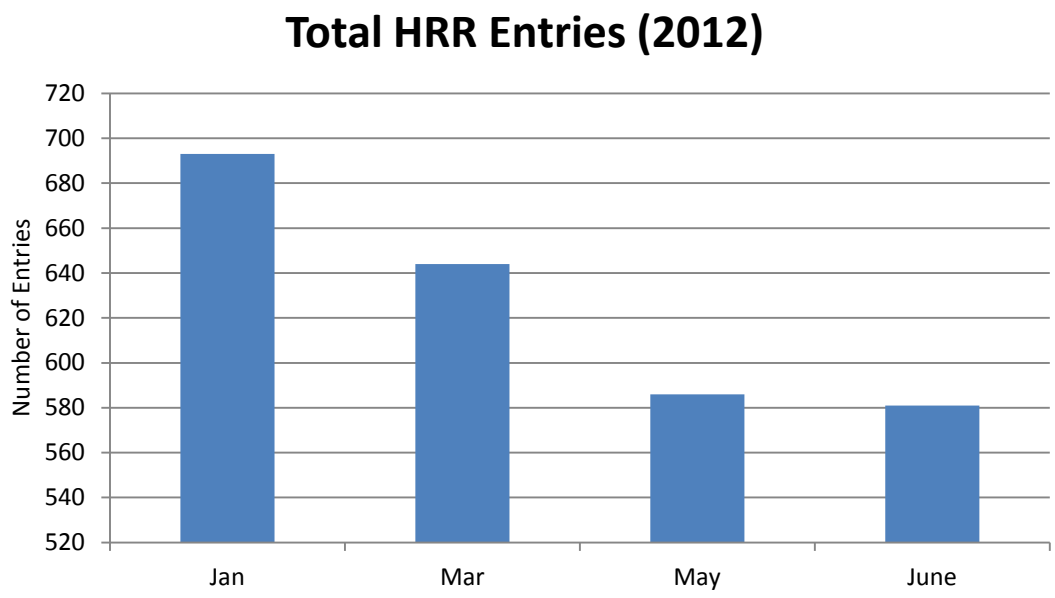
CATEGORY 3: 118

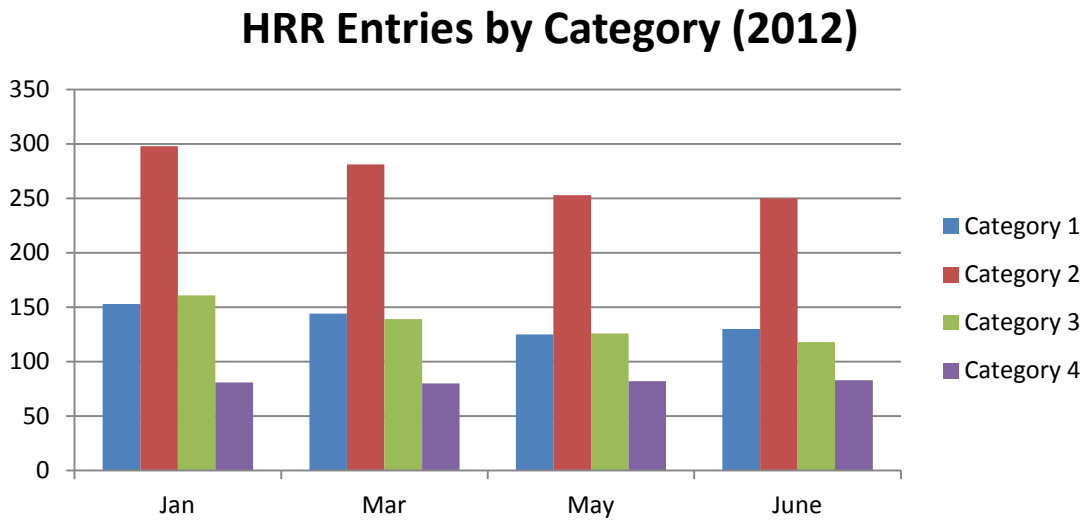
CATEGORY 4: 83

Total: 581

There has been a demonstrable decrease in the number of high risk addresses over the past six months. This is the lowest number of HRR entries since MI took over the management of the register. The Trust has notification of 363 high risk addresses from the Metropolitan Police. The Medical Directorate are reviewing all category 4 entries for continued inclusion on the HRR.







Demand Management Plan

The purpose of DMP is to provide the Trust with structured risk mitigating options to respond to demand at times when it exceeds the capacity of the service to provide a timely response. It provides a framework in which Control Services are able to respond to periods of high pressure, due to unforeseen demands, poor resourcing or on occasion where capacity does not exist to absorb unexpected patient demand.

DMP enables the LAS to prioritise higher MPDS category calls, to ensure those patients with the most serious conditions or in greatest need continue to receive a response. Escalating stages of DMP (A-H) decreases the response to lower call categories. The risk is mitigated by increased clinical involvement in the Control Room, with clinical 'floor walkers' available to assist call handlers, and by ringing calls back to provide advice, to re-triage and on occasion

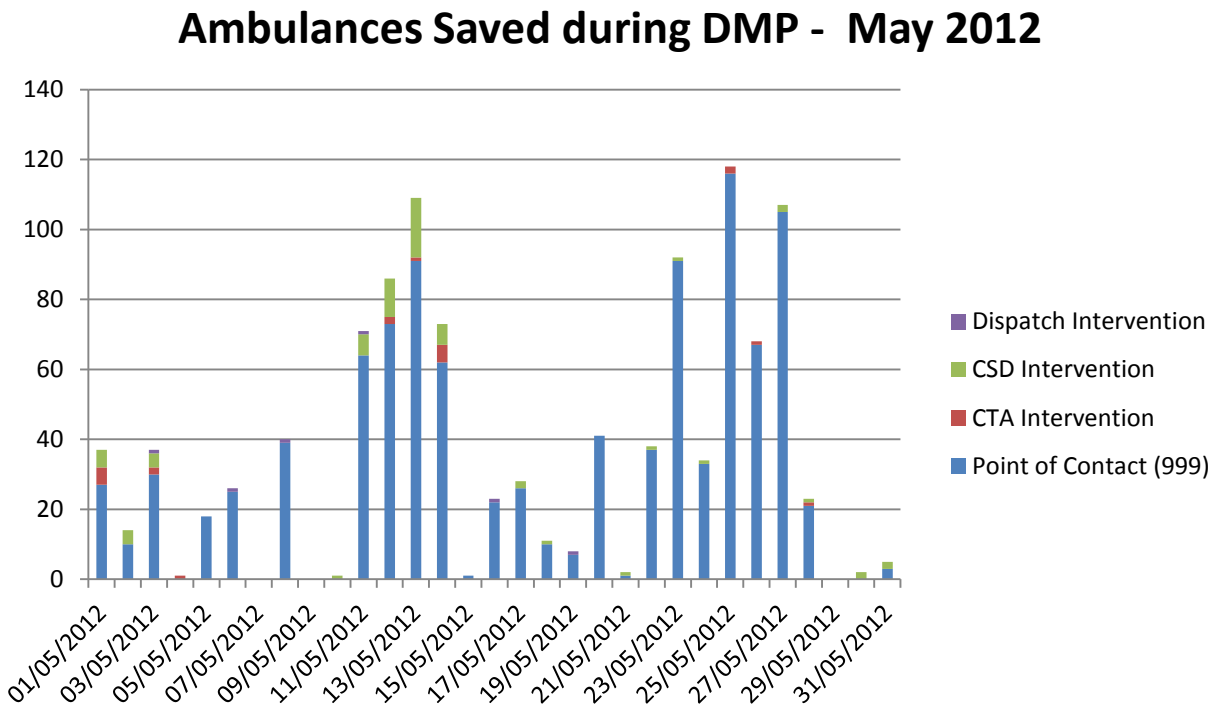
to negotiate alternative means of transport or follow up. It is also mitigated by regular senior clinical and operational review as the plan is escalated. There is a significant level of clinical risk related to the stage of the DMP invoked.

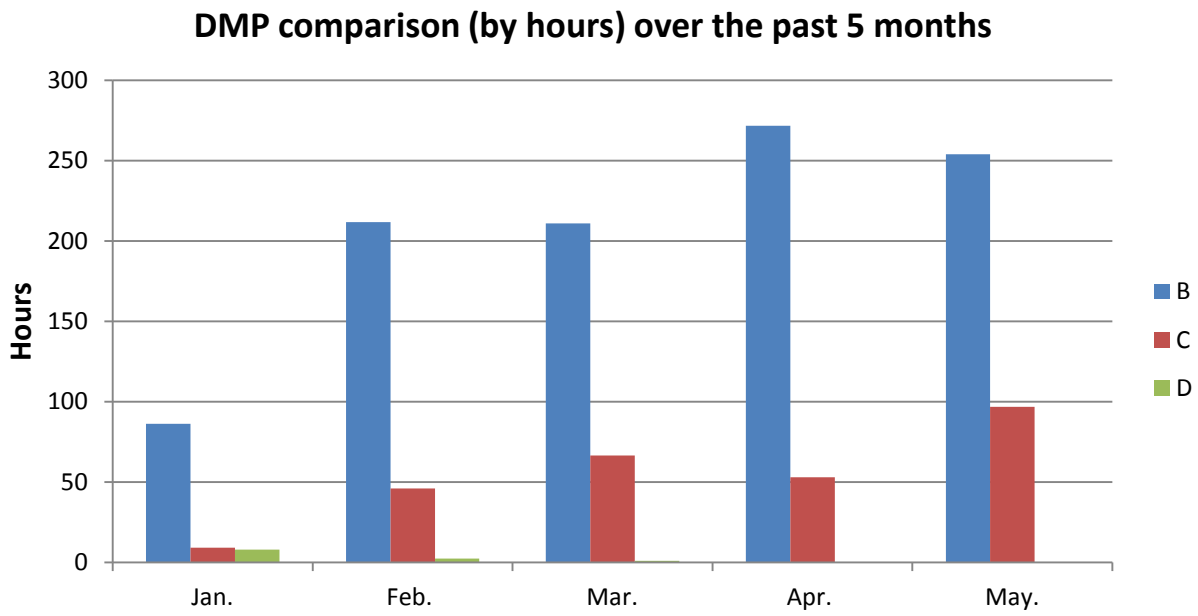
DMP was invoked on **30 separate occasions** and in place for a total duration of **350.75 hours** in May 2012. This is an increase of 46.25 hours compared to the previous month. Between the 25th and 28th May, during increased weather temperatures across the UK, DMP was in place continually for **66.5 hours** (stages B and C).

Stage **B** was in place 45 times for a total duration of **254 hours** (versus 44 times / 271.75 hours in April)
Stage **C** was in place 18 times for a total duration of **96.75 hours** (versus 12 times / 53 hours in April)

There was no escalation of DMP past stage C.

There were **1114 ambulance saves** in May 2012. This is the highest number to date for all stages.





Medicines Management

There have been no reportable Controlled Drug Incidents since the last report. However there was an incident at Romford Ambulance station that caused a miscounting error. This incident occurred because a paramedic placed naloxone ampoules back in the CD safe in error, in addition to morphine ampoules. No discrepancy actually occurred once an investigation had taken place. The Senior Clinical Adviser has asked the Met Police CDLO to assist the Trust in the subsequent investigation. A Medical Directors Bulletin was issued on the 29th May 2012 (MD 110) advising that naloxone must not removed from drug packs and placed in personal morphine holders. The bulletin also highlighted the professional and legal implications of falsifying controlled drug records as a result of an incident involving falsification of a signature in a CD Register. This incident is currently under disciplinary investigation.

There have been no further Unannounced Visits by the Metropolitan Police.

There have been no medicines CAS Alerts relevant to the Trust since the last report.

The Trust supplied controlled drugs and drug packs to all the mutual aid Crews that provided support during the Queen's Diamond Jubilee. All PRFs completed by mutual aid crews will be CPI audited. There were no drug incidents reported involving any mutual aid crews.

Vehicle based drugs bags were used at Cluster 3 Olympic Test Events during May. A vehicle based drug bag system has been mooted over several years. At the Cluster 3 Test Events the trial of the vehicle based drug bag system caused no issues and the Chair of the Medicines Management Group is now seeking a complex at which to further test vehicle based drug bags for an extended period.

Rule 43 Reports

No Rule 43 reports have been issued to the Trust since the last Board report. The Trust has not received, or is aware of, any Rule 43 reports issued to other organisations, that may be of relevance.

Quality Domain 5: Clinical Outcomes

Infection Control

Infection control is currently RAG Rated RED. The balance scorecard is now populated and compliance with the standards is good but the training element of the scorecard is RED due to the training provision for infection control. The launch of the workbook will improve this situation.
This year's annual Infection Prevention Society Conference in Emergency Care is called "Bugs and Battlefields" and was held in Birmingham on 22 May. The London Ambulance Service undertook three presentations; 1. Bioterrorism, 2.Learning from the Libyan Patient Retrieval, and 3. Flu Vaccination and healthcare workers.

Clinical Audit Aseptic Non Touch Technique

An audit of 623 PRFs has been undertaken to measure the compliance with the requirement to cannulate patients in accordance with national guidance. The audit revealed that 37% of cannulas are inserted in accordance with ANTT guidance with 49% being recorded as exempt due to the emergency nature of the intervention (it is permitted not to use the ANTT technique in an emergency). However, further examination of the PRF reveals that a considerable number of the 49% were not true emergencies. The auditor also interviewed 30 members of staff. All had received ANTT training but some reported that the ANTT equipment had not always been available. The infection control committee will consider the results in depth and add the lessons learnt to the infection control action plan.

The annual Infection Prevention & Control report is also presented at the June Trust Board.

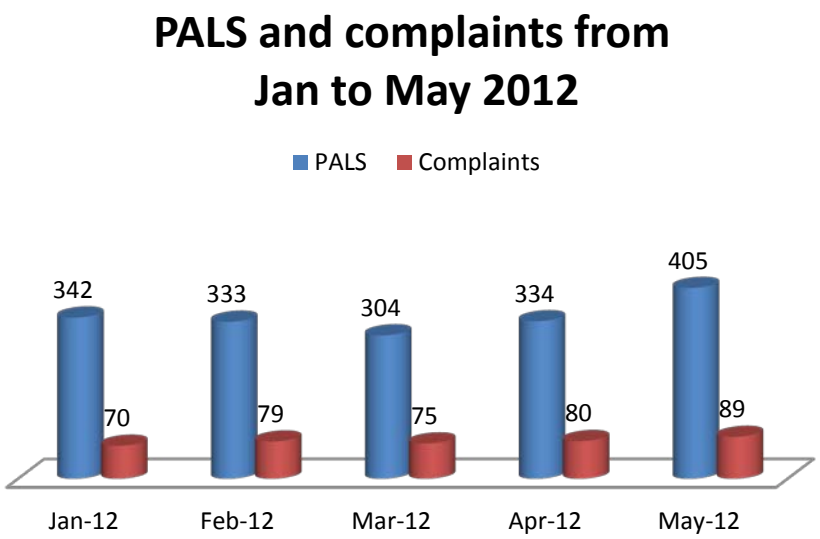
Quality Domain 6: Dignity

Nothing to report.

Quality Domain 7: Satisfaction

Complaints

This report sets out a base account of Patient Experiences Department activity versus complaints and PALS from May 2012 (excluding safeguarding activity, PCAT cases and solicitor enquiries).



Emerging themes

The usual themes are evident - staff challenging the validity of the 999 call; delay (especially calls categorised at lower emergency priority levels). PED have also provided data about calls category C1 or C2 and the affect of the Demand Management Plan. An increasingly emerging trend is the call management of patients presenting with abdominal pain. PED are also beginning to receive complaints related to High Risk Register notifications.

There has been an increase in complaints where patients have made their own way to hospital having become frustrated at the delay in an ambulance being dispatched, and a renewed increase in complaints about patients being referred to NHS Direct. Two referrals were made to the SI group, one case being declared.

Complaint by subject	Total
Delay	39
Attitude/behaviour	24
Treatment	10
Non-conveyance	8
Road handling	4
Conveyance	3
Aggravating Factors	1
Totals:	**89**

Case examples

Case number	Complaint synopsis	Outcome
6699	Patient was suffering a high temperature and nausea. The patient believed that his condition wasn't taken seriously and one of the ambulance staff was particularly dismissive. Complaint also involved infection control (syringe use) and ongoing care issues.	Paramedic offered apologies with regards to his care management. Clarification provided about a 'drawing up needle' being put in a sharps box in the ambulance, infection control and handover measures.
6787	Complaint regarding the crew who left two pools of blood and large blood soaked gauze dressing on the pavement, near to the complainant's front door.	Explanation of policy that crew should ensure that no clinical waste is left on scene - oversight in ensuring the patient was conveyed to hospital quickly- feedback to be given to attending staff. Explanation of infection control etc – blood spillage in public places is the responsibility of the local authority.

There is a rise in complaints, although the rate per incident still remains relatively low at 0.098% (against incidents) 0.06% (against call volume).

PALS Activity

PALS specific	No.	PALS specific	No.
Information/Enquiries	319	Aggravating Factors	1
Lost Property	47	Non-physical abuse	1

Incident Report - Other	7	External Incident Report - EOC	1
Clinical	5	Incident Report - A&E	1
Delay	5	Incident Report EOC	1
Conveyance	4	Incident Report - GP Surgery	1
Access	3	Incident Report - Hospital Midwife	1
Appreciation	3	Policy/ Procedure	1
Other	3	Road Traffic Collision/RTC	1
Aggravating Factors	1	**Total**	**405**

3. Quality Priorities

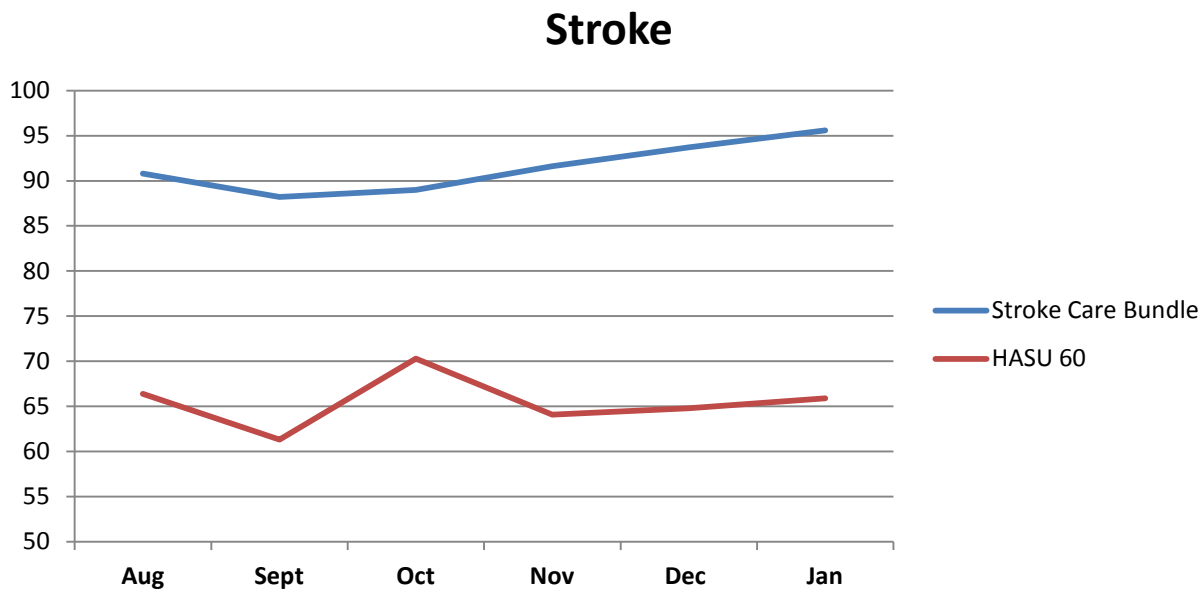
The four new quality priorities for 2012-2013 are Mental Health Care, Diabetes Care and Reducing Alcohol Related Harm. The work plans for these areas are still being finalised.

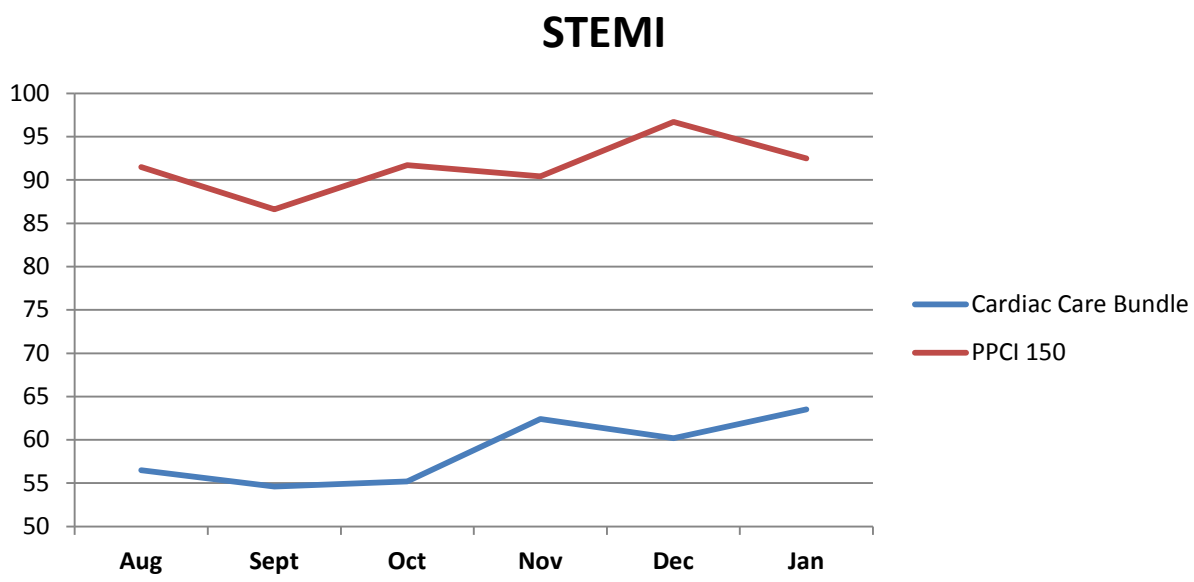
4. Clinical Audit & Research (CARU)

Audit reports

There have been no audit reports released since the last Trust Board report.

Ambulance Clinical Quality Indicators





There has been a notable increase in delivery of the cardiac (STEMI) care bundle, however the Trust remains in the lowest quartile. The national average for this indicator was 77.9% in January 2012. Performance against this indicator is affected by the Trust choosing to deviate from national guidelines for the administration of analgesia in STEMI, based on clinical advice of leading cardiologists at London Heart Attack Centres.

Call to HASU time of 60 minutes: An audit by CARU is attempting to identify the point(s) at which transport delays are occurring, in order to further understand why performance against this indicator is not higher, in view of the number of HASUs in London. This audit will determine the work that needs to be undertaken in 2012/13 to improve this position. There has been sustained improvement in the delivery of the stroke care bundle

5. Rising Tide

Public Health

A CAS Alert was released in May following notification from Health Protection Scotland of an outbreak of Legionnaires' disease. A Medical Directorate Bulletin (MD 111) was published advising clinicians to consider Legionnaires' disease as a possible diagnosis in patients who may present with flu-like symptoms and/or lower respiratory tract symptoms and who have recently visited Edinburgh.

Clinical Professional Issues

A review of the draft 2012 JRCLAC guidelines by the National Ambulance Service Medical Directors Group (formally DOCC) has identified a number of sections that require either minor amendments or complete re-writes. A national group of senior paramedics are to lead

on the revision and re-writing of these sections. This will result in the release of the guidelines being delayed.

Three clinical update days have been planned in July for Team Leaders and Training Officers. Previous dates in June needed to be cancelled due to REAP 4. The days will include updates on ASCQI, new equipment, recognition of life extinct and revision of ALS guidelines. The updates aim to provide education about best practice and promote consistent clinical messages being delivered to staff by clinical leads.

6. Cost Improvement Programme

There have been no clinical concerns raised through SMG monitoring of the CIP or by the clinical leads.

7. Other areas

Nothing to report.

Fionna Moore
Medical Director

Steve Lennox
Director of Quality & Health Promotion

15th June 2012

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH June 2012

PAPER FOR INFORMATION

Document Title:	**Temperature Check Survey Results May/June 2012**
Report Author(s):	**Charley Goddard, HR Manager- Staff Engagement**
Lead Director:	**Caron Hitchen**
Contact Details:	**Charley.Goddard@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Requested by Board members**
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 ☐ Finance and Investment Committee ☒ Other- Results of each survey are made available to all staff via the Pulse
Recommendation for the Trust Board:	**For information**

Key issues and risks arising from this paper

The results of this regular survey provide a snapshot of staff satisfaction levels at a given time. Failing to act on key themes within the results is likely to present a risk to staff motivation and in turn, productivity and patient care.

Executive Summary

The temperature check is a short and anonymous staff survey. It contains 11 “core” questions and is conducted three times a year. It forms part of the Service’s Staff Engagement Strategy and the results are intended to assist in the prioritisation of workforce objectives.

The latest survey ran between 28th May-10th June 2012. The results show a decline in staff satisfaction across all questions when compared with the results for February 2012. Of particular note are the low scores around equipment (2.21/5) and opportunities to develop knowledge and skills (2.26/5). However, despite these lower scores the majority (51%) of respondents agree or strongly agree that they enjoy working for the Service.

Attachments

Results graph and analysis of free text comments

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Quality Strategy

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- ☒ Staff/Workforce
- ☐ Performance
- ☐ Clinical Intervention
- ☐ Safety
- ☐ Clinical Outcomes
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- ☒ 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

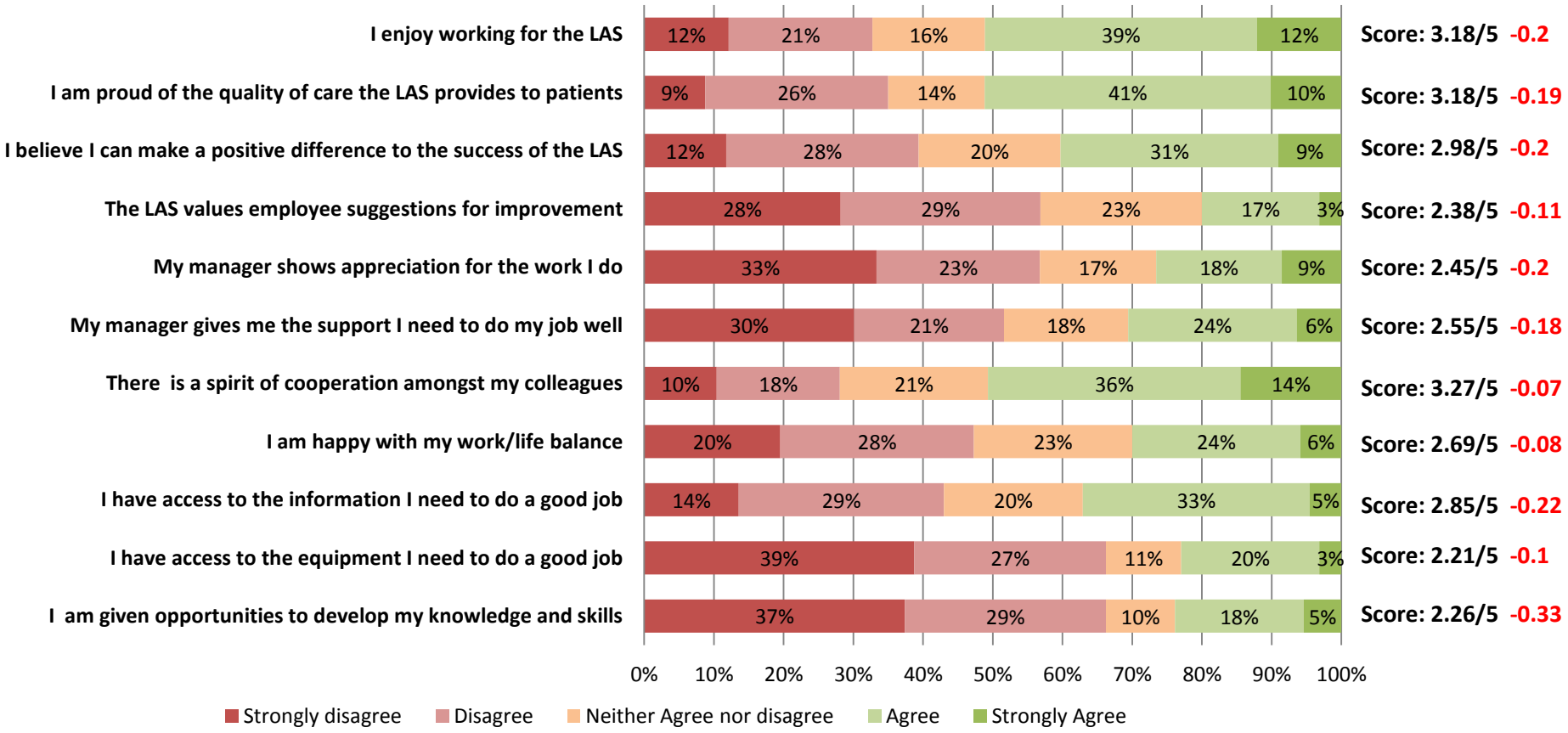
Key issues from the assessment:

The temperature check process, as part of the staff engagement strategy, has been equality impact assessed. It has the potential to positively impact all protected characteristic groups by providing an anonymous means through which staff can raise concerns. This impact is dependent upon action being taken in response to relevant survey results.

Temperature Check Results- May/June 2012

223 staff completed the survey, the majority (78%) of whom work within the A&E Operations Directorate.

The graph below shows the profile of responses for each question, along with a score out of 5* and the variance in score from the previous temperature check in February 2012 (336 respondents).



*The score for each question has been reached by assigning a score of 1 to “strongly disagree”, 2 to “disagree”, 3 to “neither agree nor disagree”, 4 to “agree” and 5 to “strongly agree” and calculating the mean score from all responses

Analysis of Free Text Comments

50 respondents provided written feedback to explain lower scores. Many of the points raised in this way can be grouped into key themes as displayed in the table below.

Theme	Number of comments	Examples of typical feedback
Management/ Feeling valued	21	• "Too much micro management" (Admin, Clerical and Management, West); • "There appears to be a lack of support and appreciation from management" (EMT)
Training days	20	• "It seems a shame that when the call rate goes up, things that are supposed to be protected are the first things to go i.e. training" (Operations, South); • "As demand increases training to develop from call handling to dispatch handling seems to be going at a very slow pace, makes morale lower" (EOC)
Equipment/ Vehicles	9	• "I feel much progress is still required in logistics particularly. We should know that every vehicle is fully equipped and that those off the road are minimised" (Administrative, Clerical and Management, West)
Relief rotas	6	• "after 3 years in the job I'm still on the relief rota" (Student Paramedic, East) • "I'm lucky enough to be working on a permanent line, but I have no stability in the form of a regular crew mate" (Operations, West)
Use of private ambulances	3	• "No information on how/why/how much we are paying private ambulance companies" (Paramedic, South) • "[I have had] bad experiences with private crews and community responders" (Paramedic, West)
Work pressures/focus on targets	7	• "more late finishes" (Paramedic, West) • "never get a meal break" (Paramedic, West)
Career progression	2	• "little opportunity for career development" (Paramedic, West)

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26 JUNE 2012

PAPER FOR NOTING

Document Title:	**Chief Executive Report**
Report Author(s):	**Peter Bradley**
Lead Director:	**N/A**
Contact Details:	**-**
Why is this coming to the Trust Board?	**To update the Board on key developments affecting the Trust**
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:	**That the Board note my report**
Key issues and risks arising from this paper	
Executive Summary This report provides information on how we intend to report progress to the Board against our key priorities in 2012/2013; the change to our IBP delivery programme arrangements; our plans to update our strategies and bring them back to the Board in July for discussion and it also provides a brief update on commissioning issues and our media work during the Queens Diamond Jubilee celebrations and Euro 2012.	
Attachments None	

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

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

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

Equality Impact Assessment

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

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING 26 JUNE 2012
CHIEF EXECUTIVE'S REPORT

1. Key priorities 2012/2013

At the end of the last financial year, the Board agreed its key priorities for 2012/2013 and we split our approach and focus in three ways –i) Board priority areas, ii) SMG objectives and finally iii) Business as Usual (BAU) activities. The attached pyramid diagram was used to illustrate this.

Linked to this, we have recently changed the format of the CEOs report to focus more on strategy and added a Chief Operating Officers report. Finally, we have been discussing at the Board how best to present our key performance reports and balanced scorecard with this in mind I am suggesting a new approach to reporting against all three key priority areas shown on the attached diagram.

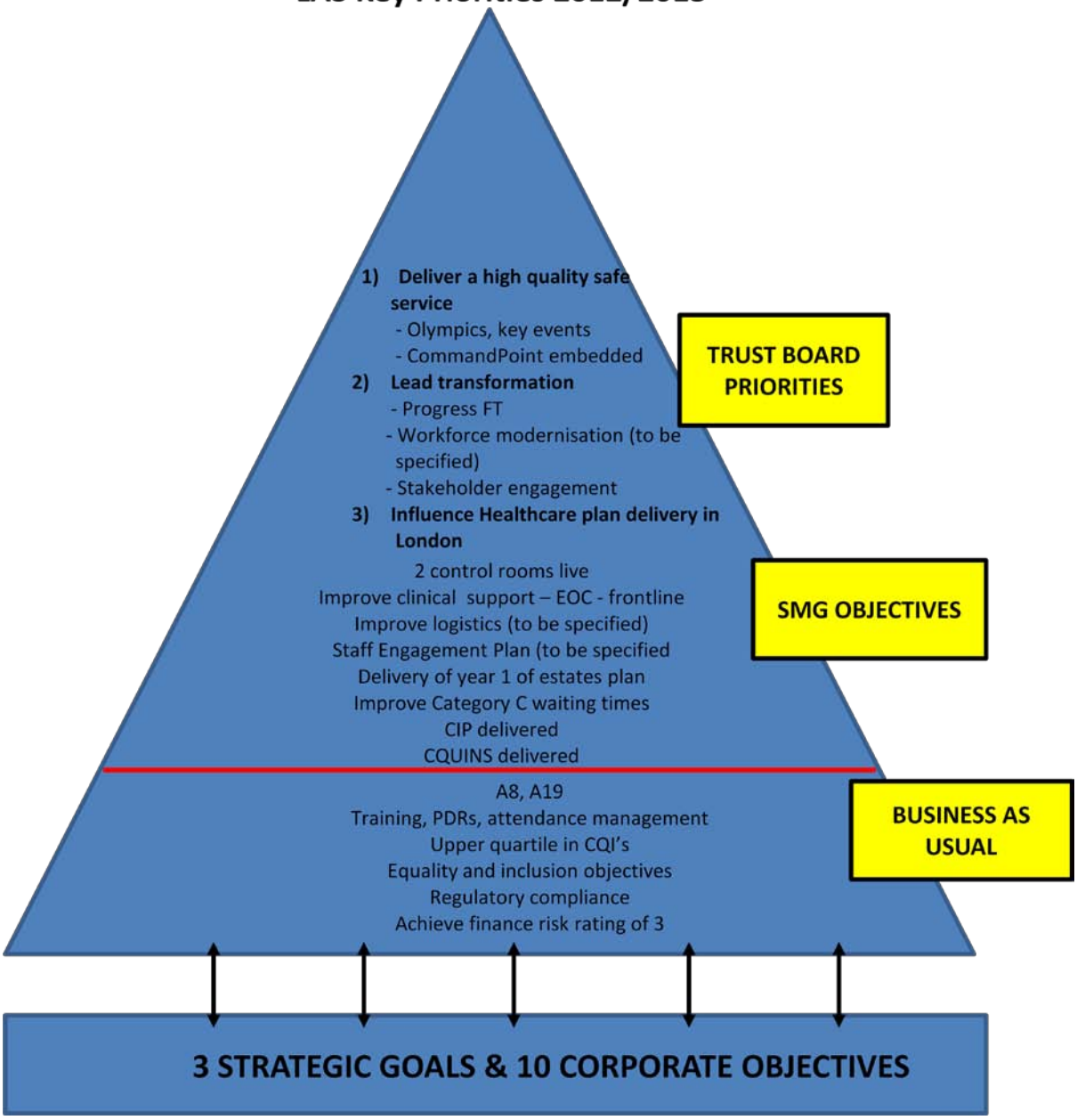
- **Board priority areas**. The intention is to report on these at each Board meeting as part of the CEOs report (deliver high quality service, lead transformation and influence healthcare delivery in London) and in other executive reports.

- **SMG Objectives.** The intention is to provide the Board with a quarterly RAG rated update against each objective. All staff have been issued with a copy of a leaflet outlining our key priorities for 2012/2013 and copies of this will be made available at the Trust Board meeting.

- **Business as Usual activities.** The intention is to use a revised balanced scorecard to report on these, renamed - **The Integrated Board Performance Report**. This report will be presented monthly by the Chief Operating Officer and brings together information submitted in other reports to provide a balanced view of the Trust's performance against statutory and quality assurance measures. The purpose of the report is to highlight exceptions for Trust Board members attention and mitigating actions.

The Integrated Report will not replace existing reports submitted to the Board including the Quality Dashboard, the Workforce report, the Chief Operating Officer's report and the Finance report. The Integrated Report will, however give all Board members an overview of organisational performance. This report (which is presented later in the agenda) is very much work in progress and feedback on content and presentation would be welcome.

LAS Key Priorities 2012/2013



2. IBP DELIVERY PROGRAMME & STRATEGY UPDATES

The senior management team have agreed that the current three programmes (Patient, Workforce and Value for Money) should close and be replaced by one consolidated IBP Delivery programme with SMG acting as the programme board. A paper was presented to the June 2012 SMG meeting proposing the 2012/13 project list for the new programme (roll-over projects from 2011/12 and new CQUIN projects only) and addressing governance issues. Pending the move to the new programme arrangements the report this month reflects the structure of the existing three programmes. Points of note regarding recent project progress are:

- **Patient Care Programme**

  - **CommandPoint:** Plans for benefits realisation and 'Decommission and Closure' (stage 7) are being finalised;
  - **Control Room (Bow as a 'hot' control**): The Uninterruptable Power Supply (UPS) upgrade and rationalisation work has now been completed. The CommandPoint servers are now on the UPS supply. Bow now has enough capacity to support a live control room with additional positions and those departments relocating to Bow;
  - **FT Application**: The Accountability Agreement has been signed off by SHA and submitted to DH. The revised Tripartite Formal Agreement is due to be signed by the DH following the Board to Board meeting on 25th June.

- **Value for Money Programme**

- **CIP:** At the end of May 2012, most projects are under control, none are out of control.
- **Starters, Movers and Leavers**: The project has been suspended as it is not a priority until after the Olympics.
- **Roster Optimisation 2**: This project has not yet started pending decisions on project scope.
- **New HQ**: The start of 'New HQ Long Term' project has been postponed indefinitely.

- **Workforce and OD Programme**

- **Service Delivery Model:** Workshops have taken place to define the Service Delivery Model including the clinical hub and workforce, estates, fleet & logistics. There may be a further one to align technology requirements of the Service Delivery Model. These will be discussed at the July SRP.
- **Team Briefings:** Team briefings has now been rolled out to all support service departments and evaluated. A decision is to be made about whether to extend elements of the system into Operations.
- **Learning Management System**; Training has been delivered to Learning and Organisation Development staff to enable them to pilot a number of modules during June before exploring a full role out.

We are currently updating our Integrated Business Plan and supporting strategies including workforce, IM&T and fleet and logistics and these will be shared with the Board in draft for discussion at the July 2012 SRP.

3. COMMISSIONING UPDATE

We continue to meet regularly with the lead commissioners from North West London to discuss performance and quality in relation to the contract. The most recent Clinical Quality Group saw an improved GP attendance on behalf of the Clinical Commissioning Groups in their Clusters and a range of discussions were held regarding increasing the information we share with GPs about the care LAS provides and the increases in demand and our plans for improving the management of bariatric patients.

The LAS has received a Contract Query Notice from the commissioners regarding our Category A performance in May as LAS did not achieve our planned trajectory. An excusing notice has been submitted citing increases in Category A at over 7% above contracted levels and an overall increase in incidents of 1% above planned levels. In addition we have seen an increase in the number of health care professionals who are requesting a Category A response for their patients without being on scene; additional work is being undertaken to review this. This was also a highlighted feature in the most recent GP newsletter which is circulated to every clinical commissioning group in London.

4. COMMUNICATIONS AND ENGAGEMENT

There are over 550 events on the PPI and Public Education activity database for 2012 so far. These include school visits, Junior Citizen schemes, knife crime awareness talks and events, basic life support training and road safety events.

Planning is underway for the CQUIN work to elicit patients' views who have not been conveyed to hospital. Development work on this will continue over the summer.

There has been a recent meeting of the national leads for patient involvement, to discuss the development of a national patient survey which would allow some benchmarking across ambulance services to take place.

We were involved in proactive media work to promote the Service's preparations for the Diamond Jubilee weekend and in particular its management of patients on the day of the river pageant generated widespread national media coverage in early June.

London media (ITV London, BBC London online, LBC) reported on the lifesaving training that the Service is helping to give to Team London Ambassadors ahead of the Games; Mayor of London Boris Johnson joined the volunteers and Service staff at a training event this month, where he was shown how to give cardio-pulmonary resuscitation.

And ahead of Euro 2012, media coverage (including LBC and the Evening Standard) highlighted how the Service planned to manage an anticipated increase in alcohol-related calls, and carried advice about how fans could enjoy the tournament without ending up in an ambulance.

5 . NATIONAL ROLES

I have advertised for expressions of interest amongst existing ambulance service Chief Executives in England to replace me as Chairman of the Association of Ambulance Chief Executives (AACE). We expect to make an appointment by the 13th of July 2012.

With regard to my Department of Health role as National Ambulance Director, I met with David Flory, Deputy Chief Executive of the NHS last week and a decision on this will be made before I leave in September.

Peter Bradley CBE
Chief Executive Officer
20 June 2012

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH JUNE 2012

PAPER FOR NOTING

Document Title:	**Update on the 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 provide assurance on the progress being made towards submitting a successful application in 2013**
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 ☐ Finance and Investment Committee ☐ Other
Recommendation for the Trust Board:	**To take assurance from the report on the progress being made against the key milestones**

Key issues and risks arising from this paper
Timeline and milestones
The application is due for submission to the Department of Health (DH) in March 2013. The accountability agreement between the LAS, NHS London, the cluster and the DH has been signed off however the Tripartite Formal Agreement (TFA) is with the DH currently for sign off after the Board to Board meeting on 25th June. It has already been signed off by NHS London and the cluster.

Executive Summary
Milestones achieved:

- Board governance assurance framework independent assessment completed and reported on 29th May. Action plan in Part II on 26th June.
- Board development plan in Part II on 26th June for discussion.

In the next two months:

- Refresh of the independent Quality Governance framework review, commencing on 23rd July and reporting to the Trust Board on 21st August.
- Maintain performance during the Olympic and Paralympic Games.

The outcome of the Board to Board on 25th June 2012 will be reported in Part II on 26th June.

Attachments
None

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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
☐ That we cannot maintain and deliver the core service along with the performance expected
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☒ 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:

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26 JUNE 2012

PAPER FOR NOTING

Document Title:	**Chief Operating Officer's Report**
Report Author(s):	**Martin Flaherty**
Lead Director:	**Martin Flaherty**
Contact Details:	**0207-7832039**
Why is this coming to the Trust Board?	**For 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:	The Board is asked to Note the paper

Key issues and risks arising from this paper

Ongoing high incoming 999 call volume and high Cat A workload
High Utilisation on ambulances and fast response units
Increasing staffing challenges given increased workload and student paramedic abstractions.

Executive Summary

The paper provides an update on the following key areas:

1.A&E Service Delivery
2.Emergency Preparedness
3.Fleet and Logistics
4 PTS
5. IBP Delivery Programme

Key messages

- The ytd position on Cat A8 minutes is 73.1% and on Cat A19 is 98.1%
- The Trust is experiencing unprecedented levels of demand particularly in May where both 999 calls and Cat A volumes are up by 20% on the same period last year.
- Utilisation levels remain very high and are increasing to record levels in May given the demand increases.
- The new Clock Start arrangements for RED 2 calls have been approved and came into effect on June 1st.
- Emergency preparedness activity is largely focussed on the Olympics preparations and the

service held a very successful national ambulance resilience exercise (Exercise Amber) in May.
- Report on the Diamond Jubilee Bank Holiday weekend
- Overall staffing is proving challenging given high levels of student paramedic training.

Attachments

Chief Operating Officer's Report May 2012
Information Pack for Trust Board April 2012

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

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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 26th JUNE 2012

CHIEF OPERATING OFFICERS REPORT

1. A&E SERVICE DELIVERY

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

Overview

The table below sets out the A&E performance against the key standards for Category A for April through to 19 June 2012 together with the current year to date (YTD) position.

Category	Cat A8	Cat A19
Key Standard	**75%**	**95%**
2011/12	75.7%	99.2%
April 2012	71.9%	98.2%
May 2012	71.3%	97.7%
2012/13 YTD	**73.0 %**	**98.1%**

The month of May saw the Trust achieve 71.3% for category A8 performance. This is below the National Key Standard for A8 and below the Trust's agreed A8 trajectory performance of 72%. The predominant factors that contributed to this level of performance in May were the extraordinary levels of category 'A' demand compounded by the inability to produce sufficient resource hours to meet this demand. As reported in May the increase in Category 'A' demand continued to build and as a result of this increasing pressure the Trust moved to REAP level 4 on the 21 May.

Demand continued to rise throughout the whole month and at month end we had responded to 37,609 Category 'A' calls this was 10.6% above our forecast and 20.3% above the same period last year. Overall activity in May also rose over the same period last year by 3098 calls not including the 1114 ambulances that were not sent during the enactment of the DMP during May. Last month also saw the fifth busiest day in our history, on the 22 May we responded to 1345 Category 'A' calls and our control room received 5,310 emergency calls.

As a result of us not achieving the national standard for A8 or our A8 commissioned trajectory for May our commissioners served us with a Contract Query Notice. We responded by submitting an excusing notice on the 11 June and we have also met with commissioners on the 12 June to discuss the issuing of the above notice. Following the meeting with commissioners we have received written confirmation from them that they have accepted with certain caveats the mitigation we provided for the performance delivery in May. We have agreed a set of actions with commissioners which now formerly lift the contract query notice.

We remain confident however that if demand remains within the agreed thresholds set we will maintain performance in line with the agreed trajectory for Category 'A'.

The production of adequate DCA & FRU hours became more challenging in the month of May, this was predominantly due to the deferred SP2 training being reintroduced and running at maximum levels. A total of 3,359 planned training abstractions occurred in May which equates to an average of 152 people per day but rose to a peak of 200 per day in parts of the month. Due to public holidays and weekends these abstractions were delivered within 22 days of the month. This level of abstraction along with the reduction in establishment and current vacancy factor provided significant challenges in producing sufficient operational hours. To mitigate these predicted challenges a number of actions were enacted throughout the month of May to improve capacity, these included:

- Enhanced the senior attendance at the weekly Operational Demand and Capacity review (ODaCR) meetings to further control abstractions, manage and monitor further remedial actions designed to improve our operational capacity.
- Increased the availability of overtime and provided enhanced rates for specific shifts to maximise capacity at projected times of peak demand.
- Introduced enhanced levels of clinical support in the Emergency Operations Centre at times of peak demand assisting us to safely remove the need to activate an ambulance response in less urgent cases more often.
- Increased the deployment of voluntary and approved third party ambulance providers in support of core business to maximise capacity.
- Deployed operational managers and Training Officers to frontline patient facing operational duties to supplement operational capacity and protect patient care.
- Escalated the REAP levels within the Trust from level 3 to level 4 signaling a period of severe pressure and deferred all non patient facing activity.
- Public messaging deployed through the media to push key messages around using the ambulance service wisely and providing health advice to Londoners particularly throughout the period of warm weather experienced in May.
- The arrangements for Pre-Planned Aid to support the delivery of our operational plans for the Queens Diamond Jubilee celebrations were finalised

Excessively high utilisation still remains a major concern for the Trust and whilst it has been agreed that the Trust will, in partnership with our commissioners, carry out a formal capacity review the high levels we experienced in 2011/12 continue and are even more acute given the current 22% increase in Cat A demand this month compared to the same period last year.

We are carrying out a number of actions to improve the overall staffing position and manage demand going forward and these are outlined below;

- Reducing the volume of rostered training being delivered to provide additional Ambulance and FRU hours.
- Accelerating the recruitment and selection process for Apprentice Paramedics
- Securing the recruitment of 78 direct entry paramedics from the university programmes from September and posting them to the areas of highest need.

- Increased targeted use of private and voluntary ambulance providers
- Continuation of overtime enhancements to incentivise overtime working at times of peak demand.
- In collaboration with commissioners commencing a formal capacity review
- Implementing a plan to maximise the opportunities to reduce multiple attendance ratios and reduce cancellations afforded by the clock start change
- Undertaking a strategic review of FRU provision across the Trust to ensure the correct balance of FRU and Ambulance provision.
- Dedicating existing management resources to robustly challenge and manage all VOR to increase the availability of produced hours.
- Working proactively with the media to try and manage down demand wherever possible.

The Trust recorded for the month of May a total of 89 Black Breaches of 60 minutes or more, which in comparison to last May is an overall reduction of 35 (28.2%). The worst day of the month for breaches occurred on the 29 May where there were 16 recorded and confirmed, 13 of these occurred at Croydon University Hospital. The South Area ADO is liaising with cluster representatives regarding the issues that remain at this acute hospital. YTD there have been 178 black breaches this compares to 236 for the same period last year, a reduction of 24.6% which is primarily as a result of collaborative working between the LAS and the acute Trust's.

On 1 June 2012 the Trust implemented the agreed Department of Health changes to clock start measurement for performance reporting. Clock start for Red 1 calls will remain unchanged. Red 2 calls will start when the chief complaint is known, the first resource is dispatched or 60 seconds has elapsed from the call being passed to the LAS, The first of these parameters will start the clock.

The first 13 days indicate that since the implementation of the new clock start measurement Red 1 performance is being maintained at previous values. Red 2 performance has seen an improvement , whilst C1 has experienced an increase of c10% in performance. The primary reason for the increase in C1 performance can be attributed to the decision to auto dispatch FRUs to all C1 calls. This was introduced at 0700 on the 8 June and demonstrated an immediate and positive effect on C1 performance. Further work will occur over the coming weeks to actively reduce the multiple attendance ratio (MAR) and the number of cancellations.

Queen's Diamond Jubilee

Over the bank holiday weekend of 2nd to 5th June 2012 mutual aid from across England was provided to LAS following a request to support operations across London for QDJ. Planning assumptions included the knowledge of c500 street parties per day and in excess of 1 million spectators being in central London each day with associated extensive road closures and disruption to routine service delivery.

The totality of mutual aid included 43 double crewed ambulances with supporting operational managers from each Trust that supplied mutual aid. All English Trusts provided 5 ambulances and crews with the exception of SECAMB who provided 3 (SCAS and IoW provided 5 together as did SWAS and GWAS).

Across the period all mutual aid staff were hosted in hotel accommodation at LHR T5. One central briefing upon arrival took place and was supported by an embedded welfare officer/single point of contact from LAS who stayed at the hotel throughout the deployment.

Mutual aid crews were deployed in central London and attended emergency calls associated with QDJ within the event areas whilst also attending calls in support of business as usual activity. In excess of 200 emergency calls were attended by mutual aid crews.

A debrief on the final day of deployment identified some minor lessons that will benefit future deployments of mutual aid. It should be noted that the feedback at this debrief was overwhelmingly positive and feedback received subsequent to this also supports this position.

A full debrief report will prepared in the coming months that covers both the event planning and management together with the mutual aid deployment.

2. Emergency Preparedness

Since the last Trust Board report the Trust Major Incident Plan has received final approval and will be published in the coming weeks, there will be a trust wide launch on the pulse and through a poster campaign. Hard copies of the plan will be distributed as soon as they are available. The 8th edition of the London Emergency Services Liaison Panel (LESLP) manual is now available electronically and hard copies with be distributed as soon as they arrive in trust. This includes findings from the Coroner's Inquest for 7th July 2055 London bombings.

We have seen yet another busy period for events and stadia with the Queen's Club Tennis, Central London Tamil Protests, State Opening of Parliament, Colonels and Major Generals Review's and Trooping of the Colour. There have been a series of local borough Diamond Jubilee events and the main Jubilee event that is covered under a separate heading.

As we move forward into June we enter the Wimbledon Lawn Tennis fortnight, Euro World Cup Football, along with the Hyde Park concert season.

We began a series of CBRN Seminars but due to the Operational pressures and increase in REAP these were subsequently postponed, new dates will be made available in due course.

We have successful identified and recruited for secondment over the next 18mths 15 staff for the London Air Ambulance (HEMS), these staff will go through the required training prior to commencement of their secondment.

3. Fleet and Logistics

Fleet

New ambulances continue to enter service in three phases. Delivery is now well into phase two with the first phase (22 vehicles) all fully commissioned. The majority of this first phase were successfully deployed during the Diamond Jubilee Weekend to

support event work. MacNeillies, the converter, is subject to a regime of close diligence and scrutiny to ensure that delivery of the entire order (66 vehicles) is complete in time for the Olympic Games.

The first phase of new FRU vehicles (30 vehicles) is in the process of passing from the manufacturer (Skoda) to the converter (AES). With conversion of each vehicle taking a matter of days, the first vehicles are expected to be fully commissioned by the end of June with the majority commissioned by the end of July.

Final tender documents for the Low Emission Zone (LEZ) conversion work will be circulated to suppliers in mid-June. Work is still expected to commence in July with completion by September in order to achieve full compliance.

Work is ongoing, led by Estates, to sign the lease for the new West Workshop (Greenford) site. Initial meetings with the planning authority have been held with positive results. Detailed floor plans have now been agreed. The Business Case will be resubmitted to the SHA for final approval once the draft lease can be appended.

Vehicle Preparation

Implementation of the "clean and stock" element of the contract is at an advanced stage and the supplier, Initial, is demonstrating significant improvements against contracted standards. The Trust's expectations are reinforced at regular contract review meetings whilst the department's implementation team continues to undertake unannounced night-time audits for quality assurance. Under the terms of the contract, formal performance management will not commence until the six-month stage (early September 2012). Initial is nearing the end of consultation with managers and staff on changes to working hours and practices identified during the competitive dialogue process. The trial of hand-held PDAs (to facilitate asset-tracking of LAS assets) has now commenced. The new Contract Manager for the Trust takes up this new post in late June.

Planning for Olympic Games and Managing Service Delivery

Fleet and Logistics have made significant progress with plans to support the Olympic Games and Maintaining Service Delivery (MSD) operations. Additional support for Workshops, the LSU and Vehicle Resource Centre (VRC) has been factored in. Vehicle Preparation will support the Olympic Deployment Centre (ODC) operation throughout the Games period. A separate duty rota for managers in the department will also be implemented for the Games period to provide resilience and a focus point for the resolution of any Fleet or Logistics matters

Performance

Fleet and Logistics KPIs have continued to improve in a number of areas. Vehicle sourcing to shift start time (when no vehicle available on station) was on target for a second month at 85%. Vehicle availability in May (Workshop performance) remained steady at 88%. Deep cleaning of vehicles showed improvement in all areas – up 40% on ambulances from March to 90% against an 85% target. FRU deep cleans were up to 90% (from 75% in March) and PTS to 85% (from 70% in March).

Overnight clean and stocking was sustained at 77% against an 80% target. Ambulance servicing to plan remains a concern as this dropped 10% to 50% in May (70% target). The demand to meet high Peak Vehicle Requirements on certain days does result in servicing being cancelled, particularly at times of heightened pressure as was seen in May. The department expects to appoint a new Fleet Servicing Manager during June 2012 (the post is currently vacant). Total Fleet-related VOR increased marginally by approximately 0.2% of total hours. Improvements have been seen in tyre-related VOR (following a strengthening of the SLA with tyre service providers) and in overall workshop-related VOR. This has been overshadowed in increases in MDT-related defects (an increase of almost 100hrs) and in breakdown-related VOR (where a vehicle requires assistance at the roadside), reflecting a combination of an aging fleet and the influence of the high temperatures in May. Between April and May there was also in increase of around 130hrs in statutory vehicle check VOR which is being investigated further with EOC colleagues.

4. PTS

Commercial

The LAS has now presented its bid to North West London Hospitals NHS Trust and Ealing Hospital NHS Trust non Emergency Patient Transport Services.

As a result of the presentation a further clarification meeting was held on 18th June and final written responses to the clarification questions returned by 20th June.

There have been a number of other opportunities advertised in the past month. These have included Hillingdon Hospital NHS Trust, Barts Health Foundation Trust and a new process to identify providers who will be entered onto a framework agreement for provision of PTS being run by the London Procurement Programme. The LAS has expressed an interest to compete in these tender exercises.

Performance

Activity in May rose to 16,100 journeys which was slightly above forecast and an increase of 2,567 journeys over the previous month.

The quality indicators for May were:

- Arrival Time: 92% same as last report
- Departure Time: 94% decrease of 1% from last report
- Time on Vehicle: 97% same as last report.

Martin Flaherty
Chief Operating Officer

London Ambulance Service
NHS Trust

Information Pack for SMG

May 2012

***** Currently we are missing two datasets for May**

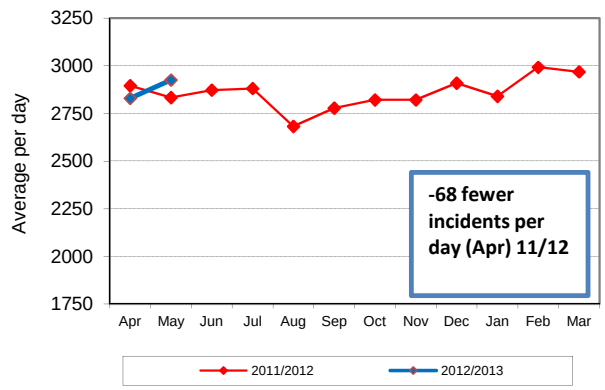
Rest Breaks
Fleet & Logistic information

***** Missing Trajectory figures for 2012-13 for one dataset**
Funded Hours

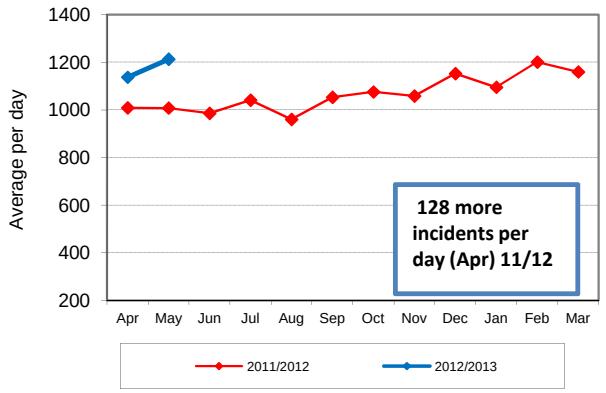
PRF's only updated 20th May
Hospital breaches included up to and including 20th May

London Ambulance Service NHS Trust
Accident and Emergency Service
Activity / Call Process -
May 2012

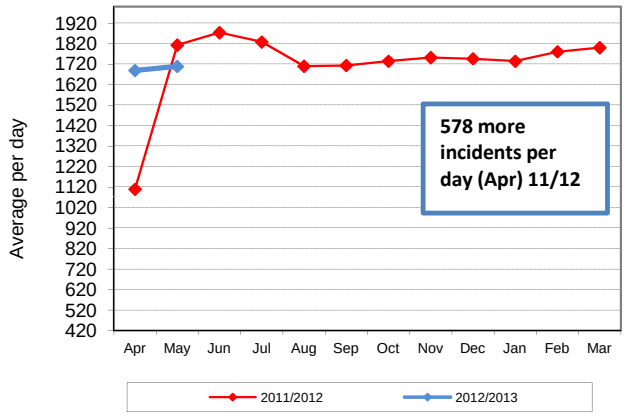
Graph 1
Average number of Total incidents per day



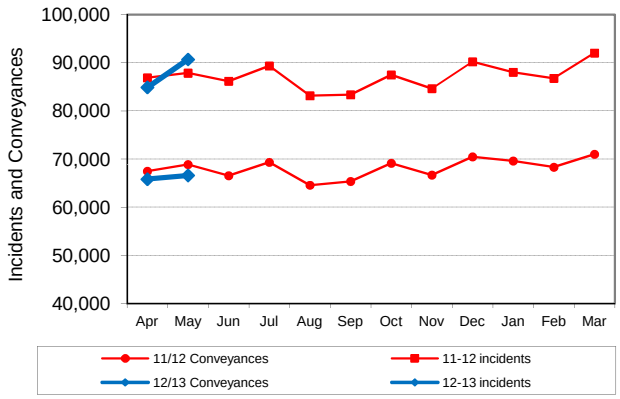
Graph 2
Average number of Cat A incidents per day



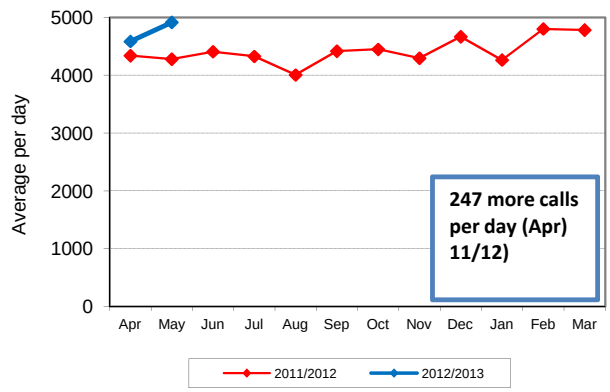
Graph 3
Average number of Cat C incidents per day



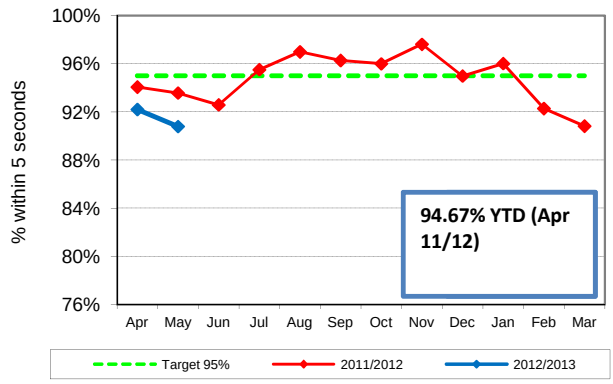
Graph 4
No of incidents conveyed



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

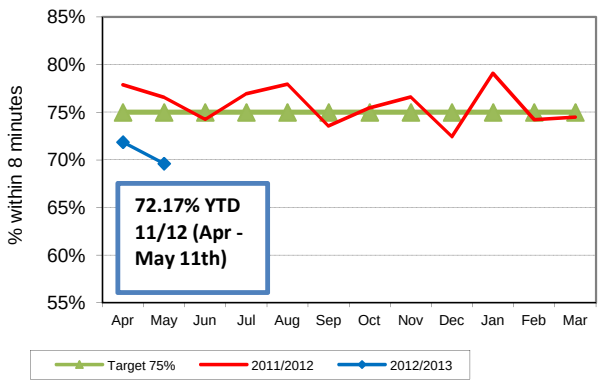


Graph 6
Percentage of calls answered within 5 seconds

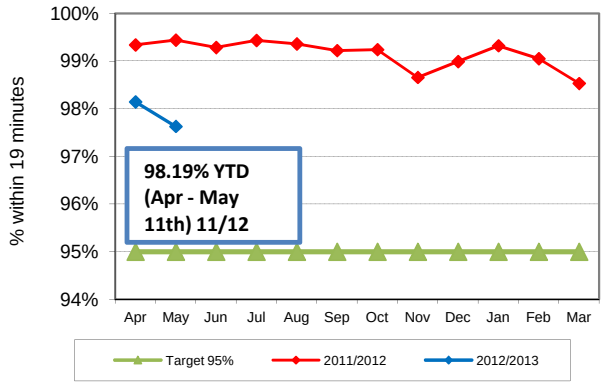


London Ambulance Service NHS Trust
Accident and Emergency Service
Performance - May 2012

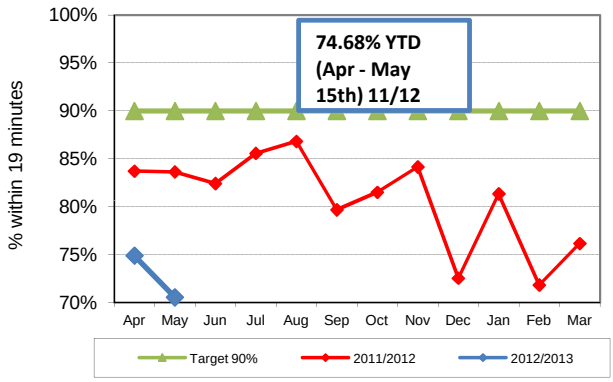
Graph 7
Category A 8 minute performance



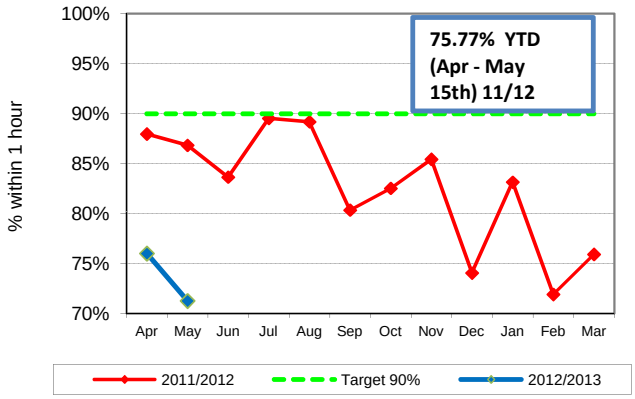
Graph 8
Category A 19 minute performance



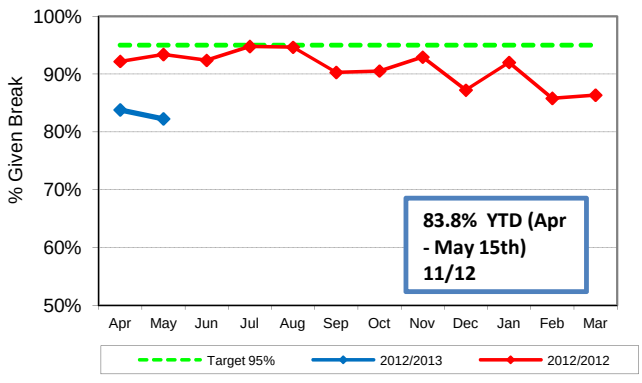
Graph 9
Category C1 20 minute performance
(Incidents responded to only)



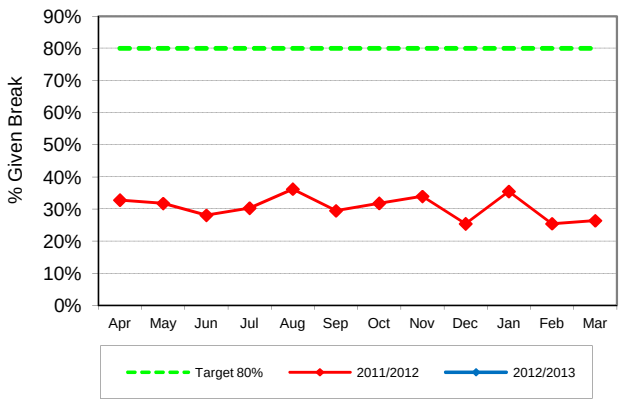
Graph 10
Category C2 30 minute performance
(Incidents responded to only)



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

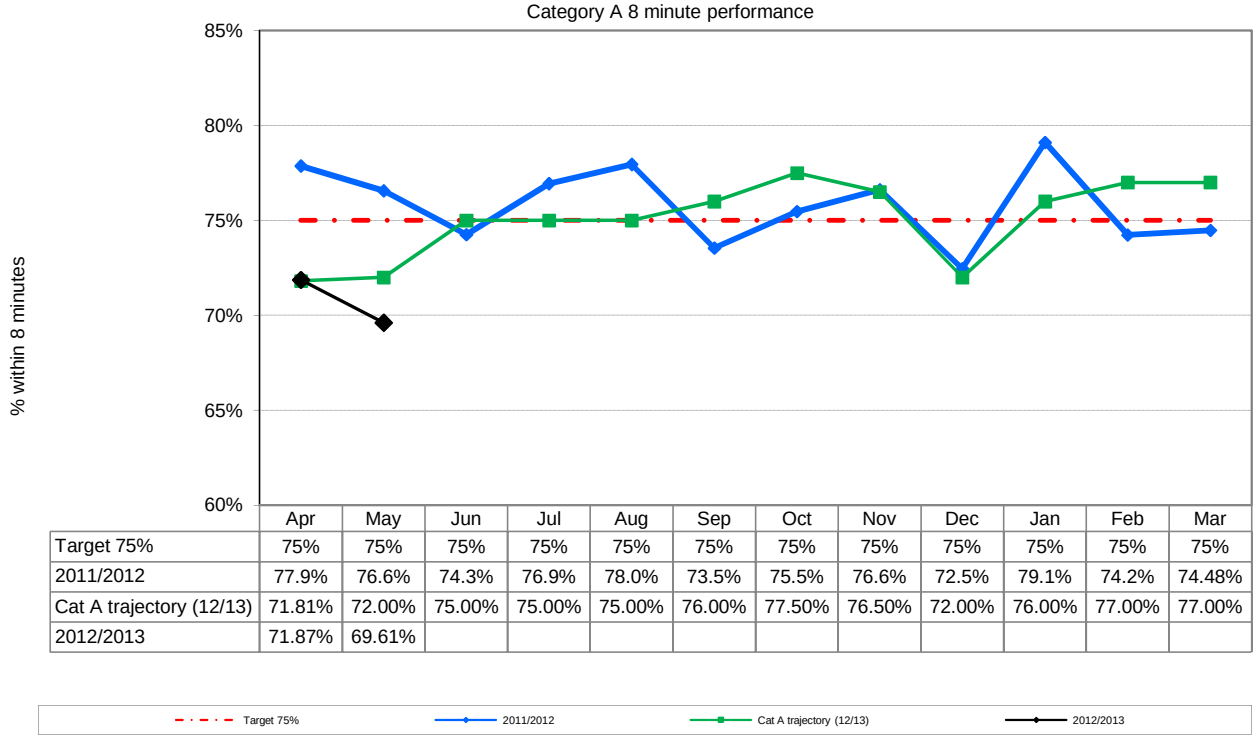


Graph 12
Rest Breaks Given



London Ambulance Service NHS Trust
Accident and Emergency Service
Performance - May 2012

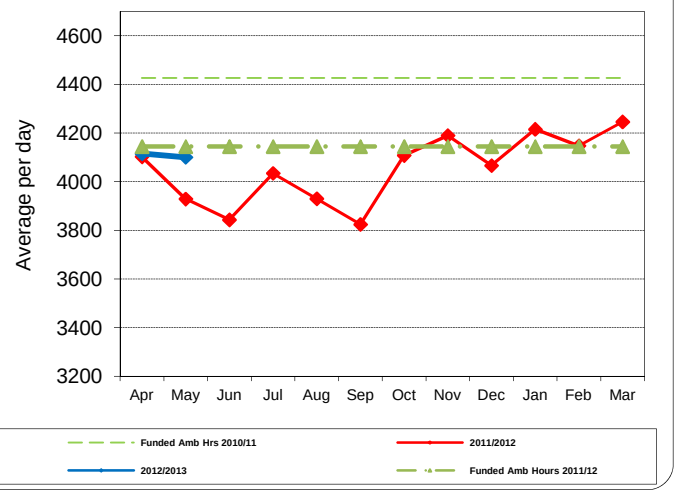
Graph 13
Category A 8 minute performance



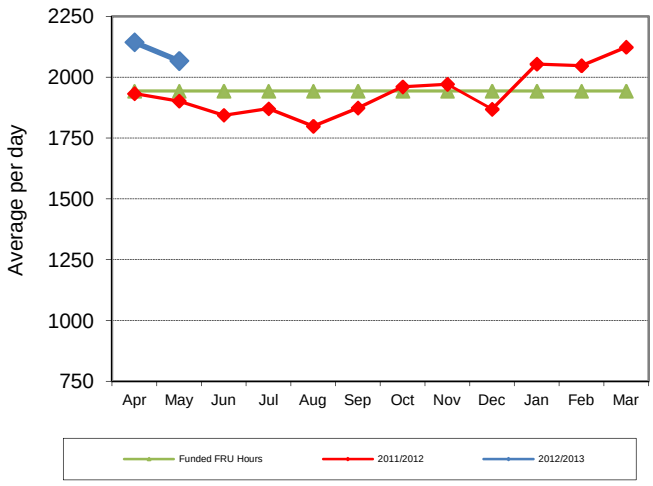
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target 75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
2011/2012	77.9%	76.6%	74.3%	76.9%	78.0%	73.5%	75.5%	76.6%	72.5%	79.1%	74.2%	74.48%
Cat A trajectory (12/13)	71.81%	72.00%	75.00%	75.00%	75.00%	76.00%	77.50%	76.50%	72.00%	76.00%	77.00%	77.00%
2012/2013	71.87%	69.61%										

London Ambulance Service NHS Trust
Accident and Emergency Service
Efficiency and Effectiveness - May 2012

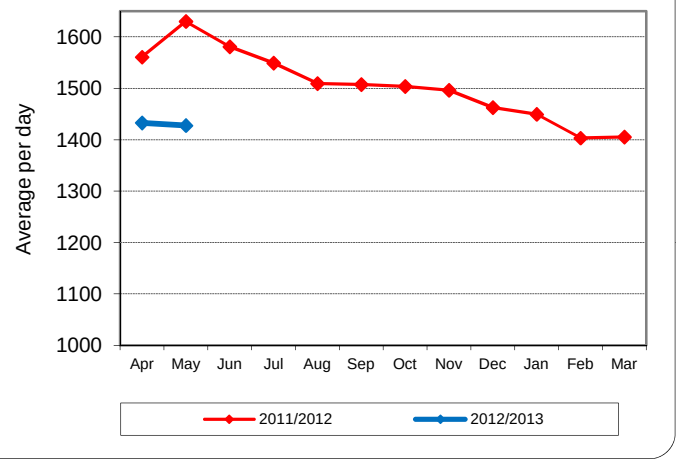
Graph 14
Ambulance Hours average available per day



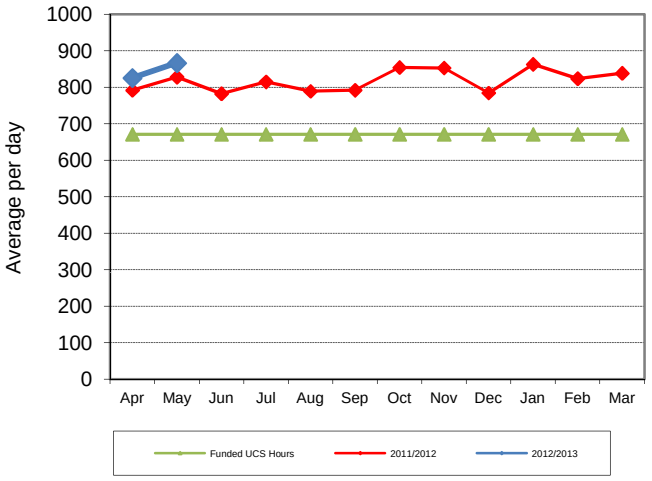
Graph 15
FRU hours average available per day



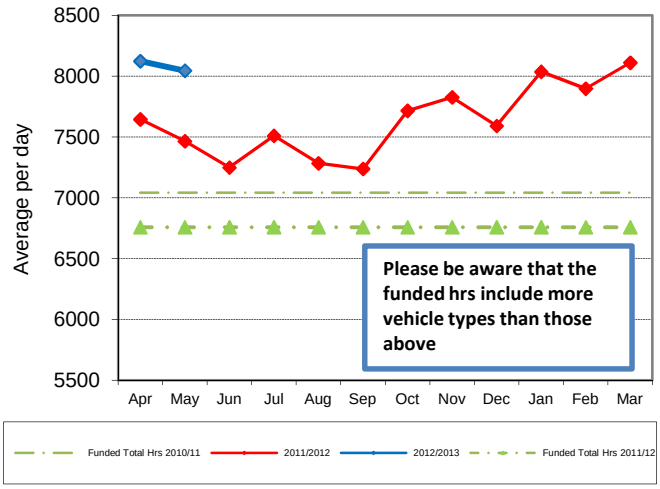
Graph 16
EOC hours staffed per day



Graph 17
UOC Hours average available per day



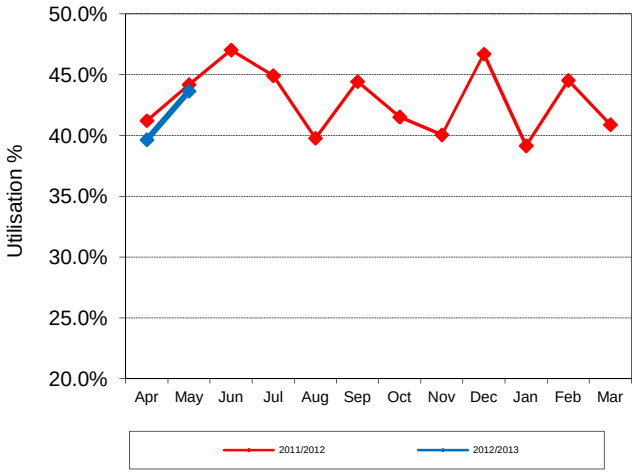
Graph 18
All Vehicle Hours average available per day



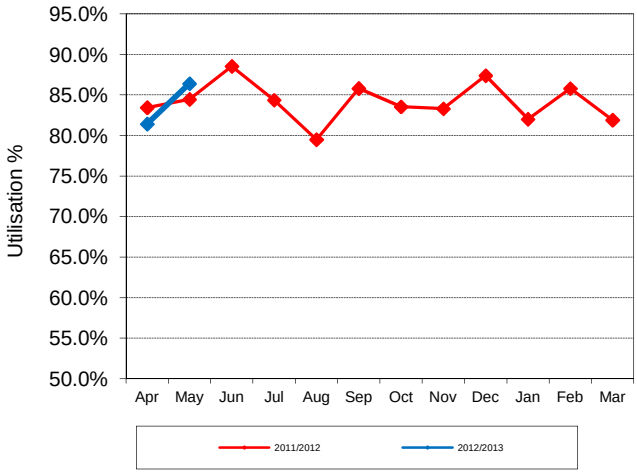
includes other vehicle types other than those above

London Ambulance Service NHS Trust
Accident and Emergency Service
Efficiency and Effectiveness - May 2012

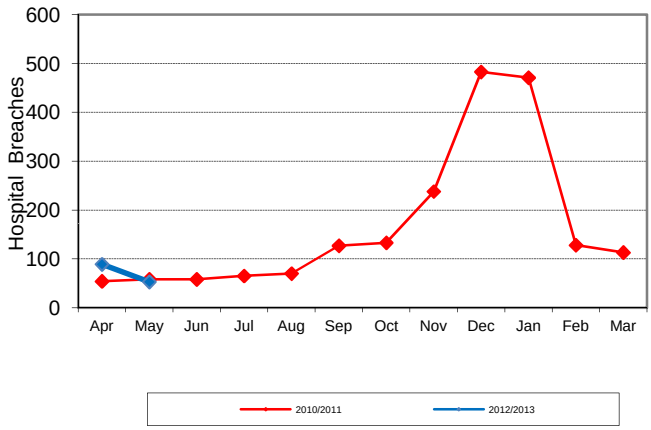
Graph 19
FRU Utilisation



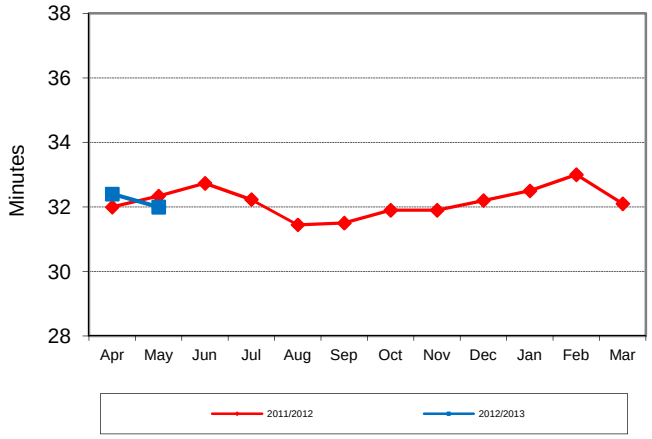
Graph 20
Ambulance Utilisation



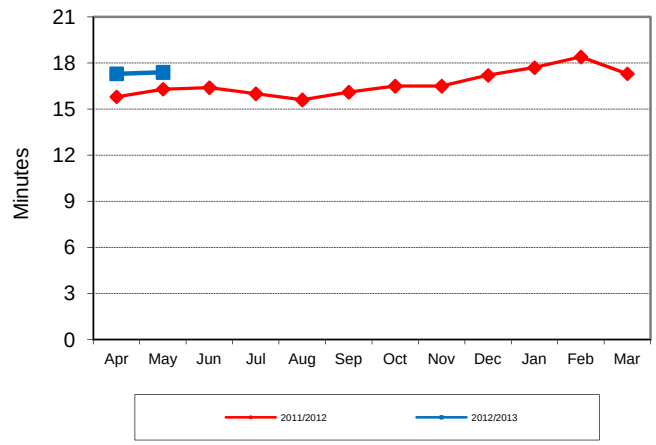
Graph 21
Hospital breaches over 60 minutes investigated



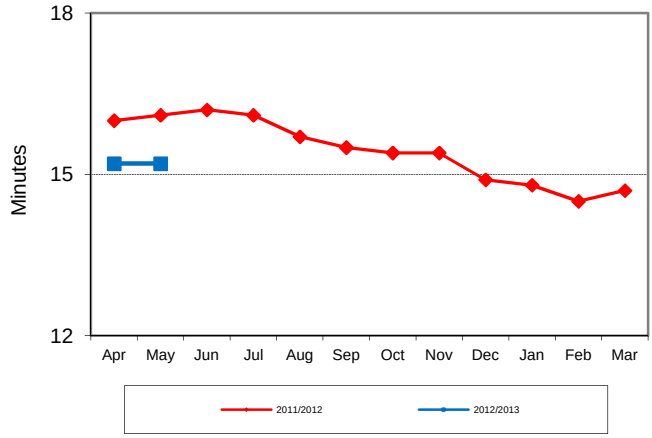
Graph 22
Average hospital turnaround time



Graph 23
Average Arrival at Hospital to Handover (Mins)

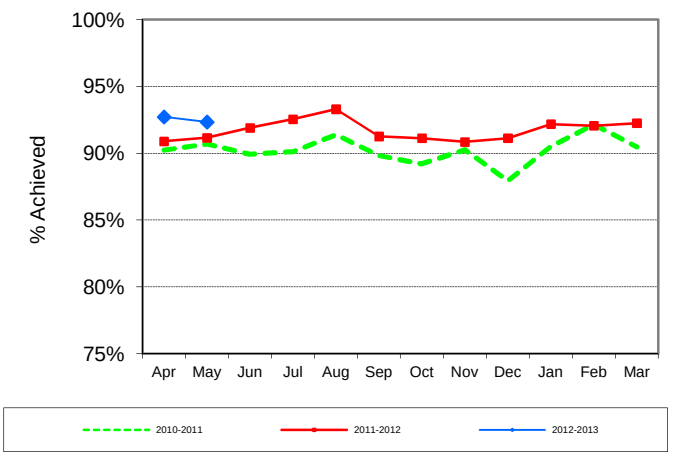


Graph 24
Average Handover to Green (Mins)

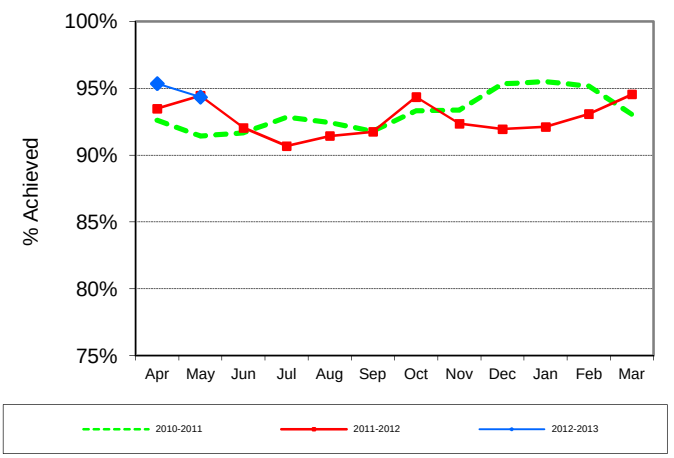


London Ambulance Service NHS Trust
Patient Transport Service
Activity and Performance - May 2012

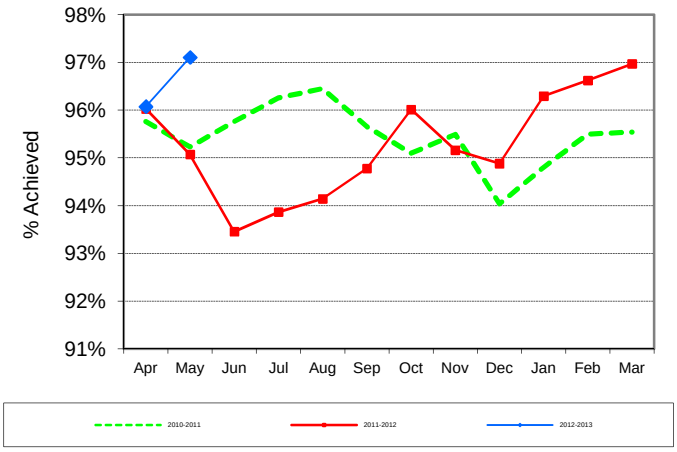
Graph 25
Arrival at Hospital Against Appointment Time



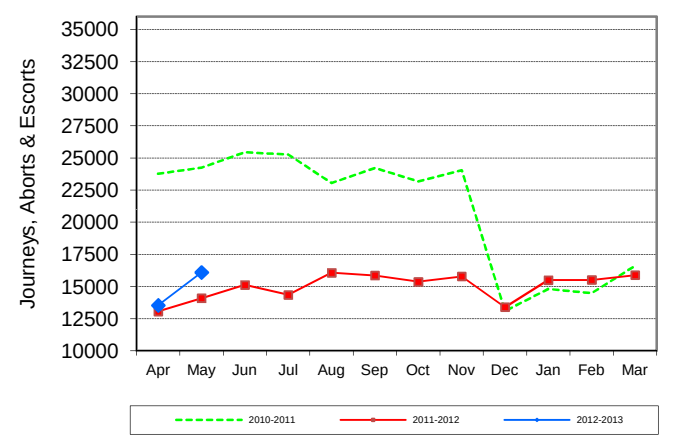
Graph 26
Departure Against Ready Time



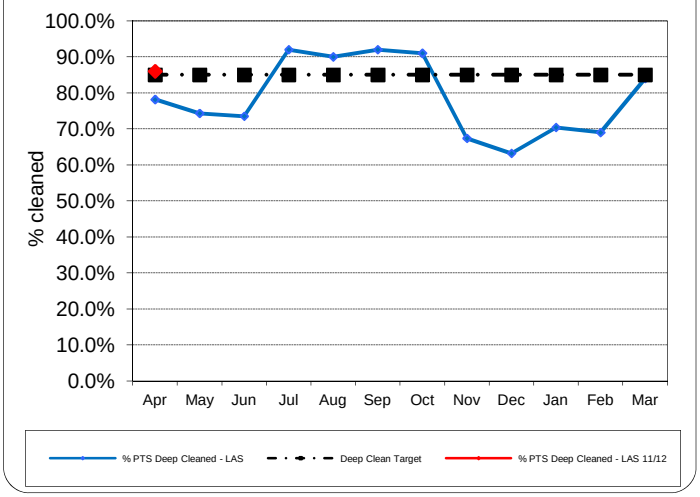
Graph 27
Time spent on Vehicle



Graph 28
PTS Total Activity



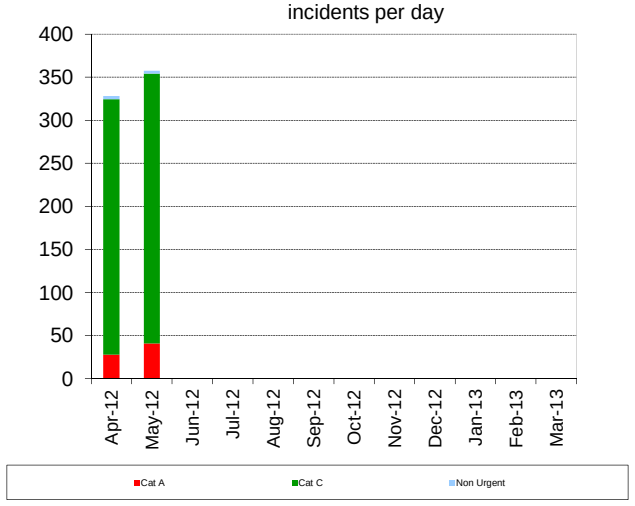
Graph 29
Deep Clean - PTS (17 weeks) - LAS



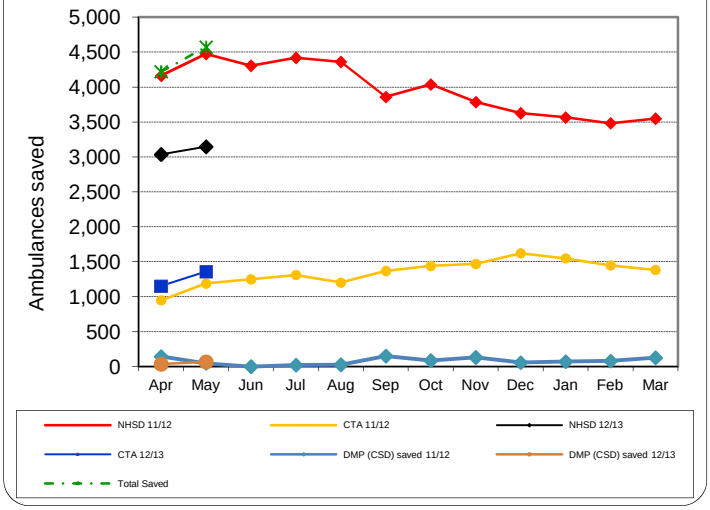
London Ambulance Service NHS Trust
Accident and Emergency Service
UOC Effectiveness - May 2012

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

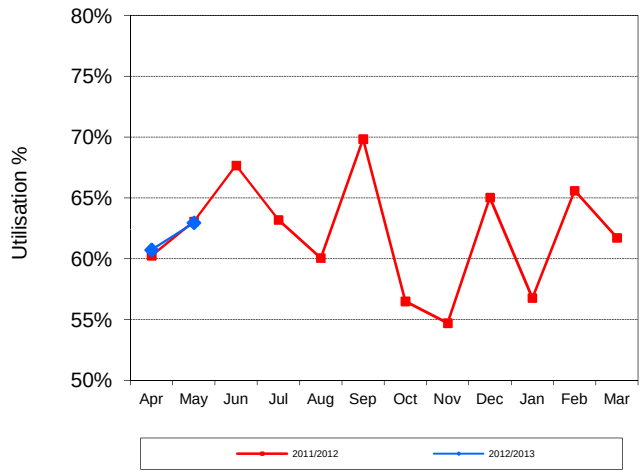
Graph 30
CAT A, B & C Workload by Urgent Care Vehicles average incidents per day



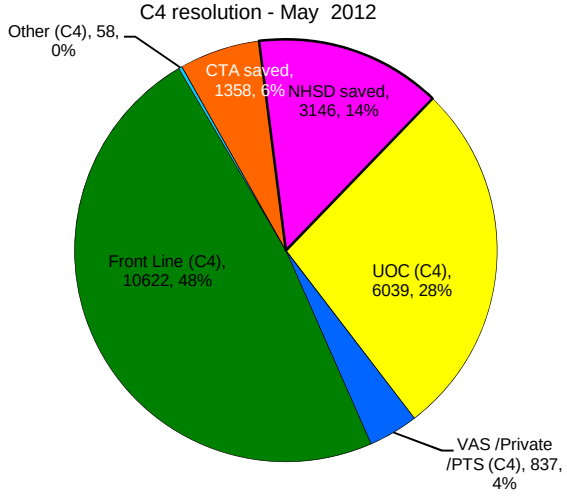
Graph 31
CTA/NHSD/DMP Ambulances saved



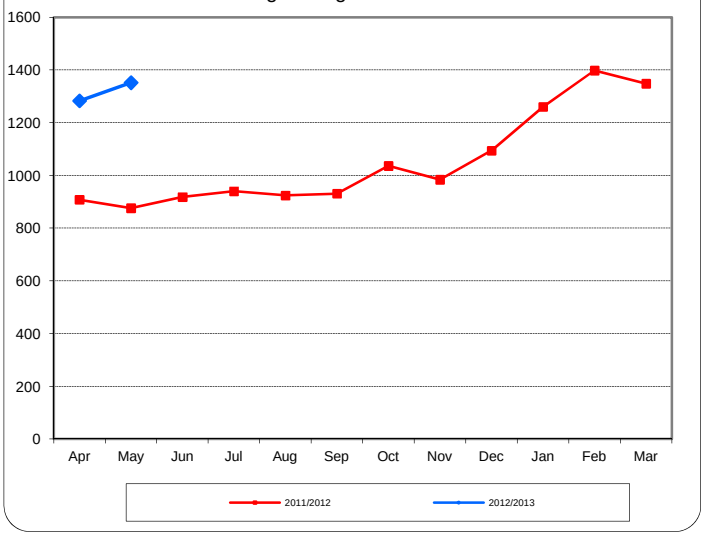
Graph 32
UOC Utilisation



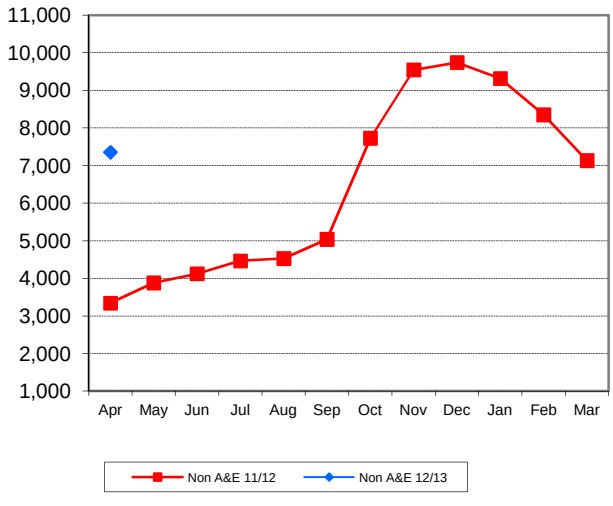
Graph 33
C4 resolution - May 2012



Graph 34
Safeguarding children and adults

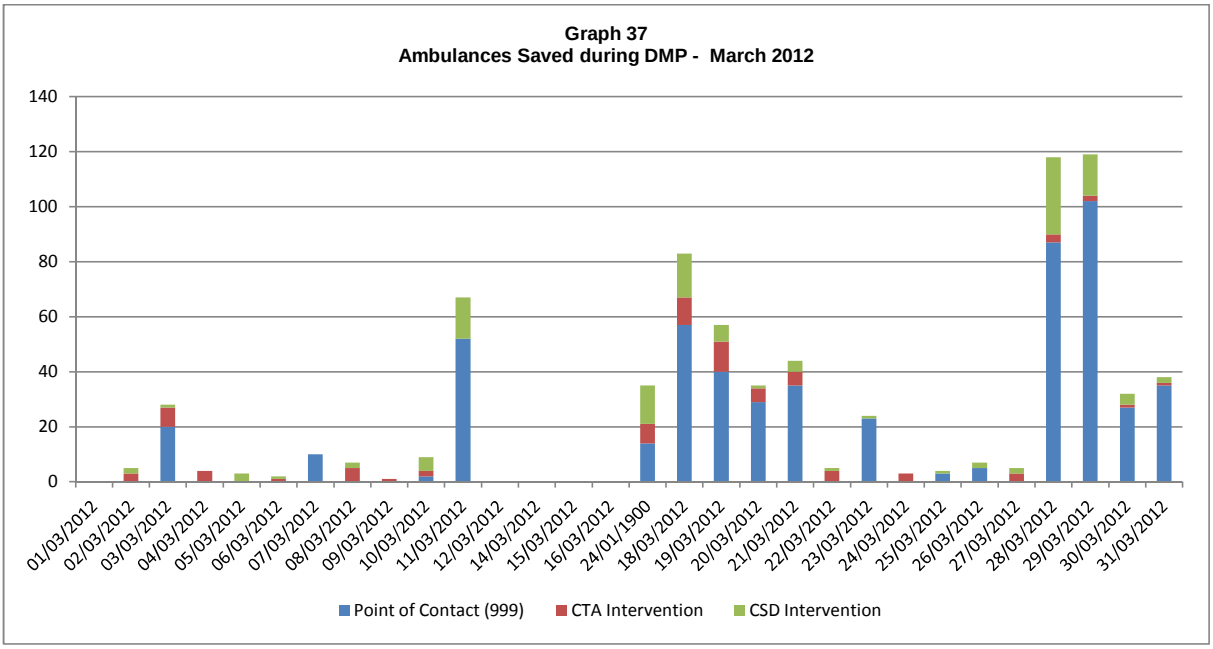


Graph 35
Patients conveyed to Non A&E Departments - LAS

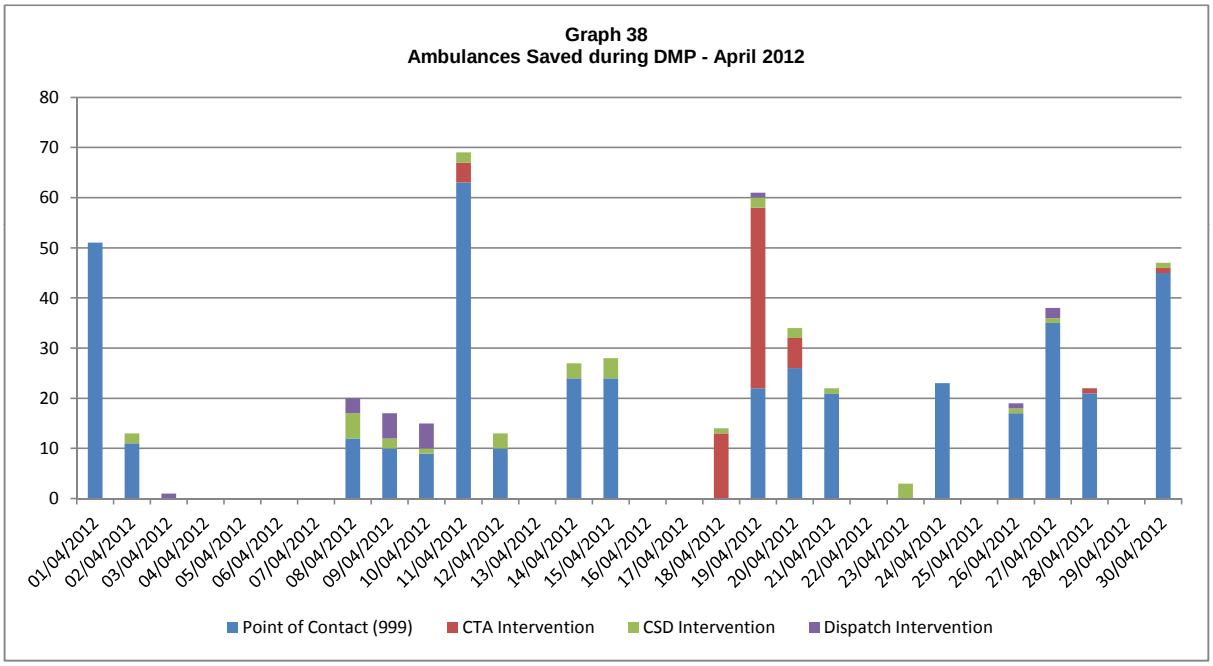


London Ambulance Service NHS Trust
Accident and Emergency Service
DMP Ambulance saves -
May 2012

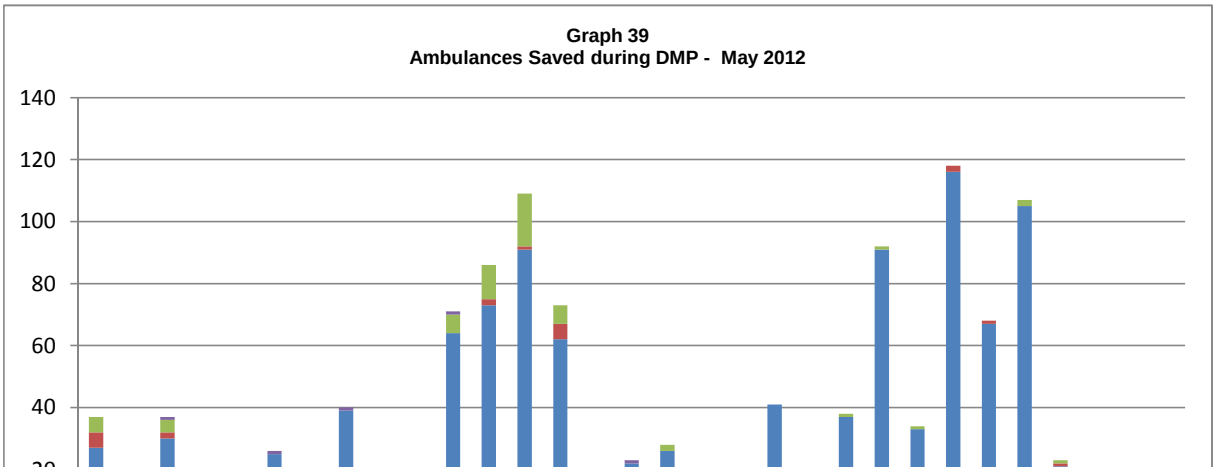
Graph 37
Ambulances Saved during DMP - March 2012



Graph 38
Ambulances Saved during DMP - April 2012



Graph 39
Ambulances Saved during DMP - May 2012



London Ambulance Service NHS Trust
Accident and Emergency Service
DMP Ambulance saves -
May 2012

DMP Stages by hour by day including number of saves from CSD - March 2012

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	Daily Total
01/03/2012																									
02/03/2012		1																					1		2
03/03/2012		1																							1
04/03/2012																									
05/03/2012																				1	1	1			3
06/03/2012																			1						1
07/03/2012																									
08/03/2012																					2				2
09/03/2012																									
10/03/2012													1									1		3	5
11/03/2012	1	1	1	1															1	2	2	5	1		15
12/03/2012																									
14/03/2012																									
15/03/2012																									
16/03/2012																									
17/03/2012																			1	1	1	2	5	4	14
18/03/2012	1	3	6	4	1															1					16
19/03/2012												1		3	1					1					6
20/03/2012																						1			1
21/03/2012																	2			2					4
22/03/2012	1																								1
23/03/2012																								1	1
24/03/2012																									
25/03/2012							1																		1
26/03/2012																				1				1	2
27/03/2012																			1			1			2
28/03/2012																			2	3	15	4	1	3	28
29/03/2012															1			1	2		3	5	1	2	15
30/03/2012	2	1																		1					4
31/03/2012		1																					1		2

DMP Stages by hour by day including number of saves from CSD - April 2012

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	ily Tot
01/04/2012																									
02/04/2012																									
03/04/2012															1										1
04/04/2012																									
05/04/2012																									
06/04/2012																									
07/04/2012																									
08/04/2012																							2	1	3
09/04/2012	4	1																							5
10/04/2012																								5	5
11/04/2012																									
12/04/2012																									
13/04/2012																									
14/04/2012																									
15/04/2012																									
16/04/2012																									
17/04/2012																									
18/04/2012																									
19/04/2012	1																								1
20/04/2012																									
21/04/2012																									
22/04/2012																									
23/04/2012																									
24/04/2012																									
25/04/2012																									
26/04/2012																						1			1
27/04/2012																1					1				2
28/04/2012																									
29/04/2012																									
30/04/2012																									

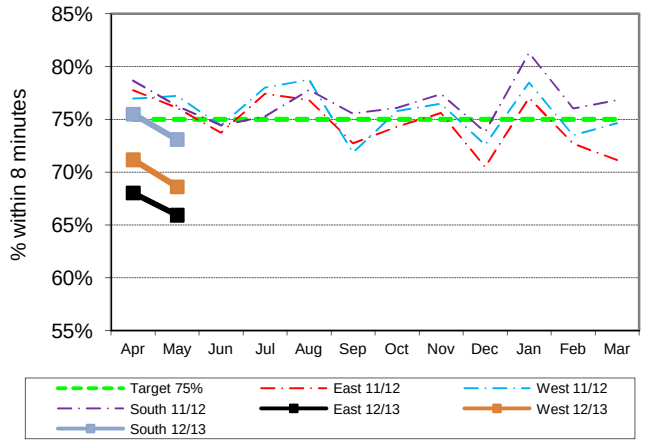
DMP Stages by hour by day including number of saves from CSD - May 2012

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	ily Tot
01/05/2012																		1	1		1			2	5
02/05/2012																		1				1	1	1	4
03/05/2012																		1		1	2				4
04/05/2012																									0
05/05/2012																									0
06/05/2012																									0
07/05/2012																									0
08/05/2012																									0
09/05/2012																									0
10/05/2012	1																								1
11/05/2012																	1				4	1			6
12/05/2012		1																1	1	5	2			1	11
13/05/2012	2	1		4	3									1	2					1		2		1	17
14/05/2012	1										1			3	1										6
15/05/2012																									0
16/05/2012																									0
17/05/2012																		1					1		2
18/05/2012	1																								1
19/05/2012																									0
20/05/2012																									0
21/05/2012																			1						1
22/05/2012																								1	1
23/05/2012																						1			1
24/05/2012																							1		1
25/05/2012																									0
26/05/2012																									0
27/05/2012																				2					2
28/05/2012										1															1
29/05/2012																									0
30/05/2012																						2			2
31/05/2012		1		1																					2

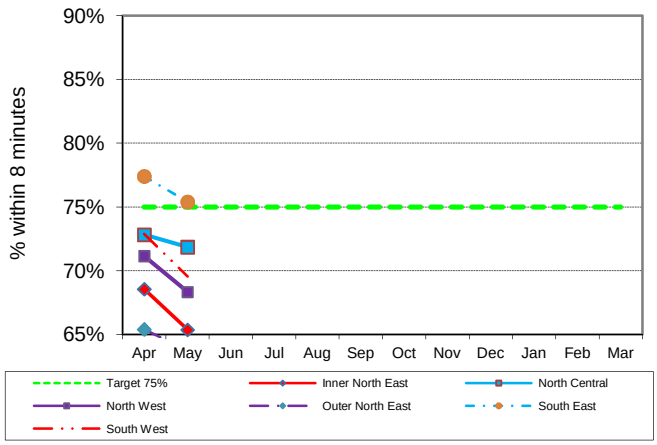
Not Recorded
Stage B
Stage C
Stage D
Stage E
Stage F
Stage G
Stage H

London Ambulance Service NHS Trust
Accident and Emergency Service
SMG Pack - Area Performance / Staffing / Utilisation - May 2012

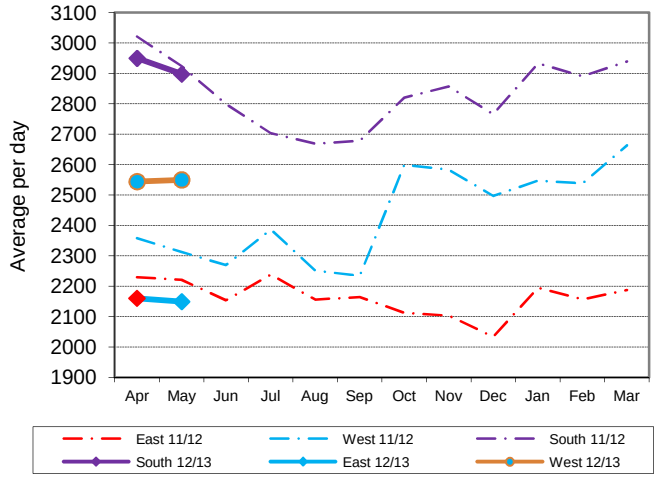
Graph 40
Area Category A 8 minute performance



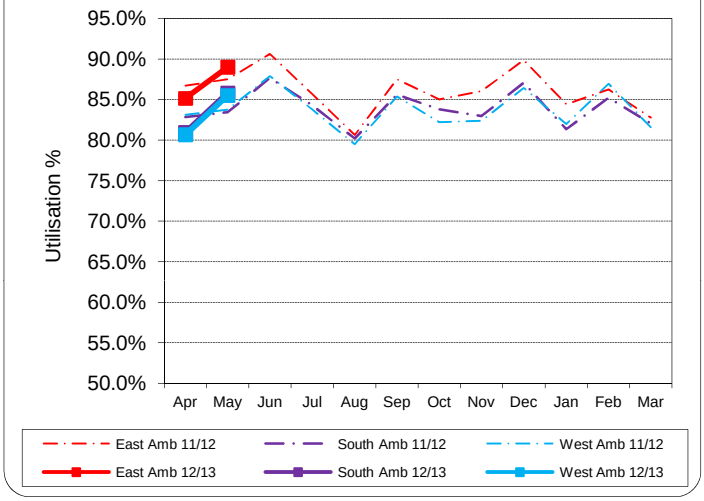
Graph 41
Sector Category A 8 minute performance



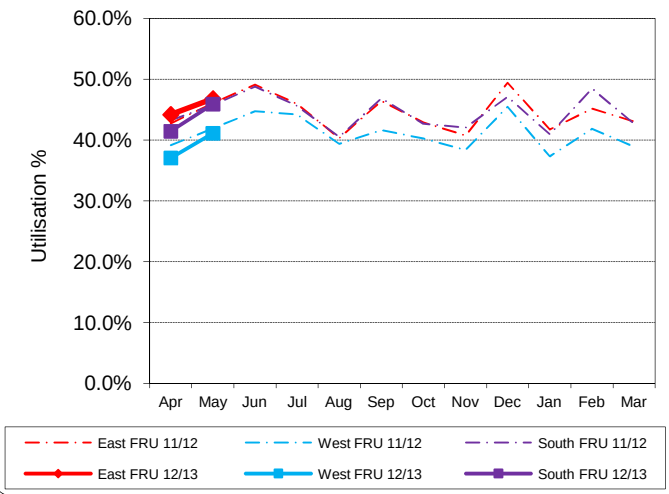
Graph 42
Area All Vehicle Hours average available per day



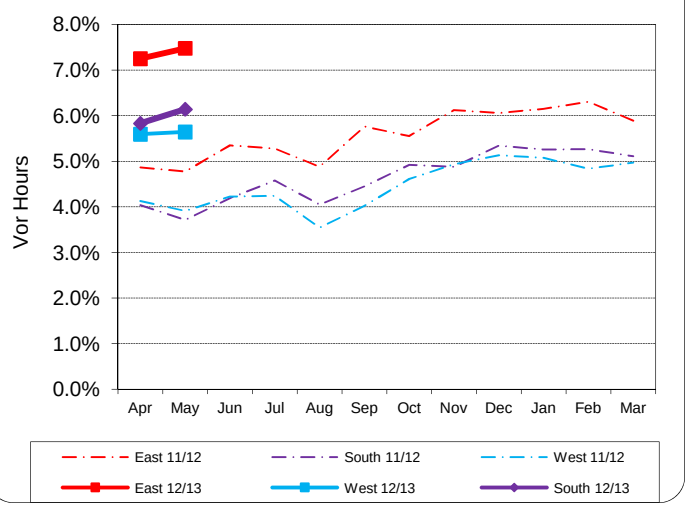
Graph 43
Area Ambulance Utilisation



Graph 44
Area FRU Utilisation

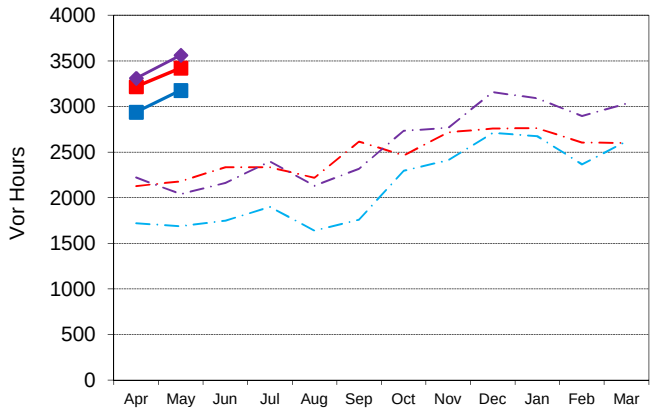


Graph 45
Area VOR

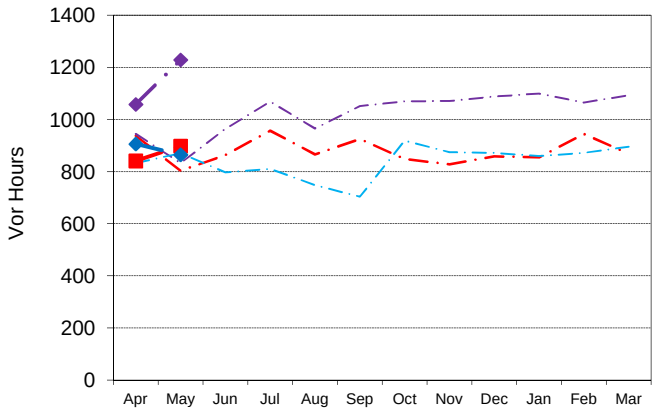


London Ambulance Service NHS Trust
Accident and Emergency Service
SMG Pack - Area Performance / Staffing / Utilisation - May 2012

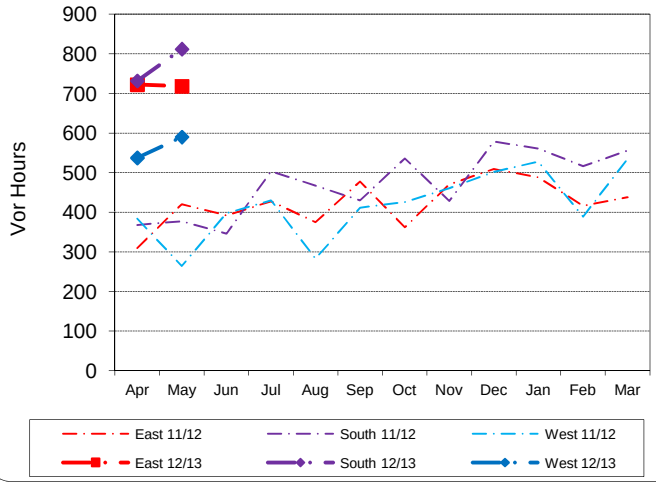
Graph 46
Area Ambulance VOR Hrs



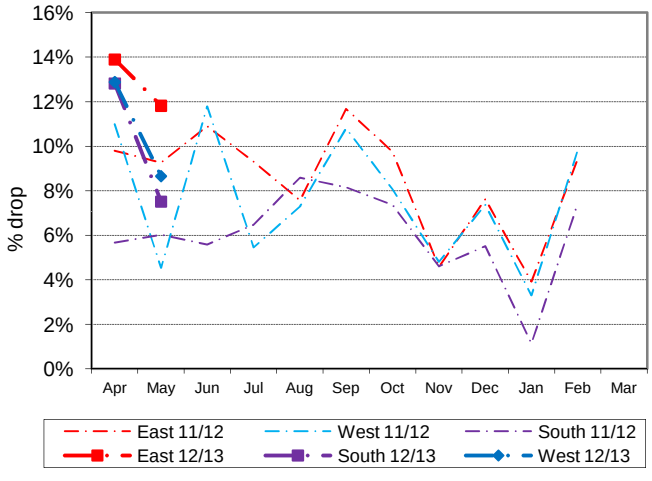
Graph 47
Area FRU VOR Hrs



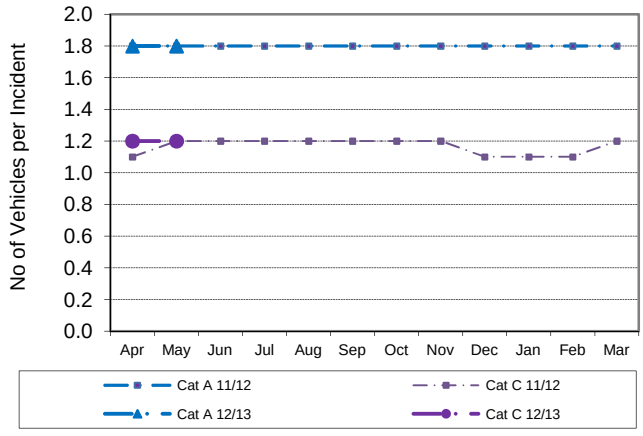
Graph 48
Area UOC VOR Hrs



Graph 49
Cat A performance drop between 1800-0000

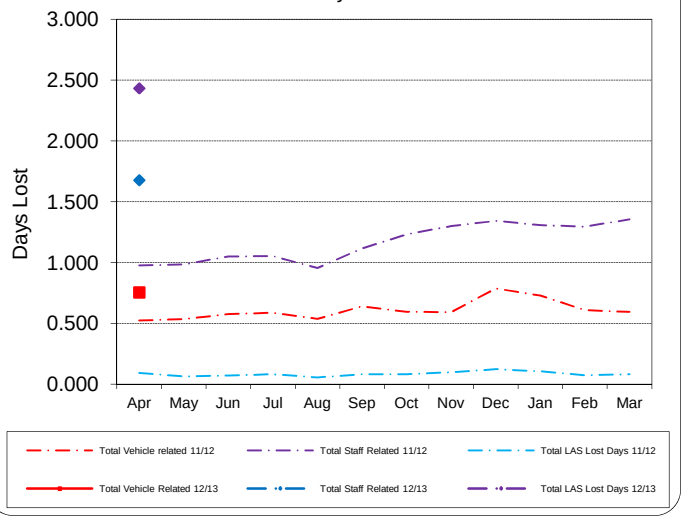


Graph 50
Multiple Attendance ratio by DOH category

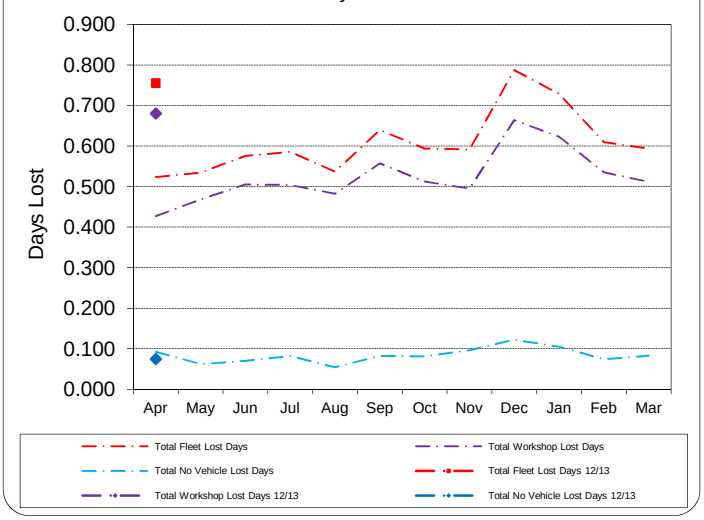


London Ambulance Service NHS Trust
Accident and Emergency Service
SMG Pack - Fleet and Logistics - May 2012

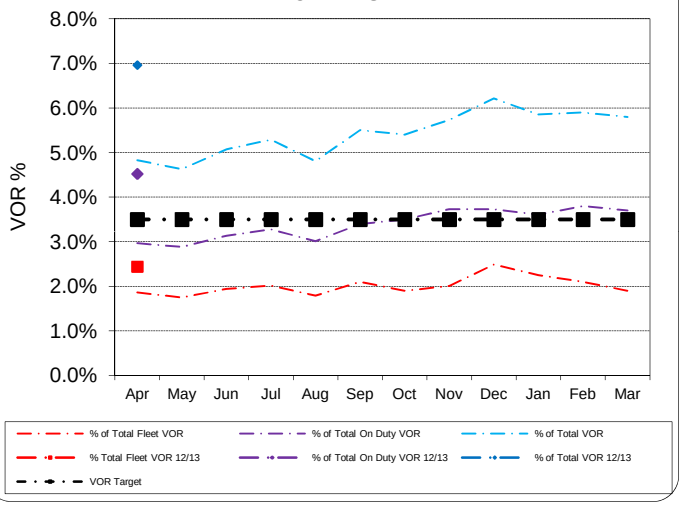
Graph 51
AEU Lost Days - LAS



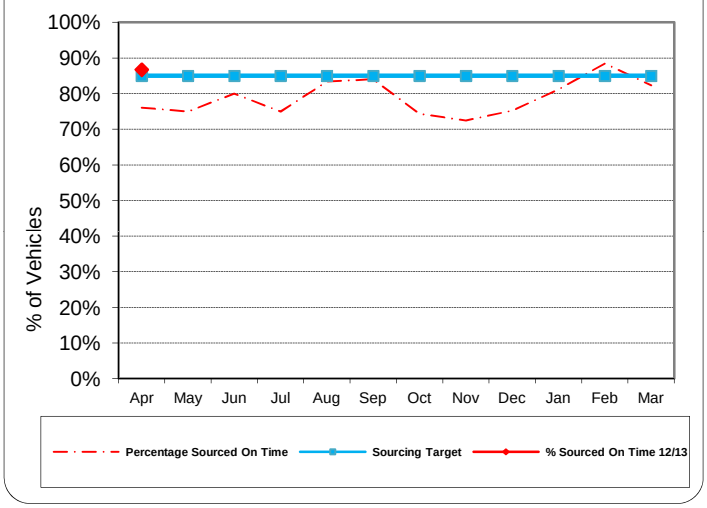
Graph 52
AEU Lost Days - Fleet Breakdown



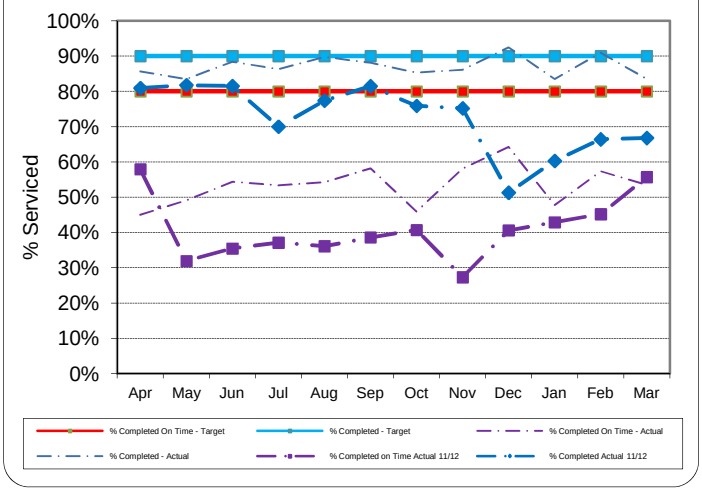
Graph 53
VOR - LAS



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

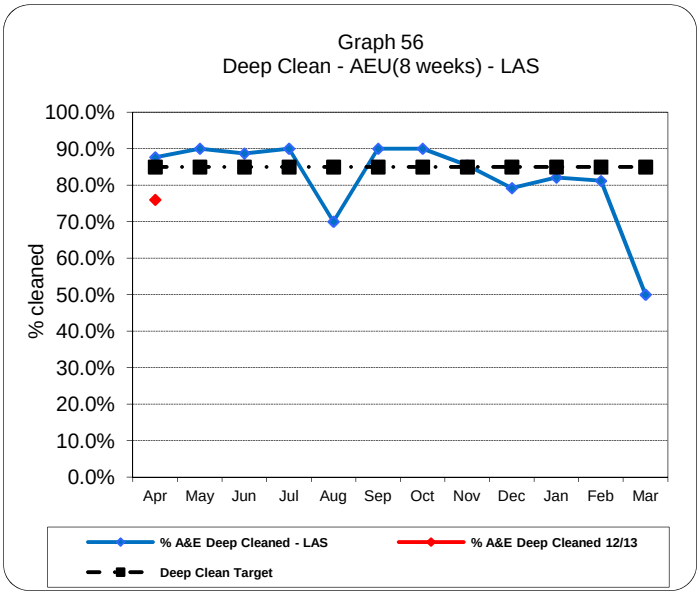


Graph 55
Servicing Performance - LAS

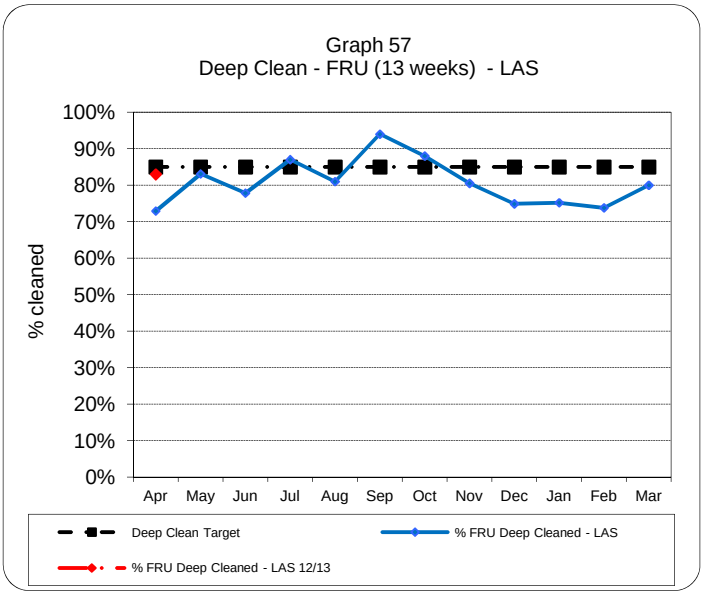


London Ambulance Service NHS Trust
Accident and Emergency Service
SMG Pack - Fleet and Logistics - May 2012

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

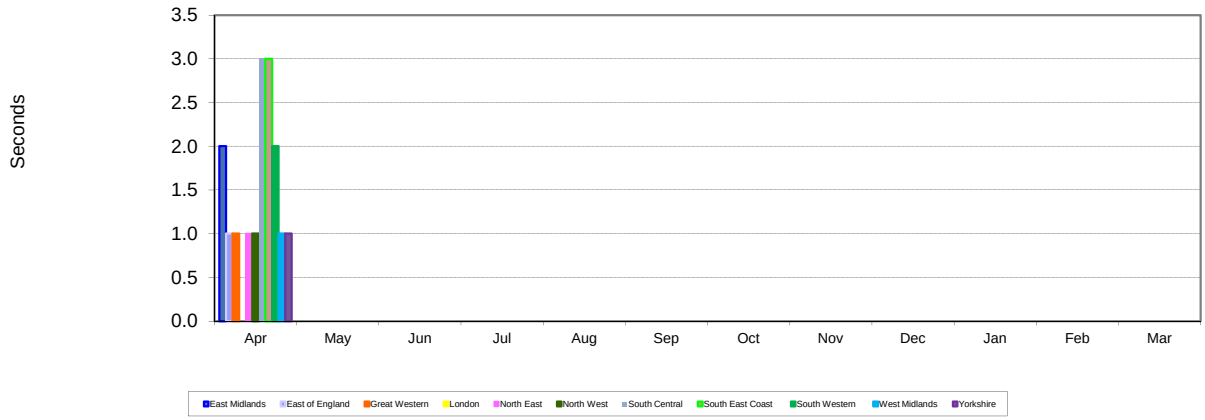


Graph 57
Deep Clean - FRU (13 weeks) - LAS

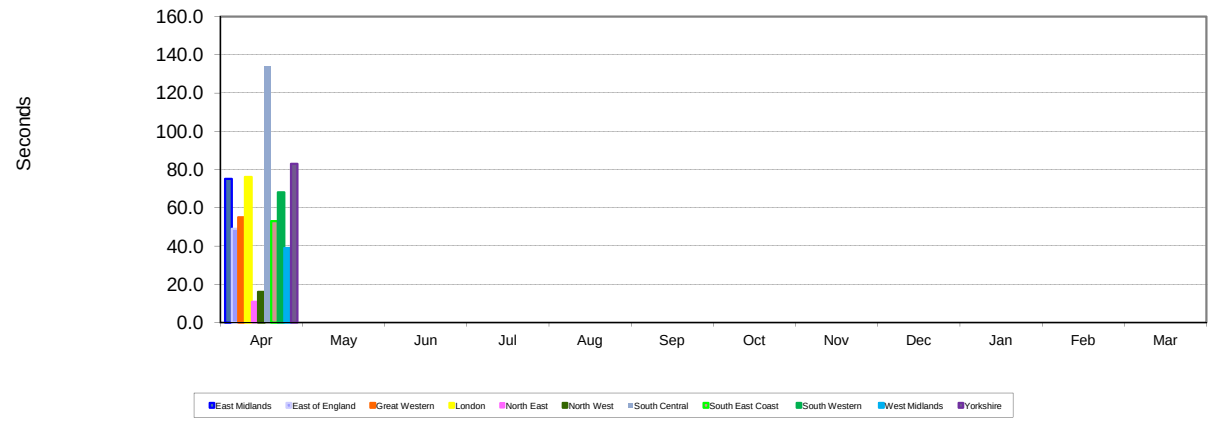


London Ambulance Service NHS Trust
Accident and Emergency Service
Ambulance Quality Indicators -
May 2012

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

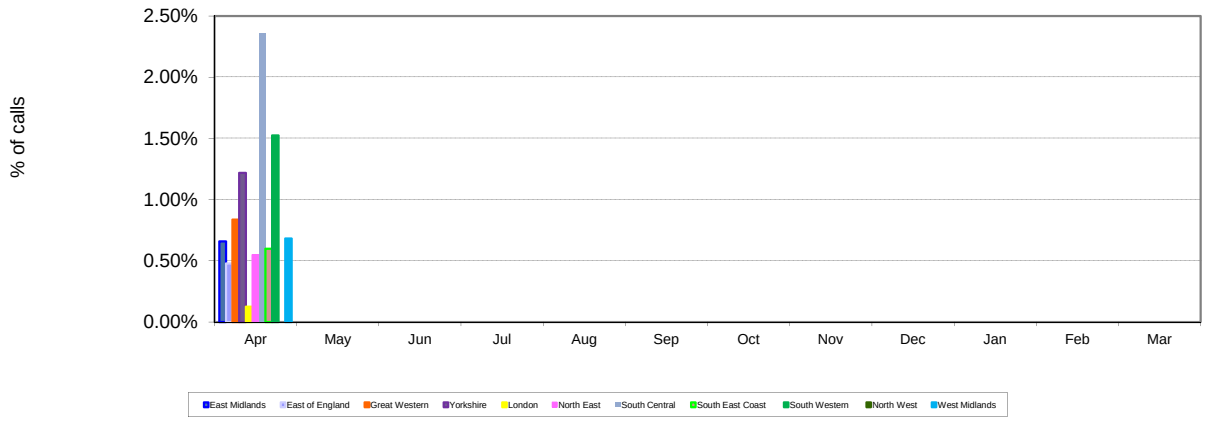


Graph 59
95th percentile - Time to answer calls (in seconds) by Ambulance Trust

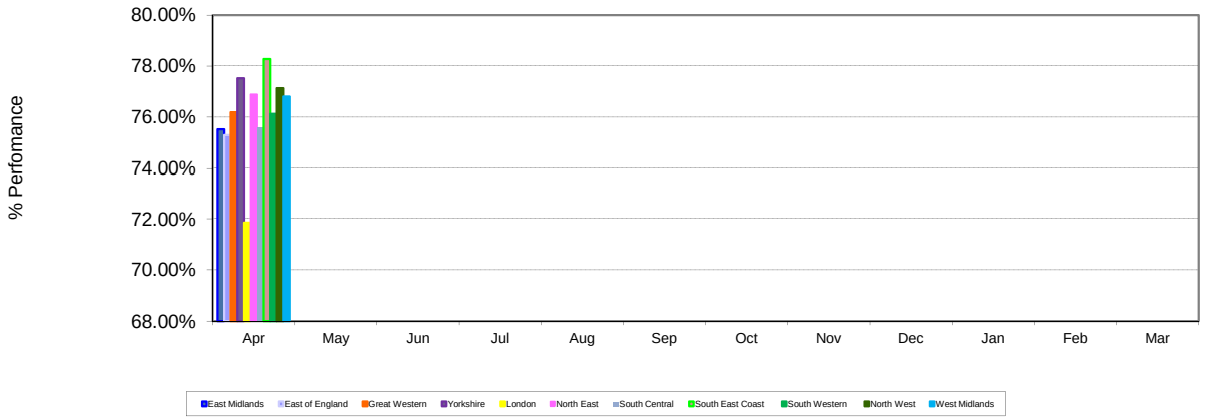


London Ambulance Service NHS Trust
Accident and Emergency Service
Ambulance Quality Indicators -
May 2012

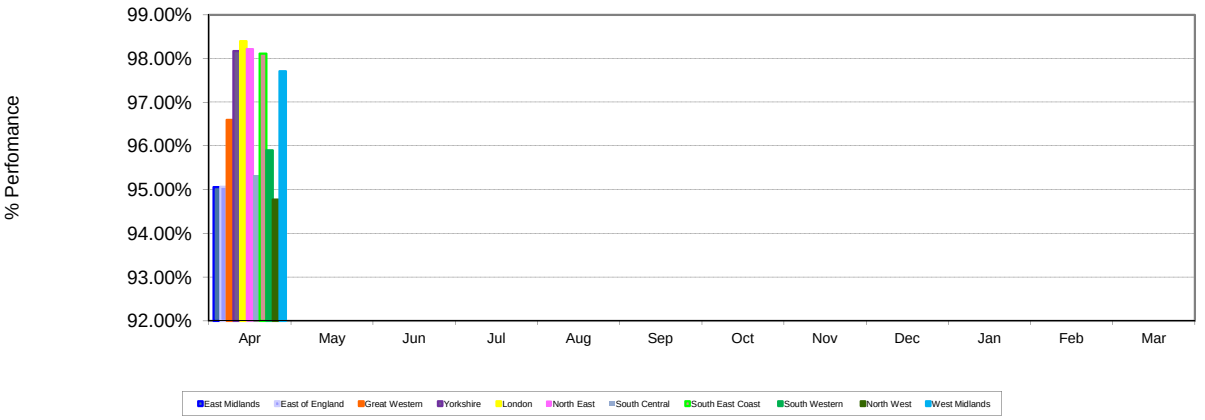
Graph 60
Proportion of calls abandoned before being answered by Ambulance Trust



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

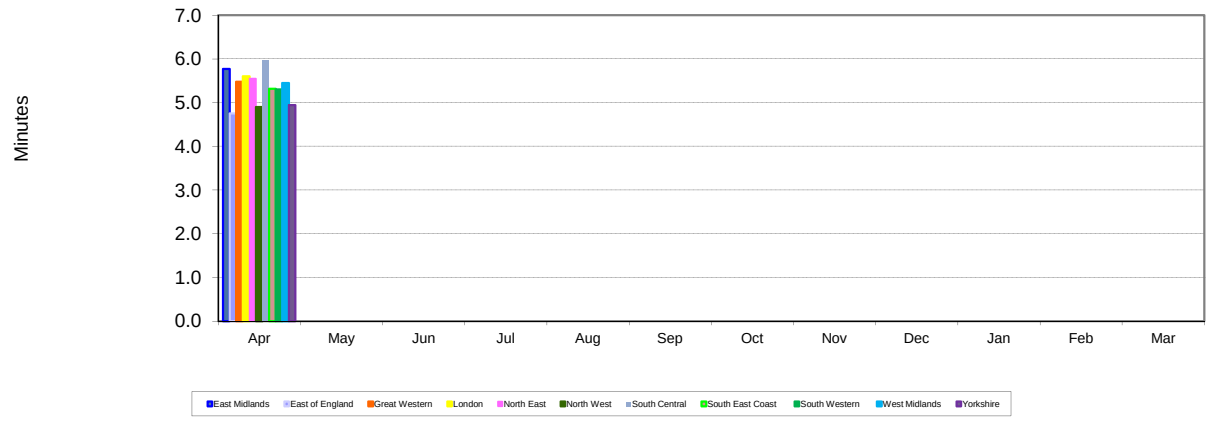


Graph 62
Proportion of calls responded to within 19 minutesby Ambulance Trust

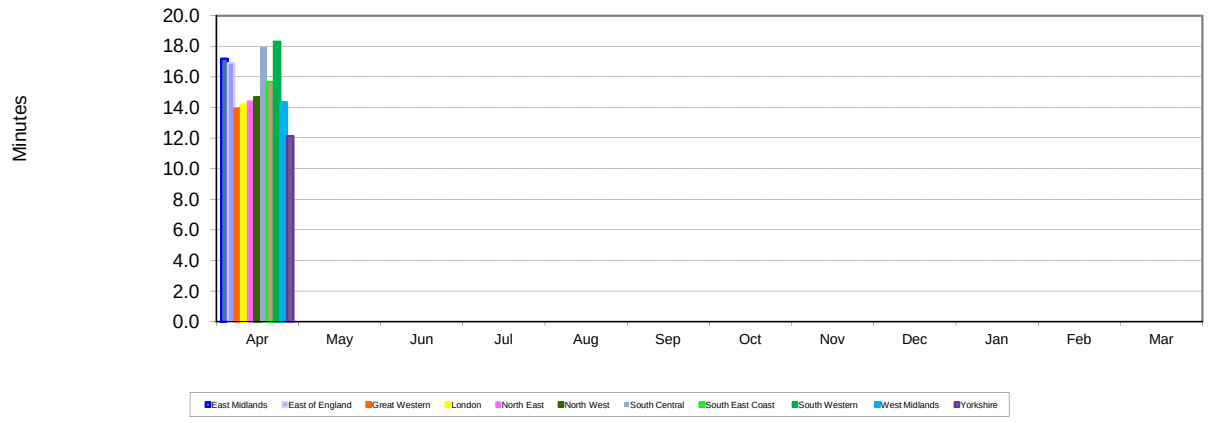


London Ambulance Service NHS Trust
Accident and Emergency Service
Ambulance Quality Indicators -
May 2012

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

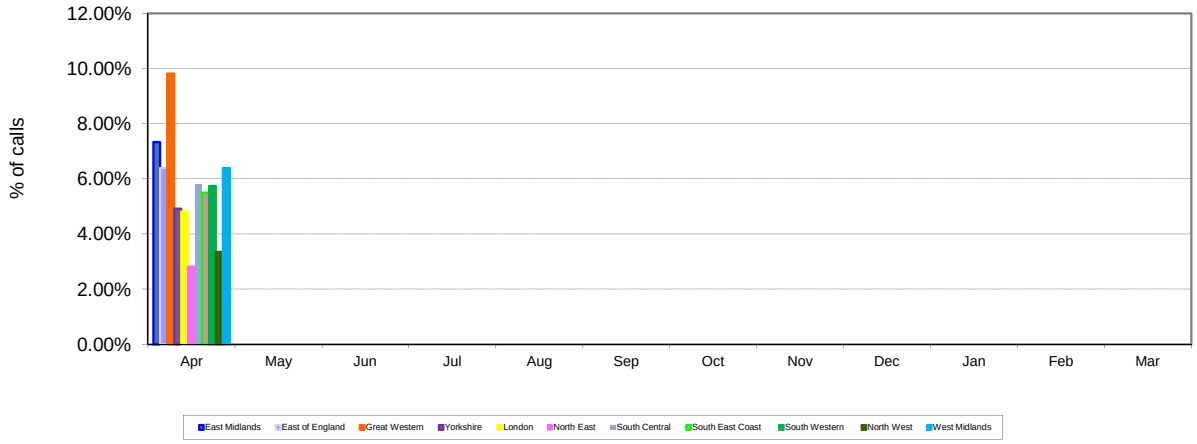


Graph 64
95th percentile - Time to treatment for Cat A calls (in minutes) by Ambulance Trust

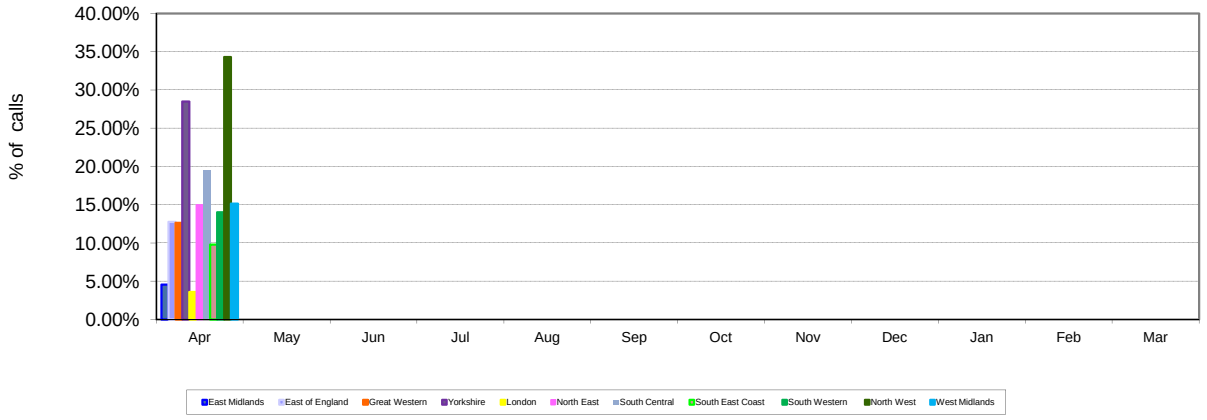


London Ambulance Service NHS Trust
Accident and Emergency Service
Ambulance Quality Indicators -
May 2012

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

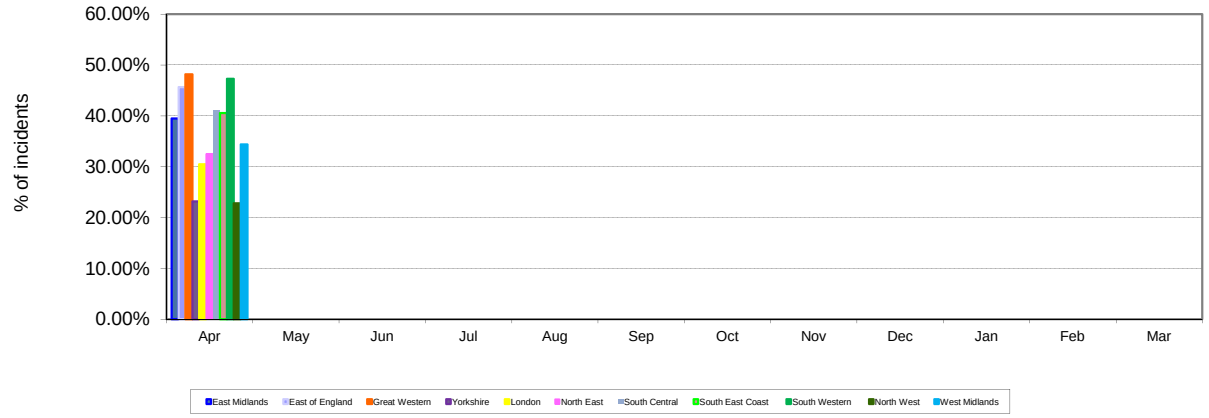


Graph 66
Proportion of patients who re-contacted following dischange of care, by telephone within 24 hours by Ambulance Trust

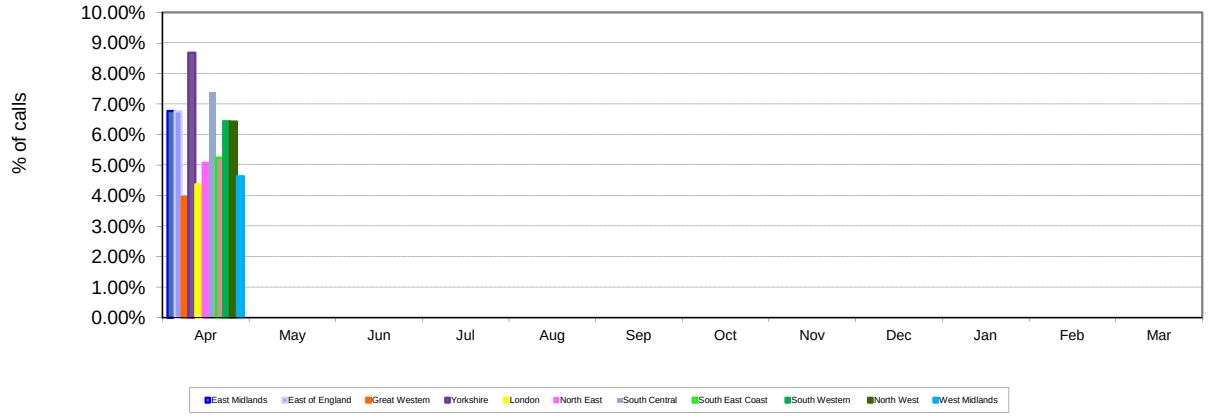


London Ambulance Service NHS Trust
Accident and Emergency Service
Ambulance Quality Indicators -
May 2012

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
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

Month 2 - May 2012

PAPER FOR REVIEW

Document Title:	**Trust Finance Board Report**
Report Author(s):	Helen Wright
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 2 report.

Executive Summary/key issues for the Trust Board
The Trust reported a surplus of £77k for the month against a plan surplus of £81k. The Cash position remains on track. The Capital position is underspent by £812k year to date due to delays in delivery of Ambulance and Fast Response Vehicles. By year end the capital position is forecast to be underspent by £51k. Revenue Financial risk of £2.3m has been identified at Month 2.
YTD the Trust is reporting a £159k surplus against plan of £159k.
CIP is £66k behind the year to date plan. Year to date is 96%
The Department of Health has set the CRL for 2012/13 at £12,4m. The Trust is planning to spend all its allocated capital funding by year end. The YTD position is a favourable variance of £812k is mainly due to delays in ambulance and Fast Response Vehicle delivery slippage. 22 of the Ambulances have now arrived.
The year end cash position is forecast to be £5.5m.
Attachments

Corporate Objectives 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
✔	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?

No

Key issues from the assessment:

Key issues from the assessment:

Summary Financial Compliance 2012/13 - Month 2

Month2 - May 2012				Description	Year to Date				FY 2012/13			
Budg	Act	Var	%		Budg	Act	Var	%	Budg	Fcast	Var	%
£000	£000	£000			£000	£000	£000		£000	£000	£000	
				Dept Health								
81	78	3	3.8%	Surplus	159	159	0	0.0%	3,093	3,093	0	0.0%
(391)	(466)	75	-16.1%	EFL	3,112	3,035	77	2.5%	(1,998)	(1,998)	0	0.0%
1,302	2,370	(1,068)	-82.0%	CRL	3,722	2,910	812	21.8%	12,400	12,349	51	0.4%
95	100	(5)	-5.0%	Suppliers paid within 30 days - NHS	95	95	0	0.0%	95	95	0	0.0%
95	91	4	4.4%	Suppliers paid within 30 days - Non NHS	95	88	7	8.0%	95	90	5	5.6%
				Monitor								
5.3%	3.5%	0	50.6%	EBITDA %	5.3%	4.6%	0	14.2%	7.5%	7.5%	(0)	-0.3%
81	78	3	3.8%	Net Margin	159	159	0	0.0%	3,093	3,093	0	0.0%
0.67%	0.66%	0		Return on Assets	0.67%	0.66%	0	0.2%	5.71%	5.70%	0	0.0%
(10.37)	(10.36)	(0)	0.1%	Liquidity Days	(10.36)	(10.36)	0	0.0%	(10.38)	(10.32)	(0)	0.6%
	2			Monitor net rating		2				2		

Commentary

Surplus - In line with plan and forecast to achieve control total of £3,093k

EFL - In line with Plan

CRL - Year to date behind plan due to delayed delivery of Ambulances and Fast Response Vehicles

EBITDA - Behind plan due to non pay expenditure exceeding plan

Return on Assets - Shows Improvement from year end position

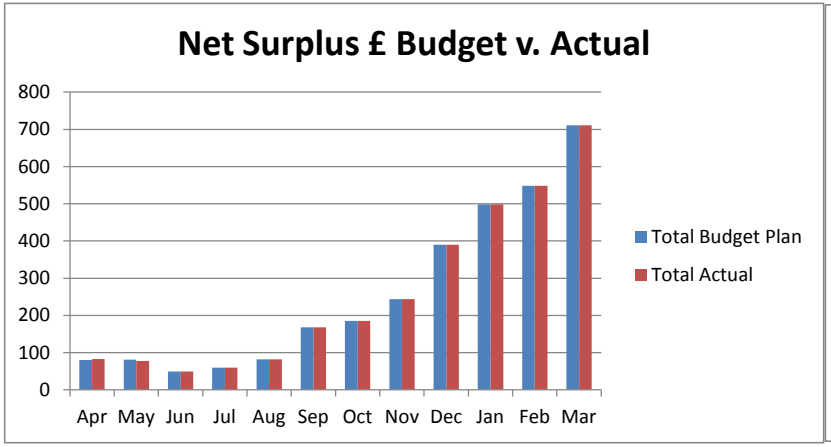
Liquidity - Whilst this currently shows a Rating of 1. When the Working Capital Loan facility is added, this will increase to 3.

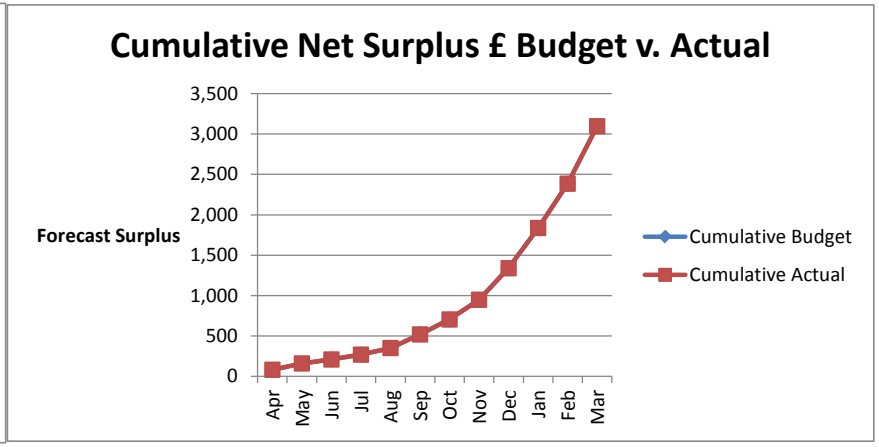
Monitor net rating - Currently 2 due to Liquidity.

London Ambulance Service
Summary Financial Information 2012/13 - Month 2

Month2 - May 2012				Description	Year to Date				FY 2012/13			
Budg	Act	Var	%		Budg	Act	Var	%	Budg	Fcast	Var	%
£000	£000	£000			£000	£000	£000		£000	£000	£000	
23,745	23,747	(2)	0.0%	Income	47,785	47,834	(49)	-0.1%	288,963	288,045	918	0.3%
1,265	840	425	50.6%	EBITDA	2,527	2,216	311	14.0%	21,746	21,746	0	0.0%
5.3%	3.5%	0	50.6%	EBITDA %	5.3%	3.5%	0	49.5%	7.5%	7.5%	(0)	-0.3%
81	78	3	3.8%	Net Surplus	159	159	0	0.0%	3,093	3,093	0	0.0%
0.3%	0.3%	0	3.9%	Net margin	0.3%	0.3%	0	0.1%	1.1%	1.1%	(0)	-0.3%
131	74	58	78.2%	CQUIN*	262	147	115	78.2%	6,202	5,284	918	17.4%
819	786	33	4.2%	CIP	1,637	1,572	66	4.2%	12,498	12,498	0	0.0%
8,168	8,091	77	1.0%	Cash balance	8,168	8,091	77	1.0%	5,500	5,500	0	0.0%
(3,258)	(4,887)	1,629	-33.3%	Net Current Assets less Current Liabilities	(3,258)	(4,887)	1,629	-33.3%	(3,406)	(6,265)	2,859	-45.6%
115,272	115,272	0	0.0%	Total Assets Employed	115,272	115,272	0	0.0%	118,206	118,206	0	0.0%
0.67%	0.66%	0	0.2%	Return on Assets	0.67%	0.66%	0	0.2%	5.71%	5.71%	0	0.0%

CQUIN The Trusts CQUIN Income risk is disclosed excluding the £1.5 million risk reserve held within the Trusts expenditure reserves. Current forecast is within the available risk reserve therefore is forecast to not impact on the Trusts overall position.





London Ambulance Service
Summary Revenue 2012/13 - Month 2

Month 2 - May 2012				Description	Year to Date				FY 2012/13			
Budg	Act	Var	%		Budg	Act	Var	%	Budg	Fcast	Var	%
£000	£000	£000			£000	£000	£000		£000	£000	£000	
				Income								
22,443	22,300	(143)	0.6%	Emergency & Urgent care	44,862	44,805	(57)	0.1%	272,251	271,333	(918)	0.3%
1,302	1,447	145	-10.0%	Other	2,923	3,029	106	-3.5%	16,712	16,712	0	0.0%
23,745	**23,747**	**2**	**0.0%**	**Subtotal**	**47,785**	**47,834**	**49**	**-0.1%**	**288,963**	**288,045**	**(918)**	**0.3%**
				Operating Expense								
17,501	17,326	(175)	1.0%	Pay	34,788	34,588	(200)	0.6%	205,026	205,026	0	0.0%
4,979	5,581	602	-10.8%	Non Pay	10,470	11,030	560	-5.1%	62,191	61,273	(918)	1.5%
22,480	**22,907**	**427**	**-1.9%**	**Subtotal**	**45,258**	**45,618**	**360**	**-0.8%**	**267,217**	**266,299**	**(918)**	**0.3%**
1,265	**840**	**(425)**	**50.6%**	**EBITDA**	**2,527**	**2,216**	**(311)**	**14.0%**	**21,746**	**21,746**	**0**	**0.0%**
5.3%	3.5%	1.8%	50.6%	**EBITDA margin**	5.3%	4.6%	0.7%	14.2%	7.5%	7.5%	0.0%	-0.3%
				Depreciation & Financial								
790	395	(395)	100.0%	Depreciation	1,580	1,304	(276)	21.2%	13,926	13,926	0	0.0%
326	326	0	0.0%	Interest	653	653	0	0.0%	3,915	3,915	0	0.0%
68	41	(27)	65.9%	PDC Dividend	135	100	(35)	35.0%	812	812	0	0.0%
1,184	762	(422)	55.4%	**Subtotal**	2,368	2,057	(311)	15.1%	18,653	18,653	0	0.0%
81	**78**	**(3)**	**(0)**	**Net Surplus/(Deficit)**	**159**	**159**	**0**	**(0)**	**3,093**	**3,093**	**0**	**0**
0.3%	0.3%	0.0%	3.9%	**Net margin**	0.3%	0.3%	0.0%	0.1%	1.1%	1.1%	0.0%	-0.3%

Commentary (items over 60k only)

Income - Emergency and Urgent Care		CQUIN currently adjusted for high risk projects in the trust forecast. This is offset by CQUIN expenditure reserve.
Income	*- Other*	*Road Traffic Accident Reports from DH currently trending 102k above budget. In previous years the DH report has proved volatile and therefore the year to date trend has not been forecast.*
Expenditure	*- Pay*	*Currently all operational areas are under their budget establishment. Third Party Providers are being utilised and this expenditure is disclosed under non pay.*
Expenditure	*- Non Pay*	*Staff related protective uniform purchases (non recurrent), Fuel & oil increase in volume & cost, vehicle insurance, 3rd Party Transport increased in line with demand, Consultancy KPMG FT work*
Depreciation	*-*	*Lower than anticipated Month 2 charges due to delay in purchase of Ambulances, however, 22 have now been delivered subsequent to Month end.*

London Ambulance Service
Summary Financial Risk 2012/13 - Month 2

	Gross Risk				Net	Notes
	Value	Impact	Likelihood	Rating	Value	
	£000		£000	£000	£000	
Income						
CQUIN	6,362	5	3	15	918	10% of gross value
Contract Penalty	10,179	5	2	10	0	Strong contract mitigation
CBRN	7,570	5	2	10	0	DH Commitment
Other Income	300	2	2	4	0	MPET
Subtotal	**24,411**				**918**	
Expense						
CIP not achieved	12,498	5	3	15	312	2.5% of gross value
Overtime control	8,004	5	2	10	400	5% of gross value. Offset by Base Pay
Economic - Fuel/Rates	574	3	3	9	287	50% of gross value
Other Expense	1,333	3	3	9	333	0.5% of operating expense (gross). 25% assumed net.
Subtotal	**22,409**				**1,332**	
Other						
PTS profitability	163	3	4	12	100	
Impact of 111	6,362	5	2	10	0	1% of operating expense (gross). 0% assumed net
Unexpected events	0	2	2	4	0	
Subtotal	**6,525**				**100**	
TOTAL	**53,345**				**2,350**	

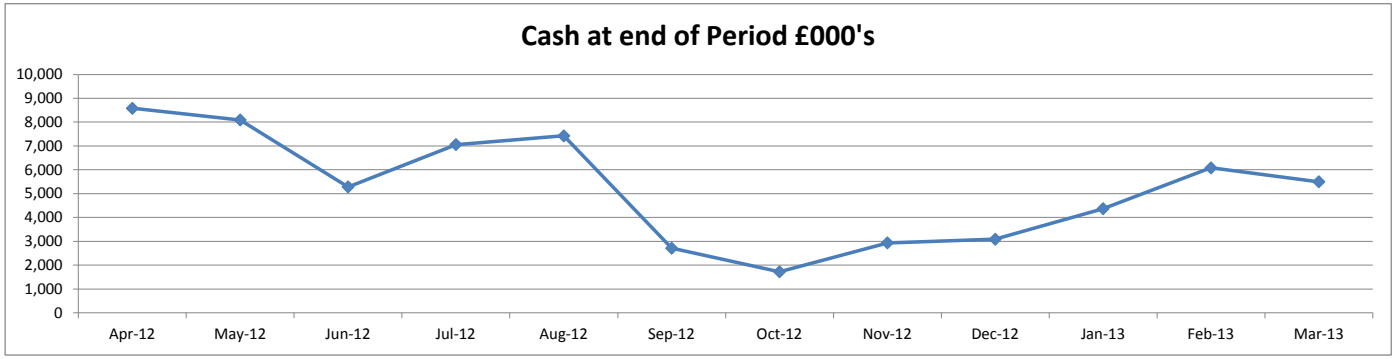
Commentary	
CQUIN	Net CQUIN risk please see commissioners report
Overtime control	Increased Cat A pressure leading to additional resource
PTS	Competative markets and on going contract negotiations

London Ambulance Service
Summary Cashflow 2012/13 - Month 2

* cash flow forecast arising from accounting forecast

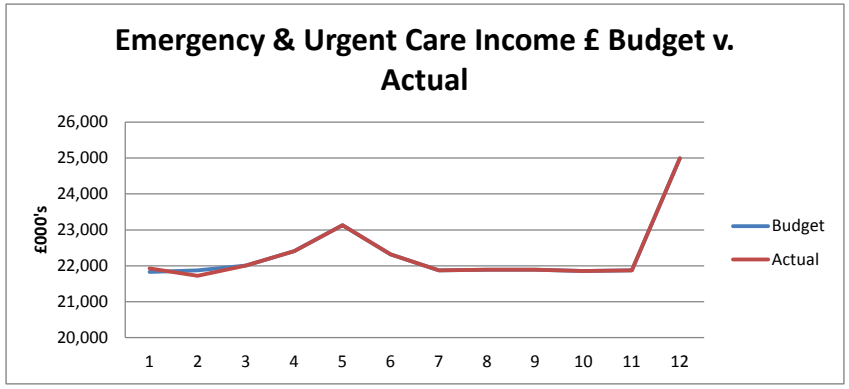
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
	Actual	Actual	Fcast	Fcast	Fcast	Fcast	Fcast	Fcast	Fcast	Fcast	Fcast	Fcast
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Opening Balance	5,250	8,578	8,091	5,286	7,060	7,423	2,714	1,725	2,938	3,089	4,370	6,081
Cash receipts												
PCTs	17,855	25,249	24,071	25,597	26,078	23,169	23,269	23,604	23,627	23,895	23,745	29,208
Other Income	0	0	0	0	0	0	0	0	0	0	0	0
PDC Drawdown	0	0	0	0	0	0	0	0	0	0	0	0
Capital Receipts	0	0	0	0	0	0	0	0	0	0	0	0
Interest Received	0	0	0	0	0	0	0	0	0	0	0	0
VAT	0	0	0	0	0	0	0	0	0	0	0	0
Repaid Investments	0	0	0	0	0	0	0	0	0	0	0	0
Other Receipts	0	0	0	0	0	0	0	0	0	0	0	0
Total receipts	**17,855**	**25,249**	**24,071**	**25,597**	**26,078**	**23,169**	**23,269**	**23,604**	**23,627**	**23,895**	**23,745**	**29,208**
Cash Payments												
Payroll	(17,136)	(17,299)	(17,174)	(17,508)	(18,372)	(17,802)	(16,495)	(16,642)	(17,161)	(17,105)	(16,919)	(16,025)
PAYE/NIC	0	0	0	0	0	0	0	0	0	0	0	0
Suppliers	(3,266)	(6,989)	(6,549)	(5,207)	(6,082)	(5,635)	(5,876)	(5,024)	(4,493)	(4,135)	(4,467)	(5,254)
Capital Expenditure	(2,880)	(2,674)	(1,239)	(410)	(688)	(1,233)	(1,146)	(148)	(1,245)	(673)	(71)	(5,342)
Interest Payable	(43)	(53)	(53)	(51)	(52)	(53)	(53)	(53)	(53)	(52)	(53)	(48)
PDC dividends	0	0	0	0	0	(2,009)	0	0	0	0	0	(1,958)
Loan repayment	0	0	0	0	0	(622)	0	0	0	0	0	(622)
Investments	0	0	0	0	0	0	0	0	0	0	0	0
Other	8,798	1,279	(1,861)	(647)	(521)	(524)	(688)	(524)	(524)	(649)	(524)	(540)
Total Payments	**(14,527)**	**(25,736)**	**(26,876)**	**(23,823)**	**(25,715)**	**(27,878)**	**(24,258)**	**(22,391)**	**(23,476)**	**(22,614)**	**(22,034)**	**(29,789)**
Net Inflows/(Outflows)	3,328	(487)	(2,805)	1,774	363	(4,709)	(989)	1,213	151	1,281	1,711	(581)
Closing Balance	**8,578**	**8,091**	**5,286**	**7,060**	**7,423**	**2,714**	**1,725**	**2,938**	**3,089**	**4,370**	**6,081**	**5,500**
Revenue Reconcilation												
Cashflow from Operating Activities	6,353	2,233	(1,431)	2,258	1,121	(773)	272	1,433	1,468	2,029	1,855	7,409
Cashflow from Investing Activities	(2,852)	(2,699)	(1,291)	(461)	(739)	(3,295)	(1,198)	(201)	(1,297)	(724)	(124)	(7,348)
Cashflow from Financing Activities	(173)	(21)	(83)	(23)	(19)	(641)	(63)	(19)	(20)	(24)	(20)	(642)
Net Inflow/outflow	**3,328**	**(487)**	**(2,805)**	**1,774**	**363**	**(4,709)**	**(989)**	**1,213**	**151**	**1,281**	**1,711**	**(581)**

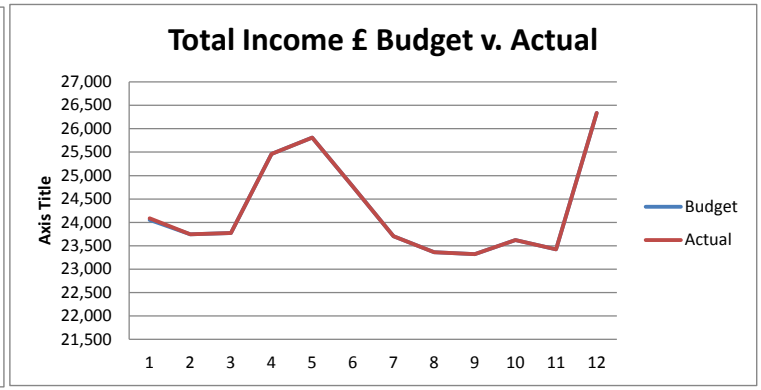
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Cash at beginning of Period	5,250	8,578	8,091	5,286	7,060	7,423	2,714	1,725	2,938	3,089	4,370	6,081
Cash at end of Period	8,578	8,091	5,286	7,060	7,423	2,714	1,725	2,938	3,089	4,370	6,081	5,500



London Ambulance Service
Summary Income 2012/13 - Month 2

Month2 - May 2012				Description	Year to Date				FY 2012/13				%
Budg	Act	Var	%		Budg	Act	Var	%	Budg	Fcast	Var	%	Act
£000	£000	£000			£000	£000	£000		£000	£000	£000		
				Emergency & Urgent Care (PCT)									
20,934	20,918	16	0.1%	Base	41,868	41,866	2	0.0%	254,308	253,390	918	0.4%	88.0%
20,934	**20,918**	**16**	**0.1%**	**Subtotal (PCT)**	**41,868**	**41,866**	**2**	**0.0%**	**254,308**	**253,390**	**918**	**0.4%**	**88.0%**
				Specialised Services									
1,738	1,185	553	46.7%	CBRN	2,369	2,369	0	0.0%	14,215	14,215	0	0.0%	4.9%
(517)	(12)	(505)	4208.3%	HART	74	26	48	184.6%	445	445	0	0.0%	0.2%
44	44	0	0.0%	MERIT	58	58	0	0.0%	350	350	0	0.0%	0.1%
1,265	**1,217**	**48**	**3.9%**	**Subtotal**	**2,501**	**2,453**	**48**	**2.0%**	**15,010**	**15,010**	**0**	**0.0%**	**5.2%**
				Commercial									
545	604	(59)	-9.8%	PTS	1,083	1,132	(49)	-4.3%	6,502	6,502	0	0.0%	2.3%
70	53	17	32.1%	BETS/SCBU	130	142	(12)	-8.5%	834	834	0	0.0%	0.3%
55	55	0	0.0%	BAA	111	111	0	0.0%	663	663	0	0.0%	0.2%
89	20	69	345.0%	Stadia	173	113	60	53.1%	1,036	1,036	0	0.0%	0.4%
3	3	0	0.0%	Training	7	4	3	75.0%	45	45	0	0.0%	0.0%
15	0	15	#DIV/0!	Other Commercial	30	6	24	400.0%	183	183	0	0.0%	0.1%
777	**735**	**42**	**5.7%**	**Subtotal**	**1,534**	**1,508**	**26**	**1.7%**	**9,263**	**9,263**	**0**	**0.0%**	**3.2%**
				Info. Services & Research									
92	92	0	0.0%	EBS	185	185	0	0.0%	1,109	1,109	0	0.0%	0.4%
11	11	0	0.0%	Research	23	20	3	15.0%	136	136	0	0.0%	0.0%
103	**103**	**0**	**0.0%**	**Subtotal**	**208**	**205**	**3**	**1.5%**	**1,245**	**1,245**	**0**	**0.0%**	**0.4%**
				Other									
85	36	49	136.1%	RTA	145	247	(102)	-41.3%	835	835	0	0.0%	0.3%
35	60	(25)	-41.7%	MPET	71	71	0	0.0%	424	424	0	0.0%	0.1%
504	522	(18)	-3.4%	Olympics 2012	1,315	1,333	(18)	-1.4%	6,851	6,851	0	0.0%	2.4%
39	157	(118)	-75.2%	Other	144	151	(7)	-4.6%	1,025	1,025	0	0.0%	0.4%
663	**775**	**(112)**	**-14.5%**	**Subtotal**	**1,675**	**1,802**	**(127)**	**-7.0%**	**9,135**	**9,135**	**0**	**0.0%**	**3.2%**
23,742	**23,748**	**(6)**	**0.0%**	**TOTAL**	**47,786**	**47,834**	**(48)**	**-0.1%**	**288,961**	**288,043**	**918**	**0.3%**	**100.0%**





London Ambulance Service
Summary Expense 2012/13 - Month 2

Month2 - May 2012						Year to Date				FY 2012/13				%
Budg	Act	Var	%			Budg	Act	Var	%	Budg	Fcast	Var	%	Act
£000	£000	£000				£000	£000	£000		£000	£000	£000		
					Payroll									
10,201	10,193	8	0.1%	BP01	Crew staff - base	20,455	20,387	68	0.3%	124,089	124,089	0	0.0%	43.6%
1,182	1,115	67	6.0%	BP02/B	Crew staff - overtime	2,218	2,179	39	1.8%	8,584	8,584	0	0.0%	3.0%
11,383	**11,308**	**75**	**0.7%**		**Subtotal**	**22,673**	**22,566**	**107**	**0.5%**	**132,673**	**132,673**	**0**	**0.0%**	**46.6%**
1,224	1,182	42	3.6%	BP04	A&E Mgt	2,468	2,397	71	3.0%	15,238	15,238	0	0.0%	5.3%
988	970	18	1.9%	BP05	EOC	1,977	1,943	34	1.7%	11,967	11,967	0	0.0%	4.2%
345	331	14	4.2%	BP06	Operational Support	691	653	38	5.8%	4,049	4,049	0	0.0%	1.4%
447	439	8	1.9%		HART/EPU	795	802	(7)	-0.9%	4,831	4,831	0	0.0%	1.7%
368	345	23	6.7%	BP07	PTS	735	682	53	7.8%	4,276	4,276	0	0.0%	1.5%
2,589	2,371	218	9.2%	BP08	Support Services	5,183	4,743	440	9.3%	30,707	30,707	0	0.0%	10.8%
74	188	(114)	-60.6%	BP09	Other Overtime	97	391	(294)	-75.2%	793	793	0	0.0%	0.3%
83	192	(109)	-56.8%	BP10	Agency	169	409	(240)	-58.7%	493	493	0	0.0%	0.2%
17,501	**17,326**	**175**	**1.0%**		**Total Payroll**	**34,788**	**34,586**	**202**	**0.6%**	**205,027**	**205,027**	**0**	**0.0%**	**72.0%**
					Non Pay									
522	740	(218)	-29.5%	BN01	Staff related	1,042	1,305	(263)	-20.2%	6,349	6,349	0	0.0%	2.2%
748	588	160	27.2%	BN02	Med equip, Csmbls & drugs	1,502	1,282	220	17.2%	6,864	6,864	0	0.0%	2.4%
276	301	(25)	-8.3%	BN03	Vehicle leasing	553	557	(4)	-0.7%	3,636	3,636	0	0.0%	1.3%
489	547	(58)	-10.6%	BN04	Fuel & Oil	960	1,079	(119)	-11.0%	5,743	5,743	0	0.0%	2.0%
92	93	(2)	-1.9%		HART/EPU	279	209	70	33.8%	1,727	1,727	0	0.0%	0.6%
563	740	(177)	-23.9%	BN05	Vehicle Maintenance	1,128	1,214	(86)	-7.1%	6,868	6,868	0	0.0%	2.4%
131	530	(399)	-75.3%	BN07	Vehicle Insurance	253	391	(138)	-35.3%	2,138	2,138	0	0.0%	0.8%
69	328	(259)	-79.0%	BN08	3rd Party transport	138	596	(458)	-76.8%	1,130	1,130	0	0.0%	0.4%
928	1,074	(146)	-13.6%	BN09	Accomodation & Estates	2,326	2,156	170	7.9%	12,981	12,981	0	0.0%	4.6%
757	679	78	11.5%	BN10	IT & Telecoms	1,509	1,488	21	1.4%	8,756	8,756	0	0.0%	3.1%
245	(292)	537	-183.9%	BN11	Finance & legal	419	271	148	54.6%	2,822	2,822	0	0.0%	1.0%
33	60	(27)	-45.0%	BN12	Consultancy	70	129	(59)	-45.7%	355	355	0	0.0%	0.1%
126	193	(67)	-34.7%	BN13	Other Non Pay	291	357	(66)	-18.5%	2,821	1,903	918	48.2%	1.0%
4,979	**5,581**	**(603)**	**-10.8%**		**Subtotal**	**10,470**	**11,034**	**(564)**	**-5.1%**	**62,190**	**61,272**	**918**	**1.5%**	**21.8%**
					Depreciation									
790	395	395	100.0%	BD03	Total Depreciation	1,580	1,304	276	21.2%	12,960	12,960	0	0.0%	4.5%
790	**395**	**395**	**100.0%**		**Subtotal**	**1,580**	**1,304**	**276**	**21.2%**	**12,960**	**12,960**	**0**	**0.0%**	**4.5%**
					Financial									
326	326	0	0.0%	BF01	PDC dividend	653	653	0	0.0%	3,915	3,915	0	0.0%	1.4%
68	41	27	65.9%	BF02	Interest	135	100	35	35.0%	812	812	0	0.0%	0.3%
394	**367**	**27**	**7.4%**		**Subtotal**	**788**	**753**	**35**	**4.6%**	**4,727**	**4,727**	**0**	**0.0%**	**1.7%**
23,664	**23,669**	**(5)**	**0.0%**		**TOTAL**	**47,626**	**47,677**	**(51)**	**-0.1%**	**284,904**	**283,986**	**918**	**0.3%**	**100.0%**

Commentary (items over 50k only)

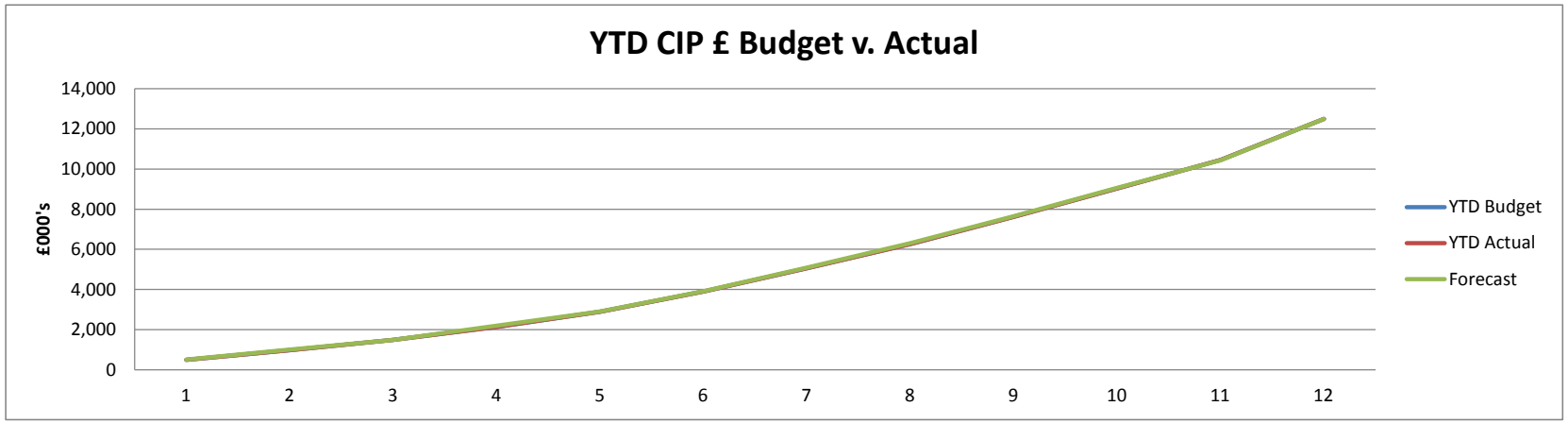
Crew staff - base - Vacancies higher than budgeted. However, this is partially offset by Overtime in order to maintain produced hours for frontline staff.
A&E Mgt - Lower spend than budgeted due to vacancies.
Support Services - Due to a number of vacancies in Corporate Areas, which will be recruited to in 2012-13.
Other overtime - EOC overtime higher than expected due to double time paid at weekends, partly offset by vacancies within frontline operations.
Agency - Higher than anticipated Agency usage due to unfilled vacancies.
Staff related - Uniform protective clothing purchases higher than expected
Fuel & Oil - Fuel consumption continues to increase in line with demand.
Vehicle Maintenance - Higher than anticipated Maintenance Costs.
Vehicle Insurance - Actual claims significantly higher than Estimates.
3rd Party transport - Due to demand pressures and vacancies in the Service, greater usage of 3rd Party has been hired to cope with demand.
Accomodation & Estates - Make Ready credit from 11/12 £70k and lower than anticipated Utility Costs.
IT & Telecoms - Higher than anticipated Computer Software and Maintenance charges.
Finance & legal - Leasing costs of new ambulances.
Consultancy - Cost of FT work completed by KPMG
Other Non Pay - CQUIN reserve adjustment to reflect current high risk projects.
Depreciation - Lower than anticipated Month 2 charges. Forecast to break even at year end.

London Ambulance Service
Summary Cost Improvement Programme 2012/13 - Month 2

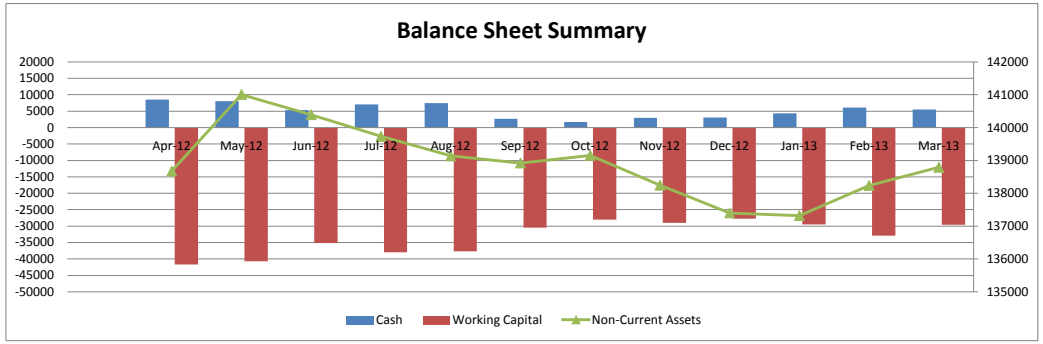
Month2 - May 2012				Description	Year to Date				FY 2012/13				%
Budg	Act	Var	%		Budg	Act	Var	%	Budg	Fcast	Var	%	Act
£000	£000	£000			£000	£000	£000		£000	£000	£000		
				Operational Pay									
248	462	214	186.2%	Process Mgt	496	924	428	186.2%	3,821	4,125	304	108.0%	30.6%
81	10	(72)	11.8%	Resource Mgt	162	19	(143)	746.3%	1,579	1,276	(304)	80.8%	12.6%
52	(58)	(110)	-111.0%	Other	104	(116)	(220)	-190.1%	739	114	(625)	15.5%	5.9%
381	**414**	**32**	**108.5%**	**Subtotal**	**762**	**827**	**65**	**-7.8%**	**6,139**	**5,515**	**(624)**	**89.8%**	**49.1%**
				Support Service Pay									
149	11	(138)	7.5%	Support Service staffing	298	22	(275)	1232.3%	2,089	2,088	(1)	100.0%	16.7%
149	**11**	**(138)**	**7.5%**	**Subtotal**	**298**	**22**	**(275)**	**1232.3%**	**2,089**	**2,088**	**(1)**	**100.0%**	**16.7%**
				Non Pay									
20	23	3	115.4%	Estates	40	46	6	-13.4%	163	163	(0)	99.8%	1.3%
269	338	69	125.8%	Other Non Pay	538	676	139	-20.5%	4,107	4,732	625	115.2%	32.9%
289	**361**	**73**	**125.1%**	**Subtotal**	**577**	**722**	**145**	**-20.1%**	**4,270**	**4,894**	**624**	**114.6%**	**34.2%**
819	**786**	**(33)**	**96.0%**	**TOTAL**	**1,637**	**1,572**	**(66)**	**4.2%**	**12,498**	**12,498**	**(0)**	**100.0%**	**100.0%**

Commentary

Process Mgt	Higher than planned to offset delays in Resource Mgt and Other programme
Resource Mgt	Control CIP under achieved due to increased overtime use as a result of the implementation of Command Point
Other Op Pay	Revised rest break policy has not been issued or implemented, impacting on subsistence payments
Support Service staffing	Support Services Pay is undereview regarding mix of post reduction and vacancy management. Ytd, SS pay is underspent by 440k.
Other Non Pay	Annual Leave calculation highlights no reduction in Annual Leave accrual. Offset by over achievement in other non pay CIP programs



London Ambulance Service
Summary Balance Sheet 2012/13 - Month 2



		Monthly Performance											
	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
	Act	Act	Act	Fcast	Fcast	Fcast	Fcast	Fcast	Fcast	Fcast	Fcast	Fcast	Fcast
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Non Current Assets													
Property, Plant & Equip	123,055	122,755	124,239	123,622	122,963	122,368	122,152	122,385	121,476	120,632	120,551	121,470	122,022
Intangible Assets	15,033	14,964	14,941	14,941	14,941	14,941	14,941	14,941	14,941	14,941	14,941	14,941	14,941
Trade & Other Receivables	1,770	956	1,829	1,829	1,829	1,829	1,829	1,829	1,829	1,829	1,829	1,829	1,829
Subtotal	139,858	138,675	141,009	140,392	139,733	139,138	138,922	139,155	138,246	137,402	137,321	138,240	138,792
Current Assets													
Inventories	2,812	3,044	3,047	3,047	3,047	3,047	3,047	3,047	3,047	3,047	3,047	3,047	3,047
Trade & Other Receivables	11,940	18,989	16,621	14,384	14,253	13,988	13,724	13,225	12,984	12,680	12,410	12,090	9,225
Cash & cash equivalents	5,250	8,578	8,091	5,286	7,060	7,423	2,714	1,725	2,938	3,089	4,369	6,081	5,500
Total Current Assets	20,002	30,611	27,759	22,717	24,360	24,458	19,485	17,997	18,969	18,816	19,826	21,218	17,772
Total Assets	159,860	169,286	168,768	163,109	164,093	163,596	158,407	157,152	157,215	156,218	157,147	159,458	156,564
Current Liabilities													
Trade and Other Payables	(21,364)	(30,779)	(30,328)	(27,650)	(28,660)	(28,041)	(26,170)	(24,857)	(24,638)	(23,215)	(23,734)	(25,458)	(22,447)
Provisions	0	0	0	0	0	0	0	0	0	0	0	0	0
Borrowings	(1,268)	(1,095)	(1,074)	(991)	(968)	(949)	(930)	(867)	(848)	(828)	(804)	(784)	(346)
Working Capital Loan - DH	0	0	0	0	0	0	0	0	0	0	0	0	0
Capital Investment Loan - DH	(1,244)	(1,244)	(1,244)	(1,244)	(1,244)	(1,244)	(622)	(622)	(622)	(622)	(622)	(622)	(1,244)
Net Current Assets/(Liabilities)	(23,876)	(33,118)	(32,646)	(29,885)	(30,872)	(30,234)	(27,722)	(26,346)	(26,108)	(24,665)	(25,160)	(26,864)	(24,037)
Non Current Assets plus/less net current a	(3,874)	(2,507)	(4,887)	(7,168)	(6,512)	(5,776)	(8,237)	(8,349)	(7,139)	(5,849)	(5,334)	(5,646)	(6,265)
Non Current Liabilities													
Trade and Other Payables	0	0	0	0	0	0	0	0	0	0	0	0	0
Provisions	(9,154)	(9,256)	(9,133)	(9,192)	(9,130)	(9,189)	(9,246)	(9,182)	(9,239)	(9,296)	(9,232)	(9,290)	(9,337)
Borrowings	(6,130)	(6,130)	(6,130)	(3,124)	(3,124)	(3,124)	(223)	(223)	(223)	(223)	(223)	(223)	(641)
Working Capital Loan - DH	0	0	0	0	0	0	0	0	0	0	0	0	0
Capital Investment Loan - DH	(5,587)	(5,587)	(5,587)	(5,587)	(5,587)	(5,587)	(5,587)	(5,587)	(5,587)	(5,587)	(5,587)	(5,587)	(4,343)
Total Non Current Liabilities	(20,871)	(20,973)	(20,850)	(17,903)	(17,841)	(17,900)	(15,056)	(14,992)	(15,049)	(15,106)	(15,042)	(15,100)	(14,321)
Total Assets Employed	115,113	115,195	115,272	115,321	115,380	115,462	115,629	115,814	116,058	116,447	116,945	117,494	118,206
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	62,516
Retained Earnings	19,304	19,386	19,463	19,512	19,571	19,653	19,820	20,005	20,249	20,638	21,136	21,685	22,397
Revaluation Reserve	33,712	33,712	33,712	33,712	33,712	33,712	33,712	33,712	33,712	33,712	33,712	33,712	33,712
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)
Total Taxpayers Equity	115,113	115,195	115,272	115,321	115,380	115,462	115,629	115,814	116,058	116,447	116,945	117,494	118,206
	0	0	0	0	0	0	0	0	0	0	0	0	0
Budgeted													
Current Assets		30,612	30,172	27,772	27,193	27,065	23,384	23,686	24,344	24,315	25,294	26,601	22,807
Current liabilities		(33,348)	(33,430)	(34,298)	(32,688)	(31,823)	(30,441)	(30,866)	(30,852)	(29,614)	(29,836)	(30,213)	(26,213)
Net Current Assets less Current Liabilities		(2,736)	(3,258)	(6,526)	(5,495)	(4,758)	(7,057)	(7,180)	(6,508)	(5,299)	(4,542)	(3,612)	(3,406)
Total Assets Employed		115,193	115,272	115,321	115,380	115,462	115,629	115,814	116,058	116,447	116,945	117,494	118,206
Cash Balance		8,578	8,168	8,016	7,611	7,819	4,321	4,984	5,976	6,251	7,499	9,126	5,500

London Ambulance Service
Summary Capital 2012/13 - Month 2

Month2 - May 2012				Description	Year to Date				FY 2012/13				%
Budg	Act	Var	%		Budg	Act	Var	%	Budg	Fcast	Var	%	Act
£000	£000	£000			£000	£000	£000		£000	£000	£000		
				Clinical Equipment									
0	0	0		LP 15	0	0	0		1,048	948	100	9.5%	8.5%
50	0	50		Other Clinical Equipment	719	0	719		0	0	0		0.0%
50	**0**	**50**		**Subtotal**	**719**	**0**	**719**		**1,048**	**948**	**100**	**10.5%**	**8.5%**
				Fleet									
551	2,142	(1,591)	-288.7%	DCA	1,102	2,530	(1,428)	-129.6%	4,352	5,229	(877)	-20.2%	35.1%
311	126	185	59.5%	FRU	622	126	496	79.7%	2,747	2,219	528	19.2%	22.2%
0	0	0		PTS	27	0	27	100.0%	500	500	0	0.0%	4.0%
140	0	140	100.0%	Other Fleet	661	0	661	100.0%	1,091	1,086	5	0.5%	8.8%
1,002	**2,268**	**(1,266)**	**-126.3%**	**Subtotal**	**2,412**	**2,656**	**(244)**	**-10.1%**	**8,690**	**9,034**	**(344)**	**-4.0%**	**70.1%**
				Estates									
0	24	(24)		New	0	24	(24)		1,997	2,021	(24)	-1.2%	16.1%
84	13	71	84.5%	Refurb	311	160	151	48.6%	480	344	136	28.3%	3.9%
0	3	(3)		Other	20	20	0	0.0%	468	468	0	0.0%	3.8%
84	**40**	**44**	**110.0%**	**Subtotal**	**331**	**204**	**127**	**62.3%**	**2,945**	**2,833**	**112**	**3.8%**	**23.8%**
				IM&T									
60	59	1	1.7%	Hardware	154	50	104	67.5%	1,545	1,512	33	2.1%	12.5%
106	3	103	97.2%	Software	106	0	106	100.0%	500	350	150	30.0%	4.0%
166	**62**	**104**	**62.7%**	**Subtotal**	**260**	**50**	**210**	**80.8%**	**2,045**	**1,862**	**183**	**8.9%**	**16.5%**
1,302	**2,370**	**(1,068)**	**-82.0%**	**Gross Capital Expenditure**	**3,722**	**2,910**	**812**	**21.8%**	**14,728**	**14,677**	**51**	**0.3%**	**118.8%**
				Disposals									
0	0	0		Estates	0	0	0		0	0	0		0.0%
0	0	0		Fleet	0	0	0		(2,328)	(2,328)	0	0.0%	-18.8%
0	**0**	**0**		**Subtotal**	**0**	**0**	**0**		**(2,328)**	**(2,328)**	**0**	**0.0%**	**-18.8%**
1,302	**2,370**	**(1,068)**	**-82.0%**	**Net Capital Expenditure**	**3,722**	**2,910**	**812**	**21.8%**	**12,400**	**12,349**	**51**	**0.4%**	**100.0%**

Commentary

LP 15 Purchase delayed awaiting outcome of Ambulance and FRU procurement strategy

Fleet

DCA Overspend due to the purchase of 22 DCAs originally planned to be lease after a financial lease vs buy analysis.

FRU Underspent as the decision has now been made to lease the FRUs rather than purchase.
This underspend will therefore offset the DCA purchase, following a financial lease vs buy analysis.

PTS Plans in development

Other Fleet This category is made up of the DSO, ESV and ECV projects. ESV and ECV conversion slots slipped to priorities DCAs.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26 JUNE 2012

PAPER FOR INFORMATION

Document Title:	**Workforce Report**
Report Author(s):	**Caron Hitchen**
Lead Director:	**Caron Hitchen**
Contact Details:	**caronhitchen@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**This is a regular report to the Trust Board detailing key workforce indicators providing assurance to the Board on workforce issues.**
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**

Key issues and risks arising from this paper

Whilst the sickness absence rate of 5.04% for April (and YTD) is below the target of 5.5%, the report shows a marked increase in Control Services absence to 7.04% (5.93% in March). With the introduction of CommandPoint on 27 March, levels of absence will be closely managed and monitored as the new system becomes more familiar to staff and we would expect to see this level of absence reduce.

Executive Summary

Key headlines from the Workforce report are:

Sickness absence

Sickness for the Trust as a whole fell again in April to 5.04%. This is similar to the same period last year.

Vacancies and Turnover

As at 31th May 2012 frontline staffing showed a vacancy level of 61wte. Recruitment is underway to fill these vacancies with the first training programme for external Apprentice Paramedic scheduled for 2 July 2012.

Turnover remains within normal range.

PDR completion for 12/13

The report shows good progress within Support Service Directorates.

A&E Operations PDR completion is currently reported on a rolling year basis and will be adjusted for next Trust Board to show PDR within the year 12/13 to align to other areas of the Trust. This will allow better visibility to progress through the year.

Partnership working

The review of the Partnership Agreement and associated consultative arrangements has commenced jointly with Unison and GMB as the two unions recognised by the London Ambulance Service.

National Pensions Dispute and Industrial Action

This still remains a "live" issue with action planned by BMA members on 21 June 2012. Whilst this does not have a direct impact on the LAS workforce, This may have an impact on demand on our services and access to some NHS services within London.

Attachments

1. Workforce Report
2. Workforce data report

****

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

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

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?
☐ Yes
☒ No (N/A)

Key issues from the assessment:

Workforce Report

Trust Board – 26 June 2012

Sickness absence

Sickness for the Trust as whole fell for the third consecutive month in April to 5.04%; short term absence fell but there was a negligible rise in long term absence March to April. Therefore sickness absence for the year 12/13 began at almost the same level as 11/12. 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).

From March to April sickness fell in the Areas at a similar rate to that for the Trust as a whole, and remained nearly 0.5% above the level for the same month last year. The figures for individual Areas was as follows (March's figures in brackets); East 5.85% (6.15%), South 6.23% (6.28%), West 3.96% (4.08%).

In April sickness in Control Services rose markedly to 7.04%; above the figure for last year (6.20%). Short term absence rose for the third consecutive month and remained at a level above that for the previous year; long term absence rose following two months improvement to a level slightly above that for last year. This is likely to be linked to the implementation of CommandPoint.

In PTS sickness fell dramatically 6.61% in March to 2.94%. Short term absence was at 1% and long term just below 2%

Unauthorised Absences (U/A)

The total figure for U/As in Areas remained static in May at 132 and was below the level for the previous year. U/As in Control Services returned to single figures.

Vacancies and Turnover

From weekly operational staff in post figures, it can be reported that as at 31st May 2012, frontline staffing showed a vacancy level of 61wte. Recruitment is underway to fill these vacancies with the first training programme fro external Apprentice Paramedics scheduled for 2 July 2012.

Turnover remains within normal range.

PDR completion for 12/13

The PDR report for May 2012 shows good progress within Support Service Directorates.

A&E Operations PDR completion is currently reported on a rolling year basis and will be adjusted for the next Trust Board to show PDR within the year 2012/13 to align to other areas of the Trust. This will allow better visibility to progress through the year. It should be noted also that some staff within the HR and OD Directorate receive their PDR on a rolling basis and will therefore not be reported until later in the year.

Partnership working

The review of the Trust's Partnership Agreement and associated consultative arrangements has commenced jointly with the two unions now recognised by LAS, Unison and GMB. This follows de-recognition of Unite this month.

National Pensions Dispute and Industrial Action

The national pensions dispute still remains a live issue in the NHS with action planned by BMA members on 21 June 2012. Whilst this does not have a direct impact on the LAS workforce, this may have an impact on demand on our services and access to some NHS services within London. A verbal update on the impact of the day can be given to the Trust Board at the meeting.

No other intelligence is currently available as to ongoing talks nationally by other healthcare unions.

London Ambulance Service
NHS Trust

HR Summary for Trust Board

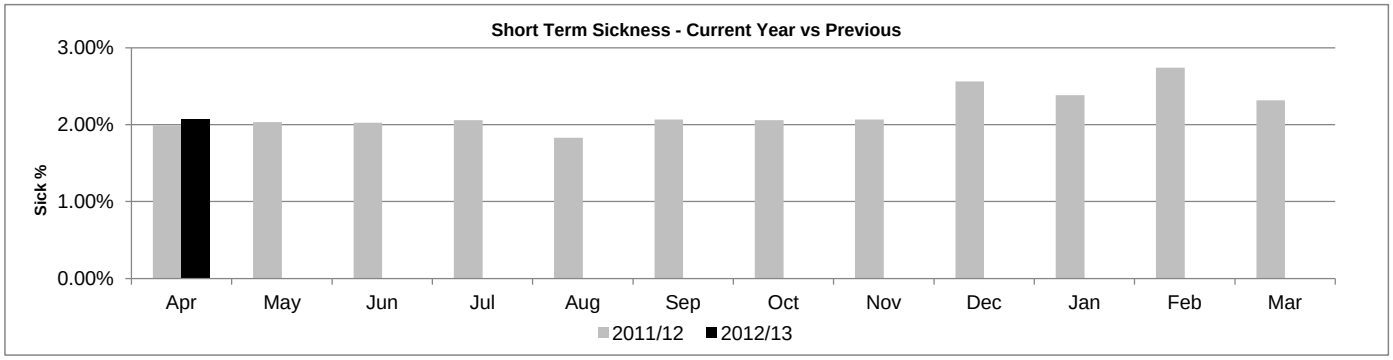
June 2012

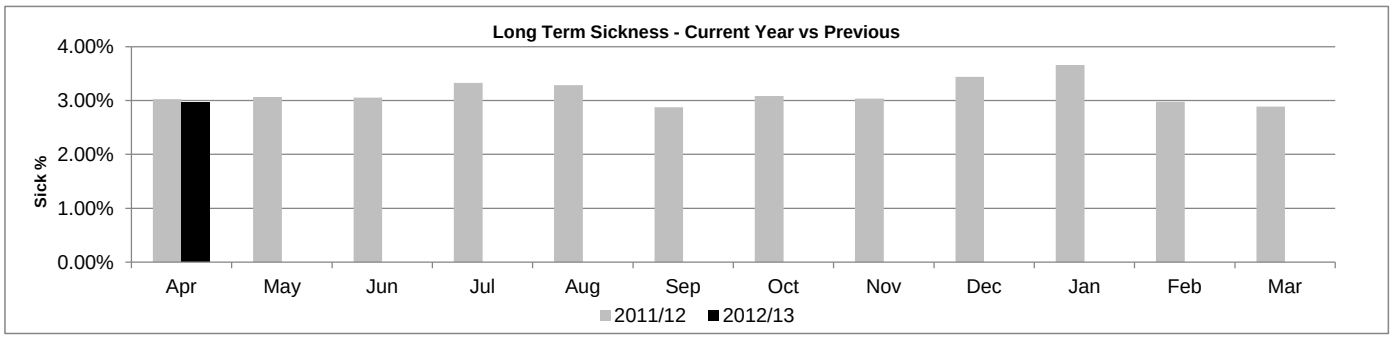
Workforce Report

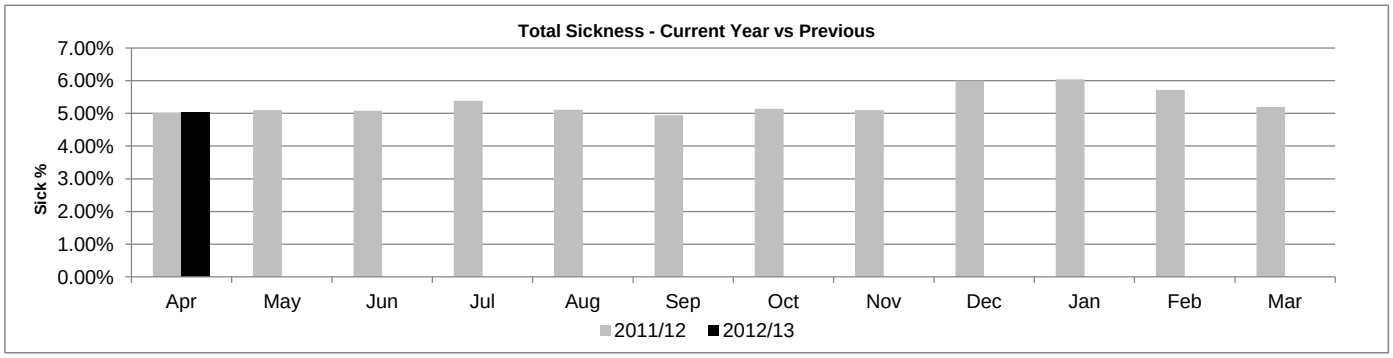
Current Month **Jun-12** **Sickness Month** **Apr-12**

Trust Summary

Sickness Absence







Sickness 2011/12	5.32%	**Current WTE**	4513.15	**NB Secondments and Acting Up Included in Totals**
YTD Sickness	5.04%	**Current Headcount**	4738.00	

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2011/12	5.01%	5.10%	5.08%	5.39%	5.11%	4.94%	5.14%	5.10%	6.00%	6.04%	5.71%	5.20%
2012/13	5.04%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Unauthorised Absence	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2011/12	163.00	167.00	161.00	192.00	171.00	164.00	161.00	312.00	98.00	167.00	179.00	168.00
2012/13	148.00	137.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Narrative

Sickness

Sickness for the Trust as whole fell for the third consecutive month in April to 5.04%; short term absence fell but there was a negligible rise in long term absence March to April. Therefore sickness absence for the year 12/13 began at almost the same level as 11/12. 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

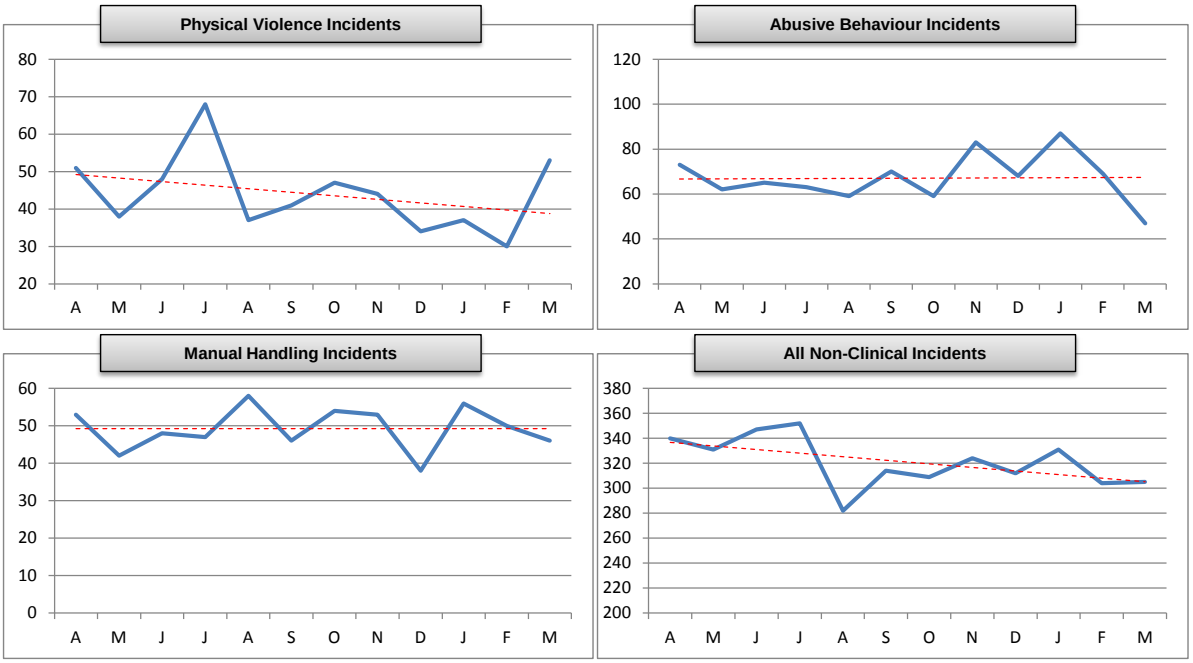
This figure shows the number of instances when staff have reported unable to attend work at short notice for reasons other than their own sickness or when they have not reported for work. Depending on the reason, the absence may be converted into annual leave or un/paid special leave or remain an unpaid unauthorised absence. Disciplinary action may result. The figure for the Trust as a whole for May 2012 showed another month-on-month reduction and was again below that for the same month last year.

Workforce Report

Current Month **May-12**

Trust Summary

Health & Safety Issues



Note - Due to the delay in receiving incidents, the majority of incidents occuring within May 2012 have yet to arrive in S&R. Due to this the figure for April 2012 is an estimate; the next SMG report will show the true figure for this month.

Manual Handling
The figure for reported manual handling incidents is lower than the current reported trend shown. We need further observation to see if this is a mean change, or simply an outlier although it appears to be levelling off at 12 incidents per 100,000 hours worked. The general trend shows that an average of 48 manual handling incidents occur per month in the LAS Trust, which equates to a steady rate of 21 incidents per 100,000 hours worked.

Non Physical Abuse
The number of reported abusive behaviour incidents has decreased following a steady rise between August 2011 and January 2012. Following a drop in March 2012 the figure rose slightly to 52 reported incidents per month but has dropped again, indicating a potential downward reduction in reporting, This is reflected in the incident rates, where the number of reported incidents of abusive behaviour has decreased from the historic average of 32 to 21 incidents per 100,000hrs worked .

Non Clinical Incidents
Reporting of non clinical incidents is expected to continue following a downward trend

Physical Violence
The number of reported physical violence cases has shown an increase, but is expected to follow a downward trend. The estimated number of physical assaults for April 2012 is 37 per month, which equates to 16.0 per 100,000 hours worked. It is assumed that the overall downward trend is due to staff awareness training in conflict resolution techniques.

SIRS Reporting
The Health, Safety and Risk department has been reporting incidents of physical violence, abusive behaviour and security incidents to NHS Protect via their SIRS (Security Incident Reporting System) Portal since January 2012. Reporting to this portal became mandatory on the 1st April 2012 with monitoring and auditing being undertaken by the CQC.

To date 52 incidents have been submitted, however due to insufficient admin cover within the Health, Safety and Risk department, keeping up with data inputting is an ongoing challange. To assist in the management of cases a member of the team is being trained as an additional Local Security Management Specialist .

Court Cases
A team leader was racially assaulted and the assailant was arrested and charged with racially aggravated common assault and has been bailed to appear in court later this month.

An incident involving a crew member being assaulted by being kicked in the knee on 6th March 2012 was due to be heard in court on 15th May. The court case was postponed until 6th July 2012.

In an on-going case where a vexacious regular caller in Croydon, who already has a restraining order against him to prevent him victimising a particular member of staff and was given an 18 week custodial sentance earlier for abuse of another member of staff, is due to appear at Croydon Magistrates Court on 21st June 2012 for an application for an ASBO to be taken out against him.

Carry Chair Transporter Pilot
The carry chair pilot now has now been evaluated at 6 out of the 7 sectors . Arrangements to train up staff for the process to be fully completed is ongoing in

Workforce Report

Current Month **Jun-12**

Trust Summary

Vacancies & Turnover

	Funded WTE	Inpost WTE	Variance
Trust Total	4692.72	4481.46	-211.26
Directorate			
A&E Operations	3407.95	3333.84	-74.11
Chief Executive	16.61	13.00	-3.61
Control Services	437.28	422.83	-14.45
Corporate Services Directorate	37.26	35.27	-1.99
Finance & Business Planning Directorate	58.20	48.13	-10.07
Health Promotion & Quality	19.27	17.27	-2.00
Human Resources & Organisation Dev Directorate	183.12	153.02	-30.10
Information Management & Technology Directorate	98.53	84.16	-14.37
Medical Directorate	25.20	20.27	-4.93
Operational Support	129.86	116.04	-13.82
Patient Transport Service	166.44	141.66	-24.78
Trust Board	6.00	5.00	-1.00

	Est.	In Post	Var.
T/L Paramedic	193.19	196.59	+3.40
Paramedic	1143.67	1361.44	+217.77
Apprentice Paramedic	80.00	0.00	-80.00
Student Paramedic 1	0.00	0.00	+0.00
Student Paramedic 2	255.00	6.00	-249.00
Student Paramedic 3	304.00	250.00	-54.00
Student Paramedic 4	4.00	77.00	+73.00
EMT 1	19.62	18.61	-1.01
EMT 2-4	796.18	836.75	+40.57
A&E Support	355.00	336.29	-18.71
CTA	54.43	46.14	-8.29

Turnover

2011/12	7.1%	Apr-11 to Mar-12
2012/13	7.4%	12 Months up to May-12

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No. Leavers (Headcount)												
2011/12	22.00	36.00	33.00	28.00	34.00	30.00	23.00	21.00	26.00	35.00	28.00	28.00
2012/13	34.00	34.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
No. Starters (Headcount)												
2011/12	6.00	7.00	7.00	21.00	7.00	32.00	50.00	8.00	15.00	4.00	6.00	3.00
2012/13	20.00	4.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	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 **Jun-12**

Trust Summary

Employee Relations Data

	Attendance	Grievances	Capabilities	Discipliary (Clinical)	Discipliary (Non Clinical)
Current Case Total	530 (618)	17 (11)	2 (2)	2 (1)	29 (20)

Current Employment Tribual Cases	11 (8)

Current Suspensions	11 (4)

Narrative

* The figure for the previous month appears in brackets.

Attendance

These 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. The rise is suspensions and disciplinary episodes is largely attributable to cases related to postings on social networking websites or police investigations.

Employment Tribunals

Three new cases were lodged during May.

PDR completions in 2012/13

Area / Directorate / Dept	No to be done	No done	% completed 12/13	% completed 11/12	Difference +/-
West	1043	405	38.8	67.0	- 28.2
South	1200	83	6.9	45.9	- 39.0
East	861	285	33.1	30.5	+ 2.6
Control Services	525	390	74.3	66.6	+ 7.7
Sub total	3629	1163	32.0	49.7	- 17.7
PTS	151	63	41.7	53.2	- 11.5
IM&T	78	49	62.8	99.0	- 36.2
Operational Support	117	85	72.8	66.3	+ 6.5
Medical	25	25	100.0	100.0	0.0
Communications	12	12	100.0	94.1	+ 5.9
Corporate Services	29	28	96.6	94.6	+ 2.0
HR & OD	152 (tbc)	82	53.9	100.0	- 46.1
Finance and Business Planning incl Estates	35	30	85.7	82.4	+ 3.3
Sub total	599	374	62.4	76.5	-14.1
Total	4228	1537	36.4	54.0	- 17.6

As at 12 June

Key:

	Currently reported on a rolling year. Future reports to record fiscal year as per other areas of the trust.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

26 JUNE 2012

PAPER FOR: NOTING/APP*ROVAL/**DISCUSSION THEN APPROVAL***

Document Title:	**Integrated Board Performance Report**
Report Author(s):	**Christine Kane/Peter Bradley**
Lead Director:	**Peter Bradley**
Contact Details:	**N/A**
Why is this coming to the Trust Board?	**For discussion and for 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:	That the Board discuss this draft Integrated Board performance report and agree the format and content for future monthly reports.

Key issues and risks arising from this paper

Not applicable for this draft report

Executive Summary

This new report replaces the old balance scorecard report and supplements the existing Workforce, clinical quality, finance and COO reports. The Board may want to take a view in due course as to whether or not this report is provided instead of any of those reports.

The plan will be to provide a monthly narrative and overview of how the Trust has performed, key risks and issues and also provide an exception report. This exception report will identify the reasons why performance is below where it should be and actions that have been taken to get it back on track.

The balanced scorecard itself is split into four quadrants; **(see attachment 1**) each of which includes a quality barometer which provides assurance from other sources. The four quadrants are supported in the centre by the operating context, this shows the average and peak 999 call volume for the month with year on year comparison percentage; the number of Category A and C incidents attended during the month, percentage of time that the Control Room was operating under the Demand Management Plan Stages and the current REAP level.

Attachment 2 provides an explanation for each measure and the intention would be to include this in the report each month.

Attachment 3 (incomplete for this report) provides an overview position for each measure for the year to date. The plan will be to include a short narrative against each measure.

****

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

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

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

Equality Impact Assessment

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

Key issues from the assessment:

Attachment 1

Attachment 2

Integrated Board Performance Report - Detail of each measure

1. Operational Context

Daily Performance & Activity				REAP 4
	Apr	May	YTD	2011
999 Call volume	4585	4914	7%	13%
Peak 999 Call volume	5081	5879	16%	17%
Cat A Calls	34177	37597	10%	20%
Cat C1 & 2 Calls	25712	26734	4%	4%
Cat C3 & 4 Calls	24964	26231	5%	-14%
DMP Stage A	56%	53%	-3%	n/a
DMP Stage B	38%	33%	-5%	n/a
DMP Stage C	6%	14%	8%	n/a
Percentage > REAP 3	100%	100%	0%	100%

Call Volumes

The report shows the average and peak number of calls per day and comparative figures from the previous month (in blue). The percentage increase/decrease YTD and comparison with the same month in the previous year is also shown.

The report shows the total number of Category A, Category C1 and C2, and Category C3 and C4 calls responded to during the month and the percentage increase/decrease on the same month in the previous year.

Demand Management Plan

The report shows the percentage of hours where the Trust's Demand Management Plan (DMP) stages were invoked in the Emergency Control Room and the percentage increase/decrease on the same month in the previous year. N.b. This does not apply for May, as DMP was not fully introduced in May 2011.

REAP Level

The report shows the current REAP level and the percentage of time that the Trust has operated at or above REAP 3.

2. Care for Patients

Caring for Patients during their Journey	
How do we care for our patients?	
* First Contact (Call Answering)	90.1%
* Treatment (CPI)	Amber
* Clinical Outcomes	Amber
* Patient Safety Index	177
* Patient Wellbeing	Green
* Clinical Quality/Barometer	Green

First Contact (Call Answering)

First contact with a patient affects their entire experience. Did we answer the call quickly, did we listen to them and/or did we give them the correct information to manage their expectations?

This is measured by the percentage of calls answered within 5 seconds against a national target of 95%.

Other qualitative measures may be introduced at a later date.

Treatment (CPI)

Did we correctly assess and treat our patients?

This is measured from the clinical outcomes from the CARU CPI Audit report, and is graded as Red, Amber or Green from the Quality Dashboard.

Other measures to be considered are the number of patients who received a poor response, based on the outliers from the Response Model performance indicators. For example, at the contracted number of Category A incident responses (1,100) we expect to respond to 75% (825 patients) within 8 minutes, 95% within 19 minutes (1045 patients). The 95% percentile would be 55 patients at risk. As call volumes increase, and performance reduces, the number of patients at risk will increase, so it may be useful to analyse whether this is a linear or a logarithmic relationship, and whether there is a tipping point.

Clinical Outcomes

Did our patients have a positive outcome?

This is a broad brush measure from the audit of CPI completion for specific patient clinical outcomes: cardiac arrest; STEMI; Stroke; Diabetes etc as defined in the Quality Dashboard Physiological indicators.

Patient Safety

How have we ensured patient safety?

This is measured by the number of clinical and non clinical incidents raised by staff, against the number of hours worked, effectively the rate of clinical and non clinical

incidents per 100,000 hours worked – a Patient Safety Index. The target is based on averages over the previous 12 months to show variance against the mean.
The current measured month is February 2012, as incident reporting is significantly delayed, which shows 40 clinical incidents/100,000 hours worked against an annual rolling mean of 45, with patient non clinical incidents showing as 137 non clinical incidents/100,000 hours worked against an annual rolling mean of 157 (Green).

Patient Wellbeing

How have we ensured that patient's concerns and complaints are acted upon?
This is a broad brush measure from the actions arising from the Learning from Experience Report, taken from performance indicators in the Quality Dashboard.

Clinical Quality/Barometer

A broad brush measure from the Director of Health Promotion

3. Care for Staff

Care for Staff - Workforce Report		
How will we sustain change and improve?		
Performance Indicators		***Survey***
∗ Staff Availability	91%	
∗ Staff Training (50%)	Amber	3.1
∗ Staff Development	Amber	2.5
∗ Staff Management	87%	2.8
∗ Staff Safety & Wellbeing	67	3.2
∗ Staff Satisfaction	3.4	

This information is obtained from the Workforce report submitted by the Human Resources Department and the quarterly Staff Temperature Check survey. Statistics on complaints and Serious Incidents are obtained from the Governance and Compliance department.

Staff Availability (to support Service Delivery)
This is calculated from the current A&E Operations and Control Room staff WTE headcount, minus the number of staff days ascribed as sick or unauthorised absence. The value is a percentage headcount available to support the Response Model, which is RAG rated as >95% Green, between 90% & 95% Amber and less that 90% Red. This needs to be validated.

Staff Training

The percentage of staff attending Core Skills Refresher training against plan.

The quality barometer is the response to the Temperature Check question: "I am given access to the information I need to do a good job".

Staff Development

How are we ensuring that staff are provided with appropriate development opportunities?
This is measured by the number of staff who have completed Performance Development Plans (PDRs) against plan. Currently there is no system which records PDRs, so the information is not currently available.

The quality barometer is how staff feel that they are being developed, based on the aggregate score for specific questions in the Staff Temperature Check survey; “I am given opportunities to develop my knowledge and skills”; and “I have access to the equipment I need to do a good job”.

Staff Management

How are we ensuring that staff are managed well?
This is measured by the number of staff being managed under the Managing Absence Policy, the number of staff reporting grievances against the Trust, the number of staff managed under capability and disciplinary policy, the number of staff who have taken the Trust to Employee Tribunals and the number of staff currently suspended from duty. This total number is divided by the total headcount to obtain a percentage of staff who are being managed under policy. This is currently showing a figure of 13%, which gives a value of 87% for this measure.
The quality barometer is how staff feel that they are being managed, based on the aggregate score for specific questions in the Staff Temperature Check survey; “The LAS values employee suggestions for improvement”; “My manager shows appreciation for the work I do”; “There is a spirit of cooperation amongst my colleagues”; and “My manager shows me the support that I need to do my job well”.

Staff Safety and Wellbeing

How are we ensuring that staff are safe at work?
This is measured by the number of lifting, handling & carrying (LFC), physical (PV) and non-physical abuse (NPA) incidents raised by staff, against the number of hours worked, effectively the rate of incidents per 100,000 hours worked – a Staff Safety Index. The target is based on averages over the previous 12 months to show variance against the mean.
The current measured month is February 2012, as incident reporting is significantly delayed, which shows 67 incidents/100,000 hours worked (Green).

Staff Satisfaction

The quality barometer is how staff feel about working for the LAS, based on the aggregate score for specific questions in the Staff Temperature Check survey: “I enjoy working for the LAS”; “I am proud of the quality of care the LAS provides”; “I believe I can make a difference to the success of the LAS” and “I am happy with my work/life balance”.
The RAG scoring mechanism is Red <3, Amber 3-3.5, Green >3.5.

4. Service Delivery Quadrant

Service Delivery		
Evidencing Delivery of the Response model		
Performance Indicators	***Actual***	***YTD***
∗ Cat A Target (75%)	69.4%	71.0%
∗ Cat C1 Target (90%)	70.6%	72.7%
∗ Cat C2 Target (90%)	71.3%	73.6%
∗ Ambulance Utilisation (55%)	86.4%	85.0%
∗ FRU Utilisation (40%)	44%	42%
∗ Complaints/Serious Incidents	91	

Cat A Target Performance

How is the Trust performing against targets?
This is measured by the percentage of Category A calls responded to in 8 minutes, and the percentage of Category C1 and C2 calls responded to in 20 minutes. The report shows actual figures for the month and the year to date.

Utilisation

The report shows the monthly and year to date utilisation percentages for ambulances and fast response vehicles.

Quality Barometer

The quality barometer for the Response Model Delivery quadrant is the number of complaints received about the Trust plus the number of serious incidents declared with NHS London.

This is measured against the previous five months average, which is 78.

5. Value for Money Quadrant

Value for Money	
Evidencing stewardship of the public purse	
∗ Financial EBITDA	21.7m
∗ Net Surplus	3.1m
∗ Cost Improvement Programme	12.5m
∗ CQUINs	0.9m
∗ Monitor Net Rating (FRR)	3
∗ Carbon Reduction Plan	Amber

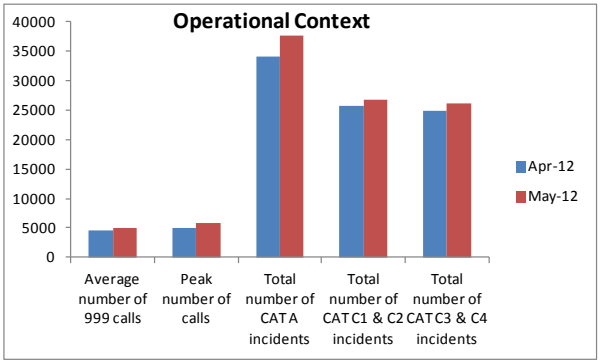
This information is obtained from the Finance Department, and all values are RAG rated against the annual forecast. The values submitted are Financial EBITDA; Net surplus, Cost Improvement Plan, CQUINs and the Monitor Net Rating (FRR).

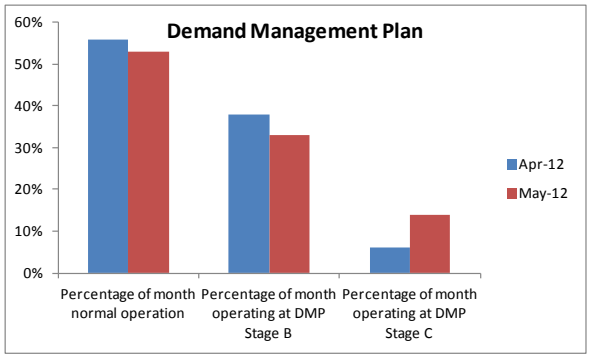
The report also includes a RAG rating on overall performance on carbon reduction, based on energy and fuel consumption, vehicle savings and recycling.

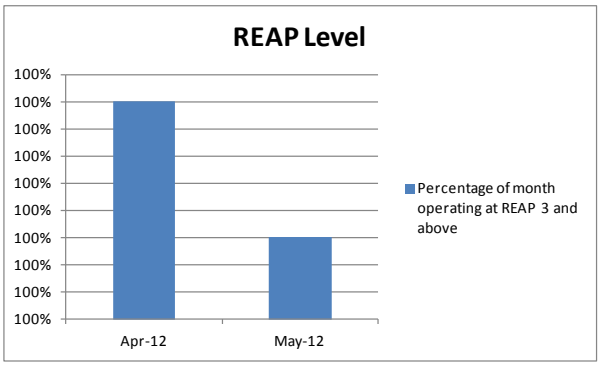
There is a separate Carbon Reduction dashboard which is submitted to the Finance and Investment Committee half-yearly, with the next meeting scheduled for September 2012. Plans are also in place to publish the Carbon Reduction dashboard on the Pulse in Q2 2012.

Attachment 3

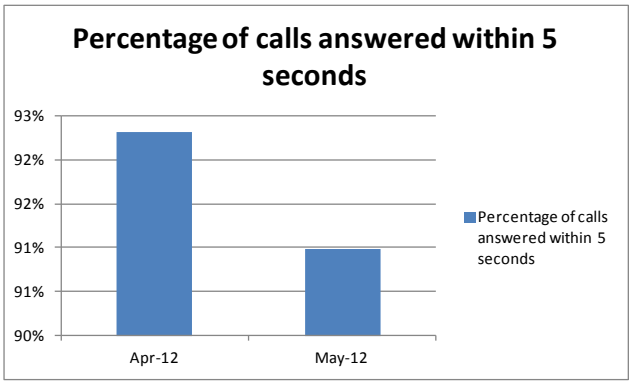
1. Operational Context

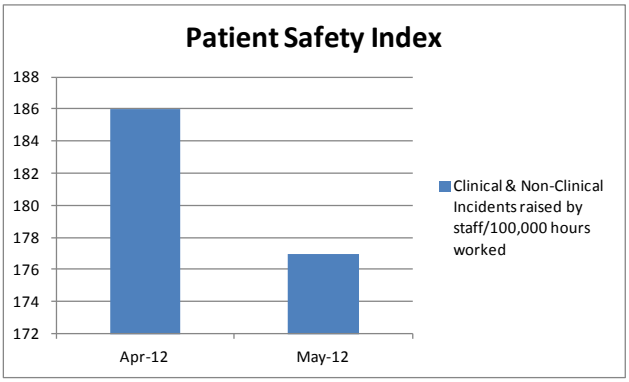




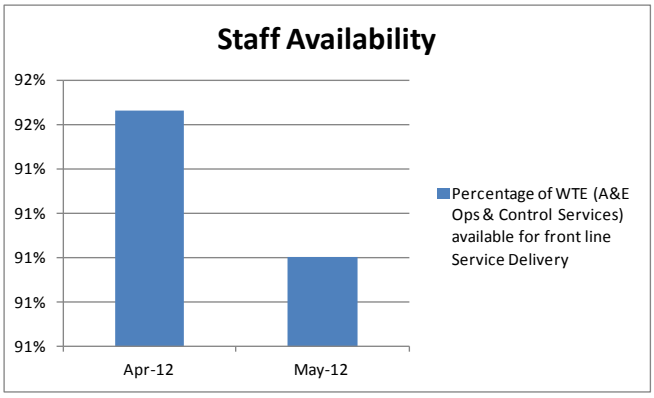


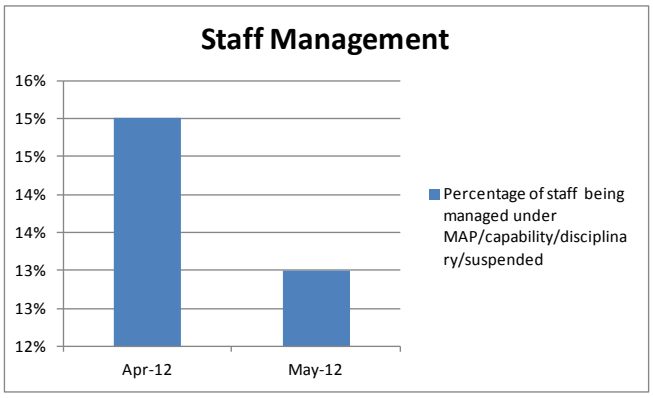
2. Care for Patients

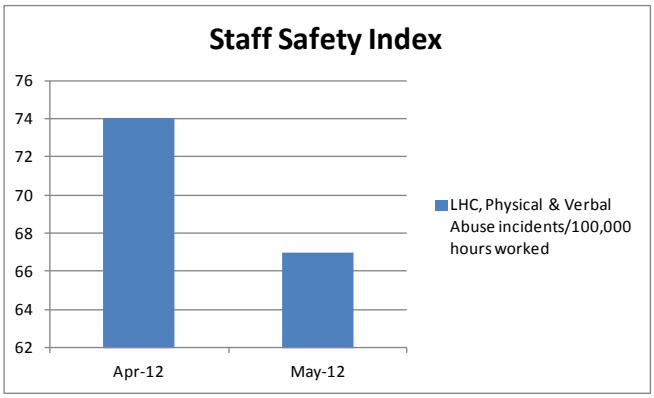




3. Care for Staff



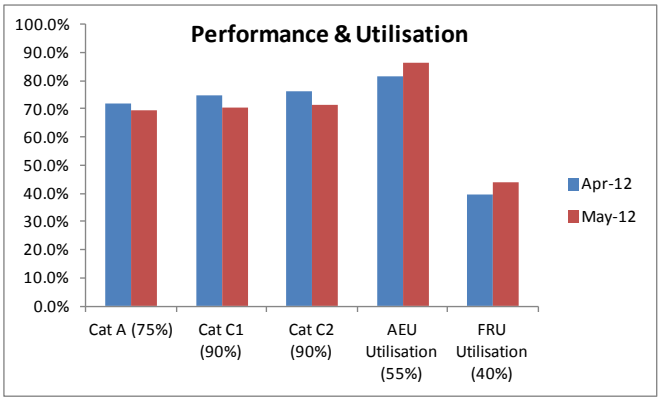


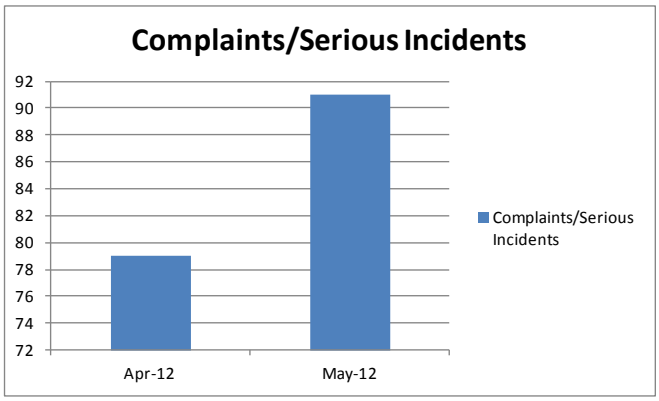


Staff Training figures only available for April

Staff development figures (PDRs) not available

4. Service Delivery





5. Value for Money

<Figures are forecast so graph not representative>

Carbon Reduction

The Trust's carbon reduction target for 2012-13 is 1,860 $_tC0_2$, and measures energy (gas and electricity) consumption for Trust buildings at Waterloo and Bow and fuel (diesel) consumption and waste recycling. The overall RAG rating is Amber based on comparison between April and May 2012.

Gas consumption at Bow has increased by 19% due to the change in usage for the Vehicle Resource Centre relocation but electricity consumption fell by 11%.

At Headquarters, electricity consumption fell by 21%, but there are no figures for gas consumption as we await the bill from British Gas.

Diesel consumption increased by 6%, but should be balanced against the 17% increase in CAT A demand compared to May 2011. Fuel savings for non-conveyance are marginally off track at 67.85% against a target of 67.7%, but both the cycle response team and multiple responses are on track.

Clinical waste and recycling are on track against milestone, but waste to landfill is marginally off track against milestone.

Procurement is a substantial element of the Trust's carbon footprint (71% 2010-11 baseline), and the Trust is working on a method to report activity in 2012/13.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH JUNE 2012

PAPER FOR INFORMATION

Document Title:	**CommandPoint Update**
Report Author(s):	**Peter Suter**
Lead Director:	**Peter Suter**
Contact Details:	**02077832044**
Why is this coming to the Trust Board?	**The objective of this paper is to provide an update on the CommandPoint Project since the last report on 29 May.**
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
Recommendation for the Trust Board:	**That the Trust Board note the contents of this report.**
Key issues and risks arising from this paper: None.	
Executive Summary: CommandPoint remains live and stable. A number of issues have been resolved, others are in progress. The Project will remain constituted and retain ownership of CommandPoint until after the Olympics.	
Attachments CommandPoint Update – June 2012	

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Quality Strategy

This paper supports the following domains of the quality strategy

- ☐ Staff/Workforce
- **X** Performance
- ☐ Clinical Intervention
- ☐ Safety
- ☐ Clinical Outcomes
- ☐ Dignity
- ☐ Satisfaction

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
- **X** 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
- **X** 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?

- **X** Yes
- ☐ No

Key issues from the assessment:

None

COMMANDPOINT PROJECT UPDATE: 26 JUNE 2012

1. INTRODUCTION AND BACKGROUND

1.1 The objective of this paper is to provide an update on the CommandPoint Project since the last report on 29 May.

2. ACTIVITIES SINCE 29 MAY.

2.1 Focus has been on maintaining stability of the system, resolving outstanding issues and migrating the project team into business as usual activities. The go-live of any new system is always followed by a period of both user familiarisation and the identification and resolution of problems. It is reasonable to report that the experience of the CommandPoint implementation is broadly within the scope of what would be anticipated. I previously reported that eleven software patches had been installed; this has now increased to fourteen. I would again point out the number of patches is not a measure of quality – multiple patches each with small modifications is, where possible, always favourable to fewer patches but each with larger code changes.

2.2 In terms of transparency, I would bring the following areas to the Trust Boards attention:

<u>The following issues have been resolved:</u>

2.3 Cable & Wireless Address Lookup: There has been a long outstanding problem (pre CommandPoint Go Live) with delays in receiving address details from Cable & Wireless. This problem has been more prevalent with the way in which CommandPoint operates. Extensive analysis between Cable & Wireless and the LAS has now identified and resolved this problem.

2.4 Server Instability: On Saturday (morning) 2 June, a problem was experienced with the perception that CommandPoint was slowing down. The situation was escalated to NG and resolved by remote support. It was an intermittent fault caused by a coding problem within the servers that control communication between the control room terminals and the main servers. A modification to address this has been made and deployed. Given the sensitivity of the Saturday being the start of the Queens Jubilee weekend, NG and LAS put additional support staff on site as well as remote monitoring. However the system remained stable and there have not been any further occurrences of this problem.

2.5 999 Telephone Upgrade: Although not a direct component of the project, the upgrade of the 999 telephone system (on hold until CommandPoint was live) was an important milestone to resolve a number of aligned errors. This was a significant piece of work has now been successfully completed.

<u>The following issues are core focus for the team:</u>

2.6 Memory Leak: There has been an ongoing problem since go live with the memory on the control rooms workstations ‘filling up’, a situation that could cause each to slow down. It is mitigated by the duty engineer re-starting the CommandPoint application on each workstation in the early hours of each morning. A multi-disciplinary team is current looking into this.

2.7 MDT synchronisation. There are certain situations where a MDT can become out of synchronisation with CommandPoint. There are alarms in place to trap this situation and a code modification is being worked though between the LAS and NG.

2.8 Mapping: There are some issues relating to accuracy of mapping in general, and the coordinates sent through by the MPS. A working group is looking into this.

2.9 Auto-Despatch Optimisation. From the first day of live use it was clear that CommandPoint auto-despatch provided an improved service. However, within its current configuration it is possible to slow down the process when demand consistently outstrips resources. There are a number of LAS configurable options and work is underway to consider how best to optimise this function.

2.10 There are other items and further requests for change that are not detailed here and should be considered as business as usual.

2.11 There has been some interest in the press (HSJ on-line) linking the fact that the Trust did not achieve its CAT A performance targets in April and May, with the implementation of CommandPoint. This was factually inaccurate in its reporting; it was the increased operational demand (above the anticipated levels) that was more linked to performance issues than CommandPoint. The Trust had previously agreed (with Commissioners) a lower trajectory for April and May and as previously reported, actual performance with CommandPoint initially returned on the eight day after go- live.

3. NEXT STEPS

3.1 Work will continue with resolving outstanding issues as detailed above and moving toward a lock down for the Olympics. Consideration is also being given to additional support from NG during the Olympic period.

3.2 The Project Board has agreed a two stage project close down. Stage one on 30 June will be the point at which many of the external project resources will step away and ongoing support will transition into business as usual. The Project and Project Board will however remain, through to at least September to oversee outstanding fault resolutions and system stability through the Olympics.

4. RECOMMENDATION

4.1 That the Trust Board note the contents of this report.

Peter Suter
Project Executive
Director of Information Management & Technology

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH JUNE 2012

PAPER TO PROVIDE ASSURANCE TO THE TRUST BOARD

Document Title:	**Audit Committee Assurance Report**
Report Author(s):	**Caroline Silver, Chair of the Audit Committee**
Lead Director:	**N/A**
Contact Details:	
Why is this coming to the Trust Board?	**To receive an update on the key items of discussion at the Audit Committee meeting on 1st June 2012 and to receive assurance from the Committee.**
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**

Key issues and risks arising from this paper

At the Audit Committee meeting on 1st June 2012, a number of risks to the Trust's key sources of assurances were identified. These risks, together with the mitigating actions, are detailed in the attached report.

Executive Summary

It is the role of the Audit Committee to focus on the controls and related assurances that underpin the achievement of the Trust's objectives and the processes by which the risks to achieving these objectives are managed. The purpose of this report is to assure the Trust Board of the effectiveness of the Trust's systems of integrated governance, risk management and internal control, and is based on the Trust's key sources of assurance as identified in the Trust's Board Assurance Framework (section C of the Board Assurance Framework).

Attachments

Report from the Audit Committee meeting on 1st June 2012.

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Quality Strategy

This paper supports the following domains of the quality strategy

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

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

- ☐ Yes
- ☒ No

Key issues from the assessment:

Report from the Audit Committee on 1st June 2012

STRATEGIC RISKS

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

ASSURANCES AND CONTROLS

It is the role of the Audit Committee to focus on the controls and related assurances that underpin the achievement of the Trust's objectives and the processes by which the risks to achieving these objectives are managed. The purpose of this report is to assure the Trust Board of the effectiveness of the Trust's systems of integrated governance, risk management and internal control, and is based on the Trust's key sources of assurance as identified in the Trust's Board Assurance Framework (section C of the Board Assurance Framework).

The following controls are in place to support the management and mitigation of our strategic risks and these are referenced against each control as appropriate (eg SR 1.2.3.4).

Risk Register (SR 1.2.3.4)

The Chief Operating Officer attended the meeting, on request of the Audit Committee, to give an update on operational risks. The fact that operational risks had not been updated in time for the full review of the Trust-wide risk register is still a concern for the Audit Committee, but the Committee is reassured that this will be undertaken by the end of June 2012. The Audit Committee took additional assurance from the fact that work is ongoing to mitigate these risks, as many of them represented the core work of the operational team. For example, the Trust is undergoing a formal capacity review, which would mitigate risk 265.

The Audit Committee requested that the Risk, Compliance and Assurance Group review the target ratings of the risks as a number are thought to be very low; much lower than the current net ratings and perhaps therefore unachievable. This is to be considered as part of a wider discussion about the Trust's risk tolerance levels and the process by which to manage business as usual risks.

The Audit Committee has requested that the Risk, Compliance and Assurance Group provide a report directly to the Trust Board at its meeting in August.

Report from the Chair of the Finance and Investment Committee (SR 2.3.4)

The Audit Committee received a report from the Director of Finance on the key areas of discussion at the recent Finance and Investment Committee meetings.

Annual Governance Report 2011/12 from the External Auditors (SR 3)

The year end external audit highlighted an issue with two missing defibrillators, one of which was likely to no longer be in use. The External Auditor had extrapolated this error against all defibrillators which resulted in an extrapolated overstated figure of £449,651.

Following an in depth discussion, the Audit Committee agreed to not adjust the accounts. The External Auditor agreed that this was an appropriate treatment of the accounts as a number of defibrillators would have a nil value and therefore it was unlikely that the asset register was overstated by £400k.

The Audit Committee is concerned however that the same issue has arisen in the past two years and has asked for this issue to be flagged to the incoming auditors, Price Waterhouse Coopers. The Audit Committee took some assurance that the new Make Ready contract will also provide greater control over the tracking of equipment.

Annual Report and Accounts 2011/12 (SR3)

The Audit Committee approved the Annual Reports and Accounts for 2011/12, subject to a few minor amendments to the wording.

Annual Internal Audit Report 2011/12 (SR 1.2.3.4)

The Audit Committee took assurance from the fact that the Trust had maintained the same level of internal control as the previous year. The internal auditor noted that the process for the finalisation of internal audit reports had been far smoother this year than in previous years and this was as a result of the work of the Governance and Compliance Team to engage managers in the internal audit process.

One red opinion had been issued in the year for information governance, but a follow up audit had demonstrated that the areas of weakness had been addressed and any outstanding recommendations completed. The Trust also achieved level 2 compliance with the toolkit at the end of March 2012.

Local Counter Fraud Specialist Annual Report 2011/12 (SR 3)

The Audit Committee took assurance from the fact that no significant control weaknesses had been identified and the number of counter fraud investigations which took place in 2011/12 was broadly in line with other ambulance trusts.

Annual Review of the effectiveness of the Audit Committee (SR 1.2.3.4)

The Audit Committee discussed its performance for the year 2011/12 and agreed that it was acting in line with its terms of reference. The Audit Committee identified a number of actions for 2012/13, which are listed in the Audit Committee Annual Report to the Trust Board.

Audit Committee Annual Report 2011/12 (SR 1.2.3.4)

The Audit Committee agreed the following actions for 2011/12:

- To satisfy itself and report to the Trust Board on the adequacy and appropriateness of the assurance processes and how these are balanced amongst the Committees (eg Audit Committee, Finance and Investment Committee and Quality Committee);
- To establish a sound working relationship with the new external auditor;
- To continue to review the target ratings of the risk register and, specifically, operational risks;
- To continue to refine working arrangements with the Finance and Investment Committee.

The full Audit Committee Annual Report for 2011/12 is provided to the Trust Board.

RISKS TO ASSURANCES AND CONTROLS

Risk	Mitigation given
5th March 2012	
Scope of the Quality Committee's remit is too wide.	▪ This will be discussed as part of the wider governance review at the Strategy Review and Planning Committee meeting on 24th July 2012; ▪ Work is ongoing to improve the quality of the reports from the sub-Committees of the Quality Committee so that the Quality Committee receives sufficient assurance and does not have to delve into the detail of the issues. ▪ Best practice recommends having an integrated Quality Committee as there is a risk that, if the Committee focuses solely on clinical quality, other aspects of quality which have an impact on clinical quality might be overlooked; ▪ The Audit Committee will continue to review the adequacy and appropriateness of the assurance processes and how these are balanced amongst the Committees.
RSM Tenon has reported a loss for the period. This has a potential impact on internal audit and local counter fraud services.	▪ No update.
Gaps in the management of project and programme risks.	▪ The key recommendation arising from the CommandPoint Risk Management Arrangements audit was that there should be better documentation to identify the cause and effect of individual risks and to understand what might trigger these risks. Progress against the actions to address this recommendation will be monitored by SMG, Quality Committee and Audit Committee.
1st June 2012	
Missing equipment	▪ The Audit Committee will continue to focus on this issue in 2012/13; ▪ The Audit Commission will flag this as an issue to the incoming external auditors, Price Waterhouse Coopers, as part of their handover; ▪ The Chair of the Audit Committee to meeting with the incoming external auditors; ▪ Audit Committee to receive an update on the asset tracking part of the new Make Ready Contract.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH JUNE 2012

PAPER FOR DISCUSSION

Document Title:	**Board assurance framework and corporate risk register**
Report Author(s):	**Sandra Adams/Frances Wood**
Lead Director:	**Sandra Adams**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To provide assurance to the Trust Board on the controls in place to manage and mitigate the most significant risks facing the organisation**
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 ☐ Finance and Investment Committee ☐ Other
Recommendation for the Trust Board:	**To receive and discuss the updates to the board assurance framework and corporate risk register**

Key issues and risks arising from this paper

1. The two top risks refer to the implementation of CommandPoint in March 2012 and the potential impact of this on performance in the short term. Both risks are due for review and closure at the Risk Compliance and Assurance Group (RCAG) on 9th July.
2. Page 1 of the BAF summarises the key issues since the Q4 2011/12 report.
3. The BAF has been updated to identify links between strategic risks, the risk focus areas agreed in 2010/11 (still to be updated) and the BAF. Not all risk focus areas have BAF linked risks now having been managed and mitigated during the past 18 months as reported in Q4.
4. Each of the operational risks is due for full review following concern expressed by the Audit Committee that the target ratings may be unrealistic. These will be discussed at RCAG on 9th July.

Executive Summary

There are 8 risks on the BAF, as per Q4, some of which have been reviewed and their ratings changed resulting in re-ordering of 361 & 334; 22, 269, & 31.
The Trust's 5-year strategy is being refreshed and the strategic risks and risk focus areas will then be reviewed during Q2 2012/13.

Attachments
Board assurance framework Q1 2012/13
Corporate Risk Register June 2012

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Quality Strategy

This paper supports the following domains of the quality strategy

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

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

- ☐ Yes
- ☒ No

Key issues from the assessment:

London Ambulance Service NHS Trust
Risk Register as at 18th June 2012

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361	There is a risk that problems during the development and testing of CommandPoint result in the system not being ready to go live as planned by the end of March 2012. This could have a contractual, financial, and reputational impact for the Trust.'	This relates to CommandPoint risks project rating @ 27/01/12: 69. Negative Publicity for LAS = 16 71. Inadequate testing of system = 10 78. Failure of new CAD system during = closed Dec 11 144. Poor Quality of supplied product = 15 111. ProQA Interface = 10	16-Dec-11	4	3, 4, 8	IM&T	Catastrophic	Certain	25	1.Ensure the "Patch Policy" (Documentation on urgent software corrections) is agreed and approved by all stakeholders. 2.Request early sight of latest build, pre-release. 3.Release and Test Schedule agreed. 4.SAT of version 65.1 successful with no major impact issues.	Peter Suter	18-Jun-12	Catastrophic	Possible	15	1.Ensure that all testing on patches by the LAS covers from Unit tests to Full Regression testing 2.Ensure that next release has been performance Tested, Interface dry runs and the dry run shadowing exercise is successful.	1. J.Downard 2. J.Downard	1. 6 March 12 2. 6 March 12	Review of quality assurance documentation supplied to ensure correct procedures followed. The "Patch Policy" (Documentation on urgent software corrections) as agreed and approved by all stakeholders is followed. 10.1.2 Initial Transition Plan and subsequent transition products to include contingency plans to identify actions to be taken to safeguard LAS emergency service in event of new CAD failure. Designed a transition programme that includes Live runs of CommandPoint	Catastrophic	Rare	5	May 2012 update: Following Go Live 2, the underlying risks are now either closed or reduced in rating, implying that the overall score is now "5", the target rating, with no further actions outstanding. Recommendation is to close this risk at the next RCAG Actions completed and a successful transfer to CommandPoint took place on March 27th and is due for sign off at the end of April.
334	There is a risk that the implementation of CommandPoint will lead to a short-term reduction in performance targets	This potential could have an impact on; a) Patient Safety and b) External stakeholders concern regarding the LAS reduction in performance figures.	12-Aug-10	***	3, 4, 8	IM&T	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	18-Jun-12	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	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 - 10 Ongoing.	Assurance by CommandPoint Project Board reporting structure to SMG and Trust Board.	Major	Certain	20	May 2012 update: Following Go Live 2, the underlying risks are now either closed or reduced in rating, implying that the overall score is now "10". The original target rating of "5" is considered unreasonable, given that there are no further actions outstanding. Recommendation is to close this risk at the next RCAG.
355	There is a risk of staff not receiving clinical and non-clinical mandatory training. This may as a consequence cause:- ● Failure to meet CQC and the Trust's TNA policy ● Dilution of clinical skills ● this includes the decentralising of operational training to New Ways of Working (NWOW)		23-Nov-11		5	Human Resources	Major	Almost Certain	20	1. PDR / KSF Agreed rostered training days. 2. Dedicated tutors. 3. Paramedic registration. 4. Weekly Operational demand capacity meetings. 5.Cluster arrangements in place from December 2011 on all complexes.	Caron Hitchen	08-Mar-12	Major	Likely	16	1.TNA to be discussed at TSG on 23 Feb, to be finalised by 31 March. 2. Develop a work book approach to support CSR training. 3. OLM implemetation into the service.	1. GH 2. KM 3. BON	1. March 2012 2. Ongoing 3. TBC	Reporting to TSG Performance Accelerator	Major	Unlikely	8	2. Development of workbook is ongoing but mitigation is not dependent on completion.
327	There is risk that the Trust does not follow Department of Health Guidelines for the re-use of linen.		12-Oct-09	***	4	Infection Control	Major	Certain	20	1. The Trust has an adequate supply of blankets, however these are not always available. 2. Increased availability of blankets for A&E crews - Additional linen and disposable blankets added to stocks and circulated. 3. Improved collection of soiled blankets from hospitals and non-contract laundries - New laundry provider appointed and increased activity being established to collect blankets. Reduction in blanket loss.	Steve Lennox	08-Feb-12	Major	Likely	16	1. To understand the scale of the problem and to develop a sstrategic solution ot blanket usage: 1 a) Audit blanket usage as part of hand hygiene auditing. 1 b) Chris Vale developing options paper to agree strategic direction. 1 c) PIMS to address compliance of single use locally. DIPC to present at conferences. Continue to audit. 1 d) Small sub group to be formed to discuss options paper and endorse recommendations	1a. Trevor Hubbard 1b. Chris Vale 1c. Trevor Hubbard 1d. Karen Merritt	1a. Mar 2012 1b.Feb 2012 1c. June 2012 1d. Feb 2012	1. KPI measuring blankets collected delivered. 2. KPI measuring blankets allocated/ delivered.	Minor	Possible	6	Infection Prevention & Control Committee 02/02/2012 proposed net rating revised to 20. A sub group is to be set up establish further actions to be taken. RCAG did not agree that the net rating is revised to 20 and felt it should remain at 16 as there was no evidence that to show that linen was currently being reused.
265	Service Performance may be adversely affected by the inability to match resources to demand.		31-Jul-06	***	3	Operational	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	MF March 2012 - ADO Group to review risk

London Ambulance Service NHS Trust
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269	At staff changeover times, LAS performance falls as it takes longer to reach patients.		08-Dec-06	***	17	Clinical	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	28-May-12	Major	Likely	16	1. Roll out of NWOW across the Trust. 2. Introduction of new rest break allocation introduced to reduce losses at shift change over. 3.The process by which new rosters are introduced is being reviewed. 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. P.Woodrow 4. P.Cassidy	1. Jan 2012 2. Jan 2012 3. Ongoing 4. Ongoing	1. Monitoring of KPIs.	Major	Unlikely	8	2012-05-24 CQS&E - revised action 2. MF March 2012 - ADO Group to review risk
31	There is a risk that the control and operational staff may fail to recognise serious maternity issues or fail to apply correct guidelines which may lead to serious adverse patient outcomes in maternity cases.		14-Nov-02	***	4	Clinical	Major	Certain	20	1. The Medical Director attends NPSA's Obstetric Pan London Forum. 2. Consultant Midwife working with the LAS one day a week, providing advice to Control Services, Legal Services, Patient Experience, and Education and Development. 3. Reports on all the reported incidents concerning obstetric cases are presented to the Clinical Quality Safety and Effectiveness Committee- Report produced in Feb 2012. 4. Training by Consultant midwife to complexes with workshops and a number of complexes have made local arrangements for midwives to deliver training sessions. 5. Maternity care updates and ongoing training through direct contact and articles in the Clinical Update.. 7. CTA now have maternity pathway to assist with triage of women in labour. 8. Monitoring the delivery of the CPD obstetrics module.Re- review planned June 2012 9. Evaluated the flow chart used to enable the safe triage of women in early labour- To be slightly modified and modifications completed Sept 2012	Fionna Moore	28-May-12	Major	Likely	16	1. Modifications to the safe triage of women in early labour flow-chart - ongoing and complete Sept 2012 2. Review incidents reported through LA52's, Patient Experiences and Legal Claims relating to problematic obstetric incidents-Ongoing	1. A.Stallard / F.Sheraton 2. A. Stallard	1. Sep 2012 2. Ongoing	1. Monitor processes at CQSE and Corporate Health and Safety Group. 2. Incident reporting.	Major	Unlikely	8	2012-05-24 CQS&E proposed the target rating is changed to Major x Possible = 12
22	There is a risk that failure to undertake comprehensive clinical assessments may result in the inappropriate non-conveyance or treatment of patient.	Inappropriate non-conveyance incident	14-Nov-02	***	5	Clinical	Major	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	02-May-12	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. 3. New action JS to add re EBS being amalgameted into Clinical Hub.	1. J.Selby 2. J. Selby 3. J. Selby	1. Nov 2011 2. May 2011 3. Date	1. Incident reporting. 2. Operational workplace reviews. 3. Regular reports to CQSE.	Moderate	Possible	9	The incident reporting pilot meeting of the 14th Feb, concluded that LA277 would be withdrawn from the pilot in the interim, but the LA52 would continue to be handled via EBS as normal in the participating complexes as part of the original pilots remit. 2012-05-25 CQS&E - J. Selby to add further action.

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324	There is a risk that cleaning arrangements are insufficient to ensure that the environment for providing healthcare is suitable, clean and well maintained.		17-May-10	***	4	Infection Control	Major	Certain	20	1. Introduction of revised cleaning programme. 2. Infection control champions are in place. 3. Audits of vehicles and premises. 4. Swabbing of vehicles by LSS. 5. Processes now in place to triangulate audit information.. 6. Opportunities within the PEAG initiative have been identified to support the audit process.	Steve Lennox	08-Feb-12	Major	Possible	12	1. To ensure Trust is consistently compliant across the service: a) conduct audit following implementation of contract.	1a. Trevor Hubbard	1a.	1a. Comprehensive dashboard	Minor	Unlikely	4	Infection Prevention Control Committee 02/02/2012 - reviewed risk remains the same until an audit has been carried out following the aware of the new make ready contract.
7	There is a risk that we do not capture errors and incidents, and do not therefore learn from these and improve service provison and working practices.	Insufficient recorded evidence of reported incidents	13-Nov-02	***	4	Health & Safety	Major	Certain	20	1. LA52 incident reporting form 2. Risk management policy and strategy has been updated and implemented 3. Incident reporting policy is implemented 4. The Learning from Experience (LfE) group is in place and starting to review integrated risk reports, patterns and trends - LfE group receive an integrated report and monitor action to be taken, including feedback to staff on incidents reported and investigated. 5. A review of incident reporting is underway and led by the PCMO. 6. Weekly SI control sheet and conference call updates. 7. Monthly reports to SMG. 8. Implemented policy on investigating and learning from incidents, complaint, PALs and claims. 9. Local risk registers have been introduced 10. Datix Coding Review has been undertaken 11. LFE group has introduced integrated reporting	Caron Hitchen	31-May-12	Moderate	Possible	9	1. Complete the review of incident reporting and make recommendations to Corporate H&S and RCAG. 2. Implement the policies on investigating and learning from incidents, complaint, PALs and claims. 3. LfE to develop the integrated risk reports and monitor action taken, including feedback to staff on incidents reported and investigated.	1. S.Sale 2. S.Adams 3. C.Dodson-Brown 4. C.Dodson-Brown	1. Sept/Oct 2012 2. 3.	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	Update to item 1 - Incident reporting pilot continues in City and Hackney, with the proposal to roll it out to Whips Cross. Generally the principle of airwave reporting has proved positive,. However there has been a decline in reporting since the removal of LA 277 from pilot and change of line management at C&H. A meeting has been arranged for 14th June to discuss relauching the pilot - JS- (31st May 2012)
343	There is a risk of staff not recognising safeguarding indicators and therefore failing to make a timely referral.		12-Aug-10		4	Clinical	Major	Likely	16	1. Monitor referrals centrally. 2. Safeguarding committee promotes practice guidance. 3. Practice guidance issues and supported by updates. 4. Training programme in place - ongoing auditing of the effectiveness of training through competency assessments. 5. Monitor training uptake - monitored centrally on scorecard. 6. Safeguarding 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	2012-05-24 CQS&E - risk to be revised at Safeguarding Committee Meeting.
349	There is a risk that the Clinical Coordination Desk will not be able to operate effectively due to a lack of suitably trained staff in EOC where secondments of specifically trained staff have ended and specialist roles with control services are being removed.	Specialist roles with control services are being removed in order to provide a more flexible workforce. This removes the experience and expertise that has been developed on the CCD and has now become a nationally recommended part of clinical network development.	11-Jul-11	***	4	Operational	Major	Likely	16	1. 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 provide support and guidance.	Martin Flaherty	18-Nov-11	Major	Likely	16	1. To identify a cohort 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	2012-05-24 CQS&E - Risk to be revised by S.Watkins All aspects of this risk specialised secondments to the CCD have ended as previously outlined. This role is now covered from within the teams as part of core duty and numbers of staff from each team have received training to allow them to carry out the full range of responsibility while working on the desk. Further staff on each team have and continue to be trained in house by experienced CCD staff so as to further improve both understanding of and resilience in staffing the desk.
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)		11-Jan-11		8	Clinical	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.	Caron Hitchen	22-Mar-12	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 2012 2. Complete	1. CommandPoint Project Group 2. Programme Delivery Board	Negligble	Rare	3	SA 2012-05-14 propsed that risk is closed / reassess risk around the service delivery model with a view to raising a new risk. Action CH/MF. Options paper was presented to delivery board in December. COO Flaherty is now leading a review in regard to the CRM, the intention is to introduce CRM towards the end of 2012 and be fully implemented by 2013

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9	There is a risk of RTC injury to persons travelling in an LAS A&E vehicles.		13-Nov-02	***	7	Operational	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 - camera switching.	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	MD and NF to ensure Motor Risk Group review risk with a view to archiving ADO Group to review risk
138	Failing to appreciate the significance of psychiatric illnesses will lead to mis-diagnosis.		12-Nov-03	***	5	Clinical	Major	Likely	16	1. The new 'Mental Health' module has been designed and has been included in the training plan for 2009/10. 2. An e-Learning Manager has been appointed and will start work wih the Trust in August 2009. 3. Mental health e-learning module has been developed - training package assessed by external assessors	Steve Lennox	22-Mar-12	Major	Possible	12	1. Development of mental health risk assessment tool 2. Roll-out of mental health e-learning training 3. Mental Health Committee to consider alternatives to e-learning 4. Mental health audit	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	2012-05-24 CQS&E - Actions dates to be reviewed. Reviewed by Mental Health Committee on 26th April who agreed no changes should be made.
205	There is a risk of not being able to readily access and manage the training records of all operational members of staff due to records being kept on separate and remote sites outside of the current records management system.	As a result of limited capacity of the Fulham archive stoes, as well as records needing to be stored at other sites Separate sites holding data which we do not have access to easily	01-Jun-05	***	7	HR	Major	Likely	16	1. Education and Development are to move to the scanning of training records. Plans from Estates for the development of the Fulham archive are awaited. 2. All staff are currently being migrated onto PROMIS with the aim of developing a centralised Learning Management System.	Caron Hitchen	01-Jun-12	Major	Possible	12	1. Review the process of archiving training records within the DoE&D (Initial work indicates there may be a need for a formal procurement and tender process for electronic archiving) 2) Pilot toOLM to commence June 2012	1. P.Billups 2. R. Habib	1. Ongoing 2. July 2012	1. Part of organisation & development of people workstream. 2. Progress of project report to workstream board.	Major	Unlikely	8	However, systems have been developed to capture training activity data in the meantime, these processes to be tested and completed by July 2012.
211	There is a risk that drug errors and adverse events may not be reported.	Concerns that drug errors may not be reported	08-May-06	***	4	Clinical	Major	Likely	16	1. No evidence of any issue of significance from service users or stake holder feedback. 3. Complaints Manager to tracked back complaints to see how many have LA52's associated with them (drug errors and adverse events not being reported) 4. Medical Directors Bulletin to remind staff of importance of reporting drug errors and adverse events. 5. Article included in the Clinical Update highlighting the importance of incident reporting. 6. Importance of clinical incident reporting highlighted in the Team Leader Clinical Update Course and Team Leader Conference.	Fionna Moore	03-May-12	Major	Possible	12	1. CQSE suggest PIMs give some thought to how this is managed. 2. Continue to encourage reporting of all clinical incidents using LA52's. 3. Continue to reinforce that the LAS has a fair blame culture by providing feedback from outcomes of complaints to staff involved in incidents.	1. J.Killens 2. ? 3. ?	2. Ongoing 3. Ongoing	1. CPI checks 2. Incident Reporting 3. CQC inspections 4. Clinical opinions provided on incidents 5. Learning from Experience Group review incident activity 6. Review of closed cases and claims. 7. Learner outcomes and achievement records documenting discussions on incident reporting.	Major	Unlikely	8	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
305	There is a risk that the management of morphine at Station level is not in accordance with LAS procedure OP/30 Controlled Drugs.	Controlled Drugs Incidents arising from poor adherence to policy	21-Oct-08	***	4	Clinical	Major	Likely	16	1. Internal Audit carried out annually. 2. Procedure to be reinforced by bulletins from Director of Operations/Medical Director. 3. Independent audits to be carried out throughout the Trust. 4. Initial peer review pilot audit carried out in the south area with results and process amendments discussed at a morphine audit group quarterly meetings.	Fionna Moore	03-May-12	Major	Possible	12	1. Peer review meeting is scheduled for following completion of peer review audits to take forward proposal to make the this part of business as usual across the areas. 2. Review of OP30 in the light of the forthcoming NHS Protect Guidance on CD management following their recommendations document of March 2012.	1. D.Whitmore 2. D.Whitmore	2. May 2012 3. June 2012	1. Internal Audit 2. Independent Audit 3. LIN oversight of system	Major	Unlikely	8	
326	There is a risk that the inadequate facilities and lack of policy for the decontamination of equipment may increase the risk of infection.		17-May-10	***	1,2	Infection Control	Major	Likely	16	1. Introduction of single-use items. 2. Introduction of more robust cleaning programme for vehicles and premises. 3. Introduction of detergent and disinfectant wipes for equipment in between patient use. 4. Decontamination policy is now in place. 5. Improved decontamination processs in operation.	Steve Lennox	02-Feb-12	Major	Possible	12	1. Decontamination sub group to review compliance with decontamination process.	1. Steve Lennox	1. Feb 2012	1. Area Governance Meetings 2. Incident reports.	Minor	Unlikely	4	Infection Prevention & Control Committee reviewed this risk 02/02/12. The risk score remains the same - the decontamination policy has gone to the ADG for sign off.

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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.	Staff injured whilst manual handling patients	23-Nov-11		7	Health & Safety	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, 1) Manual Handling Implementation Group 2) Small handling kits on all vehicles 3) BTech trained Manual Handling assessors 4) Specialist MH equipment e.g. Mangar Elk 5) All A+E and PTS operational vehicles have either tail lift of ramp access 6) All A+E and PTS operational vehicles are fitted with hydraulic trolley bed 7) Manual Handling Policy 8) Generic Risk Assessments 9) All A+E Operational vehicles have access to	Martin Flaherty	01-Jun-12	Major	Possible	12	1) Implementation of LAS/HSE Manual Handling Improvement Programme Action Plan 2) Manual Handling audits 3) Manual Handling policy has been updated and will be tabled at June ADG 4) Complete Operational Workforce Review 5) Chair Transporter Pilot - (Interim report with CH - Final report not expected to differ from interim update - (JS 1st March 2012) 6) MEG are reviewing maximum weight allowance for medical response bags (group to review bag contense in conjunction with medical directorate June 11th 2012)	1. J.Selby 2. J.Selby 3. G. Heuchan 4. 5. J.Selby 6. J.Selby	1. Ongoing 2. Ongoing 3. Complete 4. ??? 5. July 2012 6. Aug 2012	Manual Handling Implementation Group Manual Handling Policy Central Health and Safety Group Incident Statistics Monitor and Audit Reviews 1) Manual Handling Policy 2) CHSG Monitor incident trends	Minor	Unlikely	4	Identify action owner for action 4.
316	The non-reporting of faults in accordance with service procedures may result in the loss of vehicle availability.	There could be an impact on service delivery, patient care and the Trust's reputation.	17-Aug-09	***	1,2, 3,4,	Logistics	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.	Martin Flaherty	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	ADO Group to review risk 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 the mandatory vehicle checks.
153	There is a risk that fuel prices may be in excess of sums held in budgets which may lead to overspend	Increasing fuel prices	06-Jan-04	***	8	Finance	Major	Likely	16	1. Monthly review as part of month end reporting process. 2. Prices will continue to be closely monitored by the Finance Department for 2012/13. The move to an all diesel fleet will further mitigate against fuel costs.	Michael Dinan	13-Mar-12	Moderate	Possible	9	1. Finance Review of billing data underway by Director of Finance	1. M.Dinan	1. Ongoing	Monitored at SMG and Trust Board	Moderate	Possible	9	**Risk at target rating but to remain visible on Risk Register**
20	Inappropriate use/completion of the LA4H Single Response Handover form may lead to the loss of patient information.		14-Nov-02	***	1,2,5	Operational	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	ADO Group to review risk
322	There is a risk that the Trust does not receive assurance that infection prevention and control training is taken up by staff.	Current workload within the department means that there is insufficient capacity to ensure that all tutors are developed in line with the departmental tutor development strategy. This includes time to incorporate information from bulletin into teaching strategies.	17-May-10	***	1,2,4, 5	Infection Control	Major	Likely	16	1. Introduction of training programme for operational and non-operational staff. 3. Trust updates have been delivered to 1,600 staff including hand hygiene training 3. Use of Infection Control Communications Strategy to ensure that all staff are kept well-informed.	Steve Lennox	08-Feb-12	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 TBD	1a Feb 12 1b Feb 12 1c Feb 12	Reports from the central training register	Minor	Unlikely	4	Infection Prevention & Control Committee 02/02/2012 proposed new wording of risk to: There is a risk that the Trust does not receive assurance that infection prevention and control training is taken up by staff. Training now being delivered across the Trust in CSR1. Gaps in training data is being recovered. Review at next meeting. New wording agreed by the RCAG on 02/04/12.

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323	There is a risk that the audit programme is not sufficiently robust to identify to identify infection control issues across the Trust.		17-May-10	***	1,2,4, 5	Infection Control	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. 4. 7 Point Audit plan is being used as an audit tool. 5. An Escalation plan is in place.	Steve Lennox	08-Feb-12	Major	Unlikely	8	1. PIMS and AOMS to identify solution for updating the scorecard.	1a. PIMS	1. Feb 2012		Minor	Possible	6	The Infection Prevention & Control Committee 02/02/2012 reviewed this risk and the decided the net rating remains the same.
173	There is a risk to staff, patients and the organisation of staff working excessive overtime/hours in breach of the Working Time Directive.		05-Jan-05	***	4,7	HR	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 reviewed and the rating reduced.	Caron Hitchen	08-Mar-12	Major	Unlikely	8	1. Continued monitoring and review of working hours via PROMIS. 2. Reissue WTD guidance. Move to controls? 3. Further enhancements are envisaged with the roll out of GRS in 2011. move to controls?	1. G.Hughes 2. T.Crabtree 3. G.Hughes/A Khan	1. Ongoing 2. Dec 2011 3. July 2011		Major	Rare	4	RCAG: risk to be archived and replaced by new risk regarding staff not having robust systems in place for monitoring how many hours people are working for external organisations CH to look at proposing a new risk. 1. CH to review risk wording and potentially reduce risk to target rating 3. A service wide report was sent to all AOMs highlighting staff that had exceeded WTR hours for an average of 17 weeks.
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.	Patient incident	17-Mar-03	***	1,2,4, 8	Logistics	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.	Martin Flaherty	18-Jun-12	Major	Unlikely	8	1. Vehicle Preparation contractors (Initial Healthcare) are now testing the electronic asset system in a live environment ahead of rolling out later this year.	2. C. Vale	1. Oct 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.
344	Unable to assure that the current taxi contract accommodates the guidelines for regulated activity (safeguarding)		16-May-11		2,4	Governance	Moderate	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	Minor	Rare	2	ISA remit currently under review - Ops Lead and Procurement lead to meet and agree specification for Tender Process April 2012. Risk to be reviewed at safeguarding meeting in May 2012
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.	Pottential failure to achieve contracted performance targets and failure to earn CQUINs	06-May-10		3,4,8	Finance	Catastrophic	Possible	15	1. 2012/13 Continue working with specific mitigation of financial risk. 2. Monthly finance reports reviewed by Trust Board and SMG. 3. Extra financial provisions included for contract risk in 2012/13. 4. Communications with commissioners.	Michael Dinan	13-Mar-12	Catastrophic	Possible	15	1. Review by Finance Investment Committee	1. A.Cant	1. April 2012	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	Catastrophic	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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362	There is a risk that the absence of a medical devices tracking system may result in the Trust being unable to maintain and track equipment which could result in equipment not being available for patient use.	Impact on Complexes not being able to manage allocation of medical equipment to vehicles. Impact on patient safety if medical equipment is not available possibly resulting in a serious incident. Equipment is not serviced at the correct intervals and there are no indicators, if an item of equipment has not been maintained. Impact on patient safety if faulty equipment remains in use. Financial impact on the organisation through the increased likelihood of loss or theft of medical devices.	17-Apr-12			Clinical	Catastrophic	Possible	15	1. Occasional audits of equipment by complexes and logistics department. 2. Equipment lists are available from the company which maintains the medical devices, which includes services and non serviced items.	Martin Flaherty		Catastrophic	Possible	15	1. Actions are set out in the Vfm Programme - Tracking Medical Devices Project Mandate. 2. Establish confidence in the project via the project team.	1. Martyn Salter 2. Ed Potter			Catastrophic	Rare	5	
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.	Based on the National 111 Evaluation undertaken by Sheffield University of the early implementor pilot sites LAS could see between 8 and 15% of 111 call demand requiring an ambulance conveyance, which may be upto 10% higher than current demand from NHS D. This could place additional pressure on LAS. Particularly as 40-50% of these are likely to be Cat A calls.	23-Nov-11		1,2,3, 4,8	Operational	Moderate	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	12-Mar-12	Moderate	Likely	12	1. We will negotiate as a clause in the funding mechanism for 111 generated activity in the 2012/13 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	
345	The Trust currently recieves a sum of £7.7m non recrring funding to maintain a CBRN (Decontamination) Response. There is a risk that the funding may not continue. The funding is used to fund 143 WTE and the hours required for annual CBRN training	Public sector funding constraints. No formal service level agreement in place	16-May-11		1,2,3, 4,8	Finance	Catastrophic	Possible	15	1. 2011/12 contract reflects this work, if there is a shortfall PCTs are liable. 2. Reviewed by Finance Investment Committee.	Michael Dinan	13-Mar-12	Catastrophic	Unlikely	10	1. Trust to attempt to gain assurances from DH that this funding will continue. 2. Reviewed by Finance Investment Committee.	1. Lizzy Bovill 2. M. Dinan	1. Feb 2012 2. April 2012	1. Service Line Reporting	Catastrophic	Unlikely	10	Agreed with DH 2012/13
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-Aug-09	***	17	Business Continuity	Catastrophic	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	Catastrophic	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	Catastrophic	Rare	5	BC&EP and ADO Group to review risk, No updates available for March 2012 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.

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353	There is risk that Operational ambulance staff and Emergency Operations Centre Staff are unsure of the safe systems of working/procedures in relation to railway trackside working, due to the rare occurrence of such incidents.	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	23-Nov-11		5,7	Operational	Catastrophic	Possible	15	1. Emergency Medical Despatchers (EMD) receive familiarization and procedural awareness during initial training and during their dispatch training course. 2. Work Based Trainers oversee adherence to procedure during placements Student Paramedics receive trackside awareness training during initial training. 3. "Trains Can Kill" card included in Major Incident Action Cards as point of reference. 4. Contingency Plans in place for calls on Network Rail, LUL, DLR and Croydon Tramlink calls including safety awareness information. 5. Operational bulletins available via The Pulse. 6. Trackside Awareness Training provided for all student paramedics and trainee emergency medical dispatchers including demonstrations of short circuit devices	Martin Flaherty	01-Nov-11	Catastrophic	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	.	Catastrophic	Rare	5	Health and Safety Group and ADO Group to review risk
207	Risk of staff not being able to download information from Defibrillators and 12 lead ECG monitors leading to incomplete patient records.	Clinical information was not available which was required for an inquest	04-Apr-06	***	1,2,4,5	Clinical	Moderate	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	15-Jun-12	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	We have had further meetings with IM&T and are planning to start a three complex trial in October as we were unable to secure training/down time so far this year due to operational pressures With regards to FR2 data downloads – still very poor compliance mainly due to team leaders not being in the "office" due to operational pressures
226	There is a risk that the identified risks associated with lone working are not being uniformly mitigated as a result of inconsistent application of the Lone Worker Policy.		12-Jul-06	***	7,4	Health & Safety	Moderate	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; - Lone Working risk assessments are regularly reviewed; - appointed FRU coordinators at each at main stations ensure staff are aware of locally known hazards; - all operational vehicle have MDT and radio facilities; - Violence Prevention and Lone worker policies highlight specific procedures for reducing foreseeable hazards to staff.	Caron Hitchen	01-Jun-12	Moderate	Possible	9	1. Revised Lone worker policy reviewed @ Feb ADG. ADG requested TC and MN to review specific requirements for lone working in office accommodation.	1. Martin Nicholas/ Tony Crabtree	1. July 2012	1. Incident Reporting Monitoring. 2. CH&SG Monitor incident trends	Moderate	Unlikely	6	

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200	There is a risk of loss of physical assets due to the risk of fire.		01-Jan-02	***	1,2,3, 4,7	Health & Safety	Catastrophic	Possible	15	1. Fire Marshall awareness training is undertaken as a module on a 1 day Safety and Awareness Course. 2.Annual Fire Risk Assessments are undertaken by the Estates Department. 3. Fire Fighting equipment is sited at all strategic locations. 4. Premises Inspection Procedures require all premises to be inspected on a three monthly basis. 5. Local Induction Training requires managers to identify fire precaution to all new staff. 6. Updates of health and safety issues are provided at the Estates Meeting monthly. 7. Estates department annual assurance of Trusts fire safety compliance. 8) Fire Marshals are appointed by Line Manager 9) Fire & Bomb evacuation Policy	Caron Hitchen	01-Jun-12	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 - completed by Estates 3. Annual return to DOH including a fire risk statement signed off by Peter Bradley. 4. Core skills refresher 2 includes vehicle fire precaution	Minor	Rare	2	All operational vehicles are fitted with appropiate extinuishers and crew staff fire awareness is included in CSR - (JS 1st june 2012

Board assurance framework
June 2012

The Board Assurance Framework (BAF) comprises the principal risks facing the Trust in 2012/13 and looking ahead within the strategic period 2012-17 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 18th June 2012. Amended risks and those new to the BAF this quarter are highlighted.

Commentary:

1. 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. In addition, the risk has been realised as can be evidenced by the performance figures for April and May.
2. Risk 361 is CommandPoint linked and was reviewed by RCAG on 2nd April. Actions have been completed with the successful implementation of the system on 27th March and these were due for sign off at the end of April. RCAG will review this risk again on 9th July;
3. Risk 355 – mandatory training – actions were due for completion in March 2012 and this risk is to be reviewed by RCAG on 9th July;
4. Risk 327 – re-use of linen – this risk was reviewed by RCAG in April but the recommended rating revision was not agreed and this risk will be reviewed again on 9th July;
5. Risk 265 – service performance and resources – this risk is under review following discussion at the Audit Committee about the likelihood of achieving a target rating of 6. This, and other operational risks, are under review and will be discussed at RCAG on 9th July with a view to agreeing whether there is a risk tolerance approach to be adopted;
6. Risk 269 – staff changeover times/impact on performance – operational performance reports suggest that this risk is being realised so it is recommended that RCAG review the risk on 9th July with a view to agreeing the level of tolerance;
7. Risk 31 – maternity care – this risk was reviewed by the Clinical Quality Safety & Effectiveness committee (CQSEC) on 24th May who proposed a target rating change to major x possible = 12. The plan is to modify the flowchart for the safe triage of women in early labour by September 2012. Incidents, complaints and legal claims are being reviewed.

Sandra Adams 18th June 2012

8. Risk 22 – clinical assessment/non-conveyance – CQSEC reviewed the risk on 24th May and noted that the remaining actions were due for delivery in November 2011. Further actions are being added and RCAG will review this risk on 9th July.

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.

RSM Tenon reviewed the links between the corporate risk register and the BAF and identified a number of gaps between the key corporate objectives and risks on the register. These have been addressed where relevant. The addition of Risk 355 (mandatory training) to the corporate risk register provides a greater link between strategic risks and a number of the corporate objectives.

Additional sources of assurance have been included in Section C, namely the Quality Governance Framework assessment undertaken by RSM Tenon in January 2012; and the Board Governance Memorandum/Assurance Framework completed in May 2012.

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

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

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

Board assurance framework
June 2012

Strategic Goal	Key Corporate Objectives	Abbrev.	Strategic risk
Deliver value for money	To use resources more efficiently and effectively	CO7	3
	To maintain service performance during major events, both planned and unplanned, including the 2012 Games	CO8	1, 2 & 3
	To improve engagement with key stakeholders	CO9	4

Board assurance framework
June 2012

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. These strategic risks will be reviewed once work to refresh the Trust's 5-year strategy has been completed.

Strategic Risk	Causes	Likelihood of risk occurring	Risk focus BAF Yes/No	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 Yes – risk 22, 31 Key clinical skills training Yes – risk 355, 31, 22	Implementation of the clinical training and development strategy; adoption of reflective practice; Use of clinical performance indicators and benchmarking ie national ambulance quality indicators Fleet strategy New ways of working programme roll-out Electronic patient report form

Board assurance framework
June 2012

Strategic Risk	Causes	Likelihood of risk occurring	Risk focus BAF Yes/No	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 Yes – risk 265 Performance delivered against trajectories Yes – risk 269	Strong cost improvement programme and focus on gaining efficiencies and driving up productivity Service delivery 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

Board assurance framework
June 2012

Strategic Risk	Causes	Likelihood of risk occurring	Risk focus BAF Yes/No	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 No - risk falls below BAF threshold Key performance indicators No –risk falls below BAF threshold	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 service delivery model

Board assurance framework
June 2012

Strategic Risk	Causes	Likelihood of risk occurring	Risk focus BAF Yes/No	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 No – risk 337 needs updating and falls below BAF threshold Single point of access No – risk 350 falls below the BAF threshold Health policy No – risks 138 and 165 fall below the BAF threshold	Clearly articulated strategic direction with planned developments across three to five years Implementation of the service delivery model Implementation of stakeholder engagement and communications strategy Ensure that partnerships within London's health economy (LHE) are maintained to support the development of appropriate clinical pathways and utilisation of the LHE

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)	Martin Flaherty	**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)
	B] KEY CLINICAL SKILLS TRAINING	Caron Hitchen	**Risk ID:** **355** There is a risk of staff not receiving clinical and non-clinical mandatory training
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]	Martin Flaherty	**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	Martin Flaherty	**Risk ID:** **317** There is a risk that the Trust may not achieve its Category

Strategic Risks	Trust Board Risk Focus	Lead	Linked Risks
	are on track to deliver – connects policy goals with operations and tells us if we are succeeding		A target in 2011/12. *Risk to be reviewed – July RCAG*
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.	Mike 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.	Mike 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**	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

Strategic Risks	Trust Board Risk Focus	Lead	Linked Risks
compromised			Target rating 1: Added to corporate register *Risk to be reviewed – July RCAG*
	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 350** 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,	Steve Lennox	**Risk ID:** **138** – Mental health **165** – Older people

Strategic Risks	Trust Board Risk Focus	Lead	Linked Risks
	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.		

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; Quality Governance Framework; Board governance assurance framework.	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 Board Governance Memorandum.
Quality Committee	Care Quality Commission registration; DH Clinical Quality Indicators; NHS London safety and quality assurance gateway review; CQC quality risk profile; Quality Governance Framework.	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; Governance Statement; Report from Chair of the Quality Committee.
Risk Compliance & Assurance Group	Internal audit reports and recommendations; CQC quality risk profile.	Audit recommendations progress report Local risk registers; Risk register process and reports.
Clinical Quality Safety & Effectiveness Committee	Cluster clinical quality group minutes	Clinical risk register Infection control dashboard Safeguarding dashboard Clinical quality indicators Clinical audit
Learning from Experience Group	CQC registration Ombudsman reports Coroner Rule 43 reports	Integrated risk management report; Action plans and outcome reports from investigations (serious incidents, complaints, Rule 43 etc).
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;

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. There has been movement over the past 18 months in terms of the risk focus areas shown in Section B. Previously many of them appeared in the BAF however there are now only two which are scored sufficiently high enough to appear here. This suggests that the actions taken to manage and mitigate the other risks listed have brought the risk level down, possibly to tolerance level.

Principal risk and headline	Corporate objective	Risk score	CQC map	Key controls	Assurance on controls			Action plan	Responsible officer	Q4 RAG status	Year End f/cast
					Positive assurance	Gaps in controls	Gaps in assurance				
361 Problems during the development and testing of CommandPoint result in the system not being ready to go live as planned by the end of March 2012. This could have a contractual, financial, and reputational impact for the Trust.	C08 C03 C04	25	**N/A**	Trust Board decision to go live. Project assurance.	**New risk – 16/12/11** **This is an overarching risk with 5 underlying risks** **Updated 16/6/2012** **Underlying risks now closed or reduced leading to target rating of 5 for review at RCAG in July**	None identified	None identified	Actions completed and a successful transfer to the new system took place on 27th March 2012.	**PS**	H20	L5
334 There is a risk that the implementation of CommandPoint will lead to a short term reduction in performance targets	C08 C03 C04	25	**N/A**	CommandPoint Project Board; Reports to SMG and Trust Board; Planning assumption of the likely	**New risk – 23/8/2010 & reviewed 8/11/2010 and 11/11/2011** **09/05/2011** **11/7/2011** **18/6/2012**	None identified	None identified	Actions completed and a successful transfer to the new system took place on 27th	**PS**	H15	S10

				impact on performance and the plans in place to mitigate the level of impact. Board-level commitment. Fully resourced project. SMG and Trust Board discussed and accepted that this risk will be realised. Mitigation is to reduce not remove impact.				March 2012.			
355 Staff not receiving clinical and non-clinical mandatory training	C01 C02 C03 C05 C06 C07		**12 14**	1. PDR / KSF Agreed rostered training days. 2. Dedicated tutors. 3. Paramedic registration. 4. Weekly Operational demand capacity meetings. 5.Cluster arrangements in place from December 2011 on all complexes. TNA updated and published May 2012	**New risk**: **23/11/2011 Updated 8/3/12 Further update required**			NwoW roll-out; Ongoing development of the workbook; OLM implementation	**CH**	H	H Target is S - 8

327 Re-use of linen/infection prevention and control guidelines	C04	20	**8**	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.	1. KPI measuring blankets collected delivered. 2. KPI measuring blankets allocated/ 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. Reviewed 08/02/12 Further update required**	See actions	Audit results show compliance with single use is not consistent	1. To understand the scale of the problem and to develop a strategic solution on blanket usage: 1 a) Audit blanket usage as part of hand hygiene auditing. 1 b) Chris Vale developing options paper to agree strategic direction. 1 c) PIMS to address compliance of single use locally. DIPC to present at conferences. Continue to audit. 1 d) Small sub group to be formed to discuss options paper and endorse recommenda	**SL**	H	M

								tions Infection Prevention & Control Committee 02/02/2012 proposed net rating revised to 20. RCAG did not agree to revised score.			
265 Service performance affected by inability to match resource to demand	C03 C05 C07	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 Further update required**		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**	H16	M6

269 At staff changeover times, LAS performance falls as it takes longer to reach patients.	C01 C02 C03 C04 C07 C08	20	16	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.	Monitoring of KPIs. **Risk reviewed 25/10/11 28/5/2012**	See actions		1. Roll out of NWOW across the Trust. 2. Introduction of new rest break allocation introduced to reduce losses at shift change over. 3. Process by which new rosters are introduced is under review. 4. Ongoing analysis of all missed Category A calls on a daily basis to aid and improve both patient care and Category A performance.	**MF**	H15	S8

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.	C01 C02 C05 C06	20	6 16 14	1. The Medical Director attends NPSA's Obstetric Pan London Forum. 2. Consultant Midwife working with the LAS one day a week, providing advice to Control Services, Legal Services, Patient Experience, and Education and Development. 3. Reports on all the reported incidents concerning obstetric cases are presented to the Clinical Quality Safety and Effectiveness Committee- Report produced in Feb 2012. 4. Training by Consultant midwife to complexes with workshops and a number of complexes	**Risk reviewed 13/3/12 and regraded to 16 net** **Target is 8 and action due for completion in Sept 12** **Reviewed 24/5/2012 – CQSEC propose target changes to 12**	See actions	1. Monitor processes at CQSE and Corporate Health and Safety Group. 2. Incident reporting.	1. Modifications to the safe triage of women in early labour flow-chart - ongoing and complete Sept 2012 2. Review incidents reported through LA52's, Patient Experiences and Legal Claims relating to problematic obstetric incidents- Ongoing	**FM**	H16	S12

				have made local arrangements for midwives to deliver training sessions. 5. Maternity care updates and ongoing training through direct contact and articles in the Clinical Update. 7. CTA now have maternity pathway to assist with triage of women in labour. 8. Monitoring the delivery of the CPD obstetrics module. Re-review planned June 2012. 9. Evaluated the flow chart used to enable the safe triage of women in early labour- To be slightly modified and modifications completed Sept 2012							

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** **13/3/12**	Monitoring develop-ment of treat and refer pathways; Effective-ness of incident reporting system;	Review of effective-ness 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**	H15	S9

				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.							

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH JUNE 2012

PAPER FOR NOTING

Document Title:	**Audit Committee Annual Report 2011/12**
Report Author(s):	**Caroline Silver, Chair of the Audit Committee**
Lead Director:	**Sandra Adams, Director of Corporate Services** **Mike Dinan, Director of Finance**
Contact Details:	**sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**In accordance with the NHS Audit Committee Handbook and principles of good governance**
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 ☐ Finance and Investment Committee ☐ Other
Recommendation for the Trust Board:	**To note the Audit Committee Annual Report 2011/12**

Key issues and risks arising from this paper

None.

Executive Summary

In line with best practice in other sectors, *The NHS Audit Committee Handbook* recommends that the Audit Committee should prepare a report to the Trust Board that sets out how the Committee has met its terms of reference. This should cover the following:

- That the system of risk management in the organisation is adequate in identifying risks and allowing the Board to understand the appropriate management of those risks;
- That the Committee has reviewed and used the Board Assurance Framework and believes that it is fit for purpose and that the comprehensiveness of the assurances and the reliability and integrity of the sources of assurance are sufficient to support the Board's decisions and declarations;
- That there are no areas of significant duplication or omission in the systems of governance in the organisation that have come to the Committee's attention and not been resolved adequately.

In addition, the report should highlight to the Trust Board the main areas that the Committee has reviewed and any particular concerns or issues that it has addressed.

The attached report was discussed by the Audit Committee at its meeting on 1st June 2012 and the following actions were agreed for 2012/13:

- To satisfy itself and report to the Trust Board on the adequacy and appropriateness of the assurance processes and how these are balanced amongst the Committees (eg Audit Committee, Finance and Investment Committee and Quality Committee);
- To establish a sound working relationship with the new external auditor;
- To continue to review the target ratings of the risk register and, specifically, operational risks;
- To continue to refine working arrangements with the Finance and Investment Committee.

Attachments

Audit Committee Annual Report 2011/12

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

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

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

Equality Impact Assessment

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

Key issues from the assessment:

ANNUAL REPORT OF THE AUDIT COMMITTEE 2011/12

1. Scope of the report

1.1 This report outlines how the Audit Committee has complied with the duties delegated by the Trust Board through its Terms of Reference (See Appendix A), and identifies actions to address further developments in the Committee's role.

2. Constitution

2.1 The Audit Committee is established under Board delegation with approved terms of reference that are aligned with the NHS *Audit Committee Handbook* published by the HFMA and Department of Health.

2.2 In accordance with the terms of reference, the membership is currently three non-executive Directors, with a quorum of two, including one with recent relevant financial experience. The Director of Finance and the Director of Corporate Services normally attend all Audit Committee meetings and the Chief Executive attends at least annually. The non-executive Chair of the Quality Committee is invited to attend all Audit Committee meetings. The appropriate internal audit and external audit representatives and the local counter fraud specialist attend all Audit Committee meetings with the exception of one a year. Other executive members of the Trust Board are occasionally asked to attend for specific matters.

2.3 A schedule of attendance at the meetings is provided in Appendix B which demonstrates full compliance with the quorum requirements and regular attendance by those invited by the Audit Committee.

2.4 The terms of reference state that the Audit Committee should meet at least quarterly. Five meetings were held within the last financial year on 17th May 2011, 6th June 2011, 4th October 2011, 25th November 2011 and 5th March 2012. The Audit Committee now holds an additional meeting in May to review the external auditor's work on year-end matters and this practice will continue next year.

2.5 The Audit Committee has an annual forward planner with meetings timed to consider and act on specific issues within that plan.

2.6 The Audit Committee Chair reports to the Trust Board following each meeting.

3 Governance, Risk Management and Internal Control

3.1 The Audit Committee reviewed relevant disclosure statements for the 2011/12 financial year, including the Annual Governance Statement (AGS) (formerly the Statement of Internal Control) at its meeting on 14th May 2012. The Committee agreed that the AGS was consistent with its view on the Trust's system of governance and internal control and supported the Trust Board's approval of the AGS. The Audit Committee has also reviewed internal and external audit opinion and other appropriate independent assurances.

3.2 The Audit Committee received updates at each meeting on the management of organisational risks, including the register of top-rated risks. The Audit Committee's view is that, over the course of the year, the culture of risk awareness has become more deeply embedded within the organisation, which is due, in part, to the development of the local risk registers for all departments and operational areas.

3.3 In January 2012, RSM Tenon undertook a Quality Governance Framework Assessment as part of the Trust's ongoing Foundation Trust application process. The assessment highlighted that there are a number of risks on the corporate risk register which date back to 2002 and questioned whether they should by now have been resolved and closed. This has been considered by the Audit Committee and the Committee's view is that this is not indicative of a problem with the risk management processes as these risks have been systematically reviewed and updated by the relevant governance groups. The Audit Committee has expressed a desire to retain the visibility of these risks, rather than moving them to the archive risk register and the Audit and Compliance Manager will be developing a process to manage business as usual risks, for consideration by the Risk, Compliance and Assurance Group.

3.4 Overall, the Audit Committee's view is that the risk register is a live and dynamic document, which accurately reflects the key issues facing the Trust. This is an improved position on last year.

3.5 The Audit Committee received a report at each meeting on the progress made in implementing outstanding internal audit recommendations. Last year, this report was aligned with the corporate risk register to ensure an integrated approach. This year, the report has continued to evolve and there is now a much better understanding of the Trust's position in relation to the progress of recommendations made by internal audit and the extent to which this is embedded in the Trust.

3.6 The view of the Internal Auditor is that the work of the Governance and Compliance Team has made a significant difference to the management of internal audit recommendations which has in turn enabled the Audit Committee to hold more mature discussions on the risks facing the organisation. Overall, the Internal Audit Recommendations Progress Report provides significant assurance that the Trust is learning lessons from internal audit.

4 Internal Audit

4.1 Internal Audit services to the Trust are provided by RSM Tenon.

4.2 The Audit Committee received and approved the Internal Audit Strategy 2011/12 – 2013/14 at its meeting on 6th June 2011. The Committee was assured that the Internal Audit Plan and Strategy had been developed with input from the Trust's directors and was consistent with the audit needs of the organisation as identified in the Trust Board Assurance Framework. Last year, the Audit Committee agreed that the Quality Committee should be involved in the development of the Internal Audit Plan at an early stage to provide meaningful input. This has happened for 2012/13 and issues raised by the Quality Committee have been incorporated in internal audit scopes.

4.3 Internal auditors were present at all of the Audit Committee meetings and provided the Committee with key findings from each audit report and an update on progress against recommendations made. In order to enhance the audit process, meetings were held with the lead managers for each of the audits to agree the detailed scope for each review and the timings as to when these reviews would take place. Increased engagement with managers has meant that internal audit reports are now finalised within one month of the draft report being issued and actions progressed in a more timely manner.

4.4 Overall, the Audit Committee has worked effectively with internal audit to strengthen the Trust's internal control processes. The Audit Committee has considered the major findings of internal audit and is assured that management has responded in an appropriate manner and that the Head of Internal Audit Opinion and the Annual Governance Statement reflect any major control weaknesses.

5 External Audit

5.1 External Audit services are provided by the Audit Commission. Their work can be divided into two broad headings:

- To audit the financial statements and provide and opinion thereon,
- To form an assessment of our use of resources.

5.2 At its meeting on 17th May 2011, the Audit Committee agreed the nature and scope of the audit as set out in the Annual Plan and the audit fee for 2011/12 financial year. The Committee has received regular updates on the progress of work. In addition, reports and briefings have been received from the External Auditors in accordance with the Audit Commission's requirements.

5.3 Following the closure of the Audit Commission, the provision of the Trust's External Audit services will transfer to Price Waterhouse Coopers, later in 2012/13.

6 Management

6.1 The Committee has continually challenged the assurance process when appropriate and has requested and received assurance reports from Trust management and various other sources both internally and externally throughout the year. This process has also included calling managers to account when considered necessary to obtain relevant assurance.

7. Fraud

7.1 As with the Internal Audit Service, Counter Fraud was provided by RSM Tenon.

7.2 The Committee received and agreed the Counter Fraud Work Plan for 2011/12 at its meeting on 6th June 2011.

7.3 The Audit Committee received reports from the Local Counter Fraud Specialist at three of the five meetings over the course of the year. The Committee was pleased to note that more referrals were being reported directly to the Local Counter Fraud Specialist.

8. Other Assurance Functions

8.1 At all but one of the meetings during this period, the Audit Committee received an update on the key items of discussion at the most recent meeting of the Quality Committee. The Chair of the Quality Committee is also invited to attend all meetings of the Audit Committee.

9. Financial Reporting

9.1 At its meeting on 1st June 2012, the Audit Committee received and ratified the Audited Annual Accounts, incorporating the Annual Governance Statement, for the year ending 31st March 2012, prior to their submission to the Department of Health. The Audit Committee noted that the Trust had achieved the breakeven performance, and Capital Resource Limit, the Capital Cost Absorption Rate, but not the External Financing Limit. This was caused by the failure to make an adjustment for the sale and lease back of ambulances in month 9 and this oversight was not picked up until month 12 at which point it was clear that the EFL would not be met. The Audit Committee was reassured that actions had been put in place to ensure that this did not recur.

9.2 The Audit Committee was kept informed of changes in, and compliance with, accounting policies and practices and received a presentation on the implementation of the Government Banking System. The Audit Committee also approved the Treasury Management Policy at its meeting on17th May 2011. Moving forward, the newly-

established Finance and Investment Committee will take on responsibility for some of these duties.

10. Audit Committee Terms of Reference

10.1 The Audit Committee reviewed its terms of reference at its meeting on 6th June 2011.

11. Conclusion

11.1 Overall, the Audit Committee has fulfilled its duties as set out in its terms of reference.

11.2 Last year, as part of its self-assessment, the Audit Committee identified a number of actions moving forward. Progress against these actions is detailed below:

Action	Progress
To ensure that the Quality Committee has appropriate input into internal audit planning process at an early stage.	The Internal Auditor attended the Quality Committee meeting on 28th February 2012 to present the Internal Audit Plan for 2012/13. Issues raised by the Quality Committee are to be incorporated into the scope of the planned internal audits.
To refine working arrangements with the newly-established Finance and Investment Committee.	The Finance and Investment Committee provides a regular report to the Audit Committee.
To continue focus on audit follow up.	The Audit Committee has had increased focus on internal audit recommendations and the internal audit process has been tightened to ensure that draft reports are signed off within 1 month of them being issued. Action plans have been developed for those recommendations that have shown slippage.
To ensure that the Committee meets with both internal audit and external audit separately at least 1 to 2 times a year.	This has not happened in the year. Action carried forward to 2012/13.
To work with finance and internal audit to understand fully the risk/benefit analysis of potential outsourcing.	This action has been superseded by the establishment of the Finance and Investment Committee.

11.3 The actions for the Audit Committee in the financial year 2012/13 are:

- To satisfy itself and report to the Trust Board on the adequacy and appropriateness of the assurance processes and how these are balanced amongst the Committees (eg Audit Committee, Finance and Investment Committee and Quality Committee);
- To establish a sound working relationship with the new external auditor;
- To continue to review the target ratings of the risk register and, specifically, operational risks;
- To continue to refine working arrangements with the Finance and Investment Committee.

London Ambulance Service NHS Trust
Terms of Reference
September 2011
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]

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.

[1] From the NHS Audit Committee Handbook
[2] As above
[3] As above

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.

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.

[4] The NHS Audit Committee handbook

14. Quorum

The quorate number of members shall be 2 which will include the following:

- 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.

16. 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

Sandra Adams
Director of Corporate Services

APPENDIX B

	17th May 11	6th June 11	4th October 11	25th November 11	5th March 2012
Audit Committee					
Caroline Silver	✓	✓	X	✓	✓
Roy Griffins	✓	✓	✓	✓	✓
Brian Huckett	✓	✓	✓	✓	✓
Observer					
Beryl Magrath	✓	X	✓	✓	✓
Attending					
Chief Executive	✓	✓	X	X	X
Director of Finance	✓	✓	✓	✓	✓
Director of Corporate Services	X	✓	✓	✓	✓
Other officers of the Trust					
Audit and Compliance Manager	✓	✓	X	✓	✓
Financial Controller	X	✓	X	✓	✓
Assistant Director of Corporate Services	✓	X	✓	X	X
Deputy Financial Controller	✓	X	X	X	X
Cashier	X	X	X	✓	X
Deputy Director of Finance	✓	✓	X	X	✓
Internal Audit					
Chris Rising	✓	✓	✓	✓	✓
Nick Atkinson	X	X	✓	X	X
External Audit					
Dominic Bradley	✓	✓	X	X	✓
Phil Johnstone	✓	✓	✓	X	✓
Local Counter Fraud Specialist					
Hayley England	X	✓	X	X	X
Darriane Garrett	X	✓	✓	X	✓

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH JUNE 2012

PAPER FOR APPROVAL

Document Title:	**Proposed amendments to Standing Orders and Standing Financial Instructions**
Report Author(s):	**Amanda Cant and Sara Pirie**
Lead Director:	**Sandra Adams/Mike Dinan**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Amendments to these governance documents have to be approved by the Trust Board**
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 ☐ Finance and Investment Committee ☐ Other
Recommendation for the Trust Board:	**To approve the proposed changes to Standing Orders and Standing Financial Instructions to reflect the new shared financial service arrangements that take effect from 1st July 2012**

Key issues and risks arising from this paper

Amending the SOs and SFIs ensures the Trust continues to operate within an approved regulatory framework.

Executive Summary

The document attached sets out the proposed changes in the Trust's Standing Orders and Standing Financial Instructions, and including the scheme of delegation. These changes are necessary to reflect the new financial services arrangements with ELFS Shared Services as well as to reflect a general update. The changes include:

- Reflecting those areas of accountability of the Director of Finance which will, from the 1st July 2012, be undertaken under a contract for shared financial services;
- Amendment to the contact details for the Trust's Counter Fraud Specialist;
- The terms of reference for the Audit Committee have been updated to reflect the assurance function: 'review the assurances provided by the internal auditors of the Trust's Shared Financial Services provider.'

These were discussed and approved by the Senior Management Group on 13th June 2012.

Attachments

Schedule of proposed changes to the Standing Orders (SOs) & scheme of delegation and the Standing Financial Instructions (SFIs) to accommodate the Shared Financial Services from July 2012 and as a general update.

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Quality Strategy

This paper supports the following domains of the quality strategy

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

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

- ☐ Yes
- ☒ No

Key issues from the assessment:

Proposed Changes to Current Standing Orders and Standing Financial Instructions			
Reference	**Section**	**Current**	**Proposed Changes (Highlighted In Red)**
Standing Orders			
8 Definitions	Pg 8	Add definitions	A service-level agreement (SLA) is a part of a service contract where the level of service is formally defined. In practice, the SLA is used to refer to the contracted service and performance when referring to the third party or host. Key Performance Indicator is a specific indicator embedded into an SLA as a measurement to monitor the performance.
19 Shared and hosted services arrangements	Pg 44	Not presently represented - proposed new section in the scheme of delegation	New section 21 **Shared and hosted services arrangements** Where the Trust uses a shared or hosted service provided by another NHS organisation or private company to undertake part of its functions, these functions shall remain the ultimate responsibility of the Trust. ELFS Shared Service, a business division of Calderstones Partnership NHS Foundation Trust, is responsible for the provision of a Financial Shared Service on behalf of LAS. The Shared Financial Services are contractually bound to deliver the financial service to LAS over seen by the Director of Finance or their nominated officer as defined by the contract between both parties. The Director of Finance shall retain overall accountability in relation to delivery of the Financial Services provided to LAS. A contractual agreement with an overarching SLA has been agreed between LAS and the Shared Financial Services provider setting out the arrangements for the delivery of a Shared Financial Service with a clearly defined mechanism in order to monitor and report the performance in full. All arrangements are clearly set out in the KPIs detailing accountability, responsibilities and authority of the respective parties. This also set out the framework by which the Trust and its auditors can gain assurance and the timescales by which this will be provided.

Proposed Changes to Current Standing Orders and Standing Financial Instructions			
Reference	**Section**	**Current**	**Proposed Changes (Highlighted In Red)**
Appendix III: Terms of Reference – Audit Committee **6 Other Assurances**	Pg 48	Add reference to shared services audit function as a source of assurance	To review the assurances provided by the internal auditors of the Trust's Shared Financial Services provider.
Appendix XI: **SCHEME OF DELEGATION**	Pg 83 Pg 103, section 28 All subsequent sections are re-numbered	Audit arrangements This should be added to the existing scheme of delegation table	Add under Directors: to monitor reliance placed upon the internal audit function of the Trusts Shared Financial Services function by either internal or external audit. New section 28: Contracts for Computer Services with other health bodies or outside agencies Under Directors: The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes. Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.
Standing Financial Instructions			
Section 1.2 Terminology	Pg 4	Add definitions	h) A service-level agreement (SLA) is a part of a service contract where the level of service is formally defined. In practice, the SLA is used to refer to the contracted service and performance when referring to the third party or host. i) Key Performance Indicator is a specific indicator embedded into the SLA as a measurement to monitor the performance. . j) "Shared Service" is the host/third party who will provide the outsourced Services Contract and overarching SLA with the Trust.

Proposed Changes to Current Standing Orders and Standing Financial Instructions			
Reference	**Section**	**Current**	**Proposed Changes (Highlighted In Red)**
Section 1.3 Responsibilities **1.3.6**	Pg 4 Pg 5	Add definitions Add to Director of Finance responsibilities	f) defining specific contractual responsibilities placed on Shared Services as indicated in the Scheme of Delegation Document (EL(94)40 refers) h) Where management and processing of transactions is delegated to a Shared Financial Service, the Director of Finance or their nominated representative shall ensure that there are proper arrangements for procedures, records and reports as the Trust may require for the purpose of carrying out its statutory duties including appropriate internal audit arrangements.
Section 2.2	Pg 7	Add to responsibilities of the Director of Finance	c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption; In the case of the Shared Financial Services, the Director of Finance shall ensure an adequate Internal Audit Service is specified in any contractual agreement between the LAS and the Shared Financial Service provider and shall specify the assurance arrangements between the Internal and External Auditors for the LAS and the Shared Financial Services' Auditors. d) ensuring that an annual audit report is prepared for consideration by the Audit Committee and the Board. The report must cover: (i) a clear opinion on the effectiveness of internal control measures in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards; (ii) progress against the annual work plan for the Audit Committee; (iii) major internal financial control weaknesses discovered; (iv) progress in the implementation of internal audit recommendations; (v) strategic audit plan covering the coming three years; (vi) a detailed plan for the coming year. e) deciding at what stage to involve the police in cases of misappropriation

Proposed Changes to Current Standing Orders and Standing Financial Instructions			
Reference	**Section**	**Current**	**Proposed Changes (Highlighted In Red)**
			and other irregularities not involving fraud or corruption;
Section 2.3 **The role of Internal Audit**	Pg 8	Add to Internal Audit responsibilities	New paragraph 2.3.6 In obtaining third party assurance from other Auditors, in relation to Shared Financial Service's Auditors, the Head of Internal Audit should follow the assurance guidance of the Internal Audit Practitioners Group (IAPG).
2.4.2	Pg 9	Amend LCFS contact details	The contact details for the LCFS are: **Name:** Bernie English **Telephone:** 07967137126 **Email:** Bernard.English@rsmtenon.com **Address:** 6th Floor Salisbury House, 31 Finsbury Circus, London, EC2M 5SQ
2.4.2	Pg 9	Add to Local Counter Fraud Specialist responsibilities	2.4.4 Shared Financial Services should also be party to this report and as per the contractual agreement between the Shared Financial Services and the LAS be maintaining an Anti-Fraud and Corruption Policy internally, that on request should be visible to auditors. 2.4.5 Shared Financial Service providers under their contractual terms and conditions also require the Local Counter Fraud Specialist to report to the Trust's Director of Finance in accordance with the Department of Health Fraud and Corruption Manual. 2.4.6 The Trust has an Anti-Fraud and Corruption Policy which is available on the intranet site, The Pulse.
3 Security Management	Pg 9	Additional wording in 3.3	The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management. Add: The above should also be synergized by Shared Financial Services as part of their internal procedures and policies.
7.2 Bank Accounts	Pg 13	Additional responsibilities added	7.2.1 The Director of Finance is accountable for: Add new paragraph:

Proposed Changes to Current Standing Orders and Standing Financial Instructions			
Reference	**Section**	**Current**	**Proposed Changes (Highlighted In Red)**
			(f) Where an agreement is entered into with the Shared Financial Services for payment to be made on behalf of LAS from bank accounts maintained on behalf of LAS, or by Electronic Funds Transfer (BACS), the Director of Finance shall ensure that satisfactory security regulations of Shared Financial Services relating to bank accounts exist and are observed. This is specified in a Contractual Agreement between the Shared Financial Services and the LAS.
7.3 Banking Procedures	Pg 14	Additional responsibilities	7.4.2 The Director of Finance may delegate these written instructions to a Shared Financial Services provider under contractual agreement with the LAS
8 Income, Fees and Charges and Charges and Security of cash, cheques and other negotiable instruments.	Pg 14	Additional responsibilities	8.1.3 The Director of Finance may delegate the above activities as part of a Shared Financial Service under contractual agreement with the LAS.
8.2 Fees and Charges	Pg 14	Additional responsibilities	Add to 8.2.4: Employees must ensure approval is obtained on sales and goods from the Director of Finance
8.3 Debt Recovery	Pg 15	Additional responsibilities	Add to 8.3.2: The Director of Finance may delegate responsibility for ensuring that the Shared Financial Services take appropriate recovery action on all outstanding debts. This would be specified in the contractual agreement between both parties.
8.4 Security of cash	Pg 15	Additional responsibilities	Add to 8.4.1: The Director of Finance is responsible for ensuring delegated arrangements via contractual Shared Financial Services for: b) ordering and securely controlling any such stationery; Banking stationery shall be handed over to the Shared Financial Services who will, on behalf of the LAS, become the custodian of all visible audit of this and will be monitored in accordance to the contractual agreement between the LAS and the Shared Financial Services and physical

Proposed Changes to Current Standing Orders and Standing Financial Instructions			
Reference	**Section**	**Current**	**Proposed Changes (Highlighted In Red)**
			signatures required. Add to 8.4.4: The Director of Finance may delegate the above activities as part of a Shared Financial Service under contractual agreement with the LAS.
11.4 Processing of Payroll	Pg 32	Amendment	Add to 11.4.3: The Director of Finance will issue instructions to the Shared Financial Services provider in respect of:
12 Non Pay expenditure – 12.1 Delegation of authority	Pg 33	Additional responsibilities	Add to 12.1.2: e) The list of authorised signatories held by the Finance Department with such thresholds will be advised to the Shared Financial Services on a regular basis to ensure on-going compliance. This is specified in the contractual agreement between the LAS and the Shared Financial Services.
12.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services	Pg 33	Additional clarity	Add to 12.2.3: Shared Financial Services are contracted to carry out the above procedure on behalf of LAS, this is part of the contractual agreement between the Shared Financial Services and the LAS. Add to 12.2.5: The Shared Financial Services will provide the LAS with the appropriate monitoring on the Better Payment Practice Code as required.
18 Information Technology	Pg 43	Additional clarity	Add to 18.1: e) The main finance system is operated on behalf of the LAS by the Shared Financial Services. The detailed requirements are specified in the Service Level Agreement with the Contractual Agreements between the LAS and the Shared Financial Services provider.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH JUNE 2012

Compliance with Standing Orders and Standing Financial Instructions

Document Title:	**Trust Secretary Report**
Report Author(s):	**Francesca Guy**
Lead Director:	**Sandra Adams**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Compliance with Standing Orders**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ 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 21st May 2012 and to be assured of compliance with Standing Orders and Standing Financial Instructions**

Key issues and risks arising from this paper

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

Executive Summary

One tender has been received, opened and entered into the tender book since 21st May 2012:

- Conversion of 6 Incident Support Vehicles
  Tenders received and opened by Bravo Solutions on 11th June 2012:
  Bott Ltd
  Oughtred and Harrison (Facilities) Ltd
  S MacNeillie and Son Ltd
  Wilker UK Limited

There have been no new entries to the Register for the Use of the Trust Seal since 21st May 2012.

Attachments

None.

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Quality Strategy

This paper supports the following domains of the quality strategy

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

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
24 July **Strategy, Review and Planning Committee**		Community First Responders/corporate and social responsibility		IBP 5 Year Strategy, including enabling strategies and financial strategy Strategic risks	Governance Effectiveness Review	10th July – Finance and Investment Committee
21 August **Trust Board**	Report from the Trust Chairman Report from CEO Integrated Board Performance Report Report from Director of Finance Report from Sub-committees Workforce Report	Quality Dashboard and Action Plan Clinical Quality and Patient Safety Report Quality Committee Assurance Report Annual Safeguarding Report 2011/12		Approval of IBP and enabling strategies PTS Strategy	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 Report from RCAG	15th August – Quality 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
25 September **Trust Board**	Report from the Trust Chairman Report from CEO Integrated Board Performance Report Report from Director of Finance Workforce Report Report from Sub-committees	Quality Dashboard and Action Plan 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
23 October **Strategy, Review and Planning Committee**	TBC					

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
27 November **Trust Board**	Report from the Trust Chairman Report from CEO Integrated Board Performance Report Report from Director of Finance Workforce Report Report from Sub-committees	Quality Dashboard and Action Plan Clinical Quality and Patient Safety Report Quality Committee Assurance Report	Charitable Funds Annual Accounts 2011/12		Report from Trust Secretary Trust Board Forward Planner	24th Oct – Quality Committee 5th November – Audit Committee
11 December **Trust Board**	Report from the Trust Chairman Report from CEO Integrated Board Performance Report Report from Director of Finance Workforce Report Report from Sub-committees	Quality Dashboard and Action Plan 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