London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO BE HELD IN PUBLIC ON TUESDAY 26th MARCH 2013 AT 09.00 – 12.30 CONFERENCE ROOM, 220 WATERLOO ROAD, LONDON SE1 8SD

AGENDA: PUBLIC SESSION

	ITEM	SUBJECT	Purpose	LEAD	TAB
	1.	**Welcome and apologies for absence** Apologies received from: Steve Lennox Fionna Moore – Fenella Wrigley to attend			
9.00	2.	**Patient Story** To hear an account of a patient experience		FW	Oral
9.10	3.	**Declarations of Interest** To request and record any notifications of declarations of interest in relation to today's agenda		RH	
	4.	**Minutes of the Part I meeting held on 29th January 2013** To approve the minutes of the meeting held on 29th January 2013	Approval	RH	TAB 1
9.15	5.	**Matters arising** To review the action schedule arising from previous meetings		RH	TAB 2
9.25	6.	**Report from Chairman** To receive a report from the Trust Chairman on key activities since the last meeting	Information	RH	TAB 3
QUALITY, GOVERNANCE AND RISK					
9.30	7.	**Integrated Board Performance Report** To receive the integrated board performance report	Information	PW/ AG	TAB 4 – To follow
9.40	8.	**Quality Report** 8.1 Quality Dashboard 8.2 Clinical Quality and Patient Safety Report	Assurance	FW	TAB 5
9.55	9.	**Quality Committee Assurance Report** To receive an assurance report from the Quality Committee meeting on 20th February 2013	Assurance	BM	TAB 6
10.00	10.	**Board Assurance Framework and Corporate Risk Register** To review the Board Assurance Framework for 2013/14 and the corporate risk register for quarter 4 - 2012/13	Assurance	SA	TAB 7
10.05	11.	**Finance Update** 11.1 Month 11 Finance Update 11.2 Finance and Investment Committee Assurance Report	Information Assurance	AG RH	TAB 8

10.10	12.	**Francis Report** To agree the recommendations in response to the Francis Report	Discussion	SA	TAB 9
10.20	13.	**Duty of Candour and Being Open Policy** To approve the Duty of Candour and Being Open Policy	Approval	SA	TAB 10
10.30	14.	**Staff engagement and communication** To receive a briefing on the project 'Listening into Action'	Information	AR	Oral
10.40	15.	**Membership Strategy** To approve the Membership Strategy	Approval	SA	TAB 11
10.50	16.	**Action plan from November 30th 2012** To note progress against the action plan	Information	JK	TAB 12
11.00	17.	**Proposal for the Handling of Low Acuity Calls** To approve the proposal for the handling of low acuity calls	Approval	FW	TAB 13
STRATEGIC AND BUSINESS PLANNING					
11.10	18.	**2013/14 Contract Position** To receive an update on the contract negotiations for 2013/14	Information	JK	Oral
11.20	19.	**2013/14 Budget and Operating Plan** 19.1 To approve the interim budget for 2013/14 19.2 To approve the interim operating plan for 2013/14	Approval	SA/ AG	Presentation
11.40	20.	**Board Governance Assurance Framework Refresh Review** To receive the report from KPMG on the outcome of the review	Discussion	SA	Presentation
BUSINESS ITEMS					
12.15	21.	**Report from Chief Executive Officer** To receive a report from the Chief Executive Officer	Information	AR	TAB 14
12.25	22.	**Report from Trust Secretary** To receive the report from the Trust Secretary on tenders received and the use of the Trust Seal	Information	SA	TAB 15
	23.	**Forward Planner** To receive the Trust Board forward planner	Information	SA	TAB 16
	24.	**Any other business**		RH	
	25.	**Questions from members of the public**		RH	
12.30	26.	**Date of next meeting** The next meeting of the Trust Board will take place on Tuesday 4th June 2013			

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING
Part I

DRAFT Minutes of the meeting held on Monday 29th January 2013 at 9:00 a.m.
in the Conference Room, 220 Waterloo Road, London SE1 8SD

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Present:	
Richard Hunt	Trust Chair
Ann Radmore	Chief Executive Officer
Jessica Cecil	Non-Executive Director
Roy Griffins	Non-Executive Director
Andrew Grimshaw	Interim Director of Finance
Caron Hitchen	Director of Workforce
Steve Lennox	Director of Health Promotion and Quality
Beryl Magrath	Non-Executive Director
Nick Martin	Non-Executive Director
Fionna Moore	Medical Director
In Attendance:	
Sandra Adams	Director of Corporate Services
Jane Chalmers	Transition Programme Director
Francesca Guy	Committee Secretary (minutes)
Jason Killens	Director of Service Delivery (North Thames)
Angie Patton	Head of Communications
Peter Suter	Director of Information Management and Technology
Paul Woodrow	Director of Service Delivery (South Thames)
Members of the Public:	
Malcolm Alexander	LAS Patients' Forum
Paul Davies	Cycle Response Unit Leader, LAS
Tony Ollis	
Fleur Nieboer	KPMG
David Stacey	KPMG

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01. Welcome and Apologies

01.1 Apologies had been received from Caroline Silver.

01.2 The Chair welcomed Ann Radmore and Andrew Grimshaw to their first Trust Board meeting at the LAS.

02. Patient Story

02.1 The Trust Board was joined by a patient who had not been treated directly by LAS but who had been in an emergency situation and had been aided by Metropolitan Police Officers. The Police Officers had used their radio link to contact the LAS control room and had been told that an ambulance was not immediately available. The story described the experience of being told that help was not available and highlighted the fact that the LAS had not spoken directly to the patient or to the doctor who was coincidentally on scene. The information had passed directly from the Metropolitan Police Service to LAS's Control Room and this had the potential to impact on the

triage of the patient.

02.2 The patient story demonstrated that the LAS was under significant pressure, to an extent that was not recognised by the wider healthcare system. The patient and the doctor on scene (who was present at the Trust Board) were certainly not aware that an ambulance was not always available at the time of making a call.

02.3 Jessica Cecil asked whether this posed a risk given that the Trust planned to move towards giving more clinical telephone advice. Steve responded that, in the case of the patient story, he did not think that the same risk existed for hear and treat as the Trust generally spoke directly with the patient. Beryl Magrath stated that she did not think that the commissioners were aware of the clinical risks associated with hear and treat.

02.4 The patient story also touched on the role of the police and their response to no ambulance being available. Ann Radmore commented that there had been significant focus in the last few months on improving the working relationship with the Metropolitan Police Service and there was commitment from both Chief Executive Officers to progress this.

03. Declarations of Interest

03.1 Ann Radmore reported that she was the Accountable Officer for NHS South West London until 31st March 2013.

03.2 Andrew Grimshaw reported that he was the Interim Director of Transformation for Brighton Hospital until 31st March 2013.

04. Minutes of the Part I meeting held on 27th November 2012

04.1 The minutes were approved subject to an amendment to paragraph 148.4.

05. Matters Arising

05.1 The following matters arising were discussed:

05.2 **67.3:** Fionna Moore reported that the EMS Medical Director from Florida had visited the service this week. Fionna was also due to attend the Eagles Summit in February 2013.

05.3 **135.1:** The Chair reported that he had developed a proposal for the Trust to award a commendation to a member of the public who had assisted the service. This proposal would be discussed at a future Strategy Review and Planning Committee meeting.

05.4 **139.2:** Steve Lennox reported that he had looked into meeting up with the crew staff involved with the November Trust Board's patient story, but it had been agreed that this would be inappropriate. Action closed.

05.5 **149.1:** The 2012 Post-Games Report was on the agenda for today's Trust Board meeting. Action complete.

06. Report from the Chairman

06.1 The Chair reported that he continued to meet with Northrop Grumman on a regular basis. All outstanding contractual issues between LAS and Northrop Grumman had been resolved.

06.2 The Chair had met with prospective candidates for the clinical non-executive director role. The plan

was to appoint an associate non-executive director in February 2013. The Chair also hoped to maintain input from Beryl Magrath.

06.3 The Chair had met with Healthskills to discuss Trust Board development. The Trust Board was holding a development day on 26th February 2013.

06.4 The Chair and Sandra Adams had met with the Chief Executive Officer at Moorfields Eye Hospital NHS Foundation Trust to discuss how Moorfields had established its commercial brand and how the LAS might want to consider developing its own. This was something that would be taken forward at a future Strategy Review and Planning Committee meeting.

06.5 The Chair had organised an Emergency Services meeting. It was planned that these would continue to meet three times a year.

07. <u>Quality Dashboard and Action Plan</u>

07.1 Steve Lennox reported that the format of the quality dashboard had been revised to reflect the quality domains used by the National Quality Board. The dashboard showed a very similar position to last month, demonstrating the tension between performance and quality. The comparison table showed that LAS was still in the upper quartile when compared with other ambulance services nationally, which demonstrated that other ambulance services were also struggling with the impact of high demand.

07.2 Sandra Adams noted that there were some indicators in the comparison table which had shown a deterioration (eg STEMI, stroke care, re-contact rates) and asked what action was being taken to address this. Steve Lennox responded that each of the operational areas had developed an action plan which was reported to the Clinical Quality, Safety and Effectiveness Committee.

07.2 Fionna added that the lower ranking for some of these indicators could be explained by the fact that the LAS followed the JRCALC guidelines for analgesia for STEMI patients. The guidance for analgesia was being revised and was close to being agreed nationally and this should therefore have an impact on the LAS's ranking in these areas.

07.3 Beryl Magrath asked whether the dashboard would continue to be RAG rated. Steve Lennox responded that the National Trust Development Agency wanted to see a greater emphasis on trends, rather than using RAG rating to monitor quality. The Quality dashboard would therefore be further revised to reflect this guidance.

07.4 Jessica Cecil asked whether the Trust Board should be concerned about the percentage of calls closed with Clinical Telephone Advice. Steve Lennox responded that the LAS had the second best re-contact rate for Clinical Telephone Advice, which was a good indicator of the quality of the response and of patient satisfaction. Fionna added that there had been a much greater focus on Clinical Telephone Advice and that staff were now better distributed and had better training. Clinical Telephone Advice also undertook a different role under the Demand Management Plan, which would also account for the low numbers of calls closed in November and December 2012.

07.5 Ann Radmore stated that it was important to differentiate between quality and safety. The Trust's priority was to deliver a safe service. Ann asked whether it would be possible to monitor the call close down rates for individuals in the control room. Jason Killens and Paul Woodrow agreed to take this forward.

ACTION: JK/PW to look into the possibility of monitoring call close down rates for individuals in the control room.

DATE OF COMPLETION: 26th March 2013

07.6 Caron Hitchen stated that there was a conflict between demand and resource and this was currently the second highest rated risk on the Trust's corporate risk register. The key action that had been taken to mitigate this risk was the ORH capacity review, which would be discussed further in the Part II meeting.

07.7 Steve Lennox noted that the full Quality report was presented to the Quality Committee and asked whether it would be helpful for the Trust Board to see the lowest and highest percentage scores for each of the indicators. The Trust Board agreed that this would be helpful. Roy Griffins commented that it would also be helpful to have a short comment on any red-rated indicators.

ACTION: SL to include the lowest and highest percentage scores for each of the indicators in the Quality Dashboard and to include a short comment on any red-rated indicators.

DATE OF COMPLETION: 26th March 2013

07.8 The Chair summarised the discussion by stating that the Trust was currently maintaining a safe service, but that the trend suggested that it would become increasingly difficult to be assured of this in the future. Consequently a heightened vigilance was required to ensure a satisfactory and safe service was maintained.

08. <u>Clinical Quality and Patient Safety Report</u>

08.1 Fionna Moore reported the following:

- The Trust achieved the highest ever CPI completion rate in November at 98%, despite being at REAP 4. The Mental Health CPI continued to have the lowest overall compliance rates;
- The number of entries on the Locality Alert Register had reduced, although the Trust continued to receive a number of alerts from the Metropolitan Police Service;
- Staff had been asked to only report missing equipment as an incident where it had had, or could have had, a clinical impact. Additional BM kits and pulse oximeters had been ordered as these were two items which were frequently reported as missing;
- The Demand Management Plan had been used extensively throughout November and December 2012;
- The Trust had operated a new way of working over the Christmas and New Year period to proactively manage anticipated increases in demand. Consideration would be given to implementing this more frequently going forward.

08.2 Caron Hitchen noted that the increase in the number of complaints received reflected the increase in demand. A number of these complaints related to delays and Caron asked whether the Trust expected to see an associated decrease in these complaints given that performance had improved. Steve responded that the majority of these complaints related to perceived delays and he therefore expected that these would continue. However, he anticipated that there would be a decrease in complaints about actual delays. Caron suggested that the increase in resource and its impact on patient experience should be monitored.

ACTION: JK/PW to monitor the increase in resourcing and its impact on patient experience.

DATE OF COMPLETION: 26th March 2013

08.3 Beryl Magrath noted that there had been a clinical audit of immediate inter-hospital transfers by the LAS and asked whether this was a service that the Trust would look to expand. Fionna Moore responded that inter-hospital transfers would be considered as a business opportunity.

08.4 The Chair asked Nick Martin, as a new Non-executive Director, for his opinion on the situation. Nick responded that the trend of increasing demand was concerning although it appeared that the additional winter funding was making a considerable difference.

08.5 Andrew Grimshaw commented that the additional funding had allowed the LAS to address some issues, but now needed to identify what residual issues remained. Ann Radmore agreed that the funding had made a considerable difference, but that this was a short-term resolution and was therefore limited. Resourcing did not match demand levels and this needed to be addressed in the commissioning negotiations for 2013/14.

08.6 Roy Griffins commented that the LAS should be involved in Sir Bruce Keogh's review of urgent and emergency care (see minute 15.4).

09. Quality Committee Assurance Report

09.1 Beryl Magrath stated that the report from the Quality Committee echoed much of what had been previously discussed. The Quality Committee was unable to assure the Trust Board that the LAS was providing a 100% quality service. The focus had been on providing a safe service, but at times this was also compromised, as had been previously discussed at today's meeting.

10. Integrated Board Performance Report

10.1 Ann Radmore reported that the Integrated Report demonstrated high levels of activity. The financial position reflected the decisions made by the Trust Board before Christmas. Additional funding of £6.2 million had been secured to support winter pressures and the delivery of the Category A target across the year.

10.2 The need to focus resource on patient facing duties had had an impact on training and development and sickness levels had also shown an increase. The Trust had seen an increase in both complaints and serious incidents in December, which were up 10% on the rolling yearly average.

10.3 Ann Radmore stated that a plan was in place to achieve the 75% Category A performance target for 2012/13 using the additional funding. Paul Woodrow stated that the hours produced would be reviewed on a weekly basis to understand whether there were any efficiencies that could be made to reduce spend.

10.4 Trust Board members found this report provided a useful overview of the organisation and Ann Radmore suggested that the format of the report was discussed, as part of a wider discussion about information provided to the Trust Board, at a future meeting.

11. Quarter 4 Performance

11.1 Paul Woodrow reported that this action plan brought together actions from the performance

sustainability plan and the actions associated with the additional winter funding. These actions aimed to target resource to higher acuity patients in order to manage demand better. There were also a number of actions which aimed to improve operational efficiency.

11.2 Paul explained that the LAS had set stretching internal trajectories for the rest of the financial year, which included two weeks of contingency in March to allow for a significant drop in performance as a result of bad weather. The Assistant Directors of Operations had been tasked with driving the action plan forward locally and had been asked to report on progress against the actions on a weekly basis.

11.3 Paul reported that the Trust's Category A performance had been above 80% for the last three weeks. There had been a decrease in utilisation of the Demand Management Plan and some modest reduction in operational utilisation.

11.4 Roy Griffins commented that it was important for Trust Board members to be collectively involved in the discussions on the settlement for 2013/14 before the contract was signed. Ann Radmore agreed that her expectation was that the signing of a major contract would be done with the understanding and approval of the Trust Board. The Chair commented that it might be necessary for the Trust Board to hold an additional meeting in February to accommodate this.

11.5 The Chair noted that quarter 3 had been an exceptionally demanding period and that this achievement should be recognised.

12. <u>Care Quality Commission Report and Action Plan</u>

12.1 Sandra Adams reported that the full CQC report following the unannounced inspection on 14th and 15th November 2012 had previously been circulated to the Trust Board. The CQC had reported two minor breaches in compliance for equipment (moderate) and staffing (minor) and an action plan had been submitted to the CQC to address both these issues. These two areas had also been aligned to risks already on the corporate risk register.

12.2 Sandra added that the Trust Board should also focus on the positive feedback from the CQC. The inspection had found that patients were largely satisfied with the care they had received and their experience overall.

12.3 The Patients' Forum had submitted a question about what steps the LAS had taken to address the shortfall in front line staff highlighted by the CQC in their report to the LAS in December 2012. Caron Hitchen responded that these actions were set out in the paper to the Trust Board. The Trust continued to progress its recruitment plan for 2012/13, which was on track to deliver a vacancy factor of under 2% by April 2013.

13. <u>2013/14 Business Plan Submission</u>

13.1 Sandra Adams explained that the National Trust Development Authority (NTDA) had published guidance for the preparation and submission of the 2013/14 business plans. The first cut of the business plan had been submitted to the NTDA on Friday 25th January 2013. Andrew Grimshaw stated that there needed to be an integrated approach to business plan development and it was likely that an additional Finance and Investment Committee meeting was required in February to discuss the key assumptions. Ann Radmore stated that the Trust Board needed to be able to articulate the vision of where the LAS would be in five years' time.

13.2 The Chair noted that the deadline for the final submission of the business plan was 5th April 2013.

13.3 In response to a question from Beryl Magrath, Sandra confirmed that the outcome of the ORH

capacity review would be incorporated into the business plan.

14. Clinical and Quality Strategy

14.1 Steve Lennox gave a presentation on the key elements of the Clinical and Quality Strategy.

14.2 Peter Suter asked how this strategy impacted on the Emergency Operations Centre and Patient Transport Services. Steve Lennox responded that the strategy was mainly informed by A&E services, but was applicable to the Emergency Operations Centre and Patient Transport Services. Fionna Moore added that there had been increased focus on developing EOC staff. The Chair suggested that this needed to be made more explicit in the strategy.

ACTION: FM/SL to include reference to EOC and PTS staff in the Clinical and Quality Strategy.

DATE OF COMPLETION: 26th March 2013

14.3 Ann Radmore asked whether the strategy would include gathering data on the different communities in London and their specific needs. Fionna Moore responded that some of this data already existed, particularly around different disease groups.

14.4 Ann Radmore commented that the clinical leadership at board level would also need to be considered and a proposal would be made to a future Remuneration Committee meeting.

14.5 Ann stated that the Trust should brief the Greater London Authority on the strategy, particularly given that the Health and Wellbeing Boards were a key stakeholder.

ACTION: FM/SL to brief the Greater London Authority on the key elements of the Clinical Quality Strategy.

DATE OF COMPLETION: 26th March 2013

14.6 The Trust Board approved the Clinical and Quality Strategy.

15. Report from Chief Executive Officer

15.1 Ann Radmore stated that this was her first report to the Trust Board and she welcomed any feedback on the content and format of the report.

15.2 Ann reported that on 18th January 2012 the service had responded to an incident in Vauxhall where a helicopter had crashed resulting in two fatalities. Ann had been very impressed by the way in which the service had responded, whilst maintaining its business as usual service.

15.3 Ann reported that the Executive Management Team (formerly the Senior Management group) had identified key priorities for the remainder of the financial year, which had been included in the report.

15.4 Ann stated that the National Commissioning Board had launched a review of urgent and emergency services. The Chair suggested that the LAS should write to Sir Bruce Keogh to ensure that it was involved with this review.

ACTION: FM/AR to write to Sir Bruce Keogh to ask the LAS to be involved with the review of urgent and emergency services.

DATE OF COMPLETION: 26th March 2013

15.5 The Patients' Forum asked whether the LAS had received any assurances from the Trust Special Administrator about measures to alleviate the pressure on the LAS and King's College Hospital emergency department in relation to heart, stroke and trauma patients if Lewisham A&E was closed. Fionna Moore responded that patients who had suffered a STEMI would be transported directly to the cardiology department at King's College Hospital and would therefore bypass the emergency department. There were two hyper acute stroke units in the area and assurance had been received that there was sufficient capacity in the stroke units across the whole of London. King's College Hospital had recently enlarged the emergency department and had already increased its resuscitation room by 100% in the last year. The plans for implementing improvements to emergency services at all the remaining provider sites were included in the final report from the TSA.

15.6 The Patients' Forum asked whether the LAS had concerns about its ability to care for people with acute mental health problems were Lewisham A&E to close and considerable additional pressures put on King's A&E. Steve Lennox responded that there was a move away from transporting mental health patients to emergency departments and instead transporting the patient to a preferred mental health provider.

15.7 Nick Martin asked what the impact would be of the other reconfiguration changes in London. Ann Radmore responded that the LAS had been involved in the discussions for North East London, and proposals had also been put forward for North West London. The National Commissioning Board had a role to keep an overview of the reconfigurations across London and to understand how these would interplay and the LAS needed to make it clear that it would require additional resource.

15.8 The Patients' Forum asked whether, in the event of the Trust Special Administrator proposal being introduced, the divert protocol was robust enough and what the additional timings were expected to be. Paul Woodrow responded that the Secretary of State was yet to make a decision about whether the Trust Special Administrator proposal would be introduced but the service needed to ensure that safety and quality were at the forefront of any changes. The service would also need to understand what additional resources it would need to maintain a level of safety and quality.

16. 2012 Olympic Games End Report

16.1 Jason Killens gave a presentation on service delivery over the 2012 Olympic Games and the key legacy benefits. The full 2012 Post-Games Report was available on request.

16.2 The Chair acknowledged that the focus on business as usual service delivery, alongside Olympics operations had worked well and should be considered for future large scale events on a standard LAS way of working.

17. Foundation Trust Project

17.1 Sandra Adams reported that the Trust was on schedule against the milestones agreed in the accountability agreement and the Tripartite Formal Agreement. The Trust would however continue to be rated red until the contract for 2013/14 had been agreed.

17.2 There were a number of milestones to be achieved over the next three months including 2013/14

contracts and business planning, board governance assurance framework review, quality governance review and the first stage of the historical due diligence review.

17.3 The Chair requested that the timeline was presented to the Trust Board at each meeting.

> **ACTION:** SA to present the Foundation Trust timeline to the Trust Board at each meeting.
>
> **DATE OF COMPLETION:** 26th March 2013

17.4 Angie Patton asked whether the Trust would be required to undertake a formal consultation as part of the Foundation Trust application. Sandra responded that the guidance indicated that the Trust could undertake a refresh of the consultation, but this would need to be agreed with stakeholders.

17.5 The Chair stated that the Foundation Trust application should be seen as a priority.

18. Finance and Investment Committee Report

18.1 The Chair reported that the Finance and Investment Committee had last met on 15th January 2012. At this meeting, concerns had been raised about the quality of the papers and the information presented to the committee. It was suggested that the Chair discuss this with Ann Radmore, Andrew Grimshaw and Nick Martin outside of the meeting.

> **ACTION:** RH/AR/AG/NM to review the way in which the Finance and Investment Committee operated and the information presented to the Committee.
>
> **DATE OF COMPLETION:** 26th March 2013

18.2 The Chair also stated that the chairmanship of this committee also needed to be reviewed.

19. Update on Information Governance

19.1 The Trust Board noted the update on information governance. Peter Suter explained that the LAS had a tripartite arrangement in place for the management of information governance with Fionna Moore as the Caldicott Guardian, Sandra Adams overseeing all aspects of governance and compliance and Peter as the Senior Information Risk Owner.

19.2 Jason Killens asked what plans were in place to maintain training compliance. Peter responded that there was a drive to ensure that all staff updated their training on a rolling 12 month cycle.

19.3 Beryl Magrath commented that the Trust had historically always struggled to obtain outcome data from hospitals and asked whether there was any way this could be overcome in the future. Fionna Moore responded that the Trust had a data sharing agreement with Imperial hospital and would look to set up more of these agreements with other acute trusts.

20. Report from Trust Secretary

20.1 The Trust Board noted the Report from the Trust Secretary.

21. Forward Planner

21.1 The Trust Board noted the forward planner.

22. Any other business

22.1 The Chair commented that a number of Trust Board members had been testing out using iPads for the board papers and that this had worked well.

23. Questions from members of the Public

23.1 The Patients' Forum asked whether the LAS was satisfied with the progress of the Directory of Service development as a means of providing alternative care pathways. Jason Killens responded that access to the Directory of Service was subject to regular review. The Trust was also looking to supplement information on the Directory of Service with patient notes.

23.2 The Patients' Forum asked, in relation to problems with hand over times at Dartford (Darent Valley) Hospital, when LAS would be able to introduce the double button push system. Jason Killens responded that Darent Valley was a hospital that, whilst outside of the LAS operational area, was used by LAS ambulance crews to receive patients. The hospital alert system was currently being enhanced to better reflect handover and trolley clear times. The LAS was working jointly with commissioners to enhance the system and better reflect the current operating arrangements in our contract for next year.

24. Date of next meeting

24.1 The next Trust Board meeting will take place on Tuesday 26th March 2013.

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Signed by the Chair

ACTIONS

from the Meeting of the Trust Board held on 29th January 2013

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
28/06/11	**67.3**	RH to discuss world cities benchmarking with FM.	**RH/FM**	FM to attend Eagles summit in February 2013.
26/06/12	**74.12**	RH/SA to discuss how to build in staff presentations into the Trust Board forward planner.	**RH/SA**	To be explored as part of a wider programme of staff engagement, linking to Board development.
25/09/12	**131.3**	MD to write an explanation on the roles of the two LAS charities.	**AG**	Outstanding. Action to be taken forward by AG.
25/09/12	**135.1**	Trust Chair to develop a proposal for the Trust to award a commendation to a member of the public who had assisted the service.	**RH**	RH to discuss with AR.
26/03/13	**07.5**	JK/PW to look into the possibility of monitoring call close down rates for individuals in the control room.	**JK/PW**	Update to be given at the Trust Board on 29th January 2013
26/03/13	**08.2**	JK/PW to monitor the increase in resourcing and its impact on patient experience.	**JK/PW**	Update to be given at the Trust Board on 29th January 2013
26/03/13	**14.2**	FM/SL to include reference to EOC and PTS staff in the Clinical and Quality Strategy.	**FM/SL**	The Clinical and Quality Strategy is currently being revised and updated.
26/03/13	**14.5**	FM/SL to brief the Greater London Authority on the key elements of the Clinical Quality Strategy.	**FM/SL**	Updated strategy to be incorporated into the Integrated Business Plan.
26/03/13	**15.4**	FM/AR to write to Sir Bruce Keogh to ask the LAS to be involved with the review of urgent and emergency services.	**FM/AR**	FM has written to Professor Keith Willett, Chair of Domain 3 (Urgent and Emergency Care) within the NHS Commissioning Board, offering to assist with the review. No response has been received as yet.

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
26/03/13	**17.3**	SA to present the Foundation Trust timeline to the Trust Board at each meeting.	**SA**	SA to provide an oral update at the meeting on 29th January 2013

CLOSED ACTIONS

29/05/12	**46.3**	LB to publish patient story in the GP newsletter.	**LB**	Action complete.
21/08/12	**102.7**	SL to review attendance at the Safeguarding Committee.	**SL**	Attendance was reviewed at the Safeguarding Committee meeting on 4th October and a revised membership was agreed. Action complete.
25/09/12	**126.7**	MF to put forward a proposal to the Risk, Compliance and Assurance Group to consider an additional risk for Category C patients.	**PW**	Risk agreed by Chair of RCAG. Action complete.
27/11/12	**139.2**	SL to follow up with the crew involved in the Patient's story and to provide an update at the next Trust Board meeting on what action had been taken.	**SL**	Steve Lennox reported that he had looked into meeting up with the crew staff involved with the November Trust Board's patient story, but it had been agreed that this would be inappropriate. Action closed.
27/11/12	**149.1**	FG to add the 2012 Olympic Post-Games Report to the Trust Board forward planner for January.	**FG**	On the agenda for the meeting on 29th January 2013. Action complete.
26/03/13	**07.7**	SL to include the lowest and highest percentage scores for each of the indicators in the Quality Dashboard and to include a short comment on any red-rated indicators.	**SL**	Action complete.
26/03/13	**18.1**	RH/AR/AG/NM to review the way in which the Finance and Investment Committee operated and the information presented to the Committee.	**RH/AR/AG/NM**	Action complete.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH MARCH 2013

PAPER FOR INFORMATION

Document Title:	**Chairman's report**
Report Author(s):	**Richard Hunt, Trust Chair**
Lead Director:	**N/A**
Contact Details:	**marilyn.cameron@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**For information**
This paper has been previously presented to:	**N/A**
Recommendation for the Trust Board:	**To provide the Trust Board with an update on key activities since the last meeting.**

Key issues and risks arising from this paper

Executive Summary

Since the last Trust Board, I have attended an Ambulance Service Network board meeting on 5th February; a meeting with the outgoing Chair of NHS London, Dr Mike Spyer; and a meeting with KPMG to discuss the refresh of the Board Governance Assurance Framework review. I also attended the Aspiring Senior Leaders Programme meeting on 13th February.

Since January, there have been two Finance and Investment Committee meetings and a fuller update on the key items of discussion at these meetings will be provided at the Trust Board meeting. The Strategy Review and Planning Committee held an away day on 26th February at Guy's Hospital. During the period, I also undertook six non-executive director appraisals and was on the panel for the Director of Finance interviews.

I had a full shift ride out from New Malden ambulance station on 5th March.

Finally, I attended the Chairs meeting and AACE Chairs/CEOs meeting in Kenilworth on 20th March.

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:

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26 MARCH 2013

PAPER FOR INFORMATION

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

The Trust Board has been having discussions regarding quality for the last few months and the internal dashboard suggests that some of these concerns remain but the winter funding has allowed is to make some improvements. However, when comparing us to other services and when using the DH indicators as a measure we are the second top performing Ambulance Trusts in the country.

Executive Summary

There are three components to the Quality Dashboard & Action Plan

1. **Quality Dashboard**

The dashboard illustrates the Trusts performance for January 2013 against the identified Quality Measures. The challenge and discussion for each indicator has been undertaken at SMG.

The dashboard illustrates 34 measures for quality and reveals 12 Green measures 5 Amber measures and 17 Red measures.

The Trust Board requested a short commentary regarding RED indicators.

Outcome From Cardiac Arrest
These two indicators have decreased slightly on the last month but there are currently no clinical concerns as the low volume of patients means that variation is expected. The monthly figure is close to the compliance level.

On Scene Time
The three time critical conditions (cardiac, trauma and stroke) all have various elements of the pathway measured. This is included in the dashboard to monitor the effects of pressure on the entire patient pathway. On scene times are currently at 40 minutes with a target of 30 minutes. There is little change and no increase.

STEMI Care
This is Red due to the issues we have previously raised regarding analgesia. No new clinical concerns.

Not conveyed See & Treat
We aim to treat approximately 32% of patients through See and Treat. The figure of 29% was slightly below the expected level but is not a clinical concern.

Diabetes & Alcohol
The RAG rating reflects the CQUIN work. We made less referrals than expected for alcohol and diabetes alternative care pathways.

Airway Management
The indicators are in the main as expected but the RAG status reflects compliance with one indicator and that is regarding the recording of End Tidal C02 at the time of intubation. This is being addressed by the areas and was discussed at CQSEC on 20 March.

Lost Property
Lost property is again red. We had 64 cases of lost property. Property bags are available for staff to use but the use is not consistent. Again this is being addressed by the areas but progress is slow.

Mental Health
Mental Health care is improving and our sectioned patients now receive a better service but the RED rating is regarding the evidence that safeguarding issues have been considered. The Clinical Advisor for Mental health is working with the Safeguarding team to raise awareness.

Cat C Response Times
We are underperforming with category C and this is addressed in other Board reports

Handover Time
The dashboard reports the time it takes us to receive a handover. Only 77% of patients were seen within 15 minutes. This is a national issue that is being addressed by national influencers.

Supervision & Training
Staff are not currently receiving the level of OWR that has been set. There were 76 OWR sessions in January compared to a target of 200. Similalrly the training commitments were not delivered in January but this has been previously discussed at trust Board.

3rd Party Providers and Sickness
We have set a compliance level of 8% of the work to be provided by 3rd party and the month of January this was 8.1%, just over the level. No significant clinical issues. Sickness was also just above the compliance level of 5.5% at 5.8%

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. For example A8 is broken into Red 1 and Red 2.

This month the Trust is at the very top in 9 of the indicators.

The following table illustrates the number of top performing measures each Ambulance Trust has in the 48 information points (not all comparisons are drawn from statistically significant data therefore, this is merely a discussion point).

Isle of Wight 10 (20.8%)
London 9 (18.7%)
South Central 6 (12.5%)
Yorkshire 5 (10.4%)
West Midlands 5 (8.3%)
East of England 5 (8.3%)
Great Western 3 (6.2%%)
East Midlands 2 (4.1%)
South Western 2 (4.1%)
South East Coast 2 (4.1%)
North West 1 (2%)
North East 0 (0%)

3. Quality Action Plan

The action plans have now been devolved to a local level. Each area now has a quality action plan and progress is monitored at CQSEC

Attachments

1. Quality dashboard
2. DH Quality Measures (Comparison)

****

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

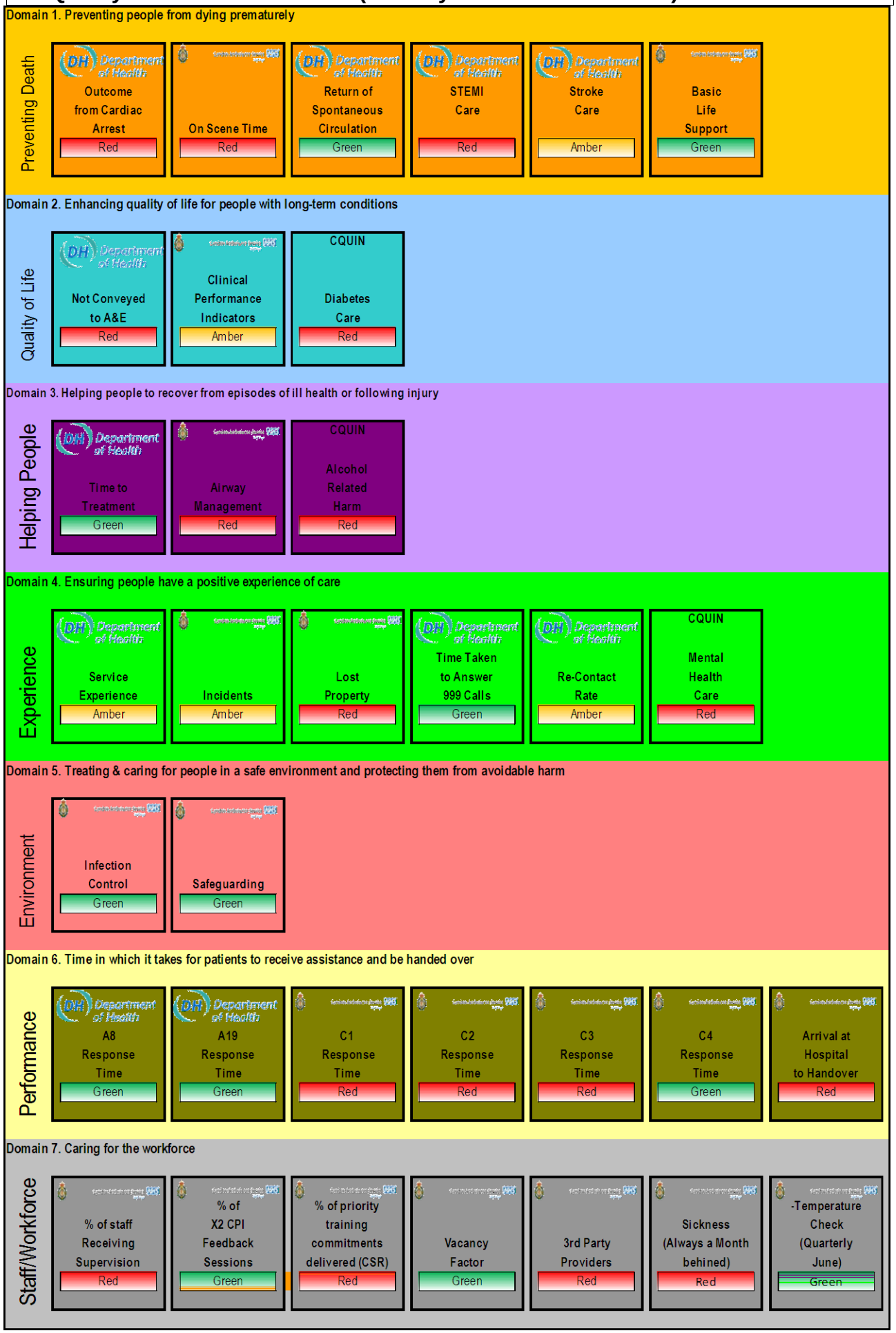
Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

- ☐ Yes
- ✓ No

Key issues from the assessment:

1. Quality Dashboard for March (January & October Measures) 2013



2. Comparison Table

2.1 The following table identifies the Department of Health Indicators and our ranking against other Ambulance Trusts and our direction of travel. Our lowest and highest compliance scores have been added at the Trust board's request.

2.2 The GREEN shading represents where the Trust is in the upper quartile when compared to other services. In May we were upper quartile in 20 (last month 18) out of 42 areas (A8 not yet reported by DH).

	March (January Data)					YTD	
	Compliance	Rank	Lowest	Highest	Direction of Travel	Compliance	Rank
A8 R1 Response Time	79.10%	2	71.70%	81.60%	↑	76.80%	4
A8 R2 Response Time	79.40%	1	67.10%	81.50%	↑	75.30%	8
A19 Response Time	98.50%	1	96.70%	99.00%	↑	98.00%	1
ROSC (all)	31.90%	2	27.30%	36.40%	↑	30.60%	2
ROSC (Utstein)	59.20%	2	45.70%	63.60%	↑	54.10%	4
Time Taken to Answer 50th Percentile	0.00%	1	0.00%	0.00%	↔	0.00%	1
Time Taken to Answer 95th Percentile	0.03%	1	29.00%	0.01%	↑	0.08%	3
Time Taken to Answer 99th Percentile	1.14%	9	1.46%	0.02%	↓	1.01%	7
Time to Treatment 50th Percentile	5.36%	3	6.11%	5.36%	↑	5.53%	7
Time to Treatment 95th Percentile	13.30%	1	16.90%	12.70%	↑	14.28%	2
Time to Treatment 99th Percentile	22.20%	2	19.40%	27.30%	↑	23.02%	3
Outcome from cardiac Arrest Survival	6.30%	8	6.30%	11.40%	↓	8.50%	3
Outcome from cardiac Arrest Survival (Utstein)	16.30%	9	16.30%	37.00%	↓	27.40%	4
STEMI Outcome 150 minutes	90.20%	5	84.30%	94.90%	↓	91.30%	4
STEMI Outcome Care Bundle	65.20%	12	63.10%	69.20%	↑	67.80%	12
Stroke Outcome 60 minutes	66.50%	5	66.00%	75.80%	↓	69.50%	4
Stroke Care Outcome Bundle	92.10%	11	92.10%	95.70%	↓	94.40%	10
Calls Closed with CTA	6.70%	6	5.30%	6.90%	↓	5.80%	8
Non A&E	29.00%	9	29.40%	33.30%	↓	31.70%	9
Re Contact rate CTA	2.60%	2	3.40%	2.20%	↑	3.00%	2
Re Contact rate See & Treat	5.30%	3	5.90%	4.90%	↑	5.30%	6
Re Contact rate Frequent callers	2.38%	4	2.35%	2.61%	↓	2.53%	5
999 Calls Abandoned	0.20%	1	0.20%	0.10%	↑	0.13%	1
Service Experience							

3. Conclusions

3.1 This dashboard has seen an improvement in compliance. This was expected as the funding for winter pressures will have made a difference on our ability to improve the quality of service provided.

3.2 There are no new issues revealed within the dashboard but some of the clinical measures remain just below the trajectory we have set although again we do reasonably well when drawing comparisons with other services. In conclusion the dashboard suggests that all ambulance services have found some challenge in delivering a high quality service within the context of increased demand across winter.

4. Updated Scorecard

4.1 The scorecard has been radically refocused and a more in-depth scorecard is now presented to the Quality committee that contains some of the graphs that were included within the accompanying report (which is no longer produced). What the new format accentuates is the number of patients that lie beneath a target and in particular the number of patients that didn't receive the standard of care. For example, in January the Trust hit the 75% target for category red 2 but underneath the compliance is the figure that 7,625 patients did not receive the standard. This is now explicit within the new scorecard. An example is attached in the following pages for information.

4.2 It is proposed to maintain the in-depth analysis of the scorecard at the Quality Committee and therefore present the full scorecard to that committee and for the Trust Board to continue with the RAG rated scorecard.

Domain 1. Preventing People from Dying Prematurely

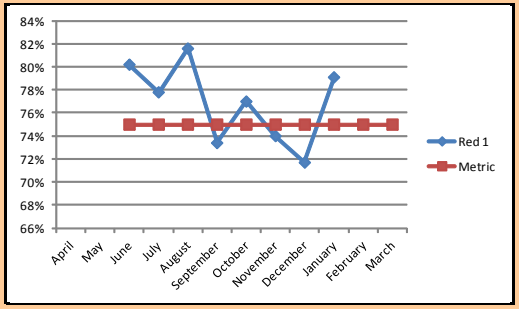
Category A8 (Red 1) Response Time

RAG	METRICS	COMPLIANCE	MISSED	RANK	COMMENTARY
Green	75% of patients to be responded to within 8 minutes	79.10%	267	2	The declining position has been recovered in the month of January.

BEST 81.60%

WORST 71.70%

TREND CHART



COMPARISON

		Numerator	Incidents	%
East Midlands	67.2	1,248	1,858	67.2
East of England	72.8	791	1,086	72.8
Great Western	75.7	530	700	75.7
Isle of Wight	76.9	10	13	76.9
London	79.1	1,009	1,276	79.1
North East	74.2	241	325	74.2
North West	73.1	2,123	2,906	73.1
South Central	78.1	532	681	78.1
South East Coast	73.7	383	520	73.7
South Western	75.9	262	345	75.9
West Midlands	81.2	526	648	81.2
Yorkshire	70.2	1,120	1,596	70.2
Overall for period	**Higher is better**	8,775	**11,954**	**73.4**

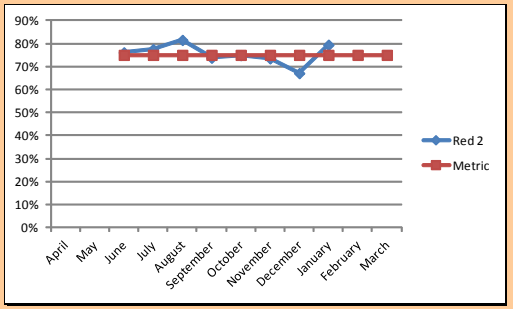
Category A8 (Red 2) Response Time

RAG	METRICS	COMPLIANCE	MISSED	RANK	COMMENTARY
Green	75% of patients to be responded to within 8 minutes	79.40%	7,626	1	The declining position has been recovered in the month of January. However, even though the percentage is a good percentage 7,626 patients did not receive a response within 8 minutes.

BEST 81.50%

WORST 67.10%

TREND CHART



COMPARISON

		Numerator	Incidents	%
East Midlands	72.9	12,580	17,245	72.9
East of England	71.7	14,990	20,892	71.7
Great Western	75.0	6,909	9,208	75.0
Isle of Wight	76.3	442	579	76.3
London	79.4	29,405	37,015	79.4
North East	75.1	10,320	13,738	75.1
North West	76.0	23,579	31,039	76.0
South Central	76.6	7,137	9,316	76.6
South East Coast	73.4	16,147	22,004	73.4
South Western	76.5	9,748	12,738	76.5
West Midlands	77.1	22,436	29,091	77.1
Yorkshire	73.8	15,820	21,442	73.8
Overall for period	**Higher is better**	169,513	**224,307**	**75.6**

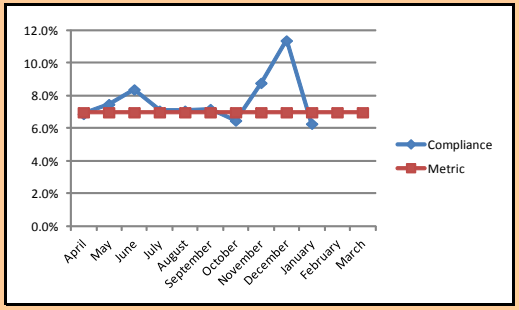
Outcome from Cardiac Arrest (Survival to Discharge - All cases)

RAG	METRICS	COMPLIANCE	MISSED	RANK	COMMENTARY
Red	Green maintaining 7% Amber drop of 0.01%-1% Red drop of 1%	6.30% 21	312	8	

BEST 11.40%

WORST 6.30%

TREND CHART



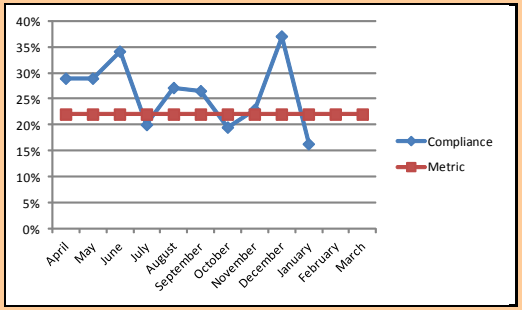
COMPARISON

		Numerator	Incidents	%
East Midlands	7.8	18	232	7.8
East of England	6.3	16	252	6.3
Great Western	12.3	14	114	12.3
Isle of Wight		0	8	0.0
London	6.3	21	333	6.3
North East	4.8	7	146	4.8
North West	7.5	24	319	7.5
South Central	12.8	11	86	12.8
South East Coast		1	137	0.7
South Western	8.5	16	188	8.5
West Midlands	8.3	19	228	8.3
Yorkshire	9.0	20	223	9.0
Overall for period	**Higher is better**	167	**2,266**	**7.4**

Outcome from Cardiac Arrest (Survival to Discharge - Utstein)

RAG	METRICS	COMPLIANCE	MISSED	RANK
Red	Green 22% Amber 20.1-21.9% Red <20%	16.30% 7	36	9 BEST 37.00% WORST 16.30%

TREND CHART



COMPARISON

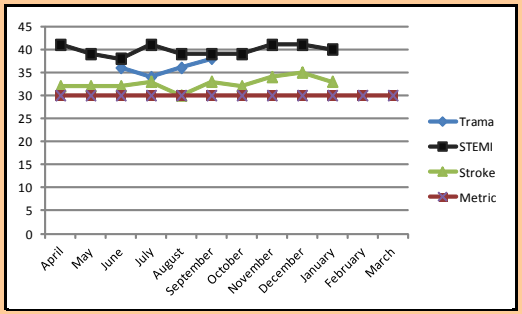
		Numerator	Incidents	%
East Midlands	10.0	4	40	10.0
East of England	26.5	9	34	26.5
Great Western	27.8	5	18	27.8
Isle of Wight		0	1	0.0
London	16.3	7	43	16.3
North East	28.6	4	14	28.6
North West	18.2	6	33	18.2
South Central	25.0	2	8	25.0
South East Coast		0	14	0.0
South Western	31.0	9	29	31.0
West Midlands	32.0	8	25	32.0
Yorkshire	31.3	10	32	31.3
Overall for period	Higher is better	64	291	22.0

COMMENTARY

On Scene Time

RAG	METRICS	COMPLIANCE	MISSED	RANK
Red	Within 30 minutes for all time critical patients (Cardiac, Trauma & Stroke)	Trauma 40 min STEMI 33 min Stroke	Trauma STEMI 244 Stroke	BEST WORST

TREND CHART



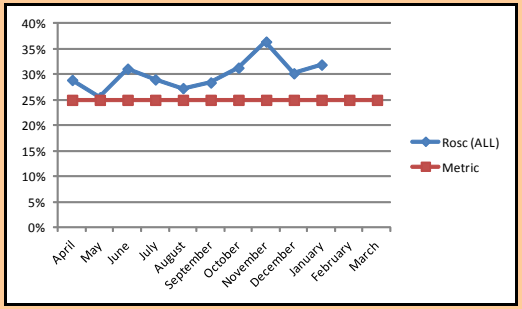
COMMENTARY

On scene time is above 30 minutes for all time critical patients. In terms of stroke there were 574 patients eligible for thrombolysis in january. For 244 we remained on scene for over 30 minutes. Friern Barnet and Chase Farm appear to take the longest time from call to hospital arrival (over 70 minutes)

Return of Spontaneous Circulation - All Cases

RAG	METRICS	COMPLIANCE	MISSED	RANK
Green	All Cases Green >25% Amber 15.1%-24.9.9% Red <15 %	31.90%	237	2 BEST 36.4 WORST 27.3

TREND CHART



COMPARISON

		Numerator	Incidents	%
East Midlands	48.8	21	43	48.8
East of England	50.0	18	36	50.0
Great Western	55.6	10	18	55.6
Isle of Wight		0	1	0.0
London	59.2	29	49	59.2
North East	43.8	7	16	43.8
North West	50.0	22	44	50.0
South Central	62.5	5	8	62.5
South East Coast	31.3	5	16	31.3
South Western	40.0	12	30	40.0
West Midlands	48.0	12	25	48.0
Yorkshire	39.4	13	33	39.4
Overall for period	Higher is better	154	319	48.3

COMMENTARY

Above trajectory

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH MARCH 2013

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 ☐ Executive Management Team ☐ 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 EMT, Quality Committee, and CQSEC
Recommendation for the Trust Board:	**For information**

Key issues and risks arising from this paper

- CPI completion rates remain the highest the Trust has ever seen. Compliance to aspects of care also remains high, apart from the Mental health CPI
- The Mental Health CPI continues to be the lowest achieving CPI and the Directorate will work together with the Mental Health Lead for the Trust to devise a strategy to improve this.
- Continued decrease in the number of entries on the Locality Alert Register. However, addresses from the Metropolitan Police Service remain high.
- One reportable Controlled Drugs incident involving the loss of morphine which has been investigated.
- A rule 43 has been received by the Trust, regarding our delayed attendance to a patient who had taken an overdose.
- Increasing number of complaints about ambulance delays, received by PED.

Executive Summary

The report is structured around the quality domains of the quality dashboard but also reports on issues wider than the quality measures. This report identifies areas of improvement required as well as successes. The Trust Board can take limited assurances that the service is maintaining a high quality service to its patients due to increasing demand, utilisation and the concern that should this continue, the introduction of the new National Clinical Guidelines and other training will have to be delayed.

Attachments

Clinical Quality and Patient Safety Report
Appendix 1: London Ambulance Service Target Inspections (Controlled Drugs)

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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
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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
☐ 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 – March 2013

Clinical Directors' Joint Report

Summary

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

This report identifies both successes and areas for improvement. The Trust Board can take limited assurances that the service is maintaining a high quality service to its patients. There is real concern over the high utilisation rate and increasing call numbers seen by the Trust in recent months. There is also concern that if this continues, there will be delays in introducing the new National Clinical Guidelines and other training and implementation planned over the following months.

Quality Domains

Quality Domain 1: Preventing People from Dying Prematurely

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

The most recent Cardiac Care Pack (Monthly Cardiac Arrest and ST-Elevation Myocardial Infarction Report January 2013) has been published. The full report can be found at:

Clinical Audit & Research Unit\Cardiac Reports\Cardiac Care Pack - Monthly Reports\April '12- March '13\Cardiac Care Pack (January'13).pdf

The most recent Stroke Care Pack (monthly report January 2013) has been published. The full report can be found at:

Clinical Audit & Research Unit\Stroke Reports\April '12-Mar '13\Stroke Care Pack (January '2013).pdf

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

Mental Health

The Mental Health action plan is being refreshed to focus attention on some key areas. For example, suicide prevention is a national priority and consideration is being given as to how the ambulance service can assist with this objective.

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

Clinical Performance Indicator completion and compliance

For the third month running, the Trust has achieved the highest ever CPI completion rate (99%), and remains above the 95% target. This was achieved despite an increased demand on the service. The mental health CPI still continues to have the lowest overall compliance, having remained the same this month as last month and having dropped since Decembers report. This remains an area of concern. The Clinical and Quality Directorate recognise that the Mental health CPI has had a below average compliance continually since it began. To attempt to rectify this, the Directorate will work together with the Mental Health Lead for the Trust and devise a strategy to improve the care we provide to this group of patients. The Trust has provided a high level of care to at least 95% of non-conveyed patients since the start of the financial year.

Full CPI reports can be accessed at:

X:\Clinical Audit & Research Unit\Clinical Performance Indicators (CPIs)\Monthly Team Leader CPI reports\2012-13\Monthly Reports 2012-13

CPI completion April 2012 to January 2013

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

CPI Compliance January 2013

	Cardiac Arrest	Glycaemic Emergencies	ACS (Including MI)	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	97%	98%	97%	98%	92%	98%	97%
South	97%	98%	97%	97%	86%	96%	98%
West	97%	97%	96%	98%	90%	97%	98%
LAS Total	**97%**	**98%**	**96%**	**97%**	**88%**	**96%**	**97%**

CPI Compliance December 2012

	Cardiac Arrest	Difficulty in Breathing	ACS (Including MI)	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	98%	95%	96%	98%	85%	97%	97%
South	98%	96%	97%	98%	89%	97%	98%
West	98%	95%	96%	98%	91%	97%	98%
LAS Total	**98%**	**95%**	**96%**	**97%**	**88%**	**97%**	**97%**

CPI Compliance November 2012

	Cardiac Arrest	Glycaemic Emergencies	ACS (Including MI)	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	97%	97%	96%	97%	89%	97%	97%
South	97%	98%	97%	98%	91%	97%	98%
West	98%	98%	97%	98%	89%	97%	98%
LAS Total	**97%**	**98%**	**97%**	**98%**	**89%**	**97%**	**98%**

Cardiac Care

Code STEMI:
A 25 minute film about cardiac care and the London Ambulance Service has been produced and is being released at EMS Today 2013, a major US EMS conference in Washington DC. It went live on Thursday 7th March. It will be uploaded onto both the LAS website and the Pulse.

High Risk ACS:
This initiative is now live pan London as of 4th March. It has been positively received and used so far. The London Ambulance Service is the first service in the world to have this pathway in place. This pathway sees approximately 12 patients per week at present, 3-4 from each area.

Emergency Arrhythmia Centres:
The procedure for patients presenting with certain Cardiac Arrhythmias is now live north of the river Thames. It is going well so far, despite some initial communication issues within EOC, which have now been addressed. Again, the London Ambulance Service is the first service in the world to have this pathway in place.

Para SVT:
This continues to go well and is on target. 69 patients have now been recruited and the research and trial should be completed within the next 12 months.

Clinical Tutor / Training Officer Updates

Following two team leader updates during February, two further updates aimed at clinical tutors and training officers have been agreed. These will run on the 3rd and 10th of April at Fulham Education Centre.

The updates will cover the following topics:

- Obstetrics Update
- New trauma triage tool update
- New JRCALC Guidelines update
- Overview of the use of PGDs
- A chance to discuss clinical issues with the Medical Directorate
- New equipment update
- Airway management update
- New drugs update (IV Paracetamol, Ondansetron, Dexamethasone, Tranexamic Acid)
- ALS and Cardiac care update

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

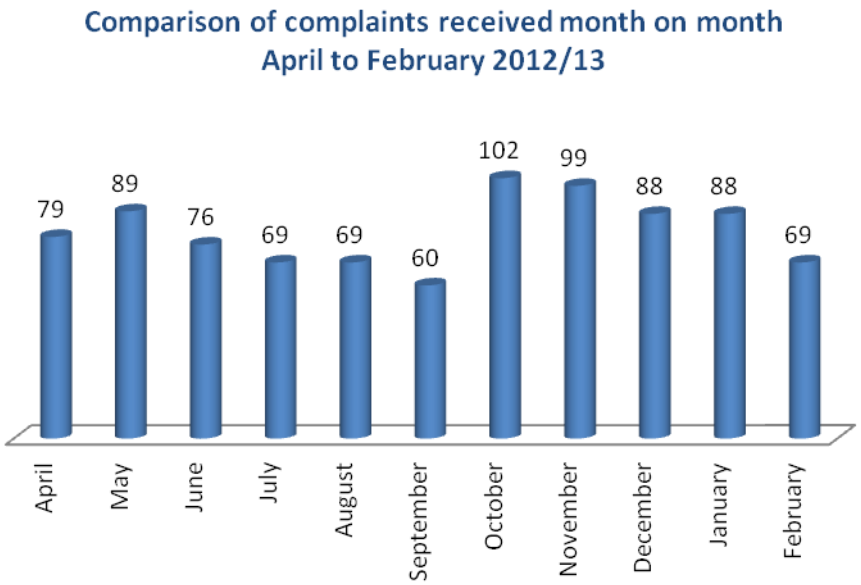
Patient Experiences

The volume of complaints fell in February, although the volume of complaints about delay and staff attitude and behaviour continue at a similar level. The major factor in achieving optimum turnaround is the delay in receiving a QA report, currently up to 8 weeks, and delays in receiving input from local complexes. This is having a significant impact within the team.

As a new development, this and future reports will include the volume of 'comebacks' (where a complainant is dissatisfied with the initial response) an area of work that tends to be labour intensive.

February 2013

There were 69 complaints in February 2013. The following graph illustrates the month on month numbers



The themes for February are identified in the following table.

Complaints by Subject (primary)	Total
Delay	29
Attitude and behaviour	16
Treatment	9
Road handling	7
Non-conveyance	4
Conveyance	2
High Risk Address Referral	1
Patient Injury or Damage to Property	1
Totals:	**69**

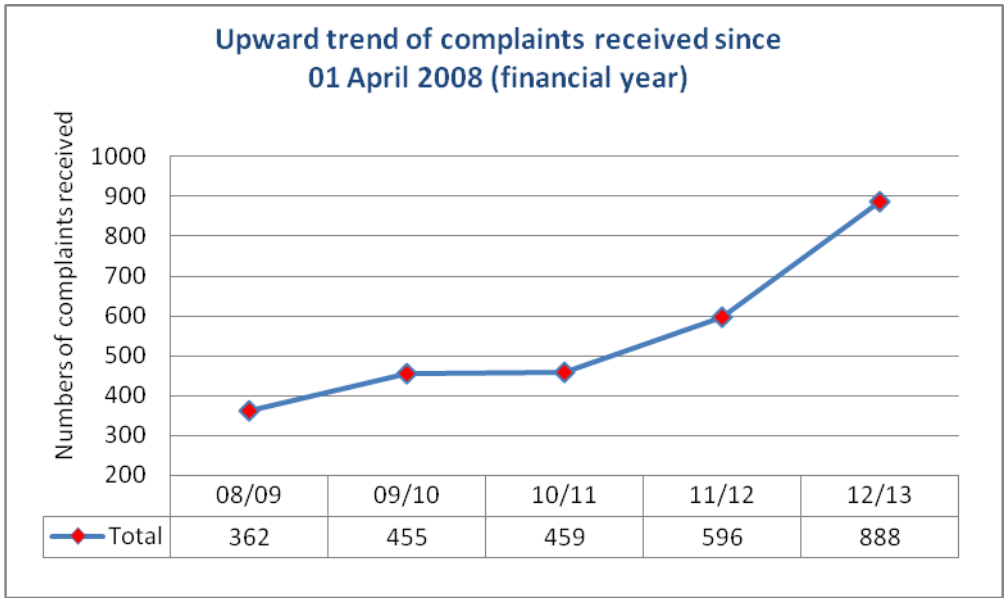
EOC and the South area received the most complaints during the month of February.

Designated origin area of complaint	Totals
EOC	29
South	15
West Area	9
Unknown (driving complaint usually)	5
Not Our Service	4
PTS	2
East	2
Contracted Services	2
Voluntary Service (St John)	1
Total	**69**

Whilst the number of complaints is showing a gradual decline since December the overall year end position will be considerably higher than previous years. Delay appears to be the main reason for the increase.

Year on Year

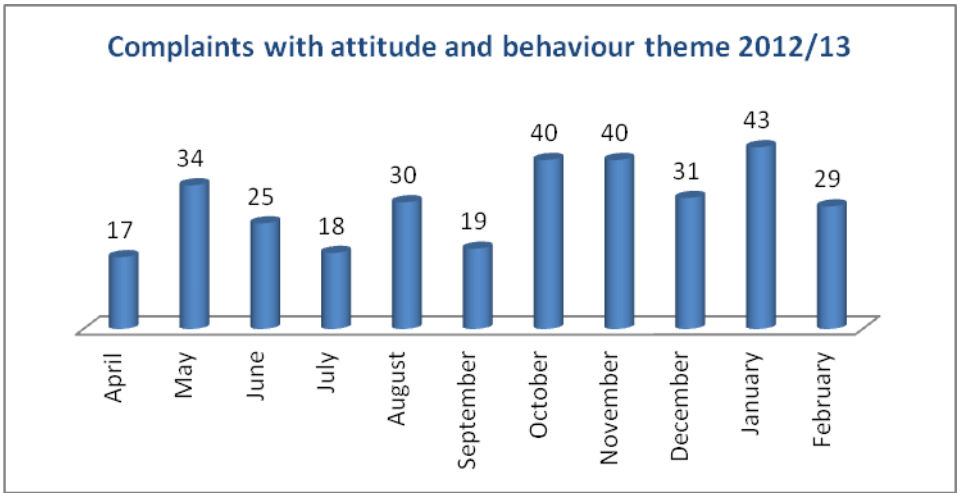
Total complaints between 2008 to 2013 financial year to date:



One of the consistent themes has been attitude and behaviour and the 236 complaints regarding staff attitude and behaviour can be sub divided into the following themes.

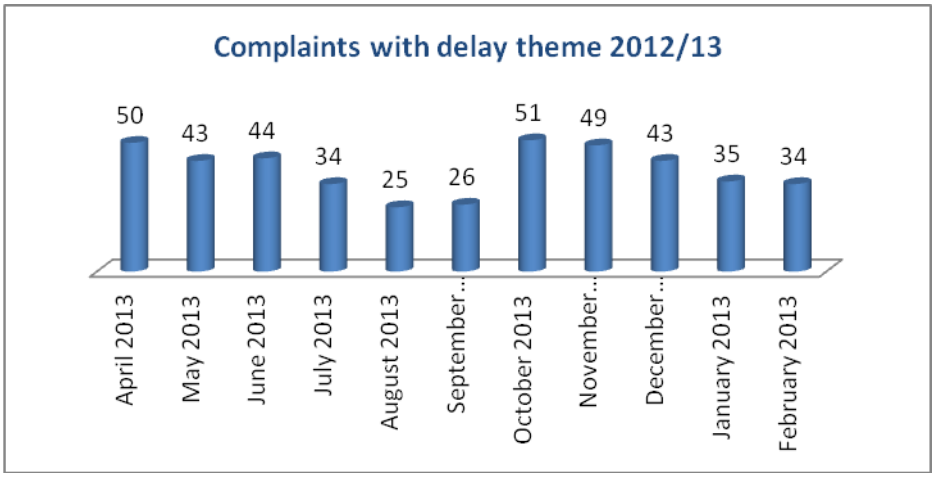
Attitude and behaviour complaints - sub subject 2012/13	
Attitude	143
Lack of compassion	116
Behaviour	114
Inappropriate comments	92
Not listening to family's wishes	64
Rudeness (patient)	63
Poor communication	24
Rudeness (HCP)	6
Total sub subject of 236 complaints in this category	**622**

The Learning from Experience Group has now identified this as one of the committees four objectives and the new action plan is being developed with the Assistant Directors of Operations. The following graph shows the month on month number of complaints regarding attitude and behaviour.



Delay remains the most frequent cause for a complaint. Again the Learning fr0om Experience Group is exploring ways to reduce the level of dissatisfaction associated with a delay but will, at the present time, be unable to improve the actual waiting times this is fundamental to our modernisation agenda.

Of those complaints where delay is a component, the following reflects the REAP level and DMP contingencies at the time:



Come back

We do receive a small number of secondary or follow up letters where complainants have felt dissatisfied with the response. This is not a large number but the team will now monitor this as a measure of quality. This is particularly important at present due to the challenges on the resources in the team.

The following table illustrates the themes within the comeback letters.

Complaints where a 'comeback' has been received (since April 2008)	**2008/2013**	**2012/2013**
Attitude and Behaviour	27	7

Delay	17	6
Treatment	16	3
Non-conveyance	10	3
Conveyance	3	3
Clinical Incident	1	0
High Risk Address Referral	1	1
Not our service	1	0
Patient Injury or Damage to Property	1	1
Road handling	1	0
Totals:	**78**	**24**

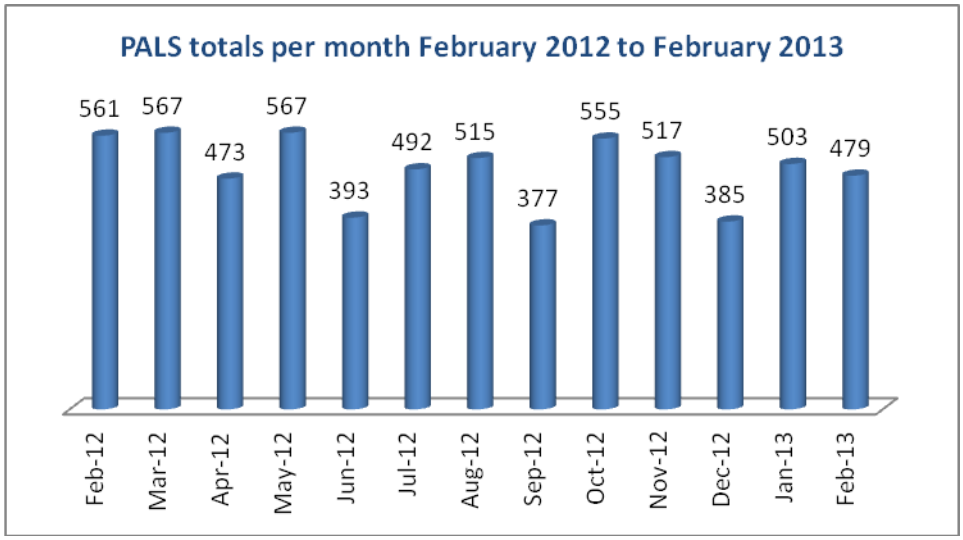
Case examples where a comeback letter has been received in 2012/13:

Datix	Complaint summary	Outcome	Comeback outcome
7186	A complaint was received from the son of a patient who died after an ambulance was delayed following an entry on the LIR. The son was no longer a resident at the location and the 'flag' was in respect of his behaviour - the family were unaware of this entry.	Explanation provided Complainant seeking compensation	Relative offered compensation of £1000 which has been accepted
7481	Complaint from family seeking clarification why an ambulance was not sent	Explanation provided but further clarity sought	Further explanation of call management during times of extreme pressure provided and further information regarding the management of patients with Novo Virus.
7396	Complaint from Care Home regarding the attitude of the attending staff	Explanation provided but concerns raised about partnership working arrangements in the future	Invitation offered to the Care Home Manager to consider attending a local resolution meeting with the involvement of CQC

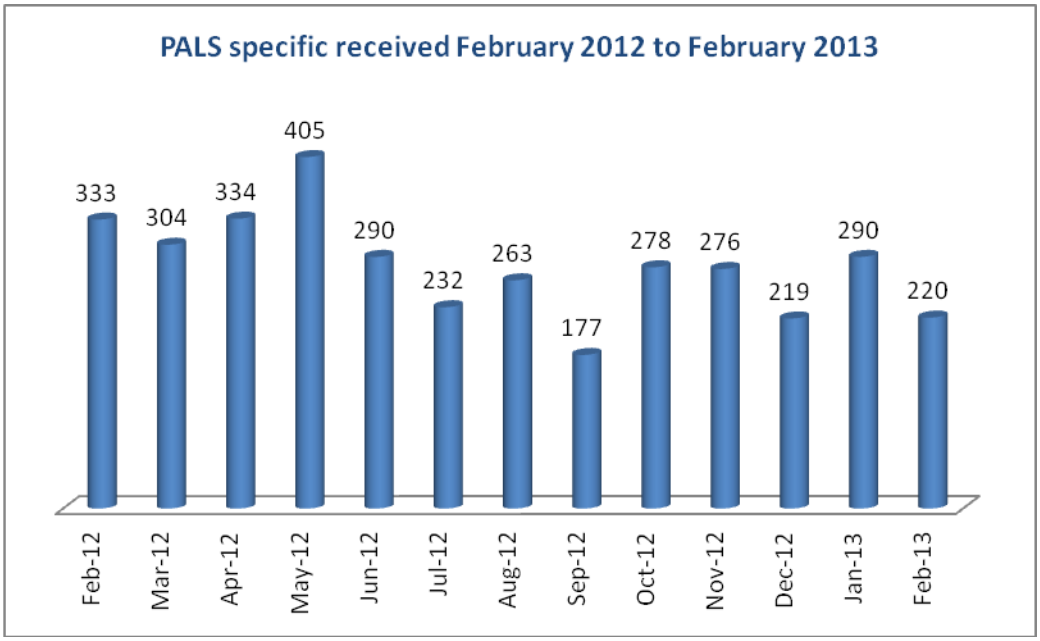
PALS

The familiar themes about destination hospitals and patient tracking are evident.

Total PALS enquiries February 2012 to February 2013



Total PALS analysis



PALS by Subject (primary)	total
Information/Enquiries	143
Medical Records	141
Safeguarding Children (final recording)	64

Lost Property	62
Safeguarding Adults	29
Frequent Callers	22
Appreciation	5
Other	4
Clinical	3
Request for Witness Statement	3
Incident Report - Other	2
Road Traffic Collision/RTC	1
Total	**479**

Lost property

There were 62 lost property enquiries in January, 50 being referred to local stations in line with the new process. 13 have recorded outcomes. Where contracted agencies are involved, these continue to be managed by PED. There were 5 such cases this month and liaison has been established with the providers involved.

12 cases were either traced by PED Duty staff or the enquirer referred to another agency, or no further contact received post voicemail.

February data

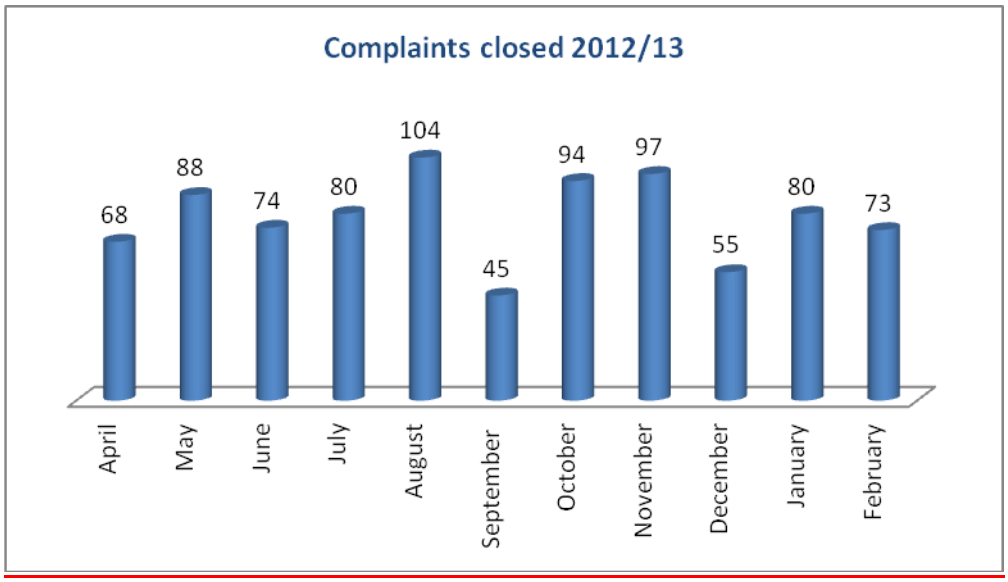
Lost property enquiries by area	**Total**
West	20
South	17
East	13
Contracted Services	5
Unknown or No Trace	5
LAS Headquarters	2
Totals:	**62**

Performance

Department managers are monitoring case completion and review those cases reaching the 35 day deadline, also covering leave, sickness etc. Closure rates are being maintained.
Closure rates:

Response time allocated December to February 2013	No. of complaints opened this period	Closed within time frame
Complaint 25 days	12	12
Complaint 35 days	229	87
Complaint 40 days	3	1
Complaint 45 Days (SI)	1	0
Totals	**275**	**100**

A true reflection of response times cannot be calculated until the furthest timescale (i.e. 35 days have elapsed) = 25 March 2013. The following table reflects the actual numbers of complaints closed by the department in each month in 2012/13.



Currently, as at 7 March 2013 there are 173 'open' complaints of which 3 are in respect of 'comebacks'.
We continue to work closely with Control Services governance team to resolve the delay in QA. A proposal is being put together for a dedicated QA officer to be made available to PED

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

Safeguarding

The Trust has been working in partnership with Hammersmith Safeguarding Adults Board and has undertaken a gap analysis of the Winterbourne Review. This will be presented at the next Quality committee.

NHS Central Alerting System (CAS)

There have been 6 Central Alerting System reports released since the last Clinical, Quality and Patient Safety Report. All of these have been acknowledged but none have any relevance to the Trust.

Locality Alert Register

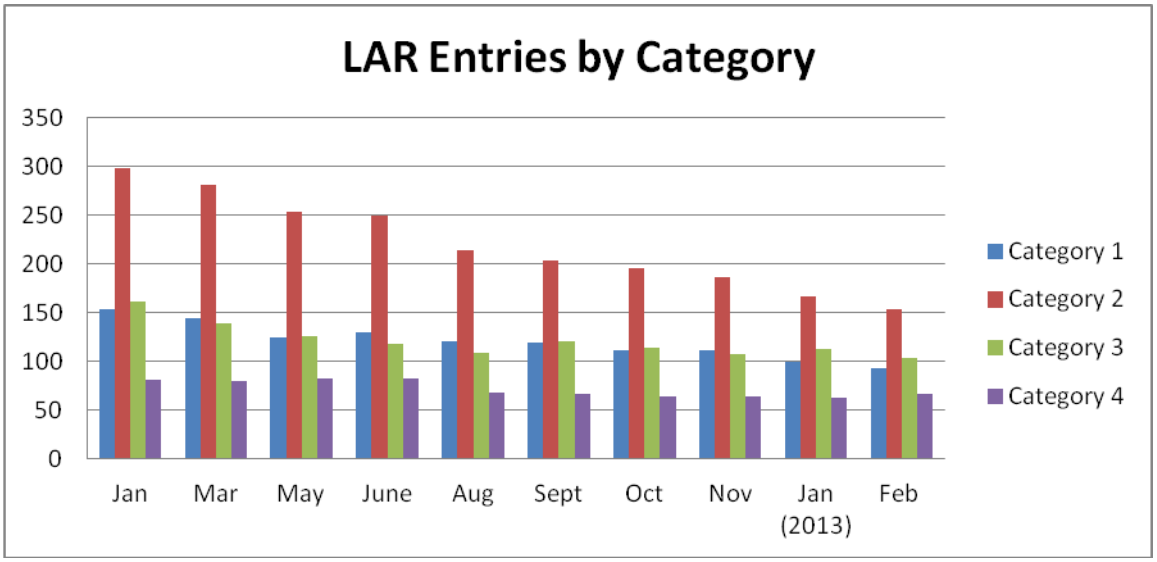
There are currently 417 LAS addresses on the system. They are broken down as follows:

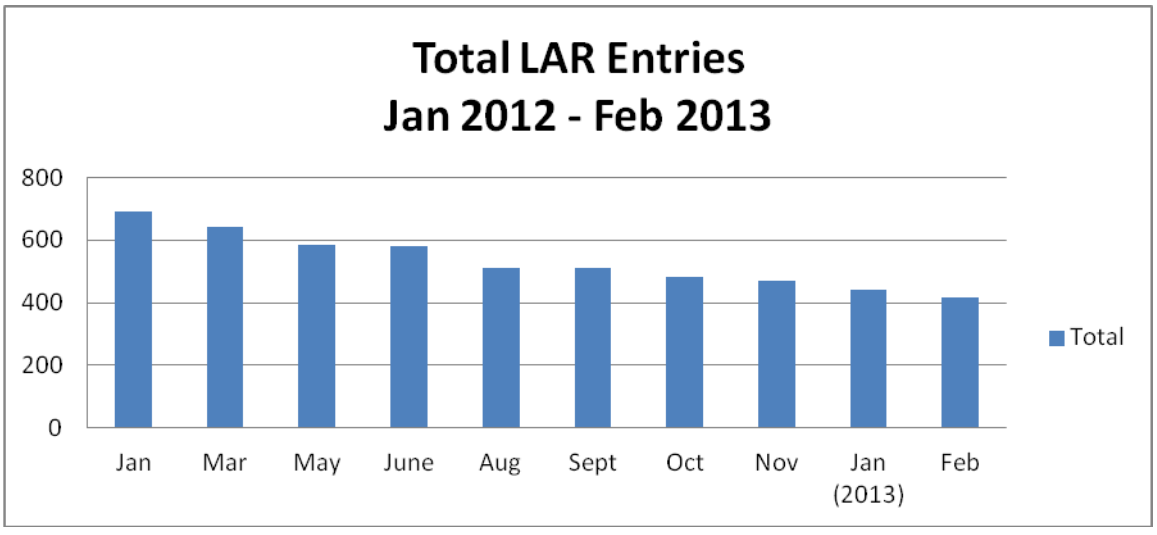
CATEGORY 1: **93**

CAT EGORY 2: **154**

CATEGORY 3: **103**

CATEGORY 4: **67**





The Trust has notification of 970 high risk addresses from the Metropolitan Police. Crews are reminded to complete a dynamic risk assessment on their arrival to the address. The number of addresses received from the Metropolitan Police has risen considerably since January 2013.

We are working in collaboration with the Metropolitan Police to try and improve the information that they provide when making referrals. This should help the Trust in making a decision on each individual referral.

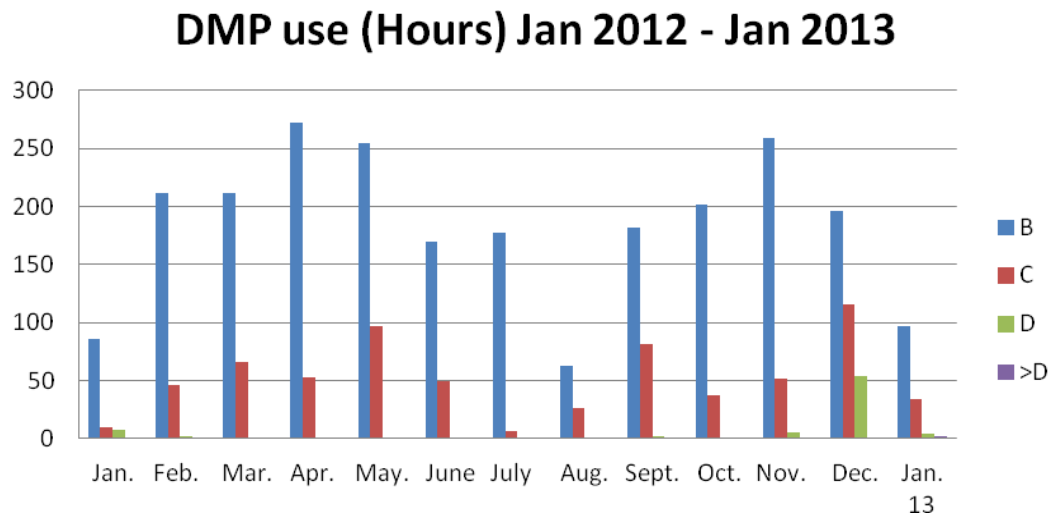
Demand Management Plan

The purpose of DMP is to provide the Trust with structured risk mitigating options to respond to demand at times when it exceeds the capacity of the service to provide a timely response. It provides a framework in which Control Services are able to respond to periods of high pressure, due to unforeseen demands, poor resourcing or on occasion where capacity does not exist to absorb unexpected patient demand.
DMP enables the LAS to prioritise higher MPDS category calls, to ensure those patients with the most serious conditions or in greatest need continue to receive a response. Escalating stages of DMP (A-H) decreases the response to lower call categories. The risk is mitigated by increased clinical involvement in the Control Room, with clinical 'floor walkers' available to assist call handlers, and by ringing calls back to provide advice, to re-triage and on occasion to negotiate alternative means of transport or follow up. It is also mitigated by regular senior clinical and operational review as the plan is escalated. There is a significant level of clinical risk related to the stage of the DMP invoked.

DMP use during December 2012 and January 2013

Month	Number of Occasions	Stage B (in hours)	Stage C (in hours)	Stage D (in hours)	Stage >D (in hours)	Ambulances reprioritised	No-send at point of contact
December	24	195.25	116	54.25	0	3463	2470
January	12	97.25	34.5	4	2.5	1527	435

January saw the longest continuous period at DMP over the past 12 months, at a total of 40 hours, 30 minutes. At the time of writing, there was no DMP report available for the February period.

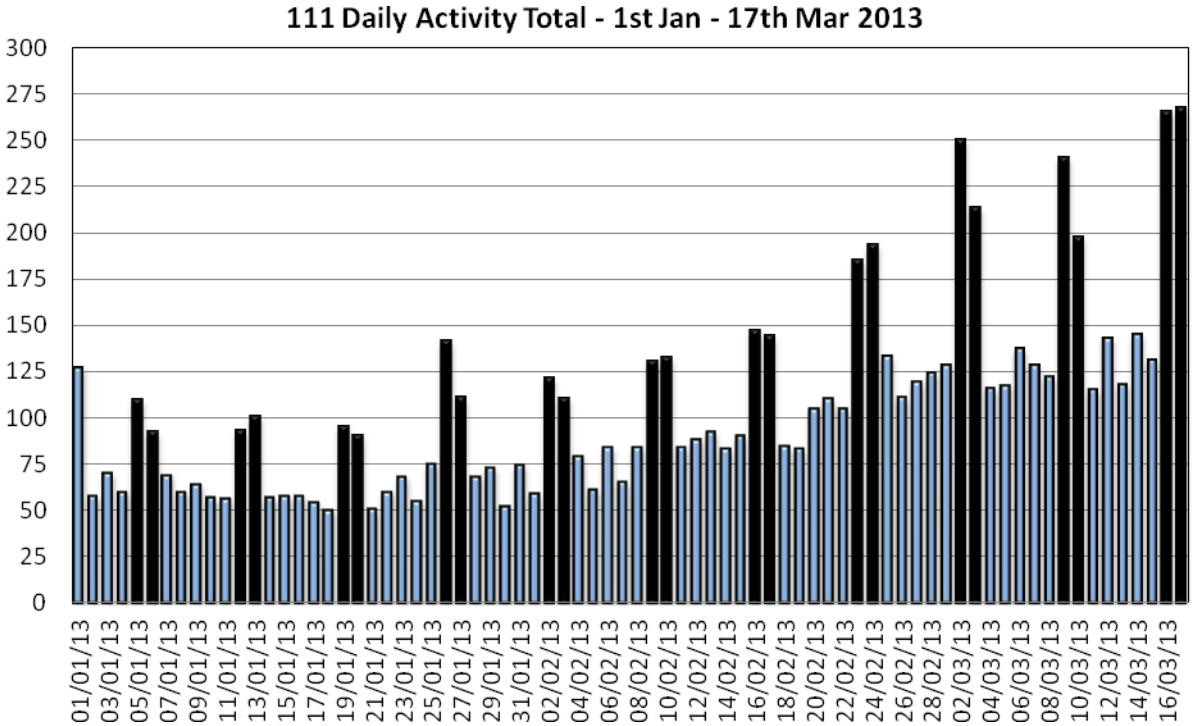


Winter Pressure Working

Due to ongoing high demand and as part of the management for Winter Pressures during Q4, the decision was made to use the arrangements for management of low category calls which had been used over Christmas / New Year and during the Adverse Weather in January. The arrangements were invoked from 07:00 on 8th February 2013. Since then calls with a C4 priority after an MPDS triage were advised on alternative pathways for further assessment and advice. Based on 2 years experience of DMP usage, several patient categories are excluded including extremes of age, patient's with PSPs, referrals from 111 / NHSD / HCP's, and patients in public gaze. All the calls where patients are advised to self refer to alternative pathways are passed to CTA where a CTA advisor reviews the information available from the log before closing down the call from the LAS system. Any call where there is a clinical concern receives a call back from an LAS clinician. These arrangements have resulted in a reduction in delays for Category C patients and supported the pan-London Q4 focus on referring patients to alternative care pathways. The pan-London 111 governance group and the Commissioner's have endorsed the arrangements as it directs the patients at point of contact to the 111 assessment service. To date the number of complaints and incidents related to these arrangements appears to be lower than when calls were being held for prolonged periods although it may be too early to draw definite conclusions.

111 System Implementation

The graph below shows the call volume received from 111 by day of week – the increase in calls at the weekend is being shared at the pan-London 111 governance group and will continue to be monitored by LAS.



Serious Incidents

For the period January/February:

13 incidents were referred to the Serious Incident Group, three of which were declared with NHS London.

1. A patient who had been behaving irrationally since the birth of her child needed restraining in order to safeguard the child and ensure that the patient did not injure herself whilst being conveyed. Two days later, the patient went into cardiac arrest and died. STEIS 2013-1438
2. The Trust identified an emerging theme of failure of Suction Unit components, with one incident resulting in death. A themed Root Cause Analysis is being performed. STEIS 2013-2990
3. A delay in attending a patient who suffered an allergic reaction to eating sweets on Halloween. STEIS 2013-4408

As at the end of February 2013, there were 9 Serious Incident investigation reports outstanding.

Medicines Management

There has been one reportable controlled drugs incident since the last report to EMT. This incident involved the loss of one ampoule of morphine sulphate. The details of the loss were reported immediately to all the correct authorities and the LAS Policy was complied with. The paramedic advised on the details surrounding the loss, and the ampoule was never found. The investigation is satisfied that this was a genuine loss and that whilst the member of staff accepts the loss is his fault, it is felt that this was a mistake and was dealt with as such. The incident, and all subsequent actions, will be reported to the INWL LIN Group in the Quarter 4 report to be submitted on 1st April 2013.

There was an unannounced visit by the Metropolitan Police to three stations, (Camden, New Addington and Romford), on 12th February 2013. The report from this visit was very favourable and there were no immediate actions that the Metropolitan Police required us to undertake. The visit highlighted that a lot of progress has been made by Complex management teams in the area of Controlled Drugs management. The internal report and subsequent action plan from the visit are attached as appendices.

The next meeting of the Medicines Management Group will be held on 27th March 2013.

There is one area that the Chair of MMG would like to draw the attention of the EMT to upon which he took Chair's Action:

In late February we were informed that Aurum Pharmaceuticals who supply our pharmacy with pre filled atropine syringes, were unable to guarantee supplies beyond March of 2013. The LAS has therefore decided to switch supplier to Hamelin for ampoules of atropine. There is a cost saving to the LAS as a consequence of this, and no clinical risk although it does mean that staff will be handling more ampoules.

Rule 43 Reports

Since the last Clinical Quality and Patient Safety Report, the Trust has received one rule 43 recommendation. This surrounds a patient who called 999 having taken an overdose. There was a delay in sending an ambulance, and various telephone calls to the location resulted in the phone not being answered. The call was held in a queue and was not upgraded despite there being no contact with the patient for some time. A further 999 call was later received to the same address for a house fire. The patient was found deceased at the location.

The Coroner recommended the LAS reconsider the policy of what should happen when an ambulance is not available to be despatched for a C2 call. In the case of YF the Coroner said that it was known an overdose had been taken (albeit not how many tablets had been taken) and questioned if it would have been a reasonable assumption to make that the patient had become unconscious and require the categorisation of the call to be reviewed.

The Coroner drew attention to the underlying issue about the adequacy of response where a patient has taken an overdose and the insufficiency of vehicles and crews to respond within a reasonable time frame. The Coroner said that the local population continues to be at risk of a repetition of the events pertaining to the inquest touching the death of YF.

The timescale for responding to the Rule 43 Report is 56 days

Quality Priorities

The Director of Health promotion & Quality has started to draft the Quality Account. The Quality priorities for 2013 will be driven by the modernisation agenda. He is due to meet with commissioners to discuss the Quality Account and the themes to be identified.

Rising Tide

Public Health

Nothing to report

Clinical Professional Issues

Nothing to report

Fionna Moore
Medical Director

Steve Lennox
Director of Quality & Health Promotion

Appendix 1

London Ambulance Service Target Inspections Tuesday 12th February 2013

Area Inspected	Ambulance Station A	Ambulance Station B (Satellite)	Ambulance Station C
Authority Signatures **Form LA227**	The form was unavailable as it was being updated to include new staff. The relevance of the form was fully appreciated by the AOM and was regularly referred to.	Form is located at Main Station and was not available for inspection at XXXX sub Station	The form was unavailable as it was being updated to include new staff. The relevance of the form was fully appreciated by the AOM and was regularly referred to.
CD Cabinet	The cabinet was locked and of the correct type. The cabinet was found to be bolted and secured to a solid wall using approved rag bolts. The drugs and register inside were in good order	The cabinet was locked and of the correct type. The cabinet was found to be bolted and secured to a solid wall using approved rag bolts. The drugs and register inside were in good order	The cabinet was found locked & was the correct type. The cabinet was bolted & secured to a concrete wall. The drugs & register inside were in good order.
CD Order Book	The book, when in the station was stored securely. On the day of our visit the book was out with the stores pending a delivery of morphine	Form is located at Main Station and was not available for inspection at XXXX sub Station	The book was locked away in the main office for which the AOM did not have access.
CD Register	The register was stored in the safe, the entries were readable. Each entry appeared correctly completed. The stock and register balanced. 99% of the entries were witnessed None of the entries for a delivery appeared excessive. There were minor admin errors BUT they had been found during the supervision of the register and dealt with	The register was stored in the safe, the entries were readable. Each entry appeared correctly completed All entries were witnessed The stock and register balanced. None of the entries for a delivery appeared excessive The register was well completed in accordance with current policy	The register was kept in the safe, entries all readable. Each entry appeared correctly completed. A few entries had not been witnessed & the AOM confirmed these were mainly single crewed vehicles. Advised to keep an eye on this to avoid complacency. The stock & register balanced. None of the entries for a delivery seemed excessive (the delivery is made to XXXXX but then some stock taken to YYYYY & ZZZZZ stations.) Delivery is by one

	accordingly The Daily Check Book was 98% completed. Days were missed and the form showed a blank entry. Blank entries was discussed and it was agreed that they should be recognized by management and not left blank i.e initial the blank entry at a later date or an explanation as to why the check was not made.		of the crews which could cause concern. AOM advised to monitor this. There had been some discrepancies & admin errors but these had all been reported and resolved fairly promptly by managers. The Daily Check Book was 98% completed. Days were missed and the form showed a blank entry. Blank entries were discussed and it was agreed that they should be recognized by management and not left blank i.e initial the blank entry at a later date or an explanation as to why the check was not made.
PRF CD Completion	All PRF that record usage of morphine are set aside for the PMF to be supervised. The importance and relevance of this was recognised	The PRF were not available as they are stored at XXXXX Entries in the register concerning usage were correctly completed and the importance of recording the usage was recognised by staff	All PMF that record usage of morphine are set aside for the PMF to be supervised. The importance and relevance of this was recognised
Recorded Disposal of CD	Disposal of any residue was discussed and dealt with in a proper manner, tipped into blue tissue and then put into the clinical waste. A record of this would be made on the PMF	Officers were fully aware of the current SOP regarding disposing of morphine waste into a tissue and disposing of it in the clinical waste bin. The fact that Morphine is wasted in this way is duly documented on the correct form	Disposal of any residue was discussed and dealt with in a proper manner, tipped into blue tissue and then put into the clinical waste. A record of this would be made on the PRF
CD Entry Code Changes	The combination of the CD safe and date of change was stored in the safe as per policy. No concerns regarding the safe code security.	The combination code is changed every 3 months and recorded on a log sheet that is kept secure within the CD cabinet. A clear and visible notice is displayed on the outside of the cabinet notifying staff of the change date. If officers are off duty at the time of the	The combination of the CD safe and date of change was stored on the inside of the CD cabinet door as per policy. The AOM said that the change date is sometimes delayed but he would now insist this was priority. No concerns regarding the

		combination code change officers are reminded to contact either Dave Whitmore of their DSO.	safe code security.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH MARCH 2013

PAPER FOR ASSURANCE

Document Title:	**Chairman's summary of the Quality Committee meeting 20th February 2013**
Report Author(s):	**Beryl Magrath, Non-Executive Director**
Lead Director:	**N/A**
Contact Details:	
Why is this coming to the Trust Board?	**Board sub-committee report**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To provide an update to the Trust board on the key issues and risks that were identified at the Quality Committee meeting on 20th February 2013**
Key issues and risks arising from this paper The problems relating to high utilisation with limited capacity to respond and the impact this had on release of staff for education, training, operational workforce reviews and personal development reviews remained. The quality of patient care, particularly for Cat C patients remained a concern.	
Executive Summary	
Attachments Report from the Quality Committee meeting on 20th February 2013	

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Quality Strategy

This paper supports the following domains of the quality strategy

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

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

Equality Analysis

Has an Equality Analysis been carried out?

☐ Yes
☒ No

Key issues from the assessment:

Report from the QC following the meeting held on 20th February 2013

Overview

The overall feeling at this meeting was that of change with the ORH full recommendations still to be finalised. A new format Quality Dashboard was presented, which members agreed had the prospect of providing much more detail on all areas and included trends, LAS best & worst performance and contemporary data; it was "a work in progress". Also apparent was that the CIP programme needed a major review and that clinicians needed to be closely involved in all projects to ensure that the quality of care and patient safety were not compromised.
The problems relating to high utilisation with limited capacity to respond and the impact this had on release of staff for education, training, operational workforce reviews and personal development reviews remained. The quality of patient care, particularly for Cat C patients remained a concern.

Quality Indicators

All the indicators in the new format report were reviewed individually. Of concern was that the 8 minute Cat A response times were being missed; the on scene time for critically ill patients was still longer than desirable, with pain relief and documentation of the FAST test noted as issues; time to defibrillation for patients in cardiac arrest had risen from < 12 minutes to 14; complaints (top-delay); Cat C response times were too long and supervision & training were limited with REAP 4

The Quality Committee received assurance from :

1. A presentation on the work of the Clinical Hub, which has evolved from the Clinical Support desk, originally set up in 2008, and now incorporates CTA and EBS and is a key project in the LAS modernisation programme. It supports not only front line staff, but also EOC supporting call takers to manage calls in a different way.
2. CQSEC- reports from groups showed progress however there was a lack of assurance on Safeguarding training.
3. The STEMI and Stroke Annual Reports both underlined the good work done by the LAS staff in these areas of critical care; the long on-scene time was the significant issue which needed further work
4. The Clinical Audit and Research update
5. The RCAG Report- although the replacement of secure PRF storage boxes is still to be completed- an outstanding action since the 16/9/2010!
6. Quality Risk Profile triangulates with the Quality Dashboard.
7. NHSLA Level 2-the LAS can opt to be assessed for this in Q3 or Q4 this year

Internal Audit Workplan

For the first time the time the Quality Committee members were able to contribute to this plan, which had been drawn up initially by the Audit & Compliance Manager and reviewed previously by SMT and EMT. It will now be passed to LAS' new internal auditors KPMG

The Francis Report

The Director of Quality and Health Promotion highlighted the following considered relevant to the LAS:

- The importance of not being distracted by a single (seemingly important) issue
- Clinical leadership and clinical education
- Appraisal
- Complaints
- Culture (fear v compassion)
- Patient and carer involvement
- Engagement with other significant stakeholders

- Putting patients at the centre
- Openness and candour

The committee believed that the Trust Board should receive a presentation accompanied by action plans for any issues where LAS could fall short. One other recommendation was that a member of the public should be asked to become a member of the QC; the Director of Corporate Services will consider a process for involving FT members in committee membership which was part of the original terms of reference.

Beryl Magrath

Non- executive director and Chair of the Quality Committee

26th March 2013

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH MARCH 2013

PAPER FOR INFORMATION

Document Title:	**Board Assurance Framework and Corporate Risk Register – March 2013**
Report Author(s):	**Sandra Adams, Director of Corporate Services**
Lead Director:	**Sandra Adams, Director of Corporate Services**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Good governance – providing assurance to the Trust Board on the identification and management of risk and the sources of assurance that these are operating effectively.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To review the key risks and mitigations in place to manage these and to confirm whether there is sufficient assurance in place.**

Key issues and risks arising from this paper

a) Three new risks added to the BAF for 2013/14
b) No risks were closed in the quarter
c) Impact of CQC inspection identified with related risks
d) New controls or issues have been highlighted in yellow

Executive Summary

The commentary on page 1 of the BAF identifies the three new risks identified, articulated and assessed during Q4 2012/13. These reach the threshold of gross rating of >15 and have been added to the BAF which starts the period 2013/14. The report in November 2012 identified the need to articulate the risk associated with the management of category C calls and this is now incorporated in the corporate risk register and the BAF as risk 379. Risk 378 refers to the quality of information within referrals from the Metropolitan Police Service to the LAS locality alert register. This is also referenced in the monthly clinical quality and safety report. Finally, risk 371 refers to the

potential impact on level 2 of the information governance toolkit if the level of training has not been achieved. An update can be provided to the Board on the day.

The CQC inspection report was published in December 2012 and the Trust has submitted action plans for the two outcomes where non-compliance was identified. Page 2 of the BAF notes the risks associated with these two outcomes.

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

Attachments

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

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

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

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

Equality Analysis

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

Key issues from the assessment:

Board assurance framework
March 2013

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

Commentary:

Risks closed in Q4 BAF:
There were no risks closed on the BAF.

Risks opened in the 2013/14 BAF:
There are three new risks on the BAF in this quarter.

Risk 378 - There is a risk that insufficient information is contained within MPS referrals for inclusion in our locality alert register. This may lead to delayed patient contact when attending MPS flagged addresses. Gross rating: 20(catastrophic/likely); Net rating: 15 (possible); Target rating at the end of 2013/14: 10 (unlikely).
Risk 379 - There is a risk that calls received and triaged as Category C; sub divided into C1, C2, C3 & C4 could receive a delayed or inappropriate response because of increased levels of Category A demand on available resources. Gross rating: 20 (catastrophic/likely); Net rating: 15 (possible); Target rating at the end of 2013/14: 10 (unlikely).
Risk 371 - There is a risk that the LAS will not continue to maintain Level 2 for IG Toolkit Requirement 112 because Operational staff will not have completed their online IG refresher training. This would mean a 'not satisfactory' return for the LAS when the Toolkit submission is made at end March 2013. Gross rating: 20 (catastrophic/almost certain); Net rating: 15 (possible); Target rating at the end of Q4 2012/13: 10 (unlikely).

The following risks are presented as agreed by the Trust Board in November 2012 although they do not reach the threshold for inclusion in the BAF:
Risk 369: there is a risk that the governance of the Trust may be adversely affected by changes at Trust Board level. Gross impact – Major/Gross likelihood – Possible = 12.
Risk 370: there is a risk that the development and sign off of the 5-year strategy may be impeded by changes within key board roles. Gross impact – Major/Gross likelihood – Possible = 12.

These risks have been included in the Tripartite Formal Agreement that has been signed off by the cluster and is currently with the NHS Trust Development Authority. Both risks are supported by mitigating actions and these can be reviewed in the March 2013 risk register. Further assurance will be gained when the board governance assurance framework refresh review is reported this month.

All operational risks on the corporate/trust registers were reviewed by RCAG in July 2012. Those operational risks on the BAF have existed for several years and are still 'live'. This indicates a level of tolerance of risks and the RCAG recommended keeping these visible for the foreseeable future. All risks are subject to regular review by the risk owners and the Trust risk register was fully updated in March 2013. The risk module on Datix (risk management system) from which risk reports will in future be generated will be implemented in some areas in April 2013 with web-based risk module training being rolled out from May. The module allows local risk registers to be linked to the corporate risk register and BAF thereby bringing greater integration in risk reporting.

The CQC undertook an unannounced compliance review on 14th November 2012. This was focused on 4 outcomes: Consent; Care and Welfare of people who use services; Staffing; and Assessing and monitoring the quality of service provision. The inspectors also asked for evidence of specific actions that we had been taking for Infection Prevention & Control and Safeguarding and, based on evidence presented to them during the inspection, they also considered compliance against Safety, Suitability and Availability of Equipment. The CQC found that the Trust had two areas of non-compliance requiring action: Staffing – moderate impact on patient care (risk 355 applies); and Equipment – minor impact on patient care (risks 352, 186, 303, 366 and 367 apply). Action plans have been submitted for both and are actively monitored by the Executive Management Team.

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

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

Board assurance framework
March 2013

Section A

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

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

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

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

Board assurance framework
March 2013

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

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

Board assurance framework
March 2013

		Strategic Goals			Risk themes
	3. There is a risk that we are unable to match financial resources with priorities	Strong link	Moderate link	Strong link	BAU risks – financial; quality
	4. There is a risk that our strategic direction and the pace of innovation to achieve this are compromised	Strong link	Moderate link	Strong link	Cat C and non-conveyance Changes to the Board – potential adverse effect on governance; potential impact on strategy development and sign-off

Board assurance framework
March 2013

Section B: risk themes
The Trust Board reviewed the risk focus areas (themes) and identified the following for focus in the next two years:

Strategic Risk	Causes	Risk focus BAF Yes/No	Mitigating actions	Sources of assurance
1. There is a risk that we fail to effectively fulfill responsibilities to deliver high quality and safe care.	Failure to recognise specific and serious clinical issues; staff not receiving clinical training and development which impacts on their ability to carry out their role effectively;	**Themes**: Category C and non-conveyance; Obstetrics; Clinical supervision, education and training. **BAF? Yes:** Risk 31 – maternity care; Risk 355 – clinical and non-clinical mandatory training; Risk 22 – comprehensive assessment/non-conveyance; Risk 379 - Impact on Category C patients of meeting 75% Category A within the context of rising demand.	Programme of clinical and non-clinical mandatory training supported by PDR/OWR and clinical supervision; Review of incidents and complaints so that errors are addressed and learnt from; Networking with maternity units; Partnership working within the local health economy to manage capacity and direct responses accordingly. Jointly commissioned capacity review reported in January/March 2013. Discussions ongoing at current time about contract and transitional support to implement the Modernisation programme from April 2013.	Quality dashboard - clinical quality indicators Risk registers CPI compliance Clinical quality and safety report Quarterly integrated risk report Risk indicators: incidents, SIs, complaints & PALs, legal, inquests Clinical audit Internal audit report on training Integrated performance report Quality Committee report to the Trust Board Commissioners' clinical quality group Care Quality Commission registration & QRP NHSLA level 1 (minimum) Quality Governance Framework score of 3.0

Board assurance framework
March 2013

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

Board assurance framework
March 2013

Strategic Risk	Causes	Risk focus BAF Yes/No	Mitigating actions	Sources of assurance
3. There is a risk that we are unable to match financial resources with priorities	Funding levels within the local health economy;	**Themes:** Business as usual; DMP/demand. **BAF? Yes** Risk 265 - matching resources to demand;	Strong cost improvement programme and focus on gaining efficiencies and driving up productivity; Partnership working within the local health economy to manage capacity and direct responses accordingly. Jointly commissioned capacity review reported in January/March 2013. Discussions ongoing at current time about contract and transitional support to implement the Modernisation programme from April 2013	Trust Finance Board report Cost Improvement Programme report to Quality Committee & Finance & Investment Committee Quality dashboard with clinical quality indicators Contract with commissioners External audit opinion Head of internal audit opinion Quality Governance Framework

Board assurance framework
March 2013

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

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; Annual Governance Statement; Annual reports – safeguarding/infection prevention and control/complaints management/corporate social responsibility; Integrated performance report: Monthly board reports from the COO, Director of Finance, Medical director, Director of Workforce, Trust Secretary; Board Governance Memorandum.
Quality Committee	Care Quality Commission registration; DH Clinical Quality Indicators; CQC quality risk profile; Quality Governance Framework; Board assurance framework.	Corporate risk register; Local risk registers; Audit recommendations progress report; Clinical audit report; Cost improvement programme reports; Minutes of RCAG, LfE, CQSEC; Quality indicators dashboard; Integrated risk management report; Observational ride-outs.
Audit Committee	NHS Litigation Authority level assessment of risk management standards; Head of Internal Audit Opinion; External Audit opinion.	Audit recommendations progress reports; Governance Statement; Report from Chair of the Quality Committee.
Finance and Investment Committee	Independent working capital assessment Due diligence reports	LTFM reports; CQUIN and contract monitoring; Cost Improvement Programme reports; Monthly finance board reports; Finance risk report.
Risk Compliance & Assurance Group	Internal audit reports and recommendations; CQC quality risk profile.	Audit recommendations progress report Local risk registers; Risk register process and reports.

Board assurance framework
March 2013

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

Section D: Principal Risks

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

Principal risk and headline	Corporate objective	Risk score	CQC map	Key controls	Assurance on controls			Action plan	Responsible officer	Net	Target
					Positive assurance	Gaps in controls	Gaps in assurance				
368 - 27th July 2012 There is a risk that messages exchanged between MDTs and the CommandPoint CAD system may become out of sequence, cross one another while one is being processed or a job being 'cycled' through to closure in error by an A&E resource. This may result in an open event being closed in the CAD system erroneously, leading to a patient not receiving a response from the LAS and their condition deteriorating, possibly resulting in serious injury or death **Sources of assurance:** Risk register; integrated board performance report and integrated risk report Risk reviewed and update January 13	C03 C04 C07	25	**N/A**	Software adaptation; manual alert systems;	Weekly director oversight – CP problem management review; Monitoring incidents – CP senior user group	None identified	None identified	Technical solutions under development	**PS**	15	5

Sandra Adams 18th March 2013

265 – 31st July 2006 Service performance may be affected by the inability to match resource to demand **Update: potential underlying causes/source of risk** identified as reductions in front line establishment in 11/12 and 12/13 CIP and the current vacancy factor against establishment. **Sources of assurance:** RCAG review 9/7/12. Risk reviewed 27/2/13 – no change to ratings. Risk remains at current level pending action	C03 C05 C07	20	**16**	Ongoing recruitment; Use of VAS and PAS in peak demand; Agreed ToR for capacity review with commissioners Operational weekly demand and capacity review group; A&E resourcing group set up in Sept 12, chaired by Director of Workforce	Operational weekly demand and capacity review group; SMG weekly and monthly performance reports; Integrated board performance report			Q4 delivery plan in place; Outcome of ORH review and modernisation programme under discussion with commissioners for 13/14 onwards.	**PW**	16	12

Daily operational reports. See BAF section B											
31 – 14th November 2002 There is a risk that the control and operational staff may fail to recognise serious maternity issues or fail to apply correct guidelines which may lead to serious adverse patient outcomes in maternity cases. **Sources of assurance:** RCAG review 9/7/12. Risk reviewed January 13. Risk remains at current level pending action Weekly serious incident review group; ADG monitoring SI action plans See BAF section B	C01 C02 C05 C06	20	6 16 14	The Medical Director attends NPSA's Obstetric Pan London Forum. LAS Consultant Midwife provides advice to Control Services, Legal Services, Patient Experience, and Education and Development. Reports on all the reported incidents concerning obstetric cases are presented to the Clinical Quality Safety and Effectiveness Committee- Report produced in Feb 2012. Training by Consultant	CQSEC minutes Integrated risk report – incidents, SIs, claims and inquests			Modifications to the safe triage of women in early labour flow-chart - ongoing and complete Sept 2012; Review incidents reported and legal and complaints.	**FM**	16	12

				midwife to complexes with workshops and a number of complexes have made local arrangements for midwives to deliver training sessions. Maternity care updates and ongoing training through direct contact and articles in the Clinical Update. CTA now have maternity pathway to assist with triage of women in labour. Liaison with Trust midwifery units. Flow chart now in use in CTA							
355 – 23rd November 2011 Staff not receiving clinical and non-clinical mandatory training **Sources of assurance:** Risk reviewed on	C01 C02 C03 C05 C06 C07	20	**12 14**	1. PDR / KSF Agreed rostered training days. 2. Dedicated tutors. 3. Paramedic registration. 4. Weekly	Clinical quality indicators; Quality dashboard; Clinical quality and safety monthly board report; Training			OLM to be used for CSR1 reporting from October 12. CQC inspection action plan	**CH**	16	8

28/5/12 – RCAG confirmed. Risk reviewed 4/3/2013. Risk remains. CQC compliance review – November 12 – identified minor impact of non-compliance relating to staffing levels and linking this to staff not receiving mandatory training. BAF Section B				Operational demand capacity meetings. 5. Cluster arrangements in place on all complexes. 6. TNA updated and published May 2012	records.			in place.			
269 – 8th December 2006 At staff changeover times, LAS performance falls as it takes longer to reach patients. **Update: underlying cause/source of risk:** Current rest break agreement permits staff to conclude shift by up to 30 minutes early where no break given by EOC. **Sources of assurance:** Risk reviewed on 8/7/12 by RCAG. Risk reviewed 27/2/13. BAF Section B	C01 C02 C03 C04 C07 C08	20	16	Daily rest break allocation to reduce losses at shift change over. Bridging shifts with VAS and PAS Staggered shifts included in roster reviews	Additional resources up to 60 AEU are currently funded to commence duty at 1500 to maintain performance through shift changeover time. Interim demand management arrangements in place.			Rest break agreement will be modified and implemented in 13/14 along with rosters as per Mod Prog. Recruitment campaign for 13/14 approved to increase resourcing.	**PW**	16	8

327 – 12th October 2009 Re-use of linen/infection prevention and control guidelines **Sources of assurance:** Risk reviewed on 7/1/2013. IP&C dashboard IP&C minutes Clinical quality and safety report to Trust Board CQC registration & compliance review – November 12 To be combined with risk 332.	C04	20	**8**	Adequate supply of blankets; Increased availability of blankets for A&E crews; Improved collection of soiled blankets from hospitals and non-contract laundries; Reduction in blanket loss.	IP&C committee – action plan in place; risk register; Reports to Quality Committee, CQSEC and Trust Board; IP&C dashboard.	Blankets not always available;	Full understanding of the scale of the problem and therefore a strategic solution in place	a) Audit blanket usage as part of hand hygiene auditing. b) developing options paper to agree strategic direction. c) QPIMS to address compliance of single use locally. DIPC to present at conferences. Continue to audit. d) Small sub group to be formed to discuss options paper and endorse recommendations	**SL**	16	6

378 – 14th January 2013 Insufficient information is contained within MPS referrals for inclusion in our locality alert register. This may lead to delayed patient contact when attending MPS flagged addresses. **Sources of assurance:** clinical quality and safety report to Trust Board.	C01 C02 C03 C04 C06 C09		1 6 10 14 21	Crews carry out dynamic risk assessment before attending the address using all available information and knowledge.	Clinical quality and safety monthly report. CQSE papers. Reporting of incidents.			Meetings with MPS to agree changes to MPS entry criteria.			
379 – 11th March 2013 There is a risk that calls received and triaged as Category C; sub divided into C1, C2, C3 & C4 could receive a delayed or inappropriate response because of increased levels of Category A demand on available resources. **Sources of assurance:** risk register; integrated performance report; integrated risk report;	C02 C03 C04 C07		1 4 16 17	1. MPDS call triage 2. Control services staff training 3. Enhanced clinical assessment through the clinical hub 4. Interim demand management arrangements in place through to the 31 March 2013 5. Existing LAS Demand Management Plan	Incident reporting; risk register; integrated performance and risk reports; CQSE papers; EMT and Trust Board papers.			1. Increases in operational efficiency 2. Increase in frontline resourcing levels 3. Reduction in the use of the Demand Management Plan	**PW/JK**		

Sandra Adams 18th March 2013

371 – 14th January 2013 There is a risk that the LAS will not continue to maintain Level 2 for IG Toolkit Requirement 112 because Operational staff will not have completed their online IG refresher training. This would mean a 'not satisfactory' return for the LAS when the Toolkit submission is made at end March 2013. **Sources of assurance:** IG toolkit submission 31/3/2013	C04 C05		13 21	1. ADOs have been reminded about the need for their staff to complete training 2. Training completion rates are being monitored by IGG 3. Directors have been provided with spreadsheets of staff who have completed training 4. ADG members were reminded in December about the need to ensure that their staff complete the refresher training and were provided with a spreadsheet of staff who have completed their training.				Work is being carried out to identify staff who have not yet completed their training by comparing ESR staff list with the IGTT listing.	**PS**		

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

				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).							

London Ambulance Service NHS Trust
Risk Register as at 18th March 2013

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	Risk Category	Gross Impact	Gross Like-lihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Like-lihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like-lihood	Target Rating	Comments
368	There is a risk that messages exchanged between MDTs and the CommandPoint CAD system may become out of sequence, cross one another while one is being processed or a job being 'cycled' through to closure in error by an A&E resource. This may result in an open event being closed in the CAD system erroneously, leading to a patient not receiving a response from the LAS and their condition deteriorating, possibly resulting in serious injury or death	Following CommandPoint go live, several incidents have been reported to the CAD support team for investigation where out of sequence messages from MDTs have resulted in events showing with an incorrect status. On a number of these the event has been closed in error. The investigations have identified a number of ways that this scenario can occur. So far the identified possible causes are: • Preempt request/event updates crossing • Status change messages echoed • MDT status changes arrive out of order • Aged MDT status	27-Jul-12			Clinical	Catastrophic	Almost Certain	25	1.Software adaptation to identify unexpected status messages or very short job cycles, alerting controlling dispatchers and managers. (Build 2.5.6) 2. Manual alerting outside the CAD system processing messages and identifying possible jobs closed in error (unexpected AOR status) setting off a pager in the control room (fall back alert.) Also Section 4 Assurances below (point 4 - daily alert checks) 3. Software adaptation to hold event updates while pre-empt requests are being processed, negating one of the above scenarios from occurring. (Build 2.5.6)	Peter Suter	07-Jan-13	Catastrophic	Possible	15	1. Request for change to CommandPoint system to enhance the functionality around message detail with message type and sequence identification, enabling CAD system rejection of erroneous status changes. 2. Request for Change to MDT system to provide message sequence identification and processing as above. 3. Additional communications material and training around the urgent messages generated to area controllers and dispatchers notifying them of message cycling. 4. Removal of 'false positive' messages from unexpected status change warnings generated by CAD to area controllers and dispatchers.	1. J. Downard 2. J. Downard 3. K. Canavan 4. K.Canavan		1. Technical solutions under development by tactical problem management team (led by John Downard) 2. Weekly director progress oversight in CommandPoint problem management review (led by Peter Suter) 3. Ongoing assessment of alert monitoring and identification of further incidents for CAD support team investigation by CommandPoint senior user group (led by Richard Webber) 4. Daily checks of	Catastrophic	Rare	5	"7/1/13 JD Request for Change (#26) is in progress with Northrop Gruman with corresponding changes to LAS owned MDT software, this is a complex change and will be subject to extensive testing before fleet deployment therefore timescale yet to be confirmed
265	There is a risk that Service Performance may be adversely affected by the inability to match resources to demand.	reductions in frontline establishment in 1/12 and 12/13 as part of CIP Current vacancy factor against 12/13 establishment	31-Jul-06	***	3	Operational	Major	Almost Certain	20	1.Ongoing recruitment to vacancies. 2. Use of voluntary and private sector at times of peak demand. 3. Agreed terms of capacity review with Commissioners. 4. Scoping use of agency Paramedics to enhance bank scheme. 5.The Trust has implemented an Operational weekly demand and capacity review group. The group has been tasked to forecast demand by utilising historic data, capacity for the Trust to meet the predicted demand, monitoring the input measures and understanding influencing factors that potentially could have an adverse effect on Category A life-threatening calls.	Paul Woodrow	27-Feb-13	Major	Likely	16	1. Review ORH implemented rosters Pan London 2. Modelling being undertaken by the Operational Weekly Demand and Capacity Review Group (OWDaCR) 4.Implement outcomes of formal capacity review.	1. C.Hitchen 2. J. Killens 4. J. Killens 5.P Woodrow	1. Q3 12/13 2. Ongoing 4. Ongoing 5. Ongoing	1. joint LAS / Commissioners ORH review funded to report Q3 12 (ORH final report still not agreed (27/2/13), funding settlement from report outcomes still at negotiation phase) 2. ODaCR meeting weekly 3. Nationally implemented 4. A&E resourcing group chaired by Dir of Workforce now established Sept 12 forward 5. DMP levels monitored monthly	Major	Possible	12	Dec 2012 LAS in process of quantifying staffing levels with LAS commissioners via analysis being undertaken by ORH to new funding levels. The risk is well known and will always occur when call volumes outstrip available resources. Q4 delivery plan enacted as a result of additional funding secured to support increased capacity through Q4 Modernisation programme, now established. Programme board chaired by CEO with fortnightly reviews
31	There is a risk that the control and operational staff may fail to recognise serious maternity issues or fail to apply correct guidelines which may lead to serious adverse patient outcomes in maternity cases.		14-Nov-02	***	4	Clinical	Major	Almost Certain	20	1. The Medical Director attends NPSA's Obstetric Pan London Forum. 2. Consultant Midwife working with the LAS one day a week, providing advice to Control Services, Legal Services, Patient Experience, and Education and Development. 3. Reports on all the reported incidents concerning obstetric cases are presented to the Clinical Quality Safety and Effectiveness Committee- Report produced in Feb 2012. 4. Training by Consultant midwife to complexes with workshops and a number of complexes have made local arrangements for midwives to deliver training sessions. 5. Maternity care updates and ongoing training through direct contact and articles in the Clinical Update.. 7. CTA now have maternity pathway to assist with triage of women in labour. 8. Monitoring the delivery of the CPD obstetrics module.Re- review planned June 2012 9. Evaluated the flow chart used to enable the safe triage of women in early labour- To be slightly modified and modifications completed Sept 2012	Fionna Moore	02-Jan-13	Major	Likely	16	1. Modifications to the safe triage of women in early labour flow-chart - ongoing and complete Sept 2012 2. Review incidents reported through LA52's, Patient Experiences and Legal Claims relating to problematic obstetric incidents-Ongoing	1. A.Stallard / F.Sheraton 2. A. Stallard	1. Complete 2. Ongoing	1. Monitor processes at CQSE and Corporate Health and Safety Group. 2. Incident reporting.	Major	Possible	12	02/02/103 DSW All measures remain in place.

London Ambulance Service NHS Trust
Risk Register as at 18th March 2013

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355	There is a risk of staff not receiving clinical and non-clinical mandatory training.	This may as a consequence cause:- ● Failure to meet CQC and the Trust's TNA policy ● Dilution of clinical skills ● this includes the decentralising of operational training to New Ways of Working (NWOW)	23-Nov-11		5	Human Resources	Major	Almost Certain	20	1. PDR / KSF Agreed rostered training days. 2. Dedicated tutors. 3. Paramedic registration. 4. Weekly Operational demand capacity meetings. 5.Cluster arrangements in place from December 2011 on all complexes. 6. 3/5/12 The TNA was approved by TSG and published	Caron Hitchen	04-Mar-13	Major	Likely	16	I. 3/5/12 The TNA was approved by TSG at the April meeting and will be published iminently. 2. A workbook has been developed for Infection prevention and control it will be launched shortly. 3. Use of OLM for recording of CSR 1 will commmence from October 2012.	1. G.Heuchan 2. K.Miller 3. B.O'Neil	1. Complete 2. Ongoing 3. Oct 2012	1. Reporting to TSG 2. Performance Accelerator 3. TNA Policy	Major	Unlikely	8	
269	There is a risk that at staff changeover times, LAS performance falls.	Current rest break agreement permits staff to conclude shift by upto 30 mins early where no break given by EOC	08-Dec-06	***	17	Clinical	Major	Almost Certain	20	1. Daily monitoring of rest break allocation to resolve end of shift losses 2. Use of bridging shifts for VAS/PAS 3. Roster reviews/changes must include staggered shifts.	Paul Woodrow	27-Feb-13	Major	Likely	16	1. Implement changes to rest break arrangements 2. Outcome of capacity review 3. Rota changes to be implemented as result of ORH review stage 1	1. C.Hitchen 2. M.Flaherty 3. G.Hughes	1. Q3/4 12/13 2. Q3/4 12/13 3. Q3/4 12/13	Additional resource upto 60 AEU are currently funded to commence duty at 15:00 to maintain performance through shift changeover time. Interim demand management arrangements in place to more	Major	Unlikely	8	Rest break agrement will be modified and implemented 2013/14 along with rosters as per modernisation programme. Aggressive recruitmen campaign for 2013/14 approved to increase resourcing
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	Almost 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	07-Jan-13	Major	Likely	16	To understand the scale of the problem and to develop a strategic solution ot blanket usage: 1 . Audit blanket usage as part of hand hygiene auditing. 2. Chris Vale developing options paper to agree strategic direction. 3. PIMS to address compliance of single use locally. DIPC to present at conferences. Continue to audit. 4. Small sub group to be formed to discuss options paper and endorse recommendations	1. Trevor Hubbard 2. Chris Vale 3. Trevor Hubbard 4. Karen Merritt	1. Complete 2.Feb 2012 3. Oct 2012 4. Complete	1. KPI measuring blankets collected delivered. 2. KPI measuring blankets allocated/ delivered.	Minor	Possible	6	The IPCC propose that risks 327 and 332 are combined as they cover the same issues. LA167 to be raised to cover both risks.

London Ambulance Service NHS Trust
Risk Register as at 18th March 2013

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378	There is a risk that insufficient information is contained within MPS referalls for inclusion in our locality alert register. This may lead to delayed patient contact when attending MPS flagged addresses.	Police fail to set an appropriate criteria for inclusion on the LAS register	14-Jan-13			Operational	Catastrophic	Likely	20	1. Crews carry out a dynamic risk assessment before attending the address using all available information and local knowledge	Paul Woodrow	27-Feb-13	Catastrophic	Possible	15	1. Meet with MPS to agree changes to the police entry criteria	1. Ops Lead/Head of MI	End 2013		Catastrophic	Unlikely	10	Paul Woodrow has reworded the risk / Feb 2013 update - Sue Meehan has met with MPS twice and agreement has been reached that the current system provides insufficient information for the LAS to assess the risk. Changes to the MPS process have been proposed and provisionally agreed. The new form and implementation are to be discussed at MPS meeting on 28 Feb.
379	There is a risk that calls received and triaged as Category C; sub divided into C1, C2, C3 & C4 could receive a delayed or inappropriate response because of increased levels of Category A demand on available resources.	The Learning from Experience Group requested an analysis of delays to category C patients which resulted in Serious Incident reviews. During the period April 2011 - March 2012 the Trust reviewed 92 serious incidents 10 involved Category C calls. 4 incidents were declared 3 as delayed response, 1 staff attitude. 6 incidents were investigated internally. 1 incident is expected to be a problematic inquest and a claim.	11-Mar-13			Operational	Catastrophic	Likely	20	1. MPDS call triage 2. Control services staff training 3. Enhanced clinical assessment through the clinical hub 4. Interim demand management arrangements in place through to the 31 March 2013 5. Existing LAS Demand Management Plan	Paul Woodrow / Jason Killens		Catastrophic	Possible	15	1. Increases in operational efficiency 2. Increase in frontline resourcing levels 3. Reduction in the use of the Demand Management Plan	1. P. Woodrow 2. P. Woodrow 3. P. Woodrow / F. Wrigley	1.April 2014 2. April 2013 3. April 2013	1. Operational Demand and Capacity Review Group 2. CTA and Control room Quality Governance Committee 3. Risk Compliance and Assurance Group 4. Medical Directorate senior clinical advice; Clinical risk and Patient safety	Catastrophic	Unlikely	10	Risk approved by Chair's Action 11/03/13
371	There is a risk that the LAS will not continue to maintain Level 2 for IG Toolkit Requirement 112 because Operational staff will not have completed their online IG refresher training. This would mean a 'not satisfactory' return for the LAS when the Toolkit submission is made at end March 2013.	Service pressures during the year have meant that Operational training has had to be deferred in many cases and winter pressures may make this situation worse.	14-Jan-13			IM&T	Major	Almost Certain	20	1. ADOs have been reminded about the need for their staff to complete training 2. Training completion rates are being monitored by IGG 3. Directors have been provided with spreadsheets of staff who have completed training 4. ADG members were reminded in December about the need to ensure that their staff complete the refresher training and were provided with a spreadsheet of staff who have completed their training.	Peter Suter		Catastrophic	Possible	15	Work is being carried out to identify staff who have not yet completed their training by comparing ESR staff list with the IGTT listing.	1. Stephen Moore	1. Dec 2012		Catastrophic	Unlikely	10	

London Ambulance Service NHS Trust
Risk Register as at 18th March 2013

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22	There is a risk that failure to undertake comprehensive clinical assessments may result in the inappropriate non-conveyance or treatment of patient.	Inappropriate non-conveyance incident	14-Nov-02	***	5	Clinical	Major	Almost Certain	20	1. An enhanced patient assessment course has been introduced for paramedics. The training has been subject to a major overhaul and now includes a supervision element. Reflective practice has also been adopted into the majority of assignments. 2. Planned CPD delivery will cover all relevant staff. However, this may be affected by operational pressures. 3. Training Services monitor the level of training delivery. 4. CPIs are used to monitor the level of assessments provided. 5. LA52 incident reporting is in place and reports are provided to the Clinical Quality Safety and Effectiveness Committee. 6. The Operational Workplace Review has been reviewed and will now include rideouts. 7. A system for clinical updates is in place. 8. A system of closed round tables is in place. 9. The development of treat and refer pathways is being continued alongside the New Ways of Working project.	Fionna Moore	04-Mar-13	Moderate	Certain	15	1. To review the effectiveness of the existing incident reporting system. 2. Pilot scheme where crew staff from 4 identified complexes will contact EBS via their airways radio. EBS will record incidents directly onto an electronic version of the existing LA52. 20/02/13 - DSW - These actions do not relate to this risk it is felt. It is suggested that the further actions are: 1. Delivery of CSR3	1. J.Selby 2. J. Selby 20/02/13 - DSW - Suggest the above is removed. 1. ? Gill Heuchan	1. Sep 2012 2. Sep 2012 20/02/13 - DSW - Suggest the above is removed 1. Refer to CSR3 plan	1. Incident reporting. 2. Operational workplace reviews. 3. Regular reports to CQSE.	Moderate	Possible	9	20/02/13 - DSW - Suggest above is removed. 20/02/13 - DSW - All measures remain in place. implementation of CSR3 for patient facing staff is deemed crucial
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	Almost 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	07-Jan-13	Major	Possible	12	To ensure Trust is consistently compliant across the service: 1) Conduct audit following implementation of contract.	1. Trevor Hubbard	1. Oct 2012	1. Comprehensive dashboard	Minor	Unlikely	4	IPCC - This risk has reached its target rating and is proposed for archive and monitoring via the local risk register.
7	There is a risk that we do not capture errors and incidents, and do not therefore learn from these and improve service provison and working practices.	Insufficient recorded evidence of reported incidents	13-Nov-02	***	4	Health & Safety	Major	Almost Certain	20	1. LA52 incident reporting form 2. Risk management policy and strategy has been updated and implemented 3. Incident reporting policy is implemented 4. The Learning from Experience (LfE) group is in place and starting to review integrated risk reports, patterns and trends - LfE group receive an integrated report and monitor action to be taken, including feedback to staff on incidents reported and investigated. 5. A review of incident reporting is underway and led by the PCMO. 6. Weekly SI control sheet and conference call updates. 7. Monthly reports to SMG. 8. Implemented policy on investigating and learning from incidents, complaint, PALs and claims. 9. Local risk registers have been introduced 10. Datix Coding Review has been undertaken 11. LFE group has introduced integrated reporting	Caron Hitchen	04-Mar-13	Moderate	Possible	9	1. Complete the review of incident reporting pilot and make recommendations to Corporate H&S and RCAG. - **(Phase 2 of this project has commenced and is being led by CDB)** 2. Implement the policies on investigating and learning from incidents, complaint, PALs and claims. 3. LfE to develop the integrated risk reports and monitor action taken, including feedback to staff on incidents reported and investigated. **4. Incident reporting project phase II commenced Jan 2012. - (JS 18th Feb 2013)**	1. S.Sale 2. S.Adams 3. C.Dodson-Brown 4. C.Dodson-Brown	1. **Pilot Complete** 2. 3. 4. - **Project commenced Jan 2012**	1. Completion of the review and recommendations to RCAG and SMG for implementation. 2. Reports and minutes from Learning from Experience, RCAG, SMG and Quality Committee. Consistent coding and reporting across the risk indicators	Moderate	Rare	3	
343	There is a risk of staff not recognising safeguarding indicators and therefore failing to make a timely referral.		12-Aug-10		4	Clinical	Major	Likely	16	1. Monitor referrals centrally. 2. Safeguarding committee promotes practice guidance. 3. Practice guidance issues and supported by updates. 4. Training programme in place - ongoing auditing of the effectiveness of training through competency assessments. 5. Monitor training uptake - monitored centrally on scorecard. 6. Safeguarding Children / Adults Gap Analysis.	Steve Lennox	04-Mar-13	Major	Likely	16	1. Capture safeguarding practice in bi-annual Operational Workforce review 2. Formulation of action plan based on completed safeguarding adults gap analysis 3. Provide monthly supervision sessions open to all staff. 4. Produce and issued individual safeguarding pocket books to all frontline staff.	1. P.McKenna, K.Millard, P.De Bruyn 2. Lysa Walder & Alan Taylor	1. April 2013 2. Dec 2012 3. Jan 2013 4. June 2013	1. Monitor at Safeguarding Committee	Major	Unlikely	8	

London Ambulance Service NHS Trust
Risk Register as at 18th March 2013

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349	There is a risk that the Clinical Coordination Desk will not be able to operate effectively due to a lack of suitably trained staff in EOC where secondments of specifically trained staff have ended and specialist roles with control services are being removed.	Specialist roles with control services are being removed in order to provide a more flexible workforce. This removes the experience and expertise that has been developed on the CCD and has now become a nationally recommended part of clinical network development.	11-Jul-11	***	4	Operational	Major	Likely	16	1. CCD now supported by enhanced clinical support in EOC with 24/7 clinical hub going live on 16/7/12 2. Team leaders and central operations staff trained and attend EOC on shift by shift basis if additional ad hoc staff required	Paul Woodrow	31-Dec-12	Major	Likely	16	1. Enhance clinical hub operations in phase 2 and 3 of implementation 2. Recruitment process in place for CSD expansion Q3 3. Formal review of CTA functionality in Control Services Q3/Q4 12/13	1. F.Wrigley 2. F.Wrigley 3. F.Wrigley	1-3. Nov 2012 / March 2013		Major	Unlikely	8	Dec 2012 - Roster review of CTA conducted Technology changes to improve call handeling cycle scoped for Q4 Latest psiam installed Nov 2012 IPM being utilised
138	There is a risk that failing to appreciate the significance of psychiatric illnesses will lead to mis-diagnosis.		12-Nov-03	***	5	Clinical	Major	Likely	16	1. The new 'Mental Health' module has been designed and has been included in the training plan for 2009/10. 2. An e-Learning Manager has been appointed and will start work wih the Trust in August 2009. 3. Mental health e-learning module has been developed - training package assessed by external assessors	Steve Lennox	31-Dec-12	Major	Possible	12	1. Development of mental health risk assessment tool 2. Roll-out of mental health e-learning training 3. Mental Health Committee to consider alternatives to e-learning 4. Mental health audit 5. CSR3 Training	1. S.Lennox 2. S.Lennox 3. S.Lennox 4. S.Lennox 5. K.Miller	1. Dec 2011 2. Dec 2011 3. Sept 2011 4. Complete 5. Oct 2012	1. CPD completion records 2. Monitor processes at CQSE 3. Monitor package completion data on e-learmng site	Major	Unlikely	8	5. The TSG has prioritised the delivery of CSR 1 during the post Olympic period and for the remainder of the current financial year. Delivery of CSR 3 should commence post April 2013. (KM 10/12/12)
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	31-Dec-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 Oct 2012 3. Plans are to be reworked due to the prohibitive cost of original proposals. 4. L&OD pilot has identified a range of issues requiring further work and development. Clinical Education to commence use of OLM for CSR1 programme from October 2012. (PB- 12th Sept'12	1. P.Billups 2. R. Habib 3. 4.	1. Ongoing 2. Oct 2012	1. Part of organisation & development of people workstream. 2. Progress of project report to workstream board.	Major	Unlikely	8	Systems have been developed to capture training activity data in the maintaime, 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	04-Mar-13	Major	Possible	12	1. CQSE suggest PIMs give some thought to how this is managed. 2. Continue to encourage reporting of all clinical incidents using LA52's. 3. Continue to reinforce that the LAS has a fair blame culture by providing feedback from outcomes of complaints to staff involved in incidents. 4. Updated policies covering the use of drugs used by the LAS to be put into the RIB. 5. The reporting of drug errors and adverse events in included in the CSR training programme which is to recommence in November.	1. J.Killens 2. J KIllens 3. D Whitmore 4. D.Whitmore 5. Keith Miller	1. Ongoing 2. Ongoing 3. Ongoing 4.Completed Oct 2012 5.Ongoing	1. CPI checks 2. Incident Reporting 3. CQC inspections 4. Clinical opinions provided on incidents 5. Learning from Experience Group review incident activity 6. Review of closed cases and claims. 7. Learner outcomes and achievement records documenting discussions on incident reporting.	Major	Unlikely	8	20/02/13 - DSW - All measures remain in place. In addition during TL update days 5th and 12th February all TLs reminded to raise the issue of durg error reporting with staff.

London Ambulance Service NHS Trust
Risk Register as at 18th March 2013

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305	There is a risk that the management of morphine at Station level is not in accordance with LAS procedure OP/30 Controlled Drugs.	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. 5. OP30 Policy and procedure for the Ordering, Storage and use of Morphine Sulphate within the LAS has been reviewed and issued. 6. Daily checks are made by Team Leaders on the issue and receipting back of Morphine ampoules on complexes.	Fionna Moore	04-Mar-13	Major	Possible	12	1. Continue to highlight practice from the peer review audits. 2. Continue to review feedback from spot checks made by the MPS.	1. D.Whitmore 2. D.Whitmore	2. October 2012 3. June 2012	1. Internal Audit 2. Independent Audit 3. LIN oversight of system	Major	Unlikely	8	20/02/13 - DSW - All measures remain in place. Unannounced visit of 12th Feb 2013 showed good compliance with CD policies.
326	There is a risk that the inadequate facilities and lack of policy for the decontamination of equipment may increase the risk of infection.		17-May-10	***	1,2	Infection Control	Major	Likely	16	1. Introduction of single-use items. 2. Introduction of more robust cleaning programme for vehicles and premises. 3. Introduction of detergent and disinfectant wipes for equipment in between patient use. 4. Decontamination policy is now in place. 5. Improved decontamination processs in operation.	Steve Lennox	07-Jan-13	Major	Possible	12	1. Decontamination sub group to review compliance with decontamination process 2. Decontamination Policy to be agreed by ADG	1. K.Merritt 2. S.Lennox	1. Oct 2012 2. Complete	1. Area Governance Meetings 2. Incident reports.	Minor	Unlikely	4	IPCC 1.11.12 - no amendments made
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 Implementation Group and Manual handling policy 2. Manual handling awareness is provided at corporate Induction; refresher training through e-learning is available through L&OD; Education and Training dept provide training to all operational staff during initial and subsequent core refresher training; all operational ambulance vehicles are fitted with tail lifts 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, 5. Small handling kits on all vehicles 6. BTech trained Manual Handling assessors 7. Specialist MH equipment e.g. Mangar Elk 8. All A+E and PTS operational vehicles have either tail lift of ramp access 9. All A+E and PTS operational vehicles are fitted with hydraulic trolley bed 10. Generic Risk Assessments 11.All A+E Operational vehicles have access to Mangar Elks 12. 3x PTS Bariatric vehicles are available by request to A+E	Paul Woodrow	04-Mar-13	Major	Possible	12	1. Implementation of LAS/HSE Manual Handling Improvement Programme Action Plan 2. Develop structured bariatric capability 3. Ongoing review of marketplace to identify new lifting aids 4) Complete Operational Workforce Review 5) Chair Transporter Pilot - (Interim report with CH - 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. Killens 3. J.Selby 4. S.Sale 5. J.Selby 6. J.Selby	1. Q3 12/13 2. 2013/14 3. Ongoing 4. March 13 5. Sept 12 6. Oct 12	1. Manual Handling Implementation Group 2. Manual Handling Policy 3. Central Health and Safety Group Incident Statistics Monitor and Audit Reviews	Minor	Unlikely	4	

London Ambulance Service NHS Trust
Risk Register as at 18th March 2013

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153	There is a risk that fuel prices may be in excess of sums held in budgets which may lead to overspend	Increasing fuel prices	06-Jan-04	***	8	Finance	Major	Likely	16	1. Monthly review as part of month end reporting process. 2. Prices will continue to be closely monitored by the Finance Department for 2012/13. The move to an all diesel fleet will further mitigate against fuel costs.	Andrew Grimshaw	04-Mar-13	Moderate	Possible	9	1. Finance Review of billing data underway by Director of Finance. Further investigation of vehicle telemetry technology to manage fuel spend.	1. M.Dinan	1. Ongoing	Monitored at SMG and Trust Board	Moderate	Possible	9	**Risk at target rating but to remain visible on Risk Register**
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. 4. Training now being delivered across the Trust in CSR1.	Steve Lennox	07-Jan-13	Moderate	Possible	9	To be fully compliant with CQC expectations and all staff to have up to date infection control training: 1. Ensure all staff receive all in one training or alternative form of update (core skills refresher and induction training) 2. Monitor and implement hand hygiene training. 3. Need to capture the training of contracted staff on the scorecard.	1. C. Dodson-Brown / I.Bullamore 2. S.Lennox 3.	1. Oct 12 2. Oct 12 3. Oct 12	Reports from the central training register	Minor	Unlikely	4	IPCC 1.11.12 - no amendments made
329	There is a risk that financial penalties will be levied on the Trust as a result of non-achievement of the contractually agreed targets.	Potential failure to achieve contracted performance targets and failure to earn CQUINs	06-May-10		3,4,8	Finance	Catastrophic	Possible	15	1. 2012/13 Continue working with specific mitigation of financial risk. 2. Monthly finance reports reviewed by Trust Board and SMG. 3. Extra financial provisions included for contract risk in 2012/13. 4. Communications with commissioners.	Andrew Grimshaw	04-Mar-13	Catastrophic	Possible	15	1. Review by Finance Investment Committee	1. A.Cant	F&I Committee 15/1/13	1. Performance is tracked daily both centrally and by area. 2. Financial risks are reviewed by SMG and Trust Board.Diary meeting every Monday reporting where performance is 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	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
373	There is a risk that crews will not carry out a comprehensive dynamic risk assessment when attending high risk addresses resulting in a delay in attending the patient	Custom and practice that crews do not do this as a matter of course	14-Jan-13			Clinical	Catastrophic	Possible	15	1. Recent new guidelines issued 2. Aide memoirs issued 3. Discussions taken place with ops, EOC and all interested parties including staffside reps 4. Policy reviewed and signed off by SMG	Fionna Moore	04-Mar-13	Catastrophic	Possible	15	1. Monitor delays results of existing controls through the numbers of assaults on staff attending know high risk addresses 2. Ongoing coms strategy to remind crews and EOC staff of the importance of dynamic risk assessment 3. Monitor delays as a result of staff applying a dynamic risk assessment and not entering a call as a result	1. J.Selby 2. Head of Control Services	1-2 Ongoing monitoring		Catastrophic	Unlikely	10	Risk to be monitored by the Corporate Health and Safety Group EOC to ensure that where DRAs are undertaken and notified to them, then the Call Log must be updated. As part of the Comms strategy Staff are reminded that all DRAs need to be documented on the PRF and their outcome noted.

London Ambulance Service NHS Trust
Risk Register as at 18th March 2013

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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	17-Apr-12			Clinical	Catastrophic	Possible	15	1. Occasional audits of equipment by complexes and logistics department. 2. Equipment lists are available from the company which maintains the medical devices, which includes services and non serviced items.	Paul Woodrow	04-Mar-13	Catastrophic	Possible	15	The Trust will ensure that appropriate equipment is provided on all front-line vehicles essential equipment = vehicle-based, portable, and personal-issue) 1. Implementation of asset tracking project 2. Monitor contractor's compliance with asset tracking process and vehicle inventory management 3. Review portable equipment supply	1. Martyn Salter 2. Ed Potter			Catastrophic	Rare	5	22/01/13 CQSEC requested the actions from the CQC's recommendations be added to the further actions required and that the risk owner is changed to Paul Woodrow. Dec 2012 -The asset tracking system is now working but is not fully implemented.The majority of the Trusts assets have been scanned into the system but the LSU are still waiting for training to enable them to scan items they pick up for service or repair.
344	There is a risk that the Trust is unable to assure that the current taxi contract accommodates the guidelines for regulated activity (safeguarding)		16-May-11		2,4	Governance	Moderate	Almost Almost Certain	15	1) Current contract stipulates all drivers must have CRB checks	Steve Lennox	04-Mar-13	Moderate	Almost Certain	15	1. Registration with the Independent safeguarding Authority needs stipulating in the contract 2. Contract monitoring 3. Currently reviewing contracts with providers ensure Safeguarding requirements are in new contracts. 4. Undertake audit of taxi company.	1.R. Deakins 2. Lysa Walder & Alan Taylor	1. 2011/12 2. 2011/12	1. Safeguarding Committee	Minor	Rare	2	
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 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. 4. A clause has been negoitated in the funding mechanism for 111 generated activity in the 2012/13 contract.	Jason Killens	23-Aug-12	Moderate	Likely	12	1. We will negotiate as a clause in the funding mechanism for 111 generated activity in the 2013/14 contract.	1. J.Killens	1. 1 May 13	1. Control Service Clinical Governance Group 2. Monthly commissioning reports 3. Attendance at NHS London Clinical Governance Group 4. Attendance at pilot site governance groups as required 5. Agreed process to manage incidents and complaints (through 111 governance teams) 6. Monthly contract and performance meeting with lead commissioner.	Moderate	Unlikely	6	

London Ambulance Service NHS Trust
Risk Register as at 18th March 2013

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377	There is a risk that the Trust will have to repsond to circa 110 to 120 additional calls a day (3600 a month) that are currently resolved by redirection from LAS to NHSD via an electronic link thus saving a vehicle response. There is currently no extra staffing provision or infrastructure focused with dealing with this level of additional activity. Any increase of this nature has the potential to impact on core service delivery especially at peak out of hours times and at weekends. There is potential for a reputational issue should the Trust be unable to fulfil this additional function. .	NHSD will cease to provide the national out of hours and primary care function it currently does as NHS111 assumes this responsibiilty. From April 2013 there is no existing agreement with the new NHS 111 providers on how these calls could be managed . Control services (EOC & CTA) Operations (A&E and Urgent care provision) Acute Hospital Tusts (increased patients) Patients (less choice)	14-Jan-13			Operational	Moderate	Almost Certain	15	National contractual agreement in place which ensures approximately 110 to 120 low acuity calls (C4s) are passed electironically to NHSD from EOC	Paul Woodrow		Moderate	Likely	12	1. Assess impact of re- contracting this cohort of calls to NHSD who will be a NHS 111 provider in south London 2. Assess impact of establishing process of transferring this cohort of calls to NHS 111 3. Consider case for increasing capacity to deal with these calls in house.	1. M.McTigue 2. M.McTigue 3. SMT/EMT	1. Oct 2012 2. Oct 2012 3. Oct 2012		Moderate	Rare	3	
377	The instability (in terms of technical failure) of the Bow telephony voice recorder service will mean that 999 calls will not be recorded. THis could then impede investigations and clarification related to decisions made by control room staff and communication with patients and other agencies.	This relates to historic investigations in retrospect and clarification sought within the control room concerning the actual details of the conversation. Both Waterloo and Bow control rooms have recorders that integrate digitally with the main control room telephone system. These are set up to record the extensions within the Control rooms at each site. Currently the Bow Control room is a fall-back control room, however by April 2013 it is intended that this room will house the East Area Dispatch function and a proportion of overall call-takers. Later in 2013 it is expected that the West Area and a further proportion of call-takers will move to Bow so that the sites	05-Feb-13			IM&T	Moderate	Almost Certain	15	1. Detailed investigataion by technology supplier. 2. Upgrade of Bow system to same software release as HQ (where we do not currently have the same issue) 3. Live monitoring during any event by technical staff. 4. Tender specification developed to encompass all recording across the Trust, with an aim to Deliver in 2013/14.	Peter Suter	Moderate	Moderate	Likely	12	1. Non service affecting testing of FBC infrastructure to be undertaken to either prove cause of failure or confirm resolution. 2. Live testing of FBC infrastucture under load in combination with a live run for the East at Bow to prove that the fault has been resolved. 3. Introduction of alerts for the condition known to occour so that servcies can be restarted. 4. Validated explanation from supplier as to previous problems. 5. Consideration of implemention an alternative recording solution in parallel at Bow - but only if cost effective. 6. As part of the capital plan for 13/14 proposal to procure a new solution to encompass all recording across the Trust, as current system is end of life.	1. V.Wynn 2. V.Wynn 3. V.Wynn 4. V.Wynn 5. V.Wynn 6. V.Wynn	1. Feb 2013 2. 19 Feb 2013 Go live	THis has been identified as the highest risk to allowing bow to going live on 27 Feb as planned, as go live cannot take place without a reliable recording system. It is under close scrutiny from the Senior Supplier & User, Project Manager and Project executive. Progress is reviewed at each Monday review meeting.	Moderate	Rare	3	To be amended waiting for confirmation from Peter Suter
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. 2012/13 contract reflects this work, if there is a shortfall PCTs are liable. 2. Reviewed by Finance Investment Committee. 3. Discussions ongoing with DH to provide appropriate SLA.	Jason Killens	07-Jan-13	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 2013	1. Service Line Reporting	Catastrophic	Unlikely	10	Under discussion 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.	Lack of robust BC arrangements in event of full scale evacuation of EOC HQ	17-Aug-09	***	17	Business Continuity	Catastrophic	Possible	15	1. New arrangements agreed with surrounding Trusts to take LAS 999 calls in event of total loss of HQ during Olympic period which need formally agreeing via NDOG as a permanent solution. 2. 2nd Control room went live at located at Bow 27-2-13 2. Smart numbers implemented 20-2-13 which allow for a rapid transfer of calls in a case of total loss of a site	Richard Webber	04-Mar-13	Catastrophic	Unlikely	10	Status Quo				Catastrophic	Rare	5	8.01.13 No update on current position on target for new control room Q 2/3 2013.

London Ambulance Service NHS Trust
Risk Register as at 18th March 2013

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353	There is risk that Operational ambulance staff and Emergency Operations Centre Staff are unsure of the safe systems of working/procedures in relation to railway trackside working, due to the rare occurrence of such incidents.	Lack of regular exposure to this risky enviornment	23-Nov-11		5,7	Operational	Catastrophic	Possible	15	1. Emergency Medical Despatchers (EMD) receive familiarization and procedural awareness during initial training and during their dispatch training course. 2. Work Based Trainers oversee adherence to procedure during placements Student Paramedics receive trackside awareness training during initial training. 3. "Trains Can Kill" card included in Major Incident Action Cards as point of reference. 4. Contingency Plans in place for calls on Network Rail, LUL, DLR and Croydon Tramlink calls including safety awareness information. 5. Operational bulletins available via The Pulse. 6. Trackside Awareness Training provided for all student paramedics and trainee emergency medical dispatchers including demonstrations of short circuit devices 7. Revised policy and procedure in place setting out requirements when attending railway incidents	Jason Killens	04-Mar-13	Catastrophic	Unlikely	10	1. Develop e-learning package for operational managers to enhance safety. 2. Inclusion of railway incidents session in Q3/4 12/13 ops managers EP updates.	1. W.Kearns 2. L.Lehane	1. Jan 2013 2. Q3/4 12/13	1. Manager briefings Undertaken 2. EOC briefings undertaken 3. Publications in RIB / LAS News / Pulse	Catastrophic	Rare	5	Dec 2012 - LUL, BTP and Network Rail are normally in attendance at all trackside incidents. LFB also attend and are responsible for site safety when in attendance.249 people have been directly briefed, EOC, DSO and AOMs. eLearning package due Jan 2013, further briefings should be given until clear about communications of power status at scene elearning package delivered Jan 2013, expected completion in Q2 2013/14
207	There is a risk of staff not being able to download information from Defibrillators and 12 lead ECG monitors leading to incomplete patient records.	Clinical information was not available which was required for an inquest	04-Apr-06	***	1,2,4,5	Clinical	Moderate	Almost Certain	15	1. Mark Whitbread is the Trust lead for the card readers project, 2. Card reading and transmission is performed by team leaders. Mark Whitbread stated that operational pressures, and therefore the availability of team leaders, may have an adverse affect on the number of cards read. 3. A performance update was incorporated in an AOM briefing session held at the Millwall Conference centre in March 2009. All AOMs were in attendance. 4. Monthly report to AOMs on areas of weak performance. 5. Messages given out at Team Leaders Conferences. 6. Encourage more routine downloading of information from data cards. 7. 147 LP1000 AED's have been rolled out and all complexes have been issued with new data readers for these units.	Fionna Moore	04-Mar-13	Moderate	Possible	9	1. To highlight the importance of clinical incident reporting in the Team Leader Clinical Update Course. 2. Physio Control to attend the T/L conference to confirm how downloading should be completed 3. Focus on Team Leaders at Oval to teach them the interpretation of downloads and hold case based meetings with staff following a cardiac arrest, to encourage staff presenting machines for downloads. 4. Audit of FR2 data cards and card readers. 5. Establish the current resources of LP 1000, how many in use, which complexes carry them, are there spares available for 1 for 1 swap. 6. Establish a process at station level to link a specific cardiac arrest to the LP1000 it is stored on. 7. Publicise download returns by complex as part of Area Governance Reports, via PIM or Staff Officer for the Area.	1. M.Whitbread 2. M.Whitbread 3. M.Whitbread 4. M.Whitbread 5. M.Whitbread 6. M.Whitbread 7. M.Whitbread	1. Complete 2. Complete 3. Ongoing 4. Ongoing 5. Ongoing 6. Ongoing 7. Ongoing	2. EOC briefings undertaken	Moderate	Unlikely	6	20/02/13 - MW - IM&T will be placing a chip in LP15 as a trial on one complex for the easier downloading of information via modem. LP1000 AEDs still remain a problem
226	There is a risk that the identified risks associated with lone working are not being uniformly mitigated as a result of inconsistent application of the Lone Worker Policy.		12-Jul-06	***	7,4	Health & Safety	Moderate	Almost Certain	15	1. The Lone Worker Policy has been reviewed. 2. The Trust received positive feedback from 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	04-Mar-13	Moderate	Possible	9	1. Revised Lone worker policy reviewed ADG approved revised policy at 27th July meeting - (JS-27/06/12)	1. Martin Nicholas/ Tony Crabtree	1. Completed	1. Publications in RIB / LAS News / Pulse 2. Lone worker policy	Moderate	Unlikely	6	**Group concidered that this item should be reviewed for archiving - (JS Feb 18th 2013)**
200	There is a risk of loss of physical assets due to the risk of fire.		01-Jan-02	***	1,2,3,4,7	Health & Safety	Catastrophic	Possible	15	1. Fire Marshall awareness training is undertaken as a module on a 1 day Safety and Awareness Course. 2.Annual Fire Risk Assessments are undertaken by the Estates Department. 3. Fire Fighting equipment is sited at all strategic locations. 4. Premises Inspection Procedures require all premises to be inspected on a three monthly basis. 5. Local Induction Training requires managers to identify fire precaution to all new staff. 6. Updates of health and safety issues are provided at the Estates Meeting monthly. 7. Estates department annual assurance of Trusts fire safety compliance. 8. Fire Marshals are appointed by Line Manager 9. Fire & Bomb evacuation Policy 10. Update on premises inspection reported to Corporate Health and Safety Group Quarterly 11. Core skills refresher 2 includes vehicle fire precaution awareness training. 12. All operational vehicles are fitted with appropiate extinuishers and crew staff fire awareness is included in CSR 13. Local induction includes fire safety awareness. 14. Local testing of fire alarm systems occurs on a weekly basis 15. Local fire drills are taken on a 6-monthly basis	Caron Hitchen	04-Mar-12	Major	Unlikely	8	1. Health Safety and Risk team to take responsibility for delivering Fire Marshall Awareness Training.	1. J.Selby	1. Ongoing	- Corporate Health and Safety Group - Emergency Evacuation policy. - Annual assessment undertaken by Estates. -	Minor	Rare	2	

London Ambulance Service NHS Trust
Risk Register as at 18th March 2013

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354	There is a risk of ongoing industrial action due to national ballots leading to disruption of service provision.	There could be an impact on service delivery, patient care and the Trust's reputation.	23-Nov-11		1,2,3, 4,7,8	Human Resources	Major	Possible	12	1. Partnership agreement with staff side. 2. Intelligence gathering. 3. Business continuity plan. 4. Developed contracts with VAS/PAS/Agency staff.	Caron Hitchen	04-Mar-13	Major	Possible	12	1. Implement recommnedations from N30 review. Note - Actions from N30 internal review are all complete, and actions from the NHSL integrated action plan are on track - (CH 27th June 2012)	1. Tony Crabtree	1. 2012/13		Major	Possible	12	
282	There is a risk that general failure of personnel to adequately 'back-up' IT may lead to the loss of data.		03-Jul-07	***	1,2,5,	Business Continuity	Major	Possible	12	1. The move of business information from hard drives to network drives. 2. Part of the 2010/11 audit programme will test this facility and give assurances. 3. IM&T Infrastructure Team to review and take actions as appropriate.	Peter Suter	07-Jan-13	Major	Possible	12	1. Audit to be carried out on the status of the move to network drives. 2. Ensure central data servers are backed up. 3. Fundamentally review how data is stored on local drives and potentially not backed up.	1 - 3 Paul Sulja			Major	Unlikely	8	SAN technical implementation is complete, the major task of data migration is yet to commence.
293	There is risk that that Patient Specific Protocols (PSP) and palliative care, out of hours forms, etc. may not be triggered by the call taker when the patient's address is identified during 999 call.	Incident where call taker had not picked up patient specific protocol	18-Feb-08	***	1,2,4, 5	Clinical	Major	Possible	12	1. The Senior Clinical Adviser has lead responsibility to PSPs. 2. The Clinical Support Desk has delegated responsibility for the accuracy of PSPs but do not have access to update them. 3. Input and maintenance are performed by Management Information who have introduced a range of control measures. 4. The introduction of CAD 2010 will allow automatic flagging and for a range of status flags to be used. 5. The Senior Clinical Advisor liaises with Management Information for the appropriate access to be provided to Clinical Support. 6. All relevant staff are periodically reminded of the requirement to correctly trigger PSPs.	Fionna Moore	26-Sep-12	Major	Possible	12	1. The introduction of Command Point 2. Increase in use and functionality of the Coordinate my Care (CmC) system across all London. (The Senior Clinical Adviser, IM&T and Management Information are working with System C, (the company that developed the newly introduced Pan London EoLC Register, (Coordinate my CAre - CmC), that will be used by all 111 sites and LAS), to look at the possibility of CmC automatically placing a flag on the patient's address. This will obviate the necessity for it to be done manually.)		1. Complete 2. November 2012	1. Incident reporting. 2. Complaints monitoring. 3. Protocols and transfer procedure	Major	Unlikely	8	20/02/13 - DSW - All controls remain in place. Work continues to implement an automatic flagging system using the CMC data. IM&T/MI and CMC are working towards a solution.
369	There is a risk that the governance of the Trust may be adversely affected by changes at Trust Board level.	a) Changes to NED appointments and b) substantive/temporary (i.e. maternity leave) changs to the executive team.	08-Oct-12			Governance	Major	Possible	12	1. Appointments process for NEDs and CEO already underway. 2. Transitional arrangements in place. 3. Interim arrangements in place. 4. Arrangements for other executive board changes to be finalised.	Sandra Adams		Major	Possible	12	1. Interim arrangements for Deputy CEO/Chief Operating Officer role. 2. Maternity cover for Director of Strategy. 3. Exploring the risk regarding the capacity of SMG. 4. Induction process for Directors. 5. Interim arrangements to be set for other executive changes.	1. Martin Flaherty / Richard Hunt 2. Martin Flaherty 3. Martin Flaherty 4. Sandra Adams / Francesca Guy 5. Martin Flaherty / Caron Hitchen	1. Sep 2012 2. Sep 2012 3. Sep 2012 4. Sep 2012 5. Sep 2012	1. Interim arrangements in place for executive positions for the next 6 to 12 months. 2. NED appointments confirmed and transitional arrangements in place. 3. Director induction plan prepared and ready for implementation.	Major	Unlikely	8	

London Ambulance Service NHS Trust
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370	There is a risk that the development and sign off of the 5-year strategy may be impeded by changes within key board roles.	The board of directors leads the strategic direction of the organisation and need to be able to articulate and support this both internally and externally to theTrust. New appointments to key roles such as the chief executive may lead to a change of strategic direction. This may impact on the FT application and destabilise progress against plans.	08-Oct-12			Governance	Major	Possible	12	1. Trust Board has agreed the strategic direction to 2017/18 2. Appointment to key director roles is underway or being planned. 3. New CEO commences 07.01.13 4. Interim FD commences Jan 13 5. Interim management structure in place for 6 months 6. Induction programme for directors implemented	Sandra Adams	04-Jan-13	Major	Possible	12	1. Building the 5-year strategy into the IBP and LTFM.	1. Sandra Adams	1. Mar 13	1. Interim arrangements in place for executive positions for the next 6 to 12 months. 2. Trust strategy communicated to newly appointed directors and incorporated in the induction process to gain understanding and support. 3. Board development programme in place. 4. New directors working within the board from January 2013. 5. New Chief Executive Officer.	Major	Unlikely	8	
360	There is a risk that the Trust will not achieve level 2 NHSLA compliance where there is a significant gap between policy/procedure and practice.	- some evidence which can be provided is not consistent with the processes outlined within the documents - non compliance with the related NHSLA standards may contribute towards overall non compliance with the NHSLA standards at a Level 2 assessment as the trust will not be able to provide evidence	09-Jan-12		1,2,4	Corporate	Major	Possible	12	1. NHSLA Level 1 compliance with 48/50 standards. 2. Established meetings with leads for NHSLA and CQC standards where gaps in compliance are monitored and actions agreed. 3. Audits conducted by Governance and Compliance Team on current CQC and NHSLA to identify non compliant areas.	Sandra Adams	03-Oct-12	Major	Possible	12	1. Review of standards in which existing policies/procedures do not match practice. 2. Update relevant polocies/procedures to ensure current practice is captured correctly. 3. NHSLA module on Health Assure to be available for evidence updates. 4. Quality Performance Improvement Managers to be invited to attend compliance standards meeting on a regular basis. 5. Disemminate current compliance status with NHSLA and CQC standards at Directorate and Area meetings with actions required. 6. Level 2 gap analysis to be updated in conjunction with standard leads, including refresher training on PA and user guides circulated. 7. The first quarterly update provided by users, including uploading of all required evidence, as specified in the gap analysis. 8. The first of the quarterly governance audits, reviewing evidence and compliance ratings, providing feedback via user group and escalation of concerns via Compliance Assessment Group. 9. Informal visit/mock level 2 assessment with NHSLA assessor to review evidence of compliance and agree date for assessment.	1. Governance and Compliance Team (GCT) 2. GCT 3. GCT 4. GCT 5. Standard Leads 6. GCT and Standard Leads 7. Standard Leads 8. GCT 9. GCT and Standard Leads	1. Completed 2. Completed 3. Oct 2012 4. Oct 2012 5. From Oct 2012 6. Nov 2012 7. Dec 2012 8. Jan 2013 9. March 2013		Major	Unlikely	8	
63	The risk of incurring liability through the re-use of "single use" equipment.		14-Nov-02	***	1,2,4, 5	Infection Control	Major	Possible	12	1. Make Ready has improved the controls over single use equipment. 2. The infection Control Policy covers "single use" equipment. 3. Staff awareness has been increased by the use of Training Bulletins, RIB, posters etc. 4. "Single use" items are in place. Risk of re-use rather than disposal is unlikely. 5. A decontamination policy is now in place.	Steve Lennox	07-Jan-13	Major	Possible	12	To have a decontamination policy that meets CQC expectations: 1. Establish Equipment Decontamination Improvement Group at Logistics Support Unit with Terms of Reference. 2. Monitor decontamination compliance	1. C. Vale/ K. Merritt 2. T.Hubbard	1. Complete 2. Sep 2012	1. Incident reporting. 2. Complaints/ claims monitoring.	Moderate	Rare	3	IPCC 1.11.12 - no amendments made
272	There is a risk that the LAS may not achieve the full CIP due to new/unforseen cost pressures.		03-Jul-07	***	8,10	Finance	Major	Possible	12	1. CIP has been agreed with SMG/ Trust Board. SMG/Trust Board review report monthly. 2. Monthly monitoring via Performance Accelerator. Monthly Finance Review includes detailed forecast. 3. 37 CIP related projects are integrated with the standard programme management arrangements through the Integrated Business Plan. 4. Continue to Identify further savings - monthly CIP reporting. 5. Continued colaboration with wider health care services.	Andrew Grimshaw	04-Mar-13	Moderate	Possible	9	1. Review as part of CIP monitoring 2. Review by Finance Investment Committee	1. M.Dinan 2. A.Cant	1. Ongoing 2. Ongoing	1. CIP reported monthly to SMG and the Trust Board. 2. Programme Governance Structure 3. Finance Investment Committee	Moderate	Possible	9	At month 10 the Trust is forecasting to deliver its agreed CIP plan in 2012-13 of £12.4 million.

London Ambulance Service NHS Trust
Risk Register as at 18th March 2013

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309	There is a risk of fraudulent activity from staff, patients and contractors.		16-Feb-09	***	4,5	Finance	Major	Possible	12	1. An annual Counter Fraud work-plan is agreed with the Director of Finance and is approved by the Audit Committee. The work-plan ensures that time is allocated to the Local Counter Fraud Specialist to undertake work in the areas of the Counter Fraud Strategy, inclusive of Creating an Anti-Fraud Culture; Deterring Fraud; - Preventing Fraud; Detecting Fraud, - Investigating any allegations of fraud that are received against the Trust; - Applying Sanctions that can involve disciplinary, civil and/or criminal hearings; - Seeking redress - seeking to recoup money that has been obtained from the Trust by fraudulent means. 2. RSM Tenon - audit function	Andrew Grimshaw	07-Jan-12	Moderate	Possible	9	1. Promoting an anti-fraud culture amongst Trust staff by giving presentations, distributing Counter Fraud literature, holding fraud awareness events. 2. Creating deterrence by promoting successfully locally and nationally investigated fraud cases. 3. Preventing fraud by reviewing Trust policies and procedures. 4. Detecting fraud by undertaking Local Proactive Exercises into areas of concern. 5. Undertaking of a Fraud Risk Assessment.	1-5. M.Dinan (via Trust Counter Fraud Group)	1-5. As scheduled in the Local Counter Fraud Specialist Annual Work Plan for 2012 / 2013	1. Reported incidents. 2. Trust Counter Fraud Group	Moderate	Unlikely	6	An LA167 is being drafted and will be considered by the Counter Fraud Group.
165	There is a risk that delivery of sub-optimal care for patients with age-related needs and failure to meet NSF milestones.		04-Jan-05	***	1,2,4, 10	Clinical	Major	Possible	12	1. Action Plan (section 5 - Older People's Strategy) is in place through which the delivery of "sub optimal care for patients with age-related illnesses" is being addressed. 2. Older People's Strategy has been updated. 3. Referral Pathways Project in progress and is now part of the Healthcare for London workstream.	Lizzy Bovill	20-Mar-12	Moderate	Possible	9	1. Development of referral pathways as our partnership work with commissioners. 2. Training for front-line staff on use of referral pathways (as part of 1.), is being developed. 3. Training for front line staff on use of referral pathways is being rolled out with particular focus on improving the management of people who have fallen, many of whom are older people.	1. Lizzy Bovill 2. Emma Williams 3. Emma Williams	1. Apr 2012 2. Apr 2011 3. Apr 2012	1. Annual report to the CQSE.	Moderate	Unlikely	6	
247	There is a risk of not achieving the 3 strategic goals where there is non-delivery of project outcomes (to time cost and/or quality) in relation to the IBP.		25-Jul-06	***	1,2,3, 4,5,6, 7,8,9, 10	Corporate	Moderate	Likely	12	1. Senior Managers have been trained through MSP and PRINCE2 courses and programme and project management methodologies are being used to deliver project outputs and realise programme benefits. 2. Project boards operate where appropriate for larger projects within the programme and smaller projects are overseen by directors leading portfolios of projects. 3. The programme maintains a risk and issue log and any new and appropriately graded risks are added to the corporate risk register. 4. Governance arrangements have been established for the IBP Delivery Programme with support provided by the programme office. 5. The Chief Executive is the Senior Responsible Owner with SMG sitting as the programme board which meets monthly. 6. Progress reporting taking place through Performance Accelerator which feeds through to monthly SMG programme board meetings and provides a section of the CEO's update to Trust Board meetings.	Sandra Adams	04-Mar-13	Moderate	Possible	9		1. M.Brand	1. Ongoing.	1. Progress reports to IPB Delivery Programme Board. 2. Reports toTrust Board as part of CEO's report.	Moderate	Unlikely	6	The strategy programme board agreed to recommend to RCAG that thus risk is archived. New risks relating to the 5 year strategy will be articulated as they are identified
308	There is a risk that LAS staff may suffer emotional or physical injury as a result of being subject to physical or verbal assult, and this may adversely affect the delivery of the service that the LAS provides and/or the reputation of the LAS.	Injury and Sickness Absence	01-Apr-11	***	1,2,5, 7	Health & Safety	Moderate	Likely	12	1. The Local Security Management Specialist (LSMS) has developed a draft Trust Security Management Plan in accordance with Counter Fraud and Security Management guidance. 2. Serious Incident Reporting system will ensure information is regularly reported to NHS Protect. 3. Local management support, LINC and counselling services are available to staff	Caron Hitchen	04-Mar-13	Moderate	Possible	9	1. Conflict Resolution Training update is included in CSR 3 of core learning skills. 2.Reinforce existing responsibilities @ complex level by line management (Specified in Security management policy 3. MN has resubmitting requisitions for Institute of Conflict Management training and accreditation (Application to TSG for funding of physical skills tutor course submitted through GH) Funding for ICM accreditation/training has been agreed and is scheduled to occur prior to 31/03/13 (MN 18/02/13).	1. M. Nicholas 2. M.Nicholas 3. M.Nicholas	1. Core Skills refresher 3 will include CRT **2013/14**. 2. Awaiting direction following ADG meeting 24/02/2012 3. **Approval of funding Dec 2012.**	1. Monitoring of Incident reports by CHSG	Moderate	Unlikely	6	

London Ambulance Service NHS Trust
Risk Register as at 18th March 2013

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186	There is a risk that the inconsistent management of Medical Devices may lead to a higher rate of failure, which would in turn have an adverse effect on the provision of clinical care.	Equipment moved to satitisfy operational needs for patient care	10-Feb-04	***	1,2,4, 5,8	Logistics	Major	Possible	12	1.Servicing schedules for medical devices are agreed with suppliers and carried out within the specified timescale. 2.Supplier records are made available to the Logistics Department. 3.There is also a system of record cards for all medical equipment held within the Logistics Department. 4. Analysis of LA52s for any training issues. 5. Monthly defib audits - returns reported to VEWG	Paul Woodrow	02-Jan-13	Moderate	Possible	9	1. Management of Medical Devices Policy being submitted to the ADO Group and ADG for approval - Chris Vale to chase up progress. 2. The project mandate for tracking medical devices has been approved by the VFM Programme Board and will take into account terms within the make ready contract once they have been agreed. 3. Policy still to be approved.	1. C.Vale/K. Merritt 2. M.Salter/ G.Gifford	1. July 2012 2. March 2012	1. Monitoring of service records for medical devices.	Moderate	Unlikely	6	Dec 2012 -The asset tracking system is now working but is not fully implemented.The majority of the Trusts assets have been scanned into the system but the LSU are still waiting for training to enable them to scan items they pick up for service or repair.
223	There is a risk, that due to operational pressures, the Trust will not be able to hold regular team meetings/briefings with frontline staff. This may have an adverse affect upon CPIs and the PDR process.	Unable to produce sufficent capacity to meet current and ongoing demand levels	12-Jun-06	***	4,5	Operational	Moderate	Likely	12	1. Demand management strategies deployd to reduce overall activity. 2. Use of third party capacity at times of peak demand.	Paul Woodrow	27-Feb-13	Moderate	Possible	9	1. Capacity review with Commissioners with a view to reduce utilisation. (ORH jointly commissioned between LAS and Commissioners to undertake review)	1. P.Woodrow/ J.Killens	1. Q3/4 2012/13		Moderate	Unlikely	6	Dec 2012 - Operational meetings are regulated / curtailed when high REAP levels are activated. Beyond that complexes have the freedom to plan meetings to suit mangers and staff alike Ongoing post ORH Capacity Review
164	There is a risk that Policies and Procedures are not adhered to due to lack of staff awareness and robust implementation plans.	Serious incidents often show that non-compliance with policy is often the root cause of an incident	04-Jan-05	***	1,2,5, 8	Corporate	Moderate	Likely	12	1. NHSLA level one achieved in October 2010 2. Ongoing review of policies and procedures linked to NHSLA . 3. Monitor incidents and serious incidents where policy has not been followed and action is required.	Sandra Adams	31-Dec-12	Moderate	Possible	9	1. All new policies and procedures and significant amendments to be announced in the RIB. 2. Policies and procedures required by NHSLA have been reviewed and revised as appropriate and approved by ADG. 3. Where there has been a breach of policy, Owners/E&D to be requested to arrange appropriate training and awareness for staff.	1. S. Moore 2. S. Moore 3. S. Moore	1. Ongoing 2. Completed 3. Ongoing	NHSLA level 1 Review of incidents and comlaints to ascertain any breach of policy	Moderate	Rare	3	

London Ambulance Service NHS Trust
Risk Register as at 18th March 2013

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356	There is a risk arising from no provision for protected training time for clinical and paramedic tutors. This may as a consequence cause:- ● Dilution of training skill levels ● Credibility and reputation concerns of trainers ● Impact on the validity of clinical training	Current workload within the department means that there is insufficient capacity to ensure that all tutors are developed in line with the departmental tutor development strategy. This includes time to incorporate information from bulletin into teaching strategies.	23-Nov-11		1,2,4, 5	Human Resources	Moderate	Likely	12	1. All tutors have recived a clinical update package. 2. All tutors have received major incident update training. 3. A clinical update training day has been provided to all clinical training staff. Additional clinical skills programmes have been run based on idnetifyied need and regular operational shifts will be incorporated into work pattern.Some staff are to receive additional training in order to support DMP	Caron Hitchen	04-Mar-13	Moderate	Possible	9	1. The training establishment is being reviewed and remodeled to ensure needs can be met. Additionally Training officers are being invited to attend clinial updates. The first of these took place in April 2012	1. GH	1. April 2013	Course review and feedback by Education Governance Manager	Moderate	Rare	3	
222	There is a risk that lack of frontline management at weekends may reduce the level of support/advice available to staff		13-Jun-06	***	1,2,4, 8	Operational	Major	Possible	12	1. DSO annual leave is restricted to ensure 5 are always available pan-London. 2. Team Leaders are also available to respond to incidents in support of crew members. 3. This risk is reduced by safety training for crew staff and the advice to await the arrival of police in high risk situations. 4. A requirement for on duty Silver officer to respond where appropriate, for this reason the Trust has a duty AOM and a on-call AOM avaialabe at all times. 5. General broadcast to other vehicles where requirement for a manager is due to crew safety. 6. Clinical Support Desk is now in place and provides a route for staff to gain support and advice on a range of matters 7. Recruited 9 Acting DSO's in Q1 2012/13	Paul Woodrow	27-Feb-13	Major	Unlikely	8	1. Review new leave rules for DSOs. 2. Develop changes to ops management structure in the light of capacity review. 3. Operational mangement restructure to be prepared for consultation for Q4 post ORH review	1. P.Woodrow 2. P.Woodrow / J.Killens	1. Q3 2012/13 2. Q4 2012/13	1. Analysis of incident reporting	Major	Unlikely	8	Dec 2012 - ORH review has not reported so far Operational Management Structure Review to be considered Q3/Q4 2013/14 Feb 2103 ORH report in final draft form, still not formally agreed
365	There is a risk that Board Members are unable to commit time required to prepare for becoming an FT Board of Directors.	Unplanned changes to FT related meetings, particularly with external stakeholders, may not be accommodated by NEDs who have other time commitments outside the LAS	03-May-12			Governance	Major	Possible	12	1. Schedule of committees includes SRP for strategic focus. 2. NEDs have a time commitment to LAS of 2.5 days. 3. FT project team re-established. 4. Risk reviewed by FT Project Team. 5. Trust Board and SRP sessions extended to full day to incorporate development time	Richard Hunt	04-Mar-13	Major	Unlikely	8	1. With Healthskills, develop a programme of Board development that focuses on key items for preparation for an FT Board. 3. Chair and NEDs agree PDPs.			1. Attendance schedule for Board development. 2. PDPs in place for all NEDs.	Major	Rare	4	
376	There is a risk that the Trust Board fails to fulfil all its statutory duties.	NHS Trust Boards have many requirements placed on them by external organisations such as CQC, NHSLA, Department of Health and Monitor, following authorisation as a Foundation Trust.	14-Jan-13			Governance	Major	Possible	12	1. Trust Board forward planner 2. Board assurance framework and corporate risk register 3. Full understanding of regulatory requirements 4. Annual Reporting and external annual audit opinion 5. Monthly SOM submission to the SHA, signed off by the Trust Board	Sandra Adams	04-Mar-13	Major	Unlikely	8	1. On becoming a Foundation Trust, adherance to Monitor's compliance framework 2. Quarterly governance submissions to Monitor 3. Independent assessment of quality governance framework 4. Self Assessment for FT Board Statements and Memorandum	1. S.Adams 2. S.Adams 3. S.Adams 4. S.Adams	2. Ongoing		Major	Rare	4	
358	There is a risk that the joiners and leavers process is not established, leavers still have access to LAS information or have assets belonging to LAS.	There is a dissconnect between HR processes and IM&T to ensure that leavers return all assest and accounts are disabled when the staff member leaves.	09-Jan-12		4	IM&T	Minor	Almost Certain	10	1. Removal of duplicate Employee IDs	Peter Suter	08-Jan-13	Minor	Unlikely	4	1. Starters and leavers process documentation being created. 2. Complete and distribute 'Managers Guide to Administration' to Managers. 3. Ensure that assets held by the leaving member of staff are identified and returned on the last day of work; New leavers process starts 01/04/13. 4. Ensure that logical access to LAS systems is disabled when the staff member leaves. This is to include, as much as possible, this is to include all remote access and NHSmail accounts. Complete. New technology automatically removes access to LAS networks upon termination in the Electronic Staff Record (ESR).	1. A.Honour 2. G.Masters 3. A.Honour 4. A.Honour /G.Farquhar	1. Complete 2. 15/03/13 3. 01/04/13 4. Complete	1, Starters and leavers meeting held every 2 weeks The new leavers process will ensure that line managers confirm they have collected any sensitive or valuable assets and compliance can be audited	Minor	Unlikely	4	8.01.13 No change SAN project implemented but no further action taken in getting data off local drives. 8.01.13 - JN New Wording - There is a risk that weaknesses in the leavers process could lead to LAS property issued to staff being taken away. The effect of this could be a loss of intellectual property, sensitive data, LAS uniforms or valuable IT equipment. The impact of this could be damage to the

London Ambulance Service NHS Trust
Risk Register as at 18th March 2013

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331	There is a risk that the Trust will not achieve the target of reducing its carbon footprint by 10% by 2015 (based on 2007 carbon footprint)	Underlying cause is the legal requirement on the Trust (in line with the rest of the NHS) to deliver on the commitment to reduce carbon footprint by 10% by 2015 (based on 2007/08 carbon footprint Scope 1&2).	06-May-10	***	4	Finance	Moderate	Possible	9	The Trust's five year carbon management plan has been edorsed by the Carbon Trust. The Plan outlines how the Trust will achive reduction in carbon footprint primarily based on changes in response model - increased use of CTA, reduction in non-conveyance and Multiple Sends	Andrew Grimshaw	08-Jan-12	Moderate	Possible	9	1. CMc 27/09/12: the Trust is exploring possibility of working external contractor re. Energy Services to continue to modernise our infrastructure and reduce our consumption by 15%. The Trust's Energy Manager is investigating joining the ReFIT programme which is a GLA sponsored inititiave with the objective of improving energy conservation in London. 08/01/13: this is work in progress. 2. Management action plan will be overseen by Carbon Reduction Project Board (chaired by Mike Dinan). 3. 6 monthly progress reports will be submitted to the Finance & Investment Committee. 08/01/13: This was done in November 2012, available data suggests Trust is on track with carbon reduction measures. 2012/13 will be submitted to the FIC in May 2013. 4. Pilot projects to be undertaken in the buildings that have half hour meters measuring electricity usage. 5.Travel plan and supporting survey to be undertaken 6. Recruitment of green champions.	1.C.McMahon 2.C.McMahon 3.C.McMahon 4.C.McMahon 5.C.McMahon 6.C.McMahon	1. March 2013 2.quarterly 3. May 2013 4. March 2013 5. March 2013 6. March 2013	1. Regular reports to Carbon Mgt Project Board & 6 monthly progress report to the Finance & Investment Committee	Moderate	Unlikely	6	Data is being gathered for both Scope 1 & 2 on a routine basis and the indications are that the downward trend is continuing.
350	There is a risk that the establishment of a Clinical Commissioning Group and reconfiguration of the SHA and PCT's may result in a temporary reduction in stakeholder engagement and partnership working and subsequent delivery of improvements in the urgent and emergency care system.	Since the implementation of the Health Bill the following issues have been highlighted. 1) Impact on providing appropriate clinical care to patients. 2) Staff clinical decision making could be affected. 3) Impact on finance due to not achieving financial targets such as CQIN and Quality, Innovation , Productivity and Prevention. 4) Impact on performance due to increased turnaround times. 5) Reputation risk for the LAS through inefficient use of the health economy. 6. Ensuring ongoing support from CCGs for our FT application.	11-Jul-11	***	1,2,4, 10	Clinical	Moderate	Possible	9	1. Monthly monitoring of current care pathway usage. 2. Feedback mechanism in place of care pathways with commissioners. 3. Creating an evidence base and continuing a dialogue with commissioners to maintain clinically appropriate pathways and reported bi monthly to Clinical Quality Group. 4. A Clinical Quality Group to engage senior GPs from clusters in strategy and quality issues meets bi-monthly. 5. Membership and attendance at NHS London and cluster level unscheduled care boards.	Jason Killens	23-Aug-12	Moderate	Possible	9	1. Attendance at cluster level clinical cabinets to gain support for LAS strategy and FT application.	1. J. Killens	1. April 2013	1. Established relationships with Senior Leads. 2. Quarterly meetings with Senior Leads and monthly meetings with Junior Leads 3. Attendance at quarterly strategic commissioning board.	Moderate	Unlikely	6	
199	There is a risk to staff safety / vandalism/theft due to inability to adequately secure premises.	There is no overarching Security Risk Policy to coordinate and bolster existing security measures within the Trust and there is no identified specific group who oversee security issues.	01-Jan-03	***	7,8	Finance	Moderate	Possible	9	1. Operational managers in conjunction with H&S representatives carry out quarterly health and safety premises inspections. If there is a perceived security issue it will be reported to Estates who will investigate and take appropriate action. 2. OP/018 Procedure On Station Duties. 3. Bulletin reminding staff to secure premises when leaving unattended. 4. A Trust Internal Security Group has been formed which will meet regularly to address security related issues within the Trust	Andrew Grimshaw	07-Jan-13	Moderate	Possible	9	1. A Security Management Policy will be developed. 2. An audit of security at stations is being undertaken (June/July) in order to privide an indication of priority for a full security survey to be undertaken. Following this audits will be carried out every two years.	1. M. Nicholas / John Selby 2. M. Nicholas	1. Completed 2. In place	1. Reported to SMG	Moderate	Unlikely	6	1. Security Management Policy has been developed and has been ratified by SMG. 2. Audit of security at stations has been undertaken and a schedule of full security audits has been drawn up and is being carried out.

London Ambulance Service NHS Trust
Risk Register as at 18th March 2013

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303	There is a risk of unavailability of critical patient care equipment on vehicles.	Equipment moved to satitisfy operational needs for patient care	21-Oct-08	***	1,2,4, 8	Logistics	Moderate	Possible	9	1. New vehicle preparation contracts in place with new contract that will introduce electronic asset tracking in Q3/4 2012/13. 2. Regular equipment amnesty. 3. New capital equipment (defibs) purchased.	Paul Woodrow	02-Jan-13	Moderate	Possible	9	1. Trial of new LA1 forms to include equipment and VDI checks being carried in the West Area for 3 months commencing June 2011. 2. Following West area review, begin roll-out to East and South areas 3. New LA4 forms and Red Bags in place across trust 4. Surplus equipment held by make ready 5. Area based equipment stores to be established by logistics Q3/Q4 working with assest tracking				Moderate	Unlikely	6	Dec 2012 -Regular audits to be undertaken and computerised once assest tracking standardised. The asset tracking system is now working but is not fully implemented.The majority of the Trusts assets have been scanned into the system but the LSU are still waiting for training to enable them to scan items they pick up for service or repair.
364	There is a risk that changes to the external commissioning and provider support environment cause uncertainty and delay in progressing the FT application	Transitional arrangements commence in 12/13 within the SHA provider/FT application support team and within commissioning. If there are changes within those teams this may create delay to the FT application whilst there are gaps or handover arrangements taking place	19-Apr-12			Corporate	Moderate	Possible	9	1. Engagement of lead commissioner in FT development 2. Strategic Commissioning Board provides the opportunity to reinforce the LTFM requirements 3. Cluster letter of support – October 13	Sandra Adams	04-Mar-13	Moderate	Possible	9	1. Strengthen the commissioner engagement in reviewing and developing the 5-year strategy through the IBP and LTFM 2. Engage commissioners in the development and sign off of the downside scenarios 3. Letter of convergence is clean and unambiguous	1. J.Killens / S.Adams / A.Grimshaw 2. A.Grimshaw / A.Cant 3. L.Bovill / A.Grimshaw/ S.Adams	1. 31 Aug 12 2. 31 Aug 12 3. Nov 12	1. Commissioner letter of convergence fully supports the LAS application and strategy 2. IBP and LTFM fully supported and signed off by commissioners 3. Downside scenarios updated and supported by the commissioners	Moderate	Unlikely	6	
46	There is a risk of infection to staff due to sharps injury.		14-Nov-02	***	4,7	Infection Control	Moderate	Possible	9	1. Introduced the Safety Canulae trial in early 2009. Results to be monitored via Infection Control Steering Group. 2. In 2008 the overall number of LA52 reported needle stick incidents for Q3 (1st July - 30th Sept) was 9 near misses and 3 actual. This represents a reduction of reported incidents from Q2 of 12 actuals and 2 near misses. The new cannulae are 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	07-Jan-13	Moderate	Possible	9	Minimise the risk of sharps injury: 1. Participate in national ambulance audit 2011. 2. Undertake a programme of staff awareness (and to incorporate new guidance from POSSH conference)	1.T.Hubbard 2. T.Hubbard	1. Complete 2. May 2013	1. Health and Safety Audits. 2. Clinical Quality Safety and Effectiveness Committee. 3. Incident reporting. 4. ICSG quarterly review 5. SUI of high risks cases.	Minor	Unlikely	4	IPCC 1.11.12 - no amendments made

London Ambulance Service NHS Trust
Risk Register as at 18th March 2013

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278	There is a risk that staff are not trained in Business Continuity and are unaware of their responsibilities and/or their departmental arrangements in the event that the Business Continuity Plan is invoked.		03-Jul-07	***	5,7	Business Continuity	Moderate	Possible	9	1. Tabletop testing programme of departmental plans is ongoing and has so far included IM&T, Communications, Estates, Logistics, Finance, Purchasing and HR (Safety & Risk and Staff Support). 2. Business Continuity is now covered in the Corporate Induction Programme and the 3 year all in one refresher for support staff. 3. Awareness raised of departmental BC plans ahead of Olympic Games 2012. Maintaining Service Delivery group also promoting need for departmental BC.	Paul Woodrow	08-Jan-13	Moderate	Unlikely	6					Moderate	Unlikely	6	8.01.13 Target Rating achieved proposed for archive by Business Continuity and Emergency Preparedness.
366	There is a risk that frontline staff may not be able to measure oxygen saturations on some paediatric patients, in particular infants due to an inconsistency in availability of paediatric pulse oximetry across the Service.	All patients who may require oxygen therapy where the attending paramedic/EMT may have not suspected hypoxia and therefore did not administer oxygen. A mitigating factor is the monitoring of the DIB CPI which looks at whether O2 sats were measured.	09-Jul-12			Clinical	Moderate	Possible	9	1. Adult, paediatric and infant pulse oximetry probes are now available to order on eseries, not all complexes are ordering them due to the high cost (paed probes are approx £175) and the fact that due to flexible fleet, probes that are ordered then go off to other areas of the Service. 2. Article published in Clinical update Sept 2011 reminding crews not to withold oxygen if pulse oximetry not immediately available and patient unwell. 3. Adult pulse oximetry available on Lifepak 12/15s available on all frontline vehicles 4. Email sent to all station management by the Senior Clinical Advisor in June 2012 reminding them that the probes are available on Eseries and that they should be equipping their vehicles with them.	Fionna Moore	04-Mar-13	Moderate	Unlikely	6	1. Discussion ongoing as to best way to overcome issue of stations not ordering paediatric probes 2. Recent (June 2012) audit of paed respiratory assessment by CARU recommended that a kit audit is undertaken to determine scale of the problem. 3. Discussion ongoing as to optimum way to overcome problem of lack of paed probes	1. F.Moore 2. ADO's 3.	1. 2. 3.	1. Adult, child and infant probes are available to purchase on eseries 2. Senior Clinical Advisor has reminded station management service wide regarding the importance of equipping LP12/15s with pulse oximetry probes.	Moderate	Rare	3	20/02/13 - DSW - Pulse oximeters have been purchased as above and will be distributed to vehicles starting April 2013.
367	There is a risk that oxygen saturations may not be able to be measured immediately after arrival of the crew (at present oxygen saturations can only be measured using a Lifepak 12/15 which can be removed from the vehicle but, being a large piece of equipment is not usually taken in initially with the primary response bag, AED and oxygen bag).	All patients who may require oxygen therapy where the attending paramedic/EMT may have not suspected hypoxia and therefore did not administer oxygen. A mitigating factor is the monitoring of the DIB CPI which looks at whether O2 sats were measured. In addition, oxygen may be administered to COPD patients who do not require it (or higher levels than necessary may be administered).	09-Jul-12			Clinical	Moderate	Possible	9	1. Adult, paediatric and infant pulse oximetry probes are now available to order on eseries, not all complexes are ordering them. 2. Article published in Clinical update Sept 2011 reminding crews not to withold oxygen if pulse oximetry not immediately available and patient unwell. 3. Adult pulse oximetry available on Lifepak 12/15s available on all frontline vehicles 4. Email sent to all station management by the Senior Clinical Advisor in June 2012 reminding them that the probes are available on Eseries and that they should be equipping their vehicles with them.	Fionna Moore	04-Mar-13	Moderate	Unlikely	6	1. Medical directorate and purchasing dept have looked into possibility of purchasing small, easily portable nonin pulse oximetry probes. A price of approx £100 each was secured funds may not available to purchase these (in addition, personal issue nonins may not be the answer). 2. Monitor the purchase of oximetry probes, both paed and adult, as a measure of success / impact. 3. Recent (June 2012) audit of paed respiratory assessment by CARU recommended that a kit audit is undertaken to determine scale of the problem. 4. Discussion ongoing as to best way to overcome this issue.	1. M.Whitbread 2. F.Moore 3. ADO's 4.	1. 2. 3. 4.	1. Adult, child and infant probes are available to purchase on eseries 2. Senior Clinical Advisor has reminded station management service wide regarding the importance of equipping LP12/15s with pulse oximetry probes.	Moderate	Rare	3	20/02/13 - DSW - Pulse oximeters have been purchased as above and will be distributed to vehicles starting April 2013.
275	There is a risk of loss of access to the Deptford Logistics Store may result in drug supplies being disturbed.		03-Jul-07	***	1,2,8, 10	Business Continuity	Moderate	Possible	9	1. The Trust has arrangements for Frimley Park Hospital NHS Trust to supply drugs on a 24 hour basis if required (but no formal arrangement is in place.). 2. London hospitals could supply drugs in an emergency.	Paul Woodrow	08-Jan-13	Moderate	Unlikely	6	1. Secure agreement with neighbouring Ambulance Trusts to access drugs in extremis.	1. E.Potter	1. Q3 12/13		Moderate	Rare	3	8.01.13 No update on previous position. Informal arrangements are in place for Frimley park to hold 2 weeks stock of drugs which is accessible in an emergency. Frimley have been asked for SLA, Purchasing Dept have agreed to look at.

London Ambulance Service NHS Trust
Risk Register as at 18th March 2013

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	Risk Category	Gross Impact	Gross Like-lihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Like-lihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like-lihood	Target Rating	Comments
271	All staff may not be in possession of a valid driving licence for the category of vehicle they are required to drive.	Seizure of licence by the courts, or attempting to drive a vehicle they hold no valid licence for	14-Mar-07	***	4,5,8	Operational	Moderate	Possible	9	1. All staff have their driving license checked upon recruitment. 2. Anyone with more than 3 points will not be appointed. 3. Driving licence checks should be undertaken for all service drivers on a 6-monthly basis (TP023a/TP065). 4. All staff claiming mileage	Ed Potter	04-Mar-13	Moderate	Unlikely	6	1. The Trust is working inconjuction with staff side viewing options on how best to robustly manage driving licence checks. 2. The Trust is exploring an automated system to check licences directly with the DVLA.	1. & 2. J. Killens / G.Hughes	1. & 2. TBA (following review)	1. Internal Audit	Moderate	Rare	3	4/12/12 IM&T (VW) Indicates that they are now awaiting a network infrastructure change to facilite the secure data connections required to enable bulk checking with DVLA. All managers with access to
372	Complex AOMs fail to write to addresses and inform individuals of their inclusion on the location alert register following initial inclusion and following review. This may result in an incorrect address being included thereby putting patients at risk. This also could lead to complaints and a reputational risk to the Trust	1. Failure to write letters 2. Failure to carry out regular, detailed and timely reviews	14-Jan-13			Operational	Moderate	Possible	9	1. Robust review process in place. 2. Policy reviewed. 3. Standard template letters are available for AOMs to use. 4. Monitoring in place by Management Information.	Paul Woodrow	27-Feb-13	Moderate	Unlikely	6	1. ADO's monotir letter writing at a local level.	1. ADO's	1. Jan 2013	1. ADOs will monitor compliance by AOMs	Moderate	Rare	3	Ongoing
182	Not being able to escape from an LAS building in the case of fire or other emergencies.	Lack of fire inspections/premises inspections, or failure of fire detection systems	09-Feb-04	***	7	Health & Safety	Moderate	Possible	9	1. Procedures are found on Pulse under Fire and Bomb Evacuation Procedure. 2. 'Statement of Fire Safety' is produced annually and is returned to NHS Estates. 3. Risk Action Plans have been produced from the Fire Risk Assessments. 4. Local Fire Marshals have been nominated. 5. Fire evacuation drills are undertaken twice yearly. 6. Fire alarm testing carried out on a weekly basis. 7. All in one and senior line manager safety and risk awareness training includes fire awareness. 8. Core learning skills 2 includes fire awareness training. 9. Premises inspections are monitored at the CHSG	Caron Hitchen	04-Mar-12	Minor	Unlikely	4	1. Health Safety and Risk team to take responsibility for delivering Fire Marshall Awareness Training. 2. Core learning skills 2 includes fire awareness training. 3. Premises inspections are monitored at the CHSG	1. J.Selby 2. K Miller 3. J Selby	1. Ongoing 2. Ongoing 3. Ongoing	1) Fire & Bomb Evacuation Policy 2) Premises Inspection Procedure 3) CHSG Monitor Premises Inspections 4) Annual Statemnt of Fire Safety submitted to DoH 5. Fire Audit completed in August 2012. RSM Tenon Audit	Minor	Rare	2	Dec 2012 - The plan agreed at the TSG has not included the delivery of CSR 2 during the current year due to the QDJ and Olympic events. (KM 10/12/12)
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	07-Jan-13	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 IPCC propose that risks 327 and 332 are combined as they cover the same issues. LA167 to be raised to cover both risks.
375	There is a risk that the single members of staff (contractors) with current responsibility respectively for: support and development of the Trusts vehicle based mobile data terminals (MDT) and a suite of Control Services supporting applications, may become unavailable with resultant loss of detailed technical knowledge and potential for a failure of services to be unresolvable causing impact to EOC and A&E Operations.	The Trusts MDT solution is proprietary to the LAS and is a legacy of a former IT regime. Code level support of the MDT software is undertaken by only one person with the acquired knowledge of the system (inherited documentation was minimal). Numerous innovative software solutions have been developed and actively contribute to the efficiency of call	14-Jan-13			IM&T	Major	Unlikely	8	1. SMG agreement to create two permanent IM&T Senior Software Engineer posts. 2. Grading of posts to reflect technical expertise, specialist knowledge and experience. Current contractors to be encouraged to apply for permanent posts.	Peter Suter		Major	Unlikely	8	1. Conclude post grading, authority to recruit and selection process. 2. On successful appointment - commence induction and knowledge sharing sufficient to allow one to cover the other during absences.	1. John Downard 2. John Downard	1. Nov 2012 2. Mar 2013		Major	Rare	4	

London Ambulance Service NHS Trust
Risk Register as at 18th March 2013

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	Risk Category	Gross Impact	Gross Like-lihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Like-lihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like-lihood	Target Rating	Comments
351	There is a risk that operational staff may be verbally abused. The consequences being an increase in staff absence through stress, and an adverse impact on staff moral/ service/ patient care.	There is the potential that any member of operational staff may be subjected to verbal abuse for a wide variety ofreasons that might include but not be restricted to alcohol, drugs and or mental health issues affecting patients and others that operational staff come into contact with during	10-Oct-11	***	5,7	Health & Safety	Minor	Likely	8	1. Conflict Resolution Training, Identification of trends through incident reporting statistics. 2. High risk address flagging, MDT updates from EOC; Airwave radio. 3. Obstructing Emergency Worker legislation. 4. Appointment of local security leads	Caron Hitchen	04-Mar-13	Minor	Possible	6	1. Run an additional "No Tolerance" campaign. 2. **Staff / Public awareness posters.** 3. Conflict Resolution Training update is included in 2nd day of core learning skills. 4.Reinforce existing responsibilities @ complex level by line management.	1. M.Nicholas 2. M.Nicholas 3. M.Nicholas 4.	1. **Nov/Dec 2013** 2. **May 2013** 3. Core Skills refresher 3 will include CRT **2013/14.** **4. Sept 2012-Sept 2013**	1. CH&SG incident statistics review 2. Review local risk registers 3. Existing responsibilities at complex level of line management to be reinforced 4. Period review of High Risk flagged addresses	Negligible	Possible	3	A review of the level of reported incidents of non-physical assault/abuse indicates a continuing general downward trend from April 2011 to Dec 2012. M Nicholas has been meeting with AOMs and complex management teams to reinforce existing responsibilities at complex level by line management following the agreement that a local security lead at complex

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH MARCH 2013.

PAPER FOR APPROVAL

Document Title:	**Finance Report Month 11 (February)**
Report Author(s):	**Director of Finance**
Lead Director:	**Director of Finance**
Contact Details:	**Andrew.grimshaw@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To ensure the Trust Board is aware of the organisations financial position**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☒ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**The Board is requested to note this paper, and the year end financial position forecast within it.**

Key issues and risks arising from this paper

- The Trust remains on track to achieve its forecast year end surplus of £0.3m.
- While some risks remain to the forecast, these are not considered material. Action is in place to mitigate them.

Executive Summary

- The Trust continues to forecast a surplus of £0.3m. This is £2.8m below plan.
- Continued high levels of activity are the main driver for the forecast being below plan.
- The Trust has been successful in securing additional funding from NHSL to support activity and other organisational specific cost pressures.
- CIP delivery is reported in line with plan. Further work is underway to validate this.
- Capital expenditure remains behind plan. The Trust will undershoot its EFL. This is permitted.
- The Trust expects to achieve the year end cash balance required to meet the External Financing Limit.

Attachments

Month 11 Finance Report

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

Equality Analysis

Has an Equality Analysis been carried out?

☐ Yes
☒ No

Key issues from the assessment:

London Ambulance Service NHS Trust
Finance Report 2012/13
Month 11: February

Trust Board (Part 1) 26th March 2013.

Andrew Grimshaw
Finance Director

Summary

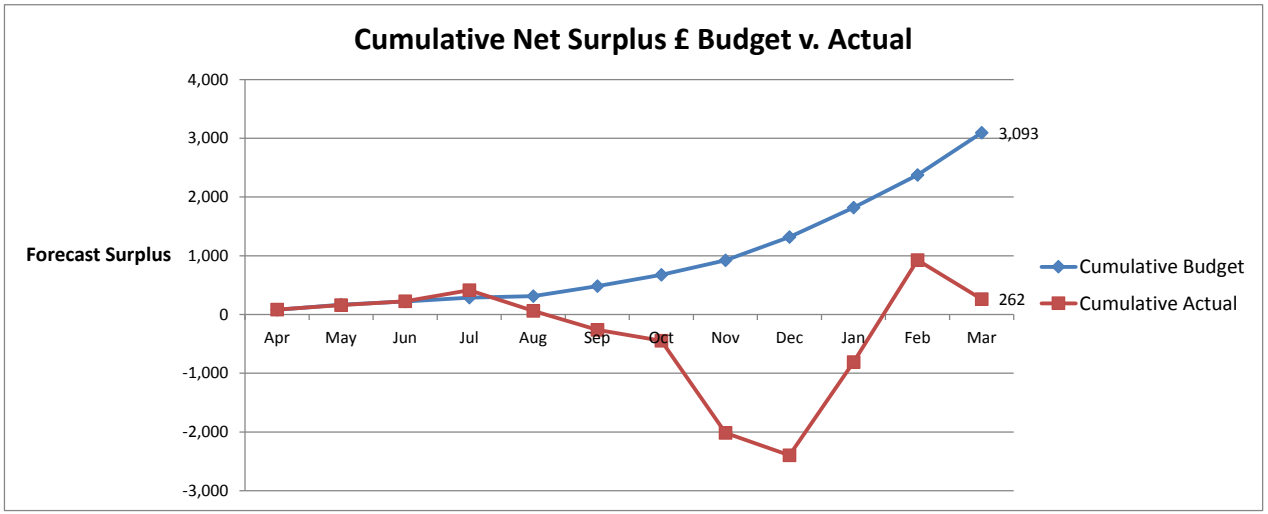
Financial Indicator	Summary Performance	Current month	Previous month
Surplus	Current forecast £2.8m adverse from plan. Expected surplus of £0.3m against target surplus of £3.1m. Activity pressure seen as key driver across year, with Trust Board electing to seek to protect service delivery over delivering surplus. Achievement of the surplus position has been secured due to the additional income from NHSL and commissioners of £2.5m. The trust continues to experience significant cost pressure driven primarily by increased demand.	**AMBER**	**AMBER**
Income	Remains significantly above plan. Majority of income recovery seen as secure. At month 10 the Trust requested additional income totalling £2.5m from NHSL and its commissioners in order to secure the delivery of the £0.3m forecast surplus. This income has now been confirmed with the NHSL.	**AMBER**	**AMBER**
Expenditure	Expenditure remains significantly higher than plan. Further action is required in order to secure the year end forecast surplus, and additional expenditure controls are in place, as well as actions to review year end positions (notably stock and annual leave accruals). Expenditure remains a risk due to variation in reporting. Year end bonus payments related to winter pressure activity will create cash pressure in early 2013/14.	**AMBER**	**AMBER**
CIPs	CIPs are reported on track. A review of CIP delivery has highlighted some reporting issues. Further work is underway to confirm. Rating reduced to Amber in month.	**AMBER**	**GREEN**
Balance Sheet	The balance sheet should not be seen as robust at this time. Not achieving the target surplus of £3.0m is creating cash pressure, while reductions in debtors are being offset by increases in creditors. In addition, payments of capital creditors and loan repayment are consuming cash. Slow capital expenditure in year is helping to retain cash, although the higher level of capex in Mar will create cash pressure in early 2013/14.	**AMBER**	**AMBER**
Cashflow	The year end target of £5.5m in cash is forecast to be achieved, but this will need to be supported by slower than planned creditor payments. Cash pressure is expected to increase in the early months of 2013/14.	**AMBER**	**AMBER**

Key Financial Metrics

Description	FY 2012/13				Commentary
	Budg	Fcast	Var	%	
	£000	£000	£000		
Dept Health					
Surplus	3,094	262	2,832	1080.4%	Amber as Surplus still expected but lower than plan
EFL	(1,998)	(2,000)	2	-0.1%	The trust is on track to deliver to deliver its EFL
CRL	12,400	7,919	4,481	56.6%	CRL will undershoot but this is within acceptable limits
Suppliers paid within 30 days - NHS	95	54	41	75.9%	The Trust is below the national standard
Suppliers paid within 30 days - Non NHS	95	80	15	18.8%	The Trust is below the national standard
Monitor					
EBITDA %	7.5%	5.9%	2%	27.5%	Below plan but maintains Monitor Level 3 delivery
Net Surplus	3,094	262	2,832	1080.4%	Amber as Surplus still expected but lower than plan
Return on Assets	5.71%	3.76%	1.95%	51.8%	Reduction in surplus driving down delivery but within tolerance
Liquidity Days	(10.38)	(9.94)	0.44	4.4%	Lower than plan but within tolerance
Monitor net rating		3			As per Financial Risk Rating

Statement of Comprehensive Income

Month 11 - February 2013			Description	Year to Date			FY 2012/13		
Budg	Act	Var		Budg	Act	Var	Budg	Fcast	Var
£000	£000	£000		£000	£000	£000	£000	£000	£000
			Income						
20,919	23,402	2,483	Emergency & Urgent care	230,537	235,992	5,456	254,308	258,732	4,424
2,506	2,246	(261)	Other	32,081	35,908	3,828	34,652	39,210	4,558
23,425	**25,648**	**2,222**	**Subtotal**	**262,617**	**271,901**	**9,283**	**288,960**	**297,942**	**8,982**
			Operating Expense						
16,800	17,068	(268)	Pay	188,862	192,086	(3,224)	205,053	210,162	(5,109)
4,469	5,400	(932)	Non Pay	55,184	63,064	(7,880)	62,164	70,202	(8,038)
21,268	**22,468**	**(1,199)**	**Subtotal**	**244,046**	**255,150**	**(11,104)**	**267,217**	**280,364**	**(13,147)**
2,157	**3,180**	**1,023**	**EBITDA**	**18,572**	**16,751**	**(1,821)**	**21,743**	**17,578**	**(4,165)**
9.2%	12.4%	-3.2%	**EBITDA margin**	7.1%	6.2%	0.9%	7.5%	5.9%	1.6%
			Depreciation & Financial						
1,210	1,087	123	Depreciation	11,866	11,831	36	13,926	12,953	973
326	326	0	PDC Dividend	3,589	3,589	(1)	3,915	3,916	(1)
67	32	35	Interest	741	405	336	809	447	361
1,603	**1,445**	**158**	**Subtotal**	**16,196**	**15,825**	**371**	**18,649**	**17,316**	**1,334**
554	**1,735**	**1,181**	**Net Surplus/(Deficit)**	**2,375**	**925**	**(1,450)**	**3,094**	**262**	**(2,832)**
2.4%	6.8%	-4.4%	**Net margin**	0.9%	0.3%	0.6%	1.1%	0.1%	1.0%



- At the end of month 11 the Trust is reporting a surplus of £0.9m YTD, £1.5m adverse from plan.
- The main reason for the adverse position from plan results from costs exceeding income across the year.
- The Year end forecast is for a surplus of £0.3m, £2.8m adverse from plan.
- In order to deliver this forecast the Trust has secured £2.5m of additional income from commissioners and NHSL.
- Delivery of the forecast remains subject to some risk but there are action plans to mitigate these.

Statement of Position: Year End Forecast

	Mar-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Mar-13		
	Act	Act	Act	Act	Act	Fcast	Plan	Var	%
	£000	£000	£000	£000	£000	£000			
Non Current Assets									
Property, Plant & Equip	123,055	120,355	119,287	118,259	119,002	119,391	119,940	549	0.46%
Intangible Assets	15,033	14,918	14,918	14,918	13,620	13,620	14,964	1,344	8.98%
Trade & Other Receivables	1,770	2,602	2,594	2,634	2,642	2,642	956	(1,686)	-176.36%
Subtotal	139,858	137,875	136,799	135,811	135,264	135,653	135,860	207	-166.92%
Current Assets									
Inventories	2,812	3,410	3,503	3,284	3,230	3,230	3,044	(186)	-6.11%
Trade & Other Receivables	11,940	7,579	10,502	13,185	9,903	10,093	14,263	4,170	29.24%
Cash & cash equivalents	5,250	6,952	7,019	5,776	9,834	5,500	5,500	0	0.00%
Total Current Assets	20,002	17,941	21,024	22,245	22,967	18,823	22,807	3,984	23.13%
Total Assets	159,860	155,816	157,823	158,056	158,231	154,476	158,667	4,191	2.64%
Current Liabilities									
Trade and Other Payables	(21,364)	(26,050)	(28,503)	(27,284)	(25,520)	(22,559)	(24,516)	(1,957)	7.98%
Provisions	0	0	0	0	(1,135)	(1,120)	(1,150)	(30)	
Borrowings	(1,268)	(402)	(380)	(353)	(331)	(313)	(453)	(140)	30.91%
Working Capital Loan - DH	0	0	0	0	0	0	0	0	
Capital Investment Loan - DH	(1,244)	(622)	(622)	(1,244)	(1,244)	(1,244)	(1,244)	0	0.00%
Net Current Liabilities)	(23,876)	(27,074)	(29,505)	(28,881)	(28,230)	(25,236)	(27,363)	(2,127)	7.98%
Non Current Assets plus/less net current assets/Liabilities	135,984	128,742	128,318	129,175	130,001	129,240	(4,556)	1,857	31.11%
Non Current Liabilities									
Trade and Other Payables	0	0	0	0	0	0	0	0	
Provisions	(9,154)	(9,415)	(9,373)	(9,265)	(8,358)	(8,881)	(8,221)	660	-8.03%
Borrowings	(6,130)	(641)	(641)	(641)	(641)	(641)	(534)	107	-20.04%
Working Capital Loan - DH	0	0	0	0	0	0	0	0	
Capital Investment Loan - DH	(5,587)	(5,587)	(5,587)	(4,965)	(4,965)	(4,343)	(4,343)	0	0.00%
Total Non Current Liabilities	(20,871)	(15,643)	(15,601)	(14,871)	(13,964)	(13,865)	(13,098)	767	0.00%
Total Assets Employed	115,113	113,099	112,717	114,304	116,037	115,375	118,206	2,831	-135.81%
Financed by Taxpayers Equity									
Public Dividend Capital	62,516	62,516	62,516	62,516	62,516	62,516	62,516	0	0.00%
Retained Earnings	19,304	17,290	16,908	18,495	20,228	19,566	22,397	2,831	12.64%
Revaluation Reserve	33,712	33,712	33,712	33,712	33,712	33,712	33,712	0	0.00%
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	0	0.00%
Total Taxpayers Equity	115,113	113,099	112,717	114,304	116,037	115,375	118,206	2,831	12.64%

- Non-current assets stand at £135.3m. This is forecast to increase to £135.7m by the end of March. The main driver of this will be the capital programme.
- Current assets stand at £23.0m, with cash totally £9.8m. By March CA will reduce to £18.8m, mainly due to the reduction in cash in line with EFL requirements. Cash is forecast to achieve the year end EFL requirement of £5.5m.
- Current Liabilities stands at £28.2m. This is forecast to reduce to £25.2m by year end. The main areas of reduction will be creditors, largely as a consequence of reducing cash holdings at year end.
- No loans is forecast for the remainder of the year.
- The following page details the monthly run rate for the balance sheet.
- In future months more detailed analysis of debtors and creditors will be developed.

Capital Expenditure

Month 11 - February 2013			Description	Year to Date			FY 2012/13		
Budg	Act	Var		Budg	Act	Var	Budg	Fcast	Var
£000	£000	£000		£000	£000	£000	£000	£000	£000
			General						
0	61	(61)	Other	0	385	(385)	0	385	(385)
0	**61**	**(61)**	**Subtotal**	**0**	**385**	**(385)**	**0**	**385**	**(385)**
			Fleet						
50	(0)	50	DCA	1,753	4,356	(2,603)	1,803	4,431	(2,628)
100	0	100	LP 15	850	0	850	1,048	794	254
83	50	33	FRU	2,663	(38)	2,701	2,747	(21)	2,768
79	0	79	PTS	422	40	382	500	75	425
0	0	0	RBS DCA	2,549	2,513	36	2,549	2,513	36
0	250	(250)	Other Fleet	1,090	442	648	1,091	468	623
312	**300**	**12**	**Subtotal**	**9,327**	**7,314**	**2,013**	**9,738**	**8,259**	**1,479**
			Estates						
399	0	399	New	798	10	788	1,997	10	1,987
0	45	(45)	Refurb	480	495	(15)	480	705	(225)
50	109	(59)	Other	420	163	257	468	361	107
449	**154**	**295**	**Subtotal**	**1,698**	**669**	**1,029**	**2,945**	**1,077**	**1,868**
			IM&T						
125	54	71	Hardware	1,422	213	1,209	1,545	370	1,175
0	3	(3)	Software	501	157	344	500	157	343
125	**57**	**68**	**Subtotal**	**1,923**	**370**	**1,553**	**2,045**	**526**	**1,519**
886	**573**	**313**	**Gross Capital Expenditure**	**12,948**	**8,737**	**4,211**	**14,728**	**10,247**	**4,481**
			Disposals						
0	0	0	Estates	0	0	0	0	0	0
0	0	0	Fleet	(2,328)	(2,328)	0	(2,328)	(2,328)	0
0	**0**	**0**	**Subtotal**	**(2,328)**	**(2,328)**	**0**	**(2,328)**	**(2,328)**	**0**
886	**573**	**313**	**Net Capital Expenditure**	**10,620**	**6,409**	**4,211**	**12,400**	**7,919**	**4,481**

- Gross capital expenditure is forecast to be £10.2m by the 31st March 2013, £4.5m below plan.
- Expenditure to date is £8.7m, £4.2m below plan.
- Since month 09 forecast capital expenditure has slipped £3.6m(24.3%).
- In March £1.6m of capital expenditure is forecast to be incurred, 17% of the annual total.
- YTD the most significant area of underspend against annual plan are IMT £1.5m (slippage) and FRU £2.8m (slippage). DCA procurement is £2.6m over plan (22 DCAs were purchased rather than leased in year).
- Full year forecast indicates these positions will continue, with the addition of a £2.0m underspend against estates projects.
- A receipt of £2.3m has been recorded. No further receipts are expected.
- Work is required to improve capital expenditure planning and forecasting.

Financial Risk analysis

	Gross Risk				Net	Not Inc	Notes
	Value	Impact	Likelihood	Rating	Value	Forecast	
	£000			£000	£000	£000	
Income							
CQUIN	6,225	5	2	10	3,272	**497**	Based on missed items in monthly commissioners report. Annual leave scheme being negotiated for recovery
Additional Income Recovery		3	3	9	0		
Contract Penalty	10,179	5	1	5	5,090	**5089.5**	Cat A currently at 75.03% ytd.
Contract Non Recurrent Funds	2,400	3	4	12	300	**0**	Based on changed hospital turnaround risk in relation to cluster performance, total £1.5m at risk current expected penalty of £300k
Additional Income	1,451	3	5	15	0	0	Additional Support for QDJ, LEZ etc.
Olympics	1,000	3	3	9	0		The Olympic position is now finalised
Other Income	300	2	2	4	0		MPET - funds confirmed via email
Subtotal	**21,555**				**8,662**	**5,587**	
Expense							
CIP not achieved	12,498	5	3	15	0	**0**	
Overtime control	9,337	3	2	6	2,300	**500**	Estimated demand Pressure
Annual leave benefit accrual	1,200	3	2	6	0	**0**	Monthly monitoring in place - residual risk based on current movement
Economic - Fuel/Rates	574	3	3	9	0	**0**	50% of gross value
Subtotal	**23,609**				**2,300**	**500**	
Other							
PTS profitability	163	3	3	9	0	**0**	
Impact of 111	6,362	5	2	10	0	**0**	1% of operating expense (gross). 0% assumed net
Unexpected events	0	2	2	4	0	**0**	
VAT	817	3	2	6	817	**817**	Value of VAT being claimed by HMRC around Sale and Leaseback arrangements for ambulances
Subtotal	**7,342**				**817**	**817**	
TOTAL	**52,506**				**11,779**	**6,904**	

- This table represents the risk schedule used by the Trust to assess risks to financial performance in 2012/13.
- It is consistent with the position reported to NHSL in the monthly KFI reports.
- Risks identified and not included within the reported financial position are;
  - Control on overtime. Reported overtime remains in line with expectations.
  - VAT, challenge from HMRC regarding sale and leaseback. Legal opinion being sought.
- Further work is necessary to improve risk identification and review.

Financial Risk Rating

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Reported Position: Year to Date	Reported Position: Forecast Outturn	Normalised Position*: Year to Date	Normalised Position*: Forecast Outturn	Comments where target not achieved
Underlying performance	EBITDA margin %	25%	11	9	5	1	<1	3	3	3	3	
Achievement of plan	EBITDA achieved %	10%	100	85	70	50	<50	4	3	4	3	Improvement in YTD performance due to additional income recognised for winter pressures and
Financial efficiency	Net return after financing %	20%	>3	2	-0.5	-5	<-5	3	3	3	3	The trust is due to return a small surplus
	I&E surplus margin %	20%	3	2	1	-2	<-2	2	2	2	2	
Liquidity	Liquid ratio days	25%	60	25	15	10	<10	3	3	3	3	
Weighted Average		100%						2.9	2.8	2.9	2.8	
Overriding rules												
Overall rating								3	3	3	3	

- The above represents the FRR reported to NHSL within the SOM.
- The Trust is currently reporting an FRR of 3. This is driven by;
  - Underlying performance – Improved EBITDA margin and EBITDA achieved due to the additional income secured. YTD at Month 11 there is a £974k surplus this will be reduced to a £262k surplus YTD in Month 12 due to expected cost pressures.
  - Financial efficiency – the Trust is reporting a small surplus at month 11.
- EBITDA achieved will reduce from a 4 to a 3 by the year end due to a reduction to surplus and EBITDA in line with the current forecast
- It should be noted that while overall EBITDA and surplus margins have been below plan, overall turnover is above plan. This has helped to mitigate some of the adverse impact of being below plan.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH MARCH 2013

PAPER FOR INFORMATION

Document Title:	**Report on Finance and Investment Committee meeting 12th March 2013**
Report Author(s):	**Richard Hunt, Trust Chair**
Lead Director:	**N/A**
Contact Details:	**marilyn.cameron@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**For information**
This paper has been previously presented to:	**N/A**
Recommendation for the Trust Board:	**To provide the Trust Board with a update on the key items of discussion at the Finance and Investment Committee meeting on 12th March 2013.**

Executive Summary
Note:

In line with previous reports, it is intended that the Terms of Reference for the Finance and Investment Committee will be reviewed ready for the new financial year. From the meeting in April, Nick Martin will take over the Chair.

The meeting on 12th March considered the following:

a) a major item on the agenda was to review the month 10 financial position and the month 11 flash position. These demonstrated the challenge for LAS to meet its year end financial performance. It was likely that further additional funding would be required based on specific one-off costs incurred during 2012/13 (since the meeting a specific outcome has been achieved and this will be reported at the board).
b) the finance report also reviewed cash management, liquidity and progress on the CIP. The committee noted that cash management would become increasingly important in the months ahead and in particular when the Trust achieved its Foundation Trust licence.
c) The committee received a briefing on the current status of contract discussions for 2013/14. It noted that it was possible these would not be concluded by the start of the financial year. Consequently funding in the first few periods of 2013/14 would reflect the arrangements of the current year. Cash would need to be carefully managed during transition to the new CCGs. The committee noted the need to ensure the contract for 2013/14 recognised the challenge of demand, included an approach to the ORH review and enabled a safe and efficient service to be delivered. A further update is planned for the board meeting.
e) The committee discussed the new approach to budget setting and ownership to come into force in 2013/14.
f) approval was given for investment in new FRUs in line with the business cost presented to the

committee which not only renewed key elements of the fleet. This will cover the years 2013/14 and 2015/16 and helps ensure an improved replacement life cycle.
g) the committee confirmed the revised case for leasing FRUs as opposed to purchase which would be the most economic approach to these vehicle investments in 2013/14. It was noted that the case for capital or operating lease was less clear cut, following a further review but leasing was still the recommended approach.
This update reflects key issues discussed. Other items are covered in the minutes.

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

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

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

Equality Analysis

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

Key issues from the assessment:

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26 MARCH 2013

PAPER FOR DISCUSSION

Document Title:	**Update on the implications of the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis)**
Report Author(s):	**Steve Lennox, Director of Health Promotion and Quality**
Lead Director:	**Sandra Adams on behalf of Steve Lennox**
Contact Details:	**steve.lennox@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**The Francis report is one of the most significant reviews undertaken in an NHS provider organisation and all organisations are being asked to discuss the recommendations.**
This paper has been previously presented to: (The issue rather than the paper has been presented to Quality Committee)	☐ 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 agree the recommendations as set out in the paper below.**
Key issues and risks arising from this paper	

Executive Summary

On February 6 2013 the second Francis report was published on the public inquiry regarding the deaths that occurred at the Mid Staffordshire NHS Foundation Trust.

The primary purpose of the Inquiry was "to examine why problems at the Trust were not identified sooner; and appropriate action taken." The report identifies a number of common themes that, when combined, led to the circumstances in which the poor care was left undetected by the senior management. Each organisation is considering the implications of the report and this paper briefly outlines the Trusts intended methodology for reviewing the Francis report.

The Board are asked to approve 3 recommendations;

1. It is recommended that all Trust Board members read, as a minimum, the Executive Summary of the Francis report and participate in the 1:1 gap analysis meetings with the Director of Health Promotion & Quality.

2. The Board is asked to approve the strategic approach over a longer period of time that includes the 1:1s, "Listening in Action" work, staff conferences, identifying actions and publication in the Quality Account. A progress report is to be presented back to the Trust board no later that July 2013 (the DH are expected to respond to Francis in June 2013).

3. It is recommended that the Director of Corporate Services and Director of Health Promotion & Quality give specific consideration to the opportunities where it is possible to raise the profile of the patient voice at the points of assurance and also when designing changes to service delivery.

Attachments

1. **Report**

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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

Trust Board

Actions Following the Publication of the Mid Staffordshire NHS Foundation Trust Public Inquiry

INTRODUCTION

In June 2010 the Secretary of State launched a full public inquiry into the Mid Staffordshire NHS Foundation Trust. The inquiry was chaired by Sir Robert Francis QC who was tasked with "examining the operation of the commissioning, supervisory and regulatory organisations and other agencies, including the culture and systems of those organisations in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009 and to examine why problems at the Trust were not identified sooner, and appropriate action taken".

On February 6 2013 the report was published and includes 290 recommendations.

EXECUTIVE SUMMARY

The Francis report is possibly the most significant review of NHS services published for a number of years. The Executive Summary is 115 pages and it is difficult to highlight salient points of such an in-depth report within this paper. Due to the value of the report Board members are encouraged to read the published Executive Summary and supplement this with the relevant sections of the full report.

The Executive Summary is available at

http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

However, the report identifies a number of common themes that, when combined, led to the circumstances in which the poor care was left undetected by the senior management. These are described as:

- The Trust was an organisation that lacked insight and awareness of the reality of the care being provided to patients. It was generally defensive in its reaction to criticism and lacked openness with patients, the public and external agencies.

- The responsibilities and accountabilities of external agencies were not well defined, often resulting in "regulatory gaps" or failure to follow up warning signs. Organisations operated in silos, without consideration about the wider implications of their role, even guarding their territories on occasion.

- There was a lack of effective communication across the healthcare system in sharing information and concerns. Organisations relied on others to keep them informed rather than actively seeking and sharing intelligence. At the heart of the failure was a lack of openness, transparency and candour in the information emanating from the Trust and over-reliance on that information by others.

- This was not helped by the constant reorganisation of NHS structures, often leading to a loss of corporate memory and misunderstandings about an organisation's functions and responsibilities. Information flow was generally poor.

- The "regulatory gaps", lack of effective communication and constant reorganisation led to a systemic culture where organisations took inappropriate comfort from assurances given either by the Trust itself or from action taken by other regulatory organisations. As a result, organisations often failed to carry out sufficient scrutiny of information, instead treating these assurances as fulfilling their own, independent obligations.

- This culture of assurances was operating in a structure where identifying systems and processes and meeting targets were the main measures of performance. Outcomes-based performance and risk-based, intelligence-informed regulation were still developing concepts.

- The focus of the system resulted in a number of organisations failing to place quality of care and patients at the heart of their work. Finances and targets were often given priority without considering the impact on the quality of care. This was not helped by a general lack of effective engagement with patients and the public, and failure to place clinicians and other healthcare professionals at the heart of decision-making. Complaints were not given a high enough priority in identifying issues and learning lessons. Patients, clinicians and the public need to be at the heart of the health service and the decisions being made.

In the press release that announced the report, Sir Robert Francis said:

"We need a patient centred culture, no tolerance of non-compliance with fundamental standards, openness and transparency, candour to patients, strong cultural leadership and caring, compassionate nursing, and useful and accurate information about services".

"The Trust Board was weak. It did not listen sufficiently to its patients and staff to ensure the correction of deficiencies brought to the trust's attention. It did not tackle the tolerance of poor standards and the disengagement of senior staff from managerial and leadership responsibilities. These failures were in part due to a focus on reaching targets, achieving financial balance and seeking foundation trust status at the cost of delivering acceptable standards of care".

The report asks for all organisations to undertake a review of the report and to consider the elements that are relevant to their business.

THE COMMON THEMES

Culture

Francis identifies culture as a theme that ran right through his investigation. The majority of organisations appeared defensive and closed and in some cases a bullying culture was apparent with staff fearful to speak out.

Putting patients first

Patients need to be the first priority for all NHS organisations and this is achieved by ensuring they receive effective care from caring, compassionate, and committed staff. Francis discusses the need to clearly identify acceptable standards of practice and

behaviour for staff. The report calls on commissioners to set requirements over and above a fundamental level.

Monitoring of compliance with fundamental standards

The report pays greater attention to the responsibility of the regulators in monitoring the compliance. However, there is of course an obligation of the provider and the commissioners to monitor compliance with any standards that have been put into place and good governance systems will need to capture the compliance. Francis does warn against over relying on formal governance structures and scorecards and asks for this information to be triangulated with observation, staff voice, and patient voice.

Accountability of board level directors

Francis calls for a system that permits the disqualification of directors who prove unfit for the role. This would prevent poor directors from moving organisations when a significant failure has occurred.

Effective complaints and incidents

Francis identifies complaints as a significant source of information. He states that their source, their handling and their outcome provide an insight into the effectiveness of an organisation's ability to uphold both the fundamental standards and the culture of caring.

The making of a complaint should be easy to do, and any expression of concern made by a patient should be treated as a complaint, unless the patient's permission is refused.

The clarity of the responsibility of a senior clinician and nurse for each patient, and their obligation to be involved in responding to any complaint, should facilitate access to the complaints system and facilitate a speedy resolution, wherever possible.

Learning from complaints must be effectively identified, disseminated and implemented, and it must be made known to the complainant and the public, subject to suitable anonymisation.

There must be real involvement of patients and the public in all that is done

Those with responsibility for commissioning should also seek the involvement of the public and providers need to review unnecessary restrictions on access to patients. Acute Trusts should be as open to visitors as would be a patient's home, subject to health protection requirements.

Openness, transparency and candour

This area receives considerable attention within the report and appears to be the main theme. For a common culture to be shared throughout the system Francis asks for three characteristics to be in place

- Openness: enabling concerns to be raised and disclosed freely without fear, and for questions to be answered
- Transparency: allowing true information about performance and outcomes to be shared with staff, patients and the public
- Candour: ensuring that patients harmed by a healthcare service are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it.

This requires all organisations and those working in them to be honest, open and truthful in

all their dealings with patients and the public. In addition, organisations and their leaders must be completely truthful when making statements to regulators, and they must not be misleading by omission. Public statements must also be truthful and not misleading.

The common culture of caring requires a displacement of a culture of fear with a culture of openness, honesty and transparency. Francis makes a powerful statement suggesting "*the only fear is the failure to uphold the fundamental standards and the caring culture*".

A statutory obligation should be imposed on healthcare providers, registered medical and nursing practitioners to observe the duty of candour. There should be a criminal offence for any registered doctor or nurse or allied health professional or director of a registered or authorised organisation to obstruct the performance of these duties or dishonestly or recklessly to make an untruthful statement to a regulator.

Caring, compassionate and considerate nursing

Francis discusses nursing as the incident occurred within acute care but the lessons and recommendations apply equally to other professional groups and again this area receives considerable attention within the report.

Francis asks for an increased focus on a culture of compassion and caring in recruitment, training and education. Training should ensure that a consistent standard is achieved by all trainees throughout the country. The achievement of this will require the establishment of national standards. The knowledge and skills framework should be reviewed with a view to giving explicit recognition to the commitment to patient care and the priority that should be accorded to dignity and respect in the acquisition of leadership skills. He makes a number of specific points:

- Continuing professional development should apply at all levels (Francis particularly focuses on nursing), from student to director, and commissioning arrangements should reflect the need for healthcare services to be delivered by those who are suitably trained.

- Nurse leadership should be enhanced by ensuring that ward nurse managers work in a supervisory capacity and are not office bound. They should be involved and aware of the plans and care for their patients.

- There should be a responsible officer for nursing in each trust, and they should be accountable to the NMC.

- Consideration should be given by the NMC to introducing an aptitude test to be taken by aspirant registered nurses prior to entering into the profession to explore the candidate's attitude towards caring, compassion and other necessary professional values.

- The professional voice needs to be strengthened and the RCN should consider how better to separate its trade union and professional representative functions.

- A forum of nursing directors should be formed and there should be at least one nurse on the executive boards of all healthcare organisations, including commissioners.

- The advice of the nursing director should be obtained and recorded in relation to the impact on the quality of care and patient safety of any proposed major change in staffing or facilities.

Healthcare support workers

Currently, healthcare support workers are not subject to any system of registration. A registration system should be created under which no unregistered person should be permitted to provide care.

Leadership

The common culture and values of the NHS must be applied at all levels of the organisation, but of particular importance is the example set by leaders. Francis makes a number of recommendations:

- A leadership staff college should be created.
- A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and should be consistent with the common culture.
- The principles appearing in those ethics and standards should apply to all staff, and it is the responsibility of employers to ensure that they are honoured.

Caring for patients: approaches applicable to all but in particular the elderly

Francis makes specific recommendations for ward managers and their clinical role in leadership and staff development. For us, our parallel is with team leaders who have a similar role. Francis asks for care to continue beyond boundaries and suggests that post discharge follow up should be established to ensure a patient's well-being. Handing over to another provider should not be seen as the end of caring.

Information

Patients need to be equipped with transparent information and real time information on performance needs to be made available.

Quality Accounts

A number of recommendations are made regarding the structure of Quality Accounts and a call to make them similar between organisations to allow comparisons to be made. The majority of their recommendations regarding Quality Accounts require a national lead.

THE LONDON AMBULANCE SERVICE INITIAL RESPONSE TO THE REPORT RECOMMENDATIONS

To provide an early but reactionary response to Francis would "tick the box" but would fly in the face of what can be described as the spirit of Francis. The issues raised within the review are so significant that a thorough reflection is a more appropriate response. Similarly it is important that the response is not to develop numerous action plans that also miss the essence of the review. But instead careful consideration is given to the overarching themes.

The Director of Health Promotion and Quality is acting as the Lead Director on developing the Trust's response. He circulated a briefing paper to members of the executive management team shortly after the publication of the enquiry. The briefing paper drew attention to the main themes and extracted the recommendations that need to be considered by the Trust.

In addition, a presentation was given to the Quality Committee on February 20 to introduce a discussion on the review and its potential implications for the Trust.

The next stage is for the Lead Director to populate a gap analysis through a series of 1:1 discussions with members of the Trust Board. The 1:1 discussions serve as an opportunity to have an in depth discussion on Francis and for each Board member to state their view. The Board interviews will also be supplemented by interviews with other senior staff who have a lead role in some of the relevant portfolios (for example complaints and staff engagement). This will help populate a gap analysis.

The learning that is obtained from the "Listening in Action" project will also feed into the gap analysis. This project is not specifically designed to focus on Francis but it is a forum for us to obtain the views of staff on what it is like to work at the Trust and to identify areas that need improvement work. This information has a direct relationship to Francis. This is a significant piece of work and actively seeks the views of approximately 400 members of staff.

There may be an opportunity to supplement the "Listening in Action" work with presentations at the next round of management conferences but this will be assessed as the "Listening in Action" project progresses.

Once the gap analysis is complete the themes will be identified and then the appropriate actions will be identified.

It is intended to incorporate a statement regarding the Trust's approach to Francis within the 2012-2013 Quality Account and the annual Quality Account can then act as an annual platform to publish our progress over the next few years.

RECOMMENDATIONS FOR TRUST BOARD

1. It is recommended that all Trust Board members read, as a minimum, the Executive Summary of the Francis report and participate in the 1:1 gap analysis meetings with the Director of Health Promotion & Quality.

2. The Board is asked to approve the strategic approach over a longer period of time that includes the 1:1s, "Listening in Action" work, staff conferences, identifying actions and publication in the Quality Account. A progress report is to be presented back to the Trust board no later that July 2013 (the DH are expected to respond to Francis in June 2013).

3. It is recommended that the Director of Corporate Services and Director of Health Promotion & Quality give specific consideration to the opportunities where it is possible to raise the profile of the patient voice at the points of assurance and also when designing changes to service delivery.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH MARCH 2013

PAPER FOR APPROVAL

Document Title:	**Being Open and Duty of Candour Policy & Procedure**
Report Author(s):	**Carmel Dodson-Brown, AD for Corporate Services**
Lead Director:	**Sandra Adams, Director of Corporate Services**
Contact Details:	**Carmel.dodson-brown@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**New Duty of Candour applies from 1st April 2013 and becomes a contractual commitment**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☒ Other: Senior Management Team
Recommendation for the Trust Board:	**To approve the policy and procedure**

Key issues and risks arising from this paper

- This is now a contractual commitment and carries a potential financial penalty imposed by Commissioners as 'recovery of the cost of the episode of care or £10k if the cost of care is unknown.'
- If the Trust fails to contact a patient/family when an incident has occurred and been reported and a complaint is subsequently received regarding non-disclosure, Commissioners are advised to consider this a 'breach'.
- Should an incident not be reported using Trust systems and Commissioners become aware of the incident, they are required to investigate and can consider reporting to the CQC.
- There is a risk of increasing claims and financial settlements.
- There will be an impact on the staff resources available to implement the *Duty*.

Executive Summary

Being Open is a set of principles to be considered when acknowledging that a patient safety incident has occurred and holding a discussion with the patient/representative. Although launched in 2005 its implementation across the NHS has depended on the endorsement of Trust leadership which has been inconsistent. The Department of Health launched a consultation in 2012 and the subsequent report concluded that a contractual duty should be placed on providers through the NHS Standard Contract to evidence the implementation of *Being Open* and *Duty of Candour*. Sir Robert Francis QC also recommended that a statutory obligation should be enacted.

The Trust has managed a *Being Open* policy for some years although this has not perhaps always been formally recorded or monitored. The attached policy has been updated and the principles of the *Duty of Candour* have been incorporated and this is presented to the Trust Board for approval.

The Trust Board is asked to note that there is still work to be done to prepare for full

implementation of the policy. Further analysis is needed of the number of incidents and complaints for example that the *Duty* could potentially apply to and then to understand the resource implications of this. Both the executive and senior management team have expressed concern about this and work will be undertaken over the coming months to better understand this. There are staff currently trained in *Being Open* and this is a requirement within the policy for those who will undertake the responsibilities. Consideration needs to be given to whether the Trust develops a 'specialist' team who build up the experience in this type of work, or whether to train all managers from DSO level upwards but who may then only deal with one such incident in a year or less.

The intention is that, whilst further work is underway as described above, the Trust will focus on those incidents considered as serious incidents, whether declared or not. The number of serious incidents reviewed is circa 100 per year and the number declared in 2012/13 (to date) is 15. The requirement is for all incidents that result in 'moderate harm, severe harm or death' to trigger a verbal contact with the patient or representatives. The Trust uses the Datix risk management system to record incidents, complaints, and claims and this will be extended to incorporate records for *Being Open* and the *Duty of Candour*. The introduction of the web-based Datix system in April 2013 will enable local access to incident reports and files to support this work.

A communications/awareness plan will also be developed as part of the implementation plan.

Attachments
TP/034 Being Open and Duty of Candour policy and procedure

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

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

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

Equality Analysis

Has an Equality Analysis been carried out?
- ☒ Yes – September 2010 so does need review
- ☐ No

Key issues from the assessment: Neutral across characteristic groups however the needs of the patient/representative should be taken into account when arranging meetings.

London Ambulance Service NHS Trust

Being Open and Duty of Candour Policy & Procedure

DOCUMENT PROFILE and CONTROL.

Purpose of the document: To ensure that the Trust meets its obligations to patients, relatives and the public in *Being Open.*

Sponsor Department: Corporate Services

Author/Reviewer: Director of Corporate Services and the Assistant Director of Corporate Services. To be reviewed by September 2014.

Document Status: draft

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
19/03/2013	4.5 (3)	Director of Corporate Services	Update following EMT
08/03/2013	4.4	AD Corporate Services	Update following workshop
01/03/2013	4.3	AD Corporate Services	Update to include Contractual duties and Francis recommendations.
05/10/2012	4.2	IG Manager	Document Profile & Control update
29/09/2012	4.1	AD Corporate Services	Update to appendix 2 post ADG
07/09/2012	3.3	IG Manager	Document Profile & Control update
05/09/2012	3.2	Assistant Director of Corporate Services	Update and Inclusion of Monitoring plan
05/10/2010	3.1	Director of Corporate Services	Minor changes following approval
06/08/2010	2.5	Head of Governance	Further amendments to process
15/07/2010	2.4	Head of Records Management	Revised s.8.2
25/06/2010	2.3	Head of Governance and Compliance/ Governance & Compliance Manager	Revised throughout
8/06/2010	2.1	Governance lead	Updated process and monitoring requirements
06/10/2008	1.2	Head of Patient Experience	Reformatted. Minor amendments.

***Version Control Note:** All documents in development are indicated by minor versions i.e. 0.1; 0.2 etc. The first version of a document to be approved for release is given major version 1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

For Approval By:	Date Approved	Version
ADG	14/09/12	4.0
SMG	15/09/10	3.0
SMG	06/10/08	2.0
Chief Executive	01/07	1.0
Ratified by Trust Board (If appropriate):		
	28/9/2010	

Published on:	Date	By	Dept
The Pulse	08/10/12	Governance Co-ordinator	GCT
The Pulse	09/10/10	Governance Administrator	GCT
LAS Website	08/10/12	Governance Co-ordinator	GCT
LAS Website	09/10/10	Governance Administrator	GCT
Announced on:	**Date**	**By**	**Dept**
The RIB	09/10/12	IG Manager	GCT
The RIB	10/10	Governance Administrator	GCT

EqIA completed on	By
06/03/2013	
26/08/2010	Governance team
Staffside reviewed on	**By**

Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**
HR/07/22	Whistleblowing Procedure	
TP004	Complaints and Feedback Policy	
TP013	Claims Handling Policy and Procedure	
TP054	The Investigation and Learning from Incidents PALS Complaints and Claims Policy	
TP006	Serious Incident Policy	
HS011	Incident Reporting Procedure	
External	NHSLA Risk Management Standards for Ambulance Services 2012/13	
External	The NHS Constitution	March 2012
External	The NHS Mandate	
External	Technical Contract Guidance 2013/14	Feb 2013

1. Introduction

In September 2005 the National Patient Safety Agency (NPSA) issued a Safer Practice Notice advising all NHS organisations to implement a "Being Open Policy". In November 2009 a Patient Safety Alert was issued by the NPSA to ensure that providers of NHS funded care implemented the principles of *Being open.* Compliance with the requirements is subject to assessment by the NHS Litigation Authority. The NHS Standard Contract 2013-14 (Annex 4) specifically requires NHS provider organisations to implement and measure the principles of *Being open* under a contractual Duty of Candour. In addition, the Francis Report (2013) makes recommendations with regard to Openness, Transparency and Candour.

This policy describes how London Ambulance Service NHS Trust (LAS) will demonstrate its openness with patients and relatives when mistakes are made.
Being open is a set of principles that healthcare staff should use when communicating with patients, their families and carers following an incident in which the patient was harmed (Appendix 1). The specific delivery of "*Being open"* communications will vary according to the severity grading, clinical outcome and family arrangements of each specific event. The Duty of Candour applies to those patient safety incidents which result in moderate harm, severe harm or death.

The Trust aims to promote a culture of openness, which it sees as a prerequisite to improving patient safety and the quality of a patient's experience.

This policy is to be implemented following all patient safety incidents where moderate, severe harm or death has occurred.

Being open relies initially on its staff and the rigorous reporting of Patient safety incidents. The Trust endorses the Francis Report Recommendation 173;
'***Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be open, honest and truthful.'*** Therefore, staff who are concerned about the non-reporting or concealment of incidents, or about ongoing practices which present a serious risk to patient safety, are encouraged to raise their concerns under the Trust's Whistleblowing Policy (HR/07/22).

2. Scope

This document outlines the Trust's policy on openness and how the LAS meets its obligations to patients, relatives and the public by *Being open* and honest about any mistakes that are made whilst Trust staff care for, treat and transport patients.

This document is aimed at all staff working within the Trust and sets out the infrastructure which is in place to support openness between healthcare professionals and patients, their families and carers, following a patient safety incident.

3. Objectives

The objectives of this policy is to evidence that a robust risk management system is in place which reflects the following:

3.1 A patient has a right to expect openness from their healthcare providers.

3.2 The Trust will learn from mistakes with full transparency and openness.

3.3 A proactive approach to patient safety with the onus on risk management systems and processes identifying incidents which require review and learning.

3.4 Working in partnership with all stakeholders

3.5 Staff do not intend to cause harm but unfortunately incidents do occur. When mistakes happen, patients/relatives/carers/others should receive an apology and explanation as soon as possible. Saying sorry is not an admission of liability and staff should feel able to apologise at the earliest opportunity.

3.6 Senior managers undertaking Serious Incident investigations must follow the LAS Serious Incident policy (TP006) guidance. They must ensure that appropriate support is offered to the patient/families/carers/others. A single point of contact will be identified with the patient/carer/relative to maintain communication and feedback of information about the incident.

3.7 Line managers should understand that an individual or team might require support during the investigation and, after discussion, should guide them to the appropriate support mechanism. Support for staff should be offered from the Staff Counselling and Occupational Health Services Manager or the Workforce Directorate. This will include contact details of both external and internal support.

3.8 The LAS aims to comply with the requirements of the NHS Litigation Authority (NHSLA) Risk Management Standards for Ambulance Services.

3.9 The Principles of *Being open* are set out in Appendix 2

4. Responsibilities

4.1 Trust Board

The Trust Board have responsibility to obtain assurance that the processes work effectively to support the board level public commitment to implementing the *Being open* principles and Duty of Candour.

4.2 Chief Executive

The Chief Executive is ultimately responsible for the process of managing and responding to the *Being open* process and for the delegation of this role when required.

4.3 Executive Directors

The Executive Management Team is responsible for compliance with the *Being open* process. They are accountable to the Trust Board and the Chief Executive for the implementation of an effective *Being open* process.

4.4 Senior Management Team
The Senior Management Team is responsible for monitoring compliance with the *Being open* and Duty of Candour policy and implementing the associated process.

4.5 Learning from Experience Group

The Learning from Experience Group will have overall responsibility for monitoring the *Being open* and Duty of Candour process.

- The Group links with the Area Quality Committees and reports to the other relevant risk management committees and groups: Quality Committee, Risk Compliance and Assurance Group, Clinical Quality, Safety and Effectiveness Group.

- The Group is responsible for ensuring continuous development of the *Being open* and Duty of Candour policy in accordance with national guidance;

- In reviewing Serious Incidents the Group will monitor the *Being open* process;

- the Group will communicate up to board level, and to the local management levels;

- The Group facilitates organisational learning and improvement as a result of effective *Being open* processes by making sure that any lessons learned are disseminated through the Trust.

- The terms of reference for the Group can be found at Appendix 3.

4.6 The Assistant Director of Corporate Services

The Assistant Director of Corporate Services is responsible for monitoring compliance with and reporting on the effectiveness of the management of *Being open* to the Learning from Experience Group. A quarterly report will be produced for the group and data will be collated for submission to the commissioners.

4.7 It is the responsibility of all **Trust managers** to support staff so that they comply with this policy

4.8 All **staff** working within the LAS are expected to follow this policy and demonstrate the principles of *Being open* and Duty of Candour when a patient safety incident occurs.

4.9 Patient and Family Liaison Manager
An appropriately trained and resourced member of Trust staff who will be the point of contact throughout an investigation between the patient and family and the Trust.

5. Definitions

Definitions of the terms used within this document are consistent with those in the Trust's Incident Reporting Policy (HS011) and Serious Incident Policy (TP006).

Patient Safety Incident

'..any unintended or unexpected incident that could have or did lead to harm for one or more patients receiving NHS-funded healthcare' *(Seven Steps to Patient Safety, NPSA 2003).*
This can be identified in the course of an incident report, complaint, and enquiry to Patient Experience Department or a claim.

Serious Incident

'...a situation in which one or more service users are involved in an event which is likely to produce a significant, legal media, or other interest and which if not properly managed, may result in loss of the Trust's reputation or assets.'*(Seven Steps to Patient Safety, NPSA 2003)*
Openness – enabling concerns and complaints to be raised and disclosed freely without fear, and for questions to be answered.

Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

Candour – any patient harmed by the provision of healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked. (Francis 2013)

6. Clinical support and advice

Immediate clinical support and advice for staff involved in a patient safety incident is provided according to how serious the patient safety incident is classified. The incident is graded using the Trust's risk management matrix (TP035) with support from operational managers and the Clinical and Quality Directorate as described below:

- The initial level of support is provided by local managers (working at station level) for staff involved in a patient safety incident who will give advice so that they are able to manage the incident in real time, as soon as possible after the incident has happened. This includes advising on the *Being open* process and general guidance about how to communicate with patients, relatives and carers.

- The second level of support is provided by complex level managers (Ambulance Operations Managers) and may include guidance from clinical tutors or Duty Station Officers. Further escalation may be required depending on the severity of the incident. Where support is needed from the Trust's senior operational managers then the Assistant Director of Operations where the complex is located will be informed.

- A further level of support is provided by the Assistant Medical Directors where they are sector based in conjunction with the Clinical Directors. For Control Services support is provided by the Deputy Medical Director. Both the Clinical and Executive Directors manage and participate in 24 hour on call rotas so that

advice can be provided when the incident happens and action implemented by staff “on scene”.

7. *Being open* and Duty of Candour Procedure

7.1 The patient or their family/carer must be informed that a suspected patient safety incident has occurred within at most **10 working days** of the incident being reported to the local systems, and sooner where possible.

7.2 The initial notification must be verbal and face to face where possible and will be followed by a letter from the appropriate manager.

7.3 An apology must be provided – a sincere expression of sorrow or regret for any suspected harm caused must be provided verbally and in writing.

7.4 The nominated operational manager will normally be the Ambulance Operations Manager as the most senior person responsible for the patient’s care and/or someone with the experience and expertise in the type of incident that has occurred. This person will be supported by at least one other member of staff within the department or Clinical and Quality directorate. If the incident is serious and a confirmed grade of 15+ is agreed the Governance & Compliance investigation manager will identify and contact the Patient and Family Liaison manager.

7.5 The Patient and Family liaison manager will meet with the staff directly involved in the incident to establish the facts and agree/understand the aims of the meeting to be held with the patient and/or relatives and others. The Patient and Family liaison manager will use this opportunity to identify the needs of the patient and/or relatives in order to ensure that no-one will be disadvantaged in any way. Factual feedback must be given to the patient or representatives at the earliest opportunity. No communication errors should arise by giving unsubstantiated facts as this can create anxiety. All meetings and correspondence will be entered into the risk management system within 24 hours or at the time of drafting. Where appropriate the Patient Experiences Department, Legal Services and Safety and Risk Managers should be informed.

7.6 If the patient or family are aware of the incident then the immediate actions as stated above should be followed by a letter.
The letter should be sent to the patient and/or relatives and others inviting them to meet with the nominated staff, offering them a choice of venues and times and advising of the independent advocacy service available to support and assist them (in accordance with the Trusts Complaints and Feedback Policy (TP004), Serious Incident Policy (TP006), and The Investigation and Learning from Incidents, PALS, Claims and Complaints Policy (TP054).

The patient and/or the relatives and others should be given the opportunity to choose:

- Whom they would prefer to meet with;
- Where and when the meeting will be held;
- Whether they would like to bring a friend to the meeting;
- The date, time and venue should be confirmed in writing including email.

7.7 The Patient and Family liaison manager may continue to meet with the patient/relatives and others to support continuity of communication and relationship building.

7.8 The meeting is held as soon as possible after the incident, taking into account the patient's and/or the relative's and others' wishes.

7.9 Any meeting should be held in deference to the patient/relative/advocate's wishes. The same applies as to any venue; it is usually for the patient/relative to decide and for the Trust to accommodate.

7.10 The local management team will be kept up to date on progress with the investigation and contacts with the patient and family.

7.11 However should the LAS become aware of a patient safety incident which has taken place and the patient and family are not aware then steps 7.1 to 7.10 will be followed and the letter will be signed by the Clinical Directors.

All learning from the incidents must be cascaded to the whole organisation, via Learning from Experience Group, Area Quality Governance Committees, and Trust communications systems including the website. e.g anonymised case studies.

Details are shared with any other healthcare organisation or relevant stakeholder as appropriate.

8. Procedure for the nominated investigation team

At the meeting with the patient and/or relatives and others, the nominated staff from the investigating team should follow the procedure below.

- Apologise for what happened;
- If known, explain what went wrong and where possible, why it went wrong;
- Give the patient and/or relatives an opportunity to ask as to why they thought it went wrong and an error occurred. This may include relevant personal circumstances should staff agree these can be shared;
- Inform the patient and/or relative(s) and others what steps are being/will be taken to prevent the incident recurring;
- Provide opportunity for the patient and/or relatives and others to ask any questions;
- Agree with the patient and/or relatives and others any future meetings as appropriate;
- Suggest any sources of additional support and counselling and provide written information if appropriate;
- When full investigation is required because the incident has been graded as 15+, a full Root Cause Analysis will be undertaken (see Trust SI Policy TP006).

The patient, relatives and others should be given this information and a Patient & Family Liaison manager will be appointed. The Patient & Family Liaison manager will be responsible for keeping the patient, relatives and others up to date with how the investigation is progressing, maintaining a dialogue by addressing new concerns, sharing new information when available and providing information on counselling as appropriate.

- Records will be created and maintained by the Governance & Compliance manager.

9. Follow-up

One of the Clinical Directors or nominated deputy will send a letter of apology, within the timescales as outlined in TP004/TP006/TP054, explaining how and, if possible, why the error occurred. If this information is not available, the letter should provide an explanation as to how the error will be investigated and when the patient/representative can expect to be provided with additional details. This letter will clarify the information previously provided; reiterate key points, and record action points and future deadlines.

10. Documentation

The requirements for documenting all communication are set out below:

- the record of an open and honest apology;
- sharing any facts that are known and agreed with the patient/carers;
- an invitation to the patient/carers to participate in the investigation and to agree how they will be kept informed of the progress and results of that investigation;
- an explanation of any likely short and long-term effects of the incident;
- a clear response to questions the patient/carer may have;
- an offer of appropriate practical and emotional support to the patient/carer;
- An auditable record of contacts will be maintained with the Root Cause Analysis Report.

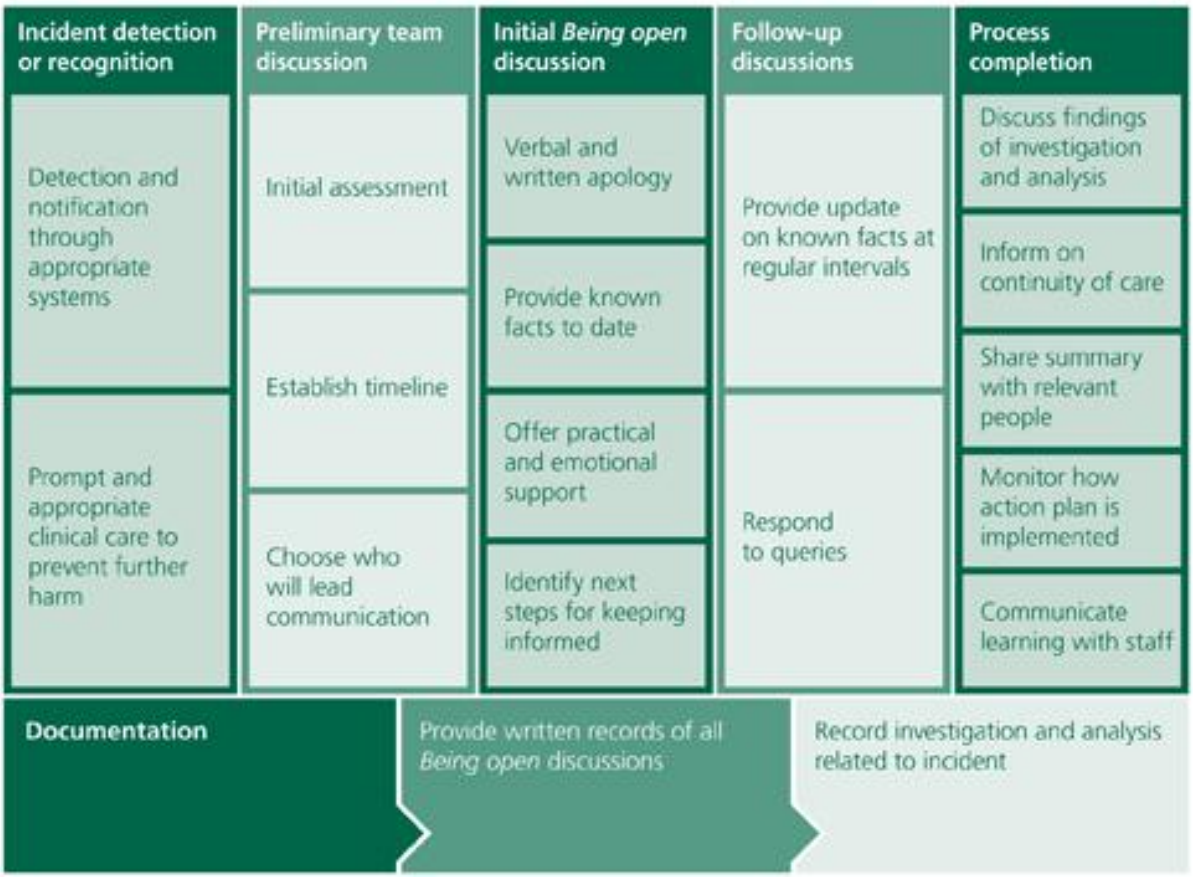
IMPLEMENTATION PLAN	
Intended Audience	All LAS Staff
Dissemination	Available to all staff on the Pulse and to the public on the LAS website.
Communications	Revised Policy and Procedure to be announced in the RIB and a link provided to the document. Consideration to be given to appropriate mechanisms for raising awareness amongst staff.
Training	The Trust provides training on Incident Investigation and Root Cause Analysis with support from the Governance & Compliance team. External Being open training is commissioned.

Monitoring:

Aspect to be monitored	Frequency of monitoring AND Tool used	Individual/ team responsible for carrying out monitoring AND Committee/ group where results are reported	Committee/ group responsible for monitoring outcomes/ recommendations	How learning will take place
The Principles of Being Open (Appendix 2), including; • How communication between healthcare organisations, healthcare teams, staff, patients, their relatives and carers is encouraged (Section 7) • How all Communication is recorded (Section 8) • How staff acknowledge, apologize and explain when things go wrong • Requirements for truthfulness, timeliness and clarity of communication • How additional support is provided (Section 6)	Activity audit Activity audit Root cause Analysis report.	Governance & Compliance PED and GCT Operations Serious Incident Annual Report	Learning from Experience Group (and, if required Quality Committee)	Learning disseminated via Learning from Experience Group

Appendix 1

Overview of the *Being open* process



NPSA. (2009). *Being open. p.3*

Stage 1: Patient safety incident detection or recognition - This covers how patient safety incidents are identified; the prompt and appropriate clinical care and prevention of further harm; and who to notify about the patient safety event.

Stage 2: Preliminary team discussions - This covers the preliminary team discussion to establish the basic clinical and other facts; undertaking the initial assessment to determine the level of response required; the timing of the discussion with the patient, their family and carers; and choosing who will be the lead in communicating with the patient, their family and carers

Stage 3: The initial *Being open* discussion - This covers the content of the discussion and what should not occur: speculation, attribution of blame, denial of responsibility and provision of conflicting information from different individuals.

Stage 4: Follow-up discussions - This covers the subsequent discussions with the patient, their family and carers.

Stage 5: Process completion - This covers repeating the apology; providing feedback on the findings of the investigation into the patient safety incident; what the organisation will be doing to prevent recurrence. The investigation report has to be shared with the patient or family within 10 working days of approval and sign off by the Trust.
It should include provision of an ongoing clinical management plan (if appropriate) and communicating with relevant community care providers and commissioners what has happened. This will also include monitoring how the recommendations have been implemented and communicating with staff the recommendations to spread the learning.

Appendix 2

The Principles of *Being open*

Being open involves apologising when something has gone wrong, Being open about what has happened, how and why it may have happened, and keeping the patient and their family informed as part of any subsequent review.

Principle of Acknowledgement

All patient safety events should be acknowledged and reported as soon as they are identified. In cases where the patient, their family and carers inform healthcare staff that something has happened, their concerns must be taken seriously and should be treated with compassion and understanding by all staff. The Trust recognises that denial of a person's concerns or defensiveness will make future open and honest communication more difficult.

Principles of Truthfulness, Timeliness and Clarity of Communication

Information about a patient safety incident must be given in a truthful and open manner by an appropriately nominated person. Communication from Operational/Clinical staff must only be from Ambulance Operation manager grade staff or above. Communication should also be timely, informing the patient, their family and carers what has happened as soon as is practicable, based solely on the facts known at that time. It will be explained that new information may emerge as the event investigation takes place and that they will be kept up to date. Patients, their families and carers and appointed advocates should receive clear, unambiguous information and be given a single point of contact for any questions or requests they may have.

Principle of Apology

Patients, their families and carers should receive a meaningful apology - one that is a sincere expression of sorrow or regret for the harm that has resulted from a patient safety event or that the experience was poor. This should be in the form of an appropriately worded agreed manner of apology, as early as possible. Both verbal and written apologies should be given. **Saying sorry is not an admission of liability and it is the right thing to do.** Verbal apologies are essential because they allow face to face contact, where this is possible or requested. A written apology, which clearly states the organisation is sorry for the suffering and distress resulting from the patient safety event, will also be given.

Principle of Recognising Patient and Carer Expectations

Patients, their families and carers can reasonably expect to be fully informed of the issues surrounding a patient safety incident, and its consequences, in a face to face meeting with representatives from the organisation and/or in accordance with the local resolution process where a complaint is at issue. They should be treated sympathetically, with respect and consideration. Confidentiality must be maintained at all times. Patients, their families and carers should also be provided with support in a manner to meet their needs. This may involve an independent advocate or an interpreter. Information about the Patient Experiences Department and Independent Complaints Advocacy Service is routinely offered accordingly; See also http://www.londonambulance.nhs.uk/talking_with_us/enquiries,_feedback_and_compla.aspx

Information enabling to other relevant support groups will be given as soon as possible and as appropriate.

Principle of Professional Support

The Trust has set out to create an environment in which all staff are encouraged to report patient safety events. Staff should feel supported throughout the patient safety event investigation process; they too may have been traumatised by the event. Resources available are referred to within the respective Trust policies, (HS011, TP004), to ensure a robust and consistent approach to patient safety event investigation. Where there are concerns about the practice of individual staff the relevant professional body and/or Human Resources department can be contacted for advice. Where there is reason to believe a member of staff has committed a punitive or criminal act, the Trust will take steps to preserve its position and advise the member(s) of staff at an early stage to enable them to obtain separate legal advice and/or representation. Staff should be encouraged to seek support from relevant professional bodies. Where appropriate, a referral will also be made to the Independent Safeguarding Authority.

Principle of Risk Management and Systems Improvement

Root Cause Analysis (RCA) or similar techniques should be used to uncover the underlying causes of patient safety events. Investigations at any identified level will however focus on improving systems of care, which will be reviewed for their effectiveness. *Being open* is integrated into patient safety incident reporting and risk management policies and processes.

Principles of Multi-Disciplinary Responsibility

Being open document applies to all staff who have key roles in patient care. Emergency care provision is often a component of the totality of total healthcare and can involve multi-disciplinary teams. This is reflected in the way that patients, their families and carers are communicated with when things go wrong. This ensures that the *Being open* process is consistent with the philosophy that patient safety incidents usually result from system failures and rarely from actions of an individual. To ensure multi-disciplinary involvement in the *Being open* process, especially if working with NHS trusts in other sectors (e.g. acute care or mental health) it is important to identify clinical and managerial leaders who will support this across the health and care agencies that may be involved. Both senior managers and senior clinicians will be asked to participate in the patient safety incident investigation and clinical risk management as set out in the respective Trust policies and practice guidance.

Principles of Clinical Governance

Being open involves the support of patient safety and quality improvement through the Trust's clinical governance framework, in which patient safety incidents are investigated and analysed, to identify what can be done to prevent their recurrence. It is a system of accountability through the chief executive to the board to ensure that these changes are implemented and their effectiveness reviewed. Findings are disseminated to staff so they can learn from patient safety incidents. Audits are an integral process, to monitor the implementation and effects of changes in practice following a patient safety incident.

Principle of Confidentiality

Details of a patient safety incidents should at all times be considered confidential. The consent of the individual concerned should be sought prior to disclosing information beyond the clinicians involved in treating the patient. The Trust will anonymise any incident it publishes but still seek the agreement of those involved.

Where it is not practicable or an individual refuses consent to disclosure, disclosure may still be lawful if justified in the public interest or where those investigating the patient safety event have statutory powers for obtaining information. Communications with parties outside of the incident lead and those involved in the investigation ill be on a strictly need to know basis and, where practicable, records are secure and anonymised where released. Where possible, it is good practice to inform the patient, their family and carers about who will be involved in the investigations before it takes place, and give them the opportunity to raise any objections.

Principle of Continuity of Care

The Trust acknowledges that patients are entitled to expect they will continue to receive all usual treatment and continue to be treated with respect and compassion.

Appendix 3

Terms of Reference
Learning from Experience Group

1. Authority

1.1 The Learning from Experience Group constitution and terms of reference shall be set out below and subject to amendment when directed and agreed by the Quality Committee.

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

1.3 The Group is authorised by the Quality Committee to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2. Purpose

2.1 The primary focus of the Learning from Experience group shall be the integrated review of incidents including SIs, PALs enquiries, complaints and claims, in order to identify actual and emerging risk themes and to recommend changes to practice and for ensuring that the objectives of the Learning from Incidents, PALs, Claims and Complaints Policy are achieved.

2.2 Oversee the arrangements for investigation and action planning on incidents, claims and complaints.

2.3 Ensure that following investigations and serious case reviews, action plans to address root causes are drawn up and their implementation monitored and reported to the Quality Committee.

2.4 Ensuring arrangements for improvement in practice following serious incidents is implemented and evaluated.

2.5 Oversee and monitor arrangements for the dissemination of learning within the organisation and where appropriate, across the ambulance service network.

3. Objectives

3.1 Examine emerging themes and issues of significance from incidents including SIs, complaints, claims, and PALs as a mechanism for service user and stakeholder feedback.

3.2 Seek assurance of action taken on, and implementation of, themes and issues and the lessons learnt and improvements made.

3.3 Seek assurance on the effectiveness and outcomes of lessons, improvements and changes to practice.

3.4 Consider ways of involving and engaging patients and the public in learning from issues and assessing the effectiveness of outcomes and improvements made.

3.5 Make recommendations to the Risk, Compliance and Assurance Group on any new risks emerging, or changes to existing risks.

3.6 Make recommendations to the Clinical Quality, Safety and Effectiveness Committee on action, monitoring or assurance required on emerging themes and risks.

3.7 Provide assurance to the Quality Committee.

3.8 Oversee the implementation and review of any Trust policies as delegated by the Quality Committee, including the following policies:

- Learning from Incidents, Claims and Complaints
- Investigating incidents, claims and complaints
- Complaints and user feedback policy
- Being open.

4. Membership and attendance

4.1 The Learning from Experience Group shall comprise:

- Director of Health Promotion and Quality (Chair)
- Assistant Director, Corporate Services (Deputy Chair)
- Director of Corporate Services
- Head of Patient Experience
- Head of Legal Services
- Head of Safety and Risk
- Head of Patient & Public Involvement
- Deputy Director of Operations
- Assistant Medical Director
- Assistant Director, Employee Relations
- Assistant Director, Professional Education & Development
- Audit and Compliance Manager
- LAS Patient Forum representative.

4.2 Other members of staff may be required to attend for specific agenda items.

5. Accountability

5.1 The Learning from Experience Group shall be accountable to the Quality Committee.

6. Reporting

6.1 The minutes of the Learning from Experience Group meetings shall be formally recorded by the Trust's Committee Secretary.

6.2 The approved minutes of each Learning from Experience Group meeting shall

be submitted to the next meeting of the Quality Committee together with a written report providing assurance on the areas covered within their terms of reference and annual work programmes, including identifying areas of good practice and any gaps in assurance together with action being taken to address these. This report shall be given to the Quality Committee four times a year.

6.3 The Learning from Experience Group shall receive reports from the Patient and Public Involvement Committee four times a year

6.4 The Chair of the Learning from Experience Group shall draw the attention of the Quality Committee to any issues that require disclosure to the full Trust Board.

6.5 Recommendations and feedback shall be made to this group as appropriate. Responsibility for monitoring action to be taken rests with the Chair of the Learning from Experience Group.

7. Administration

7.1 Secretarial support shall be provided by the Trust's Committee Secretary and shall include the agreement of the agenda with the Chair of the Learning from Experience Group and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.

7.2 Agenda items shall be forwarded to the Committee Secretary six days before the date of the committee meeting.

7.3 The draft minutes and action points shall be made available to Committee members within within four weeks of the meeting.

7.4 Papers shall be tabled at the discretion of the Chair of the Learning from Experience Group.

8. Quorum

8.1 The quorum shall be the Chair or Deputy Chair, and two other members. Learning from Experience Group members' attendance will be recorded in the minutes of each meeting and reviewed at the end of the year to ensure that this requirement is met.

9. Frequency of meetings

9.1 The Learning from Experience Group shall meet quarterly before the Executive Management Team and the Quality Committee.

10. Review of Terms of Reference

10.1 The Learning for Experience Group shall review these Terms of Reference annually.

10.2 The Chair or the nominated deputy shall ensure that these Terms of Reference are amended in light of any major changes in committee or Trust governance arrangements.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH MARCH 2013

PAPER FOR APPROVAL

Document Title:	**Membership Strategy**
Report Author(s):	**Shirley Rush, Membership Manager**
Lead Director:	**Sandra Adams, Director of Corporate Services**
Contact Details:	**shirley.rush@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**For approval**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To approve the Membership Strategy**

Key issues and risks arising from this paper

None.

Executive Summary

This strategy describes our approach to attract, engage, retain and develop a significant representative and diverse membership for the London Ambulance Service as an NHS foundation Trust.

It defines the membership community and sets out the vision, objectives and role of the membership and describes activities to develop an active and engaged membership.

The strategy is an appendix to the Integrated Business Plan (IBP).

Attachments

Membership Strategy.

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Quality Strategy

This paper supports the following domains of the quality strategy

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

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

Equality Analysis

Has an Equality Analysis been carried out?

- ☒ Yes
- ☐ No

Key issues from the assessment: None

London Ambulance Service NHS Trust

Membership Strategy
2013/14

Contents

1.0 Introduction

This strategy describes our approach to attract, engage, retain and develop a significant representative and diverse membership for the London Ambulance Service as an NHS foundation trust. As a public benefit organisation we believe that membership will enable us to deliver health care services more effectively for our patients and the community of London.

The strategy is an appendix to the Integrated Business Plan (IBP) which is the Trust's application to become an NHS foundation trust.

2.0 Vision and objectives

Membership provides a greater opportunity for us to build closer links with the community and ensure that as many people as possible have the chance to have their say in the future planning of the service.

Becoming a member of a foundation trust offers an individual the opportunity to act as a guardian overseeing the Trust's strategic vision. The membership as guardian will determine how we can develop patient-centred services that improve directly our patients' experience.

The vision for membership is simple.

"A membership that is valued, involved and engaged and given the opportunity to make a difference."

3.0 Our membership objectives:

- To ensure the opportunity to become a member of the Service is accessible to all of the eligible community
- To ensure we take every opportunity to promote membership
- To achieve a membership consisting of the range of diverse communities of London's population and workforce
- To focus on the development of our membership base and member-relations activities in order to achieve a representative membership
- To create a range of opportunities and activities so that our members have the opportunity to be involved
- To ensure members are informed, consulted and involved in changes to service plans and delivery where appropriate
- To maintain a membership services function that achieves full compliance with regulatory requirements, including a well-managed membership database and progressive mechanisms to support membership development.

Members will be informed of activities and plans, listened to and their views taken into account as the Trust develops its plans and delivers its services now and in the future.

4.0 The membership role

The membership has a major role in supporting the achievement of the Trust's objectives with a focus on continuing to grow an inclusive culture of public engagement within the organisation.

All members will have equal voting rights (one member, one vote). By giving staff, the public and our partners a stake in the organisation, we will transform the Trust into an open, outward-facing organisation that uses its members as a valuable resource to improve our performance and quality outcomes.

We will give our members the opportunity to help shape the future of our Trust by providing feedback, responding to surveys and consultations and voting in elections to the Council of Governors. We hope that some will be more actively involved by standing for election to the Council of Governors.

5.0 The membership community

There are two membership constituencies – public (divided into 7 areas) and staff (divided into two classes).

5.1 The public constituencies

People are invited to join by completing a membership form; this ensures that we have a group of members who have made a positive choice.

Public membership is available for any individual member of the public aged 16 and over and resident in a London borough or county in the surrounding counties ie

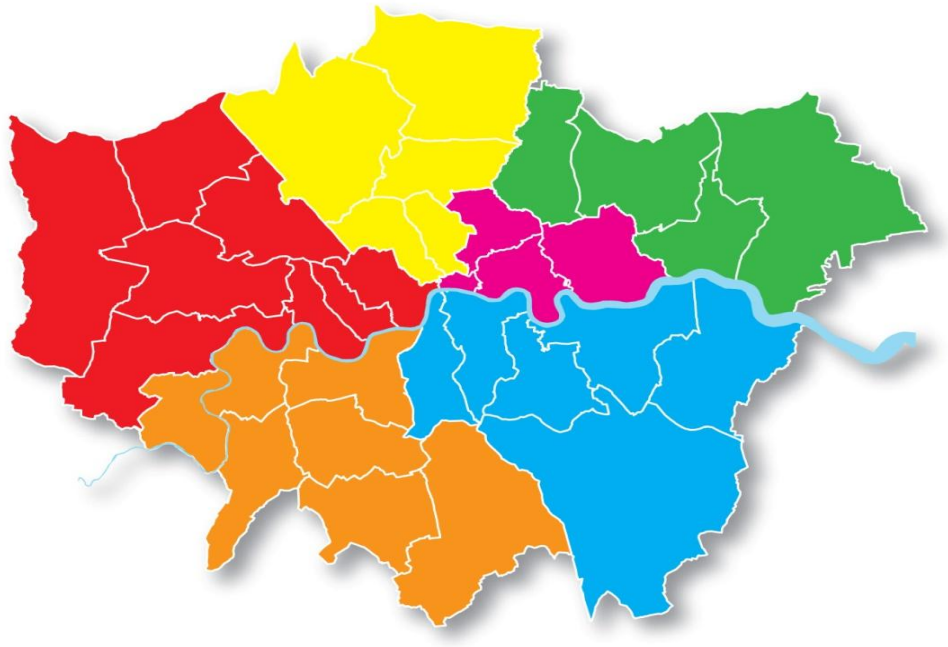
East of England: Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk

South East Coast: Surrey, Sussex and Kent;

South Central: Oxfordshire, Buckinghamshire, Berkshire, Hampshire and the Isle of Wight.

This extension to membership outside of London takes into consideration the large numbers who commute in and out of the capital daily.

There seven geographical areas for public members, six of which are based on the old primary care trust health sectors of London and one is for members 'Outside London'.



North West London Ealing, Harrow, Brent, Westminster, Kensington & Chelsea, Hammersmith & Fulham, Hounslow and Hillingdon
North Central London Barnet, Enfield, Haringey, Islington and Camden
Outer North East London Barking & Dagenham, Havering, Redbridge and Waltham Forest
Inner North East London City of London, Hackney, Newham and Tower Hamlets
South East London Bexley, Bromley, Greenwich, Lewisham, Southwark and Lambeth
South West London Richmond & Twickenham, Wandsworth, Kingston, Sutton, Merton and Croydon
Outside London East of England: Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk South East Coast: Surrey, Sussex and Kent South Central: Oxfordshire, Buckinghamshire, Berkshire, Hampshire and Isle of Wight

5.2 The staff constituency

The staff constituency is divided into two classes: frontline (staff who are directly involved in treating patients or who take 999 calls) and support staff (staff who work in our finance, HR, fleet departments etc), to reflect the make-up of the workforce. Staff will be allocated to the class that best fits the description of their role within the Service.

The Trust has an inclusive approach to staff membership using the opt-out method, whereby all existing and new staff appointments automatically become a member. If an individual employee does not want to become a member they can opt out but they will not be eligible to join another constituency while continuing to work for the Trust. Staff can opt back into membership at any time.

When a member of staff leaves Service employment their membership of the staff constituency will be terminated. If they remain a resident within the catchment area served by the Trust they will be invited to become a public member.

If a member of the public constituency becomes employed by the Service they will become a staff member.

Longer-term temporary staff and contractors can join the staff category as long as they have worked for us for at least 12 months. Volunteers and staff with a contract of employment of less than 12 months cannot be staff members, but can join us as public members if they meet the residential criteria.

A staff member may be asked to temporarily cease membership activities during any period of suspension under the Trust's code of conduct and associated staff policies and professional codes.

The staff constituency is likely have approximately 4,700 members and will be represented by three Governors on the Council, two for frontline staff and one for support staff.

6.0 Recruiting and building the membership base

We need to ensure that our membership numbers are manageable, can be resourced appropriately, and most importantly, reflect the diverse communities we serve. We aim to have a public membership of approximately 14,000 by the time we become a foundation trust in 2014 including 4,700 staff members.

The Trust has been recruiting members since early 2009 and, after reaching our initial target of 4,000 members in 2010, has been steadily increasing by approximately 1,000 new members year on year.

New public members are signed-up through face-to-face recruitment in locations with high footfall such as shopping centres and at community events. A significant number of new members sign-up via the Trust's most visited website page, the current vacancies page. This is providing a steady, sustainable and low resource method of recruiting.

Whilst the Trust wishes to recruit members in sufficient numbers to adequately represent the London population, the priority is to recruit and support a membership that is engaged and interested in the Trust's activities and in developing its plans.

6.1 Membership register

A register of public and staff members is maintained by the Trust. This information about members is held on a secure and confidential database, which is managed in accordance with the Data Protection Act 1998. The register is managed by an external supplier on behalf of the Trust through an agreed and closely monitored contract agreement.

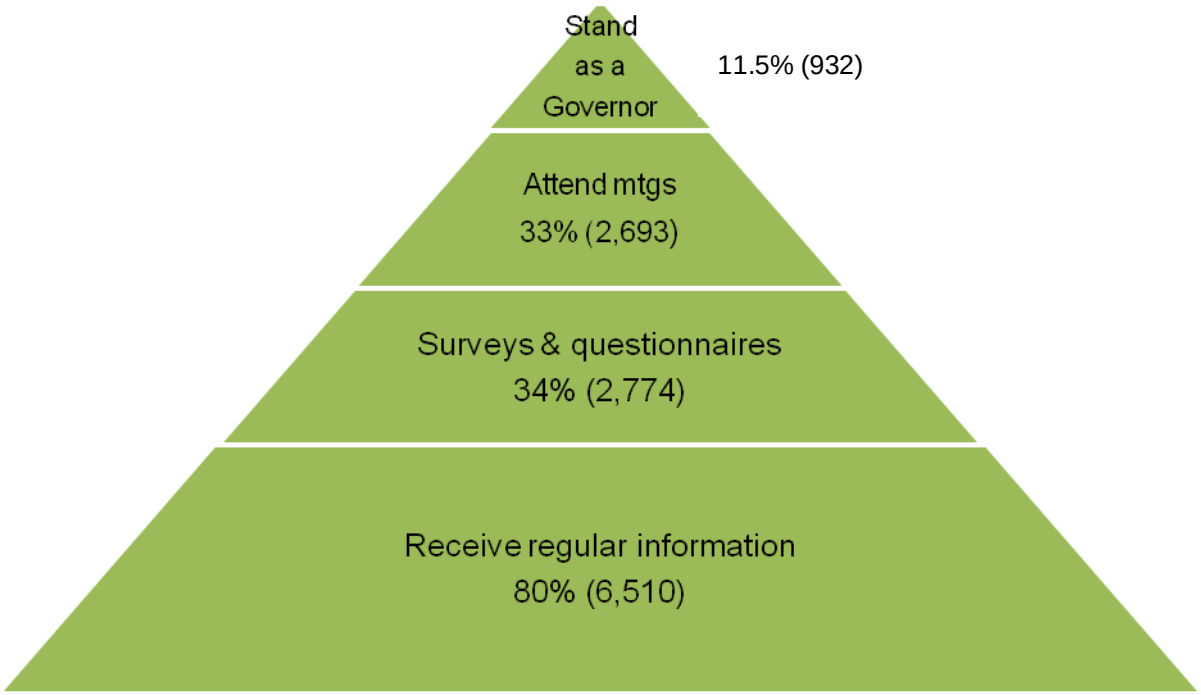
7.0 Developing an active and engaged membership

The effective engagement of members will be crucial to our success as a foundation trust. We will want to develop activities to make the most of our members and keep them involved, as much as they want to be, with the Trust.

7.1 Member activities will include:

- Receiving information about what we are doing
- Attending member events and meetings
- Involvement in special interest/focus groups about service improvement
- Participating in patient focus groups and other feedback activity
- Being consulted on any major changes that we are proposing to our service
- Attending Council of Governor meetings
- Taking part in Governor elections
- Standing as a Governor.

Our membership forms include a menu of involvement options, enabling us to identify the level of engagement that members are seeking. The engagement triangle below shows how members have selected how they would like to be involved, as at end of February 2013.



Governors will play a key role in the success of members' engagement as they will be an important link between the trust and the members.

The membership manager will lead the development of all communication with members in liaison with the Director of Corporate Services and working closely with the communications team.

There will be a planned series of communications throughout the year, hard copy newsletters, event invitations, details of special interest groups etc.

We will use as many feedback mechanisms as possible to encourage members to participate fully in the Trust – hard copy response, e-mail, members' website pages etc in accessible formats.

7.2 Newsletters

The Trust produces a quarterly newsletter, *Ambulance News*, written, produced and edited by the communications team. The newsletter is an essential engagement and communication tool as for many members this will be their only involvement they choose to have with the Trust. It is therefore important that the newsletter keeps members informed about developments and changes within the organisation.

7.3 An evening with us…

To date we have delivered six 'evening with us' events for members. These are events highlighting key developments and achievements such as cardiac arrest outcomes, stroke care and trauma care. The event is led by presentations followed by a question and answer session giving members an opportunity to ask detailed questions. We will continue to deliver about three or four of these meetings annually.

7.4 Members' meet

The Trust also aims to run three or four members' meetings per year on topics relating to our service development plans. Previous topics have included our carbon management plan, equality objectives and our corporate objectives. These meetings are an opportunity to share our plans and to seek and hear the views of our members.

7.5 Annual General Meeting

Members are invited to the Annual General Meeting to receive an overview of the year, along with the presentation of accounts. There is also an opportunity for those attending to ask questions of, and share their view with, the Trust Board.

7.6 Task and Finish Groups

From time to time there may be a need to develop task and finish groups on particular issues where patient and public views can be obtained through the membership.

7.7 Working groups/committees

There may be opportunities in the future to invite members, with the appropriate skills, to join a committee or working groups.

The management team will:

- Keep members up-to-date with service development plans through:
  - Newsletters (x4) throughout the year
  - Email updates
  - Membership section on website.

- Organise membership events and meetings, presenting items of interest
- Consult members on strategic plans and development plans (e.g. policy development)
- Invite members to attend events on health topics and service developments
- Support members through the election process
- Provide Council of Governors the opportunity to review the annual accounts, auditor's reports and annual report at a general meeting
- Provide Council of Governors the opportunity to express a view about the Trust's forward plans for the NHS FT.

The Council of Governors, within the first 12 months following authorisation by Monitor, will:

- Review an action plan for determining members' interests and involving them in the work of the trust
- Encourage the contribution of members in the planning and delivery of services
- Promote constructive working relationships and dialogue between public members and our staff
- Review the success of their communication approaches with members
- Support the programme of member events and seminars
- Participate in a well attended annual meeting of the Council.

8.0 Resourcing the membership development

We recognise that the membership strategy can only be effective over the long term if it is properly resourced.

8.1 Director of Corporate Services

The Director of Corporate Services/Trust Secretary has the executive responsibility for membership. The membership services function is established within the Corporate Services Directorate and is supported by a dedicated Membership Manager. The Director of Corporate Services will provide guidance and support to the Council of Governors and the Chair of the Trust, especially in managing the relationship between the Council of Governors and the Board of Directors.

Financial support for membership and Governor activity is a priority for the Trust and resources are already committed towards the staffing of the membership function, provision of externally commissioned specialist services, and information and activities to support and engage members. Non-pay costs associated with membership governance such as elections, support for Council of Governor meetings, Governors' "surgeries", cover for staff governors, reimbursement for travel of Governors, Members' meetings and events will also be budgeted for and funded.

8.2 Membership Manager

The management and development of the membership is the responsibility of the Membership Manager.

The Membership Manager links proactively with Trust staff and other agencies involved in community engagement and patient and public involvement activities in order to maximise all potential partnerships with local communities and groups, and takes up opportunities to recruit members and raise awareness of the benefits of membership.

Membership responsibilities will include:

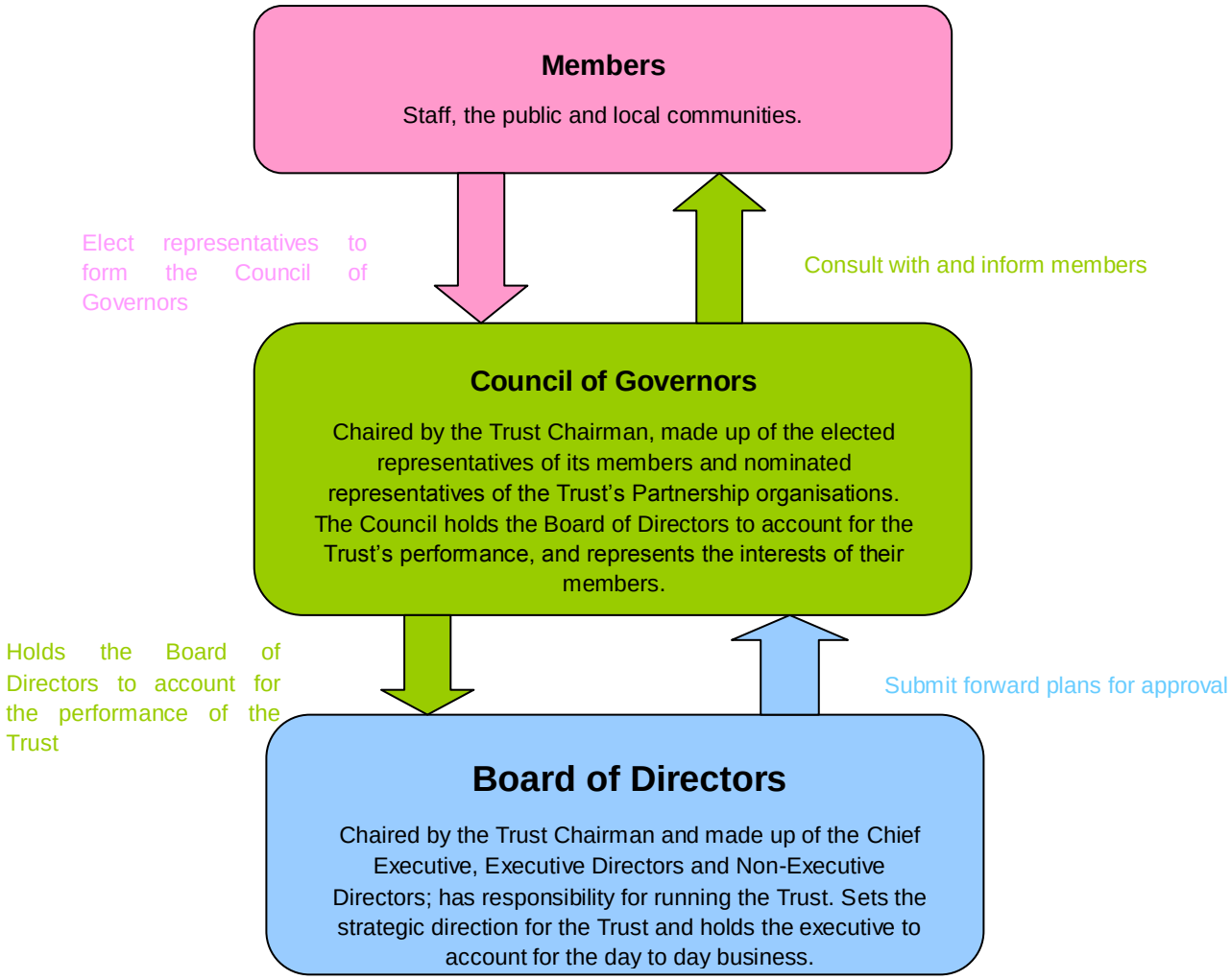
- Setting up systems and processes for the day-to-day management of the membership
- Responding to members' information requirements and any problems or queries they may have about our services
- Ensuring the Trust engages members effectively and actively involving them in Trust business
- Ongoing recruitment of members
- Targeting under-represented groups
- Ensuring effective communication with all members using electronic communication to save costs where appropriate
- Running elections using an external provider
- Conducting Governors' induction and training
- Maintaining ongoing communications with Governors
- Arranging Governor meetings
- Ensuring effective information flows and communication between Governors, members and Trust management
- Assisting Governors to produce a membership development strategy which will be evaluated and analysed in their annual report.

9.0 Establishing a Council of Governors

The Council of Governors will have a key role in supporting, advising and developing our membership. The effectiveness of the Council of Governors will be measured against how it can execute its role and responsibilities which are:

- Ambassadorial: representing and promoting the Trust and its activities within the community
- Guardianship: to act as guardian of the Service on behalf of the local communities that constitute the population of London
- Advisory: providing a steer on how the foundation trust can carry out its business in ways consistent with the needs of the members and the wider community
- Strategic: supporting the Board of Directors on the strategic approach of the Service.

To enable the Council of Governors to be effective in their role, the Trust will provide induction, training and development.

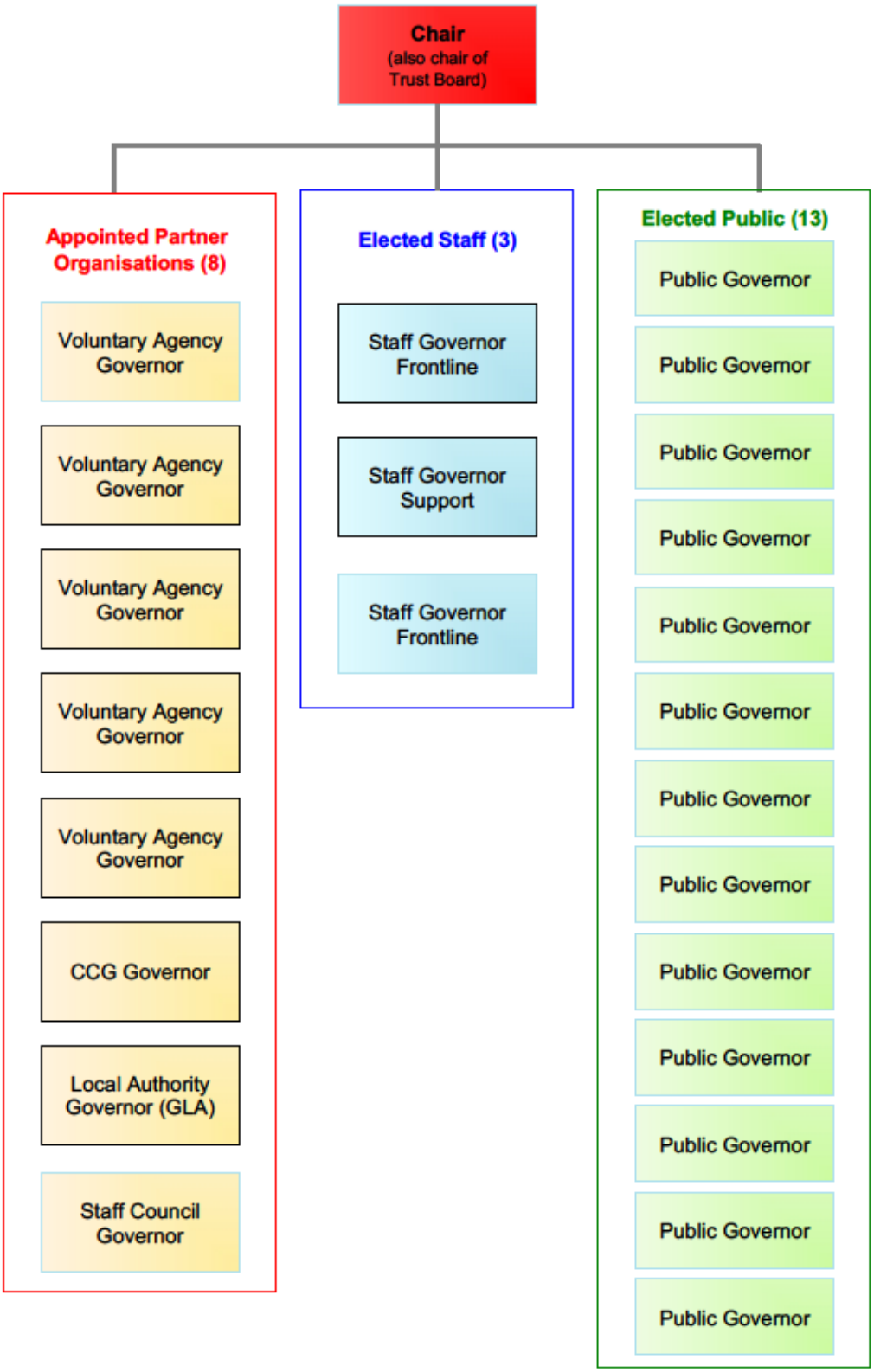


The Council of Governors will be either elected by the public, our staff or nominated from partner organisations.

It will be responsible for representing the interests of members and influencing our future plans, and made up of 24 governors:

- Thirteen will be elected by the public
- Three will be chosen by our staff
- Eight will be appointed from our partner organisations.

Proposed Council of Governors



Our Chairman will chair the Trust Board and the Council of Governors and will ensure directors and governors are aware of their respective roles and responsibilities.

The Board of Directors will be responsible for the day-to-day running of the Trust.

9.1 The role of a governor:

- Support, challenge and hold our Board of Directors to account
- Be the link between the members and Board of Directors, and
- Represent members and act as an ambassador for the Service.

Governor key responsibilities will include:

- Ensuring we are accountable to local people
- Recruiting and developing our membership, and
- Helping us plan for the future.

9.2 Staff Governors

1. Staff governors as ”representative members of staff”, have the ability to represent the interests of their constituents. Their role will be to bring ideas to the table from a staff perspective. On the other hand, staffside reps, as “staff representatives” have been trained and are experienced in establishing and representing the views of their members (and have an obligation to do so).
2. The two roles will ultimately operate in different contexts. The role of the staff governor is strategic, in that they will review and critique the Trust’s direction of travel and hold the Board to account. This is a new and additional role which need not and will not impact on the key staffside role in consultation and negotiation on specific operational/ workforce matters.
3. Staff governors, unlike staffside representatives, cannot represent individual members of staff in matters of discipline, grievance etc.

9.3 Appointed Governors

The Trust will appoint Governors from five voluntary sector partner organisations and is currently considering the following organisations as representative of some of the major groups of patients we work with: Age UK London, British Heart Foundation, Diabetes UK, Mind and The Stroke Association. We will also invite nominated representatives from a Clinical Commissioning Group (CCG) and a local authority (Greater London Authority, GLA).

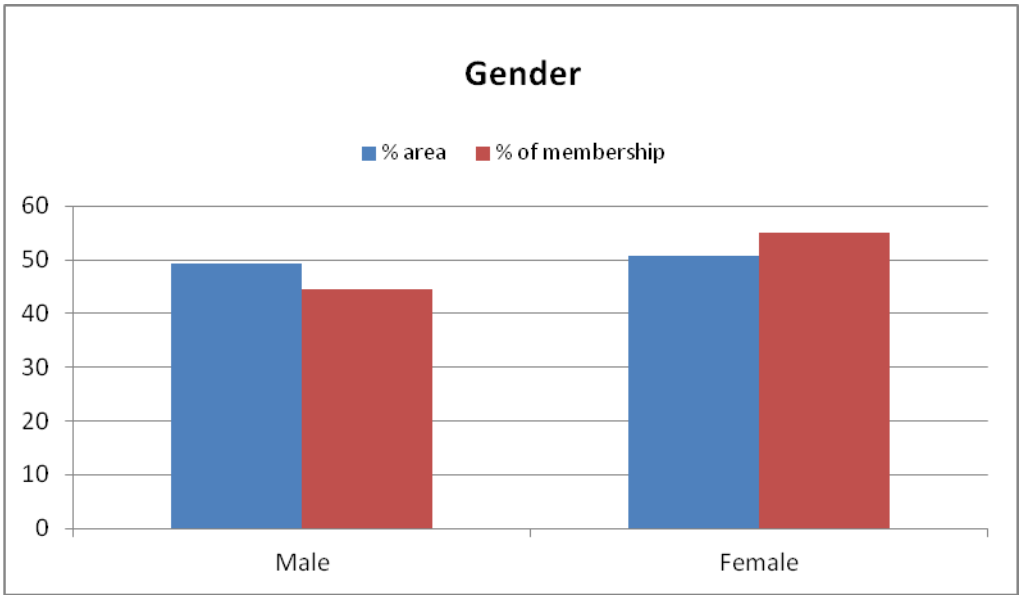
10.0 Evaluating success

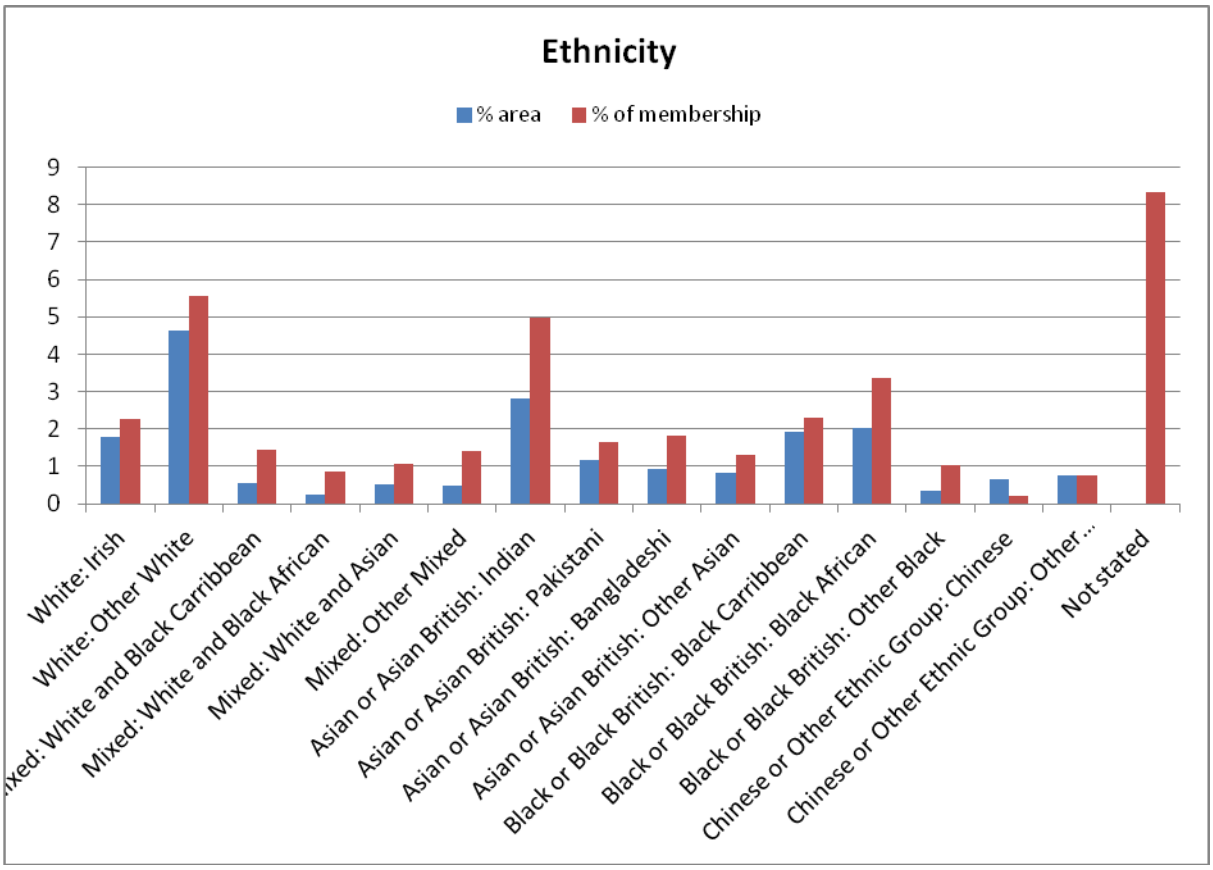
Although the Membership Strategy is initially put forward by the Trust, the Council of Governors is the most appropriate body to take on the role of developing, monitoring and evaluating it. The Council of Governors will evaluate the strategy annually and report on it at an annual meeting with the Board of Directors.

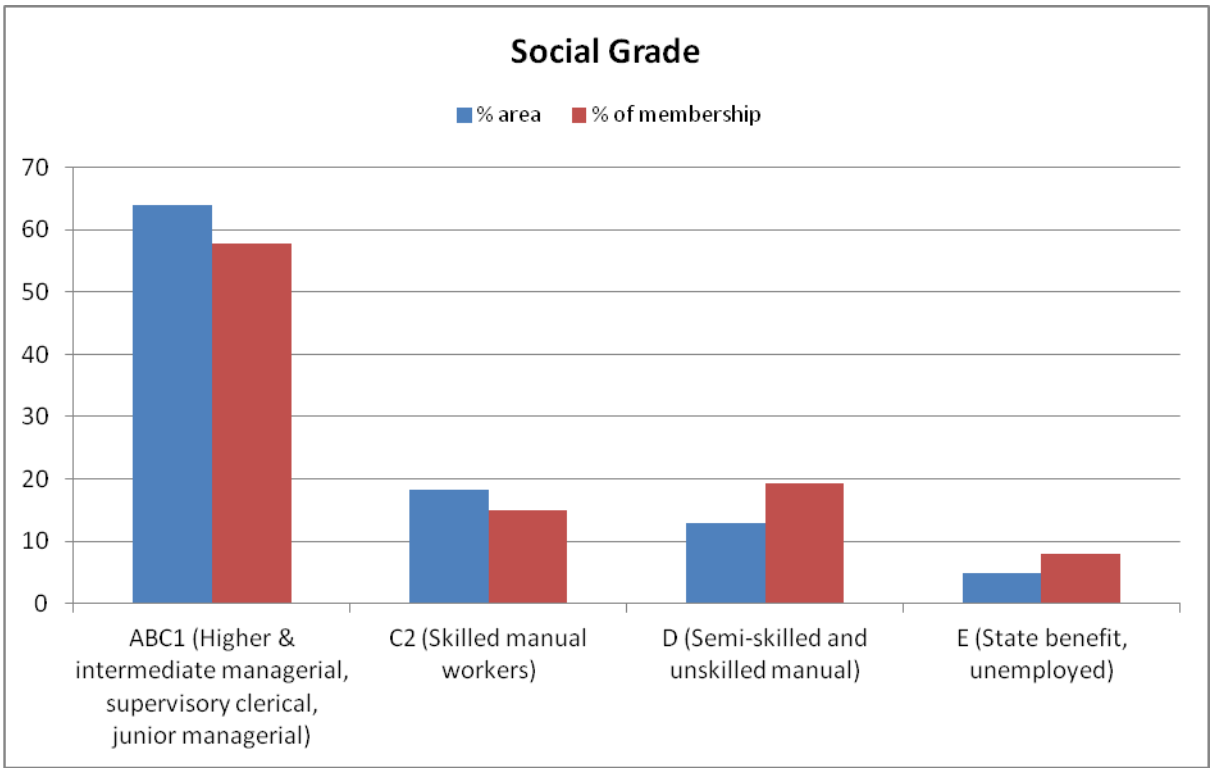
11.0 Membership profiling

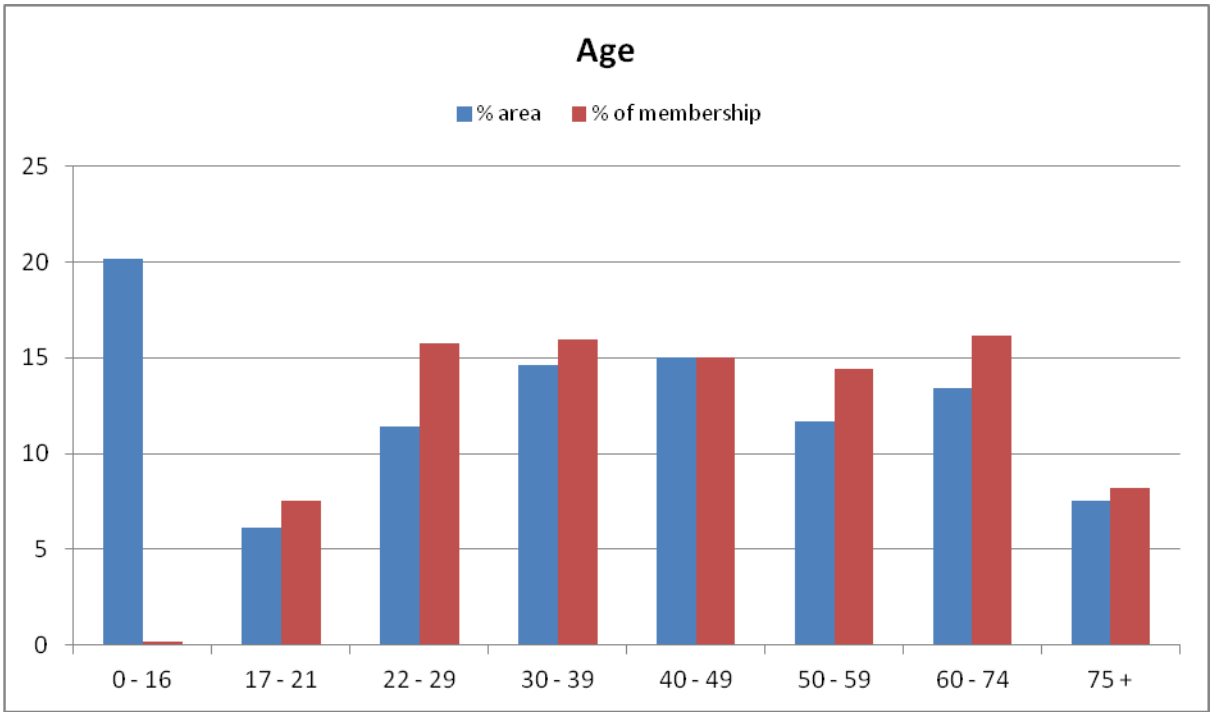
The following graphs show the membership by comparison with the eligible population for gender, ethnicity, age and social grade as at the end of December 2012.

Source 2011 population projections, CACI Ltd.




Ethnicity
% area
% of membership
9
8
7
6
5
4
3
2
1
0
White: Irish
White: Other White
ixed: White and Black Carribbean
Mixed: White and Black African
Mixed: White and Asian
Mixed: Other Mixed
Asian or Asian British: Indian
Asian or Asian British: Pakistani
Asian or Asian British: Bangladeshi
Asian or Asian British: Other Asian
Black or Black British: Black Carribbean
Black or Black British: Black African
Black or Black British: Other Black
Chinese or Other Ethnic Group: Chinese
Chinese or Other Ethnic Group: Other ...
Not stated


Social Grade
% area
% of membership
70
60
50
40
30
20
10
0
ABC1 (Higher & intermediate managerial, supervisory clerical, junior managerial)
C2 (Skilled manual workers)
D (Semi-skilled and unskilled manual)
E (State benefit, unemployed)


Age
% area
% of membership
25
20
15
10
5
0
0 - 16
17 - 21
22 - 29
30 - 39
40 - 49
50 - 59
60 - 74
75 +

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH MARCH 2013

PAPER FOR INFORMATION

Document Title:	**30th November Industrial Action Review – Integrated Action Plan**
Report Author(s):	**Joint LAS & NHS London**
Lead Director:	**Jason Killens, Director of Service Delivery**
Contact Details:	**020 7783 2046**
Why is this coming to the Trust Board?	**For review of the updated action plan**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**The Board is asked to note the progress made against the action plan and note the remaining outstanding actions.**
Key issues and risks arising from this paper	
Executive Summary Attached is the most recent updated action tracker relating to the 30th November Industrial Action Review. Contained within the report there are 26 main actions, of which 21 are completed and 5 remain outstanding. Of the 5 outstanding, all are LAS responsibility. The LAS specific actions will be completed by May 2013.	
Attachments : 30th November Industrial Action Review – Integrated Action Plan	

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Quality Strategy

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

Equality Analysis

Has an Equality Analysis been carried out?

☐ Yes
☒ No

Key issues from the assessment:

30th November Industrial Action Review – Integrated Action Plan – Updated – 14 March 2013

No.	Key Learning	Recommendation	Organisation Ownership	Action Update	When	By Who
1	The DMP has a critical role and accurately managed patients' clinical need, with a strengthened clinical support hub for monitoring and reviewing the back log of calls and dispatches. However, the wider NHS had no explicit defined role in supporting the LAS during escalation (e.g. GPs extending opening times, and Out of Hours Primary Care taking referrals)	The operational protocols of the DMP with wider NHS support should be established as part of business continuity planning through the incorporation of: • Clear triggers at defined levels of escalation for External and Internal Major Incidents, with early warning • Annual audits to ensure fitness of purpose of wider system support • Clear terminology & communication plan to ensure understanding from the wider NHS.	**LAS lead** with support from NHSL EPT & NHS NWL	Reviewed twice annually (at least) anyway and updated with learning LAS have clearly defined user-led terminology (for internal purposes) Document prepared and circulated following stakeholder workshops to NHS system partners in London that includes explanation of DMP and REAP together with suggested system wide provider impact and actions to support LAS escalation. Review of DMP triggers and actions completed in December 2012 ahead of winter and Christmas period. Interim adjustments made to actions for adverse weather in December 2012 and January 2013.	Completed Completed Complete October 12 Complete	Martin Flaherty Jason Killens
2	The response on the day could have been enhanced by wider system support to the clinical support hub, from the broader NHS.	A formal mechanism is required to enlist additional clinical resource to support the LAS clinical hub during times of significant pressure Pre-arranged agreements should be developed and tested, setting out clear triggers and definitions for resource sharing arrangements in conjunction with DMP levels (including GP's, Nurses, BASIC Doctors).	**LAS lead** with support from NHSL EPT	Agreement with St Thomas' to explore a rotation programme with Senior A&E nursing staff into the clinical hub (meeting held with Senior Nurse A&E and Director of Nursing). Following 30N workshop held 5th July (NHSL/ LAS/NHS NWL) it was agreed to review potential of primary care nursing support, as some concern regarding acute nurse familiarity with triage. Project delayed due to all organisations being under capacity constraints. Re-engagement meeting held 1/3/13 with St Thomas' and King's as both have expressed interest. Subsequent meeting first week in April to identify barriers and blocks. Job/role description to be developed for clinical support. Minimum skill level ST4 Acute Setting Band 6 ED Nurse Band 6 GP Nurse	Completed June Aug 2012 April 2013 April 2013	Steve Lennox

Note: Grey shading indicates recommendation totally completed

30th November Industrial Action Review – Integrated Action Plan – Updated – 14 March 2013

				Presentation & engagement with clinical staff identified Training & protocols finalised System tested and in place	April 2013 tbc tbc	
3	The current data systems between the ambulance service and hospitals are not linked, so patient pathways and outcomes cannot be readily evaluated.	The LAS should implement a mechanism to track and link patients (via NHS numbers) to enable the effective clinical connection of patients across providers.	**LAS lead** with support from NHS NWL	Contract agreed with CQUIN to incentivise delivery Implementation plans approved by Clinical Quality Group 19th July Five pilots to be undertaken to improve information sharing throughout 2012/13 Review of findings	Completed April 12 Completed Completed Completed Feb 13	Lizzy Bovill/ Jason Killens
4	There was no pan-London fully integrated planning and assurance process in preparation for the management of industrial action and major events.	A single integrated planning and assurance process should be coordinated by NHSL, for organisations where service delivery failure will significantly impact on rest of the NHS.	**NHSL EPT lead**	Industrial Action plans for all NHS organisations in London were assessed as part of the 2012 EP assurance process. This also included a review of all Business Continuity Plans Integrated assurance process implemented and supported the UNITE and BMA action in May and June 12. Positive feedback received.	Completed May 2012 Completed June 2012	Andy Wapling
5	Plans across the NHS economy did not specify and agree NHSL escalation management arrangements should the planned event of industrial action develop into an incident. The role of the host Cluster & LAS Commissioner was not clarified prior to the day of action	A formal pan-London integrated approach should be established to provide an overview of roles and responsibilities and the interdependencies between all organisations when managing a situation outside 'business as usual'. This needs to specifically address the role of LAS Commissioner and the host Cluster in supporting system escalation.	**NHSL EPT lead**, with support from LAS, NWL	NHS London's and NHS NWL's Olympics Concept of Operations developed to incorporate this learning Development of Industrial Action and Business Continuity escalation triggers and disseminate across London NHS organisations. London's Conops, incident response plan and command and control documents have been updated incorporating this for the new NHS structures (National Commissioning Board, London),	Completed May 2012 Feb 2013	Nicki Smith

6	LAS planning for the operational response to industrial action continued up to the day before action commenced. This made effective communication of complex on the day arrangements very difficult to achieve.	Operational contingency planning for industrial action needs to be completed to allow a minimum time of two weeks to brief all staff and external organisations.	**LAS lead,** with NHSL POD ensuring this learning is cascaded to other NHS organisations	LAS Operational staffing contingency plan updated, includes specific risk mitigation for Olympics. Actions from contingency plan implemented ahead of Olympics, including contracts with private providers. Meeting held with DH/LAS/NHSE/NHSL/NWL in order to extract national learning and disseminate appropriate guidance. NHSL attempted to gain undertaking from London Partnership for earlier notification (earlier than legal 7 day requirement) IA plan from Olympic period has been redrafted as a general IA plan to manage any future action LAS wrote to UNITE FTO requesting exemptions and early agreement to commence planning re potential day of action on 10/5/ 2012. Agreement to no action agreed. LAS to seek engagement with local and regional union officers prior to legal notification of intended action provided and make every attempt to engage in meaningful discussion early, escalating through NHS and Union structures when necessary	Completed May 2012 Completed June 2012 Completed end April 2012 Removed action as declined – May 2012 Completed Jan13 Completed May 12 Completed and principle agreed going forwards	Martin Flaherty Julie Screaton Jason Killens Caron Hitchen
7	Planning assumptions were based on shared understanding of what was most likely, and not the worst case scenario, and this was then not independently tested.	The integrated planning and assurance process should test key assumptions, in particular on staffing levels, and ensure mitigation is prepared for a worst case scenario.	**LAS lead,** with NHSL POD ensuring this learning is cascaded to other NHS organisations	Decision internally that any future action will be planned with a worst case scenario of total loss In the event of further action implement a system to canvass all staff individually Work with NHSL to independently assure future plans (links to recommendation 4) In the event of further action test the planning assumptions for staff losses with key opinion formers within staff groups – not just staff side representative NHSL to review potential of revising IR protocol/	Principle agreed for any future action in April 2012 As above As above IR sub group reviewed on	Martin Flaherty Bernade

				guiding principles Revised protocol/principles drafted and agreed by London NHS Partnership • Dissemination out to local employers via HR for London meeting • Dissemination out to unions via Co-Chair of London Health Unions	26th April, and 16th May. Completed 4th July Completed 14th August	tte El-Hadidy
8	Planned mitigations during the day of action focussed around a single strategy and did not include wider system support.	Opportunities for whole system support should be discussed and agreed against a clear set of escalation triggers and implemented into practical implementation plans across all involved parties. E.g. • Community Responders • OOH GPs • Acute Doctors / Nursing staff • BASICs • NHSD/111 providers • Primary & Community Care staff Once agreements are in place they must be tested and audited on a regular basis to ensure fitness of purpose.	**NHSL EPT lead**, with support from LAS, NWL	Initial workshop held with NHSL EPT, LAS and NWL cluster to set out proposed whole system support Draft plan to be worked up Review plan and approach via further workshop Wider system engagement workshop to finalise model Table top test of wider system model of support	Completed 5th July 2012 Completed Mid Sept12 Completed Early Nov 12	Nicki Smith
9	LAS reported expected staffing levels being lower than expected early on the morning. However, there were multiple, poorly co-ordinated escalation arrangements and these contributed to a slower a more fragmented operational response to the emerging situation.	Clear escalation principles and resultant actions should be defined and communicated in advance across the whole system to provide early warning in the event of a potential service delivery challenge.	**NHSL EPT lead**, with support from LAS, NWL	Workshops as set out in recommendation 8 above, to finalise	See Rec 8 above	Nicki Smith

10.	The industrial action was managed as a planned event not a Major Incident. It is evident that during the day the threshold of this becoming a Major Incident was breached, but the operational response did not reflect this.	Clear triggers should be defined and communicated, so the management of the event could elevate to a Major Incident which should enable a swifter and broader response from the wider NHS.	**NHSL EPT lead**	Learning built into NHSL Olympic CONOP Development of Industrial Action and Business Continuity escalation triggers and disseminate across London NHS organisations.	Completed May 2012 Completed July 2012	Nicki Smith
11.	Conference calls held between NHS NWL, NHSL and the LAS held an important function. The complexity of the discussion meant they were often time consuming (8.4.5)	A set of protocols and principles are required for pre-planned conference calls, even if not being run as a Major Incident, including clarification of roles for commissioner and NHSL. Pre-defined information sets should be agreed to provide consistent data for all partners and support strategy. These should be shared in a timely fashion and be accurate and communicated to all responders.	**NHSL EPT lead**	Development of a teleconference etiquette document that includes template agendas and clarification of roles and responsibilities. This has been built into the Olympic CONOPs.	Completed June 2012	Nicki Smith
12.	The emergency cover arrangements were complicated, significantly less efficient than routine operating and not communicated in sufficient time to the front line workforce	The hybrid 'emergency cover' model (part-pay/semi striking as used on 30th November) should not be used. The LAS should where possible secure formal exemptions (see recommendation 22), and for other services maintain a simple 'on strike or 'working normally' approach, so operational management of the service can be effective.	**LAS Lead**, with support from NHSL POD on exemptions	LAS SMG agreed not to use the part-pay model The LAS will seek to secure formal exemptions for its essential emergency services. LAS have identified list of services, and this will inform review of LAS Partnership Agreement (see Recommendation 25) LAS secured agreement not to take industrial action during Olympics from GMB and UNISON Exemptions were discussed at DH/NHSE/LAS/NHSL meeting and also at the London NHS Partnership subgroup meeting.	Principle agreed April 2012 May 2012 May 2012 Completed end April 2012	Caron Hitchen Julie Screaton

13.	The urgency of the patient need following the declaration of the Internal Major Incident was not communicated well and recognised by front line staff, and the ambulance crews did not therefore return to duties as expected under the agreement.	LAS should review and enhance communication mechanisms to front line staff to ensure urgent messages are received promptly by all (regardless of working pattern). E.g. the use of social media All LAS frontline staff should be trained in basic awareness of call handling, escalation processes, including a basic understanding of the DMP and the limitations of call categorisation All LAS frontline staff should be trained on the meaning and impact of an Internal Major Incident.	**LAS lead**	Develop a staff SMS database for all staff by group (voluntary) that can be used to notify staff of critical messages and augment existing arrangements such as the incident intranet page Briefing to all frontline staff included in internal bulletin Session to be developed for inclusion in Core Skills Refresher (CSR) programme that covers DMP, call handling, call categorisation , REAP and internal/external major incident	Due to finalise by end Q4 2012/13 Completed 2nd week July 2012 Incorporated, roll out across 2012/13 and 2013/14	Martin Flaherty
14.	Public messages were found not to reduce demand. The event had no clear incident focus via the media (unlike a rail crash etc). This meant that there was low public understanding of the severity of the situation.	A proactive communications plan, with stronger agreed lines should be developed in advance. Public messages need to be early and carry a robust message to ensure that the public appreciate the situation, especially if this is a 'rising tide' style of internal incident.	**LAS lead** with support from NHSL EPT	Communication plan developed with pre-prepared messages ahead of Olympics for staffing contingency plan. Agreement to use escalating pressure messages and start from a stronger base on future occasions dependant on prevailing circumstances	Completed end April 2012 Completed end April 2012	Martin Flaherty
15.	Emergency services worked co-operatively and did deliver an alternative operational model on the day, albeit not until the evening.	Wider system support to the LAS needs to be pre-agreed and tested, and initiated early to deliver intended benefits.	**LAS lead** with support from NHSL EPT	Agreement in principle with MPS reached about how Police resources (20-30 officers) could be deployed in the event of further action Electronic system in place enabling deployment of VAS and PAS support secured Publish revised VAS and PAS tasking criteria Agreement in principle reached for MPS staff to be used as drivers subject to totality of requirement.	Complete Complete Complete Complete	Martin Flaherty

16.	There is no pre-established LAS communications plan available to react to an internal Major Incident and staff were unaware of their responsibilities when this occurred.	LAS Internal Major Incident communication plan including role and responsibility expectations to be developed, agreed and cascaded to all staff.	**LAS Lead**	Revised major incident plan contains new section on internal major incident and has been published internally and shared with key external stakeholders Publicise new major incident plan with specific emphasis on changes and internal major incident (RIB/bulletins) Specific communication protocols for Major internal incident Specific section of new major incident plan developed and circulated describing internal major incident and likely triggers/actions.	Complete Completed July 2012 Complete Complete	Martin Flaherty
17.	The awareness of the potential consequences of industrial action is low, and its potential impact on existing Business Continuity and Major Incident plans are not well understood.	NHSL EPT to ensure that Business Continuity and Major Incident plans are reviewed in all NHS organisations in London, so that the potential of industrial action is effectively considered and mitigated.	**NHSL EPT lead**	NHS London wide integrated Business Continuity strategy delivered at the beginning of 2012 and included IA issues. This included toolkits for organisations (including GPs and community Pharmacy) training and free consultant support.	Completed end April 2012	Andy Wapling
18.	Analysis of the events of the day shows what occurred to be a rising tide Major Incident. The decision not to declare a London-wide NHS Major Incident meant that formal NHSL led command and control arrangements were not invoked, which would have enabled greater support from the wider NHS, particularly if made earlier in the working day.	It is recommended that the emergency preparedness procedures are reviewed to address this.	**NHSL EPT lead**	Development of Industrial Action and Business Continuity escalation triggers and disseminate across London NHS organisations (links to recommendation 10) London's Conops, incident response plan and command and control documents have been updated incorporating this for the new NHS structures (National Commissioning Board, London),	Completed June 2012 Feb 2013	Nicki Smith
19.	NHSL were not initially invited to the Gold Command Group, so the wider NHS issues were not fully covered.	Further work is required to ensure that the MPS and London Resilience team understand the role and function of NHSL in its system oversight and leadership function.	**NHSL EPT lead**	1:1 discussions with LRT and Met Police held with regards to this, agreed approach.	End June 2012	Nicki Smith

20.	LAS representatives at the GCG did not appear to have access to accurate and up to date information, which led to delayed decision making	NHS delegates at the GCG must have access to accurate and up to date information, and be appropriately trained and experienced to support effective decisions.	**LAS Lead,** with support from NHS EPT	Training to national occupational standards already in place for all LAS Gx officers LAS and NHSL to ensure that when both parties attend GCG they are clear which organisation they are speaking for. All LAS Gx officers received updated training prior to Olympics 2012 and development continues with multiagency tabletops and workshops in 2013 Additional joint training and exercising with NHSL/NCB and LAS Gx officers to improve familiarity	Ongoing training Agreed in principle, to be supported by training Complete Ongoing training	Jason Killens
21.	There is understandably, and creditably, a lack of recent experience in managing national strike action in an emergency service by all parties (LAS management, union officers and local officials and the wider NHS).	A full guidance document should be produced to ensure clarity of roles, responsibilities and laws surrounding industrial action, including whether staff can be asked about their intentions to strike and how. NHS Employers should enter into discussion with National Health Unions with a view to establishing a framework of principles and practical actions for the managing of industrial action affecting the NHS. A way must be found to ameliorate the current concern of Trade Union's of an injunction being served on the basis that action planned is in accordance with action balloted.	**NHS L POD to lead**, with input from NHS Employers	This was discussed at a meeting of the London NHS Partnership Executive. A decision was made to revise the protocol. IR subgroup worked up revised protocol/principles Legal workshop has been held for London NHS employers, and included a FAQs document will be circulated for information. Discussion held with NHS Employers and DH/LAS/NHSL to share learning	Decision reached end March 2012 Closed, see Rec 7 Completed May 2012 Completed end April 2012	Julie Screaton

30th November Industrial Action Review – Integrated Action Plan – Updated – 14 March 2013

22.	Exemptions were not secured and there were no clear agreements of what elements of an ambulance service needed to be protected to maintain a safe level of patient care A key point was the decision by the trades unions to ballot for full strike action, rather than action short of strike. Discussions about exemptions took place only after the ballot result was out, for fear of rendering the ballot unlawful. .	National consideration should be given to agreeing a safe level of ambulance services in the event of industrial action, and how exemptions will be agreed The agreement should be an acceptance that balloting would be for action short of full strike where ambulance services are concerned. London NHS Partnership should then ensure these agreements are translated appropriately at a regional level across London. LAS management and its recognised trade unions should then develop the operational detail, specific to the needs of the LAS.	**LAS to work nationally with other ambulance services and with support from NHS Employers** **NHS L POD to work jointly with LAS**	Unison for pensions dispute nationally balloted for action short of a strike, which was supported, and this was extended by ambulance providers to maximum time frame (now expired). This demonstrated willingness for this approach. Critical services have already been identified within LAS (see recommendation 7) National ambulance HR Directors will explore the desire and potential for national agreement of formal exemptions for essential emergency service staff, with National Ambulance Partnership Forum. National work proposed to follow revised LAS Partnership Agreement which is now in final draft with joint approval. This will therefore be formally presented to the national HRD Group at its next meeting in May 2013. NHSL POD: - Discussion held at NHS Employers/DH meeting on 27th April. - Outcome has been built into new principles document (recommendation 7)	January 2012 Completed Completed May 2013 (was end March 13) ` Completed end April 2012 Completed	Caron Hitchen Caron Hitchen Julie Screaton

30th November Industrial Action Review – Integrated Action Plan – Updated – 14 March 2013

23.	Agreements on how the LAS would operate on 30th November were only agreed with a days notice prior to the event. Agreements were then communicated in an extremely short timescale. The LAS shift patterns meant that only up to 25% of staff were likely to have seen the notices prior to the action commencing.	Any agreement made to address impending industrial action should be completed in such reasonable time (proposed two weeks in advance) to allow the necessary preparation including communication with staff, their representatives, and management. All communication of information should be undertaken in a comprehensive fashion, jointly by management and trades union representatives to ensure a common understanding.	**LAS lead,** with NHSL POD ensuring this learning is cascaded to other NHS organisations	As per Recommendation 6 NHSL will cascade learning nationally and in London, via the IR review group	Principle agreed Completed as per Rec 6 & 7	Caron Hitchen Bernadette El-Hadidy
24.	Planning assumptions were based on a collective understanding that no more than 30% staff would take industrial action. Unions were reluctant to enter into discussions regarding the number of staff likely to take strike action. LAS management were prevented from canvassing staff ahead of the day by the NHSL Partnership and UNISON co-chair.	To support planning assumptions and provide assurance that an appropriate level of ambulance resource is available during a period of industrial action, LAS management should be able to canvas staff intentions to strike in advance of the event. In addition, the estimation of level of absence must be more refined to reflect different levels of absence on a geographical basis, recognising that strength of feeling or trade union membership density may well have an impact on attendance. In recognition of the sensitivity of the issue, the way in which such information is obtained should be the subject of early discussion and agreement between management and its recognised trades unions.	**LAS lead**	SMG in Dec 2011 decided to canvas intentions of staff (ahead of pan-London protocol),and this will better enable geographical detail of intentions to be understood. Guidance development for this is contained within Rec 21 and 7. LAS following updated NHSL guidance.	Completed	Caron Hitchen

30th November Industrial Action Review – Integrated Action Plan – Updated – 14 March 2013

25.	The Partnership Agreement is due for renewal and provides a good opportunity to agree the handling of Industrial Action to include exemptions and availability of staff, earlier agreement of operational planning and to address any inter union issues.	Management and recognised trade unions should develop a standing agreement, as a subsection of the LAS Partnership Agreement. The standing agreement must incorporate an obligation on the part of all concerned to the sign off of an agreement no later than two weeks before that action is to commence.	**LAS lead**	As part of the partnership agreement review LAS will also review and strengthen the disputes resolution section. This will include the adoption of the London partnership principles (Recommendation 7). Every attempt will be made to secure this commitment locally but there is no legal requirement for unions to agree to this and it cannot be enforced. - Consultation underway with Unison & GMB - Draft agreement - Finalised agreement UPDATE OUTSTANDING (5/3/13)	End Aug 2012 End Sept 2012 End Oct 2012	Caron Hitchen
26.	The response by front line staff on the day, particularly in not responding to the request to return to work, indicates that there is an underlying issue of front line staff morale and engagement with management.	The senior management of the LAS should determine ways in which greater interaction and engagement between local management and their staff can be achieved, building on the perceived success of the open forums run by the Chief Executive, with support from NHSL's Employment Services team.	**LAS lead,** working with NHSL POD and NHS NWL	The LAS will implement actions identified within its Staff Engagement Strategy action plan in addition to those identified in the corporate and local staff survey action plans and the commitments which were made following the CEO Consultation meetings. Plan will be updated with key milestones (by end Sept 12) A short-term Implementation Group was established between NHSL and LAS HR and NWL in order to take forward the Industrial Relations recommendations and to monitor progress. Last meeting held Oct 2012, with indication that staff survey 'temperature' checks were indicating improvement. The LAS has signed up to be a National Pioneer on Staff engagement and empowerment through the nationally developed Listening into Action programme which launched on 4 March 2013. This approach will compliment and build on the initial engagement plan associated with the Trust's modernisation programme.	1st draft end July 2012 for internal use End Sept - OUTSTANDING Review held end May 2012, 1st Aug, early Oct 2012	Caron Hitchen

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH MARCH 2013

PAPER FOR APPROVAL

Document Title:	**Proposal for the handling of low acuity calls following closure of NHSD and implementation of pan-London 111 Service**
Report Author(s):	**Dr Fenella Wrigley, Deputy Medical Director**
Lead Director:	**Jason Killens, Director of Service Delivery (North)**
Contact Details:	**Jason.killens@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**For approval**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To approve the proposal**

Key issues and risks arising from this paper

- NHSD will cease to exist from 21st March 2013.
- LAS currently passes 120 calls per day to NHSD for 'hear and treat'.
- LAS do not currently have capacity to handle this additional 'hear and treat' volume and there would be a risk that a greater number of low acuity calls would be dispatched on.

Executive Summary

With the introduction of NHS 111 across the country, the national contract which supports the transfer of calls from Ambulance Services to NHSD will come to an end on 21st March 2013. This means that LAS will need to manage the current NHSD call volume (120 calls per day) in a different way. The NHS 111 London contract accounts for this activity going to the new NHS 111 sites for assessment, however there is no agreed system to pass the calls to the NHS 111 providers. Following a 111/NHS London meeting, on 15th February 2013, to look at the system of transferring current NHSD call to 111 providers from April 2013 the LAS interim method of handling the C4 calls used during the Winter was reviewed where the LAS call-taker advises the caller to

self-refer to 111. The view from NHS London and the pan-London 111 Governance Group is that this is the preferred way to proceed until a technical solution is implemented as it means the patient is signposted appropriately after an initial ambulance service triage and it supports the long term aim of changing patient behaviour.

Attachments
Proposal for the handling of low acuity calls following closure of NHSD and implementation of pan-London 111 Service

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

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

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

Equality Analysis

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

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST

Proposal for the handling of low acuity calls following closure of NHSD and implementation of pan-London 111 Service

In February 2009 LAS, along with many other Ambulance Services, began referring low risk Category C calls to NHS Direct (NHSD). The determinants suitable to be passed to NHSD were nationally agreed – those which fell outside the NHSD agreed list (e.g. extremes of age, patients in public places and some specific categories like abdominal pain) continued to receive enhanced telephone assessment within LAS Clinical Telephone Advice or receive an ambulance response. Calls were passed to NHSD using a manual web-link or telephone assessment which at peak times of demand resulted in delays for transfer due to capacity of the system.

Over the past 2 years LAS has intermittently, through the use of DMP C, handled 999 calls categorised through MPDS as non-life-threatening (C4 calls) by advising callers to self-refer to either NHSD or their GP. Exclusions to the advice to self refer were children aged less than 5 years and adults aged over 70 years where evidence suggested that telephone assessment was more difficult and these patients often required a face-to-face assessment.

In December 2012 a decision was taken that, as part of the Festive Season demand management, lowest acuity calls (C4) would be given self- referral advice to NHSD or their GP. Exclusions to these arrangements were:

- Children aged under 5
- Adults aged over 70 years
- Patients in public gaze or exposed to weather elements
- HCP / 111 calls or patients who have been advised by one of these to call 999
- Custody Suites
- Patients with patients specific protocols held by LAS

Every call where the caller was advised at call-taking to self-refer for further advice was passed to a clinician within LAS to review the call log for any information which would necessitate either an earlier face-to-face assessment or upgrade of the call category. If there was concern then the LAS re-contacted the patient to undertake a further assessment. This process is undertaken in real-time and contributes to the' hear-and-treat' service provided by LAS.

The decision to implement these interim working arrangements were multi-factorial - over December LAS saw a huge rise in call volume and this was expected to continue over the Christmas

and New Year Period. The volume of calls being held in the Emergency Operations Centre (EOC), together with the continual changes between DMP levels, was placing significant pressure on EOC staff. Other considerations which contributed to the decision were a Coroner's Rule 43 advising LAS to adopt a more open approach with callers if an ambulance was not being dispatched immediately. Finally feedback from Patient Experiences suggested that, when DMP C was invoked, there were fewer complaints as the patients had received clear advice.

These interim working arrangements were again invoked over the Adverse Weather in January 2013.

A review of the two periods of use of the interim working arrangements revealed that the complaint rate was lower, the number of calls held was reduced and the response time to C3 and C4 patients was faster. In addition, capacity was freed up within EOC to undertake welfare call backs within the agreed timeframes which improved patient safety and experience. Feedback from the EOC staff was overwhelmingly supportive of this working and the pressure the staff were under was felt my individuals and managers to significantly reduce.

Based on this feedback as part of the LAS Winter Pressure contingencies the interim working arrangements were, with the agreement of EMT and the Commissioner's, brought in on 8th February 2013 to run until 31st March 2013.

With the introduction of NHS 111 across the country, the national contract which supports the transfer of calls from Ambulance Services to NHSD will come to an end on the 21 March 2013. This means that LAS will need to manage the current NHSD call volume (120 calls per day) in a different way.

The NHS 111 London contract accounts for this activity going to the new NHS 111 sites for assessment, however there is no agreed system to pass the calls to the NHS 111 providers. Discussions to date have centred round using a web server model for all the 4 provider sites in the capital (Harmoni, LCW, NHSD, and PELC) which would enable LAS to electronically transfer calls to NHS 111 after meeting the agreed criteria.

Whilst this or another form of warm transfer remains the preferred option, owing to the commitment to launch NHS 111 nationally by March 2013 there has been insufficient time and resources to develop this method of electronic transfer given the complexity of passing calls by geographical provider.

Proposal:

In order to ensure that 999 calls categorised through MPDS as Category C4 receive a prompt referral for clinical assessment and advice it is proposed that, until the warm transfer link is available, the callers will be advised to self-refer to 111 using the following script:

"From the information given we do not need to send you an emergency ambulance. Our advice is for you to contact NHS 111 (which has replaced NHSD) who will take some additional details and further assess your symptoms. Alternatively you may call you GP or make you own way y to an urgent care centre or to an Accident and Emergency department. If anything changes, call us back immediately for further instructions".

The LAS codes matching the C4 determinants have been mapped through the NHS pathways system in order to understand the endpoint disposition. In some cases a C4 call going through a NHS Pathways triage will frequently arrive at an ambulance determinant. This would not be an appropriate experience for any patient from the LAS or the 111 system and therefore they have been excluded from this process in addition to the current exclusion list.

This proposal is supported by the Commissioner's and pan-London 111 governance leads.

Dr Fenella Wrigley
Deputy Medical Director
17 March 2013

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH MARCH 2013

PAPER FOR INFORMATION

Document Title:	**Chief Executive Report**
Report Author(s):	**Ann Radmore**
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 ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Other
Recommendation for the Trust Board:	**That the Board note my report**
Key issues and risks arising from this paper	
Executive Summary - not required	
Attachments - 2 page briefing	

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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

TRUST BOARD MEETING 27 MARCH 2013
CHIEF EXECUTIVE'S REPORT

1. Changes to NHS System

On 1 April 2013 there will be some significant changes to the way in which the NHS in England works.

1.1 In terms of commissioning, the 10 Strategic Health Authorities and 151 Primary Care Trusts will cease to exist. The new commissioning system in England will be structured as follows:

- 1.1.1 The NHS Commissioning Board will take up its full statutory duties and responsibilities on 1 April 2013. It is divided into 4 regional commissioning sectors; London, North, South and Midlands and the East.
  - 1.1.1.1 With the exception of London, each of those regions has local commissioning board offices (27 in total) which are known as Local Area Teams (LATs).
  - 1.1.1.2 London does not have LATs but has arranged its structure so that dedicated teams support the North East, North West and South
- 1.1.2 23 Commissioning Support Services (3 in London - North East, North West and South)
- 1.1.3 212 Clinical Commissioning Groups (CCGS). In London there are 32 CCGs, each aligned with the boundaries of its London borough.
- 1.1.4 Local Authorities become responsible for the commissioning of Public Health services for their local population.
- 1.1.5 Further information can be found at the following link http://www.commissioningboard.nhs.uk/

1.2 The NHS Trust Development Authority (NHS TDA) will be established and will be responsible for overseeing the performance management and governance of NHS Trusts, including clinical quality, and managing their progress towards foundation trust status.

- 1.2.1 Further information can be found here http://www.ntda.nhs.uk/about/

1.3 Public Health England (PHE) will be established. The role of PHE is to protect and improve the nation's health and wellbeing, and to reduce inequalities.

1.4 Health Education England (HEE) will be established. This is the new national leadership organisation responsible for ensuring that education, training, and workforce development drives the highest quality public health and patient outcomes.
Further information can be found at the following link http://hee.nhs.uk/

1.5 Health and Well Being Boards are established. These are forums where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. In London they are set up in each borough

1.6 Healthwatch organisations begin work.

1.6.1 Local Healthwatch will involve people of all ages and from all sections of the community. They will build on the knowledge and experience of existing Local Involvement Networks (LINks), so ensuring continuity, and will reach out into parts of the community that do not currently have a voice.

1.6.2 Healthwatch England's role, working with the Department of Health and the Local Government Association, will be to support local authorities to set up effective local Healthwatch.

1.6.3 Further information can be found at the following link http://www.healthwatch.co.uk/creating-local-healthwatch

2. Listening into Action Programme

'Listening into Action' is an approach which helps NHS organisations change the way they listen to and involve staff. This a new way of engaging with staff, to unblock the issues that stop staff getting on with their job leading to improved clinical care through an engaged workforce. It is a one year 'journey' split into four phases. In the first phase we do temperature check survey and host 'big conversations' to get a view of where we are now. We then look at what improvements we can make that will benefit patient care and later on in the journey we expand the scheme to give departments, ambulance stations etc the skills to engage locally and enable change.

3. Update on Re-Configuration Programmes in London

There are currently 3 re-configuration programmes in London. Shaping a Healthier Future in North West London, Better Services Better Value in South West London and the programme of service changes required as a result of the outcome of the Securing sustainable NHS services: the Trust Special Administrator's report on South London Healthcare NHS Trust and the NHS in south east London'.

London Ambulance Service is engaged with each of these programmes having both clinical and managerial representatives actively contributing to the discussions and decisions which need to be made.

Ann Radmore
Chief Executive

19 March 2013

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 26TH MARCH 2013

Compliance with Standing Orders and Standing Financial Instructions

Document Title:	**Trust Secretary Report**
Report Author(s):	**Francesca Guy, Committee Secretary**
Lead Director:	**Sandra Adams, Director of Corporate Services**
Contact Details:	**francesca.guy@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Compliance with Standing Orders**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ 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 January 2013 and to be assured of compliance with Standing Orders and Standing Financial Instructions**

Key issues and risks arising from this paper

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

Executive Summary

There have been no new tenders since 21st January 2013.

There has been one entry to the register for Use of the Trust Seal for the lease renewal of Unit 28 Bermondsey Trading Estate.

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 2013

4th June 2013

Standing Items	Annual Reporting	Quality Assurance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman FT Update	**Annual Report and Accounts 2012/13** **Quality Account 2012/13 for approval** **Audit Committee Assurance Report**	Quality Dashboard and Action Plan Clinical Quality and Patient Safety Report Serious Incident Update Quality Committee Assurance Report Reports from Executive Directors (COO, DoF, DoHR)	Report from Chief Executive Officer HDD1 Action Plans for approval BGAF and QGF Action Plans for approval IBP/LTFM final approval prior to submission to NTDA	Report from Finance and Investment Committee Annual Equality Report 2012/13 Update on Information Governance Report from Trust Secretary Trust Board Forward Planner	Audit Committee - 13th May Finance and Investment Committee – 14th May Quality Committee – 24th April	Caroline Silver John Jones

25th June 2013

Standing Items	Quality Governance and Risk	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman FT Update	**Quality Dashboard and Action Plan** **Clinical Quality and Patient Safety Report** **Serious Incident Update** **Quality Committee Assurance Report** **BAF and Corporate Risk Register – Quarter 1 documents** **Audit Committee Assurance Report** **Reports from Executive Directors (COO, DoF, DoHR)**	Report from Chief Executive Officer	Report from Trust Secretary Trust Board Forward Planner	Audit Committee - 3rd June Quality Committee – 19th June	Steve Lennox

23rd July 2013

Standing Items	Quality Assurance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman FT Update	**Quality Dashboard and Action Plan** **Clinical Quality and Patient Safety Report** **Serious Incident Update** **Quality Committee Assurance Report** **Reports from Executive Directors (COO, DoF, DoHR)** **Annual Infection Prevention and Control Report 2012/13** **Annual Patient Experiences Report 2012/13** **Annual Safeguarding Report 2012/13**	Report from Chief Executive Officer Outcome reports on public consultation to receive and approve	Report from Finance and Investment Committee Annual Corporate Social Responsibility Report Report from Trust Secretary Trust Board Forward Planner	Finance and Investment Committee – 9th July Quality Committee – 21st August	

24th September 2013

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

26th November 2013

Standing Items	Quality Assurance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman FT Update	**Quality Dashboard and Action Plan** **Clinical Quality and Patient Safety Report** **Serious Incident Update** **Quality Committee Assurance Report** **Audit Committee Assurance Report** **Reports from Executive Directors (COO, DoF, DoHR)**	Report from Chief Executive Officer	Report from Finance and Investment Committee Report from Trust Secretary Trust Board Forward Planner Performance Reporting compliance statement	Audit Committee - 4th November Finance and Investment Committee – 12th November Quality Committee – 23rd October	

17th December 2013

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

MEETINGS CALENDAR FOR 2014

Committee	Chair	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Timings
Trust Board	Trust Chair	**28**		**25**			**3 & 24**	**22**		**23**		**25**	**16**	9.00 - 14.00 (followed by a board development session 14.00 - 16.00)
Strategy Review and Planning	Trust Chair		**25**		**29**					**2**	**28**			9.00 - 14.00 (followed by a board development session 14.00 - 16.00)
Annual General Meeting	Trust Chair									**23**				14.00 - 15.30
Annual C/Funds Committee	Caroline Silver (NED)													
Remuneration Committee	Trust Chair						**3**							14.00 - 15.00
Audit Committee	Caroline Silver (NED)			**x**		**x**	**x**			**x**		**x**		TBC
Finance and Investment Committee	Trust Chair	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	TBC
Quality Committee	Beryl McGrath (NED)		**x**		**x**		**x**		**x**		**x**		**x**	TBC
Clinical Quality Safety and Effectiveness Committee	Medical Director	**x**		**x**		**x**		**x**		**x**		**x**		TBC
Learning From Experience Group	Director of Quality and Health Promotion		**x**			**x**			**x**			**x**		TBC
Risk Compliance & Assurance Group (RCAG)	Director of Finance	**x**		**x**		**x**		**x**		**x**		**x**		TBC
Executive Management Team (EMT)	CEO	**Every Wednesday 9.00 - 11.00**												9.00 - 11.00