London Ambulance Service NHS Trust

# TRUST BOARD MEETING (PUBLIC)

Minutes of the meeting held on Tuesday 26th July at 10.00am
in the Conference Room, 220 Waterloo Road, London SE1 8SD

**Present:**

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| Heather Lawrence | Chair |
| Fionna Moore | Chief Executive |
| Fergus Cass | Non-Executive Director |
| John Jones | Non-Executive Director |
| Nick Martin | Non-Executive Director (joined the meeting at 9:30) |
| Bob McFarland | Non-Executive Director |
| Theo de Pencier | Non-Executive Director |
| Andrew Grimshaw | Director of Finance and Performance |
| Briony Sloper | Interim Chief Quality Officer |
| Fenella Wrigley | Medical Director |
| Paul Woodrow | Director of Operations |

**In attendance:**

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| Sandra Adams | Director of Corporate Governance/Trust Secretary |
| Charlotte Gawne | Director of Strategic Communications |
| Mark Hirst | Interim Director of Human Resources |
| Karen Broughton | Director of Transformation, Strategy and Workforce |
| Melissa Berry | Interim Equality and Inclusion Manager |
| Margaret Luce | Head of Patient and Public Involvement and Public Education |
| Mercy Kusotera | Committee Secretary (Minutes) |

**Members of the Public:**

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| Kathy West | LAS Patients' Forum |

**Members of Staff**

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| Anna Macarthur | Head of Media and Campaigns |
| Dave Fletcher | Darzi Fellow |

## 75. Welcome and Apologies

75.1 The Chair welcomed all to the meeting. Apologies were received from Jessica Cecil, Non-Executive Director, and Malcolm Alexander (Kathy West attending).

## 76. Declarations of Interest

76.1 There were no declarations of interest in matters on the agenda

## 77. Minutes of the Board meeting held on 31st May 2016

77.1 The minutes of the meeting held on 31st May 2016 were approved as a true record of the meeting subject to:

- 57.2 to be amended to read: 'Jessica Cecil recognised that on scene times were above what they should be and she asked…'
- 57.13 should read 5.5%
- 58.3 should read 'end-July'
- 58.4 should read 'Clinical Quality and Risk Group' not 'Improvement Director'
- 69.2 – to change the title from Business plan to Financial plan and amend 1st bullet to read 'finalise the position regarding Quality Improvement Plan investment…'
- 69.5 should read 'the maximum reportable deficit would be £3.5m.'
- Align the numbering on page 6.

**Action: Sandra Adams**
**Date: 4th October 2016**

**78. Matters Arising**

78.1 The Trust Board reviewed the action log and noted the following:
63.8 – It was noted that Clinical Education and Standards Group would report to the Workforce Committee. Clinical Safety and Standards and Improving Patient Experience Committees would report into Quality Governance Committee.

78.2 127.3 – Andrew Grimshaw reported that the double-crewed ambulance service Business Case had been approved by NHS Improvement subject to contract agreement with the CCGs. It was confirmed that 127.5 had been completed; the action was closed.

**79. Report from the Chair**

79.1 The following points were noted from the report:

- Ministerial team update – a substantial restructure of the Department of Health (DH) ministerial team as part of Theresa May's reshuffle.
- LAS Strategy – taking the service forward.
- 360º appraisal update – a workshop had been scheduled for 2nd September 2016 to agree a plan of action to improve our collective performance and governance. An additional private Board meeting had been scheduled for 6th September 2016 to agree the Trust risk appetite.
- Clinical Review – the key issue would be deciding where best to invest our additional funding to maximum benefit.
- Workforce Race Equality Standard – The Chair and the Chief Executive had met with the Interim Equality and Diversity lead of the Trust. The Workforce committee would provide an update on the work programme and would provide assurance to the Trust Board on Trust plans and actions.
- NARU Board awareness and assurance of interoperable capabilities – the Director at the National Ambulance Resilience Unit had written to all ambulance trusts reminding us of our responsibilities regarding HART (hazardous area response team), MTFA (marauding terrorist firearms attack) and CBRN (chemical, biological, radiological and nuclear defence) service lines.
- The Chair provided feedback on the meeting with Chair of South London Mental Health Trust.

79.2 Theo de Pencier asked for feedback from the Association of Ambulance Chief Executives (AACE) conference attended by the Chair. The Chair noted that the conference was useful in particular for networking.

79.3 The Chair reported that Yvonne Coghill would be attending the next Private Board session on 6th September 2016.

79.4 Trust Board noted the Chairman's report.

**80. Report from the Chief Executive Officer**

80.1 Fionna Moore provided an overview of progress and events within the Service since the last time the Board convened. She reported on the following key areas:

- Executive Leadership Team appointments – it was noted that Paul Woodrow had been appointed Director of Operations following a full recruitment process. It was also noted that Briony Sloper had taken up the post of Interim Chief Quality Officer, pending a substantive appointment.

- Clinical Review – this was led by NHS Improvement and was completed during June to assess how the Trust was progressing against the Quality Improvement Plan to address the CQC concerns across the five quality domains. Encouraging progress had been noted; however lack of consistency in making improvements had been an issue.
- Performance in Quarter 1 (Q1) – the Trust was above the A8 performance trajectory in each of the three months in Q1 2016-17, despite actual Category A demand exceeding the combined Category A demand trajectory by 3.4%.
- LAS 111 – the planned move of the service from Beckenham to Croydon had been successful.
- Workforce Race Equality Standards (WRES) – the action plan would be submitted to NHS England by end of July. The action plan would also be published on the website.
- 'Making the LAS Great' – An internal campaign to encourage conversations and discussions between managers and staff around Trust vision, values and what people's involvement is in the improvement programme had been launched on 7th June and this had been positively received by staff.

80.2 The Trust Board noted the Chief Executive's report.

**81. Integrated Performance – April 2016**

81.1 Andrew Grimshaw presented the Integrated Performance Report providing organisational oversight of all key areas across the Trust. He noted that the report had been consistent with previous months. Delivery of care continued to be safe but quality of service remained challenged.

81.2 A8 performance ended at 65.4% against the trajectory of 63.4%. The Trust had successfully achieved above trajectory for 3 consecutive months. It was anticipated that this trajectory would be challenging in July and August.

81.3 An activity improvement notice had been issued to commissioners. It was noted that although we had achieved the performance targets in the 1st quarter, the cost of doing so was not sustainable and work was underway to seek to contain cost. An action plan had been developed to start to address job cycle time (JCT) and demand.

81.4 The Workforce Committee had questioned the level of recruitment, the establishment numbers and vacancy rate and the Chair asked how much more it would cost to recruit to 100% establishment and whether this was affordable. The lead-in time for recruitment was long so this issue needed to be resolved. It was noted that the Board had previously agreed and signed off the recruitment trajectory with a review built into Quarter 1, and that we had set the appropriate establishment for the planned level of activity together with a plan for how we manage variations to this. Fergus Cass commented that the preliminary projection of workforce in 2017/18 was of concern and he asked when the clinical model would be resolved. The Chair and non-executive directors made it clear that they wanted the executive to recruit to 100% front line establishment. It was agreed that the Workforce Committee would receive a paper in September to inform this decision taking into account the operational and financial implications. The Board agreed to delegate authority to the Chair and CEO to approve this development.
**Action: Karen Broughton and Mark Hirst/Chair and CEO**
**Date: 4th October 2016**

81.5 There was a question regarding the noticeable change to Category A8 performance at weekends and Paul Woodrow confirmed that weekends were challenging: fixed pattern rosters contributed to this and he noted that flexible working patterns needed to be rebalanced. The Chair suggested a more detailed discussion was needed in terms of how we deliver safe patient care and 7-day working.

81.6 It was acknowledged that the overall Trust sickness rate continued to improve, however it was felt that a focus on long-term sickness was needed; the Workforce Committee would follow this up.
**Action: Karen Broughton/Mark Hirst**
**Action: 4th October 2016**

81.7 The Trust Board discussed the recruitment strategy in particular Personal Development Reviews/appraisal. Paul Woodrow noted that an agreement regarding postponing PDRs during difficult period in August had been sought from the ELT. It was felt that this should have been considered in planning.

81.8 In response to a question regarding the increase in on scene time for STEMI patients, Fenella Wrigley responded that this was included in work with front line staff and she would provide a report at the next Trust Board meeting in October.
**Action: Fenella Wrigley**
**Date: 4th October 2016**

81.9 Andrew Grimshaw confirmed that NHS Improvement had issued guidance that the Sustainable Transformation Funding should not be included in Trust financial reported positions and he confirmed that this therefore presented a risk on the reported financial position

81.10 The Trust Board noted the report.

**82. Quality Report**

82.1 The Trust Board noted the report.

**83. Quality Improvement Plan (QIP)**

83.1 Karen Broughton presented the QIP report outlining the delivery of the QIP up to the end of June. The programme had been operating for over six months, following the formal launch on 16th January 2016. It was noted that some good progress had been made across all areas.

83.2 Three external assurance reviews had been carried out to assess the Trust's progression in addressing CQC concerns (i) Warning Notice Review (March 2016) (ii) NHS Improvement (NHSI) Stocktake Review (May 2016) (iii) NHSI Clinical Review (June 2016). The following key headlines were noted from the clinical review:

- The scale and speed of the recruitment programme is commended.
- In terms of resourcing the Trust must address distribution of staff across stations and pathways to autonomous operational practice.
- Medicines management at stations had improved significantly. However the Trust needed to consider the end to process from drug packing to patient administration.
- Feedback from crews and observations confirmed that vehicle preparation pilots in the Trust were improving.

83.3 Fergus Cass noted that the report had mentioned that the impact of the substantial increase in staffing is not having the anticipated positive impact on response times and staff morale and he sought clarification on this. It was noted that the Trust was hitting local targets but not yet achieving national targets or delivering economically.

83.4 The expected trajectories for improvement and timelines were outlined. It was noted that incident reporting, feedback and learning had improved; however there were still some concerns around learning from complaints.

83.5 A discussion took place around Trust Board assurance of progress against the QIP. It was felt

that more granular reports were needed. Some feedback for example short notes at the end of every month outlining areas on track and those proving to be challenging, would be helpful. Overall, more assurance was needed; there was good progress at individual stations; however there was lack of consistency. The Chair asked non-executive directors whether they took assurance from the report and John Jones suggested that further independent assurance would help. Theo de Pencier suggested that a short note to Board members after each Quality Improvement Programme Board meeting would be useful. This was agreed.
Action: Karen Broughton/Heather Lawrence
Date: 4th October 2016

83.6 The Trust Board noted:

- The QIP update report
- The QIP progress report (June performance)
- The QIP KPI report (June performance).

**84. Quality Governance Committee Assurance Report**

84.1 Bob McFarland presented the assurance report on the meeting of the Quality Governance Committee meeting held on 12th July 2016. He reported that for some time the committee has been concerned that there had not been an action plan following the review of the Emergency Operations Centre (EOC). The Quality Governance Committee was pleased to be informed that recruitment was underway for Quality Assurance staff; this would enable the EOC to fulfil both their regular audit function and their role in informing reports on Serious Incidents and Complaints.

84.2 The Quality Governance Committee had approved the following annual reports:

*Safeguarding Annual Report*

84.3 The report had been sent back for review in May 2016 because 26/38 actions planned for 2015/16 had not been completed in-year. A new column reflecting the work since May 2016 had been added to the actions table. It was noted that the most significant remaining item was the need to institute a system of regular DBS checks on staff; the Quality Governance Committee had been told that this was in hand.

84.4 It was noted that an update on DBS action would be provided in October.
**Action: Briony Sloper**
**Date: 4th October 2016**

*Infection Prevention and Control Annual Report 2015/16*

84.5 The Quality Governance Committee had been pleased to note the considerable work done in this area over the year although there were a number of areas which were identified as below standard in the CQC report following the June 2015 inspection. There were challenges last year due to sick leave of the Head of service and withdrawal of the Infection Prevention and Control support post for much of the year.

84.6 Bob McFarland also recommended to the Trust Board for approval the (i) Patient Experiences annual report and (ii) Patient and Public Involvement and Public Education annual report.

84.7 The Trust Board approved the following annual reports for 2015/16:

- Safeguarding
- Infection Prevention and Control
- Patient Experiences
- Patient and Public Involvement and Public Education

84.8 The Board noted that the action plans for safeguarding and infection prevention and control had not been completed by the end of the reporting year and Briony Sloper confirmed that action was being taken on both plans now. Briony Sloper would provide an update on both plans to the October Board. A regular review of DBS would commence from August. Briony would also look to develop a consistent format for future annual reports.
**Action: Briony Sloper**
**Date: 4th October 2016**

**85. Finance Report Month 3**

85.1 The Trust Board noted the Finance report taking into account the earlier discussion under the Integrated Performance Report.

85.2 The Board noted that there had been some slippage on Cost Improvement Plans (CIPs) and asked for more focus from ELT and to provide assurance by the October Board that this was back on track. The quality impact of the CIPs had not yet been seen and Briony Sloper and Fenella Wrigley would be asked to provide assurance to the September meeting of the Quality Governance Committee.
**Action: Briony Sloper/Fenella Wrigley**
**Date: 13th September 2016**

**86. 2016/17 Control Total**

86.1 The Trust Board approved the 2016/17 Control Total.

**87. Assurance from Finance and Investment Committee**

87.1 Nick Martin provided an update from the meeting of the Finance and Investment Committee (FIC) meeting held on 25th July 2016 with reference to the agenda included in the Board pack.

87.2 The Trust Board noted the report.

**88. Assurance from the Workforce and Organisational Development (Workforce) Committee**

88.1 Fergus Cass reported that the Committee had held its second meeting on 18th July 2016. He noted that the terms of reference of the committee had been approved by the Trust Board in May; however there was need to clarify some areas, for example, the Committee's role in relation to clinical education and training and clarification of which Executive directors would be members.

88.2 Fergus Cass recalled earlier discussion around variation of staffing and he noted that in terms of resource, more work had been done but there was need to understand the mitigation.

88.3 The Committee had reviewed the draft Workforce Race Equality Standard (WRES) action plan; this had been recommended to the Trust Board and would be discussed later on the agenda.

88.4 Fergus Cass reported that the policy in relation to DBS checks had been agreed and would be implemented.

88.5 Fergus Cass suggested there were 4 assurance questions to be considered:

- Do we have a functioning Workforce Committee and can HR support the committee? *Not yet*.
- Can we assure the Trust Board on workforce aspects of the QIP? *This had been discussed earlier.*
- Is workforce planning robust? *Partial assurance but more work to be done*.

- Do we have effective policies, processes and outcomes for equality and inclusion? *No and this is part of the Workforce Race Equality Standard discussion later on the agenda.*

88.6 The LAS Patients Forum had asked whether the Minutes of the Workforce Committee would be published on the website. Fionna Moore and Charlotte Gawne would consider this along with the Minutes of other Board committees and respond to the Forum.
**Action: Fionna Moore/Charlotte Gawne**
**Date: 4th October 2016**

88.7 The Trust Board noted the Workforce Committee report and thanked Fergus for the update.

**89. Staff Survey**

89.1 Mark Hirst provided an update on staff survey key actions. He noted that the staff survey results had been presented to the Executive Leadership Team (16th March 2016) and the Workforce Committee (16th May 2016). It had been agreed that all actions required to address key areas for improvement arising from 2015/16 staff survey results would be embedded into QIP, and these would be communicated to departments in the next month. These included:

- Senior management visibility
- Issues relating to appraisal/performance reviews.
- Actions relating to bullying and harassment.
- Actions relating to communication of patient feedback.

89.2 It was noted that the next staff survey was due to be launched in September 2016. A target had been set to increase the response rate for the 2016 staff survey to at least 40% of eligible staff. The Trust Board felt the target rate was quite low considering that the Trust was at the bottom when compared to other ambulance trusts in 2015. A much higher response rate of >50% was needed. Local leadership was essential for this along with communications to staff before the next survey came out.

89.3 It was recommended that managers should view staff surveys as part of their responsibility. This could be part of appraisal discussions. The Trust Board felt that implementing staff snap shot surveys during the year as recommended by NHSI would be helpful.

89.4 In response to a comment about the time lag between the survey results being published and the Board receiving assurance on actions taken, it was noted that the QIP took account of the issues.

**90. Workforce Race Equality Standard (WRES) Action Plan 2016-2017**

90.1 Mark Hirst and Melissa Berry presented the WRES action plan. The WRES was made available to the NHS in April 2015 and incorporated in the 2015/16 NHS Standard Contract. From April 2016 the CQC was considering WRES progress under the Well-led domain within its inspection programme. The LAS had submitted the baseline WRES data in July 2015 but it appeared that no action plan was provided and progress has been patchy. Mark Hirst was presenting a new and robust action plan to the Board which would bring about the change required to make improvements around the 9 WRES indicators. Mark highlighted that the Trust had been without an Equality and Inclusion Manager for some time and as a result, some deadlines had been missed.

90.2 It was noted that the Trust's Quality Improvement Plan included 5 objectives related to equality and diversity. The action plan had been discussed by the Executive Leadership Team and had been recommended to the Trust Board for approval. It would be submitted to the Department of Health/NHSE on 1st August 2016 and would be published on Trust website.

90.3 In discussion, it was noted that some gaps were historical, but were not excusable. The Board needed to hear from Black and Minority Ethnic (BME) staff of their experience of working in the LAS. Melissa Berry had found some resistance to holding BME staff listening events and she suggested that a lack of senior BME representation makes it more difficult to progress some things. There could be more focussed work on areas where the majority of BME staff worked.

90.4 Fergus Cass asked if the plan and dates were deliverable and he wasn't sure that it could all be achieved by March 2017. He suggested that focus was needed and that the infrastructure should be created around the plan: measurement, reporting, staffing, and enabling the staff fora to work properly. Prioritisation, clear ownership and learning from the growing examples of good practice across the NHS were needed to deliver the WRES agenda. This could include wider recruitment and a review of the recruitment process; focus on the promotion process; communication; and learning from other services. Fergus Cass recommended a sub-group be established to oversee implementation of the plan.

90.5 The Chair noted that the current Interim Equality and Inclusion Manger works for 2 days a week and she felt that post should be full time considering the scope of the job.

90.6 It was agreed to further discuss the WRES action plan at the next Private Board meeting on 6th September. Melissa Berry would priorities the action plan.
**Action: Mark Hirst/Melissa Berry**
**Date: 6th September**

90.7 The Trust Board discussed the following questions around Equality and Inclusion that had been received from the Patients Forum:

*Appointing additional Board members from BME backgrounds*

90.8 We would recommend appropriate Board representation when making new appointments.

*Enhanced action on equalities*

90.9 The Equalities Committee would be refocused to equalities issues. The terms of reference would be revised.

*How will complex characteristics be recorded and supported by the LAS?*

90.10 If someone belongs to a specific group, we are able to record that information accordingly.

*BME diversity communities under protected groups.*

90.11 Fenella Wrigley reported that she had engaged with a group of people from the Sickle Cell Society.

*How will outreach, training and support be developed to make LAS a great place to work for a variety of BME staff?*

90.12 The Trust is committed to making the LAS a great place to work; it will take us time to get to where we are supposed to be. In terms of where we are, this had been covered in earlier discussion.

**91. <u>Patient Engagement Strategy</u>**

91.1 Briony Sloper presented the strategy outlining the LAS's commitment to patient and public engagement over the next four years to 2020. She noted that the Quality Improvement Plan

(January 2016) arising from the CQC inspection included activities which would benefit from patient involvement; these were also outlined in the strategy. The strategy had been presented to the ELT and the Quality Governance Committee for sign- off in July. The work plan would be reviewed annually.

91.2 Bob McFarland suggested that Board members could get more involved in this work and we could make better use of the foundation trust members. Briony Sloper confirmed that plans were underway to invite patient and public representation on key committees and to report each quarter on patient engagement.

91.3 The Trust Board noted the strategy.

**92. Board Assurance Framework (BAF) and Corporate Risk Register**

92.1 Sandra Adams presented the latest versions of the BAF and corporate risk register and she noted that the Trust had made good progress with embedding the management of risk at a local level in the last six months. All directorates and areas had been migrating their local and Trust risks onto the risk module on DatixWeb, which they would be using to update and extract reports from in the future. It was anticipated that this would enable the flow of information through the Trust Committees with responsibility for monitoring progress with risk mitigation and ensure timely escalation where required.

92.2 Sandra reported that ongoing risk management training was being offered to staff who needed it. A risk management page had been set up on the intranet, which contained links to the relevant policies, procedures, tools and forms to assist staff and managers with the risk management process.

92.3 It was noted that three BAF risks had been were approved by the RCAG for re-grading in June 2016, and had been removed from the BAF (BAF risks 16, 24 and 27). One new risk was approved by the RCAG in June 2016 for addition to the BAF (BAF risk 35).

92.4 Sandra Adams noted ongoing work around strategic risks and mitigations and on developing the Trust risk appetite statement. This would be further discussed at a private Board session on 6th September 2016.

92.5 A discussion took place around the risk relating to staff change-over times (BAF 7) and the risk relating to lack of ring backs on delayed response calls (BAF 29). The Quality Governance Committee would have oversight of these risks.
**Action: Paul Woodrow**
**Date: 13th September 2016**

92.6 Bob McFarland asked whether, with the reducing number of risks on the BAF, it was now time to focus on the amber rated risks. It was also noted that a number of the BAF risks still required closure dates. Karen Broughton asked whether the Board considered finance, service performance and IM&T to be the top risks facing the organisation. In response it was considered that we were not matching performance to delivery and demand was significant. BAF risk 4 was more strategic and needed to be broken down into constituent parts. Karen Broughton's question would link into the strategic risk and risk appetite discussions on 6th September. Sandra Adams suggested that there should be key risks against each of the CQC domains and QIP themes but this wasn't evident currently.

92.7 The Trust Board heard that there were no material quality or safety issues and risks and were pleased with the revised format of the BAF.

**93. Report from Trust Secretary**

93.1 It was noted that no activity had been recorded for tenders or Use of the Seal since the last Trust Board meeting.

**94. Trust Board Forward Planner**

94.1 The following items were added:

- QIP Plan – October 2016
- Business priorities
- Business plan 2017/18 - outline of the key issues

94.2 The Trust Board noted the forward planner.

**95. Register of Interest**

95.1 There were no changes recorded since the previous Trust Board meeting.

**96. Questions from Members of the public**

96.1 These had been covered in earlier discussion.

**97. Any Other Business**

97.1 Theo de Pencier asked if the 360° process had identified strengths and areas for improvement to support better working as a unitary Board.

**98. Date of Next Meeting**

98.1 The next meeting of the Trust Board would be on Tuesday 4th October 2016 at 09.00am in the Conference Room, Waterloo.

98.2 The Annual General Meeting would be held on Tuesday 27th September 2016 at 2.00pm.

# ACTIONS

from the Private meeting of the Trust Board of Directors of
LONDON AMBULANCE SERVICE NHS TRUST
26th July 2016

| Meeting Date | Minute No. | Action Details | Responsibility | Progress and outcome |
|---|---|---|---|---|
| 26/07/16 | **65.1**<br>**56.4** | **Matters arising**<br>PW to send a progress report re – Blue Light Collaboration project to support delivery of the EOC strategy and improvement programme. | **PW** | To provide a report on 4th October 2016. |
| | **58.2** | Indicative national ballot - KB/PW to undertake expert training on negotiations through NHS Employers. Fionna Moore to action this. | **FM** | Details of the company we used on previous occasions have been passed to KB and PW. Session booked for October with KB/PW. |
| 26/07/16 | **66.3** | **Clinical Review**<br>To focus on long-term sickness rate. | **ELT** | Matters arising 4th October 2016 |
| | **66.9** | The Executive leadership team to recruit to 100% front line establishment. | **KB** | Presented to the Private Board on 6th September. |
| | **66.10** | To provide further assurance regarding working as a unitary Board. | **FM** | Additional development and strategy meetings arranged in September. |
| 26/07/16 | **69.2** | **Patient Experience**<br>Bob to provide action tracker as evidence for the Quality Governance Committee. | **BMcF** | Matters arising 4th October 2016 |
| 26/07/16 | **70.4** | **Security Management**<br>SA/JJ to further discuss the action plan. | **SA/JJ** | Submitted – action completed. |
| 26/07/16 | **72.1**<br>**03.4**<br>**43.1** | **Business case approval**<br>A subset of the Board to further discuss Band 6 Paramedics. | **PW/MH** | Ongoing issue. |

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| 26/07/16 | **73.** | **Emerging Issues**<br>To provide assurance that work would progress to establish a substantive Workforce function.<br><br>Resourcing for the Equality and Inclusion function - ELT to discuss where funding will come from | **KB/FM**<br><br>**FM** | Work in progress. |

## Actions from previous meetings

| Meeting Date | Minute No. | Action Details | Responsibility | Progress and outcome |
|---|---|---|---|---|
| 31/05/16 | **53.1**<br>**44.10** | Executives to work out the options with regard to IT strategy. Arrange a Board workshop on IM&T and process | **FM and ELT**<br>**AW** | IT Strategy being presented to ELT on 7th September.<br>Workshop to be arranged for July/August |
| 31/05/16 | **53.5**<br>**39.10** | Finalising dates for the Board session on the performance model. | **AG** | 15th August 2016 |
| 31/05/16 | **56.8** | PW to provide a further update on EOC. | **PW** | Quality Improvement Programme. |
| 26/04/16 | **48.3** | SA to draft the strategic risks for discussion in relevant committees and final report to Trust Board | **SA** | Discussed on 6th September 2016. |
| 02/02/16<br>26/04/16 | **08.2**<br>**43.1** | **Well-led review**<br>Remain as matters arising for update at the next meeting | **SA/HL** | Matters Arising 4th October 2016. |
| 02/02/16 | **04.9** | **Exercise Unified Response**<br>Kevin Bate to provide an update | **PW/KBate** | The detailed analysis of EUR is expected to complete in six weeks' time and will be scheduled for the appropriate Board meeting. 6th September Board Seminar. |
| **COMPLETED ACTIONS** | | | | |
| 31/05/16 | **52.1** | Sandra to amend the minutes | **SA** | Completed |
| 31/05/16 | **58.2** | A national industrial action specific to ambulance services was expected - PW to follow this up. | **PW** | Completed |
| 31/05/16 | **61.1** | Mercy to confirm full address for the next meeting. | **MK** | Completed. |
| 26/04/16 | **43.1** | Brief the Chair on the Exercise Unified Response (EUR) | **FM** | Completed |
| 26/04/16 | **44.13** | PW to include banding options for Clinical Team Leaders in his review of the operational management structure, including cost consequences | **PW** | Completed |
| 06/04/16 | **39.8** | Raise concern about deliverability of national Flu CQUIN with DH | **FW** | Completed. |

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| 26/04/16 | **44.9, 39.13, 39.21** | Add JCT benchmarking to the McKinsey scoping | **AG** | Completed |
| 26/04/16 | **44.19** | NEDs to send final comments on the 2016/17 plan to Nick Martin before the FIC on 26th May<br>EDs to send comments to FM before 26th May | **All** | Completed |
| 26/04/16 | **47.5** | FW to prepare a short paper on reporting ACQIs for the Quality Governance Committee for feedback to the May Board | **FW** | Completed |
| 26/04/16 | **47.1** | ELT to discuss the quality governance KPIs | **JP** | Completed |
| 26/04/16 | **47.4** | Profile KPIs for 2016/17 operating, financial and single plan by the end of April;<br>Final report to May Board | **JP**<br>**JP** | Completed<br>31st May Board |

# Report of the Chair – 04 October 2016

## 1. LAS Strategy – taking the Service forward

Board members have met on three occasions since the last formal board meeting to review the position with regard to strategic issues such as 111, resilience and the clinical strategy, and to review progress and agree priorities against the quality improvement plan and working towards improved compliance with CQC standards.

There is now a very clear appreciation of the focus needed by the Executive and management teams if the Service is to be successful in its objective of exiting special measures early next year.

An external expert in Corporate Governance facilitated the Board in considering its Risk appetite statement and how this might be applied to the current strategic and business planning priorities. The October board agenda provides more insight into some of these discussions and is where both the Risk Appetite statement and the Risk matrix will be ratified.

## 2. Care Quality Commission (CQC)

The date of the re-inspection has been confirmed as 07 February 2017.

## 3. Mayor of London – Sadiq Khan

The Chief Executive and I met with The Mayor and his representatives on Wednesday 07 September. It was a constructive meeting where we discussed areas of common interest, in particular, Estate issues where it was confirmed the Mayor's office were working collaboratively with the NHS and Transport for London. We were able to confirm that we had commenced a review of our estate and had already held a meeting with Sir Robert Naylor, but were also open to opportunities for site rationalisation with the other Blue Light services. Resilience was another area discussed.

We also discussed the need to recruit to the paramedic profession so that the workforce was representative of the Londoners we provide services to.

The Mayor explained that he did not wish to take over responsibility for the Service, and that he understood the very real and necessary links with the NHS whilst also working with the other emergency services where appropriate.

## 4. Blue Light collaboration

Together with our CEO I attended a Blue Light Collaboration meeting. We have a senior Control Service's manager working as part of the London-wide Blue Light Collaboration team and there is an internal LAS committee, yet to be convened. The Governance arrangements need to be resolved internally so that the LAS committee feeds into the Executive structure and then to a Board sub-committee on behalf of the Board. I welcome views on which is the most appropriate and suggest the Audit committee but welcome suggestions as to the best solution.

The work of the Blue Light Collaboration falls under five main headings:

- Control rooms
- Prevention
- Response
- Support Services
- Enablers

It was agreed that procurement maybe an area to focus on and I suggested we produced a list of areas to see which ones are worthy of further work. I also made the point that as the Service forms part of the wider NHS world so need to consider when and where we should collaborate within the NHS.

## 5. Policing and Crime Bill

On Wednesday 14 September the Lords met to discuss the Policing and Crime Bill.

There were a number of amendments put forward – the government proposed changing the criteria for collaboration to increasing efficiency OR effectiveness, rather than both. Labour put forward an amendment to add a public safety criteria and a requirement to consult employees and trade unions.

Baroness Hamwee (Lib-Dem) began the debate by saying that collaboration must be on a case-by-case basis, fitting the needs of the local community, as well the proposed employees of the proposed parties to the collaboration.

Lord Harris (Lab) said he was surprised by the amendments, as they suggested that the government were asserting that there is a failure to collaborate between emergency services. His experience is that emergency services work very well together and go out of their way to do so.

Baroness Redfern (Con) said that the demand for emergency services is changing, with decreases in demand for fire and increases for the

ambulance service. She said that the debate must be about endorsing collaboration to make significant savings.

Lord Rosser (Lab) said that public safety needs to be ensured and collaboration must not be entered into if it risks public safety. He said that the criteria for assessing whether collaboration should be entered into should be expanded to include public safety. He also raised an issue around consultation with employees and trade unions around proposed collaboration and said there should be a clause that there needs to be consultation.

The Minister of State – Baroness Williams – responded on behalf of the Government. She said that there could be collaboration where it led to service improvements through increased effectiveness or increased efficiency but it didn't necessarily improve both. She then went on to praise the great many collaboration schemes across the country but said more needs to be done to ensure it is common practice.

She said that Services already consult and she was not therefore convinced any further amendment is required. She said that the Government would expect Services to ensure projects would not have a negative impact on public safety. The Bill already says that Services would not be required to enter a collaboration agreement if would adversely affect effectiveness or efficiency. The government would expect that assessment to consider public safety.

When asked how the duty would work in practice she said that the Bill states that emergency services must keep collaboration opportunities under review and for them to implement collaboration where it would be in the interests of efficiency or effectiveness. Ambulance trusts will not be obliged to enter into collaboration agreements where they would have an adverse effect on either their non-emergency functions or the wider NHS. The duty is broad. It allows for local discretion in how it is implemented so that the emergency services themselves can decide how best to collaborate for the benefit of their communities.

The next sitting for this Bill will be 26 October 2016.

London Ambulance Service NHS
NHS Trust

| | |
|---|---|
| **Report to:** | **London Ambulance Service Trust Board** |
| **Date of meeting:** | **4th October 2016** |
| **Document Title:** | **Chief Executive's report to the Board** |
| **Report Author(s):** | **Daryl Belsey** |
| **Presented by:** | **Fionna Moore** |
| **Contact Details:** | **Fionna.moore@lond-amb.nhs.uk** |
| **History:** | ***n/a*** |
| **Status:** | ***For information*** |

**Background/Purpose**

The Chief Executive's report gives an overview of progress and events of key events within the Service since the last time the Board convened.

The report is structured in five sections, covering the primary areas of focus of the Trust and the Board:

- Strategy
- Quality
- Delivery – performance, money, workforce
- Culture and Engagement
- Emerging issues

**Action required**

The Board are asked to take note of the contents of this report as the Trust progresses with its strategic objectives.

**Assurance**

N/A

| Key implications and risks arising from this paper | |
|---|---|
| **Clinical and Quality** | **X** |
| **Performance** | **X** |
| **Financial** | **X** |
| **Governance and Legal** | **X** |
| **Equality and Diversity** | **X** |
| **Reputation** | **X** |
| **Other** | |
| **This paper supports the achievement of the following 2015/16 objectives** | |
| **Improve the quality and delivery of urgent and emergency response** | **X** |
| **To make LAS a great place to work** | **X** |
| **To improve the organisation and infrastructure** | **X** |
| **To develop leadership and management capabilities** | This paper provides key information to the Board, informing them of the progress to date of the Trust against key objectives and ensures that the Chair, Executive Leadership Team and Non Executives Directors are fully briefed on the Trust's achievements. |

**CHIEF EXECUTIVE REPORT TO THE LONDON AMBULANCE SERVICE (LAS) TRUST BOARD MEETING HELD ON 10th October 2016**

The Chief Executive's report gives an overview of progress and events since the last time the Board convened. The report is presented in five sections, covering the primary areas of focus of the Trust and the Board:

- Strategy
- Quality
- Delivery – performance, money, workforce
- Culture and Engagement
- Emerging issues

# Strategy

**Sustainability and Transformation Plans (STP)**

The London Ambulance Service has now allocated individual Directors to work with the five local Sustainability and Transformation Plans within London. This will ensure joint strategic aims and collaboration between The London Ambulance Service and Urgent and Emergency Care networks and the 32 commissioning groups. The LAS leads will identify STP joint priorities within the five STP sectors and agree on service delivery. The overarching ambition is to develop consistency and collective responsibility for transformation of the ambulance service across London

# Quality

**Paramedic 2 Trial**

Following international calls to learn more about the effect of adrenaline on neurological outcomes and survival rates in cardiac arrest patients, the Service has become a major contributor to the largest cardiac arrest drugs trial in Europe - the most significant adrenaline study of its kind in history. Evidence has raised significant concerns that adrenaline as we currently use it in cardiac arrest may actually be causing patients harm. This study will help to finally answer this question. Paramedics signing up to the trial take either adrenaline or a saline placebo on the road. The team then visit surviving cardiac patients in hospital to talk to them about the trial and ask for their consent to follow up. The trial which is approved by the Research Ethics Committee started in 2014 and is overseen by the University of Warwick in partnership with ambulance services. Results are expected in 2018. Read more on the adrenaline trial on the LAS website.

**Training Stations**

A scheme to provide newcomers to the Service with practical support from experienced mentors has been shortlisted for a prestigious Health Service Journal award. The Training Stations programme launched last June to provide entrants with supervised, clinical on the road experience has been shortlisted in the Workforce category of the awards as an example of innovation in workforce development. The popular scheme has seen almost 400 students benefit so far across the four stations - the majority are TEACs and there are also international paramedics, graduates and university students. The winners of awards will be named at an HSJ awards ceremony on 23 November 2016.

# Delivery – performance, money and workforce

**Performance**

August 2016

- In August the Cat A trajectory rose substantially from previous months.
- Despite this rise, and the continually high demand, August's A8 performance ended at 67.43% - a difference of 0.35% above the LAS trajectory of 67.08% for the month.
- This is the fifth consecutive month in which the A8 performance trajectory has been exceeded, with an overall position of 2.0% above expected performance for the first 5 months of 2016.
- R2 and A19 performance trajectories were also met; however, R1 was below plan by 1.88%
- Category A demand was up by 7.5% on the plan for August; with Category C 9.5% above plan.
- August 2016 demand was 8.0% above August 2015 total incident levels; 7.3% above August 2015 Cat A incidents; and 8.6% above August 2015 Cat C incidents.
- For total incidents and Cat A incidents year-to-date (week ending 25/09/2016) activity is up 5.1% each on contracted levels. It is up 5.2% on contract for Cat C activity.
- Job Cycle Time (JCT) for August was 84.59, almost reaching the trajectory of 84.58 minutes and showing an improvement of 0.7 minutes on the previous month.
- Multiple Attendance Ration (MAR) has remained fairly stable for the past three months, and has successfully remained below the plan of 1.29 since November 2015.
- Capacity exceeded trajectory, with 6.9% more Patient Facing Vehicle Hours than planned.
- The 111 service achieved the target of 95% of calls answered in 60 seconds during August – the first time since January.

September 2016 and beyond

- Month-to-date (1st – 25th September), A8 performance is sitting at 63.33%.
- At present, if the rest of the month follows our forecast, we will finish the month at 63.89%, well below the trajectory.
- September's trajectory forecasts a dip in demand, which then rises throughout Q3; however, even with the higher level of activity already witnessed in September, a further rise through to December should still be anticipated given the current trends this year.
- The production of patient facing vehicle hours has been regularly above the trajectory level by an average of 2000+ hours per week, although this is reliant on overtime being taken up and the use of PAS/VAS vehicles.
- Overtime was 14.3% above trajectory in August, and has produced a fairly constant number of hours each month since April. The trajectory now forecasts a lower level Overtime required, following the reduction in annual leave after the summer holidays, and the anticipated increase in substantive hours.
- PAS contribution has reduced in July and August to the revised Q2 contracted position; however, this may reduce again in Q3, and so substantive Patient Facing Vehicle Hours need to be able to maintain trajectory given this further reduction in PAS.
- JCT has been improving each month since the beginning of the year, providing greater operational resource capacity. However, the trajectory takes a steep reduction in October, and further efforts will be required to continue to improve JCT down to this level.
- MAR has seen a rise in September from a fairly stable position. With the challenging reduction in JCT trajectory ahead, this will need to be monitored closely and efforts made to bring it back in line with the August position.

- As we go into Q3, the Performance Directorate will be focusing on winter planning, and forecasting demand, capacity and performance through to the new calendar year. This is especially important given the significantly higher than planned levels of activity witnessed so far this year.

**Money**

Year to date the financial position is on plan. However, the year-end control total of £6.7m deficit will not be achievable if the current pattern of spend is maintained. The key issue is the cost of additional frontline Capacity to address higher than planned demand. Demand is currently running above contracted levels by circa 5% year to date and 8% in August. The Trust is working with commissioners to identify a mix of actions to reduce demand, improve productivity and to secure additional funds to address this pressure.

**Workforce**

The Board signed off the Workforce Race Equality Standard Action Plan on the 26th July.

The Action Plan includes a comprehensive set of actions for closing the gaps in workforce experience between White and Black and Ethnic Minority (BME) staff and to improve BME representation at all levels of the organisation. The Trust has appointed an Interim Head of Equality and Diversity, Melissa Berry to ensure the actions are driven and completed and the Executive Leadership Team has identified additional resources to support the work. A key deliverable from the Action Plan is a BME Staff Open Forum to be held during October or November at which BME staff will be invited to share their experiences of working for LAS with the CEO and the Chair and to share any ideas they have for closing the gaps and improving representation. The Trust is in discussion with the Patients Forum about using the Forum's expertise to develop links with community groups and schools and with Health Education England about ways of encouraging an increase in the number of BME applicants for graduate paramedic science programmes and accessing additional Continuous Professional Development (CPD) funding for positive action initiatives to support the development and advancement of our BME staff.

## Culture and Engagement

**Staff recognition**

A total of 322 nominations, for 220 individual members of staff, were received ahead of the closing date for the latest round of our VIP Awards programme in mid-September. These are now being judged by local staff voting panels covering each of the 13 staff award groups to select their winners. A second round of judging will take place early in the new year, before an overall winner from each group is put forward for a Service wide staff vote for our 'Employee of the Year'. A further 12 nominations have been received for public recognition awards – for members of the public who have given special support or assistance to members of staff or our Service.

**Staff engagement**

We have run two significant events to work with our staff to help improve our Service for the benefit of our patients. The first of these was a workshop with a range of people in patient-facing roles (from our control rooms and frontline) to discuss practical ways to improve team working and local staff engagement; this follows a recent survey of these particular staff groups. We have also run a week-long programme, attended by 60 staff who put themselves forward to share their views and ideas, on how to improve our average job cycle time – the time measured from when an ambulance response is dispatched to a call to the point when those staff are available to attend the next patient – for all the calls we attend. Proposals developed then being taken forward as pilots.

**Staff survey**

The 2016 NHS staff survey was distributed to all eligible staff in the last week of September, accompanied by a personal message from the Chief Executive to encourage everyone to complete it. Regular communications activity and updates will take place during the survey period before it closes on 2 December.

**Meeting with Sadiq Khan**

Heather Lawrence and Dr Fionna Moore met with Sadiq Khan on 7 September. The meeting was requested by the Mayor to discuss performance, special measures, blue light collaboration and how he can support the Service. The meeting was positive and quarterly meetings with the Mayor are being arranged.

**Visits**

Philip Dunne MP, Minister of State for Health visited the Service in August. He met with Dr Fionna Moore, visited the Emergency Operations Centre and looked met with a paramedic from MRU. He is the Minister with responsibility for Trusts in special measures, as well as having responsibility for a wide range of other health services. Dr Dnyaneshwar Shelke, Head of India's EMS service and Ms. Sujata Saunik, Principal Secretary of Public Health Department Government of Maharashtra visited the Service in September. They visited the Emergency Operations Centre and looked at some vehicles and equipment. They also met with a paramedic from CRU and were very impressed by this model of emergency response. Dr Shelke is responsible for an EMS service in India that serves 140 million people.

**LAS 111**

The 111 Service is being inspected by the CQC on 29th and 30th of September. Ahead of the inspection and to celebrate the move to a new site we held two events at the new premises in Croydon. Dr Fionna Moore and Paul Woodrow visited to meet with staff and respond to their questions about the Service and CQC visit. Dr Fenella Wrigley and others met with stakeholders to officially open the new site, meet staff and answer questions about our 111 service and the forthcoming CQC inspection.

**BBC One documentary series 'Ambulance'**

Around four million viewers tuned in to watch the first episode of our BBC One documentary series *'Ambulance'* - far exceeding predictions. The episode was extremely well received by everyone who works for the Service who talked a lot about their pride in the organisation – one of our key objectives. Early indications also show that it has increased understanding of how the Service operates and importantly boosted interest in working for us – our other two strategic aims for taking part in the series. At the end of the series we will carry out a full analysis of '*Ambulance'* to share with the Board.

**Flu campaign for staff**

The communications team has launched an internal campaign to support Simon Steven's objective of vaccinating 75 per cent of frontline staff against the flu virus by December 2016. Last year, the Service vaccinated 53 per cent of frontline staff and 48 per cent of our total workforce.

'Get a jab save a life' taps into an important motivational trait of our workforce - wanting to help people. We've created a heart-warming campaign to appeal to staff who don't normally get the vaccine to get a jab and protect their colleagues, patients, family and friends from the virus. The campaign will use all internal channels including posters, postcards on pay slips, the intranet, LiA Facebook, events, info graphics, film and pictures to ensure we have regular up to date inspiring content throughout the life of the campaign.

**Pride campaign for staff for QIP Sept**

As part of our QIP objectives, our focus for September is to inspire staff to feel proud of where they work. This is chiefly being achieved through the BBC One documentary series which has inspired staff to talk openly within the organisation and on social media about their pride in their jobs and their pride for the organisation they work for.

**Staff assaults story**

To raise awareness about the increase in assaults against staff we organised media interviews with Assistant Director of Operations Natasha Wills, she spoke to BBC London and ITV London about the increase and how it will not be tolerated. Clinical Team Leader Tim Weekes and Quality, Governance & Assurance Manager Alison Blakely were also interviewed and spoke about their experiences of being assaulted while on duty.

**Notting Hill Carnival**

Around 200 staff responded to over 1,000 people at the Notting Hill Carnival over the August bank holiday weekend. Over the course of two days, the Service worked with St John Ambulance to treat a total of 1,005 patients, with 171 of those taken to hospital. The majority of people were treated for minor injuries or illness; however as in previous years there was a number of serious assaults on both days.

The total number of patients treated was higher than the year before and more people were taken to hospital.

**CEO Charity**

Representatives of the Service praised staff and carers at a BBQ fun-day held by the Charlie Chaplin Adventure Playground charity in August. Our Chief Executive Dr Fionna Moore along with Deputy Director of Operations, Control Services Katy Millard and Staff Officers Daryl Belsey and Clinton Beale visited The Charlie Chaplin Adventure Playground (CCAP) in Elephant and Castle. The CCAP was chosen by staff as the Chief Executive's Charity for the next two years.

**Magical Taxi Tour**

Staff from the service provided care for sick and terminally ill children travelling to Disneyland Paris in a convoy of 100 cabs on the Magical Taxi Tour Staff from the service helped co-ordinate the eleven Service staff on the road with the three mile fleet of taxis, police and ambulances on both sides of the channel. The twenty third Magical Taxi Tour run by the Worshipful Company of Hackney Carriage Drivers is only possible with the medical support of the Service.

**Chief Executive Officer engagement**

2nd August – Charlie Chaplain playground Visit
10th August – Service Funeral of John Clark
28th – 29th August – Staff engagement Notting hill Carnival
7th September – Meeting with Mayor Sadiq Khan
9th September – Observer shift with Apprentice Paramedics
19th September – 111 Site visit
23rd September – Undertook an observer shift with the Voluntary First Responder Group
25th September – Attended the National Police Memorial Day

## Emerging Issues

In July, national Ambulance Boards were required to provide annual assurance to NHS England that the obligations under SC30 of the Standard NHS Contract (maintaining the EPRR Core Standards) were being maintained. Following a number of recent high profile events including flooding, terrorist attacks in Paris and the outbreak of Ebola, attention has remained focused on the specialist interoperable capabilities maintained by English Ambulance Trusts. Over recent months, the National Ambulance Resilience Unit (NARU) received a number of requests for additional information regarding these specialist and complex service lines.

As part of a wider programme of communications, NARU produced an awareness film aimed at Executive and Non-Executive Directors of Ambulance Services. The film provided our board with an overview of Board responsibilities in relation to the following high risk service

- Hazardous Area Response Teams (HART)
- Marauding Terrorist Firearms Attack (MTFA)
- Chemical, Biological, Radiological, Nuclear (CBRN)

All members of the board have now watched the NARU video and will continue to seek reassurance from the Trust regarding its resilience.

Dr Fionna Moore
Chief Executive

London Ambulance Service NHS Trust

| | |
|---|---|
| **Report to:** | **London Ambulance Service Trust Board** |
| **Date of meeting:** | **4th October 2016** |
| **Document Title:** | **Integrated Performance Report – Trust Board Executive Summary.** |
| **Report Author(s):** | **Jill Patterson** |
| **Presented by:** | **Jill Patterson** |
| **Contact Details:** | |
| **History:** | |
| **Status:** | **Information Assurance and Discussion.** |

**Background/Purpose**

This high level Integrated Performance Report serves to provide an Executive Summary for Trust Board and give organisational oversight of all key areas across London Ambulance Service.

This report brings together the areas of Quality, Operations, Workforce and Finance.

It enables effective monitoring and highlighting of potential issues to inform the business decisions of the Trust.

Key messages from all areas are escalated on the front summary pages in the report.

It is designed to highlight key risks and support benchmarking of Trust-wide performance against Key National, Local and Contractual Indicators.

**Action required**

For Trust Board to note the Integrated Performance Report and receive it for information, assurance and discussion.

**Assurance**

- To assure the provision of high quality data and intelligence to support the Trust's decision making processes.
- To provide an integrated and comprehensive picture of the Trust's overall performance.
- To ensure that the Trust Board receives early oversight of trends and issues.

| Key implications and risks arising from this paper | |
|---|---|
| **Clinical and Quality** | |
| **Performance** | |
| **Financial** | |
| **Governance and Legal** | |
| **Equality and Diversity** | |
| **Reputation** | |
| **Other** | |
| **This paper supports the achievement of the following Quality Improvement Plan Workstreams:** | |
| **Making the London Ambulance Service a great place to work** | **YES** |
| **Achieving Good Governance** | **YES** |
| **Improving Patient Experience** | **YES** |
| **Improving Environment and Resources** | **YES** |
| **Taking Pride and Responsibility** | **YES** |

London Ambulance Service NHS Trust

# INTEGRATED PERFORMANCE REPORT – TRUSTBOARD EXECUTIVE SUMMARY

## SEPTEMBER 2016

* All available data is correct as of the 15th of every month.

* Please note that this report relates to performance throughout August 2016 unless otherwise stated.

**Delivery of care continues to be safe, but quality remains challenged at times. Some patients experience longer waits due to capacity constraints. Year to date the position is on plan. The year end position of £6.7m deficit will not be achievable if the current pattern of spend is maintained. August A8 performance ended at 67.43% which is above the LAS trajectory of 67.08%. This is the fifth consecutive month A8 has been above trajectory. Trust Turnover is now at 9.7% against a threshold of 13%, down from 10.1% in July.**

## OUR PATIENTS

- 98% of all suspected Stroke patients were provided with a full pre-hospital care bundle which is a 2% increase on July 2016 data.
- 10 serious incidents were declared of 59 incidents reviewed. 2 of them were overdue incidents which have been escalated to ELT leads.
- The Trust remains at Surge Red, with three periods of Surge Purple Enhanced which focused on the bank holiday weekend incorporating the Notting Hill Carnival.
- 97 complaints remain open, with 25 (26%) exceeding the 35 working day completion target.

## OUR PERFORMANCE

- A8 Performance for August 2016 was 67.43%. This was higher than the contracted trajectory of 67.08%. This is the fifth consecutive month A8 performance has been above trajectory.
- There were 43,036 category A incidents in August (7.4% above trajectory). Category C demand was 9.5% above trajectory. Overall demand was at 91,832 incidents, 8.5% above plan.
- Job Cycle Time for August was 84.59 minutes, slightly above the monthly trajectory of 84.58.
- Capacity was above the trajectory with Patient Facing Vehicle Hours at 6.9% above plan.
- The Multiple Attendance Ratio remained below plan at 1.26 in August. August is the 10th consecutive month in which MAR has remained successfully below the plan of 1.29.

## OUR MONEY

- Plan / Target – Year to date the position is on plan, The year end position of £6.7m deficit will not be achievable if the current pattern of spend is maintained.
- Year to date the Trust reports against plan a £3.6m deficit.
- YTD CIPs is £0.3m adverse to plan. This relates to delays in the delivery of some programmes that were due to start in Q2. The full year plan of £10.5m is still expected to be achieved. An additional £0.5m has been included in the revised plan to mitigate additional pressure on the QIP programmes.
- Capital spend is £2.1m against a revised capital plan of £2.9m. The capital plan has been re-profiled throughout the year to reflect revised timescales for delivery. To date NHSI has only approved £14.7m of £19.6m CRL requested.
- Cash is £16.5m, £1.6m adverse to plan. The Trust is awaiting confirmation regarding invoicing some specific income lines from NHS England (£2.0m) and LAS Commissioners (£2.5m).

## OUR PEOPLE

- The overall vacancy rate has improved from 7.3% to 6.9%.
- Turnover has further improved from 10.1% in July to 9.7% in August. This continues to remain below the threshold of 13%.
- The sickness percentage has remained 5% against the Trust threshold of 5.5%.

**The 111 service achieved the target of 95% for calls answered in 60 seconds during August 2016, the first time since January 2016.**
**The Patient Transport Service remains constant in patient waiting times and the expected lower return for friends and family questionnaires.**

## LAS 111 (SOUTH EAST LONDON)

↑ The LAS 111 service achieved 95.9% of calls answered within 60 seconds in August. This is against a target of 95%. This is the first time this target has been achieved since January 2016.

↓ Referrals made to 999 and Emergency Treatment Centres were successfully lower than in previous two months at 7.2%. These referrals continue to remain below the threshold of 10%.

↔ Issues affecting real time reporting continue. There has been focused attention by IM&T to gain a resolution.

↔ CQC announced it will be undertaking its inspection of the 111 service on 29th and 30th September 2016.

## PATIENT TRANSPORT SERVICE

↔ 5,704 journeys were completed in August 2016, an increase of 1.3%, from the previous month's total of 5,629 journeys.

↑ The patient departure time increased this month to 96% achieving 1% above the target.

↓ The Friends and Family Test responses have seen a decrease in August. This is as a result of reducing the questionnaire mailshots to a monthly basis.

# Key Performance Indicator Report Summary

| | Key Performance Indicator | Aug-16 | Jul-16 | Jun-16 | Chart |
|---|---|---|---|---|---|
| QUALITY | Adverse Incidents (Patient) | ↑ | ↑ | ↑ | |
| | Adverse Incidents (Staff) | ↑ | ↑ | ↓ | |
| | Potential Serious Incidents referred to SI Group | ↑ | ↓ | ↑ | |
| | Serious Incidents (LAS Declared) | ↑ | ↑ | ↑ | |
| | Serious Incidents (LAS Declared) Overdue | ↓ | ↓ | ↑ | |
| | Regular Reporting of Incidents - Shared Learning | ↔ | ↔ | ↔ | |
| | Total Complaints | ↓ | ↑ | ↓ | |
| | Complaint Acknowledgement 3 days | ↔ | ↔ | ↔ | |
| | Complaints Response (Over 35 Days) | ↓ | ↓ | ↓ | |
| | Controlled Drug Incidents - Not reportable to LIN | ↑ | ↑ | ↔ | |
| | All LIN Reportable Incidents | ↔ | ↑ | ↔ | |
| | Overall Medication Errors | ↑ | ↑ | ↑ | |
| | Missing Equipment Incidents | ↑ | ↑ | ↓ | |
| | Failure of Device/Equipment/Vehicle Incidents | ↑ | ↑ | ↓ | |
| | CPI - Completion Rate | ↓ | ↓ | ↓ | |

| | Key Performance Indicator | Aug-16 | Jul-16 | Jun-16 | Chart |
|---|---|---|---|---|---|
| 111 | Calls answered within 60s | ↑ | ↓ | ↑ | |
| | Calls abandoned after 30s | ↓ | ↑ | ↓ | |
| | Percentage of calls referred to 999 | ↓ | ↓ | ↑ | |

| | Key Performance Indicator | Aug-16 | Jul-16 | Jun-16 | Chart |
|---|---|---|---|---|---|
| WORKFORCE | Vacancy Rate (Frontline Paramedic) | ↓ | ↑ | ↓ | |
| | Vacancy Rate (Frontline) | ↑ | ↑ | ↓ | |
| | Vacancy Rate (Trust) | ↓ | ↑ | ↓ | |
| | Turnover Rate (Frontline Paramedic) | ↓ | ↓ | ↓ | |
| | Turnover Rate (Frontline) | ↓ | ↓ | ↓ | |
| | Turnover Rate (Trust) | ↓ | ↓ | ↑ | |
| | Sickness (Trust) | ↔ | ↑ | ↓ | |
| | Sickness (Frontline) | ↑ | ↔ | ↓ | |

| | Key Performance Indicator | Aug-16 | Jul-16 | Jun-16 | Chart |
|---|---|---|---|---|---|
| PERFORMANCE | A8 Performance | ↑ | ↓ | ↑ | |
| | A19 | ↑ | ↓ | ↑ | |
| | R1 | ↑ | ↓ | ↑ | |
| | R2 | ↑ | ↓ | ↑ | |
| | Calls | ↓ | ↑ | ↓ | |
| | Incidents | ↓ | ↑ | ↓ | |
| | Cat A Incidents | ↓ | ↑ | ↓ | |
| | Cat C Incidents | ↓ | ↑ | ↓ | |
| | Patient Facing Vehicle Hours (PFVH) | ↓ | ↑ | ↓ | |
| | Full Job Cycle Time | ↓ | ↓ | ↑ | |
| | Job Cycle Time (JCT) | ↓ | ↓ | ↑ | |
| | Multiple Attendance Ratio (MAR) | ↔ | ↓ | ↑ | |
| | EOC - Call Answering Rate | ↑ | ↓ | ↓ | |
| | EOC - FRU Cat C Share | ↓ | ↑ | ↑ | |

| | Key Performance Indicator | Q1 | Q2 | Q3 |
|---|---|---|---|---|
| FINANCE | Financial Stability Risk Rating (FSRR) | | | |
| | Capital Service Capacity | | | |
| | Liquidity Days | | | |
| | Access to PDC for Liquidity Support | | | |

| | Key Performance Indicator | Aug-16 | Jul-16 | Jun-16 | Chart |
|---|---|---|---|---|---|
| FINANCE | Cash Balance - Monthly Profile - £000s | ↓ | ↑ | ↑ | |
| | Income and Expenditure Deficit by Month - £000s | ↓ | ↑ | ↓ | |
| | Income and Expenditure Deficit Cumulative - £000s | ↓ | ↑ | ↓ | |
| | Income Variance from Plan - £000s | ↓ | ↑ | ↑ | |
| | CIP Delivery Against Plan - £000s | ↑ | ↑ | ↑ | |
| | CIP Forecast Against Plan - £000s | ↔ | ↔ | ↑ | |
| | Forecast Capital Spend Against the CRL - £000s | ↑ | ↑ | ↑ | |

KPI Summary

These KPIs underpin the integrated performance report. This is a summary of all the KPIs and their related performance for the last 3 months. The RAG status is calculated against targets/trajectories/thresholds where available.

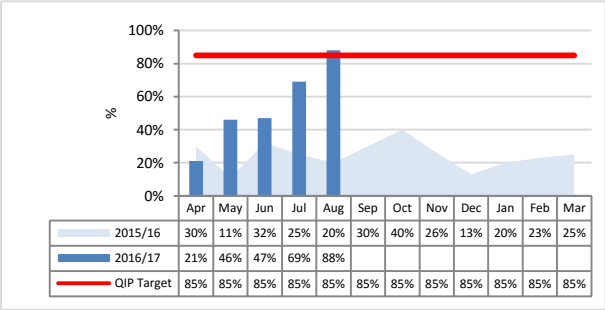
*The Chart column shows the trend over the previous 3 months | The arrows indicate the direction of KPI compared to previous month*

# Our Patients

| Section | Key Headlines |
|---|---|
| SAFE | • 10 Serious Incidents were declared in August out of 59 incidents reviewed, with 2 reports overdue. Overdue SI's have significantly reduced and those outstanding have been escalated internally to the Executive Lead.<br>• CSR2016.2 has commenced with 18% completion rate by August. This figure is as expected due to the holiday period. 30 International Paramedics have completed their training and mentoring programme and are now working autonomously.<br>• 28 medicines management issues were reported during August with the main themes being incorrect drug, incorrect dose of drug and administration errors. There was no patient harm and feedback has been provided to individual crews.<br>• There was an overall decrease in reported staff and patient related incidents. The increase in staff related issues for equipment failures involved suction units and EZIO, which are being investigated.<br>• There are 97 open complaints, of which 25 have remained open for 35 working days or more. |
| EFFECTIVE | • The Darzi Fellowship focussed on Frequent Callers and concluded at the end of August with all objectives being met and 90% of CQUIN recommendations being completed.<br>• 8 patients with ROSC had an underlying STEMI as a cause of their cardiac arrest. 36 were conveyed to Heart Attack Centres (HAC) appropriately during July 2016.<br>• 4% of cardiac arrests had defibrillator downloads in July 2016, a decrease of 4% from June 2016. The majority of downloads were submitted by the Advanced Paramedic Practitioners.<br>• 98% of all suspected Stroke patients were provided with a full pre-hospital care bundle which is a 2% increase on July 2016 data. |
| CARING | • The Sepsis CPI compliance is very good at 96%, although it was noted there was a lack of oxygen administered for a particular group station which the QGAM has been notified of and this will be followed up by Team Leaders in CISO conversations.<br>• July has seen the lowest number of CPI's completed since March 2015. The North West sector completed all available audits. This has been addressed with QGAM's and ADO's.<br>• 103 Friends and Family Tests were received during August, a noted decrease which was anticipated following the PTS direct contact with patients during June and July.<br>• 16 public events were attended by the Patient and Public Involvement team, a decrease on those attended in July which is as expected due to school holidays. |
| RESPONSIVE | • The Trust is currently at Pressure Level 2 – Moderate.<br>• The Trust remains at Surge Red, with three periods of Surge Purple Enhanced, in particular during the Bank Holiday break.<br>• Enhanced medical cover was provided at the Notting Hill Carnival over the August Bank Holiday weekend to ensure the impact on primary and secondary care was minimised.<br>• A number of hospital breaches were noted during August, with 624 exceeding 1 hour. |
| WELL LED | • The CQC inspection team visited the Trust on 2nd and 3rd August and have provided feedback of some key issues in relation to the warning notice. Specifically noted was an improvement in code access arrangements for medicines packs and security of drugs. |

# Serious & Adverse Incidents (SI)

| Patient safety incidents reported on DatixWeb within 4 days of incident occurring | | | |
|---|---|---|---|
| **Target 2016/17** | **Actual** | **Variance** | **RAG** |
| 85% | 88% | 3% | |



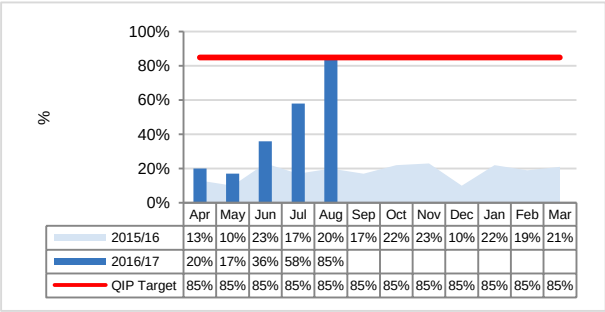

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 30% | 11% | 32% | 25% | 20% | 30% | 40% | 26% | 13% | 20% | 23% | 25% |
| 2016/17 | 21% | 46% | 47% | 69% | 88% | | | | | | | |
| QIP Target | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |

**Adverse Incidents**

The Trust continues the work to move from two methods of data capture to using DatixWeb only and as a result the incidents reported by paper continued to fall in August 2016. We estimate over 93% of incidents in August 2016 have been received at the time of publication. These are detailed below.

| | |
|---|---|
| **Patient Incidents:** | **218 (-9%)** |
| • Failure of Equipment: | 34 (+6%) |
| • Missing Equipment: | 16 (-24%) |
| • Medication Incidents: | 28 (-7%) |
| **Staff Incidents:** | **243 (-8%)** |
| • Manual Handling Incidents: | 35 (-33%) |
| • Assault and Abuse: | 67 (-17%) |

| Staff safety incidents reported on DatixWeb within 4 days of incident occurring | | | |
|---|---|---|---|
| **Target 2016/17** | **Actual** | **Variance** | **RAG** |
| 85% | 85% | 0% | |




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 13% | 10% | 23% | 17% | 20% | 17% | 22% | 23% | 10% | 22% | 19% | 21% |
| 2016/17 | 20% | 17% | 36% | 58% | 85% | | | | | | | |
| QIP Target | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |

**Adverse Incidents due to items of equipment which failed or were missing**

These were all reviewed for any impact on patient safety and outcome, and none were identified. The overall availability of equipment is being reviewed as part of the Logistics Make Ready programme.

**Failed in use (Top 5)**

| | |
|---|---|
| • Laerdal Suction | 4 |
| • EZIO | 3 |
| • Mangar Elk | 2 |
| • Entonox Cylinder | 2 |
| • LP15: ECG Leads | 2 |

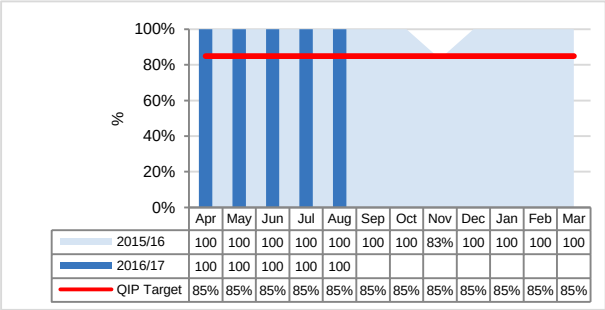
**Missing Items (Top 5)**

| | |
|---|---|
| • PALS Kit | 4 |
| • Technician Drug Pack | 3 |
| • Paramedic Drug Pack | 3 |
| • Splints | 2 |
| • Scoop Stretcher | 1 |

# Serious Incidents / Governance

**Percentage of Serious Incidents (SIs) reported on STEIS within 48 hours of being declared**

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 85% | 100% | 15% | |



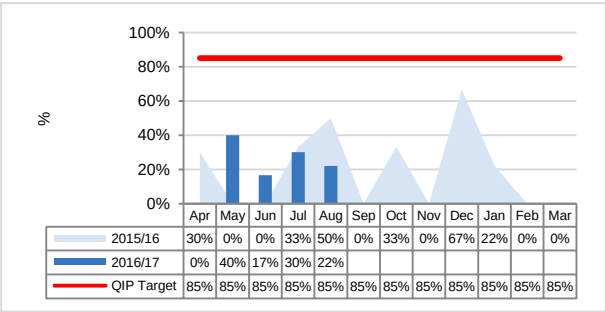

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 83% | 100 | 100 | 100 | 100 |
| 2016/17 | 100 | 100 | 100 | 100 | 100 | | | | | | | |
| QIP Target | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |

**Serious Incidents**

- 10 Serious Incidents (SI) were declared in August 2016 out of 59 incidents reviewed. There are 2 reports overdue, a decrease of 4 on the previous month and 7 on the month before that.
- Recent themes include errors in treating patients in cardiac arrest, delays in response and IM&T issues.
- Overdue SI's have been escalated internally to Executive Leads for completion and projected completion dates have been asked of ELT leads. An increase in throughput has been seen as evidenced by the reduction in overdue reports.
- 9 SI reports were completed and submitted in August, 2 of which were within the 60 day timeline target.

**Completed investigations and reports within 60 working days of a serious incident being declared**

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 85% | 22% | 63% | |

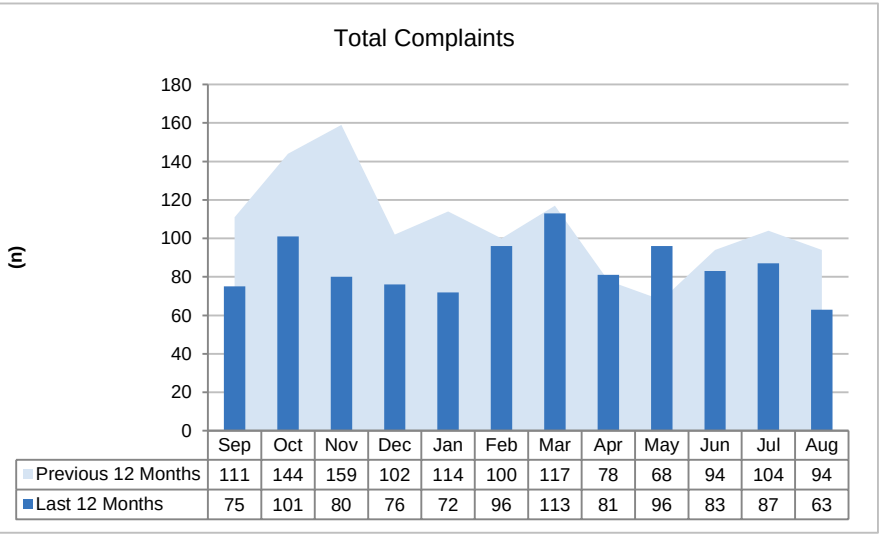



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 30% | 0% | 0% | 33% | 50% | 0% | 33% | 0% | 67% | 22% | 0% | 0% |
| 2016/17 | 0% | 40% | 17% | 30% | 22% | | | | | | | |
| QIP Target | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |

In the first 2 months of Q2 16/17 the LAS submitted 19 Serious Incident (SI) reports, already one more than the whole of Q1. The average time for completion for these SI's was 93 days, down from 107 the previous quarter. Of these, 3 were completed within 60 days in July and 2 within 60 days in August. The number of overdue reports currently stands at 2, down significantly on previous months and evidence of the work that has been done to reduce the backlog.

Further training is also taking place to increase the skillset of investigators and on investigation report writing for the Executive Leadership Team, all of which should help reduce time to complete. Course dates are booked for September.

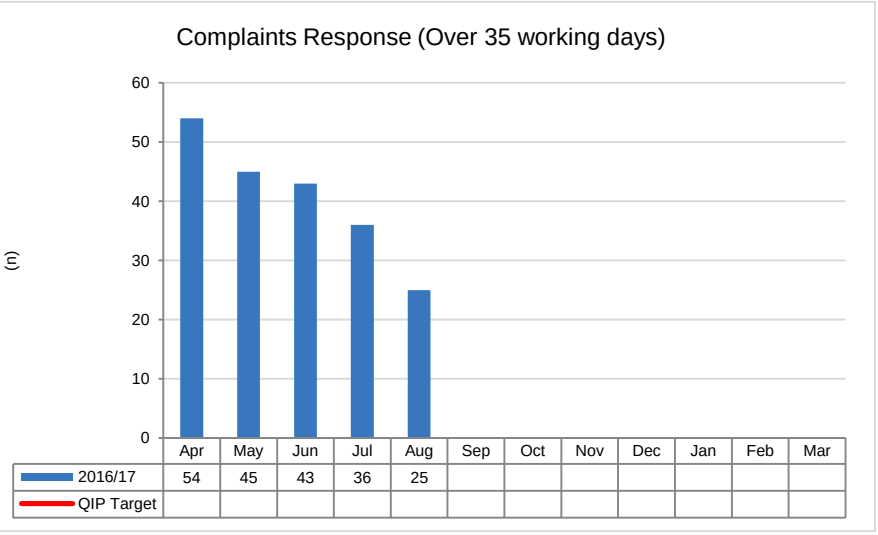
# Complaints – Volume & Response time




| | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Previous 12 Months | 111 | 144 | 159 | 102 | 114 | 100 | 117 | 78 | 68 | 94 | 104 | 94 |
| Last 12 Months | 75 | 101 | 80 | 76 | 72 | 96 | 113 | 81 | 96 | 83 | 87 | 63 |

**Total Complaints**

- 63 complaints and concerns were received in August 2016, a decrease on the number received in July 2016.
- This includes 3 from Health or Social Care providers which were treated as having been made on behalf of the patient. This illustrates how best practice is applied (as approved by HSC) and goes beyond the DOC obligations.
- Complaint volumes are the lowest overall for August in comparison to the data from 2013/14 which is used as the benchmark for complaint numbers received.




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 54 | 45 | 43 | 36 | 25 | | | | | | | |
| QIP Target | | | | | | | | | | | | |

**KPI Report – complaints responses over 35 working days**

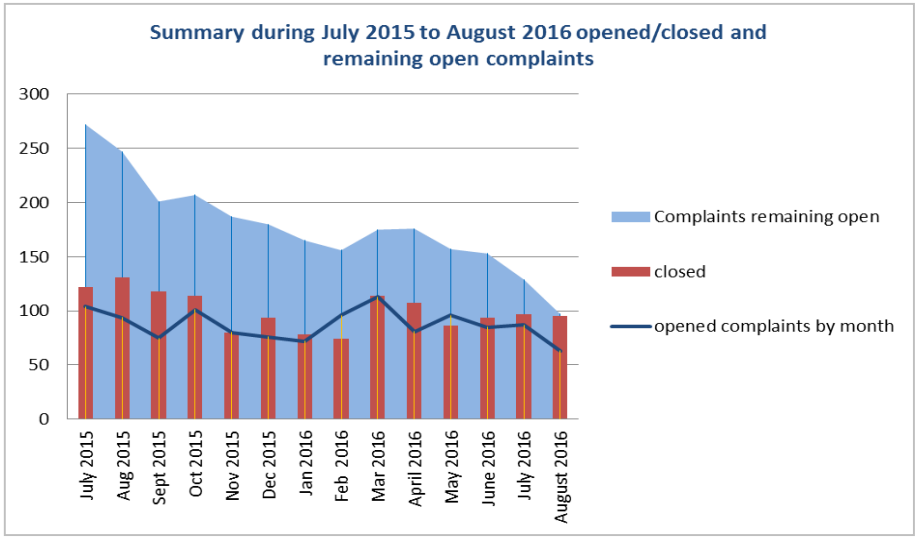
- The QIP KPI data reflects the number of complaints over 35 working days that remain open.
- There are 97 open complaints, a reduction on July (129). There are 25 over 35 working days, a decrease from July (36) as of 28th August.
- At the time of publication, there were 20 overdue complaints, of which 12 are pending sign off.

# Complaints – Volume & Response time

| | 2013/14 | 2014/15 | 2015/16 | 2016/17 |
|---|---|---|---|---|
| August Complaints | 89 | 111 | 94 | 63 |
| Average per annum | 88 | 117 | 88 | 82 |

**Complaint Volumes**

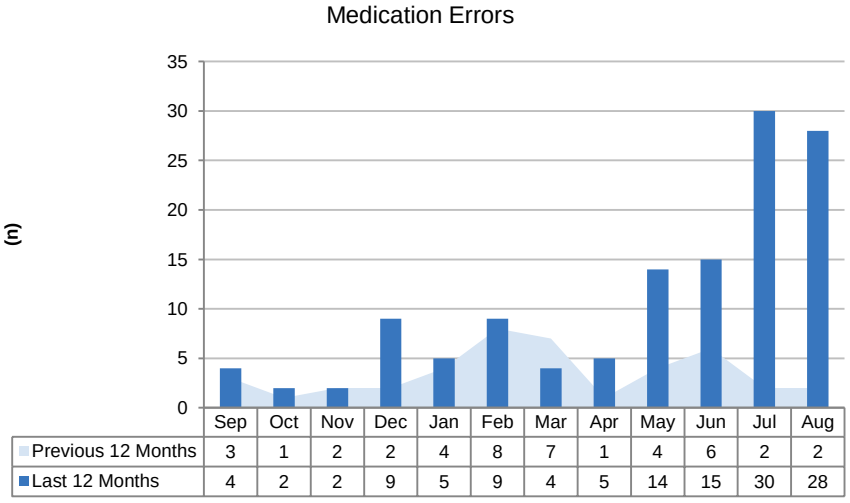
- DatixWeb has been in place for four months. All remaining cases held on the previous database have been closed. This version will be retained as Archive in the event of further enquiries from the Ombudsman or complainants.
- Data for reporting complaints by area and Local Authority / CCG has commenced with Camden receiving the highest, although notably, complaints from outside London were higher.




**Complaint Volumes**

- DatixWeb has been in place for four months. The Patient Experiences Department (PED) have ensured that any remaining open cases within the previous database have been closed. This database will be retained as an Archive in the event of further enquiries from the Ombudsman or complainants.

# Medicines Management




| | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Previous 12 Months | 3 | 1 | 2 | 2 | 4 | 8 | 7 | 1 | 4 | 6 | 2 | 2 |
| Last 12 Months | 4 | 2 | 2 | 9 | 5 | 9 | 4 | 5 | 14 | 15 | 30 | 28 |

**Medicines Management – KPI data - Controlled Drugs (CD)**

There was **one** reportable (controlled drugs) LIN incidents in August 2016:-

- A paramedic identified that one ampoule of morphine was missing from their morphine pouch on return to station. Despite a search it remained unaccounted for and was reported to the Police.

- A paramedic drug pack was handed into an ambulance station by a member of the public which was found in the street. The contents appeared intact, but some ampoules were broken, including diazepam.

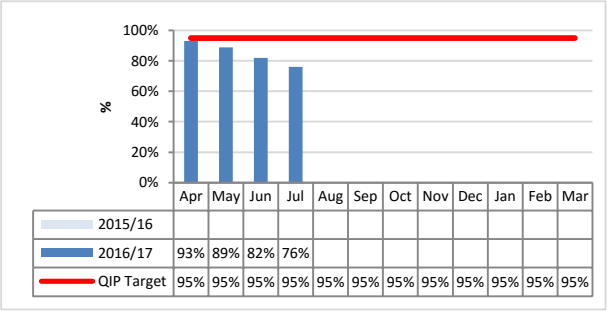
There have been **four** CD incidents that are not LIN reportable. One involving a morphine ampoule given to a GP during the care of a palliative care patient which is a contravention of policy.

**Other medicines management issues**

- The Trust Pharmacist role has been approved and has gone to advert with a view to recruit by November 2016.
- A review of new sepsis guidelines has been undertaken. This confirms that the current Trust guidelines relating to fluid administration remain fit for purpose and that due to transfer times IV antibiotics are not required.
- An audit and retrospective review of pharmacological management of acute behavioural disturbance by Advanced Paramedic Practitioners will shortly be conducted.
- Medicines management spot checks continue to be conducted by Incident Response Officers. Compliance remains consistent and the majority of issues identified relate to minor omissions.
- Supply of drugs packs in certain areas is inconsistent resulting in shortages at some times of the day. The logistics support unit are packing additional bags but these will take time filter into the supply chain.
- Audits of the new style drugs usage form contained in sealed drugs packs continue to demonstrate improvements in compliance when compared with old style forms.

# CPI Completion, Feedback Sessions and Compliance (July 2016 data)

| Number of eligible Patient Report Forms (PRFs) audited per month | | | |
|---|---|---|---|
| **Target 2016/17** | **Actual** | **Variance** | **RAG** |
| 95% | July: 76% | 19% | |




**CPI Completion**

- Overall CPI completion is at its lowest level since March 2015.
- The North West Sector were the only sector to complete all available audits, followed by the South East (96% completion) and North Central (95% completion).
- A reduction in completion was particularly evident at the MRU, New Malden, Newham, Romford and St Helier which has been communicated back to local management to address.
- Edmonton, Friern Barnet, HART and Hillingdon audited all available PRFs for the 12th consecutive month. The TRU have also maintained 100% completion this financial year.

**CPI Completion**

- The care provided to patients with a diagnosed psychiatric problem remains at 90%, with significant improvement still required in recording safeguarding concerns for the patient.
- Patients discharged at scene continue to receive a very high standard of care (97%), as do patients in cardiac arrest (97%) and glycaemic emergency (96%).
- General documentation of patient care remains high (96%), with drug pack codes recorded on 98% of relevant PRFs.
- The Severe Sepsis CPI has maintained the 96% compliance achieved in June 2016. However, the administration of high flow oxygen requires improvement, particularly in the East Central Sector which has been highlighted to the Quality Governance and Assurance Manager.

**CPI Feedback**

- Less than half the number of feedback sessions expected at this point in the year have been delivered which has been communicated back to local management to address.
- Hillingdon Group Station are the only group to deliver over 75% of expected face-to-face feedback sessions to staff, despite a decrease in the delivery of sessions over recent months.
- Very few feedback sessions have been delivered to date at Croydon, MRU, Newham, Westminster, Wimbledon and the reasons for this should be investigated. Volunteer Responders have started to provide face-to face feedback; however, improvement is still required.

# CARU Reports - Cardiac Care (July 2016)

**Cardiac Arrest**

- Resuscitation efforts were commenced on **38%** of cardiac arrest patients attended by LAS crews.
- The average time from 999 call to LAS on scene was **8 minutes**, thus meeting the target. **Fifteen** station groups had an average 999 call to scene time of 8 minutes or less.
- **27%** of cardiac arrest patients that had resuscitation commenced gained and sustained Return of Spontaneous Circulation (ROSC) until arrival at hospital, which is a **6%** decrease from June. **St. Helier** station group had the highest ROSC rate with 60% of their patients maintaining ROSC to hospital.
- **38** patients with ROSC presented with a STEMI following their cardiac arrest, **36** of which were conveyed to HACs in line with the pathway.
- An advanced airway management device was placed successfully in **88%** of cardiac arrest patients where resuscitation was attempted. Of these patients, **99%** had end tidal CO2 levels measured. **One** patient had no end-tidal CO2 level documented on their PRF nor accompanying capnography printout and these have been shared with Sector management teams for further investigation.

**ST Segment Elevation Myocardial Infarction (STEMI)**

- **99%** of patients were conveyed to an appropriate destination. **Two** patients were transported to an ED when they should have been taken to a HAC. These cases have been shared with Sector management teams for feedback.
- The average time from the 999 call to arrival on scene increased by **1** minute to **11** minutes in July.
- Average overall on scene time decreased by **2** minutes to **42** minutes while call to hospital times decreased by **1** minute to **71** minutes. These continue to remain high and require monitoring and review to identify themes.
- **Hillingdon, Romford, Bromley** and **Croydon** station groups (plus **PAS & VAS** and **Other LAS** vehicles) achieved notably lower than average overall on scene times this month.
- The percentage of patients who received a complete care bundle (aspirin, GTN, two pain assessments and analgesia) increased by **3%** to **73%**.
- **Westminster** station group provided the full care bundle to 100% of patients this month. However, **11** station groups provided a full care bundle to less than 80% of patients attended this month. Local management should look into reasons for this.

# CARU Reports - Stroke and Major Trauma (July 2016)

**Stroke**

- **98%** of all suspected stroke patients were provided with a full pre-hospital care bundle or a valid exception to its provision was recorded on the PRF. This represents a **2%** increase compared to June 2016.
- All FAST positive patients had the time of onset of symptoms recorded or it was documented that the time of onset could not be established.
- Almost all FAST positive patients (**99.5%**) were conveyed to the most appropriate destination for their condition. However, **5** FAST positive patients (0.5%) were transported to an ED when they should have been conveyed to a HASU.
- The average response time for 999 call to arrive on scene is **14** minutes. This is a 1 minute decrease from June 2016.
- The average time on scene is 35 minutes, which remains longer than the recommended 30 minutes. Just half of LAS crew (**50%**) attending stroke patients who were potentially eligible for thrombolysis spent 30 minutes or less on scene.
- The percentage of patients who were potentially eligible for thrombolysis and arrived at a HASU within 60 minutes has decreased from 64% in June to **60%** in July 2016.

**Major Trauma**

The next major trauma data will be published at the end of Q2.

# Our Performance

| Section | Key Headlines | August | July | June |
|---|---|---|---|---|
| A8 Performance | A8 Performance for August 2016 was 67.43%. This was higher than the contracted trajectory of 67.08%. This is the fifth consecutive month A8 has been above trajectory. | | | |
| Other Performance | Performance in August 2016 for A8, A19 and Red 2 measures were all above the monthly trajectory. All four of Cat C performance measures (C1 - C4) saw an increase when compared with last month. | | | |
| Demand | There were 43,036 category A incidents in August (7.4% above trajectory). Category C demand was 9.5% above trajectory. Overall demand was at 91,832 incidents, 8.5% above plan. | | | |
| Capacity | The Patient Facing Vehicle Hours (PFVH) deployed during August were above trajectory by 6.9%. This was primarily due to the continued use of PAS/VAS. Overtime vehicle hours were above plan for August. | | | |
| Efficiency | Job Cycle Time for August was 84.59 minutes, an improvement of 0.7 minutes over last month. This is slightly above the monthly trajectory of 84.58 minutes.<br>MAR was 1.26, this has successfully remained below the plan of 1.29 since November 2015. | | | |
| EOC – Call Answering | 5 Second Call Answering for August was 95.2% achieving above the target of 95%. This was a 1.9% increase from the previous month. | | | |
| EOC – FRU Cat C Share | FRU share of Cat C for August was 8.6%. This was 3.6% above the target of 5%. | | | |

# Ambulance Quality Indicators (AQI) Update – July 2016

The AQIs for July 2016 were published on 8th September 2016. The list of AQIs detailed below make up part of the Ambulance System Indicators. These indicators enable comparison between the 11 Ambulance Trusts across England.

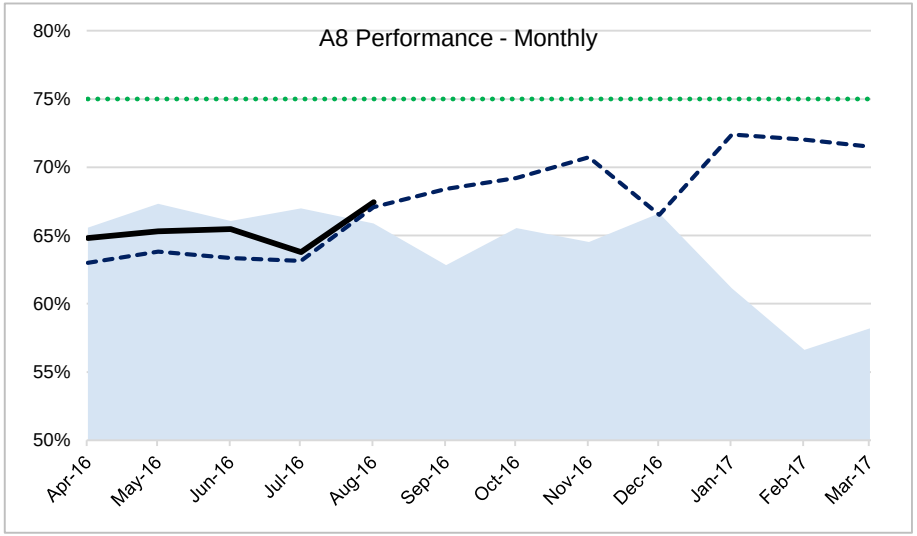
The table below details 7 of these indicators with the description and LAS performance.

Please Note: Due to the Ambulance Response Programme for Category A measures the Yorkshire, West Midlands and South Western Ambulance Trusts are only included in the first two measures in the table below (Ranking Position).

| **Source: NHS ENGLAND** | | | **Performance in Month** Last 3 months | | | **Ranking Position** | | | |
|---|---|---|---|---|---|---|---|---|---|
| **AQI Indicator Description SYSTEM INDICATORS** | **Units** | **Target** | JUL | JUN | MAY | Ranked out of | JUL | JUN | MAY |
| The time taken to answer 95% of 999 calls in the emergency control room | (secs) | 5 secs | 17 | 4 | 2 | 11 | 3 | 2 | 2 |
| The percentage of callers who have hung up before their call was answered in the emergency control room | % | | 0.5% | 0.4% | 0.2% | 11 | 2 | 2 | 1 |
| The percentage of Category A Red 1 (most time critical) calls reached within 8 minutes | % | 75% | 68.3% | 72.2% | 70.3% | 8 | 5 | 4 | 4 |
| The percentage of Category A Red 2 (serious but less immediately time critical) calls reached within 8 minutes | % | 75% | 63.6% | 65.3% | 65.1% | 8 | 3 | 6 | 6 |
| The time taken to reach 95% of Category A (Red 1) calls | (mins) | | 13.8 | 13.3 | 13 | 8 | 4 | 5 | 4 |
| The percentage of Category A calls reached within 19 minutes | % | 95% | 93.1% | 94.4% | 94.1% | 8 | 1 | 4 | 4 |
| The time taken to arrive at the scene of 95% Category A (Immediately Life Threatening) calls | (mins) | | 19.6 | 18.1 | 18.3 | 8 | 5 | 5 | 5 |

Latest Publication : 8th September 2016 (Jul-16 data)
Date of next publication : 13th October 2016

# A8 Performance

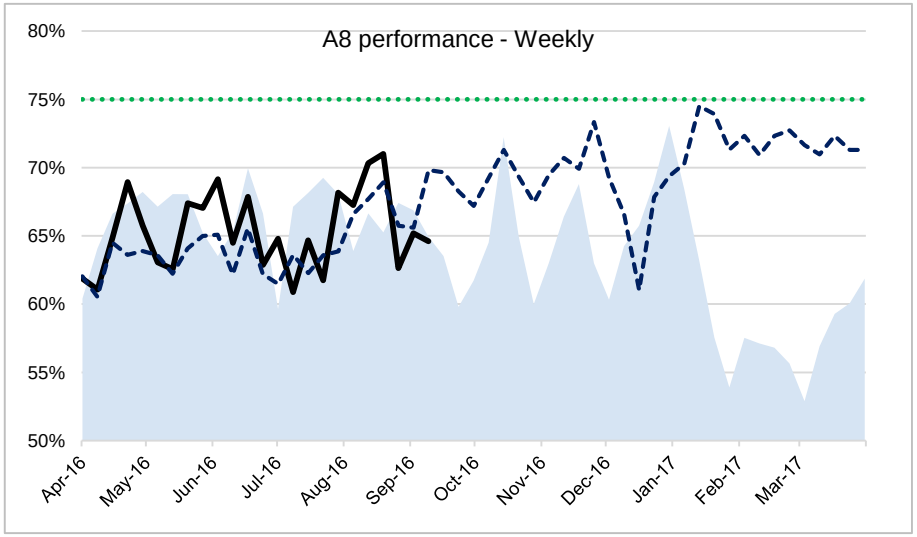


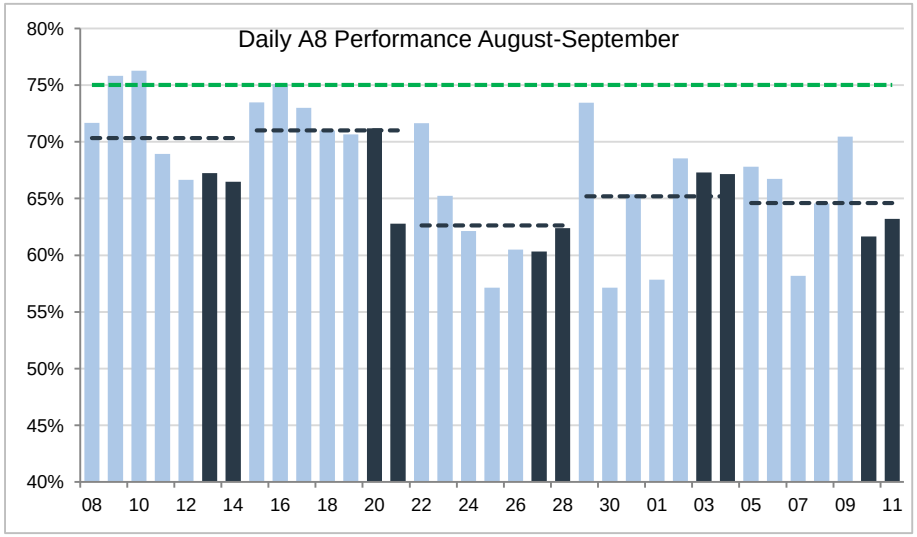

A8 Performance for August 2016 was 67.43%. This was higher than the contracted trajectory of 67.08%. For additional context August 2015's actual figure was 65.88%.

The following factors have contributed to August's Cat A performance:

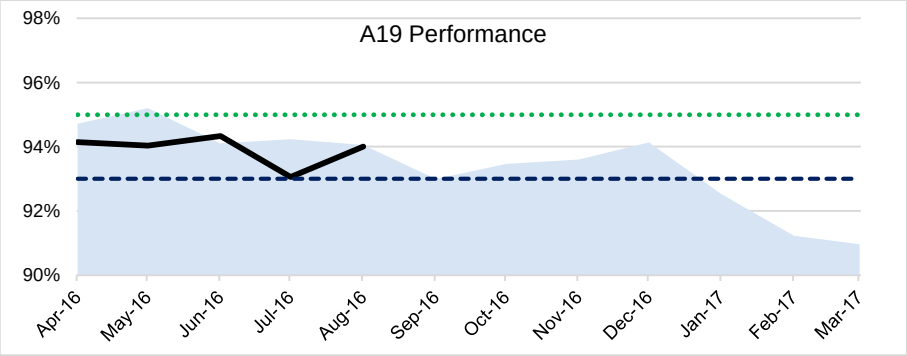
- **Demand** – Overall the number of incidents was 8.5% above plan. Cat A was 7.4% above trajectory, Cat C was 9.5% above trajectory.
- **Capacity** – Overall patient facing hours were 6.9% above plan.
- **Efficiency** - Average job cycle time was only marginally above trajectory and MAR was 1.26, successfully below the plan of 1.29.

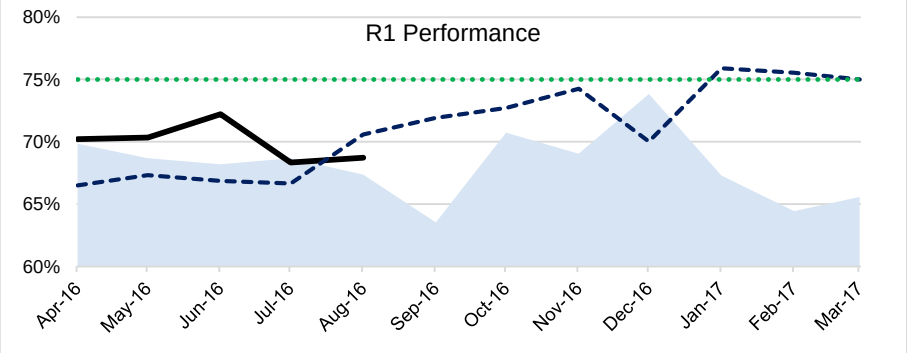
15/16 actual data
16/17 actual data
Trajectory
National target

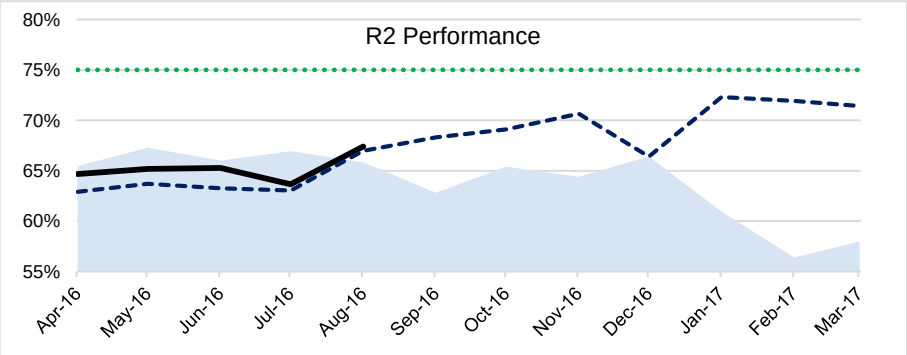


# Other Performance




Performance in August 2016 for **A8, A19** and **Red 2** measures were all above the monthly trajectory. Performance for these three measures has continued to be above trajectory for five consecutive months.

- Red 1 was 68.7%, **below** plan by 1.88%.
- Red 2 was 67.4%, **above** plan by 0.41%.
- A19 was 94%, **above** plan by 1%.

All four of the Cat C performance categories (C1 to C4) saw an increase when compared with last month.

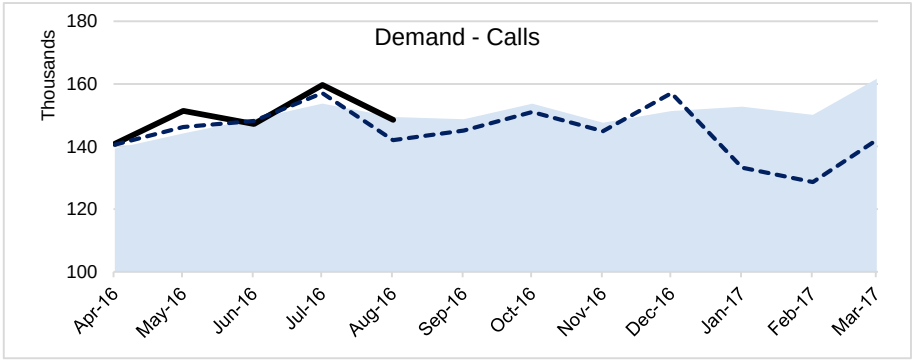
The contracted target for Cat C performance has changed for 2016-17. The new measures are:

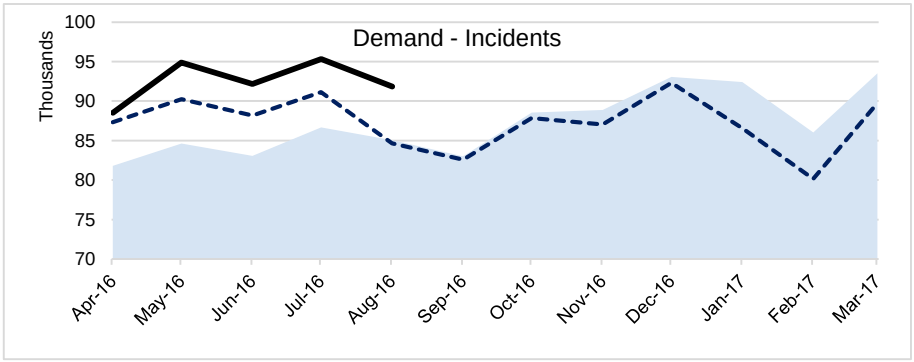
- C1 performance - 50% within 45 minutes.
- C2, C3 and C4 performance – 50% within 60 minutes.

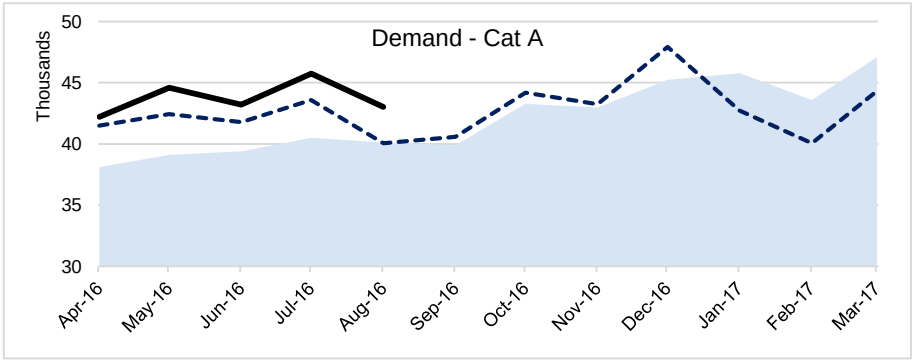
15/16 actual data
16/17 actual data
Trajectory
National target

| Week ending | A8 | A19 | R1 | R2 | C1 | C2 | C3 | C4 |
|---|---|---|---|---|---|---|---|---|
| 07-Aug | 67.2% | 94.6% | 69.5% | 67.2% | 83.6% | 84.2% | 84.3% | 67.2% |
| 14-Aug | 70.3% | 95.4% | 69.2% | 70.4% | 87.8% | 87.6% | 86.1% | 69.5% |
| 21-Aug | 71.0% | 95.1% | 74.8% | 70.9% | 87.6% | 88.2% | 87.3% | 71.0% |
| 28-Aug | 62.6% | 92.0% | 61.4% | 62.7% | 75.6% | 78.5% | 77.7% | 55.6% |
| 04-Sep | 65.2% | 93.0% | 73.6% | 65.0% | 78.5% | 80.9% | 80.5% | 63.2% |
| Jun-16 | 65.5% | 94.3% | 72.2% | 65.3% | 83.4% | 85.8% | 83.6% | 65.6% |
| Jul-16 | 63.8% | 93.1% | 68.3% | 63.6% | 79.2% | 81.4% | 81.6% | 61.1% |
| Aug-16 | 67.4% | 94.0% | 68.7% | 67.4% | 82.9% | 84.2% | 83.6% | 65.6% |

# Demand



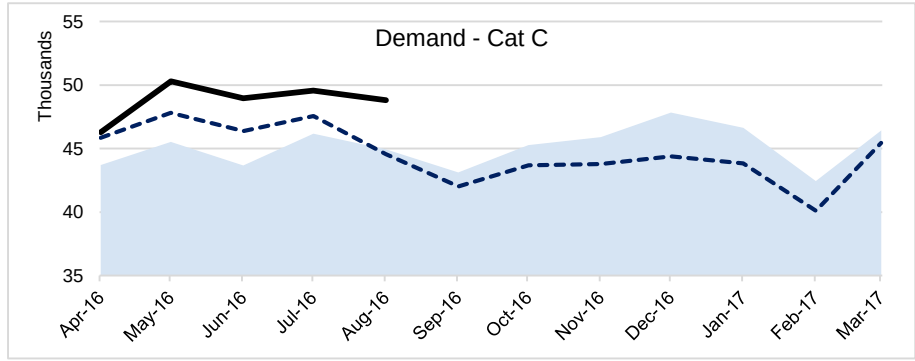

Overall demand (total incidents) was 8.5% above trajectory in August and 8% higher than August last year.

Cat A demand was 7.4% above plan and 7.3% higher than August last year. Cat A demand has been above trajectory each month since February 2016.

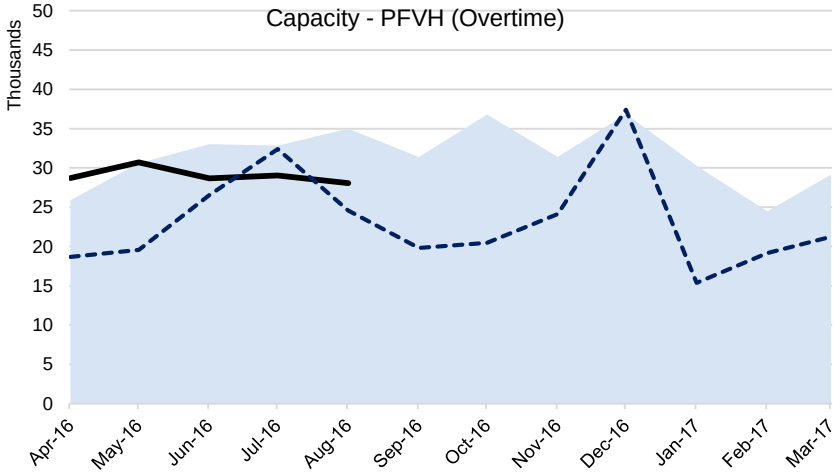
Category C incidents were above trajectory by 9.5% and higher than last year by 8.6%. Cat C demand has been above trajectory continually for the last 4 months.

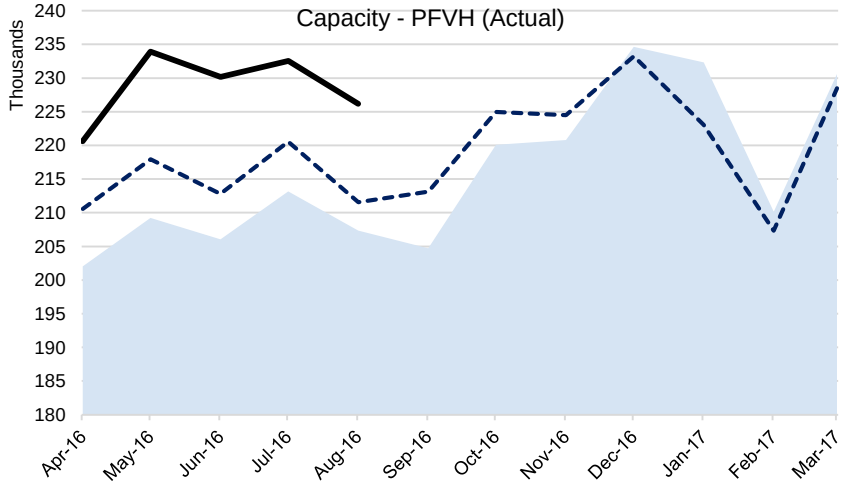
Call volumes were 4.6% above contract level for August 2016, but 0.6% below August last year.

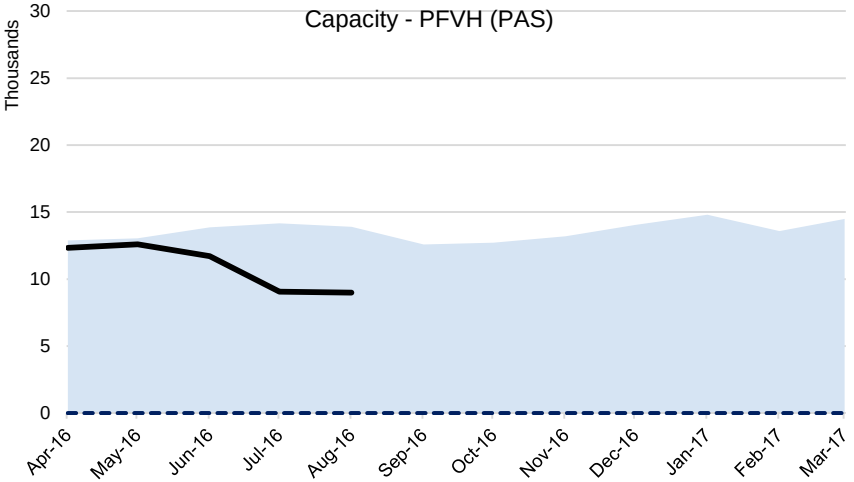
15/16 actual data
16/17 actual data
Trajectory



# Capacity



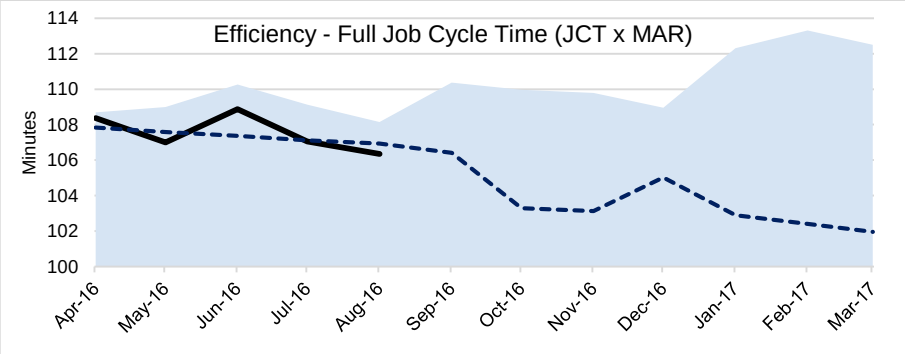

Total patient facing hours were above the trajectory for August. The actual hours at 226,185 against a plan of 211,546 hours, which is a 6.9% difference.

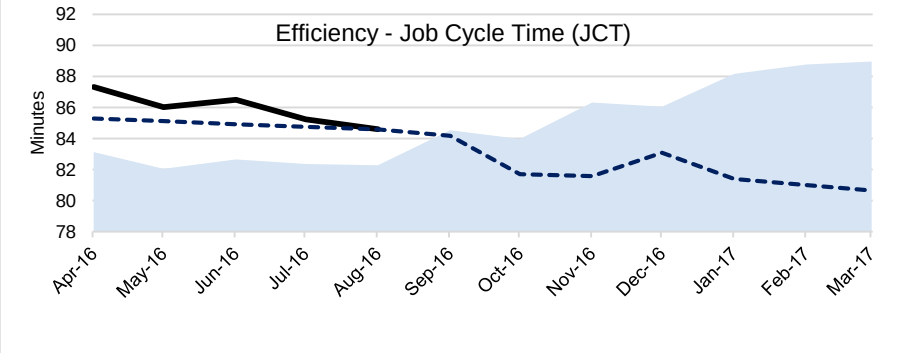
Overtime vehicle hours for August 2016 were above trajectory, at 14.3% above plan.

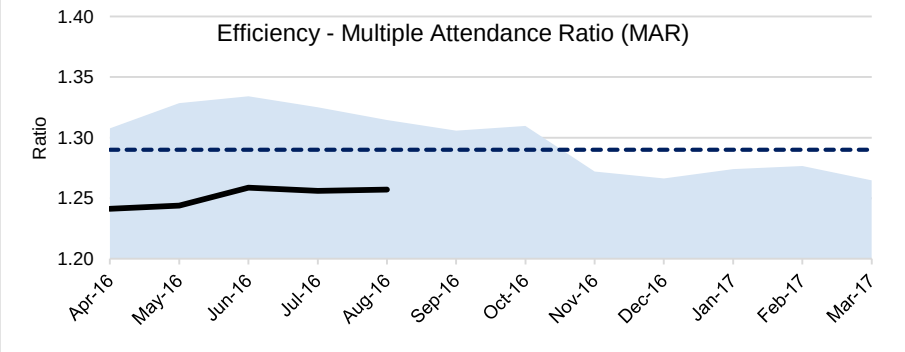
PAS/VAS hours for August 2016 were 35% below the level of August 2015.

15/16 actual data
16/17 actual data
Trajectory

# Efficiency




Job Cycle Time for August 2016 was 84.59 minutes, above the trajectory of 84.58 minutes.

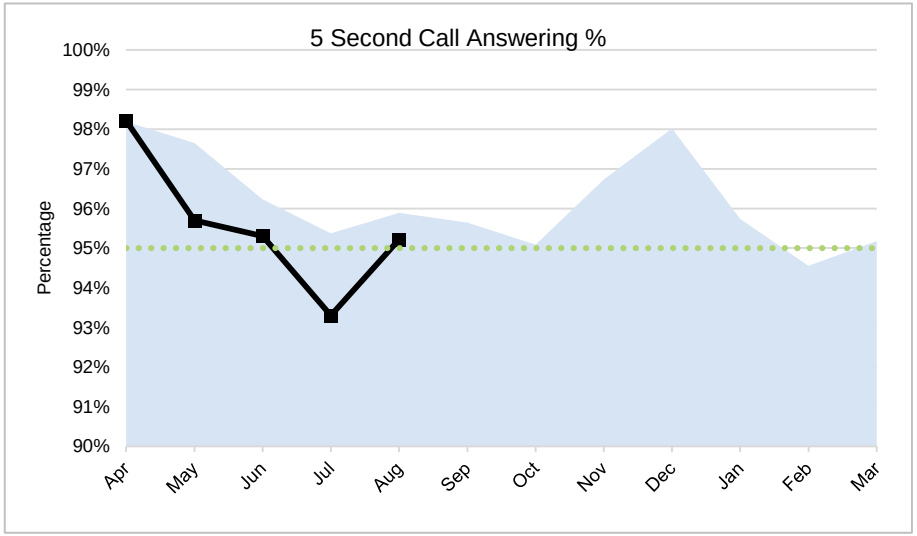
This was an improvement of 0.7 minutes on the previous month.

Full Job Cycle (JCT x MAR) was 106.3 minutes, successfully below the August trajectory of 106.9.

The Multiple Attendance Ratio (MAR) remained below trajectory for August at 1.26. This has successfully remained below plan since November 2015. The trajectory for every month this year is 1.29.

15/16 actual data
16/17 actual data
Trajectory

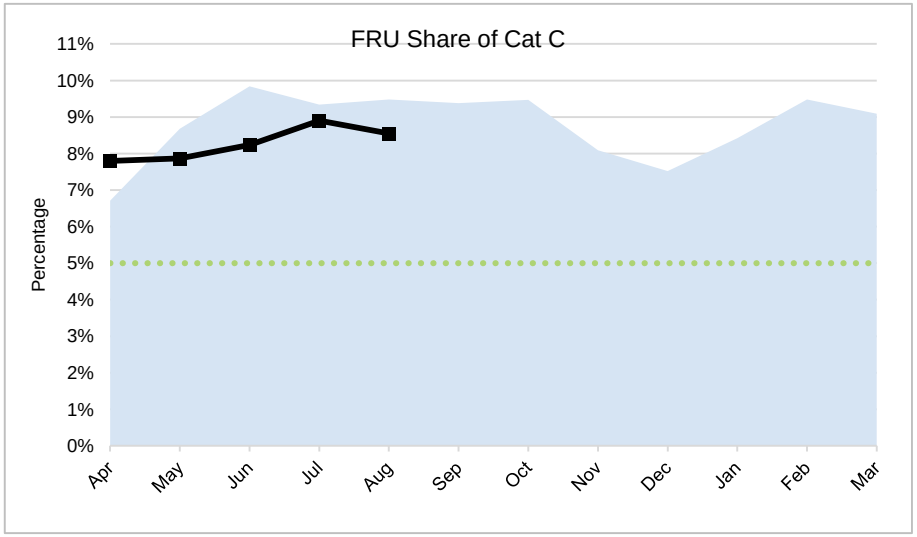
# Emergency Operations Centre (EOC)




5 Second Call Answering for August was at 95.21%, which is above the 95% target.

FRU share of Cat C for August was 8.6%, this was 3.6% above the target of 5%; however, this was a 0.35% improvement on the previous month.

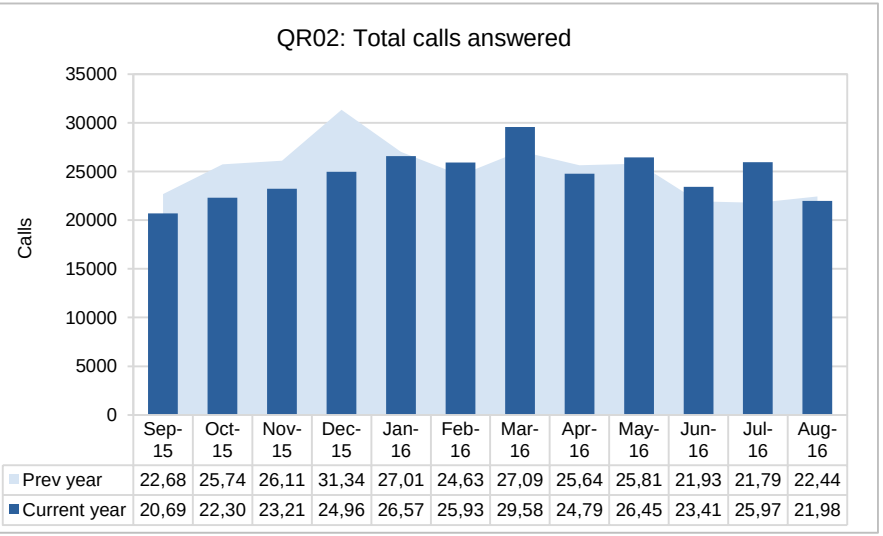
15/16 actual data
16/17 actual data
Target




| 5 Second Call Answering % | | |
|---|---|---|
| Month | 2015-16 | 2016-17 |
| Apr | 98.19% | 98.21% |
| May | 97.65% | 95.70% |
| Jun | 96.23% | 95.30% |
| Jul | 95.37% | 93.30% |
| Aug | 95.89% | 95.21% |
| Sep | 95.64% | |
| Oct | 95.09% | |
| Nov | 96.73% | |
| Dec | 98.02% | |
| Jan | 95.73% | |
| Feb | 94.55% | |
| Mar | 95.18% | |

| FRU Share of Cat C | | |
|---|---|---|
| Month | 2015-16 | 2016-17 |
| Apr | 6.71% | 7.80% |
| May | 8.68% | 7.87% |
| Jun | 9.84% | 8.32% |
| Jul | 9.34% | 8.90% |
| Aug | 9.48% | 8.55% |
| Sep | 9.38% | |
| Oct | 9.47% | |
| Nov | 8.09% | |
| Dec | 7.52% | |
| Jan | 8.42% | |
| Feb | 9.48% | |
| Mar | 9.09% | |

# LAS 111 (South East London) – Demand and Capacity




| | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Prev year | 22,68 | 25,74 | 26,11 | 31,34 | 27,01 | 24,63 | 27,09 | 25,64 | 25,81 | 21,93 | 21,79 | 22,44 |
| Current year | 20,69 | 22,30 | 23,21 | 24,96 | 26,57 | 25,93 | 29,58 | 24,79 | 26,45 | 23,41 | 25,97 | 21,98 |

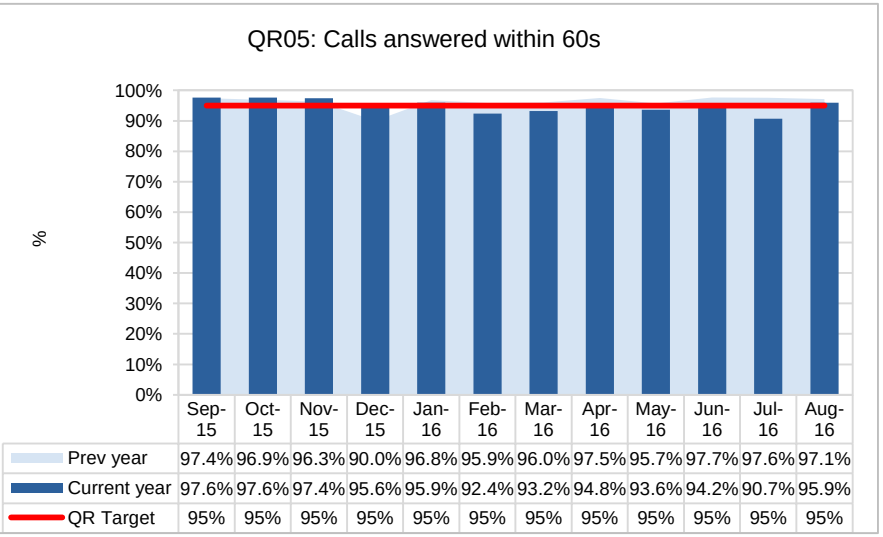
**Demand:** Call volumes were more stable during August 2016. A review of forecasts has resulted in the rebalancing of calls across the week. This is to reflect the recent changes to greater weekday demand.

**Capacity:** The rolling recruitment programme is focused on preparing for winter demands and welcoming Call Handlers that will be joining in early September.

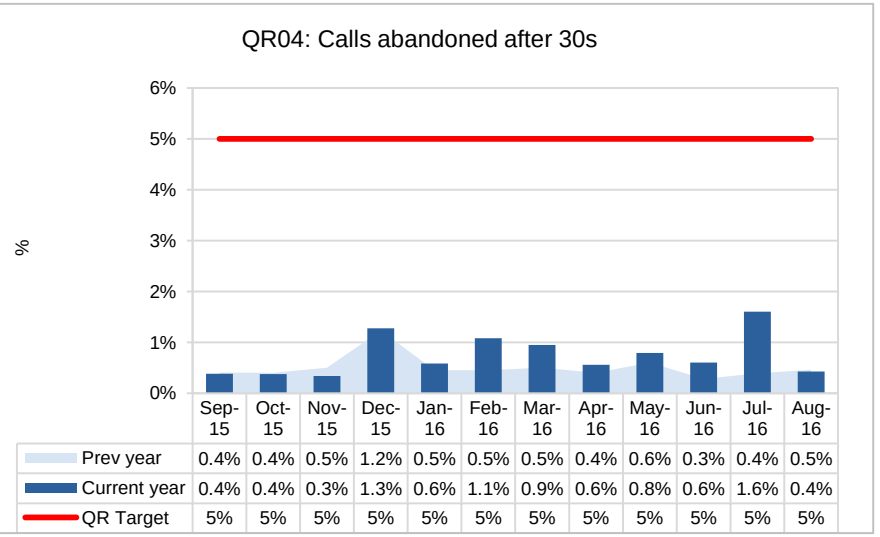
15.5 wte Clinical Advisor vacancies remain, due to challenges recruiting Nurses and Paramedics in London with a combination of overtime and agency in place to backfill roster gaps. An open day will take place in early September.

**Efficiency:** The percentage of calls answered in 60 seconds was 95.9% in August with the target achieved on 21 days.

**Service Projects:** The service focus throughout August has been dealing with reporting issues (live and historical). The 111 team are working with NHS Pathways to streamline the implementation process for future releases. Work to develop an action plan and analysis of service improvements has commenced. A visit to North West Ambulance Service (111) is planned to inform management of telephony and reporting challenges.

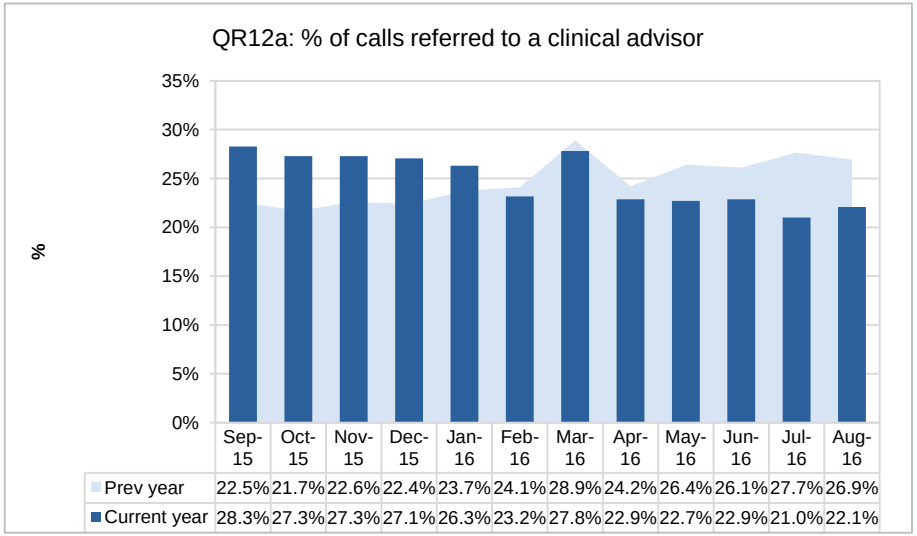



| | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Prev year | 97.4% | 96.9% | 96.3% | 90.0% | 96.8% | 95.9% | 96.0% | 97.5% | 95.7% | 97.7% | 97.6% | 97.1% |
| Current year | 97.6% | 97.6% | 97.4% | 95.6% | 95.9% | 92.4% | 93.2% | 94.8% | 93.6% | 94.2% | 90.7% | 95.9% |
| QR Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |




| | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Prev year | 0.4% | 0.4% | 0.5% | 1.2% | 0.5% | 0.5% | 0.5% | 0.4% | 0.6% | 0.3% | 0.4% | 0.5% |
| Current year | 0.4% | 0.4% | 0.3% | 1.3% | 0.6% | 1.1% | 0.9% | 0.6% | 0.8% | 0.6% | 1.6% | 0.4% |
| QR Target | 5% | 5% | 5% | 5% | 5% | 5% | 5% | 5% | 5% | 5% | 5% | 5% |

# LAS 111 (South East London) – Call Destinations

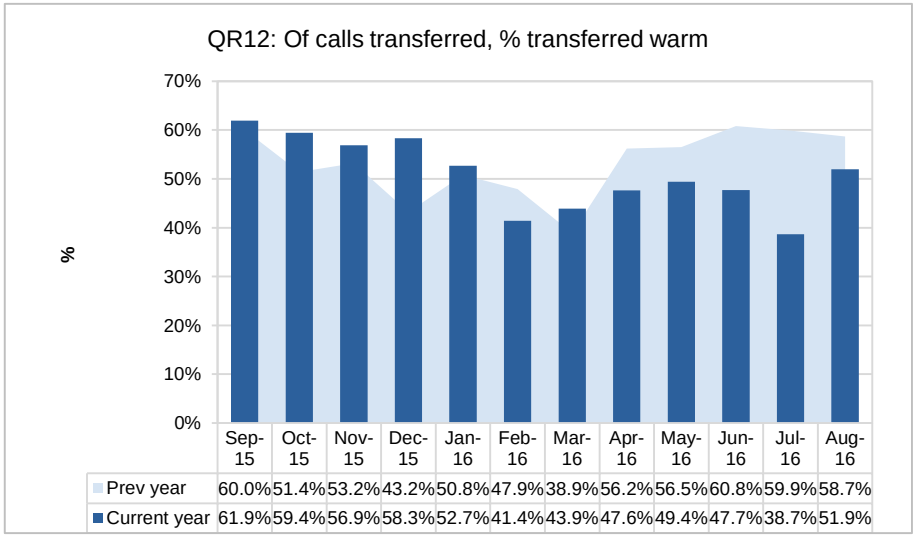



| | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Prev year | 22.5% | 21.7% | 22.6% | 22.4% | 23.7% | 24.1% | 28.9% | 24.2% | 26.4% | 26.1% | 27.7% | 26.9% |
| Current year | 28.3% | 27.3% | 27.3% | 27.1% | 26.3% | 23.2% | 27.8% | 22.9% | 22.7% | 22.9% | 21.0% | 22.1% |

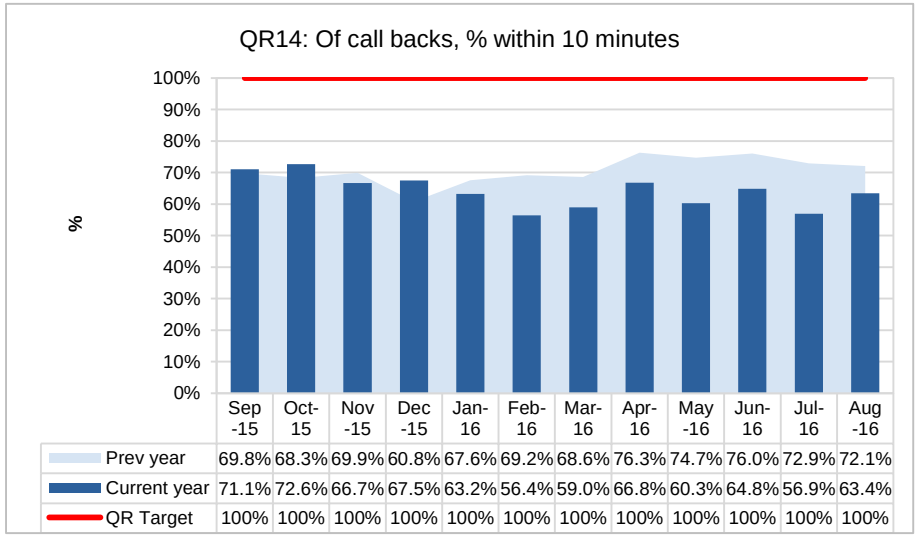
**Quality Indicators**: Calls requiring a Clinical Advisor are either transferred directly (warm transfer) or placed in a queue for call back. Factors influencing these figures include; complexity of calls, enhanced clinical assessment for low acuity ambulance outcomes and the availability of Clinical Advisors to accept a warm transfer. A prioritisation system is in place to inform these decisions.

**Safety**: There were 25 Incidents reported in Datix by the LAS 111 Team. Of these, 6 (24%) related to calls referred to an incorrect Out Of Hours Provider, 4 (16%) to failure to follow procedure, with the remaining 13 (52%) to other issues and 2 (8%) handed over to external agencies for further investigation. Incidents are under investigation and feedback given to staff where appropriate.

A Serious Incident was identified in August and an investigation is underway. The service received six complaints and two compliments.

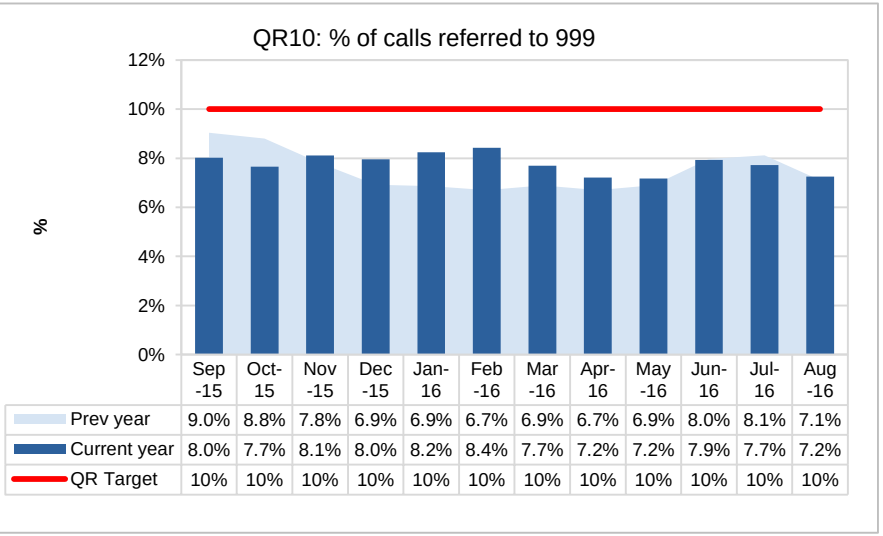



| | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Prev year | 60.0% | 51.4% | 53.2% | 43.2% | 50.8% | 47.9% | 38.9% | 56.2% | 56.5% | 60.8% | 59.9% | 58.7% |
| Current year | 61.9% | 59.4% | 56.9% | 58.3% | 52.7% | 41.4% | 43.9% | 47.6% | 49.4% | 47.7% | 38.7% | 51.9% |




| | Sep -15 | Oct-15 | Nov -15 | Dec -15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May -16 | Jun-16 | Jul-16 | Aug -16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Prev year | 69.8% | 68.3% | 69.9% | 60.8% | 67.6% | 69.2% | 68.6% | 76.3% | 74.7% | 76.0% | 72.9% | 72.1% |
| Current year | 71.1% | 72.6% | 66.7% | 67.5% | 63.2% | 56.4% | 59.0% | 66.8% | 60.3% | 64.8% | 56.9% | 63.4% |
| QR Target | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

# LAS 111 (South East London) – Triage destinations



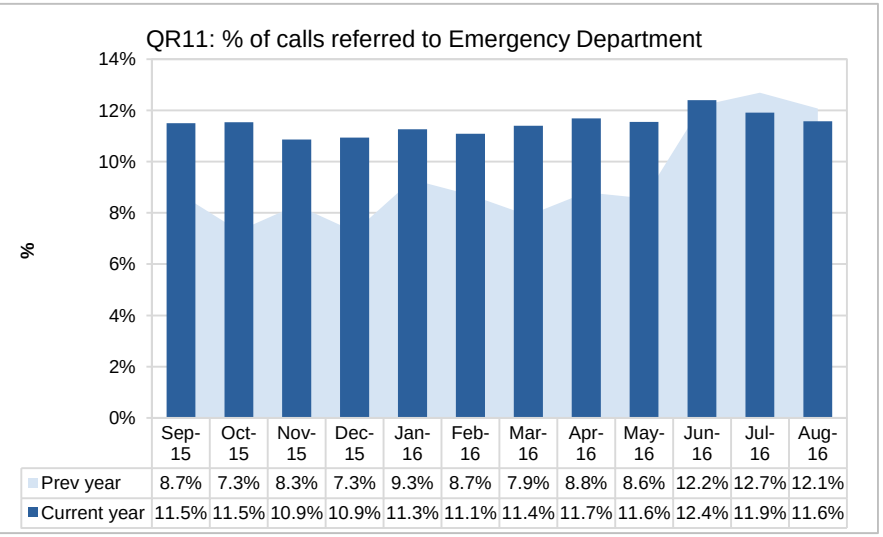

| | Sep -15 | Oct-15 | Nov -15 | Dec -15 | Jan-16 | Feb -16 | Mar -16 | Apr-16 | May -16 | Jun-16 | Jul-16 | Aug -16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Prev year | 9.0% | 8.8% | 7.8% | 6.9% | 6.9% | 6.7% | 6.9% | 6.7% | 6.9% | 8.0% | 8.1% | 7.1% |
| Current year | 8.0% | 7.7% | 8.1% | 8.0% | 8.2% | 8.4% | 7.7% | 7.2% | 7.2% | 7.9% | 7.7% | 7.2% |
| QR Target | 10% | 10% | 10% | 10% | 10% | 10% | 10% | 10% | 10% | 10% | 10% | 10% |

LAS 111 consistently and successfully has the lowest referral rate to 999 in London and the service ranks second when compared to the other London providers.

LAS 111 also has the highest percentage of enhanced re-assessment for lower acuity ambulance outcomes.

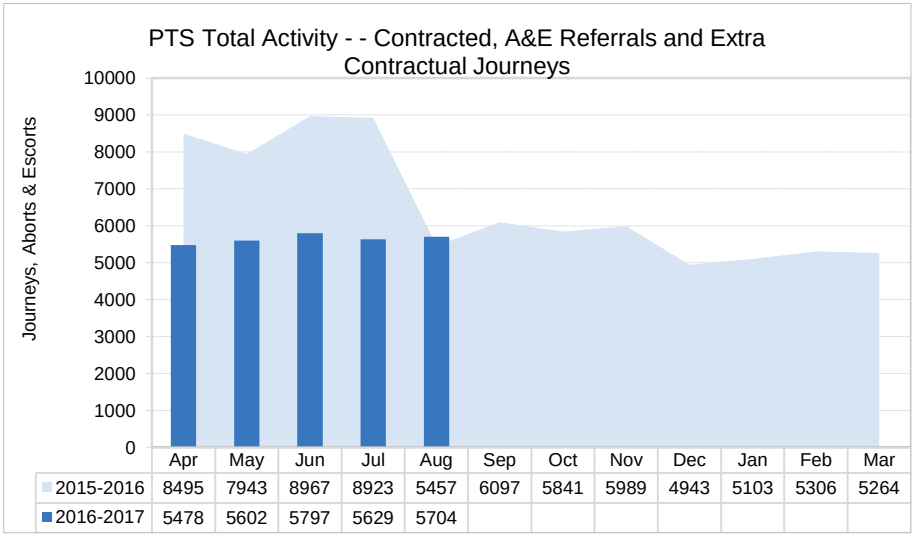
Referrals to Emergency Departments are higher than other providers however have reduced since June 2016. This figure includes referrals to Urgent Care Centres and Walk-in Centres.

When combined this gives an indication of the impact on Emergency and Urgent Care. LAS 111 is consistent with other London Providers.




| | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Prev year | 8.7% | 7.3% | 8.3% | 7.3% | 9.3% | 8.7% | 7.9% | 8.8% | 8.6% | 12.2% | 12.7% | 12.1% |
| Current year | 11.5% | 11.5% | 10.9% | 10.9% | 11.3% | 11.1% | 11.4% | 11.7% | 11.6% | 12.4% | 11.9% | 11.6% |

# Patient Transport Service – Activity and Profitability Update

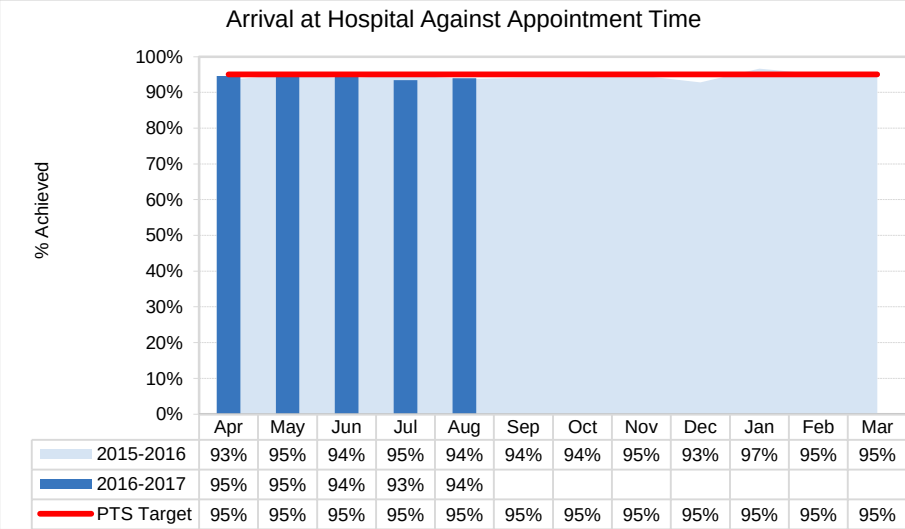



As with previous months the Patient Transport Service continues to deliver approximately 5,500 journeys a month which is consistent with the contracts in place.

5,704 journeys were completed in August 2016, an increase from the previous month's total of 5,629 journeys.

| Month | 2013-2014 | 2014-2015 | 2015-2016 | 2016-2017 |
|---|---|---|---|---|
| Apr | 15044 | 13227 | 8495 | 5478 |
| May | 15987 | 13164 | 7943 | 5602 |
| Jun | 14852 | 10129 | 8967 | 5797 |
| Jul | 16481 | 10508 | 8923 | 5629 |
| Aug | 14401 | 9028 | 5457 | 5704 |
| Sep | 15002 | 9602 | 6097 | |
| Oct | 16739 | 10957 | 5841 | |
| Nov | 15981 | 10063 | 5989 | |
| Dec | 13986 | 9250 | 4943 | |
| Jan | 16409 | 9753 | 5103 | |
| Feb | 15232 | 9787 | 5306 | |
| Mar | 13978 | 10520 | 5264 | |
| Total | 184092 | 125988 | 78328 | 5478 |

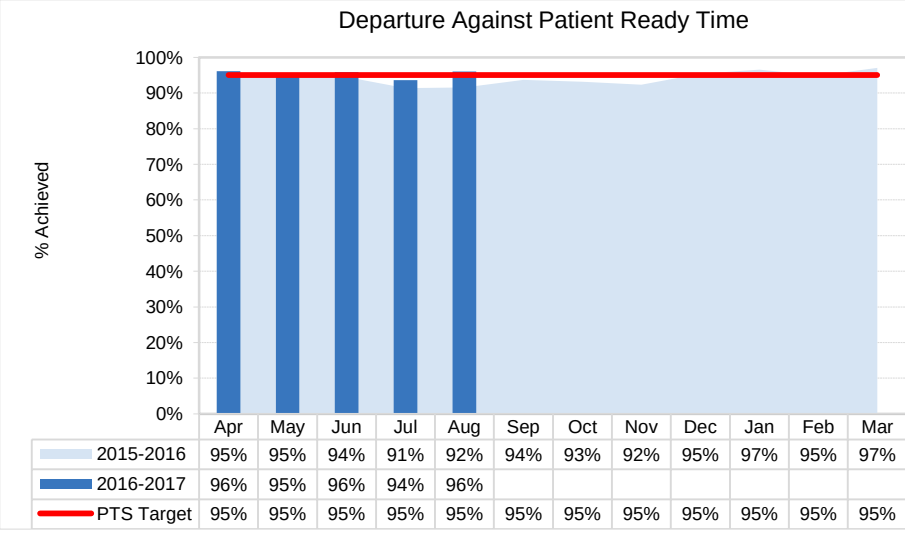
# Patient Transport Service – KPI Update



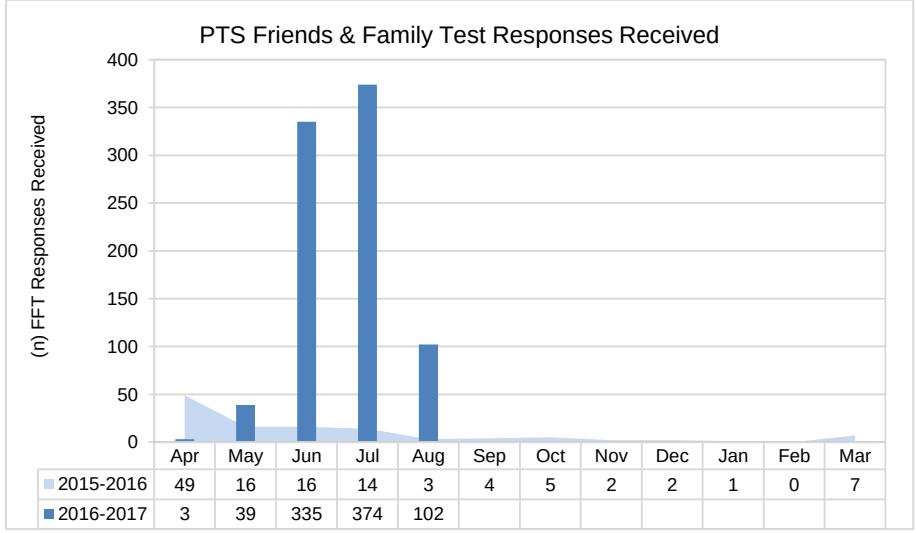

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015-2016 | 93% | 95% | 94% | 95% | 94% | 94% | 94% | 95% | 93% | 97% | 95% | 95% |
| 2016-2017 | 95% | 95% | 94% | 93% | 94% | | | | | | | |
| PTS Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |

Performance against the KPI's for the month are shown in graphs opposite. There was a slight increase in the arrival at hospital measure from 93% to 94% in August. A slight increase in the patient departure measure from 94% to 96% in August.

The Friends and Family Test responses have decreased this month as we moved to a monthly mailshot. This was due to a number of complaints around the frequency of questionnaires sent out. August questionnaires were only sent to those new patients travelling with the service. As a consequence we have seen a fall in the return rate as expected.




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015-2016 | 95% | 95% | 94% | 91% | 92% | 94% | 93% | 92% | 95% | 97% | 95% | 97% |
| 2016-2017 | 96% | 95% | 96% | 94% | 96% | | | | | | | |
| PTS Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |

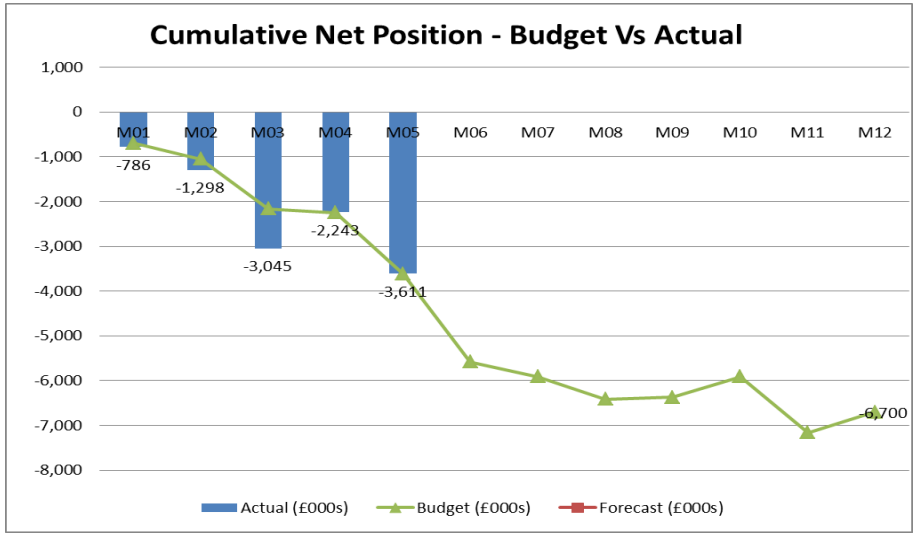



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015-2016 | 49 | 16 | 16 | 14 | 3 | 4 | 5 | 2 | 2 | 1 | 0 | 7 |
| 2016-2017 | 3 | 39 | 335 | 374 | 102 | | | | | | | |

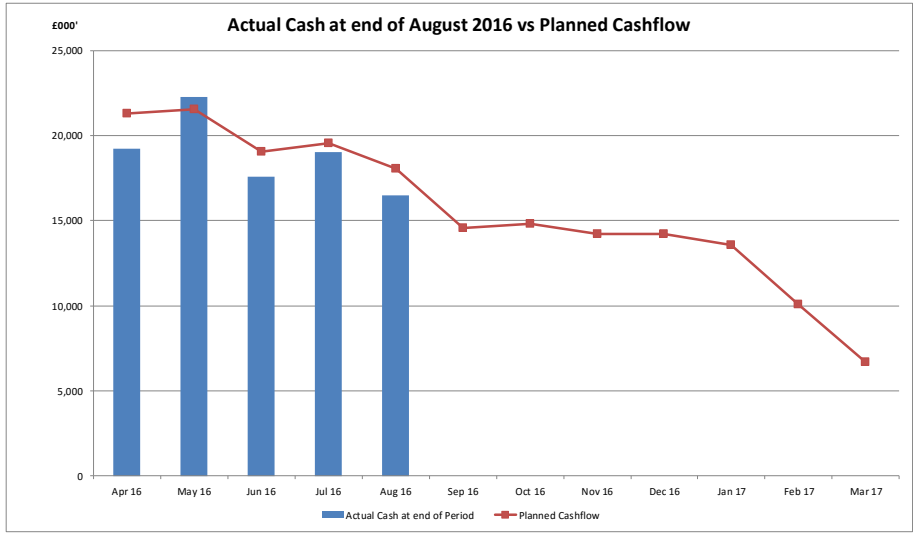
# Our Money

| Financial Indicator | Key Headlines | August | July | June |
|---|---|---|---|---|
| **Surplus (Year to date)** | Year to date the position is on plan, The year end position of £6.7m deficit will not be achievable if the current pattern of spend is maintained.<br><br>Key issues in the position are:<br>• Additional Overtime, Incentive and PAS support for Frontline Capacity to address increased demand in Q1 & Q2. Demand is currently running above contracted activity growth (circa 5% year to date and 8.5% in August). This capacity is unfunded.<br>• Across the year to date position this overspend is partly offset by underspends in other areas. This cannot be sustained across the second two quarters. | | | |
| **Income** | Income is £0.1m adverse in month and £0.5m adverse YTD.<br>• Education & Training Income is currently below the expected plan YTD by £0.3m. This could recover throughout the year if bids area successful.<br>• 111 Income is £0.4m adverse due to continuing review of operating costs with commissioners. This is offset against reduced cost.<br>• Non Contract PTS income is £0.1m favourable. This is offset by increased costs.<br>• The Trust is seeking additional funds from CCGs in relation to the costs of additional capacity to service the unplanned growth in activity. | | | |
| **Expenditure (incl. Financial Charges)** | In month expenditure is £0.1m favourable to plan, YTD the position is £0.5m favourable to plan. The key drivers for this YTD position are:<br>• Core frontline operational staff costs are £6.0m over budget. This includes £3.8m for PAS.<br>• £4.5m Favourable due to underspends in Operational Management, EPRR, NETS and EOC.<br>• £2.1m Favourable in Non Operational divisional spend. | | | |
| **CIPs** | Year to date CIPs are £0.2m adverse to plan. This relates to delays in the delivery of some programmes that were due to start in Q2. The full year plan of £10.5m is still seen as achievable. An additional £0.5m has been included in the revised plan to mitigate additional pressure on the QIP programmes. | | | |
| **Balance Sheet** | Capital spend is £2.1m against a revised Capital plan of £2.9m. The capital plan has been re-profiled throughout the year to reflect revised timescales for delivery. To date NHSI has only approved £14.7m of the £19.6m CRL requested. | | | |
| **Cashflow** | Cash is £16.5m, £1.6m adverse to plan. The Trust is awaiting confirmation regarding invoicing some specific income lines from NHS England (£2.0m) and LAS Commissioners (£2.5m). | | | |

# Executive Summary - Key Financial Metrics




| | 2016/17 - Month 5 | | | Year to Date | | | FY 2016/17 |
|---|---|---|---|---|---|---|---|
| | Budg | Act | Var | Budg | Act | Var | Budg |
| | £000 | £000 | £000 fav (adv) | £000 | £000 | £000 fav (adv) | £000 |
| **Dept Health** | | | | | | | |
| Surplus / (Deficits) | (1,371) | (1,372) | (1) | (3,620) | (3,613) | 7 | (6,700) |
| EFL | | | | 2,146 | 3,718 | (1,572) | 13,509 |
| CRL | | | | 2,832 | 2,114 | 718 | 19,599 |
| Suppliers paid within 30 days - NHS | 95% | 91% | (4.0%) | 95% | 80% | (15.0%) | 95% |
| Suppliers paid within 30 days - Non NHS | 95% | 87% | (8.0%) | 95% | 85% | (10.0%) | 95% |
| **Monitor** | | | | | | | |
| EBITDA % | 0.7% | 0.5% | -0.2% | 3.0% | 2.9% | (0.1%) | 3.6% |
| EBITDA on plan | 182 | 136 | (46) | 4,093 | 3,955 | (137) | 11,905 |
| Net Surplus | (1,371) | (1,372) | (1) | (3,620) | (3,613) | 7 | (6,700) |
| NRAF (net return after financing) | | | | (1.5%) | (1.5%) | 0.0% | (2.1%) |
| Liquidity Days | | | | (6.45) | (3.72) | 2.7 | (17.20) |
| FSRR (Financial Sustainability Risk Rating) | | | | 2.0 | 2.0 | 0.0 | 2.0 |




- In Month and YTD the Position is on plan. However, the year end position of £6.7m deficit will not be achievable if the current pattern of spend is maintained.
- Key issues in the position are:
  - Additional Overtime, Incentive and PAS support for Frontline Capacity to address increased demand in Q1 & Q2. Demand is currently running above contracted activity growth (circa 5% year to date and 8% in August). This capacity is unfunded.
  - Further reductions in PAS (25%) and Incentives (10%) have been agreed for Q3 but further action will be required to return to a sustainable position.
  - This overspend is offset by underspends in other areas.
- CRL position – The capital plan is £0.7m behind target.
- Cash is £16.5m, £1.6m below plan. The Trust is awaiting confirmation regarding invoicing some specific income lines from NHS England (£2.0m) and LAS Commissioners (£2.5m).
- FSRR is on target.

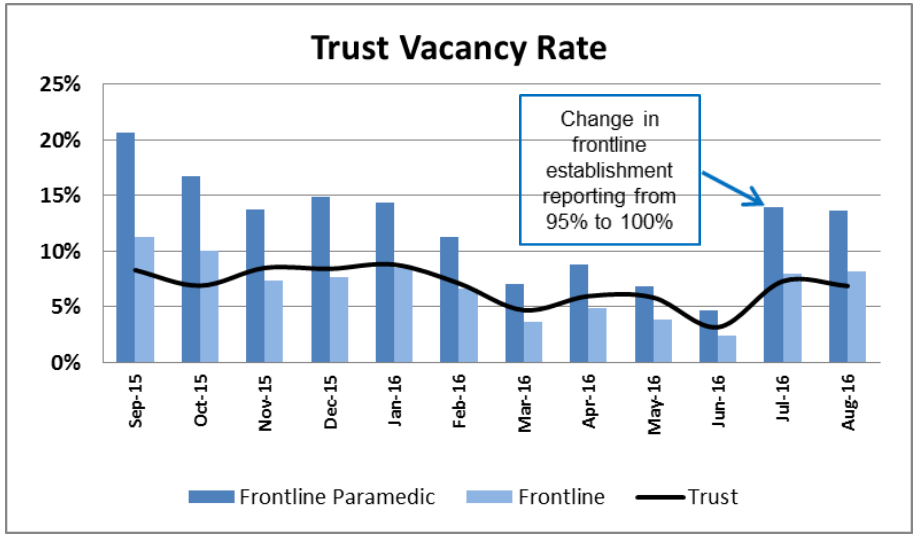
# Our People

| Section | Key Headlines | August | July | June |
|---|---|---|---|---|
| Vacancy and Recruitment | Reported vacancy rates were increased in July due to a decision made to report against 100% of establishment. Consequently, the Trust-wide vacancy rate has also increased.<br>• The overall vacancy rate has improved from 7.3% to 6.9%.<br>  • The vacancy rate for front line staff has remained at 8%.<br>  • The vacancy rate for frontline paramedics has improved from 13.9% to 13.6%. |  |  |  |
| Turnover | • Trust turnover has further improved from 10.1% to 9.7%.<br>  • Frontline turnover has improved from 9.3% to 9.2%.<br>  • Frontline paramedic turnover has improved from 8.7% to 8.5%. |  |  |  |
| Sickness | • Overall trust sickness has remained at 5% against a target/threshold of 5.5%.<br>  • Frontline sickness has increased from 5.5% to 5.6%. |  |  |  |

# Vacancy – Trust wide

| | Establishment | In post | Vacancy wte | Vacancy % |
|---|---|---|---|---|
| **Trust Total** | 5,213.3 | 4,854.4 | 358.8 | 6.9% |
| **Total Frontline** | 3,372.7 | 3,098.3 | 274.4 | 8.1% |
| Paramedic | 2,088.5 | 1,803.9 | 284.7 | 13.6% |
| Apprentice Paramedics | 85.0 | 122.61 | -37.61 | -44.35% |
| EAC / TEAC | 773.2 | 777.9 | -4.7 | -0.61% |
| EMT & support tech | 426.0 | 393.4 | 32.0 | 7.5% |
| **Total Non-frontline staff** | 1,840.6 | 1,756.1 | 84.5 | 4.6% |

- The vacancy rate for total frontline paramedics has improved from 13.9% to 13.6%.
- The frontline vacancy rate has remained at 8%.
- The overall vacancy rate has decreased from 7.3% to 6.9%.
- In August we had 67 frontline starters with 62 staff starting in Paramedic and TEAC roles. The recruitment team are preparing to attend graduate events and are establishing close links with job centres to support the Trust's drive towards more localised recruitment.

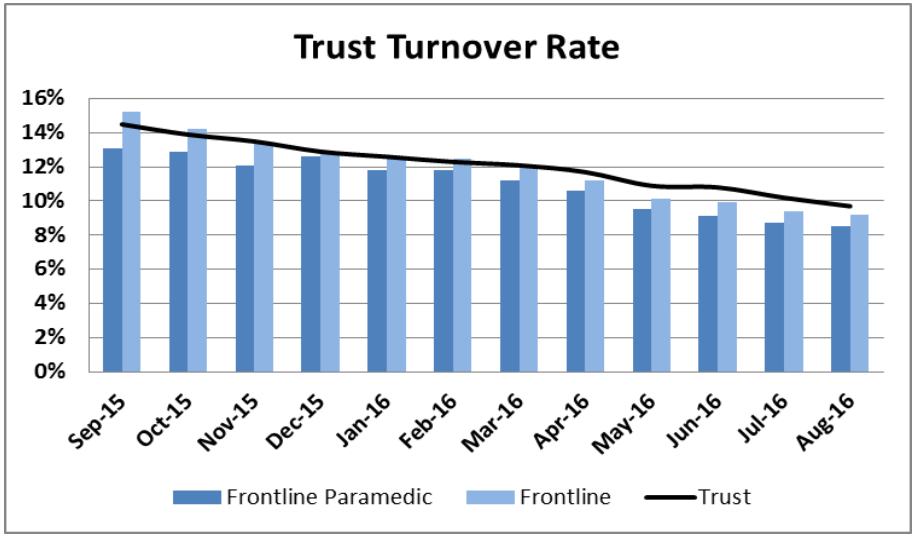



- We have had 50 paramedics start with the LAS this month - 17 international paramedics and 33 UK graduates. There are a further 38 to start in September. Keeping in touch days have taken place with students at our partner universities.
- We had 12 Trainee Emergency Ambulance Crew (TEAC) starters in August. From our recent TEAC advert, we now have over 100 candidates at assessment and interview stage.

# Turnover – Trust wide

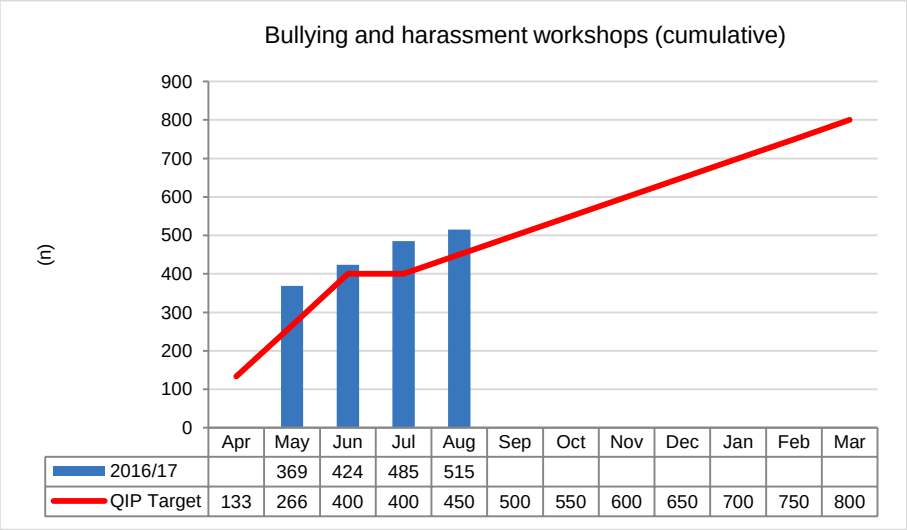
| 12 Month Rolling Turnover | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust Total | 14.5% | 13.9% | 13.5% | 12.9% | 12.6% | 12.3% | 12.1% | 11.7% | 10.9% | 10.8% | 10.2% | 9.7% |
| (All Frontline Staff) | 15.2% | 14.2% | 13.4% | 12.9% | 12.6% | 12.5% | 12.1% | 11.2% | 10.1% | 9.9% | 9.4% | 9.2% |
| Frontline Paramedics | 13.1% | 12.9% | 12.1% | 12.6% | 11.8% | 11.8% | 11.2% | 10.6% | 9.5% | 9.1% | 8.7% | 8.5% |
| Frontline Technicians | 18.0% | 15.8% | 14.9% | 13.3% | 13.5% | 13.5% | 13.2% | 11.8% | 10.9% | 10.8% | 10.2% | 10.1% |
| PTS & Ambulance Persons | 22.6% | 21.3% | 21.2% | 19.0% | 19.0% | 19.5% | 18.6% | 16.5% | 15.3% | 15.9% | 11.9% | 9.6% |
| EOC Staff on Watches | 21.8% | 22.3% | 22.9% | 22.2% | 21.1% | 18.4% | 19.3% | 19.8% | 18.6% | 19.0% | 17.8% | 17.5% |
| All Other Staff | 11.8% | 11.8% | 11.9% | 11.4% | 11.4% | 11.7% | 11.7% | 12.4% | 12.4% | 12.9% | 12.6% | 11.6% |

- The turnover figure for frontline paramedics has improved from 8.7% to 8.5% against a threshold of no more than 15%.
- The turnover for all frontline staff has continued to improve for the twelfth month in a row, currently at 9.2% (threshold 15%).
- The total Trust turnover fell slightly this month from 10.1% to 9.7% (12 month rolling figure).
- Trust turnover has improved month on month for the past twelve months.




- We had 20 WTE frontline leavers in August (12 paramedics, 5 EACs and 3 EMTs).
- 18 were unplanned resignations, 8 of which were for reason of relocation and 3 for promotion.
- The LAS staff leaver's form is being redesigned to improve the quality of data including the reason for leaving and the destination on leaving. The ESR Programme Board will be reviewing this in September.

# Bullying and Harassment



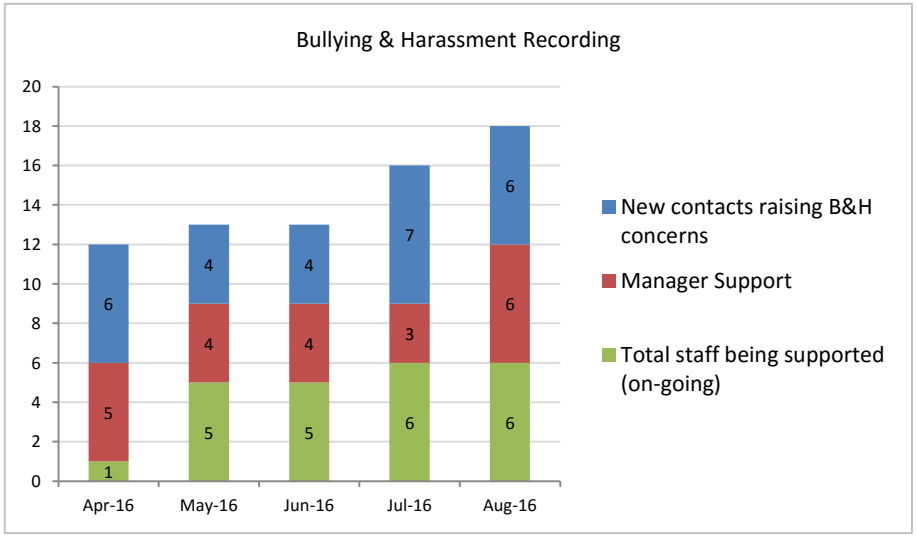

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | | 369 | 424 | 485 | 515 | | | | | | | |
| QIP Target | 133 | 266 | 400 | 400 | 450 | 500 | 550 | 600 | 650 | 700 | 750 | 800 |

We have delivered over 500 sessions to staff covering a cross-section of both operational and support services staff.

Attendees have given positive feedback on the benefits of working across different teams. The original target of 400 was increased to 800 to be achieved by the end of March 2017.

- We have held two 'Courageous Conversations' workshops (19 staff), a two day complex investigations training session and launched our mediation workshop (60 staff). Further sessions are planned for 19th/20th September.
- 68 staff have been trained in Bullying & Harassment Investigations.

There are currently three formal B&H cases in progress, one of which has exceeded the 28 day target.




The Trust's Bullying & Harassment Specialist has started to capture data which reflects the significant activity they undertake to support and advise staff and managers in bullying and harassment issues. This work accounts for approximately 25% - 30% of their time and should have a positive impact in:

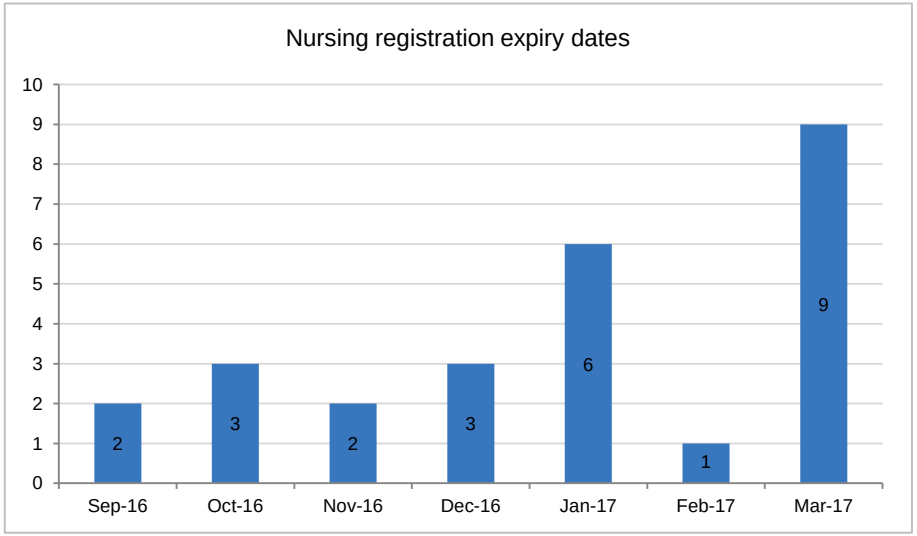
- avoiding formal cases;
- staff well-being;
- retention.

This activity is increasing month on month due to the recent mediation workshops and communications.

This data does not include chairing the pre-conciliation round table meetings (four held in August/September).

The LINC team have received a total of six B&H related calls between April and August 2016.

# Compliance – Professional Registration and DBS



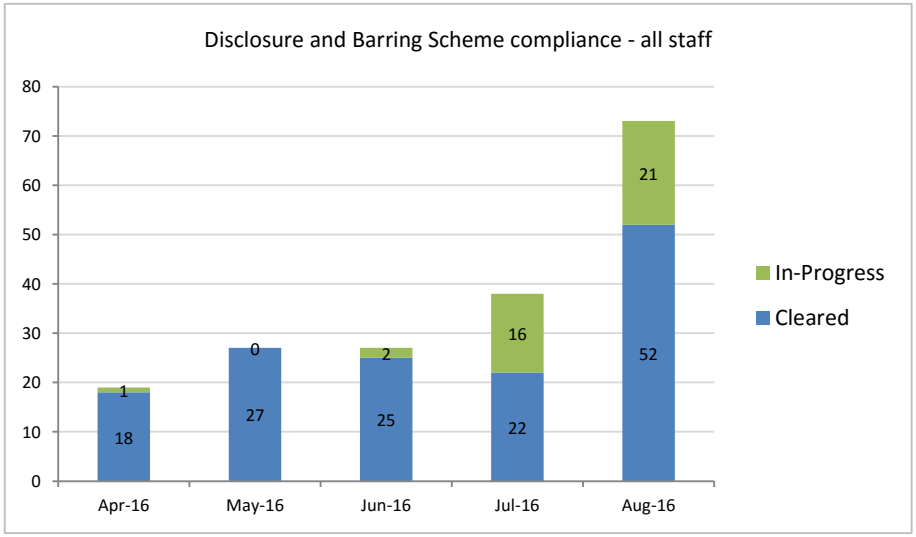

**Professional Registration**

There is a requirement to provide an annual submission to the ELT on registration checks as follows:

Paramedics – All 2,321 LAS staff holding Health Care Professions Council (HCPC) registrations have been rechecked against the website and all have expiry dates of 1st September 2017.

Nursing – There is currently one breach (NHS 111) and the nurse has been redeployed into an unregistered role.

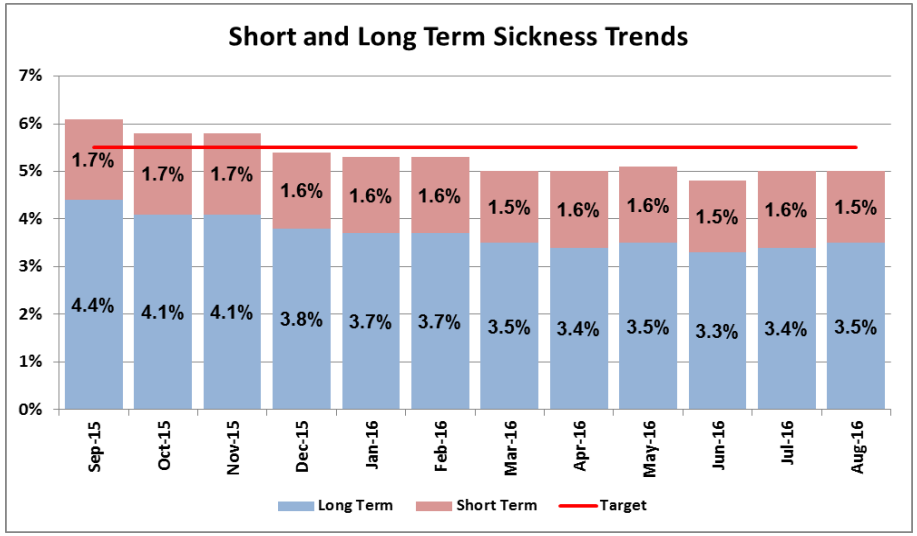
Monthly compliance reports are sent to managers one month in advance of expiry. The interface between ESR and the Nursing & Midwifery Council (NMC) is now in place which notifies the Director of Nursing and other key stakeholders where registrations have been renewed or are outstanding in advance of expiry date.



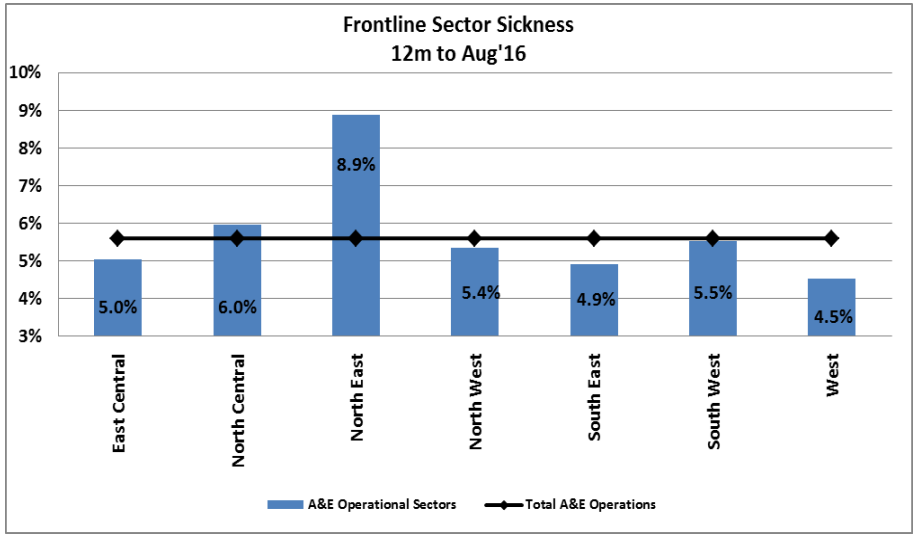

**Disclosure and Barring Scheme (DBS)**

- For the period April to August 2016 there were 203 starters, 184 of whom required the DBS checks. Of this number, 144 have been cleared to work and 40 are in progress. 35 of those in progress are international paramedics, all of whom have a Certificate of Good Standing in place.
- The DBS Update Service Roll-out for staff in patient contact roles is now in progress. This is a three year programme covering over 4,000 employees (including bank).
  - 2016 – 182 checks
  - 2017 – 1,714
  - 2018 – 1,621
  - 2019 – 582

# Sickness Absence – Trust level

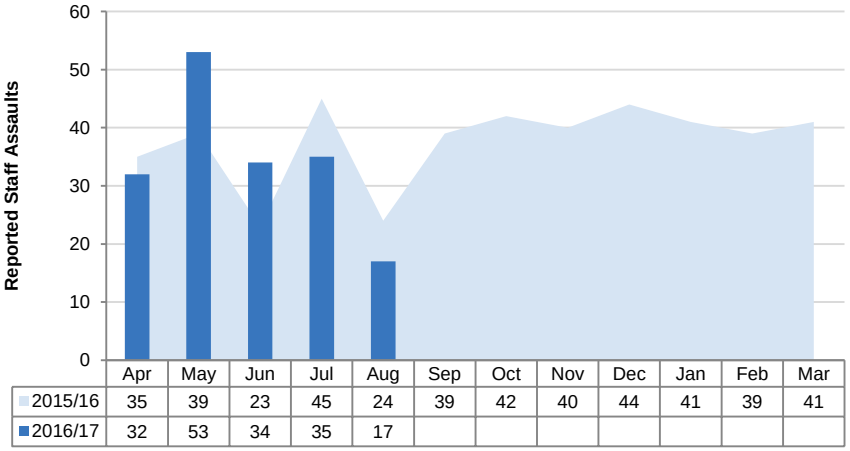



- The current trust 12 month sickness level has remained at 5% against a threshold of no more than 5.5%.
- We are reviewing our Occupational Health requirements in preparation for the retendering process.
- A national CQUIN has been set for health and wellbeing and the Trust has developed workplans to deliver three objectives which will contribute to reducing sickness absence levels.
- The current ESR improvement programme has highlighted some process weaknesses and data inaccuracies. This includes some examples where sickness has not been accurately recorded. The continuing work to improve this process will address these challenges and improve both the data quality and reporting.




- The 12 month rolling frontline sickness has increased from 5.5% to 5.6%.
- Human Resources are working closely with their management teams to support the on-going improvement in absence levels.
- There is a joint HR/management plan in place for the North East Sector to improve the levels of sickness. This includes working with all LAS health and well-being services to support those staff on long-term sickness.

# Staff Assaults




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 35 | 39 | 23 | 45 | 24 | 39 | 42 | 40 | 44 | 41 | 39 | 41 |
| 2016/17 | 32 | 53 | 34 | 35 | 17 | | | | | | | |

**Staff Assaults**

- During 2015/16 452 Staff related assaults were reported, as shown in the graph opposite.
- On average one staff member is assaulted each day in London.
- All staff are offered counselling and support following an assault. Each individual is different and the level of support required varies according to individual need. Everyone can access the same level of support, but not everyone needs it.
- We flag addresses if there is evidence of a previous assault or threat of violence against our staff. This helps to protect our staff from being sent into a potentially dangerous situation. (High Risk Register).

London Ambulance Service
NHS Trust

# INTEGRATED PERFORMANCE REPORT – TRUSTBOARD EXECUTIVE SUMMARY

## Glossary

# Integrated Performance Report – Glossary

| Acronym | Meaning / Description |
|---|---|
| A19 | Category A incidents requiring an 19 minute response |
| A8 | Category A incidents requiring an 8 minute response |
| ADO | Assistant Directors of Operations |
| APP | Advanced Paramedic Practitioners |
| AQI | Ambulance Quality Indicator |
| CARU | Clinical Audit and Research Unit |
| CCG | Clinical Commissioning Group |
| CD | Controlled Drugs |
| CISO | Clinical Information & Support Overview |
| CPI | Clinical Performance Indicator |
| CQUIN | Commissioning for Quality and Innovation |
| CRL | Capital Resource Limit |
| CRU | Cycle Response Unit |
| CSR | Core Skills Refresher (Training) |
| DOC | Duty of Candour |
| EAC | Emergency Ambulance Crew |
| ED | Emergency Department |
| ELT | Executive Leadership Team |
| EMT | Emergency Medical Technician |
| EOC | Emergency Operations Centre |
| ESR | Employee Service Record |
| FAST | Face, Arm, Speech, Time (Indicators of a Stroke) |
| FFT | Friends and Family Test |
| FRU | Fast Response Unit |
| GCS | Glasgow Com Scale |

| Acronym | Meaning / Description |
|---|---|
| GTN | Glyceryl Trinitrate |
| HAC | Heart Attack Centres |
| HART | Hazardous Area Response Teams |
| HASU | Hyper Acute Stroke Unit |
| HCP | Health Care Professional |
| JCT | Job Cycle Time |
| KPI | Key Performance Indicator |
| LIN | Local Intelligence Network |
| LINC | Listening Informal Non-Judgemental Confidential |
| MAR | Multiple Attendance Ratio |
| MRU | Motorcycle Response Unit |
| MTC | Major Trauma Centre |
| NETs | Non-Emergency Transport |
| OOH | Out Of Hours |
| PAS / VAS | Private / Voluntary Ambulance Services |
| PED | Patient Experiences Department |
| PFVH | Patient Facing Vehicle Hours |
| PRF | Patient Record Form |
| PTS | Patient Transport Service |
| QGAM | Quality, Governance and Assurance Manager |
| QIP | Quality Improvement Plan |
| ROSC | Return of Spontaneous Circulation |
| SI | Serious Incident |
| STEMI | ST-Segment Elevation Myocardial Infarction |
| TEAC | Trainee Emergency Ambulance Crew |
| TRU | Tactical Response Unit |
| WTE | Whole Time Equivalent |

# Integrated Performance Report – Glossary

| LAS 111 (South East London) | | | |
|---|---|---|---|
| **QR** | **Measure** | **Target** | **Description** |
| | Total calls answered | | Number of calls made to 111 and answered by an LAS call handler. |
| 05 | Calls answered within 60 seconds | 95% | Of the total answered calls, how many were answered within 60 seconds of being queued for an advisor? |
| 04 | Calls abandoned after 30 seconds | 1% | Of the total calls offered and reaching 30 seconds following being queued for an advisor, how many did the caller hang up before they were answered? |
| | Calls referred to a clinical advisor | | Of the total answered calls, what percentage were directly triaged by a clinician during their 111 episode? |
| | Of calls transferred, percentage transferred warm | | Of the total answered calls that were transferred to a trained 111 clinical advisor, how many were transferred while the caller was on hold? |
| 13 | Of call backs, percentage within 10 minutes | 100% | Of the total calls where person was offered a call back by a 111 clinician, for how many was the person actually called back within 10 minutes of the end of their first call? |
| 10 | Calls referred to 999 | 10% | Of the total number of calls answered, what were the number of final dispositions that result in an ambulance being dispatched? |
| 11 | Calls referred to Emergency Department | 5% | Of the total calls received and triaged by a 111 call handler or clinician, how many were referred to a type 1 or 2 A&E department? |

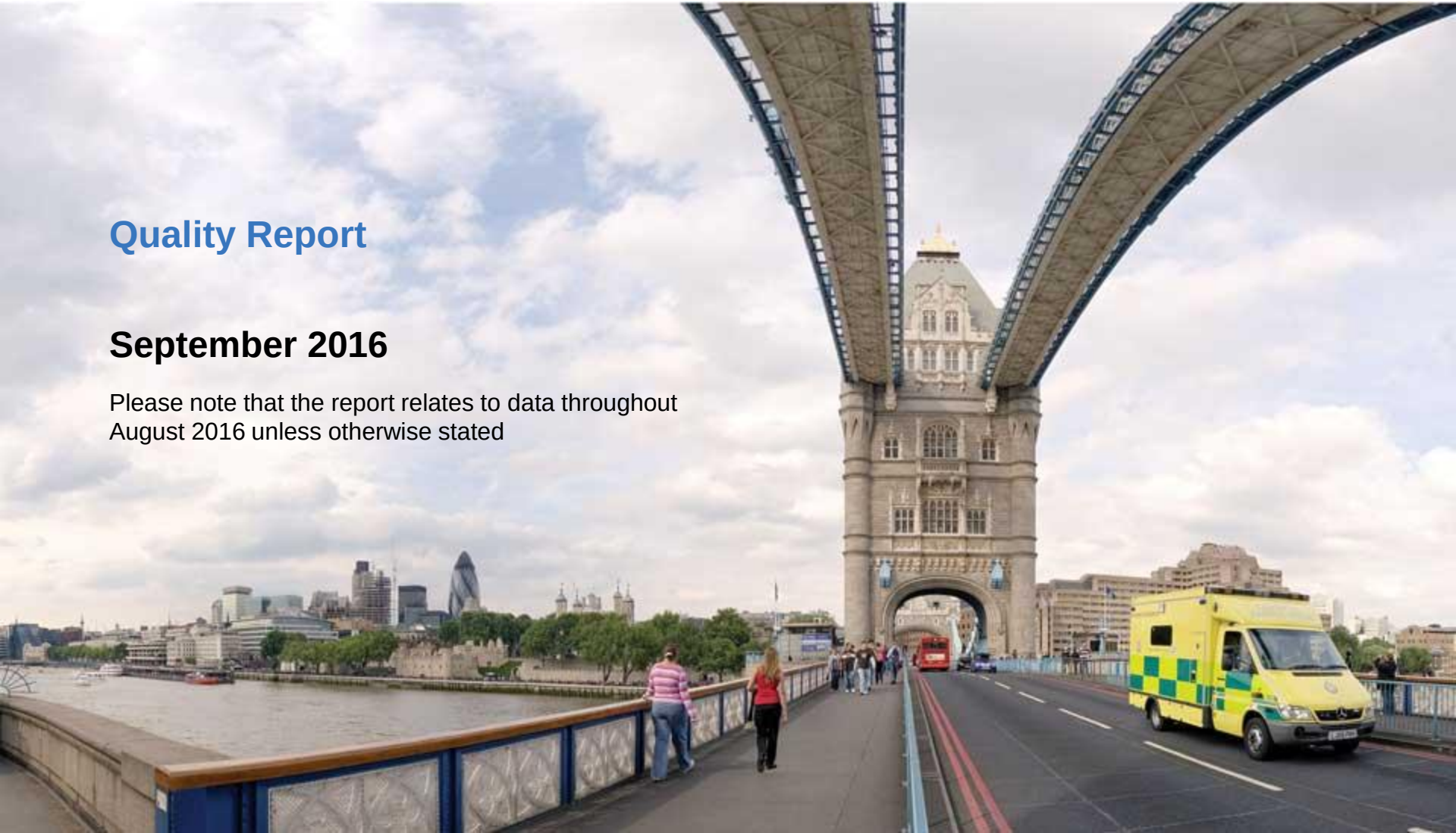
| **Other London 111 service provider** | **Areas Covered** |
|---|---|
| London Ambulance Service (LAS) | 1. South East London |
| Care UK | 1. Hillingdon, 2. Croydon, 3. Wandsworth, 4. Sutton & Merton, 5. Kingston & Richmond, 6. North West London |
| Partnership of East London Co-operatives (PELC) | 1. East London & City. 2. Outer North East London |
| London Central & West (LCW) | 1. Inner North West London, 2. North Central London |

London Ambulance Service NHS Trust

# Quality Report

## September 2016

Please note that the report relates to data throughout August 2016 unless otherwise stated



# Our Patients

| Section | Key Headlines From Each Sub-Section. |
|---|---|
| **SAFETY** | ➢ 10 SI's declared in August out of 59 incidents reviewed, with 2 reports overdue. Overdue SI's have significantly reduced and those outstanding have been escalated internally to the Executive Lead for completion compliance.<br>➢ CSR2016.2 has commenced with 18% completion rate for August, this figure was expected due to the holiday period. 30 iPara's have completed their training and mentoring programme and are now working autonomously.<br>➢ 28 medicines management issues were reported during August with main themes being incorrect drug / dose of drug and administration errors. There was no patient harm and feedback has been provided to individual crews.<br>➢ There was an overall decrease in both staff and patient related reported incidents. The increase noted was staff related reported issues for equipment failures involved suction units and EZIO which are being investigated.<br>➢ There are 97 open complaints with 25 complaints over 35 working days. |
| **EFFECTIVE** | ➢ The Darzi Fellowship focussed on Frequent Callers concluded at the end of August with all objectives being met and 90% of CQUIN recommendations being completed<br>➢ 8 patients with ROSC had an underlying STEMI as a cause of their cardiac arrest. 36 were conveyed to Heart Attack Centres (HAC) appropriately during July 2016.<br>➢ 98% of all suspected Stroke patients were provided with a full pre-hospital care bundle which is a 2% increase on July 2016 data |
| **CARING** | ➢ The Sepsis CPI compliance is very good at 96%, although it was noted there was a lack of oxygen administered for a particular group station which the QGAM has been notified off and this will be followed up by Team Leaders in CISO conversations.<br>➢ July saw the lowest number of CPI's completed since March 2015. The North West sector completed all available audits. This has been addressed with QGAM's and ADO's.<br>➢ 103 Friends and Family Test's were received during August, a noted decrease which was anticipated following the PTS direct contact with patients during June and July.<br>➢ 16 public events were attended by the Patient and Public Involvement team, a reduction on those attended in July which is expected due to School holidays. |

# Our Patients

| Section | Key Headlines From Each Sub-Section. |
|---|---|
| **RESPONSIVE** | ➢ The Trust is currently at Pressure Level 2 – Moderate.<br><br>➢ The Trust remains at Surge Red, with three periods of Surge Purple Enhanced, in particular during the bank holiday break.<br><br>➢ Enhanced medical cover was provided at Notting Hill Carnival over the August Bank Holiday weekend to ensure the impact on primary and secondary care was minimised<br><br>➢ A number of hospital breaches were noted during August, with 624 exceeding 1 hour. |

# SAFE

| Sub-Section | Key Headlines From Each Sub-Section. |
|---|---|
| Training & CSR | ➢ CSR2016.2 commenced in August with 564 staff completing the programme, 18% attendance to date. This is expected due to the summer holiday period reducing available staff to attend and courses are reduced accordingly.<br>➢ August saw the start of 2 iPara courses, 2 UK Grad programmes, 2 EAC Conversion courses and 1 EAC Course across the training department, with a number of students still in training on existing courses. August saw 30 iPara students complete their mentoring phase and are now undertaking autonomous practice as qualified practitioners.<br>➢ EOC CSR is continuing and a number of new courses have commenced. |
| Adverse Incidents | ➢ There was an overall decrease in both staff and patient related reported incidents, with a increase identified in failure of equipment, notably Suction Units and EZIO units. No harm to patients was identified<br>➢ The reported incidents of failed equipment are being investigated by Safety and Risk and the manufacturer to identify the problem.<br>➢ Reported assault / abuse incidents on staff declined by 17% in August 2016. |
| Medicines Management | ➢ There were two LIN reportable incidents and four further controlled drug incidents, which were not LIN reportable mainly due to administration error which has been investigated by the local management team. All CD incidents were appropriately investigated.<br>➢ There were 28 medicines management issues reported during August, all of which have been followed up with feedback to the relevant Group Station management teams to discuss with staff members. |
| Safeguarding | ➢ The safeguarding team are fully established following recent recruitment.<br>➢ Youth violence audit in progress which early information shows only 23% of cases are reported by staff.<br>➢ Safeguarding referrals are consistent at 1.85%. |

# SAFE

| Sub-Section | Key Headlines From Each Sub-Section. |
|---|---|
| Serious Incidents | ➢ 10 SI's declared in August out of 59 incidents reviewed, with 2 reports overdue, a decrease of 4 on the previous month. Overdue SI's have been escalated internally to the Executive Lead for completion and an increase in throughput has been seen.<br>➢ 9 SI reports were completed and submitted in August, 2 of which were within the 60 day timeline. |
| Total Complaints | ➢ 63 complaints were received in August, including 3 from Health and Social Care providers on behalf of the patient.<br>➢ There are 97 open complaints, with 25 complaints still open over 35 working days.<br>➢ August saw a decrease in complaints received about delay. Overall there has been a decrease in total complaints since 2013/14. |
| NHS CAS Alerts | ➢ 5 Medical Device alerts were received, of which none were relevant to the Trust.<br>➢ 1 General Information bulletins were received from NHSI, regarding acute kidney injury which was reviewed by the medical directorate and not relevant to the Trust. |
| Prevention of Future Deaths and Legal Claims | ➢ There were no PFD's addressed to the Trust in August 2016. |

# Training and CSRs

## New Entrant Course Numbers

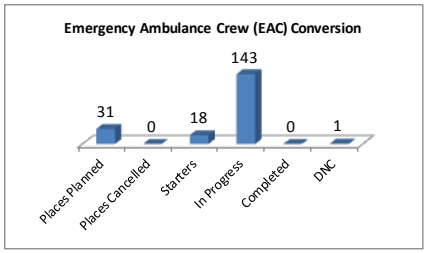
In August, 2 International Paramedic Programmes started the total capacity for these courses was 28 and 17 learners started on the programme. 2 UK Graduate programmes also started in August with a total capacity of 35, 33 learners started the programme.

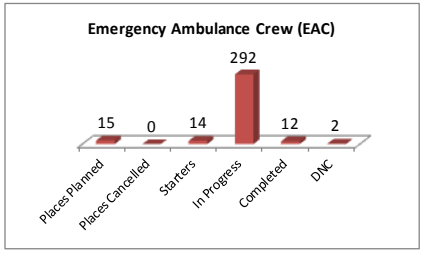
2 EAC conversion courses commenced in August with a capacity of 31, 18 learners started the programme.

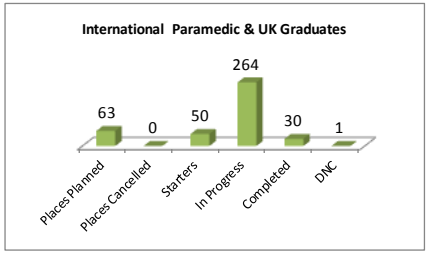
There was 1 EAC course which commenced in August with a capacity of 15 and 14 learners started the programme.

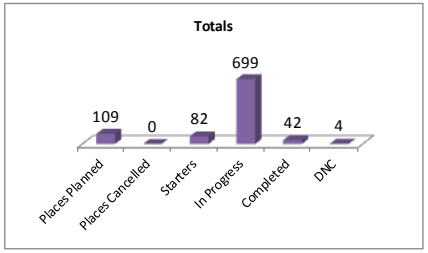
In August 12 leaners completed the EAC programme and 30 International Paramedics/UK Graduates completed their programme and became operationally unrestricted.

The PED (Placement Educator) throughput for August was;
2 courses planned for PED 1 with 24 places available, 28 places were booked, 11 learners completed and 17 learners did not complete.
2 courses planned for PED 2 with 40 places available, 30 places were booked, 20 learners completed and 7 learners did not complete.
1 course planned for PED 3 with 12 places available, 12 places were booked, 9 learners completed and 3 learners did not complete.



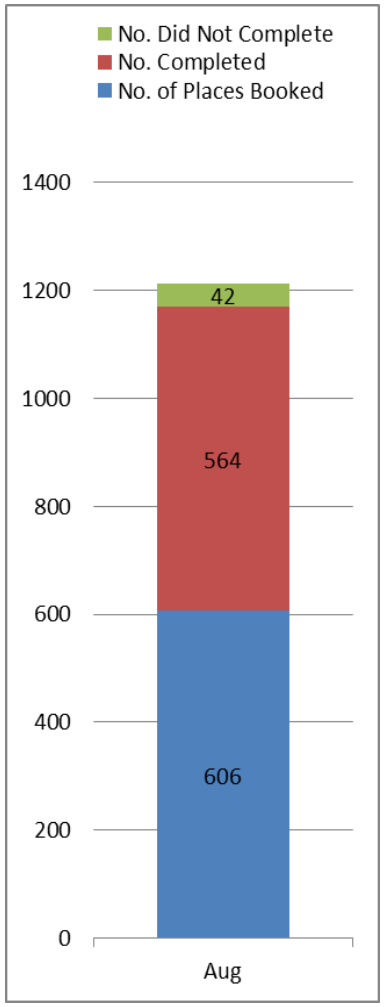



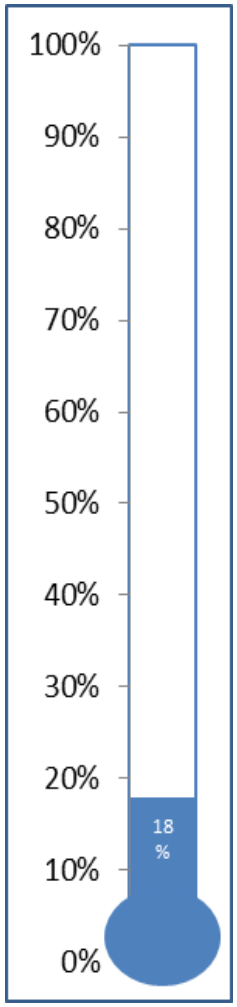




| Legend | |
|---|---|
| Places Planned = Number of Places Planned | In Progress = Number of Learners Currently on their Programme |
| Places Cancelled = Number of places Cancelled | Completed = Number of Learners Completed their Programme and are Operationally Unrestricted |
| Starters = Number of Learners Starting their Programme | DNC = Number of Learners who Did Not Complete their Programme |

# Training and CSRs




## Core Skill Refresher (CSR)

CSR 2016.2 rolled out on the 1st August. The initial roll out included sufficient time to allow for all Clinical Tutors delivering CSR training to undertake "Train the Trainer" sessions with the element leads to ensure consistent delivery of the materials.

The topics covered in CSR 2016.2 are EPRR, Maternity Update, ALS Update and Providing a Witness Statement.

In August a total of 768 places were made available, 606 places were booked with 564 staff completing the programme.

There were a total of 42 staff recorded as Did Not Complete for August. We have explored reasons for non-attendance to help further improve attendance rates. The reasons given by paramedics and clinicians recorded as 'Did Not Complete (DNC)' include:

| | |
|---|---|
| ** 3 DNCs Non Attendance (Deferred)* | ** 14 DNCs non attendance (no show)* |
| ** 2 DNCs non attendance (re-schedule)* | ** 17 DNCs no reason provided* |
| ** 5 DNCs non attendance (sickness)* | ** 1 DNCs attended but left during the class* |

Due to the need to manually enter attendees on receipt of achievement records, the dashboard data lags behind the Clinical Education and Standards Department data records. The total number of clinicians required to attend for this training period is 3135, however this does not account for some clinical groups not included in this number, which is being reviewed by the Workforce and Strategy group.

# Training and CSRs

**Core Skill Refresher (CSR) – EOC Staff**

EOC currently have two Core Skills Refresher (CSR) courses running, one focussing on EOC specific elements and the other on EPRR and Incident Awareness. Completion numbers for CSR for August were unavailable at the time of the report being published but will be included in the next months report.

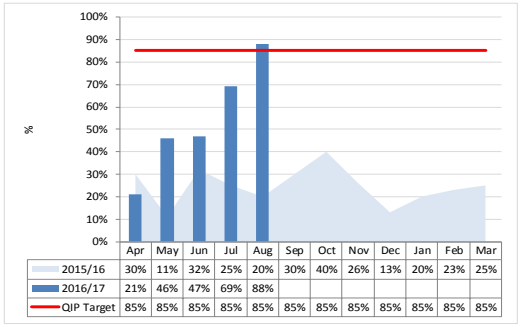
There is an increase in the number of core courses being delivered for the financial year 2016/2017 in comparison to those planned and delivered for 2015 / 2016:-

| | |
|---|---|
| 12 x Call Handling (168 staff) | (154 staff 2015/16) |
| 11 x Dispatch (154 staff) | (140 Staff 2015/16) |
| 4 x Allocator (40 staff) | (50 staff 2015/16) |
| 4 x Work Based Trainer (40 staff) | (50 staff 2015/16) |

# Adverse Incidents

**Patient safety incidents reported on DatixWeb within 4 days of incident occurring**

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 85% | 88% | 3% | |




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 30% | 11% | 32% | 25% | 20% | 30% | 40% | 26% | 13% | 20% | 23% | 25% |
| 2016/17 | 21% | 46% | 47% | 69% | 88% | | | | | | | |
| QIP Target | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |

**Adverse Incidents**

11.6% of incidents reported in August 2016 were via paper LA52's, down from 33% in July and 45% in June. Paper reports are received within a median of 19 days. Thus we estimate that 93% of all incidents occurring in August have been received.

**Staff Incidents: 243 (-8%)**

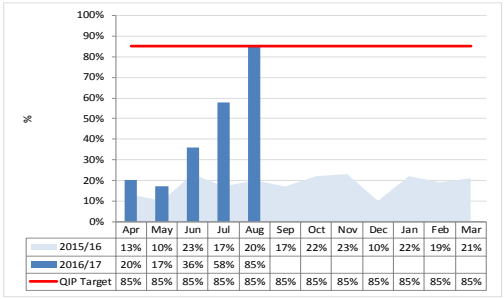
- Manual Handling incidents: 35 (-33%)
- Assault and Abuse: 67 (-17%)

**Patient Incidents: 218 (-9%)**

- Failure of equipment: 34 (+6%)
- Missing Equipment: 16 (-24%)
- Medication Incidents: 28 (-7%)

**Staff safety incidents reported on DatixWeb within 4 days of incident occurring**

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 85% | 85% | 0% | |




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 13% | 10% | 23% | 17% | 20% | 17% | 22% | 23% | 10% | 22% | 19% | 21% |
| 2016/17 | 20% | 17% | 36% | 58% | 85% | | | | | | | |
| QIP Target | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |

**Adverse Incidents due to items which failed or missing –** these are all reviewed for any impact on patient safety and outcome and none were identified however the overall availability of equipment is being reviewed as part of the Logistics Make Ready programme

Failed in use (Top 5)

- Laerdal Suction 4
- EZIO 3
- Mangar Elk 2
- Entonox Cylinder 2
- LP15: ECG Leads 2

Missing Items (Top 5)

- PALS Kit 4
- Technician Drug Pack 3
- Paramedic Drug Pack 3
- Splints 2
- Scoop Stretcher 1

# Adverse Incidents & Never Events

## Incident Workflow Management - Snapshot as of 02/09/2016

| Sector | New Incidents, awaiting review | Being investigated | Awaiting quality check | Being quality checked | Finally Approved | Rejected |
|---|---|---|---|---|---|---|
| East Central Sector | 12 | 38 | 128 | 0 | 13 | 1 |
| North Central Sector | 26 | 36 | 36 | 1 | 26 | 0 |
| North East Sector | 22 | 10 | 20 | 0 | 20 | 1 |
| North West Sector | 13 | 37 | 44 | 0 | 9 | 1 |
| South East Sector | 55 | 44 | 26 | 0 | 58 | 0 |
| South West Sector | 21 | 35 | 52 | 1 | 18 | 3 |
| West Sector | 16 | 39 | 3 | 0 | 27 | 0 |
| **Total** | **165** | **239** | **309** | **2** | **171** | **6** |

**Never Events**

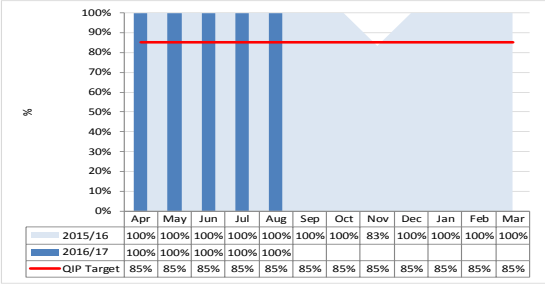
There were no **NEVER EVENTS** recorded in August 2016.

| Average of Days | New Incidents, awaiting review | Being investigated | Awaiting quality check | Being quality checked |
|---|---|---|---|---|
| East Central Sector | 16.6 | 30.6 | 39.7 | - |
| North Central Sector | 31.0 | 40.1 | 35.0 | 47.0 |
| North East Sector | 21.8 | 25.7 | 33.7 | - |
| North West Sector | 8.4 | 35.1 | 39.3 | - |
| South East Sector | 21.3 | 40.6 | 27.7 | - |
| South West Sector | 14.8 | 37.1 | 38.1 | 55.0 |
| West Sector | 19.4 | 42.3 | 23.7 | - |

# Serious Incidents (SI) / Governance

## Percentage of Serious Incidents (SIs) reported on STEIS within 48 hours of being declared

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 85% | 100% | 15% | |

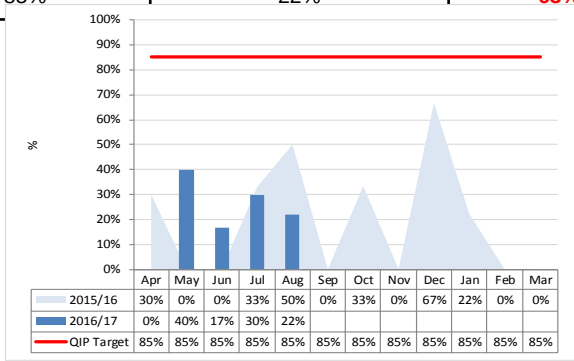



## Serious Incidents

- 10 SI's were declared in August 2016 out of 59 incidents reviewed. There are 2 reports overdue, a decrease of 4 on the previous month and 7 on the month before that.
- Recent themes include errors in treating patients in cardiac arrests, delays in response and IM&T issues.
- Overdue SI's have been escalated internally to the Executive Lead for completion compliance and projected completion dates have been asked of ELT leads. An increase in throughput has been seen as evidenced by the reduction in overdue reports.
- 9 SI reports were completed and submitted in August, 2 of which were within the 60 day timeline.

## Completed investigations and reports within 60 working days of a serious incident being declared

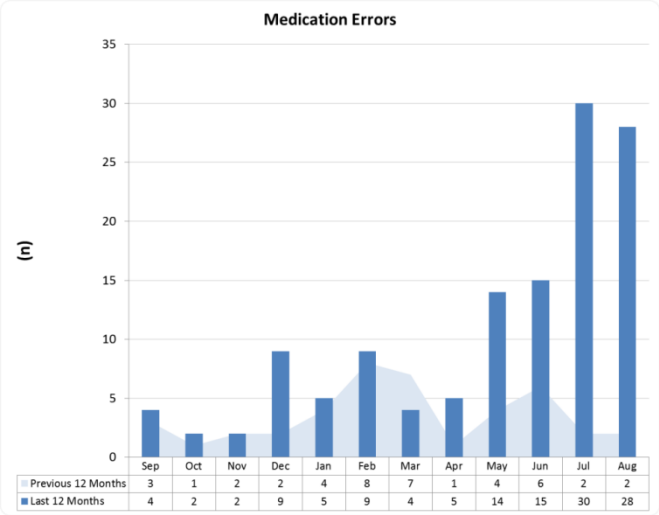
| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 85% | 22% | 63% | |




In the first 2 months of Q2 16/17 the LAS has submitted 19 Serious Incident (SI) reports, one more than the whole of Q1. The average time for completion for these SIs was 93 days, down from 107 the previous quarter. Of these, 3 were completed within 60 days in July and 2 within 60 days in August. The number of overdue reports is 2, down significantly on previous months and evidence of the work that has been done to reduce the backlog.

Further training is also taking place to increase the skillset of investigators and on investigation report writing for the Executive Leadership Team, all of which should help reduce time to completion. Course dates are booked for September.

# Medicines Management




**Medicines Management – KPI data**

**Controlled Drugs**

There were **two** reportable (controlled drugs) LIN incidents in August 2016:-

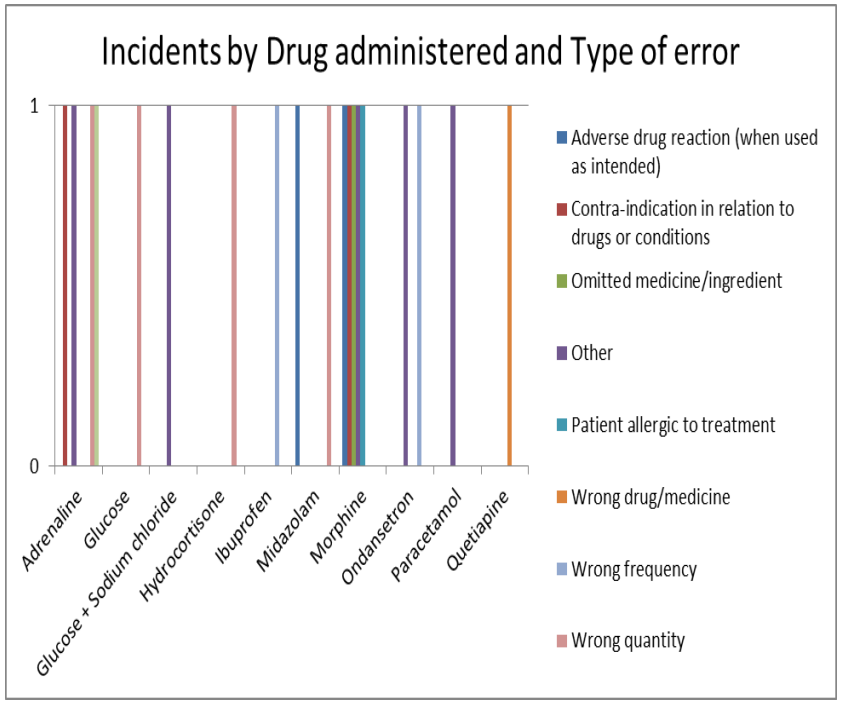
- A paramedic identified that one ampoule of morphine was missing from their morphine pouch on return to station. Despite a search it remained unaccounted for and was reported to the Police.
- A paramedic drug pack was handed into an ambulance station by a member of the public which was found in the street. The contents appeared intact, but some ampoules were broken, including diazepam.

There have been **four** CD incidents that are not LIN reportable. One involving a morphine ampoule given to a GP during the care of a palliative care patient which is contravention of policy.

Other medicines management issues

- The Trust Pharmacist role has been approved and has gone to advert with a view to recruit by November 2016.
- A review of new sepsis guidelines has been undertaken. This confirms that the current Trust guidelines relating to fluid administration remain fit for purpose and that due to short transfer to hospital times IV antibiotics are not required.
- An audit and retrospective review of pharmacological management of acute behavioural disturbance by Advanced Paramedic Practitioners will shortly be conducted.
- Medicines management spot checks continue to be conducted by incident Response Officer. Compliance remains consistent and the majority of issues identified relate to minor omissions.
- Supply of drugs packs in certain areas is inconsistent resulting in shortages at some times of the day. The logistics support unit are packing additional bags but these will take time filter into the supply chain.
- Audits of the new style drugs usage form contained in sealed drugs packs continue to demonstrate improvements in compliance when compared with old style forms.
- The CQC Warning notice formal feedback is awaited. Informal verbal feedback has enabled us to progress some actions.

# Medicines Management




## Other Medicines Errors

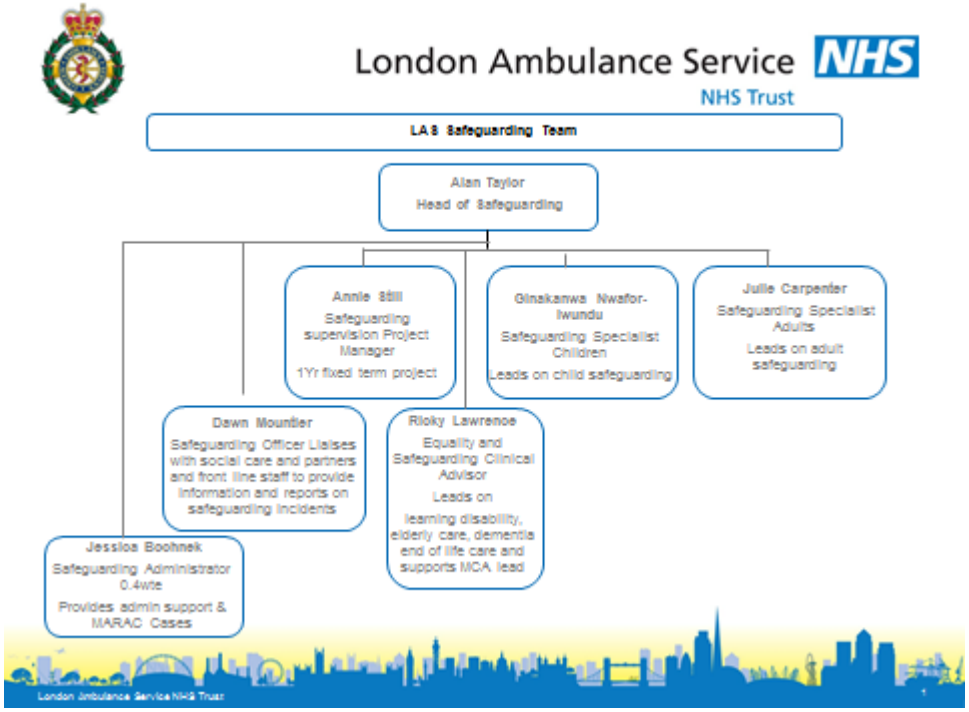
The graph shows the type of medication error i.e. wrong quantity / route etc. by drug type. For the "other" error category per type of drug, these include:

- Adrenaline – A number of errors reporting including breakage of ampoule, inappropriate administration in COPD patient, administration in VF arrest prior to third shock. No identified harm to the patient.
- Morphine – Two breakages of morphine ampoules; Adverse reaction to morphine noted, not declared by patient prior to administration. No identified harm to the patient..
- Glucose – during cardiac arrest over infusion of glucose administered. No identified harm to the patient.
- 
- Paracetamol – A discolouration was noted in IV paracetamol solution and report, not administered to the patient. Manufacturer consulted and advised this can be normal appearance and subsequent bulletin issued to staff.
- Midazolam – two incidents reported by Advanced Paramedic Practitioners. One involved reaction which was appropriately managed; one involved cumulative dose exceeding PGD requirements, no adverse effects on the patient noted.

Medication errors reported are discussed with Group Station Management teams to ensure staff receive feedback to mitigate further errors occurring.

# Safeguarding

The Safeguarding Team is now at full establishment and consists of

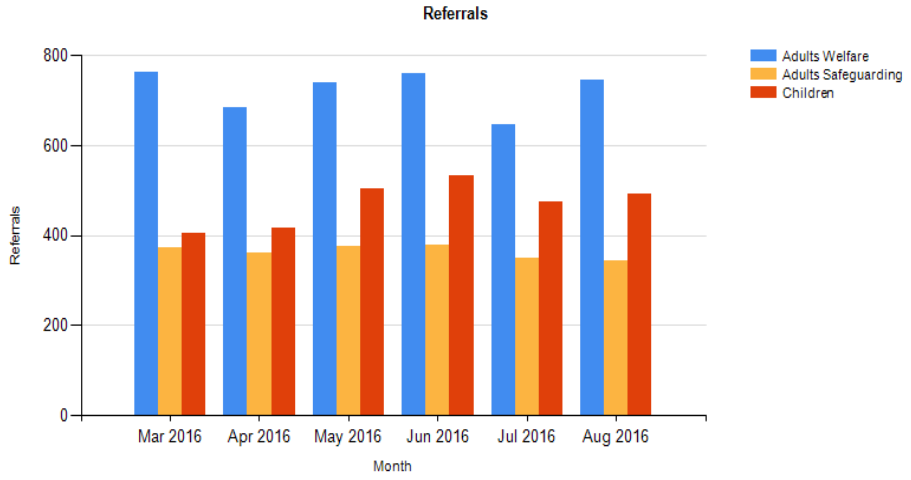



## Youth violence audit

- Trust is working with Red Thread to introduce referring to them any youth violence cases.
- Undertook an audit and discovered that referrals were only made by staff in 23% of the time.
- Action taken to re audit on a monthly basis and make retrospect referrals.
- Issued an update to staff in Trust Routine Bulletin (RIB) reminding staff of need to make referral, regardless of whether other providers eg London's Air Ambulance may be dealing with the referral.
- Article written on youth violence for Clinical update in October.
- Youth violence will be included in next Core Skills Refresher (face to face) training for staff .

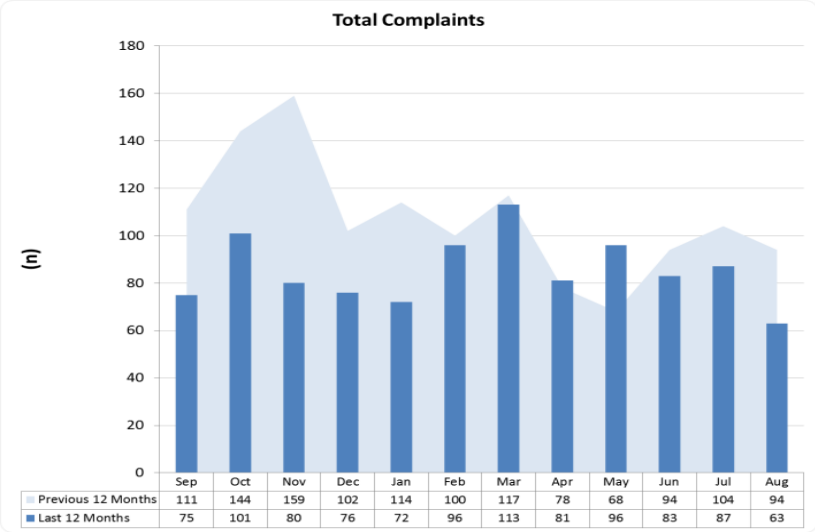
# Safeguarding Referral Activity

| | Adults Safeguarding | Adults Welfare | Children | Total Referrals | Adults Feedback | Children Feedback | Total Feedback | Incidents | Referrals as % of incidents |
|---|---|---|---|---|---|---|---|---|---|
| Total | 2182 | 4339 | 2824 | 9345 | 64 | 160 | 224 | 516,437 | 1.81% |
| Mar 2016 | 374 | 764 | 405 | 1543 | 11 | 27 | 38 | 86,441 | 1.79% |
| Apr 2016 | 362 | 683 | 416 | 1461 | 9 | 17 | 26 | 81,900 | 1.78% |
| May 2016 | 376 | 739 | 504 | 1619 | 6 | 37 | 43 | 87,849 | 1.84% |
| Jun 2016 | 378 | 761 | 532 | 1671 | 15 | 26 | 41 | 85,953 | 1.94% |
| Jul 2016 | 349 | 646 | 475 | 1470 | 14 | 31 | 45 | 88,643 | 1.66% |
| Aug 2016 | 343 | 746 | 492 | 1581 | 9 | 22 | 31 | 85,651 | 1.85% |

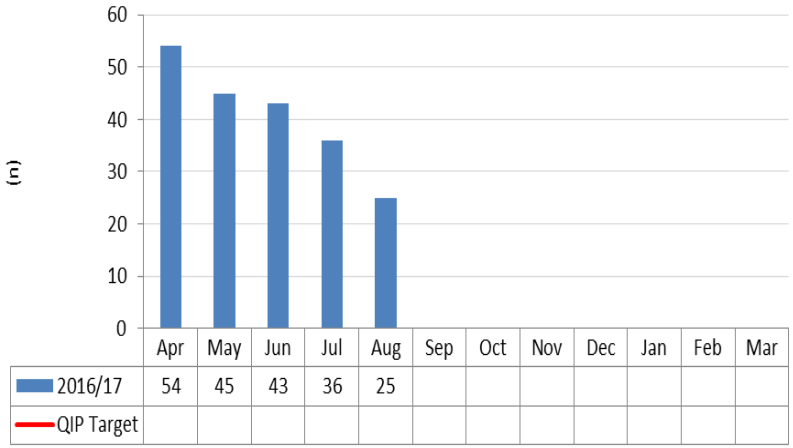



- Referral volumes have returned to average after a small drop last month.
- The rate of referral at 1.85% is slightly above the average for the period (1.81%).
- The increase is mostly in adult welfare referrals.
- There is a general upward trend in child referrals. Work is underway to analyse this and results should be available in a month or two.

# Complaints – Volume & Response time




- 63 complaints and concerns were received in August 2016, a decrease on the number received in July 2016.
- This includes 3 from health or social care providers which were treated as having been made on behalf of the patient, illustrating how the best practice is applied (and as approved by HSC) and beyond the DOC obligations.
- Complaint volumes are the lowest overall for August and as an average for the year in comparison to the dataset from 2013/14 which is used as the benchmark for complaint numbers received.



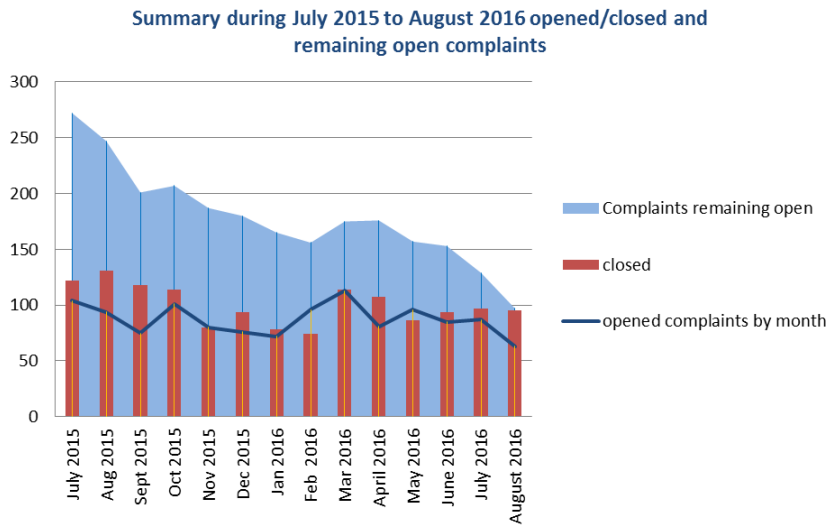

**KPI Report – complaints responses over 35 days**

- The QIP KPI data reflects the number of complaints over 35 working days that remain open.
- There are 97 open complaints, a reduction on July (129). There are 25 over 35 working days, a decrease from July (36) as of data produced on 28th August.
- As of 4th August, there are 20 overdue complaints, of which 12 are pending sign off.

# Complaints – Volume & Response time

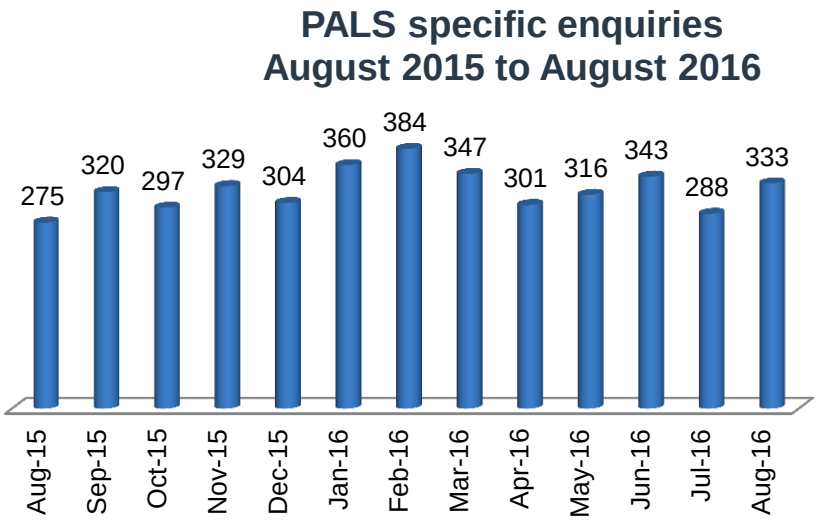
| | 2013/14 | 2014/15 | 2015/16 | 2016/17 |
|---|---|---|---|---|
| August complaints | 89 | 111 | 94 | 63 |
| Average per annum | 88 | 117 | 88 | 82 |

- Overall complaint numbers are the lowest recorded to date for the month of August historically.
- Complaints about delay have decreased in August to 20 in comparison to 45 received in July.
- Complaints about conduct and behaviour in August have increased slightly to 18 compared to 15 in June.
- 100% of complaints received were acknowledged within 3 working days during August.




- Datixweb has been in place for four months. All remaining cases held on the previous database (Rich Client) have been closed. The RC version will be retained as Archive in the event of further enquiries from the Ombudsman or complainants.
- Data for reporting complaints by area and local authorities / CCG's has commenced with Camden receiving the highest, although notably complaints from outside London were higher.
- The number of complaints closed during August 2016 was 79.

# PALS




**PALS specific enquiries August 2016 = 333**

- Average monthly PALS for 2013/14 = 287
- Average monthly for 2014/15 = 298
- Average monthly for 2015/16 = 322
- Average monthly for 2016/17 = 316

There was a increase in PALS enquiries from 288 during July to 333 in August. The team have considerably improved case entry during August and numbers have increased by 15%.

| Subject August 2016 | Number of enquiries |
|---|---|
| Information/Enquiries | 221 |
| Lost Property | 59 |
| Medical Records | 38 |
| Appreciation | 15 |
| **Total** | **333** |

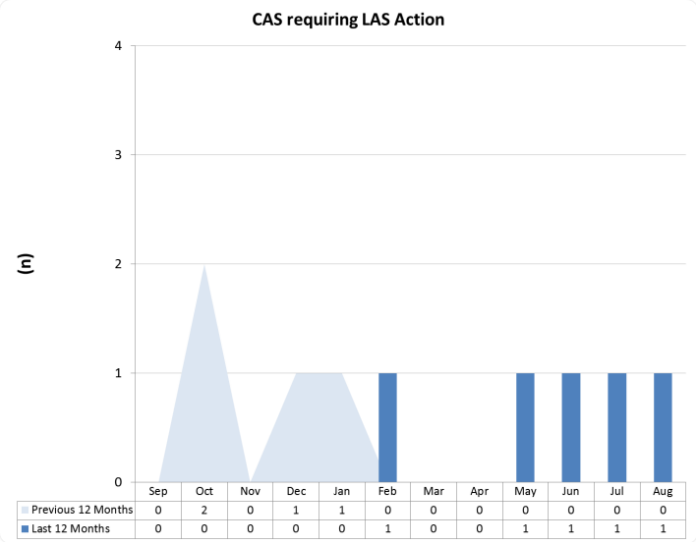
Themes are consistent with previous months regarding information and enquiries:-

- Patient destination
- Signposting to other departments
- Policy and procedure requests
- Families seeking clarification of events

Full cover is provided on the 'duty' phone and each officer undertakes a duty session.

Requests for medical records have increased in August.

# NHS CAS Alerts & Preventing Future Death (PFD) Notifications




| | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Previous 12 Months | 0 | 2 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Last 12 Months | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 1 | 1 |

**August 2016**:

- 4 high voltage alerts and 1 low voltage alert was received. None were relevant to the Trust.
- 5 alerts were received regarding medical devices that were not used by the Trust.
- 1 information notification was received from NHS Improvement regarding care of patients with acute kidney injury. This was passed to the medical directorate, who decided it was not relevant to the Trust.

All notifications were acknowledged . The Safety and Risk department continues to respond within the notification window (2 days), on behalf of the Service, for modifiable alerts.

**Preventing Future Deaths Reports:**

- There were no PFD's addressed to the Trust in August 2016.

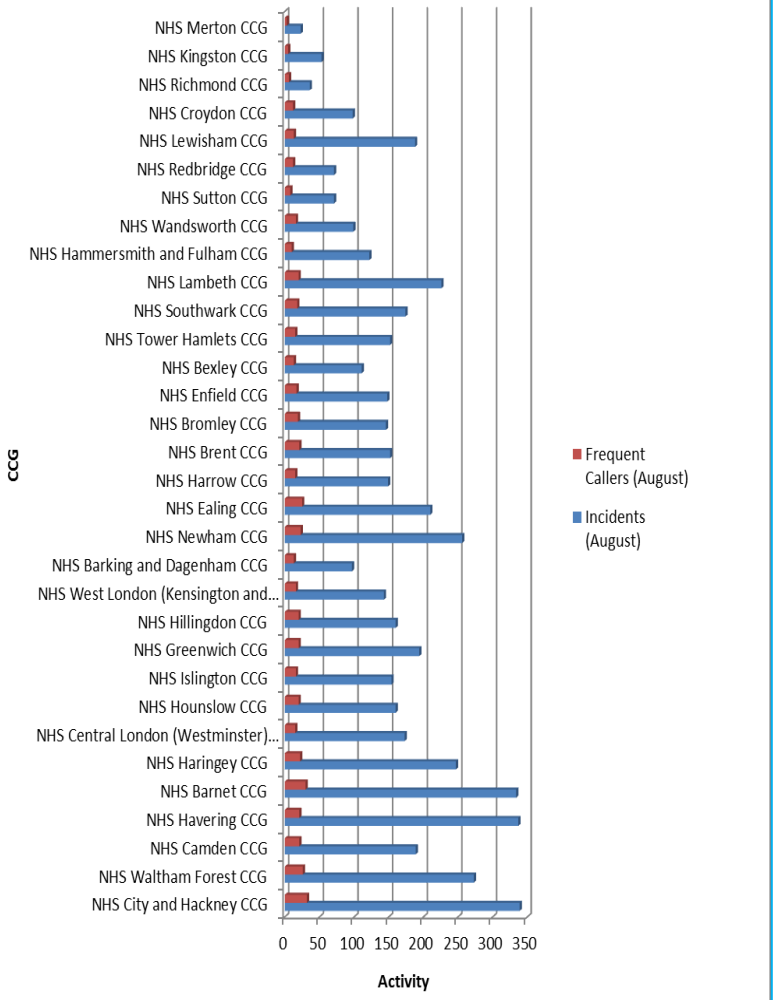
# EFFECTIVENESS

| Sub-Section | Key Headlines From Each Sub-Section. Should be supported by following slides |
|---|---|
| Frequent Callers | ➢ The number of overall Frequent Caller incidents has continues to increase with new cases being identified.<br>➢ The Darzi Fellowship focussed on Frequent Callers concluded at the end of August with all objectives being met and 90% of CQUIN recommendations being completed. |
| CARU Report Cardiac Arrest Care | ➢ Resuscitation was attempted on 38% of cardiac arrest patients attended by crews.<br>➢ 38 patients with ROSC presented with a STEMI following their cardiac arrest and 36 were conveyed to Heart Attack Centres (HAC) appropriately.<br>➢ 99% of patients who had an advanced airway placed had ETC02 recorded, with one patient not having any ETC02 recorded. This has been fed to Clinical Team Leaders for follow up with crew members.<br>➢ 4% of cardiac arrests had defibrillator downloads, a decrease of 4% from June 2016. Almost all of the downloads were submitted by the Advanced Paramedic Practitioners. |
| CARU Report STEMI Care | ➢ The average time from the 999 call to arrival on scene increased by 1 minute to 11 minutes in July, exceeding the category A target by 3 minutes.<br>➢ 99% of patients were conveyed appropriately to a heart attack centre with two patients being inappropriately conveyed to ED. The crews concerned have received feedback by the clinical team leaders.<br>➢ Analgesia administration for saw an increase in compliance by 3% to 73% in July 2016. Clinical Team Leaders continue to address this in Clinical Information and Support Overview (CISO) discussions. |

# EFFECTIVENESS

| Sub-Section | Key Headlines From Each Sub-Section. Should be supported by following slides |
|---|---|
| CARU Report Stroke Care | ➢ 98% of all suspected Stroke patients were provided with a full pre-hospital care bundle which is a 2% increase on July 2016 data.<br>➢ 5 FAST positive patients (0.5%) were transported to an ED when they should have been conveyed to a HASU. Details of these cases have been sent to the relevant Sector management teams to enable feedback to crews for learning.<br>➢ Patients eligible for thrombolysis arriving at a HASU within 60 minutes has decreased from 64% in June to 60% in July 2016. This is being reviewed by CARU to identify reasons for this decrease. |
| CARU Report Major Trauma Care | ➢ The next major trauma audit report will be produced at the end of Q2. |
| CARU Report National CPI Care | ➢ The Trust ranks on average overall 4th nationally for Elderly Faller care, which is an improvement on the previous cycle ranking.<br>➢ Key areas of compliance noted were 12 lead ECG observations and assessment of mobility which require improvement, although good compliance was noted for primary observations and direct referrals. |

# Frequent Callers




The cumulative resource time and the organisational cost of managing Frequent Callers continues to increase in August subsequent to an increase of patients .

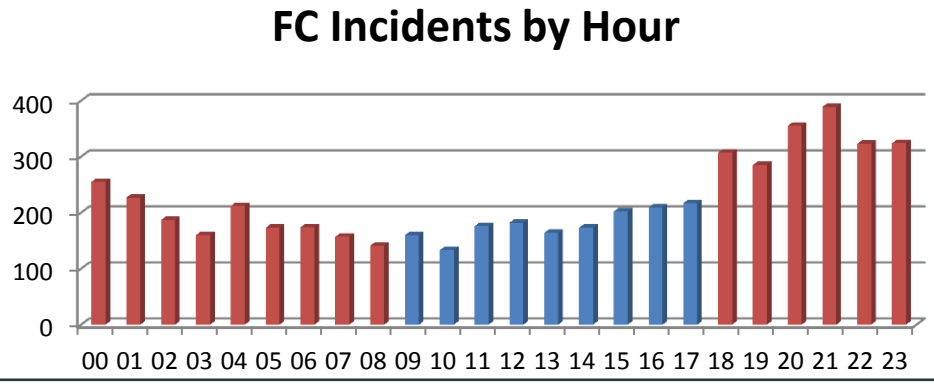
August signifies the conclusion of the Frequent Caller Darzi project. All objectives captured within the project plan have been met and 90% of recommendations from the CQUIN report have been completed.

In summary the identification and management of Frequent Callers has improved resulting in clinical quality, patient experience and operational resource efficiencies. However, the rate of frequent caller growth continues to exceed project benefit. Subsequently, an increasing number of frequent callers do not receive management or support which increases the risk of crisis escalation.

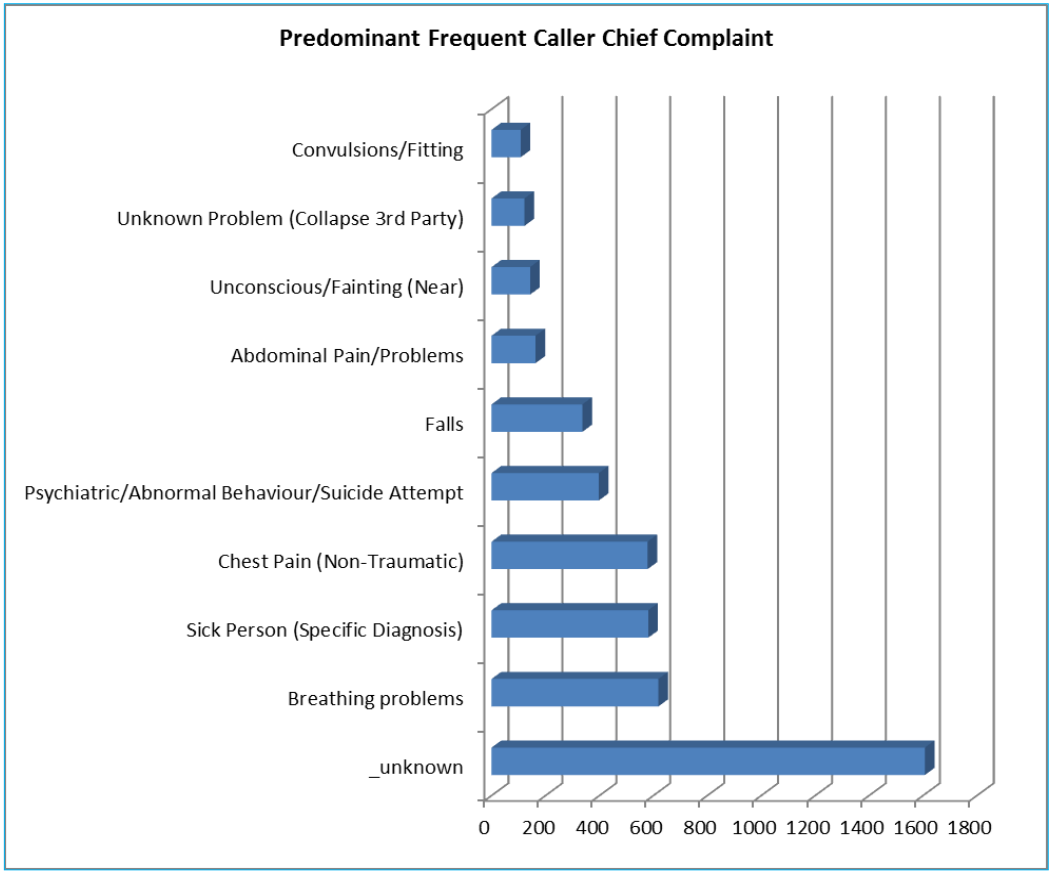
A business case seeking further resource has been submitted internally and is scheduled to be discussed at Executive level in the forthcoming weeks. The proposal captures a best practice vision for pan London Frequent Caller management which has also been shared with NHS England and wider national stakeholders.

The Frequent Caller report continues to successfully identify vulnerable patients and has been commended by the National Frequent Caller Network. Subsequent best practice sharing has taken place with the Welsh and South Western Ambulance Services who aim to utilise the report in their respective areas.

The graph to the left demonstrates the number of patients per CCG in purple and the number of incidents they generated in blue. CCG's are ranked following calculation of the number of frequent callers relative to CCG population. Better performing areas are located at the top of the graph.



# Frequent Callers




- The table to the right indicates cumulative HRG cost and resource time for frequent user activity throughout July.
- The table above demonstrates the top ten chief complaints presented by the frequent caller cohort.

| CCG | HRG Cost | Cumulative Resource Time (mins) |
|---|---|---|
| NHS Barking and Dagenham CCG | £7,737.56 | 3018 |
| NHS Barnet CCG | £28,199.74 | 16730 |
| NHS Bexley CCG | £18,210.24 | 10999 |
| NHS Brent CCG | £12,777.32 | 6922 |
| NHS Bromley CCG | £17,192.28 | 9338 |
| NHS Camden CCG | £19,910.76 | 11782 |
| NHS Central London (Westminster) CCG | £16,907.10 | 7680 |
| NHS City and Hackney CCG | £31,546.34 | 16885 |
| NHS Croydon CCG | £8,038.28 | 4235 |
| NHS Ealing CCG | £25,267.34 | 13861 |
| NHS Enfield CCG | £12,576.34 | 7352 |
| NHS Greenwich CCG | £26,063.58 | 13539 |
| NHS Hammersmith and Fulham CCG | £15,508.08 | 8296 |
| NHS Haringey CCG | £15,364.80 | 7331 |
| NHS Harrow CCG | £13,689.04 | 7287 |
| NHS Havering CCG | £26,601.68 | 14020 |
| NHS Hillingdon CCG | £18,686.18 | 11625 |
| NHS Hounslow CCG | £15,354.10 | 7912 |
| NHS Islington CCG | £11,907.02 | 6020 |
| NHS Kingston CCG | £3,737.34 | 2242 |
| NHS Lambeth CCG | £27,070.98 | 15344 |
| NHS Lewisham CCG | £16,057.84 | 8775 |
| NHS Merton CCG | £3,758.34 | 2355 |
| NHS Newham CCG | £18,265.14 | 9992 |
| NHS Redbridge CCG | £7,600.70 | 4065 |
| NHS Richmond CCG | £2,746.64 | 1679 |
| NHS Southwark CCG | £14,059.26 | 6887 |
| NHS Sutton CCG | £8,030.04 | 3917 |
| NHS Tower Hamlets CCG | £15,409.34 | 7363 |
| NHS Waltham Forest CCG | £22,750.78 | 11742 |
| NHS Wandsworth CCG | £11,017.66 | 5497 |
| NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG | £15,555.86 | 7671 |
| **Grand Total** | **£507,597.70** | **272361** |

# CARU Reports – Cardiac care (July data)

## CARDIAC CARE

- Resuscitation efforts were commenced on **38%** of cardiac arrest patients attended by LAS crews.
- The average time from 999 call to LAS on scene was **8 minutes**, thus meeting the target. **Fifteen** station groups had an average 999 call to scene time of 8 minutes or less.
- **27%** of cardiac arrest patients that had resuscitation commenced gained and sustained Return of Spontaneous Circulation (ROSC) until arrival at hospital and is a **6%** decrease from June. **St. Helier** station group had the highest ROSC rate with 60% of their patients maintaining ROSC to hospital.
- **38** patients with ROSC presented with a STEMI following their cardiac arrest, **36** of which were conveyed to HACs in line with the pathway.
- An advanced airway management device was placed successfully in **88%** of cardiac arrest patients where resuscitation was attempted. Of these patients, **99%** had end tidal CO2 levels measured. **One** patient had no end-tidal CO2 level documented on their PRF nor accompanying capnography printout and these have been shared with Sector management teams for further investigation.

## STEMI

- **99%** of patients were conveyed to an appropriate destination. **Two** patients were transported to an ED when they should have been taken to a HAC. These cases have been shared with Sector management teams for feedback.
- The average time from the 999 call to arrival on scene increased by **1** minute to **11** minutes in July.
- Average overall on scene time has decreased by **2** minutes to **42** minutes while call to hospital times have decreased by **1** minute to **71** minutes. These continue to remain high and require monitoring and review to identify themes.
- **Hillingdon, Romford, Bromley** and **Croydon** station groups (plus **PAS & VAS** and **Other LAS** vehicles) achieved notably lower than average overall on scene times this month.
- The percentage of patients who received a complete care bundle (aspirin, GTN, two pain assessments and analgesia) has increased by **3%** to **73%.**
- **Westminster** station group provided the full care bundle to 100% of patients this month. However, **11** station groups provided a full care bundle to less than 80% of patients attended this month. Local management have been asked to look into reasons for this.

# CARU Reports - Stroke care (July data)

## STROKE

- **98%** of all suspected stroke patients were provided with a full pre-hospital care bundle or a valid exception to its provision was recorded on the PRF. This represents a **2**% increase compared to June 2016.
- All FAST positive patients had the time of onset of symptoms recorded or it was documented that the time of onset could not be established.
- Almost all FAST positive patients (**99.5%**) were conveyed to the most appropriate destination for their condition. However, **5** FAST positive patients (**0.5%**) were transported to an ED when they should have been conveyed to a HASU.
- The average response time for 999 call to arrive on scene is **14** minutes. This is a 1 minute decrease from June 2016.
- The average time on scene is **35** minutes, which remains longer than the recommended 30 minutes. Just half of LAS crew (**50%**) attending stroke patients who were potentially eligible for thrombolysis spent 30 minutes or less on scene.
- The percentage of patients who were potentially eligible for thrombolysis and arrived at a HASU within 60 minutes has decreased from 64% in June to **60%** in July 2016.

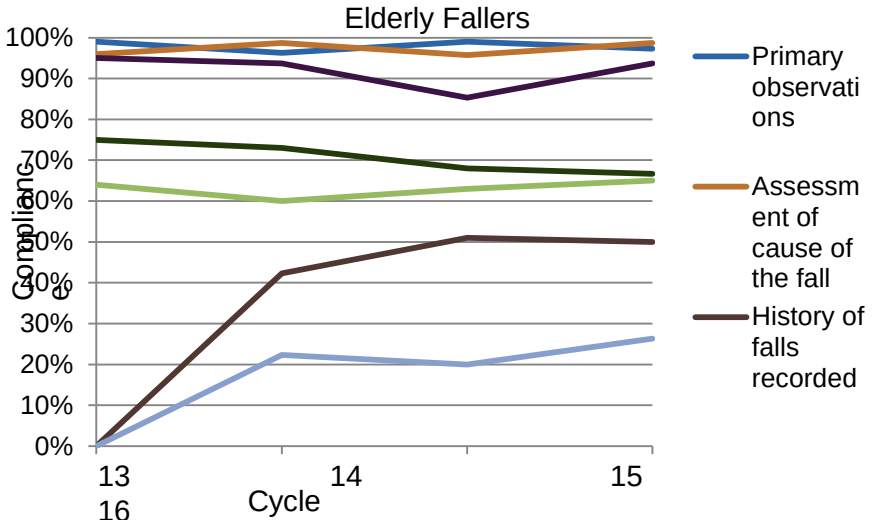
## MAJOR TRAUMA

- The next major trauma data will be published at the end of Q2.

# CARU Reports – National CPI compliance; Elderly Fallers

| | CYCLE 15 (Data sample: September 2015) | | | CYCLE 16 (Data sample: March 2016) | | |
|---|---|---|---|---|---|---|
| | LAS Performance in C15 | National Average | Rank in cycle 15 | LAS Performance in C16 | National Average | Rank in cycle 16 |
| **Primary observations** | 99.00% | 90.00% | **2nd** | 97.30% | 88.20% | **1st** |
| **Assessment of cause of the fall** | 95.70% | 93.70% | **6th>** | 98.70% | 95.80% | **4th** |
| **History of falls recorded** | 51.00% | 47.60% | **4th** | 50.00% | 47.30% | **5th** |
| **12 lead ECG recorded** | 85.30% | 88.00% | **8th** | 93.70% | 93.80% | **8th** |
| **Assessment of mobility** | 68.00% | 75.20% | **8th** | 66.70% | 79.60% | **9th** |
| **Direct referral** | 63.00% | 51.90% | **2nd>** | 65.00% | 47.80% | **1st>** |
| **Care bundle** | 20.00% | 23.80% | **7th** | 26.30% | 33.70% | **6th** |

The care bundle is comprised of all aspects of care:
› Equal with 1 other services
^ 3 services = 100%




- The Trust ranks on average overall 4th nationally for Elderly Faller care, which is 1% decrease on the previous data cycle (June 2015).
- Key areas noted are no 12 lead ECG recorded or assessment of mobility. The Trust ranked 1st for primary observations taken and direct referrals.
- The complete care bundle for elderly fallers includes all aspects of care as detailed in the table above.
- CARU are awaiting data for cycle 17 which will be further reported on the coming months.

Feedback is being provided to areas to ensure continued improvement

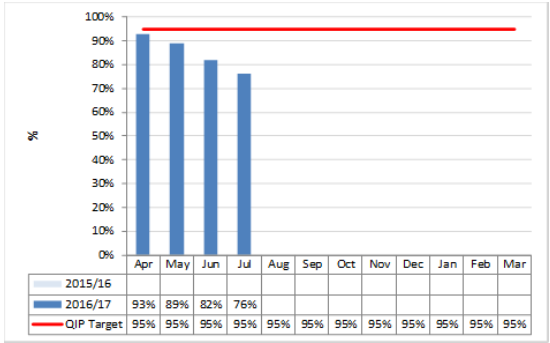
# CARING

| Sub-Section | Key Headlines From Each Sub-Section. Should be supported by following slides |
|---|---|
| CPI Compliance | ➢ The compliance for Mental Health CPI is consistent at 90% with improvements still required for safeguarding concerns.<br>➢ The Sepsis CPI compliance is very good at 96%, although it was noted there was a lack of oxygen administered for a particular group station which the QGAM has been notified off and this will be followed up by Team Leaders in CISO conversations. |
| CPI completion | ➢ July has seen the lowest number of CPI's completed since March 2015. The North West sector completed all available audits. This is being addressed via QGAM's and ADO's.<br>➢ A reduction in completion was particularly evident at the MRU, New Malden, Newham, Romford and St Helier. |
| CPI Feedback | ➢ Less than half of staff have received face to face feedback sessions since the start of the financial year. This is being addressed via QGAM's and ADO's<br>➢ Hillingdon continues to be the best performing group station for feedback. Very few feedback sessions have been delivered at Croydon, MRU, Newham, Westminster and Wimbledon which the CARU team are investigating to ascertain the reasons for this. |
| Friends & Family Test | ➢ 103 Friends and Family Test's were received during August, a decrease on the previous month, although this was anticipated following the 'one-off' direct letter campaign initiated by PTS during June. |
| Patient & Public Education | ➢ 16 events were attended out of 27 events entered on the database, a decrease on those attended in July which was anticipated due to School Holidays. This included 3 People who Help Us events, 2 LFB open days and 3 knife crime talks. |

# CPI Completion, Feedback Sessions and Compliance (June data)

**Number of eligible Patient Report Forms (PRFs) audited per month**

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 95% | July: 76% | 19% | |




## CPI Completion

- Overall CPI completion is at its lowest level since March 2015.
- The North West Sector were the only sector to complete all available audits, followed by the North Central (95% completion) and South East (96% completion).
- A reduction in completion was particularly evident at the MRU, New Malden, Newham, Romford and St Helier which has been fed back to local management to address
- Edmonton, Friern Barnet, HART and Hillingdon audited all available PRFs for the 12th consecutive month. The TRU have also maintained 100% completion this financial year.

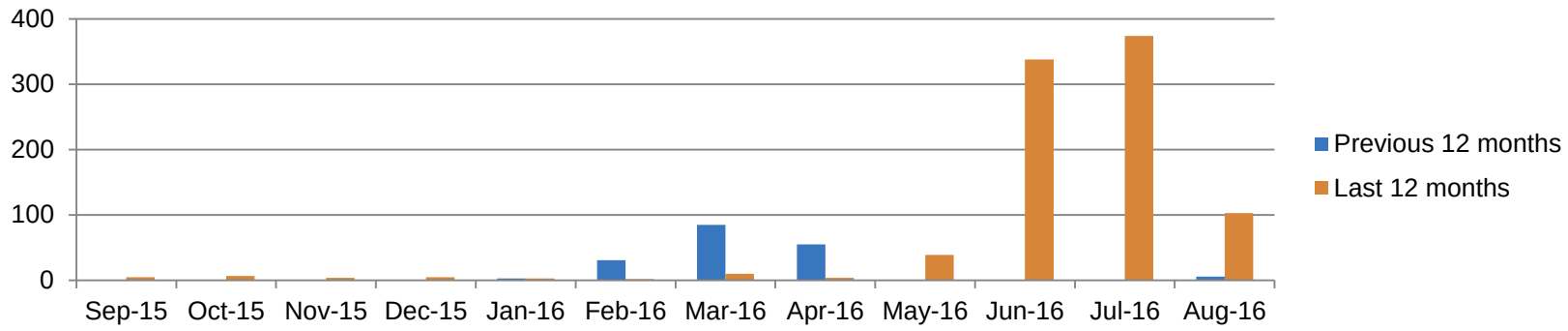
## CPI Compliance

- The care provided to patients with a diagnosed psychiatric problem remains at 90%, with significant improvement still required in recording safeguarding concerns for the patient.
- Patients discharged at scene continue to receive a very high standard of care (97%), as do patients in cardiac arrest (97%) and glycaemic emergency (96%).
- General documentation of patient care remains high (96%), with drug pack codes recorded on 98% of relevant PRFs.
- The Severe Sepsis CPI has maintained 96% compliance achieved in June 2016. However, the administration of high flow oxygen requires improvement, particularly in the East Central Sector which has been highlighted to the Quality Governance and Assurance Manager.

## CPI Feedback

- Less than half the number of feedback sessions expected at this point in the year have been delivered which has been fed back to local management to address.
- Hillingdon Group Station are the only group to deliver over 75% of expected face-to-face feedback sessions to staff, despite a decrease in the delivery of sessions over recent months.
- Very few feedback sessions have been delivered to date at Croydon, MRU, Newham, Westminster, Wimbledon and the reasons for this should be investigated. Volunteer Responders have started to provide face-to face feedback; however, considerable improvement is still required.

# Friends and Family




| | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Previous 12 months | 0 | 0 | 0 | 1 | 3 | 31 | 85 | 55 | 0 | 0 | 0 | 6 |
| Last 12 months | 5 | 7 | 4 | 5 | 3 | 2 | 10 | 4 | 39 | 338 | 374 | 103 |

Friends and Family Test figures for **August 2016**

•Total number of FFT responses received = 103

Extremely likely = 74 Likely = 23

Neither Likely or unlikely = 3 Unlikely = 2

Extremely unlikely = 1

• PTS responses = 102

• Number of PTS journeys = 4,282

• See & treat responses = 1

• Number of see & treat patients = 27,830 (this figure will change by 17th May)

**PTS number are higher as they are now sending leaflets directly to patients**

# Patient & Public Engagement

**August 2016**

Events on database = 27

Events attended = 16

- x3 People who help us (4-5yr olds)
- x2 LFB open days
- x1 LGBT
- x3 Knife Crime talks
- x7 Other

**Public engagement feedback**

**Twickenham Police Station Open Day – 7th August 2016 – GK (EAC)**
*"L was absolutely amazing and we can not thank her enough for her time. The children were thrilled to meet her and are still talking about paramedics! Thank you once again"*

*Dear G, On behalf of all of our Senior Management team, I would like to thank you for all of your support and assistance that you gave myself and colleagues for our Open Day on Sunday at our Police Station.*

*The day was a huge success with a record 2290 members of the community attending the day. The feedback on the day and on twitter has been amazing.*

*The LAS and ELS demonstration stalls that you managed were so popular - the queuing didn't stop and I know that you were busy the entire time meeting and greeting all the public, with so much useful and invaluable information to give.*

***Emergency Services Day - The Children's Trust – 9th August 2016 – BL (EMT) & RP (Paramedic)***

*Hi B and R, Thank you so much for attending our emergency services afternoon last Tuesday. The children & families all had a wonderful time.*

*It was lovely to see the children & their families exploring the ambulance in a leisurely & relaxed situation rather than an emergency one. You both win the prize for staying the longest & being the most patient*

*We really appreciate you giving up your time & understand how tight resources are so thank you (again!!).*

# RESPONSIVENESS

| Sub-Section | Key Headlines From Each Sub-Section. Should be supported by following slides |
|---|---|
| EOC Surge Plans | ➢ The Trust has remained at Surge Red as agreed by ELT. A review of the criteria to continue at this level confirms we are still operating under significant operational pressure and that Surge Red continues to enable LAS to respond to the sickest and most seriously injured patients quickly.<br><br>➢ There were three episodes of Surge Purple Enhanced throughout August 2016. The Trust encountered particularly challenging high call demand around the bank holiday period towards the end of August.<br><br>➢ Surge Purple Enhanced is designed to ensure that ensure that resources are directed to the most critically ill and injured patients to maintain patient safety. |
| Hospital Delays | ➢ Hospital handover breaches are being closely monitored and work is on-going with NHSE and a number of Acute Trusts to address this.<br><br>➢ During July, there were 1740 hospital breaches of greater than 45 minutes, of which 624 were greater than 1 hour. Of particular note there were a number of breaches at Princess Royal – Farnborough, Barnet and Hillingdon. |
| Revised REAP Levels | ➢ The Trust is operating at Pressure Level = Moderate (2)<br><br>➢ Current year to date performance as of 12th September is Cat A 8 minutes 65.21%, Cat A 19 minutes is 93.89%. |

London Ambulance Service NHS
NHS Trust

| | |
|---|---|
| **Report to:** | **London Ambulance Service Trust Board** |
| **Date of meeting:** | **4 October 2016** |
| **Document Title:** | **Quality Improvement Programme Nine-Month Review** |
| **Report Author(s):** | **Karen Broughton**<br>**Programme Director, Quality Improvement Programme** |
| **Presented by:** | **Karen Broughton**<br>**Programme Director, Quality Improvement Programme** |
| **Contact Details:** | **Karen.Broughton@lond-amb.nhs.uk** |
| **History:** | **Update on the Quality Improvement Programme** |
| **Status:** | **For assurance and information** |

**Background/Purpose**

The purpose of this paper is to provide the Trust Board a nine-month status report on the delivery of the Quality Improvement Programme

**Action required**

The Trust Board are asked to note:

- the QIP nine-month update report
- the QIP progress report (August performance)
- the QIP KPI report (August performance)

**Assurance**

The Quality Improvement Programme Board have reviewed activities delivered up to the end of August, and the main concern on programme delivery relates to the outstanding decision to fund delivery of the Quality Improvement Programme which currently sits with Commissioners.

| Key implications and risks arising from this paper | |
|---|---|
| **Clinical and Quality** | The QIP details activities to mitigate against identified clinical risks including deliverables relating to medicines management, improving patient outcomes for bariatric and mental health patient groups, and how the organisation learns from reportable incidents, risks and complaints.<br><br>Additionally, the development of a Trust Quality and Clinical strategy will set the direction and organisational approach to managing clinical and quality risks. |
| **Performance** | There may be risk to Trust performance if activities within the QIP are not delivered to time, or they do not have the anticipated impact on operational functions to improve performance. This needs to be continually reviewed and understood to maintain sustainability. |
| **Financial** | Delivery of the QIP will require dedicated funding. These requirements will be included in the 2016/17 contract negotiations with Commissioners, which are still under negotiation. |
| **Governance and Legal** | The QIP Board is a sub committee of the Trust Board which meets monthly. It will provide a report to formal Trust Board meetings on progress |
| **Equality and Diversity** | There are no specific equality and diversity risks identified in this paper. |
| **Reputation** | There may be a reputational risk if the Trust does not deliver against the QIP in making effective changes that result in meeting the standards required by the CQC and other stakeholders. |
| **Other** | |

| This paper supports the achievement of the following 2015/16 objectives | |
|---|---|
| **Improve the quality and delivery of urgent and emergency response** | Activities within the QIP will lead in due course to achievement of this objective. |
| **To make LAS a great place to work** | Activities within the QIP will lead in due course to achievement of this objective. |
| **To improve the organisation and infrastructure** | Activities within the QIP will lead in due course to achievement of this objective. |
| **To develop leadership and management capabilities** | Activities within the QIP will support achievement of this objective, over time. |

# 2016/17 QUALITY IMPROVEMENT PROGRAMME

## Progress & KPI Report: August 2016

September 2016

# CONTENTS



Definitions

| *Project Delivery* | *Project Performance* |
|---|---|
| All scheduled activities have been completed | |
| The scheduled activities are on track for completion by the due date | Performance has been met or is over 95% towards the agreed trajectory / target |
| The scheduled activities have been delayed and are no more than 4 weeks | Performance is between 85-95% towards the agreed trajectory / target |
| The scheduled activities are at risk and have delays over 4 weeks | Performance is below 85% of the agreed trajectory / target |

**Note:** KPI information presented is up to 25th of the month (unless otherwise stated) and is subjected to validation.
Previous months position is updated to reflect the entire month.
Please note that this report relates to performance throughout August 2016 unless otherwise stated

# 1. EXECUTIVE SUMMARY
## August 2016

**Progress this month**

- There has been a very small number of activities for completion in August, with 100% of scheduled activities completed.
- The CQC carried out an unannounced inspection on the 2nd and 3rd of August specifically relating to the Warning Notice that was issued. We are still awaiting their report which is expected in September.
- The Trust received notification from the CQC that they will be undertaking an inspection of NHS 111 on 29th and 30th September 2016.
- The activities that are delayed or reporting at risk relate to:
- The roll out of pan-London process for pre-booking palliative care patients which was due to be delivered at the end of July. This was delayed due to a CQC visit at the pilot site. This roll out is now expected to be delivered in September.

| Theme | Executive Director | # Complete | % Complete | RAG |
|---|---|---|---|---|
| Making LAS a great place to work | Karen Broughton | - | - | |
| Achieving good governance | Sandra Adams | 2/2 | 100% | |
| Improving patient experience | Briony Sloper | - | - | |
| Improving environment and resources | Andrew Grimshaw | - | - | |
| Taking pride and responsibility | Fenella Wrigley | - | - | |

# EXECUTIVE SUMMARY


Areas where we achieved good performance:

### Theme 1 – Making the LAS a great place to work

The Trust, in August, has started to report on the LAS people picture which gives a snapshot of in-post staff against establishment across the sectors.

- Frontline starters exceeded the August target with 68 wte frontline starters against a plan of 50. We achieved the target of 50wte paramedic starters this month with 17 international paramedics and 33 UK graduate.
- Trained Emergency Ambulance Crew (TEAC) starters exceeded the planned target this month with 12 wte starting in August.
- Staff turnover has remained consistently below the targeted threshold of 15%, with a 9.7% turnover in August . We can also report that Frontline leavers continues to remain below 33 wte at 20wte for this month.
- As at 25th of August, a total of 515 staff have attended the Bullying and Harassment workshops exceeding the target of 450 attendees.

### *Theme 2 – Achieving good governance*

- The Trust has trained 85% of managers in risk management, achieving our quarterly target of 85% and can also report that 90% of local risk registers were up to date in Q1 of 2016/17 achieving above the target of 85%.
- 100% of Serious Incidents (SIs) reported on the Strategic Executive Information System (STEIS) within 48 hours has consistently been achieved month on month for the year to date.
- There has been an increase on the July figures in patient and staff safety incidents reported in DatixWeb within 4 days this month. The reporting of patient safety incidents have exceeded the target of 85%, achieving 88% this month whilst reporting of staff safety incidents has attained the 85% target.
- Duty of Candour (DoC) training has been completed by 92% of frontline staff in the year so far, against a target of 85%.
- The Emergency Operations Centre (EOC) management surgeries continue to be held at Bow and LAS Head Quarters in August, and in line with the planned trajectory

### Theme 3 – Improving patient experience

- The Patient Transport Service operated within its 60 minute contracted departure time in 96% of cases this month, exceeding the 95% target.

### Theme 4 – Improving environment and resources

- The improved capture of 24 hour vehicles has resulted in 98% of vehicles entering the clean and equip process, both in the North East pilot area and across the whole Trust, exceeding the target of 95% in both cases.
- The North East area pilot continues to maintain 100% of vehicles made ready with essential kit.
- The Trust continues to exceed the 95 % target in August with; 12 week cycle planned vehicle maintenance and servicing against schedule(97%), vehicles deep cleaned as a rolling average every 6 weeks (100%) and planned vehicle maintenance completed within a 48 hour period (98%).
- Unplanned jobs (defects) also continues to achieve above the 90% target in August reaching 96% within the 48 hour period.
- The number of double crewed ambulances (DCA) available against peak vehicle requirements continues to exceed the 99% target, where we have provided 112% of the requirement.
- There was a 98% pass rate of stations cleaning audits in July, this KPI is reported one month retrospectively.

### Theme 5 – Taking pride and responsibility

- An audit of patient report forms (PRFs) conducted in the July showed that 98% of PRFs included a drug pack code, this KPI is reported one month retrospectively.
- In July there was 100% of drug safe codes changed which are in line with the plan to change them each quarter.

# EXECUTIVE SUMMARY


Additional focus is still required in the following areas:

**Theme 1 – Making the LAS a great place to work**

- There was a slight drop in the take up of CSR 2016.2 training in August against the target of 21%. Although 449 staff completed the training in August, we are reporting at 14%. There will be continued effort to identify the reasons for under performance in August with additional focus to ensure September's target is met.
- A total of 1,659 appraisals were completed by August which amounts to 35%; this is below the trajectory of 71% completion rate. Corporate areas have been able to improve the appraisal rate since July, reporting 83% in August.
- There were no Bullying & harassment cases resolved within 28 days in August. There are 2 open cases which are on-going at present that we will be reporting on in September.
- There was an underperformance in Director visits this month; many Directors had periods of annual leave throughout August which had an impact on the scheduled visits.

**Theme 2 – Achieving good governance**

- There has been an under performance in responding to complaints within 35 days in August. The Trust had 25 complaints that had not been responded to within this time scale. There has however, been a month on month improvement in reducing the amount of complaints responded to with 35 days since April 2016.
- Investigations and reports were completed within 60 days of an Serious Incidents being declared in only 22% of cases in August, against the target of 85%. Further training for investigators will be taking place in September to help reduce completion time. This issues is regularly raised at Executive Leadership Team to ensure plans are in place to resolve overdue investigations.

**Theme 3 – Improving patient experience**

- Handover to green took place within 15 minutes in 59% of cases in August against a target of 90%, which is below the 90% target. Progress against an action plan is regularly monitored and will align with the outcome of the external review of the Trust's job cycle time.

**Theme 4 – Improving environment and resources**

- In August, 64% of shifts had four blankets available against a target of 95%. The vehicle preparation team will be actively monitoring and ensuring adequate blankets are provided at the start of shift to improve the availability of blankets.
- During August, 94% of HART shifts had been filled against a target of 100%. The Trust have now agreed to increase the HART establishment by up to 14 staff and the recruitment of these staff commenced in the week beginning 1st August 2016.

**Theme 5 – Taking pride and responsibility**

- Last month 76% of eligible patient report forms were audited against a target of 95%. There have been variable audit rates across the Service with a continued effort to ensure sectors complete all audits.
- 26% of frontline staff completed at least one operational workforce review (OWR) in August, below the planned trajectory of 42%. There are plans for progress rates per sector to be shared with Assistant Directors of Operations as well as a review of staff eligible for OWR to improve completion rates.

# 2. PROGRAMME SUMMARY
## Forecast View

**Programme:**

- There are 35 activities to be delivered by the end of September 2016 which is high in comparison to previous months. Teams have spent time in August focussing on September deliverables to ensure the successful delivery of these activities.
- Preparation and planning for the CQC inspection of NHS 111 at the end of September. The provider information return (PIR) submission date is set for 1st September 2016.
- The development of the QIP assurance framework to deliver an audit plan in preparation for the CQC re-inspection.

| | | Sept 2016 | | | | Oct 2016 | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Theme** | **Executive Director** | Complete | On Track | Delayed | At Risk | Complete | On Track | Delayed | At Risk |
| Making LAS a great place to work | Karen Broughton | | 7 | | | | 3 | | |
| Achieving good governance | Sandra Adams | | 10 | | | | 0 | | |
| Improving patient experience | Briony Sloper | | 3 | | | | 2 | | |
| Improving environment and resources | Andrew Grimshaw | | 8 | | | | 1 | | |
| Taking pride and responsibility | Fenella Wrigley | | 7 | | | | 1 | | |
| | **Total** | | 35 | | | | 7 | | |

# 3.Performance Dashboard 2016/17


| Page | Key Performance Indicator | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Theme 1 Making the LAS a great place to work** | | | | | | | | | | | | |
| 16 | Frontline recruitment | | | | | | | | | | | | |
| | Staff recommending LAS as place of work on Friends & Family tests | | | | | | | | | | | | |
| 17 | Frontline Starters | | | | | | | | | | | | |
| | Frontline Leavers | | | | | | | | | | | | |
| 18 | Paramedic Starters | | | | | | | | | | | | |
| | Trainee Emergency Ambulance Crew (TEAC) Starters | | | | | | | | | | | | |
| 19 | Staff (all) turnover to remain below 15% | | | | | | | | | | | | |
| | Staff sickness to remain below 5.5% | | | | | | | | | | | | |
| 20 | Bullying and harassment workshops | | | | | | | | | | | | |
| | Bullying and harassment cases resolved within 28 days | | | | | | | | | | | | |
| 21 | Staff trained in bullying and harassment investigations | | | | | | | | | | | | |
| | Clinical staff completing their Core Skills Refresher (CSR) training | | | | | | | | | | | | |
| 22 | Staff with all training recorded on an online system | | | | | | | | | | | | |
| | Appraisal Rates from April 2016 | | | | | | | | | | | | |
| 23 | Planned Director visits takes place | | | | | | | | | | | | |
| | **Theme 2 Achieving good governance** | | | | | | | | | | | | |
| 31 | Updated local risk registers | | | | | | | | | | | | |
| | Managers trained in risk management | | | | | | | | | | | | |
| 32 | Percentage of Serious Incidents (SIs) reported on STEIS within 48 hours of being declared | | | | | | | | | | | | |
| | Complaints Response (Over 35 days) | | | | | | | | | | | | |

# Performance Dashboard 2016/17

| Page | Key Performance Indicator | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Theme 2 Achieving good governance** | | | | | | | | | | | | | |
| 33 | Completed investigations and reports within 60 working days of a serious incident being declared | | | | | | | | | | | | |
| | Patient safety incidents reported on DatixWeb within 4 days of incident occurring | | | | | | | | | | | | |
| 34 | Staff safety incidents reported on DatixWeb within 4 days of incident occurring | | | | | | | | | | | | |
| | Frontline staff trained on Duty of Candour | | | | | | | | | | | | |
| 35 | Support staff trained on Duty of Candour | | | | | | | | | | | | |
| | Emergency Operations Centre (EOC) management surgeries held | | | | | | | | | | | | |
| 36 | Staff taking rest break during shift | | | | | | | | | | | | |
| **Theme 3 Improving patient experience** | | | | | | | | | | | | | |
| | Patient Transport Service patients will not wait longer than the 60 min contracted departure window | | | | | | | | | | | | |
| | Handover to green (ambulance conveyances/non blue calls) take place within 15 minutes | | | | | | | | | | | | |
| | Number of hours lost for arrival to handovers Over 15 minutes - LAS | | | | | | | | | | | | |
| **Theme 4 Improving environment and resources** | | | | | | | | | | | | | |
| 45 | Available vehicles that enter the clean and equip process in the North East area pilot | | | | | | | | | | | | |
| | Available vehicles that are made ready with essential kit in the North East area pilot | | | | | | | | | | | | |
| 46 | Available vehicles that enter the clean and equip process across the Trust | | | | | | | | | | | | |
| | Available vehicles that are made ready with essential kit across the Trust | | | | | | | | | | | | |

# Performance Dashboard 2016/17

| Page | Key Performance Indicator | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Theme 4 Improving environment and resources** | | | | | | | | | | | | | |
| 47 | Vehicle deep clean completed as a rolling average every 6 weeks | | | | | | | | | | | | |
| | 12 week cycle planned maintenance/servicing to be completed against schedule | | | | | | | | | | | | |
| 48 | Planned maintenance of vehicles to be completed within 48 hour target | | | | | | | | | | | | |
| | Unplanned jobs (defects) to be completed within 48 hours | | | | | | | | | | | | |
| 49 | Minimum of 4 blankets available at start of shift | | | | | | | | | | | | |
| | Number of Double Crewed Ambulances available against peak vehicle requirements | | | | | | | | | | | | |
| 50 | Number of station premises cleaning compliance audits passed | | | | | | | | | | | | |
| 51 | HART shifts will be fully staffed with 6 HART Officers per team 24/7 | | | | | | | | | | | | |
| **Theme 5 Taking pride and responsibility** | | | | | | | | | | | | | |
| 55 | Number of eligible Patient Report Forms (PRFs) audited per month | | | | | | | | | | | | |
| | Frontline staff completing one operational workplace review annually | | | | | | | | | | | | |
| 56 | Percentage of staff trained to the appropriate Safeguarding Level by year end | | | | | | | | | | | | |
| | Audited Patient Report Forms (PRFs) drug bag numbers recorded if applicable | | | | | | | | | | | | |
| 57 | Compliance with completion of drug pack forms | | | | | | | | | | | | |
| | Percentage compliance of drug code changes | | | | | | | | | | | | |

# 3.1 People Picture Dashboard 2016/17

| page | Sector | Staff Group | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|
| 24 | North Central | *Paramedics* | -26 | | | | | | | |
| | | *Non-paramedics* | -31 | | | | | | | |
| | East Central | *Paramedics* | 11 | | | | | | | |
| | | *Non-paramedics* | 5 | | | | | | | |
| | North East | *Paramedics* | 36 | | | | | | | |
| | | *Non-paramedics* | 14 | | | | | | | |
| 25 | North West | *Paramedics* | -31 | | | | | | | |
| | | *Non-paramedics* | -38 | | | | | | | |
| | West | *Paramedics* | 8 | | | | | | | |
| | | *Non-paramedics* | -53 | | | | | | | |
| 26 | South East | *Paramedics* | -40 | | | | | | | |
| | | *Non-paramedics* | -7 | | | | | | | |
| | South West | *Paramedics* | -1 | | | | | | | |
| | | *Non-paramedics* | 22 | | | | | | | |

# WORKSTREAM PROGRESS & KPI REPORTS

# 4.1| MAKING THE LAS A GREAT PLACE TO WORK

## Executive Lead: Karen Broughton

**HIGHLIGHTS THIS MONTH**

**Equality and Inclusion**

- Although there are no activities to be delivered in this project during August there has been substantial progress to ensure that deliverables scheduled in September are achieved.
- Existing recruitment and selection training has been reviewed and a revised development session on interview techniques was rolled out to managers in August 2016, which includes content about equality and diversity. In addition, current mandatory equality and inclusion training is under review and following evaluation will determine whether a separate equality and mandatory module should be delivered to managers on a regular basis.
- The interim equality and inclusion manager has worked closely with the Trust lead for developing the staff induction programme, and has made recommendations to improve information provided at induction, relating to equality and diversity .
- The Trust has continued to broaden their interaction with other organisations and groups to understand the equality and diversity issues . Representatives from the Trust have met with the Metropolitan Police to share their knowledge and experience of managing issues of racism in the organisation, and the interim equality and inclusion manager has also met the patients forum, who have made recommendations on a number of patient groups that we should engage with.

**Advert to Action**

- A new Interim Head of Recruitment has been appointed and commenced, undertaking a full review of the current function.
- Following the partial approval of the change request to realign the completion date for the redesign of the recruitment process, work is currently underway to ensure this is delivered in line with the new deadline.
- A paper was presented to the private session of the Trust Board, detailing the recruitment plan for the remainder of 2016 and the anticipated recruitment target for 2017/18 along with the assumptions undertaken as to the sources for the new recruits.

**Bullying and Harassment**

- Although there are no activities to be specifically delivered in August for this project, phase three of the bullying and harassment programme has been drafted and focuses on moving the resolution back to local managers to ensure a more timely response.
- A second ‘Day in the life of…’ event was held with Business Intelligence, NHS 111 and EOC being involved; 20 staff took part in the exercise which is arranged to reduce the perception of silo working through the Trust

# MAKING THE LAS A GREAT PLACE TO WORK

## Executive Lead: Karen Broughton


**HIGHLIGHTS THIS MONTH**

**Corporate Induction**

- Additional process and content meetings for Induction have been held following the rollout of the new programme. Some sessions have been further reviewed, a new evaluation survey monkey questionnaire is being sent and Recruitment representatives will now be at the opening of each Induction to deal with queries and concerns.
- The ESR/OLM Transformation Project has also mapped Recruitment processes which will further support the Induction and on-boarding process.
- Statutory and Mandatory sessions bespoke eLearning content has now been mapped against the National content to define use in the rollout of OLM as well as replace some of the face to face sessions within Induction so Induction content can be further enhanced to support new starters on-boarding to the organisation.

**Training**

- All work streams are now underway within the ESR/OLM Project and significant work has been identified within ESR and GRS as a result, ensuring that both systems have mirrored structures and positions are in the correct place.
- Further open NHS Employers/Zeal Supportive Leadership and Management Behaviour courses have been scheduled and content will include identification of behaviours aligned to the Trust's Vision and Values to be developed into a Trust Behaviour Model
- Appraisal / PDR reporting has been transformed by the ESR/OLM Transformation Project Manager and with the aforementioned changes to the hierarchies, structures and positions within the system will only enhance the reporting function when it moves over to ESR from GRS as per the work stream plan
- In line with QIP deadlines courses are now being identified across the Trust with their owners with processes now in place to support adding them to Oracle Learning Management

# MAKING THE LAS A GREAT PLACE TO WORK

## Progress – August 2016

| Deliverable | Lead | Aug 2016 | | |
|---|---|---|---|---|
| | | Complete | Delayed | At Risk |
| Advert to Action (Recruitment) | Julie Cook | | | |
| Bullying and Harassment | Karen Broughton | | | |
| Training | Karen Broughton | | | |
| Equality and Inclusion | Andrew Buchannan | | | |
| Vision and Strategy | Karen Broughton | | | |
| Supporting Staff | Karen Broughton | | | |
| Retention | Greg Masters | | | |
| Workforce and Organisational Development | Karen Broughton | | | |

| Outstanding actions |
|---|
| No milestones due in August. |

# MAKING THE LAS A GREAT PLACE TO WORK

## Forecast View

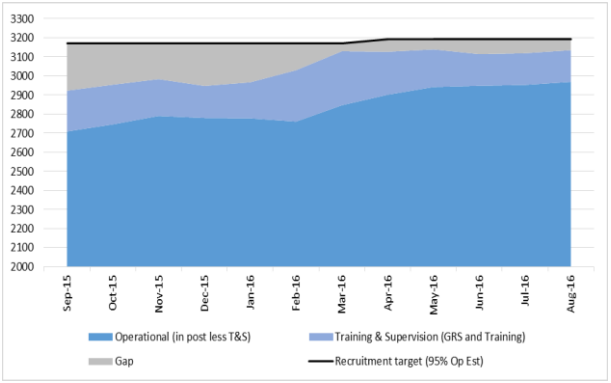
| Focus for next month | Key risks and challenges |
|---|---|
| • To complete the process mapping and subsequent redesign of the Graduate recruitment pipeline for 2017/18.<br>• Complete and sign off the third phase of bullying and harassment awareness training across the Trust, with further facilitated training courses currently organised in relation to mediation skills and complex allegation investigation training. | |

| Deliverable | Lead | Sept 2016 | | | | Oct 2016 | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Complete | On Track | Delayed | At Risk | Complete | On Track | Delayed | At Risk |
| Advert to Action (Recruitment) | Julie Cook | | 1 | | | | | | |
| Bullying and Harassment | Karen Broughton | | 2 | | | | | | |
| Training | Karen Broughton | | 1 | | | | | | |
| Equality and Inclusion | Andrew Buchannan | | 3 | | | | | | |
| Vision and Strategy | Karen Broughton | | | | | | 2 | | |
| Supporting Staff | Karen Broughton | | | | | | | | |
| Retention | Greg Masters | | | | | | | | |
| Workforce and Organisational Development | Karen Broughton | | | | | | 1 | | |

# MAKING THE LAS A GREAT PLACE TO WORK

## Frontline recruitment

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 3193 wte | 3135 wte | 58 | |

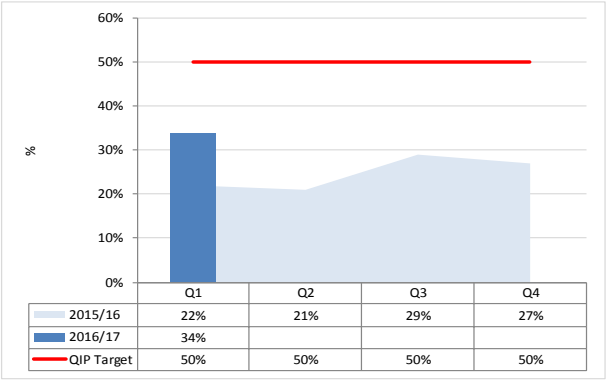



This graph shows all operational staff in post by month, including those in training and supervision. Our full establishment is 3,361 and we have a recruitment target of 3,193. This represents 95% of the establishment, or a 5% vacancy factor.

The A&E Resources Group is leading work to align the staff establishment and in post data across ESR, Finance, GRS and the People Picture. This work is progressing well and will improve the quality of reporting across all of these systems.

## Staff recommending LAS as place of work on Friends & Family tests

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 50% | Q1: 34% | 16% | |




| | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| 2015/16 | 22% | 21% | 29% | 27% |
| 2016/17 | 34% | | | |
| QIP Target | 50% | 50% | 50% | 50% |

Data showing here is for 2015/16 as a baseline for the 2016/17 reporting period.

Q1 saw an improvement from 27% to 34% compared with Q4 and there was a decrease in the numbers not recommending the LAS as a place to work from 60% to 53%. We also saw an increase from 68% to 73% for those staff recommending the LAS as a place to be treated. Response rates overall improved by 10%. This places us 8th out of the 10 Ambulance Trusts.

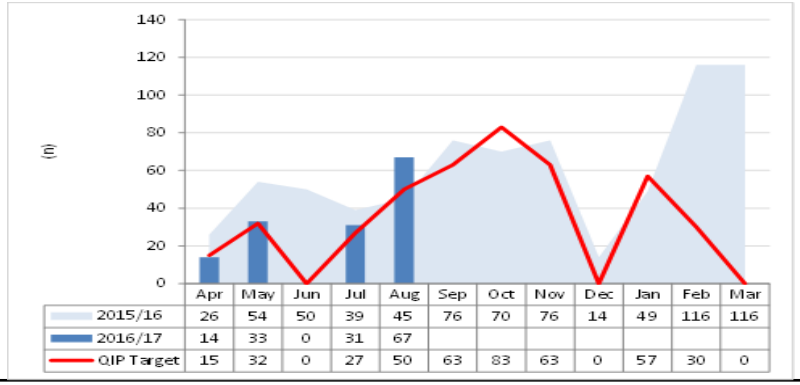
Q2 results covering July, August and September will be reported in the October KPI report.

Note: this survey is not completed during Q3 as this coincides with the National Staff Survey.

# MAKING THE LAS A GREAT PLACE TO WORK

## Frontline starters

| Planned – August 2016 | Actual | Variance | RAG |
|---|---|---|---|
| 50 wte | 67 wte | 17 | |



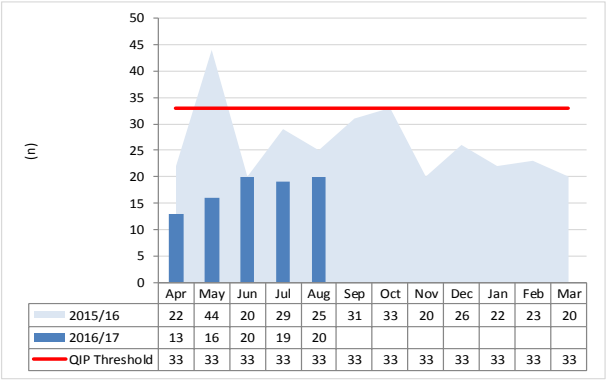

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 26 | 54 | 50 | 39 | 45 | 76 | 70 | 76 | 14 | 49 | 116 | 116 |
| 2016/17 | 14 | 33 | 0 | 31 | 67 | | | | | | | |
| QIP Target | 15 | 32 | 0 | 27 | 50 | 63 | 83 | 63 | 0 | 57 | 30 | 0 |

In August we had 67 frontline starters with 62 staff starting in Paramedic and Trainee Emergency Ambulance Crew roles.

The recruitment team are preparing to attend graduate events and job centre fairs in the coming weeks. This will also support the Trust's drive towards more localised recruitment.

## Frontline leavers

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| Below: 33 wte | 20 wte | 13 | |




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 22 | 44 | 20 | 29 | 25 | 31 | 33 | 20 | 26 | 22 | 23 | 20 |
| 2016/17 | 13 | 16 | 20 | 19 | 20 | | | | | | | |
| QIP Threshold | 33 | 33 | 33 | 33 | 33 | 33 | 33 | 33 | 33 | 33 | 33 | 33 |

We had 20 wte frontline leavers in August (12 paramedics, 5 Emergency Ambulance Crews and 3 Emergency Medical Technicians).

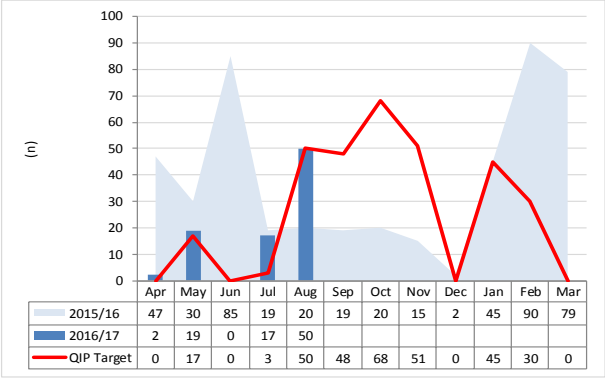
18 were unplanned resignations, 8 of which were for reasons of relocation and 3 for reasons of promotion.

The LAS staff leaver's form is being redesigned to improve the quality of data including the reason for leaving and the destination on leaving.

# MAKING THE LAS A GREAT PLACE TO WORK

## Paramedic starters

| Planned – August 2016 | Actual | Variance | RAG |
|---|---|---|---|
| 50 wte | 50 wte | 0 | |

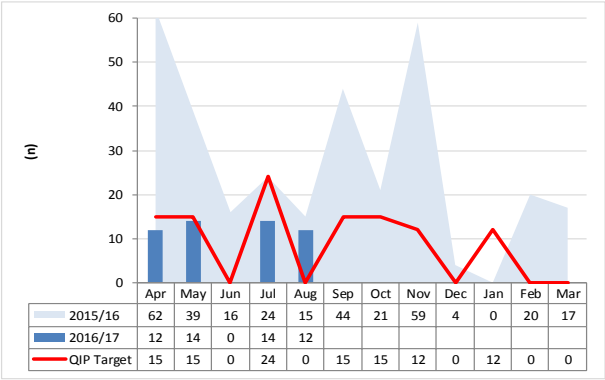



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 47 | 30 | 85 | 19 | 20 | 19 | 20 | 15 | 2 | 45 | 90 | 79 |
| 2016/17 | 2 | 19 | 0 | 17 | 50 | | | | | | | |
| QIP Target | 0 | 17 | 0 | 3 | 50 | 48 | 68 | 51 | 0 | 45 | 30 | 0 |

We have had 50 paramedics start with the LAS this month - 17 international paramedics and 33 UK graduates. There are a further 38 to start in September. Keeping in touch days have taken place with students at our partner universities.

## Frontline Starters - Trainee Emergency Ambulance Crew (TEACs)

| Planned – August 2016 | Actual | Variance | RAG |
|---|---|---|---|
| 0 wte | 12 wte | 12 | |




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 62 | 39 | 16 | 24 | 15 | 44 | 21 | 59 | 4 | 0 | 20 | 17 |
| 2016/17 | 12 | 14 | 0 | 14 | 12 | | | | | | | |
| QIP Target | 15 | 15 | 0 | 24 | 0 | 15 | 15 | 12 | 0 | 12 | 0 | 0 |

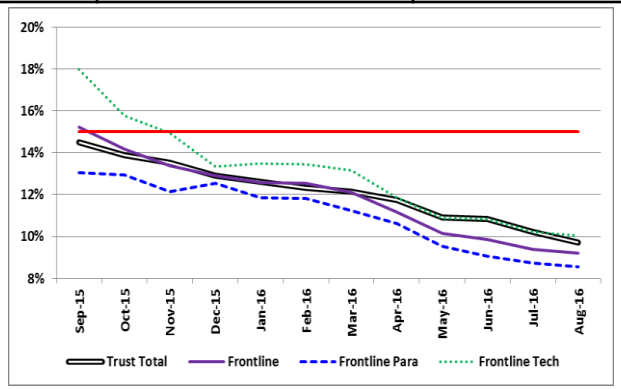
We had 12 TEAC starters in August.

From our recent TEAC advert, we now have over 100 candidates at assessment and interview stage.

# MAKING THE LAS A GREAT PLACE TO WORK

## Staff (all) turnover to remain below 15%

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| Below: 15% | 9.7% | 5.3% | |

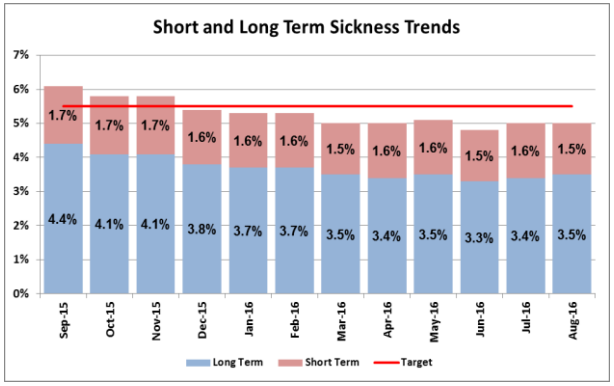



There was a further reduction in Trust turnover to 9.7%. We continue to see improvements in turnover rates for frontline paramedics and all frontline staff.

As part of the Quality Improvement Plan we are refreshing the retention strategy.

## Staff sickness to remain below 5.5%

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| Below: 5.5% | 5% | 0.5% | |



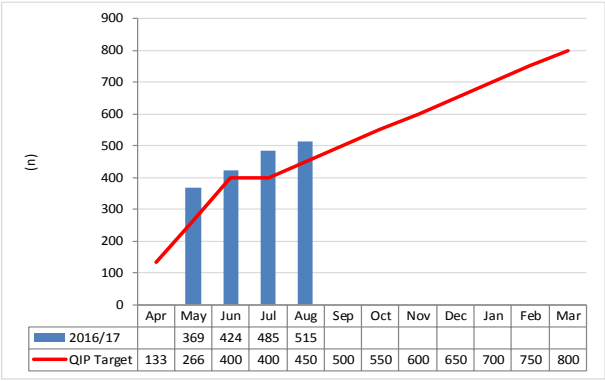

The sickness rate has remained at 5% - please note that this is accurate as at 25th August and may be subject to change. A national CQUIN has been set for health and wellbeing and the Trust has developed work plans to deliver three objectives which will contribute to reducing sickness absence levels.

The current ESR improvement programme has highlighted some process weaknesses and data inaccuracies. This includes some examples where sickness has not been accurately recorded. The process redesign work will address these challenges and improve both data quality and reporting.

# MAKING THE LAS A GREAT PLACE TO WORK

## Bullying and harassment workshops

| Target – August 2016 | Actual | Variance | RAG |
|---|---|---|---|
| 450 | Cumulative: 515 | 65 | |

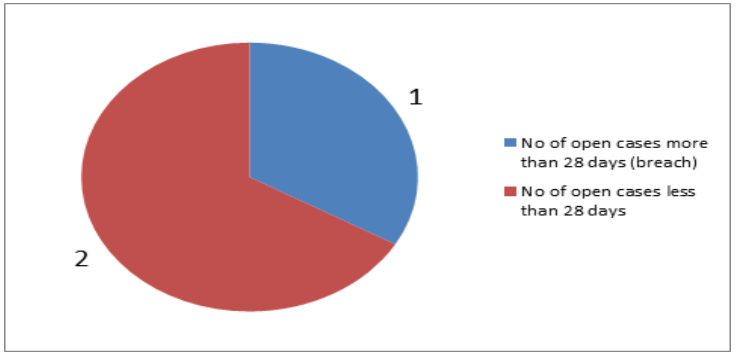



As at 25th August we have delivered over 500 sessions to staff. The original target of 400 has been doubled to 800 to be achieved by the end of March 2017. Sessions to date have been open to all staff, covering a cross-section of both operational and support services staff and attendees have provided feedback on the benefits of working across different teams.

We have also held two 'Courageous Conversations' workshops (19 staff) and launched our mediation workshop (60 staff).

## Bullying and harassment cases resolved within 28 days

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 100% | 0 | 100 | |

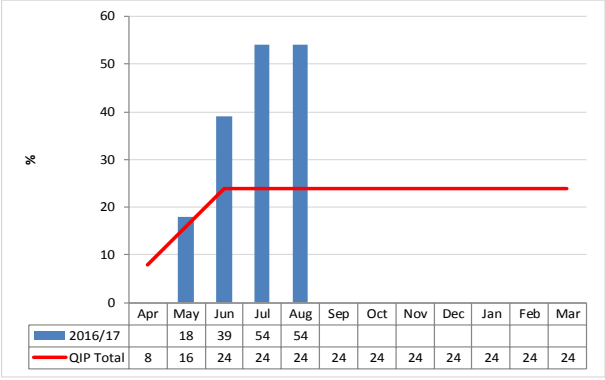



As at 30th August there were three formal bullying and harassment cases, one of which has breached this indicator. This information is currently taken from two data sources. From September all data will be reported from ESR. The Trust's Bullying and Harassment Specialist has started to capture data which reflects the significant activity they undertake to support and advise staff and managers in bullying and harassment issues. This work accounts for approximately 25%- 30% of the Specialist's time and should have a positive impact in avoiding formal cases, staff well-being and retention. This activity is increasing month on month due to the recent mediation workshops and communications.

# MAKING THE LAS A GREAT PLACE TO WORK

## Staff trained in bullying and harassment investigations

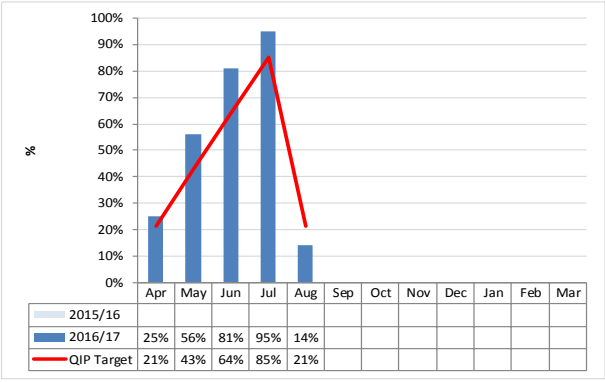
| Target – August 2016 | Actual | Variance | RAG |
|---|---|---|---|
| 24 | Cumulative: 54 | 30 | |




As planned there was no training held in August. We have delivered to a total of 54 staff this year, exceeding the QIP target. In September we will be running advanced complex investigations training in response to requests from staff to enhance their skills (19 staff).

## Clinical staff completing their Core Skills Refresher (CSR) training

| Target – August 2016 | Actual | Variance | RAG |
|---|---|---|---|
| 21% | 14% | 7.3% | |




In August, 449 staff attended CSR training and this represents 14% attendance against the target of 21%.

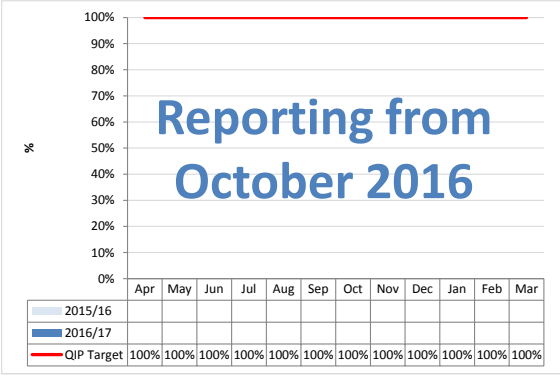
CSR 2016.2 training modules include:
Maternity
Advanced Life Support
Documentation
Manual Handling
Equality & Diversity

85% is the target for the four month duration of this particular CSR programme.

# MAKING THE LAS A GREAT PLACE TO WORK

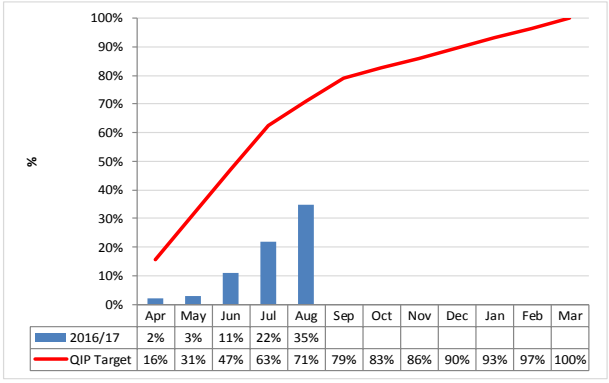
## Staff with all training recorded on an online system

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 100% | | | |




## Appraisal rates from April 2016

| Target – August 2016 | Actual | Variance | RAG |
|---|---|---|---|
| 71% | Cumulative: 35% | 36% | |




Since April there have been 1,659 appraisals completed. This figure excludes any staff not at work (long-term sickness, secondment, career break) and those who have worked for less than 9 months.

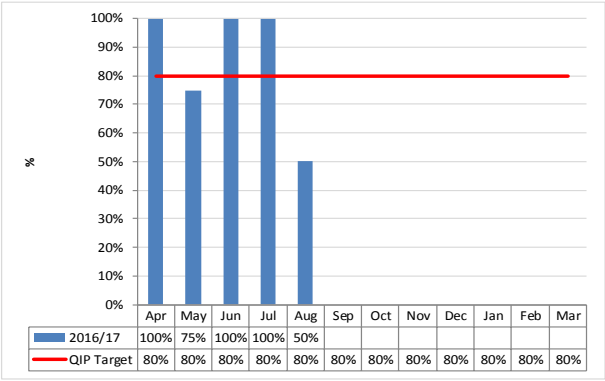
Corporate areas achieved 75% against their target of 100% as at the 31st July. This improved in August to 83%.

Appraisal reporting - managers have highlighted some data errors and these are being addressed. This will improve our data quality and reporting.

# MAKING THE LAS A GREAT PLACE TO WORK

## Planned Director visits take place

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 80% | 50% | 30% | |




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 100% | 75% | 100% | 100% | 50% | | | | | | | |
| QIP Target | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% |

Andrew Grimshaw Visited North Central with Peter Rhodes, Fionna Moore undertook several Staff engagement visits including clinical shifts throughout August. Many of the Directors had periods of Annual Leave throughout August which has resulted in a shortfall of 30% variance in August's Director visits. There were various other engagements including long service awards and a staff funeral of which, some directors represented the service. (These interactions have not been factored into August's numbers as they are not 'planned Director Visits')

# MAKING THE LAS A GREAT PLACE TO WORK

## PEOPLE PICTURE

| Sector | Group Station | | Aug | | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|
| North Central | Camden | *Paramedics* | 3 | 102.9% | | | | | | | |
| | | *Non-paramedics* | -13 | 81.8% | | | | | | | |
| | | *All* | -10 | 93.9% | | | | | | | |
| | Edmonton | *Paramedics* | -23 | 79.1% | | | | | | | |
| | | *Non-paramedics* | -8 | 90.3% | | | | | | | |
| | | *All* | -31 | 83.7% | | | | | | | |
| | Friern Barnet | *Paramedics* | -6 | 91.3% | | | | | | | |
| | | *Non-paramedics* | -11 | 80.8% | | | | | | | |
| | | *All* | -16 | 86.6% | | | | | | | |
| East Central | Homerton | *Paramedics* | 14 | 114.2% | | | | | | | |
| | | *Non-paramedics* | 3 | 103.7% | | | | | | | |
| | | *All* | 17 | 109.7% | | | | | | | |
| | Newham | *Paramedics* | -3 | 97.9% | | | | | | | |
| | | *Non-paramedics* | 3 | 102.8% | | | | | | | |
| | | *All* | 0 | 99.9% | | | | | | | |
| North East | Romford | *Paramedics* | 36 | 128.5% | | | | | | | |
| | | *Non-paramedics* | 14 | 114.6% | | | | | | | |
| | | *All* | 50 | 122.5% | | | | | | | |

# MAKING THE LAS A GREAT PLACE TO WORK

## PEOPLE PICTURE

| Sector | Group Station | | Aug | | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|
| North West | Hillingdon | *Paramedics* | -9 | 84.7% | | | | | | | |
| | | *Non-paramedics* | -4 | 91.4% | | | | | | | |
| | | *All* | -13 | 87.6% | | | | | | | |
| | Brent | *Paramedics* | -22 | 84.1% | | | | | | | |
| | | *Non-paramedics* | -34 | 66.4% | | | | | | | |
| | | *All* | -56 | 76.6% | | | | | | | |
| West | Hanwell | *Paramedics* | -8 | 92.3% | | | | | | | |
| | | *Non-paramedics* | -16 | 78.5% | | | | | | | |
| | | *All* | -24 | 86.4% | | | | | | | |
| | Fulham | *Paramedics* | 11 | 113.0% | | | | | | | |
| | | *Non-paramedics* | -25 | 60.9% | | | | | | | |
| | | *All* | -14 | 90.3% | | | | | | | |
| | Westminster | *Paramedics* | 5 | 109.7% | | | | | | | |
| | | *Non-paramedics* | -12 | 63.1% | | | | | | | |
| | | *All* | -7 | 92.0% | | | | | | | |

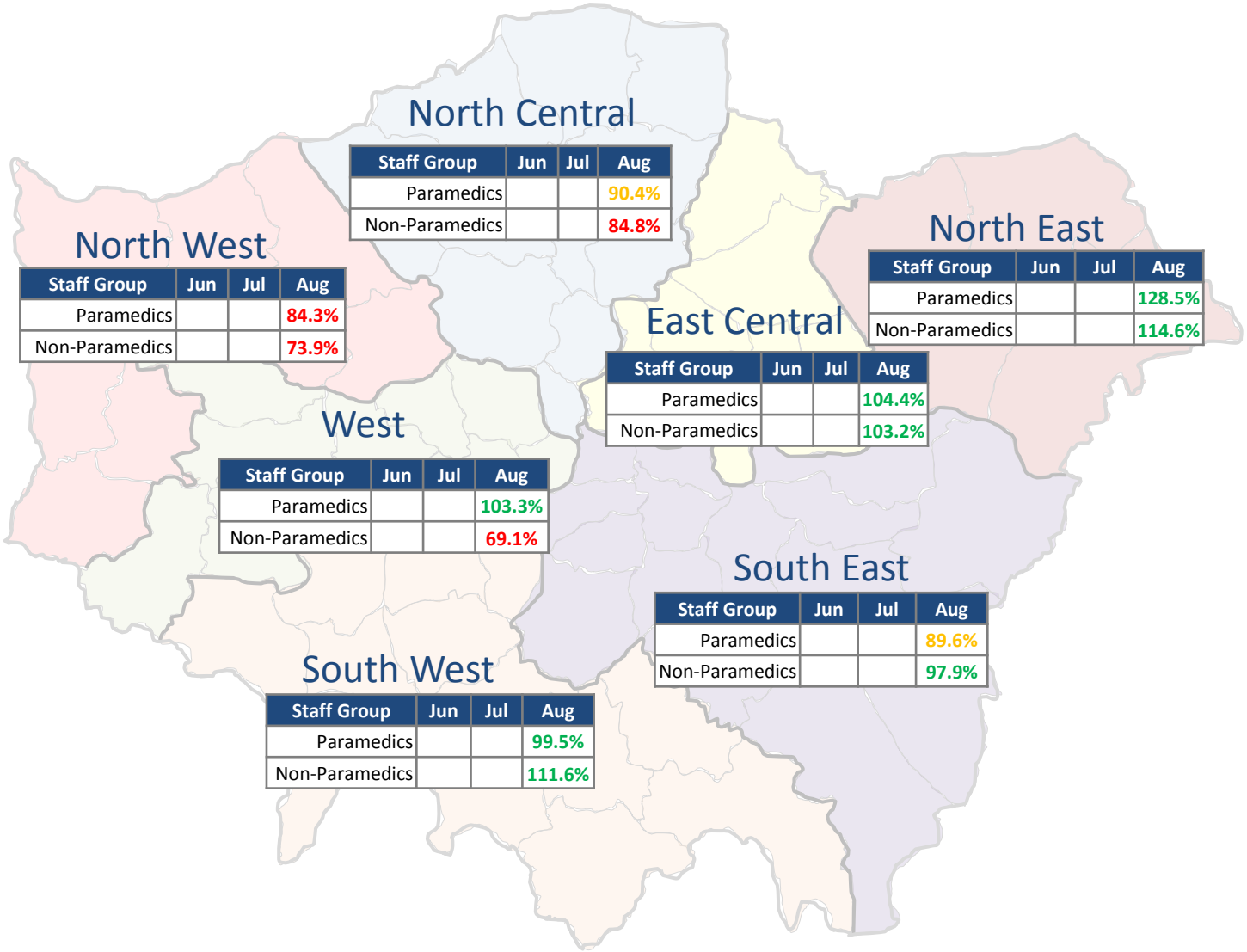
# MAKING THE LAS A GREAT PLACE TO WORK

## PEOPLE PICTURE

| Sector | Group Station | | Aug | | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|
| South East | Bromley | *Paramedics* | -34 | 68.7% | | | | | | | |
| | | *Non-paramedics* | 1 | 100.9% | | | | | | | |
| | | *All* | -34 | 82.4% | | | | | | | |
| | Deptford | *Paramedics* | -1 | 99.5% | | | | | | | |
| | | *Non-paramedics* | -10 | 92.9% | | | | | | | |
| | | *All* | -11 | 96.5% | | | | | | | |
| | Greenwich | *Paramedics* | -4 | 95.5% | | | | | | | |
| | | *Non-paramedics* | 3 | 103.9% | | | | | | | |
| | | *All* | -1 | 99.2% | | | | | | | |
| South West | Croydon | *Paramedics* | -8 | 86.1% | | | | | | | |
| | | *Non-paramedics* | 2 | 105.4% | | | | | | | |
| | | *All* | -6 | 94.5% | | | | | | | |
| | New Malden | *Paramedics* | 0 | 100.7% | | | | | | | |
| | | *Non-paramedics* | 15 | 140.0% | | | | | | | |
| | | *All* | 16 | 116.6% | | | | | | | |
| | St Helier | *Paramedics* | 1 | 101.8% | | | | | | | |
| | | *Non-paramedics* | 10 | 121.0% | | | | | | | |
| | | *All* | 11 | 110.0% | | | | | | | |
| | Wimbledon | *Paramedics* | 5 | 107.5% | | | | | | | |
| | | *Non-paramedics* | -6 | 88.9% | | | | | | | |
| | | *All* | -1 | 99.4% | | | | | | | |

# MAKING THE LAS A GREAT PLACE TO WORK

## PEOPLE PICTURE



### North Central

| Staff Group | Jun | Jul | Aug |
|---|---|---|---|
| Paramedics | | | 90.4% |
| Non-Paramedics | | | 84.8% |

### North West

| Staff Group | Jun | Jul | Aug |
|---|---|---|---|
| Paramedics | | | 84.3% |
| Non-Paramedics | | | 73.9% |

### North East

| Staff Group | Jun | Jul | Aug |
|---|---|---|---|
| Paramedics | | | 128.5% |
| Non-Paramedics | | | 114.6% |

### East Central

| Staff Group | Jun | Jul | Aug |
|---|---|---|---|
| Paramedics | | | 104.4% |
| Non-Paramedics | | | 103.2% |

### West

| Staff Group | Jun | Jul | Aug |
|---|---|---|---|
| Paramedics | | | 103.3% |
| Non-Paramedics | | | 69.1% |

### South East

| Staff Group | Jun | Jul | Aug |
|---|---|---|---|
| Paramedics | | | 89.6% |
| Non-Paramedics | | | 97.9% |

### South West

| Staff Group | Jun | Jul | Aug |
|---|---|---|---|
| Paramedics | | | 99.5% |
| Non-Paramedics | | | 111.6% |

# 4.2| ACHIEVING GOOD GOVERNANCE

## Executive Lead: Sandra Adams

**HIGHLIGHTS THIS MONTH**

**Improving Incident Reporting**

- The August Health & Safety newsletter was published on time and highlighted the way in which we audit our premises to ensure that they are fit for purpose, safe and well managed. A year planner has also been written identifying the main topics for each Health & Safety newsletter until the end of 2016/17. The year planner also identifies how ad hoc items will be identified each month through Datix reports, relevant items in the media or changes in legislation or local guidance.

**Policies & Guidance**

- The Policy Monitoring & Approval Group (PMAG) met on 3rd August to review and approve eight policies. The group also discussed and agreed which policies would be updated in time for the September meeting. The group has now met three times and has already made significant progress on reducing the number of out of date policies and will continue to do so going forward until all policies are up to date.

**Listening to Patients**

- Based on feedback from colleagues, audits have been undertaken by Fleet & Logistics to identify if there are stations where patient information leaflets are not routinely being put on ambulances. Where the audit identified gaps these are being addressed by the DDO for Fleet & Logistics and the Contract Manager for the Make Ready Service. Further audits will be undertaken to ensure that these gaps have been addressed.

# ACHIEVING GOOD GOVERNANCE

## Progress – August 2016

| Deliverable | Lead | Aug 2016 | | | Outstanding actions |
|---|---|---|---|---|---|
| | | Complete | Delayed | At Risk | |
| Risk Management | Sandra Adams | | | | |
| Capability and capacity of Health, Safety and Risk function | Sandra Adams | | | | |
| Improving incident reporting | Sandra Adams | 1 | | | |
| Duty of Candour | Sandra Adams | | | | |
| Operational planning | Paul Woodrow | | | | |
| Listening to patients | Fenella Wrigley | | | | |
| Blue light collaboration | Karen Broughton | | | | |
| CQC reinspection | Fionna Moore | | | | |
| Business intelligence systems | Jill Patterson | | | | |
| Internal audit | Sandra Adams | | | | |
| Policy and guidance review | Sandra Adams | 1 | | | |

# ACHIEVING GOOD GOVERNANCE

## Forecast View

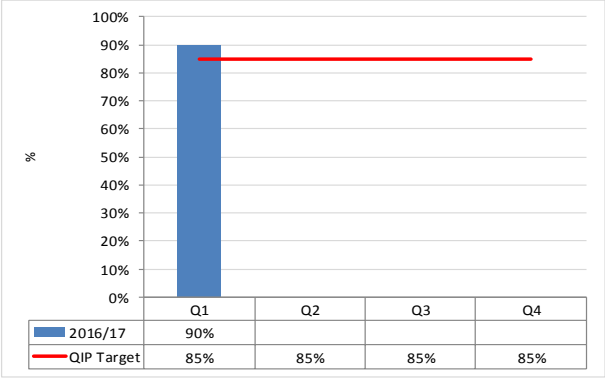
| Focus for next month | Key risks and challenges |
|---|---|
| • The majority of actions for September are on track or complete and focus will be on ensuring these do not slip.<br>• There is a probable delay to the full implementation of the Rest Break and Out of Service Policy: The rest break policy is currently in its first draft following a review of agreements in place at other Trusts. Talks are currently on going with the Trust Board and Executive Leadership Team as to how to proceed with the required negotiations. The Trust Board were fully updated by the Directors of Operations and Transformation, Strategy and Workforce during its private session this month in relation to the required actions.<br>• The Out of Service Policy has been re-written but implementation has been delayed pending further comments from senior ops colleagues. | |

| Deliverable | Lead | Sept 2016 | | | | Oct 2016 | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Complete | On Track | Delayed | At Risk | Complete | On Track | Delayed | At Risk |
| Risk Management | Sandra Adams | | 1 | | | | | | |
| Capability and capacity of Health, Safety and Risk function | Sandra Adams | | | | | | | | |
| Improving incident reporting | Sandra Adams | 1 | 1 | | | | 1 | | |
| Duty of Candour | Sandra Adams | | 1 | | | | | | |
| Operational planning | Paul Woodrow | | | 1 | | | | | |
| Listening to patients | Fenella Wrigley | | | | | | | | |
| Blue light collaboration | Karen Broughton | | | | | | | | |
| CQC reinspection | Fionna Moore | | 1 | | | | | | |
| Business intelligence systems | Jill Patterson | | | | | | | | |
| Internal audit | Sandra Adams | | 1 | | | | | | |
| Policy and guidance review | Sandra Adams | 1 | | | | | 1 | | |

# ACHIEVING GOOD GOVERNANCE

## Updated local risk registers

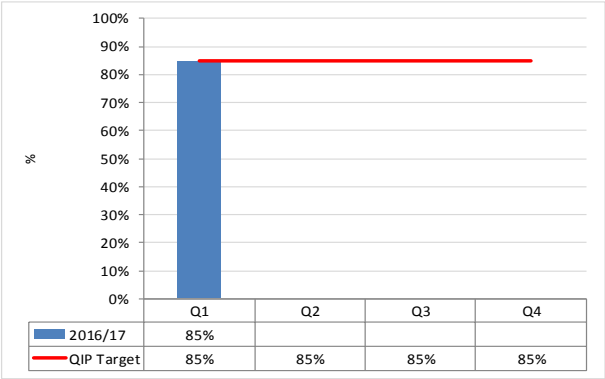
| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 85% | Q1: 90% | 5% | |




The Quarter 1 Risk Register review found that 90% of local Risk Registers were updated recently. In Quarter 2 the Trust has undergone the process of migrating Risk Registers from Excel to DatixWeb to allow for enabling more proactive Risk Management. All areas and Directorates migrated their local and Trust risks onto the risk module in Datix during June and July and there are now over 400 risks on the system. Since the rollout of the risk management training programme, more local risk registers are in place and are being reviewed within business and governance meetings.

## Managers trained in risk management

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 85% | Q1:85% | 0% | |

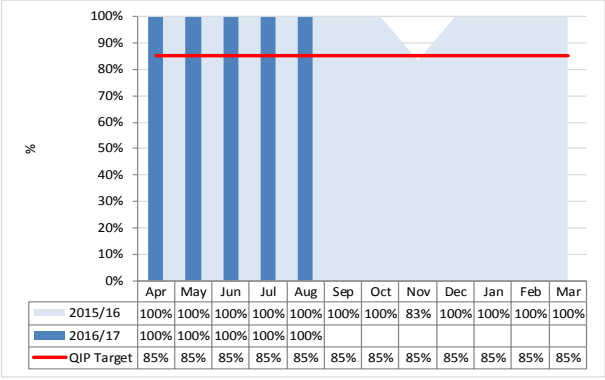



The organisation has trained 277 managers out of the 321 targeted for Risk Management training as of 25/08/16.
There are further sessions booked for September and October to train those staff still outstanding.

# ACHIEVING GOOD GOVERNANCE

## Percentage of Serious Incidents (SIs) reported on STEIS within 48 hours of being declared

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 85% | 100% | 15% | |

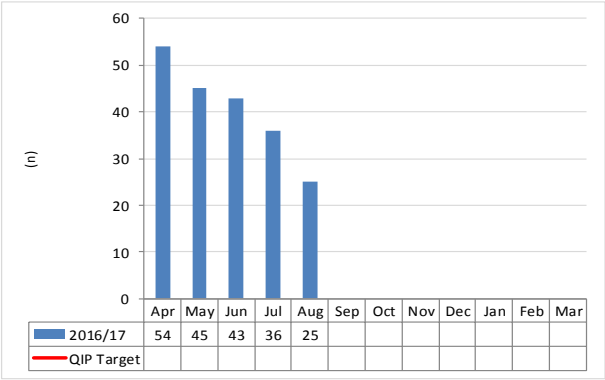



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 83% | 100% | 100% | 100% | 100% |
| 2016/17 | 100% | 100% | 100% | 100% | 100% | | | | | | | |
| QIP Target | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |

The Trust continues to meet this target for 100% of declared Serious Incidents.

## Complaints Response (Over 35 days)

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 0 | 25 | 25 | |



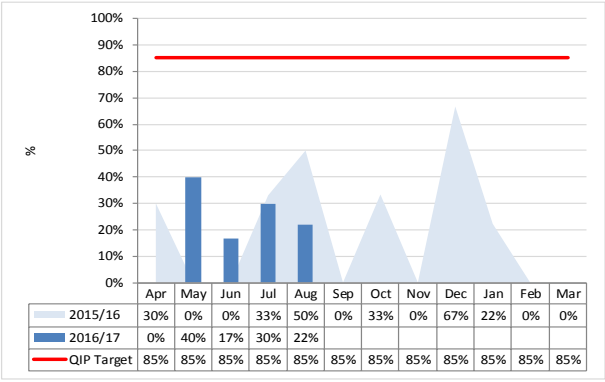

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 54 | 45 | 43 | 36 | 25 | | | | | | | |
| QIP Target | | | | | | | | | | | | |

Whilst there are still a number of complaint responses that have taken over 35 days in August, the data shows a month on month improvement with the number taking longer than 35 days.

# ACHIEVING GOOD GOVERNANCE

## Completed investigations and reports within 60 working days of a serious incident being declared

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 85% | 22% | 63% | |



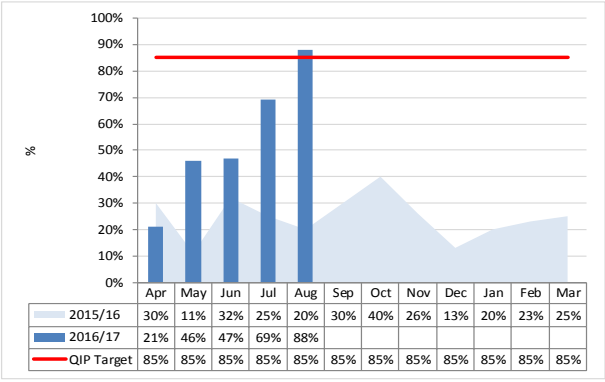

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 30% | 0% | 0% | 33% | 50% | 0% | 33% | 0% | 67% | 22% | 0% | 0% |
| 2016/17 | 0% | 40% | 17% | 30% | 22% | | | | | | | |
| QIP Target | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |

In the first 2 months of Q2 16/17 the LAS has submitted 19 Serious Incident (SI) reports, one more than the whole of Q1. The average time for completion for these SIs was 93 days, down from 107 the previous quarter. Of these, 3 were completed within 60 days in July and 2 within 60 days in August. The number of overdue reports is 2, down significantly on previous months and evidence of the work that has been done to reduce the backlog.

Further training is also taking place to increase the skillset of investigators and on investigation report writing for the Executive Leadership Team, all of which should help reduce time to completion. Course dates are booked for September.

## Patient safety incidents reported on DatixWeb within 4 days of incident occurring

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 85% | 88% | 3% | |




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 30% | 11% | 32% | 25% | 20% | 30% | 40% | 26% | 13% | 20% | 23% | 25% |
| 2016/17 | 21% | 46% | 47% | 69% | 88% | | | | | | | |
| QIP Target | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |

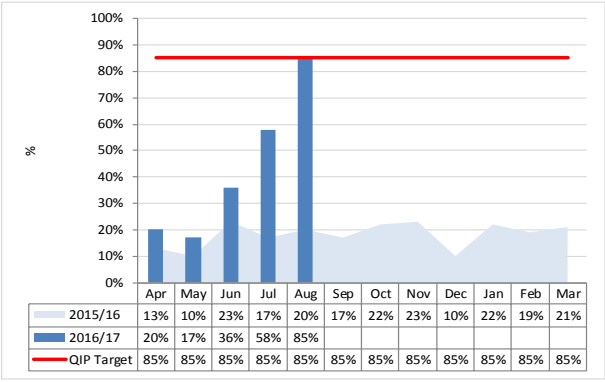
The average number of days to report incidents occurring in July was 6.43 days. 69% of all July patient safety incidents were logged onto DatixWeb within 4 days and as of 24/8/16, 88% in August, a continual increase on the previous months of reporting. This is the first time we have reached our target, having seen a month on month improvement from a starting point of 30% in April 2015/16 and an average of 25% in 2015/16.

The introduction of the functionality for staff members to call in to report incidents should see a further increase in meeting the 4 day timeframe in the coming months.

# ACHIEVING GOOD GOVERNANCE

## Staff safety incidents reported on DatixWeb within 4 days of incident occurring

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 85% | 85% | 0% | |



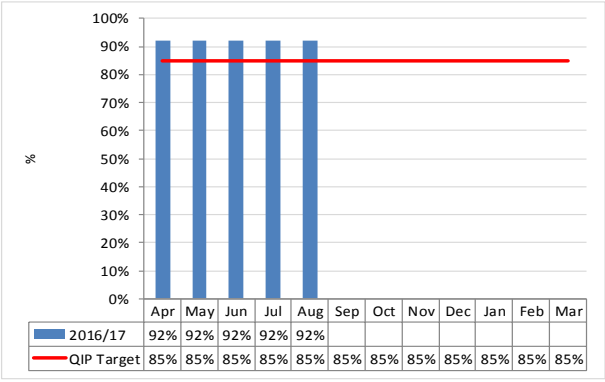

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 13% | 10% | 23% | 17% | 20% | 17% | 22% | 23% | 10% | 22% | 19% | 21% |
| 2016/17 | 20% | 17% | 36% | 58% | 85% | | | | | | | |
| QIP Target | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |

The average number of days in July between incident date and the date reported was 8 days, and 2.2 days in August. 59% of all staff safety incidents were logged onto Datix Web within 4 days in July and 85% in August to date. This represents a significant increase on the previous months of reporting.

The introduction of the functionality for staff members to call in to report incidents should see a further increase in meeting the 4 day timeframe in the coming months.

## Frontline staff trained in Duty of Candour

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 85% | 92% | 7% | |



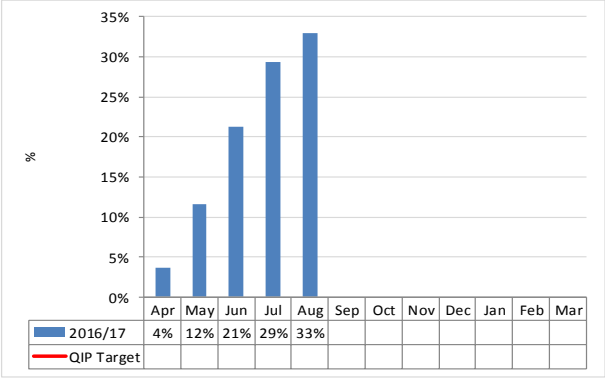

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 92% | 92% | 92% | 92% | 92% | | | | | | | |
| QIP Target | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |

Duty of candour training was deliver as part of the statutory and mandatory requirements for clinical staff in 2015/16. Duty of candour training is not required on a yearly basis and therefore all of the clinical staff who completed this training are still classed as being compliant.

# ACHIEVING GOOD GOVERNANCE

## Support staff trained in Duty of Candour

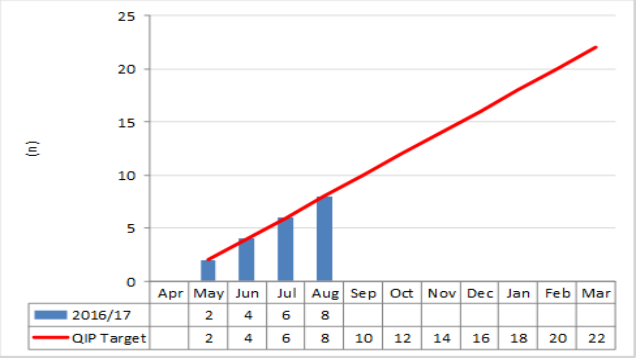
| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| [NA] | Cumulative: 33% | [NA] | [NA] |




This module is being delivered as E-learning and forms part of the statutory and mandatory training requirements for 2016/17. This data is correct as of Monday 22nd August.
A formal target for completion has not yet been set.

## Emergency Operations Centre (EOC) management surgeries held

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 22 | 2 (Cumulative: 8) | 0 | |

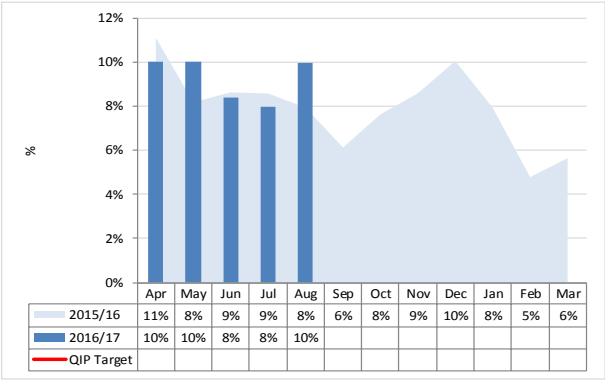



The August EOC Surgeries took place on 29th August at Bow have been planned & advertised for the following dates:
Bow, 29th August. 1100-1300
HQ, 30th August. 1100-1300

# ACHIEVING GOOD GOVERNANCE

## Staff taking a rest break during shift

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| [TBC] | 10% | [NA] | [NA] |




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 11% | 8% | 9% | 9% | 8% | 6% | 8% | 9% | 10% | 8% | 5% | 6% |
| 2016/17 | 10% | 10% | 8% | 8% | 10% | | | | | | | |
| QIP Target | | | | | | | | | | | | |

The number of staff taking a rest break during their shift has increased slightly this month. The work to determine the requirements and compliance with rest breaks is being aligned with the review of the rest break policy.

The initial review of the rest break policy was considered by the Executive Leadership Team on 13/07/2016 and further work is underway to understand the financial and operation impact of each of the different recommendations proposed. This will be resubmitted to ELT for further consideration and an agreed way forward.

# 4.3| IMPROVING PATIENT EXPERIENCE

## Executive Lead: Briony Sloper

**HIGHLIGHTS THIS MONTH**

**Patient Transport Service - Non Emergency Transport Service (NETS)**

The roll out of the pan London process for pre-booking palliative care pilot was delayed due to the CQC visit at the pilot hospice. Discussion with the pilot site continued in preparation to agree a start date that would not impact on any subsequent milestone. However, a number of clinical queries have arisen which we are aiming to resolve by the 9th September. We envisage starting the training on the system (pre-booking) week commencing 12/9/16 with a "go live" date scheduled for week commencing 19 September.

**Meeting people's needs**

Mental health – There has been continued communication on mental health continuing professional development and courses have continued to be rolled out throughout August.

Bariatric - A "show and tell "workshop was held on the 10 August with suppliers of potentially suitable specialist equipment. The workshop was followed by a further review of potential options by the Bariatric working group.

The team also went to Ashford to review the South East Coast Ambulance Service bariatric model to support the development of options for the London Ambulance Service.

# IMPROVING PATIENT EXPERIENCE

## Progress – August 2016

| Deliverable | Lead |
|---|---|
| Patient Transport Service (NETS) | Paul Woodrow |
| Meeting peoples needs | Briony Sloper/ Paul Woodrow |
| Response Times | Paul Woodrow |
| Learning from experiences | Briony Sloper |

| August 2016 | | |
|---|---|---|
| Complete | Delayed | At Risk |
| | 1 | |
| | | |
| | | |
| | | |

| Outstanding actions |
|---|
| There has been a delay in the rolling out of the pre-booking palliative care patients pilot which we are aiming to resolved by 9/9/16. An expected start date for training is 12/9/16 with the pilot starting week 19/9/16. |

# IMPROVING PATIENT EXPERIENCE

## Forecast View

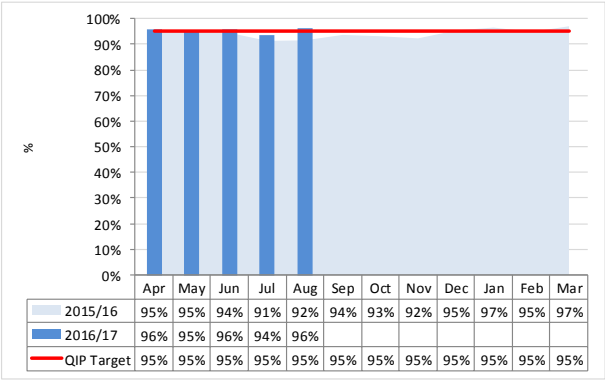
| | Key risks and challenges |
|---|---|
| • The will be a continued effort to ensure the NETS pilot goes live for- pre- booking palliative care patients in early September so that the learning from this pilot can be implemented. As there has been a slight delay on this deliverable it is expected that the review will now be carried out be early October. | |

| Deliverable | Lead | Sept 2016 | | | | Oct 2016 | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Complete | On Track | Delayed | At Risk | Complete | On Track | Delayed | At Risk |
| Patient Transport Service (NETS) | Paul Woodrow | | | 1 | | | | | |
| Meeting peoples needs | Fenella Wrigley/ Paul Woodrow | | | | | | | | |
| Response Times | Paul Woodrow | | 1 | | | | | | |
| Learning from experiences | Fenella Wrigley | | | | | | | | |

# IMPROVING PATIENT EXPERIENCES

## Patient Transport Service patients will not wait longer than the 60 min contracted departure window

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 95% | 96% | 1% | |



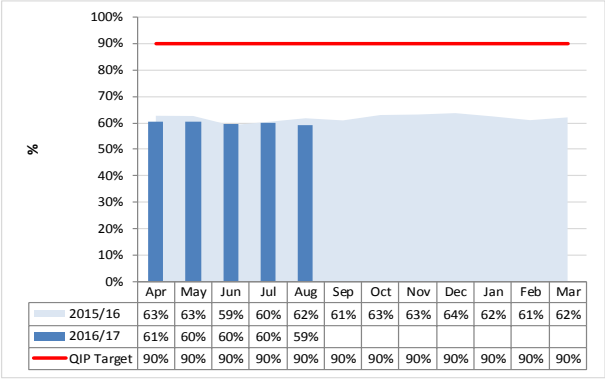

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 95% | 95% | 94% | 91% | 92% | 94% | 93% | 92% | 95% | 97% | 95% | 97% |
| 2016/17 | 96% | 95% | 96% | 94% | 96% | | | | | | | |
| QIP Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |

Performance increased by 2% in August to 96% above the 95% target.

Actions continue to review and improve areas where the departure window has been missed.

## Handover to green (ambulance conveyances/non blue calls) take place within 15 minutes

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 90% | 59% | 31% | |



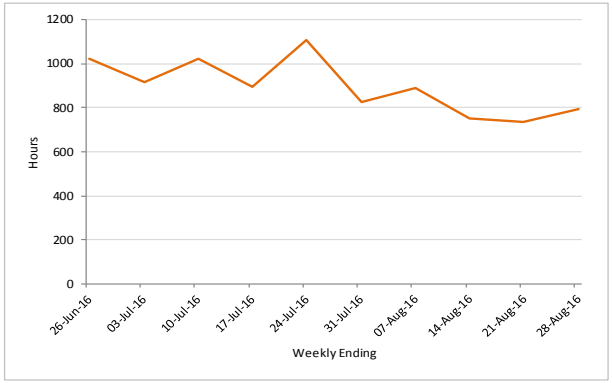

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 63% | 63% | 59% | 60% | 62% | 61% | 63% | 63% | 64% | 62% | 61% | 62% |
| 2016/17 | 61% | 60% | 60% | 60% | 59% | | | | | | | |
| QIP Target | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |

In August 2016, we achieved 59% of handovers to green within 15 minutes. An action plan has been developed to address and improve this position and continues to be implemented in Operations.
Progress against the action plan will be regularly reviewed by senior managers in the Operations Directorate as part of the newly introduced performance management framework. This action plan will be aligned with the outcome of the external review of the Trust's job cycle time.

# IMPROVING PATIENT EXPERIENCES

## Number of hours lost for arrival to Handovers Over 15 minutes - LAS

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| [NA] | 795 | [NA] | [NA] |




Over the last 10 weeks 27% (2,375 hours) of the total time lost for the LAS (8,963 hours) for handovers over 15 minutes originated entirely from Kings College, North Middlesex, Princess Royal Farnborough and Royal Free.

# 4.4| IMPROVE ENVIRONMENT AND RESOURCES

## Executive Lead: Andrew Grimshaw

**HIGHLIGHTS THIS MONTH**

**Information Management &Technology**

- A progress report detailing the mobile device trials has been submitted to ELT containing the option to accelerate the delivery of the CQUIN. A business case is currently being prepared for a full roll out by the end the end of the financial year. This will be dependent on securing additional capital funds from NHS England.

**Vehicle Make Ready**

- Two stakeholder meetings were carried out this month with Hanwell and Hillingdon staff. There are further meetings scheduled to occur in early September with Fulham and Brent staff members.
- The final draft roll out schedule has been developed with improved service offerings; this will be delivered to all hub sites by the end of March 2017.

**Vehicle Procurement**

- There has been continued work with Fast Response Unit (FRU) suppliers to deliver vehicles in accordance with the revised production plan. We expect to complete the procurement of all sixty vehicles by the end of September as planned.

**HART Recruitment – Standing Item**

- The Trust has eighty five whole time equivalent staff members in post against a establishment of 84 which is the National NARU specification. The final four new staff commenced their national training on the 1st August and are due to complete their full core training by September 2016.

# IMPROVE ENVIRONMENT AND RESOURCES

## Progress – August 2016

| Deliverable | Lead | August 2016 | | |
|---|---|---|---|---|
| | | Complete | Delayed | At Risk |
| Fleet / Vehicle Preparation | Andrew Grimshaw | | | |
| Information Management and Technology | Andrew Grimshaw | | | |
| Infection prevention and control | Fenella Wrigley | | | |
| Facilities and Estates | Sandra Adams | | | |
| Resilience functions | Paul Woodrow | | | |
| Operations Management | Paul Woodrow | | | |
| Improving operational productivity | Paul Woodrow | | | |
| Cost improvement programme | Andrew Grimshaw | | | |
| Frontline equipment and uniforms | Paul Woodrow / Andrew Grimshaw | | | |

| Outstanding actions |
|---|
| • No milestones due for August |

# IMPROVE ENVIRONMENT AND RESOURCES

## Forecast View

### Focus for next month

**Fleet/Vehicle Prep: Make Ready**
The project team will continue to progress with project planning activities relating to the Vehicle Preparation.
**Vehicle Procurement**
We will be working to ensure the procurement of Fast Response unit vehicles is completed.
The approval of the Double Crew Ambulance (DCA) business case is currently being sought.
**Fleet Strategy**
Work is being carried out to meet the September deliver date for the completion of the draft fleet strategy.
**Information Management & Technology**
There will be continued work on the implementation plan for the roll out of handheld devices to ensure completion in September.
**Infection Control and Prevention**
Protective clothing packs will be rolled out this month and made available to staff.
**Estate Strategy**
The Director of Finance is in the process of identifying and appointing external advisors to assist the Trust to complete this work.

### Key risks and challenges

**Vehicle Procurement**
**Fast Response Units – September Milestone**
Remains challenging due to on-going issues with supplier, currently 7 vehicles behind schedule however these vehicles are expected to be delivered in the September.

**Double Crew Ambulance – March Milestone**
Final Approval of business case not received from NHSI, until approval received the final date of completion of 140 vehicles can not be confirmed.

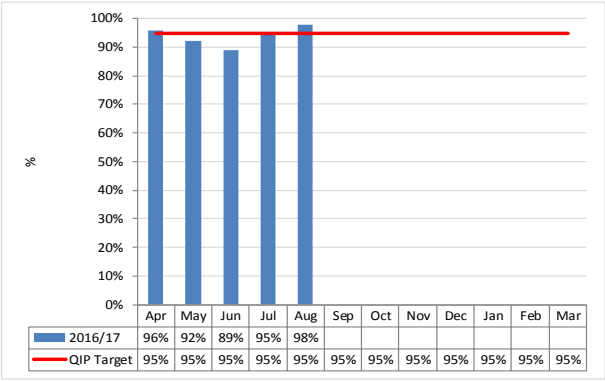
**Make Ready**
- Delivering Make ready by Mar 17 is at risk, this is being mitigated through VP Silver. A new schedule has been provided by contractor that shows an improvement at all hub sites by end of the financial year.

| Deliverable | Lead | Sept 2016 | | | | Oct 2016 | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Complete | On Track | Delayed | At Risk | Complete | On Track | Delayed | At Risk |
| Fleet / Vehicle Preparation | Andrew Grimshaw | | 3 | | | | | | |
| Information Management and Technology | Andrew Grimshaw | | 1 | | | | | | |
| Infection prevention and control | Fenella Wrigley | | 2 | | | | | | |
| Facilities and Estates | Sandra Adams | | 1 | | | | | | |
| Resilience functions | Paul Woodrow | | | | | | | | |
| Operations Management | Paul Woodrow | | | | | | | | |
| Improving operational productivity | Paul Woodrow | | | | | | | | |
| Cost improvement programme | Andrew Grimshaw | | | | | | | | |
| Frontline equipment and uniforms | Paul Woodrow / Andrew Grimshaw | | | | | | 1 | | |

# IMPROVING ENVIRONMENT AND RESOURCES

## Available vehicles that enter the clean and equip process in the North East area pilot

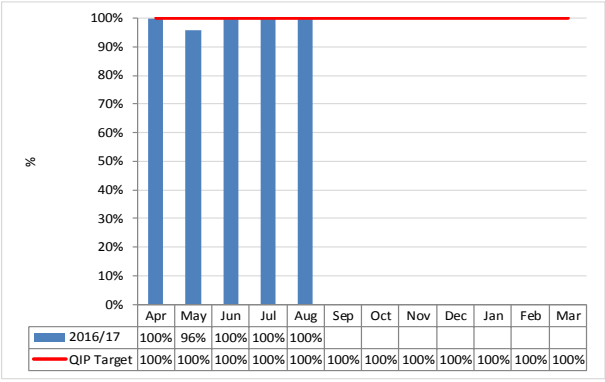
| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 95% | 98% | 3% | |




Improved Workshop performance has improved the availability to swap out 24 hour vehicles.

## Available vehicles that are made ready with essential kit in the North East area Pilot

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 100% | 100% | 0% | |

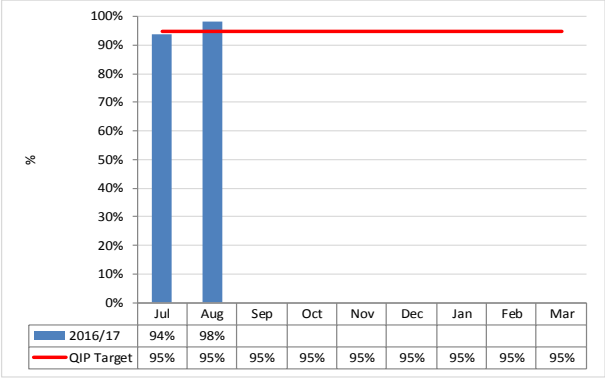



Robust performance is being maintained by North East Vehicle Preparation Hub.

# IMPROVING ENVIRONMENT AND RESOURCES

## Available vehicles that enter the clean and equip process across the Trust

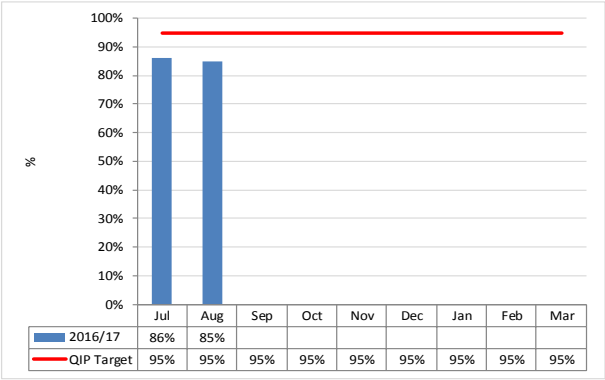
| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 95% | 98% | 3% | |




Workshop performance has assisted the improvement in this measure.

## Available vehicles that are made ready with essential kit across the Trust

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 95% | 85% | 10% | |

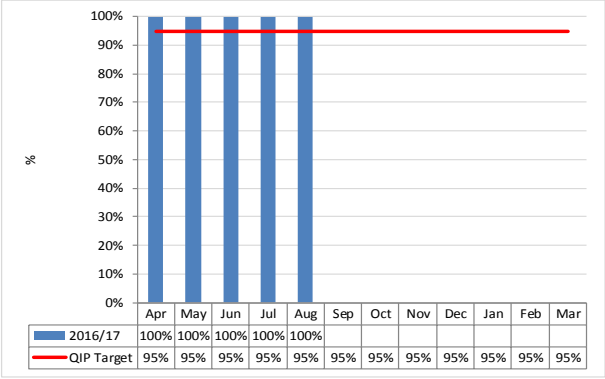



Results continue to be impacted by a large number of shell vehicles. The planned rollout of Vehicle Preparation Hubs in Autumn will further address this issue.
An action plan to refocus on current problems will also be implemented.

# IMPROVING ENVIRONMENT AND RESOURCES

## Vehicle deep clean completed as a rolling average every 6 weeks

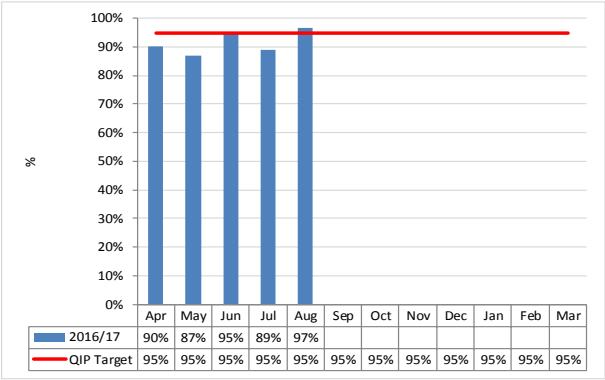
| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 95% | 100% | 5% | |




Robust performance is being maintained.

## 12 week cycle planned maintenance/servicing to be completed against schedule

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 95% | 97% | 2% | |

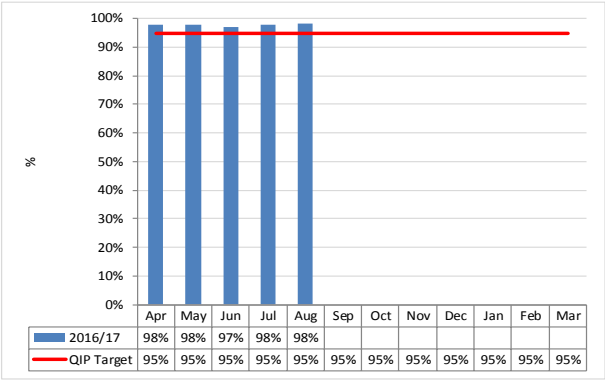



8% improvement in performance.

# IMPROVING ENVIRONMENT AND RESOURCES

## Planned maintenance of vehicles to be completed within 48 hour target

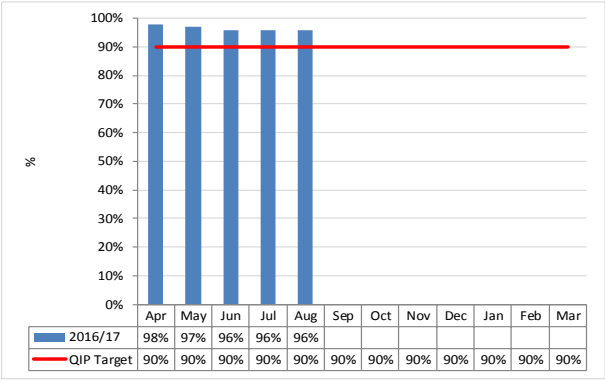
| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 95% | 98% | 3% | |




Good performance is being maintained.

## Unplanned jobs (defects) to be completed within 48 hours

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 90% | 96% | 6% | |

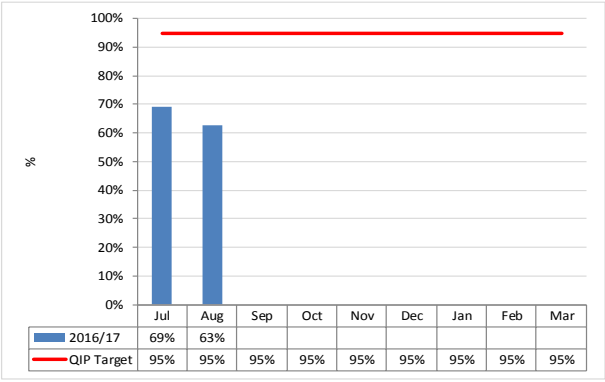



Performance maintained.

# IMPROVING ENVIRONMENT AND RESOURCES

## Minimum of 4 blankets available at start of shift

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 95% | 63% | 32% | |

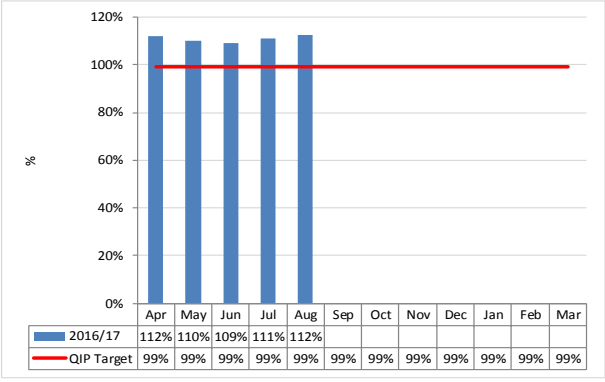



| | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 69% | 63% | | | | | | | |
| QIP Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |

Performance dropped in the week of 14th August despite the increased delivery of blankets to stations. Focus will be put on Vehicle Preparation teams to ensure adequate provision of blankets is being made and appropriately recorded.

## Number of double crewed ambulances (DCA) available against peak vehicle requirements

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 99% | 112% | 13% | |



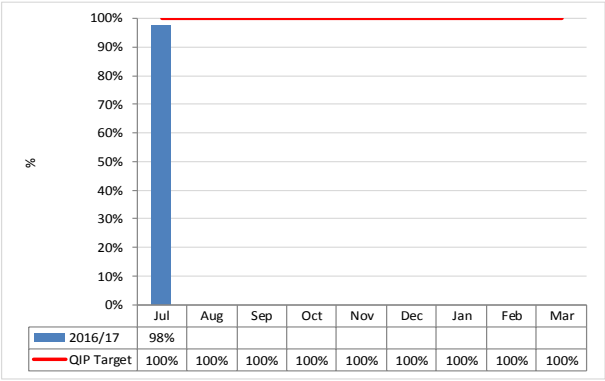

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 112% | 110% | 109% | 111% | 112% | | | | | | | |
| QIP Target | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% |

Robust performance maintained.

# IMPROVING ENVIRONMENT AND RESOURCES

## Number of station premises cleaning compliance audits are passed

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 100% | 98% | 2% | |



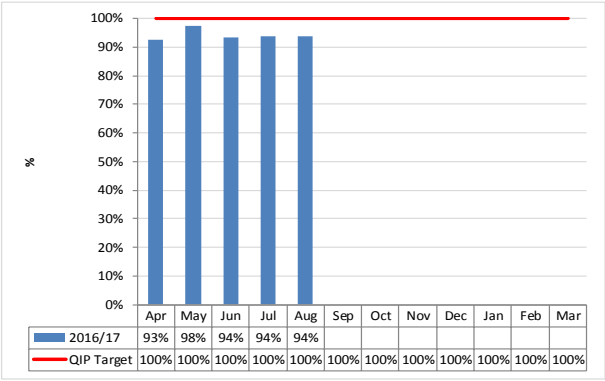

This KPI is reported one month retrospectively.

In July 2016 71 sites were audited by the cleaning contractor, 10 by local management and 7 by the estates department facilities manager. 88 Audits completed in total of which 98% achieved a pass rate of 90 or more.

# IMPROVING ENVIRONMENT AND RESOURCES

## HART shifts fully staffed with 6 officers per team 24/7

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 100% | 94% | 6% | |




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 93% | 98% | 94% | 94% | 94% | | | | | | | |
| QIP Target | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

In August, we achieved 94% compliance on filling HART shifts against a target of 100%. In line with the national specification, this KPI is required to achieve 100%.

HART rosters are reviewed on a daily basis to maximise capacity as far as possible and overtime incentives are offered to fill gaps in the rosters. The gaps experienced in August were due to staff being unavailable because of annual leave and training. The HART establishment of 84 does not take into account abstractions due to training, annual leave and short term sickness, which results in HART not always being able to produce two complete HART teams of six officers, 24 hours a day. To address this issue, work is currently underway with Working Time Solutions (a workforce optimisation company) to review HART rosters as a means of maximising cover. This work has identified that although changes to the annual leave agreement will improve roster reliability, the impact of on-day absences (such as sickness) can only be mitigated through increasing the HART establishment. The Trust undertook a review of internal capacity in order to establish the number of additional HART officers required. The Trust has now agreed to increase the HART establishment by up to 14 staff and the recruitment of these staff commences in the week beginning 1st August 2016.

In those current instances when two full HART teams are not available, we comply with the notification protocols required by NARU and we have systems in place to notify the London Fire Brigade and the Metropolitan Police Service. Our formal agreement with South East Coast Ambulance Service (SECAMB) to provide coverage at Heathrow at times when LAS HART staffing is incomplete was signed in December 2015 and is still active. While 6% of our HART shifts were incomplete in August, it should be noted that (as per our agreement with SECAMB) they did not have to move their HART assets on any of these occasions because our two HART teams always had more than ten officers on duty.

# TAKING PRIDE AND RESPONSIBILITY

## Executive Lead: Fenella Wrigley

**HIGHLIGHTS THIS MONTH**

**Medicine Management**

The Medicine Management off- the shelf e-learning modules has been reviewed. The Incident Response Officer spot checks continue to be carried out and provide useful data for benchmarking across the Trust.

The new style drugs usage form continues to demonstrate better levels of compliance when compared with the old style form. A promotional poster has been designed and distributed to all team leaders providing information on completion of the new style form to further improve compliance.

The new flu PGD has been signed and is ready for use and a meeting with Omnicell has been arranged in relation to future automated medicines management systems.

Key findings from the Greenwich pilot (management of station based drugs) are that the use of locally managed sealed drugs pouches has improved medicines management and reduced costs associated with wastage but this is a very time consuming, resource intensive process which has been feasible due to the presence of additional staff on restricted duties.

**Safeguarding**

The safeguarding training content for CSR 2016.3 was agreed by the safeguarding committee and will consist of:

- Youth Violence and Gangs
- Looked After Children
- Domestic Abuse
- Hoarding

The project manager for safeguarding supervision started in July and is currently undertaking an induction into the Trust followed by fact finding on supervision requirements.

**Clinical Supervision**

An audit of the Operational Workplace Review was undertaken by the consultant paramedics. The results from this audit suggest appreciable variation in quality and comprehensiveness of OWR paperwork. Variation in the type of OWR paperwork in use may also contribute to this variation. The recommendations from the review will be shared with the Operations Directorate.

**Mental Capacity Act**

Work is currently under way to evaluate the confidence in the application of the mental capacity act and the use of an online questionnaire.

# TAKING PRIDE AND RESPONSIBILITY

## Progress – August 2016

| Deliverable | Lead | Aug 2016 | | |
|---|---|---|---|---|
| | | Complete | Delayed | At Risk |
| Clinical supervision | Fenella Wrigley | | | |
| Consent MCA | Fenella Wrigley | | | |
| Medicine Management | Fenella Wrigley | | | |
| Safeguarding | Fenella Wrigley | | | |
| Quality and clinical strategy | Fenella Wrigley | | | |
| Operating model and clinical education & training strategy | Paul Woodrow / Karen Broughton | | | |
| Developing the 111 Service | Paul Woodrow / Karen Broughton | | | |

| Outstanding actions |
|---|
| • No milestones to be delivered in August |

# TAKING PRIDE AND RESPONSIBILITY

## Forecast View

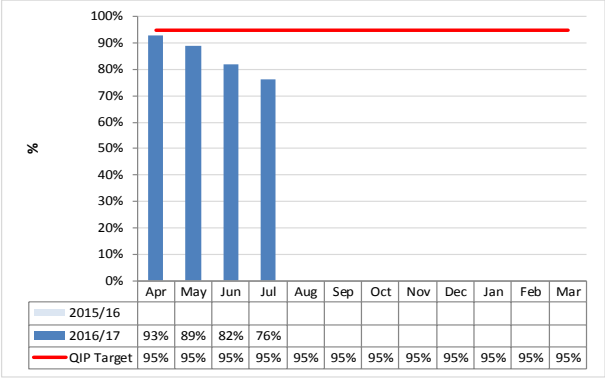
| Focus for next month | Key risks and challenges |
|---|---|
| • There will be a continued focus on all areas of Medicine Management in September to ensure milestones are met.<br>• Work also continues on the preparation for CSR2016.3 – safeguarding<br>• The project manager for safeguarding supervision will be working on scoping the elements of the plan. | |

| Deliverable | Lead | Sept 2016 | | | | Oct 2016 | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Complete | On Track | Delayed | At Risk | Complete | On Track | Delayed | At Risk |
| Clinical supervision | Fenella Wrigley | | | | | | | | |
| Consent MCA | Fenella Wrigley | | 1 | | | | | | |
| Medicine Management | Fenella Wrigley | | 1 | | | | | | |
| Safeguarding | Fenella Wrigley | | 4 | | | | 1 | | |
| Quality and clinical strategy | Fenella Wrigley | | | | | | | | |
| Operating model and clinical education & training strategy | Paul Woodrow / Karen Broughton | | | | | | | | |
| Developing the 111 Service | Paul Woodrow / Karen Broughton | | | | | | | | |

# TAKING PRIDE AND RESPONSIBILITY

## Number of eligible Patient Report Forms (PRFs) audited per month

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 95% | July: 76% | 19% | |



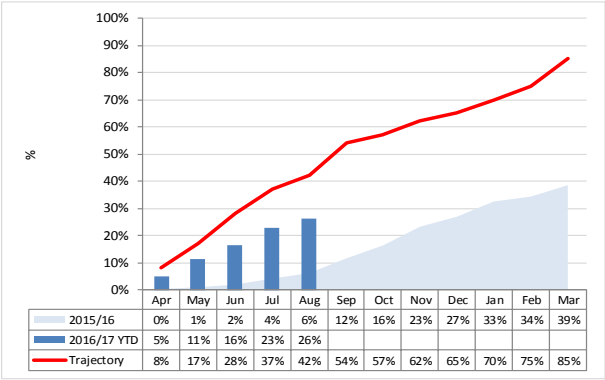

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | | | | | | | | | | | | |
| 2016/17 | 93% | 89% | 82% | 76% | | | | | | | | |
| QIP Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |

This KPI is reported one month retrospectively.

Overall CPI completion is at its lowest level since March 2015 and the proportion of audits undertaken varied across the Service. The North West Sector were the only sector to complete all available audits, followed by the North Central (95% completion) and South East (96% completion). In contrast, the East Central and North East Sectors achieved 49% and 64% completion respectively.
A reduction in completion was particularly evident at the Motorcycle Response Unit, New Malden, Newham, Romford and St Helier due to a reduction in the availability of Restricted Duties staff, vacant Team Leader positions and annual leave.
Edmonton, Friern Barnet, HART and Hillingdon audited all available PRFs for the 12th consecutive month. The Tactical Response Unit have also maintained 100% completion this financial year.

## Frontline staff completing one operational workplace review annually

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| August: 42% | Cumulative: 26% | 16% | |




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 0% | 1% | 2% | 4% | 6% | 12% | 16% | 23% | 27% | 33% | 34% | 39% |
| 2016/17 YTD | 5% | 11% | 16% | 23% | 26% | | | | | | | |
| Trajectory | 8% | 17% | 28% | 37% | 42% | 54% | 57% | 62% | 65% | 70% | 75% | 85% |

As anticipated, July's completion rate has increased since it was reported last month. This is because there is a lag between the OWR being conducted and the data being inputted by Clinical Team Leaders. In August a similar lag will occur, plus the data reported is a partial month with the cut-off date being 25th August.

Operational Workplace Review (OWR) completion rates continue to be behind trajectory. Last month the Deputy Director of Operations reminded Assistant Directors of objective 20 in the business plan (1 OWR per person per year) and this will be re-emphasised this month.

This month the following actions will be taken:
1. Progress rates per sector and group will be shared with ADOs for feedback and action with local teams.
2. The number of staff eligible for OWR will be reviewed as many staff are still in their first year of service.

# TAKING PRIDE AND RESPONSIBILITY

## Percentage of staff trained to the appropriate safeguarding level by year end

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 95% | | | |

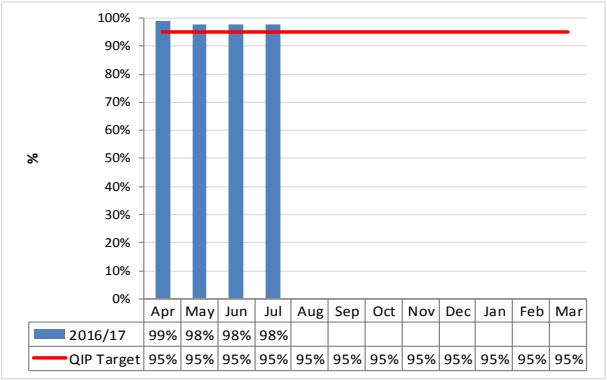
| | | April | May | June | July |
|---|---|---|---|---|---|
| Level One | Induction | 0 | 0 | 21 | 0 |
| | E learning | 48 | 53 | 71 | 172 |
| Level Two | New Recruits | 22 | 78 | 33 | 0 |
| | EOC CSR | 0 | 38 | 36 | 51 |
| | EOC New staff | 20 | 0 | 11 | 11 |
| | PTS/NETS | 0 | 9 | 56 | 0 |
| | 111 | 6 | 4 | 0 | 0 |
| Specific training | Trust Board | 4 | 3 | 0 | 0 |
| | Local Leads | 0 | 0 | 0 | 18 |
| Total | | 100 | 185 | 228 | 252 |

This KPI is reported one month retrospectively.

Safeguarding training is on track. The chart shows the number of staff trained each month. Of the 252 people trained in July, 172 completed this training through e-learning, 51 were reached through the new Emergency Operations Centre Core Skills Refresher programme and the remaining 29 through induction of new EOC staff or through local leads.

## Audited Patient Report Forms (PRFs) with drug bag numbers recorded if applicable

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 95% | July: 98% | 3% | |



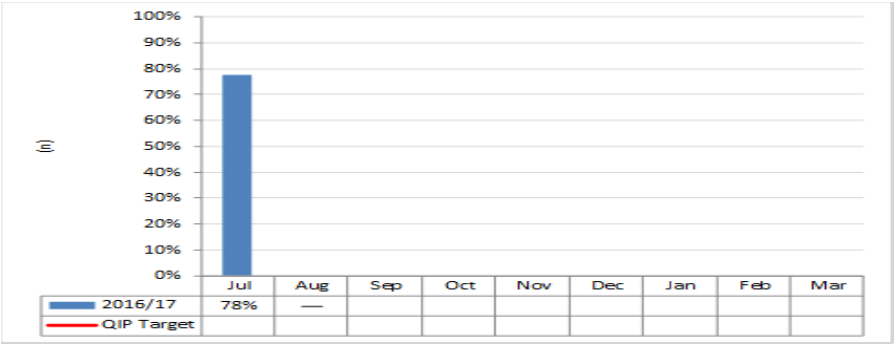

This KPI is reported one month retrospectively.

The number of PRFs which include a drug pack code following drug administration remain high at 98%.

# TAKING PRIDE AND RESPONSIBILITY

## Compliance with completion of drug pack forms

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| [NA] | - | [NA] | [NA] |



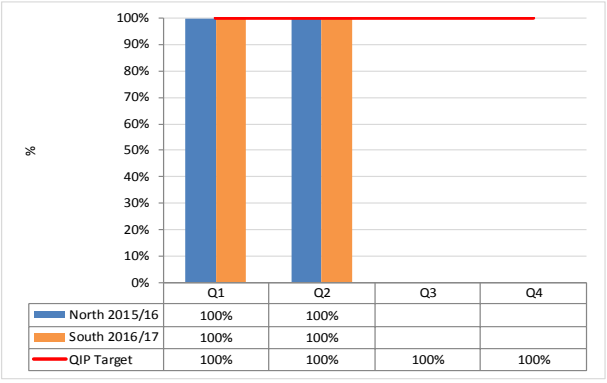

There is no reporting of this KPI this month due to a review of the data collecting process in August. This review will ensure that the data is collected in a way that correctly reflects compliance with completion of drug pack forms.

Reporting of this KPI will recommence in September.

Information has been disseminated to all crews through Team Leaders, education and the Routine Information Bulletin providing guidance on how to use the form and the need of completion.

## Percentage compliance of drug code changes

| Target 2016/17 | Actual | Variance | RAG |
|---|---|---|---|
| 100% | Q2:100% | 0% | |




The controlled drug safe code changes take place quarterly and have been facilitated in July for all stations, in line with regular communication from the Medical Directorate Medicine Management team.

The code change is checked and confirmed by the staff officers for the sector.

# 5. RISKS AND ISSUES

| Risk ID | Risk Description | Gross | Existing Controls (Already In Place) | Risk Owner | Net | Further Actions Required | Action Owner | Date Action to be Completed | Assurance Measures | Target Rating |
|---|---|---|---|---|---|---|---|---|---|---|
| 00-01 | The programme fails to achieve tangible outcomes in the first 6-12 months diminishing stakeholder support | 15 | • * In January 2016, the QIP narrative and milestone plan was published and provides detail of activities to be delivered during 2016/17<br>• * A robust governance and assurance framework for the QIP is in place to monitor achievement of scheduled activity, and regular reporting obligations to key stakeholders<br>• * A PMO has been established that will central monitor and review programme progress | Karen Broughton | 12 | * Executive Leads to regularly review upcoming activities, and to give an early indication of any potential risk to delivering project outcomes and to take steps to mitigate the risk or to escalate the matter to the QIG to seek assistance to resolve<br>* Programme KPIs have been set and should be regularly monitored by Executive Leads<br>* In April, Executive Leads have been asked to consider bringing forward activity which may have a positive impact on staff | QIP Exec Leads | ongoing - monthly review | • All assurance groups within the governance of the QIP should provide sufficient challenge to Executive Leads to ensure that tangible outcomes are achieved to time | 6 |
| 00-02 | The programme fails to engage stakeholders on the organisational changes taking place | 12 | • * In January 2016, the QIP narrative and milestone plan was published externally / internally and key stakeholders will have visibility of activities to be delivered as part of the QIP.<br>• * Stakeholders should be engaged early on in the process through the Quality Summit and LAS should seek to agree commitments<br>• * A communication and stakeholder engagement plan has been drafted to support the work of the QIP to ensure regular updates are provided to our stakeholder groups. | Karen Broughton | 8 | • Executive Leads to regularly review upcoming activities, and to give an early indication to stakeholders of their input required and to ensure there are mechanisms in place to communicate and consult on required changes. | QIP Exec Leads | ongoing - monthly review | • All assurance groups within the governance of the QIP should provide sufficient challenge to Executive Leads to ensure that tangible outcomes are achieved to time | 4 |

# RISKS AND ISSUES

| Risk ID | Risk Description | Gross | Existing Controls (Already In Place) | Risk Owner | Net | Further Actions Required | Action Owner | Date Action to be Completed | Assurance Measures | Target Rating |
|---|---|---|---|---|---|---|---|---|---|---|
| 00-03 | Funding proposals for resources or identified costs to deliver the QIP do not align with the outcome of 2016/17 contracting discussions with Commissioners, and therefore unaffordable. | 16 | • Indicative costs have been identified by each of the project workstreams, and will form the basis of contract discussions with Commissioners which is currently underway. However these costs may be subject to change as projects progress delivery of activities, and the outcome following option appraisals may require funding that was not known at the outset | Andrew Grimshaw | 12 | • * Executive Leads to consider other means of funding initiatives through existing budget or cost savings. If this is not possible, then a robust justification to be provided to ELT for further consideration<br>• * Ongoing discussions and refinement of the funding bid with Commissioners<br>• * As a result of this ELT review and commissioner conversations, any potentially unfunded activities that cannot be delivered will be raised urgently with ELT and the QIP Board | QIP Exec Leads | 30 June 2016 | • ELT have considered all requests for funding, and prioritised these into a funding bid to Commissioners.<br>• Exec discussions with lead Commissioner and SRG leads are ongoing.<br>• Programme finances will be a regular agenda item to be reviewed by ELT and QIP Board | 9 |
| 00-04 | Activities delivered as part of the QIP does not result in the impact anticipated or meet performance targets | 12 | • * In developing detailed project plans, Executive Leads should consider any dependencies that would negatively impact on the delivery or performance of their projects and to address any issues at an early stage<br>• * The TDA Improvement Director is in post and has regular meetings with the CEO and Programme Director on QIP performance 11/05/2016 Each sector within the organisation are required to develop a local action plan to deliver the QIP and progress will be reviewed on a monthly basis | Executive Leads | 8 | • * Executive Leads to ensure full compliance of project deliverables to ensure maximum benefits are realised<br>• * Executive Leads to regularly monitor KPIs and the outcome of audits, and to take action if data indicates unfavourable performance<br>• * NHSI Clinical Review planned in June 2016 to seek assurance of the Trust's progress in addressing concerns raised by the CQC<br>• * Monthly assurance visits planned with Commissioners from June 2016, and scheduled CQRG deep dive reviews on each of the QIP themes | QIP Exec Leads | ongoing - monthly review | • Internal and external assurance groups within the governance of the QIP in place to provide challenge to Executive Leads to ensure that tangible outcomes are achieved to time<br>• The QIP KPI report has been developed to provide assurance and performance against delivery of QIP activities<br>• The QIP internal assurance programme agreed with CQRG will ensure a programme of specialist inspections across the Trust<br>• NHS Improvement (TDA) completed a review of progress against the CQC Warning Notice in March 2016. Feedback from the review has been considered and included in ongoing delivery of the QIP | 6 |

# RISKS AND ISSUES

| Risk ID | Risk Description | Gross | Existing Controls (Already In Place) | Risk Owner | Net | Further Actions Required | Action Owner | Date Action to be Completed | Assurance Measures | Target Rating |
|---|---|---|---|---|---|---|---|---|---|---|
| 00-05 | Imposition of nationally driven directives could divert focus and resources from delivering the QIP | 12 | * ELT are apprised of intended changes to national standards for A8 performance and resourcing for HART | Executive Leadership Team | 9 | * Proactive planning to prepare the organisation for likely changes should be initiated as soon as possible, including identification of key stakeholders and resources likely to deliver the change<br>* Regular discussions to take place with NHSE / Commissioners / AACE / NARU of the possible implications on the QIP to deliver national directives | ELT | ongoing - monthly review | Once national requirements are known, ELT should assign an Executive Lead to take action and progress should be monitored regularly to ensure organisational obligations are met | 6 |
| 00-06 | The programme fails to provide external stakeholders relevant levels of assurance in relation to the delivery of the QIP | 9 | * a review of the CQC Warning Notice is being undertaken in preparation for the TDA audit on 16/03/2016<br><br>* The TDA Improvement Director is in post and has regular meetings with the CEO and Programme Director on QIP performance 11/05/2016<br>* a NHSI-led review of the CQC Warning Notice was completed on 16/03/2016 and a further clinical review to be completed in June 2016 | Karen Broughton | 6 | * regular assurance reporting is provided to the ROG and CQRG<br>* A schedule of QIP audit is in the process of development which will provide assurance of compliance and demonstrate the impact activities are having on operational areas | Karen Broughton | ongoing - monthly review | All assurance groups within the governance of the QIP should provide sufficient challenge to Executive Leads to ensure that tangible outcomes are achieved to time | 6 |

# RISKS AND ISSUES

| Risk ID | Risk Description | Gross | Existing Controls (Already In Place) | Risk Owner | Net | Further Actions Required | Action Owner | Date Action to be Completed | Assurance Measures | Target Rating |
|---|---|---|---|---|---|---|---|---|---|---|
| 00-07 | The Trust is not prepared for the CQC re-inspection or other external assurance audit. | 9 | * In January 2016, the QIP narrative and milestone plan was published and provides detail of activities to be delivered during 2016/17<br>* A robust governance and assurance framework for the QIP is in place to monitor achievement of scheduled activity, and regular reporting obligations to key stakeholders<br>* A PMO has been established that will central monitor and review programme progress | Fionna Moore | 9 | * Executive Leads to regularly review upcoming activities, and to give an early indication of any potential risk to delivering project outcomes and to take steps to mitigate the risk or to escalate the matter to the Quality Improvement Group (ELT) to seek assistance to resolve<br>* A schedule of QIP audit is in the process of development which will provide assurance of compliance and demonstrate the impact activities are having on operational areas<br>* ELT to take priority action following the outcome of any audits or mock inspections | ELT | ongoing - monthly review | All assurance groups within the governance of the QIP should provide sufficient challenge to Executive Leads to ensure that tangible outcomes are achieved to time | 6 |
| 00-08 | There is a risk of potential industrial action as a result of national disputes regarding pay and conditions, which will cause substantial disruption on the organisation should it go ahead | 16 | LAS are aware of discussions to date and further information will be available as to whether the industrial action will eventuate following a ballot on 31/05/2016 | ELT | 12 | *Trade unions are required to provide 6 weeks notice from when a decision has been made, which will trigger activation of Trust protocols and plans will be developed<br>*Continued talks in reference to Band 6 & Band 5 have progressed | ELT | On-going | An impact assessment will be undertaken once the extent of the industrial action is known and plans will be developed and shared widely with senior management within the Trust and the Trust Board | 9 |

**LONDON AMBULANCE SERVICE TRUST BOARD**

**4 OCTOBER 2016**

# Quality Improvement Programme
# Nine-month review

## 1. Introduction

The Quality Improvement Programme has been operating for nine months, following the formal launch on 16 January 2016. The Trust has made significant progress on the vast majority of actions included within the programme, having completed 125 deliverables so far. This equates to having completed 93% of the actions that should have been completed by the end of September 2016, and 67% of the total QIP actions.

Since the introduction of the Programme we have welcomed four external assurance inspections from NHS Improvement (NHSI) and the CQC:

- March 2016 – NHSI Warning Notice Review
- May 2016 – NHSI Stocktake Review
- June 2016 – NHSI Clinical Review
- August 2016 – CQC Focussed Inspection

## 2. Review of deliverables (as of end of September)

Below are the detailed breakdowns of each theme, what should have been completed by the end of September and the percentage that has been delivered.

*N.B where deliverables are included on a recurring basis and have been completed on time on each occasion and has a sustainable process of on-going delivery, this has been marked as completed*

| Theme 1 – Making LAS a great place to work | | | | |
|---|---|---|---|---|
| | **Completed** | **Overdue** | **Not scheduled for completion** | **% delivered of total plan so far** |
| **Advert to action** | 5 | 0 | 0 | 100% |
| **Bullying & Harassment** | 8 | 0 | 0 | 100% |
| **Training** | 6 | 0 | 2 | 75% |
| **Equality & Diversity** | 2 | 0 | 1 | 66% |
| **Vision & Strategy** | 4 | 0 | 3 | 57% |
| **Supporting Staff** | 2 | 0 | 2 | 50% |
| **Retention** | 2 | 1 | 1 | 50% |
| **Workforce & Organisational Development** | 1 | 0 | 1 | 50% |

| Theme 2 – Achieving good governance | | | | |
|---|---|---|---|---|
| | Completed | Overdue | Not scheduled for completion | % delivered of total plan so far |
| Risk Management | 9 | 0 | 0 | 100% |
| Capacity & capability of Health, Safety & Risk function | 4 | 0 | 1 | 80% |
| Improving incident reporting | 7 | 0 | 0 | 100% |
| Duty of Candour | 3 | 0 | 0 | 100% |
| Operational Planning | 2 | 0 | 3 | 40% |
| Listening to Patients | 5 | 0 | 0 | 100% |
| Blue Light Collaboration | 0 | 0 | 1 | 0% |
| CQC Re-inspection | 0 | 0 | 1 | 0% |
| Business Intelligence Systems | 0 | 0 | 2 | 0% |
| Internal Audit | 1 | 0 | 0 | 100% |
| Policy & Guidance Review | 1 | 0 | 0 | 100% |

| Theme 3 – Improving patient experience | | | | |
|---|---|---|---|---|
| | Completed | Overdue | Not scheduled for completion | % delivered of total plan so far |
| Patient Transport Service | 4 | 2 | 3 | 44% |
| Meeting people's needs | 4 | 0 | 2 | 66% |
| Response times | 3 | 0 | 1 | 75% |
| Learning from experience | 1 | 0 | 1 | 50% |

| Theme 4 – Improving environment & resources | | | | |
|---|---|---|---|---|
| | Completed | Overdue | Not scheduled for completion | % delivered of total plan so far |
| Fleet/Vehicle Preparation | 21 | 1 | 5 | 78% |
| Information Management & Technology | 3 | 1 | 2 | 50% |
| Infection Control & Prevention | 4 | 1 | 0 | 80% |
| Facilities & Estates | 5 | 1 | 0 | 83% |
| Resilience functions | 4 | 0 | 1 | 80% |
| Operations Management | 1 | 0 | 0 | 100% |
| Improving Operational Productivity | 0 | 0 | 2 | 0% |
| Cost Improvement Programme | 0 | 0 | 1 | 0% |
| Frontline equipment & uniforms | 0 | 0 | 2 | 0% |

| Theme 5 – Taking pride & responsibility | | | | |
|---|---|---|---|---|
| | Completed | Overdue | Not scheduled for completion | % delivered of total plan so far |
| Clinical Supervision | 1 | 0 | 1 | 50% |
| Consent MCA | 1 | 0 | 1 | 50% |
| Medicine Management | 7 | 1 | 1 | 78% |
| Safeguarding | 4 | 0 | 6 | 40% |
| Quality & Clinical Strategy | 0 | 1 | 0 | 0% |
| Operating Model and Clinical Education and Training Strategy | 0 | 0 | 2 | 0% |
| Developing the 111 Service | 0 | 0 | 2 | 0% |

Overall the QIP completion is as follows:

| | Deliverables | Number with Sept or earlier completion date | Number completed | % completed – Sept or earlier completion date | % completed - total deliverables |
|---|---|---|---|---|---|
| Making LAS a great place to work | 41 | 31 | 30 | 97% | 73% |
| Achieving good governance | 40 | 32 | 32 | 100% | 80% |
| Improving patient experience | 21 | 14 | 12 | 85% | 57% |
| Improving environment & resources | 55 | 42 | 38 | 90% | 69% |
| Taking pride & responsibility | 28 | 15 | 13 | 87% | 46% |
| Total | **185** | **134** | **125** | **93%** | **67%** |

### 3. External reviews

Trust Board has received individual feedback from a number of external reviews to test the impact of the Quality Improvement Programme on service quality, delivery and staff. A recent meeting of the private Board considered recurrent themes arising from all inspections.

The Board were concerned that the Trust's energies may be being dissipated by the volume of projects being undertaken at different levels within the organisation, and requested that the Executive Leadership Team review this.

This review has been undertaken and was recently discussed at a private board meeting. Some additional work is required to reconcile actions with the original QIP plan before the final version is agreed by the Board. This is urgently being progressed. Work continues on delivering the QIP plan whilst this work concludes.

## 4 Actions required of the Trust Board

The Trust Board is asked to:

- Note the progress made against the quality improvement plan launched in January 2016
- Note that the Executive Leadership Team are reviewing the quality improvement plan, in the light of external reviews, to focus and fast track actions over the next 4 months

**Karen Broughton**
**Director of Transformation and Strategy**

London Ambulance Service NHS Trust

| | |
|---|---|
| **Report to:** | **Trust Board** |
| **Date of meeting:** | **4th October 2016** |
| **Document Title:** | **Progress report on compliance with CQC domains** |
| **Report Author(s):** | **Lesley Stephen, Improvement Director** |
| **Presented by:** | **Lesley Stephen** |
| **Contact Details:** | **sandra.adams@lond-amb.nhs.uk** |
| **History:** | **N/A** |
| **Status:** | **For discussion** |

**Background/Purpose**

This report provides an assessment of the Trust's progress in improvement to become compliant with the CQC's standards.

**Action required**

The Board should ensure that blockages to any of these areas are identified and removed and channels are in place to share learning and enable engagement directly with staff.

**Key implications**

The Trust needs to demonstrate improvement towards compliance with the CQC domains in readiness for the next CQC inspection and to exit Special Mesaures.

| Key implications and risks arising from this paper | |
|---|---|
| **Clinical and Quality** | **To achieve compliance with CQC domains** |
| **Performance** | **As above** |
| **Financial** | |
| **Workforce** | **As above** |
| **Governance and Well-led** | **As above** |
| **Reputation** | **As above** |
| **Other** | |
| **This paper supports the achievement of the following Quality Improvement Plan Workstreams:** | |
| **Making the London Ambulance Service a great place to work** | **Yes** |
| **Achieving Good Governance** | **Yes** |
| **Improving Patient Experience** | **Yes** |
| **Improving Environment and Resources** | **Yes** |
| **Taking Pride and Responsibility** | **Yes** |

# London Ambulance Service: Assessment of Progress as at September 2016 in Improving Services in line with the CQC's inspection recommendations from Nov 2015

## Introduction

During a series of Board away-days, the executives presented detailed plans of next steps for; improving vehicle preparation, improving medicines management, and an overview of workforce challenges to year end. These subject areas were covered within the framework of the emerging clinical strategy and with reference to; developments in 111, latest evidence from the national dispatch on disposition pilots, and discussion and agreement of the Risk Appetite Statement.

On the 21st September the executive ran through a detailed set of slides of their work-plan to year end. The time for this session was limited by the planned agenda and the material presented on screen dense. The NEDs, and the ID in attendance, were thus unable to determine if the proposals corresponded to previous priorities for action agreed to best serve the Board's objective of exiting special measures in February 2017 when the CQC re-inspect.

The NEDs requested that the ID outline for the Board an assessment of the likelihood of the Trust achieving at least 'requires improvement' in February 2017, based upon the presentations to the Board in September and to highlight areas for further consideration. This paper sets the context for this work and provides an assessment of the Trust's trajectory against the CQC domains.

## Executive Summary

The key areas requiring the Trust's focus over the next c18 weeks to re-inspection are:

- To ensure clarity and understanding of workforce logistics, and to develop and progress plans to address inequalities of resource distribution and ensure pro-active management of existing recruits;
- To improve vehicle preparation across all sectors, and to track and share evidence of improvements in IPC, lost vehicles hours etc;
- To test and ensure evidence is regularly collected and reviewed of the pathway of drug packs from logistics to stations, onto vehicles, drug administration, return of drug packs to stations and to logistics;
- To ensure risks, incidents and complaints are analysed for themes across the service as well as 'hot spots' of practice needing intervention, and that this analysis is acted upon, and learning communicated widely.

The Board should ensure that blockages to any of these areas are identified and removed, for example, resourcing of V.P., OLM implementation, support for QGAMs, and channels to share learning and enable engagement directly with staff.

# London Ambulance Service: Overview of CQC inspection findings

**Overview of inspection and key challenges**

- CQC inspection was undertaken in **June 2015**. Overall rating of '**inadequate**'. Trust received a warning notice on 01 October identifying issues related to staffing levels, medicines management and governance. Trust was placed in **special measures in November 2015** following recommendation from the Chief Inspector.
- The key issues identified within the CQC report are set out below:
  - *Workforce & morale* – insufficient frontline staff led to missing operational standards and impacting staff morale;
  - *Culture* – bullying and harassment and a perceived culture of fear was felt in some parts of the organisation;
  - *Medicines management* – medicines management was not sufficient in the organisation, including Board level oversight, drug and medical gases security and processes of checks and audit to ensure compliance;
  - *Risk and governance* – a lack of confidence that all risks were accurately captured and reviewed, or that all incidents were reported appropriately; and that lessons from SI investigations where being identified and promulgated across the organisation.
  - *Resilience functions* – insufficient staff to fulfil the Hazardous Area Response Team (HART) establishment and to fully comply with the national specification.
- **Performance at LAS improved,** with Category A performance of 63.9% for 2015/16, with an exit run rate of 58.1% in March. LAS achieved the revised trajectory agreed with NHSI/NHSE for Apr-Aug 2016, however, performance is fragile and is supported by an overspend of c£3m per quarter to deliver adequate capacity to hit trajectory. Demand has been higher than contract predictions. Demand Management schemes have been piecemeal and slow to agree/deliver. However, the Trust has not yet recruited to 95% of its contracted staffing level for 2016/17, and is not forecast to do so until March 2017. (Contract being based upon lower than actual demand.)

# London Ambulance Service: Issues and Actions identified by Clinical Review June 2016

**Key clinical review findings – June 2016**

NHSI Quality Team and ID, with stakeholder support (NHS England, Commissioners, Patients Forum), reviewed progress made against the recommendations of the CQC inspection report in June 2016. This covered the functional areas reviewed by the CQC (Emergency and Urgent Care, Emergency Operations Centre, Patient Transport services, and Resilience. There were 18 review teams visiting stations, HART stations, EOCs, and A&E departments, plus 8 focus groups, and 4 ride outs. Documentation was used to triangulate findings. The areas below have been highlighted to the Trust for focus going forward to ensure maximum positive impact of the QIP on staff morale and service delivery:

**Staffing**

- The scale and speed of the recruitment programme is commended.
- The impact of the substantial increase in staffing is however not having the anticipated positive impact on response times or staff morale.
- There are two elements of resourcing which the Trust must address at pace: distribution of staff across stations, and pathways to autonomous operational practice.

**Vehicle Preparation**

- Feedback from crews and observations confirmed that vehicle preparation (VP) pilots in the Trust are improving the physical environment of care delivery by reducing missing equipment and improving vehicle cleanliness. The positive impact on staff morale resulting from these improvements was also evident.
- The Trust needs to push forward on the evaluation and roll-out of successful VP pilots.

**Medicines Management**

- Medicines management at stations has improved significantly from the CQC visits and the Warning Notice Review in mid-March. However, end to end drug supply chain management needs testing, logistics and stores elements need review.

**Functional Assessments**

- **HART** fully staffed, training and development opportunities improved, morale improved, compliance with NARU guidance achieved.
- **EOC** Clinical Hub development commended by all staff groups, Mental Health nursing resource seen as essential and needing additional resource; staff frustration that EOC was not recognised as part of patient pathway and not linked to incident learning etc.

**Further observations & challenges highlighted from the Clinical Review**

If the **variability** in the service could be reduced as described above (staffing, vehicle preparation, medicines management) the 'safe' domain could swiftly move from inadequate to RI and quite possibly to good.

Areas which featured consistently during the clinical review were:

- a desire for clarity of **strategy** – which could be characterised as a dilemma as whether to embrace urgent care or retrench to emergency care;
- a wealth of information from the centre outwards (top-down) but limited channels to **engage** i.e. share a dialogue; and
- a paucity of **information technology** resources inhibiting service development and modernisation.

# London Ambulance Service: Issues and Actions (CQC WN visit August 2016)

**August 2016 CQC Warning Notice Inspection (informal feedback)**

The CQC will shortly be writing to the Trust with the outcome of their July 2016 unannounced inspection. Informal feedback to the Trust on 3/8/16 highlighted the following findings:

- HART – national staffing specification now met;
- Bullying and Harassment – Trust has implemented a substantial training program in this area, but survey results needed to ascertain impact;
- Recruitment to target achieved but distribution uneven and impact on staff morale and performance not felt;
- Culture – concern the Trust is missing the opportunity such a large cohort of new staff present for positive cultural change; variability of leadership at local level, reflection that promotion is based upon clinical competency not leadership potential or management skill, and training insufficient to develop managers;
- Medicines management – awareness improved, but concerns remain as to the governance of medicines management, particularly the availability and tracking of paramedic drug bags, and gas cylinders.
- Governance – risk registers largely up to date, but approach to risk recording and management is inconsistent;
- Incident reporting – continued concerns about reporting and learning.

**Areas requiring focused action at pace**

The CQC's informal feedback suggest that whilst the Trust has made significant progress in some areas, it continues to underachieve in the following:

- Failure to secure the full benefit of increased staffing levels, impacting both staff morale, and productivity and thus performance;
- Variable performance in delivery of improvements in systems affecting staff experience, productivity and effectiveness, for example, vehicle preparation and staff development;
- Incomplete diagnosis and implementation of solutions to tackle inadequate governance of medicines management;
- Failure to instigate an effective feedback loop to secure staff engagement, learning from incidents, complaints, and staff and patient experience.

# London Ambulance Service: Assessment of Progress toward exit of Special Measures September 2016 & Summary position of risk as at 21 September 2016

**Assessment of Progress in September 2016**

The Clinical Review conducted by NHSI in June offered a positive view of the Trust's progress toward exit of special measures, based upon impact of Trust work to that date, and the direction to the Trust from NHSI that the areas highlighted as continuing challenges were improved swiftly and consistently.

The informal feedback from the CQC WN inspection echoed the findings of the Clinical Review both in acknowledging areas of improvement and highlighting similar outstanding concerns.

During the weeks that followed their informal feedback the CQC asked the Trust for evidence to substantiate the narrative provided during the inspection, particularly around the audit, logistics and end to end processes in relation to medicines management. This evidence was not available.

In September the CQC announced that it would undertake a full inspection of the Trust across 7-9 February 2017, and inspect 111 services provided by the Trust during September 2016.

Given the imminence of the Trust's re-inspection, and concern raised by the follow-up evidence requests and the Trust's inability to provide this as previously anticipated, the ID queried with the Board whether the Trust could harness the necessary focus and pace to deliver necessary changes with the desired impact before February 2017.

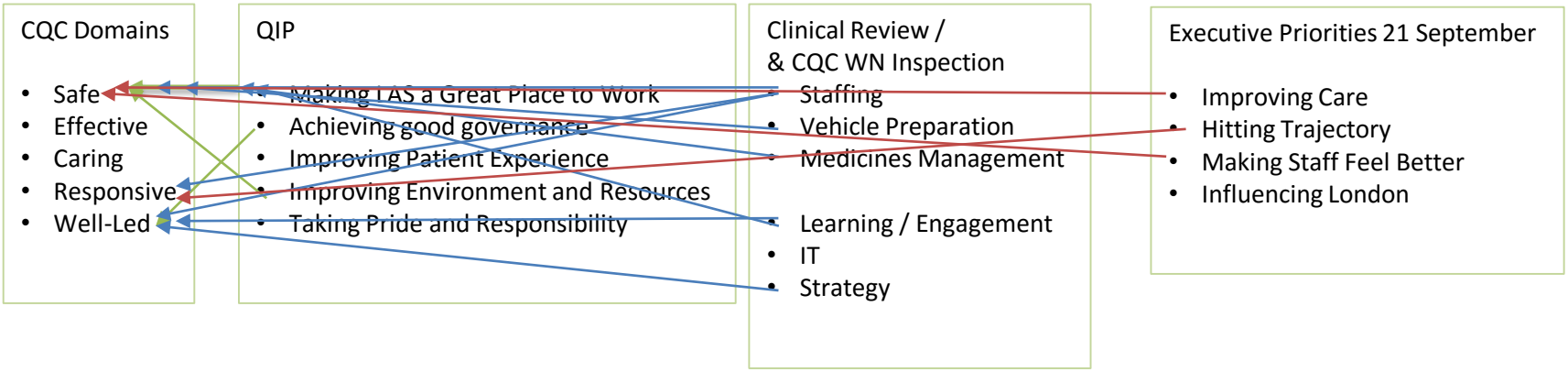
**Summary of risk September 2016**

**Summary as at 21 September 2016:**

- The Trust is at risk of breaching its control total if it continues to need to support performance through additional capacity.
- The Trust is at risk of not exiting special measures when it is re-inspected 7-9 February 2017 if it does not take specific actions now to mitigate risks in for example, medicines management.
- The Trust is at risk of not achieving its performance trajectory (lower than national target) and of performance deteriorating during winter if it cannot improve productivity or secure adequate capacity, and if demand is not reduced by CCG actions.

# London Ambulance Service: Reconciliation of QIP, Board Priorities & external feedback of priorities to CQC domains.

Reconciling the work programs of the QIP, the priorities presented at the Board on 21 September, and the findings from the Clinical Review and CQC WN inspection informal feedback, back to the CQC domains, highlights that the areas most at risk of a poor assessment during the CQC re-inspection in February are: Safe, Well-Led, and to a limited extent Responsive.




Key:
Clinical Review & CQC WN inspection informal feedback findings mapped to the CQC domains is illustrated by blue arrows.
Green arrows link the QIP to the CQC domains.
Priorities from 21 Sept Board away-day to CQC domains donated by red arrows.

# London Ambulance Service: Detailed steps to achieve improvement and secure exit from special measures (1)

**Safe - Staffing, frontline numbers and retention**

Whilst the activities proposed by the Executive in relation to the priority 'make staff feel better' are extensive and contain a number of the elements highlighted as needing focus following the CQC WN inspection, there are several concerns from the WN and Clinical Review which do not appear to have been addressed.

The deployment and distribution of staff was found to be uneven across the stations during the summer reviews. Thus some stations were fully staffed/over staffed, whilst others had significant vacancy levels. The relief system caused considerable frustration and potentially contributes to risk. The progress of recruits through their induction was inadequately understood and managed, again affecting morale and productivity.

The priorities set out by the executive do not detail/describe how progression through induction is being pro-actively managed for existing staff, although plans for cohorts of trainees from December have been drafted, with proposals for IGRads to go to 5 Education Training Centres, and IParas and UK Grads being allocated to step-down centres. Oct – Dec tracking of individuals already with the Trust and in induction/training is reliant upon manual records as the OLM is populated and actively used.

In the priorities outlined on 21 September by the Executive, the relief system appears to be scheduled for review during Oct – Nov. This is a welcome development. However, the scope and scale of this work will need to be understood and publicised.

The overall distribution of staff, and a review of rostas to ensure that staff are rostered to meet demand (which has a largely predictable pattern) could be specified for external support during Oct and delivered by January, for consultation and implementation in 2017. This is not addressed in the 21 Sept priorities. Reworking of the rostas should help to address performance challenges, and would be a response to consistent requests from staff for such a review.

The recruitment challenge for LAS in the remainder of 2016/17 is considerable (LAS is not forecast to achieve the original contract establishment target at 95% until end March 2017. Since then demand has increased above projections and the Board has agreed to increase recruitment to 100% of establishment.)

# London Ambulance Service: Detailed steps to achieve improvement and exit special measures in February 2017 (2)

| | |
|---|---|
| **Safe – Medicines Management** | In conjunction with work to date, and existing plans, the proposed audits connecting and testing the ability to trace drugs administered to patients to the source of medicines, the development of standard operating procedures for logistics distribution and collection of drug packs, and the targeting of drug packs to meet need, should help to assure the Board that the tracking and governance of medicines has improved.<br>The findings and recommendations of the KPMG audit conducted in September should provide further recommendations for end to end drug tracking, security of drug logistics facilities, and testing of the processes for the destruction of drugs. |
| **Safe – Vehicle Preparation** | The plans presented to the Board regarding Make Ready Bronze, Silver and Gold service standards and timetable for introduction appear likely to achieve CQC requirements for improvement in cleanliness and equipment provision.<br>However, the communication to crews of the changes and their belief in the delivery of improvement will be crucial to their expression of satisfaction with corporate services.<br>The evidence of achievement of the deep cleaning schedule, reduced off-road time of vehicles / crews for vehicle safety reasons etc. will need to be tracked carefully and shared Board to crew. |
| **Safe – Incidents** | Incident reporting rates are below those of all other UK Ambulance services. The rate of reporting of clinical incidents is improving since the introduction of Datix and the facility for crews to report during their shift via EBS .<br>The investigation and feedback loop is heavily dependent on QGAMs potentially causing a bottle neck.<br>Board to crew and crew to Board reporting analysing trends by station or by type of incident, complaint etc. is yet to develop.<br>The potential of internal communications using various media to feedback lessons form incidents to front line staff is being explored. There is evidence of changes to clinical policies and core skills training as a result of lessons learned. |

**Conclusion re Safe:**

The Safe domain was the area with least compliance with CQC standards when the Trust was inspected in June 2015.

During the NHSI WN review (March) and full clinical review in June the Trust continued to be assessed by NHSI as Inadequate with a forecast that from September 2016 it move into Requires Improvement.

This assessment remains if the Trust can secure the necessary short term improvements in medicines management, vehicle preparation and incident reporting.

It is unlikely that the Trust will progress beyond achievement of Requires Improvement into an assessment of good by February 2017. Development and delivery of medium term solutions such as the use of App technology for VP and Medicines inspection and audit will assist with a transition to good, but will take longer for the Trust to roll out across the whole trust and thus end the variability of support service delivery.

# London Ambulance Service: Detailed steps to achieve improvement and exit special measures in February 2017 (3)

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|---|---|
| **Effective – competent staff** | CQC during their WN visit and DMS in their 'understand' phase raised concerns that promotion was by clinical attainment and aptitude, without adequate assessment of managerial or leadership qualities. During the Clinical Review and the earlier WN review by NHSI variability in the skill of managers were frequently highlighted by crews and EOC staff.<br>PDR completion rates remain low despite the introduction of more streamlined process, and OWR completion is variable across stations i.e. the policy target is not being met.<br>Clinical Team Leaders (CTLs) have the largest reach / touch into the crews at LAS. According to the HES they are the most engaged staff group, but are concerned about the level of support they receive to contribute and deliver their leadership role. The CQC, DMS, and NHSI have all commented on the low rates of PDR completion, and the apparent emphasis on clinical qualifications and career progression through their attainment. This risks the leadership of LAS lacking the necessary management and leadership skills to improve the service and develop staff in their 'care'. This is the risk that DMS and CQC highlighted in their feedback to the Trust in February and August 2016 respectively.<br>If PDRs are completed, OLM use is extended, and the role of CTLs along with that of other mangers is determined, the commissioning of a leadership program as proposed by the Executive during December and January will help to address the development of leaders within the LAS. |
| **Effective – response times and EOC** | Whilst Trust performance has improved since the CQC original visit in 2015, the Trust is struggling to meet its locally agreed trajectory, and is incurring financial expense above its forecast spend on PAS and VAS to support capacity needed to achieve the trajectory.<br>EOC staff expressed a disengagement and frustration during the Clinical Review and observers of the control room at Bow expressed concern as to the tension in the room. Improvements at Waterloo to environment and support had been well received and were acknowledged by staff. |

# London Ambulance Service: Detailed steps to achieve improvement and exit special measures in February 2017 (4)

**Effective – access to information**

The Trust has no agreed mobile technology strategy nor data development strategy. The Board received a critical report regarding IM&T strategy development and management of the function from independent experts from EY in September.

Crews do not have mobile devices to access the intranet.

App technology is used in a limited capacity within the Trust.

App development has begun with a tight timetable and scope agreed w/of 23 Sept.

Next steps from the EY review and discussion of the draft IM&T strategy by the Board are not yet in train.

**Summary of Effective:** The Effective domain was rated as requiring improvement by the CQC inspection. This assessment was found again in March by the WN review because of continued poor PDR rates and inconsistent OWR delivery. However, the improved plans for HART training and training in safeguarding led the NHSI team to forecast this domain to reach 'good' from June, an assessment confirmed by the June inspection when performance was above trajectory for Q1.

During the March and June WN reviews the the risk to the Trust of failing the A8 performance trajectory if capacity and productivity gains from new staff could not be realised were highlighted to the Trust.

During the June review, which was a full clinical review, not targeted as per March WN review, the paucity of digital technology and specifically hand held devices, was highlighted as a risk area for the Trust, and this element of the Effective domain was downgraded to RI from Good.

**Responsive – Access and flow, deployment**

As described above, staff distribution remains uneven within the service, deployment of substantive workforce (ie not via PAS and VAS) does not match peaks in workload, rest breaks are not enforced exposing clinical risk, whilst implementation of existing rest break policy will impact deployment and needs modelling and potential supporting capacity, annual leave policy makes targeted management of resource difficult.

The executive are developing a set of options with modelled scenarios to enable achievement of performance trajectory, with consideration of implications for finance, abstractions for training etc.

**Responsive – Learning from complaints and concerns**

CTL and QGAM are providing good feedback to incident reporters, and better support to SI and complaints investigations. The challenge is to absorb and spread lessons learned from SI and complaints investigation across the organisation, in order to influence the behaviour and clinical practice of staff. While there is evidence that core skill training and policy changes have been made as a result of lessons learned, the internal communications on lessons learned is hit and miss with some good examples of simple one pagers on clinical practice from the medical directorate but little evidence that key lessons are reaching front line staff consistently enough to change practice. The audit cycle on lessons learned is not in evidence.

# London Ambulance Service: Detailed steps to achieve improvement and exit special measures in February 2017 (5)

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|---|---|
| **Well-led – Strategy** | Decisions about recruitment and training and education can only be made within the context of a strategy, including a clinical strategy, which reflects local circumstances and national drivers. Skill-mix, balance of recruitment from graduates, international graduates and paramedics and development of TEACs all need to be considered within context of the strategic future of the Trust. Similarly the IM&T, fleet, estate strategies flow from the clinical strategy.<br>Crews, EOC staff and senior managers consistently express confusion as to the Trust's strategic direction, at its simplest this is characterised as frustration as to whether they should focus on emergency care, emergency and urgent care, emergency, urgent and community care. |
| **Well-Led – Leadership** | The Trust was advised in January 2016 to strengthen its executive team, and a substantive medical director and director of operations were subsequently appointed. The recruitment of a Chief Quality Officer is still ongoing, the Deputy Director of Nursing is acting into this post, but no additional capacity has been put in place to back fill her post. An interim Director of HR has been appointed; the Chair and NEDs have asked for the substantive Dir of HR recruitment to be paused while consideration is given as to how to ensure strategy, transformation, OD, and HR are all adequately resourced, possibly across two posts. The NEDs are engaged in the Trust's progress to exit special measures and are appropriately challenging within the framework of a unitary Board, for example, use of the Board's risk appetite to weigh performance and financial tensions for Q3 & Q4.<br>As described above, the CQC during the August WN inspection and DMS both raised concerns as to the consistency & strength of local Leadership. The predominance of the clinical pathway to promotion, with limited managerial and leadership development focused on the individual (& low rates of PDR to identify talent and development areas) make it difficult for the Trust to actively manage talent. |
| **Well-led – Culture** | The Trust has actively sought to address the perceived bullying and harassing culture described in the original CQC report.<br>NHSI reviewers felt that the dialogue with staff had shifted between March and June from bullying and harassing, to a more latent sense of disengagement from 'management' and frustrations at day to day issues such a poor vehicle preparation and relief shift patterns. |
| **Well-led – Staff engagement** | The Trust has an energetic and effective communications team delivering regular and effective public engagement programs.<br>Whilst staff communication was reported as improved to the NHSI team in June, the level of engagement i.e. opportunities for staff to be actively asked for feedback and views and listened to and responded to, was deemed low. The HES survey found low staff engagement across all sectors and teams, with the exception of CTLs. |

**Summary of Well-Led:** If a Trust is assessed as inadequate in the well-led domain, plus any one other domain, special measures is automatically considered by the Chief Inspector of Hospitals. The CQC and NHSI as the Trust's regulators place emphasis on the well-led domain as this is a strong determinant of the likelihood that improvements will be sustained over the long term. As described above, the Trust has made progress in areas of the well-led domain, but remains challenged in the development of local leaders, and its ability to actively engage with its staff. These two areas must raise a question as to the ability of the Board to effect a positive change in culture from that found at the time of the CQC inspection.

# London Ambulance Service: Conclusion & Recommendations

**Conclusion & next steps**

Over the following slides an assessment by NHSI of the Trust's progress on its improvement journey is provided.

- A RAG assessment was drawn from the original CQC report published in Nov 2015 as a baseline and subsequently an assessment was made of improvement roughly every three months with the publication of the QIP, NHSI WN review, NHSI full clinical review, and this assessment as at 29 September 2016.
- The forecast to Jan 2017 remains unchanged, despite the risks highlighted above.
- This reflects NHSI's view that if the Trust can implement the actions described in the priorities session at the 21 Sept Board awayday, and can ensure blocks on progress in the four key areas previously outlined by the ID to the Board are removed, then the Trust should be able to demonstrate sufficient progress in its improvement journey to secure the removal of special measures in February 2017.

The Board will want to assure itself that:

- The distribution of the workforce and induction of new recruits is being proactively managed to realise improved capacity and morale;
- The vehicle preparation bronze plans are funded and proceeding as agreed, with robust KPIs reflective of impact on service delivery shared throughout the service to build confidence in the new system;
- medicines management logistics and tracking is improved and along with an enhanced audit program can provide evidence to the Board of strong governance of medicines across the Trust;
- methods for identifying patterns and disseminating learning from incidents is developed and instigated at pace.

In driving the delivery of these priorities, the Board will want to ensure that:

- Mobile technology and data sharing are supported through the development and implementation of bespoke Apps and the rapid supply of devices to frontline staff; and that
- Work to engage staff started by the B&H training, and continued through the HES and Improving the way we care workshops is treated as core business for all senior managers within the Trust.

# London Ambulance Service: Expected Trajectory for Improvement (1)

| CQC rating | | Objective within the improvement plan | | TDA expectations by quarter | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | BASELINE CQC report | 3 mths - Feb 16 | 4 mths - March 16 | 6 mths - June 16 | 9 mths - Sept 16 | 12 mths - Nov 16 | 15 mths - Jan 17 |
| Safe | Inadequate | Incident reporting, investigation, feedback and learning | I | I | I | RI | RI | RI | RI |
| | | Mandatory training completion and compliance | I | I | RI | RI | G | G | G |
| | | Safeguarding training, understanding and awareness | RI | RI | G | G | G | G | G |
| | | Cleanliness, infection control and hygiene across all areas of the Trust | I | I | RI | RI | G | G | G |
| | | Environment and equipment - provision of equipment, vehicle maintenance and work environment for EOC staff | I | I | RI | RI | RI | RI | RI |
| | | Medicines management - systems, checks and audits, use of PGDs, executive oversight | I | I | RI | RI | RI | RI | RI |
| | | Records security, audit and process (paper based system) | I | I | I | RI | RI | RI | RI |
| | | Assessing and responding to patient risk processes framework | G | G | G | G | G | G | G |
| | | Staffing - frontline numbers and retention | I | I | RI | RI | RI | RI | RI |
| | | Staffing - HART and resilience functions | I | I | G | G | G | G | G |
| | | Major incident awareness and training - protocols and awareness | I | RI | G | G | G | G | G |
| Effective | Requires improvement | Evidence based care and treatment - training, communications and agreements with other organisations | G | G | G | G | G | G | G |
| | | Assessment and planning of care - medical protocols, SLAs and call grading | G | G | G | G | G | G | G |
| | | Response times - frontline and EOC | I | I | RI | RI | RI | RI | RI |
| | | Patient outcomes - ROSC, cardiac patients, stroke, telephone advice and recontact rates | G | G | G | G | G | G | G |
| | | Competent staff - appraisals, clinical supervision, MCA, HART competencies | RI | RI | RI | RI | RI | G | G |
| | | Coordination with other providers - e.g. Met, 111, health and social care | G | G | G | G | G | G | G |
| | | Multidisciplinary working with other providers | G | G | G | G | G | G | G |
| | | Access to information via the intranet, dispatch system and in vehicles | G | G | G | RI | RI | RI | G |
| | | Consent, MCA and deprivation of liberty safeguards - training and capability | RI | RI | G | G | G | G | G |

# London Ambulance Service: Expected Trajectory for Improvement (2)

| CQC rating | | Objective within the improvement plan | | TDA expectations by quarter | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | BASELINE CQC report | 3 mths - Feb 16 | 4 mths - March 16 | 6 mths - June 16 | 9 mths - Sept 16 | 12 mths - Nov 16 | 15 mths - Jan 17 |
| Caring | Good | Compassionate care - communication with patients and maintaining dignity | G | G | G | G | G | G | G |
| | | Understanding and involvement of patients and those close to them | G | G | G | G | G | G | G |
| | | Emotional support to patients and carers | G | G | G | G | G | G | G |
| Responsive | Requires improvement | Service planning and delivery to meet the needs of local people - including surge management and triage of calls | G | G | G | G | G | G | G |
| | | Meeting people's individual needs through the use of appropriate care pathways | RI | RI | G | G | G | G | G |
| | | Access and flow including call abandonment and deployment | I | I | I | I | RI | RI | RI |
| | | Learning from complaints and concerns | I | I | I | I | RI | RI | RI |
| Well led | Inadequate | Vision and strategy - communication to staff | I | I | RI | RI | RI | G | G |
| | | Governance, risk management and quality management, including risk register management, call audits and HR support for poor performance | I | RI | RI | G | G | G | G |
| | | Leadership - executive and local | RI | RI | G | G | RI | G | G |
| | | Culture within the service | I | I | I | RI | RI | RI | RI |
| | | Public and staff engagement | G | G | G | RI | RI | G | G |
| | | Innovation, improvement and sustainability | G | G | G | G | G | G | G |

# London Ambulance Service: Expected Trajectory for Improvement (3)

| Summary ratings: | | | | | | | |
|---|---|---|---|---|---|---|---|
| **CQC Domain** | **BASELINE CQC report** | **3 mths - Feb 16** | **4 mths - March 16** | **6 mths - June 16** | **9 mths - Sept 16** | **12 mths - Nov 16** | **15 mths - Jan 17** |
| Safe | I | I | I | I | I/RI | I/RI | RI |
| Effective | RI | RI | RI | G | G | G | G |
| Caring | G | G | G | G | G | G | G |
| Responsive | RI | RI | RI | RI | RI | RI | RI |
| Well led | I | I | I | RI | I/RI | I/RI | RI |
| **OVERALL** | I | I | I | I | I/RI | I/RI | RI |

London Ambulance Service NHS Trust

| | |
|---|---|
| **Report to:** | **Trust Board** |
| **Date of meeting:** | **4th October 2016** |
| **Document Title:** | **Quality Governance Committee assurance report** |
| **Report Author(s):** | **Bob McFarland, Non-Executive Director and Chair of the Quality Governance Committee** |
| **Presented by:** | **Bob McFarland** |
| **Contact Details:** | **sandra.adams@lond-amb.nhs.uk** |
| **History:** | **N/A** |
| **Status:** | **Assurance** |

**Background/Purpose**

The Quality Governance Committee met on 13th September 2016 and received reports from the reporting sub-committees and on specific areas of quality and safety. The committee considered the risk appetite statement and provided additional comment for inclusion in the Board facilitated discussion on 21st September. The committee approved the 2015/16 Annual Report on Mental Health and considered progress against the actions. The committee also considered progress against the action plans for safeguarding and infection prevention and control; and reviewed the serious incident action tracker.

The attached report summarises the discussion on 13th September and highlights some areas of concern that the Board may wish to consider and also areas where improvement can be seen.

**Action required**

Presented for assurance purposes and to highlight specific areas of improvement and concern.

**Key implications**

The committee is a sub-committee of the Trust Board and has oversight of quality and safety and clinical governance. Key to the role of the committee is the provision of assurance to the Board on these issues and to identify any emerging themes and risks to the achievement of the Trust's strategic objectives from these issues.

| Key implications and risks arising from this paper | |
|---|---|
| **Clinical and Quality** | **The committee is able to provide assurance on areas where improvement has been made, and can identify areas of concern to the Board** |
| **Performance** | |
| **Financial** | |
| **Workforce** | |
| **Governance and Well-led** | **Key committee of the Board with oversight of quality governance which contributes to the well-led framework** |
| **Reputation** | |
| **Other** | |
| **This paper supports the achievement of the following Quality Improvement Plan Workstreams:** | |
| **Making the London Ambulance Service a great place to work** | **Yes** |
| **Achieving Good Governance** | **Yes** |
| **Improving Patient Experience** | **Yes** |
| **Improving Environment and Resources** | **Yes** |
| **Taking Pride and Responsibility** | **Yes** |

**Report from the Quality Governance Committee on 13th September 2016**

As the Quality Improvement Programme moves on from action into assessing outcomes the Board should be aware of some concerns.

Infection Prevention and Control – although much has been done since July and there are examples of good practice Bob McFarland expressed concern that we continue to have a lack of assurance that this would be consistent across all sites. There is a need for a clear strategy to address this issue over the next few months.

Safeguarding – There is no progress towards an electronic referral system for safeguarding (Paul Woodrow will take this matter forward). Although we had been assured in July that the overdue actions from 2015/2016 were either complete or near complete, in today's report 12/14 actions from last year are still not completed including the ones mentioned above. We received confirmation after the meeting that the issues were being resolved and now needed to be implemented along with the 24-hour/7 days per week single point of contact. We also received assurance after the meeting that the 3 yearly DBS checks on present staff were now underway and Mark Hirst would be sending out an email to confirm the position.

Serious Incidents – There has been a marked improvement in the time it takes to investigate and process serious incidents. However the SI Action Tracker spreadsheet shows 137/386 actions not completed going back to 2014. Some of these could be "grouped" under headings (e.g. recruitment) and some were just waiting for documentation (e.g. a conversation with an individual) but the committee cannot be confident that we have a robust system for learning the lessons and making changes following incidents which reflects the findings of the recent CQC Warning Notice inspection. Executive members agreed to act upon this and Fenella Wrigley and Sandra Adams would take this forward for the next meeting of the committee.

Blankets – The committee takes a view that this issue needs to be decided and sorted. Briony Sloper and Fenella Wrigley would follow this up with executive colleagues and provide an update to the next meeting.

***Clinical Governance***

The committee was pleased to take reports from the Improving Patient Experience Committee, the Risk Compliance and Assurance Group and the Clinical Safety and Standards Committee. We also reviewed the Board Assurance Framework (BAF) and Risk Register, and the Serious Incident report for July and August.

We discussed the BAF risk 29 (concerning staffing in EOC for ringbacks). Although we were disappointed that this issue was still "under review" it was explained that the need for welfare ringbacks had decreased (as the delays for Category C patients decreased) and that there were plans underway to cover this facility by recruiting and training extra control room staff above the normal replacement number, although exact numbers were still being determined. Also the content of the welfare ringback call was being reviewed as the most vulnerable patients were handled by the Clinical Hub and electronic ringback systems were being considered. We took assurance from this useful update.

Frequent Callers – The Darzi fellow has now finished and there is a clear need for the work to manage Frequent Callers to continue to be developed as it is one of the three sources of activity which, if better managed across the whole health and social care system, could significantly reduce demand on the service (along with calls from care homes and calls from other Health Professionals). We were therefore disappointed to hear that not all sectors were fully engaged in setting in place the necessary multidisciplinary structures to manage these patients. Currently the problem sits with the LAS although we are only part of the solution and so it was felt that where the local health system was not taking the initiative we had the

motivation and should organise the improvement. The figures presented suggested that even within our service alone the financial benefits were likely to justify the extra staff required.

The team have made significant progress in clearing the backlog of overdue Serious Incidents. There is an increase in incidents reported and this seems to be due to a change in culture and the availability of the Datix facility. Self-reporting of clinical incidents has increased and these are dealt with and as a learning rather than blaming opportunity. The Medical directorate is reviewing clinical errors to see if there is any correlation with the grade, training or experience of the clinician involved.

The Medical Directorate also reports an increased number of calls to attend inquests, particularly now the coroners are dealing with cases around the time when there were significant delays in attending some patients. The directorate is working with the coroners to ensure attendance is only requested when there are particular issues relevant to our service.

Briony Sloper reported a programme to develop Expert Patients (in particular for Sickle Cell disease, Mental Health, and breathlessness) and to develop "always event" protocols to ensure these patients could rely on a consistent and effective response. The training planned will also facilitate the development of a cohort of patients equipped to serve on LAS committees as patient representatives.

The ***Risk Appetite Statement*** as regards Quality was discussed. In brief it was felt that the current statement might not be clear and so we agreed the term 'Quality' should be used only as the overall umbrella term for the domain. Within Quality should be three components. 'Safety' and 'Outcome' (for which we have a low (as is reasonably possible) appetite for risk, and 'Patient Experience' (on which we have a higher appetite for risk provided safety and outcome can be assured. So in assessing any new initiative the decision to proceed would involve weighing all three components to determine whether, on balance, the possible result (which could be clinical but also could be financial or logistic or staffing) justified the risk.

***Mental Health Annual Report***
Briony Sloper presented the report for 2015/2016 in the absence of Kuda Dimbi. The committee were pleased to note the large body of work undertaken and noted in particular that the issues identified by the CQC had been addressed. The majority of the objectives for the year had been achieved and we were pleased to accept the report with the caveat that it should include the action plan for 2016/2017 and that next year we should see this at the beginning of the reporting year not half way through.
Although at the time the report was written only three Mental Health Trusts had a single access number available to the Ambulance Service, when needing advice or to refer a mental health patient, we were pleased to hear that at a recent meeting all London trusts had agreed to implement a single access point.

***Safeguarding*** – Alan Taylor brought an update on progress on the Safeguarding action plan. Although we had been assured in July that the overdue actions from 2015/2016 were either complete or near complete, in today's report 12/14 actions from last year are still not completed including the ones mentioned above.
We were pleased to hear that an initiative working with the "Red Thread" charity around gang involvement with young people was progressing.

**Infection Prevention and Control –** Eng-Choo Hitchcock brought us an update on the considerable activity in this area. We were pleased that the staffing support was being recruited and progress was being made on a number of actions from last year and this year. However we remain concerned about the reported variation in standards and lack of consistency across the trust which has also been reported in medicines management.

We would also like to highlight several cases now of which we have become aware where a function in the trust has been dependant on one person. If that person is ill or leaves there is no deputising arrangement and the responsibilities may not be covered for a period. Infection Control last year is an example.

There was no deep dive this month as the agenda was full.

***Date of next meeting***

The next meeting of the Quality Governance Committee is on Tuesday 15th November 2016. **NOTE THE MEETING WILL BEGIN AT 1300** in order that several members can still attend the full meeting which we will aim to finish by 1600.

London Ambulance Service NHS Trust

| | |
|---|---|
| **Report to:** | **Trust Board** |
| **Date of meeting:** | **4th October 2016** |
| **Document Title:** | **Mental Health Annual Report** |
| **Report Author(s):** | **Briony Sloper** |
| **Presented by:** | **Briony Sloper** |
| **Contact Details:** | **briony.sloper@londonambulance.nhs.uk** |
| **History:** | **Approved by the Quality Governance Committee** |
| **Status:** | **For information and assurance** |

**Background/Purpose**

The Annual Mental Health report is presented for information and assurance following review and approval by the Quality Governance Committee on 13th September. The report is presented in several distinct sections:

1/ Progress on those areas identified as priority areas within the Trust 5 year strategy
- Dementia care
- Training and Education
- Parity of esteem –
  Concordat engagement, Mental Health Nurses, Appropriate Care Pathways
- Care of patients detained under the Mental Health Act (1983)
- Mental health and wellbeing of LAS staff

2/ CQC inspection findings and actions undertaken
3/ Safety and Quality
4/ Risks
5/ Annual work plan

It is noted that there is no complete and validated data currently available detailing total volumes of mental health calls received by the Trust to identify growth due to issues with data extraction methodology but this will be available imminently.

**Action required**

For information and assurance

**Key implications**

The annual report presents a full and detailed record of progress, achievements and challenges for the year 2015/16.

| Key implications and risks arising from this paper | |
|---|---|
| **Clinical and Quality** | There are a significant number of areas detailed within the where tangible improvements have been made to the quality of care we deliver to patients presenting in mental health crisis and to our improved focus on staff well-being |
| **Performance** | |
| **Financial** | |
| **Workforce** | |
| **Governance and Well-led** | The Mental Health Annual Report is a pivotal paper for the Trust to demonstrate achievements and challenges across the year |
| **Reputation** | |
| **Other** | |
| **This paper supports the achievement of the following Quality Improvement Plan Workstreams:** | |
| **Making the London Ambulance Service a great place to work** | Yes |
| **Achieving Good Governance** | Yes |
| **Improving Patient Experience** | Yes |
| **Improving Environment and Resources** | |
| **Taking Pride and Responsibility** | Yes |

**Mental Health Action Plan 2015/16**

**Final Report**

The Mental Health committee agreed the action plan at the beginning of 2015/16 financial year. Six improvement items were Identified :

- Patient Involvement and Experience
- Training and Education
- Dementia
- Review of the Mental Health CPI
- Review of mental health appropriate care pathways (MH ACP)
- Mental Health Risk Awareness Tool LA383 roll out

A general overview of progress made with all improvement items is shown below:

| Overview of completion of action plan as at 01/04/16 | | |
|---|---|---|
| **Number of Improvement items completed** | **Number of Improvement items partially completed** | **Number of Improvement items outstanding** |
| 4 | 2 | 0 |

| Improvement item 1 : Patient Involvement and Experience | | | | | |
|---|---|---|---|---|---|
| **Action** | **Progress** | **Achieved/Outstanding RAG** | **Completion date** | **Impact/Action** | **Progress** |
| To conduct Focus Groups with mental health patients across London. | Seven focus groups were completed with mental health service users | | **Achieved** | | |
| Produce a paper outlining recommendations from focus groups . | A final report of findings and recommendations was presented to the MH committee on 23rd November and to the Trust Board on 4th December<br><br>Recommendations used to feed into 2016/17 MH Work plan | | **Achieved** | | |

| Improvement item 2 : Training & Education | | | | | |
|---|---|---|---|---|---|
| **Action** | **Progress** | **Achieved/Outstanding RAG** | **Completion date** | **Impact/Action** | **Status** |
| To approve training strategy and ascertain mental health is included in Trust training needs analysis yearly | No Trust wide training Group, Training needs explored with training and education. Confirmed that there is no mental health within CSR 2015/16. | | | Mental health not included in CSR. MH Committee to explore other ways of delivering MH training/updates | To be carried over to 2016/17 work plan |
| Carry out a gap analysis re-international recruits | Topics for training agreed, written and delivered. | | **Achieved** | | |
| Write mental health sessions for CSRs, APPs CTLs and International recruits. | All sessions written and delivered | | **Achieved** | | |
| Review of current Mental Health e-learning package | Initial scoping completed with e-learning managers in June 15 however due to competing priorities within e-learning post CQC inspection no capacity for work to be completed. | | | MH e-learning package is outdated and requires updates | This will be carried over to 2016/17 work plan |
| Review basic mental health training within LAS and explore other options of delivering training & education . | Training for EOC, PTS reviewed and delivered in MH and dementia | | **Achieved** | | |

| Improvement item 3 : Dementia –(cquin) | | | | | |
|---|---|---|---|---|---|
| **Action** | **Progress** | **Achieved/Outstanding RAG** | **Completion date** | **Impact/Action** | **Status** |
| 3.1 Engage with voluntary sector organisations to get the views /experiences of dementia patients and cares. | Four focus groups competed with:<br>•Alzheimer's Society (SE) 28th September 2015<br>•Camden Dementia Carers Service (NW) - 27th October 2015<br>•Dementia Concern (W)- Hanwell 26th November 2015 | | **Achieved** | | |
| Produce a paper outlining recommendations from dementia focus groups . | Paper presented to MH Committee and Board | | **Achieved** | | |
| | | | | | |

| **Improvement item 4 : Review the mental health clinical practice indicator CPI** | | | | | |
|---|---|---|---|---|---|
| 4.1 Review the MH CPI focusing on Lowest compliance aspects. | All aspects of care in the MH CPI were reviewed, CPI report presented to MH Committee 21.9.15 | | **Achieved** | | |
| Focus groups with staff in Improvement item 1 to be used to explore staff views on use of the MH CPI. | Staff focus group completed on 17th August , findings captured in final report | | **Achieved** | | |
| To write up case studies in the Clinical that highlight the importance of considering safeguarding concerns for patients even when they are being taken to a place of safety | | | **Achieved** | However MH CPI remains lowest compliance area of all the CPIs | This will be carried over to 2016/17 work plan |

| **Improvement item 5 : Review of mental health appropriate care pathways (MH ACP)** | | | | | |
|---|---|---|---|---|---|
| 5.1 Review and update all existing MH ACPs . | Work with the nine mental health trusts across London to update all MH ACPs has begun | | December 2015 | MH ACPs remain inconsistent across London but on-going work engaging MH trusts to ensure that ACPs are fit for purpose | This will be carried over to 2016/17 work plan |
| 5.2 Ascertain help of other colleagues in feeding back on ACP use and challenges following up on a case by case basis. | ACP Group in now fully operational with MH Lead included | | **Achieved** | | |

| | | | | | |
|---|---|---|---|---|---|
| 5.3 Ensure that difficulties with MH ACPs are cascaded with partners using forums like Mental Health Directors of Nursing meetings and Mental Health Partnership Board | Forums for cascading difficulties with ACP use and feedback identified- on-going process | | **Achieved** | | |

**Improvement item 6 : Mental Health Risk Awareness Tool LA383 (CQUIN).**

| **Action** | **Progress** | **Achieved/Outstanding RAG** | **Completion date** | **Impact/Action** | **Status** |
|---|---|---|---|---|---|
| Roll out LA383 across the service , evaluate and monitor impact on MH CPI compliance | LA383 fully rolled out since October 2015, now part of LAS core forms | | **Achieved** | | |

London Ambulance Service NHS Trust

# Mental Health Annual Report 2015/16
## (April 2015 to March 2016)

**Author : Kudakwashe Dimbi , Clinical Lead for Mental Health**

Care | Clinical Excellence | Commitment

## 1. Introduction

**1.1.** The LAS identified mental health as a quality priority in 2015/16. The aim was to ensure that, in line with our Purpose and Values, we continue to care for people with mental health problems effectively, saving lives, providing care and making sure that our patients with mental health needs get the help they require.

**1.2.** Our Annual Mental Health Report indicates the continuing dedication of the Trust to improving the quality of services we provide to our mental health patients and embed national policies and practices throughout the service. It also identifies the mental health risks to the organisation and the actions put in place to mitigate these.

**1.3.** The Mental Health Annual Report of the London Ambulance Service (LAS) NHS Trust aims to fulfill two functions which are to increase transparency about progress and achievements within mental health care provision during 2015/16 helping to identify improvements in mental health care across the London Ambulance Service NHS Trust (LAS) and outlines objectives for 2016/17.

## 2. The scope of this report

**2.1.** This report focuses on the different types of mental health presentations, mental health provision and the initiatives undertaken within LAS during 2015/16 to advance mental health care provision. We built upon initiatives from our 2014/15 annual report focusing on engagement with the Mental Health Crisis Care Concordat recommendations, multi-agency working, patient safety and quality of care. Our report includes sections on areas of particular importance as identified in our Five Year Strategy 2014/15-2019/20 which include:

- Dementia care
- Training and Education
- Parity of esteem
- Care of patients detained under the mental health act (1983)
- Mental health and wellbeing of LAS staff

**2.2.** In a departure from the format of previous reports, mental health and wellbeing of LAS staff is reported on. 'No Health Without Mental Health', the government's mental health outcomes strategy states that "Mental health is everyone's business – individuals, families, employers, educators and communities all need to play their part. Good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, and our work and to achieving our potential." While this report highlights a range of staff focused mental health initiatives, more detailed information is included in our Health & Wellbeing Strategy.

**2.3.** Unfortunately it has not been possible at the time of writing to retrieve the mental health activity data from the Management Information department for 2015/16. However figures for the previous year's indicate that demand for LAS has continued to grow

year on year. In 2013/14 78 124 mental health incidents were responded to by LAS rising to 98 439 in 2014/15. An increase of 26%.

**2.4.** National and local context and challenges affect everything we do and this report highlights the areas that the LAS has specifically focused on in terms of mental health care best practice in order to meet the needs of these often vulnerable and complex patients.

## 3. Dementia Care

**3.1.** In our 2015/16 Annual Quality Account, improving the care and recognition of patients with dementia and delirium was identified as a quality priority alongside a CQUIN agreed with our commissioners. As part of the dementia CQUIN we committed to undertake a pilot project to identify key areas of improvement in the experience of dementia patients and their carers when using the LAS. The CQUIN had two key aims:

- To identify areas of improvement in the experience of Dementia patients (and their carers) when using the London Ambulance Service.
- To raise dementia awareness for London Ambulance Service staff

**3.2.** The dementia work stream was successfully delivered via the LAS Mental Health Work Plan 2015/16.

**3.3.** Four focus groups were held between September and December 2015 with people who are living with dementia and their carers. Focus groups were held in venues across London and a total of 41 people participated. The focus groups were supported and arranged by voluntary and community sector partners from the Alzheimer's Society, Dementia Concern and Camden Carers. People taking part in the focus groups provided a range of constructive responses and ideas with the aim of helping London Ambulance Service improve the way it provides care to people living with dementia.

**3.4.** Overall the service provided by LAS is appreciated by the people we met, the majority of whom reported very positive experiences, an example one lady said, 'I can't speak highly enough of them'.

**3.5.** There were consistent messages about how staff should behave when responding to people who have dementia e.g. 'Be patient and listen to what is being said'. There were also a number of themes that were specifically related to dementia awareness e.g. 'Going to hospital can be very disturbing'.

**3.6.** Three key themes emerging from the focus groups have been agreed as areas for development and action at the Mental Health committee in March 2016. Recommendations from the dementia focus groups have been incorporated into the LAS Mental Health Work Plan 2016/17.


**Figure 1** : Word cloud themes emerging from focus groups

- **Managing Delays** - The nature of dementia means any delay in receiving help can lead to anxiety, an increase in dementia related symptoms, and additional pressure on already stretched carers. Participants felt that a community based scheme such as Community Responders or Dementia Champions would add reassurance and reduce risk during any wait. If a longer than usual wait is likely then this additional level of support would be a significant benefit to the person living with dementia as well as their carer.

- **Carers** - It was evident at each group that Carers are under enormous strain. We encountered people who were emotionally, physically and mentally exhausted. Recounting the experience of calling an ambulance was often a difficult and upsetting process. Many carers we spoke to were living with their own health conditions. Carers spoke of their fears for their own health as much as for the health of their loved ones. They were openly worried and upset at the thought of their loved ones being left alone or uncared for if they were to fall ill. For example: 'What worried me is if I as the carer, I need to go to hospital, what would happen to my wife who has dementia?'

- **Providing Feedback** - People living with dementia and carers alike valued the opportunity to give feedback through the focus groups. People would like to give more feedback. Patients, carers and service users would like to say thank you and get more involved in providing constructive feedback which informs service improvements and patient experience.

## 4. Training and Education

**4.1.** Although mental health was not included within our Core Skills Refresher Training (CSR), for 2015/16 , a number of initiatives were undertaken to help improve the knowledge of our workforce around mental health.

- Our Mental Health Clinical Lead delivered face to face training updates to Clinical Team Leaders and Advanced Paramedic Practitioners.

- A gap analysis in respect of international recruits was completed and our Mental Health Lead worked with training and education colleagues to ensure that appropriate training on mental health legislation was delivered to international recruits.
- The introduction of mental health nurses into our Emergency Operations Centre (EOC) has also served to improve the knowledge and skills of our staff working within that environment. EOC staff have reported gaining invaluable knowledge to enhance the patient care experience.
- Currently work is being undertaken to review our mental health e-learning package which will be carried forward to the 16/17 action plan.

**4.2.** As part of the dementia CQUIN, we provided dementia awareness training for our staff with the overall aim of improving the care and recognition of patients with dementia. We achieved this objective through three main channels.

- We published a series of Routine Information Bulletin (RIB) updates regarding dementia and dementia friends initiatives encouraging all members of LAS staff to become dementia friends.
- We worked with University College London (UCL) Partners to enable face to face delivery of dementia training to different categories of LAS Staff. We recognized that ambulance clinicians will benefit from increased knowledge and awareness of dementia to assist in the identification of patients who require dementia-appropriate community services, and initiation of appropriate liaison / links with these services, we worked with UCL Partners delivered 'train the trainer' half day sessions to groups of clinical tutors.
- We also delivered face to face Dementia Awareness sessions to our EOC staff ensuring that our Emergency Medical Dispatchers (EMD) are able to manage dementia patients appropriately. Further dementia training and education activities have been agreed for 2016/17 with a session on dementia and cognitive impairment being included in the next round of Core Skills Refresher training beginning in April 2016.

**4.3.** A further initiative was the roll out of the mental health risk awareness tool (LA383) across the service. This tool was developed as a result of a pilot conducted by LAS in the Hillingdon area and was rolled out as part of a second CQUIN initiative this year. The LA383 is being used as an aid to crews' assessment of patients presenting with mental health issues. In conjunction with the crews' clinical training and holistic view of the patient, a care response is decided.

**4.4.** One of the key concepts of the mental health risk awareness tool and objectives of the project is to effectively transfer useful patient information to secondary care. Feedback received at the evaluation stage from our partners shows that LAS have achieved this goal and the information handed over by LAS staff is appropriate and being used by receiving clinicians to make decisions and plan follow up care.

**4.5.** The overall impression of LAS staff gathered via survey monkey was a subjective reflection on the usefulness of the mental health risk awareness tool with 53.34%

finding the tool 'very helpful'. This feedback coupled with review of the Mental Health Clinical Performance Indicators (CPI) and an in-depth look at six case studies where the LA383 has been used evidences that LAS achieved its main aim of facilitating better assessment of mental health patients and conveyance to the most appropriate place of care.

## 5. Parity of Esteem for Mental Health.

**5.1.** The Mental Health Crisis Care Concordat (2014), Five Year Forward (2015) and Five Year Forward View for Mental Health (2015) have all highlighted and made recommendations for achieving the ambition of parity of esteem between mental and physical health.

**5.2.** During the course of the year we have delivered several initiatives which go some way in fulfilling the parity of esteem agenda.

**Crisis Care Concordat Mapping -**The Mental Health Crisis Care Concordat focuses on four main areas of access to support before crisis point ; Urgent and Emergency access to crisis care ensuring that a mental health crisis is treated with the same urgency as a physical health emergency; quality of treatment and care when in crisis and recovery and staying well through preventing future crises by making sure people are referred to appropriate services. During the course of the year, LAS has engaged with all mental health trusts in London with the exception of Tavistock & Portman which is a specialist trust, ensuring local and central engagement. We have endeavoured to maintain on-going partnership arrangements with all our partners. The chart below shows the level of local mental health engagement maintained by LAS. A new operational model was introduced in September 2015 which has seen the introduction of Stakeholder Engagement Managers who are able to provide LAS representation at local meetings. Attendance at all meetings is not always possible however, we have established networks locally allowing us to progress mental health initiatives and resolve issues locally more efficiently.

| **Year to date LAS local partnership engagement 2015/16** | | | |
|---|---|---|---|
| **Mental Health Trust & Areas** | **Meetings** | **Frequency** | **Attended** |
| Central and North West London NHS Trust | NWL Collaboration of CCGs - MH Programme Board | Quarterly | To attend |
| Barnet, Enfield and Haringay NHS Trust | Inter –agency Mental Health Law Monitoring Group | Bi-monthly | 100% |
| Oxleas Foundation Trust | MPS/LAS/Oxleas Liaison Meeting | Quarterly | 100% |
| South London and the Maudsley NHS Trust | Lewisham CCG Crisis Care Concordat Strategic Development Group | Bi-monthly | 80% |
| East London Foundation Trust | Tower hamlets crisis care concordat group | Quarterly | 100% |

| | | | |
|---|---|---|---|
| North East London Foundation Trust | Mental Health Partnership Meeting | Monthly | 50% |
| Camden & Islington Mental Health Trust | Camden & Islington Criminal Justice Liaison Meeting | Bi-Monthly | 90% |
| South West London & St Georges Mental Health Trust | SWL&SG Section 136 Meetings | Bi-Monthly | 80% |
| West London Mental health Trust | WLMHT Security & Safety Group | Monthly | 50% |

**5.3.** As well as supporting local engagement LAS has maintained strategic links centrally with our Deputy Director of Nursing & Quality and Mental Health Lead attending the Mental Health Partnership Board, Mental Health Partnership Operational Board, Mental Health Crisis Care Sub group and Mental Health Crisis Transport Review. All these bodies are focused on addressing the challenge for the NHS and wider health and social care partners to work together better with patients, the Government and all the wide range of organisations involved in the provision of mental health care. The Executive Lead for mental health care for the Trust, the Director of Nursing and Quality continues to attend Mental Health Trust Directors of Nursing meetings to discuss on-going issues and any other initiatives to improve partnership working arrangements.

**5.4.** LAS have experienced some excellent crisis care responses in London, but this remains inconsistent. These engagement activities support increasing the accessibility and consistency of mental health services across the capital.

## 6. Introduction of Mental Health Nurses

**6.1.** The LAS identified that demand from mental health callers was growing and that mental health specific training within the paramedic curriculum was limited. In 2015 we made a commitment to create six full time mental health clinical advisor posts to supplement existing clinical advisor roles and support the service's hear and treat model. We have currently recruited to 3.5 Whole Time Equivalents (WTE) with 5 staff in post. Recruitment efforts are continuing to fill the remaining 2.5 WTE posts. The introduction of mental health experts within our control room has gone some way in fulfilling the parity agenda. By introducing a hear and treat pathway for mental health patients, this has ensured that patients who may get a low priority response still receive a full mental health assessment and more importantly a risk assessment in a timely manner allowing for appropriate advice to be given and for people to be referred on and linked into the most appropriate service the first time. The work of the mental health nurses is broadly divided into three elements:

- **Hear and treat service** – providing a full mental health assessment and signposting appropriately, upgrading and deciding on the most appropriate course of action, advising patients over the phone.

- **Warm transfers -** assisting call handlers and fellow clinical advisors with the management of difficult mental health calls
- **Advisory Role** – provision of advice to frontline crews around mental health and mental capacity legislation as well as assisting with access to the most appropriate care pathway.

**6.2.** The Clinical Hub (CHub) mental health nurses actively target C1 (20 minute response) C4 (60 minute response) categories of mental health and overdose calls. They call the patient back to undertake a comprehensive clinical assessment using both the Manchester Triage System and Mental Health Risk Assessment methodologies. Following assessment, mental health nurses use their clinical judgment, the nature and urgency of the symptoms, the distance to the nearest hospital, the patient's social situation and available mental health support networks, age, mobility, access to transport, and the likely delay for an ambulance attendance to decide if a face to face assessment is warranted and how the face to face assessment is most appropriately achieved.

**6.3.** An initial evaluation of the mental health nurse role has shown that mental health clinicians have been a source of specialist mental health knowledge and expertise and have been able to provide support to clinical hub staff and crew staff on the road in their day to day management of mental health patients as well as assist call handlers with challenging mental health calls when appropriate. Between March 2015 and March 2016, mental health nurses have responded to 5961 calls with 15.9% of all calls closed with a hear and treat function. There have been no complaints or incidents reported. Their quality assurance reports have been excellent with nurses achieving an average compliance of 99.6% on their individual performance reviews. The accepted compliance level for clinical hub staff is 95%. The LAS will continue to audit and evaluate the role at regular intervals. As well as the collection of activity and outcome data, there are plans to include staff perceptions and quality of interaction with the post holders though semi structured interviews and through an anonymised questionnaire administered through a tool such as survey monkey. Although this has not yet commenced, informal feedback suggests that the mental health nurses have been very well received and are now a well embedded and popular resource within the service.

## 7. Reviewing of Appropriate Care Pathways (ACP)

**7.1.** The decision to use mental health nurses to carry out a hear and treat function needs to have the support of local mental health services. The on-going review and updating of ACPs for mental health urgent care access is also vital in ensuring parity between physical and mental health.

**7.2.** Efforts this year were focused on making sure people with mental health problems are able to access support 24 hours a day and that when they ask for help, they are taken seriously. While we have in place agreed ACPs with all nine mental health trusts across

London there remains significant variation with no standardised approach to how crisis pathways are provided.

**7.3.** Our successes this year have included the introduction of single point of access (SPA) pathways for LAS staff with South London & the Maudsley Mental Health Trust(SLaM), North East London Foundation Trust (NELFT) and Central & North West London Foundation Trust (CNWL). SPAs are accessible 24/7 providing referral services, not just advice, for our staff.

**7.4.** We are currently in discussion with the remaining six mental health trusts to provide a similar service and this work will be carried over to the 2016/17 mental health work plan. LAS also now has access to the three street triage initiatives in London (SlaM, SWL&SG and NELFT) with excellent responses and partnership working shown by the NELFT street triage team.

**7.5.** Going forward, we will continue working with our mental health trust partners to ensure timely and appropriate transport of mental health patients in crisis, to a destination suitable and sensitive to their needs.

## 8. Care of people detained under the Mental Health Act (1983)

**8.1.** A significant amount of our mental health work this year has been aimed at improving the care we provide for people who have been detained under the Mental Health Act (1983). The service responds to two types of patients detained under the mental health act, emergency detention which constitutes section 136 MHA (1983) and planned mental health act assessments.

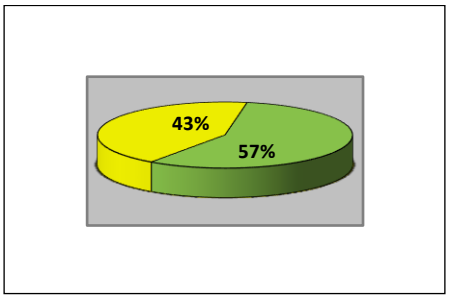
**8.2.** **Planned Mental Health Act (1983) Assessments** - Since March 2012, LAS has had a section conveyance protocol in place offering response times of between 8 minutes – 60 minutes, depending on presentation, for planned admissions under the Mental Health Act. However given the increasing demand for LAS resources there is recognition that there have been challenges in providing transport to this specific group of service users within the protocol specifications. Further concerns were also expressed by service users, carers and other agencies about the current transport arrangements which led to a review of our responses to people who have been detained under the Mental Health Act.

We have now completed this review led by NHS England and our commissioners with a recommendation to move planned mental health act assessments to our Non-Emergency Transport Service (NETS). In partnership with our mental health colleagues there was an agreement that a sizable proportion of planned mental health act assessments can be safely dealt with by the NETS. We are currently piloting this service within the Camden & Islington area with a view to rolling it across London by September 2016. The NETS uses a preplanning and scheduling system to maximize effectiveness to meet the maximum number of patients requiring transport with a performance target of pre-planned booking getting a vehicle 90% of the time, before or at the time stated and 100% of bookings will be achieved up to 30 minutes after the

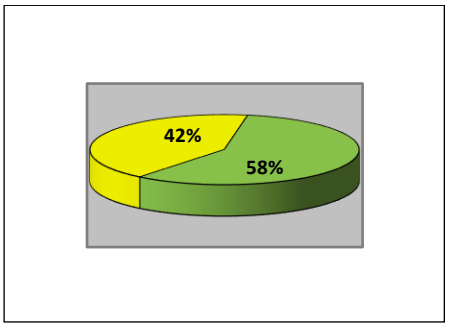
booked time. This initiative will also support the parity of esteem agenda by ensuring that mental health patients who have been detained under the mental health act receive the most appropriate resources in timely fashion.

**8.3. Detentions under Section 136 of the Mental Health Act (1983) -** A national section 136 protocol directly informed by the Mental Health Crisis Care Concordat was introduced and implemented within the Trust in April 2014. Its aim was to introduce clearer systems for NHS Ambulance Trusts when working with the Police and Mental Health Professionals resulting in a much quicker clinical response recommending a response time of 30minutes to all persons detained under section 136 of the MHA (1983). It also outlines how patients who are being actively restrained will receive an immediate, high priority response (8minutes) whilst red flag criteria have been identified as triggers for conditions requiring treatment or assessment in an emergency department. While the service continues to face challenges in our ability to respond to all section 136 incidents in the specified time frames we have seen an improvement throughout the year in our response times as shown by the pie charts below.

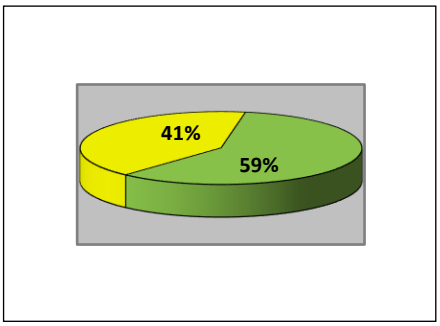
**8.4.** The pie charts below show actual section 136 response times reported by LAS to the MHPB throughout the year. A total of 871 section 136 incidents were dealt with by the LAS between March 2015 and May 2016.




**March-May 2015**



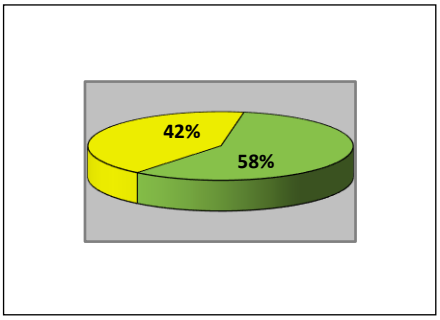

**June-August 2015**



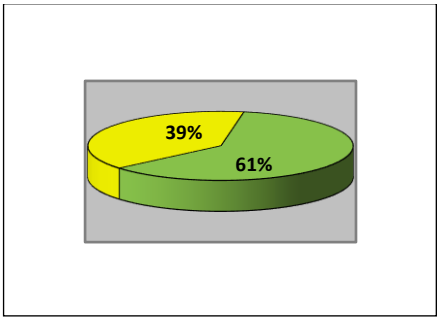

Response time> 30min

Response time <30min

**Sept-Nov 2015**




**Dec – Feb 2016**




**March – May 2016**

**8.5.** The Mental Health Crisis Concordat proposes a response within 30 minutes for all people detained under section 136 of the MHA (1983). Areas of the chart coloured green indicate response times that meet this criteria while yellow areas reflect the proportion of incident response times in excess of 30 minutes. Good performance is therefore indicated by a largely green chart. Please note these figures represent actual response times not triage categorisation. Further data analysis work is planned n 2016/17 to clarify the correlation between triage categories and actual response times to section 136 incidents.

**8.6.** The service has concentrated efforts this year on understanding the section 136 data that we collect, how we triage and respond to these calls. This data is triangulated with the Metropolitan Police Service (MPS) data at the Mental Health Partnership Board(MHPB) and is being used to improve inter-service understanding of the drivers of demand as well as enabling LAS and MPS to work collaboratively to identify areas for improvement.

**8.7.** A section 136 audit was undertaken by the Clinical Audit and Research Unit (CARU) in December 2015 which has helped to identify some of the issues associated with ambulances not being dispatched within the concordat specifications. Some issues highlighted include:

- Insufficient information supplied by MPS to LAS at the point of contact which affects the triage process.
- Internal issues around some LAS staff being unaware of some of the guidance and policies relating to Mental Health Act response times.

**8.8.** A deep dive into our section 136 data suggests that where LAS have been provided with correct information such as the use of restraint, we have been able to triage calls, apply the correct categorization and respond in line with the response time identified. Performance monitoring information from the Mental Health Partnership Board suggests that LAS are now responding to the majority (61%) of Section 136 incidents within the concordat specifications.

**8.9.** Our mental health lead has successfully reviewed all Mental Health guidance across the Trust ensuring that this is disseminated effectively to staff as well as external work with the MPS ensuring that their policies and protocols around section 136 incidents are in line with LAS procedures including the Memorandum of Understanding (MOU) between the LAS & the MPS. It is envisaged that this work will help drive improvement in LAS response times to patients detained under section 136 in particular that these patients are correctly triaged with a target response time appropriate to their presentation.

**8.10.** Our long term aspirations are that that the service will respond to all section 136 within the crisis care concordat specifications and will convey all patients except in exceptional cases. Where a police vehicle is deemed the most appropriate

conveying vehicle for reasons of safety a paramedic will accompany the police to monitor the person's clinical presentation.

## 9. Mental Health and Wellbeing of our workforce

**9.1.** In their independent report setting out how national bodies, including health agencies and government departments, should work together over the next five years to improve mental health, 'Five Year Forward View for Mental Health' (March 2015), the Mental Health Taskforce notes the importance of responding to the health and wellbeing needs of NHS and social care staff themselves, and the need to improve morale and the psycho-social working environment, especially given ever increasing pressures.

**9.2.** LAS have a vision that all staff members enjoy the greatest possible state of wellbeing and our goal is to help staff stay healthy longer. In April 2010 the LAS launched its Wellbeing Strategy which focuses on reducing workplace related stress by promoting physical and emotional wellbeing, to help our workforce reduce high levels of sickness absence from work. One of the key priorities for action identified in the LAS Wellbeing Strategy is to increase knowledge and understanding of mental health issues among our workforce.

**9.3.** This year we continued to focus our efforts around mental health awareness and available support for our workforce. The Service has signed the Blue Light Time to Change pledge, offering dedicated wellbeing support to our staff as they work round the clock to keep patients safe. Our Practice Learning Manager for Control Services has done some extensive work with the mental health charity MIND, providing significant and inspirational training around mental health awareness to the majority of our EOC staff which enhances the previous work she has completed with some managers and supervisors. 383 staff have so far attended the one day MIND courses. Several publications focusing on raising awareness and reducing stigma associated with mental illness have been shared in the organisation with over 800 booklets distributed to staff. We have supported over 300 staff to have face to face interactions with mental health service users from Hear Us, another mental health charity we have been working closely with since 2013. LAS acknowledges that supporting the mental health of our staff is fundamental to good health, quality of life and translates into good quality care for our patients. We will therefore continue to address it as part of the Trust's overall improvement strategy.

## 10. Care Quality Commission (CQC) Report-Mental Health Care

**10.1** The Care Quality Commission (CQC) carried out a planned inspection of the LAS in June 2015 and their report was published at the end of November 2015. While it gave the organisation a "good" rating for the care of patients, it highlighted a number of areas of concern and judged the Service to be "inadequate" overall, and as a result the Trust were placed in "special measures".

**10.2** Mental Health areas for improvement are to :

- Review operational guidelines for managing patients with mental health issues and communicate these to staff.
- Provide NICE cognitive assessment training for frontline ambulance staff.

**10.3** Following the CQC inspection, LAS developed a Quality Improvement Plan (QIP) and mental health actions are being delivered within the QIP. Work is already in progress to deliver the mental health actions under two QIP headings of Improving Patient Experience and Making the Ambulance Service a great place to work.

**10.4** All mental health guidelines have been reviewed by the Mental Health Lead with the support of the Deputy Director of Nursing & Quality and a session on cognitive assessment and dementia has been included in CSR 2016.1 for delivery between April –September 2016.

## 11. Improving Safety and Quality

**11.1** The LAS places emphasis on the need to continue to work to build a transparent culture that ensures incidents and near misses are reported because this is an essential part of quality improvement allowing the organisation to learn, and share that learning to inform service provision and improve patient safety and care. The Service continues to work to improve the quality of the care we provide to our mental health callers, investing in our staff, resources and technology. We listen and we learn from our patients, carers, staff and the public.

**11.2** We have focused on improving how we use incident information to identify emerging themes and common problems. Our mental health lead maintains close links with our patient experiences and governance departments providing mental health specific guidance when indicated. Patient experience and feedback remains a rich source of information that allows us to understand whether mental health care provision is meeting the needs and expectations of our patients.

**11.3** Themes identified from mental health complaints are consistent with other presentations and similar to previous years. Overall themes of delayed response and staff attitude continue to dominate. We maintain effective engagement with partner agencies when they declare serious incidents or near misses and use this information to inform our learning.

**11.4** One such complaint involved a patient who had called her mental health team initially complaining of feeling depressed and suicidal but felt that she did not get any help. She had subsequently called NHS111 who referred the call to LAS. She was conveyed to hospital where she was assessed by a mental health team and discharged. On arriving home she had called NHS111 again resulting in a second ambulance being dispatched. She made a complaint that one of the crew members had been dismissive and she felt the staff were not taking her seriously and becoming very impatient with her. A clinical review indicated that the care and assessments provided on scene had been appropriate however the staff concerned were provided with feedback and given an update on self-

awareness and treating all patients with dignity and respect in keeping with the service learning approach.

**11.5** During 2015/16 we completed two separate pieces of patient engagement work focusing on the care we provide to mental health callers and dementia patients and their carers. Recognising that service user involvement and engagement is a key focus of our mental health work, LAS engaged the services of an independent Patient and Public Involvement (PPI) facilitator who worked closely with our Patient and Public Involvement team to hold focus groups across London initially with people with mental health problems followed by people suffering from dementia and their carers.

**11.6** Some rich data was gathered relating directly to mental health service users and dementia patients experiences of using the LAS which will be used to inform the LAS mental health work plan 2016/17. It was reassuring to note that both sets of patients viewed the LAS as a caring service with dedicated staff. Themes arising from the feedback are familiar with findings from other patient engagement work with the top three being delays, staff attitude and behaviour, and the importance of staff training in mental health.

**11.7** Our Clinical Audit & Research Unit has also supported the mental health safety and quality agenda. Two clinical audits were undertaken during the year relating to care of people detained under section 136 of the mental health act (1983) and a review of the mental health CPI. The Mental Health CPI Review completed in August 2015 reviewed and updated all aspects of care under the Mental Health CPI to ensure they remain in line with the revised UK Ambulance Services Clinical Practice Guidelines. The audit also reviewed the impact of the Mental Health CPI in the three years since its implementation and assessed whether it remains fit for purpose. The audit concluded that the Mental Health CPI has been effective in allowing for the continuous monitoring of care provision to patients with a diagnosed psychiatric problem and has provided evidence for the areas for quality improvement.

**11.8** Although compliance with the mental health CPI remains lower than the 95% benchmark in some specific areas, LAS has seen overall improvements in the level of care provided to patients with a diagnosed psychiatric problem since implementation of the mental health risk awareness tool in October 2015. CARU also highlighted that compliance to mental health guidelines has improved greatly since the Mental Health CPI was introduced in April 2012.

**11.9** The effective recording of the consideration of safeguarding concerns has risen from 50% compliance in April 2015 to 67% compliance in February 2016 representing a positive improvement of 34%. There are already many initiatives underway to improve mental health care, and we acknowledge that more needs to be done to ensure this group of patients receives the high standard of care provided to other patient groups audited via the CPIs. We will continue to monitor the level of care provided to patients with a diagnosed psychiatric problem and feedback to staff via the CPI process.

| LAS Compliance | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Aspect of care** | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 |
| Safeguarding concerns for patient | 50% | 49% | 53% | 58% | 58% | 60% | 67% | 65% | 69% | 64% | 67% |
| Appearance | 77% | 73% | 74% | 73% | 68% | 69% | 77% | 70% | 67% | 70% | 73% |
| Communication | 87% | 88% | 87% | 88% | 86% | 86% | 87% | 84% | 83% | 85% | 85% |
| Mental Health Team | 89% | 89% | 91% | 90% | 92% | 88% | 93% | 89% | 91% | 89% | 89% |
| Expressed thoughts | 89% | 94% | 90% | 91% | 93% | 93% | 91% | 90% | 91% | 89% | 92% |
| Behaviour | 92% | 91% | 92% | 93% | 92% | 92% | 91% | 88% | 87% | 89% | 90% |
| At least one set of obs recorded & time logged | 97% | 95% | 97% | 95% | 94% | 94% | 95% | 96% | 96% | 95% | 94% |
| Blood glucose reading recorded | 95% | 96% | 95% | 96% | 95% | 96% | 96% | 96% | 96% | 96% | 95% |
| Safeguarding concerns for children | 95% | 96% | 95% | 94% | 95% | 97% | 94% | 93% | 85% | 92% | 89% |
| Capacity tool | 96% | 96% | 95% | 97% | 97% | 97% | 97% | 97% | 97% | 98% | 98% |
| Psychiatric history | 98% | 98% | 99% | 98% | 98% | 99% | 99% | 98% | 99% | 98% | 98% |
| History of current event | 100 | 98% | 99% | 99% | 97% | 97% | 100 | 99% | 98% | 99% | 98% |
| Medical history | 99% | 99% | 98% | 98% | 98% | 99% | 99% | 99% | 99% | 96% | 98% |

**Figure 1: Compliance to the Mental Health CPI aspects of care**

## 12 Serious Incidents

**12.1** LAS Serious Incident Group (SIG) declared one serious incident regarding mental health care in 2015/16. This related to a call received in our Emergency Operations Centre regarding a 60 year old female who reported that she had slashed her wrists. During key questions the Emergency Medical Dispatcher incorrectly selected that the patient was threatening suicide when the identifier 'Laceration;' should have been selected. Had the EMD selected the correct answer, two further questions would have presented asking the specific location of the laceration to identify if there was any serious bleeding. This led to the call receiving a C4 (60minute) response. There was a response time of 38 minutes and 44 seconds to a call which could have been identified as a Category A and been allocated an R2 (30min) response which may have caused harm to the patient. This was identified as an issue around individual learning which was addressed with the staff member concerned.

## 13 Mental Health Risks

**13.1** The LAS Mental Health Committee reviews all Mental Health Risks. Two risks are currently on the Trust corporate risk register and two are held on the local mental health risk register. **Figure 2** below shows details of all mental health risks.

| Risk number | Risk | Action to mitigate |
|---|---|---|
| **Corporate Risk 456** | There is a risk that staff may fail to identify physical health and/ or organic causes of mental health presentations which may lead to a delay in patients receiving the right care at the right time. | -introduced a mental health risk awareness tool<br>-mental health nurses in EOC |

| | | |
|---|---|---|
| | | -CPD events –Risk currently under review to be removed from corporate register. |
| **Corporate Risk 455** | There is a risk that we may not be able to convey all patients detained under section 136 MHA (1983). This leads to a lack of physical health screening for these patients which may affect the care they receive. | Ongoing engagement with police colleagues including joint training and education. Also forms part of QIP |
| **Local Risk 1** | There is a risk that all clinical staff may not receive yearly mental health training updates appropriate to their role which may lead to a dilution of mental health skills and knowledge. This could result in poor patient experiences. | Mental health updates provide by MH Lead to APPs , CTLs. |
| **Local Risk 2** | There is a risk that the Trust is not able to provide access to specialist mental health support as identified due to the limited availability of mental health specialists. | Ongoing recruitment efforts to provide 24/7 mental health nurse cover to EOC |

## 14 Conclusion - Our ambition for the future

**14.1** We are extremely proud of the progress we are making in shaping the service so that it continues to improve the quality of mental health care for our patients as well as supporting the mental health needs of our workforce.

**14.2** The service continues to provide a good quality and safe service to mental health patients with continuous improvements being undertaken despite the extremely challenging nature of managing a mental health crisis in the pre-hospital setting.

**14.3** We end 2015/16 with a focus on delivering actions from our Quality Improvement Plan as recommended by the CQC.

**14.4** While we have invested significantly over the course of the year in improving quality and safety for our mental health patients, we acknowledge that the quality of our services is not always consistently excellent. We remain committed to continuing our well-established Programme of mental health service improvement via the mental health work plan ensuring that our staff feel more valued and are motivated to deliver better care.

**14.5** The 2015/16 Mental Health Action Plan progressed well with most improvement items successfully delivered. Appendix One below provides a summary of the progress made with the mental health action plan in 2015/16. It seeks to provide details of those actions that were completed and partially completed. It also highlights improvement items that will be carried over to the 2016/17 action plan.

**14.6** As we move into 2016/17, we are planning to complement our staff training and development activities via our Quality Improvement Plan. These include our commitment to developing the mental health skills and education of our workforce with a particular focus on recruiting to the remaining 2.5 mental health nurse posts, delivering high quality, compassionate mental health care, improving existing and developing new partnerships to ensure mental health service users and carers experience seamless care which

empowers them and meets their physical, mental and social health and wellbeing needs. We also aim to develop processes that enable sharing of information between services to ensure more effective integrated, safe and joined up mental healthcare.

London Ambulance Service NHS Trust

| | |
|---|---|
| **Report to:** | **Trust Board** |
| **Date of meeting:** | **4 October 2016** |
| **Document Title:** | **Annual Emergency Preparedness, Resilience and Response (EPRR)** |
| **Report Author(s):** | **Brian Jordan, Business Manager to the Director of Operations** |
| **Presented by:** | **Paul Woodrow, Director of Operations** |
| **Contact Details:** | **paul.woodrow@lond-amb.nhs.uk** |
| **History:** | **An earlier version of this paper was discussed at the Board session held on 21 September 2016** |
| **Status:** | **This paper is presented for information and to provide assurance** |

## Background/Purpose

The London Ambulance Service (LAS) is required to submit its annual self-assessment as part of the 2016/17 EPRR assurance process. NHS England (London) uses this assessment to gain assurance that the Trust is prepared to respond to an emergency and has the resilience in place to continue to provide safe standards of patient care during a major incident or business continuity event.

This self-assessment requires 36 EPRR, 14 CBRN, 19 MTFA and 21 HART related standards to be RAG rated against our level of compliance. Our first self-assessment was submitted to NHS England (London) on 14 September 2016 and is available to members of the Board on request.

Two assurance review meetings will be held with NHS England (London), one on 17 October 2016 and the other in early November (date still to be confirmed), to review the self-assessment and agree any actions which are required to address any deficiencies. The Director of Operations will be in attendance at these meetings together with senior EPRR leads.

Should the Trust's internal ratings be accepted by NHS England (London), and if the subsequent work plan to address the areas of deficiency is accepted by the Board, then the Trust will be able to submit a final self-assessment rating of '*substantial*' compliance.

If one further standard is deemed to be amber or red then the Trust will receive a rating of '*partial*' compliance which will be the same as last year's outcome despite the improvements which EPRR has made over the last twelve months.

This paper provides the Board with the following information:

- The actions which are required to support the Trust's self-assessment submission
- The risks to achieving 'substantial' compliance
- The next steps for updating the Board.

## Action required

This paper is presented for information and to provide assurance.

| Key implications and risks arising from this paper | |
|---|---|
| **Clinical and Quality** | |
| **Performance** | |
| **Financial** | |
| **Workforce** | |
| **Governance and Well-led** | |
| **Reputation** | |
| **Other** | |
| **This paper supports the achievement of the following Quality Improvement Plan Workstreams:** | |
| **Making the London Ambulance Service a great place to work** | |
| **Achieving Good Governance** | |
| **Improving Patient Experience** | Y |
| **Improving Environment and Resources** | Y |
| **Taking Pride and Responsibility** | |

London Ambulance Service NHS
NHS Trust

**ANNUAL EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ASSURANCE ASSESSMENT**

## 1. Background

The London Ambulance Service (LAS) is required to submit its annual self-assessment as part of the 2016/17 EPRR assurance process. NHS England (London) uses this assessment to gain assurance that the Trust is prepared to respond to an emergency and has the resilience in place to continue to provide safe standards of patient care during a major incident or business continuity event.

This self-assessment requires 36 EPRR, 14 CBRN, 19 MTFA and 21 HART related standards to be RAG rated against our level of compliance. Our first self-assessment was submitted to NHS England (London) on 14 September 2016 and is available to members of the Board on request.

Two assurance review meetings will be held with NHS England (London), one on 17 October 2016 and the other in early November (date still to be confirmed), to review the self-assessment and agree any actions which are required to address any deficiencies. The Director of Operations will be in attendance at these meetings together with senior EPRR leads.

Within two weeks of the final assurance review meeting being held, LAS must submit the following documentation to NHS England (London):

- The results of LAS's final EPRR RAG scores as agreed at the review meeting
- A resulting action/work plan which details clear actions, timescales and leads to address the areas where the organisation has scored red or amber
- A declaration of the level of compliance achieved. These levels are as follows:

| Compliance Level | Evaluation and Testing Conclusion |
|---|---|
| Full | Arrangements are in place that appropriately address all the core standards that the organisation is expected to achieve. The Board has agreed with this position statement. |
| Substantial | Arrangements are in place, however they do not appropriately address one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed. |
| Partial | Arrangements are in place, however they do not appropriately address six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed |
| Non-compliant | Arrangements in place do not appropriately address eleven or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance. |

## 2. Self-assessment – 2016/17 compared to 2015/16

The definitions used to assess overall compliance have changed this year and it has been confirmed by NHS England (London) that core standards which are '*not appropriately addressed*' will now include all red and amber scores.

This change in definition could result in EPRR's significant improvements not being fully recognised in the overall compliance level.

The RAG ratings for the standards achieved last year, and currently self-assessed for this year, are as follows:

**EPRR**

| Rating | 2015/16 | 2016/17 |
|---|---|---|
| Red | 4 | 0 |
| Amber | 7 | 2 |
| Green | 23 | 32 |

**HAZMAT & CBRN**

| Rating | 2015/16 | 2016/17 |
|---|---|---|
| Red | 0 | 0 |
| Amber | 0 | 0 |
| Green | 14 | 14 |

**MTFA**

| Rating | 2015/16 | 2016/17 |
|---|---|---|
| Red | 0 | 0 |
| Amber | 1 | 0 |
| Green | 18 | 19 |

**HART**

| Rating | 2015/16 | 2016/17 |
|---|---|---|
| Red | 2 | 0 |
| Amber | 5 | 2 |
| Green | 14 | 19 |

## 3. Forecast outturn

Should the Trust's internal ratings be accepted by NHS England (London), and if the subsequent work plan to address the areas of deficiency is accepted by the Board, then the Trust will be able to submit a final self-assessment rating of '*substantial*' compliance.

If one further standard is deemed to be amber or red then the Trust will receive a rating of '*partial*' compliance which will be the same as last year's outcome despite the improvements which have been made over the last twelve months.

## 4. Actions required to support the Trust's self-assessment submission

A number of actions are required across several of the core standards to support the ratings which the Trust has submitted to NHS England (London). Undertaking these actions will help to ensure that the Trust achieves the self-assessed ratings for some core standards while other actions have the potential to improve the self-assessed rating for one core standard.

The action plan for this work is located at appendix one and details the core standard concerned; the action required; the lead for delivering the action; and the timescale for delivery.

## 5. Risks to achieving 'substantial' compliance

It is entirely possible that NHS England (London) may disagree with how the Trust has rated its core standards and provide a rating lower than 'substantial' compliance. This is despite clear evidence that significant improvements have been made over the last year (as evidenced in section 2).

Prior to the review meetings, documentary evidence will be submitted to support the Trust's submission and to demonstrate the progress that has been made over the last twelve months. At LAS's request, NHS England (London) has been assisting the Trust throughout the past year to achieve the deliverables of the action plan which was developed following last year's assurance review. As part of this assistance, NHS England (London) provided specialist staff to review our documentation and plans.

In terms of this year's annual assurance rating, the main area of risk to achieving a '*substantial*' rating relates to the four HART standards which focus on the Trust's ability to provide two teams of six HART operatives across a 24 hour period despite significant improvements having been made in this area over the last year. Such improvements include:

- LAS recruiting to all of its 84 established posts (the Trust currently has a total of 85 HART operatives in post)
- Work is underway to increase the HART establishment by a further 14 as a way of mitigating on day absences, to increase the clinical exposure of HART staff and to improve the efficiency of tactical medical operations capability. Based on the recruitment process currently being conducted, six of these 14 will start with HART in October taking HART to seven staff members above its establishment
- The Trust has sponsored five Emergency Medical Technicians (EMTs) to undertake an externally provided paramedic programme as a way of maximising this specific staff group's HART experience while also seeking to comply with the national specification.

Despite these actions previously or currently being implemented, there are occasions when the HART teams have been incomplete. On each occasion, appropriate and agreed action plans have been implemented to mitigate any risk and to meet the requirements for a HART response and activation standards primarily through the tactical placement of LAS HART staff to support either East or West teams or through mutual aid arrangements with the South East Coast Ambulance Foundation Trust (which it has never been necessary to activate). HART rosters have been reviewed on a daily basis to maximise capacity as far as possible with overtime incentives being offered to fill gaps in the rosters. The Trust also sought to second HART operatives from other ambulance trusts across England however this was not possible due to HART capacity pressures across the country.

Although there have been no reported instances when LAS has been unable to provide a full HART team to respond to an incident when required, if NHS England (London) interpret these standards as requiring 100% complete HART teams on all occasions then LAS will not achieve a green rating for these four standards which in turn will result in a '*partial*' rather than '*substantial*' compliance rating.

Appendix two shows our assessment of this risk (together with current controls and future actions) as well as other risks which threaten our delivery of the actions documented in appendix one.

**6. Next steps**

Although the assurance review meeting for the EPRR standards is being scheduled for early November, the HART, CBRN & MTFA review meeting has been scheduled for 17 October 2016. The Trust will therefore have a clearer picture in terms of the HART risks mentioned in section 5 within the next three weeks.

A further update will be provided to the Board when it meets for the Strategy Review and Planning Committee meeting on 25 October 2016. This update will provide details of the discussions held on 17 October 2016 together with a progress report on the action plan and risk log attached at appendices 1 and 2.

Paul Woodrow
**Director of Operations**
**30 September 2016**

**Appendix 1: Actions required to support self-assessment submission**

| Standard | Clarifying Information | Self- Assessment | Action required | Lead/date for delivery |
|---|---|---|---|---|
| *1 – 4. Organisations maintain a HART capability at all times within their operational service area (IRU, USAR, IWO, TMO)* | *Organisations take sufficient steps to ensure their HART unit(s) remains complaint with the National HART Standard Operating Procedures during local and national deployments.* | **GREEN**<br><br>**Actions identified in the next column must be achieved in order to fulfil the green rating as identified in the self-assessment.** | The HART consultation paper which details the plans to change the HART rosters and annual leave arrangements (in order to improve HART capacity) will be finalised | Deputy Director of Operations (Central Operations)<br><br>7 October 2016 |
| | | | A dedicated pack evidencing all the improvements which the Trust has undertaken to strengthen HART capacity will be submitted to NHS England (London) ahead of the review meeting on 17 October 2017. | Deputy Director of Operations (Central Operations)<br><br>7 October 2016 |
| *8. Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity.* | *Corporate and service level business continuity (aligned to current nationally recognised business continuity standards)* | **GREEN**<br><br>**Actions identified in the next column must be achieved in order to fulfil the green rating as identified in the self-assessment.** | The revised business continuity policy needs to be approved by the Policy Approval Group prior to the November review in order to achieve this green rating. This policy will be submitted to the group during w/c 26/09/16. | Deputy Director of Operations (Central Operations)<br><br>~~28/09/~~16 Complete |
| | *Severe weather (heatwave, flooding, snow and cold weather)* | | Adverse weather plans currently being finalised and will be ready for the November review meeting. | Assistant Director of Operations (Resilience)<br><br>Adverse weather plans to be ratified by the Operations Board<br><br>20/10/16 |

| Standard | Clarifying Information | Self- Assessment | Action required | Lead/date for delivery |
|---|---|---|---|---|
| | *Mass countermeasures (e.g. mass prophylaxis, or mass vaccination)* | | Supporting statement to be included in the Incident Response Plan about the delivery of mass countermeasures. | Deputy Director of Operations (Central Operations)<br><br>~~23/09/16~~ Complete |
| *MTFA Standard 6. Organisations have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.* | | **GREEN**<br><br>**Actions identified in the next column must be achieved in order to fulfil the green rating as identified in the self-assessment.** | Evidence of Trust revenue depreciation policy (finance planning policy) and statement of intent to be provided by the finance department. | Deputy Director of Finance<br><br>13/10/16 |
| *HART Standard 12. Organisations ensure that a capital estate is provided for HART that meets the standards set out in the HART estate specification.* | | **AMBER**<br><br>**It is possible that this standard will improve to Green prior to November subject to contractors being able to meet the required deadline.** | Security review of HART sites | Senior Health, Safety and Risk Advisor<br><br>~~August 2016~~ Complete |
| | | | Security screen installation | Estates Building Surveyor<br><br>31 October 2016 |
| | | | Increased CCTV coverage | Estates Building Surveyor<br><br>31 October 2016 |
| | | | Security card access system upgrade | Estates Building Surveyor<br>31 October 2016 |

| Standard | Clarifying Information | Self- Assessment | Action required | Lead/date for delivery |
|---|---|---|---|---|
| | | | Fire hydrant access approval | Head of CBRN and HART<br><br>~~14 October 2016~~<br>Complete |

## Appendix 2: Risks to achieving 'substantial' compliance

| # | Risk | Gross Rating | Controls | Current/ net rating | Further actions | Target Rating |
|---|---|---|---|---|---|---|
| 1 | There is a risk that NHS England (London) assess compliance against the four HART standards (which relate to the Trust's ability to provide two teams of six HART operatives across a 24 hour period) differently to the Trust. | 12  | • LAS has recruited to all of its 84 established posts (the Trust currently has a total of 85 HART operatives in post)<br>• Work is underway to increase the HART establishment by a further 14 as a way of mitigating on day absences. Based on the recruitment process currently being conducted, six of these 14 will start with HART in October 2016 taking HART to seven staff members above its establishment (91)<br>• The Trust has sponsored five Emergency Medical Technicians (EMTs) to undertake an externally provided paramedic programme as a way of maximising this specific staff group's HART experience while also seeking to comply with the national specification<br>• While there have been occasions when the HART teams have been incomplete, appropriate and agreed action plans have been in place to mitigate any risk and to meet the requirements for a HART response and activation standards primarily through the tactical placement of LAS HART staff to support either East or West teams or through mutual aid arrangements with the South East Coast Ambulance Foundation Trust (which it has never been necessary to activate)<br>• HART rosters are reviewed on a daily basis to maximise capacity as far as possible with overtime incentives being offered to fill gaps in the rosters<br>• The Trust has sought to second HART operatives from other ambulance trusts across England however this was not successful/possible due to HART capacity pressures across the country. | 9  | • A dedicated pack documenting all the evidence documented under 'Controls' will be submitted to NHS England (London) by 7 October 2016 by the Deputy Director of Operations (Central Operations)<br>• The HART consultation paper which details the plans to change the HART rosters and annual leave arrangements (in order to further improve HART capacity) will be finalised by 7 October 2016 by the Deputy Director of Operations (Central Operations)<br>• The continuous HART recruitment process will remain on-going. | 9  |

| # | Risk | Gross Rating | Controls | Current/ net rating | Further actions | Target Rating |
|---|---|---|---|---|---|---|
| **2** | There is a risk that the adverse weather plans are not ready for the November review meeting with NHS England (London) | **12**  | • The plans have been developed in consultation with the subject matter experts at NHS England (London)<br>• Comments on the final draft plans have already been received from NHS England (London). | **6**  | • An internal peer review session for the plans has been scheduled for the week commencing 3 October 2016<br>• The plans are scheduled to be ratified by the Operations Board on 20 October 2016. | **4**  |
| 3 | There is a risk that the finance planning policy is not ratified ahead of October's meeting with NHS England (London) | **12**  | • The Finance and Investment Committee (FIC) has approved this policy however minor comments were made by the Policy Management and Approval Group which have been directed back to the FIC. The Deputy Director of Finance has provided assurance that Chair's action will be taken by the FIC before 13 October 2016 to ensure that a ratified policy is available for the meeting with NHS England (London) on 17 October 2016. | **3**  | • A senior finance representative will be available on 17 October 2016 should NHS England (London) have any queries about the policy. | **3**  |
| 4 | There is a risk that the Trust fails to meet the HART estate specification. | **15**  | • Over the last twelve months, the Trust's estates department has reviewed each of the gaps against the estates HART specification<br>• The estates report was subsequently submitted to NHS England (London) and NARU and advice was sought in terms of what reasonable measures should be taken by the Trust to provide necessary assurances and compliance with the HART estate specification<br>• On the basis of their response, the Deputy Director of Operations (Central Operations) tasked the Trust's security experts to review their recommendations. The following security measures were identified as being required:<br>*a security screen at Cody Road<br>*improved CCTV coverage at both HART sites<br>*an upgraded security card access system at both sites.<br>• The complete work has been costed at approximately 30 – 40K. Finance has approved this funding.<br>• The estates building surveyor is placing orders for all of the work required with the relevant contractors on Friday 30 September with delivery deadlines of 31 October 2016. | **9**  | • Weekly contractor progress reports will be supplied to the Deputy Director of Operations (Central Operations) by the Estates Building Surveyor<br>• Named HART managers will be provided as points of contact for each of the contractors<br>• Copies of contractor agreements (with 31 October deadlines) will be provided to NHS England (London) as part of the documentary evidence submitted to them. | **6**  |

London Ambulance Service NHS Trust

| | |
|---|---|
| **Report to:** | **Trust Board** |
| **Date of meeting:** | **4th October 2016** |
| **Document Title:** | **Finance Report Month 5 (August)** |
| **Report Author(s):** | **Andy Bell, acting Deputy Director of Finance** |
| **Presented by:** | **Andrew Grimshaw, Finance Director** |
| **Contact Details:** | **andrew.grimshaw@lond-amb.nhs.uk** |
| **History:** | **This document has previously been reported to the Finance and Investment Committee** |
| **Status:** | **Presented for assurance purposes.** |

**Background/Purpose**

**Headline:**

Year to date the position is on plan, The year-end position of £6.7m deficit will not be achievable if the current pattern of spend is maintained**.**

**5 key Points**

- Plan / Target – Year to date the position is on plan, The year-end position of £6.7m deficit will not be achievable if the current pattern of spend is maintained. (Amber)
- Year to date the Trust reports on plan at a £3.6m deficit (Amber).
- Year to date CIPs is £0.3m adverse to plan. This relates to delays in the delivery of some programmes that were due to start in Q2. The full year plan of £10.5m is still expected to be achieved. An additional £0.5m has been included in the revised plan to mitigate additional pressure on the QIP programmes. (Amber)
- Capital spend is £2.1m against a revised Capital plan of £2.9m. The capital plan has been re-profiled throughout the year to reflect revised timescales for delivery. To date NHSI has only approved £14.7m of the £19.6m CRL requested. (Amber)
  Cash is £16.5m, £1.6m adverse to plan. The Trust is awaiting confirmation regarding invoicing some specific income lines from NHS England (£2.0m) and LAS Commissioners (£2.5m). (Amber)

**Action required**

The Trust Board is asked to take assurance from the report and to note the Financial Results provided.

**Key implications**

Please see the report.

| Key implications and risks arising from this paper | |
|---|---|
| **Clinical and Quality** | |
| **Performance** | |
| **Financial** | Review of the Financial Position by the Finance and Investment Committee and additional assurance will be provided through the FIC Chair's report to the Trust Board. |
| **Workforce** | |
| **Governance and Well-led** | |
| **Reputation** | |
| **Other** | |
| **This paper supports the achievement of the following Quality Improvement Plan Workstreams:** | |
| **Making the London Ambulance Service a great place to work** | |
| **Achieving Good Governance** | **X** |
| **Improving Patient Experience** | |
| **Improving Environment and Resources** | **X** |
| **Taking Pride and Responsibility** | |

**London Ambulance Service NHS Trust**
**Finance Report - Part 1 – 2016/17**
**Month 5: August**

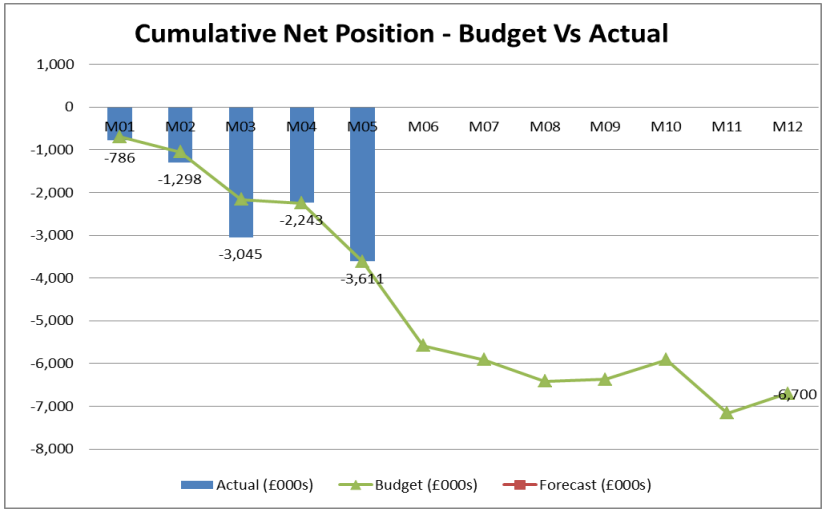
**ELT Meeting – 21st September 2016**
**Trust Board – 4th October 2016**
**FIC – 22nd September 2016**

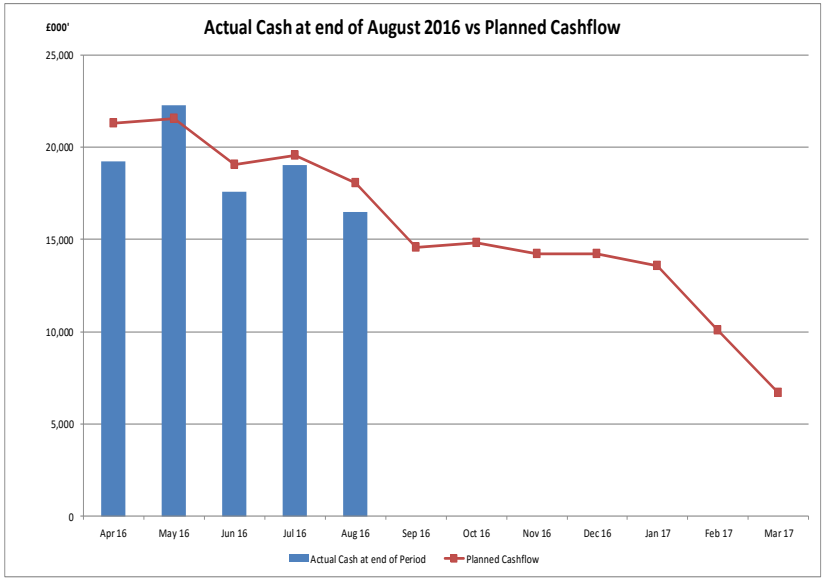
Andrew Grimshaw
Finance Director

# Finance Summary: M5 (2016/17)

| Financial Indicator | Summary Performance | Current Month | Previous month |
|---|---|---|---|
| **Surplus (Year to date)** | Year to date the position is on plan, The year end position of £6.7m deficit will not be achievable if the current pattern of spend is maintained.<br><br>Key issues in the position are:<br>• Additional Overtime, Incentive and PAS support for Frontline Capacity to address increased demand in Q1 & Q2. Demand is currently running above contracted activity growth (circa 5% year to date and 8% in August). This capacity is unfunded.<br>• Across the year to date position this overspend is partly offset by underspends in other areas. This cannot be sustained across the second two quarters. | **AMBER** | **AMBER** |
| **Income** | Income is £0.1m adverse in month and £0.5m adverse YTD.<br>• Education & Training Income is currently below the expected plan YTD by £0.3m. This could recover throughout the year if bids area successful.<br>• 111 Income is £0.4m adverse due to continuing review of operating costs with commissioners. This is offset against reduced cost.<br>• Non Contract PTS income is £0.1m favourable. This is offset by increased costs.<br>• The Trust is seeking additional funds from CCGs in relation to the costs of additional capacity to service the unplanned growth in activity. | **GREEN** | **GREEN** |
| **Expenditure (incl. Financial Charges)** | In month expenditure is £0.1m favourable to plan, YTD the position is £0.5m favourable to plan. The key drivers for this YTD position are:<br>• Core frontline operational staff costs are £6.0m over budget. This includes £3.8m for PAS.<br>• £4.5m Favourable due to underspends in Operational Management, EPRR, NETS and EOC.<br>• £2.1m Favourable in Non Operational divisional spend. | **AMBER** | **AMBER** |
| **CIPs** | Year to date CIPs are £0.2m adverse to plan. This relates to delays in the delivery of some programmes that were due to start in Q2. The full year plan of £10.5m is still seen as achievable. An additional £0.5m has been included in the revised plan to mitigate additional pressure on the QIP programmes. | **AMBER** | **AMBER** |
| **Balance Sheet** | Capital spend is £2.1m against a revised Capital plan of £2.9m. The capital plan has been re-profiled throughout the year to reflect revised timescales for delivery. To date NHSI has only approved £14.7m of the £19.6m CRL requested. | **AMBER** | **AMBER** |
| **Cashflow** | Cash is £16.5m, £1.6m adverse to plan. The Trust is awaiting confirmation regarding invoicing some specific income lines from NHS England (£2.0m) and LAS Commissioners (£2.5m). | **AMBER** | **AMBER** |

# Executive Summary - Key Financial Metrics




| | 2016/17 - Month 5 | | | Year to Date | | | FY 2016/17 |
|---|---|---|---|---|---|---|---|
| | Budg | Act | Var | Budg | Act | Var | Budg |
| | £000 | £000 | £000 fav (adv) | £000 | £000 | £000 fav (adv) | £000 |
| **Dept Health** | | | | | | | |
| Surplus / (Deficits) | (1,371) | (1,372) | (1) | (3,620) | (3,613) | 7 | (6,700) |
| EFL | | | | 2,146 | 3,718 | (1,572) | 13,509 |
| CRL | | | | 2,832 | 2,114 | 718 | 19,599 |
| Suppliers paid within 30 days - NHS | 95% | 91% | (4.0%) | 95% | 80% | (15.0%) | 95% |
| Suppliers paid within 30 days - Non NHS | 95% | 87% | (8.0%) | 95% | 85% | (10.0%) | 95% |
| **Monitor** | | | | | | | |
| EBITDA % | 0.7% | 0.5% | -0.2% | 3.0% | 2.9% | (0.1%) | 3.6% |
| EBITDA on plan | 182 | 136 | (46) | 4,093 | 3,955 | (137) | 11,905 |
| Net Surplus | (1,371) | (1,372) | (1) | (3,620) | (3,613) | 7 | (6,700) |
| NRAF (net return after financing) | | | | (1.5%) | (1.5%) | 0.0% | (2.1%) |
| Liquidity Days | | | | (6.45) | (3.72) | 2.7 | (17.20) |
| FSRR (Financial Sustainability Risk Rating) | | | | 2.0 | 2.0 | 0.0 | 2.0 |

- In Month and YTD the Position is on plan. However, the year end position of £6.7m deficit will not be achievable if the current pattern of spend is maintained.
- Key issues in the position are:
  - Additional Overtime, Incentive and PAS support for Frontline Capacity to address increased demand in Q1 & Q2. Demand is currently running above contracted activity growth (circa 5% year to date and 8% in August). This capacity is unfunded.
  - Further reductions in PAS (25%) and Incentives (10%) have been agreed for Q3 but further action will be required to return to a sustainable position.
  - This overspend is offset by underspends in other areas.
- CRL position – The capital plan is £0.7m behind target.
- Cash is £16.5m, £1.6m below plan. The Trust is awaiting confirmation regarding invoicing some specific income lines from NHS England (£2.0m) and LAS Commissioners (£2.5m).
- FSRR is on target.

# Statement of Comprehensive Income

| 2016/17 - Month 5 | | | Description | Year to Date | | | FY 2016/17 |
|---|---|---|---|---|---|---|---|
| Budg | Act | Var | | Budg | Act | Var | Budg |
| £000 | £000 | £000 fav/(adv) | | £000 | £000 | £000 fav/(adv) | £000 |
| | | | **Income** | | | | |
| 25,343 | 25,343 | 0 | Income from Activities | 128,402 | 128,402 | 0 | 307,718 |
| 1,977 | 1,898 | (78) | Other Operating Income | 9,614 | 9,091 | (523) | 22,921 |
| **27,319** | **27,241** | **(78)** | **Subtotal** | **138,016** | **137,493** | **(523)** | **330,640** |
| | | | **Operating Expense** | | | | |
| 21,286 | 20,551 | 735 | Pay | 104,175 | 99,916 | 4,258 | 252,380 |
| 5,852 | 6,549 | (697) | Non Pay | 29,748 | 33,616 | (3,868) | 66,042 |
| **27,138** | **27,100** | **38** | **Subtotal** | **133,923** | **133,532** | **391** | **318,422** |
| **182** | **141** | **(41)** | **EBITDA** | **4,093** | **3,960** | **(132)** | **12,217** |
| 0.7% | 0.5% | -0.1% | **EBITDA margin** | 3.0% | 2.9% | (0.1%) | 3.7% |
| | | | **Depreciation & Financing** | | | | |
| 1,199 | 1,152 | 47 | Depreciation | 5,943 | 5,807 | 136 | 14,668 |
| 350 | 350 | 0 | PDC Dividend | 1,752 | 1,750 | 2 | 4,204 |
| 4 | 6 | (3) | Interest | 18 | 12 | 6 | 42 |
| **1,553** | **1,508** | **45** | **Subtotal** | **7,712** | **7,569** | **144** | **18,914** |
| **(1,371)** | **(1,367)** | **4** | **Net Surplus/(Deficit)** | **(3,620)** | **(3,608)** | **12** | **(6,697)** |
| (5.0%) | -5.0% | 0.0% | **Net margin** | -2.6% | -2.6% | 0.0% | -2.0% |

The overall financial position is on plan YTD. However, the year end position of £6.7m deficit will not be achievable if the current pattern of spend is maintained.

**Income**

- Income is £0.1m adverse to plan in month £0.5m adverse to plan YTD.
- Education & Training Income is currently below the expected plan YTD by £0.3m. This could recover throughout the year if bids are successful.
- 111 Income is £0.4m adverse due to reducing 111 contracts and activity. This is offset against reduced cost
- PTS Non contract income is higher than expected (£0.1m)

**Operating Expenditure (excl. Depreciation and Financing)**

- On plan in month and £0.4m favourable YTD due to:
  - Ongoing vacancies in Frontline Pay (incl EOC)
  - Partially Offset by high PAS usage in Q1 and 2
  - Overtime, Incentives and PAS costs have all reduced in Month 4 due to agreed overtime construct and PAS contract changes. In addition PAS (25%) and Overtime Incentives (circa 10%) will reduce from Q3.

**Depreciation and Financing**

- Overall Financial Charges are £0.1m favourable to plan in month and YTD.

# Divisional Expenditure (excludes Income)

| 2016/17 - Month 5 | | | Description | Year to Date | | | FY 2016/17 |
|---|---|---|---|---|---|---|---|
| Budg | Act | Var | | Budg | Act | Var | Budg |
| £000 | £000 | £000 fav/(adv) | | £000 | £000 | £000 fav/(adv) | £000 |
| | | | **Operational Divisions** | | | | |
| 12,101 | 13,090 | (989) | Core Frontline (Rostered) | 60,575 | 66,559 | (5,983) | 144,863 |
| 1,503 | 1,330 | 173 | Core Frontline (Non Rostered) | 7,516 | 6,380 | 1,137 | 18,016 |
| 0 | 0 | 0 | Other Frontline | 0 | 0 | 0 | 0 |
| 1,971 | 1,846 | 125 | EPRR | 9,938 | 9,286 | 652 | 23,711 |
| 0 | 0 | 0 | Resource Centre | 0 | 0 | 0 | 0 |
| 2,411 | 2,130 | 281 | EOC | 12,055 | 10,768 | 1,287 | 28,929 |
| 143 | 342 | (199) | PTS | 749 | 1,237 | (488) | 1,531 |
| 689 | 365 | 324 | NETS | 3,444 | 2,018 | 1,426 | 8,278 |
| 500 | 500 | 0 | 111 Project | 3,059 | 2,627 | 432 | 6,704 |
| **19,318** | **19,603** | **(285)** | **Subtotal** | **97,337** | **98,874** | **(1,537)** | **232,032** |
| | | | **Support Services** | | | | |
| 2,119 | 2,336 | (217) | Fleet & Logistics | 10,692 | 10,843 | (152) | 25,488 |
| 932 | 996 | (64) | IM&T | 4,658 | 4,629 | 29 | 11,126 |
| 402 | 395 | 7 | HR | 2,009 | 2,257 | (248) | 4,822 |
| 0 | 0 | 0 | Education & Development | 0 | 0 | 0 | 0 |
| 808 | 851 | (43) | Estates | 3,841 | 3,936 | (94) | 9,685 |
| 18 | 21 | (3) | Support Services Management | 91 | 96 | (5) | 219 |
| **4,278** | **4,599** | **(320)** | **Subtotal** | **21,291** | **21,762** | **(471)** | **51,341** |
| | | | **Corporate** | | | | |
| 240 | 246 | (6) | Chief Executive & Chair | 1,204 | 1,241 | (37) | 2,885 |
| 374 | 359 | 16 | Corporate Services | 1,872 | 1,783 | 89 | 4,492 |
| 0 | 0 | 0 | Business Development | 0 | 0 | 0 | 0 |
| 85 | 66 | 19 | Strategic Communication | 423 | 359 | 63 | 1,015 |
| 338 | 380 | (41) | Finance | 1,692 | 2,011 | (319) | 4,060 |
| 3 | 0 | 3 | Project Management | 14 | 0 | 14 | 33 |
| 131 | 123 | 8 | Nursing & Quality | 656 | 615 | 41 | 1,574 |
| 125 | 85 | 40 | Transformation & Strategy | 623 | 583 | 40 | 1,495 |
| 550 | 1,490 | (940) | Clinical Education & Standards | 2,862 | 5,232 | (2,370) | 6,558 |
| 281 | 264 | 16 | Medical | 1,403 | 1,379 | 25 | 3,367 |
| **2,127** | **3,013** | **(886)** | **Subtotal** | **10,749** | **13,203** | **(2,455)** | **25,482** |
| | | | **Central** | | | | |
| 2,960 | 1,334 | 1,626 | Central Corporate | 12,223 | 7,148 | 5,076 | 28,401 |
| 7 | (0) | 7 | Other Central Costs | 35 | 20 | 15 | 84 |
| 0 | 59 | (59) | Central Support | 0 | 93 | (93) | 0 |
| **2,967** | **1,393** | **1,574** | **Subtotal** | **12,258** | **7,261** | **4,998** | **28,485** |
| **28,691** | **28,608** | **83** | **TOTAL** | **141,635** | **141,100** | **535** | **337,340** |
| *27,319* | *27,241* | (78) | *Income Memorandum* | *138,016* | *137,493* | *(523)* | *330,640* |
| ***(1,371)*** | ***(1,367)*** | ***4*** | ***NET POSITION MEMORANDUM*** | ***(3,620)*** | ***(3,608)*** | ***12*** | ***(6,700)*** |

**Operational Divisions**

- Expenditure is currently £0.3m adverse in month and £1.5m adverse YTD
- This is driven by continued high spends on PAS and Overtime to support frontline capacity in Q1 and Q2. Some overtime costs will be partially offset against other areas (non rostered front line, EPRR, EOC)
- Overtime, Incentives and PAS costs have all reduced in Month 5 due to agreed overtime construct and PAS contract changes.
- NETS is favourable due to timing differences between planned and actual spend as the service is developed.
- PTS is currently showing a small negative variance (£0.5m). This is however offset by income.

**Support Services**

- Support Services is adverse to plan £0.7m in month and £0.8m YTD.
- Fleet & Logistics is overspent £0.2m YTD mainly due to additional resources for medicines management and vehicle preparation and additional maintenance costs in month.
- HR is £0.3m adverse due to ongoing high levels of agency usage to support recruitment and payroll.
- Estates are £0.1m adverse to plan due to fluctuations in estates maintenance costs.

**Corporate**

- Overall Corporate divisions are £0.9m adverse in month and £2.5m adverse YTD.
- Finance is £0.3m adverse to plan due to consultancy fees for PMO support for QIP. Permanent recruitment is currently underway.
- Clinical education is £0.9m adverse in month and £2.4m adverse YTD due to the number of frontline staff currently being held in training. This will be offset with an allocation of the Fallow time QIP budget which is currently reporting in Central Corporate.

**Central**

- Central Corporate is favourable mainly due to the management of the Trust reserves position

**Income**

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

# Statement of Financial Position: YTD

| | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Aug-16 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Act | Act | Act | Act | Act | Act | Plan | Var | % |
| | £000 | £000 | £000 | £000 | £000 | £000 | | | |
| **Non Current Assets** | | | | | | | | | |
| Property, Plant & Equip | 143,403 | 142,682 | 141,776 | 140,886 | 141,523 | 140,935 | 141,289 | (354) | -0.25% |
| Intangible Assets | 8,704 | 8,341 | 8,116 | 7,900 | 7,676 | 7,453 | 7,764 | (311) | -4.01% |
| Trade & Other Receivables | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Subtotal | 152,107 | 151,023 | 149,892 | 148,786 | 149,199 | 148,388 | 149,053 | (665) | -0.45% |
| **Current Assets** | | | | | | | | | |
| Inventories | 2,999 | 3,014 | 3,012 | 2,995 | 3,086 | 3,016 | 2,999 | 17 | 0.57% |
| Trade & Other Receivables | 14,461 | 16,016 | 14,754 | 19,501 | 15,593 | 16,543 | 13,820 | 2,723 | 19.70% |
| Cash & cash equivalents | 20,209 | 19,210 | 22,243 | 17,587 | 19,000 | 16,491 | 18,063 | (1,572) | -8.70% |
| Non-Current Assets Held for Sale | 101 | 44 | 44 | 44 | 44 | 44 | 44 | 0 | |
| Total Current Assets | 37,770 | 38,284 | 40,053 | 40,127 | 37,723 | 36,094 | 34,926 | 1,168 | 3.34% |
| **Total Assets** | 189,877 | 189,307 | 189,945 | 188,913 | 186,922 | 184,482 | 183,979 | 503 | 0.27% |
| **Current Liabilities** | | | | | | | | | |
| Trade and Other Payables | (33,495) | (33,518) | (34,923) | (35,772) | (33,239) | (32,204) | (33,924) | 1,720 | -5.07% |
| Provisions | (4,609) | (4,586) | (4,481) | (4,311) | (4,199) | (4,142) | (3,729) | (413) | 11.08% |
| Borrowings | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Working Capital Loan - DH | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Capital Investment Loan - DH | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| **Net Current Liabilities)** | (38,104) | (38,104) | (39,404) | (40,083) | (37,438) | (36,346) | (37,653) | 1,307 | -3.47% |
| **Non Current Assets plus/less net current assets/Liabilities** | 151,773 | 151,203 | 150,541 | 148,830 | 149,484 | 148,136 | 146,326 | 1,810 | 1.24% |
| **Non Current Liabilities** | | | | | | | | | |
| Trade and Other Payables | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Provisions | (9,796) | (10,016) | (9,866) | (9,902) | (9,751) | (9,779) | (9,851) | 72 | -0.73% |
| Borrowings | (107) | (107) | (107) | (107) | (107) | (107) | (107) | 0 | 0.00% |
| Working Capital Loan - DH | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Capital Investment Loan - DH | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| **Total Non Current Liabilities** | (9,903) | (10,123) | (9,973) | (10,009) | (9,858) | (9,886) | (9,958) | 72 | -0.72% |
| **Total Assets Employed** | 141,870 | 141,080 | 140,568 | 138,821 | 139,626 | 138,250 | 136,368 | 1,882 | 1.38% |
| **Financed by Taxpayers Equity** | | | | | | | | | |
| Public Dividend Capital | 58,016 | 58,016 | 58,016 | 58,016 | 58,016 | 58,016 | 58,016 | 0 | 0.00% |
| Retained Earnings | 28,120 | 27,348 | 26,836 | 25,089 | 25,894 | 24,518 | 22,618 | 1,900 | 8.40% |
| Revaluation Reserve | 56,153 | 56,135 | 56,135 | 56,135 | 56,135 | 56,135 | 56,153 | (18) | -0.03% |
| Other Reserves | (419) | (419) | (419) | (419) | (419) | (419) | (419) | 0 | 0.00% |
| **Total Taxpayers Equity** | 141,870 | 141,080 | 140,568 | 138,821 | 139,626 | 138,250 | 136,368 | 1,882 | 1.38% |

**Non Current Assets**

- Non current assets stand at £148.4m, (£0.7m) below plan. This is due to capital slippage.

**Current Assets**

- Current assets stand at £36.1m, £1.2m above plan.
- Cash position as at August is £16.5m, £1.6m below plan. The trust is pursing overdue debtors.
- Within Trade & Other Receivables , Receivables (debtors) at £1.5m are £2.9m below plan, accrued income at £10.1m is £4.7m above plan and prepayments at £4.9m are £0.9m above plan.

**Current Liabilities**

- Current liabilities stand at £36.3m, a £1.3m decrease on plan.
- Payables and accruals at £31.9m, a £2.0m decrease on plan.
- The Trust has a high volume of unapproved trade payables at £3.6m.
- Current provisions at £4.1m are £0.4m higher than plan.
- Deferred Income at £0.3m are £0.2m above plan.

**Non Current Liabilities**

- Non current provisions at £9.8m are £0.1m below plan and borrowings are on plan.

**Taxpayers Equity**

- Taxpayers Equity stands at £138.3m, £1.9m higher than plan.
- Retained Earnings at £24.5m, £1.9m higher than plan.

# Cashflow Statement YTD

| | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | YTD Move | YTD Plan | Var |
|---|---|---|---|---|---|---|---|---|
| | Actual | Actual | Actual | Actual | Actual | Aug-16 | Aug-16 | Aug-16 |
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Opening Balance** | 20,209 | 19,210 | 22,243 | 17,587 | 19,000 | **20,209** | **20,209** | **0** |
| Operating Surplus | 550 | 1,011 | (200) | 2,273 | 133 | 3,767 | 3,868 | (101) |
| (Increase)/decrease in current assets | (1,570) | 1,264 | (4,730) | 3,817 | (880) | (2,099) | 804 | (2,903) |
| Increase/(decrease) in current liabilities | 766 | 1,109 | 471 | (3,933) | (333) | (1,920) | (1,277) | (643) |
| Increase/(decrease) in provisions | 185 | (267) | (145) | (275) | (41) | (543) | (880) | 337 |
| Net cash inflow/(outflow) from operating activities | (69) | 3,117 | (4,604) | 1,882 | (1,121) | (795) | 2,515 | (3,310) |
| **Cashflow inflow/outflow from operating activities** | **(69)** | **3,117** | **(4,604)** | **1,882** | **(1,121)** | **(795)** | **2,515** | **(3,310)** |
| Returns on investments and servicing finance | 8 | 7 | 0 | 27 | 6 | 48 | 40 | 8 |
| Capital Expenditure | (938) | (91) | (52) | (496) | (1,394) | (2,971) | (4,701) | 1,730 |
| Dividend paid | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Financing obtained | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Financing repaid | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Cashflow inflow/outflow from financing** | **(930)** | **(84)** | **(52)** | **(469)** | **(1,388)** | **(2,923)** | **(4,661)** | **1,738** |
| Movement | (999) | 3,033 | (4,656) | 1,413 | (2,509) | (3,718) | (2,146) | (1,572) |
| **Closing Cash Balance** | **19,210** | **22,243** | **17,587** | **19,000** | **16,491** | **16,491** | **18,063** | **(1,572)** |

There has been a net outflow of cash from the Trust of £3.7m.
Cash funds at 31 August stand at £16.5m.

**Operating Surplus**

- The operating surplus is £0.1m lower than planned.

**Current Assets**

- The ytd movement on current assets is (£2.1m), a (£2.9m) increase on plan.
- Current assets movement was lower than planned due to a decrease in receivables £2.7m, increase in accrued income (£4.7m) and increase in prepayments (£0.9m).

**Current Liabilities**

- The ytd movement on current liabilities is (£1.9m), is (£0.6m) increase on plan.
- Current liabilities movement was higher than planned due to trade and other payables (£0.4m), accruals (£0.4m) and deferred income £0.2m.

**Provisions**

- The ytd movement on provisions is (£0.5m), is £0.3m increase on plan.

**Capital Expenditure**

- Capital cash outflow is £1.7m behind plan for the year.

**Report from the Finance & Investment Committee on 22nd September 2016**

The following were the main items discussed at the FIC meeting held on 22nd September 2016:

**Financial Performance**

The I & E position to 31/8/2016 was examined and the year to date position is on plan. However, there has been considerable expenditure on overtime and use of private ambulance services to support demand. This rate of spend cannot be continued if the year end agreed target (a £6.7m deficit) is to be met.

Cash is satisfactory to date but a satisfactory12 month cash forecast position will be dependent on action taken to achieve the year end target deficit.

Potential action to address demand pressures to achieve the year end target were discussed as well as the need to meet the Cost Improvement Programme, set to save £10.5m. A financial plan for the year end is being developed with an urgency to present this to the Board for approval.

New controls have been introduced by NHSI to set limits on agency staff spend. Compliance for LAS will be reported as part of the regular Finance Report to FIC and the Trust Board.

**Financial Planning**

Trusts are required to produce plans for the next two years and seek to agree contracts for these by December 23rd. A paper on a first look at issues and the expected financial position was considered. Given the timetable there is a likely need for further meetings of FIC and the Trust Board as proposals are developed.

A business case for the Make Ready roll out was received and agreed.

**Financial Governance**

A revised Anti-Fraud, Bribery and Corruption Policy was discussed and agreed. This will now be communicated throughout the Trust.

A report on procurement activity in the first quarter of the year was presented.

**Risk Appetite**

The Board's risk appetite on financial and regulatory compliance was discussed and an approach agreed –copy attached for consideration by the Board.

**Date of next meeting: 24th November 2016**

## Risk Appetite

### Financial

There is a risk that the Trust could fail to deliver its financial plan.

The Trust has a low tolerance for taking financial risks in respect of meeting its statutory duties of maintaining expenditure within its allocated resource limits and financial control totals. However, patient safety issues are paramount for the Trust.

The Trust Risk Appetite regarding Financial matters is **MODERATE**.

The Trust is prepared to accept the possibility of some limited financial loss in the short term but this requires that in the medium term the financial position is rectified to maintain financial sustainability. The short term cash position of the Trust must be maintained. Value for money must be considered alongside the benefits of any financial commitment.

### Regulatory Compliance

There is a risk regarding governance matters and being well led that the Trust might not learn as an organisation in order to continuously develop and improve.

The trust operates within a highly regulated environment and has to meet high levels of compliance expectations from a large number of regulatory sources. It seeks to meet the expectations within a framework of prudent controls which balance the elimination of risk with meeting pragmatic operational requirements.

The Trust Risk Appetite regarding Regulatory Compliance is **LOW**.

The Trust would want to be sure that it would win any challenge to meeting its compliance requirements and that examples of similar situations elsewhere had not breached compliance.

London Ambulance Service NHS
NHS Trust

| | |
|---|---|
| **Report to:** | **Trust Board** |
| **Date of meeting:** | **4th October 2016** |
| **Document Title:** | **Workforce and OD Committee: progress report to the Board by the Committee Chair** |
| **Report Author(s):** | **Fergus Cass, Non-Executive Director and Chair of the Workforce and OD Committee** |
| **Presented by:** | **Fergus Cass** |
| **Contact Details:** | **sandra.adams@lond-amb.nhs.uk** |
| **History:** | **N/A** |
| **Status:** | **For discussion** |

**Background/Purpose**

The Workforce and Organisational Development (OD) Committee was established in 2016 and is a sub-committee of the Trust Board and therefore chaired by a Non-Executive Director. The Committee has met twice and was scheduled to meet on 26th September however the meeting was postponed due to the involvement of the HR department and members of the Executive team in the staff consultation events on job cycle time.

The attached report from the Committee Chair summarises the progress made to date by the committee and identifies areas where it has not yet been able to give assurance to the Board.

**Action required**

Presented for discussion on the progress to date and the plans to address the areas where greater assurance is sought.

**Key implications**

The committee is a sub-committee of the Trust Board and has oversight of workforce and OD. Key to the role of the committee is the provision of assurance to the Board on these issues and to identify any emerging themes and risks to the achievement of the Trust's strategic objectives from these issues.

| Key implications and risks arising from this paper | |
|---|---|
| **Clinical and Quality** | |
| **Performance** | |
| **Financial** | |
| **Workforce** | **The committee is not yet able to provide assurance on a number of areas. However, the Board receives assurances on certain workforce issues through other channels.** |
| **Governance and Well-led** | |
| **Reputation** | |
| **Other** | |
| **This paper supports the achievement of the following Quality Improvement Plan Workstreams:** | |
| **Making the London Ambulance Service a great place to work** | **Yes** |
| **Achieving Good Governance** | **Yes** |
| **Improving Patient Experience** | **Yes** |
| **Improving Environment and Resources** | |
| **Taking Pride and Responsibility** | **Yes** |

# Workforce and OD Committee: progress report to the Board by the Committee Chair

The Committee was scheduled to meet on 26th September but the meeting was postponed because of the involvement of HR Department and members of the Executive Team in the consultation about Job Cycle Time (JCT).

The opportunity has been taken to review where the Committee stands in relation to its main assurance responsibilities and to propose what needs to happen so that it can fulfil its Terms of Reference (ToR). This progress report is supported by an analysis which, for each area of the Committee's responsibility, identifies what the Committee has done during its first two meetings and assesses what action is needed so that it can give the assurances that it is asked to provide.

This assessment is not necessarily an evaluation of where the Trust stands in relation to the areas concerned: its focus is on whether the Workforce and OD Committee is able to give the required assurance. The Board receives assurances on workforce-related matters through other channels, for example performance reports or committees such as the QIP Board. Additionally, because the Committee is relatively new and has met only twice, it has not yet reviewed the whole range of activities and issues that come within its remit. In some instances, however, the Committee has not been able to give full assurance because more work is needed in the underlying area concerned.

Of the areas where the Committee has not yet been able to give assurance the following aspects appear to be particularly important:

- **Workforce strategy and planning:** while projections for frontline recruitment up to 2018 have been developed, issues around skill mix need to be resolved, projections for the whole workforce are still needed, and risks and sensitivities around the numbers need to be evaluated
- **Industrial and employee relations:** while there has been discussion elsewhere about how the Trust will tackle current issues, the Committee has not yet reviewed the Trust's strategies for industrial and employee relations
- **Diversity and the WRES:** the Committee has discussed the draft Workforce Race Equality Action plan and it now needs to review the resourcing of the plan, the progress in relation to the agreed priority actions, and the underlying arrangements for data recording and reporting
- **Workforce risks:** HR and workforce risks are likely to be among those identified in local and corporate risk registers but they have not yet been reviewed by the Committee
- **Recording and information systems:** improvements in this key area are being taken forward and the Committee will need to review strategy and progress.

It is likely that the Committee will seek further assurance on the progress and effectiveness of **staff engagement** actions in the light of the comments made in the June Clinical Review by NHS Improvement (NHSI). Additionally the Committee is likely to undertake a deep dive into the work that has been done in respect of **workforce training and education** by the People and Organisational Development Department and by the Clinical Education Group.

The Board and the Committee already see a set of **HR KPIs,** mainly relating to recruitment, vacancies, turnover, sickness, training and appraisals; HR management intends to propose developments in the reporting system and additional KPIs for review by the Committee.

At the time of writing this update the revised date for the Committee's next meeting had not been set. It is expected that the meeting will review a number of the above areas and will make plans to take its work programme forward.

27th September 2016

London Ambulance Service NHS Trust

| | |
|---|---|
| **Report to:** | **Trust Board** |
| **Date of meeting:** | **4th October 2016** |
| **Document Title:** | **Audit Committee Assurance Report** |
| **Report Author(s):** | **Sandra Adams, Director of Corporate Governance/Trust Secretary** |
| **Presented by:** | **John Jones, Non-Executive Director and Chair of the Audit Committee** |
| **Contact Details:** | **sandra.adams@lond-amb.nhs.uk** |
| **History:** | **N/A** |
| **Status:** | **Assurance** |

**Background/Purpose**

The attached report provides a summary of the meeting held on 5th September 2016 and is intended to provide assurance to the Trust Board on risk management, financial reporting, and progress against the internal audit and local anti-fraud work plans. The Committee also:

- Received and approved the revised Standing Orders, Standing Financial Instructions and Scheme of Delegation. These will be presented to the Board in November.
- Considered and accepted the annual audit letter 2015/16 for commendation to the Board and this is presented elsewhere on the agenda.

**Action required**

For the Trust Board to take assurance from the report of the meeting on 4th October 2016.

**Key implications**

The Committee continues to operate within its terms of reference and within the remit of the NHS Audit Handbook.

| Key implications and risks arising from this paper | |
|---|---|
| **Clinical and Quality** | |
| **Performance** | |
| **Financial** | **Assurance is taken on process in place for financial reporting and systems and controls** |
| **Workforce** | |
| **Governance and Well-led** | **The Audit Committee takes its assurance from the systems and process in place for managing risk** |
| **Reputation** | |
| **Other** | |
| **This paper supports the achievement of the following Quality Improvement Plan Workstreams:** | |
| **Making the London Ambulance Service a great place to work** | |
| **Achieving Good Governance** | **Yes** |
| **Improving Patient Experience** | |
| **Improving Environment and Resources** | |
| **Taking Pride and Responsibility** | |

# Report from the Audit Committee on 5th September 2016

## GOVERNANCE AND RISK MANAGEMENT

***Board Assurance Framework and Corporate Risk Register***

The Audit Committee reviewed the updated risk register and board assurance framework (BAF), which is aligned to the 2016/17 business objectives. The BAF is a dynamic document and reflects the key issues facing the Trust, and the governance and assurance team continue to work with risk owners to ensure BAF risks and key risks are regularly reviewed and updated. Each BAF risk is owned by an executive director and where there had been increasing challenge to risk owners about the actions being taken to mitigate and control the risk. It is evident that progress has been made with managing and mitigating the high level risks and the Audit Committee has seen a reduction in the number of BAF risks this year. The Committee remains concerned about two of the high level operational risks on the BAF that have not been reviewed since May 2016. The transition of the risk register onto Datixweb now requires risk owners to update the actions each month and the governance team continues to support managers in building this into routine practice.

The Committee noted the review of the risk relating to cyber security and the likely re-scoring of the risk that would bring this below BAF level, however the actions to mitigate the risk were not yet complete and the timeline was unclear.

The Committee had a deeper look at the risk relating to lack of ring backs on delayed responses (BAF 29) and received a presentation from Simon Harding Interim Head of Control Services. The risk had been on BAF for a long time and whilst there is a great deal of planning being undertaken The Audit Committee were not fully assured of when this risk will be reduced and wish to bring this to the Boards attention.

Work on local risk registers continues to progress however the Committee was concerned that the recent CQC inspection suggested these were not live documents. The Risk and Audit Manager gave assurance that local registers were live and were regularly updated with incidents reported by sectors; an update would be given to the next Audit Committee meeting in November.

The Board was considering strategic risks and risk appetite statements at its strategy session on 6th September.

***Review of Standing Orders, Standing Financial Instructions and the Scheme of Delegation***

The Committee received the revised Standing Orders, Standing Financial Instructions and Scheme of Delegation and heard that the financial sections of the Scheme had been re-worked and separated from the general Scheme of Delegation. The Committee approved the financial Scheme of Delegation subject to some final amendments, and approved the Standing Orders and Standing Financial Instructions for recommendation to the Trust Board. This will be brought to the Trust Board for approval at the November meeting.

## FINANCIAL REPORTING

***Losses and Special Payments***

The Committee received the report for the period ending 30th June 2016 and noted the comparison of information on vehicle accidents for 3 month periods to June 2015/16 and June 2016/17. Finance were following up with insurers about the high number of nil value vehicle accidents.

***Charitable Funds Annual Accounts 2015/16***

The Committee noted that the accounts would be presented to the next meeting.

## INTERNAL AUDIT AND LOCAL COUNTER FRAUD

***Internal Audit Progress Report***

The Audit Committee heard that three reports had been completed since the last meeting: Data Quality (significant assurance with minor improvements identified), Third Party Providers (partial assurance with minor improvements required), and HR Governance (partial assurance with improvements identified). Internal Audit were on track against the 2016/17 Plan.

***Review of progress against Internal Audit recommendations***
The Committee received an update on progress against recommendations and actions. It was noted that of 35 outstanding recommendations on the tracker, 33 were not yet due for completion. Of the 2 overdue recommendations, 1 was high priority relating to Fleet Management and Statutory Vehicle Checks. The Committee was pleased to note the progress in managing outstanding actions.

***Human Resources Governance***
The overall assessment was one of partial assurance with improvements required (amber/red) and a series of recommendations had been made focussing on the need for clear objectives for the HR function. All recommendations had been accepted.

***Data Quality***
The Committee noted that the overall assessment of 'significant assurance with minor improvement potential' (green/amber). Some areas of good practice identified included data validation processes on patient report forms which were checked against information held on the CommandPoint CAD system. All recommendations had been accepted.

***Third Party/Private Providers***
The overall assessment was one of 'partial assurance with improvements required' (amber/red). Areas of good practice identified included the training programme and feedback process for staff working for private ambulance service providers.

***Local Counter Fraud Specialist Progress Report***
The Committee noted the progress report since 31st May 2016 and received an update on cases.

## EXTERNAL AUDIT

External Audit presented the annual audit letter; the detailed findings had been presented to the Audit Committee on 31st May. The Committee would recommend the letter to the Trust Board.

## REPORTS FROM COMMITTEES

The Audit Committee noted the reports from the Finance and Investment Committee and the Quality Governance Committee on their recent meetings.

**Date of next meeting:** The next meeting of the Audit Committee is on Monday 7th November 2016.

London Ambulance Service NHS Trust

| | |
|---|---|
| **Report to:** | **Trust Board** |
| **Date of meeting:** | **4th October 2016** |
| **Document Title:** | **Annual audit letter 2015/16** |
| **Report Author(s):** | **Ernst & Young LLP – external auditors** |
| **Presented by:** | **John Jones, Non-Executive Director and Chair of the Audit Committee** |
| **Contact Details:** | **sandra.adams@lond-amb.nhs.uk** |
| **History:** | **Audit Committee – 5th September 2016** |
| **Status:** | **Assurance** |

**Background/Purpose**

The Audit Committee considered and accepted the annual audit letter presented by the external auditors, Ernst & Young LLP, at the meeting on 5th September, and agreed to commend the letter to the Board.

- Unqualified opinion on the financial statements
- No matters to report on the audited parts of the remuneration and staff report
- Financial information in the Annual Report and published with the financial statements was consistent with the Annual Accounts
- Unqualified value for money conclusion.

**Action required**

To note and take assurance from the annual audit letter for 2015/16.

**Key implications**

None identified.

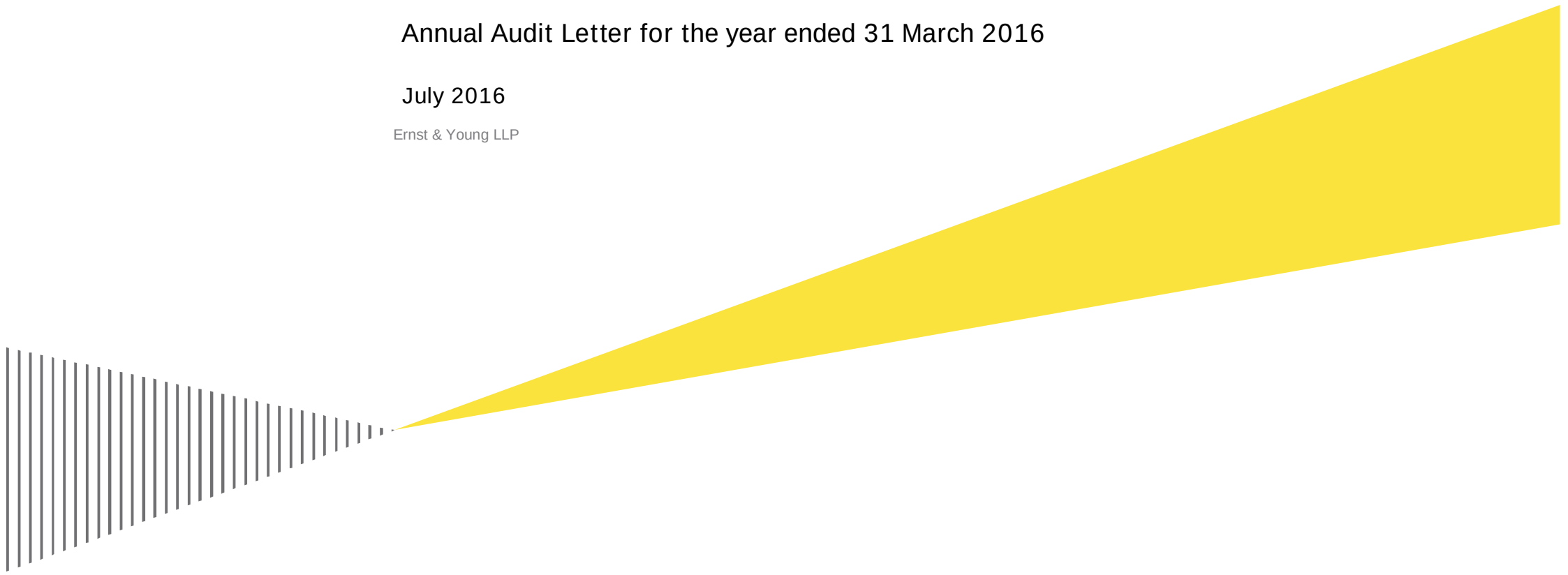
| Key implications and risks arising from this paper | |
|---|---|
| **Clinical and Quality** | |
| **Performance** | |
| **Financial** | **The report provides the results and conclusions on the significant areas of the annual audit process** |
| **Workforce** | |
| **Governance and Well-led** | **The report is issued to those charged with governance of the Trust, communicating the significant findings from the audit** |
| **Reputation** | |
| **Other** | |
| **This paper supports the achievement of the following Quality Improvement Plan Workstreams:** | |
| **Making the London Ambulance Service a great place to work** | |
| **Achieving Good Governance** | **Yes** |
| **Improving Patient Experience** | |
| **Improving Environment and Resources** | |
| **Taking Pride and Responsibility** | |

# London Ambulance Service NHS Trust

## Annual Audit Letter for the year ended 31 March 2016

July 2016

Ernst & Young LLP



Building a better working world

# Contents



In April 2015 Public Sector Audit Appointments Ltd (PSAA) issued ‘‘Statement of responsibilities of auditors and audited bodies 2015-16’. It is available from the Chief Executive of each audited body and via the PSAA website (www.psaa.co.uk)

The Statement of responsibilities serves as the formal terms of engagement between appointed auditors and audited bodies. It summarises where the different responsibilities of auditors and audited bodies begin and end, and what is to be expected of the audited body in certain areas.

The ‘Terms of Appointment from 1 April 2015’ issued by PSAA sets out additional requirements that auditors must comply with, over and above those set out in the National Audit Office Code of Audit Practice (the Code) and statute, and covers matters of practice and procedure which are of a recurring nature.

This Annual Audit Letter is prepared in the context of the Statement of responsibilities. It is addressed to the Directors/Members of the audited body, and is prepared for their sole use. We, as appointed auditor, take no responsibility to any third party.

Our Complaints Procedure – If at any time you would like to discuss with us how our service to you could be improved, or if you are dissatisfied with the service you are receiving, you may take the issue up with your usual partner or director contact. If you prefer an alternative route, please contact Steve Varley, our Managing Partner, 1 More London Place, London SE1 2AF. We undertake to look into any complaint carefully and promptly and to do all we can to explain the position to you. Should you remain dissatisfied with any aspect of our service, you may of course take matters up with our professional institute. We can provide further information on how you may contact our professional institute.


Executive Summary

# Executive Summary

We are required to issue an annual audit letter to the London Ambulance Service NHS Trust following completion of our audit procedures for the year ended 31 March 2016.

Below are the results and conclusions on the significant areas of the audit process.

| Area of Work | Conclusion |
|---|---|
| Opinion on the Trust's: | |
| ► Financial statements | Unqualified – the financial statements give a true and fair view of the financial position of the Trust as at 31 March 2016 and of its expenditure and income for the year then ended |
| ► Parts of the remuneration and staff report to be audited | We had no matters to report. |
| ► Consistency of the Annual Report and other information published with the financial statements | Financial information in the Annual report and published with the financial statements was consistent with the Annual Accounts |

| Area of Work | Conclusion |
|---|---|
| Reports by exception: | |
| ► Consistency of Governance Statement | The Governance Statement was consistent with our understanding of the Trust |
| ► Referrals to the Secretary of State | We had no matters to report |
| ► Public interest report | We had no matters to report in the public interest |
| ► Value for money conclusion | We had no matters to report |

| Area of Work | Conclusion |
|---|---|
| Reporting to the Trust on its consolidation schedules | We concluded that the Trust's consolidation schedules agreed, within a £250,000 tolerance, to your audited financial statements |
| Reporting to the National Audit Office (NAO) in line with group instructions | We had no matters to report |

As a result of the above we have also:

| Area of Work | Conclusion |
|---|---|
| Issued a report to those charged with governance of the Trust communicating significant findings resulting from our audit. | Our Audit results report was issued on 31 May 2016 |
| Issued a certificate that we have completed the audit in accordance with the requirements of the Local Audit and Accountability Act 2014 and the National Audit Office's 2015 Code of Audit Practice. | Our certificate was issued on 2 June 2016 |

We would like to take this opportunity to thank the Trust staff for their assistance during the course of our work.

Janet Dawson
Partner
For and on behalf of Ernst & Young LLP


Purpose

# Purpose

## The Purpose of this Letter

The purpose of this annual audit letter is to communicate to Directors and external stakeholders, including members of the public, the key issues arising from our work, which we consider should be brought to the attention of the Trust.

We have already reported the detailed findings from our audit work in our 2015/16 annual results report to the 31 May 2016 Audit Committee, representing those charged with governance. We do not repeat those detailed findings in this letter. The matters reported here are the most significant for the Trust.


Responsibilities

# Responsibilities

## Responsibilities of the Appointed Auditor

Our 2015/16 audit work has been undertaken in accordance with the Audit Plan that we issued on 15 February 2016 and is conducted in accordance with the National Audit Office's 2015 Code of Audit Practice, International Standards on Auditing (UK and Ireland), and other guidance issued by the National Audit Office.

As auditors we are responsible for:

Expressing an opinion:

- On the 2015/16 financial statements;
- On the parts of the remuneration and staff report to be audited;
- On the consistency of other information published with the financial statements, including the annual report; and
- On whether the consolidation schedules are consistent with the Trust's financial statements for the relevant reporting period.

Reporting by exception:

- If the annual governance statement does not comply with relevant guidance or is not consistent with our understanding of the Trust;
- To the Secretary of State for Health if we have concerns about the legality of transactions of decisions taken by the Trust;
- Any significant matters that are in the public interest;
- Forming a conclusion on the arrangements the Trust has in place to secure economy, efficiency and effectiveness in its use of resources; and
- Reporting on an exception basis any significant issues or outstanding matters arising from our work which are relevant to the NAO as group auditor.

## Responsibilities of the Trust

The Trust is responsible for preparing and publishing its statement of accounts, annual report and annual governance statement. It is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.


Financial Statement
Audit

# Financial Statement Audit

## Key Issues

The Annual Report and Accounts is an important tool for the Trust to show how it has used public money and how it can demonstrate its financial management and financial health.

We audited the Trust's Statement of Accounts in line with the National Audit Office's 2015 Code of Audit Practice, International Standards on Auditing (UK and Ireland), and other guidance issued by the National Audit Office and issued an unqualified audit report on 2 June 2016.

Our detailed findings were reported to the 31 May 2016 Audit Committee.

The key issues identified as part of our audit were as follows:

| Significant Risk | Conclusion |
|---|---|
| Management override of controls | We have not identified any material weaknesses in controls or evidence of material management override.<br>We have not identified any instances of inappropriate judgements being applied. |
| Revenue and expenditure recognition | Our testing has not revealed any material misstatements with respect to revenue and expenditure recognition. |

| Other Key Findings | Conclusion |
|---|---|
| Valuation of land and buildings | Our review of management's valuations expert work and testing the accounting treatment of valuations did not identify any material misstatements concerning the valuation of land and buildings. |
| Existence of plant and equipment, and Inventory. | We reviewed the Trust's asset verification exercise to confirm accuracy of plant and equipment records and tested a sample of assets for proof of existence. We observed the performance of the stock count procedures and performed test counts to provide evidence as to the reliability of the stock count exercise.<br>We have not identified any material misstatements concerning the existence of plant and equipment, and Inventory recorded on the balance sheet at 31 March 2016. |

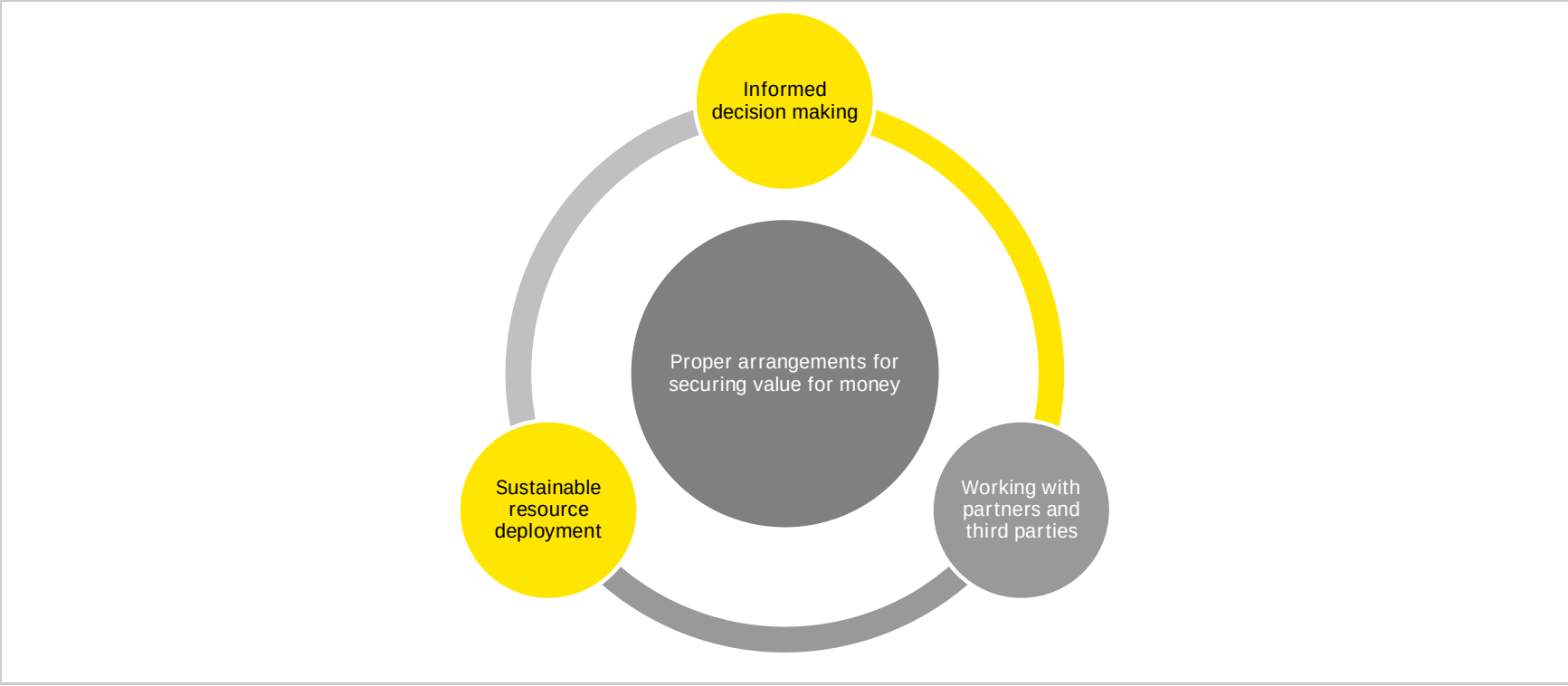

Value for Money

# Value for Money

We are required to consider whether the Trust has put in place 'proper arrangements' to secure economy, efficiency and effectiveness on its use of resources. This is known as our value for money conclusion.

Proper arrangements are defined by statutory guidance issued by the National Audit Office. They comprise your arrangements to:

- Take informed decisions;
- Deploy resources in a sustainable manner; and
- Work with partners and other third parties.



Our audit did not identify any significant matters in relation to the Trust's arrangements. We did however identify the following areas to bring to your attention.

| Key Findings |
| --- |
| To address a number of areas of concerns raised by the Care Quality Commission, following inspection of the service in June 2015, the Trust prepared a quality improvement plan. The Trust's has established arrangements to prepare financial plans. This includes working with commissioners to agree levels of performance and related funding. For 2016/17 this has included agreement on additional funding to deliver the quality improvement plan. |
| Challenges for the next year:<br>• The Trust is not achieving performance targets and is under growing financial pressure to deliver a surplus and maintain cash balances. A deficit budget is set for 2016/17, cash balances are forecast to reduce to £7m and a further decline in the net current assets/ liability ratio as at 31 March 2017 is predicted.<br>• At the time of our audit, the main contract position for 2016/17 had yet to be finalized. The main contract includes £297m of baseline and £18m of new investment for the Quality Improvement Plan. The Trust received a letter of support from NHSI for the coming year, but will need to revisit financial planning for the final agreed contract position.<br>• The medium term financial plan reflects these pressures but needs to be maintained as a live document to assess future challenges on services and the wider health economy. Key risk areas include changes in activity levels, job cycle times, performance penalties, impact of CQC actions and the delivery of a significant cost improvement plan in 2016/17 (£10m). |

# Other Reporting Issues

# Other Reporting Issues

## Department of Health Group Instructions

We are only required to report to the NAO on an exception basis if there were significant issues or outstanding matters arising from our work. There were no such issues.

## Annual Governance Statement

We are required to consider the completeness of disclosures in the Trust's annual governance statement, identify any inconsistencies with the other information of which we are aware from our work, and consider whether it complies with relevant guidance.

We completed this work and did not identify any areas of concern.

## Report in the Public Interest

We have a duty under the Local Audit and Accountability Act 2014 to consider whether, in the public interest, to report on any matter that comes to our attention in the course of the audit in order for it to be considered by the Trust or brought to the attention of the public.

We did not identify any issues which required us to issue a report in the public interest.

## Control Themes and Observations

As part of our work, we obtained an understanding of internal control sufficient to plan our audit and determine the nature, timing and extent of testing performed. Although our audit was not designed to express an opinion on the effectiveness of internal control, we are required to communicate to you significant deficiencies in internal control identified during our audit.

We have not identified any significant deficiencies in the design or operation of an internal control that might result in a material misstatement in your financial statements of which you are not aware.


Focused on your
future

# Focused on your future

| Area | Issue | Impact |
|---|---|---|
| NHS provider financial pressures | Draft 2015/16 financial statements show NHS providers overspent by a record £2.45 billion for the year. The scale of this overspending is unprecedented. Despite additional funding and significant efforts to reduce deficits, record numbers of trusts overspent and the overall deficit is likely to be three times higher than in 2014/15. Some 48 trusts reported a deficit of more than £20 million, including 11 trusts reporting an individual deficit of more than £50 million.<br>At the same time, performance against key targets is continuing to deteriorate and there are increasing concerns over the quality of services. Providers as a whole missed the Accident and Emergency waiting target of seeing 95 percent of patients within four hours for the final quarter of the year, and waiting lists for routine operations reached 3.34 million.<br>It is not yet clear whether trusts' financial performance for the year will cause the Department of Health to exceed its spending limit for 2015/16, a serious breach of parliamentary protocol. Whether or not there is a breach, NHS trusts will start 2016/17 with a collective deficit of around £1 billion more than planned. Without change there is the potential for the increasing financial pressure to impact further on levels of patient care. | The scale of the financial challenges faced by NHS providers impacts all aspects of their operations. It is therefore a key driver of audit risk and impacts our approach. |
| Sustainability and Transformation Plans | NHS England's document, Delivering the Forward View: NHS planning guidance 2016/17-2020/21, published in December 2015, asks local health systems, including local government, voluntary and community partners, to work together to secure transformation change in healthcare planning and delivery.<br>For this purpose England has been divided into 44 local health systems, made up of local councils, CCGs and NHS and other providers. Each health system needs to produce, by the end of June 2016, a Sustainability and Transformation Plan covering the next five years. | Bodies will need to work together to a far greater extent than ever before to ensure that sustainability and financial plans are viable, and successfully delivered. Failure to do this could have wider adverse financial and service delivery consequences across the whole local area.<br>As your external auditor we need to gain an understanding of your wider approach and plans, and the impact of greater partnership working on your governance, internal control and financial reporting. |

| Area | Issue | Impact |
|---|---|---|
| | The initial requirement is for CCGs and providers to control expenditure and stay within budget in 2016-17. Subsequently, spending and performance will need to be managed sustainably over the following four years in order to access the available transformation funding. This is intended to fund changes to service delivery while maintaining and improving patient safety and quality over the years 2017-21. Failure to deliver on targets agreed will results in bodies being unable to access transformation funding, which will from now on be the only additional funds available. | |
| EU referendum | The decision of the UK to begin the process of leaving the EU has introduced a period of significantly increased uncertainty for the UK and indeed Global economy. The Leave vote will lead to a significant impact for the public sector as it will be the sector that has to deliver the implementation of Brexit. We now know that there will be a change of Tory PM plus it is likely that there will be other changes to the cabinet as part of a new PM's reshuffle. In addition it is possible that an opposition leadership contest will also take place in the near future depending on how events continue to develop. It is evident at this point that there is a danger of a political vacuum for a number of months – this will only increase uncertainty both within the public sector and in the business world. | Many of the issues and challenges that face the UK public sector will continue to exist, not least because continued pressure on public finances will need responding to. Additionally it may well be that the challenges are increased if the expected economic impacts of Brexit and loss of EU grants outweigh the benefits of not having to contribute to the EU and require even more innovative solutions.<br><br>We are committed to supporting our clients through this period, and help identify the opportunities that will also arise. We will talk with you on the concerns and questions you may have and provide our insight at key points along the path. We will provide our June 2016 paper on the EU Referendum, and the impact of Brexit on the Government and Public Sector market. |

Appendix A

# Audit Fees

# Appendix A Audit Fees

Our fee for 2015/16 is £2,508 higher than the scale fee set by the PSAA and reported in our 15 February 2016 Audit Plan.

| Description | Final Fee 2015/16 GBP | Scale Fee 2015/16 GBP |
|---|---|---|
| Total Audit Fee – Code work | 59,474 | 56,966 |

The increased fee is for our additional work on the VFM conclusion concerning the significant risk identified. We are awaiting final approval from Public Sector Audit Appointments Ltd (the regulator), for the additional fee.

We confirm we have not undertaken any non-audit work outside of the PSAA's requirements.

EY | Assurance | Tax | Transactions | Advisory

Ernst & Young LLP



ED None

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London Ambulance Service NHS Trust

| | |
|---|---|
| **Report to:** | **Trust Board** |
| **Date of meeting:** | **4th October 2016** |
| **Document Title:** | **Board Assurance Framework and Trust Risk Register** |
| **Report Author(s):** | **Frances Field, Risk and Assurance Manager** |
| **Presented by:** | **Sandra Adams, Director of Corporate Governance/Trust Secretary** |
| **Contact Details:** | **sandra.adams@lond-amb.nhs.uk** |
| **History:** | **N/A** |
| **Status:** | **Trust Risk Register and Board Assurance Framework current as at 22nd September 2016** |

**Background/Purpose**

**Strategic risk and risk appetite statement**
The Trust Board has been reviewing the risk appetite statement in the context of the strategic risks and the Quality Governance and Finance and Investment Committees have considered and confirmed the risk appetite statements for quality, and for finance and regulatory compliance respectively. Work continues on the statements following 2 facilitated sessions for the Board in September.

**Feedback from the Audit Committee on the Board Assurance Framework (BAF)**

The Audit Committee met on the 5th September 2016 and commented that the Fleet and Logistics BAF risks 25 and 26 require clarification and review. This feedback has been provided to the Head of Fleet and logistics for action.

It was noted that the operational risks on the BAF required review and this action is still pending, whilst Trust operational risks are undergoing review and rewrite by Paul Woodrow and the senior Operational Managers.

BAF risk 29 was reviewed by the Audit Committee and a verbal update was provided. The Committee asked for further assurance to be provided that this risk is being managed. This feedback was provided to Katy Millard and further update and discussions took place at the Quality Governance Committee meeting on the 13th September, where further assurance was provided.

**General update on the Board Assurance Framework**

BAF 35 - There is a risk of potential industrial action as a result of national disputes regarding pay and conditions, which will cause substantial disruption on the organisation should it go ahead.
The net scoring of this risk is current major x likely = 16 but is being reviewed for re-grading.

BAF risks 14 and 34 have been reviewed by the Finance and Investment Committee where it was agreed no changes are to be made to the current risk and risk ratings.

The following three have been downgraded and are no longer included in the Board Assurance Framework, as follows:

**Patient safety for category C patients may be compromised due to demand exceeding available resources**
This risk was reviewed by the Deputy Director of Control Services who recommended that the current rating could be re-graded due to the actions being in place to mitigate the risk. This was approved by the Risk Compliance and Assurance Group on the 5th July 2016. Re-graded catastrophic x possible = 15 to catastrophic x unlikely = 10 and has been removed from the BAF.

**There is a risk that there may be insufficient vehicle numbers to meet demand**
This risk was reviewed by Fleet and Logistics who proposed the impact of this risk is reduced from 16 to 12. 17 ambulances were added to the fleet early in 2016. 20 decommissioned vehicles were refurbished and are now used for driver training and events. These measures have provided extra capacity in the fleet. 60 new Tiguan cars to be delivered by September (6 in operation now) – 20 cars will be an additional resource to increase fleet size. This was approved by the Risk Compliance and Assurance Group on the 5th July 2016 and has been removed from the BAF.

**There is a risk that the equipment for frontline vehicles may not be in an effective condition**
This risk was reviewed by Fleet and Logistics who proposed the impact of this risk is reduced from 16 to 12. A decontamination process for equipment is now fully established. This involves the collection of equipment from hospitals and transport to the Logistics Store. The equipment is then taken for decontamination before return to Logistics. The clean equipment is then made available to stations and VP teams. We would wish to see this process supported by full contractual arrangements before a further reduction is considered. This was approved by the Risk Compliance and Assurance Group on the 5th July 2016 and has been removed from the BAF.

**BAF risks 7 (shift changeover) and 4 (service performance)** require extensive review and this rests with the Operations directorate to progress.

**Feedback from the Audit Committee on the Status of Local Risk Registers**

The Committee reviewed the status of local risk registers at their meeting on the 5th September 2016 and further assurance will be presented at the next meeting in November.

**General update on the Trust Risk Register**

The following safeguarding risks have been re-graded following the Safeguarding Committee Meeting in June 2016:

- There is a risk of staff not recognising safeguarding indicators and therefore failing to make a timely referral. 93% clinical staff trained in safeguarding EOC and PTS refresher training underway, all staff issued with pocket handbook and pens, referrals remain high. Agreed to reduce to Moderate.
- Safeguarding referrals will suffer. They will be delayed, mis-referred etc; also information governance will be impacted, because EBS is unable to offer a timely and secure onward referral process. The risk impacts those patients and others who are the subject of referrals and to whom we owe statutory duties of care. it was agreed to reduce to Moderate due to the Datix implementation date being imminent.68
- There is a risk that the Trust is unable to meet statutory requirements of providing safeguarding supervision, by trained professionals. This will result in an impact on staff performance and welfare and the Trust will not be compliant with the Children Act and Care Act pertaining to safeguarding. Agreed to reduce to moderate as safeguarding supervision project manager will be in place on 18/07/16 and a plan is in place to introduce supervision by the end of the year.

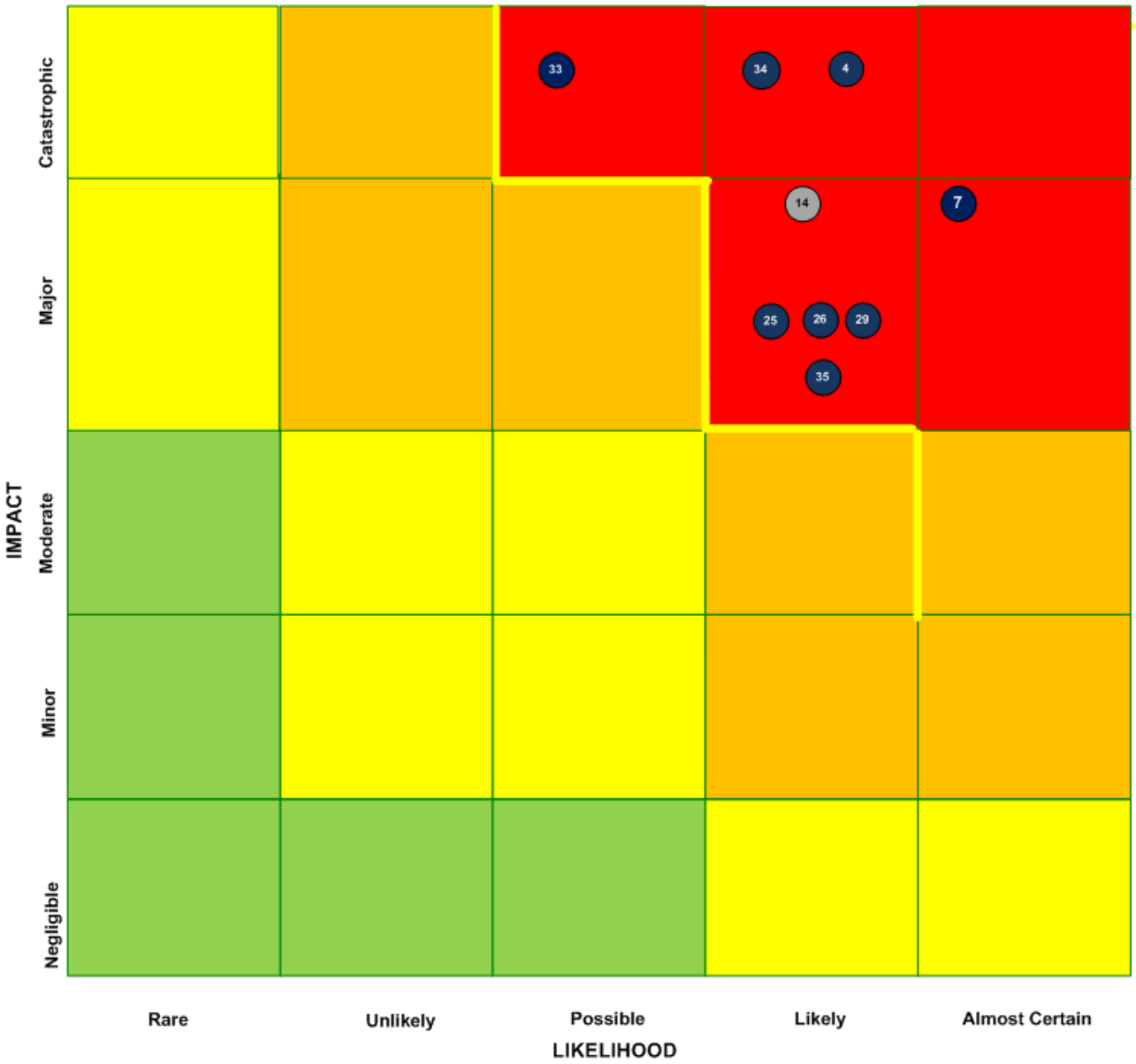
**Action required**

To note the progress made with mitigating controls and actions for risks included in the Board Assurance Framework.

| **Key implications** |
| --- |
| The Board has a responsibility to put in place governance structures and processes to ensure that the organisation operates effectively and meets its strategic objectives. |

| **Key implications and risks arising from this paper** | |
| --- | --- |
| **Clinical and Quality** | Improved response times to Category C patients as a result of improved staffing level and resources. |
| **Performance** | The risk regarding service performance needs extensive review as the underlying causes may no longer be relevant and other factors such as job cycle time may be having more impact. |
| **Financial** | No change to the two finance risks on the BAF. |
| **Workforce** | BAF risk 7 concerns shift changeover and there may be related workforce risks. |
| **Governance and Well-led** | The Board has a responsibility to put in place governance structures and processes to ensure that the organisation operates effectively and meets its strategic objectives. |
| **Reputation** | |
| **Other** | |
| **This paper supports the achievement of the following Quality Improvement Plan Workstreams:** | |
| **Making the London Ambulance Service a great place to work** | Yes |
| **Achieving Good Governance** | Yes |
| **Improving Patient Experience** | Yes |
| **Improving Environment and Resources** | Yes |
| **Taking Pride and Responsibility** | Yes |

# Board Assurance Framework – September 2016




BAF Risk 4 - Service Performance affected by the inability to match resources to demand

BAF Risk 7 - Performance falls at staff changeover time

BAF Risk 14 - Developing and delivering cost improvements

BAF Risk 25 - There may be insufficient range and volume of equipment on vehicles

BAF Risk 26 - Availability of equipment for frontline vehicles

BAF Risk 29 - Lack of ring backs on delayed response calls

BAF Risk 33 - EOC systems environment could be compromised by a cyber attack

BAF Risk 34 - Delivering a balanced financial plan for 2016/17

BAF Risk 35 - Potential industrial action as a result of national disputes regarding pay and conditions, which wil cause substantial disruption to the organisation should it go ahead

**Key:**

- Gross risk assessment
- Net risk rating
- Gross risk = net risk
- Controls to mitigate are implemented and operating effectively
- Target risk rating

Risk Severity

- High Risk (15-25)
- Significant Risk (8-12)
- Moderate Risk (4-6)
- Low Risk (1-3)

## BAF risks matched to Quality Improvement Plan 4: Improving Environment and Resources

| Risk ID: 26 | Description: | Risk opened: | 21/05/2015 |
|---|---|---|---|
| | There is a risk that the equipment for frontline vehicles may not be available when required. Staff will not have equipment required to provide appropriate patient care | Expected risk closure: | March 2017 |
| Linked Risk(s): 120 | **Risk Owner:** Director of Finance | Is this risk on track for closure? | Yes |
| | | It should be noted that whilst implementation of a Make Ready system within LAS will mitigate significantly against this risk, it is felt that this risk will always be an underlying or residual issue for any ambulance organisation. | |

| Low Risk | Medium Risk | | | | High Risk | | | |
|---|---|---|---|---|---|---|---|---|
| <=6 | 8 | 9 | 10 | 12 | 15 | 16 | 20 | 25 |
| T | | | | | | G N | | |

| Dec 2015 | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | Jul 2016 | Aug 2016 |
|---|---|---|---|---|---|---|---|---|
| 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 |

| Risk ID: 25 | Description: | Risk opened: | 21/05/2015 |
|---|---|---|---|
| | There is a risk that there may be insufficient range and volume of equipment to meet demands.Staff will not have equipment required to provide appropriate patient care | Expected risk closure: | March 2017 |
| Linked Risk(s): 121 | **Risk Owner:** Director of Finance | Is this risk on track for closure? | Yes |
| | | It should be noted that whilst implementation of a Make Ready system within LAS will mitigate significantly against this risk, it is felt that this risk will always be an underlying or residual issue for any ambulance organisation. | |

| Low Risk | Medium Risk | | | | High Risk | | | |
|---|---|---|---|---|---|---|---|---|
| <=6 | 8 | 9 | 10 | 12 | 15 | 16 | 20 | 25 |
| T | | | | | | G N | | |

| Dec 2015 | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | Jul 2016 | Aug 2016 |
|---|---|---|---|---|---|---|---|---|
| 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 |

| Risk ID: 34 | Description: | Risk opened: | 17/11/2015 |
|---|---|---|---|
| | The TDA expects all NHS trusts to achieve financial balance in 2016/17, managing within available resources. Failure to achieve this will mean the Trust is in deficit and will see a deterioration in its long term financial viability and will be subject to further scrutiny and challenge by regulators. | Expected risk closure: | 30/11/2016 |
| Linked Risk(s): 214 | **Risk Owner:** Director of Finance | Is this risk on track for closure? | Being scoped |
| | | Please note Trust wide finance risks will not close as they are systemic and recur on an annual basis. However, actions will be reviewed and refreshed annually to reflect new pressures and situations | |

| Low Risk | Medium Risk | | | | High Risk | | | |
|---|---|---|---|---|---|---|---|---|
| <=6 | 8 | 9 | 10 | 12 | 15 | 16 | 20 | 25 |
| | | | T | | | | G N | |

| Dec 2015 | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | Jul 2016 | Aug 2016 |
|---|---|---|---|---|---|---|---|---|
| 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 |

| Risk ID: 14 | Description: | Risk opened: | 10/04/2014 |
|---|---|---|---|
| | It is likely that NHS financial and operational planning will include the need to develop efficiencies in order to offset other costs pressures for the foreseeable future. Failure to identify and deliver CIPS will threaten the ongoing viability and solvency of the Trust. | Expected risk closure: | 30/11/2016 |
| Linked Risk(s): 217 | **Risk Owner:** Director of Finance | Is this risk on track for closure? | Being scoped |
| | | Please note Trust wide finance risks will not close as they are systemic and recur on an annual basis. However, actions will be reviewed and refreshed annually to reflect new pressures and situations | |

| Low Risk | Medium Risk | | | | High Risk | | | |
|---|---|---|---|---|---|---|---|---|
| <=6 | 8 | 9 | 10 | 12 | 15 | 16 | 20 | 25 |
| T | | | | | | | G N | |

| Dec 2015 | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | Jul 2016 | Aug 2016 |
|---|---|---|---|---|---|---|---|---|
| 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 |

**Legend: G = Gross Rating | N = Net Rating | T = Target Rating**

| Risk ID: 33 | Description: 420/BAF33 Without adequate patching, the risk of unauthorised access into the CAC network is increased as publicly known vulnerabilities related to the systems running on CAC will not be addressed. Any such attacks could result in a loss of sensitive data or CAC network being unavailable, severely impacting the delivery of emergency services<br><br>**Risk Owner:** Chief Information Officer | **Risk opened:** | 01/07/2016 |
|---|---|---|---|
| | | **Expected risk closure:** | Risk will reduce by 30/11/16 not close |
| **Linked Risk(s):** 420 | | **Is this risk on track for closure?** | Yes |
| | | This risk has been re-worded and proposed for amendment and re-grading for approval at the next RCAG hence the italicised Net and Target dates. | |

| Low Risk | Medium Risk | | | | High Risk | | | |
|---|---|---|---|---|---|---|---|---|
| <=6 | 8 | 9 | 10 | 12 | 15 | 16 | 20 | 25 |
| | | | | *N T* | | G | | |

| Dec 2015 | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | Jul 2016 | Aug 2016 |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | 15 | 15 |

## BAF risks matched to Quality Improvement Plan Work stream 3: Improving Patient Experience

| Risk ID: 7 | Description:<br><br>There is a risk that at staff changeover times, LAS performance falls<br><br>**Risk Owner:** Director of Operations<br><br>**Also linked to QIP Work stream 2 and 4** | **Risk opened:** | 08/12/2006 |
|---|---|---|---|
| | | **Expected risk closure:** | |
| **Linked Risk(s):** 430 | | **Is this risk on track for closure?** | |
| | | Risk currently under review by the Director of Operations. | |

| Low Risk | Medium Risk | | | | High Risk | | | |
|---|---|---|---|---|---|---|---|---|
| <=6 | 8 | 9 | 10 | 12 | 15 | 16 | 20 | 25 |
| | T | | | | | N | G | |

| Dec 2015 | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | Jul 2016 | Aug 2016 |
|---|---|---|---|---|---|---|---|---|
| 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 |

| Risk ID: 4 | Description:<br><br>There is a risk that Service Performance may be adversely affected by the inability to match resources to demand.<br><br>**Risk Owner:** Director of Operations<br><br>**Also linked to QIP Work stream 4** | **Risk opened:** | 31/07/2006 |
|---|---|---|---|
| | | **Expected risk closure:** | |
| **Linked Risk(s):** 337 | | **Is this risk on track for closure?** | |
| | | Risk currently under review by the Director of Operations. | |

| Low Risk | Medium Risk | | | | High Risk | | | |
|---|---|---|---|---|---|---|---|---|
| <=6 | 8 | 9 | 10 | 12 | 15 | 16 | 20 | 25 |
| | | | | T | | | G N | |

| Dec 2015 | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | Jul 2016 | Aug 2016 |
|---|---|---|---|---|---|---|---|---|
| 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 |

| Risk ID: 29 | Description:<br><br>There is a risk that there is a lack of ring backs on delayed response calls within EOC, we are therefore unable to monitor patient's safety whilst calls are being held.<br><br>**Risk Owner:** Director of Operations | **Risk opened:** | 10/06/2015 |
|---|---|---|---|
| | | **Expected risk closure:** | 31/03/2017 |
| **Linked Risk(s):** 339 | | **Is this risk on track for closure?** | Yes |
| | | | |

| Low Risk | Medium Risk | | | | High Risk | | | |
|---|---|---|---|---|---|---|---|---|
| <=6 | 8 | 9 | 10 | 12 | 15 | 16 | 20 | 25 |
| | T | | | | | G N | | |

| Dec 2015 | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | Jul 2016 | Aug 2016 |
|---|---|---|---|---|---|---|---|---|
| 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 |

**Legend: G = Gross Rating | N = Net Rating | T = Target Rating**

| Risk ID: 34 | Description: | Risk opened: | 14/07/2016 |
|---|---|---|---|
| | There is a risk of potential industrial action as a result of national disputes regarding pay and conditions, which will cause substantial disruption on the organisation should it go ahead | Expected risk closure: | 31/12/2016 |
| Linked Risk(s): | | Is this risk on track for closure? | No |
| 428 | Risk Owner: Director of Operations | Risk is being reviewed and being proposed for re-grading. | |

| Low Risk | Medium Risk | | | | High Risk | | | |
|---|---|---|---|---|---|---|---|---|
| <=6 | 8 | 9 | 10 | 12 | 15 | 16 | 20 | 25 |
| | | T | | N | | G | | |

| Dec 2015 | Jan 2016 | Feb 2016 | Mar 2016 | Apr 2016 | May 2016 | Jun 2016 | Jul 2016 | Aug 2016 |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | 16 | 16 |

**Legend: G = Gross Rating | N = Net Rating | T = Target Rating**

## BAF Risk no. 26 There is a risk that the equipment for frontline vehicles may not be available when required. Staff will not have equipment required to provide appropriate patient care

| | | | | |
|---|---|---|---|---|
| **Risk Classification:** Fleet and logistics | **Risk Owner:** Grimshaw, Andrew | **Scrutinising Committee:** Fleet and Logistics Risk Review Group | | |
| **Underlying Cause/Source of Risk:** This risk was 443 on the old register | | **Gross Rating** | **Current/Net Rating** | **Target Rating** |
| | | **16** | **16** | **6** |

| Existing Controls | Positive Assurance of Controls | Further Actions | | Due Date |
|---|---|---|---|---|
| 1, Serial numbers on all re-usable equipment that can be accurately tracked.<br>2, Agree and set requirements for stock levels on vehicles. Ensure regular monitoring occurs<br>3, Define 'shell' and maintain a reserve of essential equipment centrally to backfill and ensure vehicle can go back into service with minimal delays<br>4, Agree ownership and responsibilities for equipment ensuring that all VP responsibilities are included within the VP contract, to include FRUs and DCAs, ensure equipment is not transferred between vehicles<br>5, Complex based fleet in place to increase availability for VP checking and restocking/equipping vehicles<br>6, Electronic VDI pilot completed, all equipment has bar code or serial number<br>7, NE VP pilot rolled out to include secure local equipment stores and day time "Quatermaster" role<br>8, Interserve are providing feedback to Logistics regarding Vehicle Daily Inspection (VDI) reports.<br>9, Current VP contract reviewed and any immediate changes are agreed<br>10, Planned rollout of complex based fleet to increase vehicle availability for VP to enable agreed stock requirements to be provided completed<br>11, Pilot project in NE area to provide and resupply equipment store implemented.<br><br>**Gaps in Controls**<br><br>To be determined | 1, Clinical Equipment Group;<br>2, Asset tracking report;<br>3, VP reports;<br>4, VP Contract;<br>5, Equipment Process;<br>6, Project completion<br><br>**Gaps in Assurance**<br><br>None | **501** | Email Justin Wand to see if thinks this risk should be merged with 120: Further clarification required on this risk and BAF risk 26 | 07/11/2016 |

**Signed:** Justin Wand **Date Reviewed:** 25/08/2016

## BAF Risk no. 25 There is a risk that there may be insufficient range and volume of equipment to meet demands.Staff will not have equipment required to provide appropriate patient care

**Risk Classification:** Fleet and logistics

**Risk Owner:** Grimshaw, Andrew

**Scrutinising Committee:** Fleet and Logistics Risk Review Group

**Underlying Cause/Source of Risk:** This was risk 442 on the old risk register

| Gross Rating | Current/Net Rating | Target Rating |
|---|---|---|
| 16 | 16 | 6 |

### Existing Controls

1. Agreed vehicle equipment lists including re-usable v disposable in place
2. Equipment stock levels agreed and maintained
3. Responsibility for each item of equipment clearly defined
4. Budget responsibilities for replacement equipment clear
5. Review of personal issue kit
6, A “core” equipment list for DCA & FRU has been defined and agreed
7, funding for NE Sector Revised Vehicle Prep Pilot - fully managed equipment solution has been agreed
8, An equipment amnesty and physically review all stations and complexes for “retained” equipment has been undertaken
9, an new paper based VP VDI form has been introduced
10, Pilot to assess benefits of VP proposal carried out

**Gaps in Controls**

To be determined

### Positive Assurance of Controls

1, Progress made in agreement of core equipment and further equipment amnesty.
2, Decontamination of equipment commenced.
3, Analysis of asset tracking systems being undertaken.

**Gaps in Assurance**

None

| | Further Actions | Due Date |
|---|---|---|
| **498** | Roll out VP proposal to LAS area | 20/07/2016 |
| **499** | Implement working group to review personal issue kit – check status of any existing work with CEG | 20/07/2016 |
| **607** | Email Justin Wand to see if thinks this risk should be merged with 120: Further clarification required on this risk and BAF risk 25 | 07/11/2016 |

**Signed:** Justin Wand **Date Reviewed:** 25/08/2016

## BAF Risk no. 34 The TDA expects all NHS trusts to achieve financial balance in 2016/17, managing within available resources. Failure to achieve this will mean the Trust is in deficit and will see a deterioration in its long term financial viability and will be subject to further scrutiny and challenge by regulators.

| **Risk Classification:** Finance | **Risk Owner:** Grimshaw, Andrew | **Scrutinising Committee:** Finance & Investment Committee | | |
|---|---|---|---|---|
| **Underlying Cause/Source of Risk:** Failure to achieve this will mean the Trust is in deficit and will see deterioration in its long term financial viability and will be subject to further scrutiny and challenge by regulators. | | **Gross Rating** | **Current/Net Rating** | **Target Rating** |
| | | **20** | **20** | **10** |

| Existing Controls | Positive Assurance of Controls | Further Actions | | Due Date |
|---|---|---|---|---|
| 1. Demand predictions for future years are robust and understood, both for annual value and monthly, daily and weekly profiles<br>2. Clear view on operational capacity required to deliver ambulance performance targets<br>3. Clear view of achievable productivity targets which support performance targets<br>4. Clear view of operational staff recruitment against establishments targets as set. Clear sight these targets can be delivered<br>5. Funding from CCGs is consistent with capacity, productivity and demand assessments<br>6. Other factors such as investment for CQC are clearly understood, and associated funding identified<br>7. NHS wide efficiency targets can be achieved, and other opportunities to generate efficiency are identified, managed and delivered.<br>8. Inflationary pressures are understood and managed within the overall financial position<br>9. Capital investment plans and their revenue consequences are understood.<br><br>**Gaps in Controls**<br><br>See actions to be taken | Assurance of Finance Risks are provided via regular review of controls from the Finance and Investment Committee<br><br>**Gaps in Assurance**<br><br>None identified | **1139** | Productivity: Develop a clear understanding of productivity and how it can be influenced and managed. | 31/12/2016 |
| | | **1140** | Funding: Appropriately funded contract in place with commissioners | 31/05/2016 |
| | | **1141** | All other areas of investment reviewed and agreed; this must include major items such as the impact of the CQC improvement plan. | 31/05/2016 |
| | | **1142** | Efficiency targets have scoped, stress tested and clear plans are in place to deliver. | 31/07/2016 |
| | | **1143** | Capital investment plans, funding and associated revenue implications are defined and agreed. | 31/07/2016 |

**Signed:** Bell, Andy **Date Reviewed:** 22/09/2016 (Reviewed by the Finance and Investment Committee – no changes made)

## BAF Risk no. 14 It is likely that NHS financial and operational planning will include the need to develop efficiencies in order to offset other costs pressures for the foreseeable future. Failure to identify and deliver CIPS will threaten the ongoing viability and solvency of the Trust.

**Risk Classification:** Finance | **Risk Owner:** Grimshaw, Andrew | **Scrutinising Committee:** Finance & Investment Committee

**Underlying Cause/Source of Risk:**
- Appropriate supporting evidence not available
- CIPs not supported by detailed milestone plan.
- CIPs not embedded in budgets.
- CIPs not owned by relevant manager.
- Benchmarking of CIPs not undertaken.
- CIP governance not clearly defined and in place.
- Board/FIC scrutiny of CIP planning and delivery not in place.
- CIPs not delivering in line with expectations.
- Capacity and capability not available to support delivery.

| Gross Rating | Current/Net Rating | Target Rating |
|---|---|---|
| 20 | 20 | 6 |

| Existing Controls | Positive Assurance of Controls | Further Actions | | Due Date |
|---|---|---|---|---|
| 1. Appropriate supporting evidence available for CIP.<br>2. All CIPs supported by detailed milestone plan.<br>3. All CIPs embedded in budgets.<br>4. All CIPs owned by relevant manager.<br>5. Benchmarking of CIP opportunity.<br>6. CIP governance clearly defined and in place.<br>7. Board/FIC scrutiny of CIP planning and delivery in place.<br>8. CIPs delivering in line with expectations.<br>9. Capacity and capability available to support delivery.<br>10. All CIPs supported by Quality Inputs Assessments.<br><br>**Gaps in Controls**<br><br>See actions to be taken | Assurance of Finance Risks are provided via regular review of controls from the Finance and Investment Committee<br><br>**Gaps in Assurance**<br><br>None identified | **1111** | Review support and engage additional support to drive the CIP Programme. | 30/09/2016 |
| | | **1112** | Ensure all schemes have clear project plans, including evidence to support, milestone plans and are owned by project leads. | 30/09/2016 |
| | | **1113** | Embed all CIPs in budgets. | 30/09/2016 |
| | | **1114** | Review current benchmarking information. | 30/09/2016 |
| | | **1115** | Establish Management of CIP as key Function of Resource Committee | 30/09/2016 |
| | | **1116** | Ensure all CIPs have QIA in place that have been agreed with the Medical Director | 30/09/2016 |

**Signed:** Bell, Andy **Date Reviewed:** 22/09/2016 (Reviewed by the Finance and Investment Committee – no changes made)

| BAF Risk no. 4 | There is a risk that Service Performance may be adversely affected by the inability to match resources to demand. | | | |
|---|---|---|---|---|
| **Risk Classification:** Operational | **Risk Owner:** Woodrow, Paul | **Scrutinising Committee:** Operational Delivery Board | | |
| **Underlying Cause/Source of Risk:** Recruitment, Attrition, Growing vacancy factor, Increased demand, Patient Safety and Financial Penalties | | **Gross Rating** | **Current/Net Rating** | **Target Rating** |
| | | 20 | 20 | 12 |

| Existing Controls | Positive Assurance of Controls | Further Actions | | Due Date |
|---|---|---|---|---|
| 1. On-going recruitment to vacancies.<br>2. Use of voluntary and private sector at times of peak demand.<br>3. New rosters implemented successfully.<br>4. Q1 overtime incentives have been published and target specific Sectors where staff shortfalls have been identified<br>5. Surge plan in place and has been reviewed<br>6. Category C workload determinants have all been reviewed and have been realigned across the 4 C Categories<br>7. Action has been taken to reduce the multiple attendance ratios where appropriate for all categories of calls i.e. autoback up pilot including no automatic back to FRU's for certain determinants until requested by the FRU when on scene.<br>How are controls measured?<br>Vacancy factors measured fortnightly at ELT.<br>Workforce Committee monitors planning of recruitment.<br><br>**Gaps in Controls**<br><br>Further Actions Required:<br>1. Sickness management in progress – aim to reduce sickness to 5.5%. Overall sickness for frontline staff as at April 2016 is 5.6% and has remained at this position to date. Monitoring to continue<br>2. Workforce plan operations, recruitment; recruit external paramedics, direct recruitment to new band 4 role. The LAS have taken part in 'grad fairs' with UK Universities since Jan 2016 and this is on-going in a monthly basis to recruit graduates. A team returned to Australia in May 2016 and made conditional offers to 151 candidates. The target for recruiting to 3169 frontline staff by March 2016 was completed<br>3. Improve provisioning and reduce frontline ambulance response through the use of NETS and taxi service. NETS usage has increased from 600 to 700 per week against a target of 1200. Project plan being finalised to stabilize the system to 800 per week which can then be added to on a daily basis to reach the required 1200. Plan was delivered at the Tripartite meeting on 7th April.<br>4. Ambulance Response Programme, previously dispatch on disposition pilot, is on-going. Effectiveness is reviewed bi-weekly. Extends resource allocation time from 60 to 180 seconds allowing more effective decisions to be made. Ends for LAS Sept 2016<br>5. IMD incident management desk – to manage incidents. | 1) Recruitment activity reviewed fortnightly at ELT 2) Weekly Operations Group meetings with a monthly Operations Board 3) A review of the surge plan has taken place and surge triggers amended on 29th Jan 2016. REAP structure has been revised and impleme<br><br>**Gaps in Assurance**<br><br>12/05/16 reviewed and updated by P. McKenna<br>13/04/2016 - Reviewed by EC management team. Suggest current ratingremains. Demand, utilisation and performance remain challenged. the current controls are not having the required impact. Senior teams meeting | **746** | Sickness management in progress – aim to reduce sickness to 5.5%. Overall sickness for frontline staff as at January 2016 is 5%. Monitoring to continue | 14/07/2016 |
| | | **747** | Workforce plan operations, recruitment; recruit external paramedics, direct recruitment to new band 4 role. The LAS have taken part in 'grad fairs' with UK Universities since Jan 2016 and this is on-going in a monthly basis to recruit graduates. | 14/07/2016 |
| | | **748** | Improve provisioning and reduce frontline ambulance response through the use of NETS and taxi service. NETS usage has increased from 600 to 700 per week against a target of 1200. Project plan being finalised to stabilize the system to 800 per week | 31/10/2016 |
| | | **749** | Ambulance Response Programme, previously dispatch on disposition pilot, is on-going. Effectiveness is reviewed bi-weekly. Extends resource allocation time from 60 to 180 seconds allowing more effective decisions to be made. Ends for LAS Sept 2016 | 14/07/2016 |
| | | **750** | IMD incident management desk – to manage incidents. | 14/07/2016 |

**Signed:** McKenna, Peter **Date Reviewed:** 12/05/2016 – Under review 28th September 2016

| **BAF Risk no. 29** | **There is a risk that there is a lack of ring backs on delayed response calls within EOC, we are therefore unable to monitor patient's safety whilst calls are being held.** | | |
|---|---|---|---|
| **Risk Classification:** Operational | **Risk Owner:** Millard, Katy | **Scrutinising Committee:** Control Services Quality Meeting | |
| **Underlying Cause/Source of Risk:** Inability of the Service to provide resources to dispatch on calls in a timely manner.<br>Insufficient resources in EOC to carry out the ring backs.<br>Instances of Serious Incidents and Inquests where patients have deteriorated when there has been no contact by the service for a significant period of time.<br>Increased demand vs resource. | | **Gross Rating** | **Current/Net Rating** | **Target Rating** |
| | | **16** | **16** | **8** |

| **Existing Controls** | **Positive Assurance of Controls** | **Further Actions** | | **Due Date** |
|---|---|---|---|---|
| 1. More involvement by the Clinical Hub who monitors the calls and identifying priorities for ring backs.<br>2. Additional technical support to prompt re-categorisation and contact.<br>3. New ring back status monitors.<br>4. New information within EOC to be able to properly inform patients of the likely wait time for a response.<br>5. Staff removed from call handling to undertake ring backs when capacity allows. Recent training for Area Controllers and EMD 3 allocators included a session on learning from incidents, focusing on the errors /decision making which has been identified as poor risk mitigation and providing less optimal patient care.<br>6. Two call-handling courses took place in October 2105 which brought a maximum of 32 new staff to EOC pre-Christmas. Complete. – New training plan for 2016/17 for 12 call handling courses.<br><br>**Gaps in Controls**<br><br>1. On-going further vacancies against the increasing demand means the impact on ability to carry out ring backs remains high.<br>2. ORH report received due to go to ELT, identifies minimum of 31 staff required even when full establishment of operational staffing is in place. Therefore additional recruitment will be required into control services and a change in the base line staffing level.<br>3. Additional front line resources are required.(covered by BAF risk 265 and 388) | Patients who are most at risk are flagged via the hub to focus the ring backs.<br><br>**Gaps in Assurance**<br><br>1. ORH report received due to go to ELT, identifies minimum of 38 staff required even when full establishment of operational staffing is in place. Therefore additional recruitment will be required into control services and a change in the base line staff | **1062**<br><br>**1381**<br><br>**1382** | Evaluation of the ringback function ORH report received due to go to ELT, identifies minimum of 38 staff required even when full establishment of operational staffing is in place.<br><br>Therefore additional recruitment will be required into control services and a change in the base line staffing.<br><br>Control Services to provide a report to the ELT on how they can create further capacity within the in order to determine the specific number of additional staff required for the base line staffing level | 19/08/2016<br><br>31/03/2017<br><br>31/03/2017 |

**Signed:** Watkins, Susan **Date Reviewed:** 18/08/2016

## BAF Risk no. 33 420/BAF33 Without adequate patching, the risk of unauthorised access into the CAC network is increased as publicly known vulnerabilities related to the systems running on CAC will not be addressed. Any such attacks could result in a loss of sensitive data or CAC network being unavailable, severely impacting the delivery of emergency services

**Risk Classification:** Information governance

**Risk Owner:** Watson, Andrew

**Scrutinising Committee:** Information Governance Group

**Underlying Cause/Source of Risk:** TRR 420

As the CAC network does not have access to the internet or email, it is less likely that attacks will come directly from these external sources, but it may be possible to introduce an attack through infected USB drives, CD/DVDs, or other removable media (even if LAS-approved devices). Alternatively, an attacker could leverage one of the security vulnerabilities present on the other networks (external Internet facing network or Admin network) as a pivot point to launch attacks into the CAC.

Patching (on the Command and Control network)

Patching refers to updating software or its supporting data to help remediate known issues, such as security vulnerabilities. KPMG review has revealed that patching is limited for devices on the Command and Control (CAC) network (where the 999 call centre is located) as Comandpoint is unable to run on up-to-date Microsoft devices. Additionally, updates to third party software (java in particular) interfere with the running of Commandpoint. As mitigation, these devices do not have email or internet access. Review also highlighted that PCs on the CAC network have never been patched.

(highlighted by KPMG Cyber Audit -October 2013)

| Gross Rating | Current/Net Rating | Target Rating |
|---|---|---|
| 15<br>Proposed 16 | 15<br>Proposed 12 | 5<br>Proposed 12 |

| Existing Controls | Positive Assurance of Controls | Further Actions | | Due Date |
|---|---|---|---|---|
| 1. Enterprise antivirus monitoring CAC desktops<br>2. Desktop ports disabled (i.e. USB, DVD)<br>3. No access to internet /email for CAC desktops<br><br>**Gaps in Controls**<br><br>1. Lack of a Firewall between CAC and LAS corporate networks<br>2. Summary of reporting on hacking, attacks and virus protection not visible to EMT and Audit Committee.<br>3. Content f reporting on hacking, attacks and virus protection etc not defined. | IGG and RCAG agreement on completion of technical element and of the reporting format<br><br>**Gaps in Assurance**<br><br>TBC | **624**<br><br>**625**<br><br>**626**<br><br>**627** | Implement Firewall between CAC and LAS corporate Networks<br><br>Monthly reporting on hacking, attacks and virus protection for EMT and Audit Committee to be defined and agreed.<br><br>RCAG approval of report and format<br><br>Additional information, such as patches applied / outstanding to be included in subsequent reports | 31/12/2016<br><br>01/04/2016<br><br>31/10/2016<br><br>01/04/2016 |

**Signed:** Wynn, Vic **Date Reviewed:** 22/08/2016

| **BAF Risk no. 34** | **There is a risk of potential industrial action as a result of national disputes regarding pay and conditions, which will cause substantial disruption on the organisation should it go ahead** | | | | |
|---|---|---|---|---|---|
| **Risk Classification:** Corporate | **Risk Owner:** Woodrow, Paul | | | **Scrutinising Committee:** Workforce and OD | |
| **Underlying Cause/Source of Risk:** This is a national dispute, and if the industrial action goes ahead the affected parties will include: LAS staff; patients; hospitals and other healthcare providers | | **Gross Rating** | **Current/Net Rating** | **Target Rating** | |
| | | **16** | **12** | **9** | |
| **Existing Controls** | **Positive Assurance of Controls** | **Further Actions** | | | **Due Date** |
| LAS are aware of discussions to date and further information will be available as to whether the industrial action will eventuate following a ballot on 31/05/2016<br><br>**Gaps in Controls**<br><br>To be identified | An impact assessment will be undertaken once the extent of the industrial action is known and plans will be developed and shared widely with senior management within the Trust and the Trust Board<br><br>**Gaps in Assurance**<br><br>To be identified | | *Risk to be reviewed* | | *Update to RCAG in October 16* |
| **Signed:** Woodrow, Paul | **Date Reviewed:** 26/08/2016 | | | | |

| **BAF Risk no. 7** | **There is a risk that at staff changeover times, LAS performance falls** | | | | |
|---|---|---|---|---|---|
| **Risk Classification:** Operational | **Risk Owner:** Woodrow, Paul | | **Scrutinising Committee:** Operational Delivery Board | | |
| **Underlying Cause/Source of Risk:** Current rest break agreement permits staff to conclude shift by upto 30 mins early where no break given by EOC | | | **Gross Rating** | **Current/Net Rating** | **Target Rating** |
| | | | **20** | **16** | **8** |
| **Existing Controls** | **Positive Assurance of Controls** | **Further Actions** | | | **Due Date** |
| 1. Daily monitoring of rest break allocation to resolve end of shift losses.<br>2. Use of bridging shifts for VAS/PAS.<br>3. Roster reviews/changes include staggered shifts.<br>4. Incident management control desk within EOC. This currently operates when staffing allows or there is a serious incident, however sustained running relies on sufficient EOC resourcing (ORH review).<br><br>**Gaps in Controls**<br><br>1. There is no allocation process to ensure loss is spread evenly across the day to manage impact. No current progress with ELT/staff side to change rest break arrangements. Without a change this risk is unlikely to be mitigated effectively. It may reduce as staffing improves.<br>1. The incident management desk is not open consistently 24/7 due to sub-optimal staffing. | 1. New Rotas in place since Q2 14/15; Modernisation Programme Board minutes; and weekly tracking report.<br>2. Skill mix: the skill mix model was updated in Sept 2015 to include international recruits and is currently under review.<br>3. Rota changes to be impl<br><br>**Gaps in Assurance**<br><br>None identified | **757**<br>**753**<br>**754**<br>**755**<br>**756** | Out of service HUB implemented<br>Agree the process for the rest break arrangements to be implemented.<br>Recruiting frontline staff to 3169 by March 2016<br>Skill mix: the skill mix model has been updated in January 2015 to include international recruit. This was reviewed in Aug. 2015 and published in September 2015<br>On-going rigorous management of out of service. We are unlikely to meet the final target by the end of the Programme (end March 2016), however what was felt to be achievable is a target of 2.2% (vehicle element).<br><br>*RCAG need to review* | 15/07/2016<br>30/09/2016<br>15/07/2016<br>15/07/2016<br>31/03/2016<br><br>*October 16* |
| **Signed:** McKenna, Peter | | **Date Reviewed:** 12/05/2016 – under review 28th September 2016 | | | |

**August 2016 Risk Report - Trust Risks Approved by RCAG**

| ID | Description | Opened | BAF Reference: | Risk Subtype | Gross Impact | Gross Likelihood | Gross Rating | Gross Level | Controls in place | Manager | Last review date | Consequence (current) | Likelihood (current) | Rating (current) | Risk level (current) | Summary of actions to be taken to control the risk | Assurance | Consequence (Target) | Likelihood (Target) | Rating (Target) | Risk level (Target) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 341 | There is a risk that patient safety for category C patients may be compromised due to demand exceeding available resources. | 05/01/2015 | 16 | Operational | Catastrophic | Likely | 20 | High | 1. Undertaking ring backs within set time frames for held calls<br>2. Fully trained workforce with 20 minute education breaks throughout shift. LAS overtime +PAS/VAS to add capacity. Focussed incentivisation to more challenged hours of the day.<br>3. Additional focus on safety reporting. QA – MPDS (999); QA – CHUB MTS (H&T; ) – Report safeguarding incident concerns.<br>4. Falls care is being introduced. Flag elderly fallers on vulnerable person monitor (VP). Clear process of escalation of response process implemented.<br>5. Implementation of VP (mental health / elderly fallers) and CP (sickle cell / septic patients) screen to monitor higher risk patients.<br>6. Managing patients through use of NETS options where clinically appropriate. NETS desk and HCP lines starting 1st July which enables selected lower acuity patients to be conveyed by them instead of a frontline vehicle and reduces the wait | Millard, Katy | 05/07/2016 | Catastrophic | Unlikely | 10 | Significant | minus agreed vacancy factor of 5%. Details included in advert to action in improvement programme.<br>2. Deliver efficiencies in full from Capacity Review and complete Roster Implementation.<br>3. Recruit to establishment in the clinical hub. Band 6 is now agreed for all HUB posts.<br>4. Review the establishment in the CHUB (Jan 2016) and recruit into posts (March 2016). Recruitment of 40 Team Leaders, 30 band 6's and 4 Mental Health Nurses has been agreed. Currently reviewing 24/7 Mental Health Nurse coverage and adjusting the need for more band 6's and less Team Leaders.<br>5. Allocate EMDs to clinical hub to assist with ring backs (when capacity allows)<br>6. Actions included with BAF risk 4 relating to performance impact on the realisation of this risk.<br>7. NETS improvement programme in place …. Can we have more detail here | 1) Recruitment activity reviewed fortnightly at ELT 2) Weekly forecast & planning meetings. 3) Medical Director and DDO (Control Services) to review surge plan as required, and plan to do again imminently. 4) Plans for non-auto dispatch back-up have been developed and will run from 3/11/15 for 3 weeks and this should reduce MAR 5) Overtime disruption payments are in place until 6th January 2016<br>6. Medical Directorate clinical safety review carried out. | Catastrophic | Unlikely | 10 | Significant |
| 342 | There is a risk that Siemens VDO satellite navigation (SatNav) units in fleet vehicles will become unserviceable due to the age of the units and the withdrawal from the market place of the supplier resulting in increased vehicle out of service (OOS) or delayed response times and impact on operational efficiency. | 23/06/2016 | | Operational | Major | Likely | 16 | High | 1. Telent Ltd, (MDT/SatNav maintainer) to investigate alternative break/fix arrangements with a 3rd party.<br>2. Assessment of fault quantities and failure frequencies.<br>3. An audit of available equipment and spares has been conducted showing that current stocks will satisfy LAS requirements (fleet size and complexity) until after the replacement software and hardware is available. | Woodrow, Paul | 01/02/2016 | Moderate | Likely | 12 | Significant | 1. The current CAD Software is being redeveloped to interface with the alternative Sat Nav device, a necessary precursor to action 2 and 3.<br>2. Funding has been approved for trial units of the new Sat Nav as well funding for the external specialist developer required to complete 1, above.<br>3. Subject to proving the new software and devices are viable, funding will be sought to replace SatNavs across the fleet & undertake appropriate procurement process.<br>4. As a precaustionary measure the existing Sat Nav mapping software will beupdated to the latest version.<br>5. Obtain 2nd hand SatNavs from other Trusts. | IM&T have reviewed the planned fleet number and composition over the coming 12 months. IM&T have also reviewed the current stock and spares with our managed service provider. The stock and spares currently outweight the volumeof units required.<br><br>In addition the existing Sat Nav software (Maps) will be updated to ensure currency of data within the vehicles. | Minor | Unlikely | 4 | Moderate |
| 372 | 282:There is a risk that general failure of personnel to adequately 'back-up' IT may lead to the loss of data. | 28/06/2016 | | Information Governance | Major | Possible | 12 | Significant | 1. The move of business information from hard drives to network drives.<br>2. Part of the 2010/11 audit programme will test this facility and give assurances.<br>3. IM&T Infrastructure Team to review and take actions as appropriate. | Watson, Andrew | 23/06/2016 | Major | Possible | 12 | Significant | 1. Enterprise vault for emails deployed.<br><br>2. Full solution requires a Trust Wide EDRMS system which has been included in the IM&T Strategy for 2017.<br><br>3. Reminders and communications to all staff on the need to adequately backup data held on local devices." | Risk discussed and monitored by IM&T SMT | Major | Unlikely | 8 | Significant |

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 377 | 380 - The instability (in terms of technical failure) of the Bow telephony voice recorder service will mean that 999 calls may 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.<br>This risk is further exacerbated by the intermittent inability to access and retrieve historical radio and telephony conversations currently held on obsolete hardware and software. | 28/06/2016 | | Information Governance | Moderate | Almost certain | 15 | High | Tender specification developed to encompass all recording across the Trust, with an aim to Deliver in 2015/16.<br>Historical 999 call Data (over 2 yrs) will be converted to the format used by the newly selected system. Dat tapes will need to be converted to a current format and a gating template is in the development process.<br>Engineers are running proactive weekly checks over the systems to ensure service continuity.<br>Further investigations with the supplier are on-going to provide additional maintenance and operational plans to ensure the stability of the service | Watson, Andrew | | Moderate | Likely | 12 | Significant | As part of the capital plan for 15/16 proposal submitted and approved to procure a new solution to encompass all recording across the Trust, as current system is end of life.<br><br>Tender process completed and tender evaluation underway. | Replacement will be complete with the latest supported version of software. | Moderate | Rare | 3 | Low |
| 380 | 400 - There is a risk that Siemens VDO satellite navigation (SatNav) units in fleet vehicles will become unserviceable due to the age of the units and the withdrawal from the market place of the supplier resulting in increased vehicle out of service (OOS) or delayed response times and impact on operational efficiency. | 28/06/2016 | | Information Governance | Major | Likely | 16 | High | 1. Telent Ltd, (MDT/SatNav maintainer) to investigate alternative break/fix arrangements with a 3rd party.<br>2. Assessment of fault quantities and failure frequencies.<br>3. An audit of available equipment and spares has been conducted showing that current stocks will satisfy LAS requirements (fleet size and complexity) until after the replacement software and hardware is available. | Watson, Andrew | | Major | Possible | 12 | Significant | 1. The current MDT software is being redeveloped to interface with the alternative Sat Nav device, a necessary precursor to action 2 & 3.<br>2. Funding has been approved for trial units of the new Sat Nav as well funding for the external specialist developer required to complete 1, above.<br>3. Subject to proving the new software and devices are viable, funding will be sought to replace SatNavs across the fleet & undertake appropriate procurement process.<br>4. As a precautionary measure the existing Sat Nav mapping software will be updated to the latest version.<br>5. Obtain 2nd hand SatNavs from other Trusts. | IM&T have reviewed the planned fleet number and composition over the coming 12 months. IM&T have also reviewed the current stock and spares with our managed service provider. The stock and spares currently outweigh the volume of units required.<br>In addition the existing Sat Nav software (Maps) will be updated to ensure currency of data within the vehicles. | Major | Rare | 4 | Moderate |
| 410 | 423<br>There is risk that the Trust could incur unnecessary expenditure replacing lost assets. The loss of such assets could also lead to reputational damage and information governance breaches (i.e. lost/stolen desktop devices or other unencrypted devices) | 30/06/2016 | | Information Governance | Moderate | Likely | 12 | Significant | 1. Local asset registers held by IM&T Infrastructure Teams. | Watson, Andrew | | Moderate | Likely | 12 | Significant | 1. The management, recording and tracking of IT assets should be treated in the same way as all Trust key assets. An LAS wide system is required and has been planned within the IM&T Strategy for delivery in 2017/18.<br><br>2. LAS central IT assets such as servers and network components should be registered in a CMDB which can be used to assess the impact of change and provide a central library / schedule of licence renewals and software updates. | Risk discussed and monitored by IM&T SMT | Moderate | Rare | 3 | Low |
| 411 | 424<br>There is a risk that the lack of ownership of and responsibility for information assets will increase the likelihood of a security breach or data loss incident occurring. | 30/06/2016 | | Information Governance | Moderate | Likely | 12 | Significant | None | Watson, Andrew | | Moderate | Likely | 12 | Significant | 1. Perform an exercise to identify the IT information assets (systems, applications) owned by the Trust and assign owners to them to enable better asset management.<br><br>2. Introduce a policy to assign an owner (individual/department) to every new and existing IT information asset that is purchased at the Trust. | Risk discussed and monitored by IM&T SMT | Moderate | Rare | 3 | Low |

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 431 | There is a risk that...<br><br>the LARP2 project will not deliver its main objectives<br>(of implementing the new ESN based radio system in the control room, all LAS operational vehicles and other key areas before Jan 2020 when the current LAS contract with Airwave Ltd. expires).<br><br>This will result in the Trust not being able to deliver an adequate accident and emergency service. | 05/07/2016 | | Operational | Major | Likely | 16 | High | Project board set up and meeting monthly, pan Trust representation.<br><br>Close working relationship with National programme for replacement of Airwave (ARP); represented on the LAS' project board.<br><br>Project governance in place i.e. risk and issue logs etc.<br><br>National programme risks are being managed by DH and HO project teams | Watson, Andrew | | Major | Possible | 12 | Significant | Sufficient resources being available to the Project to deliver the internal changes that will be required as/when the national programmes have delivered the new ESN and different frameworks are in 2018 | Project board established, meeting regularly. Its terms of reference reviewed in December 2015 and amended to include requirement of 75% attendance by the project board members.<br><br>Close working relationship with the national programme and attendance at Pan London ES monthly meetings to ensure that risks/issues relating to London are fully understood. Representation on the national ARP board (VW); representation from the national programme on the LAS' project board (RC & CL). | Major | Unlikely | 8 | Significant |
| 432 | The Quality Improvement Programme fails to achieve tangible outcomes in the first 6-12 months diminishing stakeholder support | 15/07/2016 | | Corporate | Moderate | Almost certain | 15 | High | •* In January 2016, the QIP narrative and milestone plan was published and provides detail of activities to be delivered during 2016/17<br>•* A robust governance and assurance framework for the QIP is in place to monitor achievement of scheduled activity, and regular reporting obligations to key stakeholders<br>•* A PMO has been established that will central monitor and review programme progress | Broughton, Karen | | Moderate | Likely | 12 | Significant | Executive Leads to regularly review upcoming activities, and to give an early indication of any potential risk to delivering project outcomes and to take steps to mitigate the risk or to escalate the matter to the QIG to seek assistance to resolve<br>* Programme KPIs have been set and should be regularly monitored by Executive Leads<br>* In April, Executive Leads have been asked to consider bringing forward activity which may have a positive impact on staff | All assurance groups within the governance of the QIP should provide sufficient challenge to Executive Leads to ensure that tangible outcomes are achieved to time | Moderate | Unlikely | 6 | Moderate |
| 433 | Funding proposals for resources or identified costs to deliver the QIP do not align with the outcome of 2016/17 contracting discussions with Commissioners, and therefore unaffordable. | 15/07/2016 | | Finance | Major | Likely | 16 | High | •• Indicative costs have been identified by each of the project workstreams, and will form the basis of contract discussions with Commissioners which is currently underway. However these costs may be subject to change as projects progress delivery of activities, and the outcome following option appraisals may require funding that was not known at the outset | Grimshaw, Andrew | | Major | Possible | 12 | Significant | •* Executive Leads to consider other means of funding initiatives through existing budget or cost savings. If this is not possible, then a robust justification to be provided to ELT for further consideration<br>•* Ongoing discussions and refinement of the funding bid with Commissioners<br>•* As a result of this ELT review and commissioner conversations, any potentially unfunded activities that cannot be delivered will be raised urgently with ELT and the QIP Board | ELT have considered all requests for funding, and prioritised these into a funding bid to Commissioners.<br>• Exec discussions with lead Commissioner and SRG leads are ongoing.<br>• Programme finances will be a regular agenda item to be reviewed by ELT and QIP Board | Moderate | Possible | 9 | Significant |
| 438 | There is a risk that the inadequate facilities and lack of policy for the decontamination of equipment may increase the risk of infection in particular with regard to returned equipment from EDs which does not have an identified process for decontamination | 22/07/2016 | | Fleet and Logistics | Major | Likely | 16 | High | 1, introduction of single use items<br>2, improved cleaning programme for equipment on vehicles<br>3, Detergent and disinfectant wipes for equipment being used | Grimshaw, Andrew | | Major | Possible | 12 | Significant | 1, Contracted a subject expert matter to write a management of medical devices policy which will incorporate decontamination of equipment and meet all MHRA guidance and regulations. This will then be put through the approval process before inclusion on the pulse. To be done by an external contractor with the first draft by January 2016<br>2, Once medical devices policy is approved, communication will be required with front line staff on the arrangements in place both in and out of hospital,needs to be done following approval of MD policy | 1, Policy approved and implemented<br>2, Area governance meetings<br>3, Incident reports | Minor | Unlikely | 4 | Moderate |

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| 442 | There is a risk that there may be insufficient staff to manage the three key functions of the clinical hub (1. hear and treat 2. crew queries 3. surge level). Impact will be increased demand on operational frontline with likely increase to ED departments. | 17/06/2015 | | Operational | Major | Possible | 12 | Significant | 1. Ongoing action to maintain staffing levels<br>2. Accommodation of flexible hours to attract staff<br>3. Strong teams led by seven quality governance managers<br>4. All hub trained staff must do 120 hours annually to maintain their accreditation<br>5. Director of Operatins agreed that the Clinical Team Leaders on the HUB will receive the additional £2500 awarded to Team Leaders.<br>6. New job description for Clinical Advisors on the HUB banded at 6. | Millard, Katy | 29/02/2016 | Major | Possible | 12 | Significant | 1. Ensuring the 100 approximate staff out in operations book their 120 hours in a managed way<br>2. 50:50 split, 27 operational Clinical Team Leaders being approached to do the majority of their operational shifts in the clinical hub<br>3. Band 6 for Clinical Advisors<br>4. Review of balance of Advisors to Team Leaders | None | Major | Unlikely | 8 | Significant |
| 428 | There is a risk of potential industrial action as a result of national disputes regarding pay and conditions, which will cause substantial disruption on the organisation should it go ahead | 14/07/2016 | 34 | Corporate | Major | Likely | 16 | High | LAS are aware of discussions to date and further information will be available as to whether the industrial action will eventuate following a ballot on 31/05/2016 | Woodrow, Paul | 26/08/2016 | Major | Possible | 12 | Significant | here are plans underway to design a proposal to introduce Band 6 paramedics. The proposed approach has been agreed in principal, however detailed work is required to fully understand the operational and financial implications of introducing Banad 6 paramedics, which is heavily predicated on required funding to be agreed with Commissioners ELT 31 July 2016 | An impact assessment will be undertaken once the extent of the industrial action is known and plans will be developed and shared widely with senior management within the Trust and the Trust Board | Moderate | Possible | 9 | Significant |
| 18 | There is a risk that declared serious incidents are not investigated thoroughly and within a timely manner. TRR 405 | 27/05/2016 | | Governance | Moderate | Likely | 12 | Significant | All potential serious incidents are reviewed at an internal weekly meeting (Serious Incident Group Meeting) with the Governance Team and key stakeholders for example Head of Legal, Deputy Director of Operations, Director of Corporate affairs, Director of Nursing, Director of Paramedic Education, Medical Director and the Chief Executive.<br>A further meeting is held with the Governance Co-ordinator to ensure the necessary documentation and information has been requested and received for decision making purposes on a potential Serious Incidents.<br>A detailed Serious Incident process 'New Ways of Working' has been developed and approved by Quality Committee on 22nd August 2014.<br>Where appropriate internal RCA investigations are commenced for incidents not meeting the SI threshold.<br>Active monitoring of our reporting timescale.<br>Standing agenda item at bi-weekly | Adams, Sandra | 08/08/2016 | Moderate | Likely | 12 | Significant | 1. A further review of the Serious Incident Policy is required in light of the review of the 2015 framework . It has been agreed that a governance framework will be developed to give a robust foundation and all governance policies and procedures will be linked to the framework. Serious Incident Policy is undergoing a further review to reflect guidance on declaration timescales.<br>2. Governance to formalise process of monitoring internal deadlines. Governance to arrange a session with both ELT and SMT to clarify expectations of ELT and SMT leads in SI investigations and agree a protocol.<br>3. Increase the number and training level of lead investigators with structured training sessions. 1st session completed Oct 2015, number of investigators has increased. | A weekly outstanding investigations paper is presented at ELT detailing all SIs where a finalised report has not been submitted. This information is also presented Trust Board | Moderate | Unlikely | 6 | Moderate |
| 20 | There is a risk that…<br>The organisation does not accurately and effectively report incidents that have resulted in moderate, severe harm or death to the patient. A failure to do so will prevent the organisation accurately reporting to the NRLS.<br>TRR 462 | 27/05/2016 | | Governance | Moderate | Almost certain | 15 | High | 1. Risk Systems Manager has responsibility for submitting reports to the NRLS monthly and oversee data quality via Datix.<br>2. New Operational structure reinforces an open reporting structure<br>3. Acknowledgement given to staff for reporting incidents submitted to the Serious Incident Group<br>4.Call centre 8am-8pm in place from 28/6/16 for incident reporting<br>5. Deployment of Datixweb across the LAS now complete<br>6. Health Safety and Risk are being tasked with bringing down the backlog of incidents reported being added to Datix. BAcklog currently less than a week and Datixweb is live. _ consider this closed<br>7. Benchmark level of Serious Incident reporting against other ambulance services – results shared with EMT and Quality Governance Committee. This is included in the SI annual report currently with SA<br>8. Level of harm will be reviewed via the new operational structure | Adams, Sandra | 08/08/2016 | Moderate | Likely | 12 | Significant | 1. EBS will provide a 12 hour a day call centre for incident reporting from 28/6/16<br>2. NRLS submission report to be shared with the Governance Department and Quality Governance Committee. Second 6 month submission for 2015/16 was made on time | The Trust has submitted its NRLS data on time for the last two submission dates. Datixweb also puts harm level at the centre of incident reporting. | Moderate | Rare | 3 | Low |

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| 65 | There is a risk that due to our inability to link safeguarding referrals and identify previous referrals made to Social Services, this will impact on our ability to escalate any continued safeguarding concerns identified, which will impact on patient care.<br>Original Risk ID 458 | 08/06/2016 | | Clinical | Major | Possible | 12 | Significant | None | Sloper, Briony | 30/06/2016 | Major | Possible | 12 | Significant | 5/1/16 Safeguarding committee reviewed. Datix web is believed to be able to achieve this requirement and work is underway to introduce datix wed by April 16<br><br>22/10/15: Approved at SMT | 1. Due date for Datix web is 01/09/16.<br>2. To be developed once Datix web is imbedded. | Major | Rare | 4 | Moderate |
| 69 | There is a risk that the Trust is unable to provide assurance that it is compliant with safeguarding training requirements for clinical and non-clinical staff.<br>(Links to TRR - 446 and 439)<br>Original Risk ID 2 | 08/06/2016 | | Clinical | Major | Possible | 12 | Significant | Figures obtained from various locations.<br>Recorded on safeguarding balanced score care.<br>Part of a larger risk on Trust risk register with capturing training figures across Trust. | Sloper, Briony | 30/06/2016 | Major | Possible | 12 | Significant | Approved by Safeguarding committee 09/06/15 take to SMT for addition to TRR.<br><br>Links to Trust Risk 439 relating to operational / clinical staff training and 446 relating to support staff training . | (Links to TRR - 446 and 439 | Major | Rare | 4 | Moderate |
| 108 | There is a risk that patient safety could be compromised due to the possibility of contaminated patient equipment collected from A&E departments being reused without undergoing a decontamination process. This may breach the hygiene Code and could jeopardised continuous CQC registration. | 10/06/2016 | | Health and Safety | Major | Likely | 16 | High | 1, Education - embedded cleaning standard into LAS daily practice - induction, CSR Training content revised to raise awareness of need for equipment to be cleaned after each use by correct use of wipes and correct cleaning method<br>2, IPC arranged visit with Logistics to a third party decontamination service provider (Essentials) in March 2014 with a view to a one off clean of all ambulance equipment and setting up a regular service.<br>3, Third party decontamination service for A&E equipment and soiled equipment by St Thomas' hospital | Grimshaw, Andrew | | Major | Possible | 12 | Significant | 1, The Management of Medical Devices Policy needs to include the Decontamination process, be finalised, and communicated to front line staff on the arrangements in place both in and out of hospital??<br>2, IPC training for logistics drivers | 1, Decontamination lead to oversee and report to IPCC quarterly<br>2, Policies: Management of Medical Devices Policy, Decontamination Policy<br>3, Third party decontamination service, Pam London framework<br>4, Quarterly monitoring at IPCC | Major | Unlikely | 8 | Significant |
| 112 | There is a risk that the service does not comply with DH guidance on the re use of linen for patients and the quality of care delivered to patients may be affected which may have an adverse reputational risk to the trust | 10/06/2016 | | Fleet and Logistics | Moderate | Almost certain | 15 | High | 1, Laundry contract in place for blankets<br>2, some local arrangements for use of sheets at hospitals<br>3, Additional capacity for reusable/disposable blankets in store<br>4, Single use couch rolls in place | Grimshaw, Andrew | 23/06/2016 | Moderate | Likely | 12 | Significant | 1. Options paper to be prepared by K. Merritt to be taken forward to SMT and EMT for discussion and decision on plan of action.<br>2. Options paper has been considered by blanket group and it has been agreed that the best option is using hospital blankets, formalising what is already happening in many areas. This is the system used by other ambulance trusts.<br>3. Trial using hospital blankets at 2 sites (to be confirmed). Agreements to be put in place with hospitals.<br>4. Single use trolley cover has been sourced, this will be presented to IPC Taskforce in March and CEWG (next meeting) and VWG (April 16)by KM and CV<br><br>6. Costs paper to be written by KM | None in place | Minor | Unlikely | 4 | Moderate |

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| 116 | There is a risk that there may be insufficient emergency ambulances and cars to meet demands | 10/06/2016 | | Fleet and Logistics | Major | Likely | 16 | High | 1, Forward view of fleet requirement for next 5 years<br>2, Asset management plan in place to ensure that no frontline vehicle is over 7 years old and that unplanned maintenance levels do not adversely affect fleet capacity and the provision of safe environment to operational staff<br>3, Ensure capital investment is committed to support fleet volume and replacement<br>4,External/stakeholder support in place as required<br>5, Maintain a capacity plan base on operational rotas and other frontline vehicle requirements agreed with operations that maintains currency with the operational plan<br>6, Have an agreed vehicle specification<br>7, Agree and maintain adequate headroom in fleet numbers to manage variation<br>8, 140 new vehicles agreed<br>9, DCA and FRU specification signed off<br>10, revised fleet monitoring | Grimshaw, Andrew | 23/06/2016 | Major | Possible | 12 | Significant | 1, Review case to retain ambulances following introduction of 140 new vehicles<br>2, Retain 20 FRU cars to increase size of fleet to 180<br>3, Review additional ambulance capacity to support roll out of new Vehicle Preparation Scheme | 1, forward view of fleet requirements<br>2, Plan in place to move current fleet to under 7 years<br>3, Capital investment requirement understood and reflected in LTFM 4 vehicle specification in place<br>4, Vehicle specifications in place. | Moderate | Possible | 9 | Significant |
| 117 | There is a risk that the equipment for front line vehicles may not be properly maintained. | 13/06/2016 | | Fleet and Logistics | Major | Likely | 16 | High | 1,Replacement equipment budgets in place, process agreed and adhered to.<br>2, Maintenance/Replacement of kit undertaken when required<br>3, Process for maintenance of equipment reviewed<br>4, asset database showing maintenance records | Grimshaw, Andrew | 23/06/2016 | Major | Possible | 12 | Significant | The risk needs to be properly clarified and comprehensively detailed and reviewed | Project completion/VP reports (Report due Jan 2016); Contract, VP & Decontamination reports; New process/Fleet Reports and OOS reports | Moderate | Unlikely | 6 | Moderate |
| 119 | The potential lack of paramedic and/or Technician drug bags for use by operational staff causes a risk of providing clinical care for patients due to vehicles being deficient of drugs for all or part of a shift | 13/06/2016 | | Fleet and Logistics | Moderate | Likely | 12 | Significant | 1, OP02 The procedure covering the issues and use of drugs by LAS staff<br>2, Local management on stations monitoring adherence to OP02<br>3,Need to comply with drugs policies reinforced through messages in the RIB<br>4,Message to just take one paramedic pack per vehicle reinforced through messages on the RIB<br>5, Medicines Management event held<br>6, Instigate 'Drug Pack Amnesty' to promote return of drug packs that may have been retained by staff and are therefore not in circulation | Grimshaw, Andrew | 23/06/2016 | Moderate | Likely | 12 | Significant | 1, As part of 'getting the basics right' tracking systems are being looked at with a view to providing a solution to monitor the location of drug bags. (subject to agreement of funding)<br>2, Purchase 350 Paramedic and 350 technician drugs bags<br>3, Trial Drug Pouch System in NE later in the year | 1. Shortages of drug bags are reported via the area governance meetings.<br>2. Issues regarding medicines management are monitored at the medicines management meeting and escalated where appropriate.<br>3. New Station Managers and Quality & Assurance Managers are in post.<br>4. Medicine Safety Officer will carry out unannounced spot checks. | Moderate | Rare | 3 | Low |
| 218 | There is a risk that If the Trust does not plan effectively it will not be aware of risks and threats. These could result in significant risk to the ongoing viability of the organisation, operations and clinical safety. | 20/06/2016 | 396 | Finance | Catastrophic | Likely | 20 | High | 1. An LTFM is in place.<br>2. Regular reports are provided to the FIC on forward financials.<br>3. Future assessments take account of low level (departmental) plans as well as high level (organisational) issues.<br>4. Plans include I&E, balance sheet, capital and cash.<br>5. Future CIP plans are scoped and where possible identified, 2-3 year ahead. | Grimshaw, Andrew | 25/07/2016 | Major | Possible | 12 | Significant | 2. Develop means to collect departmental and divisional plans for review and inclusion in overall financial plan.<br>3. Develop future CIP planning.<br>4. Build integrated plan encorporating CQC and required performance improvement. | Assurance of Finance Risks are provided via regular review of controls from the Finance and Investment Committee | Moderate | Unlikely | 6 | Moderate |

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| 221 | There is a risk that operational staff sustain a manual handling type injury whilst undertaking patient care. The consequence of injuries being:-<br><br>-Increased staff absence through industrial injury.<br>-Impact on service delivery.<br>-Impact on patient care. | 20/06/2016 | | Health and Safety | Major | Likely | 16 | High | 1. Manual Handling Implementation Group and Manual handling policy<br>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<br>3. Core Skills Refresher training is monitored via the quality dash board.<br>4. The Corporate Health and Safety Group monitor manual handling incidents and training activity,<br>5. Small handling kits on all vehicles<br>6. BTech trained Manual Handling assessors<br>7. Specialist MH equipment e.g. Manager Elk<br>8. All A+E and PTS operational vehicles have either tail lift of ramp access<br>9. All A+E and PTS operational vehicles are fitted with hydraulic | Adams, Sandra | 30/08/2016 | Major | Possible | 12 | Significant | | 1. Manual Handling Implementation Group<br>2. Manual Handling Policy<br>3. Central Health and Safety Group Incident Statistics<br>Monitor and Audit Reviews | Minor | Unlikely | 4 | Moderate |
| 230 | RISK 455<br><br>There is a risk that we may not be able to convey all patients detained under section 136 MHA (1983). This leads to a lack of physical health screening for these patients which may affect the care they receive. | 20/06/2016 | | Corporate | Moderate | Almost certain | 15 | High | 1. Section 136 figures reviewed and shared with partners at the mental health partnership board with incidents reported to the Mental Health Committee.<br>2. Mental health nurses in EOC provide telephone support for both officers and patients on scene and assist with upgrading calls as appropriate.<br><br>3. A National section 136 Protocol was introduced in 2014 and adapted to LAS. | Sloper, Briony | 08/07/2016 | Moderate | Likely | 12 | Significant | 1.Review of current mental health protocols and alternative resources specifically guidance relating to control room management of people detained under section 136.<br><br>2.Review for transport arrangements for detained people in collaboration with NHS England and Brent CCG.<br><br>3. The LAS will amend the Memorandum of Understanding with the MPS to detail the information required from the police for Section 136 calls.<br><br>4.Updated section 136 protocol to be disseminated in a Control Services bulletin highlight the need to clarify the method of restraint and upgrade calls held for over 30 minutes.<br><br>5.Updated section 136 to be reflected in LAS Dispatch Policy OP/061 and Standard Operating Procedure for METDG. | 1. Detailed progress will be reported in the annual report on mental health<br><br>2. Regular attendance at the Mental Health Partnership Board to review section 136 figures with partners.<br><br>3.Quarterly Section 136 figures will be reported to and reviewed by the mental health committee which runs bimonthly prior to being shared with MHPB. | Moderate | Possible | 9 | Significant |
| 273 | LAS will not be in a position to win new NHS Integrated Urgent Care (IUC), ie 111/OoH contracts as stated in the 5-year strategy. | 20/06/2016 | | Corporate | Major | Likely | 16 | High | 1.Interim Bid team established, gathering information on service requirements / Key performance Indicator's (KPIs) / costing of service and preparing draft response.<br><br>2.Contract meetings with SEL CCG maintain local relationship<br><br>3.Bid team monitoring market to review local opportunities, gather intelligence around commissioning requirement and competitors<br><br>4.Long list of Out of Hours (OoH) 'partners' drawn up and reviewed against capability and suitability to provide<br><br>5.Legal advice being sought around 'partnership arrangement' set up and management<br><br>Update:<br>6.Regular updates on remaining opportunities provided;<br><br>7.Local engagement with | Broughton, Karen | 19/08/2016 | Major | Possible | 12 | Significant | 1. Understanding of opportunities and the timeframes for tendering opportunities established through market research structure / process – this monitors all 111 and Out of Hours procurement activity, i.e. IUC model<br><br>2. Work with CCGs to influence 111 system development across London<br><br>3. Bid for new 111 services as opportunities arise<br><br>4. Local engagement, continue to develop relationship with current SEL111 commissioners, maintain and improve service delivery<br><br>5. IUC model would require LAS to partner with provider(s), a broad review of potential OoH providers has been undertaken to identify suitable partner(s) | 1. Interim Bid team established:<br>(a) Established monitoring of market place/ on-going intelligence gathering;<br>(b)Indicative procurement time lines for bids across London monitored;<br>(c) Interim Local delivery team engaged to prep/ plan bid submission;<br>(d) Stakeholder feedback on LAS as a provider of 111 services<br><br>2. ELT updates on NHS111 bid process, opportunities and progress<br><br>3. Update reports to FIC and Trust Board where required | Moderate | Unlikely | 6 | Moderate |

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| 286 | 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. | 20/06/2016 | | Clinical | Major | Almost certain | 20 | High | 1. Consultant Midwife now employed substantively 3 days were week (commenced January 2015)<br>2. A deep dive audit was carried out which was reported to the Quality Committee in Autumn 2015. To be repeated as required.<br>Review incidents reported through LA52's, Patient Experiences and legal Claims relating to problematic obstetric incidents.<br>Delivery of CSR 2013/2014 obstetric update (detailed in 2013 UK Ambulance Service Clinical Practice Guidelines) & updates written by Consultant Midwife.<br>POETS e-learning programme in place. to be checked AM<br>Drop in sessions arranged by new consultant midwife for EOC, EMD's and Clinical Hub Staff<br>Breech Masterclasses delivered (August 2015) and to be continued around London Education Centre<br>Advanced Life Support Bootcamp course run every 2 months, including a maternity update theory session and maternity scenario, unclear on | Wrigley, Fenella | 30/08/2016 | Major | Possible | 12 | Significant | Present K2 Obstetric Emergency Training software as an alternative to current POET online training.<br>2. Programme of maternity simulations to be agreed with clinical tutors and education team.<br>3 Obstetric triage / crib card to be developed and issued to all staff. | 1. Monitor processes at CQSE and Corporate Health and Safety Group. Direct feedback to CQD from Legal Services.<br>2. Incident reporting.<br>3. Reports to CQSEC, SI group, Learning from Experiences<br>4. The six weekly maternity risk summit meeting to review collection of evidence<br>5. Obstetric emergency decision tool to be put in place this month.<br>6. Obstetrics emergencies clinical update article written and will appear in the next clinical update magazine<br>7. Birthing Sim-manikin ordered and training is planned for January with nominated clinical tutors from around London.<br>8.Maternity care update articles in the Clinical Update to be completed for March 2016. | Major | Possible | 12 | Significant |
| 288 | There is a risk that failure to undertake comprehensive clinical assessments may result in the inappropriate non-conveyance or treatment of patients. | 20/06/2016 | | Clinical | Major | Almost certain | 20 | High | 1.Monitor level of CSR training and delivery.<br>2. CPIs are used to monitor the standard of assessments provided.<br>3. LA52 incident reporting is in place and reports are provided to the Clinical Quality Safety and Effectiveness Committee (CQSEC) and the Area Clinical Quality Groups.<br>4. The Operational Workplace Review has been reviewed and will now include ride outs.<br>5. A system for clinical updates is in place.<br>6. 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.<br>7. Introduction of Paramedic Pathfinder – an adaption of the Manchester Triage System for use pre-hospitally to safely identify the most appropriate destination for individual patients.<br>8. Introduction of reflective practice | Wrigley, Fenella | 30/08/2016 | Moderate | Likely | 12 | Significant | 1.Deputy Director of Education and Standards directly oversee delivery of CSR 2016/2017.<br>2. Design processes to audit and monitor the effectiveness of the pathfinder tool. TE/JL to look at staff survey for use of pathfinder and decision making tools.<br>3. Development of the clinical career structure.<br>4.New risk to be submitted to SMT/ELT to reflect current clinical risk for ongoing clinical supervision. | CPI reports<br><br>OWRs<br><br>CSDEC<br><br>EMT/TB reports<br><br>Learning from Experience | Moderate | Possible | 9 | Significant |
| 289 | There is a risk that the management of controlled drugs at Station level is not in accordance with LAS procedure OP/008 Controlled Drugs. | 20/06/2016 | | Clinical | Major | Likely | 16 | High | 1. Policy reminder to be reinforced by bulletins from Director of Operations/Medical Director.<br>2. Independent audits to be carried out throughout the Trust.<br>4. OP30 Policy and procedure for the Ordering, Storage and use of Morphine Sulphate within the LAS has been reviewed and issued.<br>5. Daily audit checks<br>6. The policy itself defines individual responsibility<br>7. Area governance reports to CQSEC<br>8. Mandatory LIN reports to CCG<br>9. Unannounced visits by MPS<br>10. Annual attendance by MMG to AO update days<br>11. MMG reports to EMT and Trust Board<br>12. Meds mgt events for Station Group management teams ongoing.<br>13. Seconded paramedic for audit / information collation and staff engagement.<br>14. findings from unannounced MPS visits shared with DDO's and ADO's. | Wrigley, Fenella | 31/08/2016 | Major | Possible | 12 | Significant | | 1. Internal Audit<br>2. Independent Audit (MET Police carrying out spot checks)<br>3. LIN oversight of system<br>4. MMG to CQSEC, EMT and Trust Board<br>5. New Medicine Safety Officer will carry out unannounced spot checks and provide feedback | Major | Unlikely | 8 | Significant |

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| 291 | Patients being placed on the Co-ordinate my Care (CMC) Database may not have their addresses flagged in a timely manner. Particularly during the out of hours period. | 20/06/2016 | | Clinical | Major | Likely | 16 | High | 1. Automatic notification of CMC patients to LAS via email.<br>2. Staffing levels increased to support Management Information staff with the process of flagging address on the LAS Gazeteer.<br>3. Clinical Hub where possible monitor calls where a CMC flag has been triggered.<br>4. Clinical update courses run through Education and Development and internship programme which included reference to CMC and end of life care.<br>5. End of life care circulars regularly on the Pulse which references CMC.<br>6. Attendance at CMC Steering Board, CMC Governance Committee and CMC Stakeholder Group where issues are raised and investigated as necessary." | Sloper, Briony | 04/05/2016 | Major | Possible | 12 | Significant | A small project group, once Command Point has been upgraded, will be convened to test the automated update process and assess for any risks this may then produce in order to mitigate against them and move to full 24/7 automated CMC flags being placed Autumn 2015. | 1. CMC Stakeholder and CMC Steering Group meetings, (LAS have membership of both groups). Sen Clin Adv to Med Dir is LAS representative at CMC Streering Group and reports on a monthly basis to this group.<br>2. LAS monitoring of EOC / 111 systems.<br>3. LAS monitoring of clinical incidents / complaints related to EoLC and the use of CMC | Major | Unlikely | 8 | Significant |
| 302 | 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.<br>NOTE: Risk ID 205 | 21/06/2016 | | Governance | Major | Likely | 16 | High | 1. Current storage facilities have previously been compliant with IHCD accreditation requirements etc.<br>2. Training attendance records for operational staff are held on PROMIS and GRS databases, with the more recent attendances recorded on OLM (Oracle Learning Management) system | Ivanov, Tina | 03/05/2016 | Major | Possible | 12 | Significant | 1. Develop plans to move to the electronic storage of all operational training records generated within the LAS<br>2. Further develop the plans to create a central management hub (currently Fulham) to support and underpin the provision and quality of all Clinical Education & Development activity throughout the Trust. This will include the review of Fulham CE&S administrative staff levels, so as to ensure that sufficient capacity exists to fulfil the requirements of the new training record management system.<br>3. Scope the potential and options for the back scanning of existing training record documentation.<br>4. source sufficient estate to house all training records in one location with traceable/identifiable information | Manager Governance responsible for:<br>1) Records are stored safely and securely, are identifiable and easily accessed, and meet all records management policies. 2) Records are archived in a timely manner as per Information Governance policy | Major | Unlikely | 8 | Significant |
| 303 | There is a risk that all operational/clinical staff may not receive statutory and mandatory training appropriate to their role required to comply with legislation, meet CQC compliance and the Trust's TNA policy. This could result in the dilution of clinical skills<br>NOTE: Risk ID 439 | 21/06/2016 | | Human Resources | Major | Likely | 16 | High | 1. Individual Learning Accounts mitigate the impact of performance on training.<br>2. Complex management teams managing the training process.<br>3. Clinical Education and Standards monitor the uptake of course places provided (data is included on the clinical dashboard) which is reported at EMT / TB /CQSED<br>4. Letters have been sent out to staff reminding them to book onto courses and a Bulletin has been put in the RIB. | Ivanov, Tina | 03/05/2016 | Major | Possible | 12 | Significant | 1. Letters have been sent out to staff and an article has been placed in the RIB<br>2. ILAs need to be incorporated into all rosters when reviewed (some staff do not currently have ILAs)<br>3. A process needs to be put in place to monitor/review the compliance with managing the ILA process<br>4. Continual communication about the process i.e. routine bulletins / posters. | Figures are reported monthly and are overseen by the Quality Governance Committee and Trust Board | Major | Unlikely | 8 | Significant |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 279 | There is a risk of staff not being able to download information from Defibrillators and 12 lead ECG monitors leading to incomplete patient records. | 20/06/2016 | | Clinical | Moderate | Almost certain | 15 | High | 1. Mark Whitbread is the Trust lead for the defibrillator download<br>2. Card reading and transmission is performed by team leaders. - obselete contol, no card readers.<br>3. Messages given out at Team Leaders Conferences.<br>4. Encourage more routine downloading of information from defib downloads.<br>5.LP1000 AED's have been rolled out and all complexes have been issued with new defib downloads for these units.<br>6. New Malden pilot has trialled the transmission of data from the LP15.<br>7. Defib downloads are conducted by TL's and APP's via cables.<br>8. APP use of defib data download as normal practice. | Wrigley, Fenella | 30/08/2016 | Moderate | Almost certain | 15 | High | 1. Funding request for Bluetooth download technology for all LP15's<br>2. Review of IG issues with patient data transmission. | 1. Establish the current resources of LP 1000, how many in use, which complexes carry them, are there spares available for 1 for 1 swap.<br>2. Establish a process at station level to link a specific cardiac arrest to the LP1000 it is stored on.<br>3. Publicise download returns by complex as part of Area Governance Reports, via PIM or Staff Officer for the Area.<br>4. Consider roll out of transmittable data from LP15 once vehicle on station. MW to source modems and establish proof of concept.<br>5. A small pilot study is planned to take place at Westminster using two advanced paramedics in cars, which will have a cable to plug into a lap top to establish the benefits that come of out of it. The evaluation of this exercise will be reviewed in February 2015. This practice is in place all of the time now<br>Team leaders now in place 50/50 will influence the output. Determine the impact of this risk review 3 months | Moderate | Unlikely | 6 | Moderate |
| 420 | 420/BAF33 Without adequate patching, the risk of unauthorised access into the CAC network is increased as publicly known vulnerabilities related to the systems running on CAC will not be addressed. Any such attacks could result in a loss of sensitive data or CAC network being unavailable, severely impacting the delivery of emergency services | 01/07/2016 | 33 | Information Governance | Catastrophic | Possible | 15 | High | 1. Enterprise antivirus monitoring CAC desktops<br>2. Desktop ports disabled (i.e. USB, DVD)<br>3. No access to internet /email for CAC desktops | Watson, Andrew | 22/08/2016 | Catastrophic | Possible | 15 | High | 1. Implement Firewall between CAC and LAS corporate<br>2. Monthly reporting on hacking, attacks and virus protection for EMT and Audit Committee to be defined and agreed.<br>3. RCAG approval of report and format<br>4. Additional information, such as patches applied / outstanding to be included in subsequent reports | IGG and RCAG agreement on completion of technical element and of the reporting format | Catastrophic | Rare | 5 | Moderate |
| 430 | There is a risk that at staff changeover times, LAS performance falls | 15/07/2016 | 7 | Operational | Major | Almost certain | 20 | High | 1. Daily monitoring of rest break allocation to resolve end of shift losses.<br>2. Use of bridging shifts for VAS/PAS.<br>3. Roster reviews/changes include staggered shifts.<br>4. Incident management control desk within EOC. This currently operates when staffing allows or there is a serious incident, however sustained running relies on sufficient EOC resourcing (ORH review). | Woodrow, Paul | | Major | Likely | 16 | High | Agree the process for the rest break arrangements to be implemented.<br>Recruiting frontline staff to 3169 by March 2016<br>Skill mix: the skill mix model has been updated in January 2015 to include international recruit. This was reviewed in Aug. 2015 and published in September 2015<br>On-going rigorous management of out of service. We are unlikely to meet the final target by the end of the Programme (end March 2016), however what was felt to be achievable is a target of 2.2% (vehicle element).<br>Out of service HUB implemented. | 1. New Rotas in place since Q2 14/15; Modernisation Programme Board minutes; and weekly tracking report.<br>2. Skill mix: the skill mix model was updated in Sept 2015 to include international recruits and is currently under review.<br>3. Rota changes to be implemented as result of ORH review. | Major | Unlikely | 8 | Significant |

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| 339 | There is a risk that there is a lack of ring backs on delayed response calls within EOC, we are therefore unable to monitor patient's safety whilst calls are being held. | 28/02/2015 | 29 | Operational | Major | Likely | 16 | High | 1. More involvement by the Clinical Hub who monitors the calls and identifying priorities for ring backs.<br>2. Additional technical support to prompt re-categorisation and contact.<br>3. New ring back status monitors.<br>4. New information within EOC to be able to properly inform patients of the likely wait time for a response.<br>5. Staff removed from call handling to undertake ring backs when capacity allows. Recent training for Area Controllers and EMD 3 allocators included a session on learning from incidents, focusing on the errors /decision making which has been identified as poor risk mitigation and providing less optimal patient care.<br>6. Two call-handling courses took place in October 2105 which brought a maximum of 32 new staff to EOC pre-Christmas. Complete. – New training plan for 2016/17 for 12 call handling courses. | Millard, Katy | 18/08/2016 | Major | Likely | 16 | High | 1. ORH report received due to go to ELT, identifies minimum of 38 staff required even when full establishment of operational staffing is in place. Therefore additional recruitment will be required into control services and a change in the base line staffing level.<br>2. Control Services to provide a report to the ELT on how they can create further capacity within the in order to determine the specific number of additional staff required for the base line staffing level | Patients who are most at risk are flagged via the hub to focus the ring backs. | Major | Unlikely | 8 | Significant |
| 446 | Significant time lag (in excess of six months) in the reporting of medicines usage data captured by Management Information during the data entry and validation of PRFs may lead to LAS not being able to track usage of medicines by complex stations/ sectors/ practitioner group, call signs etc.<br><br>TRR number 461 | 27/01/2016 | | Clinical | Major | Almost certain | 20 | High | 1. MI capture and validate the data via the PRF scanning process<br><br>2. Drug usage statistics produced by MI - but they are several months in arrears<br><br>3. Physically isolating PRFs and then data trawling by hand if detailed analysis required. The CPI process provides limited information, but is very difficult to use for gathering service wide data..<br><br>4. Limited information can be gained by reviewing the medicine purchasing invoices | Watson, Andrew | 30/08/2016 | Major | Likely | 16 | High | 1. Consider options (and cost and staffing implications) for retrospectively recording the data that will be missed if MI start contemporaneous data capture.<br><br>2. Consider the use of technology to assist in data capture. This could include obtaining additional information off the MDT screen and / or electronic patient records. (long term plan) | Reviewing the PRF information capture but having additional resources within MI to gather this information. | Major | Rare | 4 | Moderate |
| 120 | There is a risk that the equipment for frontline vehicles may not be available when required. Staff will not have equipment required to provide appropriate patient care | 13/06/2016 | 26 | Fleet and Logistics | Major | Likely | 16 | High | 1, Serial numbers on all re-usable equipment that can be accurately tracked.<br>2, Agree and set requirements for stock levels on vehicles. Ensure regular monitoring occurs<br>3, Define 'shell' and maintain a reserve of essential equipment centrally to backfill and ensure vehicle can go back into service with minimal delays<br>4, Agree ownership and responsibilities for equipment ensuring that all VP responsibilities are included within the VP contract, to include FRUs and DCAs, ensure equipment is not transferred between vehicles<br>5, Complex based fleet in place to increase availability for VP checking and restocking/equipping vehicles<br>6, Electronic VDI pilot completed, all equipment has bar code or serial number<br>7, NE VP pilot rolled out to include secure local equipment stores and day time "Quatermaster" role<br>8, Interserve are providing feedback | Grimshaw, Andrew | 23/06/2016 | Major | Likely | 16 | High | 1, email Justin Wand to see if he thinks this risk should be merged with risk 121<br>2,Roll out enhanced VP to rest of service, Owner to be confirmed<br>3,Ensure adequate stocks of consumables and equipment are available to VP staff, Owner to be confirmed<br>4,Fully develop equipment database reports to indicate where any equipment is missing, Owner to be confirmed | 1, Clinical Equipment Group;<br>2, Asset tracking report;<br>3, VP reports;<br>4, VP Contract;<br>5, Equipment Process;<br>6, Project completion | Moderate | Unlikely | 6 | Moderate |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 121 | There is a risk that there may be insufficient range and volume of equipment to meet demands.Staff will not have equipment required to provide appropriate patient care | 13/06/2016 | 25 | Fleet and Logistics | Major | Likely | 16 | High | 1. Agreed vehicle equipment lists including re-usable v disposable in place<br>2. Equipment stock levels agreed and maintained<br>3. Responsibility for each item of equipment clearly defined<br>4. Budget responsibilities for replacement equipment clear<br>5. Review of personal issue kit<br>6, A “core” equipment list for DCA & FRU has been defined and agreed<br>7, funding for NE Sector Revised Vehicle Prep Pilot - fully managed equipment solution has been agreed<br>8, An equipment amnesty and physically review all stations and complexes for “retained” equipment has been undertaken<br>9, an new paper based VP VDI form has been introduced<br>10, Pilot to assess benefits of VP proposal carried out | Grimshaw, Andrew | 25/08/2016 | Major | Likely | 16 | High | 1, Roll out VP proposal to LAS area<br>2, Implement working group to review personal issue kit – check status of any existing work with CEG<br>3, look at merging this risk with risk 120, GD to email JW | 1, Progress made in agreement of core equipment and further equipment amnesty.<br>2, Decontamination of equipment commenced.<br>3, Analysis of asset tracking systems being undertaken. | Moderate | Unlikely | 6 | Moderate |
| 214 | The TDA expects all NHS trusts to achieve financial balance in 2016/17, managing within available resources. Failure to achieve this will mean the Trust is in deficit and will see a deterioration in its long term financial viability and will be subject to further scrutiny and challenge by regulators. | 20/06/2016 | 460 | Finance | Catastrophic | Likely | 20 | High | 1. Demand predictions for future years are robust and understood, both for annual value and monthly, daily and weekly profiles<br>2. Clear view on operational capacity required to deliver ambulance performance targets<br>3. Clear view of achievable productivity targets which support performance targets<br>4. Clear view of operational staff recruitment against establishments targets as set. Clear sight these targets can be delivered<br>5. Funding from CCGs is consistent with capacity, productivity and demand assessments<br>6. Other factors such as investment for CQC are clearly understood, and associated funding identified<br>7. NHS wide efficiency targets can be achieved, and other opportunities to generate efficiency are identified, managed and delivered.<br>8. Inflationary pressures are understood and managed within the overall financial position<br>9. Capital investment plans and their | Grimshaw, Andrew | 25/07/2016 | Catastrophic | Likely | 20 | High | 1. Productivity: Develop a clear understanding of productivity and how it can be influenced and managed.<br>2. Funding: Appropriately funded contract in place with commissioners<br>3. All other areas of investment reviewed and agreed; this must include major items such as the impact of the CQC improvement plan.<br>4. Efficiency targets have scoped, stress tested and clear plans are in place to deliver.<br>5. Capital investment plans, funding and associated revenue implications are defined and agreed. | Assurance of Finance Risks are provided via regular review of controls from the Finance and Investment Committee | Catastrophic | Unlikely | 10 | Significant |
| 217 | It is likely that NHS financial and operational planning will include the need to develop efficiencies in order to offset other costs pressures for the foreseeable future. Failure to identify and deliver CIPS will threaten the ongoing viability and solvency of the Trust. | 20/06/2016 | 394 | Finance | Catastrophic | Likely | 20 | High | 1. Appropriate supporting evidence available for CIP.<br>2. All CIPs supported by detailed milestone plan.<br>3. All CIPs embedded in budgets.<br>4. All CIPs owned by relevant manager.<br>5. Benchmarking of CIP opportunity.<br>6. CIP governance clearly defined and in place.<br>7. Board/FIC scrutiny of CIP planning and delivery in place.<br>8. CIPs delivering in line with expectations.<br>9. Capacity and capability available to support delivery.<br>10. All CIPs supported by Quality Inputs Assessments. | Grimshaw, Andrew | 25/07/2016 | Catastrophic | Likely | 20 | High | 1. Review support and engage additional support to drive the CIP Programme.<br>2. Ensure all schemes have clear project plans, including evidence to support, milestone plans and are owned by project leads.<br>3. Embed all CIPs in budgets.<br>4. Review current benchmarking information.<br>5. Ensure all CIPs have QIA in place that have been agreed with the Medical Director | Assurance of Finance Risks are provided via regular review of controls from the Finance and Investment Committee | Moderate | Unlikely | 6 | Moderate |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 337 | There is a risk that Service Performance may be adversely affected by the inability to match resources to demand. | 31/07/2006 | 4 | Operational | Major | Almost certain | 20 | High | 1. On-going recruitment to vacancies.<br>2. Use of voluntary and private sector at times of peak demand.<br>3. New rosters implemented successfully.<br>4. Q1 overtime incentives have been published and target specific Sectors where staff shortfalls have been identified<br>5. Surge plan in place and has been reviewed<br>6. Category C workload determinants have all been reviewed and have been realigned across the 4 C Categories<br>7. Action has been taken to reduce the multiple attendance ratios where appropriate for all categories of calls i.e. autoback up pilot including no automatic back to FRU's for certain determinants until requested by the FRU when on scene.<br><br>How are controls measured?<br>Vacancy factors measured fortnightly at ELT | Woodrow, Paul | 12/05/2016 | Major | Almost certain | 20 | High | 1. Sickness management in progress – aim to reduce sickness to 5.5%. Overall sickness for frontline staff as at January 2016 is 5%. Monitoring to continue<br>2. Workforce plan operations, recruitment; recruit external paramedics, direct recruitment to new band 4 role. The LAS have taken part in 'grad fairs' with UK Universities since Jan 2016 and this is on-going in a monthly basis to recruit graduates. A team returned to Australia in May 2016 and made conditional offers to 151 candidates. The target for recruiting to 3169 frontline staff by March 2016 was completed<br>3. Improve provisioning and reduce frontline ambulance response through the use of NETS and taxi service. NETS usage has increased from 600 to 700 per week against a target of 1200. Project plan being finalised to stabilize the system to 800 per week which can then be added to on a daily basis to reach the required 1200. Plan was | 1) Recruitment activity reviewed fortnightly at ELT 2) Weekly Operations Group meetings with a monthly Operations Board 3) A review of the surge plan has taken place and surge triggers amended on 29th Jan 2016. REAP structure has been revised and implemented in line with national recommendations from NARU 4) Plans for non-auto dispatch back-up have been developed and are in place 5) Skill mix: the skill mix model was updated in Sept 2015 to include international recruits and is currently under review. 6) NETS now in place with 108 staff in post. 7) Staff are being trained for FRU response to increase numbers of people who can work on a car. | Moderate | Likely | 12 | Significant |

London Ambulance Service NHS Trust

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| **Report to:** | **Trust Board** |
| **Date of meeting:** | **4th October 2016** |
| **Document Title:** | **Risk appetite statement** |
| **Report Author(s):** | **Sandra Adams, Director of Corporate Governance/Trust Secretary** |
| **Presented by:** | **Sandra Adams** |
| **Contact Details:** | **sandra.adams@lond-amb.nhs.uk** |
| **History:** | **Risk Compliance and Assurance; Executive Leadership Team; Trust Board** |
| **Status:** | **Presented for approval** |

**Background/Purpose**

The attached paper presents the proposed risk appetite statement of the Trust Board for 2016/17 and reflects the outcome of the Board strategy discussions on 6th and 21st September to finalise the statement(s). The paper proposes an implementation approach and governance arrangements and is supported by two guides on risk and risk appetite intended for managers and staff.

**Action required**

The Trust Board is asked to approve the risk appetite statement(s) and the implementation approach and to note the draft guides for managers and staff which will be further developed with the Communications team and Risk and Audit Manager.

**Key implications**

Good governance in terms of the Board's responsibilities for risk management. Also completes an action within workstream 2 of the Quality Improvement Programme.

| Key implications and risks arising from this paper | |
|---|---|
| **Clinical and Quality** | **Risk appetite statement for quality of services is Low.** |
| **Performance** | |
| **Financial** | **Risk appetite is Moderate.** |
| **Workforce** | |
| **Governance and Well-led** | **Risk appetite for regulatory compliance is Low.** |
| **Reputation** | **Risk appetite is Low.** |
| **Other** | **Risk appetite for innovation is Moderate.** |
| **This paper supports the achievement of the following Quality Improvement Plan Workstreams:** | |
| **Making the London Ambulance Service a great place to work** | |
| **Achieving Good Governance** | **Yes** |
| **Improving Patient Experience** | |
| **Improving Environment and Resources** | |
| **Taking Pride and Responsibility** | |

London Ambulance Service NHS
NHS Trust

# Staff Guide to how we manage Risk and Risk Appetite

***This guide looks at how the Trust Board sets its appetite for risk***

## Background

- All organisations face risks of various kinds during the performance of their business and in pursuit of their strategic objectives: to be successful the Trust should possess a strong risk management capability.
- Staff at all levels will be involved in understanding, analysing and addressing risk to make sure the Trust can achieve its objectives. Risk appetite sets out where and how much risk the Trust is willing to take.
- All staff have a responsibility to report risk and to contribute to safe and effective risk management.

## Why We Take Risk?

- The Trust will always face uncertainty and risk due to political, financial, regulatory and competition pressures.
- The Board will therefore consider its exposure to risk as part of making informed decisions.
- The Board will need to find the right balance in taking risk between maximising the Trust's service delivery to deliver safe services to patients, enhancing the Trust's reputation, and safeguarding its assets and capability.
- In taking risk to support that balance, the Trust's exposure to risk must not exceed its capacity and resources available to manage or respond to that risk.

## What is Risk Appetite?

- The amount of risk that the Trust Board is prepared to accept, tolerate or be the organisation be exposed to at any point in time. The Board may set different risk appetites for different risk areas, and may change these over time.
- The Board has identified the following risk areas: **Quality of Services, Reputation, Innovation, Finance, and Regulatory Compliance and these have different levels of risk appetite**.
- Any breaches of agreed risk levels require immediate notification to management, and corrective action.

## What do I need to do?

- **Report incidents:** effective accident and incident reporting is important for helping us identify areas of risk.
- **Report a potential risk** to your local manager who will know how to manage the risk.
- **Be familiar with the Board's risk appetite:**
  - **Quality of services: low appetite for risk.** We recognise that things do go wrong and there may be adverse outcomes for patients or staff but our service delivery should seek to minimise the number and extent of these events.
  - **Reputation: low appetite for risk.**
  - **Innovation: moderate appetite for risk.** We are cautious but recognise there may be other options for safe delivery of service which offer limited potential rewards.

- **Financial: moderate appetite for risk.** The Board may be prepared to take short term financial risk as long as the longer term financial stability of the Trust is protected.
- **Regulatory: low appetite for risk.**

- Understand the risk areas and appetite and identify incidents that you feel may contribute to these.

London Ambulance Service NHS
NHS Trust

# Managers' Guide to Risk and Risk Appetite

***This guide looks at how the Trust Board sets its appetite for Risk.***

**Background**

- All organisations face risks of various kinds during the performance of their business and in pursuit of their strategic objectives: to be successful the Trust should possess a strong risk management capability.
- Staff at all levels will be involved in understanding, analysing and addressing risk to make sure the Trust can achieve its objectives. Risk appetite sets out where and how much risk the Trust is willing to take.

**Why Take Risk?**

- The Trust will always face uncertainty and risk due to political, financial, regulatory and competition pressures.
- The Board will therefore consider its exposure to risk as part of making informed decisions.
- The Board will need to find the right balance in taking risk between maximising the Trust's service delivery to deliver safe services to patients, enhancing the Trust's reputation, and safeguarding its assets and capability.
- In taking risk to support that balance, the Trust's exposure to risk must not exceed its capacity and resources available to manage or respond to that risk.

**What are the Key Areas covered by our Risk Appetite?**

- The Board may set different risk appetites for different risk areas, and may change these over time.
- The Board has identified the following risk areas: Quality of Services, Reputation, Innovation, Finance, and Regulatory Compliance. These will measured in different ways.
- The Trust's overall Risk Capacity is the maximum level of risk the Trust can take on, given its resources, the business environment, and stakeholder obligations.
- Any breaches of agreed risk levels require immediate notification to management, and corrective action.

**What are the Trust's Key Considerations?**

- The Board will consider a number of issues to ensure risk is addressed appropriately at every staff level:
  - Has the Trust's appetite for risk been clearly defined across all risk areas through its Risk Appetite Statement?
  - Are the Trust's service delivery figures acceptable?
  - How much more risk should the Trust be prepared to take to generate higher levels of service delivery
  - How close is the Trust to its overall capacity for exposure to risk?
  - Which risks could seriously impact the Trust strategy or operating model?
  - How well are risks being managed within the risk management framework, and have the appropriate policies, processes, workforce skills and systems been set in place?
  - How does the Trust measure its performance and the effects of its risk appetite?
  - How should risk information and data be presented to improve the understanding of the risk position?

**What are the Trust's Key Risk Documents?**

- The key risk management documents include:
  - The Board's Strategy. This sets out the strategic plan and objectives, as well as the risk strategy and capacity
  - The Risk Management Policy TP005
  - The Board's Risk Appetite Statement and categories
  - The Board Assurance Framework
  - Trust Risk Register
  - Local Risk Registers
  - Key metrics and performance information.

***The Risk Compliance and Assurance Group will consider new risks and proposed changes to existing risks within the context of the Trust's Risk Appetite Statement. The Board continually monitors its Risk Appetite to ensure that it reflects the circumstances that it faces in the delivery of the strategic objectives and the delivery of emergency and urgent care services. All staff have a responsibility to contribute to safe and effective management of risk.***

**Developing the Risk Appetite for the London Ambulance Service NHS Trust**

## 1. Introduction

The Trust's Risk Management Policy was reviewed and approved by the Board in March 2016. This review included an update to the sections on acceptable risk and the risk appetite statement, the latter having been considered afresh by the Audit Committee and deemed too broad to implement effectively and meaningfully. Work has been underway to refresh the strategic risks and the risk appetite since April 2016 and this has culminated in an agreed Board position on the overall description of the Trust's risk appetite statement and on the different elements within this statement.

## 2. Definition and application of risk appetite

2.1 Risk appetite is 'the amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time'. [1]

2.2 It is the Board's responsibility to identify and review the risks that may affect the achievement of the strategic and corporate objectives of the organisation.

2.3 The Board has identified the following categories of risk as the most significant for the London Ambulance Service NHS Trust in 2016/17:

- Quality of services
- Reputation
- Innovation
- Financial
- Regulatory.

2.4 The Board has determined that the 3 tenets of Quality as defined by Baron Darzi[2] will define the Trust's risk appetite. These are:

- Patient safety
- Patient experience
- Effectiveness of care.

2.5 An assessment of risk will inform all Board decisions going forward and risk throughout the organisation should be managed with the Trust's risk appetite. Where a risk is assessed above the stated risk appetite then this will be managed in accordance with the risk treatment described in the Risk Management Policy. The aim should be to avoid risk but where this is not possible risks will be graded and managed accordingly.

2.6 Acceptable risks are those risks which have been identified and measured according to the risk-grading tool and for which risk mitigation action plans have been developed. Such risks are deemed to be acceptable according to the risk appetite of the Trust as determined by a delegated committee e.g. the Risk Compliance and Assurance Group or the Executive Leadership Team, depending on the nature and grade of the risk.

2.7 Acceptable risks should be monitored, reviewed and entered onto the appropriate risk register. By this definition an unacceptable risk/zero tolerance risk is one where such a risk is rated above the risk appetite of the Trust.

[1] HM Treasury Orange Book definition 2005

[2] High Quality Care for All: Secretary of State for Health June 2008

2.8 The Trust Board will determine the risk appetite at least annually for application by the ELT and throughout the organisation.

## 3. Risk appetite

3.1 The following risk appetite levels, developed by the Good Governance Institute, have been included to provide context to the Board's stated risk appetite:

| Appetite level | Described as |
|---|---|
| None | Avoid: the avoidance of risk and uncertainty is a key organisational objective |
| Low | Minimal: the preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential |
| Moderate | Cautious: the preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward |
| High | Open and being willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VFM) |
| Significant | Seek and be eager to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk.<br>Or also described as Mature: being confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust |

3.2 General risk appetite statement

'The Trust recognises that its long term sustainability depends upon the delivery of its strategic objectives and its relationship with its patients, the public and strategic partners.

As such, the Trust will not accept risks that materially impact on quality of services as defined above (safety, patient experience, and effectiveness), and similarly reputational and regulatory risks. However the Trust has a greater appetite to take considered risks in terms of finance and innovation where there may be options for limited potential gains.' This statement is depicted in the chart below:

| Risk appetite by category | | | | | |
|---|---|---|---|---|---|
| Significant | | | | | |
| High | | | | | |
| Moderate | | | | | |
| Low | | | | | |
| | Risks to quality of service | Risks to the Trust's reputation | Risks to Innovation | Financial risks | Regulatory risk |

## 4. Implementing the risk appetite statement

4.1 The Board will consider the overall risk appetite statement and categories at least annually and will take advice from its sub-committees on any recommended changes during the year.

4.2 Each Board sub-committee will consider and agree the risk appetite statement relevant to its business and will consider this at points during the year to assess whether the level is still appropriate. As a general guide:

- Quality of services: Quality Governance Committee
- Reputation: Executive Leadership Team/Trust Board
- Innovation: Finance and Investment Committee
- Financial: Finance and Investment and Audit Committees
- Regulatory: Audit and Quality Governance Committees

4.3 All Board decisions will be informed by consideration of the potential risks against the risk appetite statement.

4.4 The risk appetite statement will be communicated to all managers and staff for use in the identification, management and mitigation of risks at local level, in accordance with the Risk Management Policy.

4.5 The Risk Management Policy will be revised to incorporate the agreed statement and will be re-published on The Pulse. Guidance on the application of the risk appetite statement will be added to the risk management training for managers and to the tools and techniques section within the risk management intranet pages.

## 5. Recommendation

The Board is asked to approve the general risk appetite statement and the levels of risk appetite for 2016/17, and to approve the implementation approach outlined above.

Sandra Adams

Director of Corporate Governance/Trust Secretary

30th September 2016

London Ambulance Service NHS Trust

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|---|---|
| **Report to:** | **Trust Board** |
| **Date of meeting:** | **4th October 2016** |
| **Document Title:** | **NHS Operational Planning 2017 - 2019** |
| **Report Author(s):** | **Karen Broughton** |
| **Presented by:** | **Karen Broughton** |
| **Contact Details:** | **Karen.Broughton@Lond-amb.nhs.uk** |
| **History:** | ***n/a*** |
| **Status:** | This is the first paper that has been brought to the Trust Board on the planning and contracting processes for 2017-19. |

**Summary**

On 22 September 2016, NHS England and NHS Improvement published the 2017-2019 planning guidance and set out details of a 'significantly streamlined' planning process. The guidance prescribes a two-year approach to planning and contracting, which will be supported by a two-year national tariff and a two-year standard contract.

This paper provides a summary of the guidance including the nine 'must dos' for 2017-2019, and the national timetable set to ensure that contracts are aligned with Sustainability and Transformation Plans (STPs) and signed by 23 December 2017.

**Action required**

Trust Board is asked to:

- note the publication of the 2017/2019 planning guidance
- Consider and agree the internal timetable and arrangements for delivery

**Key implications**

| Key implications and risks arising from this paper | |
|---|---|
| **Clinical and Quality** | Clinical and quality may be impacted depending on the outcome of the 2 year contract negotiations. |
| **Performance** | Urgent and emergency care is one of the nine must do's outlined in the guidance. This must do highlights the requirement to deliver standards for ambulance response times. |
| **Financial** | The new contracting processes and requirement to achieve system financial balance in 2017-18 and 2018-19 |
| **Workforce** | A Workforce plan will be required to support the Trust's contract and plan (technical guidance yet to be published) |
| **Governance and Well-led** | The paper outlines internal governance and assurance arrangements to ensure that actions outlined in the national timetable are met. |
| **Reputation** | **n/a** |
| **Other** | **n/a** |
| **This paper supports the achievement of the following Quality Improvement Plan Workstreams:** | |
| **Making the London Ambulance Service a great place to work** | This paper is focusses on 2017-2019 are is therefore not directly relevant to this year's QIP. |
| **Achieving Good Governance** | This paper is focusses on 2017-2019 are is therefore not directly relevant to this year's QIP. |
| **Improving Patient Experience** | This paper is focusses on 2017-2019 are is therefore not directly relevant to this year's QIP. |
| **Improving Environment and Resources** | This paper is focusses on 2017-2019 are is therefore not directly relevant to this year's QIP. |
| **Taking Pride and Responsibility** | This paper is focusses on 2017-2019 are is therefore not directly relevant to this year's QIP. |

# LONDON AMBULANCE SERVICE TRUST BOARD

## 4 OCTOBER 2016

NHS Operational Planning 2017-2019

### 1. Introduction

On 22 September 2016, NHS England and NHS Improvement published the 2017-2019 planning guidance and set out details of a 'significantly streamlined' planning process.

The guidance prescribes a two-year approach to planning and contracting, which will be supported by a two-year national tariff and a two-year standard contract. The document explains how the NHS operational planning and contracting processes will now change to support Sustainability and Transformation Plans (STPs). It reaffirms national priorities and sets out the financial and business rules for both 2017/18 and 2018/19.

This paper provides a summary of the planning guidance and the timetable for delivery. A copy of the full document can be found at https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

### 2. Priorities: Nine 'must dos' for 2017-19

The guidance document outlines the must dos for the Health system, not all of which are relevant to the Ambulance sector:

| Must Dos for 2017-19 | |
|---|---|
| **1. STPs** | • Implement agreed STP milestones, so that you are on track for full achievement by 2020/21.<br>• Achieve agreed trajectories against the STP core metrics set for 2017-19. |
| **2. Finance** | • Deliver individual CCG and NHS provider organisational control totals, and achieve local system financial control totals. At national level, the provider sector needs to be in financial balance in each of 2017/18 and 2018/19. At national level the CCG sector needs to be in financial balance in each of 2017/18 and 2018/19.<br>• Implement local STP plans and achieve local targets to moderate demand growth and increase provider efficiencies.<br>• Demand reduction measures include: implementing RightCare; elective care redesign; urgent and emergency care reform; supporting self care and prevention; progressing population-health new care models such as multispecialty community providers (MCPs) and primary and acute care systems (PACS); medicines |

| | |
|---|---|
| | optimisation; and improving the management of continuing healthcare processes.<br>• Provider efficiency measures include: implementing pathology service and back office rationalisation; implementing procurement, hospital pharmacy and estates transformation plans; improving rostering systems and job planning to reduce use of agency staff and increase clinical productivity; implementing the Getting It Right First Time programme; and implementing new models of acute service collaboration and more integrated primary and community services. |
| **3. Primary Care** | • Ensure the sustainability of general practice in your area by implementing the General Practice Forward View, including the plans for Practice Transformational Support, and the ten high impact changes.<br>• Ensure local investment meets or exceeds minimum required levels.<br>• Tackle workforce and workload issues, including interim milestones that contribute towards increasing the number of doctors working in general practice by 5,000 in 2020, co-funding an extra 1,500 pharmacists to work in general practice by 2020, the expansion of Improving Access to Psychological Therapies (IAPT) in general practice with 3,000 more therapists in primary care, and investment in training practice staff and stimulating the use of online consultation systems.<br>• By no later than March 2019, extend and improve access in line with requirements for new national funding.<br>• Support general practice at scale, the expansion of Multispecialty Community Providers or Primary and Acute Care Systems, and enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes. |
| **4. Urgent & Emergency Care** | • Deliver the four hour A&E standard, and standards for ambulance response times including through implementing the five elements of the A&E Improvement Plan.<br>• By November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services.<br>• Implement the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each STP footprint, including a clinical hub that supports NHS 111, 999 and out-of-hours calls. Deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an A&E department.<br>• Initiate cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis. |
| **5. Referral to treatment times and elective care** | • Deliver the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT). |

| | |
|---|---|
| | • Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018 in line with the 2017/18 CQUIN and payment changes from October 2018.<br>• Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups.<br>• Implement the national maternity services review, Better Births, through local maternity systems. |
| **6. Cancer** | • Working through Cancer Alliances and the National Cancer Vanguard, implement the cancer taskforce report.<br>• Deliver the NHS Constitution 62 day cancer standard, including by securing adequate diagnostic capacity and the other NHS Constitution cancer standards.<br>• Make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.<br>• Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types.<br>• Ensure all elements of the Recovery Package are commissioned, including ensuring that:<br>o all patients have a holistic needs assessment and care plan at the point of diagnosis;<br>o a treatment summary is sent to the patient's GP at the end of treatment; and<br>o a cancer care review is completed by the GP within six months of a cancer diagnosis. |
| **7. Mental Health** | • Deliver in full the implementation plan for the Mental Health Five Year Forward View for all ages, including:<br>o Additional psychological therapies so that at least 19% of people with anxiety and depression access treatment, with the majority of the increase from the baseline of 15% to be integrated with physical healthcare;<br>o More high-quality mental health services for children and young people, so that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of Children and Young People Improving Access to Psychological Therapies (CYP IAPT) by 2018;<br>o Expand capacity so that more than 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral.<br>o Increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline; |

| | |
|---|---|
| | ○ Commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases; and<br>○ Reduce suicide rates by 10% against the 2016/17 baseline.<br>• Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals.<br>• Increase baseline spend on mental health to deliver the Mental Health Investment Standard.<br>• Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support.<br>• Eliminate out of area placements for non-specialist acute care by 2020/21. |
| **8. People with Learning Disabilities** | • Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism.<br>• Reduce inpatient bed capacity by March 2019 to 10-15 in CCG-commissioned beds per million population, and 20-25 in NHS England-commissioned beds per million population.<br>• Improve access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check.<br>• Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability or autism. |
| **9. Improving quality in organisations** | • All organisations should implement plans to improve quality of care, particularly for organisations in special measures.<br>• Drawing on the National Quality Board's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services.<br>• Participate in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare. |

## 3 Developing operational plans and agreeing contracts for 2017-19

The guidance outlines that the Operating Plan should be structured as follows:

- Operating plan narrative, to include:
  - Activity planning
  - Quality planning
  - Workforce planning

    - Financial planning
    - Link to the local STP
- Financial plan (technical guidance yet to be published)
- Activity plan
- Workforce plan (technical guidance yet to be published)
- Contract tracker
- Triangulation form

Within those headings, the Operating Plan must demonstrate

- How we will be deliver the relevant 'must-dos';
- How we support delivery of the local STP(s), including clear and credible milestones and deliverables;
- How we intend to reconcile finance with activity and workforce to deliver our agreed contribution to the system control total;
- Robust, stretching and deliverable activity plans which are directly derived from the STP, agreed by commissioners and providers and consistent with achieving the relevant performance trajectories within available local budgets;
- how local independent sector capacity should be factored into demand and capacity planning from the outset, and that local independent sector providers have been engaged throughout;
- Planned contribution to savings;
- How risks have been jointly identified and mitigated through an agreed contingency plan; and
- the impact of new care models

CCG and provider plans will need to be agreed by NHS England and NHS Improvement, with a clear expectation that they must be fully aligned in local contracts. Fully aligned, signed contracts are expected to be in place by 23 December 2016.

## 4 **STPs, Finance and business rule**

### **4.1 Sustainability and Transformation Plans (STPs)**

STP areas are required to submit local financial plans showing how their systems will achieve financial balance within the available resources. The planning guidance sets a clear expectation that both the commissioner sector and the provider sector to be in financial balance in both 2017/18 and 2018/19, and the Operational plans for 2017/18 and 2018/19 are identified as the detailed plans for the first two years of the STP.

NHS England and NHS Improvement expect that:

- the transformation and efficiency plans, including activity growth moderation plans, set out in STPs will be reflected in individual organisational plans;

- there will be aggregate financial activity and workforce plans at STP level, underpinned by financial control totals, and organisational level operational plans will need to reflect those aggregate plans;
- accountability for delivery will sit with individual organisations but they will need to demonstrate how their organisational plans align with STP objectives and planning assumptions; and
- STP leaders will have strong governance processes to ensure clarity as to how different organisations are contributing to agreed system working, how progress will be tracked, and how organisations will work together to manage cross-cutting transformational activity.

To support system-wide planning and transformation, financial system control totals will be set for all STP or equivalent agreed areas for planning purposes, ongoing monitoring and management. In the first instance, they will be derived from individual control totals for CCGs and provider organisations in that geography

**Efficiency and financial balance**

The guidance sets a clear expectation that providers and commissioners must have a relentless focus on efficiency in 2017/18 and 2018/19, and makes reference to the 'reset' publication 'Strengthening Financial Performance and Accountability in 2016/17 published in July 2016 in the NHS', which outlined the responsibilities of individual NHS bodies to live within the funding available and the direct accountability of providers and commissioners to live within the public resources made available by Parliament.

Subject to consultation, the guidance outlines cost uplifts in the national tariff will be set at 2.1% for 2017/18 and 2.1% for 2018/19. The cost uplifts include revised projections for pay drift, the costs of the apprenticeship levy and pass through drugs and exclude HRG-specific uplifts included in tariff prices for Clinical Negligence Scheme for Trusts (CNST). The efficiency deflator will be set at 2% in both years and inflation will be 2.3%. This information is consistent with the position presented at the Finance and Investment Committee at its September meeting.

The provider sector will be expected to achieve aggregate financial balance in each of the two years of the operational plan after taking into account deployment of the £1.8bn STF. Any deterioration in the opening position for 2017/18, or in delivery during the plan period, will require the provider to deliver efficiency levels greater than the 2% national requirement to meet the control totals set by NHS Improvement, recognising that by definition they will have unrealised and undelivered efficiency opportunity from previous years.

**Other**

Issues that will need to be included in the Trust's planning for 17/18 include:

- 5% unfunded growth in 16/17
- +/- 7% potential growth in 17/18
- Returning to 75-76% A8 performance, with an exit run rate of 71% in 16/17
- Specialist service funding £5.3m

## 5 Timetable for delivery

A national timetable has been set and is summarised below, together with the internal governance and assurance arrangements (these are highlighted in green for ease; dark blue areas indicate external submission requirements).

| Timetable Item | Date |
|---|---|
| **Planning guidance published** | 22 September 2016 |
| **Letter from NHSE indicating indicative share of Sustainability & Transformation Fund** | 30 September 2016 |
| **Summary of guidance and timetable presented to the Trust Board** | 4 October 2016 |
| **Initial engagement with commissioners to discuss 2 year contracting process and expectations** | 7 October 2016 |
| **Weekly meeting of Chief Executive, Director of Finance, Director of Transformation and Performance, Director of Operations, Medical Director** | 12 October 2016 |
| **Weekly engagement with commissioners** | 14 October 2016 |
| **NHS standard Contract consultation closes** | 21 October 2016 |
| **Weekly meeting of Chief Executive, Director of Finance, Director of Transformation and Performance, Director of Operations, Medical Director** | 19 October 2016 |
| **Weekly engagement with commissioners** | 21 October 2016 |
| **Submission of STPs** | 21 October 2016 |
| **Weekly meeting of Chief Executive, Director of Finance, Director of Transformation and Performance, Director of Operations, Medical Director** | 26 October 2016 |
| **Weekly engagement with commissioners** | 28 October 2016 |
| **Meeting of the Finance and Investment Committee to consider submission of summary level 2017/18 to 2018/19 operational financial plans** | End of October date currently being finalised |
| **Provider finance, workforce and activity templates issued with related Technical Guidance** | 1 November 2016 |
| **Submission of summary level 2017/18 to 2018/19 operational financial plans** | 1 November 2016 |
| **Commissioners to issue initial contract offers that form a reasonable basis for negotiations to providers** | 4 November 2016 |
| **Providers to respond to initial offers from commissioners** | 4 November 2016 |
| **Final NHS Standard Contract published** | 4 November 2016 |
| **Weekly meeting of Chief Executive, Director of Finance, Director of Transformation and Performance, Director of Operations, Medical Director** | 2 November 2016 |
| **Weekly engagement with commissioners** | 4 November 2016 |
| **Weekly meeting of Chief Executive, Director of Finance, Director of Transformation and Performance, Director of Operations, Medical Director** | 9 November 2016 |

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|---|---|
| **Weekly engagement with commissioners** | 11 November 2016 |
| **Weekly meeting of Chief Executive, Director of Finance, Director of Transformation and Performance, Director of Operations, Medical Director** | 16 November 2016 |
| **Weekly engagement with commissioners** | 18 November 2016 |
| **Presentation to Trust Board on draft 2017/18 to 2018/19 operational plans** | November date being finalised |
| **Meeting of the Finance and Investment Committee to steer development of the Operating Plan** | November date being finalised |
| **Weekly meeting of Chief Executive, Director of Finance, Director of Transformation and Performance, Director of Operations, Medical Director** | 23 November 2016 |
| **Submission of draft 2017/18 to 2018/19 operational plans** | 24 November 2016 |
| **Meeting of the Finance & Investment Committee** | 24 November 2016 |
| **Weekly engagement with commissioners** | 25 November 2016 |
| **Formal presentation of progress, outstanding issues and decisions required to the meeting of the Trust Board** | 29 November 2016 |
| **Weekly meeting of Chief Executive, Director of Finance, Director of Transformation and Performance, Director of Operations, Medical Director** | 30 November 2016 |
| **Weekly engagement with commissioners** | 2 December 2016 |
| **Contract mediation** | 5-23 December 2016 |
| **Where contracts are not signed and contract signature deadline of 23 December 2016 is at risk, local decisions to enter mediation** | 5 December 2016 |
| **Weekly meeting of Chief Executive, Director of Finance, Director of Transformation and Performance, Director of Operations, Medical Director** | 7 December 2016 |
| **Weekly engagement with commissioners** | 9 December 2016 |
| **Meeting of the Finance & Investment Committee** | December meeting date currently being finalised |
| **Formal presentation of progress, outstanding issues and decisions required to the meeting of the Private Board** | 13 December 2016 |
| **Weekly meeting of Chief Executive, Director of Finance, Director of Transformation and Performance, Director of Operations, Medical Director** | 14 December 2016 |
| **Weekly engagement with commissioners** | 16 December 2016 |
| **Weekly meeting of Chief Executive, Director of Finance, Director of Transformation and Performance, Director of Operations, Medical Director** | 21 December 2016 |
| **Final plans approved by Trust Board** | 22 December 2016 |
| **Contract mediation** | 5-23 December 2016 |
| **National deadline for signing of contracts** | 23 December 2016 |
| **Submission of final 2017/18 to 2018/19 operational plans, aligned with contracts** | 23 December 2016 |
| **Arbitration where contracts are not signed** | 9-31 January 2017 |

As with last year's Operating Plan, we will develop a public facing version of the Operating Plan that and publish this on our website as well as NHS Improvement's website.

## 6 In summary

On 22 September 2016, NHS England and NHS Improvement published the 2017-2019 planning guidance which prescribes a two-year approach to planning and contracting. The document explains how the NHS operational planning and contracting processes will now change to support Sustainability and Transformation Plans (STPs), and that the approach will be supported by a two-year national tariff and a two-year standard contract.

This paper provides a summary of the planning guidance and the timetable for delivery and ensures that, as in previous years, the Trust Board directs the Trust's contracting priorities and approach.

## 7 Actions required of the Trust Board

The Trust Board is asked to:

- Note the publication of the 2017-2019 planning guidance
- Consider and agree the internal timetable and arrangements for delivery

**Karen Broughton**
**Director of Transformation and Strategy**

London Ambulance Service NHS
NHS Trust

| | |
|---|---|
| **Report to:** | **Trust Board** |
| **Date of meeting:** | **4th October 2016** |
| **Document Title:** | **Update on progress against the Workforce Race Equality Scheme** |
| **Report Author(s):** | **Mark Hirst, Interim Director of Workforce**<br>**Melissa Berry, Interim Head of Equality & Diversity** |
| **Presented by:** | **Melissa Berry, Interim Head of Equality & Diversity** |
| **Contact Details:** | **melissa.berry@lond-amb.nhs.uk** |
| **History:** | **N/A** |
| **Status:** | **Presented for information and assurance on progress** |

**Background/Purpose**

The Board approved the Trust's Workforce Race Equality Standard (WRES) Action Plan at the Board meeting on 26th July 2016

The purpose of this report is to update the Board on progress against the commitments in the WRES Action Plan.

The intention is to provide the Board with quarterly updates against the Action Plan.

**Action required**

The Board is asked to note the contents of this report.

**Key implications**

Progress against the Workforce Race Equality Standard is a deliverable of the Quality Improvement Plan and should result in improved recruitment, retention and staff satisfaction including improved Staff Survey feedback

The LAS recently conducted a self-assessment against the Workforce Race Equality Standards (WRES). These standards are designed to help local and national NHS organisations to review their data against the nine WRES indicators, to produce action plans to close the gaps in workplace experience between White and Black and Ethnic Minority (BME) staff, and to improve BME representation at the Board level of the organisation.

The recently published WRES data, has delivered challenging and difficult messages to the senior management team. Currently data shows that only 11% of LAS employees are from BME groups.

| Key implications and risks arising from this paper | |
|---|---|
| **Clinical and Quality** | Research demonstrates a direct link between staff morale and engagement and patient care |
| **Performance** | The business benefits of diversity and inclusion include improved innovation and effectiveness |
| **Financial** | As above |
| **Workforce** | Improved morale and staff engagement should promote improved recruitment and retention and reduced absence |
| **Governance and Well-led** | The WRES is part of the "well-led" domain in the CQC inspection programme |
| **Reputation** | It is important that the Trust's workforce is broadly representative of the communities the Trust serves |
| **Other** | Implementation of the WRES will ensure the Trust complies with legislation and statue. |
| **This paper supports the achievement of the following Quality Improvement Plan Workstreams:** | |
| **Making the London Ambulance Service a great place to work** | Yes – see above |
| **Achieving Good Governance** | Yes – see above |
| **Improving Patient Experience** | Yes – see above |
| **Improving Environment and Resources** | Yes – see above |
| **Taking Pride and Responsibility** | Yes – see above |

**PROGRESS REPORT AGAINST THE TRUST's WRES ACTION PLAN**

The Trust Board signed off the draft Workforce Race Equality Standard (WRES) Action Plan at the Board meeting on 26th July. It was agreed that the Interim Head of Equality & Inclusion would provide quarterly reports to the Board on progress against the agreed actions.

Since the Board meeting in July the following progress has been made:

- A Board Seminar for executive and non-executive directors took place on 8th September led by Yvonne Coghill and Roger Kline, NHSE Joint WRES Programme Directors.

- A follow up meeting between the Chair, Heather Lawrence, Yvonne Coghill and Melissa Berry, Interim Head of Equality & Inclusion has taken place to discuss the seminar and next steps with the WRES.

- The Executive Leadership Team (ELT) discussed the report 'Strategic Review of Equality & Diversity in LAS' prepared by Karen Wise Consulting at the ELT meeting on 14th September and agreed:
    - That progressing the WRES was a team and organisational priority;
    - To fund two temporary additional posts to support delivery of the work programme i.e. to fund the Interim Head of Equality & Diversity full time until 30/03/17 and an additional support post.

- The Interim Head of Equality & Inclusion and the Interim Director of Workforce have met with:
    - The Director of Equality & Diversity for the Metropolitan Police to explore learning from work the Met has done in recent years to raise its profile and reputation as an employer amongst BME communities.
    - Representatives of the Patients Forum to explore the Forum's concerns about the Trust's workforce profile and any implications for patient care
    - Representatives of Health Education England to discuss ways of increasing the number of graduates in paramedic science from BME groups and possible funding for positive action initiatives to support the development and advancement of BME staff within the Trust;

- The Trust has received an invitation from HEE to submit two bids for additional funding in 2016/17:
    - a bid to run an outreach programme to promote paramedic science as a career option in schools with the specific objective of raising awareness amongst under represented BME groups;
    - A bid for funding to take positive action to provide additional Continuous Professional Development for BME staff within the Trust (for example, additional mentoring and coaching)

- The Head of Equality & Inclusion has met with:
    - Individual senior members of the Trust's BME workforce, including the Deputy Medical Director to understand their experience of working for LAS;

- BME staff working in the 111 Service at Croydon;
- Representatives of the LAS BME Staff Forum to understand obstacles faced by the BME Staff Forum and its members;
- The Chair of the LAS BME Staff Forum to explore ways of building and promoting the BME Staff Forum as a 'safe space' for BME staff and to start to plan a Staff Conference for BME staff to take place in January 2017 with guest speakers;
- The Chief Executive to start to make arrangements for a 'CEO and Chair Open Forum' for BME staff to be held during October or November 2016 (a letter inviting all BME staff to attend has been prepared for the CEOs signature and is expected to go out in week commencing the 3rd October).

- The Interim Head of Equality & Inclusion and the Corporate HR Manager have developed a series of additional local equality and diversity questions for inclusion i the 2016/17 Staff Survey to ensure a better and more comprehensive understanding of the feedback from its BME staff

- The Interim Head of Equality & Inclusion and the Director of Workforce attended the NHS Equality & Inclusion Conference 2016 and the Interim Head of Equality & Inclusion attended the National Ambulance Service Diversity Forum (chaired by Tracey Myhill, CEO of the Welsh Ambulance Service) to network and learn from best equality and inclusion practice

- The Interim Head of Equality & Inclusion has sought to supplement the Trust's Equalities & Inclusion resource by:
  - advertising an opportunity to apply for a secondment to join the LAS Equality & Inclusion Team for six months to support delivery of the WRES Action Plan
  - securing through Yvonne Coghill some free consultancy support from Byron Curry the Head of HR for the NHS Leadership Academy who is currently seconded to the national WRES team

- The Interim Head of Equality & Inclusion, working with the Interim Head of Recruitment, the Head of Professional Development, the Assistant Director of People & Organisational Development and the Deputy Director of HR has commenced reviews of:
  - The Trust's recruitment and selection processes;
  - The Trust's disciplinary processes (to further understand the relative likelihood of BME staff entering the formal disciplinary processes as measured by entry into formal disciplinary investigation)
  - The relative likelihood of BME staff accessing non-mandatory training and CPD

- The Trust is exploring the possibility of taking further positive action by running an additional LAS Academy programme in 2016/17 with 60% of places reserved for BME applicants

- The Recruitment Team have arranged a recruitment fair to take place at Westfield Shopping Centre, Stratford on Saturday 31st September with the aim of filling Trainee

Emergency Ambulance Crew vacancies and with a particular remit of attracting applicants from under represented BME groups.

- The first meeting of the Trusts WRES Implementation Group has been arranged to take place on 30th September 2016

**Mark Hirst**
**Interim Director of Workforce**
**27th September 2016**

London Ambulance Service NHS Trust

| | |
|---|---|
| **Report to:** | **Trust Board** |
| **Date of meeting:** | **4th October 2016** |
| **Document Title:** | **IM&T Strategy Review** |
| **Report Author(s):** | **Ernst & Young LLP** |
| **Presented by:** | **Fionna Moore, Chief Executive** |
| **Contact Details:** | **sandra.adams@lond-amb.nhs.uk** |
| **History:** | **N/A** |
| **Status:** | **For information** |

**Background/Purpose**

The attached report provides an independent review that the process of creating the strategy and the engagement with the business are fit for purpose. The aim is to provide the Trust with alignment between business imperatives and IM&T in: direction, timeliness, and best value for money.

**Action required**

Presented for information.

**Key implications**

As identified in the report.

**Key implications and risks arising from this paper**

| | |
|---|---|
| **Clinical and Quality** | |
| **Performance** | |
| **Financial** | |
| **Workforce** | |
| **Governance and Well-led** | **The review focusses on 3 main areas of concern: operational challenges, strategy, and the capabilities of the IM&T function** |
| **Reputation** | |
| **Other** | |

**This paper supports the achievement of the following Quality Improvement Plan Workstreams:**

| | |
|---|---|
| **Making the London Ambulance Service a great place to work** | **Yes** |

| | |
|---|---|
| **Achieving Good Governance** | **Yes** |
| **Improving Patient Experience** | **Yes** |
| **Improving Environment and Resources** | **Yes** |
| **Taking Pride and Responsibility** | |

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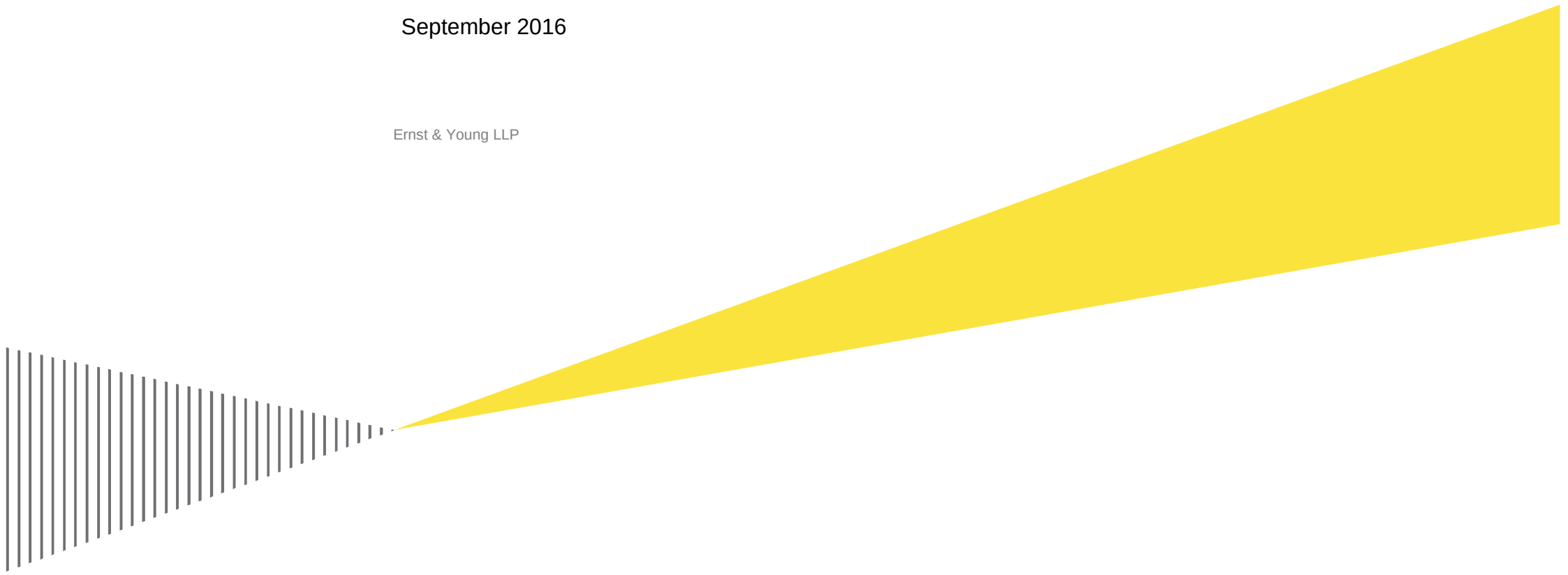
# IM&T Strategy Review

## London Ambulance Service

September 2016

Ernst & Young LLP



Building a better working world

# Contents

# Introduction

## Project Background and Approach

EY has been asked to provide a review of the process in developing the IM&T strategy. This is to give an Independent review that the process of creating the strategy and the engagement with the business, are fit for purpose. The aim being to provide the Trust with alignment between business imperatives and IM&T in, direction, timeliness and best value for money.

## Drivers for the review – CQC Report

The London Ambulance Service (LAS) trust evaluation status, provided by an independent service provider CQC, has changed from being a good performer, pre-2014, to being rated as Inadequate.

Through a series of interviews with the Executive, despite there being a number of factors contributing to this, the underlying root cause could be attributed to the lack of a clear and coherent business strategy in this period. Also there appears a lack of ownership and alignment with each of the functional groups (including IM& T) within LAS.

# Engagement Scope

The scope of work has been conducted in accordance with our engagement agreement dated 4 August 2016. In accordance with our agreed scope, this draft Red-Flag report focusses on three main areas of concern: Operational Challenges; Strategy; and, Capabilities of the IM&T function

| Item | Scope Description |
|---|---|
| 1 | Assess the current **operational challenges** and focus of the IM&T function. To ensure these have been comprehensively scoped and are being effectively delivered. |
| 2 | To review the steps being taken to develop an IM&T **Strategy**. To assess how this has been scoped and integrated with current thinking within the Trust Board and how it addresses the actions and priorities identified within the Quality Improvement Plan and themes emerging from the NHSI reviews undertaken in year. |
| 3 | To undertake an assessment of the **capabilities** of the IM&T function to fulfil the operational demands of LAS and undertake the role as described in their job descriptions and to deliver the opportunities arising from points 1 and 2. |

## Limitations

Our work commenced on 8 August 2016 and completed on 23 August 2016. This draft Red-Flag report is based on the following sources:

- Management meetings with the following LAS Executive Management team:

| Date and Time | Interview by | Interviewee | Role |
|---|---|---|---|
| **09-Aug 2016** | TB, DV, JD | Sandra Adams | Director of Corporate Governance/Trust Secretary |
| **09-Aug 2016** | DV, JD | Fenella Wrigley | Medical Director |
| **11-Aug 2016** | DV, JD | Karen Broughton | Director of Transformation, Strategy and Workforce |
| **12-Aug 2016** | TB, JD | Andrew Grimshaw | Director of Finance |
| **16-Aug 2016** | TB, DV | Charlotte Gawne | Director of Communications |
| **17-Aug 2016** | TB, DV | Fiona Moore | Chief Executive |
| **17-Aug 2016** | TB, DV | Paul Woodrow | Operations Director |
| **22-Aug 2016** | TB, CN | Andrew Watson | CIO |

- Documentation provided by LAS prior to the drafting of this report [see below]

## List of documentation sourced and provided:

- 31 16 08 17 Mobility ELT Update v1 1 (002).pdf
- Trial of mobile devices 25 July 2016 LS for FM v0.1.docx
- TAB-9.0-Cover-page-IM&T-Strategy.doc
- Ambulance-2020-and-beyond-the-AACE-vision.pdf
- LAS Final 5 Year Strategy – 20 June 2014 (4).pdf
- Final Audit-Committee-minutes-07092015.pdf
- IMT Review and Strategy Paper.pdf
- IMT Review – EMT Paper V3.docx
- Final-TB-in-public-minutes-20150324.pdf
- TAB-9.1-IM&T-Strategy-Summary.pptx
- Copy of executive Team Structure V0.5 portfolio
- 5 year Strategy Costs V5.3.xlsx
- 160708 QIP milestone plan – July.xlsx
- 16 08.17 Mobility ELT update V1.1

# Executive Summary of the key interview London Ambulance Service themes

| | Findings | Mitigating actions |
|---|---|---|
| **Operational Challenges** | Current IT business model is not seen as one of encouraging and developing staff. Although business plans for 2016 are present which include requirements identified from the CQC report, there was no view on progress to date in achieving proposed target operating model for IT. The IM&T function has been seen as operating in a silo with lack of confidence in the delivery of IT due to recent operational outages and patient data loss (placing the organisation at legislative risk). Staff changes have not been replaced and the PA Consulting recommended a TOM, signed off by the Board, has not been implemented. The result is a lack of key IT senior resource to deliver effective solutions to meet business needs. | IT needs to be part of the LAS Strategic and Tactical plans and IT issues as well as opportunities are adequately assessed and reflected in the organisation's plans. IT management and business process owners should establish and apply a structured approach regarding the Strategic planning process to effectively communicate a collaborative approach.<br>However, it is recommended that prior to the development or changing the strategic, IT plan, management should rapidly assess the existing information architecture and systems landscape in terms of business process alignment, automation, functionality, stability, complexity, costs, strengths and weaknesses in order to determine the extent to which the existing systems and staff support the LAS business requirements and how well aligned is information technology requirements with the business. |
| **Strategy** | After the appointment of a new CIO (March 2016) there was an expectation that a short-term 100 day plan, with critical milestones would have been developed and shared with the Executive. This has not occurred. Management believe that there is a disconnect between Operations and IM&T. This is preventing a coherent, joined-up approach in identifying and evaluating business needs. This has prevented the drafting of an appropriate strategy to align with current business plans. | The approach in building a strategy is both structured and sequential. IT strategy and solutions need to be identified, developed and/or acquired, as well as implemented and integrated into the broader business processes across the LAS.<br>IT Management should, in addition, establish a clear process to capture and report feedback from business process owners and users regarding the quality and usefulness of long- and short-range IM&T plans as to whether they are delivering against business needs. |

| | Findings | Mitigating actions |
|---|---|---|
| **Function Capabilities** | There is a lack of interdepartmental transparency especially concerning current focus areas of IM&T. Focus areas deemed to be a priority are to run a secure, resilient and stable IT environment to support the needs of the business before introducing digital delivery means. Especially onto what is considered to be a fragile IT estate. In addition, there is a lack of clarity surrounding the role of the IM&T function, and its areas of responsibility do not appear clearly defined nor agreed.<br><br>Resourcing constraints has led to concerns that the LAS are exposing themselves to Data Privacy risks regarding recent personal data loss and non-compliance with the UK Data Protection Act 1998, furthermore, incident response time deemed not acceptable for recent outages of critical operational systems. | A full review of the IT staff and competencies plus the appointment of 2 key TOM approved roles, Programme lead and Service head should be completed.<br><br>Establish and maintain an optimal coordination, communication and liaison structure between the IT function and various other interests inside and outside the IT function that follows an appropriate operating model for IT.<br><br>Establish a process to control IT changes in support of business change request activities. These should be an approved and management of a scheduled list of activities that deliver trackable benefits should be reviewed by a ‘Change Control Board’ with key stakeholders from senior Operational positions.<br><br>Trackable benefits may not always be cost orientated, and in the health care sector, may be based on the critical importance of patient safety. Approval and scheduling of the programme of work should be based on the oversight of an appropriate governance team. |

# IT findings from management meetings

**Potential impact/focus symbols:**

High Medium Low

| Item | Risk | Description | Impact/Recommendations/Next steps |
|---|---|---|---|
| **Operational Challenges** | | **Engagement**<br>► Following a series of interviews with the LAS executive team, there were a series of concerns raised that indicated a lack of engagement across the leadership team which has reduced both visibility of IM&T activities and confidence in the function. Still resonating with the initial findings from the 2015 review.<br>► Management acknowledge that there is a clear disconnect between management and staff. Staff do not feel valued with very little investment in development and lack of communication across the organisation which is largely down to lack of investment in time. Viewed as an excellent organisation for training, however, staff retention remains low. Viewed as important to develop sustainable plans for Estates, Workforces, and IM&T. Efforts are currently underway to improve communications across the LAS.<br>► The business model is not seen as one of encouraging and nurturing staff to be proactive in identifying and driving business needs; capturing them and introducing them. | **IT as part of the LAS Strategic and Tactical plans:**<br>► Senior management is responsible for developing and implementing Strategic and Tactical plans that fulfill the organisation's mission and goals for the LAS. Senior management should ensure that IT issues as well as opportunities are adequately assessed and reflected in the organisation's plans. IT's planning should be developed to help ensure that the use of IT is aligned with the mission and business strategies of the LAS.<br>**Communication of IT plans**<br>► IT management **and** business process owners should establish and apply a structured approach regarding the Strategic planning process. Management should ensure that there is an adequate process/forum to convey IT all plans to business process owners and other relevant parties across the LAS. |
| | | **Business Plans**<br>► The business plans for 2016 are based on meeting the needs of the Quality Improvement Programme (QIP). Encapsulated within this plan are changes made to include requirements identified from the CQC report.<br>► As part of this plan, each functional area has been instructed on the activities they need to perform to enable the successful, delivery of this Programme. Management have indicated that the six month review of this delivery plan is now due for review. | |

| Item | Risk | Description | Impact/Recommendations/Next steps |
|---|---|---|---|
| | | **LAS Operational Performance**<br>► The deterioration in performance of the LAS has been attributed to the following:<br>► The operating model has remained stagnant and not kept up with required pace of change, but nonetheless has maintained target levels;<br>► The ambulance service is not seen as an enabler of change across the health economy;<br>► Union involvement and agreement regarding IT initiatives needs to be reflected in strategic lead times;<br>► The culture of the organisation is one of running day-to-day operations rather than being more forward looking and innovative;<br>► Process and systems are immature or with largely paper-based processes resulting inefficiencies and data loss of potentially sensitive material which may contravene the Data Privacy Act.<br>► The downgrade of the LAS performance has been attributed to a lack of investment in the organisation (for example, lack of appropriate tooling, and, the ambulance fleet is typically replaced every five years, but approximately 50% of the fleet is older than seven years). | **Delivery Capacity – Assessment of Existing System Landscape**<br>► Prior to the development or changing the strategic, IT plan, IT management should assess the existing information architecture and systems landscape in terms of degree of business process alignment, automation, functionality, stability, complexity, costs, strengths and weaknesses in order to determine the degree to which the existing systems and staff support the LAS business requirements and how well aligned is information technology requirements with the business compared to what is currently being delivered.<br>**IT Delivery and Support**<br>► Recent data breaches resulting in the loss of patient data, has eroded confidence in the systems and control over patient data, specifically as awareness of this loss of data could have been done four years earlier, which also raises the question of what other data has been lost. Management should establish an appropriate incident handling capability to address security and operational systems incidents by providing a centralised platform with sufficient expertise equipped with rapid and secure communication facilities. Incident management responsibilities and procedures should be established to ensure an appropriate, effective and |
| | | **IM&T Function**<br>► IM&T function viewed as operating in a silo rather than engaging with the operational leadership team to understand the drivers of change and areas of opportunity that exist. The recommended management Target Operating Model with functional management has not been implemented.<br>► CIO role is currently not a Board positon and reports directly to the CEO. This places great challenge on the CEO to be accountable for IM & T strategy as an enabler for the organisation. Furthermore, the role and expectations of this new CIO role and reporting line has never been formally communicated or understood. The CIO role could report along with the Performance Director into the CFO as previously. This would enable a core group to focus on and address the Trusts challenges. Such a structure would enable the following:<br>► Executive Management believe that the IM&T function, should be clearly | |

| Item | Risk | Description | Impact/Recommendations/Next steps |
|---|---|---|---|
| | | focused on two areas.<br>► As an enabler for the operational areas supporting the delivery of the business plan objectives; managing business demand; CAPEX/OPEX financials, programme delivery, management reporting, and,<br>► Reviewing and addressing their own functional IT Service area, targeted at addressing operational issues or through the delivery of agreed KPI's and SLA's linked to the LAS strategic objectives.<br>► Themes supporting lack of confidence in the IM&T function stated below but is not restricted to the following:<br>► Delayed timing on awareness relating to the loss of patient data;<br>► Reported outages of key systems such as CAD;<br>► Too reliant upon paper-based processes;<br>► Lack of visibility on IM&T activities;<br>► Increasing levels of engagement required to align IM&T with functional operational needs and/or plans;<br>► Completeness or accuracy of information recorded in the Trust risk register (DATIX) was raised as a concern. | timely response to incidents is communicated effectively and in a timely manner to relevant business stakeholders. In addition, LAS should introduce an appropriate Information Security Management System to help mitigate against future sensitive data loss and contravening UK Data Protection laws.<br>**Governance, Risk and Compliance**<br>► Introduce transparency on risk taking and adherence to the agreed organisational risk profile to ensure that LAS is identifying, monitoring and actively addressing risks to the organisation, and to ensure adherence to local laws (i.e., Data Protection), regulations, industry standards (i.e., adoption of recognised IT frameworks and/or standards, e.g., COBiT/COSO and ISO27001) and potential contractual commitments with other health care services. |
| | ● | **Information Technology**<br>► Access to information technology for staff is limited due to the size of each facility and shift patterns worked, resulting in that the number of staff on site at any point in time can vary substantially leading to difficulties in provisioning.<br>► Due to recent system outages (one in particular forcing the LAS to revert back to a paper-based system), and data loss (resulting in the potential loss of patient data), the general consensus is that a hold is placed upon the introduction of new technologies until the current IT environment is stabilised and secure. Furthermore, it is felt that IM&T directives are misaligned to the business and focus should be placed upon the development of the functions own staff and delivering resilient systems compared to introducing digital technologies onto a fragile IT estate.<br>► Recognition that front-line ambulance staff require information technology to help support and drive efficiencies in their delivery of health care services. | |

| Item | Risk | Description | Impact/Recommendations/Next steps |
|---|---|---|---|
| | | ► Distributed workforce need to be able to engage with the wider system of care (digital strategy).<br>► Capital expenditure funding is deemed to fund IM&T forward looking programmes.<br><br>**Risk Management and Governance**<br>► Risk management process exists, however appears ineffective for identifying and tracking both operational and IT risks for the LAS. Trust Risk Register (DATIX Web – implemented May 2016) in situ and the Board Assurance Framework, etc. IM&T Risks exist on the register, but management lack confidence in the completeness and validity of this information.<br>► Although IM&T risks are included, it is not clear if these are either up to date, progressed or completed/closed.<br>► Business continuity is questionable to ensure the delivery of appropriate health care services, for example, OP66 is a procedure to revert to manual systems – teams were not trained and tested on using this approach.<br>► Processes are very audit focused and not readily defined, which introduced difficulties for any efficiencies to be identified and built into current processes. | |
| **Strategy** | | Interview questions were aimed at reviewing the steps taken to formulate the IM&T strategy to evaluate how this had been created, looking for evidence of how this aligned with the agreed Business strategy.<br><br>**Business Strategy**<br>► A current business strategy was reported to be in place, covering a five year period. Management indicated that this had been enhanced to include requirements of both the CQC report and relevant STPs.<br>► During the interviews, management were asked to comment on the existence, approach and content of the IM&T strategy document. Feedback indicated that there were a series of unknowns:<br>  ► A business strategy has been created (although this was highlighted as being for some and not all functional groups), but it is unclear if this has been formally approved. This covers a five year plan and has recently been amended to incorporate requirements from STPs | **Defining IT Strategy**<br>► IT strategy and solutions need to be identified, developed or acquired, as well as implemented and **integrated into** the broader business processes across the LAS [refer to previous point concerning appropriate process/forum to use as a mechanism to drive this]<br>► The approach in building a strategy is typically both structured and sequential. With the sequence potentially following the below steps:<br>1. Identify both the vision and need of the organisation, for each business |

| Item | Risk | Description | Impact/Recommendations/Next steps |
|---|---|---|---|
| | | and the CQC report. The approach followed, to set the planned objectives, sequence/priority and the associated benefits are not known (it is unknown at this stage whether this factored in considerations from NHSI and CQUIN);<br>► IM&T involvement in, or alignment with, the above strategy is not known;<br>► In the formulation of both strategies, it is unknown if considerations had been made to align with other linked or related entities, Pan London, with other Ambulance trusts or looking at other models adopted internationally. | area, covering the next 3-5 years (or what is realistic for LAS). Included within this assessment should be an evaluation based on need and dependencies to help define the appropriate timing of objective;<br>2. For each business area, identify the gap between the current position and the planned vision. If as a result of changing business needs, planned vision changes, steps 2 to 6 will need to be repeated);<br>3. For each gap, identify how technology can be used to help bridge the gap in the delivery of the plan;<br>4. Design the target technology architecture needed;<br>5. Assess the gap between the current technology architecture and the target technology architecture; and,<br>6. Develop a prioritised and dependency linked plan to deliver the target architecture. Work by PA in 2015 to be incorporated here. |
| | 🟡 | **IM&T Strategy**<br>► Although management indicated that they had worked with PA Consulting in 2015 to create an IM&T strategy, there was no view on how this had moved forward following the workshops. This strategy was created in consultation with members of the executive. This strategy was handed over to the new IM&T lead, with a view that proposed initiatives would be converted into an approved plan with associated benefits, however it is unclear post-handover, what has been done with this agreed strategy.<br>► In March 2016, following the appointment of a new CIO, there was an expectation that a short-term plan would be have been broadcast covering the initial 100 days, a critical path of short term wins, followed by a IM&T strategy, potentially aligned with the 2015 document, aligning IM&T with the business.<br>► The management team interviewed have no visibility on the existence of any updated IM&T strategy document (or supporting initiatives) following on from the above. This is compounded by the low levels of engagement across the Executive layer.<br>► It is felt that there is a disconnect between Operations and IM&T to achieve a coherent joined-up approach in identifying business needs and drafting the appropriate strategy to fulfil those. | **Monitoring and Evaluating IT Plans**<br>► Management should establish processes to capture and report feedback from business process owners and users regarding the quality and usefulness of long- and short-range plans. The feedback obtained should be evaluated and considered in future IT planning for the LAS. Closer |
| | 🔴 | **Alignment**<br>► Management stated there is a recognition of the importance of aligned strategic aims, however, departmental teams are operating in silos with each team having their own strategy focusing solely on achieving the | |

| Item | Risk | Description | Impact/Recommendations/Next steps |
|---|---|---|---|
| | | 75% target. The apparent lack of coordination, resulting in strategies not aligned and they are not part of a clear overall strategy for the LAS.<br>► The lack of any clear IM&T strategy has prevented any formal evaluation on:<br>► The approach followed to align with the business and focus on prioritised areas (Including QIP), and meeting Digital needs of LAS and the NHS;<br>► The steps taken to review externally, possible options or solutions used Pan London, with other Ambulance trusts or internationally;<br>► The steps taken to address and resolve internal IT improvement areas based on any agreed SLAs that may be currently in place;<br>► The approach taken to develop the strategy as a Digital strategy embracing the needs of the broader NHS and to align itself with National programmes such as AS999; Multi-Agency Transfer, 111 connectivity, Agency Interoperability (the latter focusing especially on the adequate protection of sensitive patient data potentially being shared)). | working ties/alignment with the Performance/MI director would be beneficial |
| **Functional Capability** |  <br>  | **Interdepartmental Transparency**<br>► The lack of transparency over current focus areas of the IM&T team and the limited levels of interaction between the IM&T leadership team with their peer groups has raised questions regarding the direction, role and responsibilities of this team. This is compounded furthermore, by IM&T matters not having the opportunity to be aired at Board level.<br>► Management are not clear as to progress against the recommendations from the 2015 review regarding prioritising the stability of the underlying IT systems.<br>**IM&T Focus Areas**<br>► IM&T has been advised that the function should be focused on the following key areas, but progress here is questioned by management as to whether it aligns with the organisations immediate aims and objectives:<br>1. Run the business: to run a secure, resilient and stable IT environment to support the needs of the business.<br>2. Change the business: to run tracked and prioritised programs of work | **Coordination**<br>► IT management should undertake the necessary actions to establish and maintain an optimal coordination, communication and liaison structure between the IT function and various other interests inside **and** outside the IT function (i.e., LAS users (including senior management), suppliers, security officers, risk managers).<br>**Target Operating Model for IT**<br>► LAS IT staff evaluations should be performed regularly to ensure the IT function has a sufficient number of competent IT staff. Staffing requirements should be evaluated at least annually. Evaluation results should be acted upon promptly to |

| Item | Risk | Description | Impact/Recommendations/Next steps |
|---|---|---|---|
| | | aligned with the approved needs and enhancing the availability of solutions and services.<br>3. NHS technology alignment: to ensure that programs of work are aligned with current and future needs of the trust and NHS. This should be supported by key business principles to ensure that the current operating model is simplified as much as possible, to remove costly and potentially unnecessary support costs. Alignment with the NHS, (example LDRs) should also include compliance with key adopted frameworks and standards such as COBIT/COSO (to provide a controlled framework for IT operations that dovetails with the business) and ISO27001 (to help protect critical processes and patient data and will be fundamental to future adoption of digital means which can blur the typical organisational boundaries).<br>4. Technology Advisor: To act as an advisor to the Trust to ensure that they are aware of changing technology developments either via their interaction with the broader NHS community or based on market changes. | ensure adequate staffing now and in the future. The above process is overdue.<br>► The Board signed off PA Consulting TOM should be reviewed urgently. It is recommended that two senior appointments from the TOM be made. One to lead the CAPEX Programmes and any Digital Pilots. One to build and Lead the IT SLA required for the business.<br>► This would provide the CIO with bandwidth to reengage the Executive and gain sig off for a 100 day Critical path plan and turnaround strategy<br>**IM&T Programme Delivery**<br>► Programme/Change business activities, should be an approved and managed to deliver trackable benefits that justify the levels of investment required. Trackable benefits may not always be cost orientated, and in the health care sector, may be based on the critical importance of patient safety. Approval and scheduling of all programmes should have the oversight of the appropriate governance team who will ensure that it:<br>► Aligns to agreed business objectives;<br>► That the programme of work is tracked by regular status updates<br>► Costs are tracked throughout;<br>► Benefits realisation is evaluated on completion of delivery; and, |
| | ● | **IM&T in support of operational processes**<br>► Response from those interviewed varied, typically based on their specific solution needs. There were a number of key, consistent areas of concern, areas that have not been recognised or specifically addressed by the IM&T function, within the last five months with the trust:<br>► The lack of clarity around the role the function is to serve and the areas of responsibility for the IM&T team;<br>► The apparent lack of a reviewed, tracked and approved IM&T strategy;<br>► A lack of understanding of what the key areas of focus are for the IM&T team;<br>► The completeness and accuracy of information shared with peer groups and above, specifically relating to the delayed time in reporting patient data and records loss requiring a more robust security incident management process particularly when it concerns personal sensitive information of patients.<br>► Management concern that the LAS are exposing themselves to Data Privacy risk regarding recent data loss and non-compliance with the UK | |

| Item | Risk | Description | Impact/Recommendations/Next steps |
|---|---|---|---|
| | | Data Protection Act.<br>► Incident response time deemed not acceptable for recent outages.<br>► Management stated that the IM&T does not contain the appropriate levels of resourcing for capacity planning; configuration management; service management (moved to Finance) and demand management (identifying and channeling business needs through to the IM&T function). | ► Changes are managed and approved by a governance team following the appropriate risk evaluation review. |

# Appendix A Questionnaire

## Introductions

Following on from the recent CQC report, EY has been asked to provide a review of the process in developing the IM&T strategy to provide comment regarding the process of creating the strategy and the engagement with the business are fit for purpose in providing the Trust alignment between business imperatives and IM&T in direction, timeliness and best value for money.

## Questions

1. How long have you been at the trust (when from?)
2. Where were you previously?
3. Can I confirm your areas of responsibility?
4. What do you believe are the changes that have occurred in the last few years that have led to the deterioration in performance of LAS, and how would you rank these changes in terms of negative impact (high, medium and low)?
5. What do you believe are some of the key negative messages being delivered by the CQC report and why?
6. With the knowledge you have now, do you feel that you have the right tools or processes in place to address these moving forwards?
7. Is there a clear business strategy moving forward and what would you see as the three key priority objectives?
8. How do you/the business identify what are your key priority items?
9. Describe how closely do you work with the IM&T function?
10. Are you aware of what there key focus areas are, and what is your level of confidence in them based on business alignment and ability to securely support LAS?
11. In context of LAS, what do you see as the key areas of accountability for IM&T?
12. Have you seen or been involved in the development of their IT Strategy? And how is this addressing the needs of your area?
13. What do you believe should be the strategic priorities of IM&T in supporting the front line services, or other areas, of LAS?

14. What level of oversight is provided to IM&T by the executive team?
15. What level of collaboration do you have with other Ambulance trusts?
16. Access to computers at Ambulance facilities has been flagged as inadequate, what has been done to address?
17. How is the IM&T Budget allocated and controlled, and how do we know we are spending on the right areas?
18. What has been done to make sure each facility is standard and with required tools to ease day to day activity?
19. How is the IM&T Spend (progress, cost, time, resource, benefits) tracked?
20. How is procurement controlled, is this linked in with tight asset management (automated or manual)?
21. What are the requirements set by the trust to track spend on IM&T activities, and how are these requirements being met?

**EY** | Assurance | Tax | Transactions | Advisory

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London Ambulance Service NHS Trust

| | |
|---|---|
| **Report to:** | **Trust Board** |
| **Date of meeting:** | **4th October 2016** |
| **Document Title:** | **Freedom to Speak Up: raising concerns/whistleblowing** |
| **Report Author(s):** | **Sandra Adams, Director of Corporate Governance/Trust Secretary** |
| **Presented by:** | **Sandra Adams** |
| **Contact Details:** | **sandra.adams@lond-amb.nhs.uk** |
| **History:** | **Executive leadership team; policy approved by the Policy Monitoring and Approval Group** |
| **Status:** | **For information and to support the launch of the Speak Up campaign in October** |

**Background/Purpose**

National guidance on Raising Concerns at Work (Whistleblowing) was first published in April 2014 following the outcome reports from reviews at Mid-Staffordshire NHS Foundation Trust and Winterbourne View Hospital, and this was supported by the updated NHS Constitution and the Public Interest Disclosure Act 1998. The LAS first published its Whistleblowing policy and procedure in July 2007 with subsequent reviews and updates to the current version of HR003. Other Trust policies include Being Open and the Duty of Candour, Incident Reporting procedure, Serious Incident policy and procedure, and the policy for Anti-fraud, bribery and corruption.
The national single integrated policy was published in April 2016 and NHS organisations have been advised to adopt this and adapt it to suit local circumstance. The revised policy was approved by the Policy Monitoring and Approval Group and by the Executive Leadership Team on 14th September 2016 and is attached for information.

NHS organisations are required to have a Freedom to Speak Up Guardian in place from 1st October 2016 and the LAS has made interim arrangements with the appointment of Cathe Gaskell, interim bullying and harassment adviser) for 0.5 days per week for a period of 8 weeks, and Margaret Luce (head of patient and public involvement and public education) who will provide the continuity in the role once Cathe's involvement finishes. Both are now on the National Guardian website and are booked to receive the national Guardian training. We are developing the recruitment process for the appointment of up to 4 Guardians and intend to engage staff in this process. The role will be voluntary and the executive leadership team have supported the proposal that staff are given protected time to undertake the role with the support of their line manager. Training, development and ongoing support will be in place. A sample job description of the Guardian role is attached to the paper.

Staff will be able to raise concerns through 4 routes: face to face; telephone; Datix; and online. Only the Guardians will have access to the information to ensure confidentiality.

Freedom to Speak Up is being launched in October as part of the Communications' team-led Speak Up campaign, in line with 'Making the LAS Great. Gaining the confidence of staff in the role and process is going to be key and communications will need to simple and clear. A

communications plan is being drawn up to support this. The revised policy is to be launched as part of the campaign.

The Speak Up communications campaign will run for the month of October and has the following objectives:

- Publicise the new Freedom to Speak Up policy to all staff
- Support the recruitment campaign for four Speak Up guardians
- Encourage local leadership and ideas about how we tackle bullying and harassment
- Encourage staff to contact the interim Speak Up guardians about concerns
- Encourage staff to report all incidents
- Remind staff about their responsibility to support Duty of Candour.

The programme of activity will ensure that staff awareness of Freedom to Speak Up is raised through a range of internal communications channels and activities.

The proposed governance route for Speak Up would be to the Executive Leadership Team for action on emerging issues and themes; to the Workforce and/or Quality Governance committees for oversight and assurance, through to the Trust Board.

**Action required**

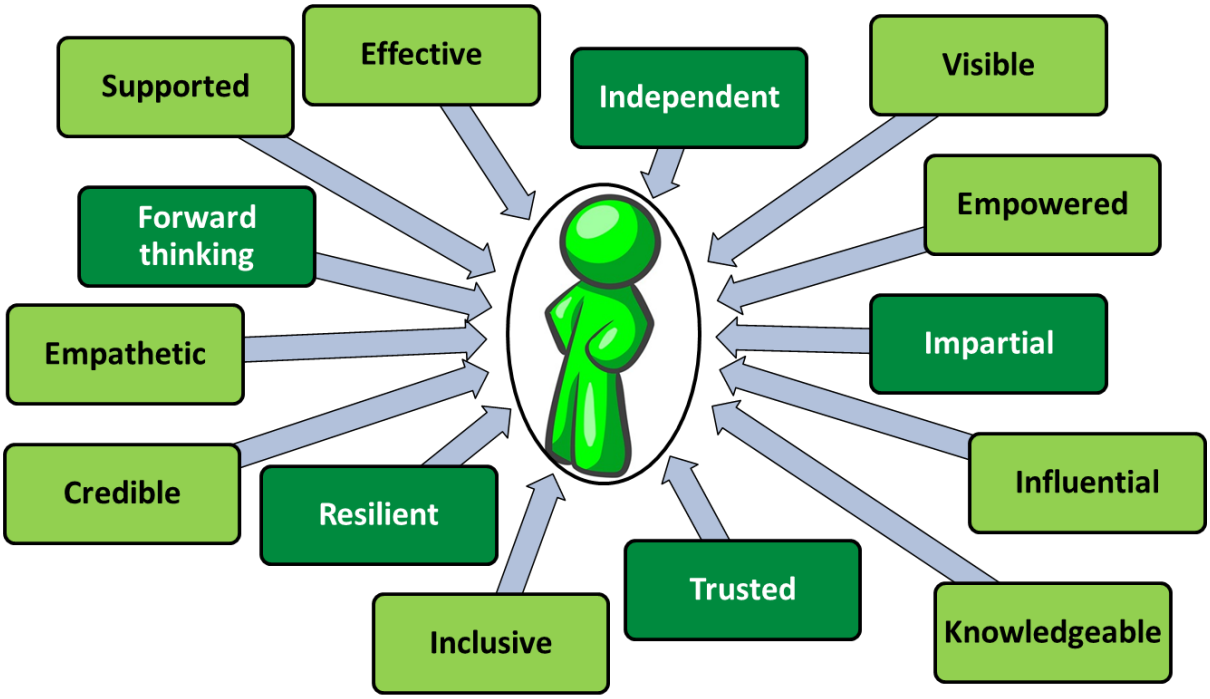
The Trust Board is asked to support the launch of Freedom to Speak Up and the Speak Up campaign.

**Key implications**

We are required to have a Guardian in place from October 2016. This role and the Speak Up campaign will support the Quality Improvement Plan work on raising awareness of incident reporting and risks; building confidence amongst staff that it's ok to speak up and raise a concern about clinical safety for example. The types of concern that Speak Up covers include unsafe patient care, unsafe working conditions, inadequate induction or training for staff, suspicions of fraud, and a bullying culture – across a team or organisation rather than individual instances – including cyber bullying.

| Key implications and risks arising from this paper | |
|---|---|
| **Clinical and Quality** | Raising concerns/ Freedom to Speak Up provides a framework within which staff can raise concerns about unsafe patient care, a lack of or poor response to a reported patient safety incident, for example. |
| **Performance** | |
| **Financial** | As above but in relation to suspicions of fraud for example |
| **Workforce** | As above, but in relation to unsafe working conditions, inadequate induction or training for staff, a bullying culture. |
| **Governance and Well-led** | For the Board and senior leadership team(s) to commit to an open and honest culture and to lead by example. |
| **Reputation** | Potential impact on the Trust if we fail to build an open and honest culture; positive impact if the Trust develops a reputation for learning, having an open and honest culture, and supporting staff. |
| **Other** | |
| **This paper supports the achievement of the following Quality Improvement Plan Workstreams:** | |
| **Making the London Ambulance Service a great place to work** | **Yes** |
| **Achieving Good Governance** | **Yes** |
| **Improving Patient Experience** | **Yes** |
| **Improving Environment and Resources** | **Yes** |
| **Taking Pride and Responsibility** | **Yes** |

**Example Job Description (Freedom to Speak Up Guardian)** (July 2016)




## Purpose of the role

The Freedom to Speak Up (FTSU) Guardian will work alongside trust leadership teams to support the organisation in becoming a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

## Outcomes

The FTSU Guardian role is designed to contribute to achieving the following outcomes:

- A culture of speaking up is instilled throughout the organisation
- Speaking up processes are effective and continuously improved
- All staff have the capability to speak up effectively and managers have the capability to support those who are speaking up
- All staff are supported appropriately when they speak up or support other people who are speaking up
- The Board is fully sighted on, and engaged in, all Freedom to Speak Up matters and issues that are raised by people who are speaking up
- Safety and quality are assured
- A culture of speaking up is instilled throughout the NHS

## Role Description

The role of the FTSU Guardian is to:

Culture

- Develop and deliver communication and engagement programmes to increase visibility of the Freedom to Speak Up Guardian amongst all staff.
- Promote local speaking up processes and sources of support and guidance, demonstrate the impact that speaking up is having in the organisation, and celebrate speaking up.
- Ensure that all 'frontline' staff are aware of, and have access to, support to help them speak up.
- Where appropriate, develop and support a network of 'advocates' to ensure that Freedom to Speak Up reaches all parts of the organisation and everyone has easy access to someone outside their immediate line-management chain who can advise and support them.

Process improvement

- Work with HR professionals and others to ensure that speaking up guidance and processes are clear and accessible, reflect best practice, and address any local issues that may hinder the speaking up process.
- Assess the effectiveness of Freedom to Speak Up processes and the handling of individual cases, intervening when these are failing people who speak up, and making recommendations for improvement.

Capability

- Assess the knowledge and capability of staff to speak up and to support people when they speak up.
- Ensure that all staff have the relevant skills and knowledge to enable them to speak up effectively, and those supporting, managing or investigating speaking up issues have the capability and knowledge to do this effectively.
- Ensure that appropriate items on speaking up are incorporated into induction programmes for all staff.
- Ensure that groups of staff and individuals who may find it difficult to speak up are given particular support.

Supporting staff

- Ensure that information and data are handled appropriately, and personal and confidential data are protected.
- Ensure that individuals receive appropriate feedback on how issues that they speak up about are investigated, and the conclusion of any investigation.

- Where necessary, give extra support, including 1-2-1 support, to people who are experiencing difficulty with speaking up, or those who are experiencing difficulty in handling or supporting someone who is speaking up.

Working with and challenging the Board

- Develop strong and open working relationships with the CEO, NEDs and other Directors, with direct access to Trust leaders as required.
- Attend board meetings regularly to report on Freedom to Speak Up activities. Reports should include assessment of issues that people are speaking up about (and trends in those issues), and barriers affecting ability of people to speak up. Particular attention should be given to concerns which may suggest a link to patient safety and quality.
- Hold the Board to account for taking appropriate action to create a Freedom to Speak Up culture, assess trends, and respond to issues that are being raised.

Safety and quality

- Take immediate appropriate action when matters that people are speaking up about indicate that safety and quality may be compromised.
- Develop measures, data sets, and indicators to monitor trends and identify linkages between issues raised through people speaking up, and issues raised through other safety and quality routes.

NHS culture

- Take part in National Guardian Office activities and training, actively supporting fellow Freedom to Speak Up Guardians, developing personal networks and peer-to-peer relationships, contributing to wider networking events, and sharing and learning from best practice.
- Raise issues that cannot be resolved locally with the National Guardian's Office, including where Trusts appear to be failing in their obligations.
- Keep abreast of developments and best practice, assessing their own development and training needs, and seeking support in addressing these.

## Personal qualities:

FTSU Guardians are expected to have the qualities and experience that will enable them to uphold these key principles:

| Key principles | …what this means |
|---|---|
| **Independent** | … in the advice they give to staff and trust's senior leaders, and free to prioritise their actions to create the greatest impact on speaking up culture<br><br>… and able to hold trusts to account for: creating a culture of speaking up; putting in place processes to support speaking up; taking action to make improvements where needed; and displaying behaviours that encourage speaking up |
| **Impartial** | … and able to review fairly how cases where staff have spoken up are handled |
| **Empowered** | … to take a leading role in supporting staff to speak up safely and to independently report on progress on behalf of a local network of 'champions' or as the single role holder |
| **Visible** | … to all staff, particularly those on the frontline, and approachable by all, irrespective of discipline or grade |
| **Influential** | … with direct and regular access to members of trust boards and other senior leaders |
| **Knowledgeable** | …in Freedom to Speak Up matters and local issues, and able to advise staff appropriately about speaking up |
| **Inclusive** | … and willing and able to support people who may struggle to have their voices heard |
| **Credible** | … with experience that resonates with frontline staff |
| **Empathetic** | … to people who wish to speak up, especially those who may be encountering difficulties<br><br>… and able to listen well, facilitate constructive conversations, and mediate to help resolve issues satisfactorily at the earliest stage possible |
| **Trusted** | … by all to handle issues fairly, take action as necessary, act with integrity and maintain confidentiality as appropriate |
| **Resilient** | … and able to handle difficult situations professionally, setting boundaries and seeking support where needed |
| **Forward thinking** | … and able to make recommendations and take action to improve the handling of cases where staff have spoken up, and freedom to speak up culture more generally |
| **Supported** | … with sufficient designated time to carry out their role, participate in external Freedom to Speak Up activities, and take part in staff training, induction and other relevant activities<br>… with access to advice and training, and appropriate administrative and other support |
| **Effective** | … monitoring the handling and resolution of concerns and ensuring clear action, learning, follow up and feedback. |

**London Ambulance Service NHS Trust**

**Implementing Freedom to Speak Up**

**October 2016**

## 1. Context

1.1 National guidance on Raising Concerns at Work (Whistleblowing) was first published in April 2014 following the outcome reports from reviews at Mid-Staffordshire NHS Foundation Trust and Winterbourne View Hospital, and this was supported by the updated NHS Constitution and the Public Interest Disclosure Act 1998. The LAS first published its Whistleblowing policy and procedure in July 2007 with subsequent reviews and updates to the current version of HR003. Other Trust policies include Being Open and the Duty of Candour, Incident Reporting procedure, Serious Incident policy and procedure, and the policy for Anti-fraud, bribery and corruption.

1.2 One of the recommendations from the Sir Robert Francis QC report 'Freedom to Speak Up' (February 2015) was the development of a single standard integrated policy and procedure for reporting incidents and raising concerns. This national policy was published in April 2016 by NHS Improvement with the aim of standardising the way NHS organisations should support staff who raise concerns, and to the development of a more open and supportive culture that encourages staff to raise any issues of patient care quality or safety. There is an expectation that all NHS organisations will adopt the national policy as a minimum standard. The LAS Whistleblowing policy has therefore been reviewed and amended in line with the national policy.

1.3 There is a statutory requirement now for NHS organisations to appoint a Freedom to Speak Up Guardian from October 2016 and the LAS has made two interim appointments to meet this deadline whilst working through a more substantive process.

1.4 Freedom to Speak Up will be launched under the communications campaign 'Speak Up' in October 2016.

1.5 A small group has been coordinating this work, led by the Director of Corporate Governance/Trust Secretary who acts as the executive lead for Whistleblowing. The group comprises the following:

Sandra Adams
Amy Anderson (replacing Alex Bass)
Sarah Angelou
Cathe Gaskell,
Lindsay Koppenhol
Margaret Luce
Julia Smyth.

1.6 Members of the group have been attending events and researching good practice elsewhere in the NHS in order to shape the proposed approach.

1.7 Fergus Cass, lead non-executive director for Whistleblowing, has been kept appraised of the developing process and plan.

## 2. Policy development and implementation

2.1 HR003 Whistleblowing policy has been re-written to meet the national standard policy and to accommodate local arrangements. This work has been led by Lindsay Koppenhol, HR Projects Manager, who has consulted staff side and HR in the process. Fergus Cass has also reviewed the policy and his comments taken into account in the final draft.

2.2 The revised policy was approved by the Policy Monitoring and Approval Group on 14th September 2016 and no further comments received from the Executive Leadership Team so the policy is now ready to publish.

2.3 The policy is being submitted to the Trust Board for information as part of the launch of the 'Speak Up' campaign and to garner Board commitment to this process.

## 3. Freedom to Speak Up Guardian – the role and appointment process

3.1 Every NHS organisation is required to have a Freedom to Speak Up Guardian in place from October 2016. Once a Guardian has been nominated their details are given to the National Guardians Office where their details are published on the website and the individuals are booked to attend the National training programme.

3.2 There are different models in place across the NHS for the Guardian role. Some organisations have opted for just one Guardian whilst others have opted for several; there is a mix of clinical and non-clinical; and varying levels of seniority. The recommendation from the National Office is that the Guardian should not be a Board member but they should have access to the Board.

3.3 Characteristics of the role include independence, credibility, resilience, empathy, impartiality and the ability to influence. The Guardian should be trusted and empowered to undertake the role with the support of the Board and the organisation. An example job description is attached.

3.4 The role of the Guardian includes: provision of confidential advice and support to staff in relation to concerns they may have; signposting; acting as a conduit between those involved; remaining impartial and independent; reviewing and escalating issues as necessary; ensuring feedback to those involved; and helping to improve awareness of raising concerns in the organisation. Individuals need to have protected time to undertake this role.

3.5 The LAS has nominated 2 Guardians as an interim measure to ensure we meet the October deadline and to allow time for a coordinated and thorough process to appoint a proposed number of 4 Guardians: 2 from operational (front line/Control/111) services and 2 from corporate and support services. Each Guardian would be able to respond to a concern from any part of the service and not just from the group from which they were appointed.

3.6 Cathe Gaskell and Margaret Luce are acting as the interim Guardians and will undertake the national training. Both appointments were made with the approval of the relevant director. Cathe Gaskell is an interim providing specialist advice and support on bullying and harassment and her contract runs to January 2017. Cathe will provide 0.5 days per week to the Guardian role for a period of 8 weeks. Margaret Luce is the Head of Patient and Public Involvement and Public Education and will provide the interim role to ensure continuity once Cathe's input finishes.

3.7 Lindsay Koppenhol and Julia Smyth are developing a values-based recruitment process. The preferred approach of the working group is to invite expressions of interest for staff to undertake the role on a voluntary basis and, through focus groups, to involve staff in the appointment process.

3.8 Applicants for the role will need support from line managers and a commitment to allow protected time. Training will be provided through the National Office and a development programme will be created in-house to support the Guardians in the role and in building the role within the LAS. This will include scenario based development on having courageous conversations for example.

3.9 Support will be available to the Guardians through peer supervision and internal coaching and we anticipate Guardians having protected time for training, supervision and development once a month.

## 4. Process and reporting

4.1 Confidentiality is paramount for staff to have confidence that they can speak up and their concerns will be investigated. A dedicated email address has been set up which will only be accessed by the local Guardians; the LAS mobile numbers for Cathe and Margaret will be published. A form is being set up on Datix that has access limited to the Guardians so that a database can be maintained. We are looking at developing an online form for The Pulse which would go directly into the Guardian inbox. This would mean that there are 4 access points for staff to raise concerns: face to face, online, telephone, and Datix.

4.2 One responsibility of the Guardian is to ensure that the Trust Board is fully sighted on, and engaged in, all Freedom to Speak Up matters. This will mean reporting to the Board on issues and trends for example as well as barriers affecting the ability of people to speak up.

4.3 A proposed governance route for Speak Up would be through ELT to take action on emerging issues and trends; to the Workforce Committee or Quality Governance Committee for oversight and assurance and then through to the Board.

## 5. Communicating Speak Up

5.1 Communications need to be very clear so that people know this is a confidential process. A communications plan is being drafted to support this and the aim is to launch Freedom to Speak Up under the Speak Up campaign in October 2016.

5.2 The revised policy will be launched as part of the campaign and we will tie this in with articles in LAS News on mediation, case incident round tables, and Datix. A dedicated

page has already been set up on The Pulse and this will be populated with information on Freedom to Speak Up and how to access the Guardian(s) to raise a concern in confidence.

## 6. Recommendations

The Executive Leadership Team has approved the proposed approach and the Trust Board is asked to support the launch of the Speak Up campaign which will incorporate that approach

Sandra Adams

Director of Corporate Governance/Trust Secretary

26th September 2016

London Ambulance Service NHS
NHS Trust

# Freedom to speak up: raising concerns (whistleblowing) policy

## DOCUMENT PROFILE and CONTROL.

**Purpose of the document**: To outline the process London Ambulance Service staff and managers should follow in reporting or managing serious concerns

**Sponsor Department:** Corporate Governance

**Author/Reviewer:** HR Manager – Projects. To be reviewed by September 2017

**Document Status:** Final

| **Amendment History** | | | |
|---|---|---|---|
| Date | *Version | Author/Contributor | Amendment Details |
| 19/09/16 | 4.2 | IG Manager | Document Profile and Control update and formatting changes |
| 15/09/16 | 4.1 | Director of Corporate Governance | Minor amendments as agreed for PMAG approval |
| 13/09/16 | 3.6 | IG Manager | Document Profile and Control update and formatting changes |
| 13/09/16 | 3.5 | HR Manager - Projects | Additions to comply with local policy guidance |
| 16/08/16 | 3.4 | HR Manager - Projects | Amendments following consultation with key stakeholders |
| 07/06/16 | 3.3 | HR Manager - Projects | Integrate national policy with local Whistleblowing Policy |
| April 2016 | 3.2 | NHS Improvement & NHS England | Standard integrated policy |
| 25/11/13 | 3.1 | IG Manager | Document Profile and Control update and formatting changes |
| 06/11/13 | 2.2 | IG Manager | Document Profile and Control update and formatting changes |
| September 2013 | 2.1 | HR Manager, Projects | Updated in line with the Enterprise & Regulatory Reform Act 2013 and incorporating recommendations from the Francis report |
| May 2011 | 1.1 | HR Manager, Staff Engagement | Policy updated in line with new guidance issued by Public Concern at Work (PCaW) and advice from Local Counter Fraud Specialist. Contact details amended. |
| July 2007 | 1.0 | Assistant Director, Employee Support Services | Original policy implemented |

***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.

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|---|---|---|
| ELT | | |
| PMAG | 14/09/2016 | 4.0 |
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| LAS Website | 26/11/13 | Governance Co-Ordinator | GCT |
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| 06/09/16 | Director of Corporate Governance |
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| **Staffside reviewed on** | **By** |
| | |

| Links to Related documents or references providing additional information | | |
|---|---|---|
| **Ref. No.** | **Title** | **Version** |
| HS011 | Incident reporting procedure | |
| HR014 | Grievance policy | |
| HR026 | Dignity at Work Policy and Procedure | |
| TP005 | Risk management policy | |
| TP006 | Policy and procedure for serious incident | |
| TP034 | Policy and procedure for being open and duty of candour | |
| TP035 | Procedure for risk reporting assessment | |
| TP097 | Policy for anti-fraud, bribery and corruption | |

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are neither controlled nor substantive.

## 1. Introduction

### 1.1 Speak up – we will listen

1.1.1 Speaking up about any concern you have at work is really important. In fact, it's vital because it will help us to keep improving our services for all patients and the working environment for our staff.

1.1.2 The London Ambulance Service NHS Trust (LAS) recognises the importance of encouraging a culture of openness in which staff and contractors can freely express their concerns without any fear of reprisal. This can contribute constructively to the development and continuous improvement of the services provided by the LAS. As a result if a member of staff raises such a concern, the matter will be dealt with positively, quickly and reasonably.

1.1.3 The LAS is committed to achieving in all its practices the highest possible standards of service to staff, patients, the public and its Commissioners.

1.1.4 You may feel worried about raising a concern, and we understand this. But please don't be put off. In accordance with our duty of candour, our executive directors and entire board are committed to an open and honest culture. We will look into what you say and you will always have access to the support you need while this is happening.

## 2. Scope

2.1 This policy is intended to provide guidance to all employees, agency workers, people who are in training with the Trust, non-executive directors, volunteers and self-employed workers who are working for and are supervised by the Trust should they wish to raise any concern at work.

## 3. Objectives

3.1 This 'standard integrated policy' was one of a number of recommendations of the review by Sir Robert Francis into whistleblowing in the NHS, aimed at improving the experience of whistleblowing in the NHS. It is expected that this policy (produced by NHS Improvement and NHS England) will be adopted by all NHS organisations in England as a minimum standard to help to normalise the raising of concerns for the benefit of all patients and staff.

3.2 Our local process has been integrated into this policy.

## 4. Responsibilities

4.1 All **employees** have a responsibility to raise any concerns they have with their employer about malpractice, patient safety, financial impropriety or any other

serious risks they consider to be in the public interest, these should be raised within the provisions and procedures set down in this policy.

Health and Care Professional Council **(HCPC) registrants** and those registered with other regulatory bodies (e.g. the Nursing and Midwifery Council and the General Medical Council), and all registered professional groups such as Finance, must act in the best interests of service users and provide to their regulatory body and any other relevant regulators any important information about their conduct and competence and that of registered colleagues.

4.2 **Line managers** to whom disclosures are made, and the Trust's designated **Freedom to Speak Up Guardians**, are responsible for acting on the information they receive in accordance with the procedures set out below. They should also do everything reasonable to ensure that whistleblowers are protected from retaliation and victimisation.

4.3 **Trade Union representatives** are responsible for advising members who approach them with regards to whistleblowing.

4.4 The **Trust Board** are responsible for reviewing any whistleblowing incidents which are brought to their attention by the Director of Corporate Governance/Trust Secretary.

## 5. Concerns you can raise

5.1 You can raise a concern about any **risk, malpractice or wrongdoing** you think is harming the service we deliver. Just a few examples of this might include (but are by no means restricted to):

- unsafe patient care
- unsafe working conditions
- inadequate induction or training for staff to ensure staff are able to perform their role
- lack of, or poor, response to a reported patient safety incident
- suspicions of fraud (which can also be reported to our local counter-fraud team Charles Medley, KPMG, charles.medley@kpmg.co.uk, Mobile: 07468 740949
- a bullying culture (across a team or organisation rather than individual instances of bullying), including cyber bullying, or a failure to act on concerns raised;

For further examples, please see the Health Education England video.

5.2 Remember that if you are a registered healthcare professional you may have a professional and contractual duty to report a concern. **If in doubt, please raise it.**

5.3 Don't wait for proof. We would like you to raise the matter while it is still a concern. It doesn't matter if you turn out to be mistaken as long as you are genuinely troubled.

5.4 This policy is not for people with concerns about their employment that affect only them – that type of concern is better suited to our grievance policy or dignity at work policy, depending on the issue being raised.

## 6. Feel safe to raise your concern

6.1 If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to bully you into not raising any such concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action.

6.2 Provided you are acting honestly, it does not matter if you are mistaken or if there is an innocent explanation for your concerns.

6.3 We want you to feel safe in raising your concern (in some instances legal protection may apply – see section 18).

## 7. Confidentiality

7.1 We hope you will feel comfortable raising your concern openly, but we also appreciate that you may want to raise it confidentially. This means that while you are willing for your identity to be known to the person you report your concern to, you do not want anyone else to know your identity. Therefore, we will keep your identity confidential, if that is what you want, unless we are required to disclose it by law (for example, by the police). You can choose to raise your concern anonymously, without giving anyone your name, but that may make it more difficult for us to investigate thoroughly and give you feedback on the outcome.

## 8. Who can raise concerns?

8.1 Anyone who works (or has worked) in the NHS, or for an independent organisation that provides NHS services can raise concerns. This includes agency workers, temporary workers, students, volunteers and governors.

## 9. Who should I raise my concern with?

9.1 In many circumstances the easiest way to get your concern resolved will be to raise it formally or informally with your line manager (or team leader, clinical tutor, or quality governance and assurance manager for example).[1] But where you don't think it is appropriate to do this, you can use any of the options set out below in the first instance.

9.2 If raising it with your line manager (or lead clinician or tutor) does not resolve matters, or you do not feel able to raise it with them, you can contact one of the following people:[2]

- our Freedom to Speak Up Guardians speakup@lond-amb.nhs.uk this mailbox is monitored by Cathe Gaskell and Margaret Luce (Interim Freedom to Speak up Guardians) cathe.gaskell@lond-amb.nhs.uk and margaret.luce@lond-amb.nhs.uk – this is an important role identified in the Freedom to Speak Up review to act as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation
- our risk management team via Frances Field frances.field@lond-amb.nhs.uk

9.3 If you still remain concerned after this, you can contact:

- our executive director with responsibility for freedom to speak up: raising concerns (whistleblowing) Sandra Adams, Director of Corporate Governance/Trust Secretary, sandra.adams@lond-amb.nhs.uk
- our non-executive director with responsibility for whistleblowing Fergus Cass, fergus.cass@lond-amb.nhs.uk

9.4 All these people have been trained in receiving concerns and will give you information about where you can go for more support.

9.5 If for any reason you do not feel comfortable raising your concern internally, you can raise concerns with external bodies, listed in section 17.1.

[1] The difference between raising your concern formally and informally is explained in our local process. In due course NHS England and NHS Improvement will consider how recording could be consistent nationally, with a view to a national reporting system.

[2] Annex A sets out the local process of how a concern might be escalated.

## 10. Advice and support

10.1 Details on the local support available to you can be found here. However, you can also contact the Whistleblowing Helpline for the NHS and social care, your professional body or trade union representative.

## 11. How should I raise my concern?

11.1 You can raise your concerns with any of the people listed above in person, by phone or in writing (including email).

11.2 Whichever route you choose, please be ready to explain as fully as you can the information and circumstances that gave rise to your concern.

## 12. What will we do?

12.1 We are committed to the principles of the Freedom to Speak Up review and its vision for raising concerns, and will ensure our responses to reports are in line with them (see Appendix 2).

12.2 We are committed to listening to our staff, learning lessons and improving patient care and experience. On receipt the concern will be recorded and you will receive an acknowledgement within two working days. The central record will record the date the concern was received, whether you have requested confidentiality, a summary of the concerns and dates when we have given you updates or feedback.

## 13. Investigation

13.1 Where you have been unable to resolve the matter quickly (usually within a few days) with your line manager, we will carry out a proportionate investigation – using someone suitably independent (usually from a different part of the organisation) and properly trained – and we will reach a conclusion within a reasonable timescale (which we will notify you of, from the outset). Wherever possible we will carry out an investigation (so, for example, where a concern is raised about a patient safety incident, we will usually undertake an investigation that looks at your concern and the wider circumstances of the incident[3]). The investigation will be objective and evidence-based, and will produce a report that focuses on identifying and rectifying any issues, as well as learning lessons to prevent problems recurring.

[3] If your concern suggests a Serious Incident has occurred, an investigation will be carried out in accordance with the Serious Incident Framework.

13.2 We may decide that your concern would be better looked at under another process; for example, our process for dealing with bullying and harassment. If so, we will discuss that with you.

13.3 Any employment issues (that affect only you and not others) identified during the investigation will be considered separately.

## 14. Communicating with you

14.1 We will treat you with respect at all times and will thank you for raising your concerns. We will listen to your concerns and reflect back what we have heard to ensure we understand exactly what you are worried about. We will tell you how long we expect the investigation to take and keep you up to date with its progress. Wherever possible, we will share the full investigation report with you (while respecting the confidentiality of others).

## 15. How will we learn from your concern?

15.1 The focus of the investigation will be on improving the service we provide for patients. Where it identifies improvements that can be made, we will track them to ensure necessary changes are made, are working effectively and can be sustained. Lessons will be shared with teams across the organisation, or more widely, as appropriate.

## 16. Monitoring and Audit

16.1 Board oversight

The board will be given high level information about all concerns raised by our staff through this policy and what we are doing to address any problems. We will include similar high level information in our annual report. The board supports staff raising concerns and wants you to feel free to speak up.

16.2 Review

We will review the effectiveness of this policy and local process at least annually, with the outcome published and changes made as appropriate.

## 17. Raising your concern with an outside body

17.1 If you do not feel comfortable raising your concerns internally, you can raise your concern outside the organisation with:

- NHS Improvement for concerns about:
  - → how NHS trusts and foundation trusts are being run
  - → other providers with an NHS provider licence

  - → NHS procurement, choice and competition
  - → the national tariff
  - → Care Quality Commission for quality and safety concerns
- NHS England for concerns about:
  - → primary medical services (general practice)
  - → primary dental services
  - → primary ophthalmic services
  - → local pharmaceutical services
- Health Education England for education and training in the NHS
- NHS Protect for concerns about fraud and corruption.

## 18. Making a 'protected disclosure'

18.1 There are very specific criteria that need to be met for an individual to be covered by whistleblowing law when they raise a concern (to be able to claim the protection that accompanies it). There is also a defined list of 'prescribed persons', similar to the list of outside bodies in section 17.1, who you can make a protected disclosure to. To help you consider whether you might meet these criteria, please seek independent advice from the Whistleblowing Helpline for the NHS and social care, Public Concern at Work or a legal representative.

## 19. National Guardian Freedom to Speak Up

19.1 The new National Guardian (once fully operational) can independently review how staff have been treated having raised concerns where NHS trusts and foundation trusts may have failed to follow good practice, working with some of the bodies listed above to take action where needed.

| Implementation Plan | | | | |
|---|---|---|---|---|
| Intended Audience | This policy applies to all employees, agency workers, people who are in training with the Trust, non-executive directors, volunteers and self-employed workers who are working for and are supervised by the Trust | | | |
| Dissemination | The Pulse and the LAS Website | | | |
| Communications | HR bulletin, included in the RIB, brought to the attention of staff at recruitment/induction, reinforced by management | | | |
| Training | Awareness training at staff induction and management training, e.g. team leader training and management development days | | | |
| Monitoring: See section 16 above | | | | |
| 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 |
| Freedom to speak up log (Datix) | Ad-hoc, used to report all concerns and produce monthly report | Freedom to Speak Up Guardians | Trust Board | Dissemination of information to managers regarding failures in the application of the policy.<br><br>Development of policy in line with legislative developments.<br><br>Promotion of policy where applicable |
| Concerns brought to the attention of the board | Quarterly | Workforce/Quality Governance Committee | Trust Board | |

## Process for raising and escalating a concern Appendix 1

**Step one**

If you have a concern about a risk, malpractice or wrongdoing at work, we hope you will feel able to raise it first with your line manager, lead clinician or tutor (for students). This may be done orally or in writing.

**Step two**

If you feel unable to raise the matter with your line manager, lead clinician or tutor, for whatever reason, please raise the matter with our local Freedom to Speak Up Guardian(s):

| Freedom to Speak up Guardian | Email | Phone |
|---|---|---|
| **Generic email address** | speakup@lond-amb.nhs.uk | |
| **Cathe Gaskell (Interim)** | cathe.gaskell@lond-amb.nhs.uk | 0207 7832425 |
| **Margaret Luce (Interim)** | margaret.luce@lond-amb.nhs.uk | 0203 0690222 / 07909 916239 |

These individuals have been given special responsibility and training in dealing with whistleblowing concerns. They will:

- treat your concern confidentially unless otherwise agreed
- ensure you receive timely support to progress your concern
- escalate to the board any indications that you are being subjected to detriment for raising your concern
- remind the organisation of the need to give you timely feedback on how your concern is being dealt with
- ensure you have access to personal support since raising your concern may be stressful.

If you want to raise the matter in confidence, please say so at the outset so that appropriate arrangements can be made.

You may want to raise your concern with the Trusts' risk management team via Frances Field.

**Step three**

If these channels have been followed and you still have concerns, or if you feel that the matter is so serious that you cannot discuss it with any of the above, please contact our executive director with responsibility for freedom to speak up: raising concerns

(whistleblowing) Sandra Adams or our non-executive director with responsibility for whistleblowing Fergus Cass.

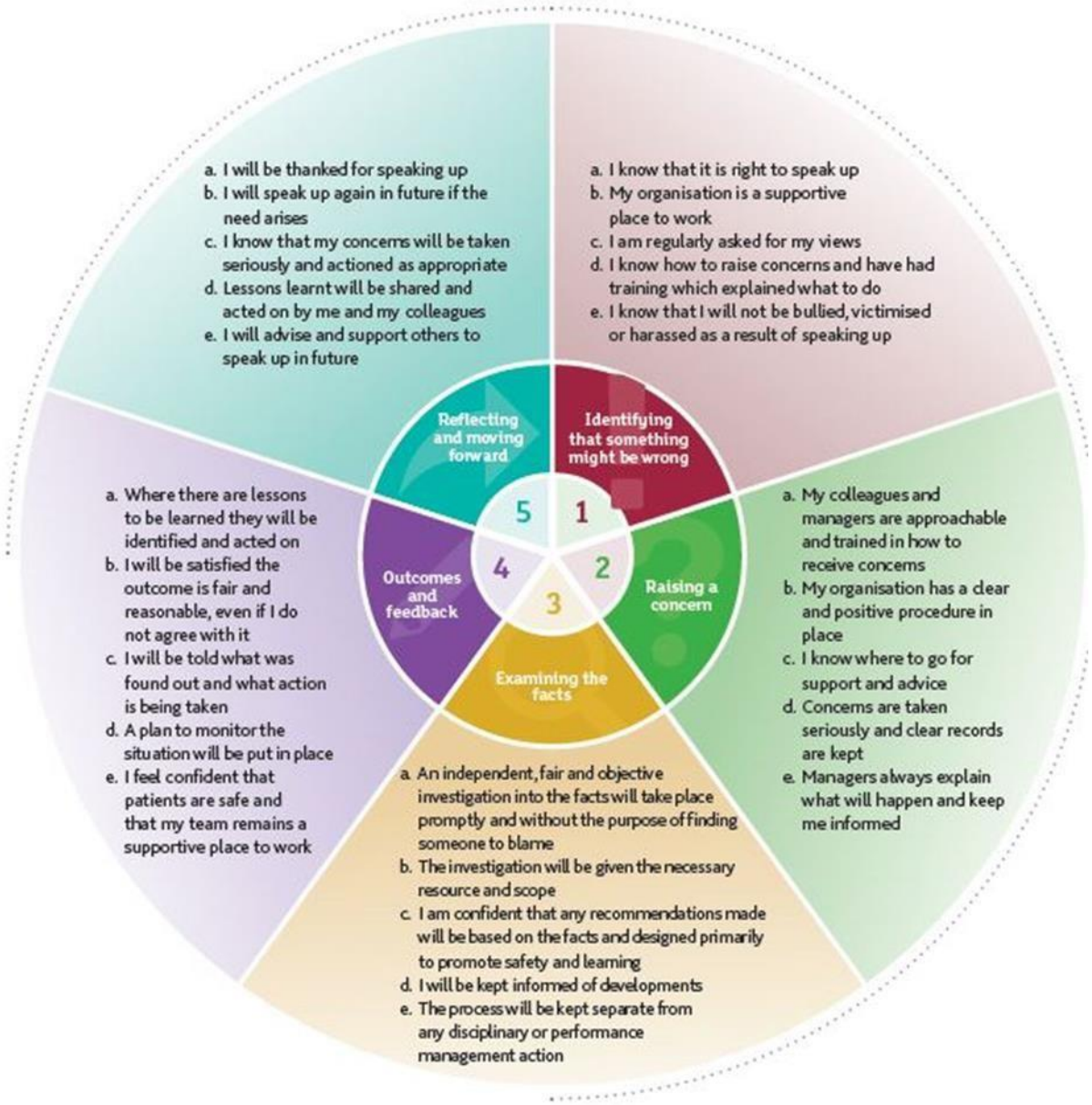
**Step four**

Seek advice and support locally, or contact the Whistleblowing Helpline for the NHS and social care, your professional body or trade union.

**Step five**

You can raise concerns formally with external bodies.

## A vision for raising concerns in the NHS Appendix 2




Source: Sir Robert Francis QC (2015) *Freedom to Speak Up: an independent report into creating an open and honest reporting culture in the NHS*.

London Ambulance Service NHS Trust

| | |
|---|---|
| **Report to:** | **Trust Board** |
| **Date of meeting:** | **4th October 2016** |
| **Document Title:** | **Trust Secretary Report** |
| **Report Author(s):** | **Sandra Adams, Director of Corporate Governance/Trust Secretary** |
| **Presented by:** | **Sandra Adams** |
| **Contact Details:** | **sandra.adams@lond-amb.nhs.uk** |
| **History:** | |
| **Status:** | **For information and assurance** |

**Background/Purpose**

Since the Trust Board meeting on 26th July 2016, there have been two tenders received and opened and entered into the register; and there have been 6 entries to the Register for the use of the Trust Seal.

**Action required**

To be advised of the tenders received and entered into the tender book and entries to the Register for the use of the Trust Seal since 26th July 2016 and to be assured of compliance with Standing Orders and Standing Financial Instructions.

**Key implications**

None identified.

| **Key implications and risks arising from this paper** | |
|---|---|
| **Clinical and Quality** | |
| **Performance** | |
| **Financial** | |
| **Workforce** | |
| **Governance and Well-led** | **Compliance with Standing Orders and Standing Financial Instructions** |

| | |
|---|---|
| **Reputation** | |
| **Other** | |
| **This paper supports the achievement of the following Quality Improvement Plan Workstreams:** | |
| **Making the London Ambulance Service a great place to work** | |
| **Achieving Good Governance** | **Yes** |
| **Improving Patient Experience** | |
| **Improving Environment and Resources** | |
| **Taking Pride and Responsibility** | |

# Trust Secretary Report – October 2016

## Tenders received

### Refurbishment of training centre at Barking (Maritime House)

Tenders received from:

- Coniston Ltd
- Orchard Build Ltd
- Millane Contract Services Ltd
- Smith and O'Sullivan

### Redecorations at HQ

Tenders received from:

- RS Contracts (London) Ltd
- Mitie Property
- Arena Maintenance Contracts
- Axis Europe PLC

## Use of the Trust Seal and entries into the Register

- Underleases of 1st, 3rd and 4th floors of Maritime House, 1 Linton Road, Barking, Essex, IG11 8HG – between Dooba Investments 111 Ltd and London Ambulance Service NHS Trust.

- Licence for alterations to the above

- Engrossment of the lease for Unit 3, Crayfields Business Park – between Legal and General Assurance Society Limited and London Ambulance Service NHS Trust.

- Renewal lease – first floor, 18-21 Morley Street, London SE1 7QZ – between Groundwork London (1) and London Ambulance Service NHS Trust.

London Ambulance Service NHS
NHS Trust

# TRUST BOARD FORWARD PLANNER 2016

## 2nd February 2016

| Standing Items | Quality Assurance | Strategic and Business Planning | Governance | Sub-Committee meetings during this period | Apologies |
|---|---|---|---|---|---|
| Patient Story<br><br>Declarations of Interest<br><br>Minutes of the previous meeting<br><br>Matters arising<br><br>Report from the Trust Chairman<br><br>Report from Chief Executive | **Integrated Board Performance Report**<br><br>**Clinical Directors' Joint Report**<br><br>**Quality Governance Committee Assurance Report**<br><br>**Finance Report M9**<br><br>**Report from Finance and Investment Committee**<br><br>**BAF and Corporate Risk Register** | 2016/17 Business and financial planning process<br><br>Fleet Replacement business case | Board Declarations<br><br>Report from Trust Secretary<br><br>Trust Board Forward Planner | Quality and Governance Committee – 12th January<br><br>Finance and Investment Committee – 21st January | |

**29th March 2016**

| Standing Items | Quality Governance and Risk | Strategic and Business Planning | Governance | Sub-Committee meetings during this period | Apologies |
|---|---|---|---|---|---|
| Staff Story<br><br>Declarations of Interest<br><br>Minutes of the previous meeting<br><br>Matters arising<br><br>Report from the Trust Chairman<br><br>Report from Chief Executive | **Integrated Board Performance Report**<br><br>**Clinical Directors' Joint Report**<br><br>**Audit Committee Assurance Report**<br><br>**BAF and Corporate Risk Register**<br><br>**Risk Management Strategy and Policy review**<br><br>**Finance Report M11**<br><br>**Report from Finance and Investment Committee** | 2016/17 Business Plan | Board Declarations<br><br>Report from Trust Secretary<br><br>Trust Board Forward Planner<br><br>Register of interests | Audit Committee – 15th February<br><br>Strategy Review and Planning - 23rd February<br><br>Quality Governance Committee – 15th March<br><br>Finance and Investment Committee – 24th March | |

**31st May 2016 – 2pm**

| Standing Items | Annual Reporting | Quality Assurance | Strategic and Business Planning | Governance | Sub-Committee meetings during this period | Apologies |
|---|---|---|---|---|---|---|
| Patient Story<br><br>Declarations of Interest<br><br>Minutes of the previous meeting<br><br>Matters arising<br><br>Report from the Trust Chairman<br><br>Report from Chief Executive | **Annual Report and Accounts 2015/16 including Annual Governance Statement**<br><br>**Quality Account 2015/16 for approval**<br><br>**Audit Committee Assurance Report**<br><br>**Annual Report of the Audit Committee 2015/16**<br><br>**BAF and Corporate Risk Register**<br><br>**Patient Voice and Service Experience Annual Report 2015/16**<br><br>**Infection Prevention and Control Annual Report 2015/16**<br><br>**Annual Safeguarding Report 2015/16** | Integrated Board Performance Report<br><br>Clinical Directors' Joint Report<br><br>Quality Governance Committee Assurance Report<br><br>Finance Report<br><br>Report from Finance and Investment Committee<br><br>Risk Management Strategy and Policy Review | 2015/16 Business Plan - summary report | Report from Trust Secretary<br><br>Trust Board Forward Planner | Audit Committee – 18th April, 19th & 31st May<br><br>Board seminar - 26th April | |

**26th July**

| Standing Items | Quality Assurance | Strategic and Business Planning | Governance | Sub-Committee meetings during this period | Apologies |
|---|---|---|---|---|---|
| Declarations of Interest<br><br>Minutes of the previous meeting<br><br>Matters arising<br><br>Report from the Trust Chairman<br><br>Report from Chief Executive<br><br>Serious Incidents | **Integrated Board Performance Report including Quality Report**<br><br>**Quality Governance Committee Assurance Report**<br><br>**BAF and Corporate Risk Register**<br><br>**Finance Report M3**<br><br>**Report from Finance and Investment Committee**<br><br>**Workforce and Organisational Development Assurance Report** | Patient Engagement Strategy<br><br>Job Cycle Time | Report from Trust Secretary<br><br>Trust Board Forward Planner and 2017 dates<br><br>Quality Improvement Programme Assurance Report<br><br>Security Management<br><br>Annual Reports:<br>- Safeguarding<br>- Infection Prevention Control<br>- Patient Experience<br>- Patient and Public Involvement and Public Education | Board seminar - 28th June<br><br>Quality Governance Committee – 12th July<br><br>Finance and Investment Committee – 25th July<br><br>Workforce – 18th July | |

**4th October 2016**

| Standing Items | Quality Governance and Risk | Strategic and Business Planning | Governance | Sub-Committee meetings during this period | Apologies |
|---|---|---|---|---|---|
| Declarations of Interest<br><br>Minutes of the previous meeting<br><br>Matters arising<br><br>Report from the Trust Chair<br><br>Report from Chief Executive<br><br>Serious Incidents | **Integrated Board Performance Report including Quality Report**<br><br>**Audit Committee Assurance Report**<br><br>**BAF and Corporate Risk Register**<br><br>**Finance Report M5**<br><br>**Report from Finance and Investment Committee**<br><br>**Report from Quality Governance Committee**<br><br>**Workforce and Organisational Development Assurance Report – not available** | Business planning 17/18<br><br>Review of 2016/17 Business Plan | Report from Trust Secretary<br><br>Trust Board Forward Planner<br><br>Quality Improvement Programme | Audit Committee – 5th September<br><br>Quality Governance Committee – 13th September<br><br>Finance and Investment Committee – 22nd September<br><br>Annual General Meeting – 27th September<br><br>Workforce and Organisational Development – 26th September - cancelled<br><br>Board seminars – 6th and 21st September | |

**29th November 2016**

| Standing Items | Quality Assurance | Strategic and Business Planning | Governance | Sub-Committee meetings during this period | Apologies |
|---|---|---|---|---|---|
| Staff or patient story<br><br>Declarations of Interest<br><br>Minutes of the previous meeting<br><br>Matters arising<br><br>Report from the Trust Chair<br><br>Report from Chief Executive<br><br>Serious Incidents | **Integrated Board Performance Report including Quality Report**<br><br>**Quality Governance Committee Assurance Report**<br><br>**Audit Committee Assurance Report**<br><br>**BAF and Corporate Risk Register**<br><br>**Finance Report M7**<br><br>**Report from Finance and Investment Committee**<br><br>**Workforce and Organisational Development Assurance Report** | 6 month review of business plan | Report from Trust Secretary<br><br>Trust Board Forward Planner<br><br>Performance Reporting compliance statement<br><br>Quality Improvement Programme | Board seminar - 25th October<br><br>Audit Committee – 7th November<br><br>Quality Governance Committee – 15th November<br><br>Finance and Investment Committee – 24th November<br><br>Workforce and Organisational Development – 28th November | |

| Board Seminar | Topic |
|---|---|
| **26th April 2016** | **Financial and business planning 2016/17**<br><br>**KPIs**<br><br>**Strategic risk** |
| **28th June 2016** | **Strategy review** |
| **6th September 2016** | **Strategy – risk appetite** |

| | |
|---|---|
| **21st September 2016** | **Strategy and planning and risk appetite** |
| **25th October 2016** | **TBC** |
| **13th December 2016** | **TBC** |

# Trust Board Register of Interest - September 2016

| Name | Date | Nil declaration | Interest declared | 1. Directorships, including non-executive Directorship helds in private companies or PLCs | 2. Ownership or partnership or private companies, businesses or consultancies likely or possibly seeking to do business with the Trust | 3. Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the Trust | 4. A position of authority in a charity or voluntary body in the field of healthcare or social services | 5. Any material connections with a voluntary or other body contracting for services with NHS organisation | 6. Any other commercial interests in a decision before a meeting of the Trust Board |
|---|---|---|---|---|---|---|---|---|---|
| Heather Lawrence | 05/04/2016 | | ✓ | Chairman Apos Medical Ltd healthcare | | | | | |
| Jessica Cecil | 25/02/2015 | | ✓ | | | | On the advisory board of IntoUniversity, a charity aimed at getting disadvantaged young people to university | One sister is an NHS physiotherapist who also sees patients privately; another sister is a public health reseracher at Imperial College. | |
| John Jones | 04/02/2015 | ✓ | | | | | | | |
| Fergus Cass | 04/03/2015 | | ✓ | Book Aid International - Charity - Trustee; Hospices of Hope - Charity - Trustee; Hospices of Hope Trading Limited - Charity related chain of shops - Chair Melton Court Parking Limited: company managing parking spaces at block where I live: Director | | | As noted above, I am a trustee of Hospices of Hope, a charity supporting hospice care in Romania and neighbouring countries | | |
| Nicholas Martin | 24/02/2015 | | ✓ | Cambridge Guarantee Holdings (Director); A2Dominion Housing Association (Director) | | | Chair, City of Westminster College | | |
| Robert McFarland | 05/02/2015 | ✓ | | | | | Trustee and Chair of the European Doctor's Orchestra. | | |
| Theo de Pencier | 04/03/2015 | | ✓ | Non-executive directorat Transport Focus | | | | | |
| Sandra Adams | 04/02/2015 | ✓ | | | | | | | |
| Karen Broughton | 05/02/2015 | ✓ | | | | | | | |
| Andrew Grimshaw | 05/02/2015 | | ✓ | Director of LSO Consulting Ltd. | | | | | |
| Charlotte Gawne | 17/03/2015 | | ✓ | Director – Vannin Consulting (currently a dormant IT consultancy) | | | | | |
| Fionna Moore | 05/03/2015 | | ✓ | Medical Director, Location Medical Services. | | | Member Executive Committee, Resuscitation Council (UK) | | |
| Paul Woodrow | 10/02/2015 | ✓ | | | | | | | |
| Jill Patterson | 18/02/2016 | | ✓ | Tall Poppies Management Ltd | Tall Poppies Management Ltd | Tall Poppies Management Ltd | | | |
| Andrew Watson | 04/05/2016 | ✓ | | | | | | | |
| Mark Hirst | 12/07/2016 | | ✓ | Managing director of Point Clear Consulting Ltd | Managing director of Point Clear Consulting Ltd | | | Undertaking current interim role through Rethink Recruitment | |
| Fenella Wrigley | 14/02/2015 | | ✓ | | | | Regional Professional Lead for Doctors - St John Ambulance London Region | | Expert Clinical Advisor to UKBA; Consultant in Emergency Medicine, Barts Health NHS Trust |