London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD
TO BE HELD IN PUBLIC ON TUESDAY 21st AUGUST 2012 AT 09.00 – 13.00
CONFERENCE ROOM, 220 WATERLOO ROAD, LONDON SE1 8SD

AGENDA: PUBLIC SESSION

ITEM	SUBJECT	LEAD	TAB
1.	**Welcome and apologies for absence** Apologies received from: Peter Suter Brian Huckett Caroline Silver		
2.	**Declarations of Interest** To request and record any notifications of declarations of interest in relation to today's agenda	RH	
3.	**Minutes of the Part I meeting held on 26th June 2012** To approve the minutes of the meeting held on 26th June 2012	RH	TAB 1
4.	**Matters arising** To review the action schedule arising from previous meetings	RH	TAB 2
5.	**Patient Story** To hear an account of a patient experience	SL	Oral
6.	**Report from Chairman** To receive a report from the Trust Chairman on key activities since the last meeting	RH	TAB 3
QUALITY ASSURANCE			
7.	**Quality Dashboard and Action Plan** To receive the most recent Quality dashboard and progress against the Quality Action Plan	SL	TAB 4
8.	**Annual Safeguarding Report 2011/12** To receive the Annual Safeguarding Report for 2011/12	SL	TAB 5
9.	**Annual Mental Health Report 2011/12** To approve the Mental Health Annual Report for 2011/12	SL	TAB 6
10.	**Clinical Quality and Patient Safety Report** To receive the monthly report on clinical quality and patient safety	FM/SL	TAB 7
11.	**Quality Committee Assurance Report** To receive a report from the Chair of the Quality Committee, including serious incident summary annual report	BM	TAB 8

12.	**Executive Director Report** 12.1 Chief Operating Officer, to receive the performance report including the delivery of service during the 2012 Olympics 12.2 Director of Finance, to receive the report on financial performance for month 4, including the cost improvement programme 12.3 Director of Human Resources and Organisation Development, to receive a report on workforce 12.4 Integrated Board Performance Report	MF MD CH	TAB 9
13.	**Report from the Risk, Compliance and Assurance Group** 13.1 To receive a report from the Risk, Compliance and Assurance Group and to receive assurance that the Trust-wide risk register has been reviewed and updated 13.2 To agree the Strategic Risks	MD/SA	TAB 10
STRATEGIC AND BUSINESS PLANNING			
14.	**Integrated Business Plan and Enabling Strategies** To receive a presentation on the updated Integrated Business Plan and Enabling Strategies`	PB	TAB 11
15.	**Report from Chief Executive Officer** To receive a report from the Chief Executive Officer	PB	TAB 12
EXECUTIVE REPORTS			
16.	**Annual Equality Report 2011/12** To receive the Annual Equality Report for 2011/12	CH	TAB 13
GOVERNANCE			
17.	**Revalidation of Doctors** To approve the appointment of a Responsible Officer to the Trust	FM	TAB 14
BUSINESS ITEMS			
18.	**Report from Trust Secretary** To receive the report from the Trust Secretary on tenders received and the use of the Trust Seal	SA	TAB 15
19.	**Forward Planner** To note the Trust Board forward planner	SA	TAB 16
20.	**Any other business**	RH	
21.	**Questions from members of the public**	RH	
22.	**Date of next meeting** The next meeting of the Trust Board will take place on Tuesday 25th September 2012		

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING
Part I

DRAFT Minutes of the meeting held on Tuesday 26th June 2012 at 10:00 a.m.
in the Conference Room, 220 Waterloo Road, London SE1 8SD

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Present:

Richard Hunt	Trust Chair
Peter Bradley	Chief Executive Officer
Mike Dinan	Director of Finance
Martin Flaherty	Deputy Chief Executive
Roy Griffins	Non-Executive Director
Caron Hitchen	Director of Human Resources and Organisation Development
Brian Huckett	Non-Executive Director
Murziline Parchment	Non-Executive Director
Beryl Magrath	Non-Executive Director
Fionna Moore	Medical Director
Caroline Silver	Non-Executive Director

In Attendance:

Sandra Adams	Director of Corporate Services
Lizzy Bovill	Deputy Director of Strategic Development
Francesca Guy	Committee Secretary (minutes)
Peter Suter	Director of Information Management and Technology
Georgina Jones	Quality Improvement Fellow (minute 74 only)
Trevor Hubbard	Infection Control Manager (minute 77 only)

Members of the Public:

Deane Kennett	North West London Commissioning Partnership
Malcolm Alexander	LAS Patients' Forum
Carol Hunt	Northrop Grumman (minute 85 only)
Ed Sturms	Northrop Grumman (minute 85 only)
Liam Sloane	Client Director, Vodafone
Michael Witter	BT

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68. Welcome and Apologies

68.1 Apologies had been received from:

Steve Lennox
Jessica Cecil
Angie Patton

69. Declarations of Interest

69.1 There were no declarations of interest.

70. Patient Story

70.1 The Trust Board was joined by a patient who had been treated by the LAS following an accident

which had taken place during the Queen's Diamond Jubilee pageant. The patient had been treated in two different ambulances and was asked in both cases if she would mind sharing the ambulance with another patient. The patient made the following observations:

- The crew took the pulse of an 80 year old patient using an ECG and discovered that the patient's pulse was very low. The crew did not however corroborate this reading by checking the radial pulse, which suggested that they were over-reliant on the machine;
- The patient's chest was exposed during the ECG and the crew had not observed that he was very cold;
- The crew offered the patient paracetamol but stated that they were not allowed to carry water for infection control reasons;
- The crew had run out of blankets;
- Pre-planned aid crew staff had difficulties in completing the documentation, which suggested that more work needed to be done to familiarise these crew members with LAS processes;
- Crew members used gloves to write the patients' observations.

70.2 Fionna Moore responded that these observations were useful and agreed that there was sometimes a tendency for crews to over-rely on the machines. Fionna stated that crews had not been permitted to carry water for infection control reasons, but that the Trust was looking to reintroduce water for the purpose of administering paracetamol to patients.

70.3 The patient asked whether the crew could have utilised space blankets on patients. Fionna responded that this would not have been appropriate for patients who were cold as it was more likely to keep their temperature low, rather than warm them up.

70.4 Martin Flaherty commented that there had been a comprehensive familiarisation process for pre-planned aid staff and overall the feedback from these members of staff had been very positive. However, these comments would be considered in advance of the Olympics to ensure that pre-planned aid staff were confident in completing LAS documentation.

70.5 The Chair noted that it was very useful to have these types of issues highlighted and thanked the patient for sharing her experiences with the Trust Board. The Chair suggested that these patient stories could be published in a newsletter.

71. Minutes of the Part I meeting held on 29th May 2012

71.1 The minutes of the Trust Board meeting on 25th May 2012 were approved subject to some minor amendments.

72. Matters Arising

72.1 The following matters arising were discussed:

72.2 **67.3:** Fionna Moore reported that the Eagles were currently looking to share best practice in advanced cardiac care. A lot of the clinical practice that the LAS was looking to introduce was already in practice in America which made it more important to press ahead with these clinical innovations.

72.3 Peter Bradley added that he had held a teleconference with the Heads of the Canadian and Australasian Ambulance Services and had agreed to set up a benchmarking group.

72.4 **128.6:** The Chair noted that the new format balanced scorecard was included in the papers today and thanked everyone involved for their input.

72.5 **26.7:** An update on the review of the High Risk Register was included in the Clinical Quality and Patient Safety Report. This action was closed.

72.6 **28.7:** The Chair would discuss the attitude and behaviour action plan with Peter Bradley at their next one to one meeting.

72.7 **44.1:** The action to amend the minutes of the meeting on 25th May 2012 was complete.

72.8 **46.3:** Lizzy Bovill reported that the patient story heard at the March meeting of the Trust Board would be published in the GP newsletter at the end of June.

72.9 **48.2:** Steve Lennox had made amendments to the Quality Account following comments received at the last Trust Board and the final version would be presented to the Trust Board today. This action was complete.

72.10 **48.3:** The action to draft an abridged version of the Quality Account would be completed in September 2012.

72.11 **51.2:** Martin Flaherty stated that he would meet with Joseph Healy outside of the Trust Board meeting to address the questions he had raised at the last Trust Board meeting.

72.12 **52.2:** The Annual Report and Accounts had now been published. This action was complete.

72.13 **56.12:** Mike Dinan confirmed that he had circulated the month 1 finance report to the Trust Board. This action was complete.

72.14 **57.3:** Francesca Guy confirmed that she had circulated the Olympic preparedness presentation to the Trust Board. This action was complete.

72.15 **62.1:** Francesca Guy confirmed that she had circulated the full version of the Major Incident Plan to the Trust Board. This action was complete.

73. Report from the Chairman

73.1 The Chair had provided the Trust Board with an update on his key areas of activity since the last Trust Board meeting. In response to a question from Murziline Parchment, the Chair explained that he had met with Ruth Carnall to understand her thoughts on the recruitment of the new Trust Chief Executive Officer.

74. Ambulance Services Cardiovascular Quality Initiative

74.1 Fionna Moore introduced Georgina Jones, Quality Improvement Fellow, who joined the Trust Board to give a presentation on the Ambulance Services Cardiovascular Quality Initiative.

74.2 Georgina explained that the project sought to involve crews in identifying ways to improve the delivery of pre-hospital care for cardiovascular disease and stroke. The project used process mapping and root cause analysis to try to encourage crews to identify every possible reason why crews might not be delivering the care bundle. In response, a number of tools had been developed to assist crews in improving the quality of care provided to stroke and STEMI patients, including a pain scoring tool and an e-learning package.

74.3 Georgina explained that there had been three ASCQI launches service-wide and although the initiative was spreading at different rates across the Trust, there had already been a positive impact

on CPI compliance in some areas.

74.4 Georgina reported that the Senior Management Group had agreed to fund her post for a further six months and her priorities would be to further spread the initiative and to work with external partners, such as care homes, to further improve the quality of care.

74.5 The Chair thanked Georgina for her presentation and stated that it helped to put the Trust Board's discussions in context.

74.6 In response to a question from Caroline Silver, Georgina stated that she had really enjoyed her role as Quality Improvement Fellow and had derived great job satisfaction from working on the project.

74.7 Martin Flaherty asked Georgina how she thought this project should be developed, if there were no financial constraints. Georgina responded that she thought that there should be someone working full time on the project and that crews should be taken off the road to take part in the project as part of their training. She thought that the Trust would see huge benefits by doing this, including an improvement in staff morale.

74.8 Caron Hitchen commented that this was a very inspirational presentation and suggested that consideration should be given to how this methodology could be used for achievement of the Trust's CQUINs.

74.9 Caroline Silver asked Georgina what condition would she chose to base the next project on, if she had the choice. Georgina responded that she would chose something complex and something where crews lacked additional training, such as mental health. The methodology had been really successful as it helped to change people's perception of the condition.

74.10 Beryl Magrath commented that, in her opinion, the key to the project's success was that Georgina was a crew member.

74.11 Fionna Moore stated that Georgina was part of a national Quality Improvement Fellow network and asked whether there was anything that could be learnt from other ambulance services. Georgina responded that she had obtained all the presentations from other ambulance services and that the Quality Improvement Fellows had shared ideas throughout the project.

74.12 Beryl Magrath stated that it was useful to hear from staff and asked that the Trust Board had more presentations from staff in the future.

ACTION: RH/SA to discuss how to build in staff presentations into the Trust Board forward planner.

DATE OF COMPLETION: 21st August 2012

75. Quality Dashboard and Action Plan

75.1 Fionna Moore explained that there were three elements to this report: the Quality Dashboard for April 2012; the Department of Health National Comparison measures and the Quality Improvement Action Plan.

75.2 The Quality Dashboard included a number of new indicators as this was the start of the new financial year. Fionna stated that she was aware that the Quality Committee had questioned the RAG rating as members thought that it did not accurately reflect the status of quality and could potentially be viewed negatively by an external reader. Fionna explained that the Trust had

deliberately set itself very challenging targets and that if one of the elements within an indicator was rated red, the whole indicator would be rated red. Fionna thought that this was a reasonable approach given that the indicators set out the Trust's vision of being world-class.

75.3 Caron Hitchen gave a clarification on the statement on the front sheet and stated that only one element of mandatory training had not be delivered in the period, not all mandatory training.

75.4 Fionna drew attention to the Department of Health National Comparison table and explained that the Trust was rated green against those indicators where it was ranked first, second or third against other ambulance trusts.

75.5 Roy Griffins commented that the Quality Committee had raised concerns about the RAG rating as there were a number of indicators that were rated red and this made for a negative initial reading. Roy added that the ratings were also not consistent with the Infection Prevention and Control Annual Report and suggested that they needed recalibrating to give a consistent message.

75.6 Peter Bradley acknowledged that there was an apparent mismatch between the two sets of indicators and stated that he would expect to see more green in the June data as a number of the April indicators had been impacted by the implementation of CommandPoint. Peter noted that there appeared to be data from different months in the same paper and agreed to follow this up with Steve Lennox outside of the meeting.

ACTION: PB to discuss with SL the fact that the Quality Report contained data from different months.

DATE OF COMPLETION: 11th July 2012

75.7 Lizzy Bovill suggested that better use could be made of the coversheet to highlight any key issues to the Trust Board, without replicating the discussion already held at the Quality Committee. Beryl stated that the key issues should also be highlighted in the report from the Quality Committee.

76. Quality Account 2011/12

76.1 Fionna Moore reported that some minor amendments had been made to the Quality Account since the last meeting of the Trust Board and the stakeholder comments had been incorporated.

76.2 Roy Griffins commented that he was not sure that it was a statutory requirement for the Quality Account to come to the Trust Board, as stated on the papers. Roy agreed to follow this up with Steve Lennox outside of the meeting.

ACTION: RG to check with SL whether it was a statutory requirement for the Quality Account to come to the Trust Board.

DATE OF COMPLETION: 21st August 2012

76.3 The Trust Board approved the Quality Account for 2011/12.

77. Annual Infection Prevention and Control Report 2011/12

77.1 Trevor Hubbard joined the meeting for this agenda item.

77.2 Beryl Magrath noted that there was a variation in the complex training figures and asked why this

was the case. Caron explained that the data showed where the training had been delivered, rather than the complex at which staff were based. Training was delivered differently at the New Ways of Working complexes, which would also account for the variance.

77.3 The Chair commented that it was not clear from this report, what the Trust's vision was in relation to infection prevention and control. Trevor responded that the vision was to embed infection control into every day practice and therefore the Trust needed to continue to do more of the same. The Chair responded that the report should therefore indicate progress against achieving this vision.

77.4 Caroline Silver commented that it was important to be able to demonstrate success and stated that it would be useful to show the percentage of staff who had been trained. Trevor agreed to make this amendment.

ACTION: TH to amend the Annual Infection Prevention and Control Report 2011/12 to show the percentage of staff who had received infection prevention and control training.

DATE OF COMPLETION: 21st August 2012

77.5 Subject to these comments, the Trust Board approved the Annual Infection Prevention and Control Report 2011/12.

78. Clinical Quality and Patient Safety Report

78.1 Fionna Moore stated that the key issues had been highlighted on the front sheet and were as follows:

- CPI compliance had dropped to 86%. This was a reflection of the increase in demand. The Mental Health CPI compliance rate was lower than the others, but was good given that it was the first month of using this indicator;
- There was an issue regarding stroke bed capacity in north east London and this was being taken forward by Professor Tony Rudd, Stroke Clinical Director;
- The review of the High Risk Register was ongoing and the number of entrants had reduced. The Medical Directorate would undertake a review of all patients in category 4;
- The Demand Management Plan had been invoked to a significant extent in May;
- There had been no controlled drugs incidents since the last report, however there had been an incident at Romford ambulance station where ampoules of naloxone had been placed in the Controlled Drugs safe, which resulted in a miscounting error. A bulletin was issued reminding staff to ensure that naloxone was not placed within personal morphine holders;
- The Trust had supplied controlled drugs and drug packs to mutual aid crews over the Queen's Diamond Jubilee weekend and no controlled drugs incidents had been reported;
- The Chair of the Medicines Management Group was seeking to further test vehicle based drug bags for an extended period;
- One Rule 43 report had been issued to the Trust since the last report, which related to an ambulance which had been cancelled;
- There had been a small increase in the number of complaints received between January and May, however this needed to be seen within the context of the large volumes of patients treated in the period. Complaints were investigated and overall there had been a significant improvement in the management of serious incidents;
- Crews had been reminded to consider Legionnaire's disease with any patients presenting with flu-like symptoms who had been to Edinburgh in the last two weeks.

78.2 Beryl noted that south CPI completion was low and asked whether there was any reason for this. Martin Flaherty agreed to follow this up with Paul Woodrow.

ACTION: MF to ask Paul Woodrow why CPI compliance was low in the South area.

DATE OF COMPLETION: 21st August 2012

78.3 Peter Bradley stated that May 2012 had been one of the busiest months in the Trust's history and the increase in complaints must be viewed in this context to ensure that there was no increase in trends. The Chair added that it would be useful for the Trust Board to hold a fuller session on complaints and service experience in the future.

ACTION: FG to add to the Trust Board forward planner a session on complaints and service experience.

DATE OF COMPLETION: 21st August 2012

78.4 Roy Griffins reported that the Quality Committee had received a report at its last meeting on the Cost Improvement Plan and asked whether this could be RAG rated. Fionna agreed to look into this and provide more detail in the next report to the Trust Board.

ACTION: FM/MD to discuss the possibility of introducing a RAG rating to the CIP report to the Quality Committee.

DATE OF COMPLETION: 15th August 2012

78.5 The Chair noted that the Trust had recently purchased 200 LifePak machines and asked what happened to the old machines. Mike Dinan responded that the Trust would look to donate any machines in working order to St John and other charities.

79. <u>Quality Committee Assurance Report</u>

79.1 Beryl Magrath reported that the Quality Committee had last met on 20th June. The Committee had been disappointed that no members of the Medical Directorate or the Operations Directorate had been present at the start of the meeting. The Deputy Medical Director attended the majority of the meeting and Paul Woodrow attended for part of the meeting. The Infection Prevention and Control Annual Report 2011/12 was not discussed as there had been no one present at the meeting to present it. The Integrated Report was also not taken as it had been emailed to members late on the 19th June.

79.2 The Chair commented that this did not indicate the appropriate level of priority was being given to the Quality Committee. Peter Bradley agreed that this was not acceptable and stated that he did not expect to see this happen again.

79.3 Beryl Magrath reported that the Quality Committee had discussed the Quality Report and had noted high utilisation rates for the period together with an increase in the use of the Demand Management Plan and REAP levels escalated to levels 3 and 4. There was ongoing work to try to understand the causes for the 20% increase in Category A demand compared with last year.

79.4 At the meeting, a number of quality issues were identified, which were principally care of Category C patients, percentage of staff having supervision and missing documentation.

79.5 The Quality Committee also noted a number of quality achievements:

- Lysa Walder, the newly appointed Safeguarding Manager, had audited the safeguarding referrals to EBS, which showed a very high compliance with the guidelines;
- 78 patients in the care of Central North West London NHSFT had been interviewed on the telephone. The majority had been very satisfied with the service they received (first time we have had direct patient satisfaction information);
- The CQC Compliance Review had found only one minor issue relating to the ordering of controlled drugs. This had now been rectified;
- CARU had now arranged the clinical audit reports in the same format as Internal Audit. The majority of agreed actions arising from the audits were complete. There were no red RAG rated actions outstanding;
- There were no outstanding issues identified by Internal Audit for those audits where there was a clinical dimension;
- The on-going overall improvement in the Quality Risk Profile continued.

79.6 Sandra Adams added that the CQC had subsequently confirmed that the LAS was compliant in all outcomes.

79.7 The Chair noted the report and stated that the last meeting had been unsatisfactory. The Quality Committee's role was to scrutinise quality and therefore needed to operate effectively with appropriate attendance from the executive team.

80. <u>Staff Survey Temperature Check</u>

80.1 Caron Hitchen reported that the Quality Committee had requested the results of the staff survey temperature checks to be presented to the Trust Board. Caron reported that there had been an overall reduction in the number of staff who had responded and the results showed a decline in staff satisfaction across all questions when compared with the results for February 2012. The intention was to extend the period over which staff could respond to encourage a better response rate. The report included some analysis of the free text comments, which highlighted a number of issues, the majority of which had already been picked up through staff consultations.

80.2 Caron reported that the temperature checks would continue on a quarterly basis and the staff engagement team would look to identify actions and initiatives to help improve these scores.

80.3 Lizzy Bovill commented that the proportion of operational staff who had completed the temperature check surveys was generally higher than the staff survey and therefore it was useful to have access to the views of this group of staff.

80.4 The Patients' Forum had submitted a question about whether the LAS had a plan for the development of a 24/7 bariatric care service and whether resources had been identified for this service. Lizzy Bovill responded that one of the CQUINs for 2012/13 related to care of bariatric patients and the Trust was currently undertaking a demand analysis for bariatric vehicles to understand whether there were any trends. An equality analysis was also being undertaken to confirm that the initial response to a bariatric patient was the same as to other patients. The outcomes of these pieces of work would be monitored through the Clinical Quality Group. Malcolm Alexander commented that the cost of using vehicles supplied by private providers was significant and this also did not allow for a 24 hour service.

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

81.1 Peter Bradley stated that his report was for noting and drew attention to the reporting arrangements for the Trust's priorities.

81.2 The Trust Board noted the report from the Chief Executive Officer.

82. Foundation Trust Progress Report

82.1 Sandra Adams reported that she had not yet received any feedback regarding yesterday's board to board meeting with the SHA. The Board Governance Assurance Framework review and the Board Development programme would be discussed in the Part II meeting.

82.2 Sandra added that the Quality Governance Review would commence next month.

83. Performance Reports

Report from the Chief Operating Officer

83.1 Martin Flaherty reported that the Trust had experienced an ongoing increase in demand and year to date performance for Category A was 73.5%, although it was expected that performance would be at 75% by the end of July. Martin reported the following:

- Category A19 performance was currently at 98.2%;
- There had been a circa 20% increase in Category A demand and 11/12% increase in call demand;
- Yesterday was one of the Trust's busiest days ever, aside from New Year's Eve, with 1388 Category A calls and 3094 incidents overall. There were over 300 calls per hour, hour after hour.

83.2 The Chair asked whether there was anything significant about yesterday which would cause the level of demand to increase. Martin responded that there was no obvious factor which would account for the rise in demand, which remained high throughout the day. High levels of DMP had been invoked to manage demand. The Chair commented that the Strategy Review and Planning Committee needed to review the increase in demand as one of the key issues facing the Trust, including whether levels of demand were becoming the new norm of 1200 Category A calls per day.

ACTION: FG to add a discussion on the increase in demand to the forward planner of the Strategy Review and Planning Committee.

DATE OF COMPLETION: 6th July 2012

83.3 Martin commented that work was ongoing to identify any actions which could be taken to improve this position, but fundamentally, the Trust did not have sufficient resource to deal with the increase in demand. The Trust was undergoing a formal capacity review which would take a further 8 weeks to complete and the Trust's commissioners had worked with the Trust to add to the specification of this review.

83.4 Martin added that preparations for the Olympics were ongoing. The Queen's Diamond Jubilee was successful and the mutual aid component in particular worked very well.

83.5 Martin acknowledged that performance in the East area was poor and he agreed to meet with Joseph Healy outside of the meeting to address his concerns.

ACTION: MF to meet with Joseph Healy to discuss the questions he had raised, in particular to performance in the East area.

DATE OF COMPLETION: 21st August 2012

83.6 Martin explained that the reasons for the low levels of performance in the East included an increase in the workload in this area and a greater number of vacancies. The operations team would look to review staffing in the East area and had focussed private ambulance resource in this area to try to recover the position.

83.7 Martin reported that the Trust currently had a contract with St John Ambulance to provide 10 ambulances to the Trust for a period of 12 months. The Trust would also look to introduce an agency staff scheme and would target this resource in the East area. The apprentice paramedic programme was also focussed in the East.

83.8 Beryl Magrath asked whether Martin had any comments about the issue raised in the patient's story about mutual aid staff. Martin responded that the overall feedback from mutual aid staff who had worked over the Diamond Jubilee weekend had been very positive, but consideration would be given to the familiarisation process and how this could be further improved.

Report from the Finance Director

83.9 Mike Dinan reported that the Trust had reported a surplus of £77k for the month against a planned surplus of £81k. The capital was underspent. The overall financial position was broadly on track. Mike suggested that the Finance and Investment Committee look at the detail of this.

83.10 The Chair commented that this was a much better report than had previously been seen by the board and suggested that this report was built into the agenda of the Finance and Investment Committee.

ACTION: MD to ensure that the Finance and Investment Committee reviewed the Finance Report in detail.

DATE OF COMPLETION: 10th July 2012

83.11 Roy Griffins commented that this report was not reconciled with the data in the integrated board performance report and therefore this issue needed to be addressed.

Workforce Report

83.12 Caron reported that the British Medical Association's day of industrial action on 21st June had had no specific, direct impact on the Trust. 520 operations and 4000 outpatient appointments had been cancelled on the day.

83.13 Caron reported that there had been one case of racially aggravated assault on a member of staff. This had gone to court with a guilty verdict.

83.14 Caron added that currently the data within the workforce report related to different periods and she would ensure that this was consistent in the future. The Chair added that any key issues should be highlighted on the front sheet.

Integrated Board Performance Report

83.15 Peter Bradley explained that the Integrated Board Performance Report replaced the balanced scorecard and he welcomed any feedback on the format of the report. The metrics for each of the elements would be reviewed throughout the year.

83.16 Members of the Trust Board agreed that this was a very useful document, which reflected previous discussions about the balanced scorecard, and that the format should be implemented.

84. <u>Presentation on Olympic Preparedness</u>

84.1 Martin Flaherty gave a presentation on Olympic preparedness and reported the following:

- Work was ongoing to prepare for the Olympics. TOPDOG had signed off the operational plans this week. There had been some late additions to LOCOG requirements, but this was not of significant concern and it was thought that these could be accommodated;
- The set up of the Olympic Deployment Centre was on track;
- Rosters were being issued to all staff for the Olympic period;
- In terms of maintaining service delivery, contracts had been agreed with three private ambulance services to provide an additional 45 ambulances per day, with one further contract to sign;
- The Trust was currently in the process of reviewing non-operational staff roles and how they could support operations in the delivery of the service throughout the Olympics;
- A staff handbook would be given to staff and an Olympic bulletin template was being used for operational updates to staff;
- The Heads of Agreement for 12/13 had been signed with NHSL and Commissioners and the schedule of payments agreed;
- Written agreement had been given from the two main LAS trades unions confirming no industrial action during the Games period.

84.2 Overall, Martin stated that the service was in a good position and this was reflected by the smooth running of the service throughout the Queen's Diamond Jubilee weekend. The Trust had previously undertaken some modelling of demand over the Olympic games, but this would need to be revisited on the basis of the current increase in demand. He expected to see the outcome of this piece of work in the next two days.

84.3 The Chair asked whether the increase in demand and the stress on business as usual service delivery would impact on the delivery of the services during the Olympics. Martin acknowledged that the service was very busy at this time but the outcome of the modelling exercise with ORH would determine the next steps. Significant attention was being paid to business as usual operations.

84.4 Lizzy Bovill added that there had been some learning from the Queen's Diamond Jubilee weekend and this would be incorporated into the plans for the Olympics. For example, Paul Woodrow was looking to add cycle response and foot teams into the areas around train stations, as these areas had proven to be very busy over the Queen's Diamond Jubilee weekend.

84.5 Peter Bradley asked whether the Trust had experienced an increase in 999 calls from other healthcare providers. Martin responded that ORH had looked into this and the number of calls received from other healthcare providers was significant. Peter Bradley commented that this was something that should be raised with NHS London and asked Martin to report back on this.

ACTION: MF to report to the Trust Board on the findings of the ORH capacity review and specifically the number of calls received from other healthcare providers.

DATE OF COMPLETION: 21st August 2012

84.6 The Chair asked Martin whether he was satisfied that the rest of the healthcare system in London was prepared for the Olympics and whether this had been considered as part of the Trust's planning. Martin confirmed that this had formed part of the Trust's planning and assurance had been sought from acute Trusts on their Olympic preparedness.

84.7 In response to a question from the Chair, Deane Kennett confirmed that he was confident about the LAS' preparations for the Olympics.

85. CommandPoint Update

85.1 Ed Sturms and Carol Hunter from Northrop Grumman joined the meeting for this agenda item.

85.2 Peter Suter stated that given that the Trust had undergone a major system changeover, the overall position was as expected and the system remained stable. Peter noted that there had been some coverage in the press, linking the Trust's Category A performance to CommandPoint. This was factually inaccurate and any performance issues were as a result in an increase in demand and not due to CommandPoint.

85.3 Peter stated that the next steps were to support the transition to business as usual. The project structure would continue until after the Olympics and would be closed in October/November 2012.

85.4 The Patients' Forum raised a query about whether CommandPoint provided opportunities for patient specific protocols to be communicated quickly to frontline staff. Peter responded that, in this respect, the system operated in the same way as CTAK, but that CommandPoint had an additional function to hold a précis of the key elements of the Patient Specific Protocol and this was already in place.

85.5 Ed Sturms supported Peter's comments and stated that the system had been live since 28th March 2012 and was ready for the Olympics.

85.6 The Chair noted that CommandPoint had not featured significantly in yesterday's board to board meeting with the SHA, which was a good reflection on the status of the project. The Chair stated that he would continue to have regular discussions with Jim Myers at Northrop Grumman until after the Olympics and welcomed the fact that the project structure would be kept open until after the Olympics.

85.7 Board members expressed some concern about any future patches and changes and risks associated with disaster recovery testing. Peter Suter confirmed that this was low risk. Peter added that the project team was currently reviewing the recovery plans and would rehearse operating on paper. During this time, the technical team would test the systems and databases at Bow and on the basis of this test, would look to undertake a full test of the system at Bow. Ed Sturms added that this was an important test and should be undertaken in advance of the Olympics given the level of activity that was expected over the coming months.

85.8 The Trust Board noted this update.

86. Audit Committee Assurance Report

86.1 Caroline Silver reported that there was one matter that she wished to bring to the attention of the Trust Board, which was that operational risks had not been updated in time for the Audit Committee's annual review of the Trust-wide risk register. The Chief Operating Officer had attended the last meeting, but there were still a number of risks to be updated. These risks would be updated in advance of the Risk, Compliance and Assurance Group meeting in July and the Audit Committee had requested that RCAG provide a report directly to the Trust Board in August.

ACTION: MD to provide a report from the Risk, Compliance and Assurance Group meeting to the August meeting of the Trust Board.

DATE OF COMPLETION: 21st August 2012

86.2 Caroline stated that the fact that these risks had not been updated was indicative of a wider issue relating to operational pressure and the demands placed on the team and she wanted to raise this as an early warning from the Audit Committee. Roy Griffins supported these comments.

86.3 The Chair noted these points and agreed that it was important to raise this issue.

87. Board Assurance Framework and Corporate Risk Register

87.1 Sandra Adams reported that the Board Assurance Framework had been updated and noted that the Strategy Review and Planning Committee would be reviewing the strategic risks and risk focus areas at its next meeting in July.

87.2 Sandra added that operational risks would be updated by the end of June and the Risk, Compliance and Assurance Group had been requested by the Audit Committee to review risk target ratings and tolerance levels for all Trust-wide risks at its next meeting in July.

87.3 The Chair expressed some concern that operational risks had not been updated in time for the Audit Committee meeting and stated that the Trust Board could not take assurance on the first strategic risk (care/safety) without this information.

87.4 Caroline Silver stated that the risk register was one of the key assurance documents for the Trust Board and therefore should get more attention at Trust Board meetings. A lot of effort had gone into ensuring that the risk register was a live and dynamic document and it should therefore be given high priority to ensure that it maintained its worth. It was difficult for the Trust Board to obtain assurance from the risk register at the moment, given that a number of the risks had not been updated.

87.5 The Chair noted this point and stated that consideration should be given to how the agenda could be structured to ensure that this got the appropriate level of attention.

ACTION: SA/RH to discuss how the Trust Board agenda could be structured to allow the Trust Board to devote an appropriate level of time to discussing risk management.

DATE OF COMPLETION: 21st August 2012

88. Annual Audit Committee Report 2011/12

88.1 Caroline Silver reported that there were no issues to report and drew attention to the actions that

the Audit Committee had set itself for 2012/13, which were as follows:

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

88.2 The Trust Board noted the Annual Audit Committee Report 2011/12.

89. Amendments to Standing Orders

89.1 Mike Dinan reported that the Standing Orders had been updated to reflect the Trust's new financial services arrangements with ELFS Shared Services. Mike suggested that the Audit Committee review the impact of some of these changes in the coming year.

89.2 The Trust Board approved the amendments to the Standing Orders.

90. Report from Trust Secretary

91.1 Sandra Adams reported that, aside from the tenders listed in the report, an additional nine tenders had been opened yesterday for work to convert vehicles in order to meet the requirements of the Lower Emission Zone.

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

91. Forward Planner

91.1 The Chair noted that the forward planner would need to be reviewed at the next Strategy Review and Planning Committee. Francesca Guy was asked to add an update on CommandPoint to every Trust Board meeting until after the Olympics.

ACTION: FG to add CommandPoint Update to the Trust Board planner for every meeting until after the Olympics.

DATE OF COMPLETION: 6th July 2012

92. Any other business

92.1 There were no items of other business.

93. Questions from members of the Public

93.1 The Chair of the Patients' Forum had submitted a number of questions to the Trust Board. The appropriate members of the executive agreed to follow these up outside of the meeting.

ACTION: LB/FM/MF/SL to respond to the questions from the Patients' Forum outside of the meeting.

DATE OF COMPLETION: 21st August 2012

94. Date of next meeting

94.1 The next Trust Board meeting will be held on 21st August 2012.

……
Signed by the Chair

ACTIONS
from the Meeting of the Trust Board of Directors of
LONDON AMBULANCE SERVICE NHS TRUST
held on 26th June 2012

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
28/06/11	**67.3**	**Chairman's Report** RH to discuss world cities benchmarking with FM.	**RH/FM**	Eagles were looking to share best practice in cardiac care. Canadian and Australasian Ambulance Services were looking to set up a benchmarking group.
27/09/11	**112.5**	RH/PB to meet to discuss whether there was anything further the Trust could be doing to meet the recommendations made by the NAO report.	**RH/PB**	Peter Bradley reported that one of the key recommendations of the National Audit Office report was to introduce the clock start change. This had now been approved and would go live from 1st June 2012. The Trust Board would be kept updated on the impact of this.
27/03/12	**28.7**	RH to discuss with PB his experiences of tackling attitude and behaviour issues.	**RH**	The Chair would discuss the attitude and behaviour action plan with Peter Bradley at their next one to one meeting.
27/03/12	**20.3**	SMG to identify the specific deliverables and deadlines against each of Trust Priorities for presentation at the next Strategy Review and Planning Committee.	**SMG**	The deliverables and deadlines against each of the Trust priorities would be the subject of discussion at the next Strategy Review and Planning Committee in July.

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
29/05/12	**46.3**	LB to publish patient story in the GP newsletter.	**LB**	GP story has been postponed until September as we have prioritised demand management messages for the Olympic period in the July edition.
29/05/12	**48.3**	PB/SL/AP to produce an abridged version of the Quality Account.	**PB/SL/AP**	Due to be completed in September 2012.
29/05/12	**51.2**	LB/MF/PB to discuss with Joseph Healy outside of the meeting the questions he had submitted to the Trust Board, which had not been dealt with at the meeting.	**LB/MF/PB**	Action complete.
26/06/12	**74.12**	RH/SA to discuss how to build in staff presentations into the Trust Board forward planner.	**RH/SA**	
26/06/12	**75.6**	PB to discuss with SL the fact that the Quality Report contained data from different months.	**PB/SL**	Action complete.
26/06/12	**76.2**	RG to check with SL whether it was a statutory requirement for the Quality Account to come to the Trust Board.	**RG**	It is a statutory requirement for the Trust Board to sign off the Quality Account. Action complete.
26/06/12	**77.4**	TH to amend the Annual Infection Prevention and Control Report 2011/12 to show the percentage of staff who had received infection prevention and control training.	**TH**	Action complete.
26/06/12	**78.2**	MF to ask Paul Woodrow why CPI compliance was low in the South area.	**MF**	
26/06/12	**78.3**	FG to add to the Trust Board forward planner a session on complaints and service experience.	**FG**	The Patient Experiences Annual Report is due to come to the Trust Board in September.

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
26/06/12	**78.4**	FM/MD to discuss the possibility of introducing a RAG rating to the CIP report to the Quality Committee.	**FM/MD**	Discussed at the Quality Committee meeting on 15th August 2012.
26/06/12	**83.2**	FG to add a discussion on the increase in demand to the forward planner of the Strategy Review and Planning Committee.	**FG**	Action complete.
26/06/12	**83.5**	MF to meet with Joseph Healy to discuss the questions he had raised, in particular to performance in the East area.	**MF**	
26/06/12	**83.10**	MD to ensure that the Finance and Investment Committee reviewed the Finance Report in detail.	**MD**	
26/06/12	**84.5**	MF to report to the Trust Board on the findings of the ORH capacity review and specifically the number of calls received from other healthcare providers.	**MF**	
26/06/12	**86.2**	MD to provide a report from the Risk, Compliance and Assurance Group meeting to the August meeting of the Trust Board.	**MD**	On the agenda for 21st August. Action complete.
26/06/12	**87.5**	SA/RH to discuss how the Trust Board agenda could be structured to allow the Trust Board to devote an appropriate level of time to discussing risk management.	**SA/RH**	
26/06/12	**91.1**	FG to add CommandPoint Update to the Trust Board planner for every meeting until after the Olympics.	**FG**	Action complete.
26/06/12	**93.1**	LB/FM/MF/SL to respond to the questions from the Patients' Forum outside of the meeting.	**SL**	Action complete.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 21ST AUGUST 2012

PAPER FOR NOTING

Document Title:	**Chairman's report**
Report Author(s):	**Richard Hunt**
Lead Director:	**N/A**
Contact Details:	**marilyn.cameron@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To provide the Trust Board with an update from the Trust Chairman on key activities since the last meeting**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Other
Recommendation for the Trust Board:	**To note key activities since the last meeting**

Executive Summary

Since the last Trust Board I have attended a Capsticks meeting on the Implications of Health and Social Care bill, attended City Hall to meet the new members after the election and joined an evening get together of the LAS Retirement Association. There have been Finance and Investment Committee meetings, the ASN board meeting, RSM Tenon meeting on Quality Governance and a meeting concerning the FTN. We have also held a Remuneration Committee meeting.

I have met the Head of Victoria Ambulance Service, Australia, Danny Milligan and Jim Myers of Northrop Grumman, Ruth Carnall, CEO and Mike Spyer, chair of NHS London. Martin Flaherty and I visited the TfL control room just prior to the Olympics, for reassurance over preparations for the Olympic Games.

I have met representatives of UNISON, conducted six preliminary meetings before the CEO appointment interviews, held a CEO shortlist interview and participated in the interviews for Director of Strategy and Development and held meetings with non executive colleagues regarding next steps on our FT application.

Key issues for the Trust Board

N/A

Attachments

None.

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

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

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

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

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

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

Equality Analysis

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

Key issues from the assessment:

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 21 AUGUST 2012

PAPER FOR INFORMATION

Document Title:	**Quality Dashboard & Action Plan**
Report Author(s):	**Steve Lennox**
Lead Director:	**Steve Lennox**
Contact Details:	**Steve.lennox@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Inform Trust Board current position against quality measures**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ✓ Senior Management Group ✓ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Other
Recommendation for the Trust Board:	**To note the report**

Key issues and risks arising from this paper
This report identifies that the LAS remains the top performing Ambulance Trust in the country when using the DH indicators as the measure.

Executive Summary
There are three components to the Quality Dashboard & Action Plan

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

The June dashboard illustrates 38 measures for quality and reveals 15 Green measures (11 last month) 7 Amber measures (10 last month) and 15 Red measures (15 last month), and 1 not populated. This is the strongest dashboard presented to date. If we can improve category C performance this would significantly strengthen the overall assessment of quality.

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

Some of the 11 DH measures (service experience has been excluded) are made up of a number of indicators. June A8 was not reported by the DH and is therefore not included.

The Trust is at the very top in 13 of the indicators

The following table illustrates the number of top performing measures each Ambulance Trust has in the 45 information points (not all comparisons are drawn from statistically significant data therefore, this is merely a discussion point).

London 13 (29%)
Great Western 6 (13%)
Isle of Wight 5 (11%)
North West 5 (11%)
Yorkshire 4 (9%)
East of England 4 (9%)
North East 3 (7%)
South Central 3 (7%)
South Western 1 (2%)
South East Coast 1 (2%)
West Midlands 0 (0%)
East Midlands 0 (0%)

3. Quality Action Plan

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

Attachments

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

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Quality Strategy

This paper supports the following domains of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

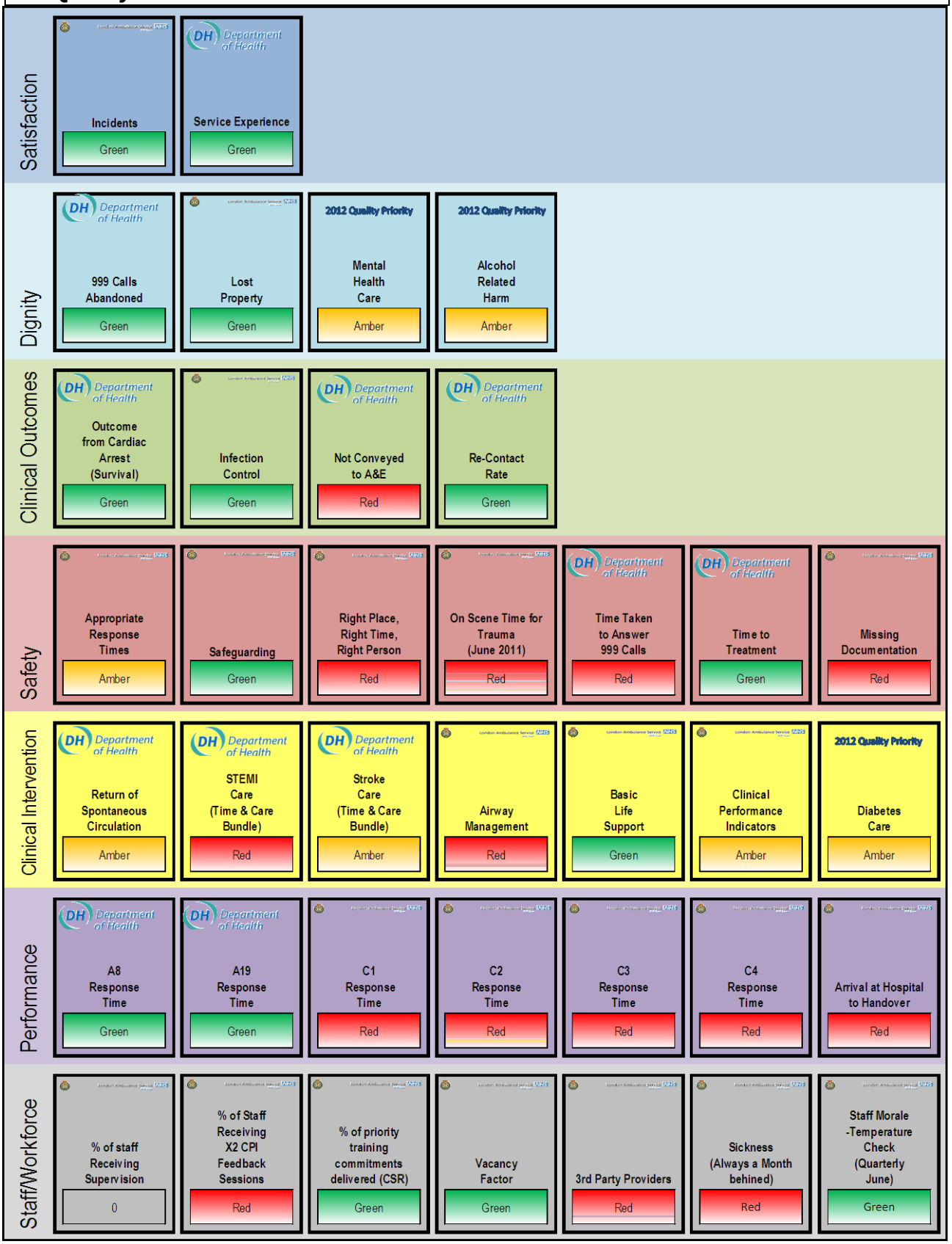
Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

- ☐ Yes
- ✓ No

Key issues from the assessment:

1. Quality Dashboard for June 2012



The Dashboard supports the corporate objectives; **CO1** - To improve the experience and outcomes for patients who are critically ill or injured. **CO2** - To improve the experience and provide more appropriate care for patients with less serious illness and injuries. **CO3** - To meet response time targets routinely. **CO4** - To meet all other quality, regulatory, and performance targets. **CO5** - To develop staff so they have the skills and confidence they need to deliver high quality care to a diverse population. **CO6** - To create a productive and supportive working environment where staff feel safe. **CO7** - To use resources more efficiently and effectively. **CO8** - To maintain service performance during major events, both planned and unplanned. **CO9** - To improve engagement with key stakeholders

2. Comparison Table

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

2.2 The GREEN shading represents where the Trust is in the upper quartile when compared to other services. In June we were upper quartile in 21 (last month 18) out of 42 areas (A8 not reported by DH in June).

	March (December)			Year to Date	
	Compliance	Rank	Direction of Travel (Compliance)	Compliance	Rank
A8 Response Time			↑		
A19 Response Time	98.3%	1	↑	98.2%	1
ROSC (all)	31.1%	2	↑	29.2%	1
ROSC (Utstein)	47.6%	4	↑	52%	1
Time Taken to Answer 50th Percentile	0	1	↔	0	1
Time Taken to Answer 95th Percentile	11.0	5	↑	61%	8
Time Taken to Answer 99th Percentile	106	11	↓	281	10
Time to Treatment 50th Percentile	348	10	↑	1038	9
Time to Treatment 95th Percentile	864	2	↑	2604	3
Time to Treatment 99th Percentile	1404	3	↔	4164	5
Outcome from cardiac Arrest Survival	8.4%	2	↑	9	1
Outcome from cardiac Arrest Survival (Utstein)	34.1%	1	↑	30.4%	1
STEMI Outcome 150 minutes	91.5%	4	↓	92.1%	4
STEMI Outcome Care Bundle	69.6%	9	↓	61.7%	11
Stroke Outcome 60 minutes	61.8%	6	↑	64.4%	6
Stroke Care Outcome Bundle	95.7%	7	↓	91.3%	11
Calls Closed with CTA	5.4%	9	↓	5.3%	9
Non A&E	32.1%	9	↑	31.3%	10
Re Contact rate CTA	2.7%	1	↓	3.1%	2
Re Contact rate See & Treat	4.1%	2	↓	4.3%	2
Re Contact rate Frequent callers	2.6%	5	↓	2.6%	5
999 Calls Abandoned	0.2%	1	↔	0.2%	1
Service Experience	No measure				

Quality Improvement Actions

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

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

		addition the training of the care bundle is being refreshed (added February 2012).				
Safety	Appropriate Response Times	Clinical Audit to recover the data and ensure a data set is available for the next report (added February 2012).	Quality & Clinical Directorate	Director of Health Promotion & Quality & Medical Director Fionna Moore & Steve Lennox		Completed March 2012
Safety	Appropriate Response Times	To be discussed at Senior Managers Conference and Area Quality Meetings (added May 2012)	SMG	Director of Health Promotion & Quality & Medical Director Fionna Moore & Steve Lennox	↑	Awaiting to see benefits from discussion at senior managers conference
Safety	Safeguarding	East area to focus on improving the timeliness of safeguarding referrals (added February 2012). Ensure maximum attendance at remaining CSR 1 sessions (added February 2012)..	East Area Governance Committee Training & Strategy Group	Assistant Director of Operations. Katy Millard Chief Operating Officer. Martin Flaherty		Completed May 2012

Safety	Right Time, Right Place, Right Person	Clinical Audit to recover the data and ensure a data set is available for the next report (added February 2012).	Quality & Clinical Directorate	Director of Health Promotion & Quality & Medical Director Fionna Moore & Steve Lennox		Completed May 2012
Safety	On scene time for Trauma	Area Governance Committee to report to CQSE the local action taken (added February 2012).	Area Governance Committees & CQSEC	PIMS		Too early in reporting cycle to report benefits. Not reported in March Quality Dashboard

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

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 21 AUGUST 2012

PAPER FOR APPROVAL

Document Title:	**Safeguarding Annual Report**
Report Author(s):	**Steve Lennox, Kudakwashe Dimbi, Lysa Walder, Alan Hay, Levi Sinden, Dawn Mountier, David Williams**
Lead Director:	**Steve Lennox**
Contact Details:	**020 7783 2299**
Why is this coming to the Trust Board?	**Statutory requirement to produce an annual report on safeguarding for Trust board. This is shared with Local Safeguarding Boards.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ✓Senior Management Group ✓ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other
Recommendation for the Trust Board:	**To approve the report**

Key issues & risks arising from this report

None.

Executive Summary

It is a statutory requirement to produce an annual safeguarding report for Trust Board and is monitored by commissioners and CQC.

The report contains updates on children, adults, mental health, learning disability, Prevent and also domestic violence. It is clear that the safeguarding requirements and expectations grow each year and the EBS team face pressure to keep up with the increasing number of referrals.

The report outlines many successes and identifies a strengthening of safeguarding children within the organisation. Mental health and learning disability are also strong areas but we have more work to do with safeguarding adults and ensuring local engagement. The new clinical advisor role for safeguarding adults will assist in strengthening this.

The summary of the report is;

- The safeguarding portfolio has significantly strengthened during the course of the year. The scorecard is embedded into the work of the committee and appears as a RAG rated measure on the Trusts Quality Dashboard.
- The indictors within the scorecard are demonstrating improvements during the course of the

year.

- All four Action Plans are progressing very well but the need to establish the Committee for Vulnerable & Disadvantaged Groups would help strengthen external scrutiny.
- There is a gap within level 1 safeguarding training and the Trust needs to complete its annual section 11 audit.
- The Trust needs to improve local engagement with Safeguarding Boards.
- We need to focus more attention on Prevent and ensure we have a well understood process for referrals.
- MARAC requirements need careful consideration.
- Overall we believe we are compliant with CQC standards for safeguarding.

Attachments

Safeguarding Annual Report 2011/12

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

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

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

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

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

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

Equality Impact Assessment

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

Key issues from the assessment:

Annual Safeguarding Report (Board Report) 2011/12

1.0 Introduction & Background

1.1 Overall we believe we are compliant with CQC standards for safeguarding.

1.2 Safeguarding is currently in the middle of a radical overhaul at a national level and some issues are still unresolved by the coalition government. Safeguarding guidance has been extensive and complex and this introductory section provides a summary and update for Board members

NHS responsibilities for Safeguarding Children

1.3 There is a clear definition to the term child. This is defined in the Children Acts 1989 and 2004 respectively and is anyone who has not reached their 18th birthday

1.4 Following the death of Victoria Climbie and Peter Connelly Lord Laming published in March 2009 “The protection of Children in England: A Progress report”. He confirmed that robust legislative, structural and policy foundations are in place, but organisations needed to work closer together.

1.5 In May 2011, Professor Eileen Munro released the final report of her review of the UK child protection system. This report called for a radical reduction in the central prescription and a move towards local decision making. Professor Munroe is of the opinion that centralised command and control accompanied with prescriptive rules inhibits rather than enhances professional judgement. This view has been wholly supported by the Government and we are seeing a radical reduction in the rules and “must do’s”. During the past year the Government has been working towards the implementation of the recommendations and has issued three documents that are currently for consultation.

Document 1: Working Together to Safeguard Children.

1.6 This document outlines what is expected of individual organisations. This contains the statutory elements and these have been clarified as follows;

- a clear line of accountability and governance within and across organisations for the commissioning and provision of services designed to safeguard and promote the welfare of children;
- a board-level lead to take senior leadership responsibility for the organisation's safeguarding arrangements;

- a culture of listening to and engaging in dialogue with children and taking account of their wishes and feelings both in individual decisions and the establishment or development and improvement of services;
- arrangements to share relevant information;
- a designated professional lead (or, for health provider organisations, a named professional) for safeguarding. Their role is to support other professionals in their agencies to recognise and respond to the possible abuse and neglect of a child or young person; and
- appropriate supervision and support for staff, including undertaking safeguarding training
- NHS Trusts and NHS Foundation Trusts to be members of their Local Safeguarding Boards in their local authority area;

Document 2; Managing Cases: the Framework for the Assessment of Children in need and their Families.

1.7 This document guides the assessment process.

1.8 The most striking change is the removal of the nationally prescribed model for "assessments of children in need" along with the nationally prescribed timescales. There are some aspects of the document that are relevant to health but the majority do not affect those of the ambulance service. There are a few points regarding referrals of relevance to the Trust;

- Anyone who has concerns about a child's welfare can make a referral to local authority children's social care. Referrals will come from the child themselves, professionals such as teachers, the police and health visitors as well as family members and members of the public. Local authority children's social care has the responsibility to clarify with the referrer the nature of the concerns and how and why they have arisen
- When professionals refer into children's social care, they must include any information they have on the child's developmental needs and the capacity of their parents to meet these within the context of their wider family and environment
- The referrer must always have the opportunity to discuss their concerns with a qualified social worker. Local authority children's social care should make clear how this should happen. Within one working day of a referral being received, a social worker must make a decision about the course of action to be taken. The social worker will need to make a professional judgment as to what type and level of help and support is needed, record this and feed back to the referrer and the child and their family

Document 3: Statutory Guidance on Learning and Improvement:

1.9 *This document* proposes new arrangements for serious case reviews of children. This piece of guidance outlines the role of the Serious Case Review and moves this process to the very centre of learning and analysis.

1.10 In addition to the changes being made following the Munroe review there are changes taken place to the commissioning of Safeguarding. Clarity on safeguarding arrangements have been relatively slow to materialise but it now appears that Safeguarding will form part of the responsibilities for the Directors of Public Health and they will need to work closely with Clinical Commissioning Groups.

1.11 The Clinical Commissioning Groups will need to identify a lead for children and young people and will take the lead for commissioning safeguarding. They will be required to assure themselves that their provider organisations are adhering to best standards. These standards include;

- Present to their Board regular performance and activity reports as well as an annual report on safeguarding children that s published as a public document
- Make public declarations of safeguarding children arrangements posted on its website and updated every 12 months
- Participate in section 11 audits
- Submit a complete performance monitoring dashboard or other performance management data to Clinical Commissioning group on a quarterly basis (or as agreed locally)
- Provide assurance of CQC registration
- Compliance with any DH, CQC, NHS London or successor organisations requirements to make performance management information publicly available
- Inform designated professionals about any requirements imposed on them by the CQC
- Provide the designated professionals with any details of any referrals of allegations against staff to the Local Area Designated Officer (LADO)
- Be able to demonstrate evidence of working towards meeting standard 5 of the Childrens National Service Framework.
- Undertake regular audits
- Demonstrate they have acted on recommendations from internal management reviews, serious case reviews and national enquiries.
- Ensure regular research based safeguarding children supervision is provided for staff who have contact with children and young people.
- Contribute as required to the LSCB annual report.

NHS responsibilities for Safeguarding Adults

1.12 There has been considerably less documentation and guidance governing the safeguarding of adults but essentially the emerging methodology mirrors that of children.

Safeguarding Adults The Role of Health Service Managers & their Boards.

1.13 Published in 2011 and In keeping with the Government's approach to decentralisation and local flexibility, this document does not prescribe processes or targets. However, the Government has agreed safeguarding principles that can provide a foundation for achieving good outcomes for patients

1.14 Safeguarding adults involves a range of additional measures taken to protect patients in the most vulnerable circumstances, patients that are currently defined within No Secrets (the DH guidance published in 2000) as 'vulnerable adults'. This may be due to illness, impaired mental capacity, physical or learning disability or frailty brought about by age or other circumstance.

1.15 On the whole the guidance follows a similar pathway to the guidance governing children. There are six fundamental principles underpinning the safeguarding of adults..These are;

- Use the safeguarding principles to shape strategic and operational safeguarding arrangements
- Set safeguarding adults within the services' strategic objectives
- Use integrated governance systems and processes to prevent abuse occurring and respond effectively where harm does occur
- Work with the local Safeguarding Adults Board, patients and community partners to create safeguards for patients.
- Provide leadership to safeguard adults
- Ensure accountability and use learning within the service and the partnership to bring about improvement

How are we responding to Safeguarding

1.16 The largest part of our safeguarding workload is the safeguarding adults. These generate more referrals than children. However, within adults there are certain vulnerable groups in which we need to focus attention; mental illness and learning disabilities.

1.17 The Trust manages the Safeguarding agenda through a number of work streams. These are; Adults, Children, People with Learning Disabilities, People with Mental Illness and Prevent.

1.18 At present we have a named lead for children, adults (vacant at the time of writing) mental health and prevent. Learning disabilities is delivered through a hub and spoke model via the learning disabilities group.

2.0 Safeguarding Arrangements

2.1 The safeguarding committee drives the Trust's action plan for safeguarding children and the safeguarding of adults and the committee meets every two months. The attendance record for safeguarding is enclosed as appendix I

2.2 The Trust has a number of roles within the organisation that have a specific safeguarding remit.

- Executive Lead: Steve Lennox, Director of Health Promotion & Quality
- Named Professional for Children: Lysa Walder, Clinical Advisor for Safeguarding.
- Named Professional for Adults: Currently vacant but Levi Sinden is covering aspects of the role.
- Lead Manager: Gary Bassett, Head of Patient Experience
- Educational lead: Gary Ralph, Practice Learning Manager
- Lead Doctor; Fionna Moore, Medical Director (as an Ambulance Trust we are not required to have a named doctor)
- Lead for referrals: Alan Hay, Emergency bed Services Manager
- Lead for mental health: Kudakwami Dimbi, Clinical Advisor
- Lead for Prevent: David Williams, Emergency Planning Advisor

2.3 There are a number of roles within the Patient Experience team and at complex level that have a specific remit in leading, championing or managing safeguarding for the Trust.

3.0 Safeguarding Governance Arrangements

3.1 The Safeguarding Committee reports to the Clinical Quality, Safety, and Effectiveness Committee and makes a short report at every meeting The Clinical Quality, Safety, and Effectiveness Committee reports safeguarding to the Quality Committee unless there is a direct report from the Safeguarding Committee to the Quality Committee.

3.2 The Safeguarding Committee is dominated by the work regarding children as this is where the stronger emphasis of legislation rests.

3.3 The designated nurse from our commissioning team is a member of the Safeguarding Committee.

3.4 The public are represented on the committee through the membership of the Patient Forum.

3.5 The Coalition Government has published its Vetting and Barring Scheme Review, but until new legislation to implement the changes is introduced, the current safeguarding responsibilities remain. This includes the legal duty for the Trust to inform the Independent Safeguarding Authority (ISA) if our organisation dismisses or removes a member of staff/volunteer from working with children and/or vulnerable adults because they have harmed a child or vulnerable adult. We have had no cases of this nature in 2011-2012.

3.6 The Trust has an obligation to inform the Local Authority Designated Officer of any concerns regarding our staff. This has occurred on two occasions during 2011-2012.

Partnership Working

3.7 It is a statutory requirement for us to attend Local Safeguarding Children Boards.

3.8 The Director of Health Promotion & Quality is a member of the Tri Borough Safeguarding Board. Locally, at individual complex level, attendance is not consistent. Across the service there are only 7 complexes regularly attending LSCB meetings. This is being addressed through identification of local safeguarding representatives and monitoring of attendance by the Named Professional. A hub and spoke model is being developed for the monitoring of attendance and the feeding into the corporate system any local learning.

3.9 A similar model will be adopted for the attendance of safeguarding adults meetings once the named professional has been recruited.

4.0 Education & Training

4.1 Education requirements are broken into Level 1, 2 and 3 training depending upon the degree of contact an individual employee has with children. As a

Trust we undertake both safeguarding adults and safeguarding children training within the same safeguarding session.

Level 1 Training

4.2 There is a plan to undertake level 1 training via on on-line package. The on-line package has been tested and is of no cost to the organisation. However, we are unable to roll this out across the Trust until OLM is implemented as we will be unable to capture successful completion of the training. It is anticipated that this will start before the end of 2012.

Level 2 Training

4.3 Level 2 training is the training given to all of our clinical staff who come into contact with children and this has been our priority.

4.4 The LAS has systems and processes in place to ensure a methodical & systematic approach to core training (which includes Safeguarding) for all 'front line' ambulance staff. This approach includes the processes to analyse training needs, plan, develop, deliver and evaluate core training, and assesses the implementation of the training on the Trust.

4.5 The LAS reviewed the core training requirements and produced a Training Needs Analysis (TNA) for all staff in line with legislation, national and professional guidance, in order to inform ongoing policy development and underpin design and delivery of appropriate Core Training programmes, in the correct volumes and at the correct levels.

4.6 Current guidance means the LAS specifies Safeguarding Children & vulnerable adults training as mandatory.

4.7 In 2011-2012 67% of our clinical staff received level 2 training.

Level 3 Training

4.8 Level 3 training. Level Three training was delivered to 27 key staff during the year . Staff were from Patient Experience Department, Emergency Bed Services, and the Clinical & Quality Directorate. Training was delivered by the Designated Nurse for Safeguarding Children for the Trust. These teams were targeted as they have a role in supporting front-line staff with safeguarding concerns. Further Level 3 training is to be delivered to all Local Safeguarding Reps (In September) to raise awareness of safeguarding issues and the duty to attend LSCB meetings in the future.

4.9 To date 78% of the Patient Experience Team have had level 3 training, 38% of the Emergency bed team and 70% of the Clinical & Quality Directorate.

4.10 Finally, the Board still needs to have awareness training.

5.0 Raising Awareness

5.1 One important aspect of Safeguarding is the need to raise awareness and a number of events and processes have taken place this year.

5.2 On 21 February 2012 a dedicated members event on safeguarding took place where our action plans and main issues were presented to members. This was very well evaluated by the attendees.

5.3 We have not yet established our parent committee "Committee for the Disadvantaged & Vulnerable Patient" this is due to difficulty in recruiting external membership. Save the Children have agreed to join as has a representative from NHS London. We are also discussing another Ambulance Trust Director joining the group. If in agreement this should complete the membership until we have appointed Governors who can also join the membership.

6.0 Audit

6.1 We did not complete our section 11 audit in 2011-2012. This audit is essentially a self assessment against the expected standards associated with safeguarding. We did however undertake a wider self assessment of our safeguarding adults work and reported this to the SHA.

6.2 The section 11 audit is currently being completed by the Clinical Advisor for Safeguarding Children.

7.0 Quality

7.1 The Trust has undertaken a number of initiatives to improve quality. Quality controls in referrals have been introduced (this is reported in section 9) and a number of other initiatives have also been developed. These are as follows:

- The balance scorecard is now embedded into the work of the safeguarding committee and used to monitoring safeguarding practice.
- The Trust has action plans in place for
- Children
- Adults
- Learning Disability
- Mental Health
- The Safeguarding Committee has representation from Operations with the addition of the Assistant Director of Operations (East) and a

member of the Clinical Telephone Advice team but representation from control services is limited

- The Trust has external members (Metropolitan police & Designated Nurse) and a patient representation on the Safeguarding Committee.

8.0 Supervision

8.1 The main vehicle for providing supervision is through the Operational Work place Reviews (OWR). These include Safeguarding elements and gave an opportunity for Team Leaders to assess knowledge and awareness of safeguarding issues and the understanding of the policies and processes in place during an observational shift with frontline staff.

8.2 Formal safeguarding supervision is also being planned for EBS, Clinical Hub and Local Safeguarding reps

9.0 Referrals

9.1 Referrals are our main contribution to the wider safeguarding agenda. By identifying children at risk and notifying local authority we are making a significant contribution to the welfare of children and vulnerable adults.

9.2 Referrals have continued to rise this year, both in absolute numbers and also as a share of all Trust incidents. This year saw a total of 12,337 referrals, an increase of 30% on last year's total of 9,443. The % of total incidents resulting in referral increased from 0.9% last year to 1.2% this year. The reasons for this are various: there is a long-term upward trend we have seen for several years to do with broad cultural change both in the Trust and more generally. Specifically this year has seen both rollout of Core Skills Refresher training and the inclusion of Safeguarding in the Mental Health CPI, both of which have driven up referral rates. The share of adult to child referrals remains fairly constant at around 10:3.

Safeguarding

Figure 1: Total Safeguarding Referrals by month for 2011-2012

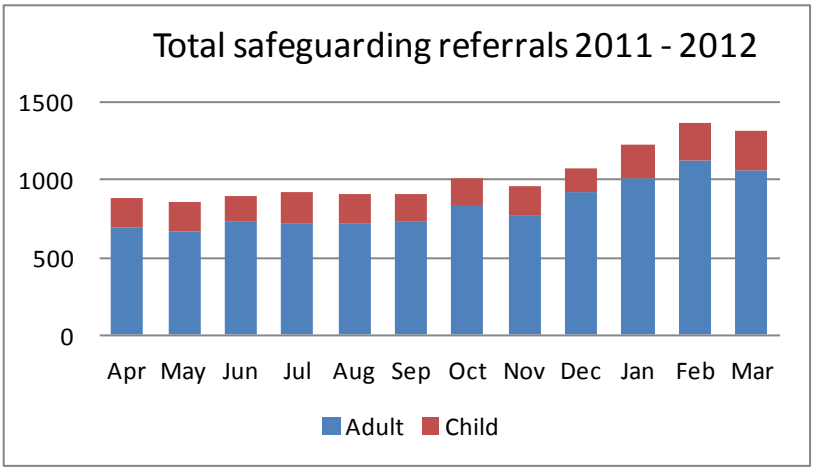
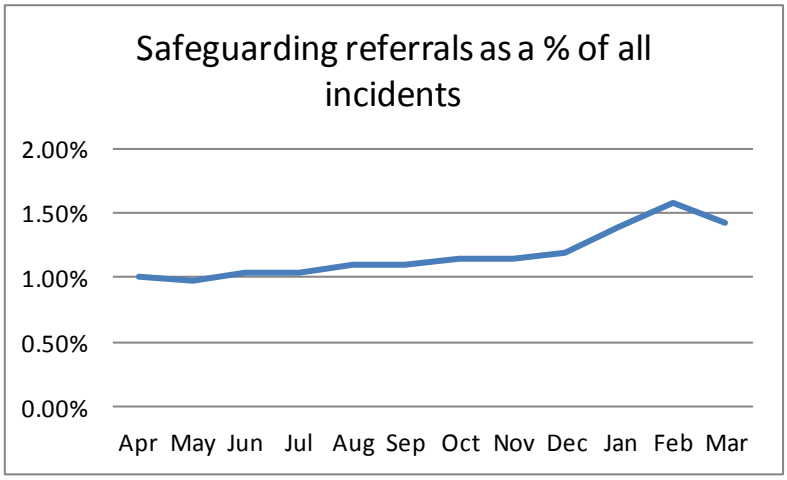


Figure 2: Total Safeguarding Referrals as a % of all incidents by month for 2011-2012



9.3 Delays in referrals have generally improved. Only about 6% of referrals are delayed more than a couple of hours after the incident, and the bulk of these delays are concentrated in a few complexes. This is an improvement on last year's total of just over 8%. Work is being undertaken to manage this problem at complex level, and we expect to see further improvements.

9.4 We continue to receive very little in the way of feedback from Local Authorities. This is a statutory obligation and features highly in Munroe's review.

9.5 Some Local Authority colleagues have raised questions as to the urgency of some of our out-of-hours referrals, suggesting they could be managed differently and passed on the next working day. A plan has been devised to

explore this possibility, associated with the piloting of direct telephone referrals scheduled for Quarter 3 of 2012/13.

10.0 Incidents

10.0 The patient experiences department works with external agencies such as local authorities and other Trust departments, in order to ensure that the Trust is compliant with its statutory responsibilities set out in the Children Act 2004 and duties under the No Secrets guidance.

10.1 Of the 688 enquires that were dealt with in 2011-2012 192 resulted in the Trust being asked to undertake further enquiry; such as the completion of an Independent Management review or a Form B.

10.2 13 of these progressed to be Serious Case Reviews and 2 had recommendations for the Ambulance Service (there is also a third case that arose in 2010-2011). These recommendations are essentially regarding missed opportunities to make referrals and are addressed with individual members of staff through reflective practice.

11.0 Serious Incidents

11.1 There were no serious incidents with a safeguarding element in 2011/12. There was one notable incident involving an infant death during the period 2011-2012 . The Trust was advised by a hospital Risk Manager that they had declared a Serious Incident regarding an infant death. Concerns had been raised that the ambulance dispatched to the patient‟s address had waited outside for the Metropolitan Police Service (MPS) to arrive. The outcome of the investigation is yet to be received by SMG.

12.0 Employment Practice

12.1 All appropriate Trust employees have undergone a CRB check. The Trust undertakes an enhanced CRB check and ISA checks on appropriate recruitment and role changes.

12.2 We need to tighten the guidance on how to manage concerns regarding employees. Guidance is available from the London procedures but this need's to be incorporated into our own Safeguarding Policy. This is being reviewed at the present time.

13.0 Safeguarding Children

11.1 The safeguarding of children is monitored by the Trust's Safeguarding Committee and they monitor the implementation of the children action plan which is led by the Clinical Advisor for Safeguarding. This is divided into a number of work streams.

Work stream A1 Risk of staff not recognising safeguarding indicators and therefore failing to make a timely referral. ***Status: open***

11.2 This is identified on the Trust Risk Register. Missed opportunities to make safeguarding referrals are collated and added to Datix, Feedback provided to staff from Team Leaders or Complex Trainers to support learning around safeguarding issues.

11.3 Operational Workplace Reviews, our main vehicle for supervision, is now undertaken regularly at all complexes although the Trust is not yet meeting the expected trajectory for 2012-2013. This includes safeguarding.

11.4 CSR2 training identifies the occasions when referrals are likely and this has been successfully rolled out with Safeguarding also being a 'Hot Topic' and regularly updated.

11.5 Referrals made for safeguarding children are increasing in numbers and continue to be of a better quality/legibility. In addition they are being made in an increasingly timely manner.

11.6 However, as this remains a risk for the Trust and we continue to see a small number of missed referrals this remains open on the action plan.

Workstream A2. Re-designation of Named Professional. ***Status: closed***

11.7 The named professional role was re-designated during 2011-2012 to the newly established position of the Clinical Advisor for Safeguarding Children,

Workstream A3 Partnership Working. ***Status: open***

11.8 The Named Professional for Safeguarding Children has met most of the local reps across London to establish a benchmark of safeguarding awareness, training, and attendance at LSCB meetings. This information has been collated in a database and provides a framework to build on.

11.9 Safeguarding is included in the new Social media Policy currently being drafted.

11.10 We still have work to do in ensuring local engagement takes place and this is a key area of focus for the Clinical Advisor. Therefore this remains open on the action plan.

Workstream A4 Education and Development. ***Status: Open***

11.11 Training undertaken as detailed in the previous training section of this report.

Workstream A5. Supervision. (Commissioned Standards & CQC) ***Status: Open***

11.12 Supervision is now being addressed through OWR but there are a few outstanding actions and OWR is not yet undertaken as comprehensively as we would wish so this work stream remains open.

Workstream A6. Clinical Governance and Risk Management. (Commissioned Standards, CQC & SIT Visit) ***Status: Open***

11.13 The majority of actions have been closed the remaining action is to ensure the High Risk Register procedures reflect safeguarding practice.

A7. Employment Practice (Commissioned Standards & CQC) ***Status: Open***

11.14 The majority of actions are closed. The open actions are regarding the need to strengthen the guidance regarding allegastions against staff and the safeguarding issues of social media. These are currently beign addressed.

Workstream A8 Procedures and Guidance. ***Status: Open***

11.15 The Safeguarding Children Policy is in the process of being reviewed and the management of Intoxicated Minors has been added to the draft (this was a CQUIN requirement for 2012-2013) and strengthening of the guidance on staff involved in safeguarding allegations.

11.16 Articles have been written for Clinical Updates on Female Genital Mutilation and the dangers of Blind Cords (Asphyxiation).

Workstream A9.Annual Report. (Commissioned Standards & CQC) ***Status: Closed***

11.17 This report meets the requirements of this work stream

Workstream A10. Audit. (Commissioned Standards, CQC & SIT visit ***Status: Open***

11.18 The Clinical Advisor for Safeguarding is currently undertaking the Section 11 Audit. This is our self assessment against mandatory and statutory elements.

Workstream A11. Unable to assure that the current taxi contract accommodates the guidelines for regulated activity (Risk Register) ***Status: Suspended***

11.19 This action is currently not progressing until we hear the outcome of the Government review. Guidance is expected shortly. .

Workstream C. Learning from Serious Case Review Recommendations. ***Status: permanently Open***

11.20 Articles providing information to inform staff about best practice in safeguarding children are regularly published in the LAS News. They are anonymous cases based on action plans that result from SCRs.

14.0 Safeguarding Adults

Safeguarding Adults and Assurance Framework

14.1 In March 2011, the Department of Health published a Safeguarding Adults and Assurance Framework to enable health Trusts to identify how well they are meeting their safeguarding adult responsibilities. This served as a gap analysis tool for the Trust and identified that (using a scale of 1 – 4, with 1 being 'not effective') 16 out of 20 measures were self graded as effective.

14.2 Areas for improvement include partnership working, improving transparency, contracts and procurement, all of which are included in the action plan for future development Although this is not validated externally, it is indicative of the Trusts position and sets us on the right path for improvement given that the measurements are taken, in part, from the CQC Essential Standards for Quality and Safety.

14.3 The Safeguarding Adults Action plan is very new to the Trust it is also monitored by the Safeguarding Committee and is divided into workstreams.

Workstream A1. Risk 343. There is a risk of staff not recognising safeguarding indicators and therefore failing to make a timely referral (Risk score 16) ***Status: Open***

14.4 The actions have now been populated and the work pattern is very similar to that of children.

Workstream A2. Service Strategy. ***Status: Open***

14.5 The Safeguarding Adults policy is currently being drafted.

Workstream A3. Procurement. ***Status: Open***

14.6 This is the most challenging part of the action plan as it requires us to know and assure that any contracted services are adhering to our safeguarding guidance. This features as part of the 2012 work plan for the safeguarding committee.

Workstream C. Learning from Serious Case Reviews ***Status: Open***

14.7 The Serious Case Review concept is relatively new across London. Consequently we have only had involvement in two cases to date and there were no service wide implications. Undoubtedly this will change as local authorities embed their safeguarding adults processes.

15.0 Learning Disability

15.1 The Trust has been extremely successful in its work with learning disabilities. A self assessment, led by the SHA, was undertaken during 2011-2013 and the outcome for the Trust was extremely positive with evidence that the Trust prioritises learning disability. The recent patient story at Trust Board is an example of the evidence produced. Again the Trust's action plan is divided into work streams.

Workstream 1. Improving access to information about LAS for people with learning disabilities ***Status: Open***

15.2 The Trust is unable to progress this beyond the Trust's web site as we are currently unable to support our work with a range of leaflets. However, we have produced a small range of material including a "choose well" leaflet in easy and the development of a telephone prompt card for use with learning disabilities. This workstream only has one remaining action

15.3 In addition, we have reviewed the content of our web site with a view to accessibility for those with learning disability.

Workstream 2. Improve staff education and training on learning disabilities and provide aids and techniques for staff when dealing with learning disabled patients ***Status: Open***

15.4 This area has received the most focus and a significant amount of work has been achieved.

- Developed a training package for the Olympic staff.
- Developed a wider training package with the support of MENCAP
- Developed a communication aid booklet for staff

- Developed a DVD for patients with learning disability on the ambulance service
- Completed case studies in clinical update.

Workstream 3. Introduce data capture of disabled people accessing our services. ***Status: Open***

15.5 The committee has been unable to progress this until disability is captured on the PRF. This is due to change this Autumn from which point it should be possible to look at outcomes for patients with a learning disability.

Workstream 4. Improve partnership working with learning disabled groups ***Status: Closed***

15.6 This work stream was closed during the year. We have representation from MENCAP on the committee and we have a high presence at various learning disability groups through the work of Margaret Vander's community involvement teams who attended 25 learning disability groups in 2011-2012.

Workstream 5. Assurance regarding CQC requirements ***Status: Closed***

15.7 Our compliance with CQC standards and learning disabilities is considered at every committee meeting, We are able to demonstrate compliance with all elements although the Trust would benefit form completing an audit of consent. This has been planned for some time and is now being led by the Deputy Director of Corporate Services.

Workstream 6. Being taken to a hospital of choice (one you are known to) ***Status: Closed***

15.8 The Trust whenever possible now conveys patients with learning disabilities to the hospital where they are known. This action was requested by MENCAP members who now report an improvement.

Workstream 7 Membership ***Status: Open***

15.9 This workstream is essentially about wider engagement from the Trust. The committee has a very active passionate membershio but there is weak representation from operations at the committee.

Workstream 8 Publicising the Successes with learning Disability ***Status: Closed***

15.10 During 2011-2012 the committee communicate the work of the committee and the success through a variety of platforms.

16.0 Mental Health

16.1 A new Mental Health CPI has been developed in collaboration with LAS clinical leads in mental health. This was launched on the 1st April 2012. It list 13 aspects of Care which have to be assessed and recorded. Two of these aspects of care are that a Safeguarding referral for patient has to be considered and Safeguarding referral to be completed for all children on scene. Early impressions of the MH CPI suggest good practice and improvement with our safeguarding referrals and procedures.

16.2 One of the recommendations which came out of the clinical audit of the care given to patients with a suspected or diagnosed mental health disorder by the London Ambulance Service was that LAS should provide training to ambulance crews so that they are familiar with the definition of the term 'neglect' and of a 'vulnerable adult' included in the LAS procedure document 'TP-019 Suspected Abuse of Vulnerable Adults Procedure'. This training should educate crews to consider safeguarding when attending a patient with a mental health disorder and the procedures surrounding the completion of a safeguarding referral. As part of future planning, the MH e-learning package is currently being reviewed and these issues should be specifically highlighted in the updated version of the learning package.

16.3 An important question concerns the risk to patients who fail to opt in to mental health referrals/assessments and are therefore not seen/followed up which could leave vulnerable adults with no support. In this regard, LAS is working on getting mental health viewed as an opt out rather than an opt in to avoid potential safeguarding concerns falling through the net.

16.4 A full update is reported in the Trust's Annual Mental Health Report 2011-2012.

17.0 Prevent

17.1 Prevent is one of the strands of the Governments counter-terrorism strategy, CONTEST. The PREVENT strand seeks to stop people from becoming terrorists or supporting terrorism.

17.2 The revised PREVENT strategy was released in 2011, and aimed to incorporate all of the partner organisations that could potentially influence radicalisation in the community. 16 of the 31 boroughs in London were identified as high priority in the new strategy, showing the importance of all London Health organisations in the overall delivery of the plan.

17.3 The health Workshop for Raising Awareness of Prevent (WRAP) training is currently delivered by one of the Emergency Planning Advisors in the trust, and is designed to illustrate the correct methods for raising concerns about individuals in the pre-criminal space, who are at risk from radicalisation.

17.4 The training has been provided on two Operational Commanders courses and one Apprentice Paramedic course at the time of the report. The intent is that this training will be provided on all commanders courses, and will be incorporated as part of the apprentice Paramedic programme.

18.0 Multi-Agency Risk Assessment Conferences

18.1 Looking ahead to 2012 -2013 the requirements of MARAC will be introduced. Multi-Agency Risk Assessment Conferences (MARACs) are meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. By bringing all agencies together at a MARAC, a risk focused, coordinated safety plan can be drawn up to support the victim. Over 260 MARACs are operating across England, Wales and Northern Ireland managing over 55,000 cases a year.

18.2 Clearly our role in such cases is limited but is not insignificant. So far we have successfully negotiated that we do not need to attend the conferences (unless specifically required to do so) but we are obligated to share the information we hold in a similar way to undertaking an Independent Management Review.

18.3 However, we are approaching a first wave pilot to test the processes and as we approach the “go live” the true commitment and numbers of information requests is emerging.

- Domestic violence is the leading cause of morbidity for women aged 19-44 - greater than cancer, war and motor vehicle accidents .
- In England and Wales, two women a week die at the hands of their domestic violence abuser.
- Home Office figures published in February 2008 reveal that thirty three children were murdered by their parents in the previous year.
- Amongst a group of pregnant women attending primary care in East London, 5% reported that domestic abuse had at sometime in the past caused them to miscarry

18.4 It takes about 20 minutes to complete a request (this has been tested by MI with a few case studies). The numbers of information requests are expected to be approximately 693 a month. This is based on the fact that the national MARC figures for last year were 55,489 cases. We are currently considering our options for this.

19.0 Summary

19.1 Overall we believe we are compliant with CQC standards for safeguarding.

19.2 The safeguarding portfolio has significantly strengthened during the course of the year. The scorecard is embedded into the work of the committee and appears as a RAG rated measure on the Trusts Quality Dashboard.

19.3 The indictors within the scorecard are demonstrating improvements during the course of the year.

19.4 All four Action Plans are progressing very well but the need to establish the Committee for Vulnerable & Disadvantaged Groups would help strengthen external scrutiny.

19.5 There is a gap within level 1 safeguarding training and the Trust needs to complete its annual section 11 audit.

19.6 The Trust needs to improve local engagement with Safeguarding Boards.

19.7 We need to focus more attention on Prevent and ensure we have a well understood process for referrals.

19.8 MARAC requirements need careful consideration.

Appendix I

Safeguarding Committee Attendance

London Ambulance Service
Safeguarding Group Members

	Surname	First name	Position	20.01.12	23.03.12	15.06.12	20.07.12	21.09.12	23.11.12
1	Lennox	Steve	Director of Health promotion & Quality	√	√	√	√		
2	Ralph	Gary	Practice Learning Manager	√	√	√	√		
3	Vander	Margaret	Head of PPI & Public Education	A	√	A	√		
4	Walder	Lysa	Named Professional Safeguarding Children	√	A	√	√		
5	Faulkner	Mark	Clinical Advisor	A	A	A	A		
6	Strother	Lynn	Patients Forum Representative	A	A	A	√		
7	Sugg	Lyn	LAS Deployment to London Organising Committee for the ODA	√	A	A	√		
8	Hay	Alan	EBS Emergency Bed Service Manager	√	√	√	√		
9	Brownjohn	Nicky	Westminster PCT	√ PG	√	√	√		
10	Basset	Gary	Head of Patient Experiences	A	√	A	A		
11	Millard	Katy	ADO – East	A	√	A	√		
12	Dodson-Brown	Carmel	Assistant Director of Corporate Services	√	A	A	√		
13	Gray Allgood	Maria Angela	Met Police	√	√	√	A		
14	Sinden	Levi	Deputy Head of Patient Experiences	-	√	A	√		
15	Moore	Stephen	Governance & Compliance Manager	A	A	A	A		
16	Palmer	Clive	Social Worker Patient Experiences	A	A	√	A		
17	Davies	Paul	Cycle Response Unit Leader	A	A	A	A		
18	Murray	Gerald	Control Services	A	A	A	A		
19	Desmond	Melanie	Clinical Telephone Advisor	√	√	A	A		
20	Faulkner	Sam	Met Police	A	A	A	A		
21	Smart	Nick	HR Training Officer	A	A	A	A		
22	Mountier	Dawn	Patient Experiences Officer	-	-	A	A		

Safeguarding

Appendix II

Safeguarding Balance Scorecard

Safeguarding

				1.25% or more	0 - 5%					1.25% or more	0 - 5%								
				0.75 - 1.25%	5 - 10%					0.75 - 1.25%	5 - 10%								
				0 - 0.75%	10% or more					0 - 0.75%	10% or more			Training			Partnership		Issues		Audit
		June						Cumulative						2012-2013	2012-2013	2012-2013					
	Complex	Numbers (Child)	Numbers (Adult)	Total referrals as a % of incidents	Quality (referrals delayed in receipt)		Known Missed Referrals	Health Referral Considered	Numbers (Child)	Numbers (Adult)	Total referrals as a % of incidents	Quality (referrals delayed in receipt)		Known Missed Referrals	Level 1 Training Compliance	Level 2 Training Compliance	Level 3 Training Compliance	LSCB Rep	Champion	IMR	Complaints	
West	Brent	8	30	0.91%	5	13.16%		50%	73	98	0.82%	11	10.58%			0%	NA	Jon Knott		1	0	
West	Camden	5	16	0.76%	2	9.52%		80%	58	83	1.02%	3	3.45%			0%	NA	Natasha Wills	Patrick Brooks	0	0	
West	Islington	8	23	1.50%	0	0.00%		40%	59	83	1.45%	1	1.16%			0%	NA	Natasha Willis	Patrick Brooks	0	0	
West	Friern Barnet	10	39	1.55%	0	0.00%		32%	70	87	0.98%	2	2.13%			0%	NA	Sean Brinicombe	Ruth Williams	0	0	
West	Fulham	7	33	1.47%	1	2.50%		80%	66	85	1.10%	4	4.44%			0%	NA	Paul Smith		0	0	
West	Hanwell	10	56	2.18%	3	4.55%		93%	131	180	2.13%	11	5.47%			0%	NA	Stuart Crichton		0	0	
West	Hillingdon	17	55	1.92%	0	0.00%		26%	110	144	1.39%	0	0.00%			0%	NA		Stuart Fleming	0	0	
West	Isleworth	14	47	1.82%	1	1.64%		35%	103	137	1.47%	5	3.36%			0%	NA		Damien Marches	0	0	
West	Pinner	11	45	1.48%	1	1.79%		80%	112	151	1.45%	2	1.21%			0%	NA	Martin Bowdler	Paul Bushell	0	0	
	West																					
East	Chase Farm	14	37	2.37%	0	0.00%		100%	57	83	1.36%	1	1.15%			0%	NA	Janice Lyons	Marianne Wright	0	0	
East	Edmonton	27	82	2.46%	4	3.67%		50%	190	260	2.05%	7	2.55%			0%	NA	Jo Scott Jones		0	0	
East	Homerton (City & Hackney)	13	39	1.49%	3	5.77%		41%	99	135	1.29%	11	7.86%			0%	NA	Nick Yard	Nick Osborne	0	0	
East	Newham	8	23	1.03%	1	3.23%		83%	58	88	0.98%	7	7.69%			0%	NA	Carmel Prior	Alan Tokely	0	0	
East	Romford	9	31	1.13%	9	22.50%		88%	77	108	1.05%	39	34.21%			0%	NA	Carmel Walling	Sonia Williams	0	0	
East	Tower Hamlets	4	19	0.96%	3	13.04%		89%	37	41	0.63%	5	11.36%			0%	NA	Paul Ward	Tanya Lee	0	0	
East	Whipps Cross	19	56	1.53%	3	4.00%		71%	130	180	1.32%	6	3.08%			0%	NA	Amanda Wheator	Simon Hewson	0	0	
	East																					
South	Barnehurst	11	73	2.36%	1	1.19%		11%	144	174	1.76%	3	1.57%			0%	NA	Martin Cook	Julie Carpenter	0	0	
South	Bromley	15	38	1.78%	2	3.77%		0%	89	113	1.36%	7	5.79%			0%	NA	Tracy Pidgeon	Conal Percy	0	0	
South	Croydon	29	58	2.10%	5	5.75%		80%	115	138	1.32%	9	5.45%			0%	NA	Paul Cook	Jo Millard	0	0	
South	Deptford	9	28	1.43%	1	2.70%		89%	66	85	1.15%	1	1.08%			0%	NA	Graham Norton		0	0	
South	Greenwich	16	58	1.95%	1	1.35%		74%	141	185	1.78%	7	3.47%			0%	NA	Andy Maxted	Tony Wilkinson	0	0	
South	New Malden	8	33	1.41%	2	4.88%		100%	79	102	1.27%	6	5.41%			0%	NA	Heather Ransom	Taff Roberts	0	0	
South	Oval	11	18	1.20%	4	13.79%		38%	43	54	0.80%	9	15.25%			0%	NA	Steph Adams	Stuart Short	0	0	
South	St Helier	19	29	1.43%	0	0.00%		43%	74	106	1.07%	1	0.88%			0%	NA	Bill Arkell	Andrea Fransen	0	0	
South	Waterloo	7	25	0.92%	4	12.50%		83%	58	80	0.84%	6	6.74%			0%	NA	Phil Powell	Brian Hayes	0	0	
South	Wimbledon	7	31	1.68%	1	2.63%		67%	56	59	0.96%	2	3.03%			0%	NA	Heather Ranson	Taff Roberts	0	0	
	South	132	391	1.62%	21	4.86%	0		865	1096	1.26%	51	4.87%									
Control	Clinical Support													N/A	N/A							
Corporate	PED													N/A	N/A	78.50%						
Corporate	EBS													N/A	N/A	38.00%						
Corporate	C&Q Directorate													N/A	N/A	70%	Steve Lennox					
	Trust Total	**132**	**391**	1.62%	**21**	4.86%	**0**		**865**	**1096**	1.26%	**51**	4.87%									
	LAS TOTAL	**523**							**1961**											1		

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 21 AUGUST 2012

PAPER FOR APPROVAL

Document Title:	**Mental Health Annual Report**
Report Author(s):	**Kudakwashe Dimbi & Steve Lennox**
Lead Director:	**Steve Lennox**
Contact Details:	**020 7783 2299**
Why is this coming to the Trust Board?	**Mental health has been identified as a Quality Improvement for 2011-2012 and 2012-2013 within the quality accounts. This report provides a review of progress made within 2011-2012.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ✓Senior Management Group ✓ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other
Recommendation for the Trust Board:	**Approve the report**

Key issues & risks arising from this report

None.

Executive Summary

This report highlights the work we have undertaken to learn from patient experience and find out what areas we need to make improvements in so that we can improve the care of mental health patients.

The report then identifies what work was undertaken in 2011-2012 to address these points and has outlined the work plan for 2012-2013.

Overall the improvements have been considerable in such a short space of time and this report reflects a successful piece of work in terms of learning from experience and making real improvements to patent care and service experience.

Attachments

Annual Mental Health Report 2011/12

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Quality Strategy

This paper supports the following domains of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

- ☐ Yes
- ✓ No

Key issues from the assessment:

MENTAL HEALTH ANNUAL REPORT 2011-2012

EXECUTIVE SUMMARY

The London Ambulance Service identified improving mental health care as a priority for the service in 2011-2012 and in 2012-2013. It is specifically highlighted in the Operating Framework and appeared in our CQUIN scheme from our commissioners in 2011-2012.

Mental health is a public health issue. Mental illness is the largest single source of burden of disease in the UK. No other health condition matches mental illness in the combined extent of prevalence, persistence and breadth of impact. Consequently, this is a significant component of our clinical work.

Mental illness is consistently associated with deprivation, low income, unemployment, poor education, poorer physical health and increased health-risk behaviour. Mental illness has not only a human and social cost, but also an economic one, with wider costs in England amounting to £105 billion a year. Despite its prevalence and importance, mental health is not prominent across public health actions and policy. Public health strategies concentrate on physical health and overlook the importance of both mental illness and mental well-being. That is why the Government and the London Mayor have decided to raise the priority.

In September 1999, the Government decided that mental health should have the same priority as coronary heart disease in their programme of National Service Frameworks which laid down models of treatment and care which people will be entitled to expect in every part of the country. The National Service Framework for Mental Health (NSF-MH), published by the Department of Health in late 1999, set a ten-year agenda for improving mental health care in England. Subsequent policy statements and guidance, including NICE guidelines, have supplemented the Framework and added to the overall scale of the task.

In February 2011 the NSF-MH 1999 was replaced by *New Horizons: A Shared Vision for Mental Health* - a cross government programme of action to improve the mental health and well-being of the population and the quality and accessibility of services. *No health without mental health* is the Coalition Government's strategy for mental health. This strategy set out six shared objectives to improve the mental health and well-being of the nation, and to improve outcomes for people with mental health problems through high quality. One of these six objectives is that 'more people will have a positive experience of care and support'.

Patients with a mental health disorders make up approximately 9 per cent of the Service's work load, and improvements in this area have received wide spread support from patients. Although these callers make up only a small percentage of our

work, mental health calls can be time consuming for responding call takers and assessing and deciding on the disposition of calls is not always straight forward. We know that mental health is important for patients from our discussions with them in patient forums, Local Involvement Networks (LINk) and Overview and Scrutiny Committee (OSC) and patients widely support us in making improvements in this area.

PATIENT SAFETY AND QUALITY 2011-2012

Many view quality health care as the overarching umbrella under which patient safety resides. Patient safety is the cornerstone of high-quality health care. Much of the work defining patient safety and practices that prevent harm have focused on negative outcomes of care, such as mortality and morbidity. However, we also believe that we need to focus not just on complaints, but the full range of enquiries received from patients and the public, as well as incident reports from other health and social care agencies.

The Trust is required to ensure that there are systems and processes in place to provide assurance that services they are commissioned, contracted and provide are safe and of a high standard. Good patient safety and quality systems should include the following elements as a minimum, Incident and near miss reporting , Use of information , patient feedback & involvement , complaints, concerns and compliments , clinical audit, good leadership and management systems , A robust approach to organisational development , A performance management framework . Many of these systems are already in place within the trust and will be monitored throughout the coming year.

SERIOUS INCIDENTS 2011-2012

The Serious Incident group considered four incidents regarding mental health patients. One was declared as a Serious Incidents and three were considered but found not to meet the criteria.

Declared Incident One (P38111)

This incident involved a patient who was found deceased by the Metropolitan Police who contacted us for support. On investigation it was revealed that we had visited on two occasions the previous day. The incident was declared as an SI as we had been unable to link the calls and that it was considered that there were signs of serious mental health issues that were missed by staff and the organisation.

Undeclared Incident One (P39636)

The incident was not considered until the 2012-2013 year but the incident occurred in 2011-2012. This was concerning a patient under the age of 18years with a history of self harming behaviour by taking overdoses. There was a delay in the dispatch of an ambulance following a mental health professional call who was looking to assess the patient under the MHA (1983). The health professional cancelled the call and the

patient died the following day. The serious incident concluded that the ownership of the incident was with the employer of the health professional who reassessed the situation but we would cooperate with any investigation requirements.

Undeclared Incident Two (53390)

This was regarding an incorrect triage for a patient referred via the CAD link. The patient was found hanging and the call was incorrectly triaged as a C3 but as our response was within 4.18 (and therefore technically responding within an A1 category) no harm fell to the patient. The learning was undertaken at a local level.

Undeclared Incident Three (54310)

This incident concerned a member of the Patient Transport Team (PTS) who was assaulted by a patient from a Mental Health Trust. Whilst the incident was significant and support and learning was extended to the PTS team the incident had occurred due to the inadequate assessment by the Mental Health Trust and the lead for the incident fell to that Trust.

COMPLAINTS

Unfortunately, it was not possible to evidence the number of PALS referrals or complaints between October 2010 and April 2012 as the case management system (Datix) does not currently have a mental health coding within it. However, Patient Experiences Department regularly seeks assistance from the Clinical Advisor for Mental Health, in relation to clinical advice pertaining to mental health issues. This may be to respond to an incident identified by a member of staff, an external agency referral, PALS enquiries or complaints. We have also assisted Acute Trusts with reports when an external Serious Incident has been declared with NHS London. In the last 6 months since joining the trust, our Clinical Adviser for Mental Health has responded to twelve such requests from the Patient Experiences Department.

One such incident where advice was sought from the Clinical Advisor for Mental Health related to a 79year old female, insulin dependent diabetic, BM 2.7, BP100/40 She was dehydrated and her GP who was on scene at time of the 999 call had undertaken blood tests the day before which indicated that she was in acute renal failure but she was refusing to go to hospital. An assessment was carried out under the Mental Capacity Act (2005) indicating that she was incapacitated. The clinical staff had called the police for assistance but they declined to attend stating they had no more powers than our staff and the GP had as the patient was in their own home. The Clinical Adviser for Mental Health reviewed the incident, clarified the Mental Capacity Act (2005), Mental Health Act (1983) and what powers are available to our clinical staff when a patient who is incapacitated is in need of life saving treatment and insured that this was fed back as developmental learning.

A second incident involved a mental health patient who was unhappy with the service provided to him by the Trust. The patient had initially approached the

Metropolitan Police Service about what he considerd to be the disproportionate number of police officers deployed to his house on the day of the incident. A 999 call was received in our Emergency Operations Centre at 20.48, from the patient who was expressing suicidal intention. The call handler ascertained the address and telephone number and selected protocol 25 (*Psychiatric/Abnormal behaviour/Suicide attempt*). The patient had also disclosed to the call handler that on the last occasion an ambulance crew had attended him he produced a Samurai sword. When asked if he had the Samurai sword with him, he had said no but then said that he had "*kitchen knives*".

The call hander spent one hour and five minutes on the telephone with the patient and the Quality Assurance review concludes that he acted in a sensitive and professional manner. She also informed him that we had notified the police who were also en-route to the patient's residence.

It was explained to the patient and his advocate that clearly given the apparent circumstances the situation remained potentially volatile and the police were kept informed throughout. We also confirmed that we have no influence about the number of police resources that are dispatched to any given incident and this remains solely a matter for the police .We did however clarify the information that appears to have influenced their decision on this occasion. It was also offered to the patient and his advocate the option to devise an emergency care component to his community care plan which he agreed with. Our Clinical Adviser for Mental Health took this work further liaising with the appropriate Mental Health Trust and agreed that certain information could be held on our system and matched against the patient's which would be made available to the attending ambulance staff, or alternatively arrangements can be made that contact should be established with the Mental Health Trust in the event of a 999 call being received from the patient.

PATIENT EXPERIENCE

We always look to use any feedback we receive as a chance to learn, and so improve the service we provide to our patients. We have been receiving patient feedback through patient forums and closely working with patient representatives as well as complaints and compliments.

We completed a patient experience survey jointly with Central & North West London Mental Health Trust. The sample was patients who have used the London Ambulance Service in a mental health crisis in the boroughs of Westminster, Brent, Kensington & Chelsea, Harrow and Hillingdon.

A total of 78 patients were interviewed over the phone about what they thought about the service they received from the London Ambulance Service and what their experiences had been, our role and our plans for the future, how they perceive us as an employer and what experience they have had of using our service. The results of

the survey generally indicated that we are providing a good service with the vast majority of participants saying that they felt satisfied with the care they received from the London Ambulance Service. There however remained a small number of respondents who are dissatisfied with the service. Main areas of patient dissatisfaction appeared to be around the conduct of crew around the respondents.

An analysis of the results helped us to focus on patient satisfaction and improving the care our frontline staff give to patients with in a mental health crisis.

We have also received valuable feedback from health professionals with the main theme being frustration at delays in dispatching resources or delays in conveyance of mental health patients.

CLINICAL AUDIT

A comprehensive audit of mental health care was also undertaken in 2011-2012 by the Clinical Audit Research Unit. Good practice was identified in this clinical audit with ambulance crews obtaining the history of the patient's presenting complaint for almost all patients. Past psychiatric and general medical history were also obtained for the large majority of patients (93% and 94% respectively). Allergies and medications were also documented for the majority of patients (80% and 78% respectively), although there was room for improvement. Whether the patient had a current Psychiatric/Community Psychiatric Nurse or Approved Social Worker was considered for just over half of patients (54%).

When assessing the patient's mental state, good practice by ambulance crews was identified when assessing the patient's condition, behaviour and ability to communicate. These assessments were conducted for 92% of patients. The patient's thoughts were sought and reported in most cases.

Areas of practice where the need for improvement was identified included the use of the capacity tool and the completion of safeguarding referrals. The capacity tool was used for just over a tenth of patients who refused a specified course of action or treatment. A safeguarding referral was not completed for any patient. It is important that ambulance crews consider completing a safeguarding referral for patients with a mental health disorder as they may be vulnerable.

SUMMARY OF PATIENT EXPERIENCE

Overall, many areas of good practice have been identified with the majority of mental health related calls having a good outcome. There are however some areas for improvement; specifically the completion of safeguarding referrals where indicated, and the use of the capacity tool as well as the absence of dedicated provision for mental health, making it difficult to fully meet the needs of mental health patients; for example where the needs to convey a patient having a mental health act assessment competes with the mainstay of demand.

ACTIONS TAKEN TO IMPROVE MENTAL HEALTH CARE

All this evidence has fed into the development of a mental health action plan and the creation of the Clinical Advisor for Mental Health post. The following highlights some of the improvements made.

- The Mental Health Committee was launched in 2011 and is chaired by our Director of Health Promotion and Quality, who is also a Registered Mental Nurse. The committee is responsible for driving the Trust's Mental Health Action plan and meets every 2months.
- Mental health has been a priority for the Trust since 2011 and has been specifically highlighted in the Operating Framework and appeared in our CQUIN scheme from our commissioners in 2011-2012 and our commissioners are partners on the Mental Health Committee.
- In February 2012, the Trust recruited a mental health expert to the Clinical & Quality Directorate team to lead some of the improvement work within Trust. We believe we are the first ambulance service to appoint a Registered Mental Health Nurse specifically to an ambulance service.
- The Trust continues to progress with its involved mental health action plan. Achieved recent action points include the negotiation of appropriate care pathways that will be made available for patients who call 999 in the future. As part of the mental health action plan our Director has met with Directors of Nursing at all of the ten Mental Health Trusts that provide acute mental health care across London and have agreed what the pathways should be. To date, we have successfully negotiated six Appropriate Care Pathways (ACP) with mental health providers which will allow us to access their specialist mental health teams. Our clinical adviser for mental health continues to negotiate the remaining ACPs with the outstanding four trusts.
- Our clinical advisor for mental health has also started to work closely with the Clinical Hub staff and has been able identify gaps in knowledge. She continues to work on up-skilling the Clinical Hub to enable our advisers to offer more appropriate advice to frontline crews and patients.
- We are currently actively involved in the creation of the mental health directory of services (MH-DoS). It is hoped that the Trust will be able to access information on the DoS resulting in successful onward referrals.
- We have significantly improved our engagement with multi-agency teams with regular attendance to Metropolitan Police Service meetings, London Approved Mental Health Professional (AMHP) leads network meetings and Mental Health Trusts meetings.
- A new protocol for how we respond to calls from Approved Mental Health Professionals (AMHPS) or doctors to attend Mental Health Act assessments in the community was launched on the 20th March 2012. This protocol was agreed following a meeting held between Trust representatives, AMHPs and the

Metropolitan Police Service (MPS) where concerns were raised in relation to the difficulties and inconsistencies of booking Trust vehicles to attend mental health assessments and transport requests. The aim of this protocol is to create a service that ensures privacy and dignity of the patient, improves reliability, allows us to deploy staff with the right level of competency for each individual case and ensures the safety of the patient and staff. Overall we have received positive feedback with some boroughs rating the process as “excellent” with ambulances coming within the specified response times, even earlier in some cases. The new protocol has been well received by our colleagues in Mental Health Trusts and we are continuing to receive some very positive feedback on our performance.

- In terms of education, Our Education Centre Manager is currently involved with an initiative from a Mental Health Trust to produce a training DVD with the LAS and the MPS dealing with acute behavioural disturbance/positional asphyxia, this is still work in progress. He has also completed updating the training package for the new Apprentice Paramedic course.
- A mental health e-learning package is available for Trust staff on dealing with mental health presentations. The mental health e-learning package is available for staff via “LAS LIVE”, the virtual learning environment. 289 staff have completed the E-Learning Module to date. This package is currently in the process of being reviewed with a possibility of changing some of the content.
- A new Mental Health Clinical Performance Indicator was introduced on 1 April 2012 and has been developed in collaboration with the clinical leads in mental health.
- A Core Skills Refresher (CSR3) has been completed and currently awaiting a re-launch date. The CSR3 contains sessions on the Mental Capacity Act and a general refresher on mental disorders as per JRCALC guidelines.

FUTURE PLANNING

In recent years, the London Ambulance Service has used additional funding made available to us to invest in staff recruitment and training and in modernising the ambulance fleet. In the year 2012-2013, Alcohol has been identified as a priority and appears as a CQUIN from our commissioners. In 2011 approximately 10% of all call outs to the London Ambulance Service in Westminster were classified as alcohol related (London Analyst Support Site provided by the CDRS).
The rate of alcohol related hospital admissions has almost doubled in the last decade in London and England. Therefore the mental health work stream will now focus attention on aspects of alcohol work.

ALCOHOL RECOVERY CENTRE

In 2010 and 2011 Westminster City Council, the PCT and the London Ambulance Service commissioned an Alcohol Recovery Centre in Soho (SARC). The primary aim was of diversion of intoxicated patients from hospital to a safe place to sober up with access to medical care should it be needed. We aim to focus on the SARC and

concentrate on health promotion, healthy choices and healthy lifestyles among the people of London, focusing particularly on those most in need, to prevent ill health and dependency.

CRISIS PLANS

Improving links with mental health trusts to ensure that known patients are taken to familiar places as much as is reasonably possible and that accurate handovers are given to hospital staff is another key focus this year for the Trust. Work is already in progress with six Appropriate Care Pathways having been already agreed. Our goal is to have agreed crisis care pathways for LAS use with all the ten mental health trusts across London and to continue engaging with Mental Health Trusts in the provision of quality care.

EDUCATION

The current mental health e-learning package is in the process of being reviewed. We aim to include in the revised package risk assessment case studies/scenarios and more up to date mental health information including the Mental Capacity Act (2005). We also aim to use team leader updates as an avenue for disseminating knowledge and information on current issues in mental health.

SAFEGUARDING

Safeguarding referrals in mental health is now part of the monthly CPI and is recorded on the safeguarding dashboard that is overseen by the safeguarding committee. Improvements are already being seen but this will receive a focus of attention in 2012-2013.

CONCLUSION

The Trust has long identified a risk that ambulance crews failing to appreciate the significance of psychiatric illnesses will lead to patients with undiagnosed mental health disorders remaining unrecognised and their illness unmanaged. The Trust has also highlighted that there is a risk of staff not recognising safeguarding indicators and therefore failing to make a timely referral for vulnerable patients and safeguarding children referrals within this patient group. The ambulance service attends patients who may or may not have received a formal diagnosis for a mental health disorder. Patients presenting with a mental health disorder, attended by the LAS, may not all have insight into their problems, regardless of whether or not they have been formally diagnosed. This may affect whether a patient is willing to accept assessment and treatment from an ambulance crew.

Assessing and treating patients who present with a diagnosed or suspected mental health disorder is extremely challenging in the pre-hospital setting as the nature and presentation of the patient’s condition will vary greatly in each case. Although some training is being provided to staff, this is limited to the speciality or related subjects e.g, self-harm, dementia, etc.

Complaints from patients with mental health problems are often the most time-consuming, one of the drivers in the Patient Experiences Department developing a close relationship with the Independent Complaints Advocacy Service. When complications do arise, they need to be thoroughly investigated and collaboration sought with external agencies as necessary. The outcomes are used as developmental learning and to inform guideline reviews. It is important to get the patient the help they require in a timely and safe manner for both our staff and the patient. This can be achieved with fully trained staff who are able to carry out risk assessments to inform their decision making and partnership working with external agencies to provide the best care to our clients.

The overriding principle is timely conveyance with trained, competent, and caring staff, to maximise better outcomes for mental health patients

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 21ST AUGUST 2012

PAPER FOR INFORMATION

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

Key issues and risks arising from this paper

- Significant reduction in CPI audit, most notably in the South area. CPI compliance remains >95% except for mental health.
- Updated PRF to be introduced in September 2012.
- Further reduction in the number of addresses held on the High Risk Register, now the lowest since MI took over management of the register.
- Decrease utilisation of DMP C. No escalation of DMP past stage C in June and July.
- No Controlled Drugs incidents to report.
- One Rule 43 Report has been received by the Trust. A response has been sent to HM Coroner and an action plan devised.
- Cycle 8 of the National Clinical Performance Indicators has been released. Improvement has been demonstrated in Stroke and Hypoglycaemia. There is continued below national average compliance against the STEMI and Difficulty in Breathing CPI.
- Two audit reports and one external research report have been released by CARU.

Executive Summary

This is the fourth edition of a revised clinical report. The report is structured around the quality domains of the quality dashboard but also reports on issues wider than the quality measures. Overall this report provides assurance that a high quality and safe clinical service is provided.

Attachments

Appendix 1: Updated Patient Report Form (LA4)
Appendix 2: Comprehensive Local Research Network (CLRN) Report

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Quality Strategy

This paper supports the following domains of the quality strategy

- ☒ Staff/Workforce
- ☒ Performance
- ☒ Clinical Intervention
- ☒ Safety
- ☒ Clinical Outcomes
- ☒ Dignity
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- ☒ To be efficient and productive in delivering our commitments and to continually improve

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

- ☐ Yes
- ☒ No

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST

Clinical Quality & Patient Safety Report – August 2012

Clinical Directors' Joint Report

1. Introduction

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

2. Quality Domains

Quality Domain 3: Clinical Intervention

Clinical Performance Indicators (CPIs)

Team Leader CPI completion rate further decreased to **70%** in June (the lowest number audit number since 2009). REAP was escalated to 4 for 12 days as a result of significantly higher than expected category A call demand, which impacted on the ability of Team Leaders to undertake CPI audit. CPI completion in the South was impacted as REAP 3 and 4 actions were enforced, resulting in all Team Leaders undertaking operational duties. Team Leader feedback remains below trajectory, limiting opportunities to try and increase the new mental health CPI. Overall compliance against all clinical care standards remains consistently high, except the new mental health CPI; the Trust target is 100%.

Table 1. CPI completion January to June 2012

Area	Jan.	Feb.	Mar.	Apr.	May	June
East	93%	86%	94%	95%	82%	82%
South	93%	83%	78%	67%	46%	42%
West	95%	84%	96%	100%	93%	88%
LAS	**94%**	**84%**	**89%**	**86%**	**72%**	**70%**

Table 2. CPI Compliance June 2012

	Cardiac Arrest	Difficulty in Breathing	ACS (Including MI)	Stroke	Mental Health	Non-Conveyed	1 in 20 PRF
East	98%	95%	96%	97%	87%	96%	97%
South	98%	95%	95%	98%	85%	95%	97%
West	98%	97%	97%	98%	87%	97%	97%
LAS Total	**98%**	**96%**	**96%**	**98%**	**87%**	**96%**	**97%**

Table 3. CPI Compliance May 2012

	Cardiac Arrest	Glycaemic Emergencies	ACS (Including MI)	Stroke	Mental Health	Non-Conveyed	1 in 20 PRF
East	98%	98%	96%	98%	87%	96%	97%
South	98%	98%	96%	97%	88%	95%	98%
West	98%	98%	97%	98%	88%	97%	97%
LAS Total	**98%**	**98%**	**97%**	**98%**	**88%**	**96%**	**97%**

Patient Report Form (Appendix 1)

A number of alterations are being undertaken on the PRF and scanning software. Key updates are linked to 2012/13 CQUINs, clinical audit and NHS Controlled Drug security and management guidance. As a consequence of additional text and boxes on the PRF, the form has needed to be increased in size by 1cm, incurring a cost increase of £3.24 per box of 500 forms (the Trust uses 3,200 boxes per year). To mitigate this, savings have been identified in the printing of other forms, resulting in the PRF update being close to cost neutral. The updated version of the PRF will be introduced in September, after existing stocks are used.

Cardiac Care

Cardiac Care Research Study: ParaSVT - This trial continues to go extremely well. There have been no adverse clinical incidents and patient feedback obtained by Bart's Healthcare has been very positive. Discussions have now started to explore how this treatment can continue after the trial comes to an end.

Cardiac Care Research Study: DANCE - Progression with DANCE remains poor due to low numbers of patients being recruited to the trial. It is planned to increase awareness of the study after the Olympic Games.

Improving Cardiac Arrest Survival – It is planned to start the role-out of this initiative in early October 2012, with Waterloo, Oval and Deptford complexes identified as pilot sites. The 2011/12 Cardiac Arrest Annual Report is due to be released in August, which is hoped to report an increase in cardiac arrest survival from last year.

Quality Domain 4: Safety

NHS Central Alerting System (CAS)

22 Alerts have been received from the MHRA for the period 15th June – 6th August 2012. All have been acknowledged by the Trust and no alerts required any action.

High Risk Register

There has been a continued decrease in the number of high risk addresses. This is the lowest number of HRR entries since MI took over the management of the register.

There are currently **512** addresses on the register broken down as follows:

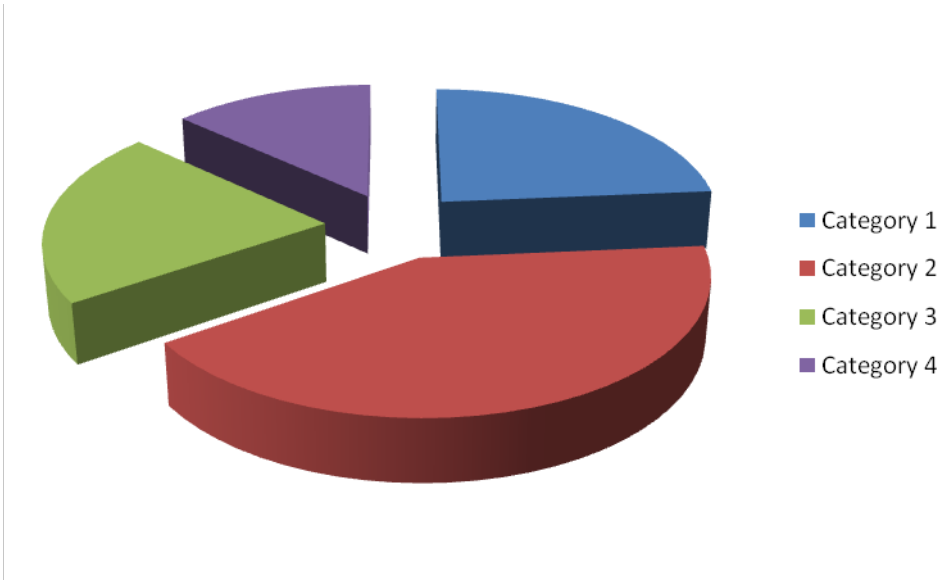
CATEGORY 1: **121**

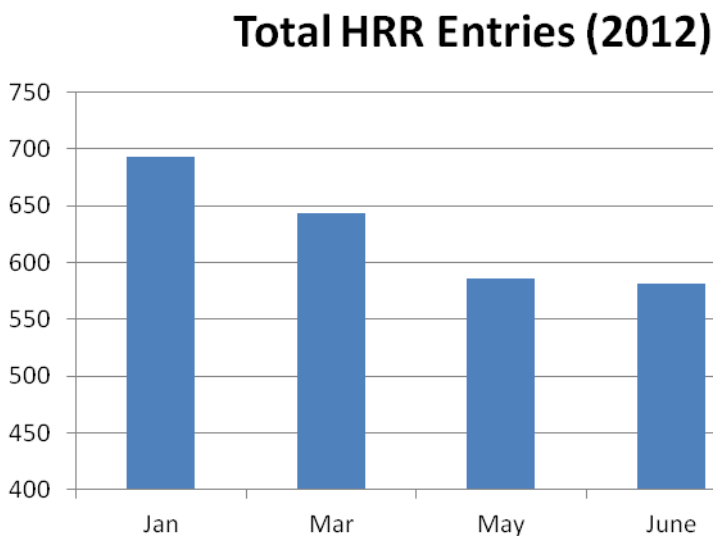
CAT EGORY 2: **214**

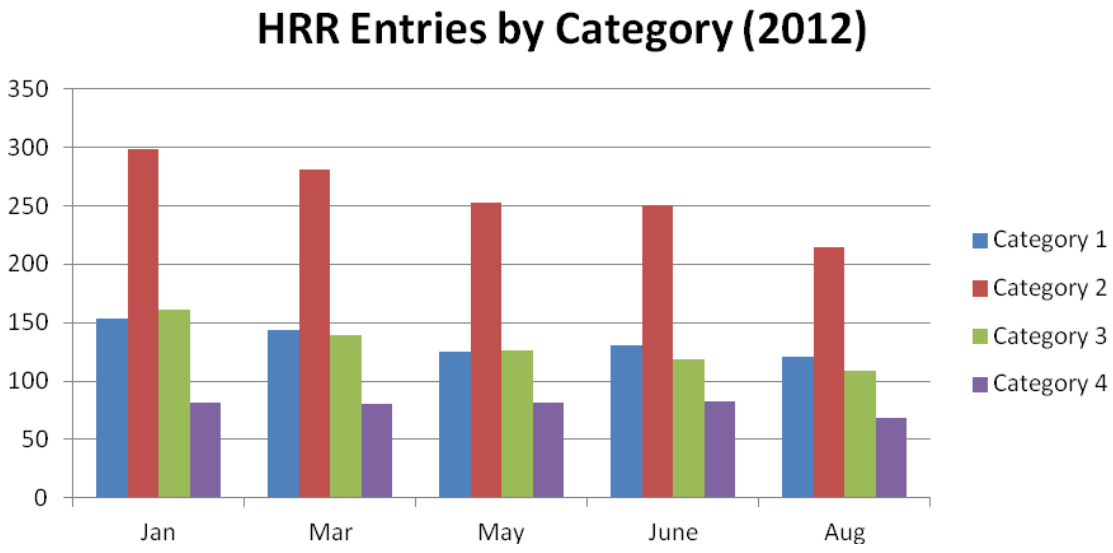
CATEGORY 3: **109**

CATEGORY 4: **68**

There has been a demonstrable decrease in the number of high risk addresses over the past six months. This is the lowest number of HRR entries since MI took over the management of the register. The Trust has notification of 179 high risk addresses from the Metropolitan Police. The Medical Directorate are reviewing all category 4 entries for continued inclusion on the HRR.







Demand Management Plan

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

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

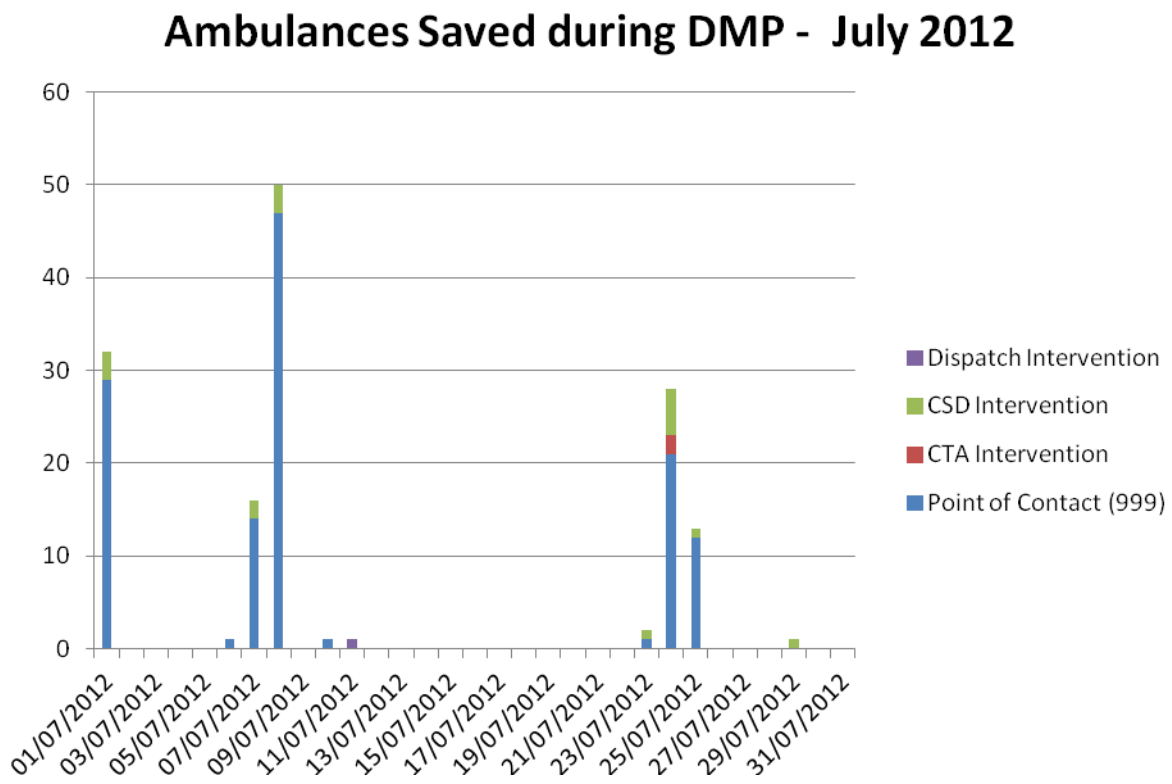
clinical and operational review as the plan is escalated. There is a significant level of clinical risk related to the stage of the DMP invoked.

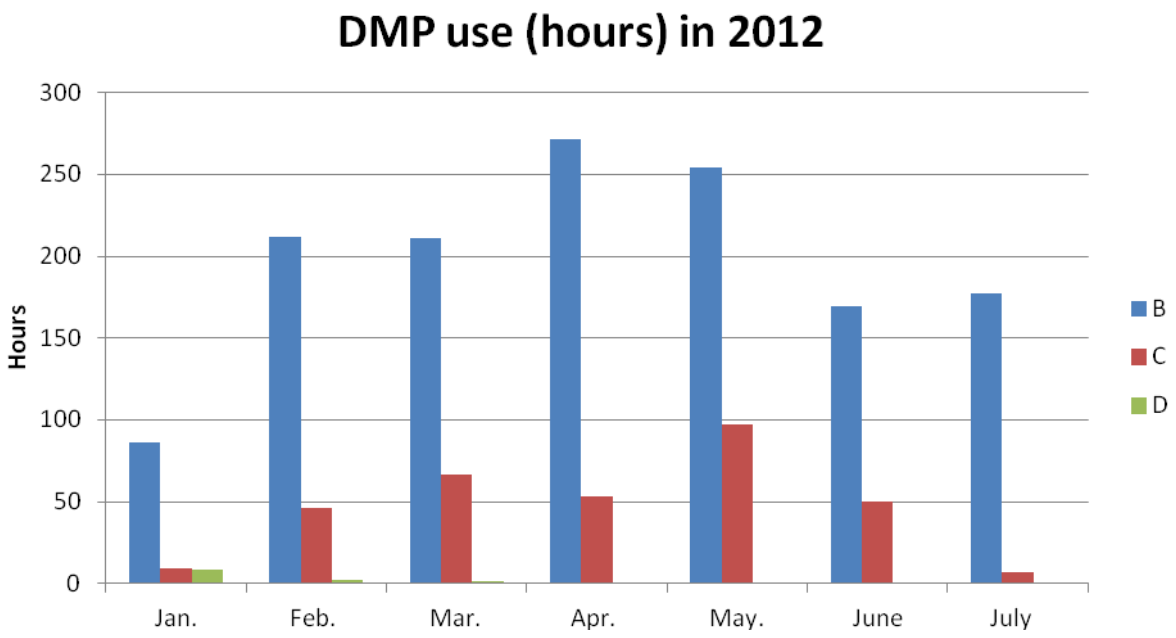
DMP was invoked on **25 separate occasions** and in place for a total duration of **184 hours** in July 2012. This is a decrease of 35.25 hours compared June (219.25 hours). Of note was a significant decrease in the use of stage C.

Stage **B** was in place 27 times for a total duration of **177 hours** (versus 29 times / 169.25 hours in June)
Stage **C** was in place only twice for a total duration of **7 hours** (versus 9 times / 50 hours in June)

There was no escalation of DMP past stage C.

There were **145 ambulance saves** in July 2012 (126 at point of contact).





Medicines Management

There have been no reportable Controlled Drug incidents since the last Trust Board report and no CAS Alerts or Signals have been received for medicines affecting the Trust.

There have been no Unannounced Visits by the Metropolitan Police.

The Medical Director and Senior Clinical Adviser to the Medical Director made an unannounced visit to the ODC on 30th July 2012. The purpose of the visit was to audit the Controlled Drugs safe and procedures. At the time of the visit, all CD Registers and CD paperwork was compliant with Trust policy and procedure.

The Chair of the Medicines Management Group and the LAS Pharmacy Supplier have sourced a different presentation of 0.9% sodium chloride fluid for infusion, following a number of clinical incidents involving the wrong IV fluid being administered to patients, due to the almost exact packaging of 10% glucose and 0.9% sodium chloride. The new presentation makes it distinctly different to a 10% glucose infusion bag and there is also a 2p per unit cost saving. The process to change from our current supply of 0.9% sodium chloride, (Baxter's Viaflex bags), to this presentation, (Braun Ecoflac bottles) is underway.

Rule 43 Reports

The Trust has received one Rule 43 Report which made a recommendation to clarify the message to callers with lower priority calls to explain that an ambulance was not being dispatched when a patient's call was transferred for clinical review or telephone advice. This would be implemented at the end of July and all actions arising from the Rule 43 report would be tracked by the Serious Incident action plan, which was monitored by ADG.

Quality Domain 5: Clinical Outcomes

The 2011/12 Cardiac Arrest Report is due to be published imminently and it is hoped that it will detail continued improvement in pre-hospital cardiac arrest survival.

Quality Domain 6: Dignity

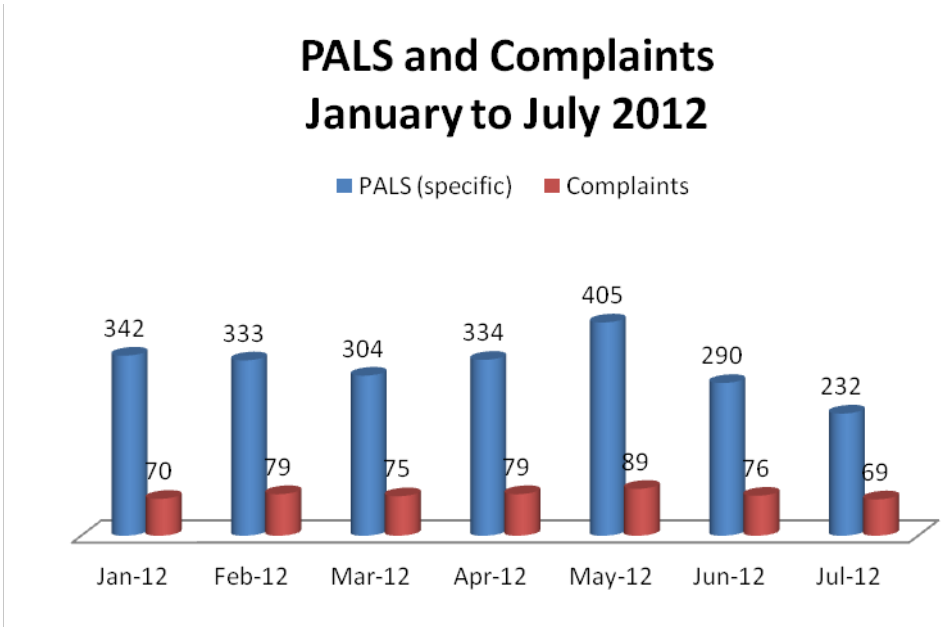
Nothing to report.

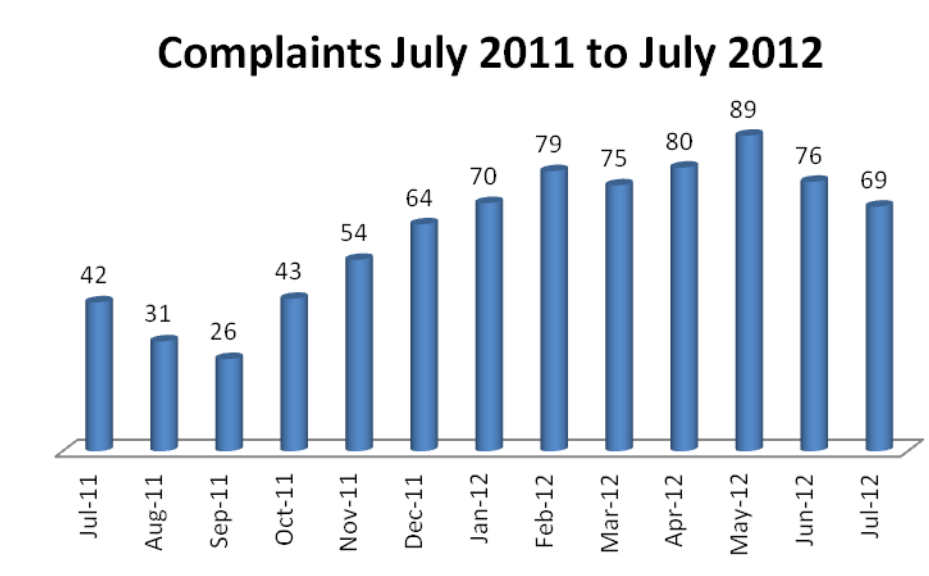
Quality Domain 7: Satisfaction

Complaints

This report sets out a base account of Patient Experiences Department activity via complaints and PALS during July 2012 (excluding safeguarding activity, PCAT cases and solicitor enquiries). There has been a slight reduction in the number of complaints this month; historically this is evidenced as an annual variation during the summer months.

Summary





Complaints and PALS – Emerging themes:

No enquiries/complaints have been declared as Serious Incidents in this month.

Familiar themes are again evident – 46% of the complaints received during July related to concerns about the delay in LAS attending or the non-dispatch of a vehicle. 16% were associated with communication and attitude issues such as staff challenging the validity of the 999 call.

From August 2012, PED will be monitoring the level of Demand Management Plan imposed by EOC to enable an audit of delay complaints in relation to the DMP.

PED are also witnessing a renewed increase in complaints about patients being referred to NHS Direct and a slow increase in complaints about being referred to ACPs. A number of complaints relate to EOC providing unrealistic estimated times of arrival for ambulance response which may subsequently be cancelled for a higher priority call.

Subject	Total
Delay	32
Non-physical abuse	11
Road handling	9
Treatment	5
Patient Injury or Damage to Property	5
Non-conveyance	3
High Risk Address Referral	2

Not our service	1
Clinical Incident	1
Totals:	**69**

Case examples (cases closed during July 2012)

Case reference	Complaints summary	Outcome
7052	A 4 month old baby choked & stopped breathing for approx 20-30 seconds. Father called 999, waited 5 min's before call answered, and then took an hour for an ambulance to arrive. FRU on scene within 6 min's of the call.	Command Point in use. 5020 x 999 calls. Apologies given for delay in ambulance arriving. Explanation re demand, FRU on scene quickly and baby stable, feeding from bottle. Apologies also given for delay in answering 999 call - should be 95% answered in 5 seconds.
7049	Hospital collating response - LAS concern is regarding approx 1 hour delay in ambulance attending to patient who had slipped and fell awkwardly at DLR station. Due to time taken, took a taxi hospital.	DMP B. Prioritised correctly as C4 - explanation given re high demand and manning levels (4849 x 999 & 81/6%). Call held as LAS dealing with higher priority emergencies. Shortcomings identified in EMDs not re-triaging call and unhelpful manner - feedback given via EOC.
7029	Patient in a care home was in severe pain when his catheter dislodged. Staff called the District Nurse who advised to call 999 at 21:00. Wife made way to hospital, however ambulance did not arrive until 01:00 and wife had left by this time. Patient arrived back at the home at 05:00.	C4 priority, CTA unable to call back due to high demand referred for amb within 30 minutes. Demand high for patients triaged higher priority - unacceptable delay incurred for this patient and no contact maintained with them from EOC. Apologies given. Case to be anonymised and highlighted to Commissioners as 999 services used to cover primary care services.
7010	Pt slipped and fell, hitting her head on the floor. Delay in ambulance attending, also unhappy that EMD's could not give ETA's and difficulty in locating Tower Bridge. Crew were also dismissive of the complainant who was on scene with the patient when they arrived.	4835 x 999 calls - Queens Diamond Jubilee River Pageant. DMP B. Apologies given, callers gave differing locations therefore EMD's had to clarify address to ensure treated as one incident. Explanation given, demand explained - confirmed EMD's cannot speculate on ETA's as may be diverted whilst en-route. Feedback to be given to EMD as one advised resource on way but this was then diverted.
7111	Patient is booked as 'car suitable' for her appts at Queen Mary's as finds it difficult to use the ramp to get in & out of the ambulance. Several times now an ambulance has arrived, a car has had to be resent and this is distressing for the patient.	Pt booked as car suitable however this often means that patients can manage car/ambulance. PTS implementing new code 'car only (not ambulance suitable)'. They have also in the mean time amended patient's booking as 'car only cannot do ramp or steps'. Apologies given.

7088	Complaint received from patient who is blind and was due to attend an appointment. Unhappy that the driver arrived too early, used his mobile whilst driving and drove too fast and erratic.	Patient is blind - did not want written response wanted to receive feedback verbally. PTS had already met with patient, action taken with regards to training aspect for their staff in reminding them to verbally guide patients who are blind. Confirmed pts asked to be ready 2 hours before appointment time.
7068	Local Homecare concerned with the time the patient had to wait before an ambulance arrived. Patients care worker phoned for an ambulance at 21:05 and following 4 further phone calls an ambulance arrived at 23:30.	DMP B, A, C throughout time of call. 4876 x 999 calls. 89/6% manning. C4 priority originally - feedback to be given to EMD re confusing advice on closure of call. Apologised for delay and explained demand. Case for Control Services governance re callers being informed of our targets at time of 999 call.

Analysis by response target period

The table below indicates the number of complaints received between April - June 2012 and the time frame within which the target response was achieved. The overall closure rate for the period within the allocated time frame was 45%. This can be attributed to severe staff shortages (5/14) due to a variety of reasons and the involvement of some of the PED team in the Olympic management process which is also causing further challenges to the department. However, by far the most significant contributor remains the lengthy delays (often 6 weeks+) in receiving Quality Assurance reports which at the instigation of EOC are now required to be agreed by Watch management teams prior to being made available to PED. We are re-negotiating this as part of the SLA with Control Services.

PED are also experiencing significant delays in receiving timely cooperation from local complexes, as a consequence of operational pressures and the involvement of senior complex managers in the management of the Olympics. Those complaints that are also subject to a SI investigation or equivalent safeguarding enquiry are naturally inevitably delayed awaiting the substantive report.

As at 3 August a total of 136 complaints remain open or re-opened following a further approach from the complainant after the substantive response has been completed.

Response time allocated April 2012 to June 2012	**No. of complaints**	**Closed within time frame**
Complaint 25 days	106	59
Complaint 30 days	66	18
Complaint 35 days	63	26
complaint 40 days	9	6
Totals	244	109

A true reflection of response times cannot be calculated until the furthest timescale (i.e. 40 days have elapsed) = 25 September 2012.

Since 1 December 2011 all complaints considered under Section 8 of the *Local Authority Social Services and NHS Complaints (England) Regulations (2009)* have been included in the complaints module within Datix case management system.

Three PALS cases were managed under s.8 as follows:

Reference	Description	Outcome
45241	Lost Property - Patient enquiring about his missing 5 gold rings.	The local management team for the ambulance staff has discussed the incident with them, particularly surrounding the missing jewellery. The ambulance staff were unable to recall what jewellery the patient had on them at the time, but have explained that due to the nature of the injuries and presenting condition they would not needed to remove your rings and have no recollection of this being requested by any one on scene.
45057	Individual is making a complaint against the Police. Pt was suicidal, public called 999 - pt concerned with management of incident by Police and LAS. Would like her records and has list of points she would like addressed/clarified.	Although the actions of the Fast Responder were taken in to account, and how he acted on the assurances given by the police as well as witnessing for himself that the patient appeared happy in their care, it would have been best practice for him to have spoken with the patient direct to gain an understanding of the situation and to ensure that there had been no miscommunication with regards to his welfare. An apology was offered and feedback given to the Fast Responder in the form of a reflective practice exercise to discuss how he may have better managed this incident.
45254	Asking for clarification on priority and response time for a baby suffering from croup, high temperature and having problems breathing? In addition, they are asking for advice on how long they should wait to contact 999 in a similar situation?	It is no longer the case that a 999 call will automatically result in an ambulance being dispatched. We will be offering far more telephone advice to callers who have needs that can be managed in this way; and in those cases where it is necessary to send an ambulance we will be looking to find more appropriate care pathways rather than always taking patients to A&E departments for treatment. In this way, we hope to better manage the variety of requests made to our service.

All PALS cases during July 2012. Of the 49 lost property enquiries, only 6 items were found (13%).

PALS by Subject (primary)	Total
Information/Enquiries	155
Medical Records	131
Lost Property	49
Frequent Callers	45
Safeguarding Adults	44
Safeguarding Children	30
Request for Witness Statement	10
Incident Report - Other	4
Communication	3
Incident Report - GP Surgery	3
Delay	2
External Incident Report - LAS Crew	2
Other	2
Aggravating Factors	1
Appreciation	1
Clinical	1
Conveyance	1
Non-physical abuse	1
Explanation of Events	1
Incident Report - A&E	1
Incident Report - Hospital Midwife	1
Non-conveyance	1
Patient Injury or Damage to Property	1
Policy/ Procedure	1
Road Traffic Collision/RTC	1
Total	**492**

PED continue to seek an improved mechanism around the controversial issue of compensatory payments under the NHS complaints procedure, which is no longer solely the province of legal action. This is in the light of complainants actively seeking compensation and the Ombudsman increasingly advocating such consideration.

We have also amended the information on the Trust website, the departmental Duty telephone message and the automatic email acknowledgment to advise callers of the pressures that are currently being experienced. The implementation of SLAs with other Trust departments has been postponed in the light of operational priority and pressure during the summer.

3. Quality Priorities

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

4. Clinical Audit & Research (CARU)

Report on National Ambulance Service Clinical Performance Indicators

Cycle 8 of the national CPI has been published by NASCQG. Key points in the report are:

- The Trust is below the national average for compliance against the STEMI care bundle. Specifically the use of analgesia (entonox and/or morphine) and GTN.
  It is of note that disparity exists between the national CPI criteria for GTN use and JRCALC guidelines. The national CPI stipulates that GTN be administered to all STEMI patients (irrespective of whether chest pain is being experienced or not). JRCALC guidelines state that GTN is indicated for 'cardiac chest pain due to angina or myocardial infarction'. At present, the Trust follows JRCALC guidelines for the use of this drug. The Ambulance Services Cardiovascular Quality Initiative (ASCQI) continues to support education to clinical staff to raise the profile of appropriate pain management in STEMI.

- The Trust has improved compliance from Cycle 7 against the stroke and hypoglycaemia CPI.

- The Trust has low compliance to the asthma CPI, due to peak expiratory flow rates (PEFR) and SpO2 not being recorded pre-treatment (compliance against all other aspects of the CPI is high). The problem of not being able to record SpO2 has been added as a risk to the Medical Directorate risk register. There are two component parts to this problem; the issue of SpO2 probes not being available on LifePak machines (missing or broken) and that at present, the measurement of SpO2 can only be undertaken by removing the LifePak from an ambulance or FRU. Scoping work is being undertaken to explore the possibility of providing a vehicle based portable pulse-oximeter.

The full National CPI report can be accessed at X:/Clinical Audit & Research Unit\Clinical Performance Indicators (CPIs)\National CPIs\Cycle 8 NCPI Report.pdf

Comprehensive Local Research Network Report

The Trust CLRN Annual Report has been submitted detailing a number of research achievements in 2011/12. (Appendix 2)

Clinical Audit Reports

Two clinical audit reports have been published by CARU. A summary of each report is detailed below.

1. Clinical Audit of Paediatric Respiratory Assessment in the London Ambulance Service (June 2012)

   This clinical audit examined paediatric respiratory assessments by the LAS. The clinical audit found room for improvement in documentation of respiratory assessments in patients two years old or younger with difficulty in breathing. Availability of equipment to record oxygen saturation levels for this patient group has been highlighted as the main concern and therefore the focus for the clinical audit recommendations.

2. A baseline clinical audit examining the management of Sudden Unexpected Death in Infants, Children & Adolescents by the London Ambulance Service (July 2012)

   This clinical audit aimed to establish whether the management of SUDICA by LAS ambulance crews was compliant with local clinical practice guidelines. An excellent standard of practice was identified in some aspects of care delivered to this patient group by crews however the need for improvement was identified in the safeguarding referral process.

5. Rising Tide

Public Health

The Trust received notification from the Health Protection Agency (HPA) of a number of confirmed cases of Anthrax linked to illicit drug injecting in Europe and the UK. A Medical Directorate bulletin has been released to highlight this issue and provide clinical guidance for treatment.

An article written by CARU evaluating the 'Know your blood pressure campaign' undertaken by the Trust in April 2010, has been accepted for publication in the Journal of Paramedic Practice.

Abstract:

The traditional role of the ambulance service as an emergency medical provider has evolved in recent times, with an emerging role being the promotion of public health. The current study explores this concept by evaluating one event in the 'know your blood pressure' (KYBP) campaign, conducted across Greater London by the London Ambulance Service NHS Trust (LAS) in April 2010. The event allowed members of the public to have blood

pressure (BP) measurements and to receive advice on the health risks of high BP including stroke. Attendees with BP ≥ 140/90 were referred to their general practitioners (GPs). A subsequent telephone survey was conducted to assess campaign effectiveness. The event was attended by 2 274 people, 23 % of whom had a high BP measurement. Overall 625 individuals participated in the telephone survey, over half of whom were referred for further medical attention. More than half of these individuals (56 %) contacted their GP's surgery as advised. A number of individuals were either prescribed antihypertensive medication for the first time or were subsequently put on a higher dose or an alternative antihypertensive agent. An increase in knowledge of the risks of high BP was also reported. The positive findings demonstrate that ambulance services can have a role in promoting public health.

6. Cost Improvement Programme

A new process has been designed to provide structured reports to the Quality Committee for CIP. CIP monitoring for 2012-13 will be undertaken via assurance statements provided by the clinical lead for each initiative, identifying any actual of potential adverse effect on clinical care and any monitoring processes that are in place.

7. Other areas

Nothing to report.

Fionna Moore
Medical Director

Steve Lennox
Director of Quality & Health Promotion

8th August 2012

Appendix 1

London Ambulance Service NHS Trust

Patient Report Form (LA4)

NHS CONFIDENTIAL

CAD / Event number | Date | Call sign | Fleet number | M.I. Patient No.

Activation details

Map | Location | Emergency | Non Emergency | Origin time

Call given as | Age | M F U/K | Called by

Dispatch time | En route | Dispatched by | Accepted by | Vehicle activation

Arrive RVP/ Stand-off | On Scene | Arrive Patient | Delay code | Other delay

LAS response on scene 1st 2nd 3rd+ | Call signs | Police | Officer ID | Fire

Also on scene: First responder | Officer / T Leader | Other LAS | VAS | HEMS/ BASICS | Other NHS Ambulance Service

Cancelled call | Time | By (initials)

Patient's details

Last name | First name | Date of birth | Age | Male | Female | Race | NHS No.

Home address | Postcode | Tel no.

Next of Kin | Relationship | Contact details

GP Name | Address | At scene | Visited | Phoned | To visit | Letter

Mental Health Team / CPN / AMHP | Contact details

Name of H.V. / Primary Carer | Name of School / Nursery

Patient accompanied by

Presenting complaint

Incident time / onset of symptoms: Time | Date

Airway
Clear | Partially obstructed | Obstructed

Breathing
Present | Absent | Complete a sentence in one breath | Unable to assess

Circulation
Bmucosa cyanosed | Peripheral cyanosis | Capillary refill > 2 sec | Distal pulse

Other
Sweating | Vomiting | Fitting | Number of fits | Burns | %

Estimated blood loss

Observations

Time	:	:
AVPU		
Resp rate		
Resp depth		
% O_2 sats	Air / O_2	Air / O_2
Peak flow		
CO_2		
Pulse rate		
Pulse character		
BP		
Colour		
BM		
Temp		
Pain 0-10		
Pupils size	R L	R L
Pupils reactive	R L (Y N)	R L (Y N)
GCS	E V M	E V M
	Total	Total
ECG rhythm	Initial rhythm	

Allergies | Known infectious

Past medical history | Medication | Medication brought in | List brought in

12 Lead ECG

Normal ECG | Inferior MI | Anterior MI | Lateral MI | Posterior MI | LBBB | ST depression | T wave changes only | Other abnormality | Inconclusive ECG

FAST

Facial weakness — Unequal smile or obvious weakness (Unable to assess | Affected side R L)

Arm weakness — One arm drifts down or falls

Speech — Word finding difficulties or slurred speech

Chest pain (cardiac in origin) | Shortness of breath | Other symptoms / pain (cardiac in origin) | T-LOC | Palpitations | Asymptomatic

Cannulation

Line 1 / Line 2: IV / IO | Size g | Time | Successful | By | No touch technique | Placed in emergency conditions | Flush

Fluid and drug administration

Drug bag codes

Code	Name	Amount	Dose	Route	Time	By

Continuation

Total Controlled Drug amount wasted | Signed | Witnessed

Airway and Respiratory management

Maintenance: Postural | Head tilt | Jaw thrust

Clearance: Suction | Manual

Airway adjunct: OP | NP | ET | SGA

ET successful | By | ET size | Time

SGA successful | By | SGA size | Time

NCr | NCr successful | By | Time

NTh | NTh successful | By | Time

Cardiac arrest, CPR, Defib, & ROSC

Arrest witnessed | By other | By crew | On scene | During removal | In Ambulance

Cause of cardiac arrest: Cardiac | Trauma | Respiratory | Other

Initial arrest rhythm: VF / VT | Asystole | PEA

Pre-LAS CPR | Time started | Effective | By

Pre-LAS Defib | Time started | By

LAS CPR | Time started | By

LAS Defib | Time of 1st LAS shock | By | Number of shocks | Paediatric electrodes used

Return of spontaneous respiration | Time

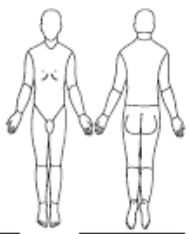
Return Of Spontaneous Circulation | Time

ROSC sustained to hospital

Recognition Of Life Extinct | Time

Heart sounds absent | Asystolic rhythm strip | Apnoeic | Confirmed dead at Hospital | Fixed dilated pupils

Injury = X | Burns = ■ | Fracture = # | Pain = ●



Transporting / Left scene | Pre-alert

Lifting and immobilisation

Carry chair | Trolley bed | Ortho | Carry sheet | Mangar Elk | Other

Splints: Collar | Rescue board | KED / RED | Box / Vacuum | Traction | Pelvic splint | Other

Tourniquet used

Arrive Hospital/Destination

Transport arrive | AVPU | Hospital / facility name | Department / Ward | Destination code (suffix)

Clinical Handover | Patient Handover | Nurse | Midwife | Doctor | Other | Signature

Patient's property bag used | SPATS barcode | Patient Hospital No.

Major Trauma

triage tool positive | Step

Private address | Work | Street | GP Surgery | Care home | Police custody | Other public

Forced entry undertaken

Treatment before LAS arrival | Patient consent obtained | Physical disability | Mental capacity | Capacity tool used | Learning disability

Additional forms completed: LA 3 | LA 5 | LA 52 | LA 277 | LA 279 | LA 280

Ambulance Personnel

	Name	Personnel No	Status
1	Attend		
2	Driver		
3	Other		
4	Other		

Continuation sheet | Primary code | Main illness/injury code | Secondary illness/injury code | Patient not conveyed / referral code | No patient code | Event complete

Appendix 2

London Ambulance Service NHS Trust CLRN Annual Report 2011/12

Summary of Performance

Six performance highlights during the reporting period:

- In 2011/12 the London Ambulance Service (LAS) increased recruitment to portfolio studies from 159 participants in 2010/11 to 1203 patients – this represents more than a six and a half-fold increase. Additionally, we recruited a further 39 patients to a non-portfolio RCT and recruited 548 ambulance staff and student paramedics as participants to non-portfolio studies. The set-up of the non-portfolio RCT trial involved training approximately 80 frontline ambulance staff to administer a drug to patients that previously had not been used in the ambulance service. We are proud to report that during 2011/12 we received the Thames Stroke Research Network award for achieving the highest level of participant recruitment.

- We worked closely with Swansea University and key operational people within the LAS to successfully set-up the SAFER2 (portfolio adopted) study. This involved the challenging task of implementing trial referral pathways for elderly fallers at the same time that the LAS was implementing its own (non-research related) fallers' referral pathways across the rest of the London. In addition, we trained over 40 members of frontline clinical staff to recruit patients into the intervention arm of the trial.

- With regards to commercial activity, we acted as a participant identification centre (PIC) for the portfolio-adopted High Risk ACS study (formerly known as the DANCE study) and contributed towards recruiting a total of 60 patients. We trained approximately 250 members of frontline ambulance staff to identify patients potentially eligible for participation in the study and convey those eligible directly to a Heart Attack Centre.

- All new entrant LAS Paramedics attended a one-day training module on Clinical Audit and Research. The course covered evidence, informed practice, research methods, literature searching skills, critical appraisal techniques, and taught students how to prepare a research proposal. As part of the module students produce ideas for new research and are encouraged to develop research projects. During 2011-12, 502 Paramedic students attended the training module.

- We undertook a lot of work to promote a research culture amongst staff at all levels in the LAS. In May 2011 we held our first ever Research Conference, which was attended by 86 members of clinical staff. This full day conference showcased all the research work in which the LAS was involved and included presentations from our collaborative research partners from as far a field as New York City. We held monthly 'Research Surgeries' where staff from the R&D department helped others from across the Trust to develop research ideas as well as providing technical and statistical advice to those already undertaking research. We held quarterly 'Journal Clubs' through which ambulance staff reviewed and critically appraised published research papers.

- During 2011/12 we utilised the services of a Research Nurse at a local hospital to assist with one of our portfolio adopted studies. Without the assistance of this Research Nurse we would not have been able to consent as many patients to the study as was required, nor would we have gained the outcome data necessary to make this study a success.

Supporting Life Sciences Industry

- As reported in the previous section, in 2011/12 we acted as a PIC for the High Risk ACS study. We completed training of approximately 250 members of frontline staff and contributed to the recruitment of 60 patients into the study.

- We published our R&D Operational Capability Statement on our external website, which provides information on the types of studies that can be supported by the LAS, our clinical service departments, and our areas of research interest.

Research Management & Governance

- We revised and streamlined our RM&G processes to reduce bureaucracy and speed up our approvals process. As an example, we reduced the amount of time given to our research steering committee members to peer review research proposals to 14 days, and asked reviewers to confirm their ability to conduct the review within the 14 day period before sending documents to them. This helped to reduce delays in the peer review process enabling us to give more timely feedback to researchers and speed up the overall process of granting NHS Permission.

- We implemented a proportionate review process for student projects and other low-risk studies (such as questionnaire studies using staff as participants) which helped to reduce bureaucracy and shorten the time taken to grant NHS Permission.

- We asked researchers to engage with, and seek approval from, local management earlier on in order to allow more timely identification of potential issues with the proposed research and to ensure that the granting of NHS Permission is not delayed unnecessarily.

- By holding monthly research advice surgeries and ad-hoc advisory appointments, we were able to advise researchers of the approvals process and identify potential issues prior to submission of their application.

- An example of where the implementation of the HR Good Practice Guidance is working well:

  Following local implementation of the HR Good Practice Guidance, we successfully used the algorithm within the guidance to inform our decisions regarding whether a Letter of Access or Honorary Research Contract is needed. Additionally, for certain types of studies (e.g. one-off interviews with staff at a specified location) we now issue only a Licence to Attend. Together this has enabled us to take a more

proportionate approach, reduce bureaucracy and speed up permission and study set-up times.

- An example of positive feedback from a researcher about local reduction in bureaucracy:

  The approvals process for a student's research project was significantly delayed because their University refused to acknowledge their responsibilities with regard to sponsorship. We informed the student of the reason for the delay and contacted the University to explain why they should be the Sponsor for the study, explained to them the responsibilities of the Sponsor and provided example letters confirming Sponsorship for their use. This resulted in the University agreeing to act as Sponsor and providing the necessary letter so that we could grant permission for the research. The researcher was very impressed with the help and support that we provided and our ability to influence the University to accept responsibility appropriately.

Workforce Deployment & Development

- An example of how redeploying workforce resource has led to a measurable increase in patient recruitment:

  In order to support the SAFER2 study at the LAS and facilitate patient recruitment, two of our frontline clinical staff were seconded on a part-time basis to the role of SAFER2 Research Support Officer (RSO). They played a vital role in maintaining enthusiasm amongst other frontline staff participating in the trial, identifying why paramedics in the intervention arm had not followed the protocol (and so had not referred eligible patients), as well as reminding those in the control arm not to refer patients. Furthermore, the RSOs were instrumental in consenting patients to the trial as they were able to draw upon their clinical experiences of working with elderly patients to build rapport and explain to them the trial in a clear and friendly manner (something that a non-clinical researcher might find more difficult to do). The RSOs' time on the project was fully funded by the CLRN.

- An example of how a training initiative improved study set up or delivery:

  To support the set-up and delivery of the High-Risk ACS study (for which we are a PIC), it was necessary to train approximately 250 members of frontline clinical staff. This required planning and providing staggered training that had to be adjusted according to operational pressures on the Service and the need for these staff to be available to respond to emergency 999 calls. To increase clinical staff attendance at training sessions and create enthusiasm for the study, the training initiative included: holding evening training sessions, delivery of the training by the LAS's Clinical Practice Manager and other highly regarded members of staff, the production of pocket-sized laminated aide-memoirs for staff, and a presentation to staff from a Cardiologist.

Patient & Public Involvement

The SAFER2 researcher based at the LAS set-up a local service user involvement group through which patients and their carers met with the researcher and the RSOs to discuss issues affecting the older faller group (i.e. those likely to be recruited to the study) and to gain feedback on the consent process, interview topic guides, questionnaires, etc. This resulted in improved communication between the RSOs and participants during the consenting process and is believed to have contributed to the LAS's high trial consent rate – a rate that was higher than that achieved at any other SAFER2 study site.

Financial Management

All research funding is managed in accordance with the Trust's Standing Financial Instructions and operating procedures, as well as in line with any contractual obligations imposed by research funders. Resources are managed and value for money is ensured via monthly reviews with the LAS's Financial Management Accountant where money received and spending against income is monitored.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 21ST AUGUST 2012

PAPER FOR INFORMATION

Document Title:	**Quality Committee Assurance Report**
Report Author(s):	**Beryl Magrath, Chair of the Quality Committee**
Lead Director:	**N/A**
Contact Details:	
Why is this coming to the Trust Board?	**To understand the topics of discussion at the Quality Committee and the issues as well as gaining assurance from the committee**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other
Recommendation for the Trust Board:	**To take assurance from the report on the governance of quality and safety**

Key issues and risks arising from this paper

N/A

Executive Summary

The last meeting of the Quality Committee took place on 15th August and therefore a written report is not available for the Trust Board meeting. The Chair will instead provide an oral update at the meeting.

The Chair of the Quality Committee was asked to provide a summary of the key points of the Serious Incident Annual Report for 2011/12, which was presented to the Quality Committee at its meeting in June. This summary is attached.

Attachments

Summary of the Annual Report on Serious Incidents – 2011/12

****

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

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

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

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

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

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

Equality Analysis

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

Key issues from the assessment:

Summary of the Annual Report on Serious Incidents – 2011/12

This was the first annual report on serious incidents specifically, with previous reports covered by the annual update on patient experiences. Serious incident data, themes and lessons learnt are incorporated in the quarterly service experience (formerly the learning from experience) report that is received by the Quality Committee.

Data summary

- 26 serious incidents declared in 2011/12 out of 92 considered by the SI group.
- Total number of incidents reported during 2011/12: 5087 = 0.5% of total incidents.
- 28 serious incident investigations completed during 2011/12: 13 from 2010/11 and 15 from 2011/12.
- Average time to complete and report an investigation: 4 months. This is an improvement on the start of the year where the average time was 7.1 months.
- Top 3 areas reported as SIs: delayed response (6); information governance (6); and BBA/obstetric emergency (4).

Themes, root causes & lessons learnt

a) Delayed response

Case 1: 999 call – chest pain – subsequent calls later in the day with ambulance arriving 5 hours after the initial call - patient experiencing a heart attack. Root cause: we were operating on paper based call-taking and dispatch for an extended period of time. Lessons: robust contingency plans for fall back in the event of critical system failure are essential. Plans must include a full assessment of the impact on patient care and performance.

Case 2: 999 call received for patient in labour at an address flagged by the MPS as high risk. Crew dispatched and asked to standby for MPS. Baby born before staff entered the location. Root cause: locality information was out of date due to lack of comprehensive review process between the LAS and the MPS. Lessons: training to be delivered to all staff on updated guidelines and for regular bulletins to be issued. Subsequent note: service level agreements between LAS and MPS being updated and implemented to support improved processes.

Case 3: 999 call to a leisure centre to attend a patient. 13 subsequent calls received from leisure centre staff, public and the MPS. Resources dispatched after 2 ½ hours. Patient found to be in respiratory arrest; treated by crew and conveyed to hospital, where attempts were made to resuscitate the patient who subsequently died. Root cause: in times of high call demand the risk of a delayed response to C1 and C2 patients increases.

Case 4: national day of public sector action over the pension's dispute led to led to limited resources available to send to emergency calls that were not immediately prioritised as serious or life threatening. Lessons include the possibility that elderly patients with complicated pre-existing conditions may be placed at greater risk during periods of high demand or extreme pressure.

Case 5: 999 call to an unconscious/fainting patient was logged as 'conscious/breathing' but manually noted as 'patient not responding' and categorised as C2. Response was made within C2 parameters but the patient was found to be deceased on arrival at the scene. Root cause: human error – call under-triaged. Lessons: call-takers should receive QA feedback at their annual PDR.

Case 6: grouping of 3 incidents relating to 3rd party calls from elderly care service providers. The investigation also looked into complaints and concerns raised about the management of calls from care service providers over the previous 12 months. Root causes: communication from 3rd party callers resulted in 999 calls being triaged as lower priority; call handling procedures do not allow staff to insist that service providers contact the client for further information or to recommend that the patient calls 999 themselves. Some similarities here with Case 3 above. Lessons: EOC staff are diligent and proactive when receiving calls from service providers and often take the initiative to ring the patient back themselves of they cannot get through to the service provider; they will also always try to triage above the minimum information provided to minimise the risk to the patient. Subsequent note: below is an extract of the response from a complainant who raised one of these incidents and received the final investigation report, demonstrating lessons learnt and action taken in partnership to improve arrangements.

'Thank you for your reminder yes we have had time to consider the very comprehensive response, there is learning that has taken place on both sides as a result of this incident & the response provided. Careline do agree that 3rd party information is not good. In many cases Careline request an ambulance at the office and the follow up calls are made from the office as they make the original call.

As a result of this incident & the response provide by LAS, this procedure has now changed, whilst the initial call (to speed things up) is still made from the office whilst the other duty officer is on route any follow up calls should be made by the duty officer who is with the service user as they can give an update and can also answer specific question, i.e. breathing getting worse. At least then the London ambulance control centre will get up to date information and can ask specific questions to the Duty Careline Officer (DCO). Relying on the office to pass on information is not the most efficient way of doing things.

This did not happen all the time, in other cases the ambulance are called directly by the DCO on site but it has now been made mandatory that if an ambulance is required then the duty officer who is with the service user needs to make the call, only using the office if it is not possible i.e. only as a back up.

The duty officer when with the service user is then able to speak to the ambulance service so that they can get further information to assess the call and triage accordingly.

This should help the ambulance service to assess the calls and for us to give as much viable information as quickly as possible as to the service users condition, therefore hopefully this type of incident will not happen again as the LAS staff will have the information they need to change the priority of need for an Ambulance & appropriately dispatch an ambulance when it is required.'

b) Information governance

Case 1: an email sent from the FT membership inbox to a large number of recipients inviting them to an event included the addresses in the 'cc' box rather than 'blind cc'. One recipient alerted the Trust to this reporting a breach of data protection laws. Root cause: there was no mechanism in place to check email content before pressing 'send'. Lessons: it is a legal and Trust requirement to manage personal data securely. The team have instituted a two-stage process to prevent any further such breach of compliance.

Case 2: a folder containing 3 PRFs was lost from the back box of an MRU en route. The loss was reported to the MPS and the Trust. The folder was found and handed into the MPS by a member of the public by the roadside. Root cause: failure to secure the storage box on the back of the motorcycle. Lessons: ensuring the older style boxes have secure locking mechanisms. Newer motorcycles in the LAS have an integrated security design with a top box locking mechanism that prevents the key being removed to use in the ignition if currently inserted in the top box.

Case 3 and case 6: the LAS routinely send SMS messages to fast response vehicles to alert them to details of a call. Both cases involve mobile numbers being entered incorrectly into the Trust system which led to a member of the public receiving the messages. Root cause: inadequate procedures for managing SMS messaging. Lessons: using SMS messaging to pass call details increases the risk of loss of confidential and personal identifiable data. Additional verifications must be introduced when entering or changing mobile numbers into Trust systems.

Case 4: six PRFs used by fast response units were found to be missing during the daily check and collation of papers. Root cause; failure to follow Trust procedure. Lessons: staff need to adhere to policy and procedure and ensure that paperwork is handed in at the end of every shift.

Case 5: two completed PRFs tucked behind a sun visor in an ambulance were blown out of the door in a strong gust of wind and onto the track-side of a railway embankment so could not be retrieved. Heavy rain was likely to have made the PRFs unreadable. Root cause: no storage area for PRFs in ambulances. Lessons: crew need to securely store PRFS on vehicles before handing over at the end of the shift.

c) Obstetric emergency

Case 1: a delay in dispatching an ambulance to an imminent birth, premature delivery; and concerns about the type of resuscitation equipment used. Root cause: ProQA software doesn't automatically triage these high risk calls as category A but relies on the call-taker to manually upgrade which did not happen in this case. The call received a 19 minute response rather than 8 minutes. It cannot be determined whether this delay would have had any effect on the outcome of the neonate. It is likely that the patient would still have been born on board the ambulance and not in the more specially equipped maternity department. The first ambulance on scene was not equipped with a suitably sized mask to fit such a premature neonate. The crew did the best they could to achieve effective ventilations (achieving some chest rise) but it wasn't until the arrival of the 2nd crew (where the paramedic happened to have 'pre neonate' sized mask in her paramedic bag) that ventilations became more effective and the neonate began to

respond through improvement in colour and circulation. Lessons: the QA department identify calls that are not manually upgraded and provide 1:1 training to those staff members but this could be extended. Appropriate sized masks for premature neonates have been supplied.

Case 2: a crew attending a baby born at home delayed contacting EOC to advise they needed a midwife to attend due to complications. The baby had to be resuscitated and blue lighted to hospital. This incident is still in the draft report stage.

Case 3: 999 call received from a patient in labour who informed them of (prolapsed cord). The call-take correctly selected the chief complaint using MPDS but the determinant was incorrectly coded as a C3 response when it should have been a Red 1 response. The call-taker did not log that the patient had a prolapsed cord. The dispatched crew were unaware of this and conveyed the patient as a normal maternity case. This incident is being reinvestigated at this time.

Case 4: an acute hospital notified the LAS that it was investigating a serious incident regarding an infant death and that the ambulance had waited outside the address for the MPS to arrive. On investigation it emerged that the call-taker had not followed Trust procedures in call-handling, and the calls had not progressed to the key clinical questions that would have established that this was an obstetric emergency. The call was automatically determined as an urgent response, Red 2. On arrival, due to information logged about the caller by the call-taker, the crew expressed some concern about potential staff safety issues and the EOC allocator requested MPS attendance. It was subsequently determined that the caller and patient were not at the address having made their own way to hospital and therefore the delay in waiting for the police to confirm when they would attend was not a causal contributory factor. Root cause: patient's lack of antenatal care precluded her from understanding the significance of symptoms experienced during pregnancy which could be indicative of maternal and foetal wellbeing. Also, the unexplained 'obstinate' behaviour of the call-taker prevented key clinical information being obtained which would have led to the patient receiving care at home more quickly. Lessons learnt relate to the management of work/role related stress.

Conclusion

Managing the serious incident process can be complex, time consuming, and resource intensive. During 2011/12 however the backlog of serious incidents dating back to 2010/11 has been cleared; improvements have been made to the processes for reviewing, declaring, investigating and reporting serious incidents; monitoring processes are more effective; final reports are of a better quality. Timeliness of investigating and reporting has improved but is still outside the recommended 45 days. There is greater ownership of serious incidents and the associate directors' and senior management groups both review the reports and monitor progress against the action plans. Lessons for service improvement are discussed through the quarterly service experience report.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: TUESDAY 21ST AUGUST 2012

PAPER FOR NOTING/APPROVAL

Document Title:	**Chief Operating Officer's Report**
Report Author(s):	**Martin Flaherty & Paul Woodrow**
Lead Director:	**Martin Flaherty**
Contact Details:	**0207-7832039**
Why is this coming to the Trust Board?	**For noting**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Other
Recommendation for the Trust Board:	The Board is asked to Note the paper

Key issues and risks arising from this paper

Ongoing increases in 999 call volume and Cat A workload against previous year
CPI completion rates still below target, principally due to capacity issues and QDJ and Olympic preparations.
PDR completion rates are challenging at present due to the significant abstractions attributable to Olympic Games.
Due to the Pre-planned suspension of training throughout the Olympic Games period there will be significant challenges delivering all the remaining CSR training throughout Q3 &Q4.
Category C performance still remains a challenge although we have seen some recent improvements due to increased capacity over the Olympic period

Executive Summary

The paper provides an update on the following key areas:

1.A&E Service Delivery
2.Emergency Preparedness
3.Fleet and Logistics
4 PTS
5. CQUIN and Business Development
6. London 2012 Olympic Games
7. Communications

Key Points

- The year to date position on Cat A8 minutes is 75.0% and on Cat A19 is 98.3%
- The Trust is still experiencing increased levels of demand in July where 999 calls are up 9% and Cat A volumes are up by 12.5% on the same period last year.
- Emergency preparedness activity is largely focussed on the Olympics preparations. The new Trust Major incident plan has also been published in July
- 62 New Mercedes ambulances have been commissioned and have been deployed within Olympic Games venues
- The new prototype Fast Response Unit was also delivered to the Trust in July and commissioning the first tranche of these vehicles will begin in August
- Olympic Games concept of operations for both routine service delivery and Olympic venue specific were enacted from the middle of July and will conclude at the end of the Paralympic Games on the 9th September 2012

Training
The Clinical Quality report includes an item in the exception report as there is a concern that the Trust may not meet all its CSR 1, 2 and 3 commitments in 2012-2013. All pre-planned CSR training was temporarily suspended at the end of May due to the large operational commitment to the Queens Diamond Jubilee and the London 2012 Olympic and Paralympic Games. Training will commence again at the beginning of October. The Resource centres are now scheduling the CSR modules across the Trust throughout Q3 and Q4.

CPI / PDR Completion
There have been continuing challenges to meet the target on these two extremely important measures. These are principally based around insufficient capacity to release Team Leaders to complete this work due to continually high activity levels. The West and East operational areas have utilised frontline staff on restricted duties to continue to audit CPI compliance. The South area has had no appropriate staff to train to complete CPI audits. The Assistant Director of Operations for the area has submitted an action plan with an improvement trajectory to the Deputy Director of Operations. This plan has been approved and was implemented on 13 August.

Category C performance
As we have continued to see Category A activity levels rise significantly over the first four months of the year this has had an impact on Category C performance. A number of actions have been taken to improve our service levels for this cohort of patients, they include:

- The introduction of the Clinical Hub within EOC on the 16 July
- All C1 category calls are now in the auto dispatch criteria for FRUs
- Increased range of 999 calls have been placed in to the auto dispatch criteria for ambulances

Over recent weeks we have seen a significant improvement in Category C performance. This essentially has been driven by the increased capacity deployed to meet projected demand levels driven by the Olympic games.

Attachments

Chief Operating Officer's Report July 2012
Integrated Performance Report for Trust Board July 2012 **(Please note that the Value For Money and Finance sections of the report have yet to be updated for July)**

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

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☐ No

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING 21st August 2012

CHIEF OPERATING OFFICERS REPORT

1. A&E SERVICE DELIVERY

Accident & Emergency Services performance and activity (please see attached integrated performance report for July 2012)

Overview

The table below sets out the A&E performance against the key standards for Category A for June through to 6TH August 2012 together with the current year to date (YTD) position.

Category	Cat A8	Cat A19
Key Standard	**75.0%**	**95.0%**
2011/12	75.7%	99.2%
July 2012	77.2%	98.5%
August 1st to 6th 2012	86.0%	99.4%
2012/13 YTD	**75.0%**	**98.3%**

The month of July saw the Trust achieve 77.2% for category A8 performance. It is pleasing to report that this is above the National Key Standard for A8 and above the trajectory target of 75% submitted to our commissioners. The Trust year to date (YTD) position of 75.0% for the year remains in excess of the commissioner's trajectory of 73.5%.

Category A incident demand for the month ended 12.2% above the same period last year, this equates to an additional 3,951 incidents. Total incidents continue to increase with the month of July seeing an overall growth of 4.1% in comparison to July 2011. The Trust's overall year to date category A demand has increased by 16% over the same period last financial year. This equates to an additional 19,746 responses, total incidents have also risen year to date by 1.9% which remains a concern for the Trust.

999 call volumes continue to increase with the month of July seeing an additional 11,946 calls enter the system this equates to a growth of 8.9% in-comparison to last July. Some of this additional call volume may be attributable to an increase in ETA calls due to the large numbers of calls holding we have been experiencing in recent months. This in month increase of 999 call volume now means that the year to date increase now stands at 9.4%. This equates to an additional 49,671 calls handled within EOC. Calls answered within 5 seconds for the month of July achieved 94.6% marginally short of the 95% threshold, with the Year to Date now sitting at 93%.

Pre-planned SP2 training continued in the month through to the 20 July where due to the commencement of the London 2012 Olympic and Paralympic games this activity temporarily ceases until the 10 September. In month, 1853 abstractions were made to facilitate this training, this equates to c124 per day for the 15 day period that this training was delivered. Pro-rata we still abstracted more people per day for pre-planned training than the equivalent month last year.

Additional abstractions commenced from the middle of July as the clinical staff seconded to the Olympic cohort started to be deployed pre-games for some late testing events and training venues. Capacity remained a huge concern in the first three weeks of July and once again we were heavily reliant on additional overtime spend and PAS support to provide 29,500 DCA hours per week. Staffing significantly improved towards the end of the third week of July as the Olympic and Paralympic overtime enhancements commenced from the 19 July.

As previously reported the Trust implemented the changes to clock start measure on the 1st June 2012. Whilst it is pleasing to report that the month of July has seen enhanced performance across all categories of calls some concern has been raised that the perceived benefits in Category 'A' performance were not being fully realised based on the projections made prior to the implementation of the change. Other perceived benefits such as a reduction of the Multiple Attendance Ratio are not being exhibited to the levels we had hoped. As a result of these concerns the Chief Operating Officer facilitated two half day workshops. The first workshop was to break down current performance levels across every metric contained within the whole call cycle process to identify which measures had deteriorated using three month and twelve month historical data. As a result of the workshop ADOs from both EOC and Areas were set actions to drive improvements in the areas identified through the process.

The Deputy Director of Operations for Service Delivery also carried out a comprehensive piece of work with the Head of Control Services and the EOC Performance Improvement Manager to identify further opportunities to enhance outturn performance. As a result of this work we have increased the number of event types in to the auto dispatch criteria for ambulances. Since making these changes we have seen an increased percentage of auto dispatch for ambulances with the associated improvement in response performance.

The second workshop held was to try to understand the reasons behind the acute increase in Category 'A' demand in this financial year. A number of areas were identified for further investigation and more work on this will continue on completion of the 2012 Games.

The first stage implementation of the clinical hub took place on 16 July. It has taken slightly longer than was anticipated to embed staff consistently in to the Hub. Some of these issues have been compounded by members of the project team being abstracted in to the Olympic cohort. I am pleased to say that these issues have reduced and we are now seeing some real benefits in managing some of cohorts of patients within the C category more clinically appropriately. We are also now starting to see albeit small numbers of enhanced triage for Red 2 patients. This element of

work within the clinical hub has been harder to influence with the improved levels of capacity the Olympic Resource plan gives. There will be an interim review of the clinical hub at the conclusion of the 2012 Games. There is now however a greater sense of ownership of the hubs performance from the EOC AOM.

A performance improvement and maintenance plan has been developed and submitted to SMG for review, the senior operational team will continue to drive up the levels of performance and discharge the actions contained within the plan as soon as it is approved.

For the month of July the Trust recorded a total of 47 Black Breaches (60 minutes or more), which in-comparison to July 2011 is an overall reduction of 3 (6%). South East London Cluster had the largest concentration of Black Breaches in month with a total of 30 of the 47 breaches, this equates to 63.8%. Hospital 60 minute Black Breaches year to date compared to the same period last year remains lower by 86 or 22.6%.

AEU utilisation for the month of July reduced to 81.2%, this was a reduction of 2.3% on the previous month with the current year to date now at 83.6%. FRU utilisation also reduced in the month of July by 1.3% to 41.7% with the year to date position being 42.1%. Urgent Care utilisation for the month of July was 56.5%. High utilisation of operational resources continues to be one of our biggest concerns.

2. Emergency Preparedness

The Major Incident Plan has now been published on the pulse and available to staff supported by a bulletin with the key changes. The feedback so far has been extremely positive. Staff and manager awareness of the changes will continue over the coming weeks.

As in previous reports we continue to be busy with public events having now almost completed the Hyde Park Concert season with the finale “Proms in the Park” in a couple of weeks time. Planning for this year’s Notting Hill Carnival is complete and the event take place over the August Bank Holiday weekend with an expected attendance of 350,000.

The first two of the Trust’s Command Support Vehicles have arrived replacing the two older outdated units, now being de-commissioned, staff training for the control service team will shortly commence in the use of the vehicles. The new fleet (six) of Emergency Support Vehicles (major incident equipment/tentage/lighting) have been delivered, with three equipped and commissioned prior to the start of the Games with the final three commissioned prior to the Paralympics Games.

As part of the multi-agency CBRN response for games time, the Hazardous Area Response Team has accommodated members of the Police and Fire initial assessment teams at our HART East, Cody Road site. This has further forged our working relationships and understanding of roles with the other emergency services.

The Emergency Planning Team has delivered a series of major incident training session to the Apprentice Paramedic programme; we will continue to support this as the programme roles out.

3. Fleet and Logistics

Fleet

62 new Mercedes ambulances are now commissioned and successfully deployed at various Olympic Games venues. This is despite additional requirements imposed by the Vehicle and Operator Services Agency (VOSA) which meant that the entire third batch (22 vehicles) had to undergo individual vehicle approval (IVA) before they could be registered. The remaining nine vehicles are due for delivery in early August but it should be noted that all Olympic vehicle requirements will be fulfilled without any impact on core fleet.

The prototype Skoda Octavia FRU arrived in London on Friday 20th July and was demonstrated at Trust HQ the following week. There will be a short delay in production while work is done to rectify a defect in a Satellite Navigation cable identified in some of the new ambulance fleet (the ambulances and cars share this particular spec). These cars will be followed later in the year by a further batch of 35 of the same vehicle.

The LEZ conversion contract was signed on 23rd July 2012 with work due to commence by the start of August. The project remains on track for completion by the end of September.

Work is ongoing, led by Estates, to sign the lease for the new West Workshop (Greenford) site. The District Valuer has now approved the proposed rental value and negotiations to confirm the lease and lease agreement are almost at their conclusion. Thereafter the revised business case will be submitted to the SHA for approval.

Logistics

Focus in July within Logistics has primarily been on providing an enhanced service for Olympic Games commitments (at the Olympic Deployment Centre) as well as significantly enhanced Maintaining Service Delivery activity. The department has been providing an additional nightly tender service as well as an improved hospital collection schedule, alongside extra activity in drug packing and routine supply chain. Planning is also underway for some significant project-based transformation within the Logistics Support Unit at Deptford, encompassing new inventory management and asset tracking to sit alongside the work being undertaken by Initial. In particular, there is work ongoing to ensure visibility of tracked assets when they pass from routine operational use into the LSU for repair or service. The Logistics team has been instrumental in the process of commissioning new ambulances at Fort Street. As Olympic ambulances start to be released for operational use, Logistics staff will begin to deliver a plan to establish an ‘equipment hub’ in each area.

Vehicle Preparation

Progress against basic contracted targets was not as strong as expected in July although the contract remains in the transition phase, meaning that contract penalties do not yet apply. Improvements have been hampered by the resignation of the

supplier's General Manager for the contract. A new GM has been appointed but does not take up his post until September. Arrangements are in hand for an effective transition. The supplier is being held to account for the progress being seen to date and achievement of the contracted standards is still expected by September 2012. Support for Olympics activities has been strong, in particular the vehicle preparation service at the ODC.

Asset tracking continues to be rolled out with tags being applied steadily to the entire front-line fleet and all identified equipment. This remains on track as specified in the project plan and the first reports are expected in late August using the new system. The managed stores element of the contract is in its early stages but remains on track against the project plan.

Performance

Key performance standards have taken a dip this month. This can be ascribed in part to the pressure to deliver the Olympic fleet, which has required focus from a number of managers in the department, combined with extraordinary peak vehicle requirements which on certain days have been as high as 340. This represents an increase of up to 30% on normal requirements. Servicing has seen the greatest impact although the figures in part reflect a change in reporting that was introduced from July onwards. The department now reports on servicing achieved against plan which is a change from the previous report which simply declared the proportion of vehicles that had a service, irrespective of whether it was early or late. A new Servicing Manager starts in his post on 10th August and this is expected to deliver significant improvements. Despite the low figures being reported in July, almost 50% of the fleet nonetheless had a service examination in the month.

From July onwards, the provision of a shell (unkitted or partially kitted vehicle) is no longer considered to fulfil a vehicle requirement, a change that has translated into a 30% increase in cases of 'no vehicle available'. This change is designed to provide greater transparency and an enhanced sense of confidence in the service being provided by the department. There is a robust action plan in place, incorporating support from Area operations, to reduce the number of shells in the fleet. Decommissioning of older vehicles later in the year will also support this work and there are plans, currently at an early stage, to introduce Area-based kit hubs which will store 'hot' spares of equipment.

FRU VOR has increased due to increased breakdowns and defective tyres. Delays in the availability of parts were also a factor. Fleet stability suffered as a result of the increased vehicle requirements, as excessive movements were required to resource shift starts. There was however a reduction in lost hours during the final week of July. This followed a number of initiatives being implemented to address the situation including additional mobile fleet cover, earlier starts for support drivers, daily activity to reduce the number of shells, increased daily parts deliveries, and improved returns from dealerships and body shops. These initiatives will be further developed in August to drive further improvements.

4. PTS

Commercial

No new tender opportunities have arisen in July 2012, although work continues with preparation of tender bids for Hillingdon Hospitals NHS Trust and the framework agreement which has been issued by the London Procurement Programme Board.

Contracts have been renegotiated and agreed with both Barnet Enfield and Haringey Mental Health Trust and Queen Victoria Hospital. The revised end dates of these contracts have now been extended to 2013.

Operational

PTS is now providing transport for both LAS and PPA staff to Olympic venues during the games period. As a consequence a number of core staff and vehicles have been removed from the core operation. These resources are being backfilled with third party and Agency staff which are being flexed up and down with requirement.

PTS normally sees a drop in demand during the summer school period and the Olympics is resulting in some clinics around the games venues closing down for the period of the Olympic Games.

Preferential rates were agreed with third parties before the start of the games and the PTS are using a company called HATs almost exclusively during the period of the games. The cost of this third party expenditure was included with the costings provided at the outset of the PTS bid to provide transport for staff.

Performance

Activity in July increased by 4413 journeys to 17,872 for June. This is a large variation and is 3522 journeys more than for the same period last year. There is an expectation that this may be due to appointments being brought forward due to the Olympics and therefore there is likely to be a drop off in activity in August.

The quality indicators for July were:

- Arrival Time: 92% same as last report
- Departure Time: 94% decrease of 1% from June.
- Time on Vehicle: 98% increase of 1% from June

5. CQUIN and Business Development

The LAS has delivered a number of the key CQUIN milestones relating to Alcohol, Diabetes and the NHS Number. Additional support from operations has been provided to the CQUIN team to support delivery over the remaining months of 12/13. Significant areas of risk remain to the delivery of see and treat and hear and treat CQUINs over Q3 and Q4. However LAS have achieved over £600k of CQUINs to date.

Business Development continues to progress with contracts finalised with BAA at Heathrow to provide both additional Olympic and day to day cover. In addition negotiations continue with a range of football and rugby clubs across London for LAS

provision. Finally NHS Pathways have met with the LAS training team with the ambition of LAS undertaking NHS Pathways training on a commercial basis over the coming months

6. London 2012 Olympic Games

The Olympic & Paralympic Games Maintaining Service Delivery (MSD) concept of operations was fully implemented from Monday 23 July. This overarching framework supports the delivery of all the operational plans that were developed to maintain routine service to the patients of London throughout the whole Games period.

Temporary changes to rotas for both the strategic and tactical command roles have had to be introduced to take in to account the large amount of managers abstracted to the Olympic cohort. 131 clinical staff have also been abstracted to the Olympic cohort from frontline operations.

The MSD Olympic resourcing plan came in to force from 27 July and is based on achieving full staffing against the current ORH plan. Additional staffing has been planned for the identified highest risk days throughout the Games period. The resourcing plan was based on the demand projections created by the ORH modelling that was commissioned earlier this year. Significant overtime has had to be deployed to fully resource our current operational plan due in part to the fact that we have reduced our frontline establishment significantly over the last two years and the Trust are currently carrying vacancies against the new establishment.

The additional contingency cohort of PAS has been used to good effect to support routine operations. Service delivery since the commencement of the Games has returned excellent levels of response time performance across all categories of calls. Activity levels have been lower than the planning assumptions thus far but the resourcing levels have given us the opportunity to consolidate the year to date position and provide a significantly better service to our lower acuity patients. We have also seen significant improvements across a range of operational metrics. A full report will be produced at the conclusion of the 2012 Games.

Games time operations began on 16th July with deployments to Pre-Games training venues and the athlete's village in the Olympic Park. In addition the Olympic Deployment Centre (ODC) opened and began to process staff and vehicles. Initial deployments swiftly increased from Monday 23rd July when the Olympic Torch arrived in London and began its journey through local boroughs. Substantial crowds turned out to watch and see the relay. Our deployment plan mirrored previous torch relays where we adapted the plan from the Beijing Torch in 2008 deploying a series of mobile resources as the torch passed through local boroughs. Planning in conjunction with local LAS management teams by the urban zone command team resulted in the torch relay passing without adverse incident.

Between 27th July 2012 (opening ceremony) and 8th August LAS responses within the Olympic Park have totalled 159, 44 in the central zone, 98 in the river zone and 394 in the urban zone. These include 64 conveyances of athletes or Games family to emergency departments including 23 to the Polyclinic within the Olympic Park.

Staff from the 220 pre-planned aid cohort who have been resident at Goldsmiths College have been deployed across Olympic venues, on reserve shifts and in a small number of cases on voluntary shifts at local LAS stations. Feedback from the cohort has been overwhelmingly positive and having commenced the formal debrief process on 8th August, whilst some minor issues have emerged steps are in place to rectify these issues for the Paralympic Games when around half of the pre-planned aid cohort return to London on 28th August. A formal debrief report will be produced at the conclusion of games time activity.

7. Communications

Visit by Secretary of State: Andrew Lansley visited the Service in early July to find out about our planning for the Olympic and Paralympic Games. As well as hearing from Martin Flaherty about how we would manage the Games, he had a tour of our event control room and met frontline and call-taking staff who were involved in the Games. BBC London TV covered the visit.

Service preparations for the Games: The Service's preparations for the Games were featured on BBC London TV news. As well as interviewing the Olympic Deployment Centre manager about the additional staff and resources that would be used, BBC London went on a ride-out with a crew who would be dedicated to the Games. BBC Radio 5 Live also broadcast an interview with staff involved in the Games; namely a manager about the specialist training staff have received and a cycle responder about the cycle response unit's role during Games time.

7/7 medic carries Olympic flame: There was national and international broadcast and press coverage of Emergency Medical Technician Tracy Russell who carried the Olympic torch for 7/7 survivor, Gill Hicks, who lost both her legs during the bombings. Gill, who was unable to travel back from Australia to carry the torch, asked Tracy to carry it on her behalf. Tracy was one of the first medics to treat Gill on 7 July 2005.

Cyclist death near Olympic Park: The death of a cyclist following a collision with an Olympic coach on a road close to the Olympic Park generated widespread national and international media coverage. The Service's lines regarding its response to the incident were widely picked up.

Spectator who had cardiac arrest in Veledrome: There was widespread media coverage about a spectator who died after collapsing in the Veledrome. The Service attended the patient; however, despite extensive efforts to resuscitate him, he later died in hospital.

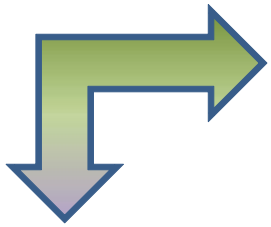
Use of private ambulances during Olympics: Guardian journalist Denis Campbell interviewed Deputy Director of Operations about the Service's use of private ambulance providers during Games time. The angle of the published story was that the Service was spending almost £900,000 on private ambulances during the Olympics; however, the overall article was balanced.

Martin Flaherty

Chief Operating Officer/Deputy CEO

Integrated Trust Performance Report July 2012

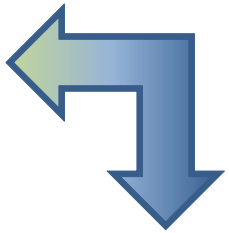
Attachment 1



Caring for Patients during their Journey

How do we care for our patients?

* First Contact (Call Answering)	94.6%
* Treatment (CPI)	73%
* Clinical Outcomes	97%
* Patient Safety Index	47
* Patient Wellbeing	Green
* Service Experience	Green



Service Delivery

Evidencing Delivery of the Response model

Performance Indicators	*Actual*	*YTD/Pr*
* Cat A Target (75%)	77.2%	75.0%
* Cat C1 Target (90%)	92.0%	77.8%
* Cat C2 Target (90%)	94.0%	76.1%
* Ambulance Utilisation	81.2%	82.3%
* FRU Utilisation (40%)	42%	43%
* Complaints/Serious Incidents	70	76

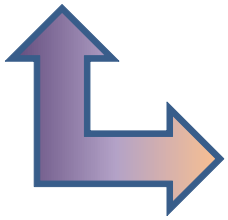
Daily Performance & Activity — REAP 3

	June	July	MoM	Y2Y
999 Call volume	4738	4315	-9%	9%
Peak 999 Call volume	5797	4890	-16%	8%
Cat A Calls	36278	36206	0%	12%
Cat C1 & 2 Calls	26372	28560	8%	8%
Cat C3 & 4 Calls	25743	27765	8%	-8%
DMP Stage A	65%	75%	10%	-14%
DMP Stage B	27%	24%	-3%	20%
DMP Stage C	6%	1%	-5%	-6%
Percentage > REAP 3	100%	75%	0%	70%

Care for Staff - Workforce Report

How will we sustain change and improve?

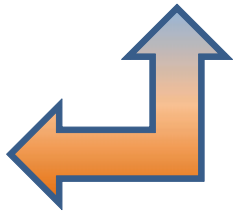
Performance Indicators		*T/C*
* Staff Sickness Levels	5.42%	---
* Staff Core Skills Training	30%	3.1
* Staff Development (PDR)	49%	2.5
* Staff Retention	7.8%	2.8
* Staff Safety & Wellbeing	88	3.2
* Staff Satisfaction	3.4	



Value for Money

Evidencing stewardship of the public purse

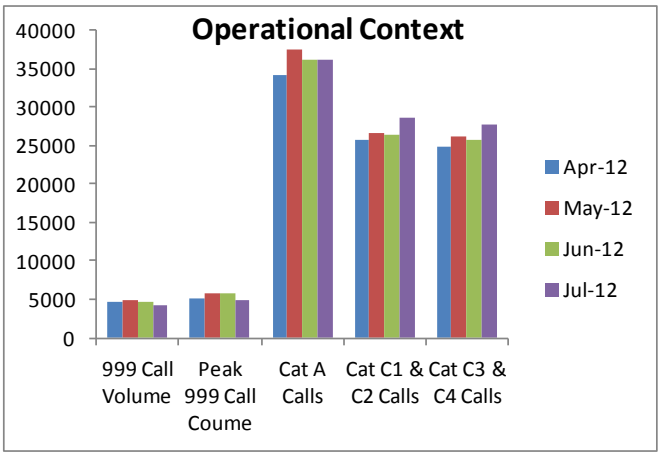
* Financial EBITDA	4,104
* Net Surplus	224
* Cost Improvement Programme	2,456
* CQUINs	523
* Monitor Net Rating (FRR)	2
* Carbon Reduction Plan	A <> G



1. Operational Context

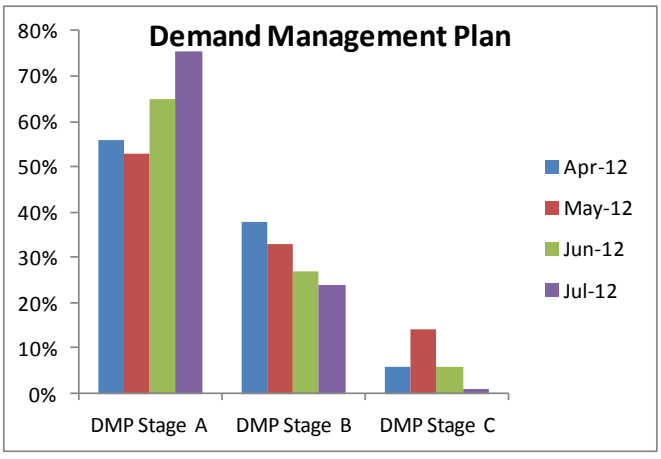
Daily Performance & Activity	June	July	MoM	Y2Y	REAP 3
999 Call volume	4738	4315	-9%	9%	
Peak 999 Call volume	5797	4890	-16%	8%	
Cat A Calls	36278	36206	0%	12%	
Cat C1 & 2 Calls	26372	28560	8%	8%	
Cat C3 & 4 Calls	25743	27765	8%	-8%	
DMP Stage A	65%	75%	10%	-14%	
DMP Stage B	27%	24%	-3%	20%	
DMP Stage C	6%	1%	-5%	-6%	
Percentage > REAP 3	100%	75%	0%	70%	

June 2012 Report	May	June	MoM	Y2Y	REAP 3
999 Call volume	4914	4738	-4%	7%	
Peak 999 Call volume	5789	5797	-1%	-1%	
Cat A Calls	37597	36278	-4%	18%	
Cat C1 & 2 Calls	26734	26372	-1%	-5%	
Cat C3 & 4 Calls	26231	25743	-2%	-11%	
DMP Stage A	53%	65%	23%	n/a	
DMP Stage B	33%	27%	-18%	n/a	
DMP Stage C	14%	6%	-57%	n/a	
Percentage > REAP 3	100%	100%	0%	70%	



July Cat A calls were similar to the June figure, but we are still running 12% higher than the same period in 2011-12.

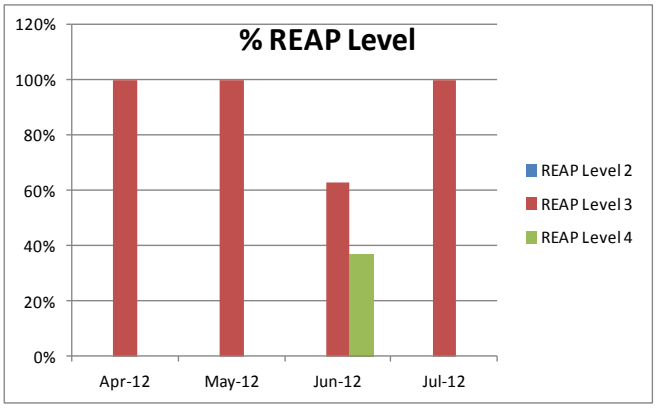
Cat C1/2 and CAT C3/4 calls are both 8% higher than June, but Cat C3/4 calls show an 8% reduction for the same period in 2011-12.



The Trust saw a 9% reduction in call volumes since the previous month, whilst increasing the percentage of time operating at normal levels (DMP Stage A) from 65% to 75%.

Operation at DMP Stage B reduced from 27% in May to 27% in June to 24% in July..

Operation at DMP Stage C reduced from 6% in June to 1% in July.

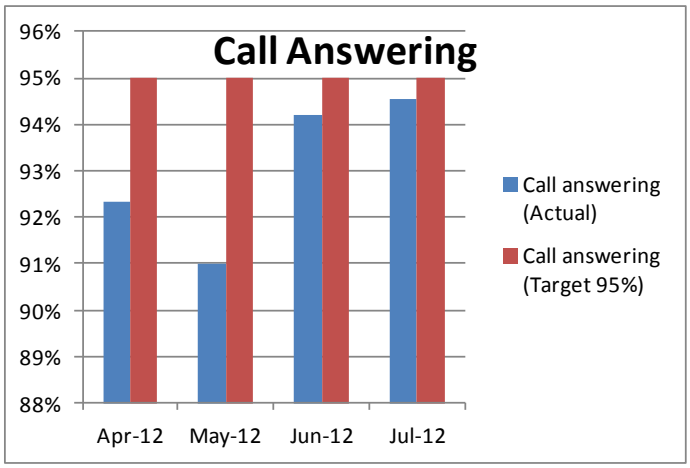


The Trust is yet to operate at less than REAP Level 3 or under to date.

2. Care for Patients

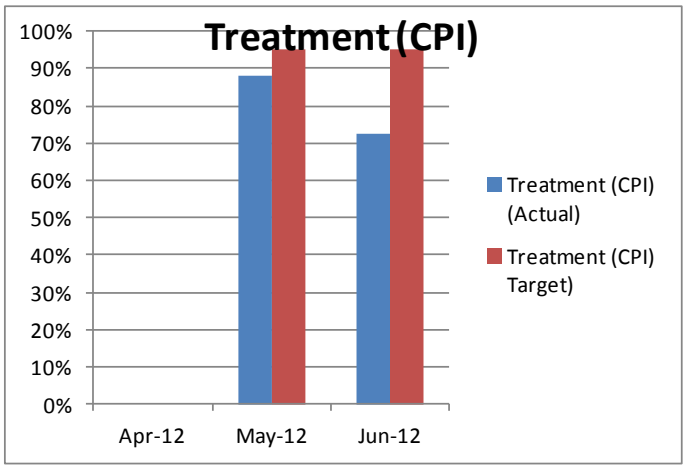
Caring for Patients during their Journey	
How do we care for our patients?	
* First Contact (Call Answering)	94.6%
* Treatment (CPI)	73%
* Clinical Outcomes	97%
* Patient Safety Index	47
* Patient Wellbeing	Green
* Service Experience	Green

June 2012 Report	
How do we care for our patients?	
* First Contact (Call Answering)	94.2%
* Treatment (CPI)	88%
* Clinical Outcomes	96%
* Patient Safety Index	59
* Patient Wellbeing	Green
* Service Experience	Green



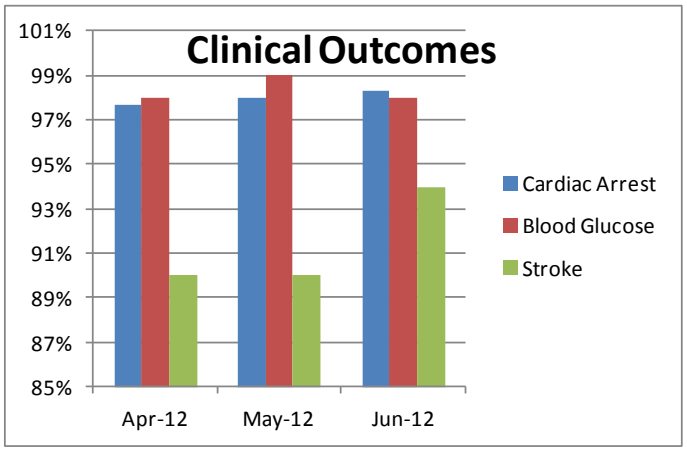
The percentage of calls answered within 5 seconds is approaching the target of 95% in July, from a low base in April and May.

This measure has been given an AMBER RAG rating.



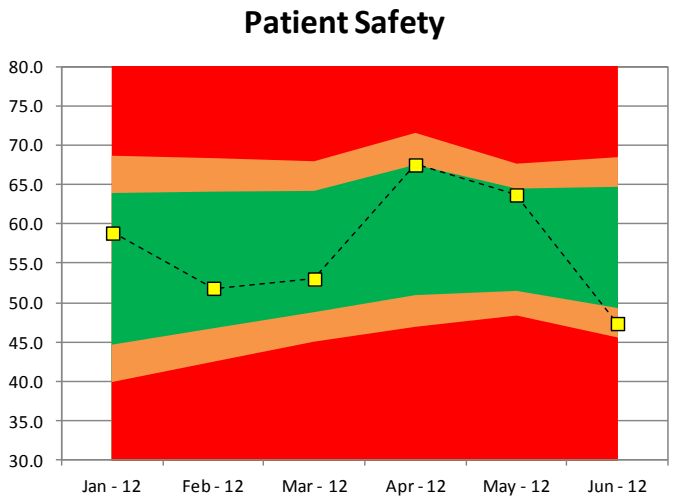
June CPI compliance was 72.5% a further decrease from May at 88%, so this measure has been given a RED RAG rating.

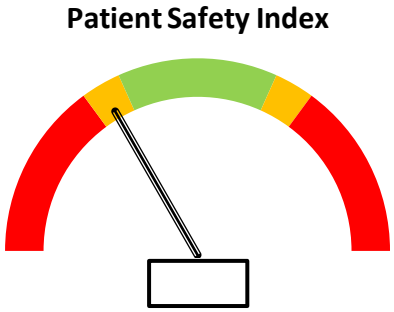
There is a theme regarding the support structures we provide to staff, which reflects the pressures the Trust was experiencing in June. We need to be mindful that as we emerge out of the Olympic period our staff will have seen a relatively lengthy period without supervision and feedback and try and ensure these are prioritised post Olympics.



Three out of four measures are reported as GREEN, which reflects a good quality service. However, we need to try and develop more comprehensive measures for 2013.-2014. This is something that our Commissioners may be able to assist with next year.

This measure has been given a GREEN RAG rating.





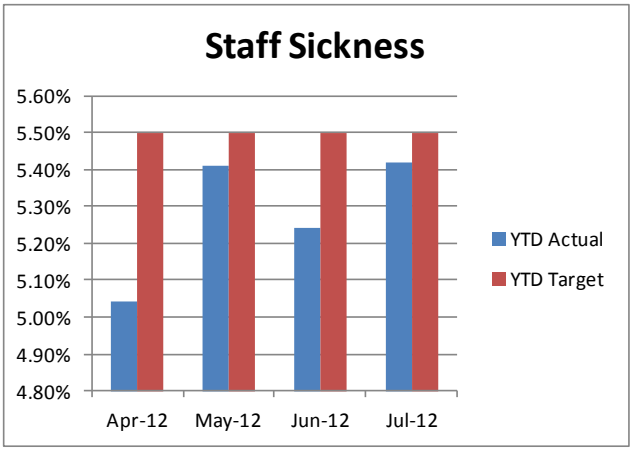
The Patient Safety Index (PSI) has been consistently within the GREEN zone since the beginning of the year, moving briefly into AMBER in April for an increased number of clinical incidents reported per 100,000 hours worked. The PSI for June shows a dramatic drop in the number of clinical incidents reported per 100,000 hours worked, showing as AMBER; this under-reporting could reflect the high demand experienced in June.

Service Experience: This measure is a DH measure. However, it is not clearly defined and there is little guidance as to what is expected. We have awarded ourselves a GREEN rating as we now have a strong Integrated Risk Report and a subsequent action plan on improving experience which is being used throughout the governance structure.

3. Care for Staff

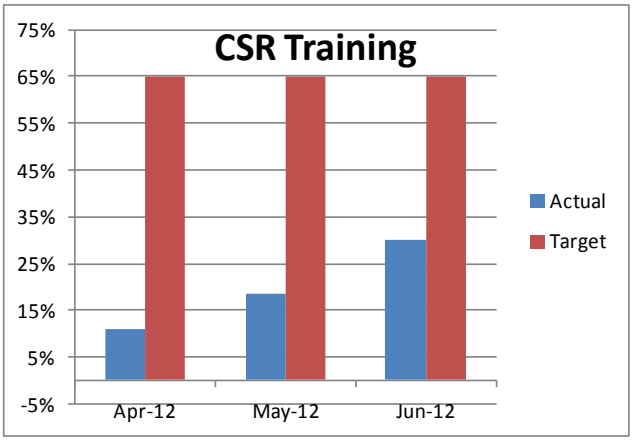
Care for Staff - Workforce Report		
How will we sustain change and improve?		
Performance Indicators		***T/C***
∗ Staff Sickness Levels	5.42%	---
∗ Staff Core Skills Training	30%	3.1
∗ Staff Development (PDR)	49%	2.5
∗ Staff Retention	7.8%	2.8
∗ Staff Safety & Wellbeing	88	3.2
∗ Staff Satisfaction	3.4	

June 2012 Report		
How will we sustain change and improve?		
Performance Indicators		***T/C***
∗ Staff Sickness Levels	5.24%	---
∗ Staff Core Skills Training	30%	3.1
∗ Staff Development (PDR)	44%	2.5
∗ Staff Retention	7.7%	2.8
∗ Staff Safety & Wellbeing	59	3.2
∗ Staff Satisfaction	3.4	



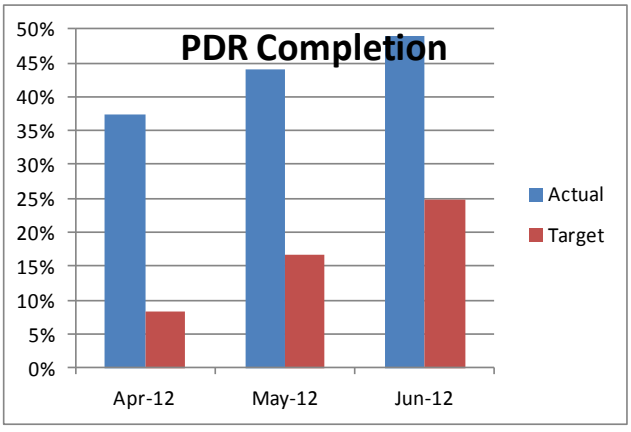
Sickness for the Trust as whole rose slightly to 5.76%, the rise being attributable to the increase in long term absence. Sickness absence YTD for 12/13 stands at 5.42%, slightly above the year end figure for 11/12, but still meeting the 12/13 target of 5.5% or below.

The RAG rated audits continue to show that, in the main, all absence is being managed appropriately and in accordance with the Managing Attendance Policy (MAP)



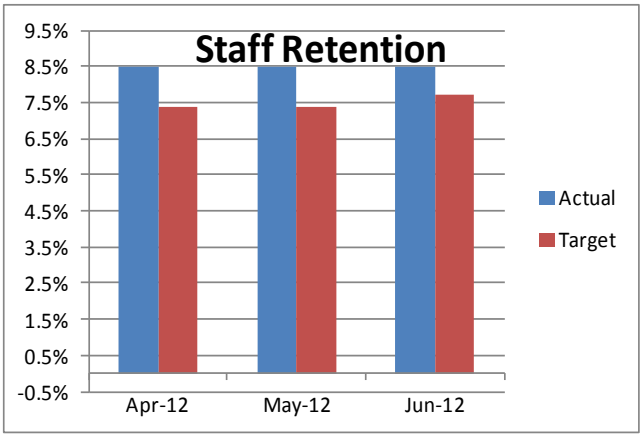
The percentage of priority training commitments delivered through the Core Skills Refresher (CSR) training is RAG rated as GREEN in the Clinical Quality report due to the scheduled plan not to provide training. However, the Clinical Quality report includes an item in the exception report as there is growing concern that the Trust may not meet all its CSR 1, 2 and 3 commitments in 2012-2013, so this is RAG rated RED here.

The Training & Strategy group is considering the options.



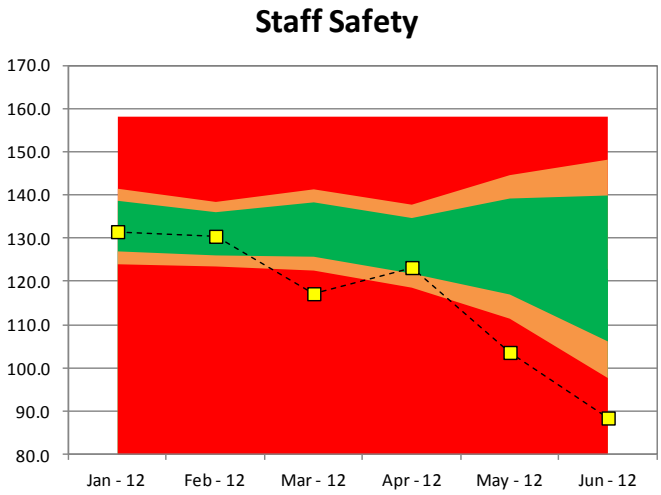
Operational Areas have reported a nil return from April with plans to undertake PDRs after the Olympics. Completion plans have been requested. This is RAG rated RED.

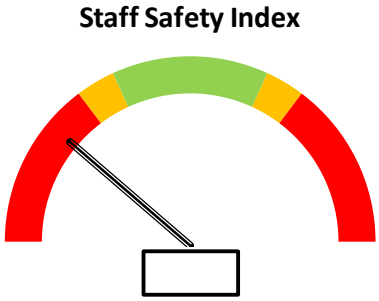
PDRs for Operations will be reported after the Olympics



Front line staffing was 3030 wte against the 12/13 establishment of 3151 wte (a vacancy level of 121 wte; 3.4%). The first initial training course for (11) externally recruited Apprentice Paramedics commenced on 30th July 2012.

29 A&E Support staff who will start the Apprentice Paramedic programme in October, commenced duty on emergency ambulances, working alongside qualified paramedics, on 9th July.





The **Staff Safety Index** (SSI) is showing a downward trend towards a decrease in the number of staff safety incidents reported per 100,000 hours worked since the beginning of the calendar year. The PSI for June shows a significant drop from the May figure, showing as RED. This under-reporting could reflect the high demand experienced in June. Further analysis of this measure will be performed when the July figures are available.

Incident Reporting: All areas of incident reporting are showing a downward trend. A cross check with other indicators is currently being undertaken to establish is this is a reflection of a real reduction in incidents occurring or a non reporting symptom.

The report shows positive results (prosecutions) from the proactive management of violent and verbal assaults. These cases are lead and supported by the Local Security Management Specialist. We are training a second member of the H&S team to provide additional LSMS support.

Health and Safety Staff Survey: An online survey has been developed in conjunction with Employment Support Services for access via the Pulse in October. It will be of a format very similar to the 'Temperature Check' surveys issued last year.

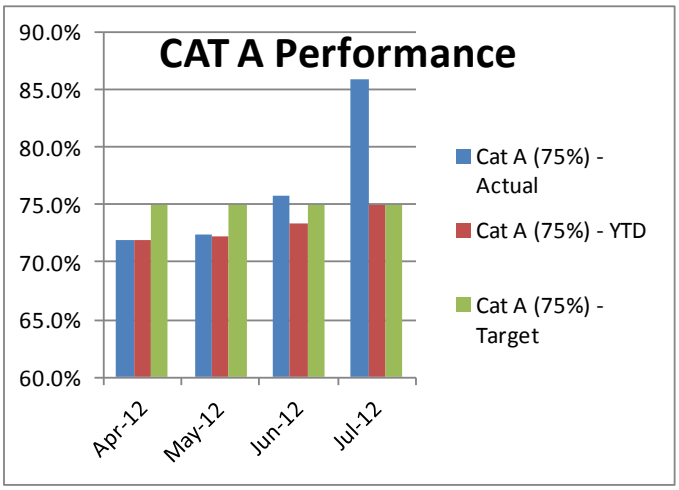
4. Service Delivery

Service Delivery		
Evidencing Delivery of the Response model		
Performance Indicators	***Actual***	***YTD/Pr***
∗ Cat A Target (75%)	77.2%	75.0%
∗ Cat C1 Target (90%)	92.0%	77.8%
∗ Cat C2 Target (90%)	94.0%	76.1%
∗ Ambulance Utilisation	81.2%	82.3%
∗ FRU Utilisation (40%)	42%	43%
∗ Complaints/Serious Incidents	70	76

June 2012 Report		
Evidencing Delivery of the Response model		
Performance Indicators	***Actual***	***YTD/Pr***
∗ Cat A Target (75%)	75.8%	73.4%
∗ Cat C1 Target (90%)	79.4%	74.9%
∗ Cat C2 Target (90%)	74.7%	74.0%
∗ Ambulance Utilisation	82.3%	86.4%
∗ FRU Utilisation (40%)	43%	44%
∗ Complaints/Serious Incidents	76	90

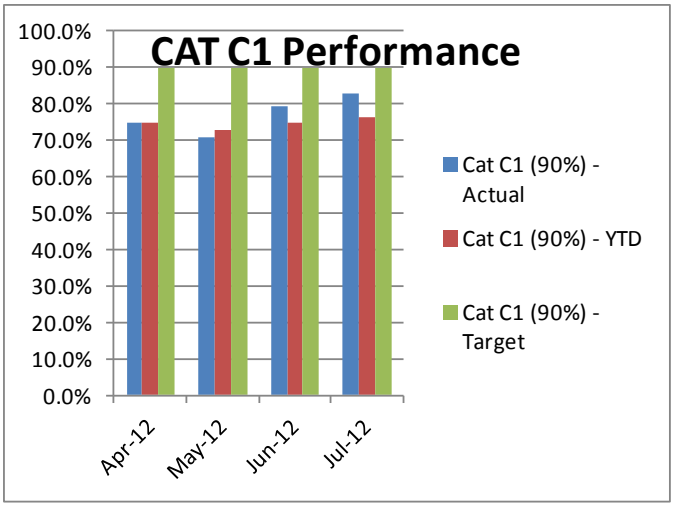
At times of high demand the Trust needs to focus resources on those cases that are the most urgent. This can mean patients who initially appear less urgent may have to wait longer; this is especially true if the Trust's Demand Management Plan is implemented. In essence this manages the risk but does not completely eradicate the risk as those lower category patients could wait for very lengthy periods.

The introduction of the Clinical Hub will help mitigate the safety risks by providing a "ring back" and welfare check on patients held in a queue but it will not mitigate against the quality risks. Waiting times is the issue that our patients identify as the most important issue and is currently the highest category in terms of complaints.



The month of July saw the Trust achieve 77.2% for category A8 performance. It is pleasing to report that this is above the National Key Standard for A8 and above the trajectory target of 75% submitted to our commissioners. The Trust year to date (YTD) position of 75.0% for the year remains in excess of the commissioner's trajectory of 73.5%.

This measure is RAG rated GREEN.

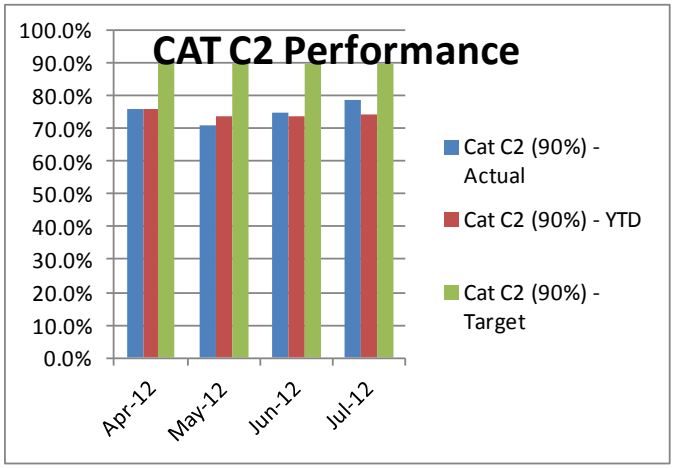


Improving C category response times has been identified by SMG as a key objective.

The trajectory is yet to be defined but we have aspirations of 90%.

In July, the Trust achieved 92%, and is RAG rated GREEN. This is an improvement on the 79.4% figure for June. YTD is running at 77.8%.

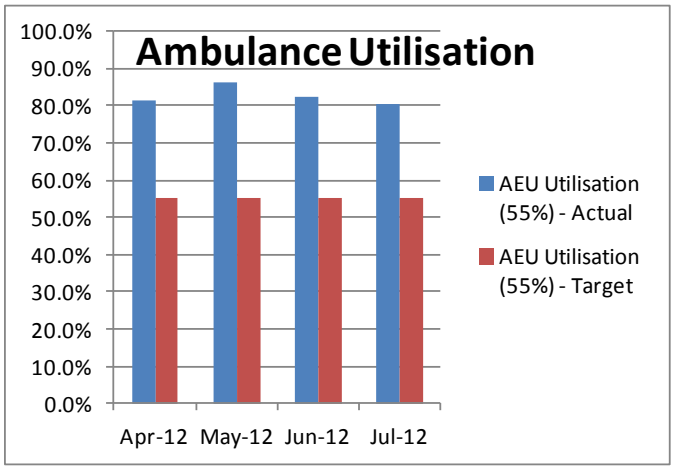
The measure has therefore been assigned a GREEN rating.



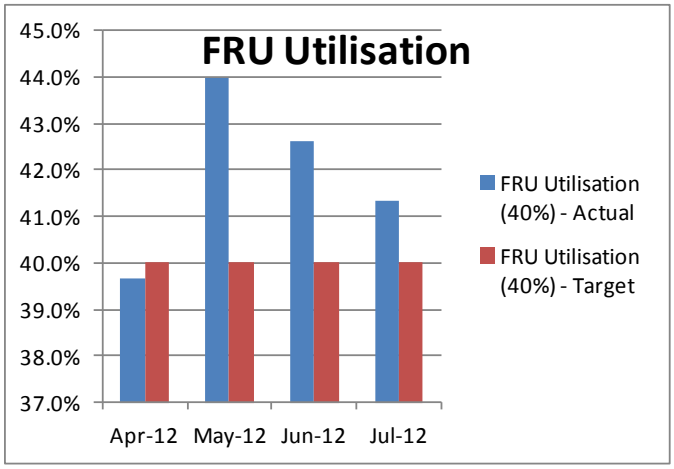
This is a new measure for 2012-2013 and has been implemented at SMG request. Improving C category response times has been identified by SMG as a key objective.

The trajectory is yet to be defined but we have aspirations of 90%.

In July, the Trust achieved 94% and is RAG Rated GREEN. This is an improvement on the 74.7% figure for July. YTD is running at 76.1%.



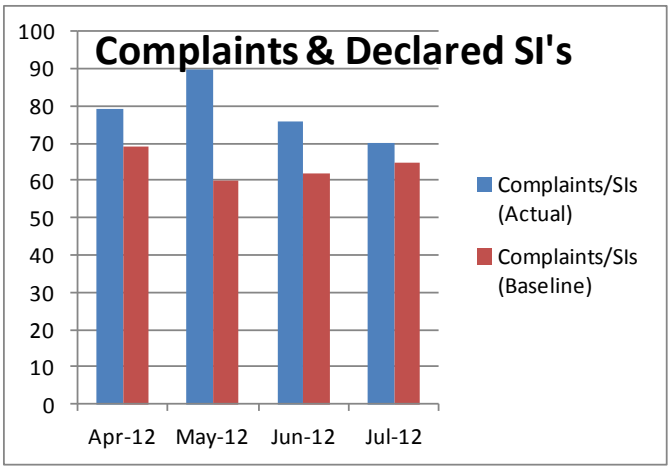
AEU utilisation for the month of July reduced to 81.2%, this was a reduction of 2.3% on the previous month with the current year to date now at 83.6% and is RAG Rated RED.



FRU utilisation also reduced in the month of July by 1.3% to 41.7% with the year to date position being 42.1%.

High utilisation of operational resources continues to be one of our biggest concerns.

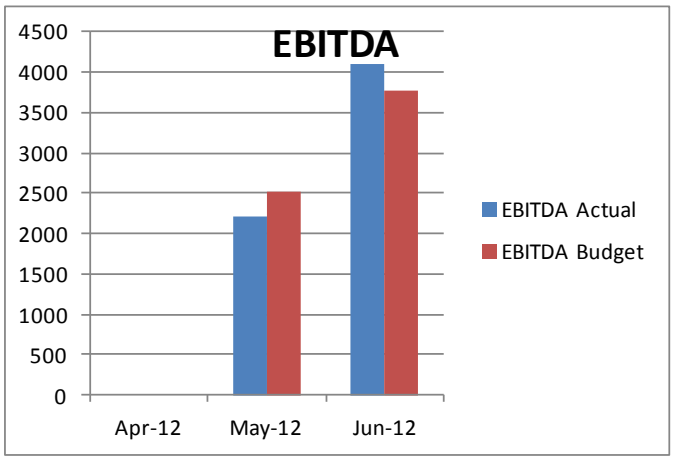
This is RAG Rated as AMBER.



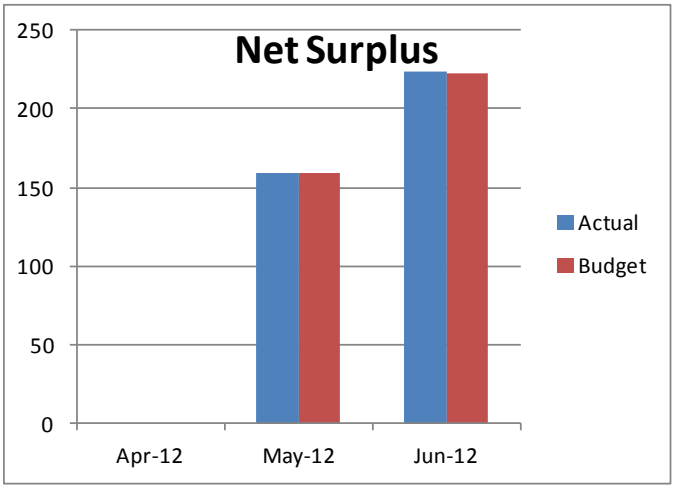
The number of complaints and Serious Incidents recorded in July is lower than that of June, and is RAG rated AMBER.

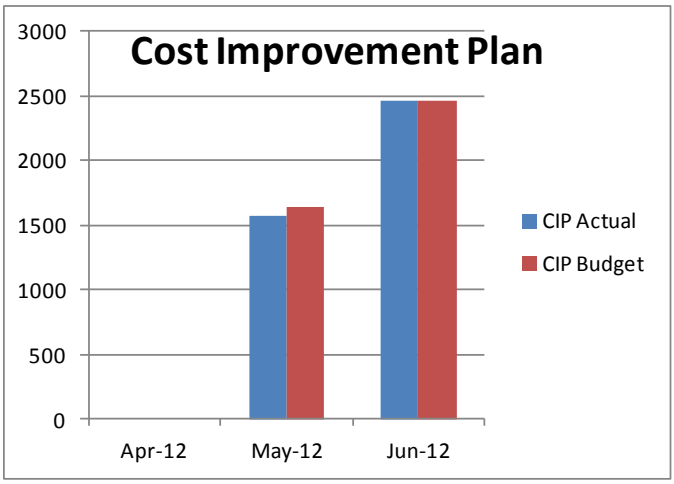
5. Value for Money

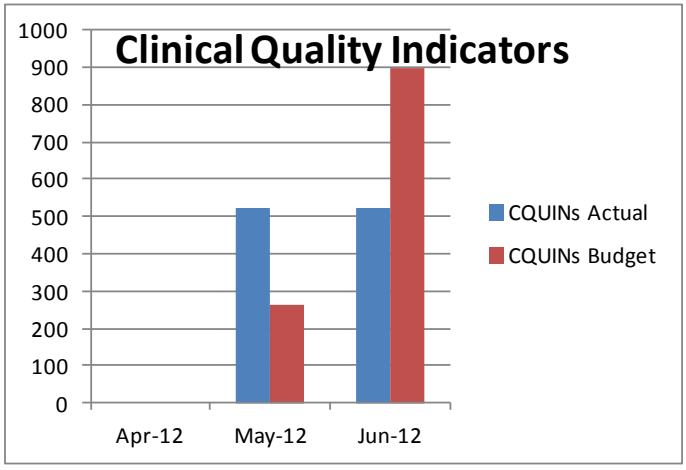
Value for Money	
Evidencing stewardship of the public purse	
* Financial EBITDA	4,104
* Net Surplus	224
* Cost Improvement Programme	2,456
* CQUINs	523
* Monitor Net Rating (FRR)	2
* Carbon Reduction Plan	A <> G



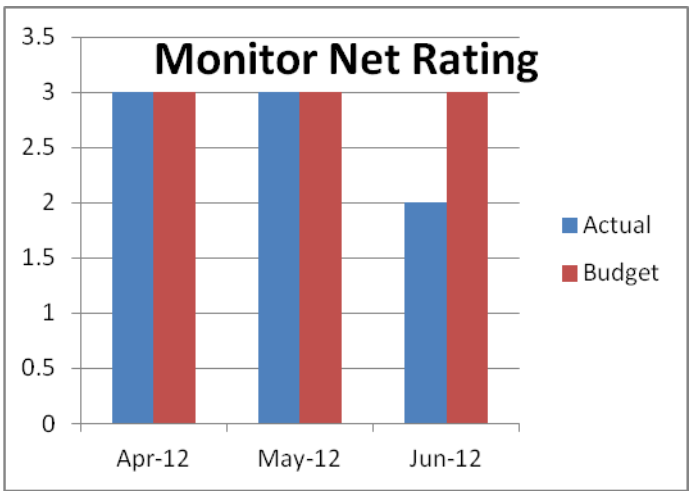
Pending Finance Report







Finance Report



Pending Latest Carbon Reduction Report

Energy Consumption

The Bow location is now a 24/7 operation. This has resulted in a 64% increase in gas consumption (overnight heating) but a 20% decrease in electricity consumption against the same period in the previous year. Headquarters is showing a similar energy consumption pattern, with electricity consumption decreasing by 10% and an increase in gas consumption, which cannot be quantified at this point as the suppliers have changed and we do not have this information yet.

Fuel Consumption

Diesel consumption has increased by 3%, which should be balanced against a 15% increase in Cat A demand over Q1 compared to the same period in the previous year.

Conveyance and Ambulance Saves

The Trust conveyed 68.77% of patients against a target of 67.7%, with the Cycle Response Team activation on track. The Multiple response activation is also on track; with the LFTM Jan 2012 report showing 1.03 against a target of 1.368. Calls referred to CTA are below target for April & May showing 4,504 against the target of 5,500.

Procurement

Procurement is a substantial element of the Trust's carbon footprint: 71% of the 2010-11 baseline and we are working on a methodology to report procurement activity for 2012-12. The new finance system, implemented in July 2012 is configured to produce a report showing expenditure to date, mapped against DEFRA emission factors, and the first report from this system will be available for the next Integrated Board Report.

Carbon footprint is RAG rated AMBER <> GREEN

Attachment 3

Quadrant	Performance Indicator	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Care for patients	**Description**	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Call Answering (Actual)	Call answering (Actual)	92%	91%	94%	95%								
Call Answering (Target)	Call answering (Target 95%)	95%	95%	95%	95%								
Treatment (CPI) (Actual)	CPI Completion from CARU Audit		88%	73%									
Treatment (CPI) Target)	CPI Completion from CARU Audit		95%	95%									
Clinical Outcomes	Cardiac Arrest	98%	98%	98%									
Clinical Outcomes	Blood Glucose	98%	99%	98%									
Clinical Outcomes	Stroke	90%	90%	94%									
Clinical Outcomes	Aggregate	95%	96%	97%									
Patient Safety Index (Actual)	Clinical & Non-Clinical Incidents raised by staff/100,000 hours worked	68	64	47									
Patient Safety Index (Target)	Clinical & Non-Clinical Incidents raised by staff/100,000 hours worked	59	58	57									
Patient Wellbeing	Actions arising from the Learning from Experiences Report		Green	Green									
Quality Barometer	Quality Dashboard		Green	Green									
Care for Staff	**Description**	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Staff Sickness (Actual)	YTD Actual	5.04%	5.41%	5.24%	5.42%								
Staff Sickness (Target)	YTD Target	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%
Actual	Actual Percentage of staff receiving CSR 1, 2 and 3 training against plan	11%	19%	30%									
Target	Target Percentage of staff receiving CPR 1, 2 and 3 training against plan	65%	65%	65%									
Actual	Percentage of staff who have completed Performance Development Plans	37%	44%	49%									
Target	Percentage of staff who have completed Performance Development Plans	8%	17%	25%	33%	42%	50%	58%	66%	75%	83%	91%	100%
Actual	Staff Retention Actual YTD Turnover	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Target	Staff Retention Target YTD Turnover	7.4%	7.4%	7.7%	7.8%								
Actual	SSI - LHC, Physical & Verbal Abuse incidents/100,000 hours worked - Actual	123	104	88									
Target	SSI - LHC, Physical & Verbal Abuse incidents/100,000 hours worked - Target	128	128	123									
Service Delivery	**Description**	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Cat A Target Performance (75%)	Cat A (75%) - Actual	71.9%	72.5%	75.8%	77.2%								
Cat A Target Performance (75%)	Cat A (75%) - YTD	71.9%	72.2%	73.4%	75.0%								
Cat A Target Performance (75%)	Cat A (75%) - Target	75.0%	75.0%	75.0%	75.0%								
Cat C1 Target (90%)	Cat C1 (90%) - Actual	75.0%	70.6%	79.4%	92.0%								
Cat C1 Target (90%)	Cat C1 (90%) - YTD	75.0%	72.7%	74.9%	77.8%								
Cat C1 Target (90%)	Cat C1 (90%) - Target	90.0%	90.0%	90.0%	90.0%								
Cat C2 Target (90%)	Cat C2 (90%) - Actual	76.0%	71.3%	74.7%	94.0%								
Cat C2 Target (90%)	Cat C2 (90%) - YTD	76.0%	73.7%	74.0%	76.1%								
Cat C2 Target (90%)	Cat C2 (90%) - Target	90.0%	90.0%	90.0%	90.0%								
Ambulance Utilisation (55%)	AEU Utilisation (55%) - Actual	81.4%	86.4%	82.3%	81.2%								
Ambulance Utilisation (55%)	AEU Utilisation (55%) - Target	55.0%	55.0%	55.0%	55.0%								
FRU Utilisation (40%)	FRU Utilisation (40%) - Actual	39.7%	44.0%	42.64%	41.7%								
FRU Utilisation (40%)	FRU Utilisation (40%) - Target	40.0%	40.0%	40.0%	40.0%								
Number of Complaints received	Complaints/SIs (Actual)	79	90	76	70								
Number of Complaints received	Complaints/SIs (Baseline)	69	60	62	65								

Value for Money	Description	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Financial EBITDA	EBITDA Actual		2216	4104									
Financial EBITDA	EBITDA Budget		2527	3775	5706	7331	9041	10830	12678	14671	16772	18924	22089
Net Surplus	Actual		159	224									
Net Surplus	Budget		159	223	285	367	534	719	963	1352	1850	2399	3111
Cost Improvement Programme	CIP Actual		1572	2456									
Cost Improvement Programme	CIP Budget		1637	2456	3057	3806	4819	5969	7179	8538	9954	11370	13414
CQUINs	CQUINs Actual		524	523									
CQUINs	CQUINs Budget		262	898	1418	1789	2160	2609	3058	3506	4486	5466	6444
Monitor Net Rating (FRR)	Actual	3	3	2									
Monitor Net Rating (FRR)	Budget	3	3	3	3	3	3	3	3	3	3	3	3
Carbon Reduction Plan	Carbon Reduction Plan		Amber										
Operational Context	**Description**	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
999 Call Volume	Average # 999 calls	4585	4914	4738	4315								
Peak 999 Call Coume	Peak # of calls	5081	5879	5797	4890								
Cat A Calls	CAT A	34177	37597	36278	36206								
Cat C1 & C2 Calls	CAT C1 & C2	25712	26734	26372	28560								
Cat C3 & C4 Calls	CAT C3 & C4	24964	26231	25743	27765								
DMP Stage A	% month DMP A	56%	53%	65%	75%								
DMP Stage B	% month DMP B	38%	33%	27%	24%								
DMP Stage C	% month DMP C	6%	14%	6%	0.93%								
REAP Level (Target)	REAP Target 75% @ Level 2	75%	75%	75%	75%								
REAP Level (Actual)	REAP Level 2	0%	0%	0%	0%								
REAP Level 3+	REAP Level 3	100%	100%	63%	100%								
REAP Level 4+	REAP Level 4	0%	0%	37%	0%								

Integrated Trust Performance Report - Explanation of each measure

1. Operational Context

Daily Performance & Activity				REAP 3
	June	July	MoM	Y2Y
999 Call volume	4738	4315	-9%	9%
Peak 999 Call volume	5797	4890	-16%	8%
Cat A Calls	36278	36206	0%	12%
Cat C1 & 2 Calls	26372	28560	8%	8%
Cat C3 & 4 Calls	25743	27765	8%	-8%
DMP Stage A	65%	75%	10%	-14%
DMP Stage B	27%	24%	-3%	20%
DMP Stage C	6%	1%	-5%	-6%
Percentage > REAP 3	100%	75%	0%	70%

Call Volumes

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

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

Demand Management Plan

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

REAP Level

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

2. Care for Patients

Caring for Patients during their Journey	
How do we care for our patients?	
* First Contact (Call Answering)	94.6%
* Treatment (CPI)	73%
* Clinical Outcomes	97%
* Patient Safety Index	47
* Patient Wellbeing	Green
* Service Experience	Green

First Contact (Call Answering)

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

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

Treatment (CPI)

Did we correctly assess and treat our patients?

This is measured from the clinical outcomes from the CARU CPI Audit report, and is graded as Red, Amber or Green from the Quality Dashboard. N.b. This indicator appears within this report for the first time since October 2011.

Clinical Outcomes

Did our patients have a positive outcome?

This is an aggregate measure from the audit of CPI completion for specific patient clinical outcomes: cardiac arrest; STEMI; Stroke; Diabetes etc as defined in the Quality Dashboard Clinical Performance indicators.

Patient Safety

How have we ensured patient safety?

This is measured by the total number of clinical and non clinical incidents raised by staff, against the number of hours worked, effectively the rate of clinical and non clinical incidents per 100,000 hours worked – a Patient Safety Index. The target is based on averages over the previous 12 months to show variance against the mean.

The target is based on a rolling 12 month average, and RAG rated the standard deviation against the mean – Green = < ± 1 STD, Amber < ± 1.5 STD, Red > ± 2 STD.

Patient Wellbeing

How have we ensured that patient's concerns and complaints are acted upon?

This is a measure of progress against the actions arising from the Learning from Experience Report.

Clinical Quality/Barometer – Service Experience

This is a DH measure. However, it is not clearly defined and there is little guidance as to what is expected. We have awarded ourselves a GREEN rating as we now have a strong Integrated Risk Report and a subsequent action plan on improving experience which is being used throughout the governance structure.

3. Care for Staff

Care for Staff - Workforce Report		
How will we sustain change and improve?		
Performance Indicators		***T/C***
* Staff Sickness Levels	5.42%	---
* Staff Core Skills Training	30%	3.1
* Staff Development (PDR)	49%	2.5
* Staff Retention	7.8%	2.8
* Staff Safety & Wellbeing	88	3.2
* Staff Satisfaction	3.4	

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

Staff Availability

This is calculated from YTD sickness levels, which have a target of 5.5%. The RAG rating is <5.5% Green and >5.5% Red.

Staff Training

The percentage of staff attending Core Skills Refresher (CSR) levels 1, 2 and 3 training against plan.

The Clinical Quality Indicators (CQUIN) target is for 65% of eligible staff to attend CSR training between January 2012 and February 2013. The Trust's approved Training plan meets these requirements, but it has been agreed that training will be suspended between May and September 2012 to ensure that adequate resources are available for the Olympics and Paralympics. The Trust's Training plan will, therefore, be recalibrated in October 2012. This will be reflected in the Integrated Report. N.b The percentage shown in the June report is the YTD figure.

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

Staff Development

How are we ensuring that staff are provided with appropriate development opportunities?

This is measured by the number of staff who have completed Performance Development Plans (PDRs) against plan. The measure is a cumulative percentage across the year.

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

Staff Retention

How are we ensuring that staff are managed well?

This is measured by staff retention/turnover percentages from a rolling twelve month period. The target is 8.5%, with the RAG rating of Amber if the figure is between 8.5% and 9% and Red if the value is above 9%.

The quality barometer is how staff feel that they are being managed, based on the aggregate score for specific questions in the Staff Temperature Check survey; “The LAS values employee suggestions for improvement”; “My manager shows appreciation for the work I do”; “There is a spirit of cooperation amongst my colleagues”; and “My manager shows me the support that I need to do my job well”.

Staff Safety and Wellbeing

How are we ensuring that staff are safe at work?

This is measured by the number of lifting, handling & carrying (LFC), physical (PV) and non-physical abuse (NPA) incidents raised by staff, against the number of hours worked, effectively the rate of incidents per 100,000 hours worked – a Staff Safety Index.

The target is based on a rolling 12 month average, and RAG rated the standard deviation against the mean – Green = < ± 1 STD, Amber < ± 1.5 STD, Red > ± 2 STD.

Staff Satisfaction

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

The RAG scoring mechanism is Red <3, Amber 3-3.5, Green >3.5.

4. Service Delivery Quadrant

Service Delivery

Evidencing Delivery of the Response model

Performance Indicators	***Actual***	***YTD/Pr***
∗ Cat A Target (75%)	77.2%	75.0%
∗ Cat C1 Target (90%)	92.0%	77.8%
∗ Cat C2 Target (90%)	94.0%	76.1%
∗ Ambulance Utilisation	81.2%	82.3%
∗ FRU Utilisation (40%)	42%	43%
∗ Complaints/Serious Incidents	70	76

Cat A Target Performance

How is the Trust performing against targets?

This is measured by the percentage of Category A calls responded to in 8 minutes, and the percentage of Category C1 and C2 calls responded to in 30 minutes. The report shows actual figures for the month and the year to date, or the previous month where applicable (for Complaints/Serious Incidents).

Utilisation

The report shows the monthly and year to date utilisation percentages for ambulances (55% target) and fast response vehicles (40% target).

Quality Barometer

The quality barometer for the Response Model Delivery quadrant is the number of complaints received about the Trust plus the number of serious incidents declared with NHS London. The average number of complaints received per day has risen from 1.5 in 2010 to 1.8 in 2011 and now stands at 2.0 for the last twelve months. The Trust declares an average of 1.4 Serious Incidents per month. The RAG Rating for this measure is therefore < 63 – 65 (Green), 65 – 75 (Amber) and >75 (Red).

5. Value for Money Quadrant

Value for Money	
Evidencing stewardship of the public purse	
∗ Financial EBITDA	4,104
∗ Net Surplus	224
∗ Cost Improvement Programme	2,456
∗ CQUINs	523
∗ Monitor Net Rating (FRR)	2
∗ Carbon Reduction Plan	A <> G

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

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

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

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 21 AUGUST 2012

PAPER FOR INFORMATION

Document Title:	**Workforce Report**
Report Author(s):	**Caron Hitchen, Director of Human Resources and Organisation Development**
Lead Director:	**Caron Hitchen, Director of Human Resources and Organisation Development**
Contact Details:	**caronhitchen@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**This is a regular report to the Trust Board detailing key workforce indicators providing assurance to the Board on workforce issues.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Other
Recommendation for the Trust Board:	**To receive the report**

Key issues and risks arising from this paper

Sickness absence will continue to be monitored closely and managed robustly to maintain satisfactory levels.

Executive Summary

Key headlines from the Workforce report are:

Sickness absence

Sickness for the Trust as a whole rose slightly in June bringing the year to date level to 5.42% which remains within target (5.5%). Levels of absence are expected to show a reduction in July, August and September due to improvement in attendance during the Olympics and the forecast over the Paralympics.

Vacancies and Turnover

As at 31st July frontline staffing showed a vacancy level of 121wte. Recruitment is on track to fill these vacancies with over 100 university graduates, direct entry of up to 80 Apprentice Paramedics and progression of 29 A&E Support staff to Apprentice Paramedic.

Turnover remains within normal range.

PDR completion for 12/13

The report shows good progress within Support Service Directorates with reporting commencing in

October for A&E Operational Areas.

Health and Safety Incidents
The report continues to show a downward trend in both clinical and non clinical incidents reported. Whilst this can be regarded as a positive, the Corporate Health and Safety Group have instigated an awareness raising exercise to ensure staff are encouraged to report incidents that do occur. We continue to encourage reporting to the police of any incidents of violence and have seen successful prosecutions as a result (26 in 2011/12) and the Trust now has an additional accredited Local Security Management Specialist (LSMS) to provide further support in this area of staff safety.

Employee relations
The report indicates continued high levels of "case management" of attendance cases together with a consistent level of non clinical disciplinary cases. The numbers of Employment tribunal cases has remained constant for some time. It will be interesting to see the impact on this of the introduction of fees next summer to both submit a claim (£230) and to have the case heard (£950).

Attachments

1. Workforce data report

****

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

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

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

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

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

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

Equality Impact Assessment

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

Key issues from the assessment:

London Ambulance Service
NHS Trust

HR Summary for Trust Board

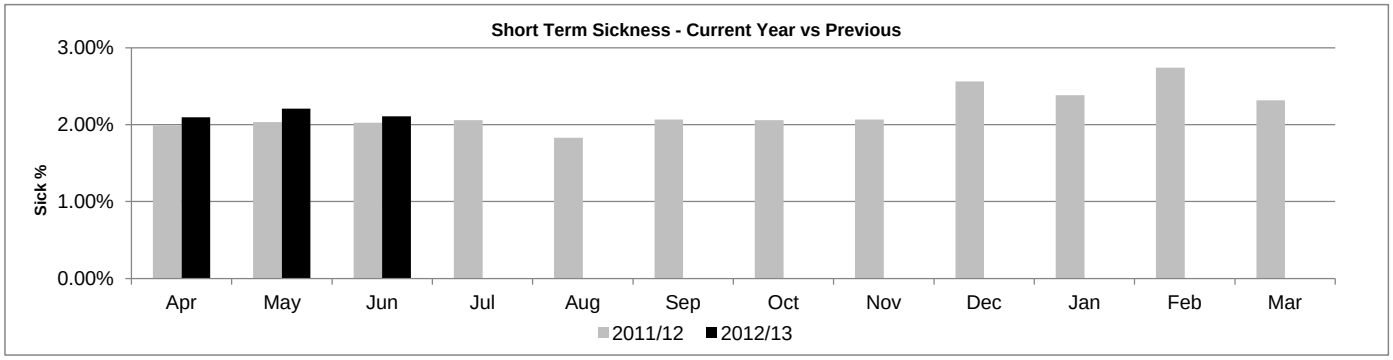
August 2012

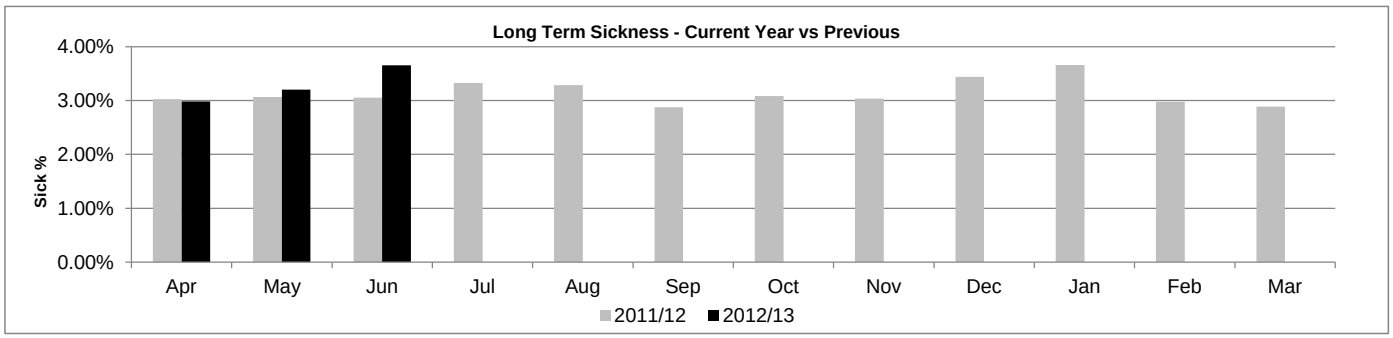
Workforce Report

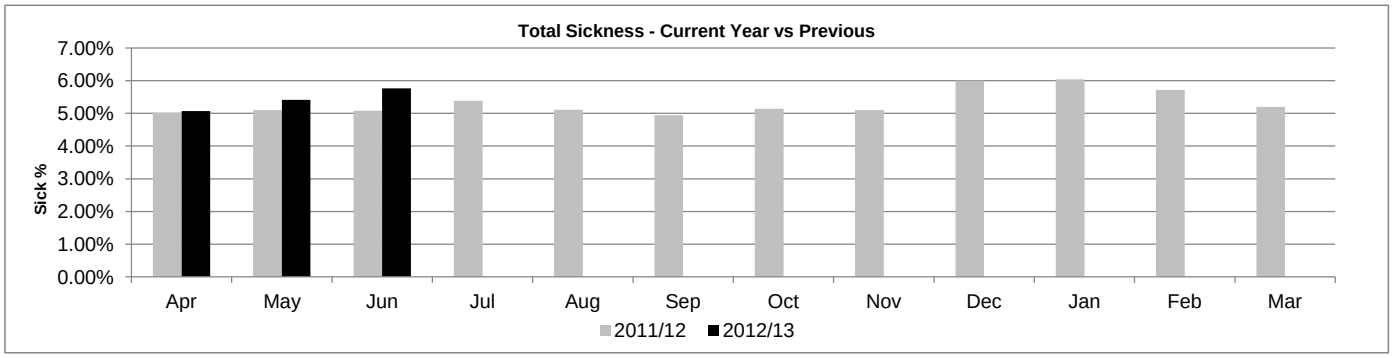
Sickness period **Jun-12**

Trust Summary

Sickness Absence







Sickness 2011/12	5.32%	**Current WTE**	4452.61
YTD Sickness	5.42%	**Current Headcount**	4677.00

NB Secondments and Acting Up Included in Totals

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2011/12	5.01%	5.10%	5.08%	5.39%	5.11%	4.94%	5.14%	5.10%	6.00%	6.04%	5.71%	5.20%
2012/13	5.08%	5.41%	5.76%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Unauthorised Absence	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2011/12	163.00	167.00	161.00	192.00	171.00	164.00	161.00	312.00	98.00	167.00	179.00	168.00
2012/13	148.00	137.00	144.00	156.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Narrative

Sickness

Sickness for the Trust as whole rose slightly again (by 0.35%) May to June to 5.76%; the rise being attributable to the increase in long term absence. Sort term absence decreased very slightly. Sickness absence YTD for 12/13 stands at 5.42%, slightly above the year end figure for 11/12, but still meeting the 12/13 target of 5.5% or below. The RAG rated audits continue to show that, in the main, all absence is being managed appropriately and in accordance with the Managing Attendance Policy (MAP).

Unauthorised Absences

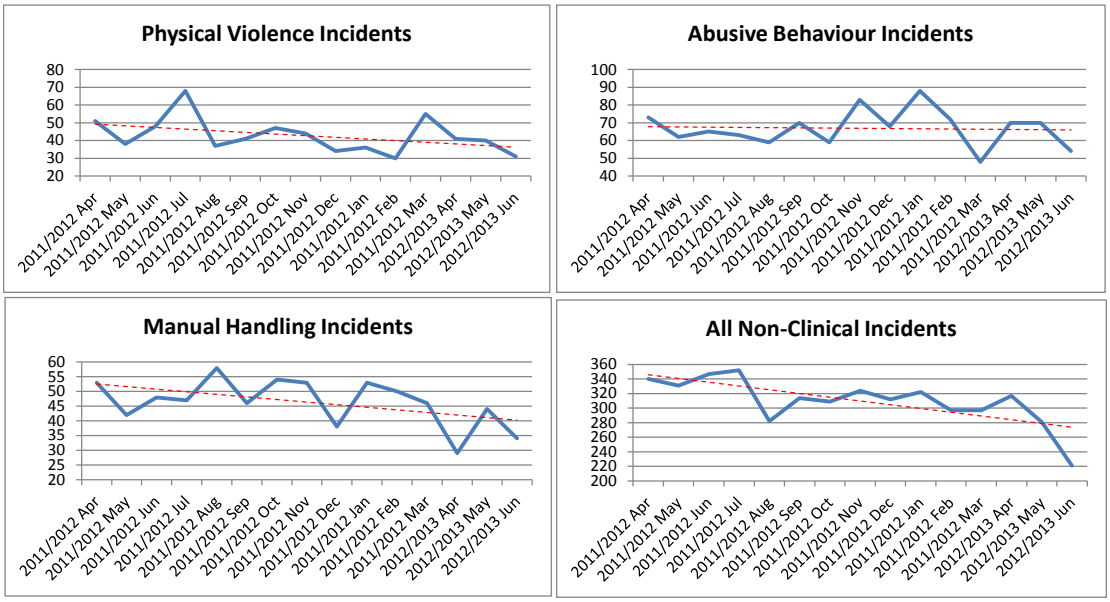
This figure shows the number of instances when staff have reported unable to attend work at short notice for reasons other than their own sickness or when they have not reported for work. Depending on the reason, the absence may be converted into annual leave or un/paid special leave or remain an unpaid unauthorised absence. Disciplinary action may result. The figure for the Trust as a whole for July 2012 showed an increase, but remained well below that for the same month last year. It should be noted that the attendance bonus was applicable during part of the month.

Workforce Report

Month reported **Jun-12**

Trust Summary

Health & Safety Issues



Note - Due to the delay in receiving incidents, the majority of reported incidents within July have yet to arrive at Safety and Risk.

Reported Incident Levels
The decline in reported incident levels continues into July with no change in its rate: approximately 11 fewer clinical incidents and 14 fewer non-clinical incidents are reported every month

Manual Handling
The figure for reported manual handling incidents remains lower than the figures for 2011/2012. The current figure shows that an average of 35 manual handling incidents occur per month in the LAS Trust, which equates to approximately 15 incidents per 100,000 hours worked. As with the general incident reporting figures the numbers of manual handling incidents occuring each month are in decline. by 0.8 incidents per month.

Non Physical Abuse
The number of reported abusive behaviour incidents continues to very slowly decline, however taking into consideration the trend for the past year, the variation is within expected levels and we can say that abusive behaviour incidents occur at approximately 65 per month.

Physical Violence
The number of reported physical violence incidents has fallen consistently in line with the numbers of reported abusive behaviour incidents.

SIRS Reporting
The Health, Safety and Risk department continues to report incidents of physical violence, abusive behaviour and security incidents to NHS Protect via their SIRS (Security Incident Reporting System) Portal since January 2012. Reporting to this portal became mandatory on the 1st April 2012.

SIRS reporting continues with most incident now being entered onto the database, with priority being given to high risk or severe-outcome incidents. The process will be facilitated following the upgrade of Datix to the latest version of the rich client, allowing the ability to enter all of the SIRS-specific data into the database.

NPSA Reporting
All Patient Safety Incidents are sent weekly to the NPSA via their online portal .

Since April 2012, the mean time between incident receipt at Safety and Risk and the NPSA being made aware of the incident is less than 25 days, this places us in the top 3 of all the ambulance trusts with regards to reporting compliance.

Court Cases
A personal trainer has been charged having threatened a paramedic as he treated a man who had collapsed in the changing room of a Barnet gym on July 17.

He was charged under the Public Order Act with using threatening words or behaviour and obstructing an emergency worker. Granted unconditional bail, he is to appear at Hendon Magistrates coiurt on 7th August .

Airwaves Reporting Pilot
The pilot continues in City and Hackney. Reporting levels have slightly declined since the last report, this is in line with the general trend of Trust wide incident reporting. A number of investigations still remain outstanding , however since highlighting with the ADO , there has been renewed efforts by the local managers to address the issue.

Discussions took place between Governance and Comliance, Safety and Risk and Information Management about merging of the LA52 and LA277, initially for this pilot but potentially to be rolled out across the Trust. Follow up discussion s are scheduled after the Olympic Games.

Carry Chair Transporter Pilot
The chair transporter pilot is now completed. Final report will be presented to ADG for consideration.

Health and Safety Staff Survey
An online survey has been developed in conjunction with Employment Support Services for access via the Pulse in Oct. It will be of a format very similar to the 'Temperature Check' surveys issued last year.

Workforce Report

Month reported **Jul-12**

Trust Summary

Vacancies & Turnover

	Funded WTE	Inpost WTE	Variance
Trust Total	4727.10	4443.89	-283.21
Directorate			
A&E Operations	3457.72	3286.86	-170.86
Chief Executive	16.60	14.20	-2.40
Control Services	462.75	421.47	-41.28
Corporate Services Directorate	36.76	33.27	-3.49
Finance & Business Planning Directorate	53.20	43.13	-10.07
Health Promotion & Quality	18.27	17.77	-0.50
Human Resources & Organisation Dev Directorate	178.22	179.31	+1.09
Information Management & Technology Directorate	87.48	80.16	-7.32
Medical Directorate	27.20	20.21	-6.99
Operational Support	134.43	117.21	-17.22
Patient Transport Service	142.21	143.23	+1.02
Trust Board	5.00	5.00	+0.00

	Est.	In Post	Var.
T/L Paramedic	197.65	191.83	-5.82
Paramedic	1252.15	1351.37	+99.22
Apprentice Paramedic	80.00	8.00	-72.00
Student Paramedic 1	0.00	0.00	+0.00
Student Paramedic 2	25.00	4.00	-21.00
Student Paramedic 3	352.00	221.00	-131.00
Student Paramedic 4	61.00	99.00	+38.00
EMT 1	18.61	18.61	+0.00
EMT 2-4	863.44	805.30	-58.14
A&E Support	333.53	331.29	-2.24
CTA	53.60	43.22	-10.38

Turnover

2011/12	7.1%	Apr-11 to Mar-12
2012/13	7.8%	12 Months up to Jul-12

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No. Leavers (Headcount)												
2011/12	22.00	36.00	33.00	28.00	34.00	30.00	23.00	21.00	26.00	35.00	28.00	28.00
2012/13	34.00	34.00	50.00	27.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
No. Starters (Headcount)												
2011/12	6.00	7.00	7.00	21.00	7.00	32.00	50.00	8.00	15.00	4.00	6.00	3.00
2012/13	20.00	5.00	18.00	25.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

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

Workforce Report

Month reported **Jul-12**

Trust Summary

Employee Relations Data

	Attendance	Grievances	Capabilities	Discipliary (Clinical)	Discipliary (Non Clinical)
Current Case Total	558 (556)	12 (11)	3 (2)	2 (2)	33 (29)

Current Employment Tribual Cases	11 (13)

Current Suspensions	7 (6)

Narrative

* The figure for the previous month appears in brackets.

Attendance
These figures and the audit results mentioned previously continue to demonstrate the focus on attendance management has been sustained.
Grievances
As reported previously , it must be expected that as managers increase the focus on all facets of performance, this figure will be higher than previously seen. Nevertheless, given the number of employees, this number still remains low.
Disciplinaries
The ratio of clinical to non-clinical cases continues to show that clincial issues are rarely dealt with under the disciplinary procedure.
Employment Tribunals
One outstanding judgement was received - the claim for unfair dismissal was upheld, the claim for age discrimination was dismissed; one claim was settled.

PDR completions in 2012/13

Area / Directorate / Dept	No to be done	No done	% completed 12/13	% completed 11/12	Difference +/-
West*				38.8	
South*				6.9	
East*				33.1	
Sub total					
Control Services	554	138	24.9	74.3	- 49.4
PTS	151	63	41.7	53.2	- 11.5
IM&T	78	49	62.8	99.0	- 36.2
Operational Support	117	85	72.8	66.3	+ 6.5
Medical	25	25	100.0	100.0	0.0
Communications	12	12	100.0	94.1	+ 5.9
Corporate Services	29	29	100.0	94.6	+ 5.4
HR & OD	145	128	88.2	100.0	- 11.8
Finance and Business Planning incl Estates	35	34	97.1	82.4	+ 14.7
Sub total	1146	563	49.1	76.5	- 27.4
Total	1146	563	49.1	54.0	- 4.9

As at 6 Aug

* Ops PDRs will be reported after the Olympics

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 21ST AUGUST 2012

PAPER TO PROVIDE ASSURANCE

Document Title:	**Report from the Risk, Compliance and Assurance Group on the progress made with the Trust Risk Register**
Report Author(s):	**Frances Wood, Audit and Compliance Manager**
Lead Director:	**Mike Dinan/Sandra Adams**
Contact Details:	**frances.wood@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Following a request made by the Audit Committee**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other
Recommendation for the Trust Board:	**To take assurance from the progress made with the Trust Risk Register**

Key issues and risks arising from this paper
None.

Executive Summary
The Trust Risk Register was updated during May and June 2012 with updates provided by the risk owners. The Trust Risk Register was discussed at the meeting of the Risk Compliance and Assurance Group on Monday 9th July 2012 and the attached document is a summary of the outcome of these discussions.

The operational risks were discussed in detail at the RCAG meeting on the 9th July and have been updated in the Trust Risk Register following the meeting.

The RCAG also identified a number of emerging risk themes during the review of the risk register. These were discussed by the Strategy Review and Planning Committee on 24th July in the context of reviewing the four strategic risks. The latter were debated and reconfirmed as relevant for the five year strategic period with the addition of 'quality' to risk 1. The emerging risk themes have been aligned to the strategic risks.

Attachments
- Report from the Risk, Compliance and Assurance Group
- Trust Risk Register

****

Quality Strategy

This paper supports the following domains of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

Has an Equality Analysis been carried out?

☐ Yes
☒ No

Key issues from the assessment:

July 2012 RCAG Update for the Quality Committee and Trust Board

The Trust Risk Register was updated during May and June 2012 with updates provided by the risk owners. The Trust Risk Register was discussed at the meeting of the Risk Compliance and Assurance Group on Monday 9th July 2012 and the following is a summary of the outcome of these discussions:

Re-grading of Risks

Two risks were discussed with a view to regrading:

- **Risk 31** 'There is a risk that the control and operational staff may fail to recognise serious maternity issues or fail to apply correct guidelines which may lead to serious adverse patient outcomes in maternity cases'.
  The RCAG agreed the proposal to re-grade the target rating from a major x unlikely = 8 to a major x possible = 12 as this is a more realistic position.

- **Risk 348** 'There is a risk that the Clinical Coordination Desk may not be able to coordinate demand across London's specialist centres due to lack of information provided by neighbouring ambulance trusts when bringing patients to London Centres'.
  The RCAG agreed the proposal to re-grade the net rating from a major x possible = 12 to a major x likely = 16 due to current problems liaising with other ambulance trusts.

Archiving of Risks

The following risks were approved by the RCAG for archiving, as the controls in place have mitigated the risks to their target rating:

- **Risk 361** 'There is a risk that problems during the development and testing of CommandPoint result in the system not being ready to go live as planned by the end of March 2012. This could have a contractual, financial, and reputational impact for the Trust'.
  The RCAG agreed that this risk should be archived as the following controls are in place: Following Go Live 2, the underlying risks are now either closed or reduced in rating, implying that the overall score is now "5", the target rating, with no further actions outstanding. The recommendation is to close this risk at the next RCAG

- **Risk 334** 'There is a risk that the implementation of CommandPoint will lead to a short-term reduction in performance targets'.
  The RCAG agreed that this risk should be archived as the following controls are in place: Following Go Live 2, the underlying risks are now either closed or reduced in rating, implying that the overall score is now "10". The original target rating of "5" is considered unreasonable, given that there are no further actions outstanding. The recommendation is to close this risk at the next RCAG.

- **Risk 296** 'Exposure of staff to carbon monoxide fumes whilst in incident premises'.
  The RCAG agreed that this risk should be transferred to the operations risk register and managed locally as the following controls are in place to mitigate this risk: 1. A steering group to manage this risk has been formed with Jason Killens to act as chair.
  2. The recommendations made within a report prepared by a member of staff from the HART team have been considered viable in some cases. The group will further scope the recommendations where necessary and will drive their implementation.

3. Steering group to develop management and monitoring procedure. To be managed through EP and BC steering group.

- **Risk 359** 'There is a risk that users may install unauthorised software which may compromise information security, service management and potentially breach software licencing agreements which would leave the Trust liable'.
  The RCAG agreed that this risk should be archived as the following controls are in place: 1. Only admin users can install software. 2. Password changes are forced every 90 days. 3. A list of authorised/unauthorised software is being developed and acted upon 4. Further locking down of desktops has been completed. 5. Reduction of the number of Admin accounts. Instances of questionable software installs have been investigated and have been removed or added to an authorised list.

- **Risk 337** 'There is a risk that there will be a delay in establishing the Clinical Response Model due to changes that need to be made to interfacing other projects (CommandPoint/CTAK)'.
  The RCAG agreed for this risk to be closed and a new risk assessed around the service delivery model.

New Risk Proposals

The following risks were proposed to the RCAG and approved for addition to the Trust Risk Register:

- 'There is a risk that frontline staff may not be able to measure oxygen saturations on some paediatric patients, in particular infants due to an inconsistency in availability of paediatric pulse oximetry across the Service'.
  Gross rating = significant 9, net rating = moderate 6, target rating = low 3.

- 'There is a risk that oxygen saturations may not be able to be measured immediately after arrival of the crew (at present oxygen saturations can only be measured using a Lifepak 12/15 which can be removed from the vehicle but, being a large piece of equipment is not usually taken in initially with the primary response bag, AED and oxygen bag)'.
  Gross rating = significant 9, net rating = possible 9, target rating = low 3.

Risk Updates

The Governance and Compliance Team updated the Trust Risk Register in May and June 2012 with updates provided by risk owners. The following directorates provided updates in July 2012 but these were not provided in time to be reported to the RCAG who met on the 9th July.

Operational Risks

Operational risks were updated in July by the risk owners and were discussed at the RCAG meeting on the 9th July. The updates have subsequently been added to the Trust Risk Register and changes to risk status are summarised below:

- **Risk 265 -** 'There is a risk that Service Performance may be adversely affected by the inability to match resources to demand'.
  The RCAG agreed that the target impact rating for this risk should be major and that the wording of the risk is amended to reflect the capacity review and planned roster reviews.

- **Risk 269 -** The RCAG agreed to change the wording of this risk to 'There is a risk that at staff changeover times, LAS performance falls'.

- **Risk 9 -** 'There is a risk of RTC injury to persons travelling in LAS A&E vehicles'. The RCAG discussed the proposals to change the likelihood rating. It was agreed not to change these as road traffic accidents were not always within the Trust's control and could therefore never be rare.

- **Risk 316 -** 'There is a risk that the non-reporting of faults in accordance with service procedures may result in the loss of vehicle availability'.
  The RCAG agreed that this risk should be archived as there had been a significant improvement in the reporting of vehicle faults.

- **Risk 20 -** 'There is a risk that inappropriate use/completion of the LA4H Single Response Handover form may lead to the loss of patient information'.
  The RCAG agreed that this risk should be archived, as it was proposed by Martin Flaherty that the inappropriate use or completion of the LA4H form was no longer a problem.

- **Risk 72 –** 'There is a risk that inconsistent action relating to the maintenance and repair of trolley beds, due to inadequate record keeping, may result in adverse clinical incidents'.
  The RCAG agreed with the proposal that this risk should be archived, as Martin Flaherty reported that the Trust had introduced a scanning system of trolley beds as part of the Initial Contract. It was also agreed by the RCAG that the risk should be reviewed in 12 months' time.

- **Risk 315 –** 'There is a risk of service failure during relocation to the FBC because effective arrangements for continuity have not been made between LAS and the Metropolitan Police'.
  Martin Flaherty reported that the wording of this risk had been updated and the risk should be reviewed again in October 2012 after the second control room had been implemented.

- **Risk 354 –** 'There is a risk of ongoing industrial action due to national ballots leading to disruption of service provision'. There was a discussion about possibly downgrading this risk which is currently graded at major x possible = significant 12, however the RCAG did not agree that the risk should be downgraded. There was also a discussion about a risk to the Trust of external agencies taking strike action such as bus drivers. It was agreed that a risk assessment and reporting form will be completed and reviewed at the next RCAG meeting regarding this risk.

- **Risk 306 –** 'There is a risk that failure to undertake Vehicle Daily Inspections before driving vehicles, in relation to roadworthiness checks as required by Road Traffic Act, may result in adverse traffic incidents'.
  The RCAG agreed that this risk had met its target its target rating and should be transferred to the operations local risk register and managed locally.

- **Risk 294 –** 'There is a risk that the Trust is unable to guarantee to provide a paramedic to attend every incident where one was requested'.
  The RCAG agreed that this risk should be archived, as Martin Flaherty reported that there was now a response profile on CommandPoint to identify where a paramedic was available.

- **Risk 217** – 'There is a risk that the Trust may not be able to contact a resource in a "Black Spot" area'.

The RCAG agreed the proposal that this risk should be archived with the following rationale provided: Whilst Airwave, as any communication system will have areas of reduced coverage, the network is far superior to the analogue system following upgrades in the last few years. The system works for LAS on London Underground and we have been successful in lobbying for network upgrades for large events.

- **Risk 186 –** 'There is a risk that the inconsistent management of Medical Devices may lead to a higher rate of failure, which would in turn have an adverse effect on the provision of clinical care'.
  Martin Flaherty commented that there had been an issue at the yearend audit as one of the defibrillators could not be located. The Audit Committee had flagged this as an issue to the Trust Board as it was the second year that this had occurred. RCAG agreed that although the position was much improved with the Initial contract, it was still a live risk and therefore should not be archived. Ed Potter will give an update on this risk to the next meeting of the RCAG in October.

- **Risk 222 –** The RCAG agreed the proposal to change the wording of this risk to 'There is a risk that lack of frontline management at weekends may reduce the level of support/advice available to staff'.

- **Risk 317 –** The RCAG agreed the proposal to archive this risk 'There is a risk that the Trust may not achieve its Category A target in the current financial year' due to the following: the Trust has achieved Cat A target for the last 9 years and changes to clock start in June 2012 resulted in more time to assess and assign calls accordingly.

- **Risk 223 –** 'There is a risk, that due to operational pressures, the Trust will not be able to hold regular team meetings/briefings with frontline staff. This may have an adverse affect upon CPIs and the PDR process'.
  The RCAG agreed that the net likelihood of this risk should be changed to possible and that the target impact should be moderate.

- **Risk 335 –** 'There is a risk that service delivery will be compromised in the event of flooding'. The RCAG agreed the proposal to archive this risk.

- **Risk 303 –** 'There is a risk of unavailability of critical patient care equipment on vehicles'. The RCAG agreed that the target impact rating should be moderate.

- **Risk 346 –** 'There is a risk that due to recruitment difficulties, there is a risk that the West Team may not be at full strength by that date' (The Trust is committed to having 2 full strength HART's by April 2010).
  The RCAG agreed the proposal to archive this risk as both HART teams are now at full strength and the recruitment to the teams is no longer an issue.
  HR Occupational Health has no formal fall back if contractors are unable to fulfil their contracts.

- **Risk 281 –** 'There is a risk that HR Occupational Health has no formal fall back if contractors are unable to fulfil their contracts'. The RCAG agreed the proposal to archive this risk due to the existing contractual arrangements with Guys & St Thomas being in place.

Infection Prevention and Control Risks

The Infection Prevention and Control risks had not been updated for the RCAG meeting on the 9th July but were subsequently reviewed at the Infection Prevention and Control Committee on the 19th July and have now been updated on the Trust Risk Register.

Finance Risks

The Finance risks had not been updated for the RCAG meeting on the 9th July but were subsequently reviewed by the risk owners and have now been updated on the Trust Risk Register.

Risk Tolerance

Where risks have been allocated a target rating at which they are accepted but may pose a risk to the organisation in future, trigger points will be set at which point the risk will be escalated for review, further actions identified, regrading and re-presentation to the RCAG. These risks will remain visible on the Trust Risk Register even when they have reached their target rating.

London Ambulance Service NHS Trust
Risk Register as at 7th August 2012

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	Risk Category	Gross Impact	Gross Like-lihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Like-lihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like-lihood	Target Rating	Comments
368	There is a risk that messages exchanged between MDTs and the CommandPoint CAD system may become out of sequence, cross one another while one is being processed or a job being 'cycled' through to closure in error by an A&E resource. This may result in an open event being closed in the CAD system erroneously, leading to a patient not receiving a response from the LAS and their condition deteriorating, possibly resulting in serious injury or death	Following CommandPoint go live, several incidents have been reported to the CAD support team for investigation where out of sequence messages from MDTs have resulted in events showing with an incorrect status. On a number of these the event has been closed in error. The investigations have identified a number of ways that this scenario can occur. So far the identified possible causes are: • Preempt request/event updates crossing • Status change messages echoed • MDT status changes arrive out of order • Aged MDT status	27-Jul-12			Clinical	Catastrophic	Almost Certain	25	1.Software adaptation to identify unexpected status messages or very short job cycles, alerting controlling dispatchers and managers. (Build 2.5.6) 2. Manual alerting outside the CAD system processing messages and identifying possible jobs closed in error (unexpected AOR status) setting off a pager in the control room (fall back alert.) Also Section 4 Assurances below (point 4 - daily alert checks) 3. Software adaptation to hold event updates while pre-empt requests are being processed, negating one of the above scenarios from occurring. (Build 2.5.6)	Peter Suter		Catastrophic	Possible	15	1. Request for change to CommandPoint system to enhance the functionality around message detail with message type and sequence identification, enabling CAD system rejection of erroneous status changes. 2. Request for Change to MDT system to provide message sequence identification and processing as above. 3. Additional communications material and training around the urgent messages generated to area controllers and dispatchers notifying them of message cycling. 4. Removal of 'false positive' messages from unexpected status change warnings generated by CAD to area controllers and dispatchers.	1. J. Downard 2. J. Downard 3. P. Cassidy 4. P. Cassidy		1. Technical solutions under development by tactical problem management team (led by John Downard) 2. Weekly director progress oversight in CommandPoint problem management review (led by Peter Suter) 3. Ongoing assessment of alert monitoring and identification of further incidents for CAD support team investigation by CommandPoint senior user group (led by Richard Webber) 4. Daily checks of	Catastrophic	Rare	5	
265	There is a risk that Service Performance may be adversely affected by the inability to match resources to demand.		31-Jul-06	***	3	Operational	Major	Almost Certain	20	1.Ongoing recruitment to vacancies. 2. Use of voluntary and private sector at times of peak demand. 3. Agreed terms of capacity review with Commissioners. 4. Scoping use of agency Paramedics to enhance bank scheme. 5.The Trust has implemented an Operational weekly demand and capacity review group. The group has been tasked to forecast demand by utilising historic data, capacity for the Trust to meet the predicted demand, monitoring the input measures and understanding influencing factors that potentially could have an adverse effect on Category A life-threatening calls.	Martin Flaherty	09-Jul-12	Major	Likely	16	1. Review ORH implemented rosters Pan London 2. Modelling being undertaken by the Operational Weekly Demand and Capacity Review Group (OWDaCR) 3. Clock start changes for Cat A in June 2012 4.Implement outcomes of formal capacity review.	1. C.Hitchen 2. J. Killens 3. M. Flaherty 4. J. Killens 5.P Woodrow	1. Q3 12/13 2. Ongoing 3. Q2 12/13 4. Ongoing 5. Ongoing		Major	Possible	12	
31	There is a risk that the control and operational staff may fail to recognise serious maternity issues or fail to apply correct guidelines which may lead to serious adverse patient outcomes in maternity cases.		14-Nov-02	***	4	Clinical	Major	Almost Certain	20	1. The Medical Director attends NPSA's Obstetric Pan London Forum. 2. Consultant Midwife working with the LAS one day a week, providing advice to Control Services, Legal Services, Patient Experience, and Education and Development. 3. Reports on all the reported incidents concerning obstetric cases are presented to the Clinical Quality Safety and Effectiveness Committee- Report produced in Feb 2012. 4. Training by Consultant midwife to complexes with workshops and a number of complexes have made local arrangements for midwives to deliver training sessions. 5. Maternity care updates and ongoing training through direct contact and articles in the Clinical Update.. 7. CTA now have maternity pathway to assist with triage of women in labour. 8. Monitoring the delivery of the CPD obstetrics module.Re- review planned June 2012 9. Evaluated the flow chart used to enable the safe triage of women in early labour- To be slightly modified and modifications completed Sept 2012	Fionna Moore	09-Jul-12	Major	Likely	16	1. Modifications to the safe triage of women in early labour flow-chart - ongoing and complete Sept 2012 2. Review incidents reported through LA52's, Patient Experiences and Legal Claims relating to problematic obstetric incidents-Ongoing	1. A.Stallard / F.Sheraton 2. A. Stallard	1. Sep 2012 2. Ongoing	1. Monitor processes at CQSE and Corporate Health and Safety Group. 2. Incident reporting.	Major	Possible	12	

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355	There is a risk of staff not receiving clinical and non-clinical mandatory training.	This may as a consequence cause:- ● Failure to meet CQC and the Trust's TNA policy ● Dilution of clinical skills ● this includes the decentralising of operational training to New Ways of Working (NWOW)	23-Nov-11		5	Human Resources	Major	Almost Certain	20	1. PDR / KSF Agreed rostered training days. 2. Dedicated tutors. 3. Paramedic registration. 4. Weekly Operational demand capacity meetings. 5.Cluster arrangements in place from December 2011 on all complexes.	Caron Hitchen	28-May-12	Major	Likely	16	I. TNA 2012/13 to be approved 2. Launch workbook for Infection prevention and control 3. OLM pilot to commence	1. G.Heuchan 2. K.Miller 3. B.O'Neil	1. June 2012 2. Ongoing 3. June 2012	1. Reporting to TSG 2. Performance Accelerator	Major	Unlikely	8	
269	There is a risk that at staff changeover times, LAS performance falls.		08-Dec-06	***	17	Clinical	Major	Almost Certain	20	1. Daily monitoring of rest break allocation to resolve end of shift losses 2. Use of bridging shifts for VAS/PAS 3. Roster reviews/changes must include staggered shifts.	Martin Flaherty	09-Jul-12	Major	Likely	16	1. Implement changes to rest break arrangements 2. Outcome of capacity review 3. Ongoing roster reviews	1. C.Hitchen 2. M.Flaherty 3. G.Hughes	1. Q3/4 12/13 2. Q3/4 12/13 3. Ongoing		Major	Unlikely	8	
327	There is risk that the Trust does not follow Department of Health Guidelines for the re-use of linen.		12-Oct-09	***	4	Infection Control	Major	Almost Certain	20	1. The Trust has an adequate supply of blankets, however these are not always available. 2. Increased availability of blankets for A&E crews - Additional linen and disposable blankets added to stocks and circulated. 3. Improved collection of soiled blankets from hospitals and non-contract laundries - New laundry provider appointed and increased activity being established to collect blankets. Reduction in blanket loss.	Steve Lennox	30-Jul-12	Major	Likely	16	To understand the scale of the problem and to develop a sstrategic solution ot blanket usage: 1 . Audit blanket usage as part of hand hygiene auditing. 2. Chris Vale developing options paper to agree strategic direction. 3. PIMS to address compliance of single use locally. DIPC to present at conferences. Continue to audit. 4. Small sub group to be formed to discuss options paper and endorse recommendations	1. Trevor Hubbard 2. Chris Vale 3. Trevor Hubbard 4. Karen Merritt	1. Complete 2.Feb 2012 3. Oct 2012 4. Complete	1. KPI measuring blankets collected delivered. 2. KPI measuring blankets allocated/ delivered.	Minor	Possible	6	A sub group is to be set up establish further actions to be taken. 2. The options paper has been developed but has not yet been discussed Action: Karen Merritt

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22	There is a risk that failure to undertake comprehensive clinical assessments may result in the inappropriate non-conveyance or treatment of patient.	Inappropriate non-conveyance incident	14-Nov-02	***	5	Clinical	Major	Almost Certain	20	1. An enhanced patient assessment course has been introduced for paramedics. The training has been subject to a major overhaul and now includes a supervision element. Reflective practice has also been adopted into the majority of assignments. 2. Planned CPD delivery will cover all relevant staff. However, this may be affected by operational pressures. 3. Training Services monitor the level of training delivery. 4. CPIs are used to monitor the level of assessments provided. 5. LA52 incident reporting is in place and reports are provided to the Clinical Quality Safety and Effectiveness Committee. 6. The Operational Workplace Review has been reviewed and will now include rideouts. 7. A system for clinical updates is in place. 8. A system of closed round tables is in place. 9. The development of treat and refer pathways is being continued alongside the New Ways of Working project. 10. An enhanced patient assessment component has been introduced within the APL Paramedic Course. The training has been subject to a major review and now includes a mentored period of operational duties. 11. Monitoring the development of treat and refer pathways. 12. Introduction of reflective practice (as part of	Fionna Moore	31-May-12	Moderate	Certain	15	1. To review the effectiveness of the existing incident reporting system. 2. Pilot scheme where crew staff from 4 identified complexes will contact EBS via their airways radio. EBS will record incidents directly onto an electronic version of the existing LA52.	1. J.Selby 2. J. Selby	1. Sep 2012 2. Sep 2012	1. Incident reporting. 2. Operational workplace reviews. 3. Regular reports to CQSE.	Moderate	Possible	9	The incident reporting pilot continues in City and Hackney. However levels of airwaves reporting has dropped off since the change of line management, and the withdrawal of LA277 reporting (due to Command point / MI pressures) EBS updated that original problems of crew staffs familiarisation with technology appear to be diminishing, but still take a contact telephone number early in the conversation due to the unpredictable nature of the Airwave radio. Line manager Investigation report delays continue to pose a concern. It is proposed to relaunch the incident reporting pilot in conjunction with safeguarding. The relaunch includes rolling out the pilot to Whipps Cross complex. The project group are due to meet again on 14th June to discuss the proposals.
324	There is a risk that cleaning arrangements are insufficient to ensure that the environment for providing healthcare is suitable, clean and well maintained.		17-May-10	***	4	Infection Control	Major	Almost Certain	20	1. Introduction of revised cleaning programme. 2. Infection control champions are in place. 3. Audits of vehicles and premises. 4. Swabbing of vehicles by LSS. 5. Processes now in place to triangulate audit information.. 6. Opportunities within the PEAG initiative have been identified to support the audit process.	Steve Lennox	30-Jul-12	Major	Possible	12	To ensure Trust is consistently compliant across the service: 1) Conduct audit following implementation of contract.	1. Trevor Hubbard	1. Oct 2012	1. Comprehensive dashboard	Minor	Unlikely	4	1. An audit has been conducted and will be reviewed again in October 2012.
7	There is a risk that we do not capture errors and incidents, and do not therefore learn from these and improve service provison and working practices.	Insufficient recorded evidence of reported incidents	13-Nov-02	***	4	Health & Safety	Major	Almost Certain	20	1. LA52 incident reporting form 2. Risk management policy and strategy has been updated and implemented 3. Incident reporting policy is implemented 4. The Learning from Experience (LfE) group is in place and starting to review integrated risk reports, patterns and trends - LfE group receive an integrated report and monitor action to be taken, including feedback to staff on incidents reported and investigated. 5. A review of incident reporting is underway and led by the PCMO. 6. Weekly SI control sheet and conference call	Caron Hitchen	31-May-12	Moderate	Possible	9	1. Complete the review of incident reporting and make recommendations to Corporate H&S and RCAG. 2. Implement the policies on investigating and learning from incidents, complaint, PALs and claims. 3. LfE to develop the integrated risk reports and monitor action taken, including feedback to staff on incidents reported and investigated.	1. S.Sale 2. S.Adams 3. C.Dodson-Brown 4. C.Dodson-Brown	1. Sept/Oct 2012 2. 3.	1. Completion of the review and recommendations to RCAG and SMG for implementation. 2. Reports and minutes from Learning from Experience, RCAG, SMG and Quality Committee.	Moderate	Rare	3	
343	There is a risk of staff not recognising safeguarding indicators and therefore failing to make a timely referral.		12-Aug-10		4	Clinical	Major	Likely	16	1. Monitor referrals centrally. 2. Safeguarding committee promotes practice guidance. 3. Practice guidance issues and supported by updates. 4. Training programme in place - ongoing auditing of the effectiveness of training through competency assessments. 5. Monitor training uptake - monitored centrally on scorecard. 6. Safeguarding Adults Gap Analysis.	Steve Lennox	24-May-12	Major	Likely	16	1. Capture safeguarding practice in bi-annual Operational Workforce review 2. Formulation of action plan based on completed safeguarding adults gap analysis	1. P.McKenna, K.Millard, P.De Bruyn 2. Steve Lennox	1. Dec 2011 2. Nov 2011	1. Monitor at Safeguarding Committee	Major	Unlikely	8	2012-05-24 CQS&E - risk to be revised at Safeguarding Committee Meeting.

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349	There is a risk that the Clinical Coordination Desk will not be able to operate effectively due to a lack of suitably trained staff in EOC where secondments of specifically trained staff have ended and specialist roles with control services are being removed.	Specialist roles with control services are being removed in order to provide a more flexible workforce. This removes the experience and expertise that has been developed on the CCD and has now become a nationally recommended part of clinical network development.	11-Jul-11	***	4	Operational	Major	Likely	16	1. CCD now supported by enhanced clinical support in EOC with 24/7 clinical hub going live on 16/7/12 2. Team leaders and central operations staff trained and attend EOC on shift by shift basis if additional ad hoc staff required	Martin Flaherty	01-Jun-12	Major	Likely	16	1. Implement new integrated clinical hub from 16 July 2012 2. Enhance clinical hub operations in phase 2 and 3 of implementation	1. F.Wrigley 2. F.Wrigley	1. July 2012 2. Nov 2012 / March 2013		Major	Unlikely	8	
9	There is a risk of RTC injury to persons travelling in an LAS A&E vehicles.		13-Nov-02	***	7	Operational	Major	Likely	16	1. Authorisation to drive any service vehicle/lease car can only be provided by a qualified service trained driving instructor. 2. Introduction of advanced training for a number of DSO's in each Sector. 3. Team Leaders complete an Operation ride out report, within which is a section categorised as self driving demonstrated 4. The Trust displays notices internally stipulating safety features and the use of safety equipment when travelling; • A&E Op's and Health Safety bulletins • Motor Vehicle notices are displayed reminding staff and passengers to wear seat belts/harnesses at all times. • Improved visibility whilst Ambulance's reverses - camera switching. 5. Revised driving policies implemented in 2011	Martin Flaherty	01-Jun-12	Major	Possible	12				1. Monitor processes at RCAG and Motor Risk Group. 2. Monitoring of RTA claims 3. ADO's to implement a robust system	Moderate	Possible	9	
138	There is a risk that failing to appreciate the significance of psychiatric illnesses will lead to mis-diagnosis.		12-Nov-03	***	5	Clinical	Major	Likely	16	1. The new 'Mental Health' module has been designed and has been included in the training plan for 2009/10. 2. An e-Learning Manager has been appointed and will start work wih the Trust in August 2009. 3. Mental health e-learning module has been developed - training package assessed by external assessors	Steve Lennox	05-Jul-12	Major	Possible	12	1. Development of mental health risk assessment tool 2. Roll-out of mental health e-learning training 3. Mental Health Committee to consider alternatives to e-learning 4. Mental health audit 5. CSR3 Training	1. S.Lennox 2. S.Lennox 3. S.Lennox 4. S.Lennox 5. K.Miller	1. Dec 2011 2. Dec 2011 3. Sept 2011 4. Complete 5. Oct 2012	1. CPD completion records 2. Monitor processes at CQSE 3. Monitor package completion data on e-learmng site	Major	Unlikely	8	
205	There is a risk of not being able to readily access and manage the training records of all operational members of staff due to records being kept on separate and remote sites outside of the current records management system.	As a result of limited capacity of the Fulham archive stoes, as well as records needing to be stored at other sites Separate sites holding data which we do not have access to easily	01-Jun-05	***	7	HR	Major	Likely	16	1. Education and Development are to move to the scanning of training records. Plans from Estates for the development of the Fulham archive are awaited. 2. All staff are currently being migrated onto PROMIS with the aim of developing a centralised Learning Management System.	Caron Hitchen	01-Jun-12	Major	Possible	12	1. Review the process of archiving training records within the DoE&D (Initial work indicates there may be a need for a formal procurement and tender process for electronic archiving) 2. Pilot toOLM to commence June 2012	1. P.Billups 2. R. Habib	1. Ongoing 2. July 2012	1. Part of organisation & development of people workstream. 2. Progress of project report to workstream board.	Major	Unlikely	8	
211	There is a risk that drug errors and adverse events may not be reported.	Concerns that drug errors may not be reported	08-May-06	***	4	Clinical	Major	Likely	16	1. No evidence of any issue of significance from service users or stake holder feedback. 3. Complaints Manager to tracked back complaints to see how many have LA52's associated with them (drug errors and adverse events not being reported) 4. Medical Directors Bulletin to remind staff of importance of reporting drug errors and adverse events. 5. Article included in the Clinical Update highlighting the importance of incident reporting. 6. Importance of clinical incident reporting highlighted in the Team Leader Clinical Update	Fionna Moore	03-May-12	Major	Possible	12	1. CQSE suggest PIMs give some thought to how this is managed. 2. Continue to encourage reporting of all clinical incidents using LA52's. 3. Continue to reinforce that the LAS has a fair blame culture by providing feedback from outcomes of complaints to staff involved in incidents.	1. J.Killens 2. 3.	1. 2. Ongoing 3. Ongoing	1. CPI checks 2. Incident Reporting 3. CQC inspections 4. Clinical opinions provided on incidents 5. Learning from Experience Group review incident activity 6. Review of	Major	Unlikely	8	All the current measures remain in place. In addition there is to be a reminder to all the Team Leaders on the forthcoming Team Leader Course about this issue
305	There is a risk that the management of morphine at Station level is not in accordance with LAS procedure OP/30 Controlled Drugs.	Controlled Drugs Incidents arising from poor adherence to policy	21-Oct-08	***	4	Clinical	Major	Likely	16	1. Internal Audit carried out annually. 2. Procedure to be reinforced by bulletins from Director of Operations/Medical Director. 3. Independent audits to be carried out throughout the Trust. 4. Initial peer review pilot audit carried out in the south area with results and process amendments discussed at a morphine audit group quarterly meetings.	Fionna Moore	03-May-12	Major	Possible	12	1. Peer review meeting is scheduled for following completion of peer review audits to take forward proposal to make the this part of business as usual across the areas. 2. Review of OP30 in the light of the forthcoming NHS Protect Guidance on CD management following their recommendations document of March 2012.	1. D.Whitmore 2. D.Whitmore	2. May 2012 3. June 2012	1. Internal Audit 2. Independent Audit 3. LIN oversight of system	Major	Unlikely	8	

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326	There is a risk that the inadequate facilities and lack of policy for the decontamination of equipment may increase the risk of infection.		17-May-10	***	1,2	Infection Control	Major	Likely	16	1. Introduction of single-use items. 2. Introduction of more robust cleaning programme for vehicles and premises. 3. Introduction of detergent and disinfectant wipes for equipment in between patient use. 4. Decontamination policy is now in place. 5. Improved decontamination processs in operation.	Steve Lennox	30-Jul-12	Major	Possible	12	1. Decontamination sub group to review compliance with decontamination process 2. Decontamination Policy to be agreed by ADG	1. K.Merritt 2. S.Lennox	1. Oct 2012 2. Complete	1. Area Governance Meetings 2. Incident reports.	Minor	Unlikely	4	
352	There is a risk that operational staff sustain a manual handling type injury whilst undertaking patient care. The consequence of injuries being:- -Increased staff absence through industrial injury. -Impact on service delivery. -Impact on patient care.	Staff injured whilst manual handling patients	23-Nov-11		7	Health & Safety	Major	Likely	16	1. Manual Handling Implementation Group and Manual handling policy 2. Manual handling awareness is provided at corporate Induction; refresher training through e-learning is available through L&OD; Education and Training dept provide training to all operational staff during initial and subsequent core refresher training; all operational ambulance vehicles are fitted with tail lifts 3. Core Skills Refresher training is monitored via the quality dash board. 4. The Corporate Health and Safety Group monitor manual handling incidents and training activity, 5. Small handling kits on all vehicles 6. BTech trained Manual Handling assessors 7. Specialist MH equipment e.g. Mangar Elk 8. All A+E and PTS operational vehicles have either tail lift of ramp access 9. All A+E and PTS operational vehicles are fitted with hydraulic trolley bed	Martin Flaherty	01-Jun-12	Major	Possible	12	1. Complete trials for new chair/lifting aids 2. Develop structured bariatric capability 3. Ongoing review of marketplace to identify new lifting aids	1. J.Selby 2. J. Killens 3. J.Selby	1. Q3 12/13 2. 2013/14 3. Ongoing	1. Manual Handling Implementation Group 2. Manual Handling Policy 3. Central Health and Safety Group Incident Statistics Monitor and Audit Reviews	Minor	Unlikely	4	**JS 2-08-12 Proposal to change wording to include reference to PTS staff being included in this risk. (i.e. There is a risk that operational staff (which includes PTS staff)**
153	There is a risk that fuel prices may be in excess of sums held in budgets which may lead to overspend	Increasing fuel prices	06-Jan-04	***	8	Finance	Major	Likely	16	1. Monthly review as part of month end reporting process. 2. Prices will continue to be closely monitored by the Finance Department for 2012/13. The move to an all diesel fleet will further mitigate against fuel costs.	Michael Dinan	31-Jul-12	Moderate	Possible	9	1. Finance Review of billing data underway by Director of Finance	1. M.Dinan	1. Ongoing	Monitored at SMG and Trust Board	Moderate	Possible	9	**Risk at target rating but to remain visible on Risk Register**
322	There is a risk that the Trust does not receive assurance that infection prevention and control training is taken up by staff.	Current workload within the department means that there is insufficient capacity to ensure that all tutors are developed in line with the departmental tutor development strategy. This includes time to incorporate information from bulletin into teaching strategies.	17-May-10	***	1,2,4, 5	Infection Control	Major	Likely	16	1. Introduction of training programme for operational and non-operational staff. 3. Trust updates have been delivered to 1,600 staff including hand hygiene training 3. Use of Infection Control Communications Strategy to ensure that all staff are kept well-informed.	Steve Lennox	30-Jul-12	Moderate	Possible	9	To be fully compliant with CQC expectations and all staff to have up to date infection control training: 1. Ensure all staff receive all in one training or alternative form of update (core skills refresher and induction training) 2. Monitor and implement hand hygiene training. 3. Need to capture the training of contracted staff on the scorecard.	1. C. Dodson-Brown / I.Bullamore 2. S.Lennox 3.	1. Oct 12 2. Oct 12 3. Oct 12	Reports from the central training register	Minor	Unlikely	4	Training now being delivered across the Trust in CSR1. Gaps in training data is being recovered

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323	There is a risk that the audit programme is not sufficiently robust to identify to identify infection control issues across the Trust.		17-May-10	***	1,2,4, 5	Infection Control	Major	Likely	16	1. Quarterly reports to Area Operations. 2. Further training of infection control champions. 3. Continued awareness training by use of Trust-wide communications. 4. 7 Point Audit plan is being used as an audit tool. 5. An Escalation plan is in place.	Steve Lennox	20-Jul-12	Major	Unlikely	8	1. PIMS and AOMS to identify solution for updating the scorecard.	1a. PIMS	1. Complete		Minor	Possible	6	IPCC propose to archive risk as the actions in place have mitigated the risk to the target rating.
173	There is a risk to staff, patients and the organisation of staff working excessive overtime/hours in breach of the Working Time Directive.		05-Jan-05	***	4,7	HR	Major	Likely	16	1. ProMis has a warning sign that is generated before the Coordinator continues to place a member of staff on a shift. The warning system highlights any contraventions of the Working Time Directive. 2. Regular ProMis reports are provided to operational managers and auditing is carried out by Station Management Teams who advise and take the appropriate measures with staff who try to compromise their own and patient safety. 3.The completion of the recruitment and training of student paramedics, coupled with the review of rosters due to compete in Summer 2010, should enable this risk to be reviewed and the rating reduced.	Caron Hitchen	08-Mar-12	Major	Unlikely	8	1. Continued monitoring and review of working hours via PROMIS. 2. Reissue WTD guidance. Move to controls? 3. Further enhancements are envisaged with the roll out of GRS in 2011. move to controls?	1. G.Hughes 2. T.Crabtree 3. G.Hughes/A Khan	1. Ongoing 2. Dec 2011 3. July 2011		Major	Rare	4	A service wide report was sent to all AOMs highlighting staff that had exceeded WTR hours for an average of 17 weeks.
329	There is a risk that financial penalties will be levied on the Trust as a result of non-achievement of the contractually agreed targets.	Potential failure to achieve contracted performance targets and failure to earn CQUINs	06-May-10		3,4,8	Finance	Catastrophic	Possible	15	1. 2012/13 Continue working with specific mitigation of financial risk. 2. Monthly finance reports reviewed by Trust Board and SMG. 3. Extra financial provisions included for contract risk in 2012/13. 4. Communications with commissioners.	Michael Dinan	31-Jul-12	Catastrophic	Possible	15	1. Review by Finance Investment Committee	1. A.Cant	1. April 2012	1. Performance is tracked daily both centrally and by area. 2. Financial risks are reviewed by SMG and Trust Board.Diary meeting every Monday reporting where performance is reviewed and recover plans are discussed. 3. Monthly meetings with PCT commissioners were performance is reviewed against targets and agreement is reached and findings are documented. 4. Performance is reported to the SHA monthly. 5. The Finance and Investment Committee will	Catastrophic	Unlikely	10	Communications have taken place with commissioners to identify financial offsets arising from higher than agreed levels of activity. Separate key financial risks as per LAS Financial Review top 15 risks schedule
362	There is a risk that the absence of a medical devices tracking system may result in the Trust being unable to maintain and track equipment which could result in equipment not being available for patient use.	Impact on Complexes not being able to manage allocation of medical equipment to vehicles. Impact on patient safety if medical equipment is not available possibly resulting in a serious incident. Equipment is not serviced at the correct intervals and there are no indicators, if an item	17-Apr-12			Clinical	Catastrophic	Possible	15	1. Occasional audits of equipment by complexes and logistics department. 2. Equipment lists are available from the company which maintains the medical devices, which includes services and non serviced items.	Martin Flaherty		Catastrophic	Possible	15	1. Actions are set out in the Vfm Programme - Tracking Medical Devices Project Mandate. 2. Establish confidence in the project via the project team.	1. Martyn Salter 2. Ed Potter			Catastrophic	Rare	5	

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344	There is a risk that the Trust is unable to assure that the current taxi contract accommodates the guidelines for regulated activity (safeguarding)		16-May-11		2,4	Governance	Moderate	Almost Almost Certain	15	1) Current contract stipulates all drivers must have CRB checks	Steve Lennox	02-Aug-12	Moderate	Almost Certain	15	1. Registration with the Independent safeguarding Authority needs stipulating in the contract 2. Contract monitoring	1. P.Webster 2. P.Webster	1. 2011/12 2. 2011/12	1. Safeguarding Committee	Minor	Rare	2	We are stuck with this one and awaiting new DH guidance which we believe will remove some of the current procedures
357	There is a risk that LAS may receive a significant increase in call demand as a result of 111 pilot sites that we do not have the capacity for.	Based on the National 111 Evaluation undertaken by Sheffield University of the early implementor pilot sites LAS could see between 8 and 15% of 111 call demand requiring an ambulance conveyance, which may be upto 10% higher than current demand from NHS D. This could place additional pressure on LAS. Particularly as 40-50% of these are likely to be Cat A calls.	23-Nov-11		1,2,3, 4,8	Operational	Moderate	Almost Almost Certain	15	1. SLA regarding clinical governance of 111 call management. 2. Agreed audit mechanisms during first month of implementation to ensure 111 calls are reviewed. 3. Agree to report back through 111 Clinical Governance meetings if calls are being passed inappropriately.	Lizzy Bovill	12-Mar-12	Moderate	Likely	12	1. We will negotiate as a clause in the funding mechanism for 111 generated activity in the 2012/13 contract.	1. L. Bovill	1. 1 May 12	1. Control Service Clinical Governance Group 2. Monthly commissioning reports 3. Attendance at NHS London Clinical Governance Group 4. Attendance at pilot site governance groups as required 5. Agreed process to manage incidents and complaints (through 111 governance teams)	Moderate	Unlikely	6	
345	The Trust currently recieves a sum of £7.7m non recrring funding to maintain a CBRN (Decontamination) Response. There is a risk that the funding may not continue. The funding is used to fund 143 WTE and the hours required for annual CBRN training	Public sector funding constraints. No formal service level agreement in place	16-May-11		1,2,3, 4,8	Finance	Catastrophic	Possible	15	1. 2012/13 contract reflects this work, if there is a shortfall PCTs are liable. 2. Reviewed by Finance Investment Committee.	Michael Dinan	31-Jul-12	Catastrophic	Unlikely	10	1. Trust to attempt to gain assurances from DH that this funding will continue. 2. Reviewed by Finance Investment Committee.	1. Lizzy Bovill 2. M. Dinan	1. Feb 2012 2. April 2012	1. Service Line Reporting	Catastrophic	Unlikely	10	Under discussion with DH 2012/13.
315	There is a risk of service failure during relocation to the FBC because effective arrangements for continuity have not been made between LAS and the Metropolitan Police.		17-Aug-09	***	17	Business Continuity	Catastrophic	Possible	15	1. New arrangements agreed with surrounding Trusts to take LAS 999 calls in event of total loss of HQ. 2. FBC opens as a _ site in October 2012	Martin Flaherty	01-Jun-12	Catastrophic	Unlikely	10					Catastrophic	Rare	5	

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353	There is risk that Operational ambulance staff and Emergency Operations Centre Staff are unsure of the safe systems of working/procedures in relation to railway trackside working, due to the rare occurrence of such incidents.		23-Nov-11		5,7	Operational	Catastrophic	Possible	15	1. Emergency Medical Despatchers (EMD) receive familiarization and procedural awareness during initial training and during their dispatch training course. 2. Work Based Trainers oversee adherence to procedure during placements Student Paramedics receive trackside awareness training during initial training. 3. "Trains Can Kill" card included in Major Incident Action Cards as point of reference. 4. Contingency Plans in place for calls on Network Rail, LUL, DLR and Croydon Tramlink calls including safety awareness information. 5. Operational bulletins available via The Pulse. 6. Trackside Awareness Training provided for all student paramedics and trainee emergency medical dispatchers including demonstrations of short circuit devices 7. Revised policy and procedure in place setting out requirements when attending railway incidents	Martin Flaherty	01-Jun-12	Catastrophic	Unlikely	10	1. Develop e-learning package for operational managers to enhance safety. 2. Inclusion of railway incidents session in Q3/4 12/13 ops managers EP updates.	1. W.Kearns 2. L.Lehane	Ongoing Q 3/4 12/13	.	Catastrophic	Rare	5	
207	There is a risk of staff not being able to download information from Defibrillators and 12 lead ECG monitors leading to incomplete patient records.	Clinical information was not available which was required for an inquest	04-Apr-06	***	1,2,4, 5	Clinical	Moderate	Almost Certain	15	1. Mark Whitbread is the Trust lead for the card readers project, 2. Card reading and transmission is performed by team leaders. Mark Whitbread stated that operational pressures, and therefore the availability of team leaders, may have an adverse affect on the number of cards read. 3. A performance update was incorporated in an AOM briefing session held at the Millwall Conference centre in March 2009. All AOMs were in attendance. 4. Monthly report to AOMs on areas of weak performance. 5. Messages given out at Team Leaders Conferences. 6. Encourage more routine downloading of information from data cards. 7. 147 LP1000 AED's have been rolled out and all complexes have been issued with new data readers for these units.	Fionna Moore	15-Jun-12	Moderate	Possible	9	1. To highlight the importance of clinical incident reporting in the Team Leader Clinical Update Course. 2. Physio Control to attend the T/L conference to confirm how downloading should be completed 3. Focus on Team Leaders at Oval to teach them the interpretation of downloads and hold case based meetings with staff following a cardiac arrest, to encourage staff presenting machines for downloads. 4. Audit of FR2 data cards and card readers. 5. Establish the current resources of LP 1000, how many in use, which complexes carry them, are there spares available for 1 for 1 swap. 6. Establish a process at station level to link a specific cardiac arrest to the LP1000 it is stored on. 7. Publicise download returns by complex as part of Area Governance Reports, via PIM or Staff Officer for the Area.	1. M.Whitbread 2. M.Whitbread 3. M.Whitbread 4. M.Whitbread 5. M.Whitbread 6. M.Whitbread 7. M.Whitbread	1. Complete 2. Complete 3. Ongoing 4. Ongoing 5. Ongoing 6. Ongoing 7. Ongoing	1. Monitor processes at Clinical Quality Saftey and Effectiveness Committee	Moderate	Unlikely	6	Planning to start a three complex trial in October - unable to secure training/down time so far this year due to operational pressures. With regards to FR2 data downloads – still very poor compliance mainly due to team leaders not being in the "office" due to operational pressures
226	There is a risk that the identified risks associated with lone working are not being uniformly mitigated as a result of inconsistent application of the Lone Worker Policy.		12-Jul-06	***	7,4	Health & Safety	Moderate	Almost Certain	15	1. The Lone Worker Policy has been reviewed. 2. The Trust received positive feedback from Bentley Jennison's audit on Lone Worker Policy: - all A&E operational Staff received Personal Safety conflict management training (1 day); - all Operational staff are issued with ECA mobile phones; - the Trust has a high risk address register; - Lone Working risk assessments are regularly reviewed; - appointed FRU coordinators at each at main stations ensure staff are aware of locally known hazards; - all operational vehicle have MDT and radio facilities; - Violence Prevention and Lone worker policies highlight specific procedures for reducing foreseeable hazards to staff.	Caron Hitchen	01-Jun-12	Moderate	Possible	9	1. Revised Lone worker policy reviewed @ Feb ADG. ADG requested TC and MN to review specific requirements for lone working in office accommodation.	1. Martin Nicholas/ Tony Crabtree	1. July 2012	1. Incident Reporting Monitoring. 2. CH&SG Monitor incident trends	Moderate	Unlikely	6	

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200	There is a risk of loss of physical assets due to the risk of fire.		01-Jan-02	***	1,2,3, 4,7	Health & Safety	Catastrophic	Possible	15	1. Fire Marshall awareness training is undertaken as a module on a 1 day Safety and Awareness Course. 2.Annual Fire Risk Assessments are undertaken by the Estates Department. 3. Fire Fighting equipment is sited at all strategic locations. 4. Premises Inspection Procedures require all premises to be inspected on a three monthly basis. 5. Local Induction Training requires managers to identify fire precaution to all new staff. 6. Updates of health and safety issues are provided at the Estates Meeting monthly. 7. Estates department annual assurance of Trusts fire safety compliance. 8. Fire Marshals are appointed by Line Manager 9. Fire & Bomb evacuation Policy 10. Update on premises inspection reported to Corporate Health and Safety Group Quarterly 11. Core skills refresher 2 includes vehicle fire precaution awareness training. 12. All operational vehicles are fitted with appropiate extinuishers and crew staff fire awareness is included in CSR	Caron Hitchen	01-Jun-12	Major	Unlikely	8	1. Health Safety and Risk team to take responsibility for delivering Fire Marshall Awareness Training.	1. J.Selby	1. Ongoing	1.Corporate Health and Safety Group 2. Annual return to DOH including a fire risk statement	Minor	Rare	2	
354	There is a risk of ongoing industrial action due to national ballots leading to disruption of service provision.		23-Nov-11		1,2,3, 4,7,8	Human Resources	Major	Possible	12	1. Partnership agreement with staff side. 2. Intelligence gathering. 3. Business continuity plan. 4. Developed contracts with VAS/PAS/Agency staff.	Caron Hitchen	08-Mar-12	Major	Possible	12	1. Implement recommnedations from N30 review.	1. J.Killens	1. 2012/13		Major	Possible	12	
282	There is a risk that general failure of personnel to adequately 'back-up' IT may lead to the loss of data.		03-Jul-07	***	1,2,5,	Business Continuity	Major	Possible	12	1. The move of business information from hard drives to network drives. 2. Part of the 2010/11 audit programme will test this facility and give assurances. 3. IM&T Infrastructure Team to review and take actions as appropriate.	Peter Suter	09-Jul-12	Major	Possible	12	1. Audit to be carried out on the status of the move to network drives. 2. Ensure central data servers are backed up. 3. Fundamentally review how data is stored on local drives and potentially not backed up.				Major	Unlikely	8	
293	There is risk that that Patient Specific Protocols (PSP) and palliative care, out of hours forms, etc. may not be triggered by the call taker when the patient's address is identified during 999 call.	Incident where call taker had not picked up patient specific protocol	18-Feb-08	***	1,2,4, 5	Clinical	Major	Possible	12	1. The Senior Clinical Adviser has lead responsibility to PSPs. 2. The Clinical Support Desk has delegated responsibility for the accuracy of PSPs but do not have access to update them. 3. Input and maintenance are performed by Management Information who have introduced a range of control measures. 4. The introduction of CAD 2010 will allow automatic flagging and for a range of status flags to be used. 5. The Senior Clinical Advisor liaises with Management Information for the appropriate access to be provided to Clinical Support. 6. All relevant staff are periodically reminded of the requirement to correctly trigger PSPs.	Fionna Moore	18-May-12	Major	Possible	12	1. The introduction of Command Point 2. Increase in use and functionality of the Coordinate my Care (CmC) system across all London. (The Senior Clinical Adviser, IM&T and Management Information are working with System C, (the company that developed the newly introduced Pan London EoLC Register, (Coordinate my CAre - CmC), that will be used by all 111 sites and LAS), to look at the possibility of CmC automatically placing a flag on the patient's address. This will obviate the necessity for it to be done manually.)		1. March 2012 2. November 2012	1. Incident reporting. 2. Complaints monitoring. 3. Protocols and transfer procedure	Major	Unlikely	8	All the current measures remain in place. Command point has now gone live and therefore the "Locality Information" flag is more noticeable to the Call Taker. The EOC Training Department have been re-iterating to all Call Takers the importance of acting on "Locality Information" flags. The development of the End of Life Electronic Register will over the next two years increase the efficiency of getting this particular group of patients flagged, particularly as this is also a CQUINN target
348	There is a risk that the Clinical Coordination Desk may not be able to coordinate demand across London's specialist centres due to lack of information provided by neighbouring ambulance trusts when bringing patients to London Centres.	Lack of awareness by operational staff of change in policy Acute Trusts, LAS operationally and reputationally and patients may be affected	11-Jul-11	***	1,2,3, 4,5,1 0	Operational	Major	Possible	12	1. Reporting back at clinical and operational network meetings to reinforce policy where it is not adhered to. 2. Tabled at NDOG/DOCC's Meetings nationally as required.	Martin Flaherty	07-Nov-11	Major	Likely	16	1.Liaison with neighbouring ambulance trusts both by LAS and network leads is on-going 2. Monitoring of information fed back to Trauma Office about number of patients from outside London brought in to London MTCs				Major	Unlikely	8	
360	There is a risk that the Trust will not achieve level 2 NHSLA compliance where there is a significant gap between policy/procedure and practice.	- some evidence which can be provided is not consistent with the processes outlined within the documents - non compliance with the related NHSLA standards may contribute towards overall non compliance with the NHSLA standards at a Level 2 assessment as the trust will not be able to provide evidence	09-Jan-12		1,2,4	Corporate	Major	Possible	12	1. NHSLA Level 1 compliance with 48/50 standards.	Sandra Adams	02-Aug-12	Major	Possible	12	1. Review of standards in which existing policies/procedures do not match practice. 2. Update relevant polocies/procedures to ensure current practice is captured correctly. 3. Collate and provide evidence on Health Assure.	1. Governance and Compliance Team (GCT) 2. GCT 3. GCT	1. Oct 2012 2. Oct 2012 3. Oct 2012		Major	Unlikely	8	

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63	The risk of incurring liability through the re-use of "single use" equipment.		14-Nov-02	***	1,2,4,5	Infection Control	Major	Possible	12	1. Make Ready has improved the controls over single use equipment. 2. The infection Control Policy covers "single use" equipment. 3. Staff awareness has been increased by the use of Training Bulletins, RIB, posters etc. 4. "Single use" items are in place. Risk of re-use rather than disposal is unlikely. 5. A decontamination policy is now in place.	Steve Lennox	30-Jul-12	Major	Possible	12	To have a decontamination policy that meets CQC expectations: 1. Establish Equipment Decontamination Improvement Group at Logistics Support Unit with Terms of Reference. 2. Monitor decontamination compliance	1. C. Vale/ K. Merritt 2. T.Hubbard	1. Sep 2012 2. Sep 2012	1. Incident reporting. 2. Complaints/ claims monitoring.	Moderate	Rare	3	
272	There is a risk that the LAS may not achieve the full CIP due to new/unforseen cost pressures.		03-Jul-07	***	8,10	Finance	Major	Possible	12	1. CIP has been agreed with SMG/ Trust Board. SMG/Trust Board review report monthly. 2. Monthly monitoring via Performance Accelerator. Monthly Finance Review includes detailed forecast. 3. 37 CIP related projects are integrated with the standard programme management arrangements through the Integrated Business Plan. 4. Continue to Identify further savings - monthly CIP reporting. 5. Continued colaboration with wider health care services.	Michael Dinan	31-Jul-12	Moderate	Possible	9	1. Review as part of CIP monitoring 2. Review by Finance Investment Committee	1. M.Dinan 2. A.Cant	1. Ongoing 2. Ongoing	1. CIP reported monthly to SMG and the Trust Board. 2. Programme Governance Structure 3. Finance Investment Committee	Moderate	Possible	9	At month 2 the Trust is forecasting to deliver its agreed CIP plan in 2012-13 of £12.4 million.
309	There is a risk of fraudulent activity from staff, patients and contractors.		16-Feb-09	***	4,5	Finance	Major	Possible	12	1. An annual Counter Fraud work-plan is agreed with the Director of Finance and is approved by the Audit Committee. The work-plan ensures that time is allocated to the Local Counter Fraud Specialist to undertake work in the areas of the Counter Fraud Strategy, inclusive of Creating an Anti-Fraud Culture; Deterring Fraud; - Preventing Fraud; Detecting Fraud, - Investigating any allegations of fraud that are received against the Trust; - Applying Sanctions that can involve disciplinary, civil and/or criminal hearings; - Seeking redress - seeking to recoup money that has been obtained from the Trust by fraudulent means. 2. RSM Tenon - audit function	Michael Dinan	22-Mar-12	Moderate	Possible	9	1. Promoting an anti-fraud culture amongst Trust staff by giving presentations, distributing Counter Fraud literature, holding fraud awareness events. 2. Creating deterrence by promoting successfully locally and nationally investigated fraud cases. 3. Preventing fraud by reviewing Trust policies and procedures. 4. Detecting fraud by undertaking Local Proactive Exercises into areas of concern. 5. Undertaking of a Fraud Risk Assessment.	1-5. M.Dinan (via Trust Counter Fraud Group)	1-5. As scheduled in the Local Counter Fraud Specialist Annual Work Plan for 2012 / 2013	1. Reported incidents. 2. Trust Counter Fraud Group	Moderate	Unlikely	6	An LA167 is being drafted and will be considered by the Counter Fraud Group.
165	There is a risk that delivery of sub-optimal care for patients with age-related needs and failure to meet NSF milestones.		04-Jan-05	***	1,2,4,10	Clinical	Major	Possible	12	1. Action Plan (section 5 - Older People's Strategy) is in place through which the delivery of "sub optimal care for patients with age-related illnesses" is being addressed. 2. Older People's Strategy has been updated. 3. Referral Pathways Project in progress and is now part of the Healthcare for London workstream.	Lizzy Bovill	20-Mar-12	Moderate	Possible	9	1. Development of referral pathways as our partnership work with commissioners. 2. Training for front-line staff on use of referral pathways (as part of 1.), is being developed. 3. Training for front line staff on use of referral pathways is being rolled out with particular focus on improving the management of people who have fallen, many of whom are older people.	1. Lizzy Bovill 2. Emma Williams 3. Emma Williams	1. Apr 2012 2. Apr 2011 3. Apr 2012	1. Annual report to the CQSE.	Moderate	Unlikely	6	
247	There is a risk of not achieving the 3 strategic goals where there is non-delivery of project outcomes (to time cost and/or quality) in relation to the IBP.		25-Jul-06	***	1,2,3,4,5,6,7,8,9,10	Corporate	Moderate	Likely	12	1. Senior Managers have been trained through MSP and PRINCE2 courses and programme and project management methodologies are being used to deliver project outputs and realise programme benefits. 2. Progress reports made to programme boards and SMG monthly and Trust Board through the CEO report monthly. Project boards set up where appropriate for larger projects within the programmes and smaller projects overseen by	Sandra Adams	18-May-12	Moderate	Possible	9	1. Governance arrangements to be established for the IBP Delivery Programme during 2011/12 to be continued in 2012/13.	1. M.Brand	1. Ongoing.	1. Progress reports to IPB Delivery Programme Board 2. SROs report monthly to SMG. 3. Reports toTrust Board as part of CEO's report.	Moderate	Unlikely	6	

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308	There is a risk that LAS staff may suffer emotional or physical injury as a result of being subject to physical or verbal assult, and this may adversely affect the delivery of the service that the LAS provides and/or the reputation of the LAS.	Injury and Sickness Absence	01-Apr-11	***	1,2,5, 7	Health & Safety	Moderate	Likely	12	1. The Local Security Management Specialist (LSMS) has developed a draft Trust Security Management Plan in accordance with Counter Fraud and Security Management guidance. 2. Serious Incident Reporting system will ensure information is regularly reported to NHS Protect.	Caron Hitchen	01-Jun-12	Moderate	Possible	9	1. Conflict Resolution Training update is included in 2nd day of core learning skills. 2.Reinforce existing responsibilities @ complex level by line management.	1. M. Nicholas 2.	1. Core Skills refresher 3 will include CRT Jun 2012. 2. Awaiting direction following ADG meeting 24/02/2012	1. Monitoring of Incident reports by CHSG	Moderate	Unlikely	6	
186	There is a risk that the inconsistent management of Medical Devices may lead to a higher rate of failure, which would in turn have an adverse effect on the provision of clinical care.		10-Feb-04	***	1,2,4, 5,8	Logistics	Major	Possible	12	1.Servicing schedules for medical devices are agreed with suppliers and carried out within the specified timescale. 2.Supplier records are made available to the Logistics Department. 3.There is also a system of record cards for all medical equipment held within the Logistics Department. 4. Analysis of LA52s for any training issues. 5. Monthly defib audits - returns reported to VEWG	Martin Flaherty	19-Mar-12	Moderate	Possible	9	1. Management of Medical Devices Policy being submitted to the ADO Group and ADG for approval - Chris Vale to chase up progress. 2. The project mandate for tracking medical devices has been approved by the VFM Programme Board and will take into account terms within the make ready contract once they have been agreed.	1. C.Vale/K. Merritt 2. M.Salter/ G.Gifford	1. July 2012 2. March 2012	1. Monitoring of service records for medical devices.	Moderate	Unlikely	6	
223	There is a risk, that due to operational pressures, the Trust will not be able to hold regular team meetings/briefings with frontline staff. This may have an adverse affect upon CPIs and the PDR process.		12-Jun-06	***	4,5	Operational	Moderate	Likely	12	1. Demand management strategies deployd to reduce overall activity. 2. Use of third party capacity at times of peak demand.	Martin Flaherty	09-Jul-12	Moderate	Possible	9	1. Capacity review with Commissioners with a view to reduce utilisation.	1. M.Flaherty	1. Q3/4 2012/13		Moderate	Unlikely	6	
164	There is a risk that Policies and Procedures are not adhered to due to lack of staff awareness and robust implementation plans.	Serious incidents often show that non-compliance with policy is often the root cause of an incident	04-Jan-05	***	1,2,5, 8	Corporate	Moderate	Likely	12	1. NHSLA level one achieved in October 2010 2. Ongoing review of policies and procedures linked to NHSLA . 3. Monitor incidents and serious incidents where policy has not been followed and action is required.	Sandra Adams	15-Jun-12	Moderate	Possible	9	1. All new policies and procedures and significant amendments to be announced in the RIB. 2. Policy and Procedure spreadsheet is being reviewed and revised to update review dates and sponsors. Sponsors will be sent a list of their policies and procedures for review requesting follow-up where review dates are overdue. 3. Where there has been a breach of policy, Owners/E&D to be requested to arrange appropriate training and awareness for staff.	1. S. Moore 2. S. Moore 3. S. Moore	1. Ongoing 2. June/July 2012 3. Ongoing	NHSLA level 1 Review of incidents and comlaints to ascertain any breach of policy	Moderate	Rare	3	
356	There is a risk arising from no provision for protected training time for clinical and paramedic tutors. This may as a consequence cause:- ● Dilution of training skill levels ● Credibility and reputation concerns of trainers ● Impact on the validity of clinical training	Current workload within the department means that there is insufficient capacity to ensure that all tutors are developed in line with the departmental tutor development strategy. This includes time to incorporate information from bulletin into teaching strategies.	23-Nov-11		1,2,4, 5	Human Resources	Moderate	Likely	12	1. All tutors have recived a clinical update package. 2. All tutors have received major incident update training. 3. A clinical update training day has been provided to all clinical training staff. Additional clinical skills programmes have been run based on idnetifyied need and regular operational shifts will be incorporated into work pattern.Some staff are to receive additional training in order to support DMP	Caron Hitchen	01-Jun-12	Moderate	Possible	9	1. The training establishment is being reviewed and remodeled to ensure needs can be met.	1. GH	1. Mar 2012	Course review and feedback by Education Governance Manager	Moderate	Rare	3	
222	There is a risk that lack of frontline management at weekends may reduce the level of support/advice available to staff		13-Jun-06	***	1,2,4, 8	Operational	Major	Possible	12	1. DSO annual leave is restricted to ensure 5 are always available pan-London. 2. Team Leaders are also available to respond to incidents in support of crew members. 3. This risk is reduced by safety training for crew staff and the advice to await the arrival of police in high risk situations. 4. A requirement for on duty Silver officer to respond where appropriate, for this reason the Trust has a duty AOM and a on-call AOM avaialabe at all times. 5. General broadcast to other vehicles where requirement for a manager is due to crew safety. 6. Clinical Support Desk is now in place and provides a route for staff to gain support and advice on a range of matters 7. Recruited 9 Acting DSO's in Q1 2012/13	Martin Flaherty	01-Jun-12	Major	Unlikely	8	1. Review new leave rules for DSOs. 2. Develop changes to ops management structure in the light of capacity review.	1. P.Woodrow 2. P.Woodrow / J.Killens	1. Q3 2012/13 2. Q4 2012/13	1. Analysis of incident reporting	Major	Unlikely	8	

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365	There is a risk that Board Members are unable to commit time required to prepare for becoming an FT Board of Directors.	Unplanned changes to FT related meetings, particularly with external stakeholders, may not be accommodated by NEDs who have other time commitments outside the LAS	03-May-12			Governance	Major	Possible	12	1. Schedule of committees includes SRP for strategic focus. 2. NEDs have a time commitment to LAS of 2.5 days. 3. FT project team re-established. 4. Risk reviewed by FT Project Team.	Richard Hunt	02-Aug-12	Major	Unlikely	8	1. Extend Trust Board and SRP days to the full day thereby allowing 0.5 days per month to focus on FT and Board development. 2. With Healthskills, develop a programme of Board development that focuses on key items for preparation for an FT Board. 3. Chair and NEDs agree PDPs.			1. Attendance schedule for Board development. 2. PDPs in place for all NEDs.	Major	Rare	4	Reviewed and regraded following RCAG 4th May 2012. Target rating corected to 4 as this had been miscalculated.
181	There is a risk of injury to staff from slips, trips and falls on LAS premises during the course of their duties.	Injury to staff and patients	09-Feb-03	***	4,7	Health & Safety	Moderate	Likely	12	1. Premises inspections are undertaken every three months and are reviewed at meetings of the Corporate Health and Safety Group. 2. The one day Health & Safety Awareness course now covers premises inspections. 3. Slips, Trips and Falls Policy approved by CQSE June 2010 4) All senior and line managers attend mandatory H&S awareness training 5) All in one training for non-operational staff, which includes awareness training 6) Local risk registers have been introduced	Caron Hitchen	18-Jun-12	Minor	Unlikely	4	1. The Slips Trips and Falls Procedure (HS/021) has been reviewed and approved by the ADG. 2. Training requirements are defined within the training Needs Analysis. Compliance in terms of content of training for different staff groups through corporate andl ocal induction and through "all in one" for non-clinical staff should be audited. 3. Review H&S Premises inspection reports 4. Vehicle equipment working group review vehicle design that includes anti slip flooring.	1. Keith Miller/ Carmel Dodson-Brown 2. Carole Livett 3. John Selby 4. VEWG	1. Complete 2. on-going - quarterly 3. Ongoing 4. Ongoing	1. Premises Inspection Reports. 2. Slips, trips and falls policy 3. CHSG monitor incident trends	Minor	Unlikely	4	
358	There is a risk that the joiners and leavers process is not established, leavers still have access to LAS information or have assets belonging to LAS.	There is a dissconnect between HR processes and IM&T to ensure that leavers return all assest and accounts are disabled when the staff member leaves.	09-Jan-12		4	IM&T	Minor	Almost Certain	10	1. Removal of duplicate Employee IDs	Peter Suter	18-Jun-12	Minor	Unlikely	4	1. Starters and leavers process documentation being created. 2. Complete and distribute 'Managers Guide to Administration' to Managers. 3. Ensure that assets held by the leaving member of staff are identified and returned on the last day of work; 4. Ensure that logical access to LAS systems is disabled when the staff member leaves. This is to include, as much as possible, this is to include all remote access and NHSmail accounts.	1. A.Honour 2. G.Masters 3. A.Honour 4. A.Honour /G.Farquhar	1. Complete 2. June 2012 3. July 2012 4. July 2012	1, Starters and leavers meeting held every 2 weeks	Minor	Unlikely	4	Significant progress has been made in improving the creation of new accounts and removing leavers in a timely fashion. The risk of a leaver retaining assets still remains although items are now being added to a database.

London Ambulance Service NHS Trust
Risk Register as at 7th August 2012

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331	There is a risk that the Trust will not achieve the target of reducing its carbon footprint by 10% by 2015 (based on 2007 carbon footprint)	Underlying cause is the legal requirement on the Trust (in line with the rest of the NHS) to deliver on the commitment to reduce carbon footprint by 10% by 2015 (based on 2007/08 carbon footprint Scope 1&2).	06-May-10	***	4	Finance	Moderate	Possible	9	1 Salix match funding agreement, which has funded a number of works that will reduce energy usage, thereby carbon footprint. 2. Replacement of LDVs in fleet. The replacement Mercade4s vehicle is more fuel efficient and its bodywork is mostly recycable. 3. in addition there is a regular progress report to SMG/Trust Board on the implementation of the carbon reduction management action plan. 4. Draft KPIs relating to reducing Trust carbon footprint is in development. 5. implementation of CRM, web based processes to replace paper based processes will support the trust's carbon reduction objective. 6. Dashboard set up on PA track different aspects of carbon footpint as well as aspects of CRM that support carbon reduction; this will be published on the Pusle page that will be set up to repor ton Carbon matters. Trust Balanced Scorecard will report on a monthly basis indicative carbon footprint against 5% 2011/12 actual for fuel/energy/procurement. (CMc 22/03/12)	Michael Dinan	15-May-12	Moderate	Possible	9	1. CMc 22/03/12: draft five year carbon management plan has been sumbitted to the Carbon Trust and is awaiting sign off. The Plan outlines how the Trust will achive reduction in carbon footprint primarily based on changes in response model - increased use of CTA, reduction in non-conveyance and Multiple Sends. Also the Trust is exploring possibility of working external contractor re. Energy Services to continue to modernise our infrastructure and reduce our consumption by 15%. 2. Management action plan will be overseen by Carbon Reduction Project Group (chaired by Mike Dinan); reporting to the VfM Programme Board. 3. Pilot projects to be undertaken in the buildings that have half hour meters measuring electricity usage. 4.Travel plan and supporting survey to be undertaken 5. Recruitment of green champions	1.C.McMahon 2. 3. 4. 5.	1. March 2012 2.July 2012 3. March 2013 4. March 2013 5. March 2013	1. Regular reports to SMG	Moderate	Unlikely	6	Data for scope 1 & 2 (fuel & energy) per incident shows a decrease of 4% from 2007/08 to 2011/12. Continued implementation of CRM, increase in hear/treat and decrease in conveyance and MARR plus implementation of energy contract should enable the Trust to achieve 10% decrease target by 2015
350	There is a risk that the establishment of a Clinical Commissioning Group and reconfiguration of the SHA and PCT's may result in a temporary reduction in stakeholder engagement and partnership working and subsequent delivery of improvements in the urgent and emergency care system.	Since the implementation of the Health Bill the following issues have been highlighted. 1) Impact on providing appropriate clinical care to patients. 2) Staff clinical decision making could be affected. 3) Impact on finance due to not achieving financial targets such as CQIN and Quality, Innovation , Productivity and Prevention. 4) Impact on performance due to increased turnaround times. 5) Reputation risk for the	11-Jul-11	***	1,2,4, 10	Clinical	Moderate	Possible	9	1. Monthly monitoring of current care pathway usage. 2. Feedback mechanism in place of care pathways with commissioners. 3. Creating an evidence base and continuing a dialogue with commissioners to maintain clinically appropriate pathways and reported bi monthly to Clinical Quality Group. 4. A Clinical Quality Group to engage senior GPs from clusters in strategy and quality issues meets bi-monthly.	Lizzy Bovill	13-Mar-12	Moderate	Possible	9	1. Membership and attendance at NHS London and cluster level unscheduled care boards. 2. Need for commissioners and community providers to audit appropriateness of LAS referrals and subsequent clinical impact on patients.	1. L.Bovill 2. L.Bovill	1. April 2012 2. April 2013	1. Established relationships with Senior Leads. 2. Quarterly meetings with Senior Leads and monthly meetings with Junior Leads	Moderate	Unlikely	6	
199	There is a risk to staff safety / vandalism/theft due to inability to adequately secure premises.	There is no overarching Security Risk Policy to coordinate and bolster existing security measures within the Trust and there is no identified specific group who oversee security issues.	01-Jan-03	***	7,8	Finance	Moderate	Possible	9	1. Operational managers in conjunction with H&S representatives carry out quarterly health and safety premises inspections. If there is a perceived security issue it will be reported to Estates who will investigate and take appropriate action. 2. OP/018 Procedure On Station Duties. 3. Bulletin reminding staff to secure premises when leaving unattended. 4. A Trust Internal Security Group has been formed which will meet regularly to address security related issues within the Trust	Michael Dinan	22-Jun-12	Moderate	Possible	9	1. A Security Management Policy will be developed. 2. An audit of security at stations is being undertaken (June/July) in order to privide an indication of priority for a full security survey to be undertaken. Following this audits will be carried out every two years.	1. M. Nicholas / John Selby 2. M. Nicholas	1. July 2012 2. July 2012	1. Reported to SMG	Moderate	Unlikely	6	
303	There is a risk of unavailability of critical patient care equipment on vehicles.		21-Oct-08	***	1,2,4, 8	Logistics	Moderate	Possible	9	1. New vehicle preparation contracts in place with new contract that will introduce electronic asset tracking in Q3/4 2012/13. 2. Regular equipment amnesty. 3. New capital equipment (defibs) purchased.	Martin Flaherty	09-Jul-12	Moderate	Possible	9	1. Trial of new LA1 forms to include equipment and VDI checks being carried in the West Area for 3 months commencing June 2011. 2. Following West area review, begin roll-out to East and South areas				Moderate	Unlikely	6	
46	There is a risk of infection to staff due to sharps injury.		14-Nov-02	***	4,7	Infection Control	Moderate	Possible	9	1. Introduced the Safety Canulae trial in early 2009. Results to be monitored via Infection Control Steering Group. 2. In 2008 the overall number of LA52 reported needle stick incidents for Q3 (1st July - 30th Sept) was 9 near misses and 3 actual. This represents a reduction of reported incidents from Q2 of 12 actuals and 2 near misses. The new cannulae are now in use which should hopefully reduce the number of injuries. 3. H&S bulletin related to 'Disposal of Sharps' was issued in 2007/08. 4. This is part of the infection prevention and control action plan.	Steve Lennox	30-Jul-12	Moderate	Possible	9	Minimise the risk of sharps injury: 1. Participate in national ambulance audit 2011. 2. Undertake a programme of staff awareness (and to incorporate new guidance from POSSH conference)	1.T.Hubbard 2. T.Hubbard	1. Complete 2. May 2013	1. Health and Safety Audits. 2. Clinical Quality Safety and Effectiveness Committee. 3. Incident reporting. 4. ICSG quarterly review 5. SUI of high risks cases.	Minor	Unlikely	4	Head of IPC is setting up a sub group to ensure the Trust is ready to implement guidance in 2013. Gap analysis currently being completed.
364	There is a risk that changes to the external commissioning and provider support environment cause uncertainty and delay in progressing the FT application	Transitional arrangements commence in 12/13 within the SHA provider/FT application support team and within commissioning. If there are changes within those teams this may create delay to the FT application whilst there are gaps or handover arrangements taking place	19-Apr-12			Corporate	Moderate	Possible	9	1. Engagement of lead commissioner in FT development 2. Strategic Commissioning Board provides the opportunity to reinforce the LTFM requirements 3. Cluster letter of support – December 2011	Sandra Adams	02-Aug-12	Moderate	Possible	9	1. Strengthen the commissioner engagement in reviewing and developing the 5-year strategy through the IBP and LTFM 2. Engage commissioners in the development and sign off of the downside scenarios 3. Letter of convergence is clean and unambiguous	1. L.Bovill / S.Adams / M.Dinan 2. M.Dinan / A.Cant 3. L.Bovill / M.Dinan / S.Adams	1. 31 Aug 12 2. 31 Aug 12 2. Nov 12	1. Commissioner letter of convergence fully supports the LAS application and strategy 2. IBP and LTFM fully supported and signed off by commissioners 3. Downside scenarios updated and supported by the commissioners	Moderate	Unlikely	6	Reviewed and agreed by FT Project Team 9th May 2012. Target rating corrected to 6 as this had been miscalculated

London Ambulance Service NHS Trust
Risk Register as at 7th August 2012

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363	There is a risk that there will be increased sickness and absence amongst staff as a consequence of support service staff headcount reductions with associated anxiety and increased workloads for those remaining leading to increased stress	Proposed support service staff headcount.	18-Apr-12			Human Resources	Moderate	Possible	9	1. Ensure that process redesign and reduction in workloads for remaining staff occur alongside reductions in support staff headcount.	Caron Hitchen		Moderate	Possible	9	1. Ensure that process redesign and reductions in workloads for remaining staff occur alongside reductions in support staff headcount.	1. C.Hitchen	1. Ongoing	Project Board meetings arranged throughout 2012 at which progress will be monitored and performance managed.	Moderate	Unlikely	6	
278	There is a risk that staff are not trained in Business Continuity and are unaware of their responsibilities and/or their departmental arrangements in the event that the Business Continuity Plan is invoked.		03-Jul-07	***	5,7	Business Continuity	Moderate	Possible	9	1. Tabletop testing programme of departmental plans is ongoing and has so far included IM&T, Communications, Estates, Logistics, Finance, Purchasing and HR (Safety & Risk and Staff Support). 2. Business Continuity is now covered in the Corporate Induction Programme and the 3 year all in one refresher for support staff. 3. Awareness raised of departmental BC plans ahead of Olympic Games 2012. Maintaining Service Delivery group also promoting need for departmental BC.	Martin Flaherty	09-Jul-12	Moderate	Unlikely	6					Moderate	Unlikely	6	
366	There is a risk that frontline staff may not be able to measure oxygen saturations on some paediatric patients, in particular infants due to an inconsistency in availability of paediatric pulse oximetry across the Service.	All patients who may require oxygen therapy where the attending paramedic/EMT may have not suspected hypoxia and therefore did not administer oxygen. A mitigating factor is the monitoring of the DIB CPI which looks at whether O2 sats were measured.	09-Jul-12			Clinical	Moderate	Possible	9	1. Adult, paediatric and infant pulse oximetry probes are now available to order on eseries, not all complexes are ordering them due to the high cost (paed probes are approx £175) and the fact that due to flexible fleet, probes that are ordered then go off to other areas of the Service. 2. Article published in Clinical update Sept 2011 reminding crews not to withold oxygen if pulse oximetry not immediately available and patient unwell. 3. Adult pulse oximetry available on Lifepak 12/15s available on all frontline vehicles 4. Email sent to all station management by the Senior Clinical Advisor in June 2012 reminding them that the probes are available on Eseries and that they should be equipping their vehicles with them.	Fionna Moore	09-Jul-12	Moderate	Unlikely	6	1. Discussion ongoing as to best way to overcome issue of stations not ordering paediatric probes 2. Recent (June 2012) audit of paed respiratory assessment by CARU recommended that a kit audit is undertaken to determine scale of the problem. 3. Discussion ongoing as to optimum way to overcome problem of lack of paed probes	1. F.Moore 2. ADO's 3.	1. 2. 3.	1. Adult, child and infant probes are available to purchase on eseries 2. Senior Clinical Advisor has reminded station management service wide regarding the importance of equipping LP12/15s with pulse oximetry probes.	Moderate	Rare	3	
367	There is a risk that oxygen saturations may not be able to be measured immediately after arrival of the crew (at present oxygen saturations can only be measured using a Lifepak 12/15 which can be removed from the vehicle but, being a large piece of equipment is not usually taken in initially with the primary response bag, AED and oxygen bag).	All patients who may require oxygen therapy where the attending paramedic/EMT may have not suspected hypoxia and therefore did not administer oxygen. A mitigating factor is the monitoring of the DIB CPI which looks at whether O2 sats were measured. In addition, oxygen may be administered to COPD patients who do not require it (or higher levels than necessary may be administered).	09-Jul-12			Clinical	Moderate	Possible	9	1. Adult, paediatric and infant pulse oximetry probes are now available to order on eseries, not all complexes are ordering them. 2. Article published in Clinical update Sept 2011 reminding crews not to withold oxygen if pulse oximetry not immediately available and patient unwell. 3. Adult pulse oximetry available on Lifepak 12/15s available on all frontline vehicles 4. Email sent to all station management by the Senior Clinical Advisor in June 2012 reminding them that the probes are available on Eseries and that they should be equipping their vehicles with them.	Fionna Moore	09-Jul-12	Moderate	Unlikely	6	1. Medical directorate and purchasing dept have looked into possibility of purchasing small, easily portable nonin pulse oximetry probes. A price of approx £100 each was secured funds may not available to purchase these (in addition, personal issue nonins may not be the answer). 2. Monitor the purchase of oximetry probes, both paed and adult, as a measure of success / impact. 3. Recent (June 2012) audit of paed respiratory assessment by CARU recommended that a kit audit is undertaken to determine scale of the problem. 4. Discussion ongoing as to best way to overcome this issue.	1. M.Whitbread 2. F.Moore 3. ADO's 4.	1. 2. 3. 4.	1. Adult, child and infant probes are available to purchase on eseries 2. Senior Clinical Advisor has reminded station management service wide regarding the importance of equipping LP12/15s with pulse oximetry probes.	Moderate	Rare	3	

London Ambulance Service NHS Trust
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275	There is a risk of loss of access to the Deptford Logistics Store may result in drug supplies being disturbed.		03-Jul-07	***	1,2,8, 10	Business Continuity	Moderate	Possible	9	1. The Trust has arrangements for Frimley Park Hospital NHS Trust to supply drugs on a 24 hour basis if required (but no formal arrangement is in place.). 2. London hospitals could supply drugs in an emergency.	Martin Flaherty	01-Jun-12	Moderate	Unlikely	6	1. Secure agreement with neighbouring Ambulance Trusts to access drugs in extremis.	1. E.Potter	1. Q3 12/13		Moderate	Rare	3	
271	All staff may not be in possession of a valid driving licence for the category of vehicle they are required to drive.		14-Mar-07	***	4,5,8	Operational	Moderate	Possible	9	1. All staff have their driving license checked upon recruitment. 2. Anyone with more than 3 points will not be appointed. 3. Driving licence checks should be undertaken for all service drivers on a 6-monthly basis (TP023a/TP065). 4. All staff claiming mileage must declare whether they have a valid driving licence.	Michael Dinan	23-Nov-11	Moderate	Unlikely	6	1. The Trust is working inconjuction with staff side viewing options on how best to robustly manage driving licence checks. 2. The Trust is exploring an automated system to check licences directly with the DVLA.	1. & 2. J. Killens / G.Hughes	1. & 2. TBA (following review)	1. Internal Audit	Moderate	Rare	3	
182	Not being able to escape from an LAS building in the case of fire or other emergencies.	Lack of fire inspections/premises inspections, or failure of fire detection systems	09-Feb-04	***	7	Health & Safety	Moderate	Possible	9	1. Procedures are found on Pulse under Fire and Bomb Evacuation Procedure. 2. 'Statement of Fire Safety' is produced annually and is returned to NHS Estates. 3. Risk Action Plans have been produced from the Fire Risk Assessments. 4. Local Fire Marshals have been nominated. 5. Fire evacuation drills are undertaken twice yearly. 6. Fire alarm testing carried out on a weekly basis. 7. Estates department annual assurance of Trusts fire safety compliance. 8. All in one and senior line manager safety and risk awareness training includes fire awareness.	Caron Hitchen	11-May-12	Minor	Unlikely	4	1. Health Safety and Risk team to take responsibility for delivering Fire Marshall Awareness Training. 2. Core learning skills 2 includes fire awareness training. 3. Premises inspections are monitored at the CHSG	1. J.Selby 2. K Miller 3. J Selby	1. Ongoing 2. Ongoing 3. Ongoing	1) Fire & Bomb Evacuation Policy 2) Premises Inspection Procedure 3) CHSG Monitor Premises Inspections 4) Annual Statement of Fire Safety submitted to DoH	Minor	Rare	2	

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332	There is a risk that Trust and National infection control procedures may be compromised as ambulance mattress covers are not routinely changed after each patient.		01-Mar-10	***	4	Infection Control	Minor	Likely	8	1. The matress is disinfected between each patient.	Steve Lennox	30-Jul-12	Minor	Likely	8	1. Identify - procure suitable disposable mattress covers; finalise assessment and make recommendation. 2. Improve returns from laundry of sheets and covers; agree process for returning sheets with the provider. 3. Eliminate soft repairs being undertaken with tape: a) Establish the incidence of repairs being undertaken to soft furnishings with tape. b) Instruct workshops to ensure spare mattresses are available to swap.	1 Chris Vale 2. Chris Vale 3.a Chris Vale 3b Chris Vale	1. Aug 2011 2. Mar 2012 3a Aug 2011 3b Aug 2011		Minor	Unlikely	4	The IPCC propose that risks 327 and 332 are combined as they cover the same issues.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 21ST AUGUST 2012

PAPER FOR APPROVAL

Document Title:	**Strategic risks 2012/13 – 2017/18**
Report Author(s):	**Sandra Adams**
Lead Director:	**Sandra Adams**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**For approval supporting the 5-year strategy**
This paper has been previously presented to:	☒ Strategy Review and Planning Committee ☐ Senior Management Group ☒ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other
Recommendation for the Trust Board:	**To approve the updated strategic risks and the associated risk themes**

Key issues and risks arising from this paper

Four strategic risks summarised as: high quality and safe care; maintaining core service delivery; matching financial resources to priorities; and achieving our strategic direction.
Five emerging risk themes: business as usual quality/performance/finance; category C and non-conveyance; clinical supervision and training; obstetrics; and demand management.

Executive Summary

In line with the work that is underway to review the 5-year strategy for the LAS the Strategy Review & Planning committee also reviewed the strategic risks facing the Trust. These had previously been developed and then refined in 2010/11 and were due for review.

The committee discussed each of the risks and agreed that, with the addition of 'quality' to strategic risk 1, these risks were still relevant and appropriate for the strategy.

The committee discussed the emerging risk themes that had been identified by the Risk Compliance and Assurance group when undertaking a full review of the risk register. These themes have now been mapped to the 4 strategic risks as relevant. The Quality Committee will also be discussing these risks and themes at their meeting on 15th August.

Attachments

Included with the front sheet

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Quality Strategy

This paper supports the following domains of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

Has an Equality Analysis been carried out?

☐ Yes
☒ No

Key issues from the assessment:

Definition of strategic risk: "Those business risks that, if realised, could fundamentally affect the way in which the LAS exists or provides services in the next 1 to 5 years. These risks will have a detrimental effect on the LAS's achievement of its strategic goals. The risk realisation will result in material failure, loss or lost opportunity."

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

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 21ST AUGUST 2012

PAPER FOR APPROVAL

Document Title:	**Integrated Business Plan and Enabling Strategies**
Report Author(s):	**Peter Bradley**
Lead Director:	**Peter Bradley**
Contact Details:	**Peter.bradley@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Organisational Strategy for 12/13 – 17/18**
This paper has been previously presented to:	☒ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other
Recommendation for the Trust Board:	**To agree the strategic direction and the contribution of the enabling strategies to its delivery**

Key issues and risks arising from this paper

The key risk is for the enabling strategies to deliver change and improvements in order to ensure the timely delivery of the overarching organisational strategy is not compromised

Executive Summary

The Chief Executive will present to the board an overview of the LAS Five Year Strategy and the enabling strategies that support this. LAS continues to strive to deliver world class care to our urgent and emergency patients by 17/18 through a range of responses supported by enabling strategies from across the organisation.

The entire Integrated Business Plan is currently being reviewed.

Attachments

None.

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Quality Strategy

This paper supports the following domains of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

Has an Equality Analysis been carried out?

☐ Yes
☒ No

Key issues from the assessment:

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 21 AUGUST 2012

PAPER FOR NOTING

Document Title:	**Chief Executive Report**
Report Author(s):	**Peter Bradley**
Lead Director:	**N/A**
Contact Details:	**-**
Why is this coming to the Trust Board?	**To update the Board on key developments affecting the Trust**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Other
Recommendation for the Trust Board:	**That the Board note my report**
Key issues and risks arising from this paper The risks associated with delivering the key priorities which are listed in the paper.	
Executive Summary This report outlines progress against the key priorities for the Service as at month 4 of the 2012/2013 financial year. It also updates on stakeholder engagement and PPI activities.	
Attachments GP News – Appendix 1	

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

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

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

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

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

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

Equality Impact Assessment

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

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING 21 AUGUST 2012
CHIEF EXECUTIVE'S REPORT

1. SERVICE UPDATE

This first section of my report focuses on the key focus areas for the Trust Board during 2012/2103 which are; Delivery of a high quality service; leading transformation and influencing the delivery of healthcare in London. (see attached pyramid diagram).

- **Delivery of high quality and safe service**

We agreed that the Boards particular focus here during 2012/2103 would be on embedding Commandpoint into service and successfully delivering care to our patients over the Queens Diamond Jubilee weekend and during the 2012 London Olympics and Paralympics.

CommandPoint has now been in live operations for almost five months. It has been successfully used to support both normal operations as well as major events including the Queens Diamond Jubilee and more recently the Olympics. The system remains stable and has performed well.

As with any new system there have been a number of issues to work through. These have been resolved successfully with NG and fixes have been applied as required. CommandPoint is now considered as normal working within EOC and the focus is on improving its use, and considering future enhancements, particularly the requirement to develop an interface to 111 providers.

The Queens Diamond Jubilee was a great success for our Service and our ability to deploy mutual aid resources from across the country was an excellent dress rehearsal for the Olympics. Although we are yet to start the Paralympics, Board colleagues will see from the Chief Operating Officers report that the Olympics has been a resounding success for the LAS and supporting ambulance services. Key lessons will be shared with the Board in due course and I would like to take this opportunity to thank everyone who has played their part to make it such a success. In particular my thanks go to Peter Thorpe and his team for the years of planning and preparation.

- **Lead transformation**

The Boards focus here is on progressing our Foundation Trust application, completing the remaining workforce modernisation initiatives and building on our stakeholder engagement. All three areas are covered either later in my report, under the FT update paper or in part 2 of the meeting.

However it is important to mention that internally we continue to progress well with the updating of our overarching Strategy and Integrated Business Plan. At the recent Board Strategy Review Group I updated Board members with the key elements of our strategy through to 2017/18; many of which have remained constant since our original submission. I will update the Board again at the meeting. In addition various chapters will be shared for Board members to comment on during part I and part II of the meeting. Following the Board

to Board in late June we are currently agreeing a revised Tripartite Formal Agreement (TFA) with NHS London to finalise our planned submission date

- **Influence the delivery of healthcare in London** (*see stakeholder engagement section also)*

The LAS continues to be involved in discussions across London relating to proposals for hospital reconfigurations to ensure we can continue to deliver a high quality service to our emergency and urgent care patients in the future

Board colleagues will be aware that we jointly hosted a hospital clinical handover summit earlier in the financial year with those hospitals that were finding this a particular challenge in London and overall this was seen as successful.

Board colleagues will also be aware that we have seen a significant growth in Category A demand so far this year and we have been undertaking our own analysis into the growth by time of day, day of week, area and illness and injury codes. We now want to host local workshops with key partner agencies to see what can be done jointly to deal with this demand.

It has been confirmed that NWL Commissioning Support Service (CSS) will host the lead commissioning arrangements for LAS for 2013/14. As the new management teams come into post both at the three London CSS and the Regional Commissioning Board it will be vital LAS ensure continued engagement and develops new relationships with the key individuals. This will form part of the Q3 stakeholder engagement plan. In addition the Trust Development Authority will also be in place from October to support LAS with our Foundation Trust Application. We are pleased that Alwen Williams, previous CEO of East London, a good supporter of the LAS, will be the lead for London and we await the appointment of our relationship manager.

2. KEY PRIORITIES 2012/2013 – MONTH 4 UPDATE

At the end of the last financial year, the Board agreed its key priorities for 2012/2013 and we split our approach and focus in three ways –i) Board priority areas, as outlined in the first part of my report, ii) SMG objectives and finally iii) Business as Usual (BAU) activities. The attached pyramid diagram was used to illustrate this. The first section of my report updates the Board as to where we are against the key focus areas at month 4.

- **SMG Objectives**

As agreed with the Board before the new financial year started, the SMG agreed a smaller number of priorities for 2012/2013. Eleven in all and these are attached to the back of the pyramid diagram as a reminder. Current progress shows that all are on track to be delivered by the end of the financial year, however there are some risks with the specific components of the workforce modernisation objective (happy to elaborate at the Board meeting); with improving waiting times for Category C patients (Category A workload dependent); and delivering the levels of hear and treat and see and treat to achieve CQUIN income.

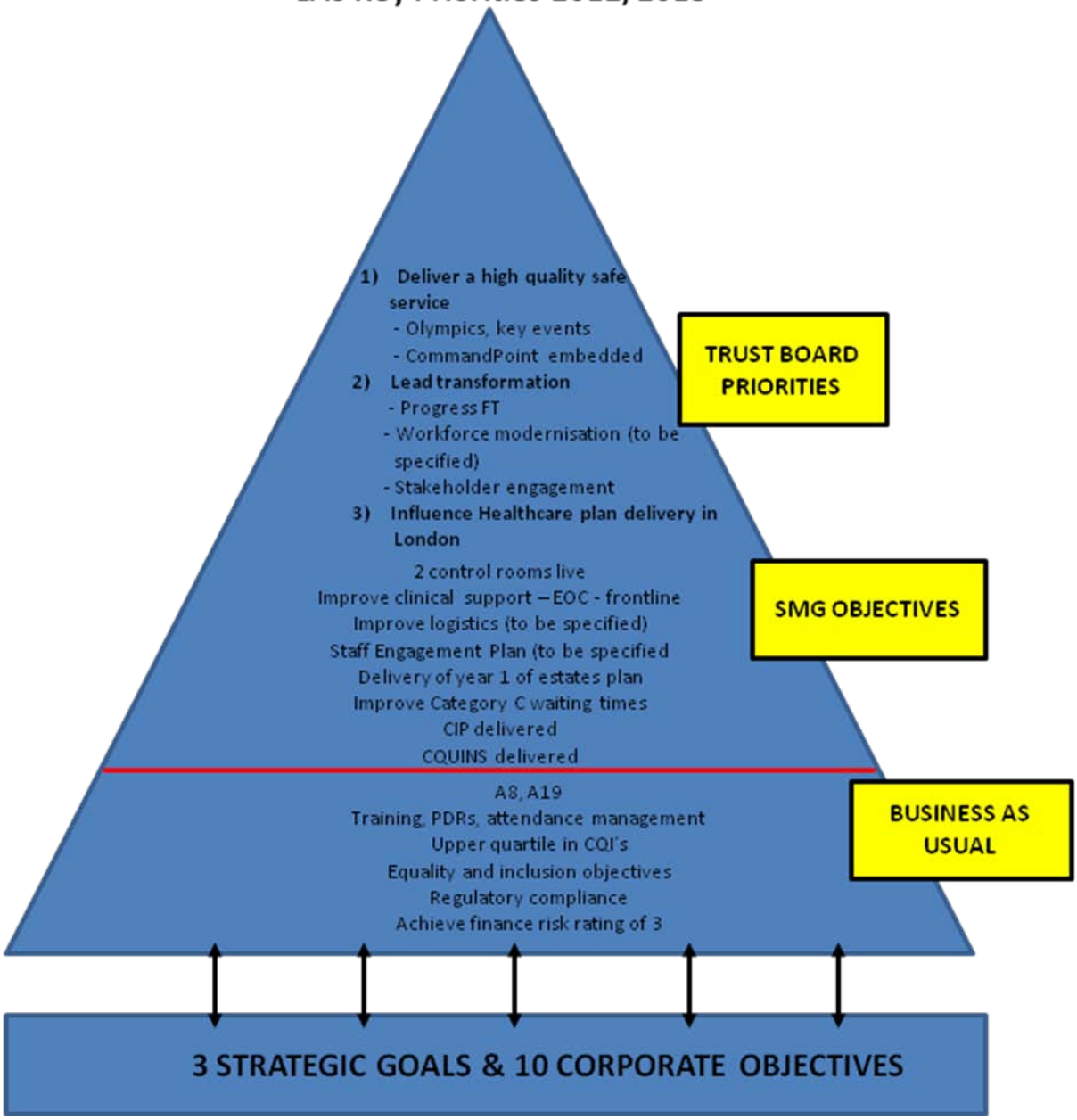
We also need to recognise that changes within the SMG team will add additional pressure on Directors during a time of transition.

- **Business as Usual activities**

The new Integrated Board Performance Report comes into use formally this month and forms a key part of the Chief Operating Officers report. It brings together key information submitted in other reports to provide a balanced view of the Trust's overall performance against statutory and quality assurance measures. The purpose of the report is to highlight exceptions for Trust Board members attention and mitigating actions. Its production is a positive step forward.

Having established this new report we now need to focus on what its tells us about the overall performance of the Trust and what we are doing to reduce risk and improve performance in those areas of most concern.

LAS Key Priorities 2012/2013



2012/2013 SMG objectives (month 4)

1. Improve operational support including the optimal availability of vehicles, equipment and supplies which will be measured by achievement of agreed trajectories reported to Trust board, a reduction in VOR to 3.5%, increased staff satisfaction evidenced by feedback from staff and see a fall in reported equipment shortages. **ON TRACK**

2. Bow control running live and operating in a similar way to that at Waterloo. **ON TRACK**

3. Continue with FT application work and embed governance and quality frameworks **ON TRACK – SUCCESSFUL SECOND QUALITY GOVERNANCE REVIEW (NEW TIMELINE TO BE AGREED)**

4. Deliver £12.5m Cost Improvement Programme **ON TRACK**

5. Complete engagement over estates strategy and deliver year one of the estates plan **ON TRACK**

6. Deliver workforce modernisation initiatives **SOME SLIPPAGE** (PART 2 UPDATE)

7. Deliver 2012/2013 stakeholder engagement plan **ON TRACK**

8. Improve clinical support in EOC and in the field through the establishment of a clinical hub in EOC and through implementing the new Team Leader job description **ON TRACK**

9. Improve waiting times for all categories of Category C patients **SOME SLIPPAGE – MUCH BETTER OVER AUGUST**

10. Deliver agreed CQUINS **SOME SLIPPAGE**

11. Successfully deliver safe and effective pre hospital care at the 2012 Olympics and other key events. **ON TRACK**

4. STAKEHOLDER ENGAGEMENT & PATIENT AND PUBLIC INVOLVEMENT

Two elements of the GP engagement strategy have been completed this month. LAS attended an event in Bromley with over 75 GPs to raise the profile of LAS amongst both practicing GPs and those involved in the Clinical Commissioning Groups. Key messages included our strategy to reduce ED conveyances, increasing referrals for fallers and diabetes back to GPs and on how we are improving our management of end of life patients. The Fourth edition of the GP news (see appendix1) was released in July focusing on Olympics and Diabetes..

The LAS strategy was presented to the Strategic Commissioning Board whose membership is made up of strategic leads from across the PCT Clusters. It was well received and we have been invited to present at clinical cabinets across London over the coming months to raise the profile of our strategic plans and gain support for our Foundation Trust application starting with North Central London in September.

There are over 670 events on the PPI and Public Education activity database for 2012 so far. Recent events have included school and church fetes, knife crime events, road safety events, Junior Citizen schemes, talks for people with learning disabilities, talks for people with diabetes, careers events, basic life support training and a charity teddy bear parachute jump!

A new PPI Action Plan (for the period to 2015) has been produced and discussed by PPI Committee. A final draft has been circulated to Committee members and it is expected that it will be approved at the next meeting. The plan sets out the PPI priorities and key developments over the next three years.

Vicki Hirst (from our comms team), has been appointed as our first Community Involvement Officer (CIO) for Croydon, commencing on 13th August. The LAS now has seven CIOs in post and we will seek to make a decision on the remaining eight appointments over the next few months. Given our desire to engage more locally with health and well being boards and the new CCGs, these positions will play an important part of that engagement.

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5. NATIONAL ROLES

Anthony Marsh, CEO of West Midlands Ambulance Service has been appointed as my replacement as Chairman of the Association of Ambulance Chief Executives (AACE) with effect from 1 August 2012.

I finish my DH role (National Ambulance Director) at the end of August and I expect David Flory to clarify the future of this role in the next few weeks.

Martin Flaherty has been successful with his application to become the new Managing Director of the Association of Ambulance Chief Executives. A start date will be agreed with the LAS Chairman and new AACE Chairman once a new LAS CEO appointment has been made. I wish Martin all the very best in this new role, it is an excellent appointment for AACE and no doubt his 33 years of loyal and dedicated service to the LAS will be recognised in due course.

6. SMG ARRANGEMENTS DURING TRANSITION

Firstly to add my congratulations to that of the Chairman on the appointment of Lizzy Bovill as Director of Strategy and Planning. I am sure Lizzy will continue to build on the good work she has started on her return from maternity leave next year.

Given the changes to SMG, we will need to put in place transition arrangements for the next period. Martin Flaherty and I are currently finalising these and they wil be shared with the Board over the next fortnight.

7. FINAL REFLECTIONS

The Chairman asked me if I wanted to reflect on my time as LAS CEO in this my final Board paper and Board meeting. I could say much, however I will limit it to a few comments.

- **The LAS is in good shape.**
- **London is different.**
- **Staff morale will be tough to shift while utilisation remains so high**
- **Our workforce has modernised**
- **The LAS brand stands above all others**
- **I have learnt more about in the last 18 months than the last ten years**

I have been blessed and privileged to work for the LAS as Chief Executive for the last 12 years. Little did I know when I emigrated from Leeds to New Zealand all those years ago that I would return to lead the best ambulance service in the world. I would like to thank the Chairman and Non Executives for all their support and in particular pay tribute to my senior management team colleagues who have stuck by me through thick and thin for over the last years.

Peter Bradley CBE
Chief Executive Officer
14 August 2012

GP News

London Ambulance Service NHS
NHS Trust

"The LAS believes it is important to keep in touch with GPs. We hope you enjoy this month's newsletter and we welcome your thoughts on the subjects featured."

Olympics 2012 - how can GPs help?

The London 2012 Olympic & Paralympic Games are finally here and London is welcoming thousands of visitors per day. They are coming to enjoy the Games and related events, but some will inevitably be taken ill or suffer injuries. The Service is predicting a 4-5% rise in call volume, and road closures and congestion will increase the time taken to respond to incidents. Please try to help the LAS by considering the following:

- Does your patient really need an ambulance to get to hospital or could they travel by car or ambulance?
- Can your patient be better managed in the community?
- Do your patients know how to access OOHs GPs or where their local UCC or MIU is?

We would like to thank you for your support. For details surrounding LAS preparations for the Games please visit:
www.londonambulance.nhs.uk/about_us/2012_games.aspx

Comparing UK Ambulance Trusts

GPs work closely with the LAS, but how do you know whether our Service is comparable with others? From April 2011, all ambulance services in England began measuring and reporting against 11 clinical quality indicators (CQIs), allowing our data to be compared with that of other Ambulance Trusts. These include 'cardiac arrest- survival to discharge', 'time to answer calls' and 'service experience'.

The Service publishes the latest data on performance against the CQIs in the form of a dashboard which shows how we are doing in each area. We closely monitor our figures and use the information to continue to improve the quality of care and treatment we provide to our patients.

The LAS is pleased to report that in 2011/12 we came 1st in the following categories: Cat A19 Performance (reaching urgent calls within 19 mins) Call Abandonment Rate | Cardiac Arrest - survival to discharge (Utstein) Time to answer calls (Median) | Time to treatment (Cat A) - 95%
For a full list of the CQIs and access to the dashboard, please click here:
www.londonambulance.nhs.uk/about_us/how_we_are_doing/clinical_quality_indicators.aspx

CQUINS - diabetes referrals

CQUINS = 'Commissioning for Quality & Innovation'

Diabetes is an area of clinical care with a high level of focus this year. There are 2 initiatives that are currently being implemented and they will be evaluated in early 2013:

1. Where an insulin dependant diabetic patient has had a hypoglycaemic episode, has recovered post-treatment and declined conveyance to the Emergency Department — these patients will be offered a telephone ring-back 2 hours post discharge to check on their condition as well as referring them back to their GP who in turn may choose to make an onward referral to a specialist team or recommend a medication review.
2. As standard practice, the LAS takes a BM on any patient attended who is over 40 years old. Where this is raised (>8mmol) and the patient is well, the patient will be referred to their GP and it is hoped that the information will be used to screen the patient for either un-diagnosed diabetes or impaired glucose tolerance / prediabetes.

For further information on all subjects covered in this newsletter please visit:
www.londonambulance.nhs.uk

LAS contact details

Address:
220 Waterloo Rd,
London,
SE1 8SD

Tel:
020 7783 2000

Please send all general enquiries to the Patient Experiences Department:
PED@lond-amb.nhs.uk

£5 million

The LAS saved the health economy this amount of money in 2011/12 by reducing the number of patients conveyed to Emergency Departments.

GPs requesting ambulance transfers

If a patient requires an ambulance, there are 4 levels of urgency for transportation:

- 8 min 'blue-light'
- 30 min 'blue-light'
- 60 min non 'blue-light'
- Over 60 minutes

Please choose wisely and refer to the LAS website for full details.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 21 AUGUST 2012

PAPER FOR NOTING

Document Title:	**Annual Equality Report 2011/12**
Report Author(s):	**Janice Markey, Equality and Inclusion Manager**
Lead Director:	**Caron Hitchen**
Contact Details:	**Caron.hitchen@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Requirement under the Equality Act 2010**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Other
Recommendation for the Trust Board:	**Trust Board are asked to note the Executive Summary, which highlights the progress made on equality and inclusion in the year 2011-12, note the availability of the full report on the Trust's website and support SMG in agreeing future actions and objectives.**

Executive Summary:

The full report provides comprehensive detail on progress on equality and inclusion issues in the Trust for the year 2011-12, highlighting any key areas of under representation for the Trust, improvements required in the collection and provision of management information on the workforce, service delivery and patient profiling and suggested initiatives to be considered to address any gaps in line with the requirements of the Equality Act 2010 and the new public sector duty.

The report also updates the Trust Board on action taken since submission of the last Annual Equality report (2010-11).

Although not within the time period of this report, the Trust has been successful in its application to become a Stonewall Health Champion in recognition of its equality policies and practices. This prestigious national programme, funded by the Department of Health, is aimed at improving health services for lesbian, gay and bisexual people. It should be noted that these policies also reflect our general approach to the broader equality and inclusion arena and serves as validation to the Trust's approach across the board.

Key issues for the Trust Board

The Trust Board should recognise that representation overall in the workforce of BME staff (9.3%) and of women (42.6%) remains low compared to the London 2001 census estimates of 28.8% and 51% respectively The percentage of staff stating that they are disabled remains very low at 0.35%.

At a time of workforce reduction there will be limited opportunity to impact on this, though at 17.4% the proportion of new starters from BME backgrounds is the highest reported to date. In line with the Trust's Positive Action Strategy the Trust's learning and development opportunities will continue to be accessible to all and staff from the protected characteristic groups will be actively encouraged to apply for any development opportunities and their access to promotions monitored and reported.

Having formally signed up to the national NHS Equality Delivery System, the Trust will be mainstreaming the work to implement the EDS in its business planning process.

The Trust Board are asked to note the contents of the Annual Equality Report 2011-12 together with its recommendations from which it can draw assurance that areas for action have been identified with intended actions clearly stated. These actions will be monitored and managed through the Equality and Inclusion Steering group.

Attachments

Annual Equality Report 2011/12

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

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

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

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

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

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

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

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST

MEETING OF THE TRUST BOARD
Date of Meeting: 21 August 2012

EXECUTIVE SUMMARY OF ANNUAL EQUALITY REPORT 2011-12

1 INTRODUCTION

1.1. This report provides an executive summary of the Annual Equality Report 2011-12, which will be available on the Trust's website, as well as in alternative formats and community languages on request.

1.2. The last Annual Equality Report, covering the period from April 1 2010 to March 31 2011, was received by the Trust Board in January 2012.

2. PROGRESS SINCE LAST REPORT

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

- New Equality Act 2010 training has been held for the Trust Board, Senior Managers and HR Managers and Assistants and is being rolled out to the Managers' and Admin Staff Conferences. Specific half-day workshops for managers and staff will be held. New equalities induction training has been produced and the trainers trained; equalities briefings continue to be delivered at the All in one refresher training and other sessions on request. The equality and inclusion e-learning module will be updated in line with the requirements of the Equality Act 2010 and will be available from July 2012;
- Pending the publication of the updated Department of Health Equalities Monitoring Guidance, Directors and Heads of Service will consider any necessary actions to enhance the data collection and analysis of take-up of services, employment and training, engagement activities and access to decision making in the Trust;
- Regular Staff Data Refreshes across the new protected characteristic groups, in line with the Equality Act 2010 Public Sector Duty, are to be programmed in;
- New members of staff are joining the Trust's Staff Diversity Forums and the activities of the forums are supported by Directors and Heads of Service, as well as through access to budgetary support;
- Directors and Heads of Service continue to resource their actions in the Trust's Equality and Inclusion Strategy action plan;
- No major new recruitment campaign has taken place, due to the necessary cost savings, but on the next available opportunity, in line with the Trust's Positive Action Strategy, the Trust will seek to actively encourage people from protected characteristic groups who do not appear to be proportionately represented at present in the Trust. The Trust can report however a higher proportion of new starters from BME backgrounds than before;
- The Trust is continuing to profile itself in the equalities media, including in the annual Stonewall "Starting Out" Guide, which goes to schools,

colleges, universities and employment centres and is an important way to attract the best talent into the service.

2.2. Other key initiatives

- The Trust formally signed up to the national NHS Equality Delivery System and held extensive engagement with stakeholders on its proposed equality objectives and ratings; work to implement the EDS will be mainstreamed into the Trust's business planning;
- Following the application against the 2012 Stonewall Workplace Equality Index, the Trust became a top 100 employer, coming joint 94th, the only ambulance service in the country and emergency service in London to do so;
- Benchmarking with the National Ambulance Diversity Forum continues through Trust representation at this and the National Ambulance BME forum;
- During 2011-12 the Trust has continued to undertake equality analysis in line with the Public Sector Equality Duty and to publish the results of these on the Pulse and the Trust website, as well as making these available in alternative formats, on request; the Governance & Compliance team co-ordinate the completion of policies and procedures and support managers in ensuring that an equality analysis has been undertaken for each new or revised document, as appropriate;
- As at 31 March 2012 the Trust had 6.073 public Foundation Trust members; the Trust regularly and closely monitors the demographic profile of its public members, including across protected characteristic groups to obtain a picture of how representative the membership is of the eligible population and to address any inequity in representation through recruitment;
- The Trust's new Staff Diversity Forums, the LGB Staff Forum, Deaf Awareness Forum and Enable (disabled staff/carers' forum), continue to be supported in their work by the Trust, with the Chairs of each of the forums invited to meetings of the Equality and Inclusion Steering Group to discuss the aims and objectives of the forums for the coming year. Work is underway to run a series of joint Staff Forum events, to promote greater awareness of the forums among staff, encourage new members to join and look at the possible establishment of further forums, depending on staff interest.

3 WORKFORCE PROFILE

The Trust Workforce Profile for 2011-12 comprises 9.3% BME staff and 42.6% women, slight increases on the year before but still some way below the Census 2001 estimates (the Census 2011 data for London is pending) respectively of 28% and 51%; only 0.35% of staff stated that they were disabled. The Healthcare Commission's "Tackling the challenge – Promoting race equality in the NHS in England" report (March 2009 – the most recent report providing an NHS-wide picture) estimated that BME staff represented 16% of the total NHS workforce, with fewer than 10% of senior managers in the NHS being BME staff. The 2011-12 Trust profile shows that 9.4% of BME staff are in senior

management grades, which is almost on a par with the estimated percentage in that report, and just above the overall representation of BME people in the Trust. However, only 7.4% of all women were at senior management grade level; this was 31.9% of all staff in senior management posts. Age ranges of staff in the Trust, as well as starting and leaving the Trust mirrored the previous year. The majority of women in post were in full-time employment (38.3% of all full-time employed staff) with 426 in part-time employment (72.9% of all part-time staff).

Of the staff leaving the Trust in 2011-12, 11% were BME staff, 39.5% were women and 0.5% said they were disabled staff.

Monitoring of new starters to the Trust showed that 17.4% were BME Staff (almost twice the percentage of the workforce profile), 50.6% were women (also higher than the current representation in the Trust), but no new starters identified as disabled, although 74.69% did not declare either way.

Applicants to the Trust showed a greater willingness than previous years to complete the religion/belief and sexual orientation fields. With the introduction of new ESR fields or further Staff Data Refreshes, these equalities statistics will be able to be captured, along with further protected characteristic group information, in future reports.

The full Annual Equality Report 2011-12 provides detailed information on the Trust's workforce profile, including breakdown by grade/rank, staff group, length of service, pay band, age, starters and leavers, promotions, employee relations activity, training and development, staff engagement, Patient and Public Involvement and Public Education activity, as well as information on take-up of key services.

4 CONCLUSION

In an extremely busy year leading up to a wide range of high-profile and unique events, which the service will be involved in, including the London 2012 Games, the Trust has continued to be very proactive on the equality and inclusion front, investigating areas needing further improvement in the collection and analysis of data and setting up more initiatives directly intended to make the Trust's workforce more representative of the communities it serves, provide targeted and specific training for its staff, targeted and enhanced services to its patients and service users and enhanced engagement with all its stakeholders.

To ensure that the Trust is more able to capture the equalities breakdown of its staff across employment and training, a specific Staff Data Refresh was carried out in December 2011, the results of which were reported in January 2012. The Equality and Inclusion team has asked NHS London and NHS Employers to request the NHS Central Team to expand the existing ESR system to include the new protected

characteristic groups. If there is a delay in this taking place, the Trust will give consideration to a further Staff Data Refresh, to ensure that monitoring across the protected characteristic groups is able to take place in as systematic and comprehensive way as possible. This should complement the implementation of the learning management system by the Trust's two training departments. The Department of Health's updated equalities monitoring guidance is still pending; the revamp of the Patient Report Form, which is being discussed with the Trust's Equality and Inclusion Steering Group, should reflect any key recommendations provided by this for the monitoring, in a sensible and effective way, of the Trust's patients and service users.

Over the coming year the Trust will need to consider how it can best seek equalities information from its patients and service users. There are some clear logistical problems related to the capturing of equalities data in certain service areas, as highlighted in the report. However, this is an area that the Trust will need to make progress on and service managers will need to consider how this can be best progressed within their service areas. Once the updated Equalities Monitoring Guidance is available from the Department of Health, the Equality & Inclusion Team will work closely with respective service managers to devise the most sensible and effective approach, which will need to be tailored to the needs of the respective service.

The Equality and Inclusion Steering Group, comprising Directors, Heads of Service, non-Executive Director, Patients' Forum/LINks and staff side partner representation, continues to meet every two months to actively support and oversee the progress of all equality and inclusion work in the Trust.

Apart from the successful achievement of becoming one of the UK's top 100 employers on the Stonewall Workplace Equality Index, the Trust will also be applying to become one of Stonewall's leading national Health Champions in the coming year.

5 RECOMMENDATIONS

To ensure that the Trust continues to be proactive in its equality & inclusion work and compliant with the requirements of the Equality Act 2010, it is recommended that the Trust continue to use the national NHS Equality Delivery System, including focusing activity on the four key objectives and continue to monitor and report on progress against them.

BACKGROUND PAPERS
Annual Equality Report 2011-12

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 21ST AUGUST 2012

PAPER FOR APPROVAL

Document Title:	**Revalidation of Doctors; implications for the London Ambulance Service NHS Trust (LAS)**
Report Author(s):	**Dr Fionna Moore, Medical Director**
Lead Director:	**Dr Fionna Moore, Medical Director**
Contact Details:	**fionna.moore@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Statutory Requirement**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other
Recommendation for the Trust Board:	**To approve the appointment of a Responsible Officer to the Trust**

Key issues and risks arising from this paper

Failure to appoint a Responsible Officer, complete an Organisational Readiness Self Assessment (ORSA) return and fulfil the obligations of a Designated Body is a reputational risk to the organisation. There is also a risk that any doctors who nominate the LAS as their Designated Body will be unable to assure the GMC of their continuing fitness to practice.

Executive Summary

This paper describes the implications for the LAS of the revalidation process for doctors.

Attachments

Paper: Revalidation of Doctors; implications for the London Ambulance Service NHS Trust (LAS).

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

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

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

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

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

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

Equality Analysis

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

Key issues from the assessment:

Clinical and Quality Directorate

Medical Directorate

Revalidation of Doctors; implications for the London Ambulance Service NHS Trust (LAS)

Introduction

Most doctors in the UK do not have to prove their fitness to practice at any time in their career except the point at which they join the medical register. Professionals in other high risk industries, with aviation being the most frequently cited, are expected to prove that their knowledge, performance and skills are up to date on a regular basis. Many members of the public assume this is already the case for doctors. In the wake of the Shipman enquiry a government white paper concluded that more needed to be done to assure the quality of doctors' practice. It is recommended that doctors prove their fitness to practice every five years; hence the concept of revalidation.

What does revalidation require

Revalidation requires doctors to complete an appraisal every year, including providing supporting information to show how they are meeting the professional values set out by the GMC, and then every five years to seek multi-source feedback from colleagues and patients.

Organisations that employ or contract medical practitioners, 'Designated Bodies' in revalidation terms, have been asked to assess and demonstrate their clinical governance structures, through the organisational readiness self assessment (ORSA). This process should be completed annually and the report submitted to the England Revalidation Support Board.

Relevance to the LAS

The LAS is regarded as a Designated Body and is therefore required to appoint a Responsible Officer (RO). This individual, usually the Medical Director, has the responsibility to undertake the assessment of any doctors for whom the LAS is their Designated Body.

The LAS currently employs or contracts five medical practitioners. Of those, three have elected to seek revalidation through those bodies where they spend the greater proportion of their working week. Of the remaining two, the Medical Director, if appointed RO, will undertake revalidation through the SHA RO, the Medical Director Dr Andy Mitchell, or a nominated deputy. The required time frame is within this financial year. The other doctor will revalidate in the second wave, planned for 2013/2014.

Next steps

The LAS should appoint an RO, ensure the RO undertakes the relevant training, and receives sufficient support to undertake the role. An ORSA should be completed for 2012/2013 and submitted to the England Revalidation Support Board.

Recommendations:

1. The Trust Board approves the appointment the Medical Director as the Responsible Officer, as recommended by the Senior Management Group
2. The RO undertakes appropriate training and completes the revalidation process
3. An ORSA return is made to the England Revalidation Support Board

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 21ST AUGUST 2012

Compliance with Standing Orders and Standing Financial Instructions

Document Title:	**Trust Secretary Report**
Report Author(s):	**Francesca Guy, Committee Secretary**
Lead Director:	**Sandra Adams, Director of Corporate Services**
Contact Details:	**francesca.guy@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Compliance with Standing Orders**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	**To be advised of the tenders received and entered into the tender book and the use of the Trust Seal since 19th June 2012 and to be assured of compliance with Standing Orders and Standing Financial Instructions**

Key issues and risks arising from this paper

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

Executive Summary

Two tenders have been received, opened and entered into the tender book since 19th June 2012:

- Call-off against framework agreement for fleet vehicles conversion to comply with London Lower Emission Zone legislation
  Tenders received and opened by Bravo Solutions on 25th June 2012:
  Baumot UK Ltd
  Dinex Exhausts Ltd
  Emicon Systems
  Kent County Council – Transport Engineering
  Marshall Fleet Services Ltd
  Volvo Truck and Bus London
  Babcock Critical Services Ltd
  Clean Diesel Technologies
  MTHL Fleet Services

- Independent working capital review to support Foundation Trust application
  Tenders received and opened by Bravo Solutions on 26th July 2012:
  Baker Tilly
  BDO LLP
  Capita
  Mazars

There has been one new entry to the Register for the Use of the Trust Seal on 20th July 2012 for the lease for Olympic Deployment Centre additional parking.

Attachments

None.

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

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

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

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

Risk Implications
This paper links to the following strategic risks:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?
Yes
No

Key issues from the assessment:

TRUST BOARD FORWARD PLANNER 2012

Date of meeting	Standing Reports to the Board	Safety and Quality (additional to standing reports)	Finance and Performance (additional to standing reports)	Strategic and Business Planning	Governance	Sub-Committee meetings during this period
25 September **Trust Board**	Report from the Trust Chairman Report from CEO Report from the COO Report from Director of Finance Report from Sub-committees CommandPoint Update	Quality Dashboard and Action Plan Clinical Quality and Patient Safety Report Workforce Report Annual Patient Experiences Report 2011/12			Report from Trust Secretary Trust Board Forward Planner BAF and Corporate Risk Register – Quarter 2 documents Annual Report of the Audit Committee KA34 Compliance Statement	21st August – Charitable Funds Committee 3rd September – Audit Committee 11th September – Finance and Investment Committee
23 October **Strategy, Review and Planning Committee**					Corporate Social Responsibility Report	

Date of meeting	Standing Reports to the Board	Safety and Quality (additional to standing reports)	Finance and Performance (additional to standing reports)	Strategic and Business Planning	Governance	Sub-Committee meetings during this period
27 November **Trust Board**	Report from the Trust Chairman Report from CEO Report from the COO Report from Director of Finance Report from Sub-committees	Quality Dashboard and Action Plan Clinical Quality and Patient Safety Report Workforce Report Quality Committee Assurance Report	Charitable Funds Annual Accounts 2011/12		Report from Trust Secretary Trust Board Forward Planner	24th Oct – Quality Committee 5th November – Audit Committee
11 December **Trust Board**	Report from the Trust Chairman Report from CEO Report from the COO Report from Director of Finance Report from Sub-committees	Quality Dashboard and Action Plan Clinical Quality and Patient Safety Report Workforce Report			Report from Trust Secretary Trust Board Forward Planner BAF and Corporate Risk Register – Quarter 3 documents	11th December – Quality Committee