UNDERTAKINGS

NHS TRUST:

London Ambulance Service NHS Trust ("the Trust")
220 Waterloo Road
London SE1 8SD

DECISION:

On the basis of the grounds set out below and pursuant to the powers exercisable by NHS Improvement under or by virtue of the National Health Service Act 2006 and the TDA Directions, NHS Improvement has decided to accept undertakings from the Trust.

DEFINITIONS:

In this document:

"the conditions of the Licence" means the conditions of the licence issued by Monitor under Chapter 3 of Part 3 of the Health and Social Care Act 2012 in respect of which NHS Improvement has deemed it appropriate for NHS trusts to comply with equivalent conditions, pursuant to paragraph 6(c) of the TDA Directions;

"NHS Improvement" means the National Health Service Trust Development Authority;

"TDA Directions" means the National Health Service Trust Development Authority Directions and Revocations and the Revocation of the Imperial College Healthcare National Health Service Trust Directions 2016.

GROUNDS:

1. The Trust

   The Trust is an NHS trust all or most of whose facilities and establishments are situated in England.

2. Issues and need for action

   2.1. NHS Improvement has reasonable grounds to suspect that the Trust has provided and is providing health services for the purposes of the health service in England while failing to comply with the following conditions of the Licence: FT4(4); FT4(5)(a), (b), (c), (e) and (f); FT4(6).

   2.2. In particular:

      2.2.1 The Trust is not meeting its own targets for mandatory safety training and there is a lack of staff awareness of infection prevention and control measures in addition to inconsistent compliance with these measures.

2.2.2 There are inconsistencies in the Trust's safety checks and internal repairs of vehicles and equipment with further work required in relation to medicines tracking.

2.2.3 The Trust has not consistently met the national performance targets for the highest priority calls attended to by emergency and urgent care crew.

2.2.4 The Trust needs to strengthen its comprehensive business continuity plan, including service delivery, control services and demand management systems, and has fully implemented the business impact assessment procedure to all parts of the service.

2.2.5 The Trust has failed to demonstrate that it has learned effectively from complaints about its services.

2.2.6 There is insufficient uptake of mandatory training subjects by staff, the Trust is not meeting its own targets and there is a lack of efficiency in recording training.

2.2.7 The board assurance framework has not adequately reflected risks likely to impact on the ability of the organisation to deliver its strategic objectives, and the understanding and application of the framework within the Trust has been confused.

2.2.8 Staff at the Trust do not feel fully engaged and consulted in the Trust's change agenda including changes relating to job cycle time (JCT) and other productivity measures

2.2.9 A lack of sufficient rest breaks poses a health and safety risk to both patients and staff.

2.2.10 An inconsistent and inflexible approach to rostering across the organisation as well as a variation in the management of sickness absence has been reported by staff.

2.2.11 The Trust currently has an interim Director of Finance, an interim Chief Information Officer, no Director of Communications, and no Director of Strategy and Transformation.

2.3 These failings by the Trust demonstrate a failure of governance arrangements including, in particular,

2.3.1 failure to establish and implement:

(a) effective board and committee structures;
(b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees;
(c) clear reporting lines and accountabilities throughout its organisation;

2.3.2 failure to establish and effectively implement systems or processes:

(a) to ensure compliance with the Trust's duty to operate efficiently, economically and effectively;
(b) for timely and effective scrutiny and oversight by the Board of the Trust's operations;

(c) to ensure compliance with healthcare standards binding on the Trust;
(d) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
(e) to identify and manage material risks to compliance with the conditions of the licence;
(f) to ensure the matters relating to quality of care specified in condition FT4(6) are complied with;

2.4 Need for action:

NHS Improvement believes that the action which the Trust has undertaken to take pursuant to these undertakings, is action required to secure that the failures to comply with the relevant requirements of the conditions of the Licence do not continue or recur.

UNDERTAKINGS

NHS Improvement has agreed to accept and the Trust has agreed to give the following undertakings.

1. Quality

1.1 The Trust should take all reasonable steps to develop and deliver at the earliest opportunity and no later than 31 March 2018:

1.1.1. the uptake of statutory and mandatory training to meet the Trust's current target;

1.1.2. effective systems and processes for timely safety checks and repairs on both vehicles and equipment, consistent with the Trust's safety policy;

1.1.3. standards in place and being monitored to establish safe staffing levels and appropriate skill mix and experience on double crewed ambulances (DCAs);

1.1.4. effective systems and processes for reporting of incidents and near misses to national standards, evidenced by the total number of low or no harm incidents;

1.1.5. mechanisms and other tools outside 'Insight' to share learning from incidents and near misses, and evidence to demonstrate that this learning is embedded;

1.1.6. the trust action plan in response to the independent health and safety review;

1.1.7. medicines management systems, processes and procedures, including tracking and audit, and safe storage arrangements for controlled drugs, consistent with the Trust's medicines management policy;

1.1.8. continued progress on emergency preparedness, resilience and response (EPRR), as evidenced by the national ambulance resilience unit (NARU) independent review;

1.1.9. improved coverage of staff appraisals and a review of their quality in line with the Trust's appraisal policy;

1.1.10. the national standards under the ambulance response programme (ARP) through a transition programme agreed with NHS Improvement, commissioners, NHS England and other key systems partners and stakeholders, ensuring.

1.1.10.1. the action plan is sufficiently resourced; and

1.1.10.2. consistency across sustainability and transformation partnerships (STP) regions and across the Trust's stations, through engagement with staff and trusts and appropriate distribution of resources;

1.1.11. improved uptake of equality and diversity training to meet the Trust's current target, evidenced by improved self-assessment indicators in the workforce race equality standard (WRES); and

1.1.12. organisational wide learning from the complaints and incident reporting evidenced by internal audits.

1.2. The Trust should take all reasonable steps to develop and deliver at the earliest opportunity and no later than the 30 November 2017:

1.2.1. target efficiencies agreed with NHS Improvement, commissioners, NHS England and other key systems partners and stakeholders to improve operational performance and demand management, including handover delays at hospitals, job cycle time and multiple attendance ratios; and

1.2.2. improved understanding by the relevant staff of the requirements of the Mental Health Act, particularly in emergency operations centre (EOC) and EPRR.

1.3. The Trust should take all reasonable steps to develop and put in place, in a timescale to be agreed with NHS Improvement and NHS England

1.3.1. business impact assessments for all functions and a comprehensive business continuity plan, including service delivery, control services and demand management systems across the whole organisation, independently assured through NARU review; and

1.3.2. a comprehensive people and organisational development strategy, which addresses recruitment and retention, supports new models of care and

underpins the new ARP programme, together with an implementation plan showing progress with actions.

2. Governance

2.1. The Trust should take all reasonable steps to develop and deliver by 1 January 2018:

2.1.1. effective board, committee structures and reporting lines, including:

2.1.1.1. evidence of recruitment of substantive executives to replace interim appointments and vacancies;

2.1.1.2. board and executive team development programmes in place to address recommendations made by the Deloitte well led review in February 2017; and

2.1.1.3. an effectively designed and implemented behaviour framework and leadership pathway;

2.1.2. accurate, comprehensive, timely and up to date information for board and committee decision-making including a comprehensive board assurance framework (BAF) to:

2.1.2.1. identify and manage material risks to compliance with the conditions of the Licence;

2.1.2.2. review and approve the risk management policy and BAF and implement risk management plans; and

2.1.2.3. manage, monitor and embed at all levels within the organisation, the quality improvement plan to rectify the concerns raised in the CQC report;

2.1.3. board approval of the Trust's overarching strategy (strategic intent);

2.1.4. a timeline to refresh the supporting strategies; and

2.1.5. consultation and engagement with staff to:

2.1.5.1. ensure progress in implementing flexible rostering, rest break policy, leave policy and flexible working practices;

2.1.5.2. manage sickness absence;

2.1.5.3. tackle bullying and harassment in line with phase two of the Trust's implementation plan;

2.1.5.4. deliver the trust staff survey action plan and at least a 50% response rate in the staff survey; and

2.1.5.5. achieve an engagement score in the staff survey increased from the 2016 baseline.

2.2. The Trust should work with the Improvement Director to support the quality improvement programme, as appointed by NHS Improvement.

2.3. The Trust must, by such dates to be agreed with NHS Improvement, undertake a well led framework review and address the findings to prepare for the CQC review.

2.4. The Trust must complete the review of Information technology (IT) governance and processes and ensure sufficient capacity and capability is in place to provide a resilient service.

3. Buddy Trust and other partner organisations

3.1. The Trust will co-operate and work with any partner organisations (this may include one or more 'Buddy Trusts') who may be appointed by NHS Improvement to support and provide expertise to the Trust.

3.2. The Trust will work with any such partner organisation on such terms as may be specified by NHS Improvement.

4. Programme management

4.1. The Trust will implement sufficient programme management and governance arrangements to enable delivery of these undertakings.

4.2. Such programme management and governance arrangements must enable the board to:

4.2.1. obtain clear oversight over the process in delivering these undertakings;

4.2.2. obtain an understanding of the risks to the successful achievement of the undertakings and ensure appropriate mitigation; and

4.2.3. hold individuals to account for the delivery of the undertakings.

5. Meetings and reports

5.1. The Trust will attend meetings or, if NHS Improvement stipulates, conference calls, at such times and places, and with such attendees, as may be required by NHS Improvement.

5.2. The Trust will provide such reports in relation to the matters covered by these undertakings as NHS Improvement may require.

Any failure to comply with the above undertakings may result in NHS Improvement taking further regulatory action. This could include giving formal directions to the trust under section 8 of the National Health Service Act 2006 and paragraph 6 of the TDA Directions.

THE TRUST

Signed 

(Chair or Chief Executive of Trust)

Dated 22nd December 2017

NHS IMPROVEMENT

Signed 

Executive Regional Managing Director (London) and Chair of the Regional Provider Support Group (London)

Dated 02/01/18