London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD
TO BE HELD IN PUBLIC ON THURSDAY 25 MAY 2017 AT 2:00-5:00PM
CONFERENCE ROOM, 220 WATERLOO ROAD, LONDON, SE1 8SD

AGENDA: PUBLIC SESSION

	ITEM		SUBJECT	LEAD	TAB
2.00	1.	**Welcome and apologies for absence** Apologies received from:			
2.05	2.	**Declarations of Interest** To request and record any notifications of declarations of interest in relation to today's agenda		HL	
	3.	**Minutes of the meeting held in public on 25 April 2017** To approve the minutes of the meeting held on 25 April 2017	Approval	HL	TAB 1
	4.	**Matters arising** To review the action schedule arising from previous meetings	Information	HL	TAB 2
2.15	5.	**Report from the Chair** To receive a report from the Trust Chair	Information	HL	TAB 3
2.25	6.	**Report from Chief Executive** To provide any further update not covered in the Chair's report	Information	AG	Oral
ANNUAL REPORTING					
2.35	7.	**Annual Report and Accounts 2016/17** 10.1 To approve the Annual Report 10.2 To approve the Annual Governance Statement 10.3 To approve the Annual Accounts 10.4 To approve the Quality Account 2016/17	Approval	 CG PH AB TB	TAB 4
PERFORMANCE AND ASSURANCE					
2.55	8	**Performance Report – April 2017** To receive the abridged performance report	Information	AB	TAB 5
3.15	9.	**Board Assurance Framework and Risk Management** To receive the Board Assurance Framework and risk register	Information	PH	TAB 6
3.30	10.	**Quality Governance Committee Assurance Report** To receive the report from the Quality Governance Committee – 16 May 2017	Assurance	TB	TAB 7

3.40	11.	**Audit Committee Assurance Report** 8.1 To receive the report from the Audit Committee – 18 May 2017 8.2 Audit Committee Annual Report 2016/17	Assurance	JJ	TAB 8
3.50	12.	**Finance and Investment Committee Assurance Report** To receive the report from the Finance and Investment Committee – 22 May 2017	Assurance	HL	Oral
STRATEGIC AND BUSINESS PLANNING					
4.00	13.	**2017-19 Business and Financial Plan**	Approval	KB	TAB 9
4.20	14.	**Fleet Strategy**	Approval	AG	TAB 10
GOVERNANCE					
4.40	17.	**Trust Board Forward Planner** To receive the Trust Board forward planner	Information	PH	TAB 11
4.45	18.	**Questions from members of the public**		HL	
4.55	19.	**Any other business**		HL	
	20.	**Meeting Closed** The meeting of the Trust Board in public closes		HL	
	21.	**Date of next meeting** The date of the next Trust Board meeting in public is on 27 June 2017 at LAS Headquarters, 220 Waterloo Road, London SE1 8SD		HL	

London Ambulance Service NHS Trust

TRUST BOARD MEETING (PUBLIC)

Minutes of the meeting held on Tuesday 25th April 2017 at 1.00pm
in the Conference Room, 220 Waterloo Road, London SE1 8SD

Present:	
Heather Lawrence	Chair
Andrew Grimshaw	Acting Chief Executive
Fergus Cass	Non-Executive Director
John Jones	Non-Executive Director
Bob McFarland	Non-Executive Director (joined the meeting at 9:30)
Jessica Cecil	Non-Executive Director
Jayne Mee	Non-Executive Director
Sheila Doyle	Non-Executive Director
Trisha Bain	Chief Quality Officer
Andy Bell	Acting Director of Finance and Performance
Fenella Wrigley	Medical Director
Paul Woodrow	Director of Operations
In attendance:	
Sally Herne	NHSI - Improvement Director
Mercy Kusotera	Corporate Governance Manager (Minutes)
Maeve Stevenson	Programme Administrator

48.	**Welcome and Apologies**
48.1	The Chair welcomed all to the meeting. Apologies were received from Theo de Pencier and Malcolm Alexander. No members of the public attended the meeting.
49.	**Declarations of Interest**
49.1	There were no declarations of interest in matters on the agenda.
50.	**Minutes of the Board meeting held on 28th March 2017**
50.1	The minutes of the meeting held on 28th March 2017 were approved as a true record of the meeting subject to a minor amendment to 39.3. **Action: Mercy Kusotera** **Date: 25th May 2017**
51.	**Matters Arising**
51.1	The Trust Board reviewed the actions log and noted the following: 29.3 – The Chair confirmed that Philippa Harding would be joining the Trust on secondment. It was noted that it was Mercy Kusotera's last London Ambulance Service (LAS) Trust Board meeting and Maeve Stevenson would be observing the meeting. The Chair urged Andrew Grimshaw to review the job descriptions of the (i) Medical Director (ii) Chief Quality Officer and (iii) Director of Corporate Governance and to provide a recommendation for approval by the Nominations and Remuneration Committee. **Action: Andrew Grimshaw** **Date: 25th May 2017**
51.2	31.6 – Emergency Operations Centre (EOC) establishment: the risk remained as previously discussed; mitigation was in place. It was agreed that Paul Woodrow would provide a paper for 27 June 2017 Trust Board. The risk would be reviewed in two/three months' time and an update would be provided to the Trust Board.

	Action: Paul Woodrow **Date: 27th June 2017**
51.3	31.8 – Board Assurance Framework (BAF) risks: ongoing work around allocating BAF risks to sub-committees. The action was not closed.
51.4	33.3 – Integrated report: Cumulative performance – this would be included in the report from April 2017 onwards. The action remained open. **Action: Andrew Grimshaw** **Date: 25th May 2017**.
51.5	33.6 and 34.5 – Staff health and wellbeing – it was agreed to merge the actions. The Chair expressed concern around sickness level; she felt the rate was still high and should reduce to the health industry norm of 3%. Paul Woodrow commented that fitness of staff should be considered during recruitment. Two issues were noted (i) recruiting the right people (fit for the job) (ii) supporting staff going back to work. Fergus, Karen and Jayne to meet and further discuss this. Fergus Cass / Jayne Mee / Karen Broughton to discuss and incorporate the above issues the following into the Staff health and well-being strategy: **Action: Karen Broughton** **Date: 25th May 2017**
51.6	41.2 – Business plan: the plan would be signed off in May.
51.7	11.6 – International paramedics: it was confirmed that a report (re – the number of paramedics returning to Australia) had been presented to the Executive Leadership Team (ELT). It was agreed to confirm the details of paramedics, the cohort they belong to, the reasons provided and the length of tenure. The detail should be shared with the ELT; the Workforce Committee should be assured. **Action: Karen Broughton** **Date: 25th May 2017**
51.8	9 – Computer Aided Despatch (CAD) New Year's Day Incident: it was noted that an update on the resilience action plan would be provided at the May Board meeting. Andrew Grimshaw noted ongoing work around Information Management and Technology (IM&T) – the management structure of IM&T and restructuring of the department. It was agreed to have a standing item re - IM&T resilience and infrastructure for the Trust Board (Part 2) until the Board is assured; further updates would be presented to the ELT on a regular basis. **Action: Andrew Grimshaw /Sheila Doyle /Steve Bass** **Date: 25th May 2017**
52.	**Report from the Chair**
52.1	The Chair provided an update on the following key points • General election – the Service is awaiting guidelines from the Department of Health regarding our communications during the period of 'purdah'. These would be circulated in due course. • Major incident (Westminster 22nd March 2017) – the LAS responded well and had been commended by the Secretary of State, Jeremy Hunt and the Prime Minster, Theresa May. • Strategy development – the Trust is in the process of reviewing and updating the Service's Five Year strategy. • Healthcare at Home Industry Coalition Group – the Chair had accepted an invitation to be a member of this group. • Healthcare discussion with Noel Gordon – the Chair and Theo de Pencier had attended this event which was hosted by Deloitte's. All Boards were required to have a senior independent NED to support ICO development. • Affordable inner city housing (JLT Lending Risk Solutions) – the Chair had agreed to be a

	member of the Group. It was felt that affordable 'micro-housing' might be an attraction to young people. • Care Quality Commission (CQC) update – the Trust had been advised that the CQC had postponed the Quality Summit until July. The Chair had sought a meeting to express her concern about the impact of this delay given the improvements already undertaken by the Trust. • Workforce Racial Equality Standard (WRES) – the Chair noted the importance of setting a culture within the organisation that incorporates the values and addressed the issues as well as ensuring people have clarity of expectations. For example cliques are not acceptable; they were perceived as a constraint to people's wellbeing and inclusivity. • Board to Ward – there was need for more structured approach for Non-executive Directors to (NEDs). This could be linked into deep dive methodology being developed by Trisha Bain. The Chair will develop a plan with the assistance of Maeve Stevenson and Chris Doyle. **Action: Chair /Maeve Stevenson /Chris Doyle** **Date: 27th June 2017** • Appraisals – the Chair had completed her self-appraisal and she was in the process of carrying out individual NEDs appraisals or post-induction / objective setting reviews. The Chair had identified her personal objectives. The Trust Board reviewed the objectives and proposed the following recommendations: - It would be helpful to have a specific objective on well-led. - Strategy – the Chair leads in refreshing the strategy in a positive way. - Sustainability Transformation Plans (STP) governance; this should be linked to Partnership Governance as well. • It was proposed that each NED should identify three-four personal objectives that link in with the corporate ones. These would be discussed with the Chair as part of individual NEDs appraisal. • Executive appointments were noted.
52.2	The Trust Board noted the Chair's report.
52.3	Fergus Cass reported some personal reflections following an NHS Providers NED Network meeting held on 21st April 2017. The meeting reviewed trends and issues in the health service. The following points were noted: • There will be a continuing need to deliver significant CIP savings.. • STPs are assuming an increasingly important role. • Workforce issues are getting greater prominence at board level, with more trusts establishing workforce committees. • Demands on NEDs are growing, presenting them with a range of challenges, including finding the right balance between being operational and being strategic, and between focusing on one's own trust and taking a total system perspective.
52.4	The Trust Board thanked Fergus Cass for sharing.
53	**Report from the Chief Executive Officer**
53.1	The report was taken as read and content noted.
54.	**Logistics and Infrastructure Committee Assurance Report**
54.1	Sheila Doyle reported on the items discussed on the meeting held on 13th April 2017, the following key areas had been discussed: • IM&T Strategy Planning 2017/2018 – Steve Bass presented the action plan for strategy implementation. Recruitment was identified as one of the key issues affecting current activities and strategy delivery.

	• Estates Strategy – the Committee agreed that the Trust's Estates Strategy (which is nearing completion) would be circulated to the Committee for comment, discussion and recommendation to the Trust Board as soon as it was agreed by the Executive Team. • Fleet and Logistics – the Committee discussed the Fleet Strategy which lays out an analysis of the operational technical challenges that impact upon delivery of a robust plan to support LAS' overall vision, its clinical strategy and the changing role of the Ambulance Service within the NHS.
54.2	It was agreed to schedule IM&T strategy for May Trust Board. **Action: Andrew Grimshaw** **Date: 25th May 2017**
55.	**Integrated Performance – March 2017**
55.1	The following key points were noted from the report: *Performance*
55.2	Paul Woodrow reported that A8 performance for the month of March returned 73.5%; this was 2.0% above the contracted trajectory. Red 1 performance was 74.9% and Red 2 performance was 73.45%. Both the national standards for A19 performance and EOC call answering were achieved in March. The A8 cumulative year end performance was 66.4 against a trajectory of 67.2%. Service levels for Category C patients all improved providing a timelier response and an improved experience for lower acuity patients.
55.3	Activity in March remained over contract levels with Category A activity being 3.6% above and Category C demand 8.0% above contract. Capacity was 7.6% above plan to meet the increased activity.
55.4	In terms of efficiency the Multiple Attendance Ratio (MAR) for the month was 1.27 against a target of 1.29 an improvement of 0.02. Job Cycle time was still three minutes above trajectory for the month but saw an improvement of 2.7 minutes on the previous month. Work continues to return this measure to trajectory levels.
55.5	Our NHS 111 service in South London continues to perform strongly and achieved the national call answering standard for the month of March and continues to have the lowest rate of referral to 999 of any London NHS 111 provider returning performance against this metric of 7.9% referral rate against a national standard of 10.0%.
55.7	Patient Transport Service (PTS) continued to deliver a relatively stable level of performance in the month of March with increased activity of c 480 journeys against the previous month. A further contract was concluded at the end of March in line with the plan, one member of staff TUPE to the new provider with the remaining staff transferred to our Non-Emergency Transport Service (NETS) or to remaining PTS contracts. NETS delivered an average of 780 journeys a week throughout March.
55.8	Main actions in operations is to ensure we provide sufficient capacity to meet activity levels at forecast and ensure there is an equitable spread of capacity to meet both STP area and Clinical Commissioning Groups (CCGs) agreed thresholds. Continued focus on rest break allocation is a priority as is increasing operational capacity. Paul ended his report by informing the Board that current levels of performance remained strong in the month of April. *Quality*
55.9	The following key points were noted from the Quality report:

	• Serious Incidents (SIs) – reporting of incidents by crews continues to increase and staff are to be commended for this openness. When an incident is reported but is not an SI feedback is provided to individuals to advise them on the decision and engage them in sharing their experiences in an anonymised and supported way. Learning from Sis is being incorporated into the Core Skills Refresher (CSR) training for 2017/18 and anonymised case-based scenarios are being used. There is a trajectory to ensure we have no breaches in SI submission by June • Complaints – the revised process will see continued improvement in delivery against the complaint responses. Increasing numbers of complaints are citing attitude and behaviour. • The Ambulance Quality Indicators (AQI) data is from November 2016 – it was recognised that the small numbers and delayed outcome data from hospitals influence the data significantly and a more accurate picture is to look at the annual report. Themes of concern are picked up by the incident reporting and complaints so we do not wait for the annual report to implement changes to improve patient care. • Staff and patient safety incidents are reported through the Clinical Safety and Standards Committee (CSSC). The Director of Quality is now responsible for Health and Safety. • A recruitment round of Clinical Team Leaders has just taken place which will increase the availability of Clinical Team Leaders (CTLs) to provide feedback on Clinical Performance Indicators (CPIs). *Workforce*
55.10	Karen Broughton reported that: • The overall vacancy rate across the Trust remained at 5.1% but that vacancy rates for frontline staff had risen marginally from 9.2% to 9.4%. She reported that the Trust had just returned from a further recruitment trip to Australia where 185 job offers had been made and that these staff were likely to join the Trust in Q4, she went onto explain that there were currently 326 applicants going through the recruitment process for Trainee Emergency Ambulance Crew. • Overall turnover across the Trust remained at 9.8% but that frontline turnover had increased slightly in March by 0.2% to 8.6%. A discussion took place on turnover of international paramedics and it was agreed that the Workforce and Organisational Development Committee would receive a detailed report into the exit analysis findings. This would include turnover by cohort and turnover predicted across the year based on current data. • Frontline sickness remained at 5.7% and when benchmarked to Ambulance Trust's was currently 3rd in relation to sickness. The Chair explained that, whilst it was helpful to see the Trust benchmarked against other Ambulance Trusts, she wanted the Trust to aspire to reach sickness levels achieved at industry best practice levels. • Since April 2016, 3,666 appraisals had been undertaken representing 81.3% of staff. She went onto report that the Trust was looking to further improve appraisal and objective setting within the Trust particularly in relation to the quality of appraisals. • The rolling programme of Disclosure Barring Service (DBS) rechecking was on plan. *Finance*
55.11	Andy Bell provided the headlines: • Care has remained at safe levels • Cat A8 Performance has improved • Workforce statistics have remained consistent • Statutory year-end financial targets have met and a draft set of accounts have been submitted.
55.12	The Trust Board noted report.

56.	**Audit Committee Assurance Report**
56.1	John Jones provided a report to the Trust Board. Key issues addressed at Audit committee were: • Draft Trust accounts – these were reviewed in detail, challenged and ultimately agreed for submission by the audit committee. • Internal Audit and Counter Fraud.
56.2	It was noted that KPMG have completed their 2016/17 audit plan and presented five final reports to the committee and these were reviewed and subsequent actions agreed.
56.3	John Jones reported that KPMG presented the plan for the 2017/18 internal audit and counter fraud plans. These were amended for ELT feedback and provisionally agreed pending final discussions on individual programmes.
56.4	In line with good practice a private meeting with the Trust Auditors took place before the Audit Committee meeting on 18th April 2017.
56.5	The Trust Board noted the report.
57.	**Business Plan 2017/18**
57.1	Karen Broughton informed the Trust Board that the plan was still in draft. Comments from members would be incorporated in the next version. As agreed in the Private Board meeting a sub-committee made up of HL / AG / KB / SH would convene to review the revised business plan.
57.2	The Trust Board thanked Karen and noted the plan.
58.	**Annual Accounts**
58.1	Andy Bell provided an overview of the 16/17 year end financial position outlining the process and timelines for submitting the accounts. The LAS has met all of its statutory duties and a set of draft accounts has been submitted to NHSI as per required deadlines. The audit of the accounts will commence 25th April 2017.
58.2	The Trust Board noted the accounts
59.	**Questions from members of the public**
59.1	No questions had been received from members of the public.
60.	**Any Other Business**
60.1	It was noted that this was Mercy Kusotera's last LAS Trust Board meeting. The Chair thanked Mercy for her support to the Trust Board.
61.	**Date of Next Meeting**
61.1	The next meeting of the Trust Board would be on Tuesday 25th May 2017 in the Conference Room, Waterloo.

ACTIONS

from the Public meeting of the Trust Board of Directors of
LONDON AMBULANCE SERVICE NHS TRUST
Date of schedule: 25th May 2017

Meeting Date	Minute No.	Action Details	Responsibility and date	Progress and outcome
28/03/17	**29.3**	**Report from the Chair** The Chair would confirm succession plans for Sandra	**HL** **25th April 2017**	Completed 25th April 2017
28/03/17	**31.6**	**Board Assurance Framework – ringback risk** Paul Woodrow to provide an update on EOC establishment.	**PW** **25th April 2017**	Closed 25th April 2017 see action ref. 51.2
28/03/17	**31.8**	**Board Assurance Framework Risks** Andrew Grimshaw would allocate BAF risks to Board Committees	**AG** **25th May 2017**	**Matters arising 25th May 2017**
28/03/17	**33.3**	**Integrated Performance – A8 Performance** Andrew Grimshaw to provide cumulative performance.	**AG** **25thMay 2017**	**Matters arising 25th May 2017**
28/03/17	**33.6**	**Integrated Performance – Workforce** Karen Broughton to provide an update on staff health and wellbeing.	KB 25th April 2017	Closed 25th April 2017 combined with action 34.5 see action ref. 51.5. To incorporate in the development of staff health and wellbeing strategy.
28/03/17	**34.5**	**Staff Survey** The Workforce Committee to receive assurance around staff safety and wellbeing.	**PW/KB**	Closed 25th April 2017 combined with action 33.65 see action ref. 51.5. Work in progress
28/03/17	**35.2**	**Quality Governance Committee Report – Bank Staff** ELT to receive further update re- bank staff mandatory training.	**KB** **25th April 2017**	**Matters arising 25th May 2017** The action is being progressed by the Executive leadership Team.
28/03/17	**41.2**	**Business Plan 2017/18** Trust Board to sign off the plan.	**Trust Board** **25th April 2017**	**Agenda 25th May 2017**
25/04/17	**50.1**	**Minutes of previous meeting** Minutes to be updated in line with amendments discussed for item 39.3.	**MK** 25th May 2017	Completed 28th April 2017

25/04/17	**51.1**	**ELT review** Andrew Grimshaw to review the following job descriptions and to provide a recommendation for approval by the Nominations and Remuneration Committee: (i) Medical Director (ii) Chief Quality Officer (iii) Director of Corporate Governance	**AG** 25th May 2017	
25/04/17	**51.2**	**EOC Review** Paul Woodrow to submit a paper providing an update of the EOC review.	**PW** 27th June 2017	Agenda 27th June 2017
25/04/17		**Staff Health & Well-being** Fergus Cass / Jayne Mee / Karen Broughton to discuss and incorporate the following into the Staff health and well-being strategy: (i) Recruiting the right people (fit for the job). (ii) Supporting staff going back to work.	**KB** 25th May 2017	**Matters arising 25th May 2017**
25/04/17	**52.1**	**Board to Ward** Chair to develop plan for NEDs with the assistance of Maeve Stevenson and Chris Doyle.	**HL / MS / Chris Doyle**	Agenda 27th June 2017
25/04/17	**54.2**	**IM&T Strategy** Andrew Grimshaw to present IM&T strategy at May Trust Board meeting.	**AG** 25th May 2017	**Agenda 25th May 2017**

Actions from Previous Trust Board meetings				
31/01/17 17/03/17	**11.6** **11.1**	**International Paramedics** Report to be provided to the Executive Leadership Team on the number of IPs returning to Australia	**KB** 28th March 2017	**Matters arising 25th May 2017** Due at ELT on 12th April Oversight through Workforce & OD Committee
28/02/17 17/03/17	**8.**	**Estates Strategy** - Finalise the strategy document - Strategic Outline Case to Trust Board	**AG** 28th March 2017 25th May 2017	**Revised date of 25th May 2017** for the Trust Board – added to the next iteration of the Forward Planner
28/02/17	**9.**	**CAD – New Year's Day incident** - Final report to Logistics and Infrastructure Committee and Trust Board	**AG** 25th May 2017	**Agenda 25th May 2017** Work in progress.

Report of the Chair – 25 May 2017

1. Cyber-attack on the NHS Friday 12 May 2017

The Service received one Cyber-attack email on Thursday 12 May; this was isolated immediately by the IT department and means that we did not suffer from the chaos that then ensued at a number of NHS organisations across the country.

We are grateful to our expert IT Non-executive Director, Sheila Doyle who was able to assist the Director of Operations, Paul Woodrow, in asking the IT staff the right questions to seek assurance. Gold group convened to understand and manage the impact to the Service throughout the weekend. This was essential in order to manage the issues arising across London, and particular in managing the increasing pressure on the Emergency Operations Centre in dealing with ambulance diverts.

I would like to thank Katy Millard, Deputy Director of Operations who led Gold group, and all of our staff who were on duty that day, both in the control room and out on the road. It is an excellent example of how it takes all parts of the organisation to be in good order to work together to prevent unnecessary harm coming to our patients.

We would also like to thank Paul Woodrow, Fenella Wrigley, John Downard and the IT department staff. Our ability to respond as we did will not have gone unnoticed by NHS England and NHS Improvement.

2. Visit by NHS Improvement (NHSI) – Dr Kathy McLean and Steve Russell

This visit was arranged in advance of the Care Quality Commission's (CQC) Quality Summit on 29 June to enable us to update Kathy and Steve and for them to see for the to see for themselves the progress we have made across the Service since the re-inspection by the CQC in February. They recognised the progress we have made in our overall performance, in implementing Quality improvements; and recruiting key senior staff to ensure we continue at pace on our improvement journey. They visited Fulham station to see the Make Ready service and speak to staff and were particularly impressed by the knowledgeable and positive staff that they met.

3. CQC Quality Summit – 29 June2017

In advance of the Quality Summit I met with Professor Edward Baker, Deputy Chief Inspector of Hospitals and Nick Mulholland, Head of Inspections at the CQC. They asked me about the progress we had made since their visit, and my assessment of where we were now at as an organisation, and said that they concurred with my view.

I clarified with them what they wanted to achieve from the Quality Summit and I can confirm it is for us to focus on the improvements that we have made since February and our plans going forward. It is for our in-coming CEO to set the tone and to share his reflections on the organisation with the aim of assuring our

regulators that whilst we are on a journey of improvement we are no longer a major cause for concern.

We can influence the topics of conversation for the breakout groups with stakeholders. My personal view is that two compelling themes should be:-

- How to we quickly access GP patient records to assist in increasing see and treat and reducing unnecessary conveyance to hospital.
- How to work with Health Education England and the College of Paramedics on developing educational programmes for nurses and Paramedics allowing for interchangeability of service delivery.

4. St John's Ambulance

I met with the Prior Surgeon Rear Admiral Lionel Jarvis to discuss areas of interest and overlap. As an organisation they are reviewing their strategy as the demand for their service and volunteers availability changes. We agreed to stay in contact and as and when both of our strategies develop, to see where working together can be mutually beneficial

5. Improving the Ambulance Response – 22 May 2017

I will be delivering a presentation at the above conference titled 'Creating and ambulance service fit for the future'.

6. Executive appointments'

Interim Chief Information Officer (CIO) – Ross Fullerton
We are delighted to introduce Ross who has joined us for a period of six months in the first instance to manage our IT department and to lead the developments.

Ross has joined from the defence and intelligence sector where he held senior IT leadership roles across the technology functions. Prior to this he led IT departments at Centrica (owners of British Gas), led the transformation of BP's IT infrastructure services and worked with Marks & Spencer to stabilise their core inventory and logistics platforms.

On Thursday last week I visited the IT department at Union Street and spent some time with him and the entire team.

Interim Director of Finance – Lorraine Bewes
Lorraine is an experienced Director of Finance will be taking over from Andy Bell and has started to meet the Finance team, John Jones as Chair of the Audit Committee and is getting up to speed on our strategic planning.

Corporate Governance – Philippa Harding
Philippa has joined us on secondment t from NHS Improvement and by now most will have met her.

Dawn Jervis and Jacqui Bate – experienced HR managers have joined us to accelerate the restructuring in Operations, Quality and IT departments and to prepare the way for Patricia Greenish to develop the People strategy.

Garrett Emerson CEO and Philippa Grealish Director of People and Organisational Development commence their roles on 30 May 2017 and their respective induction programmes are being developed.

Thank you and Good bye

This is a month of farewells… Charlotte Gawne is leaving us to join South West London STP – we are grateful to her for the energy and professionalism that she has brought to LAS; and for her role in helping us to engage better with staff and external stakeholders.

Andy Bell leaves his substantive role as Deputy Director of Finance to take up a promotion as Director of Finance in an NHS foundation Trust. Andy has been an excellent deputy and easily stepped into the role of Interim director when Andrew became interim CEO.

Andrew Grimshaw leaves to take up the role of Director of Finance at St George's' having been an excellent Director of Finance at LAS where he has overseen a team of accountants who, deliver us a clean set of results whilst also developing the next generation director.

He stepped into the interim CEO role in December 2016 and through his clear understanding of data has put structure around the Executive team, built relationships with our Regulators and Commissioners and enabled the team to make considerable improvements in our service.

We will miss all three of them and would like to take this opportunity to wish them every success in the future.

Heather Lawrence OBE
Chair

London Ambulance Service NHS Trust

Report to:	**Trust Board**
Date of meeting:	**25th May 2017**
Document Title:	**Annual report 2016/17 incorporating the Annual Governance Statement**
Report Author(s):	**Kayleigh McGrath, Stakeholder Communications Manager**
Presented by:	**Charlotte Gawne, Director of Communications**
Contact Details:	**kayleigh.mcgrath@lond-amb.nhs.uk**
History:	**A draft version of the report has previously been shared with the Audit Committee, external auditors, and the Executive Leadership Team.**
Status:	**For approval**

Background/Purpose

The annual report 2016/17 provides an overview of the London Ambulance Service NHS Trust over the past year.

The report is a requirement and is shared with NHS Improvement (NHSI) and the Department of Health, as well as being available to the public and stakeholders.

The Annual Governance Statement (AGS) is incorporated in the Annual Report but is also submitted to the auditors and the Department of Health as a standalone document. The AGS is the key governance summary for the year and describes the governance arrangements and the key risk areas.

Action required

The Trust Board is asked to approve:

- The Annual Report 2016/17
- The Annual Governance Statement 2016/17

Key implications

Both reports provide a comprehensive account of 2016/17 and the challenges facing the Trust.

Key implications and risks arising from this paper	
Clinical and Quality	
Performance	
Financial	
Workforce	
Governance and Well-led	The reports are a key governance requirement for the Trust.
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	
Achieving Good Governance	**Yes**
Improving Patient Experience	
Improving Environment and Resources	
Taking Pride and Responsibility	

London Ambulance Service
NHS Trust

Annual Report
2016/17

London Ambulance Service Annual Report 2016/17

Contents

Foreword from Chairman Heather Lawrence and Chief Executive Andrew Grimshaw

As a Trust in special measures, our focus during 2016/17 has been to bring about change to enable us to deliver better care for our patients and make our Service a better place to work. We have achieved this through our quality improvement plan which supports our vision of *Making the LAS great*, and has focused on the actions that each of us can take to improve our Service. While we recognise we remain challenged in some areas, we have made significant progress towards improvement.

Our dedicated and talented staff are critical to our success and we can only deliver excellent care when they have the right support and resources. During 2016/17 we have continued to invest in our workforce, recruiting over 350 frontline staff while implementing a range of measures to improve access to training and development. Ensuring our workforce is as diverse as the population it serves has been a priority, and an action plan has been implemented to ensure progress. Alongside this, significant work has taken place to improve our organisational culture, and make the London Ambulance Service a great place to work. Our recent staff survey results demonstrate progress; of the 88 key questions, 67 are significantly better than in 2015/16.

As part of our improvement plan, we have also strengthened our governance systems, processes and structures, including the way we report and learn from incidents and through the recruitment of a chief quality officer. The roll-out of our digital medicines management system and vehicle 'make ready' schemes has allowed our medics to work more efficiently and spend more time treating patients. The purchase of 140 new ambulances and new hazardous area response team vehicles, to be delivered in the coming year, alongside 60 new cars already on the road, will ensure our staff have the resources they need to care for patients.

Improving the quality of our services remains a key focus and we were delighted to receive a rating of "Good" from the Care Quality Commission (CQC) for our NHS 111 service for South East London in February 2017. During their visit, the CQC observed how our staff treat patients with compassion, dignity and respect, and involve them in decisions about their care and treatment. The report demonstrates our commitment to providing high quality care and the role we can play in the delivery of urgent care in the capital.

Notwithstanding our progress, we recognise there is much more we need to do to improve – our journey of change is a marathon, not a sprint. To transform as an organisation, we must become more consistent, embed improvements to make sure they are sustainable, and continue to innovate. We expect the CQC to highlight the need for further improvement in their follow up inspection report on our 999 service, to be published in the coming months.

Like almost all other ambulance trusts, the unprecedented increase in demand means we remain challenged in meeting national performance targets. During 2016/17 we attended more incidents than ever before. In real terms this means we are now handling nearly 200 more incidents a day across the capital, compared with just last year.

We have worked hard with our commissioners to measure demand and ensure our service is responsive. Yet with our aging population, and an increase in those with complex and long term health needs, we must continue to evolve our Service to ensure it remains efficient,

effective and right for our patients. This requires us to work with our partners across the health landscape to ensure our Service is fully integrated into the five sustainability and transformation plans in development across the capital. It also means we must continue to transform from a Service that delivers emergency care and transportation to hospital, towards a Service that increasingly provides diagnosis, treatment and referral in the community where appropriate. Our new clinical strategy, published in January 2017, sets out the path to achieving this.

In 2016/17 we provided BBC One with unprecedented access to our Service to film *Ambulance*, a TV series which followed our frontline medics and control room staff. We reached 4.5 million viewers and were proud to be able show the country the incredible job our staff undertake day in, day out. Opening our doors was not easy, however the documentary resulted in real benefits for staff and patients; increasing the number of people applying for jobs at our Service, significantly boosting pride among staff and crucially increasing public awareness of the pressures we face each day.

HRH The Duke of Cambridge made a private visit to thank staff for their response to the tragic events which took place in Westminster on the 22 March 2017, as did the Mayor of London Sadiq Khan. We are humbled by the response of our staff, and that of the other emergency services who responded with courage and bravery. We also hosted a visit from HRH Prince Harry who launched 'Time to Talk Day' as part of the Heads Together mental health awareness campaign at our HQ in February 2017. We are proud of the mental health support we provide to our staff and grateful to be recognised in this way.

Our new Chief Executive Garrett Emmerson will join us in May 2017. Garrett brings a wealth of experience in management, leadership and logistics in the capital and we very much look forward to welcoming him to the Service. We would like to pay tribute to Dr Fionna Moore MBE who led our organisation as Chief Executive until December 2016. Fionna's leadership brought our staff together at one of the most difficult times in our Service's history.

As we move forward into 2017/18, we continue to build on our values of care, clinical excellence and commitment. Our priorities for the coming year have been developed in partnership with our staff, including through a series of road shows that provided the opportunity for us to hear the views of over 1,000 staff members. We also continue to work closely with other important stakeholders, including our Patients Forum.

It is only through such strong engagement, and by working together, we will continue to transform our Service. We would like to thank everyone for their hard work this year and their continued commitment to delivering high quality care for Londoners.

Heather Lawrence OBE, Chairman **Andrew Grimshaw, Chief Executive**

Performance report

About Us

London Ambulance Service is the busiest ambulance service in the UK. In 2016/17, we handled over 1.8 million emergency calls from across London and attended more than 1.1 million incidents. We are the only London wide NHS trust; employing over 5,100 staff across 70 sites in London to respond to the health needs of over eight million people who live and work in the capital.

Working across London presents specific challenges: over 150 languages are spoken; we have a transient population with people moving in and out of the city; and there are extremes of wealth and poverty and significant variations in quality and health outcomes. We therefore work hard to engage with the diverse population we serve and to ensure our services are accessible to all Londoners.

The London Ambulance Service in 2016/17:

As an integral part of the NHS, we work closely with partners across London. Commissioned by 32 clinical commissioning groups and NHS England for our specialist services, we also work closely with London's hospital, mental health and specialist trusts, as well as the five sustainability and transformation plans across the city. In addition we work in partnership with the other emergency services and London's Air Ambulance.

We are governed by our Trust Board, which meets monthly. It is made up of 13 members – a non-executive Chairman, five executive directors (including the Chief Executive), and six non-executive directors[1].

[1] As of 31 March 2017.

Our services

Our main role is to respond to emergency 999 calls, getting medical help to patients who have serious or life-threatening injuries or illnesses as quickly as possible.

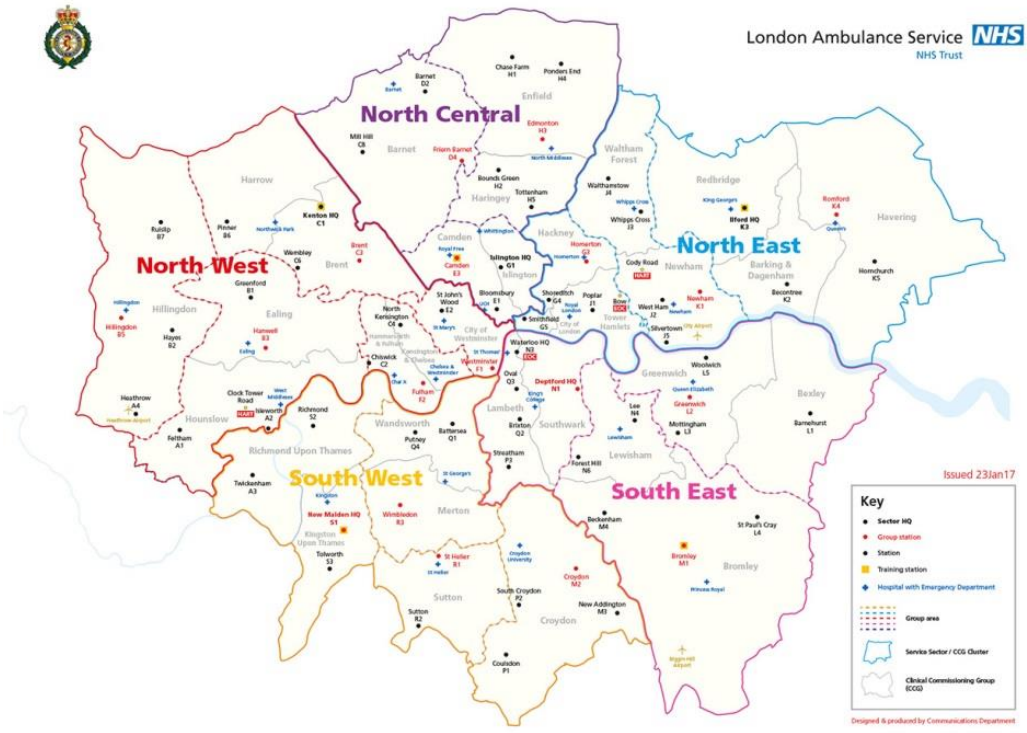
However, many of our patients have less serious illnesses or injuries, and do not need to be sent an ambulance on blue lights and sirens. Often these patients will receive more appropriate care somewhere other than at hospital and so we provide a range of care, recognising that many have complex problems or long-term medical conditions.

To meet the needs of all Londoners requiring emergency and urgent care we provide the following services:

- Call handling – taking and prioritising 999 calls
- 999 emergency and urgent care response
- Clinical telephone advice – providing advice to members of the public with less serious illnesses and injuries that don't need an immediate ambulance response
- Dispatching and providing paramedics for London's Air Ambulance
- 111 Service – we run the 111 service for south east London
- Planning for, and responding to, large-scale events or major incidents in the capital.

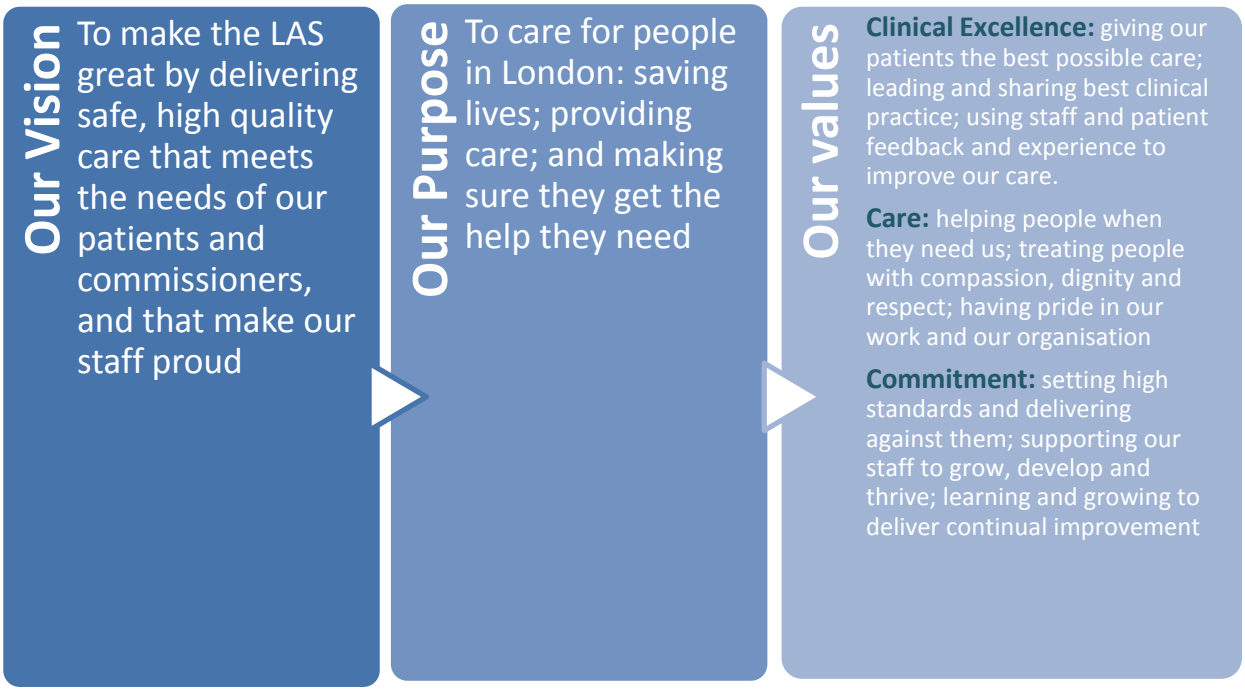
In 2016/17, we received approximately 5,000 emergency calls per day into our emergency operations centres located in Waterloo and Bow.

Our frontline services are structured to support the five sectors of London, ensuring we deliver a pan-London service and the flexibility to respond to local need. Operational and corporate support services are delivered centrally from our Headquarters in Waterloo, and from offices in Pocock Street and Union Street in central London. Our NHS 111 service is delivered from Southern House in Croydon, south London.



Our vision, purpose and values

Our vision, purpose and values shape all that we do. Developed in partnership with staff and stakeholders, these are:



Key issues

Care Quality Commission inspection and our quality improvement plan

In June 2015, we were placed in special measures on the recommendation of the Care Quality Commission (CQC) following a planned inspection.

Following this inspection, we developed our quality improvement programme – a single overarching plan to address quality improvement in our Service, led by the Chair and accountable to our Trust Board. A clear programme of delivery, accountability and governance was established, led by our Director of Transformation, Strategy & Workforce and supported by a programme management office, to ensure oversight and leadership.

Our improvement programme was categorised into five key themes, each with an executive director accountable for delivery:

- Making the London Ambulance Service a great place to work
- Achieving good governance
- Improving patient experience
- Improving environment and resources
- Taking pride and responsibility

By the end of the 2016/17, the vast majority of the projects within our plan were completed, with a number of actions being incorporated into business as usual for directorates. Projects

of a more complex nature, which are yet to be completed, are being incorporated into the 2017/18 business plan. Our focus is now on embedding change, to make it consistent across our organisation. This will be delivered through a transformation programme to begin in 2017/18.

The CQC has conducted two further inspections since June 2015. A focused inspection was carried out in September 2016 and a comprehensive full trust inspection was completed in February 2017.

The three core services listed below were inspected in February 2017:

- Emergency operations centres
- Urgent and emergency care
- Resilience planning including the hazardous area response team

During the inspection we spoke to the CQC about the impact we believe our work over the last year has made on our clinical care, our capacity and performance and our staff morale and culture. Their report is expected to be published in summer 2017.

Risks

Our Trust Board manages risk through our risk management policy, corporate risk registers and board assurance framework.

The board assurance framework and corporate risk register are presented at each meeting of our Trust Board, and further scrutiny is applied through the Quality Governance and Audit Committees. The risk register is reviewed in detail by our Executive Leadership Team each month.

Full details can be found in our governance statement on page 31 of this document.

Going concern statement

Our accounts have been prepared on a going concern basis. This is based on the expectation that we will be able to maintain a positive cashflow across 2017-18, not require any external financial support to achieve a positive cashflow and will be able to pay our creditors across 2017/18 as they fall due. Our management expect these conditions to be met in and continue beyond 2017/18.

Performance Analysis

Our Patients

We aim to provide our patients with the highest quality care and contribute towards Londoners having health outcomes among the best in the world.

Although we were placed in special measures by the CQC in 2015, our overall care of patients was rated as 'good', with the CQC recognising that patients in London receive good clinical care and that our staff are caring and compassionate.

Caring for our most seriously ill and injured patients

Cardiac arrest patients

Patients in cardiac arrest – when their heart stops, and they are clinically dead – are among our highest priority patients.

Our latest cardiac arrest report, published in November 2016, shows that during 2015/16, we attended 10,116 patients in cardiac arrest. Our published survival figures for those patients with the best chance of survival are amongst the highest in the country; just under a third (31.5 per cent) of cardiac arrest patients survived to leave hospital[2].

A defibrillator is a machine that is used to shock a patient's heart to restart it when they are in cardiac arrest. In 2013, we launched a defibrillator accreditation scheme which provides a package of support to shops, gyms, businesses and other organisations across London who purchase a defibrillator. Since its introduction, there has been a huge increase in the number of public access defibrillators across London, from 995 in 2012/13 to 4,486 as of March 2017. We have also been working closely to support our Patients Forum who have an on-going campaign to encourage businesses to install defibrillators.

Where a defibrillator in a public place was used to deliver a shock to patients in shockable heart rhythms, 57.3 per cent of patients survived to leave hospital[3].

Heart attack patients

There are eight specialist centres in London where we take patients who are believed to be having a heart attack, known as an ST-elevation myocardial infarction (STEMI). Taking patients to a specialist centre rather than a local hospital allows quicker access to treatment. This can include primary angioplasty, a procedure which involves inflating a balloon inside an artery to clear the blockage that has caused the heart attack.

Latest provisional data for 2016/17 shows our average response time for STEMI patients was within the national target of eight minutes. During the year, over 3,500 patients were treated by our staff and subsequently transported to an appropriate facility, which for the majority was a specialist heart attack centre.

[2] These survival figures relate to a specific group of patients who were witnessed to suffer an out-of-hospital cardiac arrest of cardiac cause with an initial shockable rhythm. London Ambulance Service, Cardiac Arrest Annual Report: 2015/16 published November 2016

[3] ibid

Trauma care

Patients with the most serious injuries such as falls from height, stab or gunshot wounds are taken directly to one of four specialist major trauma centres in the capital: The Royal London Hospital, St George's Hospital, King's College Hospital and St Mary's Hospital. Evidence from around the world shows that rapidly conveying these patients to centres with specialist expertise and equipment saves lives and reduces long-term disability.

Our most recent major trauma annual report, published in January 2017[4] shows that 99 per cent of patients who needed to be transported directly to a major trauma centre were identified and taken to the right hospital for their injuries.

Responding to major trauma patients is a vital albeit small part of our work, equating to less than 0.5 per cent of the total workload.

Stroke patients

We take patients we suspect to be having a stroke to one of eight specialist stroke centres in London. Here they have rapid access to life-saving treatment which can increase their chances of survival and cut the risk of long-term disability caused by a stroke.

We attend approximately 1,200 suspected stroke patients every month. Our provisional data for 2016/17 shows that we appropriately convey 99 per cent of patients believed to be having a stroke to a hyper acute stroke unit, with 61 per cent of patients eligible for thrombolysis, a clot-busting treatment, arriving at an appropriate hospital within 60 minutes of the 999 call.

Over the last year, we have represented the UK ambulance services in the development and review of evidence-based national clinical guidelines for the management of stroke in adults and children.

Full details of our performance against the national Ambulance Quality Indicators can be found in our 2016/17 Annual Quality Account.

[4] Major Trauma Annual Report 2015, published in January 2017

Improving urgent and emergency care: Advanced paramedic practitioners

We introduced an advanced paramedic practitioner scheme in 2014 to enhance the level of care provided to our most seriously ill and injured patients, as well as those with complex pre-hospital care needs. Twenty four advanced paramedic practitioners operate out of four sites around London, responding to approximately 600 calls per month.

In January 2017, eight new advanced paramedic practitioners for urgent care were recruited from within the Service to enhance the care provided to patients with complex long-term conditions and less critical illnesses. The scheme is part of a 12-month pilot which aims to treat more patients in their homes without need the need to go to hospital.

The urgent care advanced paramedic practitioners specialise in treating patients with chronic conditions such as chronic obstructive pulmonary disease and back pain, providing treatments and medications which would normally be provided in other settings, such as urgent care centres and primary care.

It is hoped the pilot will help reduce pressure on A&E services, unnecessary conveyances to hospital and lead the way in enabling us to develop urgent care services which are responsive to the needs of our patients.

Caring for patients with urgent care needs

Identifying appropriate care

Whilst our core purpose always has been to save lives, urgent and unscheduled care forms a significant and increasing part of our work.

As such, we are adapting our Service towards staff assessing and treating patients at scene and in community settings, with transport to alternative care settings where appropriate. This can include transferring patients to minor injuries units, urgent care centres and walk-in centres where appropriate.

Our clinical hubs, based in our emergency operations centres and staffed by clinical team leaders, paramedics, nurses and mental health nurses provide a range of services to ensure that patients receive the most appropriate care for their condition.

This includes a hear and treat service where we provide clinical telephone advice for callers who have called 999 but do not have a serious or life threatening condition. Our clinical advisers offer advice on the best course of treatment for the patient—this could be care at home, being referred to a doctor or local pharmacy, or having an ambulance sent to them. We transfer around 10,000 calls a month to our hear and treat service.

During 2016/17, we continued to work closely with our local commissioners, the sustainability and transformation plan partnerships, 111 providers and community services to increase and improve access to services for patients where it’s not necessary for them to go to hospital.

Improving care for mental health patients

999 and NHS 111 are often the first point of care for patients experiencing a mental health crisis, and we continue to see a year-on-year increase in calls to these patients, with a 10.5 per cent increase in incidents[5] in 2016/17 compared to last year.

We recognise the important role that we have in risk reduction, and in signposting these patients to the most appropriate point of care or service. These calls are often complex, and take time to manage well.

Two years ago we introduced specialist mental health nurses into our emergency operations centre, to provide telephone support to ambulance crews and to provide a hear and treat service for patients, with the aim of reducing the need for an ambulance response. This initiative was shortlisted for a national Patient Safety Award in 2016 and the role is continuing to develop.

Through the mental health nurse team we continued to establish links with mental health trusts across London, allowing us to liaise with the crisis teams, develop new pathways and deal with adverse incidents or concerns. We have had a number of very successful joint training events during 2016/17 and are starting to see improved staff confidence in managing this group of patients.

Working in partnership

We continue to maintain a close working relationship with London's blue light services and other organisations. During 2016/17, we developed these relationships further to improve our response to patients. This included:

- Our co-responding trial with the London Fire Brigade, where fire crews in four boroughs are responding to a small number of our highest priority calls alongside our ambulance crews. If fire officers are closer to an incident, they are able to provide emergency life support until our clinicians arrive.

- Working with the Metropolitan Police Service to increase access to defibrillators. A trial in four boroughs has seen 110 defibrillators added to police vehicles, enabling police officers to respond alongside our crews to people in cardiac arrest.

- Working in partnership with the internationally acclaimed GoodSAM app, where clinically trained ambulance staff and members of the public, trained to an approved standard, are able to sign up as volunteers to respond to life-threatening emergency calls, including cardiac arrests. The app automatically alerts the closest two responders to an emergency call.

- Active involvement with the five sustainability and transformation plans across London, with representation from both executive director level and also from senior operational managers

[5] Data for data for April 2016 to January 2017 in comparison to the same period the previous year.

Improving our care

Our clinical strategy

In January 2017, we published our clinical strategy setting out our clinical aims for the next five years and defining how we will deliver urgent care and NHS 111 services as part of the integrated and emergency care plans for each of the five London sustainability and transformation plan footprints.

The strategy outlines how ambulance clinicians will continue to develop their role in line with the Five Year Forward View, moving from delivering first aid and transportation to hospitals, towards a greater emphasis on decision-making, diagnosis, treatment and referral.

The overarching urgent and emergency care vision for our Service for 2016-2021 is:

- *for adults and children with urgent care needs*, we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients, carers and families.

- *for those people with more serious or life-threatening emergency care needs*, we should ensure they are treated at the scene and then in centres with the right expertise and facilities to maximise the prospects of survival and good recovery.

To deliver this strategy, we will continue to develop a professional multi-disciplinary workforce with enhanced clinical capabilities, decision-making skills and leadership who are able to work as an integral part of the wider London healthcare system.

Improving care for bariatric patients

We recognise that we need to do more to respond to the increasing number of bariatric patients in London, and in 2016/17, we set up a working group to review our bariatric requirements. We are currently testing new equipment suitable for moving and assisting patients, and we are also looking at buying specialist vehicles to reduce our dependence on private providers.

Over the coming year, all clinical crews will receive training in managing emergencies for this group of patients.

Palliative care: Coordinate my care

The ambulance service is often the first point of contact for patients nearing the end of their life. This includes planned transfers from an acute care setting to the patient's preferred place of death; unplanned involvement following a sudden crisis, deterioration or worsening symptoms and involvement at, or immediately after, the patient's death.

Our clinicians are often presented with situations in which they have to make decisions about attempting resuscitation. These decisions may need to be made on the basis of limited information and in the context of a distressed family.

We are improving the way we integrate with, and access, specific end-of-life care plans (Coordinate my care records) so that our clinicians have early access to these to enable them to manage these situations better.

We are also investing in a range of different educational opportunities in partnership with the third sector and other providers to ensure that our crews have a clear understanding of the legal and ethical basis for the complex decisions that need to be made in these circumstances.

Improving care for patients with sickle cell disease

We responded to over 4,000 patients in sickle cell crisis in 2016, and of all hospital admissions related to sickle cell disease in the UK each year, 75% are in London. To improve our care for patients in this group we carried out our third sickle cell crisis clinical audit during 2016/17. This analysed both clinical data and patient experiences and found that the care we provide to patients in sickle cell crisis has improved dramatically in recent years and is of a high standard. The audit also made a number of recommendations on how to further improve our service. As a result, managing the care of sickle cell patients was included in the 2016/17 annual training provided to all our clinicians.

Clinical audit and research unit

Our clinical audit and research unit has responsibility for all clinical audit and research within our Service.

We increased the number of projects last year and our external funding also increased. We attracted over £600,000 for research projects that were active during 2016/17, and received a 62 per cent increase in funding from the North West London Clinical Research Network to support activity and build capacity.

Research that we were involved in during the year includes:

- Developing and validating a triage tool (via a smartphone app) to identify potential ruptured abdominal aortic aneurysms. Over 506 of our clinicians used this app on more than 5,000 patients.
- We recruited over 1,500 patients into PARAMEDIC-2 - a ground-breaking randomised controlled trial comparing adrenaline use to a placebo in out-of-hospital cardiac arrest.

- Towards the end of the year, we started the RIGHT-2 trial - a randomised controlled trial to determine whether giving Glyceryl trinitrate (GTN) to suspected stroke patients improves survival and neurological functioning.
- We continue to manage the website for the National Ambulance Research Steering Group which provides a platform for UK ambulance services to promote their research capabilities and activities. This website is also the first point of contact for researcher's wishing to collaborate with ambulance services.

We shared our research findings by publishing eight papers in peer-reviewed journals and presenting our work at six national conferences during the year.

We continued with our comprehensive clinical audit programme to demonstrate clinical quality and inform improvements. During this period, 50 frontline staff were directly involved in working with us on clinical audit projects.

As a direct result of our clinical audit, the 2016 National UK Ambulance Service Clinical Practice Guidelines were updated to clarify the indications for giving IV Paracetamol.

Our work on paediatric sepsis helped inform the development of our paediatric sepsis screening tool, to be introduced in 2017/18.

We continued to monitor the safety and management of patients who were not taken to hospital after a 999 call, but for whom a subsequent re-contact was made (within 24 hours) and the patient had seriously deteriorated or died. Feedback was recommended for nearly 300 members of frontline and control room staff (reflecting both areas for improvement and good practice).

During the year we also developed two new clinical performance indicators (elderly falls and continuous fitting) which will be introduced in 2017/18.

Reporting and learning from incidents

Over the previous 12 months, 495 cases were reviewed and 103 incidents were declared as serious to NHS England (London), with fourteen of these since being de-escalated.

In its follow-up inspection the CQC found that incident reporting had started to increase within our Service with the introduction of the Datix online reporting system, though the system had yet to be fully embedded.

As in previous years, the number of ambulance delay-related serious incidents has remained a consistent theme, although in 2016/17 we have seen a wider range of incidents declared including issues with clinical assessment and call handling.

Our newly appointed Chief Quality Officer will lead an in-depth review of serious incidents in 2017/18, aiming to reduce the time it takes to complete investigations and improve the quality of them.

We have introduced a learning from experience group chaired by an assistant medical director with input from across the organisation. In a bid to increase learning across the organisation, the group has:

- issued two editions of Insight magazine
- provided a series of infographic posters for display in ambulance stations

- informed the content of our core skills refresher programme
- introduced positive incident reporting.

Duty of candour

Duty of Candour requires trusts to inform and involve patients and their families in investigations where there has been severe harm. It is a mandatory requirement under Regulation 20 of the Health and Social Care Act.

We continued to roll out our duty of candour training through last year to all non-clinical staff to ensure there is awareness across the organisation. There have also been a series of duty of candour training sessions as part of the serious incident investigator training that goes into more detail for the benefit of people undertaking the family liaison officer role.

Compliance with the duty is recorded on Datixweb and monitored on a monthly basis. Quality governance and assurance managers have been duty of candour champions across sectors, giving support and advice to frontline staff. Our current compliance with duty of candour is 92 per cent.

Learning from experience: Insight magazine

In November 2016 we launched 'Insight', a new learning from experience magazine which highlights learning that has happened as a result of serious incident reports, incidents, risks and complaints.

It also looks at sharing best practice and highlights the changes that have been made in the Service as a result. The magazine is circulated throughout the organisation and includes clinical andnon-clinical learning.


London Ambulance Service NHS
NHS Trust

INSIGHT

Issue 2, Spring 2017

INSIDE...

2 THE PATIENT'S BEST INTEREST

3 DON'T DELAY...

4 MORPHINE FOR CHILDREN?

5 TRACHEOSTOMY TROUBLE

6 TRIAGE PROTOCOLS

7 AIRWAY CARE SAVES LIVES

8 TRANSPORT OPTIONS

The photos featured are from the Trust Media Resources Library and are NOT linked to any of the cases reported.

Sign up to SAFETY

Listening to patients

Our Trust Board approved our new patient engagement strategy in July 2016. Developed in partnership with patient groups, the strategy outlines our commitment to patient and public engagement to 2020, focusing on:

- increasing meaningful engagement with patients so that their views influence service changes and strategic decision-making, as well as decisions about their care
- increasing our commitment to patient engagement across the organisation
- ensuring we are prepared to respond to changes in external requirements in the field of patient engagement
- improving engagement and relationships with partner agencies, patient and community groups and individuals. For example, by providing information, involving patients in our activities, and teaching life-saving skills.

During 2016/17, we launched two leaflets designed to encourage patients to tell us their views of our Service: a ‘speaking with us’ feedback leaflet available on every ambulance, and a ‘complaints feedback’ leaflet to ensure that we know how complainants felt they were treated whilst making a complaint.

We also initiated an ‘Insight Project’, designed to bring together staff and specific groups of patients to explore how we could improve our services for particular groups. In addition, we worked with the RNIB to undertake research into the experience of blind and partially-sighted patients using ambulance services, which has led to the production of braille stickers for staff ID badges.

We have an active and engaged Patients’ Forum, who regularly review our work from the point of view of service users, carers and the public. The Patients’ Forum acts as a "critical friend", and its members represent patients at a range of committees.

Community engagement events

We remain committed to supporting a wide range of patient engagement and public education events, and during 2016/17 we attended 518 events. Our ability to attend so many events is due to the ongoing support of over 1,000 staff on our database with 328 individuals taking part in multiple events, often in their own time.

The range of events we attend is extensive and includes:

- Basic life support and cardiac awareness
- Careers talks
- Junior citizen schemes
- Knife crime awareness
- London Ambulance Service talks
- First aid badges (brownies, cubs etc)
- Road safety initiatives
- Mental health awareness
- Underage drinking talks.

We have two public education officers who focus on delivering awareness sessions on the dangers of carrying knives and legal highs for young people.

Our Performance

Demand on our Service increased again this year, providing challenges for us. Whilst we provided a safe service, we were unable to reach our most seriously ill and injured patients as quickly as we wanted to, and faced with almost 200 more 999 incidents a day, we did not meet our national response time targets.

Our 111 service in south east London was recognised to be providing a good service by the CQC when it visited in September.

Delivering 999 performance

In 2016/17, we received 1,826,808 emergency calls in total - approximately 5,000 calls every day. This is a 1.4 per cent increase on 2015/16.

From these we responded to 1,115,945 emergency incidents, a 6.6 per cent increase on the previous year.

Category A – life-threatening calls:

National performance targets are set by the Department of Health and apply to every ambulance service in England. The targets measure the Service against the percentage of calls responded to in eight or 19 minutes depending on the priority of the call, with Category A calls measured as the highest priority.

Category A calls are subdivided into Red 1 calls and Red 2 Calls as follows:

Red 1 calls are the most time critical, and cover cardiac arrest patients who are not breathing and do not have a pulse, and other severe conditions such as airway obstruction. At least 75 per cent of these patients should receive a response within eight minutes.

Red 2 calls are serious, but less immediately time critical, and cover conditions such as stroke and fits. At least 75 per cent of these patients should receive a response within eight minutes.

A target known as A19 is designed to measure the percentage of Red 1 and Red 2 calls where a fully equipped ambulance arrives within 19 minutes. The target is to achieve this in 95 per cent of cases.

Of the total calls we received, 601,556 were treated as life threatening (Category A) - up more than 6.8 per cent from 2015/16 (563, 320 calls).

We attended over half a million Category A incidents last year (548, 896), up nine per cent on the previous year (505, 045 incidents). And we reached 66.4 per cent of these patients within eight minutes.

We arrived at 93.48 per cent of Category A patients within 19 minutes.

TARGET	National Target	2016/17 LAS Performance	2015/16 LAS Performance
RED 1- within 8 minutes	**75%**	69.19%	68.46%
RED 2- within 8 minutes	**75%**	66.31%	63.68%
RED 19- within 19 minutes	**95%**	93.48%	93.40%

Category C – lower priority calls

All other calls we receive fall into one of four C (lower priority) categories. Our target response times for Category C incidents are:

- Category C1 - 45 minutes
- Category C2-C4 - 60 minutes

In 2016/17, we received 1,225,216 Category C calls. We attended 567,020 Cat C incidents compared to 542,314 last year, an increase of 4.5 per cent. And we reached 74.5 per cent of these patients within our target time, compared to 73.9 per cent last year.

All statistics in this section are validated as of 21 April 2017

Delivering NHS 111 performance

Since November 2013, we have provided NHS 111 services for patients in South East London, covering Bromley, Bexley, Greenwich, Lambeth, Lewisham and Southwark. NHS 111 is a telephone assessment service for people who need urgent medical help and advice but are not in a life-threatening situation. Calls are answered by highly trained advisors, who are supported by healthcare professionals, 24 hours a day, 365 days a year.

On average our 111 service manages around 760 calls a day during the week, up to 1,480 on a Saturday or Sunday and as many as 2,080 calls on bank holidays.

In 2016/17 our 111 service received 316,946 calls. We transferred 7.6 per cent of calls to the 999 system, the lowest proportion across 111 services in London.

Following an inspection in September, the CQC rated our 111 service as ‘good’, with a rating of good achieved in every one of the five domains. The CQC stated:

'*The London Ambulance Service (LAS) NHS 111 service provided a safe, effective, caring, responsive and well-led service to a diverse population in South East London*'

As part of the report, the CQC made a small number of recommendations on how our service can be improved, which we have already started to address. These include the recruitment of permanent clinical staff, improving our telephony system and increasing opportunities for staff to meet as a team.

Providing patient transport service and non-emergency transport services

Our patient transport service takes patients to and from their pre-arranged hospital or clinic appointments, and during 2016/17, we delivered six patient transport contracts.

We are commissioned through a tender process, and due to the reducing number of contracts we hold, we made the difficult decision in September 2016 to withdraw from the patient transport service market as the service had become financially unviable.

We are currently working with our remaining commissioning trusts to ensure that services are maintained until an appropriate transfer can be made to new providers. We will stop providing our patient transport service during 2017.

Our non-emergency transport service was set up in June 2015 to support our core A&E service in transporting low priority patients to healthcare facilities where there is little or no clinical intervention required en route. As a result we are able to increase the availability of frontline crews to attend life-threatening calls and ensure lower priority patients receive transport within an agreed timeframe, providing for a better patient experience.

The number of journeys completed by our non-emergency transport service has continued to grow, from approximately 100 journeys a week when the service was set up to approximately 800 journeys a week at the end of this financial year.

Preparing for and managing large-scale events and incidents

We plan for and respond to large scale events in the capital. These include major sporting and cultural events such as the Notting Hill Carnival and the London Marathon where we work alongside St John Ambulance to provide patient care.

During major incidents, we work closely with other emergency services and partner organisations in London to save lives.

Our responsibilities include:

- putting hospitals in London on alert to receive patients
- setting up a system at the scene for prioritising and treating patients based on their medical needs
- treating, stabilising and caring for people who are injured
- taking patients who need further treatment to hospital.

We test our major incident plan on a regular basis, often with our partners. And our planning was put to the test with a number of incidents during the year, most notably the tram crash in Croydon and the terror attack in Westminster.

In early November we responded to a tram derailment in Croydon where we treated a large number of patients, taking 50 of them to hospital with the support of trauma teams from London's Air Ambulance.

Almost 70 frontline staff treated patients at Westminster in March when a man drove into people on the bridge before stabbing a police officer. We took 23 of the patients who we treated to hospital following the attack.

Our hazardous area response teams who attended both incidents are trained to provide emergency medical care in hazardous areas such as confined spaces or where there may be hazardous materials. When the CQC visited our Service in 2015, they raised a number of concerns about these teams, particularly the number of vacancies in the team and low level of shifts that were covered (at 24 per cent). We have since increased our establishment to 98 so that we now have 99 per cent of our hazardous response team shifts covered.

Improving our response

Our vehicles

During 2016/17 we have focused on increasing the availability and efficiency of our vehicles to enable our crews to provide the best possible care to patients. During the year we have:

- Approved a new fleet strategy to ensure our vehicles meet the needs of our patients and clinicians whilst providing value for money and supporting our environmental responsibilities
- Introduced 60 new fast response vehicles into service, carrying sophisticated medical equipment to support the needs of frontline staff. The vehicles have been well received and a second batch of new vehicles will enter service during 2017/18
- Purchased 140 new ambulances to be delivered throughout the coming year
- Replaced all of our hazardous area response team vehicles.

A key focus during the year has been upgrading our process for cleaning, equipping and preparing our vehicles. We are now using an approach where vehicles are ferried in to 14 hub sites across London to go through a robust preparation process, ensuring vehicles are cleaned and equipped in a consistent way across the Service. We introduced the new process through gold (final) and silver (interim) services starting in September 2016. At the end of March 2017, five gold and nine silver sites were rolled out as planned.

We have already seen a significant increase in the number of vehicles available for our crews, rising from an average of 305 vehicles per day in October 2016 to 324 vehicles in March 2017. The number of hours that vehicles are out of service hours due to missing equipment has reduced by 71 per cent between January and March 2017 compared to the same period in 2016. Feedback from gold service hub sites has been encouraging with staff recognising the improved cleanliness and equipping standards of vehicles.

The project remains on track to upgrade the remaining nine silver service sites to the gold service by the end of July 2017.

Managing medicines

Over the last year, we have seen a significant and sustained improvement in medicines management, building on measures put in place in response to the CQC's findings. We have reviewed our processes and procedures so that we are able to trace and account for medicines, from receipt in our logistics support unit to the point at which they are administered to patients. A range of technological solutions have been designed and implemented to support supply, administration and audit of medicines.

In February 2017, we appointed a full-time pharmacist to lead and develop our medicines management programme, and our medicines management group continues to meet regularly and provide advice and support to all areas of the organisation.

Over the last year we also:

- delivered a comprehensive programme of education relating to medicines management for frontline clinical staff
- introduced mobile electronic tablet technology and an associated Perfect Ward app to facilitate paperless medicines management audit and real time upload of audit results
- implemented the kit prep app to enable electronic scanning of drugs packs at stations to allow us to drug pack movements through the system
- developed MedMan an information technology portal to reconcile drugs usage forms with clinical records, providing assurance that drugs removed from packs are administered to patients. This also provides data on trends in drug usage and a means of tracing drugs in the event of batch recall or other concerns.
- introduced an additional 800 new drug packs and agreed minimum numbers to be available at each ambulance station

As a result of increased reporting methods, dedicated quality managers within the operational sectors and a tracking system for the administration of medicines to patients, we have seen a marked increase in the number of drug errors reported. And we have held round tables where members of the medical directorate have met with staff, providing time for learning, guidance and support.

Information management and technology

Throughout the year we have upgraded some of our core systems and introduced new technologies into the organisation to support the delivery of patient care. These include:

- New airwave radios on all frontline vehicles and the redevelopment of our mobile data terminals to allow new satnavs to be introduced during 2017/18
- The redesign of our digital pocket guide app, which has over 2,300 registered users, so that staff have better access to reference information and local maps for location information.
- The introduction of Surface Pro tablets and smart phones for our incident response officers and roll-out of digital display screens to stations and control rooms where key information can be made available.

- Replacement of computers in both our control rooms alongside an update to our radio control system software. A new telephony system has been installed at our 111 service in Croydon.
- The introduction of new door and gate access cards system across Service to improvement security.
- Working with our logistics and clinical teams to implement our new medicines management systems.

During 2016/17 we experienced some technical difficulties with our Computer Aided Dispatch System which we use to take emergency calls and despatch ambulances. This includes an outage on 1st January 2017 which required our staff to revert to manual processes. As a result, our control room logged emergency calls using a manual back-up system for around five hours.

Our control room staff are fully trained and practised in operating this way and continued to prioritise patients in the same way, using the same assessment process as usual. However, as a manual system is not as efficient as a computer-based one, it took longer to manage calls.

Following the incident we launched a full external investigation, working with NHS Improvement and NHS England alongside an independent IT expert to look at the exact circumstances of what happened and any impact this may have had on our patients. This report is to be published in spring 2017.

Supporting sustainability

We are committed to making improvements in all aspects of our environmental performance, recognising that reducing our carbon impact on the environment in which we operate is critical for the communities we serve, for patients, our finances, our environment, and the planet.

One of the key aims of our current procurement strategy is to embed sustainability within its supply chain. We are aiming to ensure that social, economic and environmental issues are considered during all stages of our procurement process, and are developing policy and procedures to support this.

Our sustainable procurement aims are to:

- increase awareness of sustainable procurement principles within each departmental spend category
- promote the sustainable purchasing policy, strategy, aims and objectives to key internal stakeholders
- embed good practice in sustainable procurement in day-to-day working and as part of the procurement process. Consider the whole life cycle impacts of the procurement
- undertake sustainability risk/impact assessments of products and services and their supply chains and prioritise
- ensure that environmental, social and economic impacts are appropriately considered in the assessment of value for money when setting up contracts or framework agreements

- manage tendering and lotting strategies that ensure fair access to contracting opportunities for businesses of all sizes and types
- collaborate with other ambulance trusts and other organisations to improve knowledge and understanding of sustainable procurement and to seek shared opportunities and benefits.

To reduce our carbon emissions and increase efficiency we are investing heavily in replacing a large proportion of our current fleet with new, 'greener' ambulances and cars. We anticipate that by 2020, the majority of our vehicles will meet the Euro IV standard in line with the introduction of the London Ultra Low Emission Zone (ULEZ).

We continue to work closely and in partnership with the Government's SALIX programme to procure energy efficient solutions for pipeline projects. During 2016/17, three energy efficient projects were completed, delivering an additional 2,410 tonnes of CO2 savings over the lifetime of the equipment. These projects have an average payback of 3.65 years and financial savings within the region of £23,285.

Our People

We know that to enable us to provide a quality service, our staff need to be highly-skilled, confident and motivated. They should also be representative of the communities we serve.

We continued to work with and listen to our staff to improve our service to patients.

Recruiting staff

We have worked hard to our increase frontline staffing numbers, despite a national shortage of paramedics.

Last year, we recruited 355 frontline staff, increasing our frontline workforce by over 100 whole-time equivalents.

To protect against workforce shortages in the future, we are developing a three-year recruitment plan which takes into account expected leavers from the organisation.

This includes:

- engaging with students and UK paramedic graduates to promote our Service as a prospective employer
- running 'keep in touch sessions' with our four partnership universities, to build relationships with trainee paramedics and ensure that as many as possible make our Service their employer of choice
- holding monthly assessment and interview sessions for paramedic, trainee emergency ambulance crew and emergency medical dispatcher candidates
- attending recruitment fairs and local schools to showcase the career opportunities available
- targeting recruitment campaigns across the capital to attract Londoners to work with us.
- continuing to build relationships with Australian universities to support future recruitment trips

Looking ahead, we aspire to be the employer of choice for UK paramedics and new graduates, and to attract paramedic talent from across the world by offering a depth and breadth of experience, personal development and career progression that is second to none.

So that we have an increasingly self-sufficient pipeline to meet demand, we will promote our organisation and our recruitment opportunities exploring new local recruitment markets to attract applicants for non-registered frontline staff roles; and expanding internal pathways into paramedic education.

Retaining and developing staff

The number of staff leaving our Service fell again last year, from 11.2 per cent in April 2016 to 8.6 per cent in March 2017. We have achieved this through a targeted programme of work which included:

- increasing the number of clinical team leaders and protecting their time to provide support to our frontline staff

- implementing the nationally agreed Band 6 paramedic role; and the newly qualified paramedic role to provide support and mentoring for a two year period. Over 2,000 front-line paramedics moved from Band 5 to Band 6 in 2016/17
- enhancing clinical career structures by:
  - creating our LAS Academy. The Academy provides training to support our non-registered clinical staff to become our paramedics of the future
  - working with Health Education England to pilot new Band 7 urgent care paramedics
  - appointing a consultant paramedic responsible for driving the integrated urgent care agenda, in conjunction with our emergency operations centre and 111 service
- increasing access to training bursaries. We secured £600k with the support of Health Education England to support further education/personal development for our staff. In 2015/16, the same level of funding was invested in development for 338 staff.
- improving our range of non-pay benefits; introducing lease cars and cycle schemes for our staff and providing a new occupational health provider to improve the health and wellbeing of our staff.

A significant development during the year was the introduction of a new appraisal system to ensure staff receive feedback on their performance and are clear about their focus and personal development for the year ahead. Since April 2016, we have completed 3,666 appraisals - equating to 81.3 per cent of our workforce compared with 11 per cent the previous year.

In November 2016, we won a prestigious HSJ Award for our training stations programme, designed to provide new frontline staff with practical support from experienced mentors. The HSJ judges said the initiative made a “real difference to staff morale and patient care in a challenging environment”.

Volunteer Responders

We are extremely grateful for the support of our volunteer lifesavers, who respond to patients in their communities alongside ambulance crews. Our volunteer responders include:

- Emergency responders – clinically-trained volunteers who respond to emergencies on blue lights alongside ambulances, and;

- Community first responders – defibrillator-trained St John Ambulance volunteers attending on call from their homes and responding to 999 calls alongside ambulances in their own car without blue lights

In 2016/17, volunteer responders contributed a total of 28,505 operational hours. They attended 12,193 emergencies, and in 6,996 of these cases, they were first on scene.

Our volunteers are also supported by the London Ambulance Service Voluntary Responder Group charity.

Finding out what staff think

We saw significant improvements in our staff survey last year. Out of the 88 questions that were asked, we scored significantly better in 67 of them compared to the previous year. We are pleased that in 23 questions, we have seen significant improvements of more than 10 per cent, including in:

- appraisals and career progression
- line managers and team working
- use of patient feedback
- error reporting
- training
- managers taking a positive interest in the health and well-being of their staff
- staff looking forward to going to work
- happiness with the standard of care provided by the organisation.

Specifically, we have also seen an improvement in the following metrics in 2016/17 compared to the previous year:

- Enough staff at organisation to do my job properly - an increase of 8 per cent
- Recommend organisation as place to work – up 13 per cent
- If friend/relative needs treatment would you be happy with standard of care provided- 14 per cent increase

Working to improve diversity and culture

Recent analysis of equality and diversity data shows that the black and minority ethnic (BME) population is underrepresented in our workforce, including in senior management. In 2016, 13 per cent of our workforce was from BME backgrounds; in contrast 45 per cent of London's population is from a BME background.

We recognise that the current position for BME staff requires significant improvement and are determined to achieve this, including through implementation of the Workforce Race Equality Standard (WRES) which ensures employees from BME backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

A new action plan to address race equality issues was agreed by our Trust Board in July 2016 and this is currently being implemented.

We have taken the following actions to improve diversity and equality during 2016/17:

- Employed a lead for equality and diversity.
- Introduced BME staff focus groups and round table events with the Chairman and Director of Operations to understand the issues, barriers and experiences of internal BME staff, for example, barriers to career progression. The equality and diversity lead also provided one to one sessions for staff who wanted to talk in confidence.
- Secured £500,000 from Health Education England in January 2017 to fund:
    - outreach into schools to raise the profile of our Service as an employer and paramedic science as a potential career with BME students (and others)
    - coaching and mentoring for our BME talent
    - supporting and building the BME staff network to give staff a forum for raising issues and a BME 'focus group'.
- Taken positive action advertising to encourage applicants for posts from BME (and other under-represented communities) including taking part in the London Diversity show at Westfield.
- Reviewed the recruitment process to understand challenges facing BME candidates and implemented recruitment and selection training for managers.

- Improved our data on BME staff to ensure our reporting on BME issues is accurate and of high quality, in line with the requirements of the WRES. We are now in a position to report on eight of the nine WRES indicators, with the plan to report on all of the nine indicators in 2017/18.
- Worked closely with the Patient's Forum to better understand the equality and diversity issues that have an implication on patient care.
- Established a BME talent programme to encourage people already working in our Service to encourage career progression to a senior level.

Improving our culture

We have a duty of care to all staff, and are committed to providing a safe working environment that is free from all forms of bullying and harassment in which everyone is treated with dignity and respect.

We have been increasingly active in supporting staff who have reported bullying and/or harassment at work. This has included the introduction of a telephone advice line and the interim appointment of a specialist manager who is delivering training for managers and staff across our Service. In addition, we have:

- delivered bullying and harassment awareness training sessions to 716 staff as well as our executive leadership team
- launched a new dignity at work policy to improve our approach to bullying and harassment allegations and place emphasis on mediation and facilitated conversations to encourage early resolution of concerns
- recruited dignity and respect ambassadors who provide practical guidance on the steps that can be taken to encourage successful working relationships between staff.
- delivered workshops on mediation and having 'courageous conversations' to encourage local resolution of issues prior to entering formal grievance procedures
- facilitated bespoke training/coaching sessions at the request of teams.

We also took part in the London 2016 Pride Parade and network members attended the Stonewall Conference. Lee Hyett-Powell, our LGBT forum chair, won the prestigious NHS Inclusive Leader of the Year Award.

Freedom to speak up

In October 2016, we appointed our Freedom to Speak Up Guardian, a role introduced in each NHS trust as a result of the recommendations in the Francis Report.
Since the role was introduced we have:

- ensured staff are aware of the role and its function, including by attaching a leaflet to staff payslips
- established a Freedom to Speak Up group which will meet quarterly
- agreed reporting arrangements via our Workforce Committee to our Trust Board
- designed a secure recording and reporting module on Datix, our incident reporting software, which is only visible to the Freedom to Speak Up Guardian
- hosted a successful visit by colleagues from the National Guardian's Office

- commissioned an audit of our Freedom to Speak Up arrangements from KPMG; we are the first NHS organisation to have taken this action.

Since the role has been introduced, a total of 14 concerns have been reported. Half of these have related to a bullying culture across a team or part of the organisation; two have related to our processes; two to patient safety concerns; and the remaining three have been related to infrastructure, to seek advice, or to give ideas about possible improvements.

Feedback has been very positive from staff who have used this method of raising concerns, indicating that is a method of engaging with staff that should be developed further over the coming year.

We are seeing improved impact on staff as demonstrated through the 2016 staff survey compared to the previous year:

- Not experienced bullying & harassment or abuse from managers – up 7 per cent
- Not experiencing discrimination from manager/team leader or other colleagues – an increase of 10 per cent
- My immediate manager values my work – up 14 per cent

Supporting our staff

The Five Year Forward View mental health task force findings 2015 emphasised the importance of responding to the health and well-being needs of NHS and social care staff themselves. And research from Mind[6] shows that emergency service staff are at a high risk of poor mental health, yet are less likely to seek support than others.

Last year, we continued to provide a wide range of internal and external support for our staff, including:

- our LINC (Listening; Informal; Non-Judgemental and Confidential) peer support network which provides psychological and emotional support to any member of staff. LINC workers are volunteers from all levels of our Service and receive specialist training in listening and counselling skills, bereavement, stress, burnout and PTSD. Senior LINC workers staff the dedicated 24-hour emergency on-call line for staff who need urgent support
- mental health awareness training for control room staff (to support patients with mental health conditions) and personal health and wellbeing awareness training
- support and promotion of awareness campaigns, such as mental health awareness week and world mental health day, including signing up to the Mind 'Blue light pledge' to commit to promoting an open and safe environment for our staff to share their emotions and feelings, knowing they will be supported and not judged
- wellbeing events at our HQ for staff to visit and learn about charities and networks available for both patients and themselves
- Access to the Mind Blue Light programme which offers confidential, independent and practical support, advice and signposting around mental health and wellbeing, for emergency service staff, volunteers and their families.

[6] http://www.mind.org.uk/media/2869026/blue-light-programme-research-briefing-no-one.pdf

Time to Talk Day 2017

His Royal Highness Prince Harry visited the London Ambulance Service control room to launch Time to Talk Day 2017, the annual mental health awareness day run by charity Time to Change.

Prince Harry spent time with staff encouraging them to get talking about mental health and hearing about the support offered to emergency service workers. Speaking to a group of staff outside headquarters at the end of the visit Prince Harry said: “I take my hat off to you and all the staff.”

About being able to cope with the pressures of emergency work, the Prince added: “You need to be able to deal with it, talk about it and so you don’t take your issues home with you. It’s not possible to do the job you do and not talk about it.”

Engaging, valuing and recognising our staff

In June 2016, we launched our vision of *‘Making the LAS Great’*, supported by an internal communications campaign to start hundreds of conversations to engage and motivate staff to deliver improvements within our Service.

Engagement with staff was encouraged through the distribution of conversation packs – including branded mugs, coasters and posters as well as tea and biscuits – to all stations and sites so that managers and their teams could talk about how they could contribute to our quality improvement plan and help us achieve our vision.

We also ran eight internal campaigns throughout the year based on ‘must-dos’ to help us make the London Ambulance Service great. This included ‘Shut it, lock it, prove it’ – a medicines management campaign to improve compliance across the organisation, advice around keeping information safe, and tips on how to speak up.

To improve engagement and increase the visibility of senior leaders we held a number of staff road shows hosted by members of our executive leadership team during October and

November 2016. This provided nearly 1,000 staff members with the opportunity to share their views and ideas, influencing our strategic priorities for 2017/18. In addition, we commissioned the University of Warwick to measure the engagement of patient-facing staff in the different areas of the Service, and are using this learning to inform and improve staff engagement. We will re-run the survey in 2017.

We have a monthly briefing system, Team Talk, which is designed for cascading information through the organisation and gaining feedback, which is then reported back to the executive leadership team for their information and action. This feedback is then made available to all staff – along with details of actions that are being taken as a result. Key themes and topics discussed on our closed staff Facebook site are also included in the Team Talk feedback reports. This group, which now has more than 3,300 members, enables direct communication and engagement with a large part of the workforce, as well as the chance for questions and discussions. Since July 2015, it has been successfully administrated by a group of around 20 peer moderators who volunteer their time to make the group a better forum for staff.
During the year we have strengthened our partnership working with trade union colleagues, rewriting the Partnership Agreement and strengthening our consultation processes via the quarterly Staff Council meetings and the bi-monthly Operational Partnership meetings.

Our VIP Awards scheme recognises the contribution of people across the organisation, and is now in its third year. Nominations are considered by voting panels made up of colleagues from the same staff groups, with the overall winners from each then going forward for a service wide vote to become Employee of the Year.

In the 2016/17 VIP awards cycle, across both rounds of voting, 344 nominations were received for 707 staff and a total of 441 votes were cast for Employee of the Year. We made videos of all the 13 finalists, which were advertised on the intranet and our staff Facebook group. Everyone who is nominated or has made a nomination is invited to the main awards ceremony which takes place in April each year.

We also continued to recognise the day-to-day contributions of staff through marking the achievement of long service milestones, and publishing the names of all those who have received a letter or message of thanks in our weekly bulletin.

In December 2016 our main corporate twitter feed was named best social media account in the Comms2Point0 Unawards 2016. During the year we also provided BBC One unprecedented access to our Service to film *Ambulance* – a three part series which followed our medics and control room staff making life-saving decisions. As well as increasing public awareness of the pressures on the service, the series also improved staff morale; 88 per cent of staff said they were proud to work for the Service following the documentary, compared with 54 per cent prior to broadcast. *Ambulance* was the most watched documentary on the BBC in 2016.

Accountable Officer:
Organisation: London Ambulance Service NHS Trust
Signature:

Date:

2. Accountability Report

London Ambulance Service NHS Trust

Organisation Code: RRU

Governance Statement

Scope of responsibility

The Board is accountable for internal control and, as Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding quality standards and public funds and the organisation's assets, for which I am personally responsible as set out in the Accountable Officer Memorandum.

As Accountable Officer I have overall accountability for having a robust risk management system in place which is supported by a governance structure, processes and monitoring arrangements, and an assurance and risk management framework. These arrangements are documented in the Risk Management Policy which represents a developing and improving approach to risk management achieved by building and sustaining an organisational culture which encourages risk taking, effective performance management, and accountability for organisational learning. The Trust strategy *Caring for the Capital* is the means by which the London Ambulance Service NHS Trust (LAS) will ensure its vision, aims, goals and organisational objectives are continually assessed and managed to ensure appropriate risk taking and effective performance management are in place and part of the organisational culture.

As part of London's health economy we work with our partners to minimise the risks to patient care. To do so we have met routinely with our lead commissioners, NHS Improvement (NHSI) and NHS England (London) in order to progress and maintain the key performance targets set for ambulance services. We work in partnership with health and social care organisations in the development and provision of emergency and urgent healthcare across London.

In 2016/17, the demand on the Service continued to increase, with an increase of over 68,000 incidents in comparison with 2015/16. Demand has been particularly high recently, with December 2016 seeing the highest number of Category A (life threatening) incidents the Service has ever seen. With demand increasing we have been mindful of how we respond to 999 calls, ensuring we provide the highest standards of patient care but recognising that conveying patients to hospital is not always the best option. The Trust has worked in partnership with Commissioners, NHSI and NHS England (London) under the oversight of the Regional Oversight Group, to review performance trajectories and has an agreed position going forward in 2017/18.

In 2016/17 the Trust achieved 66.40% for the national performance target of Category A 8 minutes and 93.48% 19 minutes. The Trust Board takes its assurance on the quality and accuracy of the data through the integrated performance report and national reporting of

Ambulance Quality Indicators. The LAS is not required to monitor elective waiting time data.

Whilst facing these challenges, our primary concern has been and continues to be the safety of the service we provide. It is essential as an organisation that we learn from our underperformance and apply that learning to improve services moving forwards. Managing and mitigating against any potential performance impact on patient quality and safety is our fundamental priority. A key mitigation for quality and safety is workforce and the Trust has recruited over 350 front line staff in 2016/17 and has seen a reduction in the frontline vacancy rate down to 6.6%. Paramedic turnover ended the year at an improved figure of 9% and the overall sickness rate for the Trust is down to 5%.

The Trust was placed in Special Measures on the recommendation of the Care Quality Commission (CQC) in October 2015 following the planned inspection under the Chief Inspector of Hospitals Inspection regime in June 2015 and the placement of a Section 29A Warning Notice. The CQC undertook a review of the Warning Notice in August 2016 and this was reduced to a Requirement Notice focussed on medicines management. The CQC then undertook a planned inspection in February 2017. At the time of writing the Trust remains in Special Measures and has the following ratings against the CQC domains:

- Safe – Inadequate
- Effective – Requires Improvement
- Caring – Good
- Responsive – Requires Improvement
- Well-led – Inadequate.

A Quality Improvement Plan (QIP) was implemented in January 2016 to address the recommendations in the full report and warning notice. The QIP had the following five themes:

- Making the LAS a Great Place to Work
- Achieving Good Governance
- Improving Patient Experience
- Improving Environment and Resources
- Taking Pride and Responsibility.

Oversight of the plan has been through the Quality Improvement Programme Board, chaired by the Trust Chair, which has provided assurance to the Trust Board at each formal Board meeting. The Programme Board was dis-established in March 2017, with a formal closure report to be submitted to the Trust Board in May 2017.

By the end of 2016/17, 95% of projects within the programme had been completed and had moved into business as usual. Those projects remaining that required continued focus were taken forward into the 2017/18 business plan and priorities.

The LAS 111 Service was also inspected as part of the General Practice CQC inspection programme in September 2016. The LAS 111 service was subsequently rated as Good, with a rating of good achieved in every of the five domains, with the CQC stating *'The London Ambulance Service (LAS) NHS 111 service provided a safe, effective, caring, responsive and well-led service to a diverse population in South East London'.*

NHSI required the Trust to commission Deloitte LLP in 2016 to undertake an external well-led governance review against the Monitor/NHSI Well-led framework. The Chair and Chief

Executive received the report in February 2017 and shared this with the Trust Board. An action plan is being developed to address the recommendations.

The governance framework of the organisation

Heather Lawrence, OBE, joined the Trust as Chair on 1st April 2016. Dr Fionna Moore stepped down as Chief Executive Officer in December 2016 prior to retirement from the Service in March 2017. Andrew Grimshaw took on the role of Acting Chief Executive Officer from January 2017 whilst the Trust recruited to the substantive role.

Nicholas Martin and Jessica Cecil reached the end of their terms of office in 2016/17. Nick remained as an associate non-executive director until 28th February 2017 and Jessica Cecil remains as an associate non-executive director to 31st January 2018. Jayne Mee and Dr Sheila Doyle were appointed by NHSI as non-executive directors on the Trust Board, commencing in January and February 2017 respectively.

Other changes to the Trust Board and executive team included the substantive appointment of Paul Woodrow as Director of Operations. Andrew Grimshaw (Acting Chief Executive) is the substantive Director of Finance so Andy Bell, Deputy Director of Finance, took on the role of Acting Director of Finance from January 2017. Andrew Watson, Chief Information Officer, left the Trust in January 2017, and Steve Bass took on the interim role in March 2017. Zoe Packman left the Trust and the role of Director of Nursing and Quality in May 2016 and Briony Sloper, Deputy Director of Nursing and Quality, acted into the role until Trisha Bain's appointment as Chief Quality Officer in January 2017. Sandra Adams, Director of Corporate Governance/Trust Secretary, left the Trust in April 2017 and an interim arrangement is in place whilst the post is appointed to substantively. The Trust continues to seek to recruit a substantive Director of Human Resources & Organisational Development. Jill Patterson, interim Director of Performance, and Mark Hirst, interim Director of HR, have continued to support the Board and executive team in 2016/17. In addition, as a result of being in Special Measures, the Trust has had the support from NHS Improvement through the role of the Improvement Director since February 2016.

Information on the Trust Board committee structure and the attendance records of members is attached (annexes 1 to 9).

Each Board committee is chaired by a non-executive director. Membership of the Remuneration and Nomination, and Audit committees is non-executive only with executives in attendance where relevant and required.

The Trust Board agreed to establish a Workforce and Organisational Development Committee and the first meeting was held on 18th May 2016. The Committee is a sub-committee of the Trust Board and is chaired by a non-executive director. A Quality Improvement Programme Board was established in January 2016 as a time limited committee of the Board, chaired by the Trust Chair, to provide oversight of the Quality Improvement Plan and board assurance of progress against the plan. The Logistics and Infrastructure Committee was established in January 2017 and its first meeting was held in February, chaired by a non-executive director. The Finance and Investment Committee had a name change and added oversight of performance to its remit. The terms of reference for the above mentioned Board sub-committees and for Audit and the Quality Governance, Remuneration and Nominations, and Charitable Funds Committees were all reviewed and

updated with Trust Board sign off in November 2016. Each Board sub-committee provides an assurance report to the next Trust Board meeting held in public, and the minutes of each meeting are available in the private meeting of the Trust Board.

The reporting structure for the Executive Leadership Team was reviewed in early 2016 and the new structure commenced in March 2016. The Risk Compliance and Assurance Group was re-established, and a Quality Improvement Group, Environment and Resources Group, and Operations Board were also established. Each of the key executive-chaired committees provides assurance to a Board committee. Clinical Safety and Standards, Improving Patient Experience and Risk Compliance and Assurance all provide assurance through the Quality Governance Committee to the Trust Board. The Risk Compliance and Assurance Group also provides assurance to the Audit Committee on the systems and processes for risk management. The Group also reviews and approves changes to the Board Assurance Framework.

The Finance and Investment, Quality Governance, Logistics and Infrastructure, and Workforce and Organisational Development Committees each review the relevant risks for their remit: financial, performance, quality and safety, risks pertaining to the estate, IM&T and fleet & logistics, and to workforce. The Trust Board reviews the corporate risk register and Board Assurance Framework at each meeting held in public.

The Trust Chair and Director of Corporate Governance/Trust Secretary undertake a post-board review each month to ensure the agenda has been covered, sufficient time has been allotted to agenda items and effective contribution and scrutiny given. The Board agenda, papers and practice are continuously reviewed and adapted to ensure that reporting is appropriate and timely. Following the external governance review in early 2016 the processes for Board and committee agendas and papers were strengthened. An action plan has been developed to address the findings of the independent well-led governance (Deloitte) review undertaken in late 2016/17. With the departure of the Director of Corporate Governance/Trust Secretary the Chair took the opportunity to commission a review of the portfolio and some of the governance processes and this has informed some aspects of the portfolio transferring to the Chief Quality Officer. Whilst further thought is given to the role of Director of Corporate Governance/Trust Secretary, the Trust is receiving senior corporate governance support via a secondment from NHS Improvement. The Trust Board will formally meet monthly in 2017/18, either in public or in private, and in addition will meet as a strategy group to ensure there is sufficient time and focus given to this area.

The Board agenda is informed by the forward planner which is reviewed and updated after each meeting and includes an integrated performance report incorporating quality and safety, financial, performance and workforce reporting against key performance indicators, and key business and governance items. This ensures the Trust Board receives quality, financial and performance information that provides assurance on the discharge of statutory responsibilities.

Attendance by board members at Trust Board meetings is recorded in the minutes and included in the annual governance statement. Attendance at key Board Committees is also monitored and recorded by the Committee Secretary and those providing administrative support to each of the Committees.

The Trust Board understands its responsibilities for discharging the statutory functions and takes assurance from the Audit Committee that systems are in place and that these are legally compliant.

The Chair of the Audit Committee provides a report to the next meeting of the Trust Board following each Audit Committee meeting. This report includes a summary of the business discussed and the assurances received from the executive, the internal and external auditors and from local counter fraud. The role of the Audit Committee is to focus on the controls and related assurance that underpin the achievement of the Trust's objectives and the processes by which the risks to achieving these objectives are managed. The committee undertakes a review of the effectiveness of the corporate risk register at each meeting. The committee met 5 times during the year with the internal and external auditors present and held one meeting without auditors (total of 6 meetings). The Audit Committee met once with auditors only.

At the Trust Board meeting on 25th April 2017 the Audit Committee chair provided assurance to the board of the effectiveness of the Trust's systems of integrated governance, risk management and internal control, based on the key sources of assurance identified in the board assurance framework.

The Quality Governance Committee has oversight of quality governance on behalf of the Trust Board, including review of the annual Quality Account, prior to its publication. The reporting committee structure provides assurance to the Quality Governance Committee on clinical audit, never events and serious incidents including the lessons drawn from these and the action being taken to mitigate future risk. The committee also receives assurance on the Trust's response and actions taken to address coroners' recommendations on preventing future deaths.

The Chair of the Quality Governance Committee provides a report to the following meeting of the Trust Board. This report includes the committee's assessment of quality as taken from the reports and evidence presented to the committee, including the corporate risk register. The committee receives assurance from its reporting committees: Clinical Safety and Standards and Improving Patient Experience. The committee also reviews the cost improvement programme to seek assurance that there is no detrimental impact on patient and staff safety and the quality of services provided as a result of the programme. At the Trust Board meeting the Quality Governance Committee chair provides assurance on the quality and safety of service provision, including the supporting clinical, information and corporate governance framework. The committee met 6 times during the year.

The Chair of the Finance and Investment Committee provides a report to the following meeting of the Trust Board. The committee provides assurance on the scrutiny of current finance and investment issues based on the reports and evidence presented to it throughout the year, and oversight on performance reporting. At the Trust Board meeting the chair of the committee reports on the cash position, cash management, liquidity, Cost Improvement Plan progress, and capital expenditure. The committee met 6 times during the year.

The Logistics and Infrastructure Committee was established in January 2017 and has met once. The Chair of the Committee provides an assurance report to the Trust Board on its oversight of issues pertaining to estates, IM&T and fleet and logistics. The first assurance

report was presented on 28th March 2017 and referenced high level capital investment plans for the 3 areas and the key performance indicators by which the Committee could take assurance.

The Workforce and Organisation Development Committee was established in 2016 and has met 6 times in 2016/17. The Chair of the Committee provides a report to the following meeting of the Trust Board and this report includes Workforce risks, recruitment and retention, health and wellbeing, strategy and planning.

The Trust Board works within the remit of the standing orders and standing financial instructions and the scheme of delegation. These were reviewed and approved by the Trust Board on 29th November 2016.

The Trust is registered with the CQC for the provision of the following regulated activities:

- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury
- Diagnostic and screening procedures.

Risk assessment

The organisation's major risks relate to safety, performance, finance and workforce as described in the Board Assurance Framework.

The Risk Management Policy provides the strategic framework for risk management within the Trust through the specification for risk (or change in risk) identification, assessment, treatment and management controls. It describes the process for embedding risk management throughout the Trust. The corporate risk register is reviewed by the Audit and Quality Governance Committees and by the Trust Board as it contains the highest level of risks facing the organisation. Risks can be escalated to the Risk Compliance and Assurance Group for discussion and addition to the corporate risk register if required. Project and programme management risks are aligned to and incorporated in the corporate risk register.

The Internal Auditors, KPMG, have been reviewing elements of the Trust's risk management arrangements each year. The review in 2016/17 focussed on the risk management processes within the Operations directorate and the outcome concluded with an overall assessment of 'Significant assurance with minor improvement potential'. The Trust implemented a programme of risk management training for all managers in November 2015 and had trained over 300 managers by the end of 2016. The audit process of local risk registers continued throughout the year with key performance indicators developed and monitored through the integrated performance report. The independent well-led governance review and also early feedback from the February 2017 CQC inspection suggests more focus is required to fully embed a consistent approach to risk management. Both also identified that the BAF required a fresh approach and the Acting Chief Executive is leading this development work during the first quarter of 2017/18. In March 2017 the top 3 risks facing the organisation were:

1. BAF risk 37 – there is a risk that the agreed A8 trajectory for the current year may be adversely affected by sustained over-activity against contractually agreed growth.

2. BAF risk 7 – there is a risk that patients could suffer avoidable harm across shift

change over periods due to deterioration in response times as a result of reduced resource availability.

3. BAF risk 14 – it is likely that NHS financial and operational planning will include the need to develop efficiencies in order to offset other cost pressures for the foreseeable future. Failure to identify and deliver CIPs will threaten the ongoing viability and solvency of the Trust.

Patient and staff safety and other incidents are reported in accordance with the incident reporting procedure and are then scored, either by local managers or by the safety and risk team, using a risk severity matrix in line with the Risk Management Policy and reported on Datix. Action is then taken to control, manage or mitigate the risk and depending upon the score the risk may be added to the corporate register for review by the Risk Compliance and Assurance Group or monitored at a local level. The Serious Incident Group meets weekly to review any serious incidents that need investigating and may need to be formally declared as Serious Incidents. The group monitors the progress of SI investigations and escalates any delays to the Executive Leadership Team. The Trust implemented DatixWeb in May 2016 for reporting and managing incidents, serious incidents, complaints, legal cases and inquests, and safeguarding. Risk registers transferred across to the system during the summer.

New risks with a net severity rating of High (over 15) are added to the corporate risk register and the board assurance framework which are reviewed monthly by the Risk Compliance and Assurance Group and the Executive Leadership Team. In 2016/17 the Trust added 23 new risks to the corporate risk register. A list of the new risks is attached as an annex to this statement (annex 10).

The Trust reported 4 data security incidents to the Information Commissioner and these were declared and investigated as serious incidents.

The Trust achieved 83% against the Information Governance toolkit and is at level 2 overall.

The Trust underwent two further external reviews during 2016/17:

a) Compliance against the NARU specification of the emergency planning response and resilience - the Trust Board received the assurance report on compliance at its November 2016 meeting.

b) Compliance with NHS Protect security management standards for ambulance services – the outcome of this review was one of poor compliance and an action plane was implemented. Assurance was taken through the Audit Committee to the Trust Board in November 2016 of compliance against the standards and this was confirmed by NHS Protect in March 2017.

The risk and control framework

Systems are in place to monitor compliance throughout the year and to address any emerging gaps or risks. The format of the board assurance framework shows the key risks facing the Trust during the period, mapped to the key business objectives. The Audit Committee oversees the board assurance framework and corporate risk register and provides assurance to the Trust Board on the effectiveness of the risk and control

arrangements. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are met.

The Risk Compliance and Assurance Group manage the corporate risk register whilst the Audit Committee assesses the effectiveness of the corporate risk register at each meeting. The Trust Board and Executive Leadership Team receive an integrated performance report which includes the top risks. The Board sub-committees review the risk registers and significant risks for the areas within their remit and will seek assurance on the controls and assurances in place and any actions being taken to mitigate those risks. Systems in place to deter risk include standing orders, the scheme of delegation and standing financial instructions, NHS counter fraud measures, an anti-bribery policy, and a register for declaring directors' and managers' interests. The Register of Interests was updated in the final quarter of 2016/17.

The local counter fraud specialist (LCFS) attended 5 meetings of the Audit Committee in 2016/17 and regular executive counter fraud meetings. KPMG have provided the local counter fraud service since April 2013 and the contract was extended for a further 2 years within procurement rules.

The internal auditors attended 5 meetings of the Audit Committee during 2016/17 and work closely with the Governance and Assurance team to execute the annual audit work plan which is developed in conjunction with the Trust Executive. KPMG have provided the internal audit service to the Trust since April 2013 and the contract was extended for a further 2 years within procurement rules. Both this contract and the LCFS contract will be re-tendered in 2017/18 for commencement on 1st April 2018.

Ernst Young are the external audit provider. The Trust Board established an Auditor Panel through the Audit Committee to oversee the process for appointment of the external auditor and Ernst Young were approved as the external audit provider with effect from 1st April 2017.

Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work of the internal auditors, clinical audit and the executive management team within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of the effectiveness of the system of internal control by the board, the Audit Committee and the Quality Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Significant Issues

Category A demand for the London Ambulance Service rose by 6.8% in 2016/17 to 1.83 million emergency calls from across London and we responded to more than 1.11 million incidents. This put the Trust under significant pressure and unable to recover performance to agreed contract levels in 2016/17. The Trust is now contracted to achieve 75% Category A8

by October 2017.

The CQC issued a Section 29A Warning Notice and rated the Trust 'Inadequate' in October 2015 following which the NHS TDA (NHSI as of 1st April 2016), in line with the recommendation from the Chief Inspector of Hospitals, placed the Trust in Special Measures. The Trust implemented a Quality Improvement Plan (QIP) in January 2016 which concluded in March 2017. 95% of these projects have been completed and those that remained have been incorporated either into the 2017/18 business plan or business as usual. The QIP was overseen by the Quality Improvement Programme Board which provided regular assurance to the Trust Board. External governance and oversight was provided through the Commissioners' Clinical Quality Review Group and the Regional Oversight Group which comprises membership from commissioners, NHS Improvement, and NHS England.

The Section 29A Warning Notice was lifted in September 2016 following a CQC inspection of the Notice and a Requirement Notice was issued which focussed on medicines management.

At the time of writing the outcome of the February 2017 CQC Inspection has not been published and the Trust remains in Special Measures.
The Trust Board implemented the recommendations from the 2015 TDA well-led governance review and the independent governance review in 2015/16. Deloitte LLP was commissioned to undertake an independent well-led governance review in 2016/17 with a final report to the Trust Chair and Acting Chief Executive in February 2017. An action plan will be implemented in the 1st quarter of 2017/18 and will include the review and refresh of the BAF and a board development programme.

Internal audit undertook 9 reviews during 2016/17 agreed with management to defer the PRF Management & CQC reviews to future periods. Internal audit raised 35 recommendations, including five high risk recommendations in the period which relate to:

- Committee oversight and reporting in our Clinical Audit review;
- Monitoring and annual timetable in our CIPs review; and,
- Secure storage of medicine and the management of controlled drugs in our Medicines Management review.

Actions will be identified and implemented to address each recommendation.

During 2016/17 we experienced some technical difficulties with our Computer Aided Dispatch System which we use to take emergency calls and despatch ambulances. This includes an outage on 1st January 2017 which required our staff to revert to manual processes. As a result, our control room logged emergency calls using a manual back-up system for around five hours.

Our control room staff are fully trained and practised in operating this way and continued to prioritise patients in the same way, using the same assessment process as usual. However, as a manual system is not as efficient as a computer-based one, it took longer to manage calls.

Following the incident we launched a full external investigation, working with NHS Improvement and NHS England alongside an independent IT expert to look at the exact circumstances of what happened and any impact this may have had on our patients. This report is to be published in spring 2017.

The Head of Internal Audit's opinion is one of:
"Significant assurance with minor improvements' can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control"

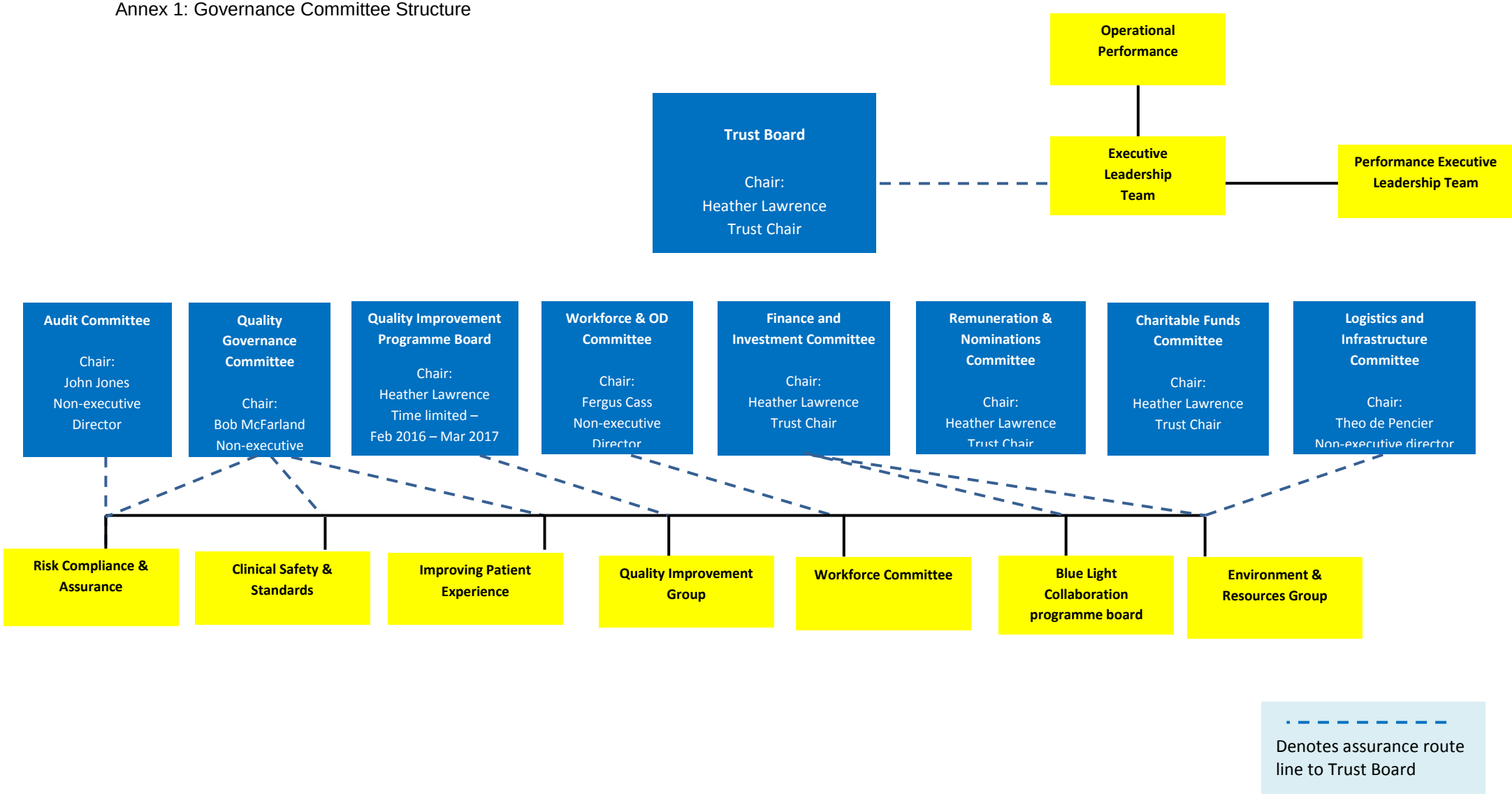
Accountable Officer :

Organisation: London Ambulance Service NHS Trust (RRU)

Signature:

Date:

Annex 1: Governance Committee Structure



Annex 2: Committee membership 2016/17

Formal Trust Board committee	Chair	Current members
Audit committee	Non-Executive director, John Jones	Theo de Pencier (Non-Executive director) Fergus Cass (Non-Executive director)
Charitable funds committee	Trust Chair, Heather Lawrence OBE	Andrew Grimshaw (Director of Finance and Performance and then Acting Chief Executive)
Quality governance committee[7]	Non-Executive director, Bob McFarland	Jessica Cecil (Non-Executive director) Nick Martin (Non-Executive director) to February 2017 Fergus Cass (Non-Executive director) Fenella Wrigley (Medical Director) Zoe Packman (Director of Nursing and Quality) to May 2016 then Briony Sloper (Acting Chief Quality Officer) from June 2016 to January 2017 Trisha Bain (Chief Quality Officer) from January 2017 Sandra Adams (Director of Corporate Governance) Paul Woodrow (Director of Operations)
Finance & investment committee	Non-Executive director, Nick Martin To January 2017 then Heather Lawrence OBE, Trust Chair, from March 2017	John Jones (Non-Executive director) Jessica Cecil (Non-Executive director) Theo de Pencier (Non-Executive director) Andrew Grimshaw (Director of Finance and Performance then Acting Chief Executive) Sandra Adams (Director of Corporate Governance) Andy Bell (Acting Director of Finance)
Remuneration and Nomination committee	Trust Chair, Heather Lawrence OBE	All Non-Executive members of the Trust Board
Quality Improvement Programme Board (time-limited committee with specific assurance role)	Trust Chair Heather Lawrence OBE	Fergus Cass (Non-Executive director) Bob McFarland (Non-Executive director) Fionna Moore (Chief Executive) to December 2016 Andrew Grimshaw (Director of Finance and Performance and then Acting Chief Executive) Karen Broughton, Director of Transformation, Strategy and Workforce Charlotte Gawne (Director of Strategic Communications) Sandra Adams (Director of Corporate Governance) Trisha Bain (Chief Quality Officer) from January 2017 Fenella Wrigley (Medical Director) Mark Hirst (Interim Director of HR) Paul Woodrow (Director of Operations) Zoe Packman (Director of Nursing and Quality) to May 2016 then Briony Sloper (Acting Chief Quality Officer) from May 2016 to January 2017

[7] Terms of reference reviewed and updated in 2016 with membership changes

Workforce and Organisation Development Committee	Non-Executive Director Fergus Cass	Theo de Pencier (Non-Executive director) to February 2017 Jayne Mee (Non-Executive director) from March 2017 Jessica Cecil (Non-Executive director) Karen Broughton, Director of Transformation, Strategy and Workforce Mark Hirst (Interim Director of HR) Paul Woodrow (Director of Operations) Fenella Wrigley (Medical Director) Briony Sloper (Deputy Director of Nursing and Quality)
Logistics and Infrastructure Committee	Non-Executive Director Theo de Pencier	Sheila Doyle (Non-Executive director) John Jones (Non-Executive director) Andy Bell (Acting Director of Finance) Sandra Adams (director of Corporate Governance)

Annex 3 – Attendance at Trust Board meetings 2016/17

= attended a = apologies	31st May 2016	26th July 2016	4th October 2016	29th November 2016	31st January 2017	28th March 2017	**Comments**
Trust Board members (voting)							
Heather Lawrence (Non-Executive Chair)	x	x	x	x	x	x	
Fergus Cass (Non-Executive Director)	x	x	x	x	x	x	
Jessica Cecil (Non-Executive Director)	x	a	x	x	x	a	
Theo de Pencier (Non-Executive Director)	x	x	x	x	x	a	
John Jones (Non-Executive Director)	x	x	x	x	x	x	
Bob McFarland (Non-Executive Director)	x	x	x	x	x	x	
Nick Martin (Non-Executive Director)	x	x	x	x	x		Left the Trust in February 2017
Jayne Mee (Non-Executive Director)					x	x	
Sheila Doyle (Non-Executive)						x	
Fiona Moore (Chief Executive)	x	x	x	x			
Fenella Wrigley (Medical Director)	x	x	x	x	x	x	
Andrew Grimshaw (Director of Finance and Performance then Acting Chief Executive)	x	x	x	x	x	x	Appointed to acting Chief Executive in January 2017
Andy Bell (Acting Director of Finance)					x	x	Appointed to acting Director of Finance in January 2017
Paul Woodrow (Director of Operations)	x	x	x	x	x	x	Appointed to substantive role from April 2016.
Trisha Bain (Chief Quality Officer)					x	x	Appointed to substantive role from January 2017
Briony Sloper (Acting Chief Quality Officer)		x	x	a			Appointed to acting Chief Quality Officer in June 2016.
Non-voting							
Sandra Adams (Director of Corporate Affairs/Trust Secretary)	x	x	x	x	x	x	
Karen Broughton (Director of Transformation, Strategy and Workforce)	x	x	x	x	a	x	
Mark Hirst (Interim Director of Human resources)	x	x			x		
Andrew Watson (Chief Information Officer)	x						Left the Trust in February 2017
Jill Patterson (Interim Director of Performance)	x						
Charlotte Gawne (Director of Strategic Communications		x					Attending by invitation

Annex 4 – Attendance at Quality Governance Committee meetings 2016/17

x = attended a = apologies	17th May 2016	12th July 2016	13th September 2016	15th November 2016	10th January 2017	7th March 2017	
Quality Governance Committee members							
Bob McFarland (Non-Executive Chair)	x	x	x	x	x	x	
Jessica Cecil (Non-Executive Director)	x	x	x	x	x	x	
Nick Martin (Non-Executive Director)	x	x	a	a	x		Left the Trust in February 2017
Fergus Cass (Non-Executive Director)	x	a	x	x	x	x	
Fiona Moore (Chief Executive)		x					Attending by invitation
Sandra Adams (Director of Corporate Governance/Trust Secretary)	x	x	x	x	x	x	
Fenella Wrigley (Medical Director)	x	x	x	x	x	x	
Briony Sloper (Acting Chief Quality Officer)		x	x	a		x	Appointed to acting Chief Quality Officer in June 2016 until January 2017
Trisha Bain (Chief Quality Officer)					x	a	From January 2017
Paul Woodrow (Director of Operations)	a	a	x	a	a	a	
Peter McKenna (Deputy Director of Operations)	x	x		x		x	Attending for Director of Operations
Tina Ivanov (Deputy Director of Clinical Education)	x	x	x	x	x	x	

Annex 5 – Attendance at Audit Committee meetings 2016/17

x = attended a = apologies	18th April 2016	19th May 2016	31st May 2016	5th September 2016	7th November 2016	15th February 2017	Comments
Audit Committee members							
John Jones (Non-Executive Director)	x	x	x	x	x	x	
Fergus Cass (Non-Executive Director)	x	x	x	x	x	x	
Theo de Pencier (Non-Executive Director)	x	x	a	x	a	x	
Attending							
Sandra Adams (Director of Corporate Governance/Trust Secretary)	x	x	x	a	x	x	
Fionna Moore (Chief Executive)	x				x		By invitation
Bob McFarland (Non-Executive)			x	x	x	x	
Andrew Grimshaw (Director of Finance and Performance and then Acting Chief Executive)	x	x	x	a	x		Appointed to acting Chief Executive in January 2017
Andy Bell (Acting Director of Finance)						x	Appointed to acting Director of Finance in January 2017

Annex 6 – Attendance at Workforce and OD Committee meetings 2016/17

x = attended a = apologies	**18th July 2016**	**26th October 2016**	**21st November 2016**	**23rd January 2017**	**20th March 2017**	**Comments**
Workforce and OD Committee members (voting)						
Fergus Cass (Non-Executive Director)	x	x	x	x	x	
Theo de Pencier (Non-Executive Director)	x	x	x	x	x	
Jayne Mee (Non-Executive director)					x	From March 2017
Jessica Cecil (Non-Executive director)		x	x		x	
Karen Broughton, Director of Transformation, Strategy and Workforce		x		x	x	
Paul Woodrow (Director of Operations)						
Fenella Wrigley (Medical Director)		x				
Briony Sloper (Deputy Director of Nursing and Quality)						
Mark Hirst (Interim Director of Workforce)	x		x	x	x	

Annex 7 – Attendance at Finance and Investment Committee meetings 2016/17

X = attended a = apologies	26th May 2016	25th July 2016	22nd September 2016	24th November 2016	19th January 2017	23rd March 2017	Comments
Finance and Investment Committee members							
Nick Martin (Non-Executive Director)	x	x	a	x	x	a	Left the Trust in February 2017
Heather Lawrence (Trust Chair)	x	a	a	a	x	x	
John Jones (Non-Executive Director)	x	x	x	x	a	x	
Jessica Cecil (Non-Executive Director)	a	a	x	x	x	x	
Theo de Pencier (Non-Executive Director)	a	x	x	x	x	x	
Andrew Grimshaw (Director of Finance and Performance and then Acting Chief Executive)	x	x	x	x	x	x	Appointed to acting Chief Executive in January 2017
Andy Bell (Acting Director of Finance)	x	x	a	a	x	x	Appointed to acting Director of Finance in January 2017
Sandra Adams	x	x	a	x	x	a	
Attending							
Jill Patterson	x	a	a	x	x	x	
Michael John	x	x	x	x	a	x	
Graeme Dunn	x	x	x	x	x	x	
Helen Conneally	x	a	a	x	x	a	

Annex 8 – Attendance at Quality Improvement Programme Board meetings in 2016/17

X = attended a = apologies	14th April 2016	17th May 2016	14th June 2016	14th July 2016	30th Augu	11th October 2016	24th November 2016	15th December 2016	19th January 2017	14th February 2017	30th March 2017	Comments
Quality Improvement Programme members												
Andrew Grimshaw (Acting Chief Executive)				x	x	x		x	x	x	a	
Andy Bell (Acting Director of Finance)									x	x	a	
Briony Sloper (Acting Chief Quality Officer)					x			a				
Charlotte Gawne (Director of Strategic Communications)	x	a	x	x	x	x		x	x	a	a	
Fenella Wrigley (Medical Director)				x	x	x	x	x	a	x	x	
Fergus Cass (Non-Executive director)	x	x	x	a	x	x	a	x		x	x	
Fionna Moore (Chief Executive)	x	x	a	x	x	x	x	x				
Heather Lawrence (Trust Chair)	x	x	x	x	x	x	x	x	x	x	x	
Karen Broughton (Director of Transformation, Strategy and Workforce)	x	x	x	x	x	x	x	x	x	x	x	
Paul Woodrow (Director of Operations)					x	x	x	a	x	x	a	
Robert McFarland (Non-Executive director)	a	x	x	x	x	x	a	x	x	x	x	
Sandra Adams (Director of Corporate Governance)					x	x	x	a	a	x	a	
Trisha Bain (Chief Quality Officer)									x	x	x	
Attending												
Alex Bass (Communications Manager)										x		
Andrew Watson (Chief Information Officer)						a						
Angie Patton (Communications Manager)		x										
Donna Fong (Programme Manager – PA Consulting)	x	x	x	x	x							
Janet Wint (Programme Manager)					x	a	x	a	x			
Justin Wand (DDO Fleet & Logistics')				x			x					
Lesley Stephen (Improvement Director NHSI)	x	x	x	x	x		x					
Maeve Stevenson (Minutes)	x	x	x	x	x	x	a	x	x	x	a	
Nic Daw (Head of PTS / NEDs)				x								
Nikki Fountain (Project Manager)						x	x	x	x		x	
Peter McKenna (DDO)				x								
Sally Herne (Improvement Director NHSI)									x		a	
Tim Edwards (Consultant Paramedic)							x					
Vic Wynn (Head of IM&T)						x		x	a		a	
Matthew Blow (Deloiites – Observing)									x			

Annex 9 - Attendance at Logistics and Infrastructure meetings in 2016/17

X = attended a = apologies	13th February 2017	Comments
Logistics and Infrastructure Committee members		
Theo de Pencier	x	
John Jones	x	
Sheila Doyle	x	
Andy Bell	x	
Sandra Adams	x	
Attending		
Justin Wand	x	
Martin Nelhams	a	
Vic Wynn	a	
Steve Bass	a	
Kevin Bate	a	
Graeme Dunn	x	

Annex 10 - New Risks Added to the Trust Risk Register in the Period 2016 – 2017

Datix ID	Risk Description
577	There is a risk that operating the LAS CAD system with continued levels of activity above the contract baseline will cause the system to fail and hence impact on patient care
531	There is a risk that the agreed A8 trajectory for 16/17 may be adversely affected by sustained over-activity against contractually agreed growth.
451	There is a risk that staff members who drive on behalf of the trust are not compliant with Trust policy, which states that checks will be undertaken every six months and these do not always occur to the standard or frequency defined.
217	It is likely that NHS financial and operational planning will include the need to develop efficiencies in order to offset other costs pressures for the foreseeable future. Failure to identify and deliver CIPS will threaten the on-going viability and solvency of the Trust.
575	Section 19 of the Road Safety Act 2006 is expected to come into force in the near future - the precise date has not been confirmed. This will stipulate a requirement to evidence completion of a driver training course and on-going assessment / competency checks. We cannot currently evidence this for all drivers. The on-going assessment will require a vast increase in the number of driving instructors as we currently would not be able to cope with demand. There is not a sufficient budget to cover this shortfall.
559	There is a risk that on-going delays in ambulance crews handing over their patients at Northwick Park Hospital ED will reduce operational cover in the surrounding area and compromise patient care.
433	Funding proposals for resources or identified costs to deliver the QIP do not align with the outcome of 2016/17 contracting discussions with Commissioners, and therefore unaffordable.
431	The LARP2 project will not deliver its main objectives (of implementing the new ESN based radio system in the control room, all LAS operational vehicles and other key areas before Jan 2020 when the current LAS contract with Airwave Ltd. expires).
428	There is a risk of potential industrial action as a result of national disputes regarding pay and conditions, which will cause substantial disruption on the organisation should it go ahead.
420	There is a risk that Trust systems are vulnerable to cyber-attacks that could defeat industry standard firewalls and virus detection systems, resulting in loss of sensitive personal data and access to critical operational systems.
240	Archiving space for training records is insufficient and now decentralised
116	There is a risk that there may be insufficient emergency ambulances and cars to meet demands.

482	Multiple IM&T incidents negatively affecting the stability of the 111 telephony platform combined with poor achievement of customer requirements has adversely affected 111's service reputation, service provision and overall stability 1. Technical faults to telephony systems causing numerous symptoms affecting 111 operational and support staff - ultimately affecting the quality of service the LAS provides to our patients 2. Telephony system reporting (live and historical) functionality: The new 111 Telephony system does not have the same reporting functionality as the previous system (new system has been place since March 31st), this limits the ability of 111 Management staff to safety and proactively manage their shift and deployment of staff against demand.
445	There is a risk that defibrillation may be delayed by clinical staff in cases where fine ventricular fibrillation (VF) is not recognised.
432	The Quality Improvement Programme fails to achieve tangible outcomes in the first 6-12 months diminishing stakeholder support.
495	Children involved in youth violence may suffer greater harm as a result of a safeguarding referral not being made and appropriate help and support may not be provided by the local authority or other agencies as a result.
219	Failure to maintain an effective financial control environment could lead to poor decision making and the waste of public funds.
69	There is a risk that the Trust is unable to provide assurance that it is compliant with safeguarding training requirements for clinical and non-clinical staff.
28	There is a risk that voice recordings of 999 calls and radio transmissions more than 2-3 years old cannot be retrieved for the purpose of investigating claims and preparing for inquests. This is contrary to Records Management: NHS Code of Practice which states that the minimum retention period for ambulance records is 10 years. Audio records are covered by the retention schedule.
13	There is a risk that the Board Assurance Framework and/or the Trust Risk Register may not be up to date because of the delays in or lack of response to requested for information. This can have a negative reflection on the LAS when involving external parties e.g. NHS Improvement.
538	There is a risk around the security of personal information that is sent around the Trust without the use of encrypted email (egress). Legal services send call logs and prfs by egress to stations and staff and receive unencrypted emails back from some stations with witness statements containing personal information attached.
308	There is a risk that we will be unable to ensure mentoring of Apprentice Paramedics, as a consequence of insufficient core line capacity, and qualified Paramedics to act as mentors.

76	Industrial Action - There is a risk that patient safety may be compromised during periods of industrial action taken by London Ambulance Service staff as a result of current national ballots.

Remuneration and staff report

Remuneration

Our Remuneration and Nominations Committee consists of the Chairman and the six non-executive directors. The Chief Executive is usually in attendance but is not present when their own remuneration is discussed.

The Remuneration and Nominations Committee is responsible for advising the Board about appropriate remuneration and terms of service for the Chief Executive and executive directors. It makes recommendations to the Board on all aspects of salary, provisions for other benefits (including pensions and cars), as well as arrangements for termination of employment and other contractual terms.

In formulating their recommendations to the Board, the Committee takes into account a number of factors, including the requirements of the role, the performance of the individuals, market rates, affordability, and the NHS Very Senior Managers Pay Framework.

Executive directors are subject to normal terms and conditions of employment. They are employed on permanent contracts which can be terminated by either party with six months' notice.

Their performance is assessed against individually set objectives and monitored through an appraisal process.

For the purposes of this report, the disclosure of remuneration to senior managers is limited to our executive and non-executive directors. Details of remuneration, including salaries and pension entitlements, are published on pages 55 to 59.

Banded Remuneration analysis

The banded remuneration of the highest paid director in the London Ambulance Service in the financial year 2016/17 was in the range of £195,001 to £200,000. The pay multiplier in 2016/17, based on annualised salary, was 5.60 times the median remuneration of the workforce, which was £35,218. In 2015/16, the banded remuneration of the highest paid director £195,001 to £200,000. The pay multiplier in 2015/16, based on annualised salary, was 5.32 times the median remuneration of the workforce, which was £36,930.

In 2016/17, as in the previous year, none of the employees received remuneration in excess of the highest paid director.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The change in ratio was due to:

- The reduction in overtime being worked by frontline staff in 2016/17 compared with 2015/16.

The appointment and remuneration of the Chairman and the non-executive directors are set nationally. Non-executive directors are normally appointed for a period of four years and usually serve two terms in office.

The information contained below in the Salary and Pension Entitlement of Senior Managers has been audited by our external auditors.

Salary and pension entitlements of senior managers

A) Remuneration 2016/17

Name and Title	Salary (bands of £5,000) £'000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £'000	Long term performance pay and bonuses (bands of £5,000) £'000	All pension related benefits (bands of £2,500) £'000	Total (bands of £5,000) £'000
Heather Lawrence, Chairman	£35,001-£40,000	£0	£0	£0	£0	£35,001-£40,000
Jessica Cecil, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Robert McFarland, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Nicholas Martin, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
John Jones, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Fergus Cass, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Theo de Pencier, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Sheila Doyle, Non-Executive Director	£0-£5,000	£0	£0	£0	£0	£0-£5,000
Jayne Mee, Non-Executive Director	£0-£5,000	£0	£0	£0	£0	£0-£5,000
Fionna Moore, Chief Executive (up to 31 December 2016)	£145,001-£150,000	£3,600	£0	£0	£0	£145,001-£150,000
Andrew Grimshaw, Director of Finance (up to 31 December 2016), Acting Chief Executive (from 1 January 2017)	£130,001-£135,000	£0	£0	£0	£40,001-£42,500	£170,001-£175,000
Andy Bell, Acting Director of Finance (from 1 January 2017)	£20,001-£25,000	£0	£0	£0	£40,001-£42,500	£60,001-£65,000
Paul Woodrow, Director of Operations	£115,001-£120,000	£7,100	£0	£0	£207,501-£210,000	£330,001-£335,000
Fenella Wrigley, Medical Director	£110,001-£115,000	£4,800	£0	£0	£202,501-£205,000	£320,001-£325,000
Zoe Packman, Director of Nursing and Quality (up to 25 May 2016)	£15,001-£20,000	£0	£0	£0	£17,501-£20,000	£35,001-£40,000
Briony Sloper, Acting Director of Nursing (from 6 June 2016 to 31 December 2016)	£45,001-£50,000	£0	£0	£0	£50,001-£52,250	£95,001-£100,000

Patricia Bain, Chief Quality Officer (from 3 January 2017)	£30,001-£35,000	£0	£0	£0	£0	£30,001-£35,000

The figures show under the heading “expenses payments” refer to the provision of lease cars.
* The following directors left the Trust during the year; Nicholas Martin on 28th February 2017, Zoe Packman on 25th May 2017 and Fionna Moore on 31st March 2017.
** The following directors joined the Trust during the year; Sheila Doyle on 6th February 2017, Jayne Mee on 9th January 2017 and Patricia Bain on 3rd January 2017.

Salary and pension entitlements of senior managers

Remuneration 2015/16

Name and Title	Salary (bands of £5,000) £'000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £'000	Long term performance pay and bonuses (bands of £5,000) £'000	All pension related benefits (bands of £2,500) £'000	Total (bands of £5,000) £'000
Richard Hunt, Chairman	£20,001-£25,000	£0	£0	£0	£0	£20,001-£25,000
Jessica Cecil, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Robert McFarland, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Nicholas Martin, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
John Jones, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Fergus Cass, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Theo de Pencier, Non-Executive Director	£5,001-£10,000	£0	£0	£0	£0	£5,001-£10,000
Fionna Moore, Medical Director Chief Executive (Acting to 23 July 2015)	£145,001-£150,000	£4,700	£0	£0	£0-£2,500	£150,001-£155,000
Andrew Grimshaw, Finance Director	£125,001-£130,000	£0	£0	£0	£20,001-£22,500	£150,001-£155,000
Jason Killens, Director of Operations (to the 25 September 2015)	£50,001-£55,000	£1,900	£0	£0	£0-£2,500	£55,001-£60,000
Paul Woodrow, Director of Operations (Acting Director of Operations from 28 September 2015)	£50,001-£55,000	£4,900	£0	£0	£22,501-£25,000	£80,001-£85,000
Fenella Wrigley, Medical Director (Acting to February 2016)	£95,001-£100,000	£4,000	£0	£0	£77,501-£80,000	£175,001-£180,000
Zoe Packman, Director of Nursing and Quality (Acting)	£75,001-£80,000	£0	£0	£0	£10,001-£12,500	£85,001-£90,000

Salary and pension entitlements of senior managers (continued)

B) Pension benefits

Name and title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2017 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2016	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Valve at 31 March 2017	Employers contribution to stakeholder pension
Heather Lawrence, Chairman	**	**	**	**	**	**	**	
Jessica Cecil, Non-Executive Director	**	**	**	**	**	**	**	
Robert McFarland, Non-Executive Director	**	**	**	**	**	**	**	
Nicholas Martin, Non-Executive Director	**	**	**	**	**	**	**	
John Jones, Non-Executive Director	**	**	**	**	**	**	**	
Fergus Cass, Non-Executive Director	**	**	**	**	**	**	**	
Theo de Pencier, Non-Executive Director	**	**	**	**	**	**	**	
Sheila Doyle, Non-Executive Director	**	**	**	**	**	**	**	
Jayne Mee, Non-Executive Director	**	**	**	**	**	**	**	
*Fionna Moore, Chief Executive (up to 31 December 2016)	*	*	*	*	*	*	*	
Andrew Grimshaw, Chief Executive (from 1 January 2017)	£2,500-£3,000	£0-£2,500	£35,001-£40,000	£95,001-£100,000	£579,079	£51,154	£630,233	
Andy Bell, Acting Director of Finance (from 1 January 2017)	£0-£2,500	£0-£2,500	£15,001-£20,000	£35,001-£40,000	£163,921	£3,455	£177,933	
Fenella Wrigley, Acting Medical Director (acting to February 2016)	£7,501-£10,000	£22,501-£25,000	£35,001-£40,000	£105,001-£110,000	£454,318	£183,247	£637,565	
Paul Woodrow, Director of Operations	£7,501-£10,000	£22,501-£25,000	£35,001-£40,000	£110,001-£115,000	£527,424	£179,600	£707,024	
Zoe Packman, Director of Nursing and Quality (from 1 April 2016 to 25 May 2016)	£0-£2,500	£0-£2,500	£40,001-£45,000	£130,001-£135,000	£775,034	£7,108	£822,205	
Briony Sloper, Acting Director of Nursing and Quality (from 6 June 2016 to 31	£0-£2,500	£0-£2,500	£15,001-£20,000	£35,001-£40,000	£189,692	£25,030	£233,405	

December 2016								
*Patricia Bain, Chief Quality Officer	*	*	*	*	*	*	*	

* Fionna Moore is not an active member of the NHS pension scheme. Trisha Bain has claimed her retirement benefits.
** As non-executive directors they do not receive pensionable remuneration, there are no disclosures in respect of pensions for non-executive directors.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No. 1050 Occupational Pension Schemes (Transfer Values) Regulations 2008 (23).

Real increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Table 1: Exit packages

Exit Package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
		£s		£s		£s		£s
Less than £10,000			1	9,262	1	9,262		
£10,000 - £25,000			1	15,531	1	15,531		
Totals			2	24,793	2	24,793		

Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year.

Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

Reporting of other compensation schemes – Exit packages

	Agreements	Total value of agreements
	Number	£000s
Voluntary redundancies including early retirements contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	2	25
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring MHT approval	0	0
Total	**2**	**25**

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

Table 1:Off-Payroll engagements

For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2017	0
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

All existing off-payroll engagements have been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 2: New Off-Payroll engagements

For all new off-payroll engagements between 1 April 2016 and 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	1
Number of new engagements which include contractual clauses giving the London Ambulance Service NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	1
Number of new engagements for whom assurance has been requested	1
Of which:	
Assurance has been received	1
Assurance has not been received	0
Engagements terminated as a result of assurance not being received	0

Table 3: Off-payroll board member/senior official engagements

For any off-payroll engagements of board member, and/or, senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year.	0
both on payroll and off-payroll engagements.	11

Staff report

Average Staff Numbers

The average number of staff has increased over last year 5,054 (2015/16 4,756) as the trust continues to recruit additional paramedics.

Staff Category	Total Number	Permanently employed Number	Other Number
Medical and Dental	2	2	0
Ambulance Service	2,597	2,553	44
Administration and estates	1,392	1,288	104
Healthcare assistants and other support staff	1,034	1,034	0
Nursing, midwifery and heath visiting staff	29	14	15
Total	**5,054**	**4,891**	**163**

The average number of employees is calculated as the whole time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year. The “contracted hours” method of calculating whole time equivalent number should be used, that is, dividing the contracted hours of each employee by the standard working hours.

Staff Composition

At the end of March 2017, we had a workforce of 5,164 staff, made up of 2,843 men and 2,321 women. This was broken down as follows:

	Total	Female	Male
Directors	25	14	11
Senior Managers	458	169	289
Employees	4,681	2,138	2,543
Total	**5,164**	**2,321**	**2,843**

Over the course of the year, a total of 510 people left the service – a turnover rate of 9.8 per cent, compared to 12.2 per cent in 2015/16.

While we were able to recruit new staff during the year, we also saw existing frontline staff leaving in greater numbers than usual, 174 paramedics left during 2016/17.

Staff Sickness

The average working days lost in 2016/17 was 11.7 (2015/16 12.60). The data is based on calendar years January 2016 (2015) to December 2016 (2015).

Staff Policies

We welcome our obligations under equalities legislation, including the Equality Act 2010. Our aim is to ensure that equality and inclusion is integral to everything we do.

We welcome people to our organisation from any background, who are committed to providing high-quality care that meets the needs of the diverse communities we serve. We aim to provide innovative and responsive healthcare which meets the needs of all these communities, providing better healthcare for all.

Our policy is to treat everyone fairly and without discrimination, and we want to ensure that:

- patients and customers receive fair and equal access to our healthcare service;
- everyone is treated with dignity and respect; and
- staff experience fairness and equality of opportunity and treatment in their workplace.

We want to be an employer of choice, and to attract the best and most talented people from all walks of life to a career where they can develop to their full potential.

As an employer, we are focusing on:

- celebrating and encouraging the diversity of our workforce and creating a working environment where everyone feels included and appreciated for their work;

- promoting and providing training and employment opportunities regardless of age, disability, gender reassignment, marital status, pregnancy or maternity, race, religion or belief, sex, sexual orientation or any other aspect of an individual person's background; and
- fostering creativeness and innovation in our working environment, so that all staff can deliver to the best of their ability and help us take forward our equality and inclusion goals.

Expenditure on Consultancy

In 2016/17 the trust spent £1.5m on various consultancy projects covering strategy, organisational and change management, performance improvement and technical services.

Accountable Officer: Andrew Grimshaw, Chief Executive

Organisation: London Ambulance Service NHS Trust

Signature:

Date:

3. Financial statements

2016/17 Introduction to the Annual Accounts

Financial Performance

2016/17 saw major recurrent investment in the London Ambulance Service by London Clinical Commissioning Groups (CCGs) in support of a programme of quality improvement. This investment was to increase capacity and recruit additional staff for the benefit of patient care. This investment was designed to replace non-recurrent funding that had been made available to the service in previous years.

For the financial year 2016/17 the Trust reported a surplus of £6.0m. The Trust had planned to report a £6.7m deficit. The improvement was due to in year non recurrent income mainly relating to sustainability and transformation funding. The following table summarises the key elements of the financial performance of the Trust in 2016/17

	Plan £m	Actual £m	Variance £m
Income	330.6	354.2	23.6
Expenditure	337.3	349.2	11.9
EBITDA	11.9	22.8	10.9
Deficit	(6.7)	6.0	12.7
Capital Resourcing Limit (CRL)	19.6	12.5	7.1
External Financing Limit (EFL)	1.6	1.6	0.0
Cash	6.7	18.6	11.9

In line with all NHS organisations LAS was required to identify efficiencies. In total £10.5m was identified and delivered in 2016/17. The Trust continued to invest in new equipment, spending in excess of £12.9m on new vehicles to help improve the age profile of the fleet, IMT system renewal and improvement and additional clinical equipment. The Trust also completed a business case for a further 140 new ambulances for delivery across 2017/18.

	£m
Capital Expenditure	12.9
Less:	
Donated assets	(0.2)
NBV of Disposals, Termination of lease	(0.2)
Capital Resourcing Limit (CRL)	12.5

NHS Trusts have a number of financial duties. This section of the annual report outlines the financial performance of the Trust for the financial year ended 31 March 2017 and the results outlined in this section relate to the full 12 month period of 1 April 2016 to 31 March 2017. A copy of the full statutory audited accounts is included in this annual report together with a glossary of terms to assist the reader in interpreting the accounts.

Financial Duties Review

Break-even duty

NHS trusts have a regulatory duty to break-even in each and every financial year. The achieved its break-even duty.

External Financial Limit

The External Financing Limit (EFL) is the means by which the Treasury, via the Department of Health and the TDA, controls public expenditure in NHS trusts. This is a statutory financial duty, with a maximum tolerance of only 0.5 per cent of turnover under the agreed limit. Exceeding these limits requires prior approval. Trusts are permitted to undershoot their EFL targets.

Most of the money spent by the Trust is generated from its service agreements for patient care and income generation (income from operations). The EFL determines how much more (or less) cash the Trust can spend in a year than is generated from its operations.

The original planned EFL was £13.5m; during the year the EFL was revised to £1.6m. The trust achieved its EFL target of £1.6m.

Capital Cost Absorption Duty

The financial regime of NHS trusts recognises that there is a cost associated with the maintenance of the capital value of the organisation. Trusts are required to absorb the cost of capital at a rate of 3.5% of average relevant net assets. The rate is calculated as

the percentage that dividends paid on public dividend capital bears to the average relevant net assets of the trust. To meet this duty, trusts must achieve a rate between three per cent and four per cent.

A return on assets (the capital cost absorption duty) of 3.5% was achieved. This was within the permitted range of 3% to 4%.

Capital Resourcing Limit

The Capital Resourcing Limit (CRL) is part of the resource accounting and budgeting arrangements in the NHS and its purpose is to ensure that resources allocated by the government for capital spending are used for capital, rather than to support revenue budgets. All NHS bodies have a capital resource limit.

A capital resource limit controls the amount of capital expenditure that a NHS body may incur in the financial year. Under spends against the CRL are permitted by the Department of Health.

The Trust spent £12.9million on a range of projects, including ambulances (115 procured in year) and fast response cars (60 new cars), new technology projects and a range of projects to improve clinical equipment and the estate. Overall, the Trust under spent by £7.1m against its capital resource limit, which it is permitted to do. The capital programme was funded internally (no loans or external support from the DH). The under spend on the capital programme will be carried forward into the next financial years capital programme.

Apply the Better Payment Practice Code

This regulatory duty requires NHS Trusts to pay all supplier invoices within 30 days. The Trust paid 84% of its NHS trade invoices respectively within 30 days; this is below the 95% target set by the Department of Health.

Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme and the accounting policy is set out in note 7.3 to the full Annual Accounts. The Remuneration report sets out information on the pension benefits of directors.

Financial plan 2017/18

The Trust has formally submitted a plan for the coming financial year, 2017/18 that takes into account planned contracted income levels and expenditure requirements. These plans have been set in line with guidance from the DH, NHSI as well as discussions with clinical commissioning groups across London. The plan is set to deliver a deficit of £2.5 million.

Financial risk

The Trust monitors financial risk through the assurance framework and risk management processes as detailed in the statement of internal control included in the financial statements.

International Financial Reporting Standards (IFRS)

The Treasury announced that public sector bodies are required to prepare their accounts under International Financial Reporting Statements (IFRS) from 2009/10. That was the first year that we prepared our accounts under IFRS, resulting in the rework of 2008/09 results to act as prior year comparators in the 2009/10 accounts.

Professional valuation was carried out by the District Valuers of the Revenue and Customs Government Department on 31 March 2016 for all land and buildings. The net gain and loss on revaluation was £10.1 million and the total impairments were £0.1 million.

IAS 19 requires us to accrue for remuneration earned but not yet taken. In this instance, we have made an accrual for annual leave of £4.6 million for the current financial year (£5.4 million in 2015/16).

Subsequent events after the balance sheet date

The Trust has not identified any important event occurring after the financial year end, 31st March 2017, that has a material effect on the 2016/17 financial statements as presented.

Other information

Ernst Young LLP were the Trusts external auditor for the year ended 31st March 2017. The Trust paid £68,000 (£68,000 in 2015/16) for audit services relating to the statutory audit. All issues relating to financial audit and financial governance are overseen by our Audit Committee. Ernst Young LLP carried out some non-audit work during the year ended 31st March 2017. It performed a review of the computer aid despatch system for the Trust at a cost £19,000.

The directors confirm that, as far as they are aware, there is no relevant audit information of which the NHS body's auditors are unaware

and that they have taken all the steps that they should have taken as directors in order to make themselves aware of any relevant audit information and to establish that the NHS body's auditors are aware of that information.

The Trust conforms to the Treasury's guidance on setting charges for information supplied to the public or commercial organisations.

The London Ambulance Service is a NHS trust established under the National Health Service Act 2006. The Secretary of State for Health has directed that the financial statements of the NHS trusts will meet the accounting requirements of the NHS Trusts Manual for Accounts, which will be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2016/17 Group Accounting Manual issued by the Department of Health.

The financial statements for the year follow. A copy can be obtained free of charge from the Head of Financial Services who can be contacted at the address given at the end of this annual report.

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place, and
- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

nb: sign and date in any colour ink except black

Signed ……..... Chief Executive

Date ……

STATEMENT OF THE DIRECTORS RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

nb: sign and date in any colour ink except black

…… Date ……. ……Chief Executive

…… Date ……. ……Financial Director

INDEPENDENT AUDITORS REPORT TO LAS

TO BE ADDED HERE

LONDON AMBULANCE SERVICE ANNUAL ACCOUNTS

FULL SET OF ACCOUNTS TO BE ADDED HERE

A copy of our full accounts is available from the Head of Financial Services at the following address:

Head of Financial Services
Finance Department
London Ambulance Service NHS Trust
220 Waterloo Road
London
SE1 8SD

Appendix - Glossary of Terms

(This glossary does not form a part of the statutory accounts)

STATEMENT OF COMPREHENSIVE INCOME

Statement Of Comprehensive Income (Income And Expenditure)
Under UK GAAP used to be called a Profit and Loss account or an Income and Expenditure account. Public sector accounts tend to use the term Income and Expenditure to indicate that they are non-profit making organisations.

Revenue From Patient Care
Activities Income from patient care activities of the Trust, usually from Clinical Commissioning Groups as the principle commissioner of services.

Income and Expenditure
Often called a Profit and Loss account or an Income and Expenditure account. Public sector accounts tend to use the term Income and Expenditure to indicate that they are non-profit making organisations.

Income from activities
Income from patient care activities of the Trust, usually from Clinical Commissioning Groups as the principle commissioner of services.

Other operating income
Income from non-patient care services such as commercial training, research funding etc.

Operating surplus
The surplus generated by the normal operations of the Trust before taking into account interest, depreciation and amortisation

Depreciation
When a fixed asset is purchased, the cost of that asset needs to be charged to the income and expenditure account over the life of the asset to recognise the contribution of that asset to the work of the Trust in each year of ownership. On purchase of a fixed asset, the expected life is assessed and the cost is spread over that life. The value of the asset therefore diminishes, or depreciates, over time.

Amortisation
Where depreciation applies to tangible fixed assets, amortisation is the same process for non-tangible fixed assets, such as loans to the Trust.

Profit / (loss) on disposal of fixed assets
The difference between the value of an asset in the balance sheet and the actual sale price of the item. This could be equipment or buildings.

Public Dividend Capital (PDC)
PDC originated in NHS Trusts as the difference between the valuation of its assets and liabilities on establishment as an NHS Trust. This originating debt is deemed an asset of the Secretary of State, and equates to taxpayers equity in the organisation. The Trust has to make a return on this capital equivalent to 3.5% per annum, and this amount has to be paid over to the Treasury. The original debt can increase over time due to the allocation of additional capital funds, and is repayable over time.

STATEMENT OF FINANCIAL POSITION

Fixed Asset / Non-Current Assets
An asset that has a life that extends beyond the current financial year and that will generate economic benefits in future accounting periods– as opposed to current assets, which are realisable immediately or in the next accounting period. Fixed assets are typically equipment or buildings.

Current Assets
These are assets that are held on the balance sheet of the organisation that have an immediate cash value. These include stocks, that could be sold and realise cash quickly, debtors that can be collected quickly to realise cash or cash held in a bank account.

Stock / Inventories
Material held as stock which could be sold to realise cash quickly. Can either be valued at cost where stock is valued in the books at the purchase price or, net realisable value where stock is valued in the books at a value that it could reasonably be expected to fetch if it was sold on open market today.

Debtors / Receivables
Money owed to the Trust for services provided.

Creditors / Payables
Money owed by the Trust for goods and services received.

Total Taxpayers' Equity
See Public Dividend Capital

NOTES TO THE ACCOUNTS

Historical Cost Convention
The value of an asset carried in the balance sheet is the amount paid for it on the purchase date.

Accruals Convention
The accounts are prepared taking account of all income received and receivable, and all expenditure paid and payable for the goods and services delivered and received in the period, and are not based on cash receipts and payments in the period.

Off Balance Sheet
Refers to fixed assets that are in use by the trust but which are not technically 'owned' by the organisation, and therefore do not appear in the balance sheet. An example of this would be operating leases, where equipment, such as vehicles, is leased by the organisation but never comes into our ownership.

Liquid Resources
Resources that can be released quickly to enable the organisation to settle debts. Typically, cash in hand or in the bank in short term accounts.

Prepayment
Where the Trust has paid in advance for goods
or services – for example, quarterly payment in advance for telephone rentals.

Deferred Income
Income received in the financial year but deferred to a subsequent accounting period because the relevant services will be provided in that future accounting period.

Reserves
Funds set aside in recognition of a future event, project or change, where the need has been recognised but the event has not happened.

TERMINOLOGY

Going Concern Basis
The accounts are prepared on the basis that the Trust will still be in existence in the next financial year, and that it will therefore be in a position to recover any debtors due to it, and that it will be around to cover its long term liabilities. If it is likely that an organisation will not be in existence beyond this set of accounts, then long term liabilities would become immediately due, and the position of long term debtors would be called into question, resulting in the need to recognise that in the results presented in this set of accounts.

Capital Expenditure
The amount expended by the Trust that enhances the value of fixed assets whose useful life extends beyond the current accounting period.

Revenue Expenditure
Expenditure on the day to day operations of the Trust, pay and rations as opposed to capital expenditure.

Consumables
Non pay expenditure on items that have a life of less than one year and are therefore not fixed assets. The term relates to everything from drugs, uniform, stationery through to pieces of disposable equipment.

CCGs - Clinical Commissioning Groups
New organisation established from 1st April 2013.

Liability
A situation where an organisation has an obligation to pay for something that has already occurred, and around which there is certainty, but is not yet physically paid for.

Provisions
An allowance in the accounts for a known item,
but where the value or timing of the event giving rise to it is uncertain. An example may be where a pay award from 1 January in a given year has not yet been agreed, and the settlement date
is uncertain. The organisation would typically provide an estimate for inclusion in the accounts to ensure that the relevant charge to Income and Expenditure is made in the correct year.

Contingent Liability
A situation where a financial obligation to pay for
something that has already happened may arise, but where there is uncertainty or where the final value is difficult to quantify due to dependencies on other things. For example, an outstanding legal claim against the organisation, where if
the verdict goes against the organisation, there will be an obligation to pay for an unquantifiable amount. Amounts carried in the accounts under this heading will inevitably be estimates based on the best information available at the time.

Value Added Tax (VAT)
May be in the form of output tax – VAT charged
on sales, or input tax – VAT paid on purchases. In the NHS, normal NHS healthcare activity does not attract VAT.

Post Balance Sheet Event

Something that is recognised after the accounts
have been finalised, but before publication, which impacts on the results as they are presented,
and has a significant impact on how the results should be interpreted.

Risk Pooling Scheme
This is essentially the NHS insurance scheme,
where we pay an annual premium to cover any insurance claims that may arise during the year.
The scheme covers all the usual insurance risks around buildings, equipment, fire etc, as well as clinical negligence issues.

NHSLA
The NHS Litigation Authority is the body responsible for handling negligence claims against NHS organisations. The NHSLA also advises NHS organisations on risk management.

Losses and Special Payments
Any payments made in respect of bad debts,
stock write offs, insurance excesses or compensation payments that are not considered a part of the normal business of the Trust.

HART
Hazardous Area Response Team

RRV
Rapid Response Vehicle

PTS
Patient Transport Service.

London Ambulance Service NHS Trust

Report to:	**Trust Board (Public)**
Date of meeting:	**25th May 2017**
Document Title:	**Annual Financial Accounts**
Report Author(s):	**Andy Bell**
Presented by:	**Andy Bell**
Contact Details:	**Andy.bell@lond-amb.nhs.uk**
History:	***ELT, FPC, Audit Committee***
Status:	***Approval***

Background/Purpose

- The accounts presented here have been produced in line with;
  - LAS accounting policies.
  - Relevant financial reporting standards.
  - NHS accounting requirements.
  - They are seen to;
  - Be by the Finance Department as a true and fair view of the financial performance of the Trust for 2016/17.
  - They are consistent with the reporting of financial performance across 2016/17.
  - Include all material transactions up to 31st March 2017, and there are No material events after the reporting period that need to be reported to the Audit Committee other than those specified.
- During the course of 2016/17 the Trust;
  - Did not enter into any new material transactions.
  - Did not take any new loans or material financing arrangements.
  - Disposed of an asset, a mast site, for £0.2m
  - The draft accounts were approved by the Audit Committee on the 18th April 2017 and as a result the draft accounts have been;
  - Submitted as top line figures to NHSI on 19th April 2017
  - Submitted as final accounts to NHSI on 26nd April (including STF incentives)
  - Subject to external audit by Ernst & Young from wc 25th April 2017.
  - The Auditors provided an interim ISA260 at the Audit Committee 18th May 2017 which showed no material issues.
  - The Auditors have provided a final ISA260 to the Audit Committee 25th May 2017.
  - The Board are asked to approve the final accounts for submission at the meeting on 25th May 2017
  - The Accounts will be signed off by the CEO and DoF ahead of final submission on 1st June 2017

Action required

The Trust Board is requested to approve the Annual Financial Accounts provided for submission by

the deadline of the 1st June 2017.

Links to Board Assurance Framework and key risks

ID	Description	Gross Level	Risk level (current)	Risk level (Target)
218	There is a risk that If the Trust does not plan effectively it will not be aware of risks and threats. These could result in significant risk to the ongoing viability of the organisation, operations and clinical safety.	High	Significant	Moderate
217	It is likely that NHS financial and operational planning will include the need to develop efficiencies in order to offset other costs pressures for the foreseeable future. Failure to identify and deliver CIPS will threaten the ongoing viability and solvency of the Trust.	High	High	Moderate
214	NHSI expects all NHS trusts to achieve financial balance in 2016/17, managing within available resources. Failure to achieve this will mean the Trust is in deficit and will see a deterioration in its long term financial viability and will be subject to further scrutiny and challenge by regulators.	High	High	Significant
232	There is risk that failure to identify and then deliver necessary capital investment could result in the Trust failing to deliver safe clinical services to the required standards.	High	Moderate	Moderate
365	There is a risk that on occasions where individuals breach the terms of the SFIs or SOs there are no consequences to those breaches and therefore risks are not properly mitigated or resolved. Therefore financial controls can be ineffective.	High	Significant	Moderate
231	There is a risk that if the Trust does not understand its cost structures, it will not be able to make effective decisions regarding the viability of services, and it may limit the organisation's ability to defend services that are subject to market testing by commissioners or to win new business.	Significant	Significant	Moderate
227	There is a risk that if the Trust does not create an effective procurement function and ensure that staff comply with its requirements when procuring goods and services, it will result in poor procurement. This could impact on both patient safety and value for money.	Significant	Significant	Moderate
226	There is a risk that the Trust fails to manage its financial position compromising the agreed financial plan and ultimately presenting a challenge to the solvency of the organisation.	Significant	Significant	Moderate
222	Failure to manage cash could result in the Trust not being able to meet its liabilities when they fall due. Ultimately poor cash management could result in the organisation and its directors acting illegally if it were to cease to be a going concern.	Significant	Significant	Moderate
219	Failure to maintain an effective financial control environment could lead to poor decision making and the waste of public funds.	Significant	Significant	Moderate

Key implications and risks in line with the risk appetite statement where applicable:	
Clinical and Quality	
Performance	
Financial	The annual accounts provide key external assurance of the Trust's financial position
Workforce	
Governance and Well-led	
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	
Achieving Good Governance	**X**
Improving Patient Experience	
Improving Environment and Resources	**X**
Taking Pride and Responsibility	

London Ambulance Service NHS Trust
Trust Board
25th May 2017

Overview 2016/17 Annual Accounts

Andy Bell
Finance Director

Production of the Annual Accounts

- The accounts presented here have been produced in line with;
  - LAS accounting policies.
  - Relevant financial reporting standards.
  - NHS accounting requirements.

- They are seen to;
  - Be by the Finance Department as a true and fair view of the financial performance of the Trust for 2016/17.
  - They are consistent with the reporting of financial performance across 2016/17.
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  - The Auditors have provided a final ISA260 to the Audit Committee 25th May 2017.
  - The Board are asked to approve the final accounts for submission at the meeting on 25th May 2017
  - The Accounts will be signed off by the CEO and DoF ahead of final submission on 1st June 2017

Actions taken to ensure the accounts represent a true and fair view.

- The income end expenditure position has been reported in line with financial performance as reported throughout the year. This has been subject to review at the FIPC.
- Income has been assessed to ensure all reported income is seen as recoverable. Specific mention is made later in this report around debts from CCGs where risks had been raised during the course of the financial year.
- Expenditure has been reviewed to ensure it is complete and relates to the accounting period being reported. The Finance Department has sought to ensure all budget holders and staff with responsibilities for ordering goods and services report all known costs and charges completed within 2016/17.
- Finance have reviewed the criteria for achieving STF funding and these are assessed to have been met.
- Fixed assets have been reviewed and validated. The estate has been subject to a revaluation.
- Stock counts have been undertaken. Finance staff have overseen that process this year working alongside local staff .

Statutory Financial Duties (As presented to 18th May Audit Committee)

Duty	Target	Outcome	Comment
Capital Cost Absorption Rate	3.5%	3.5%	Achieved
External Financing Limit (EFL)	£1.6m	£1.6m	Achieved pending EFL adjustment from NHSI.
Capital Resource Limit (CRL)	£19.2m	£12.5m	Achieved. The Trust has underspent against CRL by which it is permitted to do. This has increased by £0.1m since the previous submission due to an adjustment for donated assets.
Break-Even duty - forecast	(£6.7m)	£6.1m	Achieved. This has improved from the £5.0m reported at the previous Audit Committee due to residual STF funding
Better Payment Practice Code (non-NHS) – volume	95%	84%	Not Achieved. 3% reduction in performance on Volume but 1% improvement on Value compared to 2015/16 performance
Better Payment Practice Code (non-NHS) – value	95%	81%	

Going concern

- LAS will report a £6.1m surplus in 2016/17 which meets its breakeven statutory target.
- LAS is planning to report a deficit in 2017/18 of £2.4m. This is based on;
  - Expected income. Including circa £20.0m funding for 9% demand growth.
  - Funded budgets are consistent with expected performance forecasts.
  - Funded capital investment across 2017/18.
  - An assessment of known inflationary pressures and national financial planning requirements.
- Based on this LAS expects to;
  - Be able to maintain a positive cashflow across 2017/18 .
  - Not require any external financial support to achieve this.
  - Pay its creditors across 2017/18 as they fall due.
- There remain some risks within this position, and this has been articulated in the plan approved by FIPC and he Board. However, the gap is not seen as material in respect of the going concern judgement required at this time. This will remain under review.

Conclusion

- The accounts have been adjusted in line with increased STF funding in the SOCI and donated assets against the CRL
- Other than the items stated above there are no material variations in the core statements of the accounts

- **The Audit Committee actions :**
  - The committee has reviewed the annual accounts and external audit report in detail at the 25th May 2017 Meeting
  - The Chair of the Audit Committee will provide feedback and a recommendation to the Trust Board on the 25th May 2017.
  - Subject to the final Audit opinion provided to the committee on the 25th May 2017, The committee will recommend that the Trust Board approves the accounts for final submission by the 1st June 2017.

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**25th May 2017**
Document Title:	**Integrated Performance Report – Trust Board Executive Summary - Abridged**
Report Author(s):	**Key Leads from Quality, Finance, Workforce, Operations and Governance**
Presented by:	
Contact Details:	
History:	
Status:	**Information Assurance and Discussion.**

Background/Purpose

The High - Level Integrated Performance Report serves to provide an Executive Summary for Trust Board to give an organisational oversight of all key areas across London Ambulance Service.

This month an abridged version of this report was produced to ensure the submission schedule was met in a timely fashion.
The timing of the Trust Board dates were a contributing factor that impacted on the availability of the data, normally contained within the report.

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

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

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

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

Action required

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

Links to Board Assurance Framework and key risks	
• This report contains an overview of Trust Risks directly linked to the BAF but does not itself raise any risks.	
Key implications and risks in line with the risk appetite statement where applicable:	
Clinical and Quality	
Performance	
Financial	
Workforce	
Governance and Well-led	
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	**YES**
Achieving Good Governance	**YES**
Improving Patient Experience	**YES**
Improving Environment and Resources	**YES**
Taking Pride and Responsibility	**YES**

London Ambulance Service
NHS Trust

INTEGRATED PERFORMANCE REPORT (Abridged)

TRUSTBOARD EXECUTIVE SUMMARY

May 2017

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

* Please note that this report relates to performance throughout April 2017 unless otherwise stated.

Delivery of care continues to be safe, but the continuing demand pressures on the system remains challenging.
The Trust achieved 73.7% for A8 performance in April. This is above the 69.4% target by 4.3%.
The Trust overall turnover has reduced to 9.6%.
Year to date the position is on plan. The Trust has a full year outturn plan of a £2.5m deficit which is seen as challenging but achievable.

OUR PATIENTS

7 serious incidents were declared in April 2017 compared to 9 declared in March 2017.

The target for zero breaches for SI completion is on track for achieving in June. The new process for managing SIs will help to ensure this delivery is sustained going forward.

As result of learning from SIs and a Coroner's Inquest, a change in practice for management of ventricular fibrillation has been issued to ensure early defibrillation. (Risk 445, BAF risk 36).

The percentage of patients who were potentially eligible for thrombolysis and arrived at a HASU within 60 minutes has consequently increased from 60% in February 2017 to 67% in March 2017 against a local trajectory of 65% - this is a significant improvement.

OUR MONEY

Plan / Target – Year to date the position is on plan.

Demand is currently running at 2.8% above the baseline contract demand which is slightly below the maximum (3%) LAS can earn additionally across the year. The Trust expects that a minimum of 3% over performance will be seen across the financial year.

Year to date CIPs are on plan. Some programmes are still to be finalised but are seen as deliverable.

Capital is underspent by £1.6m due to timing differences between capital phasing and programmes roll out.

Cash is £21.9m, £4.9m below plan. This is due to lower than expected cash receipts.

OUR PERFORMANCE

A8 Performance for April 2017 was 73.7%. This is above the 69.4% target.

There were 43,734 category A incidents in April, 5.5% increase against the trajectory. Overall demand was at 89,446 incidents, 2% decrease against the trajectory.

The Trust achieved over 60% for A8 Performance across all CCGs, with 12 CCGs achieving over 80%.

Job Cycle Time for April was 82.8 minutes, this is the lowest it's been since 2015. Hours lost over 15mins in hospital handovers totalled 4,404 in April. This is equivalent to 367 vehicles working a 12 hour shift.

The Patient Facing Vehicle Hours produced were 234,939, resulting in capacity running at 7.5% above plan during April.

The multiple attendance ratio is below target at 1.26 for April.

OUR PEOPLE

The ESR Workforce Dashboard is currently in development by the ESR Project Team with an implementation date of August 2017. The dashboard will be delivered through the LAS Business Intelligence Portal and will give LAS managers and their HR teams access to key workforce data at team/station and individual level. It will cover statutory & mandatory training as well as appraisal compliance, vacancies, turnover and sickness rates.

Overall turnover has reduced to 9.6%. There were 13 frontline leavers in April. This includes 8 paramedics, 1 EMT4, 3 T/EACs and 1 Apprentice Paramedic.

The sickness percentage has reduced from 5.2% to 5.16% (March data). The frontline % has reduced to 5.6% and there are varying levels across Sectors.

The Trust vacancy rate in April was 7.7%. An additional 303wte posts have been identified to deliver the 17/18 increased demand and once factored in, increases our vacancy rate to 12.6%. Further work is to be undertaken with colleagues in Operations to determine how these posts should be allocated across the Sectors.

The 111 service achieved the required standard of 95% for calls answered in 60 seconds in April 2017.
The Patient Transport Service has seen a 9.6% increase in activity from the previous month.

LAS 111 (SOUTH EAST LONDON)

Call demand over Easter was lower than in previous years with required standard for calls answered met on all key days.

One Serious Incident was declared for the 111 service during April 2017.

Referrals to 999 remain consistently and successfully low.

Direct booking into GP hubs remains a key focus with progress towards implementation across all SEL CCGs.

PATIENT TRANSPORT SERVICE

3,891 journeys were completed in April 2017, a 28% decrease from the previous month's total of 5,387 journeys.
This decrease in activity is as a direct result of the closure of the Guys and St Thomas Community Contract.

The arrival at hospital against the appointed time remained steady at 90% in April. This is below the 95% target.

Departure against patient ready time has remained steady at 93% compared to March 2017 (93%). This is below the target of 95%.

LAS IMPROVEMENT

Single Oversight Framework

The purpose of the Single Oversight Framework (SOF) is to identify where providers may benefit from, or require, improvement support across a range of areas. The five themes are: Quality of care, Finance and use of resources, Operational performance, Strategic change, and Leadership and improvement capability.

NHSI segment the provider according to the scale of issues faced.
It does not give a performance assessment in its own right.

1 - Providers with maximum autonomy
2 - Providers offered targeted support
3 - Providers receiving mandated support for significant concerns
4 - Special measures

LAS Current Status	
LAS Shadow Segmentation	4
LAS Breach Status	Breach & Special measures

CQC Overall Rating	Caring	Effective	Responsive	Safe	Well-led
Inadequate	Good	Requires improvement	Requires improvement	Inadequate	Inadequate

OUR RISKS

The top 3 organisational risks

1. There is a risk that the agreed A8 trajectory for the current year may be adversely affected by sustained over-activity against contractually agreed growth.
2. There is a risk that patients could suffer avoidable harm across shift change over periods due to deterioration in response times as a result of reduced resource availability.
3. It is likely that NHS financial and operational planning will include the need to develop efficiencies in order to offset other costs pressures for the foreseeable future. Failure to identify and deliver CIPs will threaten the ongoing viability and solvency of the Trust.

There were 4 new risks approved at the Risk Compliance Assurance Group. 2 relating to PTS, 1 relating to Manual handling training and 1 relating to accessibility of Patient Specific Protocols.

There has been a change to escalation points. There are 5 BAF risks that require updating in line with their net rating, with overdue actions requiring review.

Key Performance Indicator Report Summary

	Key Performance Indicator	Apr-17	Mar-17	Feb-17	Chart
QUALITY	Adverse Incidents (Patient)	↓	↓	↓	
	Adverse Incidents (Staff)	↓	↑	↓	
	Potential Serious Incidents referred to SI Group	↓	↓	↑	
	Serious Incidents (LAS Declared)	↓	↔	↓	
	Serious Incidents (LAS Declared) Overdue	↓	↑	↑	
	Regular Reporting of Incidents - Shared Learning	↔	↔	↔	
	Total Complaints	↓	↑	↓	
	Complaint Acknowledgement 3 days	↔	↔	↔	
	Complaints Response (Over 35 Days)	↔	↔	↑	
	Controlled Drug Incidents - Not reportable to LIN*		↑	↓	
	All LIN Reportable Incidents*		↓	↔	
	Overall Medication Errors	↓	↓	↓	
	Missing Equipment Incidents	↓	↓	↑	
	Failure of Device/Equipment/Vehicle Incidents	↓	↓	↑	
	CPI - Completion Rate*		↓	↑	

	Key Performance Indicator	Apr-17	Mar-17	Feb-17	Chart
111	Calls answered within 60s	↓	↑	↑	
	Calls abandoned after 30s	↑	↓	↓	
	Percentage of calls referred to 999	↓	↑	↓	

	Key Performance Indicator	Apr-17	Mar-17	Feb-17	Chart
WORKFORCE	Vacancy Rate (Frontline Paramedic)	↓	↑	↓	
	Vacancy Rate (Frontline)	↓	↑	↓	
	Vacancy Rate (Trust)	↑	↔	↓	
	Turnover Rate (Frontline Paramedic)	↓	↑	↓	
	Turnover Rate (Frontline)	↓	↑	↓	
	Turnover Rate (Trust)	↓	↔	↔	
	Sickness (Trust)*		↓	↓	
	Sickness (Frontline)*		↓	↔	

* These KPIs are reported one month in arrears

	Key Performance Indicator	Apr-17	Mar-17	Feb-17	Chart
PERFORMANCE	A8 Performance	↑	↑	↑	
	A19	↑	↑	↑	
	R1**	↑	↑	↑	
	R2**	↑	↑	↑	
	Calls	↓	↑	↓	
	Incidents	↓	↑	↓	
	Cat A Incidents	↓	↑	↓	
	Cat C Incidents	↓	↑	↓	
	Patient Facing Vehicle Hours (PFVH)	↓	↑	↓	
	Full Job Cycle Time**	↓	↓	↓	
	Job Cycle Time (JCT)	↓	↓	↓	
	Multiple Attendance Ratio (MAR)	↓	↓	↑	
	EOC - Call Answering Rate	↓	↑	↑	
	EOC - FRU Cat C Share	↓	↑	↓	

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

	Key Performance Indicator	Apr-17	Mar-17	Feb-17	Chart
	Cash Balance - Monthly Profile - £000s		↓	↑	
	Income and Expenditure Deficit by Month - £000s		↓	↑	
	Income and Expenditure Deficit Cumulative - £000s		↓	↑	
	Income Variance from Plan - £000s		↓	↑	
	CIP Delivery Against Plan - £000s		↑	↑	
	CIP Forecast Against Plan - £000s		↑	↓	
	Forecast Capital Spend Against the CRL - £000s		↑	↑	

Please note, performance trajectories are provisional and trajectories for Red 1, Red 2 and Full JCT are currently being confirmed

KPI Summary
These KPIs underpin the integrated performance report. This is a summary of all the KPIs and their related performance for the last 3 months.

The RAG status is calculated against targets/trajectories/thresholds where available.
The arrows indicate the direction of each KPI compared to previous month.
The spark line charts show the trend over the previous 3 months are not to scale.

London Ambulance Service NHS Trust

TAB 6: Paper to follow

Please accept our apologies for any inconvenience this may cause.

From Quality Assurance Committee Date: 16/05/2017

Summary Report to:	**Board**	**Date of meeting:**	**16/05/2017**
Presented by:	**Non-Executive Director**	**Prepared by:**	**Robert McFarland.**

1

Matters for escalation	We reviewed the new proposals for this Board Committee – agreed in principle. The current monthly Quality Report to the Board does not provide the necessary metrics/information to assure this committee that we are meeting our regular and improvement objectives. Figures are given (often percentages) without context, trends or analysis. The Quality Report is being revised.
Other matters considered	We reviewed Example ToR for Quality Assurance Committee – recommendations will be followed up by Briony Sloper and Trisha Bain for approval at the next meeting Serious incidents for April were reviewed and there is an action plan to manage delays and deal with the backlog. A report looking at themes across the different sectors was presented and this approach is to be developed further. We are not yet assured that the activity to improve Mental Health CPI (particularly documenting safeguarding consideration) will be effective. Only with the introduction of ePRF will there be a reliable prompt to consider and record safeguarding issues and this is unlikely to be introduced before at least 2018 - 2019. In the meantime further guidance is being given to frontline crews about documentation. The draft Annual Quality Account was reviewed and further review by Communications and ELT was recommended. The report should have a message which is understandable and clear to a general reader and which clearly records our progress over the last year (including our improvement against the CQC recommendations) and which clearly looks forward with a 2017/2018 plan aligned to our strategic objectives. It was noted that in the March 2017 Quality Report 60% of patients were arrived at a HASU within 60 minutes. The locally agreed target was 65% for 2016-17 Q4. We were assured that we will continue to see improvements against the locally agreed target for 2017 -18 as the JCT improvements are realised but that in the meantime we are performing comparably, if not better, than other services. .
Key decisions made/ actions identified:	The Quality Governance (“Rotherham”) work plan structure and the proposed procedure for initiating, carrying out and reporting a “Deep Dive” were approved in principle as was the deep dive plan/internal audit plan for the next twelve months. It was suggested that the systems proposed could be usefully used by all Trust committees and groups.

	There needs to be a more structured review of the BAF by this committee, reviewing items within the clinical safety and quality area and it was agreed that members would review the list, pick one or more items each meeting and ask QOG to review progress and report back at the next meeting (Risk 120 and 121 for July meeting). We approved a plan to invite in rotation the sector Quality Governance and Assurance Managers (QGAM) to present a local report to each QAC meeting.
Risks:	Training in Manual Handling is at risk of being delayed from 2017 CSR due to a shortage of BTEC qualified trainers – options for expediting this train the trainer are being explored in order to ensure we meet our regulatory requirements and minimise risk to our staff.] It was noted that the number and distribution of Clinical Team Leaders impacts on CPI completion and other functions. CPI completion rates vary by site and date and this appears to be closely related to the availability of Team Leaders – both total numbers and those on leave or secondment. Assurance was provided that this is being closely monitored and a course for new CTLs commenced on Monday of this week. The MPS have significantly reduced their Police Controlled Drug (CD) Liaison Officers which, in the event of a reportable CD issue, will affect our timely response to incidents.
Assurance:	The recent KPMG internal audit report on Clinical Audit gave “significant assurance” that the unit was functioning well, producing reliable data for regular reporting and for specific projects. The recommendation to improve the oversight and reporting will be addressed by the Governance restructure. Although the committee was assured that the timely management of Serious Incident reports was being addressed we do not have information to assure us that the resultant remedial actions (individual and thematic) are being regularly and systematically completed and monitored.

London Ambulance Service NHS Trust

Report to:	**Trust Board**
Date of meeting:	**25th May 2017**
Document Title:	**Audit Committee Assurance Reports** **a) Assurance report from 18th May 2017** **b) Annual report 2016/17**
Report Author(s):	**John Jones, Non-Executive Director and Chair of the Audit Committee**
Presented by:	**John Jones, Non-Executive Director and Chair of the Audit Committee**
Contact Details:	
History:	**Audit Committee – 18th May 2017**
Status:	**a) For assurance** **b) For approval**

Background/Purpose

The Audit Committee met on 18th May 2017 with executive directors and internal and external audit present. The attached report provides a summary of the meeting and is intended to provide assurance to the Trust Board on the annual reporting process, progress against the internal audit and local anti-fraud work plans, and progress with the audit of the annual accounts.

In line with terms of reference, the Audit Committee produce an annual report on the execution of its duties and specifically relating to: governance, risk management and internal control; internal audit and local anti-fraud; and financial reporting. The report also provides assurance of compliance with terms of reference and achievement of specific actions in 2016/17.

Action required

For the Trust Board to:

a) Take assurance from the report of the meeting on 18th May 2017
b) Approve the annual report of the Audit Committee for the year 2016/17.

Key implications

The Audit Committee has operated within its terms of reference which are aligned to the NHS Audit Committee Handbook.

Key implications and risks arising from this paper	
Clinical and Quality	
Performance	
Financial	
Workforce	
Governance and Well-led	**The Audit Committee can provide assurance through its report on 2016/17 and also from the review of the Annual Governance Statement, on the Trust's system of governance and internal control, and from the Head of Internal Audit Opinion for 2016/17.**
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	
Achieving Good Governance	**Yes**
Improving Patient Experience	
Improving Environment and Resources	
Taking Pride and Responsibility	

Report from the Audit Committee on 18th May 2017

ANNUAL REPORTING AND REVIEW

Internal Audit Annual Report 2016/17
The Audit Committee received the annual report from the Internal Auditors, noting that nine reviews had been delivered in 2016/17 as agreed in the Internal Audit plan. 41 recommendations had been raised from the reviews, of which 7 were categorised as high priority. The Head of Internal Audit Opinion for 2016/17 is one of:

'Significant assurance with minor improvements required.

Our work has confirmed that there is generally a sound system of internal control which is designed to meet the Trust's objectives and that controls in place are being consistently applied in all key areas reviewed.'

Local Anti-Fraud Annual Report 2016/17
The Audit Committee noted that this will now be taken to the following meeting on May 25th and received assurance that trust rating against NHS Protect standards had shown an overall improvement with no failure across any of the standards.

Annual Accounts 2016/17
An update on the draft accounts submitted in April was received and the final draft of the Annual Governance Statement considered and minor amendments proposed.

Gifts and hospitality register
The Audit Committee noted the register for 2016/17.

Single Tender Waiver review
The Audit Committee reviewed single tender waivers for the period December 2016 to March 2017.
It was confirmed that tenders for private ambulance services were now being evaluated and this would negate the use of waivers in the future for this service.

Audit Committee Annual Report
The annual report of the activity of the Audit Committee was approved for submission to the Trust Board.
This report includes particular actions the Committee wishes to focus on in 2017/18.

GOVERNANCE AND RISK MANAGEMENT

Board Assurance Framework and Corporate Risk Register

The Audit Committee considered the Board Assurance Framework (BAF) and Corporate Risk register.
It is anticipated that a refresh will be undertaken to the BAF following agreement of the Trust Plan for 2017/18.

INTERNAL AUDIT AND LOCAL COUNTER FRAUD

Internal Audit Plan for 2017/18
The Audit Committee approved a revised plan for 2017/18 which takes into account comments from the last meeting. Additional reviews recommended by the Executive Leadership Team (ELT) as part of a programme of deep dives are expected to be added to the work programme of KPMG after further discussion by the ELT over their exact requirements.

EXTERNAL AUDIT

The External Auditors presented the summary of the Audit Results Progress Report (ISA 260) and noted that the final accounts audit was progressing well with no significant issues arising. It was noted that the Value for Money conclusion was expected to be positive and that there was nothing adverse identified in the risk report. The Audit Committee would be expected to recommend to the Trust Board on 25th May 2017 the adoption of the 2016/17 Annual Accounts.

REPORTS FROM COMMITTEES

The Audit Committee received an oral report on the Quality Governance Committee meeting held on 16th May.

BUSINESS ITEMS

Information Quality Framework
A report was presented from the Jill Patterson, Director of Performance which proposes an approach to delivering a Data Quality Strategy and Framework for the LAS.
This paper scopes out a strategy for achieving the aspired Data Quality Assurance Framework, discussing governance, policies, best practices and Data Quality measures. Comments were provided and there was general support for the approach however, as a priority the assurance of workforce and quality data was highlighted. This issue will now be discussed by the ELT with an update to the Audit Committee in September.

Internal Audit & Counter Fraud Tender
A review of the options for re-tendering the current internal audit and counter fraud service contracts which end on 31st March 2018 were considered by the Audit Committee. (current Internal and External Auditors were not present for this item) It was agreed to hold a mini competition using a framework agreement to take this forward.

Date of next meeting: The next meeting of the Audit Committee is on Thursday 25th May 2017 for the purpose of reviewing the Annual Report and Audited Accounts, and final Annual Governance Statement 2016/17. The next full meeting of the Audit Committee will be 4th September 2017.

ANNUAL REPORT OF THE AUDIT COMMITTEE 2016/17

1. Scope of the report

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

2. Constitution

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

2.2 In accordance with the terms of reference, the membership was three non-executive Directors, with a quorum of two, including one with recent relevant financial experience. The Director of Finance and Performance and the Director of Corporate Governance are invited to attend all Audit Committee meetings. The non-executive Chair of the Quality Governance Committee is invited to attend all Audit Committee meetings as an observer and attended four times during the year. The appropriate internal audit and external audit representatives and the local counter fraud specialist attended all Audit Committee meetings with the exception of part of the meeting on 18th April 2016, which was an internal meeting for the purposes of reviewing the draft annual accounts for 2015/16 and internal audit on 31st May 2016 meeting which considered the audited accounts for 2015/16.

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

2.4 The terms of reference state that the Audit Committee should meet at least four times per annum. Six meetings were held within the last financial year on 18th April 2016, 19th May 2016, 31st May 2016, 5th September 2016, 7th November 2016 and 15th February 2017.

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

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

3 Governance, Risk Management and Internal Control

3.1 The Audit Committee reviewed relevant disclosure statements for the 2016/17 financial year, including the Annual Governance Statement (AGS) at its meeting on 25th May 2017. The Committee agreed that the AGS was consistent with its view on the Trust's system of governance and internal control and supported the Trust Board's approval of the AGS. The Audit Committee has also reviewed internal and external audit opinion and other appropriate independent assurances.

3.2 The Audit Committee received updates at all of its meetings on the management of organisational risks, with the exception of those meetings which are focussed on the year end audit and approval of the annual accounts. Overall, the Audit Committee's view is that the system of risk management in the organisation is adequate in identifying risks and allows the Board to understand the appropriate management of those risks.

3.3 The Audit Committee reviews the Board Assurance Framework (BAF) at each of its meetings, with the exception of those meetings which are focussed on the year end audit

and approval of the annual accounts. The Audit Committee can therefore demonstrate that it has reviewed and used the Board Assurance Framework and believes that it is fit for purpose and that the comprehensiveness of the assurances and the reliability and integrity of the sources of assurance are sufficient to support the Board's decisions and declarations.

3.4 The Audit Committee received a report at each meeting on the progress made in implementing outstanding internal audit recommendations. The Audit Committee has ensured that there is follow up on internal audit recommendations and has been assured of the efforts by management to maintain progress on reducing the number of overdue recommendations.

3.5 The Audit Committee is assured that that there are no areas of significant duplication or omission in the systems of governance in the organisation that have come to the Committee's attention and not been resolved adequately.

3.6 The Audit Committee was observed by the Care Quality Commission at its meeting on 15th February 2017 as part of their updated review of the LAS.

4 Internal Audit

4.1 As of 1st April 2013, Internal Audit services to the Trust were provided by KPMG. This contract is due to end on 31st March 2018 and a tender process is underway in 2017 to award a new contract.

4.2 The Audit Committee received and approved the Strategic and Operational Internal Audit Plan for 2016/17 at its meeting on 18th April 2016. The Committee was assured that the internal audit plan and strategy had been developed with input from the Trust's directors and was consistent with the audit needs of the organisation as identified in the Trust Board Assurance Framework and that the plan would be taken forward by the Executive Leadership Team (ELT).

4.3 Internal auditors were present at all but one of the Audit Committee meetings and provided the Committee with key findings from each audit report and an update on progress against recommendations made.

4.4 In 2016/17 nine reports were received from internal audit of which:

- 2 received significant assurance
- 5 received significant assurance with minor improvements
- 2 received partial assurance with improvements required

4.5 The head of internal audit opinion for 2016/17 was one of:

'Substantial assurance with minor improvements required'.
Our work has confirmed that there is general a sound system of internal control which is designed to meet the Trust's objectives and that controls in place are being consistently applied in all key areas reviewed.

4.6 A review of the effectiveness of the Trust Internal Audit and Counter Fraud Service was carried out and feedback provided to KPMG on 18th April 2017.

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

5 External Audit

5.1 The Trust's external audit services were provided by Ernst & Young for the 2016/17 annual accounts audit.

5.2 The external auditors audited the Trust's accounts in line with approved Auditing Standards and issued an unqualified audit opinion on 25th May 2017.

5.3 The Trust Board approved the establishment of an Auditor Panel at its meeting on 29th March 2016 to oversee the process for the appointment of external auditors to take effect from 1st April 2017. The Auditor Panel met three times and following a procurement process it was recommended to the Trust Board that the contract for the provision of External Audit Services be awarded to Ernst & Young LLP.
The Contract will be for a period of three years with the option to extend for a further two years and will be effective from 1 April 2017.The Trust Board approved this at its meeting on 29th November 2016.

6 Management

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

7. Fraud

7.1 As with the Internal Audit Service, Anti-Fraud was provided by KPMG with effect from 1st April 2013 and a tendering process is underway to award a new contract from 1st April 2018

7.2 The Committee received and agreed the Anti-Fraud Work Plan for 2016/17 at its meeting on 18th April 2016.

7.3 The Audit Committee received reports from the Local Anti-Fraud Specialist at five meetings in 2016/17.

8. Other Assurance Functions

8.1 The Audit Committee receives a regular update on the key items of discussion at the most recent meeting of the Quality Governance Committee. The Chair of the Quality Governance Committee is also invited to attend all meetings of the Audit Committee and attended four meetings of the committee in 2016/17

8.2 The Audit Committee reviewed performance against its terms of reference, Appendix C.

8.3 The Audit Committee reviewed the Charitable Funds Accounts for 2015/16 on 7th November 2016

8.4 A new policy to govern any non-audit work proposed to be carried out by the Trust External Auditors was agreed at the 7th November meeting.

9. Financial Reporting

9.1 At its meeting on 25th May 2017, the Audit Committee received and ratified the Audited Annual Accounts, incorporating the Annual Governance Statement, for the year ending 31st March 2017, prior to their submission to the Trust Board and Department of Health.

10. Audit Committee Terms of Reference

10.1 The Audit Committee reviewed its terms of reference at its meetings on 19th May 2016.

11. Conclusion

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

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

11.3 Actions for 2016/17 were:

Action	Responsible
Implement recommendations of the NHS TDA review.	Completed
Continue to develop Board assurance Framework and deep dive of individual risks.	Continued development required
As the Auditor Panel oversee the appointment of the External Auditors within the timeframe	Completed

11.4 Actions for 2017/18 are:

Action	Responsible
Complete the tender process for new contracts for: Internal Audit Service & Local Counter Fraud Service	Audit Committee Chair/Director of Corporate Governance/Director of Finance
Improve the timeliness of response to internal Audit recommendations.	Audit Committee Chair/Director of Corporate Governance/Executive Leadership team
To continue to develop the Board Assurance Framework to achieve a more strategic focus	Trust Board/Audit Committee/ELT
To improve the procurement process which results in more timely and transparent procurement and a reduction in single tender waivers	Audit Committee/Procurement team
To maintain a watching brief over the data quality assurance framework	Audit Committee/Director of Performance

Appendix A

London Ambulance Service NHS Trust
Terms of Reference
March 2016
Audit Committee

1. Authority

1.1 The Audit Committee is constituted as a Standing Committee of the Trust Board of Directors. Its constitution and terms of reference shall be set out below and subject to amendment when directed and agreed by the Board of Directors.

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

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

2. Purpose

2.1 The primary focus of the Audit Committee shall be the risks, controls and related assurances that underpin the achievement of the Trust's objectives.

2.2 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities.

2.3 The Committee shall review the corporate risk register and the Board Assurance Framework and be responsible for providing assurance to the Trust Board on the identification, management and mitigation of risks to the goals and objectives of the organisation.

2.4 The Committee shall review the adequacy of risk and control related disclosure statements, in particular the Annual Governance Statement, Care Quality Commission regulations, Internal and External Audit reports, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

2.5 The Committee shall review the adequacy of the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

2.6 The Committee shall review the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements.

2.7 The Committee shall review the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect.

2.8 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, within the context of the Board Assurance Framework, but will not be limited to these audit functions. It will also seek reports and assurances from the Quality Governance and Finance and Investment Committees, and from directors and managers as appropriate, concentrating on the overarching systems of risk, controls and assurances,

together with indicators of their effectiveness.

3. Internal Audit

3.1 The Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

3.1.1 approval of the appointment of internal auditors and any question of resignation and dismissal.

3.1.2 review and approval of the Internal Audit strategy, operational plan and a more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;

3.1.3 consideration of the major findings of internal audit work (and management's response), ensuring co-ordination between the Internal and External Auditors to optimise audit resources;

3.1.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;

3.1.5 an annual review of the effectiveness of Internal Audit.

4. External Audit

4.1 The external auditor is appointed by the Trust Board on recommendation from an Auditor Panel established through the Audit Committee.

4.2 The Committee shall act as the auditor panel in line with schedule 4, paragraph 1 of the 2014 Act. The auditor panel is a non-executive committee of the board and has no executive powers other than those specifically delegated in these terms of reference.

4.3 The auditor panel's functions are to:

4.3.1 Advise the organisation's board/ governing body on the selection and appointment of the external auditor. This includes:

- agreeing and overseeing a robust process for selecting the external auditors in line with the organisation's normal procurement rules
- making a recommendation to the board/ governing body as to who should be appointed
- ensuring that any conflicts of interest are dealt with effectively.

4.3.2 Advise the organisation's board/ governing body on the maintenance of an independent relationship with the appointed external auditor;

4.3.3 Advise (if asked) the organisation's board/ governing body on whether or not any proposal from the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable;

4.3.4 Advise on (and approve) the contents of the organisation's policy on the purchase of non-audit services from the appointed external auditor;

4.3.5 Advise the organisation's board/ governing body on any decision about the removal or resignation of the external auditor.

4.4 The Committee shall review the work and findings of the External Auditor and consider the implications and management responses to their work. This will be achieved by:

4.4.1 consideration of the performance of the External Auditor;

4.4.2 discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan and ensure coordination, as appropriate, with other External Auditors in the local health economy;

4.4.3 discussion with the External Auditors of their local evaluation of audit risks;

4.4.4 review of all External Audit reports, including agreement of the Annual Audit Letter before submission to the Board and any work carried outside the Annual Audit Plan, together with the appropriateness of management responses;

4.4.5 discussion and agreement on the Trust's Annual Governance Statement.

5. Risk and Assurance Functions

5.1 The Audit Committee shall review the risk and assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. This will be achieved by:

5.1.1 review of the work of the Quality Governance Committee in the management of clinical risk including assurance gained from the clinical audit function;

5.1.2 review of the work of the Finance and Investment Committee in the management of financial risk;

5.1.3 review of the Executive Management Team in the management of business risk and the systems in place to delegate responsibility for reviewing and maintaining the corporate risk register to the Senior Management Team;

5.1.4 review the board assurance framework to ensure that it is focussed on the key strategic risks to the business and clearly identifies controls and assurances in place as well as the gaps and corresponding mitigating actions to be taken in order to take assurance from the effectiveness of the systems in place;

5.1.5 review of the findings of any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc);

5.1.6 review the assurances provided by the internal auditors of the Trust's Shared Financial Services provider.

6. Counter Fraud

6.1 The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. [1]

7. Management

[1] From the NHS Audit Committee Handbook

7.1 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

7.2 The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

8. Financial Reporting

8.1 The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the Annual Governance Statement;
- disclosures relevant to the Terms of Reference of the Audit Committee;
- changes in, and compliance with, accounting policies and practices;
- unadjusted mis-statements in the financial statements;
- significant judgments in preparation of the financial statements;
- significant adjustments resulting from the Audit;
- letter of representation; and
- qualitative aspects of financial reporting.

8.2 The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness, timeliness and accuracy of the information provided to the Board.

8.3 The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's performance.[2]

9. Whistleblowing

9.1 The Committee shall ensure that arrangements are in place for investigation of matters raised in confidence by staff relating to matters of financial reporting and control, clinical quality and patient safety, or other matters.

10. Membership

10.1 The Committee shall be appointed by the Board from amongst the Non-Executive directors of the Trust and shall consist of not less than three members, all of whom shall have voting rights. The Trust Chair shall not be a member of the Committee.

10.2 At least one member of the Audit Committee must have recent and relevant financial experience.

10.3 One non-executive director member will be the Chair of the Committee and, in their absence, another non-executive member will be nominated by the others present to deputise for the Chair.

10.4 The Director of Finance, Director of Corporate Affairs or their deputy should normally attend all Audit Committee meetings, with the Chief Executive invited to attend at least annually to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

10.5 The non-executive Chair of the Quality Governance Committee should be invited to attend all Audit Committee meetings.

10.6 Other executive directors should be invited to attend when the Committee is

[2] As above

discussing areas of risk or operation that are the responsibility of that director.

10.7 The appropriate Internal and External Audit representatives and a Local Counter Fraud representative shall normally attend all meetings. At least once a year the Audit Committee should meet privately with the External and Internal Auditors.

11. Accountability

11.1 The Audit Committee shall be accountable to the Trust Board of Directors.

12. Responsibility

12.1 The Audit Committee is a non-executive Committee of the Trust Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

13. Reporting

13.1 The minutes of Audit Committee meetings shall be formally recorded by the Trust's Committee Secretary and the approved minutes submitted to the Trust Board.

13.2 The Chair of the Audit Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Board or that require executive action.

13.3 The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against the Care Quality Commission regulations and the processes behind the Quality Accounts.[3]

14. Administration

14.1 Secretarial support will be provided by the Trust's Committee Secretary and will include the agreement of the Agenda with the Chair of the Audit Committee and attendees and collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.

14.2 The Agenda and papers will be distributed 5 working days before each meeting.

14.3 The draft minutes and action points will be available to Committee members within four weeks of the meeting.

14.4 Members will ensure provision of agenda items, papers and update the commentary on action points at least 10 days prior to each meeting.

14.5 Papers tabled will be at the discretion of the Chair of the Audit Committee.

15. Quorum

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

- The Chair of the Audit Committee or the nominated deputy (who must also be a Non-Executive Director);

[3] The NHS Audit Committee handbook

- In the absence of the Chair, Committee members will nominate a deputy chair for the purposes of that meeting.

16. Frequency

16.1 The Committee shall meet a minimum of 4 times per annum.

16.2 The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

17. Review of Terms of Reference

17.1 The Audit Committee will review these Terms of Reference at least annually from the date of agreement.

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

Document Profile and Control

Audit Committee Terms of Reference		
Version:	**Approved by:**	**Date:**
March 2016	Audit Committee	November 2015*

*Amended March 2016 by the Trust Board to incorporate the Auditor Panel

Sandra Adams
Director of Corporate Affairs/Trust Secretary

Appendix B

Attendance at Audit Committee meetings

x = attended a = apologies	18th April 2016	19th May 2016	31st May 20165	5th September 2016	7th November 20165	15th February 2017	Comments
Audit Committee members							
John Jones (Non-Executive Director)	x	x	x	x	x	x	
Fergus Cass (Non- Executive Director)	x	x	x	x	x	x	
Theo de Pencier (Non-Executive Director)	x	x	a	x	a	x	
Attending							
Sandra Adams (Director of Corporate Governance/Trust Secretary)	x	x	x	a	x	x	
Andrew Grimshaw/Andy Bell (Director of Finance and Performance)	x	x	x	a	x	x	
Bob McFarland (Non-Executive director)	a	a	x	x	x	x	By invitation

x = attended
a = apologies tendered

Appendix C

Governance Review

Paragraph	Terms of Reference	Achieved/Not achieved	RAG
9	**Membership**		
9.1	The Committee shall be appointed by the Board from amongst the Non-Executive directors of the Trust and shall consist of not less than three members, all of whom shall have voting rights. The Trust Chair shall not be a member of the Committee.	Achieved	
9.2	At least one member of the Audit Committee must have recent and relevant financial experience.	Achieved	
9.3	One non-executive director member will be the Chair of the Committee and, in their absence, another non-executive member will be nominated by the others present to deputise for the Chair.	Achieved	
9.4	The Director of Finance, Director of Corporate Affairs or their deputy should normally attend all Audit Committee meetings, with the Chief Executive invited to attend at least annually to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.	Not fully achieved – one meeting missed by Director of Corporate Governance and Director of Finance	
9.5	The non-executive Chair of the Quality Governance Committee should be invited to attend all Audit Committee meetings.	Achieved	
9.6	Other executive directors should be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that director.	Achieved	
9.7	The appropriate Internal and External Audit representatives and a Local Counter Fraud representative shall normally attend all meetings. At least once a year the Audit Committee should meet privately with the External and Internal Auditors.	Achieved Audit Committee met in private with the External Auditors15th February 2017on with Internal auditors on 18th April 2017	
14	**Quorum**		
	The quorate number of members	Achieved	

	shall be 2 which will include the following: ▪ The Chair of the Audit Committee or the nominated deputy (who must also be a Non-Executive Director); ▪ In the absence of the Chair, committee members will nominate a deputy chair for the purposes of that meeting.		
15	**Frequency**		
15.1	Meetings shall be held at least quarterly.	Achieved	
15.2	The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.		N/A
16	**Review of Terms of Reference**		
16.1	The Audit Committee will review these Terms of Reference at least annually from the date of agreement.	Achieved Reviewed on 19th May 2016	
16.2	The Chair or the nominated deputy shall ensure that these Terms of Reference are amended in light of any major changes in committee or Trust governance arrangements.	Achieved	

London Ambulance Service NHS Trust

Report to:	Trust Board
Date of meeting:	Thursday 25th May, 2017
Document Title:	London Ambulance Service NHS Trust 2017-2019 Business Plan
Report Author(s):	Karen Broughton
Presented by:	Karen Broughton, Director of Transformation, Strategy and Workforce
Contact Details:	Karen.Broughton@lond-amb.nhs.uk
History:	Trust Board - 28th February 2017 - 28th March 2017 - 25th April 2017 The Business Plan has also been developed and refined through a series of Executive Management Team meetings and working sessions as well as discussions at the Management Briefing sessions.
Status:	For Sign Off

Background/Purpose

Following comments provided at the Trust Board in April 2017, further work has been undertaken to finalise the Business Plan for 2017/18. The Business Plan has been redesigned to provide clarity on the objectives and the activities that will allow us to achieve those objectives. The 'measures of success' have also been refined.

The four overarching goals of the Business Plan are:

- Patients receive safe, timely and effective care
- Staff are valued, respected and engaged
- Partners are supported to make change in London
- Efficiency & sustainability will drive us

The attached document is the recommended business plan for 2017-2019.

Once approved, this version of the Business plan will be used to:

- Facilitate engagement sessions across the Trust by the end of June 2017 to create Directorate/ Sector Business Plans and ensure that all objectives are owned and delivered
- Cascade objectives through the appraisal process to all levels of staff across the Trust

Action required
The Trust Board are asked to approve the 2017/18 Business Plan for the London Ambulance Service NHS Trust
Links to Board Assurance Framework and key risks
An assessment of risks to delivery of the business plan has been completed and these risks have been themed against five areas: • Quality • Workforce • Demand • Productivity • Leadership The strategic risk assessment, aligned to the agreed Trust risk appetite, is included within the Business Plan.

Key implications and risks in line with the risk appetite statement where applicable:	
Clinical and Quality	The 2017-2019 Business Plan sets the priorities for the Trust and will therefore have implications across all areas of the Trust
Performance	
Financial	
Workforce	
Governance and Well-led	
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	The four goals listed below will replace the Quality Improvement Plan work streams once the business plan is agreed. 1. Patients receive safe, timely and effective care 2. Staff are valued, respected and engaged 3. Partners are supported to make change in London 4. Efficiency & sustainability will drive us
Achieving Good Governance	
Improving Patient Experience	
Improving Environment and Resources	
Taking Pride and Responsibility	

OUR 2017-2019

BUSINESS PLAN

Contents

1 Executive summary

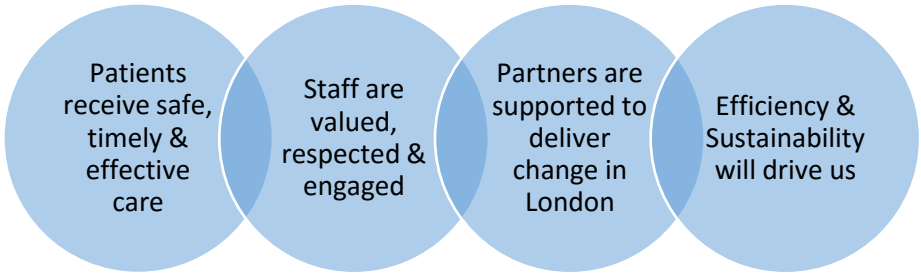
The London Ambulance Service (LAS) is here to care for people in London when they are at their greatest need.

Over the last 12 months, since receiving an inadequate rating by the Care Quality Commission (CQC) and being placed into "special measures" by our regulators we have worked hard to improve the foundations of our Service, but we recognise that we are on a journey and that it is a marathon, not a sprint. We have made good progress against our plans, and we are now starting to see some impact for our patients and our people, but we have more to do.

The year ahead will be a very challenging one for us because:

- We need to keep up our pace of change so that we provide the highest quality of care to our patients
- We must get back to meeting our national performance standards
- We need to improve consistency across our service
- We need to ensure the improvements we made last year are fully embedded
- We must make the London Ambulance Service (LAS) a great place to work for our staff so that we attract and retain the very best people
- We expect demand for our service to continue to rise
- We face growing financial pressures

This business plan outlines our focus for the year ahead as well as our finance, activity and workforce plans for the next two years. It sets four organisational goals going forward:



To achieve our four goals we have set clear objectives; to deliver these we need:

- our staff to have the right equipment, vehicles and training
- to have stable IT platforms
- to have the right estate
- to have the right culture in place
- to have the right staffing levels and skill mix, and to fill our vacancies
- to have rosters that meet fluctuations in demand so that we have the right clinicians across London to meet the needs of patients at any hour of the day, and on any day of the week

- to constantly look at what we do so that we always improve
- to be a well led Service with strong governance
- to be open when we make mistakes, learning from them and changing accordingly
- to have effective systems and flatter structures to simplify the way we do things

Improving the quality of our services will remain a key focus for us over the coming year with a strengthening of our quality governance systems, processes and structures, and a further report from the CQC expected in the summer.

Working in partnership will be essential to improve care for our patients. In the year ahead we will support the five London Sustainability & Transformation Plans (STPs) to realise their vision for healthcare improvements locally. We know that the five STPs of London have differing needs and priorities and we will ensure we support them to deliver their individual aims. We will continue our work with our Blue Light colleagues, other NHS organisations and Ambulance Services to maximise value for money from the public purse, working together where it is in the public interest to do so.

In the coming years we will build on our developments and successes to transform what we do and how we do it; our 5 year strategy will be refreshed this year to set a compelling vision for the Trust. To support delivery of our strategy, we will also agree new strategies for our Estate, Fleet and our People.

We will know that our 2017/18 Business Plan has been successful when:

- We have enhanced clinical care to patients by matching or exceeding national average outcomes in key clinical areas including STEMI, Stroke and Cardiac care
- Our staff tell us that they are happier working for the organisation as measured by the NHS staff survey and the Friends and Family Test
- We have met our national performance targets
- We can report measurable progress against our Workforce Race Equality Scheme (WRES) action plan and our BME staff have better experiences of working for LAS as measured by the NHS staff survey
- In partnership with STPs and Clinical Commissioning Groups (CCGs) we have implemented demand management initiatives to reduce our demand by 2%
- We have reduced our average job cycle time by 7 minutes
- We have reset our focus with key strategies in place (Trust Strategy, Estates, Fleet & People) to guide our organisation
- We have met our financial targets and have delivered £17.8m of cost improvements (CIPs)
- We are no longer in special measures and are working towards a “Good” CQC rating

We are holding sessions throughout the Service in May and June to ensure that directorate/sector plans are written to support delivery of the corporate business plan and turned into personal objectives for our people.

The year ahead looks to be a challenging but exciting time for us. We will welcome a new Chief Executive and set a new strategy for the Trust. We will undoubtedly encounter challenges in the year ahead, and we will rise to those challenges transforming what we do to support London's health needs and enhance our care to patients. As a Board we recognise that we are on a journey and we are absolutely committed to lead the organisation to success.

Andrew Grimshaw, Chief Executive

Heather Lawrence OBE, Chairman

2 Our Vision, Mission & Values

Our vision, mission and values shape all that we do. Developed in partnership with staff and stakeholders, these are:

Our Vision

To make the LAS great by delivering safe, high quality care that meets the needs of our patients and commissioners, and that make our staff proud

Our Mission

To care for people in London: saving lives; providing care; and making sure they get the help they need

Our values

Clinical Excellence: giving our patients the best possible care; leading and sharing best clinical practice; using staff and patient feedback and experience to improve our care.

Care: helping people when they need us; treating people with compassion, dignity and respect; having pride in our work and our organisation

Commitment: setting high standards and delivering against them; supporting our staff to grow, develop and thrive; learning and growing to deliver continual improvement

3 The London Ambulance Service Today

The London Ambulance Service is the busiest ambulance service in the country and one of the busiest in the world; with demand for our services increasing year on year. Last year we responded to over 1.9m 999 calls, attending 1.1m incidents. Despite yearly increases in demand, the Trust maintains an absolute focus on the quality and safety of services and strives to ensure that all our patients experience the highest level of clinical care.

London's health system as well as the wider NHS is being challenged with substantial and sustained rises in the demand for urgent and emergency care, which is driven in part by increases in population and a changing demographic mix. Increases in demand for A&E, emergency admissions and urgent care have all been above population growth over the past three years.

This rise in demand creates significant pressure on the LAS. Category A incidents have risen by 21% over the past 2 years, while category C incidents rose by 8%, resulting in more emergency activity. Despite innovative changes to the way we operate, e.g. hear and treat services, this demand increase translates into pressure on LAS' operational performance, quality, and our people.

Our performance against the national A8 performance standard has deteriorated from 75% in 2013 driven in part by the large increases in demand (14% overall), with faster growth in category A incidents, and an increase in job cycle time.

Looking ahead:

- London's population is predicted to rise from 8.7 million in 2016 to 10 million in 2029[1]
- Demand is forecast to rise at 7.5% annually, partly as a function of population growth and partly as a function of demographic shifts, particularly a rapidly expanding elderly population

[1] GLA - 2015 round trend-based population and household projections.

- London is a city of variations: variations in wealth and poverty and, although life expectancy has increased across the capital in recent years, wide variations remain between and within boroughs in terms of the health of the population
- NHS England (London) *Call to Action* stated THAT the "the most significant increase in population will be seen in the capital's over 65 year olds. This age group is due to increase by 19% by 2020 and over 65 year olds are typically the most significant users of health services"
- More people than ever in London are living with long-term conditions and co-morbidity and this will continue to rise
- Obesity in London is predicted to rise and with it an associated range of health problems including type 2 diabetes, cardiovascular disease and cancer[2]
- 1 in 4 people in the UK will experience a mental health problem each year[3]
- The number of people living with dementia will grow significantly over the coming years[4]
- London's diversity will continue to grow and by 2036 fourteen London boroughs are likely to have a majority of their population from BME groups (two currently have had such majorities since 2001)[5]

In response to the pressure on the NHS, the Five Year Forward View Next Steps has outlined areas in which changes to urgent and emergency care are needed. Key themes include:

- Shifts towards more lower acuity urgent care settings such as 'Urgent Treatment Centres' or GP practices
- Support for elderly people to stay healthy and at home with improved prevention and integrated care
- Improved access to primary care
- Enhanced 111 services with an increased proportion of callers receiving clinical assessment and online self-management tools
- Implementing the recommendations of the Ambulance Response Programme to reduce the number of long waits

Given the challenges ahead it is clear that we will need to transform our services over the coming years, working increasingly with our STP and other partners to ensure that the health service works together to meet London's health needs.

[2] NHS England (London) *Call to Action*
[3] MIND
[4] www.alzheimers.org.**uk**
[5] Mayor of London – 'The London Plan 2016'

4 Our achievements last year

In January 2016, we launched our Quality Improvement Programme to drive improvements across the Service. Supported with additional funding from our Clinical Commissioners the list below identifies our main achievements last year:

- We enhanced our expertise in treating patients with mental health needs: employing 5 mental health nurses; providing training to frontline crews; and partnering with MIND to deliver specialist training in our Control Rooms
- We worked in partnership with the London Fire Brigade (LFB) and the Metropolitan Police Service, co-responding to category A calls with the LFB in four boroughs and installing 110 defibrillators in police vehicles
- We launched our *GoodSAM* app, with 4,500 registered users, enabling more clinically trained ambulance staff and members of the public to voluntarily respond to life-threatening emergency calls
- We led and participated in a large number of clinical research projects. We published eight papers in peer-reviewed journals and presented our work at six national conferences. As a direct result of our clinical audit, the 2016 National UK Ambulance Service Clinical Practice Guidelines were updated to clarify the indications for giving IV Paracetamol
- We designed and implemented an electronic drugs monitoring portal, 'MedMan'. This, together with extensive communications, auditing, monitoring and the appointment of a Trust pharmacist, has greatly improved the way in which we manage medicines in the organisation
- 800 new drugs packs have been put into circulation in response to staff feedback
- We greatly improved the way in which incidents and near misses are reported, and our Quality Governance and Assurance Managers have been pivotal in improving the 'feedback loop', making sure we learn when things have gone wrong
- Improved our care to sickle cell patients, working with the Sickle Cell Society to hear their feedback and using this to change our educational programme
- We have enhanced our care to maternity patients, working with maternity units to provide guidance on the management of maternity emergencies
- We improved the way we equip and clean our ambulances through our new vehicle preparation 'hubs' resulting in the number of hours that vehicles are out of service due to missing equipment reducing by 71% between January-March 2017 when compared to the same period the previous year
- We have added 60 new Fast Response Units (FRUs) to our fleet with a further 60 FRUs and 140 Ambulances to be rolled out in 2017/18
- We have rolled out new airwave radios for all frontline vehicles and redesigned our 'digital pocket guide app' which has over 2,300 users
- We recruited 355 frontline staff between April 2016 and March 2017, increasing our frontline workforce by over 100 whole-time equivalents
- We improved retention with the number of people leaving the Service falling from 11.2% in April 2016 to 8.6% in March 2017

- We have re-launched a new simplified appraisal process, designed in partnership with staff. This has led to a significant increase in the number of appraisals being completed from 11% in 2015/16 to 81.3% in 2016/17
- In November 2016, we won a prestigious HSJ Award for our training stations programme, designed to provide new frontline staff with practical support from experienced mentors
- In 2016 we were awarded a Stonewall Award for being one of the top five Health & Social Care organisations
- In December 2016 we won the *Best social media account of the year* award
- Our Finance team were awarded the *Healthcare Financial Management Association Training Award* for the development of finance trainees in LAS
- We saw significant improvements in our staff survey last year. Out of the 88 questions that were asked, we scored significantly better in 67 of them compared to the previous year, with no questions scoring significantly worse
- In June 2016, we launched our vision of "Making the LAS Great", supported by an internal communications campaign to start hundreds of conversations to engage and motivate staff to deliver improvements within our Service
- We significantly improved our levels with engagement with staff across the organisation. This included a series of CEO road shows and holding monthly briefings for our top 400 managers to discuss organisational priorities and seek their views
- We worked with the BBC to film "Ambulance", the most watched BBC documentary last year. As well as increasing public awareness of the pressures on the service, the series also improved staff morale; 88 per cent of staff said they were proud to work for the Service following the documentary

5 Our Approach to Quality Delivery

Berwick 2013, indicated that many modern industries define "quality" as "the degree to which a system of production meets (or exceeds) the needs and desires of the people it serves". An effective quality management system includes:

- Quality control, to keep sound processes reliable on a daily basis;
- Quality improvement, to decrease variation within and among NHS organisations so that the best becomes the norm;
- Quality planning, especially fostering innovative care models that can deliver better outcomes at lower cost.

Our approach to quality aligns to Berwicks' six domains of health care quality:

- **Safe:** Avoiding harm to patients from the care that is intended to help them
- **Effective:** Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse)
- **Patient-centered:** Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions

- **Timely:** Reducing waits and sometimes harmful delays for both those who receive and those who give care
- **Efficient:** Avoiding waste, including waste of equipment, supplies, ideas and energy
- **Equitable:** Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status

Our approach to quality also aligns to the CQC 2014 Framework which is currently under review and which we will adapt once the 2017 framework is published. The five domains, aligned to our regulatory body's expectations are encompass, safe, effective, caring, responsive and well led as defined below.

These principles will be incorporated into our strategies and performance management, whereby each operational sector and corporate directorate reports monthly to Executives using a performance dashboard including outcome measures which relate to safety, effectiveness, caring, well-led, and responsive. This way of performance management is a means to ensure quality is owned by front line staff and therefore embedded in daily practice.

Our Quality Priorities for 2017/18

Each year the Service sets a range of quality priorities. The following quality priorities have been identified for the year ahead to support the Trust's goal that *Patients receive safe, timely & effective care*:

Topic	Actions
SAFE	
Review Sign Up to Safety Pledges	Develop Pathways for patients who fall, have mental health issues, are bariatric.
Improve thematic analysis of incidents, complaints, claims, to reduce avoidable harm	Develop dashboards for integrated incident analysis at corporate and sector level
Improve outcomes for patients with critical conditions	Introduce guidance for patients to improve care delivery
Improve and embed learning from incidents	Develop learning framework supported by communication strategy
CARING	
Improve the assessment of vulnerable adults with mental capacity issues	Re-design PRF forms and ensure documentation is monitored and reported
Improve responses to complaints	Re-design our complaints process and quality assessment of letters using the Patient Forum

Ensure patients have timely and appropriate access to services	Implement demand management projects to improve care and experience
EFFECTIVE	
Report on all AQIs	Implement and measure best practice models of care
Standardise hospital handovers including the use of NEWs for the sickest patients	Implement NEWs handover for pre-alert patients to test suitability pre hospital
Develop a mortality and morbidity review process	Introduce a mortality review group and ensure information is available in relation to specific groups to target learning and improvement.

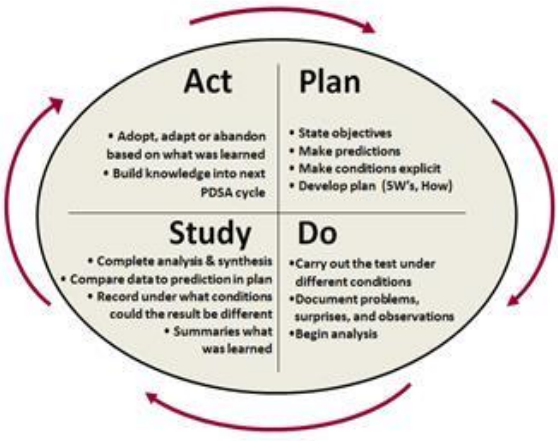
Assessing Quality Impact of service developments and costs improvement programmes

We have well established processes for assessing the quality impact of service developments and costs improvement programmes. The assessment looks at the impact on:

- Patients, with specific consideration given to
  - Patient Safety
  - Clinical Effectiveness
  - Patient Experience
  - Infection Control
- Our staff
- The Trust
- The wider NHS

Quality Impact Assessments are conducted for all our Cost Improvement Programmes (CIPs) and Improvement Programmes to establish the benefits, potential risks and mitigations associated with a particular cost-improvement or development project as well as the additional work that is needed to further reduce the risk (or improve the benefits). Quality Impact Assessments are considered and approved by the Quality Assurance Committee.

Delivering Our Quality Improvement: Methodology



When delivering quality improvement programmes across the Service the majority of our programmes will use the "Plan Do Study Act" (PDSA) methodology.

Quality Improvement methods will be based on the size and complexity of the change and the support required to deliver the change. For example; small test of change will be used at local operational level to provide 'quick wins', the more complex transformational programmes will use a variety of improvement techniques, such as Breakthrough Collaborative Methodology. This is based on the same principles of PDSA cycles but includes action learning sets and the use of driver diagrams to identify primary and secondary drivers for improvement to ensure that change is embedded and owned.

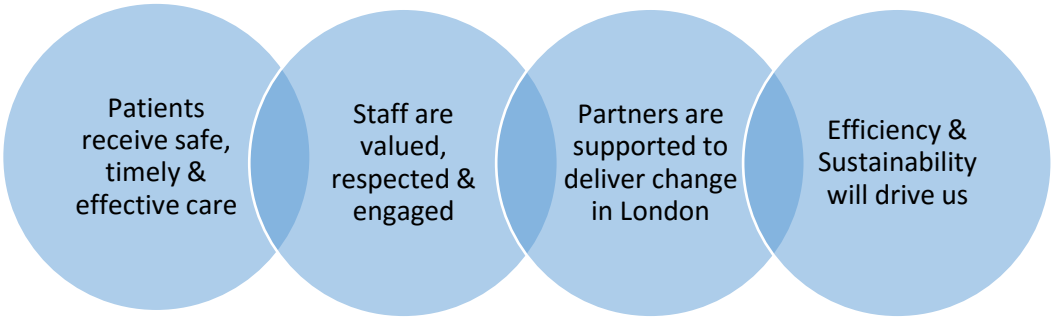
Undertaking deep dives to test improvements or services

We have developed an annual plan of deep dives to provide assurance on the quality of improvements or services. The draft plan for the year ahead is provided below:

Deep Dive Topic	Rationale and link to Business Plan Goals	Reports to	Quarter
Hospital handover	Relates to Goal 1 of the business plan Significant impact on patient experience, performance and potentially safety	Quality Governance board sub-committee	Q1/Q2 17/18
Infection Prevention and Control	Relates to Goal 1 of the business plan CQC concerns about IPC capacity	Quality Governance board sub-committee	Q1 18/19
Call handling and decision making in EOC	Relates to Goal 1 One of the top themes in the most recent thematic review of SIs	Quality Governance board sub-committee	Q2 17/18
Medicines management compliance	Relates to Goal 1 Medicines management processes significantly improved but behaviours need to follow suit	Quality Governance board sub-committee	Q4 17/18
Demand Impact on Safety	Relates to Goal 1 One of the top four themes in the most recent thematic review of SIs	Audit Committee	Q2
Risk management systems and processes	Relates to multiple strategic goals Major theme in February CQC inspection and critical to exiting special measures	Audit Committee	Q317/18
Quality of appraisal	Relates to Strategic Goal 2 Coverage has significantly improved from 2015 position. Attention needs to focus on quality.	Workforce Committee	18/19 Internal Audit
Impact of leadership development and restructure on culture and behaviour	Relates to Goal 2 but major enabler for other areas of change Key CQC theme and critical to exiting special measures	Workforce Committee	Q1 18/19
Impact of make ready roll out completion	Relates to Goal 2	Logistics and Infrastructure Committee	Q3 17/18
Response times for lower acuity patients	Relates to Goal 1	Audit Committee	Q3
Staff Health and Safety **Externally commissioned specialist review**	Relates to Goal 2	Workforce Committee	Q1/2
Annual review of Learning from SIs and incidents	Relates to Goal 1	Audit Committee	Q4
Safe staffing : Independent testing of demand and capacity assumptions **Trust to work this up in more detail and agree framework for safe staffing then test**	Underpins multiple goals in the business plan The trust has developed detailed activity plans but has yet to have independent assurance that recruitment, turnover, sickness, changing rosters and leave arrangements will deliver patient facing hours sufficient to guarantee safe staffing	Workforce Committee	Q2
IT Resilience	Deep Dive as part of post CAD review	Logistics & infrastructure Committee	Q1

6 Our goals and objectives

The Trust's four overarching goals are:



For each of the four goals, a number of objectives have been identified to form the Trust's work plan for 2017/18.

OUR GOALS	PATIENTS RECEIVE SAFE, TIMELY & EFFECTIVE CARE	STAFF ARE VALUED, RESPECTED & ENGAGED	PARTNERS ARE SUPPORTED TO DELIVER CHANGE IN LONDON	EFFICIENCY & SUSTAINABILITY WILL DRIVE US
OUR OBJECTIVES	To drive high quality and safe patient care	To ensure our workforce model meets future patient needs	To proactively work with London's five STPs to support delivery of the Five Year Forward View	To achieve financial targets and deliver a £17.8m Cost Improvement Programme
	To improve patient outcomes and enhance clinical excellence	To support the health and wellbeing of our staff	To expand our reach into the London integrated Urgent & Emergency Care System	To deliver a transformation programme to continue our improvement journey
	To achieve agreed performance, ambulance and regulatory standards	To develop our culture and improve diversity & inclusivity	To use data and system intelligence to improve patient care	To have stable and reliable IT platforms to enable 21st century working
		To support and equip our managers to lead well, from 'Board to Station'	To work with partners to improve patient care and value for money	To deliver the LAS 5 year strategy and strategic plans for essential infrastructure
		To make it easier for our staff to do their jobs		

7 What our plan means for our patients

Our top priority is to improve the care and experience of our patients as outlined in our new Clinical Strategy.

The business plan outlines a number of objectives that we will deliver ourselves to improve care to patients, as well as objectives where we will work in partnership with NHS and Emergency Service partners to improve care and meet demand.

Clinically our focus this year will be on further improving our care for major trauma, stroke and STEMI patients by reducing the amount of time we spend on scene with them, our focus will be on making sure we take these patients to London's specialist centres quickly so they receive the specialist care they need as soon as possible. We will continually review the care we provide for critically ill and injured

patients for example providing enhanced treatment guidance for patients in Ventricular Fibrillation to improve the outcome for patients in cardiac arrest.

We will increase our focus on patients with urgent care needs, providing frontline crews with information on appropriate care pathways, supportive decision making tools and improving our response times for those patients with non-life threatening conditions.

We know we need to continue to improve our services to better meet the needs of particular groups of patients, this year we are targeting care pathway improvements for patients at the end of their life, with mental health needs and patients who fall.

As patient needs change, so we need to change the way in which we provide care so that it is a seamless journey. This year we will review our rosters to make sure that our staffing levels at any given time of the day are able to meet patient needs, so that we are there when our patients need us.

This year we will continue to improve our management of medicines and make sure that each of our vehicles always have the medicines and equipment needed on-board so that our clinicians can always provide the highest standards of care.

The Business Plan includes a number of activities to enable the Service to better understand and improve the experience of our patients. A key relationship for us is with our dedicated Patients Forum and we will work with them this year to strengthen their involvement in the service so that patient voices and experience are at the heart of what we do. All of our patient experience and involvement activities are driven by the desire to make things better for patients, their families and carers.

Our business plan restates our intent that, when patients, their families or carers tell us that we've got something wrong, we will learn from those instances so that we get it right for patients we see in the future.

8 What our plan means for our people

The business plan outlines our intent to make LAS a great place to work for our people.

It focuses on making sure we have the right staffing levels in place for now and the future, and identifies that we will look to expand our workforce with other healthcare professionals following a review of our skill mix to meet the changing needs of our patients.

We heard when our people told us that they wanted us to support their health and wellbeing more than we are today and we will make this a priority in the year ahead, working in partnership with them and our new occupational health service on this. We heard that it was often difficult for staff to do their jobs and have therefore identified a range of things we will do to change that this year.

A number of directorate/service structure reviews will be completed this year so that we have the right structures in place to support our people, ensure the service is well-led and that management

accountability and decision making is clearly set so that decisions are made as far down the service as possible.

We are clear that we need to continue to change our culture. We are committed to tackling bullying and harassment and our work in this area will continue and, in the year ahead, we will take targeted action to deliver on our commitment to race equality. We expect our people to do everything they can to improve the experience of BME staff who work in the Service and those who join us as we make LAS more representative of the communities we serve. We are making inclusivity a priority for everyone in the Service this year from *"Board to Station".*

We will work in partnership with our people to improve what we do for our patients and be as productive as we can be. For our frontline crews this means critically reviewing on scene time to make sure our patients are supported to achieve the best possible clinical outcomes, it also means looking at the job cycle time and making sure that on average it is no longer than 78 minutes. For all our staff we will focus on sickness absence and management to support staff when they are ill so that they can return to work safely and quickly.

Over the last year we have significantly improved our incident reporting with people speaking up when there were issues. We need everyone to make sure they speak up when they think something is not right, when we have got it wrong, or when they have a great idea. By doing this we can set a culture of continuous improvement so that everything we learn improves our care to patients.

Given the financial environment that we will experience in the year ahead we will need all of our people to focus on what they do, how they do it and what they spend. We need the whole organisation focussed on this to make sure we are not wasting time, money or resource.

9 What our plan means for our infrastructure

For our staff to deliver high quality care to patients, we must invest in our infrastructure. Going forward we will modernise our fleet and our estate and make sure we have a stable and modern Information Technology infrastructure.

Fleet

Our new fleet strategy underpins best practise in the management of an efficient and effective emergency fleet, which matches the needs of our patients and clinicians alike, whilst representing value for money as well as supporting the Service's responsibilities towards the environment.

During 2016/17, we commenced a modernisation programme to improve the consistency and reliability by which our vehicles are fully maintained and stocked. This modernisation programme is minimising critical vehicle failures and ensuring that vehicle and equipment availability for our front line crews is consistent throughout London. These new vehicle preparation 'hubs' have been very well received by our staff and by the end of August 2017 'gold standard' hubs will have been fully rolled out across every sector.

In the year ahead we will continue to refresh and modernise our fleet by bringing in a further 60 Fast Response Units (FRUs). In addition, we have designed a new Ambulance based largely on staff feedback and will be rolling 140 of them out into our service by the end of the financial year. These ambulances will provide a better and safer working environment for our staff.

This year we will replace the entire Hazardous Area Response Team (HART) fleet, supporting our response to major incidents and emergencies that require this specialist resource.

We are committed to improving the safety and security of our staff whilst they are at work. This year we will develop a business case to introduce a state of the art driver safety system into our vehicles. The system will include speed controls, Telematics and CCTV to ensure that we are able to support our staff more effectively if they are the victims of abuse whilst at work.

Estates

We know that some of our Estate is no longer fit for purpose and, as we grow our staffing numbers, is unable to support that increase. Our new Estates Strategy this year will set the principles for our future estate and our future estate footprint.

Information Technology (IT) Infrastructure and Systems

We are clear that we need to improve our business critical IT systems and infrastructure. In the year ahead we will invest in these systems to ensure that we have the improved stability, reliability and security to enable us to respond effectively to our patients.

This year we will provide our frontline crews with mobile devices to enable access to health records and support clinical decision making. Our Clinical Hub within the Control Rooms will also benefit from improved technology so that they too have better access to patient information, support effective clinical decision making as well as better communication with the wider health system.

We will respond to the recommendations from the external review of our Computer Aided Despatch system and will continue to update and upgrade our hardware and software as necessary to protect our organisation from cyber threats.

Over the coming year we will embark on the first year of our Information Management & Technology (IM&T) strategy which will modernise IT, improve security and reliability of our critical systems, improve patient care and improve the working lives for our people.

Business Intelligence

In the year ahead we intend to expand our business intelligence services to improve patient care; developing our capability and maximising our impact both internally and externally.

We will consolidate our performance reporting this year and enhance this with additional quality information and patient outcomes. An essential addition will be benchmarking and national profiling of the Service against other NHS, national and international organisations.

Our attention will be on defining systems for data quality assurance. We will do this through the development of our new Data Quality Framework so that standards for data quality are met fully and consistently across the Service.
We will work in partnership with London's STPs to use our business intelligence across London's health systems to support local improvements in patient care. Our high quality information and intelligence means that we will continue to have a lead role in managing demand across London in the year ahead.

10 How we will deliver our business plan

10.1 Our objectives and delivery plan

The following pages show how each of our goals is supported by objectives to support delivery and the plans that support each objective.

THE LONDON AMBULANCE SERVICE BUSINESS PLAN 2017-19

OUR VISION (*What we want to be*): TO MAKE LAS GREAT BY DELIVERING SAFE, HIGH QUALITY CARE THAT MEETS THE NEEDS OF OUR PATIENTS AND COMMISSIONERS, AND THAT MAKE OUR STAFF PROUD

OUR MISSION (*why we exist*) TO CARE FOR PEOPLE IN LONDON: SAVING LIVES; PROVIDING CARE; AND MAKING SURE THEY GET THE HELP THEY NEED

OUR VALUES

- **Clinical Excellence**: giving our patients the best possible care; leading and sharing best clinical practice; using staff and patient feedback and experience to improve our care
- **Care:** helping people when they need us; treating people with compassion, dignity and respect; having pride in our work and our organisation
- **Commitment:** setting high standards and delivering against them; supporting our staff to grow, develop and thrive; learning and growing to deliver continual improvement

OUR GOALS

- PATIENTS RECEIVE SAFE, TIMELY & EFFECTIVE CARE
- STAFF ARE VALUED, RESPECTED & ENGAGED
- PARTNERS ARE SUPPORTED TO DELIVER CHANGE IN LONDON
- EFFICIENCY & SUSTAINABILITY WILL DRIVE US

OUR OBJECTIVES

- To drive high quality and safe patient care
- To improve patient outcomes and enhance clinical excellence
- To achieve agreed performance, ambulance and regulatory standards
- To ensure our workforce model meets future patient needs
- To support the health and wellbeing of our staff
- To develop our culture and improve diversity & inclusivity
- To support and equip our managers to lead well, from 'Board to Station'
- To make it easier for our staff to do their jobs
- To proactively work with London's five STPs to support delivery of the Five Year Forward View
- To expand our reach into the London integrated Urgent & Emergency Care System
- To use data and system intelligence to improve patient care
- To work with partners to improve patient care and value for money
- To achieve financial targets and deliver a £17.8m Cost Improvement Programme
- To deliver a transformation programme to continue our improvement journey
- To have stable and reliable IT platforms to enable 21st century working
- To deliver the LAS 5 year strategy and strategic plans for essential infrastructure

GOAL ONE: PATIENTS RECEIVE SAFE, TIMELY & EFFECTIVE CARE

Our Objectives *(what we want to achieve)*	**To drive high quality and safe patient care**	**To improve patient outcomes and enhance clinical excellence**	**To achieve agreed performance, ambulatory & regulatory standards**
Our plans to achieve *(How we will achieve our objectives)*	By July 2017 we will create a learning framework which involves patients in gaining feedback and service development	By year end we will ensure we have the right safe staffing levels in place, to fill our rosters to meet demand	Throughout the year we will deliver the second phase of medicine management improvement	By March 2018 we will improve our emergency control rooms and despatch processes
	By June 2017 we will strengthen our clinical governance processes, supported by a restructured Quality Assurance Directorate	By March 2017 we will have undertaken and implemented a Trust-wide review of rosters to better meet the needs of our patients	We will support delivery of pan London care pathway redesign for: fallers; patients with mental health needs; urgent care referrals; and End of Life Care	By year end we will have delivered agreed CCG performance levels so that we have more consistent performance across London
	By year end we will have implemented an annual plan of Clinical Education updates for all clinical supervisors	By June 2017 learning from feedback will be routinely incorporated into all education programmes	We will improve our care for cardiac arrest, stroke and STEMI patients by reducing on-scene time across the year	By July 2017 we will introduce new annual leave arrangements to better match patient needs and demand across the year
	By March 2018 we will have strengthen the patient voice through the delivery of an annual patient engagement work plan	Throughout the year we will deliver improvements in Infection Control and the management of safeguarding issues	By year end we will improve our performance for patients with low acuity needs by reducing the waiting time for treatment	
Our measures of success *(How we will know we have achieved our objective)*	Learning framework in place across the Trust which drives improvement in four agreed areas	Frontline capacity requirements are met by year end	Improve our performance in all Ambulance Clinical Quality Indicators	Achieve 75% A8 performance by October 2017
	A decrease achieved in repeat safety incidents, SIs and complaints and a reduction in overdue SIs	Reduced variation in performance across the hours of the day and days of the week	CQC requirement notice lifted in relation to medicines management	Delivery of local CCG minimum performance targets of 60%
	Clinical Education annual plan delivered in full	A8 performance is more equitable across the 24 hour period	Quality deep dives completed for patients receiving a C3 or C4 response and recommendations implemented	Appropriate distribution of annual leave across the year and improved substantive resourcing at peak activity times
				No regulatory breaches experienced

GOAL TWO: STAFF ARE VALUED, RESPECTED & ENGAGED

Our Objectives *(what we want to achieve)*	To ensure our workforce model meets future patient needs	To support the health and wellbeing of our staff	To develop our culture and improve our diversity	To support and equip our managers to lead well, from 'Board to Station'	To make things easier for our staff to do their jobs
Our plans to achieve *(How we will achieve our objectives)*	By September 2017, we will have agreed our new multidisciplinary skill mix model, supported by annual recruitment plans to deliver the changes required By November 2017 we will have established a pipeline for our future workforce, either via the LAS Academy, through University or other pipelines	By July 2017, we will implement new rest break and end of shift arrangements to support frontline staff By July 2017 we will introduce a new Occupational Health Service to support staff to keep staff healthy By December 2017 we will address the three top causes of sickness: Stress; muscular skeletal injuries and Mental Health By December 2017 we will improve staff engagement, creating time and space to listen and act on staff views and feedback	By September 2017, we will define our desired culture, introducing a behaviours framework and annual corporate management actions to set expectations and improve consistency Throughout the year we will deliver the actions outlined in our Workplace Race Equality Scheme action plan to improve the experience of BME staff and to make the Trust more representative of London's diversity By March 2018, we will have completed our phase four actions to tackle bullying and harassment By July 2017 we will further improve the quality of appraisals to ensure all staff support delivery of corporate objectives	By October 2017 we will set new autonomy, accountability & decision making frameworks throughout the management tiers of the Trust By March 2018, we will have designed and implemented new Talent Management arrangements to improve retention and succession planning By September 2017, we will have in place a clear Leadership Development Pathway across the Trust	We will roll out hand held devices between July 2017 and March 2018, so that our frontline crews have better information to treat patients and join up care By October 2017, we will move to vehicle based equipment and drugs bags so that vehicles are consistently equipped By October 2017 we will introduce a Business Partner model to ensure that Corporate Services are actively engaged and support frontline operations By September 2017, we will strengthen our Corporate & Operational Management structures to improve support and accountability
Our measures of success *(How we will know we have achieved our objective)*	Revised skill-mix model determined with supporting recruitment strategies and transition plan to meet agreed establishment level Year on year increase in 'home-grown' paramedics Reduction in turnover for non registered frontline staff	80% of crews will receive a rest break every shift by October 2017 and number of SIs declared during changeover will decline from February 2017 baseline Long term sickness rates will be below 3% More staff will recommend the LAS as a place to work through the friends and family test	Improvement in staff survey responses when compared to 2016/17 survey exit survey data shows a reduction in bullying and harassment when compared with previous reports and 95% of reported bullying & harassment cases addressed within 28 days Improvements in WRES indicators against the 2016/17 baseline	A talent management approach is in place that identifies the next cohort of talent and succession plans are in place for key roles Defined levels of autonomy and decision making for managers published, supported by an annual training and development plan Improvement in 'well-led' CQC rating for the Trust as well as for individual core services	All frontline crews will have a mobile device with an initial set of agreed applications by year end All crews will have access to a fully equipped vehicle with vehicle based drugs by October 2017, reducing out of service levels New Operational management and Corporate structures in place with renewed focus on quality of care to patients

GOAL THREE: PARTNERS ARE SUPPORTED TO DELIVER CHANGE IN LONDON

Our Objectives *(what we want to achieve)*	**To proactively work with London's five STPs to support delivery of the Five Year Forward View**	**To expand our reach into the London integrated Urgent & Emergency Care System**	**To use data and system intelligence to improve care**	**To work with partners to improve care and maximise value for money**
Our plans to achieve *(How we will achieve our objectives)*	We will work with health partners to improve referrals between 111 and 999 services We will work with health partners to improve services to support frequent callers to 999 We will work with health partners to improve support required by Care Homes in London We will work with health partners to improve referrals from healthcare professionals By October 2017 we will review our conveyance rates & set targets to ensure patients are referred to the most appropriate setting of care We will work with NHS Improvement & NHS England to reduce time lost through hospital handover delays	By the end of the year we will retain the South East London 111 contract By December 2017 we will have secured an additional 111 service in London By March 2018, we will begin to roll out access to special patient notes for crews on scene By March 2018, we will have transformed the way we run our 111 service, improving integration with 999	We will undertake monthly analysis of patient and health data and use this to support STPs to improve London's health system By May 2017, we will produce a Data Quality Framework to ensure that high quality, accurate data is available and well managed throughout the Trust By October 2017 we will have in place a revised set of indicators specifically related to quality of care and patient engagement	By December 2017 we will review Value for Money opportunities with partners to define collaboration and procurement priorities for the Trust Throughout the year we will maximise value for money through back office collaboration with NHS partners By March 2018 we will review control room usage and future opportunities with Blue Light partners By year end we will expand the co-responding pilot with blue light partners to reach our sickest patients quicker
Our measures of success *(How we will know we have achieved our objective)*	CCGs supported to deliver a 2% reduction in demand as agreed in our 2017/18 contract Top 5 hospitals with largest handover delays targeted with number and length of delays reduced LAS influences London's redesign and health improvement Reduction in conveyance rates in line with STP plans	New contract in place for South East London 111 for the next 3-5 years New, more efficient operating model in place for 111 that enables LAS to be competitive when bidding for future 111/Integrated and Urgent Care services Successfully expanded our 111 provision to at least one additional area of London	Internal audit of Data Quality provides an 'assured' rating Monthly LAS data packs produced for STPs & CCGs Revised quality data set included in the quality report	Review of Blue Light Emergency Control Rooms across London conducted £100k savings identified via blue light collaboration efforts Review of Corporate functions undertaken to identify opportunities for efficiencies

GOAL FOUR: EFFICIENCY & SUSTAINABILITY WILL DRIVE US

Our Objectives *(what we want to achieve)*	**To achieve financial targets and deliver a £17.8 Cost Improvement Programme**	**To deliver a transformation programme to continue our improvement journey**	**To have stable and reliable IT platforms**	**To deliver the LAS 5 year strategy and strategic plans for essential infrastructure**
Our plans to achieve *(How we will achieve our objectives)*	By the end of the year we will achieve all targets in the financial plan We will deliver in full all the elements of the CIP programme: - Frontline efficiency: £7.5m - Corporate Pay: £1.4m - Non-pay: £4.1m - Income Generation: £2.0m - Other Opportunities: £2.8m By June 2017 we will have designed a rolling programme and process to ensure CIPs are identified and delivered for future years	By September 2017 we will agree a transformation methodology and structure to ensure transformation across the Trust By year end we will transform how we operate and deliver care - Programme one of the transformation programme Programme two of the Transformation Programme will redesign the culture our organisation Transformation programme three will transform and simplify our business processes to improve organisational efficiency	By year end we will build IM&T Operating and Governance models and embed new IM&T management processes and tools to support a resilient organisation By year end we will design and implement an IM&T assurance framework to provide assurance on IM&T performance and the resilience of services By year end we will deliver our CAD resilience strategy and year 1 actions from the Resilience review focusing of the stability of the CAD environment By year end we will deliver a linked programme of new system and enhancement initiatives to deliver digital enablers for the Business Plan By year end we will deliver a linked programme of technology refreshes to ensure the Trust has a stable and sustainable technical infrastructure it can rely on	We will outline our fleet requirements in a new 5 year Fleet Strategy and commence the implementation of our year one actions By September 2017 we will launch our People & Organisational Development Strategy By September 2017 we will launch our refreshed Five Year Strategy By September 2017 we will put in place a programme to secure opportunities that arise from fleet and estates improvements We will define our Estates requirement for the next five years and commence the implementation of our year one actions By December 2017, we will have piloted an electronic response vehicle to support the Mayor's pledge to clean up London's air
Our measures of success *(How we will know we have achieved our objective)*	Cost improvement programme will release £17.8m savings and use of resources score of 3 achieved £250k savings from reduced agency usage in 2017/18 delivered Best practice Quality Impact Assessment process undertaken for all Cost Improvement Programmes	Reduction of 7 minutes achieved for Job Cycle Time Business process reengineering in plan releasing savings and efficiencies Transformation programmes have met agreed milestones across the year	Increased resilience of IM&T services through improved technical and managerial capabilities, recruiting to full establishment Key recommendations of the CAD review are addressed in line with timelines agreed Quality of services improved with SLAs in place for critical systems including CAD	Business case for LAS Estates Strategy agreed by NHSI and year one actions delivered Business case for a 5 year vehicle replacement strategy agreed by NHSI and new vehicles introduced as agreed Reduction in vehicle Out of Service when compared with April 2017 baseline Year one priorities of the LAS 5 year strategy delivered across London

10.2 Our finance and investment plan

The Service continues to operate in a challenging financial environment. In developing our two year financial plan for 2017-2019 we face a number of key challenges:

- Continued growth in activity levels
- The need to improve our productivity
- The requirement for the wider health system in London to manage demand pressures
- The need to invest in staff, vehicles, technology and equipment to improve our services and infrastructure
- The challenge of returning to financial balance and achieving sustainability
- Potential changes in response models as a result of the Ambulance Response Pilot (ARP)

Requirements of the Financial Plan

The Trust Board has reviewed this plan and sees it is as a means of achieving:

- Delivery of current national performance standards
    - A8 75% within 8 minutes
    - A19 transport options for 95% within 19 minutes
    - Hospital handover to green within 15 minutes
- Delivery of the target financial control total (£2.5m deficit in 2017/18 and £1.0m surplus in 2018/19)
- The maintenance of Safe Services to Patients.

Key Financial Headlines

Return to Financial Balance by 2019

Make Capital Investments of £132m over 5 years

Deliver CIPs of £17.8m in 17/18 and £14.9m in 18/19

Ensure the Trust maintains a sufficient cash balance

Key Financial Figures

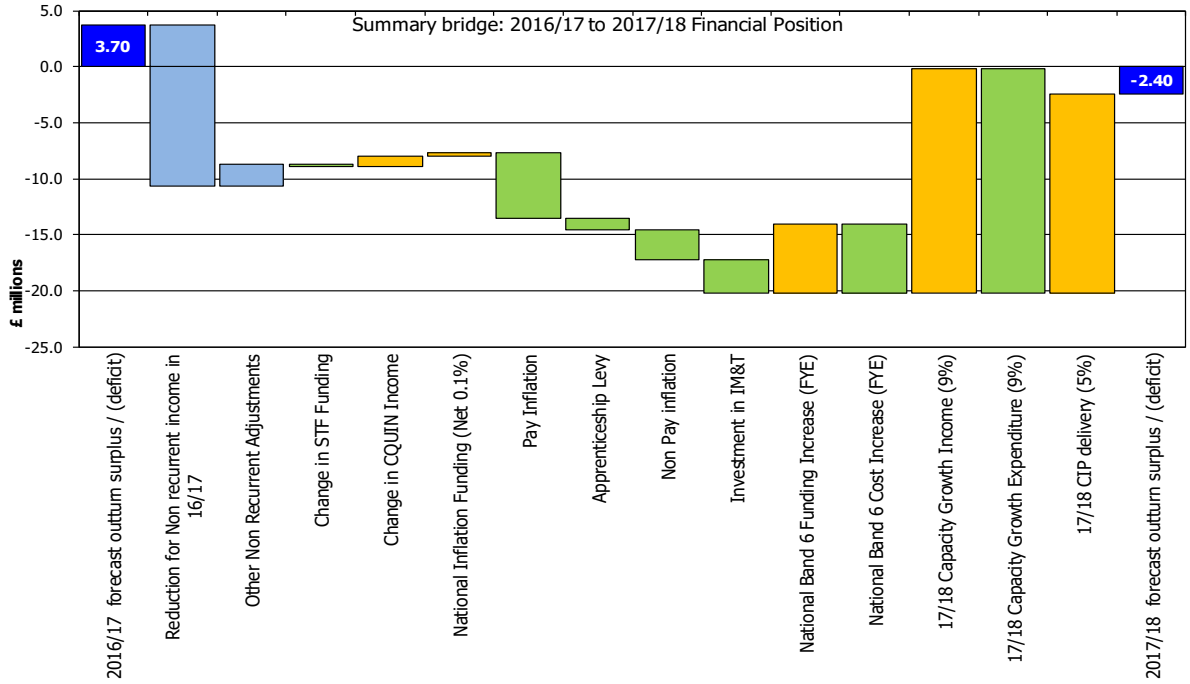
The table below shows the key financial figures for the Service:

	2017-18 Plan	2018-19 Plan
Performance against SOCI (Statement of Comprehensive Income) Control Total (Surplus / (Deficit) (£k))	- 2,410	1,035
Income (£k)	359,012	366,838
Expenditure (£k)	- 357,258	- 361,639
Financing Costs (£k)	- 4,200	- 4,200
Donated Assets Adj (£k)	36	36
Capital (£k)	29,002	31,000
Cash (£k)	14,328	7,288
Cost Improvement Programmes (CIP (£k))	17,781	14,869

- **SOCI Control Total:** The Service is planning to meet its assigned control totals in each year and return to surplus in 2018/19
- **Capital:** The Service will require significant Capital Investment across the next 5 years to support transformation in Fleet, Estates and Technology
- **Cash:** The Service Liquidity position is planned to be challenged until the Service returns to a sustainable surplus position. Working capital management strategies have been identified and Interim revenue financing would be available if required
- **Cost Improvement Programme (CIP):** There will a requirement to deliver £17.8m CIP in 2017/18 and £14.9m in 2018/19

Finance Bridge

The following graph shows the key movements between the 2016/17 expected Outturn position and the 2017/18 Financial Plan:



Financial Key Performance Indicators

The following table shows the key financial performance indicators against which the Service's finances are measured by NHS Improvement.

Plan Use of Resources Risk Rating	Forecast out-turn 31/03/2017 Year Ending Rating	Forecast out-turn 31/03/2018 Year Ending Rating	Forecast out-turn 31/03/2019 Year Ending Rating
Capital Service Cover rating	1	1	1
Liquidity rating	4	4	4
Income & Expenditure Margin rating	4	3	2
Variance From Control Total rating	1	1	1
Agency rating	1	1	1
Plan Risk Rating after overrides	3	3	3

- NHS Improvement has introduced a single oversight framework to replace risk assessment and accountability frameworks. Use of Resources is the measure used to assess financial performance.
- 1 is the best score that can be achieved whereas 4 is the worst.
- The overall scoring shows LAS with a score of 3. A score of 4 in any one metric limits the maximum score overall to 3.
- The score of 3 is triggered due to the Liquidity Rating of 4 in the plan position.
- Income & Expenditure Margin improves across the identified period as the deficit position is reduced and the Service returns to surplus.
- The Service expects to remain scores of 1 in all other areas as it delivers its plan.

Cost Improvement Programme

The Service has a target of £17.8m CIP which represents 5% of annual turnover. This is seen as a challenging but achievable target. We have developed and agreed a number of programmes which are summarised by the table of CIP themes below. £9.9m of the CIP will be delivered in Operational areas with the remainder (£7.9m) being delivered from non-frontline budgets. All CIPs are owned by an executive lead and, where required, a quality impact assessment (described in section 5) will been undertaken.

	£m
Managing Frontline Pay Growth	5.10
Rest Breaks and End of Shift Arrangements	1.50
EOC Efficiency	2.25
NETS Productivity / Retrenchment	1.00
Apprenticeship Levy	2.25
Fleet & Logistics Efficiency	1.50
Corporate & Collaboration opportunities	3.10
Managing Non Frontline Pay	1.10
	17.80

Financial Risk

Part of developing a robust financial plan is assessing potential variations to the stated plan. The key issues identified in the current plan are stated below:

Risk	Detail
Activity / Demand	Demand is projected to increase by up to 10.4% in 2017/18. Whilst up to 9% has been funded for additional capacity, 2% improvements in demand management are required (primarily by Commissioners) to deliver contracted performance standards. It should be noted that if demand reduces (up to 2% below baseline) Commissioners would reduce funding
Workforce Delivery	The Service has a challenging recruitment target for 2017/18 and beyond. If recruitment is delayed or reduced this will have a material impact on the delivery of the plan.
Cost Improvement & Productivity	The Service has committed to a challenging CIP target of £17.8m (5% of Turnover) in 2017/18. Multi-year detailed plans are currently being developed to ensure delivery
Income	Some income streams have been funded non-recurrently (e.g. Band 6 funding for 2 years). This will create financial pressure if not secured beyond 2018/19.

Key Financial Statements (Revenue and Capital Plans)

Statement of Comprehensive Income (SOCI)

	Plan Year ending 31/03/2018 £'000	**Plan Year ending 31/03/2018 £'000**
Operating income from patient care activities	356,310	363,116
Other operating income	2,702	3,722
Employee expenses	(269,306)	(274,776)
Operating expenses excluding employee expenses	(87,952)	(86,863)
OPERATING SURPLUS / (DEFICIT)	**1,754**	**5,199**
FINANCE COSTS		
Finance income	132	132
Finance expense	(132)	(132)
PDC dividends payable/refundable	(4,200)	(4,200)
NET FINANCE COSTS	**(4,200)**	**(4,200)**
Gains/(losses) on disposal of assets	0	0
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR PER ACCOUNTS	**(2,446)**	**999**
Remove capital donations/grants Income & Expenditure impact	36	36
Adjusted financial performance surplus/(deficit)	**(2,410)**	**1,035**
Control totals for planning years	(2,511)	1,011
Performance against control total	**101**	**24**

Capital Expenditure

Expenditure	31/03/2018 Year Ending £'000	31/03/2019 Year Ending £'000	31/03/2020 Year Ending £'000	31/03/2021 Year Ending £'000	31/03/2022 Year Ending £'000	31/03/2022 5 Year Plan £'000
Estates - Maintenance	1,550	750	750	750	750	**4,550**
IM&T	4,500	3,000	3,000	3,000	1,700	**15,200**
IM&T Digital Maturity Investment (external)	5,520	12,800	11,140	3,370	0	**32,830**
Equipment	1,306	1,000	1,000	1,000	1,000	**5,306**
Fleet replacement 2015/16 and 2016/17 - 2 year programme	10,006	0	0	0	0	**10,006**
Other Fleet	2,800	3,200				**6,000**
Fleet replacement - 2018/19	3,320	10,250				**13,570**
Fleet replacement - 2019/20	0		10,250			**10,250**
Fleet replacement - 2020/21	0			10,250		**10,250**
Fleet replacement - 2021/22	0				10,250	**10,250**
New Control Room	0			500		**500**
Lea Bridge / Romford Purchase	0		2,000			**2,000**
Ambulance Superstations	0			6,000	6,000	**12,000**
Total Capital Expenditure	**29,002**	**31,000**	**28,140**	**24,870**	**19,700**	**132,712**

Funding	31/03/2018 Year Ending £'000	31/03/2019 Year Ending £'000	31/03/2020 Year Ending £'000	31/03/2021 Year Ending £'000	31/03/2022 Year Ending £'000	31/03/2022 5 Year Plan £'000
Internally Generated	23,482	18,200	17,000	21,500	13,045	**93,227**
National Grants	5,520	12,800	11,140	3,370	0	**32,830**
Other	0	0	0	0	6,655	**6,655**
Total Capital Funding	**29,002**	**31,000**	**28,140**	**24,870**	**19,700**	**132,712**

The Capital Plan within the 2017/18 to 2021/22 Capital Planning window has focused primarily on internal funding with only the National IM&T digital maturity programme requiring external funding. This recognises that capital funding is likely to be extremely constrained moving forward and additional capital will not be freely available.

Asset Disposal (Estates): LAS is planning extensive estates restructuring that will involve material asset sales and purchases from 2019 to 2022 and beyond. This amounts to £14.5m across the planning period which would require interim loan funding. In 2022 the Service would make £6.7m Estate sales to repay the interim loans with further sales in future planning periods.

Technology**:** The Service has included £32.8m of external Capital funding over the 5 year planning period related to the national Driving Digital Maturity programme. This will be a key enabler to delivering future efficiencies and sustainability within the service and across the health system. If external funding is not received there will be an equal reduction in spend.

Vehicle Business Cases: The Service has an on-going need to refresh its vehicle fleet each year. The value of these refreshes exceeds the Service delegated limit as such a business case is required. As these cases will be a regular occurrence the trust will seek a solution that meets the needs of all parties without creating additional workloads.

Future Financial Challenges – 2018/19 and Beyond

The current financial plan spans the 2 years to 2018/19 with a 5 year plan for capital. Alongside this level of detail it is important to assess where future challenges and opportunities beyond the existing planning period

Financial Year 2018/19

- The Service has been set an improvement in its control total of £3.5m for 2018/19. Moving from a deficit of £2.5m to a surplus of £1.0m. Additional efficiencies will be required to achieve this.
- The impact of both the Estate and IM&T strategies will need to be addressed. Both should provide efficiencies which will support their introduction. These will need to be scoped and defined (benefits realisation).
- Growth will continue. Opportunities for demand management may be more challenging. Further work on the operating model, especially the mix of how the Service responds to incidents (Hear & Treat, See & Treat, See & Convey) will need to be defined. ARP will help define this, but action will need to be taken regardless of ARP.
- Back office consolidation and blue light collaboration will need to be addressed. With plans confirmed across 2017/18.
- Further funding challenges may arise from CCGs. We should seek to keep these linked to the operating model.
- The need to maintain and continue to improve quality.

2018/19 and Beyond

- Realising the 5 Year Forward View – As the LAS takes a more active role in STPs it will be expected to make a contribution to system sustainability. Part of this will be by being financially viable and contributing to the £5bn funding shortfall in London. That could include CIPs of up to 10%.
- Band 6 Paramedics- The Service has only secured national band 6 funding for 2 years. The recurrent cost pressure is likely to be circa £8.0m per annum
- Integrated Urgent Care (IUC) - To meet the strategic objective of becoming the IUC provider across London internal efficiencies must be maximised to ensure bids are as commercially viable as possible

Meeting Future Challenges

- Accelerating Financial Delivery – bringing forward measures to address financial sustainability could ease the transition beyond 2018/19
- Aggressively tackling inefficiency – a proactive approach to systematically targeting and eliminating excessive incentives, overtime and agency usage. 5 year trajectories should be set now.

- Actively seeking partnerships – the Service must face the reality that it will not be sustainable in its current form. This means looking at any and all areas of collaboration and driving them through (e.g. sharing back office functions, outsourcing etc.)
- Taking calculated risks – the Board must continue to foster a positive tension between Output (activity), Outcome (quality) and Outflow (resources) to ensure the Trust maximises Value (e.g. maximising hear & treat and see & treat)

Investing to succeed

The Tables below provides an overview of the funding to support delivery of the business plan

Overview of service development funding

Priority Service Development	Total Cost
Service Development Reserve	3,211
Special Measures Funding	500
QIP Recurrent	500
111 Contract	200
Sub Total	**4,411**
Service Developments in Budget	**Total Cost**
WRES	450
Strategy Development	200
IM&T Strategy Year 1	1,000
MTFA	5,300
Digital Devices	2,000
Subtotal	**8,950**

Mitigations for Over commitment	Total Cost
Part Year Effect / Slippage	-500
Costing adjustments	-500
Other Flexibilities	-211

Revised Total	**12,150**

Further breakdown of the programmes funded against the priority service developments

	A. Priority 1	B. Priority 2	Grand Total
	£000s	£000s	£000s
111 Bid Support	200		200
Additional IM&T Investment		100	100
Ambulance Conveyance		100	100
Bullying & Harassment	106		106
CIP Delivery		100	100
Clinical Strategy Support		210	210
Collaboration		30	30
Corporate Investment		15	15
Fleet Support	250		250
Improving Quality	250	50	300
Improving Workforce Systems and Processes	425	0	425
Leadership Development	230		230
Medicines Management	900		900
Operational Productivity Support	220	300	520
Project Management Office	600	300	900
Staff Engagement		25	25
Grand Total	3,181	1,230	4,411

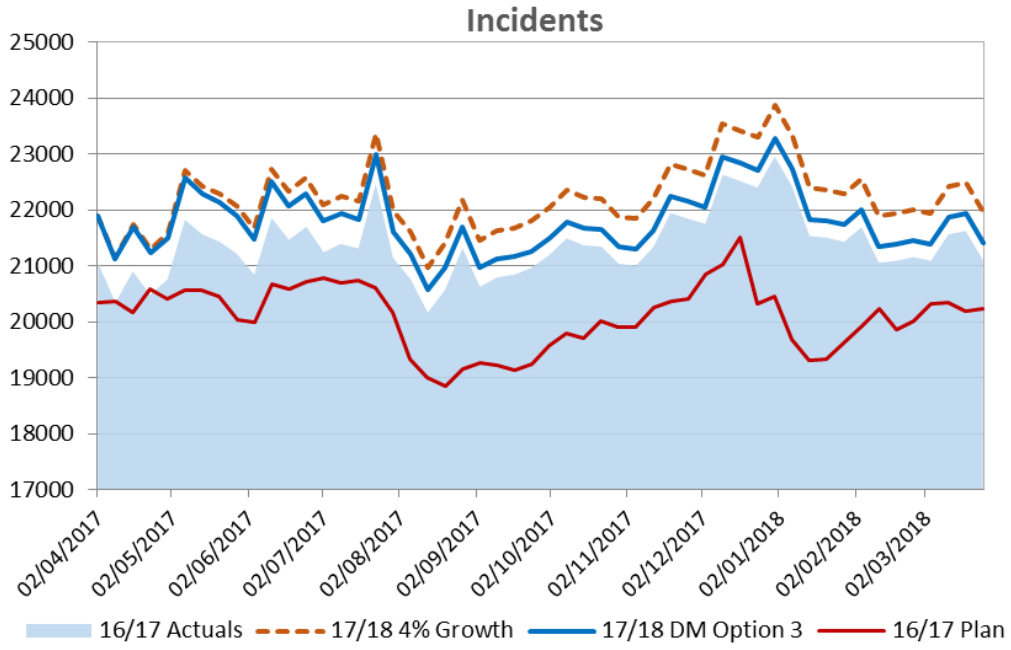
10.3 Our activity and people plan

Our Activity Planning for 2017/18 is informed by the 2017/18 contract agreed with Commissioners. This activity planning is based on a number of assumptions, some of which will require action to be taken to ensure the delivery of these assumptions.

The assumptions are:

- Modelling indicates that pan-London performance at 75% can be achieved for 1st October 2017 and maintained at an average of 75% thereafter
- Demand growth has been modelled at between 6%-9% above 2016/17 contract values
- Delivery of trajectories is dependent on demand management of at least 2%. This demand management will be undertaken in partnership with STPs and CCGs as part of this Business Plan
- Capacity will be sourced from substantive staff, overtime and Private Ambulance provision. A recruitment plan is being developed to maximise substantive staff
- Performance is dependent on the maintenance of a pan-London operating model.

The graph below shows the historic and predicted activity profile for 2016/17 and 2017/18. Demand Management will be expected to assist with periods of high demand, and times when performance is challenged. It is also assumed that demand management endeavours will be enhanced during 2017/18, with a slow build through Q1 and Q2, with significant impact in the latter half of the year.



17/18 with 4% growth on 16/17 outturn implies an unmitigated 10.4% increase on the 16/17 plan, almost an additional 111,000 incidents.

Option 3 gives the best outcome of the three Demand Management options: with **1.9%** total reduction in demand across the year, and the highest rate of performance in half 2 (Option 1 gives marginally better *annual* A8 performance).

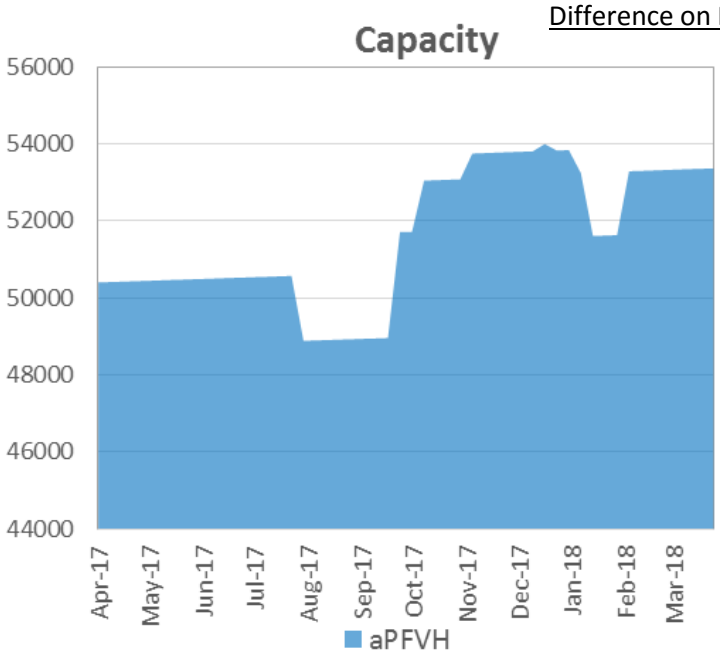
As well as the demand management initiatives, there are two elements that are crucial to achieving agreed performance standards; **increasing capacity** and **reducing Job Cycle Time**. Plans to deliver the requirements of both are outlined in "Our objectives and delivery plans" section.

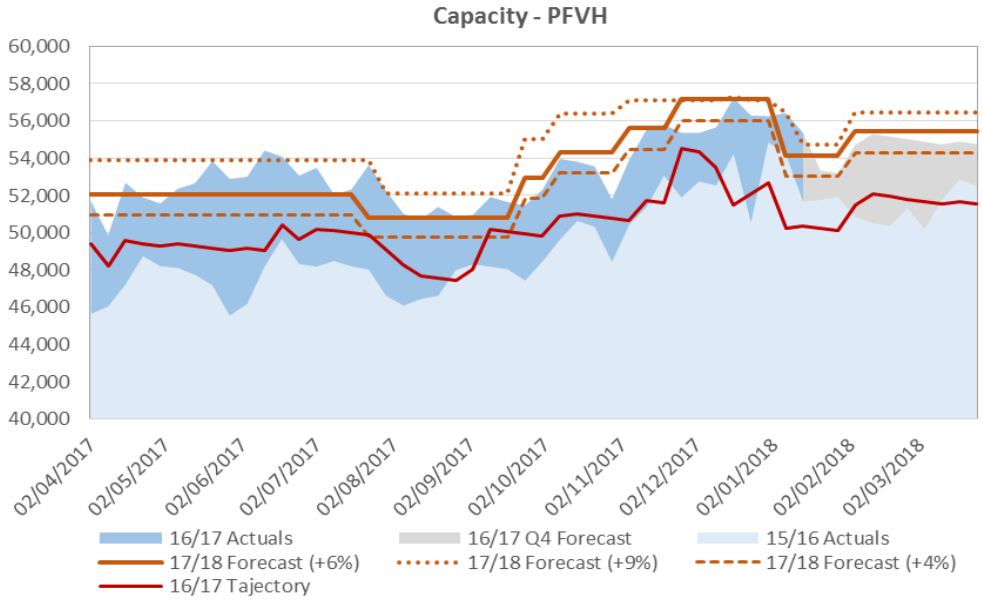
Capacity

Capacity, or Patient Facing Vehicle Hours (PFVH), has been modelled as a given level of growth on total 2016/17 planned hours. The 2017/18 profiles below apply uplifts on the 2016/17 plan (with options of +6%, +9% and +4%), and follow similar seasonal trends. Actual 2016/17 capacity was used as a guide to set the weekly variation.

16/17 Trajectory PFVH
Total Hours = 2,619,550
Average = 50,375

16/17 Actual + Forecast PFVH
Total Hours = 2,782,060
Weekly Average = 53,500
Difference on Plan = **+6.2%**





17/18 Forecast = +6% on plan
Total Hours = 2,781,960
Weekly Average = 53,500
Difference on Plan = +6.2%

17/18 Forecast = +9% on plan
Total Hours = 2,855,310
Weekly Average = 54,910

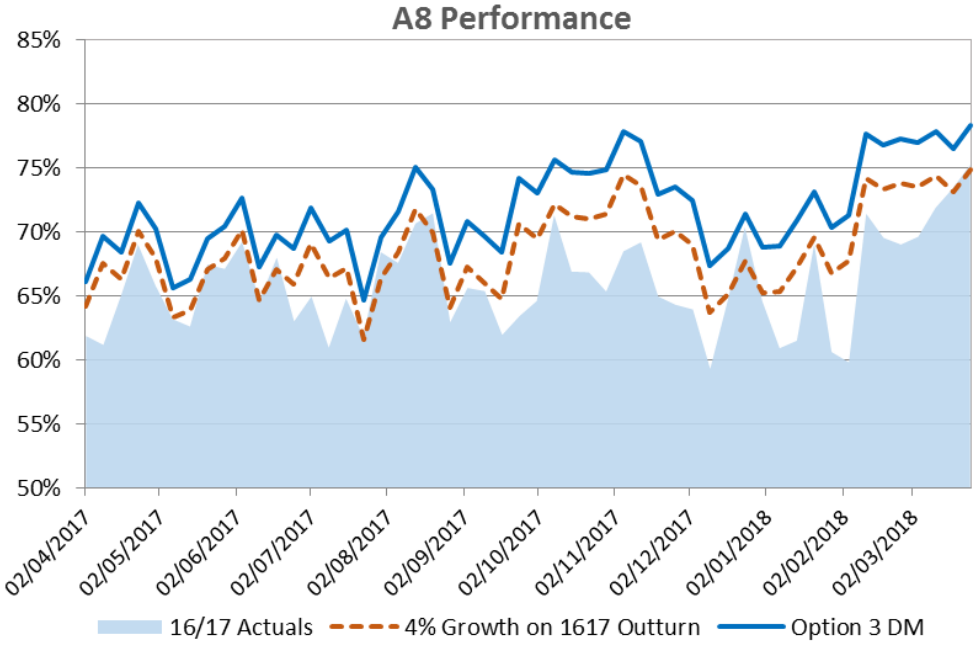
17/18 Forecast = +4% on plan
Total Hours = 2,724,330
Weekly Average = 52,390

The main contributor to our increased capacity is the increase in total frontline establishment from 3,575 in 2016/17 to 3,869 in 2017/18. The table below shows the breakdown of these figures and the wider organisational establishment:

	Substantive			Overtime			Total Establishment		
	2016/17 WTE Budget (ave)	2017/18 WTE Budget (ave)	WTE Movement	2016/17 WTE Budget (ave)	2017/18 WTE Budget (ave)	WTE Movement	2016/17 WTE Budget (ave)	2017/18 WTE Budget (ave)	WTE Movement
1. Paramedic	2,089	2,170	81	201	232	31	2,290	2,402	112
2. Apprentice Paramedics	85	85	0	0	0	0	85	85	0
3. Frontline EAC / TEAC	773	956	183	0	0	0	773	956	183
4. Frontline EMT & support tech	426	426	0	0	0	0	426	426	0
Frontline Staffing	**3,373**	**3,637**	**264**	**201**	**232**	**31**	**3,574**	**3,869**	**295**
5. Non frontline Paramedics	285	292	7	0	0	0	285	292	7
6. EOC staff on watches	378	409	31	47	47	0	425	456	31
7. All other staff	1,268	1,333	65	47	51	4	1,315	1,384	69
Non Frontline Staffing	**1,931**	**2,034**	**103**	**94**	**98**	**4**	**2,025**	**2,132**	**107**
Grand Total	**5,304**	**5,671**	**367**	**295**	**330**	**35**	**5,599**	**6,001**	**402**

The figures in the table above are current workforce figures, however they may change in light of skill mix review that will take place throughout the year.

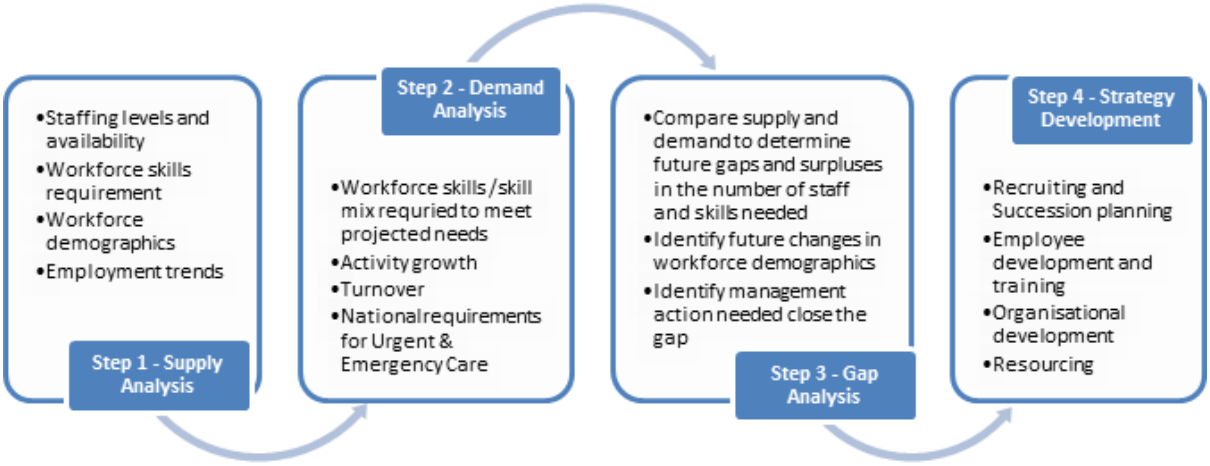
Based on demand, capacity and efficiency assumptions, our A8 performance trajectory identifies that we will be able to meet our contracted target of pan-London performance at 75% by 1st October.



Average Overall A8 Performance for DM Option 3: 72.2%
Half 1 of year (average): 69.4%
Half 2 of year (average): 74.9%

Workforce Planning

The diagram below describes the workforce planning process for the service:



Following the agreement of the 2017-19 contract, our recruitment plan is being refined to meet the 2017/18 total establishment of 6,001 whole time equivalents.

The recruitment plan takes into account:

- Growth in frontline staffing capacity to reflect demand growth
- Anticipated turnover of 13.5% for Corporate Directorates and 9.2% for Operations. This includes the conversion of agency to substantive roles in areas of high agency use.
- Conversion of overtime to substantive roles where appropriate
- Identified CIP programmes
- Any changes in skill mix and resulting staffing needs

10.4 Our improvement journey

To support delivery of the business plan and to transform the Trust we will put in place an organisation wide transformation programme.

Over the past few years, the Service has run two organisation-wide change programmes; the Performance Improvement Programme (2015-2016) and the Quality Improvement Programme (2016-2017). We now need to put in place a new transformation programme in order to ensure continued and sustained change and realise our ambition of 'Making the LAS Great'.

The aim of the Transformation Programme is to deliver sustainable change to transform the way we provide care to our patients, improve the working lives for our staff and improve organisational efficiency and effectiveness.

Transformation Programmes

Three Transformational programmes will be created to support delivery of the business plan in the year ahead. These are:

Programme A: Transforming Care Delivery

We will transform our current operating model to ensure robust delivery, enhanced care, and improved working conditions. The programme will include all aspects of our future target operating model (e.g. systems, structures, roles, responsibilities and performance metrics)

Programme B: Shaping Our Culture

Culture shaping is a methodical, comprehensive and integrated approach to shifting an organisation's culture from the top to the bottom. Building a healthy, high-performing culture involves changing the behaviours of the individuals and teams that make up the organisation.

Programme C: Simplifying for Success

We will create an internal customer approach to improve the interactions between all the staff who support LAS in corporate and support services and those who work in operational services. This programme aims to create an internal business partner model, simultaneously driving cost, efficiency and quality improvements in these areas through a process of business process redesign. Regardless of the department the way that these staff interact and work on solutions internally ultimately impacts the delivery of care.

10.5 Our strategic risks

In February 2017, the Trust Board reviewed its risk appetite and stated:

'The Trust recognises that its long term sustainability depends upon the delivery of its strategic objectives and its relationship with its patients, the public and strategic partners.

As such, the Trust will not accept risks that materially impact on quality of services as defined above (safety, patient experience, and effectiveness), and similarly reputational and regulatory risks. However the Trust has a greater appetite to take considered risks in terms of finance and innovation where there may be options for limited potential gains.'

An assessment of risks to delivery of the business plan has been completed and these have been themed against five areas: quality; workforce; demand; productivity; and leadership. The strategic risk assessment is outlined below:

Risk theme	Strategic risk/s
Quality	• Long waits experienced by patient with non-life threatening conditions • Rest breaks not implemented • Time lost due to dispatch processes • Failure to improve key clinical performance indicators

Workforce	• Insufficient capacity to fill rosters and therefore meet demand • Management of the workforce environment
Demand	• Demand increases at a level greater than planned • Agreed 2% reduction in demand management is not delivered by CCGs
Productivity	• Failure to achieve 7 minute reduction in job cycle time • Quality and appropriateness of infrastructure including estates, IM&T, medicines management
Leadership	• Vacancies at ELT level • Leadership capability and capacity

The table below details the link to the business plan that will mitigate the risks identified above.

Strategic Risk	Link to the business plan to mitigate strategic risk	Currently on the Board Assurance Framework	To be added to the Board Assurance Framework
QUALITY			
Long waits experienced by patient with non-life threatening conditions	Goal one: patients receive safe, timely and effective care		√
Rest breaks not implemented	Goal one: patients receive safe, timely and effective care	√	
Time lost due to dispatch processes	Goal one: patients receive safe, timely and effective care		√
Failure to improve key clinical performance indicators	Goal one: patients receive safe, timely and effective care		√
WORKFORCE			
Insufficient capacity to fill rosters	Goal two: staff are valued, respected and engaged	√	
Management of the workforce environment	Goal two: staff are valued, respected and engaged		√
DEMAND			
Demand increases at a level greater than planned	Goal three: partners are supported to deliver change in London	√	
Agreed 2% reduction in demand management is not delivered by CCGs	Goal three: partners are supported to deliver change in London		√
PRODUCTIVITY			
Failure to achieve 7 minute reduction in job cycle time	Business plan cross cutting theme		√

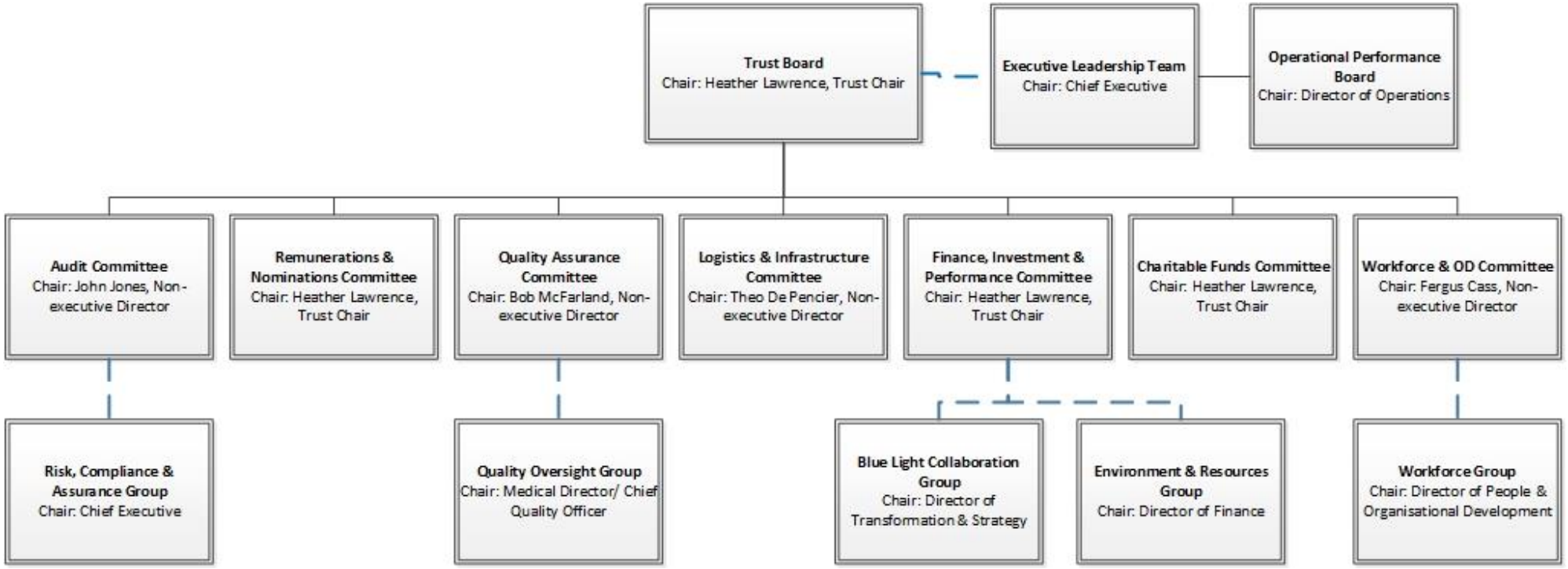
Quality and appropriateness of infrastructure including estates, IM&T, medicines management	Goal one: patients receive safe, timely and effective care Goal four: efficiency and sustainability will drive us	partially	√
LEADERSHIP			
Vacancy at ELT level	Goal four: efficiency and sustainability will drive us		√
Leadership capability and capacity	Goal two: staff are valued, respected and engaged		√

These strategic risks will be added to the risk register and the board assurance framework.

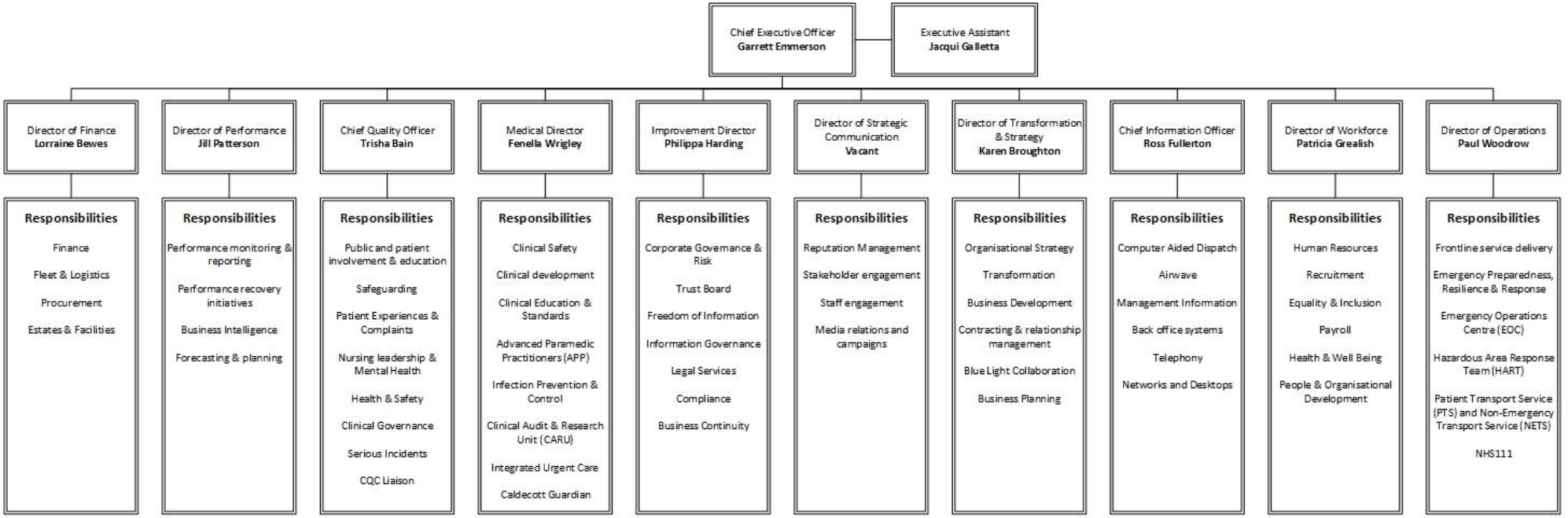
10.6 Our governance

The structures below outline the Trust Board, Trust Board sub committees and Executive Director portfolios

Trust Board & sub committees



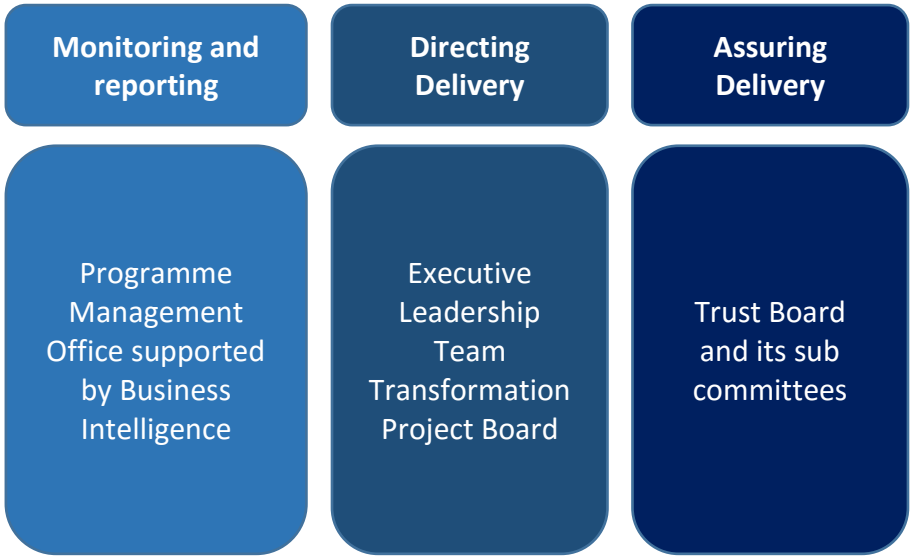
Executive Leadership Team & portfolios



Governing delivery of the business plan

We have established a clear programme of delivery, accountability and governance, led by the Chief Executive Officer, supported by the Director of Transformation and Strategy with a Programme Management Office (PMO), to ensure oversight and leadership in the delivery of our business plan.

The diagram below identifies how the business plan will be governed.



Monitoring and reporting:

The PMO will:

- Closely monitor the progress of our plan and ensure that this progress along with issues and risks are reported and managed
- Hold the baseline data, delivery dates and target trajectories so that can progress can be effectively measured
- Work in partnership with Business Intelligence to produce a monthly report on key performance indicators
- Capture any changes to planned delivery and ensure they are authorised by the Executive Leadership Team

Directing delivery

Progress towards the business plan will be a monthly agenda item for the Executive Leadership Team who will consider performance against objectives as well as the impact of actions.

Each business plan action has a nominated lead Director who will take accountability for the delivery of milestones. Where performance is not in line with the plan, the Director will provide exception reports and change requests with clear remedial actions and a delivery impact assessment for approval by Executive Leadership Team.

Progress toward the transformation programmes will be reviewed on a monthly basis by the Transformation Project Board.

Assuring delivery

Progress against milestones and assurance will be reviewed by the relevant Trust Board sub committees on a quarterly basis. A half yearly report to the Trust Board will be provided on progress against the full business plan.

London Ambulance Service NHS Trust

Report to:	**Trust Board**
Date of meeting:	**25th May 2017**
Document Title:	**Fleet Strategy**
Report Author(s):	**Justin Wand**
Presented by:	**Andrew Grimshaw**
Contact Details:	**Justin.wand@lond-amb.nhs.uk**
History:	***ELT, L&IC***
Status:	***Approval***

Background/Purpose

This strategy has been reviewed and approved by the Executive Leadership Team and the Logistics and Infrastructure Committee. It is recommended to the Trust Board for final approval.

- This paper sets out an analysis of the operational and technical challenges that impact on the Trust in its development of a robust fleet strategy to support the vision of the organisation, the clinical strategy and is able to adapt to match the changing role of the ambulance service; essentially the transition from a transport service to that of a mobile healthcare provider.
- This is to be an evolving strategy which is to be used to re-affirm annually the assumptions on which it is based and that those plans are still relevant and aligned to the Trust's Quality Improvement Plan (QIP) and from which the annual business programme can be seen to have been derived from.
- The aim of this strategy is to configure the Trust's operational fleet bringing it into line with the changing Operating model, allowing front line staff to respond quickly to emergency calls, improve clinical outcomes by maximising their clinical time with the patient and, in the process allow for the most efficient use of time and resources.

Action required

The L&IC is requested to review and note the paper

Links to Board Assurance Framework and key risks

Key implications and risks in line with the risk appetite statement where applicable:	
Clinical and Quality	**X**
Performance	**X**
Financial	**X**
Workforce	**X**
Governance and Well-led	**X**
Reputation	
Other	
This paper supports the achievement of the following Quality Improvement Plan Workstreams:	
Making the London Ambulance Service a great place to work	
Achieving Good Governance	
Improving Patient Experience	
Improving Environment and Resources	**X**
Taking Pride and Responsibility	

London Ambulance Service NHS
NHS Trust

Trust Fleet Strategy

2016 - 2020

Fleet Strategy 2016 - 2020	07/04/2017
Final Draft – not approved	

Document profile and control

Purpose of the document: This document sets out the Clinical Education Strategy for London Ambulance Service from 2016 – 2020. The Clinical Education Strategy will support the overall LAS 5 year Strategy and inform other strategies including the IM&T strategy, Operational strategy (including estates, workforce strategy and clinical strategy.

Sponsor Department: Finance Directorate

Author/Reviewer: Deputy Director Fleet & Logistics

Input has been received from stakeholders from Operations, Medical and Finance as well as the wider team.

The strategy includes the development of an annual replacement plan and will be reviewed annually to ensure the actions remain current and aligned to LAS Operational needs.

Document Status: second draft

Date	*Version	Author/Contributor	Amendment Details
April 17	0.2	Fleet & Logistics Infrastructure Comm.	
January 2017	0.1.5	Quality Improvement Board	Minor amendments based on feedback
November 2016	0.1.5	Circulation to Finance team for modelling purposes	Financial planning
November 2016	0.1.5	First draft circulated, Operations Board & SDG circulation. Fleet and logistics team distribution for comment	Numerous minor changes suggested and amendments made
October 2016	0.1	DoF, DOPS and lead NED circulation	Input to main issues and themes for strategy

Document Control

Contents

1 Executive Summary

1.1. Meeting the Operational Requirement

1.1.1. This paper sets out an analysis of the operational and technical challenges that impact on the Trust in its development of a robust fleet strategy to support the vision of the organisation, the clinical strategy and is able to adapt to match the changing role of the ambulance service; essentially the transition from a transport service to that of a mobile healthcare provider.

1.1.2. This is to be an evolving strategy which is to be used to re-affirm annually the assumptions on which it is based and that those plans are still relevant and aligned to the Trust's Quality Improvement Plan (QIP) and from which the annual business programme can be seen to have been derived from.

1.1.3. The aim of this strategy is to configure the Trust's operational fleet bringing it into line with the changing Operating model, allowing front line staff to respond quickly to emergency calls, improve clinical outcomes by maximising their clinical time with the patient and, in the process allow for the most efficient use of time and resources.

1.2. Trends and Factors Affecting the Replacement Cycle

1.2.1. The strategy recognises that there are significant internal and external factors that are likely to influence all fleet replacement policies in both the short and long term.

1.3. From the Accident & Emergency (A&E) Service perspective these factors take into account:

1.3.1. The transition of the Trust following special measures.

1.3.2. The introduction of "Make Ready" depots.

1.3.3. The implementation of an advanced paramedical Primary and Urgent Care agenda.

1.3.4. The development of and potential implementation of the Ambulance Response Programme (ARP).

1.3.5. The provision of a 'connected' mobile workplace for clinical staff.

1.3.6. The aspiration to provide a fleet life-cycled over 5 years, together with its key operational and clinical equipment.

1.3.7. Reduce variation by standardising as quickly as possible on as few vehicle platforms as is operationally viable.

1.3.8. Adopt best practise in relation to Environmental compliance and minimising the Trust's carbon footprint

1.4. The Operational strategy for Non-Emergency Transport (NETS) will make clear the Trust's intention towards the PTS market and its role in support of A&E services.

1.5. The clinical scenarios and health conditions that the vehicle fleet will have to accommodate are also going to change.

1.6. Chronic disease management in communities where obesity is set to rise to 36% by 2020, all contained also an increasingly aged population will require a greater range of sophisticated, technologically advanced, portable and vehicle borne clinical/ diagnostic equipment.

1.7. Recognition that ambulance trusts, as major transport providers will be forced to make changes in meeting our Corporate Social Responsibilities for the environment and sustainability.

1.8. With transport contributing c.80% to overall Trust carbon emissions, we must expect Government targets to reduce carbon emissions by 2020 to be more heavily enforced. In common with our emergency services partners we will undertake to examine a range of options to meet our transport needs.

1.9. **Make Ready**

1.9.1. A major contribution to operational performance and demand management within the Trust, and the key issue to impact upon the fleet over the life of the strategy is the introduction of the 'Make Ready' function.

1.9.2. The Make Ready model provides an integrated support function that minimises the risk to service delivery and maximises patient safety. It supports delivery of high quality patient care in an environment that is safe for both patients and staff and that requires a vehicle fleet that supports the concept.

Make Ready – a definition:

A crew friendly, quality assurance vehicle and equipment preparation programme designed to minimise cross infection and maximise patient safety.

1.10. **Vehicle Maintenance and Support**

1.10.1. In a climate of large Trusts and collaborative working providing greater leverage, in line with the aspirations of the Carter Review, it is recognised that we must ensure that vehicle maintenance and support is cost-effective, fit for purpose, and ensures that the fleet meets the day-to-day operational requirement.

1.10.2. This is will be achieved through the development of a Fleet and Logistics 'sector based support model' (fleet, logistics, make ready), which will provide local support to operations, structured locally, delivered locally and managed locally.

The Trust intends to monitor National initiatives in this area by both Ambulance Trusts and other emergency service partners to ensure that we derive maximum economic benefit from our fleet maintenance and support functions.

1.11. **Financial Aspects**

1.11.1. The financial regime in which we now operate presents real challenges in meeting the operational aspiration for a front line fleet that is life cycled over a shorter 5 year period. It is clear that the Trusts current levels of financial investment in the fleet, both Capital and Revenue, has not been sufficient to achieve that objective in recent years and a fundamental step change will be required if LAS is operate a younger more reliable fleet.

1.12. In short, the DCA 'modular' vehicle, the principle ambulance platform that forms the backbone of the current vehicle fleet is not affordable unless funding is diverted from other

areas of the Trust. Furthermore, there will be pressure to rationalise this area as we look to the future and the introduction of a more technically sophisticated (and by inference, more expensive) clinical model.

1.13. A number of assumptions are set out that may assist in minimising the financial impact of the programme on the basis that no additional contract income will be forthcoming to support additional capital investment, or other revenue expenditure for the fleet. The assumptions include:

1.13.1. Adopting a single common ambulance platform to standardise both the box body ambulance vehicle and non-emergency transport ambulance.

1.13.2. Rationalisation of the fleet wherever possible and removing all excess or "ad-hoc" vehicles that are not covered by contract income or defined a specialist need.

1.13.3. Achieving commonality and standardisation of all other vehicle types and equipment in line with the vehicle replacement programme and implementation of the Make Ready model.

1.14. Review the size and related operating costs of the fleet, (including fleet over-head) relative to the income generated to determine whether or not there is any scope for reducing costs.

1.15. Review the size and related costs of the specialist and EPRR fleet to determine opportunities for rationalisation and cost reduction.

1.16. Review and rationalise the size and function of the Training fleet, amalgamating training vehicles into the operational 'Patient facing' stock, allowing for operational flexing of the vehicle fleet whilst providing DCA and FRU vehicles for training as part of the 'surge' capacity within the system.

1.17. Acknowledge the environmental factors that will be imposed in support of reducing our impact on the environment, the effects that our pollutants have upon our patients and the communities we serve and the opportunities for embracing new fuel technology.

1.18. Lastly, we must consider this to be an evolving strategy that will reflect both internal and external influences on the operations, the economic climate and the environment in which the Trust operates.

2 Introduction

2.1. We have a strong and meaningful vision in our Trust – to make the LAS great! To be great means we are recognised for providing great service to patients, we pride ourselves on our clinical and technical excellence and staff believe we are a great place in which to work.

2.2. The London Ambulance Service NHS Trust (the trust) is committed to care for people in London – saving lives, providing care, and making sure they get the help they need.

2.2.1. **Clinical Excellence** - Putting the patient at the heart of everything we do; Giving our patients the best possible care; leading and sharing best clinical practice; using staff and patient feedback and experience to improve our care.

2.2.2. **Care** - Helping people when they need us; treating people with compassion, dignity and respect, having pride in our work and our organisation - Identifying the factors that create good patient experience, improved outcomes, a safe team based environment which works efficiently.

2.2.3. **Commitment** – Setting high standards and delivering against them; supporting our staff to grow, develop and thrive; Learning and growing to deliver continual improvement; Working hard technically, with integrity, shaping our structures and implementing processes and mechanisms that allow for the most efficient use of time and resources.

3 Aim

3.1. The aim of this Fleet Strategy is to provide a fit for purpose, safe, reliable and cost effective fleet of vehicles, enabling the Trust to deliver optimum patient care and services in the community, improve patient outcomes and enable the effective use of clinical time and resources.

3.2. This paper provides an overarching reference which entwines key operational, clinical and financial objectives, and as a consequence describes their impact upon the design and management of the Operational fleet.

3.3. This is to be an evolving strategy that will need to reflect both internal and external influences as they affect operational delivery, clinical quality, the economic climate and the environment in which the Trust operates.

3.4. This document is to be used to re-affirm annually the assumptions, upon which it is based, that such assumptions are still relevant - aligned to the Trust's Quality Improvement Plan (QIP) and from which the annual capital programme can be seen to have been derived.

3.5. The strategy aims to provide:

3.5.1. An outline of the Trust's fleet operation, its key objectives and the factors affecting change.

3.5.2. A clear statement to the public, staff and key stakeholders that the Trust has plans to maintain and improve its services and facilities in line with the vision of the organisation.

3.5.3. A clear statement that the Trust, as a major fleet operator, understands its obligations to the environment doing all that it can to reduce its carbon footprint and the effects our service has on the communities we serve.

3.6. Provide strategic context for the Trust to assess future capital investment plans, whilst taking into account Political aspirations and emerging legislation.

4 Fleet Services - Strategic Objectives

4.1. To identify and meet the transport needs of the Trust, for both operational and support functions.

4.2. Develop an efficient and effective fleet of vehicles, ensuring vehicles are replaced following optimum replacement cycles, in line with the financing policy.

4.3. Maintain a cost-effective and timely processes for design, procurement, commissioning, maintenance and repair, decommissioning and disposal of the vehicles.

4.4. Maximise productivity from new systems and technologies achieving value for money.

4.5. Protect and enhance the environment, supporting the concept through the Trust.

4.6. Review developments and exploit opportunities in fuel technologies and carry them through to the vehicle replacement policy in conjunction with the 'frontline ops' and the fleet management team.

4.7. Continue to develop and communicate service line reporting (SLR) for appropriate stakeholders throughout the trust, improving Management Information (MI) and budget management.

4.8. Work in collaboration with ambulance services Nationally and Internationally and with other public sector bodies for the benefit of the Trust.

5 Operating Context

5.1. Performance

5.1.1. The majority of our income funds A&E activity and the three core services that we provide in this arena; Hear and Treat, See and Treat and Treat and Transport.

5.1.2. High performing, lean system design that enables the most efficient use of time and resources, as an integrated part of the vision, places special requirements upon the operational fleet, its design, purchase, maintenance, and replacement.

5.1.3. In striving to meet the challenges of high performance, Fleet services require a step change in the way it manages its core business. Developing a fleet function which is suited to the needs of operations, the patient and Unit Hour Production (UHP):

5.1.4. **Response time reliability** – Match the expectations held by both staff and patients that the operational fleet will support response time delivery, reliably and consistently when deployed.

5.1.5. **Clinical Effectiveness** – the vehicle fleet provides a safe, reliable platform in which clinicians are able to deliver quality care and improved outcomes.

5.1.6. **Customer Satisfaction** – a fleet which provides a professional, clinically appropriate, clean and medically equipped environment, comfortable and adaptable to the needs of the patient.

5.1.7. **Economically Efficient** – supports the ethos enshrined in the Carter review, sustainable development, reduces costs and impact on the environment whilst meeting the needs of the commissioner and the taxpayer alike.

5.2. Ambulance Response Programme (ARP) and Urgent care provision

5.2.1. The clinical concept of operation for the UK Ambulance Service's is evolving at an increasing pace with a greater emphasis upon clinical triage, treatment and referral opposed to a response / transport function.

Identifier	Clock Start	Target (Clock Stop)	Definition
Red	Call Connect	8 minutes (arrival of resource)	Time critical life threatening event needing immediate intervention and/or resuscitation
Amber R (Resource) Amber T (Transport) Amber F (Face-to-Face)	Allocation, AMPDS Code or 240 seconds	19 minutes (arrival of Double Crewed Ambulance (DCA) unless Rapid Response Vehicle (RRV) arrives and DCA is not required) 19 minutes (arrival of resource)	Potential serious conditions (ABCD problem) that may require rapid assessment, urgent on-scene intervention and/or urgent transport
Green F (Face-to-Face) Green T (Transport) Green H (Hear and Treat)	Allocation, AMPDS Code or 240 seconds	60 minute (arrival of resource) 60 minute or locally determined (arrival of resource) 60 minutes (Hear and Treat)	Urgent problem (not immediately life-threatening) that needs transport within a clinically appropriate timeframe or a further face-to-face or telephone assessment and management

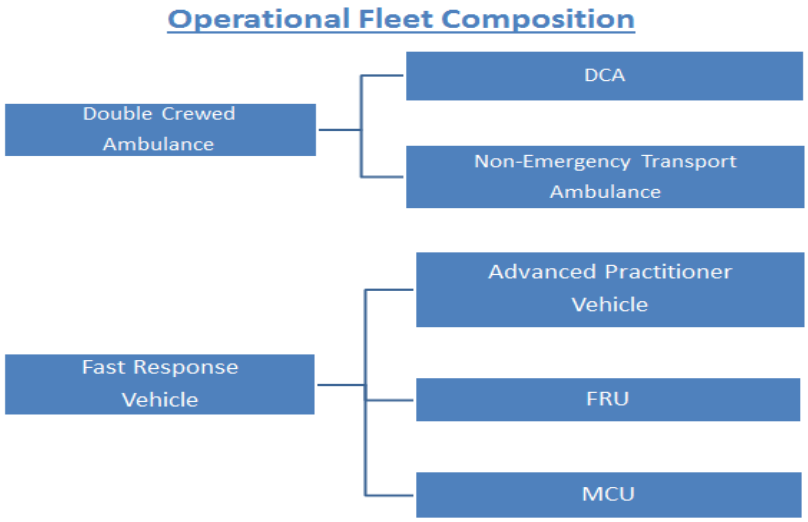
5.2.2. The ambulance service is well placed to support this intent and become the provider of choice for primary and urgent care service as well as our traditional emergency role.

5.2.3. Through the development of ARP, it will be possible to more appropriately match staff skills to vehicle provision to ensure a better utilisation of resources and therefore be more cost efficient.

5.2.4. This clinical segmentation is likely to challenge the vehicle design like never before, and may result in a greater diversity of ambulance design with significantly differing equipment requirements.

5.2.5. Getting the right formula between fleet composition, standardisation, design and interoperability is a complex task, but crucial in underpinning the business objectives of the Trust.

5.2.6. The following stratification of the operational fleet is envisaged:



5.3. Make Ready

5.3.1. A major contribution to operational performance and risk mitigation in the Trust, and a key issue to impact upon the fleet over the life of the strategy is the introduction of the 'Make Ready' function.

5.3.2. The system design of Make Ready ensures the mix of Fleet and Logistics support at 'sector' level managing vehicle and equipment reliability and therefore improving vehicle availability to a defined standard, frequency and cost.

5.3.3. This is achieved due to increased 'contact time' each vehicle technician is able to gain, on a daily basis with each of the vehicles in their system.

5.3.4. This increased reliability will in turn enable a potential reduction in the size of the overall fleet; reduce the amount of lost hours with out of service (OOS), assist performance, well as improve patient safety, and release economic benefits.

5.3.5. Make Ready enables the delivery of a high standard of patient care in an environment that is safe for both patients and staff; however it requires a vehicle that supports the concept, standardised in its design, equipment levels, layout and ease of preparation.

5.3.6. Whilst the Make Ready system supports the day to day production of Unit Hours (UH), it does little to support the in depth, technical 2nd and 3rd tier maintenance requirements that accompany a fleet function such as ours.

5.3.7. These maintenance work-streams need to be done 'off the production line' of Make Ready so as to not delay the process but configured to run parallel to it.

6 Stakeholders and Partnerships

6.1. The fleet management team seeks to develop an effective partnership and teamwork approach with all stakeholders to ensure that the fleet operation is integrated with, and fully supports the aims and objectives of the Trust.

6.2. The fleet management team will exploit collaborative opportunities both Nationally and Internationally to improve quality, standardisation and reduce costs through collaboration and economies of scale wherever possible.

6.3. When enhancing services or developing new vehicles, fleet services will react to the opinions and experiences of patients and service users alike, expressed through complaints, PALS and patient satisfaction surveys so as to eradicate where possible inherent concerns.

7 Trends in Health

7.1. The Health Survey for England is a series of annual surveys designed to measure health and health related behaviours in adults and children living in England. The most recent surveys point to areas that are likely to impact vehicle design, equipment provision and service delivery:

7.1.1. Obesity

7.1.2. Increasing obesity in the population places emphasis on the need to minimise the manual handling risks associated with the movement of obese patients. By 2020 obesity in the population is forecast to rise to 36% of the UK population which of course will include our staff as well as the patients we convey. Currently 54% of Londoners are considered overweight or Obese

7.1.3. Stroke

7.1.4. Generally the prevalence of stroke has risen in the last decade. However the respective prevalence rates among those aged 75 and over have risen markedly (stroke 8.6% to 13.1% in men and 7.5% to 10.7% in women)

7.1.5. Diabetes

7.1.6. Prevalence has more than tripled, from 1994 (2.9% to 9% among men and from 1.9% to 7.0% among women).

7.1.7. Ageing Population

7.1.8. By 2028 the number of 65-74 year olds will have increased by over 40% with a 50% increase in 75-84year olds. The over 85s will also double in number.

7.1.9. These factors potentially place specific emphasis on the need to provide for patient care in vehicle design, accounting for changes to clinical practise and medical equipment which also needs ‘support’ on the vehicle platform.

7.1.10. In addition we are likely to see a more generic need for Bariatric capability on most vehicle types serving the entire care spectrum rather than as a standalone specialist capability.

8 Legal Compliance

8.1. It is essential that the Trust conforms to a framework of industry standards and legislation as a professional operator of a major fleet.

8.2. The Corporate Manslaughter Act is the most significant in a series of legislation that Trusts have to comply with, including the addition of a fleet section to the Association of Chief Police Officers' Road Death Investigation Manual, and guidelines for the Management of Work Related Road Risk from the Health and Safety Executive.

8.3. The act is aimed at employers of Trust drivers involved in fatal accidents. It should be noted that Trust drivers include those staff provided with vehicles by the taxpayer under local lease car arrangements and also includes those staff who drive their own vehicle for work and are reimbursed for business mileage.

8.4. This key piece of legislation is an alternative to health and safety prosecution. It reinforces the obligation on the Trust to comply with health and safety legislation becoming the tool of choice when prosecuting organisations, potentially placing all accountable managers in the witness box alongside the Chief Executive and the driver of the vehicle at the time of the incident.

8.5. This legislation will be further supported by the Road Safety Act 2006 which comes into full effect for emergency services in the near future; this legislation will require the Trust to manage a register of blue light drivers for its emergency drivers and implement a scheme of Continued Professional Certification (CPC) for its other professional drivers (mechanics/ logistics) and take a much more robust approach to accident (RTC) investigation.

9 CEN and Whole Vehicle Type Approval Compliance

9.1. All NHS Ambulance vehicles in the UK are required to be CEN compliant; this has been a statutory requirement since 2000.

9.2. CEN is the name given to a collective of European directives which outline the baseline standards any converter or ambulance fleet operator is required to fulfil during the design and build of process for each vehicle type.

9.3. More recently this standard has been reinforced with Whole Vehicle Type Approval, this provides a much more robust matrix against which to manage CEN compliance and limits to what extent manufacturer systems can be altered to suit the Trusts requirements

9.4. The fleet management team are well versed in achieving compliance in this area, particularly when new medical equipment is introduced in to clinical compartment.

This skill and experience is difficult to replicate in the private sector as they have little exposure to the clinical requirements under law.

10 Service Design and Provision – Managing Capacity, Meeting Demand

10.1. Maintenance – in house Vs outsourcing

10.2. A perennial debate in ambulance Trusts is the discussion as to whether fleet maintenance should completed in house or outsourced – the 'make it or buy it' debate.

This discussion is normally instigated by perceptions that out-sourcing provides particular advantages but misses the point that the vehicle fleet, the principle tool of our clinical staff is part of the mission critical function of the Trust.

It is not by mistake that all UK ambulance trusts shows a more or less uniform approach to vehicle maintenance. Whether or not the vehicles are purchased or leased, all maintain their principle vehicles in their own workshops, with minor variations to suit local circumstances.

10.3. Some trusts who previously outsourced vehicle maintenance have taken vehicle maintenance back in-house, painfully reintroducing the function after having lost all internal expertise, and it is well recognised the PFI or externally contracted maintenance arrangements in other emergency service sectors has proven troublesome, expensive and unreliable.

10.3.1. The reasons for retaining in-house vehicle maintenance by ambulance trusts appear to be fairly consistent:

10.3.2. Trusts regard themselves as major transport operators. Vehicles and their maintenance are regarded as core business, given that the vehicle is a patient treatment environment and not solely used to carry staff or equipment to the scene of an incident.

10.3.3. Whilst all Trusts take advantage of the vehicle platform manufacturers' warranty for the vehicle platform, there are few, if any, comprehensive maintenance contracts with converters for the rest of the integrated systems that comprise an ambulance "unit". The stretchers, carry chair, ramps, seats, air suspensions, etc, all of which require planned preventative maintenance.

10.3.4. Each time a vehicle goes to an external contractor for maintenance or repair, aside from the transport costs, trusts have very little control as to when it will be repaired and returned as they are unlikely to be given any realistic priority over other customers. This results in significant vehicle down time although this can be offset by procuring more vehicles for a larger maintenance pool albeit at significantly greater cost.

10.3.5. When a vehicle is repaired by an external contractor trusts have less control over the quality of the work performed.

10.3.6. Non-ambulance service mechanics are not trained to repair or maintain ambulance equipment, or the extra electrical systems needed to fulfil our role. Therefore when a vehicle goes for repair or maintenance to a contractor only the basic vehicle chassis is repaired and there is a need to have the equipment repaired separately, increasing variation, vehicle down time and cost.

10.3.7. All maintenance work carried out in-house remains under trust control, the pace can be varied to take account of variations in operational activity, out-of-hours arrangements are flexible, and issues of immediate concern are quickly dealt with.

10.3.8. Trusts have local maintenance and repair arrangements for major vehicle components and assemblies.

10.3.9. Trusts do, as and when required, outsource specialist body repairs.

10.4. The vehicle maintenance function forms an integral part of the Make Ready process for the front line operational fleet. Nevertheless, in a climate of larger ambulance services with their

collective purchasing leverage it is recognised that we must ensure that vehicle maintenance and support is cost-effective and fit for purpose, whilst ensuring that the fleet meets the day-to-day operational requirement.

10.5. The Trust will monitor National initiatives in this area by both ambulance trusts and other emergency service colleagues to ensure that we derive maximum economic benefit from the way in which our fleet maintenance and support function is undertaken.

11 Planned Preventative Maintenance – the High Performance Principles

11.1. Vehicle maintenance regimes are required to maintain a vehicle in an optimum state to operate safely, minimise fuel consumption and provide maximum reliability in service minimising in-service failure and reduce risk to patients and staff.

11.2. There is a common recognition amongst the emergency services fleet operators that the vehicle manufacturers' standard maintenance regimes are not fit for purpose for the arduous conditions and operational extremes undertaken by emergency service vehicles. In particular the wear rate of brake, clutch and suspension components is far higher than that encountered in normal road transport operations.

11.3. The fleet management team will review all maintenance regimes and define a suite of standardised inspection, service and planned preventative maintenance (PPM) packages designed to proactively manage vehicles in service to a defined quality standard established to meet the specific requirements of the Trust.

11.4. Fleet services currently delineate maintenance activities in to three tiers, planned service, unplanned maintenance and breakdown management; these are ostensibly completed in a reactive manner. This will need to change.

11.5. To manage fleet demand and support the efficient production of Unit Hours, these can best be re-categorised in the following way and their relation to Make Ready system is self-evident;

VEHICLE MAINTENANCE ACTIVITIES	
1st Line	Routine maintenance, servicing and minor defects - all relatively quick to repair, designed to be completed within Make Ready depot.
2nd Line -	Technical, in depth maintenance such as gearbox swap out, rewire or engine rebuilds, slower to repair and potentially a hindrance to the production system of Make Ready if left 'in chute'. This tier would also account for commissioning and decommissioning activities, technical upgrades and retro - fitting of equipment. This maintenance will be undertaken in 'central hubs' located East and West.
3rd Line -	External specialist maintenance or repair such as crash repairs - activity likely to result in delayed return to service

11.6. As high performance systems develop in fleet services these PPM programmes will be tweaked reflecting critical vehicle failure trend data, information received from incident reports (LA52s) and industry safety alerts.

11.7. In addition we shall;

11.7.1. Monitor servicing performance and ensure strict adherence to our maintenance programme to minimise the risk to patient safety through a Critical Vehicle Failure Rate (CVFR) initially set at 1 per 25,000 miles.

11.7.2. Develop and implement a program of quality checks of all vehicle maintenance including contractors on a regular basis to monitor performance and provide a feedback loop to improve vehicle design and enable innovation.

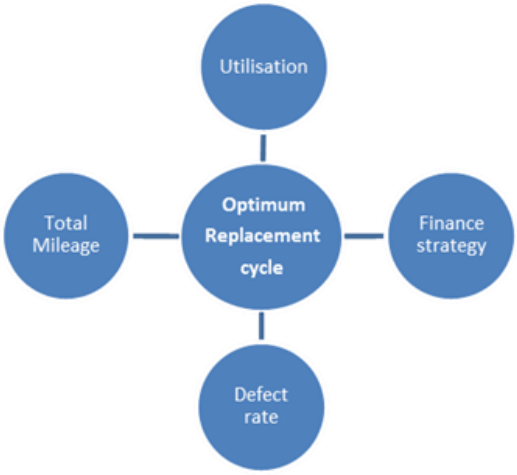
11.7.3. Implement sample inspections of in-service vehicles by 'independent' team leaders to establish an audit control mechanism for maintenance standards within the Trust.

11.7.4. Using historical data, review the Trust's current vehicle maintenance arrangements by role and function producing proposals as to which maintenance model would provide the most cost effective and efficient system for providing vehicle maintenance, namely, in-house, contracted in, external contractor, partnership with other emergency services or a combination.

11.8. Effective planned maintenance coupled with an economically effective operational life cycle and adherence to a replacement program ensures that the fleet size and composition can be robustly maintained to provide the principle requirement that there are sufficient ambulances (UHs) available to meet the peak load requirement.

11.9. Deviation from the plan creates consequences to the other vehicle elements, impacting on expenditure unnecessarily, particularly when on time expired, no longer fit for purpose vehicles, which become unreliable and therefore negatively impact on patient and crew safety.

11.10. Factors influencing the optimum replacement cycle are illustrated below.



12 Unit Hour Production (UHP)

12.1. The standard vehicle supply rate evidenced internationally for high performance ambulance systems, allows for 140% peak load staffing (which defines our peak vehicle requirement) to be met, fulfilling all Operational eventualities.

12.1.1. This rate enables 100% supply for all rostered requirements, including changes to Peak Vehicle Requirement (PVR), seasonal variation and overtime.

12.1.2. 20% (seasonal peak) vehicle abstraction for rates for maintenance, RTCs and 'critical vehicle failures' (on shift defects and break downs)

12.1.3. A 'surge capacity' to respond to major incidents or special events (such as Ride London, Notting Hill Carnival or London Marathon).

12.1.4. The Make Ready process and deep cleaning

12.1.5. PR and Media events

12.1.6. Training (as described in section 19 below).

12.2. Long Term Financial Modelling (LTFM) is designed to ensure that this standard is met across all sectors within the Trust, however the relationship between LTFM, the clinical strategy, the operating model and Capital planning is still to be defined and a transitional plan is required to merge these currently disparate plans into a single strand approach for vehicle replacement planning.

12.3. It is anticipated, given experience from 'satellite' Make Ready systems that further efficiencies will be achievable once a 'centralised' Make Ready is implemented providing economies of scale and increased vehicle availability and a reduction in critical vehicle failures which enable the reduction of this 'spare' capacity in line with increases in demand

12.4. It is anticipated that a target of 135% is achievable, particularly if the trust is able to 'multi role' vehicles - such as Non Emergency Transport ambulance (NETS) vehicles, PTS stretcher and A&E van conversion DCAs potentially. Driver Training and major incident vehicles are also some obvious opportunities.

12.5. Another opportunity is afforded by the use of Modularised, Interoperable, Interchangeable systems such as the FERNO Integrated Patient transport System that allows a standard vehicle platform to be configured to meet the task – matching the vehicle to the mission.

13 Commissioning and Decommissioning

13.1. Making vehicles fit for operational duty after delivery requires fleet to process a number of activities. As such 'commissioning' of vehicles is a growth area driving support staff development as a result of higher specification equipment going onto vehicles and ever more sophisticated on board electronic systems such as MDT, ePRF, Telematics, CCTV, Airwave and the like needing maintenance and support.

13.2. Robust systems for managing decommissioning provide the opportunity to reclaim, reuse and recycle components before disposal, currently the Trust does not maximise receipts from the

sale of vehicles at the end of their operational life. The fleet management team will seek to alter this approach positively contributing towards the Trust's cost improvement program.

14 Infrastructural Design

14.1. Currently fleet operate from a variety of twelve workshops and one administrative office across the capital, most workshops are based in out-grown, not fit for purpose, mal-located ambulance stations.

14.2. With exception of some newer workshops, little investment in the architecture of fleet services has been considered suffering from poor IT, storage and waste management facilities – all of which should be designed in relation to the demand led, requirement for each workshop.

14.3. Predominantly these facilities are small workshops attached to stations, which bear little relationship to the size of the vehicle fleet they support within the operational dispatch area, often limited in their capacity, forcing the outsourcing unnecessarily of routine maintenance to expensive external providers, incurring extended down time and cost. In addition these sites are poorly designed and not particularly fit for purpose.

14.4. The shift to Make Ready depots will see these facilities needing to change, supporting UHP in managed, cost effective manner which maximises vehicle availability.

14.5. 1st line maintenance is undertaken on the 'production line' in each Make Ready Depot.

14.6. 2nd line maintenance is to take place at 2 defined locations acting as operational support 'hubs' – to be strategically located to support the Trust - East and West notionally.

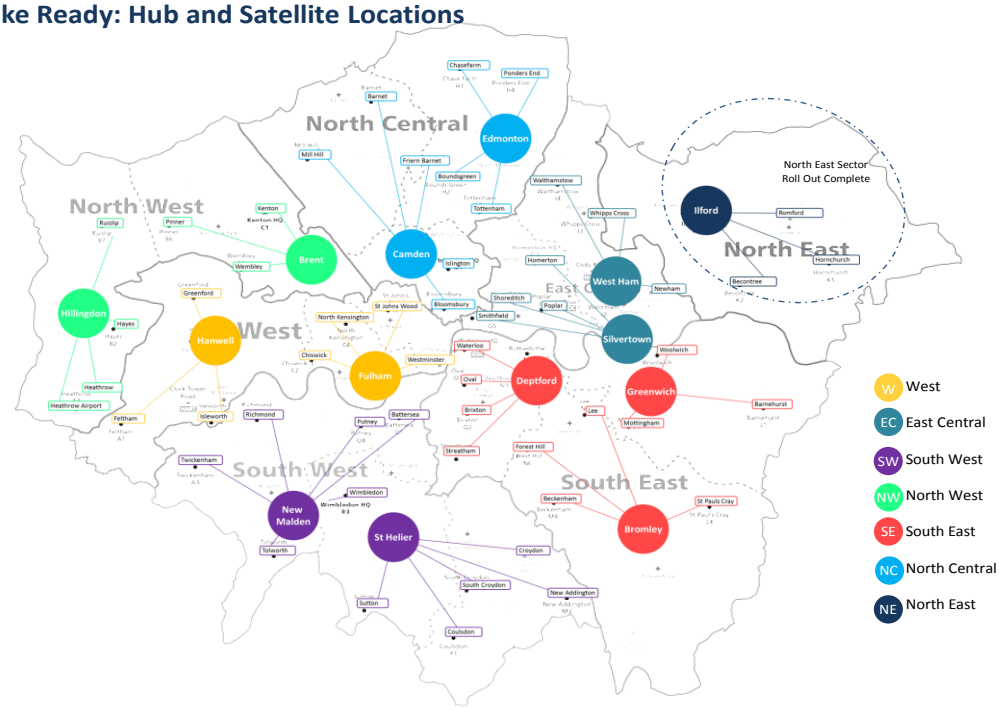
14.7. These 'hubs' will, in line with the Logistics strategy, provide the opportunity for fleet services, medical equipment support, major incident equipment support, uniform supplies, medical logistics, clinical consumables and the radio teams to be co-located.

14.8. This co-location reduces unnecessary vehicle movements reducing overheads and production costs, enhance logistics and provide fit for purpose facilities, legislatively compliant to Dept. of Transport and HSE standards.

14.9. These 'hubs' will enable the provision of integrated service support at strategic locations in the Trust and provide resilience and contingency arrangements by default.

14.10. The occupation of these facilities affords the ability to close the fleet workshops mal-aligned to performance. In addition the consolidation of legacy stores departments, and the reduction of external 'self storage' will also be possible onto sites making significant revenue savings in doing so.

Make Ready: Hub and Satellite Locations



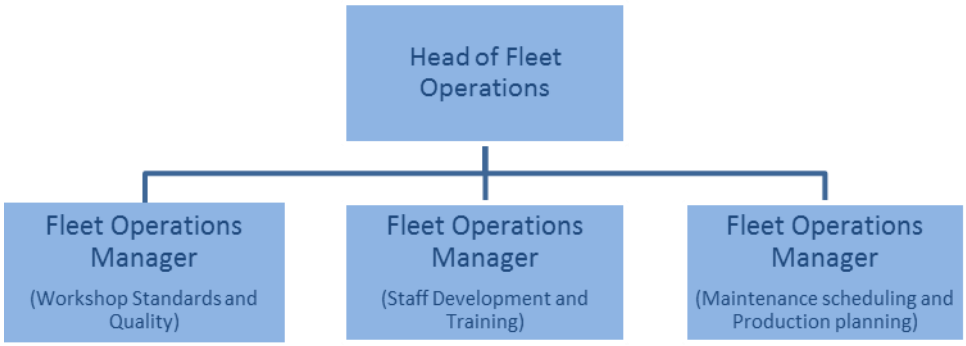
14.11. This move will see also see reduction in the use of the Production Cell – PD33 and Vehicle Resource Centre (VRC) to facilitate vehicle movements between sites for routine purposes and maintenance.

14.12. Currently the VRC undertakes in the hundreds of vehicle movements a month at an annual cost of £1.2m. This is essentially non-value adding mileage, creates unnecessary wear and tear on the vehicles, and by default incurs downtime at start of shift. Allocation of vehicle to sectors supplied against their activity profile negates the need for this service to operate in this manner.

14.13. Finally, centralisation of fleet related admin functions would see the consolidation of roles into a single space for ease of management; RTC management, fuel management, insurance claims, lease management, fleet procurement, parts inventory control, maintenance scheduling, warranty management, production planning and quality control all bought together.

Currently much of this devolved down to sector administration teams who are not accountable for either the budget are the service provision naturally this will also provide for some efficiencies.

14.14. Fleet Support Managers are also to have lead roles defined for them allowing them to concentrate on specific topics. Fleet team leaders will be developed to coordinate local activities and work in conjunction with Make Ready Managers and Logistics support. This is illustrated below;



15 Workforce Planning and Development

15.1. Fleet services staff have been recruited based on traditional models and expectations. Historically fleet recruitment tends to attract applicants who are mature, experienced mechanics, often from private sector, looking for job security and lucrative pensions at a certain point in their career. Few are 'home grown' and some quite staid in their behaviours. This tactic will need to change, so as to keep abreast of modern ways of working and embed continual improvement principles as the norm.

15.2. As Make Ready is implemented the development of fleet staff will be imperative, educated to support the delivery of the high performance systems as vehicles become more specialist, increasingly sophisticated and more technically advanced.

15.3. How to make that change is a key question. Changing the paradigm is the responsibility of the fleet management team, who, working in conjunction with HR & OD, will seek to develop with technical colleges and universities modern apprenticeship schemes or graduate internships, bringing with it an opportunity to recruit, innovate and train staff, as well as potentially provide a proving ground for Post Graduate Engineers.

15.4. It is anticipated that this nurturing of staff will allow for cross fertilisation between new and existing fleet staff, promoting joint working and a solid foundation for mentoring and growth. This should in turn lead to a more informed and involved team, more likely to be retained by the Trust, making LAS an employer of choice.

15.5. In addition, the team will be reorganised to integrate into the operation of the depot they serve, rotating between 1st tier and 2nd tier maintenance lines to avoid skill fade becoming more corporately aware and customer focussed.

16 Fleet Utilisation

16.1. As a major fleet operator we must ensure that vehicle utilisation is monitored. With the advent of in vehicle systems such as IDR this is much easier to achieve, however vehicle utilisation is actually determined by the 'functional user' (Field Ops, PTS etc) and not fleet management team.

16.1.1. The key to effective A&E fleet utilisation is the design of the rotas and the deployment practises of EOC as determined by the Operating Model and the Active Area Cover plan (AAC).

16.1.2. For PTS vehicles; utilisation is better defined as the economic load factor, the point at which an amount of passengers offset the journey overheads.

16.1.3. The support fleet, vehicles such as Major Incident and HART will be defined by the specialist nature of their role and the legislative requirement to operate such vehicles – not necessarily the mileage, hours of operation or number of shifts completed.

16.2. Vehicle allocation at Make Ready hubs will support more effective utilisation generally, support stock rotation and eventually a reduction in the vehicle fleet due to efficiencies.

16.3. In addition, the strategic 'pooling' of vehicles at hub locations linked to fleet workshops is an operational policy which reduces duplication of stock whilst improving control and facilitating breakdown management.

16.4. The role and function fleet management team is to regularly review vehicle mileages if vehicles have limited use over a three month period then the vehicle is disposed of reflecting its lack of use, unless the functional user is able to justify keeping such resources.

17 Standardisation

17.1. This strategy recognises that optimum fleet management is predicated on establishing a commonality of vehicle platform and design, even avoiding introduction of minor changes between batches of vehicles where possible.

17.2. The Trust cannot afford to change supplier or converter for the same reasons, as to do so, will not only lead to the introduction of variety, but as a consequence inevitably require additional training, tooling, diagnostic equipment and parts.

17.3. Over the next 2 years LAS has accelerated the vehicle replacement programme to standardise as far as possible the A&E fleet.

17.4. The Trust is working consistently with authorised converters who engineer out underlying quality issues, providing a consistency of approach that only long term partnership can yield.

17.5. Currently there are a variety of vehicle platforms, both cars and vans that form the A&E Fleet, A&E support and NETS.

17.6. PTS has a majority of vehicles on a single platform but support services still have a variety of vehicles chassis. Whilst this situation may be viewed as is less than ideal, realistically the replacement cycle of support service vehicles can be flexed to maximise use of these vehicle.

17.7. The Trust recognises that the current lease car policy does not support this agenda. The Head of Fleet in conjunction with the HR and Operations will seek to limit choice to a single supplier, defining a specific vehicle where possible which supports the carrying of a defined clinical load for response capable managers, enabling the transfer of vehicles from one user to another when necessary against a single set of terms and conditions compliant with Trust policy and Her Majesty's Revenue and Customs (HMRC) rules.

17.8. Benefits of fleet standardisation include;

17.8.1. Reduced training / abstraction time for staff who are expected to drive or maintain competence on several types of vehicles as required Road Safety Act 2006.

17.8.2. Increase operational redeployment options between stations, operational dispatch areas or individuals.

17.8.3. Improved interoperability, which supports hospital turnaround, enabling the swapping out of equipment and or the transfer of staff between vehicles mid -shift if required.

17.8.4. Reduce the risk of variation in clinical quality and service delivery.

17.8.5. Supports stock rotation of the fleet and balance mileages and servicing schedules.

17.8.6. Reduce maintenance costs, tooling, diagnostics and parts stock holdings.

17.8.7. Standardisation on fewer vehicle platforms across the fleet, with vehicles carrying the same equipment improves operational flexibility and also reduces both the logistical burden and the training requirement placed on the Trust.

17.8.8. Improved reliability and reduced costs in the procurement and life-cycle support of equipment can be achieved by reducing and standardising on fewer vehicle types with common equipment, which in turn will reduce the amount of stock that must be carried and the number of people who are needed to perform the supply, transport, and maintenance functions.

17.8.9. Standardisation also reduces the training burden both in complying with legislation and also new vehicle types, and must be high on the agenda.

17.8.10. The vehicle maintenance plan can be rationalised. Standardisation will permit rotation of the fleet to even out mileages and servicing schedules, and stabilise vehicle residual values. The principle will be that there will be no assets permanently dedicated to a station but strategically allocated to the Sector or dispatch desk.

17.9. Standardisation vs Specialism

17.9.1. Whist it is recognised that standardisation has an important part to play in reducing variation in service delivery, it can also potentially be perceived to stifle innovation, the balance between standardisation and specialism is challenging at times and often the two aims are likely to be directly opposed, this can only be resolved through mutual appreciation of both agendas, recognising common ground where required.

17.9.2. In practise this may result in a standard vehicle platform but specialist equipment or layout supporting the role and function of the clinician.

18 Managing Vehicle Abstractions and Out of service

18.1. Managing vehicle abstraction rates is crucial when managing the supply capacity of the system.

18.2. The vehicle fleet is used daily for a variety of reasons, and potentially can be taken out of operational service for a range of reasons such as planned preventative maintenance (PPM), on shift defects, PR and media events, training or special events such as the sporting events or Notting Hill carnival. Vehicles are also used by staff at their convenience for ad hoc journeys around the Trust – sometimes impacting on supply to Operational shift

18.3. Fleet services intend to understand more robustly the abstraction reasons thereby allowing a better understanding of the realistic amount of operational hours a vehicle is likely to produce throughout its operational life whilst also determining availability on day and establishing a priority for supply in conjunction with Operations.

18.4. The pre-eminent abstraction reasons are represented below;

19 Vehicle Design and Development

19.1. Output based specification

19.1.1. Vehicle users (Operations, EPRR, PTS etc) will be expected to confirm their key capability requirements for each vehicle type under their remit. This forms the output based specification providing the baseline from which Fleet management team work when designing new vehicles.

19.1.2. Each output based specification is transformed into a technical specification from which the Trust can competitively tender and converters and builders are able to provide a product which meets the user requirements.

19.2. Vehicle evaluation and approval

19.2.1. In conjunction with service users, fleet will develop technical user groups to assess new and alternative technologies, enabling evaluation and the results collated accordingly.

19.2.2. This allows users to test their relative strengths for the designated operational role. This will be matched with the financial case to provide objective data for the comparison of options available and ensures that the Trust achieve the best value and fit-for-purpose vehicles.

19.3. Vehicle & Equipment Specification

19.3.1. Selecting effective vehicles for the wide variety of operational roles is a complex process that takes into consideration a number of factors such as:-

- Existing fleet mix
- Technical expertise
- Specialist tooling
- Fuel type
- Performance
- Vehicle evaluation by Trust personnel
- Environmental considerations
- Health & Safety aspects of transportation
- Compliance with National standards and legislation
- Parts availability
- Manufacturer support
- After sales support network
- Additional training
- Load capacity
- Suitability for role
- Vehicle whole-life costs
- EMC testing

It is much more complex than what is cheapest or just what the staff want!

20 Allocation

20.1. Vehicle allocation is fundamentally led by matching vehicles to the rostered requirement, by matching peak load staffing needs within each dispatch area or Sector.

20.2. This approach should limit the amounts of unnecessary vehicle movement taking place, avoiding the addition of unnecessary cost, contractors, mileage and wear and tear to vehicles.

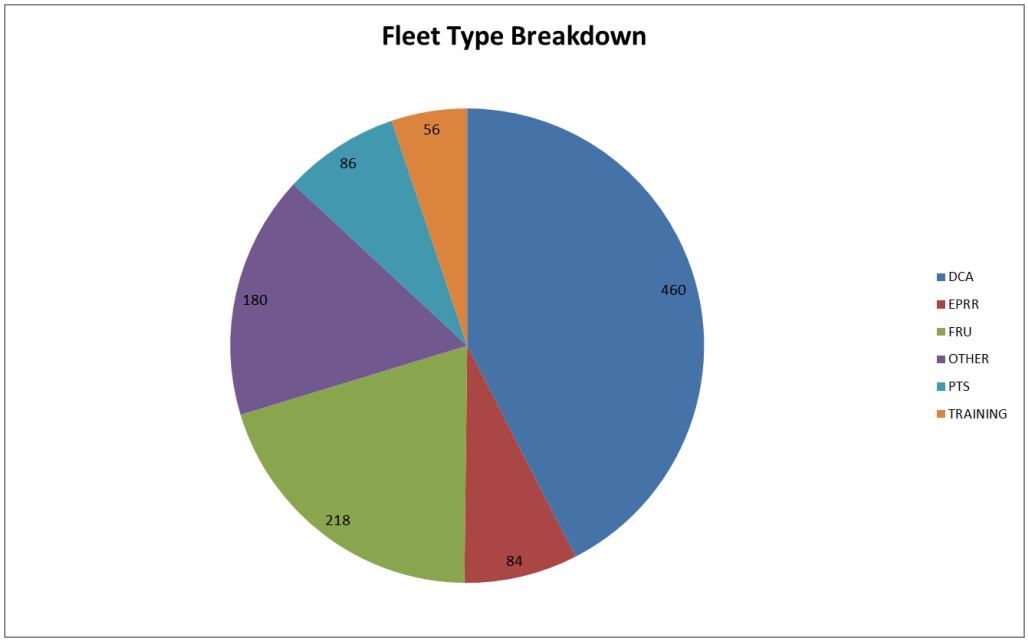
20.3. By establishing strategically placed 'pools' of vehicles within operational dispatch areas, we are able to create a functional reserve rather than supply spare vehicles at station level or artificially through the roster.

21 Fleet Composition

21.1. The fleet matrix below illustrates the composition of the current fleet within LAS.

21.2. The fleet is made up with a variety of vehicles, performing a broad span of functions aligned to directorate requirements and budgets.

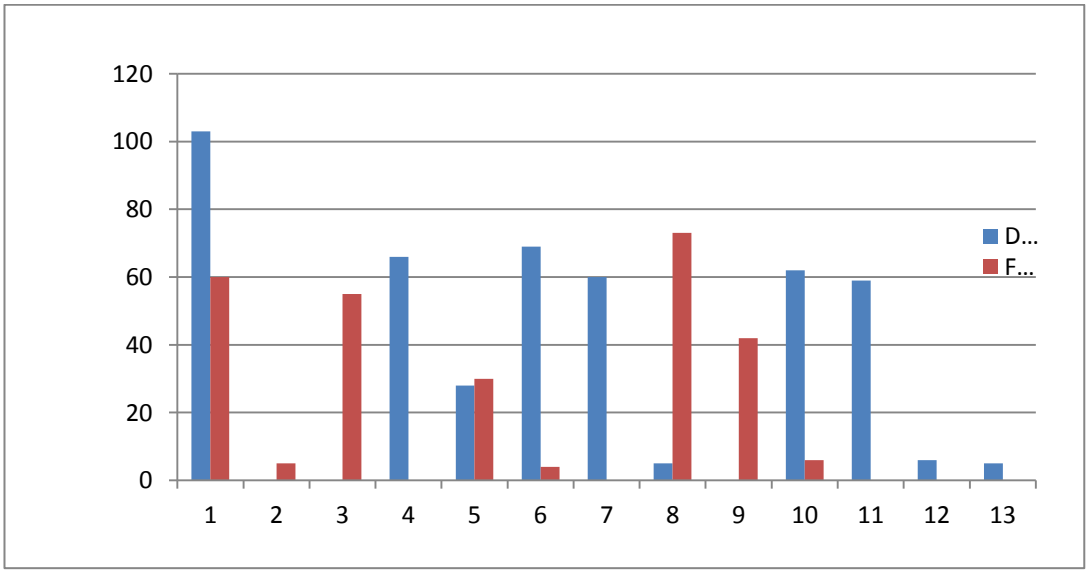
21.3. The fleet matrix is illustrated below, by volume and type. Full details are available on the Fleet service's MI system (Tranman).



21.4. Whilst there will be some 'corporate' understanding of the fleet numbers for A&E and PTS, EPRR and the like. There will be little organisational knowledge of the size and variety of the vehicles which make up the 'others' grouping. This section includes a variety of 'ad hoc' resources ranging from Major Incident support vehicles and IRO cars to trailers.

21.5. This group is often referred to as the 'domestic fleet' and again this element of the fleet will be reviewed annually for use and disposed of accordingly.

21.6. A profile of the frontline fleet by age is depicted below.



21.7. Following the accelerated approach LAS has taken to its DCA and FRU replacement programme over recent years the profile above will change significantly. The remainder of

the fleet will tend to be those in support functions being replaced on the basis of condition, functional criticality and / or economy of repair. It is proposed that these vehicles are replaced on Ad Hoc basis in line with a defined capital envelope.

22 Vehicle Retention and Replacement

22.1. A formal retention and replacement policy needs to be set fully accounting for a variety of factors, including affordability, available funding, age, mileage and condition. These criteria ensure that the optimum combination of age, mileage and use is reached, taking account of the cost of repair and maintenance to obtain best value and avoid negative impact upon patient care and revenue budgets.

22.2. Changes to specifications are built in to the replacement programme to ensure that the latest technical and safety features are included where necessary (such as ABS, electronic handling systems, start stop, parking sensors and Black box and CCTV).

22.3. Once decommissioned, owned vehicles are sold at auction or crushed. This safeguards the Trust from risk from consumer legislation by using an auction house and from possible use for terrorist purposes by removal of equipment and livery whilst in our care.

ASPIRATIONAL VEHICLE REPLACEMENT SCHEDULE			
Vehicle Type	Years	Mileage	Remarks
A&E DCA	5	250,000	From month of introduction into service
A&E FRU	5	200,000	From month of introduction into service
PTS Ambulance	7	250,000	Or aligned to lease or contract period
All Others	8 -10	250,000	Or more dependent upon annual inspection and condition

22.4. A&E Vehicle Replacement

22.4.1. The A&E fleet replacement cycle is critical in ensuring an effective fit for purpose vehicle fleet exists. The cycle will be designed to smooth out unnecessary peaks and troughs, whilst ensuring a standardisation of design and build across batches of vehicles, aiding staff familiarisation and operation. However this cycle needs to take account of the affordability of the replacement program within the financial framework of the Trust.

22.4.2. By reviewing demand for each vehicle type, based on both the operational UH forecast and the maintenance requirement, and by taking account of the duration, frequency and overlap of rota patterns for each station/depot; we are able to determine optimum size of fleet required.

22.4.3. Phasing of the procurement and build cycle will provide the opportunity to avoid commissioning and decommissioning vehicles during peak demand periods throughout the year.

22.4.4. By ordering vehicles in the last quarter of any financial year, for the delivery post April, we will ensure delivery and commissioning in time for the busy Q3 period. In contrast by delaying decommissioning during that time beyond Q4, fleet will have inbuilt the ability to ‘flex’ the size of the fleet during winter months to meet operational demand during that

time, This approach also ensures that we are able protect our core resource - mechanics time to focus on their prime remit – maintaining and repairing the fleet during the period of highest demand.

23 Lease Cars – The Grey Fleet

23.1. As previously suggested the replacement strategy for Lease cars within the Trust is predicated on a single supplier where possible on a standard platform supplied for the role as opposed to the individual.

23.2. This approach improves economies of scale at point of tender and enables interoperability and redeployment of the vehicle if staff leave or move to another role.

23.3. This strategy recognises the challenges set by the current economic climate and public perception when striving for value for money, quite often prices are driven by resale values as opposed to list cost, but this is often misunderstood and sometimes difficult to justify.

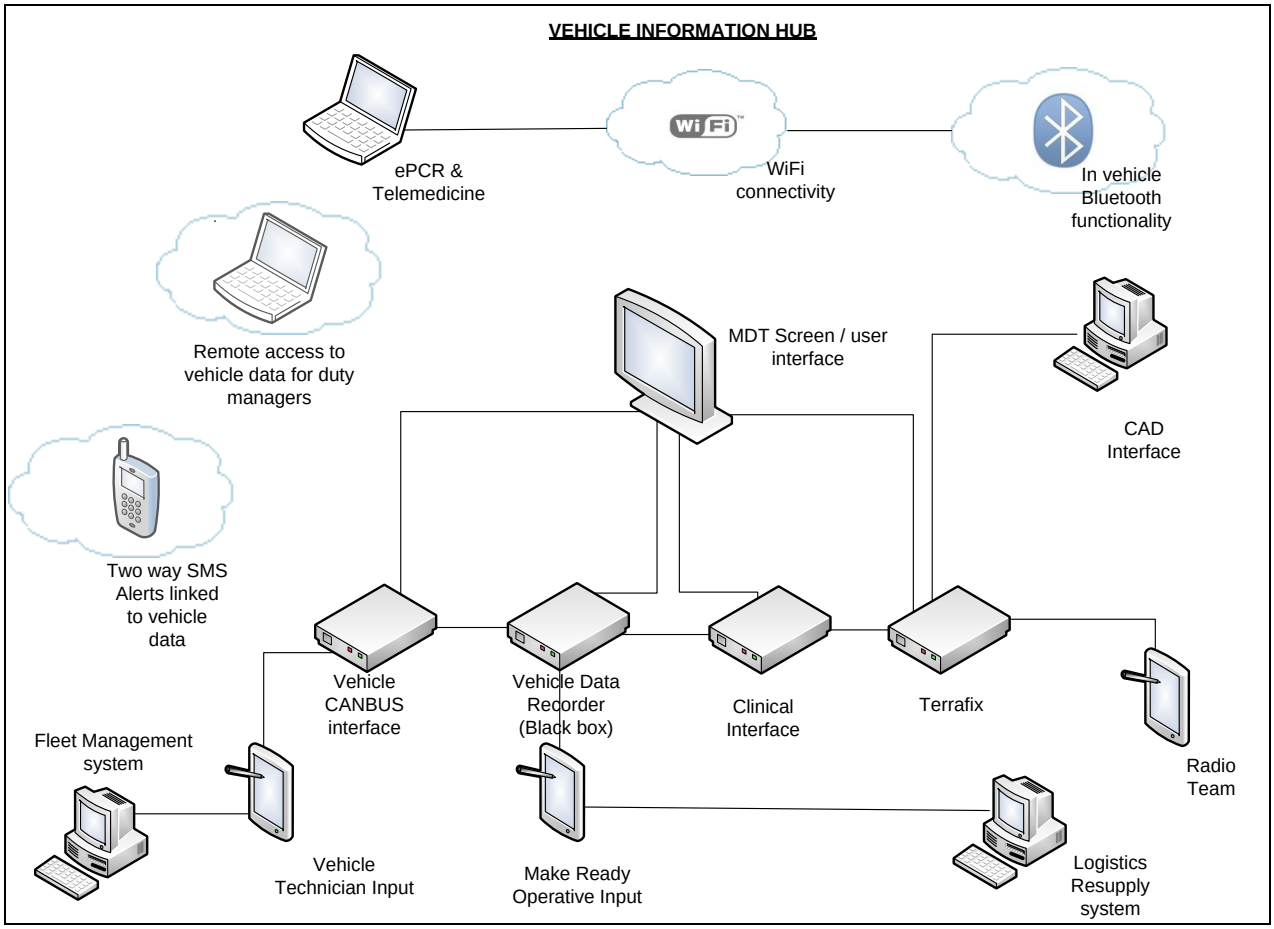
23.4. The Trust must consider the role and function of fleet services in supporting these vehicles, referred to as the grey fleet, the administration of the scheme is labour intensive and does not represent core business to fleet whose prime remit is maintenance of the operational vehicles. Lease car management is prime area for outsourcing and this should be investigated, along with salary sacrifice and cash in lieu alternatives.

24 Harnessing Technology

24.1. Vehicle based wireless technology is increasingly accessible and the organisations vision for an ‘eAmbulance’ can only be achieved in part by harnessing advanced vehicle technology not just for the mission critical transmission of CAD data, but for placing the vehicle at the heart of the process – making it an information portal for clinical information, vehicle and engine data, driver behaviour, vehicle inventory, environment and fuel information as well as the access point for staff to interact with learning and development, fleet management, scheduling and EDC.

24.2. In addition, we are likely to see technology support telehealth and telemedicine, with increased numbers of healthcare related devices connected to the internet from home and from home to the vehicle; from home to the healthcare practitioner; and from the healthcare practitioner to wider health.

Given the trends in health we envisage, the ability to “see” the patient will take a higher priority in community medicine. The impact on the fleet strategy will recognise that the front line operational vehicle will become a wireless hub and an important enabling tool in the Trust vision to become a mobile healthcare provider, an illustration of this is below.



25 Fleet Management Information System (FIS)

25.1. Currently the organisation uses a fleet management system, which in the context of a modern ambulance service striving to implement high performance production systems may not be fit for purpose.

25.2. The challenge seems to be from the developers of who have grown their product without consideration of emerging technology to support mobile working.

25.3. Whilst we are able to use 'Tranman' to record vehicle maintenance, linking it to Make Ready, Fleet and Logistics inspection records, inventory management systems, handheld technology, back office finance systems is likely to be to be challenging requiring significant investment both in terms of time, resource and funds.

25.4. It is therefore intention of the Fleet Management Team to scope the market for systems with better mobile accessibility and reporting packages designed on a platform which enables integration, tried and tested in prestige private sector fleet operators, with view to developing a business case justifying the potential replacement of the Fleet Management Information System.

26 Intelligent Data and better Patient experience

26.1. As part of future vehicle design, the Trust will fit a 'black box' style Driver Safety System to all vehicles owned or leased by the Trust.

26.2. This will ensure that the Trust is in a position to support staff and improve patient care through the capture and feedback to staff about their driving performance. The trust will also be able to protect staff by providing court admissible evidence of driving standards when a driver is involved in a road traffic collision (RTC) and potentially prosecuted under either the Corporate Manslaughter or Road Safety Act.

26.3. The fitting of a driver safety system fleet wide will also future proof the Trust in terms of making value adding operational decisions, road pricing schemes, calculating emissions output and vehicle insurance.

27 Fuel Management

27.1. This strategy recognises the Trusts responsibility to manage as robustly as possible fuel, its security and use.

27.2. Data from the road haulage industry suggests that savings in fuel use of up to 25% are achievable, 5% through payload reduction and vehicle redesign, and 20% through managing driver behaviour. Initiatives such as 'green driver training' and intelligent data recorders will empower positive management of this expensive commodity.

27.3. Refuelling OOS and Contingency Planning

27.4. Currently LAS lose the equivalent of 25 x 12hr DCA shifts a week, with staff refuelling vehicles – time spent away from responding to the needs of the patient.

27.5. Our contractor struggles to recruit staff with the right licensing categories resulting in duplicated contract spend and lost hours.

27.6. Fuel supplied through bunkered fuel depots is significantly cheaper than road side filling stations, saving on average 8p -10p per litre. LAS currently procure XXlts p.a at an annual cost of c. £6m p.a.

27.7. The benefits of reintroducing a trust wide network of bunkered fuel depots at Make Ready hubs is clear, not just to reduce expenditure, but to improve vehicle availability, enhance resilience and release further efficiencies from the Make Ready system.

27.8. The re-introduction of bunkered fuel tanks into the Trust will also support better management and control, enable remote stock management and daily issues, whilst providing the ability to remove agency cards from the operational arena.

27.9. Bunkered fuel on owned sites also enables the trust to support the wider health economy in times of shortage, providing fuel potentially for GP's, District Nurses and the like.

27.10. Specific controls for fuel management, including all aspects of the supply chain (from ordering through to issue), will be managed through the Trust Fuel Management policy in which responsibilities for staff, managers, Fleet and Procurement are clearly defined.

28 Financial Management

28.1. Procurement

28.2. The judgement around Capital purchase versus lease of vehicles is a complex and a recurrent debate. Since the change to IFRS accounting rules the benefits of leasing vehicles for operational roles is limited.

28.3. Leasing has traditionally been popular in the procurement of fleets to meet fixed term contracts – PTS vehicles are a typical example.

28.4. The vehicle replacement programme will be compliant to Trust standing orders (SOs) and standing financial instructions (SFIs) making best use of taxpayers' money, in a socially responsible manner.

28.5. In ensuring that the tendering process achieves best value the Trust will also comply with its regulatory requirements by considering the suppliers who come within the CCS framework agreement for vehicles:

29 Affordability

29.1. The aims of the strategy and the proposals made are those which would allow the Trust to operate a technically advanced and modern fleet of vehicles, designed and maintained for an ever changing pattern of service delivery and the high clinical standards required of it, in an environmentally friendly manner.

29.2. The objective of maintaining the fleet and its associated equipment to high operational standards of quality and on-going operational reliability, by replacing vehicles on the regular basis proposed, every 5 years for the front line A&E Services fleet and every 7 years for other vehicles according to functional criticality, is also highly desirable.

29.3. The basic proposal and underlying reasoning are sound but the organisation does not have the flexibility to implement independently.

29.4. It is recommended that in the coming months the objectives of achieving optimum vehicle replacement as outlined above should be given further consideration, determining and evidencing the extent to which these are optimum replacement cycles are either achievable or acceptable. However, it is essential that the Trust has an annual replacement programme that achieves the best possible outcomes practicable in an affordable manner, merging capital planning, the implementation of the operating model, make ready, the clinical strategy and the planning assumptions of the long term financial plan. Until that is achieved, robust costing models for vehicle selection and whole life cost analyses are not easily completed.

29.5. Accordingly, the projections that have been made are based on the following assumptions. The Trust will:

29.5.1. Consider alternative standards of vehicle replacement, i.e. van conversion ambulance on a single common platform in the replacement of the current ambulance DCA and NETS fleets.

29.5.2. Making that decision based on 'whole life' costing rather than just purchase price alone taking into consideration fuel consumption and the maintenance burden as well as the end of life costs and resale options.

29.5.3. Consider whether to refurbish, rather than replace with new, key clinical equipment on vehicle replacement.

29.5.4. Set aside a defined amount of the available capital annually for the purpose of replacing the Trust's support and major incident vehicles on an average 7 year cycle and as determined by supporting business case, surveyed condition and fitness for role as informed by the 'functional user' and the Fleet Management team.

29.6. The adoption of such measures provides the best potential (smoothed) replacement profile and should allow for the fleet to be replaced on the basis of the operating model projections completed to date, subject to the operational assumptions made holding good.

29.7. The range of measures open to the Trust to achieve the desired replacement cycle for key operational vehicles and to which it is recommended are pursued as the replacement policy is continuously reviewed, include the following:

29.8. The existing fleet should continue to be rationalised wherever possible and all excess vehicles removed. It should be noted that this will not necessarily remove costs as remaining assets are sweated and maintenance more frequently.

29.9. Standardised vehicle replacement and all related equipment, for all classes of vehicles, should be reviewed to determine whether or not it is possible to reduce costs of acquisition. In particular, the Trust will have to make a choice about whether to continue to operate an ambulance (Modular) DCA based fleet as opposed to a van based platforms, given a requirement to introduce larger numbers of more sophisticated and probably more expensive clinical services in the "see and treat" clinical model.

29.10. Detailed work is to be undertaken to determine that the most appropriate mix of vehicles is achieved, with the particular objective of reducing high cost vehicles by substituting those with a best value option.

29.11. In that regard, in particular the fleet management team will work closely to ensure that operational practices, rota management, vehicle deployment and the type of vehicle deployed, minimises the vehicle requirement where possible, and continue to substitute vehicles as the Trust moves to a full Make Ready operating status.

29.12. Fleet maintenance operations and processes will be reviewed in detail as the Trust introduces Make Ready, with a view to these being modernised, standardised and lean, providing the foundation for process based management systems within the function.

29.13. The impacts of the outcomes of such work should be fully integrated into the Trust's routine financial planning at its projected cost levels, and reported on regularly to the Board.

The Board should revisit the financial aspects of this strategy regularly. It should use the current forecasts, as derived from integrated operational and financial modelling, as the evidence on which future decisions on Fleet capital and revenue investment are made.

29.14. The Board shall give careful consideration of the use of any future capital and revenue savings generated by rationalisation of the Trust's infrastructure to support the optimum fleet replacement cycles.

29.15. The size of, and related operating costs of the PTS fleet, operational as well as fleet costs, should be reviewed relative to the contract income generated, with a view to determining whether or not there is any scope for freeing up any costs that may be being cross subsidised and that might more beneficially support the emergency services fleet.

29.16. Most of these may seem to be self-evident, and activities that might well be expected to be carried out as part of the Trust's routine day to day practice, and some of these may have been put in place as the Trust reorganisation continues.

29.17. It is acknowledged that too little is known at this stage about the implications in details that special measures status will have upon the Trust, its relationships with purchasers, and the operational and economic conditions that will prevail.

30 Responding to Climate Change

30.1. Climate change is the most serious global environmental threat, promoting new, modern, sustainable ways of living, working, producing and travelling.

30.2. The formation of large ambulance trusts and LAS' vision to play a major role in the development urgent care agenda requires the Fleet management team to operate at a strategic level not previously required. The need to horizon scan developments in the road transport world and assess their application and impact upon the Trust is ever more important.

30.3. A review of fleet developments and modern day best practise will form the preface to the annual review of the fleet procurement plan presented to the Board set to coincide with the capital budget setting process.

30.4. The review will update Board members on road transport developments likely to take place over the life of the plan. Over the next 5 year period these are likely to include:

30.5. **Carbon trading - forcing the polluter to pay.**

30.6. Payload management - The reduction of weight through lighter construction, and reduced rolling resistance to reduce carbon emissions.

30.7. Changing driving behaviour – reduced use of fuel through driver monitoring (IDR)

30.8. Use of technology to reduce Carbon footprint – the introduction of new fuel and vehicle technology into the fleet and station infrastructure.

30.9. Fleet Services also seeks to reduce the adverse environmental impact of our activities, We aim to encourage the efficient use of resources through the minimising of waste and through the re-use and recycling of resources wherever possible.

30.10. The Fleet Management team works with vehicle manufacturers to keep abreast of advances in technology and alternative fuels such as LPG, Bio-Diesel, Bio-ethanol, Electricity and Hydrogen and how they are presented through bi-fuel, hybrid or fuel cell technology in the operational arena.

30.11. The evaluation of new developments in vehicles will be assessed in terms of operational fitness for purpose, ease of maintenance, ease of access and environmental impact, as well as cost.

30.12. Through this approach we stand to achieve wider benefits to human health and well-being ("Securing the Future - delivering UK sustainable development strategy"). This is in accordance with the Department' of Health's commitment to sustainable development and in line with the principles of the White Paper "Our health, our care, our say" and the Trust's own Sustainable Development Plans.

30.13. We need to acknowledge this in the design and conversion of the fleet through;

30.13.1. Exploitation of environmentally friendly production methods.

30.13.2. Improved systems which manage 'whole life' emissions and reduce waste

30.13.3. Increased recyclability of 'end of life' assets.

31 Risk Management

31.1. The main risks associated with this vehicle replacement strategy are outlined below.

31.1.1. Affordability of a 5 year replacement option.

31.1.2. The lack of an updated Operating model accounting for ARP and Make Ready

31.1.3. The need for an updated clinical strategy that reflects the trust's desire to roll out Advanced Paramedics and support the Primary and Urgent Care agenda.

31.1.4. Rota patterns which reflect actual demand will impact on the fleet size if changed.

31.1.5. In line with the UH Production, increased efficiency and reducing the fleet in number.

31.1.6. The funding and procurement of 'whole unit' - Optimising the replacement strategy for mission critical front line vehicles and their associated equipment.

31.1.7. Increased cost of more clinically sophisticated clinical strategy will impact on 'whole unit costs', but a more clinically sophisticated approach to patient care and demand management will reap whole system benefits.

31.1.8. The current effectiveness of the 12 reactive maintenance programme

31.1.9. Lack of appropriate stakeholder support – NHSI, HOSC, CQC etc.

32 Funding the Whole Unit

32.1. Currently Vehicle and Equipment Replacement programmes are not linked, increasing the risk to service delivery and impacting care to the patient. Much if the kit is cannibalised from one vehicle another and this often means that obsolete and out date equipment continues to be used. The risk is mitigated by:

32.2. Procuring the vehicle as a 'whole unit' including all vehicle, communications and medical equipment in the replacement programme.

32.3. Inform stakeholders to ensure that there is understanding for the need of complementary procurement programmes.

32.4. Reduce equipment replacement programme costs through increased standardisation.

33 Vehicle Disposal Does Not Realise Planned Income

33.1.1. Inability to dispose of Trust owned vehicles at market value, particularly when written off. The risk is mitigated by:

33.1.2. Well researched end-of-life product disposal.

34 Staff Acceptance of Overall Fleet Strategy

34.1. The risk is mitigated by:

34.1.1. A clear and continuous communication and engagement plan that explains the rationale for the strategy.

34.1.2. On-going inclusion and communications with staff.

34.1.3. Readily identifiable operational and clinical benefits.

35 Equality and Access for All

35.1. The Trust will continue to ensure that all patient carrying vehicles and equipment comply with relevant legislation. All new vehicles specifications will have the potential to impact both staff and services with regards to equality and we will continue to ensure that the development of the fleet reflects, where appropriate, the requirements of the relevant legislation and guidance, including accessibility standards.

35.2. All new vehicle designs will include an Equality Impact Assessment appropriate to the use of the vehicle in order to avoid creating potential barriers. It is easier and more cost effective to address such matters in new vehicle designs than it is to redress poor vehicle design after the event.

35.3. The NPSA ambulance design, upon which the A&E ambulance is based, takes into account a number of accessibility criteria in its design and we will continue to mirror the NPSA work stream.

35.4. New vehicle designs will be reviewed to ensure continued conformity to changing legislation.

36 Insurance

36.1. Motor vehicle Insurance

36.1.1. The Trust is currently insured as a member of the Association of Ambulance services in which 10 of the national ambulance services tender for insurance services as a collective.

36.1.2. The Trust pay into a ‘fund’ which essentially indemnifies it in claims over £25k as part of a risk pooling scheme.

36.1.3. The ‘association’ has tendered for insurance cover for the next year, driving down costs in relation to the trust claims experience accordingly.

36.1.4. Insurance brokerage is provided by a third party, who assists the Trust in administration of the policy and reclamation of uninsured losses.

37 Conclusions

37.1. The development of the Trust’s fleet strategy must meet the requirements of the Trust vision, clinical strategy and operating model.

37.2. It must support the implementation of Make Ready and the journey to high performance UH production model and reflect the ever changing pattern of demand.

37.3. The replacement programme, an annual rolling resource programme, adopts the lean principles in establishing the size of the fleet and recognises that:

37.4. A procurement and replacement cycle that meets the high performance needs of the Trust cannot be achieved overnight. Working with Finance team we will seek, to achieve a replacement programme for the front line fleet that both meets the operational requirement and that is affordable. In this context it has to be accepted that, without diverting funds from other areas of the Trust, continuing with the procurement of a high cost coach build (box body) DCAs ambulance vehicle represents a significant financial risk in the face of ever increasing demand.

37.5. Whilst the case for meeting the operational requirement to move to a 5 year replacement strategy is accepted, this cannot be delivered within the available resource allocation currently. We will work to meet the aspirations of Operations within the funds available.

37.6. Operational and economic efficiency will be aided by standardising on fewer vehicle platforms and equipment thus releasing valuable resources to front line care. The current DCA box body and NETS ambulance vehicles will converge onto a single common vehicle.

37.7. There is a need, in an organisation that is likely to be always heavily dependent upon transport, to ensure that the fleet strategy adequately reflects both internal and external influences.

37.8. The design of all vehicles must meet the increasingly stringent requirement for effective hygiene and infection control in order to minimise the risk to patients and staff.

37.9. Trends in health and the need to treat patients with complex health needs must be reflected in vehicle specifications.

37.10. The Trust will play a full part in National vehicle design and development initiatives recognising that there are considerable advantages to be gained by operating collectively.

37.11. The strategy must be responsive to changing legislation and operational circumstances.

37.12. LAS must be fully involved in the “Green” debate and understand what influences this will have in vehicle design, development and procurement. The Trust will monitor developments in alternate fuels technologies and take advantage of those technologies where the operational risk has been minimised. Consideration will be given for the use of alternative fuels for support vehicles and adopt the Mayor or London and DTI targets as our own.

37.13. The guiding principles of the Trust vehicle replacement strategy are summarised at Annex xx.

Annex A – Legacy Vehicle Replacement Profile

Vehicle Replacement Required by Year

By Number:

				2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
	Vehicle Categorisation	**Total**	**Overdue**	**2016-17**	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**2021-22**	**2022-23**	**2023-24**
Hired	Support Truck	**1**	0	0	0	0	0	0	0	0	1
Hired	Support Van	**5**	4	0	0	0	0	0	0	0	1
Leased	DCA	**22**	0	0	0	0	22	0	0	0	0
Leased	FRU	**90**	0	0	30	60	0	0	0	0	0
Leased	MOBILE WORKSHOP	**1**	1	0	0	0	0	0	0	0	0
Leased	NON EMERGENCY TRANSPORT	**57**	0	0	0	0	0	0	31	26	0
Leased	POOL CAR	**1**	0	0	1	0	0	0	0	0	0
Leased	Support Car	**4**	2	0	1	0	1	0	0	0	0
Leased	Support Van	**2**	0	0	0	0	0	0	0	2	0
Loaned	Mass Casualty Vehicle	**3**	3	0	0	0	0	0	0	0	0
Owned	4WD	**14**	3	0	7	4	0	0	0	0	0
Owned	Combi Van	**10**	0	0	0	7	0	3	0	0	0
Owned	Command Vehicle	**2**	2	0	0	0	0	0	0	0	0
Owned	DCA	**469**	186	0	38	114	25	56	50	0	0
Owned	FRU	**161**	96	0	4	2	59	0	0	0	0
Owned	Mini 4WD	**1**	0	0	1	0	0	0	0	0	0
Owned	MRU	**24**	18	0	6	0	0	0	0	0	0
Owned	MUSEUM VEHICLE	**0**	0	0	0	0	0	0	0	0	0
Owned	NON EMERGENCY TRANSPORT	**1**	1	0	0	0	0	0	0	0	0
Owned	PTS Car	**12**	12	0	0	0	0	0	0	0	0
Owned	PTS Van	**41**	41	0	0	0	0	0	0	0	0
Owned	Specialist Truck	**4**	4	0	0	0	0	0	0	0	0
Owned	STAFF CAR	**1**	1	0	0	0	0	0	0	0	0
Owned	Support Car	**51**	38	0	0	0	13	0	0	0	0
Owned	Support Truck	**6**	6	0	0	0	0	0	0	0	0
Owned	Support Van	**47**	23	0	2	16	2	4	0	0	0
	Total	**1030**	**441**	**0**	**90**	**203**	**122**	**63**	**81**	**28**	**2**

Capital Cost of Owned Vehicles to be Replaced (£k):

			Overdue	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
	Vehicle Categorisation	**Total**	**Overdue**	**Sep-16**	**Mar-18**	**Apr-18**	**Mar-20**	**Apr-20**	**Mar-22**	**Apr-22**	**Mar-24**
Hired	Support Truck	**£ -**	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Hired	Support Van	**£ -**	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Leased	DCA	**£ -**	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Leased	FRU	**£ -**	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Leased	MOBILE WORKSHOP	**£ -**	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Leased	NON EMERGENCY TRANSPORT	**£ -**	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Leased	POOL CAR	**£ -**	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Leased	Support Car	**£ -**	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Leased	Support Van	**£ -**	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Loaned	Mass Casualty Vehicle	**£ -**	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Owned	4WD	**£ 420,758**	£ 73,794	£ -	£ 226,772	£ 120,192	£ -	£ -	£ -	£ -	£ -
Owned	Combi Van	**£ 176,793**	£ -	£ -	£ -	£ 125,200	£ -	£ 51,593	£ -	£ -	£ -
Owned	Command Vehicle	**£ 1,636,929**	£ 1,636,929	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Owned	DCA	**£ 30,683,951**	£ 6,372,615	£ -	£ 1,062,976	£ 7,660,184	£ 3,032,379	£ 6,635,997	£ 5,919,800	£ -	£ -
Owned	FRU	**£ 4,378,487**	£ 2,800,437	£ -	£ 108,296	£ 40,455	£ 1,429,299	£ -	£ -	£ -	£ -
Owned	Mini 4WD	**£ 23,000**	£ -	£ -	£ 23,000	£ -	£ -	£ -	£ -	£ -	£ -
Owned	MRU	**£ 418,951**	£ 304,945	£ -	£ 114,006	£ -	£ -	£ -	£ -	£ -	£ -
Owned	MUSEUM VEHICLE	**£ -**	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Owned	NON EMERGENCY TRANSPORT	**£ 34,440**	£ 34,440	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Owned	PTS Car	**£ 179,016**	£ 179,016	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Owned	PTS Van	**£ 1,815,360**	£ 1,815,360	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Owned	Specialist Truck	**£ 1,557,471**	£ 1,557,471	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Owned	STAFF CAR	**£ 29,193**	£ 29,193	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Owned	Support Car	**£ 589,351**	£ 383,049	£ -	£ -	£ -	£ 206,302	£ -	£ -	£ -	£ -
Owned	Support Truck	**£ 290,741**	£ 290,741	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Owned	Support Van	**£ 1,818,748**	£ 854,727	£ -	£ 79,968	£ 714,661	£ 39,872	£ 129,521	£ -	£ -	£ -
	Total	**£ 44,053,191**	**£ 16,332,718**	**£ -**	**£ 1,615,017**	**£ 8,660,694**	**£ 4,707,851**	**£ 6,817,110**	**£ 5,919,800**	**£ -**	**£ -**

Annex B – Current operating Life of Trust vehicles

Vehicle Categorisation	Operating Life
NON EMERGENCY TRANSPORT	6
FRU	5
Support Van	7
Support Car	5
DCA	7
PTS Van	7
MRU	5
Combi Van	7
POOL CAR	5
4WD	5
Support Truck	7
PTS Car	5
Command Vehicle	7
Specialist Truck	7
Mini 4WD	5
Mass Casualty Vehicle	7
STAFF CAR	5
MOBILE WORKSHOP	7

Annex C – Whole Unit Cost – DCA (15/16 prices)

DCA VEHICLE - 2016 UNIT COSTS					COST £
CHASSIS COST					
Mercedes Benz 519 CDI					30,713.00
VAT @ 20%					6,142.60
Sub Total					36,855.60
CONVERSION COST					
Telma					N/A
Approximate cost					58,000.00
VAT @ 20%					11,600.00
Sub Total					69,600.00
COMMUNICATIONS EQUIPMENT					
Approximate cost					1,479.42
VAT @ 20%					295.88
Sub Total					1,775.30
EQUIPMENT COST					
Qty	Item	Supplier		Price Per Item	
1	LP 15 Defibrillators	Physio Control	£	10,275.00	
1	LP 1000 Defibrillator	Physio Control	£	1,625.00	
1	Laerdal Suction with Serrres System	Laerdal	£	580.00	
1	Entonox Regulator and Hose	Oxylitre Medical	£	159.10	
1	Entonox Bag	Openhouse Products	£	75.60	
2	Triage Pack	TSG Associates	£	173.34	
1	Vacuum Splint Set Complete Set	Medtree	£	94.95	
1	Loxley Splint - Large	Medtree	£	19.50	
1	Loxley Splint - Medium	Medtree	£	17.89	
1	Loxley Splint - Small	Medtree	£	15.99	
2	Kendrick Traction Splint	Prometheus	£	136.00	
1	Frac Strap Pack	Medtree	£	38.99	
1	KED	Medtree	£	49.99	
1	Spinal Board	Medtree	£	72.00	
1	Straps for Spinal Board	Prometheus	£	70.00	
2	Bag for Straps	Medtree	£	17.98	
1	Head Immobiliser	Medtree	£	40.25	
1	Orthopaedic Scoop Stretcher	Femo	£	458.16	
	Straps for ScoopStretcher	Prometheus	£	51.75	
1	Carry Chair	Femo	£	1,260.00	
1	Mangar Elk	Mangar International	£	1,028.00	
1	Patient Handling Kit	Prism Medical	£	249.00	
1	Patient Handling Kit Bag	Openhouse Products	£	49.89	
1	Primary Response Bag	Openhouse Products	£	170.00	
1	Oxygen Barrel Bag	Openhouse Products	£	98.99	
1	Dressings Bag	Openhouse Products	£	68.69	
1	Infectious Bag	Openhouse Products	£	76.05	
1	Maternity Bag	Openhouse Products	£	80.43	
1	Burns Bag	Openhouse Products	£	68.69	
1	Trauma Kit Bag	Openhouse Products	£	80.43	
1	Collar Bag	Openhouse Products	£	29.98	
1	Red Vehicle Bag	Openhouse Products	£	48.87	
2	Debris Gloves	Key Industrial	£	2.70	
1	Seat Belt Cutter	Woodway Engineering	£	1.79	
1	PALS Kit Bag	Openhouse Products	£	76.98	
1	EZIO Kit complete	Teleflex Medical	£	292.50	
1	Nonin 8500 Pulse Oximeter	Proact Medical	£	311.08	
1	Map Books	Geographers	£	15.00	
1	Manual B/P Cuff	Proact Medical	£	8.36	
1	Pedimate	Femo	£	194.41	
1	Stryker Power Pro TL Trolley/Stretcher	Stryker (cost incl. in conversion	£	7,428.48	
	Net Total			25,611.81	
	Vat @ 20%			5,122.36	
	Gross Total			30,734.17	30,734.17
TOTAL GROSS COST PER UNIT					138,965.08

*Having to recycle obsolete equipment (value £5,400), @ £1,000 now included in conversion cost

**Price includes vehicle charger and bracket

***Backing plate include in conversion cost

Annex D – DCA suggested 7yr Smoothed Replacement programme

DCA VEHICLE REPLACEMENT PROGRAMME

Indicative Whole Unit Cost (K) **140** 2015/16 PRICES

Table 1	OVERDUE	A&E AMBULANCE REPLACEMENT YEAR - LEGACY TRUST PROGRAMME							TRUST TOTALS	AVERAGE ANNUAL REPLACEMENT
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24		
DCA	**46**	140	38	114	25	56	50	0	469	67.00
DCA LEASED				22					22	3.14
TRUST TOTAL	**46**	140	38	136	25	56	50	0	491	70.14
Projected Annual Cost	**6,440**	19,600	5,320	19,040	3,500	7,840	7,000	-		

Table 2	OVERDUE	A&E AMBULANCE 7YR REPLACEMENT YEAR - SMOOTHED							TRUST TOTALS	AVERAGE ANNUAL REPLACEMENT
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24		
DCA	**46**	140	97	51	51	51	51	50	537	76.71
DCA LEASED				22					22	3.14
TRUST TOTAL	**46**	140	97	73	51	51	51	50	559	79.86
Projected Annual Cost	**6,440**	19,600	13,580	10,220	7,140	7,140	7,140	7,000		

Table 3	OVERDUE	A&E AMBULANCE 6YR REPLACEMENT YEAR							TRUST TOTALS	AVERAGE ANNUAL REPLACEMENT
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23			
DCA	**46**	140	107	61	61	61	61		537	89.50
DCA LEASED				22					22	3.14
TRUST TOTAL	**46**	140	107	83	61	61	61		559	93.17
Projected Annual Cost	**6,440**	19,600	14,980	11,620	8,540	8,540	8,540			

Table 4	OVERDUE	A&E AMBULANCE 5YR REPLACEMENT YEAR							TRUST TOTALS	AVERAGE ANNUAL REPLACEMENT
		2017/18	2018/19	2019/20	2020/21	2021/22				
DCA	**46**	140	122	76	76	77			537	107.40
DCA LEASED				22					22	3.14
TRUST TOTAL	**46**	140	122	98	76	77			559	111.80
Projected Annual Cost	**6,440**	19,600	17,080	13,720	10,640	10,780				
Recommended year replacement policy										

Annex E – Whole unit cost – FRU (16/17 prices)

FAST RESPONDER VEHICLE - FRU - 2015 COSTS					COST £
VEHICLE COST					
VW Tiguan 2.0 DSG 4 x 4					18,491.00
VAT @ 20%					3,698.20
Sub Total					22,189.20
CONVERSION COST					
Approximate cost					14,500.00
VAT @ 20%					2,900.00
Sub Total					17,400.00
COMMUNICATIONS EQUIPMENT					
Approximate cost					1,174.68
VAT @ 20%					234.94
Sub Total					1,409.62
EQUIPMENT COST					
Qty	**Item**	**Supplier**		**Price per item**	
1	LP 15 Defibrillators	Physio Control	£	10,275.00	
1	LP 1000 Defibrillator	Physio Control	£	1,625.00	
1	Laerdal Suction with Serrre	Laerdal	£	580.00	
1	Entonox Regulator and Hos	Oxylitre Medical	£	159.10	
1	Entonox Bag	Openhouse Products	£	75.60	
1	Triage Pack	TSG Associates	£	86.67	
1	Oxygen Barrel Bag	Openhouse Products	£	98.99	
1	Dressings Bag	Openhouse Products	£	68.69	
1	Infectious Bag	Openhouse Products	£	76.05	
1	Maternity Bag	Openhouse Products	£	80.43	
1	Burns Bag	Openhouse Products	£	68.69	
1	Trauma Kit Bag	Openhouse Products	£	80.43	
1	Collar Bag	Openhouse Products	£	29.98	
1	Red Vehicle Bag	Openhouse Products	£	48.87	
1	Debris Gloves	Key Industrial	£	1.35	
1	Seat Belt Cutter	Woodway Engineering	£	1.79	
1	PALS Kit Bag	Openhouse Products	£	76.98	
1	EZIO Kit complete	Teleflex Medical	£	292.50	
1	Nonin Pulse Oximeter	Proact Medical	£	311.08	
1	Map Books	Geographers	£	15.00	
1	Manual B/P Cuff	Proact Medical	£	8.36	
1	Seat Tidy	Openhouse Products	£	41.48	
	Net Total			14,102.04	
	Vat @20%			2,820.41	
	Gross Total			16,922.45	16,922.45
TOTAL GROSS COST PER UNIT					**57,921.26**

Annex F – FRU suggested smoothed 5 Yr Replacement Programme

FRU REPLACEMENT PROGRAMME

Indicative Whole Unit Cost (K) **58** 2015/16 PRICES

Table 1	OVERDUE	FRU AMBULANCE REPLACEMENT YEAR - LEGACY TRUST PROGRAMME							TRUST	AVERAGE
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	TOTALS	ANNUAL
FRU	36	60	40	2	59	0	0	0	161	23.00
FRU LEASED	**0**	0	30	60	0	0	0	0	90	12.86
TRUST TOTAL	36	60	70	62	59	0	0	0	251	35.86
Projected Annual Cost	**2,088**	3,480	4,060	3,596	3,422	-	-	-		

Table 1	OVERDUE	FRU AMBULANCE 7YR REPLACEMENT YEAR - SMOOTHED							TRUST	AVERAGE
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	TOTALS	ANNUAL
FRU	36	60	40	2	59	0		60	221	31.57
FRU LEASED	0	0	30	60	0	60	0	0	150	21.43
TRUST TOTAL	36	60	70	62	59	60	0	60	371	53.00
Projected Annual Cost	2088	3,480	4,060	3,596	3,422	3,480	-	-		

Table 3	OVERDUE	FRU AMBULANCE 6YR REPLACEMENT YEAR							TRUST	AVERAGE
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23		TOTALS	ANNUAL
FRU	36	0	40	2	59	0	60	0	161	23.00
FRU LEASED	0	60	30	60	0	60	0	0	210	30.00
TRUST TOTAL	36	60	70	62	59	60	60	0	371	53.00
Projected Annual Cost	2088	3,480	4,060	3,596	3,422	3,480	3,480	0		

Table 4	OVERDUE	FRU AMBULANCE 5YR REPLACEMENT YEAR - SMOOTHED							TRUST	AVERAGE
		2017/18	2018/19	2019/20	2020/21	2021/22			TOTALS	ANNUAL
FRU	36	0	40	2	59	0	0	0	101	14.43
FRU LEASED	0	60	30	60	0	60	0	0	210	30.00
TRUST TOTAL	36	60	70	62	59	60	0	0	311	44.43
Projected Annual Cost	2088	3480	4060	3596	3422	3480	0	0		
Recommended replacement policy										

Annex G – NETS vehicle whole vehicle cost

PTS 3 VEHICLE - 2015 COSTS				COST £
VAN				
Fiat Ducato H3L3 Auto Box				20,557.00
VAT @ 20%				4,111.40
Sub Total				24,668.40
CONVERSION				
Approximate cost				33,361.00
VAT @ 20%				6,672.20
Sub Total				40,033.20
COMMUNICATIONS EQUIPMENT				
Approximate cost				1,127.52
VAT @ 20%				225.50
Sub Total				1,353.02
EQUIPMENT COST				
Qty	**Item**	**Supplier**	**Price per item**	
1	Lifepak CR+ AED	Physio Control	650.00	
1	Nonin 8500 Pulse Oximeter	Proact Medical	311.08	
1	Patient Wheelchair	NHS Logistics	140.00	
1	Entonox System	Oxylitre	235.60	
1	Patient Handling Kit	Prism Medical	297.89	
1	Compact Track Chair	Ferno	1,260.00	
1	Stryker Power Pro TL Trolley/Stretcher		7,428.48	
	Net Total		10,323.05	
	Vat @20%		2,064.61	
	Gross Total		12,387.66	12,387.66
TOTAL GROSS COST PER UNIT				**78,442.28**

Annex H – Suggested NETS smoothed6 Yr Replacement programme

NETS REPLACEMENT PROGRAMME

Indicative Whole Unit Cost (K) **79** 2015/16 PRICES

Table 1	**OVERDUE**	**A&E AMBULANCE REPLACEMENT YEAR - LEGACY TRUST PROGRAMME**							TRUST	AVERAGE
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	TOTALS	ANNUAL
NETS									0	0.00
NETS LEASED								59	59	8.43
TRUST TOTAL		0	0	0	0	0	0	59	59	8.43
Projected Annual Cost	-	-	-	-	-	-	-	4,661		

Table 1	**OVERDUE**	**A&E AMBULANCE 7YR REPLACEMENT YEAR - SMOOTHED**							TRUST	AVERAGE
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	TOTALS	ANNUAL
NETS				0	0	0	0	0	0	0.00
NETSLEASED									0	0.00
TRUST TOTAL			0	0	0	0	0	0	0	0.00
Projected Annual Cost	0	-	-	-	-	-	-	-		

Table 3	**OVERDUE**	**A&E AMBULANCE 6YR REPLACEMENT YEAR**							TRUST	AVERAGE
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23		TOTALS	ANNUAL
NETS									0	0.00
NETS LEASED				14	14	16	16		60	8.57
TRUST TOTAL		0	0	14	14	16	16	0	60	8.57
Projected Annual Cost	0	-	-	1,106	1,106	1,264	1,264			

Table 4	**OVERDUE**	**A&E AMBULANCE 5YR REPLACEMENT YEAR**							TRUST	AVERAGE
		2017/18	2018/19	2019/20	2020/21	2021/22			TOTALS	ANNUAL
DCA									0	0.00
DCA LEASED			14	15	15	15			59	8.43
TRUST TOTAL		0	14	15	15	15	0	0	59	8.43
Projected Annual Cost	0	0	1106	1185	1185	1185	0	0		
Recommended year replacement policy										

Annex I - LAS Fleet High Performance KPIs

FLEET SERVICES & LOGISTICS		
SER	**PERFORMANCE INDICATOR**	**STANDARD/MEASURE**
	FLEET SERVICES	
1.	**Critical Vehicle Failure Rate (CVFR)**: Number of miles/vehicle breakdowns or lack of availability due to failure.	By Workshop Daily, Month & YTD A&E – 1:25,000 (miles) PTS - 1:50,000 Others - 1:20,000
2.	**Daily Availability Rate**: Percentage of vehicles roadworthy and fit for use. Maximum, minimum and average.	By Workshop / Sector Daily at 0900 and 1600, Month & YTD A&E - 90% PTS - 90% Others - 95%
3.	**Condition of Fleet**: Condition of the Trust vehicle fleet by A&E, PTS, and others: a. **Class A**. Top condition in all respects - mechanically, bodywork, trim and fully equipped for task. b. **Class B**. Serviceable and equipped but with same body/trim damage or rust. c. **Class C**. Awaiting inspection, servicing, repair or equipment and could be made serviceable within 24 hours. d. **Class D**. Awaiting major repairs - not available within 24 hours. e. **Class E**. Awaiting disposal.	By Workshop / Sector Monthly & YTD A - 35% B - 50% C - 10% D - 5% E - Surplus only
4.	**Fleet Activity & Costs Per Mile**: Fleet numbers, mileage, total costs to include maintenance and operating costs, depreciation, insurance expressed as a cost per mile.	By Workshop / Sector Month & YTD Mileage - Actual v Plan Maint Costs CPM - A&E , PTS, Others Fixed Costs - A&E, PTS, Others
5.	**Fleet Maintenance Activity**: Hours provided against total hours utilised in servicing, repair and recovery by workshop to show efficiency by workshop and total.	Contracted / Actual By Workshop Month & YTD 90% utilisation
6.	**Fleet Stretcher Maintenance**. Number achieved versus number planned for: a. A&E Services.	By Workshop / Sector Month & YTD

	b. PTS	A&E (Plan vs Actual) per month PTS (plan vs Actual per month) per month
7.	**Fleet Carry Chair Maintenance**. Number achieved versus number planned for: a. A&E Services. b. PTS	By Workshop/ Sector Month & YTD A&E 24 per month PTS 10 per month
8.	**Vehicle Accident Statistics and Damage:** Number of reported accidents, numbers blameworthy and non-blameworthy, cost to Trust and total costs by A&E, PTS, CTS and others.	By Workshop / Sector Month & YTD Total cost by sector per month

Annex J – Fleet Procurement Options

PROCUREMENT OPTIONS

1. The range of procurement options for a new fleet includes:

    1.1. Outright purchase, through a term contract.

    1.2. Outright purchase, through a term contract, with subsequent lease-back.

    1.3. Contract hire.

    1.4. Hire purchase/Contract purchase.

2. Until VAT was imposed on leasing arrangements for NHS Trusts, leasing was more popular than it is now. The advantages and disadvantages of each of these options are summarised below.

    2.1. **Outright Purchase, Through a Term Contract.**
    The Trust purchases the vehicles through the CCS procurement route. Purchases are funded directly from revenue or capital budgets. The advantage of this approach are that the Trust achieves total fleet control and we would receive income for the vehicle at the end of its life, some of which may well be available for longer than we may originally have planned. The disadvantage is that we could not be certain of the residual value of the vehicle at the end of its life.

    2.2. **Outright Purchase, Through a Term Contract, With Lease-Back.**
    In this scenario the Trust specifies the vehicles and arranges for a lessor to finance the purchase. Lessors are normally banks of finance houses, and thus able to access funds cheaply. Their specialist knowledge of the vehicle market enables them to more cost effectively dispose of the asset – i.e. the vehicle - at the end of its life. There are two types of lease: Finance and Operating:

        2.2.1. A finance lease is set out over an agreed period and consists of a number of equal payments and often a one-off payment at the end of the contract. At the end of the period, the risk of residual value lies with the lessee, as it is up to the lessee to dispose of the vehicle and recover the residual cost.

        2.2.2. An operating lease also covers an agreed period, with a number of equal payments. Unlike a finance lease, the risk of residual value lies with the lessor, as the lessor calculates the residual value in advance, and reduces the quarterly payments accordingly. This is the leasing method used as standard by the Trusts, as it does not benefit from the tax allowances available to the private sector for finance leases, and the need for the Trust to cover its Minimum Revenue Position (MRP) means that finance leases for high value assets such as vehicles can be unaffordable.

    It should be noted that the distinctions mentioned above are different from those that relate to the use of those terms in respect of accounting treatment, particularly with regard to the current introduction of International Accounting Standards. The classification of a lease for accounting purposes is determined by a wide range of factors, with the ultimate distinction being that a Finance lease is treated as akin to actual ownership and accounted for accordingly.

2.3. **Contract Hire**.

The Trust pays a lease fee, agreed over a certain period and – if applicable – a service charge, which covers any maintenance, required on the vehicle. At the end of the period, the vehicle is returned to the contract hire company with no further payment from the customer. The advantage of this approach is that there is little pricing risk because monthly rental rate is unaffected by changes in the used vehicle market and the client departments do not need to fund the capital costs for vehicles in a single year. There is also some flexibility to accommodate short-term requirements. The disadvantages are that it is unlikely that the rates would be as competitive as a leasing arrangement. In addition the contract hire market is notorious for disputes over fair wear & tear at contract end.

2.4. **Contract Purchase / Hire Purchase**.

Vehicles are purchased via regular (monthly or quarterly) instalments. The main advantage is that the overall risk lies with the purchasing company. The disadvantage is that the payments are higher than leasing or contract hire and is generally only considered appropriate for small fleets of less than 10 vehicles.

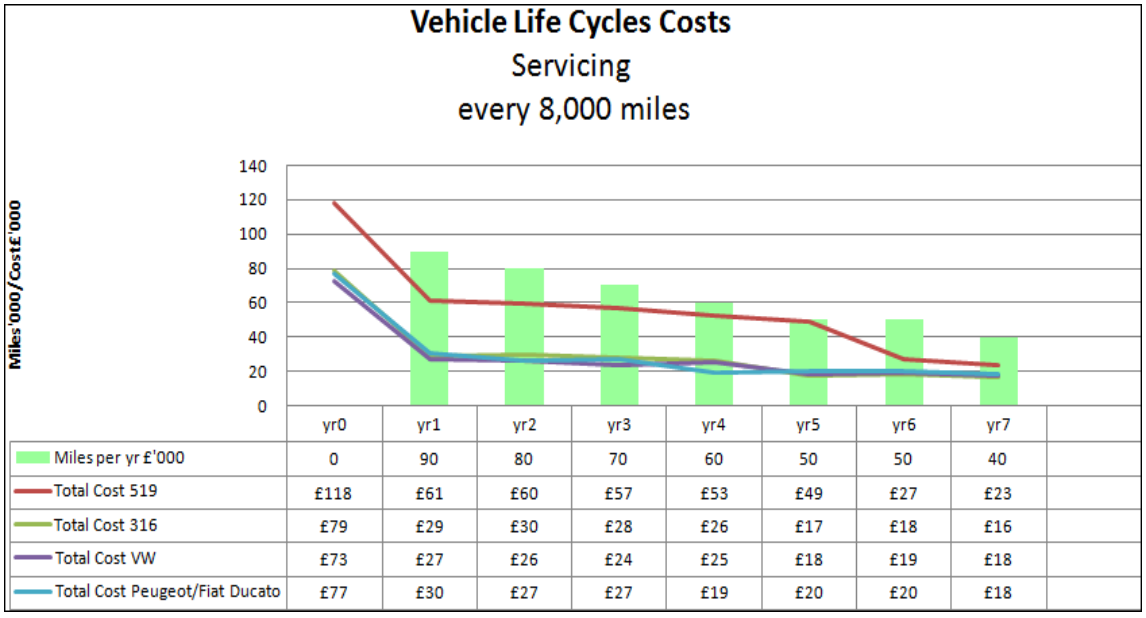
Annex K – Illustrative Financial/ Operating forecasting assumptions

Further input required by Finance team to set in context and LTFM and Operational forecasting

	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Transports	324,339	343,386	375,194	397,150	402,032	397,343	386,433	375,183	369,936	377,558
Responses	475,920	508,029	536,362	564,613	591,223	602,035	613,386	625,306	637,821	650,962
Actvity Increase		6.3%	5.0%	5.0%	6.8%	5.0%	5.0%	5.0%	5.0%	5.0%
Staff Increase		0.0%	6.3%	0.6%	5.0%	0.0%	-1.5%	0.0%	0.0%	-4.6%
Tspt Rate	68.1%	67.6%	70.0%	70.0%	68.0%	66.0%	63.0%	60.0%	58.0%	58.0%
Tspt Uhs	1,101,648	1,101,648	1,117,243	1,117,618	1,025,096	984,802	915,909	889,046	889,046	768,803
Rsp Uhs	1,351,858	1,351,858	1,500,463	1,515,149	1,746,082	1,786,376	1,813,239	1,840,102	1,840,102	1,840,102
Staff Hrs	2,453,506	2,453,506	2,617,706	2,632,767	2,771,178	2,771,178	2,729,148	2,729,148	2,729,148	2,608,905
% Ambs	81.5%	81.5%	74.5%	73.8%	58.7%	55.1%	50.5%	48.3%	48.3%	41.8%
% Cars	18.5%	18.5%	25.5%	26.2%	41.3%	44.9%	49.5%	51.7%	51.7%	58.2%
Tspt UHU	0.294	0.312	0.336	0.355	0.392	0.403	0.422	0.422	0.416	0.491
Rsp UHU	0.352	0.376	0.357	0.373	0.339	0.337	0.338	0.340	0.347	0.354
Establishment	1751	1751	1868	1879	1978	1978	1948	1948	1948	1862
WTE Variance on Year		0	117	11	99	0	-30	0	0	-86
Ambs Required				247	188	176	176	176	176	176
Cars Required				89	138	157	157	157	157	157
DMA Staff	1573	1573	1595	1595	1463	1406	1308	1269	1269	1098
SRV Staff	179	179	274	284	515	572	640	679	679	765

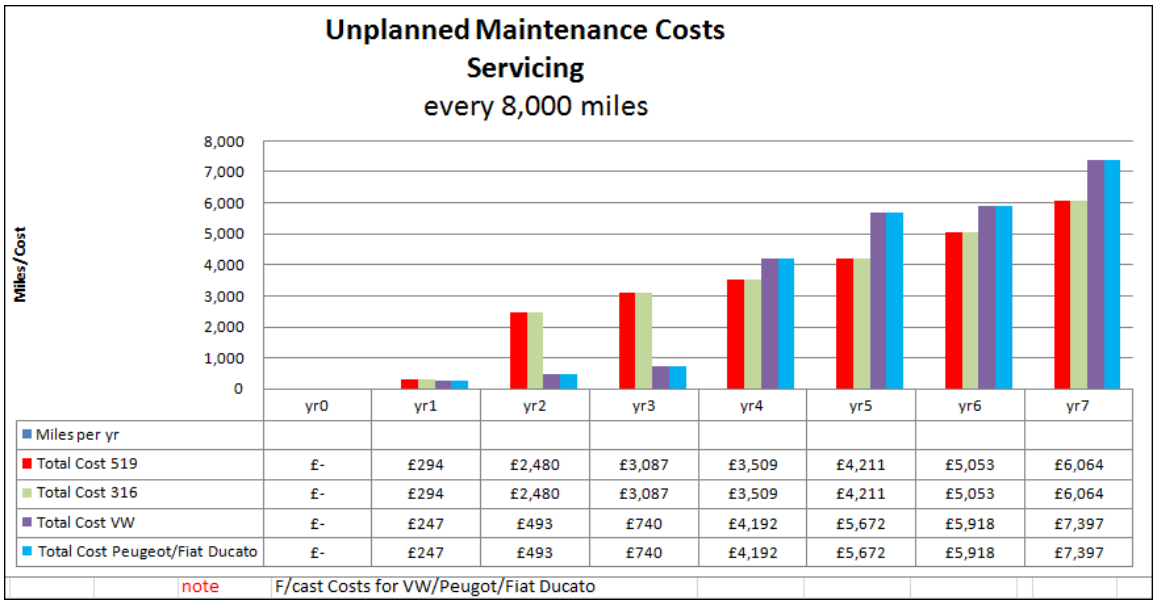
CIP + TECH + MR + H&T + HART + FLSM

Annex G – Illustrative Whole Life Vehicle Costing Analysis (SECAMB) – Planned servicing – Van conversion Vs. Modular DMA



	yr0	yr1	yr2	yr3	yr4	yr5	yr6	yr7
Miles per yr £'000	0	90	80	70	60	50	50	40
Total Cost 519	£118	£61	£60	£57	£53	£49	£27	£23
Total Cost 316	£79	£29	£30	£28	£26	£17	£18	£16
Total Cost VW	£73	£27	£26	£24	£25	£18	£19	£18
Total Cost Peugeot/Fiat Ducato	£77	£30	£27	£27	£19	£20	£20	£18

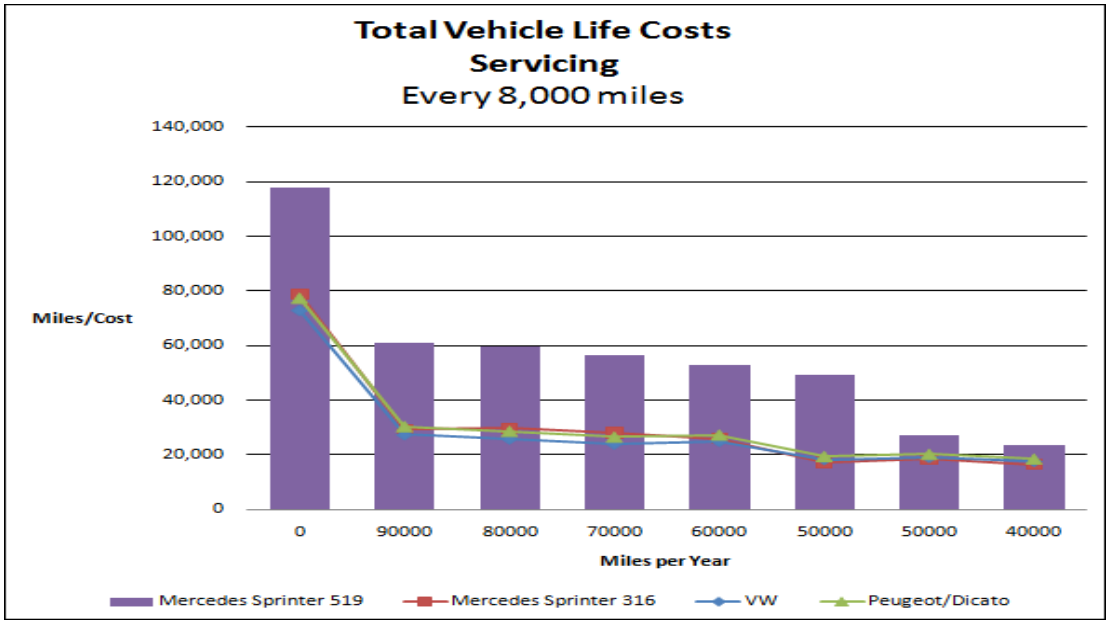
Annex H – Illustrative Whole life vehicle costing Analysis (SECAmb) – Unplanned Maintenance – Van conversion Vs, Coach built DMA



	yr0	yr1	yr2	yr3	yr4	yr5	yr6	yr7
Miles per yr								
Total Cost 519	£-	£294	£2,480	£3,087	£3,509	£4,211	£5,053	£6,064
Total Cost 316	£-	£294	£2,480	£3,087	£3,509	£4,211	£5,053	£6,064
Total Cost VW	£-	£247	£493	£740	£4,192	£5,672	£5,918	£7,397
Total Cost Peugeot/Fiat Ducato	£-	£247	£493	£740	£4,192	£5,672	£5,918	£7,397

note F/cast Costs for VW/Peugot/Fiat Ducato

Annex I – illustrative Whole Life Costing Analysis (SECAmb) – Total Cost Van conversion Vs Coachbuilt DMA



London Ambulance Service NHS Trust

TRUST BOARD FORWARD PLANNER 2017

Tuesday 27th June 2017

Standing Items	Assurance Performance / Quality / Workforce / Finance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Contents of meeting to be confirmed					

Tuesday 1st August 2017

Standing Items	Assurance Performance / Quality / Workforce / Finance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman Report from Non-Executive Directors Report from Chief Executive Serious Incidents	**Integrated Board Performance Report including Quality Report** **Assurance Reports from sub-committees** **BAF and Corporate Risk Register** **Finance Report M3**	Patient Engagement Strategy STPs Business Continuity Plan	Report from Trust Secretary Trust Board Forward Planner and 2018 dates Security Management Annual Reports: - Patient Experience - Patient and Public Involvement and Public Education	Board seminar - 27th June 2017 Quality Governance Committee – 11th July 2017 Finance Investment and Performance Committee – 20th July 2017 Logistics and Infrastructure Committee – 16th June 2017 Workforce and Organisational Development – 24th July 2017	

Tuesday 3rd October 2017

Standing Items	Assurance Performance / Quality / Workforce / Finance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chair Report from Non-Executive Directors Report from Chief Executive Serious Incidents	**Integrated Board Performance Report including Quality Report** **Assurance Reports from sub-committees** **BAF and Corporate Risk Register** **Finance Report M5** **EPRR assurance from the Audit Committee**	Review of 2017/18 Business Plan STPs	Report from Trust Secretary Trust Board Forward Planner	Audit Committee – 4th September 2017 Quality Governance Committee – 19th September 2017 Finance Investment and Performance Committee – 21st September 2017 Annual General Meeting – 26th September 2017 Workforce and Organisational Development – 18th September 2017	

Tuesday 31st October 2017

Standing Items	Assurance Performance / Quality / Workforce / Finance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Contents of meeting to be confirmed					

Tuesday 28th November 2017

Standing Items	Assurance Performance / Quality / Workforce / Finance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chair Report from Non-Executive Directors Report from Chief Executive	**Integrated Board Performance Report including Quality Report** **Assurance Reports from sub-committees** **BAF and Corporate Risk Register** **Finance Report M7** **EPRR assurance from the Audit Committee**	6 month review of business plan STPs	Report from Trust Secretary Trust Board Forward Planner Performance Reporting compliance statement HES report	Board seminar - 31st October 2017 Audit Committee – 6th November 2017 Quality Governance Committee – 14th November 2017 Finance Investment and Performance Committee – 23th November 2017 Logistics and Infrastructure Committee – 9th October 2017 Workforce and Organisational Development – 13th November 2017	

Tuesday 12th December 2017

Standing Items	Assurance Performance / Quality / Workforce / Finance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Contents of meeting to be confirmed					