London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO BE HELD IN PUBLIC ON TUESDAY 25th APRIL 2017 AT 1:00 -4:00PM CONFERENCE ROOM, 220 WATERLOO ROAD, LONDON, SE1 8SD

AGENDA: PUBLIC SESSION

	ITEM	SUBJECT	PURPOSE	LEAD	TAB
	1.	**Welcome and apologies for absence** Apologies received from:			
	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 28th March 2017** To approve the minutes of the meeting held on 28th March 2017	Approval	HL	TAB 1
	4.	**Matters arising** To review the action schedule arising from previous meetings	Information	HL	TAB 2
	5.	**Report from the Chair** 5.1 To receive a report from the Chair 5.2 Feedback from Non-Executive Directors	Information	HL	TAB 3
	6.	**Report from Chief Executive** To receive a report from the Chief Executive	Information	AG	TAB 4
PERFORMANCE AND ASSURANCE					
	7.	**Performance Report – March 2017** To receive the following performance reports: - Quality - Finance - Workforce	Information	AB	TAB 5
	8.	**Audit Committee Assurance Report** To receive the Audit Committee Assurance Report – 18th April 2017	Assurance	JJ	TAB 6
STRATEGY AND BUSINESS PLANNING					
	9.	**Financial and Business Plan 2017/18** To approve the Business Plan	Approval	KB	TAB 7
GOVERNANCE					
	10.	**Annual Accounts 2016/17** To review and note the report	Information	AB	TAB 8
	11.	**Questions from members of the public**		HL	
	12.	**Any other business**		HL	
		Meeting Closed The meeting of the Trust Board in public closes		HL	
		Date of next meeting The date of the next Trust Board meeting in public is on 25th May 2017 at 2.00pm		HL	

London Ambulance Service NHS Trust

TRUST BOARD MEETING (PUBLIC)

Minutes of the meeting held on Tuesday 28th March 2017 at 9.00am
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)
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:	
Sandra Adams	Director of Corporate Governance/Trust Secretary
Sarina Saiger	Interim Assistant Director of Quality, Brent CCG
Philippa Street	BHH, CCG
Philippa Harding	NHS Improvement (observing)
Mercy Kusotera	Corporate Governance Manager (Minutes)
Members of the Public:	
Daryl Smith	Ferno UK Ltd
Ross Lydall	Evening Standard
Malcolm Alexander	Patients Forum Chair
Members of Staff:	
Jenny Alford	Media and Campaigns Manager

25.	**Welcome and Apologies**
25.1	The Chair welcomed all to the meeting. Apologies were received from Jessica Cecil and Theo de Pencier.
26.	**Declarations of Interest**
26.1	There were no declarations of interest in matters on the agenda
27.	**Minutes of the Board meeting held on 31st January 2017**
27.1	The minutes of the meeting held on 31st January 2017 were approved as a true record of the meeting subject to a minor amendment to 7.4. **Action: Mercy Kusotera** **Date: 25th April 2017**
28.	**Matters Arising**

28.1	The Trust Board reviewed the actions log and noted the following: 4.1 – Demand analysis tools: a session had been scheduled for 25th April 2017.
28.2	4.3 – Clinical Team Leader role: Paul Woodrow confirmed that this would be covered when reviewing operations structure.
28.3	9.4 – Quality Governance reporting committees: the item was on the agenda for discussion.
28.4	11.5 – Skill mix: this would be included in workforce planning discussion scheduled for 25th April.
28.5	12.5 – Workforce: it was confirmed that workforce strategy was being developed; this would include Health and Wellbeing and WRES issues.
28.6	14.2 – Operational and financial planning 2017-2019: the item was on the agenda for discussion.
28.7	16.3 – IM&T Strategy: it was confirmed that capital was aligned with the financial plan. There was need to review the strategy in the light of the CAD review.
28.8	2- STPs: it was noted that there was lack of clarity around governance arrangements for Boards, in particular for Ambulance Trusts in this process. There was need to understand the plans for London. The Chair and Karen to discuss this outside the meeting.
28.9	3 – CQC Feedback: Fergus Cass confirmed that DBS checks were being monitored by the Workforce Committee; work was underway.
28.10	3 – Rest Breaks: Paul Woodrow noted ongoing work around rest breaks and end of shift. It was confirmed that meetings with Unions were being held.
29.	**Report from the Chair**
29.1	The report was taken as read and content noted.
29.2	The Chair provided an update on Chief Executive appointment; the selection process took place on 16th March. A preferred candidate had been selected and a provisional offer had been made and had been accepted.
29.3	It was noted that this was Sandra Adams' last LAS Trust Board meeting after 8 years of service. The Chair thanked Sandra for her contribution and diligence in her role over that period. Succession plans were being finalised; the Chair would update the Board in due course. **Action: Chair** **Date: 25th April 2017**
30.	**Report from the Chief Executive Officer**
30.1	The report was taken as read and content noted.

30.2	The following key areas were noted: • ***Organisation Performance*** – this was higher than planned demand; in total demand was 5.8% above contracted values for the month. This was the most significant issue impacting on the Trust's performance. • ***Strategy and Business Planning*** – this had been scheduled on the agenda for discussion. • ***CQC inspection*** – the Trust was waiting for a final report following a full re-inspection which took place in February. • ***New Year's Day Computer Assisted Dispatch system outage*** – a report would be presented to the Trust Board in May • ***Westminster attack*** – it was noted that the service had responded very well; the Chief Executive would write a formal letter thanking staff for the hard work. **Action: Andrew Grimshaw** **Date: 25th April 2017**
31.	**<u>Board Assurance Framework (BAF) and Risk Management</u>**
31.1	Andrew Grimshaw reported that the current BAF had been reviewed and updated by the lead directors. Further work was underway; the next version of BAF which would be presented to the Trust Board in May would reflect the strategy development work and the emerging strategic risks. The following key points were noted :
31.2	• The Trust risk register would be updated and amended to reflect the changes made to the BAF risks. • Three risks had been identified as top risks: (i) BAF risk 37 – agreed A8 trajectory and activity against contractually agreed growth. Further actions had been identified and added but these needed to be reflected in the gaps in controls. (ii) BAF risk 7 – patient harm due to reduced resource availability. It was noted that the heat map wording would be updated. (iii) BAF risk 14 – failure to identify and deliver CIPs.
31.3	It was noted that further updates and amendments would be presented following the review by the ELT and the feedback from the Workforce Committee.
31.4	A new risk had been added to the BAF: there was a risk that the Trust might not be able to recruit sufficient paramedics to meet workforce profile requirements (BAF risk 40).
31.5	Paul Woodrow reported that the CAD meeting had been rescheduled to 25th April 2017.
31.6	Bob McFarland asked whether the risk relating to ringback was still on track; the risk had been on the risk register for a long time. Paul Woodrow responded that overall, the position was much improved. A further update on EOC establishment would be provided to the Trust Board. **Action: Paul Woodrow** **Date: 25th April 2017**
31.7	Fergus Cass recognised that it was anticipated that BAF risk 7 would be closed by 30th September and he sought assurance re – how this could be achieved. He also sought for clarity on the impact on performance during that period. It was noted that rest break impact would be monitored.
31.8	There was need to clarify sub-committees responsible for specific BAF risks. It was agreed to allocate BAF risks to Board Committees. **Action: Andrew Grimshaw** **Date: 25th April 2017**

32.	**Clinical Governance Structure**
32.1	The report was taken as read and content noted.
32.2	The current clinical governance framework had been reviewed and a new rationalised structure had been proposed. The Quality Governance Committee acts as an assurance committee rather than an operational group for quality. Trisha Bain outlined the following key changes: • The Quality Governance Committee would be re-named the Quality Assurance Committee. • Medicines Management, Infection Prevention and Control and Safeguarding would be standalone corporate committees. • Quality Oversight Group to be introduced to provide corporate and strategic oversight and direction to the quality agenda across the Trust. • Health and Safety committee would be a corporate level committee.
32.3	It was noted that the next step would be to review the terms of reference of the committees, to develop standardised agendas and to review committee reporting and escalation processes.
32.4	The Trust Board approved the proposed structure; this would be implemented from 1st April.
33.	**Integrated Performance – February 2017**
33.1	Andrew Grimshaw reported that the format of the Integrated Performance Report would be reviewed. The Trust Board discussed the integrated performance report noting the following:
	Bullying and harassment
33.2	John Jones commented on bullying and harassment cumulative graph; he felt that this was going up. It was noted that this could be due to improvement in reporting system. The Chair reported that the bullying and harassment specialist would be leaving the Trust at the end of March; the work associated with this role needed to be mainstreamed to keep the momentum.
	Performance
33.3	Paul Woodrow reported that A8 performance for February 2017 was 67.4%; this was lower than the contract trajectory. He noted that the first five days of February were challenging; overall demand was 4.9% above plan. It was recommended to provide cumulative performance. **Action: Paul Woodrow** **Date: 25th April 2017**
	Quality
33.4	It was noted that 74 complaints had been received during February. The Chair commented that the number of open complaints were significantly high. Trisha Bain highlighted that it was anticipated that the changes to the complaints process would speed up the process.
33.5	In response to a question regarding medicines management, Fenella Wrigley reported that there had been an improvement in staff reporting updates and individual feedback. The Trust pharmacist was working with Estates to provide assurance around sites.
	Workforce
33.6	It was noted that sickness level should be reduced to 3%. However there was need for a clear plan on how this could be managed. Karen Broughton reported that the Trust was in a process of securing new occupational health provider. There was more work to be done to improve staff health and wellbeing. **Action: Karen Broughton**

	Date:
33.7	Fergus Cass sought clarity on JCT plans. Paul Woodrow noted that JCT was multifactorial; however there was need to remain focused. Some actions were needed to improve JCT; a clear plan was needed; the operations board should progress this. **Action: Paul Woodrow** **Date: 25th April 2017**
33.8	*CQUINS* There was a need to link key objectives to key people. It was anticipated that with IM&T strategy, we need to link the objectives. There was need for better communication with the Commissioners in terms of CQUIN expectations.
33.9	*Finance* The Trust Board noted report; this had been shared for information.
34.	**Staff Survey**
34.1	Karen Broughton presented 2016 staff survey results which had been published on 7th March 2017. The purpose of the report and associated documents was to enable the Trust Board to compare 2016 results with those of 2015, to compare the Trust's results with those of other Ambulance Trusts and to identify priority areas for action over the coming year. The next Staff Survey is scheduled for September.
34.2	The following focus areas were noted: • Appraisal quality • Error reporting • Dignity at work/values/professionalism • Wellbeing drive • Leadership and management development.
34.3	Jayne Mee commented that patient feedback should be a corporate focus area. This would enable to Trust to identify and develop local action plans which would be pulled together at board level.
34.4	It was noted that overall ambulance scores were not great; however when compared to other Ambulance Trusts, there were some areas where the Trust fell behind the average. There were also some areas in the Picker report where the Trust's scores were particularly low.
34.5	Fergus Cass highlighted that the key finding of the staff survey, including comparisons with the previous year, comparison with other ambulances overall had been reviewed by the Workforce Committee. It was noted that more detail for example, at sector level, was needed to ascertain issues at a more granular level. The Committee would consider how it could receive and provide assurance on staff safety and wellbeing, taking into consideration existing reporting to other committees. **Action: Karen Broughton/Paul Woodrow** **Date: 25th May 2017**
35.	**Quality Governance Committee Assurance Report**
35.1	The report was taken as read and content noted.
35.2	Bob McFarland drew the attention of the Trust board to the following key points: • Quality Governance Assurance Managers (QGAMs) – the Committee had received a presentation from QGAMs describing their experiences and achievements • Clinical Governance Structure and Quality Report – Trisha Bain was reviewing the

	structure. • Bank staff – the Committee were concerned that there was not a robust system for ensuring that bank staff (approximately) 150 staff) were subject to clinical updates and mandatory training. It was noted that this needed to be reviewed. The ELT would progress this. **Action: Karen Broughton** **Date: 25th April 2017**
36.	**Finance Investment and Performance (FIPC) Assurance Report**
36.1	The Chair reported on the items discussed on the meeting held on 23rd March 2017, the following key areas had been discussed: • CIPs – this would be discussed in detail in Part 2. • 111 Business Case – a paper was scheduled for discussing in Part 2. • Finance Investment and Performance Committee terms of reference had been reviewed.
36.2	The Trust Board noted the update.
37.	**Assurance from the Workforce and Organisational Development (Workforce) Committee**
37.1	The report was taken as read and content noted.
37.2	Fergus Cass reported on the meeting held on 20th March 2017. The Committee was updated on progress in developing a revised organisation structure for the Operations Directorate.
37.3	In terms of workforce planning, the Committee was informed that a modelling capability was being finalised that would enable evaluation of the key variables and production of comprehensive forecasts of manpower requirements. Assuming the current projections were valid, the Committee was not yet assured that the required number of paramedics could be recruited in 2017/18. It was noted that the Trust Board could not take assurance from the workforce planning due to lack of that clarity. The Executive should explore how this could be clarified. **Action: ELT** **Date: May 2017**
37.4	The Committee could not give full assurance in respect of the system for managing workforce related risks, mainly because the HR/Workforce Risk Register could not capture all risks as yet for example risks relating to Organisational Development and training. The Committee recommended speedy and pragmatic resolution of these issues.
37.5	The Trust Board noted the Workforce Committee report and thanked Fergus for the update.
38.	**Audit Committee Assurance Report**
38.1	The report was taken as read and content noted.
38.2	The following key points were highlighted from the report: • Progress against Internal Audit recommendations – it was noted that good progress had been made since the last meeting with 15 recommendations implemented and updates provided on all recommendations. • Board Assurance Framework and Corporate Risk register – work was underway to revise and refresh the approach to the development of the BAF. • Data Quality – the Interim Director of Performance gave a presentation to the Committee; further work was needed on the quality of workforce and quality. The Interim Director would develop a data quality framework and organisational policy to underpin this.

	• Contract of Internal Audit and LCFS – work was underway to review and update specifications for these services with a view to commencing the competitive tendering process this year in time to award the contract at the November 2017 Audit Committee meeting.
38.3	It was noted that the interim Director of Performance was writing a report around Data Quality. This would be shared with the Audit Committee.
39.	**Logistic and Infrastructure**
39.1	Andy Bell provided a verbal update; the first meeting of the group had been held on 13th February 2017.
39.2	The terms of reference had been agreed. The Group would focus on the following key areas: • IM&T • Estates • Fleet and Logistics
39.3	Strategy implementations updates were provided for each area.
39.4	The Committee would receive exception reports from each area. Appropriate representation was being sought from other areas to ensure the meeting was quorate.
40.	**Operational and Financial planning 2017-2019**
40.1	Andy Bell provided an update outlining the followed headlines: • The Financial Plan was approved by the Trust Board in December and submitted to the NHS Improvement on 24th December 2016. • The Trust was required to resubmit the plan by midday on 30th March adjusting for any material variations that had been developed in quarter 4. • A detailed report had been reviewed and approved by the FIPC and further detailed review sessions would be arranged with Non-Executive directors on request. • The Trust would be re-submitting a financial plan that was materially the same as the one submitted in December.
40.2	The main changes were outlined; these included minor adjustments in workforce not impacting the overall financial envelope for pay.
40.3	The Trust Board approved the plan for submission to NHSI.
41.	**Business Plan 2017/18**
41.1	Karen Broughton tabled the business plan. She noted that following discussion of the 2017/18 Business Plan goals at the previous Strategy Review and Planning (SRP) session held on 17th March, further work had been undertaken by the ELT to identify key objectives for 2017/18. The following four overarching goals had been agreed for the Business Plan: • Patients receive safe, timely and effective care • Staff are valued, respected and engaged • Partners are supported to make change in London • Efficiency and sustainability will drive us.
41.2	It was noted that some goals had cross cutting impact. The Trust Board was asked to provide comments on draft objectives by 7th April 2017. The ELT would finalise the Business Plan outcomes and details by 7th April 2017The Business Plan would be presented for sign of at the

	Trust Board SRP on 25th April 2017. Members to email Karen Broughton with feedback. **Action: Trust Board** **Date: 7th April 2017**
41.3	The Chair queried whether the timelines were realistic, in particular corporate functions plans (scheduled for end of May). She felt the timeline was tight. Karen Broughton would take that forward. **Action: Karen Broughton** **Date: 25th April 2017**
41.4	It was anticipated that the Business Plan objectives should be reflected in individual objectives by end of June 2017.
41.5	The Trust Board noted the plan.
42.	**Report from Trust Secretary**
42.1	The Trust Board noted the report.
43.	**Trust Board Forward Planner**
43.1	The Trust Board noted the forward planner.
44.	**Questions from members of the public**
44.1	***WRES leadership*** It was acknowledged that Melissa Berry had been a great asset to the Trust. There were ongoing discussions around substantive appointment to the post.
44.2	***Lord Harris recommendations (funding aspect)*** The Trust is yet to be informed which of Lord Harris recommendations are to be implemented.
44.3	***Business Plan public consultation*** Usually no consultation was held when developing a business plan.
44.4	Malcolm Alexander thanked Sandra for her involvement with the Patients Forum.
44.5	The Chair confirmed that the Trust would move to monthly Board meetings consisting of Part A and Part B.
45.	**Register of Interest**
45.1	The Trust Board noted the register.
46.	**Any Other Business**
46.1	Sandra Adams reported that the Security Management action plans had been progressed. NHSE protect had confirmed that they were satisfied (re- how the Trust had addressed the issues).
46.2	The Trust Board thanked Sandra and John Jones for progressing the work.
47.	**Date of Next Meeting**
47.1	The next meeting of the Trust Board would be on Tuesday 25th April 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 April 2017

Meeting Date	Minute No.	Action Details	Responsibility and date	Progress and outcome
28/03/17	**27.1**	**Minutes of the Board meeting held on 31st January 2017** Mercy Kusotera to amend the minutes.	**MK** **25th April 2017**	Completed
28/03/17	**29.3**	**Report from the Chair** The Chair would confirm succession plans for Sandra	**HL** **25th April 2017**	Matters arising 25th April 2017
28/03/17	**30.2**	**Report from the Chief Executive Officer** Andrew Grimshaw would write a formal letter thanking staff for the hard work re- Westminster attack.	**AG** **25th April 2017**	Completed
28/03/17	**31.6**	**Board Assurance Framework – ringback risk** Paul Woodrow to provide an update on EOC establishment.	**PW** **25th April 2017**	Matters arising 25th April 2017
28/03/17	**31.8**	**Board Assurance Framework Risks** Andrew Grimshaw would allocate BAF risks to Board Committees	**AG** **25th April 2017**	Matters arising 25th April 2017
28/03/17	**33.3**	**Integrated Performance – A8 Performance** Paul Woodrow to provide cumulative performance.	**PW** **25th April 2017**	Matters arising 25th April 2017
28/03/17	**33.6**	**Integrated Performance – Workforce** Karen Broughton to provide an update on staff health and wellbeing.	**KB** **25th April 2017**	To incorporate in the development of staff health and wellbeing strategy. Work in progress.
28/03/17	**33.8**	**Integrated Performance – CQUINS** To clarify communication process with Commissioners.	**25th April 2017**	The newly recruited Associated Director of contracts would be the contact person for Commissioners. Action completed.
28/03/17	**34.5**	**Staff Survey** The Workforce Committee to receive assurance around staff safety and wellbeing.	**PW/KB**	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**	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 April 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**	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**	Work in progress.

London Ambulance Service NHS Trust

Report of the Chair – 25 April 2017

1. General election – 08 June 2017

As you are aware a general election has been called for Thursday 08 June 2017.

In the run-up to the election the Service will enter a period of 'Purdah' and I would like to remind the Board that we should not be commenting or become involved in anything that may be construed as political or partisan.

We are awaiting guidelines from the Department of Health regarding our communications during this period and will circulate these in due course.

2. Major incident (Westminster) - 22 March and follow up visits by HRH Duke of Cambridge and the Mayor

You will all have seen the details of the Major Incident that took place at Westminster on 22 March. Working alongside other emergency services and hospital staff, the LAS responded well and our efforts did not go unnoticed, as we received thanks from both the Secretary of State Jeremy Hunt and the Prime Minister, Theresa May.

Following the incident we received a private visit from HRH The Duke of Cambridge (30 March) and a public visit from the Mayor, Sadiq Khan (24 March) to meet and thank the staff who had been involved in the Service's response.

3. Strategy development

NHS Provider paper Five year forward view (see attached for information).

We are in the process of reviewing and updating the Service's Five year strategy and forward refresh and may wish to consider and explore the possibility of becoming an 'accountable care' organisation; i.e. employing GPs and community staff with the aim of providing an effective demand management solution for London to relieve the pressure on hospitals.

Karen Broughton will be providing an update on the Service's strategic development at the Board meeting and we will have had a further session with McKinsey in the morning.

4. Healthcare at Home (HaH) Industry Coalition Group - 23 March

I accepted an invitation to be a member of this group which is an industry coalition group looking at transforming health and social care models. The group has been put together by Sir William Wells, Chair, The Practice

Group and will be chaired by Mike Bell, Chair, Croydon Health Services NHS Trust; and is made up of members from the public sector, independent bodies and third sector organisations who will meet over the coming months (March / June / Sept.)

The group has set the following objectives:

- The group will look to create a new vision and framework to align healthcare services for the NHS with a focus on the elderly.
- The group will look forward to 2025 rather than focus on the STPs and Five Year Forward View.

5. Healthcare discussion with Noel Gordon - 06 April

Theo and I attended an event hosted by Deloitte's with Noel Gordon Chair of NHS Digital as the guest speaker. One of his key messages is that all Boards need to have a senior independent NED to support ICO development, and I am delighted that we already have Sheila Doyle as a NED with this expertise'.

He also highlighted that amongst the key issues are the lack of political appetite for risk and sharing of data, and the need to understand to how future generations will wish to access healthcare.

6. Affordable inner city housing (JLT Lending Risk Solutions) - 11 April

We have been approached by Steven Rance of JLT Lending Risk Solutions; he was introduced by Shaun Bailey, London Assembly member, to discuss an approach to affordable 'micro housing'. I have agreed to approach Lord Carter of Coles with a view to gaining his advice and support for this initiative.

7. CQC update

We have been advised that the CQC have postponed the Quality summit until July, I have sought a meeting to express my concern about the impact of this delay given the improvements already undertaken by the Service.

8. Workforce Racial Equality Standard (WRES)

Since last Board meeting I have met with Marie Gabriel, Chair of East London NHS Foundation Trust, who has been successful in recruiting BME candidates to both executive and non-executive roles. Marie advised of the importance of setting a culture within the organisation that incorporates the values and addresses the issues, as well as ensuring people have clarity of expectations e.g. cliques are not acceptable; and I concur with this approach.

Internal activity – Control Services BME Listening events (18 April)

Paul Woodrow and Melissa Berry met with BME colleagues from Control Services at Waterloo; and I joined them in meeting staff at Bow. It was clear that people's experiences are very individual; however many have advised that cliques within the organisation are a constraint to people's well-being and inclusivity. In another example a Muslim member of staff expressed anxiety as to how they would be treated by the public if they were in a patient facing role. This has reiterated the strong need for clarity of professionalism across the board and Operations management restructure will seek to address this.

9. Board to Ward

I am keen for the LAS to develop a more structured approach to our interpretation of 'Board to Ward' (e.g. a programme of observational visits / ride-outs) and would welcome a discussion with each of the NEDs at their appraisal as to how we can develop this.

10. Appraisals

I have completed my self-appraisal and am now in the process of carrying out the NEDs appraisal or post-induction reviews and would be grateful if you could each attend with three-four personal objectives that link in with the corporate ones.

My personal objectives are:

- To develop a Unitary Board where assurance is gained from the Executives.
- To successfully embed the new CEO and support the embedding of the new Finance Director and Director of Corporate Governance.
- To lead the Trust out of 'Special Measures'.
- To be actively involved in the STP Governance.
- To support the Trust in developing an open culture of continuous learning.

11. Executive appointments' (verbal update):

- Chief Executive Officer
- Director of People and Organisational Development
- Director of Corporate Governance
- Interim Director of Finance
- Chief Information Officer

Heather Lawrence OBE
Chair

31 March 2017

on the day BRIEFING

NHS Providers

NEXT STEPS ON THE FIVE YEAR FORWARD VIEW: NHS PROVIDERS ON THE DAY BRIEFING

This briefing is a NHS Providers summary of the Next Steps on the NHS Five Year Forward View document (FYFVNS for the purposes of this briefing), published on 31 March 2017.

FYFVNS has been drafted by both NHS Improvement (NHSI) and NHS England (NHSE). It outlines progress on the ambitions set out in the *Five year forward view* since its original publication in October 2014, defines what still needs to be achieved over the next two years, and how this will be achieved. It also outlines priorities for the service specifically in 2017/18 as follows:

- Deliver financial balance across the NHS
- Improve A&E performance
- Strengthen access to GP & primary care services
- Improve cancer and mental health services

The document breaks down into 11 chapters covering a range of areas - however this briefing focuses on the most relevant points for NHS trusts and foundation trusts in particular the "what still needs to be achieved" parts of the document and new announcements. To see the full FYFVNS document please follow this link: https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/. At the end of this briefing we have attached the NHS Providers press statement. If you have any questions about this briefing, please contact Edward.Cornick@nhsproviders.org.

KEY AREAS OF INTEREST

Urgent and emergency care and RTT waiting times

Urgent and emergency care

The document notes the progress made in urgent and emergency care over the past three years, then outlines the key deliverables for urgent and emergency care in both 2017/18 and 2018/19. These deliverables are a mix of actions for both for local organisations and national bodies to deliver.

The key item to note here is the adjustment to the 95% A&E standard trusts will be required to meet. This is in line with what was announced in the Government's 2017/18 mandate to the NHS. These changes are:

- before September 2017 over 90% of emergency patients are treated, admitted or transferred within 4 hours (up from 85% currently being delivered)
- the *majority* of trusts will have to meet the 95% standard in March 2018
- the NHS overall returns to the 95% standard within the course of 2018
- Also to note, the document confirms the previous standard contract fines for A&E have been dropped for those providers who have agreed control totals. From April 2017 the rules governing the performance element of the £1.8 billion sustainability and transformation fund (STF) for acute trusts that relates to A&E will be amended. The non-appealable rules expected for access to the STF are set out at the end of the FYFVNS document at reference 24.

The document also prescribes how the trusts should achieve these changes and improve their current A&E performance:

By October 2017:

- Every hospital must have "comprehensive front-door clinical streaming".
- Every hospital and its local health and social care partners must have "adopted good practice to enable appropriate patient flow". This includes better hand-offs between A&E and acute physicians, 'discharge to assess', 'trusted assessor' arrangements, streamlined continuing healthcare processes, and seven day service (7DS) discharge capabilities.

By March 2018:

- Trusts should work with local councils to ensure that the extra £1 billion provided in the March 2017 budget for adult social care is used in part to reduce delayed transfers of care (DTOC), thereby helping to free up 2000-3000 acute hospital beds. Progress against this figure "will be regularly published" - the document does not say by whom or how frequently.
- ensure that 85% of all assessments for continuing health care funding take place out of hospital in the community setting,
- Implement the "High Impact Change Model" for reducing DTOCs.

It also notes a range of actions that the national bodies will undertake:

- Roll-out by spring 2018 of 150 standardised new 'Urgent Treatment Centres' which will open 12 hours a day, seven days a week, integrated with local urgent care services.
- Implement the recommendations of the Ambulance Response Programme by October 2017, putting an end to long waits not covered by response targets.

It also notes a range of actions that the national bodies will undertake regarding with NHS 111 and primary care:

- Enhance NHS 111 by increasing from the proportion of 111 calls receiving clinical assessment by March 2018,
- By 2019, NHS 111 will be able to book people into urgent face to face appointments
- Roll out evening and weekend GP appointments, to 50% of the public by March 2018 and 100% by March 2019.

To support these changes, the FVFVNS outlines the following support measures:

- £100m in capital funding, as announced in the budget, to support modifications to A&Es to enable clinical streaming by October 2017.
- Aligned national programme management. NHSI/NHSE will appoint a single national leader accountable for all of the above actions. Also from 1 April 2017 a single Regional Director drawn from either NHSI or NHSE will hold to account both CCGs and trusts in each STP area for the delivery of the local urgent care plan.

RTT waiting times

The document makes reference to the referral to treatment time 18 week 92% target. It says:

"Looking out over the next two years we expect to continue to *increase* the number of NHS-funded elective operations. However given multiple calls on the constrained NHS funding growth over the next couple of years, elective volumes are likely to expand at a slower rate than implied by a 92% RTT incomplete pathway target. While the median wait for routine care may move marginally, this still represents strong performance compared both to the NHS' history and comparable other countries."

This has been taken as recognition by NHSI and NHSE that performance against the 92% constitutional standard is not likely to be achieved in 2017/8.

Integrating care - STPs, ACOs and ACSs

The FYFVNS document has a chapter dedicated to integrating care. This provides two main functions:

1. Outlining key areas of clarification for STPs (now referred to in the document as Sustainability and Transformation Partnerships), accountable care system and accountable care organisation integration models
2. Outlining new policy changes associated with these models

These areas are summarised in the two tables following below:

Area of clarification	Explanation
Statutory role of STPs	• The document says: "STPs are not new statutory bodies. They supplement rather than replace the accountabilities of individual organisations. It's a case of 'both the organisation and our partners', as against 'either/or'"
Uniformity and running of STPs	• The document says: "The way STPs work will vary according to the needs of different parts of the country. Place-based health and care systems should be defined and assessed primarily by how they practically tackle their shared local health, quality and efficiency challenges. We do not want to be overly prescriptive about organisational form… [but] all STPs need a basic governance and implementation 'support chassis' to enable effective working "
What Accountable Care Systems (ACSs) are	• Essentially what the most advanced STPs will aspire to be. The document says: "ACSs will be an 'evolved' version of an STP that is working as a locally integrated health system. They are systems in which NHS organisations (both commissioners and providers)…choose to take on clear collective responsibility for resources and population health …specifically, ACSs are STPs - or groups of organisations within an STP sub-area… that get far more control and freedom over the total operations of the health system in their area"

What ACS's can or should do	• Agree an "accountable performance contract" with NHSE and NHSI to commit to make faster improvements in the key deliverables set out in the FYFVNS • Manage funding for their defined population, committing to shared performance goals and a financial system 'control total' across CCGs and providers. • Effectively abolish the annual transactional contractual purchaser/provider negotiations within their area. • Create an effective collective decision making and governance structure • Demonstrate how their provider organisations will operate on a horizontally integrated basis • Demonstrate how they will simultaneously also operate as a vertically integrated care system, partnering with local GP practices. • Deploy rigorous population health management capabilities that improve prevention • Establish clear mechanisms by which residents within the ACS' defined local population will still be able to exercise patient choice.
What Accountable Care Organisations (ACOs) are	• The document says: "In time some ACSs may lead to the establishment of an accountable care organisation. This is where the commissioners in that area have a contract with a single organisation for the great majority of health and care services and for population health in the area. A few areas in England are on the road to establishing an ACO, but this takes several years"

Area of policy change	Explanation
Assessment of STPs	• NHSI and NHSE will publish metrics at STP level in July that will "align" with the Single Oversight Framework for NHS provider trusts and NHSE's annual CCG Improvement and Assessment Framework.
Governance of STPs	STPs must: • form an STP board drawn from constituent organisations and including appropriate non-executive participation, partners from general practice, and in local government wherever appropriate. • establish formal CCG Committees in Common or other appropriate decision making mechanisms where needed for "strategic decisions between NHS organisations." • ensure the STP has the necessary programme management support by pooling expertise and people from across local trusts, CCGs, CSUs and other partners.

Communication of STPs	• From 1 April 2017, NHS organisations will have to show that proposals for significant hospital bed closures, requiring formal public consultation, can meet one of three "common sense conditions":
	  • That sufficient alternative provision is being put in place alongside or ahead of bed closures, and that a new workforce can deliver it; and/or
	  • That specific new treatments or therapies will reduce specific categories of admissions; and/or
	  • Where a hospital has been using beds less efficiently than the national average, has a credible plan to improve performance without affecting patient care

How to become an ACS	• The document says: "We expect that candidates for ACS status to include successful vanguards, 'devolution' areas, and STPs that have been working towards the ACS goal. In Q1 2017/18, NHSE and NHSI will jointly run a light-touch process to encourage other STPs (or coherent parts of STPs) to come forward as potential ACSs. This is a complex transition which requires careful management, including of the financial framework so as to create opportunity while also reducing instability and managing risk."
Freedoms given to ACSs by the national bodies	• The ability for the local commissioners in the ACS to have delegated decision rights in respect of commissioning of primary care and specialised services. • A devolved transformation funding package from 2018, potentially bundling together national funding for GPFV, mental health and cancer. • A single 'one stop shop' regulatory relationship with NHSE and NHSI with streamlined oversight arrangements, with an integrated CCG IAF and trust single oversight framework. • The ability to redeploy attributable contracting staff and related funding from NHSE and NHSI to support the work of the ACS.

OTHER AREAS OF INTEREST

Funding and efficiency

The document outlines a 10 point plan for the next two years to increase efficiency for the NHS in England. This briefing picks out the key points of this plan below and the keys areas where they impact on providers.

1. Free up 2000 to 3000 hospital beds
   - Using the extra £1bn awarded to adult social care in the last budget hospital trusts "must now work with their local authorities, primary and community services to reduce delayed transfers of care."
2. Further clamp down on temporary staffing costs and improve productivity
   - Trusts are set a target of cutting £150m in medical locum expenditure in 2017/18. NHSI will require public reporting of any locum costing over £150,000 per annum.

3. Use the NHS' procurement clout
   - All trusts will be required to participate in the Carter Nationally Contracted Products programme, by submitting and sticking to their required volumes and using the procurement price comparison tool.
4. Get best value out of medicines and pharmacy
   - NHSI support trusts to save £250m from medicines spend in 2017/18 by publishing the uptake of a list of the top ten medicines savings opportunities, and work with providers to consolidate pharmacy infrastructure
5. Reduce avoidable demand and meet demand more appropriately
   - NHS provider trusts will have to screen, deliver brief advice and refer patients who smoke and/or have high alcohol consumption in order to qualify for applicable CQUIN payments in 2017/18 and 2018/19.
6. Reduce unwarranted variation in clinical quality and efficiency
   - Trusts to improve theatre productivity in line with Get it right first time (GIRFT) benchmarks and implement STP proposals to split 'hot' emergency and urgent care from 'cold' planned surgery clinical facilities for efficient use of beds.
7. Estates, infrastructure, capital, and clinical support services
   - The NHS and Department of Health are aiming to dispose of £2bn of surplus assets this parliament, following recommendations from the forthcoming Naylor review.
8. Cut the costs of corporate services and administration
   - NHSI is targeting savings of over £100m in 2017/18, from trusts consolidating these services, where appropriate across STP areas. NHSI is also establishing a set of national benchmarks.
9. Collect income the NHS is owed
   - The Government has set the NHS the target of recovering up to £500m a year form overseas patients, Twenty trusts will now pilot new processes to improve the identification of chargeable patients
10. Financial accountability and discipline for all trusts and CCGs
    - Outlines the operation of control totals - 70% of the STF will again be tied to delivery against control totals. Provider trusts not agreeing control totals will lose their exemption from contract fines. From August 2017 CQC will begin incorporating trust efficiency in their inspection regime based on a Use of Resources rating. Trusts missing their control totals may be placed in the Special Measures regime.

Mental Health

What still needs to be achieved

- An extra 35,000 children and young people being treated through NHS-commissioned community services next year compared to 2014/15
- NHSE to fund 150-180 new CAMHS Tier 4 specialist inpatient beds, rebalancing beds from parts of the country where more local CAMHS services can reduce inpatient use.
- 74 24-hour mental health teams at the Core 24 standard, covering five times more A&Es by March 2019
- An extra 140,000 physical health checks for people with severe mental illness in 2017/18.

How it will be achieved

- Expand the mental health workforce – 800 mental health therapists embedded in primary care by March 2018, rising to over 1500 by March 2019.
- Reform of mental health commissioning so that local mental health providers control specialist referrals and redirect around £350m of funding.
- Clear performance goals for CCGs and mental health providers, matched by unprecedented transparency using the new mental health dashboard.

Cancer

What still needs to be achieved

- Introduction of a new bowel cancer screening test for over 4m people from April 2018.
- Introduce primary HPV testing for cervical screening from April 2019 to benefit 3m women per year.
- Expand diagnostic capacity so that England is meeting all 8 of the cancer waiting standards.
- Performance incentives to trusts for achievement of the cancer 62-day waiting standard will be applied to extra funding available to our cancer alliances.
- 23 hospitals have received new or upgraded radiotherapy equipment in early 2017, and over 50 new radiotherapy machines in at least 34 hospitals will be rolled out over the next 18 months.

How it will be achieved

- Targeted national investment, including £130m for a national radiotherapy modernisation fund. £36m has been spent so far, with a further £94m planned to be spent over the next 18 months.
- Expand the cancer workforce: HEE to have trained 160 non-medical endoscopists by 2018, alongside 35 more places for ST1 clinical radiology training.
- Performance goals for CCGs and cancer providers, and transparency using the new cancer dashboard.
- Three cancer vanguards creating population cancer budgets so as to integrate commissioning of cancer surgery, radiotherapy and cancer drugs for 9.6m people., and

Other areas of relevant interest the document says will be delivered in the next two years

Workforce

- A new nurse retention collaborative run by NHSI and NHS Employers will support 30 trusts with the highest turnover.
- A consultation will be launched on creating a Nurse First route to nursing, similar to the Teach First programme.
- NHSI will publish guidance on effective electronic rostering.
- Undergraduate medical school places will grow by 25% adding an extra 1500 places, starting with 500 extra places in 2018 and a further 1000 from 2019.

Technology

- By summer of 2017 GPs will be able electronically to seek advice and guidance from a hospital specialist without the patient needing an outpatient appointment.
- In the summer 2017 an updated online patient appointment system will be launched, providing patients with the ability to book their first outpatient appointment with access to waiting time information on a smartphone, tablet or computer.
- The NHS e-Referral Service is currently used by patients to arrange just over half of all referrals into consultant-led first outpatient appointments. By October 2018 all referrals will be made via this route, improving patients' experience and offering real financial and efficiency benefit
- By December 2018 there will be a clear system in place across all STPs for booking appointments at particular GP practices and accessing records from NHS 111, A&Es and UTCs

NHS PROVIDERS PRESS STATEMENT

NHS PROVIDERS COMMENTS ON THE NHS FIVE YEAR FORWARD VIEW DELIVERY PLAN

Embargoed until 00.01 hours, Friday 31 March 2017

Commenting on the NHS Five Year Forward View Delivery Plan published today, Chris Hopson, NHS Providers Chief Executive said:

"We welcome the plan's recognition of the scale of challenge the NHS faces - rapidly rising demand, the longest and deepest financial squeeze in NHS history and growing staff shortages."

On the task facing NHS trusts in 2017/18 and 2018/19

"Two weeks ago, in our *Mission Impossible?* report, we set out how impossible the task was for NHS trusts in 2017/18 and we called for greater realism. We therefore welcome the new performance trajectories for the key four hour A&E and 18 week elective surgery targets next year. But we do need to remember the impact on patients. More will have to wait longer in A&E and for routine surgery than they should. That's why, in our report, we said that NHS trusts would much prefer to be properly funded to meet the NHS constitutional standards.

"Trusts look forward to working with NHSE and NHSI to finalise two key details not covered in the plan.

"First, we need to finalise the 2017/18 financial targets. Our recent survey of trust finance directors estimated a £1 billion gap in the 2017/18 budget if trusts are to achieve the required financial balance. Given the new financial year starts tomorrow we need to rapidly work out how to fill this gap and what the overall provider sector financial target should be. We believe trusts will be doing well to reproduce this year's likely performance of an £800-900m deficit.

"Second, we need to work out what can actually be delivered in 2018/19 given that NHS frontline funding increases drop even further from +3.6% in 2016/17 to +1.3% in 2017/18 and then to +0.4% in 2018/19. This means that NHS real terms spending per person (adjusting for age) will actually decrease in 2018/19 - a very rare occurrence.

"We also welcome the explicit acknowledgement in the plan of the scale of risk facing NHS trusts in delivering all they are required to in 2017/18. We must not forget how difficult this winter was for staff and patients with unacceptable levels of patient safety risk. We need to ensure this risk is much better managed next winter. For example, the NHS needs between 2,000 and 3,000 beds freed up as a result of the extra £1 billion social care funding allocated in the Budget. Without this, or other extra capacity, the plan's A&E performance trajectories in the second half of 2017/18 already look very difficult indeed – even though these are already below the NHS constitutional standard.

"Trust leaders also recognise the importance of their role in delivering the new cancer and mental health improvements for patients and service users. It is important that we continue to make progress in these two areas."

On the development of Sustainability and Transformation Partnerships (STPs)

"We welcome the pragmatic and flexible approach to developing STPs. The plan recognises that the 2012 Health and Social Care Act prevents the creation of a formal 'mid level STP tier' with statutory powers.

"The plan also recognises the importance of existing governance and accountability structures focussed on trusts, but also the opportunity for shared decision making at the STP level.

"Finally, it allows different STPs to move at different speeds: enabling the fastest to progress without delay but not forcing others to adopt a single uniform approach they neither want nor are ready for.

"We look forward to working with NHSI and NHSE on the details of how STPs will develop in future over the next few weeks."

On workforce

"Trust leaders tell us that concerns over workforce are now at the top of their worry list. This includes concerns about growing staff shortages, the unsustainable pressure on staff and the viability of maintaining a 1% pay cap. We note the workforce proposals in the plan and will want to test with NHS trusts whether these really do represent a viable and sustainable solution."

On the future strategic direction of the NHS

"We welcome the restatement of the Five Year Forward View vision of closing the health, care and financial gaps and the move to new care models, which we strongly support.

"We also welcome recognition that transformation at the required speed can only occur with capital investment and by growing capacity closer to people's homes in the community. The Chancellor's commitment to address these needs in the Autumn Statement is welcome but the detail of how that commitment is met will be important. Trust leaders tell us they are very worried by the current approach to capital – it is short sighted and unsustainable to carry on robbing capital budgets to prop up daily running costs

"Transformation also requires the right leadership capacity that is in desperately short supply given the increasing fragility of services and the leadership time required to keep them stable."

Summary

"The plan reinforces a simple, stark, truth: that you get what you pay for. Trusts will do all they can to transform and realise efficiencies as quickly as possible. But if NHS funding increases fall way behind demand and cost increases NHS services inevitably deteriorate. That is clearly now happening."

ENDS

Assurance report to the Trust Board following the meeting of the Logistics and Infrastructure Committee on 13th April 2017.

Introduction

At the committee's inaugural meeting on 13th February 2017 the focus had been on identifying Key Performance Indicators (KPIs) for Fleet and Logistics, Estates and IM&T and upon investment plans over the 5 year Plan period 2017 - 2022. These three functions account for almost all of the Trust's capital expenditure (Capex). In addition membership of and modus operandi for the committee was agreed.

The second meeting of the committee on 13th April 2017 focused particularly on IM&T Strategy Planning 2017 - 2018 and on the Trust Fleet Strategy 2016 - 2020. Key issues affecting current activities and strategy delivery of each were discussed. At the same meeting it was agreed that the Trust's Estates Strategy, which we understand is nearing completion, would be circulated to the committee for comment, discussion and recommendation to the Board as soon as it was agreed by the Executive team.

Statutory reporting required of Estates by the NHS would also be a focus for the June L&IC meeting alongside new innovations in ambulance design, equipment and fit out.

IM&T

The IM&T team identifies four key strategic plan themes:

+ Resilience improvements
+ Service improvements
+ Strategic projects
+ Maintenance and improvement projects

If these are to be delivered then additional resources and skills must be added to the team to ensure that potential hurdles are overcome. Specifically additional leadership, capacity and funding will be needed alongside clear business ownership - ' project sponsors ' - and organisational alignment.

Only if all of these elements are in place will the strategy be feasible and the needed speed of delivery assured.
High level KPIs to measure the ongoing benefits of the projects were also agreed.

Fleet and Logistics

The committee discussed the Fleet Strategy which lays out an analysis of the operational and technical challenges that impact upon delivery of a robust plan to support LAS's overall vision, its clinical strategy and the changing role of the Ambulance Service within the NHS. The strategy seeks to align itself with the Trust's Quality Improvement Plan (QIP) in determining annual business programmes to deliver the evolving service.

The strategy aims to reconfigure the Trust's operational fleet to bring it in line with the changing business model allowing frontline staff to respond quickly and efficiently to emergency calls, improve clinical outcomes and in the process make better use of time and resources. The L&IC were very impressed with the quality of thinking, the thoroughness of the analysis and the comprehensiveness of the Fleet strategy which is recommended for approval by the Trust Board.

In addition the committee were appraised of current progress in implementing the Vehicle Preparation (VP) programme - on time and on budget - and other challenges faced by the logistics

team. Specifically issues with IT functionality, availability of equipment for VP rollout and the large number of supply contracts in Fleet which required detailed retendering putting a strain on resources of cash and time.

Assurance

Notwithstanding the challenges faced by Fleet and IM&T the committee were impressed with the analysis and oversight exhibited by the leadership of these important functions. With the imminent arrival of a comprehensive Estates strategy and reassurance that current statutory reporting and cost data is under control the committee has begun to develop a fuller understanding of these important elements of the Trust's resource base.

Theo de Pencier
18th April 2017.

London Ambulance Service NHS Trust

Report to:	**Trust Board**
Date of meeting:	**25th April 2017**
Document Title:	**Chief Executive's Report**
Report Author(s):	**Chief Executive**
Presented by:	**Chief Executive**
Contact Details:	**Jacqui.Galletta@lond-amb.nhs.uk**
History:	**n.a.**
Status:	***Information***

Background/Purpose

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

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

Action required

To note the report.

Links to Board Assurance Framework and key risks

The CEO report provides the overview of Trust activity in the period since the last Board meeting.

Key implications and risks in line with the risk appetite statement where applicable:	
Clinical and Quality	**Yes**
Performance	**Yes**
Financial	**Yes**
Workforce	**Yes**
Governance and Well-led	**Yes**
Reputation	**Yes**
Other	**Yes**
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
Trust Board 25th April 2017
Chief Executive's Report

This report provides an update on key issues and events since the last meeting of the Trust Board.

Incident at Westminster, 22nd March.

1. The Trusts response to the events at Westminster on 22nd March demonstrated the exceptional levels of skill, professionalism and dedication we have come to expect from our staff. I would like the Trust Board to recognise this.
2. We have received many letters recognising our contribution to the overall response, including from the Prime Minster, Leader of the Opposition and the Mayor of London.
3. I had the privilege to represent LAS at the Service of Hope at Westminster Abbey on the 05th April as well as the funeral of PC Keith Palmer on the 10th April.

Organisational Performance

1. In March higher than planned demand is the most significant issue impacting on the Trust's performance. In total demand was 3.6% above contracted values for the month. This level of growth is lower than in previous months but remains very challenging. Commissioners have supported LAS to source more capacity to help address this demand.
2. Across March the Trust was able to respond to 73.5% of Category A patients in under 8 minutes. LAS remains one of the strongest performing ambulance trusts in the country. The Board is asked to note the ongoing performance challenge resulting from high demand, this is highlighted in the Integrated Performance Report (IPR).
3. The quality of services provided remains good as evidenced in the IPR, although some patients continue to experience longer wait times for a response.
4. Staff continue to respond professionally and with outstanding care and compassion to meet these unprecedented levels of demand and the Trust Board will want to recognise their continued hard work in what are often challenging circumstances.
5. Financially we have achieved our plan for the year, and the Finance Department has been focusing on completing the Year End Accounts Submission to NHSI, due on the 25th April. This will be completed on time, with the Trust reporting that it has successfully achieved all of its statutory financial duties for the year.
6. The Trust's 111 service in South East London continues to deliver strong performance. The Trust Board are asked to note their appreciation for the hard work of all those involved in this service.

Strategy and Business Planning

7. Planning for 2017/18 and 2018/19 continues, and there are papers included in these Board papers on the financial and operating plan, and organisational objectives. The executive Team is working to ensure the delivery of the Business Plan sits at the core of its agenda.
8. Work continues with CCGs to identify actions to reduce demand on LAS services by identifying alternative avenues for certain patient groups meaning they do not need to call 999. This is a challenging area, but is key to how the system works

together to manage operational pressures. CCGs are looking to reduce demand by 2% in year; the LAS Executive Team are committed to working with them.

9. The Trust has agreed performance positions with LAS Commissioners for 2017/18, these commit the Trust to return to 75% A8 performance by October 2017. Focus will also be placed on ensuring minimum levels of performance are maintained at STP and CCG level. .

Governance

10. The Care Quality Commission completed the planned inspection in February. This was a full re-inspection and will result in a new rating being issued to the Trust later in the year. The report is still expected in May.
11. Work has continued to develop the Risk Management Framework and Board Assurance Framework within the Trust.

Executive Team

12. The Trust has recruited a new Director of People and Organisational Development, Patricia Grealish. Patricia will start with us in May.

Andrew Grimshaw, Chief Executive
April 2017.

London Ambulance Service NHS
NHS Trust

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

Background/Purpose

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

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

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

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

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

Action required

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

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 – TRUSTBOARD EXECUTIVE SUMMARY

April 2017

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

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

Delivery of care continues to be safe, but the rising demand pressures on the system continues to remain challenging. A8 performance ended at 73.5%. This is above the LAS trajectory of 71.51%. Overall Demand 5.8% above plan. Vacancies, turnover and sickness have not changed and remain within our tolerance levels.

OUR PATIENTS

OUR PERFORMANCE

↑ A8 Performance for March 2017 was 73.5%. This is 2% above the contract trajectory of 71.5%.

↑ There were 45,909 category A incidents in March (3.61% above plan). Category C demand was 7.9% above plan. Overall demand was at 94,917 incidents, 5.8% above plan.

↓ Job Cycle Time for March was 83.7 minutes, above the monthly trajectory of 80.7 minutes by 3 minutes. Hours lost in hospital handovers reached 5,784 in March, this is the equivalent of 482 vehicle 12 hour shifts on the road.

↑ Capacity was above trajectory with patient facing vehicle hours at 7.6% above plan.

↓ The multiple attendance ratio is below target at 1.27 for March. This is the lowest its been since August 2016.

OUR MONEY

OUR PEOPLE

↔ The overall vacancy rate has remained at 5.1% (reporting against 100% of establishment).
Following a successful trip to Australia the trust has made offers to 185 iParamedics.

↔ Overall turnover remained within tolerance levels at 9.8%. There were 26 frontline leavers in March. This includes 17 paramedics, 3 EMT4s and 6 T/EACs.

↔ The sickness percentage has remained at 5.2% (February data). The frontline percentage has remained at 5.7% and the levels vary across Sectors.

The 111 service achieved 97% for calls answered in 60 seconds during March 2017.
The Patient Transport Service has seen a 9.6% increase in activity from the previous month.

LAS 111 (SOUTH EAST LONDON)

↑ The 111 service achieved 95% (or more) of calls answered within 60 seconds on 26 days in March. This is above the 95% target.

↔ Referrals made to 999 have remained consistently low.

↔ Call volumes was lower than for March 2016 and 6.1% higher than in February this year.

PATIENT TRANSPORT SERVICE

↑ 5,387 journeys were completed in March 2017, a 9% increase from the previous month's total of 4,913 journeys.

↔ March will see the termination of another contract. Staff have been transferred either to NETs or to remaining contracts.

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

Key Performance Indicator Report Summary

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

	Key Performance Indicator	Mar-17	Feb-17	Jan-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)*		↔	↑	

* Sickness KPIs are reported a month in arrears

	Key Performance Indicator	Mar-17	Feb-17	Jan-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	Mar-17	Feb-17	Jan-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		↑	↑	

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.

Our Patients

The Quality Report is currently under review

Our Performance

Section	Key Headlines	Mar	Feb	Jan
A8 Performance	A8 Performance for March 2017 was 73.5%. This is above the contract trajectory of 71.51%.			
Other Performance	A19 performance was at 95.43% in March 2017. There was an increase in performance C1 to C4 during March 2017.			
Demand	There were 45,909 category A incidents in March (3.6% above trajectory). Category C demand was 7.9% above trajectory. Overall demand was at 94,917 incidents, 5.8% above plan.			
Capacity	The patient facing vehicle hours (PFVH) deployed during March were above trajectory by 7.6%. Overtime vehicle hours were 53.6% above plan for March.			
Efficiency	Job Cycle Time (JCT) for March 2017 was 83.7 minutes, a decrease of 2.4 minutes compared to February 2017. JCT was 3.7 minutes above the monthly trajectory of 80.7 minutes. The multiple attendance ratio was 1.27 which is below the target of 1.29.			
EOC – Call Answering	The 5 Second Call Answering for March was at 96.8%, this was 1.8% above the target of 95% and remained the same when compared to the previous month.			
EOC – FRU Cat C Share	FRU share of Cat C for March was 9.46%, this was 4.46% above the target of 5%.			
Resource Escalation Action Plan (REAP)	In line with the National Ambulance Resilience Unit recommendations, our REAP identifies the level of pressure the Service is under at any given time, and gives a range of options to deal with the situation. Four levels of escalation are used, which aim to help ambulance services integrate into the wider NHS surge or escalation framework. These levels are used to determine what actions are necessary to protect service delivery and supply the best possible level of service to patients with the resources available. The REAP score remained at level 2 (Moderate) during March 2017.			

Ambulance Quality Indicators (AQI) Update – February 2017

The AQIs for February 2017 were published on 13th April 2017. The list of AQIs detailed below make up part of the Ambulance System Indicators. These indicators enable comparison between the 11 Ambulance Trusts across England.

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

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

Source: NHS ENGLAND			**Performance in Month** Last 3 months			**Ranking Position**			
AQI Indicator Description SYSTEM INDICATORS	**Units**	**Target**	FEB	JAN	DEC	Ranked out of	FEB	JAN	DEC
The time taken to answer 95% of 999 calls in the emergency control room	(secs)	5 secs	2	14	3	11	2	4	1
The percentage of callers who have hung up before their call was answered in the emergency control room	%		0.1%	1.0%	0.1%	11	1	7	1
The percentage of Category A Red 1 (most time critical) calls reached within 8 minutes	%	75%	71.7%	67.1%	66.3%	8	3	5	5
The percentage of Category A Red 2 (serious but less immediately time critical) calls reached within 8 minutes	%	75%	67.7%	62.2%	64.0%	8	2	3	3
The time taken to reach 95% of Category A (Red 1) calls	(mins)		12.4	13.6	13.7	8	1	1	1
The percentage of Category A calls reached within 19 minutes	%	95%	93.3%	91.3%	91.9%	8	2	2	2
The time taken to arrive at the scene of 95% Category A (Immediately Life Threatening) calls	(mins)		19.7	22.4	21.7	8	3	3	3

Latest Publication : 13th April 2017 (Feb-17 data)
Date of next publication : 11th May 2017

Ambulance Quality Indicators (AQI) Update – November 2016

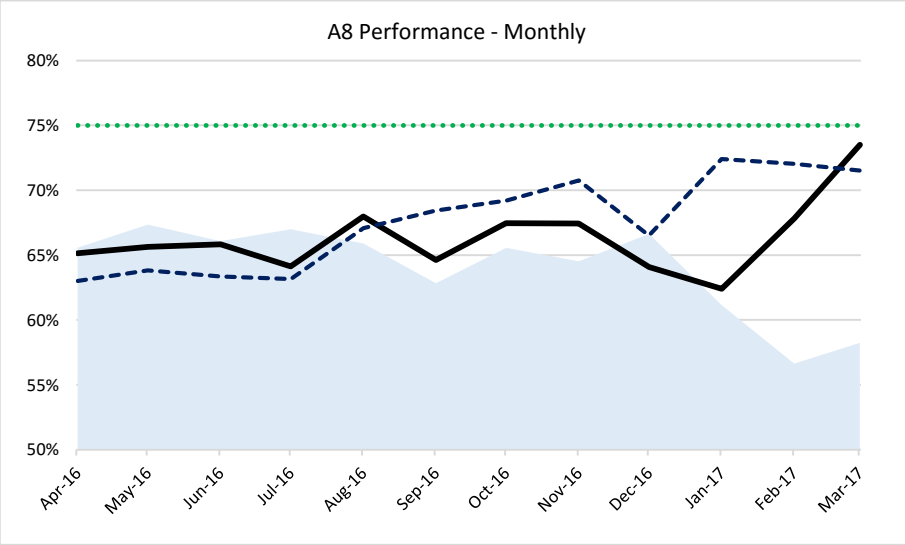
The AQIs for November 2016 were published on 13th April 2017. The list of AQIs detailed below make up part of the Ambulance System Indicators. These indicators enable comparison between the 11 Ambulance Trusts across England.

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

Source: NHS ENGLAND			**Performance in Month** Last 3 months			**Ranking Position**		
AQI Indicator Description CLINICAL OUTCOMES	**Units**	**Target**	NOV	OCT	SEP	NOV	OCT	SEP
Return of spontaneous circulation (ROSC) at time of arrival at hospital (Overall)	%	27%	28.3%	27.1%	31.6%	4	4	3
Return of spontaneous circulation (ROSC) at time of arrival at hospital (Utstein Comparator Group)	%	55%	58.3%	48.1%	37.1%	4	5	9
Percentage of patients suffering a STEMI who are directly transferred to a centre capable of delivering primary percutaneous coronary intervention (PPCI) and receive angioplasty within 150 minutes of call	%		88.2%	87.8%	93.5%	7	5	2
Percentage of patients suffering a STEMI who receive an appropriate care bundle	%	74%	72.5%	72.0%	74.2%	8	9	9
Percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of call	%	63%	61.9%	56.2%	61.4%	3	3	2
Percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle.	%	98%	96.4%	96.9%	97.0%	8	9	7
Survival to discharge – Overall survival rate	%		7.6%	7.6%	8.1%	6	6	9
Survival to discharge – Utstein Comparator Group survival rate	%		27.9%	25.5%	11.8%	4	5	11

Latest Publication : 13th April 2017 (Nov-16 data)
Date of next publication : 11th May 2017

A8 Performance

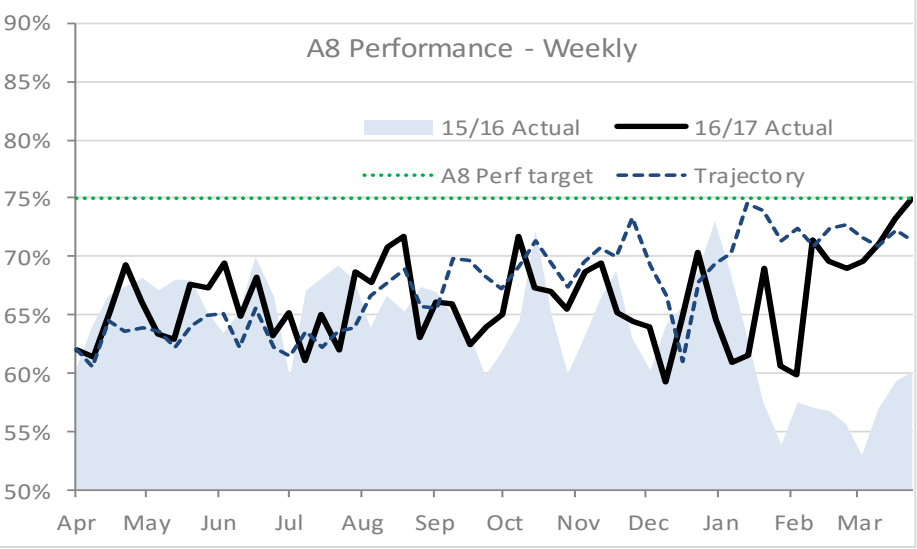


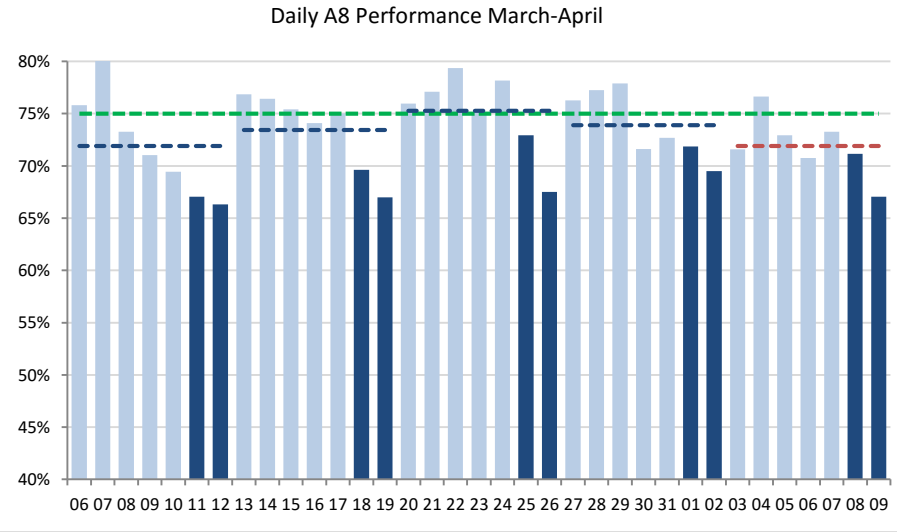
A8 Performance for March 2017 was 73.5%. This was lower than the contract trajectory of 71.51%. For additional context, the figure for March 2016 was 58.23%.

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

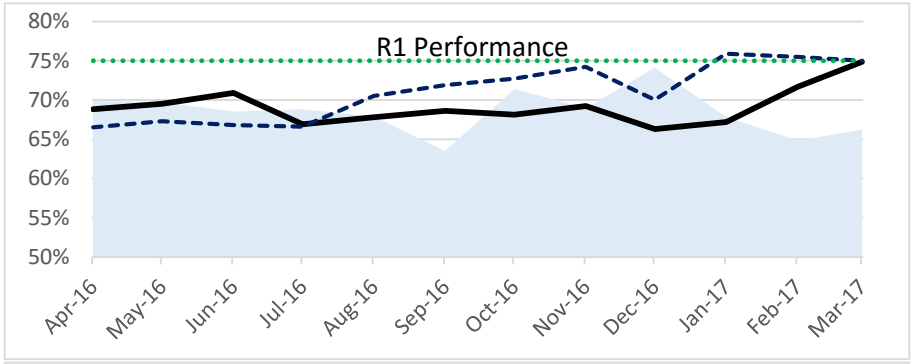
- **Demand** – Overall the number of incidents was 5.4% above plan. Cat A was 3.5% above trajectory, Cat C was 7.3% above trajectory.
- **Capacity** – Overall patient facing vehicle hours were 7% above plan.
- **Efficiency** - Average job cycle time was 3 minutes above trajectory and MAR was 1.27 and below target.

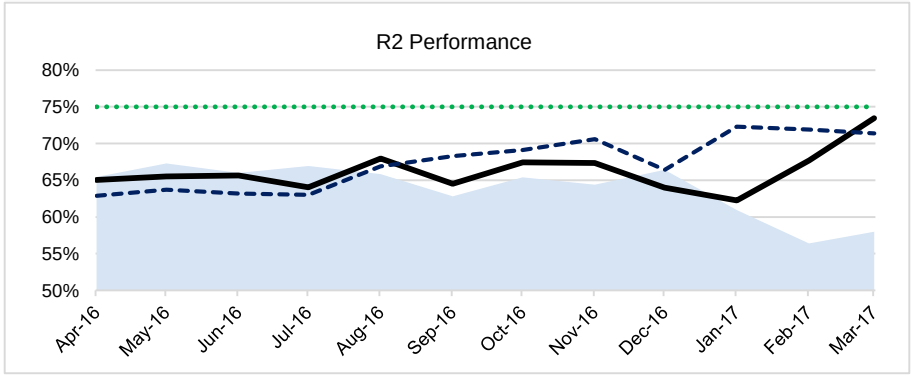
15/16 actual data
16/17 actual data
Trajectory
National target

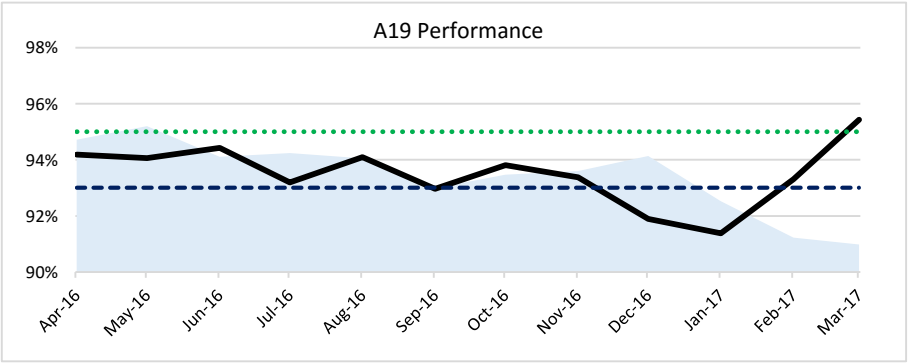




Other Performance







A19 performance in March increased by 2.13% compared to last month.

- Red 1 was 74.86%, below plan by 0.14%.
- Red 2 was 73.45%, above plan by 2.05%.
- A19 was 95.43%, above plan by 2.43%.

C1 to C4 performance all saw increases in March when compared to February.

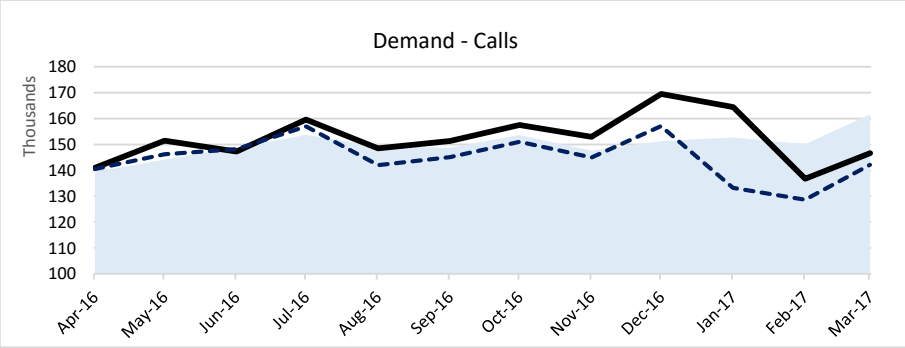
The contracted target for Cat C performance has changed for 2016-17. The new measures are:

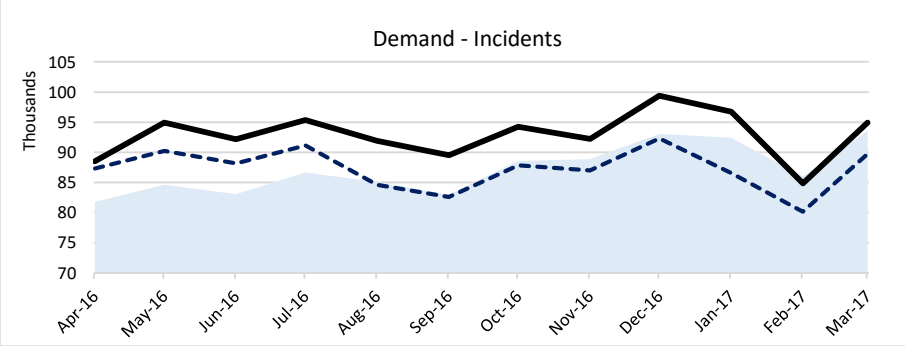
- C1 performance - 50% within 45 minutes.
- C2, C3 and C4 performance – 50% within 60 minutes.

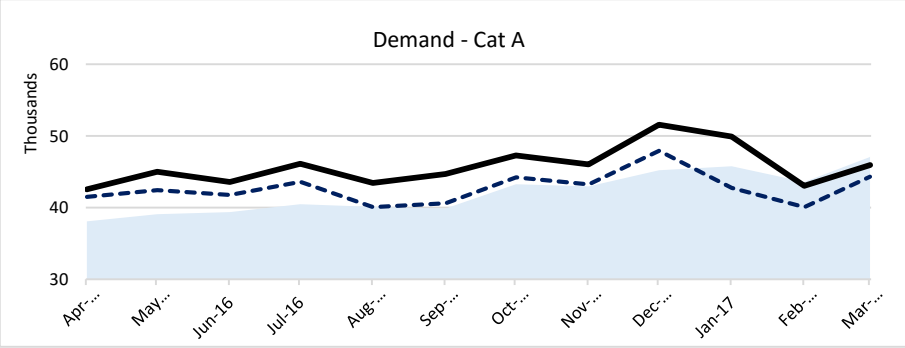
15/16 actual data
16/17 actual data
Trajectory
National target

Week ending	A8	A19	R1	R2	C1	C2	C3	C4
12-Mar	71.9	95.1	74.3	71.8	81.4	86.2	82.4	63.8
19-Mar	73.4	95.1	75.8	73.4	81.4	87.7	86.2	69.9
26-Mar	75.3	95.9	75.7	75.3	85.7	89.0	87.7	70.4
02-Apr	73.9	96.3	76.8	73.8	82.2	83.8	84.9	66.4
09-Apr	71.9	95.2	79.6	71.6	79.5	86.4	84.8	67.7
Jan-17	62.4	91.4	67.2	62.2	65.9	70.9	73.4	52.0
Feb-17	67.8	93.3	71.7	67.7	74.1	77.8	79.0	58.2
Mar-17	73.5	95.4	74.9	73.4	82.5	86.5	84.9	66.9

Demand







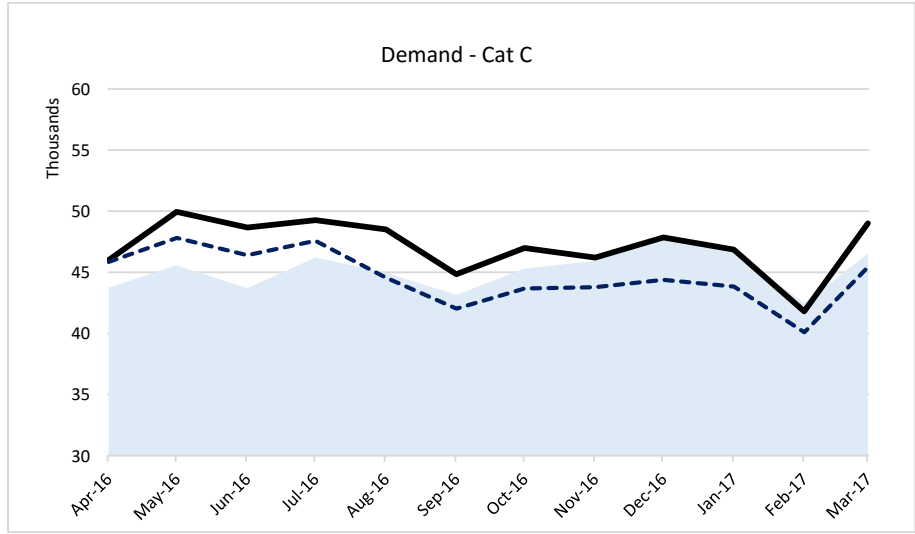
Overall demand was 5.4% above trajectory in March and 1.4% higher than March last year.

Cat A demand was 3.5% above plan but 2.4% lower than March last year.

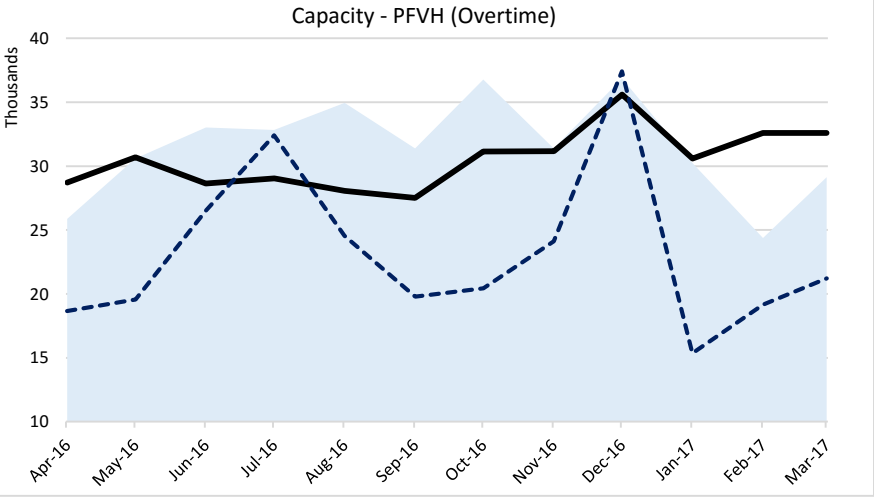
Category C incidents were above trajectory by 7.3% and 5.3% higher than March 2016's incidents.

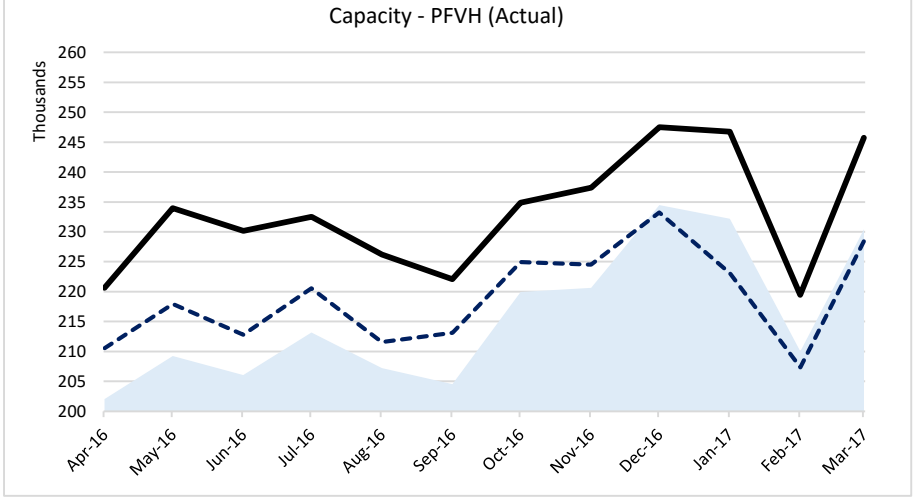
Call volumes were 3.2% above contract level for March 2017 but 9.2% lower than March last year.

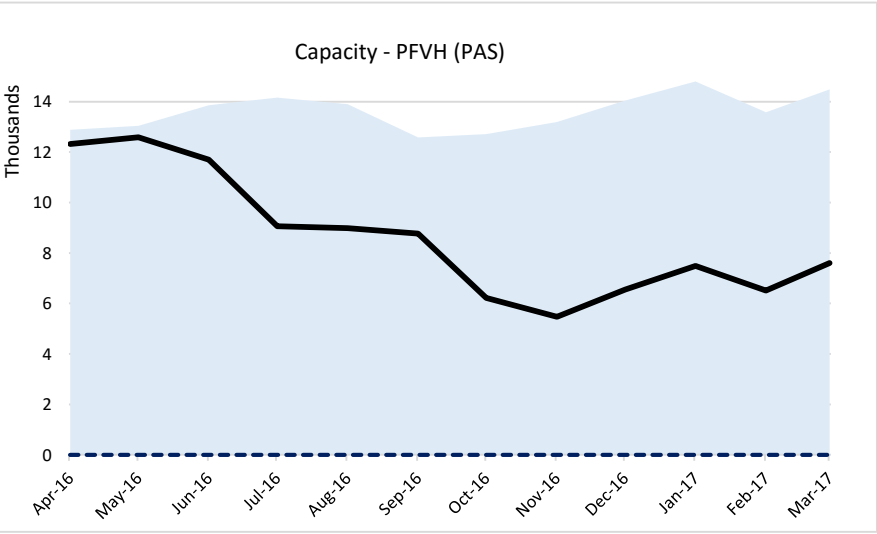
15/16 actual data
16/17 actual data
Trajectory



Capacity







Total patient facing vehicle hours were above trajectory for March.

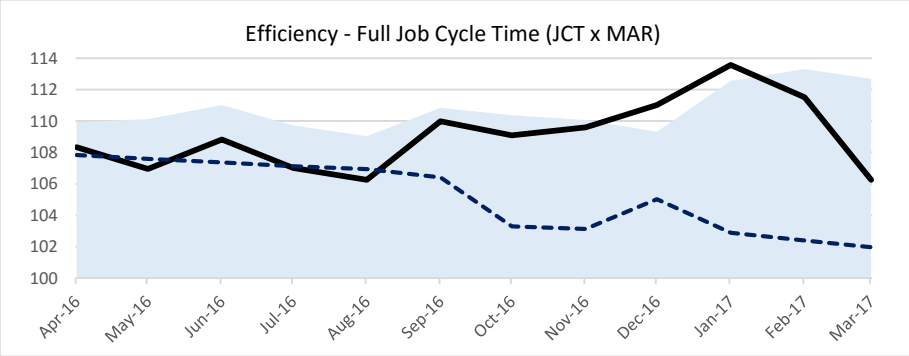
The hours deployed were 230,260 against a plan of 216,948 hours, a 5.8% difference.

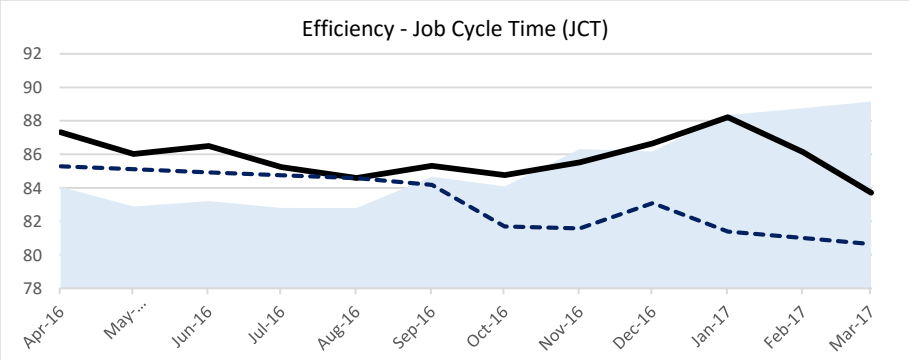
Overtime vehicle hours for March 2017 were 53.6% above trajectory.

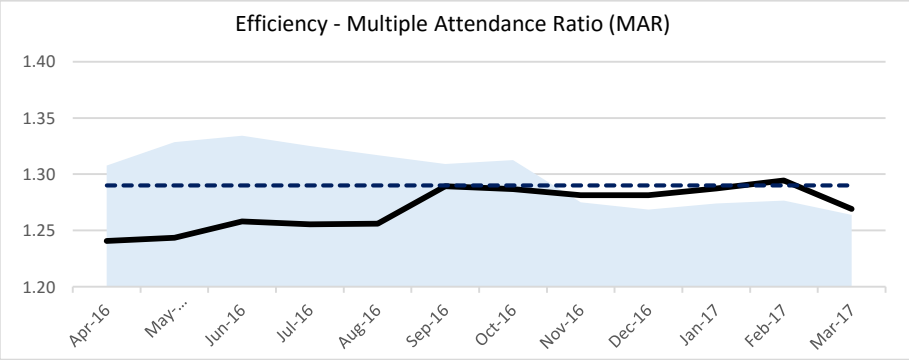
PAS/VAS hours for March 2017 were 47.6% below the level of March 2016.

15/16 actual data
16/17 actual data
Trajectory

Efficiency







Job Cycle Time for March 2017 was 83.7 minutes, above the trajectory of 80.7 by 3 minutes.

This was a decrease of 2.4 minutes from the previous month.

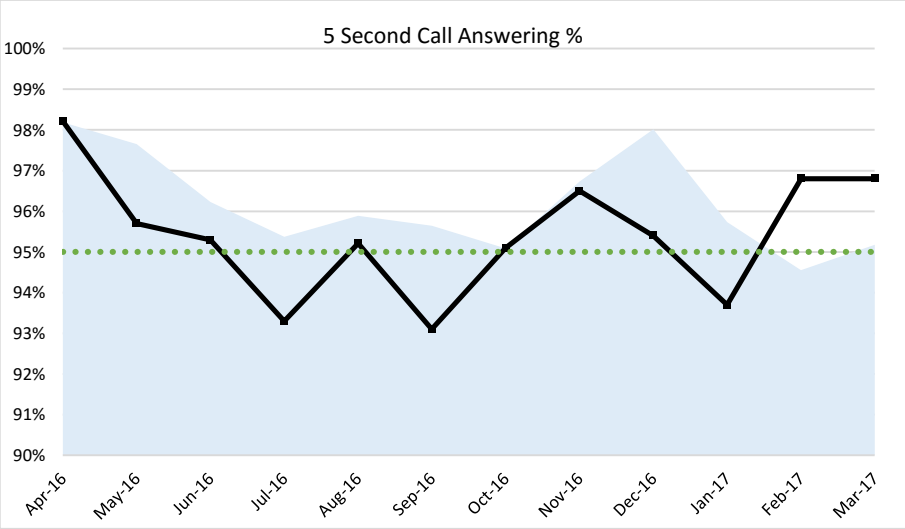
Hours lost in hospital handovers were at 5,784 in March (an equivalent of 482 twelve hour shifts). In February there were 5,121.

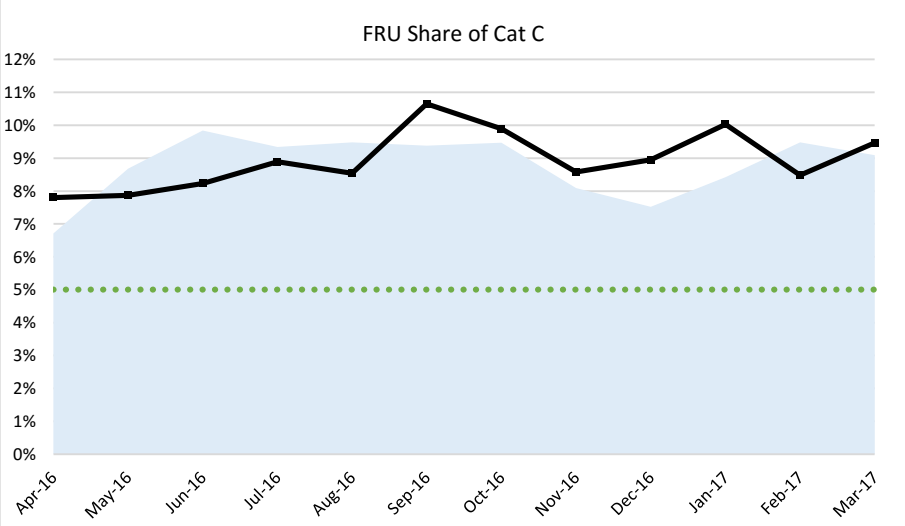
Full Job Cycle (JCT x MAR) was 106.3 minutes, above the March trajectory of 102.

The Multiple Attendance Ratio (MAR) was below target for March at 1.27. The trajectory for every month this year is 1.29.

15/16 actual data
16/17 actual data
Trajectory

Emergency Operations Centre (EOC)





5 Second Call Answering for March was at 96.8%, which is above the 95% target.

When compared to the 11 Ambulance Services across England, the London Ambulance Service ranks first in answering 95% of all 999 calls within 5 seconds.

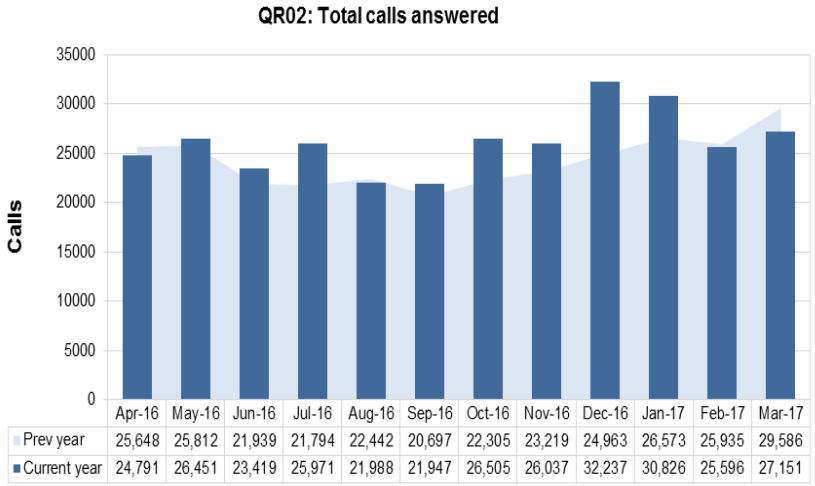
FRU share of Cat C for March was 9.46%, this was 4.46% above the target of 5%. This was a 0.98% decrease on the previous month.

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

Month	5 Second Call Answering %	
	2015-16	2016-17
Apr-16	98.19%	98.21%
May-16	97.65%	95.70%
Jun-16	96.23%	95.30%
Jul-16	95.37%	93.30%
Aug-16	95.89%	95.21%
Sep-16	95.64%	93.10%
Oct-16	95.09%	95.10%
Nov-16	96.73%	96.50%
Dec-16	98.02%	95.40%
Jan-17	95.73%	93.70%
Feb-17	94.55%	96.80%
Mar-17	95.18%	96.80%

Month	FRU Share of Cat C	
	2015-16	2016-17
Apr-16	6.71%	7.80%
May-16	8.68%	7.87%
Jun-16	9.84%	8.23%
Jul-16	9.34%	8.89%
Aug-16	9.48%	8.54%
Sep-16	9.38%	10.65%
Oct-16	9.47%	9.89%
Nov-16	8.09%	8.58%
Dec-16	7.52%	8.95%
Jan-17	8.42%	10.03%
Feb-17	9.48%	8.48%
Mar-17	9.09%	9.46%

LAS 111 (South East London) – Demand and Capacity



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Prev year	25,648	25,812	21,939	21,794	22,442	20,697	22,305	23,219	24,963	26,573	25,935	29,586
Current year	24,791	26,451	23,419	25,971	21,988	21,947	26,505	26,037	32,237	30,826	25,596	27,151

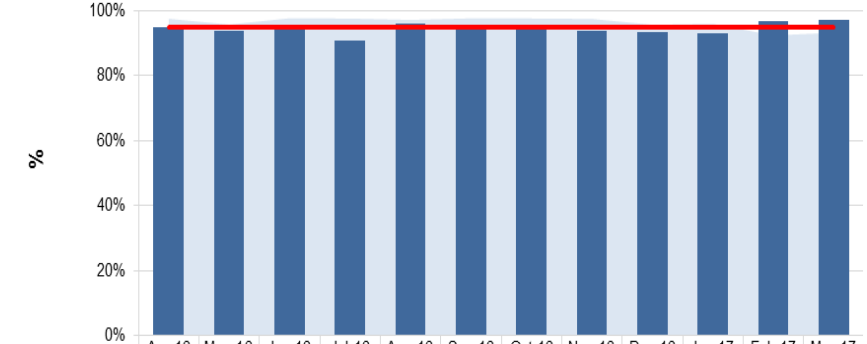
Demand: Call volumes were lower this month than March 2016. call volumes were 6.1% higher than February this year.

Capacity: Induction commenced on 20th March to maintain robust Call Handler capacity and increase Clinical Advisor establishment. Current vacancy factor for clinical Advisors is 19.58WTE (69%). Established agency workforce in place to mitigate risk.

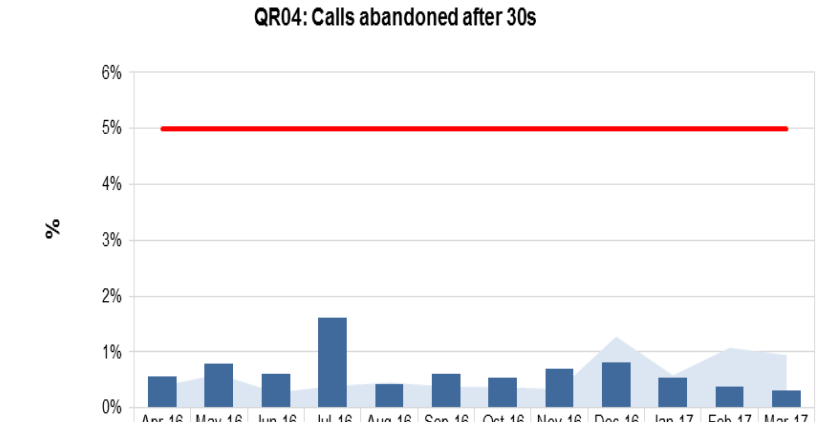
Efficiency: The percentage of calls answered in 60 seconds was 97.1% in March with the target achieved on 26 days.

The operational focus has been on balancing access to the service and minimizing time to clinical call back and saw an increase in call backs achieved within 10 minutes.

Service Projects: The service focus throughout March has been on 111 / Integrated Urgent Care, Winter Pilots to support Health Care Professionals and reducing demand on 999 & Emergency Departments.



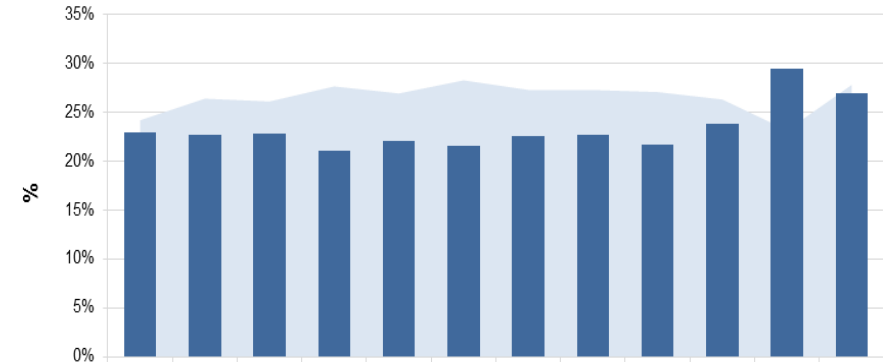
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Prev year	97.5%	95.7%	97.7%	97.6%	97.1%	97.6%	97.6%	97.4%	95.6%	95.9%	92.4%	93.2%
Current year	94.8%	93.6%	94.2%	90.7%	95.9%	94.6%	95.0%	93.6%	93.3%	92.9%	96.6%	97.1%
QR Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Prev year	0.4%	0.6%	0.3%	0.4%	0.5%	0.4%	0.4%	0.3%	1.3%	0.6%	1.1%	0.9%
Current year	0.6%	0.8%	0.6%	1.6%	0.4%	0.6%	0.5%	0.7%	0.8%	0.6%	0.4%	0.3%
QR Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%

LAS 111 (South East London) – Call Destinations

QR12a: % of calls referred to a clinical advisor



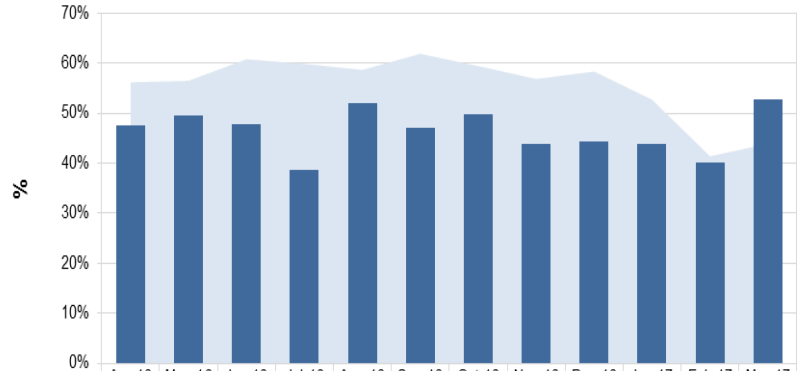
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Prev year	24.2%	26.4%	26.1%	27.7%	26.9%	28.3%	27.3%	27.3%	27.1%	26.3%	23.2%	27.8%
Current year	22.9%	22.7%	22.9%	21.0%	22.1%	21.5%	22.6%	22.7%	21.7%	23.8%	29.5%	26.9%

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

Safety: There were 55 Incidents in Datix with completed investigations in March. Of these 18 (33%) related to authorised breaches in confidentiality including safeguarding referrals made with our patient consent, 16 (29%) to failure to follow procedure and the remaining 21 (38%) to other issues. Incidents are under investigation and feedback given to staff where appropriate.

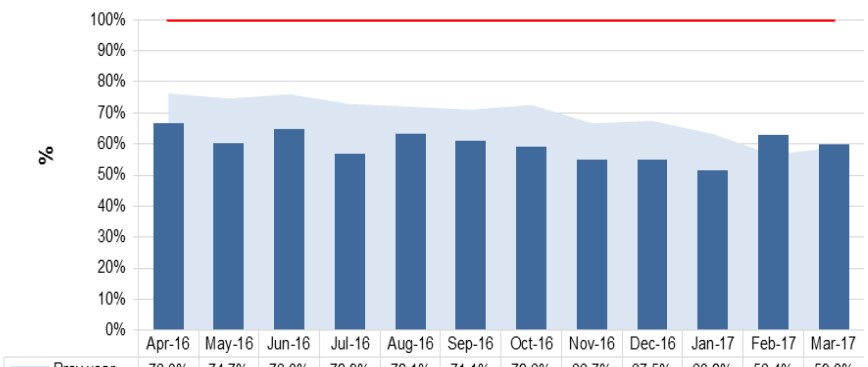
No Serious Incidents (SIs) were identified and the service received ten complaints, one compliment and feedback from Health Care Professionals. The reason for the increase in complaints is being investigated.

QR12: Of calls transferred, % transferred warm



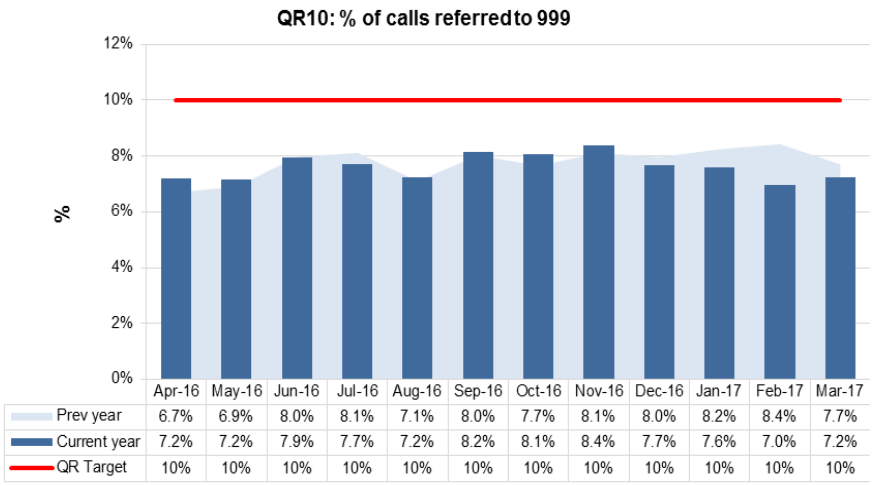
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Prev year	56.2%	56.5%	60.8%	59.9%	58.7%	61.9%	59.4%	56.9%	58.3%	52.7%	41.4%	43.9%
Current year	47.6%	49.4%	47.7%	38.7%	51.9%	47.0%	49.9%	43.8%	44.4%	43.8%	40.1%	52.8%

QR14: Of call backs, % within 10 minutes

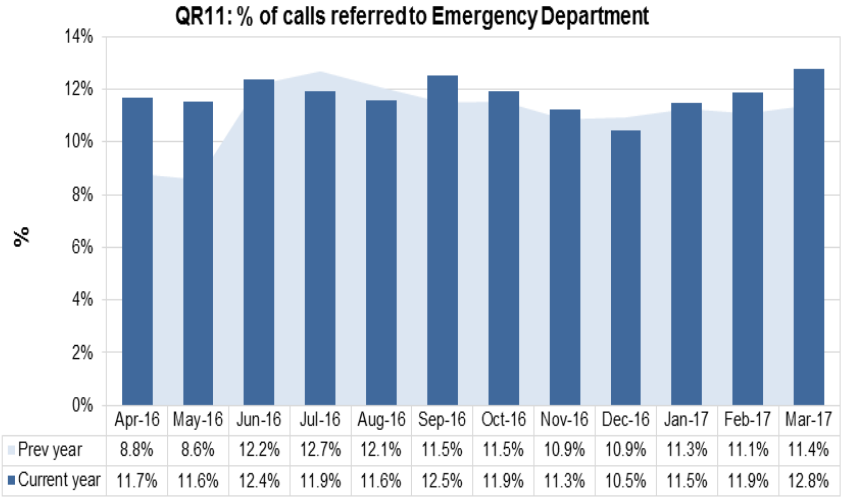


	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Prev year	76.3%	74.7%	76.0%	72.9%	72.1%	71.1%	72.6%	66.7%	67.5%	63.2%	56.4%	59.0%
Current year	66.8%	60.3%	64.8%	56.9%	63.4%	61.0%	59.0%	55.0%	55.1%	51.6%	62.9%	59.8%
QR Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

LAS 111 (South East London) – Triage destinations



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Prev year	6.7%	6.9%	8.0%	8.1%	7.1%	8.0%	7.7%	8.1%	8.0%	8.2%	8.4%	7.7%
Current year	7.2%	7.2%	7.9%	7.7%	7.2%	8.2%	8.1%	8.4%	7.7%	7.6%	7.0%	7.2%
QR Target	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%



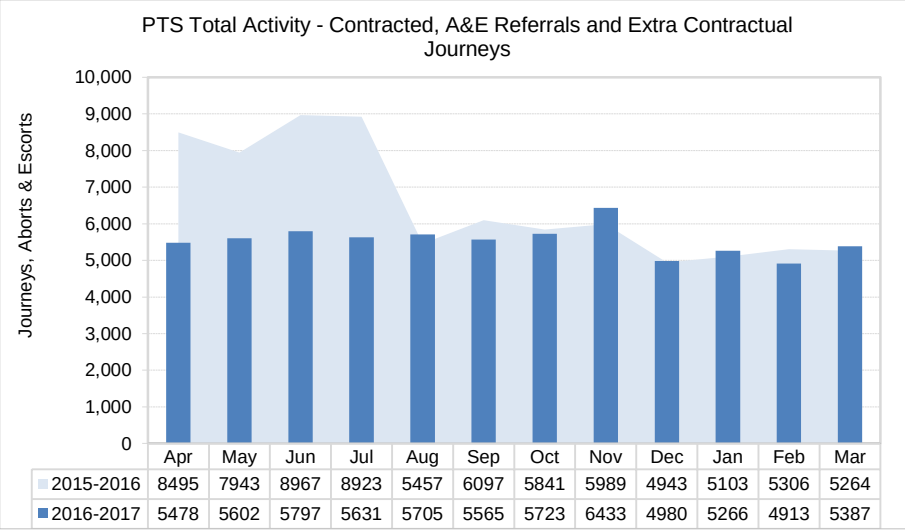
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Prev year	8.8%	8.6%	12.2%	12.7%	12.1%	11.5%	11.5%	10.9%	10.9%	11.3%	11.1%	11.4%
Current year	11.7%	11.6%	12.4%	11.9%	11.6%	12.5%	11.9%	11.3%	10.5%	11.5%	11.9%	12.8%

Referrals: LAS 111 consistently and successfully has the lowest referral rate to 999 in London and the highest percentage of enhanced re-assessment for low acuity ambulance outcomes.

Referrals to Emergency Departments are higher than for other providers, this figure includes Urgent Care Centres and Walk-in Centres.

When combined this gives an indication of the impact on Emergency and Urgent Care. LAS 111 successfully refers the lowest number of calls overall.

Patient Transport Service – Activity Update and Profitability Update

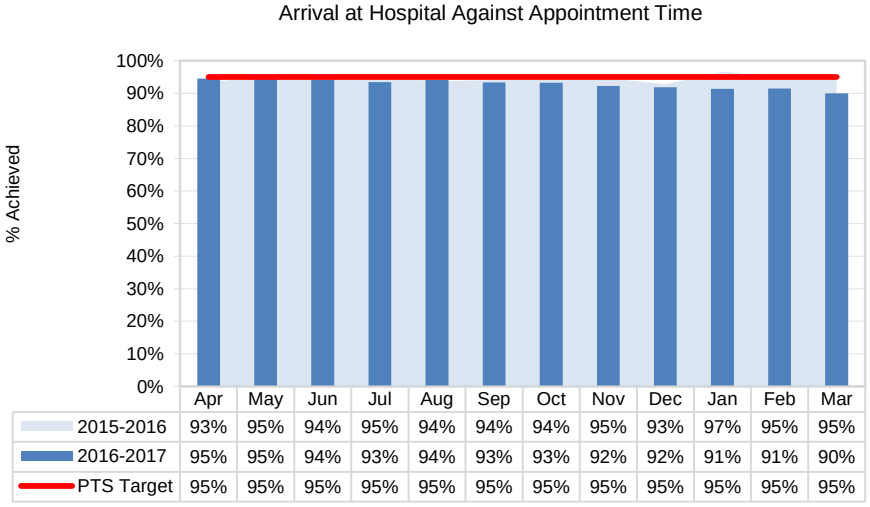


5,387 journeys were completed in March 2017, an increase from the previous month's total of 4,913 journeys.

At the end of March we will see another contract finish. One member of staff will TUPE to the new provider. Other staff have transferred either to NETs or to remaining contracts.

Month	2013-2014	2014-2015	2015-2016	2016-2017
Apr	15044	13227	8495	5478
May	15987	13164	7943	5602
Jun	14852	10129	8967	5797
Jul	16481	10508	8923	5631
Aug	14401	9028	5457	5705
Sep	15002	9602	6097	5565
Oct	16739	10957	5841	5723
Nov	15981	10063	5989	6433
Dec	13986	9250	4943	4980
Jan	16409	9753	5103	5266
Feb	15232	9787	5306	4913
Mar	13978	10520	5264	5387
Total	184092	125988	78328	66480

Patient Transport Service – KPI Update

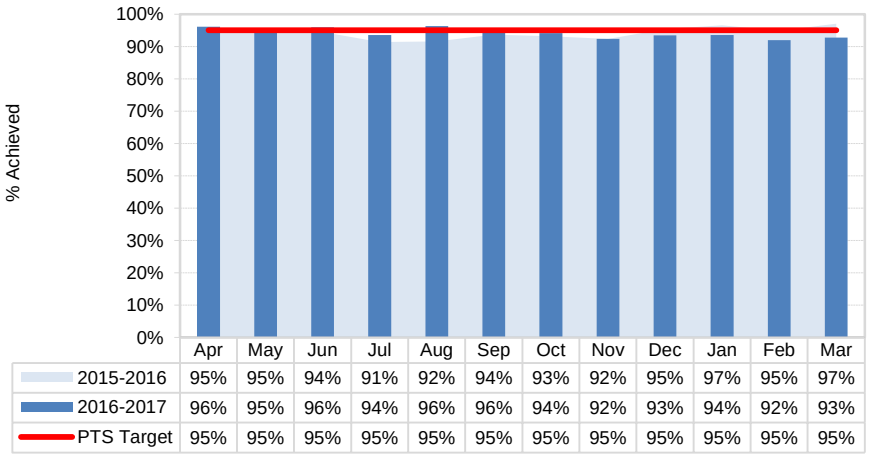


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-2016	93%	95%	94%	95%	94%	94%	94%	95%	93%	97%	95%	95%
2016-2017	95%	95%	94%	93%	94%	93%	93%	92%	92%	91%	91%	90%
PTS Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

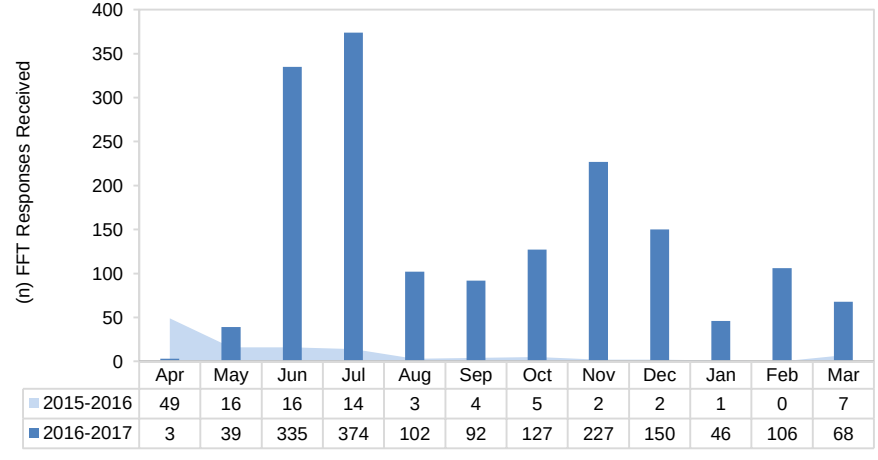
Performance against KPI's for the month are shown in graphs. The arrival KPI decreased to 90% down from 91% whilst departure KPI increased to 93% in March.

Quality Statistics will become more difficult to sustain as the impact of the closure of contracts and the fragmented operational model shrinks as a result.

The Friends & Family Test is only sent to new patients using the service in the month and as the overall activity reduces this is reflected proportionally in the number of returns.

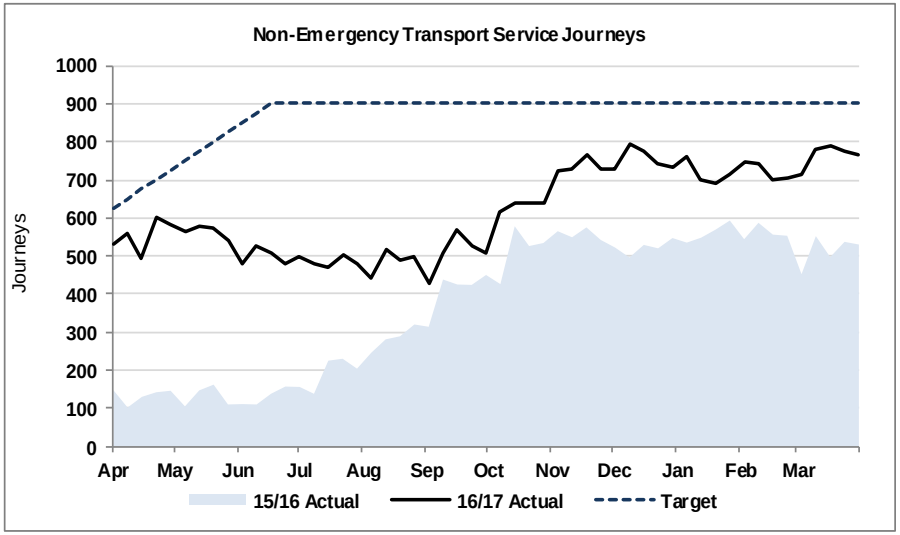


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-2016	95%	95%	94%	91%	92%	94%	93%	92%	95%	97%	95%	97%
2016-2017	96%	95%	96%	94%	96%	96%	94%	92%	93%	94%	92%	93%
PTS Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-2016	49	16	16	14	3	4	5	2	2	1	0	7
2016-2017	3	39	335	374	102	92	127	227	150	46	106	68

Non-Emergency Transport Service



Non-Emergency Transport Update

NETs saw an improvement in the month and delivered an average of 780 journeys per week for the month.

Throughout March, NETs overall performance has suffered due to increasingly lengthy handover times at hospitals along with the impact of a drop in the number of calls provided to NETs.

From the daily conference call, plans and reporting have been put in place to continue to increase the number of calls given to NETs and completed.

Week Commencing	Calls Conveyed	Calls Handed Back	Total Provided
23/01/2017	720	225	945
30/01/2017	761	215	976
06/02/2017	745	169	914
13/02/2017	705	188	893
20/02/2017	711	189	900
27/02/2017	718	209	927
06/03/2017	781	159	940
13/03/2017	796	118	914
20/03/2017	777	63	840
27/03/2017	770	165	935

Our Money

The Finance Report will be on the agenda of the Finance Committee.

CQUIN Schemes for 2016/17

The Commissioning for Quality and Innovation (CQUIN) framework supports improvements in the quality of services and the creation of new, improved patterns of care. These slides show the CQUIN schemes contained within the 2016/17 LAS contract and progress against milestones.

#	CQUIN Indicator title – Quarter 2 UPDATE	Annual value (% of contract)	Final indicator period	Milestone/ weighting (% available)	Progress Status Qtr 1	Qtr 2	Qtr 3	Qtr 4	Risk/ issue
1	**E-Solution 1**: Preparing the roadmap for LAS digital integration with London wide U&E Care **Quarter 2 deliverable/milestone**: Provide a quarterly update detailing project progress, to include an update on project plan, activity, assurance on progress and evidence of achievement of key milestones or deliverables and lessons learned	£871,371 (0.30%)	Final Period – Q4 2016-17	Q1 = 20% £174,274 Q2 = 25% £217,843 Q3 = 25% £217,843 Q4 = 30% £261,411					Qtr 3 commissioner report submitted (w/c 06/03/17). Qtr 3 funding potentially at risk. Commissioners requested further assurance - to be provided with Qtr 4 reports. Qtr 4 reports due 21st April.
2	**E-solution 2**: supporting a mobile workforce To seek to identify initiatives which will bring forward some benefits of the e-Ambulance digital healthcare initiative, to improve patient care and staff welfare and LAS service delivery. **Quarter 2 deliverable/milestone:** Provide a quarterly update detailing project progress, to include an update on project plan, activity, assurance on progress and evidence of achievement of key milestones or deliverables and lessons learned	£2,2178,428 (0.75%)	Final Period – Q4 2016-17	Q1 = 15% £326,764 Q2 = 25% £544,607 Q3 = 30% £653,528 Q4 = 30% £653,528					Qtr 3 commissioner report submitted (w/c 6/03/17). Awaiting feedback. Qtr 3 funding potentially at risk. Commissioners requested further assurance - to be provided with Qtr 4 reports. Qtr 4 reports due 21st April.
3	**E-learning development** - Supporting the move to a total workforce information approach, a review to identify a comprehensive learning management system. **Quarter 2 deliverable/milestone:** Provide a quarterly update detailing project progress, to include an update on project plan, activity, assurance on progress and evidence of achievement of key milestones or deliverables and lessons learned	£726,143 (0.25%)	Final Period – Q4 2016-17	Q1 = 30% £217,843 Q2 = 20% £145,229 Q3 = 20% £145,229 Q4 = 30% £217,843					Qtr 2 feedback - Commissioner concern over delays and query over achievement of Qtr 2 and Qtr 3 due to IM&T delay – further assurance on technology based CQUINs is required prior to approval. Qtr 3 - commissioner report submitted on 21st Jan. Further assurance provided at CQRG by Andrew Grimshaw. Pending update report from leads. Assurance paper required. Qtr 3 and Qtr 4 funding potentially at risk. Roll out delayed.
4	**Improving LAS focus on special patient groups:** Bariatric, Mental Health & Sickle Cell crisis **Quarter 2 deliverable/milestone:** Provide a quarterly update detailing project progress, to include an update on project plan, activity, assurance on progress and evidence of achievement of key milestones or deliverables and lessons learned	£435,686 (0.15%)	Final Period – Q4 2016-17	Q1 = 30% £130,706 Q2 = 20% £87,137 Q3 = 20% £87,137 Q4 = 30% £130,706					Qtr 3 achievement confirmed at CQRG meeting 28th March 2017. Qtr 4 reports due 21st April.

Key - RAG status

Red denotes: no or marginal progress made, appropriate evidence & documentation yet to be provided, funding is at risk.

Amber denotes: in progress, all appropriate evidence & documentation yet to be provided, funding at potential risk.

Green denotes: in progress, appropriate evidence & documentation provided, no evident risk to funding.

CQUIN Schemes for 2016/17

#	CQUIN Indicator title – Quarter 2 UPDATE	Annual value (% of contract)	Final indicator period	Milestone/ weighting (% available)	Progress Status				Risk/ issue
					Qtr 1	Qtr 2	Qtr 3	Qtr 4	
5	**Improving LAS Emergency Operations Centre**: supporting consistent delivery of improved patient care, patient safety, experience and outcomes and strengthening LAS governance and quality assurance processes. **Quarter 2 deliverable/milestone**: Provide a quarterly update detailing project progress, to include an update on project plan, activity, assurance on progress and evidence of achievement of key milestones or deliverables and lessons learned	£781,371 (0.30%)	Final Period – Q4 2016-17	Q1 = 20% £174,274 Q2 = 25% £217,843 Q3 = 25% £217,843 Q4 = 30% £261,411					Qtr 3 achievement confirmed at CQRG meeting 28th March 2017. Qtr 4 reports due 21st April.
6	**National CQUIN 1a (Opt B)**: The introduction of health & wellbeing initiatives covering physical activity, mental health & improving access to physiotherapy for people with MSK issues **Quarter 2 deliverable/milestone**: Provide a quarterly update detailing project progress, to include an update on project plan, activity, assurance on progress and evidence of achievement of key milestones or deliverables and lessons learned	£726,143 (0.25%)	Final Period – Q4 2016-17	Q1 = 20% £145,229 Q2 = % £ --- Q3 = % £ --- Q4 = 80% £580,914					No submission due in Qtr3 Qtr 4 reports due 21st April.
7	**National CQUIN 1b**: Healthy food for NHS staff, visitors and patients **Quarter 2 deliverable/milestone:** Provide a quarterly update detailing project progress, to include an update on project plan, activity, assurance on progress and evidence of achievement of key milestones or deliverables and lessons learned	£726,143 (0.25%)	Final Period – Q4 2016-17	Q1 = 20% £145,229 Q2 = % £ --- Q3 = % £ --- Q4 = 80% £580,914					No submission due in Qtr3 Qtr 4 reports due 21st April.
8	**National CQUIN 1c:** Improving the uptake of flu vaccinations for front line staff within Providers **Quarter 2 deliverable/milestone:** Provide a quarterly update detailing project progress, to include an update on project plan, activity, assurance on progress and evidence of achievement of key milestones or deliverables and lessons learned	£726,143 (0.25%)	Final Period – Q4 2016-17	Q1 = % £ --- Q2 = % £ --- Q3 = % £ --- Q4 = 100% £726,143					Qtr3 figures submitted. Commissioners have agreed limited exclusions but achievement likely to remain at 50% of available value. Qtr 4 reports due 21st April.
	Total Value (2.5% of contract value)	**£7,261,427**							

Our People

Section	Key Headlines	Mar	Feb	Jan

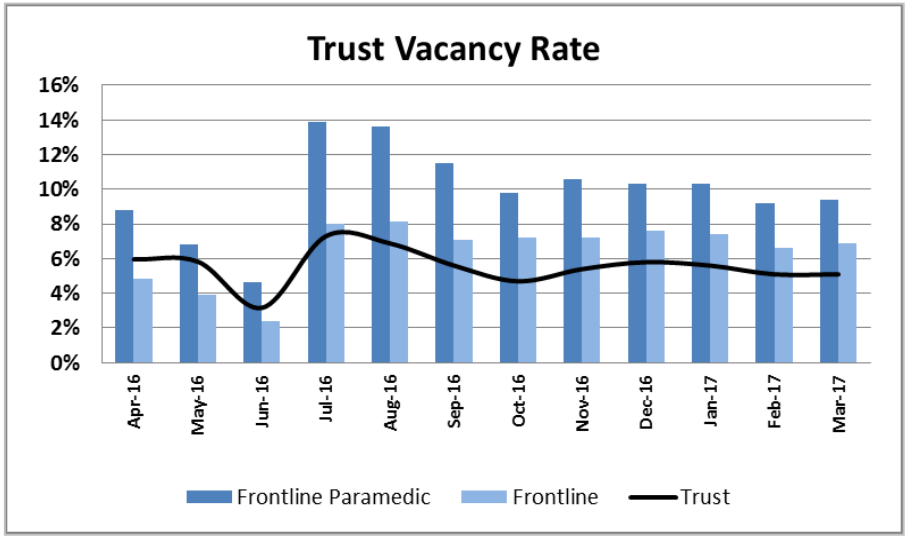
Vacancy and Recruitment	• The overall vacancy rate has remained at 5.1%.
	  • The vacancy rate for front line staff has increased from 6.6% to 6.9%.
	  • The vacancy rate for frontline paramedics has increased from 9.2% to 9.4%.
				

Turnover	• Trust turnover has remained at 9.8%.
	  • Frontline turnover has increased from 8.4% to 8.6%.
	  • Frontline paramedic turnover has increased from 8.8% to 9%.
				

Sickness	• Overall trust sickness has remained at 5.2% against a threshold of 5.5%. • Frontline sickness has remained at 5.7%. * Sickness is reported two months in arrears (as at 28th February 2017).			

Vacancy – Trust wide

	Establishment	In post	Vacancy wte	Vacancy %
Trust Total	5,200.1	4,935.4	265.4	5.1%
Total Frontline	3,372.7	3,140.4	232.5	6.9%
Paramedic	2,088.5	1,892.9	195.64	9.4%
Apprentice Paramedics	85	99.1	-14.1	-16.6%
EAC / TEAC	773.2	794.1	-20.9	-2.7%
EMT & support tech	426.0	354.1	71.9	16.9%
EOC staff on watches	378.0	382.3	-4.3	-1.1%
Other staff (Corporate, 111, NETS, PTS, Admin)	1,449.1	1,412.9	36.1	2.5%



Paramedic Recruitment

The Trust had a successful trip to Australia and have made offers to 185 iParamedics. This group are expected to start in Q4 2017/18.

In March we had 20 iPara starters and we have 12 UK Graduates starting in April. The Trust also recruited seven qualified paramedics and 16 UK graduates from the partner universities.

We continue to advertise monthly for paramedics and hold monthly assessments and interviews.

We have visited our four partner universities to run application and interview workshops to ensure as many UK graduates as possible make LAS their employer of choice.

Source of data: Financial Ledger.

Trainee Emergency Ambulance Crew Recruitment

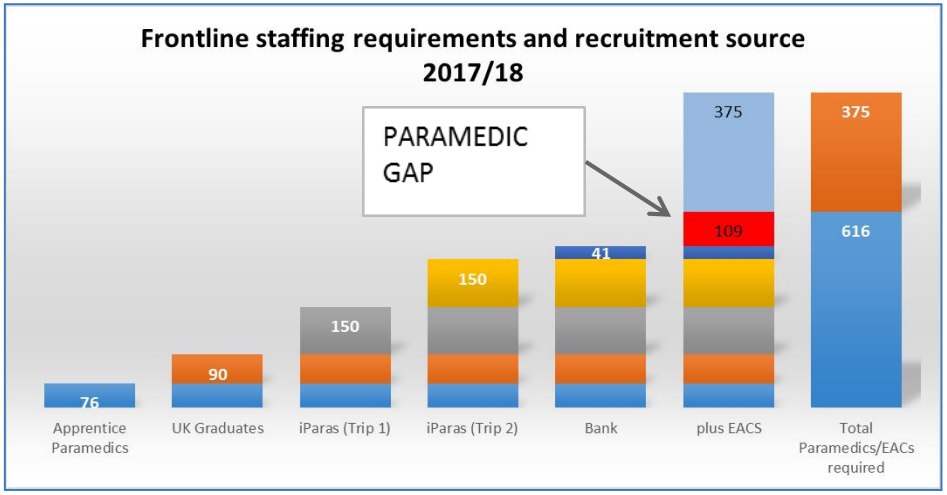
Our current pipeline has 326 applicants going through the recruitment process. We continue to advertise locally to support sector based vacancies i.e. North West / North Central.

We attended the London Job Show on 31st March and 1st April and attracted over 550 expressions of interest for positions at the LAS.

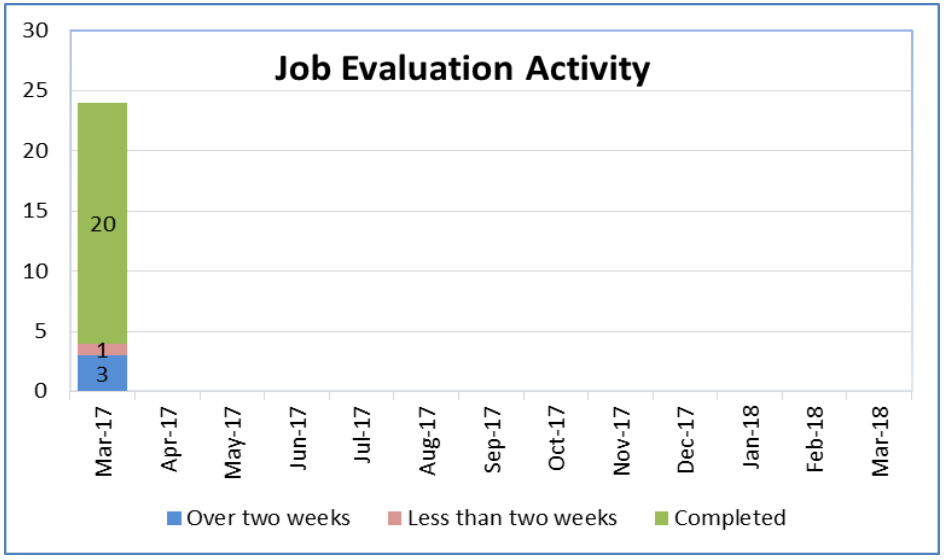
EOC recruitment (Emergency Medical Dispatchers)

There are Trainee EMD courses in May, June and July. We have a monthly rolling advert and hold regular assessments and interviews. We had an EMD open evening in April which attracted over 30 potential applicants and we have a further 25 booked for May.

Job Evaluation/Workforce Planning



- The 2017/18 frontline recruitment plan has been developed and has identified an estimated requirement of 616 paramedics and 375 T/EACs. 300 paramedics are expected to come from Australia, 90 from the UK plus 76 from the LAS Academy.
- Modelling capability has been created to enable evaluation of changes in demand, skill mix and turnover. Work is underway to consider how other variables can be added including the impact of the Ambulance Response Programme and any changes in efficiency.
- Other clinical professions and support services are to be incorporated.
- The 109wte gap is based on the current skill mix and a worst case turnover assumption for our iPara cohorts.

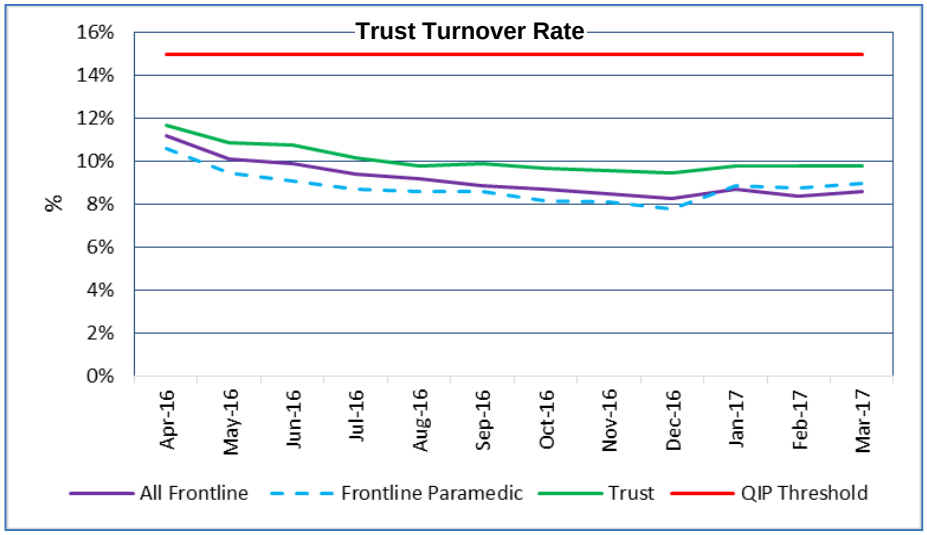


- The timeliness of the job evaluation process has a direct impact on the recruitment time to hire process. We have developed a KPI which monitors both the volume and performance against a two week timescale and this will minimise any delays to the recruitment process.
- In the last 12 months 72 new job descriptions have been banded plus there have been a large number of re-bandings.

March 2017

- Number submitted in March – 4 new, plus 20 resubmitted for re-banding.
- Number outstanding as at 31st March 2017 **–** 4.
- Number over two weeks – 3.

Turnover – Trust wide



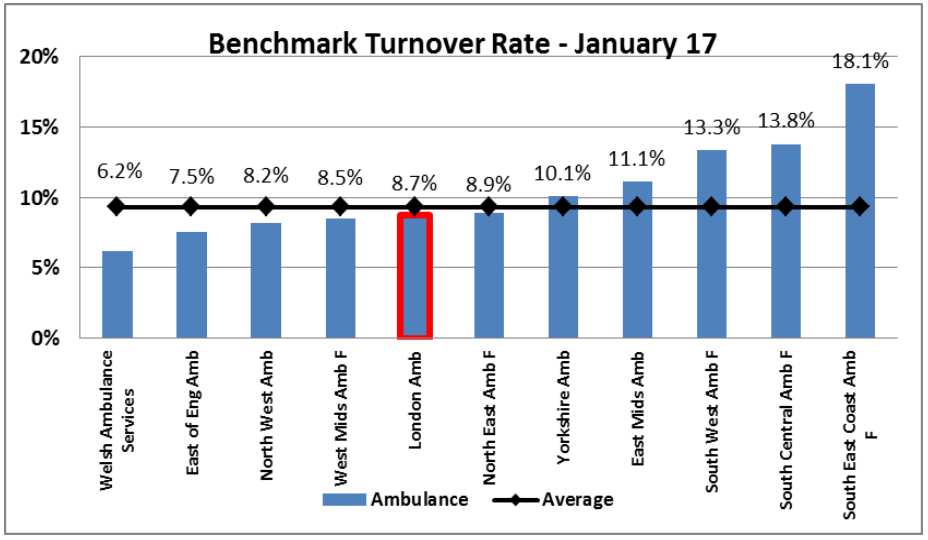
Trust Turnover

There were a total of 46 leavers in March. This includes 7 EOC staff and 26 frontline leavers. The frontline leavers include 17 paramedics, 3 EMT4s and 6 T/EACs. 10 of the paramedic staff are relocating, 5 of whom are international staff.

Frontline turnover has increased from 8.4% to 8.6% and Frontline paramedic turnover has increased from 8.8% to 9%.

The total Trust turnover has remained at 9.8% (12 month rolling figure).

It is has been agreed with Senior HR colleagues that all paramedic leavers (not only iParas) are invited for an exit interview with local HR. These teams will work with their Group Station Managers and Team Leaders to encourage discussions in determining their future plans and aspirations. This should form part of the appraisal review process, ideally on a quarterly basis.



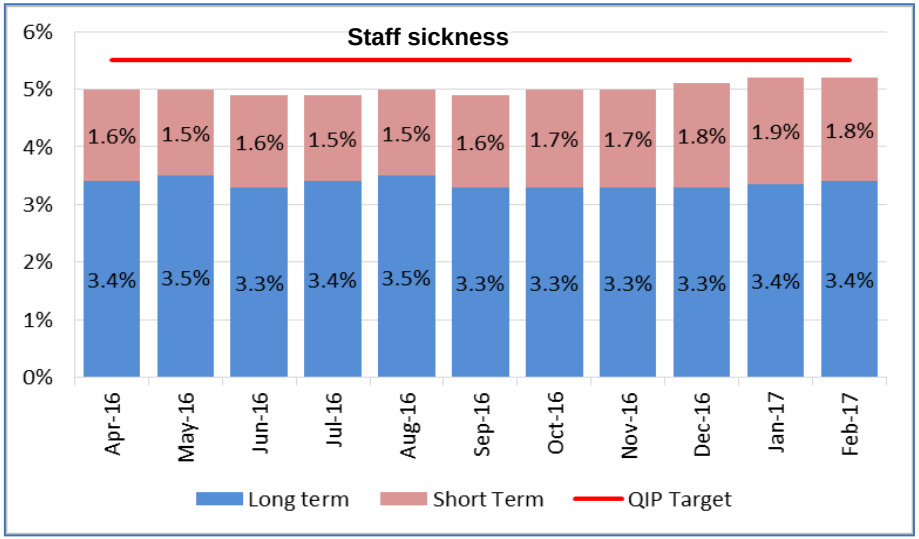
Trust Turnover

This graph shows the 12 month rolling turnover rate for all 11 Ambulance Trusts.

The London Ambulance Trust has the 5th best turnover rate, down from 4th in the previous month. The LAS is below the national average of 9.31%.

Source of data: NHS Health and Social Care Information Centre – data as at 31st January 2017.

Sickness Absence – Trust level



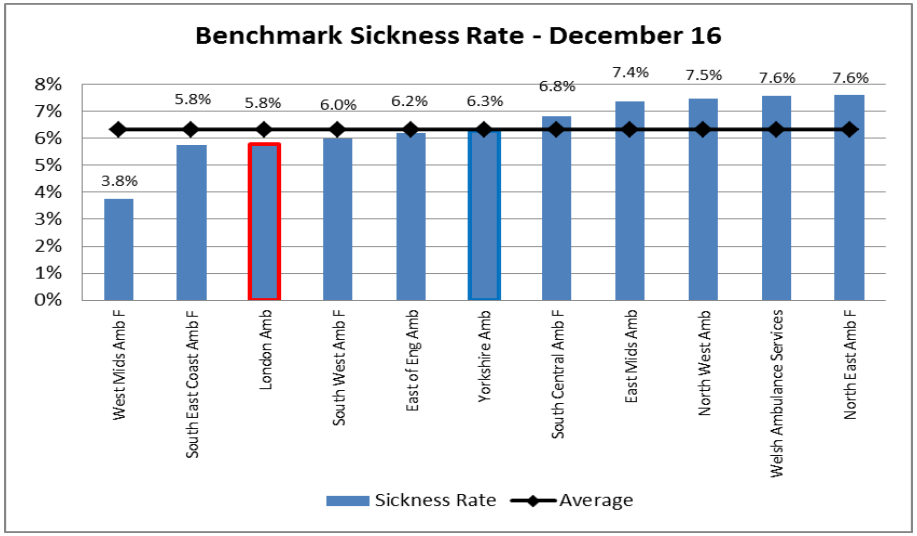
Trust Sickness

The LAS sickness level has remained at 5.2%. This is equal to 92,591 days lost or an average of 18 days for each of our 5,185 staff (for the 12 month period).

Long-term sickness is any episode of sickness of 28 days or more duration. It accounts for 65% of days lost and 12.4% of episodes (892 episodes).

Frontline sickness has remained at 5.7%.

Sickness rates per Sector	February 17	January 17
North Central	6.02%	6.19%
North East	7.08%	6.90%
North West	4.28%	4.30%
South East	5.45%	5.53%
South West	5.88%	5.82%



Trust Sickness

This graph shows the sickness rate for all 11 Ambulance Trusts.

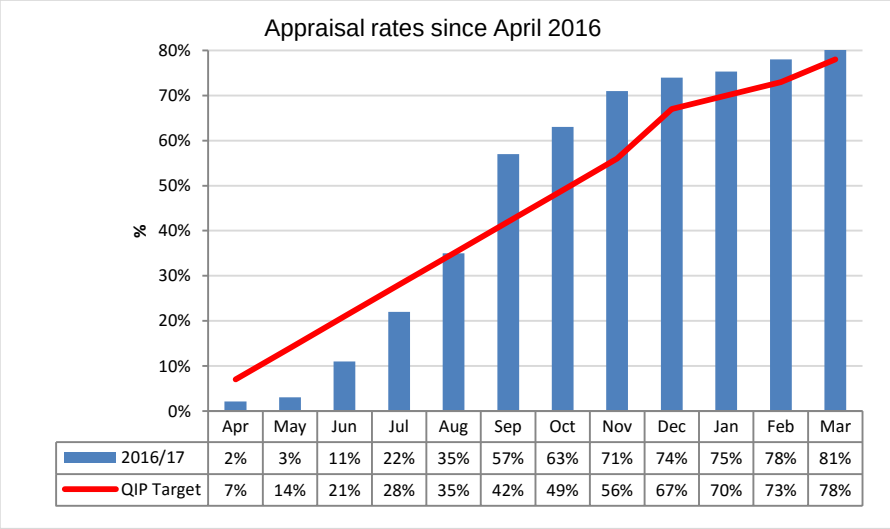
The London Ambulance Service has remained in 3rd place.

The LAS is below the national average of 6.3%.

Source of data: NHS Health and Social Care Information Centre – data as at 31st December 2016.

NB. Please note that a different formula is used by HSCIC to calculate sickness rates. All Trusts are therefore showing a slightly lower % than their local reporting.

Appraisals and Disclosure & Barring Service (DBS)



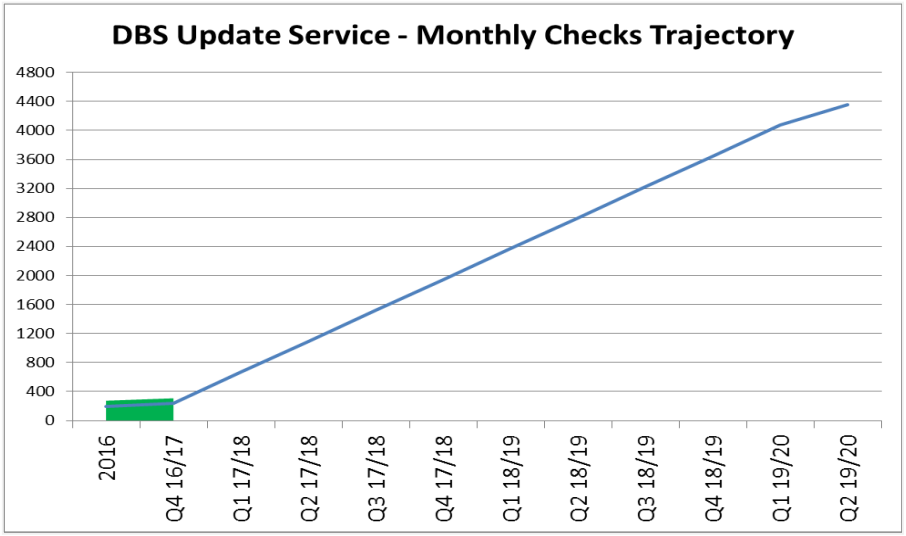
Appraisals

Since April there have been 3,666 appraisals completed (81.3% compliance). Operations have completed 80% of appraisals, Corporate 93%.

In line with most other NHS Trusts, we will be reporting our PDR Appraisal compliance on a 12 month rolling basis from April 2017. This will enable the Trust to build on our highest ever end of year performance of 81.3% compliance.

The weekly appraisal compliance report has been enhanced to support managers to prioritise their PDR Appraisals.

NB. Please note that these figures exclude those on long-term sick leave, career break, maternity leave and those who have worked for less than 9 months at the LAS.



Disclosure and Barring Service

We have exceeded the planned number of DBS re-checks for 2016 and our trajectory for Q4 16/17 is on plan.

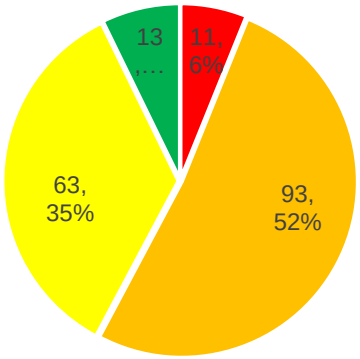
The plan remains to complete the 4,500 checks by September 2019 (three years). To meet this target we need to ensure that 142 applications are in progress with the DBS each month.

We have communicated the new process to HR and local management teams who will be supporting the process. These teams are best placed to identify staff availability and can escalate any resourcing or compliance issues.

All starters from 1st April 2017 have a contractual term which requires them to sign up to the DBS Update Service. All recruitment adverts also highlight this requirement.

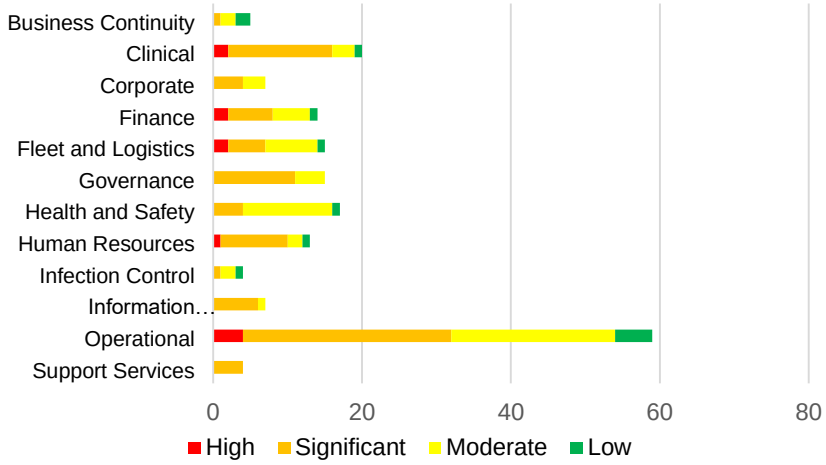
OUR RISKS

Trust Risks by Risk Level



	Risk Rating	Risk Level	Risks	
	15-25	High	11	6%
	8-12	Significant	93	52%
	4-6	Moderate	63	35%
	1-3	Low	13	7%
		Total	180	

Risks by Subtype



The Trust's risks are escalated via an established governance framework of committees, from local level meetings to the Trust Board. Thresholds are set for local, Trust, and Board Assurance level risks. They are reviewed and monitored at the appropriate committee meeting as set out in the Trust's Risk Assessment and Reporting Procedure.

Risks qualifying for inclusion for the Trust Risk Register (risks with a net score of 10 and above) and risks qualifying for inclusion on the Board Assurance Framework (risks with a net rating of 15 and above) need to be approved by the Risk Compliance and Assurance Group (RCAG) which currently sits monthly and reports into ELT.

The RCAG also has responsibility for approving the de-escalation of risks currently included on the Board Assurance Framework and Trust Risk Register. Compliance with management of risk at all levels is reviewed by the RCAG. A status report of local risk management is provided to the group and areas of non-compliance are highlighted to and escalated via the RCAG on a regular basis.

There has been a Quarter 4 local risk register review, undertaken in March which reported into RCAG and identified areas of escalation areas where required. The Governance Team are working with risk coordinators and leads across all departments to assist them in ensuring their risks are updated on a regular basis in line with their net rating.

Feedback has been provided to each area on their risk registers and they have been invited to either attend a drop-in session or a meeting to facilitate their risk discussions.

The register of risks approved showed the following at 10th April:

• Over half of the Trusts risk register has a risk level of High or Significant (58%) an increase of 1% on the previous month.

• Just over half of the overall Trusts risks are Operations risks (56%), with Finance risks accounting for 12% and Governance risks 10%.

• There are 10 risks with a risk level of High, these sit in Finance (4), Operations (3), Medical directorate (Clinical) (2) and IM&T (2). 2 of these risks are rated at 20 out of 25.

These charts reflect the trust risks by risk level and risk subtype. These are the approved risks rated 10 and above approved by RCAG and risks 9 and below which have been locally approved as at 10th April 2017.

Our Risks

The following risks are rated between 15 and 20 out of 25 as at 18th April 2017.

Description	Controls in place	Assurance	Last review date	Risk Subtype	Rating (current)	Risk level (current)
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.	1. Demand predictions for future years are robust and understood, both for annual value and monthly, daily and weekly profiles 2. Clear view on operational capacity required to deliver ambulance performance targets 3. Clear view of achievable productivity targets which support performance targets 4. Clear view of operational staff recruitment against establishments targets as set. Clear sight these targets can be delivered 5. Funding from CCGs is consistent with capacity, productivity and demand assessments 6. Other factors such as investment for CQC are clearly understood, and associated funding identified 7. NHS wide efficiency targets can be achieved, and other opportunities to generate efficiency are identified, managed and delivered. 8. Inflationary pressures are understood and managed within the overall financial position 9. Capital investment plans and their revenue consequences are understood.	Assurance of Finance Risks are provided via regular review of controls from the Finance and Investment Committee	22/03/2017	Finance	15	High
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.	1. Appropriate supporting evidence available for CIP. 2. All CIPs supported by detailed milestone plan. 3. All CIPs embedded in budgets. 4. All CIPs owned by relevant manager. 5. Benchmarking of CIP opportunity. 6. CIP governance clearly defined and in place. 7. Board/FIC scrutiny of CIP planning and delivery in place. 8. CIPs delivering in line with expectations. 9. Capacity and capability available to support delivery. 10. All CIPs supported by Quality Inputs Assessments.	Assurance of Finance Risks are provided via regular review of controls from the Finance and Investment Committee	23/03/2017	Finance	20	High
There is a risk that the agreed A8 trajectory for 16/17 may be adversely affected by sustained over-activity against contractually agreed growth.	1.CCGs have been directed to develop action plans to reduce activity by 5% by 1st January 2017 2.Surge Plan 3.REAP 4.OOS hub 5.Clinical Hub 6.Dispatch on Disposition 240 seconds implemented on 4th October 2016 7.Static defib performance recovery group 8.Non-clinical vacancy freeze and financial controls implemented in order to target additional spending at operational capacity 9.Sickness management on-going 10.Removed cat C determinants from FRU	NHSE regional oversight group monthly review (1) NHSI Performance oversight group monthly review (1) Strategic commissioning management board monthly review (1) Service Delivery Group (2, 3, 4, 9, 10) A&E Resource Group (9)	15/03/2017	Operational	20	High

London Ambulance Service
NHS Trust

INTEGRATED PERFORMANCE REPORT – TRUSTBOARD EXECUTIVE SUMMARY

Abbreviations & Glossary

Integrated Performance Report – Abbreviations & Glossary

Acronym	Meaning / Description
A19	Category A incidents requiring a 19 minute response
A8	Category A incidents requiring an 8 minute response
ADO	Assistant Directors of Operations
APP	Advanced Paramedic Practitioners
AQI	Ambulance Quality Indicator
BME	Black and Minority Ethnic
CARU	Clinical Audit and Research Unit
CCG	Clinical Commissioning Group
CD	Controlled Drugs
CDLO	Controlled Drugs Liaison Officers
CISO	Clinical Information & Support Overview
CPI	Clinical Performance Indicator
CQUIN	Commissioning for Quality and Innovation
CRL	Capital Resource Limit
CRU	Cycle Response Unit
CSR	Core Skills Refresher (Training)
DBS	Disclosure & Barring Scheme
DOC	Duty of Candour
EAC	Emergency Ambulance Crew
ED	Emergency Department
ELT	Executive Leadership Team
EMD	Emergency Medical Dispatcher
EMT	Emergency Medical Technician
EOC	Emergency Operations Centre
ESR	Employee Service Record
FAST	Face, Arm, Speech, Time (Indicators of a Stroke)
FFT	Friends and Family Test
FLACC	Face, Legs, Activity, Cry, Consolable - paediatric pain scale
FRU	Fast Response Unit

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

Integrated Performance Report – Glossary

Other Terminology	Meaning
Green ambulance outcomes	Lower acuity ambulance outcomes

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

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

Audit Committee 18th April 2017
Assurance report to the Trust Board

Two main items of business were considered at the Audit Committee meeting:

- Internal Audit and Counter Fraud plans for 2017-2018 and progress report
- Draft Annual Accounts for 2016/2017

Internal Audit and Counter Fraud Service

The internal audit and counter fraud plans for 2017/18 were approved by the Audit Committee after taking into consideration comments from the members of the Committee and the Executive Team. The plans for 2017/18 are proposed after taking into account an assessment of the risks faced by LAS and include mandatory reviews for the Head of Internal Audit opinion (e.g. core financial controls) and optional reviews (e.g. cyber security).

A progress report on audit plans for 2016/17 showed that all reviews have now been completed. The recommendations tracker indicates a further improvement to implementation of recommendations with 25 overdue (40 overdue on last report).

Five reports were received after Internal Audit review with the following levels of assurance:-

1. Cost Improvement Plans

Partial assurance with improvement required.

Seven recommendations were made (two high priority)
This report will be further discussed at the May Audit Committee meeting.

2. Data Quality and Performance Reporting

Significant assurance

The report provides assurances that the Trust operates an extensive data quality process and Jill Paterson and her team are to be congratulated on this assessment.

3. Freedom to Speak up

Significant assurances with minor improvement opportunities

The report concludes that the Trust is broadly in line with best practice identified in Francis's Freedom to Speak up Review but with some clarification required on the recommendations made this report will be brought back to the May Audit Committee meeting.

4. Information Governance Toolkit report

Significant assurances

A very positive report with only one low priority recommendation.

5. Clinical Audit report

Significant assurance with minor improvement opportunities.

This positive report will be further discussed at the Quality Assurance Committee.

Draft Annual Accounts 2016/17

The draft Annual Accounts for 2016/17 were reviewed by the Audit Committee and approved for submission to NHSI by the due date of 19th April 2017. They are subject to further adjustment when the final Sustainability and Transformation Fund (STF) allocations are known (expected 24th April 2017), with a further submission then to NHSI on 26th April 2017.

The Accounts will now be subject to External Audit examination, with the final audited accounts set for review by the Audit Committee on 25th May 2017 and adoption by the Trust Board on the same date.

John Jones
Chair of Audit Committee

London Ambulance Service NHS Trust

Report to:	London Ambulance Service NHS Trust Board
Date of meeting:	Tuesday 25th April, 2017
Document Title:	London Ambulance Service NHS Trust 2017/18 Business Plan
Report Author(s):	Karen Broughton; Adam Levy; Nikki Fountain
Presented by:	Karen Broughton, Director of Transformation, Strategy and Workforce
Contact Details:	Nikki.fountain@lond-amb.nhs.uk / adam.levy@lond-amb.nhs.uk
History:	Executive Management Team working sessions / Trust Board Meetings (28th February 2017 / 28th March 2017)
Status:	For Approval

Background/Purpose

Following the discussion of the 2017/18 Business Plan goals at the recent Strategy, Review and Planning session (SRP) and the Trust Board meeting in March, further work has been undertaken by the Executive Leadership Team to identify the key business objectives for 2017/18.

At the March Trust Board, four overarching Goals were agreed for the Business Plan:

- 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 2017/18. It identifies the objectives that will be delivered under goal, financial, workforce and activity plans; provides a strategic risk assessment and identifies outcome measures. The recommended governance of the business plan is also included.

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

- Facilitate engagement sessions across the Trust by the end of May 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
Although no specific risks have been raised regarding the Business Plan in its entirety, Directors have been requested to risk assess each of their objectives. These are currently summarised in the Business Plan, and will be added to the Board Assurance Framework or Trust Corporate Risk Register dependent on the net scoring assigned.

Key implications and risks in line with the risk appetite statement where applicable:	
Clinical and Quality	The 2017/18 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	

London Ambulance Service NHS
NHS Trust

OUR 2017/18 BUSINESS PLAN

Contents

Executive Summary

The London Ambulance Service (LAS) is the busiest ambulance service in the UK and one of the busiest in the world. Demand for our services is increasing; in the year ahead we expect to support more than 1.8 million patients across London, seeing 1.1 million patients to provide care.

London and the needs of the population are changing:

- London's population is predicted to rise from 8.7 million in 2016 to 10 million in 2029[1]
- 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) recent *Call to Action* stated 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]

These are just some of the ways that London will continue to change and it is clear that we will need to transform our services over the coming years, working increasingly with our partners to ensure that the health service works together to meet London's health needs.

Improving the quality of our services will remain a key focus for the Trust Board over the coming year with a strengthening of quality governance systems, processes and structures, with a further report from the Care Quality Commission expected in the summer to support our quality improvement journey.

Our talented and caring people are critical to our success and this year we will launch a new People and OD Strategy to make the London Ambulance Service a great place to work for them. Leadership will be strengthened and supported with development programmes which we will co-design with our managers.

Financially, we face a challenging year ahead and our focus will be on ensuring value for money and sustainability in all we do, as well as on delivering our financial plans and standards.

[1] GLA - 2015 round trend-based population and household projections.
[2] NHS England (London) *Call to Action*
[3] MIND
[4] www.alzheimers.org.uk
[5] Mayor of London – 'The London Plan 2016'

Over the last two years we have regrettably not met the national ambulance targets. We have worked hard over the past year to set a solid foundation for performance improvement and this year we will hit the current national ambulance targets from October 2017.

Working in partnership is essential for our success. In the year ahead we will support the five London STPs to realise their vision for healthcare improvements locally. 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 through working together where is it 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, setting strategic themes and a portfolio of initiatives to deliver these.

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
- In partnership with STPs and 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 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
- We have met our financial targets and have delivered £18m of CIPs
- We have met our national performance targets
- We have reset our focus with key strategies in place (Trust Strategy, Estates & Fleet) to guide our organisation
- We are no longer in special measures and are working towards a “Good” CQC rating

The year ahead looks to be an exciting time for the London Ambulance Service. 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.

Andrew Grimshaw
Chief Executive

Heather Lawrence, OBE
Chairman

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

The London Ambulance Service Today

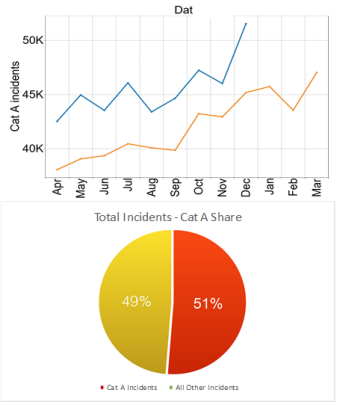
The London Ambulance Service (LAS) is the busiest ambulance service in the country and one of the busiest in the world; with demand for our services increasing year on year. Last year we responded to over 1.9m 999 calls, attending 1.1m incidents. Despite yearly increases in demand, the Trust maintains 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 as the capital city is home to the heart of central government, the financial district, royal residencies, high profile landmarks and tourist attractions, where extremes of wealth and poverty sit side by side. Major transport hubs operate throughout the city, and each year London hosts a large number of high profile events, including state visits, royal occasions and sporting events. London's culturally diverse population swells each day with people who work in or visit the city.

Demand is increasing

Total incidents 1,115,518 – up 6.6% from last year
(comparing 2015/16 to 2016/17)

Cat A incidents 548,892 – up 8.8% from last year
(comparing 2015/16 to 2016/17)



1.83m calls
Demand for our services increase year on year, last year we responded to over 1.9m calls and 1.1m incidents

Growing number of frail elderly people with complex health needs are living alone, and therefore more likely to call upon the LAS

4,893 staff
63% of which are frontline
Our staff are changing – more graduates, more women, higher expectations, no longer a "job for life"

Average job cycle time is **86 minutes**

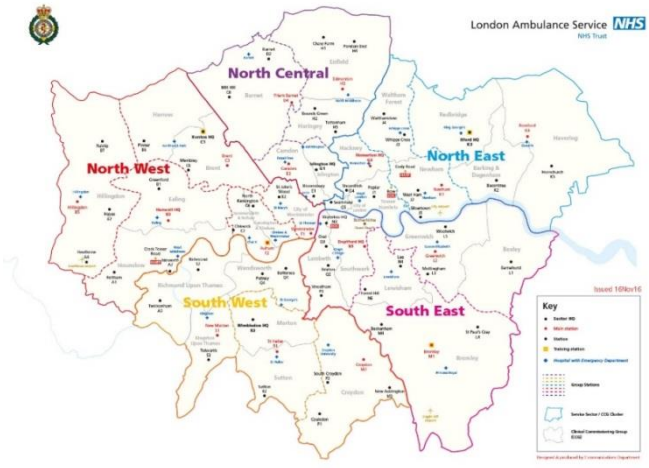
Average time with a patient is **47 minutes**

Pan-London Service

Patients with dementia, mental health needs and obesity provide increasing challenges for our services

Employing just over 5300 staff, our frontline services are structured to support the 5 sectors of London; ensuring we deliver a pan-London service whilst responding to local need.

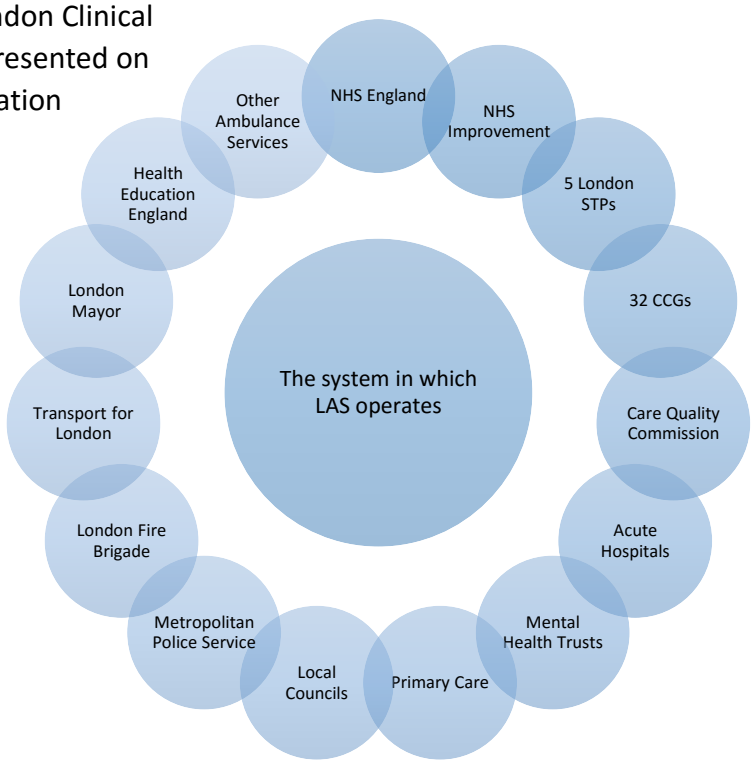
We operate out of 70 sites across the 620 square miles of London.



As the only pan-London NHS Trust, we work with a wide variety of partner organisations and as part of a complex NHS and public sector system.

We are jointly commissioned by the 32 London Clinical Commissioning Groups (CCGs) and are represented on London's five Sustainability and Transformation Plans.

We work in close partnership with the Metropolitan Police Service and the London Fire Brigade on a blue light collaboration programme with the overall aim of making London the safest global city.



How our plans for 2017/18 have been shaped

The Trust experienced a challenging year in 2016/17, not achieving performance against national ambulance targets and being placed in special measures following the Care Quality Commission's (CQC) inspection in June 2015.

Following the CQC's inspection, we launched our Quality Improvement Programme (QIP) and made significant changes and improvements during 2016/17 across five overarching work streams:

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

The aim of the Quality Improvement Programme was to make the LAS great for patients and great for staff.

We aimed to make LAS great for patients by:

- Improving the way we lead the organisation
- Improving our response
- Improving safety and clinical effectiveness
- Ensuring we learn and improve
- Making sure we meet our patients needs
- Having a clear direction for our service
- Ensuring our clinicians have the equipment they need to do their jobs

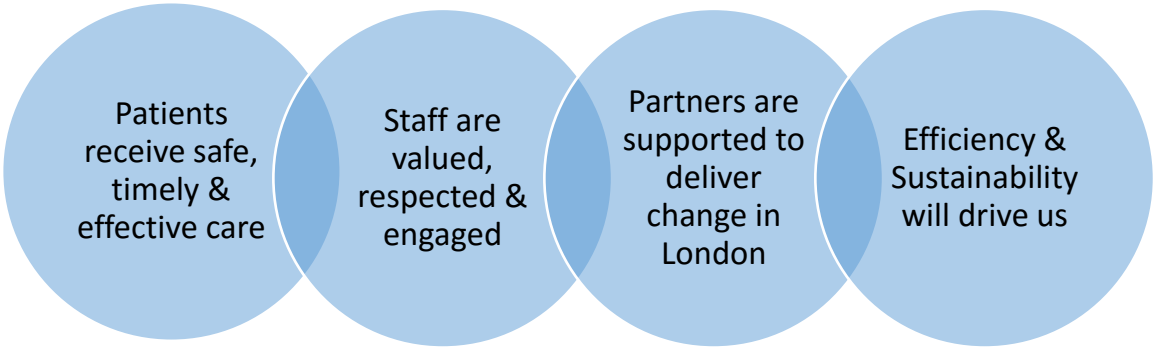
We aimed to make LAS great for staff by:

- Recruiting to vacancies
- Valuing, supporting and recognising our staff
- Working to improve our diversity and culture
- Strengthening career progression and education and training
- Engaging our staff in the development of the Service

95% of the objectives in the Quality Improvement Programme were achieved and our 2017/18 Business Plan looks to build on the improvements that have been made over the past 12 months to continue our journey of improvement. We have undertaken an analysis of the Quality Improvement Plan and identified any objectives that were not achieved in full and, where relevant, carried them across either into the 2017/18 Business Plan.

Our 2017/18 Goals

The Trust Board has set four overarching goals for 2017/18:



Within each of these goals, a number of objectives have been identified which will form the basis of the Trust's work plan for 2017/18.

Each objective has been developed in a variety of ways:

- Direction set by the Trust Board
- Using initial feedback received from our February 2017 CQC inspection
- Feedback received from the LAS Top 400 Managers Forum
- Engagement with the LAS Leadership Forum
- Feedback from the staff survey
- Analysis of performance and key performance indicators
- Executive Leadership Team meetings and away-days
- Analysis of the Quality Improvement Programme (QIP)

Our Plans to Achieve our Goals

Goal One: Patients receive safe, timely & effective care

Whilst we have been challenged over the last two years in meeting the national ambulance performance target, our priority has always been to ensure we get the right response to our sickest patients as quickly as possible. This year we will review our operating model, encompassing any national changes, to shape the way we provide care to our patients, improve quality and ensure the best possible outcomes for patients.

Our new five year Clinical Strategy, of which 2017/18 is its first year, outlines the transformative ways we will improve how we care for patients in an integrated urgent and emergency care system.

To achieve this goal:

- By May 2017, we will Improve the way the Trust collectively learns, creating a learning framework which sets out the systems, processes and structures for continuous improvement
- By June 2017, we will have strengthened our governance processes with a new Quality Governance Assurance and Learning Framework across the Trust
- We will agree a quality improvement plan to respond to the anticipated CQC report and share this at the CQC Quality Summit in Summer 2017
- By July 2017, we will have agreed our new multidisciplinary skill mix model, recruiting to frontline vacancies throughout the year
- We will roll out hand held devices between July and 2017 and March 2018, so that our frontline crews can have better information to treat patients and we provide better joined up care
- By October 2017, we will move to vehicle based equipment and drugs
- By March 2018, we will deliver all elements of the 2017/18 patient engagement work plan
- By March 2018, we will have transformed the way we run our 111 service, improving integration with 999
- By March 2018, we will have completed the implementation of the EOC review
- By March 2018, we will have implemented year one actions of the Clinical Strategy, comprising of four main areas of delivery: improving care for the sickest and most

seriously injured patients; development of integrated and urgent care; sharing learning; and improved governance

- By March 2018, we will have undertaken and implemented a Trust-wide roster review to better meet the needs of our patients and staff

- By March 2018, we will deliver the digital solution to support delivery of the National CQUIN "Ambulance Conveyance: To enable a reduction in the proportion of ambulance 999 calls that result in transportation to a type 1 or type 2 A&E Department."

- Throughout the year we will deliver the second phase of medicine management improvement

Goal two: Staff are valued, respected & engaged

Our staff are our greatest asset and over the coming year we will continue to work hard to make sure that LAS is a great place to work. Our new People and OD Strategy will outline our priorities for the next three years. Diversity will be a cornerstone of our recruitment, training and progression initiatives so that we become more representative of the communities we serve.

To achieve this, by the end of 2017/18 we will:

- By June 2017, we will establish a pipeline for future paramedics, either via the LAS Academy or through University partnerships

- In July 2017, we will launch our People and OD Strategy to outline our workforce priorities for the next three years

- By July 2017, we will implement new rest break and end of shift arrangements to support frontline staff

- We will introduce new annual leave arrangements by end of July 2017 to better match activity demand with staff needs

- By September 2017, we will define our desired culture and introduce a staff charter, together with annual corporate management actions so that staff and manager's know what they can expect from the Trust and what is expected of them

- By September 2017, we will have in place a clear Leadership Development Pathway across the Trust

- By September 2017, we will strengthen our Operational Management structure to improve support to our frontline, and ensure management accountability is clear and in place

- By September 2017, we will have put in place a Board Development Programme to address board development needs including CQC and well led feedback

- By March 2018, we will have delivered the recruitment plan to fill the frontline rosters

- By March 2018, we will have designed and implemented new Talent Management arrangements to improve retention and succession planning

- By March 2018, we will meet the national CQUIN requirements to improve the health and wellbeing of our people

- By March 2018, we will complete phase four actions to tackle bullying and harassment

- 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 the communities we serve

Goal three: Partners are supported to deliver change in London

We deliver the best possible care to our patients by working as an integral part of the wider NHS and public sector systems. In the year ahead, we will work proactively in each of the five London STPs, using our unique position as the only pan-London Trust, to positively influence improvements in Urgent and Emergency Care across London. We will work with our Emergency Services partners to develop efficiency savings and service improvements where it is in the public interest to do so.

To achieve this, by the end of 2017/18 we will:

- Throughout the year we will develop appropriate care pathways in partnership with STPs and Clinical Commissioning Groups to ensure patients are taken to the most appropriate setting of care

- We will work with London's five STPs to co-design and support delivery of demand management initiatives across London including: appropriateness of referrals between 111 and 999 services; services to support frequency callers; referrals from healthcare professionals to 999; support required by Care Homes in London

- In partnership with our Blue Light colleagues, other NHS organisations and Ambulance Services we will maximise value for money from the public purse through working together where is it in the best public interest to do so, for example procurement, sharing estates and services

- Influence health improvement and redesign across London through our active engagement in the five London STPs

Goal four: Efficiency & sustainability will drive us

We will continually review what we do to make sure that it is still required and that we are doing it in the best way possible. As demands on our service rise, we are committed to improving our efficiency as well as playing our part in meeting the NHS' financial challenge. Our annual Cost Improvement Programme will support our continued drive for efficiency across the Trust and we will ensure that, whilst change is delivered at pace, the changes that we are making are sustainable and embedded throughout our organisation.

To achieve this, by the end of 2017/18 we will:

- 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 June 2017, we will outline our fleet requirements in a new 5 year Fleet Strategy and commenced the implementation of our year one actions

- By June 2017, we will have defined our Estates requirement for the next five years and commence the implementation of our year one actions

- By July 2017, we will launch the Trust's 5 year strategy to reflect changing needs of patients and STPs across London

- By October 2017, we will review corporate and support functions to drive efficiency through simplified processes, systems and structures, linking with STP and Blue Light services as appropriate

- By March 2018, we will have implemented new business continuity plans throughout the Trust to ensure business critical functions are maintained at all times

- By March 2018, we will have delivered year one IM&T strategy actions including a review of IM&T systems and services which will see delivery of improvements across the year

- Ensure processes are put in place to ensure CIPs are identified and delivered across multiple periods

Cross Cutting Priorities

The objectives outlined in the preview pages identify our objectives for 2017/18. However there are a number of high level, cross-cutting priorities which are contributed to by a number of the objectives.

Job Cycle Time (JCT)

Our Job Cycle Time has increased over the last few years. As part of our 2017/18 – 2018/19 contract with our commissioners we have agreed to reduce JCT by 7 minutes by October 2017.

All objectives that have an impact on our clinical model, our operating and response model, actions to reduce demand or increase capacity or objectives that reduce administrative tasks that frontline crews need to carry out, will all impact upon our overall Job Cycle Time.

Workforce Race Equality Scheme (WRES)

We have identified that in order to better represent the communities we serve, we need to improve the diversity of our workforce. We also need to improve the experiences of our BME staff.

Whilst WRES is an objective on its own, there are a number of objectives that will impact upon it. All of the objectives that relate to recruitment, training and development, talent management and retention will have bearing on WRES and will all be encompassed in our People Strategy.

Well Led

Well-Led was one area of focus of our 2017 CQC inspection and one which is a top priority for the Trust Board. A number of objectives will impact upon how well-led our organisation is.

Ambulance Response Programme (ARP)

The Ambulance Response Programme is currently in its pilot phase before being rolled out nationally across the UK. ARP will be a major strand of our 2017/18 Transformation Programme and has the potential to change our Operating Model depending on the final outcome of the trial.

Commissioning for Quality & Innovation framework (CQUINS) & Cost Improvement Programmes (CIP)

CQUINs and CIPs are an important element of our work annually to ensure we improve the quality of what we do, as well as meeting our financial challenges. A number of objectives will impact on these important areas.

Delivering Transformational Change

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 London Ambulance 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.

Sustainability will be central to the Transformation Programme as we need to make sure that changes are truly embedded within the organisation. The NHS Quality, Service Improvement & Redesign (QSIR) workbook provides guidance on ensuring transformation is sustainable. The Transformation Programme will be developed to reflect these principles and will be run and monitored to ensure that changes are sustainable and effectively embedded within the organisation.

Transformation Approach

In designing our approach to transformation, we have considered both guidance from leading change experts, experience from other NHS organisations and our own learning from the Quality Improvement Programme to ensure we achieve sustainable transformation, which in summary concludes that successful, long lasting change requires effective planning and the willingness to change. We are therefore using a two pronged approach to realising the transformation required; **'Driving & Releasing Change'.**

Our approach of **'Driving & Releasing Change'** is formed of two complimentary components to ensure a balanced, well run programme. The first component; **'Driving Change'**, includes activities to structure, drive, direct and automate the required transformation, incorporating traditional project and programme management activities. It involves:

- Determining the compelling case for change for each project
- The plans, processes, procedures, systems and rules in place to drive the change programme
- The business structure and design in place to ensure the required structure, organisation, roles, and accountabilities.

Core to the Drive component will be clearly defined benefits realisation plans that include both cash and non-cash (e.g. productivity or quality) outcomes.

The second component; **'Releasing change'** is focussed around the activities to inspire, enable, encourage and facilitate, requiring strong interpersonal skills and the ability to co-create with the people involved in the change. It involves:

- Enabled leadership, providing role models, symbols, ideas and inspiration
- The engagement and enablement of staff through dialogue and engagement activities
- Embedding new behaviours through energy, motivation and collaboration

Staff engagement will be crucial throughout each stage of every project, ensuring staff are involved and a broad range of views are heard. The specific method of engagement is dependent on the particular project and could incorporate: staff surveys; small focus groups; or large engagement events. We will seek to involve our Trade Union colleagues at the outset of the Programme to agree the terms of engagement.

Transformation Programmes

Three Transformational programmes have been created to support delivery of the business plan in the year ahead. These are;

Programme A: Transforming Care Delivery

Embracing the opportunity of the implementation of the Ambulance Response Pilot outcomes, we will transform our current operating model to ensure robust delivery, enhanced care, and improved working conditions. The programme will need to 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 organization'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. Cultural transformation requires personal transformation as its foundation.

Programme C: Simplifying for Success

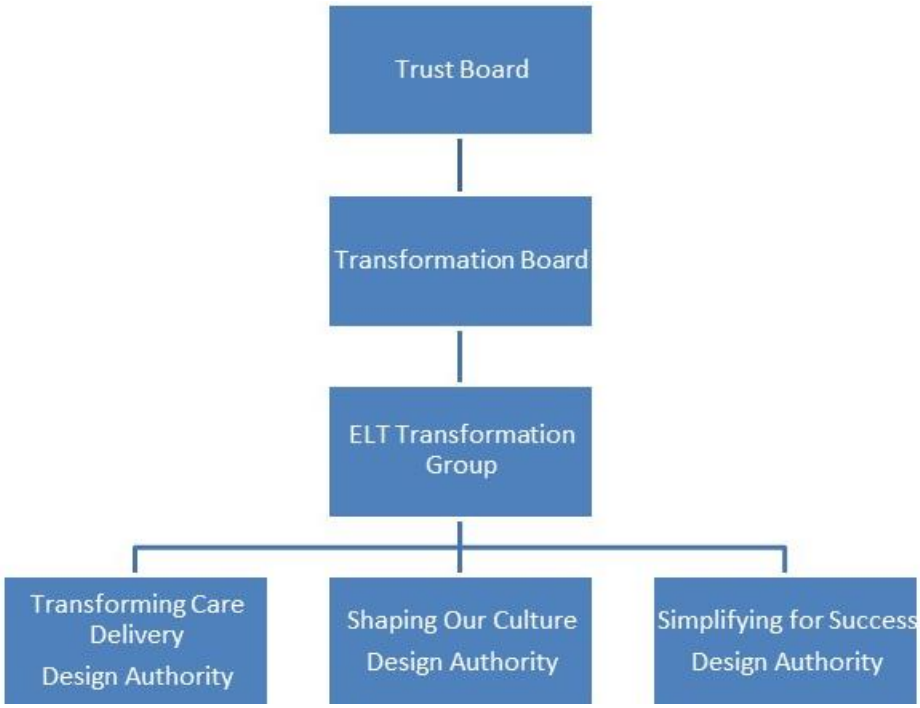
Creating an internal customer approach to improve the interactions between all the staff who support LAS in corporate and support services and those who work in operational services. This programme aims to create an internal business partner model, simultaneously driving cost, efficiency and quality 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.

Programme D: Optimising Technology

The use of information and technology underpins everything that we do. To improve the quality of our services and become an effective and learning organisation, requires a transformation in the way we manage, develop and link information. This programme will enhance and optimise internal capabilities to robustly support existing information systems and technologies, and improve patient care through the use of new modern systems and technologies.

Programme Governance

We will build on the programme governance model used for the QIP programme, which incorporates Executive and Board Level engagement. Adopting this established governance structure will enable us to quickly establish the new programme and ensure improvement momentum is not lost. This is shown in the structure overleaf:



The Transformation Programme Board will be chaired by the Chief Executive and will meet on a monthly basis and report to the Trust Board, with the core membership including the Director leads and three Non-Executive Directors, who will:

- Review progress of the Transformation Programme and work streams
- Review Key Performance Indicators
- Consider potential gaps in delivery and the plans for mitigation
- Ensure benefits realisation is on track

The Executive Leadership Team (ELT) Transformation Group, consisting of all members of the Executive Leadership Team and chaired by the CEO, will formally review progress against the plan in its entirety on a monthly basis, assessing any potential risks and directing mitigations to ensure delivery.

Each of the individual work streams will ensure that each of the projects are delivering against plan, to budget and on time, achieving the identified benefits. Monthly work stream meetings will be attended by project leads, project managers, and representatives from HR, Finance, Performance, IM&T, Operations and Medical Directorates as appropriate. These groups will agree papers which will be submitted to the ELT Transformation Group.

Our Quality Priorities for 2017/18

During the year the Trust have been monitoring progress against the targets set in the last year's quality report. Due to progress made, the Trust has chosen to set new targets in areas which are current priorities and where maximum benefit will be achieved

We have consulted and received feedback through various methods from our key stakeholders including staff, patients, public, Patient Forum and our commissioners. Who have agreed with the further development of topics and continued links to our CQUIN priorities.

The Executive Leadership Team agreed the priorities and will continue to monitor progress through the Quality Oversight Group and the Quality Assurance Committee and via the Board in the Integrated Quality and Performance Report. The projects will support the Trusts overarching aims of providing 'high quality and safe care to our patients.'

Topic	Outcomes 2017-18
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.

Our 2017/18 CQUINS

Below is a list of the nationally agreed CQUINS, how they will be delivered and the Director accountable:

Improvement of health and wellbeing of NHS Staff	Business Plan Objective	Director of HR and OD
Health food for NHS staff, visitors and patients	Business as Usual	Director of Finance
Improving the uptake of flu vaccinations for front line staff	Business as Usual	Medical Director

Below is a list of our locally agreed CQUINS, how they will be delivered and the Director accountable:

A reduction in the proportion of 999 calls which are conveyed to an A&E Department	Business Plan Objective	Medical Director
Support enagement in local STP initiatives	Business Plan Objective	Director of Transformation and Strategy

Financial Plan

The London Ambulance Service continues to operate in a challenging financial environment for the NHS and the whole public sector. In developing our two year financial plan for 2017-2019 we faced 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

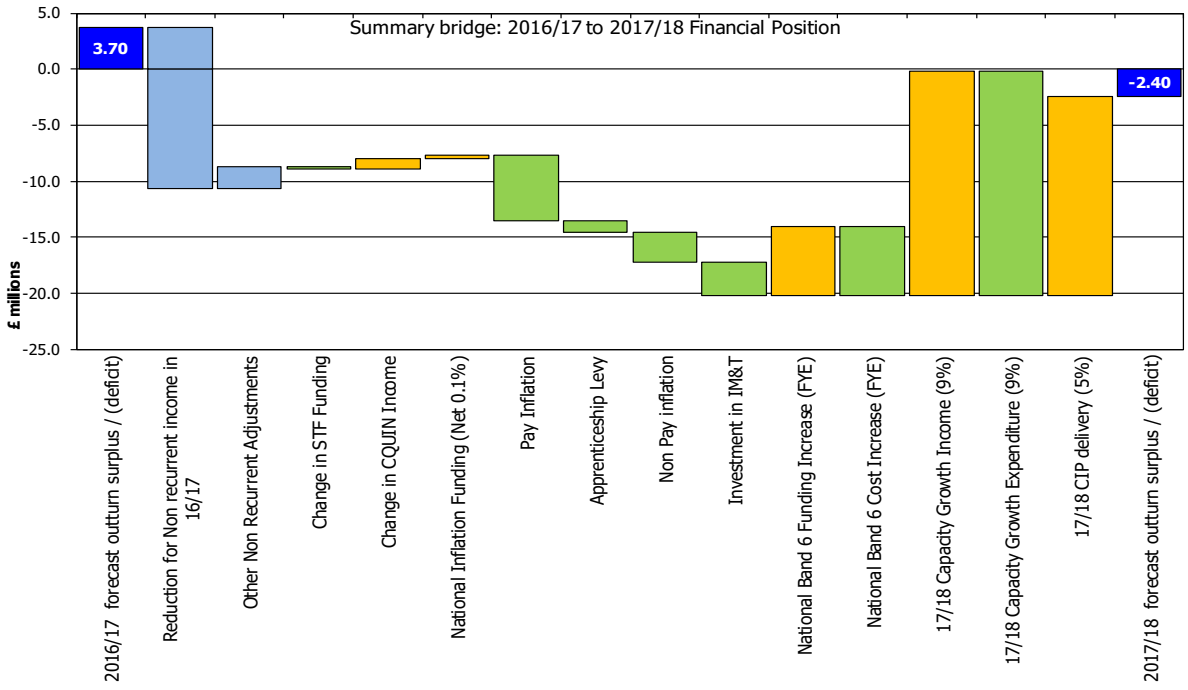
The table below shows the key financial figures for the Trust:

	2017-18 Plan	2018-19 Plan
Performance against SOCI 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 Trust is planning to meet its assigned control totals in each year and return to surplus in 2018/19
- Capital: The Trust will require significant Capital Investment across the next 5 years to support transformation in Fleet, Estates and Technology.
- Cash: The Trust Liquidity position is planned to be challenged until the Trust returns to a sustainable surplus position. Working capital management strategies have been identified and Interim revenue financing would be available if required.
- 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 Trust'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
I&E 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.
- I&E Margin improves across the identified period as the deficit position is reduced and the Trust returns to surplus.
- The Trust expect to remain scores of 1 in all other areas as it delivers its plan.

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 Trust 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 Trust 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 I&E 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 Trust would make £6.7m Estate sales to repay the interim loans with further sales in future planning periods.

Technology: The Trust 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 Trust has an ongoing need to refresh its vehicle fleet each year. The value of these refreshes exceeds the Trust 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 Trust 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 Trust

responds to incidents (H&T, S&T, S&C) 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 trust 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 Trust strategy 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 Trust 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)

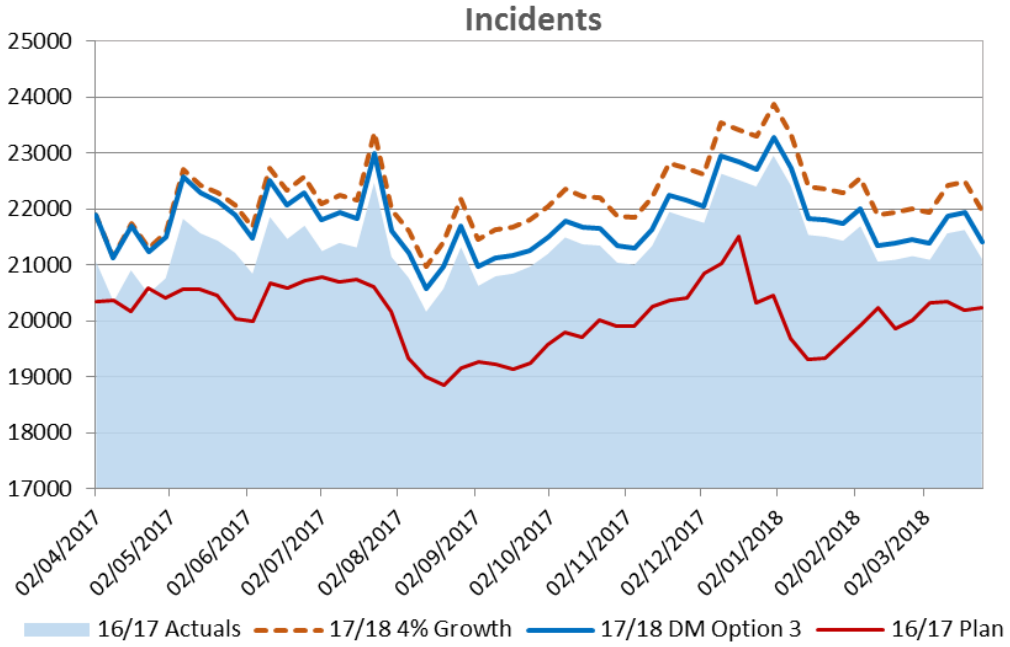
Activity & Workforce Plan

Our Activity Planning for 2017/18 is informed by the 2017/18 LAS 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 challenges. 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).

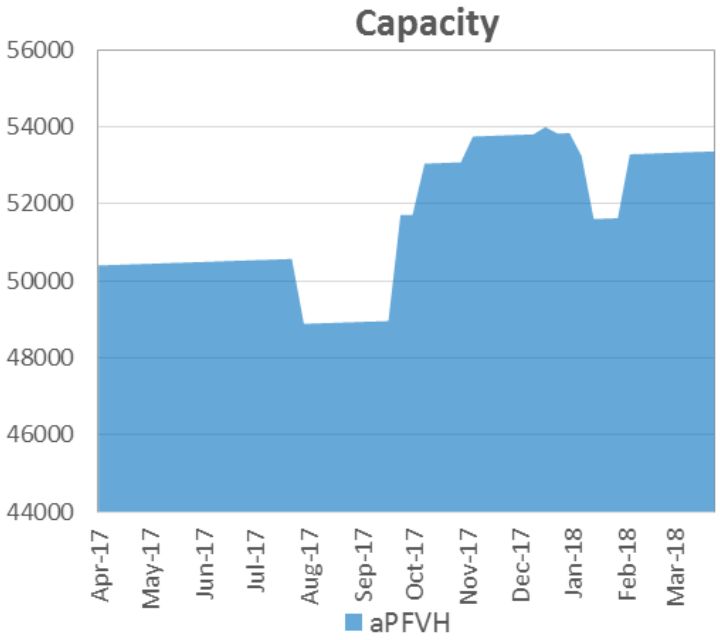
As well as the demand management initiatives, there are two elements that are crucial to achieving agreed performance standards; **increasing capacity** and **reducing Job Cycle Time**. Plans to deliver the requirements of both are outlined in "our plans to achieve our goals" section.

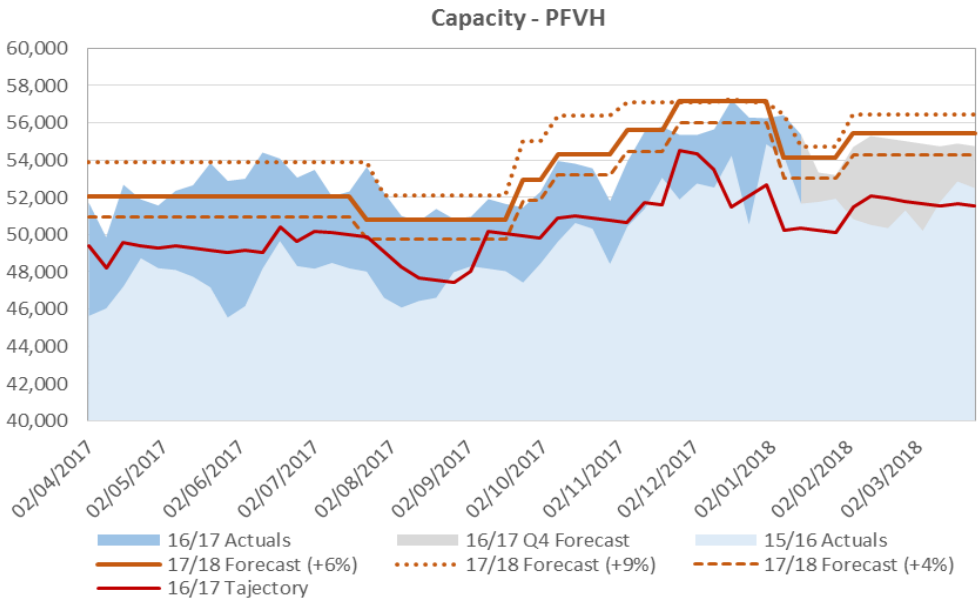
Capacity

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%

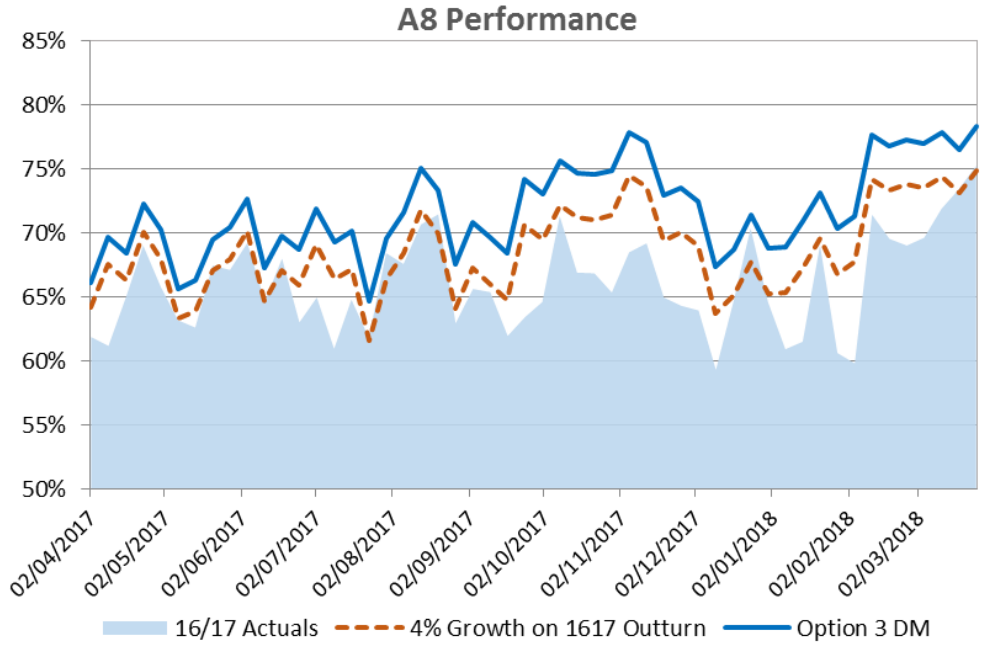
17/18 Forecast = +9% on plan
Total Hours = 2,855,310
Weekly Average = 54,910

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**

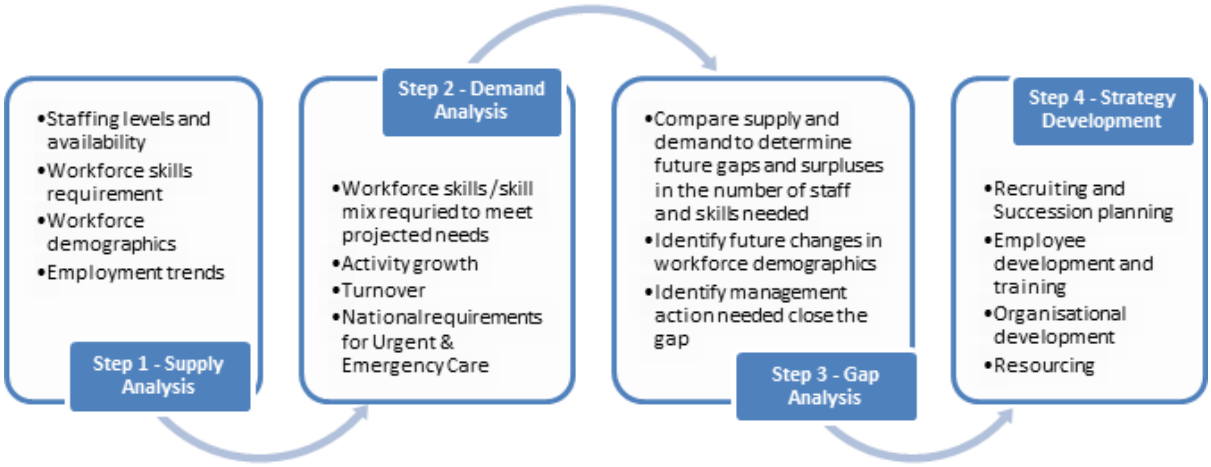
Based on demand, capacity and efficiency assumptions, our A8 performance trajectory identifies that we will be able to meet our contracted target of pan-London performance at 75% by 1st October.



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 Methodology

A workforce plan has been developed in conjunction with the finance and activity plan. All plans are informed and driven by the Trust's activity planning model produced by the Business Intelligence Team. The diagram below describes the workforce planning process.



Overall Staffing Plan

The 2017/18 Position and 2018/19 total workforce positions are based on the 2016/17 establishment the movement between 16/17 and 17/18 establishment can be seen below. For the most part total establishment will remain stable across the Trust with the exception of:

- Growth in frontline staffing capacity to reflect demand growth (circa 150 frontline WTEs in 2017/18)
- Conversion of agency to substantive roles
- Conversion of overtime to substantive roles where appropriate
- Identified CIP Programmes

Directorate	Funded WTE	Staff in Post	Vacancies	Anticipated Turnover	Maximum Recruitment requirement WTE
Chief Executive and Directors	28.30	14.69	13.61	28.8%	21.76
Communications	15.00	13.60	1.40	36.8%	6.92
Corporate Services	30.53	22.03	8.50	9.10%	11.28
Estates	11.73	10.73	1.00	9.30%	2.09
Fleet & Logistics	154.44	129.84	24.60	8.30%	37.42
Finance	32.00	31.61	0.39	23.40%	7.87
Information Management & Technology	82.48	60.46	22.02	16.80%	35.88
Medical	140.73	133.17	7.56	8.60%	19.67
Nursing & Quality	28.47	27.60	0.87	12.10%	4.31
Performance	20.00	14.00	6.00	7.10%	7.42
Transformation, Strategy & Workforce	87.19	62.32	24.87	21.80%	43.88
Corporate Totals	**630.87**	**520.05**	**110.82**	**13.50%**	**195.99**

111 Services	114.85	93.09	21.76	18.30%	42.78
Central Operations	421.81	403.81	18.00	5.40%	40.78
Control Services	575.65	571.71	3.94	16.30%	97.77
Non-Core Contracts	10.00	7.00	3.00	50.00%	8.00
Non-Emergency Transport Service	148.58	145.37	3.21	3.30%	8.11
Director of Operations*	19.00	74.80	-55.80	16.20%	-52.72
Patient Transport Service	35.41	38.61	-3.20	23.40%	5.08
Sector Operations	3361.04	3037.75	323.29	8.00%	592.17
Sector Operations Management	33.00	33.00	0.00	14.70%	4.85
Operational Totals**	**4719.34**	**4405.14**	**314.20**	**9.20%**	**748.38**
Trust Total	**5350.21**	**4925.19**	**425.02**	**9.70%**	**943.99**

* Currently this includes Trainee Emergency Ambulance Crew (TEACs) which is why it is showing as over establishment

**Operational totals currently does not include the additional growth in establishment and fallow time planned for 2017/18

Strategic risk assessment

Strategic Risk Assessment

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.

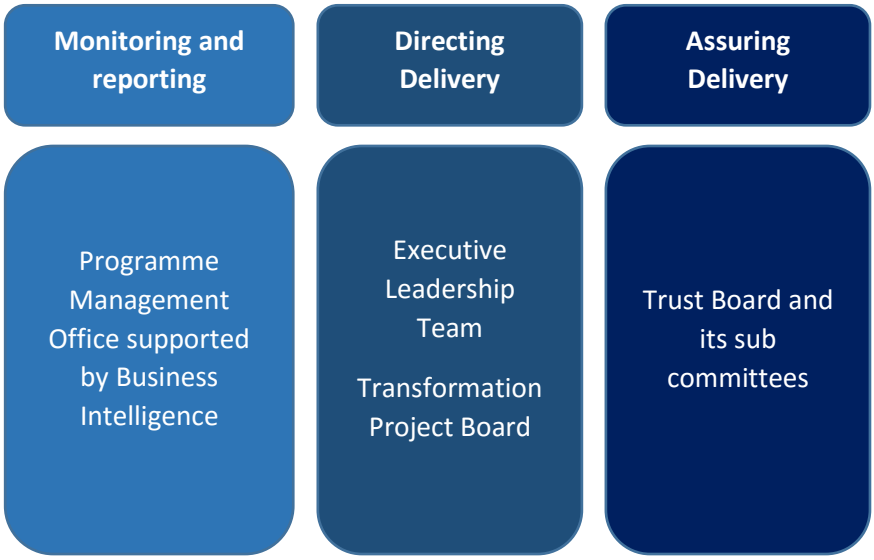
Strategic Risk	Link to the business plan to mitigate strategic risk	Currently on the Board Assurance Framework	To be added to the Board Assurance Framework
QUALITY			
Long waits experienced by patient with non-life threatening conditions	Goal one: patients receive safe, timely and effective care		√
Rest 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		√

The process for adding strategic risks to the risk register and the board assurance framework will be completed across Q1.

Business Plan Governance

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
2017/18 Business Plan

Our Goals	No.	Our Objectives	How the objective will be delivered					How the objectives will support organisational priorities					Our Expected Outcomes
			Directorate led	Transformation Programme 2017/18				CIPs	Great Place to Work	Job Cycle Time	Well Led	WRES	
				Programme 1: Transforming Care Delivery	Programme 2: Shaping Culture	Programme 3: Simplifying for success	Programme 4: Optimising Technology						
Patients receive safe, timley and effective care	1.1	By May 2017, we will Improve the way the Trust collectively learns, creating a learning framework which sets out the systems, processes and structures for continuous improvement	X						X		X		• Learning framework in place across the Trust which drives improvement in the four agreed areas • Improvement in results of relevant staff survey questions when compared to 2016/17 survey • Decrease in repeat safety incidents, SIs and complaints
	1.2	By June 2017, we will have strengthened our governance processes with a new Quality Governance Assurance and Learning Framework across the Trust	X						X		X		• A programme of regular deep dives conducted on four improvement areas • External quality assurance prior to future CQC inspection • New SI & complaints processes & reduction in overdue SIs
	1.3	We will agree a quality improvement plan to respond to the anticipated CQC report and share this at the CQC Quality Summit in Summer 2017	X						X	X	X	X	• Improvement in overall CQC rating • To be removed from special measures
	1.4	By July 2017, we will have agreed our new multidisciplinary skill mix model, recruiting to frontline vacancies throughout the year		X					X	X	X	X	• Revised skill-mix model determinded with supporting recruitment strategies and transition plan to meet agreed establishment level
	1.5	We will roll out hand held devices between July and 2017 and March 2018, so that our frontline crews can have better information to treat patients and we provide better joined up care	X				X		X				• All frontline crews will have mobile devices with an initial set of agreed applications by year end
	1.6	By October 2017, we will move to vehicle based equipment and drugs	X						X	X	X		• All crews will have access to a fully equipped vehicle with drugs by October 2017, reducing out of service • Improvement in results of relevant staff survey questions when compared to 2016/17 survey
	1.7	By March 2018, we will have transformed the way we run our 111 service, improving integration with 999		X				X	X				• 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 • SEL 111 contract retained and successfully expand our 111 provision to at least one additional area od London
	1.8	By March 2018 we will have completed the implementation of the EOC review		X					X	X	X	X	• Permanent EOC management structure in place • Improvement in workforce indicators within EOC and relevant staff survey questions • Maintenance of national standards and contractual obligations • EOC ready for implementation of changes to national Ambulance response standards
	1.9	By March 2018, we will have implemented year one actions of the Clinical Strategy, comprising of four main areas of delivery: improving care for the sickest and most seriously injured patients; development of integrated and urgent care; sharing learning; and improved governance	X						X	X	X		• Improvement in cardiac arrest clinical indicators • Management of suicidal patients, bariatric patients and paedeatric sepsis is improved with coresponding improvements in clinical KPIs
	1.10	By March 2018, we will have undertaken and implemented a Trust-wide roster review to better meet the needs of our patients and staff		X					X	X			• New rosters in place by April 2018 to meet demand profiles and deliver national performance standards • Reduced variation in performance across the hours of the day and days of the week • Delivery of local CCG performance targets of 60%
	1.11	By March 2018, we will deliver the digital solution to support delivery of the National CQUIN "Ambulance Conveyance: To enable a reduction in the proportion of ambulance 999 calls that result in transportation to a type 1 or type 2 A&E Department."					X			X			• LAS receive full funding allowance attributed to the CQUIN
	1.12	By March 2018, we will deliver all elements of the 2017/18 patient engagement work plan	X								X		• Patient representation on key committees • Increased engagement with hard to reach patient groups and BME communities with identified health inequalities
	1.13	Throughout the year we will deliver the second phase of medicine management improvement	X						X		X		• CQC requirement notice lifted in relation to medicines management • Secure drug environment with no drug thefts

Our Goals	No.	Our Objectives	How the objective will be delivered					How the objectives will support organisational priorities					Our Expected Outcomes
			Directorate led	Transformation Programme 2017/18				CIPs	Great Place to Work	Job Cycle Time	Well Led	WRES	
				Programme 1: Transforming Care Delivery	Programme 2: Shaping Culture	Programme 3: Simplifying for success	Programme 4: Optimising Technology						
Staff are valued, respected and engaged	2.1	By June 2017, we will establish a pipeline for future paramedics, either via the LAS Academy or through University partnerships	X					X	X	X	X	X	• Year on year increase in 'homegrown' paramedics • Reduction in turnover for non registered frontline staff
	2.2	In July 2017, we will launch our People and OD Strategy to outline our workforce priorities for the next three years	X						X		X	X	• Comprehensive People & OD Strategy encompassing; OD Plan, L&D Strategy, Health and Wellbeing, Recruitment Plan and trajectory • Improvement in workforce indicators when measured against the April 2017 baseline
	2.3	By July 2017, we will implement new rest break and end of shift arrangements to support frontline staff		X				X	X	X	X		• 80% of crews will receive a rest break every shift by 01/10/17 • Closure of 10 year old BAF Risk • Number of late jobs crews attend will reduce • Number of serious incidents declared during changeover period will decline from February 2017 baseline • Hourly A8 performance will be more equitable across the 24 hour period.
	2.4	We will introduce new annual leave arrangements by end of July 2017 to better match activity demand with staff needs	X					X	X	X	X		• Equaitable distribution of annual leave across the year • Improved substantive resourcing at peak activity times • Staff receive adequate periods of holiday to support health & wellbeing
	2.5	By September 2017, we will define our desired culture and introduce a staff charter, together with annual corporate management actions so that staff and manager's know what they can expect from the Trust and what is expected of them			X				X		X	X	• Improvement in results of relevant staff survey questions when compared to 2016/17 survey
	2.6	By September 2017, we will have in place a clear Leadership Development Pathway across the Trust			X				X		X	X	• Improvement in results of relevant staff survey questions when compared to 2016/17 survey • Improvement in CQC 'well-led' rating • Defined levels of autonomy and decision making for managers published, supported by an annual training and development plan
	2.7	By September 2017, we will strengthen our Operational Management structure to improve support to our frontline, and ensure management accountability is clear and in place		X					X		X		• New Operational management structure in place with renewed focus on quality of care to patients • Improved staff engagement and coresponding staff survey scores when compared to 2016/17 results
	2.8	By September 2017, we will have put in place a Board Development Programme to address board development needs including CQC and well led feedback	X						X		X		• Improvement in CQC 'well-led' rating
	2.9	By March 2018, we will have delivered the recruitment plan to fill the frontline rosters	X										• Frontline capacity requirements are met
	2.10	By March 2018, we will have designed and implemented new Talent Management arrangements to improve retention and succession planning			X			X	X		X	X	• A talent management approach that identifies the next cohort of talent • Increased staff awareness of LAS expectations for career progression • Succession plans are in place for key roles
	2.11	By March 2018, we will meet the national CQUIN requirements to improve the health and wellbeing of our people	X										• LAS receive full funding allowance attributed to the CQUIN
	2.12	By March 2018, we will complete phase four actions to tackle bullying and harassment	X						X		X		• Improvement in results of relevant staff survey questions when compared to 2016/17 survey • exit survey data shows a reduction in bullying and harassment when compared with previous reports • 95% of reported bullying & harassment cases addressed within 28 days
	2.13	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 the communities we serve	X						X		X	X	• Improvements in WRES indicators against the 2016/17 baseline • A system for recording employees acessing non-mandatory training (to support WRES indicator 4) • Improvements in staff satisfaction for BME staff as measured by the staff survey when compared to the 2016 results • Outreach into a minimum of two London schools per month

Our Goals	No.	Our Objectives	How the objective will be delivered					How the objectives will support organisational priorities					Our Expected Outcomes
			Directorate led	Transformation Programme 2017/18				CIPs	Great Place to Work	Job Cycle Time	Well Led	WRES	
				Programme 1: Transforming Care Delivery	Programme 2: Shaping Culture	Programme 3: Simplifying for success	Programme 4: Optimising Technology						
Partners are supported to deliver change in London	3.1	Throughout the year we will develop appropriate care pathways in partnership with STPs and Clinical Commissioning Groups to ensure patients are taken to the most appropriate setting of care		X						X			• pan-London falls pathway agreed by end of October 2017
	3.2	We will work with London's five STPs to co-design and support delivery of demand management initiatives across London including: appropriateness of referrals between 111 and 999 services; services to support frequency callers; referrals from healthcare professionals to 999; support required by Care Homes in London	X					X		X	X		• Support CCGs to deliver a 2% reduction in demand as agreed in our 2017/18 contract
	3.3	In partnership with our Blue Light colleagues, other NHS organisations and Ambulance Services we will maximise value for money from the public purse through working together where is it in the best public interest to do so, for example procurement, sharing estates and services		X		X		X	X	X	X		• Review of Blue Light Emergency Control Rooms across London concluded • £100k savings identified via collaboration efforts
	3.4	Influence health improvement and redesign across London through our active engagement in the five London STPs	X					X	X	X	X		• When defined, year one priorities of the LAS 5 year strategy delivered across London • LAS influences London's redesign and health improvement
Efficiency & sustainability will drive us	4.1	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	X								X		• Internal audit on data quality repeated and demonstrates that data quality is robust
	4.2	By June 2017, we will outline our fleet requirements in a new 5 year Fleet Strategy and commenced the implementation of our year one actions	X						X	X	X		• Business case for a 5 year vehicle replacement strategy agreed by NHSI • Introduce new vehicles as detailed in fleet replacement plan • Reduction in Out of Service when compared with April 2017 baseline
	4.3	By June 2017, we will have defined our Estates requirement for the next five years and commence the implementation of our year one actions	X					X	X	X	X		• Business case for LAS Estates Strategy agreed by NHSI
	4.4	By July 2017, we will launch the Trust's 5 year strategy to reflect changing needs of patients and STPs across London	X					X	X	X	X	X	• Improvement in results of relevant staff survey questions when compared to 2016/17 survey • Engaged stakeholders with a shared vision for LAS • Engaged workforce with a clear understanding of LAS's ambition for the future • Improvement in well-led domain relating to strategy and vision
	4.5	By October 2017, we will review corporate and support functions to drive efficiency through simplified processes, systems and structures, linking with STP and Blue Light services as appropriate				X		X			X		• Review undertaken to identify opportunities for efficiencies • Participate in STP and Blue Light efficiency reviews • Agreed CIP from back office reviews in 2017/18 delivered • £250k savings from reduced agency usage in 2017/18 delivered • ESR self-service implemented and rolled out throughout the Trust
	4.6	By March 2018, we will have implemented new business continuity plans throughout the Trust to ensure business critical functions are maintained at all times	X								X		Confirm wording with Paul
	4.7	By March 2018, we will have delivered year one IM&T strategy actions including a review of IM&T systems and services which will see delivery of improvements across the year	X				X		X	X	X		• 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 • Reduction in risk scores for IM&T risks on the BAF
	4.8	Ensure processes are put in place to ensure CIPs are identified and delivered across multiple periods	X					X			X		• The Trust-wide cost improvement programme will release c.£18m savings • Clear and renewed process to deliver a rolling CIP programme that goes beyond one year

	Q1	Q2	Q3	Q4
Patients receive safe, timely & effective care	Clinical Strategy milestone 1 Learning Organisation Framework Quality Governance Assurance Framework	Skill Mix Model Clinical Strategy milestone 2 Introduce mobile devices Quality Improvement Plan	Vehicle based equipment Clinical Strategy milestone 3	Medicines Management Deliver Patient Engagement Workplan 111 & 999 Integration Digital Enabler CQUIN Clinical Strategy milestone 4 Implement new Rosters EOC Review
Staff are valued, respected & engaged	Establish future paramedic pipeline WRES Actions Monthly recruitment plan	Operational Management Structures Monthly recruitment plan Desired culture & Staff Charter WRES Actions Launch People Strategy Set workforce skill mix levels Board Development Programme Rest Breaks & end of shift Annual leave arrangements Leadership Development Pathway	Monthly recruitment plan WRES Actions	Monthly recruitment plan Talent Management WRES Actions Health & Wellbeing CQUIN B&H Work
Partners are supported to make change in London	New AHPs; with CCGs & STPs Bluelight collaboration projects STP engagement Demand management initiatives	New AHPs; with CCGs & STPs Bluelight collaboration projects STP engagement Demand management initiatives	New AHPs; with CCGs & STPs Bluelight collaboration projects STP engagement Demand management initiatives	New AHPs; with CCGs & STPs Bluelight collaboration projects STP engagement Demand management initiatives
Efficiency & sustainability will drive us	Estates Strategy Year 1 IM&T Strategy Delivery Fleet Strategy Data Quality Framework CIP Delivery	Launch 5 year strategy Year 1 IM&T Strategy Delivery CIP Delivery	Year 1 IM&T Strategy Delivery CIP Delivery Review Corporate & Support Functions	Business continuity plans Year 1 IM&T Strategy Delivery CIP Delivery

London Ambulance Service NHS Trust

Report to:	**Trust Board (Public)**
Date of meeting:	**28th April 2017**
Document Title:	**Draft Annual Accounts Summary 2016/17**
Report Author(s):	**Andy Bell**
Presented by:	**Andy Bell**
Contact Details:	**Andy.bell@lond-amb.nhs.uk**
History:	***Audit Committee***
Status:	***information***

Background/Purpose

- An overview of the production of the draft accounts and key deadlines
- A summary of the financial position reported in the accounts and whether statutory duties have been met

Action required

The Trust Board is requested to review and note the report.

Links to Board Assurance Framework and key risks

BAF Risk 214 – Achieving Financial Balance in 2016/17

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

London Ambulance Service NHS Trust
Trust Board (Public): 25th April 2017.

2016/17 Financial Position and Accounts Summary

Andy Bell
Finance Director

Production of the Draft 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 correct 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.
  - The Trust Board need to be aware of the Sustainability & Transformation fund (STF) Incentives which will be confirmed by NHS Improvement on 24th April 2017. This has been assessed in detail at FIPC and the Audit Committee.
- 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
  - The Trust will be informed of exact STF incentive figures on 24th April 2017.
  - Submitted as final accounts to the NHSI on 26nd April (including STF incentives)
  - Subject to external audit by Ernst & Young from wc 25th April 2017.
  - Final Accounts will be submitted to the DH by 1st June 2017.

Summary Financial Position at Month 12

Financial Indicator	Summary Performance	Current Month	Previous month
Surplus	The Trust has met its Statutory Financial Requirement to break even and met its Financial control total as set by NHSI. Once all non-recurrent items are removed the Trust meets its original control total of £6.7m deficit. A draft set of accounts has been approved by the audit committee for submission to NHS Improvement on the 26th April 2017 in line with requirements.	**GREEN**	**AMBER**
Income	The Trust had a final income position of £354.4m. • The Trust was able to secure additional income from CCGs to support a 6.5% increase in demand above plan across the financial year (£8.9m). • The Trust secured STF funding as agreed with NHS Improvement. • Quality Improvement funding was secured across the year. • There has been some challenge to the CQUIN income but this is not seen as a risk to the reported position.	**GREEN**	**GREEN**
Expenditure (incl. Financial Charges)	The Trust had total operating expenditure of £349.4m. This consisted of: • £244.8m of pay related expenditure • £105.7m of non pay related expenditure (incl. Financial Charges) • This spend was higher than plan primarily to support additional capacity (Overtime, Incentives and Private Ambulance Usage) required due to the 6.5% demand seen above contract across 2017/18.	**AMBER**	**AMBER**
CIPs	The full year plan of £10.5m was achieved. Additional opportunities were identified to close the CIP gap across Q4.	**GREEN**	**AMBER**
Balance Sheet	Capital spend was £12.5m against our approved CRL of £19.1m. Residual funds will be rolled forward into 2017/18 financial year as agreed with NHS Improvement. The Trust undershot its statutory Capital Resource Limit (CRL) which it is approved to do.	**GREEN**	**AMBER**
Cashflow	The Trust has met its statutory External Finance Limit (EFL) target for cash. The cash position for 17/18 has finished ahead of plan.	**GREEN**	**AMBER**
BPPC	The Statutory target on volume (95%) and Value (95%) was not Achieved. 3% reduction in performance on Volume but 1% improvement on Value compared to 2015/16 performance.	**AMBER**	**AMBER**