London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO BE HELD IN PUBLIC ON TUESDAY 3RD JUNE 2014 AT 09.30 – 12.00 CONFERENCE ROOM, 220 WATERLOO ROAD, LONDON SE1 8SD

AGENDA: PUBLIC SESSION

	ITEM	SUBJECT	PURPOSE	LEAD	TAB
09.30	1.	**Welcome and apologies for absence** Apologies received from: Fionna Moore – Fenella Wrigley to attend			
	2.	**Patient Story** To hear an account of a Patient Story			
09.40	3.	**Declarations of Interest** To request and record any notifications of declarations of interest in relation to today's agenda		RH	
	4.	**Minutes of the Part I meeting held on 25TH March 2014** To approve the minutes of the meeting held on 25th March 2014	Approval	RH	TAB 1
	5.	**Matters arising** To review the action schedule arising from previous meetings	Information	RH	TAB 2
09.50	6.	**Report from the Trust Chairman** To receive a report from the Trust Chairman on key activities since the last meeting	Information	RH	ORAL
ANNUAL REPORTING					
10.00	7.	**Annual Report and Accounts 2013/14** 7.1 To approve the annual report for 2013/14 7.2 To approve the annual accounts for 2013/14	Approval	SA AG	TAB 3 To follow
QUALITY GOVERNANCE AND PERFORMANCE REPORTING					
10.15	8.	**Quality Report** 8.1 Safety, Development & Practice, and Effectiveness & Experience 8.2 Report from the Quality Committee meeting on 23rd April 2014	Assurance	SL/FW/ MW BMc	TAB 4
10.30	9.	**Integrated Board Performance Report** To receive the integrated board performance report	Information	PW	TAB 5
10.45	10.	**Board Assurance Framework and Corporate Risk Register – Quarter 1 documents** 10.1 To receive the Board Assurance Framework and Corporate Risk Register for Quarter 4 10.2 Report from the Audit Committee on 22nd May and 2nd June 2014	Assurance	SA JJ	TAB 6

11.00	11.	**Finance Report** 11.1 Finance Report M1 11.2 Report from Finance and Investment Committee on 22nd May 2014	Information	AG NM	TAB 7 ORAL
BUSINESS ITEMS					
11.10	12.	**Report from Chief Executive** To receive a report from the Chief Executive	Information	AR	TAB 8
11.20	13.	**Modernisation Programme** To receive an update on the Modernisation Programme	Information	JC	ORAL
11.30	14.	**Board Declarations – self certification, compliance and board statements** To approve the submission of the Board declarations for April and May 2014	Approval	SA	TAB 9
	15.	**Report from Trust Secretary** To receive a report on use of the Trust Seal and tenders received	Information	SA	TAB 10
	16.	**Forward Planner** To receive the Trust Board forward planner	Information	SA	TAB 11
	17.	**Questions from members of the public**		RH	
	18.	**Any other business**			
11.45	19.	**Meeting Closed**			
	20.	**Date of next meeting** The date of the next Trust Board meeting is 25th June 2014			

LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING
Part I

DRAFT Minutes of the meeting held on Tuesday 25th March 2014 at 09:30 a.m.
in the Conference Room, Fielden House, 28 London Bridge Road, London SE1 9SG

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Present:	
Richard Hunt	Chairman
Ann Radmore	Chief Executive
Jessica Cecil	Non-Executive Director
Fergus Cass	Non-Executive Director
Theo de Pencier	Non-Executive Director
Andrew Grimshaw	Director of Finance and Performance
John Jones	Non-Executive Director
Jason Killens	Director of Operations
Steve Lennox	Director of Nursing and Quality
Nick Martin	Non-Executive Director
Bob McFarland	Non-Executive Director
Fionna Moore	Medical Director
In Attendance:	
Sandra Adams	Director of Corporate Affairs/Trust Secretary
Karen Broughton	Director of Transformation and Strategy
Jane Chalmers	Director of Modernisation
Roy Griffins	Former Non-Executive Director
Francesca Guy	Committee Secretary
David Prince	Director of Support Services
Caroline Silver	Former Non-Executive Director
Mark Whitbread	Director of Paramedic Education and Development
Members of the Public:	
Angela Cross-Durrant	Chair of the Patients' Forum
LAS Commissioner	
Evening Standard reporter	Member of the public
Paul Pepe	Medical Director, Emergency Medical Services, Dallas
Members of Staff	
Anna McArthur	Communications Manager
Helen Mason	Ambulance Operations Manager - Control Services
Simon Bell	Voluntary Responder Group, Team Leader
Chris Hartley-Sharpe	Ambulance Operations Manager

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20. Welcome and Apologies

20.1 No apologies had been received.

21. Staff Story

21.1 Simon Bell and Chris Hartley-Sharpe joined the meeting for this agenda item.

21.2 Simon explained that he had been both an emergency responder and a community first responder

and therefore had experience in both roles. Simon explained his motivation for joining the scheme, his experiences and some of the issues he had encountered. The key issues included not being utilised fully, the risk of skills fade and a lack of communication, guidance and support. Once he had been appointed as a Team Leader, Simon had introduced a secure website which enabled volunteer responders to test their skills and to store relevant information. He had also introduced a monthly email to improve communication between teams.

21.3 Simon commented that the utilisation of voluntary responders had improved but that he still heard of some instances where they were not being utilised fully or had been cancelled down from attending patients. Simon commented that the voluntary responders were not a replacement for skilled professionals, but a useful resource which could be used to respond to calls particularly at a time when demand was increasing year on year. Simon believed that London could be top in the world in terms of cardiac survival rates and part of achieving this was for the service to take ownership of the voluntary responders and to provide them with appropriate support and training.

21.4 The Chair thanked Simon for joining the Trust Board to tell his story and noted that there was a lot more that could be done to educate people on the role of the voluntary responders. The Chair also noted that there was more that could be done to invest in the voluntary responder scheme.

21.5 Ann Radmore also thanked Simon for telling his story and noted that the voluntary responder scheme could help with the recruitment of the paid workforce. Ann stated that she would like to discuss ideas on how to attract new recruits from the minority communities in London.

22. Declarations of Interest

22.1 No declarations of interest were declared.

23. Minutes of the Part I meeting held on 28th January 2014

23.1 The minutes of the Part I meeting held on 28th January 2014 were approved.

24. Matters Arising

24.1 The following actions were discussed:

24.2 **06.3:** Action complete.

24.3 **06.4:** Sandra Adams reported that the action to provide the Trust Board with a briefing note on the role of the committees was in progress.

24.4 **06.9:** Sandra noted that information on serious incidents had been included in the Clinical Quality and Patient Safety Report. Action complete.

24.5 The following matters arising were discussed:

24.6 **06.11:** The Chair drew attention to a comment made at the last Trust Board meeting about whether the Trust gave sufficient profile to clinical audit and research activity. The Chair suggested that the Trust Board receive a presentation on the work of the clinical audit and research unit.

ACTION: FG to arrange for the Trust Board to have a presentation on the work of the clinical audit and research unit.

DATE OF COMPLETION: 3rd June 2014

25. Report from the Trust Chairman

25.1 The Chair noted that he had visited the ambulance service whilst he was in New Zealand and noted that the Trust would need to think innovatively about the possibility of recruiting staff from New Zealand.

25.2 Roy Griffins joined the meeting.

26. Quality Report

Quality Report

26.1 Steve Lennox reported that the overall position had improved which demonstrated that when the Trust was sufficiently resourced the quality position improved as well as operational performance.

26.2 Jessica Cecil noted that handover to hospital time had increased and asked whether this was a concern. Steve Lennox responded that this was not within the LAS's control to improve, but was an indication of demand at hospital emergency departments.

26.3 The Chair noted that lost property was consistently rated amber and asked whether this would be reported differently in the future. Steve Lennox responded that it had been proposed that this indicator was removed from the quality dashboard as the data recorded the number of enquiries about lost property, rather than the number of incidents where the LAS had been found responsible for the loss. Fionna Moore added that there was little evidence to suggest that patient property was lost whilst the patient was in our care.

26.4 Steve noted that the infection control (cleaning) indicator was currently rated red. This was due to the fact that the KPIs for the vehicle cleaning contract were based the whole fleet and performance against the KPIs was bolstered by Patient Transport Service (PTS) vehicles which were easier to clean. The structure of the contract would be revised next year so that there were separate KPIs for A&E vehicles and PTS vehicles. Jason Killens added that crews would clean any vehicle that was soiled or would change their vehicle if heavily soiled.

26.5 Ann Radmore suggested that the Trust Board should approve the vehicle cleaning contract for next year. Theo de Pencier suggested that next year's contract should include a clause which allowed the contract to be reviewed within its period of operation.

Clinical Quality and Patient Safety Report

26.6 Fionna Moore noted that the Trust had been invited to participate in a multisite clinical research trial, comparing both the clinical outcomes and the cost effectiveness of adrenaline versus a saline placebo in out-of-hospital cardiac arrest. An LAS paper had also been published in an international peer reviewed journal relating to the management of STEMI patients with return of spontaneous circulation.

26.7 The Chair asked whether the Trust did enough to publicise these achievements. Ann Radmore responded that the LAS had done well in terms of sharing good practice with other ambulance

trusts, but could publicise these achievements more widely. Bob McFarland commented that the findings from these research trials supported the argument for the restructure of emergency care.

26.8 Fionna Moore noted the following:

- Progress had been made to ensure that Co-ordinate My Care (CMC) records were reflected in the Control Room and were logged on CommandPoint. An electronic interface was being developed so that CMC addresses would be flagged automatically within the CommandPoint system and it was anticipated that this interface would be in place from Q3;
- An overview of serious incidents that had been declared since January was included in the report;
- The LAS had appointed the first cohort of 13 Advanced Paramedic Practitioners.

26.9 Steve Lennox reported that additional resource had been added to the Patient Experience team, however there were currently 138 complaints in the system.

26.10 Jessica Cecil noted that the overall arrival on scene for STEMI patients had reduced, however the length of time on scene remained high and asked which indicator had a greater impact on patient care. Fionna Moore responded that the overall time from call to angioplasty was the most significant factor and the arrival on scene would have a greater impact on this. The Trust was above target for the percentage of patients receiving angioplasty within 150 minutes of calling the ambulance service.

26.11 Bob McFarland asked why CPI completion had reduced. Fionna Moore responded that this was due to the unavailability of Team Leaders who had been deployed to frontline operational duties during this period. The ability to provide face to face feedback to staff had also suffered. Jason Killens added that from April 2014, Team Leaders would be released back to their usual duties and therefore this indicator should show an improvement. The Trust was also recruiting an additional 50 Clinical Team Leaders.

26.12 Ann Radmore noted that mental health had been identified as a priority for next year and Steve was drawing up an action plan which would include staff training and education. Ann Radmore added that the action plan should be finalised within the next two months and suggested that the plan was reviewed and discussed by the Quality Committee.

ACTION: SL to ensure that the Quality Committee reviewed the mental health action plan.

DATE OF COMPLETION: 18th June 2014

26.13 The Trust Board considered the following question from the Patients' Forum:

26.14 As the incidence of complaints about staff attitude and behaviour have remained the most frequent cause of complaint from patients over many years, what action will the Board take to ensure that staff training and appraisal are focused on reducing the incidence of these complaints?

26.15 Steve Lennox responded that attitude and behaviour was not the most frequent reason for making a complaint, however this category of complaints was taken very seriously and the profile of attitude and behaviour had been raised during the year. Any member of staff who had a complaint made against them for attitude and behaviour had a reflective exercise and they also received a copy of the final response letter. Complaint figures were monitored at the Learning from Experience Committee where the Patients' Forum was represented. Ultimately, this work would sit within our revised vision and values work which would be implemented in 2014.

26.16 Ann Radmore commented that complaints about attitude and behaviour were complex and did not necessarily always relate to customer service. For example, it could be that a member of staff had been unable to diffuse a highly-charged situation or that they had recommended an alternative response. Attitude and behaviour needed to be considered in the context of supporting a younger workforce who may have limited life experience. Ann added that, although a relatively small proportion of incidents resulted in a complaint about attitude and behaviour, the learning from Mid-Staffordshire NHS Foundation Trust was that complaining was difficult and therefore complaints should be viewed as a reflection of the organisation.

26.17 Caroline Silver asked whether there was an opportunity to pair up younger members of staff with older members of staff. Jason responded that there was some scope to do this, but it would be difficult to achieve across the organisation due to the fact that there were many more younger members of staff.

26.18 Theo de Pencier asked whether compliments were used to inform communications. Ann Radmore responded that some were used as case stories, however the ambulance service received fewer letters of thanks than hospitals as patients were only in our care for part of their care journey. The LAS had recently enhanced the website to make it easier for patients and public to express their thanks.

26.19 The Trust Board considered the following question from the Patients' Forum:

26.20 Can the Board supply figures showing how many Serious Incidents (SIs) declared over the past six months were connected to the care of patients designated as requiring a C1 and C2 response?

26.21 Sandra responded that 5 SIs had been declared in the past 6 months relating to C2 patients. These incidents had occurred in November/December 2013 and related to a time when performance had been difficult to maintain. No serious incidents relating to C1 or C2 patients had been declared since January 2014.

Report from the Quality Committee

26.22 Bob McFarland reported that, at its last meeting, the Quality Committee had reviewed the Surge Plan and, on the basis of this discussion, was able to provide assurance to the Trust Board on its safety and effectiveness. The plan was well thought out and came into action in periods of both high and low demand.

26.23 Bob added that the committee had also discussed its future role and membership and this would be discussed further in the Part II meeting.

27. Integrated Board Performance Report

27.1 Andrew Grimshaw reported the following:

- The workforce indicators remained static;
- The performance position had improved as a consequence of additional capacity. The Trust was tracking performance on a daily basis to achieve the 75% A8 year end target;
- The finance position was on track, although there were some issues relating to the underspend on the capital plan. Further detail would be provided under the finance report.

27.2 The Chair noted that the integrated board performance report was a useful document and it was encouraging to hear that the Trust was on track to achieve the year end performance target. The

Chair recognised that significant effort from across the organisation had gone into improving this position.

27.3 Bob McFarland noted that C1 performance had also been maintained.

27.4 Caroline Silver noted that it was very impressive to come through the performance challenges that the Trust had faced this winter and to achieve the targets.

27.5 The Trust Board considered the following questions from the Patients' Forum:

27.6 Can the Board supply figures showing how many patients requiring a Category C1 response waited for more than an hour for an ambulance during December, January and February 2013/14?

27.7 Jason responded that the following number of C1 patients waited for more than an hour:

- December – 480 (9.8% of total C1 patients)
- January – 201 (4.5% of total C1 patients)
- February – 221 (4.8% of total C1 patients)

27.8 Can the Board supply figures showing how many patients requiring a Cat C2 response, waited for more than one and a half hours for an ambulance during December, January and February 2013/14?

27.9 Jason responded that the following number of C2 patients waited for more than an hour:

- December – 2307 (9.2% of total C2 patients)
- January – 847 (3.3% of total C2 patients)
- February – 1084 (4.6% of total C2 patients)

28. <u>Board Assurance Framework and Corporate Risk Register – Quarter 4 documents</u>

28.1 Sandra Adams noted that the Board Assurance Framework (BAF) gave an overview of the key risks to achieving the strategic objectives and corporate objectives and the Trust's high risks. Page 2 of the document illustrated the movement of key risks, some of which it was expected would be closed in quarter 1.

28.2 Caroline Silver commented that the Audit Committee had had a thorough discussion on the BAF, including whether it was acceptable for a risk to remain red even after the mitigating actions had been taken. The Audit Committee thought that the new format of the board assurance framework was a good piece of work and a helpful graphic.

28.3 The Chair agreed that the BAF was a useful document and asked whether the Trust Board should devote more time to this, for example at a Strategy Review and Planning Committee meeting. Caroline suggested that it would be useful as an initial step for the whole board to understand the Audit Committee's deep dive of risks.

28.4 Theo de Pencier commented that risk management was a significant part of other boards' agendas and asked whether there were any external risks that should be considered eg a significant curtailment of the NHS budget.

28.5 John Jones drew attention to risk 387 (There is a risk that LAS could be in a position where its call handling system is unsupported by Priority Dispatch Systems from late 2014 onwards…) and asked whether the workshop had taken place as indicated. Jason Killens confirmed that the workshop had

taken place and it had been agreed that the Trust would continue to work with MPDS for the time being. This decision had removed the immediacy of this risk, however the medium and long-term risks would need to be worked through. Ann Radmore added that the Trust would need to consider a strategic decision about whether it adopted NHS Pathways going forward.

Report from the Audit Committee

28.6 Caroline Silver noted that the Audit Committee had last met on 3rd February and had been joined by Bob McFarland as chair of the Quality Committee. Caroline noted the following:

- The Audit Committee considered routine business as outlined in the report;
- The Audit Committee reviewed the modernisation programme risks as part of its programme of deep dive reviews. Internal Audit had made suggestions of how the Audit Committee could conduct the deep dive reviews in future;
- Internal Audit had assessed cyber security as providing limited assurance. A number of the recommendations made had resourcing implications and the Audit Committee had asked for an update at its next meeting. The Audit Committee was encouraged by the fact that the executive had put forward cyber security as an area for review and this demonstrated that the executive was comfortable with bringing these issues forward;
- There had been some slippage against internal audit recommendations and the committee had asked for this position to be improved by the time of the next meeting;
- Progress had been made against the internal audit recommendations for serious incidents.

28.7 Caroline noted that this was her last meeting as Chair of the Audit Committee and stated that over the years the internal audit function and risk management function had materially improved. The transition to new internal and external auditors had also gone well. Caroline noted that in other organisations she had seen an emerging view that there should be a separate committee for risk management and this was something that LAS should bear in mind. Roy Griffins agreed that there was a clear case for differentiating audit and risk functions.

28.8 The Chair noted these points and stated that they should be considered in Trust Board discussions about how the organisation managed risk. The Chair thanked Caroline for her chairmanship of the Audit Committee.

29. Finance Report

Month 11 report

29.1 Andrew Grimshaw noted the following:

- The delivery of the target surplus was secure. There were some remaining issues to resolve relating to the capital spend;
- The report showed significant expenditure at variance to the budget, which related to winter working. This additional expenditure was funded, however the Trust was not permitted to vary its budget in-year. The overall position was therefore balanced. Consideration would need to be given to how this would be reported more clearly in the future.

29.2 The Chair noted that performance had been achieved due to the additional funding.

Charitable Funds

29.3 Andrew Grimshaw proposed that he became the executive lead for charities and a non-executive lead would need to be identified. The Trust Board was also asked to rescind its previous decision to

wind up the general charitable fund.

29.4 Caroline Silver commented that there was an ongoing issue to consider relating to long-service and retirement gratuities and other gratuities that had been funded by the charitable fund, such as the staff Christmas parties. These items might seem like small amounts of money, but often meant a lot to staff.

29.5 The Chair noted that the Trust Board needed to have a wider discussion about charitable funds going forward, including the Community Responder charity, and how the funds would be used.

29.6 Ann Radmore commented that every other NHS trust had a general charitable fund which funded a range of different activities. The LAS might also consider whether it wanted to have a "friends of" charity, which was separate from the general fund. Ann Radmore commented that any fund raising activity for the LAS general fund should not detract from what staff currently did to raise money for the Chief Executive's charity.

29.7 The Trust Board agreed to rescind its previous decision to wind up the general charitable fund.

Report from the Finance and Investment Committee

29.8 Nick Martin commented that the Finance and Investment Committee was pleased to note that the Trust was on track to achieve its year end financial targets. The committee would take a detailed look at costings, efficiencies and agenda for change at its meeting in May. Andrew Grimshaw added that a formal review of the committee was underway.

30. Clwyd Report: A Gap Analysis

30.1 Steve Lennox explained that the Clwyd Report had been commissioned after the Francis report into Mid-Staffordshire NHS Foundation Trust had highlighted that complaints were an early warning sign of problems.

30.2 The gap analysis demonstrated that the Trust was compliant with the majority of the recommendations, however there was more that the Trust could do to enhance the patient voice. This would be progressed throughout the year in conjunction with other areas of work.

30.3 The Trust Board approved the gap analysis and recommended action.

31. Francis and Berwick: Progress Update and the way forward

31.1 Steve Lennox reported that the briefing updated the Trust Board on the intended strategic direction of the Trust's response to Francis and Berwick, which would focus on strengthening the staff and patient voice.

31.2 The Trust Board approved the strategic direction for the Trust's Francis and Berwick work.

32. The NHS Constitution

32.1 Steve Lennox reported that this paper outlined the Trust's position against the rights and pledges of the NHS Constitution. The gap analysis would inform the Trust's review of its organisational values. Steve urged Trust Board members to read the NHS Constitution as all Trust Board members would need to take ownership of this.

32.2 A discussion followed about appropriate care pathways and Caroline Silver noted that there was an

apparent conflict between what the patient might deem was right for them and what a member of staff might think was best for them. Ann Radmore added that there was also a potential conflict between the NHS Constitution and the service the Trust was commissioned to provide. The Chair noted that, as directors, the Trust Board members needed to understand the NHS Constitution and this potential conflict.

32.3 Roy Griffins stated that Trust Board members needed to understand the legal position in relation to the NHS Constitution. Ann Radmore responded that, in her knowledge, there had not been any prosecutions so far.

32.4 The Chair noted that it would be useful to meet with Steve Lennox to understand this further.

ACTION: RH to meet with SL to discuss the NHS Constitution and its application.

DATE OF COMPLETION: 3rd June 2014

32.5 The Trust Board noted this report.

33. Operating Plan 2014 - 2016

Operating Plan 2014 – 16

33.1 Karen Broughton explained that this paper brought the Trust Board up to date with the submissions made. A further return would be required to be made at the beginning of April. Development of the strategy would continue working towards submission to the NHS Trust Development Agency in June.

Financial Plan

33.2 Andrew Grimshaw gave a presentation on the financial plan for 2014/15 and noted that there had been no significant changes since it had been presented to the Strategy Review and Planning Committee in February 2014.

33.3 Karen Broughton noted that they had had productive conversations with commissioners this year and they had agreed to review utilisation rates going forward.

33.4 Andrew noted that the financial plan had been discussed at the Finance and Investment Committee meeting and Nick Martin, chair of the committee, was content to recommend that the Trust Board approve the plan.

33.5 The Trust Board agreed to delegate authority to Andrew Grimshaw and Ann Radmore for making minor alterations to the plan.

33.6 Ann Radmore commented that they had had a constructive discussion with commissioners and the plan was in a sufficiently developed state for approval by the Trust Board.

33.7 Fergus Cass asked how the issue of utilisation would be addressed. Ann responded that this issue had been raised with the commissioners who now recognised the issue, however it was unlikely that the issue would be resolved in one contracting round. The Trust also had to manage the probable loss of the CBRN funding.

33.8 The Chair commented that he did not think that there was sufficient understanding that high

utilisation rates limited the Trust's capacity to flex performance. The ORH review had indicated that the LAS utilisation rate was amongst the highest in the world.

33.9 Nick Martin commented that a further item to consider was the movement towards payment by results. Karen responded that it would be part of the contract that the LAS would be committed to reviewing how the service was funded going forward.

33.10 Subject to these comments, the Trust Board approved the financial plan for 2014/15.

34. Staff Survey Action Plan

34.1 Jane Chalmers joined the meeting for this agenda item.

34.2 Jane reported that five key issues had been identified following the staff survey: pressure on staff; feeling valued; appraisals; communications and interactions with managers; and bullying and harassment. Staff responses might have been influenced by external factors such as unsocial hours pay and the pay freeze, however there were a number of actions that the Trust could take internally to improve the position. The action plan outlined the actions that would be taken over a three year period, which would be aligned with the staff engagement strategy. The quarterly temperature checks would enable progress to be tracked.

34.3 The Chair noted that the staff survey results represented an opportunity to make material improvements. There did seem however to be a misalignment between feedback from Listening into Action and the results of the staff survey. The Trust Board noted that this was because the questions in the NHS staff survey did not always relate to LAS staff, however the quarterly temperature checks would be more relevant to our staff.

34.4 The Chair noted that there were a number of issues to be addressed which would feature in the Trust's priorities going forward.

34.5 Bob McFarland asked what progress had been made in the training and recruitment of Team Leaders. Mark Whitbread responded that Team Leaders had started to receive clinical training. Jason added that they would also receive management development to enable them improve the management and leadership of their teams. Theo de Pencier noted that first line management could have a significant impact on staff engagement.

35. Report from Chief Executive

35.1 Ann Radmore noted that a member of staff, who had been based at Croydon ambulance service, had died in service following a short illness. Our thoughts were with his family and colleagues at this sad time.

35.2 Ann noted the following:

- Staff had been deployed to South Central Ambulance Service and South Western Ambulance Service NHS Foundation Trust following a request for mutual aid during the periods of heavy flooding. The service had also provided aid within London in response to the flooding;
- The Trust had won the Flu Fighter Award for 2013/14 and hoped to build on this further for next year;
- The Foundation Trust Network had highlighted significant financial challenges across NHS Trusts as they entered 2014/15;
- Health Education England wanted to see the paramedic profession move towards a

graduate BSC qualification;
- The inspection of ambulance services as part of the Foundation Trust process was still an unknown, however it was unlikely that the LAS would be the first to undergo inspection.

35.3 The Trust Board noted this update.

36. Modernisation Programme

36.1 Jason Killens reported that the outcome of the agenda for change matching panel had assessed the role of Ambulance Practitioner (working title) at band 4. Annex U of the agenda for change handbook would be used in order to control the pay of staff transitioning into this new role. The transition process would be drawn up in the next four weeks.

36.2 Jane Chalmers stated that this meant that implementation planning could begin. Approximately 6 rosters remained to be finalised within the next few weeks.

36.3 The Chair noted that this represented good progress.

37. Board Declarations – self-certification, compliance and board statements

37.1 The Trust Board approved the submission of the declarations for February and March 2014 stating full compliance with the Board Statements and Monitor Compliance.

37.2 Sandra Adams noted that the full documents were available if required.

38. Trust Board Register of Interests

38.1 The Trust Board noted the register of interests.

39. Report from Trust Secretary

39.1 The Trust Board noted the report from the Trust Secretary.

39.2 Sandra Adams commented that there had been one instance where the Trust had had to retender as there had not been sufficient competition in the first tendering round.

40. Forward Planner

40.1 The Trust Board noted the forward planner.

41. Questions from members of the Public

41.1 There were no new questions from members of the public.

42. Any other business

42.1 There were no items of other business.

42.3 The public meeting closed at 12.50

43. Date of next meeting

43.1 The next meeting of the Trust Board is on Tuesday

……
Signed by the Chair

ACTIONS

from the Meeting of the Trust Board held on 25th March 2014

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
20/12/13	**164.2**	AG to present a proposal for measuring value for money and a paper on non-productive time to the next Finance and Investment Committee before the Trust Board meeting in January.	**AG**	Paper to March Finance and Investment Committee. To be addressed in the Finance and Investment Committee updates to the Board.
28/01/13	**06.4**	SA to arrange for the Trust Board to have a briefing on the governance structure and the role of the committees.	**SA**	Document to be updated and circulated.
25/03/13	**24.6**	FG to arrange for the Trust Board to have a presentation on the work of the clinical audit and research unit.	**FG**	To be arranged.
25/03/13	**26.12**	SL to ensure that the Quality Committee reviewed the mental health action plan.	**SL**	
25/03/13	**32.4**	RH to meet with SL to discuss the NHS Constitution and its application.	**RH**	

CLOSED ACTIONS

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
20/12/13	**164.7**	JK to provide information to the Quality Committee on the specification for third party providers for the transportation of patients who presented a risk to themselves or others.	**JK**	Action complete. A response has been written from the Chair of the Quality Committee to the Chair of the Patients' Forum.
20/12/13	**166.4**	Steve Lennox to present a report to the Trust Board on the Clwyd Review on Complaints Management.	**SL**	Action complete.

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
28/01/13	**06.3**	RG to send SA details of a recent appeal which he thought would have an impact on the way in which serious incidents were managed.	**RG**	Completed. SA to review and determine the action to be taken.
28/01/13	**06.9**	SA/FM to include a quarterly serious incident update in the Clinical Quality and Patient Safety Report.	**SA**	More detailed update report to be incorporated from April 2014. Summary information already provided in the monthly report.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 3RD JUNE 2014

PAPER FOR APPROVAL

Document Title:	**Annual Report 2013/14**
Report Author(s):	**Sandra Adams/Alex Bass**
Lead Director:	**Sandra Adams, Director of Corporate Services**
Contact Details:	**sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To obtain approval for the annual report**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Executive Management Team ☐ Quality Committee ☒ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**That the Trust Board approves the annual report and the Annual Governance Statement**

Key issues and risks arising from this paper

None.

Executive Summary

- As an NHS organisation, we have a statutory duty to publish, as a single document, an annual report and accounts to include the annual report; the remuneration report; a statement of the Accounting Officer's responsibilities; a governance statement; the primary financial statements and notes and the audit opinion and report.
- The minimum content for the annual report is set out in the Department of Health's NHS Finance manual (Manual for accounts chapter 2).
- The Trust Board is asked to approve the annual report.
- The annual report will then be combined into one document with the accounts and published on the Service's website along with the Quality Account.
- The annual report will be presented at the AGM in September.

Attachments

Draft copy of the 2013/14 annual report.
Annual Governance Statement for 2013/14

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Quality Strategy

This paper supports the following domains of the quality strategy

☒ Preventing people from dying prematurely
☒ Enhancing quality of life for people with long-term conditions
☒ Helping people to recover from episodes of ill health or following injury
☒ Ensuring people have a positive experience of care
☒ Treating and caring for people in a safe environment and protecting them from avoidable harm
☒ Caring for the workforce

LAS Strategic Goals and Priorities

This paper supports the achievement of the following strategic goals and priorities:

LAS Strategic Goals

☒ To improve the quality of care we provide to our patients
☒ To develop care with a highly skilled and representative workforce
☒ To provide value for money

2013/14 Priorities

☒ Modernisation Programme
☒ Communication and Engagement
☒ Sustain performance to ensure safe service to patients
☒ Building sustainable financial position for 14/15 and beyond

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

Has an Equality Analysis been carried out?

☐ Yes
☒ No

Key issues from the assessment:

London Ambulance Service NHS
NHS Trust

Annual Report

2013/14

Strategic report

Who we are

The London Ambulance Service NHS Trust is the busiest emergency ambulance service in the UK providing healthcare that is free to patients at the point of delivery. We are also the only London-wide NHS trust.

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

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

We also run a patient transport service which provides pre-arranged transportation for patients to and from their hospital appointments. In addition, we manage the emergency bed service, a bed-finding system for NHS healthcare professionals who need to make arrangements for their seriously-ill patients.

We are led by a Trust Board made up of 12 members – a non-executive chairman, five executive directors, including the Chief Executive, and six non-executive directors.

As an integral part of the NHS in London, we work closely with hospitals and other healthcare professionals, as well as with other emergency services. We are also central to planning for, and responding to, large-scale events or major incidents in the capital.

We have over 4,500 staff who work across a wide range of roles. We serve more than eight million people who live and work in the London area. This covers about 620 square miles, from Heathrow in the west to Upminster in the east, and from Enfield in the north to Purley in the south.

In 2013/14 we handled over 1.7 million emergency calls from across London and attended more than one million incidents.

We are committed to developing and improving the service we provide to the people who live in, work in, and visit London.

Chairman Richard Hunt's views

What were the key achievements last year?

It is important to recognise the efforts of all colleagues in helping to ensure that once again we achieved our main performance target, which saw us reaching more of the most seriously ill and injured patients more quickly.

On top of this, we also took on the running of the NHS 111 system in south east London and it has been very pleasing to see it working well.

What improvements have patients seen over the last year?

We continued to improve the quality of care provided to patients, especially those who were most seriously ill and injured. They received a fast response from us, even though we were attending more life-threatening (Category A) calls than ever.

Improved ways of working meant that patients who needed to go to hospital had a better experience. They waited less time to be handed over by our clinicians at emergency departments, and we introduced a system to manage the flow of patients into hospitals across London, reducing queuing and diverts.

What is the board's thinking around the future direction of the Service?

We have been developing a new five-year strategy, building on all our previous work. We will be looking at how we can make it easier for people in London to get the urgent and emergency care they need quickly and how we can do more for patients by providing more treatment at the scene or at home without needing to take them to hospital.

We also want to offer more advice and care over the phone where it is clinically safe to do so, while at the same time working closely with our partners across health, social care and the other emergency services.

How is the Service's application to become a foundation trust progressing?

We have been working with the NHS Trust Development Authority to agree a timeline on a new application, which as we meet all the necessary requirements will, given current timescales, probably see us licensed as an NHS foundation trust in 2016/17.

One of the main areas of work this year as part of this process is likely to be around consulting with our stakeholders, staff and public members about our current membership arrangements and constituency groups.

Chief Executive Ann Radmore's views

You launched a programme of changes this year. How has this gone?

We have made huge progress. This is a significant programme of change for how we run the Service. We have agreed a new rota for every ambulance station and, with union colleagues, a new role and job description for staff to work with paramedics.

Thanks to the investment we received from our commissioners, we were able to recruit more than 220 of these new staff.

We are moving in 2014/15 to implement these changes.

How have recent changes to the wider NHS affected the Service?

We are the cornerstone of the health service in London and want to work closely with clinical commissioning groups (CCGs) – who buy our services – to support their plans to improve care locally for their patients. We have been developing these relationships this year as CCGs have settled into their roles.

As part of this, during the year we started to make changes to our operational management structure to mirror the new CCG groupings and help enhance relationships with local commissioners.

What are your plans to attract new staff, and retain existing staff, over the next twelve months?

We want to increase paramedic numbers due to increases in demand and because we want to have more of these registered healthcare professionals overseeing the care of our patients. We are actively recruiting in the UK, abroad and from other sources to both increase paramedics and other healthcare staff.

What we did see during the year was more frontline staff leaving than we were expecting, which obviously put increased pressure on other colleagues.

We have now developed a clear clinical career structure to provide staff with opportunities to develop their skills and progress their career with us. The first team of 12 advanced paramedic practitioners started delivering care in May 2014.

What are your other priorities for this year?

As always we need to continue with our focus on patients and clinical issues to deliver better care to our patients, particularly those with mental health issues. Over the next 12 months, we are also planning to get 1,000 extra defibrillators placed in public places across London.

Our vision and strategic goals

Our vision is to be a world-class service, meeting the needs of the public and our patients, with staff who are well-trained, caring, enthusiastic and proud of the job they do.

We want to deliver the highest standards of healthcare and contribute towards people who live and work in London having health outcomes that are among the best in the world.

Our strategic goals for 2013/14 were:

- to improve the quality of care we provide to our patients
- to deliver care with a highly skilled and representative workforce
- to provide value for money.

These are supported by a number of corporate objectives, details of which can be found in the following pages of this report.

Looking ahead, we are now in the process of developing a longer term strategy to take the organisation forward to 2020.

This is due to be finalised later in 2014, and is likely to include how we can provide a more flexible response to our patients and work more closely with partners across health and social care to integrate our services so that patients receive joined up care and experience better outcomes.

We have also continued to work with the NHS Trust Development Authority on a timeline to become an NHS foundation trust.

Our achievements during 2013/14

Strategic goal: Improve the quality of care we provide to our patients

We have an increasingly important role to play in improving the health outcomes of patients in London.

Our objectives are:

- To improve the experience and outcomes for patients who are critically ill or injured
- To improve the experience and provide more appropriate care for patients with less serious illnesses or injuries
- To meet response times routinely, and
- To meet all other quality, regulatory and performance targets.

2013/14 was another very challenging year, but despite this we were able to continue to reach our most seriously ill and injured patients quickly and provide them with a safe service.

Increasing levels of demand again made it more difficult to always attend those with less serious conditions as quickly as we would have wanted to, and we will continue to look to improve the ways in which we manage and respond to these calls.

As well as time based targets, all ambulance services were measured against a set of clinical indicators that help assess the quality of care provided to patients.

Full details on these and other patient care issues can be found in our Quality Account, which will be published in the summer.

Change programme

At the end of April 2013, we announced plans for a two-year change programme to help improve the care we provide to patients and the working lives of our staff.

This started with a consultation process with staff, followed by the setting up of a number of different projects to look at issues such as staff rotas, annual leave arrangements and a clinical career structure, with the intention of then being able to change the way we respond to some patients.

During the year, we worked closely with staff and our unions to move this work forward, so that in 2014/15 we will be able to bring in a new frontline staffing system that will see more patient care overseen by paramedics, along with new rotas and annual leave arrangements to help ensure that we have staff working when patients need us most.

- ***Improving the experience and outcomes for patients who are critically ill or injured***

  Trauma care: Our staff continued to take patients with life-threatening injuries to one of four specialist centres in the capital which are open round the clock, with expert clinicians available to provide the best possible care.

Cardiac care – heart attack:
There are eight specialist centres in London where patients who are diagnosed as suffering a common type of heart attack, known as an ST-elevation myocardial infarction, can be taken directly by ambulance staff. They can then undergo primary angioplasty, a procedure which involves inflating a balloon inside an artery to clear the blockage that has caused the heart attack.

One of the national clinical indicators looks at the percentage of those patients who receive this treatment within two and a half hours of the 999 call being received. The latest available figure for the Service - from April to December 2013 - was 92.3 per cent[1], compared to 93 per cent for the full 2012/13 year.

Cardiac care – cardiac arrest:
Thanks to the quality of care provided by our staff, the survival rates of patients who suffer an out-of-hospital cardiac arrest continue to rate as some of the highest in the country, and our published figures are also among the best in the world.

Published figures for between April to December 2013 show that 30.5 per cent[2] of patients whose hearts stopped beating, at home or in public, were resuscitated and discharged from hospital. In 2012/13, the full year figure was 28.4 per cent.
There are now over 1,000 defibrillators available in public places across the capital. These include tourist attractions, airports and train stations.

During the year, we also trained 19,900 members of the public in cardio-pulmonary resuscitation – a simple life-saving technique which involves giving chest compressions and rescue breaths to someone whose heart has stopped beating.

We currently manage 63 community responder and co-responder schemes in London whereby volunteers are trained to attend emergency calls in their local area and provide first aid to patients until an ambulance arrives. We now have 1,273 trained volunteers within these schemes.

Michelle's story: In June last year, Michelle Kendall, a nurse from Bromley, met up with the paramedics who treated her when she suffered a cardiac arrest in April 2013.

Michelle's husband David started CPR while help was on the way and Paramedics

[1] This figure is provisional, based on data available in May 2014
[2] This figure is provisional, based on data available in May 2014

Kieren Marks, Lynsey Grant, Kenneth Chibata along with Emergency Medical Technician Matthew Marsh arrived on scene shortly after. They gave Michelle's heart four shocks with a defibrillator and it restarted.

Michelle was taken to Lewisham Hospital. Three days later, she was transferred to King's College Hospital, where she was fitted with an internal defibrillator that shocks her heart back to normal rhythm if it starts to beat irregularly.

Stroke care:
We take patients who we diagnose with stroke symptoms directly to one of eight specialist stroke centres in London. Here they have rapid access to life-saving treatment which can increase their chances of survival and cut the risk of long-term disability caused by a stroke – which occurs when the blood supply to part of the brain is cut off.

During the year, we took just over 10,300 stroke patients to a hyper acute stroke unit, equating to around 98 per cent of all stroke patients who we attended.[3]

One of the national indicator measures is the percentage of stroke patients who arrive at a specialist centre within 60 minutes of us receiving the 999 call. Figures available for the first nine months of last year show that we achieved this in 65.7 per cent of cases.

- ***Improving the experience and providing more appropriate care for patients with less serious illnesses and injuries***

During 2013/14, we treated a wide range of patients presenting with less serious conditions.

Taking patients to the right place of care: As part of a wider NHS response to managing patients with less serious conditions, we continued our work to identify suitable alternative destinations where appropriate care can be provided away from the traditional hospital environment.

These include minor injuries units, urgent care centres and walk-in centres, some of the latter being provided as part of the services at some larger GP practices. Frontline staff have received training and guidance to enable them to better assess minor injuries, illnesses and conditions, and from this decide on the appropriate destination for patients.

Clinical telephone advice: Our clinical telephone advisors helped 70,195 patients over the phone, up from 68,479 in the previous year.

This way of responding to those with less serious illnesses and injuries was supported by the development of a new clinical hub in our main control room. This is made up of two parts – clinical advisors, who review calls and ring back patients, and clinical team leaders, who provide advice to frontline ambulance staff as well as patients.

[3] This figure is provisional, based on data available in May 2014

NHS 111: In November 2013, we took over the running of the NHS 111 system in south east London after NHS Direct withdrew from the contract.

As part of the step-in arrangements – which will run until March 2015 – around 120 former NHS Direct staff joined our organisation and we also took over the management of the existing call centre.

Between the start of the contract and the end of March 2013, we handled 106,698 calls, with 97.57 per cent answered within 60 seconds against a target of 95 per cent.

In the same period, only 1.8 per cent of patients had to be called back as their query could not be directly dealt with at the time of it being received, and when this did happen more than 79.6 per cent of call backs were made within 10 minutes.

Care of mental health patients: We have continued to work with mental health trusts across London to develop arrangements so that any mental health patients who we attend can be taken to the right place for treatment.

Improving our care to all mental health patients, including those with dementia, is a priority for us in 2014/15, and our commissioners have made additional funding available for training so that we can increase our frontline staff's awareness and understanding of mental health and dementia, and equip them with the skills to enable them to decide on the best care for these patients.

We also continued to examine complaints with a mental health component, and where possible are meeting with mental health trusts to agree personalised care plans for their patients, and the options available to them apart from calling for an ambulance.

End-of-life care: We continued to work with both NHS and hospice-based end-of-life care providers to provide appropriate care and support. We also continued to develop staff skills, training and competencies, the way we collate patient information and how we communicate with local providers of end-of-life care services.

Patients with pre-arranged hospital appointments: As well responding to emergency calls, we offer pre-arranged transport for patients to and from their hospital appointments.

We carried out 184,092 of these journeys during the year, compared to 177,379 in 2012/13.

We delivered patients to hospital on time for 93 per cent of the journeys, which compares to 92 per cent in 2012/13.

In terms of departing from hospital, we left on time in 93 per cent of cases (94 per cent in 2012/13).

Ninety eight per cent of our patients had a journey time of less than an hour, an increase from 97 per cent last year.

- ***Meeting response times routinely***

We received a total of 1,733,397 emergency calls during the year, up 1.5 per cent on 2012/13.

From these, we responded to 1,090,277 emergency incidents, up from 1,068,338 in the previous 12 months.

We took 748,531 patients to a hospital accident and emergency department, compared to 747,360 in 2012/13.

We also conveyed 91,380 people to another appropriate care centre, such as a minor injuries unit – this figure was 89,996 last year.

A further 256,448 patients were attended by our staff but were not taken anywhere for further medical treatment.

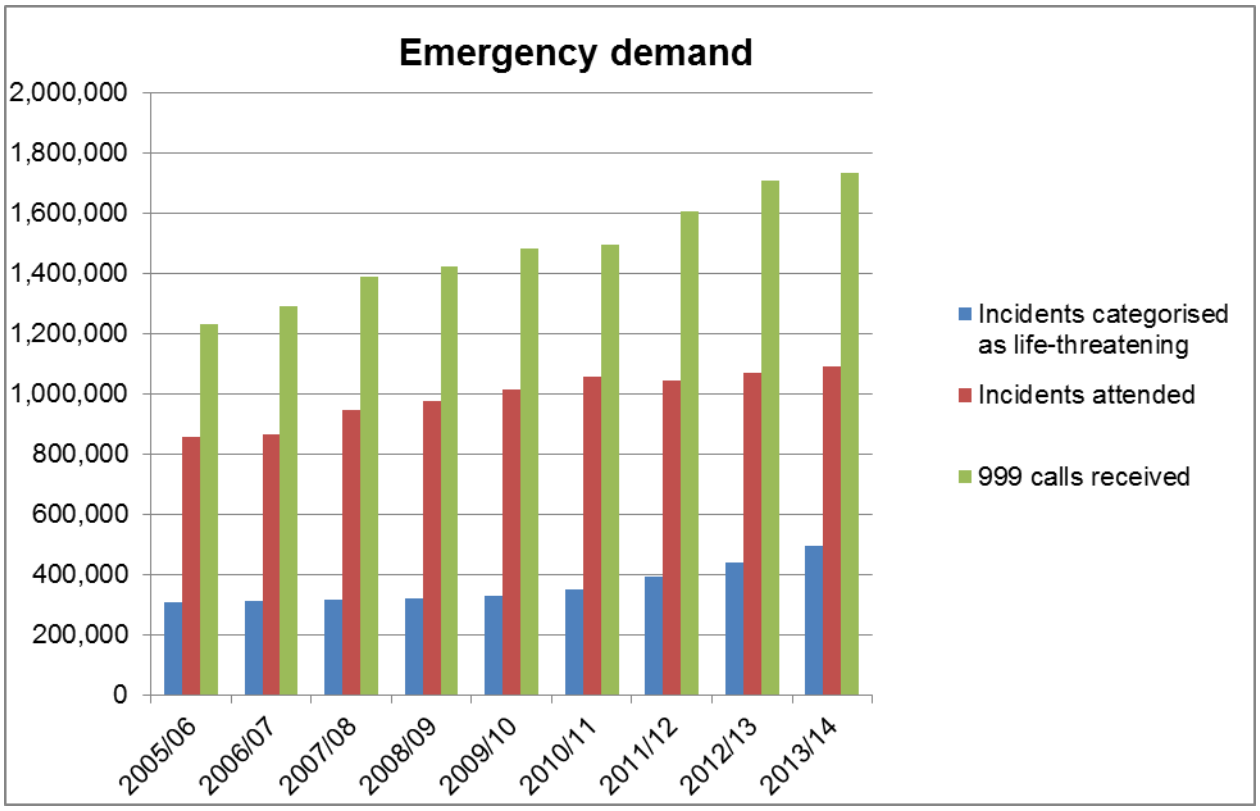
Category A: Of the total calls received, 496,348 were treated as life-threatening (Category A), compared to 465,197 in 2012/13.

Despite this increase, for the eleventh year in a row we managed to achieve the national response time targets to reach:

- 75 per cent of Category A calls within eight minutes
- 95 per cent of Category A calls within 19 minutes

We attended a total of 460,615 Category A incidents, compared to 438,067 in 2012/13, and we reached 75.36 per cent (347,150) of these patients within eight minutes.

We arrived at 97.86 per cent (450,787) of Category A patients within 19 minutes, against the target of 95 per cent.



Category C: All other calls fall into one of four C categories. We received 1,227,879 calls to Category C (lower priority) patients, up from 1,242,279 last year. A total of 629,149 were responded to by ambulance crews (compared to 642,233 in 2012/13) and we reached 84.1 per cent of these patients within our target time of 60 minutes, compared to 86.47 per cent in last year.

- ***Meeting all other quality, regulatory and performance requirements***

The Care Quality Commission carried out an inspection visit in August 2013 which found that we met all key standards and that "the organisation was well-led with arrangements in place to monitor the quality of its service and effectiveness in the provision of care."

The Director of Nursing and Quality is the lead for infection prevention and control and a scorecard is presented each month showing performance against key infection prevention and control indicators.

The Trust Board is also now being held to account by the NHS Trust Development Authority for compliance with the new provider licence requirements and the Board statements, and during the year the Board approved submission of declarations stating full compliance with the Board Statements and Monitor Compliance for 2013/14.

We have a local counter fraud specialist, whose contact details are available to all staff on our intranet site, and also an anti-bribery policy.

Strategic goal: Deliver care with a highly skilled and representative workforce

We want all staff on the frontline to have the skills to assess and treat a wide range of conditions, and those in other functions have the right skills to support them.

We also want to improve the diversity of our workforce, and focus on engaging with our staff more so that they are motivated and feel valued, and have a greater say in how we improve our service.

To achieve this goal we will:

- develop our staff so that they have the skills and confidence they need to deliver high quality care to a diverse population, and
- engage with our staff to improve patient care and productivity.

- ***Developing our staff so that they have the skills and confidence they need to deliver high quality care to a diverse population***

  Our workforce: At the end of March 2014, we had a workforce of 4,650 staff, made up of 2,602 men and 2,048 women.

  This was broken down as follows:

Staff group	Male	Female	Total
Directors	8	5	13
Other senior managers	276	139	415
All other staff	2318	1904	4222
Total	2602	2048	4650

  Over the course of the year, a total of 447 people left the Service – a turnover rate of 10.7 per cent, compared to 9.6 per cent in 2012/13.

  While we were able to recruit new staff during the year, we also saw existing frontline staff leaving in higher numbers than usual. Over 160 paramedics left during 2013/14, and so despite actively recruiting to this role we were left with around 250 vacancies at the end of the year.

  As well as offering eligible staff within our Service the opportunity to train to become paramedics and increasing our intake of graduates from universities, we have started to look overseas and have been approved to sponsor work visas for non-European paramedics.

  On a more positive note, we were able to recruit more than 220 new A&E support staff, who in the future will work alongside paramedics as part of the frontline response to emergency calls.

  We also made significant progress in developing a formal clinical career structure to help attract new staff and retain current employees. This included introducing a new role of advanced paramedic practitioner, who has additional skills to treat patients with complex conditions. The first group of advanced paramedic practitioners became operational in May 2014.

The rate of sickness among our staff for was 6.5 per cent, against a target of 5.5 per cent. This compares with a sickness rate of 5.32 per cent in 2012/13.

Our approach to equality and inclusion: Our aim is to ensure that equality and inclusion is integral to everything we do.

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

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

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

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

As an employer, we are focusing on:

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

During the year, we took 19th place in the charity Stonewall's Top 100 Employers list – up from 22nd place in the previous year. We were also recognised in the top 10 of their Healthcare Equality Index. Both were significant achievements and recognition of our inclusive policies and support networks for staff. As well as a Lesbian, Gay, Bisexual and Transgender Forum (LGBT), we also have a very active Deaf Awareness Forum and a new Black and Minority Ethnic (BME) Forum. Our LGBT forum was also recognised as one of Stonewall's star performer network Groups.

In terms of disabled employees, we are members of the Business Disability Forum as well as Carers UK. We have signed up to the Two Ticks 'positive about disabled people scheme' and our diversity forum for disabled people and carers, known as Enable, provides staff with a voice on policy and decision-making for our disabled employees and staff who are carers, including their involvement as 'critical friends' in our equality analysis.

We are members of Stonewall's Diversity Champions Scheme and the Employers' Network for Equality and Inclusion.

We are also members of Opportunity Now, a membership organisation representing employers who want to transform the workplace by ensuring inclusiveness for women; and we are members of Race for Opportunity which is a race diversity campaign committed to improving employment opportunities for ethnic minorities across the UK.

This year we will be updating our Equality and Inclusion Strategy as it has reached the end of its three-year cycle.

- ***Engaging with our staff to improve patient care and productivity***

We recognise that an engaged workforce is key to improving our services and productivity, and we are committed to communicating and engaging with staff to achieve this.

Our staff engagement score, informed by the 2013 NHS staff survey, was 2.97 (based on a score range from 1 to 5). This was calculated from findings related to staff members' perceived ability to contribute to improvements at work; their willingness to recommend the Service as a place to work or receive treatment; and the extent to which they feel motivated and engaged with their work.

This was down from 3.18 in 2012 and compared with a national ambulance trust average of 3.19.

Staff survey findings: A total of 1,777 staff members completed the 2013 survey, giving a response rate of 40.8 per cent. This was an increased rate of response against the 2012 staff survey which saw a response rate of 37.1 per cent.

The results showed a number of areas of concern, including increases in the percentage of employees who feel we do not have enough staff which is impacting on their ability to do their job properly, and an increase in staff who do not feel valued or recognised for the work they do.

Work has already started to address a number of the areas which staff have highlighted, but it is clear that there is still much more to do. This includes our modernisation programme (announced last April, with the aim of improving patient care and the working lives of staff), recruitment campaigns and a new approach to reward and recognition which is being developed as a result of the work of the Listening into Action reward and recognition project.

Listening into Action: In March 2012, we signed up to be part of Listening into Action (LiA), which was already being used by a number of other trusts across the country to change the way they listen to and involve staff.

Led by the Chief Executive, it is an approach designed to bring about positive change through collaboration with staff and has taken place through 2013/14.

In May 2013 over 250 members of staff attended 'Big Conversation' events where they got together to talk about the issues that get in the way of doing their job.

Key themes from the events informed seven projects to be taken forward: communications, 111 feedback, refreshments at hospitals, Medical Priority Dispatch System, learn about each other, recognition of excellence and Health Care Professional (HCP) education and development.

Each project had members of staff working on trialling and implementing new ideas to improve the way things work.

A number of changes have been made across the Service and we are planning to run LiA for a second year. We have been talking to those staff who worked on the 2013/14 projects to identify lessons learned and to get their views on what year two of the programme could look like.

Staff conferences: There were a number of internal conferences throughout the year which provided staff with an opportunity to hear about our future plans, and to raise issues that matter to them. In total, 10 events were held for managers and team leaders, while there were also six held for all staff last July to find out about developments in the Service.

We also held our first webinars for staff, and plan to run more of these in the future.

Opportunities for giving feedback and sharing ideas: We continued to use 'temperature check' surveys for staff to give feedback and suggestions on how to make improvements for the benefit of patients and their own working lives.

We also set up a closed social networking site, where staff can discuss issues and ask questions of managers. This now has around 1,500 staff as registered users.

Health and well-being: Staff volunteering as part of the LINC (Listening, Informal, Non-judgemental, Confidential) peer support worker initiative continued to provide support to colleagues on issues from work-related stress to family and social problems.

All staff are also encouraged to report any incidents or near misses, such as those involving patient safety or abuse or violence that they may themselves have experienced from patients or members of the public. The reports are collated by the Health, Safety and Risk department and information shared for the Risk Management and associated group and appropriate departments – please see the Annual Governance Statement for more information.

Partnership working with the unions: We continued to use our long-established partnership working arrangements with our trade union colleagues, with a formal consultation and negotiation framework in place. These arrangements helped to support the introduction of a number of different initiatives and ways of working to maintain levels of patient care over the winter period.

We consulted on the major issues, opportunities and challenges facing the Service, and we plan to maintain these working relationships when we become a foundation trust.

The staff side to the Staff Council, the senior consultative group within our Service, has been offered and accepted a governor seat as part of the planning process for foundation trust status.

Representation on our Council of Governors: When we achieve foundation trust status, staff will be able to stand for election to our Council of Governors. We are proposing three seats for staff representatives. This is separate from, and in addition to, the seat for a staff side representative from the Staff Council.

Strategic goal: Provide value for money

It continues to be very important that we provide Londoners with a service that represents value for money.

To achieve this goal we will use our resources efficiently and effectively.

- ***Using our resources efficiently and effectively***

  We received £14.8m of investment from our commissioners to support the first year of our change programme and recruit more than 220 new A&E support staff.

  We were also allocated a further £7.7m to fund a range of initiatives to ease pressure on the wider NHS in London during the busy winter period. The money formed part of the allocation to London's health system and was used to fund a number of initiatives, including a dedicated team to help to manage the pressure on all London hospitals by monitoring the numbers of patients taken to each hospital and requesting ambulance crews travel to a different emergency department when a particular hospital started to become too busy.

  At the same time, we continued to make savings in line with the NHS wide need for efficiencies and achieved our target of £10 million during the year.

  Major incident planning: We continued to train and prepare for major incidents, both within our own organisation and as part of exercises with other emergency services.

  The collapse of a ceiling at the Apollo Theatre in December 2013 was declared a major incident and around 100 staff attended the scene in Shaftesbury Avenue. A casualty clearing area was set up in the foyer of the theatre and 79 patients were treated – with 56 of them taken to hospital, mostly with minor injuries.

  A number of debrief sessions were held after the incident to find out what lessons could be learned ahead of any future incidents.

Governance of our organisation

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

The board assurance framework and corporate risk register are presented to the Trust Board each quarter, and further scrutiny is applied through the Quality and Audit Committees. The risk register is reviewed in detail by the Risk Compliance and Assurance group on a quarterly basis.

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

Our use of feedback to make improvements

We view feedback from patients, their families and the public as important way of driving improvements to our service.

One of the most valuable forms of feedback we receive is through complaints, of which we received 1,060 during the year, up from 976 in 2012/13.

This increase reflected a growth in 999 demand, with the most frequent cause for complaint being a delay in an ambulance being sent, especially to patients assessed as less seriously ill or injured; and changes in how we manage 999 calls, with some callers being referred to NHS 111 or other care providers.

Our Learning from Experience Group continue to monitor emerging trends arising from complaints and other sources of feedback, and a patient or a relative regularly attends our Trust Board meetings to tell their story about their experience of using our Service.

Our Patient Experiences Department received more than 6,000 general enquiries last year.

Principles for Remedy

We manage our complaints handling process in accordance with the Health Service Ombudsman's good practice guidance, Principles of Remedy. This includes:

- All complaint responses include information about the recourse opportunity to, and contact details for, the Health Service Ombudsman.
- Our website and all our staff can offer information about how to make a complaint about the service we provided.
- Activity and themes arising from complaints are regularly reported to the Trust Board
- Our Learning from Experience Group reviews the themes and issues emerging from complaints and the action taken to improve services and the experience of patients.

Sustainability report

We remain committed to making improvements in all aspects of our environmental performance.

Environmental monitoring and reporting enables us to quantify the environmental and social effects of delivering our service; to improve both our management of any associated adverse environmental and social impact, and our overall environmental performance; and to work towards achieving the targets in the NHS Carbon Reduction Strategy.

In 2012, the Carbon Trust reviewed and approved our five-year carbon management plan which sets out how we will reduce our carbon footprint as part of our contribution to tackling climate change. A carbon footprint is measured in tonnes of carbon dioxide equivalent (tCO2e). This is based on a baseline for the Service of 61,950 tonnes CO2e that was calculated in 2010/11.

There are three areas in which we will focus our activity – fuel consumption, energy use and procurement. We aim to reduce our energy and fuel consumption by 25 per cent over the five-year period, and by focusing on procurement we will cut indirect emissions from products and services by 10 per cent. It is envisaged that this will achieve total costs savings of over £5.5m. As the data we are using becomes more reliable, we are able to better assess our carbon footprint and to identify areas where additional efforts are required.

The overall trajectory is downwards from the baseline figure of 61,950 tCO2e – a reduction of 32 per cent achieved primarily from a reduction in procurement spend and fuel.

Environmental impact performance indicators

Area		Non financial data 10/11 (baseline)	Non financial data 11/12	Non financial data 12/13	Non financial data 13/14	Financial data 10/11 (baseline)	Financial data 11/12	Financial data 12/13	Financial data 13/14
Finite resource	Water	24	17	15	12	97,189	91345	102,028	97,297
	Electricity	3994	4125	4407	4260	1,055,486	1,054,406	1,136,592	1,262,162
	Gas	1576	1313	1807	1563				
	Fuel	12387	12082	11519	11346	5,846,323	5,383,166	4,316,464	4,912,252
Procurement	Procurement	43,969	19,285	24,730	24,877	74,524,230	56,084,612	68,651,920	67,709,602
Total		**61950**	**36822**	**42478**	**42058**	**81,523,228**	**62,613,529**	**74,191,005**	73,981,313

1. Carbon footprint estimated from water and energy consumption data submitted to ERIC
2. The carbon footprint for procurement in 2011/12 -2013/14 has been estimated by assigning DEFRA emission factors per pound of spend against individual cost centres. This is an improvement on the method used in 2011 to estimate the baseline figure for 2010/11.

Fuel consumption: Our core business means that we have high levels of fuel consumption. In 2013/14 we used over 4.2 million litres of fuel, compared to 4.3 million litres in 2012/13. In 2013/14 there was an increase of 1.45 per cent in incidents attended but a decrease of circa 2.5 per cent in fuel consumption. As well as treating more patients in their homes we are also resolving more calls through clinical telephone advice. Thirty three per cent of the 70,195 calls that were assessed as being suitable for clinical telephone advice in 2013/14 were resolved without a physical response being dispatched.

Energy use: Although over half of our 70 ambulance stations are more than 50 years old, when measured against other ambulance services we score well in our energy consumption per metre. In partnership with SALIX we have ring fenced funding for investment in a number of initiatives. However, despite the investment we have seen an increase of 4.5 per cent in our energy consumption compared to our baseline data for 2010/11. This was due to changes in our estate and Bow becoming our second 24/7 control room. In 2014/15, the majority of our estate had SMART metering installed; this will enable us to receive data and bills based on actual consumption rather than estimates. In addition we recycled 93 per cent of our waste.

Procurement: The overall trend is downwards from the baseline of circa 43,969tCO2e to 24,877tCO2e.

Looking ahead to this and future years, our environmental priorities will include:

- further investment in energy conservation works to reduce carbon emissions from energy use across our estate
- continuing to raise staff environmental awareness
- reviewing procurement arrangements to identify opportunities for carbon reduction and cost savings
- working with suppliers to minimise waste and identify opportunities for associated carbon reduction.

Changes to the London healthcare system

The Health and Social Care Act 2012 came into effect on 1 April 2013 and signalled significant changes to the management of NHS services in London. We are now commissioned by 32 clinical commissioning groups and this is coordinated through the North West London Commissioning Support Unit.

London's strategic health authority was disestablished on 31 March 2013 and we are now performance managed through the NHS Trust Development Authority, who will also support us through the foundation trust application process.

NHS England (London) coordinates the commissioning arrangements across London and holds the 32 clinical commissioning groups accountable.

Directors' report

Our Trust Board

In 2013/14 our Trust Board was made up of 12 members – a non-executive chairman, five of the Service's executive directors, including the Chief Executive, and six non-executive directors.

The Chief Executive and the other executive directors are appointed through a process of open advertising and formal selection interview. All executive appointments are permanent and subject to normal terms and conditions of employment. The non-executive directors are appointed by the same method through the NHS Trust Development Authority.

There were a number of changes to the Trust Board during the year.

Non executive directors:

Roy Griffins and Caroline Silver both completed their second term of office on 28 February 2014. Theo de Pencier and Fergus Cass were appointed as non-executive directors with effect from 1 March 2014.

Roy Griffins, non-executive director, was deputy chairman of the Trust Board until the end of his office on 28 February 2014. Jessica Cecil, non-executive director, has taken on the role with effect from 1 March 2014. Jessica previously held the role of senior independent non-executive director, which has now passed to Theo de Pencier.

Bob McFarland was appointed as the clinical non-executive director and chair of the Quality Committee with effect from 1 December 2013, following a period of acting as an associate non-executive director.

Executive management team:

The Chief Executive reviewed and then implemented a new executive management team structure comprising the following:

Fionna Moore, Medical Director (voting member of the Trust Board)

Steve Lennox, Director of Nursing and Quality (voting member of the Trust Board)

Jason Killens, Director of Operations (voting member of the Trust Board)

Andrew Grimshaw, Director of Finance and Performance (voting member of the Trust Board)

Sandra Adams, Director of Corporate Affairs/Trust Secretary (non-voting regular attendee of Trust Board)

Karen Broughton, Director of Transformation and Strategy (non-voting regular attendee of Trust Board)

Charlotte Gawne, Director of Strategic Communications (non-voting)

Mark Whitbread, Director of Paramedic Education (non-voting regular attendee of Trust Board)

David Prince, Director of Support Services (non-voting regular attendee of Trust Board)

Paul Woodrow, Director of Performance (non-voting)

Mike Evans, Director of Business Development (non-voting)

Jane Chalmers, Director of Modernisation (non-voting and interim position).

Lizzy Bovill commenced a long-term secondment with NHS England (London) in June 2013. Peter Suter left the Service in June 2013 and Caron Hitchen, Director of Workforce, in September 2013.

The Board has six formal sub-committees: the Strategy Review and Planning Committee, the Quality Committee, the Audit Committee, the Finance and Investment Committee, the Remuneration and Nominations Committee and the Charitable Funds Committee.

The Strategy Review and Planning Committee is made up of all the board members and is chaired by the Chairman.

Four non-executive directors and the Chief Executive made up the membership of the Quality Committee, which was chaired during the year by non-executive director Roy Griffins and then Bob McFarland from December 2013. The composition of the committee was reviewed in March 2014 and the new structure will commence in the first quarter of 2014/15.

The membership of the Audit Committee comprises three non-executive directors and was chaired by non-executive director Caroline Silver, who also chaired our Charitable Funds Committee.

The Finance and Investment Committee was chaired by non-executive director Nick Martin and has three non-executive directors as its members. The Remuneration and Nominations Committee, also chaired by the Chairman, comprises all non-executive directors.

Non-executive directors

Richard Hunt CBE joined us as Chairman in July 2009. He was formerly the International President of the Chartered Institute of Logistics and Transport, and has experience extending across the aviation, logistics, international oil and brewing sectors. Richard is a former Chief Executive of Aviance Ltd which handles logistics at UK airports, and he was Chief Executive of EXEL Logistics Europe, the largest UK transport and logistics business. He has also served as a non-executive on the Highways Agency Advisory Board. Richard was appointed CBE for services to logistics and transport in the 2004 New Year Honours.

Jessica Cecil took up her post on 1 December 2010. She has over 20 years of experience working in broadcasting on flagship television programmes such as *Newsnight*, *Panorama* and *Tomorrow's World*. She is now Head of Business Management at the BBC. Jessica was the senior independent non-executive director in 2013/14.
She is the member of the Quality and the Finance and Investment committees.

John Jones started as an associate non-executive director in October 2012, and took up his substantive role on 1 January 2013. He has 17 years' experience at board level in the NHS and has held a number of executive finance director positions. As a Director of Finance with Hertfordshire Partnership NHS Foundation Trust, John helped them to attain foundation trust status. John is a member of the Chartered Institute of Management Accountants and the Chartered Institute of Public Finance and Accountancy. He is a member of the Audit Committee, and Finance and Investment Committee.

Nicholas Martin took up the post in October 2012, and is a member of the quality committee. He has thirty years' experience of corporate finance advising a wide range of companies from different sectors. He has served on a number of boards and governing bodies in executive and non-executive roles, including Cambridge University, Hammersmith Hospitals NHS Trust, NHS City & Hackney Primary Care Trust and NHS Haringey Primary Care Trust. Nick is a barrister, a Chartered Fellow of the Chartered Institute of Securities & Investment, and a former Cabinet Special Adviser.
He is the chair of the Finance and Investment Committee and a member of the Quality Committee.

Robert McFarland took up his post in May 2013, as an associate non-executive director. Robert worked as a Consultant General and Vascular Surgeon for over 20 years and recently retired from St George's Healthcare NHS Trust. Throughout his career he has worked in both district hospitals and regional teaching hospitals. In 2007, Robert was appointed as Clinical Director for Trauma and Emergency Surgery at St George's Hospital, which opened as one of four major trauma centres serving London and Surrey in 2010. Robert was also Clinical Director of the South West London and Surrey Trauma Network and was a member of the Clinical Advisory Panel, London Trauma System.
He is the chair of the Quality Committee and attends the Audit Committee.

Fergus Cass joined us in March 2014. He was a non-executive director of NHS North West London until the replacement of primary care trusts in 2013 and previously served on the board of NHS Kensington and Chelsea. He worked for the multinational consumer goods company Unilever for 36 years, initially in finance and later as a general manager, heading businesses in Africa and South Eastern Europe. He holds degrees in economics and is a qualified accountant. Fergus is a trustee of Hospices of Hope, which supports palliative care in Romania and neighbouring countries, and of Book Aid International.

He is a member of the Quality and the Finance and Investment Committees.

Theo de Pencier joined the Service in March 2014. Theo is the Chief Executive of the Freight Transport Association (FTA) representing industry's freight interests by road, rail, sea and air. The FTA has over 14,000 members who operate more than 200,000 trucks (half of the total in the UK), consign 90 per cent of rail freight and 70 per cent of visible exports. Theo's early career was spent in sales and marketing with brand leading food and drink manufacturers Heinz and Diageo. He has over 30 years' Board level experience in the logistics and supply chain industry working for NFC and Danzas before joining Bibby Line Group in 1999 as Managing Director of Bibby Distribution. He joined FTA in July 2007.
He is a member of the Audit and Finance and Investment Committees.

Executive directors

Chief Executive Ann Radmore joined the Service in January 2013 after working as Chief Executive of NHS South West London where she led the establishment of the South West London Cluster in early 2010. Ann was previously Chief Executive of NHS Wandsworth and led the trust out of financial difficulties into a high performing primary care trust. After graduating from Cambridge University, Ann joined the NHS in 1983 as a national management trainee. She has worked in both specialist teaching and acute hospital and community settings as well as commissioning and a strategic health authority, and has managed a wide range of clinical and support services. She has led two major hospital redevelopments, one in Greenwich and one at Queen Mary's Roehampton. Ann also led the Londonwide implementation of the ground-breaking stroke and cardiovascular models – which significantly improved outcomes for patients through specialist units.

Director of Finance and Performance Andrew Grimshaw initially joined the Service on an interim basis in January 2013 and was appointed to the permanent post in March. Having joined the NHS as a trainee accountant in 1989, he has worked at district general hospitals, specialist and teaching hospitals throughout his career. He has worked as a Director of Finance since 2004 both for NHS trusts and foundation trusts.

Director of Nursing and Quality Steve Lennox was appointed as an executive director in January 2011, after joining us in September 2010. He was previously a member of the Chief Nurse's healthcare-associated infections and cleanliness team at the Department of Health where he worked at a national level with acute trusts, mental health trusts and ambulance trusts. A Registered General Nurse and a Registered Mental Nurse, Steve has worked in a variety of different clinical fields including HIV, critical care and neurosurgery.

Medical Director Dr Fionna Moore MBE was appointed in December 1997 and was made an executive director in September 2000. She chairs our clinical, quality safety and effectiveness committee, and clinical audit and research group. Fionna has more than 21 years' experience as a consultant in emergency medicine, currently with Charing Cross Hospital and previously at University College and John Radcliffe Hospitals. She is a BASICS doctor and holds a fellowship in immediate medical care from the Faculty of Pre-Hospital Care of the Royal College of Surgeons Edinburgh. In 2009, Dr Moore was appointed Trauma Director for London.

Director of Operations Jason Killens has 16 years' experience working in both clinical and senior management posts. His current responsibilities include the strategic planning and command of major public events, and he was the Service's Strategic Commander for the Queen's Diamond Jubilee celebrations and the 2012 Olympic and Paralympic Games.

The Trust Board is supported by other non-voting directors and one senior manager who attend the Board meetings.

Director of Corporate Affairs Sandra Adams took up her post in July 2009. Sandra joined us from Moorfields Eye Hospital NHS Foundation Trust, where she held the post of Director of Corporate Governance and had project managed the application to become one of the first NHS foundation trusts in the country. Sandra had previously worked in commissioning of acute services, and in a number of community and hospital posts, including managing acute service reconfiguration in south west London.

Director of Transformation and Strategy Karen Broughton joined the Service in December 2013 after working as Chief Operating Officer at the North West London Commissioning Support Unit. She has 28 years of experience in the health service and has held a variety of operational and strategic positions at acute hospitals, community health organisations and primary care trusts. Karen leads on the development and implementation of the Service's strategy for 2020 and on the negotiations with our commissioners.

Director of Business Development Mike Evans has 20 years of business development experience and a track record of delivering top line growth and commercial improvements for world leading healthcare and medical device businesses, including AXA Assistance and BUPA. He has significant commercial strategy and international sales and marketing expertise, and he has worked at board level for the past ten years.

Director of Strategic Communications Charlotte Gawne joined the Service in January 2014. She has led communications teams at NHS England, London hospitals and NHS Direct and directed several public consultations for service reconfigurations using innovative patient-engagement techniques. She recently led on setting up the new communications processes for emergency planning for NHS England in London and south England. Charlotte has considerable experience of working with political stakeholders, patient groups, national media, GP commissioners and local communities.

Director of Support Services David Prince joined the Service in January 2014. A business leader with 26 years' experience at executive level across most business functions but specialising in HR. For most of his career, he worked in the Royal Mail holding a number of senior positions. He has also worked for the National Autistic Society and a large care company. David is passionate about cultural change, business performance improvement and service transformation.

Director of Performance Paul Woodrow joined the Service in 1991. His career has included time spent working as a paramedic – including a secondment on London's Air Ambulance – and clinical team leader. He has since held a number of managerial positions with responsibility for the operational delivery and performance. Before taking up his current post, Paul completed secondments with NHS London and Great Western Ambulance Service.

Director of Paramedic Education and Development Mark Whitbread took up his post in January 2014 and is responsible for the clinical training, education and development of frontline staff. He was the Service's first Paramedic Consultant leading on the cardiac and major trauma strategy for London.

Director of Modernisation Jane Chalmers joined the Service in January 2013. Her first career was in the Royal Air Force, where she trained as an air traffic controller and then completed a number of senior appointments. These included roles in national and multi-national strategic communication, strategic planning and commanding the training school which trained all the air traffic controllers and operations officers for the RAF and the Royal Navy. Since leaving the RAF, Jane has worked in the public sector and took up her first role in the NHS in 2009. She has been a programme manager for a reconfiguration programme and for the re-organisation programme which planned and delivered the transition of five primary care trusts into one cluster. Latterly she was the Director of the Chief Executive's office in NHS South West London.

Meetings

The Board meets in public eight times a year. Details of the meetings are published on our website at www.londonambulance.nhs.uk

We comply with the code of practice on openness in the NHS and our Trust Board meetings are always open to the public, with time set aside for their questions at the beginning and end of the meetings.

Directors' interests

A register is held of directors' interests. This is available on request from the Director of Corporate Affairs.

London Ambulance Service NHS Trust

Organisation Code: RRU

Governance Statement

Scope of responsibility

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

As Accountable Officer I have overall accountability for having a robust risk management system in place which is supported by a governance structure, processes and monitoring arrangements, and an assurance and risk management framework. These arrangements are documented in the Risk Management Policy and Strategy which defines risk as anything threatening the achievement of our strategic objectives. It defines the ownership and subsequent management of the identified risks and the responsibilities of individuals and it describes the Trust Board's corporate responsibility for the system of internal control and robust risk management.

As part of London's health economy we work with our partners to minimise the risks to patient care. To do so we have met routinely with our lead commissioners and with the portfolio team at the NHS Trust Development Authority in order to progress and maintain the key performance targets set for ambulance services. We work in partnership with health and social care organisations in the development and provision of emergency and urgent healthcare across London. In 2013/2014 this has included service developments in the provision of 111 services to South East London from November 2013 and the implementation of a range of initiatives to enhance capacity and ensure safe care is provided during the Winter months. We have continued to increase the number of calls we handle and resolve through hear and treat and, during the year, we introduced the Clinical Hub which is operated by senior paramedics and provides enhanced clinical assessments to support hear and treat dispositions for appropriate patients. The Clinical Hub also provides clinical support and expertise for operational ambulance crews and non-clinical staff within the control rooms. We have worked with emergency departments and commissioners to improve the handover of patients from our service into an acute healthcare setting with a particular emphasis on improving handover and turnaround times. We started the programme of modernisation during 2013/14 and this remains on track to be fully implemented in 2014/15. This programme includes: the review and development of new roster patterns across frontline operations to match the current activity profiles, bringing a local focus to the future arrangements; implementation of the Clinical Hub and a structured clinical career progression; changes to annual leave, active area cover and rest break arrangements for front line operational staff; a review of the skill mix on front line ambulances and proposals to move towards a single tier of emergency ambulances that are able to respond to the full range of emergency calls thereby increasing the capacity of the

Service to meet demand.

We actively engage with a wide range of stakeholders across London. We have undertaken approximately 1086 patient and public involvement events including local community and foundation trust membership events, all of which have been well received, based on feedback from those attending.

The governance framework of the organisation

Information on the Trust Board committee structure and the attendance records of members is attached (annexes 1 to 7).

Each board committee is chaired by a non-executive director. Membership of the Remuneration and Nomination, and Audit committees is non-executive only with executives in attendance where relevant and required. The governance structure was fully reviewed in the first half of the year with the new arrangements implemented from 1st October 2013. This included transferring the oversight for risk management from the Quality Committee to the Audit Committee. A further review of the function and remit of the Quality Committee was undertaken in March 2014 following the appointment of a new non-executive director chair. The committee will take on more of a clinical focus in 2014/15 with membership revised to include the three clinical director leads – Medical, Nursing and Quality and the newly-appointed Director of Paramedic Education and Development – and these new arrangements will commence from April 2014.

The Trust Board reviews its effectiveness annually along with that of the reporting committees and the quality, safety and risk-related committees: Risk Compliance and Assurance, Clinical Quality Safety & Effectiveness, and Learning from Experience. The Risk Compliance and Assurance Group was disestablished in 2013/14 following the review of the governance structure. Risks are now reviewed by the Senior Management Team before being added to the corporate risk register for review and oversight by the Audit Committee. With these changes implemented and the later review of the Quality Committee, the Trust Board can take assurance from the governance structure that was in place by 31st March 2014. The Trust Chair and Director of Corporate Affairs/Trust Secretary undertake a post-board review each month to ensure the agenda has been covered, sufficient time allotted to agenda items and effective contribution and scrutiny given. The board agenda, papers and practice are continuously reviewed and adapted to ensure that reporting is appropriate and timely. The board agenda is informed by the forward planner which is reviewed and updated after each meeting.

The annual board effectiveness review reflects the Corporate Governance Code and other recommended good practice on board governance, such as Monitor's Code of Governance, and The Healthy NHS Board 2013. The Trust Board reviewed its effectiveness in July 2013, based on the Code and there were no areas of non-compliance to report. The review identified an overall rating of 'good' and areas where further development was required, for example; board structure and processes, board composition and diversity, time commitment of non-executive directors, and relationships with external stakeholders. These were reflected in the independent board governance assurance framework review which had been undertaken in March 2013 and reported in April 2013 and for which actions were already

underway. Positive assurance was given by the independent accountants and the outcome of the review reflected the changes being undertaken with board appointments; formal succession planning; the need for the board to continue to focus on developing the Trust strategy; and better use of board committees. A board development programme is in place which is coordinated by the Director of Corporate Affairs and comprises training and development across strategy, governance and statutory duties. The board holds 4 strategy sessions each year, and two of these are awaydays.

The Trust Board receives quality, financial and performance information that provides assurance on the discharge of statutory responsibilities. The NHS Trust Development Authority implemented a system of monthly submissions of self-certification of compliance with a set of board statements and Monitor's compliance framework. A number of areas were identified as requiring further work to achieve full compliance including: fit and proper persons test; CQC registration compliance; and competition oversight. These have all been addressed during the year and full compliance statements are now submitted.

Attendance by board members at Trust Board meetings is recorded in the minutes and included in the annual effectiveness review. Attendance at key board committees is also monitored and recorded by the Committee Secretary.

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

The Chair of the Audit Committee provides a report to the next meeting of the Trust Board following each Audit Committee meeting. This report includes a summary of the business discussed and the assurances received from the executive, the internal and external auditors and from counter fraud. The role of the Audit Committee is to focus on the controls and related assurance that underpin the achievement of the Trust's objectives and the processes by which the risks to achieving these objectives are managed. During 2013/14 the committee took on responsibility for the review of the corporate risk register as well as oversight of the systems and processes in place to manage risk. From October 2013 the committee undertakes a review of the effectiveness of the corporate risk register at each meeting. The committee meets 5 times during the year with one meeting held without the internal or external auditors present.

At the Trust Board meeting on 3rd June 2014 the Audit Committee chair provided assurance to the board of the effectiveness of the Trust's systems of integrated governance, risk management and internal control, based on the key sources of assurance identified in the board assurance framework.

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

The Chair of the Quality Committee provides a report to the following meeting of the Trust Board. This report includes the committee's assessment of quality as taken from the reports and evidence presented to the committee, including the corporate risk register. The committee receives reports from its reporting committees: Clinical Quality Safety and Effectiveness and Learning from Experience. This included the Risk Compliance and Assurance group until September 2013 prior to that group being disestablished. The committee also reviews the cost improvement programme to seek assurance that there is no detrimental impact on patient and staff safety and the quality of services provided as a result of the programme. At the Trust Board meeting on 25th March 2014 the Quality Committee chair provided assurance on the quality and safety of service provision, including the supporting clinical, information and corporate governance framework. The committee meets 6 times during the year.

The Chair of the Finance and Investment Committee provides a report to the following meeting of the Trust Board. The committee provides assurance on the scrutiny of current finance and investment issues based on the reports and evidence presented to it throughout the year. At the Trust Board meeting the chair of the committee reports on the cash position, cash management, liquidity, CIP progress, and capital expenditure. The committee meets 6 times during the year although this increased in frequency during 2013/14 to meet the volume of work required.

The Trust Board works within the remit of the Standing Orders and Standing Financial Instructions and Scheme of Delegation. Each of these is currently under review as part of an annual review. The Trust has prepared its constitution, governance rationale and standing orders in readiness for foundation trust status and will update these prior to application. The constitution has been updated in draft form in 2013/14 to reflect Monitor's Model Core Constitution and therefore the requirements of the Health and Social Care Act 2012. The governance rationale meets the requirements of Monitor's Code of Governance and will be updated in 2014/15 in readiness for the application process.

The Trust was subject to a number of external independent reviews during 2013/14. KPMG undertook the Board Governance Assurance Framework review.

The Trust received unconditional registration from the Care Quality Commission (CQC) in March 2010 to provide the following regulated activities:

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

The CQC undertook an unannounced compliance inspection in August 2013 and the Trust achieved full compliance against the standards assessed.

The Trust can confirm that all premises which we own, occupy or manage had fire risk assessments that complied with the Regulatory Reform (Fire Safety) Order 2005. We also achieved compliance with the Department of Health Fire Safety Policy.

Risk assessment

The organisation's major risks relate to safety, performance, finance and workforce as

described in the Board Assurance Framework. Two clinical risks were included in the Board Assurance Framework in 2013/14 relating to maternity and non-conveyance.

The Risk Management Policy and Strategy defines the risk management process which specifies the way risk (or change in risk) is identified, assessed and managed through controls. We were reassessed at level one of the NHSLA risk management standards for ambulance trusts with full compliance reported.

The Risk Management Policy and Strategy describes the process for embedding risk management throughout the Trust and during 2013/14 we have made further progress with managing local risk register processes. The corporate risk register is reviewed by the Audit and Quality Committees and by the Trust Board as it contains the highest level of risks facing the organisation. Risks can be escalated to the Senior Management Team for discussion and addition to the corporate risk register if required. We have also aligned project management risks with the corporate risk register. The policy and strategy were updated and re-formatted in 2012/13 in line with NHSLA requirements and are currently under review. KPMG undertook a review of risk management in August 2013 and stated that improvement was required. The key areas for improvement related to: top down risk identification; implementation of board assurance framework processes and changes to the structure and reporting; and risk training for the board. The board took assurance at the meeting on 25th March 2014 from the revised board assurance framework that progress was being made to address the recommendations of the review in order to strengthen risk management processes. Members of the Audit Committee have received risk training as have the executive directors and senior management team. Top down risks are identified through the risk register, board assurance framework and programme work.

Patient and staff safety and other incidents are reported in accordance with the incident reporting procedure and are then scored, either by local managers or by the safety and risk team, using a risk severity matrix. Action is then taken to control, manage or mitigate the risk and depending upon the score the risk may be added to the corporate register for review by the Senior Management Team or monitored at a local level. The Serious Incident Group meets weekly to review any serious incidents that need investigating and may need to be formally declared as Serious Incidents.

New risks with a net severity rating of High (over 15) are added to the corporate risk register and the board assurance framework which are reviewed by the Executive Management Team, Audit Committee and the Trust Board on a quarterly basis. Twenty three risks were added in 2013/14 and 15 were archived having reached their target level or being closed as they were no longer relevant. A list of the new risks is attached as an annex to this statement (annex 8).

The Trust has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

There were 13 lapses of data security in 2013/14 but none reached the threshold for reporting to the Information Commissioner.

The Trust achieved 81% against the Information Governance toolkit and is at level 2 overall. The slight dip from last year's 82% is due to the fact that the Trust no longer meets Level 3 for two of the Information Security requirements. Not all of the work required to maintain Level 3 had been completed, due to the fact that the Information Security manager post was vacant from October 2013 to March 2014. An appointment has now been made and progress will be made with relevant areas of the toolkit in 2014/15.

The risk and control framework

Systems are in place to monitor compliance throughout the year and to address any emerging gaps or risks. The format of the board assurance framework was reviewed and simplified. This now shows the key risks facing the Trust during the quarter, mapped to the strategic objectives and annual priorities. Not all of these risks will be the highest scoring risks on the corporate register as some may have a lower risk score but be particularly key at that point in time. The Audit Committee oversees the board assurance framework and corporate risk register and provides assurance to the Trust Board on the effectiveness of the risk and control arrangements. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Senior Management Team manages the corporate risk register whilst the Audit Committee assesses the effectiveness of the corporate risk register at each meeting. The Trust Board, Quality Committee and Executive Management Team receive an integrated performance report and a quality dashboard showing monthly performance and any identified risks, from which improvements and mitigations will be sought.

Systems in place to deter risk include standing orders, the scheme of delegation and standing financial instructions, NHS counter fraud measures, an anti-bribery policy, and a register for declaring directors' and managers' interests.

The local counter fraud specialist (LCFS) attends four meetings of the Audit Committee per year and monthly executive counter fraud meetings. KPMG have provided the local counter fraud service since April 2013.

The Internal Auditors attend four meetings of the Audit Committee per year and work closely with the Governance and Compliance team to execute the annual audit workplan. Internal audit also attend meetings of the Quality Committee and the committee has input to the development of the annual audit workplan. This work is also informed by the executive team. KPMG have provided the internal audit service to the Trust since April 2013.

Pricewaterhouse Coopers are the external audit provider.

Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work of the internal auditors, clinical audit and the executive management team within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the

content of the Quality Account and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of the effectiveness of the system of internal control by the board, the Audit Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Significant Issues

The Trust declared 36 Serious Incidents to commissioners in 2013/14. The top two themes relate to delays in response times for C2 patients and to mental health/overdose patients. The Trust recognised the potential risks to patient care arising from the increasing gap between demand and the available resources and, together with its lead commissioners, commissioned ORH to undertake a capacity review. This informed the contract for 2013/14 with the first year of a two-year modernisation programme that would support the Trust in its modernisation plans thereby improving and increasing the Trust's ability and resources to respond to demand on its services. The Trust also received additional funding in December 2013 to support increased resourcing to meet the winter demands. The pressures of demand continue and are subject to ongoing discussions with commissioners

Three Internal Audit reviews received limited assurance with the following key issues raised:

a) Serious incidents were not being investigated and reported within the timescales required within the National Framework.
b) Cyber security required action against a number of high priority recommendations in order to improve the Trust's controls to prevent and detect cyber attacks.
c) Contract management testing identified a number of areas of high spend where no contractual arrangements were in place and also indicated that procurement processes were not consistently followed.

The outcome of these reviews identified six high priority recommendations resulting in a limited assurance opinion.

During Christmas day and then separately during Boxing day the service experienced problems with the CAD system which resulted in control reverting to paper systems. The problems and the causes were separate and not related and were relatively quickly resolved. A full review was undertaken and immediate mitigating action taken. The full review has resulted in a number of recommendations which are now being pursued or are already implemented.

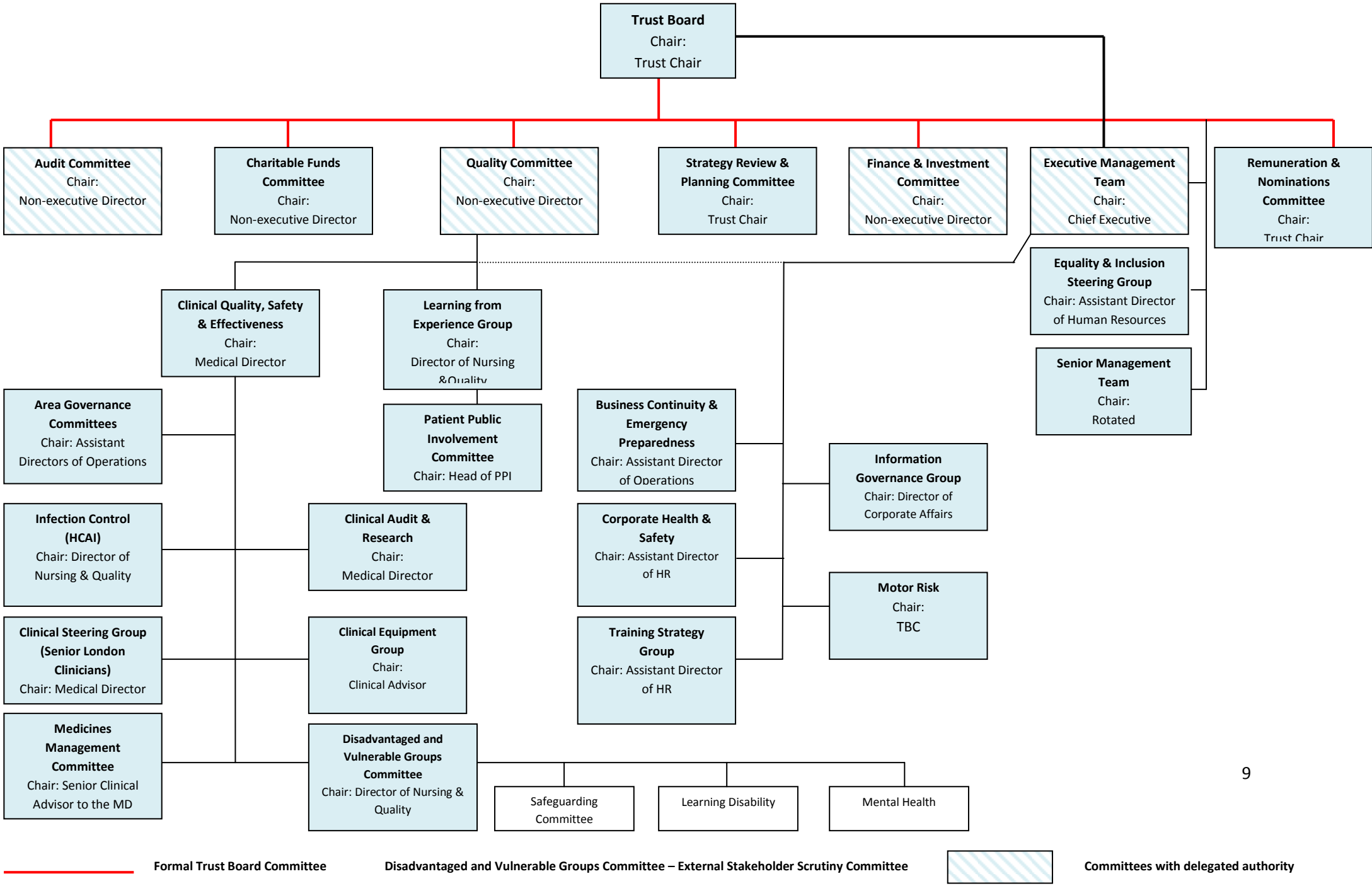
The Head of Internal Audit's opinion is as follows:

Based on the work undertaken in 2013/14, **significant** assurance can be given for core financial systems, however **limited** assurance can be given that there is a generally sound system of internal control on key financial and management processes.

Accountable Officer : Ann Radmore, Chief Executive

Organisation: London Ambulance Service NHS Trust (RRU) **Signature:** **Date:**

Annex 1 Governance Structure – February 2014



Annex 2 Committee membership

Formal Trust Board committee	Chair	Current members
Audit committee	Non-executive director, Caroline Silver until 28 February 2014 Non-executive director, John Jones from 1 March 2014	Roy Griffins (non-executive director) John Jones (non-executive director) Theo De Pencier (non-executive director) – member from 1 March 2014 Fergus Cass (non-executive director) – member from 1 March 2014
Charitable funds committee	Non-executive director, Caroline Silver	
Quality committee	Non-executive director, Roy Griffins until 10 December 2013 Non-executive director, Bob McFarland from 11 December 2013	Ann Radmore(Chief Executive) Jessica Cecil (non-executive director) Nick Martin (non-executive director) Fergus Cass (non-executive director) from 1st March 2014 Fionna Moore (Medical Director) Steve Lennox (Director of Nursing and Quality)
Finance & investment committee	Non-executive director, Nick Martin	John Jones (non-executive director) Jessica Cecil (non-executive director) Theo De Pencier (non-executive director) from 1st March 2014 Andrew Grimshaw (Director of Finance and Performance) Sandra Adams (Director of Corporate Affairs) Steve Lennox (Director of Nursing and Quality) David Prince (Director of Support Services) Karen Broughton (Director of Transformation and Strategy)
Strategy review and planning committee	Trust Chair, Richard Hunt CBE	All board directors, voting and non-voting.
Remuneration and Nomination committee	Trust Chair, Richard Hunt CBE	All non-executive members of the Trust Board

Annex 3 – Attendance at Trust Board meetings

	4 June 2013	25 June 2013	23 July 2013	24 September 2013	26 November 2013	20 December 2013	28 January 2014	25 March 2014	Comments
Trust Board members (voting)									
Richard Hunt (Non-Executive Chair)	✓	x	✓	✓	✓	✓	✓	✓	
Fergus Cass (Non-Executive Director)							✓	✓	Joined on 01/03/2014
Jessica Cecil (Non-Executive Director)	✓	✓	x	✓	✓	✓	✓	✓	
Theo de Pencier (Non-Executive Director)								✓	Joined on 01/03/2014
Roy Griffins (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	✓	Term ended on 28/02/2014
Andrew Grimshaw (Director of Finance and Performance)	✓	✓	✓	✓	✓	✓	✓	✓	
Caron Hitchen (Director of Workforce)	x	x	x						Left on 18/09/2013
John Jones (Non-Executive Director)	x	✓	✓	✓	✓	✓	✓	✓	
Steve Lennox (Director of Nursing and Quality)	✓	✓	✓	✓	✓	x	✓	✓	
Jason Killens (Director of Operations)	✓	✓	✓	x	✓	✓	✓	✓	Became voting member on 01/10/2013
Nick Martin (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	✓	
Bob McFarland (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	✓	Associate NED until 01/12/2013
Fionna Moore (Medical Director)	✓	✓	✓	✓	✓	✓	✓	✓	
Ann Radmore (Chief Executive)	✓	✓	✓	x	✓	✓	✓	✓	
Caroline Silver (Non-Executive Director)	✓	✓	✓	x	x	✓	✓	✓	Term ended on 28/02/2014
Non-voting									
Sandra Adams (Director of Corporate Affairs/Trust Secretary)	✓	✓	x	✓	✓	✓	✓	✓	
Lizzy Bovill (Director of Strategy and Planning)	✓	✓							On secondment from June 2013
Karen Broughton (Director of Transformation and Strategy)						✓	✓	✓	Joined on 16/12/2013
Jane Chalmers (Director of Modernisation)	✓	✓	✓	✓	✓	✓	✓	✓	
Tony Crabtree (Assistant Director of HR)	✓	✓	✓	✓	✓	✓			
Angie Patton (Head of Communications)	✓	✓	✓	✓	✓	✓			
David Prince (Director of Support Services)							✓	✓	Joined on 02/01/2014
Peter Suter (Director of Information Management and Technology)	✓								Left on 07/06/2013
Mark Whitbread (Director of Paramedic Education and Development)							✓	✓	Joined on 02/01/2014
Paul Woodrow (Director of Performance)	✓	✓	✓	✓	✓	x	✓	x	
Vic Wynn (Acting Director of Information Management and Technology)	✓	✓	✓	✓	✓	✓			

Annex 4 – Attendance at Quality Committee meetings

	17 June 2013	21 August 2013	23 October 2013	11 December 2013	26 February 2014	Comments
Quality Committee members						
Roy Griffins (Non-Executive Chair)	✓	✓	✓	✓	✓	Term ended on 28/02/2014
Jessica Cecil (Non-Executive Director)	x	✓	✓	✓	✓	
Nick Martin (Non-Executive Director)	✓	✓	x	✓	✓	
Bob McFarland (Non-Executive Director)	x	✓	✓	✓	✓	Associate Non-Executive Director until 01/12/2013 Chair of the Committee from 11/12/2013
Ann Radmore (Chief Executive)	x	x	x	x	x	
Steve Lennox (Director of Nursing and Quality)	✓	✓	✓	✓	✓	Full member from 23/10/2013
Fionna Moore (Medical Director)	✓	✓	✓	✓	x	Full member from 23/10/2013
Attending						
Sandra Adams (Director of Corporate Affairs/Trust Secretary)	x	✓	✓	✓	✓	
Tony Crabtree (Assistant Director of Human Resources)	✓	x	x	x		Acting Director of Workforce until December 2013
Andrew Grimshaw (Director of Finance and Performance)	✓	✓	x	x	x	
Caron Hitchen (Director of Workforce)	x					Left on 18/09/2013
Jason Killens (Director of Operations)	x	x	x	x	x	
David Prince (Director of Support Services)					✓	Joined on 02/01/2014
Paul Woodrow (Director of Performance)	✓	x	✓	✓	✓	

Annex 5 – Attendance at Audit Committee meetings

	15 April 2013	18 April 2013	13 May 2013	3 June 2013	2 September 2013	11 November 2013	3 February 2014	Comments
Audit Committee members								
Caroline Silver (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	Term ended on 28/02/2014
Roy Griffins (Non- Executive Director)	✓	✓	✓	✓	✓	✓	✓	Term ended on 28/02/2014
John Jones (Non-Executive Director)	✓	✓	✓	x	✓	✓	✓	
Attending								
Sandra Adams (Director of Corporate Affairs/Trust Secretary)	✓	✓	✓	X	✓	✓	✓	
Andrew Grimshaw (Director of Finance and Performance)	✓	✓	✓	✓	✓	✓	✓	
Ann Radmore (Chief Executive)	✓	✓	✓	x	x	x	✓	

Annex 6 – Attendance at Strategy Review and Planning Committee meetings

	30 April 2013	10 September 2013	25 February 2014	Comments
Trust Board members (voting)				
Richard Hunt (Non-Executive Chair)	✓	✓	✓	
Fergus Cass (Non-Executive Director)			✓	Joined on 01/03/2014
Jessica Cecil (Non-Executive Director)	✓	✓	✓	
Theo de Pencier (Non-Executive Director)			✓	Joined on 01/03/2014
Roy Griffins (Non-Executive Director)	x	x	x	Term ended on 28/02/2014
Andrew Grimshaw (Director of Finance and Performance)	✓	✓	✓	
Caron Hitchen (Director of Workforce)	x			Left on 18/09/2013
John Jones (Non-Executive Director)	✓	✓	x	
Steve Lennox (Director Nursing and Quality)	✓	✓	✓	
Jason Killens (Director of Operations)	✓	✓	✓	Became voting member on 01/10/2013
Nick Martin (Non-Executive Director)	✓	x	✓	
Bob McFarland (Non-Executive Director)	X	x	✓	Associate NED until 01/12/2013
Fionna Moore (Medical Director)	✓	✓	x	
Ann Radmore (Chief Executive)	✓	x	✓	
Caroline Silver (Non-Executive Director)	✓	x	✓	Term ended on 28/02/2014
Non-voting				
Sandra Adams (Director of Corporate Affairs/Trust Secretary)	✓	✓	✓	
Lizzy Bovill (Director of Strategy and Planning)	✓			On secondment from June 2013
Karen Broughton (Director of Transformation and Strategy)			✓	Joined on 16/12/2013
Jane Chalmers (Director of Modernisation)	✓	✓	✓	
Tony Crabtree (Assistant Director of Human Resources)	✓	✓		
Mike Evans (Director of Business Development)			✓	Joined on 11/11/2013
Charlotte Gawne (Director of Strategic Communications)			✓	Joined on 02/01/2014
Angie Patton (Head of Communications)	✓	✓		
David Prince (Director of Support Services)			✓	Joined on 02/01/2014
Peter Suter (Director of Information Management and Technology)	✓			Left on 07/06/2013
Mark Whitbread (Director of Paramedic Education and Development)			✓	Joined on 02/01/2014
Paul Woodrow (Director of Performance)	✓	✓	✓	
Vic Wynn (Acting Director of Information Management and Technology)	✓	✓		

Annex 7 – Attendance at Finance and Investment Committee meetings

	14 May 2013	20 June 2013	19 July 2013	18 September 2013	18 October 2013	22 November 2013	24 January 2014	20 March 2014	Comments
Finance and Investment Committee members									
Nick Martin (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	✓	
Jessica Cecil (Non-Executive Director)	x	x	✓	x	✓	✓	x	✓	
John Jones (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	✓	
Theo de Pencier (Non-Executive Director)								✓	Joined on 01/03/2013
Attending									
Sandra Adams (Director of Corporate Affairs/Trust Secretary)	✓	✓	x	x	✓	✓	✓	✓	
Karen Broughton (Director of Transformation and Strategy)							✓	✓	Joined on 16/12/2013
Tony Crabtree (Assistant Director of Human Resources)	x	x	x	x	✓	✓			
Andrew Grimshaw (Director of Finance and Performance)	✓	✓	✓	✓	✓	✓	✓	✓	
Steve Lennox (Director of Nursing and Quality)	x	x	x	x	✓	x	✓	x	
Vic Wynn (Acting Director of Information Management and Technology	✓	✓	✓	✓	✓	✓			

Annex 8

New Risks Added to the Trust Risk Register in the Period 2013 – 2014

Risk ID	Headline Risk
371	Maintaining Level 2 for IG Toolkit requirement.
372	Failure to write to addresses and inform individuals of their inclusion on the location alert register, resulting in incorrect address being included putting patients at risk.
373	Crews not carrying out a comprehensive dynamic risk assessment when attending high risk addresses resulting in delays in treating the patient.
375	Single members of staff with responsibility for supporting and developing MDTs may become unavailable resulting in loss of detailed technical knowledge and potential failure of services.
376	The Trust Board fails to fulfil all its statutory duties.
379	Category C call could receive a delayed or inappropriate response because of increased levels of Category A demand on available resources.
381	The service does not comply with DH guidance on the re-use of linen for patients affecting quality of cared delivered and reputation risk to the organisation.
382	(MPS) being incorrectly triaged affecting the ability of the LAS to effectively prioritise resources.
383	The processes and enabling technology for operating on paper across two sites are not sufficiently resilient resulting in a delayed LAS response.
384	Unsecured LAS equipment taken onto a third party ambulance may cause injury following an RTC.
385	Total level of financial loss due to theft and criminal damage to the organisation is not accurately reported.
386	Tail lift failures on operational ambulances will impact on patient care.
387	Call handling system being unsupported by Priority Dispatch Systems
388	Increase in turnover rates leading to staff reducing by significant numbers.
389	Unexpected cost liabilities arising from operating 111 Services from Beckenham.
390	Demand for patients in South East London for 111 services exceed capacity at Beckenham.
391	Patients placed on the Co-ordinate my Care (CMC) Database may not have their addresses flagged in a timely manner.
392	Expenditure will not be maintained within budget - adverse impact on income and expenditure position and credibility with the NTDA and DH plus FT application.
393	Cash not being properly managed impacting on credibility with NTDA and the DH and impact on FT application.
394	CIPS may not be identified or delivered – impacting our credibility with the NTDA and DH plus impact on FT application.
395	Effective financial control environment is not maintained leading to fraud and errors in financial reporting - impacting our credibility with the NTDA and DH plus impact on FT application.
396	No disciplines exist for planning ahead could impact on our credibility with the NTDA and DH plus impact on FT application.
397	Capital expenditure is not properly planned or delivered leading to loss of control over capital projects. Could impact on our credibility with the NTDA and DH plus impact on FT application.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 3RD JUNE 2014

PAPER FOR INFORMATION

Document Title:	**Safety, Development & Practice, and Effectiveness & Experience**
Report Author(s):	**Fionna Moore, Steve Lennox, Mark Whitbread**
Lead Director:	**Fionna Moore, Steve Lennox, Mark Whitbread**
Contact Details:	
Why is this coming to the Trust Board?	**For information**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☒ Other: Parts of this report have been reported elsewhere
Recommendation for the Trust Board:	For noting only

Key issues and risks arising from this paper

There is a risk to the Trusts reputation following the Preventing Future Deaths report which is detailed in the attached report.

Executive Summary

The report is structured around the quality domains of the quality dashboard but also reports on issues wider than the quality measures.

Demand Management Plan / Surge Plan: The 'Surge' plan was implemented on 17th April. Since December, the Trust has been operating at Winter working, now 'Surge Amber' under the surge plan. Despite this, the hours spent at DMP D have increased during April.
Clinical Performance Indicators: The CPI completion rate has increased during March, and now sits above the level met in January. The mental health CPI continues to fall below the expected standard. It is hoped the mental health CSR training will improve compliance to this audit.
Prevention of Future Deaths Reports: The Trust was given a regulation 28, prevention of future deaths by HM Coroner. This relates to a fatal RTC after an ambulance was incorrectly parked on a multi-carriageway road. During April 2014, all ambulance Trusts were given a regulation 28 preventing future deaths report, regarding oesophageal intubations. The Trust has issued mandatory actions for clinical staff to follow.
Medicines Management: There have been no mandatory reportable controlled drugs incidents since the last report to Trust Board. There have been no reported drug errors.
Locality Alert Register: The number of addresses held on the locality alert register remains on a par with the previous month.

Attachments
Report
Annual Organisational Audit 2013/14

****

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

☒ Preventing people from dying prematurely
☒ Enhancing quality of life for people with long-term conditions
☐ Helping people to recover from episodes of ill health or following injury
☒ Ensuring people have a positive experience of care
☒ Treating and caring for people in a safe environment and protecting them from avoidable harm
☒ Caring for the workforce

LAS Strategic Goals and Priorities
This paper supports the achievement of the following strategic goals and priorities:

LAS Strategic Goals
☒ To improve the quality of care we provide to our patients
☐ To develop care with a highly skilled and representative workforce
☐ To provide value for money

2013/14 Priorities
☐ Modernisation Programme
☐ Communication and Engagement
☒ Sustain performance to ensure safe service to patients
☐ Building sustainable financial position for 14/15 and beyond

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

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

Equality Analysis

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

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST

Quality Report – June 2014

Clinical Directors' Joint Report on

Safety, Development & Practice, and Effectiveness & Experience

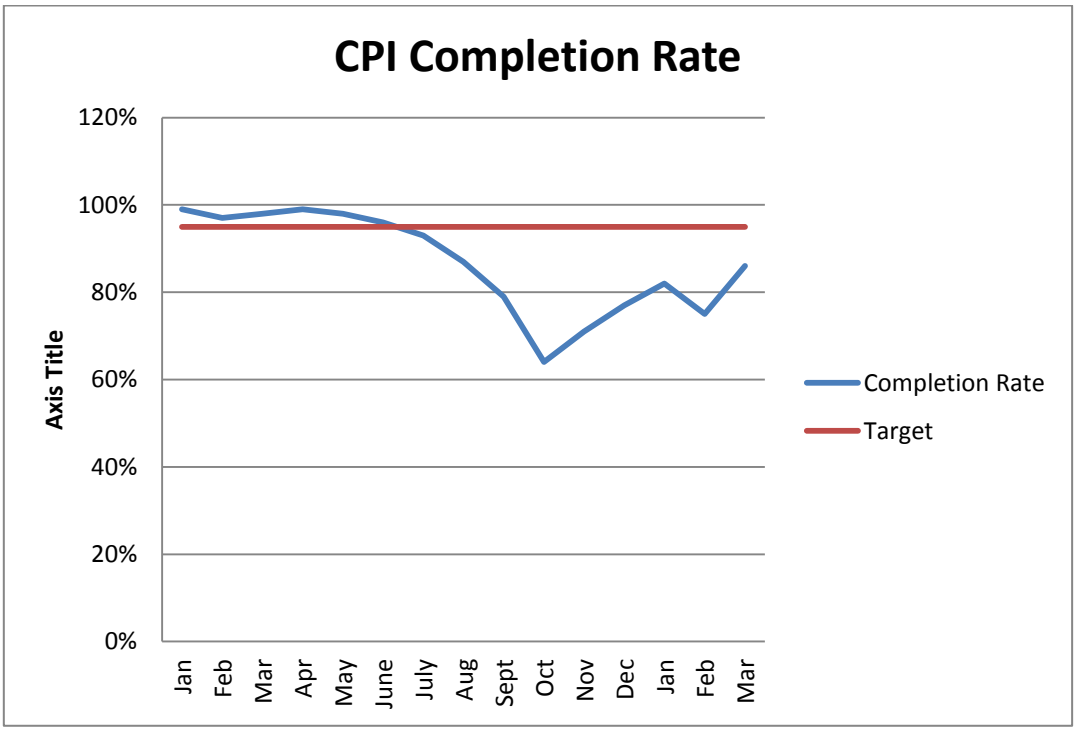
This report has been restructured around the new quality domains within the dashboard. Inevitably there is overlap between the domains and as the development & practice domain is the newest addition this will be further developed during the course of the year.

Domain 1 - Safety

This section reports on the areas that are directly relevant to safety.

Clinical Performance Indicator completion and compliance

The CPI completion rate has increased in March, to above the January rate, following a drop during February. The completion rate in March was the highest since August 2014 which is an achievement considering the current operational focus of most Team Leaders. 15 complexes achieved the >95% completion rate, an increase on last month (February). There is still a risk that the end of year targets for CPI completion will not be met. There is also a risk that the end of year CPI feedback targets will not be met.



CPI Completion April 2013 to March 2014

Area	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
East	100%	99%	97%	95%	91%	71%	30%	62%	64%	85%	81%	91%
South	100%	99%	95%	93%	89%	88%	79%	65%	89%	94%	77%	81%
West	99%	96%	97%	90%	83%	76%	76%	82%	77%	68%	69%	88%
LAS	**99%**	**98%**	**96%**	**93%**	**87%**	**79%**	**64%**	**71%**	**77%**	**82%**	**75%**	**86%**

CPI compliance remains >95% against all clinical care standards, except mental health which has now been on-going for a number of months. The care provided under the mental health CPI varied by 18% across the LAS, from 80%-98% by complex. It has been recommended that complexes with a good compliance share best practice with those who don't have such a good compliance.

The core skills refresher on mental health has been introduced since April 2014, and it is hoped that this will improve the compliance to the mental health CPI.

CPI Compliance March 2014

Area	Cardiac Arrest	Glycaemic Emergencies	ACS	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	97%	97%	97%	97%	89%	97%	97%
South	98%	97%	97%	96%	92%	97%	97%
West	98%	98%	96%	98%	90%	97%	97%
LAS Total	**97%**	**97%**	**96%**	**97%**	**90%**	**97%**	**97%**

CPI Compliance February 2014

Area	Cardiac Arrest	Difficulty Breathing	ACS	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	97%	94%	97%	97%	88%	98%	98%
South	97%	95%	97%	97%	92%	97%	98%
West	98%	95%	96%	97%	90%	97%	97%
LAS Total	**97%**	**95%**	**96%**	**97%**	**90%**	**97%**	**98%**

Full CPI reports are available on request.

National CPI

The National Clinical Performance Indicator for Asthma, cycle 12 has been released. This report shows steady improvement within the Trust and is a real achievement.

NHS Central Alerting System (CAS)

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

In total during April, there were 9 CAS alerts, none of which required any further action by the Trust, but all of which were acknowledged.

NHS Signals

Key risks emerging from review of serious incidents reported by the NHS to its National Reporting and Learning System (NRLS) are shared in the form of Signals. There have been no alerts since the last report to Trust Board.

NICE Guidance

The NICE guidance updates for April have been released.

Of relevance to the London Ambulance Service are the following two updates:

QS58 – Sickle cell acute painful episode
This is of most relevance to hospital-based clinicians. However, the Trust may be able to learn from this update and provide an update to vehicle crew staff.
In particular the update focuses on:

- A pain and clinical assessment, followed by pain relief within 30 minutes
- Health care professionals having access to locally agreed protocols on treatment and management of sickle cell patients

QS61 – Infection prevention and control
In particular, the update focuses on:

- Hand Hygiene
- The importance of a clean environment including equipment
- Focus on inappropriate glove use and the high risk of contamination from poor practice
- Aseptic techniques

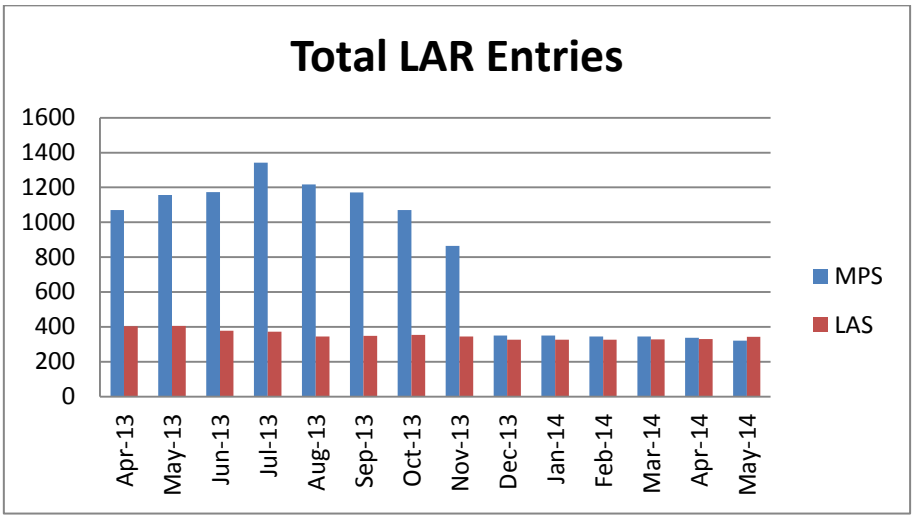
NICE have also requested input into a draft transient loss of consciousness guideline; which members of the medical directorate will be involved with from a pre-hospital care perspective.

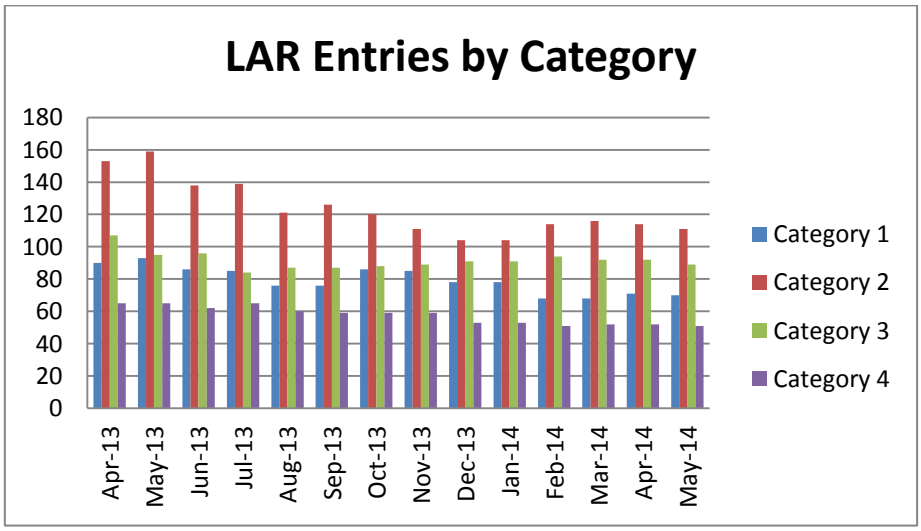
Locality Alert Register

There are currently 321 addresses on the Locality Alert Register (LAR). These are broken down as follows:

CATEGORY 1: 70
CATEGORY 2: 111
CATEGORY 3: 89
CATEGORY 4: 51

The Trust has notification of 342 high risk addresses from the Metropolitan Police. This is an increase since last month.





Some work is being undertaken at a complex level with assistance from the Medical Team in an attempt to reduce the number of category 4 risk addresses. These are patients who present a potential risk to crew staff due a medical condition. The aim is to reduce the number held, in conjunction with the patient's GP or lead consultant; and to check that those that are required are safe to remain on the register.

Demand Management Plan / Surge Plan

The Trust implemented the new Surge plan on 17th April 2014.

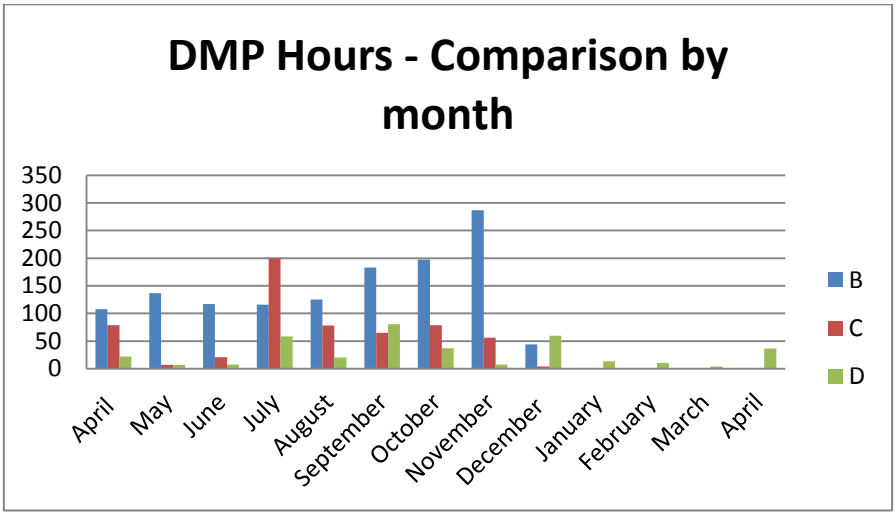
The purpose of The Surge Plan is similar to that of the former DMP. It aims to provide the Trust with structured risk mitigating options to respond to demand at times when it exceeds the capacity of the service to provide a timely response. It provides a framework in which Control Services are able to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

Surge enables the Trust to prioritise calls with a higher MPDS triage category, and to ensure those patients with the most serious conditions or in greatest need continue to receive a response. The escalating stages of Surge (Green through to Black) reduces the response to lower call categories. The risk of this is mitigated by increasing clinical involvement in the Control Room as the levels increase, with clinical 'floor walkers' available to assist call handlers and by ringing calls back to provide advice, to re-triage and if appropriate to negotiate alternative means of transport or follow up. It is also mitigated by regular senior clinical and operational review as the plan is escalated. There is a significant level of clinical risk related to the stage of the Surge which is invoked.

In December, implementation of the Winter Working plan was invoked. This changed the way that DMP was recorded, and as such, the first reporting of DMP was at DMP D or above. Since the implementation of the winter working plan and until Surge was implemented, the total hours at DMP D had dramatically reduced. Since the implementation of Surge, the Trust has been working at Surge Amber; which is an equivalent within the Surge plan, to that of 'winter working'. However, April saw a sharp increase in the use of DMP D, and then Surge Red post implementation of Surge.

DMP and Surge use November 2013 - April 2014

Month	Number of occasions DMP invoked	Stage B (hours)	Stage C (hours)	Stage D (hours) Surge RED	Stage >D (hours)	Ambulances reprioritised
November	25	286.75	56	7.5	0	2068
December	15	**43.75**	**4**	59.5	0	6395
January	2	**Winter Working**		13.5	0	5770
February	3	**Winter Working**		10.5	0	6272
March	2	**Winter Working**		4.25	0	6591
April	10	**Winter Working / Surge Amber**		36.25	0	7163



Prevention of Future Deaths Reports; Regulation 28 of The Coroners (Investigations) Regulations 2013

The Trust received a Prevention of Future Deaths, regulation 28 from HM Coroner since the last report.

The regulation 28 relates to an incident which occurred in 2013, where an ambulance stopped in the outside lane of a three carriageway road, and was then involved in a collision with a motorcyclist.

The Trust has been asked to provide guidance and training to all staff in relation to stopping on multi-carriageway roads, and that each staff member is updated on this regularly. The Trust has updated TP/065 Conduct on the Road and it will be printed and issued to staff individually. On receipt of this, staff must sign to say they have received the document.

This guidance and ruling has also been issued to AACE for dissemination to all ambulance trusts across the UK.

Following the issue of a regulation 28 last month, to another ambulance Trust, but also via AACE, the London Ambulance Service issued a Medical Directors bulletin regarding the insertion of an advanced airway and the checks to be completed after this insertion. The bulletin clearly states that should an advanced airway be placed with no proof that it was placed correctly or if it was placed incorrectly but not recognised, that the advanced skill may be removed permanently from that individual. The Medical Team are now working closely with clinical tutors and clinical team leaders at a complex level to follow up any incidents where this occurs.

Infection Prevention & Control

The first re-launched Infection Prevention % Control committee took place in May where the committee focussed on the South stations and looked at all the available metrics for these stations. The metrics include, hand hygiene, cleaning, decontamination, storage, legionella compliance, training and flu immunisation uptake.

The new format worked well and the committee took the view that the South Area was compliant with the majority of metrics.

The plan is to undertake a deep analysis of every area on an annual basis but to monitor actions at each subsequent meeting (not wait for the whole year cycle).

Domain 2 – Development and Practice

This domain is a new domain and reports on those areas that are directly related to practice or the development of the clinical workforce.

Advanced Paramedic Practitioners

The first 13 Advanced Paramedic Practitioners (APP) have been live since 5th May. One APP is based within the Emergency Operations Centre (EOC) at Waterloo between 11:00-23:00, and there are two APP's working on cars from Westminster station and from Brent station. The EOC based APP despatches the car based APP to appropriate calls, and also deals with crew requests for an APP.

Since go-live, the utilisation of the APPs has been excellent. Interestingly they are also being utilised to a variety of calls.

CSR 2013

The core skills refresher training 2013 module has been live as planned, since April 2014.

Medicines Management

There were no reportable CD Incidents during April 2014. There were no unannounced visits in April 2014. There are three matters that the Chair of the Medicines Management Group would like to bring to the attention of Trust Board, the first is the most important to the LAS, but the second also impacts the LAS for very similar reasons;

It came to our attention on 15th May 2014 that Pfizer who manufacture ketamine will now have difficulty supplying stocks until March 2015. The Trust is working through a solution.

There is also a potential shortage of adrenaline 1:10,000 and Amiodarone but this has already been catered for by the Chair of MMG working with our pharmacy suppliers to secure stocks to "protect" supply for several months. We have also changed the presentation of Amiodarone from pre-filled syringes to ampoules in order to obtain a better guarantee of supply.

These situations are also known to the National Ambulance Service Pharmacy Advisers Group who are also attempting to take steps to rectify the situation.

As the situation develops the Chair of MMG will keep the Medical Director and EMT informed

The chair of MMG has been in contact with a company to see if they are able to use their expertise in medicines asset tracking to provide assistance with the perennial problem of accurate tracking of medicine(s) stock throughout the LAS Logistics and Operational areas. In particular methods of tracking medicines bags whilst "on the road" is being sought.

For information:
The NWL Local Intelligence Group for Controlled Drugs, and the Met Police Controlled Drugs Liaison Team have been informed that the LAS APPs are now using ketamine and midazolam. For the purposes of LAS policy and procedure we have decided to treat ketamine as a controlled drug under the terms of the LAS policy.

Domain 3 - Effectiveness and Experience

This section reports on areas that reflect patient experience or effectiveness of the service.

Clinical Audit

The Monthly Cardiac Arrest and ST-Elevation Myocardial Infarction Reports (Cardiac Care Pack) for March 2014 have been published. The full report is available on request.

Key Findings:

- Defibrillator data download rate remains at less than 1% *

- 32% of cardiac arrest patients that had resuscitation commenced, gained and sustained ROSC (Return of Spontaneous Circulation) until arrival at hospital. This is a decrease of 1% on last month.
- 97% of the advanced airway's placed during a cardiac arrest had end-tidal CO2 measured and recorded. 11 patients had no ETC02 noted and no printout of the waveform included with the PRF. (There is further information regarding this later in the report, indicating how this will be managed going forward).
- All but one of STEMI patients attended by the LAS were transported to the most appropriate destination.
- Overall call to arrival at hospital time for STEMI increased to 67 minutes over the past month. The length of time on scene remains high at 42 minutes. Both of these figures are higher than expected.
- The number of patients receiving the full STEMI care bundle has fallen from 74% to 71% this month.

* NB: From 5/5/14 the Advanced Paramedic Practitioners have been able to download data from LP15 and LP1000s, as the first change in implementing and testing the benefits of direct downloads and data review from cardiac arrests. It is hoped that the benefit of this will be visible over the coming months.

Serious Incidents

A new SI dashboard has been created and is on the agenda as a separate item submitted by the Director of Corporate Services.

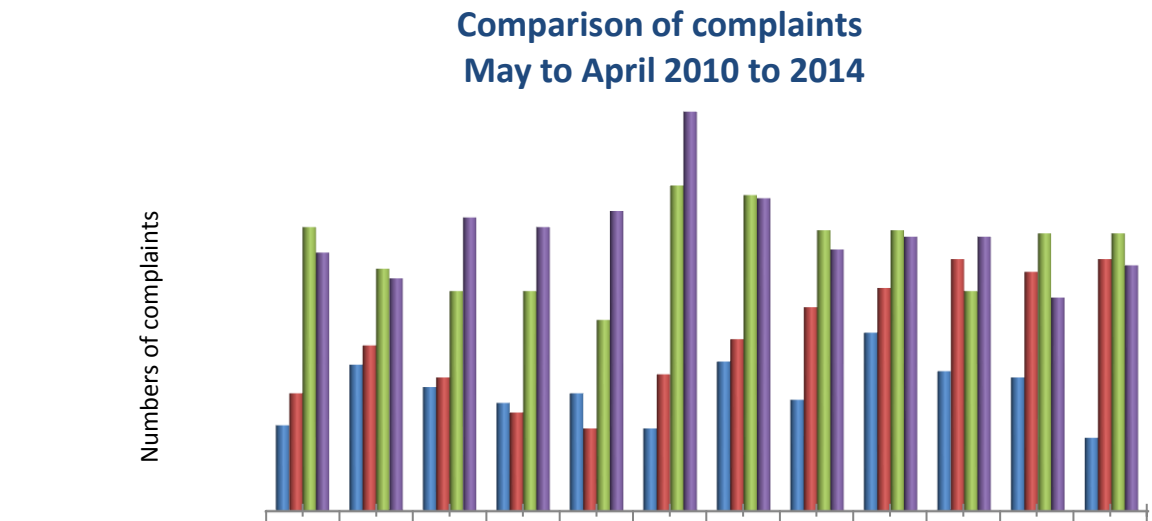
Patient Experiences

COMPLAINTS

Complaint Volumes

The number of Complaints this month totalled 77, slightly higher than March, possibly as REAP was increased to Level 3. Of these 33 related to delays (44%). Complaints about staff conduct remained constant (20 against 24 in March).

Graph one. **The following graph demonstrates the increase in complaints managed in 2013/15 (purple)**



	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April
Complaints 2010/11	27	46	39	34	37	26	47	35	56	44	42	23
Complaints 2011/12	37	52	42	31	26	43	54	64	70	79	75	79
Complaints 2012/13	89	76	69	69	60	102	99	88	88	69	87	87
Complaints 2013/15	81	73	92	89	94	125	98	82	86	86	67	77

6 complaints involved other Trusts/agencies including four x Acute Trusts, one x 111 provider, and one from a private ambulance company. 2 cases were referred to SIG (C8863 – outcome awaited; C8861 – not declared) with 3 further cases pending further information.

Complaint Themes

Complaints relating to delay (33) and staff conduct (20) continue to be the main themes. Complaint volumes are increasing again as the operational focus on performance returns to more familiar levels.

There has been a noted increase in complaints where the patient has challenged the LA279/LA280 referral to Social Services. The case management system has been updated to include this new code which has enabled identification of seven such cases.

Table one. The following table shows the complaint subjects May 2013 to April 2014

Complaints by subject 2013 - 2015	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April
Delay	37	29	38	30	50	53	41	38	22	29	24	33
Conduct	26	17	22	27	15	30	19	11	29	16	22	20
Road handling	12	8	15	12	9	10	8	9	8	12	7	8
Non-conveyance	0	6	5	5	7	8	11	10	10	11	7	5
Not our service	1	7	4	4	1	1	1	2	3	0	1	0
Treatment	2	3	4	4	5	13	11	6	12	13	4	8
Patient Injury or Damage to Property	0	0	3	0	1	4	2	1	2	0	0	1
High Risk Address Referral	1	0	1	3	1	2	2	1	0	0	0	0
Conveyance	2	2	0	4	2	3	1	2	0	3	2	1
Clinical Incident/Equipment	0	0	0	1	0	1	0	1	0	0	0	0
Assisting with external agency	0	0	0	0	2	0	2	0	0	0	0	0
Disputes safeguarding referral	0	1	0	0	1	0	0	1	0	2	0	1
Totals:	**81**	**73**	**92**	**90**	**94**	**125**	**98**	**82**	**86**	**86**	**67**	**77**

There have been no Locality Alert Register complaints since December 2013.

Case examples - cases closed in March/April 2014

Treatment

Concerns were raised by the patient's husband about the care provided by the Fast Responder when his wife experienced a miscarriage. The Fast Responder agreed that the patient should attend hospital but that an ambulance was not necessary resulting in the patient being conveyed by car. Our response agreed that it would have been more compassionate to have taken the couple in the response vehicle.

Call management

A complaint was received via an MP about the triage level of a 999 call. The Quality Assurance review concluded that the call handler should have selected the 'stroke' protocol which may have determined a higher priority. Although is very unusual for call handlers not to select the most apposite triage protocol the issue has been brought to the attention of our Control Services Clinical Governance group to decide whether there is a case to increase our routine audit of this aspect of call management.

Conduct

A patient called 999 for advice and felt she needed to be on a drip, having experienced symptoms of diarrhoea and weakness for 3 days. The call handler explained that we could refer the patient to another service but the patient was insistent that she needed an ambulance as she could not get to see her GP. Fast Responder was sent to a patient who complained that an ambulance had not been sent. The patient further complained about the care provided and that the Fast Responder did not have any sterile wipes after taking a blood sugar reading. An explanation was provided against each head of complaint with feedback being given to the Fast Responder highlighting the patient perspective in seeking help from the NHS.

Performance/Quality

71 cases were closed in April. The availability of a QA Manager to the department has been extended until the end of May but only for one day per week (as opposed to the three days previously) which will impact on performance.

As at 8 May, 136 complaints remain open or re-opened, an identical number to March.

Currently 28% of 'open' complaints are awaiting a QA report (compared to 15% at the same stage in March) and 15% operational input (15% in March). 16% await Director of Nursing sign off this includes 3 'comeback' responses.

Closure rates for 2013 are set out in the table below. This evidences that cases are being closed more quickly and far less open for an extended period.

Table Two **The following table extracts data from the above and demonstrates the number of complaints closed each month within the 35 day target:**

Date	0-25 working days	0-35 working days	closed within 35 working days	Total complaints per month
2013 05	21	10	31	81
2013 06	30	7	37	73
2013 07	34	7	41	92
2013 08	27	5	32	89
2013 09	20	4	24	94
2013 10	23	9	32	125

2013 11	17	9	26	98
2013 12	22	7	29	82
2014 01	16	23	39	86
2014 02	25	15	40	86
2014 03	24	10	34	67
2014 04	4	0	4	77
Totals:	**263**	**106**	**369**	**1050**

It should be emphasised that a true reflection of response times cannot be calculated until the furthest timescale (i.e. 35 days working days have elapsed) = minimum of 22 May 2014.

'Comeback' Activity

Table Three This table evidences the numbers of comeback enquiries.

Year	Numbers of comeback responses recorded
2009/10	9
2010/11	4
2011/12	12
2012/13	35
2013/14	64
Totals:	**124**

5 complaints were re-opened in April. One questioned the destination choice of hospital as the complainant felt that the response did not address that adequately (C8619). The remainder have sought further clarification, mostly about the same issue previously raised. The increase in general terms is proportionate to the increase in complaints volumes over the periods indicated.

Health Service Ombudsman

Between 1 January 2013 - 30 April 2014, 16 cases have been referred to the Ombudsman. Historically, complainants can take some whilst to refer a case to the Ombudsman, for example one recent case relates to an incident in October 2013.

PALS

PALS specific enquiries were fewer in April (271 over 363 in March).

Average monthly PALS for 2012/13 = 269, roughly equivalent with 2013/14 = 287.

Of those cases remaining open (69), these include patient requests for medical records (20), requests for general information, other agencies seeking clarification of given incidents (8) (e.g. H&S

Executive, care homes, CCGs etc) and specific information where collaboration has been sought with other agencies/departments (26). The remaining cases (15) await allocation as at 08 May.

Graph two The following graph highlights the numbers of PALS SPECIFIC enquiries by month May 2013 to April 2014

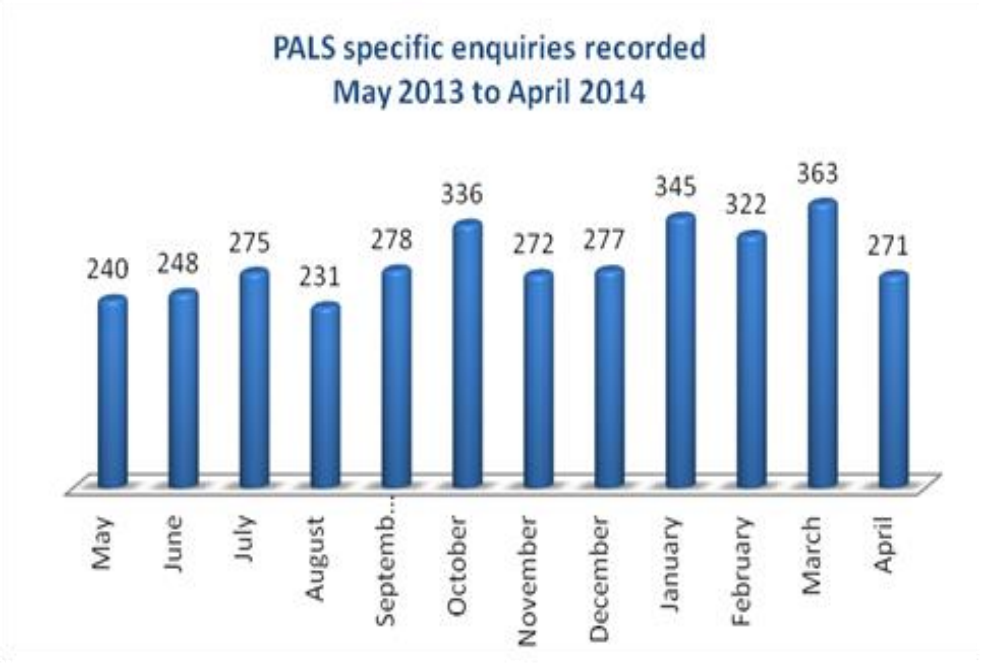


Table Four Total PALS enquiries received in the past 6 years is as follows:

Financial Year	Total PALS
2008/09	5606
2009/10	5674
2010/11	6031
2011/12	6264
2012/13	5714
2013/14	6790
Totals:	**36079**

PALS Themes

Consistent themes as described above. Enquiries include signposting to other departments, policy and procedure requests and families seeking clarification of events.

Table Five **The following table breaks down the PALS specific enquiries in April 2014**

Subject - April 2014	Number of enquiries
Information/Enquiries	191
Lost Property	37
Medical Records (patient request)	23
Other general	10
Appreciation	8
Safeguarding Adults	2
Totals:	**271**

Other (Non Domain Reporting)

The Framework of Quality Assurance

The former Organisational Readiness Self-Assessment (ORSA) has changed and is now the Framework of Quality Assurance. Each Trust is required to provide assurance to patients and the public, as well as to the service itself, that there are systems and processes in place for revalidation for the doctors working for that Trust.

An initial audit (Annual Organisational Audit) has been completed and submitted and is attached for Trust Boards information.

The responsible officer is required to submit an annual report, which needs to be submitted to the Board prior to formal submission by 31st August 2014. This will be brought to Trust Board in July.

Fionna Moore
Medical Director

Steve Lennox
Director of Nursing & Quality

Mark Whitbread
Director of Paramedic Development & Education

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 3RD JUNE 2014

PAPER FOR ASSURANCE

Document Title:	**Report from Quality Committee**
Report Author(s):	**Bob McFarland, Non-Executive Director**
Lead Director:	**N/A**
Contact Details:	
Why is this coming to the Trust Board?	**To ensure appropriate reporting between the committees and up to the Trust Board**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☒ Audit Committee (verbal update) ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**The recommendation to the Trust Board is to note the report**

Key issues and risks arising from this paper

- Quality Governance
- Management of self-harm (overdose)
- Category C performance
- Secure transport for patients

Executive Summary

The attached paper provides an update from the Quality Committee meeting on 23rd April 2014. An oral update was also provided to the Audit Committee at its meeting on 22nd May 2014.

Attachments

Quality Committee Report from 23rd April 2014

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Quality Strategy

This paper supports the following domains of the quality strategy

☒ Preventing people from dying prematurely
☒ Enhancing quality of life for people with long-term conditions
☒ Helping people to recover from episodes of ill health or following injury
☒ Ensuring people have a positive experience of care
☒ Treating and caring for people in a safe environment and protecting them from avoidable harm
☒ Caring for the workforce

LAS Strategic Goals and Priorities

This paper supports the achievement of the following strategic goals and priorities:

LAS Strategic Goals

☒ To improve the quality of care we provide to our patients
☒ To develop care with a highly skilled and representative workforce
☒ To provide value for money

2013/14 Priorities

☒ Modernisation Programme
☒ Communication and Engagement
☒ Sustain performance to ensure safe service to patients
☒ Building sustainable financial position for 14/15 and beyond

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

Has an Equality Analysis been carried out?

☐ Yes
☒ No

Key issues from the assessment:

Report of the Quality Committee meeting 23rd April 2014.

The Quality committee was pleased to welcome Ursula Gallagher who is Director of Quality and Safety BHH Federation and who has agreed to regularly attend our meetings.

Quality Committee review. The committee endorsed the new governance structure put forward by Steve Lennox.

- The proposed name of the reformed committee is the "Quality Assurance and Improvement Committee"
- Membership – Four Non-Executive Directors (including the Chair); Medical Director, Director of Quality, Director of Paramedic Education (see below); Director of Operations, Trust Secretary, Consultant Midwife. Director of Support Services should be a member at present in view of the issues around staff involvement. There are a number of other individuals whose input to the meetings would be welcomed and who should receive the Agenda and Minutes but who would not be expected to attend every meeting. They could however be asked to attend to speak to a particular agenda item. These will include all members of the Executive and Senior Management teams but this is not exclusive.
- A reformed committee (as yet unnamed) will take over the role of the current CQSE, LEG, and a new Professional Development activity reviewing each of these streams in turn and reporting to a quarterly Quality Assurance and Improvement Committee. The leads for these three streams (Fionna Moore, Steve Lennox and Mark Whitbread) will initiate this process over the summer months to make their first new-style report to the committee at our October meeting.
- One of the four Non Executive Directors will be the chair (currently RJM). Each of the other three would act as "link NED" for one of the three reporting streams.
- The committee discussed and approved the overall design of a new dashboard being developed by Steve Lennox which will inform these Quality discussions.
- The committee will at each meeting review in depth one or more specific areas which have been highlighted as cause for concern and which require discussion in a clinical forum to enable us to assure the Board they are being managed appropriately. Topics for future meetings are "Safeguarding in the context of Mental Health" and "Management of Obstetric Emergencies".
- There will be two extra meetings in the year – these events will be for the whole board and open to all staff in the Service to focus together on the quality of clinical care. Such a meeting may include reports from individual areas highlighting achievements and concerns; presentations from external speakers; panel discussions of areas of concern and critical questioning. Each meeting will have a theme and be intended to raise awareness of issues and flag up areas for attention. It is proposed that the first of these meetings will be in the Autumn 2014 with "Mental Health" as the theme.

In depth review – Managment of Self Harm (overdose)

The committee had presentations by Katy Millard and Emma Williams reviewing Complaints and Serious incidents including three deaths. Areas of concern were

- All occurred at times of high demand when there were long delays for C1 and C2 patients.

- Categorisation of such patients calls to a C1 (20 minutes) or C2 (30 minutes) response was appropriate reserving the Category A (8 Minute)response to immediately life threatening conditions. However when C1 And C2 patients are waiting two hours or more then it is necessary to put in special measures to care for these patients while waiting.

Fenella Wrigley then elaborated the measures that had been put in place to mitigate these defiencies. These included

- Changes to the MPDS questioning and categorisation.
- Ensuring these patients receive regular “welfare ringbacks” especially if alone
- Failure to answer prompts escalation to a red response with Police attendance.
- The Clinical Hub is now monitoring held calls
- The new “Surge” protocols do not direct intentional overdoses elsewhere but keep them within the Service.
- Initiatives on Mental Health care (Mental Health Nurse on the Clinical Hub; Mental Health Risk Assessment Tool), though not directly aimed at these situations, will help.

The committee felt able to assure the Board that the actions undertaken are sufficient to mitigate the risks discussed. However the committee is concerned that “Ringback” is the mainstay of this mitigation, but as activity increases and there is a need to maintain 999 call responses it becomes more difficult to delegate staff to this welfare function.

The committee was also concerned that this group was just one example of the way in delay for Category C1 and C2 calls is affecting quality of response and that there are other groups for which mitigation may be less effective. The underlying problem is the mismatch between capacity and demand.

Report - Secure transport for patients

In response to a question from the Patients Forum to the Board the committee asked for a report on the secure transport of mental health patients. There will always be a small number of patients who require secure transport although there are processes to minimise the use of this type of transport. The number is small (average 50/month), not enough currently to justify the service purchasing its own vehicle. The vehicle used meets strict specifications. These include a two man cell of suitable materials and a centre section with normal manufacturers seating for compliant patients. The cell is separated by a clear panel which allows communication and observation and the cell can be accessed from with the vehicle. There is no marking to indicate the purpose of the vehicle. It is very different from a police van. These are planned transfers and these vehicles are never used to transfer emergencies.

The committee was reassured that these patients are being managed in a way which, as far as possible, preserves their dignity and comfort while still ensuring that the transfer is secure and safe for both the patient and staff. The Chairman has written to the Patients Forum.

Other

The committee also received and commented on:

The BAF (Business Assurance Framework) – this is reviewed in detail by the Audit committee and also reviewed by the Board. This committee will review any risks highlighted in the BAF which may compromise clinical quality

Draft Quality Account

Serious Incident Tracker

Quality Risk Profile

Indicative Internal Audit plan.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 03 JUNE 2014

PAPER FOR APPROVAL/INFORMATION

Document Title:	**Month 1 Trust Board Integrated Performance Report**
Report Author(s):	**Paul Woodrow**
Lead Director:	**Paul Woodrow**
Contact Details:	
Why is this coming to the Trust Board?	**For information**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	N/A

Key issues and risks arising from this paper

- Significant quality issues in the level of service being provided to patients in the Category C cohorts with excessive waits. Complaints and SIs are still above target levels
- Red 2 performance is significantly off target. Significant decrease in FRU performance attributable to poor DCA availability
- Frontline recruitment and retention still prove to be the biggest challenge to the Trust. Sickness is also off target particularly in operations
- Current level of expenditure is not sufficient to achieve planned performance. Imposition of penalties for Red performance

Executive Summary

- The LAS continues to perform against the Red 1 eight minute national standard but the Trust failed to achieve the eight minute Red 2 response time standard. Category C performance overall has worsened compared to the level we saw in month 12. Further actions have been identified to try to mitigate this and have been added to the Operational action plan owned by the Director of Operations
- Complaints have increased to 77 in month one over the previous month (68) and again are above target levels. The increase is mainly attributable to delays. Sis continue to remain above target but are not at the levels seen in Q3
- Operational vacancies, particularly qualified Paramedics are a significant concern and the attrition rate for this grade is of considerable concern. The Director of Support Services has developed a comprehensive action plan to address the recruitment of frontline staff and a similar plan to address retention of our existing Paramedic workforce.
- Sickness remains above target levels, organisational sickness has remained fairly static but operational sickness levels still remain a concern. An action plan to address this position has now been formulated

- Finance metrics remain within projected levels and there are no current exceptions to report other than the risks that have been identified above

Attachments
I x Integrated performance report

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2013/14 Priorities
☐ Modernisation Programme
☐ Communication and Engagement
☒ Sustain performance to ensure safe service to patients
☐ Building sustainable financial position for 14/15 and beyond

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

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

Equality Analysis

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

Key issues from the assessment:

London Ambulance Service NHS Trust

Trust Board Integrated Performance report

April Data
23-May-14

LONDON AMBULANCE SERVICE NHS TRUST

INTEGRATED PERFORMANCE REPORT 2014/15: April 2014 (MONTH 1)

Quality Exceptions		**Significant quality issues in the level of service being provided to patients in the Category C cohorts with excessive waits**
Performance Exceptions		**Red 2 performance is significantly off target. Significant decrease in FRU performance attributable to poor DCA availability**
Workforce Exceptions		**Frontline vacancies still prove to be the biggest challenge to the Trust. Sickness is also off target particularly in operations**
Value for Money Exceptions		**Current level of expenditure is not sufficient to achieve planned performance. Imposition of penalties for Red performance**

QUALITY

	Quality measures	Target	Current month	Previous month	Year end forecast
1	Serious Incidents declared	1	4	3	RED
2	Complaints received	69	77	68	RED
3	999 Call Answering - 5 secs	95.0%	97.6%	98.6%	GREEN
4	NHS111 Call Answering- 60secs	95.0%	97.2%	97.2%	GREEN
5	NHS 111 Transfer rate to 999	10.0%	7.5%	8.5%	GREEN
6	Aspects of care compliance (MH)	95.0%	90.0%	90.0%	GREEN
7	Deep Clean of vehicles % completed	90.0%	90.3%	90.4%	GREEN
8	Category C1 (20 mins)	75.0%	65.4%	78.4%	RED
9	Category C2 (30 mins)	75.0%	59.9%	71.2%	RED
10	CSR 2014 Delivery - % of Frontline	60.0%	11.0%	88.0%	GREEN

PERFORMANCE / ACTIVITY

	Performance / activity measures	Target	Current month	Previous month	Year end forecast
1	Red 1 Performance	75.0%	76.8%	81.6%	AMBER
2	Red 2 Performance	75.0%	70.7%	80.9%	RED
3	Trust A19 Performance	95.0%	98.5%	99.5%	GREEN
4	FRU A8 Performance	80.0%	71.5%	81.5%	RED
5	Cat A Red 1 Incidents	1,252	1,240	1,277	GREEN
6	Cat A Red 2 Incidents	38,911	38,013	39,234	AMBER
7	Cat A Total Incidents	40,163	39,226	40,317	GREEN
8	Total incidents	92,031	88,443	96,971	GREEN
9	Total Activity against Plan	98,225	97,611		GREEN
10	Clinical Hub Discharges	6,450	9,156	7,975	GREEN

WORKFORCE

	Workforce measures	Target	Current month	Previous month	Year end forecast
1	Staff Turnover % All Trust	8.5%	10.6%	10.7%	RED
2	Vacancies (%) All Trust	5.0%	8.8%	11.2%	RED
3	Paramedic Vacancies against EST	5.0%	14.3%	-	RED
4	Vacancies as number for All Trust	241	555	-	RED
5	Paramedic Leavers	TBC	8	28	RED
6	Sickness (%) All Trust	5.0%	5.9%	5.8%	AMBER
7	Sickness (%) Frontline	5.0%	6.5%	6.5%	RED

VALUE FOR MONEY

		Target	Current month	Previous month	Year end forecast
1	EBITDA (£000)	717	717	-	AMBER
2	Net surplus (£000)	701	701	-	AMBER
3	Cost Improvement Programme (£000)	487	450	-	GREEN
4	Capital expenditure (£000)	-	-	-	GREEN
5	Monitor FRR	3	3	-	AMBER
6	Cash balance (£000)	14,238	13,800	-	GREEN

Supporting Commentary for exceptions against specific quadrants

QUALITY

Commentary: Serious Incidents remain above target and the main contributing factor is delays in responding to patients. Complaints are also just above target levels. Quality is currently being significantly compromised for patients in the category C cohorts. This is caused by significant delays in reaching patients in these groups in a timely way. The main cause for this is the reduced level of operational capacity which at times is being completely stripped out by the activity we are seeing this year despite the fact that the activity is within contracted levels. NHS 111 Services from Beckenham continue to perform well against their KPIs.

Actions: More capacity is being made available to the Clinical Hub to try to manage more effectively the held calls queue. We are trying alternative ways of transporting the low acuity patients to try to reduce waiting times. We have commenced a review of all the determinants in the C Category to ensure that the clinical hub is exposed to the optimum number of calls where Hear and Treat dispositions can be achieved, thus reducing demand

PERFORMANCE / ACTIVITY

Commentary: Performance for the month of April saw a significant decrease in our response time performance for RED 2 patients. We failed to meet the national standard of 75% in 8 minutes. This is principally due to a signifcant decrease in operational capacity. The Red 1 target was met as was the A19 transportation target. Call answering within EOC was also above target for the month. Activity remains within contracted levels.

Actions: The Director of Performance and Director of Operations have developed an action plan to try to improve the level of outturn performance against the Red 2 target. Increased funding has been made available to further incentivise overtime but these shifts are not attracting full take up by operational staff. Critical to a sustainable recovery is the retention of existing staff and a concerted recruitment drive to close the

WORKFORCE

Commentary: Recruitment and retention of the frontline workforce remains the biggest challenge for the workforce directorate. The issue is particularly acute for the Paramedic skill grade. The attrition rate is placing operations under real pressure and is causing a significant capacity gap to meet activity and achieve planned performance. This issue is further compounded by the higher than target level of sickness and this is more acute in frontline operations and is an indicator of the pressure currently felt within operations with the high level of utilisation and lack of headroom currently to meet demand.

Actions:

Comprehensive plans for an agressive recruitment campaign for Paramedic and Emergency Ambulance Crew (ECA) frontline staff.

Comprehensive plan in final stages of development to address the retention issue.

Director of Performance overseeing the case management of our longest long term sickness cases

VALUE FOR MONEY

Commentary: A high level assessment has been made of of the month one financial position. This has not identified any significant variances aganst the month one financial plan and current agreed income and expenditure levels. However, it must be recognised that current expenditure is not sufficient to achieve planned performance. Significant risks have been identified to the financial position across 2014/15. These relate to the potential imposition of penalties and the level of expenditure that would need to be incurred to achieve planned performance

Actions:

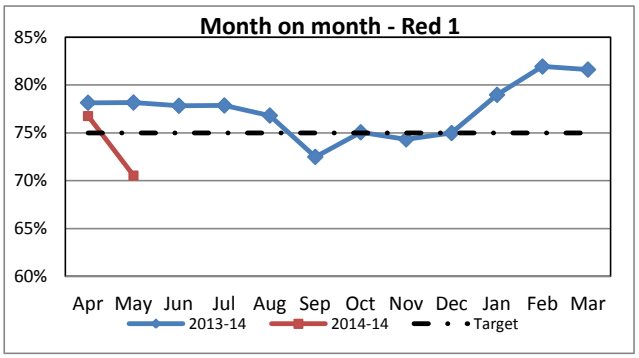
Continued focus on maximising frontline staffing.

Discuss penalties with commissioners

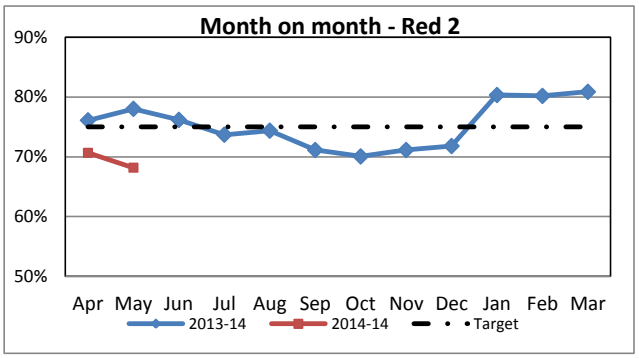
Maintain focus on cash and capital management

PERFORMANCE / ACTIVITY

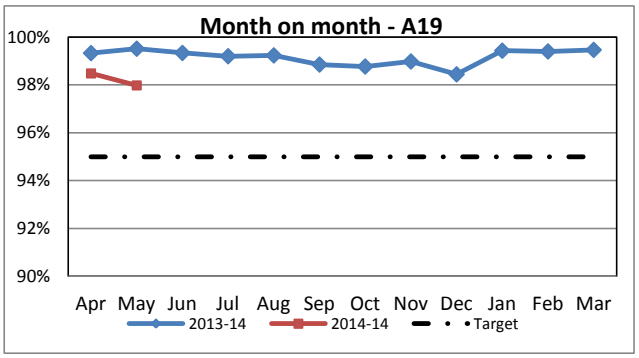
1. Cat A - Red 1 Performance



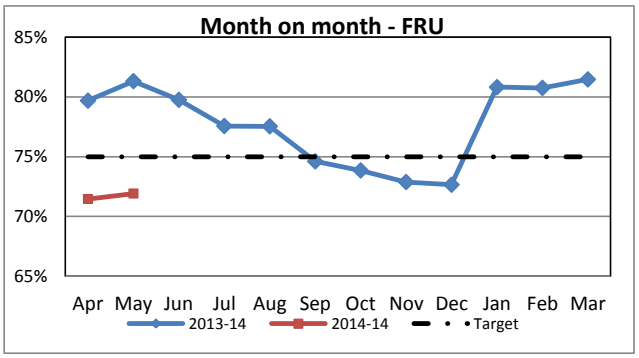
2. Cat A - Red 2 Performance



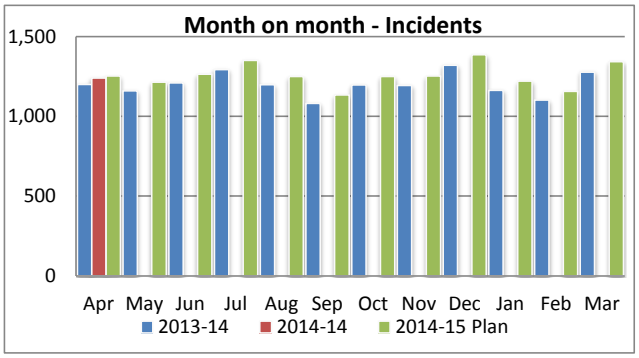
3. Trust A19- Performance



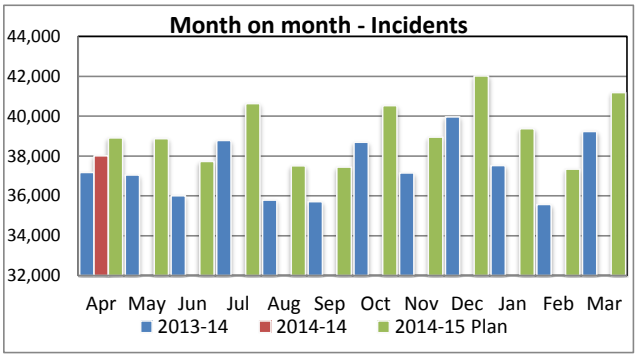
4. FRU A8 - Performance



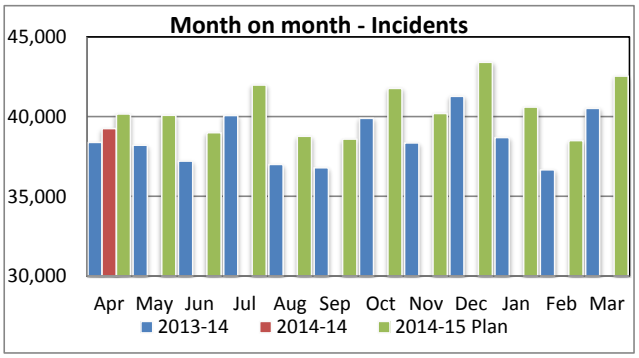
5. Cat A - (Red 1) Incidents



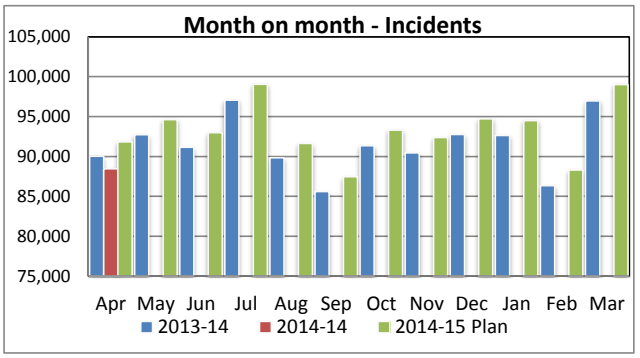
6. Cat A (Red 2) Incidents



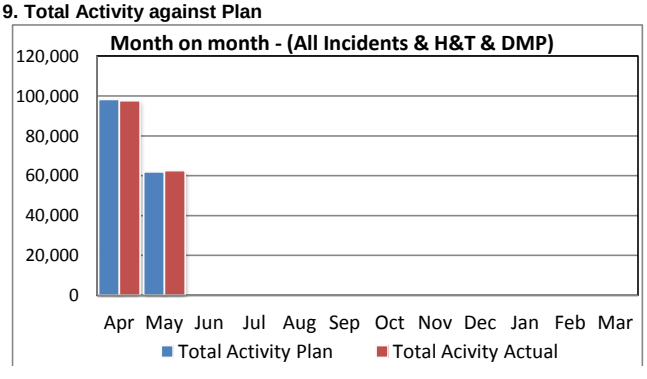
7. Cat A - Total Incidents



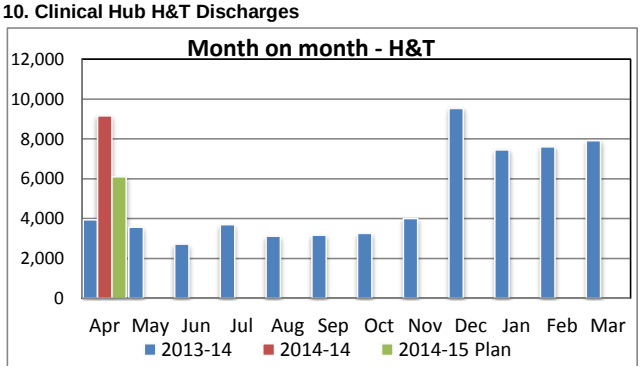
8. Total Incidents



9. Total Activity against Plan

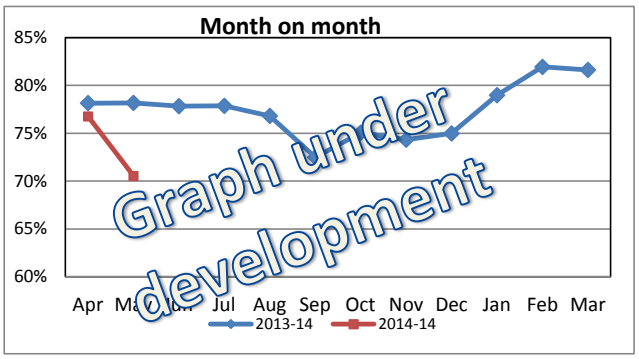


10. Clinical Hub H&T Discharges

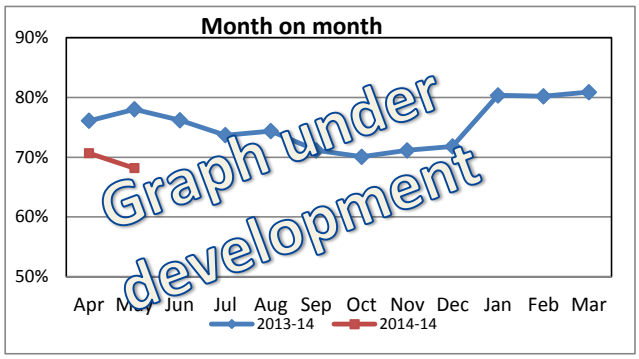


QUALITY

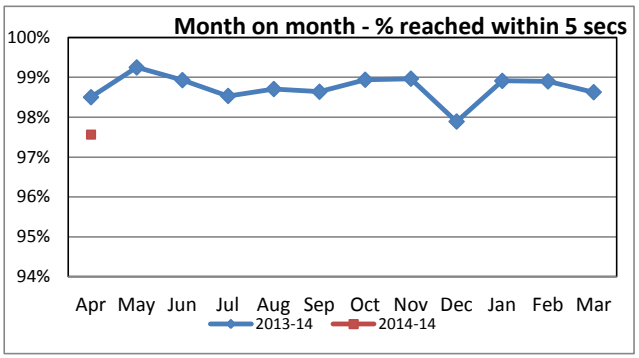
1. Serious Incidents declared



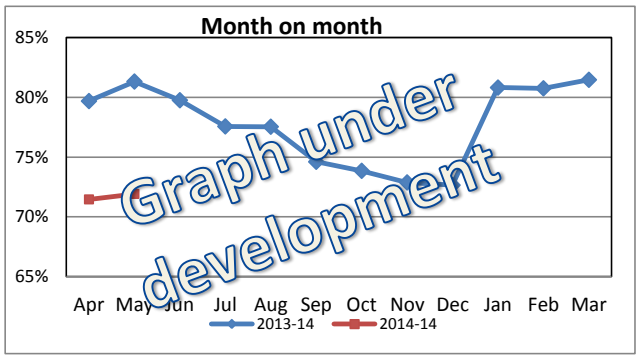
2. Complaints received



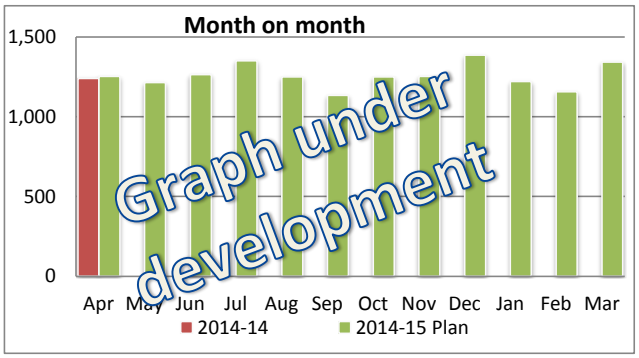
3. 999 Call Answering - 5 secs



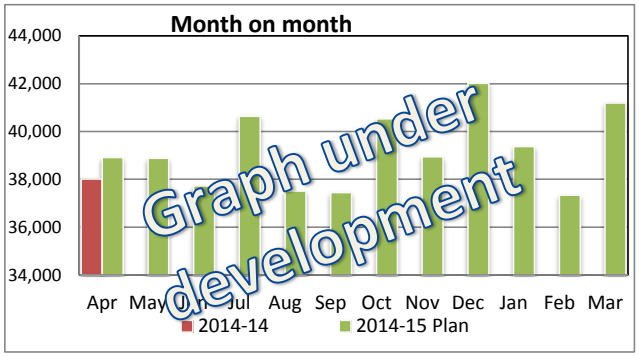
4. NHS111 Call Answering- 60secs



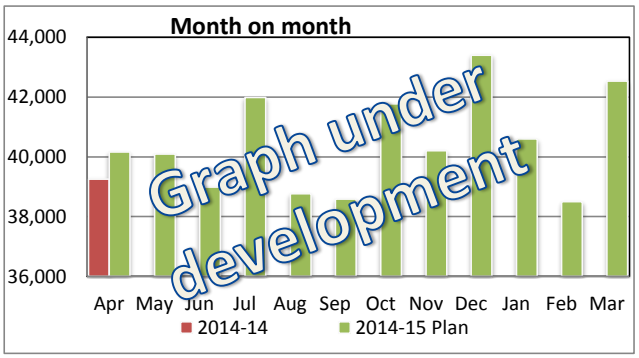
5. NHS 111 Transfer rate to 999



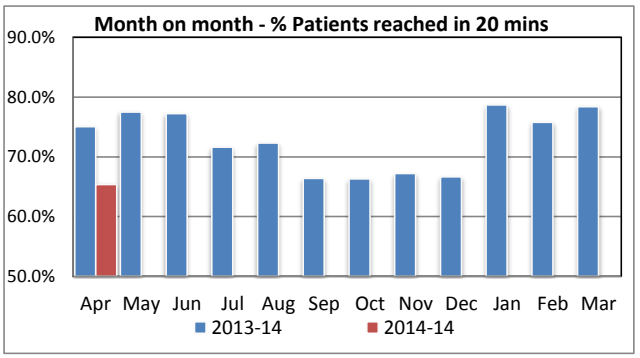
6. Aspects of care compliance (MH)



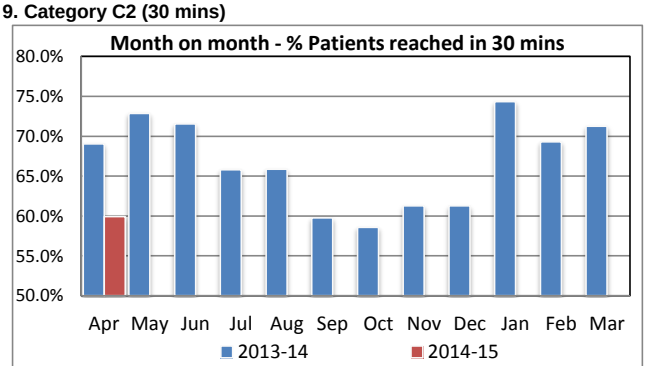
7. Deep Clean of vehicles % completed



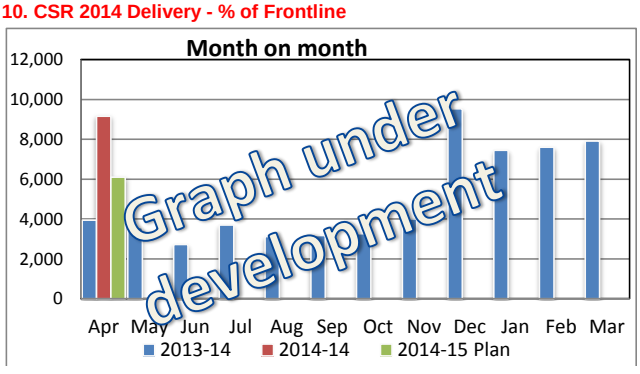
8. Category C1 (20 mins)



9. Category C2 (30 mins)

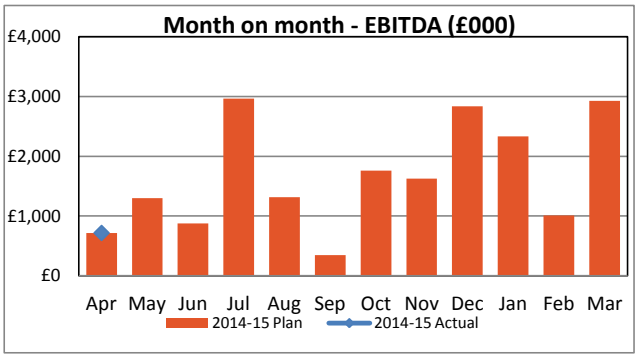


10. CSR 2014 Delivery - % of Frontline

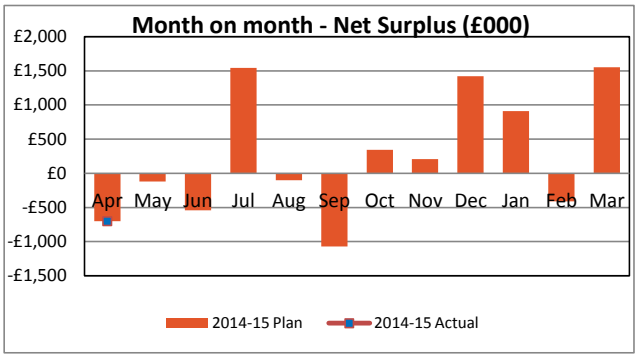


VALUE FOR MONEY

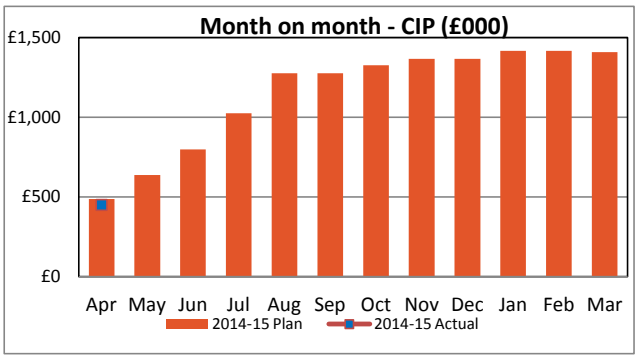
1. EBITDA (£000)



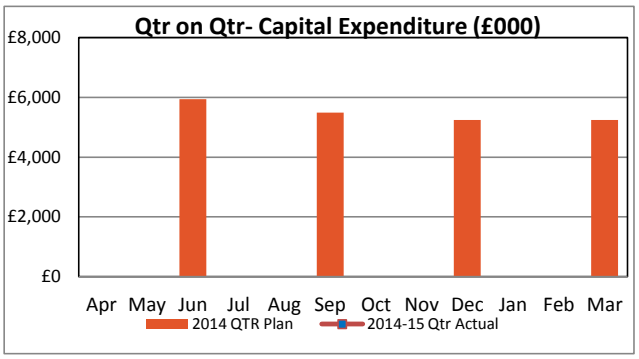
2. Net Surplus (£000)



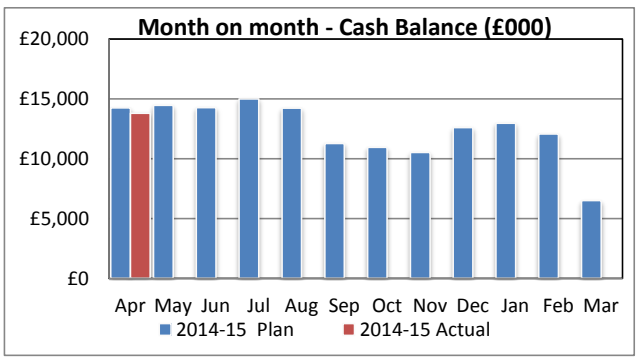
3. Cost Improvement Programme (£000)



4. Capital Expenditure (£000)

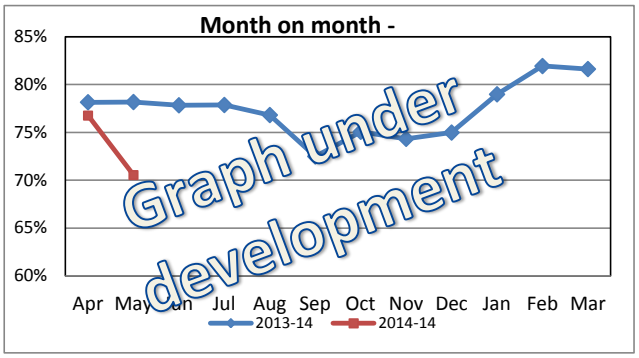


5. Cash Balance

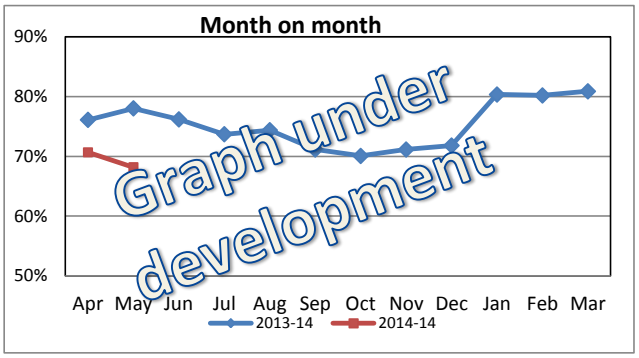


WORKFORCE

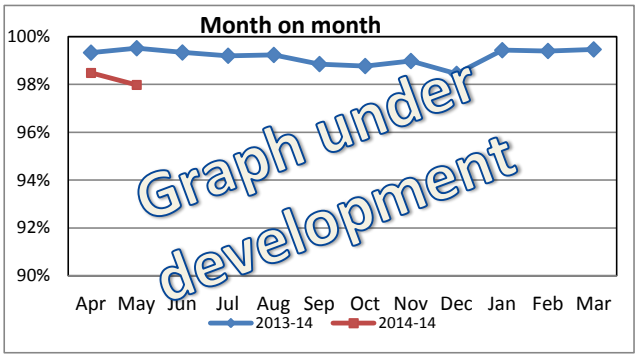
1. Staff Turnover



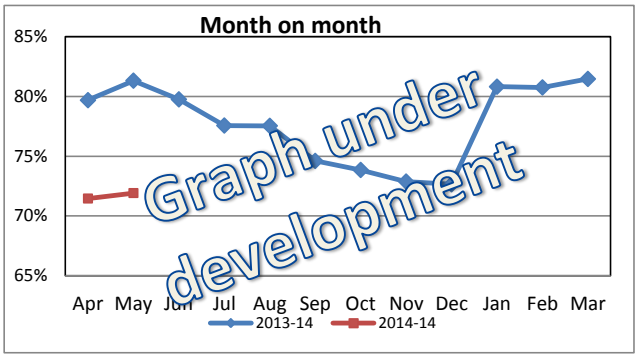
2. Vacancies (%)



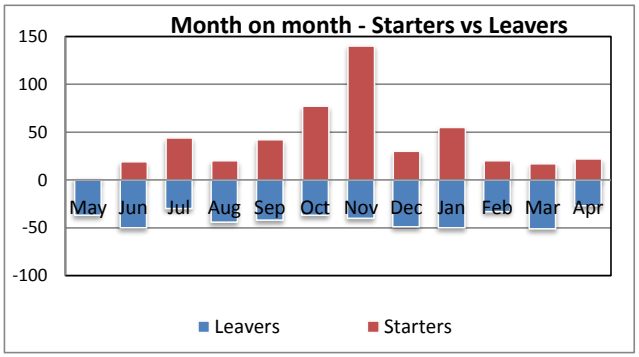
3. Vacancies (WTE) - Paramedic



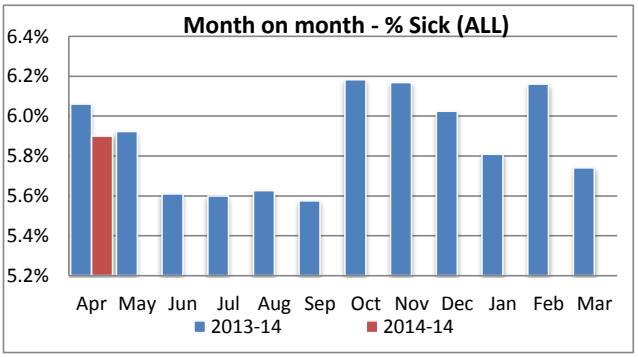
4. Vacancies (WTE) - All Trust



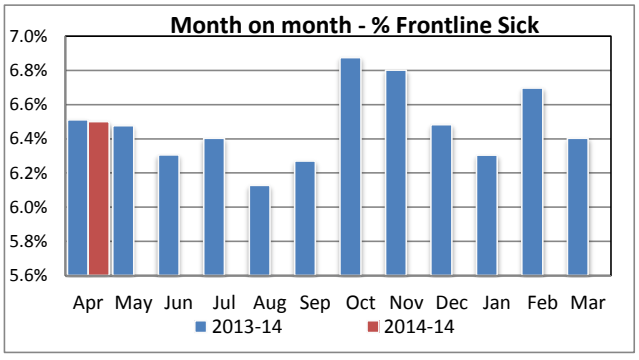
5. Starters vs Leavers



6. Sickness - All Staff (%)



7. Frontline Sickness (%)



Definitions relating to Summary Page

Quadrant	Name	Description / Measure Used
Quality measures	Serious Incidents declared	
	Complaints received	
	999 Call Answering - 5 secs	The % of 999 calls answered within 5 seconds of the call connect time. This measure is only available [illegible]AS as a whole.
	NHS111 Call Answering- 60secs	
	NHS 111 Transfer rate to 999	
	Aspects of care compliance (MH)	
	vehicles % completed	
	Category C1 (20 mins)	The % of Category C C1 incidents where any responder arrived on scene within 20 min[illegible]s, m[illegible]asured from the call connect time. If no call connect time is available, the time the call was answered is used.
	Category C2 (30 mins)	The % of Category C C2 incidents where any responder arrived on scene within 30 m[illegible]nute[illegible] measured from the call connect time. If no call connect time is available, the time the call was answered is u[illegible]d
	CSR 2014 Delivery - % of Frontline	
Performance	Red 1 Performance	The % of Category A Red 1 incidents where any responder arrived on scene wi[illegible]n 8 minutes, measured from the call connect time. If no call connect time is available, the time the call was answe[illegible]used.
	Red 2 Performance	The % of Category A Red 2 incidents where any responder arrived on sc[illegible]e within 8 minutes, measured from either first dispatch, chief complaint or 60 seconds, whichever comes first.
	Trust A19 Performance	[illegible] minutes, measured from the call connect time. If a motorcycle or cyc[illegible]the only responder (and arrives within 19 mins) this will be counted
	FRU A8 Performance	The % of Category A Incidents where an FRU (Single responder) arri[illegible] scene within 8 minutes. The time to start the clock will depend on if it is a Red 1 or Red 2 incident.
	Cat A Red1 Incidents	Incidents are all calls where at least one responder/resource capa[illegible]le of stopping the clock arrived on scene on a Red1 incident. It does not matter how many vehicles arrive on scene, it[illegible]still only counted as one incident.
	Cat A Red2 Incidents	Incidents are all calls where at least one responder/resource c[illegible]ble of stopping the clock arrived on scene on a Red2 incident. It does not matter how many vehicles arrive on scen[illegible]s, still only counted as one incident.
	Cat A Total Incidents	Incidents are all calls where at least one responder/reso[illegible]e ca[illegible]e of stopping the clock arrived on scene on Cat A incident. It does not matter how many vehicles arrive on sc[illegible]t is still only counted as one incident.
	Total incidents	Incidents are all calls where at least one responder/resou[illegible]e ca[illegible]ble of stopping the clock arrived on scene. These
	Total Activity against Plan	This is the result of combining Cat A, C, Other, H&T (Hear a[illegible]reat) and DMP related incidents together and comparing this against the agreed plan with commision[illegible]s that period.
	Clinical Hub Discharges	These are calls which have been triagged without th[illegible]nee[illegible]or transports by EOC clinicians within the HUB.
Workforce Measures	Staff Turnover % All Trust	
	Vacancies (%) All Trust	
	Paramedic Vacancies against EST	
	Vacancies as number for All Trust	
	Paramedic Leavers	No of Paramedic leaving frontline op[illegible]s.
	Sickness (%) All Trust	
	Sickness (%) Frontline	
Value for Money	EBITDA (£000)	
	Net surplus (£000)	
	Cost Improvement Programme (£000)	
	Capital expenditure (£000)	
	Monitor FRR	
	Cash balance (£000)	

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 3RD JUNE 2014

PAPER FOR INFORMATION

Document Title:	**Board Assurance Framework and Corporate Risk Register**
Report Author(s):	**Frances Field, Audit & Compliance Manager**
Lead Director:	**Sandra Adams, Director of Corporate Affairs/Trust Secretary**
Contact Details:	**Board Assurance Framework – May 2014** **Corporate Risk Register – May 2014**
Why is this coming to the Trust Board?	
This paper has been previously presented to:	**Executive Management Team** **Audit Committee** **Quality Committee**
Recommendation for the Trust Board:	**To note the progress made with mitigating controls and actions for risks included in the Board Assurance Framework and Corporate Risk Register (15+)**

Key issues and risks arising from this paper

The key risks to strategic goals and improvement priorities are detailed in the paper.

Executive Summary

The Board Assurance Framework (BAF) and risks qualifying for inclusion on the Corporate Risk Register (15+) have been reviewed with risk owners to provide an update of the Trust's current position. This review considered:

- Checking and challenging current controls noted against the risks to ensure that they were current and appropriate and updated where required.
- The need to re-score the current risks following an assessment of the controls in place.
- The setting and monitoring of target risk scores in line with the Trust's tolerance level for the risk.

Changes to the Board Assurance Framework

A few minor changes have been made to the format of the document following feedback from the Audit Committee previously, these include:

- The Trust Risk ID numbers are now linked to the mapped risks on the risk matrix on the second page.
- An indicator of the direction of travel of the risks has also been added against each risk on

the second page.

- The word 'residual' risk has been exchanged for 'net' risk on the control sheets.

Changes to the Corporate Risk Register

A number of changes have been to the controls as a result of the review, these have not been listed separately. There have been changes in the risk scores in relation to the following risks:

Risk Ref	Risk Description	Change in score	
		Jan 2014	May 2014
368	Message exchanged between MDTs and CommandPoint system becoming out of sequence.	15	10
22	There is a risk that failure to undertake comprehensive clinical assessments may result in the inappropriate non-conveyance or treatment of patient.	15	12
378	Insufficient information is contained within MPS Referrals for inclusion in our locality alert register	15	10

These risks are proposed for removal from the Corporate Risk Register as they have been de-escalated below the level which qualifies risks for inclusion on their (as per the Trust's Risk Assessment and Reporting Procedure (TP035).

Attachments

Board Assurance Framework – May 2014
Corporate Risk Register – May 2014

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

☒ Preventing people from dying prematurely
☒ Enhancing quality of life for people with long-term conditions
☒ Helping people to recover from episodes of ill health or following injury
☒ Ensuring people have a positive experience of care
☒ Treating and caring for people in a safe environment and protecting them from avoidable harm
☒ Caring for the workforce

LAS Strategic Goals and Priorities
This paper supports the achievement of the following strategic goals and priorities:

LAS Strategic Goals
☒ To improve the quality of care we provide to our patients
☒ To develop care with a highly skilled and representative workforce
☒ To provide value for money

2013/14 Priorities
☒ Modernisation Programme
☒ Communication and Engagement
☒ Sustain performance to ensure safe service to patients
☒ Building sustainable financial position for 14/15 and beyond

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

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

Equality Analysis

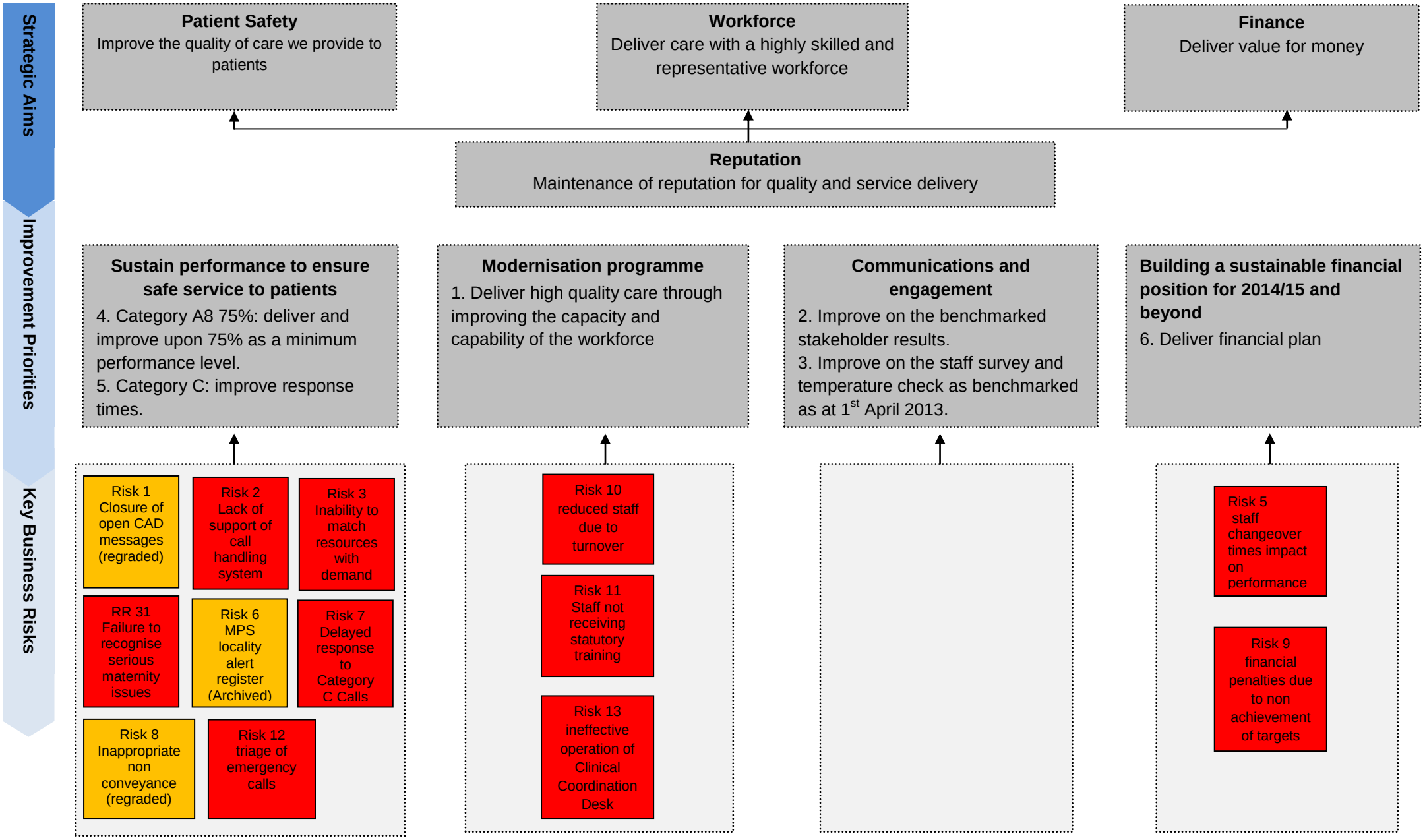
Has an Equality Analysis been carried out?

☐ Yes
☒ No

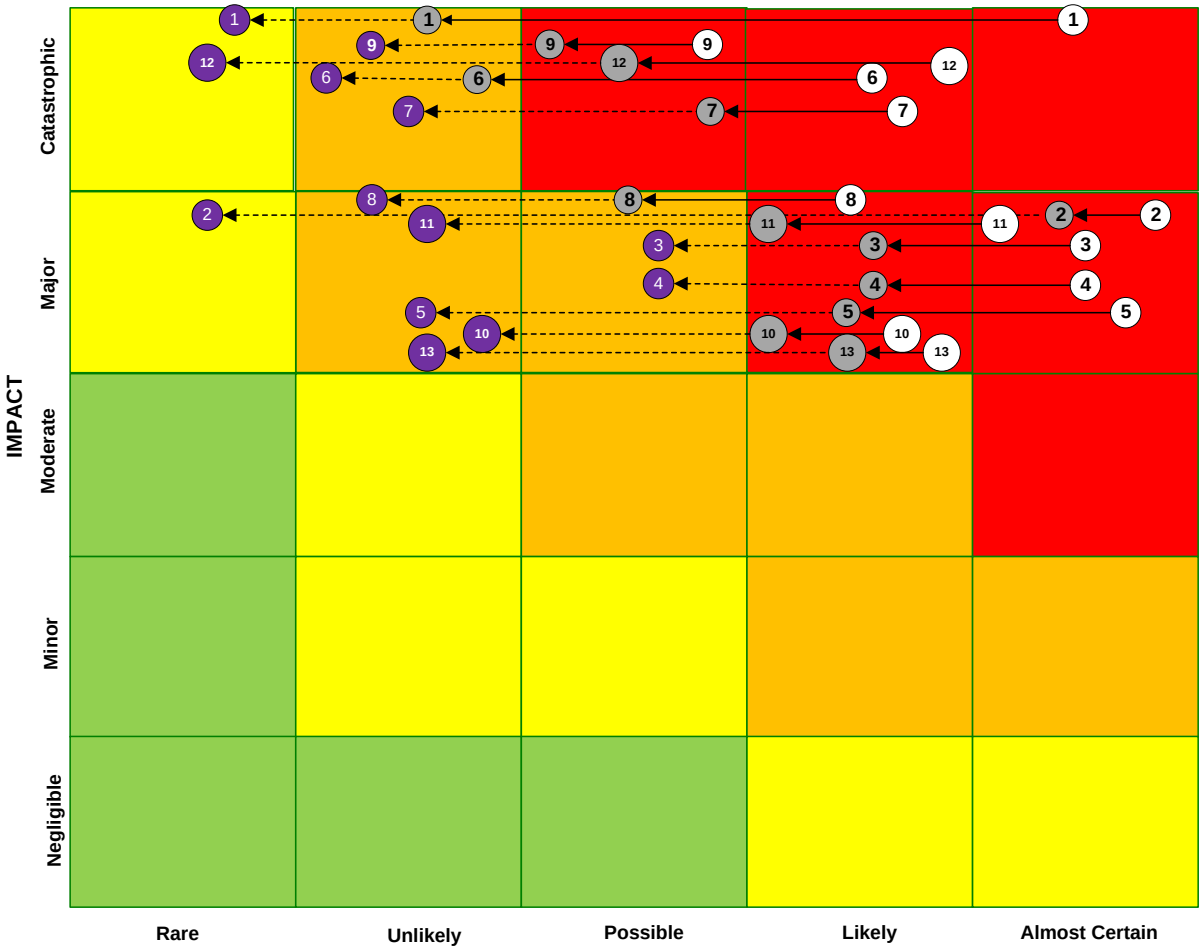
Key issues from the assessment:

Board Assurance Framework - May 2014

Key Risks to the Strategic Plan



Key Risks to the Strategic Goals and Improvement Priorities



Key:

- Gross risk assessment
- Net risk rating
- Target risk rating

- High Risk
- Significant Risk
- Moderate Risk
- Low Risk

Risk trajectory since January 2014

↓	Risk 1	RR 368	Messages exchanged between MDTS and CommandPoint system becoming out of sequence
↔	Risk 2	RR 387	Call handling system may be unsupported by Priority Dispatch System
↔	Risk 3	RR 265	Service Performance affected by the inability to match resources to demand
↔	Risk 4	RR 31	Failure to recognise serious maternity issues
↔	Risk 5	RR 269	Performance falls at staff changeover times
↓	Risk 6	RR 378	Insufficient information from MPS on locality alert register
↔	Risk 7	RR 379	Delay to Category C calls
↓	Risk 8	RR 22	Inappropriate non-conveyance of patients
↔	Risk 9	RR 329	Non achievement of contractually agreed targets
↔	Risk 10	RR 388	Reduced staff due to turnover
↔	Risk 11	RR 355	Staff not receiving statutory training
↔	Risk 12	RR 382	MPS calls are incorrectly triaged
↔	Risk 13	RR 349	Ineffective operation of Clinical Co-ordination Desk

London Ambulance Service NHS Trust
Risk Register - May 2014

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	Risk Category	Gross Impact	Gross Likelihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Likelihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Likelihood	Target Rating	Comments
387	There is a risk that the LAS could be in a position where its call handling system is unsupported by Priority Dispatch Systems (the suppliers) from late 2014 onwards. this will involve both our call taking system (ProQA) and the MPDS version we are using (12.2). This will significantly impact our ability to maintain and use both systems and compromise efficient working and patient safety.	Priority Dispatch have developed an updated and improved operating system for MPDS. This system, ProQA Paramount, repleaces the existing ProQA, Paramount is currently available for UK users and is compatible with the current version of MPDS, 12.2.. In Q3/4 2013/14 a new verison of MPDS, version 13, will be released. It is not possible to use use Version 13 without Paramount. It is likely that, following normal business practise, having released V13 and Paramount, Priority Dispatch will withdraw technical support for the existing verions of ProQAand version 12.2. This should be within a year. Loss of the technical support would cause significant impact and	23-Oct-13	2		Business Continuity	Major	Almost Certain	20	1. Work has been undertaken by IM&T to scope the work required to integrate Paramount to facilitate identifying the costs involved. 2. Task and finish group prepared a detailed paper of the options which went to the Executive Management and Senior Management Teams on the 18th December 2013.	**David Prince (Vic Wynn)**	01-Apr-14	Major	Almost Certain	20	1. A workshop has been planned for January 2014 involving the Executive and Senior Management Teams based on the recommendations made in the report.	1. EMT/SMT	1. Jan 2014		Major	Rare	4	Latest update on timing is that the development may not meet the timescale required, propose net rating is regraded to Possible x Major = 12 Rationale for downgrade - - confirmation now provided by Northrop Grumman that they will produce an interface to the new version of ProQA (Paramount) at nominal cost, the risk to the Trust is reduced. The need for a confirmed Trust strategic (Paramount vs Pathways) direction is therefore not currently critical.
265	There is a risk that Service Performance may be adversely affected by the inability to match resources to demand.	Recruitment Attrition Growing vacancy factor	31-Jul-06	3	3	Operational	Major	Almost Certain	20	1.Ongoing recruitment to vacancies. 2. Use of voluntary and private sector at times of peak demand. 3. Use of agency Paramedics to enhance bank scheme. Modernisation programme. Targeted use of overtime. Surge plan	Jason Killens	15-Apr-14	Major	Likely	16	Modernisation programme to implement efficiencies from capacity review. 1. Sickness management 2. Attendance management 3. Roster review 4. Skill mix 5. Annual leave review 6. New response model 7. Workforce plan operations / recruitment and retention	1 - 2 J. Killens 3 - 6 M. Kennedy / J. Chalmers 7. T.Crabtree / D. Prince	3. Complete 4. May 2014 5. May 2014 6. Sep/Oct 2014 7. Q4 2014/15		Major	Possible	12	
31	There is a risk that the control and operational staff may fail to recognise serious maternity issues or fail to apply correct guidelines which may lead to serious adverse patient outcomes in maternity cases.		14-Nov-02	4	4	Clinical	Major	Almost Certain	20	1. Consultant Midwife working with the LAS one day a week, providing advice to Control Services, Legal Services, Patient Experience, and Education and Development. 2. Reports on all the reported incidents concerning obstetric cases are presented to the Clinical Quality Safety and Effectiveness Committee (CQSEC). 3. Review incidents reported through LA52's, 4. Patient Experiences and legal Claims relating to problematic obstetric incidents. 5. Maternity care update articles in the Clinical Update. 6. Monitoring the delivery of the CPD obstetrics module. 7. The maternity pathway for use by Clinical Hub has been redesigned after audit findings. This has been implemented and reviewed. A planned reaudit will occur in 2014. 8. Delivery of CSR 2013/2014 obstetric update (detailed in 2013 UK Ambulance Service Clinical Practice Guidelines) & updates written by Consultant Midwife. 9. Pan-London Maternity Divert Policy (Updated Sept. 2013): Robust framework to limit temporary closures of maternity units and to organise redirection.	Fionna Moore	14-Apr-14	Major	Likely	16	1. Director of Paramedic Development & Education to directly oversee delivery of CSR 2013/2014. CSR to be delivered to >85% clinical staff. 2. Appointment of Consultant Midwife (post vacant) to provide professional advice and education. Update post from 0.2 WTE to 0.4 WTE to increase availability and impact through obstetric education.	1. End 2014 2. May 2014	1. Review during each quarter and any serious or recurrent themes highlighted through updates to operational and/or control staff and CQSEC. 2. End of 2013/14 financial year 3. End of 2014/15 financial year	1. Monitor processes at CQSE and Corporate Health and Safety Group. Direct feedback to CQD from Legal Services. 2. Incident reporting. 3. Reports to CQSEC, SI group, Learning from Experiences	Major	Possible	12	FM 14/04/14 suggested that net rating remains at 16 until the consultant midwife is in post and will review in 6 months time. the recruitment process is underway with expressions of interest for the post being made. SMT 09/04/14 approved regrading but requested the risk remain visible on the register (not archived). Proposal to reduce current rating to possible x major = 12

London Ambulance Service NHS Trust
Risk Register - May 2014

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355	There is a risk of staff not receiving clinical and non-clinical statutory training.	This may as a consequence cause:- ● Failure to meet CQC and the Trust's TNA policy ● Dilution of clinical skills	23-Nov-11	11	5	Corporate	Major	Almost Certain	20	1. Agreement with operations that there will be an agreed abstraction of up to 90 staff per week to attend CSR during agreed periods. 2. Paramedic registration.	Mark Whitbread	01-Apr-14	Major	Likely	16	1. The TNA which applies to April 2014 to be reviewed and agreed by TSG. 2.A workbook has been developed for Infection prevention and control it will be launched shortly. 3. Use of OLM for recording of CSR 1 will commence from October 2012. 4. Operational Resources will need to book staff onto courses to capacity in order to train all staff within year.	1. J. Chalmers 2. J.Thomas 3. P. Billups 4. P. Cook	1. May 2014 2. Complete 3. Complete 4. Ongoing	1. TSG review and agree TNA on an annual basis. 2. TNA used as basis for agreeing service training plan. 3. TSG review reulgar reports of uptake on training.	Major	Unlikely	8	SMT 09/04/14 suggested that current risk rating remains until the risk is reviewed for splitting between clinical and non clinical. Update control sheet. Propose risk owners made up of Directors within TSG / or its successor for principal risk. Action plans underpin headline risk made up of clinical and non clinical training action plans. discuss with Karen B / Jane Chalmers and Mark W. Split risk between clinical (MW) and non clinical (B'ON) 8/1/14- BO'N proposes change of net rating to Major x Possible = 12. Evidence of attendance at CSR training course by 1/12/13 1906 front line staff had attended CSR Representing 62.6% of the eligible workforce. Sufficient courses are planned for Jan,Feb and March to accommodate 100% of staff. Agreement in place with Ops that up to 90 people will attend per week. Still issue of all in one training
269	There is a risk that at staff changeover times, LAS performance falls.	Current rest break agreement permits staff to conclude shift by upto 30 mins early where no break given by EOC	08-Dec-06	5	17	Clinical	Major	Almost Certain	20	1. Daily monitoring of rest break allocation to resolve end of shift losses 2. Use of bridging shifts for VAS/PAS 3. Roster reviews/changes must include staggered shifts.	Jason Killens	15-Apr-14	Major	Likely	16	1. Implement changes to rest break arrangements 2. Rota changes to be implemented as result of ORH review 3. Recruitment 4. Skill mix: the skill mix model which is intended to be implemented under Modernisation is under discussion between trust management and trades unions. The target date for completion of the discussions and agreement of the skill mix is May 2014. Skill mix has been included in the modernisation programme's implementation planning and subsequent implementation into BAU 5. Ongoing vigorous management of out of service. J. Killens to set improvement trajectory to get out of service levels back within target.	1. T. Crabtree 2. J. Killens 3. D. Prince 4. M.Kennedy / J. Chalmers 5. K. Brown / Sean Westrope	1. Q2 14/15 2. Q2 14/15 3. Q2 14/15 4. May 2014 5. Q2 14/15		Major	Unlikely	8	
349	There is a risk that the Clinical Coordination Desk will not be able to operate effectively due to a lack of suitably trained staff in EOC where secondments of specifically trained staff have ended and specialist roles with control services are being removed.	Specialist roles with control services are being removed in order to provide a more flexible workforce. This removes the experience and expertise that has been developed on the CCD and has now become a nationally recommended part of clinical network development.	11-Jul-11	13	4	Operational	Major	Likely	16	1. CCD now supported by enhanced clinical support in EOC with 24/7 clinical hub going live on 16/7/12	Jason Killens	15-Apr-14	Major	Likely	16	1. Increase the number of staff trained to undertake the Clinical Coordination Role 2. Ensure that, if there is no option but to split the desk between Waterloo and Bow, the CCD is co-located with the Clinical Hub at both sites				Major	Unlikely	8	SA - recommend for archiving JK - 15/04/14 recommend to SMT for archiving due to the clinical hub now being in place.

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Risk Register - May 2014

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388	There is a risk that the increase in turnover rates may lead to frontline staff reducing by significant numbers impacting the Trust's ability to deliver safe patient care.	1. Competitive recruitment market for Paramedics 2. Increasingly mobile workforce with a multitude of recruitment possibilities 3. Cost of living pressures in London coupled with increasing travel costs for commuting 4. Opportunities for clinical career progression in other organisations, which do not exist within the LAS, such as 111 and other public, private and voluntary healthcare providers 5. Staff morale 6. Perceptions of access to funding for personal development and study leave 7. Concerns about job security 8. National shortage of registered paramedics 9. Relocation packages elsewhere	10-Apr-14	10		Clinical	Major	Likely	16	1. NHS staff benefits 2. Listening into Action - to understand staff improvements. 3. Developing the modernisation programme – including rota reviews and development of a clinical career structure. 4. Actively recruiting university and registered paramedics and A&E support. 5. Monitoring and developing plans to address trends in turnover. 6. The use of overtime, private and voluntary ambulance services to increase the number of available resources.	David Prince	15-Apr-14	Major	Likely	16	1. Development of Clinical Career Structure. 2. Skill mix review. 3. Review exit interview process and data capture. 4. Discussion at EMT regarding framework / strategy to address 5 key actions that assist retention. 5. Promote learning and development opportunities. 6. Recruitment group meeting fortnightly identified 6-7 streams from which paramedics can join the service, also establishing the process to enable this. 7. Implementing the modernisation programme.	1. F.Moore 2. J.Chalmers/ P.Woodrow 3. L.Koppenhol 4. J.Chalmers 5. B.O'Neil 6. D. Prince 7. J.Chalmers/P.Woodrow	1. 2014/15 2. 2014/15 3. Completed 4. 2014/15 5. 6. Dec 15 7. Dec 15	1. Comprehensive workforce and recruitment plan. 2. Regular monitoring of turnover and responding to developing trends, making necessary adjustments to current plans. 3. Ongoing recruitment drive, in addition to proactively seeking out new markets to target additional recruitment drives. 4. Training programme in progress for ongoing cohorts of A&E support and Paramedic staff. 5. Development of reward strategy. 6. Development of clear clinical career structure. 7. Review of flexible	Major	Unlikely	8	1. Advanced Paramedic Practitioner role agreed, all 12 posts of tranche one have now been recruited to. New role 'goes live' in May 14 Recruitment to vacant Team Leaders posts commenced in Feb 14 2. New band 4 role now agreed with trade unions. Transition planning for move to new role now underway. 4. Rewards strategy sits with Charlotte Gawne and she is incorporating it into part the wider staff engagement strategy. Retention is being led by David Prince – a comprehensive retention plan is being devleoped. 7. work continues to implement all 9 projects of the modernisation programme. 3 have been delivered to date, detailed implementation planning is now underway for new rosters and new response model and annual leave, rest breaks and active area cover are being actively discussed with Trade Unions
379	There is a risk that calls received and triaged as Category C; sub divided into C1, C2, C3 & C4 could receive a delayed or inappropriate response because of increased levels of Category A demand on available resources.	40% of total volume of calls are Category A. Inability to match resource to demand as the responding priority is focussed on more seriously ill patients.	11-Mar-13	7		**Clinical**	Catastrophic	Likely	20	1. Undertaking ring backs within set time frames for held calls. 2. Fully trained workforce with 20 minute education breaks throughout shift. 3. C3 calls passed to hub for enhanced assessment C1 and C2 held calls are reviewed by hub 4. LAS Surge Management Plan. 5. Targeted additional resource at times of peak pressure using PAS/VAS/LAS overtime.	Jason Killens	15-Apr-14	Catastrophic	Possible	15	1. Recruit to Establishment minus agreed vacancy factor of 4% 2. Deliver efficiencies in full from CapacityReview and complete Roster Implementation. 3. Review the determinants to best maximise resource availability, to assist with reduction multiple attendance ratio for single incidents. 4. Recruit to establishment in the clinical hub. 5. Allocate EMDs to clinical hub to assist with ring backs – Service Development put in for additional staff to undertake this work 6. Offer near misses for APP and CTL to spend 6 months in the clinical Hub in preparation for next tranche of recruitment 7. Introduce surge plan and make appropriate revisions 8. More accurate reporting of category C delays and monitoring of safety incidents	**1. D.Prince** **2. J.Killens** 3. J. Killens 4. K. Millard 5. K. Millard 6. K. Millard 7. K. Millard 8.	1. 2015/16 2. Q3 14/15 3. Q1 14/15 4. Q3 14/15 5. Q2 14/15 6. 2014/15 7. Ongoing 8.	1. Operational Demand and Capacity Review Group 2. Senior Management Team 3. Medical Directorate senior clinical advice; Clinical risk and Patient safety 3. The weekly SI group reviews patient safety incidents	Catastrophic	Unlikely	10	
382	There is a risk that Emergency calls from Metropolitan Police Service (MPS) are incorrectly triaged by the MPS, affecting the ability of the LAS to effectively prioritise resources. This risk also directly compromises the clinical safety of patients.	In 2001 CAD link was developed, which enabled the MPS and LAS to exchange emergency calls and other messages directly via each organisation's CAD system. This process bypasses the standard triage system that all other 999 calls are subject to. To request the LAS, the MPS complete a basic triage of the call, known as the SEND protocol (Secondary Notification of Dispatch). SEND requires the MPS to answer five key questions to determine the medical priority of the call. Requests for the LAS from the MPS may be incorrectly triaged as a result of the limitations of the medical triage system used by the MPS Central Communications Command (SEND protocol). Erroneous	07-May-13	12		Clinical	Catastrophic	Likely	20	1. LAS METDG in in place 7 days a week. 2. The Clinical Hub reviews low priority 999 calls that are being held and have the ability to identify MPS calls that have been incorrectly triaged and interrogate / upgrade the call priority if indicated. 3. EMDs can identify calls that appear to be miss-triaged by the SEND protocol or MPS Operator and upgrade / dispatch on the call immediately. 4. The MPS are now notified of incorrectly triaged calls sent to the LAS, to facilitate learning.	Jason Killens	15-Apr-14	Catastrophic	Possible	15	1. ~~A risk based evaluation of the pilot study will be undertaken and the results will be discussed with the Operational and Clinical leads.~~ ~~2. Dependent on the results it will be for the LAS to consider removing the CAD link for primary notification of emergency calls from the MPS which will then be triaged via the LAS 999 system and MPDS~~	1. P.Woodrow / F.Wrigley 2. P.Woodrow	1. Completed 2. Completed		Catastrophic	Rare	5	All mitigating actions have been put in place and the risk. JK 15/04/14 residual risk to be tolerated.

London Ambulance Service NHS Trust
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329	There is a risk that financial penalties will be levied on the Trust as a result of non-achievement of the contractually agreed targets.	Potential failure to achieve contracted performance targets and failure to earn CQUINs	06-May-10	9	3,4,8	Finance	Catastrophic	Possible	15	1. 2013/14 Continue working with specific mitigation of financial risk. 2. Monthly finance reports reviewed by Trust Board and EMT. 3. Regular communication with commissioners. 4. The contract of the Director of Modernisation and OD has been extended to end of June 2014 to maintain focus on the Modernisation Programme.	Andrew Grimshaw	01-Apr-14	Catastrophic	Possible	15	1. Review by Finance Investment Committee 2. Review capacity vs demand 3. Develop a programme of sustainable performance and performance management 4. Develop clear escalation procedures when measuring performance . 5. Establish relationship with Commissioners 6. Negotiate suitable operating contract with Commissioners. 7. Recruitment	1. K.Hervey 2. J. Killens 3. P. Woodrow 4. P. Woodrow 5. K. Broughton 6. K. Broughton 7. D. Prince		1. Performance is tracked daily both centrally and by area. 2. Financial risks are reviewed by SMG and Trust Board. Diary meeting every Monday reporting where performance is reviewed and recover plans are discussed. 3. Monthly meetings with PCT commissioners were performance is reviewed against targets and agreement is reached and findings are documented. 4. Performance is reported to the SHA monthly. 5. The Finance and Investment Committee will	Catastrophic	Unlikely	10	This risk is under review for re-assessment and proposal of new risk to replace it. K. Broughton - May 2014.
22	There is a risk that failure to undertake comprehensive clinical assessments may result in the inappropriate non-conveyance or treatment of patient.	Inappropriate non-conveyance incident	14-Nov-02	8	5	Clinical	Major	Almost Certain	20	1.Monitor level of CSR training and delivery. 2. CPIs are used to monitor the standard of assessments provided. 3. LA52 incident reporting is in place and reports are provided to the Clinical Quality Safety and Effectiveness Committee (CQSEC) and the Area Clinical Quality Groups. 4. The Operational Workplace Review has been reviewed and will now include ride outs. 5. A system for clinical updates is in place. 6. There is continuing development of appropriate care pathways, which forms part of the 'Time for Change'. 7. An enhanced patient assessment component has been introduced within the APL Paramedic Course. The training has been subject to a major review and now includes a mentored period of operational duties. 8. Introduction of Paramedic Pathfinder – an adaption of the Manchester Triage System for use pre-hospitally to safely identify the most appropriate destination for individual patients. 9. Introduction of Paramedic Pathfinder – an adaption of the Manchester Triage System for use pre-hospitally to safely identify the most appropriate destination for individual patients. 10. Introduction of reflective practice (as part of Module J programme). 11. 2013 Clinical Practice Guidelines include some updates on clinical assessment.	Fionna Moore	14-Apr-14	Moderate	Likely	12	1. Director of Paramedic Development & Education to directly oversee delivery of CSR 2013/2014. CSR to be delivered to >85% clinical staff. 2. The Medical Directorate will continue to monitor trends. The new Datix system will assist with this. 3. Recruit to post of Service Delivery & Policy Manager, to develop / review ACPs and ensure robust referral criteria. 4. Design processes to audit and monitor the effectiveness of the pathfinder tool. 5. Development of the clinical career structure.	1. Director of Paramedic Education and Development 2. Clinical Advisor to the Medical Director 3. Director of Transformation & Strategy 4. Pathfinder Leader 5. Mark Whitbread	1. End of 2014 2. Ongoing 3. May 2014 4. Commence April 2014 5. May 2014 - 2017	CPI reports OWRs CQSEC EMT/TB reports Learning from Experience	Moderate	Possible	9	SMT 09/04/14 approved regrading Proposal to reduce current rating to likely x moderate = 12 DSW 14/04/16 Further Action 2 - The Medical Directorate will be continuing to give clinical opinions
368	There is a risk that messages exchanged between MDTs and the CommandPoint CAD system may become out of sequence, cross one another while one is being processed or a job being 'cycled' through to closure in error by an A&E resource. This may result in an open event being closed in the CAD system erroneously, leading to a patient not receiving a response from the LAS and their condition deteriorating, possibly resulting in serious injury or death	Following CommandPoint go live, several incidents have been reported to the CAD support team for investigation where out of sequence messages from MDTs have resulted in events showing with an incorrect status. On a number of these the event has been closed in error. The investigations have identified a number of ways that this scenario can occur. So far the identified possible causes are: • Preempt request/event updates crossing • Status change messages echoed • MDT status changes arrive out of order • Aged MDT status change messages appear • A&E resource 'cycles' through the button presses to close the job.	27-Jul-12	1		Clinical	Catastrophic	Almost Certain	25	1.Software adaptation to identify unexpected status messages or very short job cycles, alerting controlling dispatchers and managers. Also, adaptation to hold event updates while pre-empt requests are being processed, negating one of the above scenarios from occurring. (Build 2.5. (Build 2.5.6). 2. Manual alerting outside the CAD system processing messages and identifying possible jobs closed in error (unexpected AOR status) setting off a pager in the control room (fall back alert.) Also Section 4 Assurances below (point 4 - daily alert checks).	**David Prince (Vic Wynn)**	10-Apr-14	Catastrophic	Unlikely	10	1. Request for change to CommandPoint system to enhance the functionality around message detail with message type and sequence identification, enabling CAD system rejection of erroneous status changes. 2. Request for Change to MDT system to provide message sequence identification and processing as above. 3. Additional communications material and training around the urgent messages generated to area controllers and dispatchers notifying them of message cycling. • Bulletin Issued May 2012 • Updates Issued to EOC management team June 2013 • Software Update Info issued August 2013 4. Removal of 'false positive' messages from unexpected status change warnings generated by CAD to area controllers and dispatchers. Review after software release shows no false positive message generated in CAD.	1. J. Downard 2. J. Downard 3. K. Canavan 4. K. Canavan	1- 2 Nov 2013- Completed	1. Technical solutions under development by tactical problem management team (led by John Downard) 2. Weekly director progress oversight in CommandPoint problem management review 3. Ongoing assessment of alert monitoring and identification of further incidents for CAD support team investigation by CommandPoint senior user group 4. Daily checks of the following Alerting systems in place: • That the software running alerts is running (CAD Support Team) • That there are	Catastrophic	Rare	5	SMT 09/04/14 approved downgrading of net rating of risk to catastrophic x unlikely = 10. J Downard April 2014 - proposed likelihood is reduced to rare Therefore risk score is now major x rare = 4 and has reached its target rating, Proposed for archiving. Rationale - as a result of the completed deployment of latest MDT software which works in conjunction with the enhanced CommandPoint™ software, I believe that that the risk has reached its target rating with a likelihood reduced to Rare with impact Major (score 4). It has been recommended to Control Services that the contingency monitor/alert process be discontinued (as it only triggers on false positives) J Downard January 2014 - Proposed downgrading to catastrophic x unlikely = 10.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 3RD JUNE 2014

PAPER TO PROVIDE ASSURANCE TO THE TRUST BOARD

Document Title:	**Audit Committee Assurance Report**
Report Author(s):	**John Jones, Chair of the Audit Committee**
Lead Director:	**N/A**
Contact Details:	
Why is this coming to the Trust Board?	**To receive an update on the key items of discussion at the Audit Committee meeting on 22nd May 2014 and to receive assurance from the Committee.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☒ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Other
Recommendation for the Trust Board:	**To note the report**

Key issues and risks arising from this paper

None.

Executive Summary

It is the role of the Audit Committee to focus on the controls and related assurances that underpin the achievement of the Trust's objectives and the processes by which the risks to achieving these objectives are managed. The purpose of this report is to assure the Trust Board of the effectiveness of the Trust's systems of integrated governance, risk management and internal control.

Attachments

- Report from the Audit Committee meeting on 22nd May 2014

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Quality Strategy

This paper supports the following domains of the quality strategy

☐ Preventing people from dying prematurely
☐ Enhancing quality of life for people with long-term conditions
☐ Helping people to recover from episodes of ill health or following injury
☐ Ensuring people have a positive experience of care
☐ Treating and caring for people in a safe environment and protecting them from avoidable harm
☐ Caring for the workforce

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☒ No

Key issues from the assessment:

Report from the Audit Committee on 22nd May 2014

ANNUAL REPORTING

Annual Accounts 2013/14

The Audit Committee was assured that the year end external audit was progressing well and was on track to meet the deadline. At the time of the meeting, there were a small number of outstanding issues to be resolved however it was not expected that these would significantly change the accounts as presented to the Audit Committee on 17th April 2014.

The Audit Committee will be meeting again on 2nd June, prior to the Trust Board meeting, to review the final year end accounts for 2013/14.

The Audit Committee reviewed the schedule of losses and special payments and asked for a briefing at its next meeting of the processes which support these.

Annual Report and Annual Governance Statement for 2013/14

The Audit Committee reviewed the Annual Report and Annual Governance Statement for 2013/14. A number of adjustments were made particularly in the light of the Head of Internal Audit Opinion.

Internal Audit Annual Report 2013/14 including Head of Internal Audit Opinion

The Audit Committee noted the Head of Internal Audit Opinion, which is as follows:

> The overall opinion is that limited assurance can be given that there is a generally sound system of internal control on key financial and management processes, with the exception of core financial systems, for which significant assurance can be given.

Although the Audit Committee is disappointed with this opinion, it should be recognised that management had identified a number of areas as priority for the internal audit plan as there had been concerns. A number of the reviews had resulted in limited assurance and high priority recommendations. The Audit Committee took assurance from the fact that none of the findings were a surprise to management and that progress has already been made to put in place action plans to address the recommendations.

Gifts and Hospitality Register and Register of Interests

The Audit Committee noted the Gifts and Hospitality Register and Register of Interests.

Single Tender Waiver Register

The Audit Committee noted the Single Tender Waiver Register, which is likely to be longer next year as a result of implementing the recommendations from the contract management audit. The Audit Committee asked for a column to be added to the register to explain the reason why the single tender waiver had been agreed.

RISK MANAGEMENT AND GOVERNANCE

Board Assurance Framework and Corporate Risk Register

The Audit Committee reviewed the updated risk register and board assurance framework (BAF) and noted that the BAF will be updated to reflect the 2014/15 corporate objectives.

Andrew Grimshaw gave a presentation on the process for identifying and managing finance risks.

INTERNAL AUDIT

The Audit Committee reviewed the internal audit recommendations progress report and although there are a number of outstanding recommendations, this is partly due to the fact that a number of reports have recently been issued. Internal audit is in the process of reviewing recommendations made by the previous internal auditors and will transfer recommendations to the risk register where no further action can be taken.

The Audit Committee received an update on progress against the recommendations from the review of serious incidents. Although significant progress has been made to improve the management and investigation of serious incidents, the Audit Committee emphasised the importance of timely investigations and follow up of actions. This was also supported by the Trust Quality Committee. This has been escalated to the Executive Management Team to take forward.

The Audit Committee noted that good progress had been made against the recommendations from the review of Cyber Security and requested a further update at the meeting in September.

The Audit Committee received the contracts management internal audit report which was given limited assurance. This is an example of executive management directing internal audit to an area of known weakness. The Audit Committee is assured that the recommendations have been agreed with a quick deadline for completion. Fleet management will also be reviewed as part of the internal audit programme for review in 2014/15.

The Audit Committee received the core financial systems internal audit report which had been given adequate assurance. Overall the controls are designed well and a number of low priority recommendations have been made.

The Audit Committee received the internal audit report for Information Governance which was given an opinion of requiring improvement. A number of issues have been identified and some medium and low recommendations made.

The Audit Committee approved Internal Audit Plan for 2014 – 2015.

LOCAL COUNTER FRAUD

The Audit Committee noted the Local Counter Fraud progress report. The proactive review on purchasing cards was given a limited assurance opinion. Andrew Grimshaw reported that the Executive Management Team had already begun to review the purchasing card arrangements and would act on the recommendations made in the report.

The Audit Committee noted the Counter Fraud Annual Report for 2013/14 and noted that there was one 'inadequate' rating against the NHS Protect Self-Assessment Toolkit, relating to pre-employment checks. A proactive review is underway and the findings and recommendations will be reported to the Audit Committee.

The Audit Committee approved the Counter Fraud Strategic and Operational Plan for 2014/15.

REPORTS FROM COMMITTEES

The Audit Committee noted the report from the Finance and Investment Committee and the Quality Committee.

Date of next meeting

The next meeting of the Audit Committee is on Monday 2nd June 2014.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE
Trust Board

DATE: 3RD JUNE 2014

PAPER FOR INFORMATION

Document Title:	**Finance Report: Month 01 (April) 2014/15**
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Why is this coming to the Trust Board?	**To update the Board on the Trust's financial performance**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Finance & Investment Committee ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Other
Recommendation for the Trust Board:	**The Trust Board is requested to note this paper.**

Executive Summary

This paper provides a summary of the Trust's financial performance at month one. Performance is reported as being in line with plan at month one although significant risks to overall financial performance have been identified.

Key issues for the Trust Board

To note the emerging risks to the financial plan especially potential performance penalties and the cost of maximising frontline staffing levels.

Attachments

Finance Report: Month 01 (April) 2014/15

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

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

Risk Implications
This paper links to the following strategic risks:

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

NHS Constitution
This paper supports the following principles that guide the NHS:

☐ 1. The NHS provides a comprehensive service, available to all
☐ 2. Access to NHS services is based on clinical need, not an individual's ability to pay
☐ 3. The NHS aspires to the highest standards of excellence and professionalism
☐ 4. NHS services must reflect the needs and preferences of patients, their families and their carers
☒ 5. The NHS works across organisational boundaries and in partnership with other organisations in the
☐ interest of patients, local communities and the wider population
☒ 6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
☒ 7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

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

Key issues from the assessment:

London Ambulance Service NHS Trust
Trust Board
Finance Report: Month 01 (April) 2014/15

02nd June 2014.

Director of Finance

Finance Summary: M1 (2014/15)

Financial Indicator	Summary Performance	Plan	Act	Var
Surplus	On track for month 1. Costs and income in line with plan.	**(0.70)**	**(0.70)**	**---**
CIP	Early assessment would indicate slight shortfall due to slow start to several schemes. Detailed reviews underway to confirm actual delivery	**0.48**	**0.45**	**(0.03)**
Cash	On plan. Some delays from CCGs in paying 2013/14 CQUIN balance (£2.0m), plus some issues over payment in full of 2014/15 contract values. Both issues being escalated with commissioners.	**14.23**	**13.80**	**(0.43)**
Capital	No spend expected in month 1.	**0**	**0**	**---**

Finance Risks

Risk	Explanation and mitigation	Value	RAG
Performance below 75% (Red 1)	Risk of penalty being imposed if current poor performance is not arrested. Performance at end of month 1 70.8%	**£5.2m**	**High**
Performance below 75% (Red 2)	Risk of penalty being imposed if R2 performance slips below 75%. Above 75% at end of Mth 1	**£5.2m**	**Med**
Staff turnover	Increased rate of turnover is increasing the need for sourcing temporary staff, especially overtime and private ambulance hire. Staff currently being offered triple time overtime for some shifts – and these are not being taken. Funding above budget made available, to Operational management in Mth 01 but currently we are not able to spend this money. The failure to secure staff acts to increase the risk of penalties being incurred due to poor performance. Proactive paramedic recruitment campaigns underway; graduates, overseas, ex-military and other UK paramedics. Plans being developed to speed up Emergency Ambulance Crew recruitment and reduce re-training (and abstraction from frontline) of existing staff.	**+/- £5m**	**High**
CIPs	Plans in place. Risk that attention placed on CIPs may suffer given the need to focus on recovering operational performance. CIP delivery being incorporated into overarching efficiency and Effectiveness Plan	**tbc**	**Low**
Enhanced recruitment	Actions to arrest the current levels of resignation may require investment in enhanced grades, education and equipment. Plans being finalised.	**tbc**	**Med**
Winter sustainability	Current operational pressures will make the need for enhanced performance across winter more difficult. Early clarity over winter funding would be advantageous. The current plan assumes £2.0m is made available to LAS across winter	**tbc**	**Med**

Activity versus plan: April 2014

	Annual Plan	In month				Year to Date			
		Plan	Actual	Variance	% var	Plan	Actual	Variance	% var
Red 1	15,071	1,252	1,239	- 13	-1.0%	1,252	1,239	- 13	-1.0%
Red 2	475,505	38,911	37,990	- 921	-2.4%	38,911	37,990	- 921	-2.4%
Category A	**490,576**	**40,163**	**39,229**	**- 934**	**-2.3%**	**40,163**	**39,229**	**- 934**	**-2.3%**
C1	56,514	4,593	4,771	178	3.9%	4,593	4,771	178	3.9%
C2	299,140	24,004	23,258	- 746	-3.1%	24,004	23,258	- 746	-3.1%
C3	84,938	7,332	6,105	- 1,227	-16.7%	7,332	6,105	- 1,227	-16.7%
C4	193,644	15,744	14,968	- 776	-4.9%	15,744	14,968	- 776	-4.9%
Category C	**634,236**	**51,673**	**49,102**	**- 2,571**	**-5.0%**	**51,673**	**49,102**	**- 2,571**	**-5.0%**
Hear and Treat	73,416	6,104	9,156	3,052	50.0%	6,104	9,156	3,052	50.0%
Total responses	**1,198,228**	**97,940**	**97,487**	**- 453**	**-0.5%**	**97,940**	**97,487**	**- 453**	**-0.5%**

- Overall activity 0.5% below plan in M1.
- The mix of activity has been impacted by the focus on additional Hear and Treat and Surge management in order to reduce operational pressures.
- While category A activity is 2.3% below plan April has seen considerable variation both in geography and time, with considerable peaks in demand occurring that prove difficult to manage with the current high utilisation rates. This oftens causes backlogs in demand which then have a knock on effect after the initial increase.
- The variations in demand by CCG are shown on the next page.

Activity versus plan by CCG: April 2014

CCG Names	Cat A Plan	Cat A Actual	Diff	Diff %	Cat C Plan	Cat C Actual	Diff	Diff %	Other Plan	Other Actual	Diff	Diff %	Total Incidents Plan	Total Incidents Actual	Diff	Diff %	H&T Plan	H&T Actual	Diff	Diff %	Total Activity Plan	Total Activity Actual	Diff	Diff %	DMP Actual	Complete Activity Plan	Complete Activity Actual	Diff	Diff (%)
NHS Barking & Dagenham CCG	1,005	1,033	28	2.8%	1,260	1,151	-109	-8.7%	1	1	0	-2.5%	2,266	2,185	-81	-3.6%	170	283	113	66.3%	2,436	2,468	32	1.3%	3	2,439	2,471	32	1.3%
NHS Barnet CCG	1,553	1,553	0	0.0%	2,031	1,861	-170	-8.4%	1	4	3	267.0%	3,585	3,418	-167	-4.7%	220	337	117	53.3%	3,805	3,755	-50	-1.3%	2	3,807	3,757	-50	-1.3%
NHS Bexley CCG	1,050	1,037	-13	-1.2%	1,381	1,341	-40	-2.9%	1	0	-1	-100.0%	2,432	2,378	-54	-2.2%	108	165	57	53.0%	2,540	2,543	3	0.1%	0	2,540	2,543	3	0.1%
NHS Brent CCG	1,529	1,506	-23	-1.5%	1,921	1,770	-151	-7.9%	1	3	2	192.8%	3,451	3,279	-172	-5.0%	272	400	128	47.2%	3,723	3,679	-44	-1.2%	5	3,728	3,684	-44	-1.2%
NHS Bromley CCG	1,368	1,219	-149	-10.9%	1,780	1,753	-27	-1.5%	1	3	2	185.2%	3,149	2,975	-174	-5.5%	117	180	63	53.4%	3,266	3,155	-111	-3.4%	1	3,267	3,156	-111	-3.4%
NHS Camden CCG	1,253	1,382	129	10.3%	1,675	1,595	-80	-4.8%	4	0	-4	-100.0%	2,933	2,977	44	1.5%	162	257	95	58.9%	3,094	3,234	140	4.5%	2	3,096	3,236	140	4.5%
NHS Central London (Westminster) CCG	1,394	1,478	84	6.1%	1,799	1,685	-114	-6.3%	0	0	0		3,193	3,163	-30	-0.9%	168	249	81	48.1%	3,361	3,412	51	1.5%	5	3,366	3,417	51	1.5%
NHS City and Hackney CCG	1,417	1,301	-116	-8.2%	1,807	1,754	-53	-2.9%	5	5	0	-3.1%	3,229	3,060	-169	-5.2%	241	373	132	54.8%	3,470	3,433	-37	-1.1%	1	3,471	3,434	-37	-1.1%
NHS Croydon CCG	1,822	1,787	-35	-1.9%	2,381	2,314	-67	-2.8%	2	1	-1	-51.5%	4,205	4,102	-103	-2.5%	251	391	140	56.1%	4,456	4,493	37	0.8%	4	4,460	4,497	37	0.8%
NHS Ealing CCG	1,519	1,515	-4	-0.3%	1,906	1,820	-86	-4.5%	0	1	1		3,425	3,336	-89	-2.6%	252	355	103	41.1%	3,677	3,691	14	0.4%	4	3,681	3,695	14	0.4%
NHS Enfield CCG	1,651	1,600	-51	-3.1%	1,886	1,726	-160	-8.5%	2	1	-1		3,539	3,327	-212	-6.0%	281	422	141	50.1%	3,821	3,749	-72	-1.9%	1	3,822	3,750	-72	-1.9%
NHS Greenwich CCG	1,306	1,178	-128	-9.8%	1,630	1,499	-131	-8.0%	1	1	0		2,937	2,678	-259	-8.8%	190	274	84	44.0%	3,128	2,952	-176	-5.6%	1	3,129	2,953	-176	-5.6%
NHS Hammersmith and Fulham CCG	861	853	-8	-0.9%	1,107	1,028	-79	-7.1%	0	0	0		1,968	1,881	-87	-4.4%	146	176	30	20.6%	2,113	2,057	-56	-2.7%	3	2,116	2,060	-56	-2.7%
NHS Haringey CCG	1,328	1,371	43	3.3%	1,612	1,562	-50	-3.1%	1	2	1		2,941	2,935	-6	-0.2%	277	434	157	56.7%	3,218	3,369	151	4.7%	7	3,225	3,376	151	4.7%
NHS Harrow CCG	964	884	-80	-8.3%	1,199	1,112	-87	-7.2%	2	0	-2	-100.0%	2,165	1,996	-169	-7.8%	136	179	43	31.3%	2,301	2,175	-126	-5.5%	4	2,305	2,179	-126	-5.5%
NHS Havering CCG	1,108	1,217	109	9.8%	1,502	1,476	-26	-1.7%	7	2	-5	-72.2%	2,617	2,695	78	3.0%	87	213	126	145.7%	2,704	2,908	204	7.5%	1	2,705	2,909	204	7.5%
NHS Hillingdon CCG	1,547	1,499	-48	-3.1%	2,246	2,093	-153	-6.8%	0	0	0		3,793	3,592	-201	-5.3%	174	244	70	39.9%	3,968	3,836	-132	-3.3%	4	3,972	3,840	-132	-3.3%
NHS Hounslow CCG	1,269	1,208	-61	-4.8%	1,473	1,445	-28	-1.9%	1	2	1	97.2%	2,743	2,655	-88	-3.2%	276	275	-1	-0.3%	3,019	2,930	-89	-3.0%	1	3,020	2,931	-89	-2.9%
NHS Islington CCG	1,201	1,176	-25	-2.1%	1,495	1,462	-33	-2.2%	0	0	0		2,696	2,638	-58	-2.2%	205	236	31	15.1%	2,901	2,874	-27	-0.9%	2	2,903	2,876	-27	-0.9%
NHS Kingston CCG	667	629	-38	-5.7%	988	907	-81	-8.2%	0	0	0		1,655	1,536	-119	-7.2%	51	108	57	112.8%	1,706	1,644	-62	-3.6%	1	1,707	1,645	-62	-3.6%
NHS Lambeth CCG	1,573	1,424	-149	-9.5%	2,122	2,000	-122	-5.8%	3	5	2		3,698	3,429	-269	-7.3%	274	405	131	47.9%	3,972	3,834	-138	-3.5%	4	3,976	3,838	-138	-3.5%
NHS Lewisham CCG	1,291	1,244	-47	-3.6%	1,719	1,728	9	0.5%	1	1	0		3,011	2,973	-38	-1.3%	210	355	145	68.8%	3,222	3,328	106	3.3%	5	3,227	3,333	106	3.3%
NHS Merton CCG	735	712	-23	-3.1%	1,151	916	-235	-20.4%	1	1	0	-1.6%	1,887	1,629	-258	-13.7%	103	145	42	41.4%	1,990	1,774	-216	-10.8%	2	1,992	1,776	-216	-10.8%
NHS Newham CCG	1,573	1,617	44	2.8%	1,922	1,821	-101	-5.3%	2	3	1	42.3%	3,497	3,441	-56	-1.6%	370	525	155	41.9%	3,867	3,966	99	2.5%	5	3,872	3,971	99	2.5%
NHS Redbridge CCG	1,255	1,245	-10	-0.8%	1,549	1,414	-135	-8.7%	1	2	1	97.0%	2,805	2,661	-144	-5.1%	185	326	141	76.2%	2,990	2,987	-3	-0.1%	4	2,994	2,991	-3	-0.1%
NHS Richmond CCG	650	610	-40	-6.1%	953	868	-85	-8.9%	1	0	-1		1,604	1,478	-126	-7.8%	70	116	46	66.3%	1,673	1,594	-79	-4.7%	1	1,674	1,595	-79	-4.7%
NHS Southwark CCG	1,510	1,475	-35	-2.3%	2,002	1,893	-109	-5.4%	0	0	0		3,512	3,368	-144	-4.1%	262	412	150	57.2%	3,774	3,780	6	0.1%	6	3,780	3,786	6	0.1%
NHS Sutton CCG	806	729	-77	-9.5%	1,185	1,148	-37	-3.2%	0	0	0		1,991	1,877	-114	-5.7%	85	120	35		2,076	1,997	-79	-3.8%	2	2,078	1,999	-79	-3.8%
NHS Tower Hamlets CCG	1,326	1,343	17	1.3%	1,520	1,472	-48	-3.2%	1	2	1	92.3%	2,847	2,817	-30	-1.1%	215	364	149	69.6%	3,062	3,181	119	3.9%	5	3,067	3,186	119	3.9%
NHS Waltham Forest CCG	1,220	1,167	-53	-4.4%	1,496	1,486	-10	-0.7%	0	0	0		2,717	2,653	-64	-2.3%	232	351	119	51.6%	2,948	3,004	56	1.9%	1	2,949	3,005	56	1.9%
NHS Wandsworth CCG	1,256	1,180	-76	-6.1%	1,684	1,542	-142	-8.4%	4	1	-3	-75.5%	2,944	2,723	-221	-7.5%	193	250	57	29.2%	3,138	2,973	-165	-5.3%	2	3,140	2,975	-165	-5.2%
NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG	1,077	1,065	-12	-1.1%	1,423	1,422	-1	0.0%	0	3	3		2,500	2,490	-10	-0.4%	163	236	73	45.0%	2,663	2,726	63	2.4%	1	2,664	2,727	63	2.4%
LAS	**40,120**	**39,237**	**-883**	**-2.2%**	**51,865**	**49,064**	**-2801**	**-5.4%**	**46**	**44**	**-2**	**-3.8%**	**92,031**	**88,345**	**-3686**	**-4.0%**	**6,104**	**9156**	**3052**	**50.0%**	**98,135**	**97,501**	**-634**	**-0.6%**	**90**	**98,225**	**97,591**	**-634**	**-0.6%**

CCG Names	Complete Activity Plan	Complete Activity Actual	Diff	Diff (%)	Cat A plan as a % of Total	Cat A actual as a % of Total	Cat A 8 Min %	Time taken to reach 75%
NHS Barking & Dagenham CCG	2,439	2,471	32	1.3%	41.3%	41.9%	66.70%	09:10
NHS Barnet CCG	3,807	3,757	-50	-1.3%	40.8%	41.4%	63.30%	09:40
NHS Bexley CCG	2,540	2,543	3	0.1%	41.3%	40.8%	69.05%	08:50
NHS Brent CCG	3,728	3,684	-44	-1.2%	41.1%	40.9%	65.67%	09:20
NHS Bromley CCG	3,267	3,156	-111	-3.4%	41.9%	38.6%	70.88%	**08:30**
NHS Camden CCG	3,096	3,236	140	4.5%	40.5%	42.7%	79.52%	**08:00**
NHS Central London (Westminster) CCG	3,366	3,417	51	1.5%	41.5%	43.3%	77.47%	**08:00**
NHS City and Hackney CCG	3,471	3,434	-37	-1.1%	40.8%	37.9%	68.33%	08:50
NHS Croydon CCG	4,460	4,497	37	0.8%	40.9%	39.8%	72.92%	**08:20**
NHS Ealing CCG	3,681	3,695	14	0.4%	41.3%	41.0%	65.94%	09:15
NHS Enfield CCG	3,822	3,750	-72	-1.9%	43.2%	42.7%	66.75%	09:30
NHS Greenwich CCG	3,129	2,953	-176	-5.6%	41.8%	39.9%	78.01%	**08:00**
NHS Hammersmith and Fulham CCG	2,116	2,060	-56	-2.7%	40.7%	41.5%	75.26%	**08:00**
NHS Haringey CCG	3,225	3,376	151	4.7%	41.3%	40.7%	61.85%	10:05
NHS Harrow CCG	2,305	2,179	-126	-5.5%	41.9%	40.6%	67.99%	08:55
NHS Havering CCG	2,705	2,909	204	7.5%	41.0%	41.9%	69.10%	**08:45**
NHS Hillingdon CCG	3,972	3,840	-132	-3.3%	39.0%	39.1%	71.18%	**08:40**
NHS Hounslow CCG	3,020	2,931	-89	-2.9%	42.0%	41.2%	66.72%	09:10
NHS Islington CCG	2,903	2,876	-27	-0.9%	41.4%	40.9%	70.41%	**08:45**
NHS Kingston CCG	1,707	1,645	-62	-3.6%	39.1%	38.3%	72.34%	**08:25**
NHS Lambeth CCG	3,976	3,838	-138	-3.5%	39.6%	37.1%	77.60%	**08:00**
NHS Lewisham CCG	3,227	3,333	106	3.3%	40.1%	37.4%	73.31%	**08:20**
NHS Merton CCG	1,992	1,776	-216	-10.8%	36.9%	40.1%	74.86%	**08:05**
NHS Newham CCG	3,872	3,971	99	2.5%	40.7%	40.8%	72.85%	**08:15**
NHS Redbridge CCG	2,994	2,991	-3	-0.1%	42.0%	41.7%	69.32%	**08:45**
NHS Richmond CCG	1,674	1,595	-79	-4.7%	38.8%	38.3%	67.38%	09:35
NHS Southwark CCG	3,780	3,786	6	0.1%	40.0%	39.0%	77.36%	**08:00**
NHS Sutton CCG	2,078	1,999	-79	-3.8%	38.8%	36.5%	70.92%	**08:35**
NHS Tower Hamlets CCG	3,067	3,186	119	3.9%	43.3%	42.2%	72.15%	**08:25**
NHS Waltham Forest CCG	2,949	3,005	56	1.9%	41.4%	38.8%	63.58%	09:30
NHS Wandsworth CCG	3,140	2,975	-165	-5.2%	40.0%	39.7%	74.41%	**08:05**
NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG	2,664	2,727	63	2.4%	40.5%	39.1%	73.62%	**08:10**
LAS	**98,225**	**97,591**	**-634**	**-0.6%**			**70.81%**	**08:35**

Performance by Day: April 2014

		% of calls answered in 5 seconds	Category A					Category C1			Category C2		Category C3 & C4	
			Activations	% activated in 90 secs	Incidents	% reached in 8 mins	% reached in 19 mins	% activated in 90 secs	Incidents	% reached in 20 mins	Incidents	% reached in 30 mins	Incidents	All Demand
Tue	01/04/14	94.54%	1412	50.85%	1373	68.54%	94.54%	34.19%	133	62.41%	793	53.59%	741	3040
Wed	02/04/14	95.74%	1354	49.78%	1313	68.62%	95.96%	32.37%	191	59.16%	783	45.34%	740	3027
Thu	03/04/14	94.10%	1504	48.67%	1467	63.19%	95.98%	33.70%	154	62.34%	768	51.95%	715	3104
Fri	04/04/14	96.76%	1432	56.84%	1373	72.10%	96.50%	38.15%	156	62.18%	753	53.78%	731	3013
Sat	05/04/14	97.10%	1478	53.18%	1426	68.30%	96.21%	32.18%	230	56.09%	769	47.59%	616	3041
Sun	06/04/14	97.73%	1433	54.01%	1373	64.31%	96.21%	31.69%	155	49.03%	687	53.28%	536	2751
		95.96%	8613	52.22%	8325	67.46%	95.90%	33.53%	1019	58.29%	4553	50.87%	4079	17976
Mon	07/04/14	96.99%	1451	52.03%	1410	70.50%	96.24%	37.29%	153	54.25%	739	48.17%	681	2983
Tue	08/04/14	99.71%	1214	60.63%	1175	73.45%	97.79%	40.59%	149	59.13%	768	53.93%	666	2758
Wed	09/04/14	96.98%	1405	51.74%	1364	68.04%	95.09%	35.14%	160	54.38%	778	56.68%	688	2990
Thu	10/04/14	98.90%	1332	60.36%	1283	72.72%	96.80%	40.68%	163	76.69%	778	68.89%	785	3009
Fri	11/04/14	99.43%	1408	58.66%	1350	75.63%	97.26%	42.29%	162	66.67%	807	67.41%	799	3118
Sat	12/04/14	99.32%	1345	60.97%	1310	74.12%	97.33%	51.06%	170	77.06%	813	70.48%	698	2991
Sun	13/04/14	94.94%	1410	51.21%	1347	65.70%	93.39%	29.89%	153	54.25%	808	61.14%	621	2929
		97.94%	9565	56.35%	9239	71.36%	96.23%	39.57%	1110	66.31%	5491	62.56%	4938	20778
Mon	14/04/14	98.44%	1323	54.88%	1290	70.00%	95.97%	37.50%	129	59.69%	690	52.61%	720	2829
Tue	15/04/14	99.19%	1242	60.06%	1195	75.56%	97.24%	50.31%	137	70.80%	725	59.72%	683	2740
Wed	16/04/14	96.84%	1323	56.31%	1281	67.99%	95.63%	45.00%	155	59.35%	681	50.81%	671	2788
Thu	17/04/14	95.95%	1343	54.43%	1310	64.35%	95.34%	37.06%	154	59.09%	708	57.06%	685	2857
Fri	18/04/14	99.68%	1186	65.94%	1150	78.00%	96.96%	59.73%	140	77.14%	873	80.53%	716	2879
Sat	19/04/14	97.14%	1257	59.82%	1214	75.29%	97.61%	41.01%	163	80.37%	859	75.20%	732	2968
Sun	20/04/14	97.54%	1326	54.45%	1280	68.75%	96.88%	36.51%	170	72.35%	769	65.28%	635	2854
		97.78%	9000	57.82%	8720	71.23%	96.49%	43.51%	1048	68.61%	5305	64.03%	4842	19915
Mon	21/04/14	99.19%	1318	61.15%	1276	74.37%	97.49%	44.94%	158	75.95%	816	66.42%	672	2922
Tue	22/04/14	99.12%	1405	55.09%	1374	69.80%	96.07%	35.11%	159	58.49%	705	51.77%	710	2948
Wed	23/04/14	98.63%	1323	59.56%	1288	73.99%	96.97%	41.57%	151	66.89%	701	63.05%	759	2899
Thu	24/04/14	99.55%	1327	59.76%	1281	70.65%	96.72%	43.27%	156	69.87%	849	60.54%	730	3016
Fri	25/04/14	99.14%	1247	58.70%	1218	74.06%	97.29%	39.25%	165	70.30%	797	64.24%	799	2979
Sat	26/04/14	93.72%	1341	54.96%	1292	71.44%	97.83%	38.55%	164	68.29%	863	57.59%	655	2974
Sun	27/04/14	98.04%	1393	59.37%	1330	73.23%	97.07%	32.52%	151	61.59%	799	61.70%	653	2933
		98.18%	9354	58.34%	9059	72.47%	97.05%	39.32%	1104	67.39%	5530	60.85%	4978	20671
Mon	28/04/14	98.46%	1393	56.57%	1346	73.92%	96.14%	38.66%	176	64.77%	778	57.46%	735	3035
Tue	29/04/14	98.47%	1304	56.83%	1261	72.09%	96.43%	38.85%	145	64.83%	807	59.60%	752	2965
Wed	30/04/14	97.74%	1319	55.65%	1277	71.03%	96.16%	35.87%	169	69.82%	799	62.70%	752	2997
		98.22%	4016	56.35%	3884	72.37%	96.24%	37.76%	490	66.53%	2384	59.94%	2239	8997

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 3 JUNE 2014

PAPER FOR INFORMATION

Document Title:	**Chief Executive's Report**
Report Author(s):	**Jane Chalmers, Director of Modernisation**
Lead Director:	**Ann Radmore, Chief Executive**
Contact Details:	**Jane.chalmers@lond-mab.nhs.uk**
Why is this coming to the Trust Board?	**For information**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To note the report**
Key issues and risks arising from this paper N/A	
Executive Summary The Board is asked to note the contents of the Chief Executive's Report	
Attachments Chief Executive's Report	

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Quality Strategy

This paper supports the following domains of the quality strategy

- ☐ Preventing people from dying prematurely
- ☐ Enhancing quality of life for people with long-term conditions
- ☐ Helping people to recover from episodes of ill health or following injury
- ☐ Ensuring people have a positive experience of care
- ☐ Treating and caring for people in a safe environment and protecting them from avoidable harm
- ☐ Caring for the workforce

LAS Strategic Goals and Priorities

This paper supports the achievement of the following strategic goals and priorities:

LAS Strategic Goals

- ☐ To improve the quality of care we provide to our patients
- ☐ To develop care with a highly skilled and representative workforce
- ☐ To provide value for money

2013/14 Priorities

- ☐ Modernisation Programme
- ☒ Communication and Engagement
- ☐ Sustain performance to ensure safe service to patients
- ☐ Building sustainable financial position for 14/15 and beyond

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

Has an Equality Analysis been carried out?

- ☐ Yes
- ☐ No

Key issues from the assessment:

CHIEF EXECUTIVE REPORT TO THE LONDON AMBULANCE SERVICE (LAS) TRUST BOARD MEETING HELD ON 25 JUNE 2014

1. New Chief Executive for NHS England

Simon Stevens took up his post as the Chief Executive of NHS England on 1 April 2014. The full text of his inaugural speech can be found at the following link.

http://www.england.nhs.uk/2014/04/01/simon-stevens-speech/

2. Chief Executive of NHS England appears in front of the Health Select Committee

Simon Stevens appeared in front of the Health Select Committee on Tuesday 29 April. A video of his evidence can be found here:

http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news/14-04-24-work-of-nhs-england/

3. Care Quality Commission (CQC)

The CQC has asked for comment on its proposal for the regulation of ambulance services - 'A fresh start for the regulation of ambulance services Working together to change how we regulate ambulance services. '
LAS has provided comment directly to CQC.

4. Pan-London Tripartite (NHS England, NHS TDA & Monitor) Urgent & Emergency Care Events

LAS has been invited to attend two pan-London Tripartite Urgent and Emergency Care Events on 24 June 2014.

- The first will be the *Pan-London Review of Winter 2013/14* event, which will look back at the challenges faced last winter and ensure that the lessons learnt from last year can be taken forward; this will also be an opportunity to celebrate some of the good practice examples from the system.
- The second event looks to the future of Urgent & Emergency Care and focuses on how NHS England, NHS TDA and Monitor can support the development of Urgent and Emergency Care leaders for the immense task ahead.

Additionally, the Chief Executive has been asked to Chair a working group on behalf of the National Tripartite to review lessons learnt in the ambulance sector during the Winter of 13/14

5. Blue Light Collaboration

Work has commenced to explore what further opportunities there may be for collaboration between LAS, Metropolitan Police Service and London Fire Brigade. This is in addition to work which was already underway.

The first workshop took place on Thursday 22 May and looked at Control Rooms and Mobile Communication including Information Management and Technology. Further workshops over the next few weeks will look at Estates and Facilities Management and Commercial and Procurement. It is planned that a report will be produced for the 3 Service Chiefs for them to consider at their meeting on 1 July 2014.

6. NHS Trust Chief Executive & Chairs Conference 29th April 2014

The Chairman and Chief Executive attended the NHS Trust Chief Executive & Chairs Conference on 29th April 2014

Speakers at the event included Sir Peter Carr and David Flory.

Key messages which came from the Conference were as follows:

- Movement of Trusts through the Foundation Trust pipeline has regained momentum
- The financial challenge across the NHS remains considerable
    - Working hard with commissioners to address the challenges
- Need to focus on safety especially in context of reducing funds
- 5 year planning process now in place with commissioners
- Trust Development Authority (TDA) focussing on helping Trusts to develop and improve
    - TDA wants to enable and support Trusts

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 3RD JUNE 2014

PAPER FOR APPROVAL

Document Title:	**Board declarations – self certification, compliance and board statements**
Report Author(s):	**Sandra Adams**
Lead Director:	**Richard Hunt/Ann Radmore**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Approval of the monthly self certification requirements for submission to the NHS Trust Development Authority**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To approve the submission of the Board declarations for April and May 2013**

Key issues and risks arising from this paper

The Trust Board will be held to account by the NHS Trust Development Authority for compliance with the new provider licence requirements and the Board statements.

Executive Summary

The Trust Board is asked to approve submission of the declarations, noting that we are making good progress to achieve full compliance before the end of 2013/14.

1. Board statements

Board statement 10 requires the Board to sign off that: it is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.

The Board is unable to declare compliance with this statement having carefully reviewed the performance in month one and current trending information for activity and capacity in month two and has put urgent work in train to seek to address issues and produce a revised plan.

Attachments

None.

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Quality Strategy

This paper supports the following domains of the quality strategy

- ☐ Preventing people from dying prematurely
- ☐ Enhancing quality of life for people with long-term conditions
- ☐ Helping people to recover from episodes of ill health or following injury
- ☒ Ensuring people have a positive experience of care
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- ☐ Caring for the workforce

LAS Strategic Goals and Priorities

This paper supports the achievement of the following strategic goals and priorities:

LAS Strategic Goals

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- ☒ To develop care with a highly skilled and representative workforce
- ☒ To provide value for money

2013/14 Priorities

- ☐ Modernisation Programme
- ☐ Communication and Engagement
- ☒ Sustain performance to ensure safe service to patients
- ☒ Building sustainable financial position for 14/15 and beyond

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

Has an Equality Analysis been carried out?

- ☐ Yes
- ☒ No

Key issues from the assessment:

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 3RD JUNE 2014

Compliance with Standing Orders and Standing Financial Instructions

Document Title:	**Trust Secretary Report**
Report Author(s):	**Sandra Adams, Director of Corporate Affairs/Trust Secretary**
Lead Director:	**Sandra Adams, Director of Corporate Affairs/Trust Secretary**
Contact Details:	**sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Compliance with Standing Orders**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To be advised of the tenders received and entered into the tender book and the use of the Trust Seal since 25th March 2014 and to be assured of compliance with Standing Orders and Standing Financial Instructions**

Key issues and risks arising from this paper

This report is intended to inform the Trust Board about key transactions thereby ensuring compliance with Standing Orders and Standing Financial Instructions.

Executive Summary

No new tenders have been received since the Trust Board meeting on 25th March 2014.

There have been no new entries to the register for the use of the Trust Seal since 26th January 2014.

Attachments

None.

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Quality Strategy

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2013/14 Priorities

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- ☒ That we are unable to match financial resources with priorities
- ☐ That our strategic direction and pace of innovation to achieve this are compromised

Equality Analysis

Has an Equality Analysis been carried out?

- ☐ Yes
- ☒ No

Key issues from the assessment:

London Ambulance Service NHS
NHS Trust

TRUST BOARD FORWARD PLANNER 2014

24th June 2014

Standing Items	Quality Assurance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Staff Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman FT Update	**Integrated Board Performance Report** **Quality Dashboard** **Clinical Quality and Patient Safety Report (including serious incident update)** **Quality Committee Assurance Report** **Finance Report** **Friends and Family Test**	Report from Chief Executive Officer Modernisation Programme Communications Strategy NHS 111 post-step in progress report (KM)	Board Declarations Report from Trust Secretary Trust Board Forward Planner		
Board Development Session					
"Westminster and Whitehall explained"					

29th July 2014

Standing Items	Quality Assurance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman FT Update	**Integrated Board Performance Report** **Quality Dashboard** **Clinical Quality and Patient Safety Report (including serious incidents)** **Quality Committee Assurance Report** **Annual Infection Prevention and Control Report 2013/14** **Annual Safeguarding Report 2013/14** **Finance Report** **Report from Finance and Investment Committee**	Report from Chief Executive Officer Modernisation Programme Equality and Inclusion Strategy	Annual Equality Report 2013/14 Governance Review Board Declarations Report from Trust Secretary Trust Board Forward Planner	Finance and Investment Committee on 17th July 2014	Karen Broughton
Board Development Session					
TBC					

30th September 2014

Standing Items	Quality Governance and Risk	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Staff Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman FT Update	**Integrated Board Performance Report** **Quality Dashboard** **Clinical Quality and Patient Safety Report (including serious incident report)** **Friends and Family Test** **Audit Committee Assurance Report** **Annual Audit Letter 2013/14** **BAF and Corporate Risk Register – Quarter 2 documents** **Annual Report of the Audit Committee** **Finance Report** **Report from Finance and Investment Committee**	Report from Chief Executive Officer Modernisation Programme Business planning 15/16	Board Declarations Report from Trust Secretary Trust Board Forward Planner Annual Corporate Social Responsibility Report 2013/14	Audit Committee on 8th September 2014 Finance and Investment Committee on 18th September 2014	
Board Development Session					
TBC					

25th November 2014

Standing Items	Quality Assurance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman FT Update	**Integrated Board Performance Report** **Quality Dashboard** **Clinical Quality and Patient Safety Report (including serious incident update)** **Quality Committee Assurance Report** **Audit Committee Assurance Report** **BAF and Corporate Risk Register – Quarter 3 documents** **Finance Report** **Report from Finance and Investment Committee**	Report from Chief Executive Officer Modernisation Programme Business planning 15/16	Board Declarations Report from Trust Secretary Trust Board Forward Planner Performance Reporting compliance statement	Audit Committee on 10th November 2014 Finance and Investment Committee on 20th November 2014	
Board Development Session					
TBC					

16th December 2014

Standing Items	Quality Governance and Risk	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Staff Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman FT Update	**Quality Dashboard** **Clinical Quality and Patient Safety Report (including serious incident update)** **Quality Committee Assurance Report** **Finance Report**	Report from Chief Executive Officer Modernisation Programme Business planning and commissioning 15/16	Board Declarations Report from Trust Secretary Trust Board Forward Planner		
Board Development Session					
TBC					

2014 Meetings Calendar

Committee	Chair	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Timings
Trust Board	Trust Chair	**28**		**25**			**3 & 24**	**29**		**30**		**25**	**16**	9.00 - 14.00 (followed by a board development session 14.00 - 16.00)
Strategy Review and Planning	Trust Chair		**25**		**29**					**2**	**28**			9.00 - 14.00 (followed by a board development session 14.00 - 16.00)
Annual General Meeting	Trust Chair									**30**				14.00 - 15.30
Annual C/Funds Committee	Caroline Silver (NED)													TBC
Remuneration Committee	Trust Chair													TBC
Audit Committee	Caroline Silver (NED)		**3**		**17**	**22**	**2**			**8**		**10**		
Finance and Investment Committee	Nick Martin (NED)	**24**		**20**		**22**		**24**		**25**		**20**		
Quality Committee	Bob McFarland (NED)		**26**		**23**		**18**		**27**		**29**		**19**	
Clinical Quality Safety and Effectiveness Committee	Medical Director	**23**		**24**		**19**		**21**		**29**		**24**		
Learning From Experience Group	Director of Nursing and Quality	**13**			**28**			**14**			**13**			14.00 - 17.00
Executive Management Team (EMT)	CEO	**Every Wednesday 9.00 - 11.00 (except last Wednesday of the month)**												9.00 - 11.00