London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO BE HELD IN PUBLIC ON TUESDAY 29TH MAY 2012 AT 10.00 – 13.00 CONFERENCE ROOM, 220 WATERLOO ROAD, LONDON SE1 8SD

AGENDA: PUBLIC SESSION

ITEM	SUBJECT	LEAD	TAB
1.	**Welcome and apologies for absence** Apologies received from: Richard Hunt – the meeting is to be chaired by the Deputy Chair, Roy Griffins Angie Patton		
2.	**Declarations of Interest** To request and record any notifications of declarations of interest in relation to today's agenda	RG	
3.	**Minutes of the Part I meeting held on 27th March 2012** To approve the minutes of the meeting held on 27th March 2012	RG	TAB 1
4.	**Matters arising** To review the action schedule arising from previous meetings	RG	TAB 2
5.	**Patient Story** To hear an account of a patient experience	SL	Oral
QUALITY ASSURANCE			
6.	**Quality Dashboard and Action Plan** To receive the most recent Quality dashboard and progress against the Quality Action Plan	SL	TAB 3
7.	**Quality Account 2011/12** To note the Quality Account for 2011/12	SL	TAB 4
8.	**Clinical Quality and Patient Safety Report** To receive the monthly report on clinical quality and patient safety	FM/SL	TAB 5
9.	**Quality Committee Assurance Report** To receive a report from the Chair of the Quality Committee	BM	TAB 6
STRATEGIC AND BUSINESS PLANNING			
10.	**Report from Chief Executive Officer** To receive a report from the Chief Executive Officer	PB	TAB 7
11.	**Annual Report and Accounts 2011/12** To approve delegation of authority to the Audit Committee to approve the Annual Report and Accounts for 2011/12	MD/AP	TAB 8

12.	**Foundation Trust Progress Report** To receive an update on progress made towards submitting a successful application in 2013	SA	TAB 9
13.	**2012/13 Summary Budget** To approve the 2012/13 LAS budget	MD	TAB 10
14.	**Carbon Management Plan** To approve the five year Carbon Management Plan	MD	TAB 11
PERFORMANCE			
15.	**Performance Report** 15.1 Chief Operating Officer, to receive the performance report 15.2 Director of Finance, to receive a report on financial performance for month 1 15.3 Director of Finance, to receive a report on progress against the Cost Improvement Programme 15.4 Director of Human Resources and Organisation Development, to receive a report on workforce	 MF MD MD CH	TAB 12 To follow
16.	**Presentation on Olympic Preparedness** To receive a presentation on Olympic Preparedness	MF	Presentation
17.	**CommandPoint Update** To receive an update on the CommandPoint project	PS	TAB 13
ASSURANCE AND RISK REPORTS			
18.	**Audit Committee Assurance Report** To receive a report from the Audit Committee meeting on 14th May	CS	TAB 14
19.	**Finance and Investment Committee Report** To receive a report from the Finance and Investment Committee meeting on 15th May	BH	TAB 15
GOVERNANCE			
20.	**Bank Mandates** To approve the Bank Mandates	MD	TAB 16
21.	**Major Incident Plan** To note the Major Incident Plan	MF	TAB 17
BUSINESS ITEMS			
22.	**Report from Trust Secretary** To receive the report from the Trust Secretary on tenders received and the use of the Trust Seal	SA	TAB 18
23.	**Forward Planner** To note the Trust Board forward planner	SA	TAB 19

24.	**Any other business**		
25.	**Questions from members of the public**		
26.	**Date of next meeting** The next meeting of the Trust Board is on Tuesday 26th June 2012 at 10.00		

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING
Part I

DRAFT Minutes of the meeting held on Tuesday 27th March 2012 at 10:00 a.m.
in the Conference Room, Fielden House

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Present:	
Richard Hunt	Chairman
Peter Bradley	Chief Executive Officer
Mike Dinan	Director of Finance
Martin Flaherty	Deputy Chief Executive
Roy Griffins	Non-Executive Director
Caron Hitchen	Director of Human Resources and Organisation Development
Steve Lennox	Director of Health Promotion and Quality
Murziline Parchment	Non-Executive Director
Beryl Magrath	Non-Executive Director
Fionna Moore	Medical Director
Caroline Silver	Non-Executive Director
In Attendance:	
Sandra Adams	Director of Corporate Services
Lizzy Bovill	Deputy Director of Strategic Development
Francesca Guy	Committee Secretary (minutes)
Peter Suter	Director of Information Management and Technology
Members of the Public:	
Pam Chrispin	Medical Director, East of England Ambulance Trust
Fleur Nieboer	KPMG
David Stacey	KPMG
Katie Childs	North West London Commissioning Partnership
Mrs P.	Mother of LAS Patient (minute 21 only)
Ed Sturms	Northrop Grumman (minute 33 only)

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19. Welcome and Apologies

19.1 Apologies had been received from Jessica Cecil, Brian Huckett and Angie Patton.

20. Declarations of Interest

20.1 There were no declarations of interest.

21. Patient's Story

21.1 Mrs P, the mother of an LAS patient, joined the Trust Board meeting to share her experiences of the LAS and that of her daughter. She explained that the LAS had drawn up a Patient Specific Protocol for her daughter and that this had had a significant impact on her daughter's life, allowing her to live independently of her parents, and had saved her a number of unnecessary admissions to hospital. There were some instances of the crew being reluctant to leave her daughter at home, but that overall the system worked very well.

21.2 Fionna Moore stated that increasingly staff were proactively identifying patients who might benefit from a Patient Specific Protocol and that currently the Trust held approximately 200 Patient Specific Protocols of this nature.

21.3 The Trust Board thanked Mrs P for attending the meeting to give an account of her experiences. The Trust Board agreed that patient stories provided a valuable source assurance and helped to put the subsequent discussions in context.

21.4 Beryl Magrath commented that it would also be useful for the Trust Board to hear the views of members of staff. Peter Bradley responded that the SMG had considered a range of activities to develop better engagement between the Trust Board and members of staff and this included members of staff attending Trust Board meetings.

22. Minutes of the Part I meeting held on 24th January 2012

22.1 The minutes of the Part I meeting held on 24th January 2012 were approved, subject to the following amendments:

- To add Caroline Silver to the list of attendees;
- To amend paragraph 10.3 to state that 'Short Form Standing Orders had been drawn up, which allowed for greater flexibility in making changes to the Standing Orders.'

ACTION: FG to amend the minutes of the Part I meeting held on 24th January 2012.

DATE OF COMPLETION: 30th March 2012

23. Matters Arising

23.1 The following actions and matters arising were discussed:

23.2 **67.3:** Fionna Moore reported that she had attended a meeting of the 'Eagles', which comprised the medical directors of ambulance trusts in large cities across the world. The meeting provided a forum to discuss topics of interest and each of the attendees were asked to make a 10 minute presentation. This provided a good opportunity to showcase the work and innovative practice of the LAS. Peter Bradley commented that he had strong links with the Canadian and Australasian ambulance services and would continue to share best practice. The Chair summed up the discussion by stating that the LAS would continue to focus externally to define what it meant by a 'world-class' service.

23.3 **112.5**: The Chair and the Chief Executive Officer would continue to discuss the LAS' response to the recommendations made in the NAO report and the report by the London Assembly.

23.4 **128.6:** The balanced scorecard would be included in the Trust Board pack for the next meeting.

23.5 **02.1:** Sandra Adams reported that she had not yet received formal notification of Jessica Cecil's declaration of interest. This action was outstanding.

23.6 **07.12:** This action was complete.

23.7 **08.5:** Roy Griffins asked what action had been taken to revise the balanced scorecard with a view to it becoming the primary document for monitoring the Trust's performance. Peter Bradley responded that the plan was to consolidate the balanced scorecard with performance information

and this would be ready for the next meeting of the Trust Board.

23.8 **09.9:** The risks of running with CTAK throughout the Olympics had been included in Peter Suter's paper to the extraordinary Trust Board meeting on 14th February 2012. This action was complete.

23.9 **09.12:** This action was complete.

23.10 **12.5:** Sandra Adams confirmed that she had updated the Risk Management Strategy and Policy to reflect the comments made at the last Trust Board meeting. This action was complete.

24. Report from the Chairman

24.1 The Chair had provided a report of the key meetings he had attended since the last meeting of the Trust Board. In summary, the Chair stated that he would continue to focus on developing the relationship with the Chairs of other ambulance trusts in order to form a joint view on how ambulance trusts should be represented in the wider healthcare system.

24.2 The Chair noted that he had attended meetings with Monitor to understand their perspective in the development of the Foundation Trust process, which had provided a valuable insight.

25. Quality Dashboard and Action Plan

25.1 Steve Lennox reported that the Quality Committee had reviewed the Quality Dashboard in detail. A recommendation had been made, following the RSM Tenon Quality Governance Review, that this report was also presented to the Trust Board.

25.2 Steve drew attention to the Department of Health Quality Measures Comparison table which listed the Department of Health indicators and the LAS ranking against other ambulance trusts. This showed that the LAS was in the upper quartile for the majority of indicators.

25.3 The Chair commented that this result was heartening and the Trust Board should not fail to recognise this sort of performance. He suggested that consideration should be given to setting an internal target for this comparison table.

25.4 In response to a question from Murziline Parchment, Caron confirmed that staff had been informed of this comparison table as it had been circulated in the team brief and mentioned in Peter Bradley's blog.

26. Clinical Quality and Patient Safety Report

26.1 Fionna Moore noted that this report had been presented in a new format and was jointly written by Fionna and Steve Lennox.

26.2 Fionna noted the following:

- The high utilisation rate that the Trust was currently experiencing was impacting on the Trust's ability to release staff for training outside of the priorities identified within the Training Strategy. This had a knock-on impact on the Trust's ability to innovate and to introduce new clinical initiatives;
- CPI completion was high and was the highest since August 2010;
- A new pre-hospital pain-scoring tool had been developed and disseminated to staff as a result of the Ambulance Service Cardiovascular Quality Initiative Project;
- There had been one controlled drugs incident in the reporting period, which indicated that the override code for the controlled drugs safes had been given to a wider number of people

than the policy allowed. This has meant that all controlled drugs safes had to be re-programmed with a different override number. There was no evidence that there had been any loss of drugs as a result of this incident;
- Paracetamol and ibruprofen tablets had been introduced to the Technician drugs bag;
- The Clinical Audit Work Plan and Clinical Audit triggers had been included as an appendix to the paper.

26.3 Beryl Magrath expressed some concern that high utilisation was having a knock on impact on the Trust's ability to innovate. This was part of what made the LAS a 'world-class' service and this issue should be addressed as a matter of priority.

26.4 Beryl noted that two appropriate care pathways had been developed with mental health providers. Lizzy Bovill commented that the Trust now had three appropriate care pathways in place with mental health providers and was working to implement the remaining five. Fionna added that the Trust would be implementing a mental health CPI from 1st April 2012.

26.5 The Chair commented that this report provided the Trust Board with assurance on the quality and safety of the service, although recognised that there were a number of factors that needed to be considered, given the amount of pressure that was currently place on the Trust. The Chair expressed some concerns that the issue of patient lost property did not appear to be improving and suggested that a zero tolerance approach should be taken.

26.6 Roy Griffins asked what would happen with the recommendations made following the clinical audit of end of life care in the LAS. Fionna responded that these would be incorporated into an action plan which would be monitored by the Clinical Audit and Research Steering Group.

26.7 Peter Bradley expressed some concern that the letters to the High Risk Register entrants had not yet been sent out and stated that this delay was not acceptable. Sandra added that the risks associated with the High Risk Register had not yet come forward to the Risk, Compliance and Assurance Group for approval. Martin Flaherty agreed to follow up on both these issues with John Pooley.

ACTION: MF to follow up with John Pooley on the status of the letters to the entrants on the High Risk Register and the associated risks.

DATE OF COMPLETION: 29th May 2012

27. Quality Committee Assurance Report

27.1 Beryl Magrath noted that a full report from the Quality Committee had been included in the Trust Board pack and highlighted the key items of discussion at the meeting on 28th February 2012:

- Use of the Demand Management Plan and the links between this and the Cost Improvement Programme;
- The Staff Survey results were worse overall than last year and local commitments would be developed to address problem areas;
- The Trust was looking to introduce a training passport and a live training record;
- The C60 response time target had not been achieved. This had been highlighted in both the Quality Report and the Cost Improvement Programme Monitoring Plan;
- There was a problem with missing PRFs, although it was thought that the majority of these were delays in the PRFs reaching Management Information, rather than a reflection of actual delays;
- There had been three maternity serious incidents in the last year, all of which had involved

EOC and as a result, EOC had been provided with additional training in this area. Pregnant patients with abdominal pains were no longer passed to NHS Direct and this was an example of the Trust changing practice in response to learning from incidents;
- There had been an increasing number of complaints regarding delays;
- There was an increasing problem with violence and aggression towards staff and staff were being encouraged to report any incidents of this nature;
- REAP 3 had been invoked 85% of the time for quarter 3, which prompted the question of whether this should become the new baseline and therefore attract appropriate funding;
- There had been some delays in sourcing bariatric vehicles.

27.2 Beryl reported that there had been a number of positive achievements to quality and these included:

- 891 PPI and public education events had taken place in 2011. Staff largely participated in these in their own time;
- The Trust's overall rating on the Quality Risk Profile had moved from one of high amber to low neutral over the past year;
- The timescale for serious incident investigations had reduced.

27.3 The Chair noted that the issue of pressure appeared in a number of reports to the Trust Board. Peter Bradley responded that the use of the Demand Management Plan should not be viewed negatively as this was put in place to minimise the number of calls waiting for ambulances, which represented a greater clinical risk.

28. <u>Workforce Report</u>

<u>Workforce Report</u>

28.1 Caron Hitchen reported that this was the first report in this format and was currently work in progress. The intention was for the future reports to contain narrative explanation on key themes and trends.

28.2 Caron reported the following:

- Sickness absence was slightly above target, although the LAS was the third best-performing ambulance trust in the country in this respect. Caron was satisfied that sickness absence was being monitored robustly and would continue to be monitored against national figures;
- Staff turnover remained static and was in line with the forecast position;
- There had been an upward trend in manual handling and verbal abuse incidents. This would be monitored in the upcoming months to determine whether this was an ongoing trend;
- The attitude and behaviour action plan had been attached as an appendix to this report and had been developed to address the highest category of complaints received by the Trust.

28.3 The Chair stated that the Trust should not accept failure to achieve targets and he was keen to see this change in culture. Caron noted this point, but with the caveat that the target for sickness absence might need to be revised to ensure that it was realistic and achievable. Peter Suter agreed that, in his experience of working in the emergency services, a 5% sickness absence target was extremely ambitious.

28.4 Sandra Adams noted that there seemed to be a greater number of manual handing incidents in the west and asked whether there was a reason for this and whether there would be any targeted training for staff in the west. Caron responded that it was thought that this was due to the fact that staff were attending a greater number of calls that required manual handling.

28.5 Peter Bradley stated that PDR completion had been an ongoing discussion at Senior Management Group meetings and stated that it would be useful for the Trust Board to receive an end of year outturn report.

ACTION: CH to produce an end of year outturn report on PDR completion.

DATE OF COMPLETION: 29th May 2012

Action plan to address attitude and behaviour

28.6 Murziline Parchment commented that this was a good action plan, but that the actions needed deadlines. There should also be some idea of the intended outcome of the action plan so that its impact could be monitored. Steve Lennox responded that his intention was for the Area Governance Committees to set their own targets and monitor progress. Beryl Magrath commented that she would like to see this action plan monitored at the Quality Committee.

ACTION: FG to add the attitude and behaviour action plan to the forward planner for the Quality Committee.

DATE OF COMPLETION: 25th April 2012

28.7 The Chair thought that the action plan was not quite sufficient to tackle the problem and suggested that a longer campaign was required. The Chair agreed to share his experience with Peter Bradley of a previous workplace which had produced a DVD to tackle attitude and behaviour.

ACTION: RH to discuss with PB his experiences of tackling attitude and behaviour issues.

DATE OF COMPLETION: 29th May 2012

28.8 Martin Flaherty commented that occasionally there was a particular member of staff who had received repeat complaints and that this sort of trend should be addressed.

28.9 The Trust Board noted the attitude and behaviour action plan.

29. Report from the Chief Executive Officer

29.1 Peter Bradley stated that this report had been presented in a new format to reflect the discussions at previous Trust Board meetings. This report now focussed on strategy, key developments and communication and engagement. Peter Bradley noted the following:

- The Trust had formally responded to the recommendations made within the London Assembly's Health and Public Services Committee review into the LAS. The LAS would be working with the London Fire Brigade to address some of these recommendations;
- The London Assembly had also conducted a review into the Trust's preparedness for the London Olympic and Paralympic Games;
- He had arranged a London-wide summit on 12th April 2012 with those acute trusts who particularly struggled to improve their hospital handover times;
- A national exercise had been arranged on 5th May in preparation for the London Olympics;
- NHS London's report into the day of strike action on 30th November had been shared with the press and LAS was currently responding to this;

- Clock Start changes had been approved subject to a final meeting. The provisional go live date was 1st June 2012.

29.2 The Chair noted that format of the report had improved and the focus on strategic issues was appropriate. The issue of hospital handover times had been discussed at the recent Chairs' meeting. There followed a discussion about the issue of hospital handovers and Trust Board members expressed concern that this had been an ongoing issue for some time and that there seemed to be a lack of incentive amongst key stakeholders to address it. The Chair summarised the discussion by stating that this was an ongoing problem which had significant impact on the LAS's ability to deliver and had an impact on the overall patient experience. The Trust Board considered this to be a major area for improvement and expected this issue to be resolved.

29.3 Lizzy Bovill commented that representatives from Whipps Cross hospital would be attending the summit to give a presentation on the actions they had taken to improve its hospital handover waiting times. This was a good example of sharing best practice and it was hoped that this would have a positive impact.

30. 2012/13 Trust Priorities

30.1 Peter Bradley reported that 2011/12 had been one of the most successful in the Trust's history, with the best ever cardiac survival rates and the quickest call-answering performance. It had also been the ninth consecutive year that the Trust had achieved the Category A performance target in addition to delivering its control total and Cost Improvement Programme. This was even more impressive given that these achievements had been realised against the backdrop of a busy year which included the 7/7 inquests, the Royal Wedding, civil unrest, CAD system change and strike action on 30th November 2011.

30.2 Peter added that there had been a lot of focus on the Foundation Trust process, but that the Trust now found itself having to go through an amended authorisation process. This therefore meant that this objective had not been achieved for 2011/12.

30.3 Peter noted that 13 objectives had been identified for 2012/13 and the Senior Management Team would come back to the Trust Board with specific deliverables and deadlines against each of these. The detail of this would be reported to the Strategy Review and Planning Committee meeting on 24th April 2012.

ACTION: SMG to identify the specific deliverables and deadlines against each of Trust Priorities for presentation at the next Strategy Review and Planning Committee.

DATE OF COMPLETION: 24th April 2012

30.4 The Chair responded by stating that the Trust Board recognised that the LAS was on a journey and needed to set efficiency improvement objectives. It was important to ensure that, given the level of scrutiny the Trust was subjected to, that staff did not lose morale and motivation.

30.5 The Trust Board approved the 2012/13 Trust Priorities.

31. 2012/13 Equality Objectives

31.1 Caron Hitchen reported that all public bodies were required to publish at least one equality objective by 6th April 2012. The LAS had adopted the new NHS Equality Delivery System and it was agreed that there should be one objective for each of the four overarching goals contained within the EDS. The four objectives had been subject to a range of consultation and engagement activities with

stakeholders, patients and service users and had been endorsed by Senior Management Group. Caron added that there would be an opportunity to review the objectives throughout the year and progress against these would be monitored.

31.2 The Trust Board approved the Equality Objectives for 2012/13.

32. Performance Report

Chief Operating Officer's Report

32.1 Martin Flaherty reported that the Trust had achieved its Category A target for the ninth consecutive year. The Trust had also achieved the best A19 performance in the country and this was in the context of high demand and utilisation. Category A demand had shown an upward trend, which had been experienced nationally, peaking in February 2012. Overall the Trust had reached 32k more patients in 8 minutes, but some patients were waiting longer in order for the Trust to achieve this.

32.2 Martin added that the Trust was coping with increasingly high demand and with that came an associated clinical risk. The organisation had high utilisation and therefore had no headroom to manage any further increase in demand.

32.3 Caroline Silver referred back to the patient story heard at the beginning of the Trust Board meeting and noted that this patient had often received a Fast Response Unit and an ambulance and asked therefore whether there was something that the Trust could be doing to review its response model. Martin agreed that there were things that the Trust could do to cope with increasing demand, including a review of rosters and annual leave arrangements; a review of the response model; introducing clock start change; and increasing hear and treat and see and treat. However, even if all of these were completed, it would not go the whole way to resolving the problem. Caron Hitchen added that the review of rest breaks and annual leave arrangements would not result in significantly more resource being available and therefore the Trust Board needed to be realistic about what these actions could achieve.

32.4 The Chair stated that the Trust Board needed to agree its longer term view for satisfying the ongoing increase in demand. This discussion raised a red flag around the expectations placed on the Trust in the context of its funding. Martin confirmed that this issue had been raised with the commissioners and would be part of the ongoing negotiations for funding for 2012/13. The Trust was also attempting to gain some non-recurrent compensation for lost hours at hospital, given that currently the LAS bore all the financial and operational risk.

32.5 Martin also reported that an Assistant Director of Operations was due to be appointed shortly and vehicle procurement was broadly on track.

Report from the Director of Finance

32.6 Mike Dinan reported the following:

- The Trust had reported a surplus of £554k for the month against a planned surplus of £26k;
- The Trust was on track to deliver its control total;
- 92% of the Cost Improvement Programme had been delivered year to date and it was on track to deliver the planned £14.8m for the year;
- The financial risks remained the same.

32.7 Mike reported that the clinical and quality impact of the Cost Improvement Programme was being monitored and had been reported in the Clinical Quality and Patient Safety Report.

32.8 Mike noted that the contract negotiations for 2012/13 had not yet been resolved and therefore this made planning for the initial months of the financial year more challenging. The Chair noted this point and stated that the contract negotiations would be discussed further in the Trust Board Part II meeting.

33. <u>CommandPoint Update</u>

33.1 Ed Sturms joined the meeting for this agenda item.

33.2 The Chair noted that the Trust Board had held an additional Trust Board meeting on 20th March 2012 to give approval to proceed with go live on 28th March 2012.

33.3 Peter Suter reported that the paper included in the Trust Board pack was the same as that presented on 20th March. Peter noted the following:

- Significant issues had been fixed and the testing of the system was complete;
- The readiness review checklist was nearly complete and it was anticipated that the Chief Operating Officer would sign off the review and would authorise Gold Command to commence go live;
- The MPS had announced that they would be undertaking an upgrade to the CAD link at 4am on 28th March. The appropriate steps had been taken to manage this and it was not anticipated that this would cause disruption.

33.4 Peter Suter commented that the key issue now was to manage expectations going forward as it was inevitable that the system would encounter problems during the first weeks of its operation.

33.5 Ed Sturms confirmed that the technical system was ready to go live and the technical team was ready to support the system. The LAS was keen to bring the system live.

33.6 The Chair concluded that the system was ready to go live and had been rigorously tested. The users were also keen to go live with the system and a support team was in place to assist with the transition. The Chair added that a robust contingency plan was in place and that the Trust had the ability to revert to CTAK if necessary, although it was hoped that it would not come to this. The Chair wished everyone luck with the final go live tonight.

33.7 The Trust Board unanimously approved go live of CommandPoint on 28 March 2012 subject to the Chief Operating Officer being satisfied that;

- The five issues identified during Live Run 3 were either fully resolved, or had an acceptable mitigation plan (that effectively downgrades them) or are re-graded to a lower priority.
- There are no other issues that are identified either as a result of more thorough analysis of the Live Run 3 data or from any other source.

34. <u>Board Assurance Framework and Corporate Risk Register</u>

34.1 Sandra Adams reported that the risk register would be reviewed by the Risk, Compliance and Assurance Group meeting next week. This report focussed on the year end position of risks:

- There were currently 8 risks on the Board Assurance Framework, 2 of which related to CommandPoint;
- There were only 2 new risks for 2011/12 and these were 361 (CommandPoint implementation) and 355 (Mandatory training). She also highlighted the need to review risk appetite and tolerance for longer term risks which would be presented to the Risk,

Compliance and Assurance Group next week, whilst recognising the need to maintain the visibility of these risks;
- Progress had been made to manage and mitigate the risks in the risk focus areas and only 2 remained on the Board Assurance Framework;
- New sources of assurance had been added to the Board Assurance Framework.

34.2 Sandra recommended that the Trust Board needed to review the strategic risks and suggested that this was done at the next meeting of the Strategy Review and Planning Committee.

34.3

ACTION: FG to add review of strategic risks to the forward planner for the Strategy Review and Planning Committee.

DATE OF COMPLETION: 30th March 2012

34.4 The Trust Board noted this report.

35. Audit Committee Assurance Report

35.1 Caroline Silver reported that the last meeting of the Audit Committee on 5th March 2012 had been a fairly routine meeting and did not raise any significant concerns. Caroline noted the following:

- The Audit Committee reviewed the risk register and Board Assurance Framework. A full review of the risk register was scheduled for the next meeting of the Audit Committee;
- The Quality Governance Review undertaken by RSM Tenon had highlighted the fact that there were a number of the risks on the corporate risk register that date back to 2002 and questioned whether these should have now been resolved and closed. A proposal to manage these risks would be presented to the next meeting of the Risk, Compliance and Assurance Group;
- The Audit Committee received a report from the Quality Committee and was assured that the committee was addressing a number of issues. There were, however, some remaining concerns about the scope of the Quality Committee;
- The Audit Committee received a report from the Finance and Investment Committee and noted that it was still in the stage of refining its role and remit;
- The External Auditor had reported that no significant issues had been identified during the interim audit. A number of risks had been identified as relevant to the auditing of the accounting statements and the External Auditor outlined how each of these would be managed;
- The External Audit services would be transferred to Grant Thornton following the closure of the Audit Commission. This could present a potential conflict of interest as Grant Thornton currently provided the LAS' historical due diligence service as part of the Foundation Trust process;
- The Audit Committee heard that the Internal Audit Work Plan was on track and the Work Plan for 2012/13 had been presented to the Quality Committee;
- The Audit Committee was assured that the management of internal audit recommendations had improved;
- The Audit Committee received a report on progress against the clinical audit work plan and would look to strengthen links with the Clinical Audit and Research Unit;
- The NHSLA Steering Group had agreed to go for level 1 assessment this year, with the level 2 assessment to take place early next year.

35.2 The Trust Board noted this report.

36. Finance and Investment Committee Report

36.1 The Trust Board noted the report from the Finance and Investment Committee.

37. Report from the Trust Secretary

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

37.2 Sandra Adams reported that the Trust had established a Single Tender Waiver Register. Mike Dinan suggested that the Audit Committee review this on a regular basis.

ACTION: FG to add a review of the Single Tender Waiver Register to the forward planner for the Audit Committee.

DATE OF COMPLETION: 14th May 2012

38. Forward Planner

38.1 The Trust Board noted the forward planner.

38.2 The Chair commented that the Trust Board might want to consider holding an additional away day this financial year.

39. Any other business

39.1 The Chair noted that he would be holding one to one meetings with all non-executive directors to discuss the time commitments required of them over the coming months, particularly with regards to the Board Governance Framework Review.

39.2 The Chair noted that he would be unable to attend the next Trust Board meeting on 29th May 2012 and therefore had asked the Deputy Chair, Roy Griffins, to chair the meeting in his absence.

40. Questions from members of the Public

40.1 There were no questions from members of the public.

41. Date of next meeting

41.1 The next meeting of the Trust Board will be on Tuesday 29th May 2012.

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Signed by the Chair

ACTIONS
from the Meeting of the Trust Board of Directors of
LONDON AMBULANCE SERVICE NHS TRUST
held on 24th January 2012

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
28/06/11	**67.3**	**Chairman's Report** RH to discuss world cities benchmarking with FM.	**RH/FM**	FM reported that she had attended a meeting of the 'Eagles', which comprised the medical directors of ambulance trusts in large cities across the world. The meeting provided a forum to discuss topics of interest and each of the attendees were asked to make a 10 minute presentation. This provided a good opportunity to showcase the work and innovative practice of the LAS. PB commented that he had strong links with the Canadian and Australasian ambulance services and would continue to share best practice. This action was ongoing.

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
27/09/11	**112.5**	RH/PB to meet to discuss whether there was anything further the Trust could be doing to meet the recommendations made by the NAO report.	**RH/PB**	The Chair confirmed that he and Peter Bradley had met to discuss the recommendations made in the NAO report. This would be an ongoing discussion and would be considered in the context of the Trust's objectives for 2012/13. The Public Accounts Committee report and the report by the London Assembly would also need to be considered as part of this discussion.
29/11/11	**126.9**	SL to look into options for presenting patient stories at Trust Board meetings.	**SL**	Patient stories are on the forward planner for each of the Trust Board meetings. Action complete.
29/11/11	**128.6**	RH to discuss with Peter Bradley the decision to use the balanced scorecard as the primary review document for the organisation and how this would be taken forward in practice.	**RH**	New reporting format to be trialled at the June meeting of the Trust Board.
24/01/12	**02.1**	Jessica Cecil to send details of her declaration of interest to Sandra Adams.	**JC**	Action complete.
27/03/12	**22.1**	FG to amend the minutes of the Part I meeting held on 24th January 2012.	**FG**	Action complete.
27/03/12	**26.7**	MF to follow up with John Pooley on the status of the letters to the entrants on the High Risk Register and the associated risks.	**MF**	Letters are being sent, from a number of stations, to entrants in categories 1 to 3 of the High Risk Register. An update is provided in the Clinical Quality and Patient Safety Report.
27/03/12	**28.5**	CH to produce an end of year outturn report on PDR completion.	**CH**	

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
27/03/12	**28.6**	FG to add the attitude and behaviour action plan to the forward planner for the Quality Committee.	**FG**	On forward planner for 20th June 2012. Action complete.
27/03/12	**28.7**	RH to discuss with PB his experiences of tackling attitude and behaviour issues.	**RH**	
27/03/12	**20.3**	SMG to identify the specific deliverables and deadlines against each of Trust Priorities for presentation at the next Strategy Review and Planning Committee.	**SMG**	
27/03/12	**34.3**	FG to add review of strategic risks to the forward planner for the Strategy Review and Planning Committee.	**FG**	
27/03/12	**37.2**	FG to add a review of the Single Tender Waiver Register to the forward planner for the Audit Committee.	**FG**	On forward planner for 5th November 2012. Action complete.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29 MAY 2012

PAPER FOR INFORMATION

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

Key issues and risks arising from this paper
This report identifies that the LAS is currently one of the top performing Ambulance Trusts in the country.

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

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

The Trust is Green for 14 of the indicators, Amber for 9 of the indicators and Red for 13 of the indicators. This is an improved position on the last scorecard but more indicators are now populated.

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

Some of the 11 DH measures (service experience has been excluded) are made up of a number of indicators. There are 23 indicators in total. In addition, there are 2 different ways of looking at the 23 indicators; year to date and monthly performance. Therefore, technically there are 46 information points. For LAS there are only 44 as we do not participate in one of the indicators (thrombolysis).

The Trust is in the upper quartile for 18 (25 at the last report) of the 44 information points (40%). We are the top performing Ambulance Trust in 11(12 last time) of those 44 points (25%).

Overall the Trust is the top performing ambulance Trust for March 2012. The following table illustrates the number of top performing measures each Ambulance Trust has in the 44 information points (not all comparisons are drawn from statistically significant data therefore, this is merely a discussion point).

London 11 (25%)
Isle of Wight 10 (23%)
Great Western 8 (18%)
North East 5 (11%)
East Midlands 3 (7%)
South East Coast 2 (4.5%)
South Western 2 (4.5%)
East of England 2 (4.5%)
Yorkshire 2 (4.5%)
South central 1 (2%)
West Midlands 0
North West 0

3. Quality Action Plan

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

Attachments

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

****

Quality Strategy

This paper supports the following domains of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

- ☐ Yes
- ✓ No

Key issues from the assessment:

London Ambulance Service NHS
NHS Trust

QUALITY REPORT
May 2012
March 2012 Dashboard & Annual Review

Quality Dashboard for March 2012

DH Measures Comparison Table

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

- The GREEN shading represents where the Trust is in the upper quartile when compared to other services. In January we were upper quartile in 21 areas. In February we are upper quartile in 22 areas and this month we are upper quartile in 17 areas. However, this was CommandPoint implementation month and we end the year in a strong position nationally.

	March (December)			Year End	
	Compliance	Rank	Direction of Travel (Compliance)	Compliance	Rank
A8 Response Time	74.5%	10th	↑	75.7%	8th
A19 Response Time	98.6%	1st	↓	99.1%	1st
ROSC (all)	25.7%	4th	↓	29.4%	1st
ROSC (Utstein)	34.7%	10th	↓	53.7%	1st
Time Taken to Answer 50th Percentile	0 Seconds	1st	↔	0 Seconds	1st
Time Taken to Answer 95th Percentile	29 Seconds	11th	↓	9 Seconds	6th
Time Taken to Answer 99th Percentile	98 Seconds	11th	↓	0.58 seconds	6th
Time to Treatment 50th Percentile	336 Seconds	8th	↑	337 seconds	11th
Time to Treatment 95th Percentile	780 Seconds	2nd	↓	738 seconds	1st
Time to Treatment 99th Percentile	1284 Seconds	2nd	↓	1143 seconds	2nd
Outcome from cardiac Arrest Survival	5.4%	8th	↓	9.5%	1st
Outcome from cardiac Arrest Survival (Utstein)	15.2%	10th	↓	30.3%	1st
STEMI Outcome 150 minutes	90.4%	7th	↓	90.4%	6th
STEMI Outcome Care Bundle	96.7%	2nd	↑	91.9%	5th
Stroke Outcome 60 minutes	64.8%	7th	↓	65.1%	6th
Stroke Care Outcome Bundle	93.7%	11th	↓	90%	11th
Calls Closed with CTA	5.8%	7th	↓	6.4%	4th
Non A&E	31.4%	10th	↓	29.4%	10th
Re Contact rate CTA	6.2%	3rd	↑	5.2%	3rd
Re Contact rate See & Treat	4.3%	3rd	↓	4.3%	4th
Re Contact rate Frequent callers	2.86%	5th	↑	3.0%	5th
999 Calls Abandoned	0.21%	1st	↓	0.1%	1st
Service Experience	No measure				

Quality Improvement Actions

Domain	Quality Measure	Action	Where Monitored	Who is Responsible	Impact	Progress (May 2012)
Staff/Worforce	% of staff receiving supervision	Director of Operations/Deputy Chief Executive clarifies the need to populate OWR data with the Assistant Directors of Operations. (added February 2012)	Operations meetings	Deputy Chief Executive; Martin Flaherty	↓	OWR SMART target changed to 200 per month. Overall OWR and PPED have significantly increased from Dec. Observe for a further month.
Staff/Worforce	% of Priority Training Commitments Delivered (CSR)	1) Training figures to be accurately reported by marrying corporate figures with new ways of working data capture. (added February 2012)	Training & Strategy Group	Director of Human Resources; Caron Hitchen	↑	CSR 1 improved from 60% to 67% CSR 2 is 59%
Performance	Average Arrival at Hospital to handover	Continue to champion with GPs and through commissioning and performance routes (added February 2012)	Clinical Quality Group	Deputy Director of Strategic Development Lizzy Bovill	↑	LAS chaired a summit at NHS London. Continues to be addressed as a whole economy approach
Physiological	Airway Management	Area Quality Leads to focus on local actions and report to CQSE (added February 2012)	Area Governance & CQSEC	Director of Health Promotion & Quality & Medical Director Fionna Moore & Steve Lennox	↔	Area Quality Committees asked to forward actions taken to CQSEC (too early in reporting cycle to report)
		Paramedic Consultant meeting with senior training staff to review training (added March 2012)	Clinical & Quality Directorate	Paramedic Consultant	↔	Too early to report.

Physiological	CPIs	Area leads to reinforce the need to undertake a full assessment prior to deciding not to convey (added February 2012)	Area Governance Committees & CQSEC	PIMS	↔	Reporting cycle too early to observe any real benefits.
		Asthma improvement is being addressed through the Area Governance Committees with each being asked to report actions being taken, In addition the training of the care bundle is being refreshed (added February 2012).	Area Governance Committees & CQSEC	PIMs and Paramedic Consultant. Mark Whitbread.	Not specifically identified on the dashboard	Quarterly reporting and monitoring
Safety	Appropriate Response Times	Clinical Audit to recover the data and ensure a data set is available for the next report (added February 2012).	Quality & Clinical Directorate	Director of Health Promotion & Quality & Medical Director Fionna Moore & Steve Lennox		Completed March 2012
Safety	Appropriate Response Times	To be discussed at Senior Managers Conference and Area Quality Meetings (added May 2012)	SMG	Director of Health Promotion & Quality & Medical Director Fionna Moore & Steve Lennox	↔	Discussed at Senior Managers Conference
Safety	Safeguarding	East area to focus on improving the timeliness of safeguarding referrals (added February 2012). Ensure maximum attendance at remaining CSR 1	East Area Governance Committee Training & Strategy Group	Assistant Director of Operations. Katy Millard Chief Operating Officer. Martin Flaherty		Completed May 2012

		sessions (added February 2012)..				

Safety	Right Time, Right Place, Right Person	Clinical Audit to recover the data and ensure a data set is available for the next report (added February 2012).	Quality & Clinical Directorate	Director of Health Promotion & Quality & Medical Director Fionna Moore & Steve Lennox		Completed May 2012
Safety	% Taken to Trauma Centre	Area Governance Committee to report to CQSE the local action taken (added February 2012).	Area Governance Committees & CQSEC	PIMS	↔	Too early in reporting cycle to report benefits. Not reported in March Quality Dashboard
Safety	Missing Documentation	Ensure Performance Improvement Managers are aware this is now monitored centrally and is seen as a fundamental part of safety and is to feature within area governance reports (added February 2012).	Area Governance Committees & CQSEC	PIMS	↔	Continue action to drive further improvement.
Clinical Outcomes	Outcome from Cardiac Arrest	This is a complex issue Paramedic Consultant is going to explore and feedback to Medical Directorate (added February 2012).	Medical Directorate	Paramedic Consultant. Mark Whitbread		Improved results. Action closed.

Clinical Outcomes	STEMI Outcome	Medical Director to continue to push for national agreement on analgesic intervention for STEMI care (added February 2012).	CQSEC	Medical Director, Fionna Moore	↑	This is a long term action point but there has been a further degree of improvement in the indicator this month.
Clinical Outcomes	Infection Control	PIMS to recover the data capture system for the scorecard (added February 2012).	Area Governance Committees & CQSEC	PIMS	↑	Scorecard now recovered and populated. Training compliance now hindering full green RAG rating
Clinical Outcomes	Outcome from Stroke	Medical directorate to Review the impact of the new ECG instructions (added February 2012).	Medical Directorate	Assistant Medical Director. Neil Thompson	↑	Small improvement but directorate will continue to monitor impact of ECG changes.
Clinical Outcomes	Outcome from Stroke	Quality Improvement managers to reinforce the need for complete documentation and report back though area Governance to CQSE (added February 2012).	Area Governance Committees & CQSEC	PIMS	↑	Continue to monitor impact of ECG changes.
Esteem & Respect	Pain Relief	Clinical Audit to recover the data and ensure a data set is available for the next report (added February 2012).	Quality & Clinical Directorate	Director of Health Promotion & Quality & Medical Director Fionna Moore & Steve Lennox		Action Closed in May 2012
Satisfaction	Service Experience	Performance managers to report on actions being taken to improve attitude and behaviours (added February 2012).	Area Governance Committees & CQSEC	PIMS	↔	Too early in reporting cycle.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH MAY 2012

PAPER FOR INFORMATION

Document Title:	**Quality Account 2011/12**
Report Author(s):	**Steve Lennox, Director of Quality and Health Promotion**
Lead Director:	**Steve Lennox, Director of Quality and Health Promotion**
Contact Details:	
Why is this coming to the Trust Board?	**To note the draft Quality Account for 2011/12. A final version will go to the Trust Board in June for approval.**
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 draft Quality Account for 2011/12. A final version will go to the Trust Board in June for approval.**

Key issues and risks arising from this paper

The Quality Account forms part of our quality governance and reporting.

Executive Summary

The Quality Account follows a similar process as the annual accounts and acts as our final review on quality for 2011-2012. The final published version will include stakeholder comments.

The quality priorities for 2012-2013 are;

Mental health
Diabetes
Alcohol
Maintaining quality during the Olympics

The account reports progress in quality and uses the DH indicators to report our key successes. It also reports upon the priorities identified in the Quality Account 2011-2012.

A final version that will include the stakeholder comments will go to Trust Board in June for approval.

Attachments

Quality Account 2011/12

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Quality Strategy

This paper supports the following domains of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

- ☐ Yes
- ☐ No

Key issues from the assessment:

London Ambulance Service NHS
NHS Trust

Quality Account
2011/12

Contents

Contents

Part 1. Introductions

We believe London is one of the greatest cities in the world and it is a privilege to provide urgent and emergency health care to this world city.

We are the busiest ambulance service in the UK and probably the world and we respond to the emergency needs of up to 8 million London residents, commuters and tourists. The work we undertake is varied and ranges from dealing with major incidents, providing clinical support to large public events to giving advice to those patient not requiring an ambulance. In addition, we also provide a transport service for patients who require assistance with their travelling needs when needing healthcare away from home.

This past year has been yet another challenging year. We responded to 1,100,000 incidents for assistance. A greater percentage of these incidents were within our highest priority category which means we responded to more patients within 8 minutes than ever before. In August 2011 London suffered widespread rioting, looting and arson and we were required to respond quickly to the needs of Londoners at this difficult time. We also saw a day of industrial action in November, which significantly challenged our service. We have looked to learn lessons from these major events.

The past year also saw the introduction of the ambulance clinical quality indicators. This is a set of indicators, which we fully report on in this account, which maintains a focus on the speed of response but also introduces a greater emphasis on other measures such as experience and clinical outcomes. We very much welcome this development as it reinforces our belief that quality and patient safety need to be at the very top of our priority list and is part of our vision to be a world class service.

This is our third quality account and it reports on the quality improvements that we highlighted in our second quality account. We have made considerable progress and have implemented the vast majority of the 51 specific actions that we said we would address. This year is Olympic year and this brings a different challenge to our service and as such we have identified a smaller number of priorities for the coming year. Nevertheless some of these are of significant magnitude and when considered alongside our CQUIN priorities it is clear that this is going to be another year where we make further improvements for patients.

To the best of my knowledge the information contained in this report is accurate and reflects a true and account of our service.

Peter Bradley CBE
Chief Executive

Welcome to the third quality account from the London Ambulance Service NHS Trust. This account fulfils our legal obligation to make public our achievements on quality during the past year. It reports progress on the four quality objectives identified in last year's quality account and identifies new ones for the coming year.

Last years priorities were;
Improving Mental health care
Improving the care of patients who have fallen
End of Life Care
Implement a quality dashboard

The Trust has drawn on information form a number of data sources and service areas and many individuals have contributed to the creation of this account. We have also engaged with a wide group of patients in identifying the priorities for the coming year and consequently we believe we have developed objectives that are meaningful to patients and will further improve the quality of the services that we provide.

Next year we will be required to progress the quality account through the same audit pathway as our financial accounts but even now the account sits alongside our Annual Report and as such has been approved by the Trust Board and its sub committees.

Our lead commissioner and local LiNKS groups have had the opportunity to comment on this account and we have presented an overview of quality to two Overview and Scrutiny Committees.

This account has been designed for on line publication on the NHS Choices web site. However, printed copies will be made available on request for 2 years from the Trust headquarters.

Executive Offices
London Ambulance Services Headquarters
220 Waterloo Road
London
SE1 8SD

Vision & Values

Our **vision** remains the same for 2012-2013 as it was for 2011-2012. However, our underpinning goals and objectives were reviewed in 2011 and a summary of the changes is attached as Appendix I.

The following diagram illustrates the relationship between our vision, goals and our current objectives

OUR VISION

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.

1st Strategic Goal

To improve the quality of care we provide to patients: to improve our delivery of safe and high quality patient care using all appropriate pathways

2nd Strategic Goal

To deliver care with a highly skilled and representative workforce: to have staff who are skilled, confident, motivated, feel valued and who work in a safe environment

3rd Strategic Goal

To deliver value for money: to be efficient and productive in delivering our commitments and to continually improve

Supporting Corporate Objectives

CO1. To improve the experience and the outcomes for patients who are critically ill or injured

CO2. To improve the experience and provide more appropriate care for patients with less serious illness and injuries

CO3. To meet response times routinely

CO4. To meet all other quality, regulatory and performance targets

Supporting Corporate Objectives

CO5. To develop staff so they have the skills and confidence they need to deliver high quality care to a diverse population

CO6. To create a productive and supporting work environment where staff feel safe, valued and influential

Supporting Corporate Objectives

CO7. To use resources more efficiently and effectively

CO8. To maintain service performance during major events, both planned and unplanned, including the 2012 Games

CO9. To improve engagement with key stakeholders

Our **values** remain the same for 2012-2013 as they were for 2011-2012;

We have seven values that underpin the culture of the London Ambulance Service and these are also known as our critical values. They portray the culture of the organisation and reflect the values enshrined in the NHS constitution. Our values are as follows:

- **Clinical excellence** – we will demonstrate total commitment to the provision of the highest standards of patient care. Our services and activities will be ethical, kind, compassionate, considerate and appropriate to patients' needs
- **Respect and courtesy** – we will value diversity and will treat everyone as they would wish to be treated, with respect and courtesy
- **Integrity** – we will observe high standards of behaviour and conduct, making sure we are honest, open and genuine at all times and ready to stand up for what is right
- **Teamwork** – we will promote teamwork by taking the views of others into account. We will take genuine interest in those who we work with, offering support, guidance and encouragement when it is needed
- **Innovation and flexibility** – we will continuously look for better ways of doing things, encourage initiative, learn from mistakes, monitor how things are going and be prepared to change when we need to
- **Communication** – we will make ourselves available to those who need to speak to us and communicate face to face whenever we can, listening carefully to what is said to us and making sure that those we work with are kept up to date and understand what is going on
- **Accept responsibility** – we will be responsible for our own decisions and actions as we strive to constantly improve
- **Leadership and direction** – we will demonstrate energy, drive and determination especially when things get difficult, and always lead by example.

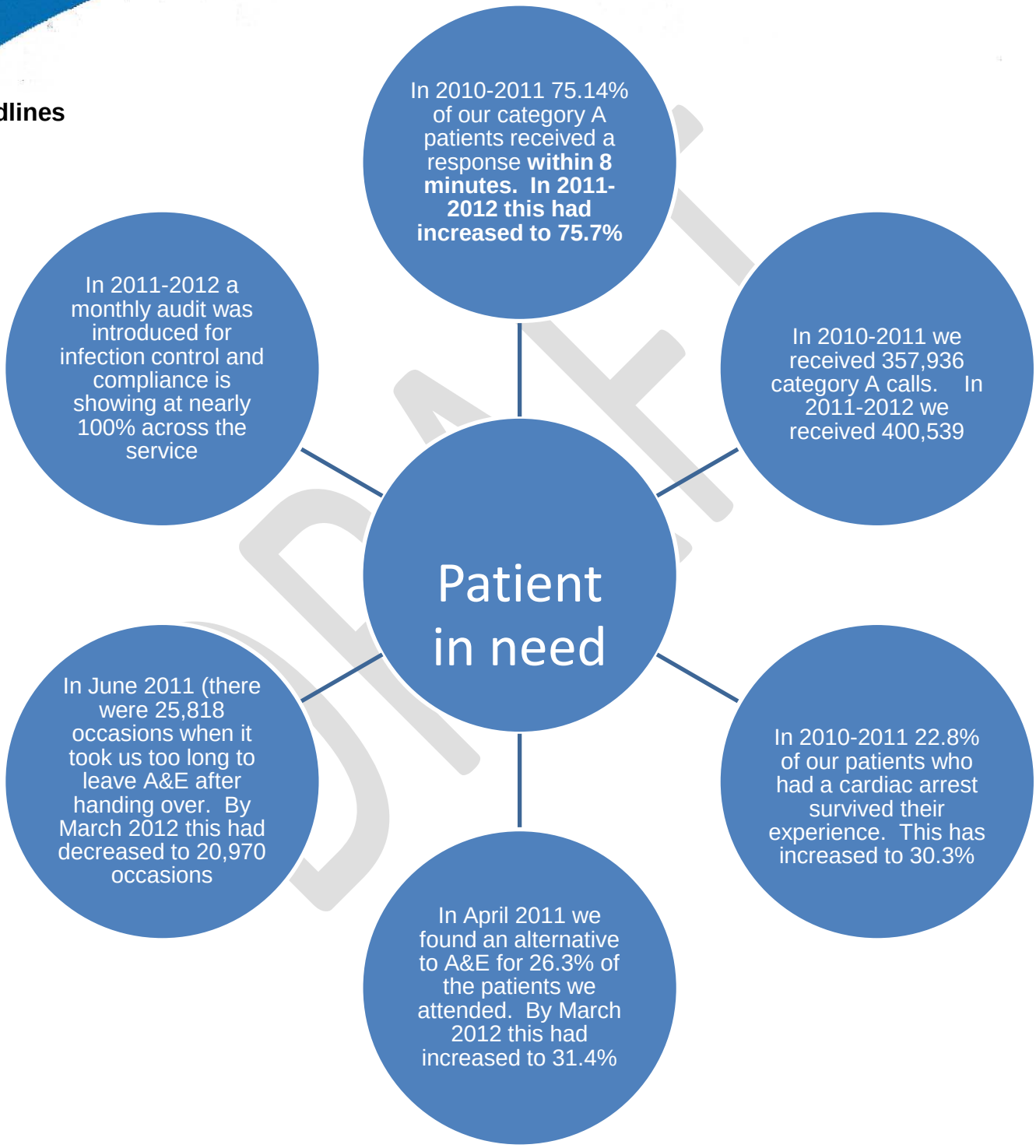
This Quality Account describes some of the progress we have made in 2011-2012 and we believe we are amongst the best ambulance services in the Nation. However, by delivering our identified objectives and adhering to our critical values we believe that we will deliver our vision to be world class. We have also broadly identified three specific areas that would help us to identify world class;

- **Patient outcomes across a range of conditions benchmarked amongst the best in the world**
- **Highly productive, professional motivated workforce leading clinical improvements in their communities**
- **Fully integrated healthcare partner leading urgent and emergency care system development and improvement in London**

During the course of the year we will make further clarifications and make contact with other ambulance services in other countries to start comparing, where possible, outcome data. However, in order to be world class we need to have clinical evidence to support this. We have the aspiration to be upper quartile in all of the Ambulance Clinical Quality Indicators and this year expect to move up a quartile in those areas where we are not currently in the upper quartile

Quality Headlines

Headlines



Data

It is important to note that some of the data sources are not the same as data quality improves over time. In addition, some of the 2011-2012 data is for a partial year. This is intended to serve as headline messages. The cardiac survival figures are for those events that are witnessed and the 30.3% is up to December 2011.

Writing the quality account

The overriding principle of the 2012-2013 Quality Account, as in 2011-2012, is that the account should reflect the views of patients.

However, we needed to take a different approach this year as many of the voluntary groups that were approached did not have the capacity to make a contribution. Therefore, we took the opportunity to seek patient views in a more integrated way and asked for feedback at a number of engagement events that were run towards the end of 2011-2012.

We asked people who attended 19 different engagement events and 72 participants made some suggestions. The majority of these people were potential patients rather than people who had previously called an ambulance.

Two suggestions featured highly 1) speed of response and 2) the knowledge of our staff. Otherwise the suggestions were broad in nature. Some participants suggested personal qualities such as kindness and understanding as important factors in determining their experience.

The following table outlines the most popular suggestions.

Speed of the ambulance arrival	64
Competence of the clinical staff	22
Good advice by the call takers	16
Speed taken from scene to hospital	10
Kindness & polite	9
Efficient triage on the telephone	7
Language skills of clinical staff	6

We also asked patients for their views at a number of other opportunities. These included;

- Presentation to Westminster LiNKS
- Presentation to Hillingdon External Oversight Committee
- Presentation to the City of London Overview & Scrutiny Committee
- Presentation to London Ambulance Service NHS Trust Members
- Interviews with patients who have used our service in Accident & Emergency

The feedback from all of these engagement events has been positive and with the exception of speed there were no consistent quality concerns arising from patients. We also undertook a patient survey in 2011-2012 in partnership with North and Central London NHS Foundation Trust and specifically asked for feedback on a number of quality aspects. Most of the respondents, 81.3%, said that the Service was as they had expected.

We also approached Trust staff and invited suggestions to be made via a dedicated e-mail account and through engagement with over 80 managers at our internal Senior Manager's Conference. In addition, on completion of the Quality Account a number of stakeholders were invited to make comments on the report and their feedback is contained within the report

How we are prioritising quality

Quality remains the focus of what we do and drives the decision making process. However, it is no longer enough to simply focus on quality. We are increasingly being asked to evidence how quality drives the decision making within the Trust and need to pay more attention to how quality is recorded and documented throughout our governance structure. In 2011-2012 we had a number of internal and external quality reviews and these assisted us in further strengthening our governance.

The most recent review was undertaken by the Care Quality Commission. They found the Trust to be compliant with the observed standards but non complaint with a specific aspect of controlled drug ordering which the Trust is addressing. We also had a number of additional reviews undertaken as part of the Foundation Trust application process. These have been positive experiences and on each occasion examples of good practice were identified and a number of areas where further improvements could be made have also been raised.

Examples of Good practice have included;

A Quality Dashboard: Having a dashboard in place that reports on a number of quality measures and has the ability to break a number of them down to the level of individual ambulance station.

Clinical Performance Indicators: Having monthly measures that are audited monthly and can be broken down to the level of the individual member of staff.

A single data point for evidence: Having a central electronic store to file quality evidence was praised by the CQC.

Opportunities for further strengthening quality included;

Engaging more with staff: It is recognised that communicating across 70 Trust sites is challenging. However, we need to find a way that allows us to do more of this. We also intend to drive the quality dashboard through the organisation which will require stronger communication links with clinical staff.

We believe quality is the responsibility of all of our staff and each of our areas has a governance mechanism for monitoring quality and uses this as an opportunity to bring together all of the information that is necessary when reviewing quality. This includes; performance measures, quality indicators, lessons learned from complaints, and also the lessons learned from adverse incidents. We are now moving these mechanisms to focus on the quality dashboard and are introducing systems that mirror the Ward to Board information procedures of Acute Trusts.

In 2011-2012 we stated that we would strengthen the way we learn from serious incidents and we have made significant improvements and now include the lessons into an integrated report that highlights them within the context of other issues. We now also complete serious incident investigations more quickly than in the previous year. However, we now need to roll some of these systems into our less serious incidents so that we have a single robust process.

During 2011-2012 we had a comprehensive cost improvement programme that included a wide range of projects for reducing the cost to the public of running the ambulance service. Each of these projects, no matter how small, had a

clinical lead who was actively engaged in monitoring the impact of the project on patient care. Whilst our two clinical directors maintained an overview each clinical lead was empowered to challenge their project. This was very successful. However, in 2012-2013 we need to strengthen the governance and the evidence of the clinical engagement as it is currently only recorded when concerns were raised. We need to be able to demonstrate continual scrutiny of clinical quality.

One of our biggest successes in measuring quality has been the implementation of the quality dashboard. This identifies our priorities for quality within seven domains and is used as one of our key mechanisms for reporting quality to the Trust Board and to our commissioners.

Quality Domain 1: Staff/Workforce

The workforce domain includes a set of measures regarding our workforce. We have had mixed success with these measures. We have some of the lowest absence levels of any ambulance service and have low turnover when comparing us with other NHS employers. However, we need to improve the supervision we offer to staff and be able to evidence training more robustly than our current system allows.

The Service's 2011 staff survey results were published in March 2012. Significant improvements include the percentage of staff who have used e-learning opportunities (72%, up from 12% in 2010) and receive training in how to handle confidential information (80%, up from 55% in 2010). Scores which went down include the percentage of respondents who report that there are not enough staff in the Trust for them to do their job properly (up to 54% from 39% in 2010) and that there are no opportunities for career progression (up to 47% from 36% in 2010).

The Department of Health benchmarked the Service's scores against other Ambulance Trusts, based on a sample of responses. The LAS is significantly better than average for the percentage of staff using flexible working options (48% compared with an average of 44%). However, the Trust's overall staff engagement score, taking into account motivation, staff ability to contribute towards improvement at work and staff recommendation of the Trust as a place to work, is below average (3.15/5 compared with an average of 3.23/5).

However, the key areas of focus in response to the results will be communication between senior management and staff. 67% reported that this is not effective and 65% said senior managers do not try to involve them in important decisions. We will undertake further analysis in early 2012-2013.

Quality Domain 2: Performance

The performance domain essentially reports the key response time targets and the length of time we wait to handover to other professionals. In 2011-2012 commissioners focussed on those patients who were the most urgent and need a response within 8 minutes. We are delighted that we have met this response time for the ninth consecutive year. However, we now need to turn our attention to those patients that do not require an 8 minute response to ensure they get a timely intervention. The Quality Dashboard for 2012-2013 will include the speed of response for all our patient groups.

Quality Domain 3: Clinical Intervention

The clinical intervention domain contains measures that monitor what we actually do to patients whilst in our care for example our success at resuscitation following a cardiac arrest. We are very proud that we have made even further improvements on last year's results. Whilst the data collection was only available up to December 2011 for witnessed cardiac arrest survival London was the highest in the country at just over 30%.

Quality Domain 4: Safety

The safety domain monitors key elements to patient safety. One of the measures is how quickly we answer the telephone. We have one of the best emergency call handling services in the world and we consistently have the quickest call answering in the country and the lowest level of dissatisfaction measured through "hanging up" before answering.

We have also made significant improvements to safeguarding. At the end of the previous year we participated in a London wide review of safeguarding that was led by NHS London. The review was positive and found us to be compliant but identified a number of areas that could be strengthened. As such we have worked through an action plan in collaboration with our commissioners. We have also appointed a named professional and have

introduced a safeguarding dashboard that monitors safeguarding referrals, training and networking. This is monitored at our Safeguarding Committee. We have further work to do in recording and quality assuring our safeguarding training.

Quality Domain 5: Clinical Outcomes

The clinical outcomes domain reports on the outcomes of patients. This domain has limitations as we are dependent upon receiving information from other organisations for true outcome measures. However, we have made a number of improvements in this domain during 2011-2012. Most notably the number of patients receiving telephone advice and the satisfaction of this service when measured by the number of patients telephoning us again within 24 hours is amongst the best in the country.

We now also have an infection control dashboard that measures a number of important infection control indicators such as compliance with practice guidelines (hand hygiene), training, and cleaning. This has significantly raised the profile of infection control and has strengthened our ability to evidence that we do all we can to protect patients from the infection risks associated with healthcare.

Quality Domain 6: Dignity

There are a number of measures within the dignity domain that measure the way we treat patients. Last year the essence of our quality priorities, mental health, patients who have fallen, and end of life care fell within this domain and we added these to the dashboard. We have had mixed success in this area and the detail is reported elsewhere in this quality account.

Quality Domain 7: Satisfaction

The satisfaction domain monitors the feedback we receive from patients. We do this through our newly developed service experience action plan. The actions on the service experience action plan arise from the integrated report and the indictor measures the effectiveness of the action plan by Red, Amber, and Green rating the indicator based on the delivery of the actions.

Part 2. Quality Priorities

Looking forward

Each year NHS Trusts are asked to identify a small number of areas, a maximum of four, where Quality Improvements can be made and these should be made explicit within the Quality Account.

When identifying these priorities it is important to turn to a number of sources. For the London Ambulance Service we have identified six main sources to guide our prioritisation.

1. The Operating Framework
2. Patient ideas and experience
3. Staff ideas and experience
4. Learning from incidents, complaints and other feedback
5. Commissioning intentions
6. Our quality indicators

1. The Operating Framework

Each year the Department of Health publishes a framework that identifies the priorities for the NHS in the coming year. The priorities within the framework include issues that have been raised nationally throughout the previous year. They are strategic in nature and rarely include defined actions. Although a series of indicators may arise from the framework. For example, the ambulance clinical quality indicators which are fully reported in this Quality Account arose from the 2011/2012 Operating Framework.

There is an expectation that NHS organisations will use this to inform local quality work. We believe our four quality priority areas capture the essence and the relevant specifics of the Operating Framework.

This year the Operating Framework identified seven areas for prioritisation;

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions (including mental health)
- 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

The whole Operating Framework has been used to guide our approach and all areas are relevant to the work of the ambulance service.

2. Patient ideas and experience

As already reported within this account, we have engaged with a wide number of patients and staff when identifying our quality priorities. Many patient groups were supportive of the work we have been undertaking in mental health and expressed a desire that we continue to improve mental health care. This is also supported by our staff who often feel less able to meet the needs of mental health patients who are in crisis. For this reason we will continue to identify mental health as a quality priority next year.

In addition, possibly due to considerable media interest in 2011-2012, some patient groups were also concerned about alcohol. Many patients appear concerned that our need to respond to intoxicated patients has an impact on our resources. Others are concerned that we need to work with other providers to identify an alternative to Accident and Emergency departments for patients who are only vulnerable through alcohol. Therefore, we have made alcohol a priority for the coming year.

Long term conditions are a high priority nationally and they form a significant part of our work. We believe that we can make

improvements for these patients by not always conveying them to a hospital and by informing other professionals of our interventions. However, to do this with all long term conditions would be overwhelming and we need to take a strategic approach. Last year's work with patients who have fallen gave us a good foundations from which to build. Our patient groups were supportive of our desire to focus on one specific long term condition. Last year we attended 6,981 patients presenting with a diabetic related incident. We have agreed with our patient groups and commissioners that we should focus on this patient group this coming year.

Finally, the other factor raised was a concern regarding the rest of London during the Olympic period. We are of the view that it is "business as usual" for London during this period and this is reflected in our corporate objectives. However, the fact that this has been identified as an area of concern by patients means we have given the communication of our plans some additional focus.

3. Staff ideas and experience

The views of our staff were not significantly different to those of our patient groups. However, learning through clinical incidents was raised and whilst we have not made this a specific quality priority we intend to strengthen the way we capture lessons from all incidents as part of our governance improvements in 2012-2013.

4. Learning from incidents, complaints and other feedback

We now produce an integrated report called The "Service Experience Integrated Report". This collates all the lessons that are to be found from a number of sources. These are;

- Incidents
- Patient Advice & Liaison Service
- Complaints
- Claims and Inquests

The report highlights the main themes arising across the Trust and also reports on the supporting action plan.

On the whole the lessons learned are specific to individual cases. However, even with the low numbers that fall into specific categories it is possible to identify the top three issues. These are violence and aggression to staff, delayed response, and medical devices. However, the low numbers means these themes have not been carried into our quality priorities but the measures we are taking to improve these areas will be reported within the Service Experience Integrated Report.

5. Commissioning Intentions

Each year our commissioners announce their priority intentions for the following year. This often contains a number of priorities that are wider than just quality.

This year the commissioning intentions were banded into categories. These were as follows;

- Quality
- Productivity
- Prevention
- Clinical engagement
- Financial performance
- Workforce development
- Data reporting
- Service change
- Performance
- Social & environmental
- Emergency preparedness
- Public and patient involvement

The detail within these priorities is captured within our core contract and also within the Commissioning for Quality and Innovation (CQUIN) payment framework. This scheme allows our commissioners to financially reward us for achieving a successful change. This year, alcohol and diabetes are specifically reflected within the CQUINs for the Trust and within our quality priorities for 2012-2013.

6. Quality Indicators

The final area for consideration is the quality measures that are reported within the quality dashboard. Overall these measures have revealed a successful year for quality. However, there is an emerging theme that we are increasing the length of time we are spending on scene. This is not necessarily a negative change for some patient groups as it can be translated into a thorough assessment and time spent giving information and advice. However, for some patient groups, such as trauma and stroke the increase in time needs to be understood.

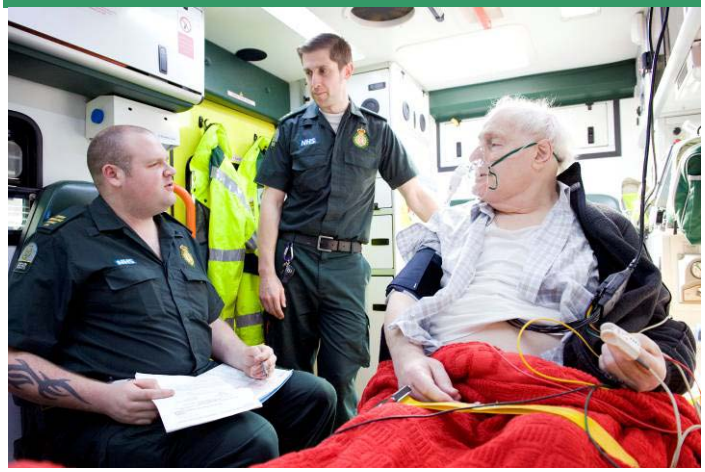
The coming year will see the development of a clinical strategy for the Trust. The learning obtained through the current quality measures, including the lengthening of on scene time, will be incorporated into this strategy.

Therefore, from summarising the themes arising from the six areas we have identified four quality priority areas for 2012-2013. The four areas are;

1. **Improving Mental Health Care**
2. **Improving alcohol related harm**
3. **Providing a quality service for the whole of London during the Olympics**
4. **Improving diabetic care**

Having applied the methodology to the selection process we are confident that we have selected areas that are important to patients and consistent with the Operating Framework. They are also consistent with our strategic goals and our corporate objectives.

The following pages outline the case for inclusion in more detail and identify a number of improvements that we intend to make in each of those areas.



Priorities for Improvement: 1 Mental Health Care

Improving Mental Health Care

Mental health is featured within the Operating Framework and has featured from talking with patients and our staff. It is also supported by our commissioners even though it does not feature specifically within the current CQUINs.

Last year we made considerable improvements to the way we respond and care for mental health patients and this progress is reported later in this account. This year we will further develop the supporting action plan to make even more improvements.

1. Education & training

Education and training is key to any service developments and we have developed a comprehensive training package that includes an element of e-learning, face to face training and reflective learning.

Action; To make mental health training mandatory for all our clinical staff and ensure at least 60% of the relevant workforce receives the face to face element of training in the coming year.

2. Clinical support

We have a team of senior and experienced clinicians that are responsible for supporting all our staff requiring clinical advice whilst attending patients. The skills and advice given at this point are key to how supported our staff feel and are also key to implementing clinical changes. Therefore we will give some focus to this group of staff this year.

Action; To ensure 100% of our permanent clinical advisors have an advanced understanding of mental health.

3. Patient experience

Last year we undertook a patient survey in conjunction with North Central and West London Foundation NHS Trust. This demonstrated that the vast majority of their mental health patients, that participated in the survey, were happy with our care. However, we need to ask a wider group of patients before we can be confident that are care is meeting patient expectations.

Action; To undertake further engagement activities with mental health patients that gives us patient feedback on experience and satisfaction.

4. Care pathways

We have started to develop agreements with all of London's mental health providers that allow us to access their specialist teams for advice and support. We now need to roll out these agreements across the Trust so that our staff are aware and understand what is available.

Action; To role out the agreed care pathways across the whole Trust.

Priorities for Improvement: 2 Alcohol Related Harm

Improving alcohol related harm

In 2011-2012 alcohol received widespread media attention and it is a high priority across London for a number of other organisations; such as the office of the London Mayor. Our patient groups have also informed us that they are concerned about alcohol. This is supported by our commissioners and is featured within the CQUINs for the coming year.

1. Alcohol recovery service

Over the past few years we have developed an innovative way of managing those at risk from alcohol consumption but without the need to convey them to accident and emergency departments at key times such as New Year. This service, where patients rest under the supervision of one of our clinicians before being discharged, has been financially supported to run for the whole year. This service now needs a full evaluation.

Action; To undertake a comprehensive audit of the alcohol recovery service that considers the benefits to patients and the health economy.

2. Recommendations

We need to consider the future service delivery model for alcohol related calls with our commissioners and with other providers. Following the review of the current alcohol recovery service we will draw together conclusions and make recommendations based on the learning from running the service for a full year.

Action; To make recommendations, to our commissioners, on the future delivery model for alcohol.

2. Health promotion

We will explore how we can undertake a short assessment of alcohol consumption when attending a broader range of calls and identify what action we can take when a patient triggers the assessment protocol.

Action; To identify three ambulance stations where we can introduce an alcohol assessment protocol.

Action; To identify what course of action can be taken when a patient triggers the assessment.

Priorities for Improvement: 3 Quality during the Olympics

Providing a quality service for the whole of London during the Olympics

We recognise that the public are concerned about the Olympic period and this has featured at a number of our patient meetings.

We are committed to ensuring that London receives a normal service during the Olympics and will put into place a number of measures that will maximise our ability to deliver "business as usual".

We have identified three strategic objectives for the Olympic period

- Preserve lives and protect patient care throughout the games period,
- To ensure sufficient resources and management assets are available to manage core activity to national and locally agreed quality standards in preparation for restoration of the new normality,
- To maintain the reputation of the Trust with the general public and stakeholders.

To support the delivery of these three objectives we are developing our operational arrangements which are defined by the following elements.

1. Matching demand with supply

In order to understand the impact of the Olympic Games upon demand during this period a demand profile has been developed. This profile has been overlaid with the timetable of pre-planned events to provide a comprehensive picture of demand by day and by location. Initial assessments of our resourcing against this projected demand profile highlighted some pinch points in our operational cover.

Action; We will deliver our action plan to manage these times. In addition, we will establish a weekly Olympic Demand and Capacity Review Meeting to review the latest position and initiate actions as required.

2. Managing demand

Consideration is being given to how we can enhance the capacity on our existing Clinical Support Desk and Clinical Telephone Advice departments. These areas are key to our ability to respond to all our patients. These enhancements will ensure that our patients receive the appropriate response from the LAS based on their clinically assessed needs. Ensuring that we optimise the use of these existing services throughout the period of the games will also ensure we maximise the availability of our ambulance resources to respond to patients requiring additional clinical assessment, intervention and conveyance to definitive care centres.

Action; We will implement a new model of clinical support that will provide greater flexibility and strengthen our ability to meet the additional demands of the games.

3. Emergency Operations Centre (EOC)

Daily call volume demand profiles have been developed and reconciled with incident projections for the games period. Resourcing levels to match these profiles are currently being populated.

Action; We will explore the possibility of using flexible staff to support the call handling agents and will ensure the governance and quality issues are addressed.

4. Communications

A communications plan for the Olympics and Maintaining Service delivery is being drawn up and has been divided into 5 key themes:

1. Travelling to & from work
2. Operational staff driving in London
3. Flexible working
4. Annual leave
5. Support services working differently

Action; These messages will be communicated as required and need to be reinforced by robust local messages.

5. Quality and Safety Indicators

In order to know we are providing a high quality service to the rest of London during the games we will need to develop a set of indicators that can be measured in real time that will inform us of any variation in service so that we can make decisions at the time.

Action; Identify the quality indicators to monitor in real time during the period of the Olympic games.

Priorities for Improvement: 4 Diabetes

Improving diabetic care

The need to undertake further work on long term conditions has a high profile within the operating framework and features within the commissioning intentions. Our talks with patients also revealed their wishes for us to consider alternative ways of meeting the needs of these patient groups.

The Trust has chosen to focus clinical development work on the area of diabetes for next year. In particular, those patients who suffered a hypoglycaemic episode and recovered, and also those patients over 40 years of age who on a random blood sugar testing have been identified as having a raised blood sugar level.

It has been identified at a national level that improved early diagnosis and management of patients with diabetic issues can reduce complications and costs to the NHS.

For those having recurrent hypoglycaemic episodes, by referring these patients back to their GP or diabetic team, improved care through better, more accurate, management of medications may prevent/reduce further episodes.

There is an opportunity for the Trust to consider how we manage patients with altered blood sugar levels. Current practice is that where this reading is raised, the patient is advised to contact their own GP, but the work to be implemented this year, will mean that all patients who have a reading above 8mmol will be automatically referred to their GP for follow-up. In many cases, these referrals will lead in further investigations with the aim of early diagnosis and therefore improved management and a reduction in longer-term complications.

Action; Develop a protocol and training for our clinical staff that supports patients with a reading of 8mm to be referred, when appropriate, to their GP.


HORROR
OF THE UNWASHED
HANDS

The Department of Health identifies a number of mandatory statements that the Quality Account must report upon. These are predominately regarding data, audit and research and are presented in this section of the report.

Statement Area 1: Data Review

During 2011/2012 the London Ambulance Service NHS Trust provided three NHS services and has reviewed the data available to them on the quality of care in all three of these NHS services.

Statement Area 2: Income

The income generated by the NHS services reviewed in 2011/2012 represents 100 per cent of the total income generated from the provision of NHS services by the London Ambulance Service NHS Trust for 2011/2012.

Statement Area 3: Clinical Audit

During 2011/2012 four national clinical audits and no national confidential enquires covered NHS services that the London Ambulance Service NHS Trust provides. During that period the London Ambulance Service NHS Trust participated in 100% of national clinical audits which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the London Ambulance Service NHS Trust was **eligible** to participate in during 2011/2012are as follows;

- Department of Health Ambulance Clinical Quality Indicators covering:
    - Outcome from cardiac arrest – Return of Spontaneous Circulation (ROSC)
    - Outcome from cardiac arrest – Survival to discharge
    - Outcome from acute ST-elevation myocardial infarction (STEMI)
    - Outcome from stroke
- National Clinical Performance Indicators (CPI) programme covering:
    - STEMI
    - Stroke
    - Hypoglycaemia
    - Asthma
- Ambulance Service Cardiovascular Quality Initiative (ASCQI) covering:
    - STEMI
    - Stroke
- National Ambulance Non-Conveyance Audit (NANA)

The national clinical audits that the London Ambulance Service NHS Trust **participated** in during 2011-2012 are as follows:

- Department of Health Ambulance Clinical Quality Indicators covering:
    - Outcome from cardiac arrest – Return of Spontaneous Circulation (ROSC)
    - Outcome from cardiac arrest – Survival to discharge
    - Outcome from acute ST-elevation myocardial infarction (STEMI)
    - Outcome from stroke
- National Clinical Performance Indicators (CPI) programme covering:
    - STEMI
    - Stroke
    - Hypoglycaemia
    - Asthma
- Ambulance Service Cardiovascular Quality Initiative (ASCQI) covering:
    - STEMI
    - Stroke
- National Ambulance Non-Conveyance Audit (NANA)

The national clinical audits and national confidential enquiries that the London Ambulance Service NHS Trust participated in and for which data collection was completed during 2011/2012 are listed below alongside the

number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit	Number of cases eligible for inclusion	Number of cases submitted	Percentage of cases submitted
DH ACQI: Outcome from cardiac arrest – ROSC for: a) Overall group b) Utstein comparator group	 a) 3104 b) 415	 a) 3104 b) 415	 100% 100%
DH ACQI: Outcome from cardiac arrest – Survival to discharge a) Overall group b) Utstein comparator group	 a) 3047 b) 396	 a) 3047 b) 396	 100% 100%
DH ACQI: Outcome from acute STEMI a) Thrombolysis delivered within 60 minutes of call b) Primary percutaneous coronary intervention (PPCI) delivered within 150 minutes of call. c) Care bundle delivered	 a) 6 b) 938 c) 2010	 a) 6 b) 938 c) 2010	 100% 100% 100%
DH ACQI: Outcome from stroke a) Face Arm Speech Test (FAST) positive stroke patients potentially eligible for thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of call b) Care bundle delivered	 a) 3980 b) 9269	 a) 3980 b) 9269	 100% 100%
National CPI: STEMI – auditing delivery of aspirin, GTN and analgesia and recording of two pain scores and oxygen saturation level.	600	600	100%
National CPI: Stroke – auditing assessment of Face, Arm, Speech Test (FAST), blood glucose levels, blood pressure and time of onset of stroke symptoms.	600	600	100%
National CPI: Hypoglycaemia – auditing recording of blood glucose levels before and after treatment, delivery of treatment for hypoglycaemia and if a direct referral was made to an appropriate health professional.	600	600	100%
National CPI: Asthma – auditing assessment of respiratory rate, peak flow (before treatment), oxygen saturation levels (before treatment), delivery of oxygen and beta-2 agonist.	600	600	100%
ASCQI: improve delivery of the care bundle to STEMI patients	3025	3025	100%
ASCQI: improve delivery of the care bundle to Stroke patients	3025	2375	79%
NANA: a snapshot audit of ambulance non-conveyance practice for 999 calls attended on the 24th October 2011 for a 24 hour period examining: a) Patient demographics b) Highest level of clinician at scene c) Patient Assessment d) Intervention e) Reason for non-conveyance f) Safety netting g) Re-attendance within the subsequent 24 hour period	605	605	100%

The report of three national clinical audits were reviewed by the provider in 2011-2012 and the London Ambulance Service NHS Trust intends to take the following actions to improve the quality of healthcare provided:

- Raise awareness of the STEMI care bundle through initiatives such as posters, newsletters and further education
- Increase the proportion of patients presenting with a STEMI who receive pain-relieving medicine by developing an LAS pain management training session
- Increase the number of patients presenting with a STEMI for whom two pain assessments are undertaken by creating a pain assessment tool to help patients who struggle to understand the concept of pain scoring

- Raise awareness of the stroke care bundle with posters, newsletters and further education
- Increase the number of referrals to GP's and diabetes teams for diabetic patients in London through the implementation of a new call back and referral process for non conveyed patients suffering from hypoglycaemic emergencies
- Increase the proportion of patients presenting with asthma who have their oxygen saturation level measured before treatment by exploring the introduction of portable oxygen saturation probes and paediatric probes
- Increase the number of data that is downloaded from defibrillators through feedback to staff on the findings from downloads.

The report of four local clinical audits was reviewed by the provider in 2011-2012 and the London Ambulance Service NHS Trust intends to take the following actions to improve the quality of healthcare provided:

Clinical audit of the care provided to elderly patients with a hip injury by the London Ambulance Service

- Highlight the importance of assessing the patient's pain and administering analgesia where appropriate through developing an LAS pain training session
- Reduce the number of vehicle cancellations when a response is allocated to a patient through the introduction of CommandPoint.

Clinical audit of the Clinical Telephone Advice given to patients triaged by the Medical Priority Dispatch System as '24B1' Labour (delivery not imminent, ≥5months/20 weeks) by the London Ambulance Service

- Review, shorten, and clarify the way Clinical Telephone Advice (CTA) staff should be using the Maternity Pathway Questioning Tool.
- Develop an initial screening tool that can be used by senior CTA staff members prior to the Maternity Pathway Questioning Tool.
- Develop a quality assurance process for calls where CTA staff use the Maternity Pathway Questioning Tool.
- Feedback the results of this clinical audit to the Medical Priority Dispatch System Working Group and to the Emergency Operations Centre.
- Send CTA staff a questionnaire asking for their views on the usability of the Maternity Pathway Questioning Tool.

A clinical audit examining End of Life Care in the London Ambulance Service

- Increase staff knowledge and confidence in their assessment and treatment of patients with an end-stage terminal illness through an End of Life Care training package to all crews and an advanced education package for Clinical Support Desk staff.
- Increased number of Palliative Care/End of Life Care Handover forms registered on the Patient Special Needs Locality database
- Introduce Co-ordinate My Care so Clinical Support Desk staff are able to access all palliative care patient plans to ensure correct management as per patient wishes.
- Publish guidance to instruct crews to call the Clinical Support Desk for further support and advise crews to contact the patients' palliative care team, particularly out-of-hours when deciding on a course of action.
- Remind staff about the correct use of Patient Report Form (PRF) illness codes in relation to end of life care so that incidents are coded correctly as such and not only capturing the presenting complaint.

A baseline clinical audit examining the measurement of end tidal carbon dioxide ($ETCO_2$) during advanced airway management of cardiac arrest patients by the London Ambulance Service

- Increase the number of $ETCO_2$ waveforms that are included in the electronic clinical record for this patient group by ensuring the corresponding Computer Aided Dispatch (CAD) number

is documented when an $ETCO_2$ reading is taken and remind Station Administrators that waveforms should be sent to Management Information with the associated PRF.

- Remind staff the preferential use of a supraglottic airway devices, emphasising that it is a safe and effective way of maintaining a patient's airway by writing an article for the Clinical Update.
- Review Advanced Life Support in the Core Skills Refresher 1 training to include particular emphasis on the preferential use of supraglottic airway devices and including waveform print outs in the patient's clinical record.

The results of 7 local clinical audits were presented to the Trust Board in 2011/2012.

- April 11 – National CPI Cycle 5, Summary of Findings
- June 11 – Stroke Care Project Summary Report
- August 11 – LAS Cardiac Arrest Annual Report 10/11
- November 11 – Clinical Audit of CTA given to patients triaged by MPDS as 24B1 labour
- December 11 – National CPI Cycle 6, Summary of Findings
- January 12 – Clinical Audit and Research Summary Report on ASCQI
- March 12 – Clinical Audit of End of Life Care in LAS

In addition, the London Ambulance Service NHS Trust conducts a of programme of Clinical Performance Indicators and four ongoing clinical quality audits which monitor the care provided to patients who have had a cardiac arrest, STEMI or stroke, or have been involved in a major trauma incident. Monthly reports outlining performance in these areas are produced to enable quality improvements in clinical care.

Information: Clinical Performance Indicators (CPIs) are a tool designed to bring continual improvement to the clinical care provided by the London Ambulance Service NHS Trust. They focus on clinical areas where there is strong evidence that following the correct practice leads to the best outcome for patients, or where there is a clinical risk associated with the patient group. The delivery of care in these areas is fed back to crew members on a one-on-one basis so they can make personalised recommendations on how they can improve performance. This process has led to clear improvements in care over time. For example, as a direct result of the CPI process the London Ambulance Service NHS Trust has improved reporting of second set of observations for all patient groups, but in particular for those patients not conveyed to hospital where there has been a 7% Service wide improvement since the beginning of the financial year.

Statement Area 4 Research

The number of patients receiving NHS services provided or sub-contracted by the London Ambulance Service NHS Trust in 2011/12 that were recruited during that period to participate in research approved by a research ethics committee was 1,028. This represents a significant increase in recruitment from 2010/11, when we recruited 164 patients into research approved by a research ethics committee.

Participation in clinical research demonstrates the London Ambulance Service NHS Trust's commitment to improving the quality of care and contributing to wider healthcare improvement. Our clinical staff stay abreast of the latest possible treatment options and actively participate in research that leads to successful patient outcomes.

The London Ambulance Service NHS Trust was involved in three clinical research studies in pre-hospital care during 2011/12. There were 417 clinical staff participating in research approved by a research ethics committee at the London Ambulance Service NHS Trust during 2011/12.

These staff participated in research covering two medical specialties. These were:

- DANCE (high risk acute coronary syndrome): Pilot randomised controlled trial (RCT) comparing direct angioplasty for non-ST-elevation acute coronary events vs. conventional management.
- Paramedic SVT: RCT comparing the safety and efficacy of paramedic treatment of regular supraventricular tachycardia using pre-hospital administration of adenosine vs. conventional management.
- SAFER 2: Cluster RCT comparing the clinical and cost effectiveness of new protocols for ambulance workers to assess and refer elderly fallers to appropriate community based care vs. conventional practice.

It is important to note that as well as recruiting patients we also conducted research involving staff and student paramedics as participants. These recruitment numbers have not been included in the 1,028 figure above, which only includes patient numbers. The total number of LAS staff and student paramedics participating in research as participants in 2010/11 was 915.

The number of participants and the number of staff involved in conducting all types of studies in the LAS during 2011/12 are displayed in the table below.

Study name	**Participants recruited in 2011/12**	**LAS clinical staff involved**
NHS REC approved studies involving patients		
Care of older people who fall: evaluation of the clinical and cost effectiveness of new protocols for emergency ambulance paramedics to assess and refer to the appropriate community based care (SAFER2)	930	87
High Risk Acute Coronary Syndrome (ACS) (*formerly known as 'DANCE'*)	60	250
Safety and Efficacy of Paramedic treatment of regular Supraventricular Tachycardia (ParaSVT)	38	80
NHS REC approved studies involving LAS staff and student paramedics as participants		
Engaging Ambulance Clinicians in Quality Improvement: Questionnaire Study (ASCQI)	308	1
Quality and Safety in the NHS: Evaluating Progress, Problems and Promise (QSN)	59	-
Identifying emergency personnel at risk of post traumatic stress disorder (PTSD)	390 (in follow-up)	-
How do emergency service workers cope with the traumatic events they are exposed to?	10	-
The student experience of university paramedic education/training – from classroom learning to situational understanding	1	-
Studies involving LAS staff and student paramedics as participants (not requiring NHS REC review)*		
Quantitative Assessment of simulated infant chest compressions on a novel infant CPR manikin as delivered by trained healthcare personnel	9	-
Is 'Practice Placement Education' (PPEd) appropriate for student paramedics?	25	1
Does solo emergency responding have an impact on psychological health and levels of work-related stress in ambulance workers	113	1

- From 1st September 2011, research involving NHS staff no longer requires NHS REC review unless there is a legal requirement for review as specified in 'Governance arrangements for research ethics committees: a harmonised edition'

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In addition, during the last three years, eleven publications have resulted from our involvement in research, which shows our commitment to disseminating practice and desire to improve patient outcomes and experience across the NHS. The publications include, in 2009: *'Out of Hospital Cardiac Arrest in South Asian and White Populations in London'* published in the Heart journal and *'Complexity of the decision making process of ambulance staff for assessment and referral of older people who have fallen: a qualitative study*' in the Emergency Medical Journal; in 2010: *'CPR with chest compression alone or with rescue breath'* in the New England Journal of Medicine and *'Out of hospital cardiac arrest in patients aged 35 years and under: A four year study of incidence and survival in London'* in the Resuscitation journal, and in 2012: *'Decision-making by ambulance clinicians in London when managing patients with epilepsy: a qualitative study'* published in the Emergency Medicine Journal. Our engagement with clinical research also demonstrates the London Ambulance Service NHS Trust's commitment to testing and offering the latest medical treatments and techniques.

In addition to research, the LAS also facilitates a number of descriptive, feasibility and evaluation projects aimed at improving patient experiences and the quality of care delivered.

Our commitment to research as a driver for improving the quality of care and the patient experience is further demonstrated by our Annual Research Conference, Journal Clubs and Research Advice Surgeries. Our Annual Conference 'Research to Clinical Practice: How Research in the LAS Influences Patient Care' was held on 4th May 2011 and was attended by 86 members of staff. Topics included, 'Ventricular Fibrillation - A Tale of Two Cities' which presented the findings of an international project, the preliminary results of a large scale prospective study in Post-Traumatic Stress Disorder, and a presentation of the 'Improving Stroke Recognition by Ambulance Services' study which was led by the LAS. During 2011/12, we held 3 Journal Clubs, attended by 54 staff, through which staff reviewed and critically appraised scientific publications; topics covered include trauma in London, the quality of chest compressions in cardiac arrests, Chronic Obstructive Pulmonary Disease and care of mental health patients. Additionally, we held Research Advice Surgeries for staff interested in undertaking research to help guide and develop new research. Furthermore, the contents pages of medical journals are circulated to all staff on a monthly basis to enable them to keep updated with the latest scientific evidence; copies of the full articles can then be accessed through our library.

We have an extensive collaborative research portfolio for the forthcoming 2012/13 period, which includes the following studies:

- High Risk ACS (*formerly known as 'DANCE'*): Pilot RCT comparing direct angioplasty for non-ST-elevation acute coronary events vs. conventional management.
- Safety and Efficacy of Paramedic treatment of regular Supraventricular Tachycardia (ParaSVT): RCT comparing the safety and efficacy of paramedic treatment of regular supraventricular tachycardia using pre-hospital administration of adenosine vs. conventional management.
- Care of older people who fall: evaluation of the clinical and cost effectiveness of new protocols for emergency ambulance paramedics to assess and refer to the appropriate community based care (SAFER 2): Cluster RCT comparing the clinical and cost effectiveness of new protocols for ambulance workers to assess and refer elderly fallers to appropriate community based care vs. conventional practice.
- Identifying emergency personnel at risk of post traumatic stress disorder (PTSD): Longitudinal study investigating risk factors of post-traumatic stress disorder in student paramedics.
- Assessment of call handling speed and equity of calls from non-English speaking callers to a large metropolitan Ambulance Service: An investigation into whether call handling speed and allocated response differs between English and non-English speaking callers.
- The student experience of university paramedic education/training – from

classroom learning to situational understanding: Observational study exploring acculturation within the ambulance service and how this may influence student paramedics.

- Informing delivery of care through research evidence: An investigation of randomised control trial implementation in pre-hospital emergency care: An investigation into the factors affecting implementation of RCTs in pre-hospital emergency care.
- The use of section 136 of the UK mental health act in SW London: Investigation into healthcare professionals' experiences of using Section 136 of the UK Mental Health Act.
- A Critical Discourse Analysis of Paramedics' talk about their administration of analgesia to patients who are cognitively impaired: Qualitative study exploring how paramedics decide to administer analgesia to cognitively impaired patients.

Statement Area 5 CQUINs

A proportion of the London Ambulance Service NHS Trust's income in 2011/2012 was conditional on achieving quality improvement and innovation goals agreed between London Ambulance Service NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the commissioning for Quality and Innovation payment framework.

The details of the agreed goals for 2011/2012 are as follows;

1a. Reducing conveyance rate to A&E services (£996,765 maximum and £747,574 achieved).
1b. Hear & treat resolution (no convey) via clinical telephone advice & NHS Direct (£746,640 maximum and £746,640 achieved).
1c. Implementation of NHS pathways in clinical telephone advice (£746,640 maximum and £447,984 achieved.
1d Clinical performance indicator non conveyed (£248,631 maximum and £0 achieved).

2a Falls and older people referrals to GPs (£248,631 maximum and £248,631 achieved).
3a End of life care patients held on our system (£90,129 maximum and £52,834 achieved).
3b End of life care usage of register by our staff to affect outcome (£124,316 maximum and £71,482 achieved).

4a Mental health service improvement plan, including outcome of wider mental health review (£124,362 maximum and £99,476 achieved).
4b Development of mental health protocols for direct access to mental health crisis teams (£127,271 maximum and £62,138 achieved).

5a Whole system clinical group established & effective including joint review of referral, treatment & discharge protocols, including specific review of protocol frequent callers, metropolitan police & high referring/call locations (£111,837 maximum and 99,404 achieved.
5b Whole system clinical incident reporting & resolution 124,372 maximum and 105,714 achieved).

The details of the agreed goals for 2012/2013 are as follows

1a. Increase in See & Treat and See & Refer (£372,000)
1b. Increase in Appropriate/Alternative Care Pathways (£310,000)
1c. Overall reduction in conveyance to Emergency Department (£372,000)

2. Increase in hear & treat (£496,000)

3a. Diabetes Management (hypoglycaemia) (£248,000)
3b. Diabetes Management (Hyperglycaemia) (£248,000)

4a. Evaluation of Alcohol Recovery Service (£558,000)
4b. Alcohol health promotion (£372,000)

5a. GP information sharing of patient level data (£496,000)
5b. GP Information sharing of NHS Number (£496,000)
5c Information regarding frequent callers (£248,000)

6a. Patient experience audit (£186,000)
6b. Use of Urgent Care Toolkit (£186,000)
6c. Core Skills Training for staff (£186,000)
6d. Monitoring long delays (£186,000)

7a. Introduction of allocated rest breaks (£496,000)
7b. Change the annual leave arrangement (£496,000)
7c. Review of the staff roster (£248,000)

Statement Area 6 Care Quality Commission

The London Ambulance Service NHS Trust is required to register with the Care Quality Commission and its current registration status is "registered". The London Ambulance Service NHS Trust has no conditions on registration

The Care Quality Commission has not taken enforcement action against The London Ambulance Service NHS Trust during 2011/2012.

The London Ambulance Service NHS Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2011/2012.

Statement area 7 Data Quality

The London Ambulance Service NHS Trust will be taking the following actions to improve data quality;

Data features within our CQUINs in 2012-2013 particularly our compliance with the capture of patients NHS number. Specific targets and measures for this will be agreed with our commissioners.

Statement area 8 NHS Number and General medical Practice Code Validity

The London Ambulance Service NHS Trust was not required to submit records during 2011/2012 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

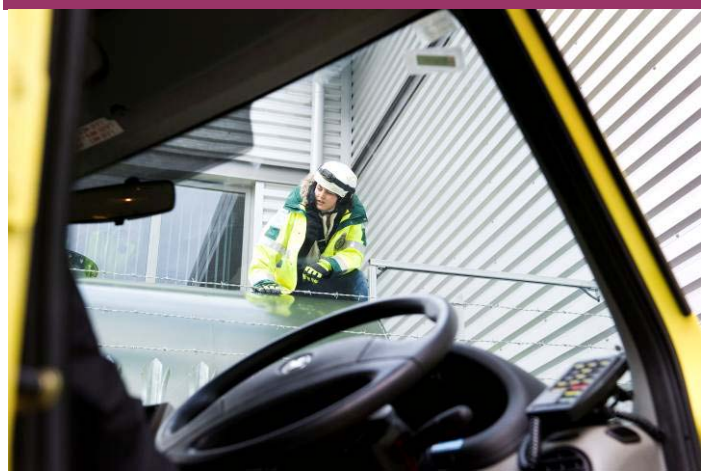
The London Ambulance Service NHS Trust was not required to submit records during 2011/2012 using patient's valid General medical Practice Code

Statement area 9 Information Governance Toolkit Attainment Levels

The London Ambulance Service NHS Trust Information Governance Assessment Report score overall score for 2011/2012 was 79% and was graded at level 2

Statement area 10; Payment by results

The London Ambulance Service NHS Trust was not subject to the Payment by Results clinical coding audit during 2011/2012 by the Audit Commission.



Part 4: Looking Back

Section A. National Quality Indicators

Review of Quality Performance 2011/2012

2011/2012 saw the introduction of the national ambulance quality indicators. These are a set of measures that allow individual Ambulance Trusts to look where they lie in comparison with other NHS ambulance providers. It is not always possible to draw direct comparisons as services differ slightly across the country but it allows Ambulance Trusts to use the information analytically.

The following graphs illustrate the London Ambulance Service NHS Trust year end position in all 12 quality measures. However, not all the measures include a whole year of data as some of the measures required extensive data quality checking therefore the data for those includes data from April to December 2011.

Measure 1. Outcome from acute ST-elevation myocardial infarction (STEMI)

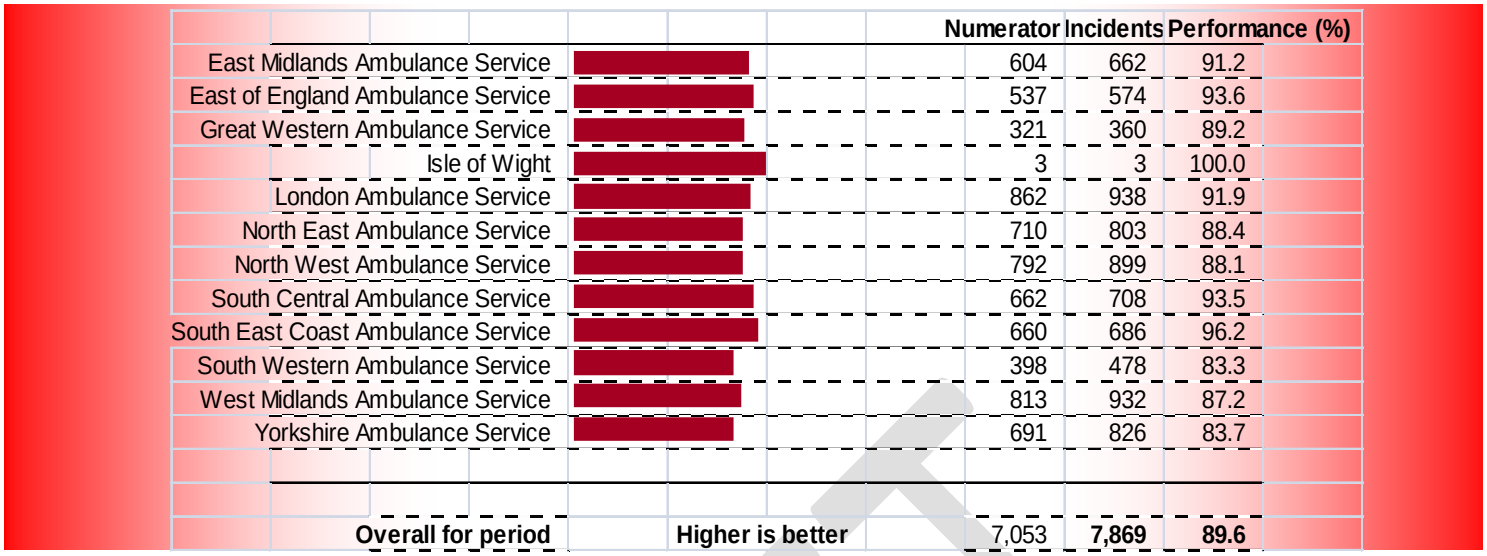
STEMI is an acronym meaning 'ST (a particular segment) Elevation Myocardial Infarction', which is a type of heart attack. Early access to cardiac intervention is considered an important element in reducing the mortality and morbidity associated with a STEMI.

There are three elements to this quality measure the first two of which measure speed or time. The final element measures the care undertaken by the clinical staff employed in the ambulance service and asks Trusts to record when aspirin is given, when Glyceryl Trinitrate (GTN) is given, when 2 pain scores are recorded and when a patient has received analgesia of either Morphine or Entenox.

Element 1; Percentage of patients suffering a ST-elevation myocardial infarction (STEMI) receiving thrombolysis within 60 minutes of call (Year end position)

The London Ambulance Service NHS Trust does not participate in this measure as the service does not administer thrombolysis. This is because there are no areas within the services catchment where an appropriate hospital that can administer the intervention can be accessed within the hour. This is different in other areas in the country where Accident & Emergency departments are some distance away so ambulance clinical staff are trained to deliver the intervention.

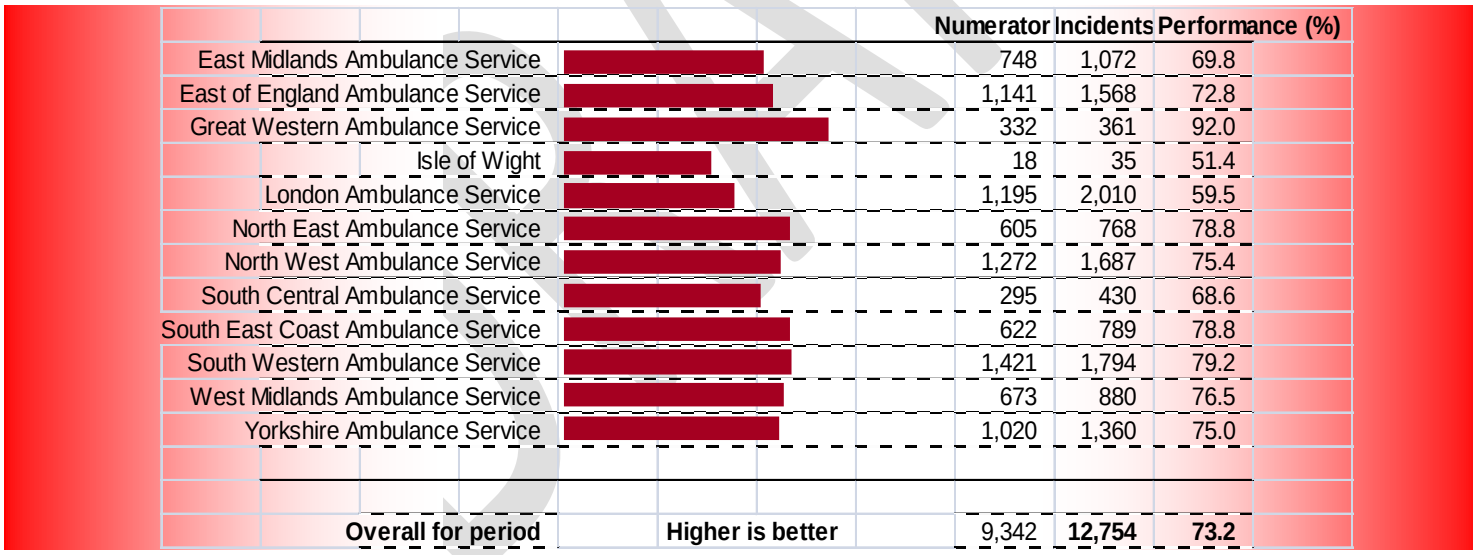
Element 2; Graph 1:Percentage of patients suffering a STEMI who are directly transferred to a centre capable of delivering primary percutaneous coronary intervention (PPCI) and receive angioplasty within 150 minutes of call (Year end position)



		Numerator	Incidents	Performance (%)
East Midlands Ambulance Service		604	662	91.2
East of England Ambulance Service		537	574	93.6
Great Western Ambulance Service		321	360	89.2
Isle of Wight		3	3	100.0
London Ambulance Service		862	938	91.9
North East Ambulance Service		710	803	88.4
North West Ambulance Service		792	899	88.1
South Central Ambulance Service		662	708	93.5
South East Coast Ambulance Service		660	686	96.2
South Western Ambulance Service		398	478	83.3
West Midlands Ambulance Service		813	932	87.2
Yorkshire Ambulance Service		691	826	83.7
Overall for period	**Higher is better**	7,053	**7,869**	**89.6**

The majority of ambulance services are performing at a level where over 90% of patients are receiving the intervention within 150 minutes of the call. The London Ambulance Service NHS Trust achieved a rate of 91.9% from April 2011-December 2011.

Element 3; Graph 2: Percentage of patients suffering a STEMI who receive an appropriate care bundle (Year end position)



		Numerator	Incidents	Performance (%)
East Midlands Ambulance Service		748	1,072	69.8
East of England Ambulance Service		1,141	1,568	72.8
Great Western Ambulance Service		332	361	92.0
Isle of Wight		18	35	51.4
London Ambulance Service		1,195	2,010	59.5
North East Ambulance Service		605	768	78.8
North West Ambulance Service		1,272	1,687	75.4
South Central Ambulance Service		295	430	68.6
South East Coast Ambulance Service		622	789	78.8
South Western Ambulance Service		1,421	1,794	79.2
West Midlands Ambulance Service		673	880	76.5
Yorkshire Ambulance Service		1,020	1,360	75.0
Overall for period	**Higher is better**	9,342	**12,754**	**73.2**

The London Ambulance Service appears to be under performing when compared to other Ambulance Trusts with 59.5% of patients receiving an appropriate care bundle. However, this is not strictly accurate as the data submission only permits the counting of patients who receive Morphine or Entenox for pain relief. As a service the London Ambulance Service NHS Trust offers alternative pain relief therapy, such as positioning, for patients who declare their pain is relatively minor.

Measure 2. Outcome from cardiac arrest - return of spontaneous circulation.

The aim of this indicator is to reduce the mortality associated with a cardiac arrest. The indicator measures the overall effectiveness of the urgent and emergency care services by considering how many patients have a pulse or heartbeat on arrival to hospital following a cardiac arrest. However, it is known that those patients who have their cardiac arrest witnessed are more likely to survive the episode than those who have a cardiac arrest while unobserved. This significantly shortens the length of time that it takes the emergency services to respond.

Therefore, the measure is broken into two indicators. The first counts all of the cardiac arrests whilst the second cunts only those that are witnessed.

Element 1; Graph 4 Return of spontaneous circulation (ROSC) at time of arrival at hospital (Overall) (Year end position)

		Numerator	Incidents	Performance (%)
East Midlands Ambulance Service		123	747	16.5
East of England Ambulance Service		408	2,424	16.8
Great Western Ambulance Service		158	730	21.6
Isle of Wight		19	91	20.9
London Ambulance Service		913	3,104	29.4
North East Ambulance Service		211	985	21.4
North West Ambulance Service		543	2,161	25.1
South Central Ambulance Service		248	1,334	18.6
South East Coast Ambulance Service		453	1,662	27.3
South Western Ambulance Service		374	1,520	24.6
West Midlands Ambulance Service		446	1,680	26.5
Yorkshire Ambulance Service		349	1,998	17.5
Overall for period	**Higher is better**	4,245	**18,436**	**23.0**

Residents and visitors to London appear to have a good outcome with 29.4% of all cardiac arrests having a pulse, or heartbeat, on arrival at hospital.

Element 2; Graph 5Return of spontaneous circulation (ROSC) at time of arrival at hospital (Utstein) (Year end position)

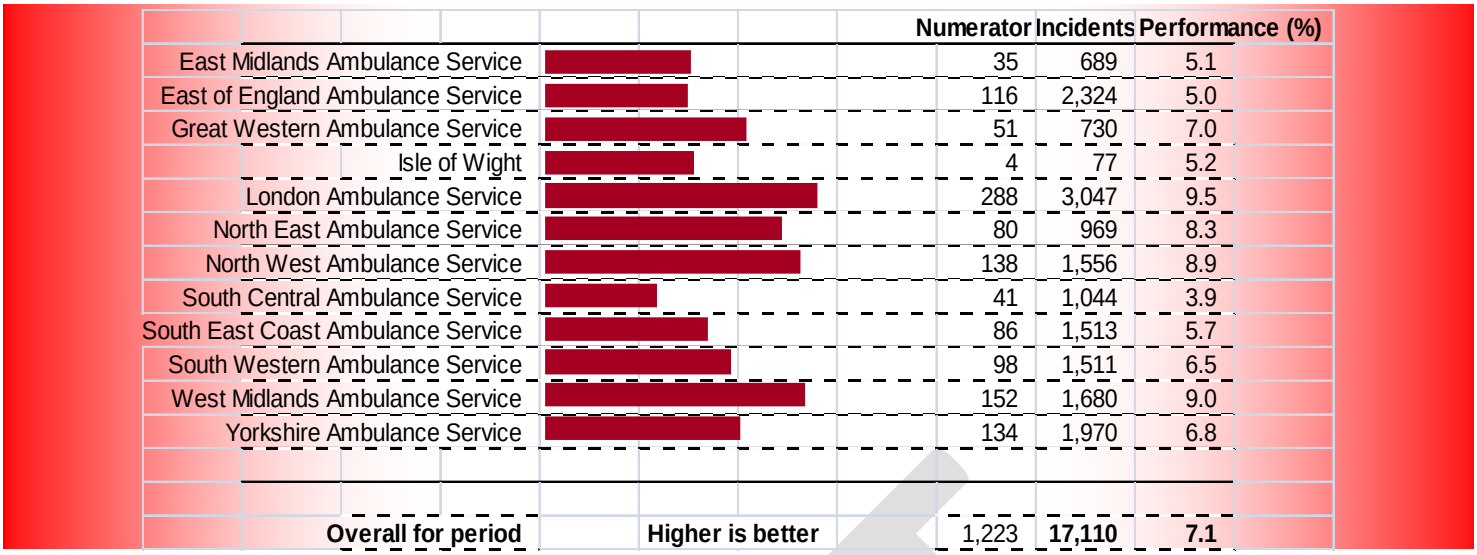
		Numerator	Incidents	Performance (%)
East Midlands Ambulance Service		36	100	36.0
East of England Ambulance Service		141	311	45.3
Great Western Ambulance Service		51	130	39.2
Isle of Wight		7	17	41.2
London Ambulance Service		223	415	53.7
North East Ambulance Service		110	236	46.6
North West Ambulance Service		107	288	37.2
South Central Ambulance Service		40	119	33.6
South East Coast Ambulance Service		107	204	52.5
South Western Ambulance Service		96	229	41.9
West Midlands Ambulance Service		95	210	45.2
Yorkshire Ambulance Service		87	242	36.0
Overall for period	**Higher is better**	1,100	**2,501**	**44.0**

London has the highest number of witnessed arrests and again the table shows a good outcome with 53.7% of witnessed cardiac arrests having a pulse or heartbeat on arrival at hospital.

Measure 3. Outcome from cardiac arrest - survival to discharge

Following on from the second indicator, this one measures the rate of those who recover from cardiac arrest and are subsequently discharged from hospital. Again this is broken into the all cardiac arrest group and the witnessed cardiac arrest group.

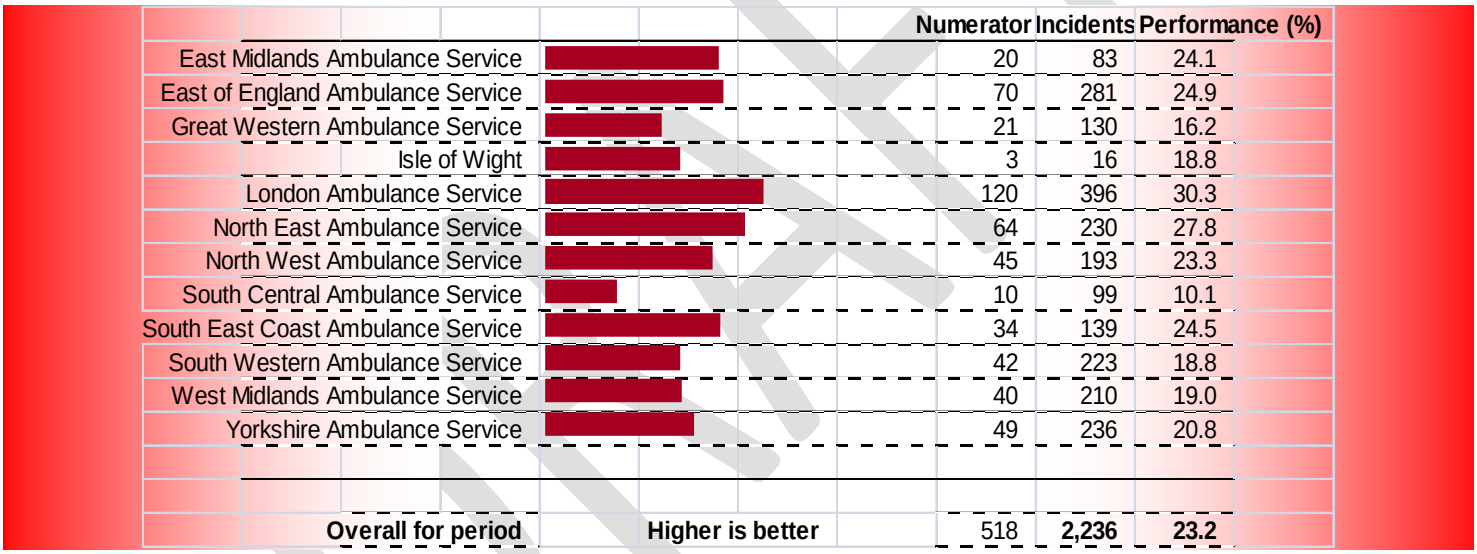
Element 1; Graph 6 Survival to discharge – Overall survival rate (Year end position)



		Numerator	Incidents	Performance (%)
East Midlands Ambulance Service		35	689	5.1
East of England Ambulance Service		116	2,324	5.0
Great Western Ambulance Service		51	730	7.0
Isle of Wight		4	77	5.2
London Ambulance Service		288	3,047	9.5
North East Ambulance Service		80	969	8.3
North West Ambulance Service		138	1,556	8.9
South Central Ambulance Service		41	1,044	3.9
South East Coast Ambulance Service		86	1,513	5.7
South Western Ambulance Service		98	1,511	6.5
West Midlands Ambulance Service		152	1,680	9.0
Yorkshire Ambulance Service		134	1,970	6.8
Overall for period	**Higher is better**	1,223	**17,110**	**7.1**

This shows that 9.5% of all patients who had a cardiac arrest in the London region survived to be discharged from hospital. This is the best rate in the country.

Element 2; Graph 7: Survival to discharge – Utstein Comparator Group survival rate (Year end position)



		Numerator	Incidents	Performance (%)
East Midlands Ambulance Service		20	83	24.1
East of England Ambulance Service		70	281	24.9
Great Western Ambulance Service		21	130	16.2
Isle of Wight		3	16	18.8
London Ambulance Service		120	396	30.3
North East Ambulance Service		64	230	27.8
North West Ambulance Service		45	193	23.3
South Central Ambulance Service		10	99	10.1
South East Coast Ambulance Service		34	139	24.5
South Western Ambulance Service		42	223	18.8
West Midlands Ambulance Service		40	210	19.0
Yorkshire Ambulance Service		49	236	20.8
Overall for period	**Higher is better**	518	**2,236**	**23.2**

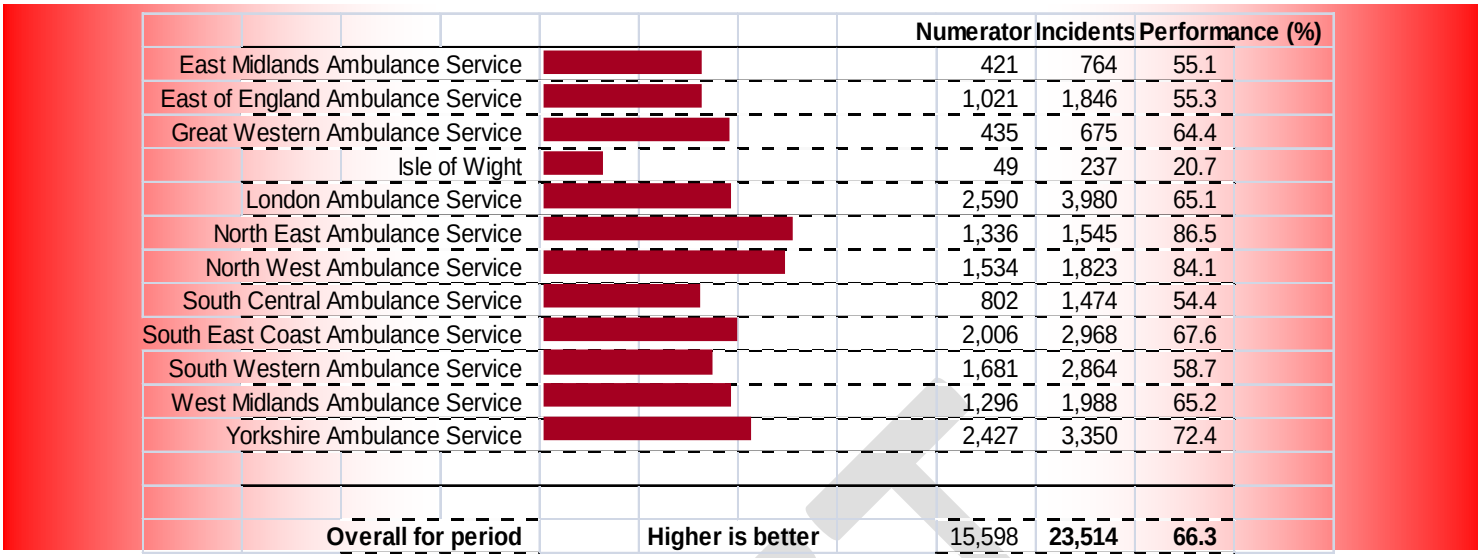
This graph really demonstrates the benefits to outcome when a cardiac arrest is witnessed as this shows that 30.3% of all patients who had a cardiac arrest witnessed in the London region survived to be discharged from hospital. This is also the best rate in the country

Measure 4. Outcome following stroke for ambulance patients

Patients should be arriving at an appropriate place as soon as possible following the onset of a stroke. Time to confirmed diagnosis and treatment is key to reducing mortality associated with a stroke. This indicator requires ambulance services to measure the time it takes from the 999 call to the time it takes those positive stroke patients to arrive at a specialist stroke centre so that they can be rapidly assessed for thrombolysis treatment.

There are two indicators to this measure. The first records the time and the second considers the care given by ambulance clinical staff. The care should include the completion of a stroke diagnostic test (called a FAST test), the checking of a patient's blood glucose and a complete blood pressure taken.

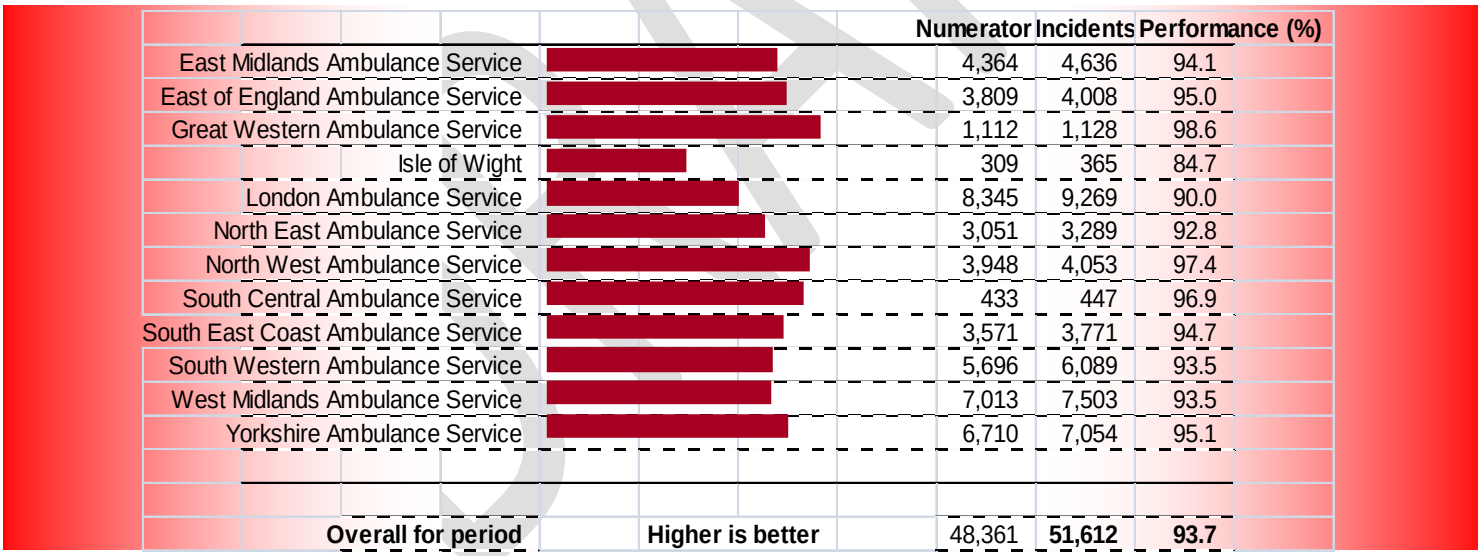
Element 1; Graph 8: Percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of call (Year end position)



		Numerator	Incidents	Performance (%)
East Midlands Ambulance Service		421	764	55.1
East of England Ambulance Service		1,021	1,846	55.3
Great Western Ambulance Service		435	675	64.4
Isle of Wight		49	237	20.7
London Ambulance Service		2,590	3,980	65.1
North East Ambulance Service		1,336	1,545	86.5
North West Ambulance Service		1,534	1,823	84.1
South Central Ambulance Service		802	1,474	54.4
South East Coast Ambulance Service		2,006	2,968	67.6
South Western Ambulance Service		1,681	2,864	58.7
West Midlands Ambulance Service		1,296	1,988	65.2
Yorkshire Ambulance Service		2,427	3,350	72.4
Overall for period	**Higher is better**	15,598	**23,514**	**66.3**

This graph reveals that some other ambulance services are managing to convey stroke patients to a hyperacute unit faster than the London Ambulance Service. The service needs to understand this further and will undertake work in 2012/2013 to improve this position.

Element 2; Graph 9: Percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle (Year end position)



		Numerator	Incidents	Performance (%)
East Midlands Ambulance Service		4,364	4,636	94.1
East of England Ambulance Service		3,809	4,008	95.0
Great Western Ambulance Service		1,112	1,128	98.6
Isle of Wight		309	365	84.7
London Ambulance Service		8,345	9,269	90.0
North East Ambulance Service		3,051	3,289	92.8
North West Ambulance Service		3,948	4,053	97.4
South Central Ambulance Service		433	447	96.9
South East Coast Ambulance Service		3,571	3,771	94.7
South Western Ambulance Service		5,696	6,089	93.5
West Midlands Ambulance Service		7,013	7,503	93.5
Yorkshire Ambulance Service		6,710	7,054	95.1
Overall for period	**Higher is better**	48,361	**51,612**	**93.7**

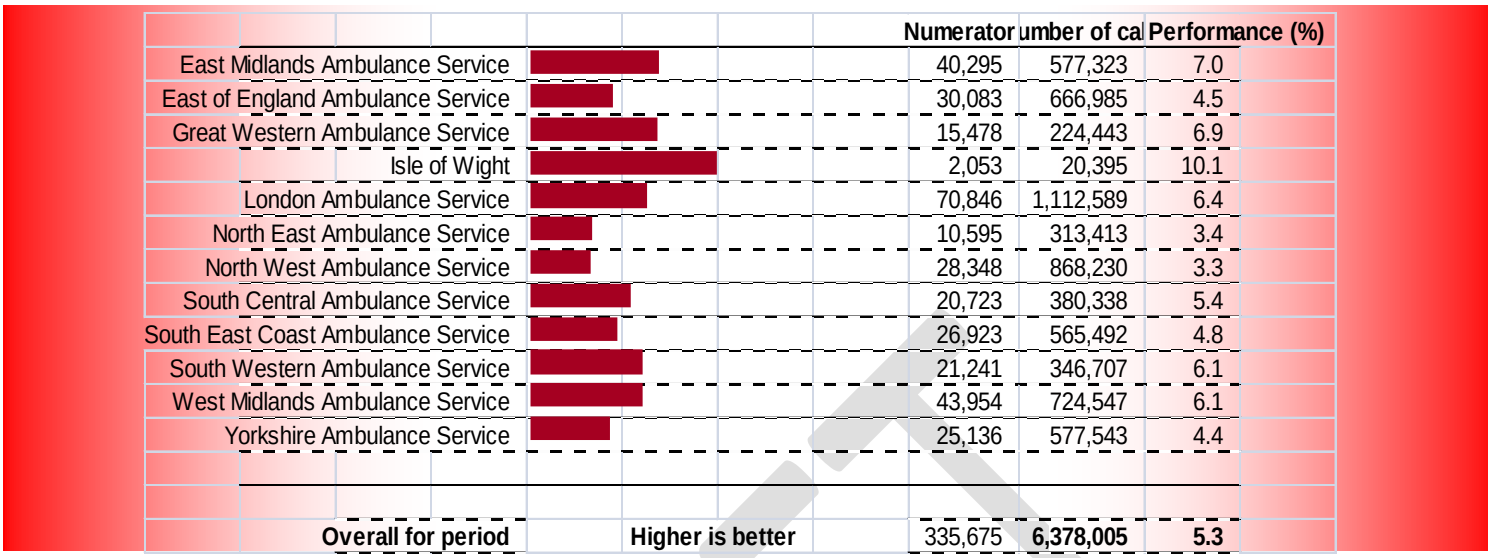
This graph suggests other ambulance services perform better than the London Ambulance Service. However, the Trust is reasonably confident that this is a data collection issue in that the clinical staff are not recording FAST test performed in the correct area of the form and therefore compliance is not recorded by the automated scanning of documentation. This will also be reviewed in 2012/2013.

Measure 5. Proportion of calls closed with telephone advice or managed without transport to A&E (where clinically appropriate)

This indicator reflects how the whole urgent care system is working, rather than simply the ambulance service or Accident & Emergency, as it will reflect the availability of alternative urgent care destinations (for example, walk-in centres) and providing treatment to patients in their home.

This is a single indicator that is simply made up of the number of calls the London Ambulance Service provided an intervention where an ambulance was not required.

Graph 10: Percentage of 999 calls that have been resolved by providing telephone advice (Year end position)



		Numerator	umber of ca	Performance (%)
East Midlands Ambulance Service		40,295	577,323	7.0
East of England Ambulance Service		30,083	666,985	4.5
Great Western Ambulance Service		15,478	224,443	6.9
Isle of Wight		2,053	20,395	10.1
London Ambulance Service		70,846	1,112,589	6.4
North East Ambulance Service		10,595	313,413	3.4
North West Ambulance Service		28,348	868,230	3.3
South Central Ambulance Service		20,723	380,338	5.4
South East Coast Ambulance Service		26,923	565,492	4.8
South Western Ambulance Service		21,241	346,707	6.1
West Midlands Ambulance Service		43,954	724,547	6.1
Yorkshire Ambulance Service		25,136	577,543	4.4
Overall for period	**Higher is better**	335,675	**6,378,005**	**5.3**

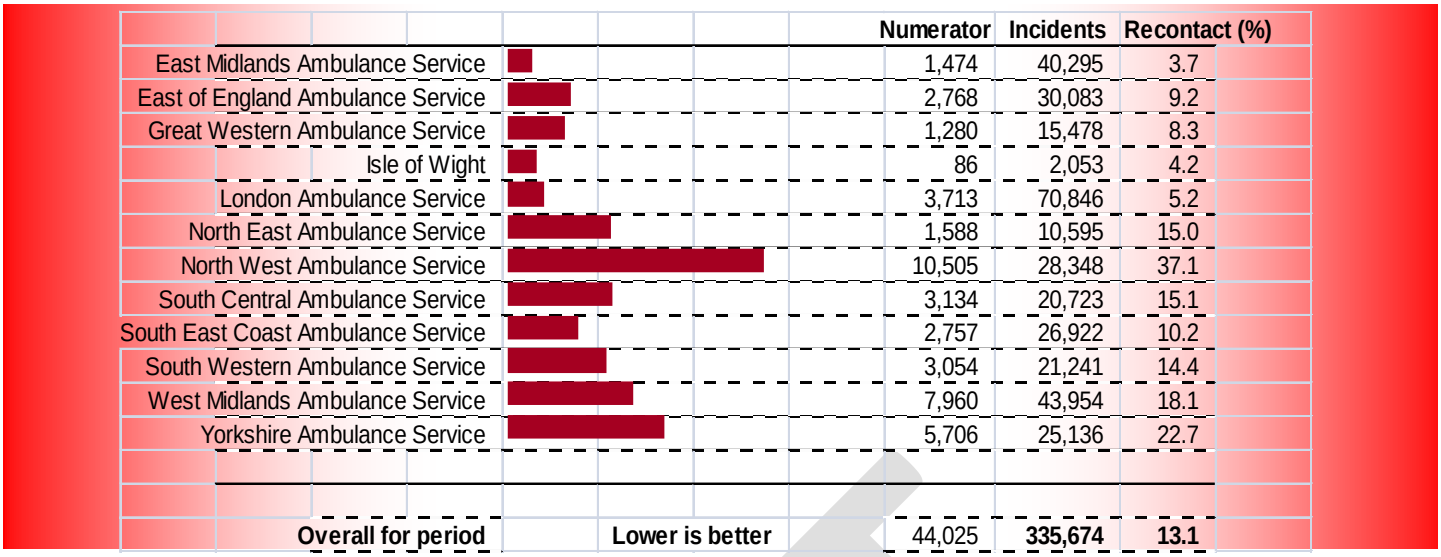
The graph reveals that the London Ambulance Service has the highest number of calls and the highest number of calls that receive a telephone intervention. As a rate the Trust is the second highest ambulance service in the country. This means that many patients were not inconvenienced by being taken to Accident & Emergency when a more immediate solution was possible.

Measure 6. Re-contact rate following discharge of care (i.e. closure with telephone advice or following treatment at the scene)

If patients have to go back and call 999 a second time, it is usually because they are anxious about receiving an ambulance response or have not got better as expected. Occasionally it may be due to an unexpected or a new problem. To ensure that ambulance trusts are providing safe and effective care the first time this indicator will measure how many callers or patients call the Ambulance Trust back within 24 hours of the initial call being made.

The measure is broken down into 2 indicators. The first is the number of patients that call back following clinical advice over the telephone and the second is the number of patients that call back after being given an intervention at home and discharge (not taken to Accident & Emergency)

Element 1. Graph 11:Percentage re-contact following discharge of care by telephone (Year end position)

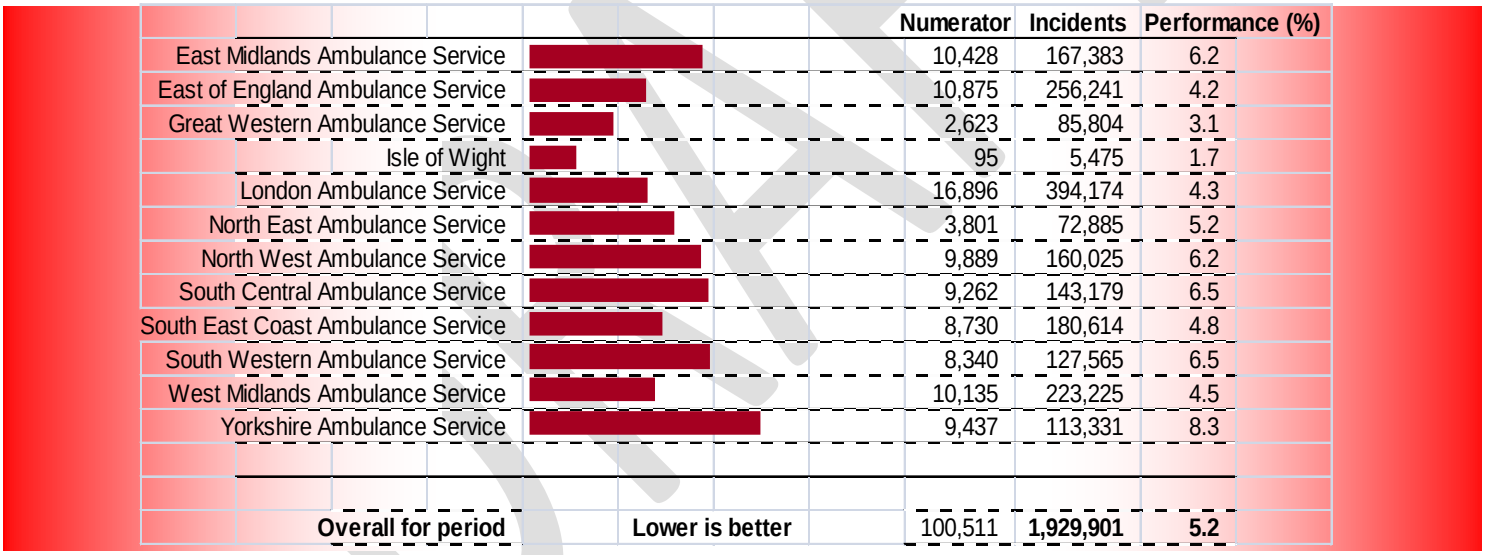


	Numerator	Incidents	Recontact (%)
East Midlands Ambulance Service	1,474	40,295	3.7
East of England Ambulance Service	2,768	30,083	9.2
Great Western Ambulance Service	1,280	15,478	8.3
Isle of Wight	86	2,053	4.2
London Ambulance Service	3,713	70,846	5.2
North East Ambulance Service	1,588	10,595	15.0
North West Ambulance Service	10,505	28,348	37.1
South Central Ambulance Service	3,134	20,723	15.1
South East Coast Ambulance Service	2,757	26,922	10.2
South Western Ambulance Service	3,054	21,241	14.4
West Midlands Ambulance Service	7,960	43,954	18.1
Yorkshire Ambulance Service	5,706	25,136	22.7
Overall for period	44,025	**335,674**	**13.1**

Lower is better

The graph demonstrates that the London Ambulance Service has the second lowest recontact rate following telephone advice.

Element 2. Graph 12: Percentage re-contact rate following discharge of care on scene (Year end position)



	Numerator	Incidents	Performance (%)
East Midlands Ambulance Service	10,428	167,383	6.2
East of England Ambulance Service	10,875	256,241	4.2
Great Western Ambulance Service	2,623	85,804	3.1
Isle of Wight	95	5,475	1.7
London Ambulance Service	16,896	394,174	4.3
North East Ambulance Service	3,801	72,885	5.2
North West Ambulance Service	9,889	160,025	6.2
South Central Ambulance Service	9,262	143,179	6.5
South East Coast Ambulance Service	8,730	180,614	4.8
South Western Ambulance Service	8,340	127,565	6.5
West Midlands Ambulance Service	10,135	223,225	4.5
Yorkshire Ambulance Service	9,437	113,331	8.3
Overall for period	100,511	**1,929,901**	**5.2**

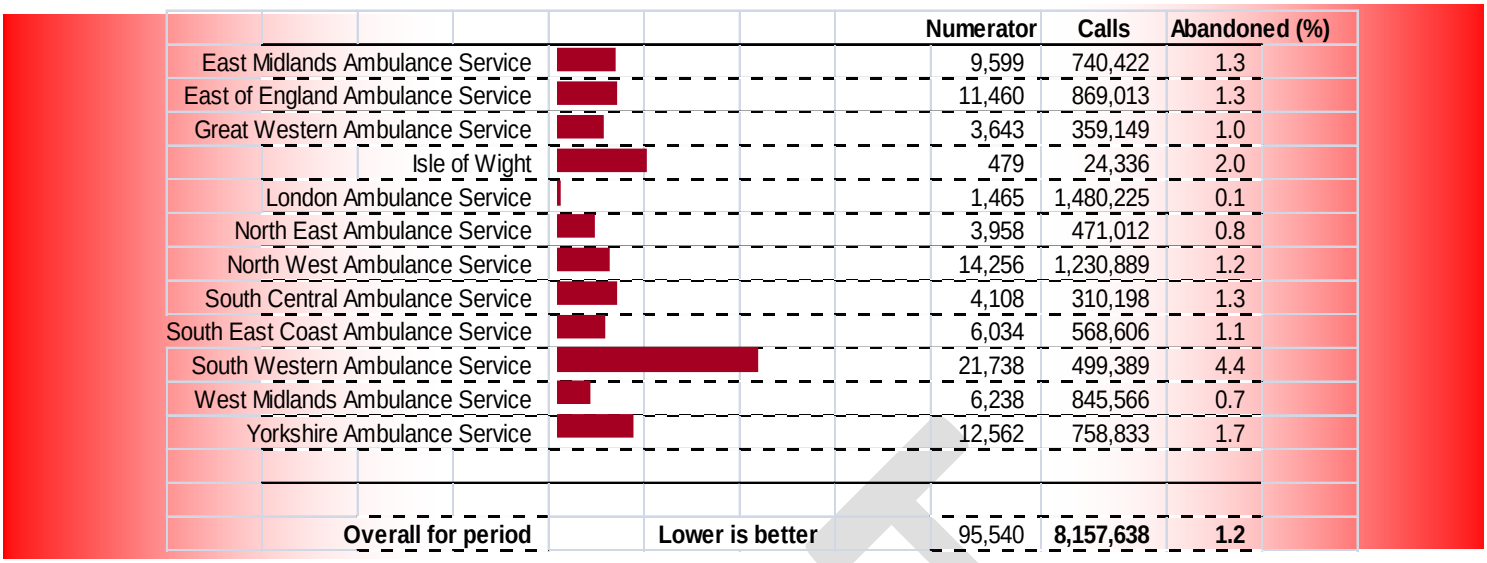
Lower is better

The graph demonstrates that the London Ambulance Service has the third lowest recontact rate following telephone advice.

Measure 7. Call abandonment rate

This indicator measures if patients phoning 999 and not being able to get through and are hanging up before being answered.

Graph 13: Percentage of calls abandoned before being answered (Year end position)



		Numerator	Calls	Abandoned (%)
East Midlands Ambulance Service		9,599	740,422	1.3
East of England Ambulance Service		11,460	869,013	1.3
Great Western Ambulance Service		3,643	359,149	1.0
Isle of Wight		479	24,336	2.0
London Ambulance Service		1,465	1,480,225	0.1
North East Ambulance Service		3,958	471,012	0.8
North West Ambulance Service		14,256	1,230,889	1.2
South Central Ambulance Service		4,108	310,198	1.3
South East Coast Ambulance Service		6,034	568,606	1.1
South Western Ambulance Service		21,738	499,389	4.4
West Midlands Ambulance Service		6,238	845,566	0.7
Yorkshire Ambulance Service		12,562	758,833	1.7
Overall for period	**Lower is better**	95,540	**8,157,638**	**1.2**

Time to answer calls

It equally important that if patients dial 999 that they get their call answered quickly. This indicator measures how quickly all 999 calls that are received are answered.

No Graph Percentage of calls abandoned before being answered (Year end position)

There is no comparison graph available for this measure as the results are not statistically significant. However, our performance is monitored at three intervals; 1) 50th percentile where we achieve a rate of 0.0 seconds 2) 95th percentile where we achieve a rate of 0.09 seconds and 3) the 99th percentile where we achieve a rate of 0.58 seconds.

Our results demonstrate that at the 50th and 95th percentile we are the best in the country.

Measure 8. Service experience

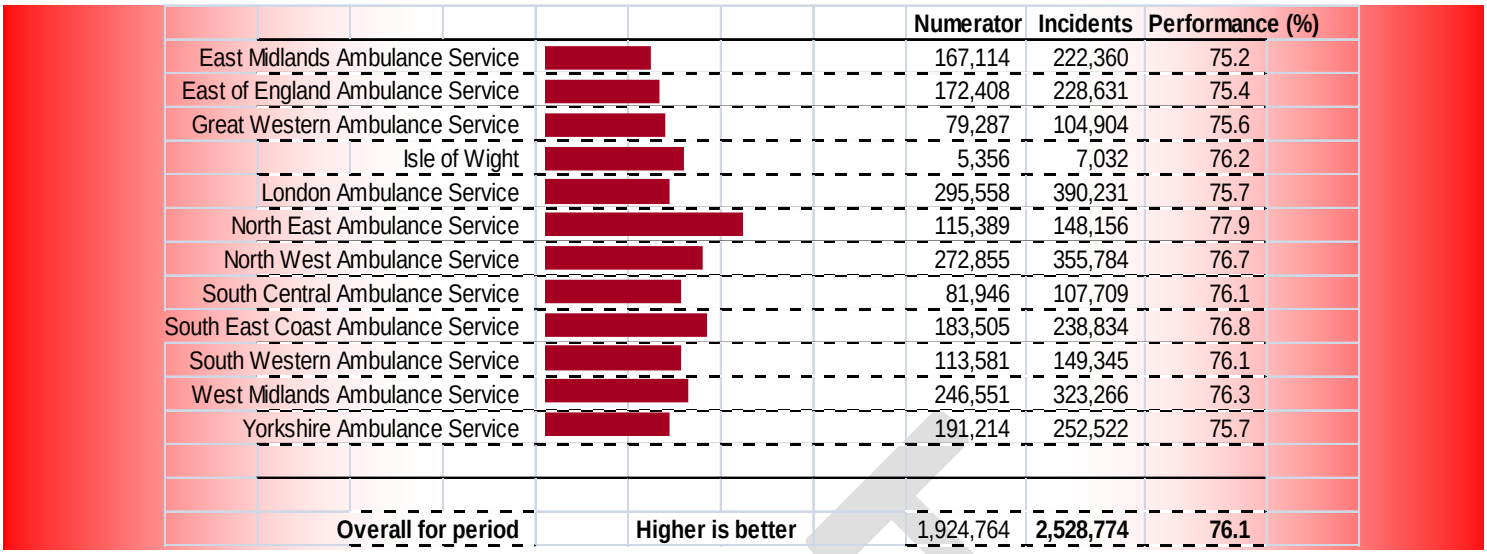
All ambulance services need to demonstrate how they find out what people think of the service they offer (including the results of focus groups and interviews) and how they are acting on that information to continuously improve patient care.

There is no mandatory element and each individual Trust is able to decide how they meet the expectations of this measure. The London Ambulance Service NHS Trust has introduced a service experience action plan that is formulated from any lessons arising out of patient complaints, incidents, serious incidents, and legal claims. The London Ambulance Service believes it satisfies the expectations of this indicator.

Measure 9. Category A 8 minute response time

This indicator measures the speed of all ambulance responses to the scene of potentially life-threatening incidents and measures that those patients who are most in need of an emergency ambulance gets one quickly. It is divided into two measures. The first is the length of time taken to respond within an 8 minute window and the send measure is the time taken to respond in a 19 minute window

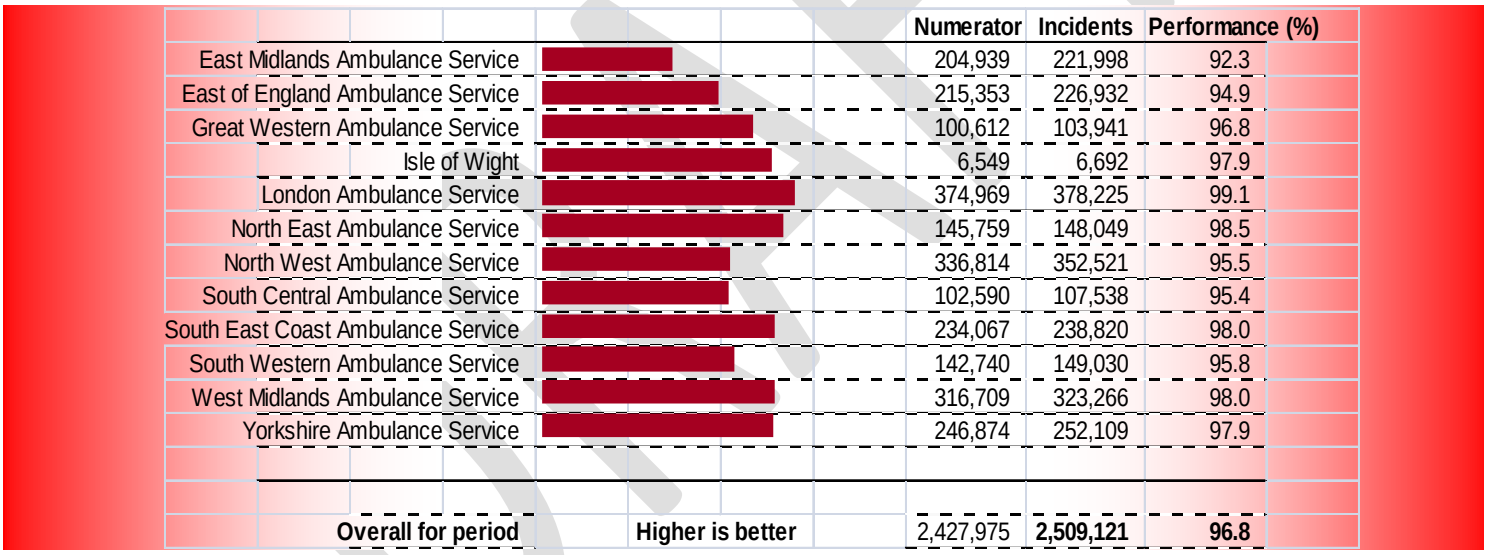
Element 1. Graph 14: Category A 8 Minute Response Time (Year end position)



		Numerator	Incidents	Performance (%)
East Midlands Ambulance Service		167,114	222,360	75.2
East of England Ambulance Service		172,408	228,631	75.4
Great Western Ambulance Service		79,287	104,904	75.6
Isle of Wight		5,356	7,032	76.2
London Ambulance Service		295,558	390,231	75.7
North East Ambulance Service		115,389	148,156	77.9
North West Ambulance Service		272,855	355,784	76.7
South Central Ambulance Service		81,946	107,709	76.1
South East Coast Ambulance Service		183,505	238,834	76.8
South Western Ambulance Service		113,581	149,345	76.1
West Midlands Ambulance Service		246,551	323,266	76.3
Yorkshire Ambulance Service		191,214	252,522	75.7
Overall for period	**Higher is better**	1,924,764	**2,528,774**	**76.1**

The graph reveals that the London Ambulance Service achieved the requirement to complete 75% of all calls within 8 minutes.

Element 2. Graph 15: Category A 19 Minute Response Time (Year end position)



		Numerator	Incidents	Performance (%)
East Midlands Ambulance Service		204,939	221,998	92.3
East of England Ambulance Service		215,353	226,932	94.9
Great Western Ambulance Service		100,612	103,941	96.8
Isle of Wight		6,549	6,692	97.9
London Ambulance Service		374,969	378,225	99.1
North East Ambulance Service		145,759	148,049	98.5
North West Ambulance Service		336,814	352,521	95.5
South Central Ambulance Service		102,590	107,538	95.4
South East Coast Ambulance Service		234,067	238,820	98.0
South Western Ambulance Service		142,740	149,030	95.8
West Midlands Ambulance Service		316,709	323,266	98.0
Yorkshire Ambulance Service		246,874	252,109	97.9
Overall for period	**Higher is better**	2,427,975	**2,509,121**	**96.8**

The graph reveals that the London Ambulance Service achieved the requirement to complete 95% of all calls within 19 minutes.

Measure 10. Time to treatment by an ambulance-dispatched health professional

It is important that if patients need an emergency ambulance response, that the wait from when the 999 call is made to when an ambulance-trained healthcare professional arrives is as short as possible, because urgent treatment may be needed.

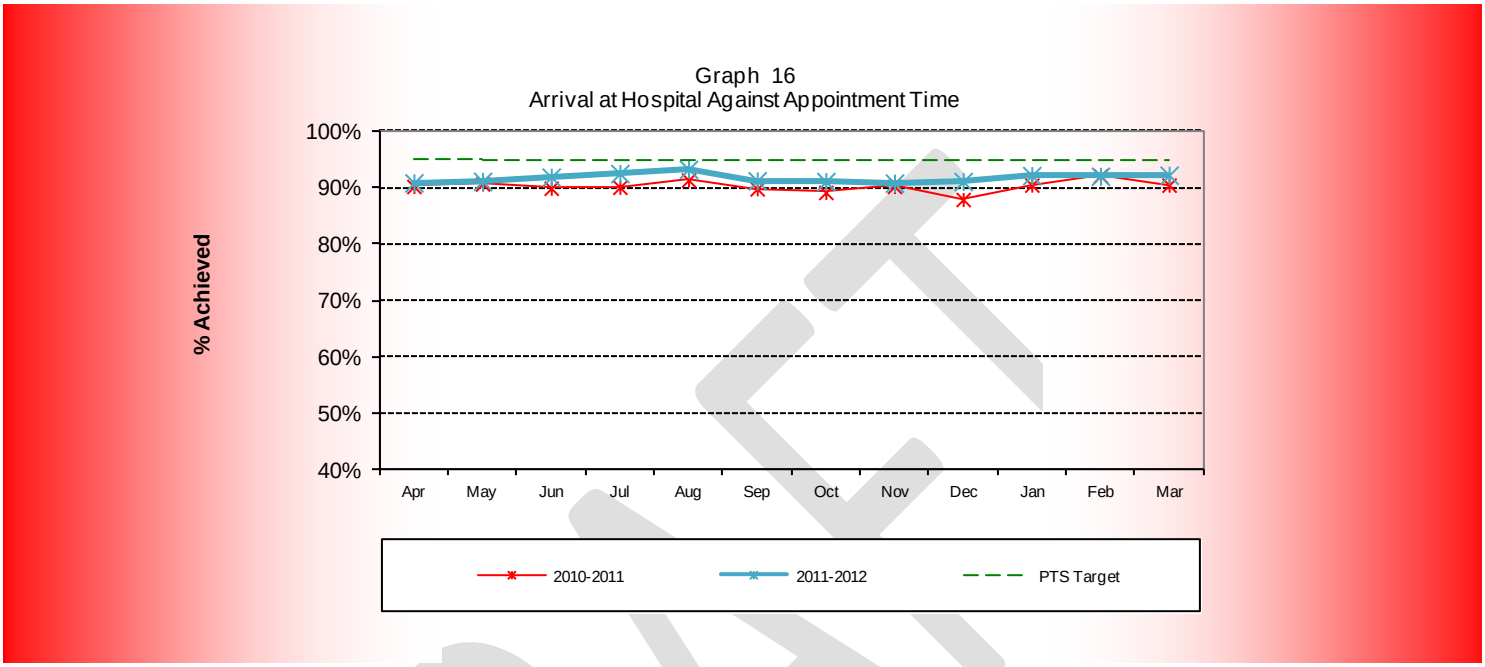
Category A 19 Minute Response Time (Year end position)

There is no comparison graph available for this measure as the results are not statistically significant. However, our performance is monitored at three intervals; 1) 50th percentile where we achieve a rate of 5.37 seconds 2) 95th percentile where we achieve a rate of 12.18 seconds and 3) the 99th percentile where we achieve a rate of 19.03 seconds. These figures are consistent with other ambulance services.

Patient Transport Services

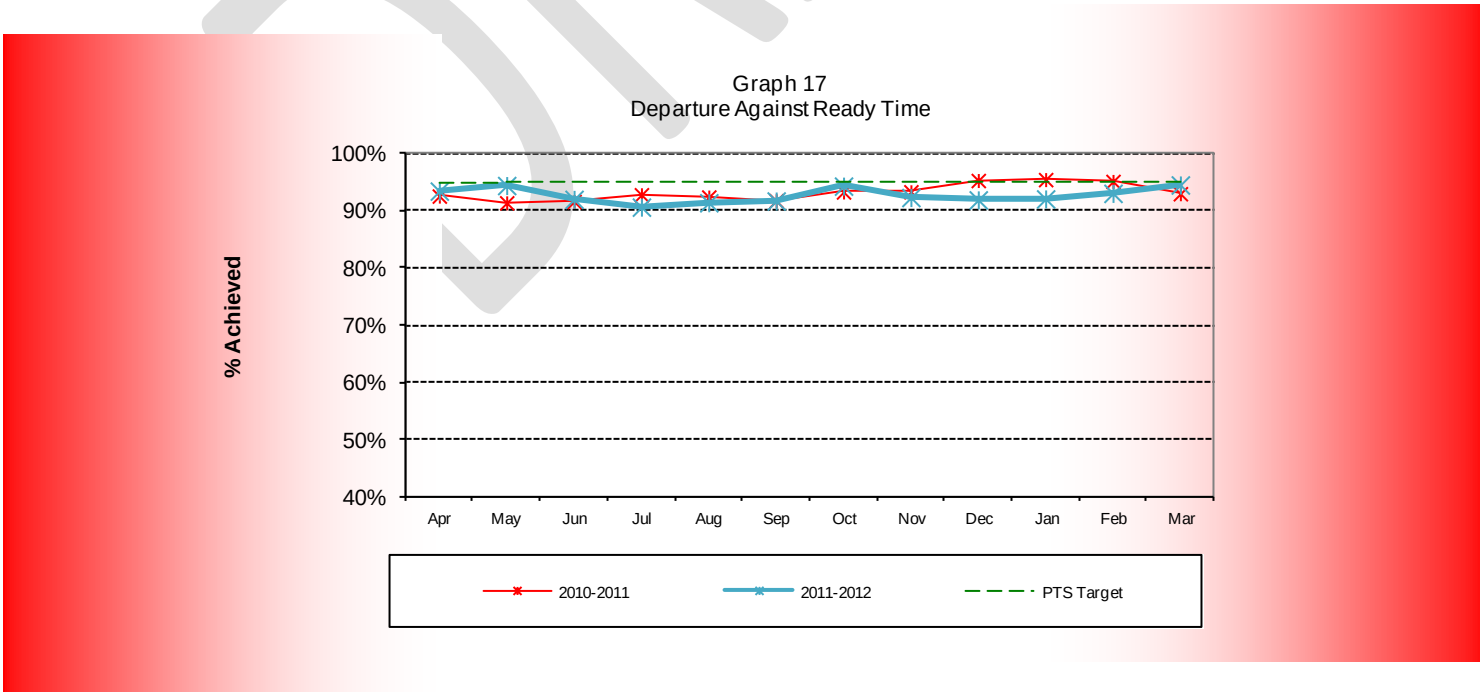
We are commissioned by a number of London NHS trusts and PCTs to provide non-emergency patient transport for patients attending hospital or clinic appointments carried out by, or on behalf of, the contracting trust/PCT. Each contract is specific to the requirements of the individual organisation and therefore the scope of each contract is different. For example, hours of operations, areas covered, types of patients conveyed. However we have a number of quality standards that we strive to achieve across our Patient Transport Service.

Graph 16: The percentage of patients who arrive within an agreed time frame of their appointment



The graph illustrates that our patient transport service has continued to improve the timeliness of arrival for appointment times. We are however, slightly below the trajectory that we have set ourselves.

Graph 17: Departure against ready time



The graph illustrates that our patient transport service has maintained a similar year end position for the timeliness of collection times and we are slightly below the trajectory that we have set ourselves.

Section B. Last year's priorities

Last year's Quality Account, despite only identifying four main quality priorities, actually highlighted 51 individual action points for 2011-2012.

This section provides a progress update on all of the 51 points identified.

Improvements to our quality processes

1. We need to embed the quality dashboard
   The Quality Dashboard has been refined through the year and now features as part of the Senior Management Team meetings, Quality Committee, Trust Board and Area Governance/Quality Meetings. The dashboard has also been presented at a number of internal conferences during the year and is also presented to the Clinical Quality Group; our meeting with commissioners.

2. We need to improve the way we structure and use feedback from patients
   The Integrated Report has significantly strengthened the way we learn from patient feedback. In addition in 2011-2012 the Trust saw the introduction of the "Patient Story" at the Trust Board. This means a patient is now invited to Trust Board to give a personal account of their experience.

3. We need to improve the way we learn and share the learning from serious incidents
   We have made significant improvements in the way we manage Serious Untoward Incidents. They are completed quicker and to a higher standard of finishing and each investigation is presented at the Senior Management Group and an outline given at Trust Board. The Associate Director's Group monitors the implementation of the learning from Serious Incidents.

Improving mental health care

4. Improve the skill and competence of our clinical staff
   We now have an e-learning package available for staff and have now developed face to face training as part of our Clinical Skills Refresher training which we plan to deliver to each member of staff every three years.

5. Participate in whole system transformation work with partner organisations
   The Trust is now well represented in a number of pan London Mental Health Forums, including the Mental Health Programme Board at the Metropolitan Police and the Pan London Overview Scrutiny Of Section Patients Board.

6. Improve the advice and support available to our clinical staff
   We have now established the post of Mental Health Clinical Advisor and have successfully recruited into this post. We believe we are the only Ambulance Trust to employ a registered mental health professional in this capacity.

7. Improve the actual clinical intervention we provide to mental health patients
   This is dependent upon the delivery of action point 4 which is due to commence in April 2012.

8. Improve our governance and safeguarding arrangements with mental health patients
   The mental health work stream is now part of our safeguarding structure. We are currently considering the issues of

safeguarding and mental health and taking a view about referrals for mental health patients.

9. Improve the care of patients with dementia

There was little progress in this area as we were unable to identify any specific improvements that needed to be made from the published reports. We will continue to observe for improvements that can be made with this group and it remains on the agenda for the mental health committee.

10. Consider how we can use health promotion work with mental health patients

We have considered mental health promotion and in 2012-2013 we will focus on alcohol related health promotion. However, we also recognised our role in physical health care for those affected by mental illness and undertook an audit in 2011 to ensure we were maximising the opportunity of face to face contact by also assessing patients physical health.

The audit results demonstrated that good practice was identified in this clinical audit with ambulance crews obtaining the history of the patient's presenting complaint for almost all patients. Past psychiatric and general medical history were also obtained for the large majority of patients (93% and 94% respectively).

Allergies and medications were also documented for the majority of patients (80% and 78% respectively), although there was room for improvement. Whether the patient had a current psychiatric/ community psychiatric nurse or approved social worker was considered for just over half of patients.

11. Improve the management of alcohol related harm

This work was started in 2011-2012 and will be developed further in 2012-2013. During the year we opened an alcohol recovery service at times of high demand for alcohol related calls which proved successful at preventing admissions to Accident & Emergency for such patients.

Improving end of life care

12. Improve the skill and competence of our clinical staff

The Trust has developed a bespoke End of Life Care course for all front line clinical staff. The course is four hours duration and is being delivered as part of our mandatory training programme in 2012/2013.

13. Hold and share the information about a patient's current care preferences

At the end of the year we held 2,500 individual care plans on our system. These plans help guide our clinical staff in their decision making and reduce the need to convey patients to accident & emergency.

14. Clarify how we obtain clinical support from local providers

We have worked closely with the Royal Marsden NHS Foundation Trust and have worked with a number of clinicians. Each care plan has as a minimum the contact details of clinicians that we can contact for support and advice.

15. Improve the confidence in the systems so we can handover care

This has not been so successful. We found a number of the care plans on the system were not specific to End of Life Care and we have worked hard to improve the way that care plans are flagged to the Trusts. This work has not yet completed.

16. Have the knowledge to take appropriate action if the agreed care provision breaks down

We now have a Senior Clinical Advisor who takes the lead on End of Life Care. He acts as a specialist for those occasions when our clinical staff our our clinical support desk staff are unable to resolve particular issues.

17. Improve the knowledge in the dying process,

and

18. Improve the ability of clinical staff to make an examination and assessment,

and

19. Improve the knowledge of drug use in and out of hospital end of life care,

and

20. Understand the challenges associated with end of life care for people with dementia

The training package that we have developed will address the following objectives;

- Understanding palliative diagnosis and illness trajectories
- Understanding prognostication when attending to the palliative patient and how this impacts on the management plan
- Recognise the dying phase
- Assessment and management of palliative care emergencies and common symptoms at the end of life
- Knowledge of the pharmacology of commonly used drugs in End of Life Care
- Reflect on the needs of the carer and families of the dying patients
- Knowledge of contracts to support the care of the palliative patient

Improving the care for patients who have fallen

21. We will further develop the tool to assist our clinicians in decision making and make this more widely available to staff

and

22. We will implement training so that staff are familiar with the developed tool

The initial development work focused on the need to design a training package and decision-support tool to enable staff to better assess and manage elderly patients who had fallen. The aim of the training package was to provide supporting education and knowledge around general issues affecting older people as well as specific falls information taken from national guidelines. The training package rollout was commenced in the late autumn of 2010, and continued throughout the following 12 months, with most of the training sessions being delivered on complex/area-based training days. All operational staff were included in the group identified for training, with additional engagement offered to Team Leaders and staff on the Clinical Support Desk to enable them to provide additional support to staff who may have specific queries.

During the initial discussions regarding the process of onward referral, scoping work was undertaken to map local falls community care providers across London. It became clear that the services provided varied widely in type and capacity of the team, as well as ability to accept referrals from different sources. A decision was taken that the route of referrals for elderly fallers within the LAS would be to their own GP, and it would then be the doctor's decision regarding any further onward referral.

23. We will improve our monthly referral rates following agreed falls protocol (back to GP) for uninjured people who have fallen.

At the start of the 'go-live' for the Referral Support Team', approximately 270 referrals were made to GPs across London, and through continued communications with staff via a variety of media (including posters, LAS News and Clinical Update articles, and a podcast), this number increase to a little under 1100 by March 2012. Across the year, a total of 9940 referrals were made from crew staff to London GPs specifically for elderly patients who had fallen.

Implementing a quality dashboard

24. Implement the use of the dashboard through our quality governance structure

The quality dashboard is now implemented through the organisation.

25. The implementation of the additional quality measures identified within our quality strategy

All the quality measures have been included on the dashboard although we were unable to collect any evidence or audit data for controlling body temperature and have therefore decided to remove this indictor from the dashboard for 2012-2013.

26. To continue listening to patients so that we can identify new measures to replace measures that consistently demonstrate success

The integrated report is considered alongside the quality dashboard and indicators are added and removed as evidence suggests. Last year we added "missing documentation" due to feedback obtained during the year.

Improving cardiac care

27. Due to the abundance of data indicating the benefits of therapeutic hypothermia, and the fact that it is recommended in the 2010 Resuscitation Council UK guidelines, this treatment will be rolled out pan London as soon as the most feasible means of instigating hypothermia is determined

We were unable to consider rolling this out during the year as the training programme was fully committed. However, we will continue to monitor and consider as part of our clinical strategy.

28. Enable the downloading of information from defibrillators to be made as accessible as possible

We have made little progress on this priority during the year. The clinical directors will champion this during the coming year.

Improving trauma care

29. In conjunction with the London trauma office work is ongoing to develop a triage tool suitable for paediatric patients

Currently Trust staff are encouraged to convey any child with serious injuries to one of the four Major Trauma Centres, as an interim position and pending the possible designation of paediatric major trauma centres. The adult triage tool advises staff to discuss the management of injured children with the Clinical Coordination Desk. A specific paediatric triage tool will strengthen the decision making process for this group of patients. The London Trauma Office established a paediatric subgroup, chaired by Dr Tina Sajjanhar, Consultant in Paediatric Emergency Medicine. One of the objectives of the group was to develop a paediatric triage tool, based on the adult tool which was introduced in March 2010. The paediatric version was signed off by the group in September 2011, and presented for information at the London Trauma Office Triage Tool workshop on 26th March 2012. Next steps are to reflect any relevant changes made to the adult triage tool (see below), arrange for the printing, lamination and distribution of the paediatric triage tool to LAS staff.

30. Evidence suggests that the major trauma field decision tree is currently over sensitive and may be taking more patients than necessary to major trauma centres. This needs reviewing in 2011/12

The London Trauma Office held a Triage Tool Development workshop on 26th March 2012, where the data linking the use of the triage tool with TARN outcome data, collected within the past two years, was reviewed. The data suggests that the tool has proved a safe and effective means of identifying seriously injured patients, with an average of 11 patients a day being transported to one of the four Major Trauma Centres. A third of these patients are subsequently shown to have an injury severity score of above 15 (major trauma). The positive predictive value of the tool is 31% and the negative predictive value 99%, the sensitivity is 77% and specificity 99.5%. The number of inter hospital transfers for seriously injured patients has fallen by 50%.
The workshop was attended by representatives from the Major Trauma Centres, Trauma Units, LAS and SECAMB, HEMS, Surrey and Sussex Air Ambulance, and other experts from relevant hospital specialities. There was agreement that the fundamental principles of the triage tool were sound. A number of minor modifications, including the triage of burns, open lower limbs fractures and the inclusion of 'crew concerns' as an additional trigger were suggested. The output of the workshop

will be finalised and presented to the London Trauma Board, prior to reprinting the triage tool and ensuring the dissemination of the changes to LAS staff and relevant stakeholders.

Progressing alternative & appropriate care pathways

31. There are further opportunities to develop the care pathways and this has been identified as a specific priority for 2011/12

and

32. We will continue to explore opportunities within urgent care centres

Over the 12 months from 1st April 2011, there has been strategic drive to improve the use of all types of ACP by operational staff – this has been encouraged by the Trust's commissioning team who has in-turn been liaising with commissioning cluster leads to understand local priorities relating to the management of urgent care cases in particular.

In April 2011 a total of 2706 patients were conveyed or referred to alternative care pathways (with 904 to Acute Departments, 570 to urgent units and 1232 were not-conveyed and referred to community services), by March 2012 these numbers had increased to 6931 in total, (1519 acute, 2555 urgent, 2857 referred).

33. We will look for ways to obtain patient feedback on how the pathways benefit patients

Whilst we did undertake a mental health survey this did not directly address the action point. This has been rolled into a specific CQUIN for 2012-2013 and we will undertake a piece of evaluation work on those patients who are left at home.

Improving stroke care

34. Support the final hyper acute stroke unit to open

During the year, the HASU at the Princess Royal University Hospital in Farnborough opened, which saw a reduction in journey times for patients in the south east of London. The slight adverse impact of this was the planned closure of the Temporary HASU at St Thomas' in October, which has lead to a loss of central resilience. However, we now convey over 700 patients per month to a Hyperacute Stroke Unit, and have demonstrated that we consistently triage over 97% of stroke patients to a clinically appropriate destination

35. The bed capacity had initially appeared to be more than needed. However the final months of the year saw units reporting zero bed status. This has meant ambulance crews being sent to more distant hyper acute stroke units. We will support the network in reviewing the arrangements

Bed capacity is constantly monitored. There is generally a good capacity in the north west and south west. Capacity appears lowest in the north east. We were able to support the network through outbreaks of norovirus in two HASUs.

Ambulance Availability

36. We will continue to drive down times when vehicles are of the road for avoidable circumstances

The Vehicle Resource Centre has developed overnight planning systems to reduce avoidable vehicle off road time. The centre conduct triage of vehicle faults over the phone to direct an appropriate resource to the fault, rather than send every vehicle to a workshop location. Increasingly, third party fleet suppliers are held to robust service level agreements but there is more work to do.

The Vehicle Resource Centre are asked to meet a target of sourcing vehicles within 30 minutes of shift start (85%). Steady progress has been made in achieving this target in 2011/12, rising from 45% to 82% by the end of the reporting period.

The vehicle preparation (make ready) contract has been awarded to a new supplier. Demanding Key Performance Iindicators, in terms of vehicle cleanliness and equipment, are being implemented aimed at ensuring that 100% of available vehicles are made ready - reducing the burden on operational staff and managers, and in turn the downtime

associated with vehicles in a poor state of readiness.

Also, 500 new Lifepak defibrillators have been brought into use. The availability of new equipment has improved reliability and contributed to a 50% reduction in unequipped vehicles. Vehicle packs ("red bags") are now in place across the entire fleet following strong partnership working with Operations. Critical equipment that is known to contribute to vehicle downtime is provided within these packs including key portable diagnostic equipment.

The new mobile communications provider, Telent, started work during 2011/12. Fault diagnosis and repairs are now carried out by mobile technicians travelling to the vehicle, eliminating protracted and unproductive journeys to a single, central location under the previous contract.

37. We will look at the times that mechanical or equipment repair result in lost vehicle availability

Average vehicle availability remained on target for 2011/12 at 88%. The percentage of lost hours against plan for fleet related issues fell below 2% at the end of the reporting year – a reduction of nearly 1% from the previous year. The number of vehicles with insufficient equipment to operate on a daily basis has reduced on average by 50%. Targets are set for these areas and monitored on a daily and monthly basis. A daily conference call has been introduced in the Fleet and Logistics Department aimed at assessing and improving the percentage of ambulances available to Operations by taking immediate corrective actions when necessary. The call considers resources available against planned shifts, workshop manning and loading, percentage of vehicles made ready overnight, and maintenance of the daily supply chain to Station Complexes.
Mobile vehicle technicians have been introduced to work overnight to reduce lost vehicle time impacting on early shift starts. It is estimated that mobile resources can resolve up to 75% of reported faults. Early results from this initiative have been encouraging. There is significant further work planned in 2012/13 to shift the burden of running repairs out of workshops and onto mobile workshops provided internally (lessening the reliance on third parties).

38. We will continue to drive down the length of unnecessary delay during the transfer of care between ourselves and other Trusts

We have made considerable reduction in the elements of handover that lie wholly within our responsibility. However, the time that hospitals contribute to this delay has lengthened. We are continuing to work with commissioners to drive down unnecessary waiting at Accident & Emergency departments.

Emergency Operations Centre

39. Implement and embed the new computer system

The new computer system went live on 28th March 2012 and whilst we are still early in the implementation we are seeing some encouraging improvements with performance better than expected.

40. Embed new ways of working in dispatch

New dispatch model version 2 implemented in the Autumn of 2011.

41. Understand impact of the new Department of Health code changes

These have been implemented as required

42. Focus on developing our hear and treat activities to optimise response to certain categories of calls

This has been achieved with LAS exceeding the new 6,300 monthly target consistently from August.

43. Introduce a new system for supporting our clinical telephone advice

Not yet implemented.

44. Move to dual control rooms

Second control room planned and prepared. The operational move is scheduled for October 2012

45. Support the re-launch of our clinical response model

Not yet delivered.

46. Continue to plan for the Olympics and Paralympic Games

Olympic Board continue to plan for the Olympic event.

Patient transport services

47. Continuing to lower the age of the fleet to a projected 1.2 years old by the end of 2011

The average age of the PTS fleet by the end of 2011 was 2.9 years. This has been reduced from 4.1 years at the start of 2011. The difference between what has been achieved and what was projected has been as a result of variation in the portfolio of contracts held by PTS. The subsequent addition of a new contract in August has resulted in the necessity to retain some of our older vehicles whilst plans are put in place to procure additional new vehicles as part of our rolling replacement programme.

48. We will see enhancements to the equipment carried on our bariatric vehicles as well as the introduction of a bariatric support vehicle. This will provide additional specialist equipment such as a hoist, lifting cushions and a variety of ramps for the most challenging situations

As this new service has developed over the last year, we have reviewed the requirement to implement a support vehicle with additional equipment. Our experience to date has been that there was no requirement for us to carry a hoist, lifting cushions etc. What we have found is that there have been difficulties on occasion with more primary equipment in stretcher and chair to cater for larger patients. Consequently, we have used funding to purchase more specialised stretchers and have been trialling a number of different carry chairs.

We will continue to monitor the bariatric service we provide and consequently the equipment we require to undertake this work safely and efficiently. If there becomes a growing demand for a support vehicle we will develop this solution in a timely manner.

Emergency bed services

49. Roll out the incident reporting and critical care pilot work

The Incident Reporting Pilot was implemented in early 2011. The interim evaluation has been positive. This will be developed further into 2012/13 alongside the introduction of a pilot for Safeguarding Telephone Referrals. Now all London adult and PICU bed data stored on our Clinical Manager System with other parts of the country joining the process later this year.

50. Introduce a falls referrals support service

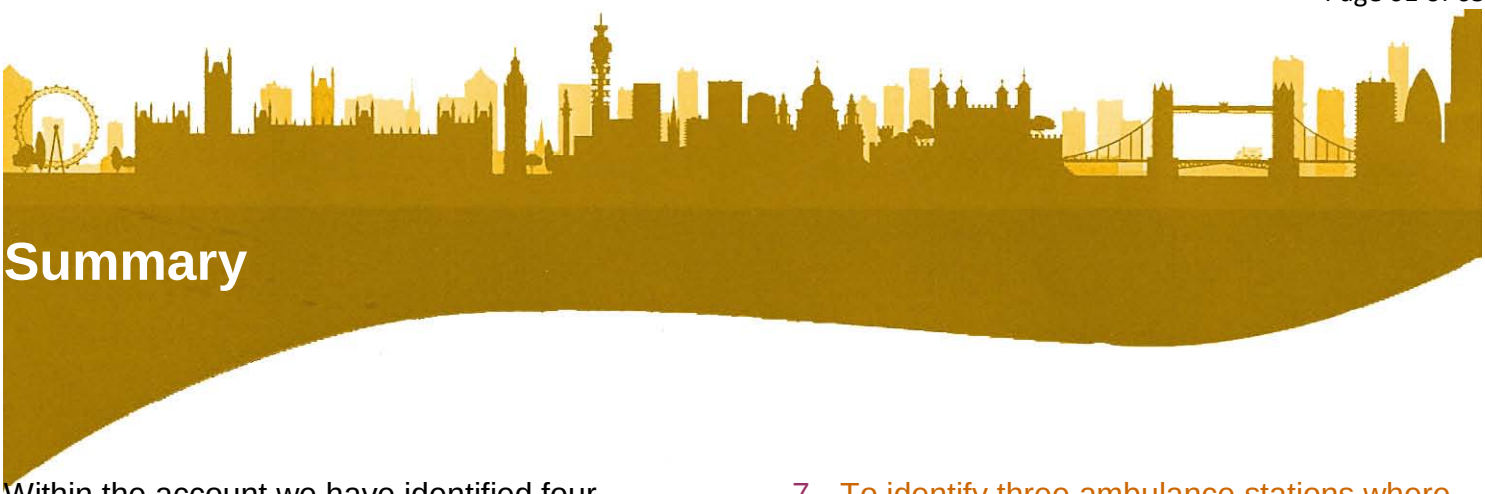
This has been implemented. An interim evaluative survey asking GP's if they valued the service was overwhelmingly positive.

51. Implement call voice recording for safeguarding referrals

After extensive analysis this option has been discounted on the grounds that the added value is minimal for the associated costs. However, a safeguarding telephone referral pilot will commence shortly which will strengthen the referral process.

Stakeholder comments


CARE RECORD
PARAMEDIC
PARAMEDIC



Summary

Within the account we have identified four priority areas for the coming year. In addition, we have also identified a number of other quality improvements that we have said we will make. This section summarises all the main quality improvements cited within this account.

Improving Mental Health Care

1. To make mental health training mandatory for all our clinical staff and ensure at least 60% of the relevant workforce receives the face to face element of training in the coming year.

2. To ensure 100% of our permanent clinical advisors have an advanced understanding of mental health.

3. To undertake further engagement activities with mental health patients that gives us patient feedback on experience and satisfaction.

4. To role out the agreed care pathways across the whole Trust

Improving Alcohol Related Harm

5. To undertake a comprehensive audit of the alcohol recovery service that considers the benefits to patients and the health economy.

6. To make recommendations, to our commissioners, on the future delivery model for alcohol.

7. To identify three ambulance stations where we can introduce an alcohol assessment protocol.

8. To identify what course of action can be taken when a patient triggers the assessment

Quality during the Olympics

9. We will implement a new model of clinical support that will provide greater flexibility and strengthen our ability to meet the additional demands of the games.

10. We will explore the possibility of using flexible staff to support the call handling agents and will ensure the governance and quality issues are addressed.

11. These messages will be communicated as required and need to be reinforced by robust local messages.

12. Identify the quality indicators to monitor in real time during the period of the Olympic games.

Improving diabetic care

13. Develop a protocol and training for our clinical staff that supports patients with a reading of 8mm to be referred, when appropriate, to their GP.

Other quality improvements

14. During the course of the year we will make further clarifications and make contact with other ambulance services in other countries to start comparing, where possible, outcome data(page 9)

15. We have the aspiration to be upper quartile in all of the Ambulance Clinical Quality Indicators and this year expect to move up a quartile in those areas where we are not currently in the upper quartile (page 9).

16. We also intend to drive the quality dashboard through the organisation which will require stronger communication links with clinical staff (page 12).

17. We need to roll some of these systems into our less serious incidents so that we have a single robust process (page 12).

18. We will undertake further analysis of staff feedback in early 2012-2013 (page 13).

19. We have further work to do in recording and quality assuring our safeguarding training (page 14).

20. This coming year will see the development of a clinical strategy for the Trust (page 18)

National Clinical Audit

21. Raise awareness of the STEMI care bundle through initiatives such as posters, newsletters and further education (page 27)

22. Increase the proportion of patients presenting with a STEMI who receive pain-relieving medicine by developing an LAS pain management training session (page 27)

23. Increase the number of patients presenting with a STEMI for whom two pain assessments are undertaken by creating a pain assessment tool to help patients who struggle to understand the concept of pain scoring (page 27)

24. Raise awareness of the stroke care bundle with posters, newsletters and further education(page 28)

25. Increase the number of referrals to GP's and diabetes teams for diabetic patients in London through the implementation of a new call back and referral process for non conveyed patients suffering from hypoglycaemic emergencies (page 28, but this will be addressed through our diabetic work)

26. Increase the proportion of patients presenting with asthma who have their oxygen saturation level measured before treatment by exploring the introduction of portable oxygen saturation probes and paediatric probes (page 28)

27. Increase the number of data that is downloaded from defibrillators through feedback to staff on the findings from downloads (page 28).

Clinical audit of the care provided to elderly patients with a hip injury by the London Ambulance Service

28. Highlight the importance of assessing the patient's pain and administering analgesia where appropriate through developing an LAS pain training session (page 28)

29. Reduce the number of vehicle cancellations when a response is allocated to a patient through the introduction of CommandPoint (page 28).

Clinical audit of the Clinical Telephone Advice given to patients triaged by the Medical Priority Dispatch System as '24B1' Labour (delivery not imminent, ≥5months/20 weeks) by the London Ambulance Service

30. Review, shorten, and clarify the way Clinical Telephone Advice (CTA) staff should be using the Maternity Pathway Questioning Tool (page 28).

31. Develop an initial screening tool that can be used by senior CTA staff members prior to the Maternity Pathway Questioning Tool (page 28).

32. Develop a quality assurance process for calls where CTA staff use the Maternity Pathway Questioning Tool (page 28).

33. Feedback the results of this clinical audit to the Medical Priority Dispatch System Working Group and to the Emergency Operations Centre (page 28).

34. Send CTA staff a questionnaire asking for their views on the usability of the Maternity Pathway Questioning Tool (page 28).

A clinical audit examining End of Life Care in the London Ambulance Service

35. Increase staff knowledge and confidence in their assessment and treatment of patients with an end-stage terminal illness through an End of Life Care training package to all crews and an advanced education package for Clinical Support Desk staff (page 28).

36. Increased number of Palliative Care/End of Life Care Handover forms registered on the Patient Special Needs Locality database (page 28)

37. Introduce Co-ordinate My Care so Clinical Support Desk staff are able to access all palliative care patient plans to ensure correct management as per patient wishes (page 28).

38. Publish guidance to instruct crews to call the Clinical Support Desk for further support and advise crews to contact the patients' palliative care team, particularly out-of-hours when deciding on a course of action (page 28).

39. Remind staff about the correct use of Patient Report Form (PRF) illness codes in relation to end of life care so that incidents are coded correctly as such and not only capturing the presenting complaint (page 28).

A baseline clinical audit examining the measurement of end tidal carbon dioxide ($ETCO_2$) during advanced airway management of cardiac arrest patients by the London Ambulance Service

39. Increase the number of $ETCO_2$ waveforms that are included in the electronic clinical record for this patient group by ensuring the corresponding Computer Aided Dispatch (CAD) number is documented when an $ETCO_2$ reading is taken and remind Station Administrators that waveforms should be sent to Management Information with the associated PRF (page 28).

40. Remind staff the preferential use of a supraglottic airway devices, emphasising that it is a safe and effective way of maintaining a patient's airway by writing an article for the Clinical Update (page 29).

41. Review Advanced Life Support in the Core Skills Refresher 1 training to include particular emphasis on the preferential use of supraglottic airway devices and including waveform print outs in the patient's clinical record (page 29).

Improving trauma care

42. Reflect any changes to the adult triage tool in the paediatric care, arrange for the printing, lamination and distribution of the paediatric triage tool to LAS staff (page 49).

43. The output of the workshop will be finalised and presented to the London Trauma Board (page 50).

Patient Transport Services

44. We will continue to monitor the bariatric service we provide and consequently the equipment we require to undertake this work safely and efficiently. If there becomes a growing demand for a support vehicle we will develop this solution in a timely manner (page 52).

Emergency Bed Services

45. Implement the telephone referral pilot to strengthen the safeguarding referral process (page 52).

Appendix I: Vision & Values

Our **vision** remains the same for 2012-2013 as it was for 2011-2012;

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.

In 2011-2012 this vision was underpinned by three strategic goals which were considered essential for the delivery of our vision. Each strategic goal had a number of corporate objectives which supported the delivery of the strategic goals.

During 2011-2012 we reviewed our corporate objectives and made the importance we give to quality more explicit within three of the objectives.

The three changed objectives for 2011-2012 were as follows;

Corporate Objective 1.	**To improve outcomes for patients who are critically ill or injured.**
Corporate Objective 2.	**To provide more appropriate care for patients with less serious illness or injury.**
Corporate Objective 4.	**To meet all other regulatory and performance targets**

The three objectives for 2012-2013 are as follows;

Corporate Objective 1.	**To improve the experience and outcomes for patients who are critically ill or injured.**
Corporate Objective 2.	**To improve the experience and provide more appropriate care for patients with less serious illness or injury**
Corporate Objective 4.	**To meet all other quality, regulatory and performance targets**

In addition we also made changes to the corporate objective supporting us to improve the diversity of the workforce. In 2011-2012 we were awarded top 100 employer status by Stonewall, whilst we recognise there are always improvements that can be made in the number of staff recruited from different groups, we took the decision to change the emphasis to quality by focussing on the diversity needs within our patient group.

The changed objectives for 2011-2012 were as follows;

Corporate Objective 5.	**To develop staff so they have the skills and confidence they need to do their job.**
Corporate Objective 6.	**To improve the diversity of the workforce.**

The change saw us combine the objectives and reword the objective for 2012-2013 as follows;

Corporate Objective 5.	**To develop staff so they have the skills and confidence they need to deliver high quality care to a diverse population.**

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH MAY 2012

PAPER FOR INFORMATION

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

Key issues and risks arising from this paper

Overall this report provides assurance that a high quality and safe clinical service is provided.

Key issues and risks identified include:

Some recovery in completion rates of the Clinical Performance Indicators in March
High utilisation rates which impact on our ability to introduce clinical innovations.
Increasingly frequent use of the Demand Management Plan from January onwards.
An increase in on scene times for all MPDS codes from 2008 onwards.
Progress in the delivery of the clinical audit work plan.
Further reduction in the number of addresses held on the High Risk Register and progress in writing to the addresses.

Executive Summary

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

Attachments:

Appendix 1: Increasing on scene times 2008 - 2012
Appendix 2: Cycle 7 national Clinical Performance Indicators
Appendix 3: A Progress against the Clinical Audit work plan 2011/2012 clinical audit examining End of Life Care in the London Ambulance Service. Executive summary. February 2012

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Quality Strategy

This paper supports the following domains of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☒ No

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST

Clinical Quality & Patient Safety Report – May 2012

Clinical Directors' Joint Report

1. Introduction

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

This report identifies a number of issues and a number of clinical successes and overall provides assurance to the Trust Board that the LAS is maintaining a high quality and safe service. However, there remains a concern over the high utilisation rate. This means that there is a lack of headroom that can be used to introduce new clinical initiatives or undertake training beyond the priorities identified within the Training Strategy. There is a real concern that with a heightened financial climate in 2012-2013 this will impact on clinical developments and our ability to maintain a world class service.

2. Quality Domains

Quality Domain 3: Clinical Intervention

This section will report on the work of the Clinical and Quality Directorate to improve the actual interventions given to patients and also any concerns regarding clinical interventions.

Clinical Performance Indicators (CPIs)

The overall Team Leader CPI completion rate for January was the highest since August 2010 with a 100% CPI completion rate for cardiac arrest, by all complexes. Since then we have seen a fall to 84% in February but a recovery to 89% in March. Overall compliance against all clinical care standards remains consistently high. In March 2012, compliance was 95% or higher; the Trust target is 100%.

The new mental health CPI data will be published in the next CPI report from CARU.

Diagram 1. CPI completion September 2011 to March 2012

Area	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.
East	84%	96%	94%	93%	86%	94%
South	84%	87%	78%	93%	83%	78%
West	90%	95%	95%	95%	84%	96%
LAS	**86%**	**93%**	**88%**	**94%**	**84%**	**89%**

Diagram 2. CPI Compliance March 2012

	Cardiac Arrest	Difficulty in Breathing	ACS (Including MI)	Stroke	Glycaemic Emergencies	Non-Conveyed	1 in 20 PRF
East	98%	95%	96%	97%	97%	95%	96%
South	97%	96%	96%	98%	99%	95%	97%
West	98%	96%	97%	98%	97%	96%	98%
LAS Total	**98%**	**96%**	**96%**	**98%**	**98%**	**96%**	**97%**

Diagram 3. CPI Compliance February 2012

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

Cardiac Care

ParaSVT – This trial continues to go extremely well, with over half the patients required for the trial now recruited (46 out of 90). A further training day has taken place, increasing the number of paramedics involved in the trial to just over 100 pan-London. A meeting the Professor Schilling, the lead researcher from Bart's and The London NHS Trust, is planned to discuss the next steps in taking the research forward.

DANCE – Recruitment to this trial remains very poor. Only 70 out of 200 patients required have been recruited. Work is being undertaken around the feasibility of transporting Non-ST Elevation Acute Coronary Syndrome (NSTEACS) patients directly to one of the eight Heart Attack Centres.

On-Scene times

Following a 4 year data analysis of on scene times for all MPDS codes (2,604,694 records), it is evident that time on scene is increasing. Crucially, this is significant for potentially time-critical stroke, heart attack and trauma groups. This finding has been highlighted at both the Senior Managers' and Mangers' conferences. An illustrative graph is included as appendix 1.

Quality Domain 4: Safety

This section will report on the work of the Clinical and Quality Directorate to improve the safety of patients and also any concerns regarding safety.

Central Alerting System (CAS)

17 Alerts have been received from the MHRA for the period 15th March – 15th May 2012. All have been acknowledged by the Trust. Action on one alert, relating to equipment using ultra violet (UV) tubes has been completed. No other alerts required action.

High Risk Register

There are currently 586 addresses on the register broken down as follows:

CATEGORIES

CAT 1: 125

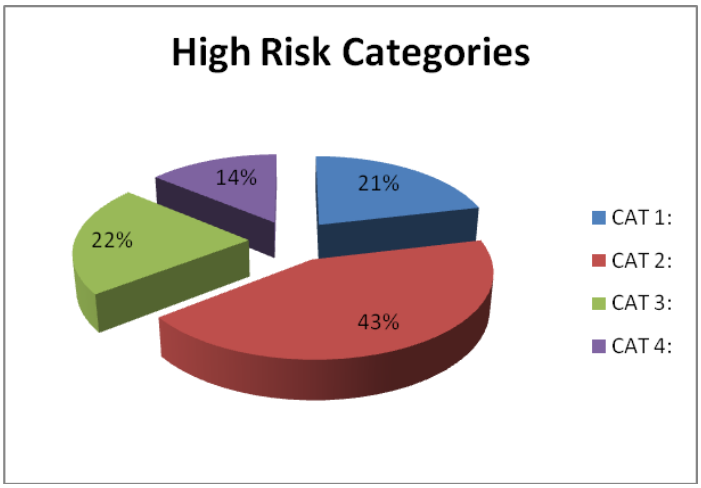
CAT 2: 253

CAT 3: 126

CAT 4: 82

Total: 586

Again this is a fall on the previous month – lowest level since MI took over the management of the register



Sending out letters for Category 1, 2 and 3 has commenced in the following stations.

ISLEWORTH: 1

HANWELL: 6

HOMERTON: 1

CHASE FARM: 2

WHIPPS CROSS: 14

TOTAL: 24

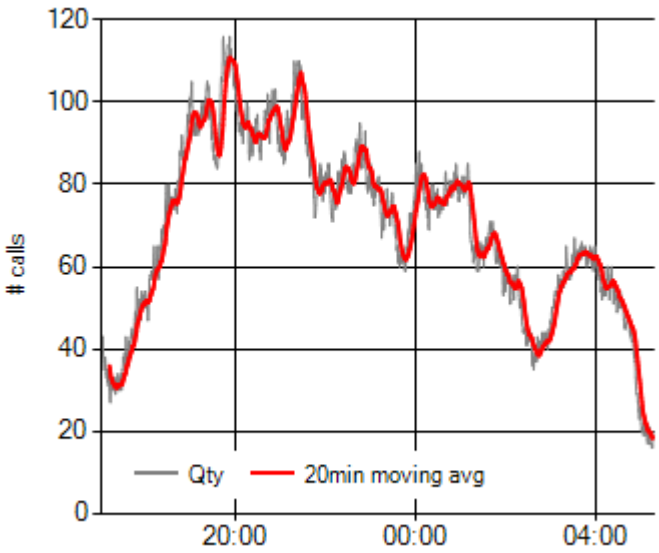
All stations have been briefed and should have commenced writing to all new addresses plus any that are due for a review. There are also 409 addresses on the register from the Metropolitan Police.

Demand Management Plan

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

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

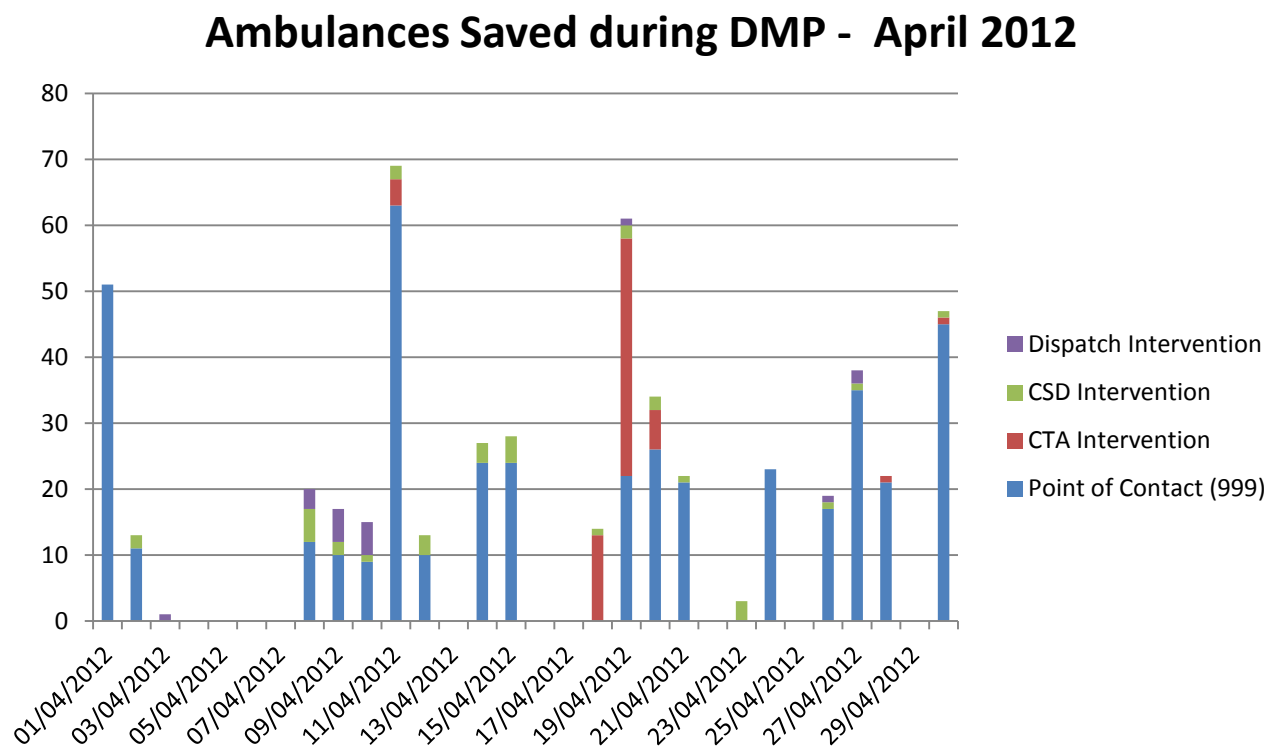
An example of the real time information available to the Gold Team, showing calls held by hour from a busy Saturday evening is included.

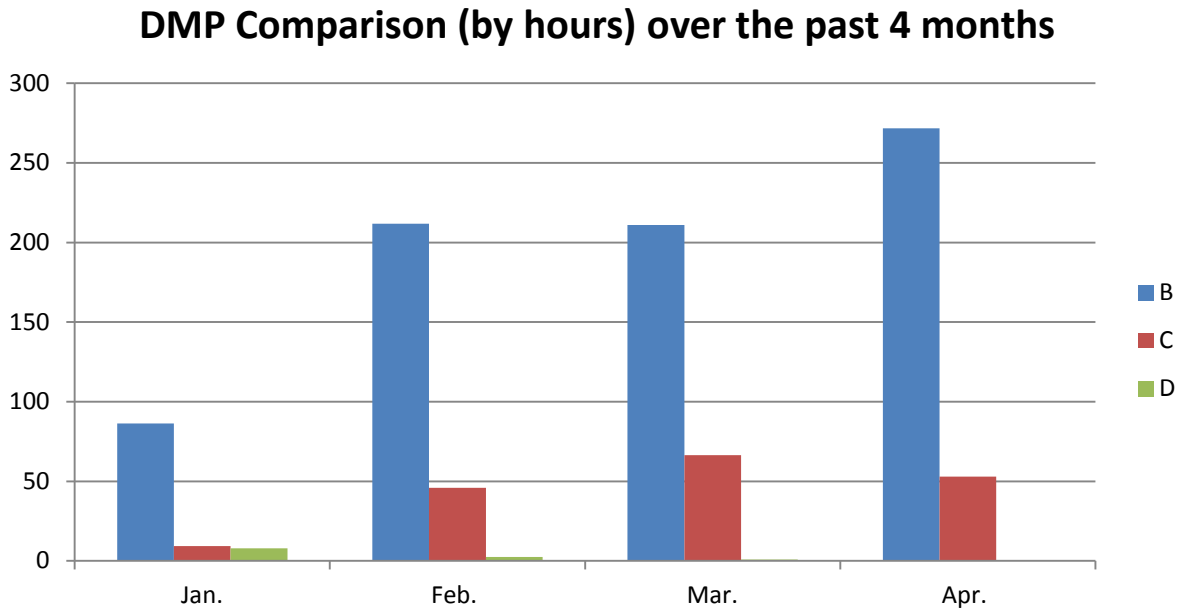


DMP was invoked on **56 separate occasions** and in place for a total duration of **324.75 hours** in April 2012. This is an increase of 46.25 hours compared to the previous month. There is an evident increase in the use of DMP stage B in 2012.

Stage **B** was invoked 44 times for a total duration of **271.75 hours** (versus 44 times / 211 hours in March)
Stage **C** was invoked 12 times for a total duration of **53 hours** (versus 14 times / 66.5 hours in March)

There was no escalation of DMP past stage C.





Medicines Management

The last meeting of the Medicines Management Group was held on 1st May 2012. CQSEC to approve actions concerning the removal of one dose of glucagon from the drugs bags, to offset the cost of the increase in price of amiodarone and epinephrine 1:10,000.

There has been one reportable Controlled Drug Incident since the last report. This involves another falsification of a signature in a CD Register. This incident is currently under disciplinary investigation and the paramedic concerned has been advised to self report to the HPC. The LAS will inform the HPC once the disciplinary process has been completed. A

Medical Directors Bulletin will be issued, however the precise time of release will be determined by the disciplinary process – in order that the process is not jeopardised.

There have been no further Unannounced Visits by the Metropolitan Police.

The Metropolitan Police CDLO made a visit by invitation to the Olympic Deployment Centre to be shown and discuss arrangements for the storage and issue of CDs. The CDLO was satisfied that the Trust was following existing policy and procedure, and made no recommendations or requests.

Following the unannounced CQC inspection in April 2012, the process by which CDs orders are signed before being sent to Frimley Pharmacy, has been amended. From June 2012, the final order for Frimley Pharmacy will be signed by either the Deputy Medical Director, or one of the three Assistant Medical Directors.

There have been no medicine CAS Alerts relevant to the Trust since the last report.

Following an update to the Misuse of Drugs Regulations (2001) released in April 2012, the Group Authority in respect of ketamine and midazolam has now been altered to allow paramedics both possession and administration rights. Plans have been outlined detailing how the drugs will be used in clinical practice within the Trust, however further work is required. As a result, ketamine and midazolam will not be introduced into practice before October 2012.

The new JRCALC Guidelines will be published in July / August 2012. It has been decided by the Medicines Management Group which new drugs included in the guidelines will be introduced. Further work on identifying the exact presentations / dosages we will buy is ongoing. There is a cost increase to the Trust, but this offset to some degree by savings made elsewhere in rationalising other drugs and clinical equipment.

Rule 43 Reports

No Rule 43 reports have been issued to the Trust since the last Board report. The Trust has not received, or is aware of, any Rule 43 reports issued to other organisations, that may be of relevance.

Safeguarding

A task and finish meeting was held by a number of the safeguarding committee members to refresh the safeguarding action plan for 2012-2013. The safeguarding work is progressing well with no significant concerns for Trust Board at this time.

Quality Domain 5: Clinical Outcomes

This section will report on the work of the Clinical and Quality Directorate to improve the clinical outcomes of patients and also any concerns regarding clinical outcomes.

Infection Control
Infection control is currently RAG Rated RED on the Quality Dashboard. This is because we did not meet our target for infection control training in 2011-2012. There are no other significant issues for Trust Board at this time.

Quality Domain 6: Dignity

This section will report on the work of the Clinical and Quality Directorate to improve the dignity of patients and also any concerns regarding dignity.

Patient Survey (Mental Health Patients)
A patient survey was hosted by Central & North West London Foundation Trust on behalf of London Ambulance Service NHS Trust and Central & North West London Foundation Trust. The survey was "patients who have used the London Ambulance Service in a mental health crisis in the Boroughs of Westminster, Brent, Kensington & Chelsea, Harrow and Hillingdon". An analysis of the results has helped us to focus on patient satisfaction and improving the care our frontline staff give to patients with in a mental health crisis.

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

- 80.5% of respondents said that the ambulance crew introduced themselves when they arrived. Only 6.5% said that the crew did not introduce themselves and a further 13% could not remember.

- The majority of patients (97.4%) felt that they were treated with respect and dignity and only 2.6% felt otherwise.

- Of the 97.4% respondents who felt safe in the care of London Ambulance crew, 10.4% stated that they felt "safe to some extent" and only 2.6% did not feel safe.

- 78.9% said that the crew spoke to them directly while 17.1% felt that the crew mostly spoke to other people about them and 3.9% reported that the crew did not talk to them at all.

Whilst the results were overwhelmingly positive there were some actions arising from the survey and these have been incorporated into the Mental Health Action Plan.

Quality Domain 7: Satisfaction

Complaints

Emerging themes
The usual themes are again evident - staff challenging the validity of the 999 call; delay (especially calls categorised at lower emergency priority levels). We are compiling an analysis of delayed response to calls triaged at category C1 or C2 and the affect of the

Demand Management Plan. There has also been an increase in the numbers of complaints where no vehicle has been dispatched and nine complaints relating to calls referred to NHS Direct. Two referrals were made to the SI group and one was declared.

Complaints by Subject	Total
Delay	42
Non-conveyance	12
Non-physical abuse	11
Treatment	5
Conveyance	4
Aggravating Factors	2
Road handling	2
Not our service	1
Patient Injury or Damage to Property	1
Totals:	**80**

45% of complaints were received by email, 37% by telephone, only 17% by letter and less than 1% by other means (in person/fax) during the period April 2011 to April 2012.

Analysis by response target period

The table below indicates the number of complaints received between February 2012 – April 2012 and the time frame within which the target response was achieved. The overall closure rate for the period within the allocated time frame has increased to 79%. This can be attributed to improved case management and supervision processes within the department despite staff shortages, the Easter Bank Holiday and continuing delays in receiving Quality Assurance reports which are required to be agreed by Watch management teams.

As at 11th May a total of 146 complaints remain open or re-opened following a further approach from the complainant after the substantive response has been completed.

Response time allocated January 2012 to March 2012	No. of complaints	Closed within time frame
Complaint 25 days	155	127
Complaint 30/35 days	36	24
Complaint 40 days	27	20
45 days (SI)	6	6
Totals	**224**	**177**

A true reflection of response times cannot be calculated until the furthest timescale (i.e. 40 days) has elapsed, which will be 25th June 2012.

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

There was one known case of property reimbursement during April and of the 57 lost property items, 23% were traced. We are also currently reviewing the management of lost property and the effectiveness of the introduction of improved SmartSafe property bags.

PALS by Subject (primary) and Received	Totals
Information/Enquiries	256
Lost Property	57
Appreciation (via PED)	4
Other	4
Clinical	3
Incident Report - Other	3
Road Traffic Collision/RTC	3
Communication	2
Delay	1
External Incident Report - EOC	1
Totals:	**334**

We are seeking an improved mechanism around the highly contentious issue of compensatory payments under the NHS complaints procedure, which is no longer solely the province of legal action. This is in the light of the Ombudsman increasingly advocating such consideration.

Currently a Section 8 PALS complaint/declared SI is pending the outcome of an investigation by the Ombudsman.

3. Quality Priorities

The three quality priorities for 2011-2012 are End of Life Care, Patients Who Have Fallen, and Mental Health Care

End of Life Care. This has now been evaluated by the commissioners and although we did not implement all the things that we initially identified we did achieve 57% of the CQUIN targets and have made significant changes to the way we approach End of Life Care.

Patients Who Have Fallen. This has now been evaluated by the commissioners and we achieved 100% of the things that we said we would achieve.

Mental Health Care. This has now been evaluated by the commissioners and we achieved 64% of the things that we said we would achieve. The main reason for not achieving 100% was due to the partnership work required to negotiate agreements with 10 other Mental health Trusts. This work is progressing into 2012. However, on presenting our achievements to patient groups all groups commended our success and asked for this to remain a priority in the coming year.

The Quality Account will be presented at the June Trust Board but all patient groups have supported the identified quality priority areas for 2012-2013.

1). To continue to drive improvements in mental health care 2). Diabetes care 3) Alcohol and 4). Maintaining a quality service for all through the Olympic period.

4. Clinical Audit & Research (CARU)

Three audit reports have been published by CARU.

Mental Health
Overall, many areas of good practice were identified in this clinical audit, in particular, obtaining the history of the patient's condition and presenting complaint. There were however some areas for improvement; specifically the completion of safeguarding referrals where indicated, and the use of the capacity tool. Whether the patient had a current Psychiatric/Community Psychiatric Nurse or Approved Social Worker was only considered for just over half of patients (54%).

Paediatric pain management re-audit
This re-audit has demonstrated a significant increase in the assessment of pain in children since the initial audit in 2006, and an improvement in the administration of analgesia – although for the latter further improvement is needed. Unfortunately the use of immobilisation techniques has decreased significantly and the underlying cause of this finding is unclear. In order to sustain the improvements in pain assessment and to further enhance pain management (and in particular address the under use of immobilisation techniques) seven recommendations are made by the report.

Assessment and advice given by the LAS to paediatric patients with pyrexia
This clinical audit demonstrated good practice by ambulance crews when initially assessing paediatric patients with pyrexia. For the majority of patients anti-pyretic drugs were considered, advice to seek medical help if the patient's condition deteriorated was given and a copy of the PRF was left on scene. However there was room for improvement identified in the care provided to some patients. Specific improvements required include: recording of a second set of observations 20 minutes after the initial observations have been taken; awareness amongst crews of the observations and medical history that indicate conveyance for this patient group and direct GP referrals.

A new mental health clinical performance indicator (CPI) is being introduced from April 2012. The CPI will audit 13 aspects of care, including assessment of behaviour, communication and appearance.

The results from the national CPI cycle 7 are included under Appendix 2. These focus on four clinical areas: ST-elevation myocardial infarction (STEMI), Stroke, Hypoglycaemia and Asthma. Following agreement with the Directors of Clinical Care for Ambulance Services (DoCCs), Quality and Risk Profiling (QRP) targets have been set by the Care Quality Commission (CQC) for some of the National CPI measures. The LAS achieved nine of the 13 targets set by the CQC, but four CQC targets were not met. In addition, the LAS was below the national average for eight measures. Clearly this is of concern; however this data was collected in June 2011 and we would hope that the messages disseminated through the Consultation meetings, and more importantly the work being progressed through the

Ambulance Service Cardiovascular Quality Initiative (ASCQI) project will improve the care delivered to stroke and cardiac patients.

There has been considerable progress against the Clinical Audit and Research Unit's annual work plan, with completion of a further 3 audits and significant improvement in the provision of routine reports. (included under appendix 3 for information). This, along with progress against the action plans published for each of the completed audits will now be monitored by the Clinical Quality, Safety and Effectiveness Committee.

5. Rising Tide

Public Health

The Clinical Directors are not aware of any relevant public health matters since the last Board report.

Clinical Professional Issues

The awaited 2011 Joint Royal Colleges Ambulance Liaison Committee Guidelines are now finalised and awaiting print. Release is expected by summer 2012.

External and Partnership working

There are no new partnership areas to report on since the March report to Trust Board.

6. Cost Improvement Programme

There have been no further clinical concerns raised regarding the implementation of the Cost Improvement Programme.

7. Other areas

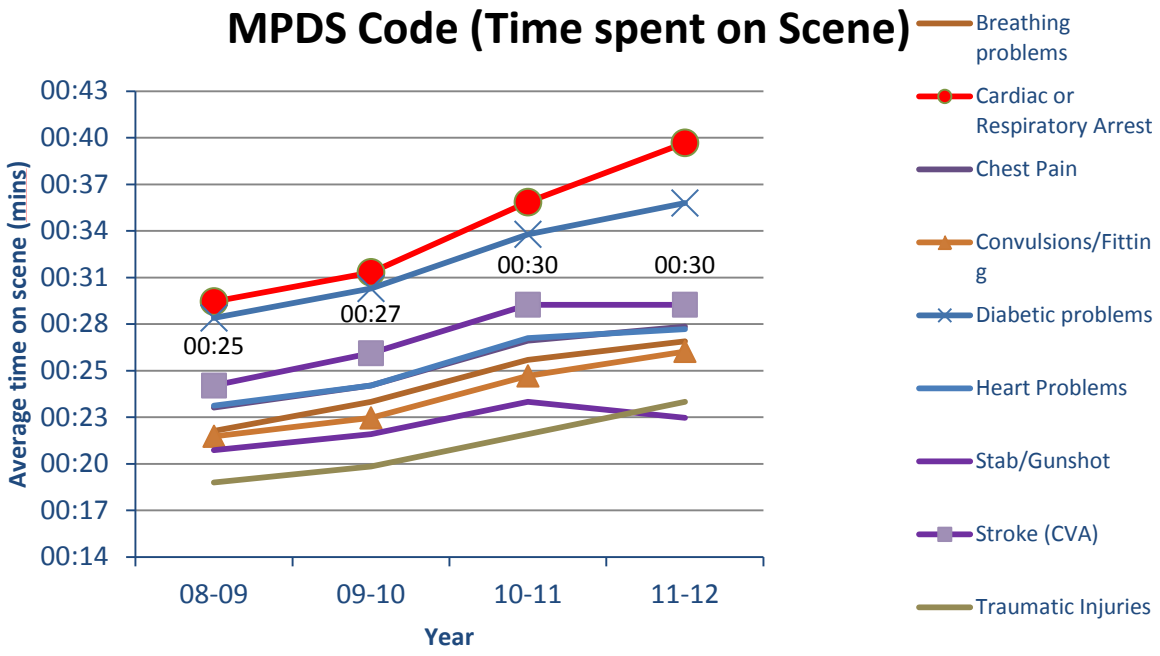
Nothing to report.

Fionna Moore
Medical Director

Steve Lennox
Director of Quality & Health Promotion

18th May 2012

Appendix 1.


MPDS Code (Time spent on Scene)
Average time on scene (mins)
00:43
00:40
00:37
00:34
00:31
00:28
00:25
00:23
00:20
00:17
00:14
00:25
00:27
00:30
00:30
08-09
09-10
10-11
11-12
Year
Breathing problems
Cardiac or Respiratory Arrest
Chest Pain
Convulsions/Fitting
Diabetic problems
Heart Problems
Stab/Gunshot
Stroke (CVA)
Traumatic Injuries

Appendix 2.

London Ambulance Service NHS Trust

Trust Board Meeting – May 2012

Clinical Audit & Research Summary Reports for the Trust Board

National Clinical Performance Indicators: Summary of Findings from Cycle 7

Introduction

The National Clinical Performance Indicators (CPIs) measure and compare the care provided to patients by the twelve ambulances services in England. They currently focus on four clinical areas: ST-elevation myocardial infarction (STEMI), Stroke, Hypoglycaemia and Asthma. Following agreement with the Directors of Clinical Care for Ambulance Services (DoCCs), Quality and Risk Profiling (QRP) targets have been set by the Care Quality Commission (CQC) for some of the National CPI measures. The results from cycle 7 are presented below.

Results

ST segment elevation myocardial infarction (STEMI)

National CPI measure	Data collection month	CQC target	LAS data	National data	LAS trend
Proportion recorded as receiving aspirin by crew or as having received aspirin since onset of symptoms.	June 2011	90%	94.80%	96.50%	↓
Proportion recorded as having been administered glyceryl trinitrate (GTN)	June 2011	90%	89.60%	92.70%	↑
Proportion where two pain scores were recorded	June 2011	75%	91.70%	80.80%	↑
Proportion recorded as having been administered analgesia (morphine and/or entonox)	June 2011	65%	84.30%	86.20%	↑

- A further decline in the % of patients receiving aspirin.
- Slight increase in the % of patients receiving GTN, although still below target.

- Increase in the % of patients for whom two pain scores were recorded and analgesia (entonox and/or morphine) was administered.

Stroke or transient ischaemic attack

National CPI measure	Data collection month	CQC target	LAS data	National data	LAS trend
Proportion for whom the Face Arms Speech Test (FAST) is recorded.	July 2011	95%	89.00%	95.60%	↓
Proportion for whom the blood glucose level has been recorded.	July 2011	95%	96.00%	95.60%	↑
Proportion for whom the blood pressure has been recorded.	July 2011	95%	99.67%	99.50%	↑

- Further decline in FAST recording and failure to meet the CQC target.
- Increased recording of blood glucose and blood pressure

Hypoglycemia

National CPI measure	Data collection month	CQC target	LAS data	National data	LAS trend
Proportion who had a blood glucose level recorded prior to treatment by the ambulance responder(s)	August 2011	95%	95.33%	98.80%	↓
Proportion who had a blood glucose level recorded after treatment by the ambulance responder(s).	August 2011	95%	94.33%	97.90%	↑
Proportion for whom treatment is recorded (oral carbohydrates, glucagon, IV glucose, including self-treatment or treatment administered by bystanders)	August 2011	95%	98.33%	97.90%	↑

- Slight decrease in the % of patients who had their blood glucose level recorded before treatment. This met the CQC target, but remains below the national average.
- Increase in recording of blood glucose levels after treatment, although still below target.
- Increase in recording of treatment delivered

Asthma

National CPI measure	Data collection month	CQC target	LAS data	National data	LAS trend
Proportion who had their respiratory rate measured.	September 2011	95%	99.30%	99.10%	↓
Proportion who had the Peak Expiratory Flow Rate (PEFR) measured before treatment.	September 2011	40%	71.70%	78.70%	↓
Proportion for whom spot oxygen saturation (Sp02) was recorded before treatment.	September 2011	90%	74.00%	92.70%	↓
Proportion for whom administration of a Beta-2 agonist was recorded.	September 2011	None Set	97.70%	96.60%	↑

- Decrease in the % of patients who had their respiratory rate, peak flow and oxygen saturation recorded. The CQC target for oxygen saturation was not met, with compliance falling from the last data collection period.
- Increase in the % of patients that had a Beta-2 agonist recorded.

Summary

The number of National CPI measures where LAS compliance has decreased in cycle 7 is of concern. The LAS achieved nine of the 13 targets set by the CQC, but four CQC targets were not met. In addition, the LAS was below the national average for eight measures. It is anticipated that the Ambulance Service Cardiovascular Quality Initiative (ASCQI) will lead to improvements in care provided to STEMI and Stroke patients by the LAS.

Clinical Audit Work Plan 2011/12 – Progress Report

Clinical audit projects

Project/task	Achievement	
Swine Flu Community Assessment Tool	Complete	
CTA Maternity Pathway Questioning Tool	Complete	
Hip Injuries	Complete	
Under Twos Not Conveyed	Complete	
Advanced Airway: $ETCO_2$	Complete	
End of Life Care	Complete	
Mental Health	Complete	
Assessment and Advice for Paediatric Patients with Pyrexia	Complete	
Paediatric Pain Management Re-audit	Complete	
Sudden Unexpected Death in Infants, Children and Adolescents (SUDICA)	Underway	
Abdominal Pain	Underway (utilising front line staff)	
COPD: Patient Specific Protocols (PSP), Oxygen Administration	Underway (utilising front line staff)	
Inter-hospital Transfers (Immediate)	Underway (utilising front line staff)	
Syncope	Underway (utilising front line staff)	
Paediatric Respiratory Assessment	Underway (Student/Paramedic led)	
Kingston Emergency Department	Underway (Student/Paramedic led)	
Alcohol Intoxication	Underway (Student/Paramedic led)	
Sepsis	Underway (Student/Paramedic led)	
A&E Support: Treatment of Hypoglycaemic Patients	Reconsidered	
Clinical Advice provided during Demand Management Plan (DMP)	Reconsidered	

EOC Categorisation of GP Calls	Reconsidered	
Non-conveyed Patients: sign off for A&E Support	Reconsidered	
Self Harm	Reconsidered	
Substance Abuse	Reconsidered	

LAS Clinical Performance Indicators (CPIs)

Project/task	**Achievement**	
Monthly Complex Reports	Monthly deadlines met	
Mental Health CPI	Complete	
Non-conveyed CPI	Amendments complete	
Non-conveyed awareness campaign	Commissioning for Quality and Innovation (CQUIN) target met for October-March	

National clinical audit projects

Project/task	**Achievement**	
National Ambulance Non-Conveyed Audit	Complete	
National Clinical Performance Indicators: STEMI, Stroke, Asthma and Hypoglycaemia	Monthly deadlines met	

Continual Monitoring – Cardiac Arrest

Project/task	**Achievement**	
DH Clinical Quality Indicators (CQIs)	Monthly deadlines met	
Care pack report	Monthly deadlines met	
Internal reporting for the quality dashboard, balanced scorecard and AOM objectives	Monthly deadlines met	
Annual report (2010/11)	Complete	

Continual Monitoring – STEMI

Project/task	**Achievement**	
DH Clinical Quality Indicators (CQIs)	Monthly deadlines met	

Provision of data to hospitals for entering onto MINAP	Ongoing	
Care pack report	Monthly deadlines met	
Internal reporting for the quality dashboard, balanced scorecard and AOM objectives	Monthly deadlines met	
Ambulance Service Cardiovascular Quality Initiative (ASCQI)	Complete	
Annual report (2010/11)	Complete	

Continual Monitoring – Stroke

Project/task	**Achievement**	
DH Clinical Quality Indicators (CQIs)	Monthly deadlines met	
Provision of data to stroke network and external stakeholders	Ongoing	
Care pack report	Monthly deadlines met	
Internal reporting for the quality dashboard, balanced scorecard and AOM objectives	Monthly deadlines met	
Ambulance Service Cardiovascular Quality Initiative (ASCQI)	Complete	

Continual Monitoring – Major Trauma

Project/task	**Achievement**	
Care pack report	Ongoing (6 months in arrears)	
Provision of data to trauma network and external stakeholders	Ongoing	
Internal reporting for the quality dashboard, balanced scorecard and AOM objectives	Ongoing (6 months in arrears)	

Key

	Project/task complete
	Project/task underway or ongoing
	Project/task abandoned or on hold

Clinical Audit Work Plan 2012/13 – Progress Report

Clinical Audit Projects

Project/task	Achievement	
Non-conveyed patients (including outcomes)	Not started	
LAS Alcohol treatment facilities	Not started	
Obstetrics emergencies	Not started	
Assessment and conveyance decision when attending patients in nursing/care homes	Not started	
Inappropriate resuscitations when the patient has a DNAR	Not started	
Cardiac arrhythmias	Not started	
Adrenaline re-audit	Not started	
ROLE re-audit	Not started	
Needle thoracocentesis	Not started	

LAS Clinical Performance Indicators (CPIs)

Project/task	Achievement	
Monthly Complex Reports	Monthly deadlines met	

National clinical audit projects

Project/task	Achievement	
National Clinical Performance Indicators: STEMI, Stroke, Asthma and Hypoglycaemia	Monthly deadlines met	

Continual Monitoring – Cardiac Arrest

Project/task	Achievement	
DH Clinical Quality Indicators (CQIs)	Monthly deadlines met	
Care pack report	Monthly deadlines met	
Internal reporting for the quality dashboard, balanced scorecard and AOM objectives	Monthly deadlines met	
Annual report (2011/12)	Underway	

Continual Monitoring – STEMI

Project/task	**Achievement**	
DH Clinical Quality Indicators (CQIs)	Monthly deadlines met	
Provision of data to hospitals for entering onto MINAP	Ongoing	
Care pack report	Monthly deadlines met	
Internal reporting for the quality dashboard, balanced scorecard and AOM objectives	Monthly deadlines met	
Annual report (2011/12)	Underway	

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH MAY 2012

PAPER FOR INFORMATION

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

Key issues and risks arising from this paper

A number of risks to quality were identified at the meeting on 25th April 2012 and these, together with the mitigation actions, are outlined in the attached paper.

Executive Summary

The Quality Committee is a formal committee of the Trust Board providing assurance on quality and safety of service provision, including the supporting clinical, information and corporate governance framework. The committee meets every two months and receives standing item reports from supporting committees as well as holding a focussed discussion on strategic quality issues.

The attached report provides the Trust Board with an update on the key items of discussion at the meeting on 25th April against each of the domains of the Quality Strategy.

Attachments

Report from the Quality Committee meeting held on 25th April 2012.

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Quality Strategy

This paper supports the following domains of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☒ No

Key issues from the assessment:

Report from the QC following the meeting held on 25th April 2012

Quality Indicators

Overview

There are a number of recurrent themes, of which high utilisation with an on-going increase in the number of Cat A incidents is a significant issue. This has an impact on Team Leaders being available to do face to face feedback on CPIs and Workplace Assessments. Delays in hospital turnaround time do not help because resources are tied up at hospital.

There are also a number of areas which are steadily improving as shown in the QRP, internal audits and the LAS' overall position in the National CPI audits.

Using the Quality Dashboard Indicators

1. Workforce There are 2 significant areas RAG rated red
    - %staff receiving supervision. OWR although improved in last month is short of target 200 by 35.
    - % priority training commitments delivered CSR 1 has been delivered, but CSR 2 is still unlikely to reach its target for the year
2. Performance There are 4 RAG rated red
    - A8 response time
    - C60 response time
    - Average hospital turnaround time
    - Average arrival to hospital handover times
3. Clinical interventions The RAG rated red area is
    - Airway management-the main problem is that end tidal CO2 is not monitored in 100% cases to confirm airway placement
4. Safety There are 2 RAG rated red
    - Safeguarding-due only 60% staff receiving training in CSR1 course
    - Time taken to answer 999 calls-slower as a result of CP implementation
5. Clinical Outcomes There are 3 RAG rated red
    - STEMI outcomes-LAS is not providing the care package as per protocol
    - Infection control –due to only 60% staff having received this in CSR1 course
    - Calls closed with telephone advice the LAS is less than commissioning expectations
6. Dignity 1 Rag rated red indicator
    - Lost property 78 incidents in February (red target >60)

Risks to Quality

Risk	**Mitigation given**	**Links to**
Mismatch between rostered training days & availability of training resources, even on NWOW sites	Introduction of "cluster" model of training	CO5
67% staff attended CSR1. 59% attended CSR2	5189 staff have attended, although 8657 places were provided	CO5
Accuracy of staff attendance & training needs of staff not always clear	Introduction of a clinical training passport	CO5
Area Quality Reports not consistent in reporting	Work in progress	CO1-CO7
Secure PRF boxes seem to be difficult to source. PRFs are important evidence of the care given by front-line staff to patients		CO4
Work pressure felt by staff- worse than expected (QRP-Picker)		CO6
Staff receiving well-structured appraisals-worse than expected(QRP-Picker)		CO5 CO6
SpO2 measurement before treatment not recorded red RAG rated on QRP report		CO1 CO2

Assurance on Quality

Through discussion and challenge the QC noted the following quality achievements:

1) The LAS is ranked in the upper quartile in 12 out of 22 areas in the National CPI audit
2) There is a 97% pass rate for student paramedics on the internal programme
3) The Trust has successfully bid for funding to develop an application to keep patients informed of what has happened as a result of their call
4) The draft Quality Account underlines the work undertaken by the staff of the LAS to improve the quality of care given
5) The LAS has achieved 79% pass rate for the level 2 compliance for the IG Toolkit
6) The on- going overall improvement in the Quality Risk Profile
7) The improvement in the status of the action plans following recent internal audit final report recommendations.

Beryl Magrath May 2012

London Ambulance Service NHS
NHS Trust

QUALITY COMMITTEE

Minutes of the Quality Committee meeting on Wednesday 25th April 2012
in Conference Room, Fielden House

Present:

Beryl Magrath	Chair
Jessica Cecil	Non-Executive Director
Roy Griffins	Non-Executive Director
Murziline Parchment	Non-Executive Director

In attendance:

Sandra Adams	Director of Corporate Services
Mike Dinan	Director of Finance
Francesca Guy	Committee Secretary (minutes)
Caron Hitchen	Director of Human Resources and Organisation Development
Steve Lennox	Director of Quality and Health Promotion
Fionna Moore	Medical Director

20. Welcome and apologies for absence

20.1 Apologies were received from Peter Bradley and Martin Flaherty.

21. Minutes of the meeting held on 28th February 2012

21.1 The minutes of the meeting held on 28th February 2012 were approved subject to an amendment to paragraph 12.7.

22. Matters arising

22.1 The following actions and matters arising were discussed:

22.2 **71.3:** The Chair commented that the Quality Committee needed to look at the impact of the Cost Improvement Programme to ensure that it had not had an adverse impact on quality. Mike Dinan responded that the year end governance for each of the projects was in the process of being completed. He proposed that the clinical leads write a post-implementation review on each of the projects to be reported to the Part II Trust Board meeting. Mike agreed to circulate these reports to members of the Quality Committee prior to the next meeting.

ACTION: MD to circulate the post-implementation reviews on the CIP projects to members of the Quality Committee.

DATE OF COMPLETION: 20th June 2012

22.3 Mike suggested that internal audit should also undertake a review of the Cost Improvement Programme. Mike added that there were other factors outside of the Cost Improvement Programme which might have had an impact on quality, eg the increase in Category A demand. Mike Dinan, Martyn Salter and Fionna Moore were currently discussing how to

improve the practical governance of the CIP for 2012/13.

22.4 **03.3:** Caron Hitchen reported that she had provided Murziline Parchment with the relevant guidance on the role of the non-executive director with responsibility for Local Security Management. This action was complete.

22.5 **03.8:** Fionna Moore reported that as yet, no letters had been sent to entrants on the High Risk Register. The letters would be sent from local AOMs and the East Area was aiming to send its letters out by the end of April. The South and West Areas would send their letters out by the end of May. Any new entrants to the register would receive a letter immediately.

22.6 **03.9:** Sandra Adams reported that work to identify risks associated with the High Risk Register was ongoing.

22.7 **04.4:** The Quality Committee noted that improvement of Category C response times was one of the SMG objectives for 2012/13.

22.8 **05.6:** The Chair commented that she would like to see a summary report on the findings of the temperature check surveys reported to the Trust Board.

ACTION: FG to add staff survey temperature check to the forward planner of the Trust Board.

DATE OF COMPLETION: 31st May 2012

22.9 **07.2:** Steve Lennox reported that he and Fionna Moore had been reviewing the membership of the Clinical Quality, Safety and Effectiveness Committee and the revised terms of reference would be agreed at the next meeting.

22.10 **08.5:** It was suggested that Margaret Vander attend the June meeting of the Quality Committee to give a presentation on public and patient involvement and public education activity.

ACTION: FG to add update on public and patient involvement and public education to the forward planner of the Quality Committee.

DATE OF COMPLETION: 31st May 2012

22.11 **09.3:** Following the serious incident in which staff had not been aware that they had to press the inverter button on the control panel for the electric sockets to work on the ambulance, an update had been sent to staff. Fionna confirmed that there was a good induction pack in place for new vehicles.

22.12 **09.4:** The Chair commented that, as well as incidents, the Trust needed to consider near misses and identify whether there were any key themes or trends. Caron Hitchen suggested that the first step should be to determine whether staff were reporting near misses and this could be identified from the staff survey results. Caron agreed to follow up on this.

ACTION: CH to check whether staff were reporting near misses.

DATE OF COMPLETION: 20th June 2012

22.13 **09.8:** Sandra commented that the summary report on the Integrated Report would be provided for the next meeting of the Quality Committee as the Learning from Experience Group had not met since the last meeting of the Quality Committee.

22.14 A discussion followed about the integrated report and Roy Griffins commented that the report needed to be more focussed and should point the Committee to any issues and key themes and trends. Sandra stated that the Learning from Experience Group would be meeting next week and would discuss this issue. The Governance and Compliance Team was also pulling together an annual report on serious incidents to identify the key themes and the Learning from Experience Group would extract the learning from these. Steve Lennox added that the service experience indicator on the quality dashboard was based on the integrated report and that this was already reported to the Trust Board.

22.15 **11.4:** Mike Dinan reported that the Motor Risk Group was meeting next week and would discuss trends in relation to road traffic accidents. Initial analysis suggested that the third day of a shift pattern was a more significant factor in road traffic accidents than length of shift. The Motor Risk Group would look into this in more detail along with other factors.

22.16 **12.3:** Fionna Moore had circulated the clinical audit triggers to members of the Quality Committee. This action was complete.

22.17 **12.5:** A discussion followed about how recommendations arising from clinical audit should be reported to the Trust Board and to the Quality Committee. RSM Tenon had recommended that these actions should be presented in the same format as the internal audit recommendations and should be monitored by the relevant groups.

23. Quality Report

23.1 Steve Lennox noted that the lost property indicator had been incorrectly rated and should be rated as red. Overall, there were slightly more red rated indicators this month, a number of which had only just missed their SMART target.

23.2 The Quality Committee reviewed each of the indicators in turn, particularly those that were rated red or amber, and noted the following

- 3.2: Percentage of Staff receiving Supervision – This had been rated red as the OWR target had been missed despite reducing the target to 200 per month. The Quality Committee expressed concern that staff were not receiving the supervision they required and thought that this in part accounted for the low scores for staff morale and engagement in the staff survey. Steve Lennox suggested that there might also be a problem with underreporting and this would need to be explored further;
- Beryl Magrath expressed concern that CPI feedback was given to staff via a note in their pigeonhole, especially as staff invariably learnt better from face to face feedback. Fionna Moore responded that this would also be picked up in OWRs, where a number of CPIs would be discussed;
- 3.3: Percentage of priority training commitments delivered through CSR - This target had been missed by 1%;
- 3.4: Agency Headcount - SMG had held a discussion about whether this indicator was capturing the correct data and whether it should also include third party providers. Steve Lennox had agreed to consider this further as it was thought that this indicator was not fit for purpose at the moment;
- 4.1: A8 Response Time Target – This target had not been met, but difficulties had been experienced nationally;
- 4.2 – C60: Response Time Target – Performance against this target was very poor and the improvement of Category C response times was one of the SMG objectives for 2012/13;
- 4.3 and 4.4: Average Hospital Turnaround Time and Average Arrival at Hospital to Handover – Jessica Cecil asked about the ability the Trust had to place pressure on

the London health service to improve this situation. Mike Dinan responded that the Trust had been granted £2.5m as compensation as part of the contract for 2012/13, which was based on the Trust's estimate of the hours lost at hospitals last year. The Trust had also held a hospital summit led by Peter Bradley and Lizzy Bovill, which had received good attendance. Whipps Cross had given a presentation to explain what actions they had put in place to address this problem. However, it was acknowledged that with increased pressure on the system, it would be difficult to rectify this problem. Roy Griffins suggested that perhaps a warning could be given to the Trust Board that further action would need to be taken at a higher level eg writing to the Secretary of State. Caron Hitchen commented that serious incidents were escalated to the Department of Health and therefore they should already be aware that there was a problem with hospital handovers;

- 5.2: Airway Management – Steve had asked the Area Quality Committees to look into this further and to develop local actions;
- 6.2: Safeguarding – The rate of referrals had remained static, but there had been a small improvement in the quality of referrals. However, training remained a concern which is why this indicator had been rated red;
- 6.5: Time Taken to Answer 999 Calls – There had been a slight deterioration this month due to the implementation of CommandPoint, however it was expected that this would show an improvement next month;
- 6.7: Missing Documentation – This had shown a deterioration due to PRFs generated by other contracted services such as Red Cross, St John and special event vehicles;
- 7.2: STEMI Outcome – Crews were currently spending longer on scene than expected;
- 7.3: Infection Control – Overall, infection control had shown an improvement, but had been rated red due to training;
- 7.4: Outcome from Stroke – The first indicator had shown a deterioration. Steve Lennox agreed to look into this further;
- 7.5: Calls closed with Telephone Advice – Overall performance was good in this area, but the SMART target for the second indicator had not been achieved and therefore the overall indicator was rated red;
- 8.3: Lost Property – Steve noted that this indicator should be rated red. Jessica Cecil commented that the Trust received a significant number of complaints relating to lost property. Steve agreed that he would look into this further;
- 10: Comparison table – This showed that the LAS compared favourably with other ambulance trusts nationally.

23.3 Fionna Moore commented that the report was very useful, but suggested that it would be helpful to have a trend analysis to compare data with previous months. Fionna added that there would be much greater focus on Category C patients this year, which would include reviewing complaints from Category C patients.

23.4 Murziline Parchment commented that it was important to understand how many of these indicators would need to turn red before there was concern. Steve Lennox responded that the SMART targets were very stretching and defined what it meant to be a world class city. Therefore it was not unusual for some of these indicators to be red.

23.5 There followed a discussion about the comparison table and it was suggested that this should be displayed locally in ambulance stations as it gave a very good picture of how the Trust performed nationally.

24. Training and Education

24.1 Caron Hitchen stated that the report provided to the Quality Committee was an interim end of year report on training and education. Caron noted the key points which were as follows:

- More training was delivered last year than in previous years;
- Between April and June 2011 the department agreed to minimise training delivery to support operations in achieving performance targets in preparation for CommandPoint implementation;
- Some training sessions had been cancelled due to the fact that not enough people were due to attend. The lesson learnt for this year was to align training delivery with rostered training sessions;
- In December 2011, an interim cluster model for training delivery was put in place alongside the existing NWoW model currently in place at 7 complexes. This had seen an improvement in both the delivery and reporting of training;
- The key areas of training delivery were focussed on CSR; CommandPoint; Olympics and in-house student paramedic training. A decision had been taken in-year to defer the student paramedic training to protect operational performance. It would therefore not be possible to defer this training for a further year;
- The Training Needs Analysis had been reviewed, which set out the type and frequency of statutory and mandatory training. This would be signed off by the Training Strategy Group tomorrow;

24.2 Murziline Parchment asked what action would be taken to ensure that the misalignment of training delivery and rostered training days was rectified. Caron Hitchen responded that the Human Resources and Organisation Development department was looking to introduce an individual learning account, which would guarantee training time for each individual. The department was currently working through how this would work practically.

24.3 Caron reported that the apprentice paramedic programme would be advertised internally next week and would be used as a direct entry recruitment opportunity.

24.4 Caron added that there would be a regular report on CSR training to ensure that the numbers attending are kept to an appropriate level.

25. Clinical Quality, Safety and Effectiveness Committee

25.1 Fionna Moore reported that the last meeting of the Clinical Quality, Safety and Effectiveness Committee had focussed on the reports from the Area Quality Committees. The reports from the areas were still evolving in terms of quality and Steve Lennox was working with the Staff Officers to develop a template.

25.2 Fionna reported the following:

- No significant issues had been highlighted from the areas, but the level of assurance given was not deemed as sufficient and therefore this outcome had been rated amber. No report had been received from Patient Transport Services and this would instead be reported to the next meeting of the Clinical Quality, Safety and Effectiveness Committee;
- The Committee had discussed the integrated report including the use of the Demand Management Plan and availability of bariatric vehicles;
- The Committee noted the list of Never Events for 2012/13. Three Signals bulletins had been published since 28th February 2012 which had some relevance to LAS. There was an opportunity for a 'hot topic' slot at the beginning of CSR training sessions to bring issues like these to the attention of staff;
- The Committee discussed the issue of a member of staff who was practicing as a paramedic without professional registration and the actions taken to ensure that this type of incident did not recur.

25.3 Sandra Adams commented that this information needed to be triangulated with evidence from other sources eg the staff survey.

26. Draft Quality Account 2011/12

26.1 Steve Lennox reported that this was an early version of the Quality Account for 2011/12 for comment.

26.2 The following comments were made:

- The contextual history on the vision and values was confusing and it was thought that this would be better placed in an appendix;
- There was too much benchmarking data and there needed to be more narrative explanation;
- The audience needed to be defined and terms such as world-class needed to be defined and explained.

26.3 Steve Lennox reported that the Quality Account would also be presented to the Trust Board and the final publication date would be the end of June 2012.

27. Audit Recommendations Progress Report

27.1 Sandra Adams reported that the key item to note was that RSM Tenon had undertaken a follow up audit on information governance and had found the evidence they had required which supported the submission for the information governance toolkit. This meant that there was no impact on the Head of Internal Audit Opinion.

27.2 Sandra reported that progress had also been made with the data back up recommendations and a secure safe was now in place at Bow. There were no other issues of concern and most other recommendations were progressing to plan.

27.3 Jessica Cecil asked what processes were in place to ensure clinical oversight of CommandPoint. Fionna responded that a number of cases had been reviewed where there had been delays reaching the patient. The outcomes of these reviews were that the delays were not related to CommandPoint. Fionna confirmed that the clinical oversight of CommandPoint would continue the closing ceremony of the 2012 Paralympic Games, however there would always be focus on any calls which had an adverse outcome and this was not particular to CommandPoint.

27.4 Mike Dinan added that once every Watch had gone through 2 to 3 Friday nights using CommandPoint, this would provide reasonable assurance that the system was operating effectively and call-takers were confident in using the system. Call-answering performance, which had initially been a concern, had subsequently shown an improvement.

27.5 Fionna added that the floor walkers in the Control Room were not as involved as they had previously been and this was indicative of the levels of growing confidence amongst staff using CommandPoint.

27.6 The Chair noted that at the next meeting, the Quality Committee would receive a report on clinical audit recommendations presented in a similar format to that of the internal audit recommendations. Fionna agreed that she would discuss this with Gurkamal Virdi.

ACTION: FM to discuss with Gurkamal Virdi the format of the clinical audit recommendations report.

DATE OF COMPLETION: 20th June 2012

27.7 Roy Griffins noted that overall, there was much better progress in the way in which internal audit recommendations were being managed and much better performance against recommendations. The Chair agreed that there had been a significant improvement over the last 18 months. Mike Dinan commented that this was credit to Frances Wood and Jasjit Dhaliwal.

28. Clinical Audit Work Plan 2012/13

28.1 Fionna Moore reported that the Clinical Audit Work Plan 2012 had been presented to the Quality Committee for information. Steve Lennox confirmed, as a member of the Clinical Audit and Research Steering Group, that he was happy with the plan.

28.2 The Quality Committee noted the Clinical Audit Work Plan for 2012/13.

29. Cost Improvement Programme

29.1 It was agreed that this agenda item had already been covered by the earlier discussion on the Cost Improvement Programme.

30. Care Quality Commission Feedback

30.1 Steve Lennox commented that the initial feedback from the CQC visit had been reported at yesterday's Strategy Review and Planning Committee meeting. The final report from the CQC had not yet been received.

30.2 Sandra Adams added that the CQC had undertaken a routine visit at King College Hospital and had taken the opportunity to get feedback on the LAS. The feedback given was very positive and the CQC had agreed to incorporate these comments into the final report.

31. Quality Risk Profile

31.1 Sandra Adams reported that the data from the recent staff survey had been included. This had had a variable impact on the ratings, but had not highlighted any areas of significant concern. There were a number of red rated items relating to the Information Governance Toolkit, but these were based on last year's submission. The Trust had achieved 79% in its recent submission, which was slightly above target and meant that the Trust had successfully achieved level 2 compliance. It was therefore hoped that a number of these red rated items would change to amber/green.

31.2 The Chair drew attention to the red rated item on page 19 which related to the proportion of patients identified with asthma by ambulance crew for whom Sp02 was measured before treatment or a valid exception recorded. Fionna Moore responded that the Trust had always been vulnerable in this area, but that there had been a significant drop for cycle 7 compared with the cycle 6 results. It was not clear whether this was related to a lack of equipment or that crews were not recording this information. This would continue to be monitored.

32. Risk, Compliance and Assurance Group

32.1 Mike Dinan reported that there had been reasonable attendance at the last meeting of the Risk, Compliance and Assurance Group, but that there had been no attendance from

Operations due to CommandPoint implementation. The Group had discussed risk management processes and in particular how to manage business as usual risks. The Group received reports from the sub-groups, including the Information Governance Group, the Training Strategy Group, Business Continuity Group and the Motor Risk Group. The Motor Risk Group would consider a Rule 43 recommendation to introduce central locking into ambulances and what options were available.

32.2 Roy Griffins stated that it would be helpful for this report to highlight any risks that are of sufficient concern. The Chair added that this would also come through the review of the Board Assurance Framework.

33. Any other business

33.1 There were no items of other business.

34. Date of the next meeting and forward planner for 2012

34.1 The Chair commented that it would be useful to have Lysa Walder, Named Professional for Safeguarding Children, and Kudakwashe Dimbi, Clinical Advisor for Mental Health, attend a future meeting to give an account of their role.

34.2 Steve Lennox asked whether there should be a deputy representative from operations for this committee. Mike Dinan suggested that the ADOs should rotate attendance.

34.3 The next meeting of the Quality Committee will take place on 20th June 2012.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29 MAY 2012

PAPER FOR INFORMATION

Document Title:	**Chief Executive Report**
Report Author(s):	**Peter Bradley**
Lead Director:	**N/A**
Contact Details:	**-**
Why is this coming to the Trust Board?	**To update the Board on key strategic developments and announcements**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Other
Recommendation for the Trust Board:	**That the Board note my report**
Key issues and risks arising from this paper	
Executive Summary This report updates the Board on a range of key issues including: signing of the 2012/2013 A&E contract with Commissioners; changes to Category A clock start; the announcement of changes at the London Assembly, my resignation and the work underway to update the LAS strategy.	
Attachments None	

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

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

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

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

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

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

Equality Impact Assessment

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

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING 29 MAY 2012
CHIEF EXECUTIVE'S REPORT

1. STRATEGIC DEVELOPMENTS

In early April the London Ambulance Service signed the Heads of Terms with our lead commissioner in North West London on behalf of all the London PCTs. The key aim for LAS for 2012/13 was to agree a contract that focused on supporting our strategic direction to continuously improve the quality of our services by ensuring we develop our staff to deliver the right care for the patient, in the right place at the right time.

This ambition was achieved and includes activity assumptions for 2012/13 of a further increase in call volume of 5%, hear and treat of 11%, Cat A incidents of 10.8% and overall incident volume to rise by over 2%. The CQUINs reflect a range of areas to improve front line care as well as increasing the work we are undertaking with primary care in line with developing strong partnerships ahead of the change to commissioning arrangements in 2013. In addition there are the national key performance indicators regarding delivering category A performance with 4% of the contract value in penalties for non achievement. We have also been awarded £2.4m non recurrent funding in recognition of the lost ambulance provision from handover delays at some of London's A&E departments. The final and full contract for A&E, Emergency Bed Service and HART was signed in early May.

Finally, the LAS is currently finalising a service level agreement to secure CBRN funding for 2012/13 and to determine the commissioning arrangements for this funding for 2013/14.

In April a Hospital Summit was hosted by LAS and NWL to bring together partners from acute Trusts across London and NHS London to share good practice and strategies for improving hospital handover. This included a presentation from colleagues at Whipps Cross Emergency Department who have significantly improved their hospital turnaround and virtually eliminated patient handovers that exceed 60minutes over 2011/12. The LAS also took the opportunity to raise awareness of the range of activities we are undertaking to reduce demand and conveyance to accident and emergency departments and specific Olympic assumptions to support planning across the emergency system during the summer of 2012.

Highlights from the progression of our identified service developments for this period include; the successful implementation of CommandPoint; continued planning and assurance for Olympics delivery and that funding has been secured for the LAS Emergency Bed Service to ensure we continue to provide emergency and specialist service demand and capacity information to London as part of our 'Co-ordinating Healthcare in London' plan.

As the Board will hear later in as part of the Foundation Trust update, we are currently updating our strategy and Integrated Business Plan. This is in part in recognition of the time that has elapsed since we first wrote the IBP and also the fact that a number of the service developments have been delivered. (The draft independent review of the Board Governance Memorandum undertaken by KPMG also highlights the need for a refresh of the strategy). A number of enabling

strategies will also be produced including estates, IM&T and workforce. The intention will be to discuss these with Board ahead of final sign off at the July Board meeting.

Clock start change confirmed: The Department of Health announced that the time from which response times are measured is to change to allow up to an extra 60 seconds for an initial assessment of the patient's condition. I have lobbied for this change for some time in my capacity as National Ambulance Director, as it will ensure that more information is obtained before a vehicle is dispatched, meaning there should be fewer cancellations when staff are on their way to calls, and we should have more staff available to respond to other patients.

This change supports the findings of the National Audit Office and the House of Commons Public Accounts Committee reviews last year which highlighted the need for more flexibility in being able to prevent too many staff being sent to calls.

The Category A target of reaching 75 per cent of our most critically ill and injured patients within eight minutes will stay the same. However, all ambulance services will be expected to work towards achieving 80 per cent for Red 1 calls – such as cardiac arrests and airway obstructions – by next April.

On the day of the announcement, I gave a briefing to media, along with Medical Director Dr Fionna Moore and two members of London Ambulance Service staff. There was positive media coverage of the changes in The Telegraph, BBC online, The Independent and the Press Association.

2. COMMUNICATIONS AND ENGAGEMENT

Changes at the London Assembly: The Chairman and I visited City Hall after the recent London elections to meet members of the London Assembly. Victoria Borwick has been appointed Deputy Mayor, and James Cleverly has replaced Brian Coleman as Chairman of London Fire and Emergency Planning Authority.

The Assembly has set up a new Health and Environment Committee which is chaired by Mured Qureshi. Other members include Jenny Jones (Deputy Chair), Victoria Borwick, James Cleverly, Nicky Gavron, Stephen Knight, Kit Malthouse, Onkar Singh Sahota, and Fiona Twycross.

Our stakeholder engagement has continued since the last report with the publication of a further GP newsletter and meetings with the new Clinical Commissioning Groups over the coming months. . Furthermore, the LAS continues to support the roll out of 111 across London in partnership with NHS London and local providers. Pilots are now live in Hillingdon, Croydon and Inner North West London.

Announcement about my departure: I announced this month that I will be leaving the Service later this year to take up the post of Chief Executive of St John in New Zealand – a role that will include running the ambulance service.

I have been Chief Executive of the London Ambulance Service for 12 years, and have been privileged to lead such a great organisation. However, this opportunity, which came completely out of the blue, is a challenge too tempting to resist. Work has begun in earnest to find a suitable replacement for me.

I will not be leaving until after the Olympic and Paralympic Games, and I will be fully committed to leading the Service until my last day.

All key stakeholders and staff were made aware of my news at the same time that my appointment was announced in New Zealand.

I will be meeting with David Flory in June to discuss what happens with the DH National Ambulance Director role after my departure and will also meet ambulance Chief Executives and the Board of the Association of Ambulance to agree a date for me to relinquish my Chair role.

There are over 450 events on the PPI and Public Education activity database for 2012 so far. These include school visits, Junior Citizen schemes, knife crime awareness talks and events, basic life support training and road safety events.

Very positive feedback was received from mental health service users who took part in a telephone survey undertaken by Central & North West London Mental Health Trust. All participants had been sectioned under the Mental Health Act.

97.4% of respondents said they were treated with respect and dignity by the ambulance crew, and the same number reported feeling safe with them. 82.9% said the ambulance crew appeared to take their needs and feelings into account. Most (77.6%) were taken to a place where staff already knew them, and 74.4% said the ambulance crew kept them completely informed and reassured during the journey. 81.8% said they felt very satisfied with the care they received from the London Ambulance Survey.

This year's CQUINs include obtaining patient experience data from patients who have not been conveyed to hospital by ambulance. This project will form part of the work programme for the Patient & Public Involvement and Public Education team.

Last week I hosted my final Ambulance Leadership Forum (ALF) in Coventry. This is the tenth ALF event we have arranged over the last few years and it brings together over 150 Chairs, Chief Executives and Directors from ambulance services around the UK. This year's speakers included Sir David Nicholson and the Minister with responsibility for ambulance services Mr Simon Burns MP. My thanks to Steve Irving, Gill Cristiani, members of the LAS comms team and latterly Louise Wilson who have provided invaluable support organising and supporting ALF over the years.

One story in the media that captured headlines across the world this month was that of an ambulance crew who, with help from Hollywood star Dustin Hoffman, saved the life of a man who collapsed and stopped breathing while out jogging. The 27-year-old patient went into cardiac arrest as the Fulham crew arrived on scene; they were able to resuscitate him using CPR and a shock from a defibrillator. Dustin Hoffman, who had waited with the patient, acknowledged their good work.

Peter Bradley CBE
Chief Executive Officer
21 May 2012

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD (pt 1)

DATE: 29 MAY 2012

PAPER FOR APPROVAL

Document Title:	**Annual report and accounts 2011/12**
Report Author(s):	**Angie Patton/Michael John**
Lead Director:	**Mike Dinan**
Contact Details:	
Why is this coming to the Trust Board?	**To obtain approval for the annual report and request for delegated authority to be given to the Audit Committee to approve the accounts on 1 June 2012**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group
Recommendation for the Trust Board:	**That the Trust Board:** • **approves the annual report section** • **delegates authority to the Audit Committee to approve the accounts on 1 June 2012**

Executive Summary:

- As an NHS organisation, we have a statutory requirement 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).
- This year the Service's annual report focuses on meeting the minimum requirements for content.
- The Trust Board is asked to approve the annual report (the following sections: Who we are, Chairman's views, Chief Executive's views, Directors' report, and Our Trust Board)
- The Board is also asked to delegate authority to the Audit Committee to approve the financial accounts at its meeting on 1 June 2012.
- The annual report and accounts will be submitted to the auditors on Friday 8 June 2012.
- The annual report will be published on the Service's website along with the Quality Account at the end of June.
- An annual review, based on the format of the Ambulance News newspaper, will be produced for the Service's wider stakeholder base and this will be published prior to the AGM in September.
- Both the annual report and the annual review will be presented at the AGM in September.

Key issues for the Trust Board
Recommendations as detailed.

Attachments
None.

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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
NHS Trust

Annual Report

2011/12

Contents

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.

As the mobile arm of the health service in the capital, 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 which comprises a non-executive chairman, six non-executive directors and six executive directors, including the Chief Executive.

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 the emergency response for large-scale or major incidents in the capital.

We have over 4,500 staff who work across a wide range of roles. We serve more than seven-and-a-half 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 2011/12 we handled over 1.6 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, or visit London.

Chairman's views

What were the key achievements last year?

Last year was one of our best ever in terms of the number of calls handled, patients attended to within eight minutes, and lives saved.

It was also a year in which we hit our financial targets. We were near the top of the new clinical quality indicators, and our chief executive has been instrumental in pushing for a new clock start time initiative, which will help triage our calls more efficiently and ensure we send the appropriate response.

What were the biggest challenges and how were these met?

Our events planning experience was put to the test as London hosted a number of high-profile events during the year including the Royal Wedding and President Obama's state visit.

The 7 July bombings inquests, which concluded May 2011, were a hugely challenging experience for colleagues who had to relive those terrible events as they gave evidence. And I recall watching the London riots unfold in August and thinking about the daunting task faced by our staff attending patients in those difficult circumstances.

On top of that, as the financial year drew to a close, we brought in our new call-taking and dispatch system. This has been a difficult and demanding project, as all such complex system upgrades tend to be. However, the dedication and commitment of staff from all areas of the organisation has paid off, and the system is working well.

What improvements have patients seen?

We attended more critically ill and injured patients than ever before last year, and we have continued to improve the care we provide to them.

We play a vital role in the London trauma system, taking patients with life-threatening injuries such as amputations and stab wounds to specialist centres for treatment; latest figures show that, as a result, an additional 58 of these patients survived in London compared to the national average.

More people who suffer a cardiac arrest, when their heart stops beating, are surviving because of the care we provide. And our staff now take over 90 per cent of our patients who have heart attacks to specialist treatment centres.

It is not only our most seriously injured and ill patients who are getting better care; we are referring more elderly people who fall in their home to their GP so that solutions can be found to prevent this. And we are working with more mental health trusts to improve the care we provide to their patients.

When do you expect to become a foundation trust?

We were disappointed not be granted foundation trust status this year. We were rated on a framework and when everything was added up, we were told we were not quite ready. We aim to achieve it next year instead.

The Government expects us to become a foundation trust, so we need to respond to that. But we do see advantages, including the opportunity to retain any surplus budget to reinvest in our business, and this brings with it greater freedom to shape our Service for the future.

Chief Executive's views

What kind of year has it been for the Service?

It has been one of our most successful years ever. We have continued to answer 999 calls to world-class standards and can point to improvements in the quality of care we provide across a range of patient groups, from stroke, cardiac care and trauma patients to those who need end of life care.

Alongside our successes, we've faced some challenges. We received a record number of 999 calls last year, making it our busiest year ever. We came under pressure when half of our staff withdrew their labour during industrial action over the Government's proposed pension reforms last November, and we have been the focus of reviews by the London Assembly and the National Audit Office.

There is no doubt that the issues and scrutiny we face in London are different to elsewhere in the country, and I feel really privileged and proud to have led the London Ambulance Service over the last 12 years. It is, in my view, the best capital city ambulance service in the world.

How has the Service performed against the new national clinical quality indicators?

The new national indicators show us how the quality of care we provide compares with other ambulance services across the country, and the first year's results are encouraging.

We have some of the fastest 999 call answering rates in the country, and we are doing particularly well in terms of our re-contact rates, which show that the number of patients who call us back after we have given them advice over the phone or treated and discharged them at scene is very low.

The care we provide to patients in cardiac arrest is of a very high standard, and we provide more clinical advice over the telephone than many ambulance services. Of course, there is always more we can do and we will focus on those areas where we are doing less well over the next year.

You announced a five-year savings plan of £53m. How will you achieve this without compromising patient care?

All NHS trusts need to achieve their share of savings and we are no different.

In the first year of our savings plan we made £15m of savings without affecting patient care. This year, we need to find further savings of £12.5m and we will continue to keep a close eye on whether budget reductions are having any impact on the quality of care we provide.

We know that we can work more efficiently, and we continue to look at more appropriate ways of responding to our patients to ensure they get the right care, first time.

This includes providing more clinical advice over the phone, reducing the number of resources we send to calls when it is not necessary, and working with hospitals to reduce the amount of time it takes our crews to hand over patients at A&E departments. We also

want to identify more alternative places of care to hospital where our staff can take patients for treatment.

Are you ready for the Olympic and Paralympic Games?

Yes, we are. We have spent a number of years preparing and planning for what will be the biggest event we have ever dealt with.

We have around 440 frontline staff dedicated to working at Games venues – half of these are coming from other NHS ambulance services around the country.

We expect demand on our Service to be around five per cent higher than normal, with it increasing by nine per cent during peak periods. Our priority will be to maintain our day-to-day emergency service across the capital whilst providing medical care to Olympic-related patients.

We have tested our plans and held our first ever national exercise to test all aspects of our response. The Games promise to be a great opportunity to show how the NHS ambulance services in England can work together to deliver high quality patient care.

What are the other priorities for this year?

The Trust Board has agreed to have fewer priorities this year given that we have the 2012 Games and a range of other large events to manage.

However, it is important that we continue develop our Service so we will open a second call-taking room this year to provide more resilience; we will continue to work towards becoming a foundation trust; and we will further improve our fleet. We will address issues that were raised by our staff at last year's consultation meetings and through the staff survey, and we want to continue to develop our relationships with key stakeholders including the new clinical commissioning groups who will buy our services.

Directors' Report

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 Londoners having health outcomes that are among the best in the world.

We have a vital role to play in delivering healthcare in London, and have achieved much to improve the quality of our service, and ensure that our patients receive the right care, delivered in the right place at the right time.

Our strategic goals are:

- 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.

We believe that we will be better placed to achieve our goals by becoming an NHS foundation trust.

This status will:

- make us more accountable to our patients and the communities we serve
- give us greater financial freedom
- provide us with more opportunities to lead and work in partnership across London to develop and improve healthcare services
- provide more opportunities for longer term planning through clarity of vision and strategy
- recognise us as an excellent organisation.

In December last year, NHS London gave approval for our foundation trust application to be submitted to the Department of Health. Having reviewed our application, the Department of Health has asked for additional assurance to be provided on some areas. We have revisited the timescales for our submission, taking account of our focus over the summer to provide a safe Olympic and Paralympic games, and we anticipate that we will resubmit our application to the Department of Health in March 2013.

Our achievements during 2011/12

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

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

As a 24/7 pan-London healthcare provider, we are often the first point of contact for people who want medical help, whether it is an emergency or a less serious condition. Our response will determine whether they get the right treatment to meet their needs.

To achieve this goal we will:

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

We attended more patients than ever before in 2011/12, responding to more than one million incidents.

Over the last 12 months, we have continued to improve the care we provide to our patients, whether they have life-threatening conditions or less serious illnesses or injuries. And since April last year, the quality of care we provide has been measured against a range of clinical indicators, which extend beyond time-based targets.

Our Quality Account reports in detail on the progress we have made in improving the quality of care we provide to our patients. Below are some of the key achievements.

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

  Trauma care: Our staff continue to play a vital role in the new London trauma system which saw 58 additional patients with life-threatening injuries, such as amputations and gunshot wounds, survive during 2010/11, compared with the national average.

  Following a clinical assessment and vital treatment at scene, ambulance crews take trauma patients direct to one of four specialist centres in the capital where consultants are on hand 24/7 to provide expert clinical care, giving patients the best possible chance of survival. The average ambulance journey time from the scene of an incident to a major trauma centre is 16 minutes.

  Cardiac care – heart attack patients: In 2011/12, we took over 2600[1] patients who were diagnosed as suffering a common type of heart attack, known as an ST-elevation myocardial infarction, directly to a heart attack centre. There are eight specialist heart centres in London where patients undergo primary angioplasty, a procedure which involves inflating a balloon inside an artery to clear the blockage that has caused the heart attack.

  The new national clinical indicators measure how many heart attack patients receive primary angioplasty within two and a half hours of having a heart attack; in London the latest available figure (for the period April to December 2011) is 91.9 per cent.

  Cardiac care – cardiac arrest patients: The chances of surviving a cardiac arrest in London are better than ever, and are higher than elsewhere in the country.

  Our most recent figures (for the period April to December 2011) show that 30.3 per cent of patients whose hearts stopped beating, at home or in public, were resuscitated and discharged from hospital. Back in 1998/99, only 2.5 per cent of these patients survived.

[1] This figure is provisional based on data available on 18 May 2012

The current figures are also a significant increase on the cardiac arrest survival rate for 2010/11 which was recorded as 22.8 per cent, when 259 patients survived after their hearts stopped.

The improvement in cardiac arrest survival rates reflects a wide range of developments in the care and treatment of cardiac patients in the capital.

The public has an important part to play as well, and we have done a great deal of work to enable others to start giving life-saving treatment to cardiac arrest patients before we arrive.

Working with the British Heart Foundation, we placed a further 185 defibrillators – machines that are used to re-start a patient's heart with an electric shock – in public places last year. This means there are now over 750 defibrillators across London including at tourist attractions, and in airports and train stations. And we trained almost 1,400 people working in these areas in their use in 2011/12, bringing the total to 8,058 across the capital.

During the last 12 months, our staff also trained 8,234 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 30 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 750 trained volunteers within these schemes.

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.

We took 8200 stroke patients to a hyper acute stroke unit in 2011/12; this was 95 per cent of all stroke patients who we attended[2].

One of the national indicators measures 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 65.1 per cent of cases. We are concerned with our performance against this measure, bearing in mind the relatively short journey time to the stroke units – on average this is 17 minutes. We will be looking at how we can reduce the time our crews are spending with stroke patients before they take them to hospital.

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

  During 2011/12, we treated a wide range of patients presenting with less serious conditions.

[2] Figures given here are provisional based on data available 18 May 2012

Taking patients to the right place of care: As part of a wider NHS response to managing patients with less serious conditions, we have 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 70,842 patients over the phone, an increase from 50,058 last year and 47,180 in 2009/10.

Care for elderly fallers: We have introduced a new system to improve the care given to older people who fall in their homes. Every month we respond to around 6,500 people aged 65 and above who have had a non-traumatic fall – usually a slip or stumble – at home. Last April we started to refer those patients who did not need hospital treatment to their GP. The referral means GPs can spot if their patients are falling regularly, and help prevent this. We are now referring almost 1,200 patients each month to their GP, with a total of just under 9,000 being referred since the start of this initiative.

Care to mental health patients: We now have arrangements in place with four of London's nine mental health trusts so that any mental health patients we attend receive the right care in the right place. We plan to agree similar arrangements with the other trusts.

We have also started work 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.

The process for other agencies to request support from us to transfer any mental health patients who are assessed in the community was revised during the year. The policy for booking ambulances for mental health sections now enables us to provide a service that ensures privacy and dignity for the patient, improves reliability, allows us to send staff with the right skills for an individual's needs, and ensures the safety of the patient and our staff.

End-of-life care: Supporting end-of-life care strategies across London is a growing priority for us, and fits with ongoing strategic developments including identifying and making use of appropriate health care centres other than hospital emergency departments and giving people a choice about where they die.

We have been working with both NHS and hospice-based end-of-life care providers to provide end-of-life care support that is appropriate. We have 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: We offer pre-arranged transport for patients to and from their hospital appointments, and we carried out 180,004 of these journeys last year, compared to 204,454 in 2010/11.

We delivered patients to hospital on time for 92 per cent of the journeys, compared with 90 per cent the year before, and 92 per cent in 2009/10. And we departed hospital on time in 93 per cent of cases. This compares with 95 per cent in 2010/11, and 93 per cent in the year before that.

Ninety five per cent of our patients had a journey time of less than an hour; this was the same as the previous three years.

Our total number of contracts at the end of the year stood at 20. One of these is a new contract that started in July 2011 at Queen Mary's Hospital Roehampton.

- ***Meeting response times routinely***

In 2011/12, we received 7.5 per cent more 999 calls than in the previous year. A total of 1,605,956 emergency calls were handled in our control room, compared to 1,494,207 in 2010/11 and 1,480,275 in the year before.

We have introduced a new system for handling 999 calls and sending staff and vehicles to patients. The system, CommandPoint, was initially implemented in June 2011, but there were technical problems and we had to switch it off. The faults which caused the system to fail were fixed, and following further developments and staff training, live tests were carried out before it was re-introduced fully at the end of March this year.

The system, which has been running well since it was brought in, will improve our ability to handle 999 calls and meet the challenges of population growth in the capital and ever-increasing demand on our service.

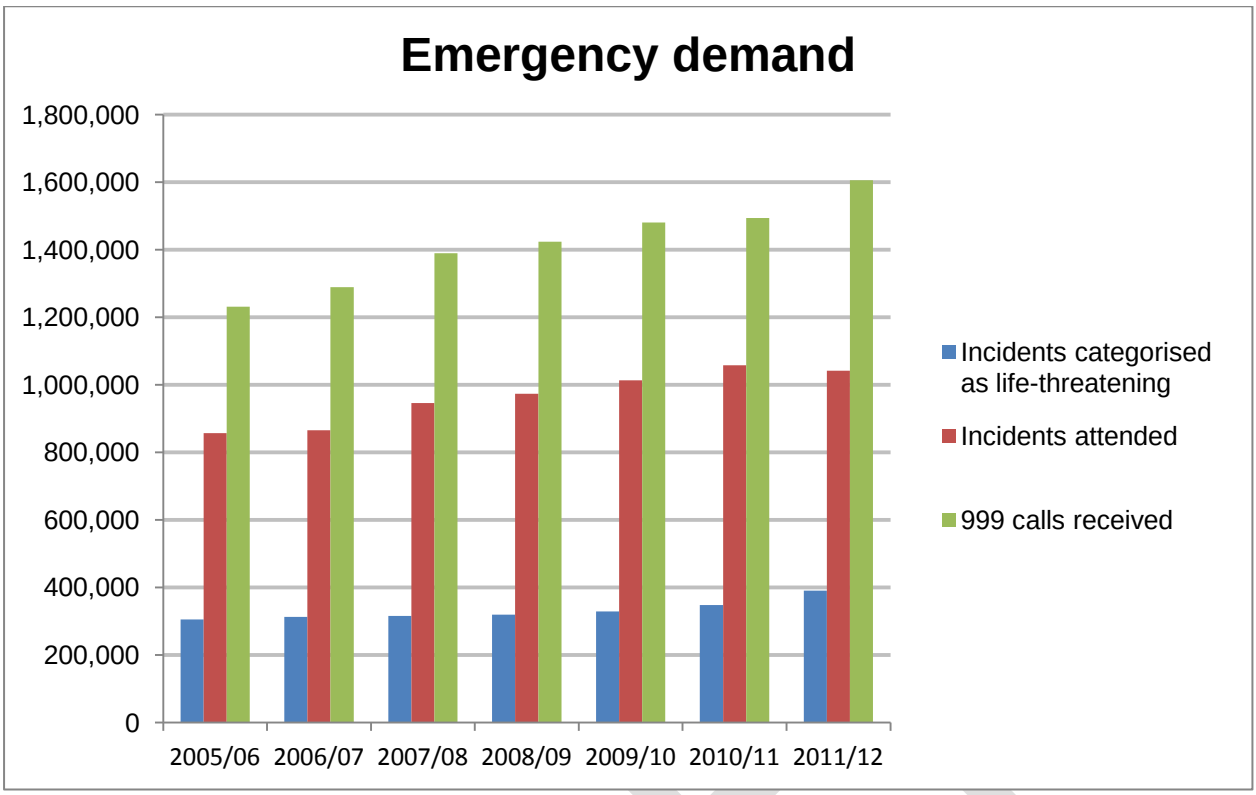
Of all the calls we received last year, we responded to 1,041,739 emergency incidents, down from 1,058,132 the year before.

We took fewer patients to a hospital accident and emergency department – 735,270 compared to 785,014 the year before. And we conveyed more people to an appropriate care centre such as a minor injuries unit; in 2011/12 this was 74,127 compared to 27,578 and 21,896 in 2010/11 and 2009/10 respectively. In 232,342 cases, our staff attended a patient but did not take them anywhere for further medical treatment. We also gave clinical advice over the phone to 70,842 patients with minor illnesses or injuries, up from 50,058 the year before.

Despite a busy year, we achieved the national response time targets to reach:

- 75 per cent of Category A (life-threatening) calls within eight minutes
- 95 per cent of Category A calls within 19 minutes

The number of life-threatening (Category A) calls received during 2011/12 increased by over 12.5 per cent (412,426 calls were received compared to 366,296 in 2010/11). We attended 390,229 of these incidents, compared to 347,675 the year before, and we reached 75.74 per cent (295,551) of these patients within eight minutes. This is the ninth year in a row that we have achieved this national response time target.
We reached 99.14 per cent (374,970) of Category A patients within 19 minutes, exceeding the target of 95 per cent.



All other calls fall into one of four C categories. We received 1,048,894 calls to category C (lower priority) patients last year. Of these, 628,526 received an ambulance response, and we reached 91.04 per cent of these patients within our target time of 60 minutes.

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

We achieved unconditional registration in March 2010 with the Care Quality Commission which we maintained in 2010/11. The Commission carried out a routine visit to the Service at the end of March 2011. The review identified one minor concern against outcome 9. This has already been addressed and action taken, and a new compliant system has been implemented. Areas of strength observed by inspectors including the care we provide to mental health patients and those with learning disabilities, and the work of our public education team. In terms of improvement, inspectors stated that there was scope for us to tighten our recording of mandatory training.

We were reassessed at level 1 of the NHS Litigation Authority risk management standards for ambulance trusts in October 2010 and achieved this with a much improved score on the 2008 assessment. We are due to have another assessment in October 2012.

The Director of Health Promotion and Quality is the lead for infection prevention and control and has strengthened our monitoring and audit processes for compliance with the hygiene code regulations. A scorecard is presented each month showing performance against key infection prevention and control indicators.

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

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

We continue to invest in their development so that staff on the frontline 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 2012, we had a workforce of 4,526 staff; this was against a total of 4,708 funded posts.

  As part of our savings plan, we reduced our workforce by 151 posts at the start of the year; 132 were frontline posts, and the remainder were support posts. We had 166 people join the organisation, down from 325 in 2010/11. And over the year, 342 people left the Service – a turnover rate of 7.1 per cent, which is the same as the previous year.

  Our numbers of paramedics continued to increase, as more of our student paramedics qualified during the year. Approximately 700 people were recruited into the new role of student paramedic between 2008 and 2010, and those who successfully complete a three-year training programme become fully qualified paramedics. In 2011/12, 281 student paramedics qualified. In addition, 70 emergency medical technicians completed training to become paramedics, 25 students qualified on higher education foundation degree programmes, and 18 qualified on BSc degree programmes.

  In the coming year, we expect a further 379 student paramedics to qualify as paramedics, as well as 48 emergency medical technicians and 71 students through higher education. This will bring the total number of paramedics to around 1,950, taking us closer to our ambition to ensure all patients who receive an emergency ambulance response are treated by a paramedic.

  In terms of training, we provided 7,447 units of training, against a plan of 10,374 covering 42 subject areas. This compares with approximately 6,000 units last year. The rate of sickness among our staff for 2011/12 was 5.32 per cent, against a target of five per cent. This compares with a sickness rate of 5.2 per cent in the previous year.

In relation to severance payments, no employees left the Service under terms that required Treasury approval last year.

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.

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 also aim to ensure that:

- our patients and customers are aware of our services and that those services are accessible to all
- our public buildings and information are accessible to all
- our diverse communities in London can be involved in the development and monitoring of our policies and services.

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 2011, we were named amongst the country's most gay-friendly workplaces. We took 94th place in Stonewall's Top 100 Employers list, being the only ambulance service to be recognised. Stonewall's workplace equality index recognises organisations that have inclusive policies, engage with staff on sexual orientation issues, demonstrate visible leadership for lesbian, gay and bisexual (LGB) equality, and have well-supported LGB network groups that play a constructive role in the organisation.

We are members of the Employers' Forum on Disability as well as Carers UK. 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 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.

- ***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 consulting with staff to achieve this.

Our staff engagement score last year, informed by the NHS staff survey, was 3.15 (based on a score range from 1 to 5). This is 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 score is down from 3.28 in 2010 which is disappointing, although nationally there has been a decline across ambulance service scores from 3.30 in 2010 to 3.23 last year.

Staff survey findings: Last year's survey highlighted improvements in areas such as the number of staff who received e-learning and those who were trained to handle confidential information. At a local level, 60 per cent of respondents at our Greenwich complex felt managers encouraged team working and helped them with difficult tasks; at Isleworth over 65 per cent felt they had clear objectives; and 87 per cent of staff at Hanwell said they are trusted to do their job.

In terms of overall results, however, job satisfaction was below average compared to other ambulance services. And the survey highlighted some staff involvement issues that we need to improve. For example, fewer staff said that they felt able to contribute to improvements at work and there was a drop in the number of staff who said that communication between senior management and staff was effective.

Staff conferences and consultation meetings: We ran programme of internal conferences and consultation meetings throughout the year which provided staff with an opportunity to hear about our future plans, and to raise issues that matter to them.

There were a total of 13 conferences held for managers, support staff and team leaders, and our Chief Executive and Medical Director spoke with over 1,200 frontline staff at local consultation meetings. Meetings also took place with call handling staff, student paramedics and university students.
The main issues that came up at consultation meetings for frontline staff - and which the Chief Executive has made a commitment to address this year - are the lack of rest breaks given to staff, late finishes on shifts, the frequency that staff have to go out of their local area to attend patients, the arrangements for shift rotas, and the lack of vehicles and equipment. A&E support staff also feel that they have limited opportunities for career progression and training.

Opportunities for giving feedback and sharing ideas: Last year we introduced a 'temperature check' survey which is carried out three times a year to enable staff to

give running feedback on their views about working for the Service and how they think working life can be improved.

When we announced our five-year cost saving plans, we also encouraged staff to suggest ideas about where they felt savings could be made. Staff shared ideas directly with the Chief Executive and members of his management team through face-to-face meetings, and over 400 cost saving suggestions were submitted through a dedicated email address.

Over fifty ideas have been received through another recently-launched initiative, Change one thing, which gives staff the opportunity to make suggestions that will improve the working lives of staff or the experiences of patients.

As a result of staff feedback, for example, a clinician has been working with the procurement department to review contracts with suppliers in a bid to purchase better products for less. It is expected that the renegotiation of prices for ECG electrodes and other equipment such as defibrillator pads could achieve annual savings of £100,000.

Health and well-being: Our LINC (Listening, Informal, Non-judgemental, Confidential) peer support worker initiative marked its tenth year this year. The informal, voluntary network has 100 trained staff who can listen to and support Service colleagues on issues from work-related stress to family and social problems.

Partnership working with the unions: We have long-established partnership working arrangements with our trade union colleagues, with a formal consultation and negotiation framework in place.

We have continued to consult 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.

We worked with the unions during the year to successfully bid for funding for the development of apps for staff as part of the strategic health authority's Engaging for Quality initiative. We have been granted £52,000 to produce the apps, and plan to engage with staff to decide on the topics that should be covered, as well as the content and look and feel of the products.

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 is extremely important that we provide Londoners with a service that represents value for money.

It currently costs residents £30 each per year for their ambulance service. This is less per head of population than most other ambulance services in the country, but in the future we will need to maintain levels of service for less money.

To achieve this goal we will:

- use our resources efficiently and effectively
- maintain service performance during major events, both planned and unplanned including the 2012 Games, and
- improve engagement with key stakeholders.

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

  In April last year, we announced a five-year plan to make savings of £53m.

  Our aim is to maintain high levels of patient care despite having to make cuts over this period. This will involve us working differently and more efficiently.

  With 80 per cent of our budget going on staff costs, however, staffing numbers will be affected. We are therefore planning to reduce the number of posts across the organisation by 890 over the five-year period.

  We have achieved our first-year savings target of £15m in 2011/12.

  The reductions, which equated to five per cent of our £282m budget, were delivered through reducing pay costs and making savings in areas of non-pay.

  In all, 151 posts were removed from the workforce establishment as part of the savings plan, and agency costs were reduced by £2m.

  Savings in non pay costs have been made by renegotiating contracts with suppliers, and acting on ideas suggested by staff, particularly about the equipment they use in their jobs.

- ***Maintain service performance during major events, both planned and unplanned including the 2012 Games***

  We have to be prepared for anything that may happen in the capital, whether it is a planned event or an unplanned emergency.

  Managing events in 2011/12: We successfully managed a range of large-scale planned events during the year, notably the Royal Wedding, as well as New Year's Eve, the London Marathon, and the Notting Hill Carnival.
  During early August, we assessed and treated around 250 people who were injured during the violent disturbances that hit the capital. Specially trained response teams attended calls to help patients in the main areas of disorder, working closely with Metropolitan Police public order officers. Crews also had to be escorted by the police to attend some patients not involved in the violence but who lived nearby and needed medical help.

We have recently revised our major incident plan which outlines the operational steps we will take in the event of a major or catastrophic incident occurring. The amended plan, which will be published early in the 2012/13 financial year, has incorporated a number of issues from the London bombings inquests.

London bombings: At the end of the inquests, coroner Lady Justice Hallett stated that there was more that could and should be done to learn lessons from the bombings, and she published nine recommendations intended to prevent loss of life in the future.

One recommendation was specific to the Service – "that the LAS, together with Barts and the London NHS Trust (on behalf of London's Air Ambulance) review existing training in relation to multi-casualty triage (ie the process of triage sieve) in particular with respect to the role of basic medical intervention".

The coroner expressed concern that the speed of the triage (assessment and treatment) process did not "encourage treatment", and although it allowed for putting an unconscious patient into the recovery position and providing basic airway management and applying a dressing to serious bleeding, this had not happened at each of the incident sites on 7 July 2005. As a result, we have committed to delivering major incident training to all frontline staff over the next two years which will address these issues.

In addition, our updated major incident plan advises staff who are carrying out the initial triage to work in pairs, take key equipment with them – and if necessary leave it nearby for other staff to use, look for signs of life when they assess patients and record patient observations and treatment details more fully. The plan also explains the protocol for covering deceased patients, another issue raised by the coroner.

Planning for London 2012: Planning has continued throughout the year to ensure that the Service is prepared so that it can play its part in delivering a safe and secure Olympic and Paralympic Games.

Our focus during the Games will be to maintain our service to Londoners while providing medical care to Olympic-related patients. We expect demand to increase on average by 5.6 per cent; this may rise to nine per cent at peak times – an increase of around 360 calls a day.

The Department of Health has agreed funding of £7.6m to help us deliver our service during Games time. In addition, we have absorbed a further £2.5m of costs within our current budget.

We plan to meet the increased demand in a number of ways. We will have over 400 staff working at the Games venues, and half of these will be from other NHS ambulance services. All clinical staff will complete a six-day tailored training package before the Games begin.
There are a large number of cultural events in the run-up to and during the Games period, and we will work with voluntary and private ambulance providers to cover these.

Other measures to help us maintain our service include deferring planned training and postponing non essential activities, so that we can maximise the number of ambulance staff working on the frontline during Games time.

And we have worked with Transport for London to get access to the Olympic and Paralympic route networks to attend emergencies and take patients to hospital, as well as to transport staff to and from venues.

Throughout the last year, we have taken part in joint agency exercises to test our plans for the summer. We have also supported the London 2012 Organising Committee (LOCOG) at sporting test events, including the road races and those within venues.

- ***Improving engagement with key stakeholders***

We have a challenging change programme ahead, and we recognise the need to engage with a range of stakeholders to enable us play our part in improving emergency and urgent care in the capital.

NHS reform means that our stakeholders within the health economy are changing. As well as engaging with our strategic health authority and our primary care commissioners, we have started to develop relations with GPs leads in the local clinical commissioning groups that will buy our services in the future.

We have improved our relations with the Mayor's Office during the year, particularly with the Mayor's advisor for health and families. And the review carried out by the London Assembly of our Service gave us a valuable opportunity to engage with members of the Health and Public Services committee. We formally responded to the committee's review recommendations in March 2012.

In addition, we have met a number of London MPs throughout the year from all parties.

Governance of our organisation

Our Trust Board manages risk through our risk management policy and strategy, corporate risk register and board assurance framework, all of which were reviewed during 2011/12.

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. Our Trust Board has been able to take assurance that the work carried out to mitigate and manage the key risk areas has effectively reduced the level of risk and removed all but two of the risks from the corporate register by the end of 2011/12.

The Board reviewed the effectiveness of each of its committees and the overall governance structure in July 2011 and no further changes were made. Our Chair seeks assurance from committee chairs at each Board meeting as to the effectiveness of the committee and the relationship with others. The structure benefits from cross-representation of non-executive directors on the key board committees. The Finance and Investment Committee was established in early 2011 and will be included in the committee effectiveness review in June 2012.

We went through a refresh of our external due diligence assessment in April and November 2011 in support of our foundation trust application. The Trust Board and the strategic health authority have been able to take assurance from the progress made within the year to manage and remove areas of concern.

A new process – the Board Governance Assurance Framework – was introduced by the Department of Health in December 2011 and our Trust Board undertook its self assessment and signed off the Board Governance Memorandum on 27 March 2012. This is being independently assessed by accountants and the final report will be presented to the Trust Board on 29 May 2012. An action plan has been prepared to address areas for improvement.

We also had an external assessment of our quality governance arrangements in December last year as part of the foundation trust application process. The outcome of this contributed to the delay to our application and an action plan is in place to address areas for improvement. This will be reassessed in July 2012.

Our use of feedback to make improvements

We continue to use the feedback we receive, including complaints, to improve our services and the quality of care we provide.

This year, for example, we have made changes to the advice we give to callers when we are not sending them an ambulance straight away; this helps to manage their expectations as not all calls need an ambulance response despite people thinking this will happen automatically.

We have also redesigned our maternity packs so that they have more appropriate equipment in them; a hat has been added to keep the baby warm, and the addition of an extra towel means ambulance crews no longer use two packs when helping with the delivery of a baby.

We work very closely with other organisations regarding the feedback we receive, and this helps to drive change across health and social care in London. This has led, for example, to one acute hospital introducing better directional signage for patients and visitors, and another has reviewed its maternity care practice.

We also have governance mechanisms in place so that we can gain a better picture of any emerging trends and incidents of particular importance to patient care.

During 2011/12, we received 673 complaints, which equates to 0.04 per cent of the total calls we received. This compares with approximately 450 complaints in each of the two previous years. There are a number of reasons for the increase. Firstly, the impact of a change introduced in 2009 to how complaints are recorded is now becoming evident; secondly, the Service is handling more 999 calls which brings with it a corresponding increase in complaints; and thirdly, as we have changed the way we deliver our service, including providing more clinical advice over the phone, the public's expectations of automatically receiving an ambulance are no longer being met.

Our Patient Experiences Department also received 6,200 enquiries, including approximately 100 incident reports from other health and social care agencies.

We remain committed to safety and public accountability by being open about matters when something goes wrong, and we publish case studies on our website at www.londonambulance.nhs.uk under *About us > What we do > Making your experiences count.*

Our use of a care plan approach, where we tailor the needs of patients to an individual care programme, has been widely adopted by UK ambulance services. As well as helping us to meet the needs of patients, this approach enables us to manage demand more effectively. Details about our Patient Centred Action Team are available on our website under *Health professionals > Caring for frequent callers.*

We continue to liaise more and more with other agencies to promote safeguarding of both adults and children. More information is available on our website under the *Health professionals* section.

Our plans to reduce our carbon footprint

The Carbon Trust has recently 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.

Our aim is to reduce our carbon emissions by 8,959 tonnes CO^2 by March 2016. This is based on a baseline for the Service of 62,776 tonnes CO^2 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.

In 2011/12, we reduced our total carbon emissions by four per cent to 60,084 tonnes CO^2.

Fuel consumption: Our core business means that we have high levels of fuel consumption. In 2011/12, we responded to more than one million incidents, using over 4.2 million litres of diesel.

Over the last two years we have replaced our old LDV ambulances. Our new ambulances can cover an average of 18 miles per gallon, compared to nine miles covered by the old ambulances. The new vehicles are almost 90 per cent recyclable by weight.

We will be developing a business case in 2012/13 to purchase electric vehicles for use by our post room and our patient transport service, following a trial during the last 12 months.

Energy use: We have over 70 ambulance stations across London, half of which are over 50 years old. Our average daily consumption of gas and electricity for all our properties is 42,355 kWh.

Last year, we carried out a number of initiatives to reduce energy consumption. These included garage lighting projects at three of our ambulance stations, the replacement of boilers at two properties including our headquarters, and the installation of LED lighting at other stations.

Procurement: Each day we spend on average £204,175 on supplies and equipment; 17 per cent of this is on medical equipment and 13 per cent on computer related items. Over the last year, clinical staff have worked with our procurement team to reduce unnecessary purchases and stock levels, to help reduce our carbon footprint.

Other initiatives: A range of other initiatives have helped reduce our carbon footprint, including recycling over 55 per cent of our waste – equivalent to 178 tonnes CO^2, and the rollout of a web based expenses system to eliminate the need for paper-based claims which has saved at least three tonnes CO^2.

Looking ahead, we will consider other measures including:

- installing meters on all of our property to reduce energy consumption
- ensuring new properties meet sustainability standards
- reducing the number of patients who we transport to hospital or other treatment centres, as part of our strategy to ensure patients receive the right treatment in the right place at the right time.

Our internal auditors recently carried out a review of our response to sustainability legislation and requirements, and we will be incorporating their findings and recommendations into our five-year plan.

Our Trust Board

Our Trust Board is made up of 13 members – a non-executive chairman, six 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. The non-executive directors are appointed by the same method but independently through the Appointments Commission. All executive appointments are permanent and subject to normal terms and conditions of employment.

The Board has six formal sub-committees: the Strategy Review and Planning Group, 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 Group is made up of all the board members and is chaired by the Chairman.

Four non-executive directors and the Chief Executive make up the membership of the Quality Committee, which is chaired by non-executive director Dr Beryl Magrath.

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

The Finance and Investment Committee is chaired by the Chairman and has three non-executive directors, three executive directors and three directors as its members, and 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.

Brian Huckett is a former director of finance and information technology with Visa International, where he helped to bring card-based banking services to people in the developing worlds of Africa, the Middle East, and Eastern Europe. He has previously worked for TSB Bank, PA Management Consultants, and a variety of international construction companies. Brian is a member of the Audit Committee.

Dr Beryl Magrath MBE took up her post as non-executive director in 2005, and is chair of our Quality Committee. She is a former consultant anaesthetist and previously worked at Bromley Hospitals NHS Trust in Kent. She was a founder of South Bromley HospisCare in 1984 and was medical director of Bromley Hospitals NHS Trust between 1992 and 2000. Beryl is Vice Chairman of Governors for Castlecombe primary school in Bromley.

Caroline Silver took up her post as a non-executive director with us in March 2006 and is chair of our Audit Committee and the Charitable Funds Committee. A chartered accountant by background, she is a partner and Managing Director of Moelis and Company, an independent investment banking firm. Prior to that, Caroline spent 20 years in major international investment banks, where her roles included Vice Chairman of Bank of America Merrill Lynch EMEA Investment Banking and Vice Chairman of Morgan Stanley's global Investment Banking Division. She is a specialist in advising clients on international mergers, acquisitions and financings, particularly in the financial services and healthcare sectors. Caroline started her career as a chartered accountant with Price Waterhouse (now PWC).

Roy Griffins CB took up his post as a non-executive director in March 2006. He is chairman of London City Airport and Vice Chairman of Camden's Standards Committee. He is also a non-executive director of NHS Blood and Transplant. Roy has had a 30-year career in the British civil and diplomatic service, and was the UK's director of civil aviation between 1999 and 2004, and director-general of Airports Council International Europe from 2004 to 2006. Roy is a member of the Audit and Quality Committees, and is also our Deputy Chairman.

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 the Director General's Office at the BBC, responsible for strategic projects, senior stakeholder management and running the major boards of the corporation on his behalf.

Murziline Parchment took up her post in September 2011. She is currently the Head of the Mayor's Office in Tower Hamlets. Murziline has had a 15-year career in law as a barrister specialising in public law. She was Director of Major Projects and Service Delivery at the Greater London Authority between 2003 and 2008, and has been a member on the boards of Transport for London, London Bombings Relief Fund and London Organising Committee for the Olympics and Paralympics Games.

Executive directors

Chief Executive Peter Bradley CBE joined the London Ambulance Service in May 1996 as Director of Operations and was appointed Chief Executive and Chief Ambulance Officer in 2000. He has worked for 20 years in a variety of posts with ambulance services in New Zealand, mostly as a paramedic and latterly as Chief Ambulance Officer of the Auckland Ambulance Service. In his additional role for the Department of Health as National Ambulance Director, he led the strategic review of NHS ambulance services, *Taking Healthcare to the Patient*, which was the catalyst for the transformation in ambulance services over the last seven years. Peter was awarded the CBE in the 2005 New Year Honours.

Deputy Chief Executive Martin Flaherty OBE joined the Service in 1979. His career has included time spent as a paramedic, followed by 20 years as a manager in a variety of positions. He became an executive director in April 2005 and was responsible for coordinating the emergency medical response to the 7 July bombings that year. He was awarded an OBE in the 2006 New Year Honours and became Deputy Chief Executive in May 2009. Between July 2010 to November 2011 Martin was on secondment with the Irish Ambulance Service and Great Western Ambulance Service where he held interim Chief Executive positions. He returned to the Service in November 2011 as Chief Operating Officer and Deputy Chief Executive.

Director of Finance Michael Dinan joined us in November 2004. He had worked for 13 years for United Parcel Service in a variety of positions including Group Finance Director for the European logistics business. Michael is a fellow of the Chartered Institute of Management Accountants (CIMA).

Director of Health Promotion 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.

Director of Human Resources and Organisation Development Caron Hitchen was appointed in May 2005. Caron is a qualified nurse, and her career has been predominantly NHS-based. She worked for five years at Mayday Hospital NHS Trust as Director of Human Resources and, prior to that, she spent seven years in human resources management roles at Ealing Hospital NHS Trust.

Medical Director Dr Fionna Moore 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 20 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.

The Trust Board is supported by three other directors who are non-voting directors.

Directors

Director of Information Management and Technology Peter Suter was appointed in November 2004, after serving as Head of Information Technology at Sussex Police for 10 years. Before that, he had worked for Siemens-Nixdorf, GEC in South Africa, and BT. He is joint chair of the Information Governance. Peter holds a BSc in Information Technology from the Open University.

Director of Corporate Services 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.

Deputy Director of Strategic Development Lizzy Bovill joined the Service as an assistant director of operations in 2008, moving from Guy's and St Thomas' NHS Foundation Trust. Her career to date has focused on general management and service improvement roles both in large teaching hospitals, specialist networks and the voluntary sector. Lizzy's current role includes managing and delivering the range of contracts held by the Service with our commissioners, leading on commercial and strategic

developments, stakeholder and partner management within and external to the NHS and delivering demand management initiatives.

Meetings

The Board meets in public eight times a year on Tuesdays from 10am in the conference room at our headquarters. 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 Services.

2010/11 financial summary statements

Financial review

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

Break-even performance	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Retained surplus/(deficit) for the year	1,258	113	398	725	-420	740	2,527
Adjustments for impairments	0	0	0	0	1,845	262	247
Adjustments for impact of policy change re donated grants asset	0	0	0	0	0	0	-23
Break-even in-year position	1,258	113	398	725	1,425	1,002	2,751
Break-even cumulative position	1,333	1,446	1,844	2,569	3,994	4,996	7,747
Break-even cumulative position as a percentage of turnover	0.62	0.67	0.78	0.98	1.43	1.76	2.75

The surplus in 2011/12 meant that the cumulative position improved for the 11th year running, and remained well within the limit of 0.5 per cent of turnover permitted by the Department of Health.

On income and expenditure we reported a surplus of £2,751,000 for the year, and therefore did better than the break-even target set by the Department of Health for 2011/12.

We had a £2,156,000 overshoot against our external financing limit (EFL) for the year. We are not permitted to overshoot our EFL.

A return on assets (the capital cost absorption duty**)** of 3.5 per cent was achieved. This was within the permitted range of three per cent to four per cent.

In the capital programme, £16.2million was spent on a range of projects, including ambulances, new technology projects and projects to improve the estate. Overall, we underspent by £2,508,000 against our capital resource limit, which we are permitted to do.

We were able to pay 89 per cent and 85 per cent of our non-NHS and NHS trade invoices respectively within 30 days, which was below the 95 per cent target set by the Department of Health.

Balance sheet

The largest item on the balance sheet is £138 million of fixed assets (£143 million in 2010/11) comprising land, buildings, plant and machinery, information technology, fixtures and intangibles. We fund the investment in capital assets through our capital programme. In 2011/12, we invested £16.2 million (£15.2 million in 2010/11). The most significant additions were related to the project to replace the emergency operations centre computer system, ambulances, vehicles, defibrillators and mobile data terminals.

We sold Park Royal ambulance station during the year for £900,150.

We have a net working capital of -£5.6 million (-£4.7 million in 2010/11) and long-term creditors and provisions of £19.1 million (£32.9 million in 2010/11). We had £5,250,000 cash in the bank as at 31 March 2012 (£872,000 in 2010/11).

We obtained and fully drew down a £10 million loan from the Department of Health to fund capital expenditures in 2009/10. The loan is spread over eight years with an average fixed interest rate of 2.65 per cent (£265,000) per annum.

In 2010/11, we obtained a loan of £107,000 from SALIX Finance Ltd to support our capital investment in technical measures to improve energy efficiency. The loan was drawn down in August and December 2010 for £60,000 and £47,000 respectively. It is an interest free, unsecured loan with two to five year repayment terms.

Our assets are ultimately owned by the public and the taxpayers' equity section of the balance sheet shows the component elements. Public dividend capital is £62.5 million (£62.5 million in 2010/11) of the equity – this represents the Department of Health's investment in us and annual dividends are payable on this sum. A further £33.7 million (£35.7 million in 2010/11) is held in a revaluation reserve representing the accumulated increase in value of our estate.

Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme and the accounting policy is set out in note 11 to the full Annual Accounts. The Remuneration report sets out information on the pension benefits of directors.

Financial plan 2012/13

We have formally submitted a plan for 2012/13 that takes into account planned contracted income levels and the expenditure budgets that have been set for the new financial year. The plan is set to deliver a surplus of £3 million.

Detailed financial planning work is in progress in preparation for our foundation trust application.

Financial risk

We monitor financial risk through the assurance framework and risk management processes as detailed in the statement of internal control included in the financial statements.

International Financial Reporting Standards (IFRS)

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

Professional valuation was carried out by the District Valuers of the Revenue and Customs Government Department on 31 March 2012 for all land and buildings. The net gain and loss on revaluation and impairments was £1,125,000 and £422,000 respectively.

IAS 19 requires us to accrue for remuneration earned but not yet taken. In this instance, we have made an accrual for annual leave of £3,460,000 for the current financial year (£3,521,000 in 2010/11).

Subsequent events after the balance sheet date

There was no important event occurring after the financial year end that has a material effect on the 2011/12 financial statements.

Other information

The Audit Commission was our external auditor for the year ending 31 March 2012. We paid the Audit Commission £139,000 (£158,000 in 2010/11) for audit services relating to the statutory audit. All issues relating to financial audit and financial governance are overseen by our audit committee.

The financial statements for the year follow. These are summary financial statements extracted from the full accounts, which are available free of charge from the Financial Controller who can be contacted at the address given at the end of this annual report.

GOVERNANCE STATEMENT

Scope of responsibility

Our Trust Board is accountable for internal control. 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 the 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 management structure, processes and monitoring arrangements, an assurance and risk management framework, and a programme of staff training and development. We publish bulletins on the intranet and use our weekly information bulletin to communicate clinical and risk management issues. These arrangements are documented in our 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 local health economy, we work with our partners to minimise the risks to patient care. To do so, we meet routinely with our lead commissioners and with the performance team at NHS London, and strive to meet and maintain the key performance targets and clinical indicators set for ambulance services. In 2011/12, we were ranked as the top performing ambulance trust for seven performance indicators and were placed in the upper quartile for 21 of the 23 indicators.

We work in partnership with health and social care organisations in the development and provision of emergency and urgent healthcare across London. In 2011/2012, this has included the development of pathways for elderly people that fall and end-of-life care for patients across London, as well as developing pathways for urgent and emergency care in local areas. We have increased the number of calls we handle and resolve through hear and treat, and we have worked with emergency departments and NHS London to improve the handover of patients from our service into an acute healthcare setting. We continue to achieve good outcomes for some of our sickest patients through conveyance to cardiac centres, hyper acute stroke units and major trauma centres.

We successfully implemented a new call-taking and dispatch system in March 2012. We have been working with the London Olympic Games Organising Committee and associated partners to prepare for the 2012 London Olympic and Paralympic Games when we will be providing the emergency healthcare response as well as maintaining a safe and high-quality service to the rest of London. We engage with a wide range of stakeholders across London and have carried out approximately 900 patient and public involvement and education events during the year.

Our governance framework

We implemented a new governance structure in April 2010 and added the Finance and Investment Committee to this in early 2011. All board committees are chaired by a non-executive director and membership of the Remuneration and Nomination, and Audit committees is non-executive only with executives in attendance where relevant and

required. The structure was fully reviewed in July 2011 along with the annual effectiveness review of the Trust Board, its reporting committees and the quality, safety and risk-related committees: Risk Compliance and Assurance, Clinical Quality Safety and Effectiveness, and Learning from Experience. No further changes were made to the governance structure and our Trust Board has continued to take assurance from this throughout 2011/12.

Our Chairman and Director of Corporate Services carry out 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 has been formally observed on at least one occasion during the year and feedback has been built into subsequent board meetings and taken up with individual board members where appropriate.

Attendance by Board members at Trust Board meetings is recorded in the minutes and included in the annual effectiveness review. From 2011/12, attendance at key board committees will also be monitored.

The Chair of the Audit Committee provides a report to the next meeting of the Trust Board. 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 our objectives and the processes by which the risks to achieving these objectives are managed. At our Trust Board meeting on 27 March 2012, the Audit Committee chair provided assurance to the Board of the effectiveness of our systems of integrated governance, risk management and internal control, based on the key sources of assurance identified in the board assurance framework. The committee undertakes a detailed review of the corporate risk register annually. The committee meets five times during the year with one meeting held without the internal or external auditors present.

The Chair of the Quality Committee provides a report to the next meeting of the Trust Board. This report includes a summary of the committee's assessment of quality and risk as taken from the reports and evidence presented to the committee, and from quarterly review of the board assurance framework and corporate risk register. 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 our Trust Board meeting on 27 March 2012, 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 six times during the year.

The Chair of the Finance and Investment Committee provides a report to the next 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. The committee meets five times during the year.

Our Trust Board works within the remit of the standing orders and standing financial Instructions and scheme of delegation, and each of these has been reviewed and updated during 2011/12. We have prepared our constitution, governance rationale and standing orders in readiness for foundation trust status and will update these prior to application. The governance rationale meets the requirements of Monitor's code of governance.

Risk assessment

We are compliant with level one of the NHSLA risk management standards for ambulance trusts.

Our 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. It describes the process for embedding risk management throughout our Trust, and during 2011/12 we have made further progress with developing and managing local risk register processes. Risks can be escalated to the Risk Compliance and Assurance Group for discussion and addition to the corporate risk register if required. Further progress has been made to align project management risks with the corporate risk register.

Incidents are reported in accordance with the incident reporting procedure and are scored, either by local managers or by the risk and safety team, using the NPSA 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 Risk Compliance and Assurance Group or monitored at a local level. An integrated risk report is produced quarterly for review by Learning from Experience, the Senior Management Group, and the Quality Committee.

We 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 carried out a routine compliance visit on 29 March 2012 and identified one minor concern for Outcome 9 – management of medicines. We have implemented new processes that will ensure compliance with this outcome.

Our risk and control framework

We have systems in place to monitor compliance throughout the year and to address any emerging gaps or risks. Our board assurance framework shows the linkages between our strategic goals for the next five years and the most significant strategic risks to the achievement of these. This is mapped to the key risks that the Trust Board chose to focus on during the year as well as the top risks on the corporate risk register. A review in the fourth quarter of 2011/12 showed that through this focus we have been able to mitigate and reduce the level of risk for all but two of the risk focus areas.

The board assurance framework is mapped to the CQC outcomes and requirements. The Quality Committee reviews the board assurance framework and corporate risk register quarterly as does the Trust Board. The Risk Compliance and Assurance Group review the corporate risk register in detail at each meeting. The Audit Committee reviews the corporate risk register annually. Risks with a net severity rating of High >15 are added to the corporate risk register and the board assurance framework.

The Trust Board, Quality Committee and Senior Management Group receive a quality dashboard showing monthly performance and any identified risks, from which they seek improvements and mitigations.

The local counter fraud specialist (LCFS) attends four meetings of the Audit Committee per year and monthly executive counter fraud meetings. In 2011/12, the LCFS undertook 93 days of proactive work including designing and publishing fraud literature; developing an e-learning package; and reviews into agency staff usage and purchasing cards. The LCFS undertook 191.35 days of reactive counter fraud work. We were awarded level 3 in its Qualitative Assessment which is an indication that we performed well in relation to counter fraud.

The three risks that were identified and added to the corporate risk register (with a gross and net rating of >15) in 2011/12 were:

- the risk that problems arising during the development and testing of CommandPoint result in the system not being ready to go live as planned by the end of March 2012. This risk is due for formal review at the end of Quarter 1 2012/13; however, this risk was not realised and the system has been fully implemented.

- the risk that staff do not receive clinical and non-clinical mandatory training. This risk is due for review at the end of Quarter 1 2012/13.

- the risk that the clinical coordination desk will not be able to operate effectively due to a lack of suitable trained staff. Action has been taken to train additional staff and this risk will be reviewed in Quarter 1 2012/13.

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

As an employer with staff entitled to membership of the NHS pension scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer’s contributions and payments in to the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

We have carried out 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.

The system of internal control has been in place for the year ended 31 March 2012 and up to the date of approval of the annual report and accounts. The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives. It can, therefore, only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

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 of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and our senior management team who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the content of the quality report 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 Trust Board, the Audit Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

We have made significant progress against the information governance toolkit in-year achieving the required Level 2 standards. There has also been a focus on the management and reporting of serious incidents during 2011/12.

We declared 24 serious incidents to NHS London during 2011/12. These included the unsuccessful implementation of our new call-handling and dispatch system, CommandPoint, on 8 June 2011 which led to delays in responding to patients, and the impact on our capacity to maintain normal service provision due to industrial action related to the national public sector pensions dispute on 30 November 2011. These two incidents are described more fully below.

The remaining serious incidents are broadly categorised as loss of information (five), delayed response (13), equipment and software (two), and staff and patient behaviour (two). Of the five information governance/security serious incidents, one met the threshold for notification to the Information Commissioner. Actions have been taken to address the root causes. The investigation reports for serious incidents include recommendations and actions to be implemented to reduce the likelihood of recurrence. The successful introduction of CommandPoint in March 2012 is evidence of robust investigation techniques, organisational learning and actions implemented. There is no evidence to suggest that the declared serious incidents prevented the successful achievement of the Business Plan in 2011/12.

CommandPoint: On Wednesday 8 June 201, we began to implement the new electronic call-taking and dispatch software system, CommandPoint. Following the technical cut-over, the system initially operated for several hours before slowing and ultimately failing. Our control room reverted to operating on paper until transferring to the old computer aided system some hours later. This failure delayed responses to patients representing a serious risk. A serious incident was declared and a full investigation was undertaken. The Trust Board was kept fully aware of the risks and issues during the subsequent months. The root causes were identified and resolved and a new phased approach to

implementation was agreed by the Trust Board. CommandPoint was successfully implemented and the new system brought live on Wednesday 28 March 2012.

National public sector pensions dispute: On Wednesday 30 November 2011, we experienced one of our most difficult days in many years. A combination of higher staff shortages associated with industrial action as part of a national public sector pensions dispute, and an unexpected increase in demand, meant that we were unable to respond to hundreds of patients either at all or in line with agreed response times standards.

National planning assumptions were that between 10 and 30 per cent of staff would opt to take full industrial action during the national day of action. On the day, half of our frontline staff decided to withdraw their labour entirely. Of the remaining frontline staff, 15 per cent chose to work normally and 35 per cent provided emergency cover. Assurances were given by the trade unions at national, regional and local level that patient care was at the top of the agenda during the industrial action and that staff would commit to the provision of emergency cover within the arrangements agreed. Therefore, we planned that 75 per cent of staff would be available for normal working or as part of the agreed emergency cover arrangements. This was not the case.

We declared a serious incident and I, as Chief Executive, carried out a full investigation. The outcome report was presented to our Trust Board with 19 recommendations which have all been accepted and are now being developed and implemented. A separate investigation and report by NHS North West London on behalf of NHS London was completed and published on 27 March 2012.

Head of Internal Audit Opinion
Based on the work undertaken in 2011/12 to date, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Conclusion
As Accountable Officer and based on the review process outline above, we have identified and taken action to address control issues arising in the year which have been disclosed in the body of this report.

Accountable Officer: Peter Bradley CBE
Chief Executive

Organisation: London Ambulance Service NHS Trust

Signature: 

Date: 16 May 2012

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2012

	2011-12 £000	2010-11 £000 (restated)
Employee benefits	**(205,986)**	(210,895)
Other costs	**(68,774)**	(69,208)
Revenue from patient care activities	**278,267**	280,284
Other operating revenue	**3,464**	3,946
Operating surplus/(deficit)	**7,709**	4,127
Investment revenue	**281**	823
Other gains and (losses)	**(715)**	1,068
Finance costs	**(864)**	(1,508)
Surplus/(deficit) for the financial year	**6,411**	4,510
Public dividend capital dividends payable	**(3,884)**	(3,772)
Retained surplus/(deficit) for the year	**2,527**	738
Other comprehensive Income		
Impairments and reversals	**(956)**	414
Net gain/(loss) on revaluation of property, plant & equipment	**922**	510
Net gain/(loss) on revaluation of intangibles	**0**	0
Net gain/(loss) on revaluation of financial assets	**0**	0
Net gain/(loss) on other reserves	**0**	0
Net gain/(loss) on available for sale financial assets	**0**	0
Net actuarial gain/(loss) on pension schemes	**0**	0
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Total comprehensive income for the year	**2,493**	1,662

All income and expenditure is derived from continuing operations.

Reported NHS financial performance position [Adjusted retained surplus/(deficit)]

Retained surplus/(deficit) for the year	**2,527**
Prior period adjustment to correct errors	**0**
IFRIC 12 adjustment	**0**
Impairments	**247**
Adjustments to/from donated asset	**(23)**
Reported NHS financial performance position [Adjusted retained surplus/(deficit)]	**2,751**

A trust's reported NHS financial performance position is derived from its retained surplus/(deficit), but adjusted for the following:

- Impairments to fixed assets. 2009/10 was the final year for organisations to revalue their assets to a modern equivalent asset basis of valuation. An impairment charge is not considered part of the organisation's operating position.
- The revenue cost of bringing PFI assets onto the balance sheet (due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009/10). NHS trusts' financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to PFI, which has no cash impact and is not chargeable for overall budgeting purposes, 089 should be reported as technical. This additional cost is not considered part of the organisation's operating position.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2012

	31 March 2012 £000	31 March 2011 £000
Non-current assets:		
Property, plant and equipment	**123,055**	128,044
Intangible assets	**15,033**	14,479
Investment property	**0**	0
Other financial assets	**0**	0
Trade and other receivables	**1,770**	7,736
Total non-current assets	**139,858**	150,259
Current assets:		
Inventories	**2,812**	2,571
Trade and other receivables	**11,940**	19,246
Other financial assets	**0**	0
Other current assets	**0**	0
Cash and cash equivalents	**5,250**	872
Total current assets	**20,002**	22,689
Non-current assets held for sale	**0**	650
Total current assets	**20,002**	23,339
Total assets	**159,860**	173,598
Current liabilities		
Trade and other payables	**(21,364)**	(21,827)
Other liabilities	**0**	0
Provisions	**(1,638)**	(1,418)
Borrowings	**(1,375)**	(3,603)
Other financial liabilities	**0**	0
Working capital loan from Department	**0**	0
Capital loan from Department	**(1,244)**	(1,244)
Total current liabilities	**(25,621)**	(28,092)
Non-current assets plus/less net current assets/liabilities	**134,239**	145,506
Non-current liabilities		
Trade and other payables	0	0
Other Liabilities	0	0
Provisions	(7,516)	(7,955)
Borrowings	(6,023)	(18,100)
Other financial liabilities	0	0
Working capital loan from Department	0	0
Capital loan from Department	(5,587)	(6,831)
Total non-current liabilities	**(19,126)**	(32,886)
Total assets employed:	**115,113**	112,620
Financed by taxpayers' equity:		
Public dividend capital	62,516	62,516
Retained earnings	19,304	14,851
Revaluation reserve	33,712	35,672
Other reserves	(419)	(419)
Total taxpayers' equity:	**115,113**	112,620

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Other reserves	Total
	£000	£000	£000	£000	£000
Balance at 1 April 2011	62,516	14,851	35,672	(419)	**112,620**
Opening balance adjustments		0	0	0	**0**
Adjustments for transforming community services transactions		0	0	0	**0**
Restated balance at 1 April 2011	62,516	14,851	35,672	(419)	**112,620**
Changes in taxpayers' equity for 2011-12					
Retained surplus/(deficit) for the year		2,527			**2,923**
Net gain / (loss) on revaluation of property, plant, equipment			922		**922**
Net gain / (loss) on revaluation of intangible assets			0		**0**
Net gain / (loss) on revaluation of financial assets			0		**0**
Net gain / (loss) on revaluation of assets held for sale			0		**0**
Impairments and reversals			(957)		**(957)**
Movements in other reserves				0	**0**
Transfers between reserves		1,926	(1,926)	0	**0**
Release of reserves to SOCI			0		**0**
Transfers to/(from) other bodies within the resource account boundary	0	0	0	0	**0**
Reclassification adjustment on disposal of available for sale financial assets			0		**0**
Reserves eliminated on dissolution	0	0	0	0	**0**
Originating capital for Trust established in year	0				**0**
New PDC received	0				**0**
PDC repaid in year	0				**0**
PDC written off	0				**0**
Transferred to NHS foundation trust	0	0	0	0	**0**
Other movements in PDC in year	0				**0**
Net actuarial gain/(loss) on pension	0			0	**0**
Net recognised revenue/(expense) for the year	0	4,453	(1,960)	0	2,493
Balance at 31 March 2012	**62,516**	**19,304**	**33,712**	**(419)**	**115,513**

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY (Continued)

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Other reserves	Total
	£000	£000	£000	£000	£000
Changes in taxpayers' equity for 2010-11					
Balance at 1 April 2010	60,885	12,947	35,914	(419)	109,327
Retained surplus/(deficit) for the year		738			738
Net gain / (loss) on revaluation of property, plant, equipment			510		510
Net gain / (loss) on revaluation of intangible assets			0		0
Net gain / (loss) on revaluation of financial assets			0		0
Net gain / (loss) on revaluation of assets held for sale					0
Impairments and reversals			414		414
Movements in other reserves				0	0
Transfers between reserves		1,166	(1,166)	0	0
Reclassification adjustment on disposal of available for sale financial assets			0		0
Reserves eliminated on dissolution		0	0	0	0
Originating capital for Trust established in year	0				0
New PDC received	1,631				1,631
PDC repaid in year	0				0
PDC Written Off	0				0
Transferred to NHS foundation trust	0	0	0	0	0
Other movements in PDC in year	0				0
Net actuarial gain/(loss) on pension		0		0	0
Net recognised revenue/(expense) for the year	1,631	1,904	(242)	0	3,293
Balance at 31 March 2011	**62,516**	**14,851**	**35,672**	**(419)**	**112,620**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2012

	2011/12 £000	2010/11 £000
Cash flows from operating activities		
Operating surplus/deficit	**7,709**	**4,127**
Depreciation and amortisation	**11,430**	**11,713**
Impairments and reversals	**248**	**262**
Other gains/(losses) on foreign exchange	**0**	**0**
Donated assets received credited to revenue but non-cash	**(23)**	**0**
Government granted assets received credited to revenue but non-cash	**0**	**0**
Interest paid	**(670)**	**(1,341)**
Dividend paid	**(3,832)**	**(3,972)**
Release of PFI/deferred credit	**0**	**0**
(Increase)/decrease in inventories	**(241)**	**212**
(Increase)/decrease in trade and other receivables	**9,676**	**499**
(Increase)/decrease in other current assets	**0**	**0**
Increase/(decrease) in trade and other payables	**(8,277)**	**2,497**
(Increase)/decrease in other current liabilities	**0**	**0**
Provisions utilised	**(1,047)**	**(727)**
Increase/(decrease) in provisions	**636**	**(953)**
Net cash inflow/(outflow) from operating activities	**15,609**	**12,317**
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest received	**59**	61
(Payments) for property, plant and equipment	**(13,987)**	(15,006)
(Payments) for intangible assets	**(1,600)**	(5,686)
Proceeds from disposal of plant, property and equipment	**6,988**	7,018
Proceeds from disposal of intangible assets	**0**	0
(Payments) for investments with DH	**0**	0
(Payments) for other investments	**0**	0
Proceeds from disposal of investments with DH	**0**	0
Proceeds from disposal of other financial assets	**0**	0
Revenue rental income	**0**	0
Net cash inflow/(outflow) from investing activities	**(8,540)**	**(13,613)**
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**7,069**	(1,296)
CASH FLOWS FROM FINANCING ACTIVITIES		
Public dividend capital received	0	1,631
Public dividend capital repaid	0	0
Loans received from DH - new capital investment loans	0	0
Loans received from DH - new working capital loans	0	0
Other loans received	0	107
Loans repaid to DH - capital investment loans repayment of principal	(1,244)	(1,244)
Loans repaid to DH - working capital loans repayment of principal	0	0
Other loans repaid	0	0
Cash transferred to NHS foundation trusts	0	0
Capital element of payments in respect of finance leases and On-SoFP PFI and LIFT	(1,411)	(3,443)
Capital grants and other capital receipts	0	0
Net cash inflow/(outflow) from financing activities	**(2,655)**	**(2,949)**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	**4,414**	**(4,245)**
Cash and cash equivalents (and bank overdraft) at beginning of the period	836	5,081

Opening balance adjustment - TCS transactions	0	
Restated cash and cash equivalents (and bank overdraft) at beginning of the period	836	5,081
Effect of exchange rate changes in the balance of cash held in foreign currencies	0	0
Cash and cash equivalents (and bank overdraft) at year end	5,250	836

Remuneration report

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

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

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

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

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

For the purposes of this report, the disclosure of remuneration to senior managers is limited to our executive and non-executive directors. Details of remuneration, including salaries and pension entitlements, are published on pages 44 and 45**.**

The banded remuneration of the highest paid director in the London Ambulance Service in the financial year 2011/12 was in the range of £190,001 to £195,000. This was 6.2 times the median remuneration of the workforce, which was £31,259.64. In 2010/11, the banded remuneration of the highest paid director £190,001 to £195,000. This was 6.1 times the median remuneration of the workforce, which was £31,489.56.

In 2011/12, as in the previous year, none of the employees received remuneration in excess of the highest paid director.

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

The change in ratio was due to:

- a change to the remuneration of the most highly-paid individual through an increase in benefits-in-kind received in 2011/12
- a change in the workforce composition in 2011/12 leading to a slight decrease in median pay.

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

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

Salary and pension entitlements of senior managers

A) Remuneration

Name and Title	2011/12			2010/11		
	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Benefits in Kind Rounded to the nearest £100	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Benefits in Kind Rounded to the nearest £100
Richard Hunt, Chairman	£20,001-£25,000	£0		£20,001-£25,000	£0	
Caroline Silver, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Brian Huckett, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Jessica Cecil, Non-Executive Director	£5,001-£10,000	£0		£0-£5,000	-	
Beryl McGrath, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Roy Griffins, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
**Murziline Parchment, Non-Executive Director	£0-£5,000	£0		£0-£5,000	£0	
* Peter Bradley, Chief Executive	£180,001-£185,000	£0	£4,091	£110,001-£115,000	£0	£2,277
Michael Dinan, Director of Finance	£115,001-£120,000	£0		£115,001-£120,000	£0	
**Martin Flaherty, Deputy Chief Executive	£60,001-£65,000	£0	£3,134	£50,001-£55,000	£0	£1,326
Caron Hitchen, Director of Human Resources	£100,001-£105,000	£0		£100,001-£105,000	£0	
Stephen Lennox, Director of Health Promotion & Quality	£95,001-£100,000	£0		£5,001-£10,000	-	
*** Fionna Moore, Medical Director	£75,001-£80,000	£0		£70,001-£75,000	£0	

The figures shown under the heading 'benefit in kind' refer to the provision of lease cars.
* Excludes remuneration recharged to the Department of Health for role as National Ambulance Director.
** Martin Flaherty was on a secondment to the Great Western Ambulance Service NHS Trust until 15 October 2011. Murziline Parchment joined the Service as a non-executive director in September 2011.
*** Fionna Moore is an employee of Imperial College Healthcare NHS Trust who works part-time for the London Ambulance Service as Medical Director.

Salary and pension entitlements of senior managers
(continued)

B) Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2,500)	Lump sum at aged 60 related to real increase in pension (bands of £2,500)	Total accrued pension at age 60 at 31 March 2012 (bands of £5,000)	Lump sum at age 60 at related to accrued pension at 31 March 2012 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2012	Cash Equivalent Transfer Value at 31 March 2011	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension To nearest £100
Richard Hunt, Chairman	**	**	**	**	**	**	**	
Caroline Silver, Non-Executive Director	**	**	**	**	**	**	**	
Beryl Magrath, Non-Executive Director	**	**	**	**	**	**	**	
Brian Huckett, Non-Executive Director	**	**	**	**	**	**	**	
Jessica Cecil, Non-Executive Director	**	**	**	**	**	**	**	
Roy Griffins, Non-Executive Director	**	**	**	**	**	**	**	
Murziline Parchment, Non-Executive Director	**	**	**	**	**	**	**	
Peter Bradley, Chief Executive	£0-£2,500	£5,001-£7,500	£20,001-£25,000	£65,001-£70,000	£450,224	£389,077	£34,360	
Michael Dinan, Director of Finance	£0-£2,500	£2,501-£5,000	£10,001-£15,000	£30,001-£35,000	£187,834	£146,122	£26,027	
Martin Flaherty, Deputy Chief Executive	£0-£2,500	£0-£2,500	£20,001-£25,000	£70,001-£75,000	£483,979	£428,656	£29,424	
Caron Hitchen, Director of Human Resources	£0-£2,500	£0-£2,500	£25,001-£30,000	£80,001-£85,000	£508,540	£441,267	£37,516	
Stephen Lennox, Director of Healthcare Promotion	£5,001-£7,500	£2,501-£5,000	£30,001-£35,000	£100,001-£105,000	£567,149	£415,155	£97,387	
Fionna Moore, Medical Director	£0-£2,500	£2,501-£5,000	£45,001-£50,000	£145,001-£150,000	£1,137,365	£1,137,365	-£24,681	

** As non-executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

C) Expenses 2011/12

Name and Title	Travel - UK	Travel - Overseas	Provision of Lease Cars	Mobile Phones	Subscription	Hospitality	Total
	£	£	£	£	£	£	£
Richard Hunt, Chairman	3,405	-	-	-	-	16	**3,421**
Beryl Magrath, Non-Executive Director	113	-	-	-	-	-	**113**
Roy Griffins, Non-Executive Director	-	-	-	-	-	-	**-**
Brian Huckett, Non-Executive Director	-	-	-	-	-	-	**-**
Caroline Silver, Non-Executive Director	-	-	-	-	-	-	**-**
Jessica Cecil, Non-Executive Director	-	-	-	-	-	-	**-**
Murziline Parchment, Non-Executive Director	-	-	-	-	-	-	**-**
Peter Bradley, Chief Executive	3,084	-	6,272	729	-	139	**10,224**
Michael Dinan, Director of Finance	604	-	-	486	-	349	**1,439**
Martin Flaherty, Deputy Chief Executive	34	-	7,344	-	-	-	**7,378**
Caron Hitchen, Director of Human Resources	616	511	-	457	143	-	**1,727**
Fionna Moore, Medical Director	-	-	1,996	799	-	-	**2,795**
Stephen Lennox, Director of Health Promotion & Quality	-	-	-	-	-	-	**-**
Total	**7,856**	**511**	**15,612**	**2,471**	**143**	**504**	**27,097**

The Trust Board approves all travel outside of the European Community.

The above expense figures have not been audited.

Reporting of other compensation schemes – exit packages 2011/12

The Trust did not make any compensation payments in 2011/12.

Better payment practice code – measure of compliance

	2011/12		2010/11	
	Number	**£000**	Number	£000
Non-NHS payables				
Total non-NHS trade invoices paid in the year	**51,604**	**69,019**	62,654	83,829
Total non-NHS trade invoices paid within target	**46,136**	**60,795**	52,816	75,015
Percentage of NHS trade invoices paid within target	89%	88%	84%	89%
NHS Payables				
Total NHS trade invoices paid in the year	**339**	**4,133**	421	4,379
Total NHS trade invoices paid within target	**289**	**2,331**	352	3,392
Percentage of NHS trade invoices paid within target	85%	56%	84%	77%

The better payment practice code requires us to aim to pay all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

EXTERNAL FINANCING

We are given an external financing limit which it is permitted to undershoot.

		2011/12	2010/11
	£000	**£000**	£000
External financing limit		**(9,225)**	1,371
Cash flow financing	(7,069)		1,296
Finance leases taken out in the year	0		0
Other capital receipts	0		0
External financing requirement		**(7,069)**	1,296
Undershoot/(overshoot)		**(2,156)**	75

This summary financial statement does not contain sufficient information to allow as full an understanding of our results and state of affairs,, nor of our policies and arrangements concerning directors' remuneration as would be provided by the full annual accounts and reports. Where more detailed information is required a copy of our full accounts and reports are obtainable free of charge.

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

Financial Controller
Finance Department
London Ambulance Service NHS Trust
220 Waterloo Road
London
SE1 8SD

Explanation of statutory financial duties

Break-even duty

We are required to break-even on our income and expenditure account taking one year with another.

External financing limit (EFL)

The external financing limit (EFL) is the means by which the Treasury, via the NHSE, controls public expenditure in NHS trusts. This is an absolute financial duty, with a maximum tolerance of only 0.5 per cent of turnover under the agreed limit. There is no tolerance above the EFL target without prior notification and agreement.

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

Each year, we are allocated an EFL as part of the national public expenditure planning process. We have a statutory duty to maintain net external financing within our approved EFL.

Capital resourcing limit (CRL)

The CRL is part of the resource accounting and budgeting arrangements in the NHS and its purpose is to ensure that resources allocated by the government for capital spending are used for capital, rather than to support revenue budgets. All NHS bodies have a capital resource limit. The CRL is accruals based as opposed to the cash-based EFL in NHS trusts.

Underspends against the CRL are permitted and overspends against the CRL are not permitted.

A capital resource limit controls the amounts of capital expenditure that a NHS body may incur in the financial year.

Capital cost absorption duty

The financial regime of NHS trusts recognises that there is a cost associated with the maintenance of the capital value of the organisation. We are required to absorb the cost of capital at a rate of 3.5 per cent of average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital bears to the average relevant net assets of the trust. To meet this duty, we must achieve a rate between three per cent and four per cent.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH MAY 2012

PAPER FOR INFORMATION

Document Title:	**Update on the foundation trust application**
Report Author(s):	**Sandra Adams**
Lead Director:	**Sandra Adams**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To keep the Trust Board apprised of the progress being made towards submitting a successful application in 2013**
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 take assurance from the report on the progress being made against the key milestones**

Key issues and risks arising from this paper

Timeline and milestones

The new timeline is for submission of the FT application to the Department of Health in March 2013. Key milestones are as follows:

- Trust Board signs off the IBP, LTFM and enabling strategies on 21st August 2012
- SHA assurance phase commences in September
- Quality governance assurance review needs to achieve a rating of <3.5 in August
- Board development plan to be updated, taking into account the outcome of the board governance assurance framework independent review
- Enabling strategies, IBP, LTFM, and downsides need to be ready for the Strategy Review and Planning meeting on 24th July, and commissioner support for these must be in place.

Executive Summary

<u>Foundation Trust application</u>

- The timeline and milestones have now been agreed internally and with the SHA and cluster and the updated TFA has been signed off. The monthly progress monitoring form will reflect this from now on.
- The board governance assurance framework (BGAF) process is nearly at an end. Confirm and challenge sessions have been held with the Chairman (16/5) and Peter Bradley and Sandra Adams on 18/5. The report is being finalised by KPMG and will be presented in Part II of the Trust Board on 29th May. The action plan will be updated from this and we can expect to be monitored against this by the SHA as the year progresses.

- The additional Board to Board meeting is scheduled for 25th June and will focus on progress against key areas of assurance and performance.
- Additional information about the board development programme proposed by Healthskills was reviewed by the FT project team on 9th May and Richard Hunt and Peter Bradley have agreed to proceed. NO dates have been set as yet.
- The Quality Governance Framework follow-up review is planned for 20th July – 13th August 2012. The action plan is being managed by Steve Lennox.
- FT project management arrangements – Martin Brand, Carmel Dodson-Brown and Jasjit Dhaliwal are now supporting the project. Weekly meetings are in place, with additional membership from Amanda Cant and Lizzy Bovill, and these meetings support the fortnightly project team so that best use can be made of the time available.

Development of the IBP and enabling strategies

- Each of the enabling strategies is being reviewed and updated in order to inform the new IBP and updated LTFM.
- Enabling strategies identified are: clinical and quality; estates; fleet and logistics; IM&T; operational; stakeholder engagement; and workforce.

Attachments

None

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

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

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

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

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

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

Equality Impact Assessment

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

Key issues from the assessment:

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29 MAY 2012

PAPER FOR APPROVAL

Document Title:	**LAS Summary Budgets 2012-13**
Report Author(s):	**Amanda Cant**
Lead Director:	**Mike Dinan**
Contact Details:	**Michael.Dinan@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To seek Board approval for the 2012-13 summary budget**
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 Finance & Investment Committee
Recommendation for the Trust Board:	To approve the 2012-13 LAS summary budget

Executive Summary

The board are asked to approve the LAS Budget for 2012-13 which will deliver a surplus of £3.1 million. The high level budgets are as follows:

	£million
• Total income	289.0
• A&E income	254.3
• Surplus	3.1
• Cost Improvement Program	12.5
• Capital	12.4

Key financial risks arise in relation to:

- Delivery of Cost Improvement Programme
- Significant changes in activity impacting upon ability to deliver performance leading to KPI penalties
- CQUIN value has increased from 1.5% of the contract value to 2.5% or £6.2 million

A detailed overview of risks is contained within the financial risk register in the main body of this report.

Key issues for the Trust Board

The following key issues are brought to the attention of the Board:

- The proposed budget will deliver a surplus of £3.1 million in line with DH requirements.
- The income assumptions within the proposed budget are in line with the Heads of Terms signed on the 3rd April 2012 in relation to the main A&E contract.
- The proposed budget includes a cost improvement programme of £12.5 million.
- Both SMG and the Finance & Investment Committee have reviewed this summary budget

Attachments

London Ambulance Service Budget 2012-13

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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 Budget 2012-13

Executive Summary

This paper outlines the key features of the proposed LAS 2012-13 budgets presented to the Board on the 29th May 2012 for approval.

The Board is asked to:

- **To Approve** the 2012-13 LAS budget with a revenue surplus of £3.1 million.

- **To note the following:**

- The key features of the funding agreements with Commissioners for 2012-13. Heads of term for the A&E contract with PCT Commissioners were signed on the 3rd April 2012.
- The proposed treatment of the income from A&E contract in relation to CQUINs and KPIs
- The level of cash releasing cost improvement programme (£12.5 million) required to achieve the £3.1 million surplus.
- The financial risks flagged to management during business planning.
- The LAS proposed budget for 2012-13 reconciles to the budget submissions made to DH and NHS London plan.

Budget Assumptions

The LAS 2012-13 budgets have been prepared using the following assumptions:

- In line with A4C terms of conditions i.e. incremental drift and £250 for band 3 and below. No other pay inflation assumed.
- 4.3% efficiency saving
- 0.5% Contingency
- 1% minimum planning surplus

The high level budget summary can be found below.

LAS Budget 2012-13				
	2011/12 Fcast Year	2012/13 Plan Year	Diff 1213 vs 1112	% 1213 vs 1112
	£000	£000	£000	
Income				
PCT Commissioned	251,281	254,308	3,027	1.2%
Olympics 2012	1,365	7,063	5,698	417.4%
Other	29,151	27,581	(1,570)	-5.4%
Total Income	281,797	288,952	7,155	2.5%
Operating Expense				
Pay	204,421	200,188	(4,233)	-2.1%
Non Pay	57,332	59,959	2,627	4.6%
Olympics 2012	1,365	7,063	5,698	417.4%
Total Operating Expense	263,118	267,209	4,091	1.6%
EBITDA	18,679	21,743	3,064	16.4%
EBITDA %	6.6%	7.5%	0.9%	13.5%
Depreciation & Financial	15,942	18,650	2,708	17.0%
Net Surplus	2,737	3,093	356	13.0%
Net margin	1.0%	1.1%	0.1%	10.2%
CIP	14,840	12,498	(2,342)	-15.8%
CIP as % of total income	5.3%	4.3%		

The key areas of movement relating to income arise from the increase in Olympics funding and the reduction of MPET funding in 2012-13.

NHS London planning guidance requires all NHS bodies to hold a contingency equal to 0.5% of resources. LAS contingency would be £1.46 million. In the LAS proposed budget for 2012-13 this contingency is to be the same as the expenditure reserve established for non achievement of CQUIN's and KPI's i.e. £1.5 million.

Contract Income

The high level summary above assumes income levels in line with the Heads of terms were signed with lead commissioners on the 3rd April 2012.

Reconciliation of A nd E Contract 12/13				
PCT Commissioned				254,308,000
EBS (PCT Commissioned)				1,000,000
MERIT				350,000
HCAS				-483,000
				255,175,000

The Heads of Terms have been signed with commissioners agreeing £255,175 (inclusive of EBS) which is a 0.6% increase on prior year.

The main areas of note are as follows:

- CQUIN value £6.22m (2.5% of contract value) as follows:
    - Reducing Conveyance to A&E services - 0.4% of Contract Value
    - Increase in the use of Hear and Treat - 0.2% of Contract Value
    - Management of Long Term Conditions - 0.2% of Contract Value
    - Health Promotion/Soho Alcohol Recovery Centre – 0.4% of Contract Value
    - Sharing Information with GPs – 0.5% of Contract Value
    - Patient Experience – 0.3% of Contract Value
    - Workforce Changes – 0.5% of Contract Value

In 2010-11 LAS budget, the full value of A&E contract and the CQUIN value were incorporated into the organisations base budget. In 2012-13, as with 2011-12, it is proposed to account for CQUIN income and a risk reserve for under performance against K.P.I's by creating an expenditure reserve of £1.5 million.

If CQUIN and KPI performance is in line with trajectory/milestones agreed with commissioners at the check points i.e. quarterly these funds would be released.

Cost Improvement Programme

The proposed 2012-13 budgets include a cost improvement programme of £12.5 million, which is a reduction from £14.8 million in the 2011-12 budgets. All savings need to be recurrent and cash releasing for directorates' current pay or non pay expenditure budgets.

Cost Improvement Programme 2012/13		
	2012/13 Plan	Pct of Total
	£000	
A&E Operations Pay	5,408	43%
EOC Pay	739	6%
Support Services Pay	1,549	12%
Agency	540	4%
Subtotal - Pay	8,237	66%
PTS	250	2%
Non Pay	4,011	32%
Total	12,498	100%
CIP as % of total income		4.3%
CIP as % of total income (excl Olympics, HART & CBRN)		4.7%

A detailed overview of the development of the 5 year cost improvement programme, its governance arrangements and reporting were developed during 2011-12 and will be continued into this financial year.

Financial Risk

The Trusts Financial risks are set out below**:**

Financial Risks 2012/13						
	Gross Risk				Net	
	Value	Impact	Likelihood	Rating	Value	Comments
	£000				£000	
Income						
CQUIN	6,362	5	3	15	636	10% of gross value
Contract Penalty	10,179	5	2	10	0	Strong contract mitigation
CBRN	7,570	5	2	10	0	DH Commitment
Other Income	300	2	2	4	0	
Subtotal	24,411				636	
Expense						
CIP not achieved	12,498	5	3	15	312	2.5% of gross value
Overtime Control	8,004	5	2	10	400	5% of gross value. Offset by Base pay
Economic - Fuel/Rates	574	3	3	9	287	50% of gross value
Other	1,333	3	3	9	333	0.5% of operating expense (Gross). 25% assumed net
Subtotal	22,410				1,333	
Other						
PTS profitability	163	3	4	12	100	
Impact of 111	6,358	5	2	10	0	1% of operating expense (Gross). 0% assumed net
Unexpected Events	0	2	2	4	0	
Subtotal	6,520				100	

Total gross financial risk has been assessed at £53m with a net value of £2m. These will be updated on a monthly bases in the Finance Board Pack.

Balance Sheet

There are no significant changes planned in the Trust's balance sheet.

Capital Plan

The Trusts' capital plan for 2012-13 is £12.4m as set out below.

Capital Programme 2012/13		
	2012/13 Plan	**Pct of Total**
	£000	
Fleet	7,023	57%
Estates	3,333	27%
IM&T	2,044	16%
Total	12,400	100%

2012-13 NHS Budget and Business Plans

Initial budgets were submitted to NHS London on the 16th January 2012. NHS London provided written feedback on this submission.

Final 2012-13 budgets and business plan narrative were submitted on the 10th April 2012.

NHS London submitted a final consolidated budget and business plan for the NHS in London to the Department of Health on the 13th April 2012.

An additional resubmission was made on the 23rd May 2012 to NHS London and DH

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH MAY 2012

PAPER FOR APPROVAL

Document Title:	**Carbon Management Plan 2012/13 – 2016/17**
Report Author(s):	**Christine McMahon**
Lead Director:	**Mike Dinan**
Contact Details:	**07717 806329**
Why is this coming to the Trust Board?	**Trust Board approval of the five year carbon management plan**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☒ Finance & Investment Committee (13th March 2012)
Recommendation for the Trust Board:	**To approve the objective of reducing our fuel and energy consumption by 25% and procurement by 10% by 2016/17**.

Key issues and risks arising from this paper

Key issues

1. There is no major additional investment required to deliver the carbon management plan as the majority of projects/initiatives are part of our five year corporate strategy set out in our Integrated Business Plan. The gross estimated cumulative savings attached to realising the carbon reduction plan is £49,097,777 (not including capital costs of projects to meet the target) measured against the business as usual, do nothing scenario.
2. Communications is a key tool in achieving carbon reduction; it has been estimated that approximately 5% reduction can be achieved through staff engagement to change behaviour. Whether by reducing consumption, eco-driving or considering alternatives ie telephone conference/webinars rather than face:face meetings and adopting web based processes rather than continuing with paper based processes. There is currently no communications lead assigned to this initiative.

Risks

1. That the Trust does not achieve the undertaking it gave in March 2010 to reduce the Trust's carbon footprint by 10% reduction (based on 2007/08 baseline) by 2015; this would be a reputational risk for the Trust, and has been added to the Trust's risk register. However, as at 31/03/12 we have achieved a 4% decrease in tonnes of carbon per incident.
2. That the Trust does not fully implement the clinical response model, reduce conveyance and multiple attendance and increase in hear/treat, key strategies for the Trust in managing demand. The successful implementation of these key strategies is closely monitored.
3. That the Trust does not achieve the potential savings identified from reducing carbon footprint, contrary to achieving best value.

Executive Summary

In March 2010 the Trust Board, joined colleagues in the rest of the NHS, in adopting the objective to reducing its carbon footprint (based on 2007/08 scope 1 and 2 emissions) by 10% by 2015. Available data suggests that scope 1 and 2 carbon footprint per incident has decreased by 4% since 2007/08.

In 2011/12 the Trust successfully participated in the Carbon Trust's NHS Carbon Management Programme; the five year carbon management plan has been endorsed by the Carbon Trust.

Table 1 – baseline data

	Scope 1 & 2		Scope 3	
Year 2010/11	Transport *fleet*	Stationery *energy*	Further sources *Procurement & waste*	Total emissions
Baseline emissions tCO_2	12,394	5,485	44,897	62,776
Expenditure £s	£5,850,176	£1,038,345	£75,415,274	£82,303,795
Percentage of baseline	20%	10%	70%	

Fleet reflects the nature of our core business, an accident and emergency service that in 2010/11 responded to 1,062,871 incidents across London, using 438 Ambulances, 221 Fast Response Units or 22 Motorbikes and consumed 4,667,462 litres of petrol and diesel (4.4 litres per incident). In 2011/12 we responded to 1,007,163 incidents, using 4,236,935 litres of diesel (4.2 litres per incident). Energy reflects the gas and electricity consumed across our estate. The implementation of our five estate strategy will result in the rationalisation of properties from 70 small/medium sized ambulance stations to a number yet to be determined that will be multifunctional sites. Our procurement carbon footprint is significant and reflects the expenditure on medical supplies, fleet maintenance stock, logistics equipment, insurance and banking services etc.

Table 2 below sets out the forecast annual savings of carbon based on the anticipated carbon savings identified for various projects/initiatives the Trust is implementing over the next five years. The total carbon savings identified is 21,949t$CO_{e2.}$ We have set ourselves two targets; reducing fleet and energy related emissions by 25% and procurement related emissions by 10%. As the plan is implemented and annually refreshed the targets will be reviewed.

Table 2- annual targets and forecasted financial savings.

	2012/13	2013/14	2014/15	2015/16	201617
Annual cost saving	**£722,209**	**£2,146,847**	**£2,185,394**	**£2,423,251**	**£2,728,736**
Annual CO_2 saving	**1,860**	**4,510**	**4,596**	**5,130**	**5,603**

The cumulative savings of achieving the targets measured against the BAU do nothing scenario is £6,129,981 in respect of Fleet & Energy and £43,097,777 in respect of procurement.

Attachments

Summary of five year Carbon Management Plan, sections 1-4.

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Quality Strategy

This paper supports the following measures of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

- ☐ That we fail to effectively fulfil care/safety responsibilities
- ☐ That we cannot maintain and deliver the core service along with the performance expect
- ☒ 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

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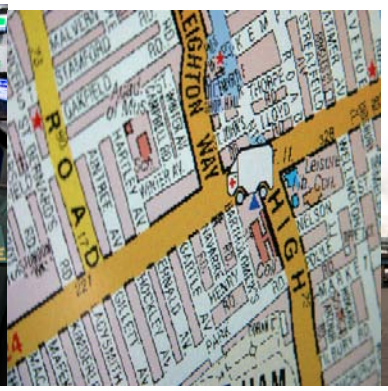
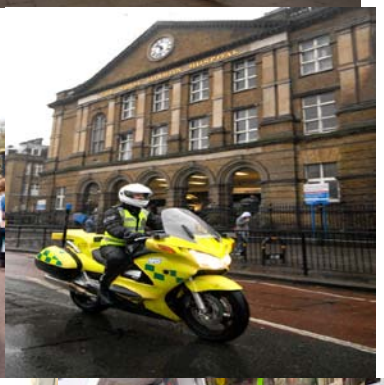
London Ambulance Service NHS Trust
Carbon Management Plan
2012/13 – 2016/17

Summary



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Foreword from Michael Dinan, Finance Director

The vision of the London Ambulance Service NHS Trust is to deliver a world class service to London responding to accident and emergency calls and incidents quickly and appropriately. We are the busiest emergency ambulance service in the world providing healthcare free at the point of use. We are also the only London-wide NHS trust.

On an average day (in our baseline year of 2010/11) we received 4,094 calls, to which we sent a physical response to 2,899 incidents [1] using an average 7.5 litres of fuel per incident. Of the calls that were deemed suitable for clinical telephone advice we were able to resolve over 50,000 calls without sending an ambulance. We have over 70 ambulance stations scattered around London, of which half are older than the NHS and our average daily consumption of gas and electricity was 42,355 kWh. Our daily spend via procurement was £204,175, of which 17% was spent on medical equipment and 13% on computer related expenditure. Our total carbon footprint per incident, taking into account the infrastructure that supports the organisation, was 59 kg of carbon [2].

In taking an active approach to managing our carbon usage we are seeking to deliver good value to the taxpayer, ensuring that we minimise waste. We also recognise the environmental impact that our vehicles and buildings have and seek to minimise.

In March 2010 the Trust Board approved a 'Carbon Reduction Policy' and committed us to reducing our 2007/08 energy and fuel baseline by 10% by 2015. We have undertaken work in different parts of the organisation to reduce our fuel and energy consumption, e.g. through the redesign of the Accident & Emergency Mercedes Vehicle in 2010 which subsequently was comprised of 90% of recyclable material, or working in partnership with SALIX to match fund energy reducing projects that in 2010/11 delivered savings of 259 tonnes of carbon.

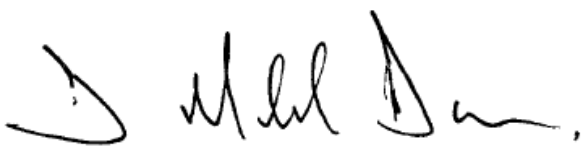
We are undertaking the stretching target of reducing our fuel and energy carbon footprint by 25% and our procurement's carbon footprint by 10% by 2016/17. In the same period we will deliver an ambitious Integrated Business Plan as part of our ambition to become an NHS Foundation Trust and a challenging five year cost improvement programme of £62,300,000**.**

Many of the projects identified to deliver the carbon savings are part of our business as usual, two examples are:

- the increased use of Hear & Treat, where it is clinically appropriate, will reduce the number of responses despatched.
- the rationalising our estate which will to some degree modernise our stations

Some of the measures to reduce our carbon footprint will be technological; others will be changes in practices (e.g. web based processes) whilst others still will involve changing aspects of our culture to encourage everyone to think about reducing waste, reducing usage and considering alternatives e.g. the use of teleconferencing instead of travelling to meetings being held across the capital or in other parts of the country. We are constantly working with public and private partners to deliver maximum value for money for London taxpayers and we continue to identify innovative ways to manage the ever increasing levels of demand.

Progress will be monitored on the Trust's Balanced Scorecard which is reviewed monthly by the Senior Management Group. Governance arrangements have been put in place to ensure that the identified projects deliver, as well as being a forum for identifying new projects. Achieving the targets will require support from members of staff working across the Trust. We will review the Carbon Management Plan on a regular basis with progress being reported in our annual Financial Statement.



[1] NB: an incident may result in one or more emergency responses arriving at the scene of the incident

[2] total carbon 2010/11 62,766,000kg CO_2 (see table 1) divided by number of incidents 1,062871 = 59 kg CO_2 per incident

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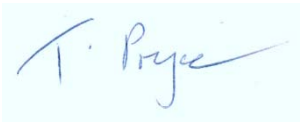
Foreword from the Carbon Trust

Cutting carbon emissions as part of the fight against climate change should be a key priority for all public sector organisations. Carbon management is about realising efficiency savings, transparency, accountability and leading by example. The UK government has identified the public sector as key to delivering carbon reduction across the UK in line with its Climate Change Act commitments, and the Carbon Trust is pleased to have partnered with London Ambulance Service on our 2011/12 NHS Carbon Management Programme to help it meet this challenge.

This carbon management plan will help London Ambulance Service to save money on wasted energy and put it to better use in other areas, while making a positive contribution to the environment by lowering carbon emissions. It commits LAS to a target of reducing CO2 by 25% (+10% from procurement) by 2017 and underpins potential financial savings and cost avoidance to the organisation of around £49m by that date.

Public sector organisations can contribute significantly to reducing CO2 emissions and improving efficiency. The Carbon Trust is therefore very proud to support London Ambulance Service in their on-going implementation of carbon management.



Tim Pryce
Head of Carbon Management
Carbon Trust

Introduction

The London Ambulance Service (LAS) NHS Trust acknowledges that its activity and operations have an effect on the local, regional and global environment.

Legally we are required to comply with the Climate Change Bill which became law on 26th November 2008. The Act enshrined in law an 80% target for carbon reduction by 2050; the NHS, set out how it will play its part in the NHS Carbon Reduction Strategy. In 2010 the LAS' Trust Board approved a Carbon Reduction Strategy, which committed us to reducing our carbon footprint by 10% by 2015 (baseline 2007/08 carbon emissions), Scope 1 and Scope 2[1].

To minimise the impact of this effect we are committed to making continuous improvements in environmental performance and preventing pollution. In making this commitment we will aim to meet the requirements of current environmental regulations, laws and codes of practice as a minimum standard.

We have identified our fleet, energy and procurement emissions for 2010/11 (baseline year) as follows:

Table 1, LAS 2010/11 baseline year

		Scope 1 & 2		Scope 3
Year 2010/11	Total emissions	Transport *fleet*	Stationery *energy*	Further sources *Procurement & waste*
Baseline emissions tCO_2	62,776	12,394	5,485	44,897
Expenditure £s	£82,303,795	£5,850,176	£1,038,345	£75,415,274
Percentage of baseline		20%	10%	70%

The target reduction in emissions is = 8,959 tCO_2 in five years[2]

Fleet reflects the nature of our core business, an accident and emergency service that in 2010/11 responded to 1,062,871 incidents across London, using 438 Ambulances, 221 Fast Response Units or 22 Motorbikes and consumed 4,667,462 litres of petrol and diesel.[3]

Energy reflects the gas and electricity consumed across our estate (Figure 5 below illustrate the dispersed nature of our estate). The age profile of our property (see Table 3) demonstrates that 46% is over 50 years old (older than the NHS itself). The objective of our five estate strategy is to rationalise the number of properties from 70 small/medium sized ambulance stations to a number less than 70 that will be multifunctional sites.

Our procurement carbon footprint is significant and reflects the expenditure on medical supplies, fleet maintenance stock, logistics equipment, insurance and banking services etc.

By March 2017 the London Ambulance Service NHS Trust will reduce its fuel and energy consumption by 25% from a 2010/11 baseline of 17,879 tonnes CO_2 and reduce its procurement carbon footprint by 10% from a 2010/11 baseline of 44,897 tonnes CO_2.

Figure XXX lists the projects/initiatives that we are and will be undertaking as part of our day to day operations that will deliver a reduction in carbon emissions.

Because the majority of projects/initiatives are part of our business as usual, as part of the delivery of our five year corporate strategy as set out in our Integrated Business Plan there is no

[1] Scope 1: Scope 2

[2] 25% stationery/transport = 4,469.75 + 10% further sources 4,439 = 8,909 (rounded up)

[3] 2010/11 Fleet Plan, Integrated Business Plan V9.4, Tables 9 and Table 37

major additional investment required. Where investment has been identified the simple payback period is less than a year.

Below are a couple of illustrations to help the reader visualise how one tonne of CO_2, and 139,000 tonnes of CO_2 would physically appear.[4]

Figure 1, A tonne of CO_2, a person and a London double decker bus

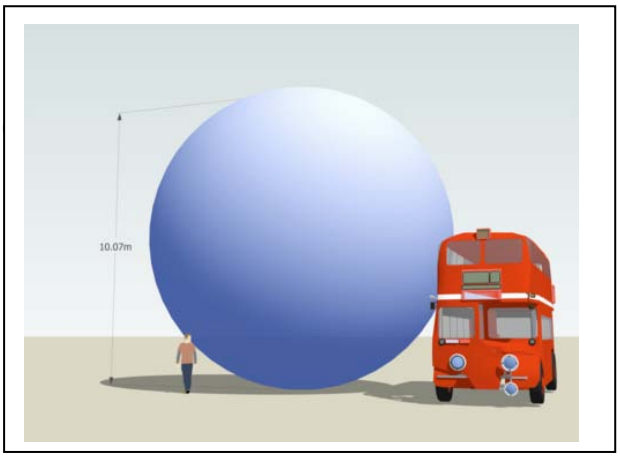


Figure 2, 39 thousand tonnes of CO_2 & London landmarks

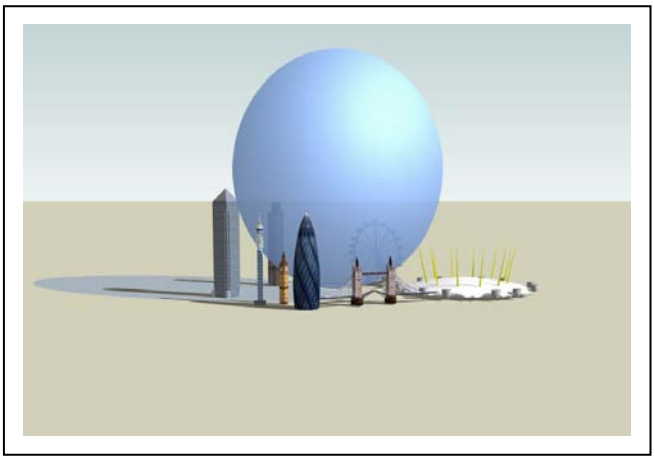


Table 2 below sets out the forecast annual savings of carbon based on the anticipated carbon savings identified for various projects/initiatives the Trust is implementing over the next five years as set out in sectio1.5.8 The total carbon savings identified = 21,949tCO_2. This is equivalent to 34% of our baseline emissions for 2010/11. We have set ourselves the target of 25%/10% based on what we currently feel is achievable, as the plan is implemented and annually refreshed the targets will be reviewed.

Table 2 – five year plan

	2012/13	2013/14	2014/15	2015/16	2016/17
Annual cost saving	**£722,209**	**£2,146,847**	**£2,185,394**	**£2,423,251**	**£2,728,736**
Annual CO_2 saving	**1,860**	**4,510**	**4,596**	**5,130**	**5603**
% of target achieved	**10%**	**30%**	**51%**	**74%**	**100%**

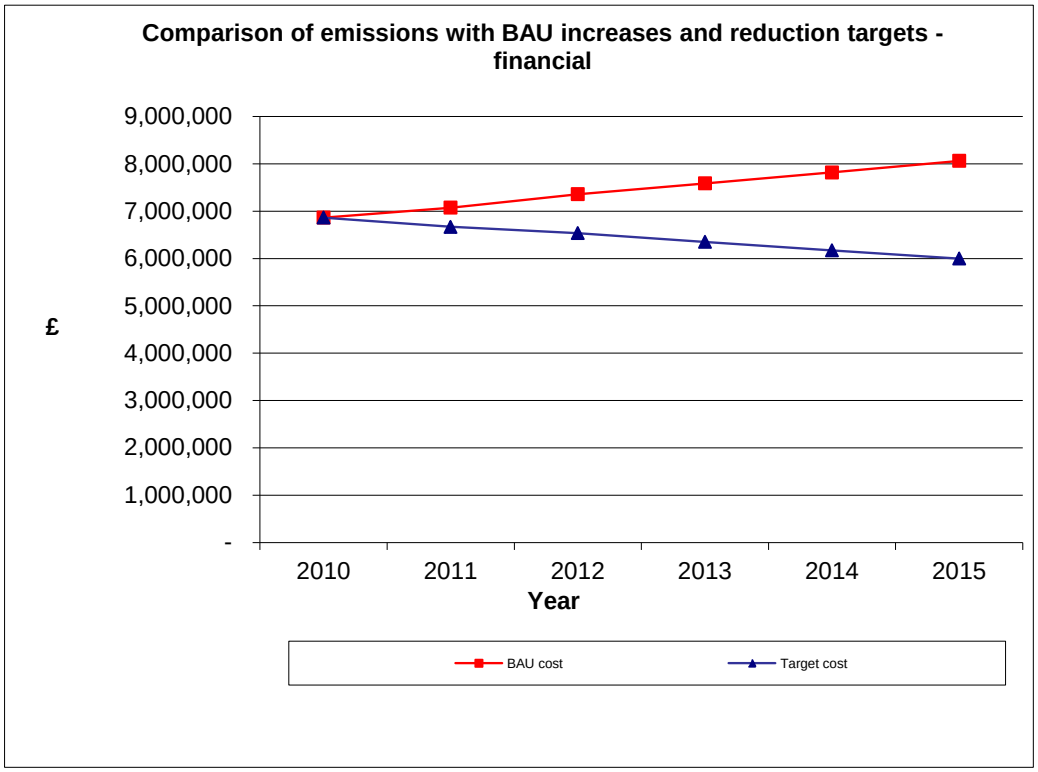
Value at Stake (VAS) is the year-on-year difference between the BAU and RES scenarios. The Value at Stake shows us the potential savings, or avoided cost, from implementing our plan and hitting our target against the alternative of doing nothing (BAU). The capital costs of projects required to meet the target are not included. The Value at Stake is a useful high level analysis, as it can be produced early on in the process of developing the carbon management plan and helps make the case for action

The reduced-emissions-scenario (RES) shows what the yearly carbon emissions would be if we hit our 25%/ 10% target and also what the yearly energy, water and waste costs would be. The capital costs of projects required to meet the target are not included in this analysis.

Figure 18 and 19 sets out the estimate of what the cumulative value at stake is for our two targets, over the course of the five year plan the total at stake will be £49,227,758 (fleet/estates is £6,129,981 and for procurement is £43,097,777).

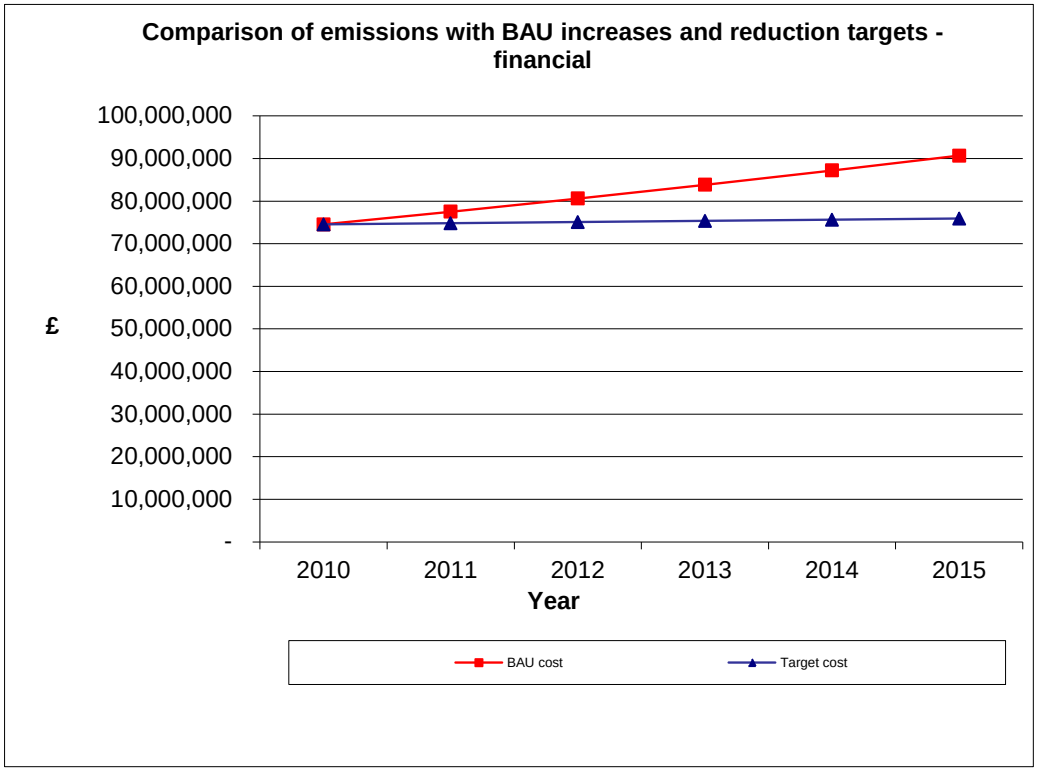
[4] Source: from website CarbonVisuals.com

Figure 3, Estate & Fleet projected financial savings against BAU increases



Final year annual cost savings (£)	**£2,048,950**
Cumulative cost savings (£)	**£6,129,981**

Figure 4: procurement projected financial savings against BAU increases



Final year annual cost savings (£)	**£14,784,527**
Cumulative cost savings (£)	**£43,097,777**

How are we going to achieve the reduction in carbon emissions?

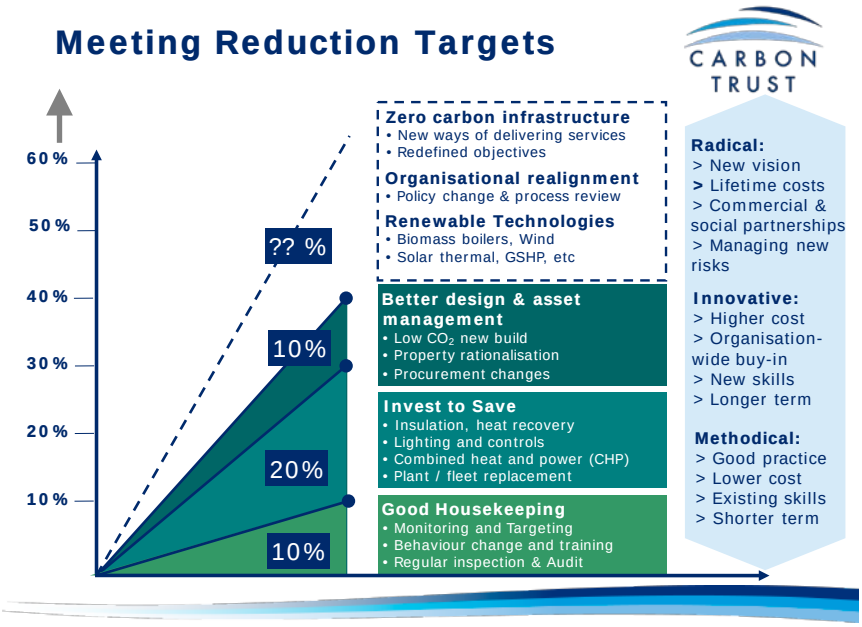
I have mapped a number of our initiatives and projects against the Carbon Trusts 'Meeting Reduction Targets'.

Mapping our past and future activities against the matrix in Figure 3 demonstrates how the Trust will achieve its ambition to reduce its carbon footprint.

good housekeeping: we now have a baseline based on carbon emissions in 2010/11, and have set targets for a reduction in carbon emissions that will be monitored on a monthly basis (see Section 5);

invest to save: we are working in partnership with SALIX and, to date have implemented a number of projects that delivered a reduction in carbon emissions and there are plans to continue using the savings to fund future projects. We are in the process of awarding an energy performance contract that will entail installation of meters on all our properties as well as deliver a reduction of at least 15% in our energy consumption in 2013. The procurement team has recently drafted a procurement environmental policy to supplement our Procurement Strategy and has a challenging target of reducing expenditure by 10% over the next five years.

Figure 5: how organisations achieve reduction in their carbon footprint.



better design and asset management: our estate strategy is to reduce our current portfolio, of which 46% is over 50 years old, to a number that has yet to be determined but the new properties will be modern and adhere to BREAM standards.

new ways of delivering services: we are faced year-on-year with increasing demand. To manage this we are changing our operating model whereby when someone calls us we identify those that need an immediate physical response (often more than one response in life-threatening situations) and those that need telephone advice from a clinically qualified member of staff. (See Figure 7 which sets out the response and treatment options for patients). In addition, our future front line work force will be predominantly paramedics who will be in a position to make decisions about patients' needs. As a result it is expected that more patients will receive treatment in their home with some patients being referred on to other community health services. For those patients who do require further assessment or treatment this will increasingly be provided in facilities other than an emergency department.

In addition to the different workstreams that focus on managing demand, we are also placing greater focus on the quality, innovation, productivity and prevention (QIPP) initiative that is aimed at organisations improving the quality of care delivered whilst making efficiency savings

for reinvestment in the Trust, delivering year-on-year quality improvements[5]. Of the 12 national work streams, the following six are relevant to us:

- long-term conditions: implementing generic models locally for supporting patients with long-term conditions.
- urgent care: aiming to achieve 10 per cent reduction in the number of patients attending emergency departments with associated reductions in ambulance journeys and admissions.
- End of Life care: putting in place care plans for high risk groups of patients.
- provider efficiency: back office efficiency and optimal management.
- procurement: best practice procurement to ensure maximum local efficiency.
- technology and digital vision: helping to put in place the underpinning technology required for other national work streams; supporting development, compatibility and interoperability of IT systems.

A number of these workstreams will see a reduction in our carbon emissions through ensuring that our physical resources are deployed as and when it is clinically appropriate to do so.

Projects: the CMP includes 19 projects. The initial list of projects have been identified by

- the Trust's five year Integrated Business Plan
- the NHSCM Project Team
- the NHSCM Project Board;
- the Salix application;
- costs saving ideas from members of staff that potentially have a positive environmental impact.

There are a number of Trust strategies that will potentially have a positive environmental impact such as:

- the reduction in the estate, both in terms of the number of ambulance stations and workshops; the changing composition of the fleet and a reduction in the number of ambulances;
- the increase in the use of Hear & Treat (thereby not despatching a vehicle response unless absolutely necessary);
- the introduction of an electronic patient report form[6]
- increase in the rate of the utilisation of the cycle response team.

Monitoring & reporting: we will use a web based system to capture data concerning fuel and energy consumption; waste and recycling, and procurement spend on a monthly basis. The Carbon Management Project board, whose membership is pan Trust, will meet quarterly to review progress and identify potential new projects that will contribute to a reduction in the Trust's carbon footprint.

The CMP is a 'live' document and will be refreshed annually as projects are completed and new projects identified. Regular reporting will be undertaken to ensure that the Trust Board and stakeholders are kept informed of our progress in achieving our reduction targets.

[5] Department of Health (2010) Quality, Innovation, Productivity and Prevention (QIPP).

[6] subject to approval of business case

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Table 9, Projects scheduled to be delivered in Years 2011/12 – 206/17 of the Carbon Management Plan

This table will be reviewed by the project board when it meets to initiate the plan in July 2012. Over time projects will drop off as they are completed and become business as usual and new projects/initiatives will be added.

Ref	Project	Lead	Cost		Annual Savings (yr 1)		Pay back (yrs)	Net Present Cost(£)	% of Target	Implementation Year	Achieved
			Capital	Operational	Financial (Gross)	tCO_2					
14	St Andrews Hse - voltage optimisations	MD	£27,877	£500	£7,452	43.7	3.7	-£29,940	1.6%	2010	√
15	Bromley - replacement garage lighting & controls	MD	£16,833	£500	£3,686	21.6	4.6	-£9,662	0.8%	2010	√
16	Newham - boiler replacement	MD	£16,890	£500	£2,906	17.0	5.8	-£3,122	0.6%	2010	√
17	Wimbledon - boiler replacement	MD	£15,525	£500	£3,163	18.5	4.9	-£6,619	0.7%	2010	√
19	Chase Farm - new boiler	MD	£4,703	£500	£1,316	7.7	3.6	-£2,086	0.3%	2010	√
21	St Andrews Hse - evaporative cooling	MD	£11,500	£500	£7,864	46.1	1.5	-£49,743	1.7%	2010	√
5	Ambulance News - electronic	MD	£0	£0	£5,000	3.0	0.0	-£22,575	0.1%	2011	√
11	LED garage lighting - Barnehurst	MD	£11,762	£0	£2,697	15.8	4.4	-£10,668	0.6%	2011	√
12	Tolworth AS boiler/controls	MD	£1,700	£500	£390	2.3	4.4	£2,617	0.1%	2011	√
13	HQ - car park/common areas lighting	MD	£16,500	£500	£5,592	32.8	3.0	-£25,848	1.2%	2011	√
18	Bromely - heating controls	MD	£8,050	£500	£1,710	10.0	4.7	-£2,009	0.4%	2011	√
20	Waterloo HQ - replacement boilers	MD	£69,000	£500	£16,241	95.2	4.2	-£61,910	3.6%	2011	√
22	Fulham lighting	MD	£11,383	£500	£6,838	40.1	1.7	-£41,330	1.5%	2011	√
23	Fulham workshop lighting	MD	£2,144	£500	£1,368	8.0	1.6	-£5,072	0.3%	2011	√
25	Isolation redundant heating pipework	MD	£1,044	£500	£1,368	8.0	0.8	-£6,172	0.3%	2011	√
1	Battery powered/electrical vehicles	MF	£60,000	£7,440	£15,572	45.2	3.9	-£7,629	1.7%	2012	

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2	Remove desk bins	MD	£1,500	£0	£0	17.0		£1,500	0.6%	2012	
3	Telematics in vehicles [7]	MD	£300,000	£100,000	£41,650	93.5	7.2	£610,921	3.5%	2012	
6	IM&T: rationalise servers	PS	£5,000	£0	£79,431	465.7	0.1	-£655,599	17.4%	2012	
7	IM&T: cyclical replacement of laptops	PS	£0	£0	£3,192	18.7	0.0	-£26,545	0.7%	2012	
8	Procurement	MD	£0	£0	£825,000	486.8	0.0	-£6,861,199	18.1%	2012	
9	Turn off tvs when not in use	MD	£24,500	£0	£4,812	28.2	5.1	-£15,521	1.1%	2012	
10	Energy performance contract estate wide (wip)	MD	£100,000	£0	£155,432	821.8	0.6	-£1,192,667	30.6%	2012	
24	St Hellier Garage lighting	MD	£4,573	£500	£855	5.0	5.3	£1,622	0.2%	2012	√
26	Reduction in non-conveyance	RW	£0	£0	£403,976	907.1	0.0	-£3,359,709	33.8%	2012	
28	Reduction in Multiple Sends Stage 1	RW	£0	£0	£208,138	467.3	0.0	-£1,731,003	17.4%	2012	
27	Printer Rationalisation	PS	£0	£0	£4,788	28.1	0.0	-£39,817	1.0%	2013	
29	Reduction in Multiple Sends Stage 2	RW	£0	£0	£219,726	493.4	0.0	-£1,827,377	18.4%	2013	
32	Operations: increase in the use of Hear & Treat - Year 1	RW	£0	£10,000	£116,685	262.0	0.0	-£481,690	9.8%	2013	
33	Operations: increase in the use of Hear & Treat - Year 2	RW	£0	£10,000	£38,547	86.6	0.0	-£128,892	3.2%	2014	
4	e-PRFs [8]	PS	£30,000	£10,000	£129,000	76.1	0.2	-£959,676	2.8%	2015	
30	Reduction in Multiple Sends Stage 3	RW	£0	£0	£216,606	486.4	0.0	-£1,801,428	18.1%	2015	
34	Operations: increase in the use of Hear & Treat - Year 3	RW	£0	£10,000	£21,250	47.7	0.0	-£50,796	1.8%	2015	
31	Reduction in Multiple Sends Stage 4	RW	£0	£0	£154,655	347.3	0.0	-£1,286,203	12.9%	2016	
35	Operations: increase in the use of Hear & Treat - Year 4	RW	£0	£10,000	£21,831	49.0	0.0	-£53,416	1.8%	2016	

[7] subject to approval of business case

[8] subject to approval of business case

London Ambulance Service
NHS Trust

Information Pack for Trust Board

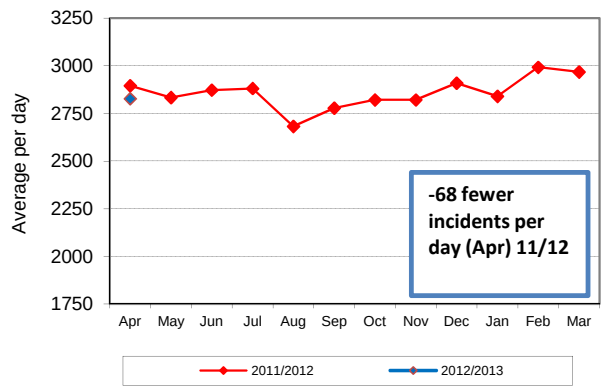
April 2012

***** Currently we are missing one dataset for April**

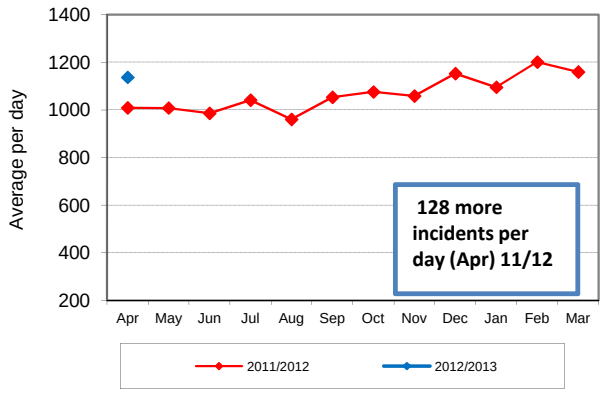
Rest Breaks

London Ambulance Service NHS Trust
Accident and Emergency Service
Activity / Call Process -
April 2012

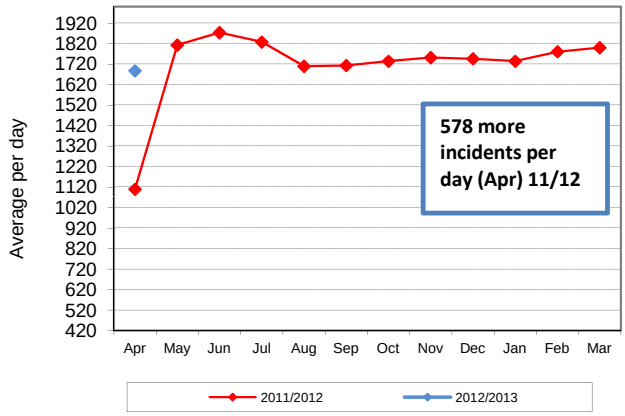
Graph 1
Average number of Total incidents per day



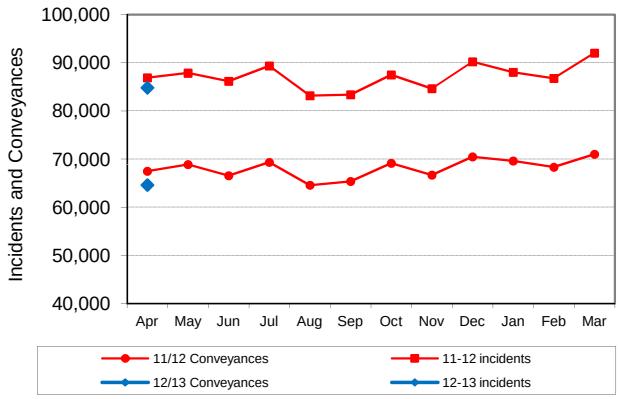
Graph 2
Average number of Cat A incidents per day



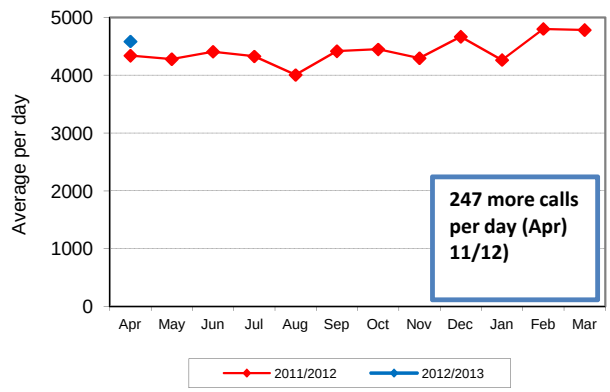
Graph 3
Average number of Cat C incidents per day



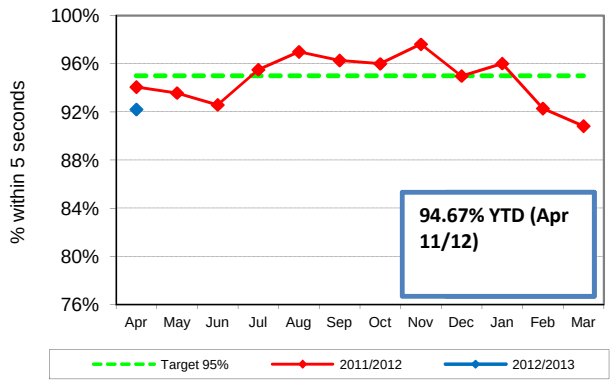
Graph 4
No of incidents conveyed



Graph 5
Average number of 999 (+ MPS) calls received per day

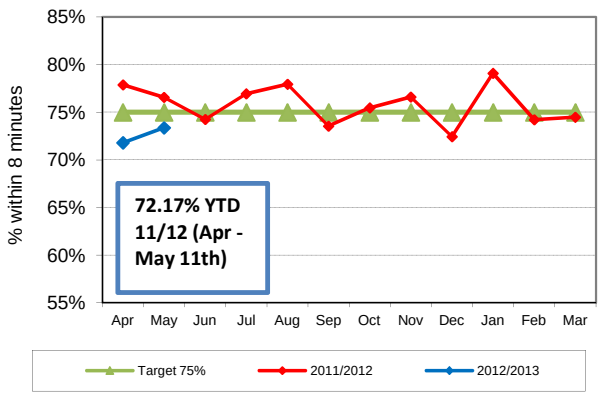


Graph 6
Percentage of calls answered within 5 seconds

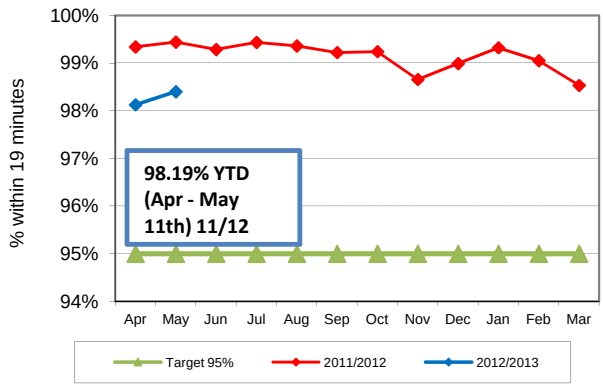


London Ambulance Service NHS Trust
Accident and Emergency Service
Performance - April 2012

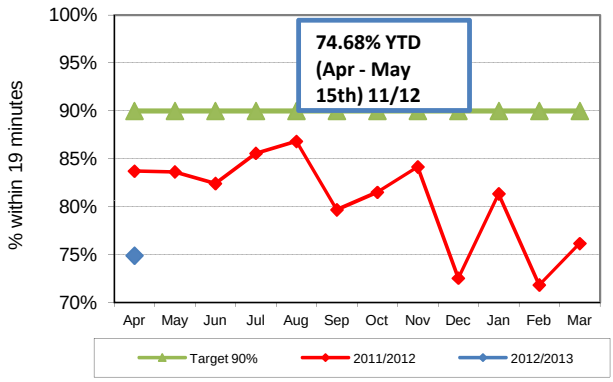
Graph 7
Category A 8 minute performance



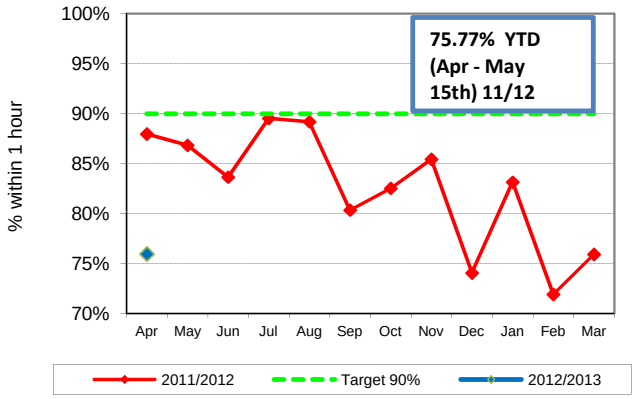
Graph 8
Category A 19 minute performance



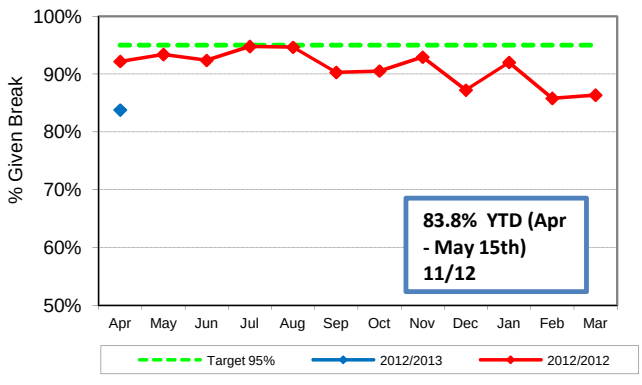
Graph 9
Category C1 20 minute performance
(Incidents responded to only)



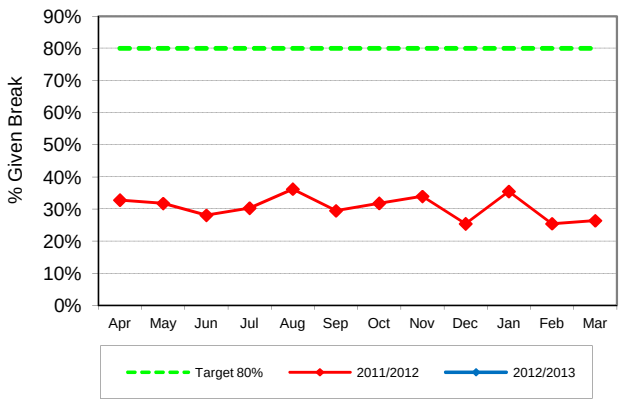
Graph 10
Category C2 30 minute performance
(Incidents responded to only)



Graph 11
Cat C incidents 60 Minute Performance
(Incidents responded to only)

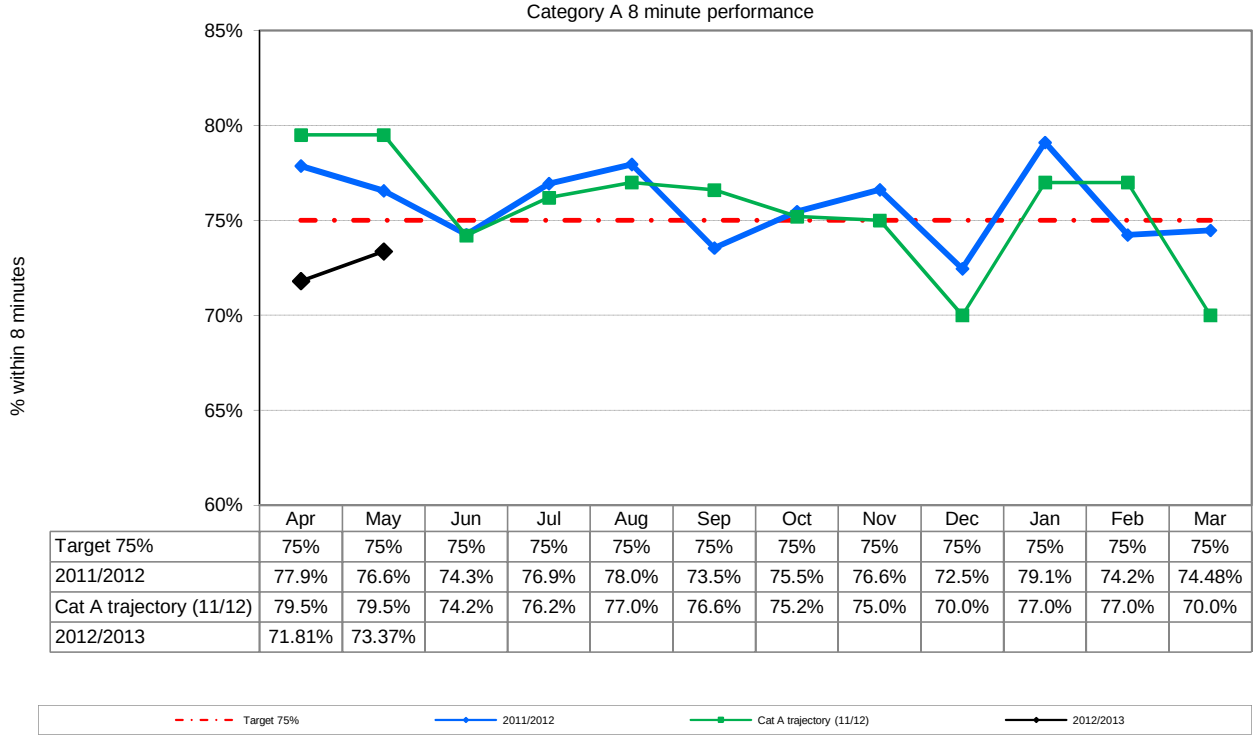


Graph 12
Rest Breaks Given



London Ambulance Service NHS Trust
Accident and Emergency Service
Performance - April 2012

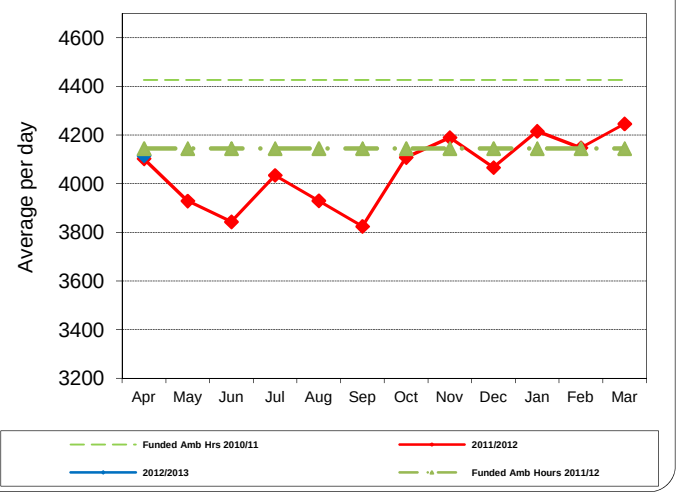
Graph 13
Category A 8 minute performance



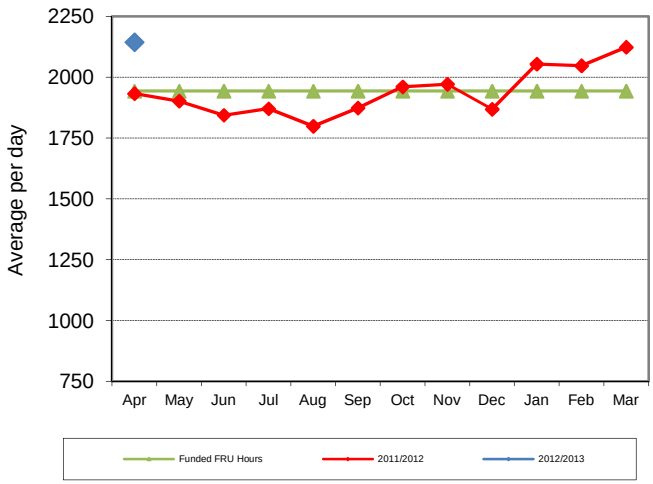
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target 75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
2011/2012	77.9%	76.6%	74.3%	76.9%	78.0%	73.5%	75.5%	76.6%	72.5%	79.1%	74.2%	74.48%
Cat A trajectory (11/12)	79.5%	79.5%	74.2%	76.2%	77.0%	76.6%	75.2%	75.0%	70.0%	77.0%	77.0%	70.0%
2012/2013	71.81%	73.37%										

London Ambulance Service NHS Trust
Accident and Emergency Service
Efficiency and Effectiveness - April 2012

Graph 14
Ambulance Hours average available per day



Graph 15
FRU hours average available per day

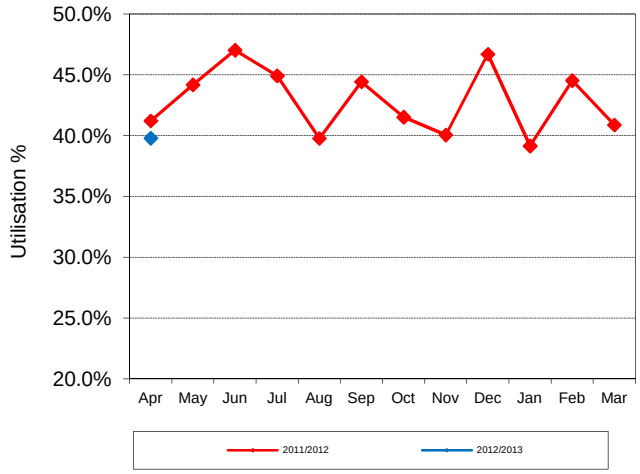


Please be aware that the funded hrs include more vehicle types than those above

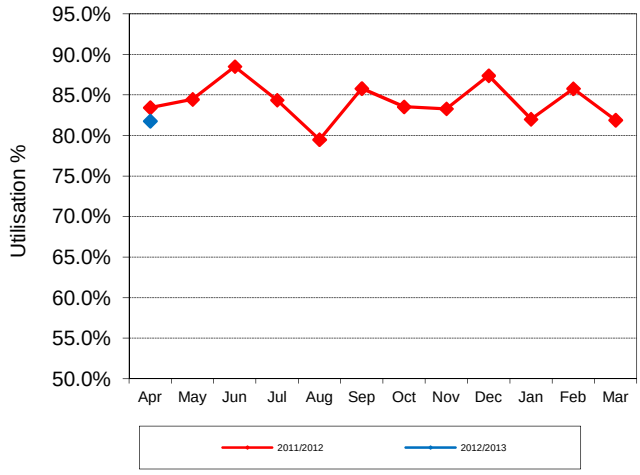
includes other vehicle types other than those above

London Ambulance Service NHS Trust
Accident and Emergency Service
Efficiency and Effectiveness - April 2012

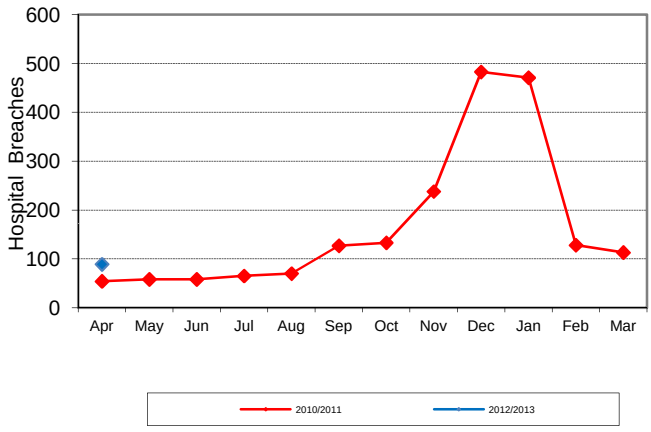
Graph 19
FRU Utilisation



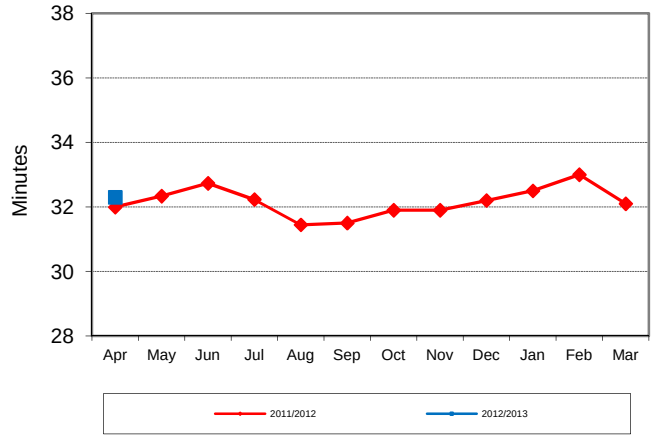
Graph 20
Ambulance Utilisation



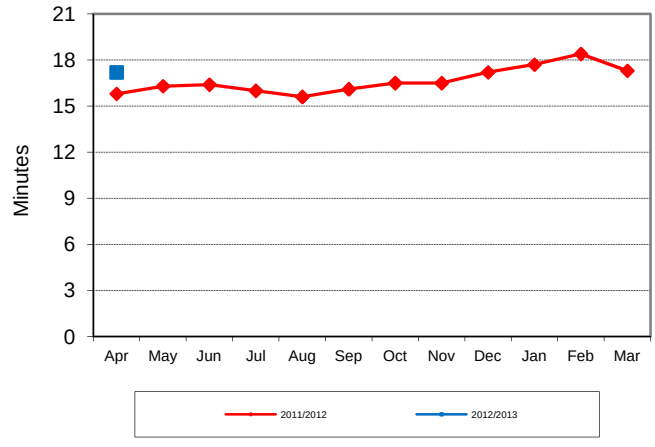
Graph 21
Hospital breaches over 60 minutes investigated



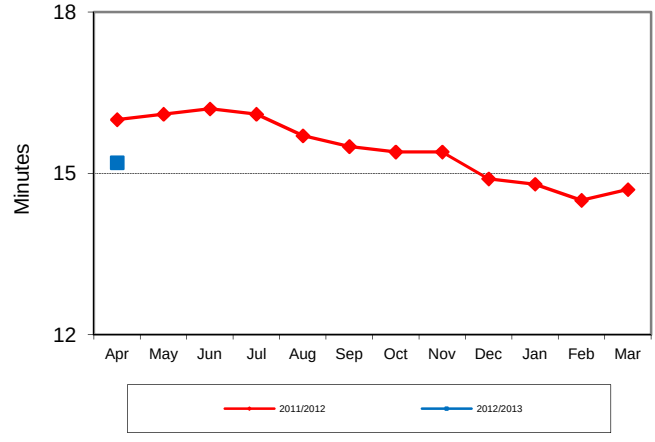
Graph 22
Average hospital turnaround time



Graph 23
Average Arrival at Hospital to Handover (Mins)

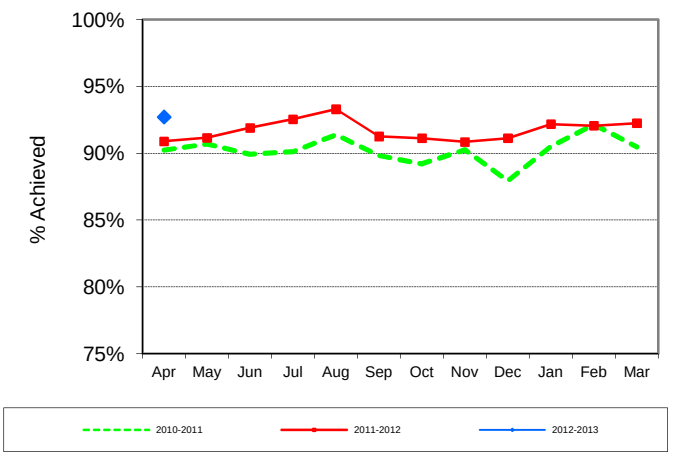


Graph 24
Average Handover to Green (Mins)

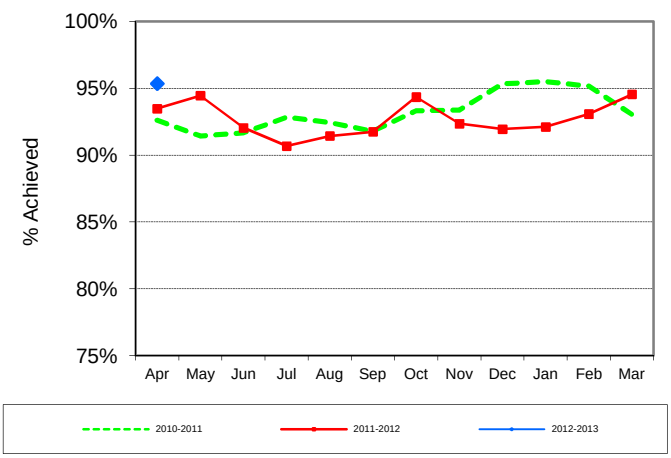


London Ambulance Service NHS Trust
Patient Transport Service
Activity and Performance - April 2012

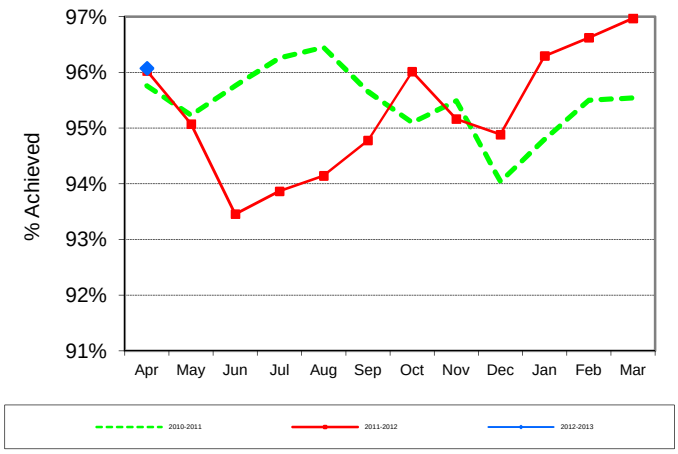
Graph 25
Arrival at Hospital Against Appointment Time



Graph 26
Departure Against Ready Time



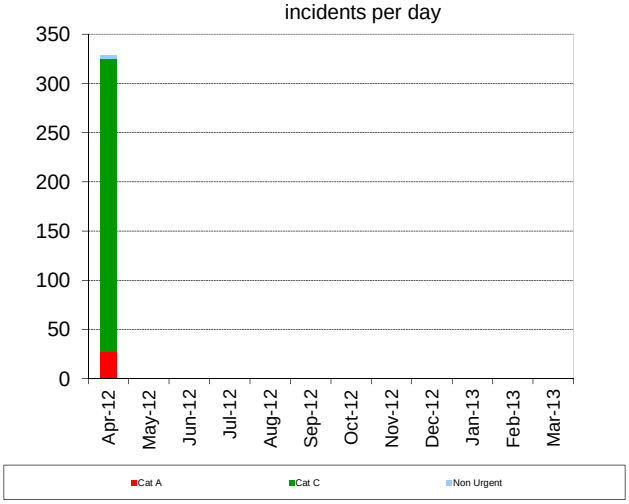
Graph 27
Time spent on Vehicle



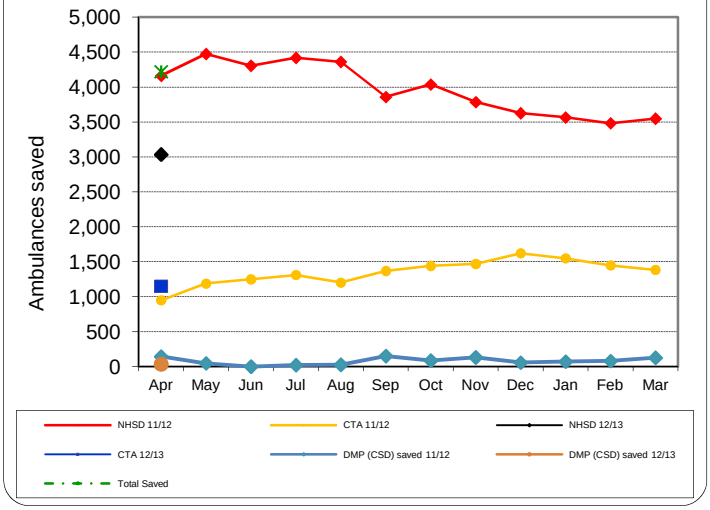
London Ambulance Service NHS Trust
Accident and Emergency Service
UOC Effectiveness - April 2012

Incident information is based on responses where a vehicle has arrived on scene for dispatches occuring during UOC operational hours (0700 -02259)

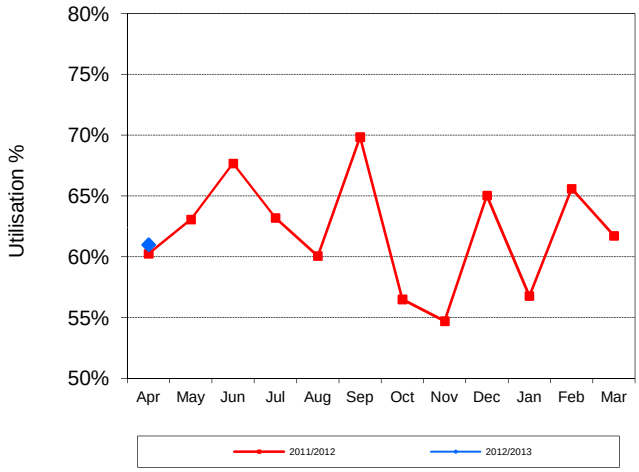
Graph 30
CAT A, B & C Workload by Urgent Care Vehicles average incidents per day



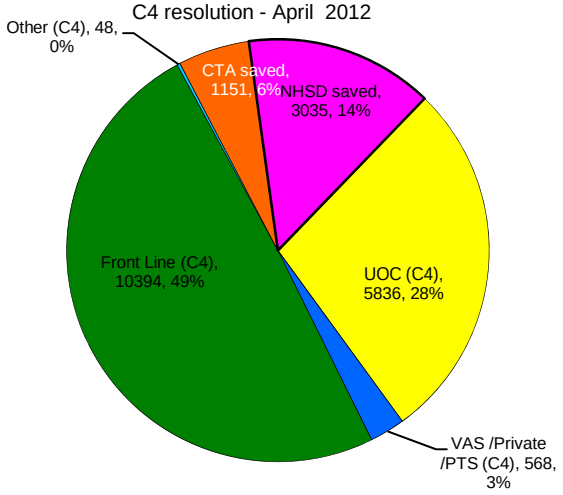
Graph 31
CTA/NHSD/DMP Ambulances saved



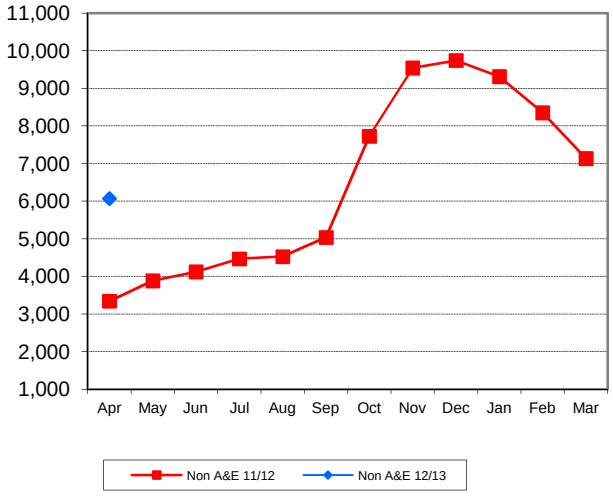
Graph 32
UOC Utilisation



Graph 33
C4 resolution - April 2012



Graph 35
Patients conveyed to Non A&E Departments - LAS



London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29 MAY 2012

PAPER FOR NOTING

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

Key issues and risks arising from this paper

The Trust Board is asked to note that the sickness absence rate of 5.24% remains slightly above the target rate of 5% and that PDR levels are disappointing and will be a focus of attention for 2012/13.

Executive Summary

Key headlines from the Workforce report are:

Sickness absence
Sickness for the Trust as whole fell again in March to 5.24% and the YTD figure fell slightly to 5.32% for year end (above the target for 2011/12 of 5% or below).

Unauthorised Absences
The total figure for U/As in Areas fell again in April to 126 and was below the level for the previous year.

Vacancies and Turnover
From weekly operational staff in post figures, it can be reported that as at 30th April 2012 frontline staffing showed a vacancy level of 43wte. Recruitment is underway to fill these vacancies. Turnover remains within normal range.

PDR completion for 11/12

The details of manual the returns received have been included in this report. The final completion rate for 11/12 was:

23.5% for Operational Areas
74.3% for Control Services
35.1% for PTS
91.2% for Support Services.

Partnership working

Agreement reached with Unison and GMB regarding co-operative partnership working in preparation for and service delivery during the Olympics with the avoidance of any disruption.

National Pensions Dispute and Industrial Action

Await confirmation of the national response to the final pension reform proposals.
The risk of further industrial action related to pensions reform appears to have reduced though is it remains live.

Following a challenge on the legality of the Unite notification of intention for action on 10 May 2012, the notification was rescinded and no action was taken.

Attachments

1. Workforce Report
2. Workforce data report

****

Quality Strategy

This paper supports the following domains of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

- ☐ Yes
- ☒ No (N/A)

Key issues from the assessment:

Workforce Report

Trust Board – 29 May 2012

Sickness absence

Sickness for the Trust as whole fell again in March to 5.24%; short term absence fell and long term absence remained exactly the same. As a consequence, the YTD figure fell slightly to 5.32% for year end, which was above the target for 2011/12 of 5% or below, and above the figure for 10/12 of 5.28%. Nevertheless, it is expected that when benchmarking data is available, the final figure for 11/12 will compare favourably with other ambulance trusts. The RAG rated audits continue to show that, in the main, all absence is being managed appropriately and in accordance with the Managing Attendance Policy (MAP).

Sickness in the Areas again fell at a rate slightly above that for the Trust as a whole, but remained 0.5% above the level for the same month last year. The year end figure for the Areas was 5.49%. The figures for individual Areas was as follows (February's figures in brackets); East rose to 6.26 (5.86%), South 6.24% (6.75%), West 4.07% (5.72%).

In January sickness rose in Control Services to 5.93 (5.82%), YTD 5.93%.

In PTS sickness fell markedly from 8.89% in February to 6.38% in March; the year end figure for 11/12 was 8.89%. Short-term absence fell in March from 2.6% to 1.4% and long term fell from 6.3% to just under 5%. All cases are being managed appropriately through the MAP.

Unauthorised Absences

The total figure for U/As in Areas fell again in April to 126 and was below the level for the previous year; East 37 from 53; South 53 from 74; West was static at 36. U/As in Control Services remained in single figures.

Vacancies and Turnover

From weekly operational staff in post figures, it can be reported that as at 30th April 2012 frontline staffing was 3170 wte against the 11/12 establishment of 3301 (vacancy level of 149 wte; 4.5%).

Turnover in February was within normal range. Year to date levels are also within normal range.

PDR completion for 11/12

The details of manual the returns received have been included in this report. The final completion rate for 11/12 for the Areas was 23.5% - varying from 6.9% in South to 34.5% in West and 33.1% in East; 74.3% for Control Services; 35.1% for PTS; 91.2% for Support Services.

Work is ongoing to revise and improve a method of electronic reporting going forward.

Partnership working

A formal review of the Trust's Partnership and recognition agreements, including all joint consultative arrangements, is to commence at the end of May.

Agreement has been reached regarding annual leave and overtime arrangements during the Olympic and Paralympic Games, with Unison and GMB providing an undertaking to work in partnership with the Trust to ensure the smooth running of the Olympic and Paralympic

Games; to avoid disruption to planning and preparation; and to supporting the maintenance of normal service delivery up to and throughout the period of the Games.

National Pensions Dispute and Industrial Action

Unison has balloted its members nationally on whether to accept the Government's final pensions offer. The result did not deliver a mandate either to accept or reject, and the turnout was just under 15%. THE RCN ballot delivered a majority in favour of rejection, but again on a very low turnout. GMB has recommended that its members reject the offer, and its ballot closes on 21 May 2012. An extraordinary meeting of the Trade Union side of the NHS Staff Council is to be arranged to discuss the position. The risk of further industrial action related to pensions reform appears to have reduced though remains live.

Nationally, Unite remains opposed to the offer and has continued to participate in industrial action with other public sector unions, most recently on 10 May. The Trust wrote to Unite ahead of any declaration of intent to call on members in the Service to participate in such action, and formally requested that our staff were exempted. After initial assurances that LAS members would not be taking action, a formal notice of strike action was issued. The legality of the notification was challenged and the strike notice was subsequently rescinded. No Trust staff participated in industrial action on 10 May.

London Ambulance Service
NHS Trust

HR Summary for Trust Board

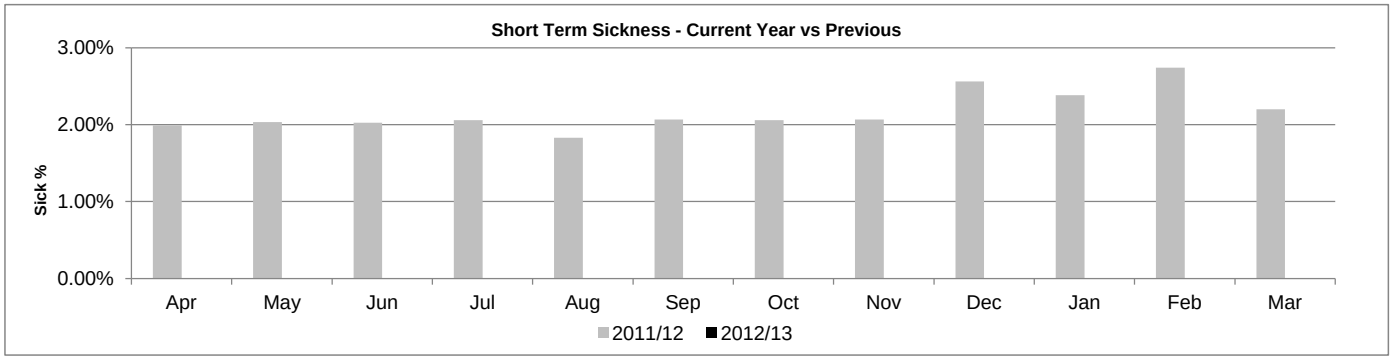
April 2012

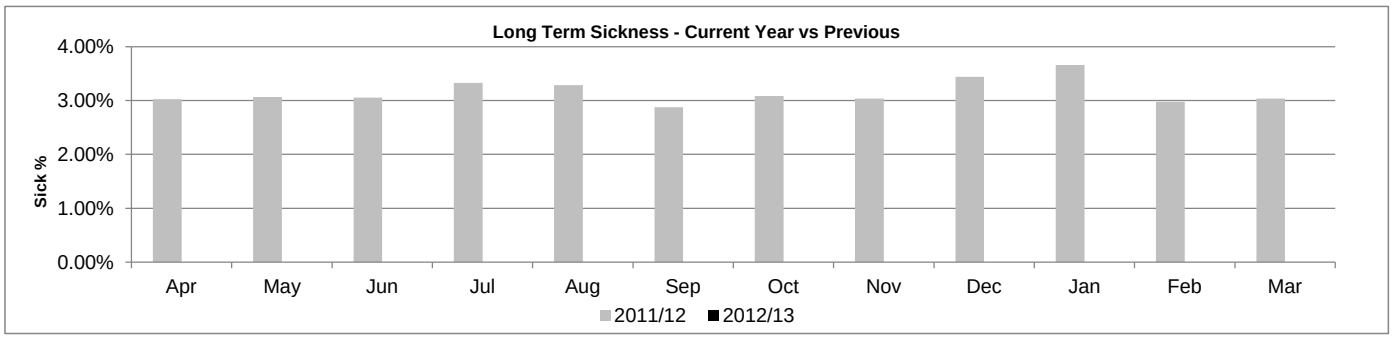
Workforce Report

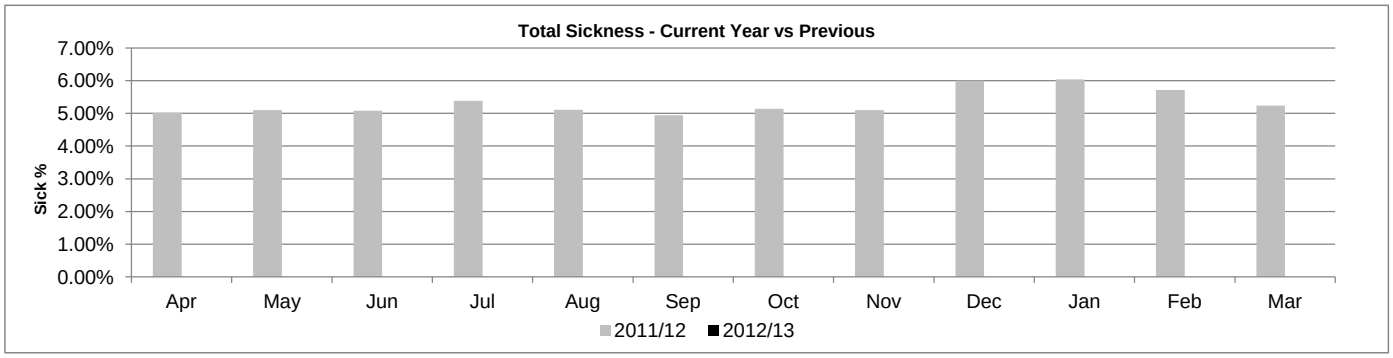
Current Month Apr-12 **Sickness Month** Mar-12

Trust Summary

Sickness Absence







Sickness 2010/11	5.28%	**Current WTE**	4526.26	**NB Secondments and Acting Up Included in Totals**
YTD Sickness	5.32%	**Current Headcount**	4750.00	

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	5.01%	5.10%	5.08%	5.39%	5.11%	4.94%	5.14%	5.10%	6.00%	6.04%	5.71%	5.24%
2011/12	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Unauthorised Absence	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	163.00	167.00	161.00	192.00	171.00	164.00	161.00	312.00	98.00	167.00	179.00	168.00
2011/12	134.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Narrative

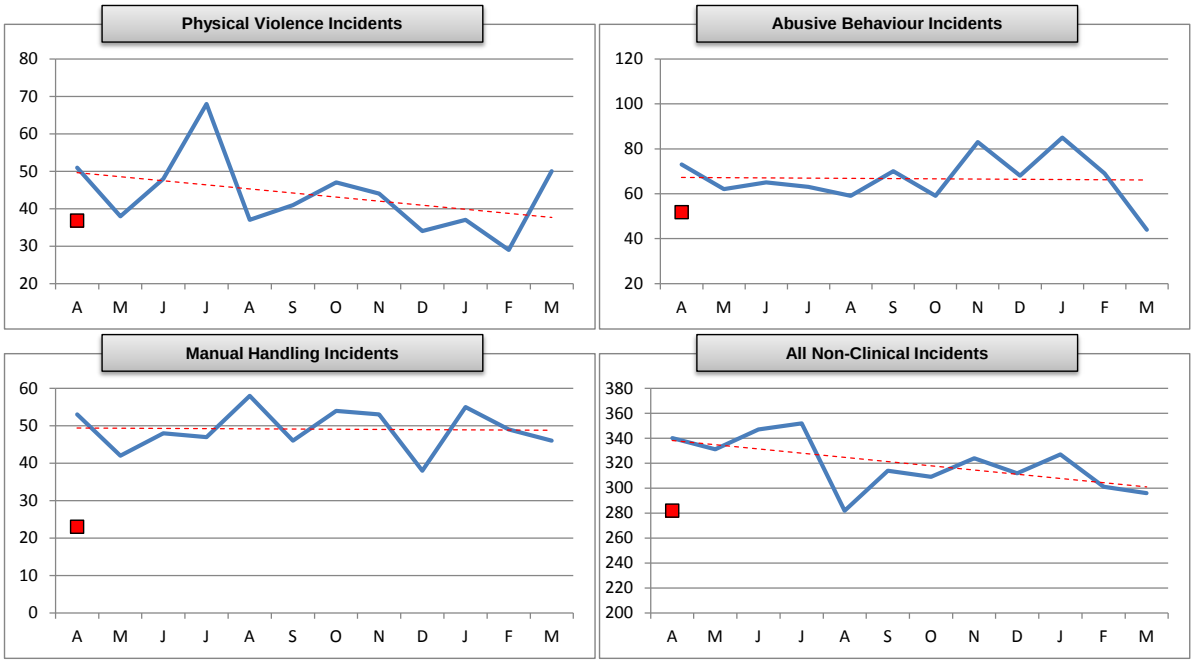
Sickness

Sickness for the Trust as whole fell again in March to 5.24%; short term absence fell and long term absence remained exactly the same. As a consequence the final YTD figure fell slightly to 5.32% which was above the target for 2011/12 of 5% or below, and above the figure for 10/11 of 5.28%. Nevertheless, it is expected that when benchmarking data is available, the final figure for 11/12 will compare favourably with other ambulance trusts. The RAG rated audits continue to show that, in the main, all absence is being managed appropriately and in accordance with the Managing Attendance Policy (MAP).

Unauthorised Absences

This figure shows the number of instances when staff have reported unable to attend work at short notice for reasons other than their own sickness or when they have not reported for work. Depending on the reason, the absence may be converted into annual leave or un/paid special leave or remain an unpaid unauthorised absence. Disciplinary action may result. The figure for the Trust as a whole for April 2012 was a reduction on March and below that for the same month last year.

Health and Safety Issues



Note - Due to the delay in receiving incidents, it is expected that 84.9% of reports have been received for incidents occuring within April 2012. Due to this the figure for April 2012 is an estimate; the next SMG report will show the true figure for this month.

Manual Handling
The figure for reported manual handling incidents is excessively lower than the current trend shows, and we need further observation to see if this is a mean change or simply an outlier. The general trend shows that an average of 48 manual handling incidents occur per month in the LAS Trust, which equates to a steady rate of 21 incidents per 100,000 hours worked.

Non Physical Abuse
The number of reported abusive behaviour incidents has decreased following a steady rise between August 2011 and January 2012. Following a sharp drop in March 2012 the figure has risen slightly to 52 reported incidents per month. This is reflected in the incident rates, where the number of reported incidents of abusive behaviour has risen from 18.2 per 100,000 hours worked to 22.6, which is overall down from the historic average of 32 per 100,000hrs worked.

Physical Violence
The number of reported physical violence cases shows an overall downward trend though with an increase in reported incidents in March. The estimated number of physical assaults for April 2012 is 37 per month, which equates to 16.0 per 100,000 hours worked. It is assumed that this overall fall is due to staff awareness training in conflict resolution techniques.

SIRS Reporting
The Health, Safety and Risk department has been reporting incidents of physical violence, abusive behaviour and security incidents to NHS Protect via their SIRS (Security Incident Reporting System) Portal since January 2012. Reporting to this portal became mandatory on the 1st April 2012 with monitoring and auditing being undertaken by the CQC.

Court Cases
A crew member was assaulted on January 1st this year by being grabbed particularly hard by the offender who attempted to bite and kick the victim. The offender was successfully prosecuted and sentanced on 26th April 2012 for assault by beating, recieving a 12 week custodial sentance, suspended for 2 years, together with a 3 month curfew with electronic monitoring and 150 hours commuity service.

A crew member was assaulted by being kicked in the knee on 6th March 2012. The offender is being prosecuted and the case was due to be heard at Stratford Magistrates Court on 15th May 2012. However, the case has been postponed and a new date is yet to be advised.

A vexacious regular caller in Croydon, who already has a restraining order against him to prevent him victimising a particular member of staff, was given an 18 week custodial sentance for abuse of another member of staff. We are working with the Police in Croydon to put an Anti Social Behaviour Order (ASBO) in place to reduce his abuse of the Service. This will be taken forward upon his release. To this end, the Deputy Director of Operations has provided a statement on behalf of the LAS, describing the negative impact this individual has upon the Service.

Airwaves Reporting Pilot
In the recent escalation report from Governance and Compliance, 18 incident investigations remain outstanding with 4 of these awaiting investigation for over 10 weeks.

It is intended that the pilot will be extended to Whipps Cross in the near future.

Carry Chair Transporter Pilot
The carry chair pilot is nearing a close, with two more stations to review the carry chairs over the next two months. It is planned that the pilot will draw to a close at the end of July 2012.

Workforce Report

Current Month **Apr-12**

Trust Summary

Vacancies & Turnover

	Funded WTE	Inpost WTE	Variance
Trust Total	4711.72	4512.25	-199.47
Directorate			
A&E Operations	3427.95	3358.17	-69.78
Chief Executive	16.61	13.00	-3.61
Control Services	437.28	414.25	-23.03
Corporate Services Directorate	37.26	34.27	-2.99
Finance & Business Planning Directorate	59.20	49.13	-10.07
Health Promotion & Quality	19.27	17.27	-2.00
Human Resources & Organisation Dev Directorate	183.12	166.60	-16.52
Information Management & Technology Directorate	93.53	84.56	-8.97
Medical Directorate	25.20	18.87	-6.33
Operational Support	129.86	115.43	-14.43
Patient Transport Service	166.44	142.66	-23.78
Trust Board	6.00	6.00	+0.00

	Est.	In Post	Var.
T/L Paramedic	193.19	199.59	+6.40
Paramedic	1143.67	1354.88	+211.21
Student Paramedic 1	0.00	0.00	+0.00
Student Paramedic 2	348.00	7.00	-341.00
Student Paramedic 3	304.00	271.00	-33.00
Student Paramedic 4	4.00	65.00	+61.00
EMT 1	19.62	18.61	-1.01
EMT 2-4	796.18	848.85	+52.67
A&E Support	355.00	339.29	-15.71
CTA	54.43	46.01	-8.42

Turnover

2011/12	7.1%	Apr-11 to Mar-12
2012/13	7.4%	12 Months up to Apr-12

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

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

Workforce Report

Current Month **Apr-12**

Trust Summary

Employee Relations Data

	Attendance	Grievances	Capabilities	Discipliary (Clinical)	Discipliary (Non Clinical)
Current Case Total	618 (598)	11 (14)	2 (2)	1 (1)	20 (21)

Current Employment Tribual Cases	8 (10)

Current Suspensions	**4 (4)**

Narrative

* The figure for the previous month appears in brackets.

Attendance
These figures and the audit results mentioned previously continue to demonstrate the focus on attendance management has been sustained.

Grievances
As reported previously , it must be expected that as managers increase the focus on all facets of performance, this figure will be higher than previously seen. Nevertheless, given the number of employees, this number still remains low.

Disciplinaries
The ratio of clinical to non-clinical cases continues to show that clincial are rarely rarely a cause for use of the disciplinary procedure.

Employment Tribunals
One case was lost and one was withdrawn during April. No new cases were lodged.

Workforce Report

Current Month **Apr-12**

Trust Summary

PDR Completion Rates

Area / Directorate / Dept	No to be done	No done	% completed	% 10/11	Difference +/-
West	1043	360	34.5	67.0	- 32.5
South	1200	83	6.9	45.9	- 39.0
East	861	285	33.1	30.5	+ 2.6
Control Services	525	390	74.3	66.6	+ 7.7
Sub total	3629	1118	30.8	49.7	-18.9
PTS	151	53	35.1	53.2	-18.1
IM&T	80	79	99.0	96.3	+2.7
Operational Support	117	85	72.8	66.3	6.5
Medical	25	25	100.0	100.0	0.0
Communications	12	12	100.0	94.1	+ 5.9
Corporate Services	29	28	96.6	94.6	+ 2.0
HR & OD	145	145	100.0	95.3	+ 4.7
Finance and Business Planning incl Estates	35	30	85.7	82.4	+ 3.3
Sub total	594	457	76.9	76.5	+ 0.4
Total	4223	1575	37.3	54.0	- 16.7

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH MAY 2012

PAPER FOR INFORMATION

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

Key issues and risks arising from this paper

Ongoing high incoming 999 call volume and high Cat A workload
High Utilisation on ambulances and fast response units
Increasing staffing challenges given increased workload and student paramedic abstractions.

Executive Summary

The paper provides an update on the following key areas:

1.A&E Service Delivery
2.Emergency Preparedness
3.Fleet and Logistics
4 PTS
5. IBP Delivery Programme

Key messages

- The ytd position on Cat A8 minutes is 71.1% and on Cat A19 is 98%
- The Trust is experiencing unprecedented levels of demand particularly in May where both 999 calls and Cat A volumes are up by 20% on the same period last year.
- Utilisation levels remain very high and are increasing to record levels in May given the demand increases.
- The new Clock Start arrangements for RED 2 calls have been approved and come into effect on June 1st.
- Emergency preparedness activity is largely focussed on the Olympics preparations and the service held a very successful national ambulance resilience exercise (Exercise Amber) in

May.

- Preparations for the Queens Diamond Jubilee are in their final stages.
- Overall staffing is proving challenging given high levels of abstraction for student paramedic training.

Attachments

Chief Operating Officer's Report May 2012
Information Pack for Trust Board April 2012

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

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

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

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

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

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

Equality Impact Assessment

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

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING 29TH MAY 2012

CHIEF OPERATING OFFICERS REPORT

1. A&E SERVICE DELIVERY

Accident & Emergency service performance and activity (please see attached information pack)

Overview

The table below sets out the A&E performance against the key standards for Category A for April through to 13 May 2012 together with the current year to date (YTD) position.

Category	Cat A8	Cat A19
Key Standard	**75%**	**95%**
2011/12	75.7%	99.2%
April 2012	71.8%	98.1%
May 1st to 22nd 2012	70.1%	97.9
2012/13 YTD	**71.1%**	**98%**

The month of April saw the Trust achieve 71.8% for category A8 performance. This is below the National Key Standard for A8 but significantly above the Trust's agreed A8 trajectory performance of 65%. Given this was the first month in which we were live with the new CommandPoint CAD system it should be seen as a significant achievement and indeed had it not been for the increased demand levels which are detailed later in the report we might well have reached 75%.

Now that we have confirmation of the clock start changes which will take effect on June 1st we have finalised and submitted a Cat A trajectory to commissioners for this year which will deliver 75.1%. We have specifically designed the trajectory to stay as close to 75% each month given the significant challenges the Trust faces this year.

The trust exceeded that agreed trajectory of 65% in April but will now not meet the 72% set for May. This is due to unprecedented levels of demand in May coupled with staffing challenges. We are confident however that subsequent months can be met in full.

Category A volumes continue to rise significantly above predicted levels. In April we saw a 12.7% increase in Category A incidents. Overall incident activity however showed a 2.3% decrease on the same period last year although actual 999 call volume increased by 5.7%. The decrease in overall incidents is primarily driven by our ability to 'hear and treat' and secondly deploy the use of our demand management plan which ultimately decreases our overall activity.

The unrelenting increase in Cat A volumes has continued In May, to date this month we have seen incoming call volumes rise by up to 20% and Cat A volumes are also

up 20% on the same period last year. May is also showing an increase in overall incident activity albeit marginally at present at +1.5%.

Category A volumes year to date are now 15% up on last year with overall call volume up 6.5% which equates to an additional 11,000 more calls coming in to EOC.

Tuesday 22nd May was an exceptional day and proved to be the 5th busiest day we have ever experienced. The other four busier days were all previous New Years Eve's. We dealt with 5310 emergency calls and attended 1344 Category A calls responding to 3063 incidents overall which would have been greater if not for the extensive use of the Demand Management Plan (DMP).

This upward demand trend is mirrored nationally though the LAS increases are at the higher end. This is a significant area of concern and we are working to try and understand the causes more fully. This piece of work will also involve liaising with colleagues around the country to see if any specific causes can be identified. Initial work again shows increases across the board but with particular peaks around respiratory and cardiac conditions.

Producing sufficient DCA and FRU hours to match this increasing demand profile is now starting to become a significant challenge for the Trust as we start to feel the effects of the abstractions to accommodate the deferred SP2 training. Within the next two weeks we will be abstracting more than 200 + staff a day on pre-planned training, this combined with the reduced number of A&E frontline posts as part of the CIP has resulted in a significant shortfall in production hours. To mitigate this we have had to introduce some enhancements to overtime rates to attract further overtime take up at weekends where we are seeing the majority of shortfalls manifesting themselves. We have also used additional third party resources to further enhance our operational cover at times of peak demand.

The Trust recorded for the month of April a total 89 black breaches of 60 minutes or more, which in comparison to last April is an overall reduction of 23 breaches. According to the latest report available at the time of writing the first 8 days of May the Trust has so far recorded 17 breaches with the biggest impact being South West London cluster reporting 7 of the 17 breaches. YTD there has been a total of 106 breaches with Outer North East London cluster breaching 44 times which equates to 41.5% of the total breaches. The LAS hosted a hospital summit in April where senior LAS managers met with their acute counterparts to identify areas of further collaboration to understand and resolve barriers to achieving a further reduction in hospital handover delays.

Excessively high utilisation still remains a major concern for the Trust and whilst it has been agreed that the Trust will, in partnership with our commissioners, carry out a formal capacity review the high levels we experienced in 2011/12 continue and are even more acute given the current 20% increase in Calls and Cat A demand.

We are carrying out a number of actions to improve the overall staffing position and manage demand going forward and these are outlined below;

- Reducing the volume of rostered training being delivered to provide additional Ambulance and FRU hours.
- Raising the Reap level to Level 4 Severe Pressure from 21st May and carrying out the associated actions.
- Accelerating the recruitment and selection process for Apprentice Paramedics

- Securing the recruitment of 78 direct entry paramedics from the university programmes from September and posting them to the areas of highest need.
- Increased targeted use of private and voluntary ambulance providers
- Continuation of overtime enhancements to incentivise overtime working at times of peak demand.
- In collaboration with commissioners commencing a formal capacity review
- Implementing a plan to maximise the opportunities to reduce multiple attendance ratios and reduce cancellations afforded by the clock start change
- Undertaking a strategic review of FRU provision across the Trust to ensure the correct balance of FRU and Ambulance provision.
- Dedicating existing management resources to robustly challenge and manage all VOR to increase the availability of produced hours.
- Working proactively with the media to try and manage down demand wherever possible.

The Board will be aware of the proposed changes to the clock start for RED 2 calls a subset of the overall Category A calls. This was approved by DH on 16th May for introduction on the 1st June 2012. This will allow up to an additional 60 seconds to allow more information to be gathered on these calls prior to despatch. We are implementing changes in EOC from June 1st which we hope will allow us to reduce the numbers of cancellations and multiple responses to these calls where it is appropriate to do so. It should be noted that there is no change to the despatch arrangements to the most serious RED 1 calls and that all ambulance trusts have been asked to reach 80% of these patients within 8 minutes by April 2013.

2. Emergency Preparedness

We have experienced a busy period within emergency planning since the last Trust Board report. There have been a number of events including the London Marathon – where over 5000 patients were treated of which the majority were athletes. There were 135 LAS staff deployed across the Marathon footprint. Also during this period there have been around 45 Olympic Cluster 3 Test events which have been attended by LAS staff and several Diamond Jubilee visits to London Boroughs by her Majesty the Queen.

Over the May Bank Holliday weekend and in addition to the Cluster 3 test events the LAS hosted Exercise Amber at the service's Olympic Deployment Centre (ODC) in the Docklands. This involved Ambulance staff from across the country taking part in a national emergency preparedness exercise. Exercise Amber, which is the first event of its kind to ever be held -involved multiple different scenarios designed to test and showcase the extensive specialist capabilities across the ambulance sector nationally.

Members of ambulance staff involved including the hazardous area response teams and CBRN Trained operatives from ambulance services around England worked with staff from other agencies such as the Metropolitan Police, London Fire Brigade and the RNLI to test and demonstrate the response to the different incidents. In addition we demonstrated the ability of the ODC to process and deploy both LAS and Pre-planned Aid staff to live test events within the Olympic park.

Guests invited to view the exercise over the two days including representatives from the NHSL, Department of Health and the other emergency services. The event was a resounding success and has reaffirmed the LAS and indeed the Ambulance Sector's readiness to deliver the games.

This national exercise will become an annual event in the UK Ambulance Service calendar. The next exercise will take place in West Midlands Ambulance Service in May 2013.

There have been a series of other Olympic related exercises during the last six weeks designed to test all aspects of the multi-agency response to the games and the LAS has participated fully in all aspects to good effect.

With only a mater of days to go to the Diamond Jubilee, the final preparations are being made, staff being briefed and equipment readied. The ODC will be utilised for the staff deployments over the Jubilee weekend and during the peak day we will see around 250 LAS staff deployed to ensure a safe event for the estimated 1million people that may attend the Central London footprint.

3. Fleet and Logistics

Fleet

New ambulances continue to enter service in three phases. The majority of phase one vehicles (15) were commissioned successfully by the department in preparation for Operation Amber and will now enter operational service. The full complement of 66 vehicles will be delivered and commissioned by the start of the Olympic Games. 30 new Skoda cars (to expand the existing FRU fleet) are in the country and are awaiting conversion. The first vehicle will be on Trust premises and commissioned in the first week of July. Vehicles will continue to be delivered thereafter at a rate of five per week during the Olympic Games period.

Tenders in response to LEZ conversion work have been received by the Trust and are being considered. Work on LEZ conversion is planned to start in July 2012.

Negotiations are progressing to agree a draft lease for the West Workshop (Greenford) site. Initial meetings with the planning authority have been held with positive results. Detailed floor plans have now been agreed. The Business Case will be resubmitted to the SHA for final approval once the draft lease can be appended.

Personal-issue fuel cards have now been rolled out across the Service. Early indications are that losses have been drastically reduced with no serious cases of suspected fraud.

Logistics

The Department gave strong support for Exercise Amber earlier this month in equipping and preparing vehicles. This involved close collaboration between Fleet Technicians, Logistics personnel, Telent, and Initial vehicle preparation staff. In total 18 vehicles were equipped and supplied on-time for this high-profile exercise, in addition to routine vehicle resourcing.

Paracetamol and Ibuprofen have now been added to general (technician) drugs packs and are in routine use across the Trust.

Vehicle Preparation

The vehicle preparation contract (formerly Make Ready) is now moving out of the early mobilisation stage into transition. Nightly clean and stock performance has shown consistent improvement in April and this will continue to improve as legacy challenges from the previous provider are overcome. The Trust's expectations on performance against contracted standards are being persistently reinforced during this transition period. Initial are now consulting managers and staff on changes to working hours and practices identified during the competitive dialogue process and designed to deliver sustainable, good quality performance. The trial of hand-held PDAs (to facilitate the asset tracking of key items) is expected to commence in May.

Performance

Department KPIs have maintained the improvements achieved in 2011/12. Vehicle sourcing for shift start time (when no vehicle was available on station) was on target at 85%. On-time vehicle servicing rose again in April with further work to do (up to 58% against a 70% target). Vehicle availability was steady at 88%. Deep cleaning of vehicles showed improvement in all areas - up by 25% for ambulances to 77% against an 85% target. FRU and PTS cleaning was on target.

The department is embarking upon an ambitious programme to develop productivity and efficiency across all aspects of its operations. As changes are made, details will be shared with SMG and the wider Trust. Key outputs to the Trust will be improved fleet planning, greater productivity in vehicle maintenance and servicing, full realisation of the vehicle preparation contract, and a transformation in the tracking and management of equipment assets. Underpinning these activities, the department will take measures to publish transparent, relevant Key Performance Indicators as well as defining expected levels of productivity on a corporate level and by individual members of staff. Clearly defined, self-contained projects will be a significant part of the department's activity. The department will seek to exploit technology wherever it can support core activity by enhancing efficiency.

The whole department has now moved successfully to St. Andrew's House, Bow, completing the project to consolidate all Fleet & Logistics activity onto one site. This is also an enabler for the future consolidation of VRC and CSU. Edward Potter took up a secondment to the post of Assistant Director, Fleet & Logistics on 23rd April 2012 after a competitive recruitment process.

4. PTS

Commercial

The LAS was successful in being invited to submit a tender bid for North West London Hospitals NHS Trust and Ealing Hospital NHS Trust non Emergency Patient Transport Services.

The tender document has to be submitted on Monday 28th May 2012 and we have already been invited to a presentation which is due to be held on 13 June 2012. This tender is being run as a competitive dialogue and success at this stage will place us in phase 2 with 2 other providers. The timetable for this process suggests a start date for this contract of 1 October 2012.

Operational

PTS will take delivery of new stretchers for its bariatric vehicles in June. This will provide a better solution for this resource with the ability to cope with larger weight and mass of bariatric patients.

In addition, the service is about to trial a revised stair climber which has an increased load bearing capacity up to 35 stone. This is an increase from the maximum load capacity of our current equipment which can only take patients up to a weight of 23 stone.

Performance

Activity in March rose to 15,886 journeys which is in line with forecasted activity and is an increase of 300 journeys over the previous month.

The quality indicators for March were:

- Arrival Time: 92% same as last report
- Departure Time: 95% increase of 2% from last report
- Time on Vehicle: 97% same as last report

5. Integrated Business Plan (IBP) Delivery Programme

IBPD overall

Discussions are on-going about the programme structure and governance arrangements for 2012/13 in the context both of capacity constraints around the Olympics and the new list of CQUINs - who is responsible for them to whom under which programme.

A meeting is scheduled for 15th May between Sandra Adams, Lizzy Bovill and the three programme managers Martin Brand, Johnny Pigott and Martyn Salter, along with Emma Williams. The purpose of this is to stock-take all that is going-on across the IBPD in light of agreed SMG objectives to identify priorities and sequence activity. A possible outcome maybe recommendation as to which projects in the IBPD are postponed until later in the year.

Patient Care Programme

- *Programme development*
  - The project portfolio for the programme in 2012/13 is being defined as described above.
  - The Cardiac Arrest Pilot at Oval and Deptford is now suspended until after the Olympics as staff need to be released for training.

- The Hospital Turnaround project is closing and migrating to business as usual. Future performance improvement action will rest with Operations senior management.
- An update for the Hear and Treat initiative has not been provided for a number of months (as indicated previously) hence the red RAG status.

- *Project progress*
  - Implementation of ACPs: The end March 2012 ED conveyance rate (to be used as the baseline for 2012/13) was 68.4%. Whilst not a reduction to 67.5% this still demonstrates a 5.1% decrease from April 2011. Falls referrals have been well achieved against trajectory with a final figure of 1051 in March 2012.
  - CommandPoint: CommandPoint is live in all LAS Control environments. Draft production of the Business Change Plan Approach is underway and planning for stage 7 ('Decommission and Closure') has commenced.
  - Control Room (Bow as a 'hot' control): Building work is finished and desks have been installed.
  - FT Application: Board to Board (B2B) held on 23rd April 12 and the draft report is due at the end of May. The new Timeline has been presented to SMG and accepted, the project team is working through the detail. Key to a successful application will be commissioner support so plans will be developed to engage them early on. The SHA have requested a B2B follow up meeting which is planned for the 25th June.

- *Risks and Issues to note*
  - NHS Pathways: 999 Proposal: Guidance is awaited on the way forward following presentation of briefing papers to SMG.

- *Next steps*
  - Rest Breaks: Work on the forecast impact of the new rest break policy will be completed by week commencing 7th May to provide a view on potential savings. CommandPoint: Finalise known problems to be fixed, prepare closure of the 'Migration' stage of the project plan for formal LAS acceptance on 25th May 12 and finalise plans for 'Decommission and Closure' (stage 7) to commence.
  - FT Application: Project plan and Commissioner engagement plan to be developed.

Value for Money Programme

- *Programme development*
  - Only two live projects have not been updated at the end of March 2012. GRS Upgrade and Resource Centre Consolidation. Neither project is causing concern; in fact GRS upgrade has delivered all major products and should be closed shortly.
  - Some further work will be needed to the draft benefit definitions and the CIP related projects now the 2012/13 budget has been agreed.
  - Initial PIAs have been completed on a number of projects.

- *Project Progress*
  - At the end of March 2012, most projects appear to be under control, none are out of control.
  - Two have not yet started (New HQ Long Term and Roster Optimisation 2), where decisions on scope are awaited.
- GRS Update has delivered all its key products and is now being used to manage annual leave for all operational and control staff.
- The SRO approved the Request to Change to the project mandate of the Starters, Movers & Leavers project. This widened its scope to meet some audit recommendations around tracking of personal issue items.
- Arrangements have been made for a full PIA in Starters, Movers & Leavers project.

- *Risks and issues to note*
  - The Programme Manager reviewed all project risks scored Significant or above again this month. This review required one change to the programme's risk register; the risk of delays from CommandPoint was downgraded.

- *Next steps*
  - Complete work on benefits definitions and loading into PA.
  - Complete the initial PIAs for the remaining projects within the programme.

Workforce and OD Programme

- *Programme Progress*
  - All projects have been up-dated within PA this month, with the exception of the learning management system project.
    - The two projects that have CQUINs attached to them are currently being scoped to ensure that the milestone delivery is aligned with the CQUIN target delivery. The two projects include annual leave & rest break policy.
    - Delivery Board – A full report on these projects is covered under a separate agenda item.

- *Project Progress*
  - Two projects are red (Off-Track and Out of Control):
    - CRM – This hasn't progressed and there is the recognition that the model needs to be developed further and modelled in order to gain agreement from all that it is the right model for the future. Therefore this project will be rescoped and include the clinical hub, once this revised scope has been agreed a revised plan will be developed. This will be changed for the next month's report.
    - KSF/PDR – There is still no PM in place and therefore no work has progressed on this project for a number of months.

  - SDM workshops – 4 workshops have now taken place to define the SDM including the clinical hub and workforce requirements. A further one is planned for the end of May to work through the estates and fleet & logistics requirements to support the model.
  - NWoW: No successful candidates were appointed from the CIO Croydon interviews on 11th April. Post advertised in RIB with planned interview date of 7th June 2012.

- Team briefings: the team briefings has now been rolled out to all support service departments and evaluated. A decision is to be made about whether to extent elements of the system into Ops.

- *Risks and issues to note*
  - Scope creep across the programmes – The addition of the workforce, clinical hub and logistics project to the delivery board will impact upon the integration of the overall programmes as well as the governance of the projects. Any new projects or change to where they are governed will need to be signed off by SMG.
  - The impact of the Olympics – the programme has not yet been formally assessed for the impact of the Olympics on its delivery. A meeting is to take place next week across the programme to start this work, it is important that this is communicated across the programme teams so that expectations are set.

- *Next steps*
  - Service Delivery Model: the final workshop will take place on the 29th of May, from these workshops an Operational Strategy is being developed that pulls together how the SDM is support by the workforce, fleet & logistics and estates. This needs to feed into the up-date of the IBP and will be completed in similar timescales.
  - Workforce – an implementation plan for the clinical team leader pilot is being developed to assess its feasibility to launch in June prior to the Olympics. The workstream leads are meeting to plan the required activities and make a decision regarding the pilot.
  - EOC Roster Review: Sign off of CTA Consultation document expected by 11th May. Control Room consultation document will be completed swiftly as it will follow the same process and procedures as the CTA document.
  - Learning management system: An implementation consultant will deliver training (29th May) and review the project plan to advise and support the Trust in launching 2 modules within OLM. The pilot of OLM should begin in June.

Martin Flaherty

Chief Operating Officer/Deputy CEO

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH MAY 2012

PAPER FOR INFORMATION

Document Title:	**CommandPoint Update**
Report Author(s):	**Peter Suter**
Lead Director:	**Peter Suter**
Contact Details:	**02077832044**
Why is this coming to the Trust Board?	**To provide an update to the Trust Board on the CommandPoint Project.**
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 - Trust board on 20 March
Recommendation for the Trust Board:	**That the Trust Board notes the contents of this report.**

Key issues and risks arising from this paper:

None specifically identified.

Executive Summary:

CommandPoint was brought successfully live on 28 March 2012. The system is stable and capable of delivering good operational performance. The project is on track to hand over to business as usual and close down by 30 June.

Attachments

CommandPoint Project update: 29 May 2012

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Quality Strategy

This paper supports the following domains of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

- ☒ Yes
- ☐ No

Key issues from the assessment:

None

COMMANDPOINT PROJECT UPDATE: 29 MAY 2012

1. INTRODUCTION AND BACKGROUND

1.1 The objective of this paper is to provide an update on the CommandPoint Project.

1.2 On the 20 March the Trust Board met at a special meeting to review the results of the three CommandPoint live-run exercises. After due consideration, the Trust Board accepted that the system was ready for live use and delegated responsibility to the Chief Operating Officer to give the go live approval once he was satisfied as a result of the final readiness review. This process was duly completed and approval given.

2. GO-LIVE

2.1 The actual go-live was managed using the normal operational command structures. The Gold Commander was the Head of Control Services, supported by the Deputy Director of Operations. The Medical Director and Deputy Medical Director led on clinical safety, scrutinising calls to ensure that there were no issues caused by the introduction of the new system. There was also additional clinical support put into the EOC. The conference room was converted to a technical hub staffed by IM&T and Northrop Grumman. These arrangements remained in place around the clock for the initial seven days before commencing a gradual step down to on-site and on-call arrangements as appropriate.

2.2 The operation to bring CommandPoint live commenced late evening on Tuesday 27 March. The EOC was taken to paper, all system interfaces switched over and CommandPoint brought live. The first call was taken on CommandPoint at 02:45 on 28 March. The day was challenging in terms of operational demand, the weather was unusually warm and demand high. There were in excess of 200 calls an hour from 09:00 onwards, and by the end of the day there were 3006 incidents of which 1120 were Cat A.

2.3 During the first week, there were effectively five ‘go-lives’ as each Watch came on duty for the first time. There were no issues in relation to the technical problems that were experienced on June 8 last year and this has remained the case. There was limited media interest, some online articles and a few comments on social network sites, but nothing of any significance.

2.4 It became very clear, early on in the go-live process that the automatic despatch part of the CommandPoint was working very efficiently and producing good results. The planning assumption was that on day one, operational performance would be in the order of 55% and that a return to achieving Cat A target of 75% would probably take up to 30 days, with 60 days being a worst case scenario. The actual results were much better. Cat A performance on 28 March was 61.7% and 75% was achieved on 4 April, nine days after go live.

2.5 As expected during the first days and weeks, a number of technical problems were identified. and alarms were implemented to manage certain scenarios. Northrop Grumman responded to these problems (as planned) and delivered a number of software patches. None were intrusive and were applied without effecting live operations. To date eleven software patches have been applied. One or two more are anticipated before the LAS will be in a position to accept that the go-live has been completed.

2.6 There is no doubt that the three live runs undertaken in late February and early March were a significant factor in the overall success of the go-live. One of the key lessons from 8 June was the differential between what was achievable in the test environment compared to live operational use. The live runs allowed an iterative approach to identify issues and resolve them before committing to the final go-live. These live run exercises were considerably difficult for EOC and technical staff, however the benefit has been clear to see.

3. CONTEXT OF GO-LIVE AND LOOKING FORWARD

3.1 Looking back, the week commencing Saturday 24 March was quite extraordinary for the LAS:

- Overnight on Saturday 24 March into Sunday 25 March the clocks changed to British Summer Time. Historically this has been a problem for the Trusts IM&T systems. However continual work to identify and resolve latent problems finally paid off, and this year there were no issues.
- 28 March - Met Police undertook work on their system that could affect the Cad - Cad interface (in the event it did not cause any problems).
- 28 March CommandPoint went live
- 28 March CQC announced an inspection, commencing in the next 24 hours
- 31 March end of year performance targets met
- 31 March end of year financial balance achieved.

3.2 Looking forward, the plan is to close the project by 30 June and hand all support and management arrangements over to 'business as usual'. Work for this is already well in hand, including a full consultation process as staff are redeployed from the project.

3.3 A CAD system is complex and real time system and it would be wrong to give the impression that everything is perfect. There remain a number of ongoing issues, mainly related to interfacing with external systems. Examples are the accuracy of the address locations from the MPS CAD system and some of the messaging protocols from the MDT's. There is also an outstanding bug list that will be progressed through the normal maintenance releases (as per the contract). The LAS are also starting to identify potential system enhancements that will go through the normal evaluation and budget bidding process.

3.4 The final comment must be to compliment the LAS staff involved in bringing CommandPoint successfully live. There have been many involved from right across the organisation e.g.; Operations, Training & IM&T. I would however like to pay specific tribute to the staff and managers in EOC who have done an outstanding job in managing significant disruption and change while continuing to meet operational demand.

4. RECOMMENDATION

4.1 That the Trust Board note the contents of this report.

Peter Suter
Project Executive
Director of Information Management & Technology

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH MAY 2012

PAPER TO PROVIDE ASSURANCE TO THE TRUST BOARD

Document Title:	**Audit Committee Assurance Report**
Report Author(s):	**Caroline Silver, 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 14th May 2012 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

At the Audit Committee meeting on 14th May, a number of risks to the Trust's key sources of assurances were identified. These risks, together with the mitigating actions, are detailed in the attached report.

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, and is based on the Trust's key sources of assurance as identified in the Trust's Board Assurance Framework (section C of the Board Assurance Framework).

Attachments

Report from the Audit Committee meeting on 14th May 2012.

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Quality Strategy

This paper supports the following domains of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

- ☐ Yes
- ☒ No

Key issues from the assessment:

Report from the Audit Committee on 14th May 2012

STRATEGIC RISKS

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

ASSURANCES AND CONTROLS

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, and is based on the Trust's key sources of assurance as identified in the Trust's Board Assurance Framework (section C of the Board Assurance Framework).

The following controls are in place to support the management and mitigation of our strategic risks and these are referenced against each control as appropriate (eg SR 1.2.3.4).

Risk Register and Board Assurance Framework (SR 1.2.3.4)

The Audit Committee undertook its annual review of the full risk register and can report that good progress has been made in the management of risks. The Audit Committee took assurance from the fact that the risk register accurately reflects the current issues facing the Trust, which demonstrates that it is a live and dynamic document. This is supported by greater engagement with the local areas and departments as reported at the last Trust Board meeting. The Audit Committee members all agreed that this is an improved position on last year.

Operational risks had not however been updated in time for the meeting and the Audit Committee Chair has requested for these risks to be updated and discussed at the next meeting of the Audit Committee on 1st June, with the Chief Operating Officer in attendance. The Audit and Compliance Manager has assurance from the Area Quality Committees and progress against internal audit recommendations that work is ongoing to mitigate these risks, but that these updates now need to be captured on the risk register.

The Audit Committee requested that the Risk, Compliance and Assurance Group review the target ratings of the risks as a number are thought to be very low; much lower than the current net ratings and perhaps therefore unachievable. This is to be considered as part of a wider discussion about the Trust's risk tolerance levels and the process by which to manage business as usual risks.

Report from the Chair of the Quality Committee (SR 1.2.4)

The Audit Committee received a report from the Chair of the Quality Committee, which highlighted a number of risks to quality and the mitigating actions that will be taken to address these. These include high utilisation, the increase in Category A demand and hospital turnaround times. A full report from the Quality Committee is presented to the Trust Board.

Overall, it is felt that the Quality Committee is operating effectively, although there is some concern about the scope of its remit. It is also thought that the Quality Committee benefits greatly from the depth of clinical insight provided by the Chair and this therefore raises issues of succession planning. These issues will be discussed as part of the governance review at the Strategy Review and Planning Committee meeting on 24th July 2012.

Report from the Chair of the Finance and Investment Committee (SR 2.3.4)

The Audit Committee received a report from the Director of Finance on the key areas of discussion at the recent Finance and Investment Committee meetings. A full report is provided to the Trust Board.

Draft Annual Report and Accounts 2011/12 (SR3)

The Audit Committee reviewed the Draft Annual Report and Accounts for 2011/12 and noted that the Trust had achieved its control total and had met three of its statutory duties.

The Trust has, however, overshot its external financing limit (EFL) by £2,156k, which represents a failure to achieve one of the Trust's key financial duties. This was caused by the failure to make an adjustment for the sale and lease back of ambulances in month 9 and this oversight was not picked up until month 12 at which point it was clear that the EFL would not be met.

This raises a concern for the Audit Committee that there is not adequate attention to the priority of tasks and that processes are not sufficiently formalised to allow for the appropriate level of scrutiny of financial returns.

The Audit Committee is assured however that a number of actions have been put in place to ensure that this did not recur:

1. RSM Tenon has been engaged to review the Trust's cashflow and EFL;
2. A monthly report will be produced to track progress against the EFL and to highlight any changes that might affect the EFL, ensuring that any issues are dealt with promptly;
3. A checklist of year-end issues and accounting changes will be maintained and reviewed quarterly.

The plan for 2012/13 has also been reviewed to ensure that the accounting treatment of the two Bank of Scotland leases due to be terminated in June 2012 and September 2012 is appropriate.

Head of Internal Audit Opinion (SR 1.2.3.4)

The Head of Internal Audit Opinion for the year ended 31st March 2012 is that:

> Based on the work undertaken in 2011/12 to date, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

The caveat on information governance which was included in the draft head of internal audit opinion has been removed as a result of the follow up audit which demonstrated that evidence was in place to provide the internal auditor with sufficient assurance that a significant amount of progress had been made in this area.

External Audit Opinion (SR 3)

The External Auditor gave an update on the progress of the year end audit and in particular the four risks that have been identified as relevant to the auditing of the accounting statements. The Audit Committee is assured by the fact that no significant issues have been identified so far.

The Audit Committee heard that the Audit Commission's services for LAS will now be outsourced to Price Waterhouse Coopers. There is some concern that the Trust will lose the benefit of its existing external auditors, however it is anticipated that this arrangement will only be in place for a year until the Trust is authorised as a Foundation Trust. The Deputy Director of Finance will seek confirmation that this arrangement will not represent any additional cost to the Trust.

Report from the Internal Auditor (SR 1.2.3.4)

The Audit Committee is assured that five internal audit reports have been finalised since the last meeting of the Audit Committee, none of which raise any issues of significant concern.

The Information Governance follow up audit demonstrates that 80% of the recommendations have been fully implemented and the remaining recommendations require only minor actions. The Internal Auditor is therefore sufficiently assured that progress has been made in this area and has removed the caveat from the Head of Internal Audit Opinion.

The Trust achieved 79% in its recent submission for the Information Governance Toolkit, which is slightly above target and means that the Trust has successfully achieved level 2 compliance.

Audit Recommendations Progress Report (SR 1.2.3.4)

There has been significant progress in the management of internal audit recommendations and this has also been noted by the Quality Committee. Overall, there is better engagement with managers in the initial scoping of audits and this has meant that draft reports are finalised and recommendations are followed up in a much more timely manner. Action plans are in place for those recommendations which are currently rated amber and it is expected that a number of these will be green by the time of the next Audit Committee meeting.

The view of the Internal Auditor is that the work of the Governance and Compliance Team has made a significant difference to the management of internal audit recommendations which has in turn enabled the Audit Committee to hold more mature discussions on the risks facing the organisation. The Audit Committee agreed that the Internal Audit Recommendations Progress Report provides significant assurance that the Trust is learning lessons from internal audit.

Report from the Local Counter Fraud Specialist (SR 3)

The Audit Committee approved the Local Counter Fraud Specialist Work Plan for 2012/13.

RISKS TO ASSURANCES AND CONTROLS

Risk	Mitigation given
5th March 2012	
Scope of the Quality Committee's remit is too wide.	▪ This will be discussed as part of the wider governance review at the Strategy Review and Planning Committee meeting on 24th July 2012; ▪ Work is ongoing to improve the quality of the reports from the sub-Committees of the Quality Committee so that the Quality Committee receives sufficient assurance and does not have to delve into the detail of the issues. ▪ Best practice recommends having an integrated Quality Committee as there is a risk that, if the Committee focuses solely on clinical quality, other aspects of quality which have an impact on clinical quality might be overlooked.
External Audit transferring to Grant Thornton: Potential conflict of interest; Risk that the quality of external audit will not be maintained.	▪ PWC have been appointed as the Trust's external auditors for 2012/13. This is therefore no longer a risk.
RSM Tenon has reported a loss for the period. This has a potential impact on internal audit and local counter fraud services.	▪ No update.
Gaps in the management of project and programme risks.	▪ The key recommendation arising from the CommandPoint Risk Management Arrangements audit was that there should be better documentation to identify the cause and effect of individual risks and to understand what might trigger these risks. Progress against the actions to address this recommendation will be monitored by SMG, Quality Committee and Audit Committee.
Gaps between policies and practice could lead to failure at Level 2 NHSLA.	▪ NHSLA Level 2 postponed and 1 to be reassessed in Q3 2012. This is no longer a risk.
The number of staff vacancies within the Clinical Audit and Research Team have impacted on the team's ability to deliver components of the clinical audit work plan.	▪ The Clinical Audit and Research Steering Group reviewed the clinical audit work plan in October 2011, and reduced the number of projects giving priority to the Department of Health Ambulance Clinical Quality Indicators. This is no longer a risk.
14th May 2012	
Lack of a formalised process around key financial duties.	▪ RSM Tenon has been engaged to review the Trust's cashflow and EFL; ▪ A monthly report will be produced to track progress against the EFL and to highlight any changes that might affect the EFL, ensuring that any issues are dealt with promptly; ▪ A checklist of year-end issues and accounting changes will be maintained and reviewed quarterly.

London Ambulance Service NHS
NHS Trust

AUDIT COMMITTEE

Draft Minutes of the meeting held on Monday 14th May 2012, 15.00
Conference Room, 220 Waterloo Road, London SE1 8SD

Present:

Caroline Silver	Non-Executive Director (Chair)
Roy Griffins	Non-Executive Director
Brian Huckett	Non-Executive Director

In attendance:

Sandra Adams	Director of Corporate Services
Dominic Bradley	Audit Commission
Amanda Cant	Deputy Director of Finance
Mike Dinan	Director of Finance
Carmel Dodson-Brown	Assistant Director of Corporate Services, Governance and Compliance
Darriane Garrett	Local Counter Fraud Specialist
Francesca Guy	Committee Secretary (minutes)
Michael John	Financial Controller
Phil Johnstone	Audit Commission
Beryl Magrath	Non-Executive Director (observer)
Chris Rising	RSM Tenon
Frances Wood	Audit and Compliance Manager

19. Welcome and Apologies

19.1 Apologies had been received from Peter Bradley.

20. Minutes of the meeting on 5th March 2012

20.1 The minutes of the meeting on 5th March 2012 were approved.

21. Matters Arising

21.1 The following matters arising were discussed:

21.2 **56.2:** Mike Dinan gave an update on the Make Ready contract and reported that the asset tracking and inventory management element of the contract would commence in two months and the Audit Committee would be kept updated on this element of the contract.

21.3 **06.3:** The Chair reported that there was no longer a conflict of interest with RSM Tenon as the relevant partner in her company had left. This action was closed.

22. Risk Register Update – Full Review

22.1 Frances Wood reported that a full review of the Trust-wide risk register had been undertaken and all risks, with the exception of operational risks, had been updated. Martin Flaherty, Paul Woodrow and Jason Killens had agreed to follow

up on operational risks via the Associate Directors Group.

22.2 Frances explained that as part of the review, risk assurances had been mapped across to the controls, which had made it easier to determine the overall position and define what progress looked like for each of the risks. Any key issues arising from the risk register had been incorporated into the internal audit scoping process.

22.3 The Chair asked whether Frances attended the Area Quality Committees, given that operational risks were discussed at these meetings. Frances confirmed that she and the Governance and Compliance Manager attended the Area Quality Committees and she was confident that progress had been made against operational risks, but that this now needed to be captured in the risk register. Frances added that she also received updates on progress against the internal audit recommendations which again confirmed that appropriate action was being taken.

22.4 The Audit Committee expressed concern that operational risks had not been updated and the Chair requested for these risks to be updated by the time of the next Audit Committee meeting on 1st June.

ACTION: FW to follow up with MF to ensure that operational risks were updated by the time of the next Audit Committee.

DATE OF COMPLETION: 1st June 2012

22.5 Sandra Adams suggested that Martin Flaherty should also be asked to attend the meeting to give a verbal update on progress against these risks. The Audit Committee requested the attendance of either Martin, or another representative of equivalent seniority in the event that Martin was unable to attend.

ACTION: FG to invite MF to the next meeting of the Audit Committee.

DATE OF COMPLETION: 18th May 2012

22.6 Sandra commented that she had taken comfort from the fact that the top-rated risks on the register reflected the key issues facing the Trust, which therefore demonstrated that the risk register was a live and dynamic document and was an accurate reflection of the Trust's current position. There had been an ongoing discussion on business as usual risks and risk tolerance levels and a proposal about how to manage this would be put to the next meeting of the Risk, Compliance and Assurance Group (RCAG)

22.7 Frances commented that she felt that the Trust's risk management processes were much improved on last year and that the information was triangulated with CQC and NHSLA evidence.

22.8 The Chair agreed that the risk register was far more of a live document than it had been in the past and was an accurate reflection of reality. The Chair observed however that the target ratings for a number of risks were very low; much lower than the current net ratings and questioned whether they were in fact unachievable. This linked to the discussions on risk appetite and the Chair suggested that the target ratings might be reviewed in light of the outcomes of these discussions at the next RCAG meeting.

ACTION: MD to ensure that RCAG reviewed the target ratings of risks at its next meeting on 9th July 2012.

DATE OF COMPLETION: 9th July 2012

23. Report from the Quality Committee

23.1 Beryl Magrath reported that a number of recurrent themes had arisen from the discussions at the last meeting of the Quality Committee, including high utilisation and an increase in the number of Category A incidents. Delays in hospital turnaround times were a contributory factor as this meant that resources were tied up at hospital.

23.2 At its meeting on 25th April, the Quality Committee had discussed the Quality Dashboard Report in detail and had noted that the target for Operational Workforce Reviews had not been met, despite reducing the target to 200 per month. The target for Core Skills Refresher 2 training had also not been met.

23.3 Beryl Magrath commented that there was an ongoing issue relating to the procurement of secure PRF boxes and asked what was being done to address this. Frances Wood answered that the PRF boxes had originally been purchased in bulk at a discounted price and the issue was therefore replacing PRF boxes for a reasonable price whilst ensuring that the current locks were retained. Frances reported that the procurement team was working to resolve this issue.

23.4 The Chair asked members of the Quality Committee whether they were comfortable with the remit of the Committee. Roy Griffins responded that he had ongoing concerns about the remit of the Quality Committee and he had previously raised these concerns. Beryl Magrath agreed that the Quality Committee did have a large agenda, but that usually all items on the agenda were adequately covered at the meetings. Beryl added that the sub-groups had improved their reporting to the Quality Committee and that this helped to assure the Committee so that it did not have to delve into the detail of issues. Beryl added that she planned to visit other ambulance trusts to understand how they managed their Quality Committee.

23.5 Sandra Adams stated that in her opinion, the governance structure was working effectively, although acknowledged that there was pressure on the Quality Committee. Sandra's concern was that, if the Quality Committee focussed solely on clinical quality, there was a risk that other key issues would be missed. Greater focus would be needed to improve the assurance provided from the sub-groups in order to manage better the Quality Committee's workload.

23.6 The Chair acknowledged that there was some concern around this and suggested that it was something that should be discussed further at the Strategy Review and Planning Committee meeting as part of the wider governance effectiveness review.

23.7 Sandra explained that clinical audit had now been brought into the mainstream of reporting and there was a much clearer understanding of clinical audit triggers. The plan was to report clinical audit recommendations in the same format as the internal audit recommendations. The detail of clinical audits would be reported to the Quality Committee, but any risks or gaps in assurances identified would be reported to the Audit Committee.

23.8 The Chair commented that the Trust Board needed to consider succession planning for the committees as she thought that the Quality Committee's effectiveness was due, in part, to the chair and her depth of understanding of clinical issues.

24. Report from the Finance and Investment Committee

24.1 Mike Dinan gave an update on the last meeting of the Finance and Investment Committee which had taken place on 13th March 2012 and noted that the Committee had discussed the following:

- Olympics Programme budget;
- Commercial positioning for contracting in 2012/13;
- Year to date finances and budget update;
- Capital Plan 2012/13
- Liquidity and Working Capital Report
- Carbon Management Plan. This was approved by the Committee and would be submitted to the next meeting of the Trust Board for approval.

24.2 Mike reported that the Committee was due to meet again tomorrow and that the agenda was broadly the same as the last meeting. Brian Huckett commented that he valued the opportunity to discuss finance issues to a greater level of detail than was possible at Trust Board meetings.

25. Draft Annual Report and Accounts 2011/12

25.1 Michael John gave an overview of the draft accounts for 2011/12 and noted that the Trust had fulfilled three of its statutory financial duties in 2011/12:

- The Trust had reported a surplus of £2,527k for the year against a plan surplus position of £2,736k. After adding back impairments and other adjustments of £224k the Trust's final NHS financial performance was £2,751k against an agreed control NHS London control total of £2,738k.
- The Trust's return on assets (the capital cost absorption duty) of 5.94 per cent was achieved. This was above the permitted range of 3.0 per cent.
- In the capital programme £9.1m was spent on a range of projects, including ambulances, new technology projects, and projects to improve the estate. Overall the Trust under spent by £2.5 million against its capital resource limit, which it is permitted to do.
- The annual accounts had been submitted within the deadline set by the Department of Health.

25.2 Michael John reported that the Trust had overshot its external financing limit (EFL) by £2,156k and therefore had failed to meet one of its key financial duties. This was caused by the failure to make an adjustment for the sale and lease back of ambulances in month 9 and this oversight was not picked up until month 12 at which point it was clear that the EFL would not be met.

25.3 Roy Griffins stated that this was a significant issue and asked whether actions had been put in place to ensure that this did not recur. Michael John confirmed that action had been taken to rectify this and that the plan for 2012/13 was being reviewed to ensure that the accounting treatment of the two Bank of Scotland leases due to be terminated in June 2012 and September 2012 was appropriate.

25.4 The Chair expressed some concern about whether this would affect the Trust's Foundation Trust application and suggested that there needed to be a better understanding of the priority of work to be done to ensure that this type of incident did not recur. The Chair stated that the Trust needed to ensure that the right resources were in place at the right level to ensure that there was not just one person who could complete a particular task. Sandra Adams suggested that the compliance framework needed to be updated and used more proactively.

25.5 Mike Dinan commented that he had perhaps not reviewed the FIMs report to the appropriate level and that in the future there needed to be a greater level of formality in the process.

26. Head of Internal Audit Opinion

26.1 The Audit Committee noted that the Head of Internal Audit Opinion for the year ended 31st March 2012 was that:

> Based on the work undertaken in 2011/12 to date, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

26.2 Chris Rising explained that the caveat regarding the information governance toolkit had been removed as a result of the follow up audit which demonstrated that evidence was in place to provide the internal auditor with sufficient assurance that a significant amount of progress had been made.

27. Audit Commission Progress Report

27.1 Dominic Bradley gave an update on the external audit and noted that so far there had been no significant findings. Dominic gave an update on each of the four risk areas:

- Assets – There had been difficulties in the past with the ownership of assets, and during the 2010/11 audit, a defibrillator had been found to be missing. However the stock take this year was much further ahead than last year and all defibrillators had been identified;
- Provisions or contingent liabilities - The external auditor was currently reviewing the basis of the Trust's accounting treatment for any provisions and/or contingent liabilities in the 2011/12 financial statements. This was progressing well;
- Alignment Project – The external auditor was happy with the adjustments made;
- Leases – The accounting treatment of leases was satisfactory. The external auditor was currently reviewing individual transactions, but no significant issues had been raised so far.

27.2 Dominic added that the finance team had been very helpful and had provided information in a timely way, which had contributed to the smooth running of the external audit and that overall the audit was on track. Mike Dinan added that the contribution of the finance team was particularly commendable given that this part of the team would be outsourced in the coming year.

27.3 The Audit Committee noted this update.

28. External Audit Consultation Appointment

28.1 Amanda Cant explained that PWC had been appointed as the Trust's external auditors and that the Trust had an opportunity to feedback on this. Mike added that this arrangement would only be in place for a year, until the Trust became a Foundation Trust, but acknowledged that there was concern that the Trust would lose the benefit of its existing auditors. Mike added that PWC should not represent any additional costs, but suggested that the Trust seek confirmation of this in writing.

ACTION: AC to ask for written confirmation from the Audit Commission that the appointment of PWC as external auditors of the Trust would not represent any additional costs.

DATE OF COMPLETION: 1st June 2012

28.2 Aside from these comments, the Audit Committee raised no significant issues about the appointment of PWC as external auditors of the LAS from 2012 – 13.

29. RSM Tenon Internal Audit Progress Report

29.1 Chris Rising reported that five reports had been finalised since the last meeting of the Audit Committee.

- The Information Governance follow up audit had demonstrated that 80% of the recommendations had been fully implemented and the remaining recommendations required only minor actions;
- An advisory review had been undertaken on Carbon Management and therefore no formal recommendations had been made:
- An amber/green opinion had been given for Data Management and therefore reasonable assurance could be given on this;
- The IT follow up audit demonstrated that good progress had been made in the implementation of the recommendations;
- The key recommendation arising from the CommandPoint Risk Management Arrangements audit was that there should be better documentation to identify the cause and effect of individual risks and to understand what might trigger these risks.

29.2 Chris added that the Benefits Realisation audit report had been finalised and the report would be presented to the next meeting of the Audit Committee. Scoping meetings were in place for the 2012/13 internal audit plan.

29.3 Roy Griffins asked whether the Cost Improvement Programme audit was underway. Chris responded that this audit was in progress and so far no issues of concern had been identified.

29.4 Chris confirmed that internal audit would have input into the new format for clinical audit reporting and would review best practice examples from other organisations.

30. Audit Recommendations Progress Report

30.1 Frances Wood reported that overall there had been significant progress in the implementation of internal audit recommendations. A lot of effort had been focussed on finalising reports and this was now done in a much more timely

manner. Action plans had been included in the papers for three amber-rated actions: CommandPoint Project Management Arrangements; PRF Management at Station Level; and Proactive Review of ProMis.

30.2 Frances added that a solution had been found to address the recommendations in relation to digital radios and it was expected that these actions would be reported as green at the next meeting of the Audit Committee.

30.3 Frances was also working with Karen Merritt and the procurement team to identify a solution to address the recommendations relating to PRF Boxes. There were currently no immediate concerns about the safety and security of PRFs.

30.4 Frances reported that overall there was better engagement with managers in the scoping of audits and this had meant that draft reports were finalised and recommendations followed up in a much more timely manner. The internal audit process was closely aligned to other agendas such as the risk register, CQC and NHSLA and this integrated approach meant that it was incorporated into staff members' day to day work.

30.5 The Audit Committee agreed that significant progress had been made with the management of internal audit recommendations and that this had also been noted by the Quality Committee. The Chair commented that there was now a much better understanding of the Trust's position in relation to the progress of recommendations made by internal audit and the extent to which this was embedded in the Trust.

30.6 Chris Rising commented that the work of Frances and the Governance and Compliance team had made a significant difference to the management of internal audit recommendations and this in turn had enabled the Audit Committee to more mature discussions on the risk register.

30.7 The Chair agreed with these comments and stated that this report was a really helpful way of assuring the Audit Committee that the Trust learnt lessons from internal audit.

31. Local Counter Fraud Specialist Progress Report

2012/13 Annual Counter Fraud Work Plan

31.1 Darriane Garrett noted that the 2012/13 Annual Counter Fraud Work Plan had been presented to the last Audit Committee meeting in draft form. The Audit Committee approved the work plan.

Annual Counter Fraud Staff Survey 2011/12

31.2 Darriane explained that the staff survey had been conducted online this year and the result of the survey would feed into the counter fraud strategy going forward. Darriane acknowledged that the survey had had a low response rate, but that this was comparable with other organisations. Consideration would be given to the timing of the survey next year to encourage participation.

31.3 Mike Dinan added that staff would be reminded of their responsibilities for counter fraud and bribery, particularly in the run up to the 2012 Olympics. Sandra added that an email had been sent out last week reminding staff of their duties to report any gifts or hospitality received.

32. Any other business

32.1 There were no items of other business.

33. Forward planner

33.1 The Audit Committee noted the forward planner and noted the items for the next meeting on 1st June 2012, with the addition of the review of operational risks.

33.2 Mike Dinan suggested that the Audit Committee review the finance and governance arrangements for the new LAS charity at its meeting on 3rd September.

ACTION: FG to add a review of the finance and governance arrangements of the new LAS charity to the forward planner for 3rd September.

DATE OF COMPLETION: 18th May 2012

34. Date of Next Meeting

34.1 The next meeting of the Audit Committee will be on Friday 1st June 2012 at 10.00.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH MAY 2012

PAPER FOR INFORMATION

Document Title:	**Report from the Finance and Investment Committee**
Report Author(s):	**Richard Hunt**
Lead Director:	**Richard Hunt, Chair**
Contact Details:	**Francesca.guy@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Report from a board committee to provide assurance on finance and investment issues**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Other
Recommendation for the Trust Board:	**To seek clarification on any areas of concern and then to note the report for information**

Key issues and risks arising from this paper

1. Reviewed final contract as agreed with commissioners including the higher level of CQUIN payments. This put further focus on achieving our workforce objectives for 2012/13. It was considered achievable. This will need further discussion and reporting at future board/SRP.

2. As follow up to the last meeting received a presentation on funding for the Olympic Programme. Considered satisfactory and adequate though specification for service and eventual demand uplift remained uncertainties. Issue remained around criteria for access to the additional £1m contingency held by the SHA. In general and as expected, in good shape.

3. As per 1above received both revenue and capital budgets reflecting agreed contract. Capital funding seen as adequate and achievable.

4. Received up date on CIP proposals for 12/13. All to be tracked and reported as before. It was noted that the run rate challenge for CIP would get more significant. An early result from the capacity review was needed if arguments about resourcing and utilisation were required. This may take it outside of the LTFM. Strategy needed to be revisited.

5. The headline amounts for the capital plan for the next 5 years were considered. Further discussions at a future SRP were required. The funding requirement (internal in the future) was considered manageable. The discussion highlighted that considerations of capital spend and funding options plus associated cost would become more significant in the future.

6. The committee received brief updates on previously considered projects; West Area Workshop and implementation of the Financial Services Plan. All progressing.

7. The liquidity and working capital positions were satisfactory and could now be based on the agreed contract funding. It was noted that the EFL for the close of 2011/12 had not been achieved. This was a disappointing end to an otherwise highly satisfactory and demanding year. This needed further discussion at the board meeting. A brief finance report on month 12 would be given to the board.

Attachments

None

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

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

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

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

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

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

Equality Impact Assessment

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

Key issues from the assessment:

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH MAY 2012

PAPER FOR APPROVAL

Document Title:	**Change of Lloyds Bank Accounts**
Report Author(s):	**Ken Thompson, Cashier**
Lead Director:	**Michael Dinan, Director of Finance**
Contact Details:	**0207-783-2754 (192754)**
Why is this coming to the Trust Board?	**The Trust Board is required by Lloyds Banking Group to pass resolutions contained in the new bank mandates.**
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 pass the resolutions requested by Lloyds Banking Group**

Key issues and risks arising from this paper

None

Executive Summary

The Lloyds Banking Group is reducing its number of branches. Southbank, the branch at which we currently bank, is one of the branches closing. As a result we are being moved to their City office branch – this involves the closing of our existing accounts and the opening of new accounts.

We are taking this opportunity to rationalise and modernise our commercial banking arrangements. We are reducing the number of exchequer accounts from three to one and the number of charitable funds accounts from two to one. We are also adding the Charitable funds account to the on-line Lloydslink system which will give us almost real time access to the transactions and balances on that account.

In order to achieve the above Lloyds require us to fill in a new bank mandate for each of the new accounts and an authority form to place the additional account onto Lloydslink. These new mandates require the Trust Board to pass resolutions in accordance with the mandate and that this be noted in the Trust Board minute book.

Attachments

None.

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Quality Strategy

This paper supports the following domains of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

- ☐ Yes
- ☒ No

Key issues from the assessment:

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH MAY 2012

PAPER FOR INFORMATION

Document Title:	**LAS Major Incident Plan**
Report Author(s):	**Martin Flaherty**
Lead Director:	**Martin Flaherty**
Contact Details:	**0207-783-2039**
Why is this coming to the Trust Board?	**For Information**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Other
Recommendation for the Trust Board:	**That the Board receives the report for information**

Key issues and risks arising from this paper

As detailed below.

Executive Summary

The London Ambulance Service Major Incident Plan (MIP) has been received and approved by the SMG under the signature of the responsible Executive Director, which in this case is the CEO. It is provided for information to the Board. The Major Incident Plan is by its very nature a long and complex document running to some 118 pages. A link will be provided for Board members to access an electronic copy and hardcopies can be provided on request.

The Major Incident Plan has been revised following:

- The National Emergency Preparedness Audit 2010,
- HM Coroners Inquest 2011, recommendations and Rule 43 regarding the July 7th 2005 London Bombings
- NHS London Emergency Preparedness Assurance Process 2012.

The principle areas which have been revised or augmented are as follows:

- The plan has been updated to use plain English where possible and in doing so takes note of a general recommendation to all emergency services following the 7/7 inquest
- The definition of a serous incident has been introduced along with the pre-determined attendance for such an incident and guidance as to how initial responses should be managed
- The major incident plan now makes mention of and refers to other relevant LAS plans such

as Demand Management Plan (DMP), Resource Escalatory Action Plan (REAP) and National Ambulance Co-ordination Centre (NACC) plan and in doing so recognises that the LAS forms part of the critical national infrastructure

- The definition of an internal major incident has been included and an appendix will be published in June setting out the triggers for such an incident, the requirements of teams and directorates and the likely responses to manage such circumstances (this will be supported by an internal communications plan when published)
- The scene reporting term CHALETS has been removed from the plan standardising the scene reporting with other services where by we now use METHANE
- Initial crews arriving at the scene of a major incident are now required to take equipment forward to begin the development of a forward equipment stock
- Dynamic risk assessment processes have been introduced to ensure the management of scene safety and staff welfare and where appropriate these are supported by a risk management matrix setting out levels of risk and their appropriate authority to manage
- The forward control team role provided by staff from the emergency operations centre has been developed following feedback from incident deployments, now focuses on at scene command support and is deployed utilising a new range of command support vehicles
- A predetermined suite of airwave talk groups has been introduced for the managements of incidents and takes account of the potential for a multi-sited simultaneous incident occurring
- Learning from complicated, multi-sited or dynamic incidents has led to a review of the location of the Ambulance Incident Commander (Silver) whereby the revised plan places this crucial command role within the incident control room although flexibility remains dependant on the nature of the incident for this officer to deploy to scene
- The title of Medical Incident Officer has been replaced with a new nationally agreed title of Medical Advisor
- The nationally recognised title of Ambulance Incident Commander now replaces previous titles such as Silver, Silver Medic and Ambulance Incident Officer
- The role of strategic and tactical command support loggist has been introduced
- The revised plan now requires triage to be undertaken in pairs and the use of basic airway management and catastrophic haemorrhage control for patients during the triage sieve
- MERIT has been incorporated into the revised plan
- Learning from N30 has been incorporated into the new plan and the use of the SHA situational reporting tool has now been introduced
- London's trauma network is recognised within the plan and takes into account the specialist centres in the guidance for the distribution of patients (also takes account of regional and national burns arrangements)
- Changes have been made to the on scene management of deceased patients in line with the 7/7 Rule 43 report
- Every patient seen, treated or conveyed now requires the completion of either an HRF or PRF (this was not a requirement of the previous plan and was highlighted in the 7/7 Rule 43 report)
- Staff support arrangements have been overhauled and improved
- Scene identification tabards are now consistent with nationally agreed guidance
- A strategic and tactical decision support tool has been introduced
- Revised special contingency arrangements have been published that now include the management of public order and have updated sections on COMAH sites, attendance at airports, attending routine firearms calls and CBRN incidents

The London Ambulance Service NHS Trust has a statutory obligation to be prepared to deal with Major Incidents. In such cases there may be little or no warning. This Major Incident Plan has been prepared in light of guidance from the Department of Health, Home Office and builds on the Civil Contingencies Act 2004 guidance together with the above reviews and audits.

The trust will continue to engage with its partner agencies with the Local and Regional Resilience Forums to ensure joined up multi-agency emergency preparedness and resilience.

The arrangements in this document form the basis of response to an incident occurring in the operational area covered by the Trust or in support of other Trusts and organisations in the immediate area. It should be emphasised that the operational area contains a wide variety of

hazards and that no two incidents will produce the same scenario. It is important therefore, to remember that this is very much a generic plan designed to be adapted to deal with a wide range of different scenarios. Where necessary it is augmented by site specific or scenario specific operational plans.

All Staff, Managers and Directors will be made aware of this plans existence and their particular role within it. The action cards within the appendix are intended to be an aide memoir to assist with the management of an incident and not a set of instructions. Specific training on the MIP will remain a mandatory element of core induction and refresher training for staff and managers across the Trust.

These procedures will be further validated by training, exercising and use in actual major emergencies. They will be reviewed annually or more frequently if required by the Emergency Planning Unit, and amendments issued to ensure best practice.

The existing MIP was developed in 2007 and as indicated earlier has now been subject to significant revision. The 2012 plan will therefore be issued and enacted in June complete with appropriate training and briefing in readiness for the 2012 Olympic Games.

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

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

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

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

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

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

Equality Impact Assessment

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

Key issues from the assessment:
None

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH MAY 2012

Compliance with Standing Orders and Standing Financial Instructions

Document Title:	**Trust Secretary Report**
Report Author(s):	**Francesca Guy**
Lead Director:	**Sandra Adams**
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 ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	**To be advised of the tenders received and entered into the tender book and the use of the Trust Seal since 20th March 2012 and to be assured of compliance with Standing Orders and Standing Financial Instructions**

Key issues and risks arising from this paper

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

Executive Summary

One tender has been received, opened and entered into the tender book since 20th March 2012:

- Fleet Vehicle conversion to comply with the London Low Emission Zone (LEZ) standards
  Tenders received and opened by Bravo Solutions on 26th March 2012:
  Babcock Critical Services Limited
  Baumot UK Ltd
  Clean Diesel Technologies
  Dinex Exhausts Ltd
  Emicon Systems
  Emission Control Ltd
  Fawngrove Suiton Limited
  Grays Truck and Van
  HJs Emission Technology GMBH and Co KG
  Kent County Council – Transport Engineering
  Marshall Fleet Services Limited
  MTHL Fleet Services
  Volvo Truck and Bus London

There have been no new entries to the Register for the Use of the Trust Seal since 20th March 2012.

Attachments

None.

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

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

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

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

Risk Implications
This paper links to the following strategic risks:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?
Yes
No

Key issues from the assessment:

TRUST BOARD FORWARD PLANNER 2012

Date of meeting	Standing Reports to the Board	Safety and Quality (additional to standing reports)	Finance and Performance (additional to standing reports)	Strategic and Business Planning	Governance	Sub-Committee meetings during this period
26 June **Trust Board** **Apologies: Steve Lennox**	Report from the Trust Chairman Report from CEO Report from the Trust Chairman Report from CEO Report from the COO Report from Director of Finance Report from Sub-committees	Annual Safeguarding Report 2011/12 Annual Infection Prevention and Control Report 2011/12 Quality Dashboard and Action Plan Clinical Quality and Patient Safety Report Workforce Report Quality Committee Assurance Report Presentation on the Ambulance Services Cardiac Quality Initiative		FT Progress Report to include BGM action plan	Report from Trust Secretary Trust Board Forward Planner BAF and Corporate Risk Register – Quarter 1 documents Annual Equality Report 2011/12	29th May – Remuneration Committee 1st June – Audit Committee 20th June – Quality Committee
24 July **Strategy, Review and Planning Committee** **All day away day**		Community First Responders/corporate and social responsibility		IBP 5 Year Strategy PTS Strategy	Committee Effectiveness Review	10th July – Finance and Investment Committee

Date of meeting	Standing Reports to the Board	Safety and Quality (additional to standing reports)	Finance and Performance (additional to standing reports)	Strategic and Business Planning	Governance	Sub-Committee meetings during this period
21 August **Trust Board**	Report from the Trust Chairman Report from CEO Report from the COO Report from Director of Finance Report from Sub-committees	Quality Dashboard and Action Plan Clinical Quality and Patient Safety Report Workforce Report Quality Committee Assurance Report		IBP 5 Year Strategy	Report from Trust Secretary Trust Board Forward Planner Annual Trust Board Effectiveness Review 2011/12 Annual Equality Report 2011/12 Annual Corporate Social Responsibility Report 2011/12 Annual Patient Experiences Report 2011/12 KA34 Compliance Statement	15th August – Quality Committee
25 September **Trust Board**	Report from the Trust Chairman Report from CEO Report from the COO Report from Director of Finance Report from Sub-committees	Quality Dashboard and Action Plan Clinical Quality and Patient Safety Report Workforce Report			Report from Trust Secretary Trust Board Forward Planner BAF and Corporate Risk Register – Quarter 2 documents Annual Report of the Audit Committee	21st August – Charitable Funds Committee 3rd September – Audit Committee 11th September – Finance and Investment Committee

Date of meeting	Standing Reports to the Board	Safety and Quality (additional to standing reports)	Finance and Performance (additional to standing reports)	Strategic and Business Planning	Governance	Sub-Committee meetings during this period
23 October **Strategy, Review and Planning Committee**						
27 November **Trust Board**	Report from the Trust Chairman Report from CEO Report from the COO Report from Director of Finance Report from Sub-committees	Quality Dashboard and Action Plan Clinical Quality and Patient Safety Report Workforce Report Quality Committee Assurance Report	Charitable Funds Annual Accounts 2011/12		Report from Trust Secretary Trust Board Forward Planner	24th Oct – Quality Committee 5th November – Audit Committee
11 December **Trust Board**	Report from the Trust Chairman Report from CEO Report from the COO Report from Director of Finance Report from Sub-committees	Quality Dashboard and Action Plan Clinical Quality and Patient Safety Report Workforce Report			Report from Trust Secretary Trust Board Forward Planner BAF and Corporate Risk Register – Quarter 3 documents	11th December – Quality Committee