LONDON AMBULANCE SERVICE NHS TRUST
AUDIT COMMITTEE MEETING
8 JUNE 2009

LONDON AMBULANCE SERVICE NHS TRUST

AUDIT COMMITTEE

Monday, 8th June 2009, 2.30-5.00pm

Conference Room, LAS HQ

Agenda

10	**1**	**Private meeting between the Audit Committee & the Auditors**		
	2	**Welcome & Apologies:** • **Mike Dinan**		
15	**3**	**Minutes of the last meeting held 9th March 2009**	**Enclosure 1**	
	4	**Matters Arising**		
15	**5**	**Risk Register**	**Enclosure 2**	
15	**6**	**Audit Commission**		**Audit Commission lead - PJ & DB**
		• Audit Progress Report 2008/09	**Enclosure 3**	
		• Annual Governance Report – Audit 2008/09	**Enclosure 4**	
		• Audit and Inspection Plan 2009/10	**Enclosure 5**	
15	**7**	**Internal Auditors' report**		**CR**
		• Internal audit progress report	**Enclosure 6**	
		• Internal auditors' report	**Enclosure 7**	
15	**8**	**Ratification of Final 2008/09 Audited Accounts – Ratification**	**Enclosure 8**	**MJ**
10	**9**	**Audit Recommendations Database**	**Enclosure 9**	**LA**
10	**10**	**Report of the Local Counter Fraud Specialist**		**DF**
		• Annual report 2008/09	**Enclosure 10**	
		• Annual work plan for 2009/10	**Enclosure 11**	
15	**11**	**Audit Committee annual report, including effectiveness & best practice recommendations**	**Enclosure 12**	**LA**
10	**12**	**Review of Financial risks 2009/10**	**Enclosure 13**	**AI**
5	**13**	**Update re. HCC / NHSLA**	**Verbal**	**LA**

5	**14**	**Standing Committee Items**	**Enclosure 14**	**AI**
5	**15**	**Draft minutes of the Clinical Governance Committee**		**SW**
		• **February 2009**	**Enclosure 15**	
		• **April 2009**	**Enclosure 16**	
5	**16**	**Draft minutes of the RCAG (18th May 09)**	**Enclosure 17**	**PB**
5	**17**	**Audit Committee work plan and timetable for 2009/2010 meetings (N.B. 2010 dates - proposed only)**	**Enclosure 18**	
	18	**Any Other Business**	**Verbal**	

Date of next meeting – 2.30pm, 7th September 2009

Members:

Caroline Silver	Sarah Waller	Roy Griffins	Brian Huckett

In attendance:

Peter Bradley	Asif Islam	Michael John	Laila Abrahams
Phil Johnstone	Dominic Bradley	Chris Rising	David Foley
Gary Douglas	Clive Parker-Wood		

3 Minutes of the previous Meeting held 9 March 2009

LONDON AMBULANCE SERVICE NHS TRUST

AUDIT COMMITTEE

Minutes of the meeting held on Monday 9 March 2009
in the Conference Room, LAS HQ, 220 Waterloo Road, London SE1 8SD

Present:	Caroline Silver	Non-Executive Director (Chair)
	Sarah Waller	Vice Chairman
	Brian Huckett	Non Executive Director
In Attendance:	Peter Bradley	Chief Executive Officer
	Mike Dinan	Director of Finance
	Martin Smith	Director of Corporate Services
	Beryl Magrath	Non Executive Director
	Laila Abraham	Interim Head of Governance
	Michael John	Financial Controller
	Phil Johnstone	Audit Commission
	Dominic Bradley	Audit Commission
	Chris Rising	RSM Bentley Jennison
	David Foley	RSM Bentley Jennison
	Clive Parker-Wood	Capita - Interim Trust Secretary

01/09 **Welcome & Apologies**

The Chairman welcomed everybody present at the meeting and noted that apologies had been received from Roy Griffins.

02/09 **Minutes**

After review and due consideration by the Committee,

IT WAS RESOLVED THAT the minutes of the Audit Committee meeting held on 10 November 2008 be and are hereby approved as a true record of the meeting, and that they be signed by the Chairman.

03/09 **Matters Arising**

Minute 47/08: FIMS: Assurance was given that the Trust, working together with the external auditors, would have prepared a "hard close" of the accounts by month nine and that the accounts would then be audited in month twelve in line with the revised deadline for submission of the audited accounts.

Minute 52/08: Reference Costs: Mr Dinan reported that the progress report in respect of reference costs had been presented to the Service Development Committee in December 08 as well as to the Board in January 09.

Minute 53/08: Review Standing Orders and Financial Regulations: Mr Dinan reported that following the query from Sarah Waller as to whether the limit was too low, the level of tendering had be increased from a budget of £3,000 to £10,000.

04/09 **International Financial Reporting Standards ("IFRS")**

Mr John reported that the Trust's 2008/09 Financial Report and Accounts were being prepared under the new IFRS.

Mr John stated that the Auditors had been asked to provide ratings on all reporting aspects covered by IFRS and it was noted that the Trust had received an Amber Rating for Processes. The two amber ratings were awarded to:

a) Holiday pay on Promiss.
b) Ambulance leases on Fixed Asset Register.

Mr John informed the Committee that despite some of issues, including the length of time it was taking to transfer "brought forward holiday" onto the new system, all the operational issues would be completed by the 31 March 2009.

Mr John updated the Committee on the progress of the annual Audit. It was noted that the audit would be completed towards the end of 2009 and that a full set of audited accounts would be produced under IFRS for submission to the Health Authority in April 2010. It was further noted that changes to the current accounting polices reflecting changes brought in by the new IFRS would be reported to the Board at their next meeting.

05/09 Audit Commission: Progress Report

Financial Statements in 2008/09:
Mr Bradley provided an update to the Committee on the work undertaken by External Audit to date as measured against the 2008/09 audit plan and the key findings identified by External Audit.

Mr Bradley informed the Committee that the interim audit of each system had been completed and that some controls testing had also been undertaken. It was noted that the external auditors had not found any significant issues in the systems.

Mr Bradley stated that the work on the payroll system had not been completed yet. This was due to the fact that Internal Audit was currently in the process of testing the system. It was noted that the external auditors would defer on this matter to prevent duplication of the work.

Auditor Local Evaluation (ALE):
Mr Bradley reported that the external auditors had commenced an assessment of the internal control, financial management and value for money Key Lines Enquiry (KLOE) and had brought forward their knowledge from the 2008 ALE Assessment.

It was noted that the Trust used the Performance Accelerator system as a document store for ALE and that as a result a few gaps in the evidencing on the system had been discovered. This was currently being followed up. It was further noted that the Trust had missed out on the opportunity to self assess using a thorough and evaluative commentary, signposting the key sections with a range of documents and pinpointing the notable practice that would be needed to justify any score of 4.

After some discussion, The Board agreed that there was a lot of work that still needed to be undertaken to achieve a Performance Work score of 4. It was agreed that all the evidence needed to be collated and compared to other Trusts in order to achieve this. It was noted that there were currently 3 performance projects being run and in spite of this reassurance was provided by the external auditors that Trust was on target to deliver its planned 2008/09 performance work on time.

06/09 Internal Audit: Progress Report – March 2009

The Board considered the internal audit progress report.

Mr Rising reported that since the last audit committee meeting, seven reports had been finalised. It was noted that the Trust was the first Trust to received positive assurance for all its projects currently being worked on.

After further discussion, the internal audit progress report and all assurances contained within that could potentially impact the Assurance Framework and the Statement of internal control were noted.

07/09 Internal Audit: 2009/10 Audit Plan

The Internal Audit plan for 2009/10 and 3-year internal audit strategy was taken as read.

Mr Risling confirmed that the plan had been developed through consideration of a number of drivers. These included the Trust Board Assurance Framework, those areas to assist External Audit in their work, areas identified for review by Management and Areas identified by Internal Audit.

It was noted that the Internal Auditors had met with the Director of Finance and reviewed the Trust Assurance Framework. It was noted that the plan also contained an indicative 3-year Internal Audit Strategy 2009/10 – 2011/12.

After some discussion it was resolved that the 2009/10 Audit Pan, subject to some minor amendments, be approved.

08/09 Report of the Local Counter Fraud Specialist

The report was taken as read.

Mr Foley, the Nominated Local Counter Fraud Specialist (LCFS) reported that all Trust staff had been positive, responsive and accepting of all the Counter Fraud policies and procedures. The Committee agreed that an "Anti-Fraud Culture" had been installed within the Trust and that this had stemmed from top management feeding right down into its core. It was noted that the effects of this culture were very positive.

Mr Foley informed the Committee that he had issued two relevant fraud alerts to the Trust since the last Committee Meeting:

1. Alert relating to false invoices purporting to be from Dell Computers. It was noted that this was actioned by the Trust to ensure that they had not been victim to this alleged fraud.
2. DH Guidance, Re: suspension of Chairs/NED's whereby they are suspected of involvement in fraud.

The Committee discussed some of the key issues including the cost of fraud to the Trust on a yearly basis, whistleblowing and communications. It was agreed that in order to improve the current rating of 2, the Trust needed to continue to focus on embedding the Anti-Fraud culture within the organisation.

09/09 Assurance Framework and Risk Register

The report and risk register was taken as read and noted by the Committee.

The Committee agreed that all risks needed to be anticipated in advance and best practice needed to be encouraged throughout the Trust.

The Assurance Framework would be presented to the Board on the 31 March 2009.

10/09 Subsistence

Mr John reported that "Back-to-Back" arrangements would be decreased before 31 March 2009 and that A&E (Accident and Emergency) elements were down from 7 million to 1 million.

11/09 Better Payment Practice Code

The Better Payment Practice Code ("The Code") – Invoices paid by Department for Period 09, ending 31st December 2008 was taken as read.

After some discussion, it was noted that Operations needed to improve by 10% in terms of paying their invoices within 30 days. It was agreed that the Code would be included in the monthly finance report as a Key Performance Indicator (KPI).

12/09 Removal or Suspension of Chairs & NEDs of Health Bodies

The Feedback on the consultation to introduce powers of suspension was taken as read. There was nothing further to report.

13/09 Audit Committee Effectiveness

The self assessment checklist was taken as read and the Committee agreed that the tool would be used to undertake a self assessment of performance over the year.

It was agreed that the self assessment would also include recommendations for Best Practice. It was noted that the assessment would be completed before the next Audit Committee meeting to be held in June 2009.

14/09 **Risk Management**

Mr Dinan circulated a power point presentation on Risk Management and provided an update

It was noted that the Assurance Framework provided the Trust with a simple but comprehensive method for the effective and focused management of the principle risks to meeting their objectives.

It was agreed that the presentation would be included into the plan for SDC in June.

15/09 **Standing Committee Items**

The Committee noted the contents of the report and there was nothing further to report.

16/09 **Draft Minutes of the of the RCAG, 16 February 2009**

The draft minutes were taken as read.

17/09 **Next Meeting**

It was noted that the next Audit Committee meeting would be held at 2:30 pm on Monday 8 June 2009 in the Conference Room at LAS HQ.

18/09 **Any Other Business**

There being no further business, the Chairman declared the meeting closed at 4:00 pm.

…….
Chairman

4 Matters Arising

5 Risk Register

London Ambulance Service
NHS Trust

Audit Committee Front Sheet

Title: Risk Register : New Format High Risks	**Agenda Item: 5**
	Enclosure: 2

Purpose:

To provide the Audit Committee with an update on the Corporate Risk Register.

Summary:

The revision of the Trust Wide Risk Register was agreed at the RCAG meeting in February. The accompanying Risk Register includes the following columns: assurance; link to strategic goals of organisation and target rating for all **High** risks. Proposals were made to RCAG concerning target ratings for the high level risks on the Register and changes have been incorporated.

The GDU have updated the risks in the following ways:-

1) Made amendments to the risks following the RCAG meeting on 18th May;
- 314 = New clinical risk added regarding inability to deliver CPD courses and the risk of this to patients,
- 250 = Changed risk wording, from 'paediatrics' to 'children',
- 279 = Risk re-worded and updated.

2) Assessed the risks and re-graded specific risks as a reflection of current controls in place and actions that have taken place;

	Original Net Risk Rating	New Net Risk Rating
- 250 -	5 / 4 = 20 High*	4 / 4 = 16 High
- 269 -	4 / 5 = 20 High	4 / 4 = 16 High
- 312 -	4 / 4 = 16 High	4 / 3 = 12 Sig
- 9 -	4 / 4 = 16 High	4 / 3 = 12 Sig
- 31 -	4 / 4 = 16 High	4 / 3 = 12 Sig
- 138 -	4 / 4 = 16 High	4 / 3 = 12 Sig
- 273 -	4 / 4 = 16 High	3 / 3 = 9 Sig
- 207 -	3 / 5 = 15 High	3 / 3 = 9 Sig
- 298 -	5 / 3 = 15 High	4 / 2 = 8 Sig

(*Impact x Likelihood = Rating)

This is a work- in-progress document and all other risks on the risk register will be reviewed by the GDU team who will meet with risk owners to update the risks before the Risk Register is moved over to Performance Accelerator in August 09.

Recommendations/and or actions required:

The Committee is asked to note;

i) the controls in place to mitigate these risks and the progress made in implementing the action plans,
ii) that the risk register and process will be moving onto Performance Accelerator to enhance and streamline reporting.

Author and Date:
Governance Development Unit - 28/05/2009

London Ambulance Service NHS Trust Wide Risk Register

Risk Ref.	Risk Description	Assurance	Risk Category	Gross Impact	Gross Like-lihood	Gross Rating	Management Actions (Key Controls) Already In Place	Risk Owner	Date Risk Last Updated	Strategic Goals	Net Impact	Net Like-lihood	Net Rating	Further Actions Required	Further Action Owner	Date Further Action to be Completed	Assurance (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like-lihood	Target Rating	Comments
314	There is a risk that the inability to deliver CPD courses to existing staff and the low completion rate of key Clinical Performance Indicators (currently 38% against a target of 95%) due to operational pressures will lead to the Trust losing clinical focus which will result in sub-standard clinical care, causing patient harm.	***	Clinical	4	5	20	1) CPD (700 hours) has been delivered to those members of staff who were most out of date. 2) Staff are accessing some training in their own time 3) Recruitment of student paramedics will see significant increases in staffing levels and a decrease in the number of uncovered shifts, but difficulties are anticipated until at least September 2009.	Medical Director	18-May-09		4	4	16	1. Target Team leaders in the first instance with a course covering the initial 2 modules delivered on the ECP course (patient assessment and clinical decision making). 2. Set achievable targets for ADOs to release existing members of staff for CPD and monitor uptake. ADOs to be held accountable for releasing staff.	Medical Director	01 Sep 2009	1.Monitoring of reported clinical incidents 2.CPI completion rates	4	2	8	This is a key risk to the Trust and the further action required need to be implemented as a matter of urgency
250	There is a risk that out of date equipment (PALS PACK) may result in inability to treat children.	***	Logistics	5	4	20	1) Additional PALS Packs being packed. 2) Vehicle audit and swap out of packs carried out in Feb/March	Christopher Vale	28-May-09		4	4	16	1. PALS Packs to be included in asset tracking process 2. A more robust process for monitoring 3. Additional PALS packs to be swapped out in each operational area.	D.Adams	1. July 08 2. March 09 3. June 09	1.Weekly audits.	2	4	8	
269	At shift changeover times, LAS performance falls as we take longer to reach patients.	***	Clinical	4	5	20	1) Rest break agreement is under review, in particular the current arrangement whereby if a crew is not allocated a rest break they finish their shift 30mins early. 2) New rotas agreed with staff will not allow a 7am or 7pm start or finish. 3) Team Leaders to start a new shift, working from 14.00 to 20.00 each day to bridge the evening changeover period. 4) 'New Ways of Working' model will introduce staggered start and finish times at all stations. 5) Dir of Ops has put together a 15 point Operational plan "Operations Workstream 2009/10" covering a number of Resourcing issues which will once implemented impact on changeover times and patient care. All the workstream initiatives have a workstream lead at either Assistant Director Operations (ADO) Assistance Chief Ambulance Officer (ACAO) or nominated Ambulance Operations Manager (AOM) level.	Richard Webber	28-May-09		4	4	16	1. Roster Reviews Is a large project which will require an entire roster review across the service in line with the ORH recommendations. It is anticipated it will require full time dedicated resource to undertake the project. Resourcing to ORH Plan across 168 hours, to monitor Resourcing compliance Pan London and each area 168 hours a week as compared to ORH level D. Active Area Cover (AAC) is to review both the current AAC arrangement ensuring increased and appropriate use of AAC.	R.Webber	1. March 2010		4	3	12	
310	Loss of access/use of LAS Properties due to flooding, from any source.	***	Business Continuity	5	4	20	1) London Strategic Flood Plan 2) EPU Identification of LAS sites at risk 3) Signed up to the Environment agency Early warning System 4) PPS -25 Development and Flood Risk (Government guidance on planning new development and making current buildings more flood resilient.) 5) LAS Business Continuity Plans - individual stations have business continuity plans 6) Mutual aid policies 7) EA mapping.	Stephen Moore	16-Feb-09		4	4	16	1. LAS Flooding plan being written (Date TBC) 2. Station Business Continuity Plans to include flooding contingencies 3. EA Flood Mapping available through Emergency Preparedness 4. Staff training to include Water Awareness.	David Williams			4	3	12	
22	There is a risk that failure to undertake comprehensive clinical assessments which may result in the inappropriate non-conveyance or t/ment of patient.	***	Clinical	4	5	20	1) Excellent feedback from students on enhanced patient assessment course 2) Good delivery of CPD modules in 2007/08. Significant shortfall in delivery in 2008/09 due to operational pressures. 3) Explore the current use of treat and refer protocols - Mgmt Info are currently refining a report to monitor current use of treat and refer pathways.We'll then be focusing on the NWOW sights to roll out further pathways and trial new local initiatives that if successful, can be adopted elsewhere. The pathway development work will continue and work hand in hand with NWOW project. 4) Develop systems whereby staff learn from mistakes. 5) Risk Info Report presented to CGC 6) The proforma for the Operational workplace review has been finalised and communicated with managers and staff side colleagues. CPIs identify an array of clinical skills that indicate the level of patient care by auditing PRF. 7) Introduction of reflective practice. Specific example, EOC Training officers now conduct such exercises with EOC staff. Outcome reports completed to indicate action taken, although further work required to explain what this should entail. Former Complaints Panel being revised to ensure emerging themes, practice & methodology widely incorporated.	Fionna Moore	01-May-09		3	5	15	1. Enhanced patient assessment introduced to paramedic course 2. CPD for all staff	1. M.Whitbread /P.Johnson 2. K.Miller		1. Use Datix to demonstrate a reduction in incidents. 2. Half yearly operational workplace. 3. Regular reports to CGC.	3	3	9	
279	There is a risk that a Pandemic could lead to increased service pressure due loss of personnel and increased emergency calls.	***	Business Continuity	5	4	20	1) LAS Flu Pandemic Planning Group met 08/01/09. National Ambulance Steering Group met 19/01/09. Version 6 of Pandemic Plan issued for comment. This is still under development as well as an operational plan. 2) Increasing staff awareness about infections via bulletins in RIB and also hand hygiene posters on all sites.	Fionna Moore	28-May-09		5	3	15	1. Encourage take-up of appropriate vaccine as available /developed by LAS personnel (critical services and vital support) 2. Strategic Flu Plan being revised 3. New LAS Operational Pandemic Plan to be produced	1. F.Moore 2. J Pooley	1.Ongoing 2. Jan 2009 3. March 2009		4	3	12	

London Ambulance Service NHS Trust Wide Risk Register

Risk Ref.	Risk Description	Assurance	Risk Category	Gross Impact	Gross Like-lihood	Gross Rating	Management Actions (Key Controls) Already In Place	Risk Owner	Date Risk Last Updated	Strategic Goals	Net Impact	Net Like-lihood	Net Rating	Further Actions Required	Further Action Owner	Date Further Action to be Completed	Assurance (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like-lihood	Target Rating	Comments
312	There is a risk that the required drug/equipment may not be avialable in the drug pack which will lead to the patient not being treated appropriately.	***	Clinical	5	4	20	1) Bulletin from Director of Operations to all staff reinforcing drug protocols 2) Letter from Director of Operations to AOM's reinforcing local management responsibilities 3) Gradual improvement in audit results. Audit compliance improving. No significant improvement in number sof packs being returned.	Christopher Vale	28-May-09		4	3	12	1. Reinforce weekly audit requirement. 2. Amalgamate risk with 266 and 307, present new risk to SMG in June	1. C.Vale 2. C.Hitchen/ L.Abraham	1. Ongoing 2. 8 June 09		4	2	8	

Definitions & guidance

Impact

	1	2	3	4	5
Descriptor	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Injury (Physical & Mental to anyone)	Minor injury not requiring first aid	Minor injury or illness, first aid treatment needed	Reportable to external agencies/statutory bodies (e.g. RIDDOR, HSE, NPSA., etc.)	Major injuries, or long term incapacity / disability (loss of limb)	Death or major permanent incapacity
Patient Experience	Unsatisfactory patient experience not directly related to patient care	Unsatisfactory patient experience – readily resolvable	Mismanagement of patient care / breach of working practices	Serious mismanagement of patient care / breach of working practices	Totally unsatisfactory patient care / working practices
Complaint / Claim Potential	Locally resolved complaint	Justifiable complaint peripheral to clinical care	Justifiable complaint involving lack of appropriate care. Claim below excess	Multiple justifiable complaints. Claim above excess	Multiple claims or single major claim
Objectives / Projects	Insignificant cost increase / schedule slippage. Barely noticeable reduction in scope or quality	<5% over budget / schedule slippage. Minor reduction in quality / scope	5 – 10% over budget / schedule slippage. Reduction in scope or quality requiring client approval	10 – 25% over budget / schedule slippage. Does not meet secondary objective(s)	> 25% over budget / schedule slippage. Does not meet primary objectives
Service / Business Interruption	Loss / interruption < 1 hour	Loss / interruption >1 hour and < 8 hours	Loss / interruption > 8 hours and < 24 hours	Loss / interruption > 24 hours and < 1 week	Loss / interruption > 1 week
Human Resources / Organisational Development	Short term low staffing level temporarily reduces service quality (< 1 day)	Ongoing low staffing level reduces service quality	Late delivery of key objective / service due to lack of staff (recruitment, retention or sickness). Minor error due to insufficient training. Ongoing unsafe staffing level(s)	Uncertain delivery of key objective / service due to lack of staff (recruitment, retention or sickness). Serious error due to insufficient training.	Non delivery of key objective / service due to lack of staff. Very high turnover. Critical error due to insufficient training.
Financial	Small loss (< £100)	Loss > 0.1% of budget or > £100 and < £1,000	Loss > 0.25% of budget or > £1,000 and < £5,000	Loss > 0.5% of budget or > £5,000 and < £10,000	Loss > 1% of budget or > £10,000
Inspection / Audit	Minor recommendations. Minor non-compliance with standards	Recommendations given. Non-compliance with standards	Reduced rating. Challenging recommendations. Non-compliance with core standards. Reportable to associated external /statutory agencies	Enforcement action. Low rating. Critical report. Multiple challenging recommendations. Major non-compliance with standards	Prosecution Zero rating. Severely critical reports.
Adverse Publicity / Reputation	Rumours	Local Media – short term. Minor effect on staff morale.	Local Media – long term. Significant effect on staff morale.	National Media < 3 days. Local MP concern	National Media > 3 days. National MP concern (questions in House)

Probability/Likelihood

	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency	Not expected to occur annually	Expected to occur at least annually	Expected to occur at least every 6 months	Expected to occur at least monthly	Expected to occur at least weekly
Probability	< 1%	1 – 5%	6 – 25%	26 – 60%	> 60%
	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not

Risk Colour	Risk Level
Green 1 to 3	**Low**
Yellow 4 to 6	**Moderate**
Orange 8 to 12	**Significant**
Red 15 to 25	**High**

Gross Risk Rating - Without any controls in place
Net Risk Rating - With controls in plance-
Target Risk - Rating the Trust taget to achieve or accept (Also knowk as Residual Risk)

6 Audit Commission

- Audit Progress Report - 2008/09

London Ambulance Service
NHS Trust

Audit Committee Front Sheet

Title: Audit Commission Progress Report	**Agenda Item: 6** **Enclosure: 3**
The attached progress report is from the external auditor, with an update on progress against the 2008/09 audit plan.	
Purpose: The purpose of this paper is to provide the Audit Committee with a report on progress in delivering our responsibilities as the Trust's external auditor, in line with the Audit Plan for 2008/09	
Summary: Progress report contains reference to: Annual Governance Report – issues coming out of the 2008/09 statement of accounts audit. 2009/10 audit fee and plan	
Recommendations/and or actions required: Note items within Annual Governance Report that impact on 2008/09 statement of accounts. Approval of 2009/10 audit fee and plan	
Author and Date: Dominic Bradley 29 May 2009	

Progress Report

London Ambulance Service NHS Trust

Audit 2008/09

June 2009

The Audit Commission's
Trust Practice

audit commission

Contents

Status of our reports

The Statement of Responsibilities of Auditors and Audited Bodies issued by the Audit Commission explains the respective responsibilities of auditors and of the audited body. Reports prepared by appointed auditors are addressed to non-executive directors/members or officers. They are prepared for the sole use of the audited body. Auditors accept no responsibility to:

- any director/member or officer in their individual capacity; or
- any third party.

Progress update

Introduction

1 The purpose of this paper is to provide the Audit Committee with a report on progress in delivering our responsibilities as the Trust's external auditor, in line with the Audit Plan for 2008/09, which was agreed on 16 June 2008. See Appendix 1, Table 1.

2 This update also highlights key emerging national issues and developments which may be of interest to members of the Committee. We also set out for the Committee's attention a brief summary of reports issued by the Audit Commission in the last few months which are relevant to this Trust.

3 If you require any additional information regarding the issues included within this briefing, please contact your Engagement Lead or Engagement Manager using the contact details at Appendix 1, Table 2 of this update.

Summary of progress

4 The last meeting of the Audit Committee was on 9 March 2009. Since that meeting, we have carried out the following areas of work with the Trust.

Financial statements in 2008/09

5 The Annual Governance Report sets out the issues that we found in the course of our audit.

6 We have completed our triennial review of the Internal Audit function, and it is our view that Internal Audit are meeting the required NHS internal audit standards.

Auditor Local Evaluation (ALE)

7 We have concluded the first part of the 2009 ALE assessment for the sections on internal control, financial management and value for money and this has now been through our regional and national quality control process.

8 The Trust provided a good standard of evidence for each area and two good Financial Management Notable Practice examples that will increase the score of financial management to a level 4. Internal control and Value for Money remain unchanged at level 3. It should be noted that these scores are not final at this stage.

9 We will complete the remaining sections of ALE; financial reporting and financial standing, as we complete the statements audit.

2009/10 plan and fee

10 The 2009/10 audit fee, set at £136,000 (£131,325 in 2008/09) has been agreed with the Director of Finance and is presented to the Audit Committee for approval.

11 The fee letter has been included separately alongside this progress report.

12 The fee is based on the risk-based approach to audit planning as set out in the Code of Audit Practice and work mandated by the Audit Commission for 2009/10.

13 Effectively, this means that we are not issuing a detailed audit plan as such at this stage. Our work in the preceding accounts often identifies any major risks that should go into the planned year ahead. Essentially, the audit of 2008/09 will feed into the 2009/10 audit plan, and an updated 2009/10 plan will be issued in November 2009.

Other matters of interest

14 This section updates Audit Committee members on recent national publications by the Audit Commission and other key emerging national issues and developments which may be of interest to the Committee.

NHS Trust accounts guidance

15 In 2007, the HFMA and the Audit Commission published NHS Trust accounts: A guide for non-executives. The guide was developed to help non-executive directors understand, draw conclusions and ask pertinent questions about a trust's accounts, and are a useful tool in getting to grips with the primary financial statements.

16 An update to the guide has been produced in April 2009 to complement the original guides, describing the main changes to the accounts since publication and including additional questions for non-execs to assure themselves that the financial statements represent a true and fair view of the organisation's finances.

17 See link for reports via the Audit Commission website:

http://www.audit-commission.gov.uk/reports/NATIONAL-REPORT.asp?CategoryID=&ProdID=EC02B700-7225-4cd4-922E-807C919FDA9F&fromREPORTSANDDATA=NATIONAL-REPORT

National Fraud Initiative 2008/09

18 Participating bodies received the majority of the results for National Fraud Initiative 2008/09 on 11 February 2009 via the Audit Commission's secure on-line NFI website. Any matches to the 'deceased data' provided by the Department of Work and Pensions will be made available in mid March.

19 This exercise takes place every two years and, to date, an estimated £450 million of fraud and overpayments have been identified - with £140 million being identified in 2006/07 alone.

20 The Audit Commission has recently published the first edition of its newsletter for 2008/09 - NFI Matters - and this, together with other helpful NFI documents, is available on our website.

21 In order to derive the maximum benefits from this important exercise, Trusts should develop a plan to ensure that any issues raised are appropriately reviewed.

Costs of the transition to IFRS

22 The Audit Commission is to use savings from its efficiency programme to help organisations with the cost of moving to the International Financial Reporting Standards (IFRS).

23 The package, worth £3.3 million, is designed to cover the transitional costs of moving to the new standard which the government requires of all public bodies. It will be funded from reductions in the cost of the Audit Commission's operations.

24 NHS trusts are first in line to move to the International Financial Reporting Standard and will receive a one-off rebate in December 2009.

ALE in 2009/10

25 The Auditors' Local Evaluation (ALE) work will be more risk-based in 2009/10 and auditors will not re-assess a theme in which the score was either a 3 or a 4 in 2008/09.

26 However, to guard against an undetected deterioration in performance, it is proposed that auditors will keep a number of key issues or 'triggers' under review.

27 If one of these triggers indicates that a Trust may not be performing at the level evident in 2008/09 then auditors will carry out appropriate work on that theme in 2009/10.

28 The Audit Commission will shortly be consulting trusts on the key lines of enquiry and assurances for 2009/10 and also on the new risk based approach to ALE.

Appendix 1 – 2008/09 audit timetable and audit contacts

Table 1 Proposed 2008/09 audit timetable

Report	Date of issue
2008/09 Audit plan	16 June 2008
Pre-statements interim audit memorandum (oral)	09 March 2009
Report on financial statements to those charged with governance (Annual Governance Report)	08 June 2009
Opinion on the financial statements and Value for Money conclusion	12 June 2009
Final accounts memorandum	10 July 2009
Auditor's Local Evaluation	07 September 2009
Annual Audit letter	07 September 2009
Estates Report	07 September 2009
CAD2010	07 September 2009
E-procurement	07 September 2009

Table 2 Contact details

Name	Telephone	Email
Philip Johnstone Engagement Lead	0844 798 2895	p-johnstone@audit-commission.gov.uk
Dominic Bradley Engagement Manager	0844 798 2608	d-bradley@audit-commission.gov.uk

The Audit Commission

The Audit Commission is an independent watchdog, driving economy, efficiency and effectiveness in local public services to deliver better outcomes for everyone.

Our work across local government, health, housing, community safety and fire and rescue services means that we have a unique perspective. We promote value for money for taxpayers, auditing the £200 billion spent by 11,000 local public bodies.

As a force for improvement, we work in partnership to assess local public services and make practical recommendations for promoting a better quality of life for local people.

Copies of this report

If you require further copies of this report, or a copy in large print, in Braille, on tape, or in a language other than English, please call 0844 798 7070.

For further information on the work of the Commission please contact:

Audit Commission, 1st Floor, Millbank Tower, Millbank, London SW1P 4HQ

Tel: 0844 798 1212, Fax: 0844 798 2945, Textphone (minicom): 0844 798 2946

www.audit-commission.gov.uk

6 Audit Commission

- Annual Governance Report – Audit 2008/09

Annual Governance Report

London Ambulance Service NHS Trust

Audit 2008/09

Date **08 June 2009**

Contents

2008/09 Annual Governance Report

I am pleased to present the final version of my report on the results of my audit work for 2008/09.

A draft of the report was discussed and agreed with the Chief Executive and Director of Finance on 28 May 2009 and has been updated since as issues have been resolved.

The report sets out the key issues that you should consider before I complete the audit.

It asks you to:

- consider the matters raised in the report before approving the financial statements (pages 6 to 9);
- take note of the adjustments to the financial statements which are set out in this report (Appendix 2);
- agree to adjust the errors in the financial statements I have identified which management has declined to amend or set out the reasons for not amending the errors (Appendix 3);
- approve the letter of representation on behalf of the Trust before I issue my opinion and conclusion (Appendix 4); and
- agree your response to the proposed action plan (Appendix 6).

Yours faithfully

Philip Johnstone
District Auditor
08 June 2009

Key messages

This report summarises the findings from our 2008/09 audit which is substantially complete. It includes the messages arising from my audit of your financial statements and the results of the work I have undertaken to assess your arrangements to secure value for money in your use of resources.

Financial Statements	Results	Page
Unqualified audit opinion	Yes	6
Financial statements free from error	No	6
Adequate internal control environment	Yes	7
Value for money	**Results**	**Page**
Adequate arrangements to secure value for money	Yes	9

Audit opinion

1 Subject to satisfactory clearance of outstanding matters, I plan to issue an audit report including an unqualified opinion on the financial statements.

Financial statements

2 The financial statements were submitted to audit a day before the deadline, and did not contain any material or significant errors. Three non-trivial errors were identified, which officers have amended and one non-trivial error that has not been amended. See Appendix 2 (adjusted misstatements) and Appendix 3 (unadjusted misstatements).

3 The use of the register of interests and the controls surrounding stock were found to be weak. An extrapolated position was identified for the stock overstatement, but this has not been adjusted in the statements. See Appendix 3.

4 A number of trivial amendments have also been made by officers and these will be reported in full, in the course of our accounts memo.

Value for money

5 I intend to issue an unqualified conclusion stating that the Trust had adequate arrangements to secure economy, efficiency and effectiveness in the use of resources.

Next steps

This report identifies the key messages that you should consider before I issue my financial statements opinion, value for money conclusion, and audit closure certificate. It includes only matters of governance interest that have come to my attention in performing my audit. My audit is not designed to identify all matters that might be relevant to you.

6 I ask the Audit Committee to:

- consider the matters raised in the report before approving the financial statements (pages 6 to 9);
- take note of the adjustments to the financial statements which are set out in this report (Appendix 2);
- agree to adjust the errors in the financial statements I have identified which management has declined to amend or set out the reasons for not amending the errors (Appendix 3);
- approve the letter of representation on behalf of the Trust before I issue my opinion and conclusion (Appendix 4); and
- agree your response to the proposed action plan (Appendix 6).

Financial statements and statement on internal control

The Trust's financial statements and statement on internal control are important means by which the Trust accounts for its stewardship of public funds. As Directors you have final responsibility for these statements. It is important that you consider my findings before you adopt the financial statements and the statement on internal control.

Opinion on the financial statements

7 Subject to satisfactory clearance of outstanding matters, I plan to issue an audit report including an unqualified opinion on the financial statements. Appendix 1 contains a copy of my draft audit report.

Errors in the financial statements

8 The Trust had overprovided by including part of the NHS Litigation Authority liability as well as the Trust's own liability in their provision. The provision, and corresponding debtor, was reduced by £318,000 in the balance sheet. Also, amendment to the Income and Expenditure account by £187,000 by removing the income which had been incorrectly recognised in the overprovision and the corresponding £187,000 anticipated initial expense on the part of the Trust.

9 There were some re-categorisations within the cash flow statement due to errors noted in compilation of note 1 to cash flow statement which had been wrongly adjusted. These can be summarised between net cash flow for operating activities £1.366 million, payments to acquire tangible fixed assets (£1.321 million) and receipts from sale of tangible fixed assets (£45,000). The cash flow statement has now been amended.

10 There was £318,000 understatement of excess depreciation transferred between the revaluation reserve and the Income & Expenditure reserve. This was identified by the Trust when the working papers were put together after the financial statements had been submitted. The amendment to the revaluation reserve and corresponding adjustment to the Income & Expenditure reserve has been made.

Unadjusted errors in the financial statements

11 The Trust has overprovided the provision against the HMRC subsistence claim, which PWC has estimated at £590,000. The Trust does not wish to amend to this figure and

has kept a provision in the accounts of £1 million. This is because the Trust considers that they would be left with any additional cost if the final figure should prove to be above the PWC balance, as the Trust would find it difficult to ask the PCTs for further funding if they were to state a lower figure in their statements.

12 It is a mandatory audit requirement to attend the year end stock count where stock is material. The Trust has a high turnover of stock, which makes prediction of the year end balance difficult. The Trust though did not make us aware that they had much higher levels of training related stock this year. This, together with the natural fluctuation in stock, contributed to the stock balance just being material at year end. However, the Trust did not inform us until the accounts were submitted to the auditor on 22 April 2009.

13 Consequently, we had to undertake a stock take on 28 April and attempt to reconcile the snapshot back to the position at 31 March 2009. A number of errors were found which totalled £6,000 under-counted and £12,000 over-counted, netting to a £6,000 overstated position. If this error is extrapolated across the whole stock population, there is an £85,000 overstated position. This has not been adjusted in the statements but has been reflected in Appendix 3 (unadjusted mistatements).

14 The control issues we found during the stock process have been set out under other matters to report to you.

Material weaknesses in internal control

15 We have not identified any weakness in the design or operation of an internal control that might result in a material error in your financial statements of which you are not aware.

16 We have not provided a comprehensive statement of all weaknesses which may exist in internal control, or of all improvements which may be made. We have reported only those matters which have come to our attention because of the audit procedures we have performed.

Other matters to report to you

17 During the stock take process, it was noted that the controls around non-drug items were weak. The following errors and control issues were found:

- Not all paperwork could be found to verify that individual items had been issued.
- Where an Ambulance is sent out with a 'complete kit', a number of lines within the stock sheets were not annotated as being 'taken' despite logistics officers being certain that they would not have been issued without these key items. One station later confirmed they had been issued with an item, even though the paperwork was left blank as if it had not been issued.
- There were 3 'stock counting errors' from the year end exercise, which had been undercounted / over counted, where there was no movement of stock either in or out to explain the difference.

- There was a mis-categorisation between two items that looked similar in the store room
- One example of double counting of an item, where it appeared on the stock sheets in two different places.

18 It should be noted that the controls around stored drugs were good, and that no errors were found during the stock count of drugs.

19 Our review of the register of interests found that the register of interest was not being used in an appropriately robust way:

- There were several entries added just before hand over to us, of which the action and date information were not always legible.
- No action of review by a suitable senior member of staff to ensure any necessary action is taken.

Recommendation	
R1	Implement electronic bar coded stock controls in all stock areas, in a similar vein to the existing (Integra) drug stock system.
R2	Regularly update the register of interests. Review should be undertaken by a suitable senior member of staff to ensure that any necessary action is taken.

Letter of representation

20 Before I issue my opinion, auditing standards require me to obtain appropriate written representations from you and management about your financial statements and governance arrangements. Appendix 4 contains the draft letter of representation I seek to obtain from you.

Key areas of judgement and audit risk

21 In planning our audit we identified specific risks and areas of judgement that we have considered as part of our audit. Our findings are set out in Table 1.

Table 1 Key areas of judgement and audit risk

Issue or risk	Finding
The Trust's treatment of Mercedes leases in 2007/08 resulted in an amendment from creditors to provisions in the statement of accounts that was close to being material. The provision was based on estimates and subject to a number of variable factors. The provision in 2008/09 may require further changes as information is updated.	The Mercedes lease provision has been updated for the latest information, and our review of the latest position found that there was an increase of £450,000 in the provision, which reflects more up to date estimates. The accounting treatment behind the provision remains unchanged.

Value for money

I am required to conclude whether the Trust put in place adequate corporate arrangements for securing economy, efficiency and effectiveness in its use of resources. This is known as the value for money conclusion. My conclusion is informed by my work on the scored use of resources judgement.

Value for money conclusion

22 I assess your arrangements to secure economy, efficiency and effectiveness in your use of resources against 12 criteria specified by the Audit Commission. Our conclusions on each of the 12 areas are set out in Appendix 5.

23 I intend to issue an unqualified conclusion stating that the Trust had adequate arrangements to secure economy, efficiency and effectiveness in the use of resources. Appendix 1 contains the wording of my draft report.

Appendix 1 – Independent auditor's report to the Board of Directors of London Ambulance Service NHS Trust

Opinion on the financial statements

I have audited the financial statements of London Ambulance Service NHS Trust for the year ended 31 March 2009 under the Audit Commission Act 1998. The financial statements comprise the Income and Expenditure Account, the Balance Sheet, the Cashflow Statement, the Statement of Total Recognised Gains and Losses and the related notes. These financial statements have been prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service set out within them. I have also audited the information in the Remuneration Report that is described as having been audited.

This report is made solely to the Board of Directors of London Ambulance Service NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 36 of the Statement of Responsibilities of Auditors and of Audited Bodies prepared by the Audit Commission.

Respective responsibilities of Directors and auditor

The directors' responsibilities for preparing the financial statements in accordance with directions made by the Secretary of State are set out in the Statement of Directors' Responsibilities.

My responsibility is to audit the financial statements in accordance with relevant legal and regulatory requirements and International Standards on Auditing (UK and Ireland).

I report to you my opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England. I report whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England. I also report to you whether, in my opinion, the information which comprises the commentary on the financial performance included within the Operational and Financial Review [included in the Annual Report, is consistent with the financial statements.

I review whether the directors' Statement on Internal Control reflects compliance with the Department of Health's requirements, set out in 'Guidance on Completing the Statement on Internal Control 2008/09' issued 25 February 2009. I report if it does not meet the requirements specified by the Department of Health or if the statement is misleading or inconsistent with other information I am aware of from my audit of the financial statements. I am not required to consider, nor have I considered, whether the directors' Statement on Internal Control covers all risks and controls. Neither am I required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. This other information, comprising the Foreword, the unaudited part of the Remuneration Report, the Chairman's Statement and the remaining elements of the Operating and Financial Review included in the Annual Report, is consistent with the financial statements. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinion

I conducted my audit in accordance with the Audit Commission Act 1998, the Code of Audit Practice issued by the Audit Commission and International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements and the part of the Remuneration Report to be audited. It also includes an assessment of the significant estimates and judgments made by the directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that:

- the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error; and
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared.

In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report to be audited.

Opinion

In my opinion:

- the financial statements give a true and fair view, in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England, of the state of the Trust's affairs as at 31 March 2009 and of its income and expenditure for the year then ended;

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England; and
- information which comprises the commentary on the financial performance included within the Operational and Financial Review, included within the Annual Report, is consistent with the financial statements.

Conclusion on arrangements for securing economy, efficiency and effectiveness in the use of resources

Directors' Responsibilities

The directors are responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance and regularly to review the adequacy and effectiveness of these arrangements.

Auditor's Responsibilities

I am required by the Audit Commission Act 1998 to be satisfied that proper arrangements have been made by the Trust for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires me to report to you my conclusion in relation to proper arrangements, having regard to the criteria for NHS bodies specified by the Audit Commission. I report if significant matters have come to my attention which prevent me from concluding that the Trust has made such proper arrangements. I am not required to consider, nor have I considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Conclusion

I have undertaken my audit in accordance with the Code of Audit Practice and having regard to the criteria for NHS bodies specified by the Audit Commission and published in December 2006, I am satisfied that, in all significant respects, London Ambulance Service NHS Trust made proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2009.

Certificate

I certify that I have completed the audit of the accounts in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Philip Johnstone

District Auditor

Appendix 1 – Independent auditor's report to the Board of Directors of London Ambulance Service NHS Trust

Audit Commission

First Floor Millbank Tower

Millbank

London

SW1P 4HQ

xx June 2009

Appendix 2 – Adjusted amendments to the accounts

The following misstatements were identified during the course of my audit and the financial statements have been adjusted by management. I bring them to your attention to assist you in fulfilling your governance responsibilities.

Table 2

		Income and Expenditure Account		Balance Sheet	
Adjusted misstatements	**Nature of Adjustment**	**Dr £000s**	**Cr £000s**	**Dr £000s**	**Cr £000s**
Provisions	Overprovision as some NHSLA liability had been recognised, as well as the Trust's liability. Debtors	187	187	318	318
Revaluation Reserve	Excess depreciation from Revaluation Reserve now transferred to I&E reserve.			318	318
Intangible / tangible fixed assets	Reclassification from tangible fixed assets to intangible fixed assets.			69	69

		Cashflow	
Adjusted misstatements	**Nature of Adjustment**	**Negative**	**Positive**
cash-flow statement	net cashflow for operating activities		1,366
cash-flow statement	payments to acquire tangible fixed assets	1,321	
cash-flow statement	receipts from sale of tangible fixed assets	45	

Appendix 3 – Unadjusted misstatements in the accounts

The following misstatements were identified during the course of my audit and the financial statements have not been adjusted by management. I bring them to your attention to assist you in fulfilling your governance responsibilities. If you decide not to do so, please tell us why in the representation letter. If you believe the effect of the uncorrected errors, individually and collectively, is immaterial, please reflect this in the representation letter. Please attach a schedule of the uncorrected errors to the representation letter.

Table 3

Description of error	Accounts effected	Value of error or uncertainty £000
Provisions: Overprovision in accounts for HMRC.	Provisions and debtors.	£410 overstated.
Stock errors - over and under counting - net overstated effect.	Stock and expenditure.	£85 overstated if extrapolated.

Appendix 4 – Draft letter of representation

Draft management representation letter

To: Philip Johnstone

District Auditor

Audit Commission

1st Floor, Millbank Tower

Millbank

London

SW1P 4HQ

London Ambulance Service NHS Trust - Audit for the 2008/09 ended 31 March 2009.

I confirm to the best of my knowledge and belief, having made appropriate enquiries of other directors and officers of London Ambulance Service NHS Trust, the following representations given to you in connection with your audit of the Trust's financial statements for the 2008/09 year ended 31 March 2009.

Compliance with the statutory authorities

I acknowledge my responsibility under the relevant statutory authorities for preparing the financial statements in accordance with the NHS Manual for Accounts which present fairly/ give a true and fair view of the financial position and financial performance of the Trust and for making accurate representations to you.

Uncorrected misstatements

I confirm that I believe that the effects of the uncorrected financial statements misstatements listed below are not material to the financial statements. This misstatement has been discussed with those charged with governance within the Trust and the reason for not correcting this item is as follows;

- The Provision for HMRC liability
- Stock overstated

Supporting records

All the accounting records have been made available to you for the purpose of your audit and all the transactions undertaken by the Trust have been properly reflected and recorded in the accounting records. All other records and related information, including minutes of all Board and Audit Committee meetings, have been made available to you.

Going Concern

I am satisfied that it is appropriate to adopt the going concern basis in the preparation of the financial statements and that the financial statements include, such disclosures, if any, relating to going concern.

Irregularities

I acknowledge my responsibility for the design and implementation of internal control systems to prevent and detect fraud or error.

There have been no:

- irregularities involving management or employees who have significant roles in the system of internal accounting control;
- irregularities involving other employees that could have a material effect on the financial statements; or
- communications from regulatory agencies concerning non-compliance with, or deficiencies on, financial reporting practices which could have a material effect on the financial statements.
- I also confirm that I have disclosed:
- my knowledge of fraud, or suspected fraud, involving either management, employees who have significant roles in internal control or others where fraud could have a material effect on the financial statements; and
- my knowledge of any allegations of fraud, or suspected fraud, affecting the entity's financial statements communicated by employees, former employees, analysts, regulators or others.

Law, regulations, contractual arrangements and codes of practice

There are no instances of non-compliance with laws, regulations and codes of practice, likely to have a significant effect on the finances or operations of the Trust.

Fair Values

I confirm the reasonableness of the significant assumptions within the financial statements. For financial instruments and the value of leases, I confirm:

- the appropriateness of the measurement method;
- the basis used by management to overcome the presumption under the financial reporting framework;

- the completeness and appropriateness under the financial reporting framework; and
- if subsequent events require adjustment to the fair value measurement.

Assets

The following have been properly recorded and, where appropriate, adequately disclosed in the financial statements:

- losses arising from sale & purchase commitments;
- agreements & options to buy back assets previously sold; and
- assets pledged as collateral.

Compensating arrangements

There are no formal or informal compensating balancing arrangements with any of our cash and investment accounts. Except the bank overdraft disclosed in Note 19.3 to the financial statements, we have no other lines of credit arrangements.

Contingent liabilities

There are no other contingent liabilities, other than those that have been properly recorded and disclosed in the financial statements. In particular:

- there is no significant pending or threatened litigation, other than those already disclosed in the financial statements;
- there are no material commitments or contractual issues, other than those already disclosed in the financial statements; and
- no financial guarantees have been given to third parties.

Related party transactions

I confirm the completeness of the information disclosed regarding the identification of related parties.

The identity of, and balances and transactions with, related parties have been properly recorded and where appropriate, adequately disclosed in the financial statements

Post balance sheet events

Since the date of approval of the financial statements by the Audit Committee, no additional significant post balance sheet events that have occurred which would require additional adjustment or disclosure in the financial statements.

The Trust has no plans or intentions that may materially alter the carrying value or classification of assets and liabilities reflected in the financial statements.

Appendix 4 – Draft letter of representation

Signed on behalf of London Ambulance Trust

I confirm that this letter has been discussed and agreed by the Audit Committee on 08 June 2009.

Signed

Name	Peter Bradley	Mike Dinan	Caroline Silver
Position	Chief Executive	Director of Finance	Audit Committee Chairman

Date xx June 2009

Appendix 5 – Value for money criteria

Code Criteria	Description	Met
1	The body has put in place arrangements for setting, reviewing and implementing its strategic and operational objectives.	**Yes**
2	The body has put in place channels of communication with patients and their representatives, and other stakeholders including partners, and there are monitoring arrangements to ensure that key messages about services are taken into account.	**Yes**
3	The body has put in place arrangements for monitoring and scrutiny of performance, to identify potential variances against strategic objectives, standards and targets, for taking action where necessary, and reporting to the board.	**Yes**
4	The body has put in place arrangements to monitor the quality of its published performance information, and to report the results to board members.	**Yes**
5	The body has put in place arrangements to maintain a sound system of internal control.	**Yes**
6	The body has put in place arrangements to manage its significant business risks.	**Yes**
7	The body has put in place arrangements to manage and improve value for money.	**Yes**
8	The body has put in place a medium-term financial strategy, budgets and a capital programme that are soundly based and designed to deliver its strategic priorities.	**Yes**
9	The body has put in place arrangements to ensure that its spending matches its available resources. [For SHAs, to ensure that spending matches available resources across the health economy.]	**Yes**
10	The body has put in place arrangements for managing performance against budgets.	**Yes**

Appendix 5 – Value for money criteria

Code Criteria	Description	Met
11	The body has put in place arrangements for the management of its asset base.	**Yes**
12	The body has put in place arrangements that are designed to promote and ensure probity and propriety in the conduct of its business.	**Yes**

Appendix 6 – Action Plan

Page no.	Recommendation	Priority 1 = Low 2 = Med 3 = High	Responsibility	Agreed	Comments	Date
	Annual Governance Report 2008/09 - Recommendations					
8	Implement electronic bar coded stock controls in all stock areas, in a similar vein to the existing (Integra) drug stock system.	1	Director of Finance			
8	Regularly update the register of interests. Review should be undertaken by a suitable senior member of staff to ensure that any necessary action is taken.	2	Assistant Director of Finance			

6 Audit Commission

- Audit and Inspection Plan – 2009/10

The Audit Commission's
Trust Practice

audit commission

22 April 2009

Mr M Dinan
Director of Finance
London Ambulance Service NHS Trust
220 Waterloo Road
London
SE1 8SD

Direct line 0844 798 2881
E-mail p-johnstone@audit-commission.gov.uk

Dear Mike,

Annual audit fee 2009/10

Further to our discussions, I am writing to confirm the audit work that we propose to undertake for the 2009/10 financial year at London Ambulance NHS Trust. The fee is based on the risk-based approach to audit planning as set out in the Code of Audit Practice and work mandated by the Audit Commission for 2009/10.

As I have not yet completed my audit for 2008/09, the audit planning process for 2009/10, including the risk assessment, will continue as the year progresses and fees will be reviewed and updated as necessary.

2009/10 Fee

The total indicative fee for the audit for 2009/10 is for £136,000 (excluding VAT), which compares to the planned fee of £131,325 for 2008/09. A summary of this is shown in the table 1 below.

Table 1

Audit area	**Planned fee 2009/10**	**Planned fee 2008/09**
Financial statements	£101,270	£95,580
IFRS Restatement audits	£12,030	£0*
Use of Resources/ VFM Conclusion	£11,650	£20,600
Risk Based Performance Work	£11,050	£15,145
Total audit fee	**£136,000**	**£131,325**

** the planned fee did not include a circa £12,000 fee for IFRS restatements (arrangements) exercise that was undertaken in February and March 2009.*

The Audit Commission has published its work programme and scales of fees 2009/10. The Audit Commission scale fee for the Trust is £193,325. The fee proposed for 2009/10 has been set at 29.7% below the scale fee and will be billed in monthly instalments.

The increase in fee for the financial statements element of the audit reflects the costs of additional audit work arising from the introduction of International Financial Reporting Standards.

In setting the fee at this level, I have assumed that the general level of risk in relation to the audit of the financial statements is not significantly different from that identified to 2008/09. A separate plan for the audit of the financial statements will be issued in November 2009. This will detail the risks identified, planned audit procedures and any changes in fee. If I need to make any significant amendments to the audit fee during the course of the audit, I will first discuss this with you and then prepare a report outlining the reasons why the fee needs to change for discussion with the audit committee.

My work on use of resources informs my 2009/10 value for money conclusion. My initial risk assessment for value for money audit work is shown in table 2 below:

Table 2

Risk	Planned work	Timing of work
Benchmarking performance improvement to other ambulance trusts	Benchmarking national toolkit under improvement investigation.	November 2009 to March 2010

I will issue a separate project specification for the benchmarking review before beginning the work.

I will issue a number of reports relating to my work over the course of the audit. These are listed at Appendix 1.

The above fee excludes any work requested by you that the Commission may agree to undertake using its advice and assistance powers. Each piece of work will be separately negotiated and a detailed project specification agreed with you.

The key members of the audit team for the 2009/10 are:

Engagement Leader: Phil Johnstone 0844 798 2881

Engagement Manager: Dominic Bradley 0844 798 2608

I am committed to providing you with a high quality service. If you are in any way dissatisfied, or would like to discuss how we can improve our service, please contact me in the first instance. Alternatively you may wish to contact the London Head of Operations, Les Kidner.

Cost of Transition to IFRS

In recognition of the financial pressures that public bodies are facing in the current economic climate, the Commission has decided that it should rebate an element of the cost of transition to IFRS. For NHS bodies, the amount refunded will be 3 per cent of the scale fee as specified in the published work programme and scale fees for 2009/10. The Commission centrally is currently collecting information about NHS bodies planned gross revenue expenditure for 2009/10 and in June 2009 a schedule of rebates will be published. Payments will be made to NHS bodies in December 2009.

Yours sincerely

Philip Johnstone
District Auditor

cc Mr P Bradley, Chief Executive, London Ambulance NHS Trust

Ms C Sliver, Chairman of the Audit Committee, London Ambulance NHS Trust

Appendix 1: Planned outputs

Our reports will be discussed and agreed with the appropriate officers before being issued to the audit committee.

Table 1

Planned output	**Indicative date**
Audit plan	November 2009
Interim audit memorandum (oral)	April 2010
Annual governance report	June 2010
Auditor's report giving the opinion on the financial statements and value for money conclusion	June 2010
ALE report	August 2010
Annual audit letter	October 2010
Project specifications and reports	
Benchmarking	November 2009 - specification March 2010 - report

7 Internal Auditors' Report

- Internal Audit Progress Report

London Ambulance Service
NHS Trust

Audit Committee Front Sheet

Title: Internal Audit Progress Report	**Agenda Item: 7** **Enclosure: 6**

Purpose:

To update the committee on the key findings from Internal Audit.

Summary:

Four final Internal Audit reports are included within our progress report. Of these, two are limited assurance reports on Drugs and Policies and Procedures.

The Committee should pay particular attention to the drugs report, as this has highlighted a number of significant weaknesses with regards to the management of drug packs within the Trust, particularly with regards to the use of Out of Date packs, which increases the risk of out of date drugs being used on patients.

The Trust has taken prompt actions to address these issues, however these have impacted on the Standards for Better Health Declaration for 2008/09.

Conversely, the Standards for Better Health process within the Trust was found to be very robust and a number of areas of good practice were identified. Improvements in the process for the management of medical devices were also found in comparisons to previous audits.

Recommendations/and or actions required:

The Committee is asked to note the contents of this report and assure themselves that sufficient actions are being taken by management to address the weaknesses identified.

Author and Date:

Chris Rising, RSM Bentley Jennison

28th May 2009.

RSM Bentley Jennison

London Ambulance Service NHS Trust

Internal Audit Progress Report

Audit Committee Meeting – June 2009

Contents

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1. Introduction

1.1 The periodic internal audit plan for 2008/09 was approved by the Audit Committee in November 2008 and the plan for 2009/10 in March 2009. This report summarises the outcome of work completed to date against these plans.

2. Final Reports Issued

2.1 We have issued four final reports since the last Audit Committee from the 2008/09 Internal Audit Plan, these being in the areas of:

- 8.08/09 Policies and Procedures
- 11.08/09 Medical Devices
- 12.08/09 Standards for Better Health
- 13.08/09 Drug Controls

3. Key Findings from Internal Audit Work

3.1 The following issues have been identified in respect of these audits:-

Policies and Procedures: Limited assurance provided. The following key issues were identified as part of our audit:

- The Trust has recently implemented a new standard corporate format to be applied to all policies and procedures, which includes a document profile and control page; however, testing showed that this has not yet been utilised for all policies and procedures. There is a risk that policies will not be reviewed, approved and ratified on a timely basis. The corporate format also has the advantage of ensuring consistency and increased understanding.
- The standard corporate format also includes an implementation plan which a number of policies and procedures do not yet incorporate. This could lead to them not being disseminated to staff appropriately, not being communicated clearly, inadequate training being provided to staff and ultimately in them being insufficiently monitored.
- A number of policies and procedures have not gone through the process of ratification or do not have an indicated date of ratification which could lead to them being used prior to sanctioning;
- The Equality and Diversity and Employment policy which was due to be reviewed in June 2008, has yet to be reviewed because the new Diversity Manager has only recently started in post;
- The RIB is an important and vital communication channel, to staff, of policies and procedures. It is normal policy to announce new and revised policies and procedures in the RIB although this could not be tracked for some of them A number of policies and procedures have not been communicated on the RIB. Once policies and procedures are approved an announcement on the RIB should be made to LAS staff to ensure they are aware of them being distributed.

- The Trust does not hold any records of staff having read and accepted key policies and procedures. This acceptance of having read policies maintains a log of who has read, understood and accepted the policies and procedures.

Medical Devices: Adequate Assurance Provided. This represents an improvement on previous audits for this area. The following key issues were identified:

- 22 of 56 vehicles tested where recorded as ready for use, however these vehicles contained unsealed PALs Packs. If packs are not sealed then this increases the risk of devices falling out of storage compartments and becoming either damaged or contaminated.
- At 1 station, 1 item of medical equipment awaiting repair had not been thoroughly cleaned. This increases the risk of cross-contamination of other devices.

Standards for Better Health: It was confirmed that the Trust has established god processes for the completion of the annual healthcare declaration and a number of areas of good practice were identified as part of our review.

Drug Controls: Limited Assurance provided. The following key issues were identified as part of our audit:

- Testing undertaken as part of the audit identified fundamental weaknesses in the control over drug packs, particularly in respect of the management of out of date drug packs. Testing identified that packs are not being returned on a timely basis. In addition, due to shortages in the numbers of drug packs in the system, it was identified that return drug pack lockers at two stations had been opened to enable access to used packs to address shortages at individual stations. Finally, it was noted that at least 6 drugs packs returned to Logistics in January 2009 were over a year out of date, the oldest of which went out of date in 2006. All of the above increases the risk that out of date drugs may be used by Trust staff. The Trust therefore needs to review as a matter of urgency the numbers of drug packs in circulation within the Trust, the processes for the issue and return of the these packs to ensure that a) there are sufficient numbers of drug packs in circulation and b) that only new packs are used by staff and that all used or out of date drug packs are returned to logistics on a timely basis.
- As weaknesses have been identified within this audit in respect of the storage of drugs and the use of completed or out of date drug packs, the Trust needs to consider whether it should be declaring itself non-compliant in respect of the Standards for Better Health declaration.
- Finally, it was noted that serious untoward incidents in respect of drug errors are not formally reported to the Board via the report of the Medical Director. The introduction of reporting against this would ensure that the Board are made aware of any trends in the numbers of drug errors and can ensure that suitable actions are taken in respect of this.

4. Draft Reports & Work in Progress

4.1 We have issued five draft reports since the last Committee meeting; these are in the areas of:

- Payroll

- Training and Development
- Strategic Planning – Programme Management Arrangements
- Assurance Framework
- Follow Up

4.2 The following audits are in varying stages of progress:-

- Incident Reporting
- Information Governance
- Risk Maturity

4.3 To enhance the audit process, scoping meetings are being held with the Lead Directors for each of the audits on the plan to agree the detailed scope for each of our reviews and the timings as to when these reviews will take place. A number of these have already taken place, with the remainder planned over the next few weeks.

5. Health Sector Guidance

5.1 We have attached as Appendix C, the client briefings that have been issued since the last Audit Committee for your reference.

Appendix A: Operational Plan Performance 2008/09

Detailed below is a summary of the work undertaken in 2008/09 to date, showing the levels of assurance given and the number of recommendations arising. Reports being considered at this Committee are shown in italics. Definitions with regard to the levels of assurance and the classification of recommendations are provided overleaf.

	Auditable Area	Start Date	Debrief date	Draft report issued	Responses received	Final report issued	Audit Committee	Audit approach	Days	Assurance level given	Number of Recommendations Made				
							Actual (Planned)		Planned		F	S	MA	In Total	Agreed
	Medical Devices	12.2.09	23.2.09	12.3.09	27.5.09	28.5.09	June 2009	Systematic	10	Adequate	0	2	3	5	5
	Incident Reporting	24.4.09						Systematic	7						
	Drug Controls	*2.2.09*	*23.2.09*	*13.3.09*	*28.4.09*	*28.4.09*	*June 2009*	Systematic	*10*	*Limited*	*5*	*2*	*0*	*7*	*7*
	Child Protection	2.2.09	Audit deferred until 2009/10 and included within 2009/10 audit plan						9						
	Strat Planning	2.3.09	9.3.09	17.3.09				Systematic	8						
	Training and Development	5.1.09	261.09	20.2.09				Systematic	6						
	Performance Management	20.3.09	Audit deferred to 2009/10 and included within 2009/10 audit plan					Systematic	8						
Finance Systems	General Ledger	27.10.08	31.10.08	17.11.08	2.12.08	2.12.08	March 2009	Systematic	5	Substantial	0	0	2	2	2
	Creditors	13.10.08	17.10.08	4.11.08	16.12.08	17.12.08	March 2009	Systematic	6	Substantial	0	0	3	3	3
	Debtors	20.10.08	24.10.08	17.11.08	11.2.09	11.2.09	March 2009	Systematic	5	Adequate	0	1	0	1	1
	Treasury Management	8.12.08	10.12.08	22.12.08	11.2.09	11.2.09	March 2009	Systematic	5	Substantial	0	0	0	0	0
	Asset Register	27.11.08	28.11.08	16.12.08	17.12.08	17.12.08	March 2009	Systematic	5	Substantial	0	0	2	2	2
	Payroll	2.2.09	10.2.09	17.2.09				Systematic	6						
	Budgetary Control	24.11.08	28.11.08	3.12.08	4.1.09	5.1.09	March 2009	Systematic	6	Substantial	0	1	1	2	2
	Assurance Framework	2.3.09	29.5.09					Key Controls	4						
	Standards for Better Health	2.3.09	4.3.09	13.3.09	22.5.09	28.5.09	June 2009	Key Controls	4	-	0	0	1	1	1
0 1	Risk Management	2.3.09						Thematic	8						

Auditable Area	Start Date	Debrief date	Draft report issued	Responses received	Final report issued	Audit Committee	Audit approach	Days	Assurance level given	Number of Recommendations Made				
						Actual (Planned)		Planned		F	S	MA	In Total	Agreed
Maturity Review														
Invest To Save	29.10.08	10.12.08	19.12.08	19.2.09	20.2.09	March 2009	Systematic	10	Adequate	0	5	4	9	9
CAD 20:10 Implementation	23.2.09	Review being undertaken by external audit					Systematic	8						
Governance - Policies and Procedures	13.1.09	19.1.09	5.2.09	27.5.09	28.5.09	June 2009	*Systematic*	6	Limited	0	6	3	9	9
PTS	2.3.09	Audit deferred until 2009/10						10						
Computer Audit	23.3.09	Audit deferred until 2009/10						15						
Information Governance	10.3.09						Systematic	8						
Workforce Planning	26.1.09	Audit deferred until 2009/10						8						
Follow Up	11.3.09	27.5.09	29.5.09					6	Reasonable	0				
Audit Management	Ongoing							15						

Appendix A: Operational Plan Performance 2009/10

Detailed below is a summary of the work undertaken in 2009/10 to date, showing the levels of assurance given and the number of recommendations arising. Reports being considered at this Committee are shown in italics. Definitions with regard to the levels of assurance and the classification of recommendations are provided overleaf.

	Auditable Area	Start Date	Debrief date	Draft report issued	Responses received	Final report issued	Audit Committee	Audit approach	Days	Assurance level given	Number of Recommendations Made				
							Actual (Planned)		Planned		F	S	MA	In Total	Agreed
	Medical Devices	18.1.10						Systematic	10						
	Complaints	25.8.09						Systematic	7						
	Drug Controls	3.08.09						Systematic	*10*						
	Performance Management	7.9.09						Systematic	10						
	Records Management	17.8.09						Systematic	7						
	CPD	4.1.10						Systematic	7						
	Child and Adult Protection	20.7.09						Systematic	8						
	Changes in Clinical Practice	13.8.09						Systematic	10						
	Business Continuity	21.10.09						Systematic	10						
	Computer Audit	TBA						Systematic	12						
Finance Systems	General Ledger	14.9.09						Systematic	5						
	Creditors	21.9.09						Systematic	6						
	Debtors	5.10.09						Systematic	5						
	Treasury Management	12.10.09						Systematic	5						
	Asset Register	2.11.09						Systematic	5						
	Payroll	9.11.09						Systematic	6						
	Budgetary Control	2.11.09						Systematic	6						

	Auditable Area	Start Date	Debrief date	Draft report issued	Responses received	Final report issued	Audit Committee	Audit approach	Days	Assurance level given	Number of Recommendations Made				
							Actual (Planned)		Planned		F	S	MA	In Total	Agreed
	Procurement	24.8.09						Systematic	6						
HoIA	Assurance Framework	7.12.09						Checklist	4						
	Standards for Better Health	28.9.09						Checklist	4						
	Risk Management	23.11.09						Checklist	8						
	Governance	7.12.09						Systematic	8						
	Make Ready	1.7.09						Systematic	6						
	Budget Forecasting	29.6.09						Systematic	6						
	Digital Radio Implementation	12.10.09						Systematic	8						
	Patient Transport Services	16.11.09						Systematic	7						
	New Ways of Working	9.11.09						Systematic	7						
	MPET	5.10.09						Systematic	6						
	Dangerous Addresses	18.2.10						Systematic	7						
	Follow Up	March 2010						Follow Up	6						
	Audit Management								15						

Appendix B: Executive Summaries and Action Plans

8.08/09 Policies and Procedures

Introduction

An audit of Policies and Procedures was undertaken as part of the approved internal audit periodic plan for 2008/09.

Policies and procedures are a vital part of an organisation. It facilitates all staff in carrying out their duties within agreed and suitable processes in addition to complying with legal and government legislations. Policies and Procedures ultimately allow management to guide operations; it ensures consistency and improves quality without the need for too much of their intervention. These advantages are the reasons why it is important that staff, specifically, operational staff are made well aware and are well informed, and well trained, of the policies and procedures that are applicable to their duties, roles and responsibilities.

We sampled ten policies and procedures across four categories (HR, Health & Safety, Trust wide and Operational) to verify that not only have they been updated, reviewed and approved but also that they have been communicated appropriately and are workable and understandable. The policies and procedures reviewed are:

- HS019 - Infection Control Manual
- HR05/07 - Equality and Diversity and Employment Policy
- HR08/01 - Disciplinary Policy
- TP/ 004 - Complaints Procedure
- TP/017 - Procedure for Health Records Used, Generated and Stored by the LAS
- OP/002 - Procedure covering the issue & use of drugs by LAS Staff. (POMs)
- OP/010 - High Risk Address Register Procedure:
- OP/ 014 Patient Hand Over Procedure
- OP/015 - Procedure for the Conveyance of Patients
- OP/016 - Procedures on Actions DIRECTLY Relating to the Patient

London Ambulance Service has made a concerted effort to ensure that all policies and procedures are added onto the intranet in a timely fashion so as to allow staff to refer to them as and when they wish. The main issue revolves around operational staff not having electronic access to these policies and procedures as due to the nature of their roles.

The specific risks considered as part of this audit is that key policies and procedures are not read by staff within the Trust. The risk relates to the objective of ensuring that all key policies and procedures are read, communicated and understood by all staff throughout the Trust.

Scope of the review

The objective of our audit was to evaluate the adequacy of risk management and control within the system and the extent to which controls have been applied, with a view to providing an opinion. Control activities are put in place to ensure that risks to the achievement of the organisation's objectives are managed effectively. When planning the audit, the following controls for review and limitations were agreed:

Control activities relied upon:

- Standardised Policy and Procedural guidance for developing policy and procedures;
- Review, Approval, Ratification of Policies and Procedures;
- Staff local induction provides them with adequate exposure to Policies and Procedures;
- Training/staff appraisals and CPD for each staff member;
- Communication of Policy and Procedures via the intranet and newsletters; and
- Incident Reporting;

Limitations to the scope of the audit:

- The audit will provide assurance over the processes in place for ensuring that policies and procedures are read and understood by all staff. It will not provide assurance over the content of individual policies and procedures or that all staff within the Trust are complying with every aspect of every policy.
- In addition, our work does not provide any guarantee against material errors, loss or fraud or provide an absolute assurance that material error, loss or fraud does not exist.

The approach taken for this audit was systematic Audit and included the following:

- Establishing the risks affecting the achievement of your corporate objectives
- Reviewing the adequacy and application of the controls in place to mitigate the risk(s)

Conclusion

Taking account of the issues identified, in our opinion the Board can take Limited assurance that the controls upon which the organisation relies to manage this risk, as currently laid down and operated, are effective.

This assurance level has been formulated on the basis of conclusions drawn on the individual elements of design and application of controls in place:

	SUBSTANTIAL	ADEQUATE	LIMITED
DESIGN OF CONTROL FRAMEWORK		X	
APPLICATION OF AND COMPLIANCE WITH CONTROL FRAMEWORK			X
OVERALL OPINION			X

The above conclusions feeding into the overall assurance level are based on the evidence obtained during the review. The key findings from this review are as follows:

- There is no centralised and comprehensive listing of all policies and procedures. This could assist in ensuring policies and procedures are updated and reviewed by due dates.
- The Trust has recently implemented a new standard corporate format to be applied to all policies and procedures, which includes a document profile and control page; however, testing showed that this has not yet been utilised for all policies and procedures. There is a risk that policies will not be reviewed, approved and ratified on a timely basis. The corporate format also has the advantage of ensuring consistency and increased understanding.
- The standard corporate format also includes an implementation plan which a number of policies and procedures do not yet incorporate. This could lead to them not being disseminated to staff appropriately, not being communicated clearly, inadequate training being provided to staff and ultimately in them being insufficiently monitored.
- A number of policies and procedures have not gone through the process of ratification or do not have an indicated date of ratification which could lead to them being used prior to sanctioning;
- The Equality and Diversity and Employment policy which was due to be reviewed in June 2008, has yet to be reviewed because the new Diversity Manager has only recently started in post;
- The RIB is an important and vital communication channel, to staff, of policies and procedures. It is normal policy to announce new and revised policies and procedures in the RIB although this could not be tracked for some of them A number of policies and procedures have not been communicated on the RIB. Once policies and procedures are approved an announcement on the RIB should be made to LAS staff to ensure they are aware of them being distributed.
- The Trust does not hold any records of staff having read and accepted key policies and procedures. This acceptance of having read policies maintains a log of who has read, understood and accepted the policies and procedures.
- Although training is adequate, it is best practise and advised that the Trust introduces a question and answer session, electronically i.e. E-Learning, to test operational staffs reading and understanding of the policies and procedures.
- The Trust currently does not report on the non compliance with policies and procedures. Although there are reports produced on incidents and that by its nature, at times bring up the subject of policies and procedures, it is not a comprehensive report. A clear and comprehensive link between incidents and non compliance of policies and procedures should be introduced and documented and reported so as to ensure adequate monitoring of the policy and procedures effectiveness, workability and whether they are adequately sufficient.

Further background to these findings and recommendations to address these issues are provided in Section 3 of this report.

Recommendations Summary

The following tables highlight the number and categories of recommendations made. The Action Plan at Section 2 details the specific recommendations made as well as agreed management actions to implement them.

Recommendations made during this audit:

Risk	Fundamental	Significant	Merits Attention

KEY POLICIES AND PROCEDURES ARE NOT READ BY STAFF WITHIN THE TRUST	0	6	3
TOTAL	0	6	3

Additional Feedback

GOOD PRACTICE IDENTIFIED DURING THE AUDIT
LAS have implemented a comprehensive standard format to their policies and procedure which describes in detail the approach to effective development, implementation, monitoring and review.
LAS is about to implement an "Operational Workplace Review" which consist of operational observation with feedback for staff to ensure they are supported in carrying out their duties, and also to update them in any new procedures, thereby achieving regular staff development on at least a six monthly basis.
Ambulance Operations Managers at each ambulance station are briefing operational staff of any updates to policies and procedures and notifying them of the importance of extracts of policies and procedures that must be adhered to.

2 Action Plan

The priority of the recommendations made is as follows:

FUNDAMENTAL	SIGNIFICANT	MERITS ATTENTION
ACTION IS IMPERATIVE TO ENSURE THAT THE OBJECTIVE FOR THE AREA UNDER REVIEW IS MET	REQUIRES ACTION TO AVOID EXPOSURE TO SIGNIFICANT RISK IN ACHIEVING THE OBJECTIVE FOR THE AREA UNDER REVIEW.	ACTION IS ADVISED TO ENHANCE CONTROL OR IMPROVE OPERATIONAL EFFICIENCY

REF	RECOMMENDATION	CATEGORISATION	ACCEPTED Y/N	MANAGEMENT COMMENT	IMPLEMENTATION DATE	MANAGER RESPONSIBLE
1.1	The Policy for the Development and Management of Procedural Documents should be amended to "final" status and both Policy and associated procedures should be ratified by the appropriate committee/staff member.	Merits Attention	Y	Both the policy and procedure will be ratified by RCAG	11/9/09	Head of Records and Business Continuity
1.3	All policies and procedures should have the corporate standard format applied so as to ensure consistency and ensure that staff are not confused as to whether they are the most up-to-date and recent versions. The standard corporate format should include: • A completed document profile and control page including the authors name; correct document status and approval and ratification information. • An implementation plan in place This is in adherence to the Policies and Procedures outlined in Para 1.1. It is also important as this ensures they have an identifiable lead; are disseminated correctly; are communicated clearly; the relevant training provided and importantly the review dates and monitoring process are defined.	Significant	Y	As stated in the test result column the recommendation is LAS policy and being implemented although this will take some time as the policy was only approved at the end of September and there are more than 100 procedural documents in force.	To be completed by March 2010	Head of Records and Business Continuity

REF	RECOMMENDATION	CATEGORISATION	ACCEPTED Y/N	MANAGEMENT COMMENT	IMPLEMENTATION DATE	MANAGER RESPONSIBLE
1.6	a) All policies and procedures should go through a ratification process as per policy and procedures to ensure that they are sanctioned prior to being in use. b) All policies and procedures should have a date of approval documented so as to ensure that future dates of approvals are within the guidance as laid out by the procedure for development and management of procedural documents.	Significant Merits Attention	Y	Recommendations (a) and (b) are both being implemented following approval of TP/001 and TP/002.	1/9/09	Head of Records and Business Continuity
1.8	An announcement to all staff should be made via the RIB on a timely basis once any new policy and procedure is placed on PULSE. The date of the announcement should also be noted on the implementation page.	Significant	Y	It is normal policy to announce new and revised procedural documents on the Pulse. To ensure consistency in future the date will be noted in the communications section of the Implementation Plan.	1/9/09	Head of Records and Business Continuity
1.12	LAS should consider introducing a system whereby, at each ambulance station, all staff are required to sign a sign off form, electronically or hard copy, declaring that they have read and understood the key policies and procedures relevant to their role.	Merits Attention	Y	This will be considered by IGG but it is uncertain whether a simple signoff would result in greater understanding and adherence to procedural documents. It would also require additional administration and monitoring to ensure effectiveness.	1/9/09	Head of Records and Business Continuity
1.14	As part of training, the Trust should introduce a question and answer session, electronically, to test operational staffs reading and understanding of the policies and procedures. This could help in the application of policies and procedures.	Significant	Y	It is viewed that an electronic system is the way forward, though this cannot be effectively introduced for operational staff until they can be given easy access to electronic information systems and no date has yet been agreed for this	1/9/09	Head of Records and Business Continuity
1.15	A clear and comprehensive link between incidents	Significant	Y	This will be discussed with the	1/9/09	Head of

REF	RECOMMENDATION	CATEGORISATION	ACCEPTED Y/N	MANAGEMENT COMMENT	IMPLEMENTATION DATE	MANAGER RESPONSIBLE
	and non compliance of policies and procedures should be introduced and documented and reported so as to ensure adequate monitoring of policies and procedures are conducted. This could assist in updating policies and procedures to make it more workable for staff and to identify reasoning for			Senior H&S Advisor. It is important that incidents that have been caused by non-compliance with a policy or procedure are clearly identified.		Records and Business Continuity
1.17	The Equality and Diversity Manager should review the Equality and Diversity Employment policy as soon as possible.	Significant	Y	GDU has only just agreed with HR to incorporate their procedural documents in the corporate monitoring system. The Diversity Manager has now been notified that this policy requires review.	1/9/09	Head of Records and Business Continuity

11.08/09 Medical Devices

Introduction

An audit of Medical Devices was undertaken as part of the approved internal audit periodic plan for 2008/09.

The Corporate Logistics Department is responsible for the procurement, distribution and maintenance of medical devices and equipment for the Trust.

A Third party contractor, LSS Lightbridge Support Services are employed to run the Make Ready team with the responsibility to check and test medical equipment, restock all consumable items, clean, refuel and wash Ambulance vehicles. Make Ready are based at each site. Only when a vehicle is fully stocked and all equipment checked, is the Ambulance made available for use.

Currently, an electronic asset tracking project is being undertaken. This process will involve the Make Ready team and Logistics and should lead to improved management of the location, repair and maintenance of equipment

The specific risks considered as part of this audit were:

- Unavailability or the non-functioning of critical patient care equipment on vehicles.
- Inability to treat paediatrics due to equipment out of date (PALS packs)

These risks relate to the objective that all medical devices are effectively managed within the Trust.

Scope of the review

The objective of our audit was to evaluate the adequacy of risk management and control within the system and the extent to which controls have been applied, with a view to providing an opinion. Control activities are put in place to ensure that risks to the achievement of the organisation's objectives are managed effectively. When planning the audit, the following controls for review and limitations were agreed:

Control activities relied upon:

- Vehicle Inspections
- PALs Pack seals
- The Vehicle and Equipment Working group as the decision making body

Limitations to the scope of the audit:

- The objective of the audit is to evaluate systems and procedures in place with a view to providing reasonable assurance as to adequacy of the design of the internal control system and its application in practice. The audit cannot provide assurance over any clinical decisions taken in respect of the purchase, use and replacement of medical devices. The audit cannot provide assurance as to the content and suitability of training provided with regards to medical devices, only that the training has been provided. Testing will be undertaken on a sample basis only. Whilst every effort will be made to ensure that material error, loss or fraud has not occurred we cannot provide any guarantee against material error, loss or fraud, or provide absolute assurance that material error, loss or fraud does not exist.

The approach taken for this audit was systematic audit and included the following:

- Establishing the risks affecting the achievement of your corporate objectives
- Reviewing the adequacy and application of the controls in place to mitigate the risks

1.3 Conclusion

Taking account of the issues identified, in our opinion the Board can take adequate assurance that the controls upon which the organisation relies to manage this area, as currently laid down and operated, are effective.

This assurance level has been formulated on the basis of conclusions drawn on the individual elements of effectiveness, design and application of controls in place:

	Substantial	Adequate	Limited
Design of control framework		X	
Application of and compliance with control framework		X	
OVERALL OPINION		X	

The above conclusions feeding into the overall assurance level are based on the evidence obtained during the review. The key findings from this review are as follows:

- 22 of 56 vehicles tested where recorded as ready for use, however these vehicles contained unsealed PALs Packs. If packs are not sealed then this increases the risk of devices falling out of storage compartments and becoming either damaged or contaminated.
- At 1 station, 1 item of medical equipment awaiting repair had not been thoroughly cleaned. This increases the risk of cross-contamination of other devices.

1.4 Recommendations Summary

The following tables highlight the number and categories of recommendations made, showing which have been brought forward from previous audits. The Action Plan at Section 2 details the specific recommendations made as well as agreed management actions to implement them.

Recommendations made during this audit:

Risk	Fundamental	Significant	Merits Attention
Unavailability or the non-functioning of critical patient care equipment on vehicles.	0	1	3
Inability to treat paediatrics due to equipment out of date (PALS packs)	0	1	0

TOTAL	0	2	3

Recommendations implemented since the previous audit in this area:

DATE OF PREVIOUS AUDIT: 8 September 2007

RECOMMENDATION CATEGORIES	FUNDAMENTAL	SIGNIFICANT	MERITS ATTENTION
NUMBER OF RECOMMENDATIONS MADE DURING PREVIOUS AUDIT	0	1	6
NUMBER OF RECOMMENDATIONS IMPLEMENTED	0	1	2
RECOMMENDATIONS NOT YET FULLY IMPLEMENTED:	0	1	4

A summary issues raised at the last audit on which recommendations where made but not implemented are:

- The cleaning and disinfection of equipment prior to sending this for repair. One item was found not to have been appropriately cleaned and a recommendation made to address this.
- Procedures for the Acquisition, Trail and Purchase of Ambulance Aid Equipment, Medical Treatments or Devices were last updated in October 1998. Therefore a recommendation to address this has been made.
- Procedures followed by the Equipment Support Officer at the logistics warehouse concerning medical devices are not documented. A recommendation to address this has been made as part of this audit.
- Equipment records held at Bow are incomplete and out of date. This should be addressed through the current Asset Tracking project.
- A robust monitoring process for the control and issue of single use devices is not in operation. The current Inventory Management project should address this issue.

1.5 Additional Feedback

GOOD PRACTICE IDENTIFIED DURING THE AUDIT
An Equipment Cleaning and Maintenance Manual is used by the vehicle service teams and is available at ambulance stations as a reference document. The Equipment Cleaning and Maintenance Manual details the cleaning procedures for 59 pieces of equipment.
The Stryker Trolley bed is subject to thorough trail and assessment as part of the acquisition process.

3 Action Plan

The priority of the recommendations made is as follows:

FUNDAMENTAL	SIGNIFICANT	MERITS ATTENTION
ACTION IS IMPERATIVE TO ENSURE THAT THE OBJECTIVE FOR THE AREA UNDER REVIEW IS MET	REQUIRES ACTION TO AVOID EXPOSURE TO SIGNIFICANT RISK IN ACHIEVING THE OBJECTIVE FOR THE AREA UNDER REVIEW.	ACTION IS ADVISED TO ENHANCE CONTROL OR IMPROVE OPERATIONAL EFFICIENCY

REF	RECOMMENDATION	CATEGORISATION	ACCEPTED Y/N	MANAGEMENT COMMENT	IMPLEMENTATION DATE	MANAGER RESPONSIBLE
1.1	The Protocol for The Acquisition, Trial and Purchase of Ambulance Aid Equipment, Medical Treatments or Devices should be revised to reflect current working practices.	Merits Attention	Y	Agreed. This has been assigned to the Logistics Manager	August 2009	Corporate Logistics Manager
1.6	Stations should to be reminded of their responsibilities to clean and decontaminate all equipment put in the faulty equipment bins.	Significant	Y	A reminder was sent out on the 27.4.09	April 2009	Corporate Logistics Manager
1.11	The Protocol for the Acquisition, Trial and Purchase of Ambulance Aid Equipment, Medical Treatments or Devices purchased, should include a section on undertaking risk assessments on new items of equipment introduced to the service.	Merits Attention	Y	As per 1.	August 2009	Corporate Logistics Manager
1.15	Standard Operating Procedures should be updated to include procedures covering medical device handling by staff at the Deptford Support Unit.	Merits Attention	Y	Agreed	November 2009	Corporate Logistics Manager
2.2	The Trust should review whether the current seals used on PALS packs are the most appropriate and whether a more appropriate seal could be identified which would reduce the risk of equipment falling out of storage lockers and becoming damaged or contaminated	Significant	Y	Agreed	July 2009	Corporate Logistics Manager

12.08/09 Standards for Better Health

Introduction

An audit of Standards for Better Health was undertaken as part of the approved internal audit periodic plan for 2008/09.

For the year 2007/08, the Trust's declaration stated full compliance with the applicable standards. For 2008/09 the Trust are required to complete and sign off the annual declaration which will including the additional standards applicable to Ambulance Trusts this year, Standards C3, C4c, C22b and C7e. The declaration will be presented to the Board for sign off on 31 March 2009 prior to the declaration deadline of 30 April 2009.

The specific risks considered as part of this audit were:

- The Trust is unable to make an informed declaration against the Healthcare Standards
- The Trust fails to take action to improve compliance with a standard, or is not aware that it needs

These risks relate to the objective of the Trust has established a process for ensuring that it can make an informed declaration at the year end.

Scope of the review

The objective of our audit was to evaluate the adequacy of controls in place to ensure appraisals and supervisions take place in line with Trust requirements; the extend to which these controls have been applied; and how effective they have been, with a view to providing an opinion on the extent to which the risk is being managed. Control activities are put in place to ensure that risks to the achievement of the organisation's objectives are managed effectively. When planning the audit, the following controls for review and limitations were agreed:

Control activities relied upon:

- Evidence for the Standards for Better Health declaration are recorded and stored centrally by the Governance Development
- The Standards for Better Health Group members are responsible for the declaration, reviewing gaps in assurance and creating action plans where gaps exist
- The Medical Director reports issues relating to each Standards for Better Health domain at each Board meeting, therefore the Board is aware of issues relevant to the declaration throughout the year.

Limitations to the scope of the audit:

- The objective of the audit is to evaluate systems and procedures in place with a view to providing reasonable assurance as to adequacy of the design of the internal control system and its application in practice. Testing will be undertaken on a sample basis only. The audit will only consider a sample of standards only, and therefore cannot provide assurance that the Trust is compliant with all of the Healthcare Standards, rather that the processes in place for the monitoring of achievement of the standards is robust. Whilst every effort will be made to ensure that material error, loss or fraud has not occurred we cannot provide any guarantee against material error, loss or fraud, or provide absolute assurance that material error, loss or fraud does not exist.

The approach taken for this audit was systematic Audit and included the following:

- Establishing the risks affecting the achievement of your corporate objectives
- Reviewing the adequacy and application of the controls in place to mitigate the risks

Conclusion

As a result of our work we consider that the Trust has a reasonable process to support the preparation of its declaration.

No significant weaknesses were identified as part of our audit, and it was confirmed that the Trust has good processes in place for monitoring compliance against each of the standards.

Recommendations Summary

The following tables highlight the number and categories of recommendations made, showing which have been brought forward from previous audits. The Action Plan at Section 2 details the specific recommendations made as well as agreed management actions to implement them.

Recommendations made during this audit:

Risk	Fundamental	Significant	Merits Attention
The Trust is unable to make an informed declaration against the Healthcare Standards	0	0	1
The Trust fails to take action to improve compliance with a standard, or is not aware that it needs	0	0	0
Total	0	0	1

Recommendations implemented since the previous audit in this area:

Date of previous audit: 3 March 2008

Recommendation categories	Fundamental	Significant	Merits Attention
Number of recommendations made during previous audit	0	0	1
Number of recommendations implemented	0	0	1
Recommendations not yet fully implemented:	0	0	0

The recommendation made in March 2008 highlighted the importance that all evidence submitted is current evidence is applicable to the declaration year. On review of all evidence added to the evidence recording spreadsheet to date relates to the declaration year 2008/09.

Additional Feedback

GOOD PRACTICE IDENTIFIED DURING THE AUDIT
The Governance Officer coordinates the evidence gathering process
Standard owners are identified and are responsible for providing evidence for their specified standard
The Governance Development Unit is in the process of implementing a software system, Performance Accelerator. The system allows deadlines for evidence submission to be set and reminders to be issued automatically to responsible officers.
The Standards for Better Health group has overall the responsibility for the self assessment process
High level risks within the Assurance Framework are referenced to a Core Standard and reviewed by the Clinical Governance Group

4 Action Plan

The priority of the recommendations made is as follows:

FUNDAMENTAL	SIGNIFICANT	MERITS ATTENTION
ACTION IS IMPERATIVE TO ENSURE THAT THE OBJECTIVE FOR THE AREA UNDER REVIEW IS MET	REQUIRES ACTION TO AVOID EXPOSURE TO SIGNIFICANT RISK IN ACHIEVING THE OBJECTIVE FOR THE AREA UNDER REVIEW.	ACTION IS ADVISED TO ENHANCE CONTROL OR IMPROVE OPERATIONAL EFFICIENCY

REF	RECOMMENDATION	CATEGORISATION	ACCEPTED Y/N	MANAGEMENT COMMENT	IMPLEMENTATION DATE	MANAGER RESPONSIBLE
1.3	The Standards for Better Health declaration for 2008/09 should be signed by all members of the Trust Board, including Non-Executive Directors where possible.	Merits Attention	Y	The Trust accepts that Healthcare Commission recommend that all members of a Trust's board 'sign off' the Declaration to indicate that the whole board has reflected on its responsibilities in relation to core standards. The Trust will try to get all members of the Board to sign off the Declaration in October 2009	October 2009	Laila Abraham

Drug Controls (13.08/09)

Executive Summary

Introduction

An audit of Drug Controls was undertaken as part of the approved internal audit periodic plan for 2008/09.

Drugs which Ambulance staff administer under the Prescription Only Medicines (Human Drugs) Order 1997, are stored in Paramedic or Technician drug packs with the exception of Morphine and a number of low risk treatments. Paramedic or Technician drug packs are stored at Ambulance Stations and must be signed in and out by staff on each shift.

The Logistics department should ensure adequate provision and exchange of the 2000 drug packs in circulation to 72 ambulance stations across Greater London.

Several drug pack amnesties for staff have been organised by the Trust. Each amnesty has resulted in staff handing in a significant number of drug packs.

As part of this audit we visited the Deptford Supply and Logistics Centre, Romford Ambulance Station, Wimbledon Ambulance Station, Newham Ambulance Station and Deptford Ambulance Station.

The specific risks considered as part of this audit were:

- Drugs packs are not effectively controlled or recorded

This risk relates to the objective of ensuring that all drugs packs are effectively controlled and recorded, achievement of which is measured using the following outcome(s):

- That all drug pack errors are accurately reported
- Drugs packs are securely held
- Supply of drugs to ambulance stations meets demand

Scope of the review

The objective of our audit was to evaluate the adequacy of risk management and control within the system and the extent to which controls have been applied, with a view to providing an opinion. Control activities are put in place to ensure that risks to the achievement of the organisation's objectives are managed effectively. When planning the audit, the following controls for review and limitations were agreed:

Control activities relied upon:

- Policies and procedures in place
- Drug packs issue and return log
- Records of outstanding drug packs maintained
- Reporting to the Trust Board

Limitations to the scope of the audit:

- The objective of the audit is to evaluate systems and procedures in place regarding paramedic and technician drugs packs with a view to providing reasonable assurance as to adequacy of the design of the internal control system and its application in practice. The audit cannot provide assurance over any clinical decisions taken in respect of the prescription and use of drugs. The audit cannot provide assurance that suitable actions have been identified to reduce the risk of future occurrence of errors. Testing will be undertaken on a sample basis only. Whilst every effort will be made to ensure that material error, loss or fraud has not occurred we cannot provide any guarantee against material error, loss or fraud, or provide absolute assurance that material error, loss or fraud does not exist.

The approach taken for this audit was systematic Audit and included the following:

- Establishing the risks affecting the achievement of your corporate objectives
- Reviewing the adequacy and application of the controls in place to mitigate the area or testing to assess the extent or cause of problems identified

Conclusion

Taking account of the issues identified, in our opinion the Board can take limited assurance that the controls upon which the organisation relies to manage this area, as currently laid down and operated, are effective.

This assurance level has been formulated on the basis of conclusions drawn on the individual elements of effectiveness, design and application of controls in place:

	SUBSTANTIAL	ADEQUATE	LIMITED
EFFECTIVENESS OF CONTROL FRAMEWORK			X
DESIGN OF CONTROL FRAMEWORK			X
APPLICATION OF AND COMPLIANCE WITH CONTROL FRAMEWORK			X
OVERALL OPINION			X

The above conclusions feeding into the overall assurance level are based on the evidence obtained during the review. The key findings from this review are as follows:

- Testing undertaken as part of the audit identified fundamental weaknesses in the control over drug packs, particularly in respect of the management of out of date drug packs. Testing identified that packs are not being returned on a timely basis. In addition, due to shortages in the numbers of drug packs in the system, it was identified that return drug pack lockers at two stations had been opened to enable access to used packs to address shortages at individual stations. Finally, it was noted that at least 6 drugs packs returned to Logistics in January 2009 were over a year out of date, the oldest of which went out of date in 2006. All of the above increases the risk that out of date drugs may be used by Trust staff. The Trust therefore needs to review as a matter of urgency the numbers of drug packs in circulation within the Trust, the processes for the issue and return of the these packs to ensure that a) there are sufficient numbers of drug packs in circulation and b) that only new packs are used by staff and that all used or out of date drug packs are returned to logistics on a timely basis.
- As weaknesses have been identified within this audit in respect of the storage of drugs and the use of completed or out of date drug packs, the Trust needs to consider whether it should be declaring itself non-compliant in respect of the Standards for Better Health declaration.
- Finally, it was noted that serious untoward incidents in respect of drug errors are not formally reported to the Board via the report of the Medical Director. The introduction of reporting against this would ensure that the Board are made aware of any trends in the numbers of drug errors and can ensure that suitable actions are taken in respect of this.

Recommendations Summary

The following tables highlight the number and categories of recommendations made. The Action Plan at Section 2 details the specific recommendations made as well as agreed management actions to implement them.

Recommendations made during this audit:

Risk	Fundamental	Significant	Merits Attention
Drugs packs are not effectively controlled or recorded	5	2	0
Total	5	2	0

Additional Feedback

Good Practice Identified During the Audit
A 24 hour Clinical Support Desk is available for staff to obtain advice from Senior Clinical Advisors on all medical issues
A Clinical Steering Group has been established which acts in an advisory capacity to the Clinical Governance Committee. Members of the Clinical Steering Group are experts in their field and are willing to be contacted when required emergency situation.

Action Plan

The priority of the recommendations made is as follows:

FUNDAMENTAL	SIGNIFICANT	MERITS ATTENTION
ACTION IS IMPERATIVE TO ENSURE THAT THE OBJECTIVE FOR THE AREA UNDER REVIEW IS MET	REQUIRES ACTION TO AVOID EXPOSURE TO SIGNIFICANT RISK IN ACHIEVING THE OBJECTIVE FOR THE AREA UNDER REVIEW.	ACTION IS ADVISED TO ENHANCE CONTROL OR IMPROVE OPERATIONAL EFFICIENCY

REF	RECOMMENDATION	CATEGORISATION	ACCEPTED Y/N	MANAGEMENT COMMENT	IMPLEMENTATION DATE	MANAGER RESPONSIBLE
1.6	A sufficient number of drug packs need to be kept at each ambulance station to avoid shortages of packs and the risk that drugs are not available when required. The Trust needs to identify the most appropriate method for issuing and usage of drug packs to ensure that these are not retained by staff, and results in a shortage of drugs in the system. This could include assigning packs to vehicles as opposed to paramedics to ensure a sufficient number of packs are in use within the Trust.	Fundamental	Y	The shortages are caused by the withholding of packs, not because there is a fundamental shortage in the first place .Pack numbers are based on shifts, not numbers of staff. Assignment of packs to vehicles will be difficult because of Flexible Fleet system which means vehicles move around frequently. The audit trail of drug usage would also become more difficult – there would still need to be an element of packs being signed in and out (if used or out of date). There still needs to be a personal responsibility for drug management	Complete	Director of Operations
1.7	Ambulance station managers should remind staff of their responsibilities to accurately log drug packs using the Drug Pack Issue / Return Form LA295/A (Paramedic / MRU / CRU) and the LA296 (General) form.	Fundamental	Y	An email to staff reminding their responsibilities to log packs using LA295 and LA256 forms. Bar code or RFID technology might replace this in future.	Complete	Director of Operations

REF	RECOMMENDATION	CATEGORISATION	ACCEPTED Y/N	MANAGEMENT COMMENT	IMPLEMENTATION DATE	MANAGER RESPONSIBLE
	A check of drugs packs logged out and returned using the LA295 and LA296 forms should be undertaken by the Ambulance Station Manager on a weekly basis to identify staff not complying with the logging procedures. At this point, instances where a drugs pack has not been signed back in can be followed up. The Trust should also undertake, on a sample basis at least, checks to ensure that only drugs which have been used on patients have been removed from the packs.	Significant		An audit programme needs to be developed to achieve this		Director of Operations
1.8	Management should ensure that the Drugs Return Lockers at London Ambulance stations are locked and the damaged doors made secure as a matter of urgency. Access should be restricted to only the designated staff at the Logistics Support Unit in compliance with the Procedure Covering the Issue and use of Drugs by London Ambulance Service staff. Management should ensure that all drugs packs are stored securely and that access controls such as key pad door locks and lockers are used and security maintained.	Fundamental Fundamental	Y	Review and replacement of drug cupboards – more secure cupboards for used/out of date pack storage. Robust and regular auditing of cupboards/pack status by local managers. Logistics Support Unit to send out electronic message the day before a pack is due to expire .Pre and post shift for drug pack administration and vehicle roadworthiness checks. Have quarterly drug audits for next year to follow up action plan. Have quarterly drug audits for next year to follow up action plan	Complete	Director of Operations
1.11	Management should ensure that the Paramedic and General drug packs are returned to the Logistics Support Unit as soon as drugs are expired to prevent the risk of out of date drugs being used for patient care.	Fundamental	Y	Robust enforcement of drug procedures by local managers – signing packs out and in at start/finish of shift – no personal retention of packs.	Complete	Director of Operations

REF	RECOMMENDATION	CATEGORISATION	ACCEPTED Y/N	MANAGEMENT COMMENT	IMPLEMENTATION DATE	MANAGER RESPONSIBLE
	Guidelines on drug pack procedures need to be communicated to staff. Station Managers need to enforce rules where they find staff are keeping drugs packs.			Packs to be removed from vehicles and signed back into station cupboard before they are moved to different Complex by Flexible Fleet.		
1.21	Management should ensure that the Medical Directors report to the Trust Board details of any drug related incidents. Where there have not been any Drug related issues, a nil return should be reported.	Significant	Y	An analysis of all the drug related incidents will be done to ascertain whether any SUIs have been missed.	Complete	Director of Operations

Appendix C: Client Briefings

Client Briefing NHS Update February 2009

CB NHS 04.09 **13 March 2009**

This briefing provides a summary of some of the publications and issues across the NHS during February 2009.

Transaction Manual

On 19 February 2009 the Department of Health (DH) and Monitor jointly published their Transaction Manual. The Transaction Manual is designed to support best practice amongst providers of NHS services, commissioners and strategic health authorities (SHAs) as they develop transactions within the UK health economy. The transactions that are covered by the Manual include acquisitions, divestments or disposals, demergers, joint ventures, franchises and statutory mergers. The Transaction Manual incorporates best practice but also mandatory practice required by law or policy. As law or policy may change the Manual may well be updated in future

The Manual is available on both Monitor and the DH's website. Follow this link to access the document:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_095001

Statement of Internal Control

On 25 February 2009 the DH issued two Dear Colleague Letters regarding the Statement of Internal Control 2008/09. The DH has provided guidance on the year end timetable and information on the disclosures. The DH makes specific reference to the new requirement for 2008/09 for organisations to include a mandatory disclosure on their compliance with equality, diversity and human rights legislation.

Further Information from Third Parties

As part of the 2008/09 annual healthcheck the Healthcare Commission has requested third party commentaries from Learning Disability Partnership Boards (LDPBs). This is the first year the Commission has requested such information.

LDPBs include people with learning disabilities and as such the Commission has prepared three easy to read guides. The guides outline the core standards within the annual healthcheck; how members of LDPBs should go about voicing their opinions; and a list of other key standards.

WHO - UK Strategy

The report, *World Health Organization, UK Institutional Strategy 2008-13* has been published by government. It sets out the key global health challenges, as seen by the World Health Organization (WHO). WHO is the coordinating authority for health within the United Nations (UN) system and is responsible for providing leadership on global health matters. The Institutional Strategy sets out both the rationale and objectives of the UK to support the WHO. The objectives of the strategy are to:

- Set out the UK's vision of WHO's contribution to better global health over the period of the medium-term strategic plan, that is 2008-2013.
- Outline what the UK will do to support WHO in the delivery of its objectives.
- Highlight priority areas in the Eleventh General Programme of Work, which runs from 2006 to 2015 which the UK will focus on.
- Provide a performance monitoring framework to measure progress and account for the UK's investment in WHO's work.

The Institutional Strategy is available from the DH's website at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_095296

Practice Based Commissioning

The DH has published *Practice Based Commissioning: Budget Guidance for 2009/10*, which provides information on the changes to the recommended methodology for deriving practices' fair shares for 2009/10; changes to the minimum pace of change to practices' budgets for 2009/10; and guidance on how to use the toolkit that helps PCTs set budgets. The document sets out other changes made to the methodology however it also provides guidance on using the new toolkit.

This document together with the toolkit is available on the DH's website at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094364

Clinical Costing Standards

On 24 February 2009 the DH published the *Acute Health Clinical Coding Standards 2009/10*. This document essentially sets out best practice guidance for organisations using Patient Level Information & Costing Systems (PLICS). Clinical Costing is often known as PLICS and is where the full cost of resources for patient diagnosis and treatment is calculated.

The DH anticipates that adoption of the standards will lead to increased levels of consistency in the costing methods used by hospitals. They are designed to improve the costing of health services across England and they will provide the basis for continuous development of the Standards in line with international best practice.

The Clinical Costing Standards are available from the DH website at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_095359

Complaints
The Healthcare Commission has recently published the report *Spotlight on Complaints, A Report on Second-Stage Complaints about the NHS in England*. The report looks at areas of both good and poor practice the Commission has seen in response to complaints. The report, published 16 February 2009, found that some NHS trusts are still not responding to complaints effectively or learning lessons from them. In almost half of complaints received the Commission either upheld the complaint or sent it back to the trust for further work as the trust's initial response was not good enough.

Patients and the public also continue to raise issues concerning the same basic aspects of healthcare such as:

- Poor communication (12% of cases, down from 17% in 2006/07);
- Standard of treatment (11%, up from 6% in 2006/07);
- Delay or failure to diagnose a condition (9%); and
- Delays in accessing care (8% up from 4% in 2006/07).

The report is the third of its kind and covers 8,949 complaints reviewed in the year to 31 July 2008. The full report is available on the Commission's website at:
http://www.healthcarecommission.org.uk/_db/_documents/Spotlight_on_Complaints_09.pdf

Comprehensive Area Assessments Framework
The Audit Commission has published their *Comprehensive Area Assessment, Framework Document*. It essentially sets out how Comprehensive Area Assessment (CAA) will be delivered from 1 April 2009.

Patient Reported Outcome Measures
The DH has published *Guidance on the Routine Collection of Patient Reported Outcome Measures* (PROMs). The guidance, which applies from 1 April 2009, sets out:

- The procedures for which PROMs data should be collected;
- Details of the national Standard PROMs questionnaires;
- Roles and responsibilities of the various organisations involved in the delivery of the PROMs programmes; and
- A step-by-step guide to the administration of PROMs questionnaires.

This document supersedes the Guidance on the Routine Collection of Patient Reported Outcome Measures published December 2007.

The updated guidance is available on the DH's website at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_092647

Payment By Results
The DH has published *Payment by Results Guidance for 2009-10*. This document provides information to support organisations in the operation of Payment by Results (PbR). In 2009-10 the new Healthcare Resource Group 4 (HRG4) will be introduced, which has been specifically designed to support a national tariff payment system for healthcare. In addition to the introduction of HRG4 there are a number of other changes, including:

- The introduction of the planned same day (PSD) tariff, which will initially only apply to day case activity only and for outpatient procedures the PSD tariff will be non-mandatory for 2009-10.

- The introduction of the short stay elective tariff, which is designed to ensure that very short lengths of stay are appropriately rewarded.
- A new Market Forces Factor (MFF) payment index.
- The MFF payment associated with activity within the scope of PbR for mandatory tariff will be paid directly by the responsible commissioning PCT.
- The DH will not be publishing indicative tariffs for 2009-10 and have instead issued a number of non-mandatory prices.
- Under HRG4 the definition of a child is a patient aged under 19, with an adult being defined as 19 and over.

The full guidance is available on the DH's website at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094183

Efficiency
The DH has issued a letter to NHS organisations urging them to think more carefully about their back office services, especially in the current economic climate. Delivering efficiencies in back office functions can be sought from a number of areas including, finance and accounting, human resources and payroll, family health services, estates and security.

The letter goes on to discuss the NHS Shared Business Services (a partnership between the NHS and Steria) and how it now works with over 100 NHS bodies and has achieved operational efficiencies of between 20% and 30% for NHS Trusts. As such the DH urges NHS management boards to be clear that their decision to retain corporate services in-house actually represents value for money.

Cooperation and Competition Panel
Involving patients in decisions about their care such as offering people a choice of provider or options regarding the time and location of their treatment is all part of a high quality NHS. However the DH now has an obligation to ensure cooperation and competition operates in the interests of both patients and taxpayers. As such the Secretary of State is establishing a Cooperation and Competition Panel to support Strategic Health Authorities (SHAs) and to give advice on compliance rules in individual cases. The role of the Panel will be advisory to SHAs, the DH and Monitor. SHAs will, however, retain responsibility for strategic, competitive and comparative oversight for their locality but will have the added support of the Panel, who will ensure the NHS has effective oversight and governance.

Centre of Excellence
In light of the emphasis on workforce strategic planning the DH commissioned the King's Fund to undertake a review on the proposal for a Centre of Excellence. As such, the report *Proposals for a Centre of Excellence for Workforce Strategy and Planning* was published in January 2009.

Essentially, the Centre of Excellence is a long-term, strategic investment for the workforce planning system and the report sets out a number of recommendations that aim to support the effective implementation of the Centre. The Centre of Excellence will:

- To be a one-stop shop for expert advice and support on workforce strategy and planning.
- Take a longer term perspective on workforce trends, which will be informed by an analysis of the broader environment.
- Facilitate improved knowledge management and communication of intelligence on workforce issues.
- Facilitate better co-ordination of activities on workforce planning and reduce duplication.

The Centre's core mission as recommended by the King's Fund is to:

- Be an objective, trusted, credible source of workforce intelligence, analysis, and evidence for the health and care system.
- Facilitate access to high-quality leadership, technical and management development support relating to workforce strategy and planning.

It was originally planned that the Centre's 'customers' will include the DH, SHAs, professional advisory boards, as well as local commissioners and providers. However, concerns were raised as to whether it would be possible to satisfy equally all of these customers and the King's Fund suggested that the DH should engage more fully with social care stakeholders to ensure where possible the centre is designed to support integrated workforce strategy and planning at the local level between PCTs and local authorities.

This report is available on the King's Fund website at: http://www.kingsfund.org.uk/publications/other_work_by_our_staff/proposals_for_a.html

Review of NHS Pay Modernisation

The National Audit Office (NAO) has published the report *NHS Pay Modernisation in England: Agenda for Change*. The Agenda for Change programme was implemented between December 2004 and December 2006 and was designed to reform and standardise pay and conditions of NHS staff.

The Agenda for Change introduced a system that would pay staff consistently in relation to the work they do and the knowledge and skills they apply. The NAO report examines the implementation and costs surrounding the Agenda for Change and whether the desired benefits have been achieved.

This report is available on the NAO's website at: http://www.nao.org.uk/publications/0809/nhs_pay_modernisation.aspx

Client Briefing NHS Update March 2009

CB NHS 05.09

3 April 2009

This briefing provides a summary of some of the publications across the NHS during March 2009.

Quality Reporting

On 26 February 2009 Monitor published the consultation *Quality Reporting in 2008-09 Annual Reports and Accounts: A Consultation for NHS Foundation Trusts and NHS Organisations in East of England*. This consultation essentially sets out the proposals for a quality reporting framework to be included in 2008-09 annual reports and accounts of foundation trusts (FTs) and NHS organisations in NHS East of England. Importantly, the introduction of quality accounts should become a legal requirement, subject to passage of legislation and so introducing Quality Reports could help shape the legal requirements for 2010.

The proposed reporting framework would require FTs and NHS provider organisations in the east of England to include in their annual accounts:

- A statement on the quality of care offered by the organisation, signed by the Chief Executive.
- A description of the priorities for quality improvement, that action the organisation plans to take, and the rationale for the prioritisation.
- A response to issues raised by the regulators or public representatives in the last year.
- A quantitative description of the quality of care which should include indicators selected by the organisation covering patient safety, clinical effectiveness and patient experience as well as indicators which covers the Department of Health (DH) core standards as declared to the Healthcare Commission/Care Quality Commission.

The consultation is available on Monitor's website at:
http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/consultations/monitors-consultations/quality-reporting-2008-09

Clinical Commissioning

The DH has published the document *Clinical Commissioning: Our Vision for Practice-Based Commissioning*. The NHS Next Stage Review concluded that practice based commissioning (PBC) has an important part to play in empowering clinicians to shape the health and healthcare of local populations. The DH has worked with a number of clinicians, PCTs and SHAs to produce this document, which essentially sets out the vision for clinical commissioning, the hallmarks of successful commissioning, the support and entitlements PBCs can expect and the principles that should underpin productive partnerships between PCTs and PBCs.

The full document can be found on the DH's website at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_095692

Guidance on Internal Separation

The DH has also published *Guidance on Internal Separation for SHAs to Support Business Readiness in PCT Provision*. The requirement to produce guidance for Strategic Health Authorities (SHAs) to support PCTs in internally separating their commissioning and provider functions was outlined in the report, *Enabling New Patterns of Provision*. Essentially, the creation of internal separation of commissioning and provision is important so that conflicts of interest can be avoided.

Importantly the internal separation guidance focuses primarily on the critical business, financial and governance issues facing PCTs and PCTPS (PCT Provider Services) as they seek to separate their functions.

This guidance is available on the DH's website at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_096020

Carbon Reduction Commitment

As you may be aware we have recently issued a briefing on the Carbon Reduction Commitment (CRC). The CRC is a mandatory emissions trading scheme that will be introduced in January 2010. The scheme will apply to large non-energy intensive organisations in the public and private sector, whose emissions are not currently included in the EU Emission Trading Scheme (ETS) or Climate Change Agreements.

Organisations will be included within the scheme if they have at least one meter settled on the half hourly market and the total half-hourly metered (HHM) electricity used is greater than 6000 megawatt-hours between 1 January and 31 December 2008. This is the equivalent to an electricity spend of approximately £500,000. Under the scheme all qualifying organisations will be required to calculate and report their carbon emissions annually from April 2010 and must buy CRC allowances to cover their anticipated emissions each year from April 2011.

Ensuring Patient Care

On 12 March 2009 the Healthcare Commission published the report *Safe in the Knowledge, How do NHS trust boards ensure safe care for their patients?* This report aims to support the boards of NHS trusts to both identify and develop the key behaviours, systems and measures that should be reviewed on a regular basis. This is to ensure that trusts are commissioning and delivering the safest possible care, and if they are not, what needs to change to achieve this.

The Commission has taken into account some of the key performance information relating to safety in care over the last few years and found that:

- Levels of reporting of incidents to the National Reporting and Learning System are increasing. However rates of reporting are still below what is expected, and there are inconsistencies in the levels of reporting made by different types of trusts.
- Implementation of the actions required in national safety varies by trust.
- The indirectly standardised all-cause 30 day hospital mortality rate for all acute trusts in England (for the period 1 April 2006 to 31 December 2006) varies between trusts by more than eight-fold.
- At a national level the number of healthcare associated infections continues to fall however there are variations in achievement at trust level.
- Violence against staff is still an issue.
- Performance against the core standards of safety over the last three years of the annual health check has been mixed.

The Commission has identified a number of common factors that underpin serious failures in healthcare services. These include poor leadership, ineffective management, an undue focus on targets and finances at the expense of other key risks and also a lack of information at board level to gain assurance on key safety concerns.

The Commission undertook research and found that board members had a fairly clear view of their role i.e. setting strategy and goals and obtaining high level assurance that these goals are being achieved. The Commission found that safety is rarely the first item on board agendas and that board's are generally highly dependent on committees to scrutinise information effectively and to progress the right issues. It was also found that among non-executives there were varying degrees of clarity about their roles and responsibilities with regards to safety issues and the information that should be reported to the board.

The Commission recognises that boards have a limited amount of time to scrutinise information and as such what they do receive should be meaningful and relate to key objectives, which should include aspects of quality and safety.

The Commission recommends that boards of NHS provider trusts should make safe care their number one priority and should set explicit, challenging and measurable goals for improvement. They should also promote a behaviour of understanding (rather than blame) and maintain an open and fair culture of safety. Boards should receive the right information and where appropriate work in partnership with other organisations to promote safe care. The Commission also recommends the boards of PCTs (as commissioners) work in partnership, where information can be proactively used to inform commissioning decisions.

This report is available on the Care Quality Commission's website at:
http://www.cqc.org.uk/publications.cfm?fde_id=10969

Warning over Child Hospital Care
According to the Healthcare Commission NHS staff need better training in how to spot signs of child abuse. The Commission found that just under one-third of the 154 hospital trusts in England failed to meet child protection training standards. It also warned 63% did not do enough to ensure surgeons maintained the skills needed to operate on children. The latest analysis found there had been some improvements, but there were still problem areas.

Delay to New Safeguarding Regulations
The government is to delay the introduction of new safeguarding regulations for 11 million staff working with vulnerable adults and children. More than 6 million people, such as teachers and social care workers, are already subject to Criminal Records Bureau (CRB) checks and other forms of registration, but over the next five years a new vetting process will be implemented. Although the scheme is due to start in October 2009, Home Office minister Meg Hillier said the introduction of crucial components would be staggered.

Office of the Health Professions Adjudicator
On 20 March 2009 the DH published the report *Tackling Concerns Nationally, Establishing the Office of the Health Professions Adjudicator*. The legislative framework for the Office of the Health Professions Adjudicator (OHPA) was set out in the Health and Social Care Act 2008. The body will essentially adjudicate on Fitness to Practice cases for, in the first instance, the General Medical Council. The legislation also provides for the General Optical Council's adjudication function to be transferred to the OHPA in due course.

The "Tackling Concerns Nationally" Working Group has looked at more detailed structures and procedures for the establishment of the proposed independent adjudicator and this report sets out their recommendations. The report considers:

- The status of the new body and its interaction with other organisations.
- The composition of the board and principles of the governing body.
- General principles around the composition and conduct of Fitness to Practice panels.
- Funding mechanisms.
- The development of policies on the disclosure of information.
- The need to collect information on equality and diversity issues.
- The process for transition to the new body.

In addition to issuing this publication the DH is also running a formal consultation specifically relating to provisions in respect of:

- The number of non-executives and executive members there should be in addition to the Chair.
- The requirements applying to persons appointed as a member of the OHPA, including:
  - Aggregate terms of office for members in respect of the Chair and Non-Executive Directors; and
  - Criteria for disqualification.

Both the report and the consultation are available on the DH's website at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_096502

Paying for Additional Private Care

The DH has published *Guidance on NHS Patients Who Wish to Pay for Additional Private Care*. This guidance essentially provides information on how to proceed with situations where NHS patients want to buy additional secondary care services that the NHS does not fund. Key points from the guidance include:

- NHS organisations should not withdraw NHS care simply because a patient chooses additional private care.
- All additional private care must be delivered separately from NHS care.
- The NHS must never charge for NHS care (except in the case where there is specific legislation in place to allow it) and the NHS should never subsidise private care.
- The NHS should continue to provide free of charge all care patients would have been entitled to had the patient not chosen to have additional private care.
- NHS Trusts and FTs should have clear policies in place to ensure the DH's guidance is followed. This includes protocols for working with other NHS or private providers where the NHS Trust or FT has chosen not to provide additional private care.
- Strategic Health Authorities and PCTs should work together to ensure this guidance is being implemented properly within their local areas.

Further clarification has been provided as it was reported by Professor Mike Richards on 4 November 2008 that there was a great deal of confusion surrounding the rules in this area.

This guidance is available on the DH's website at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_096428

A Guide to Customer Care

DH has published the report *Listening, Responding, Improving, A Guide to Better Customer Care*. The guide has been designed to help complaints professionals who are working with colleagues to make their organisations better at listening, responding and learning from peoples' experiences. The guide includes advice sheets covering a range of issues to help complaints professionals.

The document is available on the DH's website at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_095408

Client Briefing
CB NHS 06.09

NHS Update April 2009
6 May 2009

This briefing provides a summary of some of the publications across the NHS during April 2009.

NHS Performance Framework

The Department of Health (DH) has published *The NHS Performance Framework: Implementation Guidance*, which sets out the department's approach to identifying underperformance and when intervention should occur. Essentially, the Performance Framework introduces a single definition of success against which all NHS organisations will be judged. The Performance Framework will apply to all providers that are not a foundation trust (FT) and also to NHS commissioners. The Framework will be underpinned by existing national indicators and mandatory data collections in 2009/10. The Performance Framework will be implemented in three phases:

- From April 2009 to acute and ambulance trusts;
- By October 2009 to mental health trusts and PCT provided services; and
- From April 2010 to PCT Commissioners.

The Framework sets out a threshold for intervention in underperforming organisations and defined timescales for demonstrating improved performance. The Framework will be administered by the DH and applied quarterly. The results will be published in the DH publication *The Quarter* however Strategic Health Authorities (SHAs) will be provided with results before they are formally published.

The Framework does not set out how concerns with regards to performance should be dealt with and instead leaves room for local knowledge about the challenges that are applicable to certain localities to be taken into account.

As part of the Performance Framework organisations will be categorised as:

- Performing;
- Performance under review; or
- Underperforming.

An organisation's overall performance category will be determined by the lowest score across the domains of Finance, Operational Standards & Targets and Quality & Safety. In exceptional circumstances where serious failings have occurred an organisation can automatically be designated as *Underperfoming* or even *Challenged*. Such circumstances include:

- Major failings of clinical governance; or
- Major failings of service or financial performance.

Guide for Foundation Trust Governors

On 20 April 2009 Monitor published its *Guide for NHS Foundation Trust Governors: Meeting your Statutory Responsibilities, A Draft Document for Consultation*. In 2007 Monitor began research to find out how engaged governors felt in their organisation, how effective communications are with the Chair and board of directors and importantly how governors are exercising their statutory duties. The research alerted Monitor to the fact that in the area of discharging statutory duties, governors would welcome further guidance and support.

This guide provides information on the statutory powers and duties of governors, what is required of governors in relation to their duties and how governors can meet these challenges.

It is not down to governors to deliver the operational management of FTs; they are required to challenge the board of directors and hold it to account for the FTs performance. Governors are obliged to represent their members' interests, particularly in relation to the strategic direction of the trust. The specific statutory powers and duties of the board of governors are to:

- Appoint and, if appropriate, remove the Chair;
- Appoint and, if appropriate, remove the other non-executive directors;
- Decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and other non-executive directors;
- Approve the appointment of the Chief Executive;
- Appoint and, if appropriate, remove the FT's external auditor; and
- Receive the FTs annual accounts, any report of the external auditor on them and the annual report.

However governors are also involved in many areas that are not covered by legislation such as:

- Holding constituency meetings to communicate with members;
- Patient and service user liaison regarding patient experience;
- Developing and reviewing the membership strategy; working with hospital volunteers; and giving talks to interested stakeholders.

This consultation runs until 13 July 2009. The consultation is available on Monitor's website at: http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/consultations/monitors-consultations/consultation-guide-nhs-fo

Quality Reporting

Monitor has published its response to the consultation it ran on quality reporting in 2008-09 annual reports. As such Monitor has announced that all FTs and all NHS organisations in the East of England are required to report on the quality of care they deliver, as well as how they aim to improve it, as part of their 2008-09 annual reports. Essentially, FTs and NHS organisations in the East of England are asked to:

- Produce a quality narrative, providing an overview of the quality of care the organisation offers, its priorities for improvement and how these improvements will in reality be achieved. Patients and the public can then use this information to hold Boards to account on the commitments they make.
- Respond to any concerns that may have been raised by regulators or representatives of the public and the actions taken to address these concerns.
- Report on their performance on the basis of indicators chosen by the trust for patient safety, clinical effectiveness and patient experience. In addition to local indicators, organisations must also report on its performance against national priorities and core standards.

Overall the majority of responses with regards to the concept and proposed structure of quality reports was positive. It is recognised that quality reporting is a developmental process and will over time become more comprehensive.

As a result of this new requirement Monitor has updated its NHS Foundation Trust Financial Reporting Manual 2008/09 (FT FReM), which is available at: http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/guidance-foundation-trusts/mandatory-guidance/nhs-foundation-t-0

Compliance Framework

On 31 March 2009 Monitor published its *Compliance Framework 2009/10*. The Compliance Framework sets out Monitor's approach to monitoring compliance within FTs. The 2009/10 version of the Compliance Framework includes a number of revisions, including:

- Additions to the Framework to accommodate ambulance FTs.
- Updates to healthcare targets to reflect changes in priorities in the Operating Framework for 2009/10.
- Actions relating to decisions arising from the Principles and Rules of Cooperation and Competition.
- Amendments to reflect the introduction of the Care Quality Commission.
- Introduction programmes for newly appointed chairs and chief executives.
- Amendments to reporting of governor election turnout rates.
- Requirements for assurance of adequate information governance.

The Compliance Framework is available on Monitor's website at: http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/guidance-foundation-trusts/mandatory-guidance/compliance-frame

Care Quality Commission Formally Launched

On 1 April 2009 the Care Quality Commission (CQC) became fully operational. The CQC is the new independent regulator of all health and adult social care in England. The overall aims of the commission are to:

- Improve services across health and adult social care and act swiftly to remedy bad practice.
- Put people who use services first and champion their rights.
- Share their knowledge and expertise on health and social care services.
- Involve providers, commissioners and people who use services in the design and development of their work.

Enforcement Policy

The CQC has published its *Enforcement Policy*. The policy essentially sets out how the CQC intend to use their enforcement powers to protect the health, safety and welfare of the people that use health and social care services, and to improve the quality of those services. The CQC was established as part of the Health and Social Care Act 2008. As such, the CQC has enforcement powers that include those under the Care Standards Act 2000 (CSA 2000) and three new powers under the 2008 Act. The enforcement powers in the CSA 2000 and 2008 Acts are to:

- Issue a warning notice;
- Impose, vary or remove conditions;
- Issue a penalty notice in lieu of prosecution;
- Suspend registration;
- Cancel registration; and
- Prosecute for specified offences.

The 2008 Act does not fully come into force until April 2010; however regulations are being made under Section 20 of the Act that will apply to NHS organisations covered by the *Code of practice for the prevention and control of healthcare associated infections*. These regulations came into force in April 2009. As such from April 2009, NHS providers are required to register with the CQC and comply with the new requirements and regulations under the 2008 Act, which require them to protect patients and staff from acquiring a healthcare-associated infection.

If the CQC take enforcement action over healthcare associated infections during 2009/10, it will use the powers set out in the 2008 Act. For all other purposes the CQC will use the same powers and enforcement frameworks that the Healthcare Commission and the Commission for Social Care Inspection used i.e. those in CSA 2000.

How Boards get their Assurance

The Audit Commission has published the report *Taking it on Trust, A Review of How Boards of NHS Trusts and Foundation Trusts get their Assurance*. This report assesses the rigour with which boards operate as well as how they assess the assurances they need (specifically linked to the Board Assurance Framework). We will shortly be producing a separate briefing on this publication.

Data Quality

The Audit Commission has also recently published the report *Figures you can Trust, A Briefing on Data Quality in the NHS*. Ensuring that data is correct is important as good quality information essentially underpins the delivery of effective patient care. Lord Darzi's *Next Stage Review* signalled a shift in emphasis toward measuring and publishing quality outcome indicators. In turn this will give more information to patients and will enable them to make more informed decisions in choosing the service that best suits them. There will also be increased accountability with the introduction of Quality Accounts and ultimately link to payment mechanisms through Commissioning for Quality and Innovation. The majority of hospital funding is already dependent on accurate costing under Payment by Results (PbR). World Class Commissioning and the development of practice based commissioning rely on good data.

Recent work by the Audit Commission has shown that the quality of data in the NHS is not to the standard it needs to be. In 2004 the Audit Commission published the report *Information and Data Quality in the NHS: Key Messages from Three Years of Independent Review*, which concluded that although data quality had improved since the 1990's there were a number of recurring issues that needed to be addressed. These included:

- Waiting list and reference cost data at the national level was in fact reliable however different interpretations of guidance and definitions caused inconsistencies locally.
- NHS organisations could improve data quality by making more and better use of patient based information, promoting and reporting data to board members, training and developing staff and keeping systems up to date.
- Key organisations such as the DH, the then NHS Information Authority and regulators did not have a clear and coordinated approach to both reviewing and improving data quality.
- A culture of good data quality was not embedded within organisations.

Essentially, all of these issues that were raised in 2004 are still, in the most part, relevant today and progress in addressing these areas has been limited according to the Audit Commission, which proposes five steps to improve data quality:

- Clear leadership;
- Greater clinical engagement;
- A stronger interest from the Board;
- External monitoring and review; and
- More support for organisations.

Client Briefing Carbon Reduction Commitment

CB Gen 01.09 **March 2009**

The Carbon Reduction Commitment (CRC) is a new mandatory emissions trading scheme that will be launched in January 2010, for which organisations need to be preparing now.

The scheme will apply to large non-energy intensive organisations in the public and private sector (e.g. supermarket chains, hotels chains, office based corporations, government departments, hospitals and large local authorities), whose emissions are not currently included in the EU Emission Trading Scheme (ETS) or Climate Change Agreements.

Under the scheme qualifying organisations will be mandated to calculate and report their carbon emissions annually from April 2010 and will have to buy CRC allowances to cover their anticipated emissions for each year from April 2011.

Who will be affected?
Your organisation will be included in the CRC if it has at least one meter settled on the half hourly market and the total half-hourly metered (HHM) electricity used is greater than 6000 megawatt-hours between 1 January 2008 and 31 December 2008. This is equivalent to an electricity spend of approximately £500,000, although it will apply to emissions from direct energy use as well as electricity purchased.

In September 2009, the Environment Agency – who will administer the CRC – will contact all UK billing addresses with half hourly meters providing them with Registration Packs. In 2010, all organisations with an HHM will need to provide information on their total half-hourly electricity consumption for 2008 together with a list of their half-hourly meters, assisted by their electricity supplier. Those falling below the qualification criteria will still need to make an information disclosure every few years that tells the administrator about their electricity usage. Failure to do so by the end of the registration period will result in a fine.

The CRC will target UK emission of the highest parent organisation on behalf of all organisations in the group. If you are the highest parent organisation you will need to consider the electricity use of your subsidiaries/group organisations to assess whether you are included in the scheme. You will also be responsible for reporting on your total energy use emissions, including those of your Subsidiaries/group organisations. If you are a subsidiary of an organisation, you will need to pass on information about your energy use to your parent for them to report to Government at the end of each year.

All Central Government departments are also included in CRC regardless of whether they meet the qualification threshold or not. There are also specific guidelines for schools and universities.

These sector specific guidelines can be found in the CRC User Guide on the DEFRA website referred to overleaf.

How will it work?
On an annual basis participants will be required to monitor and report all their UK-based CO_2 emissions from all their fixed point energy sources. This includes electricity, gas and other fuel types such as LPG and diesel. However, organisations will not be required to report on their transport emissions, emissions covered by the EU ETS and emissions covered by Climate Change Agreements.

At the start of each compliance year (April) commencing from 2011, participants will have to purchase carbon allowances from the auction (or fixed price sale during the introductory phase) to cover their total emissions. All the income from the auctions will be recycled back to participants (October) by the means of an annual payment based on participants' average annual emissions since the start of the scheme, with a bonus or penalty according to the organisation's position in a CRC league table which will be published by the Government.

Consequently, there will be an adverse cashflow impact on all qualifying organisations. This will be a particular issue in 2011 when allowances will need to be purchased for actual energy usage in 2010/11 and estimated usage for 2011/12. However, this can be limited through improved carbon management. Nonetheless, CRC will typically result in a range of costs for participating organisations. These could include administration and consultancy advice, implementation of new technology, as well as the potential for fines and penalties due to non-compliance or poor performance. However, in the long term, it is likely that most organisations will enjoy significant financial benefits due to improved efficiency and lower energy costs.

For some organisations that do well on the CRC league table, CRC presents the opportunity to benefit from bonus payments that could more than outweigh any financial investment.

What are the metrics for the CRC league table?
From 2011 the government will publish a league table of carbon performance of participants, or at least name and shame those organisations at the bottom of the table. Therefore there is the potential for the reputation and brand of an organisation to be affected. Participants will receive a score for each of the three metrics and these will be combined to give an overall score. This will determine where a participant is placed in the overall league table.
The three metrics are:

- The *absolute metric* which is the base metric on which the league table will be formulated and will be the percentage change of annual emissions relative to the organisation's previous five year rolling average. This will account for a 60% weighting in the league table during the introductory phase.
- The *growth metric* which will measure the organisation's percentage change in emissions per unit of turnover relative to its average emissions per unit of turnover. For the public sector it will be per unit of revenue expenditure rather than unit of turnover. This will account for a 20% weighting in the league table for the introductory phase.
- The *early action metric* which will be in two parts. The first part is the extent that an organisation has installed non-mandatory automatic, or 'smart' metering. This will be measured as the percentage of an organisation's emissions covered by non-mandatory automatic metering. The second part of the early action metric will be the percentage of an organisation's emissions covered by the Carbon Trust's Energy Efficiency Accreditation Scheme (EEAS) or new Carbon Trust Standard (CTS).

The two parts of the early action metric will carry equal weighting (50/50) and account for a 20% weighting in the league table. The metering part of the early action metric will be frozen after the first year of the scheme and the entire early action metric will be discontinued after the introductory phase.

In the first year of the scheme, however, the early action metric will be the sole measurement and thereby will give recognition for good energy management undertaken prior to the start of the scheme.

To improve your chances of doing well in this metric you can voluntarily install automatic meters (AMR) and attain the Carbon Trust Standard, ensuring you have a valid compliance certificate for the relevant compliance year.

What should you be doing now?

- Making sure you have the information, or can get the information, about your annual energy use.
- Working out whether you need to make an information disclosure to the administrator. If you need to, or think you may need to, start gathering the necessary information.
- Evaluating whether you will need to register as a full participant of the scheme based on your electricity data for 2008.
- Developing a CRC compliance strategy appropriate to your business
- Calculating your likely CRC emissions footprint in order to calculate the allowances you will need to purchase (and the likely impact on your cash flow). Failure to purchase the correct level of permits may incur higher charges, penalties and further impact cash flow.
- Assessing compliance costs and optimal payment timings.
- Looking for ways to achieve the Early Action Measures.
- Building your energy saving plan.

Useful Resources

More details relating to CRC can be found on the following websites:

- The Carbon Trust provides many useful sources of information for those wishing to manage their energy use effectively. They also provide site survey and carbon management products for companies with energy bills over a certain size. www.carbontrust.co.uk
- Details of the Carbon Trust Standard for which accredited organisations will receive recognition in the CRC performance League Table. www.carbontruststandard.com
- The Department of Energy and Climate Change is mandated to bring about the transition to a low-carbon Britain. www.decc.gov.uk
- The Department for Environment, Food and Rural Affairs enables registration for updates on the scheme as well as access to the CRC User Guide. www.defra.gov.uk/carbonreduction

Client Briefing Independent Safeguarding Authority

CB Gen 02.09 **May 2009**

Introduction

The Independent Safeguarding Authority (ISA) was created to help prevent unsuitable people from working or volunteering with vulnerable adults and children. The ISA will assess every person that wishes to work with vulnerable people and will work in partnership with the Criminal Records Bureau (CRB). The CRB will continue to gather information about individuals and the ISA will then use this information to assess whether each person is suited to undertake work with vulnerable groups.

The ISA was initially created in January 2008 and has since:

- Provided advice to secretaries of state on who should be barred from working with children and vulnerable adults. The ISA assumed full responsibility for these decisions in January 2009.
- Recruited its Board and key members of staff.
- Developed its decision making process on which it will base its barring decisions.
- Taken referrals and placed individuals on the Protection of Vulnerable Adults (PoVA) and Protection of Children Act (PoCA) lists and List 99 (a list of individuals that are barred from working with children in the education sector). These three lists will be replaced by two new barred lists from October 2009.

The ISA was created by the Safeguarding Vulnerable Groups Act 2006, which defines the scope of the Vetting and Barring Scheme the ISA will follow. The Vetting and Barring Scheme (VBS) will cover England, Wales and Northern Ireland and begins on 12 October 2009. From this date increased safeguards will be brought into effect, with over five million more jobs and voluntary positions (including most NHS jobs) becoming subject to checks. Registrations with the ISA will be phased in over a five year period from July 2010.

The VBS is essentially designed to create a more streamlined, faster system of workplace vetting for those working with children or vulnerable adults and will build on current good practice. The ISA is in the final stages of producing detailed guidance that will enable employers, voluntary organisations and registered bodies to understand and implement the Scheme. As such, this briefing provides only an overview of the ISA's role and the Scheme it will operate.

Regulated and Controlled Activity

The ISA divides work with vulnerable groups into two categories: regulated and controlled. Regulated activity includes:

- Any activity that involves contact with children or vulnerable adults, frequently, intensively and / or overnight.
- Any activity allowing contact with children or vulnerable adults that is in a specified place frequently or intensively.
- Fostering and childcare.
- Any activity that involves people in certain defined positions of responsibility.

A 'frequent' activity is classed as once a month or more and 'intensive' is where activity takes place on three or more days in a 30 day period.

Those who provide support work in areas such as the NHS and further education, which will include roles such as cleaners, caretakers, receptionists and catering staff, are classed as controlled activities. All employers are required to check the status of any employee in this category however an employer can permit a barred individual to work in a controlled activity only if sufficient safeguards are put in place.

The ISA has not yet fully defined what roles are classed as regulated or controlled. As such, the ISA aim to publish additional guidance that covers sector specific information for a number of sectors, including: Higher Education, Further Education, Schools, Transport, Taxi & Private Hire Vehicle Drivers, Prison and Probation Services, Faith Groups, NHS and Healthcare, Sport and Youth, Volunteering, Local Authorities, Employment Agencies, Job Centres, Early Years and Childcare.

From July 2010 when an employer recruits someone to work with either children or vulnerable adults their status must be checked with the ISA. Likewise from July 2010, anyone who is recruited to provide a regulated activity must be registered with the ISA. It is a criminal offence for any barred person to take part in any regulated activity. It will be a legal requirement for an employer to check a person's status if they undertake regulated activity. If a person that has not been registered with the ISA is employed in either a regulated or controlled role the employer could face imprisonment or a fine of up to £5,000.

Existing Employees
From 2011 all existing employees will also need to be registered with the ISA. In the first instance, those employees who have not been checked by the CRB should apply to the ISA. Following this, employers should ask those who have been CRB checked to apply. Employers should encourage those with CRB checks that are the oldest to do this first. Importantly, it is the responsibility of the individual to register with the ISA and it is the employer's responsibility to check that all existing and potential employees are registered. Registration can be done through the existing employer or prospective employer. There will be a fee of £64 for registering with the ISA, although volunteers will be exempt from this charge. An employer can check the status of a potential employee free of charge.

Sharing Information
Some organisations are legally required to share information with the ISA. The organisations that have a legal obligation to provide information on an individual where there is concern that they pose a risk include:

- Adult / child protection teams in local authorities.
- Professional bodies and supervisory authorities named in the Safeguarding Vulnerable Groups Act.
- Employers and service providers of regulated and controlled activity.
- Personnel suppliers i.e. employment agencies and education institutions.

The ISA does, however, encourage other organisations to provide any information they may have.

Preparing for the Scheme
The ISA encourages organisations and individuals working with children or vulnerable people to build ISA registration into their forward planning. Human Resource and Finance departments should be made aware of the Scheme and organisations should be thinking about how they will phase their workforce through the ISA registration process over the five year period.

New Barred Lists

From 12 October 2009 the PoCA, PoVA and List 99 Schemes will cease to exist and in their place will be the Children's Barred List and the Adults' Barred List. Both lists will be administered by the ISA. These new barred lists will hold information about those individuals that are deemed unsuitable to work with either children or vulnerable adults. The ISA is currently reviewing all those already on the existing barred lists to determine whether they should be included on the new lists.

Timescales

From October 2009:

- A number of increased safeguards will be introduced including a wider definition of registered activities.
- The three current barring systems (POCA, POVA and List 99) will be replaced by two new barred lists. Essentially, checks against these new lists can be made as part of an Enhanced CRB check.
- Specified organisations have a duty to refer any information to the ISA about any individual that may pose a risk.
- There will be criminal penalties for any barred individual that either seeks to or actually does undertake work with vulnerable groups and likewise for employers who knowingly take them on to work with those groups.
- The eligibility criteria for Enhanced CRB checks will be extended to include anyone working in a regulated position.

From July 2010:

- Those individuals that currently work with children or vulnerable adults and are changing jobs will be required to become ISA registered. Those individuals who already work with vulnerable groups but are staying in their current role will not need to become ISA registered until later in the five year phasing in period.
- Employers and voluntary organisations working with children or vulnerable adults cannot recruit anyone that is not ISA registered.
- Individuals will be able to apply for ISA registration and a CRB check on one new application form.
- When a person becomes ISA registered they will be continuously monitored and their status will be reassessed if any new information comes to light.

From November 2010:

- The legal requirement for employees to register with the VBS and employers to check their status will come into force.

From 2011:

- All existing employees and volunteers with no CRB check are required to apply for ISA registration.
- All existing employers and volunteers with CRB checks need to apply for ISA registration, beginning with those staff members whose CRB checks are the oldest.

Full details with regards to registering with the ISA and exactly which roles are classed as regulated and controlled are yet to be released. Further information is available on the ISA webs

RSM Bentley Jennison

London Ambulance Service NHS Trust

Internal Audit Annual Report

Year ended 31 March 2009

Draft

Presented at the Audit Committee meeting of: June 2009

Approved by: Mark Jones as Head of Internal Audit

Contents

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1 Introduction

1.1 The Role of Internal Audit

The role of internal audit is to provide management with an objective assessment of the adequacy and effectiveness of internal control, risk management and governance arrangements. Internal audit is therefore a key part of London Ambulance Service's assurance cycle and if used properly can be inform and update the organisation's risk profile. Internal Audit is just one of the sources of assurance available to the Board and Audit Committee.

Exhibit A: The Assurance Cycle. © RSM Bentley Jennison

1.2 Statement on Internal Control

NHS bodies are required to make an annual Statement on Internal Control (SIC), which should include issues relating to risk management as well as control. As your internal audit provider, the assignment opinions that RSM Bentley Jennison provides the organisation during the year are part of the framework of assurances that assist the Accountable office in the preparation of an informed SIC.

The purpose of our opinion is to contribute to informing the Board on its completion of its SIC, but may also be taken into account by the Healthcare Commission in the conduct of its work under the Standards for Better Health.

2 The Head of Internal Audit Opinion

2.1 The Opinion

Internal Audit has not reviewed all risks and assurances relating to the Trust. The opinion is substantially derived from the completion of a risk based internal audit plan generated from the Trust's Assurance Framework. As such it is one component that the Board takes into account when making its Statement on Internal Control.

2.2 Internal Audit Assurance Statement

My opinion is set out as follows:-

Based on the work undertaken in 2008/09, **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. However, some weaknesses in the inconsistent application of controls put the achievement of particular objectives at risk. The key risks and issues are:-

Drug Controls
Our audit of drug controls identified a number of significant weaknesses in the management of drug packs at a station level within the Trust. Testing undertaken as part of our audit identified that there is a shortage of packs within the system due to the withholding of packs by Ambulance staff. This has resulted in out of date packs being used on occasions within a number of stations which exposes the risk of out of date drugs being given to patients, which may impact on the quality of care provided by the Trust. The Trust has taken immediate action following the issue of our report to address the weaknesses identified from our audit. A detailed action plan has been developed which also includes actions both to address the issues identified and to ensure ongoing compliance within the Trust.

2.3 The Basis of the Opinion

The basis for forming my opinion is as follows:

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes;
- An assessment of the range of individual opinions arising from audit assignments reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in addressing control weaknesses;
- An assessment of the process by which the organisation has arrived at its declaration in respect of the Standards for Better Health; and
- Any reliance that is being placed upon third party assurances, in particular:

2.4 Information Supporting the Opinion

The **commentary** below provides the context for my opinion and together with the opinion should be read in its entirety.

2.4.1 The design and operation of the Assurance Framework and associated processes

The Trust has a long established assurance framework which is utilised on a regular basis at both Audit Committee and Trust Board level. The framework is appropriately structured

however could be further enhanced through better recording of both the assurances in place to provide assurance that controls are operating effectively and the results of these assurances once they are received. The Trust is also undertaking a Board Workshop in 2009/10 to review the risk management and assurance processes in place to and enhance these further.

2.4.2 The range of individual opinions arising from risk based audit assignments, contained within the risk based plans that have been reported throughout the year

A number of the audits contained within the plan were specifically linked to the Trust's risk register, or were reviews requested by the Trust. Of the 14 reviews where a level of assurance was provided, the breakdown of levels of assurance is as below:
Substantial Assurance – 5
Adequate Assurance – 7
Limited Assurance – 2

The two limited assurance opinions were in respect of our audits of drug controls and policies and procedures. The key issues relating to our limited assurance opinion on drugs are highlighted within section 2.2 above.

Our audit of policies and procedures received limited assurance due to weaknesses in the systems to ensure that all policies and procedures are subject to regular review and dissemination to all applicable staff throughout the Trust. As the majority of staff within the Trust are based on ambulance vehicles for the majority of their working day, it is difficult for a process to be established which will ensure that all staff are able to easily access and read all new policies and procedures once these are issued. However, the Trust is considering a number of alternatives to address this in the future.

An assurance map is provided at Appendix A, linking our opinions to the Trust's risks. Details of our reviews, including the opinions given and the numbers of recommendations made is provided at Appendix B.

Common Weaknesses

No common weaknesses have been identified as part of our internal audit testing.

Acceptance of Recommendations

All of the recommendations made during the year were accepted by management.

Recommendations Not Receiving Adequate Management Attention

The Trust has a recommendation tracking process in place for following up on the degree of implementation of internal audit recommendations. A report is submitted to each Audit Committee for review. An audit was undertaken to assess the degree of implementation of those recommendations reported to the March 2009 Audit Committee. It was confirmed by review that reasonable progress in been made by the Trust in implementing the significant recommendations which had been reported as part of this paper, and that reporting against the status of these recommendations was accurate.

2.3.3 Standards for Better Health Processes and Declaration

As a result of our work it is considered that the Trust have a reasonable process in place to support the completion of the Standards for Better Health declaration.

2.3.4 Reliance Placed Upon Work of Other Assurance Providers

We have not place reliance on the work of any other assurance providers.

2.5 Issues Judged Relevant to the preparation of the Statement on Internal Control

Based on the work we have undertaken on the Trust's system of internal control the Trust should consider highlighting those issues flagged as significant within our report on drug controls and highlighted in Section 2 above. In addition, the Trust also needs to declare themselves non-compliant against standard C4d as part of their Standards for Better Health declaration.

2.6 Conflicts of Interest

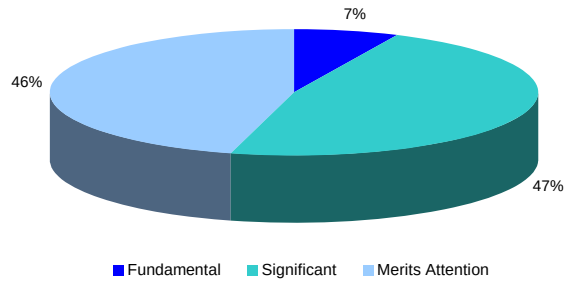
We have not undertaken any work or activity during 2008/09 that would lead us to declare any conflict of interests.

2.7 Benchmarking Data

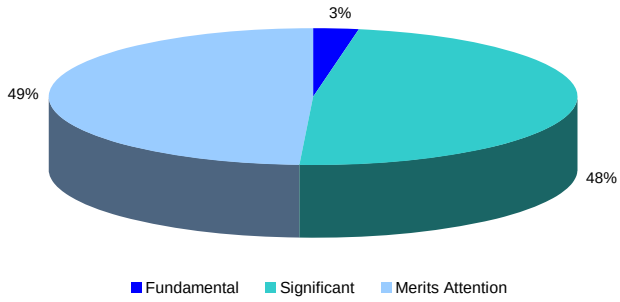
The tables below show the split of internal audit recommendations and opinions for London Ambulance Service NHS Trust in 2008/09 and those made in 2007/08. There has been very little difference in the percentage of positive assurance reports issued or the categorisation of recommendation made. Whilst there has been an increase for 2008/09 in the volume of fundamental recommendations made, all of these are in respect of one audit, on drug controls. In addition, where limited assurance opinions have been provided, these are in areas where audit resources have been directed by Trust management such as policies and procedures.

Comparison of the categories of internal audit recommendations made 2008/09 and 2007/08

Recommendations 2008/09



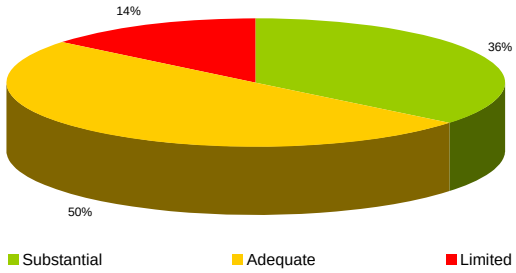
Recommendations 2007/08



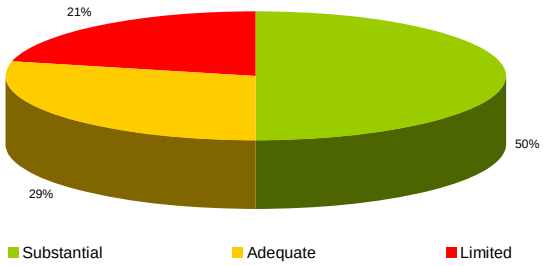
Comparison of assurance levels provided by internal audit in 2008/09 and 2007/08

Risk Based Assurance Assignments Only

Assurance Levels 2008/09

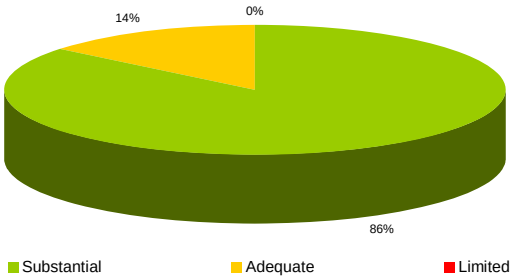


Assurance Levels 2007/08

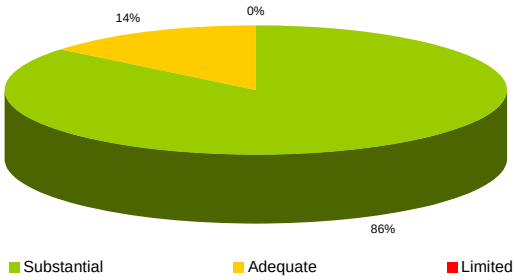


Assignments for External Audit Reliance

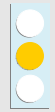
Assurance Levels 2008/09

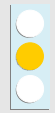
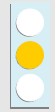


Assurance Levels 2007/08



Appendix A: Internal Audit Assurance Map 2008/09

Risk Based Coverage				
Risk(s)	**Source**	**Headline Findings**	**Assurance**	
Unavailability or the non-functioning of critical patient care equipment on vehicles. Inability to treat paediatrics due to equipment out of date (PALS packs)	Assurance Framework	Our audit of medical devices provided **adequate** assurance that effective controls are in place to manage medical devices at a station level. The following significant issues were identified:- ▪ 22 of 56 vehicles tested where recorded as ready for use, however these vehicles contained unsealed PALs Packs. If packs are not sealed then this increases the risk of devices falling out of storage compartments and becoming either damaged or contaminated. ▪ At 1 station, 1 item of medical equipment awaiting repair had not been thoroughly cleaned. This increases the risk of cross-contamination of other devices.	Adequate	
Drug errors and adverse events not being reported.	Assurance Framework	Our audit of drug controls provided **limited** assurance over the management of drug packs within the Trust. The following significant issues were identified: ▪ Testing undertaken as part of the audit identified fundamental weaknesses in the control over drug packs, particularly in respect of the management of out of date drug packs. Testing identified that, due to shortages in the numbers of packs within the system, that packs are not being returned on a timely basis. In addition, due to shortages in the numbers of drug packs in the system, it was identified that return drug pack lockers at two stations had been opened to enable access to used packs to address shortages at individual stations. Finally, it was noted that at least 6 drugs packs returned to Logistics in January 2009 were over a year out of date, the oldest of which went out of date in 2006. All of the above increases the risk that out of date drugs may be used by Trust staff. The Trust therefore needs to review as a matter of urgency the numbers of drug packs in circulation within the Trust, the processes for	Limited	

		the issue and return of the these packs to ensure that a) there are sufficient numbers of drug packs in circulation and b) that only new packs are used by staff and that all used or out of date drug packs are returned to logistics on a timely basis. ▪ As weaknesses have been identified within this audit in respect of the storage of drugs and the use of completed or out of date drug packs, the Trust needs to consider whether it should be declaring itself non-compliant in respect of the Standards for Better Health declaration. ▪ Finally, it was noted that serious untoward incidents in respect of drug errors are not formally reported to the Board via the report of the Medical Director. The introduction of reporting against this would ensure that the Board are made aware of any trends in the numbers of drug errors and can ensure that suitable actions are taken in respect of this.		
Without a clear, formal business strategy confirmed and an understanding of these other factors, there is less clarity about the financial implications, in terms of risk to income, investment and income growth forecasts.	Assurance Framework	Our audit of strategic planning provided **adequate** assurance over Programme Management arrangements for a sample of major projects within the Trust. The following significant issues were identified: ▪ Benefits/targets should be more measurable to allow the success or achievement of programmes to be gauged. This could be in the form of an outcome scorecard reported in the progress report on a monthly/quarterly basis. ▪ Ensure the End Report reviews the achievement of the objectives and benefits outlined in the PID, to provide assurance that programmes and projects are meeting initial expectations.	Adequate	
Risk of operational staff not being released to attend regular CPD modules and complex based training activities as defined in the Training Plan.	Assurance Framework	Our audit of training and development provided **adequate** assurance over the processes in place for the management of the Trust's training programme. The following significant issues were identified: ▪ Line managers are not always informed if their staff do not attend training courses and a valid reason is not	Adequate	

		always given. A non-attendance form should be filled in stating a valid reason for non attendance. This should then be submitted to the Education and Development Administration team. This is in order to minimise the risk of staff missing courses without a valid reason and also to ensure that the maximum number of staff attend each course. ▪ Staff who do not attend a course are then not guaranteed to be rebooked onto another course. The Resource Centre must ensure that, where possible, all staff who do not attend a course are re-booked onto the same programme at a later date as soon as possible to ensure that all staff attend the appropriate CPD training. Staff who are unable to be rebooked onto a course should be put onto a priority list to ensure that they are booked onto the course next time it becomes available. ▪ The Education and Development Administration team should communicate with the Resource centre to ensure that staff enrolled on courses that were cancelled are then re-enrolled onto the same course on a different date. This is to ensure that operational staff attend all mandatory training courses required of them to carry out their job roles effectively.		

Other Coverage				
Area	**Rationale for coverage**	**Headline Findings**	**Assurance**	
General Ledger	External Audit Reliance	Our audit of the general ledger system provided **adequate** assurance over the effectiveness of the ledger systems. The following significant issue was identified: ▪ Clear segregation of duties in the raising and authorisation of journals was not evident, as testing of journal entries confirmed one journal had been prepared and authorised by the same member of staff within the Finance Department.	Substantial	

Creditors	External Audit Reliance	Our audit of the creditors system provided **substantial** assurance with no significant issues identified.	Substantial	
Debtors	External Audit Reliance	Our audit of the debtors system provided **adequate** assurance with the following significant issue identified:- ▪ The Trust does not monitor Aged Debtors sufficiently to ensure that all monies due are recovered in a timely manner. Testing identified a number of aged debtors that had not been chased on a timely basis.	Adequate	
Payroll	External Audit Reliance	Our audit of the payroll system provided **substantial** assurance with the following significant issue identified:- ▪ Termination forms are being submitted late to payroll by the line managers and this is a main reason for the overpayments each month. Payroll must ensure that the line managers are aware of the deadlines each month for termination forms and that they submit these on time.	Substantial	
Budgetary Control	External Audit Reliance	Our audit of budgetary control provided **substantial** assurance with the following significant issue identified:- ▪ Not all budget holders had signed up to their budgets at the start of the financial year.	Substantial	
Asset Register	External Audit Reliance	Our audit of the asset register system provided **substantial** assurance with no significant issues identified.	Substantial	
Treasury Management	External Audit Reliance	Our audit of the treasury management system provided **substantial** assurance with no significant issues identified.	Substantial	
Benefits Realisation -Invest to Save Project	Management Concern	Our audit the benefit realisation arrangements around the Invest to Save project provided **adequate** assurance with the following significant issues identified:- ▪ The nature of the Invest to Save project was that a large sum of money became available at short notice which could be used for a wide range of projects but which	Adequate	

		was required to be spent by 31 March 2008. This presented a considerable challenge to the governance and project management arrangements around Invest to Save. ▪ Individual project briefs varied considerably in terms of their quality. Risks and the mitigating actions could have been better defined and this might have helped to improve the likelihood of successful and timely outcomes; ▪ Benefits to be achieved from each project were in general not well defined within the individual project briefs. Specifically, the benefits that were outlined did not contain clear measurements which meant it would be hard for the Trust to determine whether these benefits had been achieved; ▪ The closure reports for each of the projects did not refer to the performance against budgeted costs. Whilst cost management was not the key driver of the Invest to Save Project this is a discipline which should be embedded within project management at the Trust; ▪ The Trust commenced a large number of disparate projects as part of the Invest to Save project and this placed a large amount of pressure upon the corporate services and in particular the IT function. This directly led to some delays in the timely delivery of individual projects; and ▪ Many of the projects remain to be completed or have only recently completed. In the case of some of the implementation projects it would be sensible to apply some detailed benefits analysis around the start of the next financial year, which will have allowed sufficient time for new systems to embed within the Trust and for appropriately measureable benefits to be determined and assessed against.		

Assurance Framework	DoH Requirement	The Trust has a long established assurance framework which is utilised on a regular basis at both Audit Committee and Trust Board level. The framework is appropriately structured however could be further enhanced through better recording of the assurances in place to provide assurance that controls are operating effectively and the results of these assurances once they are received. The Trust is also undertaking a Board Workshop in 2009/10 to review the risk management and assurance processes in place to and enhance these further.	Advisory	-
Standards for Better Health	DoH Requirement	As a result of our work we consider that the Trust has a reasonable process in place to support the completion of its declaration	Reasonable	
Policies and Procedures Governance	Management Concern	Our audit of policies and procedures provided limited assurance over the processes in place for the control and issue of policies throughout the Trust. The following significant issues were identified:- ▪ There is no centralised and comprehensive listing of all policies and procedures. This could assist in ensuring policies and procedures are updated and reviewed by due dates. ▪ The Trust has recently implemented a new standard corporate format to be applied to all policies and procedures, which includes a document profile and control page; however, testing showed that this has not yet been utilised for all policies and procedures. There is a risk that policies will not be reviewed, approved and ratified on a timely basis. The corporate format also has the advantage of ensuring consistency and increased understanding. ▪ The standard corporate format also includes an implementation plan which a number of policies and procedures do not yet incorporate. This could lead to them not being disseminated to staff appropriately, not being communicated clearly, inadequate training being provided to staff and ultimately in them being insufficiently monitored. ▪ A number of policies and procedures have not gone	Limited	

		through the process of ratification or do not have an indicated date of ratification which could lead to them being used prior to sanctioning; ▪ The Equality and Diversity and Employment policy which was due to be reviewed in June 2008, has yet to be reviewed because the new Diversity Manager has only recently started in post; ▪ The RIB is an important and vital communication channel, to staff, of policies and procedures. It is normal policy to announce new and revised policies and procedures in the RIB although this could not be tracked for some of them A number of policies and procedures have not been communicated on the RIB. Once policies and procedures are approved an announcement on the RIB should be made to LAS staff to ensure they are aware of them being distributed. ▪ The Trust does not hold any records of staff having read and accepted key policies and procedures. This acceptance of having read policies maintains a log of who has read, understood and accepted the policies and procedures. ▪ Although training is adequate, it is best practise and advised that the Trust introduces a question and answer session, electronically i.e. E-Learning, to test operational staffs reading and understanding of the policies and procedures. ▪ The Trust currently does not report on the non compliance with policies and procedures. Although there are reports produced on incidents and that by its nature, at times bring up the subject of policies and procedures, it is not a comprehensive report. A clear and comprehensive link between incidents and non compliance of policies and procedures should be introduced and documented and reported so as to ensure adequate monitoring of the policy and procedures effectiveness, workability and whether they		

		are adequately sufficient.		
Follow up	Ongoing assurance over the implementation of internal audit recommendations.	The Trust has made reasonable progress towards implementing previous internal audit recommendations.	Reasonable progress	

Appendix B: Internal Audit Opinions and Recommendations 2008/09

Auditable Area	Draft Report Issued	Responses Received	Final Report Issued	Assurance Level given	Number of Recommendations made				
					Fundamental	Significant	Merits Attention	In Total	Agreed
Risk Based Audits linked to the Assurance Framework									
Medical Devices	12-03-2009	27-05-2009	28-05-2009	Adequate	0	3	2	5	5
Drug Controls	13-03-2009	28-04-2009	28-04-2009	Limited	5	2	0	7	7
Strategic Planning	17-03-2009	-	-	Adequate	0	2	5	7	-
Training and Development	20-02-2009	-	-	Adequate	-	3	1	4	-
Audits undertaken for external audit reliance									
General Ledger	17-11-2008	02-12-2008	02-12-2008	Substantial	0	1	1	2	2
Creditors	4-11-2008	16-12-2008	17-12-2008	Substantial	0	0	3	3	3
Debtors	17-11-2008	11-02-2009	11-02-2009	Adequate	0	2	0	2	1
Treasury Management	22-12-2008	11-02-2009	11-02-2009	Substantial	0	0	0	0	0
Asset Register	16-12-2008	17-12-2008	17-12-2008	Substantial	0	0	2	2	2
Payroll	17-02-2009	-	-	Substantial	0	1	2	3	-
Budgetary Control	04-12-2008	04-12-2008	05-12-2008	Substantial	0	1	1	2	2
Assurance Framework	28-05-2009	-	-	Advisory	0	3	5	8	-
Standards for Better Health	13-03-2009	27-05-2009	27-05-2009	Reasonable	0	0	1	1	1
Other									
Benefits Realisation – Invest to Save Programme	19-12-2008	19-02-2009	20-02-2009	Adequate	0	5	4	9	9
Policies and Procedures	05-02-2009	28-05-2009	28-05-2009	Limited	0	6	3	9	9
Follow Up	2-06-2009	-	-	Reasonable	0	4	3	7	-

The definitions for the level of assurance that can be given are:

	Level	Effectiveness	Control Adequacy	Control Application
positive opinions	Substantial Assurance	Targets have been met or exceeded.	Robust framework of controls ensures objectives are likely to be achieved.	Controls are applied continuously or with minor lapses.
	Adequate Assurance	Targets have been closely missed or there are appropriate reasons as to why they have not been met	Sufficient framework of key controls for objectives to be achieved but, control framework could be stronger.	Controls are applied but with some lapses.
negative opinion	Limited Assurance	Targets have not been met and no reasons are given as to why.	Risk of objectives not being achieved due to the absence of key internal controls.	Significant breakdown in the application of controls.

Recommendations made during the year have been categorised as follows:

Fundamental	Action is imperative to ensure that the objectives for the area under review are met.
Significant	Requires action to avoid exposure to significant risks in achieving the objectives for the area under review.
Merits Attention	Action advised to enhance control or improve operational efficiency.

8 Ratification of Final 2008/09 Audited Accounts

London Ambulance Service
NHS Trust

Audit Committee Front Sheet

Title:	**Agenda Item: 8**
Final 2008/09 Audited Accounts	**Enclosure: 8**

Purpose:

To inform the audit committee on the financial performance of the Trust for the year ending 31st March 2009.

Summary:

Financial Performance - The retained surplus for the year was £725k.

Capital Cost Absorption Rate – The Trust is required to make a 3.5% financial return on average net relevant assets. The actual rate of return in 2008/09 was 4.2%; this was above the permitted range of 3.0% to 4.0%. The variance from 3.5% is due to the fall in value of land & buildings attributable to the current economic downturn.

External Financing Limit (EFL) – The Trust achieved its External Financial Limit (EFL) target of £7,467k for the year.

Capital Resource Limit (CRL) – The Trust is given a CRL which it is not permitted to overspend. The CRL was under spent by £1,247k against the limit agreed with the London Strategic Health Authority of £15,865k.

Public Sector Payment Policy (PSPP) – The PSPP performance for Non-NHS trade invoices was 85% and for NHS invoices 89% (in numbers of invoices); the target set by the Strategic Health Authority is 95%.

The Trust is required to submit its audited accounts to the Department of Health on or before the 12 June 2009.

Recommendations/and or actions required:

The committee is asked to ratify the final 2008/09 audited accounts for the year ending 31 March 2009.

Author and Date: Michael Dinan, 29 May 2009

LONDON AMBULANCE SERVICE NHS TRUST

Audit Committee – 8 June 2009

Report on behalf of the Executive Trust Director Finance

Audited Annual Accounts for the year ending 31 March 2009

1. **Annual Accounts**

   The Audited Annual Accounts for the year ending 31 March 2009 are attached.

2. **Statutory Duties (Note 24, pages 36/37)**

   Performance against the four statutory duties was as follows:

   - **Breakeven performance – achieved**

     The retained surplus for the year was £725k.

   - **Capital Cost Absorption Rate – not achieved**

     The Trust is required to make a 3.5% financial return on average relevant net assets. The actual rate of return in 2008/09 was 4.2%; this was above the permitted range of 3.0% to 4.0%. The variance from 3.5% is due to the fall in value of land & buildings attributable to the current economic downturn.

   - **External Financing Limit – achieved**

     The Trust achieved its External Financial Limit (EFL) target of £7,467k for the year.

   - **Capital Resource Limit – achieved**

     The Trust is given a Capital Resource Limit (CRL) which it is not permitted to overspend. The CRL was under spent by £1,247k against the limit agreed with the London Strategic Health Authority of £15,865k.

3. **Accounts Completion**

   The Annual Accounts were completed by the 23rd April 2009 target date and submitted to the NHSE, Audit Commission and London SHA.

4. Public Sector Payment Policy (PSPP) (Note7.1, page 22)

The PSPP performance for Non-NHS trade invoices was 85% and for NHS invoices it was 89% (in numbers of invoices); the target set by the Strategic Health Authority was 95%.

5. **Auditors Local Evaluation (ALE)**

The ALE assessment for 2008-09 has not been completed at the time of this report. Last year the Trust achieved a 'Good' rating out of a possible Excellent, Good, Fair or Weak rating. The table below shows the current position, the highest score achievable for any category is 4:

ALE	2007-08	2008-09	Comments
Financial Management	3	4	Provisional - To be confirmed
Internal Control	2	3	Provisional - To be confirmed
Value for Money	3	3	Provisional - To be confirmed
Financial Standing	4	4	Provisional - To be confirmed
Financial Reporting	3	3	Provisional - To be confirmed
Final Overall Score	3	4	Provisional - To be confirmed

6. **Other Matters**

A verbal commentary on the annual accounts will be provided at the meeting.

The Committee are asked to ratify the annual accounts, in readiness for the Trust Board's approval.

Michael Dinan
Director of Finance
29th May 2009

Data entered below will be used throughout the workbook:

Trust name:	London Ambulance Service NHS Trust
This year	2008/09
Last year	2007/08
This year ended	31 March 2009
Last year ended	31 March 2008
This year beginning	1 April 2008

DIRECTORS' STATEMENT

Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Secretary of State has directed that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Department of Health. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the Trust;

- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

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

Signed……Chief Executive Date……

Statement of directors' responsibilities in respect of the accounts

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

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgements and estimates which are reasonable and prudent;

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

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

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

By order of the Board

Signed……Chief Executive, Date ……

Signed……Finance Director, Date ……

Independent auditor's report to the Board of Directors of London Ambulance Service NHS Trust

Opinion on the financial statements

I have audited the financial statements of London Ambulance Service NHS Trust for the year ended 31 March 2009 under the Audit Commission Act 1998. The financial statements comprise the Income and Expenditure Account, the Balance Sheet, the Cashflow Statement, the Statement of Total Recognised Gains and Losses and the related notes. These financial statements have been prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service set out within them. I have also audited the information in the Remuneration Report that is described as having been audited.

This report is made solely to the Board of Directors of London Ambulance Service NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 36 of the Statement of Responsibilities of Auditors and of Audited Bodies prepared by the Audit Commission.

Respective responsibilities of Directors and auditor

The directors' responsibilities for preparing the financial statements in accordance with directions made by the Secretary of State are set out in the Statement of Directors' Responsibilities.

My responsibility is to audit the financial statements in accordance with relevant legal and regulatory requirements and International Standards on Auditing (UK and Ireland).

I report to you my opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England. I report whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England. I also report to you whether, in my opinion, the information which comprises the commentary on the financial performance included within the Operational and Financial Review and included in the Annual Report, is consistent with the financial statements.

I review whether the directors' Statement on Internal Control reflects compliance with the Department of Health's requirements, set out in ' Guidance on Completing the Statement on Internal Control 2008/09' issued on 25 February 2009. I report if it does not meet the requirements specified by the Department of Health or if the statement is misleading or inconsistent with other information I am aware of from my audit of the financial statements. I am not required to consider, nor have I considered, whether the directors' Statement on Internal Control covers all risks and controls. Neither am I required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. This other information, comprising the Foreword, the unaudited part of the Remuneration Report, the Chairman's Statement and the remaining elements of the Operating and Financial Review included in the Annual Report, is consistent with the financial statements. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinion

I conducted my audit in accordance with the Audit Commission Act 1998, the Code of Audit Practice issued by the Audit Commission and International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements and the part of the Remuneration Report to be audited. It also includes an assessment of the significant estimates and judgments made by the directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that:

- the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error; and
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared.

In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report to be audited.

Opinion

In my opinion:

- the financial statements give a true and fair view, in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England, of the state of the Trust's affairs as at 31 March 2009 and of its income and expenditure for the year then ended;

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England; and

- information which comprises the commentary on the financial performance included within the Operational and Financial Review, included within the Annual Report, is consistent with the financial statements.

……

……. ***Date***

Philip Johnstone
District Auditor
Audit Commission
First Floor, Millbank Tower
30 Millbank, London, SW1P 4HQ

Conclusion on arrangements for securing economy, efficiency and effectiveness in the use of resources

Directors' Responsibilities

The directors are responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance and regularly to review the adequacy and effectiveness of these arrangements.

Auditor's Responsibilities

I am required by the Audit Commission Act 1998 to be satisfied that proper arrangements have been made by the Trust for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires me to report to you my conclusion in relation to proper arrangements, having regard to the criteria for NHS bodies specified by the Audit Commission. I report if significant matters have come to my attention which prevent me from concluding that the Trust has made such proper arrangements. I am not required to consider, nor have I considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of recources are operating effectively.

Conclusion

I have undertaken my audit in accordance with the Code of Audit Practice and having regard to the criteria for NHS bodies specified by the Audit Commission and published in December 2006, I am satisfied that, in all significant respects, London Ambulance NHS Trust made proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31st March 2009.

Certificate

I certify that I have completed the audit of the accounts in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

……

……. ***Date***

Philip Johnstone
District Auditor
Audit Commission
First Floor, Millbank Tower
30 Millbank, London, SW1P 4HQ

Statement of Internal Control 2008-09

1. Scope of Responsibility

The 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.

The accountability arrangements that surround this role are supported by the management structure, processes and monitoring arrangements set out in the Risk Management Policy. The Policy defines risk as anything threatening the achievement of our strategic objectives. It defines the ownership and the subsequent management of the identified risk. The Chief Executive has overall responsibility for risk management in the London Ambulance Service.

A summary of the Risk Management Policy can be found on our website.

As part of our strategic planning process, a wide range of stakeholders have been involved in determining our strategic objectives and associated risks. The views of our stakeholders have been key to the development of our Strategic plan 2007-2013 which will enable us to provide Londoners with an ambulance service for the future. A 14 week public consultation, about the Trust's proposals to become a Foundation Trust, was also launched in February 2009 to gather the views of the public.

The Trust meets with NHS London and the lead Commissioners on a regular basis, to ensure that both the national and local targets are met and risks are mitigated to acceptable levels.

2. The purpose of the system of internal control

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 on-going 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.

The system of internal control has been in place in the London Ambulance Service NHS Trust for the year ended 31 March 2009 and up to the date of the approval of the annual report and accounts.

3. Capacity to handle risk

The management of risk within the London Ambulance Service (LAS) is delegated by the Trust Board through the Chief Executive who attends the Audit Committee and is chair of the Risk Compliance and Assurance Group. Risk is divided into Governance, Business Continuity, Clinical, Corporate, Financial, HR, Health and Safety, IM&T, Infection Control, Logistics, Operational and Reputation; with the Director of Finance having overall responsibility for financial risk and any other corporate risks not covered by other directors. He attends the Audit Committee and chairs the standards for Better Health Group, overseeing part of the Annual Health Check that includes the healthcare standards. The Medical Director is responsible for clinical risk which is reported to and monitored by the Risk Compliance and Assurance Group through the mechanism of the Clinical Governance Committee. The Medical Director is a member of the Risk Compliance and Assurance Group and Clinical Governance Committee. She is Director of Infection Prevention and Control and monitors the Trust's compliance with the Code of Hygiene. Individual executive directors are responsible for, and manage, the corporate risks within their particular areas of responsibility.

Risks, as identified using the risk assessment tool in the Risk Reporting and Assessment Procedure, are approved at the Risk Compliance and Assurance Group. The tool uses a numerical scoring system grading risks. The management of the identified risks is coordinated by the Risk Compliance & Assurance Group. Those of a high priority are monitored by one of the sub-committees of the Board. All significant risks are recorded on the Risk Register which is used to help prioritise and make decisions on spending allocations for service development.

The Trust holds its governance arrangements under continuous review .It ensures that other infrastructure requirements (statutory, mandatory or desirable) for the organisation are in place. Strengths and weaknesses of current governance practice within the Trust will be amended where necessary to meet the requirements for becoming a Foundation Trust. Systems of internal control will be fully maintained during the authorisation process for becoming a Foundation Trust.

4. The risk and control framework

The Risk Management Policy defines the risk management process which specifies the way risk (or change in risk) is identified, evaluated and controlled. In addition to this the Trust is compliant with level 1 of the revised NHSLA Risk Management Standards for Ambulance Services.

The Risk Management Policy also describes responsibilities for embedding risk management in the organisation. On a local level staff report clinical and non-clinical incidents as indicated in the Incident Reporting Procedure. All incidents are assessed using the LAS Risk Scoring Matrix and according to grade and score investigated so that actions can be implemented to prevent a re-occurrence. A rolling quarterly programme of audit assesses compliance with infection control policy. The Trust has submitted an assessment to the Care Quality Commission confirming compliance with its infection control standard.

In addition to the Risk Management Policy and the Risk Register, the Assurance Framework enables us to examine how we are managing risks that are threatening the achievement of our strategic objectives and key targets in the Healthcare Commission Annual Health check. This has been achieved by mapping risks from the Risk Register against the standards contained within the health check, identifying the key controls in place that are managing these risks and listing assurances (positive or negative) that we have received assuring the effectiveness of these controls. Progress with mitigating the risks is reviewed by the Risk Compliance and Assurance Group.

The development of the Assurance Framework is an ongoing process and it will be amended with Board level objectives as they are reviewed and developed in strategic plans. As the Framework covers all of our organisation's main activities, it is a key tool in examining the system of internal control that is in place to manage our risks. The 25 highest scoring risks populate the Assurance Framework and are cross referenced to the domains and core standards of the Annual Health Check. The Standards for Better Health Group updated the controls as they analysed the evidence of compliance with the requirements of the Annual Health Check 08/09.

Control Measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Assurance Framework is used as a decision making tool and it has highlighted some gaps in control and assurance to the Board. Notably controls around the booking of annual leave were strengthened and on going actions are being taken to ensure that the processing of Patient Report Forms (PRF) adheres to the Trust's procedures.

The London Ambulance Service NHS Trust is 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 are complied with. This includes ensuring that deductions from salary, employer's contributions and payments 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.

Actions have been taken in the following areas to strengthen controls and minimise risk:

Human Resources and Organisation Development

The Trust has implemented a new generic equality and diversity strategy, taking forward the work from the previous Race Equality, Disability Equality and Gender Equality Schemes and encompassing the three additional strands of age, religion or belief and sexual orientation in preparation for the new Single Equality Act.

Establishment of a new senior management-led Equality and Diversity Steering Group.

The Trust has recruited an additional 398 paramedics to improve the delivery of the Category B target.

Clinical

Documentation of clinical care has been identified as a clinical risk for the Service. In addition to a robust programme of clinical audit, we have in place a structured Clinical Performance Indicator (CPIs) process by which Team Leaders monitor the standards of clinical care delivered to patients and PRF documentation. Information from the CPIs is used to provide individual feedback to operational staff highlighting areas of concern and good clinical practice. Monthly reports providing compliance to care standards, levels of PRF completion and rates of staff feedback are provided to Complex Management Teams across the Service to enable them to benchmark and monitor performance, and take remedial action where necessary. The findings from these reports are routinely discussed at the quarterly Area Business Meetings chaired by Assistant Directors of Operations. Area reports are then presented to Clinical Governance Committee.

Control Services

In the year the basis for the measurement of the Trust's performance changed. The measurement now commences from the point at which the call is connected to the Emergency Operations Centre. This on average reduces the time to respond to an incident by two minutes. Procedures in the Trust have been streamlined and investment in systems made to deliver against the changed method of measurement.

Information Management and Technology

The project to replace the control system, CTAK, with a new system designated CAD2010 is underway. This will significantly enhance the resilience and capability of the service.

Software to automatically despatch Fast Response Units and Ambulances has been installed to support compliance with the operational targets.

Smartcards have been introduced for the storage of clinical data.

Work on the establishment of a third data centre has been undertaken to improve robustness of the network.

Business Continuity

A rolling programme of testing departmental plans was carried out.

A review of all Business Continuity plans was undertaken on 5 February 2009.

As a result of these actions changes were made to the overall Trust Business Continuity Plan.

A&E Operations

National Category B targets have been highlighted by internal performance monitoring mechanisms as being at high risk for non-achievement. The senior A&E management team worked with commissioners and NHS London to overcome hospital challenges experienced over the winter months. The Trust achieved 84.5% for the year as a whole which is the best performance ever against the Category B target.

5. Significant Control Issue

The Trust was not fully compliant with the core standard for better health C4d between the period January 2009 and March 2009. Instances were found of weakness in the management of non-controlled drugs carried by ambulance crews. The Trust took immediate action to address the issues and ensure that there are sufficient drug packs in circulation. Only new packs are used and all used or out of date packs are returned to Logistics on a timely basis. I consider that the Trust is now compliant with the core standard. It must be emphasised that patient safety was not compromised during the period in question.

6. Review of Effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by bodies such as external auditors, the Healthcare Commission, the HSE and the validation team of Improving Working Lives.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Audit Committee and Risk Compliance & Assurance Group. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board is informed of the effectiveness of the system on internal control through its sub-committees. The Audit Committee advises the Board about how well the Trust is operating the Risk Management System. To carry out this responsibility it receives reports from the Chief Executive and from both internal and external audit when they review risk management systems and processes.

The Clinical Governance Committee has responsibility for ensuring the provision of high quality clinical care in the Trust. This is achieved through monitoring and making appropriate recommendations on performance in areas of clinical governance reviewed by the Healthcare Commission. The Risk Compliance & Assurance Group has delegated responsibility for taking a general overview of all risk management activities within the Trust and to pick up any specific risk management issues which are not covered by the specific Audit and Clinical Governance Committees. This committee also receives a report on the management of all identified high priority risks that have been identified by Trust systems and processes.

The structure is supported by the Executive Managers of the Trust including the Director of Finance who has overall responsibility for financial risk, and for any corporate risks not covered by other directors. The Medical Director has overall responsibility for clinical governance, and is a member of the Clinical Governance Committee and Information Governance Group. The Director of IM&T is responsible for all risks arising out of the provision, use, operation and maintenance of the Trust's technology and communication systems and he also jointly chairs the Information Governance Panel.

To supplement this mechanism, information is provided to the Board through minutes and annual reports from the Audit Committee, and on risk management, infection control, PALS and complaints, and clinical governance to assure the Board that sufficient progress has been made.

To conclude, procedures are in place to ensure a robust system of internal control is in place which is reflected in the risk and assurance frameworks.

Chief Executive Officer
(on behalf of the Board)

FOREWORD TO THE ACCOUNTS

LONDON AMBULANCE SERVICE NHS TRUST

These accounts for the year ended 31 March 2009 have been prepared by the London Ambulance Service NHS Trust under section 98(2) of the National Health Service Act 1977 (as amended by section 24(2), schedule 2 of the National Health Service and Community Care Act 1990) in the form which the Secretary of State has, with the approval of the Treasury, directed.

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31 March 2009

	NOTE	2008/09 £000	2007/08 £000
Income from activities	3	**251,378**	234,117
Other operating income	4	**10,154**	2,013
Operating expenses	5-7	**(256,832)**	(232,451)
OPERATING SURPLUS/(DEFICIT)		**4,700**	3,679
Cost of fundamental reorganisation/reconstruction*		**0**	0
Profit/(loss) on disposal of fixed assets	8	**(52)**	(41)
SURPLUS/(DEFICIT) BEFORE INTEREST		**4,648**	3,638
Interest receivable		**651**	989
Interest payable	9	**0**	(3)
Other finance costs - unwinding of discount	17	**(160)**	(147)
SURPLUS/(DEFICIT) FOR THE FINANCIAL YEAR		**5,139**	4,477
Public dividend capital dividends payable		**(4,414)**	(4,079)
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR		**725**	398

The notes on pages 5 to 43 form part of these accounts.
All income and expenditure is derived from continuing operations.

BALANCE SHEET AS AT 31 March 2009

	NOTE	31 March 2009 £000	31 March 2008 £000
FIXED ASSETS			
Intangible assets	10	**6,752**	3,765
Tangible assets	11	**107,061**	119,652
Financial assets	14	**0**	0
TOTAL FIXED ASSETS		**113,813**	123,417
CURRENT ASSETS			
Stocks and work in progress	12	**2,600**	1,930
Debtors	13	**12,467**	21,417
Investments		**0**	0
Other financial assets	14	**0**	0
Cash at bank and in hand	19.3	**2,651**	10,478
TOTAL CURRENT ASSETS		**17,718**	33,825
CREDITORS: Amounts falling due within one year	15.1	**(14,462)**	(18,471)
Financial liabilities	16	**0**	0
NET CURRENT ASSETS/(LIABILITIES)		**3,256**	15,354
TOTAL ASSETS LESS CURRENT LIABILITIES		**117,069**	138,771
CREDITORS: Amounts falling due after more than one year	15.2	**0**	0
Financial liabilities	16	**0**	0
PROVISIONS FOR LIABILITIES AND CHARGES	17	**(11,931)**	(18,589)
TOTAL ASSETS EMPLOYED		**105,138**	120,182
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital	23	**57,523**	56,488
Revaluation reserve	18	**32,810**	50,605
Donated asset reserve	18	**9**	68
Government grant reserve	18	**0**	0
Other reserves*	18	**(419)**	(419)
Income and expenditure reserve	18	**15,215**	13,440
TOTAL TAXPAYERS' EQUITY		**105,138**	120,182

The financial statements on pages 1 to 43 were approved by the Audit Committee on 8th June 2008 and signed on its behalf by:

Signed: ……(Chief Executive) Date: ……

Signed: ……(Chairman) Date: ……

STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES FOR THE YEAR ENDED 31 March 2009

	2008/09	2007/08
	£000	£000
Surplus/(deficit) for the financial year before dividend payments	**5,139**	4,477
Fixed asset impairment losses	**0**	0
Unrealised surplus/(deficit) on fixed asset revaluations/indexation	**(16,742)**	8,341
Increases in the donated asset and government grant reserve due to receipt of donated and government grant financed assets	**0**	0
Defined benefit scheme actuarial gains/(losses)	**0**	0
Additions/(reductions) in "other reserves"	**0**	0
Total recognised gains and losses for the financial year	**(11,603)**	12,818
Prior period adjustment	**0**	0
Total gains and losses recognised in the financial year	**(11,603)**	12,818

CASH FLOW STATEMENT FOR THE YEAR ENDED
31 March 2009

	NOTE	2008/09 £000
OPERATING ACTIVITIES		
Net cash inflow/(outflow) from operating activities	19.1	**7,867**
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:		
Interest received		**625**
Interest paid		**0**
Interest element of finance leases		**0**
Net cash inflow/(outflow) from returns on investments and servicing of finance		**625**
CAPITAL EXPENDITURE		
(Payments) to acquire tangible fixed assets		**(11,082)**
Receipts from sale of tangible fixed assets		**3,912**
(Payments) to acquire intangible assets		**(4,375)**
Receipts from sale of intangible assets		**0**
(Payments to acquire)/receipts from sale of fixed asset investments		**0**
(Payments to acquire)/receipts from sale of financial instruments		**0**
Net cash inflow/(outflow) from capital expenditure		**(11,545)**
DIVIDENDS PAID		**(4,414)**
Net cash inflow/(outflow) before management of liquid resources and financing		**(7,467)**
MANAGEMENT OF LIQUID RESOURCES		
(Purchase) of finacial assets with the Department of Health		**0**
(Purchase) of other current financial assets		**0**
Sale of financial assets with the Department of Health		**0**
Sale of other current financial asset		**0**
Net cash inflow/(outflow) from management of liquid resources		**0**
Net cash inflow/(outflow) before financing		**(7,467)**
FINANCING		
Public dividend capital received		**1,035**
Public dividend capital repaid		**0**
Loans received from the Department of Health		**0**
Other loans received		**0**
Loans repaid to the Department of Health		**0**
Other loans repaid		**0**
Other capital receipts		**0**
Capital element of finance lease rental payments		**0**
Cash transferred (to)/from other NHS bodies*		**0**
Net cash inflow/(outflow) from financing		**1,035**
Increase/(decrease) in cash		**(6,432)**

* This line is only used by NHS Trusts that are dissolved mid-year.

2007/08 £000
18,970
913
(3)
0
910
(6,703)
6
(1,745)
0
0
0
(8,442)
(4,079)
7,359
0
0
0
0
0
7,359
2,329
(1,367)
0
0
0
0
0
0
0
962
8,321

NOTES TO THE ACCOUNTS

1 ACCOUNTING POLICIES

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the NHS Trust Manual for Accounts which shall be agreed with HM Treasury. The accounting policies contained in that manual follow UK generally accepted accounting practice and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to the NHS. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of fixed assets at their value to the business by reference to their current costs. NHS Trusts are not required to provide a reconciliation between current cost and historical cost surpluses and deficits.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are acquired from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Income Recognition

Income is accounted for applying the accruals convention. The main source of income for the Trust is from commissioners in respect of healthcare services provided under local agreements. Income is recognised in the period in which services are provided. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.4 Intangible fixed assets

Intangible assets are capitalised when they are capable of being used in a Trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

Intangible fixed assets held for operational use are valued at historical cost and are depreciated over the estimated life of the asset on a straight line basis, except capitalised Research and Development which is carried at historic cost as a proxy for current cost. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred. They are amortised over the shorter of the term of the licence and their useful economic lives.

1.5 Tangible fixed assets

Capitalisation

Borrowing costs associated with the construction of new assets are not capitalised.
Tangible assets are capitalised if they are capable of being used for a period which exceeds one year and they:

- individually have a cost of at least £5,000; or
- collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Valuation

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs such as installation directly attributable to bringing them into working condition. They are restated to current value each year. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

All land and buildings are restated to current value using professional valuations in accordance with FRS15 every five years and in the intervening years by the use of indices. The buildings index is based on the All in Tender Price Index published by the Building Cost Information Service (BCIS). The land index is based on the residential building land values reported in the Property Market Report published by the Valuation Office.

Professional valuations are carried out by the District Valuers of the Revenue and Customs Government Department. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. In accordance with the requirements of the Department of Health, the last asset valuations were undertaken in 2004 as at the prospective valuation date of 1 April 2005 and were applied on the 31 March 2005.

The valuations are carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property. The value of land for existing use purposes is assessed at Existing Use Value. For non-operational properties including surplus land, the valuations are carried out at Open Market Value.

Additional alternative Open Market Value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

1.5 Tangible fixed assets (cont'd)

Gains arising from indexation and revaluations are taken to the Revaluation Reserve. Losses arising from revaluation are recognised as impairments and are charged to the revaluation reserve to the extent that a balance exists in relation to the revalued asset. Losses in excess of that amount are charged to the current year's Income & Expenditure account, unless it can be demonstrated that the recoverable amount is greater than the revalued amount in which case the impairment is taken to the revaluation reserve. Diminutions in value when newly constructed assets are brought into use are charged in full to the Income & Expenditure account. These falls in value result from the adoption of ideal conditions as the basis for depreciated replacement cost valuations

Assets in the course of construction are valued at current cost using the same indexes as for land and buildings as above. These assets include any existing land or buildings under the control of a contractor.

Operational equipment is carried at current value. Where assets are of low value, and/or have short useful economic lives, these are carried at depreciated historic cost as a proxy for current value. Equipment surplus to requirements is valued at net recoverable amount.

Depreciation, amortisation and impairments

Tangible fixed assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives. No depreciation is provided on freehold land and assets surplus to requirements.

Assets in the course of construction are not depreciated until the asset is brought into use.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as advised by the Valuer. Leaseholds are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the estimated life of the asset using the following lives:

	Years
Medical equipment & engineering plant & equipment	5 to 15
Furniture	10
Set up costs in new buildings	10
PTS Ambulances & Other Vehicles	7
A&E Ambulances & Rapid Response Vehicles	5
Office equipment	5
Information Technology Equipment	3

1.6 Donated fixed assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the Donated Asset Reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the Donated Asset Reserve and, each year, an amount equal to the depreciation charge on the asset is released from the Donated Asset Reserve to the Income and Expenditure account. Similarly, any impairment on donated assets charged to the Income and Expenditure Account is matched by a transfer from the Donated Asset Reserve. On sale of donated assets, the value of the sale proceeds is transferred from the Donated Asset Reserve to the Income and Expenditure Reserve.

1.7 Government Grants

Government grants are grants from government bodies other than funds from NHS bodies or funds awarded by Parliamentary Vote. Gains and losses on revaluations are also taken to the Government Grant Reserve and, each year, an amount equal to the depreciation charge on the asset is released from the Government Grant Reserve to the Income and Expenditure Account. Similarly, any impairment on grant funded assets charged to the Income and Expenditure Account is matched by a transfer from the Reserve.

1.8 Stocks and work-in-progress

Stocks and work-in-progress are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to current cost due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

1.9 Research and development

Expenditure on research is not capitalised. Expenditure on development is capitalised if it meets the following criteria:

- there is a clearly defined project;
- the related expenditure is separately identifiable;
- the outcome of the project has been assessed with reasonable certainty as to:
  - its technical feasibility;
  - its resulting in a product or service which will eventually be brought into use;
- adequate resources exist, or are reasonably expected to be available, to enable the project to be completed and to provide any consequential increases in working capital.

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the income and expenditure account on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost. The amortisation charge is calculated on the same basis as used for depreciation i.e. on a quarterly basis. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. NHS Trusts are unable to disclose the total amount of research and development expenditure charged in the income and expenditure account because some research and development activity cannot be separated from patient care activity.

1.10 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is material, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 2.2% in real terms.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 17.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses as and when they become due.

1.11 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying Scheme assets and liabilities. Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

The Scheme is subject to a full actuarial valuation every four years (until 2004, based on a five year valuation cycle), and a FRS17 accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the Scheme actuary reported that employer

1.11 Pension costs (cont)

b) FRS17 Accounting valuation
In accordance with FRS17, a valuation of the Scheme liability is carried out annually by the Scheme Actuary as at the balance sheet date by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the Scheme Actuary. At this point the assumptions regarding the composition of the Scheme membership are updated to allow the Scheme liability to be valued

The valuation of the Scheme liability as at 31 March 2009, is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2009 with summary global member and accounting data.

The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

Scheme Provisions as at 31 March 2009
The scheme is a 'final salary' scheme.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the income and expenditure account at the time the Trust commits itself to the retirement, regardless of the method of payment.

The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made. From 1 April 2008 a voluntary additional pension facility becomes available, under which members may purchase up to £5,000 per annum of additional pension at a cost determined by the actuary from time-to-time.

Early payment of a pension is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

Existing members at 1 April 2008

Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. From 1 April 2008 there is the opportunity of giving up some of the pension to increase the retirement lump sum. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse or eligible unmarried partner.

New entrants from 1 April 2008

Annual pensions for new entrants from 1 April 2008 will be based on 1/60th of the best three-year average of pensionable earnings in the ten years before retirement. Members wishing to obtain a retirement lump sum may give up some of this pension to obtain a retirement lump of up to 25% of the total value of their retirement benefits. Survivor pensions will be available to married and unmarried partners and will be equal to 37.5% of the member's pension.

1.12 Liquid resources

Deposits and other investments that are readily convertible into known amounts of cash at or close to their carrying amounts are treated as liquid resources in the cashflow statement. The Trust does not hold any investments with maturity dates exceeding one year from the date of purchase.

1.13 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.14 Foreign Exchange

Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the Income and Expenditure Account.

1.15 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 29 to the accounts.

1.16 Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Trust, the asset is recorded as a tangible fixed asset and a debt is recorded to the lessor of the minimum lease payments discounted by the interest rate implicit in the lease. The interest element of the finance lease payment is charged to the Income and Expenditure Account over the period of the lease at a constant rate in relation to the balance outstanding. Other leases are regarded as operating leases and the rentals are charged to the Income and Expenditure Account on a straight-line basis over the term of the lease.

1.17 Public Dividend Capital (PDC) and PDC Dividend

Public Dividend Capital represents the outstanding public debt of an NHS Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the NHS Trust.

A charge, reflecting the forecast cost of capital utilised by the NHS Trust, is paid over as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the forecast average carrying amount of all assets less liabilities, except for donated assets and cash with the Office of the Paymaster General. The average carrying amount of assets is calulated as a simple average of opening and closing relevant net assets. A note to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year.

1.18 Losses and Special Payments

Losses and Special Payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and Special Payments are charged to the relevant functional headings in the Income and Expenditure Account on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, note 30 is compiled directly from the losses and compensations register which is prepared on a cash basis.

1.19 EU Emmissions Trading Scheme

EU Emission Trading Scheme allowances are accounted for as Government Granted Other Current Asset Investments, valued at open market value. As the Trust makes emissions a provision is recognised, with an offsetting transfer from the Government Grant Reserve. The provision is settled on surrender of the allowances. The current asset, provision and Government Grant Reserve are valued at current market value at the Balance Sheet date.

1.20 Financial Instruments

Financial assets

Financial assets are recognised on the balance sheet when the Trust becomes party to the financial instrument contract or, in the case of trade debtors, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: financial assets ‘at fair value through profit and loss’; ‘held to maturity investments’; ‘available for sale’ financial assets, and ‘loans and receivables’. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.20 Financial Instruments (cont)

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible. Where this is not possible values given are those prepared under the historical cost convention except where specified otherwise.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the net carrying amount of the financial asset.

At the balance sheet date, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Income and Expenditure Account and the carrying amount of the asset is reduced directly, or through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the Income and Expenditure Account to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.20 Financial Instruments (cont)

Financial liabilities

Financial liabilities are recognised on the balance sheet when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade creditors, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

Financial liabilities are classified as either financial liabilities 'at fair value through profit and loss' or other financial liabilities.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through

1.21 Other Reserve

This reserve was created when London Ambulance Service became an NHS Trust. The negative reserve balance was caused by the legal title of the property not being properly transferred from NHS Estates when the Trust was created. Once the error had been identified the London Ambulance Service NHS Trust purchased the property from the NHS estates and thereby created a negative reserve.

2 SEGMENTAL ANALYSIS

The Trust does not have more than one business segment as defined in Statement of Standard Accounting Practice 25 and therefore there is no requirement for segmental reporting.

3. Income from Activities

	2008/09	2007/08
	£000	£000
Strategic Health Authorities	**0**	376
NHS Trusts	**7,345**	7,895
Primary Care Trusts	**234,679**	220,987
Foundation Trusts	**1,246**	1,587
Local Authorities	**4**	15
Department of Health	**4,207**	899
NHS Other	**0**	0
Non NHS:		
- Private patients	**0**	0
- Overseas patients (non-reciprocal)	**0**	0
- Injury cost recovery*	**1,674**	0
- Other	**2,223**	2,358
	251,378	234,117

* 'Injury cost recovery income is subject to a provision for doubtful debts of 7.8% to reflect expected rates of collection

4. Other Operating Income

	2008/09	2007/08
	£000	£000
Patient transport services	**0**	0
Education, training and research	**8,564**	754
Charitable and other contributions to expenditure	**2**	0
Transfers from Donated Asset Reserve	**62**	234
Transfers from Government Grant Reserve	**0**	0
Non-patient care services to other bodies	**0**	0
Rental income from finance leases	**0**	0
Rental income from operating leases	**0**	0
Income generation	**0**	0
Other income	**1,526**	1,025
	10,154	2,013

5. Operating Expenses

5.1 Operating expenses comprise:

	2008/09	2007/08
	£000	£000
Services from other NHS Trusts	**0**	0
Services from PCTs	**0**	0
Services from other NHS bodies	**0**	0
Services from Foundation Trusts	**0**	0
Purchase of healthcare from non NHS bodies	**0**	0
Directors' costs	**745**	702
Staff costs	**192,167**	167,839
Supplies and services - clinical	**5,263**	6,503
Supplies and services - general	**1,376**	1,126
Consultancy services	**1,155**	1,519
Establishment	**7,348**	6,293
Transport	**23,026**	21,488
Premises	**11,337**	11,101
Impairment of debtors	**48**	8
Depreciation	**6,484**	6,076
Amortisation	**996**	328
Tangible fixed asset impairments and reversals	**0**	0
Intangible fixed asset impairments and reversals	**0**	0
Impairments and reversals of financial assets (by class)	**0**	0
Change in the fair value of financial instruments	**0**	0
External contracts	**1,599**	1,950
Lease vehicle modification costs	**502**	1,764
Legal & professional fees	**840**	811
Non motor insurance	**0**	(5)
Audit fees	**166**	152
Other auditor's remuneration	**1**	0
Clinical negligence	**324**	312
Redundancy costs	**73**	920
Education and training	**1,179**	1,152
Other	**2,203**	2,412
	256,832	232,451

5.2 Operating leases

5.2/1 Operating expenses include:

	2008/09	2007/08
	£000	£000
Hire of plant and machinery	**0**	0
Other operating lease rentals	**7,614**	7,722
	7,614	7,722

5.2/2 Annual commitments under non - cancellable operating leases are:

	Land and buildings		**Other leases**	
	2008/09	2007/08	**2008/09**	2007/08
	£000	£000	**£000**	£000
Operating leases which expire:				
Within 1 year	**20**	117	**378**	368
Between 1 and 5 years	**640**	447	**164**	542
After 5 years	**780**	674	**4,286**	4,377
	1,440	1,238	**4,828**	5,287

5.3 Salary and Pension entitlements of senior managers

A) Remuneration

Name and Title	2008-09			2007-08		
	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
Sigurd Reinton, Chairman	£20,001-£25,000	£0		£20,001-£25,000	£0	
Beryl Magrath, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Sarah Waller, 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	
Ingrid Prescod, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Brian Huckett, Non-Executive Director	£5,001-£10,000	£0		£0-£5,000	£0	
Caroline Silver, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
* Peter Bradley, Chief Executive	£105,001-£110,000	£0	£3,700	£120,001-£125,000	£0	£4,300
Michael Dinan, Director of Finance	£120,001-£125,000	£0		£110,001-£115,000	£0	
Martin Flaherty, Director of Operations	£115,001-£120,000	£0	£1,300	£105,001-£110,000	£0	£2,600
Caron Hitchen, Director of Human Resources	£100,001-£105,000	£0		£95,001-£100,000	£0	
** Fionna Moore, Medical Director	£80,001-£85,000	£0		£75,001-£80,000	£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 Advisor.

** Fionna Moore is an employee of Imperial College Healthcare NHS Trust who works part-time for the London Ambulance Service as Medical Director.

5.3 Salary and Pension entitlements of senior managers

B) Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2009 (bands of £5,000)	Lump sum at age 60 at related to accrued pension at 31 March 2009 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2009	Cash Equivalent Transfer Value at 31 March 2008	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension To nearest £100
Sigurd Reinton, Chairman	**	**	**	**	**	**	**	
Barry MacDonald, Non-Executive Director	**	**	**	**	**	**	**	
Beryl Magrath, Non-Executive Director	**	**	**	**	**	**	**	
Sarah Waller, Non-Executive Director	**	**	**	**	**	**	**	
Roy Griffins, Non-Executive Director	**	**	**	**	**	**	**	
Ingrid Prescod, Non-Executive Director	**	**	**	**	**	**	**	
Caroline Silver, Non-Executive Director	**	**	**	**	**	**	**	
Peter Bradley, Chief Executive	£0-£2,500	(£0)-(£2,500)	£5,001-£10,000	£25,001-£30,000	£278,943	£159,729	£80,654	
Michael Dinan, Director of Finance	£2,501-£5,000	£5,001-£7,500	£5,001-£10,000	£15,001-£20,000	£106,371	£59,347	£31,878	
Martin Flaherty, Director of Operations	£5,501-£7,500	£10,001-£12,500	£35,001-£40,000	£115,001-£120,000	£788,142	£538,562	£165,281	
Caron Hitchen, Director of Human Resources	£0-£2,500	£0-£2,500	£20,001-£25,000	£65,001-£70,000	£386,437	£289,009	£63,142	
Fionna Moore, Medical Director	£0-£2,500	£2,501-£5,000	£40,001-£45,000	£120,001-£125,000	£968,526	£686,485	£185,415	

** 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 scheme or arrangement) and uses common market valuation factors for the start and end of the period.

6. Staff costs and numbers

6.1 Staff costs

	2008/09			2007/08
	Total	**Permanently Employed**	**Other**	
	£000	**£000**	**£000**	£000
Salaries and wages	**160,853**	153,331	7,522	140,191
Social Security Costs	**13,457**	13,457	0	11,538
Employer contributions to NHS BSA - Pensions Division	**17,661**	17,661	0	16,905
Other pension costs	**953**	953	0	834
	192,924	**185,402**	**7,522**	169,468

6.2 Average number of persons employed

	2008/09			2007/08
	Total	**Permanently Employed**	**Other**	
	Number	**Number**	**Number**	Number
Medical and dental	**0**	0	0	0
Ambulance staff	**3,054**	3,054	0	2,972
Administration and estates	**1,102**	955	147	1,087
Healthcare assistants and other support staff	**0**	0	0	0
Nursing, midwifery and health visiting staff	**0**	0	0	0
Nursing, midwifery and health visiting learners	**0**	0	0	0
Scientific, therapeutic and technical staff	**0**	0	0	0
Social care staff	**0**	0	0	0
Other	**0**	0	0	0
Total	**4,156**	**4,009**	**147**	**4,059**

6.3 Employee benefits

There were no employee benefits in the year and there were none in 2007/08.

6.4 Management costs

	2008/09	2007/08
	£000	£000
Management costs	**17,414**	16,509
Income	**253,399**	236,049

6.5 Retirements due to ill-health

During 2008/09 there were 5 (2007/08, 5) early retirements from the NHS Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £373,435 (2007/08: £670,833). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

7. Better Payment Practice Code

7.1 Better Payment Practice Code - measure of compliance

	2008/09	
	Number	**£000**
Total Non-NHS trade invoices paid in the year	**62,971**	**78,469**
Total Non NHS trade invoices paid within target	**53,776**	**70,888**
Percentage of Non-NHS trade invoices paid within target	**85%**	**90%**
Total NHS trade invoices paid in the year	**489**	**3,001**
Total NHS trade invoices paid within target	**436**	**2,798**
Percentage of NHS trade invoices paid within target	**89%**	**93%**

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

7.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2008/09	2007/08
	£000	£000
Amounts included within Interest Payable (Note 9) arising from claims made under this legislation	**0**	3
Compensation paid to cover debt recovery costs under this legislation	**0**	0
TOTAL	**0**	**3**

8. Other gains and losses

	2008/09	2007/08
	£000	£000
Gain on disposal of fixed asset investments	**0**	0
(Loss) on disposal of fixed asset investments	**0**	0
Gain on disposal of intangible fixed assets	**0**	0
(Loss) on disposal of intangible fixed assets	**0**	0
Gain on disposal of land and buildings	**0**	0
(Loss) on disposal of land and buildings	**0**	0
Gains on disposal of plant and equipment	**0**	0
(Loss) on disposal of plant and equipment	**(52)**	(41)
Gain/(loss) on foreign exchange	**0**	0
Change in fair value of financial assets carried at fair value through profit and loss	**0**	0
Change in fair value of financial liabilities carried at fair value through profit and loss	**0**	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	0
	(52)	(41)

9. Finance Costs & Interest receiveable

	2008/09	2007/08
	£000	£000
Finance Costs		
Finance leases	**0**	0
Late payment of commercial debt	**0**	3
Loans	**0**	0
Bank loans and overdrafts	**0**	0
Other interest and finance costs	**0**	0
TOTAL	**0**	3
Interest Receivable		
Bank accounts	**568**	937
Impaired financial assets	**0**	0
Other financial assets	**83**	0
TOTAL	**651**	**937**

10. Intangible Fixed Assets

	Software licences	Licenses and trademarks	Patents	Development expenditure	Total
	£000	£000	£000	£000	£000
Gross cost at 1 April 2008	2,915	0	0	2,599	5,514
Indexation	0	0	0	0	0
Impairments	0	0	0	0	0
Reclassifications	1,375	0	0	(1,375)	0
Revaluation	0	0	0	0	0
Additions purchased	415	0	0	3,568	3,983
Additions donated	0	0	0	0	0
Additions government granted	0	0	0	0	0
Disposals	0	0	0	0	0
Gross cost at 31 March 2009	**4,705**	**0**	**0**	**4,792**	**9,497**
Amortisation at 1 April 2008	1,749	0	0	0	1,749
Indexation	0	0	0	0	0
Impairments	0	0	0	0	0
Reversal of impairments	0	0	0	0	0
Reclassifications	0	0	0	0	0
Revaluation	0	0	0	0	0
Charged during the year	996	0	0	0	996
Disposals	0	0	0	0	0
Amortisation at 31 March 2009	**2,745**	**0**	**0**	**0**	**2,745**
Net book value					
- Purchased at 1 April 2008	1,166	0	0	2,599	3,765
- Donated at 1 April 2008	0	0	0	0	0
- Government granted at 1 April 2008	0	0	0	0	0
- Total at 1 April 2008	**1,166**	**0**	**0**	**2,599**	**3,765**
- Purchased at 31 March 2009	**1,960**	**0**	**0**	**4,792**	**6,752**
- Donated at 31 March 2009	**0**	**0**	**0**	**0**	**0**
- Government granted at 31 March 2009	**0**	**0**	**0**	**0**	**0**
- Total at 31 March 2009	**1,960**	**0**	**0**	**4,792**	**6,752**

11. Tangible Fixed Assets

11.1 Tangible fixed assets at the balance sheet date comprise the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construct and poa*	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2008	50,697	55,308	0	3,762	9,250	21,154	10,847	59	151,077
Additions purchased	0	2,798	0	5,157	277	1,526	886	0	10,644
Additions donated	0	0	0	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	567	0	(3,333)	46	1,114	1,606	0	0
Indexation	(14,698)	(2,812)	0	0	386	2,798	0	1	(14,325)
Revaluation	0	0	0	0	0	0	0	0	0
Disposals	0	(61)	0	0	(320)	(412)	(42)	0	(835)
Cost or Valuation at 31 March 2009	**35,999**	**55,800**	**0**	**5,586**	**9,639**	**26,180**	**13,297**	**60**	**146,561**
Depreciation at 1 April 2008	0	0	0	0	7,337	15,978	8,103	7	31,425
Charged during the year	0	2,319	0	0	588	1,785	1,786	6	6,484
Impairments	0	0	0	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Indexation	0	0	0	0	311	2,106	0	0	2,417
Revaluation	0	0	0	0	0	0	0	0	0
Disposals	0	(61)	0	0	(320)	(403)	(42)	0	(826)
Depreciation at 31 March 2009	**0**	**2,258**	**0**	**0**	**7,916**	**19,466**	**9,847**	**13**	**39,500**
Net book value									
- Purchased at 1 April 2008	50,697	55,308	0	3,762	1,855	5,166	2,744	52	119,584
- Donated at 1 April 2008	0	0	0	0	58	10	0	0	68
- Government granted at 1 April 2008	0	0	0	0	0	0	0	0	0
- Total at 1 April 2008	**50,697**	**55,308**	**0**	**3,762**	**1,913**	**5,176**	**2,744**	**52**	**119,652**
- Purchased at 31 March 2009	35,999	53,542	0	5,586	1,723	6,705	3,450	47	107,052
- Donated at 31 March 2009	0	0	0	0	0	9	0	0	9
- Government granted at 31 March 2009	0	0	0	0	0	0	0	0	0
- Total at 31 March 2009	**35,999**	**53,542**	**0**	**5,586**	**1,723**	**6,714**	**3,450**	**47**	**107,061**

Of the totals at 31 March 2009, £Nil related to land valued at open market value and £Nil related to buildings valued at open market value and £Nil related to dwellings valued

11 Tangible Fixed Assets (contd)

11.2 Asset Financing

	Land	Buildings, excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value 31 March 2009									
Owned	**35,999**	**53,542**	**0**	**5,586**	**1,723**	**6,714**	**3,450**	**47**	**107,061**
Finance Leased	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
On balance sheet PFI contracts	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
PFI residual interests	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total 31 March 2009	**35,999**	**53,542**	**0**	**5,586**	**1,723**	**6,714**	**3,450**	**47**	**107,061**
Net book value 1 April 2008									**0**
Owned	50,697	55,308	0	3,762	1,913	5,176	2,744	52	**119,652**
Finance Leased	0	0	0	0	0	0	0	0	**0**
On balance sheet PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
Total 1 April 2008	**50,697**	**55,308**	**0**	**3,762**	**1,913**	**5,176**	**2,744**	**52**	**119,652**

11.3 The total amount of depreciation charged to the income and expenditure in respect of assets held under finance leases and hire purchase contracts:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Depreciation 31 March 2009	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Depreciation 31 March 2008	0	0	0	0	0	0	0	0	**0**

11.4 The net book valuae of land, buildings and dwellings at 31 March 2009 comprises:

	2008/09	2007/08
	£000	£000
Freehold	**86,253**	103,558
Long Leasehold	**2,116**	2,108
Short Leasehold	**1,172**	339

TOTAL	**89,541**	**106,005**

12. Stocks and Work in Progress

	31 March 2009 £000	31 March 2008 £000
Raw materials and consumables	**2,600**	1,930
Work-in-progress	**0**	0
Finished goods	**0**	0
TOTAL	**2,600**	1,930

13. Debtors

13.1 Debtors at the balance sheet date are made up of:

	31 March 2009 £000	31 March 2008 £000
Amounts falling due within one year:		
NHS debtors	**2,832**	1,281
Non NHS trade debtors	**0**	0
Provision for impairment of debtors	**(59)**	(11)
Other prepayments and accrued income	**4,561**	5,292
Current part of PFI payment	**0**	0
Other debtors	**960**	4,976
Sub Total: falling due within one year	**8,294**	11,538
Amounts falling due after more than one year:		
NHS debtors	**4,167**	9,875
Non NHS trade debtors	**0**	0
Provision for impairment of debtors	**0**	0
Other prepayments and accrued income	**0**	0
Other debtors	**6**	4
Sub Total: falling due after more than one year	**4,173**	9,879
TOTAL	**12,467**	21,417

Other Debtors include £Nil prepaid pension contributions at 31 March 2009 (£Nil at 31 March 2008)

	31 March 2009 £000
13.2 Provision for impairment of debtors	
Balance at 1 April	**11**
Amount written off during the year	**0**
Amount recovered during the year	**0**
(Increase)/decrease in debtors impaired	**48**
Balance at 31 March	**59**

13.3 Debtors past due date but not impaired:	**31 March 2009 £000**
By up to 3 months	**1,182**
By 3 to 6 months	**232**
By more than 6 months	**38**
TOTAL	**1,452**

14 Other Financial Assets

	Current financial assets 31 March 2009 £000	Fixed financial assets 31 March 2009 £000
Financial assets carried at fair value through profit and loss	0	0
Held to maturity investments at amortised cost	0	0
Available for sale financial assets carried at fair value	0	0
Loans carried at amortised cost	0	0
TOTAL	**0**	0

15. Creditors

15.1 Creditors at the balance sheet date are made up of:

	31 March 2009 £000	31 March 2008 £000
Amounts falling due within one year:		
Bank overdrafts	**118**	1,513
Current instalments due on loans	**0**	0
Interest payable	**0**	0
Payments received on account	**0**	0
NHS creditors	**1,092**	198
Non - NHS trade creditors - revenue	**6,439**	11,462
Non - NHS trade creditors - capital	**1,926**	2,756
Tax	**561**	975
VAT	**0**	0
Social security costs	**0**	0
Obligations under finance leases and hire purchase contracts	**0**	0
Other creditors	**3,326**	797
Accruals and deferred income	**1,000**	770
Current part of finance leases element of on balance sheet PFI contracts	**0**	0
Sub Total: amounts falling due within one year	**14,462**	18,471
Amounts falling due after more than one year:		
Long - term loans	**0**	0
Obligations under finance leases and hire purchase contracts	**0**	0
NHS creditors	**0**	0
Imputed finance leases element of on balance sheet PFI contracts	**0**	0
Other	**0**	0
Sub Total: amounts falling due in more than one year	**0**	0
TOTAL	**14,462**	18,471

Other creditors include;

- £Nil for payments due in future years under arrangements to buy out the liability for early retirements over 5 years; and

- £133,284 outstanding pensions contributions at 31 March 2009 (31 March 2008 £251,208).

15.2 Loans [and other long-term financial liabilities]

The Trust had not entered in to any loan arrangement at 31 March 2009 or 31 March 2008.

15.3 Finance lease obligations

	31 March 2009 £000	31 March 2008 £000
Payable:		
In one year or on demand	**0**	0
In more than 1 year but no longer than 2	**0**	0
In more than 2 years but no longer than 5	**0**	0
In more than 5 years	**0**	0
	0	0
Less finance charges allocated to future periods	**0**	0
	0	0

15.4 Finance Lease Commitments

London Ambulance Service NHS Trust has not entered into any new finance lease arrangements during the year.

16 Other Financial Liabilities

	Due within one year 31 March 2009 £000	Due after more than one year 31 March 2009 £000
Financial liabilities carried at fair value through profit and loss	**0**	**0**

17 Provisions for liabilities and charges

	Pensions relating to former directors	Pensions relating to other staff	Legal claims	Restructurings	Other	**Total**
	£000	£000	£000	£000	£000	**£000**
At 1 April 2008	0	5,473	636	812	11,668	**18,589**
Arising during the year	0	699	267	283	602	**1,851**
Utilised during the year	0	(280)	(181)	(665)	(478)	**(1,604)**
Reversed unused	0	0	(381)	(147)	(6,537)	**(7,065)**
Unwinding of discount	0	120	0	0	40	**160**
At 31 March 2009	**0**	**6,012**	**341**	**283**	**5,295**	**11,931**
Expected timing of cashflows:						
Within one year	0	280	341	283	376	**1,280**
Between one and five years	0	1,400	0	0	4,043	**5,443**
After five years	0	4,332	0	0	876	**5,208**

Pensions relating to other staff - payments relating to this provision will be made quarterly over the life of each member of staff and have been discounted using a rate of 2.2%. Every year the provision is adjusted for inflation.

Legal claims - claims brought against the Trust provided for above vary between probablities of 50% to 94%. The amount provided are based upon estimates of costs and settlements provided by the NHS Litigation Authority.

Restructuring - £282,657 (2007/08 £811,505) relates to a redundancy provision.

Other - £1.0 million (2007/08 £7.0 million) of the balance relates to an estimate for our tax liability on subsistence payments made to staff. HMRC have agreed to a dispensation in respect of A&E staff and the provision has subsequently been reduced by £6.0 million. The remaining provision relating to PTS staff should be ruled on by HMRC within the next year. Both the exact amount and the expected timing of the payout are currently uncertain. £1,866,888 (2007/08 £1,835,949) is an estimate for pension payments due to employees being made redundant prior to 1995 as a result of the restructuring of the Trust. The provisions are calculated using actuarial tables and are payable quarterly over the life of the employees. The balance also includes £2,210,283 estimated costs for modifying the Mercedes Ambulances, £Nil relating to AFC (2007/08 £391,334) & £210,898 relating to excesses on motor insurance claims (2007/08 £644,553).

£522,179 is included in the provisions of the NHS Litigation Authority at 31 March 2009 in respect of clinical negligence liabilities of the NHS Trust (31 March 2008 £331,107).

18 Movements on Reserves

Movements on reserves in the year comprised the following:

	Revaluation Reserve	Donated Asset Reserve	Government Grant Reserve	Other Reserves	Income and Expenditure Reserve	**Total**
	£000	£000	£000	£000	£000	**£000**
At 1 April 2008 as previously stated	50,605	68	0	(419)	13,440	**63,694**
PPA:other	0	0	0	0	0	**0**
PPA: elimination of negative revaluation reserves in respect of change in policy on impairments	0	0	0	0	0	**0**
At 1 April 2008 as restated	50,605	68	0	(419)	13,440	**63,694**
Transfer from the income and expenditure account	0	0	0	0	725	**725**
Fixed asset impairments	0	0	0	0	0	**0**
Surplus/(deficit) on other revaluations/indexation of fixed/current assets	(16,745)	3	0	0	0	**(16,742)**
Transfer of realised profits/(losses) to the income and expenditure reserve	0	0	0	0	0	**0**
Receipt of donated/government granted assets	0	0	0	0	0	**0**
Transfers to the income and expenditure account for depreciation, impairment, and disposal of donated/government granted assets	0	(62)	0	0	0	**(62)**
Other transfers between reserves	(1,050)	0	0	0	1,050	**0**
Other movements on reserves	0	0	0	0	0	**0**
Reserves eliminated on dissolution	0	0	0	0	0	**0**
At 31 March 2009	**32,810**	**9**	**0**	**(419)**	**15,215**	**47,615**

19 Notes to the cash flow Statement

19. 1 Reconciliation of operating surplus to net cash flow from operating activities:

	2008/09	2007/08
	£000	£000
Total operating surplus/(deficit)	**4,700**	3,679
Depreciation and amortisation charge	**7,480**	6,404
Asset impairments and reversals, and movement in financial instruments	**0**	0
Transfer from Donated Asset Reserve	**(62)**	(234)
Transfer from the Government Grant Reserve	**0**	0
(Increase)/decrease in stocks	**(670)**	35
(Increase)/decrease in debtors	**5,021**	(1,630)
Increase/(decrease) in creditors	**(1,784)**	7,738
Increase/(decrease) in provisions	**(6,818)**	2,978
Net cash inflow/(outflow) from operating activities before restructuring costs	**7,867**	18,970
Payments in respect of fundamental reorganisation/restructuring	**0**	0
Net cash inflow from operating activities	**7,867**	18,970

19.2 Reconciliation of net cash flow to movement in net debt

	2008/09	2007/08
	£000	£000
Increase/(decrease) in cash in the period	**(6,432)**	8,321
Cash (inflow) from new debt	**0**	0
Cash outflow from debt repaid and finance lease capital payments	**0**	0
Cash (inflow)/outflow from (decrease)/increase in liquid resources	**0**	0
Change in net debt resulting from cash flows	**(6,432)**	8,321
Non - cash changes in debt	**0**	0
Net debt at 1 April 2008	**8,965**	644
Net debt at 31 March 2009	**2,533**	8,965

19.3 Analysis of changes in net debt

	At 1 April 2008	Cash Transferred (to)/from other NHS bodies	Other cash changes in year	Non-cash changes in year	**At 31 March 2009**
	£000	£000	£000	£000	**£000**
OPG cash at bank	10,440	0	(7,829)	0	**2,611**
Commercial cash at bank and in hand	38	0	2	0	**40**
Bank overdraft	(1,513)	0	1,395	0	**(118)**
Loan from the Department of Health due within one year	0	0	0	0	**0**
Other debt due within one year	0	0	0	0	**0**
Loan from the Department of Health due after one year	0	0	0	0	**0**
Other debt due after one year	0	0	0	0	**0**
Finance leases	0	0	0	0	**0**
Current asset investments	0	0	0	0	**0**
Current financial assets	0	0	0	0	**0**
	8,965	**0**	**(6,432)**	**0**	**2,533**

20 Capital Commitments

Commitments under capital expenditure contracts at 31 March 2009 were £15,104,000 (31 March 2008 £564,726)

	2008/09 £000
Vehicles - Ambulances	6,139
Information Technology CAD2010	8,836
Information Technology Network Bandwidth	129
Capital Commitments as at 31 March 2009	15,104

21 Post Balance Sheet Events

The Trust is applying for foundation trust status in 2009/10. Post Balance sheet events having a material effects on the accounts are nil.

22 Contingencies

	2008/09 £000	2007/08 £000
Contingent liabilities	**(187)**	(764)
Amounts recoverable against contingent liabilities	**0**	582
Net value of contingent liabiliies	**(187)**	(182)
Contingent Assets	**0**	0

All contigencies relate to personal injury and other legal claims which are being dealt with by the NHS Litigation Authority on behalf of the trust. These claims relate to cases where provisions have been made on Note 17.

23 Movement in Public Dividend Capital

	2008/09 £000	2007/08 £000
Public Dividend Capital as at 1 April 2008	**56,488**	55,526
New Public Dividend Capital received (including transfers from dissolved NHS Trusts)	**1,035**	2,329
Public Dividend Capital repaid in year	**0**	(1,367)
Public Dividend Capital written off	**0**	0
Other movements in Public Dividend Capital in year	**0**	0
Public Dividend Capital as at 31 March 2009	**57,523**	**56,488**

24 Financial Performance Targets

24.1 Breakeven Performance

The Trust's breakeven performance for 2008/09 is as follows:

	2003/04	2004/05	2005/06	2006/07
	£000	£000	£000	£000
Turnover	168,508	192,588	215,947	215,941
Retained surplus/(deficit) for the year	89	332	1,258	113
Adjustment for:				
- Use of pre - 1.4.97 surpluses [FDL(97)24 Agreements]	0	0	0	0
- 2004/05 Prior Period Adjustment (relating to 1997/98 to 2003/04)	0	0	0	0
- 2005/06 Prior Period Adjustment (relating to 1997/98 to 2004/05)	0	0	0	0
- 2006/07 Prior Period Adjustment (relating to 1997/98 to 2005/06)	0	0	0	0
2007/08 Prior Period Adjustment (relating to 1997/98 to 2006/07)	0	0	0	0
2008/09 Prior Period Adjustment (relating to 1997/98 to 2007/08	0	0	0	0
- Adjustments for Impairments				
- Other agreed adjustments	0	0	0	0
Break-even in-year position	89	332	1,258	113
Break-even cumulative position	(257)	75	1,333	1,446
Materiality test (I.e. is it equal to or less than 0.5%):				
- Break-even in-year position as a percentage of turnover	0.05%	0.17%	0.58%	0.05%
- Break-even cumulative position as a percentage of turnover	-0.15%	0.04%	0.62%	0.67%

24.2 Capital cost absorption rate

The Trust is required to absorb the cost of capital at a rate of 3.5% of average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital, totalling £4,414,000, bears to the average relevant net assets of £106,096,000, that is 4.2%.

The variance from 3.5% is due to the fall in value of land & buildings attributable to the current economic downturn.

24.3 External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	£000	**2008/09 £000**	2007/08 £000
External financing limit		**7,467**	(7,359)
Cash flow financing	7,467		(7,359)
Finance leases taken out in the year	0		0
Other capital receipts	0		0
External financing requirement		**7,467**	(7,359)
Undershoot/(overshoot)		**0**	0

24.4 Capital Resource Limit

The Trust is given a capital resource limit which it is not permitted to overspend

	2008/09 £000	2007/08 £000
Gross capital expenditure	**14,627**	10,783
Less: book value of assets disposed of	**(9)**	(3,909)
Plus: loss on disposal of donated assets	**0**	0
Less: capital grants	**0**	0
Less: donations towards the acquisition of fixed assets	**0**	0
Charge against the capital resource limit	**14,618**	6,874
Capital resource limit	**15,865**	8,978

25 Related Party Transactions

London Ambulance Service NHS Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with London Ambulance Service NHS Trust.

The Department of Health is regarded as a related party. During the year London Ambulance Service NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

	Income £000	Expenditure £000
London Strategic Health Authority	8,650	11
Richmond & Twickenham PCT	12,411	0
Primary Care Trusts	222,658	59
NHS Pension Agency	0	17,660
NHS Litigation Authority	0	505
NHS Business Service Authority	0	557

The Trust received an administration fee of £2,500 (2007/08 £2,500) from the London Ambulance Service charitable funds. The London Ambulance Service NHS Trust is the corporate trustee of the funds.

26 Private Finance Transactions

26.1 PFI schemes deemed to be off-balance sheet

The Trust has not entered into any PFI schemes deemed to be off balance sheet.

26.2 'Service' element of PFI schemes deemed to be on-balance sheet

The Trust has not entered into any PFI schemes deemed to be on balance sheet.

27 Pooled Budget

The Trust did not participate in any Pooled Budget projects.

28 Financial Instruments

Financial Reporting Standard 29 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with Primary Care Trusts and the way those Primary Care Trusts are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which these standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest-rate risk

The Trust borrows from Government for capital expenditure subject to affordability as confirmed by the Strategic Health Authority. The borrowings are for 1-25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because of the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposure as at 31 March 2009 are in receivables from customers, as disclosed in the debtors note.

Liquidity risk

The Trust's new operating costs are incurred under contract with Primary Care Trusts, which are financed from resources voted annually by Parliament. The trust funds its capital expenditure from funds obtained within its Prudential Borrowing Limit. The Trust is not, therefore, exposed to significant liquidity risks.

28.1 Financial Assets

Currency	Total	Floating rate	Fixed rate	Non-interest bearing	Fixed rate: Weighted average interest rate	Fixed rate: Weighted average period for which fixed	Non-interest bearing: Weighted average term
	£000	£000	£000	£000	%	Years	Years
At 31 March 2009							
Sterling	**11,444**	2,625	4,482	4,337	2	21	0
Other	**0**	0	0	0	0	0	0
Gross financial assets	**11,444**	**2,625**	**4,482**	**4,337**			
At 31 March 2008							
Sterling	**19,854**	10,471	9,376	7	0	8	0
Other	**0**	0	0	0	0	0	0
Gross financial assets	**19,854**	**10,471**	**9,376**	**7**			

28.2 Financial Liabilities

Currency	Total	Floating rate	Fixed rate	Non-interest bearing	Fixed rate: Weighted average interest rate	Fixed rate: Weighted average period for which fixed	Non-interest bearing: Weighted average term
	£000	£000	£000	£000	%	Years	Years
At 31 March 2009							
Sterling	**(19,173)**	0	0	(19,173)	0	0	2
Other	**0**	0	0	0	0	0	0
Gross financial liabilities	**(19,173)**	**0**	**0**	**(19,173)**			
At 31 March 2008							
Sterling	**7**	0	0	7	0	21	0
Other	**0**	0	0	0	0	0	0
Gross financial liabilities	**7**	**0**	**0**	**7**			

Note: The public dividend capital is of unlimited term.

28.3 Financial Assets

	At 'fair value through profit and loss £000	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives	0	0	0	**0**
NHS debtors	0	6,834	0	**6,834**
Non NHS debtors	0	1,977	0	**1,977**
Cash at bank and in hand	0	2,533	0	**2,533**
Other financial assets	0	100	0	**100**
Total at 31 March 2009	**0**	**11,444**	**0**	**11,444**

28.4 Financial Liabilities

	At 'fair value through profit and loss £000	Other £000	Total £000
Embedded derivatives	0	0	**0**
NHS creditors	0	579	**579**
Non NHS creditors	0	12,562	**12,562**
Borrowings	0	0	**0**
Private Finance Initiative and finance lease obligations	0	0	**0**
Other financial liabilities	0	6,032	**6,032**
Total at 31 March 2009	**0**	**19,173**	**19,173**

29 Third Party Assets

The Trust held £Nil cash at bank and in hand at 31 March 2009 (£Nil - at 31 March 2008) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

30 Intra-Government and Other Balances

	Debtors: amounts falling due within one year	Debtors: amounts falling due after more than one year	Creditors: amounts falling due within one year	Creditors: amounts falling due after more than one year
	£000	£000	£000	£000
Balances with other Central Government Bodies	1,835	4,167	1,351	0
Balances with Local Authorities	14	0	4	0
Balances with NHS Trusts and Foundation Trusts	1,178	0	302	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Intra Government balances	3,027	4,167	1,657	0
Balances with bodies external to Government	5,267	6	12,805	0
At 31 March 2009	**8,294**	**4,173**	**14,462**	**0**
Balances with other Central Government Bodies	638	9,875	1,025	0
Balances with Local Authorities	1	0	0	0
Balances with NHS Trusts and Foundation Trusts	1,074	0	148	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Intra Government balances	1,713	9,875	1,173	0
Balances with bodies external to Government	9,825	4	17,298	0
At 31 March 2008	**11,538**	**9,879**	**18,471**	**0**

31 Losses and Special Payments

There were 1,286 cases of losses and special payments (2007/08: 1,544 cases) totalling £1,295,630 (2007/08: £1,012,379) during 2008/09.

9 Audit Recommendations Database

Audit Committee Front Sheet

Audit Recommendations	**Agenda Item:** 9
	Enclosure: 9

Purpose:

The report outlines the current status of all significant/fundamental Internal Audit Recommendations which have not previously been reported as implemented to the Audit Committee.

Summary:

Managers are required to establish action plans for the implementation of accepted recommendations within a reasonable timeframe. Progress reported since the previous committee meeting is as follows;

New Reports

The following final reports have been issued:

- Drug Controls (all fundamental recommendations have been completed).
- Standards for Better Health (only Merits Attention Recommendations)

No draft reports have been included in this report.

Fundamental Recommendations

5 recommendations have been made. (See Drugs Control on Page 11)

Significant Recommendations

2 new recommendations have been made.(See Drugs Control)

This report provides for three categories of recommendation:

Green - Completed
Amber – In Progress
Red – No Action

Recommendations/and or actions required:

The Committee is asked to;

1. Note the progress

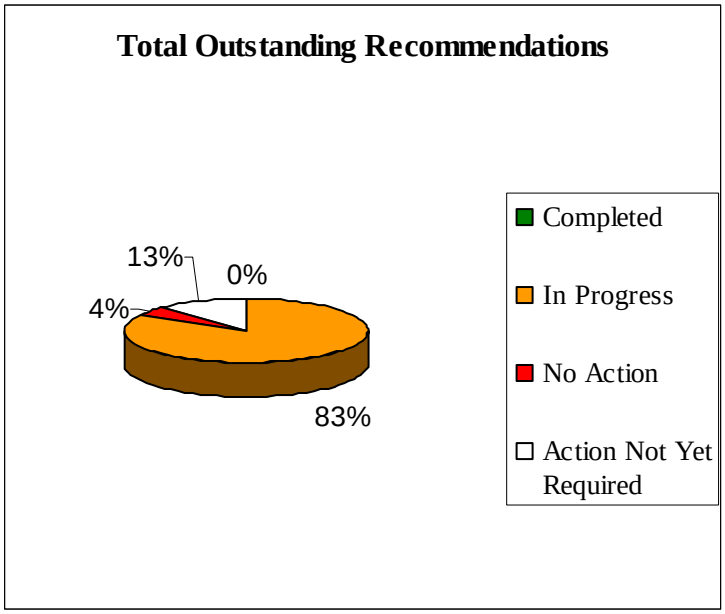
2. Review any further action required to improve implementation of the recommendations.

Author and Date:
GDU – 2009

SUMMARY OF AUDIT RECOMMENDATIONS

Significant/Fundamental Recommendations

	Completed	In Progress	No Action	Action Not Yet Required	Total
Recommendations reported to the 10/03/09 meeting.	4	21	1	3	29
Recommendations completed since the 10/03/09 meeting. (I duplicate removed)	2	0	1	0	3
New recommendations since the 10/03/09 meeting.	6	1	0	0	7
Total outstanding recommendations.	0	20	1	3	24



AUDIT RECOMMENDATION PROGRESS REPORT				
Responsibility	**Recommendation Details**	**Action Agreed / Management Comment**	**Current Status**	**Due Date**
Patient Transport Services - June 2006 – Limited Assurance				
Nic Daw	Management should ensure that detailed policies and procedures are developed for Patient Transport Services staff in regards to the responsibilities of central services, ECJ's; contracted journeys and excess journeys. These procedures should be made easily accessible on the intranet.	Agreed.	The new Transport Operation Centres have superceded the Central Services Group. They check all PTS journeys including ECJs. In addition, we have a specific project within the Corporate Processes & Governance programme which is reviewing all ad hoc invoicing.	**Oct 2009**
Clinical Telephone Advisors - July 2006 - Adequate Assurance				
Sue Watkins/ Stephen Moore	The CTA function should be included as part of business continuity plans and major incident planning.	Included as part of the Fall Back procedure, which is currently under review, and the Major Incident Plan. Both are updated on a regular basis.	Completed The CTA function is now included within the FBC at Bow. The next test is scheduled for September 2009.	**Sept 2009**
Records Management - November 2006 – Adequate Assurance				
Stephen Moore	A training programme should be established covering the key aspects of records management, including compliance with both the Data Protection act and the Freedom of Information Act.	RM training to take place when the Records Preparation & Mapping project is fully underway. Liaison will need to take place with Education & Development, and IM&T for DPA & FOI training.	Training was discussed at IGG on 3/2/09 and again in May. The Learning and Organisational Development Department are developing a programme which will include IG training for existing members of support staff. A pilot scheme is due to be in place by September 2009. Educational and Development will be developing a similar training package for operational staff.	**Sept 2009**

AUDIT RECOMMENDATION PROGRESS REPORT				
Responsibility	**Recommendation Details**	**Action Agreed / Management Comment**	**Current Status**	**Due Date**
S Moore/S Meehan	The Trust should ensure that: • All PRFs are completed and signed by staff on duty; • Routine audits are undertaken by the Station Managers to ensure all PRFs are accounted for against the LA1; • All LA1 forms are signed by the drivers; and • All black boxes are attached to the wall and any broken black boxes are replaced as soon as possible.	This is covered by TP/017 which is currently being reviewed. Completion of PRFs and LA1s is the responsibility of local AOMs and administrators. When TP/017 is reissued managers will be reminded of their responsibilities to ensure that this procedure is followed.	PRF Project Board completed its report with recommendations accepted by SMG. TP 17 has been completed and issued. All other issues to do with patient report forms are being channelled through the Handling and Processing of Patient Report Forms project board specifically set up to provide more robust systems for handling PRFs Following a meeting in March 2009 the PRF Project Board has been reconstituted under Peter McKenna, AOM, and will work on the implementation of all recommendations.	**Sept 2009**
Emergency Bed Service - February 2007 – Adequate Assurance				
Lizzy Bovill	The Trust should ensure that the risk of not being able to receive incoming calls in the event of an evacuation of Waterloo should be included on the risk register and a potential resolution should also be pursued.	Agreed.	The EBS Fall Back procedures include relocation to Fielden House. EBS are now in discussions with IM&T Networks about the provision of a facility to transfer calls in the event of relocation being required.	**Sept 2009**
Urgent Care - February 2007 – Limited Assurance				
Sue Watkins	A risk assessment of the Urgent Care Function should be undertaken.	Agreed	A risk assessment of the Urgent Care Function has still to be undertaken.	Dec 2009
Sue Watkins	Once the Urgent Care service has been restructured and recruitment issues resolved, the Trust should undertake an analysis of cost savings to the organisation as a result of the service provided by urgent care.	Agreed	The restructure is still ongoing. CTA Reviewers have received their restructure letters and Paramedics will become CTA Team Leaders and EMT4's will become CTA Area Controllers. CTA recruitment is now close to Establishment (48/50) .	Sept 2009

AUDIT RECOMMENDATION PROGRESS REPORT				
Responsibility	**Recommendation Details**	**Action Agreed / Management Comment**	**Current Status**	**Due Date**
Sue Watkins	The urgent care dispatch team should develop suitable methods to ensure forward planning is undertaken for dispatch of urgent care vehicles and thereby using the vehicles in a cost effective and efficient manner.	Agreed	Completed The change request for splitting of the UC operational sector has now been completed. Changes to viewing restrictions for AS3 non-urgents are still awaited, and these will aid forward planning considerably The mental health booking system is now bedded in and ensures that on a daily basis mental health transfers are staggered in allocated time slots throughout the day allowing for greater planning on the part of urgent care. A review of EBS end of life transfers is being undertaken.	**Sept 2009**

AUDIT RECOMMENDATION PROGRESS REPORT				
Responsibility	**Recommendation Details**	**Action Agreed / Management Comment**	**Current Status**	**Due Date**
Annual Leave Management - February 2008 – Limited Assurance				
Gareth Hughes	The arrangements and accountability for annual leave management should be clearly defined and formally approved as soon as possible. The current arrangements do not provide adequately controlled and documented control mechanisms which should specifically detail management responsibilities regarding the arrangements for annual leave, including appropriate segregation of duties with regards to annual leave approval, recording and monitoring.	Year start figures are being obtained for annual leave entitlement for all operational staff to be inputted onto Promis which will produce a status report.	From May 2009 all Complex annual leave and time off in lieu is managed from Promis.	**May 2009**
Gareth Hughes	Current procedures should be enhanced to include an additional level of annual leave authorisation. A management check should be included in the process to ensure that all annual leave is taken in line with the current policy and adheres to the terms and conditions set out under section 13 of the service handbook.	An additional check will be added when crew staff place initial request for leave.	All leave is now requested electronically to one of two Resource Centres. Leave is only granted where time is available and the request is in line with the relevant terms and conditions.	**April 2009**
Mental Health Strategy - August 2008 – Adequate Assurance				
Nick Lawrence	To ensure that the strategy is taken forward and implemented throughout the Trust a steering group should be set up in line with the strategy and prior to the publication of the revised mental health act due for issue April 2008.	Agreed	The need for a strategy was discussed at a stakeholder event held in October 2008. Two pilots for mental health services are currently underway and following their evaluation the strategy will then be developed.	**Dec 2009**
Nick Lawrence	The general instruction on admitting mentally ill patients to hospital should be reviewed and dated to ensure that it is up to date and covers all the necessary roles, responsibilities and procedures relating to the admission of mentally ill patients.	As job titles, responsibilities and procedures are due to be rewritten with the impending Mental Health Bill, the re writing of GI 10 (staff booklet) will be postponed until the precise changes have been agreed.	At the stakeholder event it was decided that new and existing referral guidelines will provide crews with guidance for mental health services. A decision on whether to recreate the staff booklet, in light of the above, has still to be taken.	**Dec 2009**
Nick Lawrence	A reporting structure should be agreed to ensure that the progress of the mental health strategy's implementation is adequately monitored.	Agreed	This will be included in the mental health strategy. (See above).	**Dec 2009**

AUDIT RECOMMENDATION PROGRESS REPORT				
Responsibility	**Recommendation Details**	**Action Agreed / Management Comment**	**Current Status**	**Due Date**
Medical Devices - August 2008 – Adequate Assurance				
Daniel Adams	The Trust should ensure that a copy of each Equipment Repair Tag is retained by each Ambulance Station.	Issue Bulletin to stations reminding them	Bulletins have been issued in September 2008 and April 2009 to all stations, AOMs, DSOs and team leaders. On-going	**Sept 2009**
Daniel Adams	Stations should be reminded of the requirement to disinfect all equipment prior to requesting a repair, and evidencing this by fully completing the appropriate Equipment Repair Tag. Additionally, the Service Engineers should be instructed not collect equipment if confirmation of the disinfection status has not been recorded, and maintain a record of instances where this has occurred, reporting findings as appropriate.	Issue Bulletin to stations reminding them	Bulletins have been issued in September 2008 and April 2009 to all stations, AOMs, DSOs and team leaders. On-going	**Sept 2009**
Records Management - August 2008 – Limited Assurance				
S Moore	Regular reminders should be sent to any member of staff who was late/unable to submit their Patient Report Form following the check of the PRFs against the LA1, to reduce the time delay on the distribution of PRFs.	Agreed.	The PRF Project Board was reconstituted in March 2009 and will oversee the implementation of this recommendation.	**Sept 2009**
S Moore	Regular training courses should be provided to all Trust staff on records management requirements. Particular attention should be given to administration staff and that proper training on PRFs and LA1s is provided.	Agreed.	Training was discussed at IGG on 3/2/09 and again in May. The Learning and Organisational Development Department are developing a programme which will include IG training for existing members of staff. A pilot scheme is due to be in place by September 2009. Educational and Development will be developing a similar training package for operational staff.	**Sept 2009**

AUDIT RECOMMENDATION PROGRESS REPORT				
Responsibility	**Recommendation Details**	**Action Agreed / Management Comment**	**Current Status**	**Due Date**
S Moore	Staff crew should ensure that when LA1 and PRF forms are completed at a particular incident, that these be completed with utmost care, to ensure that the correct information is captured and that it is completed to an acceptable level. Forms should be signed and details of crew members should be shown on the forms at all times.	Agreed.	Regular audits are performed by CARU (Clinical Audit and Research Unit) as part of the clinical audit programme. CARU reports periodically to the Clinical Governance Committee.	**Sept 2009**
S Moore	The role of Administration Staff with regards to administration of Patient Report Forms (PRF) and LA1 should be more formally defined. As part of their role the Trust should consider that all administration staff for all stations checks the Patient Report Forms (PRF) against their corresponding Accident/ Emergency Journey Summary Forms (LA1) on a daily basis, to identify the number of Patient Record Forms that are missing/not submitted.	New arrangements are now in place to ensure more efficient collection and delivery. Tender drivers have been replaced by Equipment Support Personnel	The PRF Project Board was reconstituted in March 2009 and will oversee the implementation of this recommendation.	**Sept 2009**
Business Continuity – November 2008 - Adequate Assurance				
S Moore	The Trust should consider developing a Training Strategy specifically designed for the benefit of Business Continuity, outlining key objectives and targets for the year. Key Performance Indicators should be incorporated to allow the Trust to monitor progress and that sufficient training has been provided to members of staff concerned, including members of the Steering Group and other senior management staff. Training for Emergency Preparedness should also be modified to include an element of Business Continuity and recovery.	Training Strategy to be developed, with the aim of tailoring Business Continuity training for the relevant people within the Trust at different management posts, especially those members of the Business Continuity Steering Group.	Training/awareness continues through the departmental plan testing programme. Stephen Moore and John Pooley, Head of Emergency Preparedness, are looking to appoint a Business Continuity Coordinator who will be tasked with developing a training programme for the Trust.	**Sept 2009**
Budgetary Control - January 2009 – Substantial Assurance				
Karen Walker/ Andrew Bell	The Trust should ensure that all budgets are signed by their respective budget holders	Recommendation from report issued in August 2008.	See below.	

AUDIT RECOMMENDATION PROGRESS REPORT				
Responsibility	**Recommendation Details**	**Action Agreed / Management Comment**	**Current Status**	**Due Date**
Karen Walker	The Trust should ensure that all budget managers sign up to their budgets following the approval by the Trust Board. Where budgets are not signed off by individual budgets holders on a timely basis, this should be escalated to their line manager to ensure that there is agreement of the budget for the year. Any queries that budget holders have should be resolved as possible.	Agreed. Advice to be sought from Bentley Jennison.	Bentley Jennison have advised that budget managers sign up to their budgets at the monthly budget holder meetings. Any issues should then be escalated through the appropriate line manager.	**July 2009**
Benefits Realisation - Invest To Save - February 2009 – Adequate Assurance				
Martyn Salter/ Andrew Bell	Any closure report should ensure that it comments on all of the following: • Performance against budgeted cost • Delivery against agreed timescales • Delivery of benefits against benefits outlined within the Project brief	A project closure report template should be developed, which stresses the recommendations made in the report. Finance needs to adjust reporting structures to allow project managers and programme boards adequate visibility of project spends.	Action not yet due.	**June 2009**
Karen Walker	When agreeing a series of projects the overall Programme Co-ordinator should consider the impact upon corporate resources and especially the IT Department and Procurement and seek to identify mitigating actions to help prevent delay on the delivery of individual projects/schemes. The interdependencies between departments are a key consideration when planning projects.	The current interdependency arrangements need to be extended to encompass the consideration of SPPPs.	Action not yet due.	**July 2009**

AUDIT RECOMMENDATION PROGRESS REPORT				
Responsibility	**Recommendation Details**	**Action Agreed / Management Comment**	**Current Status**	**Due Date**
Martyn Salter	Management should carry out a final post project implementation to measure the benefits against a handful of the major projects in six to twelve months time. This will provide a more realistic timeframe to assess whether each of the projects has achieved its objectives and the benefits have been realised. Management may decide to focus only on projects above a certain financial expenditure threshold or possibly only on project implementations. It would be useful to ensure that for those where the Trust is to assess whether the benefits have been realised that clear and measureable benefits are determined at this point in time.	Agreed.	Action not yet due.	**Mar 2010**
Drug Controls - April 2009 – Limited Assurance				
Director of Operations	A sufficient number of drug packs need to be kept at each ambulance station to avoid shortages of packs and the risk that drugs are not available when required. The Trust needs to identify the most appropriate method for issuing and usage of drug packs to ensure that these are not retained by staff, and results in a shortage of drugs in the system. This could include assigning packs to vehicles as opposed to paramedics to ensure a sufficient number of packs are in use within the Trust.	The shortages are caused by the withholding of packs, not because there is a fundamental shortage in the first place .Pack numbers are based on shifts, not numbers of staff. Assignment of packs to vehicles will be difficult because of Flexible Fleet system which means vehicles move around frequently. The audit trail of drug usage would also become more difficult – there would still need to be an element of packs being signed in and out (if used or out of date). There still needs to be a personal responsibility for drug management	Director of Operations to issue bulletin to all managers and staff reinforcing requirements of drug management procedures. Instruction to be issued to return all out of date, incomplete, and unsealed bags to LSU. Staff also to be instructed not to retain bags and to sign them out and in as required by the procedures. Complete.	**Mar 2009**

AUDIT RECOMMENDATION PROGRESS REPORT				
Responsibility	**Recommendation Details**	**Action Agreed / Management Comment**	**Current Status**	**Due Date**
Director of Operations	Ambulance station managers should remind staff of their responsibilities to accurately log drug packs using the Drug Pack Issue / Return Form LA295/A (Paramedic / MRU / CRU) and the LA296 (General) form. A check of drugs packs logged out and returned using the LA295 and LA296 forms should be undertaken by the Ambulance Station Manager on a weekly basis to identify staff not complying with the logging procedures. At this point, instances where a drugs pack has not been signed back in can be followed up.	An email to staff reminding their responsibilities to log packs using LA295 and LA256 forms. Bar code or RFID technology might replace this in future.	Covered as above. Weekly auditing of packs to be carried out (OSD to update and issue form - compliance to be regularly monitored). Complete.	**Mar 2009**
Director of Operations	The Trust should also undertake, on a sample basis at least, checks to ensure that only drugs which have been used on patients have been removed from the packs.	An audit programme needs to be developed to achieve this	Drug Usage form to be included in packs (referenced to PRF). Forms to be made available for cross checking with PRF. Complete.	**Mar 2009**
Director of Operations	Management should ensure that the Drugs Return Lockers at London Ambulance stations are locked and the damaged doors made secure as a matter of urgency. Access should be restricted to only the designated staff at the Logistics Support Unit in compliance with the Procedure Covering the Issue and use of Drugs by London Ambulance Service staff.	Review and replacement of drug cupboards – more secure cupboards for used/out of date pack storage. Robust and regular auditing of cupboards/pack status by local managers. Logistics Support Unit to send out electronic message the day before a pack is due to expire. Pre and post shift for drug pack administration and vehicle roadworthiness checks. Have quarterly drug audits for next year to follow up action plan. Have quarterly drug audits for next year to follow up action.	Audit of drug cupboards and key safes to be carried out. Security of cupboards to be assessed. LSU to send out electronic message to AOM 48 hours before drug pack due to expire. Quarterly external audit of compliance with drug procedures to be introduced to check progress. On-going	**Dec 2009**
Director of Operations	Management should ensure that all drugs packs are stored securely and that access controls such as key pad door locks and lockers are used and security maintained.	See above.	See above.	**Mar 2009**

AUDIT RECOMMENDATION PROGRESS REPORT				
Responsibility	**Recommendation Details**	**Action Agreed / Management Comment**	**Current Status**	**Due Date**
Director of Operations	Management should ensure that the Paramedic and General drug packs are returned to the Logistics Support Unit as soon as drugs are expired to prevent the risk of out of date drugs being used for patient care. Guidelines on drug pack procedures need to be communicated to staff. Station Managers need to enforce rules where they find staff are keeping drugs packs.	Robust enforcement of drug procedures by local managers – signing packs out and in at start/finish of shift – no personal retention of packs. Packs to be removed from vehicles and signed back into station cupboard before they are moved to different Complex by Flexible Fleet.	Instruction to be issued to managers and staff to remove packs from vehicles being moved under Flexible Fleet operation. Complete.	**Mar 2009**
Director of Operations	Management should ensure that the Medical Directors report to the Trust Board details of any drug related incidents. Where there have not been any Drug related issues, a nil return should be reported.	An analysis of all the drug related incidents will be done to ascertain whether any SUIs have been missed.	Analysis to be carried out. Complete.	**Mar 2009**

10 Report of the Local Counter Fraud Specialist

- **Annual Report 2008/09**

London Ambulance Service
NHS Trust

Audit Committee Front Sheet

Title: LCFS Annual Report 2008/9	**Agenda Item: 10** **Enclosure: 10**

Purpose:

Annual Report detailing work conducted by Local Counter Fraud Specialist during period 2008/9. Statutory requirement to produce report to Trust on an annual basis.

Summary:

This LCFS Annual Report provides details of work conducted by the LCFS during the work plan year of 2008/9 (April 2008 – 31 March 2009) across the generic areas of the counter fraud strategy, and in line with the agreed work plan for this period.

Recommendations/and or actions required:

The Committee is requested to accept the document and provide comment as necessary.

Author and Date:

David Foley
Senior Manager, RSM Bentley Jennison
27 May 2009

London Ambulance Service NHS Trust

Local Counter Fraud Specialist Annual Report

Audit Committee Meeting – 8 June 2009

CONFIDENTIAL

Prepared by: David Foley

Bentley Jennison Risk Management Limited
Bentley Jennison Risk Management Limited is wholly owned by RSM Bentley Jennison
Registered in England & Wales No. 3444889
Registered Office 1 Hollinswood Court Stafford Park 1 Telford TF3 3DE

Contents

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1. Executive Summary

1.1 In 1999, Secretary of State Directions (the Directions) were issued to Trusts, PCTs, Ambulance Services and Strategic Health Authorities setting out the requirements for countering fraud in the NHS. These Directions were revised in 2004 and issued to all NHS health bodies (including Special HAs) and also amended in 2007. They are currently supported by the version 3 of the NHS Counter Fraud and Corruption Manual (the Manual). The Auditor's Local Evaluation Lines of Enquiry (KLOE 4.3 – Use of Resources) and the Health Care Commission's Annual Health Check Standard C7b also identified the need for NHS organisations to demonstrate that they have systems in place that comply with these Directions. In addition, Compound Indicators have been introduced by the NHS CFSMS as a task-based self assessment mechanism to rate the standard of counter fraud work delivered at health bodies.

1.2 The LCFS provision at London Ambulance Service NHS Trust is provided by RSM Bentley Jennison. Their 'Business Integrity and Investigation Services' arm specialises in all aspects of counter fraud and investigations work across the public, corporate and not-for-profit sectors. RSM Bentley Jennison is the largest commercial provider of the Local Counter Fraud Specialist (LCFS) in the NHS, with a large integrated team with accredited and experienced LCFS personnel.

David Foley is the nominated lead LCFS for the health body and is based at the RSM Bentley Jennison offices in Moorgate, London. Jenny West is the secondary LCFS for the Trust.

1.3 This report has been written in accordance with the provisions of the Directions, which require the LCFS to provide a written report, at least annually, to the health body on counter fraud activities which have been undertaken. This report details all activities undertaken of both a proactive and reactive nature in the year 1 April 2008 to 31 March 2009. A copy of the progress made against the LCFS 2008/9 workplan is included at Section 3 of this report.

1.4 The Counter Fraud and Security Management Service (CFSMS) requires a workplan to be in place which outlines core LCFS activities to be undertaken during a financial year and the related resources expected to enable such tasks to be delivered and completed successfully. A workplan for 2008/9 for the health body was agreed with the Director of Finance and approved at the Audit Committee.

1.5 The health body is compliant with the Secretary of State's Directions (see Appendix 1). However, the health body should be aware that guidance from CFSMS for an organisation of a similar size and budget as London Ambulance Service NHS Trust suggests an LCFS resource of ninety one (91) days, excluding investigations. The agreed plan for 2008/9 was 64 days which is less than the suggested number of days. It should be noted, that upon a review of the 2008/9 conducted by the LCFS in October 2008, in consultation with the Director of Finance, a significant increase in days was allocated to counter fraud work, of an additional twenty (20) days. This has resulted in a proactive work plan allocation of eighty four (84) days. This was based on the level of work undertaken during the work plan up until that point, a response to the NHS CFSMS Compound Indicator Assessment result, for year 2007/8, as well as the proposed work which was agreed required undertaking to further improve the counter fraud arrangements and ensure they are clearly embedded within the Trust. This demonstrates a clear commitment by the Senior Management Team and the Trust, that countering fraud is treated with such importance, to ensure that the funds, assets and great reputation of

the Trust are best placed to be protected. Therefore, a total of eighty one (81) proactive days were completed, including eleven (11) reactive days for investigations, and one (1) day for off-work plan activity, totalling ninety three (93) days work undertaken.

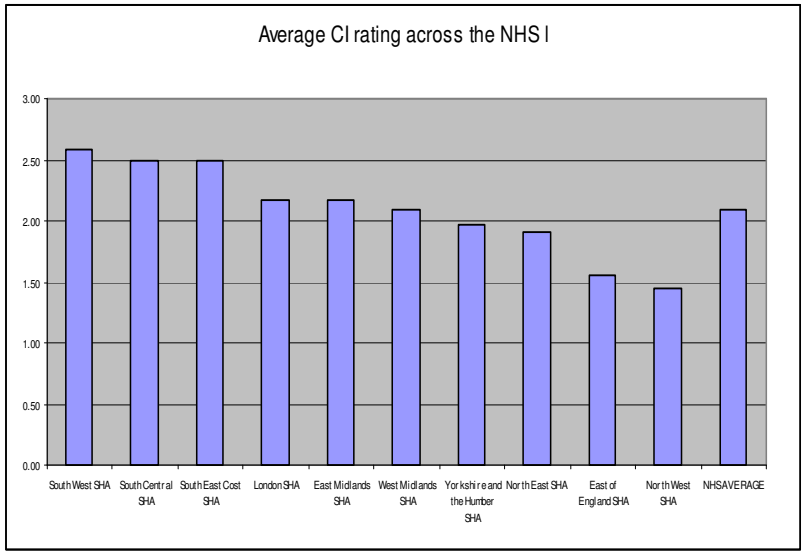
1.6 However, it should be noted that the agreed proactive days specified in the plan were based on a combination of the following criteria:

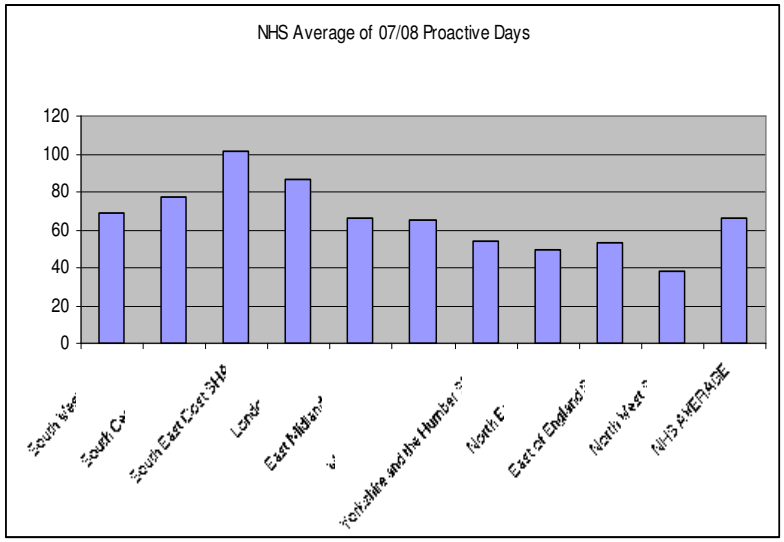
a) An informed assessment of counter fraud needs, based on a determination of perceived and/or known fraud risks to the health body;
b) Consideration of both historical and ongoing counter fraud measures and activities in place at the health body;
c) The clear economies of scale which derive from the appointment of an experienced national provider of counter fraud services and that, accordingly, benefit the health body;
d) The budgetary considerations which the Director of Finance is necessarily required to take into account when prioritising and agreeing the LCFS workplan activity areas.

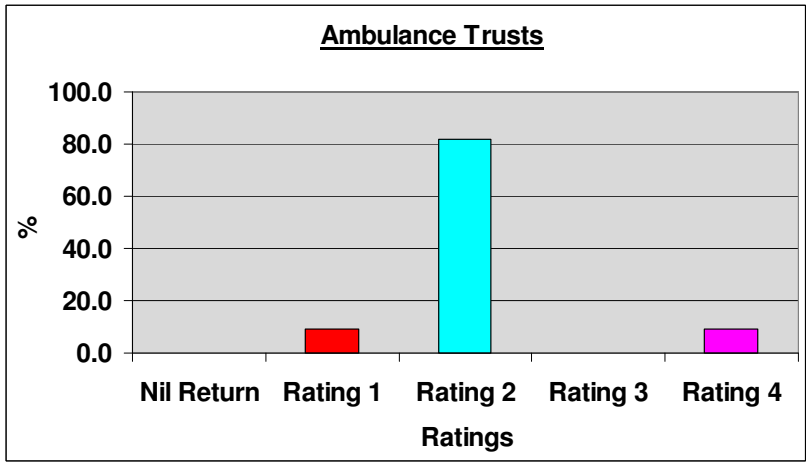
1.7 Compound Indicators (CIs) are a self assessment tool developed by the CFSMS to measure the effectiveness of the Local Counter Fraud resource provision. CIs are required to be completed as part of the LCFS Annual Report and forwarded, with supporting evidence, to CFSMS.

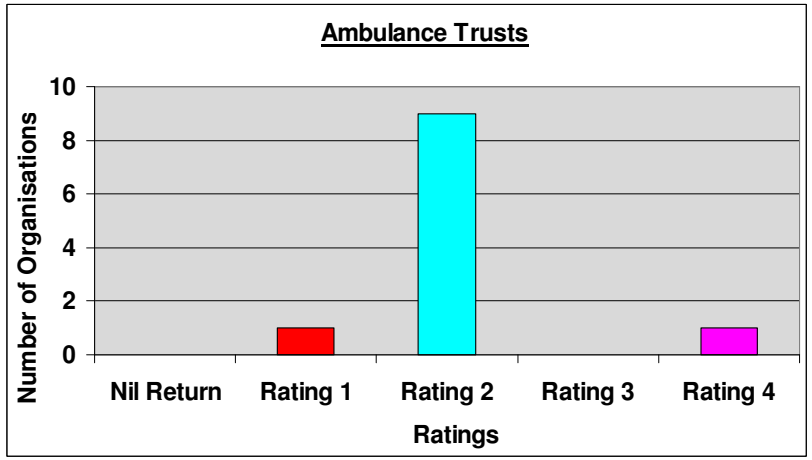
1.8 CIs were used to rate NHS organisations on a level of 1-4 with 1 being 'inadequate performance' and 4 being 'performing strongly'. London Ambulance Service NHS Trust was awarded a rating of 2, the definition of category 2 is "*adequate performance, completion of all or the majority of the tasks in the CI Assessment document will need to be evident as these are basic requirements for achieving adequate performance*".

We have included some comparative data to benchmark the Trust's CI rating, as shown in the graphs below.


Average CI rating across the NHS I
3.00
2.50
2.00
1.50
1.00
0.50
0.00
South West SHA
South Central SHA
South East Cost SHA
London SHA
East Midlands SHA
West Midlands SHA
Yorkshire and the Humber SHA
North East SHA
East of England SHA
North West SHA
NHS AVERAGE


NHS Average of 07/08 Proactive Days
120
100
80
60
40
20
0


Ambulance Trusts
100.0
80.0
60.0
40.0
20.0
0.0
%
Nil Return
Rating 1
Rating 2
Rating 3
Rating 4
Ratings


Ambulance Trusts
10
8
6
4
2
0
Number of Organisations
Nil Return
Rating 1
Rating 2
Rating 3
Rating 4
Ratings

1.9 Figures released by CFSMS Quality Department indicate that the average number of days that are actually used to attain a given rating were as follows:

- Rating 1 - average number proactive days 37.72
- Rating 2 - average number proactive days 60.24
- Rating 3 - average number proactive days 97.06
- Rating 4 - average number proactive days 106

Ambulance Trusts Ratings:

- There were no Nil Returns for Ambulance Trusts
- 9.1% (1) Ambulance Trust received a Rating 1
- 81.8% (9) Ambulance Trusts received a Rating 2
- No Ambulance Trusts received a Rating 3
- 9.1% (1) Ambulance Trust received a Rating 4

1.10 The rating 2 achieved by the London Ambulance Service NHS Trust indicates that the days purchased were in line with the benchmark for a rating 2.

1.11 CFSMS reviewed the inaugural CIs and made changes for the 2008/9 declaration. The most significant change relates to the removal of points for task completion. The declaration for 2008/9 focuses on the importance of demonstrating effectiveness and the correlation between task, output and impact. It also encourages the submission of supporting documentation which should be clearly referenced. However, it should be noted that this has required a significant increase in the time required to complete this process.

1.12 A Compound Indicator self assessment document for 2008/9 has been completed prior to the 30 April 2009 deadline. A copy of the Compound Indicator Report will accompany this Annual Report.

Executive Summary (Key LCFS Activities in 2008/2009)

1.13 The current LCFS, David Foley commenced the role for Trust during August 2008, having taken over from the previous LCFS.

1.14 The LCFS has represented the Trust during attendance at the NHS Counter Fraud & Security Management Service (NHS CFSMS) National Annual Fraud Conference. Representation has also provided at the NHS CFSMS regional biannual forums, whereby training is provided in conjunction with the dissemination of current trends and threats within the NHS fraud arena.

1.15 The London Ambulance Service NHS Trust is the only London-wide NHS Trust, which is also the largest emergency ambulance service in the world to provide healthcare. This covers about 620 square miles The Trust has more than 4,000 staff, who work across a wide range of roles

based in 70 ambulance stations and multiple other sites, inclusive of a centralised head office and regional centres. By this very geographical nature, encompassed by the services that the Trust delivers, this presents a challenge to ensuring that fraud awareness is effectively delivered utilising a number of different mechanisms across the service, to ensure that arrangements are embedded.

1.16 The LCFS has reviewed the Fraud & Corruption Policy, Declaration of Interests Policy & Procedure, Standing Financial Instructions (SFI's), Gifts & Hospitality Policy, Fuel & Lubricant Policy, Internet Policy, Disciplinary Policy & Procedure, Managing Attendance Policy and Data protection Policy. The review has identified some areas where best practice guidance has been shared to enable the policies to be amended to adequately reflect counter fraud arrangements. This assists in ensuring that policies considered "high risk" are robust in the prevention and deterrence of fraud.

1.17 The LCFS conducted a staff survey (June 08) which identified that continued, but increased fraud awareness training was required throughout the London Ambulance Service NHS Trust. Significant resources were spent throughout the year in the aim to enhance the LAS anti fraud culture as the LCFS significantly increased the level of fraud awareness training sessions, on a priority basis to key groups across the Trust. The LCFS has supplied a comprehensive pack of material to be provided to new starters at each LAS induction course. This informs new entrants to the Trust that fraud is not tolerated whilst encouraging whistle blowing. The LCFS has also delivered a presentation at a number of senior and middle manager meetings, key personnel group meetings, such as payroll, finance and procurement teams. The LCFS has also visited a number of LAS sites, consisting of Headquarters, regional centres and ambulance stations. This has enabled the LCFS to interact in person with a wide range of staff across the Trust. The response from the vast majority of staff has demonstrated an appetite for counter fraud and has been very positive and encouraging.

1.18 The LCFS has liaised with the LAS Risk Manager and Head of Legal Services. A heading of fraud has been included as an entry on the LAS risk register. Completion of the NHS CFSMS risk assessment tool and a local fraud risk assessment has lead to further fraud entries being made on the LAS risk register.

1.19 The Audit Commissions' National Fraud Initiative was undertaken by the London Ambulance Service NHS Trust and managed by the LCFS. This generated a total of one thousand and eighty seven (1087) data matches which are subject to ongoing enquires.

1.20 The LCFS received referrals during 2008/9 which resulted in thirteen (13) investigations being conducted. No investigations were ongoing from the previous financial year. Seven (7) investigations were concluded: five (5) with no fraud proven, two (2) concluded with no sanctions possible. One (1) of these was referred for further disciplinary action to be considered.

1.21 Six (6) investigations are currently ongoing. Of these, two (2) are currently being progressed using a parallel sanctions process, whereby they are subject to ongoing disciplinary procedure. The LCFS is working closely with the investigating leads in these cases to ensure that the appropriate sanctions are being considered.

1.22 No matters have been reported to the LCFS which would impact on the Statement of Internal Control.

2. Introduction

The Local Counter Fraud Specialist (LCFS) work plan for 2008/9 was agreed with the Director of Finance and subsequently approved by the Audit Committee on 16 June 2008. This report:

- summarises the outcome of work completed for the year against the agreed workplan;
- highlights any current counter fraud matters that the Audit Committee should be aware of; and
- provides data in support of LCFS performance.

The work plan is based on a range of activities as defined by the NHS CFSMSS Counter Fraud Strategy, with key areas of work across the following areas;

- Creating an anti fraud culture
- Deterring Fraud
- Preventing Fraud
- Detecting Fraud
- Investigations
- Sanctions
- Seeking redress
- Mandatory counter fraud arrangements

Work conducted is undertaken using a risk based approach, ensuring that that the work is both compliant with Directions, is relevant whilst seeking to add value to the Trust. Work across these areas is also linked, focusing on outcomes and measuring impact.

The agreed work plan for 2008/9 was agreed by the Director of Finance covering the generic areas, using a total of sixty four (64) days for proactive work, whilst allowing reactive work to be undertaken with additional resources.

As a consequence of a review of the work plan, the Director of Finance agreed to provide additional resources to the counter fraud work, increasing the number of days for the proactive work plan to a total of eighty four (84) days.

3. Performance against 2008/9 LCFS Workplan

The table below shows final outcome of deliverables against the 2008/9 workplan for the year.

Generic Area of Activity	Planned days	Days Completed to Year End	Reasons for Any Variance
Creating an Anti Fraud Culture	22	21.5	
Deterring Fraud	4	3	
Preventing Fraud	18	18	
Detecting Fraud	28.25	25	NFI & local proactive exercise work ongoing into 09/10 plan
Total Proactive	**74**	**67.5**	
Investigation	0	11	
Sanction	1	1	(actual proactive plan days delivered)
Redress	0.75	0.5	(actual proactive plan days delivered)
Total Reactive	**1.75**	**12.5**	
Management Activities	10	12	Increased reporting requirements to NHS CFSMS
Off Plan Activities	0	1	(in addition to proactive plan – LAS ALE assessment returns)
Total	**84**	**93**	

4. Developing an Anti-Fraud Culture:

The LCFS will work with the NHS Counter Fraud Services organisation to develop a real anti-fraud culture within the NHS.

The development of a real anti fraud culture across the Trust was a key area of work, which was increased significantly, as a consequence of the increase in resources to the Trust counter fraud work plan. This was delivered utilising a range of methods and activities, to ensure that a clear message was conveyed across the Trust, initially through a focused approach on the key areas and staff, across the management teams and areas of high budgetary spend, such as payroll, finance, management accounts, logistics, fleet section, workshops, inclusive of areas which are deemed risk key areas to ensure that fraud is prevented and detected, such as human resources and recruitment teams. This has been an effective approach, which is demonstrated through the clear outputs delivered and increased level of referrals for investigation, and requests for advice and guidance directly being made to the LCFS.

Actions taken:

4.1 The London Ambulance Service NHS Trust has a high level of inductions across the Trust, delivered from different areas of the business. To ensure that the LCFS is effective and is able to deliver the counter fraud message to these staff, a DVD was produced, which is played at all new starter induction sessions. This DVD provides information on the Strategy and also provides information on the reporting lines for concerns, inclusive of the contact details of the LCFS. This was disseminated to all sites across the Trust, with a covering letter from the Director of Finance, requesting that all staff be shown the DVD.

4.2 The LCFS has compiled a comprehensive pack of informative fraud awareness material, which is included amongst the new starters induction pack. This pack was reviewed during the year and updated, with content which was current and relevant.

4.3 The LCFS has delivered a total of twelve (12) fraud awareness training sessions to staff across the Trust. This included the following managers and staff from within the following departments:

- Finance Team / Management Accounts Team / Procurement Team

  These groups were trained over three sessions, to ensure that all staff within these key departments attended. In total, thirty four (34) staff attended over the three sessions. The sessions concentrated on the risk to fraud within these areas, and particular importance was placed on compliance with policies and procedures, segregation of duties and verification of information which passes through the department. Staff were also encouraged to report any concerns to the LCFS.

  Feedback provided after this meeting was positive, in that is was both informative and assisted greatly in raising the level of awareness to fraud.

- Human Resources Managers

  This awareness session was provided to a total of fifteen (15) staff, who undertake duties within HR across a number of sites across the Trust. This focused of the role of human resources in countering fraud, as often HR is viewed as a “gateway” for fraudsters entering organisations, through committing identity fraud, falsifying qualifications, false employment histories and failure to disclose previous criminal convictions. Practical advice was provided on their role in countering fraud and examples of cases (outside of LAS) whereby systems have failed, contributing to fraud occurring. The approach to parallel sanctions, through the implemented HR & LCFS Working Protocol was discussed.

  This presentation was well received and resulted in the continued development of the working relationships.
  This has resulted in a number of ongoing requests for advice and guidance on potential fraud matters, surrounding employment checks, CRB and other HR issues.

  This has also resulted in an investigation referral being submitted to the LCFS, as well as a request for training, specifically surrounding the risks to organisations for failure to comply with the Immigration, Asylum & Nationality Act 2006 when employing illegal workers.

- Recruitment & CRB Team
  This presentation was as a result of the previous HR Managers awareness session. A total of fifteen (15) staff attended. This was a bespoke session delivered to the Recruitment team and was focused on the risks to organisations for failure to comply with the Immigration, Asylum & Nationality Act 2006 when employing illegal workers, and generic risks with recruitment, such as qualification, previous employments and CV verification.

  This was very well received. A number of contacts have been made with this department since the session, whereby the LCFS has provided advice on specific potential fraud matters which have arisen. This has also led to a referral of a potential investigation to the LCFS.

- Payroll Team
  An awareness session was delivered to the payroll department, who are a key stakeholder in detecting and preventing fraud. This was attended by the entire department and generated some interesting discussions surrounding risks within this area of the Trust. Staff were encouraged to report any concerns to the LCFS.

  The LCFS has regular interaction with this department. A LCFS & Payroll team working protocol has also been devised.

- Assistant Director's of Operations (ADO) Meeting
  This awareness session was provided to a total of twelve (12) members of senior management. This focused on the role of a manager in countering fraud, and the risks to the LAS should a high profile fraud occur within the service. Managerial accountability and case examples were discussed at length.

  This meeting resulted in two further requests for training sessions on countering fraud. This also resulted in a referral being submitted to the LCFS for investigation.

- Lightbridge Support Services (LSS) "Make-ready" Senior Managers
  This awareness session was undertaken for the purpose of engaging with our partner organisations, which provide vital support services to the Trust. This involved undertaking an awareness sessions at LSS offices, with nine (9) managers present. This was a very positive and well received presentation, which has led to the building of relationships, and adoption of the fraud reporting number to their staff.

  This has resulted in a referral being made to the LCFS regarding a potential fraud. A good working relationship has been developed, which as a result has resulted in the managers disseminating fraud awareness key rings to all LAS sites, for attaching to all LAS fleet vehicles. This will assist in advertising the fraud reporting line number.

- Fleet Managers

  This awareness session was delivered to six (6) fleet managers at the Greenwich site. This session covered the risks associated within the area of fleet services, such as workshops; staff overtime claims, mileage claims and use of Trust equipment and resources. This session was very well received and has led to a number of requests for advice and guidance since this date.

- Logistics Managers

  A session was provided to the logistics managers group, raising levels of awareness of fraud within their business units and areas of work. Six (6) managers were in attendance. This presentation generated lengthy discussions surrounding issues of potential fraud within this area.

- AOM Meeting

  A fraud awareness session was provided to the AOM meeting, which covered details of the approach to countering fraud within the Trust, in conjunction with the necessity for effective management of staff, segregation of duties and reporting lines for allegations and whistle blowing. This was attended by twenty four (24) members of the team.

- East London Area Business Meeting

  A session was delivered during this meeting, to promote the counter fraud message, explain the role of the LCFS and the part that all staff have to play in the creation of an anti fraud culture. The group in attendance covers a range of positions across the Operations department across East London Area. This session involved discussion over examples of fraud cases and the reporting mechanisms of encouraging referrals and the identification of system weakness across each of their areas of business. This was attended by sixteen (16) staff members.

  All presentations delivered are tailored accordingly to the relevant audience, to ensure that the generic message of counter fraud, as well as specific risks within the areas of the groups in attendance is covered. The Fraud & Corruption Policy and fraud material contained upon the intranet site “The Pulse” is mentioned. The Whistle blowing Policy is also discussed, in conjunction with the reporting mechanisms for making referrals to the LCFS. Either via direct, through thru Director of Finance, or the National Fraud Reporting Line number, operated by NHS CFSMS.

  Fraud awareness material, consisting of leaflets, pens, newsletters and other material is distributed at all presentations delivered. This assists with cascading the reporting contact details. All presentations have been described by those in attendance as relevant and appropriate. A total of approximately 150 staff have received direct fraud awareness training sessions during this work plan year. This is a rolling programme which will be further developed in year 2009/10.

4.4 The LCFS has become further embedded within the Trust over the last work plan year. This has been assisted by the LCFS having dialogue and interaction with a number of key personnel, either through formal meetings or other regular contact and liaison, in the course of his duties. This assists in promoting the counter fraud message and reporting lines. Contact has taken place amongst the following key personnel; Chief

Executive Officer, Director of Finance, Director of Human Resources, Associate Director of Employee Relations, Head of Legal Services, Payroll Manager, Financial Controller, Procurement Manager, Assistant Medical Director, Director of Operations, Communications Manager, Risk Manager, AOM's ADO's, DSO's, Local Security Management Specialist (LSMS), Head of Fleet Services, Logistics Managers, Patient Transport Managers, EOC staff, Station Administrators, and Internal Auditors.

4.5 The LCFS has also become part of the Risk Compliance and Assurance Group, which is chaired by the CEO, to enable the risk of fraud to be entered onto the risk register, whilst also being afforded the opportunity to provide advice and guidance on the risk of fraud across the Trust. The LCFS has also attended the Joint Staff Committee meeting, whereby as short talk was given on the role of the LCFS. This group was attended by a number of senior managers and Union representatives.

4.6 The Trust participated in the NHS CFSMS initiative fraud awareness month "FAM" which took place during the month of October 2008. This involved the LCFS presenting a stand at the Headquarters reception area, allowing the opportunity of staff to discuss matters with the LCFS and gain a greater understanding of the LCFS role and general fraud awareness. The LCFS distributed publicity material, inclusive of pens, mugs, clocks and leaflets, CFSMS Insight leaflets, containing contact details of the LCFS and the national fraud reporting line. The LCFS also distributed material across the site, including the restaurant area, taking the opportunity to speak with staff present. This enabled the LCFS to interact with over 130 staff during this event, discussing fraud matters which occur in the NHS.

FAM material was also posted onto the Intranet site, The Pulse, which included a newsletter providing counter fraud being undertaken across the NHS, including details of successful investigations which led to prosecution proceedings. This was published across the Trust using the LAS bulletin "RIB".

4.7 The LCFS has produced information which has been circulated by the Trust, via email, on the Intranet site and also within the newsletter "RIB" on fraud related matters. This has included LCFS counter fraud newsletters, which have been distributed using the methods above, during June, October, December 208 and March 2009. This provides information relevant to ambulance trusts, whilst also providing fraud awareness information, such as scams and other fraud which occurs across the wider NHS.

4.8 The LCFS has circulated a global introductory email to all Trust user email accounts. This provided staff with information on the LCFS role, how to report any concerns, whilst also providing them with details of the areas of work which the LCFS will be undertaking during the work plan year. This has resulted in a number of requests for advice, guidance and training.

4.9 The LCFS has compiled a fraud awareness pack, which has been distributed to all Trust sites. This included a covering letter, explaining the role and contact details of the LCFS. The pack consisted of; copies of the LCFS counter fraud newsletter, fraud awareness information leaflets, business cards with contact details for the LCFS, a "do's & don'ts" guide for staff and posters for displaying across sites, promoting the counter fraud message and contact details for the LCFS.

4.10 The LCFS has completed a comprehensive overhaul of the counter fraud section of the Trust intranet site" The Pulse." This has been updated, with a variety of material, which consists of; details of what fraud is and its impact on the LAS and wider NHS, posters for printing by staff, informative information on the role of the LCFS including reporting details, a reporting form for submitting referrals, a presentation on fraud with case examples to aid awareness and versions of all newsletters distributed. The fraud section of the site also contains a number of links, to external websites, such as NHS CFSMS and Public Concerns at Work sites.

4.11 An Annual Fraud Awareness Survey was completed by the LCFS in June 2008. This was completed via an electronic form on the intranet site "The Pulse" Only 36 responses were received from staff across the Trust. However, it was established that owing to technical issues with the link, this may have contributed to the relatively low number of returns. Of those returns, the results were analysed and submitted to the Director of Finance in a report. The key findings from this report were as follows;

- Very few had received any fraud awareness training during their induction training; 1%
- A limited number of people knew the LCFS ;18%
- Those who requested further information on counter fraud; 58%
- Those who had reported any concerns to the LCFS, described the service as *"Timely, Informative and Useful"* All reported that the referral they submitted had been dealt with sufficiently by the LCFS.

The annual staff survey will be developed further, with a number of mechanisms being used to ensure that a greater response is received during 2009/10 work plan.

This survey has resulted in the increase to counter fraud awareness training being delivered across the Trust.

4.12 The LCFS has obtained a postage stamp, which publicises the National Fraud Reporting Line Number, which has been provided to the postage room at Headquarters. This is being used to ensure that as much internal mail as possible is marked with the message "Report NHS Fraud – 0800 028 40 60"

4.13 A payslip message promoting the counter fraud message and contact details for the LCFS was submitted for distribution to the payroll manager in February 2009.

5. Deterring Fraud:

The LCFS ensures that an effective deterrence message is evident and disseminated across the Trust where possible.

Actions taken:

5.1 Through regular liaison with the Director of Finance and Communications Team, the LCFS distributes counter fraud information, consisting of newsletters, fraud alerts and other relevant fraud information. This is disseminated as appropriate, either through the intranet site, via the Trust newsletter “RIB” or via email to appropriate groups, such as the management team, station administrators, Assistant Directors of Operation and Duty Station Officers.

5.2 The LCFS has submitted four (4) fraud alerts, disseminated by the NHS CFSMS to the Trust. These were submitted to the appropriate departments for action, inclusive of the Audit Committee. The LCFS has also liaised with the human resources team regarding frequent requests for assistance, via LCFS from other Trusts, for requests for information concerning potential fraudulent matters under investigation.

5.3 The LCFS has developed a comprehensive Counter Fraud Communications Strategy which gives clear guidance on national publicity, advance warning systems, the NHS CFSMS Corporate Affairs Directorate and also details specific tasks and actions that were to be completed during the year. The LCFS has met with the Communications team on several occasions during the year to discuss the role of the LCFS and the importance of publicity within the NHS nationally and locally with the objective of heightening counter fraud awareness in the Trust. This ongoing liaison continues on a regular basis.

5.4 The LCFS has produced four (4) counter fraud newsletters during 2008/09 (June, Oct & Dec 08 and March 09). These newsletters highlighted recent NHS cases that had been prosecuted nationally. Information was also published giving contact details of the LCFS and NHS Fraud & Reporting Telephone Line to encourage the reporting of any suspected fraud. The circulation of these newsletters have included the Trust's Risk Manager.

5.5 To be effective locally, publicity needs to have local relevance and it is important for the LCFS to communicate local successes, particularly around sanctions and redress. The LCFS publicises during all presentations, recent local investigations and their successes to ensure attendees can see clear relevance to their own areas of work and responsibilities.

6. Preventing Fraud:

Prevention is a key area of the counter fraud strategy, by ensuring that a different range of measures is utilised to protect the funds, assets and reputation of London Ambulance Service NHS Trust.

Actions taken:

6.1 Throughout the year, in addition to redrafting the Fraud and Corruption Policy, the LCFS has reviewed the following Trust policies from a counter fraud perspective. This is necessary to ensure that they are clear and concise, in detailing the reporting lines of fraud, where appropriate, whilst also ensuring that they are robust;

- Standing Financial Instructions,
- Declaration of Interests Policy & Procedure,
- Gifts & Hospitality policy,
- Fuel & Lubricant policy,
- Internet Policy,
- Disciplinary Policy & Procedure,
- Managing Attendance Policy,
- Data protection policy.

6.2 The LCFS has provided guidance documentation, issued by the UK Border Agency, to the Recruitment & CRB Team concerning new identity card legislation on overseas workers and their entitlement to work in the UK. A guide providing practical prevention and detection advice, on the Immigration, Asylum & Nationality Act 2006 was also provided to the department.

This has enabled the team to identify a potential employment fraud, which has been referred to the LCFS for investigation.

6.3 The LCFS has regular liaison with the Head of Legal Services and Risk Manager, both through regular contact and also the RCAG group. A heading of fraud has been included as an entry on the risk register. The Risk Manager is appraised by the LCFS of all current fraud trends which are likely to impact on the Trust as and when they occur.

6.4 The LCFS maintains a close liaison with the LSMS and a working protocol has been agreed. The LCFS updates the LSMS on current fraud trends which encourages an effective partnership and prevents any duplication of work in the Trust.

This has resulted in the LCFS referring security management issues to the LSMS for consideration. The LSMS has also referred a referral to the LCFS, which was investigation concerning a potential fraud.

6.5 The LCFS has agreed a number of protocols during the course of 2008/9 with the following;

- Payroll,
- Internal Audit,
- Human Resources,
- LSMS

6.6 The LCFS has completed and implemented a number of strategies within the Trust during the course of 2008/9 with the following:

- Communications Strategy
- Redress Strategy
- Prosecution Strategy

The protocols ensure that the work of the LCFS is understood outlines clearly the interaction between parties. It also ensures that there is no likelihood of work being duplicated. The protocols benefit the stakeholders by giving guidance when fraud and corruption is found. This also demonstrates that working relationships with key personnel are being formed, for the NHS CFSMS Compound Indictor Assessment process.

6.7 The LCFS has also undertaken a Fraud Risk Assessment of the Counter Fraud provisions within the Trust during the commencement of the work plan for 2008/9. This identified areas considered at risk, which focused the work plan activities undertaken during the year.

The LCFS has also completed the NHS CFSMS Risk Assessment Tool (RAT) which provides a strategic overview of the fraud risk within the Trust. This identified a number of areas which focused the work plan for the last quarter of 2008/9. An area that this identified, was the lack of a redress strategy in pace in the Trust. This resulted in the completion of a redress strategy by the LCFS, to be implemented. This has also assisted in the drafting of the work plan for 2009/10, to ensure that the areas of weakness identified are considered and appropriate action taken.

6.8 Regular System Weakness reporting is considered by the LCFS to the CFS on a monthly basis, as party of the role. This includes submitting nil returns. There have not been any relevant system weaknesses which have been identified during this year, which have required reporting the NHS CFSMS under this procedure. When completed, these reports assist the CFSMS nationally in ascertaining areas of weakness prevalent throughout the NHS.

7. Detecting Fraud:

7.1 When prioritising detection work, the LCFS will take account of:

- Information from the internal and external audit functions regarding system weaknesses; and,
- NHS CFS analysis on data, reports and trends

Action taken:

7.2 A comprehensive Fraud Risk Assessment was carried out by the LCFS. The findings from this work was used as an intelligence source for planning and prioritising proactive reviews to be undertaken as part of the 2008/09 LCFS work. From completion of our internally developed Fraud Risk Assessment, this highlighted (2) areas which were selected for local proactive exercises to be undertaken;

- Volunteer Transport Drivers
- "On-Call" arrangements

The Fraud Risk Assessment also identified that there were several examples of Trust property appearing on an auction website, eBay. This has resulted in the LCFS implementing a mechanism on the website, which notifies the LCFS of any LAS Trust property advertised for sale. This has resulted in a number of investigations being conducted. The LCFS is currently liaising with eBay, with the intention of identifying sellers of this property, for the purpose of investigating this further. The LCFS is also seeking to engage with eBay to identify a mechanism to prevent such property being sold on their site in the future.

The LCFS undertook a proactive exercise examining the payroll data for on call payments. It was identified during this exercise, that there was no policy or procedure in place, outlining this system, which posed a risk to potential fraud.

It was recommended that a policy and procedure document be completed and staff made aware.

It was requested by the Director of Finance that the LCFS conduct a local proactive exercise into the following two areas;

- Mileage Claims
- Overtime Claims.

The LCFS has commenced this work, however at the time of writing this report; these exercises have not been fully completed. They will be finalised in the first quarter of 2009/10 work plan.

7.3 The LCFS is managing the process of the Audit Commission's National Fraud Initiative 2008/09 exercise. The data was extracted by the Trust's payroll and finance departments in October 2008. The data matches were released in February 2009 of which there were 1087 matches that have required further investigation by the LCFS.

These currently being worked upon, with enquiries being undertaken with the Trust HR team and outside agencies. Owing to the timing of this exercise and level of data matches received, this area of work will continue into the 2009/10 work plan.

7.4 There has been no mandatory National Proactive or Risk Measurement Exercises instructed by the NHS CFSMS to be undertaken during the year.

7.5 The LCFS is a member of a National Ambulance Special Investigators Group, which involved fraud investigators representing all ambulance trusts across the UK. The LCFS represents the Trust at this group, who meet every quarter and discuss currently trends, patterns and fraud cases which are occurring across the ambulance service sector. This enables the sharing of intelligence and also the identification of best practice which is of benefit to the Trust. The LCFS reports back to the Director of Finance during the counter fraud monthly meetings, any intelligence or information arising from this group.

This has resulted in intelligence being shared on a number of ongoing issues, prevalent to ambulance Trusts, including eBay frauds. Two (2) referrals were received by the LCFS as a consequence of the membership of this group, for investigation.

7.6 Continuous liaison has taken place with the Internal Audit team throughout the year. This is beneficial and efficient owing to the IA provider being from RSM Bentley Jennison and working from the same offices. This enables regular interaction and sharing of reporting and joint working.

8. Investigations:

To assist with increasing the level of referrals, the LCFS has implemented an email, to assist in staff contacting the LCFS, via the internal email system. This has resulted in a secure email being set up: fraud@lond-amb.nhs.uk

This is a secure account which is diverted to the LCFS' NHS.net account, to ensure that the LCFS receives any contacts, even when not on site within the Trust. This was arranged with the approval and support of the Director of Finance. This has been widely advertised via the "RIB" newsletter, the intranet site "The Pulse" and also mentioned during every fraud awareness training session. This has resulted in a noticeable increase in the level of requests for advice and guidance. It has also assisted in the receipt of referrals for investigation.

8.1 The LCFS received referrals during 2008/9 which resulted in thirteen (13) investigations being conducted. No cases were carried over from the 2007/08 year. All of the referrals were investigated in accordance with the Secretary of State's Directions. No cases had to be referred to the NHS CFSMS London Regional Team for investigation. Six (6) cases are being carried over into 2009/10 whilst investigations continue.

8.2 Five (5) of these investigations were concluded with no fraud proven; one (1) of these was referred for further disciplinary action to be considered. Two (2) cases were closed, as no sanctions were possible. One (1) of these was that the Police were unable to locate or identify a suspect in a fuel card fraud case, the other a suspect of was believed to exaggerating their qualifications and experience, whilst on a voluntary attachment. This subject has absconded and cannot be located.

8.3 Six (6) investigations are ongoing of which two (2) are being progressing in parallel through the disciplinary process.

8.4 All investigations are recorded on the NHS CFSMS Case Management System and discussed with the Director of Finance and also the Regional Counter Fraud Manager, where appropriate.

8.5 Closure reports for all cases are produced and uploaded onto the case management system.

8.6 The investigations conducted within the year did not match the criteria set out within the Counter Fraud & Corruption Manual for referral to the regional CFSMS team. The LCFS has, however, informed the CFSMS team of the investigations for intelligence purposes, through the quarterly statistics reporting system.

8.7 A summary of the investigations (closed and ongoing) are summarised in the tables below.

The table below shows the status of current **ongoing** referrals at Year end.

Area	**Total No. of referrals in this area**	**Source** ***(to include sanitised details of referral source, mindful of PIDA and need for protections)***	**Details** ***(add very brief sanitised details)***	**Case Reference**	**Status/Action Taken** ***(include any process and system weaknesses identified and action taken to rectify).***
Payroll	4	1) Anon letter to	1) Number of allegations	1) 0708LAS	1) PTS manager interviewed. Several issues not corroborated and inaccurate.

			Details *(add very brief sanitised details)*		
		LCFS	within PTS regarding payroll / claims issues.	LORT/09/00346	- Enquiries ongoing
		2) AOM / & Anon. referral to LCFS	2) Allegation that staff are working elsewhere for a private medical company whilst claiming to be on sick leave from LAS.	2) 0908LAS LORT/09/00348	2) Number of witnesses identified. Believed that company concerned has lost contract, but has moved to other location. - Enquiries continue / LPE to be conducted.
		3) DSO	3) Allegation that an ECP is not fulfilling hours / suspected working elsewhere during shift times.	3) 1108LAS LORT/09/00350	3) DSO interviewed, case discussed. Agreed to progress case via parallel route. Disciplinary procedure to continue. LCFS to liaise with Inv. Officer. - Enquiries ongoing.
		4) PTS Manager	4) Allegation that a staff member has submitted fraudulent overtime	4) 1308LAS LORT/09/00352	4) PTS Manager interviewed. Case discussed. Agreed to progress case via parallel route. Disciplinary procedure to continue. LCFS to liaise with Inv. Officer and collate evidence for criminal investigation. - Enquiries ongoing

			Details *(add very brief sanitised details)*		
			claims		
Other [Specify which]	2	1) Proactive - Detected by LCFS / DSO 2) Contractor / LSS Manager	1) Allegation that LAS equipment is being sold on eBay 2) Allegation that a contractor LSS staff member has stolen an ambulance and stab proof vests from a station site	1) 1208LAS LORT/09/00351 2) 1008LAS LORT/09/00349	1) Seller details identified. Items offered sale identified, believed LAS property. Ongoing liaison with eBay for evidence. - Enquiries ongoing 2) LSS Manager spoken to. Subject identified. Subject has been dismissed from employment. Awaiting further details from LSS manager. Liaison with LSMS. - Enquiries ongoing

The table below shows details of closed cases for the Year

Area	Total No. of referrals in this area	Source *(to include sanitised details of referral source, mindful of PIDA and need for protections)*	Details *(add very brief sanitised details)*	Case Reference	Status/Action Taken *(include any process and system weaknesses identified and action taken to rectify).*
Payroll	2	1) NHS CFSMS – Fraud reporting Line	1) Allegation that a DSO was claiming for fraudulently claiming for inflated mileage claims	1) 0308LAS LORT/08/00601	1) Enquiries with Payroll no evidence to corroborate allegation. - No fraud.
		2) HR Manager	2) Allegation that it was believed that a member of staff was working whilst on sick leave	2) 0808LAS LORT/09/00347	2) Enquiries conducted to locate believed company that subject were working for. Allegation not substantiated. - No Fraud – Case referred back to HR to consideration of disciplinary proceedings
Staff	1	Staff	Non LAS employee doing voluntary attachment. Exaggerated qualification	0208LAS LORT/08/00600	Several staff interviewed. Enquiries to locate subject unsuccessful. Believed left UK. Alert circulated amongst DSO's and stations to prevent subject being allowed access to premises.

			Details *(add very brief sanitised details)*		
			and experience, to attempt at undertaking paramedic role		- No sanction possible
Other [Specify which]	1 – Fuel Card	DSO	Unknown suspect caught on CCTV at service station filling non LAS vehicle with fuel. Used LAS fuel card top make payment	0108LAS LORT/08/00599	Reporting DSO was interviewed. Matter referred to Police. Vehicle details obtained and enquiries to locate driver unsuccessful, as vehicle not registered to no current keeper at time of offence. CCTV picture circulated amongst Police Intelligence Units. - No Sanction Possible.
	eBay Fraud	Proactive - Detected by LCFS	Believed LAS paramedic vest identified for sale on website.	0408LAS LORT/08/00602	Enquiries revealed that item was not LAS property. Matter referred to another ambulance trust LCFS for enquiries. - No fraud.
	eBay fraud	Proactive - Detected by LCFS	Believed LAS suction device identified for sale on website.	0508LAS LORT/08/603	Enquiries revealed that item was not LAS property. Matter referred to another ambulance trust LCFS for enquiries. - No fraud.
	Fraud / Theft of supplies	LSMS	Allegation that a “make-ready” operative was stealing sundry items, such as blue rolls from station.	0608LAS LORT/08/00604	LSMS spoken to. Potential subject identified. LSS “Make-ready” senior manger interviewed. No viable leads identified. Decisions agreed with DoF not to proceed further. Matter referred to LSS manager to monitor staff member. - No fraud.

9. Applying Sanctions & Seeking Redress:

9.1 The LCFS gives consideration to the different sanctions available to them and have regard to the triple tracking approach to investigations.

9.2 The LCFS has drafted and implemented the Human resources & LCFS Working Protocol during this work plan year. Attached alongside this, is the NHS CFSMS policy on applying appropriate sanctions consistently document. This has been agreed with the Associate Director of Employee Relations. A copy of the protocol and flowchart, which clearly outlines the investigation process and each others responsibilities. This was also explained in detail during the HR & Recruitment & CRB Team presentation sessions.

9.3 The LCFS has become embedded within the Trust, which is evident by the regular liaison which takes place, often through the provision of advice and guidance to the HR and Recruitment & CRB teams.

9.4 The LCFS has supplied the Trust with a Redress Strategy, which outlines the approach to be used during investigations where fraud is established to enable them to recover the lost resources. This was identified as a result of the completion of the Risk Assessment Tool (RAT) which highlighted this as a weakness, in that there was no such procedure in place.

9.5 The LCFS has also implemented a Prosecutions Strategy, which clearly outlines the considerations for a Director of Finance to consider when signing off an authority to seek prosecution proceedings. This procedure clearly outlines the process to adopt.

10. Reporting Lines

Chief Executive	Peter Bradley London Ambulance Service NHS Trust Headquarters 220 Waterloo Road London SE1 8SD
Director of Finance	Michael Dinan London Ambulance Service NHS Trust Headquarters 220 Waterloo Road London SE1 8SD
Local Counter Fraud Specialist	David Foley RSM Bentley Jennison 45 Moorfields London EC2Y 9AE Tel: 020 7920 3200 Email: david.foley@rsmbentleyjennison.com

Appendix 1. Compliance with Secretary of State for Health's Directions

Paragraph	Instruction	Actions Taken by the Trust
2 (1)	Each NHS body must take all necessary steps to counter fraud in the National Health Service in accordance with these Directions and in accordance with: a) The NHS Counter Fraud and Corruption Manual and; b) The policy statement "Applying appropriate sanctions consistently" published by the CFSMS; and, c) having regard to guidance or advice issued by the CFSMS.	Work has been carried out to comply with the Directions. All work conducted is in accordance with the NHS Fraud and Corruption Manual and with each investigation consideration is given to the parallel sanctions policy.
2 (2)	Each NHS body must require its Chief Executive and Director of Finance to monitor and ensure compliance with these Directions.	The LCFS reports directly to the Director of Finance who is aware of the need to comply with the Directions and is fully supportive of all LCFS work. The Chief Executive is equally supportive of the work of the LCFS.

Paragraph	Instruction	Actions Taken by the Trust
3 (1)	Each NHS body must co-operate with the CFSMS to enable the CFSMS efficiently and effectively to carry out its counter fraud functions and in particular each NHS body must, subject to the following paragraphs of this direction: a) Enable the CFSMS to have access to its premises; b) Put in place arrangements which will enable the CFSMS to have access, as appropriate, to the NHS body's staff; and, c) Supply such information, including files and other data (whether in electronic or manual form) as the CFSMS may require for the purposes of the NHS CFSMS's Counter fraud functions.	The LCFS has received full support from the health body in carrying out the required duties. No failure to comply with requests from the LCFS or CFSMS have been identified.
3 (2)	In the case of information required under paragraph 3 (1) (c) above, in connection with the CFSMS' responsibility for quality inspection, fraud measurement, National Proactive Exercises (NPE's) and fraud prevention reviews, inspections and instructions, an NHS body must respond to any request from the CFSMS as soon as reasonably practicable.	The LCFS/Trust would effectively respond to any request for information from the CFSMS. No quality inspection has been undertaken. There was no Local Risk Measurement Exercise for 2008/9.
3 (3)	In the case of information required under paragraph 3 (1) (c) above, for the purposes of investigations relating to the CFSMS' counter fraud functions, an NHS body must respond to	The Trust provides information at the request of the LCFS promptly and is fully co-operative with all investigations.

Paragraph	Instruction	Actions Taken by the Trust
	a request as soon as reasonably practicable and in any event within seven days from the date the request was made.	
3 (4)	Nothing in paragraph 3 (1) (b) above contravenes any right a member of staff may otherwise have to refuse to be interviewed.	All staff have been fully co-operative with interviews and there have been no instances where a member of staff has refused to be interviewed.
3 (5)	Nothing in paragraph 3 (1) (c) above, or Direction 7 (f) below, obliges or permits an NHS body to supply information which is prohibited from disclosure by or under any enactment, rule of law or ruling of a court of competent jurisdiction or is protected by the common law.	No evidence exists that the Trust has disclosed any information contrary to this direction.
3 (6)	Without prejudice to the generality of direction 2 (1) (a), each NHS body must comply with the requirements specified in the NHS Counter Fraud and Corruption Manual concerning: a) The arrangements for reporting fraud cases to the LCFS and to the NHS body's audit committee and auditors; b) The arrangements for agreeing to undertake a criminal prosecution and to refer a matter to the police; c) The confidentiality of information relevant to the investigation of suspected fraud;	The Anti Fraud and Corruption Policy states that all allegations of fraud are to be reported to the LCFS. Progress reports are presented to the Audit Committee and verbal updates of LCFS activity are also given at the meetings. The requirements outlined in the Counter Fraud and Corruption Manual are fully complied with.

Paragraph	Instruction	Actions Taken by the Trust
	d) The confidentiality of information relevant to the investigation of suspected fraud; e) The arrangements for the LCFS to report weaknesses in fraud related systems to the CFSMS and the NHS body's audit committee and auditors; and, f) The arrangements for gathering information to enable the Director of Finance to seek recovery of money lost through fraud.	The LCFS ensures that confidentiality is maintained at all times ensuring that the Data Protection Act is adhered to. The LCFS produces a final report at the conclusion of all investigations to report on system weaknesses and to provide recommendations. These reports are made available to Internal Audit and an update is presented at the Audit Committee. The LCFS is aware of the importance of assisting the DoF in seeking recovery of money lost through fraud in compliance with the Counter Fraud and Corruption manual.
Paragraphs 4 (1) – 4 (3) related to the appointment of Non-Executive Director at the health body to promote counter fraud measures. This requirement was revoked soon after the 2004 Revised Secretary of State for Health's Directions were issued.		
5 (1)	Each NHS body must nominate at least one person that it proposes to appoint as the body's LCFS within six weeks of the date on which the revised Directions came into force.	The current Lead LCFS is David Foley The secondary LCFS is Jenny West
5 (2)	A person nominated under paragraph 5 (1) may be either employed by the NHS body or a person whose services are provided to it by an outside organisation.	David Foley is employed by RSM Bentley Jennison.
5 (3)	The name of the nominee must be notified to	The Trust complied with this requirement at the time of the

Paragraph	Instruction	Actions Taken by the Trust
	the CFSMS together with the information specified in the NHS Counter Fraud and Corruption Manual within 7 days of the nomination.	nomination.
5 (4)	Without prejudice to the generality of Direction 2 (1), before making a nomination each NHS body must take into account any guidance issued by the CFSMS relating to a) on the suitability criteria for an LCFS. b) Where an LCFS is to be is to be employed by the NHS body, the terms on which an LCFS is to be employed ; and c) Where the services of an LCFS are to be provided to the NHS body by an outside organisation, the terms on which those services are to be provided	The Trust and RSM Bentley Jennison were aware of the guidance issued by CFSMS prior to making the nomination.
5 (5)	After a nominee has - a) Been approved by the CFSMS as a person suitable for appointment; b) Successfully completed any training required by the CFSMS; c) Been accredited by the CFPAB, The NHS body may appoint the person as its LCFS.	This was fully complied with prior to the appointment of the LCFS.

Paragraph	Instruction	Actions Taken by the Trust
5 (6)	Where an NHS body nominates a person whose services are provided to it by an outside organisation, it must: a) Comply with the requirements of the CFSMS as to the suitability of the organisation in question; b) Satisfy itself and the CFSMS that the terms on which those services are provided are such as to enable the LCFS to carry out his functions effectively and efficiently and in particular that he will be able to devote sufficient time to that NHS body; and, Give the CFSMS a copy of the contract under which the services of the LCFS are supplied to it.	The Trust has complied with this requirement. RSM Bentley Jennison provides LCFS services to over 60 NHS bodies throughout England and Wales. David Foley's nomination was approved by the Counter Fraud Service. The LCFS has a plan based on a clear risk assessment of the Trust's local needs and consideration of the CFSMS workplan guidance, however it is clearly communicated that the plan is a flexible document. Investigation days are additional to the plan which allows the LCFS to carry out all work effectively and efficiently. A copy of the contract and the job description has been issued to the health body and CFSMS.
5 (7)	A further nomination must be made within 3 months of the date on which an NHS body learns that there is to be a vacancy for an LCFS.	The LCFS and the Trust are aware of this requirement and will comply as appropriate.
5 (8)	The procedures in paragraphs 5 (3) to 5 (6) also apply to a person nominated under paragraph 5 (7).	The Trust will comply when appropriate.
6 (1)	Each NHS body must specify a job description	The Trust has been issued with a job description which is compliant

Paragraph	Instruction	Actions Taken by the Trust
	for its LCFS which includes the operational and liaison responsibilities specified by the CFSMS.	with the requirements set out by CFSMS. The Trust and the LCFS have a copy of the job description.
6 (2)	The job description under paragraph 6 (1) must include a requirement that the LCFS adheres to the CFPAB Principals of Professional Conduct as set out in the NHS Counter Fraud & Corruption Manual.	This requirement has been included in the issued LCFS job description.
6 (3)	An LCFS must report directly to the NHS body's Director of Finance.	The LCFS reports directly to the Director of Finance to discuss ongoing investigations and proactive work.
6 (4)	An LCFS must not undertake responsibility for or be in any way engaged in the management of security for any NHS body.	The LCFS is not engaged in the management of security at the Trust.
7	Each NHS Body must: a) Require that in addition to the job description mentioned in Direction 6 (1), the LCFS and the Director of Finance agree, at the beginning of the financial year, a written work plan which outlines the LCFS' projected work for the financial year by reference to the seven generic areas of counter fraud activity set out in the NHS Counter Fraud and Corruption Manual; b) Enable its LCFS to attend the NHS body's audit committee meetings; c) Require its LCFS to keep full accurate records of any instances of fraud or	A written workplan for 2008/9 had been discussed and agreed between the LCFS and the Director of Finance. This workplan was based on the requirement of the seven generic areas as outlined in the template plans issued by CFSMS, but reflected local needs of the Trust. The LCFS has attended Audit Committees during the year and has full access to the committee. The LCFS is compliant with all the requirements of the manual, both in the manner in which allegations are recorded and investigations conducted. All final investigation reports which identify system weaknesses are issued to CFSMS. The LCFS has the full support of the Trust in all areas of work that is

Paragraph	Instruction	Actions Taken by the Trust
	suspected fraud;	required to fulfil the role.
	d) Require its LCFS to report to the CFSMS any weaknesses in fraud related systems of the NHS body and any other matters which may have fraud related implications for the NHS;	The LCFS has experienced full co-operation in all investigations undertaken.
	e) Ensure that its LCFS has all necessary support including access to the CFSMS secure site to enable him efficiently and effectively carry out his responsibilities;	The LCFS has received all the relevant training required by the Counter Fraud Services with the full support of the Trust and RSM Bentley Jennison.
	f) Subject to any contractual or legal constraints, require all staff to co-operate with the LCFS and in particular that those responsible for human resources disclosure information which arises in connection with any matters (including disciplinary matters) which may have implications in relation to the investigation, prevention, or detection of fraud;	The LCFS would consult the CFSMS Press Liaison Officer for advice and assistance if required. Successful national and local cases of fraud detection and convictions have been circulated to the health body for the information of management and staff. The Trust has participated in the National Fraud Initiative for 2008/9. The LCFS has access to office space when on site at the Trust and also has access to secure and private offices provided by RSM Bentley Jennison.
	g) Enable its LCFS to receive training recommended by the CFSMS;	The health body is fully supportive of the LCFS to ensure that she/he can fulfil his requirements. The LCFS has access to the Chief Executive, Director of Finance and Board members who have ensured staff co-operate fully with his requirements.
	h) Require its LCFS, its other employees and any persons whose services are	

Paragraph	Instruction	Actions Taken by the Trust
	provided to the NHS body in connection with counter fraud work to have agreed guidance and advise on media handling of counter fraud matters which may be issued by the NHS CFSMS; i) Enable its LCFS to participate in activities in which the CFSMS is engaged, including national anti-fraud measures, where he is requested to do so by the NHS CFSMS; j) Enable its LCFS to work in conditions of sufficient security and privacy to protect the confidentiality of his work; and, k) Enable the LCFS generally to perform his function effectively, efficiently, and promptly.	
7A	Responsibilities of NHS Bodies where the services of the Local Counter Fraud Specialist are provided by an outside organisation 1) This paragraph applies where an NHS Body has appointed as its LCFS a person whose services are provided to	This requirement was issued in the amendment to the Secretary of State Directions. The Director of Finance and the Audit Committee were notified of this amendment to the SoSD's and will comply with the requirements in ensuring the services enable the LCFS to carry out functions effectively and efficiently.

Paragraph	Instruction	Actions Taken by the Trust
	it by an outside organisation. 2) The NHS body must ensure that the terms on which those services are provided to it continue to be such as to enable its LCFS to carry out the LCFS's functions effectively and efficiently and in particular that the LCFS is to devote sufficient time to that NHS Body. 3) The NHS body must notify CFSMS if- a) it considers that its LCFS has failed to carry out the LCFS's functions effectively or efficiently; or b) there is a material change in the terms on which the services of its LCFS are provided to it.	The Trust is aware of the requirements and instances when CFSMS are to be notified.

Appendix 2: Compound Indicator Declaration 2008/9

Available Electronically

10 Report of the Local Counter Fraud Specialist

- **Annual Work Plan for 2009/10**

London Ambulance Service
NHS Trust

Audit Committee Front Sheet

Title: LCFS Draft Work Plan 2009/10	**Agenda Item: 10** **Enclosure: 10**

Purpose:

Draft LCFS Work Plan for 209/10 outlining areas of work across 7 generis areas of the national Counter Fraud Strategy. Statutory requirement to have in place an agreed work plan.

Summary:

This LCFS Work Plan for 2009/10 is based on a template plan as required by the NHS Counter Fraud & Security Management Service (NHS CFSMS)

This provides details of the areas of work to be completed across the generic areas of the strategy, to provide a robust approach to countering fraud within the Trust.

The Trust can be assured that the plan is based upon a rolling plan of work conducted during 2008/9, which is to be developed further using a risk based approach within the Trust.

This plan has been discussed and agreed with the Director of Finance, Head of Legal Services & Associate Director of Employee Services during a monthly counter fraud meeting.

Progress against this plan will be reported upon at each Audit Committee**.**

Recommendations/and or actions required:

The Committee is asked to note this plan and provide comment as necessary.

Author and Date:

David Foley
Senior Manager, RSM Bentley Jennison
27 May 2009

RSM Bentley Jennison

London Ambulance Service NHS Trust

Local Counter Fraud Specialist
Annual Work plan for 2009/2010

DRAFT

David Foley & Gary Douglas
Local Counter Fraud Specialist

Executive Summary

This document is for discussion with the Director of Finance for London Ambulance Service NHS Trust, to determine the range and level of Local Counter Fraud provision for the Trust over the work plan year of 2009/10. (84 days as detailed on page 26)

During the completion of this draft discussion document, consideration was given to the level of activity undertaken over the last year, the recommended numbers of days as applied by the NHS Counter Fraud & Security Management Service (NHS CFSMS) for a Trust of this size and type.

The LCFS provision is provided by RSM Bentley Jennison on the basis that the intention is to ensure client satisfaction by providing a service using qualified professional staff, which not only complies with the relevant legislation, as regulated by the NHS CFSMS, (Secretary of States Directions for Countering Fraud and Corruption in the NHS) but also with the intention of providing assurance to the Senior Management Team, inclusive of the Audit Committee and Board, that the arrangements in place are effective and ad value to the business of the Trust.

This is undertaken by ensuring the work plan is bespoke to the Trust, whilst also complying with the requirements of NHS CFSMS. The areas of work suggested provide sufficient coverage across the seven (7) generic areas of the Counter Fraud Strategy, which consist of:

- Creating an anti fraud culture, Deterring Fraud, Preventing Fraud, Detecting Fraud, Investigations, Sanctions, Seeking redress.

There also a number of mandatory functions which the LCFS is required to undertake to ensure compliance with the Directions and CFSMS guidelines. This are covered under the section of:

- Mandatory counter fraud arrangements

The below plan allows the newly introduced LCFS, Gary Douglas to undertake a lead role of dealing with daily matters, to ensure that we as a firm provide the best possible coverage for you our client, by remaining responsive to your needs. David Foley will continue to work alongside Gary in a strategic role.

This year will involve an increased further range of activities to undertaken work across the Trust to raise the profile o the LCFS and promote an effective anti fraud culture. This will be completed by increased promoting of the CF Policy, A review and promotion of the whistle blowing policy and encouraging of staff to report matters of concerns and system weakness through the reporting phone numbers and dedicated mail address. Specific tasks to be undertaken, will engaging with key stakeholders across the Trust, such as: Station Administrators, DSO's Fleet & Logistics Services, EMC staff, events staff, Procurement Team, Corporate Processes Team & the Olympic Procurement Team.

Proactive exercises are also to be undertaken, inclusive of the NHS CFSMS Recruitment Agency exercise. Input into the newly proposed Attendance Management system will be provided to those involved in designing and implementing he scheme. It is recommended that some testing is undertaken to test the compliance and robustness of the scheme a few months after its inception. Attendance a number of the training courses for the new student paramedics will also be covered. To ensure clear lines of reporting, a cebntral contact number will be publicised alongside the email address, to promote reporting.

David Foley - LCFS

CREATING AN ANTI-FRAUD CULTURE			
Taking action to tackle the problem	**Recommended task / objective**	**LCFS comments and justification**	**Agreed Y/N**
1a) Does the organisation have a clear programme of work attempting to create a real anti-fraud and corruption and zero tolerance culture (including strong arrangements to facilitate whistleblowing)? 2a) Are there clear goals for this work (to maximize the percentage of staff and public who recognise their responsibilities to protect the organisation and its resources)? 3a) Is this programme of work being effectively implemented?	TASK A programme of counter fraud awareness training to be delivered to staff at all levels within the trust. Developed on from 08/09: to include – PTS, DSO's, Station Administrators, Workshops, Ops Staff in HQ. OBJECTIVE The aim of this is to ensure the trust is proactive in raising fraud awareness and able to build a real anti-fraud culture.	The LCFS will conduct a number of presentations / training sessions, targeting staff / areas on a priority basis, to increase the profile of the LCFS and CF work.	
	TASK Review / Develop a useful pack to contribute to the new starter's induction pack. Revised, update and ensure current DVD is effective, to include updated LCFS details. OBJECTIVE Raise profile of CF work amongst new starters, by outlining Trusts commitment to CF work is robust. To assist in creating anti fraud culture	The Trust Induction pack was updated in 2007/08. Minimal work is required to review and ensure that pack is current and up to date during year. Owing to level of staff inductions, it is not practicable or possible to attend every induction in person (every week) Therefore material and DVD will capture new starters. DVD requires updating, to ensure it is relevant with current LCFS details and updated content.	
4a) Are there arrangements in place to evaluate the extent to which a real anti-fraud and corruption culture exists or is developing throughout the	TASK Evaluate and measure effectiveness of both DVD and Induction material distributed to staff, by capturing responses and feedback from new starters within periods of the year to	Currently, no further contact is made with new starters, unless they report fraud. This will enable measurement of effectiveness of the induction material and DVD to be measured.	

organisation? 5a) Are agreements in place with stakeholder representatives to work together to counter fraud and corruption? 6a) Have arrangements been made to ensure that stakeholder representatives benefit from successful counter fraud and corruption work?	establish effectiveness of above task, through email / person contact. Results will be fed back during monthly CF meetings. OBJECTIVE Evaluate above task, to establish whether material / DVD is effective with the material provided, has been of use, and is effective in explaining their role within the CF strategy and the reporting mechanisms for referring concerns of fraud.		
	TASK Evaluate presentations, collate results, and amend presentations as a result of feedback. Provide feedback to Finance Director during CF meetings OBJECTIVE Enable LCFS to ensure work undertaken is relevant. Allows accountability of LCFS to be measured by Finance Director	Ensures that work is effective and expectations of service are met.	
	TASK Participation in National Fraud Awareness Month. OBJECTIVE Raise Fraud awareness	This takes place in June 2009. Will invoice various tasks including stands at HQ and other strategic locations	
	TASK Place at least two LCFS articles per year in in-house RIB and or LAS News magazine. OBJECTIVE Raise profile of LCFS / CF and also inform staff of ongoing matters of interest	An effective tool in reaching a wide audience across Trust. The in house publications are received by all across Trust	
	TASK Arrange for a pay-slip message to be utilised annually. OBJECTIVE Raise profile of LCFS	Cost effective mechanism of providing either contact details of LCFS or relevant information to a wide raging audience.	

	TASK Review / Develop and maintain counter fraud information on the trust intranet – The Pulse. Having a counter fraud site allows staff easy access to counter fraud information. Items to include on the site are: OBJECTIVE Provides information to staff of fraud related matters and also enable reporting	The Fraud section of the intranet was updated in 2008. This should be reviewed at regular intervals and also be updated with relevant information / deterrence articles.	
	TASK Undertake and analyse a staff survey, to measure effectiveness of CF work, measure profile of LCFS and also to identify areas of further awareness work. Will include one or more of the following: • staff survey • focus groups • internet quizzes • hits on the fraud webpage	The LCFS will undertake these tasks as agreed, to demonstrate, any areas or weakness identified.	
	TASK Each month, meet with a station officer to highlight the role of the LCFS and obligations on the staff to report fraud according to trust policy, and to promote whistle blowing. OBJECTIVE Assists in creating anti fraud culture / measurement of awareness	Will raise profile of LCFS and allow interaction with front line staff. Would aid reporting of concerns.	
	TASK Review local fraud leaflets and posters to promote the anti-fraud work being undertaken. Distribute across Trust in cost effective / efficient method. OBJECTIVE Raise awareness / promote reporting	LCFS will utilise post rooms to distribute material to station administrators / DSO. Also utilise electronic methods as far as possible	

	TASK Meet with key personnel in the trust to discuss fraud matters / promote LCFS work and build on relationships to increase communication. To include key personnel, heads of departments and areas considered at risk, on a priority basis. OBJECTIVE Raise awareness of fraud and LCFS role	Will increase awareness and should improve communication flows. Lead to further referrals.	
	TASK E-mail an introduction or reminder to all staff with the details of the LCFS, their role and contact details, including matters of interest when required. OBJECTIVE Raise profile of LCFS / CF work	Another electronic cost effective mechanism to raise profile of LCFS. Raise awareness and promote reporting of concerns.	
	TASK Undertake Local fraud awareness initiatives and events during the year across a number of sites (to be determined) to allow access to greater number of staff. Outside of FAM OBJECTIVE Promote CF work	Awareness initiatives will be reviewed within the allocation for presentations.	
Total			**24 days**

DETERRING FRAUD			
Taking action to tackle the problem	**Recommended task / objective**	**LCFS comments and justification**	**Agreed Y/N**
1b) Does the organisation have a clear programme of work attempting to create a strong deterrent effect? 2b) Does the organisation have a clear programme of work to publicise the: • hostility of the honest majority to fraud and corruption; • effectiveness of preventative arrangements; • sophistication of arrangements to detect fraud and corruption; • professionalism of those investigating fraud and corruption and their ability to uncover evidence; • likelihood of proportionate sanctions being applied; and • likelihood of losses being recovered? 3b) Has the organisation successfully publicised work in this area? 4b) Has the publicity been targeted	TASK Meet with press officer/communications liaison officer, and discuss: • NHS CFSMS Comms. Tea, / Trust Comms Team interaction during FAM and when investigations arise • National publicity of counter fraud work • Advance warning system in use by CFSMS / LCFS OBJECTIVE Ensure an effective working relationship and publicity is utilised when appropriate and necessary.	Will agree either periodic or as required meetings with Coms Lead	
	TASK Review communications strategy so that the most effective ways of communicating with staff at the trust are utilised. OBJECTIVE Ensure protocol is relevant and up to date. Allow measurement of effectiveness	The Communication Strategy was devised / agreed in early 2009. Minimal resources are required to undertake this role.	
	TASK Prepare paper(s) of recent NHS proven fraud cases for inclusion within publicity material / Intranet for displaying Provide relevant departments with key risks identified within proven cases outside of the Trust which are relevant to our service delivery lines. OBJECTIVE Provides deterrence to staff.	Will be factored in with newsletters etc	

at the areas of greatest fraud losses?	TASK Design a quarterly fraud newsletter to publish NHS proven fraud cases and other beware notices.	Quarterly newsletters will be drafted and widely disseminated, including the Trust Intranet.	
	REACTIVE BOX **Publicise successful investigations.**		
Total			**4 days**

PREVENTING FRAUD			
Taking action to tackle the problem	**Recommended task / objective**	**LCFS comments and justification**	**Agreed Y/N**
1c) Does the organisation seek to design fraud and corruption out of new policies and systems and to revise existing ones to remove apparent weaknesses?	TASK Review existing counter fraud policy and update and amend as appropriate. OBJECTIVE Ensures that staff are fully aware of their responsibilities and the Trusts response to countering fraud.	This policy was last reviewed as part of the 2008/09 work plan. Minimal work will be required to ensure the current policy is relevant, up to date and takes into account best practice.	
2c) Do concluding reports on investigations include a specific section on identified policy and systems weaknesses that allowed the fraud and corruption to take place?	TASK Ensure that the whistleblowing policy, disciplinary policy, standards of business conduct, declaration of interests, gifts and hospitality policies and other relevant HR policies are adequately robust to counter fraud. OBJECTIVE Ensures that policies are robust to preventing fraud	These polices were reviewed within the 08/09 plan. Minimal time will be required to undertaken an overview, to ensure that they are relevant and based on current best practice.	
3c) Is there a system for considering and prioritising action to remove these identified weaknesses?	Review distribution of the annual conflict of interest statements and ascertain if this is sufficient to address potential risks in this area. Are the sanctions for fraud clearly indicated on the declaration signed by staff?	This review was undertaken as part of the 08/09 plan. Unless changes are made, this will not be required, although the LCFS will verify this during the work plan year.	

	TASK Review the standing financial instructions at the trust and ensure that they reflect the requirements under Secretary of State Directions and the *NHS Counter Fraud and Corruption Manual*. Update and amend as required. OBJECTIVE Ensures that policies are robust	These were subject to a comprehensive review during 08/09 plan. Document will be checked during work plan year to ensure they are up to date. Minimal time required to undertake this task.	
	TASK Include an entry in the risk register to record fraud as a risk. Review periodically the register to ensure that it accurately acknowledges specific fraud risks within the Trust OBJECTIVE Ensures that Trust responds and manages the risks of fraud. Accountability	The entry was made during 08/09 plan; however this should be reviewed on a regular basis to take account of changing threats, weaknesses identified, or trends occurring.	
	TASK Attend and liaise with Rick Compliance & Assurance Group meetings, to provide advice guidance and play a role in the group, to ensure the Trust manages risks of fraud OBJECTIVE Provides Trust with qualitative outputs of LCFS role and work. Ensures risks are addressed	The LCFS will attend where possible all RCAG meetings and provide reports as required.	
	TASK Review protocol with LSMS to ensure it is working and relevant. Meet periodically with LSMS to discuss risk areas and refer high risk areas or trends to the NHS CFS Head of Risk. OBJECTIVE Ensures a comprehensive response to minimising risk	Regular liaison with LSMS throughout the year, either agreed periodic meetings, or as required	

	TASK Conduct a risk assessment on overall counter fraud arrangements in place using the NHS CFS issued *"Assessing the Risks"* tool. Utilise outcomes from this assessment to target areas where arrangements were identified as weak. OBJECTIVE Will focus counter fraud work in line with areas of strategic risks to fraud.	A comprehensive Fraud Risk Assessment was completed in 2008/09. However, this should be completed annually to ensure that work undertaken is directed and appropriate, making best use of resources.	
	TASK Review a protocol with internal audit. OBJECTIVE Ensures that work is relevant, complements each others role and ensures that no overlap of work is undertaken. Cost effectiveness.	An IA & LCFS working protocol was completed as per 08/09 plan. Will be reviewed to ensure relevance. Minimal time required.	
	TASK Meet regularly with internal audit to discuss potential system weaknesses identified during audits or investigations and highlight work being undertaken by the LCFS, e.g. national or local proactive work. OBJECTIVE As above.	Regular meetings take place assisted by regulate natural contact through being same provide of both services. Minimal time required.	

	TASK ➢ Liaise with eBay Auction Site regarding prevention measures to sop LAS equipment & property being offered for sale OBJECTIVE • Proactive approach to prevent sale of LAS equipment on eBay.	To deal with an ongoing issue of property being offered for sale without authorisation.	
	TASK Fraud-proof a selection of general policies, procedures and claim forms used throughout the trust where there is a potential risk of fraud occurring. *Policies/procedures/claim forms that should be considered for fraud-proofing include:eg* ➢ *recruitment controls, including those covering qualification, employment history, driving licence and CRB checks* ➢ *timesheets and associated procedures/policies, including on-call arrangements and remote working controls* OBJECTIVE Ensure they are robust to preventing fraud	The LCFS has reviewed a number of policies as part of 08/09 plan. Policies to be reviewed in agreement of Finance Director and Heads of Departments.	

	TASK Provide authorised signatories with information on signing documents for payment – reviewing the risks involved and the need to have adequate checking mechanisms in place. OBJECTIVE Assist of fraud prevention	This is addressed via various other tasks, such as fraud awareness training, policy reviews and newsletters providing guidance. No time required in addition to this area.	
	TASK Use the Systems Weakness Reporting (SWR) form to inform	This is completed as under mandatory reporting tasks to CFSMS.	

	the NHS CFS at the earliest opportunity of any system weaknesses identified during the course of investigations which have potential national implications. OBJECTIVE Ensure that prevention is proactively driven	Should areas of risk nationally or ambulance trust specific be identified, then liaison will take place with CFSSM as required. No additional time required.	
	TASK Ensure that any fraud prevention instructions issued by the NHS CFS are actioned, and the relevant compliance statements are completed and returned. Pass appropriate risk information to the NHS CFS Head of Risk for possible consultation. OBJECTIVE Ensures that Trust is proactive in ensuring that do not fall victim to identified areas of fraud	The required resource currently unknown, however it can be undertaken in accordance with available time within plan.	
	TASK Ensure that any fraud notices/intelligence bulletins are appropriately actioned to avoid the trust falling victim to similar activities. OBJECTIVE Ensures that Trust is proactive in ensuring that do not fall victim to identified areas of fraud	The required resource currently unknown, however it can be undertaken in accordance with available time within plan.	
	TASK Follow up and review that fraud prevention instructions / fraud notices are actually actioned and recommendations have been implemented. OBJECTIVE Ensures actions are completed	The required resource currently unknown, however it can be undertaken in accordance with available time within plan.	

	REACTIVE BOX **Deal with any weaknesses identified by investigation or received from intelligence sources.** **To ensure consideration is given to preventative work on receipt of all referrals. Preventative action should be taken as necessary and this work should be accurately reported to the trust and to the NHS CFS Fraud Prevention Unit.**	This task will be completed as and when appropriate.	
Total			**17 days**

DETECTING FRAUD			
Taking action to tackle the problem	**Recommended task / objective**	**LCFS comments and justification**	**Agreed Y/N**
1d) Are there effective 'whistleblowing' arrangements in place? 2d) Are analytical intelligence techniques used to identify potential fraud and corruption? 3d) Are there effective arrangements for collating, sharing and analysing intelligence? 4d) Are there arrangements in place to ensure that suspected cases of	TASK Undertake any mandatory national proactive exercises as instructed by the NHS CFS. This will include the LCFS's involvement in the National Fraud Initiative. MANDATORY	NHS CFSMS have requested that health bodies participate in a NPE – Recruitment Agencies – Temporary Staff as a result of FN 84 (May 09). Scale of this work is currently being assessed.	
	TASK Undertake any mandatory risk measurement exercises as instructed by the NHS CFS. Assist where required in setting protocols for decision making in risk exercises in conjunction with NHS CFS risk staff. Complete NFI (if applicable) exercise from 08/09 plan MANDATORY		

fraud or corruption are reported promptly to the appropriate person for further investigation? 5d) Are arrangements in place to ensure that identified potential cases are promptly and appropriately investigated? 6d) Are proactive exercises undertaken in key areas of fraud risk or known systems weaknesses?	TASK Undertake a local proactive exercise at the Trust as agreed with the Director of Finance. *Exercises that should be considered for local initiatives include:* • *mobile phone use* • *transport costs* • *travel claims, including lease cars and volunteer car drivers* • *pre- and post-appointment checks* • *travel claims* • *timesheets* • *audit concerns of financial abuse occurring due to poor system controls.* Importantly, these exercises are guided by local proactive work in gathering useful information. All exercises must only be undertaken where there is good reason to do so and only as directed by the Director of Finance. **REACTIVE BOX** **Local proactive detection exercises undertaken. These exercises are undertaken when information is received that provides reasonable grounds for looking into a particular area.**	LPE's will be agreed with Finance Director. Will be areas considered at risk, either as identified through fraud risk assessment, or by heads of department who have identified system weakness or risks. Proposed for consideration: Directors & Ned's expenses claims Attendance System (once implemented)	
Total			**24 days**

INVESTIGATIONS			
Taking action to tackle the problem	**Recommended task / objective**	**LCFS comments and justification**	**Agreed Y/N**
1e) Is the organisation's investigation work effective? Is it carried out in accordance with clear guidance? 2e) Do those undertaking investigations have the necessary powers, both in law, where necessary, and within the organisation? 3e) Are referrals handled and investigations undertaken in a timely manner? 4e) Does the organisation have arrangements in place for assessing the effectiveness of investigations?	Conduct investigations as required in line with Appendix 5 of the *NHS Counter Fraud and Corruption Manual*, which outlines relevant procedural investigative legislation. The LCFS must ensure that arrangements are in place so that all work is undertaken in an environment conducive to criminal investigation work. This includes the maintenance and storage of records.	Investigation days will be additional to workplan.	
	Assist the NHS CFS with information required for any regional or national fraud cases. Ensure comprehensive information to enable Risk exercises to be conducted effectively and submitted in a timely manner.	Investigation days will be additional to workplan.	
	<u>TASK</u> Meet with the data protection manager and reviewed DPA Policy, to ensure that it covers the work of the LCFS. And assists in forming effective working relationships. <u>OBJECTIVE</u> Ensures that Trust is compliant with legislation.	The DPA policy was reviewed as per the 08/09 plan. It is not envisaged that this will required reviewing. Ad hoc liaison with the DPA manager will take place as required. No additional time required.	
	Ensure access to the NHS CFS Case Management System and maintain detailed records of all referrals that have been received.	The Case Management System will be updated on an ongoing basis and be resourced as part of each investigation undertaken.	

	REACTIVE BOX **To deal with referrals and undertake investigation work in a professional and diligent manner, adhering fully to legislation and guidance outlined in the *NHS Counter Fraud and Corruption Manual.*** **This could be a considerable demand on LCFS time.**		
Total			**0 days**

SANCTIONS			
Taking action to tackle the problem	**Recommended task / objective**	**LCFS comments and justification**	**Agreed Y/N**
1f) Does the organisation have a clear and consistent policy on the application of sanctions where fraud or corruption is proven to be present? 2f) Are all possible sanctions – disciplinary / regulatory, civil and criminal - considered?	TASK Review / Amend as required policy with Human Resources on the interaction of these parties and the application of parallel sanctions – civil, disciplinary and criminal, the NHS policy document *Applying Appropriate Sanctions Consistently* should provide a framework to this work. OBJECTIVE Compliance with parallel sanctions policy and effective interaction / relationship between LCFS & HR	This protocol was introduced in 2008/09 and will be reviewed and circulated to ensure continued knowledge within the Trust HR team. Mentioned during presentations to staff	
3f) Does the consideration of appropriate sanctions take place at the end of the investigation when all the evidence is available?	TASK Undertake meetings periodically with HR leads, to discuss ongoing investigations, to ensure that all available sanctions are being applied, where appropriate. OBJECTIVE Builds on working relationships and ensure sanctions are applied.	Arrangements for regular dialogue / meetings TBC with HR lead.	
4f) Does the organisation monitor the extent to which the application of sanctions is successful?	**REACTIVE BOX** **Considerable time might be taken in ensuring the most appropriate sanction is applied. If criminal proceedings are being taken, the LCFS might need to attend the court hearing.**		
Total			**1.5 day**

REDRESS			
Taking action to tackle the problem	**Recommended task / objective**	**LCFS comments and justification**	**Agreed Y/N**
1g) Does the organisation have a clear policy on the recovery of losses incurred to fraud and corruption? 2g) Is the organisation effective in recovering any losses incurred by fraud and corruption? 3g) Does the organisation use the criminal and civil law to the full in recovering losses? 4g) Does the organisation monitor proceedings for the recovery of losses? 5g) What is the organisation's successful recovery rate?	Maintain comprehensive records of time spent on each investigation so that this can be included in any compensation claim made by the trust. Identify and maintain a record of the actual proven amount of loss to the trust so that appropriate recovery procedures can be actioned.	The LCFS maintains comprehensive records of time spent on investigations as part of their normal duties. This is resourced in line with the time spent on related investigations.	
	TASK Review / amend redress strategy in place in Trust. Measure effectiveness of such strategy. OBJECTIVE Ensures the Trust are maximising opportunity for seeking redress at every availability	The Redress Strategy was devised in 08/09 plan. Minimal time required.	
Total			**0.5 days**

MANDATORY COUNTER FRAUD ARRANGEMENTS (STRATEGIC WORK)			
Taking action to tackle the problem	**Recommended task / objective**	**LCFS comments and justification**	**Agreed Y/N**
1h) Does the organisation have a counter fraud and corruption strategy that can be clearly linked to the organisation's overall strategic objectives? 2h) Is there a clear remit 'to reduce losses to fraud and corruption to an absolute minimum' covering all areas of fraud and corruption affecting the organisation? 3h) Are there effective links between 'policy' work (to develop an anti-fraud and corruption and 'zero tolerance' culture, create a strong deterrent effect and prevent fraud and corruption by designing and redesigning policies and systems) and 'operational' work (to detect and investigate fraud and corruption and seek to apply sanctions and recover losses where it is found)? 4h) Is the full range of integrated action being taken forward or does the organisation 'pick and choose'? 5h) Does the organisation focus on outcomes (i.e. reduced losses) and not just activity (i.e. the number of investigations, prosecutions, etc.)?	TASK Attendance at LCFS meetings held by the NHS CFS Regional Teams. OBJECTIVE Represent Trust at meetings, undertake training and relay relevant information back to Trust.	2 meetings per year.	
	TASK Attendance at the NHS CFS annual conference. OBJECTIVE Represent Trust at meetings, undertake training and relay relevant information back to Trust.	1 annual conference	
	TASK Compile necessary information, complete and submit agreed CI Declaration for Trust annually. Review CI Declaration Action Plan points provided by NHS CFS and consider response / amendments to Work plan Review work plan, in line with above, to ensure plan is appropriate and focussed on current relevant areas. OBJECTIVE Ensures best use of resources and compliance for Trust in returning CI declaration, to achieve best possible scoring.	Will ensure best possible score during CI process	
	TASK Completion and agreement of workplan with Director of	This relates to the completion of the 20010/11 workplan.	

6h) Has the strategy been directly agreed by those with political and executive authority for the organisation? 7h) Do those tasked with countering fraud and corruption have the appropriate authority needed to pursue their remit effectively, linked to the organisation's counter fraud and corruption strategy? 8h) Is there strong political and executive support for work to counter fraud and corruption? 9h) Is there a level of financial investment in work to counter fraud and corruption that is proportionate to the risk that has been identified? 10h) Are all those working to counter fraud and corruption professionally trained and accredited for their role? 11h) Do those employees who are trained and accredited formally review their skills base and attend regular refresher courses to ensure they are abreast of new developments and legislation? 12h) Are all those working to counter fraud and corruption undertaking this work in accordance with a clear ethical framework and standards of personal conduct? 13h) Are there framework agreements in place to work with other organisations and agencies?	Finance, including periodic review MANDATORTY		
	<u>TASK</u> Regular meetings/liaison with Director of Finance. <u>OBJECTIVE</u> Ensures Finance Director is able to monitor plan progress and accountability of LCFS.	Currently monthly meetings, but propose we move to bi monthly meetings, to ensure productivity and outputs	
	<u>TASK</u> Attend Ambulance Special Investigators Group (ASIG) and participate in intelligence sharing, promotion of best practice and identifying of current threats / trends in Ambulance Trusts across UK. <u>OBJECTIVE</u> Represent Trust and enable opportunity of identifying best practice for benefit of Trust	Attendance at Forum is every ¼ All Ambulance Trusts represented currently	
	<u>TASK</u> Drafting the annual report of counter fraud work MANDATORY	This relates to the drafting of the 2008/2009 annual report and CI declaration.	
	<u>TASK</u> Preparation for and attendance at Audit Committee meetings (including progress reports). MANDATORY	The LCFS plans to attend all Audit Committee meeting and provide progress reports together with any other relevant papers to support the report.	
	Assist in the quality inspection process as and when required.	Days to be allocated as and when required.	
	Undertake additional training as required by the trust or NHS CFS.	Days to be allocated as and when required.	

14h) Are the framework agreements focused on the practicalities of common work? 15h) Are there regular meetings to implement and update these arrangements? 16h) Is the organisation undertaking the full range of necessary action?	Provide *ad hoc* information to the NHS CFS & Trust as required. Includes quarterly statistics on LCFS activity System Weaknesses Reporting (SWR) and other reports as appropriate and deemed necessary ALE / Use of Resources & HCC Trust Return	The CFS requires statistical data to be issued to them on a quarterly return basis. An allocation of 1 day is made to enable the LCFS to meet this requirement.	
Total			**13 days**

Summary of workplan areas and resources allocation

	LCFS recommended number of days
Creating an anti Fraud Culture	24
Deterring Fraud	4
Preventing Fraud	17
Detecting Fraud	24
Investigations	0 as required
Sanctions	1.5
Redress	0.5
Mandatory Counter Fraud Arrangements	13
Total recommended days	**84 days**

11 Audit Committee annual report, including effectiveness & best practice recommendations

RSM Bentley Jennison

London Ambulance Service NHS Trust

Internal Audit Annual Report

Year ended 31 March 2009

Draft

Presented at the Audit Committee meeting of: June 2009

Approved by: Mark Jones as Head of Internal Audit

Contents

Bentley Jennison Risk Management Limited
Bentley Jennison Risk Management Limited is wholly owned by RSM Bentley Jennison
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1 Introduction

1.1 The Role of Internal Audit

The role of internal audit is to provide management with an objective assessment of the adequacy and effectiveness of internal control, risk management and governance arrangements. Internal audit is therefore a key part of London Ambulance Service's assurance cycle and if used properly can be inform and update the organisation's risk profile. Internal Audit is just one of the sources of assurance available to the Board and Audit Committee.

Exhibit A: The Assurance Cycle. © RSM Bentley Jennison

1.2 Statement on Internal Control

NHS bodies are required to make an annual Statement on Internal Control (SIC), which should include issues relating to risk management as well as control. As your internal audit provider, the assignment opinions that RSM Bentley Jennison provides the organisation during the year are part of the framework of assurances that assist the Accountable office in the preparation of an informed SIC.

The purpose of our opinion is to contribute to informing the Board on its completion of its SIC, but may also be taken into account by the Healthcare Commission in the conduct of its work under the Standards for Better Health.

2 The Head of Internal Audit Opinion

2.1 The Opinion

Internal Audit has not reviewed all risks and assurances relating to the Trust. The opinion is substantially derived from the completion of a risk based internal audit plan generated from the Trust's Assurance Framework. As such it is one component that the Board takes into account when making its Statement on Internal Control.

2.2 Internal Audit Assurance Statement

My opinion is set out as follows:-

Based on the work undertaken in 2008/09, **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. However, some weaknesses in the inconsistent application of controls put the achievement of particular objectives at risk. The key risks and issues are:-

Drug Controls
Our audit of drug controls identified a number of significant weaknesses in the management of drug packs at a station level within the Trust. Testing undertaken as part of our audit identified that there is a shortage of packs within the system due to the withholding of packs by Ambulance staff. This has resulted in out of date packs being used on occasions within a number of stations which exposes the risk of out of date drugs being given to patients, which may impact on the quality of care provided by the Trust. The Trust has taken immediate action following the issue of our report to address the weaknesses identified from our audit. A detailed action plan has been developed which also includes actions both to address the issues identified and to ensure ongoing compliance within the Trust.

2.3 The Basis of the Opinion

The basis for forming my opinion is as follows:

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes;
- An assessment of the range of individual opinions arising from audit assignments reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in addressing control weaknesses;
- An assessment of the process by which the organisation has arrived at its declaration in respect of the Standards for Better Health; and
- Any reliance that is being placed upon third party assurances, in particular:

2.4 Information Supporting the Opinion

The **commentary** below provides the context for my opinion and together with the opinion should be read in its entirety.

2.4.1 The design and operation of the Assurance Framework and associated processes

The Trust has a long established assurance framework which is utilised on a regular basis at both Audit Committee and Trust Board level. The framework is appropriately structured

however could be further enhanced through better recording of both the assurances in place to provide assurance that controls are operating effectively and the results of these assurances once they are received. The Trust is also undertaking a Board Workshop in 2009/10 to review the risk management and assurance processes in place to and enhance these further.

2.4.2 The range of individual opinions arising from risk based audit assignments, contained within the risk based plans that have been reported throughout the year

A number of the audits contained within the plan were specifically linked to the Trust's risk register, or were reviews requested by the Trust. Of the 14 reviews where a level of assurance was provided, the breakdown of levels of assurance is as below:
Substantial Assurance – 5
Adequate Assurance – 7
Limited Assurance – 2

The two limited assurance opinions were in respect of our audits of drug controls and policies and procedures. The key issues relating to our limited assurance opinion on drugs are highlighted within section 2.2 above.

Our audit of policies and procedures received limited assurance due to weaknesses in the systems to ensure that all policies and procedures are subject to regular review and dissemination to all applicable staff throughout the Trust. As the majority of staff within the Trust are based on ambulance vehicles for the majority of their working day, it is difficult for a process to be established which will ensure that all staff are able to easily access and read all new policies and procedures once these are issued. However, the Trust is considering a number of alternatives to address this in the future.

An assurance map is provided at Appendix A, linking our opinions to the Trust's risks. Details of our reviews, including the opinions given and the numbers of recommendations made is provided at Appendix B.

Common Weaknesses

No common weaknesses have been identified as part of our internal audit testing.

Acceptance of Recommendations

All of the recommendations made during the year were accepted by management.

Recommendations Not Receiving Adequate Management Attention

The Trust has a recommendation tracking process in place for following up on the degree of implementation of internal audit recommendations. A report is submitted to each Audit Committee for review. An audit was undertaken to assess the degree of implementation of those recommendations reported to the March 2009 Audit Committee. It was confirmed by review that reasonable progress in been made by the Trust in implementing the significant recommendations which had been reported as part of this paper, and that reporting against the status of these recommendations was accurate.

2.3.3 Standards for Better Health Processes and Declaration

As a result of our work it is considered that the Trust have a reasonable process in place to support the completion of the Standards for Better Health declaration.

2.3.4 Reliance Placed Upon Work of Other Assurance Providers

We have not place reliance on the work of any other assurance providers.

2.5 Issues Judged Relevant to the preparation of the Statement on Internal Control

Based on the work we have undertaken on the Trust's system of internal control the Trust should consider highlighting those issues flagged as significant within our report on drug controls and highlighted in Section 2 above. In addition, the Trust also needs to declare themselves non-compliant against standard C4d as part of their Standards for Better Health declaration.

2.6 Conflicts of Interest

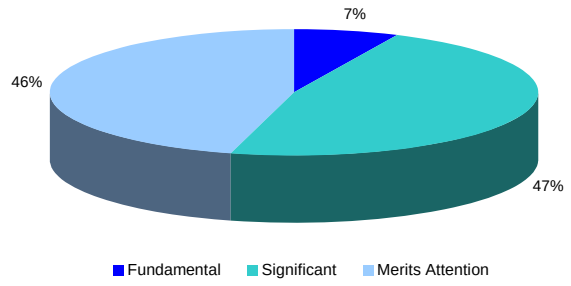
We have not undertaken any work or activity during 2008/09 that would lead us to declare any conflict of interests.

2.7 Benchmarking Data

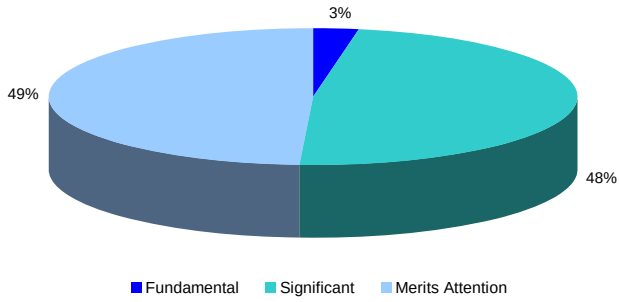
The tables below show the split of internal audit recommendations and opinions for London Ambulance Service NHS Trust in 2008/09 and those made in 2007/08. There has been very little difference in the percentage of positive assurance reports issued or the categorisation of recommendation made. Whilst there has been an increase for 2008/09 in the volume of fundamental recommendations made, all of these are in respect of one audit, on drug controls. In addition, where limited assurance opinions have been provided, these are in areas where audit resources have been directed by Trust management such as policies and procedures.

Comparison of the categories of internal audit recommendations made 2008/09 and 2007/08

Recommendations 2008/09



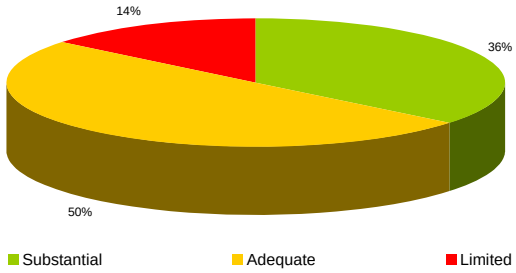
Recommendations 2007/08



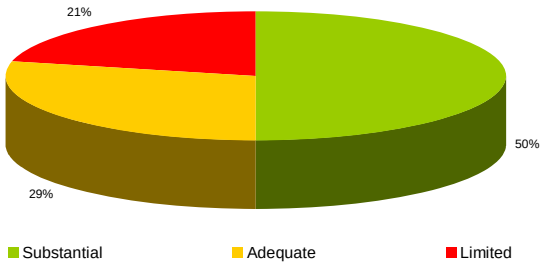
Comparison of assurance levels provided by internal audit in 2008/09 and 2007/08

Risk Based Assurance Assignments Only

Assurance Levels 2008/09

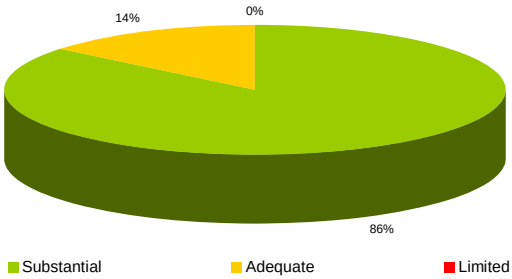


Assurance Levels 2007/08

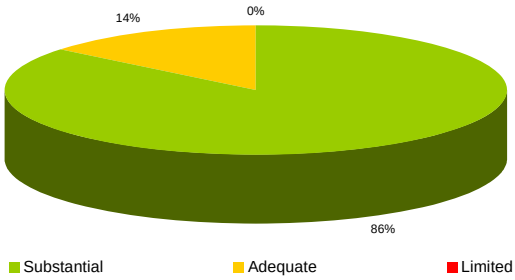


Assignments for External Audit Reliance

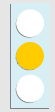
Assurance Levels 2008/09

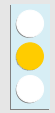
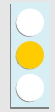


Assurance Levels 2007/08



Appendix A: Internal Audit Assurance Map 2008/09

Risk Based Coverage				
Risk(s)	**Source**	**Headline Findings**	**Assurance**	
Unavailability or the non-functioning of critical patient care equipment on vehicles. Inability to treat paediatrics due to equipment out of date (PALS packs)	Assurance Framework	Our audit of medical devices provided **adequate** assurance that effective controls are in place to manage medical devices at a station level. The following significant issues were identified:- ▪ 22 of 56 vehicles tested where recorded as ready for use, however these vehicles contained unsealed PALs Packs. If packs are not sealed then this increases the risk of devices falling out of storage compartments and becoming either damaged or contaminated. ▪ At 1 station, 1 item of medical equipment awaiting repair had not been thoroughly cleaned. This increases the risk of cross-contamination of other devices.	Adequate	
Drug errors and adverse events not being reported.	Assurance Framework	Our audit of drug controls provided **limited** assurance over the management of drug packs within the Trust. The following significant issues were identified: ▪ Testing undertaken as part of the audit identified fundamental weaknesses in the control over drug packs, particularly in respect of the management of out of date drug packs. Testing identified that, due to shortages in the numbers of packs within the system, that packs are not being returned on a timely basis. In addition, due to shortages in the numbers of drug packs in the system, it was identified that return drug pack lockers at two stations had been opened to enable access to used packs to address shortages at individual stations. Finally, it was noted that at least 6 drugs packs returned to Logistics in January 2009 were over a year out of date, the oldest of which went out of date in 2006. All of the above increases the risk that out of date drugs may be used by Trust staff. The Trust therefore needs to review as a matter of urgency the numbers of drug packs in circulation within the Trust, the processes for	Limited	

		the issue and return of the these packs to ensure that a) there are sufficient numbers of drug packs in circulation and b) that only new packs are used by staff and that all used or out of date drug packs are returned to logistics on a timely basis. ▪ As weaknesses have been identified within this audit in respect of the storage of drugs and the use of completed or out of date drug packs, the Trust needs to consider whether it should be declaring itself non-compliant in respect of the Standards for Better Health declaration. ▪ Finally, it was noted that serious untoward incidents in respect of drug errors are not formally reported to the Board via the report of the Medical Director. The introduction of reporting against this would ensure that the Board are made aware of any trends in the numbers of drug errors and can ensure that suitable actions are taken in respect of this.		
Without a clear, formal business strategy confirmed and an understanding of these other factors, there is less clarity about the financial implications, in terms of risk to income, investment and income growth forecasts.	Assurance Framework	Our audit of strategic planning provided **adequate** assurance over Programme Management arrangements for a sample of major projects within the Trust. The following significant issues were identified: ▪ Benefits/targets should be more measurable to allow the success or achievement of programmes to be gauged. This could be in the form of an outcome scorecard reported in the progress report on a monthly/quarterly basis. ▪ Ensure the End Report reviews the achievement of the objectives and benefits outlined in the PID, to provide assurance that programmes and projects are meeting initial expectations.	Adequate	
Risk of operational staff not being released to attend regular CPD modules and complex based training activities as defined in the Training Plan.	Assurance Framework	Our audit of training and development provided **adequate** assurance over the processes in place for the management of the Trust's training programme. The following significant issues were identified: ▪ Line managers are not always informed if their staff do not attend training courses and a valid reason is not	Adequate	

		always given. A non-attendance form should be filled in stating a valid reason for non attendance. This should then be submitted to the Education and Development Administration team. This is in order to minimise the risk of staff missing courses without a valid reason and also to ensure that the maximum number of staff attend each course. ▪ Staff who do not attend a course are then not guaranteed to be rebooked onto another course. The Resource Centre must ensure that, where possible, all staff who do not attend a course are re-booked onto the same programme at a later date as soon as possible to ensure that all staff attend the appropriate CPD training. Staff who are unable to be rebooked onto a course should be put onto a priority list to ensure that they are booked onto the course next time it becomes available. ▪ The Education and Development Administration team should communicate with the Resource centre to ensure that staff enrolled on courses that were cancelled are then re-enrolled onto the same course on a different date. This is to ensure that operational staff attend all mandatory training courses required of them to carry out their job roles effectively.		

Other Coverage				
Area	**Rationale for coverage**	**Headline Findings**	**Assurance**	
General Ledger	External Audit Reliance	Our audit of the general ledger system provided **adequate** assurance over the effectiveness of the ledger systems. The following significant issue was identified: ▪ Clear segregation of duties in the raising and authorisation of journals was not evident, as testing of journal entries confirmed one journal had been prepared and authorised by the same member of staff within the Finance Department.	Substantial	

Creditors	External Audit Reliance	Our audit of the creditors system provided **substantial** assurance with no significant issues identified.	Substantial	
Debtors	External Audit Reliance	Our audit of the debtors system provided **adequate** assurance with the following significant issue identified:- ▪ The Trust does not monitor Aged Debtors sufficiently to ensure that all monies due are recovered in a timely manner. Testing identified a number of aged debtors that had not been chased on a timely basis.	Adequate	
Payroll	External Audit Reliance	Our audit of the payroll system provided **substantial** assurance with the following significant issue identified:- ▪ Termination forms are being submitted late to payroll by the line managers and this is a main reason for the overpayments each month. Payroll must ensure that the line managers are aware of the deadlines each month for termination forms and that they submit these on time.	Substantial	
Budgetary Control	External Audit Reliance	Our audit of budgetary control provided **substantial** assurance with the following significant issue identified:- ▪ Not all budget holders had signed up to their budgets at the start of the financial year.	Substantial	
Asset Register	External Audit Reliance	Our audit of the asset register system provided **substantial** assurance with no significant issues identified.	Substantial	
Treasury Management	External Audit Reliance	Our audit of the treasury management system provided **substantial** assurance with no significant issues identified.	Substantial	
Benefits Realisation -Invest to Save Project	Management Concern	Our audit the benefit realisation arrangements around the Invest to Save project provided **adequate** assurance with the following significant issues identified:- ▪ The nature of the Invest to Save project was that a large sum of money became available at short notice which could be used for a wide range of projects but which	Adequate	

		was required to be spent by 31 March 2008. This presented a considerable challenge to the governance and project management arrangements around Invest to Save. ▪ Individual project briefs varied considerably in terms of their quality. Risks and the mitigating actions could have been better defined and this might have helped to improve the likelihood of successful and timely outcomes; ▪ Benefits to be achieved from each project were in general not well defined within the individual project briefs. Specifically, the benefits that were outlined did not contain clear measurements which meant it would be hard for the Trust to determine whether these benefits had been achieved; ▪ The closure reports for each of the projects did not refer to the performance against budgeted costs. Whilst cost management was not the key driver of the Invest to Save Project this is a discipline which should be embedded within project management at the Trust; ▪ The Trust commenced a large number of disparate projects as part of the Invest to Save project and this placed a large amount of pressure upon the corporate services and in particular the IT function. This directly led to some delays in the timely delivery of individual projects; and ▪ Many of the projects remain to be completed or have only recently completed. In the case of some of the implementation projects it would be sensible to apply some detailed benefits analysis around the start of the next financial year, which will have allowed sufficient time for new systems to embed within the Trust and for appropriately measureable benefits to be determined and assessed against.		

Assurance Framework	DoH Requirement	The Trust has a long established assurance framework which is utilised on a regular basis at both Audit Committee and Trust Board level. The framework is appropriately structured however could be further enhanced through better recording of the assurances in place to provide assurance that controls are operating effectively and the results of these assurances once they are received. The Trust is also undertaking a Board Workshop in 2009/10 to review the risk management and assurance processes in place to and enhance these further.	Advisory	-
Standards for Better Health	DoH Requirement	As a result of our work we consider that the Trust has a reasonable process in place to support the completion of its declaration	Reasonable	
Policies and Procedures Governance	Management Concern	Our audit of policies and procedures provided limited assurance over the processes in place for the control and issue of policies throughout the Trust. The following significant issues were identified:- ▪ There is no centralised and comprehensive listing of all policies and procedures. This could assist in ensuring policies and procedures are updated and reviewed by due dates. ▪ The Trust has recently implemented a new standard corporate format to be applied to all policies and procedures, which includes a document profile and control page; however, testing showed that this has not yet been utilised for all policies and procedures. There is a risk that policies will not be reviewed, approved and ratified on a timely basis. The corporate format also has the advantage of ensuring consistency and increased understanding. ▪ The standard corporate format also includes an implementation plan which a number of policies and procedures do not yet incorporate. This could lead to them not being disseminated to staff appropriately, not being communicated clearly, inadequate training being provided to staff and ultimately in them being insufficiently monitored. ▪ A number of policies and procedures have not gone	Limited	

		through the process of ratification or do not have an indicated date of ratification which could lead to them being used prior to sanctioning; ▪ The Equality and Diversity and Employment policy which was due to be reviewed in June 2008, has yet to be reviewed because the new Diversity Manager has only recently started in post; ▪ The RIB is an important and vital communication channel, to staff, of policies and procedures. It is normal policy to announce new and revised policies and procedures in the RIB although this could not be tracked for some of them A number of policies and procedures have not been communicated on the RIB. Once policies and procedures are approved an announcement on the RIB should be made to LAS staff to ensure they are aware of them being distributed. ▪ The Trust does not hold any records of staff having read and accepted key policies and procedures. This acceptance of having read policies maintains a log of who has read, understood and accepted the policies and procedures. ▪ Although training is adequate, it is best practise and advised that the Trust introduces a question and answer session, electronically i.e. E-Learning, to test operational staffs reading and understanding of the policies and procedures. ▪ The Trust currently does not report on the non compliance with policies and procedures. Although there are reports produced on incidents and that by its nature, at times bring up the subject of policies and procedures, it is not a comprehensive report. A clear and comprehensive link between incidents and non compliance of policies and procedures should be introduced and documented and reported so as to ensure adequate monitoring of the policy and procedures effectiveness, workability and whether they		

		are adequately sufficient.		
Follow up	Ongoing assurance over the implementation of internal audit recommendations.	The Trust has made reasonable progress towards implementing previous internal audit recommendations.	Reasonable progress	

Appendix B: Internal Audit Opinions and Recommendations 2008/09

Auditable Area	Draft Report Issued	Responses Received	Final Report Issued	Assurance Level given	Number of Recommendations made				
					Fundamental	Significant	Merits Attention	In Total	Agreed
Risk Based Audits linked to the Assurance Framework									
Medical Devices	12-03-2009	27-05-2009	28-05-2009	Adequate	0	3	2	5	5
Drug Controls	13-03-2009	28-04-2009	28-04-2009	Limited	5	2	0	7	7
Strategic Planning	17-03-2009	-	-	Adequate	0	2	5	7	-
Training and Development	20-02-2009	-	-	Adequate	-	3	1	4	-
Audits undertaken for external audit reliance									
General Ledger	17-11-2008	02-12-2008	02-12-2008	Substantial	0	1	1	2	2
Creditors	4-11-2008	16-12-2008	17-12-2008	Substantial	0	0	3	3	3
Debtors	17-11-2008	11-02-2009	11-02-2009	Adequate	0	2	0	2	1
Treasury Management	22-12-2008	11-02-2009	11-02-2009	Substantial	0	0	0	0	0
Asset Register	16-12-2008	17-12-2008	17-12-2008	Substantial	0	0	2	2	2
Payroll	17-02-2009	-	-	Substantial	0	1	2	3	-
Budgetary Control	04-12-2008	04-12-2008	05-12-2008	Substantial	0	1	1	2	2
Assurance Framework	28-05-2009	-	-	Advisory	0	3	5	8	-
Standards for Better Health	13-03-2009	27-05-2009	27-05-2009	Reasonable	0	0	1	1	1
Other									
Benefits Realisation – Invest to Save Programme	19-12-2008	19-02-2009	20-02-2009	Adequate	0	5	4	9	9
Policies and Procedures	05-02-2009	28-05-2009	28-05-2009	Limited	0	6	3	9	9
Follow Up	2-06-2009	-	-	Reasonable	0	4	3	7	-

The definitions for the level of assurance that can be given are:

	Level	Effectiveness	Control Adequacy	Control Application
positive opinions	Substantial Assurance	Targets have been met or exceeded.	Robust framework of controls ensures objectives are likely to be achieved.	Controls are applied continuously or with minor lapses.
	Adequate Assurance	Targets have been closely missed or there are appropriate reasons as to why they have not been met	Sufficient framework of key controls for objectives to be achieved but, control framework could be stronger.	Controls are applied but with some lapses.
negative opinion	Limited Assurance	Targets have not been met and no reasons are given as to why.	Risk of objectives not being achieved due to the absence of key internal controls.	Significant breakdown in the application of controls.

Recommendations made during the year have been categorised as follows:

Fundamental	Action is imperative to ensure that the objectives for the area under review are met.
Significant	Requires action to avoid exposure to significant risks in achieving the objectives for the area under review.
Merits Attention	Action advised to enhance control or improve operational efficiency.

London Ambulance Service
NHS Trust

Audit Committee Front Sheet

Title:	**Agenda Item: 11**
Financial Risk Review	**Enclosure:13**
Review of Potential Risks	

Purpose:

Audit Committee to review potential risks, grade and agree reporting mechanisms

Summary:

<u>Potential Financial Risks for review and grading</u>

1. A&E Penalty	£1.4M
2. CIP	£1.2M
3. Capital Loan	£1.0M
4. PTS Profit	£0.3M
5. Other Income	£1.0M
6. MPET Funding	£2.0M
7. Capital Expenditure Control	£1.0M
8. Fuel	£0.2M

Recommendations/and or actions required:

Review risks and agree reporting mechanisms

Author and Date:

Asif Islam
29 May 2009

Financial Risks 2009/10 Plan				
	2009/10 Value £000	**Risk** %	**Adjusted Risk** £000	**Mitigating Actions**
Income				
A&E Penalty	7,000	20	1,400	Performance Delivery and Turnaround
MPET Finding	10,210	20	2,000	Increase in CIP to compensate for loss
Other Income	13,992	7	979	Increased DH liaison. Limit in line with spend
	31,202	**14**	**4,380**	
Other				
Cost Improvement Plan	11,683	10	1,168	Built into department budgets. Monthly monitoring by SMG.
PTS Profit	300	50	150	Current run rate plus conservative plan.
Capital Loan (CAD 2010)	10,000	10	1,000	Loan application submitted.
Phasing	3,000	10	300	Front loaded recruitment to achieve full operating establishment
Fuel	4,656	5	233	Monitoring
Capital Expenditure Control	3,000	33	990	Improved Monitoring and Forecasting
	32,639	**12**	**3,841**	

13 Update re: HCC / NHSLA - Verbal

14 Standing Committee Items

London Ambulance Service NHS Trust

AUDIT COMMITTEE MEETING
8 June 2009

Report on behalf of the Executive Director of Finance

Standing Committee Items

1. Since the Audit Committee met in March, 2009 there have been 7 entries in the Directors' Hospitality Registrar to report.

- **Sigurd Reinton: Chairman of the Board**

09/3 lunch with Sir William Wells (former Chair NHS Appointments Commission), Bow Wine Vaults.
24/3 lunch with Mike Smith, Non Exec director, West Essex PCT, Travellers Club.
07/4 lunch Rudy Markham, Chairman, Moorfields, Athaeneum.
14/4 lunch Brian Philpott, Chairman Mayday NHS Trust, Baltic restaurant.
21/4 lunch David Jervis, former Director, LAS (SER paid £70).
11/5 lunch David Harris, Curzons, Livebait.
12/5 lunch Hamish Meldrum, chairman, BMA (SER paid £50).

15 Minutes of the Clinical Governance Committee - (February 2009 & April 2009)

Enclosure 15

LONDON AMBULANCE SERVICE NHS TRUST

SUMMARY OF THE DRAFT MINUTES
CLINICAL GOVERNANCE COMMITTEE 23 February 2009

1. **Chairman of the Committee** **Beryl Magrath**

2. **Purpose:** **To provide the AUDIT COMMITTEE with summary of proceedings of Clinical Governance Committee meeting on 23 February 2009**

3. **Agreed**

.

- Head of Clinical Audit and Research to give update on scanners and cards at CGC meeting in August (now revised to July).
- That future Area Governance reports include graphic comparisons with previous reports/ years and concentrate on exception reporting
- ADO East to conduct an annoymised case study and place on the Pulse once completed. and to ensure that Internal Auditors conduct a morphine audit
- That Dr. Tom Evans to be invited to the CGC meeting in August (now revised to July)) to discuss V.A.S. (Voluntary Ambulance Services), in particular governance, quality assurance, education and training and any other issues of significance.
- That the discussion required around CGC planning should take place outside the Committee meetings and be reported to the next CGC meeting in August 2009 (revised to a date in July).
- The August meeting would take place in July 09

4. **Approved**

- OP/045 procedure for Patients Suspected of Alcohol and/ or drug Intoxication subject to agreement being received from staff-side
- TP/008 Policy n the Supply and Administration of Medicines under Patient Group Direction subject to minor amendments by the Assistant Director of Organisational development.

5. **Noted**

- A presentation on Healthcare for London
- PPI Action Plan 2008-2012
- A presentation on Community First Responders (CFR)
- HCC: 2008/09 Final Declaration - The Trust would be able to declare compliant on all standards by 31 March 2009 – though at present C4-d "Medicines are not handled safely and securely" was not met , but all actions will be completed by 31March 09
- Updated NHSLA Standards and Assessments - Preparing for achieving Level2 standard in 2010

6. **Minutes Received**

PPI Committee
Infection Control Steering Group
Standards for Better Health Group
Risk Compliance & Assurance Group
Clinical Steering Group
Training Services Group

7. **Recommendation** **THAT the AUDIT COMMITTEE note the draft minutes of the Clinical Governance Committee, 23rd February 2009.**

London Ambulance Service NHS Trust

CLINICAL GOVERNANCE COMMITTEE
(Core meeting)

Minutes of the meeting held on Monday 23 February 2009
in the Conference Room, LAS HQ, 220 Waterloo Road, London SE1 8SD
****

Present:	Beryl Magrath	Chair
	Fionna Moore	Vice Chair
	Sarah Waller	Non Executive Director
	Kathy Jones	Director of Service Development
	Richard Webber	Deputy Director of Operations
	Nicola Foad	Head of Legal Services
	Bill O'Neill	Assistant Director, Organisation Development
	Stephen Moore	Head of Records Management & Business Continuity
	Margaret Vander	PPI Manager
	Phil Flower	ADO Control Services
	Paul Tattam	AOM D Watch
	Jason Killens	ADO East
	Tony Crabtree	Assistant Director, Employee Support Services
	Phil de Bruin	PIM South (for ADO South)
	Jon Knott	PIM West (for ADO West)
	Gary Bassett	Head of Patient Experiences
	John Selby	Senior Health and Safety Adviser
	Pat Billups	Educational Governance Manager
	Daniel Adams	Corporate Logistics Manager (for Head of Operational Support)
	Gurkamal Virdi	(for Head of Clinical Audit and Research)
	Barry Silverman	Patients Forum (for Malcolm Alexander)
	John Ellman-Brown	Trust Secretary
Apologies	Ingrid Prescod	Non Executive Director
	Fenella Wrigley	Assistant Medical Director, Control Services
	Peter McKenna	ADO West
	Paul Woodrow	ADO South
	Lizzy Boville	ADO
	Rachael Donohoe	Head of Clinical Audit and Research
	Chris Vale	Head of Operational Support
In attendance:	Chris Hartley-Sharpe	AOM in charge of Community First Responder Project

****

01/09 <u>Apologies</u>

The Chair noted apologies had been received from Ingrid Prescod, Fenella Wrigley, Peter McKenna, Lizzy Boville, Rachael Donohoe and Chris Vale.

02/09 Minutes

After review and due consideration by the Committee:

IT WAS RESOLVED THAT the minutes of the Clinical Governance Committee meeting held on 12 November 2008 be and are hereby confirmed as a true record of the meeting.

03/09 Matters Arising

1. ***Minute 56/08(2):*** It was confirmed that the data collected concerning the audit of CTA calls had been shared with CARU;
2. ***Minute 56/08(4):*** Some information in respect of the findings arising from the recent general review of the CTA function (that included the random review of PSIAM) was incorporated within the ADO Control Services Report. More detailed information was required and would be included as a separate Agenda item for the next meeting; **Action: ADO Control Services**
3. ***Minute 57/08(1)*:** The Trust Secretary confirmed that 5 job titles within the Committee's Terms of Reference had been changed as required;
4. ***Minute 57/08(2)*: It was noted that all clinical groups acting for the LAS as 3rd party agencies have CG arrangements in place. All these groups will be asked to submit a short annual report to the CGC**
5. ***Minute 60/08*** The following policies were agreed for ratification by the Trust Board:
    - Policy & Procedures for the Management of Frequent Callers
    - Policy for Pre-Hospital Blood Taking
    - ECPPolicy for Health, Safety & Risk Management Training & Provision of H&S information

    SMG will endorse the following policies after modification:
    Resuscitation
    Advising staff where Deviation from guidelines is considered
    Policy for Community First Responders
    Policy Statement on Staff Induction
    were being amended to take into account changes to ???? and would be brought back to the CGC for approval in due course;

    Action: Head of Patient Experiences
6. ***Minute 60/08(7)*:** The reference to the legal duty of LAS to attend calls where key symptoms had been reported was confirmed as deleted from the Frequent Callers Policy.

04/09 Area Governance Reports

The Committee received the following Area Governance Reports:

- Control Services. It was noted that:
    - CSD staff took on some of the CTA work over Christmas and the New Year
    - Community Involvement Officers were working hard to raise the profile of the CSD
    - EBS took GP calls from CTA in the previous 3 months, saving 85hours of CTA call-takers time

- EBS-GP referral service numbers were low & Commissioners had requested a 15% increase in activity during 2009
- CTA is trying to recruit a designated Training Officer, to help them identify their training & development needs

- South Area
  - CPI completion rate had fallen fom a peak of 77% last May to 18% at present. The high REAP levels & use of Team Leaders & managers , as operational staff or to manage acute hospital pressure were largely to blame
  - 5 staff members in South Area were responsible for 18 vehicle accidents, which is being investigated
  - South Area ADO has concerns and stated that improvements need to be made to satisfy the new reforms coming in October 2009 (Ministry of Justice Response to Consultation on Personal Injury Claims Process & Case Track Limits - The new process will apply to RTA claims only)

- East Area
  - Two useful case studies were presented, which highlighted once again the difficulties disseminating information and learning in a large organisation such as the LAS

- West Area
  - The need to recruit more Practice Placement Educators onto vehicles in a 3rd manning or supernummary position was highlighted. The West Area employs 146 at present, which will need to increase to 200
  - The Brent Complex has introduced 2 new means of communication with staff 1)A monthly Complex Newsletter on all topical information. All staff can submit articles 2)An electronic notice board

.The Committee thanked all presenters for their reports, which provided detailed and very useful information They requested all future reports included graphical comparisons with previous reports/years and concentrated on exception reporting etc. where this was not done already. **Action: ADOs**

05/09 **Medical Directorate Update**

The Committee received and noted the update presented by the Medical Director.

06/09 **Clinical Risks**

The Committee reviewed the Clinical Risks update, noting in particular that at its meeting on 16 February 2009, the RCAG had reviewed the controls in place and had agreed the following:

- ID71 be downgraded to Mod/6
- Approval of the Risk Register process and new Risk Register Layout

The Committee then reviewed the risks in detail as follows:

- 269: Likely to be downgraded once new staff are recruited;
- 31: Obstetrics data will be shared with Bill O'Neill for NWOW;
- 138: To be rolled out in May 2009;
- 22: Likely to remain permanently high risk;
- 207: Update on scanners and cards to next CGC meeting
  Action: Head of Clinical Audit and Research
- 20: To be reverted to RCAG;
- 296: Wording in respect of staff exposed to risk at an incident to be reworded

Action: ADO East

- 301: "Anonymised" case study to be conducted and placed on The Pulse
  Action: ADO East
- 211: Agreed for Team Leaders to report anonymously. ADO East to take on at ADO level
  Action: ADO East
- 138: Noted;
- 165: Noted;
- 179: Re-wording might be required due to new Race Relations Act
  Action: Diversity and Equality Manager
- 305: Morphine audit to be conducted by Internal Auditors and presented to Audit Committee
  Action: ADO East
- 71: ADO Group to take responsibility
  Action: ADO East
- 295: Noted

07/09 **Clinical Policies and Procedures**

The Committee considered the draft of a new procedure for Patients suspected of Alcohol and/or Drug Intoxication as well as a revised policy on the supply and administration of medicines under Patient Group Directions, and received briefings on both.

After due consideration and debate:

- **OP/045 Procedure for Patients suspected of Alcohol and/or Drug Intoxication** was approved subject to agreement being received from staff-side;
- **TP/008 Policy on the Supply and Administration of Medicines under Patient Group Directions** was approved subject to minor amendment by the Assistant Director, Organisational Development.

08/09 **New Strategies/Developments**

The Committee received a presentation on Healthcare for London from the Director of Service Development.

It was noted by the Patients Forum representative that the consultation document made no mention of LAS. Ms Jones confirmed that the LAS was being funded for stroke but had received no promises in respect of Trauma. Accordingly, no response had been made by LAS as no assurances had been provided by H*f*L.

09/09 **PPI**

The Committee were reminded of the PPI Action Plan 2008-2012, previously presented to them, a copy of which had been included in the Committee papers, and received a presentation from the PPI Manager.

10/09 **Special Reports**

The Committee received a presentation on CFR ("Community First Responders") from Chris Hartley-Sharpe, who took questions on completion. The Committee thanked Mr Hartley-Sharpe for his presentation.

The Committee requested that Dr Tom Evans be invited to the CGC meeting in August 2009 to discuss V.A.S. (Voluntary Ambulance Services), in particular governance, quality assurance, education and training, and any other issues of significance.
Action: Deputy Director of Operations

11/09 **CGC Planning Discussion**

The Committee agreed that this discussion should take place outside the Committee meetings and be reported to the next CGC meeting in August 2009.
Action: Trust Secretary

12/09 **Annual Health Check 2009/10**

The Committee received an update on the progress of the SfBH declaration due on 30 April 2009.

The Committee noted that it was likely the Trust would be able to declare itself compliant on all core standards by March 2009. However considerable work remained to be done especially on 3 new standards. At present **C4d-"Medicines are not handled safely and securely"** was not met, but an Action Plan was in place to ensure that compliance would be met by the 31st March 2009

The Committee noted the report.

13/09 **NHSLA**

The Trust achieved NHSLA level one Standard following an improvement period.. The report recommends to review the document management processes for approval and rectification and also to accurately describe the systems and processes in the documents. An action plan is developed for achieving compliance with the standards where LAS did not meet the minimum requirements. The Trust has agreed with the assessor to have informal visits on a quarterly basis to ensure that the Trust is on track with the progress of the action plan and on track for progress towards Level 2 by 2010

The Committee noted the report.

14/09 **Reports from Groups/Committees**

The Committee noted minutes and reports from the following Groups and Committees:

- PPI Committee;
- Infection Control Steering Group
- Standards for Better health Group
- Risk Compliance & Assurance Group
- Clinical Steering Group
- Training Services Group

The Committee noted that the CARSG, Race Equality Strategy Group and Feedback, Learning and Improvement Group (superseding the Complaints Panel) had not met since the last CGC meeting.

15/09 **Next Meetings**

It was noted that the next CGC meetings were scheduled as follows:

- 27 April 2009 at 2:00 pm (core meeting)
- 10 August 2009 at 2:00 pm (full meeting)

Due to the August meeting falling within the school summer holidays, the Committee agreed that the August meeting be reprogrammed for a date in July.
Action: Trust Secretary

16/09 **<u>Any Other Business</u>**

The Assistant Director, Organisation Development reported that several of his roles were being taken over by Gill Heuchan an example being Clinical Education. This would allow him to concentrate on other issues within his responsibilities. He would introduce her to the next meeting of the Committee. **Action: Assistant Director, Organisation Development**

There being no further business, the Chair declared the meeting closed at 17:50.

……
Chair

Enclosure 16

LONDON AMBULANCE SERVICE NHS TRUST

AUDIT COMMITTEE - 8 June, 2009

SUMMARY OF THE MINUTES
CLINICAL GOVERNANCE COMMITTEE

1. **Chairman of the Committee** Beryl Magrath

2. **Purpose:** To provide the AUDIT COMMITTEE with a summary of proceedings of Clinical Governance Committee meeting on 27 April 2009

3. **Agreed**
   - **Minute 19/09(7): Next Meeting**
     Next meeting rescheduled for 13 July 2009.
   - **Minute 20/09: Clinical Policies/Procedures**
     All clinical policies/procedures to be presented to staff-side for review/comment before presentation to CGC for approval/ratification.
   - **Minute 21/09: Staff Training**
     Training of current staff lagging behind that for new staff. To become SMG standing item. NEDs to take forward at TB level.
   - **Minute 30/09: Clinical Risks**
     1. Risk ID31 approved for amendment on Risk Register.
     2. Following new risks approved for addition to Risk Register:
        - Required drugs/equipment not being available in drug packs/on vehicles leading to patients not receiving appropriate treatment;
        - Similar packaging of Glucose and Sodium Chloride may result in administration of incorrect drug, causing patient harm;
     3. Consideration of Risk ID71 deferred until next CGC meeting;
     4. Re-packaging of Glucose or Sodium Chloride to be considered to ensure easy identification and prevent administration of incorrect drug.
   - **Minute 31/09: Risk Information Report**
     "Audit trail" to be created for all SUIs. Head of Patient Experiences to propose mechanism for reporting incidents as part of SUI policy.
   - **Minutes 32/09: "Six Lives" Report**
     Director of Service Development to comment on "Six Lives" report prior to Committee agreeing to recommendations.

4. **Noted**
   - Infection Control Update
   - Area Governance Reports
   - Internal Audit Action Plans
   - New National Targets 2008/09
   - HCC: 2008/09 Final Declaration
   - Updated NHSLA Standards and Assessments
   - PPI Update
   - CARU Update
   - Patient Experiences Update

5. **Minutes Received**
   - Infection Control Steering Group: 10 February 2009
   - Risk Compliance & Assurance Group: 16 February 2009
   - Clinical Audit and Research Steering Group: 13 March 2009
   - Standards for Better Health Group: 26 March 2009
   - Clinical Steering Committee: 20 October 2008

6. **Recommendation** **THAT the AUDIT COMMITTEE note the minutes of the Clinical Governance Committee.**

LONDON AMBULANCE SERVICE NHS TRUST

CLINICAL GOVERNANCE COMMITTEE
(Core meeting)

Minutes of the meeting held on Monday 27 April 2009 at 2:00 p.m.
in the Disney Room, The Union Jack Club, Sandell Street, London, SE1 8UJ

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Present:	Beryl Magrath	Non Executive Director: Chair
	Fionna Moore	Medical Director: Vice-Chair *(until 3:55 p.m.)*
	Sarah Waller	Non Executive Director *(from 2:15 p.m.)*
	Martin Smith	Head of Corporate Services *(from 2:30 p.m.)*
	Nicola Foad	Head of Legal Services
	Stephen Moore	Head of Records Management & Business Continuity
	Fenella Wrigley	Assistant Medical Director, Control Services *(until 3:55 p.m.)*
	Gary Bassett	Head of Patient Experiences
	Chris Vale	Head of Operational Support *(until 3:55 p.m.)*
	Laila Abraham	Head of Governance (Interim)
	Andrew Stainthorpe	Head of Clinical Audit and Research (Interim)
	Peter McKenna	ADO West *(until 3:55 p.m.)*
	Paul Woodrow	ADO South
	John Selby	Senior Health and Safety Adviser
	Paul Tattam	AOM D Watch
	Sue Watkins	(for ADO Control Services) *(until 3:55 p.m.)*
	Margaret Vander	PPI Manager
	Malcolm Alexander	Patients Forum
	John Ellman-Brown	Capita Company Secretarial Services (Minutes)
Apologies:	Ingrid Prescod	Non Executive Director
	Kathy Jones	Director of Service Development
	Richard Webber	Deputy Director of Operations
	Bill O'Neill	Assistant Director, Organisation Development
	Phil Flower	ADO Control Services
	Jason Killens	ADO East
	Paul Gates	PIM East
	Tony Crabtree	Assistant Director, Employee Support Services
	Pat Billups	Educational Governance Manager
	Lizzy Boville	ADO

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17/09 <u>Apologies</u>

Apologies were noted as having been received from Ingrid Prescod, Kathy Jones, Richard Webber, Bill O'Neill, Phil Flower, Jason Killens, Tony Crabtree, Paul Gates, Pat Billups and Lizzy Boville.

18/09 <u>Minutes</u>

After review and due consideration by the Committee, subject to minor amendment:

IT WAS RESOLVED THAT the minutes of the Clinical Governance Committee meeting held on 23 February 2009 be and are hereby confirmed as a true record of the meeting, and that they be signed by the Chair.

19/09 Matters Arising

1. ***Minute 03/09(4):*** *Previous Minute: 57/08(2)* All clinical groups acting for LAS as 3rd party agencies were to be asked to present a written report to the CGC on an annual basis.
   Action: Head of Governance (Interim)
2. ***Minute 03/09(5):*** *Previous Minute: 60/08* The Policy for Community First Responders was noted as having been published, however it was very short of purpose and therefore was to be completely rewritten.
   Action: AOM i/c Community First Responder Project
3. ***Minute 06/09:*** **Risk No. 207: S**taff uptake of scanners and cards was noted as being only 16%, and ways to increase this were discussed. The issue would be considered at the next meetings of both the ADOs and the Information Governance Group.
   Action: ADOs/Head of Records Management & Business Continuity
4. ***Minute 06/09:*** **Risks Nos. 71, 179, 211, 296, 301 and 305**: Discussion of these issues was deferred until the next meeting.**Action: ADO East**
5. ***Minute 08/09***: The Medical Director confirmed that LAS was now being funded in respect of Trauma, but that the funding was not included within the Trust's budgets.
6. ***Minute 11/09***: The CGC Planning Discussion was noted as not yet having been held. As previously indicated, the results of the discussion would be reported to the full CGC meeting in August 2009.
   Action: Trust Secretary/Interim Head of Governance
7. ***Minute 15/09:*** It was agreed that the full CGC meeting currently programmed for 10 August 2009 be rescheduled for 13 July 2009.
   Action: ALL

20/09 Clinical Policies and Procedures

The Committee considered drafts of the following new policies and procedures for approval or ratification:

- **OP/32: Alternative Response Procedure**;
- **TP/03: Policy Statement of Duties to Patients;**
- **OP/10: Procedure for the Maintenance of the High Risk Address Register**

It was noted that none of the drafts had been presented to staff-side for review/comment. Accordingly, it was agreed that all three policies/procedures be referred to staff-side first and then presented to the CGC for approval/ratification. This process was also approved for all such actions in the future.
Action: Head of Records Management & Business Continuity

21/09 Medical Directorate Update

The Committee received a briefing from the Medical Director, who expressed her concern that LAS was losing its clinical focus and needed to concentrate on patient care.

Whilst there was new and improved training being provided for **new** staff, training for **current** staff was out of date and official training time insufficient – both needed to be updated and built in to ensure **all** staff were up to date. She confirmed that this was to

become a standard item on the SMG agenda. The Non Executive Directors agreed to take the issue forward at Trust Board level.
Action: Medical Director/Non Executive Directors

22/09 **Infection Control Update**

The Medical Director reported that the Trust was registered with the CQC and was in process of implementing the Ambulance Guidelines and applying for necessary funding.

The major issue at the present time was swine flu. Although the current threat to the UK was very small, pandemic planning was well advanced. It was reported that calls transferred to CTA from the EOC did not include pandemic advice; however it was possible that, following a meeting later in the afternoon, Card 36 could be introduced.

The Medical Director reported that no Infection Control Audits had been carried out within the Areas.

With effect from 1 May, there would be one member of staff employed fulltime on Infection Control. Trevor Hubbard would be providing a report to the Trust Board on an annual basis.

23/09 **Area Governance Reports**

The Committee received the following Area Governance Reports:

- **Control Services**

Paul Tattam presented the report on behalf of Control Services:

- Within CTA, reviewers were currently being reviewed;
- CSD workload remained high with access reported per month between 900 and 1000 times (although February had been significantly underreported);
- Paul Tattam to ascertain EBS Medical Referees who validates their practise and report at the next meeting.
  Action: AOM D Watch

- **South Area**

Paul Woodrow presented the report on behalf of South Area:

- CPI completion rates were noted. From 1 May 2009, the Area had committed to release Team Leaders for clinical audit and PRF feedback;
- RT Collision Forms had been reviewed and were now in use across the Area. It was considered that 12 hour shifts had an influence on both staff attitude and the number of RTAs, but was not proven.

- **East Area**

No-one was available to report but the following points were noted:

- CPI completion(14%) continued to be a challenge due to operational pressures;
- An Area Risk Register was to be developed which would highlight specific risks germaine to the Area. It was noted as imperative that **all** risks be able to be seen by the Trust Board and relevant Managers; Ms Abraham would ensure this occurred.
  Action: Head of Governance (Interim)

- **West Area**

Paul McKenna presented the report for the West Area. There were no comments or questions arising from his report.

The Committee thanked all presenters for their reports, which provided detailed and very useful information and which the Committee considered to be much improved. ADOs were requested to keep up the improvement.
Action: ADOs

24/09 **Internal Audit Action Plans**

The Committee reviewed the papers presented, noting that the Audit Committee was responsible for **all** risks. The CGC saw all Clinical Risks first; these were then reviewed and graded by the RCAG before being put to the Audit Committee for final review ADOs were requested to impress upon staff that technician and paramedic packs **must** be returned at the ends of shifts.

The issue of encouraging staff to admit to making errors were discussed at length. The Trust was aiming to develop a "no blame" culture, to encourage staff to come forward to report errors and mistakes they have committed in their working day, by ensuring that no disciplinary action would be taken against them (unless the incident was extremely serious). Ms Abraham would discuss the issue with Andrew Stallard and revert.
Action: Head of Governance (Interim)

25/09 **New National Targets 2008/09**

The Committee reviewed the paper presented that gave an overview of the scoring system for the New National Targets (and the predictions for the Trust) for 2008/09. These targets (some of which had a greater clinical focus than others) were part of the CQC's Annual Health Check of ambulance trusts, and the report outlined the 8 indicators used to assess their performance against existing commitments and national priorities based on the outlined point system.

The Committee questioned why Target 6 "Repair and Safe Environment of Ambulances" had been withdrawn. Ms Abraham would confirm and revert at the next meeting.
Action: Head of Governance (Interim)

26/09 **HCC: 2008/09 Final Declaration**

Ms Abraham confirmed that the LAS would be compliant with the requirements of the HCC, and would therefore be able to sign and deliver the final declaration for 2008/09, by the deadline.

NHSfL had provided feedback on draft declarations only to certain organisations with whom they were experiencing difficulties – this did **not** include the Trust. Ms Abraham had attempted to obtain written confirmation from NHSfL that the Trust's declaration was acceptable, but had only managed to obtain verbal confirmation.

Once completed, the Declaration would be circulated to Committee members.
Action: Head of Governance (Interim)

27/09 **Updated NHSLA Standards and Assessments**

Ms Abraham reported that the Action Plan (Level 1) had been approved. An assessor from the NHSLA would be visiting the Trust on 20 May for the agreed informal quarterly visit to ensure that the Trust is on track with the progress of the action plan and on track for progress towards Level 2 by 2010 and she would be discussing the progress with them.
Action: Head of Governance (Interim)

28/09 **Patient & Public Involvement Update**

The Committee received an oral update from Margaret Vander who reported on a successful PPI Committee meeting held on 16 April 2009. A number of very positive items had come out of that meeting, amongst which were the following:

- Bev Jeal had been appointed as PPI & Public Education Co-ordinator and started work on 20 April 2009;
- The Patient Care Conference was scheduled for 15 September 2009, the focus of which would be on 'engagement' with patients and the Public;
- A pilot Staff Development Programme evaluation was underway, as was planning the next programme for the summer;
- Secondments with the Prince's Trust had proven to be very positive. An Open Day had been held on 21 April 2009; 41 people had attended and there had been a waiting list for places;
- The Resources sub-group had been busy designing and circulating items, aimed specifically at 10/11 year olds. New Oyster Card Holders and Leaflets had been received and banners were on order;
- A new knife crime initiative was underway within Tower Hamlets. ADO South requested more information in respect of this in order to feed into the London Weapons Forum.
  Action: PPI Manager

Further to the above, confirmation had been received that morning of agreement to develop a Joint Ambulance Services Museum. This had the backing of the GLA, however funding had not yet been discussed.

The Committee thanked Ms Vander for a most positive report.

29/09 **Clinical Audit and Research Unit ("CARU") Update**

The Committee received an oral update from the Interim Head of CARU, Andrew Stainthorpe.

Mr Stainthorpe reported on a restructuring of the Unit that had occurred prior to Rachael Donohoe departing on Maternity Leave. The Unit would be at full strength by May 2009 with less agency staff employed.

30/09 **Clinical Risk Update**

The Committee received an update on progress made with action plans in place to mitigate clinical risks on the Risk Register, and reviewed the risks involved.

After due consideration:

IT WAS RESOLVED TO RECOMMEND THAT Risk ID31 "Misuse of the LA4H Single Responder Handover Form" be and is hereby approved to be amended on the Risk Register from its current grading and level of ***12 – significant*** to a new grading and level of ***3 – low***.

IT WAS FURTHER RESOLVED THAT the following new risks as presented be and should be recommended for addition to the Risk Register:

- That required drugs/equipment may not be available in drug packs leading to patients not receiving appropriate treatment;
- That the similar packaging of Glucose and Sodium Chloride may result in the administration of the incorrect drug, causing patient harm.

It was agreed that, due to the absence of ADO East, consideration of Risk ID71 "Not learning and changing practice, following receipt of complaints, due to inadequately trained officers or any other cause" be deferred until the next meeting of the Committee.
Action: Head of Governance (Interim)

It was further agreed that the re-packaging of either Glucose or Sodium Chloride be recommended to the manufacturers to ensure the drugs are easily identifiable and to prevent the administration of the incorrect drug.
Action: Medical Director

31/09 **Risk Information Report ("RIR")**

The Committee reviewed the regular RIR, intended to demonstrate the effectiveness of clinical governance arrangements, and received a briefing from John Selby, the Senior Health and Safety Advisor, who reported that the figures contained therein were correct. Categories of incidents were considered and the Committee noted that delays featured prominently throughout the report.

The Committee agreed that an "audit trail" be created for all Serious Untoward Incidents ("SUIs"). As part of this, the Head of Patient Experiences intended to propose a mechanism for reporting such incidents as part of the updated SUI policy.

32/09 **"Six Lives": the provision of public services to people with learning disabilities**

The Committee reviewed a paper on the "Six Lives" report, published on 24 March 2009 by the Health Service and Local Government Ombudsman. It had focussed on investigations into the death of six individuals and called for an urgent review of health and social care for people with learning disabilities.

The Committee was being asked to agree to the recommendations within the report. However, after due consideration, it was agreed to approach the Director of Service Development in the first instance for comment.**Action: Medical Directore**

33/09 **Reports from Groups/Committees**

The Committee noted minutes and reports from the following Groups and Committees:

- Infection Control Steering Group: 10 February 2009;
- Risk Compliance & Assurance Group: 16 February 2009;
- Clinical Audit and Research Steering Group: 13 March 2009;
- Standards for Better Health Group: 26 March 2009;
- Clinical Steering Committee: 20 October 2008

34/09 **Patient Experiences**

A paper was circulated by Gary Bassett, the Head of Patient Experiences, who apologised to the Committee for the late delivery. He asked that Committee members review the paper and revert to him with any questions.

35/09 **Next Meeting**

Following the change to the August date agreed earlier in the meeting, it was noted that the next CGC meeting (full) would now be held on 13 July 2009 at 2.00 pm.

36/09 **Any Other Business**

There being no further business, the Chair declared the meeting closed at 17:10.

……
Chair

16 Minutes of the RCAG Meeting – 18 May 2009

London Ambulance Service NHS TRUST

Risk Compliance and Assurance Group –18th May 2009

1. **Chairman of the Group** — **Peter Bradley**
2. **Purpose of the summary:** — **To provide the Audit Committee with a summary of the proceedings of the RCAG meeting, to highlight items of interest, what has been agreed and noted.**

3. **RCAG agreed:**

1. Minute 03/09 that the following four risks, which had been proposed for deletion/downgrading in February 09, remain on the Register at their original risk rating as there was insufficient evidence to support deletion/downgrading.
   - ID 249 *loss of FRU cover due to inappropriate tasking*
   - ID 9 *risk of RTA injury to persons travelling in an LAS A&E vehicle*
   - ID 269 *at shift changeover times, LAS performance falls as we take longer to reach patients*.
   - ID 271 *crew staff not in possession of valid driving licences for category of vehicle they are required to drive*.
2. That risk 9 should be monitored by Motor Risk Group & risks 31,138 and 207 be assigned to the Clinical Governance Committee to monitor.
3. That it was important that risks such as risk 279, *total of 25% personnel ill for about 8 days (duration of pandemic c. 12 weeks), with predicted 10% additional absenteeism due to caring for dependents = 35% over total period* are up to date and reflect the mitigating action being undertaken by the Trust in March 09. ACTION: interim head of Governance/owner of risks
4. That risk 295 *using coloured syringes instead of oral syringes to administer oramorph* be regraded from 6/moderate to 3/low and that it should remain on the risk register in order that the Group monitor it.
5. That risk 302, *there is a risk that failure to recruit and train, within necessary/planned timeframe, sufficient Student Paramedics to meet the reviewed Workforce Plan* be regraded from 12/significant to 1/low and reviewed in six months time with deletion considered if it is no longer a risk for the Trust.
6. That the opportunity will be taken at the Chief Executive's annual consultation meetings to raise awareness of fraud.
7. The IM&T business continuity systems recovery plan

4 RCAG noted:

8. That risk 274 *there is a risk that no Incident Control room (ICR) back up site will lead to service failure* will be mitigated when Events Control is established at Bow as it will incorporate a back up incident control room (ICR) function.

9. That the three risks on the Risk Register relating to CPD and training will be amalgamated and the new risk considered by SMG in June 09.

10. That although there has been a rise in reported incidences of fraud it was unclear as to whether this was due to an increase in fraudulent activity or simply that greater awareness had led to an increase in the number of incidents reported.

11. The contents of the six monthly claims report, October 2008-March 2009 which included the broad themes in areas that gave rise to employer liability claims against the Trust.

RCAG received the following minutes and noted the activity undertaken by the groups in monitoring/managing risks on the Risk Register:

Motor Risk Group, 5th March 09	Business Cont. & Steering Group, 9th March 09
Corporate Health & Safety Group, 14th April 09	Emergency Planning Strategy Group, 20th February 09
Vehicle Equipment Working Group 2nd April 09	Information Governance Group, 30th September 09
Clinical Governance Committee February and April 2009	

6. Recommendation That the Audit Committee NOTE the minutes of the RCAG.

Enclosure 16

LONDON AMBULANCE SERVICE NHS TRUST

RISK COMPLIANCE & ASSURANCE GROUP

2pm, Monday 18th MAY 2009

Present:	Peter Bradley	Chief Executive (Chair)
	Caroline Silver	NED (Chair of Audit Committee) via tele conference
	Beryl Magrath	NED (Chair of Clinical Governance Committee)
	Richard Webber	Director of Operations (until 3.10)
	Caron Hitchen	Director of Human Resources and Organisation Development
	Mike Dinan	Director of Finance
	Laila Abrahams	Interim Head of Governance
	Chris Vale	Head of Operational Support
	Christine McMahon	Minutes
In Attendance:	John Downward	IM&T (deputising for Director of IM&T)
	Maxine Ruff	Legal Services (deputising for Head of Legal Services)
	David Folley	LCFS Bentley Jennison
	Gary Douglas	LCFS Bentley Jennison
Apologies	Fionna Moore	Medical Director
	Peter Suter	Director of IM&T (until 3.20)
	Nicola Foad	Head of Legal Services

10/09 Minutes of the last RCAG meeting – 17th February 2008

Agreed: The minutes of the RCAG meeting held 17th February 2008

11/09 Matters Arising

Agreed:

1. Minute 03/09 that the following four risks which had been proposed for deletion/downgrading in February 09, should remain on the Register at their original risk rating as there was insufficient evidence to support deletion/downgrading.
   ID 249 loss of FRU cover due to inappropriate tasking
   ID 9 risk of RTA injury to persons travelling in an LAS A&E vehicle
   ID 269 at shift changeover times, LAS performance falls as we take longer to reach patients.
   ID 271 crew staff not in possession of valid driving licences for category of vehicle they are required to drive. ACTION: Interim Head of Governance to add the checking of drivers licences to the Internal Auditor's Plan 2009/10

Noted:

2. Minute 02/09 (1): the personal issue of C02 monitors to front line crews had been considered but was felt to be unnecessary as the issue had arisen due to a fault with the LDV ambulances which had been resolved.
3. Minute 02/09 (2): the Head of Communications said that the software had been acquired to enable the 70 articles featured in the LAS News, which highlighted the learning from SUIs, to be placed on the Pulse. This work was expected to be completed by the end of June 2009.
4. Minute 02/09 (3): the Director of Finance said that the reminder re. the proper usage of pool cars was being drafted. ACTION: Director of Finance
5. Minute 02/09 (4) Risk 292 will be proposed for deletion from the Risk Register in August 09. ACTION: Director of IM&T
6. Minute 02/09 (5): following consultation with Staff Side the Policy on Statement of Duty will be presented to RCAG/SMG for approval. ACTION: Head of Records Management/Head of Legal Services
7. Minute 02/09 (7): the Head of Operational Support said that following consultation with colleagues in the Legal and Training & Learning Departments the Trust was close to agreeing the wording for the daily inspection forms to record the vehicle daily

inspections to evidence that checks were being undertaken. Crews were required to undertake a preliminary road safety check of vehicles before driving vehicles and to do a more detailed vehicle check at some point during their shift. The form will be issued to crews by September 09. ACTION: Head of Operational Support

8. Minute 07/09: the Motor Risk Group in December 08 had proposed two new risks for the Risk Register concerning FRU driver training and conveyance of infectious or violent patients. RCAG did not agree to the two risks being added to the Risk Register as the Director of HR & OD said these risks had been discussed at a recent Corporate Health & Safety Group meeting where they were considered to have been addressed as:
   - recruits undergo full FRU driver training as part of their initial training; existing members of staff receive training on FRU as/when the need has been identified.
   - Existing staff receive familiarisation, assessment and further training if necessary.
   - members of staff were expected to undertake a dynamic risk assessment when treating patients who may be infectious or violent and not transport them if they deem it unsafe.

9. Minute 07/09: the Head of Operational Support said that the VEWG deferred consideration of changing the current metal scoop stretchers, which had been chosen for infection control reasons, for plastic stretchers (as used by HEMS). It was recognised that the use of metal scoop stretchers was not a clinical risk but was more a matter of patient comfort.

10 RCAG will receive a demonstration in August 09 of the Performance Accelerator and how it will enable the Trust to manage the Risk Register. ACTION: Interim Head of Governance.

12/09 Risk Register

Risk Register

RCAG reviewed the incomplete proposed Risk Register (including new components i.e. target risk setting).

The Chief Executive said that he wished the Risk Register presented to RCAG in August to be up to date, with no debates as to accuracy of comments etc. It was suggested that where possible the 'owners' of risk should attend RCAG to respond to queries raised by the Group. ACTION: Interim Head of Governance.

Agreed:

1. That risk 9 be monitored by Motor Risk Group & risks 31,138 and 207 be assigned to the Clinical Governance Committee to monitor.
2. That it was important that risks such as risk 279 (Pandemic) are up to date and reflect the mitigating action being undertaken by the Trust in March 09. ACTION: interim head of Governance/owner of risks

Noted:

3. That the Chairman of the Clinical Governance Committee wished Risk 250 be changed from treating paediatrics to treating children. ACTION: interim Head of Governance.
4. That risk 274 will be mitigated when Events Control is established at Bow as it will incorporate a back up Incident Control Room (ICR) function.
5. That the Risk Register (existing) was circulated for information.

Risks proposed for deletion & re-grading

Agreed:

6. That risk 295 be regraded from 6/moderate to 3/low and that it should remain on the risk register in order that the Group monitor it.
7. That risk 302 be regraded from 12/significant to 1/low and reviewed in six months time with deletion considered if it is no longer a risk for the Trust.

New Risks

Agreed:

8. That the three risks associated with training and CPD (266, 307 and the recently proposed risk 312) be amalgamated as one risk on the Register which will be presented to SMG in June for approval. ACTION: HR Director/ Interim Head of Governance

9. That new risk 313 should not be placed on the Risk Register. RCAG did not agree with The risk scoring, and considered that there were legal and commercial reasons why the mitigating action would not be viable.
10. That RCAG reviews new risks prior to their inclusion on to the Risk Register.

13/09 Presentation by David Foley – LCFS

David Foley, Local Counter Fraud Specialist, gave a presentation to RCAG, highlighting:

- That it has been estimated that between 4-8% of NHS Trust's budget was lost due to fraud.
- The role of Local Counter Fraud Specialist includes: creating an anti-fraud culture; prevention of fraud; deterrence of fraud; detection of fraud; investigation of fraud; to apply sanctions and seek address.
- That the following represented ongoing risks to LAS in respect of fraud: reputation of the Service; public confidence; staff morale; patient safety; security of assets; data security.
- That the role of the manage is as follows: to be aware of fraud issues; report concerns and systems weaknesses and secure information.

Agreed: 1. That the opportunity will be taken at the Chief Executive's annual consultation meetings to raise awareness of fraud.

Noted: 2. That the reported incidences of fraud have risen but it was unclear as to whether this was due to an increase in the number of frauds taking place or whether it was simply as a result of greater awareness and an increase in reporting.

14/09 Six monthly claims report, Oct 2008-March 2009

Noted: The contents of the report.

The report was presented by Maxine Ruff, Legal Services, who highlighted the following from the six monthly claims report that included the broad themes in areas that gave rise to employer liability claims against the Trust:

- **Staff claims:** 18 personal injury and 9 employment tribunal claims were opened in the second half of 2008/09, compared with 12 personal injury claims and 3 employment tribunal claims opened in the previous six months.
- **Lifting & handling claims:** of the 18 personal injury claims, 9 related to lifting & handling (5 claims received in the period April-September). Four claims made allegations about the use of a trolley bed.
- **violence & aggression:** no new claims were received in Oct. 08 – March 09.
- **Inoculation incidents:** one claim was opened where it was alleged that an injury was sustained from a cannula that had not been correctly disposed of as clinical waste.
- **Vehicles**: 6 claims were opened concerning use of vehicles and/or equipment on vehicles. In four of these claims it was alleged that carbon monoxide poisoning had been suffered.
- **Employment tribunals:** 12 employment tribunal claims received in 2008/09; compared to 13 in 2007/08.
- **Clinical negligence claims & inquests:** of the 566 inquiries by Coroner's Officers between Oct 08 and March 2009 in respect of inquests where the Trust was asked to provide documentary and/or oral evidence 14 requests were deemed to be contentious for the Trust and the opinion of the Medical Director sought.
- **Road traffic accident claims** (where the Trust is expected to have some financial liability): there was a reduction in reported accidents in the second year largely attributable to the decision to self insure found on inspection accident damage.

The claims frequency, based on the number of accidents per vehicle, increased from 119% in 2007/08 to 146% in 2008/09 (quarter one); these were benchmarked against four other ambulance services which ranged from 54% to 83%. It was suggested that a combination of

adverse weather conditions and the redesignation of low mileage vehicles to the non operational fleet had caused the accident frequency rates to rise.

The number of road traffic accidents reported per 10,000 activations on the A&E fleet continued to show a favourable trend. The insurance broker provided an analysis of the top five most expensive causes of accident:

- insured hit parked TP vehicle, £318,143;
- hit immobile property, £287,045
- junction collision, £172, 604
- traffic light collision, £129,311
- hit TP in rear, £181, 417

Clinical Negligence & Inquests

- A round table review of clinical negligence/contentious inquest files Oct-Sep 08 was conducted on 16th April 2009 to identify the individual and organisation learning and to recommend any further action to RCAG.
- The Head of Legal Services reported on the assurance received from colleagues to date that the recommendations made following two SUI which had arisen due to a caller's first language not being English (PSU OO08/08/SUI) and the conveyance of patients with mental health problems (PUS 0044/07/SUI) have been implemented.
- Two Clinical Updates on positional asphyxia and acute behavioural disturbance and awaiting the attendance of the Helicopter Emergency medical Services in case of trauma and major illness would be issued by the Medical Directorate.

Staff & public liability

- The Liability Claims Review Group (LCRG) held a conference on 30th April 2009 to review the individual and organisation learning from employer and public liability claim files closed between Oct. 08 and March 09 (details presented in appendices 6). The LCRG recommended that the ADOs for East and South should ensure that the LAS policies/procedures on the administration of NARCAN and the conveyance and handover of patient property to hospital staff is reinforced with their members of staff who were involved in the incidents that resulted in liability claims.
- With regard to the wider organisation learning LRCG recommended that the Head of Estates should ensure that contractors' compliance with the requirement to display cleaning in progress signs is monitored on an ongoing basis.
- In the instances where entry had been forced and property damaged staff had followed the Operational Procedure OP/017 – procedure on actions INDIRECTLY relating to patient, and no changes to the procedure were necessary or recommended.

15/09 IM&T business continuity systems recovery plan

Approved 1. The IM&T business continuity systems recovery plan

Noted: 2. The plan covers actions required by IM&T to

- acquire and configure hardware
- reload system(s) from off-site backups
- make network connections
- confirm recovery point(s) and integrity [with business owners] of the system(s)
- operates to agreed service levels.

16/09 **Update re. NHSLA including NHSLA Standards 08 – level 1 draft action plan**

Noted:

1. That a workshop will be taking place on 20th May to identify how the Trust progress the Action Plan to ensure the Trust successfully attains Level 1 NHSL Standards 08.
2. That the Trust will be seeking to demonstrate compliance with Level 2 circa May 2010 which will require it to evidence what it does rather than providing evidence of policies/procedures required at Level 1.
3. As part of the process the Trust is planning to meet with the NHSLA assessor on a

4. That changes to the type of NICE guidance will not come into effect until 2010/11 and the criterion will be assessed against **clinical guidelines** only for 2009/10. Trusts will be expected to update their documentation at Level 1 to take account of the changes to the minimum requirements. Relevant NICE guidance includes clinical guidelines, interventional procedures and technology appraisals. Organisations being assessed at Level 1 will need to demonstrate that the approved document contains details on each of these three guidance areas.

17/09 **Core Standards Declaration update**

Noted:
1. That the Trust's declaration re. compliance with core standards has been submitted.
2. That the Trust will require the support of NHS London in respect of the submission of the extenuating circumstances on why the Trust did not achieve the performance target of 95% for Category B.
3. That the Deputy Chief Executive was liaising with ORH to evidence the impact of delays at hospitals on the Service so as to provide NHS London with the data to support the contention of extenuating circumstances.

18/09 Reporting groups

A. **Corporate Health & Safety Group:**

Noted:
1. The contents of the minutes of CH&SG, 14th April 09.
2. The HR Director drew RCAG's attention to the following:
   - That over 90% of A&E staff had received Personal Safety Training
   - That industrial incident statistics were at an all time low
   - That Trevor Hubbard had been seconded as the Infection Control lead
   - That stab vest trial results had concluded that garments were fit for purpose
   - That the availability of the additional Mangar Elk lifting aids agreed and procured over and above the initial numbers for DSO vehicles has continued to be compromised. Charger units/leads were not initially procured, and when this was rectified there was doubt and concern as to their suitability. There have also been issues about the brackets to fix the equipment in the vehicles. This issue has been resolved for newer vehicles with further work required for older fleet.

B. **Motor Risk Group,**

Noted:
1. The contents of the minutes of the Motor Risk Group, 5th March 09.
2. The Finance Director drew RCAG's attention to the following:
   - A risk assessment on the risk of carbon monoxide exposure inside LDVs is being prepared following the implementation of necessary control measures advised by the Senior Safety and Risk Adviser and Head of Fleet.
   - The Director of Finance will seek agreement on setting a cost reduction target on RTA related costs.
   - The Counter Fraud Security Management Specialist will issue a bulletin on fraud arising from motor claims.
   - Workshops to improve the processes for reporting and investigating RTAs were being undertaken; the first workshop was held on 30/4/2009.
   - That the most expensive and frequent cause of accident was hitting a parked vehicle.
   - That priority was being given to conducting FRU familiarisation in driver training; AOMs have been asked to ensure that all eligible staff were released to complete the training.
   - That representatives from Training & Development and Procurement have been asked to review and make recommendations on the arrangements for conducting driver training.

C. **Vehicle & Equipment Working Group (VEWG)**

Noted:

1. The contents of the VEWG's minutes, 2nd April 2009.
2. The Head of Operational Support highlighted the following:
   - That pedi-mate child harnesses were being issued with the new Mercedes Ambulance equipment
   - That the roll out of the first 35 new Mercedes Ambulances had been delayed by supplier and quality issues
   - That a user guide for the new 515 ambulance will be available on the Pulse
   - That the Stryker Trolley Bed was being put on all new vehicles following a successful evaluation
   - That 25 new PTS stretcher vehicles have been delivered
   - That Michelin had been appointed as the tyre supplier to the Trust

D **Business Continuity Steering Group (BCSG)**

Noted:

1. The contents of the minutes of the BCSG, 9th March 09
2. The Finance Director highlighted the following:
   - A successful limited call-taking test took place at Fallback on 4/12/08 but the planned full test on 21st April & the revised date of 12/13 May did not take place. A full test will not now take place before September due to Airwave training.
   - Department plans were successfully reviewed on 5th February. Only representatives from Resource Centres (Gareth Hughes), CBRN (Marc Rainey) and Patient Experiences (Gary Bassett) were unable to attend. A report will be compiled and taken to SMG.
   - The Purchasing BC tabletop exercise took place on 16/12/08 and the test of Finance's BCP took place on 24/2/09. Staff Support had another exercise on 7/4/09 and the Safety & Risk test followed on 8/4/09
   - An overall Severe Weather Plan was being drafted rather than separate plans for snow, flooding, drought etc.
   - A report on fuel supply was being drafted for consideration at the next BCC meeting.

E **Information Governance Group – 30th September 08**

Noted: The contents of the summary of the Information Governance Group minutes, 29th April 09; the minutes were not available for the meeting.

- Encryption for laptops had been completed. Encryption for USB keys has been delayed because of problems with the software but these have now been resolved and should be in place within the next four weeks.
- The FOI Summary Report for 08/09 showed that:-
  - 155 requests were received during the period, compared with 119 the previous year – an increase of 30%.
  - Compliance with the 20 day deadline was at 91.6%.
  - Exemptions were applied in 15 cases
  - Fee limit was exceeded in 16 cases
- At the last meeting it was recommended that the LAS adopt the NHS guidance for a protective marking scheme. The Trust has been informed that all NHS ambulance trusts, as Cat 1 responders, are required to adopt the Civil Contingencies Secretariat (CCS) Scheme, rather than the NHS scheme. In the meantime work is taking place to identify current use of protectively marked documents throughout the Trust and when the situation is resolved a new proposal will be made to the Group and SMG.

- The Information Governance Toolkit submission was completed at end of March.
  - The Trust faired well and maintained an average of 90%.
  - Improvements have been made but increasing effort is required to meet requirements year on year.
  - The IGT must be reviewed quarterly for v7 submissions as opposed to annually which is the current arrangement.
- Following a meeting held on 31st March work on the PRF project to implement the recommendations agreed by SMG in August 2008 was now moving forward again with Peter McKenna as project executive.
- Funding has now been released for The Intelligent Trust (Sharepoint) Project and work will shortly commence with our consultants on the development of the corporate information architecture.

F **Emergency Planning Strategy Group**

Noted: The contents of the EPSG's meeting held on 20th February 2009.

G **Clinical Governance Committee, Feb & April 09**

Noted:

1. The contents of the CGC's minutes for February and April 2009.
2. The Chairman of the Committee drew RCAG's attention to the following:
   - That future Area Governance reports include graphic comparisons with previous reports/ years and concentrate on exception reporting
   - That the ADO East will conduct an annoymised case study and place on the Pulse once completed
   - That the Internal Auditors will be asked to conduct a morphine audit
   - That Dr. Tom Evans will be invited to the CGC meeting in August (now revised to July)) to discuss V.A.S. (Voluntary Ambulance Services), in particular governance, quality assurance, education and training and any other issues of significance.
   - That all clinical policies/procedures will be presented to staff-side for review/comment before presentation to CGC for approval/ratification.
   - That training of current staff lagging behind that for new staff; this will become SMG standing item with NEDs taking this forward at Trust Board level.
   - That the following new risks approved for recommendation to RCAG for addition to Risk Register:
     - Required drugs/equipment not being available in drug packs/on vehicles leading to patients not receiving appropriate treatment;
     - Similar packaging of Glucose and Sodium Chloride may result in administration of incorrect drug, causing patient harm;
     - Re-packaging of Glucose or Sodium Chloride to be considered to ensure easy identification and prevent administration of incorrect drug.
   - That an "Audit trail" will be created for all SUIs. Head of Patient Experiences to propose mechanism for reporting incidents as part of SUI policy.

19/09 Date of next meeting: 14.00, 17th August 2009, conference room, HQ.

Meeting finished at 3.45pm

17 Audit Committee Work Plan and Timetable for 2009/2010 meetings – Please note: 2010 dates are proposed dates only.

LONDON AMBULANCE SERVICE NHS TRUST
Work-plan & timetable of Audit Committee meetings for 2009 & 2010

Enclosure 18

Proposed Date of Meeting	Date for Distribution of Papers	Final Date for Receipt of Papers for Inclusion	Date for Review of Audit Database by GDU	Date for Request for Papers for Committee	Date Draft Agenda to be Sent to Chairman for Approval	Anticipated Agenda Items
8 June 09	1 June	28 May	Week commencing 18th May	18 May	11 May	• External Audit Plan 2008/09 • Annual Accounts** • Internal Audit Progress Report for current year • Assurance Framework • Standing Items Report • Audit Recommendations Database • Report of the Local Counter Fraud Specialist • HCC & NHSL update
7 September 09	28 August	25 August *	Week commencing 17 August	17August	10 August	• **Annual Audit Committee Report** • Progress report External Audit Plan 2008/09 • Internal Audit Progress Report for current year • Standing Items Report • Assurance Framework • Audit Recommendations Database • Report of the Local Counter Fraud Specialist • Assurance Framework • NHSLA/HCC update • External Audit Management Letter
9 November 09	30 October	27 October	Week commencing 19 October	19 October	12 October	• Full financial review including 20010/11 budgetary process (TBA) • MD's direct reports in attendance for discussion with Audit Committee. (TBA) • Bentley Jennison to audit the benefits realisation process, as requested by CS

Proposed Date of Meeting	Date for Distribution of Papers	Final Date for Receipt of Papers for Inclusion	Date for Review of Audit Database by GDU	Date for Request for Papers for Committee	Date Draft Agenda to be Sent to Chairman for Approval	Anticipated Agenda Items
8 March 2010	1 March	26 February	Week commencing 16 February	19 February	8 February	• Audit Commission Progress report for 2009/10 & audit plan for 2011/12 • Internal Audit Plan 2010/11 and progress report for current year • Standing Items Report • Audit Recommendations Database • Report of the Local Counter Fraud Specialist and plan for 200 • HCC update • Annual Audit Committee report (to May TB)
7 June 2010	28 May	25 May	Week commencing 17 May	11 May	8 May	• External Audit Plan 2009/10 • Annual Accounts - 2009/10 • Internal Audit Progress Report for current year • Assurance Framework • Standing Items Report • Audit Recommendations Database • Report of the Local Counter Fraud Specialist • HCC & NHSL update
8 November 2010	29 October	26 October	Week commencing 18 October	18 October	11 October	• Full financial review including 20011/12 budgetary process (TBA) • MD's direct reports in attendance for discussion with Audit Committee. (TBA) • Bentley Jennison to audit the benefits realisation process, as requested by CS

* Committee's work schedule to be reviewed to take account of the recommendations contained in the Audit Committee Handbook and the Governance Review

** This item may not be ready for distribution with main set of papers due to potential difficulties with timing of sign-off/agreement

18 Any other business