London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO BE HELD IN PUBLIC ON TUESDAY 24th MARCH 2015 AT 09.30 - 12.30 CONFERENCE ROOM, 220 WATERLOO ROAD, LONDON, SE1 8SD

AGENDA: PUBLIC SESSION

	ITEM	SUBJECT	PURPOSE	LEAD	TAB
09.30	1.	**Welcome and apologies for absence** Apologies had been received from: Paul Woodrow			
	2.	**Declarations of Interest** To request and record any notifications of declarations of interest in relation to today's agenda		RH	
	3.	**Minutes of the Part I meeting held on 27TH January 2015** To approve the minutes of the meeting held on 27th January 2015	Approval	RH	TAB 1
	4.	**Matters arising** To review the action schedule arising from previous meetings	Information	RH	TAB 2
09.45	5.	**Report from the Trust Chairman** To receive a report from the Trust Chairman on key activities since the last meeting	Information	RH	ORAL
	6.	**Report from Chief Executive** To receive a report from the Chief Executive	Information	FM	TAB 3
QUALITY GOVERNANCE AND PERFORMANCE REPORTING					
10.00	7.	**Quality and Safety** To receive reports and assurance on the quality and safety of the service 7.1 Quality Report - January 2015 7.2 Clinical Directors' Joint Report - February 2015 7.3 Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile	Assurance	ZP/ FW/ MW	TAB 4
	8.	**Integrated Board Performance Report - February 2015** To receive the integrated board performance report	Information	PW	TAB 5
	9	**Board Assurance Framework and Corporate Risk Register** 9.1 To receive the Board Assurance Framework and Corporate Risk Register for Quarter 3 9.2 Report from the Audit Committee on 2nd February 2015	Assurance	SA JJ	TAB 6
	10.	**Finance Report – February 2015** To receive the finance report for month 11, 2014/15 10.1 Finance Report Month 11 10.2 Report from Finance and Investment Committee on 19th March 2015	Information and Assurance	AG NM	TAB 7 ORAL

STRATEGIC AND BUSINESS PLANNING					
11.00	11.	**Recruitment and Workforce update** • Retention Strategy • Staff Survey 2014 Action Plan • To receive an update on the recruitment programme and other workforce issues	Approval Information Information	MG MG KB	TAB 8 PRESENT-ATION ORAL
	12.	**IM&T Strategy** To approve the IM&T Strategy	Approval	AG	TAB 9
	13.	**2015/16 Integrated Business Plan and 5-year workforce and finance plan update** To note the progress on the 2015/16 Integrated Business Plan	Approval	AG/KB	PRESENT-ATION
BUSINESS ITEMS					
12.00	14.	**Board Declarations – self certification, compliance and board statements** To approve the submission of the Board declarations for March 2015	Approval	SA	TAB 10
	15.	**Report from Trust Secretary** To receive a report on use of the Trust Seal and tenders received	Information	SA	TAB 11
	16.	**Trust Board Forward Planner** To receive the Trust Board forward planner	Information	SA	TAB 12
	17.	**Register of Interests** To note the register of interests	Information	SA	TAB 13
	18.	**Questions from members of the public**		RH	
12.25	19.	**Any other business**		RH	
	20.	**Meeting Closed**			
	21.	**Date of next meeting** The date of the next Trust Board meeting is 2nd June 2015			

LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING IN PUBLIC

DRAFT Minutes of the meeting held on Tuesday 27th January 2015 at 09:00 a.m.
in the Conference Room, 220 Waterloo Road, London SE1 8SD

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Present:	
Richard Hunt	Chairman
Fionna Moore	Interim Chief Executive
Fergus Cass	Non-Executive Director
John Jones	Non-Executive Director
Bob McFarland	Non-Executive Director
Nick Martin	Non-Executive Director
Theo de Pencier	Non-Executive Director
Andrew Grimshaw	Director of Finance and Performance
Jason Killens	Director of Operations
Zoe Packman	Director of Nursing and Quality
In Attendance:	
Sandra Adams	Director of Corporate Affairs/Trust Secretary
Karen Broughton	Director of Transformation and Strategy
Mark Gammage	Interim Director of Human Resources
Mark Whitbread	Director of Paramedic Education and Development
Paul Woodrow	Director of Performance *(items 1-8 only)*
Brenda Thomas	Committee Secretary
Members of the Public:	
Malcolm Alexander	Chair of the London Ambulance Service Patients' Forum
Evening Standard Reporter	Member of the public
Members of Staff:	
Anna Macarthur	Communications Manager

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01. Welcome and Apologies

01.1 Apologies for absence had been received from Jessica Cecil and Fenella Wrigley.

02. Declarations of Interest

02.1 There were no declarations of interest in matters on the agenda.

03. Minutes of the Board meeting held on 16th December 2014

03.1 The minutes of the meeting held on 16th December 2014 were approved subject to amendment to the attendance list to include Andrew Grimshaw as present at the meeting.

04. Report from the Trust Chairman

04.1 The Chairman gave an update on activity since the last Trust Board meeting and noted the following:

- Ann Radmore, the former Chief Executive of the London Ambulance Service (LAS) Trust, had left the Trust on Friday 23rd January 2015 to take up a new role with NHS England. The Chairman welcomed Fionna Moore to her first meeting in her role as Interim Chief Executive, and wished her every success on behalf of the Board. He further noted that the substantive appointment would require a full public appointment process, which had not yet commenced;
- The Chairman also welcomed Mark Gammage, Interim Director of Human Resources to his first Board meeting;

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- The Chair had spent some time in the control room on New Year's Eve and said that it had been a privilege to spend time with the staff working that night, and he noted that there was a definite change in the pressure level compared to previous New Year eves;
- The Chair had visited the East and South sectors with the Assistant Directors of Operations and planned to visit the West sector. He had also visited a number of Emergency departments and observed the Hospital Liaison Officers in action at some of the more challenging departments.
- The Chair had met with NHS Trust Development Authority a number of times which he believed would continue.

05. Quality and Safety

Quality Dashboard for October to December 2014

05.1 Zoe Packman reported that the Quality dashboard had been discussed at the Quality Governance Committee meeting and she noted the following:

- The data had been prepared and presented two months in arrears, with the timing and submission proving quite challenging during 2014;
- Data completeness had been an issue of concern, firstly in regards to data received from the operational areas due to operational pressures and secondly in regards to a number of the metrics where data had not been populated in the dashboard since its inception;
- Significant elements were missing from the dashboard in terms of trend analysis, patterns, and external benchmarking with other Ambulance Trusts, as only in-month data was provided.

05.2 Zoe outlined the key actions that were being taken to address the various issues relating to the dashboard:

- Work was underway with the performance team and the subject matter experts to redesign and refresh the dashboard and ensure that the data presented was one month in arrears, showed a trend analysis and in the fullness of time had the capacity to be benchmarked externally. In addition, work was on-going to either review the data set to allow collection or to identify the data source and ensured this was accessed in a timely fashion.
- It was envisaged that the first version of the new dashboard would be available in February 2015 with work currently being undertaken to design and automate the process and to discuss the form and content with key stakeholders, for example the Commissioners.

05.3 The Board noted the key headlines for October and November 2014.

05.4 The Chairman noted that the report stated that the Trust had not been meeting the standard target for CPI completion, although the standard of quality remained high. Zoe Packman explained that the Trust's sample size was smaller than planned and that samples were randomly taken; the results showed that when completed, standards were very good.

05.5 *Is the Board satisfied that the safeguarding process is working adequately during the period of significantly raised pressures on the LAS?(Question from the Patients' Forum)*

05.6 Zoe Packman responded that there was a very strong and robust safeguarding referral process in place and that the Trust had very good relationships with Local Authorities; and crews take the process very seriously. It was further noted that quality and safety were maintained regardless of the operational pressure and that there was a mandatory stand down for front line crews when a safeguarding issue had been identified and needed reporting;

05.7 Malcolm Alexander asked whether the resources were adequate for the job. Zoe Packman responded that in terms of safeguarding referrals, resources were adequate and that the Trust wanted to work towards an electronic referral system.

05.8 Bob McFarland noted that there were two columns on safeguarding in the dashboard, with the ratio

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of referrals being all green for the months of October and November and pink for December, and sought clarification as to the reason for the difference. Zoe Packman explained that one of the columns showed the Clinical Performance Indicators, and the second provided assurance that referrals were being made. She noted that the new dashboard would resolve the problem of reporting the same thing in a slightly different way.

05.9 In response to Bob McFarland's question on patients' conveyance and safeguarding, Zoe Packman responded that sometimes, patients get referred multiple times, and that a way forward was for the crews to identify with the A&E staff whether safeguarding referrals had been made at that point. Zoe noted that this was a particularly complex area, especially in the case of a patient with mental health difficulty, as referrals would not be made without meeting the Local Authority safeguarding threshold, whereas the LAS crews would.

05.10 The Chairman noted that the report should be made more Board-specific in terms of the information that was required to be focused on.

05.11 Paul Woodrow reported that the Integrated Board Report would encompass all the information currently reported for quality and clinical indicators, with robust commentary and data. Jill Patterson had been working with the relevant teams developing the integrated report, which was intended to be ready for 2015/16 and would present more consistency in the information provided and allow for continual review.

Clinical Quality and Patient Safety Report

05.12 Fionna Moore noted the following:

- Although CPI (Clinical Performance Indicators) completion had fallen significantly over the past months, CPI compliance remained high, demonstrating excellent patient care. Compliance in the Mental Health CPI had improved to 90% and above;
- The Serious Incident reporting process was more robust and was being reported on a timely basis to both the Executive Management Team (EMT) and the Trust Board;
- Increase in the use of Surge, with daily use of Surge Red since the beginning of October and the implementation of Surge Purple and then Surge Blue for the first time during December 2014;
- A concern surrounding the number of Patient Report Forms (PRFs) being submitted without illness code, which presented a risk that a PRF was not auditable via the CPI system. This will continue to be reported to the EMT in the coming months.

05.13 *In relation to calls referred to Hear and Treat, is the Board satisfied that a robust clinical audit system is in place to ensure that patients have been appropriately categorised?(Question from the Patients' Forum)*

05.14 Fionna Moore responded that a robust clinical audit system was in place, and that Hear and Treat was undertaken in two ways: Medical Priority Dispatch System (MPDS) triage and the Clinical Hub using the Manchester Triage System. Fionna was satisfied that appropriate categorisation was being met and was also satisfied that there was a good quality assessment process in place on a sample of calls.

05.15 The Board also noted that the Trust had recently regained its Centre for Excellence accreditation, which was lost 3years ago.

05.16 The Chairman suggested that Chris Hartley-Sharpe should be invited to the Quality Governance Committee to discuss CPI completion and quality governance of the voluntary responders. In addition, the Chairman noted that significant improvement was required in the CPI completion and recording of illness codes.

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05.17 **Action:** ZP to invite Chris Hartley-Sharpe to the next Quality Governance Committee meeting to present on CPI completion and quality governance of voluntary responders.

Date of Completion: 14th April 2015

05.18 Theo de Pencier asked whether the issue of drug shortage was due to production problems or due to the Trust's inability to forecast demand and whether the issues in the UK were similar to the US. Fionna Moore and Mark Whitbread responded that this was due to the limited number of manufacturers (only two currently), therefore more of a production issue and that the challenges were different in the two countries.

05.19 Andrew Grimshaw suggested that a review of the critical drugs should be undertaken, and where there was a reasonable shelf life, the shortage could be mitigated by holding more stock and any further issues identified and dealt with.

05.20 **Action:** The Clinical Directors to review the critical drugs with a view of mitigating shortage.
Date of completion: 15th April 2015

05.21 Mark Whitbread assured the Board that the Trust was fully compliant with all NICE guidance, and in a number of areas ahead of their requirements, which was an important achievement from a clinical point of view and noted that NICE was evidenced based.

05.22 *Will the Board review its approach to complaints investigation in light of the recent report of the Health Select Committee on complaints investigation and outcomes? (Complaints and Raising Concerns Fourth Report of Session 2014–15) (Question from the Patients' Forum)*

05.23 Zoe Packman responded that there had been a number of reviews on complaints and complaints modelling following The Francis Review. As these reviews are being published, organisations have the responsibility to change or refresh their processes. The LAS was compliant with all the areas highlighted in the report and significant changes would not be required, as the Trust already had a robust complaints process in place, with the CEO or Director of Nursing and Quality signing off on all complaints.

05.24 Nick Martin questioned whether there had been an improvement in the process in recent years to which Zoe Packman responded that there had been improvements in the complaints process, although the Trust had not yet reached a level of timely response. She noted that one of the areas that accounted for the slow response times had been the depth and quality of the response which had been well received by complainants and by the Ombudsman.

05.25 Zoe Packman and Sandra Adams confirmed that the quality assurance system supported complaints and serious incidents and were aware that the level of resource required was under review.

05.26 Jason Killens confirmed this was being actioned and that an external organisation had been commissioned to model the control services staffing requirement which included quality assurance. The report was due in February 2015.

05.27 The Chairman noted that complaints could give some warning signs of issues that may emerge later and should be kept under review, with an understanding of the levels of complaints. He further noted that the Board would require an in-depth understanding of the difference between the Resourcing Escalatory Action Plan (REAP) levels and Surge Plan.

05.28 **Action:** Jason Killens to present on the difference between the REAP levels and Surge Plan at the Strategy and Review Planning meeting.

Date of Completion: 24th February 2015

05.29 The Board noted the Clinical Quality and Patient Safety Report and proposed actions.

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06. Industrial Action

06.1 Jason Killens gave an update on the proposed Industrial action and noted the following:

- Formal notification to take NHS wide strike action over a national pay dispute had been received from Unison for a 12 hour strike on 29th January from 12:00hrs to 00:00hrs and from GMB for a 24 hour strike from midnight 28th January to midnight 29th January;
- About 80% of all staff in operations are in a trade union;
- The Trust was planning for a potential loss in frontline capacity of 50% from midnight on Wednesday 28th January to midday on Thursday 29th January and complete loss of frontline capacity from midday to midnight on Thursday 29th January;
- As previously, exemptions had been locally agreed with trade unions to not call on specific staff groups to take strike action;
- Life and limb cover arrangement had been agreed with both Trade Unions. This meant that staff on the picket line could be recalled to duty under certain circumstances to respond to emergency calls.
- Contingency arrangements had been planned to arrange an emergency ambulance service response. These contingency arrangements would be supported by the Military, the Metropolitan Police and the NHS, who would be trained and ready to be deployed across the period of strike action.
- Disruption was possible starting from 27th January, due to the movement of a significant portion of the operating ambulance fleet to locations away from the Trust's estate;
- Restoration of normality would take longer than the two previous occasions, due to the duration of the strike action, the level of contingency arrangements and the scale of the fleet movement;
- Regular talks were being held with the Trade Unions to ensure that a level of contingency operation was in place and that both sides were sighted on these plans and arrangements.

06.2 The Chairman emphasised that this was a national dispute, not an LAS issue and therefore advised that the Trust was required to manage this position recognising this.

06.3 John Jones and Nick Martin noted that there were financial implications which could be significant should there be further strike actions. Jason Killens confirmed that an announcement had been made by the Trade Unions to take further strike action at the end of February, although the scale and duration remained unclear.

06.4 The Board acknowledged the effort that had been put in to ensure that the contingency arrangements were in place and to provide for the scale of the training commitment, and thanked all the staff that had been involved in the process.

06.5 Theo de Pencier asked whether the communication to the public had a significant effect in terms of demand from the previous industrial action. Jason Killens responded that a reduction in demand had not been seen as a result of media campaign on the two previous occasions of strike action; however, a two-way communications process had been agreed with partners and a message had already been sent out to the public, with further planned coverage to serve as a reminder. Fionna Moore added that primary care had been contacted through NHS England (London) to explore the possibility of increasing primary care facilities - for example, GPs having walk-in appointments.

06.6 Bob McFarland sought clarification on the life and limb cover and asked whether core staff might not be available to cover emergencies. Jason Killens responded that the contingency arrangements would be the third layer of response, with the first layer being the use of 40 private ambulances that would be deployed to the sickest patients and the second layer being ambulances driven by the police or the military. Jason however noted that it was less likely this time to have staff on the picket line for the third layer of response due to the duration of the strike and the shift patterns.

06.7 The Chairman asked Jason whether he was content that those agreements being established with

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the Unions were effectively communicated down to those participating. Jason Killens responded that the lessons learned from the previous two strike actions had been used to inform current arrangements and that the document that contained the life and limb cover arrangements, had been circulated to all operational staff, and included in the various LAS media. In addition, adjustments had been made to annual leave arrangements and a personal letter from Jason had been sent out explaining the arrangements in place and informing staff of where to access these documents.

06.8 Fionna Moore noted the amount of time and planning involved for a 24 hour period of strike action and that it was a completely different challenge to previously. She further noted the cooperation from the military, the Metropolitan Police and the NHS England, which had been significant.

07. <u>Infection Prevention and Control Annual Report</u>

07.1 Zoe Packman reported that there was a requirement for all NHS organisations to submit an annual report from the Director of Infection Prevention and Control (DIPC). Due to the time that had lapsed between the year end and the presentation of the report, an addendum to the report had been provided to reassure the Board that progress had been made in a significant number of areas.

07.2 Zoe recognised that the submission was late and reported that a contingency plan had been put in place to ensure that the annual report would be submitted in June/July for 2014/15.

07.3 Zoe drew the Board's attention to a number of areas of good practice and that other areas had been identified for further action and learning. The actions in a number of the higher risk areas had been completed.

07.4 Of particular note was the standard and robustness of the procedures for management and conveyance of patients with suspected Viral Haemorrhagic Fever, particularly in terms of the protective gear which had been one of the difficult areas internationally. A report would be produced on the calls made and the number of patients conveyed at the end of the financial year.

07.5 The Board noted that the report was disappointing; however, significant progress was being made with a conscious effort directed at dealing with the issues.

07.6 *Can the Board provide assurances that blankets used for individual patients in ambulances are never reused for other patients?(Question from the Patients' Forum)*

07.7 Zoe Packman responded that there were occasions when a patient may have been cold and a blanket placed over their outer clothing and that the blanket had then been reused if it had not touched the patient's body. Crews were reminded that blankets are single use items.

07.8 Malcolm Alexander noted that reports had been received regarding multiple reuse of blankets and asked whether this amounted to an infection control risk. Zoe Packman responded that the Infection Prevention and Control task force would focus more on this issue and that infection control would remain on the agenda going forward.

07.9 John Jones noted that risk 327 (There is a risk that the Trust does not follow Department of Health Guidelines for the reuse of linen) had not been included in the Trust's risk register even though it had a score of 16, which classified it as a high risk.
Sandra Adams responded that a review of the risk was to be undertaken.
[DN: this was later confirmed in the meeting to be an old risk that was showing within the 2013/14 Infection Prevention and Control report but had since been mitigated to a lower level of risk as per the current risk register]

07.10 Theo de Pencier sought reassurance on whether contractual arrangements would allow the Trust to change contractors for underperformance. Andrew Grimshaw responded in the affirmative and noted that the general approach was for the Trust to set the appropriate standards.

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08. Integrated Board Performance Report

08.1 Paul Woodrow reported the following:

- Month 9 had proved to be the most challenging month of the 2014/15 financial year so far resulting in significant pressure on the Trust including the week ending 11th December seeing the LAS respond to 11200 Category A incidents. This pressure was seen nationally across the ambulance sector and the wider NHS;
- The principal driver for the Trust in terms of performance was the significant and unprecedented increase in Category A activity, which was monitored to identify whether there was a spike in demand or a step change in activity;
- Month 9 saw a 7.6% increase in Category A activity, with 5.5% contractual uplift in activity and seasonal variation included in the forecast;
- As a result of these challenges, the Trust had moved to level 5 of the national REAP plan, which was a significant escalation and remained at that level throughout month 9;
- The clinical hub dealt with over 18000 calls, the highest number of calls, since its inception;
- Significant and sustained level in the surge management plan was seen throughout month 9 with the lower acuity calls managed in a different way. The priority, however, was to focus and target existing resources to high acuity patients;
- The level of complaints exceeded the target level;
- Training was deferred, as part of overall planning for Christmas and New Year period, to maximise resources;
- The Trust was reporting £0.3m adverse to plan and £1.2m adverse to plan for the year to date;
- There was a reduction in the level of CPI completion rate due to the requirement of the Trust, particularly at REAP 5, to put as many clinical staff in patient facing roles to deal with the level of demand;
- Figures for workforce metrics remained fairly static, with a reduction in the number of leavers and slight increase in the overall vacancy rate, with the Trust aiming to recruit 199 staff across quarter 4;

08.2 The Chairman asked whether there were notable reasons why Emergency Ambulance Crews (EACs) failed their exams. Mark Whitbread responded that the two main reasons was that they failed their C1 driving test, which was done externally and was a requirement for ambulance drivers to have on their licence and secondly, the first exam, module D of the clinical pathway exams, was being failed twice. Mark however noted that there was a tendency for a slight increase in the number of failures when mass recruitment was undertaken. Karen Broughton added that the action plan was to look at the reasons why a number of EACs are failing their exams and take corrective action.

08.3 Paul gave an update on performance for the week ending 25th January:

- Actual performance was 61.24%, against a trajectory of 61.93%; however PRFs were yet to be validated and this figure could rise;
- The Trust had been on trajectory for the previous two weeks;
- The Performance Improvement Board would review the programme and make recommendations for actions to achieve sustainable performance against the trajectory going forward.

09. Plan to implement national pilot changes to clock start performance and determinant categorisation

09.1 Jason Killens gave a verbal update as follows:

- The Secretary of State for Health announced on Friday 16 January 2015 that NHS England was to pilot a possible change to the way ambulance services respond to 999 calls.
- Currently, ambulance services are allowed 60 seconds for Red 2 calls before the clock starts, to decide the right response for patients. This sometimes led to ambulances being dispatched unnecessarily so that fewer ambulances are available for patients who really

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needed emergency assistance.

- The London Ambulance Service (LAS) and South West Ambulance Service NHS Foundation Trust (SWAS) are the chosen sites for this pilot. The LAS uses the MPDS, whilst SWAS uses Pathways, therefore the impact would be assessed using these two different triage tools.
- Call handlers would be allowed a maximum 180 seconds (the current 60 seconds allowed plus an additional 120 seconds) to assess a call. Giving call handlers extra assessment time would therefore ensure that ambulances are better deployed to where they are most needed and would allow a faster response time for those patients who really need it. This would not however include those calls which are immediately life threatening (Red 1 calls).
- Under this proposal, 8 potentially life-threatening codes would be moved from Red 2 to Red 1 to support clinical safety and a more rapid response.
- The implementation proposed for mid-February, would be informed by the outcome of the modelling currently underway and expected to report on Friday 6th February.
- A number of teams were being used to support preparation - IT, CAD support, control services, Communications, Medical Directorates and associated clinical colleagues.

09.2 A very detailed set of monitoring metrics would be reported to the EMT and the tripartite arrangements in London and at the end of the pilot. Together with SWAS, a review would be undertaken of the impact of the changes.

09.3 Fionna Moore stated the importance of gaining an understanding of the benefits for the patients moved from Red 2 to Red 1 and the likely impact of the additional 120 seconds for Red 2 patients and whether there could be any disadvantage as a result of the additional pressure on the service to respond to a large number of patients.

09.4 Jason Killens responded in the affirmative, in response to the Chairman's question of whether the differential of moving from 60 seconds to 180 seconds for Red 2 calls was technically achievable and explained the process involved, which was noted.

09.5 Nick Martin asked whether there were any other changes or suggestions to make changes to categorisation, particularly with category C. Fionna Moore responded that some work had been done around whether some of the target within the Red 2 calls could have a slightly longer duration, but which had not yet progressed.

09.6 Fergus Cass asked how the Trust would recognise whether the pilot had been successful. Jason Killens responded that 3 groups of measures would be collectively looked at through the pilot period - numbers in terms of response times standards (reduced cancellations, reduced MAR, better use of resources), monitoring qualitative outcomes of the patient and clinical impact.

10. Board Assurance Framework and Corporate Risk Register

10.1 Sandra Adams reported that the Board Assurance Framework had been updated in January 2015, and noted the changes since November 2014.

10.2 Risk 388 (There is a risk that increase in turnover rates may lead to frontline staff reducing by significant numbers impacting the Trust's ability to deliver safe patient care) had been escalated to the EMT and had been reviewed again by the subject matter expert. An error was noted in that the gross score was higher than the net score. In addition, significant number of actions had taken place and assurances in place to bring the risk level down.

10.3 Bob McFarland noted that risk 8 (Equipment on Ambulance) had been on the BAF for a long time which suggested that proper analysis or an action plan had not been in place to take this forward. Andrew Grimshaw responded that a report had been submitted to the Finance and Investment Committee on 26th January 2015, with a deep dive carried out. He further noted that this represented an action within the performance improvement plan and that clear actions were being developed with responsibilities and time frames. An initial report would be submitted to the Quality Governance Committee to provide assurance that the issues were being addressed.

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10.4 **Action:** Andrew Grimshaw to submit a report to the Quality Governance Committee on risk 8 (Equipment on Ambulance)

Date of Completion: 14th April 2015

10.5 The Board noted the Board Assurance Framework and Corporate Risk Register.

Audit Committee Report

10.6 John Jones noted the Audit Committee met on the 10th November 2014 and a further meeting was convened on 16th December 2014 at which the auditors had been present. The following was noted:

- A report had been received on progress against the internal audit recommendations;
- At the last Audit Committee, there were 33 outstanding recommendations, which had increased to 34. The 7 high priority recommendations were discussed in some detail and there was some assurance that activity was ongoing. However, these were being closely monitored, with the objective of bringing the number of recommendations down to acceptable levels.
- Progress report would be discussed at the 2nd February Audit Committee meeting.

10.7 The Board noted the Audit Committee report.

11. Quality Governance Assurance Report

11.1 Bob McFarland noted the following:

- That there had been a reorganisation of working arrangements;
- The current quality dashboard structure does not provide the necessary assurance, but was under review as the Board had noted earlier in the meeting;
- The Committee was reassured by the report from the external clinical safety review that the LAS was providing a clinically safe service;
- The Committee was aware of the CQC inspection in June and noted that any issues identified relating to quality and safety among others that are within the system should be dealt with prior to the inspection.

11.2 The Board noted the Quality Governance and Assurance report.

12. Finance Report

Finance Report (month 9)

12.1 Andrew Grimshaw noted that the Trust was moving away from trajectory in the financial plan, due to additional resources to support capacity and improve performance. The Trust was on track to deliver a reduced surplus of £1m and all capital spend would have been completed by the year end. The Trust had more cash than anticipated; however, however it was anticipated that this would be resolved by the year end. There is a risk around the potential number of strikes/ industrial action and the resulting costs.

12.2 The Chairman asked whether the Trust was required to fund the additional costs for strike action. Andrew responded that it depended on the scale of the pressure this presented to the Trust. This was being monitored and would continue to be raised with the Commissioners, TDA and NHS England and confirmed that funding would be required externally.

Financial and Business Planning Process 2015/16

12.3 Andrew Grimshaw reported the following:

- The first submission of the draft plan to the NHS Trust Development Agency (TDA) was done on 13th January 2015 following publication of guidance by the TDA, Monitor and NHS England (London);
- Major issues were currently being worked through with the Commissioners and NHS England;
- Work was in progress to address the efficiency requirement, as all NHS organisations are required to achieve a 3.8% efficiency;

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- The next date for submission was 27th February 2015, for which plans were in place and adequate approval would be sought through the EMT, Board Assurance processes and Board sign off on 24th February 2015. The Trust was working proactively with Commissioners and NHS England on Contracts;
- The final submission was due in April, prior to which the Trust Board sign off was required at the 24th March 2015 Board meeting.

12.4 *How much did the LAS spend on hiring independent contractors to provide emergency care during 2014-15 compared with 2013-14?(Question from the Patients' Forum)*

12.5 Andrew Grimshaw responded that this would be referenced against private ambulance provision in support of emergency work and that the cost included equipped vehicles and staff. For the 2013/14 financial year, the Trust spent £9.1m. In the year to date (9months), the Trust had spent £5.5m. The projected spend by the year end would be marginally higher than the previous year.

Report from Finance and Investment Committee (FIC)

12.6 Nick Martin reported as follows:

- The Trust was on track to meet the £1m surplus although there remained some risks;
- The draft financial plan for 2015/16 had been discussed - the challenge of having over 85% utilisation rate and shortages in frontline staff would require a much higher level of recurrent funding going forward from 2015/16 and had to be properly addressed;
- The FIC was recommending for approval a second batch of new ambulances;
- A strategic review was to be undertaken of the longer term requirement in the fleet;
- An analysis of useful equipment and out of service situations was carried out, with a number of planned actions for quarter 4.

12.7 The Chairman asked whether Nick was happy that the Finance and Investment Committee was now moving in the right direction in terms of its agenda. Nick Martin responded in the affirmative and mentioned that as part of the review of the financial plan, a Finance and Investment Committee meeting would be held prior to the Board.

12.8 The Chairman noted that the Committees were improving their processes and ways of working, dealing with issues, and reporting back to the Board. Andrew Grimshaw also mentioned that a quarterly fleet performance update had been agreed and that work was being carried out in terms of reshaping of responsibilities and reviewing of all reporting lines within the organisation.

13. Recruitment and workforce update

13.1 Karen Broughton gave a presentation to update the Board on recruitment and noted that the starting profile of national paramedics had altered with candidates choosing to complete training in March opposed to January. 79 EACs were currently in training and would join the Trust between January and March 2015. 15 of the 79 EACs joined operations on 19 January 2015. 105 international paramedics had indicated they wished to join the LAS in quarter 4.

13.2 Karen reported that she had presented at the Migration Advisory Council on why paramedics should be added to the shortage of occupation list, which would give more flexibility in moving paramedics from across the world much quicker and easier and was hopeful of a positive outcome.

13.3 The Chairman asked whether the LAS, being the initiators of paramedic recruitment from Australia, was the right step or whether the Trust could have taken more ownership of this channel with the other ambulance trusts having to seek assistance from the LAS or whether this was not possible. Karen Broughton responded that the Trust had good relationships with universities in Australia that other ambulance trusts do not yet have and that other Trusts could not be prevented from carrying out international recruitment. She noted that the international paramedics joining the Trust would serve as ambassadors for other paramedics.

13.4 Karen Broughton noted that work was underway in setting up some specific arrangements with some of the international paramedic schools and that rotation between countries was being considered.

Chair's initials……..

13.5 The Chairman noted embedding internationals into future resourcing plans, with consideration given to cross secondments and offering bursaries and scholarships in due course, as examples.

13.6 Theo de Pencier noted that a good driver psychometric testing was available which would determine whether an applicant would become a good driver or not. This could then be used as a screening process for EACs, as the Trust would have an early insight into whether EACs might fail their C1 driving test.

13.7 Fergus Cass noted that the scale of recruitment presented a big opportunity for the Trust to make a significant impact on the proportion of the various groups in the workforce where concerns had been raised in the past that the Trust was not mirroring the London population and asked whether the Trust was putting an effort into this and how success would be monitored.
Karen Broughton responded that monitoring would be done with the next batch of recruitment and mentioned that there had been a discussion on how to make use of Community Involvement Officers, while Zoe Packman noted opportunities for working with Job Centres and Job Centre Plus.

13.8 Mark Gammage noted that a Retention Strategy was being drafted in consultation with senior management, with a focus on staff morale. This draft document would be presented for approval at the 24th March Trust Board.
The Chairman noted that staff morale should be one of just a few objectives to be prioritised in 2015/16, and recognised that the Board would support this and treat it as a priority.

13.9 Nick Martin noted that the Listening into Action surveys report had not yet been seen, even though he had earlier made a request for it. Nick further noted that consideration should be given to more staff surveys to determine whether the actions that were being taken were effective.

13.10 **Action:** Mark Gammage to circulate to the Board the report of the Listening into Action surveys.
Date of Completion: 10th March 2015

13.11 Bob McFarland noted that the South Central Ambulance Service carry out ride outs systematically, with written reports and not ad hoc. The LAS could consider emulating this. The Chairman responded that this would be included in personal objectives for 2015/16.

14. eAmbulance Strategic Outline Case

14.1 The Board approved the eAmbulance Strategic Outline Case for submission to the TDA for approval, as the overall potential value of the investment exceeded the Trust's delegated limit for approval.

15. Fleet Replacement Business Case

15.1 The Board approved the Fleet Replacement Business Case for submission to the TDA for review and approval, as the value of the investment exceeded the Trust's delegated limit for approval.

15.2 Andrew Grimshaw confirmed that a Fleet Strategy was being developed.

16. Report from Chief Executive

16.1 The Chairman noted that the preparation for the CQC inspection should be embedded in the Trust's objectives, with an agreement on the priorities and focus. Zoe Packman reported that a task group had been set up to ensure that standards are met and that the EMT was being very supportive.

16.2 Sandra Adams reported that, following publication of the Dalton Review, the TDA had reviewed the likely timetable for the Foundation Trust (FT) application process and was recommending that the LAS be classified as A3. This meant that the LAS was seen as likely to progress to FT status with some intensive support from the TDA.

16.3 The Board noted the report from the Chief Executive.

Chair's initials……..

17. Charitable Funds annual report and accounts

17.1 The Board noted that a discussion on the sustainability of the charitable funds (how to evolve, develop and resource) would be had in future.

17.2 The Board approved the Charitable Funds annual report and accounts for 2013/14 and the Chairman would sign these off.

18. Board Declarations - Self certification, compliance and board statements

18.1 The Board approved the Board Declarations for January 2015.

18.2 Andrew Grimshaw suggested taking this to the EMT to consider how to evidence and report compliance and which committees would provide assurance on these. This would then become part of governance and assurance process.

19. Trust Board Report

19.1 The Board noted the Trust Secretary report.

20. Forward Planner

20.1 The Chairman suggested having a fundamental review of the forward planner to have a more objective evaluation to reflect what the Board should be driving.

20.2 **Action:** Sandra Adams to review the forward planner
Date of completion: 24th March 2015

21. Questions from members of the public

21.1 The questions from the Patients' Forum had been answered under earlier agenda items with the exception of question 5 (*Is the Board satisfied that clinical care provided by independent sector is adequate and are PRFs being submitted in line with LAS policies?),* for which a formal response would be sent to the Patients' Forum.

21.2 **Action:** Sandra Adams to provide the response for the Patients' Forum
Date of Completion: Completed

22. Any Other Business

22.1 There were no items of other business.

23. Date of next meeting

23.1 The next meeting of the Trust Board is on Tuesday 24th March 2015 at 09.30am in the Conference Room, Waterloo.

……
Signed by the Chair

Chair's initials……..

ACTIONS

from the Public meeting of the Trust Board of Directors of
LONDON AMBULANCE SERVICE NHS TRUST
held on 27th January 2015

Meeting Date	Minute No.	Action Details	Responsibility	Progress and outcome
27/01/15	**05.17**	ZP to invite Chris Hartley-Sharpe (CHS) to the next the Quality Governance Committee meeting to present on CPI completion and quality governance of voluntary responders.	**CHS**	Jason Killens had informed CHS to present at the 14th April Quality Governance Committee meeting. Brenda Thomas to include on the agenda.
27/01/15	**05.20**	The Clinical Directors to review the critical drugs with a view of mitigating shortage.	**FW/ ZP/ MW**	
27/01/15	**05.28**	Jason Killens to present on the difference between the REAP levels and Surge Plan at the Strategy and Review meeting on 24th February 2015.	**JK**	Complete
27/01/15	**10.4**	Andrew Grimshaw to submit a report to the Quality Governance Committee meeting on 14th April 2015, on risk 8 (Equipment on Ambulance).	**AG**	
27/01/15	**13.10**	Mark Gammage to circulate to the Board the report of the Listening into Action surveys	**MG**	
27/01/15	**20.2**	Sandra Adams to review the forward planner.	**SA**	Complete
27/01/15	**21.2**	Sandra Adams to provide the response to question 5 for the Patients' Forum.	**SA**	Complete

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**24th March 2015**
Document Title:	**Chief Executive Report**
Report Author(s):	**Adam Levy, Business Manager**
Presented by:	**Fionna Moore, Interim Chief Executive**
Contact Details:	**Adam.Levy@lond-amb.nhs.uk**
History:	**N/A**
Status:	**Information**

Background/Purpose

This report covers the following items:

- **Devolution of Health and Social Care budget and responsibilities in Greater Manchester**
- **Morecambe Bay Investigation and Report**
- **NHS Vanguard sites**
- **Freedom to Speak Up Report**

Action required

To note.

Assurance

Key implications and risks arising from this paper

Clinical and Quality	
Performance	
Financial	
Legal	
Equality and Diversity	
Reputation	
Other	

This paper supports the achievement of the following 2014/15 objectives	
Improve patient care	
Improve recruitment and retention	
Implement the modernisation programme	
Achieve sustainable performance	
Develop our 111 service	
Simplify our business processes	
Increase organisational effectiveness and development	

CHAIRMAN AND CHIEF EXECUTIVE REPORT TO THE LONDON AMBULANCE SERVICE (LAS) TRUST BOARD MEETING HELD ON 24 MARCH 2015

1. Devolution of Health and Social Care budget and responsibilities in Greater Manchester

Following work done by The King's Fund, it was announced that Greater Manchester will have its £6bn health and social care budget devolved from the region's 10 councils, 12 CCGs and 14 NHS providers to a single body covering the whole of the area. One of the primary aims of 'Devo Manc' is to pull all of the elements of health and social care into a more joined up system where it is easier to coordinate care around individual needs.

However, a major concern highlighted by Healthwatch and others is how any single body will be held accountable and in particular how much decision making authority local councillors will be given over Health monies. There is also the question of how the new system will manage given the financial challenges faced by both Local Councils and the NHS.

Much of the detail of how the system will work is yet to be agreed but if progressed as expected will represent a major new approach to how Health and Social Care is delivered.

2. Morecambe Bay Investigation and Report

The Morecambe Bay Investigation was established by the Secretary of State for Health in September 2013 following concerns over serious failures of carein the maternity department at Furness General Hospital. The report looking into this was published on 3 March 2015 and makes 44 recommendations for that Trust and the wider NHS. Whilst the investigation was centred around Morecambe Bay, the majority of the recommendations actually fall to the whole NHS system, including some relevant to the LAS including:

- Introducing the duty of candour for all NHS professionals and includes the involvement of patients and relatives in the investigation of serious incidents.
- A duty should be placed on all NHS boards to report openly the findings of any external investigation into clinical services, governance or other aspects of the trust.
- A fundamental review of the NHS complaints system is required
- Clear national standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels.
- Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers.

The full report can be found here.

The LAS Consultant Midwife will undertake a review of the investigation and report her view on particular areas of learning to the Quality Committee.

3. NHS Vanguard sites

NHS England has announced the first 29 'vanguard' sites that will look to transform the way that care is provided across England. The sites, which have been selected from over 260 organisations and partnerships which expressed interest, supported by the New Care Models Programme will look at ways of providing more joined-up, personal care for patients and also try to increase efficiency. This programme of initiatives is seen as one of the first major steps towards delivering the NHS Five Year Forward View.

The initiatives are grouped into three categories:

- Integrated Primary & Acute Care Systems – joining up GP, hospital, community and mental health services
- Multispeciality Community Providers – moving specialist care out of hospitals into the community
- Enhanced Health in Care Homes – offering older people better, joined up health, care and rehabilitation services.

The initiatives are taking place across the country with 2 based in London:

- Tower Hamlets Integrated Provider Partnership (Multispeciality Community Providers project).
- Sutton CCG (Enhanced care in care homes)

More information on the London vanguard projects and others across England can be found here.

4. Freedom to Speak Up Report

On 11 February Sir Robert Francis published his report on the Freedom to Speak Up review. The report, which can be found at http://freedomtospeakup.org.uk/the-report/ was set up in response to concerns about the way that NHS organisations dealt with concerns raised by NHS staff. The report sets out 20 principles which are categorised into the following groups:

- Culture Change
- Better Handling of Cases
- Measures to Support Good Practice
- Particular Measures for Vulnerable Groups
- Extending the Legal Protection

Following the publication of the report, David Flory, Chief Executive of NHS TDA, sent a letter to all NHS Trusts emphasising the importance of listening to staff and acting on their concerns. This letter has been sent on to all managers in LAS from Fionna Moore. Sandra Adams, Director of Corporate Affairs, is leading the Trust's response to this report.

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**24th March 2015**
Document Title:	**Clinical Directors' Joint Report**
Report Author(s):	**Zoe Packman, Director of Nursing and Quality**
Presented by:	**Zoe Packman, Director of Nursing and Quality**
Contact Details:	**Zoe.packman@lond-amb.nhs.uk**
History:	**N/A**
Status:	***Information and Approval***

Background/Purpose

On appointment the Interim Director of Nursing and Quality was asked to

- Review and evaluate current quality governance processes
- Work with other Clinical Directors to build agenda for Quality Governance Committee and evaluate effectiveness of feeder committees

During December 2014 and January 2015 this has involved reviewing the current quality dashboard and the committee structure which supports the Trust Quality Governance Committee. This paper describes those changes and the feedback from the key stakeholders.

March 2015 is a transition month between the current quality reporting and the revised changes. Due to the time in the month of the meeting the February 2015 data is not available therefore the February 2015 dashboard is not able to be presented. In order to assure the Trust in regards to clinical safety and quality an updated version of the January dashboard has been appended to this paper. A review of information presented in January 2015 has been undertaken and where February 2015 information is available that will be presented.

Attached for information is the letter from David Flory, Chief Executive of the NHS Trust Development Authority, requiring action by Trusts to address the recommendations from the NHS Investigations into Jimmy Savile and the Kate Lampard Lessons Learnt Report. Trusts are required to respond by 31st May 2015 so action will be identified and implemented and brought to back to the Trust Board in line with the deadline.

Action required

Trust Board to formally approve changes to the quality governance reporting committee structure
Trust Board to acknowledge changes to the quality dashboard and reporting
Trust Board to receive updates on January 2015 information
Trust Board to receive quality information for January 2015 and updates on for February 2015

Assurance
Quality information for the period January – February 2015 Proposals to strengthen the quality governance reporting lines into the Trust Board

Key implications and risks arising from this paper	
Clinical and Quality	**X**
Performance	**X**
Financial	
Legal	
Equality and Diversity	
Reputation	**X**
Other	**X**
This paper supports the achievement of the following 2014/15 objectives	
Improve patient care	**X**
Improve recruitment and retention	
Implement the modernisation programme	
Achieve sustainable performance	
Develop our 111 service	
Simplify our business processes	
Increase organisational effectiveness and development	**X**

LONDON AMBULANCE SERVICE NHS TRUST

Clinical Directors' Joint Report – 24th March 2015

1. Background

On appointment the Interim Director of Nursing and Quality was asked to

- Review and evaluate current quality governance processes
- Work with other Clinical Directors to build agenda for Quality Committee and evaluate effectiveness of feeder committees

During December 2014 and January 2015 this has involved reviewing the current quality dashboard and the committee structure which supports the Trust Quality Governance Committee.

A draft of the new dashboard was presented in January 2015 and feedback has been received on this from both internal and external stakeholders. Presented with this paper are an updated version of the January 2015 dashboard and a summary of the stakeholder comments and requirements and the proposed next steps.

Following attendance at the Clinical Safety, Development and Effectiveness Committee, safety element and clinical safety and standards element it was agreed by members of those committees and the Clinical Directors that from April 2015 the following changes would be enacted:

The Clinical Safety, Development and Effectiveness Committee in its current format will cease to exist and will be replaced with three stand-alone committees:

1. Safety – chaired by Medical Director – deputy chair either Director of Paramedic Education or Director of Nursing & Quality. The Medical Director will determine the frequency of meeting and preferred title of the meeting
2. Development and Education – chaired by Director of Paramedic Education – deputy chair either Director of Nursing & Quality or the Medical Director. The Director of Paramedic Education will determine frequency of meeting and preferred title of the meeting
3. Effectiveness and Experience committee – chaired by Director of Nursing and Quality deputy chair either Director of Paramedic Education or the Medical Director.

This paper is presented at that meeting and it is proposed that in future this meeting will be bi monthly and it will be re-named Improving Patient Experience.

It is proposed that the three meetings then provide an exception report and their minutes to the Quality Governance committee for scrutiny and assurance.

The quality dashboard will provide the quantitative information to be shared at the committees and will be the single source of quality data. It will be available after the 14th of each month and the meeting schedule will need to be finessed to support this.

The meetings will be supported by a series of feeder committees and or papers from relevant subject matter experts. The final detail of this will be confirmed during March 2015.

The dashboard will be presented at each committee with a supporting paper highlighting the exceptions to be noted and scrutinised at that committee.

This will culminate in the dashboard and a combined paper being presented at the Quality Governance meeting.

Furthermore the dashboard and its paper will be shared with the Commissioners at the monthly Clinical Quality review group (CQRG) meeting and the Trust Development Authority (TDA) at the Integrated Delivery meeting.

2 Quality Dashboard

Following feedback from stakeholders, internal and external, a variety of improvements have been piloted in regards to the Quality Dashboard, its content, reporting timeframes and narrative.

Stakeholder feedback

Feedback form the TDA, NHS England London and Commissioners has been received and actioned. An update was provided to CQRG on the 27 February 2015 clarifying that the following points were being progressed:-

- All of the metrics are now available for review only one month in arrears.
- Trend lines have been included.
- A data governance template is in development establishing every metric source, description, methodology and identified keeper of the data where appropriate.
- Further information will be included within the report covering various elements such as name and contact details of data source owner, standard refresh/update rate, benchmarks, numerators and denominators.
- An overarching executive level summary will form part of the report highlighting key areas for focus and actions to be undertaken.
- More detailed sub sets of different data items for different purposes and audiences reflecting specific areas of practice can be extracted.
- RAG ratings for each indicator will be considered.
- External benchmarking against other ambulance trusts to help identify comparatives is an important factor we are reviewing and aim to progress at the earliest opportunity
- Inclusion of more care bundles has been suggested especially for those where LAS performance is below peers and we would propose it is equally important to reflect where LAS performance is above peers.
- Following feedback a review of the domains to which each metric is currently allocated will be undertaken.
- There will be a review of the value of including those indicators that are historically extremely infrequent.
- Escalation to boroughs of specific issues/concerns would remain unchanged.
- A glossary will be developed and attached to support external partners understanding of the report

Next steps/actions required

- Each metric is currently being reviewed with the appropriate teams to ensure the measures are correct and any duplication is extracted.
- To date this has been completed with Clinical Audit Research Unit (CARU) and this will be applied to February's dataset with CARU supporting direct input of data ensuring a single data source is applied across each of their metrics.
- A similar process will be undertaken with Human Resources to ensure reporting on the correct measures, drawing from the correct data source.

- Where applicable targets will be applied to each of the metrics – based on commissioned levels of service, national quality indicators etc. The dashboard will be rag rated so that visually areas of under and over performance are easily identified.
- Meeting and data reporting schedules are currently not congruent resulting in both incomplete data sets being reviewed and data that is historical beyond a period of one month alignment of this will be facilitated.

3 Quality report March 2015

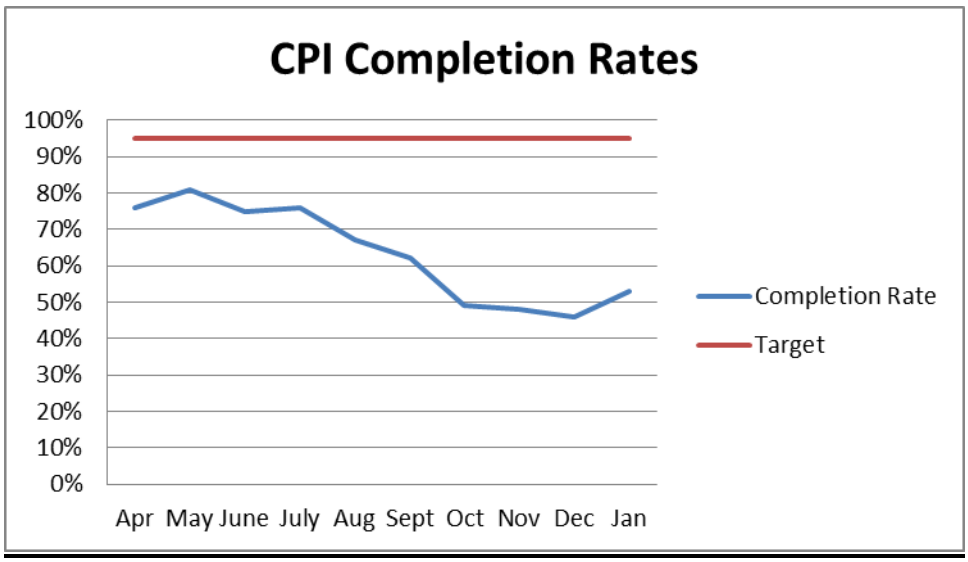
March 2015 is a transition month between the current quality reporting and the revised changes. Due to the time in the month of the meeting the February 2015 data is not available therefore the February 2015 dashboard is not able to be presented. In order to assure the Trust in regards to clinical safety and quality an updated version of the January dashboard has been appended to this paper. A review of information presented in January 2015 has been undertaken and where February 2015 information is available that will be presented.

4 January 2015 update

4.1 Clinical Performance Indicator completion and compliance

The CPI completion rate has been falling since June, but had an increase during January 2015. The compliance level now sits at 53% Trust wide. This is an increase of 7% on the last reported month (December 2014). All areas saw an increase in completion, which they should be congratulated on. The poor compliance to audits being undertaken is mainly due to the performance pressures, as team leaders are spending the majority of their time patient facing and not in the office.

Five complexes (Newham, Fulham, Croydon, St Helier and HART) achieved over the agreed target of 95% completion which they should be congratulated for. A number of complexes however, fell far below the desired completion rate, with Motor Cycle Response Unit and Chase Farm having a completion rate of 0%, Edmonton 3%, Bromley 11%, Wimbledon 12%, Deptford 16% and Barnehurst 22%.



CPI Completion April 2014 to January 2015

Area	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan
East	71%	71%	62%	72%	65%	70%	60%	52%	51%	57%
South	79%	91%	79%	73%	62%	62%	49%	37%	39%	43%
West	76%	77%	79%	80%	71%	54%	38%	55%	51%	59%
LAS	**76%**	**81%**	**75%**	**76%**	**67%**	**62%**	**49%**	**48%**	**46%**	**53%**

CPI Compliance January 2015

Area	Cardiac Arrest	Glycaemic Emergencies	ACS	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	98%	97%	97%	98%	91%	97%	97%
South	97%	96%	96%	95%	92%	97%	98%
West	97%	97%	96%	96%	87%	96%	96%
LAS Total	**98%**	**96%**	**96%**	**96%**	**90%**	**96%**	**97%**

CPI Compliance December 2014

Area	Cardiac Arrest	Difficulty Breathing	ACS	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	98%	92%	95%	96%	87%	97%	96%
South	98%	94%	96%	96%	89%	96%	98%
West	98%	95%	96%	97%	89%	95%	96%
LAS Total	**98%**	**94%**	**96%**	**96%**	**88%**	**96%**	**97%**

CPI compliance remains >95% against most clinical care standards, but mental health has fallen below this threshold. Only Croydon and HART complexes were above the expected care standard under the Mental Health audit. The aspects of care requiring improvement were the documentation relating to whether there are safeguarding concerns for the patient, and the patient's appearance.

Care for Cardiac Arrest patients remains consistently high.

The compliance to the non-convey audit fell to 96% in December and has remained at this level in January 2015.

Romford, Whipps Cross, Isleworth, Croydon and HART complexes should be congratulated for their compliance of >95% to all audits.

4.2 PRFs submitted without illness or injury codes

This was previously reported flagged as a concern. The Assistant Directors of Operations for each area were contacted and asked for action plans to begin to rectify this issue.
Action Plans submitted:

- Admin teams at each complex will visually scan the PRFs for missing illness and injury codes

- PRFs without an illness/injury code will be removed and given to an authorised (CTL/DSO/Training Officer/Registered restricted duties staff) for them to add the illness code.
- A photocopy will be made of the PRF and feedback given to crew staff. This will be recorded locally.
- An in-cab briefing will be written and placed in all ambulances reminding staff of the importance of these codes.
- The issue of missing codes will be placed into the Team Talk update (local level) next month.

Clinical Audit and Research have also been asked to put a poster together to be sent to each station highlighting the issues when illness or injury codes are not present.

4.3 Time on scene for STEMI

Previous reports highlighted a small increase in time spent on scene with patients suffering an ST-elevation Myocardial Infarction. Following a discussion with Mark Whitbread, no action needs to be taken at present, but this will be closely monitored and reported to EMT if the position changes.

4.4 Theft of a Paramedic Bag

The theft of an Advanced Paramedic Practitioner (APP) bag was reported to police, and widely reported in London media. The theft was during a call that the APP was attending. The items inside the bag were replaceable equipment but with some considerable value. This is now being dealt with by the police and the legal department.

4.5 Medicines Management

1 Controlled Drugs (CD) / General Drugs

i/ There have been no reportable CD incidents since the last report. However, in late December 2014, the LAS did receive by accident 4 boxes of S-Ketamine instead of the usual racemic ketamine, (the difference being that S-ketamine is twice as potent as racemic ketamine). The fact was drawn to the Trust's attention by Frimley Park Hospital Pharmacy who contacted us as soon as they realised they had supplied us the wrong strength of ketamine. The boxes were sequestered at Deptford, and have since been returned to Frimley in exchange for the correct strength of ketamine.

ii/ There has been one incident involving general drugs. On 23rd Jan 2015 a crew administered 1g of paracetamol via the IV route and noticed that a piece of the rubber bung had "cored" back into the bottle. The piece was approximately 2-3mm in length. The IV infusion was stopped and alternative analgesia provided. No harm came to the patient and the incident has been reported to B Braun UK, Frimley Park Pharmacy and LAS Safety and Risk. There was no danger to the patient as every giving set used has a micro filter in the chamber and is designed for just such an eventuality. B Braun UK report that this is the first episode for this product that they have had reported to them, likewise Frimley Pharmacy. The LAS uses approx. 950 units of IV paracetamol a month and this is the first instance of its type reported to us. It is a known possibility with any drug vial / bottle that utilises a rubber bung. The Chair of the MMG and the Assistant Medical Director (East) have fully investigated and are of the opinion that this is one off episode and that it is likely to occur very rarely, and the equipment that the LAS utilises for managing IV infusions is appropriate to manage this risk.

iii/ The Chair of MMG has issued, via the Clinical Section of the RIB (2nd Feb), advice to staff regarding “spice” which is a synthetic cannabinoid sprayed onto various herbs and then smoked. The effects can be much more potent than ordinary cannabis. Anecdote is suggesting that it is gaining in popularity, in particular with the Prison system as it is difficult to detect. Treatment is symptomatic, there is no antidote.

2 Medicines Management Group (MMG)

The next meeting is on 11th March 2015 at LAS HQ. Due to the retirement of the Chair of the MMG, Tim Edwards, Consultant Paramedic and Dr. Neil Thomson have been approached to take on the position of Chair and Vice Chair respectively. The membership of the MMG will be informed of this decision before the next meeting and both Mr. Edwards and Dr. Thomson will be invited to the March meeting.

As previously highlighted there are still two medicines supply issues still affecting the Trust. One is for the supply of hydrocortisone, the other for the supply of rectal diazepam (Stesolid). These two drugs are not high use drugs by LAS staff. Unfortunately there are no other manufacturers that hold UK licences for these two drugs – thus we cannot easily substitute like-for-like. The interim supply measures detailed in previous reports still stand and will remain in place until supplies are regularised again.

3 Drug errors

There has been one reportable drug error brought to the attention of the Medical Directorate and the Medicines Management Group (MMG). This involved the incorrect administration route for the drug (Morphine Sulphate). There was no harm to the patient, and no further action is required. This was also documented via an LA52 incident report.

4.6 Equipment Failures

There has been one reported incident regarding an equipment failure. This involved a laryngoscope bulb failure during use on a paediatric patient in cardiac arrest. This did not have a negative impact on the patient as a replacement laryngoscope was used within seconds of the failure. This was also reported via the LA52 incident reporting system.

4.7 Clinical Team Leader Conferences (CTL)

Four CTL conferences are booked and planned for the coming two weeks. These will give an update on the operations re-structure, the changes to the CTL role and a clinical update for half the day. The clinical update will focus on:

- **CQC** – The upcoming CQC visit and key ways that the CTL group can assist with this inspection and the impact they can have. This will be a key engagement process for this group of staff who may identify risks and achievements that haven’t yet been considered. This group of staff are especially important due to the close working relationship they have with both local management teams and operational staff.
- **Sepsis** – A discussion on the importance of Sepsis recognition. This follows a field safety notice on this issue and the requirement to design a sepsis recognition tool.
- **Advanced Life Support** – A practical update will be given on the recent changes to ALS, and will ensure that CTLs are giving the most appropriate advice and treatment to their staff and patients.
- **Nursing in the LAS** – a discussion surrounding the potential role for nurses within an ambulance service, how LAS have been progressing this to date and the elements of care that they are responsible for. There will also be a brief update on frequent callers, important as CTLs are often local level leads for this difficult group of patients.

- **Clinical Audit and Research Unit** – a presentation on the recent audits and research being undertaken by CARU. Of note, there will be information surrounding the Paramedic2 trial.
- **Medical Director** – The Medical Director will give a short presentation about the directorate and it's structure and then some key messages:
    - **Incident reporting and escalation**
    - **Learning from Serious Incidents**
    - **National CPIs, specifically Single Lower Limb fractures requiring immobilisation and documentation of distal pulse.**

4.8 Structure of the Medical Directorate

The Medical Directorate has had some significant changes recently, and these will continue over the coming months.

David Whitmore is retiring at the end of March 2015 after 35 years in the Ambulance Service. This will be a significant loss to the directorate, although David has agreed on a temporary basis to provide some cover on a bank contract.

Both Assistant Medical Director Positions have been advertised, one as a secondment to cover Neil Thomson who is acting up to Deputy Medical Director; and one a permanent position to replace Peta Longstaff who leaves at the end of April 2

4.9 Serious Incidents

5 new SIs were declared during January:-

- 3 x delayed response
- 1 x missed diagnosis
- 1 x LAS vehicle involved in an RTA

5 February 2015

A Responsiveness

1 Surge Plan February 2015

Surge Red has been in place within the Trust since early October 2014 due to the performance pressures and the high numbers of calls being held continually in London. Despite Surge Red being in place 24 hours a day, Surge Purple and Surge Blue have also been in place on a number of occasions.

As the Surge level increases, the associated level of risk also increases. The use of Surge Red has enabled the Trust to respond to the higher priority calls within the required timeframe. However, the Trust has seen some extended delays for lower priority calls, as well as delays for some of the higher priority calls when no available resources have been identified.

Following a revision of Surge, an observation was made that there were a number of elements within Surge Purple which didn't appropriately address the number of calls being held, and the continual incoming call volume. With this in mind, Surge Purple (Enhanced) was written and implemented.

Surge use April 2014 – January 2015

Month	Number of occasions Surge increased (above normal working)	Surge Pre-Amber (hours)	Surge Amber (hours)	Surge RED (hours)	Surge PURPLE Upwards (hours)
April	10	**Winter Working / Surge Amber**		36.25	0
May	18	**Surge Amber**		112.25	0
June	26	**Surge Amber**		217.25	11.5
July	26	**Surge Amber**		347.5	16.25
August	28	**Surge Amber**		401.75	0
September	26	**Surge Amber**		404.5	24.75
October	5*	**Surge Amber**		**Surge Red**	30.0
November	10*	**Surge Amber**		**Surge Red**	64.75
December	26*	**Surge Amber**		**Surge Red**	275.75
January	4*	**Surge Amber**		**Surge Red**	34.25
February	**8***	**Surge Amber**		**Surge Red**	**30.5**

*The number of occasions that Surge was invoked is not a true representation of this information as the Trust has been continually operating at Surge Red from the beginning of October, and Surge Amber prior to that.

2 Open and Honest Care

NHS England made a commitment in January 2015 that the London region will join the Open and Honest Care: Driving Improvement Programme.
The aim of the Programme is a central part of NHS England's commitment to making more information available about the quality of care in the NHS. The overarching aims are to ensure that every patient receives high-quality care and to build improved services for the future.

The Open and Honest Care: Driving Improvement Programme is intended to support organisations to become more transparent and consistent in publishing safety, patient and staff experience and improvement data, using clear definitions in a format that is easy to understand. The programme began in the North in December 2013 with 23 Acute organisations publishing monthly reports. Subsequently the programme has advanced with the development of Community and Maternity metrics, and there are currently thirty two organisations in the North publishing monthly acute, community and maternity reports. An independent evaluation of the programme in the North has demonstrated that it is a highly valued part of the NHS improvement strategy, which facilitates ward based staff to identify areas for improvement, empowers them to act and contributes to a culture of learning across their organisations.

Midlands and East region have recently signed up to the programme, with 15 early implementers planning to publish information on their websites within the next three months. A group of early implementer Mental Health organisations in the North are also currently working together to develop a set of mental health metrics and a reporting template.
NHS England are asking for organisations across London to identify themselves as early implementers, publishing monthly reports on their websites using an agreed template. The current metrics being reported on are largely not applicable to an Ambulance trust and therefore in the programmes current stage of development it has been confirmed that the LAS are not envisaged to participate. It may be that in future an adapted and relevant quality measure may be developed.

B Effective

1 Clinical Audit and Research

i/ Cardiac
The Monthly Cardiac Arrest and ST-Elevation Myocardial Infarction Reports (Cardiac Care Pack) for January 2015 have been published.

The full report is available upon request.

Key Findings:

- 30% of cardiac arrest patients that had resuscitation commenced, gained and sustained ROSC (Return of Spontaneous Circulation) until arrival at hospital. This percentage includes all arrest rhythms. This is a slight decrease (1%) on the previous month.
- 98% of the advanced airways placed during a cardiac arrest had end-tidal CO2 measured and recorded. 10 patients had no ETC02 noted and no printout of the waveform included with the PRF.
- 100% of STEMI patients attended by the LAS were transported to the most appropriate destination.
- Overall call to arrival at hospital time for STEMI decreased to 74 minutes during December. The length of time on scene remains high at 45 minutes (a decrease of 1 minute). Both of these figures are higher than expected and continue to require monitoring.
- The number of patients receiving the full STEMI care bundle increased to 78%.

ii/ Stroke
The monthly Stroke report for January 2015 has been released.

The full report is available upon request.

Key findings:

- 97% of stroke patients received the expected full pre-hospital care bundle.
- 98% of stroke patients had the time of onset of symptoms recorded, or documented that this time was unknown.
- 99% of FAST positive patients were conveyed to the most appropriate destination.
- The average on scene time remains longer than the recommended 30 minutes, currently 36 minutes. However, the time spent on scene once a conveying resource arrived on scene (not just the first resource) was 29 minutes.
- The percentage of patients who were eligible for thrombolysis and arrived at a stroke unit within 60 minutes has increased to 58%

iii/ Trauma
The quarterly Major Trauma Care Pack for Q2 2014 has been released.

The full report is available upon request.

Key Findings:

- 1282 major trauma patients were attended by the Trust between July and September 2014.
- The average on-scene time for major trauma is 40 minutes; 32 minutes for a conveying resource. By mechanism, the on-scene time for blunt injuries is 36 minutes, and for penetrating injuries is 16 minutes.
- 84 patients were conveyed to a major trauma centre despite the major trauma tree not indicating that it was required.

C/ Safety

1/ NHS Central Alerting System

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

In total during February 2015 there were 8 CAS alerts. None were of relevance to the Trust but all have been noted.

2/ NHS Signals

Key risks emerging from review of serious incidents reported by the NHS to its National Reporting and Learning System (NRLS) are shared in the form of Signals. There have been no alerts in 2015.

3/ Serious Incidents

3 x serious incidents were declared during February:

- 1 x missed diagnosis
- 1 x joint Metropolitan Police and LAS, delayed response
- 1 x delayed response

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

The trust has not received any prevention of future deaths reports since the last report

4 Infection Prevention & Control (IPC)

i/ IPC Governance

The governance structure for IPC has been reviewed and was enhanced. A new monthly operational meeting the IPC taskforce has been established and had its inaugural meeting in February 2015. The taskforce will feed into the IPC quarterly committee to provide which will continue to be the assurance conduit for the Trust Board.

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ii/ Compliance with Hand hygiene

Self-audits (based on the 5 moments) undertaken by operational staff showed high compliance at 95%; data submission has improved this month with only 2 complexes not

returning data. Data capture for IPC performance data for PTS, Community Responders, specialist teams and VAS/PAS services, will commence in April 2015.

iii/ Compliance with training

Existing patient facing staff IPC refreshers re-commenced in September through CSR 2014.2. Training compliance to date achieved 39% against a target of 65%. All-in-One training for non-patient facing staff remained static at 13% at end of February. *Ad hoc* training sessions continues to be available to services, likewise e-learning. E-learning package is currently being tailored for our ambulance requirements. The Head of IPC will work with relevant leads to address the progress in the 2015/2016 delivery plan. The DIPC is moving this forward with the Head of Training.

Currently there is a gap in capturing training compliance data for every staff group in LAS, PTS, Community Responders, specialist teams and voluntary and private contractors. This is a system-wide issue and oversight of all training compliance is being taken forward by the transformation team. IPC training data for Community Responders and VAS/PAS, will commence in April 2015.

iv/ Compliance with Decontamination

The Finance Director has been identified as Executive Lead for Medical Devices and Decontamination. Policies for the Management of Medical Devices, as well as for Decontamination have been drafted. The Lead is scoping the Trust's decontamination requirements and delivery model.

Cleanliness – Improvement in vehicle deep clean compliance for A&E vehicles is maintained for 4 consecutive months, 92% compliance at the end of February. Premises cleaning standards continue to exceed the 85% target set. To further reduce cross contamination there should be clear demarcation for clean and dirty areas in the stations.

v/ Flu fit programme including VHF assurance

Annual Flu programme - Flu uptake at end of February was 33% (1659/5094) overall. Specific uptake for frontline healthcare workers (Source: IMFORM Data) during this period 44% (1249/2839).
Fit Testing - FFP3 Fit testing and supply of respirators during period achieved 32% overall; and 58% (1659/2839) for frontline healthcare staff. All who passed their fit test were personally issued with their own FFP3 respirator. An alternative reusable respirator (Versaflow) was reviewed by the Flu Lead to address the needs of those who failed their fit testing, and those with beards. As a consequence of the VHF work stream, the PPE for general crews have also been enhanced, which will require additional training to use.
No update was received for transfers of 'high' possibility or confirmed cases of VHF for the month of February.

In regards to IPC the key areas to note are

- The lack of capacity in the IPC team delaying the delivery of the following; to review and development of policies, audit programme development and implementation, enhanced PPE training video for general crew, provision of *ad hoc* customized IPC sessions to specific groups to assist in training compliance in readiness for CQC.
- Performance data lacking from other services and VAS/PAS providers.

5 Locality Alert Register

There are currently 293 addresses on the Locality Alert Register (LAR). These are broken down as follows:
CATEGORY 1: 84
CATEGORY 2: 90
CATEGORY 3: 72
CATEGORY 4: 47

The above figures are a slight decrease in the numbers reported last month.

The Trust has notification of 420 high risk addresses from the Metropolitan Police. This is an increase when compared to last month (401).

D Caring

1 Complaints

i/ Complaint Volumes

100 complaints were received during February 2015, a slight decrease over the previous month (115 x 15%). The disposition call trial was introduced on 10 February and PED are participating in the provision of complaints data for the review. This may impact on the numbers of complaints which will become evident at the conclusion of the trail on 10 April 2015. Call rates during February were also lower than previous months in 2014/15.

Complaint volumes year on year have increased generally, with complaints about delays and ambulances not being sent once again the predominant subjects. The current monthly average for 2014/15 is 117 (in 2013/14 the monthly average was 90).

Graph 1. The following graph demonstrates the increase in complaints managed in 2010/15

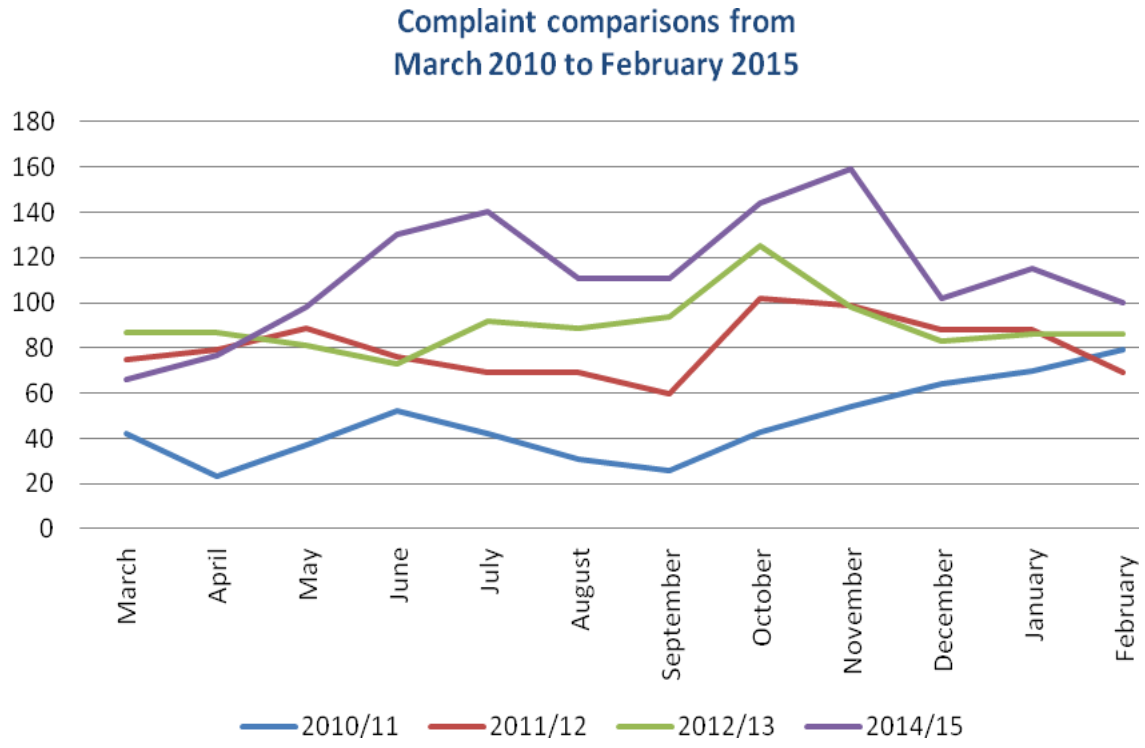


Table 2: Comparison of complaints received against calls attended by month

Month	Calls attended	Complaints received	Percentage of complaints against calls attended
Apr-14	88361	77	0.09
May-14	88348	98	0.11
Jun-14	88454	130	0.15
Jul-14	85287	140	0.16
Aug-14	82840	111	0.13
Sep-14	78857	111	0.14
Oct-14	86566	144	0.17
Nov-14	84101	159	0.19
Dec-14	87487	102	0.12
Jan-15	84090	114	0.14
Feb-15	76560	100	0.13
Totals	**930951**	**1286**	**0.13 average**

Complaints by Area

Table 3: Complaints by Area by percentage of total:
NB complaints about delays are attributed to Control services when the problem may actually represent less than optimum operational resourcing.

Area	Number of complaints February	Ratio of total (% rounded)
Control Services (EOC, UOC, CTA etc)	50	50%
East Area	13	13%
West Area	12	12%
South Area	10	10%
Unknown	6	6%
Not our service	4	4%
Contracted Services	2	2%
111 Beckenham	2	2%
Patient Transport Service	1	1%
Total	**100**	**100%**

ii/ Complaint Trends and Themes

Complaints relating to delay (50) and staff conduct (25) continue to be the main themes. These are increasingly inter-related. There was a decrease of 11% (70 v 50) in complaints relating to delay over January perhaps reflecting the mild winter and seasonal variations.

Table 4: The following table shows complaint subjects: April 2014 to February 2015

Complaints by subject 2013 - 2015	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Totals
Delay	33	50	72	62	45	65	87	95	71	70	50	700
Conduct	20	22	16	27	18	23	33	37	19	32	25	272
Road handling	8	9	9	14	9	7	7	10	4	5	8	90
Non-conveyance	5	5	16	19	16	8	6	5	3	2	5	90
Not our service	0	0	2	0	1	0	3	1	0	2	3	12
Treatment	8	7	12	12	17	4	1	5	1	3	5	75
Patient Injury or Damage to Property	1	0	1	0	1	2	3	1	0	0	3	12
Location Alert referral	0	1	1	1	1	0	2	1	1	0	1	9
Conveyance	1	1	1	1	2	1	1	2	3	0	0	13
Clinical Incident/Equipment	0	0	0	1	1	0	0	0	0	0	0	2
Assisting with external agency	0	0	0	0	0	0	0	1	0	0	0	1
Disputes safeguarding referral	1	2	0	2	0	0	1	1	0	0	0	7
Challenging paramedic qualification	0	1	0	0	0	0	0	0	0	0	0	1
Aggravating factors	0	0	0	1	0	1	0	0	0	0	0	2
Totals	**77**	**98**	**130**	**140**	**111**	**111**	**144**	**159**	**102**	**114**	**100**	**1286**

iii/ Case examples from December 2014 - February 2015

Service provision

1. A complaint was received from the family of a young rugby player concerning the care he received in relation to his injuries. Clinical findings identified that the patient would have benefited from neck immobilisation. An article relating to this scenario will be placed in a Clinical Update to widen learning across the Trust

2. The family of a patient who was declined an ambulance on Christmas Day have flagged their concerns that the patient had no other means of transport and was unable to get down the stairs. It transpired that the patient had an underlying medical condition which was not identified by the call handler. To widen the learning, we have asked that guidance is offered to all Control Services staff that if they are not aware of any particular clinical condition, they should seek advice from our Clinical Hub.

3. The family of a terminally ill patient were upset that the request for a four person ambulance crew was not adhered to resulting in the delay in conveying the patient to the hospice. A review of the tape recording of the request for an ambulance identified that the call handler had omitted to record that a four person ambulance crew was

required. We have asked that this case is cited, in anonymised terms, in a Team Briefing which is disseminated to all Control Services staff about the importance of attention to detail.

iv/ Complaint response targets

Table 5: Closed complaints April 2014 to February 2015

2014/15	Total complaints	Number of closed complaints by month	Totals closed within 35 working days	Percentage of complaints closed within 35 working days
April	77	69	35	45%
May	98	88	45	45%
June	130	85	40	30%
July	140	115	41	29%
August	111	96	24	22%
September	111	66	26	23%
October	144	117	30	21%
November	159	97	29	18%
December	102	146	17	17%
January	114	106	30	26%
February	100	91	14	14%
Totals:	**1286**	**1076**	**331**	**26% average per month**

This table reflects the numbers of complaints received each month and the numbers of complaints closed in each month. The 35 closure rate represents where complaints have been closed within that time frame. It should however be emphasised that a true reflection of response times cannot be calculated until the furthest timescale (i.e. 35 days working days have elapsed) = minimum of 26 March 2015.

Concerted efforts by staff resulted in a higher than normal number of complaints being closed during recent months as we continue to concentrate resources on the backlog of older complaint responses. This impacts on the closure rate of newer complaints. We continue to ensure that holding letters are being sent to complainants where the 35 day target will not be met. Feedback from the National Complaints Managers group suggests that NHS Trusts across the Country are receiving a higher number than usual complaints via MP's and the Department of Health. This trend has also been observed in this Trust

As at 12 March 2015 353 complaints remain open including 272 awaiting input from other depts., QA etc..

Progress has been made with Datix with the web project being re-implemented. The roll out of the web for dedicated users will impact on the admin functions and improve case management practices once all the recommendations are in place.

v/ Health Service Ombudsman

Table 6 The following table presents cases referred by the Ombudsman 2013 – 15

Datix reference	Current status	Summary	Outcome
C8535	File requested by HSO 17 Oct 2014	Complaint from patient, who is upset that the FRU thought she was uninjured, walked her to his car and conveyed her to hospital by car. She had suffered severe fractures to her hip and is still recovering	File sent to HSO 17 October 2014
C8707	File requested by HSO 16 October 2014	Complaint from patient's mother concerned at the delay in an ambulance attending her son with testicular pain. She conveyed her son to hospital after receiving the recorded message but was called back 3 hours later by LAS - advised that Service was still busy	File sent to HSO 17 October 2014. Additional information requested 09 February 2015
C8772	File requested 30 October 2014	Complaint from patient who is concerned that her condition of strangulated hernia was not triaged effectively. Also concerned about the delay at A&E	File sent 30/10/14
C8787	Further details requested by Ombudsman	Complaint via MP that an ambulance was not available & pt had to make his own way to hospital.	Complaint not upheld - closed
C8882	File requested 20 August 2014	Complaint from patient's partner at the delayed response to the scene and why the crew waited a considerable time on scene before conveying the patient to hospital. The patient may now no longer be able to speak or walk following a stroke	Local Resolution undertaken further correspondence with HSC and complainant
C8885	Enquiry from HSO who may investigate	Complaint from patient who believes that the crew mistook her for someone else and treated her unfairly and made inappropriate comments	Outcome awaited
C9023	File requested 28 August 2014	Complaint from patient's wife at the lengthy delay (2 hours) in an ambulance attending her husband who had severe abdominal pain. Was told high number of calls and one EMD was abrupt in their manner advising that other people were waiting too.	File sent 05 September 2014/CD sent 06/01/15
C9030	File requested 29 December 2014	Complaint from patient who is upset at the long delay in attending and the unsympathetic attitude of one of the EMD's	File sent 29 December 2014.CD of 999 call sent 09 Feb 2015

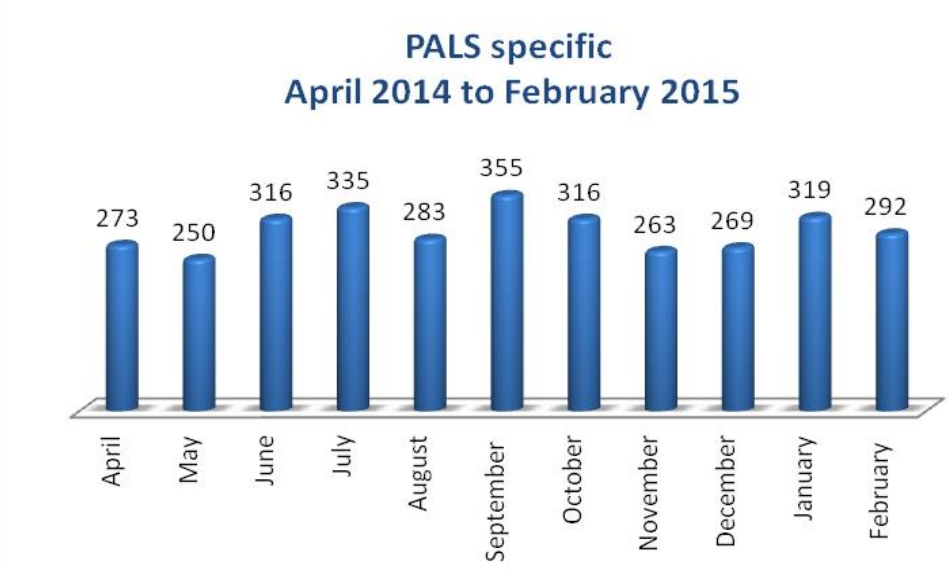
C9129	File requested 02 January 2015	Complaint from patient's brother who is very upset about the delay in an ambulance attending his sister who suffered from ulcerated legs. He believes that this contributed to her fall some days later	File sent 15 January 2015
C9313	File requested 15 August 2014	HSC investigation - complaint has never been put to LAS by hospital Trusts involved. Issue involves delay in transferring pt between hospitals.	Complaint not upheld - closed
C9321	File requested 22 December 2014	Complaint from patient's son regarding the delay in attending to his mother who had sustained a fall and injured her back and shoulder.	File sent 22 Dec 2014
C9414	File requested 02 March 2015	Complaint from patient's son that there was a delay in attending his father who died	File sent 02 March 2015
C9580	File requested 10 Feb 2015	Complaint from patient that the attending ambulance staff did not examine her and was rude and inconsiderate	File sent 17 Feb 2015
C9606	File requested 17 Feb 2015	Complaint from patient (a nurse) who is concerned that her 999 call was triaged as not requiring an ambulance. Later needed surgery	File sent 17 Feb 2015
C9638	Request for details from HSC 26 January 2015	Complaint from patient that the attending staff did not secure his bicycle post incident and it has been stolen from the hospital	Upheld. LAS to reimburse complainant for loss of bicycle. Recommendation to amend OP14

2/ PALS

PALS specific enquiries = 292, which is about average for the month
Average monthly PALS for 2013/14 = 287.
Current average for 2014/15 = 296.

Currently there are 84 PALS cases remaining open, this includes 26 requests for medical records awaiting consent from the patient, 38 cases awaiting QA reports/further supporting information and the remainder (20) still under enquiry (i.e. lost property etc).

Graph 3: The following graph highlights the numbers of PALS SPECIFIC enquiries by month April 2014 to February 2015



PALS Specific Themes

Consistent themes as ever; patient destination, signposting to other departments, policy and procedure requests and families seeking clarification of events. Currently there are 2 cases where relatives are seeking to meet the staff who attended the deceased. The local complex have made arrangements to meet the family at the end of March in one of these instances.

PALS remains a valuable service to patients. Some cases remain immensely time consuming and on occasion have escalated to a complaint. Lost property inquiries remain at a consistent level.

Table 7: The following table breaks down the PALS specific enquiries in February 2015

Subject – February 2015	**Number of enquiries**
Information/Enquiries	156
Lost Property	66
Medical Records (patient request)	35
Other general	32
Appreciation	3
Totals:	**292**

There has also been a slight decrease in solicitor requests this year which possibly reflects changes in legislation (i.e., access to legal aid).

Table 8: Solicitor requests for medical records

Solicitors request for medical records					
	2010/11	**2011/12**	**2012/13**	**2013/14**	**2014/15**
April	83	71	124	127	110
May	76	84	126	101	107
June	87	100	96	112	104
July	89	100	117	126	116

August	80	81	139	104	92
September	92	120	108	117	128
October	85	86	140	152	120
November	123	114	128	142	99
December	73	69	94	86	91
January	90	96	129	119	106
February	93	111	124	130	94
March	97	113	126	99	
Totals	**1068**	**1145**	**1451**	**1415**	**1167**

E Well Led

1 NMC re-validation

The Nursing and Midwifery Council (NMC) is changing the requirements that nurses and midwives must meet when they renew their registration every three years.
Revalidation will replace the post-registration education and practice (PREP) standards from 31 December 2015. Revalidation aims to improve upon the PREP system by setting new requirements for nurses and midwives.
Under revalidation nurses and midwives will be required to declare they have:
• Met the requirements for practice hours and continuing professional development;
• Reflected on their practice based on the requirements of the Code, using feedback from service users, patients, relatives, colleagues and others;
• Received confirmation from a third party that their declaration is reliable in accordance with the NMC's revised Code.
A tool will shortly be circulated from the Nursing and Midwifery Revalidation Programme Board for England to help self-assess organisational readiness. We are currently identifying how many staff we have working for the LAS who maintain a nursing or midwifery qualification that we will therefore need to support through this process.

2 Savile Report

The Trust Development Authority has circulated the 'NHS Investigations into Jimmy Saville and the Kate Lampard Lessons Learnt Report' which was published on the 26th February 2015. Each organisation is asked to:

- Read the report and review the recommendations for NHS Trusts
- Develop and action plan to identify where additional action is needed against these recommendations
- Provide assurance that the necessary action has been taken – or where this is in progress, the date by which it will be completed.

The actions are to be completed within 3 months and a progress report submitted by 31st May 2015 to the TDA.

Quality reports

London Ambulance Service NHS Trust

DRAFT v2B

Please select your reporting month here:

Jan-15

Updated 25/02/2015

Ambulance System Outcomes Dec-14

Ambulance Clinical Outcomes Sep-14

New Data is subject to validation results

Operational Area: **London Ambulance Service**

Contents

#N/A in the data allows trend lines to operate correctly.

Quality Reports

London Ambulance Service NHS Trust

DRAFT v2B

Data Source	Metric Number and Name	Description
Safety	1 - No. WTE Undertaking Training (Not CSR)	WTE staff numbers that receive training above and beyond "Core Skills Refreshers", i.e. driver training, hospital placements, new equipment, modules of paramedic courses
	2 - CSR (Training Days Delivered)	WTE delivery of CSR training for Month
	3 - Adverse Incidents (LA52 Reports)	Number of adverse incidents reported via LA52 per month
	4 - Serious Incidents (NHS Signals)	Number of SI's announced via NHS Signals. N.B. There has not been a Signal Alert issued since Feb 2012
	5 - Never Events (Numbers Reported within LAS)	Number of Never Events occurring within LAS in the month
	6 - Medication Errors (Numbers Reported)	Number of medication errors reported to LAS by staff during Month
	7 - Number Of Serious Incidents (LAS Declared)	Serious Incidents raised within LAS for the month
	8 - Number Of Incidents As Ratio (of Call Volume)	Number of Adverse incidents (LA52) as a percentage of Incident volume per month
	9 - Number Of Complaints (total)	Number of written / logged complaints' against the LAS per month
	10 - NHS Central Alert System (CAS) (Numbers Alerted to LAS)	CAS Alerts circulated by NHS by month
	11 - NHS Central Alert System (CAS) (Requiring Action)	CAS alerts that LAS have needed to undertake some action to address
	12 - Vehicle Cleaning	Number of vehicles receiving cleaning by contractors to standard
	13 - Locality Alert Register (totals on register)	Addresses were staff may suffer threats of violence, and verified that threat exists
Effective	14 - RED 1 calls arrived at scene within 8 mins	The number of Category A (Red 1) calls resulting in an emergency response arriving at the scene of the incident within 8 minutes.
	15 - RED 1 calls arrived at scene (Total)	The number of Category A (Red 1) calls resulting in an emergency response arriving at the scene of the incident.
	16 - RED 1 Time to achieve 95% at scene	The 95th centile of time from Call Connect of a Category A (Red 1) call to an emergency response arriving at the scene of the incident
	17 - RED 2 calls arrived at scene within 8 mins	The number of Category A (Red 2) calls resulting in an emergency response arriving at the scene of the incident within 8 minutes.
	18 - RED 2 calls arrived at scene (Total)	The number of Category A (Red 2) calls resulting in an emergency response arriving at the scene of the incident.
	19 - CAT A Ambulance at scene within 19 mins	The number of Category A calls resulting in an ambulance arriving at the scene of the incident within 19 minutes.
	20 - CAT A Ambulance at scene (ability to transport)	The number of Category A calls resulting in an ambulance able to transport the patient arriving at the scene of the incident.
	21 - EOC Abandoned calls before answering	Number of emergency and urgent calls abandoned before being answered
	22 - Calls connected to Switchboard (excludes CAD 2 CAD)	Total number of emergency and urgent calls presented to switchboard
	23 - Emergency Calls resolved with CTA that recontact in 24	Emergency calls closed with telephone advice where re-contact occurs within 24 hours.
	24 - Emergency Calls resolved with CTA (Hear & Treat)	Emergency calls closed with telephone advice.
	25 - See & Treat (Recontact)	Patients treated and discharged on scene where re-contact occurs within 24 hours
	26 - See & Treat Total	Patients treated and discharged on scene.
	27 - Frequent Callers who have an established procedure	Emergency calls from patients for whom a locally agreed frequent caller procedure is in place
	28 - Total Calls inc Frequent Callers	Total number of emergency calls presented to switchboard
	29 - Patients with a ROSC at hospital	Of the patients included in the denominator, the number of patients who had return of spontaneous circulation on arrival at hospital.
	30 - Patients with a ROSC from out of hospital	All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac arrest.

	Metric Number and Name	Description
Effective	31 - Patients with a ROSC at hospital UTSTEIN	Of the patients included in the denominator, the number of patients who had return of spontaneous circulation on arrival at hospital.
	32 - Pts. with ROSC witnessed arrest cardiac origin CPR UTSTEIN	All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac arrest of presumed cardiac origin, where the arrest was bystander witnessed and the initial rhythm was VF or VT.
	33 - STEMI within 150 mins after ECG confirmed AMI > PPCI	Patients with initial diagnosis of 'definite myocardial infarction' for whom primary angioplasty balloon inflation occurred within 150 minutes of emergency call connected to ambulance service, where first diagnostic Electrocardiogram (ECG) performed is by ambulance personnel and patient was directly transferred to a designated PPCI centre as locally agreed
	34 - Angioplasty after ECG confirmed AMI > PPCI	Patients with initial diagnosis of 'definite myocardial infarction' who received primary angioplasty, where first diagnostic ECG performed is by ambulance personnel and patient was directly transferred to a designated PPCI centre as locally agreed
	35 - STEMI and appropriate care bundle	Patients with a pre-hospital diagnosis of suspected ST elevation myocardial infarction confirmed on ECG who received an appropriate care bundle
	36 - Pre Hospital STEMI confirmed by ECG	Patients with a pre-hospital diagnosis of suspected ST elevation myocardial infarction confirmed on ECG
	37 - F2F FAST (+ve) eligible > HASU within 60 call origin	FAST positive patients (assessed face to face) potentially eligible for stroke thrombolysis within agreed local guidelines arriving at hospitals with a hyper acute stroke centre within 60 minutes of emergency call connecting to ambulance service
	38 - F2F FAST (+ve) potentially eligible for thrombolysis	FAST positive patients (assessed face to face) potentially eligible for stroke thrombolysis within agreed local guidelines
	39 - F2F suspected Stroke receiving appropriate care bundle	The number of suspected stroke patients assessed face to face who received an appropriate care bundle
	40 - F2F Suspected Stroke	The number of suspected stroke patients assessed face to face
	41 - Pts. discharged alive post Cardiac Arrest	Of the patients included in the denominator, the number of patients discharged from hospital alive
	42 - Pre Hospital Arrest to Discharge	All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac arrest
	43 - Pts. discharged alive post Cardiac Arrest UTSTEIN	Of the patients included in the denominator, the number of patients discharged from hospital alive
	44 - Pre Hospital VT/VF witnessed Arrest to Discharge UTSTEIN	All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac arrest of presumed cardiac origin, where the arrest was bystander witnessed and the initial rhythm was VF or VT.
	45 - EOC Time to answer 50% Emergency & Urgent calls	Time to answer calls (emergency and urgent), measured by median, 95th percentile and 99th percentile.
	46 - EOC Time to answer 95% Emergency & Urgent calls	
	47 - EOC Time to answer 99% Emergency & Urgent calls	
	48 - Time Of Arrival of Response for CAT A @ 50%	Time to arrival of an ambulance-dispatched health professional dispatched by the ambulance service for immediately life-threatening (Category A) calls, measured by median, 95th percentile and 99th percentile
	49 - Time Of Arrival of Response for CAT A @ 95%	
	50 - Time Of Arrival of Response for CAT A @ 99%	
	51 - Total of Emergency Calls to Switchboard (exc CAD 2 CAD)	Number of emergency calls that have been resolved by providing telephone advice.
	52 - All Telephone or F2F Calls (Attend Scene or CTA)	All emergency calls that receive a telephone or face-to-face response from the ambulance service
	53 - Conveyance to Non A&E Transport (ACP) and See & Treat	Patient journeys to a destination other than Type 1 and 2 A&E + number of patients discharged after treatment at the scene or onward referral to an alternative care pathway
	54 - All incidents with vehicle arrival (exc No Patient)	All emergency calls that receive a face-to-face response from the ambulance service
	55 - Emergency Journeys conveyed to A&E	Number of emergency journeys
	56 - Cat C Incidents (Total)	Number of Category C Incidents received by Month (C1-C4)
	57 - Defib patient data downloads to central storage	Count of electronic downloads submitted for central storage (LAS Clinical Performance Indicators)

	Metric Number and Name	Description
Effective	58 - ACS - Blood Glucose (BM) Initial Test	Count of BM Tests associated with Acute Coronary Syndrome patients (LAS Clinical Performance Indicators)
	59 - ACS - 12 Lead Monitoring undertaken	Count of 12 Lead ECGs associated with Acute Coronary Syndrome patients (LAS Clinical Performance Indicators)
	60 - STROKE - Time of Onset recorded	For patients with thrombotic stroke, treatment with thrombolytic therapy is highly time-dependent. Admission to a stroke unit for early specialist care is known to be life saving and to reduce disability, even if thrombolysis is not indicated. (LAS Clinical Performance Indicators)
	61 - See & Treat - Observations Recorded	A full set of observations is defined as: Time (hh:mm), AVPU, respiratory rate, respiratory depth, O2 saturation (must be written as a percentage), pulse rate, pulse character, blood pressure and colour. (LAS Clinical Performance Indicators)
	62 - See & Treat - PRF copy Left at scene	There must be clear documentation that a copy of the PRF was left with the patient (either on the reverse of the PRF or in the free text). (LAS Clinical Performance Indicators)
	63 - See & Treat - Advice Given to Patient	Team Leaders should review the documented advice given to the patient on either the reverse of the PRF or the free text and assess whether it was appropriate. (LAS Clinical Performance Indicators)
	64 - Glycaemia Audit - BM Test After Treatment	(LAS Clinical Performance Indicators)
	65 - Attended LAS Induction Course (Not workplace)	WTE of New Staff receiving a formal service induction course. This does not count localised inductions
Caring	66 - Safeguarding (child) referral numbers	Count of Children referred by Service to appropriate authorities
	67 - Safeguarding (adult) referral numbers	Count of Adults referred by Service to appropriate authorities
	68 - CPI - Mental Health - Capacity Tool	Where a patient refuses assessment, a form of treatment and/or conveyance and patient capacity is in doubt, the capacity tool should be used to determine whether patient has capacity to refuse. (LAS Clinical Performance Indicators)
	69 - CPI - Mental Health - Overall LAS compliance	(LAS Clinical Performance Indicators)
	70 - Friends and Family Test	Numbers by month of returns from Friends and Family Test (Formally commences April 2015)
Responsive	71 - Calls Received (Total) ex CAD2CAD	Total calls to LAS
	72 - Ring Backs	Abandoned Calls rung back
	73 - Surge (above Amber) inc Red (EOC Excess demand management)	Data from July 14 Onwards, replaced Demand Management Plan
	74 - Surge (above Red) (EOC Excess demand management)	Data from July 14 Onwards, replaced Demand Management Plan
	75 - Response To Complaints (Closed in Days)	A true reflection of response times cannot be calculated until the furthest timescale (i.e. 35 days working days have elapsed) - Approximately 33% of complaints are closed within the 35 day time frame
	76 - CPI - Feedback Sessions Undertaken (F2F & Written)	CUMULATIVE Team leaders are required to feedback to operational staff an overview of recent compliance against the PRF audits undertaken. This element is about ensuring staff are actively monitored to provide documentation of appropriate care.
	77 - Positive Feedback Compliments (Letters of Thanks)	Letters of thanks sent to the Service addressed to any member of staff and notified to the Communications Team. (Pre Nov 2013 letters scanned Total 733)
	78 - OWR (Operational Workplace Review) / PDP	Reviews of staff, variously recorded as CPD (Continuing Professional Development) CPDI (Interview), IPR (Individual Performance Review), PDR (Personal Development Review), PCD (Personal Career Development)
	79 - Job Cycle Time (Ave All)	Job Cycle Time Average for Month (Conveyed and Non Conveyed rpt 644)
	80 - Intelligent Conveyance	Number of Vehicles diverted to create capacity at alternative Emergency Departments
	81 - Community Responders	Number of persons recognised and deployable by Service as authorised community responders
	82 - Community Defibs	Number of Public Access Defibs available pan London
	83 - MAR (A & C) Combined	Multiple Attendance Ratio. A calculation based on A & C responses of how many occasions an additional vehicle has attended a scene. Acceptable reasons would be cardiac arrest or multiple casualties

	Metric Number and Name	Description
Well Led	84 - 111 (Call Volume)	Number of calls presented to 111 within London and recorded by LAS
	85 - 111 (Responded To)	Number of 111 calls transferred to the LAS for attendance with patient
	86 - 111 (Conveyed)	Number of 111 calls who receive LAS attendance at scene and are subsequently conveyed to hospital
	87 - Frontline Clinical Staffing - All In Post (Para & Tech)	Count of paramedic and Non Paramedic frontline staff (excludes management / admin grades etc.)
	88 - Paramedic - In Post (Frontline)	Qualified Paramedical Staff deployed on frontline duties
	89 - Non Paramedic - In Post (Frontline)	Non Paramedical Staff deployed on frontline duties (Numbers includes student paramedics etc.)
	90 - Paramedic Ratio	Paramedic to Non Paramedic expressed as percentage. Commisioners Target for 2016 is 70%
	91 - Frontline Staffing Numbers (planned inc Relief)	Frontline staff plan including 32% relief factor (from September 2014)
	92 - Starters (All Frontline Grades)	WTE Trainees and joiners who will take up frontline duties, once qualified
	93 - Vacancy (All Frontline)	Monthly WTE vacancy factor including 32% relief
	94 - Paramedic Vacancies (Frontline)	Paramedic only vacancies (inc Relief)
	95 - Staff Turnover (Joiners Minus Leavers)	Numeric positive or negative swing by WTE for frontline duties
	97 - Leavers (Frontline Techs & Para)	Staff leaving LAS for other jobs from frontline
	98 - Sickness (frontline)	Combined Short and Long Term Sickness for frontline staff
	99 - 3rd Party Providers (PAS/VAS) Hours Available	Total Hours recorded as being supplied by Private Ambulance Service (PAS) or Voluntary Ambulance Service (VAS) to support frontline operations
	100 - NHS Litigation Authority Level	NHSLA Level

		Quality Reports - DRAFT v2B	metric	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Safety	001	1 - No. WTE Undertaking Training (Not CSR)	(n)	277	331	378	661	515	1073	1013	1034	871	809	749	609
	002	2 - CSR (Training Days Delivered)	(n) of days	112	142	396	376	327	281	87	26	169	260	173	53
	003	3 - Adverse Incidents (LA52 Reports)	(n)	374	380	373	379	307	357	349	333	319	332	293	237
	004	4 - Serious Incidents (NHS Signals)	(n)	0	0	0	0	0	0	0	0	0	0	0	0
	005	5 - Never Events (Numbers Reported within LAS)	(n)	0	0	0	0	0	0	0	0	0	0	0	0
	006	6 - Medication Errors (Numbers Reported)	(n)	1	3	3	0	2	2	1	3	1	2	1	3
	007	7 - Number Of Serious Incidents (LAS Declared)	(n)	0	3	1	1	0	4	3	3	9	3	8	5
	008	8 - Number Of Incidents As Ratio (of Call Volume)	(dec)	0.0028	0.0026	0.0025	0.0024	0.0019	0.0021	0.0023	0.0021	0.0019	0.0020	0.0012	0.0017
	009	9 - Number Of Complaints (total)	(n)	86	66	77	98	130	140	111	111	144	159	102	114
	010	10 - NHS Central Alert System (CAS) (Numbers Alerted to LAS)	(n)	11	23	9	7	12	12	11	7	14	6	17	13
	011	11 - NHS Central Alert System (CAS) (Requiring Action)	(n)	0	2	0	0	0	0	0	1	0	2	1	1
	012	12 - Vehicle Cleaning	(n)	84.55%	90.96%	90.02%	90.04%	92.62%	87.34%	86.85%	85.77%	83.37%	91.56%	91.33%	#N/A
	013	13 - Locality Alert Register (totals on register)	(n)	328	329	321	313	315	306	303	303	302	308	305	302
Effective	014	14 - RED 1 calls arrived at scene within 8 mins	(n) > 8 mins	898	1,039	951	1,007	837	858	799	734	824	789	852	700
	015	15 - RED 1 calls arrived at scene (Total)	(n)	1,096	1,273	1,239	1,381	1,194	1,221	1,163	1,185	1,285	1,228	1,436	1346
	016	16 - RED 1 Time to achieve 95% at scene	(t)	14.8	15.4	17.7	16.4	19.3	20.3	18.4	19.4	22.9	18.7	17.0	15
	017	17 - RED 2 calls arrived at scene within 8 mins	(n) > 8 mins	28,384	31,574	26,845	27,509	25,102	24,050	22,724	20,415	23,593	22,399	21,493	23727
	018	18 - RED 2 calls arrived at scene (Total)	(n)	35,400	39,044	37,987	39,836	39,157	39,825	36,741	37,788	41,056	40,760	45,222	39723
	019	19 - CAT A Ambulance at scene within 19 mins	(n)	35,623	39,435	37,597	39,271	37,907	38,027	35,365	35,003	38,466	37,169	39,610	37533
	020	20 - CAT A Ambulance at scene (ability to transport)	(n)	36,294	40,105	38,995	40,973	40,099	40,775	37,645	38,685	42,065	41,657	46,743	41069
	021	21 - EOC Abandoned calls before answering	(n)	22	15	96	337	209	1,331	114	809	663	863	1165	92
	022	22 - Calls connected to Switchboard (excludes CAD 2 CAD)	(n)	122,868	136128	139380	148878	152311	156863	140012	146411	147626	139672	152028	123111
	023	23 - Emergency Calls resolved with CTA that recontact in 24	(n)	178	128	217	185	239	335	41	36	9	428	639	#N/A
	024	24 - Emergency Calls resolved with CTA (Hear & Treat)	(n)	7,648	7,975	9,207	9,947	10,629	12,721	12,008	13,778	15,431	15,210	18,327	13979
	025	25 - See & Treat (Recontact)	(n)	1,015	1,217	1,100	1,120	1,134	1,215	1,133	1,154	1,261	1,304	1569	#N/A
	026	26 - See & Treat Total	(n)	14,406	17,216	15,856	16,919	16,653	16,792	15,399	15,447	16,374	15,807	17436	#N/A
	027	27 - Frequent Callers who have an established procedure	(n)	2,259	2,617	2,902	2,936	2,757	2,642	2,583	2,329	2,046	2,204	2187	#N/A
	028	28 - Total Calls inc Frequent Callers	(n)	122,868	136128	139380	148878	152311	156863	140012	146411	147626	139672	152028	123111
	029	29 - Patients with a ROSC at hospital	(n)	122	120	125	120	104	110	131	89	#N/A	#N/A	#N/A	#N/A
	030	30 - Patients with a ROSC from out of hospital	(n)	359	371	379	377	317	335	349	325	#N/A	#N/A	#N/A	#N/A
	031	31 - Patients with a ROSC at hospital UTSTEIN	(n)	32	34	26	29	21	26	26	13	#N/A	#N/A	#N/A	#N/A
	032	32 - Pts. with ROSC witnessed arrest cardiac origin CPR UTSTEIN	(n)	55	51	42	53	36	42	39	27	#N/A	#N/A	#N/A	#N/A
	033	33 - STEMI within 150 mins after ECG confirmed AMI > PPCI	(n)	121	127	96	52	42	40	66	87	#N/A	#N/A	#N/A	#N/A
	034	34 - Angioplasty after ECG confirmed AMI > PPCI	(n)	130	142	100	60	45	40	71	89	#N/A	#N/A	#N/A	#N/A
	035	35 - STEMI and appropriate care bundle	(n)	180	189	198	178	163	166	149	144	#N/A	#N/A	#N/A	#N/A
	036	36 - Pre Hospital STEMI confirmed by ECG	(n)	248	270	266	236	227	226	208	213	#N/A	#N/A	#N/A	#N/A

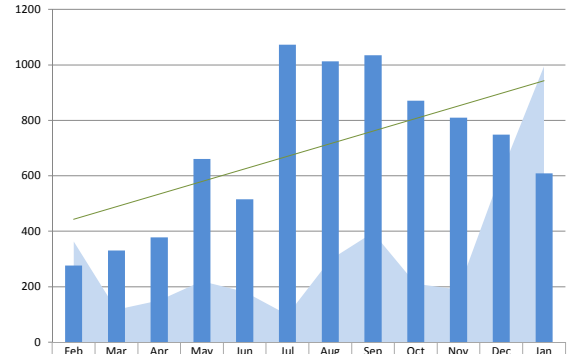
		Quality Reports - DRAFT v2B	metric	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Effective	037	37 - F2F FAST (+ve) eligible > HASU within 60 call origin	(n)	426	459	419	421	325	338	326	294	#N/A	#N/A	#N/A	#N/A
	038	38 - F2F FAST (+ve) potentially eligible for thrombolysis	(%)	640	706	645	663	529	567	531	516	#N/A	#N/A	#N/A	#N/A
	039	39 - F2F suspected Stroke receiving appropriate care bundle	(n)	894	1,044	940	1,009	884	923	884	802	#N/A	#N/A	#N/A	#N/A
	040	40 - F2F Suspected Stroke	(n)	932	1,077	985	1,036	918	943	918	844	#N/A	#N/A	#N/A	#N/A
	041	41 - Pts. discharged alive post Cardiac Arrest	(n)	42	43	21	14	17	26	31	16	#N/A	#N/A	#N/A	#N/A
	042	42 - Pre Hospital Arrest to Discharge	(n)	350	367	350	343	296	322	332	318	#N/A	#N/A	#N/A	#N/A
	043	43 - Pts. discharged alive post Cardiac Arrest UTSTEIN	(n)	21	19	7	5	4	7	11	4	#N/A	#N/A	#N/A	#N/A
	044	44 - Pre Hospital VT/VF witnessed Arrest to Discharge UTSTEIN	(n)	52	51	29	37	28	36	33	25	#N/A	#N/A	#N/A	#N/A
	045	45 - EOC Time to answer 50% Emergency & Urgent calls	(s)	0	0	0	0	0	0	0	0	0	0	0	0
	046	46 - EOC Time to answer 95% Emergency & Urgent calls	(s)	1	2	2	5	4	21	2	24	14	16	35	5
	047	47 - EOC Time to answer 99% Emergency & Urgent calls	(s)	8	13	25	62	46	69	36	74	67	67	85	30
	048	48 - Time Of Arrival of Response for CAT A @ 50%	(t)	5.6	5.5	6.4	6.5	7.0	7.4	7.2	8.1	7.7	8.0	9.0	7
	049	49 - Time Of Arrival of Response for CAT A @ 95%	(t)	13.4	13.3	15.8	16.5	18.3	19.9	18.9	22.5	21.2	24.2	29.0	21
	050	50 - Time Of Arrival of Response for CAT A @ 99%	(t)	21.5	21.6	25.6	27.7	31.8	35.8	33.0	39.8	38.0	46.8	59.0	41
Effective	051	51 - Total of Emergency Calls to Switchboard (exc CAD 2 CAD)	(n)	7,648	7,975	9,207	9,947	10,629	12,721	12,008	13,778	15,431	15,210	18,327	13979
	052	52 - All Telephone or F2F Calls (Attend Scene or CTA)	(n)	93,981	104,946	97,648	101,246	99,144	100,736	94,935	95,224	102,070	99,719	105839	#N/A
	053	53 - Conveyance to Non A&E Transport (ACP) and See & Treat	(n)	27,448	31,620	29,014	30,484	30,346	30,930	28,668	28,561	30,008	29,135	30702	#N/A
	054	54 - All incidents with vehicle arrival (exc No Patient)	(n)	86,333	96,971	88,441	91,299	88,515	88,015	82,927	81,446	86,639	84,509	87261	#N/A
	055	55 - Emergency Journeys conveyed to A&E	(n)	66,355	73,681	67,014	68,568	65,623	64,519	61,393	60,347	64,445	62,862	63667	#N/A
	056	56 - Cat C Incidents (Total)	(n)	49375	56026	49133	50005	48100	46915	44936	42388	44272	42516	40493	43456
	058	58 - ACS - Blood Glucose (BM) Initial Test	(%)	96%	96%	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	97%	98%	95%	#N/A
	059	59 - ACS - 12 Lead Monitoring undertaken	(%)	98%	96%	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	97%	97%	97%	#N/A
	060	60 - STROKE - Time of Onset recorded	(%)	93%	93%	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	94%	94%	94%	#N/A
	061	61 - See & Treat - Observations Recorded	(%)	91%	93%	93%	93%	93%	91%	91%	93%	91%	90%	90%	#N/A
	062	62 - See & Treat - PRF copy Left at scene	(%)	96%	92%	92%	92%	92%	93%	93%	95%	92%	93%	91%	#N/A
	063	63 - See & Treat - Advice Given to Patient	(%)	96%	96%	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	97%	97%	97%	#N/A
	064	64 - Glycaemia Audit - BM Test After Treatment	(%)	#N/A	98%	#N/A	98%	#N/A	98%	#N/A	98%	#N/A	98%	#N/A	#N/A
	065	65 - Attended LAS Induction Course (Not workplace)	(n) WTE	19	29	33.29	24	18	19.7	18.6	95.28	36	122.2	34	27

		Quality Reports - DRAFT v2B	metric	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Caring	066	66 - Safeguarding (child) referral numbers	(n)	493	542	449	417	435	428	396	381	440	404	284	354
	067	67 - Safeguarding (adult) referral numbers	(n)	1945	645	520	472	435	476	449	378	432	458	393	345
	068	68 - CPI - Mental Health - Capacity Tool	(%)	94%	95%	95%	97%	96%	96%	99%	97%	98%	98%	99%	#N/A
	069	69 - CPI - Mental Health - Overall LAS compliance	(%)	#N/A	#N/A	90%	93%	91%	92%	94%	92%	91%	91%	88%	#N/A
	070	70 - Friends and Family Test	(n)	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	1	3
Responsive	071	71 - Calls Received (Total) ex CAD2CAD	(n)	122888	136128	139380	148878	152311	156863	140012	146411	147626	139672	152028	123112
	072	72 - Ring Backs	(n)	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
	073	73 - Surge (above Amber) inc Red (EOC Excess demand management)	(hrs.)	#N/A	#N/A	#N/A	197:19	258:17	424:21	452:29	355:13	713:59	646:15	425:57	744
	074	74 - Surge (above Red) (EOC Excess demand management)	(hrs.)	#N/A	#N/A	#N/A	0:00	17:35	16:14	0:00	24:42	29:59	73:43	318:01	591:25:00
	075	75 - Response To Complaints (Closed in Days)	(d)	39	38	35	45	40	41	24	26	30	29	17	17
	076	76 - CPI - Feedback Sessions Undertaken (F2F & Written)	(n)	3963	4243	356	722	1022	1315	1412	1577	1540	1690	730	#N/A
	077	77 - Positive Feedback Compliments (Letters of Thanks)	(n)	74	79	48	59	28	63	37	68	57	76	84	#N/A
	078	78 - OWR (Operational Workplace Review) / PDP	(n)	32	28	7	26	166	178	31	26	15	5	1	5
	079	79 - Job Cycle Time (Ave All)	(t)	74.31	74.29	74.89	75.34	76.15	76.92	77.18	79.28	79.88	81.54	84.54	83.37
	080	80 - Intelligent Conveyance	(n)	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	589	678	1143	1197	1590	1815
	081	81 - Community Responders	(n)	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
	082	82 - Community Defibs	(n)	#N/A	#N/A	#N/A	#N/A	2,322	2,422	2,486	2,529	2,576	2,607	2,635	2,668
	083	83 - MAR (A & C) Combined	(n)	1.40	1.39	1.39	1.39	1.37	1.36	1.35	1.32	1.33	1.30	1.31	1.32
Well Led	084	84 - 111 (Call Volume)	(n)	#N/A	#N/A	88382	91225	88382	87833	82847	81373	86568	84099	86950	84110
	085	85 - 111 (Responded To)	(n)	#N/A	#N/A	9099	9243	8371	8146	8972	8635	9982	10038	10283	9602
	086	86 - 111 (Conveyed)	(n)	#N/A	#N/A	7237	7300	6490	6287	6851	6646	7675	7563	7341	7124
	087	87 - Frontline Clinical Staffing - All In Post (Para & Tech)	WTE SUM	2632	2665	2655	2628	2647	2636	2588	2535	2467	2490	2471	2410
	088	88 - Paramedic - In Post (Frontline)	WTE	1485	1470	1451	1442	1441	1411	1397	1380	1371	1370	1368	1363
	089	89 - Non Paramedic - In Post (Frontline)	WTE	1147	1195	1204	1186	1206	1225	1191	1155	1096	1119	1103	1047
	090	90 - Paramedic Ratio	>70%	56%	55%	55%	55%	54%	54%	54%	54%	56%	55%	55%	57%
	091	91 - Frontline Staffing Numbers (planned inc Relief)	WTE	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	3016	3016	3016	3016	3016
	092	92 - Starters (All Frontline Grades)	WTE	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
	093	93 - Vacancy (All Frontline)	WTE	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	481	549	526	545	606
	094	94 - Paramedic Vacancies (Frontline)	WTE	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	354	364	364	367	371
	095	95 - Staff Turnover (Joiners Minus Leavers)	WTE	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
	097	97 - Leavers (Frontline Techs & Para)	WTE	11.1	8.3	4.6	2.6	5.5	12.5	7.1	21.5	22.4	25.0	22.5	21.9
	098	98 - Sickness (frontline)	%	9.44%	9.07%	8.45%	8.65%	8.55%	8.76%	8.90%	9.25%	9.32%	9.19%	9.44%	9.24%
	099	99 - 3rd Party Providers (PAS/VAS) Hours Available	(hrs.)	12453	5196	8631	8181	7641	6654	6451	7138	9352	10444	11929	12928
	100	100 - NHS Litigation Authority Level	(n)	1	1	1	1	1	1	1	1	1	1	1	1

Safe - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

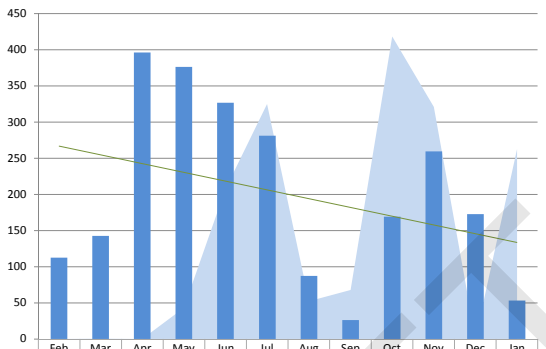
1 - No. WTE Undertaking Training (Not CSR)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	363	117	150	220	182	98	297	396	211	190	612	995
2014-15 Actuals	277	331	378	661	515	1073	1013	1034	871	809	749	609

WTE staff numbers that receive training above and beyond "Core Skills Refreshers", i.e. driver training, hospital placements, new equipment, modules of paramedic courses

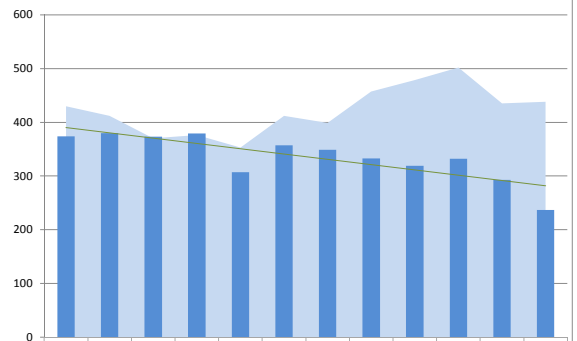
2 - CSR (Training Days Delivered)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	0	0	0	43	207	325	52	68	418	321	1	262
2014-15 Actuals	112	142	396	376	327	281	87	26	169	260	173	53

WTE delivery of CSR training for Month

3 - Adverse Incidents (LA52 Reports)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	430	412	370	376	353	412	399	457	479	502	435	438
2014-15 Actuals	374	380	373	379	307	357	349	333	319	332	293	237

Number of adverse incidents reported via LA52 per month

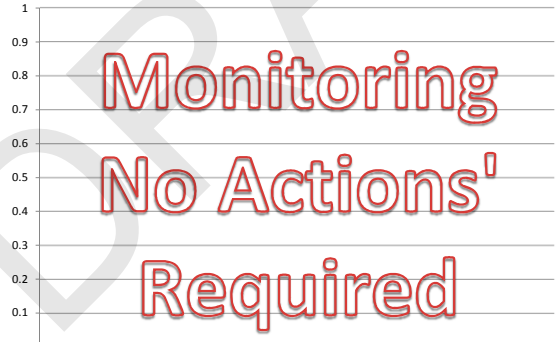
4 - Serious Incidents (NHS Signals)

Monitoring No Actions' Required

	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	0	0	0	0	0	0	0	0	0	0	0	0
2014-15 Actuals	0	0	0	0	0	0	0	0	0	0	0	0

Number of SI's announced via NHS Signals. N.B. There has not been a Signal Alert issued since Feb 2012

5 - Never Events (Numbers Reported within LAS)

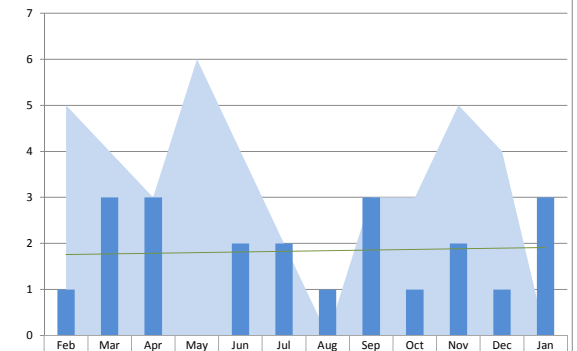


Monitoring No Actions' Required

	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	0	0	0	0	0	0	0	0	0	0	0	0
2014-15 Actuals	0	0	0	0	0	0	0	0	0	0	0	0

Number of Never Events occurring within LAS in the month

6 - Medication Errors (Numbers Reported)



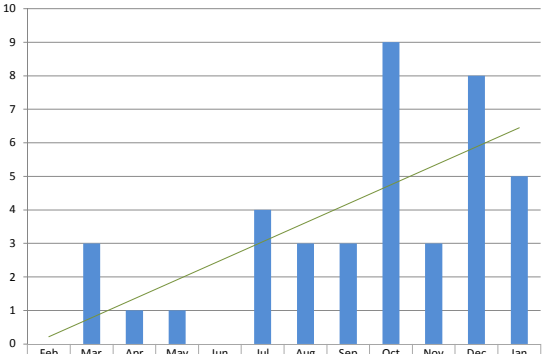
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	5	4	3	6	4	2	0	3	3	5	4	0
2014-15 Actuals	1	3	3	0	2	2	1	3	1	2	1	3

Number of medication errors reported to LAS by staff during Month

Safe - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

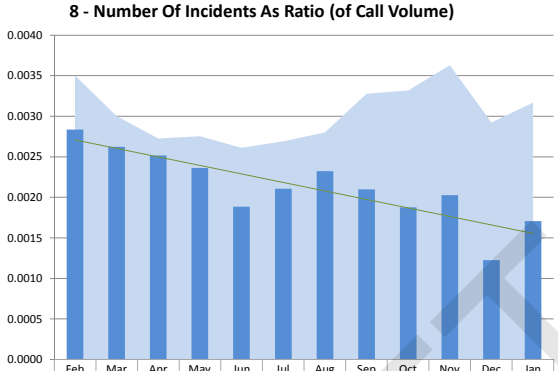
7 - Number Of Serious Incidents (LAS Declared)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												0
2014-15 Actuals	0	3	1	1	0	4	3	3	9	3	8	5

Serious Incidents raised within LAS for the month

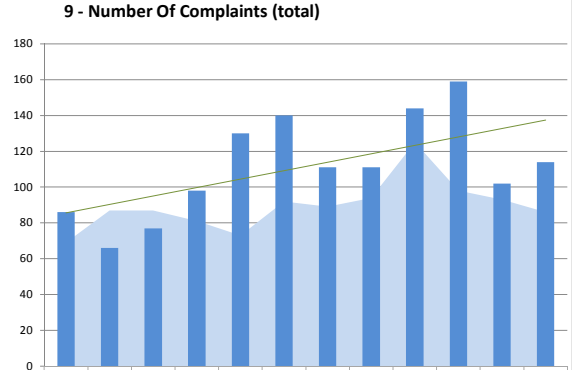
8 - Number Of Incidents As Ratio (of Call Volume)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	0.0035	0.0030	0.0027	0.0028	0.0026	0.0027	0.0028	0.0033	0.0033	0.0036	0.0029	0.0032
2014-15 Actuals	0.0028	0.0026	0.0025	0.0024	0.0019	0.0021	0.0023	0.0021	0.0019	0.0020	0.0012	0.0017

Number of Adverse incidents (LA52) as a percentage of Incident volume per month

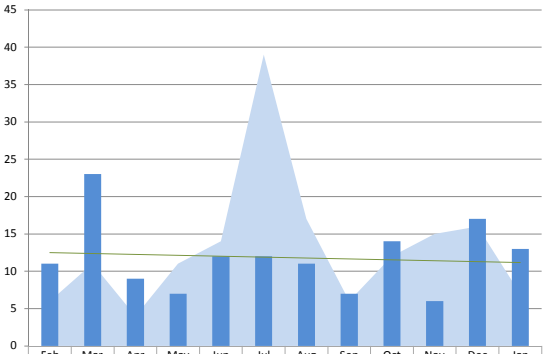
9 - Number Of Complaints (total)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	69	87	87	81	73	92	89	94	125	98	93	86
2014-15 Actuals	86	66	77	98	130	140	111	111	144	159	102	114

Number of written / logged complaints' against the LAS per month

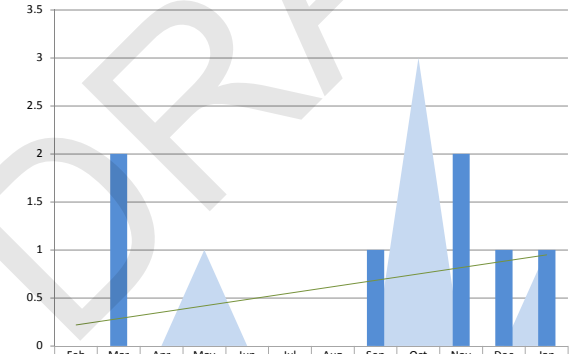
10 - NHS Central Alert System (CAS) (Numbers Alerted to LAS)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	6	11	4	11	14	39	17	6	12	15	16	7
2014-15 Actuals	11	23	9	7	12	12	11	7	14	6	17	13

CAS Alerts circulated by NHS by month

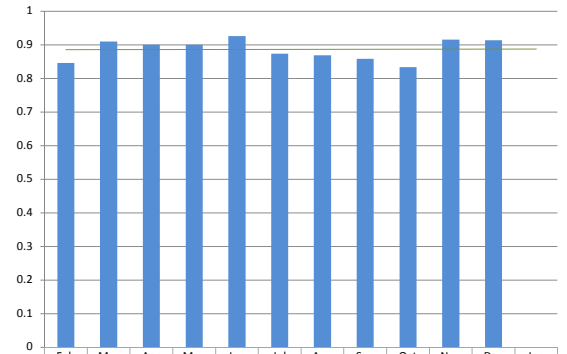
11 - NHS Central Alert System (CAS) (Requiring Action)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	0	0	0	1	0	0	0	0	3	0	0	1
2014-15 Actuals	0	2	0	0	0	0	0	1	0	2	1	1

CAS alerts that LAS have needed to undertake some action to address

12 - Vehicle Cleaning



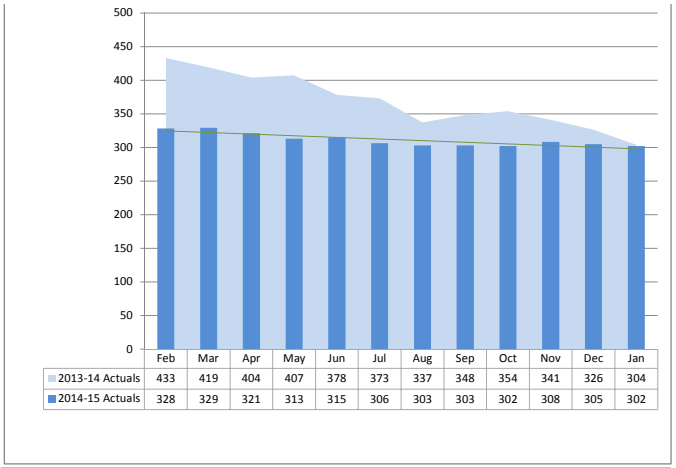
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals	84.55%	90.96%	90.02%	90.04%	92.62%	87.34%	86.85%	85.77%	83.37%	91.56%	91.33%	

Number of vehicles receiving cleaning by contractors to standard

13 - Locality Alert Register (totals on register)

Safe - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.



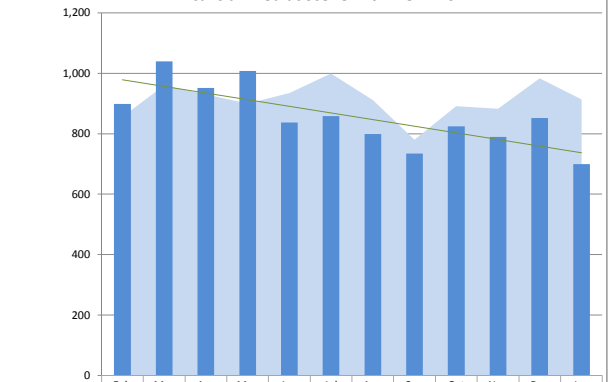
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	433	419	404	407	378	373	337	348	354	341	326	304
2014-15 Actuals	328	329	321	313	315	306	303	303	302	308	305	302

Addresses were staff may suffer threats of violence, and verified that threat exists

Effective - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

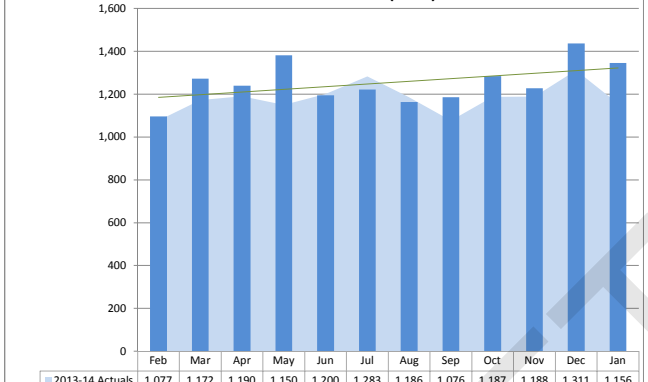
14 - RED 1 calls arrived at scene within 8 mins



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	856	960	930	899	934	999	911	780	891	883	983	913
2014-15 Actuals	898	1,039	951	1,007	837	858	799	734	824	789	852	700

The number of Category A (Red 1) calls resulting in an emergency response arriving at the scene of the incident within 8 minutes. (ACQI HQU03_1_1_3)

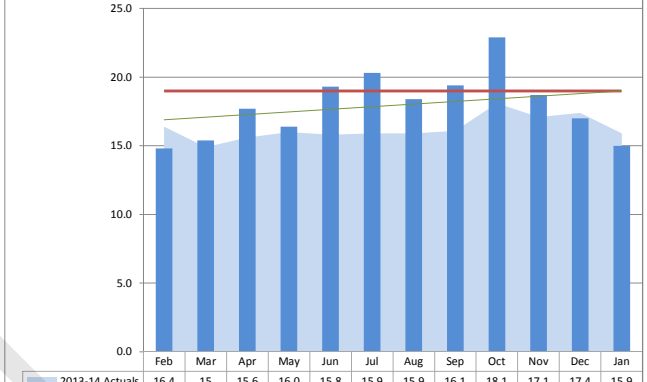
15 - RED 1 calls arrived at scene (Total)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	1,077	1,172	1,190	1,150	1,200	1,283	1,186	1,076	1,187	1,188	1,311	1,156
2014-15 Actuals	1,096	1,273	1,239	1,381	1,194	1,221	1,163	1,185	1,285	1,228	1,436	1346

The number of Category A (Red 1) calls resulting in an emergency response arriving at the scene of the incident. (ACQI HQU03_1_1_4)

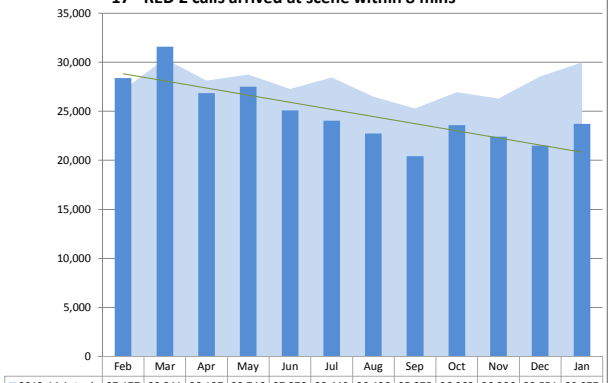
16 - RED 1 Time to achieve 95% at scene



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	16.4	15	15.6	16.0	15.8	15.9	15.9	16.1	18.1	17.1	17.4	15.9
2014-15 Actuals	14.8	15.4	17.7	16.4	19.3	20.3	18.4	19.4	22.9	18.7	17.0	15
Target	19	19	19	19	19	19	19	19	19	19	19	19

The 95th centile of time from Call Connect of a Category A (Red 1) call to an emergency response arriving at the scene of the incident (ACQI HQU03_1_1_5)

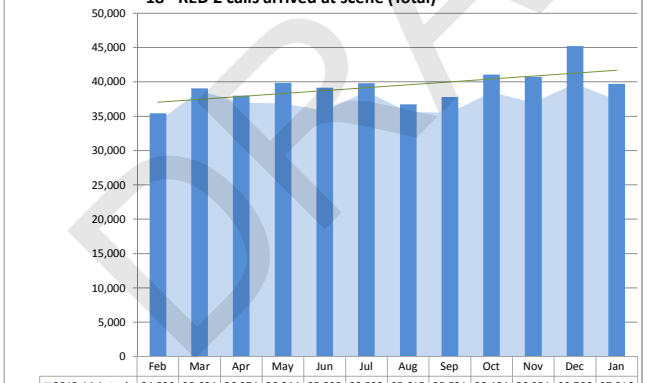
17 - RED 2 calls arrived at scene within 8 mins



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	27,177	30,341	28,137	28,746	27,272	28,440	26,486	25,275	26,962	26,286	28,551	29,977
2014-15 Actuals	28,384	31,574	26,845	27,509	25,102	24,050	22,724	20,415	23,593	22,399	21,493	23727

The number of Category A (Red 2) calls resulting in an emergency response arriving at the scene of the incident within 8 minutes. (ACQI HQU03_1_1_6)

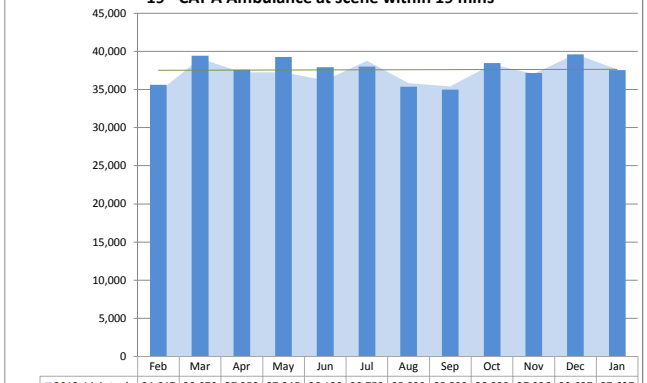
18 - RED 2 calls arrived at scene (Total)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	34,230	38,684	36,974	36,844	35,802	38,592	35,615	35,531	38,484	36,951	39,766	37,316
2014-15 Actuals	35,400	39,044	37,987	39,836	39,157	39,825	36,741	37,788	41,056	40,760	45,222	39723

The number of Category A (Red 2) calls resulting in an emergency response arriving at the scene of the incident. (ACQI HQU03_1_1_7)

19 - CAT A Ambulance at scene within 19 mins



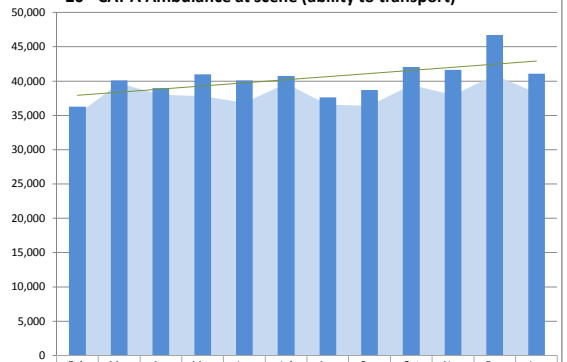
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	34,647	39,070	37,252	37,245	36,180	38,753	35,829	35,392	38,292	37,026	39,637	37,607
2014-15 Actuals	35,623	39,435	37,597	39,271	37,907	38,027	35,365	35,003	38,466	37,169	39,610	37533

The number of Category A calls resulting in an ambulance arriving at the scene of the incident within 19 minutes. (ACQI HQU03_1_2_1)

Effective - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

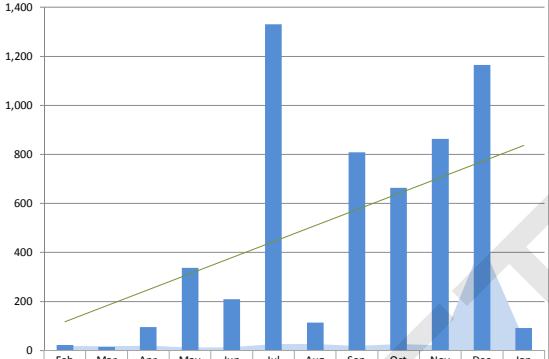
20 - CAT A Ambulance at scene (ability to transport)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	35,163	39,682	37,987	37,812	36,829	39,611	36,558	36,390	39,440	37,948	40,833	38,266
2014-15 Actuals	36,294	40,105	38,995	40,973	40,099	40,775	37,645	38,685	42,065	41,657	46,743	41069

The number of Category A calls resulting in an ambulance able to transport the patient arriving at the scene of the incident. (ACQI HQU03_1_2_2)

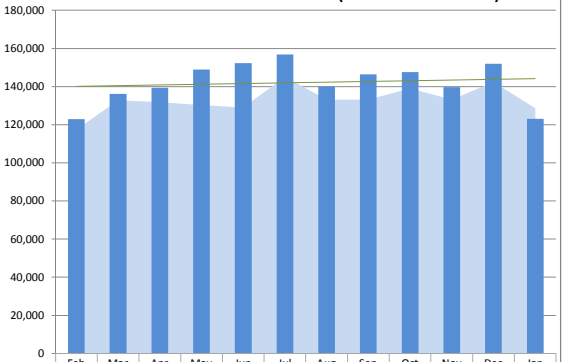
21 - EOC Abandoned calls before answering



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	18	17	20	12	14	26	27	18	26	21	438	47
2014-15 Actuals	22	15	96	337	209	1,331	114	809	663	863	1165	92

Number of emergency and urgent calls abandoned before being answered (ACQI SQU03_1_1_1)

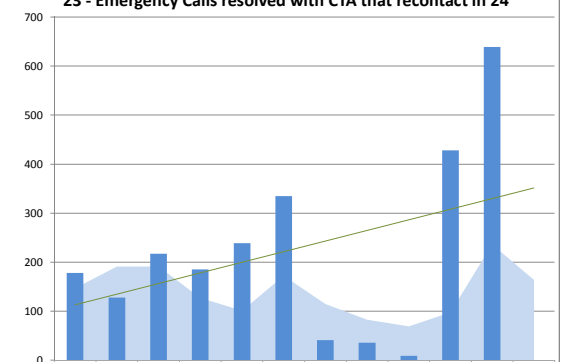
22 - Calls connected to Switchboard (excludes CAD 2 CAD)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	117,43	132,85	131,81	130,23	128,97	145,10	133,12	133,06	139,07	133,08	142,31	128,65
2014-15 Actuals	122,86	136128	139380	148878	152311	156863	140012	146411	147626	139672	152028	123111

Total number of emergency and urgent calls presented to switchboard (ACQI SQU03_1_1_2)

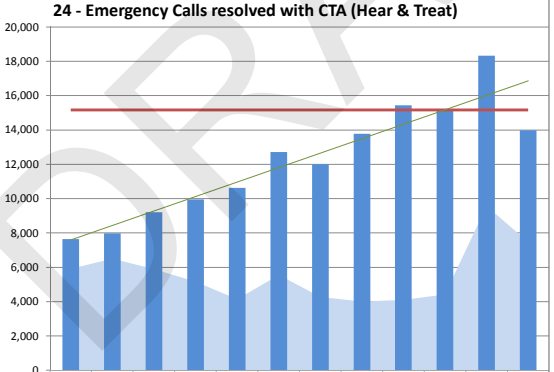
23 - Emergency Calls resolved with CTA that recontact in 24



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	147	191	191	127	101	172	115	83	69	98	236	164
2014-15 Actuals	178	128	217	185	239	335	41	36	9	428	639	

Emergency calls closed with telephone advice where re-contact occurs within 24 hours. (ACQI SQU03_2_1_1)

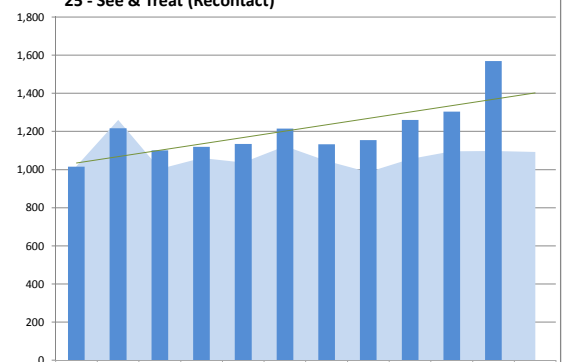
24 - Emergency Calls resolved with CTA (Hear & Treat)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	5,905	6,503	5,882	5,170	4,142	5,552	4,274	3,998	4,106	4,420	9,559	7,469
2014-15 Actuals	7,648	7,975	9,207	9,947	10,629	12,721	12,008	13,778	15,431	15,210	18,327	13979
Target	15166	15166	15166	15166	15166	15166	15166	15166	15166	15166	15166	15166

Emergency calls closed with telephone advice. (ACQI SQU03_2_1_2)

25 - See & Treat (Recontact)



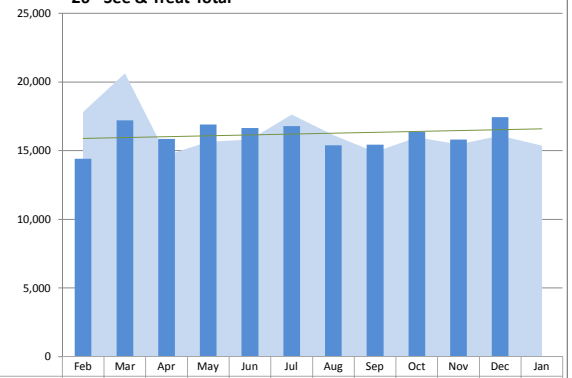
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	1,017	1,261	1,003	1,060	1,037	1,123	1,045	986	1,056	1,096	1,097	1,092
2014-15 Actuals	1,015	1,217	1,100	1,120	1,134	1,215	1,133	1,154	1,261	1,304	1569	

Patients treated and discharged on scene where re-contact occurs within 24 hours (ACQI SQU03_2_2_1)

Effective - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

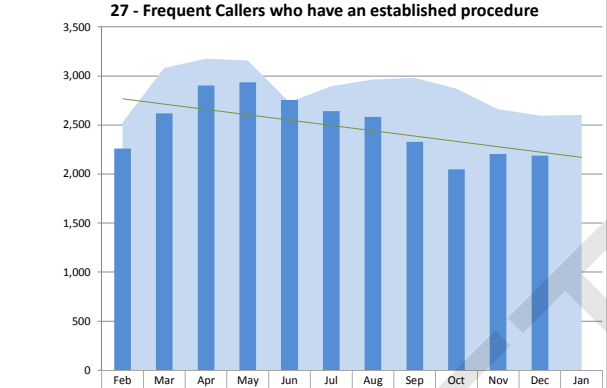
26 - See & Treat Total



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	17,810	20,642	14,666	15,650	15,821	17,624	16,151	14,908	15,974	15,474	16,082	15,368
2014-15 Actuals	14,406	17,216	15,856	16,919	16,653	16,792	15,399	15,447	16,374	15,807	17436	

Patients treated and discharged on scene. (ACQI SQU03_2_2_2)

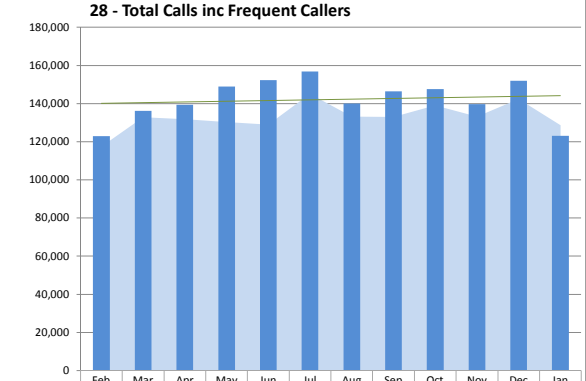
27 - Frequent Callers who have an established procedure



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	2,526	3,083	3,178	3,158	2,733	2,896	2,963	2,980	2,871	2,662	2,595	2,601
2014-15 Actuals	2,259	2,617	2,902	2,936	2,757	2,642	2,583	2,329	2,046	2,204	2187	

Emergency calls from patients for whom a locally agreed frequent caller procedure is in place (ACQI SQU03_2_3_1)

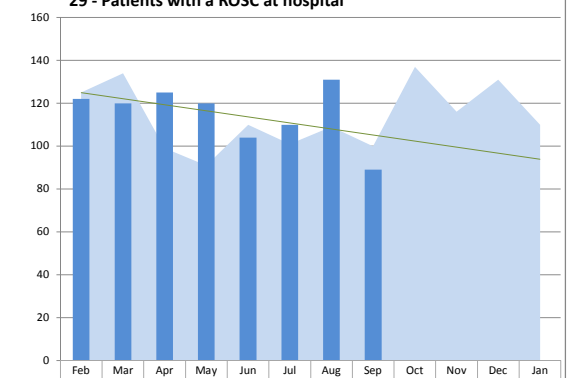
28 - Total Calls inc Frequent Callers



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	117,43	132,85	131,81	130,23	128,97	145,10	133,12	133,06	139,07	133,08	142,31	128,65
2014-15 Actuals	122,86	136128	139380	148878	152311	156863	140012	146411	147626	139672	152028	123111

Total number of emergency calls presented to switchboard (ACQI SQU03_2_3_2)

29 - Patients with a ROSC at hospital

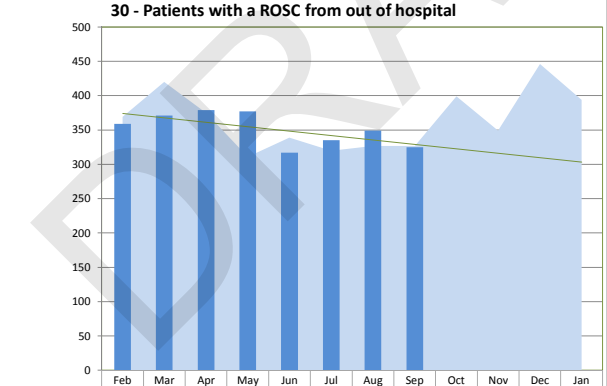


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	125	134	99	91	110	101	109	100	137	116	131	110
2014-15 Actuals	122	120	125	120	104	110	131	89				

Clinical Indicators Track circa 6 months behind

Of the patients included in the denominator, the number of patients who had return of spontaneous circulation on arrival at hospital. (ACQI SQU03_3_1_1)

30 - Patients with a ROSC from out of hospital

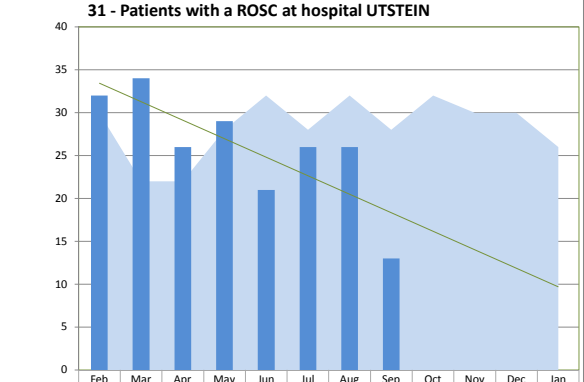


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	369	420	375	311	339	320	327	327	399	349	446	394
2014-15 Actuals	359	371	379	377	317	335	349	325				

Clinical Indicators Track circa 6 months behind

All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac arrest. (ACQI SQU03_3_1_2)

31 - Patients with a ROSC at hospital UTSTEIN



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	30	22	22	28	32	28	32	28	32	30	30	26
2014-15 Actuals	32	34	26	29	21	26	26	13				

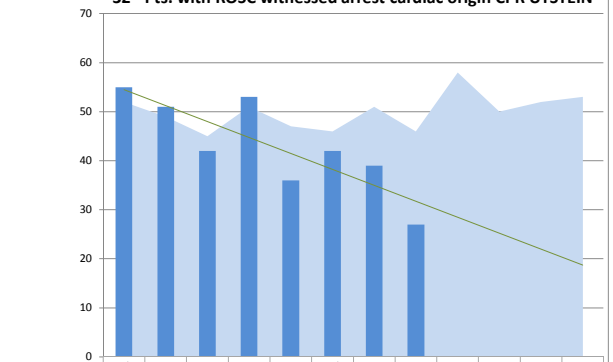
Clinical Indicators Track circa 6 months behind

Of the patients included in the denominator, the number of patients who had return of spontaneous circulation on arrival at hospital. (ACQI SQU03_3_2_1)

Effective - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

32 - Pts. with ROSC witnessed arrest cardiac origin CPR UTSTEIN

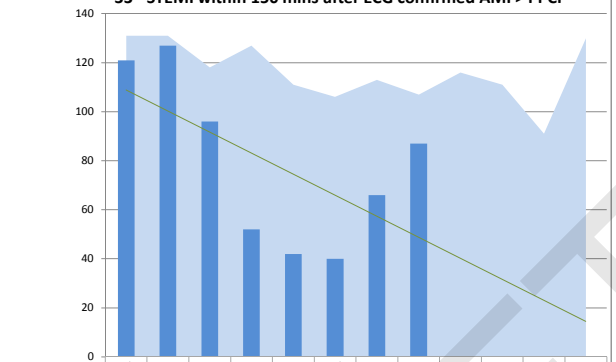


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	52	49	45	51	47	46	51	46	58	50	52	53
2014-15 Actuals	55	51	42	53	36	42	39	27				

Clinical Indicators Track circa 6 months behind

All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac arrest of presumed cardiac

33 - STEMI within 150 mins after ECG confirmed AMI > PPCI

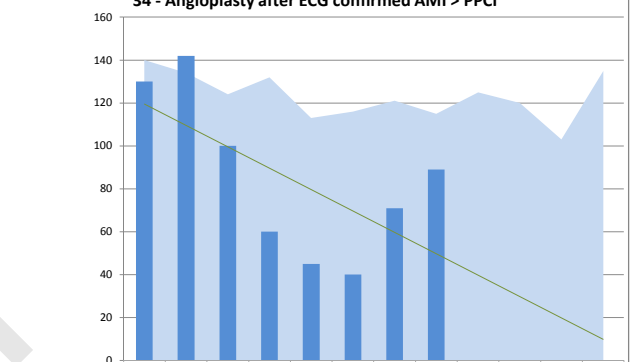


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	131	131	118	127	111	106	113	107	116	111	91	130
2014-15 Actuals	121	127	96	52	42	40	66	87				

Clinical Indicators Track circa 6 months behind

Patients with initial diagnosis of 'definite myocardial infarction' for whom primary angioplasty balloon inflation occurred within 150 minutes of emergency call connected to

34 - Angioplasty after ECG confirmed AMI > PPCI

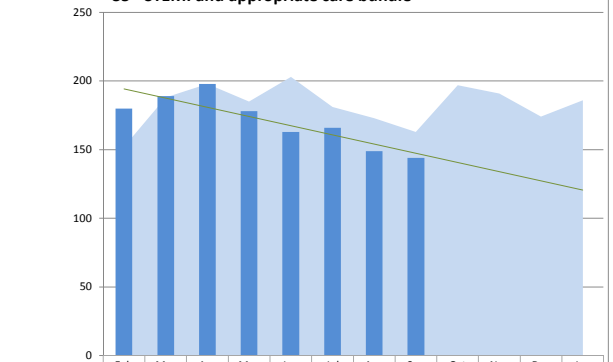


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	140	134	124	132	113	116	121	115	125	120	103	135
2014-15 Actuals	130	142	100	60	45	40	71	89				

Clinical Indicators Track circa 6 months behind

Patients with initial diagnosis of 'definite myocardial infarction' who received primary angioplasty, where first diagnostic ECG performed is by ambulance personnel and patient was directly transferred to a designated PPCI centre as locally agreed (ACQI S

35 - STEMI and appropriate care bundle

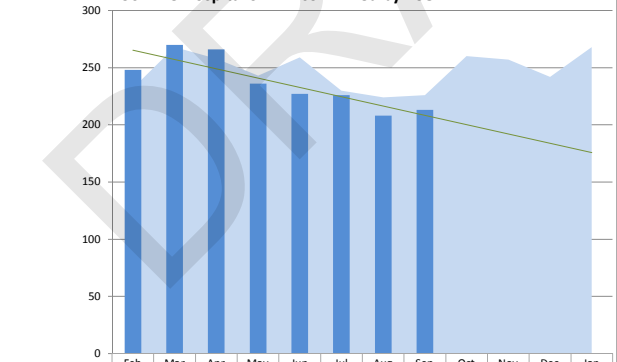


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	152	188	198	185	203	181	173	163	197	191	174	186
2014-15 Actuals	180	189	198	178	163	166	149	144				

Clinical Indicators Track circa 6 months behind

Patients with a pre-hospital diagnosis of suspected ST elevation myocardial infarction confirmed on ECG who received an appropriate care bundle (ACQI SQU03_5_3_1)

36 - Pre Hospital STEMI confirmed by ECG

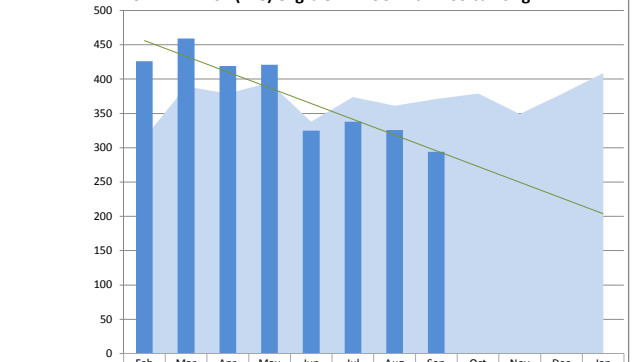


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	232	268	258	243	259	230	224	226	260	257	242	268
2014-15 Actuals	248	270	266	236	227	226	208	213				

Clinical Indicators Track circa 6 months behind

Patients with a pre-hospital diagnosis of suspected ST elevation myocardial infarction confirmed on ECG (ACQI SQU03_5_3_2)

37 - F2F FAST (+ve) eligible > HASU within 60 call origin



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	314	389	379	395	338	374	361	371	379	349	378	409
2014-15 Actuals	426	459	419	421	325	338	326	294				

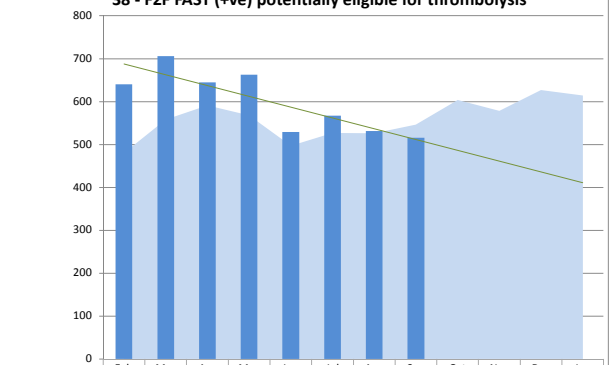
Clinical Indicators Track circa 6 months behind

FAST positive patients (assessed face to face) potentially eligible for stroke thrombolysis within agreed local guidelines arriving at hospitals with a hyper acute stroke centre within 60 minutes of emergency call connecting to ambulance service (ACQI SQU

Effective - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

38 - F2F FAST (+ve) potentially eligible for thrombolysis

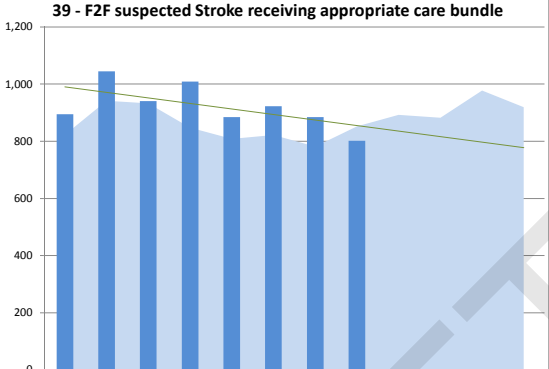


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	480	558	591	568	497	527	526	546	604	578	627	614
2014-15 Actuals	640	706	645	663	529	567	531	516				

Clinical Indicators Track circa 6 months behind

FAST positive patients (assessed face to face) potentially eligible for stroke thrombolysis within agreed local guidelines (ACQI SQU03_6_1_2)

39 - F2F suspected Stroke receiving appropriate care bundle

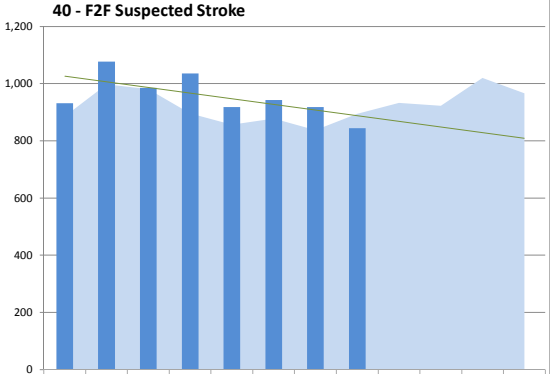


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	823	941	933	848	808	822	781	852	892	882	977	919
2014-15 Actuals	894	1,044	940	1,009	884	923	884	802				

Clinical Indicators Track circa 6 months behind

The number of suspected stroke patients assessed face to face who received an appropriate care bundle (ACQI SQU03_6_2_1)

40 - F2F Suspected Stroke

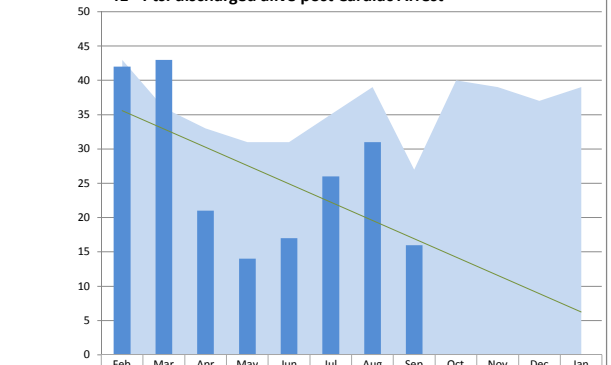


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	886	998	981	896	856	878	837	894	932	923	1,020	966
2014-15 Actuals	932	1,077	985	1,036	918	943	918	844				

Clinical Indicators Track circa 6 months behind

The number of suspected stroke patients assessed face to face (ACQI SQU03_6_2_2)

41 - Pts. discharged alive post Cardiac Arrest

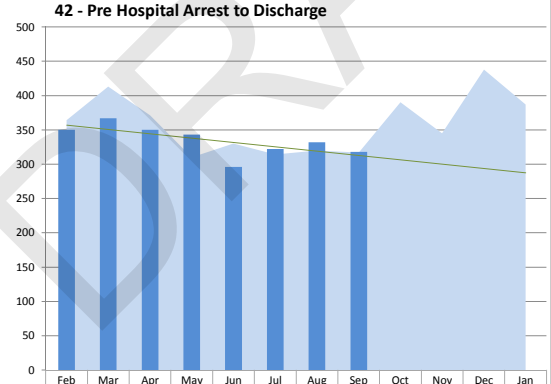


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	43	36	33	31	31	35	39	27	40	39	37	39
2014-15 Actuals	42	43	21	14	17	26	31	16				

Clinical Indicators Track circa 6 months behind

Of the patients included in the denominator, the number of patients discharged from hospital alive (ACQI SQU03_7_1_1)

42 - Pre Hospital Arrest to Discharge

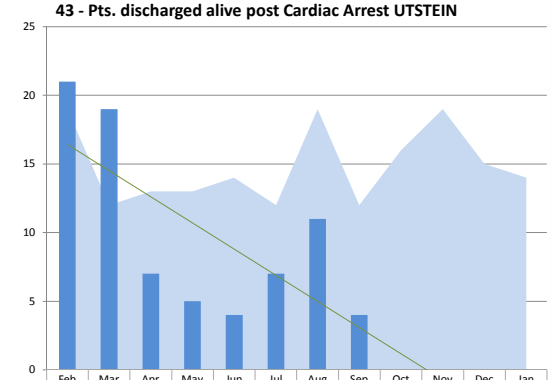


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	364	413	371	310	330	314	320	317	390	345	438	387
2014-15 Actuals	350	367	350	343	296	322	332	318				

Clinical Indicators Track circa 6 months behind

All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac arrest (ACQI SQU03_7_1_2)

43 - Pts. discharged alive post Cardiac Arrest UTSTEIN



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	19	12	13	13	14	12	19	12	16	19	15	14
2014-15 Actuals	21	19	7	5	4	7	11	4				

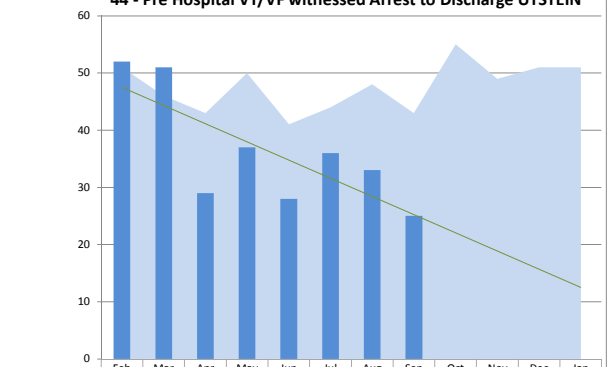
Clinical Indicators Track circa 6 months behind

Of the patients included in the denominator, the number of patients discharged from hospital alive (ACQI SQU03_7_2_1)

Effective - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

44 - Pre Hospital VT/VF witnessed Arrest to Discharge UTSTEIN

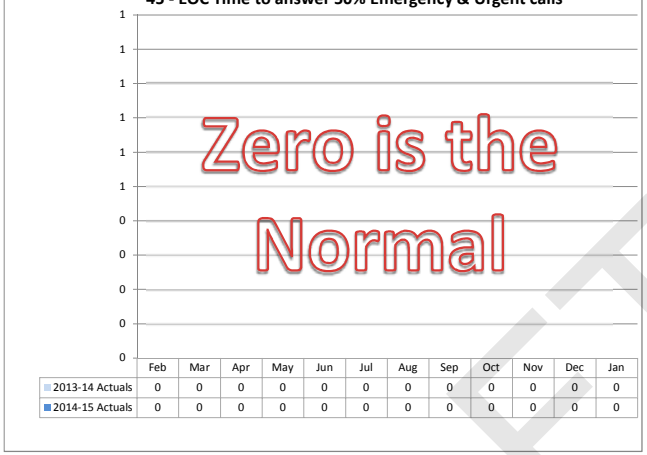


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	51	46	43	50	41	44	48	43	55	49	51	51
2014-15 Actuals	52	51	29	37	28	36	33	25				

Clinical Indicators Track circa 6 months behind

All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac arrest of presumed cardiac origin, where the arrest was bystander witnessed and the initial rhythm was VF or

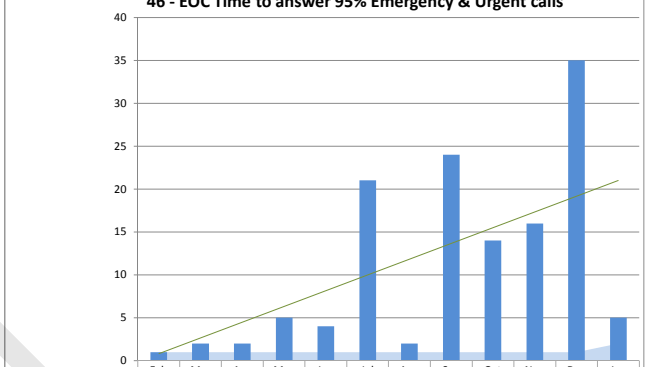
45 - EOC Time to answer 50% Emergency & Urgent calls



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	0	0	0	0	0	0	0	0	0	0	0	0
2014-15 Actuals	0	0	0	0	0	0	0	0	0	0	0	0

Time to answer calls (emergency and urgent), measured by median, 95th percentile and 99th percentile. (ACQI SQU03_8_1_1_50)

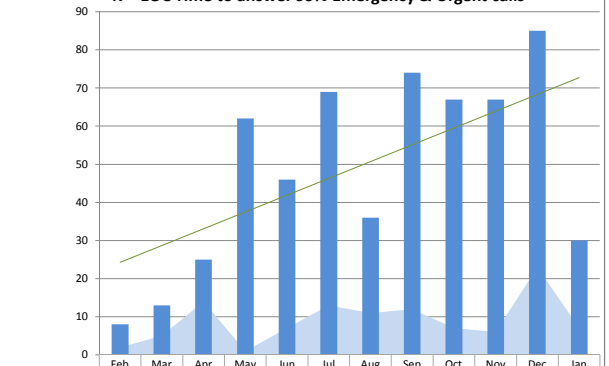
46 - EOC Time to answer 95% Emergency & Urgent calls



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	1	1	1	1	1	1	1	1	1	1	1	2
2014-15 Actuals	1	2	2	5	4	21	2	24	14	16	35	5

(ACQI SQU03_8_1_1_95)

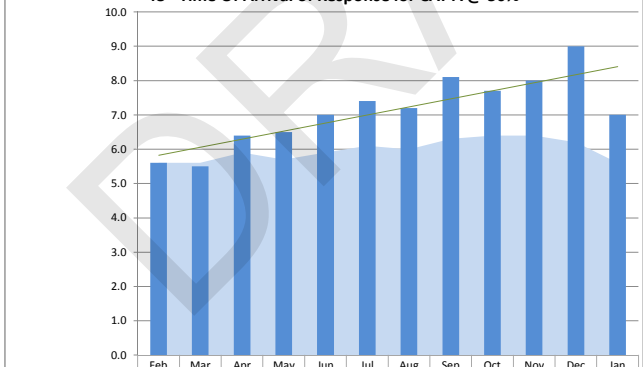
47 - EOC Time to answer 99% Emergency & Urgent calls



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	2	5	14	1	7	13	11	12	7	6	23	7
2014-15 Actuals	8	13	25	62	46	69	36	74	67	67	85	30

(ACQI SQU03_8_1_1_99)

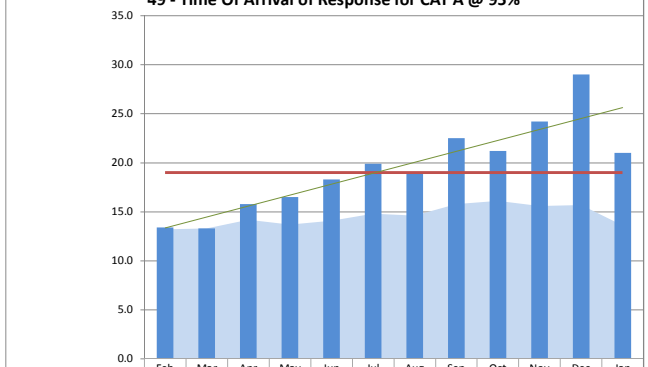
48 - Time Of Arrival of Response for CAT A @ 50%



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	5.6	5.6	5.9	5.7	5.9	6.1	6.0	6.3	6.4	6.4	6.2	5.6
2014-15 Actuals	5.6	5.5	6.4	6.5	7.0	7.4	7.2	8.1	7.7	8.0	9.0	7

Time to arrival of an ambulance-dispatched health professional dispatched by the ambulance service for immediately life-threatening (Category A) calls, measured by median, 95th percentile and 99th percentile (ACQI SQU03_9_1_1_50)

49 - Time Of Arrival of Response for CAT A @ 95%



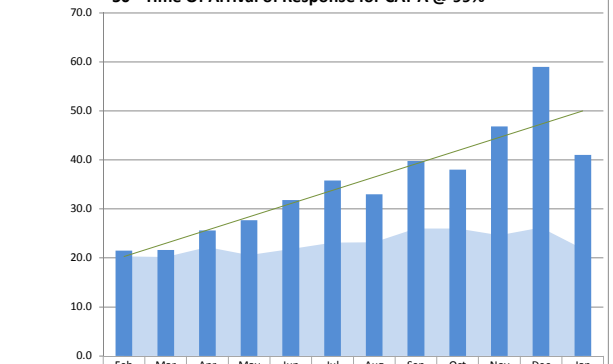
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	13.2	13.3	14.2	13.7	14.1	14.8	14.6	15.8	16.1	15.6	15.7	13.6
2014-15 Actuals	13.4	13.3	15.8	16.5	18.3	19.9	18.9	22.5	21.2	24.2	29.0	21
Target	19	19	19	19	19	19	19	19	19	19	19	19

(ACQI SQU03_9_1_1_95)

Effective - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

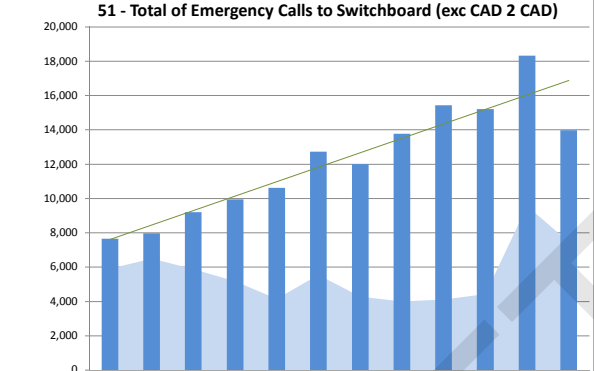
50 - Time Of Arrival of Response for CAT A @ 99%



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	20.3	20.2	22.2	20.6	21.8	23.1	23.2	26.0	26.0	24.6	26.2	21.8
2014-15 Actuals	21.5	21.6	25.6	27.7	31.8	35.8	33.0	39.8	38.0	46.8	59.0	41

(ACQI SQU03_9_1_1_99)

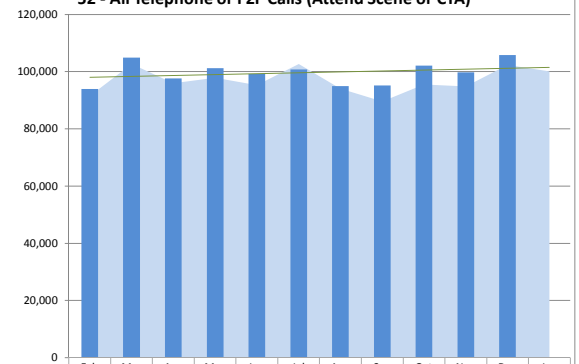
51 - Total of Emergency Calls to Switchboard (exc CAD 2 CAD)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	5,905	6,503	5,882	5,170	4,142	5,552	4,274	3,998	4,106	4,420	9,559	7,469
2014-15 Actuals	7,648	7,975	9,207	9,947	10,629	12,721	12,008	13,778	15,431	15,210	18,327	13979

Number of emergency calls that have been resolved by providing telephone advice. (ACQI SQU03_10_1_1)

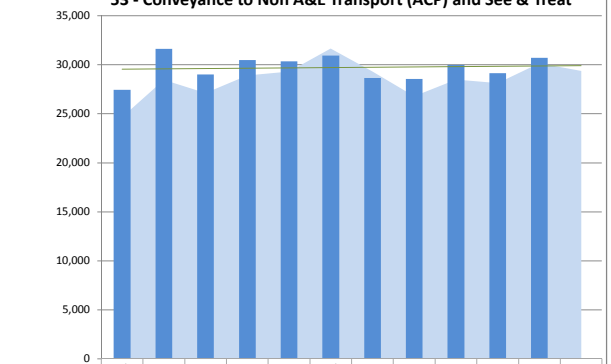
52 - All Telephone or F2F Calls (Attend Scene or CTA)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	91,515	102,71	95,895	97,880	95,299	102,61	94,096	89,582	95,460	94,862	102,30	100,08
2014-15 Actuals	93,981	104,94	97,648	101,24	99,144	100,73	94,935	95,224	102,07	99,719	105839	

All emergency calls that receive a telephone or face-to-face response from the ambulance service (ACQI SQU03_10_1_2)

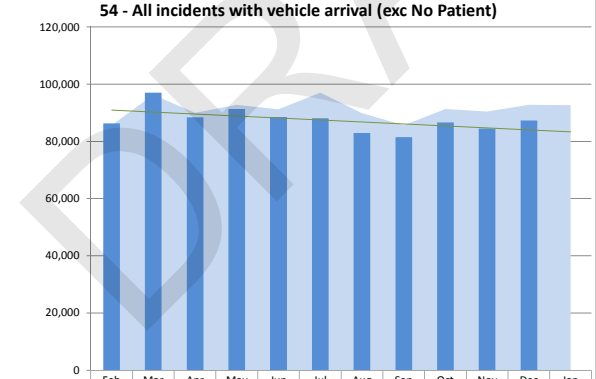
53 - Conveyance to Non A&E Transport (ACP) and See & Treat



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	24,675	28,458	27,115	28,918	29,301	31,664	29,307	26,782	28,499	28,121	30,153	29,357
2014-15 Actuals	27,448	31,620	29,014	30,484	30,346	30,930	28,668	28,561	30,008	29,135	30702	

Patient journeys to a destination other than Type 1 and 2 A&E + number of patients discharged after treatment at the scene or onward referral to an alternative care pathway (ACQI SQU03_10_2_1)

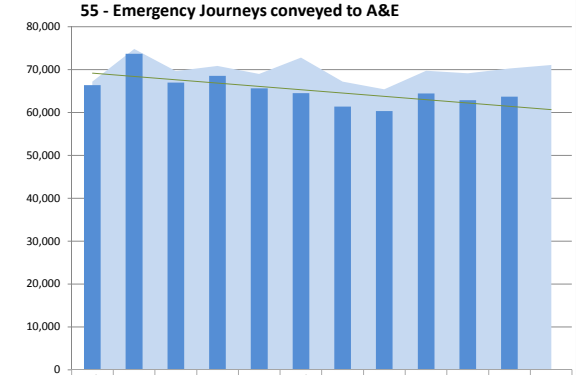
54 - All incidents with vehicle arrival (exc No Patient)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	85,610	96,212	90,013	92,710	91,154	97,064	89,822	85,584	91,354	90,442	92,748	92,614
2014-15 Actuals	86,333	96,971	88,441	91,299	88,515	88,015	82,927	81,446	86,639	84,509	87261	

All emergency calls that receive a face-to-face response from the ambulance service (ACQI SQU03_10_2_2)

55 - Emergency Journeys conveyed to A&E



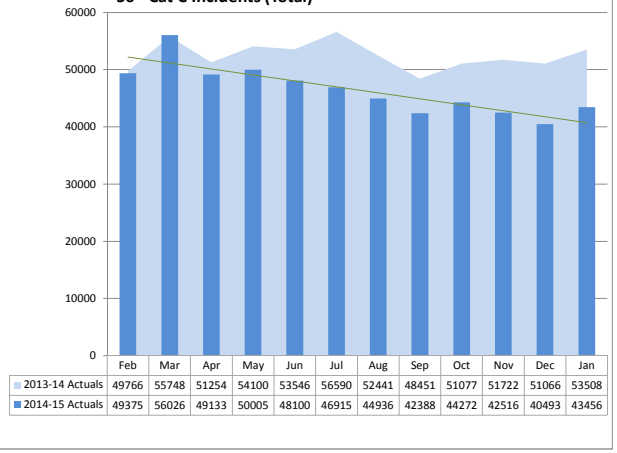
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	67,225	74,827	69,665	70,883	68,992	72,800	67,198	65,410	69,756	69,117	70,241	71,082
2014-15 Actuals	66,355	73,681	67,014	68,568	65,623	64,519	61,393	60,347	64,445	62,862	63667	

Number of emergency journeys (ACQI ASI SRS17 1 1 1)

Effective - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

56 - Cat C Incidents (Total)



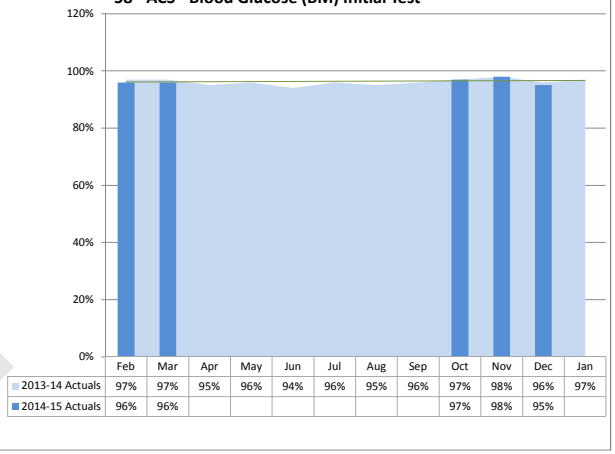
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	49766	55748	51254	54100	53546	56590	52441	48451	51077	51722	51066	53508
2014-15 Actuals	49375	56026	49133	50005	48100	46915	44936	42388	44272	42516	40493	43456

Number of Category C Incidents received by Month (C1-C4)

Awaiting Data Source

Count of electronic downloads submitted for central storage (LAS Clinical Performance Indicators)

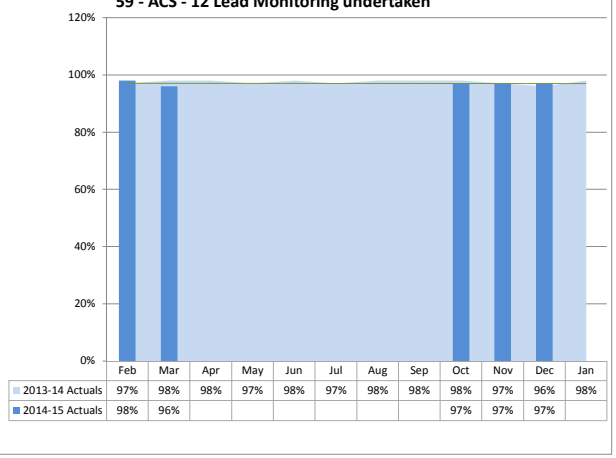
58 - ACS - Blood Glucose (BM) Initial Test



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	97%	97%	95%	96%	94%	96%	95%	96%	97%	98%	96%	97%
2014-15 Actuals	96%	96%							97%	98%	95%	

Count of BM Tests associated with Acute Coronary Syndrome patients (LAS Clinical Performance Indicators)

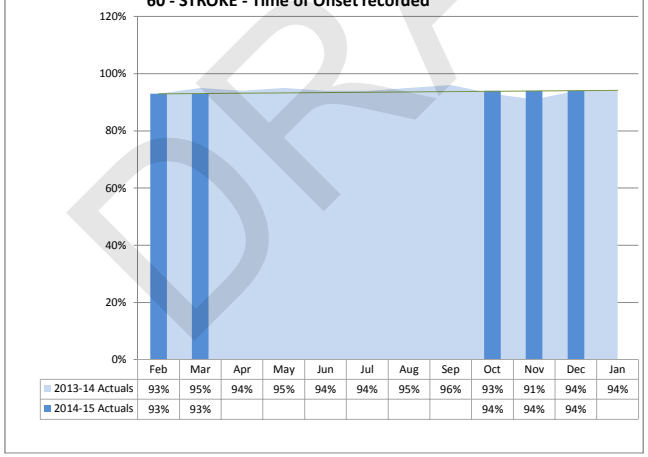
59 - ACS - 12 Lead Monitoring undertaken



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	97%	98%	98%	97%	98%	97%	98%	98%	98%	97%	96%	98%
2014-15 Actuals	98%	96%							97%	97%	97%	

Count of 12 Lead ECGs associated with Acute Coronary Syndrome patients (LAS Clinical Performance Indicators)

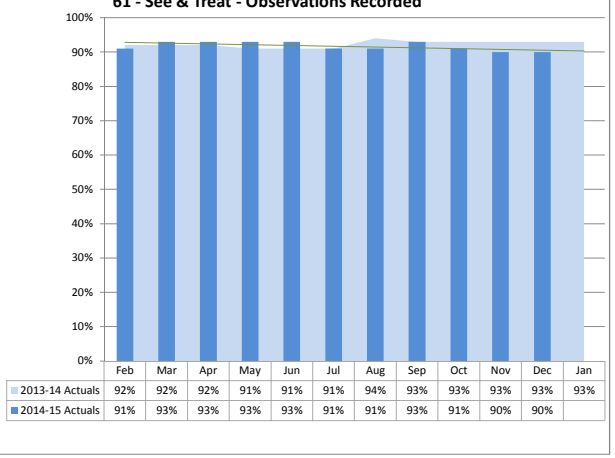
60 - STROKE - Time of Onset recorded



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	93%	95%	94%	95%	94%	94%	95%	96%	93%	91%	94%	94%
2014-15 Actuals	93%	93%							94%	94%	94%	

For patients with thrombotic stroke, treatment with thrombolytic therapy is highly time-dependent. Admission to a stroke unit for early specialist care is known to be life saving and to reduce disability, even if thrombolysis is not indicated. (LAS Clinic

61 - See & Treat - Observations Recorded



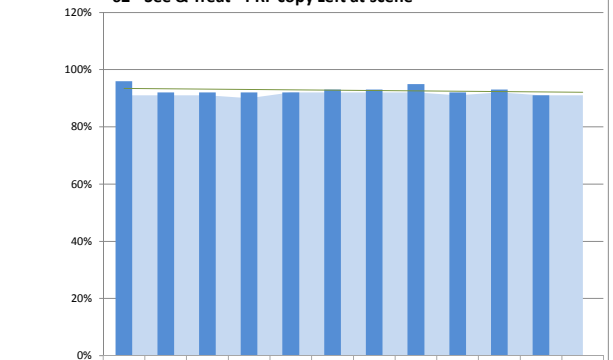
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	92%	92%	92%	91%	91%	91%	94%	93%	93%	93%	93%	93%
2014-15 Actuals	91%	93%	93%	93%	93%	91%	91%	93%	91%	90%	90%	

A full set of observations is defined as: Time (hh:mm), AVPU, respiratory rate, respiratory depth, O2 saturation (must be written as a percentage), pulse rate, pulse character, blood pressure and colour. (LAS Clinical Performance Indicators)

Effective - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

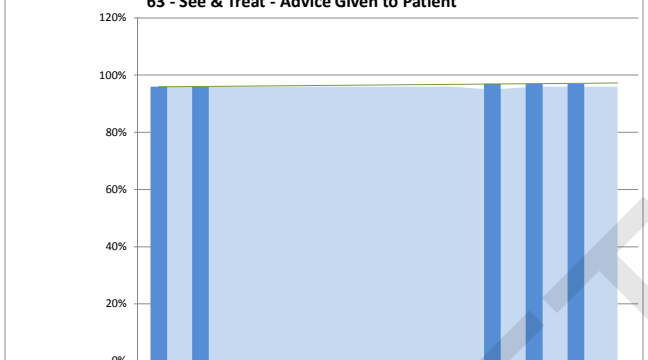
62 - See & Treat - PRF copy Left at scene



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	91%	91%	91%	90%	92%	92%	92%	92%	91%	92%	91%	91%
2014-15 Actuals	96%	92%	92%	92%	92%	93%	93%	95%	92%	93%	91%	

There must be clear documentation that a copy of the PRF was left with the patient (either on the reverse of the PRF or in the free text). (LAS Clinical Performance Indicators)

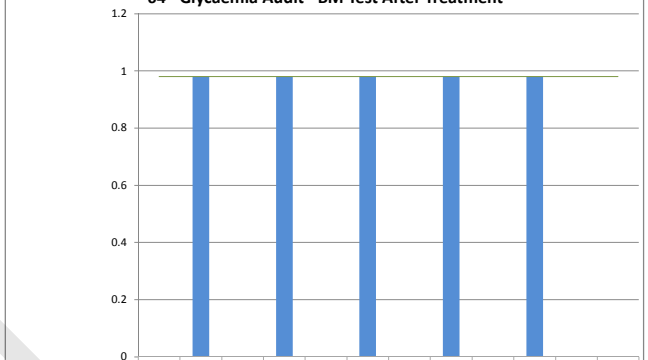
63 - See & Treat - Advice Given to Patient



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	96%	96%	96%	96%	96%	96%	96%	96%	95%	96%	96%	96%
2014-15 Actuals	96%	96%							97%	97%	97%	

Team Leaders should review the documented advice given to the patient on either the reverse of the PRF or the free text and assess whether it was appropriate. (LAS Clinical Performance Indicators)

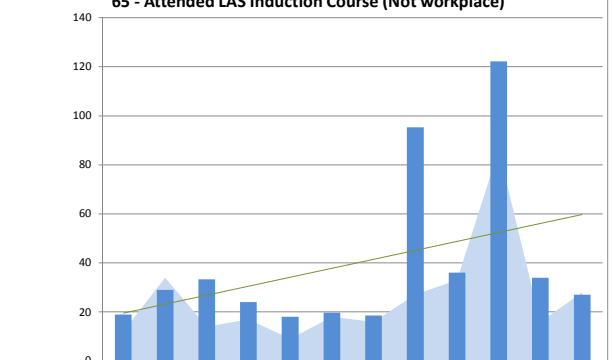
64 - Glycaemia Audit - BM Test After Treatment



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals		98%		98%		98%		98%		98%		98%
2014-15 Actuals		98%		98%		98%		98%		98%		

(LAS Clinical Performance Indicators)

65 - Attended LAS Induction Course (Not workplace)



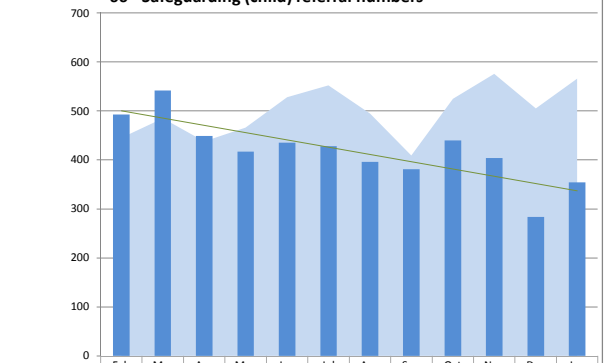
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	12	34	14	17	9	18	16	27	33	86	16	28
2014-15 Actuals	19	29	33.29	24	18	19.7	18.6	95.28	36	122.2	34	27

WTE of New Staff receiving a formal service induction course. This does not count localised inductions

Caring - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

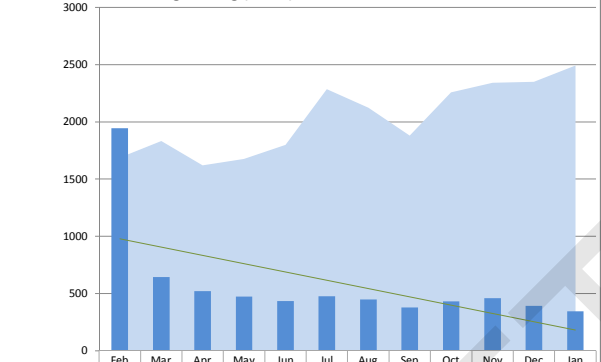
66 - Safeguarding (child) referral numbers



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	445	485	438	466	528	552	495	409	525	576	505	566
2014-15 Actuals	493	542	449	417	435	428	396	381	440	404	284	354

Count of Children referred by Service to appropriate authorities

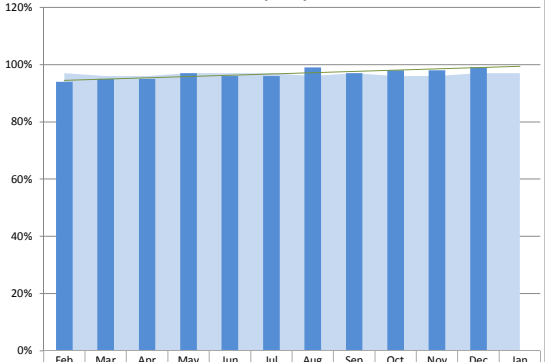
67 - Safeguarding (adult) referral numbers



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	1686	1834	1620	1676	1798	2287	2124	1880	2257	2341	2350	2493
2014-15 Actuals	1945	645	520	472	435	476	449	378	432	458	393	345

Count of Adults referred by Service to appropriate authorities

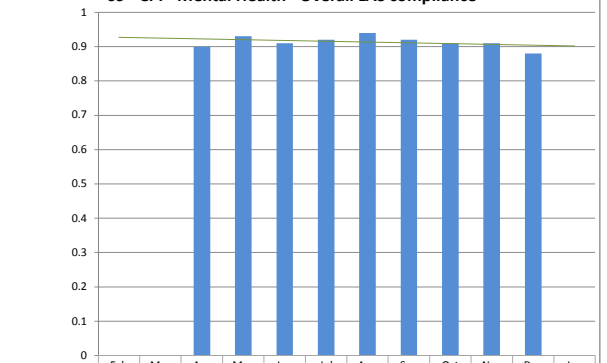
68 - CPI - Mental Health - Capacity Tool



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	97%	96%	96%	97%	97%	97%	96%	97%	96%	96%	97%	97%
2014-15 Actuals	94%	95%	95%	97%	96%	96%	99%	97%	98%	98%	99%	

Where a patient refuses assessment, a form of treatment and/or conveyance and patient capacity is in doubt, the capacity tool should be used to determine whether patient has capacity to refuse. (LAS Clinical Performance Indicators)

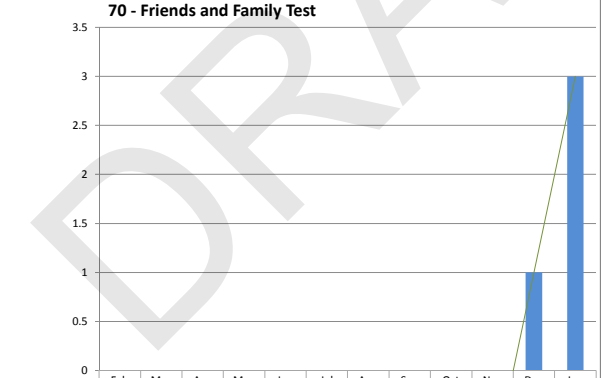
69 - CPI - Mental Health - Overall LAS compliance



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals			90%	93%	91%	92%	94%	92%	91%	91%	88%	

(LAS Clinical Performance Indicators)

70 - Friends and Family Test



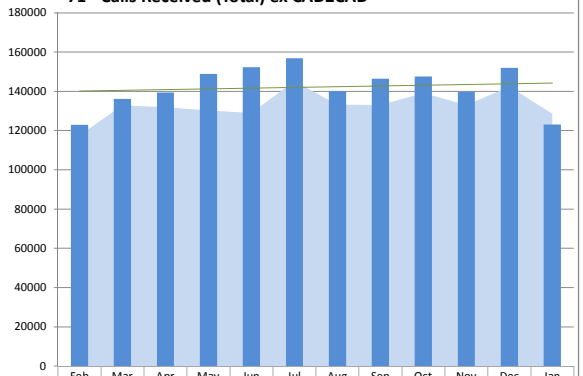
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals											1	3

Numbers by month of returns from Friends and Family Test (Formally commences April 2015)

Responsive - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

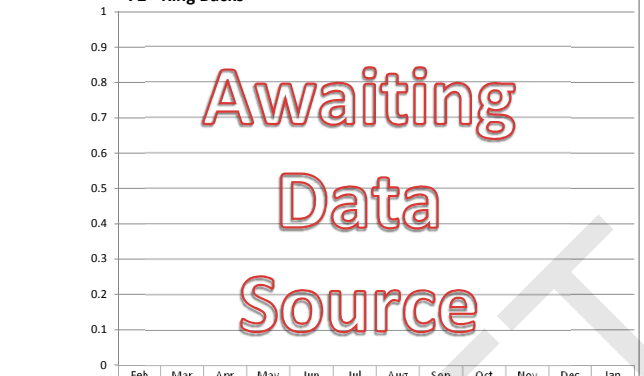
71 - Calls Received (Total) ex CAD2CAD



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	117485	132899	131862	130275	129014	145152	133163	133107	139108	133112	142350	128705
2014-15 Actuals	122888	136128	139380	148878	152311	156863	140012	146411	147626	139672	152028	123112

Total calls to LAS

72 - Ring Backs

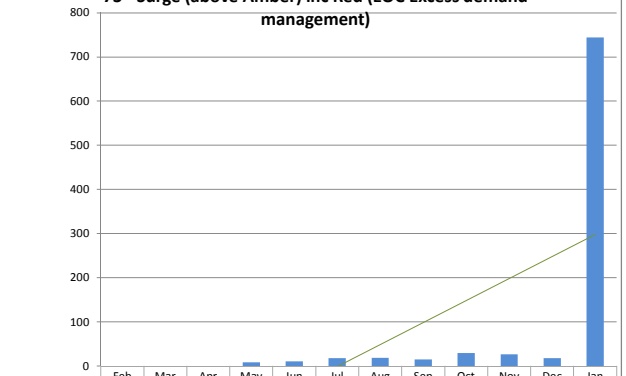


Awaiting Data Source

	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals												

Abandoned Calls rung back

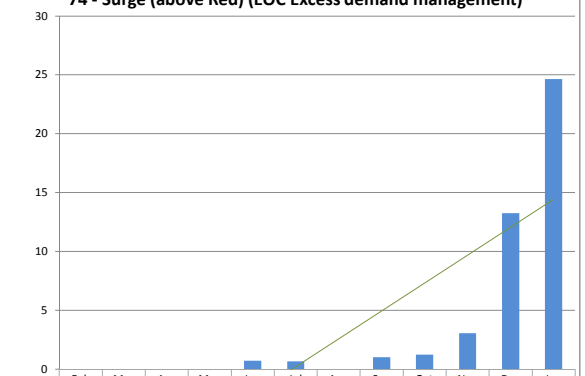
73 - Surge (above Amber) inc Red (EOC Excess demand management)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals				197:19	258:17	424:21	452:29	355:13	713:59	646:15	425:57	744

Data from July 14 Onwards, replaced Demand Management Plan

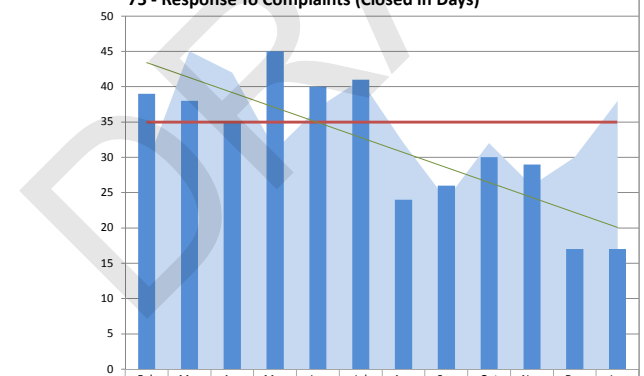
74 - Surge (above Red) (EOC Excess demand management)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals				0:00	17:35	16:14	0:00	24:42	29:59	73:43	318:01	591:25

Data from July 14 Onwards, replaced Demand Management Plan

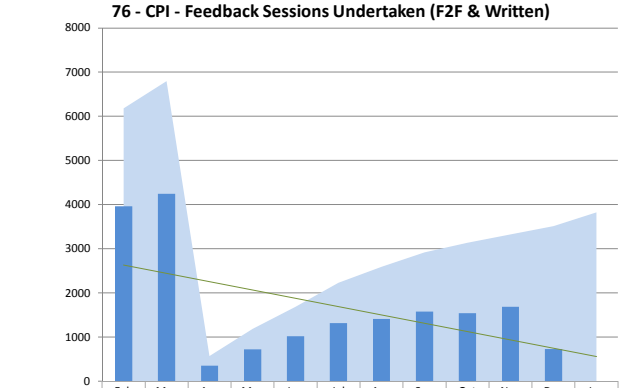
75 - Response To Complaints (Closed in Days)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	29	45	42	31	37	41	32	24	32	26	30	38
2014-15 Actuals	39	38	35	45	40	41	24	26	30	29	17	17
Target	35	35	35	35	35	35	35	35	35	35	35	35

A true reflection of response times cannot be calculated until the furthest timescale (i.e. 35 days working days have elapsed) - Approximately 33% of complaints are closed within the 35 day time frame

76 - CPI - Feedback Sessions Undertaken (F2F & Written)



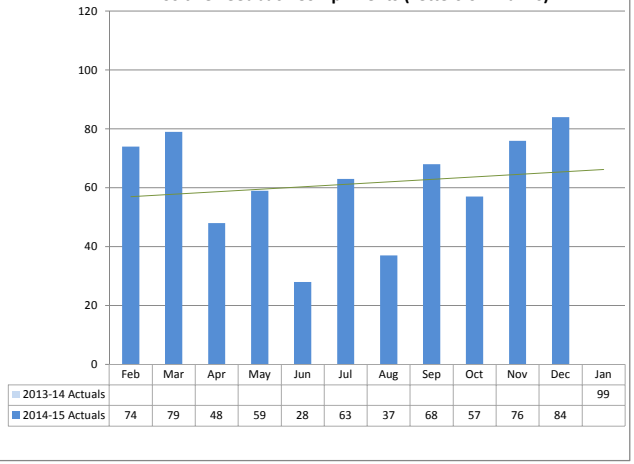
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	6182	6795	573	1184	1689	2229	2590	2918	3133	3327	3510	3823
2014-15 Actuals	3963	4243	356	722	1022	1315	1412	1577	1540	1690	730	

CUMULATIVE Team leaders are required to feedback to operational staff an overview of recent compliance against the PRF audits undertaken. This element is about ensuring staff are actively monitored to provide documentation of appropriate care.

Responsive - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

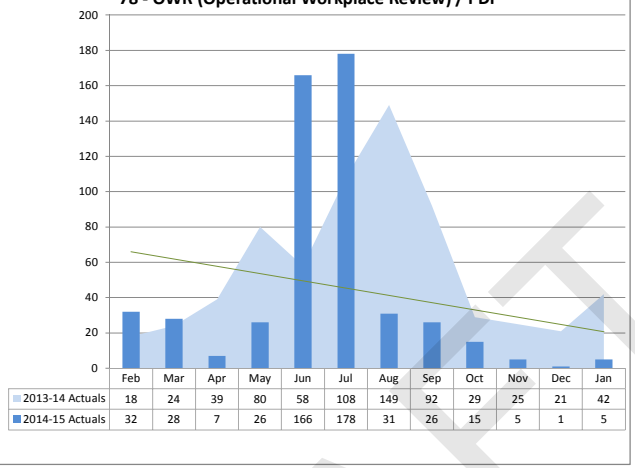
77 - Positive Feedback Compliments (Letters of Thanks)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												99
2014-15 Actuals	74	79	48	59	28	63	37	68	57	76	84	

Letters of thanks sent to the Service addressed to any member of staff and notified to the Communications Team. (Pre Nov 2013 letters scanned Total 733)

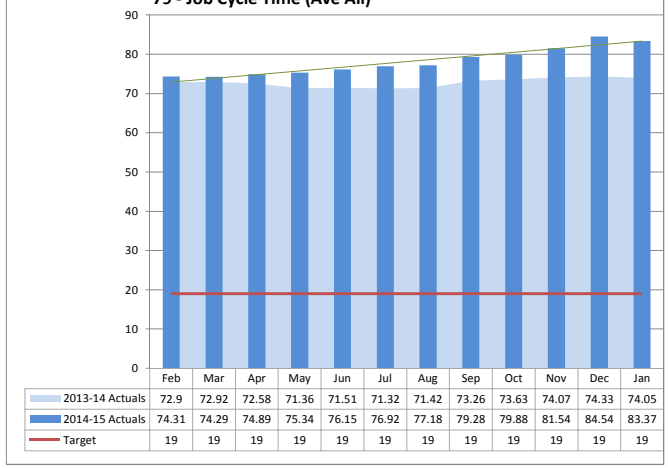
78 - OWR (Operational Workplace Review) / PDP



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	18	24	39	80	58	108	149	92	29	25	21	42
2014-15 Actuals	32	28	7	26	166	178	31	26	15	5	1	5

Reviews of staff, variously recorded as CPD (Continuing Professional Development) CPDI (Interview), IPR (Individual Performance Review), PDR (Personal Development Review), PCD (Personal Career Development)

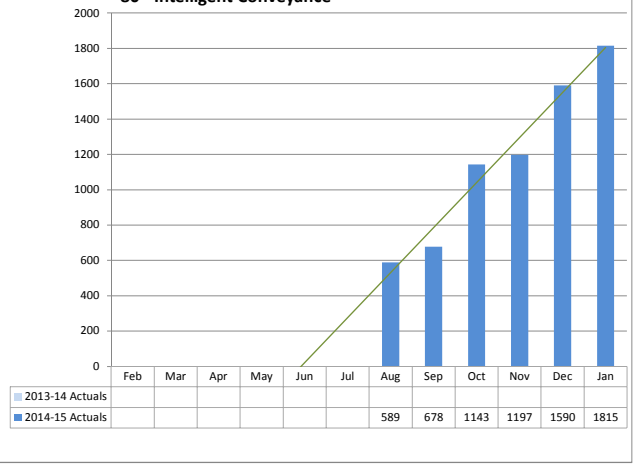
79 - Job Cycle Time (Ave All)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	72.9	72.92	72.58	71.36	71.51	71.32	71.42	73.26	73.63	74.07	74.33	74.05
2014-15 Actuals	74.31	74.29	74.89	75.34	76.15	76.92	77.18	79.28	79.88	81.54	84.54	83.37
Target	19	19	19	19	19	19	19	19	19	19	19	19

Job Cycle Time Average for Month (Conveyed and Non Conveyed rpt 644)

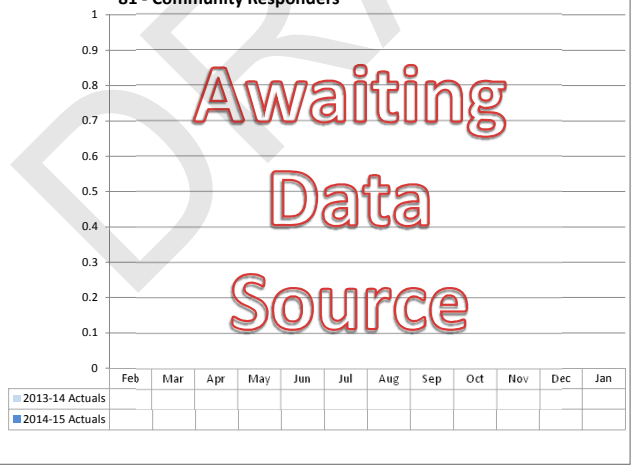
80 - Intelligent Conveyance



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals							589	678	1143	1197	1590	1815

Number of Vehicles diverted to create capacity at alternative Emergency Departments

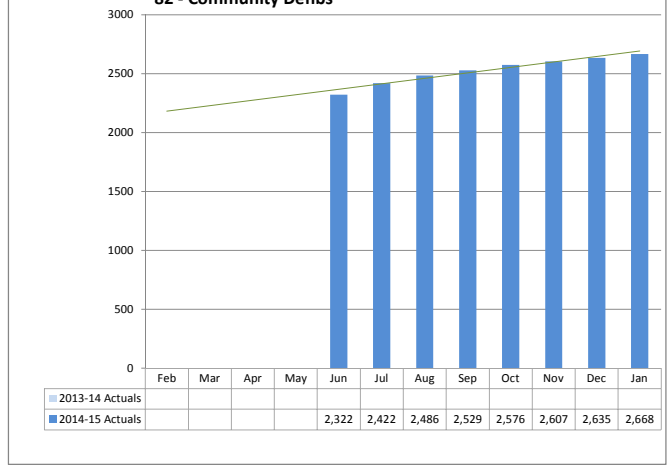
81 - Community Responders



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals												

Number of persons recognised and deployable by Service as authorised community responders

82 - Community Defibs

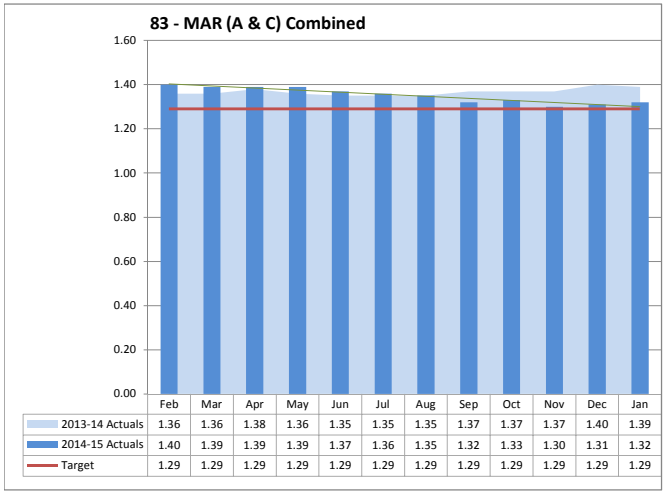


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals					2,322	2,422	2,486	2,529	2,576	2,607	2,635	2,668

Number of Public Access Defibs available pan London

Responsive - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.



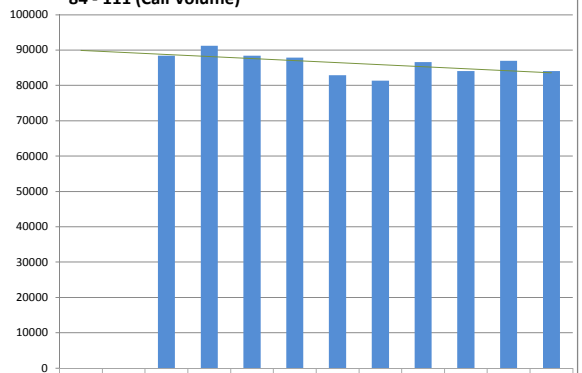
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	1.36	1.36	1.38	1.36	1.35	1.35	1.35	1.37	1.37	1.37	1.40	1.39
2014-15 Actuals	1.40	1.39	1.39	1.39	1.37	1.36	1.35	1.32	1.33	1.30	1.31	1.32
Target	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29

Multiple Attendance Ratio. A calculation based on A & C responses of how many occasions an additional vehicle has attended a scene. Acceptable reasons would be cardiac arrest or multiple casualties

Well Led - Dashboard Metric Graphs - Draft v2B

Green Line is a Linear Trend line of 2014-15 data.

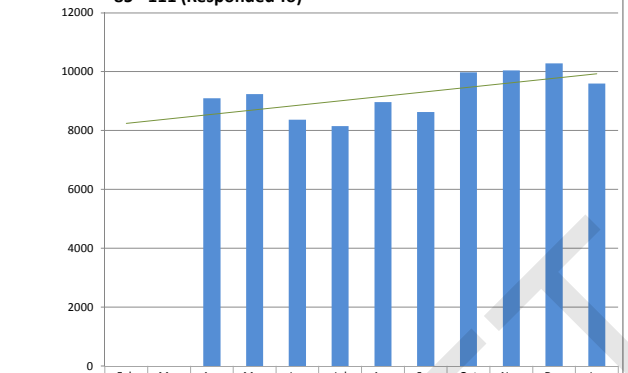
84 - 111 (Call Volume)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals			88382	91225	88382	87833	82847	81373	86568	84099	86950	84110

Number of calls presented to 111 within London and recorded by LAS

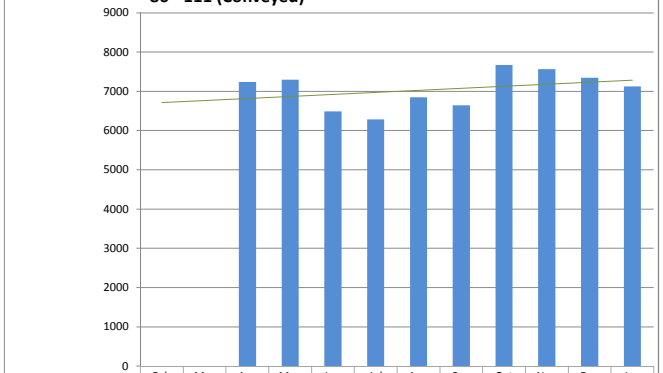
85 - 111 (Responded To)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals			9099	9243	8371	8146	8972	8635	9982	10038	10283	9602

Number of 111 calls transferred to the LAS for attendance with patient

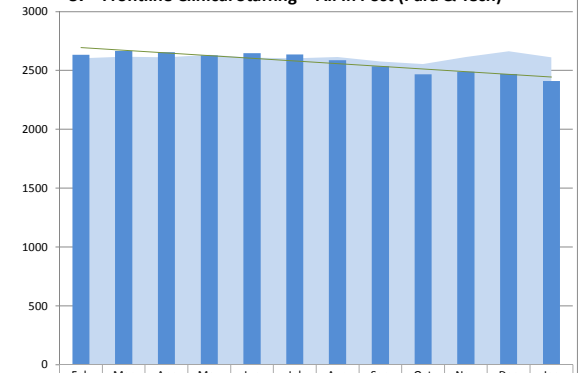
86 - 111 (Conveyed)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals			7237	7300	6490	6287	6851	6646	7675	7563	7341	7124

Number of 111 calls who receive LAS attendance at scene and are subsequently conveyed to hospital

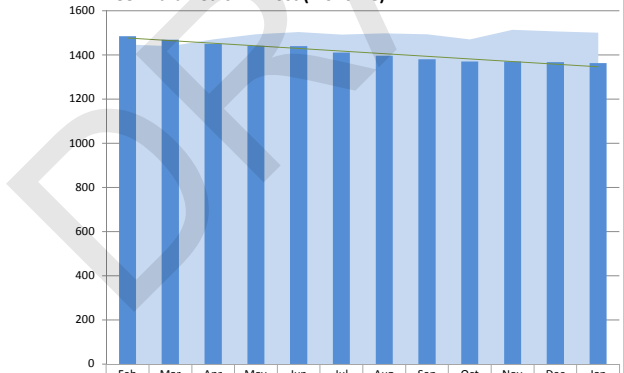
87 - Frontline Clinical Staffing - All In Post (Para & Tech)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	2603	2616	2611	2633	2608	2604	2613	2575	2555	2614	2662	2611
2014-15 Actuals	2632	2665	2655	2628	2647	2636	2588	2535	2467	2490	2471	2410

Count of paramedic and Non Paramedic frontline staff (excludes management / admin grades etc.)

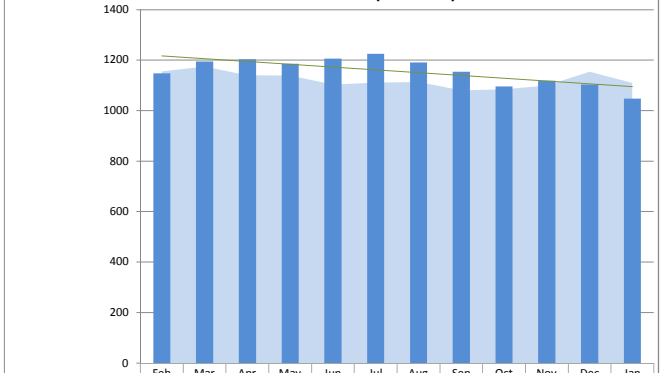
88 - Paramedic - In Post (Frontline)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	1448	1441	1472	1494	1505	1493	1499	1494	1471	1514	1507	1502
2014-15 Actuals	1485	1470	1451	1442	1441	1411	1397	1380	1371	1370	1368	1363

Qualified Paramedical Staff deployed on frontline duties

89 - Non Paramedic - In Post (Frontline)



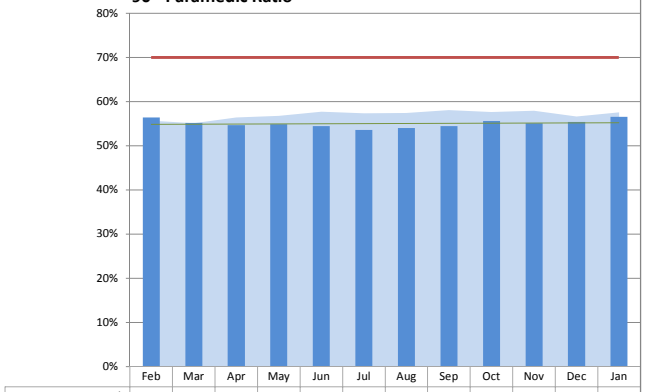
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	1155	1175	1140	1139	1104	1111	1114	1081	1084	1100	1154	1110
2014-15 Actuals	1147	1195	1204	1186	1206	1225	1191	1155	1096	1119	1103	1047

Non Paramedical Staff deployed on frontline duties (Numbers includes student paramedics etc.)

Well Led - Dashboard Metric Graphs - Draft v2B

Green Line is a Linear Trend line of 2014-15 data.

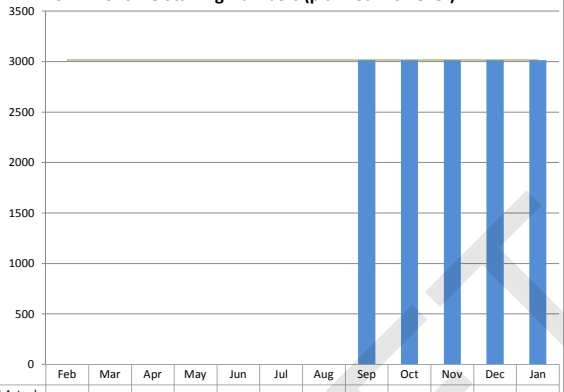
90 - Paramedic Ratio



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	56%	55%	56%	57%	58%	57%	57%	58%	58%	58%	57%	58%
2014-15 Actuals	56%	55%	55%	55%	54%	54%	54%	54%	56%	55%	55%	57%
Target	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7

Paramedic to Non Paramedic expressed as percentage. Commisioners Target for 2016 is 70%

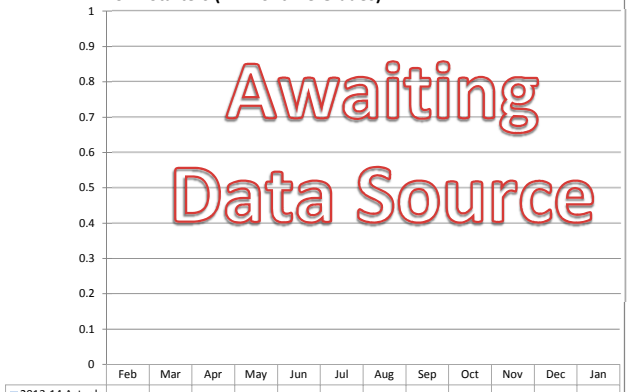
91 - Frontline Staffing Numbers (planned inc Relief)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals								3016	3016	3016	3016	3016

Frontline staff plan including 32% relief factor (from September 2014)

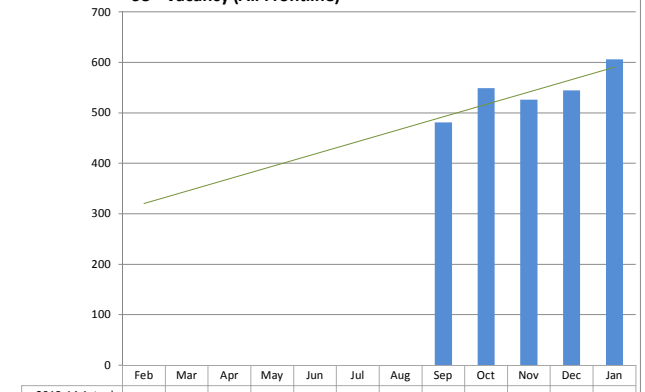
92 - Starters (All Frontline Grades)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals												

WTE Trainees and joiners who will take up frontline duties, once qualified

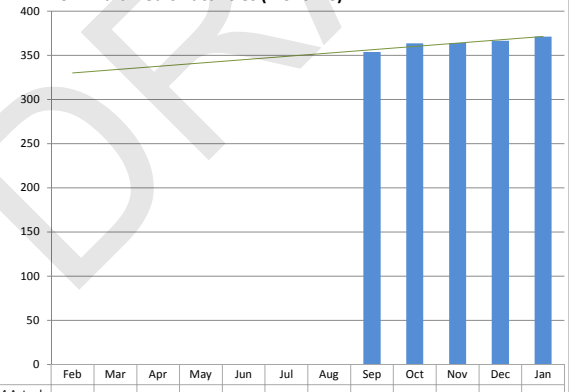
93 - Vacancy (All Frontline)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals								481	549	526	545	606

Monthly WTE vacancy factor including 32% relief

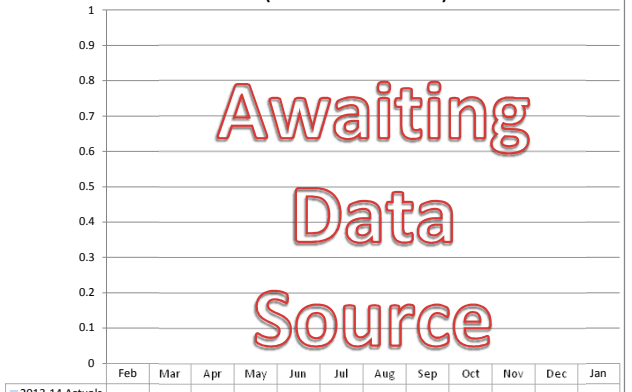
94 - Paramedic Vacancies (Frontline)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals								354	364	364	367	371

Paramedic only vacancies (inc Relief)

95 - Staff Turnover (Joiners Minus Leavers)



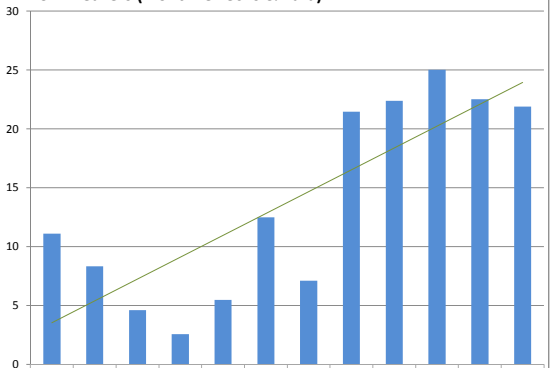
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals												

Numeric positive or negative swing by WTE for frontline duties

Well Led - Dashboard Metric Graphs - Draft v2B

Green Line is a Linear Trend line of 2014-15 data.

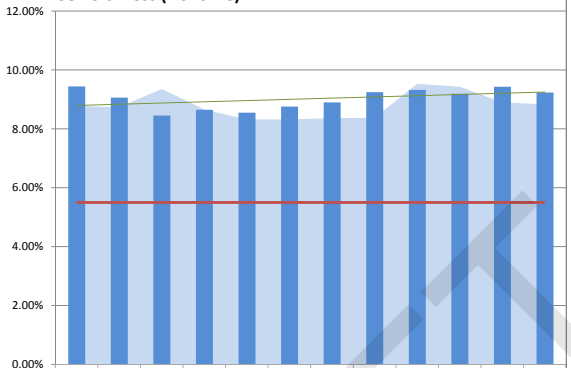
97 - Leavers (Frontline Techs & Para)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												5.726
2014-15 Actuals	11.1	8.3	4.6	2.6	5.5	12.5	7.1	21.5	22.4	25.0	22.5	21.9

Staff leaving LAS for other jobs from frontline

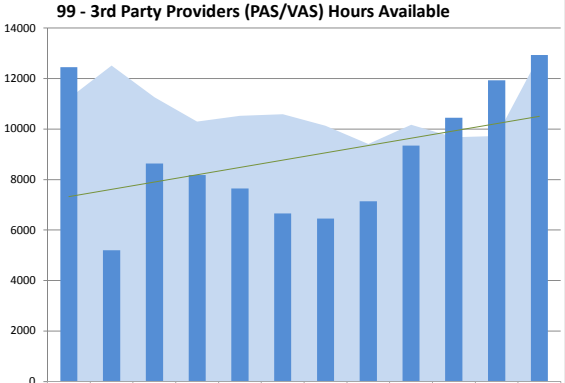
98 - Sickness (frontline)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	8.78%	8.74%	9.36%	8.66%	8.32%	8.33%	8.37%	8.38%	9.53%	9.43%	8.90%	8.83%
2014-15 Actuals	9.44%	9.07%	8.45%	8.65%	8.55%	8.76%	8.90%	9.25%	9.32%	9.19%	9.44%	9.24%
Target	0.055	0.055	0.055	0.055	0.055	0.055	0.055	0.055	0.055	0.055	0.055	0.055

Combined Short and Long Term Sickness for frontline staff

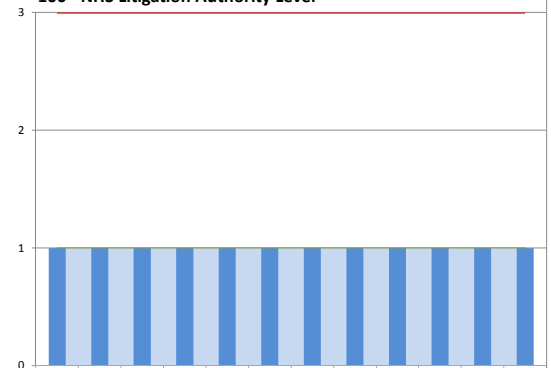
99 - 3rd Party Providers (PAS/VAS) Hours Available



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	11210	12519	11259	10300	10531	10583	10138	9406	10169	9677	9721	12894
2014-15 Actuals	12453	5196	8631	8181	7641	6654	6451	7138	9352	10444	11929	12928

Total Hours recorded as being supplied by Private Ambulance Service (PAS) or Voluntary Ambulance Service (VAS) to support frontline operations

100 - NHS Litigation Authority Level



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	1	1	1	1	1	1	1	1	1	1	1	1
2014-15 Actuals	1	1	1	1	1	1	1	1	1	1	1	1
Target	3	3	3	3	3	3	3	3	3	3	3	3

NHSLA Level

Quality reports

London Ambulance Service NHS Trust

DRAFT v2B

Please select your reporting month here:

Jan-15

Updated 25/02/2015

Ambulance System Outcomes Dec-14

Ambulance Clinical Outcomes Sep-14

New Data is subject to validation results

Operational Area: **London Ambulance Service**

Contents

#N/A in the data allows trend lines to operate correctly.

Quality Reports

London Ambulance Service NHS Trust

DRAFT v2B

Data Source	Metric Number and Name	Description
Safety	1 - No. WTE Undertaking Training (Not CSR)	WTE staff numbers that receive training above and beyond "Core Skills Refreshers", i.e. driver training, hospital placements, new equipment, modules of paramedic courses
	2 - CSR (Training Days Delivered)	WTE delivery of CSR training for Month
	3 - Adverse Incidents (LA52 Reports)	Number of adverse incidents reported via LA52 per month
	4 - Serious Incidents (NHS Signals)	Number of SI's announced via NHS Signals. N.B. There has not been a Signal Alert issued since Feb 2012
	5 - Never Events (Numbers Reported within LAS)	Number of Never Events occurring within LAS in the month
	6 - Medication Errors (Numbers Reported)	Number of medication errors reported to LAS by staff during Month
	7 - Number Of Serious Incidents (LAS Declared)	Serious Incidents raised within LAS for the month
	8 - Number Of Incidents As Ratio (of Call Volume)	Number of Adverse incidents (LA52) as a percentage of Incident volume per month
	9 - Number Of Complaints (total)	Number of written / logged complaints' against the LAS per month
	10 - NHS Central Alert System (CAS) (Numbers Alerted to LAS)	CAS Alerts circulated by NHS by month
	11 - NHS Central Alert System (CAS) (Requiring Action)	CAS alerts that LAS have needed to undertake some action to address
	12 - Vehicle Cleaning	Number of vehicles receiving cleaning by contractors to standard
	13 - Locality Alert Register (totals on register)	Addresses were staff may suffer threats of violence, and verified that threat exists
Effective	14 - RED 1 calls arrived at scene within 8 mins	The number of Category A (Red 1) calls resulting in an emergency response arriving at the scene of the incident within 8 minutes.
	15 - RED 1 calls arrived at scene (Total)	The number of Category A (Red 1) calls resulting in an emergency response arriving at the scene of the incident.
	16 - RED 1 Time to achieve 95% at scene	The 95th centile of time from Call Connect of a Category A (Red 1) call to an emergency response arriving at the scene of the incident
	17 - RED 2 calls arrived at scene within 8 mins	The number of Category A (Red 2) calls resulting in an emergency response arriving at the scene of the incident within 8 minutes.
	18 - RED 2 calls arrived at scene (Total)	The number of Category A (Red 2) calls resulting in an emergency response arriving at the scene of the incident.
	19 - CAT A Ambulance at scene within 19 mins	The number of Category A calls resulting in an ambulance arriving at the scene of the incident within 19 minutes.
	20 - CAT A Ambulance at scene (ability to transport)	The number of Category A calls resulting in an ambulance able to transport the patient arriving at the scene of the incident.
	21 - EOC Abandoned calls before answering	Number of emergency and urgent calls abandoned before being answered
	22 - Calls connected to Switchboard (excludes CAD 2 CAD)	Total number of emergency and urgent calls presented to switchboard
	23 - Emergency Calls resolved with CTA that recontact in 24	Emergency calls closed with telephone advice where re-contact occurs within 24 hours.
	24 - Emergency Calls resolved with CTA (Hear & Treat)	Emergency calls closed with telephone advice.
	25 - See & Treat (Recontact)	Patients treated and discharged on scene where re-contact occurs within 24 hours
	26 - See & Treat Total	Patients treated and discharged on scene.
	27 - Frequent Callers who have an established procedure	Emergency calls from patients for whom a locally agreed frequent caller procedure is in place
	28 - Total Calls inc Frequent Callers	Total number of emergency calls presented to switchboard
	29 - Patients with a ROSC at hospital	Of the patients included in the denominator, the number of patients who had return of spontaneous circulation on arrival at hospital.
	30 - Patients with a ROSC from out of hospital	All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac arrest.

	Metric Number and Name	Description
Effective	31 - Patients with a ROSC at hospital UTSTEIN	Of the patients included in the denominator, the number of patients who had return of spontaneous circulation on arrival at hospital.
	32 - Pts. with ROSC witnessed arrest cardiac origin CPR UTSTEIN	All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac arrest of presumed cardiac origin, where the arrest was bystander witnessed and the initial rhythm was VF or VT.
	33 - STEMI within 150 mins after ECG confirmed AMI > PPCI	Patients with initial diagnosis of 'definite myocardial infarction' for whom primary angioplasty balloon inflation occurred within 150 minutes of emergency call connected to ambulance service, where first diagnostic Electrocardiogram (ECG) performed is by ambulance personnel and patient was directly transferred to a designated PPCI centre as locally agreed
	34 - Angioplasty after ECG confirmed AMI > PPCI	Patients with initial diagnosis of 'definite myocardial infarction' who received primary angioplasty, where first diagnostic ECG performed is by ambulance personnel and patient was directly transferred to a designated PPCI centre as locally agreed
	35 - STEMI and appropriate care bundle	Patients with a pre-hospital diagnosis of suspected ST elevation myocardial infarction confirmed on ECG who received an appropriate care bundle
	36 - Pre Hospital STEMI confirmed by ECG	Patients with a pre-hospital diagnosis of suspected ST elevation myocardial infarction confirmed on ECG
	37 - F2F FAST (+ve) eligible > HASU within 60 call origin	FAST positive patients (assessed face to face) potentially eligible for stroke thrombolysis within agreed local guidelines arriving at hospitals with a hyper acute stroke centre within 60 minutes of emergency call connecting to ambulance service
	38 - F2F FAST (+ve) potentially eligible for thrombolysis	FAST positive patients (assessed face to face) potentially eligible for stroke thrombolysis within agreed local guidelines
	39 - F2F suspected Stroke receiving appropriate care bundle	The number of suspected stroke patients assessed face to face who received an appropriate care bundle
	40 - F2F Suspected Stroke	The number of suspected stroke patients assessed face to face
	41 - Pts. discharged alive post Cardiac Arrest	Of the patients included in the denominator, the number of patients discharged from hospital alive
	42 - Pre Hospital Arrest to Discharge	All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac arrest
	43 - Pts. discharged alive post Cardiac Arrest UTSTEIN	Of the patients included in the denominator, the number of patients discharged from hospital alive
	44 - Pre Hospital VT/VF witnessed Arrest to Discharge UTSTEIN	All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac arrest of presumed cardiac origin, where the arrest was bystander witnessed and the initial rhythm was VF or VT.
	45 - EOC Time to answer 50% Emergency & Urgent calls	Time to answer calls (emergency and urgent), measured by median, 95th percentile and 99th percentile.
	46 - EOC Time to answer 95% Emergency & Urgent calls	
	47 - EOC Time to answer 99% Emergency & Urgent calls	
	48 - Time Of Arrival of Response for CAT A @ 50%	Time to arrival of an ambulance-dispatched health professional dispatched by the ambulance service for immediately life-threatening (Category A) calls, measured by median, 95th percentile and 99th percentile
	49 - Time Of Arrival of Response for CAT A @ 95%	
	50 - Time Of Arrival of Response for CAT A @ 99%	
	51 - Total of Emergency Calls to Switchboard (exc CAD 2 CAD)	Number of emergency calls that have been resolved by providing telephone advice.
	52 - All Telephone or F2F Calls (Attend Scene or CTA)	All emergency calls that receive a telephone or face-to-face response from the ambulance service
	53 - Conveyance to Non A&E Transport (ACP) and See & Treat	Patient journeys to a destination other than Type 1 and 2 A&E + number of patients discharged after treatment at the scene or onward referral to an alternative care pathway
	54 - All incidents with vehicle arrival (exc No Patient)	All emergency calls that receive a face-to-face response from the ambulance service
	55 - Emergency Journeys conveyed to A&E	Number of emergency journeys
	56 - Cat C Incidents (Total)	Number of Category C Incidents received by Month (C1-C4)
	57 - Defib patient data downloads to central storage	Count of electronic downloads submitted for central storage (LAS Clinical Performance Indicators)

	Metric Number and Name	Description
Effective	58 - ACS - Blood Glucose (BM) Initial Test	Count of BM Tests associated with Acute Coronary Syndrome patients (LAS Clinical Performance Indicators)
	59 - ACS - 12 Lead Monitoring undertaken	Count of 12 Lead ECGs associated with Acute Coronary Syndrome patients (LAS Clinical Performance Indicators)
	60 - STROKE - Time of Onset recorded	For patients with thrombotic stroke, treatment with thrombolytic therapy is highly time-dependent. Admission to a stroke unit for early specialist care is known to be life saving and to reduce disability, even if thrombolysis is not indicated. (LAS Clinical Performance Indicators)
	61 - See & Treat - Observations Recorded	A full set of observations is defined as: Time (hh:mm), AVPU, respiratory rate, respiratory depth, O2 saturation (must be written as a percentage), pulse rate, pulse character, blood pressure and colour. (LAS Clinical Performance Indicators)
	62 - See & Treat - PRF copy Left at scene	There must be clear documentation that a copy of the PRF was left with the patient (either on the reverse of the PRF or in the free text). (LAS Clinical Performance Indicators)
	63 - See & Treat - Advice Given to Patient	Team Leaders should review the documented advice given to the patient on either the reverse of the PRF or the free text and assess whether it was appropriate. (LAS Clinical Performance Indicators)
	64 - Glycaemia Audit - BM Test After Treatment	(LAS Clinical Performance Indicators)
	65 - Attended LAS Induction Course (Not workplace)	WTE of New Staff receiving a formal service induction course. This does not count localised inductions
Caring	66 - Safeguarding (child) referral numbers	Count of Children referred by Service to appropriate authorities
	67 - Safeguarding (adult) referral numbers	Count of Adults referred by Service to appropriate authorities
	68 - CPI - Mental Health - Capacity Tool	Where a patient refuses assessment, a form of treatment and/or conveyance and patient capacity is in doubt, the capacity tool should be used to determine whether patient has capacity to refuse. (LAS Clinical Performance Indicators)
	69 - CPI - Mental Health - Overall LAS compliance	(LAS Clinical Performance Indicators)
	70 - Friends and Family Test	Numbers by month of returns from Friends and Family Test (Formally commences April 2015)
Responsive	71 - Calls Received (Total) ex CAD2CAD	Total calls to LAS
	72 - Ring Backs	Abandoned Calls rung back
	73 - Surge (above Amber) inc Red (EOC Excess demand management)	Data from July 14 Onwards, replaced Demand Management Plan
	74 - Surge (above Red) (EOC Excess demand management)	Data from July 14 Onwards, replaced Demand Management Plan
	75 - Response To Complaints (Closed in Days)	A true reflection of response times cannot be calculated until the furthest timescale (i.e. 35 days working days have elapsed) - Approximately 33% of complaints are closed within the 35 day time frame
	76 - CPI - Feedback Sessions Undertaken (F2F & Written)	CUMULATIVE Team leaders are required to feedback to operational staff an overview of recent compliance against the PRF audits undertaken. This element is about ensuring staff are actively monitored to provide documentation of appropriate care.
	77 - Positive Feedback Compliments (Letters of Thanks)	Letters of thanks sent to the Service addressed to any member of staff and notified to the Communications Team. (Pre Nov 2013 letters scanned Total 733)
	78 - OWR (Operational Workplace Review) / PDP	Reviews of staff, variously recorded as CPD (Continuing Professional Development) CPDI (Interview), IPR (Individual Performance Review), PDR (Personal Development Review), PCD (Personal Career Development)
	79 - Job Cycle Time (Ave All)	Job Cycle Time Average for Month (Conveyed and Non Conveyed rpt 644)
	80 - Intelligent Conveyance	Number of Vehicles diverted to create capacity at alternative Emergency Departments
	81 - Community Responders	Number of persons recognised and deployable by Service as authorised community responders
	82 - Community Defibs	Number of Public Access Defibs available pan London
	83 - MAR (A & C) Combined	Multiple Attendance Ratio. A calculation based on A & C responses of how many occasions an additional vehicle has attended a scene. Acceptable reasons would be cardiac arrest or multiple casualties

	Metric Number and Name	Description
Well Led	84 - 111 (Call Volume)	Number of calls presented to 111 within London and recorded by LAS
	85 - 111 (Responded To)	Number of 111 calls transferred to the LAS for attendance with patient
	86 - 111 (Conveyed)	Number of 111 calls who receive LAS attendance at scene and are subsequently conveyed to hospital
	87 - Frontline Clinical Staffing - All In Post (Para & Tech)	Count of paramedic and Non Paramedic frontline staff (excludes management / admin grades etc.)
	88 - Paramedic - In Post (Frontline)	Qualified Paramedical Staff deployed on frontline duties
	89 - Non Paramedic - In Post (Frontline)	Non Paramedical Staff deployed on frontline duties (Numbers includes student paramedics etc.)
	90 - Paramedic Ratio	Paramedic to Non Paramedic expressed as percentage. Commisioners Target for 2016 is 70%
	91 - Frontline Staffing Numbers (planned inc Relief)	Frontline staff plan including 32% relief factor (from September 2014)
	92 - Starters (All Frontline Grades)	WTE Trainees and joiners who will take up frontline duties, once qualified
	93 - Vacancy (All Frontline)	Monthly WTE vacancy factor including 32% relief
	94 - Paramedic Vacancies (Frontline)	Paramedic only vacancies (inc Relief)
	95 - Staff Turnover (Joiners Minus Leavers)	Numeric positive or negative swing by WTE for frontline duties
	97 - Leavers (Frontline Techs & Para)	Staff leaving LAS for other jobs from frontline
	98 - Sickness (frontline)	Combined Short and Long Term Sickness for frontline staff
	99 - 3rd Party Providers (PAS/VAS) Hours Available	Total Hours recorded as being supplied by Private Ambulance Service (PAS) or Voluntary Ambulance Service (VAS) to support frontline operations
	100 - NHS Litigation Authority Level	NHSLA Level

		Quality Reports - DRAFT v2B	metric	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Safety	001	1 - No. WTE Undertaking Training (Not CSR)	(n)	277	331	378	661	515	1073	1013	1034	871	809	749	609
	002	2 - CSR (Training Days Delivered)	(n) of days	112	142	396	376	327	281	87	26	169	260	173	53
	003	3 - Adverse Incidents (LA52 Reports)	(n)	374	380	373	379	307	357	349	333	319	332	293	237
	004	4 - Serious Incidents (NHS Signals)	(n)	0	0	0	0	0	0	0	0	0	0	0	0
	005	5 - Never Events (Numbers Reported within LAS)	(n)	0	0	0	0	0	0	0	0	0	0	0	0
	006	6 - Medication Errors (Numbers Reported)	(n)	1	3	3	0	2	2	1	3	1	2	1	3
	007	7 - Number Of Serious Incidents (LAS Declared)	(n)	0	3	1	1	0	4	3	3	9	3	8	5
	008	8 - Number Of Incidents As Ratio (of Call Volume)	(dec)	0.0028	0.0026	0.0025	0.0024	0.0019	0.0021	0.0023	0.0021	0.0019	0.0020	0.0012	0.0017
	009	9 - Number Of Complaints (total)	(n)	86	66	77	98	130	140	111	111	144	159	102	114
	010	10 - NHS Central Alert System (CAS) (Numbers Alerted to LAS)	(n)	11	23	9	7	12	12	11	7	14	6	17	13
	011	11 - NHS Central Alert System (CAS) (Requiring Action)	(n)	0	2	0	0	0	0	0	1	0	2	1	1
	012	12 - Vehicle Cleaning	(n)	84.55%	90.96%	90.02%	90.04%	92.62%	87.34%	86.85%	85.77%	83.37%	91.56%	91.33%	#N/A
	013	13 - Locality Alert Register (totals on register)	(n)	328	329	321	313	315	306	303	303	302	308	305	302
Effective	014	14 - RED 1 calls arrived at scene within 8 mins	(n) > 8 mins	898	1,039	951	1,007	837	858	799	734	824	789	852	700
	015	15 - RED 1 calls arrived at scene (Total)	(n)	1,096	1,273	1,239	1,381	1,194	1,221	1,163	1,185	1,285	1,228	1,436	1346
	016	16 - RED 1 Time to achieve 95% at scene	(t)	14.8	15.4	17.7	16.4	19.3	20.3	18.4	19.4	22.9	18.7	17.0	15
	017	17 - RED 2 calls arrived at scene within 8 mins	(n) > 8 mins	28,384	31,574	26,845	27,509	25,102	24,050	22,724	20,415	23,593	22,399	21,493	23727
	018	18 - RED 2 calls arrived at scene (Total)	(n)	35,400	39,044	37,987	39,836	39,157	39,825	36,741	37,788	41,056	40,760	45,222	39723
	019	19 - CAT A Ambulance at scene within 19 mins	(n)	35,623	39,435	37,597	39,271	37,907	38,027	35,365	35,003	38,466	37,169	39,610	37533
	020	20 - CAT A Ambulance at scene (ability to transport)	(n)	36,294	40,105	38,995	40,973	40,099	40,775	37,645	38,685	42,065	41,657	46,743	41069
	021	21 - EOC Abandoned calls before answering	(n)	22	15	96	337	209	1,331	114	809	663	863	1165	92
	022	22 - Calls connected to Switchboard (excludes CAD 2 CAD)	(n)	122,868	136128	139380	148878	152311	156863	140012	146411	147626	139672	152028	123111
	023	23 - Emergency Calls resolved with CTA that recontact in 24	(n)	178	128	217	185	239	335	41	36	9	428	639	#N/A
	024	24 - Emergency Calls resolved with CTA (Hear & Treat)	(n)	7,648	7,975	9,207	9,947	10,629	12,721	12,008	13,778	15,431	15,210	18,327	13979
	025	25 - See & Treat (Recontact)	(n)	1,015	1,217	1,100	1,120	1,134	1,215	1,133	1,154	1,261	1,304	1569	#N/A
	026	26 - See & Treat Total	(n)	14,406	17,216	15,856	16,919	16,653	16,792	15,399	15,447	16,374	15,807	17436	#N/A
	027	27 - Frequent Callers who have an established procedure	(n)	2,259	2,617	2,902	2,936	2,757	2,642	2,583	2,329	2,046	2,204	2187	#N/A
	028	28 - Total Calls inc Frequent Callers	(n)	122,868	136128	139380	148878	152311	156863	140012	146411	147626	139672	152028	123111
	029	29 - Patients with a ROSC at hospital	(n)	122	120	125	120	104	110	131	89	#N/A	#N/A	#N/A	#N/A
	030	30 - Patients with a ROSC from out of hospital	(n)	359	371	379	377	317	335	349	325	#N/A	#N/A	#N/A	#N/A
	031	31 - Patients with a ROSC at hospital UTSTEIN	(n)	32	34	26	29	21	26	26	13	#N/A	#N/A	#N/A	#N/A
	032	32 - Pts. with ROSC witnessed arrest cardiac origin CPR UTSTEIN	(n)	55	51	42	53	36	42	39	27	#N/A	#N/A	#N/A	#N/A
	033	33 - STEMI within 150 mins after ECG confirmed AMI > PPCI	(n)	121	127	96	52	42	40	66	87	#N/A	#N/A	#N/A	#N/A
	034	34 - Angioplasty after ECG confirmed AMI > PPCI	(n)	130	142	100	60	45	40	71	89	#N/A	#N/A	#N/A	#N/A
	035	35 - STEMI and appropriate care bundle	(n)	180	189	198	178	163	166	149	144	#N/A	#N/A	#N/A	#N/A
	036	36 - Pre Hospital STEMI confirmed by ECG	(n)	248	270	266	236	227	226	208	213	#N/A	#N/A	#N/A	#N/A

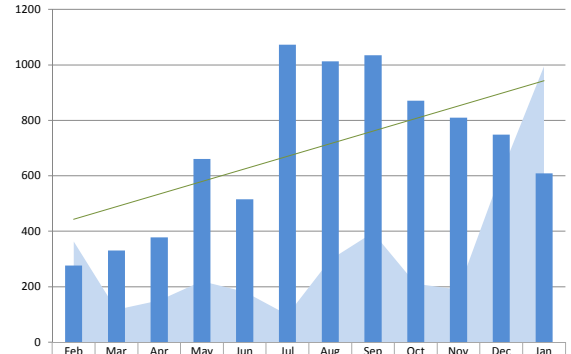
		Quality Reports - DRAFT v2B	metric	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Effective	037	37 - F2F FAST (+ve) eligible > HASU within 60 call origin	(n)	426	459	419	421	325	338	326	294	#N/A	#N/A	#N/A	#N/A
	038	38 - F2F FAST (+ve) potentially eligible for thrombolysis	(%)	640	706	645	663	529	567	531	516	#N/A	#N/A	#N/A	#N/A
	039	39 - F2F suspected Stroke receiving appropriate care bundle	(n)	894	1,044	940	1,009	884	923	884	802	#N/A	#N/A	#N/A	#N/A
	040	40 - F2F Suspected Stroke	(n)	932	1,077	985	1,036	918	943	918	844	#N/A	#N/A	#N/A	#N/A
	041	41 - Pts. discharged alive post Cardiac Arrest	(n)	42	43	21	14	17	26	31	16	#N/A	#N/A	#N/A	#N/A
	042	42 - Pre Hospital Arrest to Discharge	(n)	350	367	350	343	296	322	332	318	#N/A	#N/A	#N/A	#N/A
	043	43 - Pts. discharged alive post Cardiac Arrest UTSTEIN	(n)	21	19	7	5	4	7	11	4	#N/A	#N/A	#N/A	#N/A
	044	44 - Pre Hospital VT/VF witnessed Arrest to Discharge UTSTEIN	(n)	52	51	29	37	28	36	33	25	#N/A	#N/A	#N/A	#N/A
	045	45 - EOC Time to answer 50% Emergency & Urgent calls	(s)	0	0	0	0	0	0	0	0	0	0	0	0
	046	46 - EOC Time to answer 95% Emergency & Urgent calls	(s)	1	2	2	5	4	21	2	24	14	16	35	5
	047	47 - EOC Time to answer 99% Emergency & Urgent calls	(s)	8	13	25	62	46	69	36	74	67	67	85	30
	048	48 - Time Of Arrival of Response for CAT A @ 50%	(t)	5.6	5.5	6.4	6.5	7.0	7.4	7.2	8.1	7.7	8.0	9.0	7
	049	49 - Time Of Arrival of Response for CAT A @ 95%	(t)	13.4	13.3	15.8	16.5	18.3	19.9	18.9	22.5	21.2	24.2	29.0	21
	050	50 - Time Of Arrival of Response for CAT A @ 99%	(t)	21.5	21.6	25.6	27.7	31.8	35.8	33.0	39.8	38.0	46.8	59.0	41
Effective	051	51 - Total of Emergency Calls to Switchboard (exc CAD 2 CAD)	(n)	7,648	7,975	9,207	9,947	10,629	12,721	12,008	13,778	15,431	15,210	18,327	13979
	052	52 - All Telephone or F2F Calls (Attend Scene or CTA)	(n)	93,981	104,946	97,648	101,246	99,144	100,736	94,935	95,224	102,070	99,719	105839	#N/A
	053	53 - Conveyance to Non A&E Transport (ACP) and See & Treat	(n)	27,448	31,620	29,014	30,484	30,346	30,930	28,668	28,561	30,008	29,135	30702	#N/A
	054	54 - All incidents with vehicle arrival (exc No Patient)	(n)	86,333	96,971	88,441	91,299	88,515	88,015	82,927	81,446	86,639	84,509	87261	#N/A
	055	55 - Emergency Journeys conveyed to A&E	(n)	66,355	73,681	67,014	68,568	65,623	64,519	61,393	60,347	64,445	62,862	63667	#N/A
	056	56 - Cat C Incidents (Total)	(n)	49375	56026	49133	50005	48100	46915	44936	42388	44272	42516	40493	43456
	058	58 - ACS - Blood Glucose (BM) Initial Test	(%)	96%	96%	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	97%	98%	95%	#N/A
	059	59 - ACS - 12 Lead Monitoring undertaken	(%)	98%	96%	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	97%	97%	97%	#N/A
	060	60 - STROKE - Time of Onset recorded	(%)	93%	93%	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	94%	94%	94%	#N/A
	061	61 - See & Treat - Observations Recorded	(%)	91%	93%	93%	93%	93%	91%	91%	93%	91%	90%	90%	#N/A
	062	62 - See & Treat - PRF copy Left at scene	(%)	96%	92%	92%	92%	92%	93%	93%	95%	92%	93%	91%	#N/A
	063	63 - See & Treat - Advice Given to Patient	(%)	96%	96%	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	97%	97%	97%	#N/A
	064	64 - Glycaemia Audit - BM Test After Treatment	(%)	#N/A	98%	#N/A	98%	#N/A	98%	#N/A	98%	#N/A	98%	#N/A	#N/A
	065	65 - Attended LAS Induction Course (Not workplace)	(n) WTE	19	29	33.29	24	18	19.7	18.6	95.28	36	122.2	34	27

		Quality Reports - DRAFT v2B	metric	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Caring	066	66 - Safeguarding (child) referral numbers	(n)	493	542	449	417	435	428	396	381	440	404	284	354
	067	67 - Safeguarding (adult) referral numbers	(n)	1945	645	520	472	435	476	449	378	432	458	393	345
	068	68 - CPI - Mental Health - Capacity Tool	(%)	94%	95%	95%	97%	96%	96%	99%	97%	98%	98%	99%	#N/A
	069	69 - CPI - Mental Health - Overall LAS compliance	(%)	#N/A	#N/A	90%	93%	91%	92%	94%	92%	91%	91%	88%	#N/A
	070	70 - Friends and Family Test	(n)	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	1	3
Responsive	071	71 - Calls Received (Total) ex CAD2CAD	(n)	122888	136128	139380	148878	152311	156863	140012	146411	147626	139672	152028	123112
	072	72 - Ring Backs	(n)	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
	073	73 - Surge (above Amber) inc Red (EOC Excess demand management)	(hrs.)	#N/A	#N/A	#N/A	197:19	258:17	424:21	452:29	355:13	713:59	646:15	425:57	744
	074	74 - Surge (above Red) (EOC Excess demand management)	(hrs.)	#N/A	#N/A	#N/A	0:00	17:35	16:14	0:00	24:42	29:59	73:43	318:01	591:25:00
	075	75 - Response To Complaints (Closed in Days)	(d)	39	38	35	45	40	41	24	26	30	29	17	17
	076	76 - CPI - Feedback Sessions Undertaken (F2F & Written)	(n)	3963	4243	356	722	1022	1315	1412	1577	1540	1690	730	#N/A
	077	77 - Positive Feedback Compliments (Letters of Thanks)	(n)	74	79	48	59	28	63	37	68	57	76	84	#N/A
	078	78 - OWR (Operational Workplace Review) / PDP	(n)	32	28	7	26	166	178	31	26	15	5	1	5
	079	79 - Job Cycle Time (Ave All)	(t)	74.31	74.29	74.89	75.34	76.15	76.92	77.18	79.28	79.88	81.54	84.54	83.37
	080	80 - Intelligent Conveyance	(n)	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	589	678	1143	1197	1590	1815
	081	81 - Community Responders	(n)	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
	082	82 - Community Defibs	(n)	#N/A	#N/A	#N/A	#N/A	2,322	2,422	2,486	2,529	2,576	2,607	2,635	2,668
	083	83 - MAR (A & C) Combined	(n)	1.40	1.39	1.39	1.39	1.37	1.36	1.35	1.32	1.33	1.30	1.31	1.32
Well Led	084	84 - 111 (Call Volume)	(n)	#N/A	#N/A	88382	91225	88382	87833	82847	81373	86568	84099	86950	84110
	085	85 - 111 (Responded To)	(n)	#N/A	#N/A	9099	9243	8371	8146	8972	8635	9982	10038	10283	9602
	086	86 - 111 (Conveyed)	(n)	#N/A	#N/A	7237	7300	6490	6287	6851	6646	7675	7563	7341	7124
	087	87 - Frontline Clinical Staffing - All In Post (Para & Tech)	WTE SUM	2632	2665	2655	2628	2647	2636	2588	2535	2467	2490	2471	2410
	088	88 - Paramedic - In Post (Frontline)	WTE	1485	1470	1451	1442	1441	1411	1397	1380	1371	1370	1368	1363
	089	89 - Non Paramedic - In Post (Frontline)	WTE	1147	1195	1204	1186	1206	1225	1191	1155	1096	1119	1103	1047
	090	90 - Paramedic Ratio	>70%	56%	55%	55%	55%	54%	54%	54%	54%	56%	55%	55%	57%
	091	91 - Frontline Staffing Numbers (planned inc Relief)	WTE	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	3016	3016	3016	3016	3016
	092	92 - Starters (All Frontline Grades)	WTE	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
	093	93 - Vacancy (All Frontline)	WTE	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	481	549	526	545	606
	094	94 - Paramedic Vacancies (Frontline)	WTE	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	354	364	364	367	371
	095	95 - Staff Turnover (Joiners Minus Leavers)	WTE	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
	097	97 - Leavers (Frontline Techs & Para)	WTE	11.1	8.3	4.6	2.6	5.5	12.5	7.1	21.5	22.4	25.0	22.5	21.9
	098	98 - Sickness (frontline)	%	9.44%	9.07%	8.45%	8.65%	8.55%	8.76%	8.90%	9.25%	9.32%	9.19%	9.44%	9.24%
	099	99 - 3rd Party Providers (PAS/VAS) Hours Available	(hrs.)	12453	5196	8631	8181	7641	6654	6451	7138	9352	10444	11929	12928
	100	100 - NHS Litigation Authority Level	(n)	1	1	1	1	1	1	1	1	1	1	1	1

Safe - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

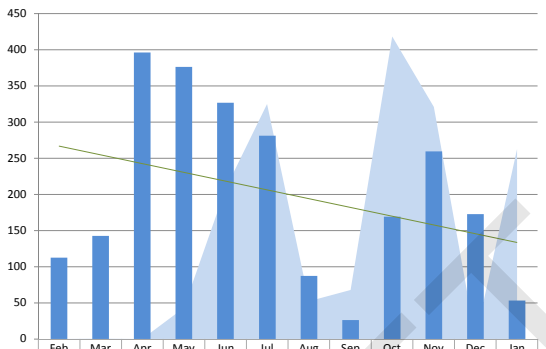
1 - No. WTE Undertaking Training (Not CSR)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	363	117	150	220	182	98	297	396	211	190	612	995
2014-15 Actuals	277	331	378	661	515	1073	1013	1034	871	809	749	609

WTE staff numbers that receive training above and beyond "Core Skills Refreshers", i.e. driver training, hospital placements, new equipment, modules of paramedic courses

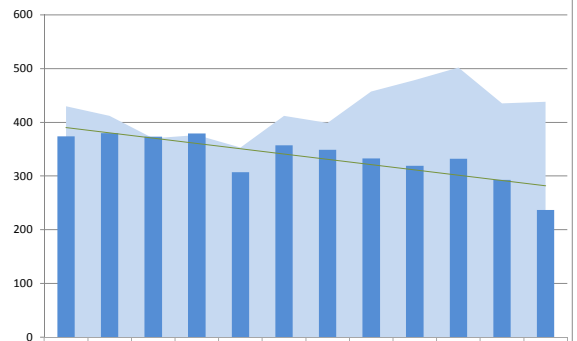
2 - CSR (Training Days Delivered)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	0	0	0	43	207	325	52	68	418	321	1	262
2014-15 Actuals	112	142	396	376	327	281	87	26	169	260	173	53

WTE delivery of CSR training for Month

3 - Adverse Incidents (LA52 Reports)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	430	412	370	376	353	412	399	457	479	502	435	438
2014-15 Actuals	374	380	373	379	307	357	349	333	319	332	293	237

Number of adverse incidents reported via LA52 per month

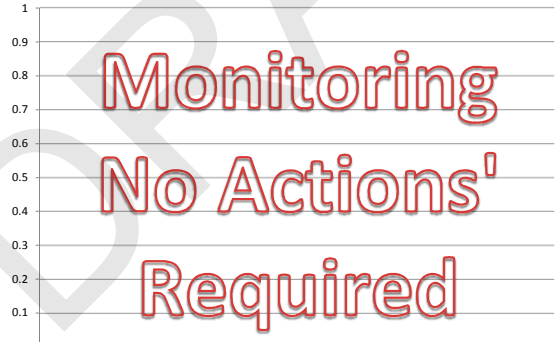
4 - Serious Incidents (NHS Signals)

Monitoring No Actions' Required

	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	0	0	0	0	0	0	0	0	0	0	0	0
2014-15 Actuals	0	0	0	0	0	0	0	0	0	0	0	0

Number of SI's announced via NHS Signals. N.B. There has not been a Signal Alert issued since Feb 2012

5 - Never Events (Numbers Reported within LAS)

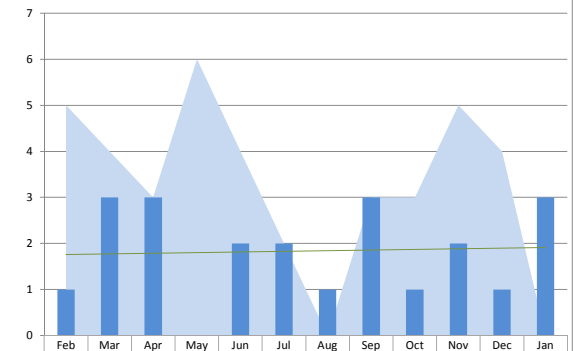


Monitoring No Actions' Required

	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	0	0	0	0	0	0	0	0	0	0	0	0
2014-15 Actuals	0	0	0	0	0	0	0	0	0	0	0	0

Number of Never Events occurring within LAS in the month

6 - Medication Errors (Numbers Reported)



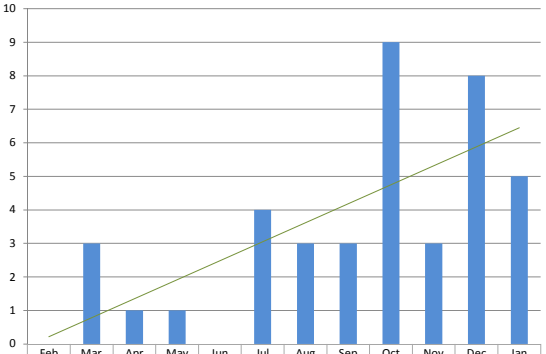
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	5	4	3	6	4	2	0	3	3	5	4	0
2014-15 Actuals	1	3	3	0	2	2	1	3	1	2	1	3

Number of medication errors reported to LAS by staff during Month

Safe - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

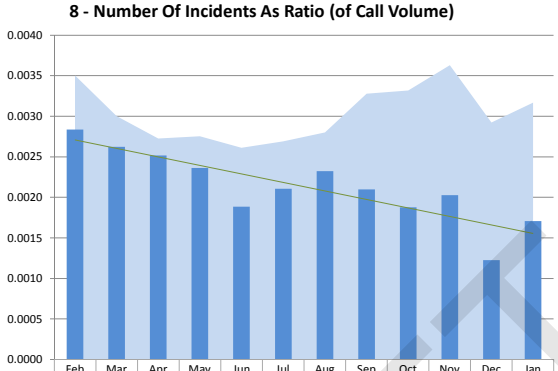
7 - Number Of Serious Incidents (LAS Declared)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												0
2014-15 Actuals	0	3	1	1	0	4	3	3	9	3	8	5

Serious Incidents raised within LAS for the month

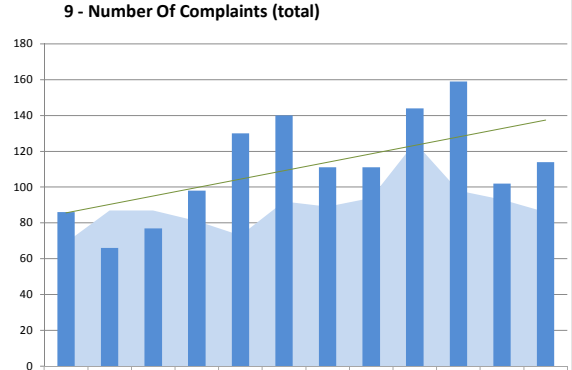
8 - Number Of Incidents As Ratio (of Call Volume)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	0.0035	0.0030	0.0027	0.0028	0.0026	0.0027	0.0028	0.0033	0.0033	0.0036	0.0029	0.0032
2014-15 Actuals	0.0028	0.0026	0.0025	0.0024	0.0019	0.0021	0.0023	0.0021	0.0019	0.0020	0.0012	0.0017

Number of Adverse incidents (LA52) as a percentage of Incident volume per month

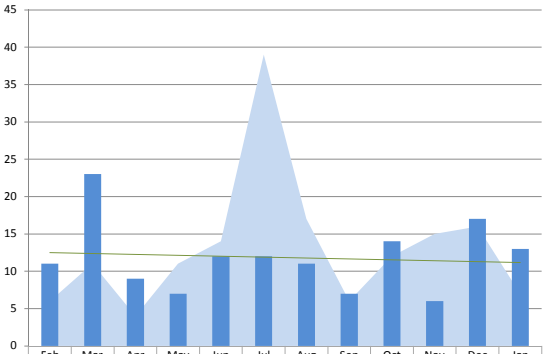
9 - Number Of Complaints (total)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	69	87	87	81	73	92	89	94	125	98	93	86
2014-15 Actuals	86	66	77	98	130	140	111	111	144	159	102	114

Number of written / logged complaints' against the LAS per month

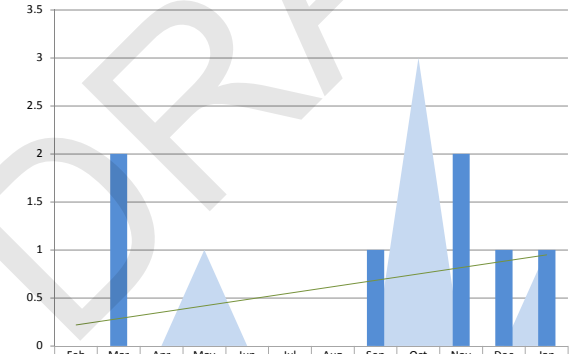
10 - NHS Central Alert System (CAS) (Numbers Alerted to LAS)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	6	11	4	11	14	39	17	6	12	15	16	7
2014-15 Actuals	11	23	9	7	12	12	11	7	14	6	17	13

CAS Alerts circulated by NHS by month

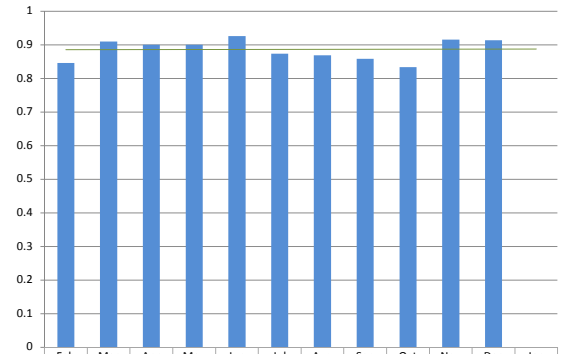
11 - NHS Central Alert System (CAS) (Requiring Action)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	0	0	0	1	0	0	0	0	3	0	0	1
2014-15 Actuals	0	2	0	0	0	0	0	1	0	2	1	1

CAS alerts that LAS have needed to undertake some action to address

12 - Vehicle Cleaning



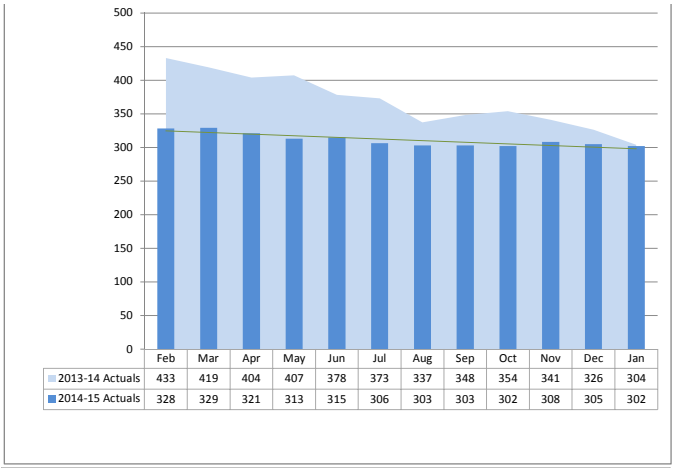
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals	84.55%	90.96%	90.02%	90.04%	92.62%	87.34%	86.85%	85.77%	83.37%	91.56%	91.33%	

Number of vehicles receiving cleaning by contractors to standard

13 - Locality Alert Register (totals on register)

Safe - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.



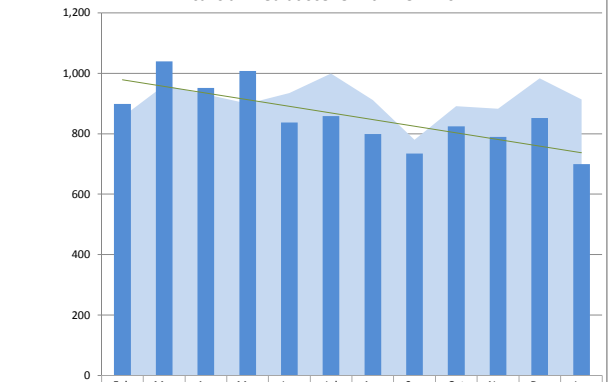
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	433	419	404	407	378	373	337	348	354	341	326	304
2014-15 Actuals	328	329	321	313	315	306	303	303	302	308	305	302

Addresses were staff may suffer threats of violence, and verified that threat exists

Effective - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

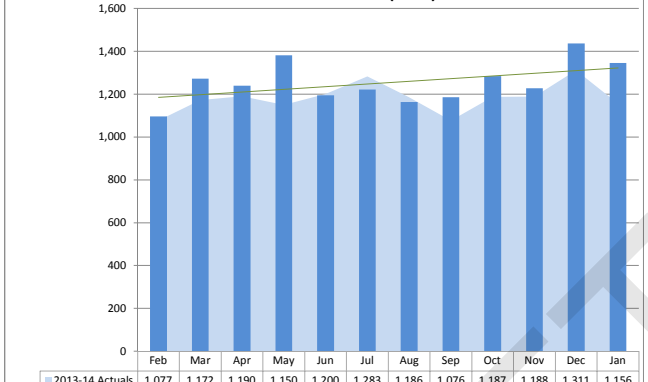
14 - RED 1 calls arrived at scene within 8 mins



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	856	960	930	899	934	999	911	780	891	883	983	913
2014-15 Actuals	898	1,039	951	1,007	837	858	799	734	824	789	852	700

The number of Category A (Red 1) calls resulting in an emergency response arriving at the scene of the incident within 8 minutes. (ACQI HQU03_1_1_3)

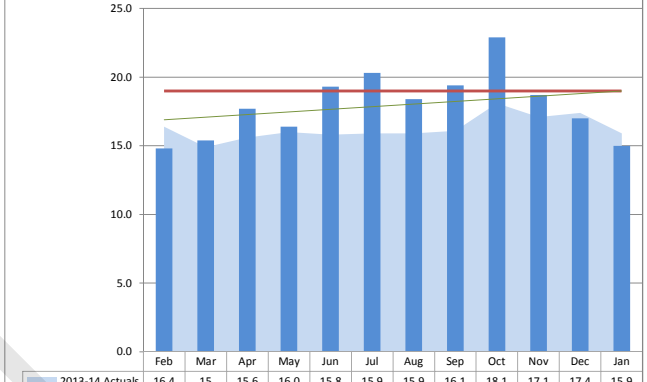
15 - RED 1 calls arrived at scene (Total)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	1,077	1,172	1,190	1,150	1,200	1,283	1,186	1,076	1,187	1,188	1,311	1,156
2014-15 Actuals	1,096	1,273	1,239	1,381	1,194	1,221	1,163	1,185	1,285	1,228	1,436	1346

The number of Category A (Red 1) calls resulting in an emergency response arriving at the scene of the incident. (ACQI HQU03_1_1_4)

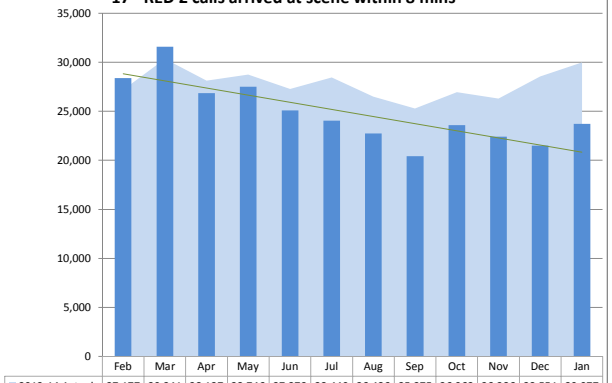
16 - RED 1 Time to achieve 95% at scene



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	16.4	15	15.6	16.0	15.8	15.9	15.9	16.1	18.1	17.1	17.4	15.9
2014-15 Actuals	14.8	15.4	17.7	16.4	19.3	20.3	18.4	19.4	22.9	18.7	17.0	15
Target	19	19	19	19	19	19	19	19	19	19	19	19

The 95th centile of time from Call Connect of a Category A (Red 1) call to an emergency response arriving at the scene of the incident (ACQI HQU03_1_1_5)

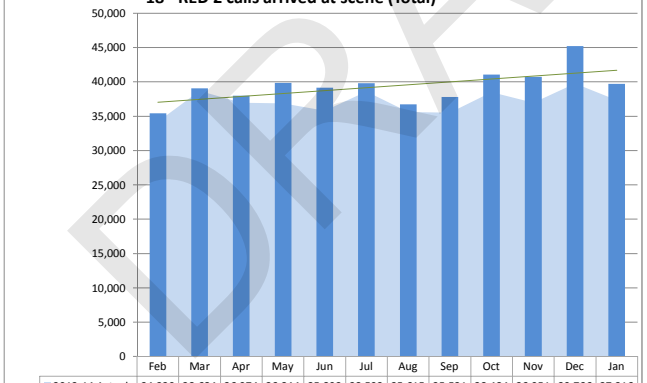
17 - RED 2 calls arrived at scene within 8 mins



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	27,177	30,341	28,137	28,746	27,272	28,440	26,486	25,275	26,962	26,286	28,551	29,977
2014-15 Actuals	28,384	31,574	26,845	27,509	25,102	24,050	22,724	20,415	23,593	22,399	21,493	23727

The number of Category A (Red 2) calls resulting in an emergency response arriving at the scene of the incident within 8 minutes. (ACQI HQU03_1_1_6)

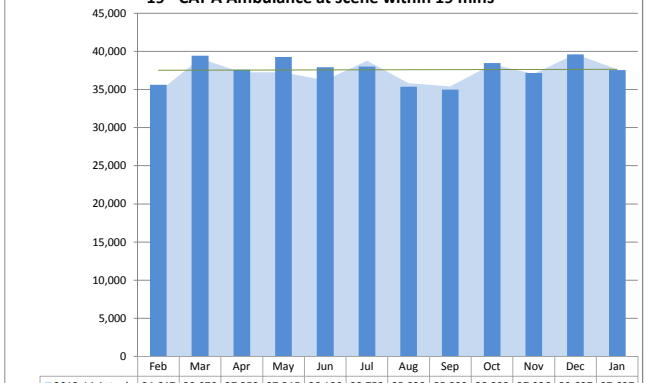
18 - RED 2 calls arrived at scene (Total)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	34,230	38,684	36,974	36,844	35,802	38,592	35,615	35,531	38,484	36,951	39,766	37,316
2014-15 Actuals	35,400	39,044	37,987	39,836	39,157	39,825	36,741	37,788	41,056	40,760	45,222	39723

The number of Category A (Red 2) calls resulting in an emergency response arriving at the scene of the incident. (ACQI HQU03_1_1_7)

19 - CAT A Ambulance at scene within 19 mins



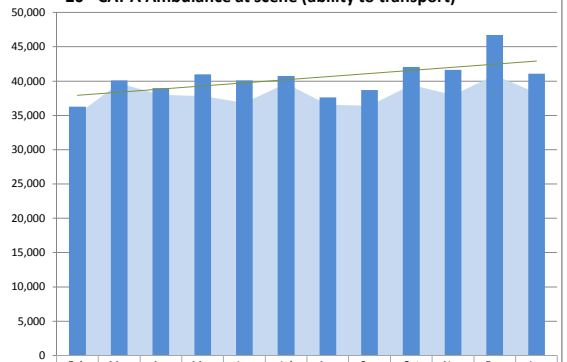
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	34,647	39,070	37,252	37,245	36,180	38,753	35,829	35,392	38,292	37,026	39,637	37,607
2014-15 Actuals	35,623	39,435	37,597	39,271	37,907	38,027	35,365	35,003	38,466	37,169	39,610	37533

The number of Category A calls resulting in an ambulance arriving at the scene of the incident within 19 minutes. (ACQI HQU03_1_2_1)

Effective - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

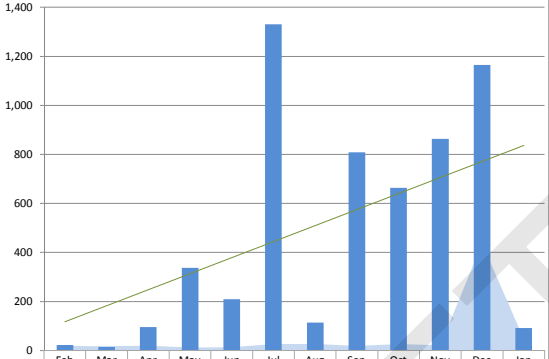
20 - CAT A Ambulance at scene (ability to transport)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	35,163	39,682	37,987	37,812	36,829	39,611	36,558	36,390	39,440	37,948	40,833	38,266
2014-15 Actuals	36,294	40,105	38,995	40,973	40,099	40,775	37,645	38,685	42,065	41,657	46,743	41069

The number of Category A calls resulting in an ambulance able to transport the patient arriving at the scene of the incident. (ACQI HQU03_1_2_2)

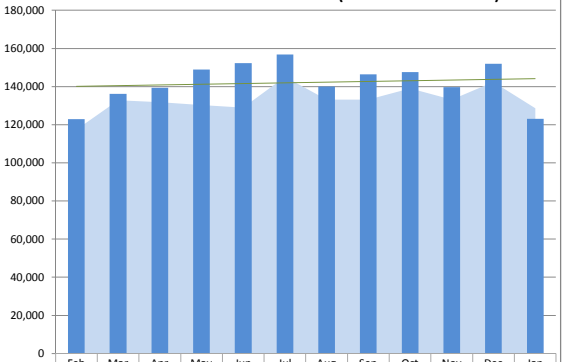
21 - EOC Abandoned calls before answering



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	18	17	20	12	14	26	27	18	26	21	438	47
2014-15 Actuals	22	15	96	337	209	1,331	114	809	663	863	1165	92

Number of emergency and urgent calls abandoned before being answered (ACQI SQU03_1_1_1)

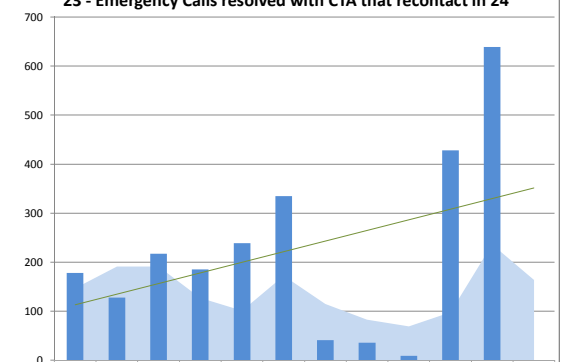
22 - Calls connected to Switchboard (excludes CAD 2 CAD)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	117,43	132,85	131,81	130,23	128,97	145,10	133,12	133,06	139,07	133,08	142,31	128,65
2014-15 Actuals	122,86	136128	139380	148878	152311	156863	140012	146411	147626	139672	152028	123111

Total number of emergency and urgent calls presented to switchboard (ACQI SQU03_1_1_2)

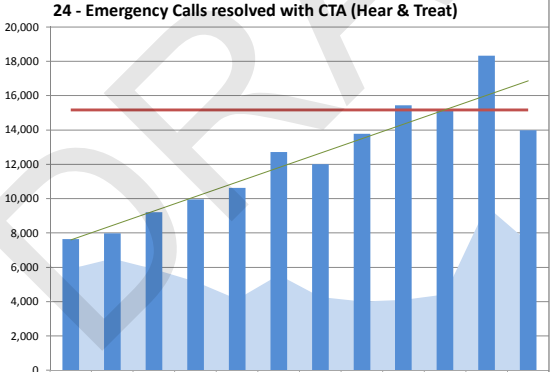
23 - Emergency Calls resolved with CTA that recontact in 24



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	147	191	191	127	101	172	115	83	69	98	236	164
2014-15 Actuals	178	128	217	185	239	335	41	36	9	428	639	

Emergency calls closed with telephone advice where re-contact occurs within 24 hours. (ACQI SQU03_2_1_1)

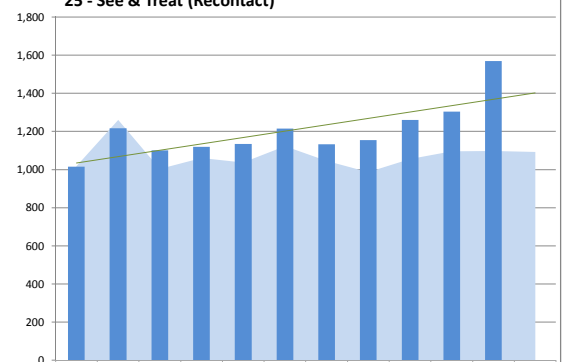
24 - Emergency Calls resolved with CTA (Hear & Treat)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	5,905	6,503	5,882	5,170	4,142	5,552	4,274	3,998	4,106	4,420	9,559	7,469
2014-15 Actuals	7,648	7,975	9,207	9,947	10,629	12,721	12,008	13,778	15,431	15,210	18,327	13979
Target	15166	15166	15166	15166	15166	15166	15166	15166	15166	15166	15166	15166

Emergency calls closed with telephone advice. (ACQI SQU03_2_1_2)

25 - See & Treat (Recontact)



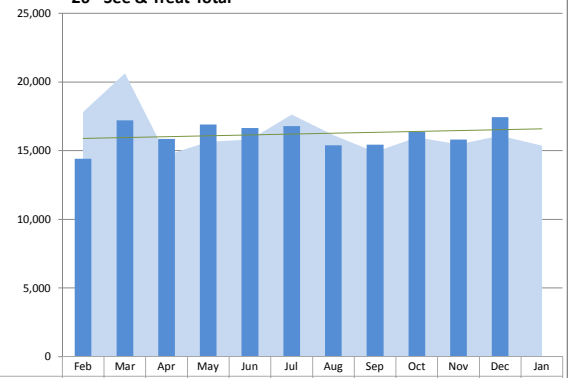
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	1,017	1,261	1,003	1,060	1,037	1,123	1,045	986	1,056	1,096	1,097	1,092
2014-15 Actuals	1,015	1,217	1,100	1,120	1,134	1,215	1,133	1,154	1,261	1,304	1569	

Patients treated and discharged on scene where re-contact occurs within 24 hours (ACQI SQU03_2_2_1)

Effective - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

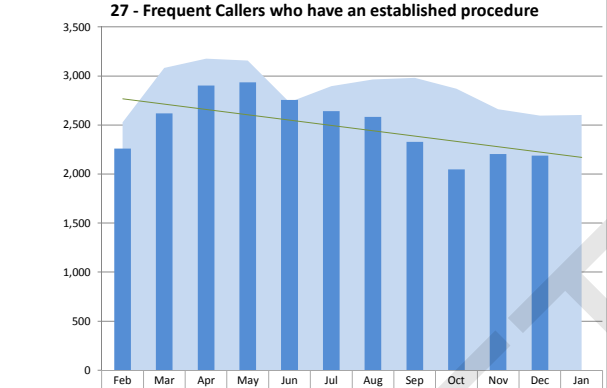
26 - See & Treat Total



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	17,810	20,642	14,666	15,650	15,821	17,624	16,151	14,908	15,974	15,474	16,082	15,368
2014-15 Actuals	14,406	17,216	15,856	16,919	16,653	16,792	15,399	15,447	16,374	15,807	17436	

Patients treated and discharged on scene. (ACQI SQU03_2_2_2)

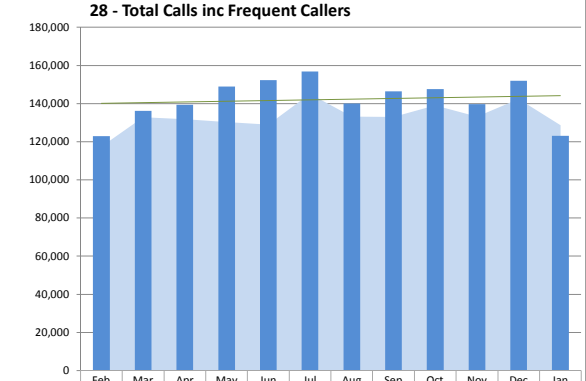
27 - Frequent Callers who have an established procedure



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	2,526	3,083	3,178	3,158	2,733	2,896	2,963	2,980	2,871	2,662	2,595	2,601
2014-15 Actuals	2,259	2,617	2,902	2,936	2,757	2,642	2,583	2,329	2,046	2,204	2187	

Emergency calls from patients for whom a locally agreed frequent caller procedure is in place (ACQI SQU03_2_3_1)

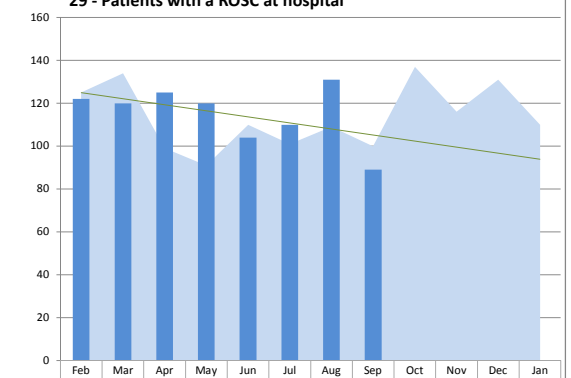
28 - Total Calls inc Frequent Callers



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	117,43	132,85	131,81	130,23	128,97	145,10	133,12	133,06	139,07	133,08	142,31	128,65
2014-15 Actuals	122,86	136128	139380	148878	152311	156863	140012	146411	147626	139672	152028	123111

Total number of emergency calls presented to switchboard (ACQI SQU03_2_3_2)

29 - Patients with a ROSC at hospital

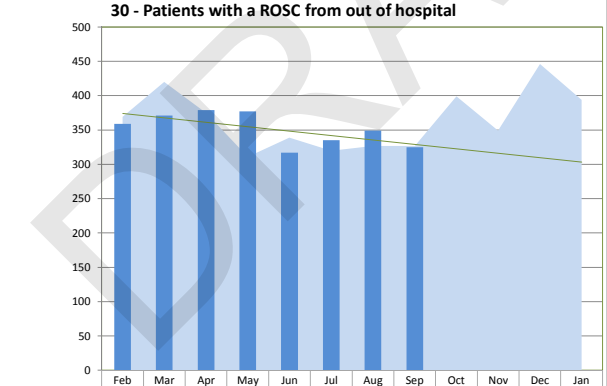


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	125	134	99	91	110	101	109	100	137	116	131	110
2014-15 Actuals	122	120	125	120	104	110	131	89				

Clinical Indicators Track circa 6 months behind

Of the patients included in the denominator, the number of patients who had return of spontaneous circulation on arrival at hospital. (ACQI SQU03_3_1_1)

30 - Patients with a ROSC from out of hospital

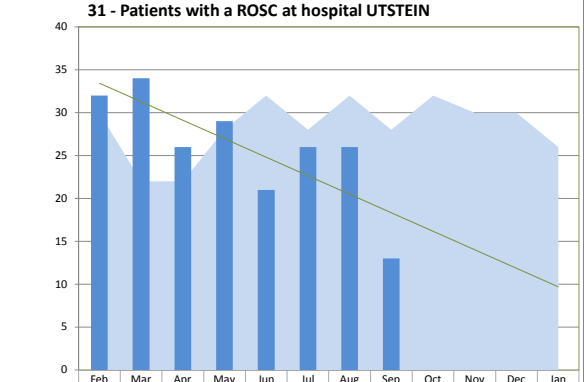


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	369	420	375	311	339	320	327	327	399	349	446	394
2014-15 Actuals	359	371	379	377	317	335	349	325				

Clinical Indicators Track circa 6 months behind

All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac arrest. (ACQI SQU03_3_1_2)

31 - Patients with a ROSC at hospital UTSTEIN



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	30	22	22	28	32	28	32	28	32	30	30	26
2014-15 Actuals	32	34	26	29	21	26	26	13				

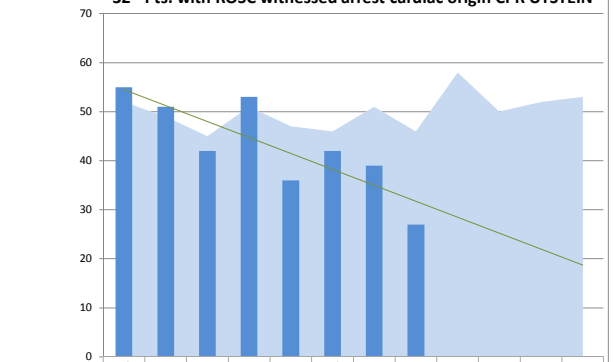
Clinical Indicators Track circa 6 months behind

Of the patients included in the denominator, the number of patients who had return of spontaneous circulation on arrival at hospital. (ACQI SQU03_3_2_1)

Effective - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

32 - Pts. with ROSC witnessed arrest cardiac origin CPR UTSTEIN

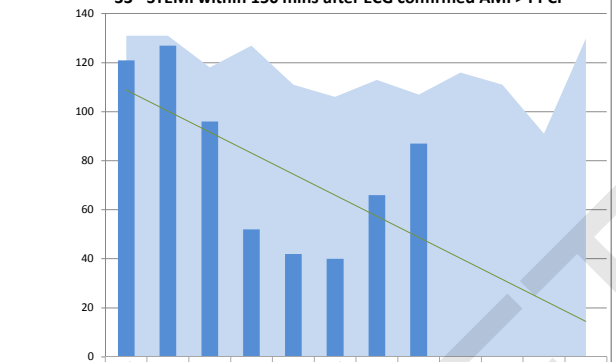


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	52	49	45	51	47	46	51	46	58	50	52	53
2014-15 Actuals	55	51	42	53	36	42	39	27				

Clinical Indicators Track circa 6 months behind

All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac arrest of presumed cardiac

33 - STEMI within 150 mins after ECG confirmed AMI > PPCI

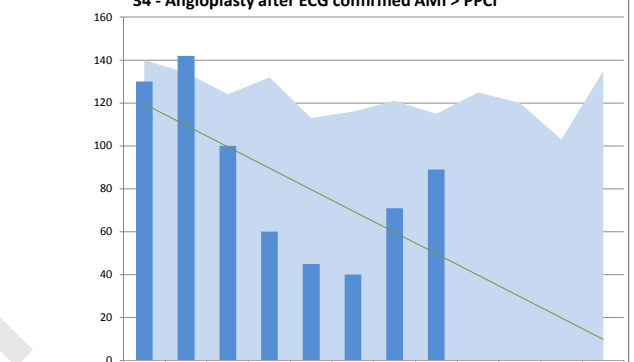


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	131	131	118	127	111	106	113	107	116	111	91	130
2014-15 Actuals	121	127	96	52	42	40	66	87				

Clinical Indicators Track circa 6 months behind

Patients with initial diagnosis of 'definite myocardial infarction' for whom primary angioplasty balloon inflation occurred within 150 minutes of emergency call connected to

34 - Angioplasty after ECG confirmed AMI > PPCI

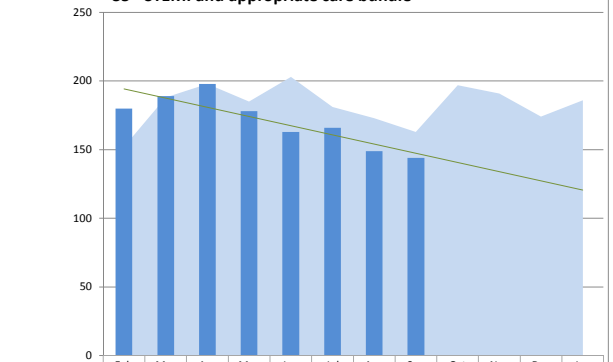


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	140	134	124	132	113	116	121	115	125	120	103	135
2014-15 Actuals	130	142	100	60	45	40	71	89				

Clinical Indicators Track circa 6 months behind

Patients with initial diagnosis of 'definite myocardial infarction' who received primary angioplasty, where first diagnostic ECG performed is by ambulance personnel and patient was directly transferred to a designated PPCI centre as locally agreed (ACQI S

35 - STEMI and appropriate care bundle

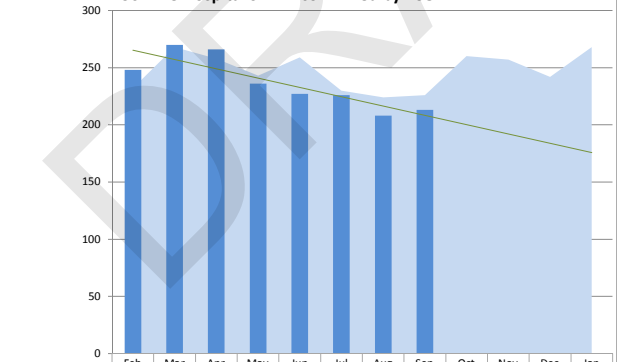


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	152	188	198	185	203	181	173	163	197	191	174	186
2014-15 Actuals	180	189	198	178	163	166	149	144				

Clinical Indicators Track circa 6 months behind

Patients with a pre-hospital diagnosis of suspected ST elevation myocardial infarction confirmed on ECG who received an appropriate care bundle (ACQI SQU03_5_3_1)

36 - Pre Hospital STEMI confirmed by ECG

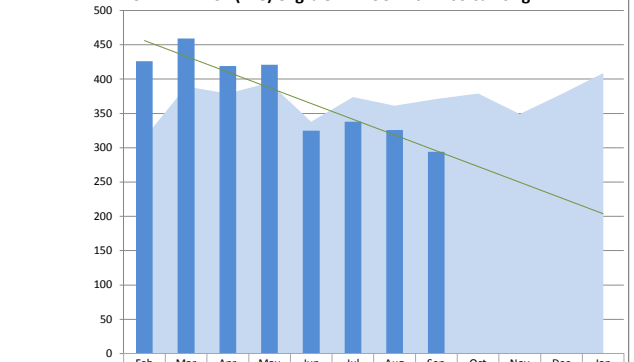


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	232	268	258	243	259	230	224	226	260	257	242	268
2014-15 Actuals	248	270	266	236	227	226	208	213				

Clinical Indicators Track circa 6 months behind

Patients with a pre-hospital diagnosis of suspected ST elevation myocardial infarction confirmed on ECG (ACQI SQU03_5_3_2)

37 - F2F FAST (+ve) eligible > HASU within 60 call origin



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	314	389	379	395	338	374	361	371	379	349	378	409
2014-15 Actuals	426	459	419	421	325	338	326	294				

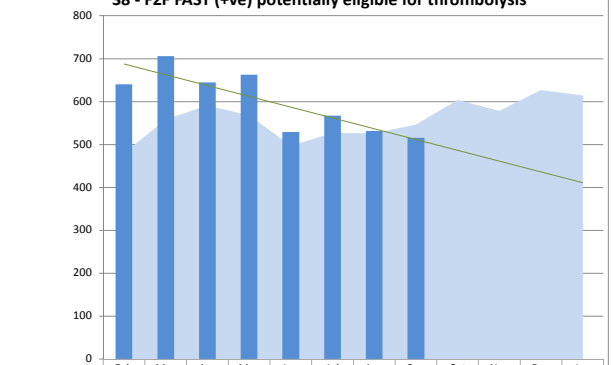
Clinical Indicators Track circa 6 months behind

FAST positive patients (assessed face to face) potentially eligible for stroke thrombolysis within agreed local guidelines arriving at hospitals with a hyper acute stroke centre within 60 minutes of emergency call connecting to ambulance service (ACQI SQU

Effective - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

38 - F2F FAST (+ve) potentially eligible for thrombolysis

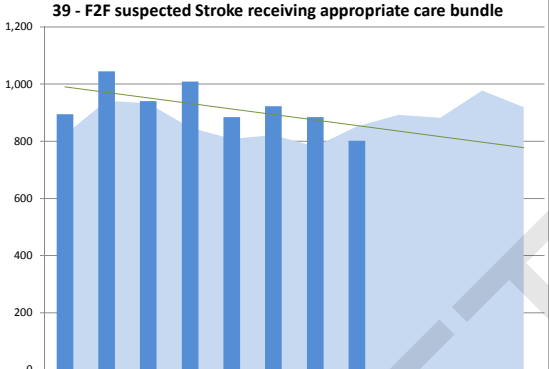


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	480	558	591	568	497	527	526	546	604	578	627	614
2014-15 Actuals	640	706	645	663	529	567	531	516				

Clinical Indicators Track circa 6 months behind

FAST positive patients (assessed face to face) potentially eligible for stroke thrombolysis within agreed local guidelines (ACQI SQU03_6_1_2)

39 - F2F suspected Stroke receiving appropriate care bundle

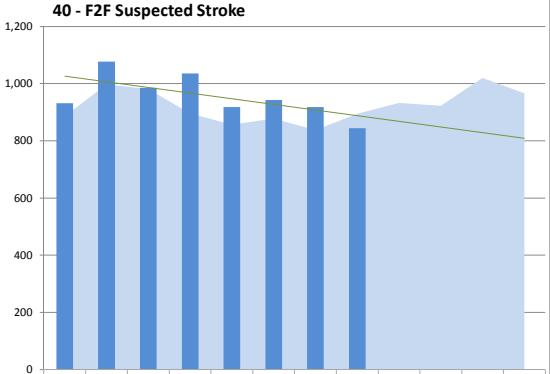


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	823	941	933	848	808	822	781	852	892	882	977	919
2014-15 Actuals	894	1,044	940	1,009	884	923	884	802				

Clinical Indicators Track circa 6 months behind

The number of suspected stroke patients assessed face to face who received an appropriate care bundle (ACQI SQU03_6_2_1)

40 - F2F Suspected Stroke

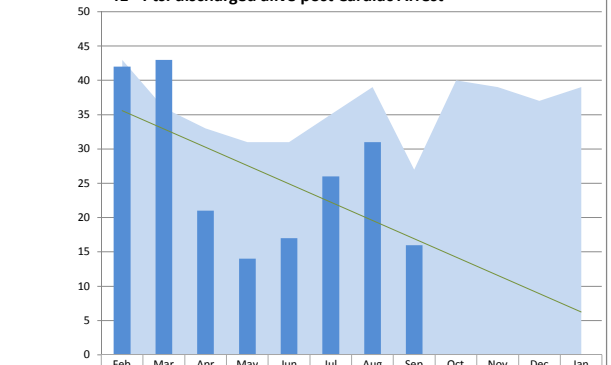


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	886	998	981	896	856	878	837	894	932	923	1,020	966
2014-15 Actuals	932	1,077	985	1,036	918	943	918	844				

Clinical Indicators Track circa 6 months behind

The number of suspected stroke patients assessed face to face (ACQI SQU03_6_2_2)

41 - Pts. discharged alive post Cardiac Arrest

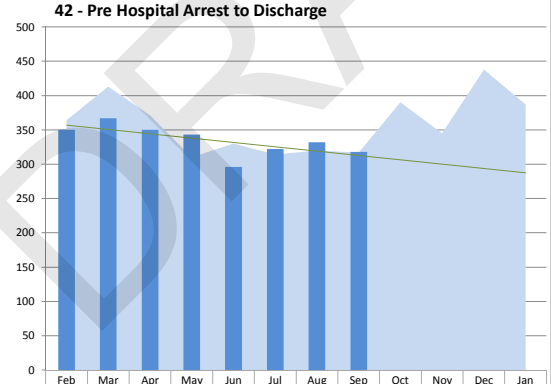


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	43	36	33	31	31	35	39	27	40	39	37	39
2014-15 Actuals	42	43	21	14	17	26	31	16				

Clinical Indicators Track circa 6 months behind

Of the patients included in the denominator, the number of patients discharged from hospital alive (ACQI SQU03_7_1_1)

42 - Pre Hospital Arrest to Discharge

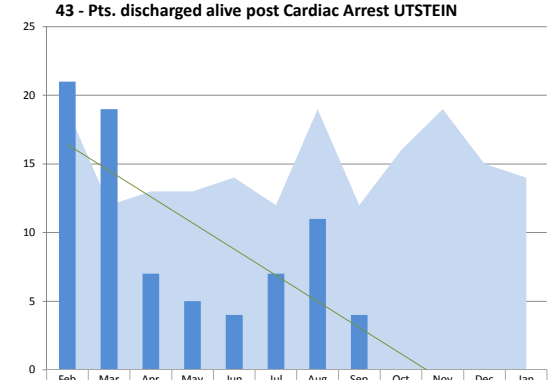


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	364	413	371	310	330	314	320	317	390	345	438	387
2014-15 Actuals	350	367	350	343	296	322	332	318				

Clinical Indicators Track circa 6 months behind

All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac arrest (ACQI SQU03_7_1_2)

43 - Pts. discharged alive post Cardiac Arrest UTSTEIN



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	19	12	13	13	14	12	19	12	16	19	15	14
2014-15 Actuals	21	19	7	5	4	7	11	4				

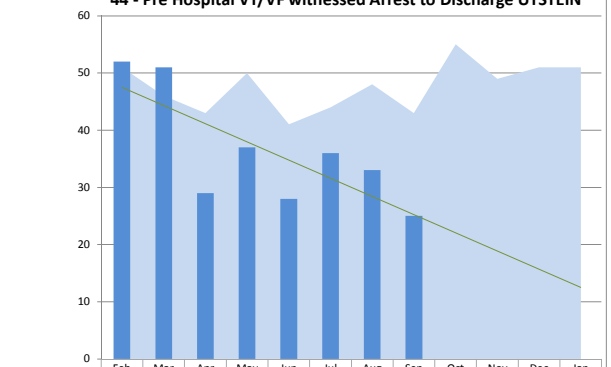
Clinical Indicators Track circa 6 months behind

Of the patients included in the denominator, the number of patients discharged from hospital alive (ACQI SQU03_7_2_1)

Effective - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

44 - Pre Hospital VT/VF witnessed Arrest to Discharge UTSTEIN

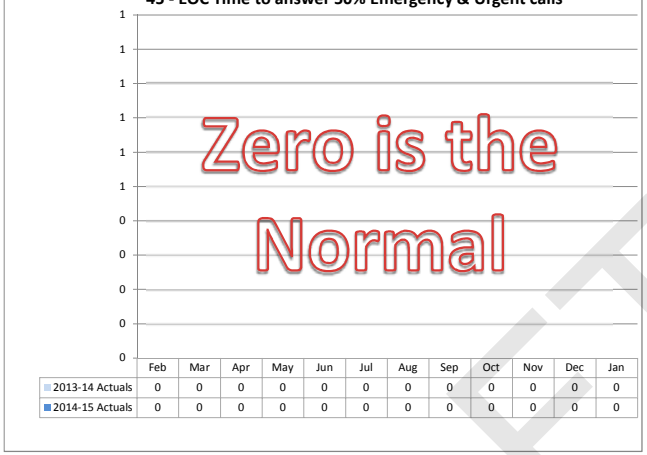


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	51	46	43	50	41	44	48	43	55	49	51	51
2014-15 Actuals	52	51	29	37	28	36	33	25				

Clinical Indicators Track circa 6 months behind

All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac arrest of presumed cardiac origin, where the arrest was bystander witnessed and the initial rhythm was VF or

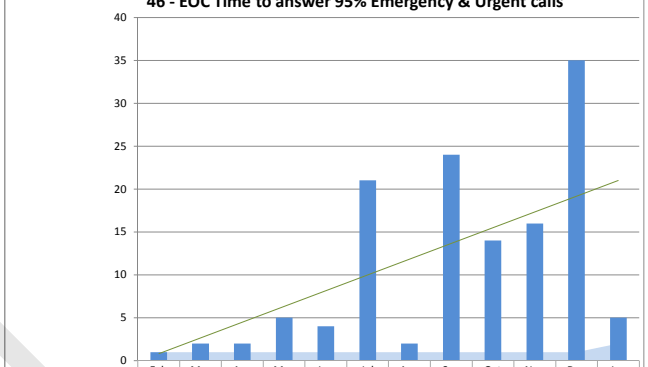
45 - EOC Time to answer 50% Emergency & Urgent calls



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	0	0	0	0	0	0	0	0	0	0	0	0
2014-15 Actuals	0	0	0	0	0	0	0	0	0	0	0	0

Time to answer calls (emergency and urgent), measured by median, 95th percentile and 99th percentile. (ACQI SQU03_8_1_1_50)

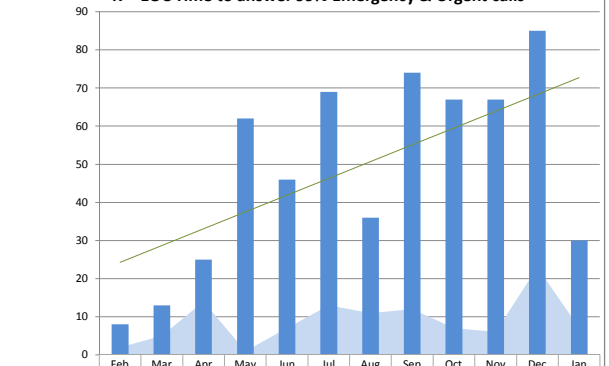
46 - EOC Time to answer 95% Emergency & Urgent calls



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	1	1	1	1	1	1	1	1	1	1	1	2
2014-15 Actuals	1	2	2	5	4	21	2	24	14	16	35	5

(ACQI SQU03_8_1_1_95)

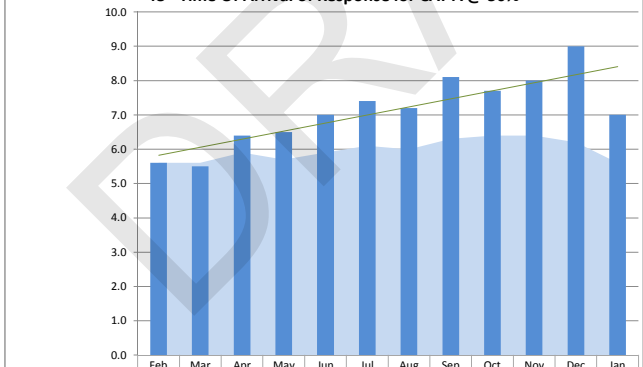
47 - EOC Time to answer 99% Emergency & Urgent calls



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	2	5	14	1	7	13	11	12	7	6	23	7
2014-15 Actuals	8	13	25	62	46	69	36	74	67	67	85	30

(ACQI SQU03_8_1_1_99)

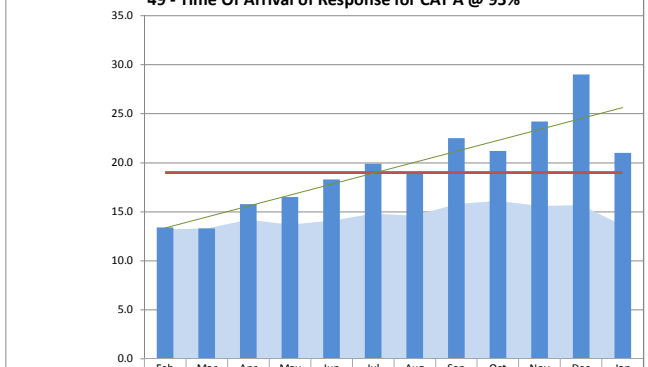
48 - Time Of Arrival of Response for CAT A @ 50%



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	5.6	5.6	5.9	5.7	5.9	6.1	6.0	6.3	6.4	6.4	6.2	5.6
2014-15 Actuals	5.6	5.5	6.4	6.5	7.0	7.4	7.2	8.1	7.7	8.0	9.0	7

Time to arrival of an ambulance-dispatched health professional dispatched by the ambulance service for immediately life-threatening (Category A) calls, measured by median, 95th percentile and 99th percentile (ACQI SQU03_9_1_1_50)

49 - Time Of Arrival of Response for CAT A @ 95%



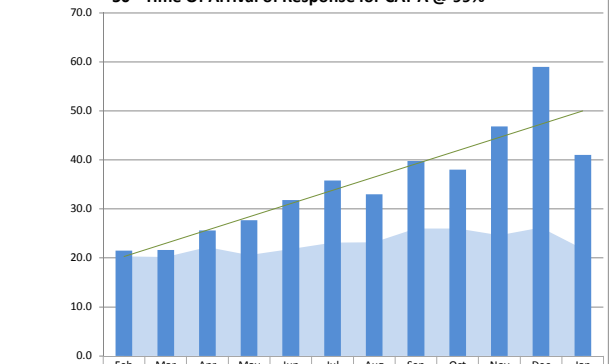
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	13.2	13.3	14.2	13.7	14.1	14.8	14.6	15.8	16.1	15.6	15.7	13.6
2014-15 Actuals	13.4	13.3	15.8	16.5	18.3	19.9	18.9	22.5	21.2	24.2	29.0	21
Target	19	19	19	19	19	19	19	19	19	19	19	19

(ACQI SQU03_9_1_1_95)

Effective - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

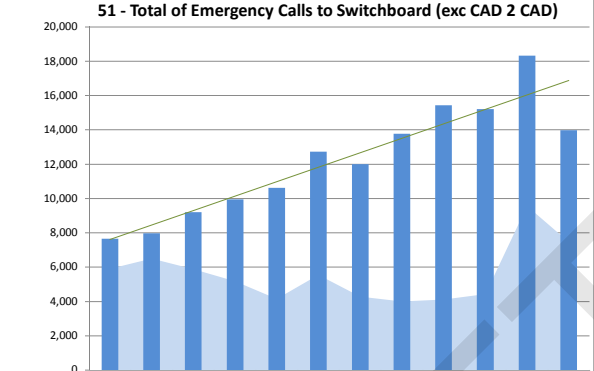
50 - Time Of Arrival of Response for CAT A @ 99%



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	20.3	20.2	22.2	20.6	21.8	23.1	23.2	26.0	26.0	24.6	26.2	21.8
2014-15 Actuals	21.5	21.6	25.6	27.7	31.8	35.8	33.0	39.8	38.0	46.8	59.0	41

(ACQI SQU03_9_1_1_99)

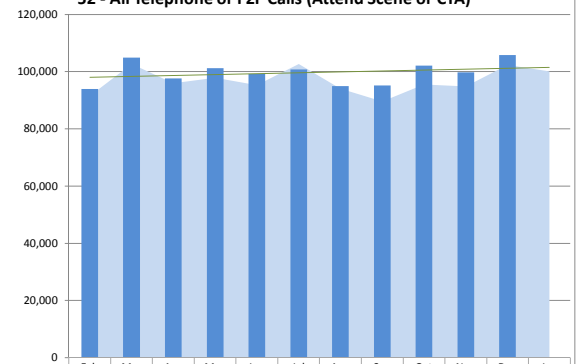
51 - Total of Emergency Calls to Switchboard (exc CAD 2 CAD)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	5,905	6,503	5,882	5,170	4,142	5,552	4,274	3,998	4,106	4,420	9,559	7,469
2014-15 Actuals	7,648	7,975	9,207	9,947	10,629	12,721	12,008	13,778	15,431	15,210	18,327	13979

Number of emergency calls that have been resolved by providing telephone advice. (ACQI SQU03_10_1_1)

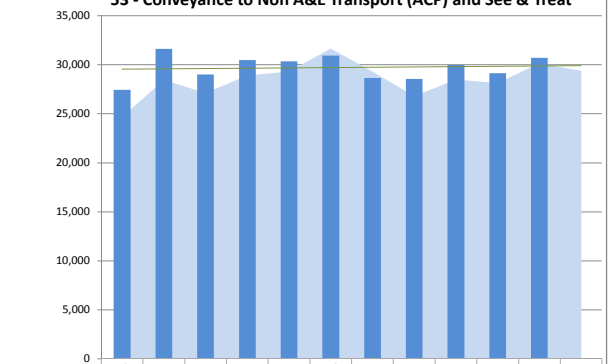
52 - All Telephone or F2F Calls (Attend Scene or CTA)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	91,515	102,71	95,895	97,880	95,299	102,61	94,096	89,582	95,460	94,862	102,30	100,08
2014-15 Actuals	93,981	104,94	97,648	101,24	99,144	100,73	94,935	95,224	102,07	99,719	105839	

All emergency calls that receive a telephone or face-to-face response from the ambulance service (ACQI SQU03_10_1_2)

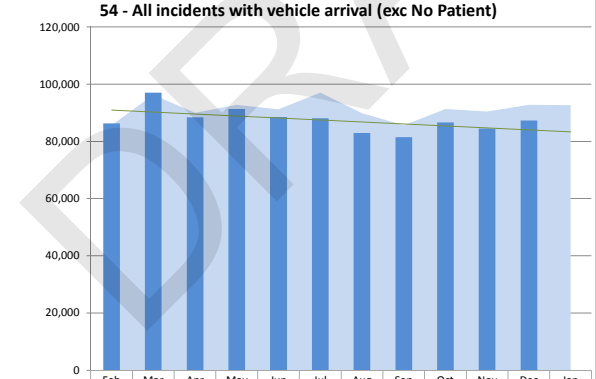
53 - Conveyance to Non A&E Transport (ACP) and See & Treat



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	24,675	28,458	27,115	28,918	29,301	31,664	29,307	26,782	28,499	28,121	30,153	29,357
2014-15 Actuals	27,448	31,620	29,014	30,484	30,346	30,930	28,668	28,561	30,008	29,135	30702	

Patient journeys to a destination other than Type 1 and 2 A&E + number of patients discharged after treatment at the scene or onward referral to an alternative care pathway (ACQI SQU03_10_2_1)

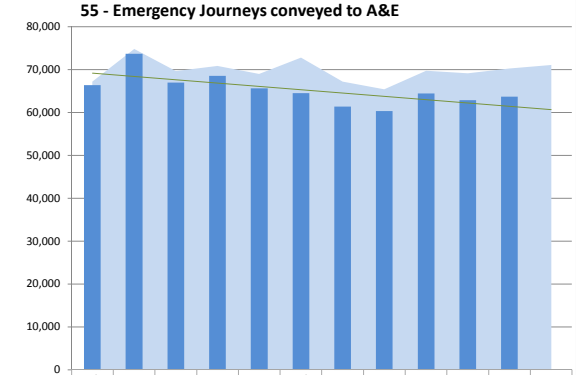
54 - All incidents with vehicle arrival (exc No Patient)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	85,610	96,212	90,013	92,710	91,154	97,064	89,822	85,584	91,354	90,442	92,748	92,614
2014-15 Actuals	86,333	96,971	88,441	91,299	88,515	88,015	82,927	81,446	86,639	84,509	87261	

All emergency calls that receive a face-to-face response from the ambulance service (ACQI SQU03_10_2_2)

55 - Emergency Journeys conveyed to A&E



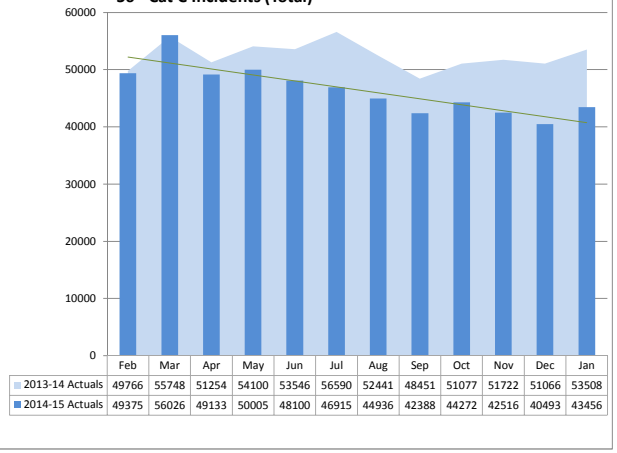
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	67,225	74,827	69,665	70,883	68,992	72,800	67,198	65,410	69,756	69,117	70,241	71,082
2014-15 Actuals	66,355	73,681	67,014	68,568	65,623	64,519	61,393	60,347	64,445	62,862	63667	

Number of emergency journeys (ACQI ASI SRS17 1 1 1)

Effective - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

56 - Cat C Incidents (Total)



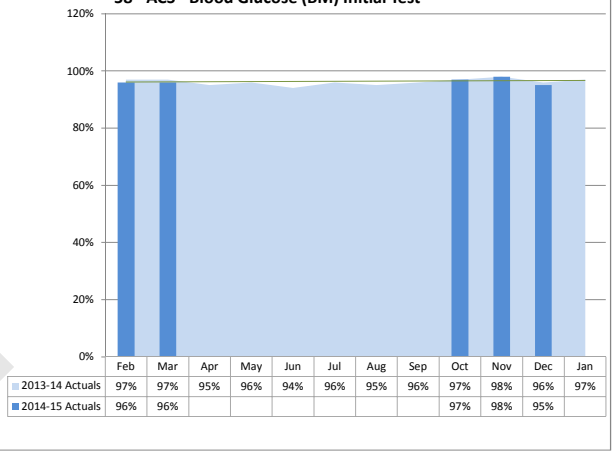
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	49766	55748	51254	54100	53546	56590	52441	48451	51077	51722	51066	53508
2014-15 Actuals	49375	56026	49133	50005	48100	46915	44936	42388	44272	42516	40493	43456

Number of Category C Incidents received by Month (C1-C4)

Awaiting Data Source

Count of electronic downloads submitted for central storage (LAS Clinical Performance Indicators)

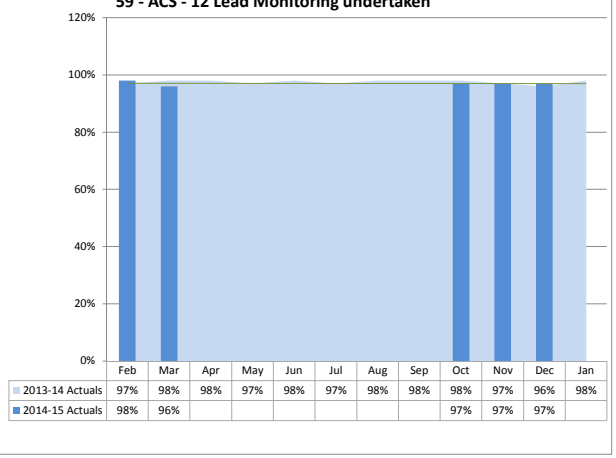
58 - ACS - Blood Glucose (BM) Initial Test



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	97%	97%	95%	96%	94%	96%	95%	96%	97%	98%	96%	97%
2014-15 Actuals	96%	96%							97%	98%	95%	

Count of BM Tests associated with Acute Coronary Syndrome patients (LAS Clinical Performance Indicators)

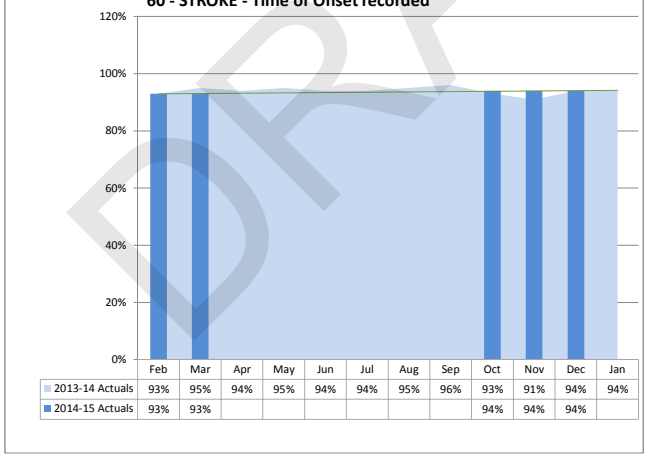
59 - ACS - 12 Lead Monitoring undertaken



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	97%	98%	98%	97%	98%	97%	98%	98%	98%	97%	96%	98%
2014-15 Actuals	98%	96%							97%	97%	97%	

Count of 12 Lead ECGs associated with Acute Coronary Syndrome patients (LAS Clinical Performance Indicators)

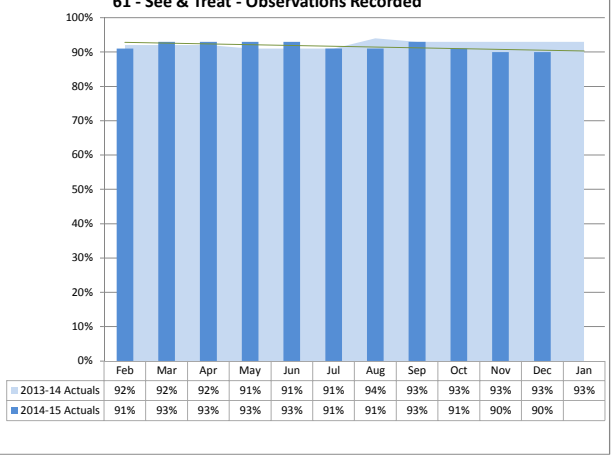
60 - STROKE - Time of Onset recorded



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	93%	95%	94%	95%	94%	94%	95%	96%	93%	91%	94%	94%
2014-15 Actuals	93%	93%							94%	94%	94%	

For patients with thrombotic stroke, treatment with thrombolytic therapy is highly time-dependent. Admission to a stroke unit for early specialist care is known to be life saving and to reduce disability, even if thrombolysis is not indicated. (LAS Clinic

61 - See & Treat - Observations Recorded



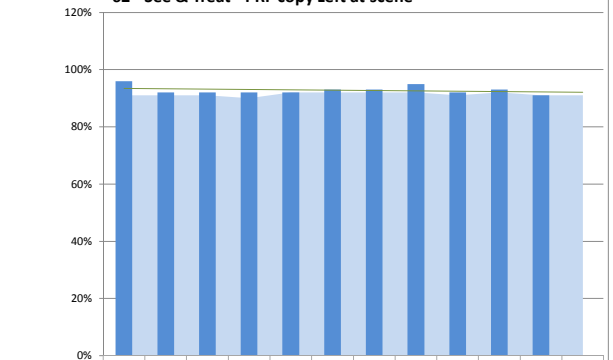
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	92%	92%	92%	91%	91%	91%	94%	93%	93%	93%	93%	93%
2014-15 Actuals	91%	93%	93%	93%	93%	91%	91%	93%	91%	90%	90%	

A full set of observations is defined as: Time (hh:mm), AVPU, respiratory rate, respiratory depth, O2 saturation (must be written as a percentage), pulse rate, pulse character, blood pressure and colour. (LAS Clinical Performance Indicators)

Effective - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

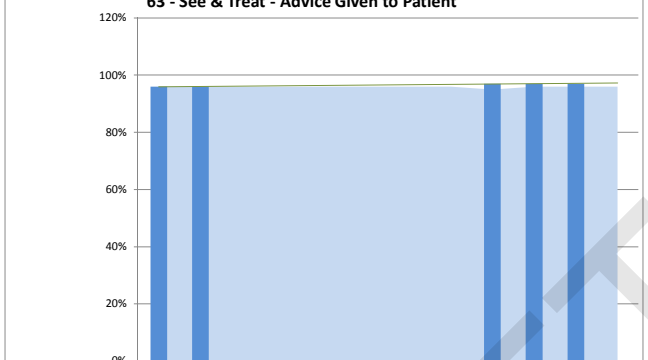
62 - See & Treat - PRF copy Left at scene



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	91%	91%	91%	90%	92%	92%	92%	92%	91%	92%	91%	91%
2014-15 Actuals	96%	92%	92%	92%	92%	93%	93%	95%	92%	93%	91%	

There must be clear documentation that a copy of the PRF was left with the patient (either on the reverse of the PRF or in the free text). (LAS Clinical Performance Indicators)

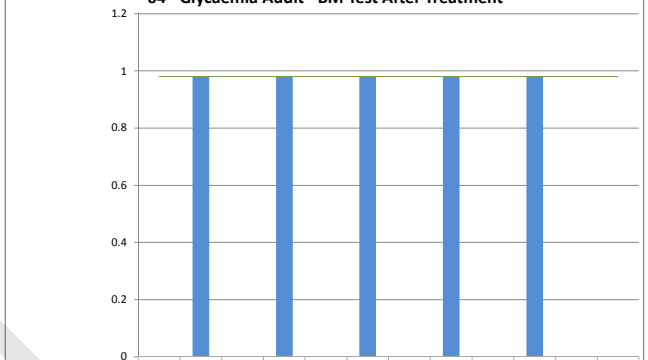
63 - See & Treat - Advice Given to Patient



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	96%	96%	96%	96%	96%	96%	96%	96%	95%	96%	96%	96%
2014-15 Actuals	96%	96%							97%	97%	97%	

Team Leaders should review the documented advice given to the patient on either the reverse of the PRF or the free text and assess whether it was appropriate. (LAS Clinical Performance Indicators)

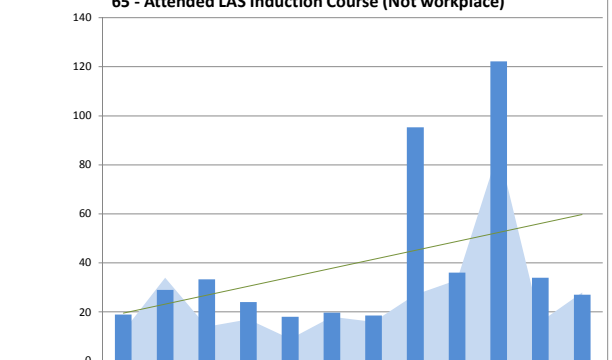
64 - Glycaemia Audit - BM Test After Treatment



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals		98%		98%		98%		98%		98%		98%
2014-15 Actuals		98%		98%		98%		98%		98%		

(LAS Clinical Performance Indicators)

65 - Attended LAS Induction Course (Not workplace)



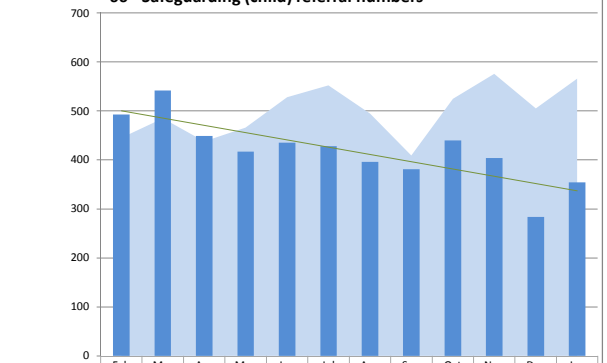
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	12	34	14	17	9	18	16	27	33	86	16	28
2014-15 Actuals	19	29	33.29	24	18	19.7	18.6	95.28	36	122.2	34	27

WTE of New Staff receiving a formal service induction course. This does not count localised inductions

Caring - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

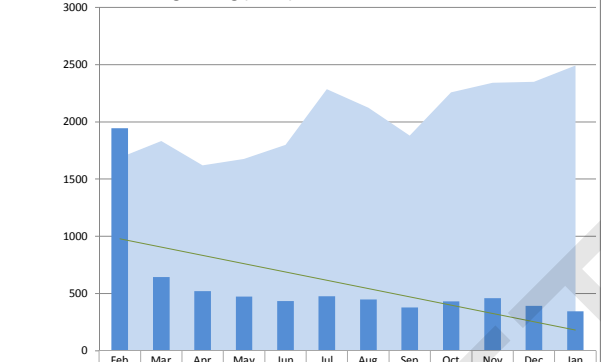
66 - Safeguarding (child) referral numbers



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	445	485	438	466	528	552	495	409	525	576	505	566
2014-15 Actuals	493	542	449	417	435	428	396	381	440	404	284	354

Count of Children referred by Service to appropriate authorities

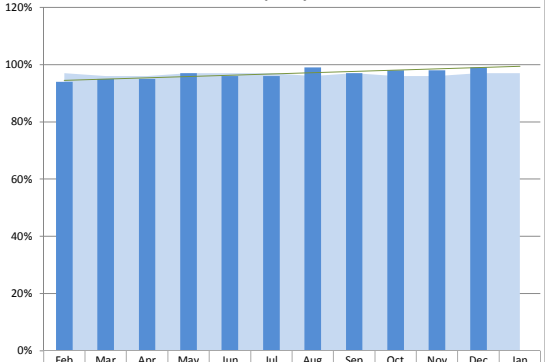
67 - Safeguarding (adult) referral numbers



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	1686	1834	1620	1676	1798	2287	2124	1880	2257	2341	2350	2493
2014-15 Actuals	1945	645	520	472	435	476	449	378	432	458	393	345

Count of Adults referred by Service to appropriate authorities

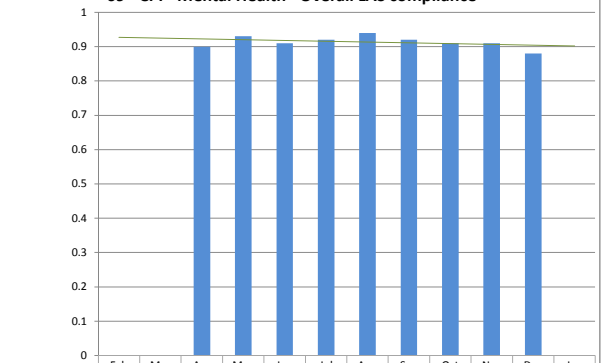
68 - CPI - Mental Health - Capacity Tool



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	97%	96%	96%	97%	97%	97%	96%	97%	96%	96%	97%	97%
2014-15 Actuals	94%	95%	95%	97%	96%	96%	99%	97%	98%	98%	99%	

Where a patient refuses assessment, a form of treatment and/or conveyance and patient capacity is in doubt, the capacity tool should be used to determine whether patient has capacity to refuse. (LAS Clinical Performance Indicators)

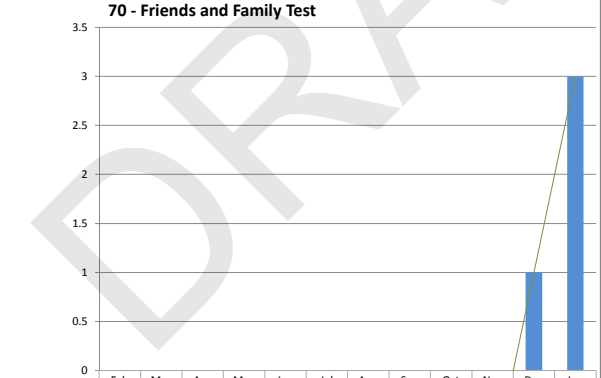
69 - CPI - Mental Health - Overall LAS compliance



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals			90%	93%	91%	92%	94%	92%	91%	91%	88%	

(LAS Clinical Performance Indicators)

70 - Friends and Family Test



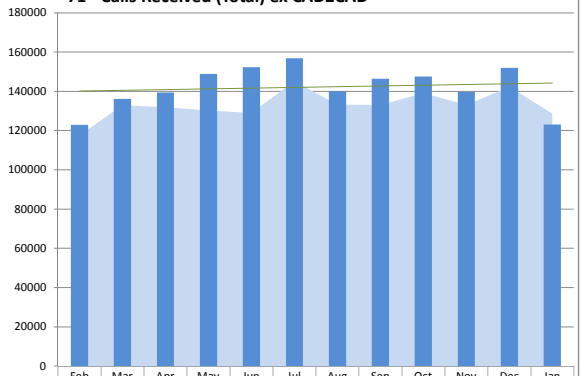
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals											1	3

Numbers by month of returns from Friends and Family Test (Formally commences April 2015)

Responsive - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

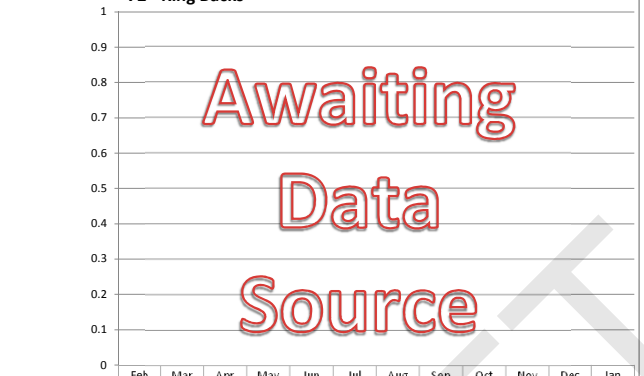
71 - Calls Received (Total) ex CAD2CAD



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	117485	132899	131862	130275	129014	145152	133163	133107	139108	133112	142350	128705
2014-15 Actuals	122888	136128	139380	148878	152311	156863	140012	146411	147626	139672	152028	123112

Total calls to LAS

72 - Ring Backs

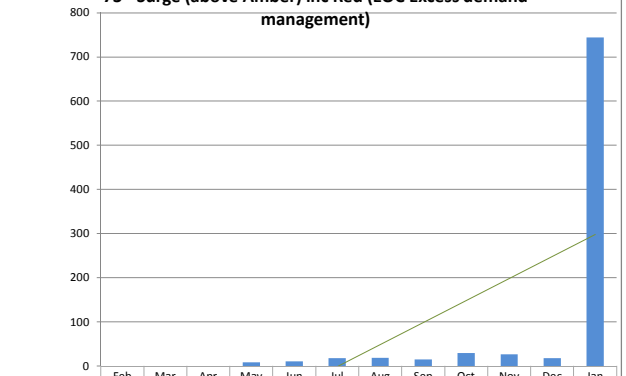


Awaiting Data Source

	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals												

Abandoned Calls rung back

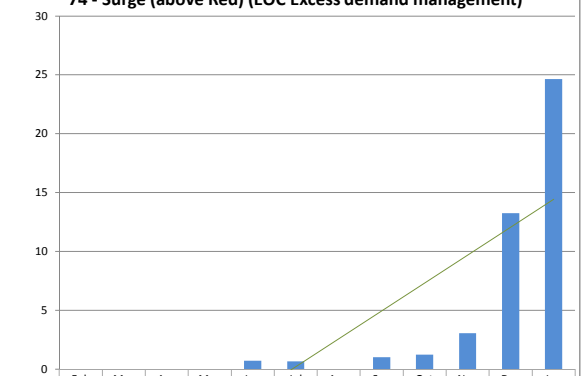
73 - Surge (above Amber) inc Red (EOC Excess demand management)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals				197:19	258:17	424:21	452:29	355:13	713:59	646:15	425:57	744

Data from July 14 Onwards, replaced Demand Management Plan

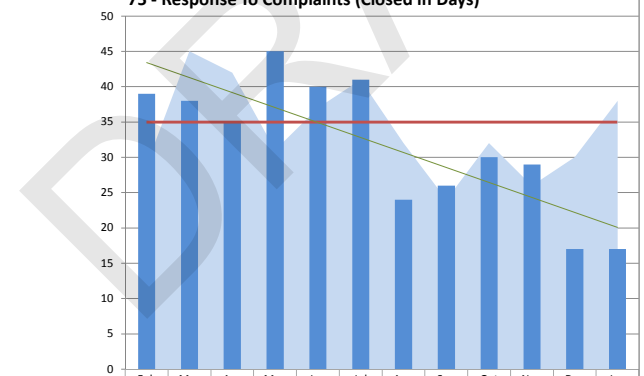
74 - Surge (above Red) (EOC Excess demand management)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals				0:00	17:35	16:14	0:00	24:42	29:59	73:43	318:01	591:25

Data from July 14 Onwards, replaced Demand Management Plan

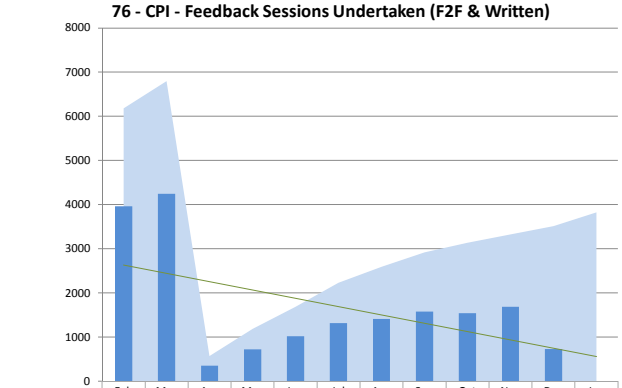
75 - Response To Complaints (Closed in Days)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	29	45	42	31	37	41	32	24	32	26	30	38
2014-15 Actuals	39	38	35	45	40	41	24	26	30	29	17	17
Target	35	35	35	35	35	35	35	35	35	35	35	35

A true reflection of response times cannot be calculated until the furthest timescale (i.e. 35 days working days have elapsed) - Approximately 33% of complaints are closed within the 35 day time frame

76 - CPI - Feedback Sessions Undertaken (F2F & Written)



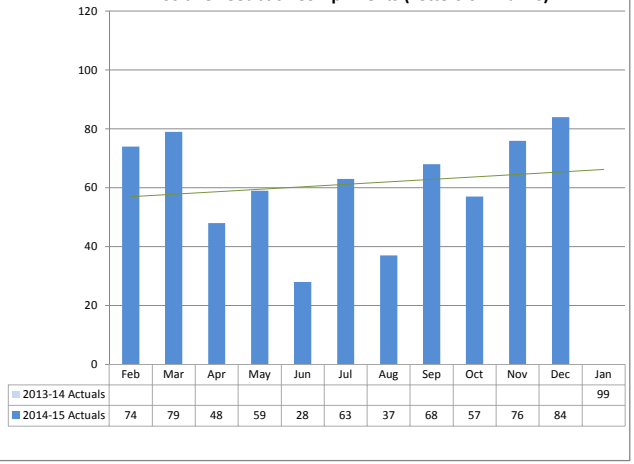
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	6182	6795	573	1184	1689	2229	2590	2918	3133	3327	3510	3823
2014-15 Actuals	3963	4243	356	722	1022	1315	1412	1577	1540	1690	730	

CUMULATIVE Team leaders are required to feedback to operational staff an overview of recent compliance against the PRF audits undertaken. This element is about ensuring staff are actively monitored to provide documentation of appropriate care.

Responsive - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.

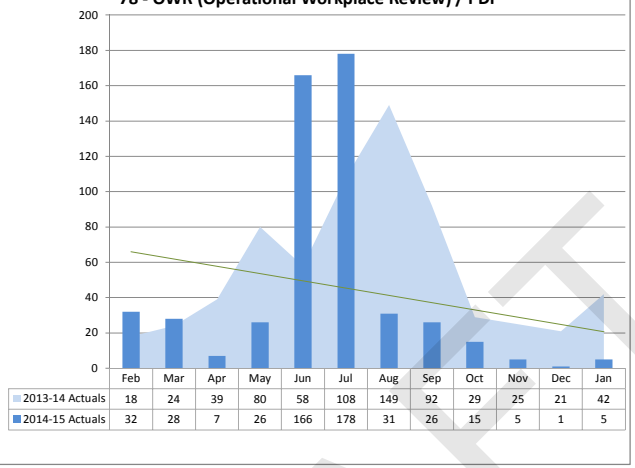
77 - Positive Feedback Compliments (Letters of Thanks)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												99
2014-15 Actuals	74	79	48	59	28	63	37	68	57	76	84	

Letters of thanks sent to the Service addressed to any member of staff and notified to the Communications Team. (Pre Nov 2013 letters scanned Total 733)

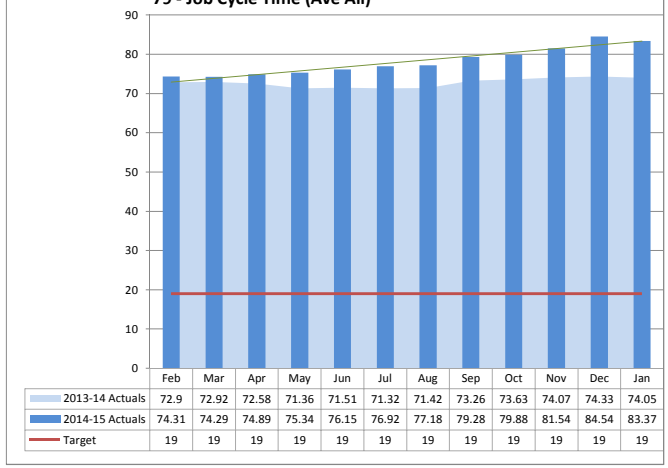
78 - OWR (Operational Workplace Review) / PDP



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	18	24	39	80	58	108	149	92	29	25	21	42
2014-15 Actuals	32	28	7	26	166	178	31	26	15	5	1	5

Reviews of staff, variously recorded as CPD (Continuing Professional Development) CPDI (Interview), IPR (Individual Performance Review), PDR (Personal Development Review), PCD (Personal Career Development)

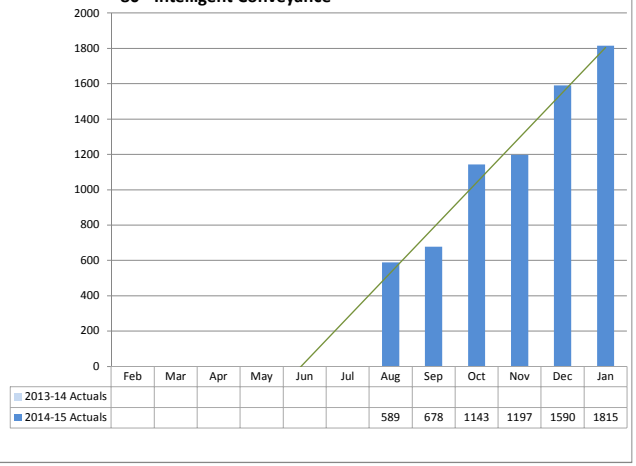
79 - Job Cycle Time (Ave All)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	72.9	72.92	72.58	71.36	71.51	71.32	71.42	73.26	73.63	74.07	74.33	74.05
2014-15 Actuals	74.31	74.29	74.89	75.34	76.15	76.92	77.18	79.28	79.88	81.54	84.54	83.37
Target	19	19	19	19	19	19	19	19	19	19	19	19

Job Cycle Time Average for Month (Conveyed and Non Conveyed rpt 644)

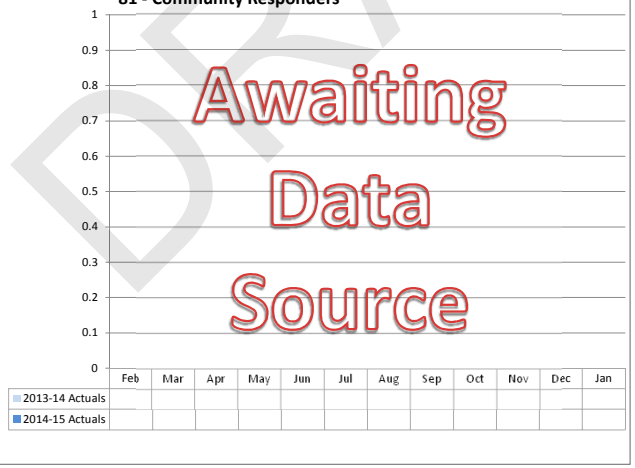
80 - Intelligent Conveyance



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals							589	678	1143	1197	1590	1815

Number of Vehicles diverted to create capacity at alternative Emergency Departments

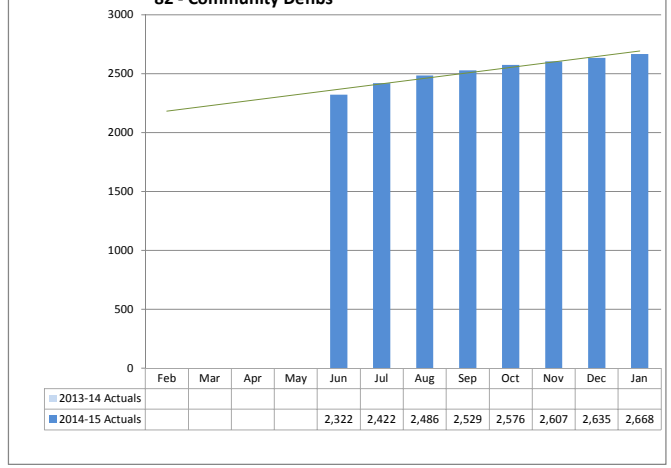
81 - Community Responders



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals												

Number of persons recognised and deployable by Service as authorised community responders

82 - Community Defibs

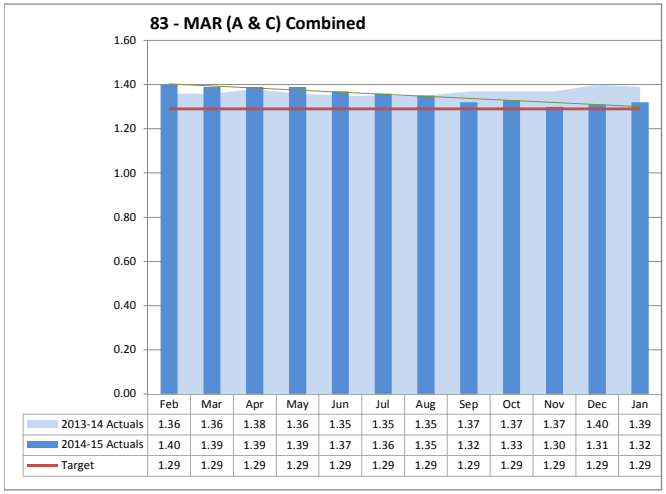


	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals					2,322	2,422	2,486	2,529	2,576	2,607	2,635	2,668

Number of Public Access Defibs available pan London

Responsive - Dashboard Metric Graphs - DRAFT v2B

Green Line is a Linear Trend line of 2014-15 data.



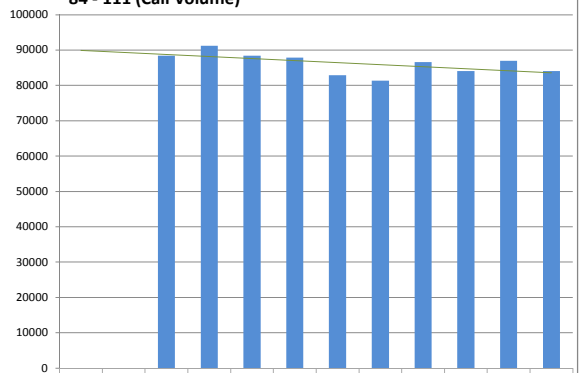
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	1.36	1.36	1.38	1.36	1.35	1.35	1.35	1.37	1.37	1.37	1.40	1.39
2014-15 Actuals	1.40	1.39	1.39	1.39	1.37	1.36	1.35	1.32	1.33	1.30	1.31	1.32
Target	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29

Multiple Attendance Ratio. A calculation based on A & C responses of how many occasions an additional vehicle has attended a scene. Acceptable reasons would be cardiac arrest or multiple casualties

Well Led - Dashboard Metric Graphs - Draft v2B

Green Line is a Linear Trend line of 2014-15 data.

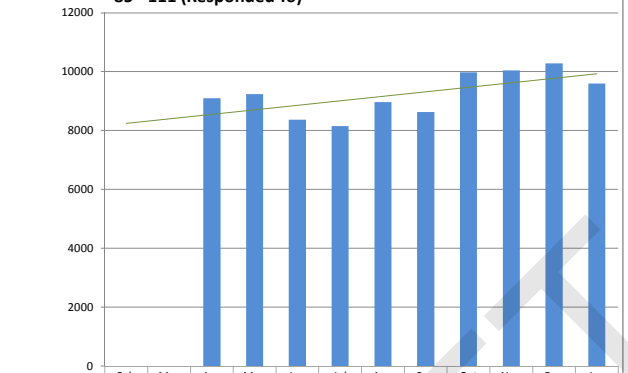
84 - 111 (Call Volume)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals			88382	91225	88382	87833	82847	81373	86568	84099	86950	84110

Number of calls presented to 111 within London and recorded by LAS

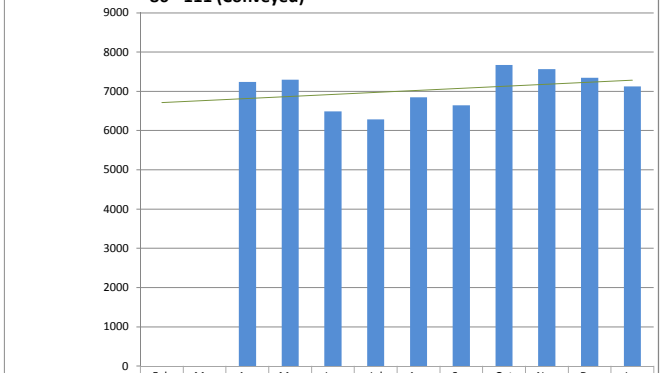
85 - 111 (Responded To)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals			9099	9243	8371	8146	8972	8635	9982	10038	10283	9602

Number of 111 calls transferred to the LAS for attendance with patient

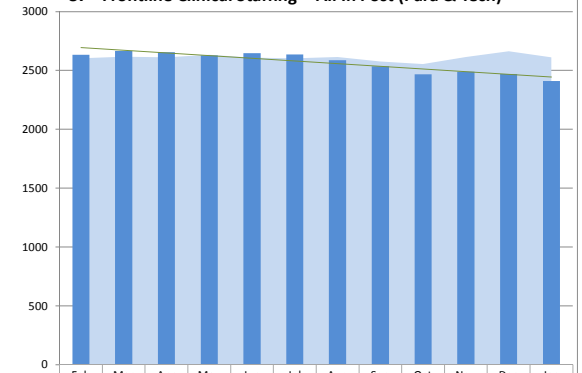
86 - 111 (Conveyed)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals			7237	7300	6490	6287	6851	6646	7675	7563	7341	7124

Number of 111 calls who receive LAS attendance at scene and are subsequently conveyed to hospital

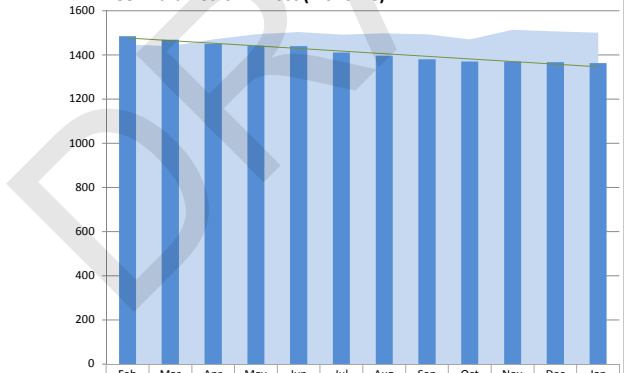
87 - Frontline Clinical Staffing - All In Post (Para & Tech)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	2603	2616	2611	2633	2608	2604	2613	2575	2555	2614	2662	2611
2014-15 Actuals	2632	2665	2655	2628	2647	2636	2588	2535	2467	2490	2471	2410

Count of paramedic and Non Paramedic frontline staff (excludes management / admin grades etc.)

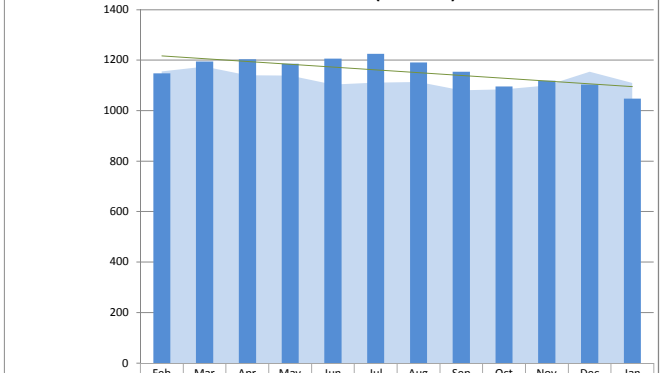
88 - Paramedic - In Post (Frontline)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	1448	1441	1472	1494	1505	1493	1499	1494	1471	1514	1507	1502
2014-15 Actuals	1485	1470	1451	1442	1441	1411	1397	1380	1371	1370	1368	1363

Qualified Paramedical Staff deployed on frontline duties

89 - Non Paramedic - In Post (Frontline)



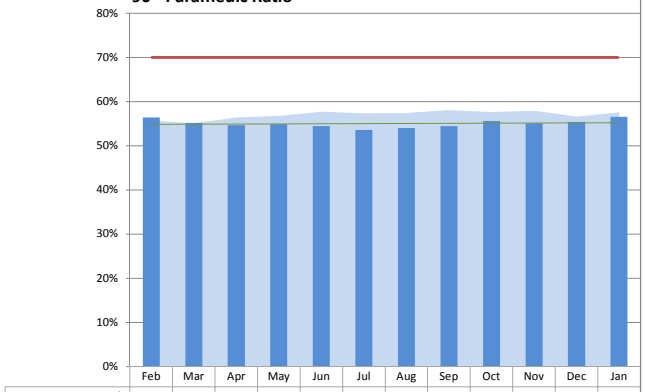
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	1155	1175	1140	1139	1104	1111	1114	1081	1084	1100	1154	1110
2014-15 Actuals	1147	1195	1204	1186	1206	1225	1191	1155	1096	1119	1103	1047

Non Paramedical Staff deployed on frontline duties (Numbers includes student paramedics etc.)

Well Led - Dashboard Metric Graphs - Draft v2B

Green Line is a Linear Trend line of 2014-15 data.

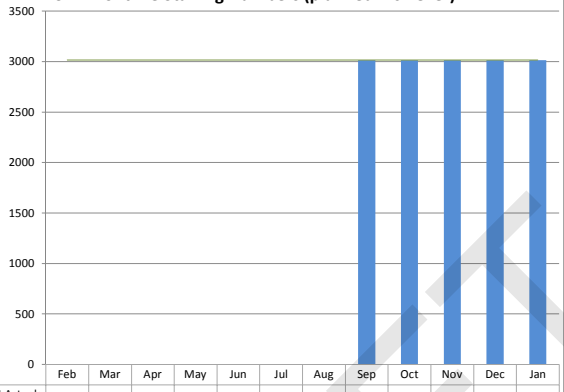
90 - Paramedic Ratio



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	56%	55%	56%	57%	58%	57%	57%	58%	58%	58%	57%	58%
2014-15 Actuals	56%	55%	55%	55%	54%	54%	54%	54%	56%	55%	55%	57%
Target	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7

Paramedic to Non Paramedic expressed as percentage. Commisioners Target for 2016 is 70%

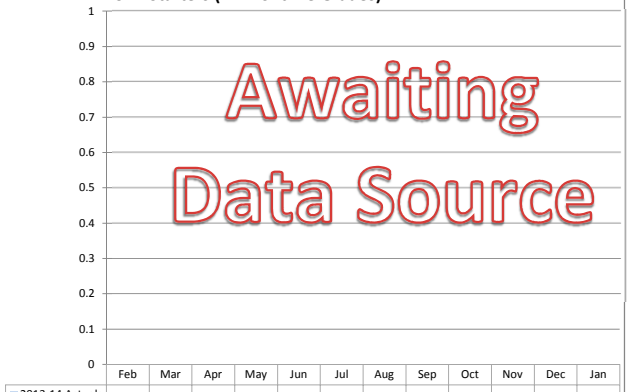
91 - Frontline Staffing Numbers (planned inc Relief)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals								3016	3016	3016	3016	3016

Frontline staff plan including 32% relief factor (from September 2014)

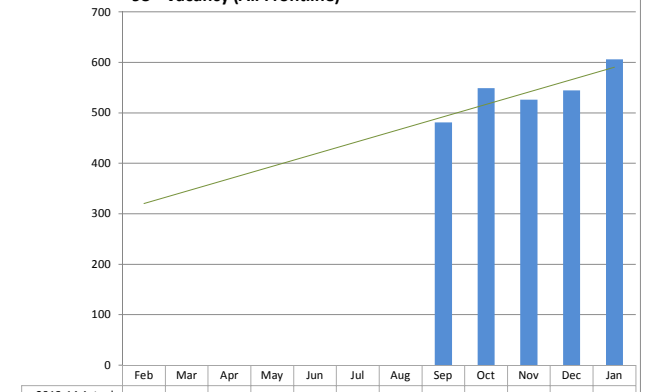
92 - Starters (All Frontline Grades)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals												

WTE Trainees and joiners who will take up frontline duties, once qualified

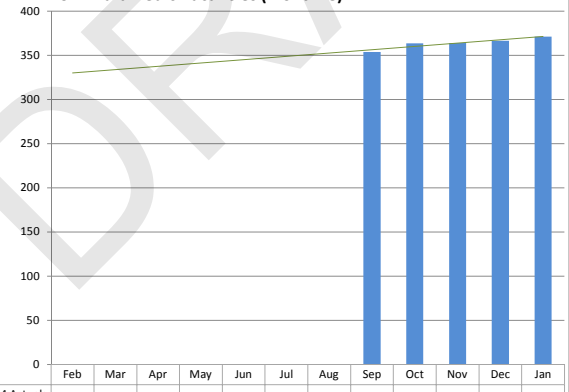
93 - Vacancy (All Frontline)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals								481	549	526	545	606

Monthly WTE vacancy factor including 32% relief

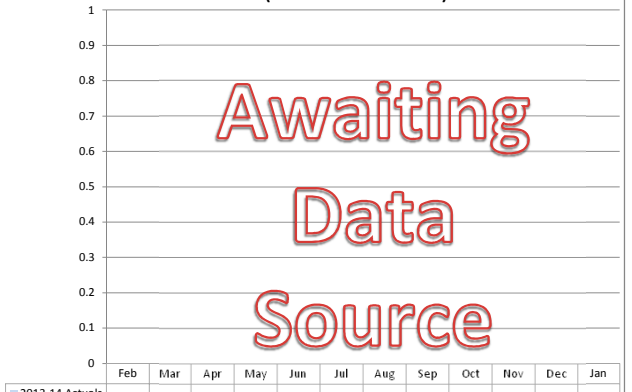
94 - Paramedic Vacancies (Frontline)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals								354	364	364	367	371

Paramedic only vacancies (inc Relief)

95 - Staff Turnover (Joiners Minus Leavers)



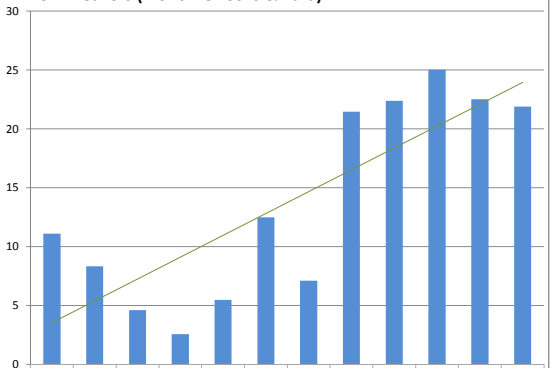
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												
2014-15 Actuals												

Numeric positive or negative swing by WTE for frontline duties

Well Led - Dashboard Metric Graphs - Draft v2B

Green Line is a Linear Trend line of 2014-15 data.

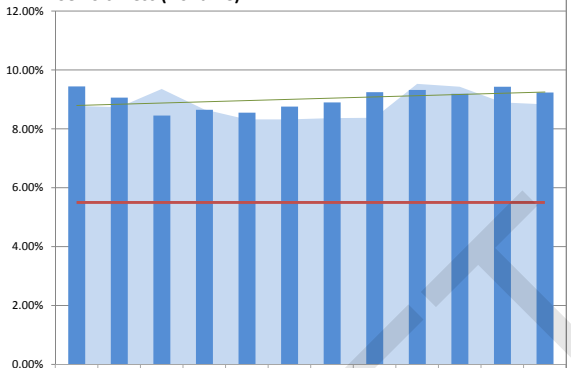
97 - Leavers (Frontline Techs & Para)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals												5.726
2014-15 Actuals	11.1	8.3	4.6	2.6	5.5	12.5	7.1	21.5	22.4	25.0	22.5	21.9

Staff leaving LAS for other jobs from frontline

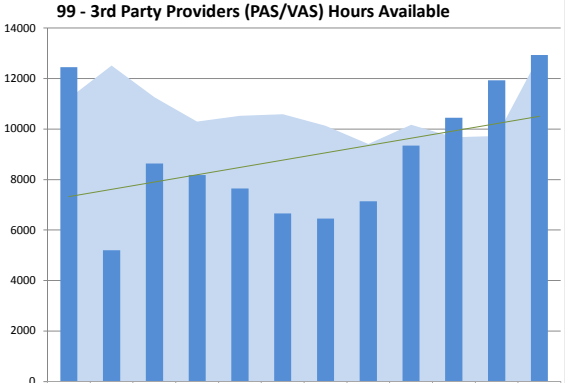
98 - Sickness (frontline)



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	8.78%	8.74%	9.36%	8.66%	8.32%	8.33%	8.37%	8.38%	9.53%	9.43%	8.90%	8.83%
2014-15 Actuals	9.44%	9.07%	8.45%	8.65%	8.55%	8.76%	8.90%	9.25%	9.32%	9.19%	9.44%	9.24%
Target	0.055	0.055	0.055	0.055	0.055	0.055	0.055	0.055	0.055	0.055	0.055	0.055

Combined Short and Long Term Sickness for frontline staff

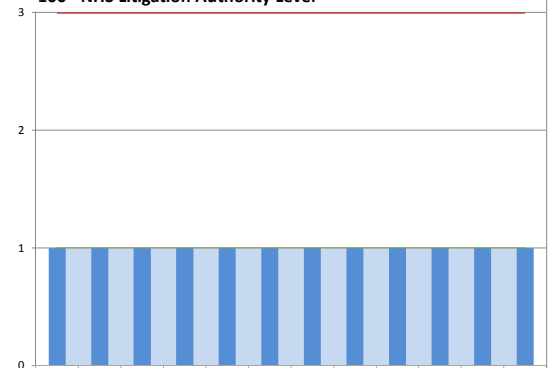
99 - 3rd Party Providers (PAS/VAS) Hours Available



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	11210	12519	11259	10300	10531	10583	10138	9406	10169	9677	9721	12894
2014-15 Actuals	12453	5196	8631	8181	7641	6654	6451	7138	9352	10444	11929	12928

Total Hours recorded as being supplied by Private Ambulance Service (PAS) or Voluntary Ambulance Service (VAS) to support frontline operations

100 - NHS Litigation Authority Level



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2013-14 Actuals	1	1	1	1	1	1	1	1	1	1	1	1
2014-15 Actuals	1	1	1	1	1	1	1	1	1	1	1	1
Target	3	3	3	3	3	3	3	3	3	3	3	3

NHSLA Level

From the office of David Flory CBE, Chief Executive

NHS
Trust Development Authority

To: NHS Trust Chief Executives

Southside
105 Victoria Street
London
SW1E 6QT
www.ntda.nhs.uk

11 March 2015

Dear Chief Executive

Re: NHS Investigations into Jimmy Savile and the Kate Lampard Lessons Learnt Report

You may recall that I wrote to you last July concerning the publication of NHS investigation reports relating to the activities of Jimmy Savile on NHS premises.

I am writing now to draw your attention to the publication on 26 February of a further 16 NHS reports investigation reports from Trusts, as well as the overarching Lessons Learnt Report authored by Kate Lampard. I attach a copy of Kate Lampard's report here. You can access the Trust reports through the link below:

https://www.gov.uk/government/news/the-nhs-savile-investigations

The Secretary of State for Health has accepted in principle 13 recommendations that Kate Lampard makes, including on access, volunteering, safeguarding, complaints and governance. Although Secretary of State did not accept recommendation 6 on DBS checks, Trusts are urged to take a considered approach to DBS checks on volunteers, including the use of enhanced DBS services where volunteers may work closely with patients in the future.

Therefore, I ask that you:

- Read the Kate Lampard Report and review the recommendations for NHS Trusts
- Develop an action plan to identify where additional action is needed against these recommendations
- Provide assurance that the necessary action has been taken - or where this is in progress, the date by which it will be completed.

I am asking that you complete the actions above within 3 months and confirm progress by 31 May 2015, using the template attached.

NHS
Trust Development Authority

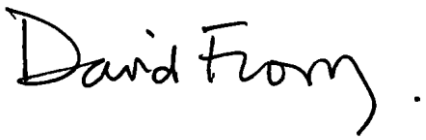
Legacy arrangements

As you may be aware, the NHS Savile Legacy Unit was established in July 2014 as an independent body to provide oversight and assurance of any new NHS investigations into allegations of abuse or risks of abuse by Savile. Upon publication of the trusts investigation reports in February 2015 the work of the Unit has now been drawn to a close.

Where further allegations of abuse or risks of abuse by Savile come to light, going forward, Trusts will be required to investigate these under their own safeguarding or Serious Untoward Incident policies.

Thank you for your assistance in this matter,

Yours sincerely,



David Flory
Chief Executive

Annex A: REPORT ON TRUST PROGRESS IN RESPONSE TO KATE LAMPARD'S LESSONS LEARNT REPORT

NAME OF TRUST:	

Recommendation	Issue identified	Planned Action	Progress to date	Due for completion
I. All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors.				
II. All NHS trusts should review their voluntary services arrangements and ensure that: • They are fit for purpose; • Volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and, • All voluntary services managers have development opportunities and are properly supported.				
III. All NHS hospital staff and volunteers should be required to undergo formal refresher training in safeguarding at the appropriate level at least every three years.				
IV. All NHS Hospital trusts should undertake regular reviews of: • Their safeguarding resources, structures and processes (including their training programmes); and, • The behaviours and responsiveness of management and staff in relation to safeguarding issues. • to ensure that their arrangements are robust and operate as effectively as possible.				
V. All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of				

this recommendation should be supported by NHS Employers.				
VI. All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.				
VII. All NHS hospital trusts should ensure that arrangements and processed for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.				
VIII. NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.				
IX. NHS hospital trusts and their associated charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect this.				
I confirm that this Trust Board has reviewed the full recommendations in Kate Lampard's lessons learnt report: SIGNED: DATE: CE NAME:				

Return to Natalie Dixon, Senior Policy Advisor, NHS TDA – Natalie.Dixon7@nhs.net

London Ambulance Service NHS
NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	24 March 2015
Document Title:	Integrated Performance report
Report Author(s):	Paul Woodrow
Presented by:	Andrew Grimshaw
Contact Details:	
History:	Executive Management Team meeting on 18 March 2015
Status:	Information

Background/Purpose

The integrated performance report provides an overview of organisational performance for month 9 of this financial year. The dashboard reports on the following domains:

1. Quality
2. Performance and activity
3. Workforce
4. Value for money

The current report provides the board with a visual dashboard covering the domains above supported by additional tabs providing additional commentary on each and actions currently being taken to address identified issues. The report also provides a series of graphs for each measure to provide the board with trend information on a rolling monthly basis since the beginning of this financial year. This format of this report is subject to further development.

Key points to note from the report are:

The Trust failed to achieve the national response time targets for Red 1 and Red 2 as well as A19 in month 11. Performance against the Red 1 and red 2 targets remained fairly static against the previous month outturn. There was a slight improvement in A19 performance in month 11. Category A activity has stabilised since December and month 11 ended 2.4% below forecast. Total incidents in month were down by 13% in part driven by the need to escalate levels of the surge plan to manage spikes in Category A activity which removes more Category C responses as well as the impact of the NHS111 enhanced assessment of Category C calls from NHS 111 providers which again reduces total activity.

Operational resourcing hours were broadly in line with our forecasted position in month 11. The Clinical Hub continues to over perform and dealt with over 13,500 calls without the requirement to send a resource. The number of new recruits becoming fully operational in quarter 4 has been restated due to identified additional training and supervision requirements for some cohorts of new recruits. This has impacted on our original capacity forecasts and thus outturn performance. Training has been remodelled to reflect these changes for future cohorts.

Following review of 6 potential Serious Incidents 3 were declared in month 11 which is further decrease of two incidents on the previous month. Complaints showed a continued reduction in month 11 but remain above the target measure. The majority of complaints were associated with delayed response times. Patients in Category C continue to see a poorer quality of service than the Trust would like, principally driven by Category A activity increases in month 11.

The Trust achieved the national call handling targets for both 999 and NHS 111 in month 11 and the rate of transfer to 999 from our NHS 111 led service remains below the national target. The overall response time distribution curve for both Red 1 and Red 2 patients improved slightly in month 11. Escalation of the surge plan above Red was again required in month to try to manage spikes in demand and protect resources to send to the most serious and life threatening calls. The Trust is currently operating at REAP Level 4 (Severe Pressure).

There is still a low level of compliance associated with CPI audits due to Clinical Team Leaders (CTLs) being deployed to patient facing duties. This will be addressed in the new financial year when CTLs will move to a 50%/50% split between patient facing duties and clinical supervision duties. The Trust has over performed against the delivery of the Core Skill Refresher (14) training now having completed this for 78% of the eligible frontline establishment. Training for non-frontline staff is still a cause for concern and is being addressed through the education and development team. The Current dispatch on disposition pilot went live in February and no clinical incidents or known safety issues have been identified. The pilot has been extended to 10 April 2015.

Turnover metrics remained fairly static in month 11 compared to previous month. The number of Paramedics leaving decreased in month 11 with the associated slight reduction in the Paramedic vacancy rate. The Trust also saw a reduction in the overall Trust level vacancy rate. The 14/15 frontline recruitment plan has achieved the target number of new recruits and continues to be reviewed weekly. New training facilities are now fully operational in Central and South West London in order for the Trust to increase its capacity to deliver training to new recruits. Sickness remains above target levels for the Trust and still remains higher in frontline operations than the rest of the Trust. The operational management restructure continues and is due for completion at the beginning of June 2015.

In month the Trust is reporting £1.0m favourable to plan. YTD the Trust is £0.2m favourable to plan. The Trust forecast will be a reduced surplus position of £1.0m following agreement with the NTDA. The Trust remains on track to deliver its £13.8m CIP. The Trusts cash position remains robust and is significantly ahead of plan; this is mainly due to underspend on capital. Capital Expenditure is expected to be £16.9m by the end of the year. Against the Continuity of Service Risk Rating used by Monitor to assess aspirant Foundation Trusts , LAS has scored a 4.0 which is a good score and in excess of the Trust's plans (3.5)

Action required

To note the contents of this report.

Assurance

This report provides the Board with an overview of the current organisational challenges facing the Trust and the actions being taken to address these.

Key implications and risks arising from this paper	
Clinical and Quality	**Yes**
Performance	**Yes**
Financial	**Yes**
Legal	**No**
Equality and Diversity	**No**
Reputation	**Yes**
Other	**Yes**
This paper supports the achievement of the following 2014/15 objectives	
Improve patient care	**Yes**
Improve recruitment and retention	**Yes**
Implement the modernisation programme	**No**
Achieve sustainable performance	**Yes**
Develop our 111 service	**No**
Simplify our business processes	**No**
Increase organisational effectiveness and development	**No**

London Ambulance Service NHS Trust

Trust Board Integrated Performance report

February Data

13-Mar-15

LONDON AMBULANCE SERVICE NHS TRUST

INTEGRATED PERFORMANCE REPORT 2014/15: Feb 2015 (MONTH 11)

Quality Exceptions		**Quality of service to patients in Category C still remains below expected levels. Call answering is back to within the national standards**
Performance Exceptions		**The Trust is still not meeting the three main response time standards in month 11 but performance has remained stable against month 10**
Workforce Exceptions		**There has been a slight reduction in Paramedic and overall vacancy numbers for the Trust. The remainder of the metrics are fairly static**
Value for Money Exceptions		**Finance metrics have stayed fairly static in Month 11 with no exceptions to report**

QUALITY

	Quality measures	Target	Current month	Previous month	Year end forecast
1	Serious Incidents declared	1	3	5	RED
2	Complaints received	69	100	114	RED
3	999 Call Answering - 5 secs	95.0%	96.6%	97.6%	GREEN
4	NHS111 Call Answering- 60secs	95.0%	96.8%	96.8%	GREEN
5	NHS 111 Transfer rate to 999	10.0%	7.3%	7.4%	GREEN
6	Aspects of care compliance (MH)	95.0%	90.0%	90.0%	AMBER
7	Deep Clean of vehicles % completed	90.0%	92.0%	91.0%	GREEN
8	Category C1 (20 mins)	75.0%	44.5%	49.9%	RED
9	Category C2 (30 mins)	75.0%	53.7%	61.2%	RED
10	CSR 2014 Delivery - % of Frontline	60.0%	78.2%	70.2%	GREEN
11	Red 1 - 75% reached in mins/secs	8 minutes	08:50	08:45	GREEN
12	Red 1 number of responses >10 mins		175	225	
13	Red 1 95th Percentile Time to respond		14.13	14.28	
14	Red 2 -75% reached in mins/secs	8 minutes	10:40	10:30	
15	Red 2 number of responses >10 mins		9694	10328	
16	Red 2 95th Percentile Time to respond		19.88	20.75	
17	Surge plan escalation > RED (Hours)		30:40	34:16	

** Please note Percentile time shown as a decimal **

PERFORMANCE / ACTIVITY

	Performance / activity measures	Target	Current month	Previous month	Year end forecast
1	Red 1 Performance	75.0%	67.1%	68.6%	RED
2	Red 2 Performance	75.0%	58.7%	59.7%	RED
3	Trust A19 Performance	95.0%	91.9%	91.3%	AMBER
4	FRU A8 Performance	80.0%	61.5%	64.6%	RED
5	Cat A Red 1 Incidents	1,156	1,110	1,346	GREEN
6	Cat A Red 2 Incidents	37,343	36,455	39,748	GREEN
7	Cat A Total Incidents	38,499	37,565	41,094	GREEN
8	Total incidents	88,292	76,600	84,579	AMBER
9	Total Activity against Plan	0	90,085	98,456	GREEN
10	Clinical Hub Discharges	7,853	13,583	13,907	GREEN

VALUE FOR MONEY

		Target	Current month	Previous month	Year end forecast
1	EBITDA (£000)	-1010.0	1,784	2,460	GREEN
2	Net surplus (£000) (negative - deficit)	- 408	1,232	1,352	AMBER
3	Cost Improvement Programme (£000)	1,416	1,416	1,416	GREEN
4	Capital expenditure (£000)	5,936	7,494	5,074	AMBER
5	Monitor FRR	4	4.0	4.0	GREEN
6	Cash balance (£000)	12,051	32,807	35,662	GREEN

WORKFORCE

	Workforce measures	Target	Current month	Previous month	Year end forecast
1	Staff Turnover % All Trust	8.5%	14.3%	14.1%	RED
2	Vacancies (%) All Trust	5.0%	-16.0%	-16.6%	RED
3	Paramedic Vacancies against EST		330	346	RED
4	Vacancies as number for All Trust		727	875	RED
5	Paramedic Leavers	6	10	19	RED
6	Sickness (%) All Trust	5.0%	6.6%	6.6%	RED
7	Sickness (%) Frontline	5.0%	7.5%	7.4%	RED

Supporting Commentary for exceptions against specific quadrants

QUALITY

Commentary: Following review of 6 potential Serious Incidents 3 were declared in month 11 which is further decrease of two incidents on the previous month. Complaints showed a continued reduction in month 11 but remain above the target measure. The majority of complaints were associated with delayed response times. Patients in Category C continue to see a poorer quality of service than the Trust would like, principally driven by Category A activity increases in month 11 . The Trust achieved the national call handling targets for both 999 and NHS 111 in month 11 and the rate of transfer to 999 from our NHS 111 led service remains below the national target. The overall response time distribution curve for both Red 1 and Red 2 patients improved slightly in month 11. Escalation of the surge plan above Red was again required in month to try to manage spikes in demand and protect resources to send to the most serious and life threatening calls. The Trust is currently operating at REAP Level 4 (Severe Pressure). There is still a low level of compliance associated with CPI audits due to Clinical Team Leaders (CTLs) being deployed to patient facing duties. This will be addressed in the new financial year when CTLs will move to a 50%/50% split between patient facing duties and clinical supervision duties. The Trust has over performed against the delivery of the CSR14 training now having completed this for 78% of the eligible frontline establishment. Training for non-frontline staff is still a cause for concern and is being addressed through the internal education and development team. The Current dispatch on disposition pilot went live and no clinical incidents or known safety issues have been identified. The pilot has been extended to 10 April 2015.

WORKFORCE

Commentary: Turnover metrics remained fairly static in month 11 compared to previous month. The number of Paramedics leaving decreased in month 11 with the associated slight reduction in the Paramedic vacancy rate. The Trust also saw a reduction in the overall Trust level vacancy rate. The 14/15 frontline recruitment plan has achieved the target number of new recruits and continues to be reviewed weekly. New training facilities are now fully operational in Central and South West London in order for the Trust to increase its capacity to deliver training to new recruits. Sickness remains above target levels for the Trust and still remains higher in frontline operations than the rest of the Trust. The operational management restructure continues and is due for completion at the beginning of June 2015.

PERFORMANCE / ACTIVITY

Commentary: The Trust failed to achieve the national response time targets for Red 1 and Red 2 as well as A19 in month 11. Performance against the Red 1 and red 2 targets remained fairly static against the previous month outturn. There was a slight improvement in A19 performance in month 11. Category A activity has stabilised since December and month 11 ended 2.4% below forecast. Total incidents down by 13% in part driven by the need to escalate levels of the surge plan to manage spikes in activity which removes more Category C responses as well as the impact of the NHS111 enhanced assessment of Category C calls from NHS 111 providers which again reduces total activity. Operational resourcing hours were broadly in line with our forecasted position in month 11. The Clinical Hub continues to over perform and dealt with over 13,500 calls without the requirement to send a resource. The number of new recruits becoming fully operational in quarter 4 has been restated due to identified additional training and supervision requirements for some cohorts of new recruits. This has impacted on our original capacity forecasts and thus outturn performance. Training has been remodelled to reflect these changes for future cohorts.

VALUE FOR MONEY

Commentary: In month the Trust is reporting £1.0m favourable to plan. YTD the Trust is £0.2m favourable to plan. The Trust forecast will be a reduced surplus position of £1.0m following agreement with the NTDA. The Trust remains on track to deliver its £13.8m CIP. The Trusts cash position remains robust and is significantly ahead of plan, this is mainly due to underspend on capital. Capital Expenditure is expected to be £16.9m by the end of the year. Against the Continuity of Service Risk Rating used by Monitor to assess aspirant Foundation Trusts , LAS has scored a 4.0 which is a good score and in excess of the Trust's plans (3.5)

Supporting Action for exceptions against specific quadrants

QUALITY

Actions: The quality of service for patients will improve as we start to see the 175 Paramedics and EACs that have joined the Trust this quarter finish their training and supervisory placements and become fully operationally productive. This will impact on operational capacity in Quarter 1 of the new financial year. We remain fully focussed on patient safety by resourcing sufficient clinical staff on duty in the Clinical Hub and these staff will continue to be supported by additional nursing staff that have been recruited to also work on the Clinical Hub. We have been working with NHSE (London) to reduce the number of Category C calls from NHS 111 providers to assist us in managing inappropriate demand for ambulance resources and we are seeing a reduction in activity for Category C calls from 111 providers as a result of this work. We continue to utilise PTS vehicles to provide transport to those patients who do not require any clinical intervention but do need transportation to protect our frontline resources to attend those patients with more serious illnesses and injuries. The Trust are currently working on preparations for a scheduled CQC inspection of the Trust in June 2015.

PERFORMANCE / ACTIVITY

Actions: The Performance Improvement programme continues to deliver against the projects contained within it for 14/15 and is subject to formal review through the Programme Board chaired by the CEO. The majority of demand management actions are routinely delivering the expected benefits. As part of the on going work to develop the transformation business case a new suite of projects have been identified to increase productivity and reduce utilisation. These are currently being scoped and will form tier1 of the improvement programme for 15/16. In the short term focus is being concentrated on FRU performance, an action plan to increase performance from these resources has been developed and signed off by the Director of Operations .This plan is being enacted under the governance umbrella of the improvement Programme . The Trust has now introduced a more sophisticated predictive model to use as part of operational planning going forward in 15/16. The Trust continues to work closely with the TDA Improvement Director to ensure the necessary actions are being taken to improve operational performance.

WORKFORCE

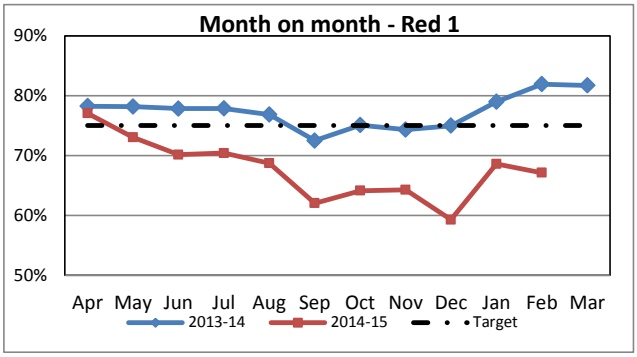
Actions: The Trust now has robust recruitment plans in place for both Paramedics and Trainee Emergency Ambulance Crew. The Director of Strategy and Transformation is now the executive lead in recruitment and reviews delivery against the plan on a weekly basis with EMT. Quarter 4 will see in the region of 200 new staff of both grades joining the Trust although the majority of these staff will not become fully productive until Quarter 1 of the new financial year. There are also robust plans in place for further recruitment in 2015/16. A team from the Trust are currently on their second trip to Australia to recruit both experienced and newly graduated Paramedics. There are 109 existing Australian Paramedics that will join the Trust between now and the end of March. These recruits are taking between eight and seventeen weeks before becoming fully operational dependant on their levels of experience. A comprehensive review of the Trust's Bank scheme has been undertaken and we are actively recruiting staff to the new scheme. Actions to improve attendance are now built in to the Performance improvement programme and will deliver actions to reduceboth short term and long term sickness in frontline operations with clear milestones and targets now in place. The development of a workforce committee led by members of the executive team has commenced with terms of reference to be agreed by the end of March. A retention strategy for the Trust is in the final stages of development and an exercise to identify the financial implications of the associated actions is underway.

VALUE FOR MONEY

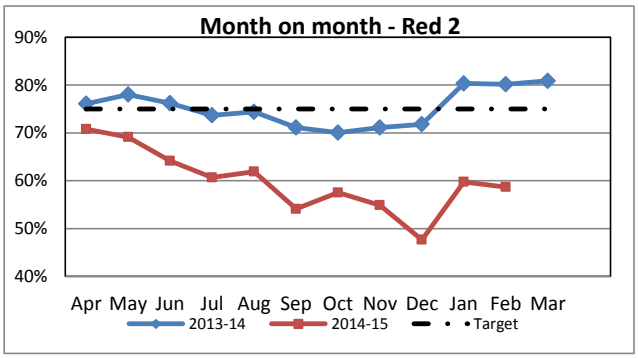
Actions: The Trust has now recognised £7.5m resilience funding of an expected total of £10.0m. A number of key trust activities (international recruitment, training etc.) have been identified and finance will closely monitor and ensure expenditure takes place and is reported as appropriate. Close monitoring and engagement with the organisation on CIP delivery and achievement of the Capital plan to ensure full year targets are met will continue.

PERFORMANCE / ACTIVITY

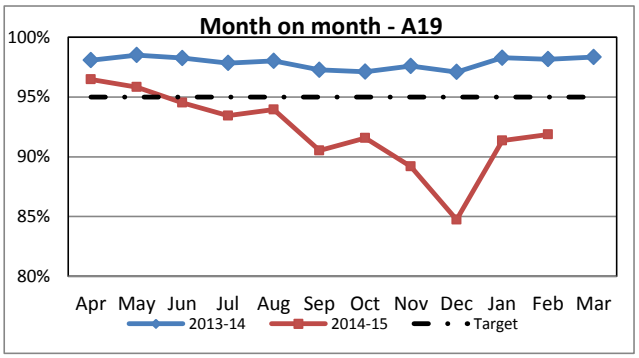
1. Cat A - Red 1 Performance



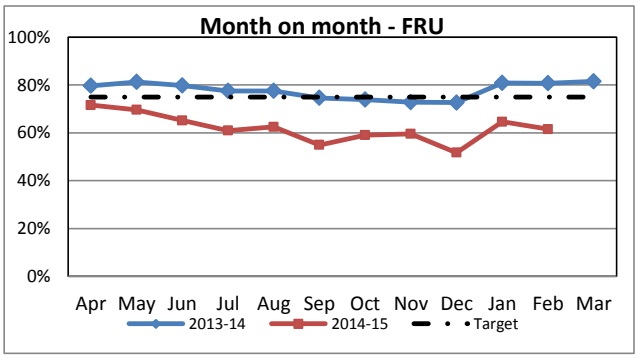
2. Cat A - Red 2 Performance



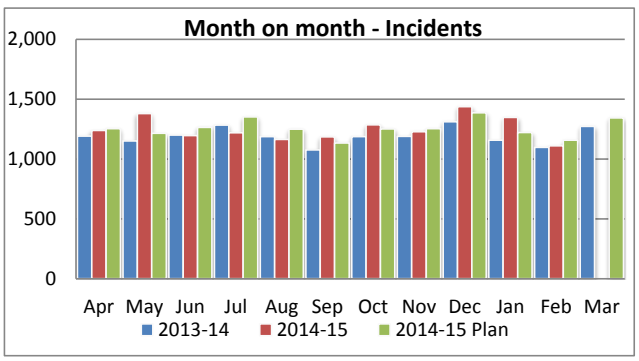
3. Trust A19- Performance



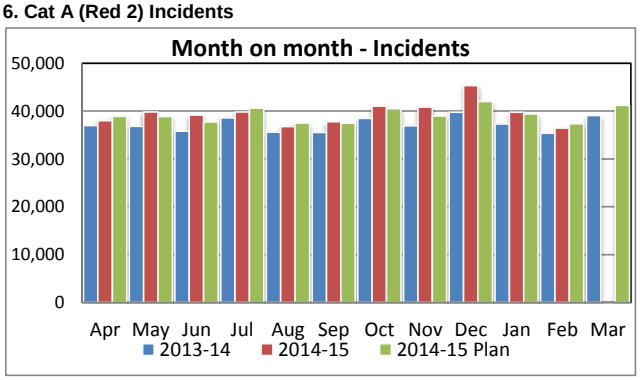
4. FRU A8 - Performance



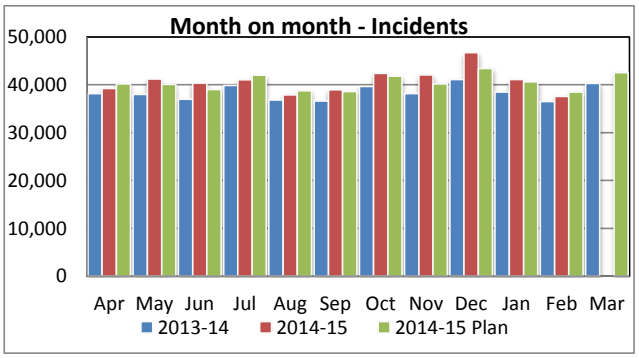
5. Cat A - (Red 1) Incidents



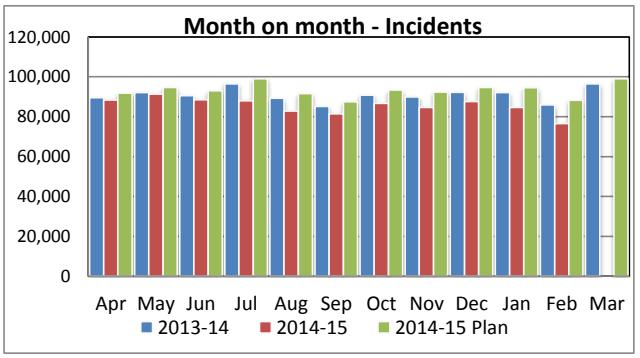
6. Cat A (Red 2) Incidents



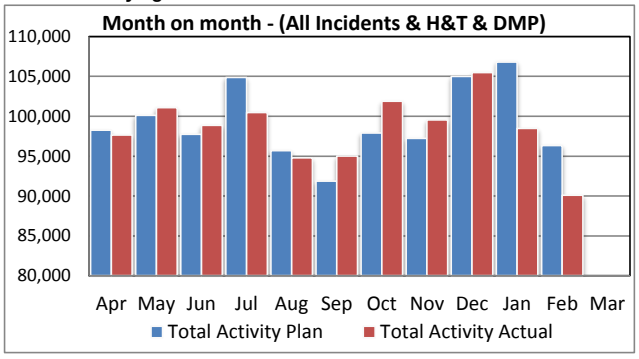
7. Cat A - Total Incidents



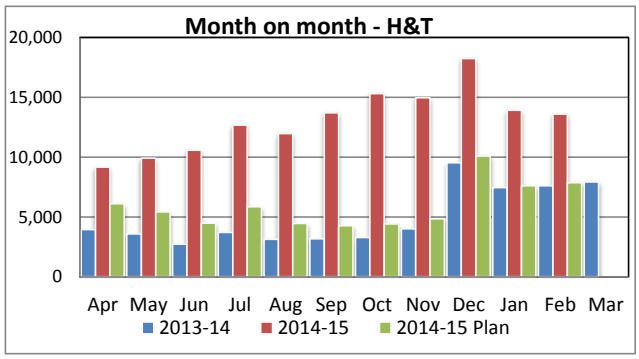
8. Total Incidents



9. Total Activity against Plan

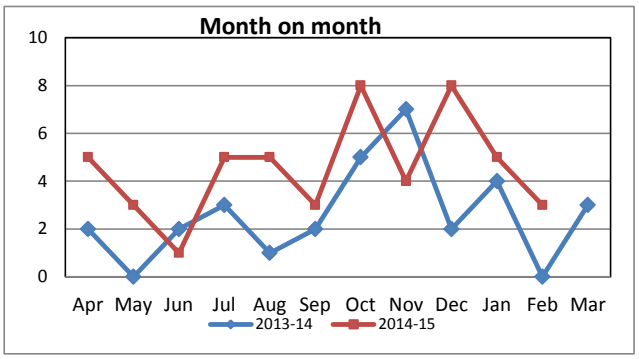


10. Clinical Hub H&T Discharges

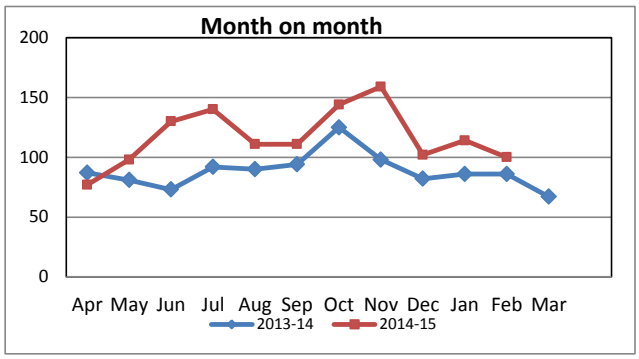


QUALITY

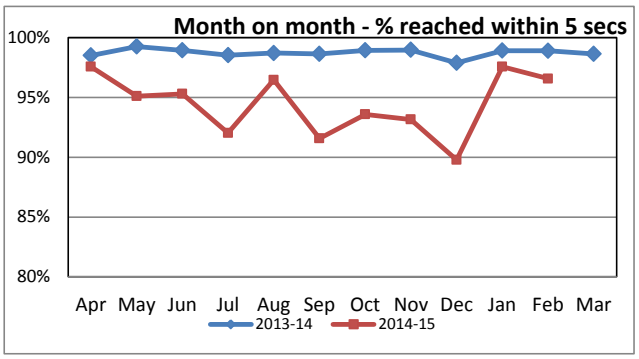
1. Serious Incidents declared



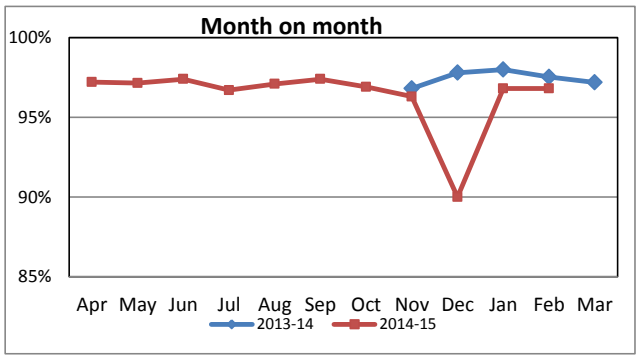
2. Complaints received



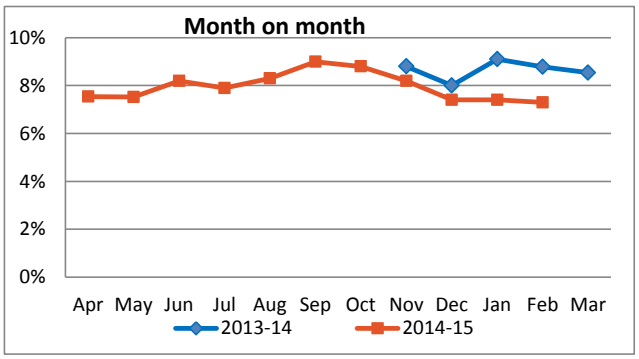
3. 999 Call Answering - 5 secs



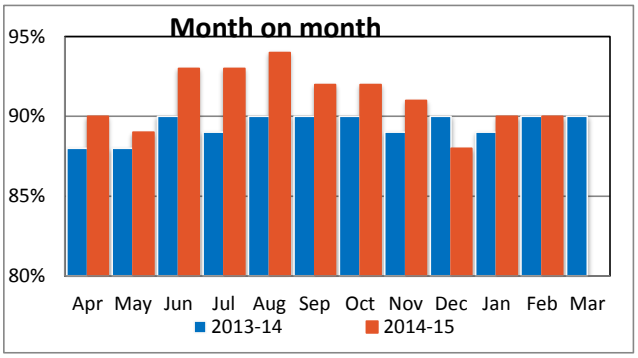
4. NHS111 Call Answering- 60secs



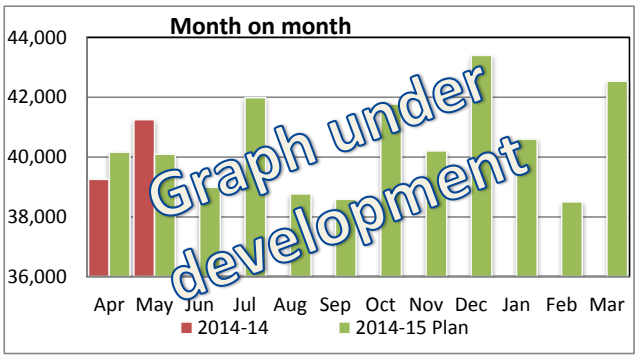
5. NHS 111 Transfer rate to 999



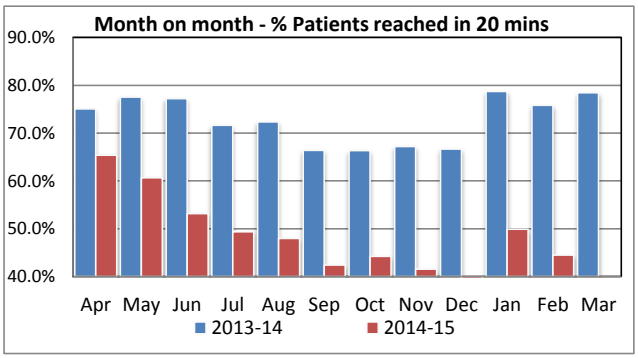
6. Aspects of care compliance (MH)



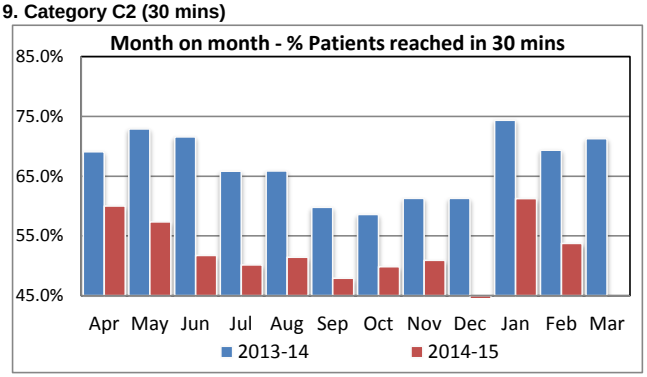
7. Deep Clean of vehicles % completed



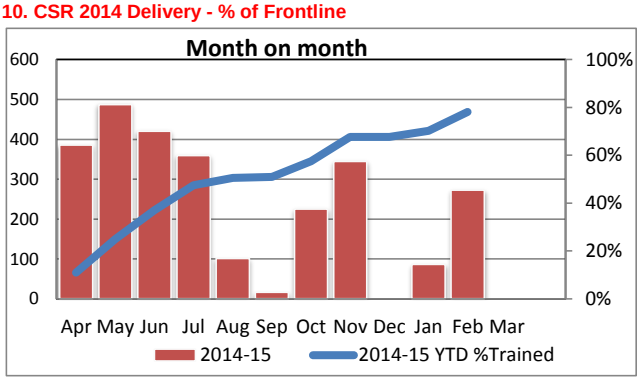
8. Category C1 (20 mins)



9. Category C2 (30 mins)

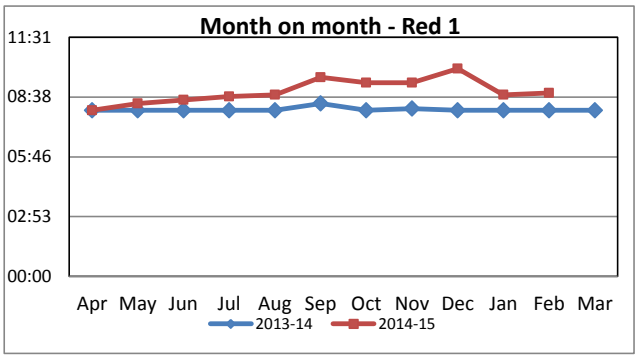


10. CSR 2014 Delivery - % of Frontline

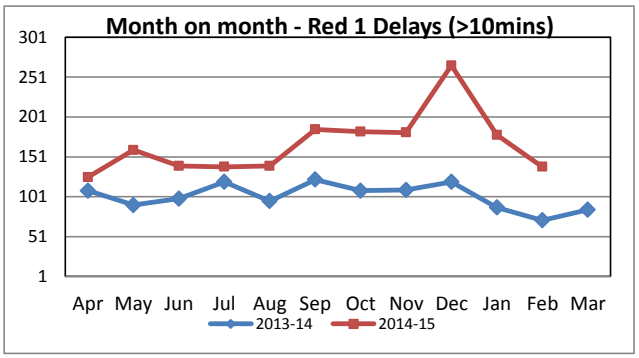


SAFETY

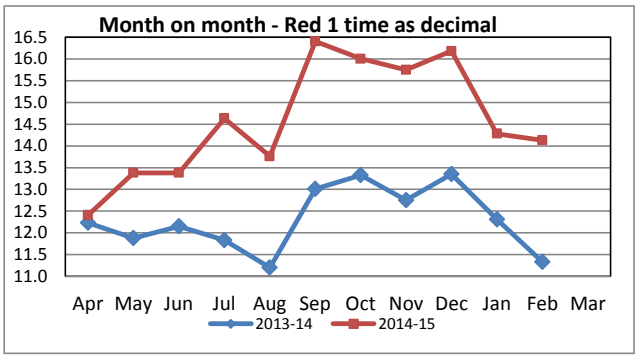
1. Red 1 - 75% reached in Mins/secs



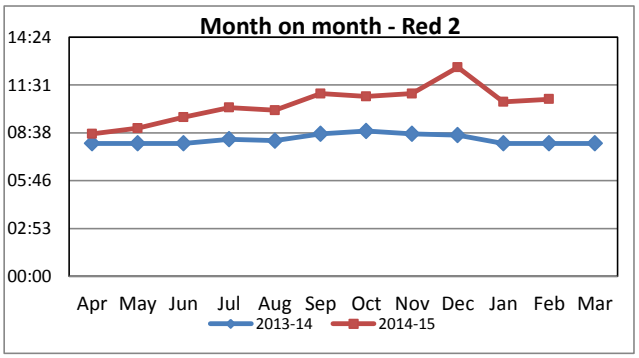
2. Red 1 - number of responses>10mins



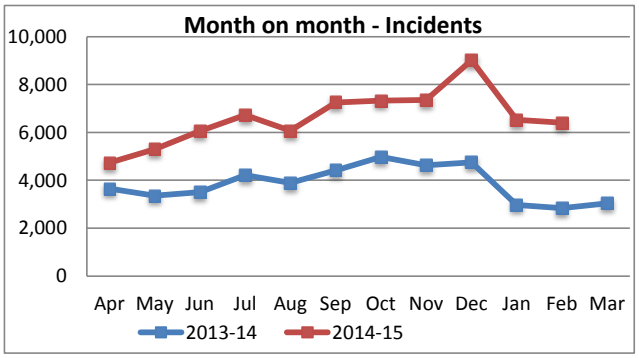
3. Red 1 - Time to get to 95th Percentile



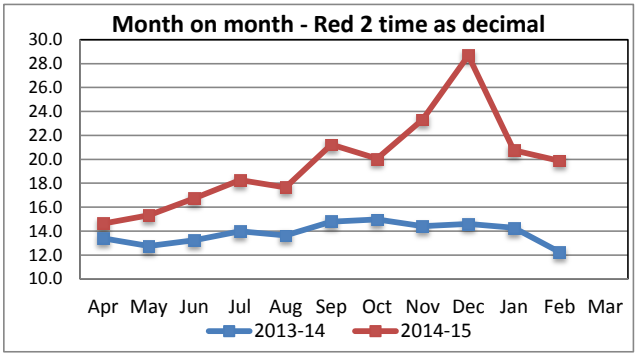
4. Red 2 - 75% reached in Mins/secs



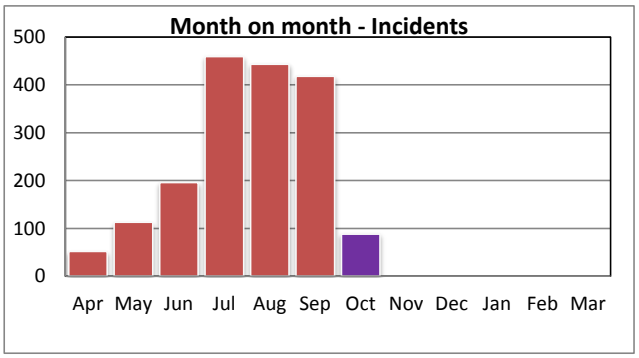
5. Red 2 - number of responses>10mins



6. Red 2 - Time to get to 95th Percentile

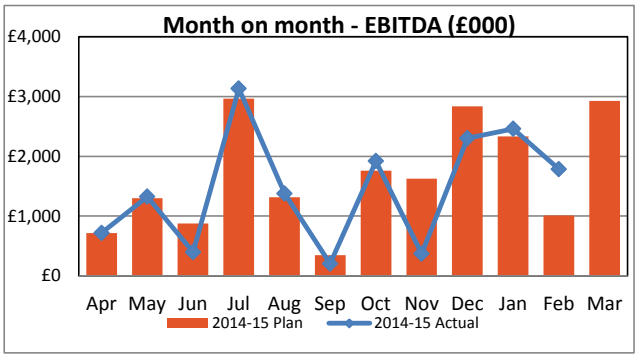


7. Surge plan escalation > Amber (Hours)

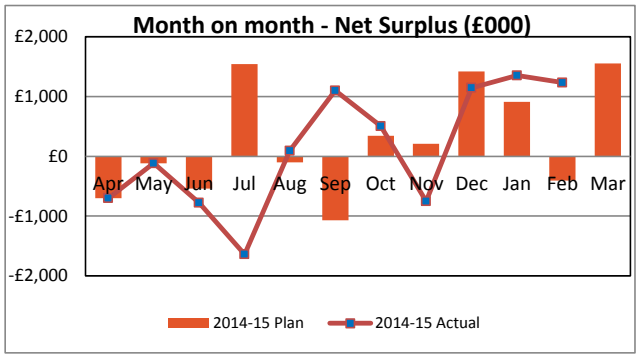


VALUE FOR MONEY

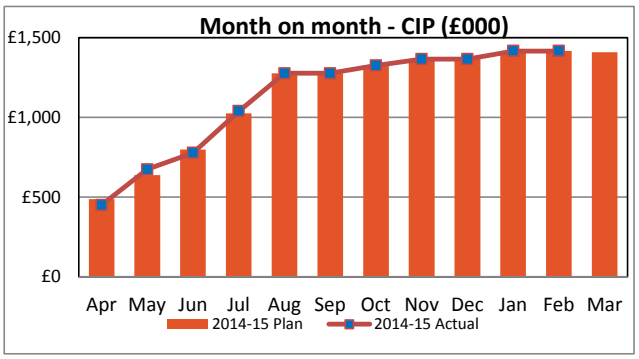
1. EBITDA (£000)



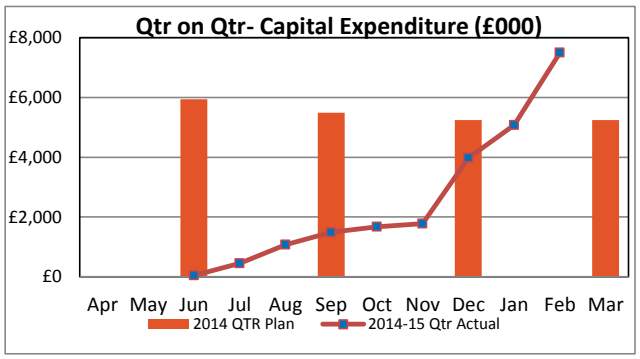
2. Net Surplus (£000)



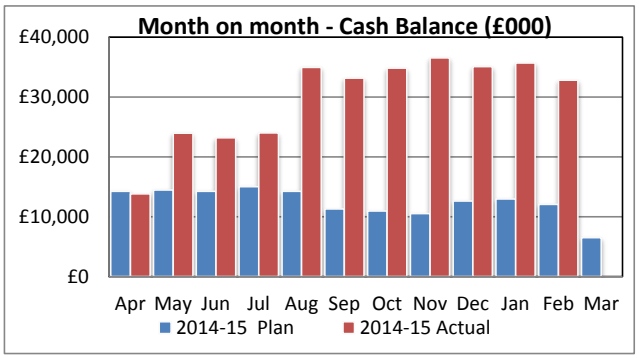
3. Cost Improvement Programme (£000)



4. Capital Expenditure (£000)

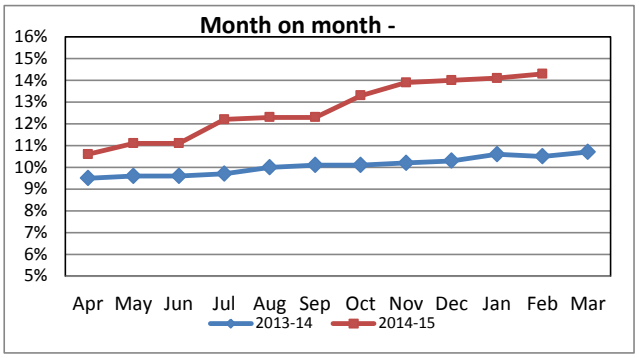


5. Cash Balance

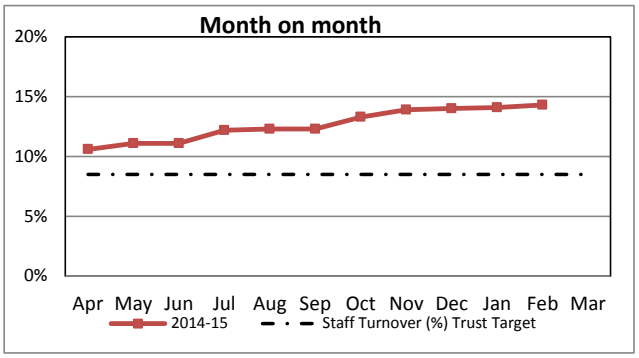


WORKFORCE

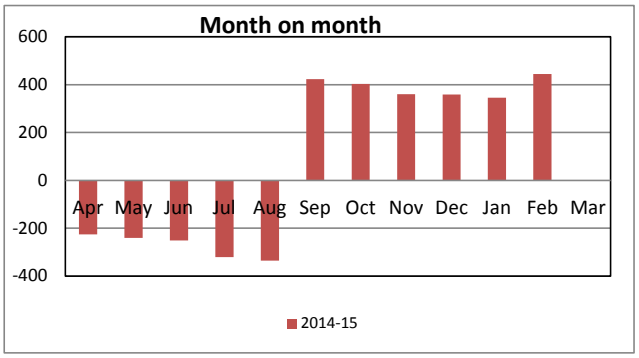
1. Staff Turnover



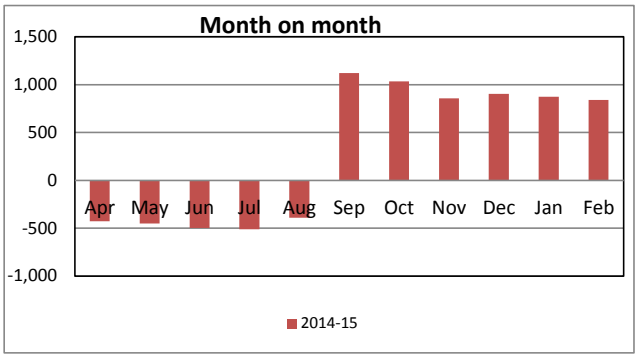
2. Vacancies (%)



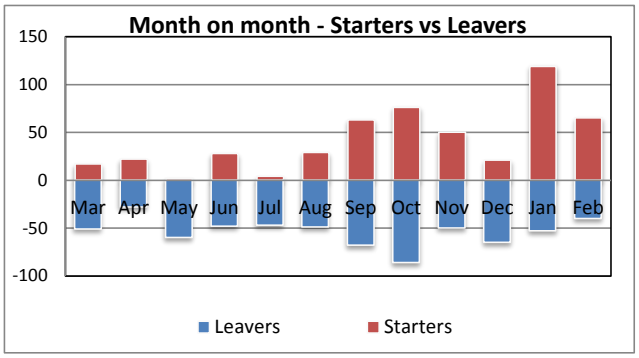
3. Vacancies (WTE) - Paramedic



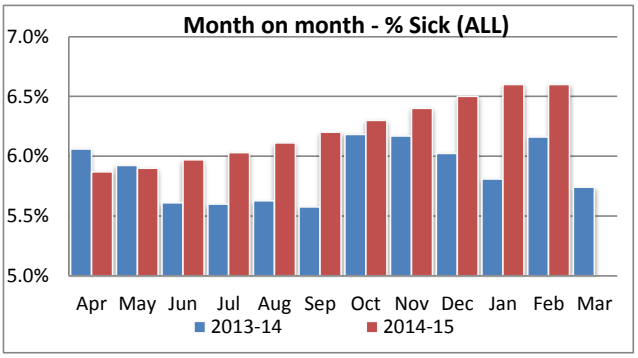
4. Vacancies (WTE) - All Trust



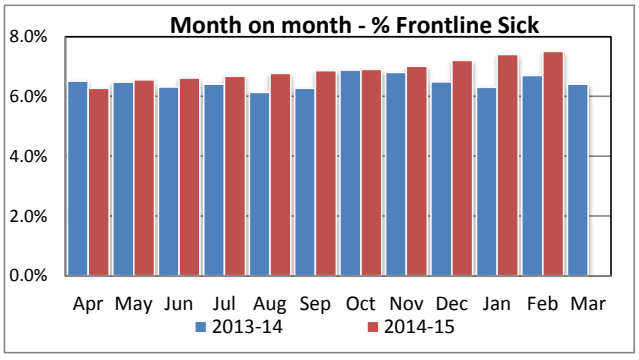
5. Starters vs Leavers



6. Sickness - All Staff (%)



7. Frontline Sickness (%)



London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**24th March 2015**
Document Title:	**Board Assurance Framework and Trust Risk Register (Strategic Risks)**
Report Author(s):	**Frances Field, Risk and Audit Manager**
Presented by:	**Sandra Adams, Director of Corporate Affairs**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
History:	**Executive Management Team**
Status:	**Board Assurance Framework and Trust Risk Register (Strategic Risks) updated to reflect current status of risks - March 2015**

Background/Purpose

Board Assurance Framework

The attached Board Assurance Framework (BAF) was updated in March 2015 and changes to the BAF since January 2015 are set out in the tables below. The BAF will be further developed over the next month to reflect the key strategic and corporate objectives for 2015-16, with the key risks mapped against these.

a) The following new strategic risk has been added to the Trust Risk Register since January 2015 and now appears on the BAF.

		Initial				Target				Current			
ID	Title	Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating	Change to rating since last review
433	There is a risk that directors and line managers do not fully commit to staff engagement in terms of time and focus. In some cases there may be a risk that this is due to capacity of managers to find time to talk to their staff. This would result in staff becoming more disengaged which may prevent the organisation improving performance, and staff being	4	4	16		4	2	8		4	4	16	

	motivated to play their part.												
434	There is a risk that that new sector Assistant Directors of Operations (ADOs) are very focused on internal performance improvement and do not give time or focus to borough-based external stakeholder engagement (CCGs, MPs, OSCs, Health watch). This could result in a lack of support by stakeholders: at best this would mean no support for change or growth programmes, at worst it could mean opposition. This may lead to lack of investment in the service in the future and reputational damage	4	4	16		4	2	8		4	4	16	

b) The following strategic risks have been re-graded since January 2015.

		Initial				Target				Current			
ID	Title	Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating		Impact	Likelihood	Risk Rating	rating prior to last review
388	There is a risk that the increase in turnover rates may lead to frontline staff reducing by significant numbers impacting the Trust's ability to deliver safe patient care.	4	4	16		4	2	8		4	5	20	4 4 16 ⇩ (net rating)

Trust Risk Register (Strategic Risks)

The attached risk register details all of the strategic risks that have been included in the current BAF with any additions, amendments and deletions set out in the tables above.

Action required

For information and noting.

Assurance

To take assurance from the management of the key risks currently facing the organisation and to highlight any potential gaps that need to be addressed.

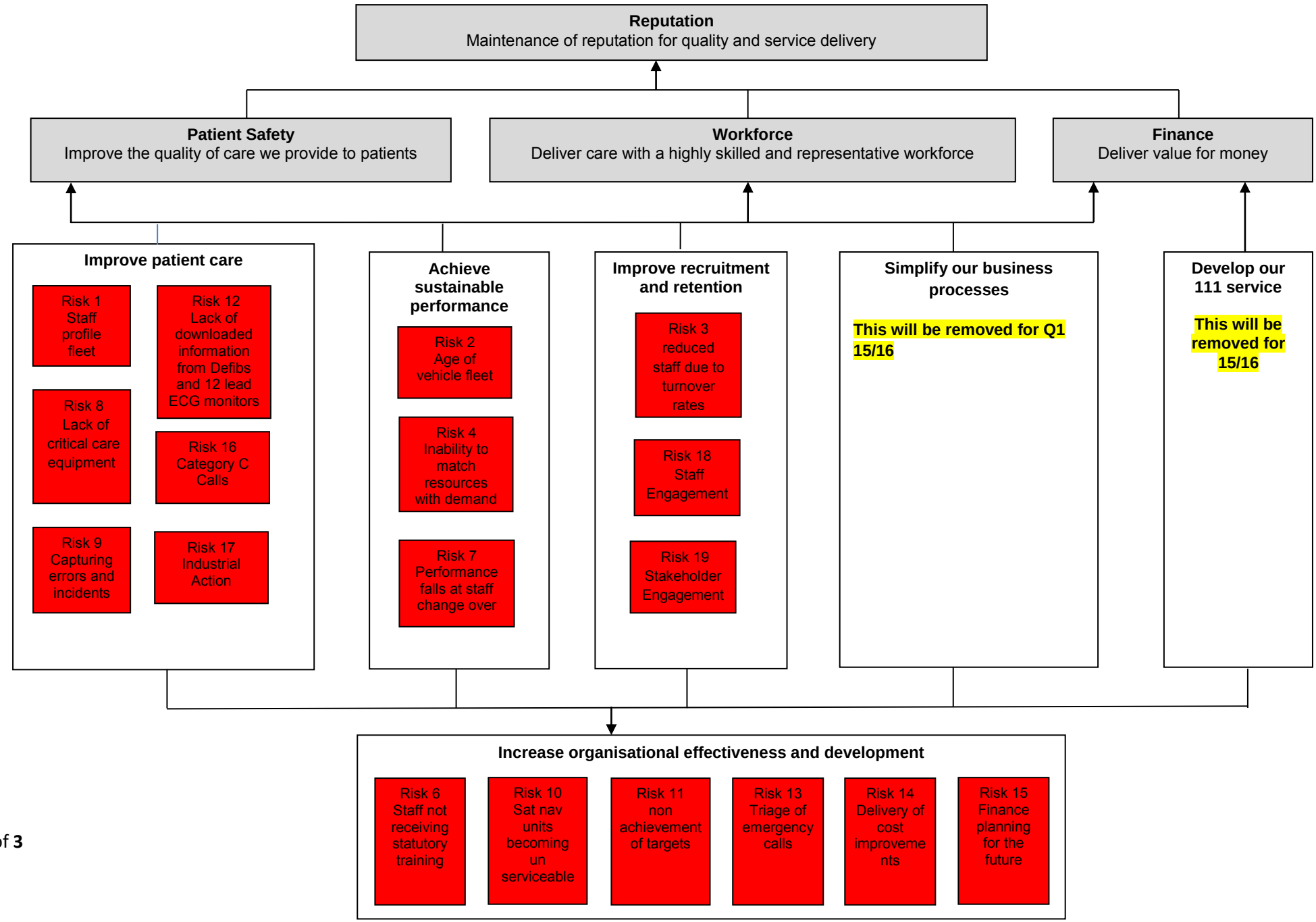
Key implications and risks arising from this paper	
Clinical and Quality	*
Performance	*
Financial	*
Legal	*
Equality and Diversity	*
Reputation	*
Other	* The Board Assurance Framework sets out the key risks to the organisation achieving its strategic objectives. These will need to be closely managed and monitored by the risk owners and timely action taken to mitigate them
This paper supports the achievement of ALL of the following 2014/15 objectives	
Improve patient care	
Improve recruitment and retention	
Implement the modernisation programme	
Achieve sustainable performance	
Develop our 111 service	
Simplify our business processes	
Increase organisational effectiveness and development	

Board Assurance Framework – March 2015

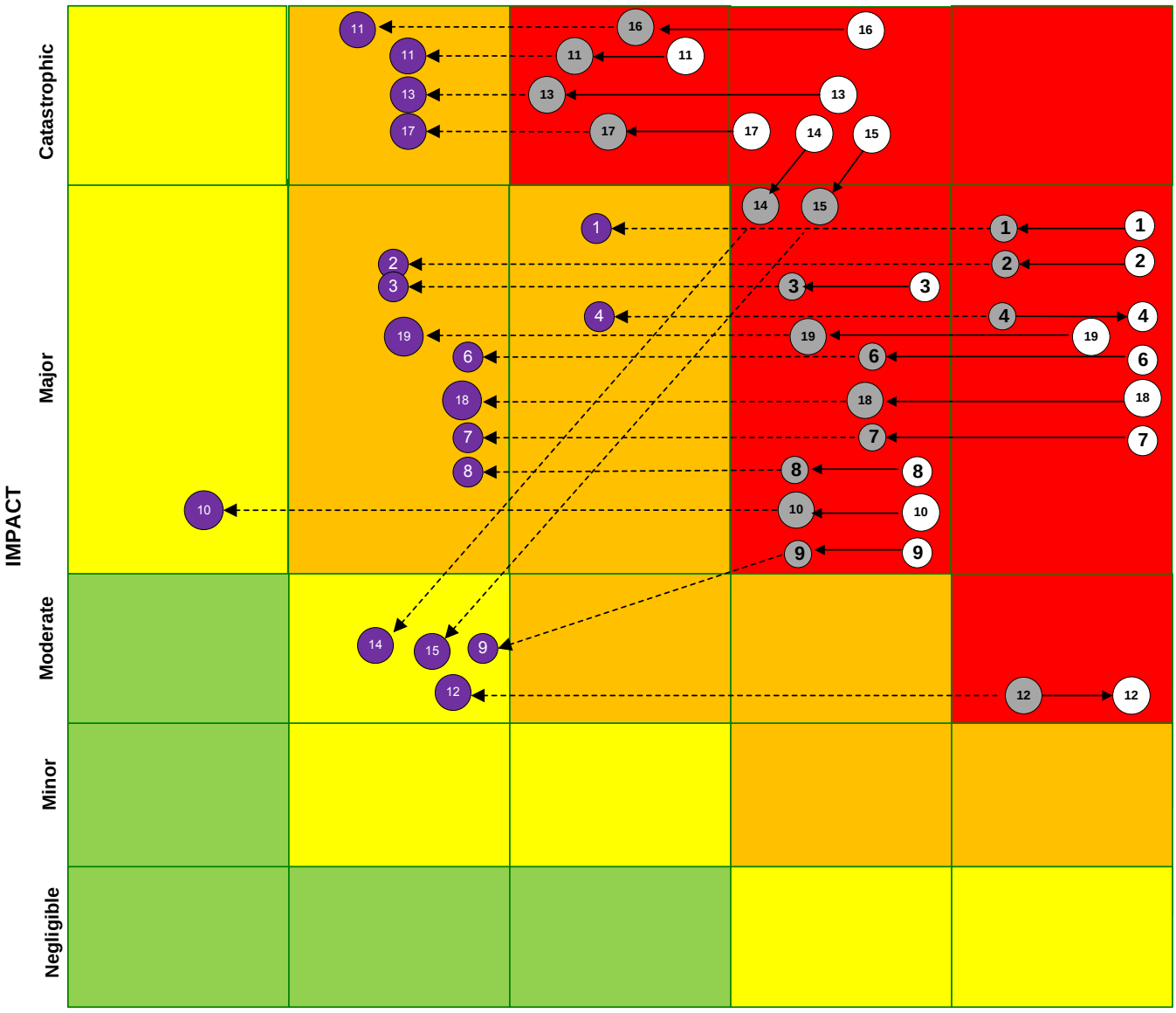
Key Risks to the Strategic Plan

Strategic Aims

Business Objectives 2014-15



Board Assurance Framework – March 2015



Key:

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

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

Risk trajectory since January 2015

	BAF Risk 1	- RR 402	Potential loss of skills of fleet Workshop Managers and Technicians
	BAF Risk 2	- RR 401	Current age profile of the LAS Vehicle Fleet will result in increased downtime
	BAF Risk 3	- RR 388	Reduced staff due to turnover
	BAF Risk 4	- RR 265	Service Performance affected by the inability to match resources to demand
	BAF Risk 6	- RR 355	Staff not receiving statutory training
	BAF Risk 7	- RR 269	Performance falls at staff changeover times
	BAF Risk 8	- RR 399	A lack of critical equipment on ambulances
	BAF Risk 9	- RR 404	Accurately and effectively capturing errors and incidents in accordance with national guidelines
	BAF Risk 10	- RR 400	Satellite navigation units becoming unserviceable
	BAF Risk 11	- RR 329	Non achievement of contractually agreed targets
	BAF Risk 12	- RR 207	Staff not being able to download information from Defibrillators and 12 lead ECG monitors
	BAF Risk 13	- RR 382	MPS calls are incorrectly triaged (target rating regraded)
	BAF Risk 14	- RR 394	Developing and delivering cost improvements
	BAF Risk 15	- RR 396	Finance – effective planning for the future
	BAF Risk 16	- RR 410	Patient safety for category C patients
	BAF Risk 17	– RR 427	Patient safety during periods of industrial action
New Risk	BAF Risk 18	– RR 322	Staff engagement
New Risk	BAF Risk 19	– RR 434	Stakeholder engagement

London Ambulance Service NHS Trust
March 2015 Corporate Risk Register

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	Risk Category	Gross Impact	Gross Like-lihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Like-lihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like-lihood	Target Rating	Comments
265	There is a risk that Service Performance may be adversely affected by the inability to match resources to demand.	Recruitment Attrition Growing vacancy factor Increased demand	31-Jul-06	4		Operational	Major	Almost Certain	20	1 .On-going recruitment to vacancies. 2. Use of voluntary and private sector at times of peak demand. Increased as of September 2014. 3. Use of agency Paramedics to enhance bank scheme. 4. New rosters implemented successfully. 5. Targeted use of overtime and increased bonus payments. 6. Surge plan was reviewed again in January 2015. 7. Category C workload determinants have all been reviewed and have been realigned across the 4 C Categories. This enables us to carry out an enhanced clinical assessment in the clinical hub on an additional 90,000 calls a year. A percentage of these circa 35% will be discharged through Hear and Treat 8. Action has been taken to reduce the multiple attendance ratios where appropriate for all categories of calls. This reduction when achieved will provide capacity to respond to a further 300 calls a day within our existing capacity. 9. An extension in the operating hours for active area cover was implemented on the 21st July 2014. 10. METDG is running 24 hours and is producing an average of 60% savings on AEU sends, MAR down to 1.32/1.33.	Jason Killens	06-Mar-15	Major	Almost Certain	20	1. Sickness management. A performance management dashboard is being developed. The occupational health contract is being reviewed. 2. Roster review: Rosters for all complexes have been agreed and implemented and are currently under review. 3. Skill mix: the skill mix model has been updated in January 2015 to include international recruits and is currently under review. 4. Annual leave review: a revised annual leave policy is in its final draft stage. The revised annual leave arrangements as defined in the draft policy are under discussion between trust management and trades unions. 5. The new response model: a request for change (RFC31) has been approved and is under developed by the CommandPoint supplier. The software was delivered in August but did not pass testing and there have been several re-releases since. We expect the final release, with all known errors corrected, to be delivered 24/12. Testing will recommence but is constrained by release of testers (CAD trained staff) from the control room. Implementation of the software will only occur once testing has been successfully completed ws planned for mid March but as part of a package of changes now looking a new dates. Delay caused by external capita issue. 6. Workforce plan operations, recruitment; recruit external paramedics, direct recruitment to new band 4 role (December 2014), overseas recruitment of paramedics (on-going), in-house conversion from EMT to paramedic 2014/15, university paramedic recruitment (October 2014), military recruitment. Retention; exit interviews, research reasons for leaving, consider reward and recognition initiatives, career progression and support.	1. P. Woodrow 2. M. Pearce 3. J. Killens / M. Whitbread 4. S. Sale 5. J. Killens 6. K. Broughton / T. Crabtree 7.J. Goldie / K. Millard 8. K. Millard 9. K. Millard	1. On-going 2. Completed 3. Completed 4. Sep 2014 5. April 2015 6. Q4 2014/15 7. On-going 8. On-going 9. On-going		Major	Possible	12	Reviewed by ADO's 06/03/15. J. Killens 21/08/14 approved regrading of risk from major x likely = 16 to major x almost certain = 20 Updates provided by P.Woodrow 8/08/14
402	There is a risk that the current age profile of Fleet Workshop Managers and Technicians will impact on the future resilience of the Fleet Operation	Age profile of Fleet Workshop Managers and Technicians	09-Jul-14	1		Business Continuity	Major	Almost Certain	20	Regular recruitment of Vehicle Technicians. Recruitment aimed at long term temporary staff.	Sean Westrope	21-Nov-14	Major	Almost Certain	20	1. Establishment of apprenticeship scheme. 2. Continuing recruitment into vacancies.	1. S. Westrope 2. S. Westrope	1. April 2015 2. On-going		Major	Unlikely	8	Risk reviewed by S. Westrope November 2014. Risk Approved by SMT at meeting on 9th July 2014
401	There is a risk that the current age profile of the LAS Vehicle Fleet will result in increased downtime impacting on operational performance and implementation of the modernisation process.	Age profile of the LAS Vehicle Fleet	09-Jul-14	2		Operational	Major	Almost Certain	20	1. Capital programme for 2014/15 includes replacements. 2. Asset management plans in place.	Sean Westrope	21-Nov-14	Major	Almost Certain	20	1. Agree comprehensive 5 year replacement plan.	1. S. Westrope	1. December 2014	5 year plan to be managed by Fleet Procurement Board and monitored by Vehicle Working Group	Major	Unlikely	8	Reviewed by S. Westrope 21/11/14. Risk Approved by SMT at meeting on 9th July 2014
355	There is a risk of staff not receiving clinical and non-clinical statutory training.	This may as a consequence cause:- ● Failure to meet CQC and the Trust's TNA policy ● Dilution of clinical skills	23-Nov-11	6		Corporate	Major	Almost Certain	20	1. Agreement with operations that there will be an agreed abstraction of up to 90 staff per week to attend CSR during agreed periods. 2. Paramedic registration. 3. Individual Learning Accounts implemented for all operational staff from September 2014. This will increase attendance on CSR training. 4. Comprehensive review of statutory and mandatory training delivery, including All In One, under way, due for completion late November 2014 5. E-learning packages under development to provide staff with access to on-line achievement for core statutory elements	Mark Whitbread	28-Oct-14	Major	Likely	16	1. The TNA which applies to April 2014 to be reviewed and agreed by TSG. 2.A workbook has been developed for Infection prevention and control it will be launched shortly. 3. Use of OLM for recording of CSR 1 will commence from October 2012. 4. Operational Resources will need to book staff onto courses to capacity in order to train all staff within year.	1. J. Chalmers 2. J.Thomas 3. P. Billups 4. P. Cook	1. May 2014 2. Complete 3. Complete 4. Ongoing	1. TSG review and agree TNA on an annual basis. 2. TNA used as basis for agreeing service training plan. 3. TSG review reulgar reports of uptake on training.	Major	Unlikely	8	2 new risks presented to SMT in December 2014 and asked for further detail to be added and brought back. SMT 09/04/14 suggested that current risk rating remains until the risk is reviewed for splitting between clinical and non clinical.
269	There is a risk that at staff changeover times, LAS performance falls.	Current rest break agreement permits staff to conclude shift by upto 30 mins early where no break given by EOC	08-Dec-06	7		Clinical	Major	Almost Certain	20	1. Daily monitoring of rest break allocation to resolve end of shift losses 2. Use of bridging shifts for VAS/PAS 3. Roster reviews/changes must include staggered shifts. 4. Incident management control desk within EOC.	Jason Killens	06-Mar-15	Major	Likely	16	1. Agree and implement changes to rest break arrangements 2. Rota changes to be implemented as result of ORH review 3. Recruitment 4. Skill mix: the skill mix model has been updated in January 2015 to include international recruits and is currently under review. 5. Ongoing vigorous management of out of service. J. Killens to set improvement trajectory to get out of service levels back within target. 6. Proactive use of the surge plan. 7. Out of service being HUB implemented.	1. T. Crabtree / J. Killens 2. J. Killens 3. K. Broughton 4. J. Killens 5. K. Brown / Sean Westrope 6. ADO's 7. TBC	1. 2015/16 2. Completed 3. Q4 14/15 4. Completed 5. Ongoing 6. Ongoing 7. Ongoing		Major	Unlikely	8	December 2014 Risk reviewed by ADO group. Updated provided by P.Woodrow and J.Killens August 2014

London Ambulance Service NHS Trust
March 2015 Corporate Risk Register

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	Risk Category	Gross Impact	Gross Like-lihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Like-lihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like-lihood	Target Rating	Comments
394	It is likely that NHS financial and operational planning will include the need to develop efficiencies in order to offset other costs pressures for the foreseeable future. Failure to identify and deliver CIPS will threaten the ongoing viability and solvency of the Trust. ~~There is a risk that CIPs may not be identified or delivered which would impact our credibility with the NTDA and the DH and would adversely impact on our FT Application. There may also be a loss of control on the Income and Expenditure position~~.	• Appropriate supporting evidence not available • CIPs not supported by detailed milestone plan. • CIPs not embedded in budgets. • CIPs not owned by relevant manager. • Benchmarking of CIPs not undertaken. • CIP governance not clearly defined and in place. • Board/FIC scrutiny of CIP planning and delivery not in place. • CIPs not delivering in line with expectations. • Capacity and capability not available to support delivery.	10-Apr-14	14		Finance	Catastrophic	Likely	20	1. Appropriate supporting evidence available for CIP. 2. All CIPs supported by detailed milestone plan. 3. All CIPs embedded in budgets. 4. All CIPs owned by relevant manager. 5. Benchmarking of CIP opportunity. 6. CIP governance clearly defined and in place. 7. Board/FIC scrutiny of CIP planning and delivery in place. 8. CIPs delivering in line with expectations. 9. Capacity and capability available to support delivery. 10. All CIPs supported by Quality Inputs Assessments.	Andrew Grimshaw	26-Jan-15	Major	Likely	16	1. Review support to drive the CIP Programme. 2. Ensure all schemes have clear project plans. 3. Embed all CIPs in budgets. Ensure managers sign off. 4. Review current benchmarking information.	1. A. Grimshaw 2. A. Grimshaw 3. K. Hervey / A. Bell 4. A. Grimshaw	1. Confirm by 27-02-15 2. Confirm by 30-04-15 3. Confirm by 30-04-15 4. Confirm by 30-04-15	Regular FIC oversight Controls can be tested	Moderate	Unlikely	6	Reviewed by FIC 25/01/15. FIC papers dated 29/09/14 changes in ratings to: gross catastrophic x likely = 20, net major x likely = 16 and target moderate x unlikely = 8. K. Approved by SMT 09/04/14 for inclusion on the risk register. To be cleared during Q3
396	There is a risk that if the Trust does not plan effectively it will not be aware of risks and threats. These could result in significant risk to the ongoing viability of the organisation, operations and clinical safety. ~~There is a risk that no disciplines exist for planning ahead which would impact our credibility with the NTDA and the DH and would adversely impact on our FT Application~~	• An LTFM is not in place. • Regular reports are not provided to the FIC on forward financials. • Future assessments do not take account of low level (departmental) plans or high level (organisational) issues. • Plans exclude I&E, balance sheet, capital and cash. • Future CIP plans are not scoped and where possible identified, 2-3 years ahead.	10-Apr-14	15		Finance	Catastrophic	Likely	20	1. An LTFM is in place but needs revision. 2. Regular reports are provided to the FIC on forward financials. 3. Future assessments take account of low level (departmental) plans as well as high level (organisational) issues. 4. Plans include I&E, balance sheet, capital and cash. 5. Future CIP plans are scoped and where possible identified, 2-3 year ahead.	A.Grimshaw	25-Jan-15	Major	Likely	16	1. Further development of LTFM required. Make live tool (including B/S and Cashflow). 2. Review format and frequency of reports to FIC on future planning. 3. Develop means to collect departmental and divisional plans for review and inclusion in overall financial plan. 4. Develop future CIP planning.	1. DoF 2. DoF 3. DDoF 4. All Execs.	1. 31-03-15 2. Monthly until June 2015 3. Include in 15/16 planning 31-03-15 4. End Q1 15/16	Regular FIC oversight Controls can be tested	Moderate	Unlikely	6	Reviewed by FIC 25/01/15. FIC amended the risk description. FIC papers dated 29/09/14 changes to ratings: gross from major x likely = 16 to catastrophic x likely = 20, net from major x unlikely = 8 to major x likely = 16 target from major x rare = 4 to moderate x unlikely = 6. Updates to FIC in June 2014 and LTFM sent to NTDA in June 2014. Approved by SMT 09/04/14 for inclusion on the risk register.
388	There is a risk that the increase in turnover rates may lead to frontline staff reducing by significant numbers impacting the Trust's ability to deliver safe patient care.	1. Competitive recruitment market for Paramedics 2. Increasingly mobile workforce with a multitude of recruitment possibilities 3. Cost of living pressures in London coupled with increasing travel costs for commuting 4. Opportunities for clinical career progression in other organisations, which do not exist within the LAS, such as 111 and other public, private and voluntary healthcare providers 5. Staff morale	10-Apr-14	3		Clinical	Major	Likely	16	1. NHS staff benefits (e.g. pensions, T&Cs, etc.) 2. LAS staff benefits (e.g. cycle scheme) 3. LAS retention staff benefits (EMT suggestions) 4. Listening into Action - to understand staff improvements. 5. Developing the modernisation programme – including rota reviews and development of a clinical career structure. 6. Actively recruiting university and registered paramedics and emergency ambulance crew 7. Monitoring and developing plans to address trends in turnover. Retention Strategy agreed in principle at EMT 7 January 2015. Data to include establishment, vacancies, stability, turnover (split between paramedics and other), and sickness rate. To include trends and benchmarked data. 8. The use of overtime, private and voluntary ambulance services to increase the number of available resources. Impact on utilisation rate, i.e. to reduce it. 9. Clinical support structure provides career	**Mark Gammage / Rainy Faisey**	20-Jan-15	Major	Likely	16	1. Development of Clinical Career Structure. Skill mix review. 2. Review exit interview process and data capture. 3. Review and update rewards and retention strategy. 4. Discussion at EMT regarding framework / strategy to address 5 key actions that assist retention. 5. Promote learning and development opportunities. 6. Recruitment drive to fill vacant established posts. Recruitment group meeting fortnightly identified 6-7 streams from which paramedics can join the service, also establishing the process to enable this. 7. Implementing the modernisation programme. 8. Exercise taking place to look at a sample of leavers to assess reasons for leaving 9. Develop a Health and Wellbeing Strategy	1. F.Moore 2. J. Killens 3. M. Gammage 4. M. Gammage 5. K. Broughton 6. K. Broughton 7. P.Woodrow 8. M. Gammage 9. T. Crabtree	1. Completed 2. Ongoing 3. Ongoing 4. 2014/15 5. TBC 6. Ongoing 7. Completed 8. Completed 9. March 15	1. Comprehensive workforce and recruitment plan. 2. Regular monitoring of turnover and responding to developing trends, making necessary adjustments to current plans. 3. Ongoing recruitment drive, in addition to proactively seeking out new markets to target additional recruitment drives. 4. Training programme in progress for	Major	Unlikely	8	EMT reviewed the rating based on current assurance on 20/1/15 and agreed net rating to graded at major x likely = 16. R. Faisey updated risk 7th January 2015. Proposed regrading of net rating from major x almost certain = 20 to major x likely = 16 back in line with the gross rating. SMT discussed risk rating on 14/1/15 and suggested risk remained at 20.
399	There is a risk that a lack of essential (*) equipment on an Ambulance may impact on the crew's ability to respond ~~to all category A calls and /or any calls requiring specialist equipment to be deployed at the scene.~~ * essential equipment as defined in TP091 - Out of Service (OOS) Policy and Procedure - sections 7.9 and 7.10.	Underlying causes are varied and emanate from various functions of the Trust. This potentially affects the ability of a crew to provide the appropriate response at a scene which may delay treatment to the patient. Due to the equipment either being: Defective Contaminated Impounded Missing Replaces Risk 303 & 362	11-Jun-14	8		Fleet and Logistics	Major	Likely	16	1. Vehicle Daily Inspection completed, as part of the Vehicle Preparation process, by the Vehicle Preparation complex Team indicating which items are missing. ~~2. The crew will also check for critical equipment and try to source. (OP/026)~~ 2. Crews should advise EOC/DSO which equipment they are missing, this should also be reflected in their LA1 (OP/026).	Sean Westrope	28-Oct-14	Major	Likely	16	1. Improved equipment exchange by the LSU team. Equipment will be carried on their vehicles enabling a swifter exchange. This is dependant upon time of visit by LSU team. 2. Joint site visits by Logistics/Estates advising relevant process involving equipment 3. Joint education on equipment issues and continuous declaration of spare equipment. A process will be put in practice advising how equipment can be relocated to a frontline vehicle. A group needs to be set up including a lead DSO from each area. 4. Logistics Support Unit now hold a central budget to replace broken equipment which is processed through Deptford Stores. This will provide an improved and speedier replacement/exchange process. 5. Procurement of additional equipment to equip shells	1. Karen Merritt 2. Fleet & Logistics / Estates 3. Fleet & Logistics / Estates 4. Karen Merritt 5. Karen Merritt	1. October 2014 2. Ongoing 3. Ongoing 4. Ongoing 5. November 2014	Continuous review of the actions	Major	Unlikely	8	Reviewed risk with MW 9/12/14 - proposed rewording and regrading of net rating from major x likely = 16 to major x possible = 12 28/10/14 risk reviewed by Fleet and Logistics team. Approved by SMT 11/06/14

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354	There is a risk of ongoing industrial action due to national ballots leading to disruption of service provision.	There could be an impact on service delivery, patient care and the Trust's reputation.	23-Nov-11		1,2,3, 4,7,8	Human Resources	Major	Likely	16	1. Partnership agreement with staff side. 2. Intelligence gathering. 3. Business continuity plan. 4. Developed contracts with VAS/PAS/Agency staff. 5. Activation of operation Phoenix during the periods of industrial action.	Tony Crabtree	12-Nov-14	Major	Likely	16	1. Implement recommendations from N30 review. Note - Actions from N30 internal review are all complete, and actions from the NHSL integrated action plan are on track. National meetings currently taking place with staffside regarding issues of payment of unsocial hours during sickness absence. At this point any changes are on hold. 2. Activation of operation phoenix during next period of industrial action.	1. Tony Crabtree 2. Jason Killens	1. During period of industrial action 2. 24/11/14		Major	Unlikely	8	T. Crabtree / K. Millard / D. Hallilley 4/11/14 Review gross rating from major x possible = 12 to major x likely = 16 and review of net rating from major x possible = 12 to major x likely = 16. Approved by SMT 12/11/14. T. Crabtree 14/08/14 - An industrial action group has been established. Initial engagement with staffside has commenced with a view to provide emergency cover during industrial action.
433	There is a risk that directors and line managers do not fully commit to staff engagement in terms of time and focus. In some cases there may be a risk that this is due to capacity of managers to find time to talk to their staff. This would result in staff becoming more disengaged which may prevent the organisation improving performance, and staff being motivated to play their part.	All staff need time with their line manager to support them to deliver what the organisation needs them to in terms of performance improvement, better care for patients and looking after and retaining our staff.	11-Feb-15			Corporate	Major	Likely	16	1. Corporate communications channels reviewed and refreshed as part of communications strategy approved by the Board in June 2014. Team Talk introduced in September 2014 but not universally being delivered. 2. Some good staff engagement practice with line management – but not universal. 3. Operational restructure will improve line management – but not yet delivered.	C. Gawne		Major	Likely	16	1. Performance management and appraisal of engagement objectives for line managers. 2. Training and support for senior managers 3. Evaluation with front line staff	1. Directors 2. Directors and Organisation Development 3. Director of Communications	1. On completion of operational structure 2. Ongoing conferences and training in Spring 2015 3. Ongoing	Team Talk feedback report to EMT. Team Talk as part of performance framework Evaluation of operational restructure to assess effectiveness of line management.	Major	Unlikely	8	Approvd by C. Gawne and noted by SMT 11.02.15
434	There is a risk that that new sector Assistant Directors of Operations (ADO's) are very focused on internal performance improvement and do not give time or focus to borough-based external stakeholder engagement (CCGs, MPs, OSCs, Healthwatch). This could result in a lack of support by stakeholders: at best this would mean no support for change or growth programmes, at worst it could mean opposition. This may lead to lack of investment in the service in the future and reputational damage	ADO's are essential for strong local stakeholder management, it cannot be done effectively centrally	11-Feb-15			Corporate	Major	Likely	16	1. ADOs have relationships with some key stakeholders. 2. Communications support ADO's in external stakeholder relations.	C. Gawne		Major	Likely	16	1. Provide support and training and regular stakeholder perception testing 2. EMT to support ADO's in their involvement with stakeholder engagement 3. Work with new stake holder managers to develop their role.	1. Director of Communications and Director of Operations 2. EMT 3. Director of Communications / Assistant Directors of Operations	1. March 2015 2. Ongoing 3. Ongoing	Planned stakeholder perception audits and RAG rating with ADOs on regular basis	Major	Unlikely	8	Approved by C. Gawne and noted by SMT 11.02.15
404	There is a risk that the Trust does not accurately and efficiently capture errors and incidents and process them in accordance with national guidelines and within specified internal procedures (LA52 reporting). We are not accurately reporting RIDDOR. The organisation therefore has poor visibility and understanding of the types and causes of incidents that occur which would restrict learning and further risk mitigation.	Insufficient recorded evidence of reported incidents (total number and quality).	09-Jul-14	9		Corporate	Major	Likely	16	Moved all controls to risk 405 relating to SIs. Line manager instructed to provide the office details for the Safety and Risk Department when completing a RIDDOR F2508 form, resulting in a hard copy being received by the department from the HSE. RIDDOR F2508 forms are completed electronically, allowing reporters to save a copy as a PDF file. Absences due to industrial injury are recorded on GRS, allowing instances of an injury being RIDDOR reportable (due to absence) to be tracked. HS011 requires all incidents to be reported within 7 days, allowing a Safety and Risk Advisor to request a RIDDOR form to be completed. The Datix Web system used in 3 complexes has inbuilt guidance regarding RIDDOR reporting, and a direct hyperlink to the RIDDOR form. LA52 packs to be kept on vehicles. A meeting was held to discuss the strengthening	Sandra Adams	07-Jan-15	Major	Likely	16	1. All incidents received by the Safety and Risk Department are to be reviewed by a Safety and Risk Advisor to follow up RIDDOR reporting, updating the DATIX record with the reference number. 2. Absences of more than 7 days resulting from industrial injury is to be tracked on a spreadsheet to allow Safety and Risk Advisors to chase RIDDOR references, updating the DATIX record with this reference number. 3. Incidents from January 2013 are to be reviewed for data quality on DATIX by Governance and Safety and Risk. As part of this, the incident will be reviewed to establish if it is RIDDOR reportable to gather more accurate numbers. 4. HS011 requires all incidents to be reported within 7 days, allowing a Safety and Risk Advisor to request a RIDDOR form to be completed. It is the line managers responsibility to ensure RIDDOR is completed as required.	1. Safety and Risk 2. Safety and Risk 3. 4.	1. Complete 2. Ongoing action 3. Q3 2014	HS011 requiring all incidents to be reported within 7 days. HS011 requires all RIDDOR reportable incidents to be reported, giving instructions on doing so.	Moderate	Unlikely	6	J. Selby, 16/10/14 - Item 1 - This action is addressed Item 2 - This item is addressed via GRS program that S&R run on a regular basis Item 3 - Item covered in above response Risk Approved by SMT at meeting on 9th July 2014

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400	There is a risk that Siemens VDO satellite navigation (SatNav) units in fleet vehicles will become unserviceable due to the age of the units and the withdrawal from the market place of the supplier resulting in increased vehicle out of service (OOS) or delayed response times and impact on operational efficiency.	SatNav's were originally specified and procured in 2001. The selected manufacturer was Siemens VDO, distributed in the UK by MixTelematics Ltd. Over time the unit design has evolved (CD to DVD to SDcard) but fundamentally they have remained backward compatible as far as the interface to the MDT was concerned. The device is no longer manufactured and spare parts are becoming scarce. Alternative SatNav devices from other manufacturers are not a simple retrofit and will require reengineering of the MDT interface. The impact of failures and inabilty to repair will build gradually (a rising tide) with increasing effect on fleet maintenance and availability, ultimately the	11-Jun-14	10		Operational	Major	Likely	16	1. Telent Ltd, (MDT/SatNav maintainer) to investigate alternative break/fix arrangements with a 3rd party. 2. Assessment of fault quantities and failure frequencies.	Jason Killens	22-Dec-14	Major	Likely	16	1. An early action of the eAmbulance project is to review the specification and carry out market sounding to identify alternative SatNav products. An alternative SatNav device has been identified and a sample has been now acquired 2. Software is being redeveloped to interface with the alternative Sat Nav device, a necessary precursor to action 4 3. If a satisfactory alternative device is identified AND the MDT software development is viable, funding will be sought to replace SatNavs across the fleet & undertake appropriate procurement process.. If full functionality can be achieved then action 3 funding and procurement will be progressed. 4. ~~Development of software &~~ Retrofitting of solution to fleet 5. eAbmulance project to refine current requirements and procure viable commercial (h/w & s/w) solution, which is likely to require in-house bespoking contribution to ensure overall facilities are not compromised.	1. CAD support 2. CAD support 3. Assistant Director of IM&T 4. CAD support 5. eAmbulance Project Manager	1. Complete 2. June 2015 3. Q2 2015 4. TBC 5. TBC		Major	Rare	4	Risk reviewed by IM&T December 2014. 01.09.2014. Telent Ltd, the supplier contracted to maintain MDT/SatNavs , have entered now into an agreement with Jazz Auto Repairs to repair LAS Sat Nav's . Approved by SMT 11/06/14
410	There is a risk that patient safety for category C patients may be compromised due to demand exceeding available resources.	40% total volume of calls are Category A. Inability to match resource to demand as the responding priority is focused on more seriously ill patients.	01-Oct-14	16		Clinical	Catastrophic	Likely	20	1. Undertaking ring backs within set time frames for held calls. 2. Fully trained workforce with 20 minute education breaks throughout shift. 3. C3 calls passed to hub for enhanced assessment C1 and C2 held calls are reviewed by hub 4. LAS Surge Management Plan. 5. Targeted additional resource at times of peak pressure using PAS/VAS/LAS overtime. 6. C1-C4 buckets have been redefined based on clinical outcomes. 7. Removal of exit message and clarity to patients regarding time delays. 8. Additional focus on safety reporting. 9. Falls care is being introduced. 10. METDG to be in place 24/7. 11. The CHUB now have a Clinical Manager overseeing each shift	Jason Killens	03-Dec-14	Catastrophic	Possible	15	1. Recruit to Establishment minus agreed vacancy factor of 4%. 2. Reviewing the determinants to best maximise resource availability, to assist with reduction multiple attendance ratio for single incidents. 3. Deliver efficiencies in full from Capacity Review and complete Roster Implementation. 4. Recruit to establishment in the clinical hub. 5. Allocate EMDs to clinical hub to assist with ring backs – Service Development put in for additional staff to undertake this work 6. Offer near misses for APP and CTL to spend 6 months in the clinical Hub in preparation for next tranche of recruitment 7. Introduce surge plan and make appropriate revisions 8. More accurate reporting of category C delays and monitoring of safety incidents	1. M. Gammage 2. J. Killens 3. J. Killens 4. K. Millard 5. K. Millard 6. K. Millard 7. K. Millard 8.	1. Ongoing 2. Complete 3. Q4 14/15 4. Q3 14/15 5. Q2 14/15 6. 2014/15 7. On-going 8.	1. Operational Demand and Capacity Review Group 2. Senior Management Team 3. Medical Directorate senior clinical advice; Clinical risk and Patient safety 4. The weekly SI group review patient safety incidents.	Catastrophic	Unlikely	10	F. Moore reviewed risk on 5/01/15 FW / DSW 03/12/14 Additional measures to mitigate risk are increased number of CHUB QA mangers to ensure 24/7 and implementation of VP and CP screen to monitor higher risk patients Trust operating at increased Surge level without regular review conference calls New risk proposed to replace previous risk ID 379. Approved by EMT 1/10/14
382	There is a risk that Emergency calls from Metropolitan Police Service (MPS) are incorrectly triaged by the MPS, affecting the ability of the LAS to effectively prioritise resources. This risk also directly compromises the clinical safety of patients.	In 2001 CAD link was developed, which enabled the MPS and LAS to exchange emergency calls and other messages directly via each organisation's CAD system. This process bypasses the standard triage system that all other 999 calls are subject to. To request the LAS, the MPS complete a basic triage of the call, known as the SEND protocol (Secondary Notification of Dispatch). SEND requires the MPS to answer five key questions to determine the medical priority of the call. Requests for the LAS from the MPS may be incorrectly triaged as a result of the limitations of the medical triage system used by the MPS Central Communications Command (SEND protocol). Erroneous	07-May-13	12		Clinical	Catastrophic	Likely	20	1. LAS METDG in in place 24 hours and is producing an average of 60% savings on AEU sends, MAR down to 1.33. 2. The Clinical Hub reviews low priority 999 calls that are being held and have the ability to identify MPS calls that have been incorrectly triaged and interrogate / upgrade the call priority if indicated. 3. EMDs can identify calls that appear to be mis-triaged by the SEND protocol or MPS Operator and upgrade / dispatch on the call immediately. 4. The MPS are now notified of incorrectly triaged calls sent to the LAS, to facilitate learning. 5. Police have put a message on their intranet relating to pressure on the service.	Jason Killens	06-Mar-15	Catastrophic	Possible	15	1. ~~A risk based evaluation of the pilot study will be undertaken and the results will be discussed with the Operational and Clinical leads.~~ ~~2. Dependent on the results it will be for the LAS to consider removing the CAD link for primary notification of emergency calls from the MPS which will then be triaged via the LAS 999 system and MPDS~~	1. P.Woodrow / F.Wrigley 2. P.Woodrow	1. Completed 2. Completed		Catastrophic	Unlikely	10	ADO group reviewed risk 03/06/15. Propose to review net rating. Medical Directorate commented 18/12/14. Proposed to increase target rating from catastrophic x rare = 5 to catastrophic x unlikely = 10. Approved by SMT 14/01/14 24/10/14 - CSDEC - proposed to review the status of MPS calls prior to archiving the risk. Review in 3 months. J.Killens August 2014 - propose to review risk rating when METDG is running 24hours a day.
427	There is a risk that patient safety may be compromised during periods of industrial action taken by London Ambulance Service staff as a result of current national ballots around pay arrangements.	Ongoing industrial action relating to continuing dispute relating to national pay arrangements.	12-Nov-14			Clinical	Catastrophic	Likely	20	1. Incident reporting process in place 2. Serious incident arrangements in place 3. Set up of Clinical Cell in EOC	Tony Crabtree		Catastrophic	Possible	15	1. Activation of the operational plan (Operation Phoenix)	1. J. Killens	1. Activated on days of industrial action		Catastrophic	Rare	5	Risk Approved by SMT at meeting on 12th November 2014

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329	There is a risk that financial penalties will be levied on the Trust as a result of non-achievement of the contractually agreed targets.	Potential failure to achieve contracted performance targets and failure to earn CQUINs	06-May-10	9	3,4,8	Finance	Catastrophic	Possible	15	1. Continue working with specific mitigation of financial risk. 2. Monthly finance reports reviewed by Trust Board and SMT. 3. Communications with commissioners.	Karen Broughton	16-Jan-15	Catastrophic	Possible	15	1. Review by Finance and Investment Committee 2. Review capacity vs. demand 3. Develop a programme of sustainable performance and performance management. 4. Develop clear escalation procedures when measuring performance (clarify action with Paul Woodrow) 5. Negotiate suitable operating contract with Commissioners. 6. Deliver 2015/15 Recruitment Plan	1. A. Grimshaw / A. Bell 2. A. Grimshaw / P. Woodrow 3. P. Woodrow 4. P. Woodrow 5. K. Broughton 6. K. Broughton	1. Next meeting 2. Ongoing 3. Achieved 4. 5. March 2015 for 2015/16 contract 6. March 2015	FIC minutes Weekly Tripartite reports • LAS Performance Board • Weekly Trust Board presentations • Weekly Tripartite reports Agreed 2015/16 contract Weekly recruitment reports	Catastrophic	Unlikely	10	
207	There is a risk of staff not being able to download information from Defibrillators and 12 lead ECG monitors leading to incomplete patient records.	Clinical information was not available which was required for an inquest / patient handover	04-Apr-06	***	1,2,4,5	Clinical	Moderate	Almost Certain	15	1. Mark Whitbread is the Trust lead for the card readers project, 2. Card reading and transmission is performed by team leaders. 3. Messages given out at Team Leaders Conferences. 4. Encourage more routine downloading of information from data cards. 5.LP1000 AED's have been rolled out and all complexes have been issued with new data readers for these units. 6. New Malden pilot has trialled the transmission of data from the LP15	Mark Whitbread	06-Mar-15	Moderate	Almost Certain	15	1. Establish the current resources of LP 1000, how many in use, which complexes carry them, are there spares available for 1 for 1 swap. 2. Establish a process at station level to link a specific cardiac arrest to the LP1000 it is stored on. 3. Publicise download returns by complex as part of Area Governance Reports, via PIM or Staff Officer for the Area. 4. Consider roll out of transmittable data from LP15 once vehicle on station. This is not being taken forward 5. A small pilot study is planned to take place at Westminster using two advanced paramedics in cars, which will have a cable to pub into a lap top to establish the benefits that come of out of it. T 6. Put a suggestion forward for it to be included as a CQUIN in the next financial year to the CQRG.	1. M.Whitbread 2. M.Whitbread 3. M.Whitbread 4. M.Whitbread 5. M.Whitbread	1. Complete 2. Complete 3. Complete 4. Not being taken forward 5. Commenced in Feb 2015	EOC briefings undertaken	Moderate	Unlikely	6	18/12/14 - Risk reviewed by medical directorate. 23/07/2014 - If the fleet was less "flexible" it would allow for modems to be used to assist with downloads. SMT 14.05.14 approved regrading to moderate x almost certain = 15 M.Whitbread to raise with EMT regarding mitigating actions. Proposed increasing current rating to moderate x almost certain = 15 APPs will be conducting a feasibility study using laptops to download data at two sites - Brent and Westminster with the intention of reviewing the outcomes with the attending crew in order to establish any learning from the event.
426	There is a risk that the Trust is unable to meet the obligation of engagement with partner agencies within set timescales due to lack of capacity within the safeguarding team to manage the increased workload, notably Marac requests for information.	The Trust will fail in its statutory responsibilities to respond to safeguarding requests within time scales. There continues to be an increase in the requirement for LAS partnership involvement as Multi-Agency Risk Assessment Conferences (MARACs) these are being introduced across London and require the LAS to provide data on our involvement with individuals over a given timescale and attendance at regular meetings. The LAS is seen as a key partner in these meetings.	10-Sep-14			Governance	Moderate	Almost Certain	15	1. Local managers running own reports in absence of safeguarding officer. 2. Out of office message to manage expectations.	Zoe Packman		Moderate	Almost Certain	15	1. Increase in members of safeguarding team to provide support across trust and partners (pending agreement of funding). 2. Develop an administrator post for safeguarding to cover increase workload and also support Safeguarding Officer when off (pending agreement of funding).	1. Z. Packman 2. Z. Packman	1. TBC 2. TBC		Minor	Possible	6	Agreed by SMT 10/09/14
417	There is a risk that unauthorised access and threats to the Trust's network will not be detected, and, after a breach occurs, it will not be possible to identify and pursue the attackers. This could lead to serious security breaches not being identified and action not taken to prevent such attacks happening in the future. Ultimately, this could impact on the operational delivery of services.	There is no intrusion detection process in place for the Admin network (internal network of the Trust). Unless a user identifies and reports an incident, this is not brought to the attention of the IM&T team. Networking devices such as routers and switches (which help interconnection within a network) have a limited set of logs that are stored locally on the devices. These include logon attempts and other key security information, but they are not aggregated or analysed for trends. Some monitoring is done on the Command and Control network (specifically of the Oracle database and the CAD system). (highlighted by KPMG Cyber Audit- October	08-Oct-14			Information Governance	Catastrophic	Possible	15	1. Gateway firewalls to protect LAS from external attacks. 2. Enterprise antivirus monitoring LAS infrastructure.	Vic Wynn	22-Jan-15	Catastrophic	Possible	15	1. Deploy an intrusion detection system along with associated processes to ensure that any incidents are logged and acted upon. As a minimum, the last 12 months of logs should be stored and be readily available after a breach for analysis.	1. R. Clifford	1. April 2015	1. Risk discussed and monitored by IM&T SMT	Catastrophic	Rare	5	22/01/2015 Funding approved and procurement completed. Implementation to be completed by 28/02/2015 (subject to detailed planning of implementation) 18/12/2014 IM&T approved the purchasing/deployment of an Intrusion Detection System (IDS) to monitor LAS networks ; procurement is currently processing the request. Risk Approved by SMT at meeting on 8th October 2014

London Ambulance Service NHS Trust
March 2015 Corporate Risk Register

Risk ID	Risk Description	Underlying Cause/ Source of Risk	Date Opened	Assurance Framework Ref.	Corporate Objective	Risk Category	Gross Impact	Gross Like-lihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Like-lihood	Net Rating	Further Actions Required	Action Owner	Date Action to be Completed	Assurance In Place (how do we gain assurance that the controls in place are effective)	Target Impact	Target Like-lihood	Target Rating	Comments
418	There is risk that a malware outbreak or a hacking attack originating from LAS admin network is propagated to the CAC network area. This could result in a loss of sensitive data or CAC network being unavailable, severely impacting the delivery of emergency services.	Firewalls exist only on the interface to the internet, and not between the virtual networks, (such as the one to segregate the CAC network from the rest of the Trust network). The internal network is flat and open, meaning that there is no separation between groups of computers and all devices on the network are treated with the same level of trust. This allows easy access within the network once an unauthorised individual has accessed the network. Once a device is compromised in one section of the network, the rest of the network is available to the attacker.	08-Oct-14			Information Governance	Catastrophic	Possible	15	1. Gateway firewalls to protect LAS from external attacks 2. Enterprise antivirus monitoring LAS infrastructure	Vic Wynn	22-Jan-15	Catastrophic	Possible	15	1. Introduce strategic firewalls to segregate sensitive sections of the network, particularly the CAC. 2. Additionally, consider placing a firewall or similar between the two main CAC physical networks located at Bow and Waterloo.	1. R. Clifford 2. R. Clifford	1. 31/03/15 2. 31/03/15	Risk discussed and monitored by IM&T SMT	Catastrophic	Rare	5	22/01/2015 .The network audit is needed to determine valid network traffic paths which will be incorporated into the new security rules / controls . This will continue until the next planned Control Services exercise/operation "on paper" (planned for the end of February). It is planned that the firewalls will be inserted in between the networks alongside other works. IM&T are exploring with Control Services the possibility of an additional exercise/operation "on paper" before the planned event, however this is highly unlikely. Once in place, the security rules determined from the network audit will be implemented. Revised Due date: 31/03/2015*** (subject to the detail planning of the "on paper" exercises and technical
420	Without adequate patching, the risk of unauthorised access into the CAC network is increased as publicly known vulnerabilities related to the systems running on CAC will not be addressed. Any such attacks could result in a loss of sensitive data or CAC network being unavailable, severely impacting the delivery of emergency services	Without adequate patching, the risk of unauthorised access into the CAC network is increased as publicly known vulnerabilities related to the systems running on CAC will not be addressed. As the CAC network does not have access to the internet or email, it is less likely that attacks will come directly from these external sources, but it may be possible to introduce an attack through infected USB drives, CD/DVDs, or other removable media (even if LAS-approved devices). Alternatively, an attacker could leverage one of the security vulnerabilities present on the other networks (external Internet facing network	08-Oct-14			Information Governance	Catastrophic	Possible	15	1. Enterprise antivirus monitoring CAC desktops 2. Desktop ports disabled (i.e. USB, DVD) 3. No access to internet /email for CAC desktops	Vic Wynn	22-Jan-15	Catastrophic	Possible	15	1. 1.Liaise with the supplier of the Comandpoint software to ensure that patching is undertaken regularly. This needs to include updating the software to be compatible with the latest versions of software used by the CAC Network, in particular the Microsoft Operating System and Office products.	1. E Beqiri	1. 31-Mar-15	Risk discussed and monitored by IM&T SMT	Catastrophic	Rare	5	22/01/2015 The new (required) CommandPoint software is still in testing, due to defects identified. The observed defects have been rectified and are being retested. This is now due for implementation at the end of February 2015. Testing on Windows 7 has re-commenced using operational resources. Implementation of the solution is expected to be completed by 31/03/2015 however will be subject to the rollout of new PCs. 18/12/2014 CommandPointV2.6 passed final test and was implemented August. LAS is currently testing CP clients on W7. Risk Approved by SMT at
416	There is a risk that the Trust might not satisfy IGT 11-313 requirements concerning network security.	The Trust does not have a Network Security policy in place. Information Governance Toolkit (IGT) attainment 313 requires a network security in place (formally approved by LAS SIRO (Senior Information Risk Owner). Until the policy is formally approved/deployed LAS will not achieve the necessary score target to satisfy DH requirements and to avoid any possible penalties or reputational damage. The network security policy is intended to reduce risks to LAS systems and data by defining a common security policy for the management of the LAS network infrastructure.	08-Oct-14			Information Governance	Moderate	Almost Certain	15	1. Local network operating procedures.	Vic Wynn	22-Jan-15	Moderate	Almost Certain	15	1. Draft and formally approve a Network Security policy.	1. E. Beqiri	1. Dec 2014	1. Risk discussed and monitored by IM&T SMT	Moderate	Rare	3	22/01/2015 Network Procedure approved by IM&T SMT and IGG (subject to small amendments) for implementation within IM&T.The approved procedure satisfies IGT submission requirements. 18/12/2014 First draft of the Network Security policy approved by IM&T - policy to approved by SMT **:propose to downgrade the risk to 12.** Approved by SMT 14/01/15 Risk Approved by SMT at meeting on 8th October 2014

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**24th March 2015**
Document Title:	**Report from the Audit Committee on 2nd February 2015**
Report Author(s):	**John Jones, Chair of the Audit Committee**
Presented by:	**John Jones, Chair of the Audit Committee**
Contact Details:	
History:	**Assurance report from the most recent Audit Committee**
Status:	**For information**

Background/Purpose

The purpose of this report is to update the Trust Board on the key items of discussion at the Audit Committee meeting on 2nd February 2015.

Action required

The Trust Board is asked to note the report from the Audit Committee meeting on 2nd February 2015.

Assurance

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

Key implications and risks arising from this paper	
Clinical and Quality	
Performance	
Financial	**X**
Legal	
Equality and Diversity	
Reputation	
Other	**X Assurance on risk systems and processes**
This paper supports the achievement of the following 2014/15 objectives	
Improve patient care	**X**
Improve recruitment and retention	
Implement the modernisation programme	
Achieve sustainable performance	
Develop our 111 service	
Simplify our business processes	**X**
Increase organisational effectiveness and development	**X**

Report from the Audit Committee on 2nd February 2015

GOVERNANCE AND RISK MANAGEMENT

Board Assurance Framework and Corporate Risk Register

The Audit Committee reviewed the updated risk register and board assurance framework (BAF), which has been aligned to the business objectives for 2014/15. The BAF is a more dynamic document than it has been previously and reflects the key issues facing the Trust and the committee heard that the Executive Management Team would review and update the risks and controls prior to the March meeting of the Trust Board. This was also an opportunity for the executives to provide an update on specific risk issues identified at the January Board meeting. Particular emphasis needed to be given to reducing the level of risk and removing the risk from the BAF and to explain why any long standing BAF risk was not being sufficiently mitigated to reduce the severity level.

In summary, the Audit Committee is assured that the risk management process is working well, and that there will be more focus going forward on what this process is telling us and the actions to mitigate the risks.

Risk Focus Areas

Andrew Grimshaw presented the deep dive on IM&T risks. The deep dive was based on the updated review of IM&T undertaken by PA Consulting in January 2015 following a review in April 2014. The paper presented identified six recommendations, each with a risk rating, of which four risks would qualify for the BAF and corporate risk register:

- Leadership and management
- Single points of failure
- Strategy and enterprise architecture
- Demand and business management.

The committee took assurance on the interim appointment of a Chief Information Officer to oversee the day to day operation of IM&T.

AQI Peer Review Audit

The Audit Committee welcomed the presentation from the Performance Improvement Manager for Control Services on the actions taken to address the AQI Peer Review Audit recommendations. It was noted that the LAS's data governance quality was good and that there were systems and processes in place to control changes to data collection, recording and reporting within the Control Room environment, led by the Control Services Change Board.

Review of progress against Internal Audit recommendations

The Committee received an update on progress against recommendations and actions having previously expressed concern at the lack of movement, particularly with high risk recommendations. It was noted that 30 outstanding recommendations remained of which 23 were overdue, comprising 5 high priority, 17 medium priority and 1 of low priority; 7 recommendations were still within the timeframe proposed by management. The executive were focussing on managing the actions with a much improved position to be reported to the next meeting.

Internal Audit Progress Report

The Committee noted the progress against the 2014/15 Internal Audit plan: Information Governance, Core Financial systems and Governance Arrangements reports had been concluded and there were positive assurances, particularly in the Financial Systems review. Fieldwork for the review on workforce management: staff absence, was underway and scoping work had started on reviews of Patient feedback and Safeguarding. It was noted that the executive would discuss the best time for the review of CQC monitoring given the forthcoming CQC inspection in June 2015. [DN: since confirmed as part of 2015/16 plan associated with the action plan from the planned inspection].

The Committee received confirmation that the Trust's financial systems had reached an overall assessment of 'significant assurance', demonstrating robust systems and controls in place; that significant assurance was had on the progress that had been made on the Information Governance review; and that progress had been made on the recommendations from the review of Governance Arrangements.

The Internal Auditors reported that work on the 2015/16 plan would commence in March 2015 for review and approval at the May Audit Committee.

Local Counter Fraud Specialist Progress Report

The Committee noted the progress report and in particular the completion of two reviews, and a focus on completing the remaining (two) ongoing cases.

Annual Review of the Effectiveness of Internal Audit and Local Counter Fraud

The committee noted that the review was underway and the outcome could be considered at the next meeting of the Audit Committee.

FINANCIAL REPORTING

Draft Year-End Reporting Timetable

The Audit Committee was informed of the process and timetable for the draft and final annual accounts for 2014/15. The key dates being:

- Review of the draft Annual Accounts on 17 April 2015;
- Trust to submit draft Annual Accounts on 23 April 2015;
- The Audit Committee to review the Governance Statement, Annual Accounts & Annual Report on 1 June 2015;
- Trust Board to approve Audited Annual Accounts & Annual Report on June 2015.

PwC presented the External Audit plan for 2014/15 that set out a number of key risk areas:

- Income recognition extended to expenditure recognition
- Levels of materiality set
- Overall materiality set at £5.97m
- Would report back to the Committee anything above £250k in terms of any misstatements. This level was set as they believed this is the level the Committee would want to understand and also required to report at this level to the NAO.

The Audit Committee agreed to a threshold of £250k.

Losses and Special Payments Report

The report on the level of losses and special payments for the period April – November 2014 was reviewed and the final report would be submitted to the meeting on 17th April with the draft accounts and recommended for approval as part of the final accounts process. The Committee would be able to take assurance from the final report.

REPORTS FROM COMMITTEES

The Audit Committee noted the reports from the Finance and Investment Committee and the Quality Governance Committee on their recent meetings.

Date of next meeting: The next meeting of the Audit Committee is on Friday 17th April 2015 with a focus on the draft Annual Accounts.

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**24th March 2015**
Document Title:	**Finance Report – Part 1 – 2014/15 Month 11**
Report Author(s):	**Andy Bell**
Presented by:	**Andrew Grimshaw**
Contact Details:	**Andy.bell@lond-amb.nhs.uk (02077832793)**
History:	***The Part 1 report is reviewed by EMT and FIC on a monthly basis***
Status:	***information***

Background/Purpose

The report contains the detailed financial results and statements outlining the in month and year to date financial position as at the 28th February 2015. Additional, commentary has been provided to provide insight into the figures.

The Trust is forecasting a year end surplus of £1.0m, this is lower than the original planned surplus of £3.0m. This is in line with the Performance Improvement Plan agreed with the TDA, NHSE and Commissioners in November.

Action required

The EMT is asked to note the Financial Results for Month 11

Assurance

Key implications and risks arising from this paper	
Clinical and Quality	
Performance	
Financial	**X**
Legal	
Equality and Diversity	
Reputation	
Other	
This paper supports the achievement of the following 2014/15 objectives	
Improve patient care	
Improve recruitment and retention	
Implement the modernisation programme	
Achieve sustainable performance	**X**
Develop our 111 service	
Simplify our business processes	
Increase organisational effectiveness and development	

London Ambulance Service NHS Trust
Finance Report - Part 1 – 2014/15
Month 11: February

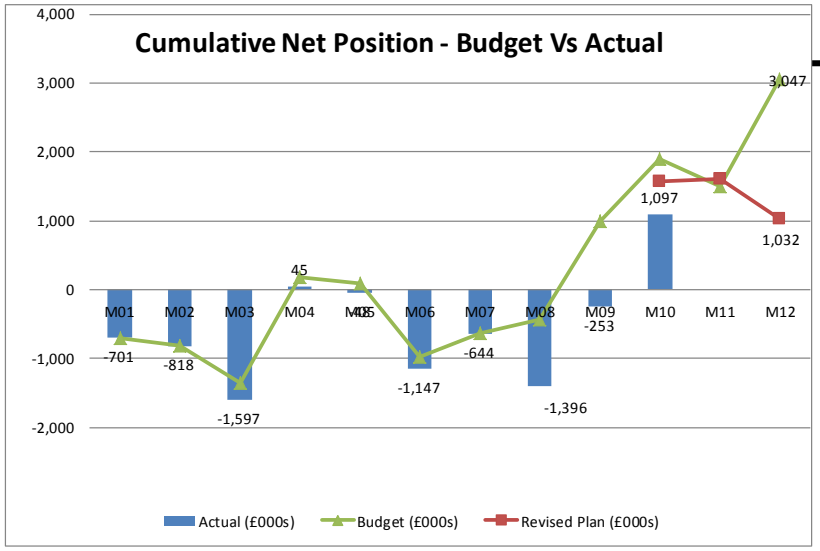
Trust Board (Part One) – 24th March 2015

Andrew Grimshaw
Finance Director

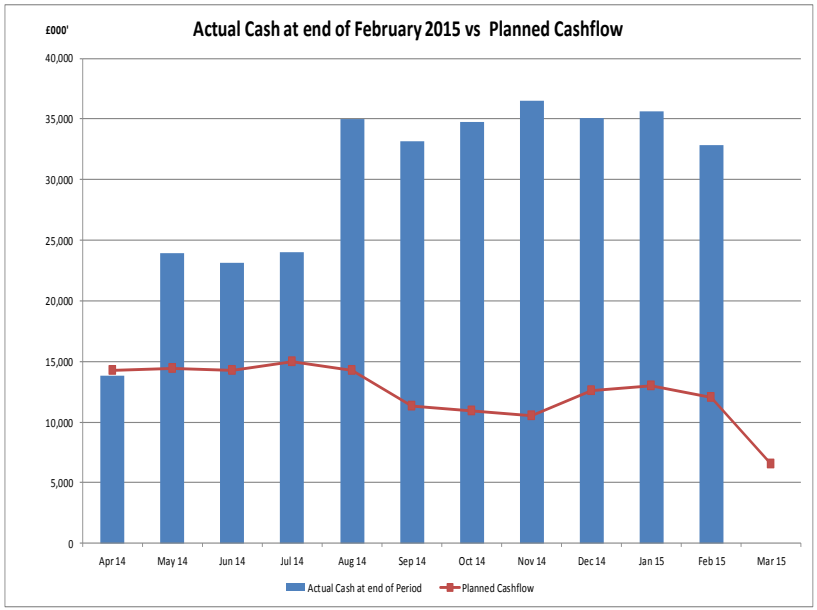
Finance Summary: M11 (2014/15)

Financial Indicator	Summary Performance	Current month	Previous month
Surplus	In month the Trust is reporting a £1.0m favourable result against plan. YTD the Trust is reporting a £0.2m favourable variance to plan. As previously reported the forecast surplus has been reduced to £1.0m for the financial year to reflect the planned investment in additional capacity as agreed with Commissioners, NHSE and the NTDA. The RAG ratings are shown as Amber as the Trust's financial position is in line with revised plans but not in line with the original plan for the year. Commissioners have indicated that any penalties will be reinvested. Formal confirmation of this is pending.	**AMBER**	**AMBER**
Income	Income is £2.4m favourable to plan in month and £9.3m favourable YTD. £7.5m has now been recognised relating to resilience income. The Trust expects to recognise circa £10m resilience funding in total. Other favourable variances are derived from ongoing PTS over-performance (£0.8m) and higher than expected LETB income (£1.6m).	**GREEN**	**GREEN**
Expenditure	In month total spend is £1.5m adverse, YTD there is a £9.2m adverse position. This is being driven by additional resources to support performance and relates primarily to additional incentivised overtime and expanded Private Ambulance usage. As previously reported revised expenditure plans based on achieving an improved run rate in Cat A performance across the remainder of the financial year have now been and will continue to be implemented. The Trust has committed to significant additional expenditure and this has manifested itself in the adverse YTD position at Month 11. Additional funding has now been partially recognised to support the position and the final income settlement is being finalised with the NTDA and NHSE.	**AMBER**	**AMBER**
CIPs	Currently reporting on plan.	**GREEN**	**GREEN**
Balance Sheet	Capital expenditure remains below plan at this point of the year. It is anticipated that the capital programme will completed by year end with significant deliveries of vehicles in March. The Amber RAG rating is driven by the slower than expected capital expenditure position.	**AMBER**	**AMBER**
Cashflow	Cash is £20.8m above plan.	**GREEN**	**GREEN**

Executive Summary - Key Financial Metrics



Description	2014/15 - Month 11			Year to Date			FY 2014/15
	Budg	Act	Var	Budg	Act	Var	Budg
	£000	£000	£000 fav (adv)	£000	£000	£000 fav (adv)	£000
Dept Health							
Surplus / (Deficits)	(408)	552	960	1,494	1,649	154	1,000
EFL				(2,487)	(27,024)	24,537	3,692
CRL				16,660	7,481	(9,179)	20,900
Suppliers paid within 30 days - NHS	95%	83%	(12.0%)	95%	78%	(17.0%)	95%
Suppliers paid within 30 days - Non NHS	95%	91%	(4.0%)	95%	90%	(5.0%)	95%
Monitor							
EBITDA %	4.1%	6.6%	2.5%	6.2%	5.6%	(0.6%)	6.0%
EBITDA on plan	1,010	1,784	774	17,092	16,017	(1,075)	18,016
Net Surplus	(408)	552	960	1,494	1,649	154	1,000
Return on Assets	3.75%	3.65%	(0.1%)	3.75%	3.65%	(0.1%)	5.10%
Liquidity Days	0.52	0.50	(0.02)	0.52	0.50	(0.02)	0.52
Continuity of Service Risk Rating	3.5	4.0	0.5	3.5	4.0	0.5	3.5



- In month £1.0m favourable, YTD overall position is £0.2m favourable to the original plan. The Trust expects to achieve its revised £1.0m year end surplus target.
- On-going pressures are:
  - Additional spend in support of performance improvement
  - Recruitment and retention of substantive staff and the cost of overtime and PAS (Private Ambulances) to cover vacancies and enhance capacity.
  - Servicing an ageing fleet whilst new vehicles are on order
  - Management of operational staff – particularly relief factor
- Cash is £20.8m above plan. This is mainly due to an increase in trade and other payables, current provisions and lower than planned capital expenditure at this point in the year.
- The EFL variance is due to higher than planned cash balances, and PDC funding for the CommandPoint resilience capital project not having been received as the project has been deferred to 2015/16.
- The Trust would expect to score a Continuity of Service Risk Rating (CSRR) of 4 for the YTD results based on the current Monitor metrics (maximum rating).
- CRL position – The capital plan is currently £9.2m behind plan. The underspend is due to programme delays but the overall spend will be achieved by 31 March (large deliveries of vehicles in March).
- In order to assist the Trust with the management of its cash position at 31 March, it has been agreed with DH and NTDA that the remaining balance of the DH loan (£3,099k) may be repaid before the year end. The loan would otherwise have been repayable over 3 years at 31 March 2015. The Trust will have sufficient cash resources to meet all its ongoing obligations after the repayment.

Statement of Comprehensive Income

2014/15 - Month 11			Description	Year to Date			FY 2014/15
Budg	Act	Var		Budg	Act	Var	F'cast
£000	£000	£000 fav/(adv)		£000	£000	£000 fav/(adv)	£000
			Income				
21,290	23,764	2,475	Income from Activities	240,150	247,417	7,267	263,370
3,213	3,185	(28)	Other Operating Income	35,273	37,313	2,040	38,504
24,503	**26,950**	**2,447**	**Subtotal**	**275,423**	**284,730**	**9,307**	**301,874**
			Operating Expense				
17,909	17,843	65	Pay	196,188	199,977	(3,789)	216,155
5,584	7,322	(1,739)	Non Pay	62,144	68,737	(6,593)	67,704
23,493	**25,166**	**(1,673)**	**Subtotal**	**258,332**	**268,714**	**(10,382)**	**283,858**
1,010	**1,784**	**774**	**EBITDA**	**17,092**	**16,017**	**(1,075)**	**18,016**
4.1%	6.6%	2.5%	**EBITDA margin**	6.2%	5.6%	(0.6%)	6.0%
			Depreciation & Financing				
1,111	881	231	Depreciation	12,223	10,517	1,707	13,334
301	297	4	PDC Dividend	3,306	3,268	39	3,607
6	54	(48)	Interest	68	583	(516)	74
1,418	**1,232**	**186**	**Subtotal**	**15,598**	**14,368**	**1,230**	**17,016**
(408)	**552**	**960**	**Net Surplus/(Deficit)**	**1,494**	**1,649**	**154**	**1,000**
(1.7%)	2.0%	3.7%	**Net margin**	0.5%	0.6%	0.0%	0.3%

- The Trust has submitted a revised year end forecast to the NTDA reflecting a £1.0m surplus. This results from the need to spend more to support performance improvement.

- The YTD favourable variance of £0.2m reflects additional resilience and LETB income, offset by additional spend on PAS and overtime.

Income

- YTD £9.3m favourable due to partial recognition of resilience income (£7.5m), and continuing over performance on PTS (£0.8m). In addition the Trust has recognised more LETB income (£1.6m).

Operating Expenditure (excl. Depreciation and Financing)

- Overall £10.4m adverse YTD primarily due to increased incentivised overtime spend in pay on the frontline and continuing high levels of PAS in non-pay.
- In month there is a £1.7m adverse variance that relates primarily to additional measures to improve performance (overtime and PAS usage).
- Pay is adverse by £3.8m ytd due mainly to frontline vacancies. International Paramedics are now starting and there will be 97 new Paramedics by the end of March.
- There remains extensive use of Private Ambulances offsetting this position (Non Pay).
- Spend on Frontline resourcing will continue across Q4. Additional funding and mitigation has been agreed to deliver performance improvements and income for this has been partially recognised.
- CIPs are seen as delivering on plan YTD.

Depreciation and Financing

- Currently £1.2m favourable to plan. The depreciation plan has been revised down due to timing delays in the Capital programme against plan. This will continue to be reviewed each month.

Statement of Financial Position: YTD

	Mar-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Feb-15		
	Act	Act	Act	Act	Act	Act	Act	Plan	Var	%
	£000	£000	£000	£000	£000	£000	£000			
Non Current Assets										
Property, Plant & Equip	121,627	117,764	117,001	116,507	128,097	128,878	129,144	122,648	6,496	5.30%
Intangible Assets	12,296	11,165	11,004	10,791	10,579	10,393	10,205	13,783	(3,578)	-25.96%
Trade & Other Receivables	0	0	0	0	0	0	0	0	0	
Subtotal	133,923	128,929	128,005	127,298	138,676	139,271	139,349	136,431	2,918	2.14%
Current Assets										
Inventories	3,498	3,502	3,497	3,505	3,533	3,513	3,506	3,257	249	7.65%
Trade & Other Receivables	22,804	11,863	11,016	11,306	17,784	17,126	19,182	17,094	2,088	12.21%
Cash & cash equivalents	6,436	33,163	34,793	36,512	35,051	35,662	32,838	12,051	20,787	172.49%
Non-Current Assets Held for Sale	0	101	101	101	106	101	101	0	101	
Total Current Assets	32,738	48,629	49,407	51,424	56,474	56,402	55,627	32,402	23,225	71.68%
Total Assets	166,661	177,558	177,412	178,722	195,150	195,673	194,976	168,833	26,143	15.48%
Current Liabilities										
Trade and Other Payables	(22,840)	(35,307)	(34,661)	(36,513)	(42,354)	(37,926)	(38,075)	(30,450)	(7,625)	25.04%
Provisions	(4,750)	(4,750)	(4,750)	(4,750)	(3,747)	(8,447)	(8,447)	(1,272)	(7,175)	564.07%
Borrowings	0	0	0	0	0	0	0	0	0	
Working Capital Loan - DH	0	0	0	0	0	0	0	0	0	
Capital Investment Loan - DH	(1,244)	(622)	(622)	(622)	(1,244)	(1,244)	(1,244)	(1,244)	0	0.00%
Net Current Liabilities)	(28,834)	(40,679)	(40,033)	(41,885)	(47,345)	(47,617)	(47,766)	(32,966)	(14,800)	44.89%
Non Current Assets plus/less net current assets/Liabilities	137,827	136,879	137,379	136,837	147,805	148,056	147,210	135,867	11,343	8.35%
Non Current Liabilities										
Trade and Other Payables	0	0	0	0	0	0	0	0	0	
Provisions	(9,114)	(9,313)	(9,309)	(9,519)	(9,967)	(8,868)	(8,832)	(10,306)	1,474	-14.30%
Borrowings	(107)	(107)	(107)	(107)	(107)	(107)	(107)	(107)	0	0.00%
Working Capital Loan - DH	0	0	0	0	0	0	0	0	0	
Capital Investment Loan - DH	(3,099)	(3,099)	(3,099)	(3,099)	(2,477)	(2,477)	(2,477)	(2,477)	0	0.00%
Total Non Current Liabilities	(12,320)	(12,519)	(12,515)	(12,725)	(12,551)	(11,452)	(11,416)	(12,890)	1,474	-11.44%
Total Assets Employed	125,507	124,360	124,864	124,112	135,254	136,604	135,794	122,977	12,817	10.42%
Financed by Taxpayers Equity										
Public Dividend Capital	62,516	62,516	62,516	62,516	62,516	62,516	62,516	66,266	(3,750)	-5.66%
Retained Earnings	22,674	21,527	22,031	21,279	22,421	23,771	24,322	22,088	2,234	10.11%
Revaluation Reserve	40,736	40,736	40,736	40,736	50,736	50,736	49,375	35,042	14,333	40.90%
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	0	0.00%
Total Taxpayers Equity	125,507	124,360	124,864	124,112	135,254	136,604	135,794	122,977	12,817	10.42%

A key issue driving the balance sheet variances has been movements in the 2013/14 year end position which were not known in time to inform the 2014/15 plan (forecast on the 2013/14 month 10 position).

Non Current Assets

- Non current assets stand at £139.3m, a £2.9m increase against plan.
- The movement from plan is related to variances between the plan (set in February 2014) and the actual year end position following the property revaluation exercise carried out at the year-end. Fixed assets increased by £7.7m. The property revaluation exercise performed by the valuation office has started earlier this year and an estimated revaluation surplus of £8.2m as at 28 February 2015 has been included in the accounts. Work still needs to be undertaken to finalise the values.

Current Assets

- Current assets stand at £55.6m, a £23.2m increase against plan.
- Cash position as at February is £32.8m, a £20.8m increase against plan. This is due to a higher than planned trade & other payables and provision balances , and lower than planned capital spend in both 2013/14 and 2014/15.
- Receivables (debtors) at £5.2m are £2.5m below plan , accrued Income at £9.4m is £4.3m above plan, prepayments at £4.5m are £0.3m above plan, stocks at £3.5m are £0.2m above plan and assets held for sale are £0.1m above plan.

Current Liabilities

- Current liabilities stand at £47.8m, a £14.8m increase on plan.
- Payables and accruals at £37.9m are £7.5m above plan.
- Deferred Income at £0.2m is £0.1m above plan; this includes £7.2m CBRN income for the year to 31/3/15 being raised in June. The Trust has a high volume of unapproved trade payables at £5.3m. Current provisions at £8.5m are £7.2m higher than plan. This is due to £4.7m increase in redundancy provision . The Trust is still waiting for a decision to be made by the HMRC on its liability relating to contracted out services VAT due to back-dated changes in rules.

Non Current Liabilities

- Non current provisions are £1.5m higher than planned. This is due to a re-allocation of provisions for VAT between current and non-current .

Taxpayers Equity

- Taxpayers Equity stands at £135.7m, a £12.8m increase on plan.
- PDC is £3.8m lower than planned due to slippage on the capital programme. PDC was the budgeted source of funding for the CommandPoint capital project.
- The revaluation reserve and retained earnings increase is due to the property revaluation exercise at the 2013/14 year-end. The data was not available when the plan was prepared. Also the reserves includes a £8.2m estimate for the increase in property values as at 28 February 2015 prepared by the Valuation Office.

Cashflow Statement YTD

	In Month Movement						YTD Move	YTD Plan	Var
	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Feb-15	Feb-15	Feb-15
	Actual	Actual	Actual	Actual	Actual	Actual			
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Opening Balance	34,959	33,163	34,793	36,512	35,051	35,662	**6,436**	**6,436**	**0**
Operating Surplus	201	1,916	367	2,266	2,056	1,739	15,523	17,081	(1,558)
(Increase)/decrease in current assets	1,542	852	(298)	(6,506)	678	(2,049)	3,614	2,330	1,284
Increase/(decrease) in current liabilities	(816)	(602)	1,557	4,003	(3,931)	(1,942)	11,934	6,205	5,729
Increase/(decrease) in provisions	61	(18)	196	(569)	3,587	(50)	3,211	(1,162)	4,373
Net cash inflow/(outflow) from operating activities	988	2,148	1,822	(806)	2,390	(2,302)	34,282	24,454	9,828
Cashflow inflow/outflow from operating activities	**988**	**2,148**	**1,822**	**(806)**	**2,390**	**(2,302)**	**34,282**	**24,454**	**9,828**
Returns on investments and servicing finance	0	8	3	3	41	4	57	(20)	77
Capital Expenditure	(379)	(526)	(106)	(658)	(1,820)	(526)	(5,532)	(20,144)	14,612
Dividend paid	(1,783)	0	0	0	0	0	(1,783)	(1,803)	20
Financing obtained	0	0	0	0	0	0	0	3,750	(3,750)
Financing repaid	(622)	0	0	0	0	0	(622)	(622)	0
Cashflow inflow/outflow from financing	**(2,784)**	**(518)**	**(103)**	**(655)**	**(1,779)**	**(522)**	**(7,880)**	**(18,839)**	**10,959**
Movement	(1,796)	1,630	1,719	(1,461)	611	(2,824)	26,402	5,615	20,787
Closing Cash Balance	**33,163**	**34,793**	**36,512**	**35,051**	**35,662**	**32,838**	**32,838**	**12,051**	**20,787**

Cash funds at 28 February stand at £32.8m, which is £20.8m above plan.

Current Assets

- The ytd movement on current assets is £3.6m, a £3.1m decrease on plan.
- Current assets movement was lower than planned due to an decrease in accrued income £1.7m, and increases in prepayments £2.2m and receivables £0.7m.

Current Liabilities

- The ytd movement on current liabilities is £11.9m, a £5.7m increase on plan.
- Current liabilities movement was higher than planned due to increases in accruals £3.3m, deferred income £0.2m and trade and other payables £2.2m. The Trust has a high volume of unapproved invoices.

Provisions

- The ytd movement on provisions is £3.2m, a £4.4m increase on plan. The Trust has made a provision of £4.7m in the period to cover planned redundancy costs.

Capital Expenditure

- The ytd movement on Capital Expenditure payments is £5.5m, £14.6m lower than plan.
- The lower than planned capital expenditure payments is due to slippage on the 2014/15 capital programme. Capital expenditure to February 2015 is £7.5m.
- The ytd movement on financing obtained is nil, £3.8m lower than planned. The application for PDC funding for the CommandPoint capital project will not take place in 2014/15.

Acronyms

- A&E – Accident & Emergency
- AES – Adult Emergency Services
- BAA – British Ambulance Association
- BETS – Baby Emergency Transfer Service
- BPPC – Better Payment Practice Code
- CBRN – Chemical Biological Radiological Nuclear
- CCG – Clinical Commissioning Group
- CHUB – Clinical Hub
- CIP – Cost Improvement Plan
- CQUIN – Commissioning for Quality & Innovation
- CRL – Capital Resource Limit
- CTA – Clinical Telephone Advisors
- DD – District Details
- DCA – Dual Crewed Ambulances
- DH – Department of Health
- EBITDA – Earning before Interest, Tax, Depreciation & Amortisation
- EBS – Emergency Bed Service
- ECA – Emergency Crew Assist
- ED – Emergency Departments
- EFL – External Financing Limit
- EMD – Emergency Medical Dispatcher
- EMT – Emergency Medical Technicians
- EOC – Emergency Operations Centre
- FIC – Finance Investment Committee
- FRR – Financial Risk Rating
- FRU – First Response Unit
- FYE – Full Year Effect
- HART – Hazardous Area Response Team
- HMRC – Her Majesty's Revenue & Customs
- HR – Human Resources
- I&E – Income & Expenditure
- IFRIC – International Financial Reporting Interpretations Committee
- IM&T – Information Management & Technology
- MPET – Multi Professional Education & Training
- NI – National Insurance
- NTDA – National Trust Development Authority
- OD – Organisational Development
- ORH – Operational Research in Health
- OT - Overtime
- PAS – Private Ambulance Service
- PCT – Primary Care Trust
- PDC – Practice Development Centre
- PMO – Programme Management Office
- PTS – Patient Transport Service
- RFC – Request for Change
- RTA – Road Traffic Incident
- SCBU – Special Care Baby Unit
- SLA – Service Level Agreement
- SO – Specialist Operations Department
- SoCI – Statement of Comprehensive Income
- WCF – Weekly Cash Flow
- WTE – Whole Time Equivalent
- YTD – Year to Date

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**24th March 2015**
Document Title:	**Retention Strategy**
Report Author(s):	**Mark Gammage, HR**
Presented by:	**Mark Gammage, HR**
Contact Details:	**HR**
History:	**Presented to EMT on 18 March 2015**
Status:	**For approval**

Background/Purpose

The results of the recent (2014) Staff Survey and feedback from other external reports (e.g. Connectwell report on staff leavers) and staff focus groups highlight that staff morale is low. This is further evidenced by high turnover, vacancy and staff absenteeism rates

This strategy brings together strands of current work together with new initiatives into one report focussing on eight overarching objectives.

A summary detailing current action accompanies providing details of what action is being taken, by when and by whom and includes success criteria. It is of necessity high level and more detailed planning underpins these initiatives. A full and costed action plan will monitored by EMT.

These objectives and actions also cross reference with the draft staff survey action plan.

Action required

For the Trust Board to approve this strategy and request the executives implement the actions as outlined.

The strategy will be communicated throughout the organisation and progress monitored and managed through the senior management team.

Updates on implementation of the strategy will be provided to the Trust Board on a regular basis.

Assurance

Key implications and risks arising from this paper	
Clinical and Quality	
Performance	**Failure to address issues of retention will have a negative impact on performance**
Financial	**The financial implications of actions outlined have been accounted for where known (e.g. management restructure, introduction of team leaders, training budgets), but a separate review will be required of actions where it becomes apparent additional funding is required and approval give by the executives at that stage (e.g. travel)**
Legal	
Equality and Diversity	
Reputation	**Failure to address issues of retention will adversely effect our reputation**
Other	
This paper supports the achievement of the following 2014/15 objectives	
Improve patient care	
Improve recruitment and retention	□
Implement the modernisation programme	□
Achieve sustainable performance	□
Develop our 111 service	
Simplify our business processes	□
Increase organisational effectiveness and development	□

LONDON AMBULANCE SERVICE NHS TRUST

RETENTION STRATEGY 2015

1. EXECUTIVE SUMMARY

Turnover of staff has increased over the last few years and, coupled with increases in demand for the services at LAS, has led to considerable pressure on staff and systems. This has resulted in a lowering of morale, a worsening in ambulance response times and a consequent deleterious effect on turnover. Considerable energy and effort has been concentrated on trying to resolve this issue with significant attention focussed on dealing with the day to day acute effects of this situation. Targeting staff retention through improving staff morale should bring turnover levels down to their natural level.

There is unanimous agreement on the need to take decisive action and commitment from the senior management and executive team to address issues that affect retention, and considerable work is underway to this end. This work has been based on feedback from staff and staff-side colleagues.

This strategy aims to bring this work together and ensure there is a coherent approach to addressing issues affecting retention. It recognises the need for clear actions and time lines with individuals held responsible for delivery and the need for cultural change throughout the organisation in how people are managed and led.

Eight retention objectives have been agreed, requiring London Ambulance Service to:

- Support you to do your job to the best of your ability
- Support you to balance your home and work life
- Support your health and wellbeing
- Ensure you have the right management and leadership support
- Ensure you can work within the right environment
- Support you to continually learn, develop and progress within the LAS
- Support you to work and live in London – “The London Ambulance Service Proposition”
- Ensure we entice people to work for LAS and come back to work for us

Each of these objectives has actions underpinning it with dates and a named manager responsible for delivery.

Success will be measured by our ability to achieve these objectives to the timescales outlined and also by use of a balanced score card approach. This will enable monitoring staffing metrics including turnover rates, vacancy levels, sickness absence rates and appraisals as well as how staff feel about working at LAS and recommending the service as somewhere to be treated. If we get this right, staff

should feel more empowered, enabled and supported to deliver the best service possible to patients.

2. CONTEXT

The London Ambulance Service is a labour intensive organisation. At month 11, the general ledger states a budgeted 4892 wte (actual 4390 wte) workforce. Of this, budgeted 3374 wte (actual 2978 wte) are core front line rostered and non rostered staff.

Stability within the workforce is an essential feature of a fully functioning organisation and whilst some turnover is necessary to ensure there is fresh perspective and is an inevitable feature of career progression, it should be contained at low levels.

At the end of February 2014, from the Electronic Staff Record (ESR) currently staff turnover is at around 14%, with the paramedic rate at 13%. Vacancy rates are at 13% with the paramedic vacancy rate at 19% and sickness absence (as recorded on ESR) is at 6.5% for all staff and 6.2% for paramedics . This compares to turnover within ambulance services in England ranging from 6% to 16%, with the ambulance trusts neighbouring London possessing the highest turnover rates (South Central 15.76%, South East Coast 15.74% and East of England 8.29%).

The annual staff survey (see Appendix Two) has seen an increase in the percentage of staff who would not recommend LAS as place to work, currently standing at 62% compared to an average of 40% for all staff in ambulance services (Picker Survey 2014)

Similarly there has been a rise in the percentage of staff who would be concerned with the standard of care and treatment if a friend/ relative needed currently standing at 35% (2014) compared to an average with ambulance trusts of 23% in 2014.

Evidence from exit interviews and research work undertaken by an external body, 'Connectwell' (see Appendix Three), have provided an understanding of the reason why staff feel demoralised and are leaving LAS. These include:

- Work pressure/utilisation – particularly the utilisation and rostering of front line staff
- Management and leadership including how change and performance are managed and the systems that are used to monitor performance;
- Cost of living in London
- Educational and training support including meaningful performance development reviews/ appraisals
- Welfare and pastoral support for staff
- An imbalance between demand and supply for the service creating unrealistic expectations of the level of service that is possible to provide

It should be noted that whilst emphasis is placed on front line staff and the pressures placed on these staff to deliver increasingly high levels of service, support staff also feel demoralised. A survey of 359 support staff (see Appendix Four) showed that 58% have had no appraisal in the last 12 months and only 23% of the total had a useful appraisal. Importantly 73% said the service doesn't value them.

Evidence suggests that turnover rates particularly in London are likely to remain relatively high and whilst a reduction in turnover to around 10% should be a key focus for the organisation, it is unlikely to reduce to the levels since 10 years ago. The most important issue therefore is to ensure that the organisation has a satisfied and motivated workforce and where people do leave they are, in the main, leaving for positive reasons. Thus much of the emphasis within this strategy is on how staff are managed and engaged within the organisation.

3. HEALTH CARE CONTEXT

During 2014 operational delivery against national standards became increasingly challenged. By the end of February 2015 Red 1 (R1) performance fell to 64.92%; Red 2 (R2) fell to 59.28% and A19 to 92.19%. The Regional Tripartite1 (NHS England London *Report from an External Clinical Review of the London Ambulance Service* Final Report Circulated: 17 December 2014) commissioned a diagnostic review of the key reasons for underperformance. The key findings of the review were that utilisation of the service had increased significantly so impacting on the operational capability of the service. Utilisation levels are driven by the number of Category A incidents, the job cycle time and the number of vehicle hours. When utilisation rates rise, calls to the Trust are held: when this number reaches a certain agreed level the Trust raises the threshold at which it will respond to a call at Surge level. Clinically, this means a reduced level of service to some categories of patients.

Serious Incidents (SIs) and complaints have also risen. Although the causes of these remain unclear; there is evidence that an increased focus on clinical risk management systems in the Trust and increased awareness of SIs could be contributory causes. The proportion of these that relate to delays has also increased.

The Connectwell research commissioned by LAS concluded the perception from all staff is that the supply side (crews on duty and associated infrastructure) no longer bears a good relationship with the demand side (volume and nature of emergency calls for Ambulance services) and a more fundamental review of the future state of the service is required.

4. LONDON AMBULANCE SERVICE CONTEXT IN ADDRESSING RETENTION

4.1 Previous work

Excellent analysis has already undertaken and shared with staff, the feedback from which highlights the following issues that need to be considered in the strategy going forward:

- Managers are affronted at the implication they are 'no good'
- Regular communication with staff is essential; however there is a danger of too many messages
- Timelines need to be added to ensure staff have a sense of what is being done by when
- Attention is disproportionately focussed on front line staff and it alienates other staff
- Most people joined the LAS because they have a genuine belief in what it does and the role they will play

- Staff are unsure of the PDR process (appraisal process) and suspicious of it
- Visibility of directors and SMT members is seen as very important

4.2 Coherency

There has been a mass of data and suggested actions around the Trust that have needed to be pulled together into one coherent plan that we can then share with staff and staff-side. Gaining coherency will ensure that effort isn't duplicated or worst still that people aren't pulling in opposite directions and it recognises the connected nature of the issues LAS faces – engagement, morale, recruitment, employer brand, vision of the service and staff and patient's perception of service quality.

4.3 Specific actions and dates with responsibilities

The key risk with much of the work on retention is that it doesn't move from the conceptual to the practical. We need to ensure there is a plan with specific actions and dates and with individuals named as responsible for the various elements. In so doing we need to be clear about what success looks like and what interim goals we expect to achieve.

4.4 Cultural change

The greatest strength of LAS is the pride staff generally feel (or say they have felt) in being part of the service and therefore the organisation. Whilst turnover may be high, the service enjoys a high number of long serving staff and the pride in the name, the motif and the green uniform is palpable. Sustaining pride in being part of LAS and the service it provides is essential and this should include the corporate social responsibility that the Trust has to educate the public and other health care providers and provide support to other parts of the country or other countries on occasions.

Celebrating success and the 'things that are good around here' – team work, cardiac arrest survival rates, thanking people individually as well as collectively – is essential. A constant theme in concerns raised by staff is the perceived lack of recognition on an organisational and individual basis and this, therefore, is an area that needs to be addressed.

Development of a positive culture includes reiterating and embedding the values and behaviours expected of all staff and ensuring that these are engrained in everything the LAS does. It is clear from leavers' information that pay isn't the main issue (although action is being taken to resolve grade disparity between ambulance trusts and ensuring staff can receive good rates of pay), but how staff *feel* they are treated and concern that they are being 'watched at work'. This needs to start with the executives and cascade throughout the organisation.

The overall situation has resulted in a perception of a negative culture which, in many respects, is around certain behaviours and practices that are seen and experienced as bullying. Incidence level appears medium to high and the negative perceptions seems to be strong and growing.

4.5 Communication with staff.

This is clearly a fundamental issue and considerable efforts have been made to improve communications within the organisation and externally. Nonetheless perceptions of poor communication feature heavily in the Connectwell report. Improving communication is crucial to addressing retention and although some of this is at the organisational wide level, much of individuals' view of communication is between themselves and their immediate line manager. Communicating the retention plan and specific actions will of course be part of the plan. Linked to this is improving the organisation's ability to manage change, including HR and line managers.

It should be noted that key areas of management deemed weakest or inadequate by staff is engagement and change management.

5. RETENTION OBJECTIVES

The Trust's retention strategy focuses on the following eight core objectives.

We will:

- Support you to do your job to the best of your ability
- Support you to balance your home and work life
- Support your health and wellbeing
- Ensure you have the right management and leadership support
- Ensure you can work within the right environment
- Support you to continually learn, develop and progress within the LAS
- Support you to work and live in London – "The London Ambulance Service Proposition"
- Ensure we entice people to work for LAS and come back to work for us

5.1. Supporting you to do your job to the best of your ability

We all come into work to do the best job that we can in the knowledge of what is expected of us, within the resources available to us and the training and understanding that we have received. LAS will put in place specific measures to support you to do your job which include:

- An effective appraisal and PDR systems which is systematically undertaken, is considered helpful to individuals and managers and supportive in understanding individual's training and development needs
- Putting in place a "back to basics" programme so that clinical staff have the equipment they need, including reviewing and improving Personal Issue Kit
- Putting in place a range of staff engagement activities so that you are informed and influencing the work of the Trust
- Introducing a new intranet so that you have all the information you need to do your job
- Ensuring IT systems and processes are fit for purpose
- Commitment to have 90% of the fleet under 7 years old by end of 2016/17

5.2. Supporting you to balance home and work life

We all have home lives and LAS has an obligation and commitment to support you in being able to balance your work commitments with your home life and specific action includes:

- Reviewing our flexible working arrangements to make sure they are effective and maintain the balance between reconciling individual requests with the practicalities of fixed rotas for some staff
- Reviewing our rosters for front line staff to ensure they remain fair and reasonable
- Improving our range of work-life balance initiatives including further publicising the benefits that we have in place including childcare vouchers and holiday play schemes
- Reviewing our HR policies so that we support staff when you have carers responsibilities

5.3. Supporting your health and well being

Work can be stressful and in order to support you to remain healthy, LAS will support the following initiatives:

- Reviewing our managing attendance processes including policy, training and practice to ensure they are simple to follow and that they support you to return to work as quickly as appropriate

- Reviewing our occupational health service, putting place a new service that provides support, advice and care when and where you need it
- Introducing stress management programmes so that you have the things you need to help you deal with stress
- Introducing new procedures for annual leave and rest breaks so that you get the rest you need (see section 5)
- Taking a zero tolerance approach to bullying and harassment and reviewing our processes to make sure it is easy for you to alert us to issues, including drawing on the recent evidence of focus groups
- Working with commissioners to bring down the utilisation rates of our clinicians
- Ensuring there is adequate serious incident support (following a fatality or similar experience of intensive trauma)

5.4. Ensuring the right management and leadership

Managing is a difficult and strenuous job and requires skill, experience and training. LAS will support managers, including those aspiring to management positions, to gain the skills and aptitudes necessary to successfully manage and lead and provide the right support for our staff. Specific actions include:

- Introducing a new management structure for Operations
- Introducing team leaders with an initial maximum of 16 staff with 50% of time on line management
- Developing management and leadership competencies and putting in place comprehensive and effective management and leadership development training and programmes which will define what we need to continue to do and what we need to do differently in future in order to retain staff
- Reviewing systems for performance management to ensure it is fair, reasonable, appropriate and effective i.e. performance appraisals, sickness absence management, line management relationships, forms and conversations, and reward.
- Holding management conferences at least twice a year to support the development and set the focus of managers
- Devolving responsibility and accountability to our managers for, amongst other things, staffing, absence and resource management
- Ensuring there is visible leadership so that you can meet with and speak to leaders in the Trust

- Involving staff in the appraisal of their managers including formal and externally facilitated 360-degree appraisal for directors and senior managers and methods of ensuring staff can contribute to the appraisal of their manager at all levels

5.5. Ensuring you can work within the right environment

People join the London Ambulance Service because of a genuine belief in what the service does, the role they will play and the pride they have in being part of a fantastic organisation. We want to sustain this feeling and rekindle it where it has waned.

- We will embed the organisational values and the behaviours underpinning these values and ensure that they are reflected in everything we do from recruitment, induction, appraisal, training and how staff are treated and treat others
- Ensure that the organisation has the capability to manage change effectively with the least detrimental effect on staff as possible
- We will continue to invest in our corporate social responsibility, attending schools, other health care providers, other countries and major conferences to maintain the pride that we all have in the service
- Put in place a range of recognition activities and awards so that we recognise achievement, commitment and clinical excellence and celebrate success
- We will address issues regarding the fabric of the working day for operational staff, eg breaks and rest periods

5.6. Supporting you to continually learn, develop and progress within LAS

Part of LAS's commitment to staff is the learning, development and training that will be provided to enable you to do your job to the best of your ability and progress within your career.

- Continue to development our new clinical career structure outlining a clear development and progression path
- Publish an annual clinical and non-clinical training plan outlining the range of development opportunities available
- Work with the Local Education and Training Boards (LETBs) to increase educational investment in the London Ambulance Service with a commitment to secure additional funding in 2015/16
- Introduce annual Trust-wide educational and training bursaries
- Review induction to ensure the process is 'fit for purpose' and ensure staff are able to experience other parts of the ambulance service within their orientation period

- Review and publish opportunities for coaching and mentoring
- Review and improve our talent management programme

5.7. Supporting you to live and work in London – "The London Ambulance Service proposition"

There is an urgent need to review our overall employee proposition to include the provision of a range of pay and non-pay benefits that reflect the costs of living in London.

- Introduce a range of non-pay benefits in place which help you save money – lease cars, cycle to work, computer vouchers, mobile phones - and review our existing benefits
- Continue to work with the London Health Commission on cost of living support programmes for NHS staff
- Work with local London companies to negotiate reductions for you on their services or products
- Work with housing associations and others to support you with affordable housing
- Create a new working partnership with staff side partners to address areas they have raised as causes of concern

5.8. Ensure we entice people to work for LAS and come back to work for us

Whilst LAS is actively working to reduce current turnover rates, it is recognised that higher levels of turnover are a feature of organisations particularly those in London and involved in health care, and therefore maintaining a constant stream of recruitment is essential.

- Creating of a bespoke 'welcome home' package and offer to former colleagues to come back to the service
- Encourage people who do not successfully complete paramedic training to take on other roles within LAS
- Reviewing our recruitment of staff (currently underway) and how staff are inducted

6. SUMMARY OF CURRENT ACTION BEING TAKEN

A comprehensive and fully costed Action Plan will be monitored by EMT.

Objective	Priority/ work underway[1]	Action	Responsible Manager and Director	Date	Success criteria
1. Supporting you to do your job					
Personal issue kit reviewed	High (green)	Following approval of the new policy last year, the first items of kit have been issued. SMT recently approved moving this to "business as usual" with items of kit being identified and approved as personal issue on a phased basis.	ADO Fleet and Logistics (Dir of Finance and Performance)	June 2015	All front line staff have the personal kit issued as required Position to be reviewed in June 2015
Staff engagement strategy	High (green)	A detailed communications and engagement strategy was agreed by the Trust Board in June 2014. This emphasises importance of line management support and communication, introduced Team Talk and feedback reports to EMT in September, staff survey results to EMT with action plan, LiA Facebook page introduction, local Facebook pages being constructed, introduction of webinars on key corporate issues, Tuesday is Newsday – reduction of multiple channels of communication – now all through RIB, use of video from CE and others on corporate issues, good news plan to get positive news out to staff, staff recognition group formed – created and delivering VIP awards in	Dir Communications and Engagement	ongoing	Staff evaluation would be positive. Team Talk Audit – next financial year will show good coverage and messages received by large numbers of staff. Staff TT feedback reports shown to influence EMT decision- making. Strong staff evaluation of other communications initiatives.

[1] Priority – high, medium, low; Work underway – green (significant work started), amber (some work started);

		April, "You Said: We Did" with photo in RIB each week.			
New intranet	Medium (amber)	New intranet supplier procured. Currently working with staff focus groups to design best interface and content, including internal social media functions for better real time engagement with staff. On schedule for delivery in the Spring.	Dir Communications and Engagement	Q2	Staff find it easier to engage with the organisation – shown through positive evaluation of the intranet. Inter-active social media functions are more helpful in analysing themes of staff concerns.
90% of fleet under 7 years old by 2016/17	High (amber)	Part of the review of the Capital Investment Strategy	ADO Fleet and Logistics (Dir of Finance and Performance)	TBA	90% target achieved.
2. Supporting you to balance home and work life					
Review flexible working arrangements	Medium (amber)	HR with operational management team reviewing current practices and policies, make changes to policies and approach and implement these Flexible workers policy was reviewed and updated in 2014.	Asst Dir HR (Dir of Operations)	March 2015	Flexible working requests reviewed and considered, decisions made and conveyed
3. Supporting your health and well being					
Occ Health tender and service	High (green)	New OH service to deliver core NHS services which meet the DH standards, address employee and managers needs and include health and well-being activities. New service to provide self-service health and well-being tools; 'Every Contact Counts Approach' to consultations; reporting which identifies areas and issues which need to be addressed to improve the health and well-being of the workforce; staff able to access more guided or self-managed	Asst Dir HR (Dir of Transformation, Strategy, HR)	April 2015	Contract in place with new provider which includes survey monkey assessment at 6 and 12 months

		health options			
Stress management	High (amber)	Range of stress management support and initiatives already available. Review management training Well-being and retention officer appointed (secondment). Review resourcing of staff support team	Asst Dir HR (Dir of Transformation, Strategy, HR)	March 2015 April 2015 March 2015	Reduction in sickness absence rates from 6.3% currently to 5%
Support for staff in dealing with serious incidents	Medium (green)	Peer Support (LINC), OH and counselling all in place. TRIM assessments undertaken.	Asst Dir HR (Dir of Transformation, Strategy, HR)	June 2015	Additional LINC workers have been appointed and more staff to receive TRIM training.
4. Ensuring the right management and leadership					
New management structure	High (amber)	New line management structure to be implemented; positions in new structure appointed to and managers inducted into new roles and ways of working	Head of Operational Business Change and Innovation (Dir of Operations)	Q2	Effective operational management structure Improved line management of staff
Introduce new team leaders	High (amber)	195 funded posts available with 50% clinical: 50% management split, from 70:30.	Deputy Directors of Operations (Dir of Operations)	From 1 Jan 2015	Improved management of staff as reported by staff and seen in staffing metrics
Hold management conferences	Medium (green)	Regular management conferences to be held to support line managers and ensure they are cognisant of latest thinking	Dep Dir Transformation Strategy (Dir of Transformation, Strategy, HR)	Annual plan in place	Review effectiveness through participant feedback Improved staff awareness of organisational strategy and latest thinking
5. Ensuring you can work within the right environment					
Recognition - Awards	Medium	Staff recognition group formed out of LiA work. This	Dir Communications and	ongoing	Evaluation of VIP awards

Schemes	(green)	group made up of frontline staff proposed new staff awards scheme to recognise staff and improve morale. VIP Awards have been launched in Jan – awards evening in April. Thank you card scheme also introduced. Other long service and retiree recognition also reviewed and consolidated. Integrate values into the awards.	Engagement		after the event – to ask staff their views. The aim is for staff to give us positive feedback and help us improve them for next year.
6. Supporting you to continually learn, develop and progress within LAS					
LETB investment	High (amber)	Ensure adequate investment is secured from the LETB to support the Trust in providing education and training opportunities for staff	Dir of Transformation, Strategy, HR	May 2015	Investment secured 2015/16
7. The London Ambulance Service Proposition					
Review salary sacrifice schemes	Medium (amber)	Lease car scheme awaiting EMT/DoF approval.	Wellbeing and Retention Officer (Dir of Transformation, Strategy, HR)	March 2015	Improved retention as noted in 'exit interview' reports.
8. Entice people to work at LAS					
Recruitment approach and processes	High (green)	New recruitment processes and approach to become embedded in the way the organisation does things	Senior HR Manager (Dir of Transformation, Strategy, HR)	Summer 2015	New process in place NHS jobs fully utilised for recruitment

7. MEASURING SUCCESS

Success will be measured through the achievement of the objectives and actions as outlined in the plan. It will also be measured through the following qualitative and quantitative metrics.

Balanced score card	Current position 31.12.2014	One year Target 31.3.16	Two year Target 31.3.17
Turnover (all staff)	14%	11.8% (10.7% in month by March 2016)	10% (9.9% in month by March 2017)
Turnover (paramedic staff)	13.6%	11.2% (10.6% in month by March 2016)	10% (9.8% in month by March 2017)
Vacancy (Variance) rates (all staff)	13.5%	10%	10%
Vacancy (Variance) rates (paramedic staff)	21.3%	10%	10%
Active Vacancy Rate (paramedic staff) i.e. those actively recruiting for	To be calculated and targets set	To be calculated and targets set	To be calculated and targets set
Stability rates	87.9%	92%	92%
Sickness absence	6.3%	5.8%	5%
Appraisal rates	37%	60%	80%
Family and friends test - recommend the service as somewhere to work	22%	35%	50%
Response to staff survey - recommend as somewhere to work	38%	45%	55%

Balanced score card	Current position 31.12.2014	One year Target 31.3.16	Two year Target 31.3.17
- recommend as somewhere to be treated	65%	75%	85%
- dissatisfied with how work is valued	64%	55%	45%
- response to the survey	36%	40%	50%
Local Pulse survey data to be included			

NB: Trajectories to achieve targets have been set

Mark Gammage

18th March 2015

Appendix One: Staffing Metrics

- Turnover rate – calculation: headcount of leavers over last 12 months divided by average staff in post headcount over that period. These figures are available from ESR and are usually accurate after payroll has been run. The single month annualised turnover rate is volatile and unlikely to add significant value, so a rolling 12-month average is used to assess trends.
- Paramedic turnover rate – as above, but for paramedic staff only.
- Voluntary turnover rate – as for turnover rate, but only counting those who are recorded on ESR as voluntary resignations. This gives an indication of the turnover we are likely to be able to influence.
- Voluntary paramedic turnover rate – as above, but for paramedic staff only.
- Trust vacancy (variance) rate – Difference between funded establishment for substantive posts (excluding reserves, cost improvements, etc.) and substantive staff in post (both as reported through the general ledger) expressed as a percentage. General ledger should be used in order to retain consistency. The value of this statistic is in knowing the scale of the vacancy problem.
- Paramedic vacancy (variance) rate – as above, but for paramedic staff only.
- Active vacancy rate – the vacant posts that the Trust is actively seeking to fill (i.e. not including posts which are in the establishment and unfilled but which the manager does not wish to fill because they have the role covered on the interim or wish to use funding differently on the short-term etc)
- Stability – proportion of staff in post 12 months ago who are still working for us now. Calculated from staff in post figures for available on ESR, staff with greater than 1 year service at report date as a proportion of staff in post 12 months ago. This gives an indication of whether the staff leaving are those with long or short service and can highlight issues with induction and orientation.
- Paramedic stability – as above, but for paramedic staff only.
- Monthly numbers – gross numbers of staff leaving under each of the following categories: total leavers, voluntary leavers, retirements, dismissals. Note that short-term contract ends and deaths are not expected to be collected. All these headcount figures are available through ESR and are usually accurate after payroll has been run. Monthly starters can also be reported. The value of these numbers is in highlighting peaks and troughs, and giving an idea of the types of numbers, which will need to be recruited on a regular basis.
- Monthly numbers, paramedics – as above but for paramedic staff only.
- Sickness absence rate – available from ESR.
- Paramedic sickness absence rate – as above, but for paramedic staff only.
- Age profile / age profile for paramedics – able to produce this from ESR, useful to predict long term changes in paramedic staff from staff retiring. It is suggested that this be produced quarterly

Appendix Two: Staff Survey-2014

There has been an increase in the percentage of staff that would not recommend the Trust as a place to work with 36% in 2012, 52% in 2013 and 62% in 2014. The figure for those in A&E Operations was 57% (2013). These figures compare with an average of 40% for all staff in ambulance trusts surveyed by Picker (2014).

There would appear to be a similar increase in the response to the question concerning if a friend/relative needed treatment that they would not be happy with the standard of care provided by the organisation with 16% in 2012, 23% in 2013 and 35% in 2014. The figure for those in A&E Operations stating that they would not be happy with the standard of care was 26% (2013). These figures compare with an average of 23% for ambulance trusts (2014).

It should also be noted that positive responses to these questions – recommending the trust as a place to work and recommending the trust as somewhere to be treated – have deteriorated in other ambulance trusts, although the scores at LAS remain worse than average.

Staff sense of dissatisfaction concerning how their work is valued increased between 2012 (56%) and has stayed steady at 68% in 2013 and 2014. The figure for those in A&E operations was 72% (2013) compared with 55% across other ambulance services (2013).

Friends and Family Test – Quarter 2 (2014-15)

The Friends and Family test, which is published three times a year and supplements the Staff Survey (which is done in the third quarter) appears to be in line with the results of the full survey. The survey is carried out voluntarily; 247 people (approximately 5.5% of the workforce) responded to this and are not asked to identify their job role. Out of those who responded on how likely they would be to recommend the Service to friends and family as a place to work 22% said that they would do so, whilst those who said that they would not be likely to do so was 68%.

These scores were the worst of all trusts (including ambulance trusts) that responded. It should be noted that ambulance trusts in general appear to provide a more negative response than other trusts, the most positive ambulance trust response saying that they would be likely/not likely to recommend as a place to work was 71%/11% and the least positive (other than the LAS) 24%/63%. It should also be noted that one ambulance service appeared not to return a response.

Appendix Three: Connectwell Summary

1. Trust & Monitoring Review

There is an urgent need to review all of the monitoring activity encountered by all staff groups. Included in this a specific focus on how feedback is received (mechanisms and impact). The research from Connectwell strongly suggests that trust has broken down and that there are too many inappropriate monitoring systems. The review should focus not just on the mechanics but instead the impact and efficacy of the systems, looking for duplication and negative consequences. Some of this is about management style (which is addressed separately) but some also about the current systems that are in place.

2. Employee Proposition Programme

With staff involvement there is room and opportunity for a review on the overall employee proposition as a precursor to a review on recruitment and engagement. This programme should be holistic and include what might be considered as the more basic or hygiene factors as well as more subtle attractions, i.e. Travel to / from place of work, accommodation and cost of living, welfare and pastoral care. Data from the 'Friends & Family' scores and the annual NHS staff survey can be incorporated into this work.

3. Wider Recruitment & Retention Strategic Debate

There is a nested set of challenges for London as an Ambulance Service but it is not alone and these issues don't happen in isolation. The EMT need to champion and host a cross sector debate with other Ambulance and NHS Trusts, Dept. of Health and others on Paramedic and other Ambulance Service staff. This debate should encompass a sharing of some people data and some basic statistics on Ambulance Service Staff. The objective would be to embrace the reality of this not being solely a LAS issue and therefore recognising that some of the solutions may be co-owned or come from outside of the service.

4. Restructuring Practices Review

A very significant impact on retention and engagement more generally is felt from how restructuring is done. This is regarding both changes to the overall organisational design and structure as well as the change at an individual role level (introduction, removal or change of role and responsibilities). The research suggests that the true impact of how the LAS conduct these changes is not well understood and is detrimental. Create an action group to review and implement positive changes to how restructuring happens as well as how people are supported in their new roles.

5. Individual Performance Monitoring Review (Competency)

In additional to a review of monitoring mechanisms we'd recommend a look at 'how' monitoring systems and feedback mechanisms are handled and implemented at the personal level. Confidence in the capability of the managers who enact the monitoring has been questioned. Perceptions about the performance and ability here are critical.

As part of this recommendation it would make sense to look at how performance management works, i.e. Performance appraisals, sickness absence management, line management relationships, forms and conversations, and reward.

It is recommended that where managers have responsibilities involving the application of rules and standards, their level of discretion and their ability to apply discretion objectively be reviewed. We are advocating more discretion in some areas and an objective look at this aspect of managerial capability.

6. **Roster – Working Day Task Force**

At the most basic level there seems to be a system flaw in the fabric of the working day for operational staff. Some key areas must be included in the change plan that are deemed critical.

- Breaks (and the payments associated with missing break(s)
- Physical 'work space' & 'rest space' – LAS territory for rest and break purposes outside of an Ambulance
- Minimum Rest Periods between shifts (including review of commuting times from base to home)
- Shift finish location Practices (the unpaid time associated with finishing the last job away from official base)
- Time for debriefing

7. **Emergency Services: Supply & Demand Review**

It appears that the perception from all staff is that the supply side (crews on duty and associated infrastructure) no longer bears a good relationship with the demand side (volume and nature of emergency calls for Ambulance services). They are wondering when (not if) an Executive or Politician will break ranks and call for a more fundamental review of the future state of the service.

8. **Communications, Engagement, and Change Management Task Force**

There appears to be the need for an urgent review and change plan in this area judging by the force of evidence from this research. One of the biggest capability areas deemed weakest or inadequate by staff is both engagement and change management.

Review the engagement model and strategy.

Review the change profile of the organisation (change landscape) and map to existing capability and capacity. Create an investment plan to strengthen this area.

9. **Behaviours & Individual Performance Management Review (incl. Bullying and Harassment)**

The overall situation has resulted in a perception of a negative culture is many respects around certain behaviours and practices that are seen and experienced as bullying. Incidence level appears medium to high and the negative perceptions seems to be strong and growing.

Conduct research into this area paying attention to the cultural norms and how the organisation responds to incidences.

Review of the Whistle Blowing Policy and a modelling exercise of the actual scale of the real problem (including unreported)

11. Professional Development and Training Review

Professional development is a contentious issue for the LAS. This is connected to the overall employee proposition and arguably has a particularly high impact on retention.

12. Welfare & Pastoral Review

The overall wellbeing and care of employees has been questioned throughout commentary of the retention project (including acknowledgement of some excellent provision). Alongside looking at 'who' the LAS is to any given individual (line manager or other) we recommend a wider look at how staff feel cared for both physically and emotionally.

Appendix Four: Results from a survey of support staff

How likely are you to recommend the organisation to friends and family if they needed **care or treatment?** 54% recommend; 24% not recommend

How likely are you to recommend this organisation to friends and family as a **place to work?** 22% recommend; 68% not recommend

Results for the previous quarter:

How likely are you to recommend the organisation to friends and family if they needed **care or treatment?** 46% recommend**;** 33% not recommend

How likely are you to recommend this organisation to friends and family as a **place to work?** 15% recommend**;** 71% not recommend

The results show a slight improvement from last time, however, we are still likely to be near the lower end of the scale nationally and have therefore prepared an 'if asked' response for media.

The survey was conducted with 359 support staff with a good spread of age, LOS and gender

Highlights include:

- 58% have had no appraisal in the last 12 months
- Of the 42% that did, only 40% said it wasn't useful – so if I read this right means only 23% of the total have had a useful appraisal
- 51% have no objectives
- 69% have no PDP
- 73% said the service doesn't value them (although 65% consider their manager values them) – interesting reflection; is this managers 'blaming' the service?

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**24th March 2015**
Document Title:	**IM&T strategy**
Report Author(s):	**Executive Management Team supported by PA Consulting**
Presented by:	**Andrew Grimshaw**
Contact Details:	**Andrew.grimshaw@lond-amb.nhs.uk**
History:	**This paper represents the final presentation of the IM&T strategy for agreement. It follows on from previous presentations seen by EMT**
Status:	***For approval***

Background/Purpose

This paper represents the final draft of the IM&T strategy for review and agreement by the Trust Board. It is follows on from discussions with staff across the Trust together with presentations and discussions at EMT, and reflects those discussions.

The Strategy recommends that LAS retains the aspiration to be a technology leader but indicates that current demands mean that in the short term the focus needs to be on current service provision and planning and supporting refreshing infrastructure. The strategy does not make specific recommendations regarding individual systems, but rather it should be seen as setting out a route map of the work that needs to be undertaken to achieve this. Various actions and timelines are indicated to support this work. The IM&T Departments are already working to establish the detailed action plans to support this..

The Executive Team reviewed and agreed the IM&T Strategy should be recommended to the Trust Board for approval when it met on 18th March 2015.

Action required

The Trust Board is requested to approve this strategy.

Assurance

Earlier iterations of this paper have been discussed at EMT and the Audit Committee. A small group of executive directors have also been more directly involved in its development.

Key implications and risks arising from this paper	
Clinical and Quality	**X**
Performance	**X**
Financial	**X**
Legal	
Equality and Diversity	
Reputation	
Other	
This paper supports the achievement of the following 2014/15 objectives	
Improve patient care	**X**
Improve recruitment and retention	
Implement the modernisation programme	**X**
Achieve sustainable performance	**X**
Develop our 111 service	
Simplify our business processes	**X**
Increase organisational effectiveness and development	**X**

IM&T STRATEGY

2015 - 2020

Trust Board

24th March 2015

Executive Summary

London Ambulance Service (LAS) has historically led the field in the provision of innovative and high quality Information Management and Technology (IM&T) services and capabilities.

In the last 18 months the IM&T function has been hit by a number of high profile IM&T system and service failures that has raised concern within the LAS executive team. This is against a backdrop of a business that strongly needs further IM&T enabled change to improve.

The LAS business has identified a range of new IM&T capabilities and services that must be implemented over the coming years in order to deliver future ambulance services, ranging from front line eAmbulance capabilities to new HR services. In addition to the pressure from the internal business, there are a number of external constraints that are quickly approaching – the most important of which is the Airwave replacement – which will have a substantial impact on IM&T requirements.

The IM&T department have estimated that they currently focus 75%-80% of their resource time to keeping the existing operation running. Only 20%-25% of resource time is dedicated to new projects and change. The greater level of change that the business is requiring from the IM&T function is having an impact on both the day to day operations and the perception of IM&T as a function.

Through the development of this strategy, the current position of IT has been better appreciated. The strategy development process has provided a better view of the current situation and a path forwards.

This strategy is designed to provide a vision for IM&T to focus resource and effort in the coming years and provide a rough framework for IM&T to prioritise and engage with the business.

The Executive Management Team within LAS have agreed that the IM&T strategy must be to phase improvement over time.

The EMT continues to have an aspiration for LAS to be a world leading, innovative ambulance service, described as in the following Scenario:

A leading clinical organisation - LAS as a sector and technology leader. *LAS would act as a portal for all urgent patient care and actively look to take on new business, for example further 111 regions. This will be a truly transformative situation where care quality improvement is central.*

However, the EMT has also recognised that the capital investment and the organisational change capability required to achieve this are not in place. A more realistic level of service is required, more in line with the following Scenario:

An efficient logistics organisation - LAS only taking on a selection of projects to improve performance. *Projects would only be implemented where there would be an operational performance improvement. These would include only those capabilities that exist today but improved to be more efficient.*

The EMT has therefore committed to target the latter scenario of being an efficient logistics organisation in the next 12-18 months with the longer term ambition to become a leading clinical organisation.

01

CURRENT STATE OF IM&T

Current state of IM&T

The following slides summarise the likely demand for change enabled by IM&T over the coming years. Detail on the current state of IM&T and the challenges to overcome is contained within the following documents:

- **IM&T Review Report (March 2014) –** original review report showing a list of recommendations to address IM&T risks; *many of which are still outstanding*
- **IM&T Review Refresh Report (January 2015)** – provides a detailed review of IM&T across resilience, value for money and efficiency, complexity and fit for business need.
- **IM&T Strategy Background Research document** – provides the background research for the strategy, including business operating model, business relationship with IT, financial analysis and the current IT estate.
- **IM&T Strategy EMT update 120215** – provides information on the LAS business drivers, external (national and regional) constraints and the key challenges the business has faced with IM&T to date.
- **IM&T Strategy EMT update 250215** – provides a budget analysis and detail on the future scenarios and implications on IM&T and the business.

We discovered a number of issues to address in IM&T in addition to the resilience points raised previously

Business engagement

- **Effective communication** - there is a lack of communication on issues, such as updates for email outages. Messages can be unclear and conflicting messages, such as using technical language and recalling announcements.
- **Business engagement** - engagement to understand current and future business initiatives and needs is lacking, along with understanding the likely benefits before requesting IT change, formal business requirements capture, communicating the start of a project, business change and training.
- **Service desk** - the service desk is frequently not the first point of call, resulting in IM&T staff being distracted from resolving issues. When requests are submitted they are not always shared with the appropriate IM&T area.
- **Single point of contact** - there is a lack of a single point of contact to resolve an issue, in that staff are passed between multiple people within IM&T.

Service management

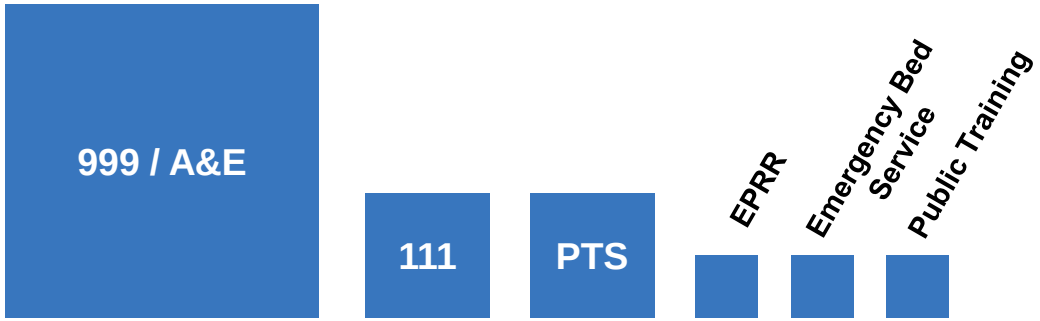
- **Service Level Agreements** – SLAs have not been clearly communicated and agreed with the business.
- **Service availability** - The IM&T department thinks in terms of systems availability rather than service availability, for example monitoring individual components of the emergency dispatch solution rather than the overall service.

Delivery capability and internal management

- **Delivery capacity** - IM&T has a low delivery capacity and thus longer timescales can cause the business to procure their own solutions.
- **Tasking within IM&T** - there is no overall, single comprehensive view of the projects and activities IM&T is undertaking. Task delivery is driven through objectives rather than formal control and reporting progress. Project and task work is not prioritised with or by the business, leading to the perception that IM&T is prioritising its own needs over the business.
- **Mid-term investment strategy** – There is no mid-term investment strategy leading to late funding requests for projects. There is also no annual refresh budget for IT, so capital spend for refresh is not an ongoing activity and comes in chunks.
- **Escalation** - Issues within IM&T are not effectively escalated, particularly around service management and service desk. For example, the increasing number of unresolved tickets month on month has not been escalated.

The IBP sets out the key business changes required which will require support from IM&T

The Integrated Business Plan (IBP) outlines 6 key service areas of LAS – the diagram below demonstrates an approximate scale of the respective priorities as shared by the business.



Key business changes (from IBP)

- Intelligent conveyance
- Development of existing NHS 111 services
- Reviewing our clinical triage system
- Development of a new transport service to transport less seriously ill patients to the appropriate healthcare service
- e-Ambulance
- Estates review
- Clinical education and standards
- Fleet replacement

Key needs from IM&T

Stabilising – including storage infrastructure and email	**Refreshing**– Including corporate applications, assets and contracts	**Automating manual tasks**– including timecards, vehicle rostering and electronic forms	**Innovating** – including enhanced MDTs, career management, eLearning, video to the control room and HR self-service

From our interviews, there are a wide set of other capabilities required by the business in addition to the IBP

Stabilise

- Storage infrastructure
- Reliable email
- Single point of contact with IM&T

Additional drivers:
- Governance
- Decreased time to recovery

Innovate

- MDTs for bikes
- Mobile email, training
- Faster and better-routing SatNavs
- PDAs for supply delivery drivers
- HR career and training management software
- Single view of LAS staff
- Show Ops the art of the possibility with technology
- eLearning and LAS academy
- Vehicle equipment monitoring solution
- Enhanced MDTs
- Decision support tools
- Video to the control room
- MDT lite for private ambulances, bicycles, pedestrians and CFRs
- Apps for personal devices
- HR self-service
- Apps for health and well-being
- Integration between vehicle management, ledger and parts
- Trackers for ambulances

Automate

- Timecard
- Annual Holiday booking system
- Electronic forms including ePRF and safeguarding forms
- Mobile directory of service - pathways information for all of London
- Vehicle rostering software/vehicle availability software
- Automatic vehicle report generation
- Enhanced interoperability between LAS IT and others around London
- Payroll system that accommodates the incentives offered
- Operational demand forecasting
- Board financial reporting
- Notify GPs of 999 calls
- Rio for mental health notes

Refresh

- Facilities Management Software
- Card Access System
- Multi-functional office devices
- Training center IT
- Interactive Policies
- Salary sacrifice options
- Operational demand forecasting
- Next generation triage

Furthermore, there are several external programmes and policies which will require an IM&T response

There are a range of key external drivers that will put pressure on LAS and IM&T in particular and include:

National technology programmes
Ambulance services 999 connectivity (AS999)
Multi-agency Information Transfer (MAIT 999-999)
Ambulance services 111 connectivity (AS111)
Emergency Services Mobile Communications Programme (ESMCP)

National and regional policies
Integrated Care Services – “Whole System Care”
Agency interoperability
Alternate commissioning models – driving alternate targets
Safeguarding policies
NIB – paperless NHS

IM&T will have no choice but to respond to these changes.

02

TARGET STATE AND ROADMAP

To align IM&T's ambition with the wider strategy, we've characterised four scenarios for LAS's development, in decreasing order of cost

Scenario 1: A leading clinical organisation - LAS as a sector and technology leader

LAS would act as a portal for all urgent patient care and actively look to take on new business, for example further 111 regions. This will be a truly transformative scenario where care quality improvement is central.

Scenario 2: LAS transforming itself through larger projects

A portfolio of larger projects would be implemented, looking at the business benefit of each. These would be new capabilities and projects that do not exist today.

Scenario 3: An efficient logistics organisation - LAS only taking on a selection of projects to improve performance

Projects would only be implemented where there would be an operational performance improvement. These would include only those capabilities that exist today but improved to be more efficient.

Scenario 4: Minimum viable service - LAS running largely as-is in terms of capability, with focus on stability

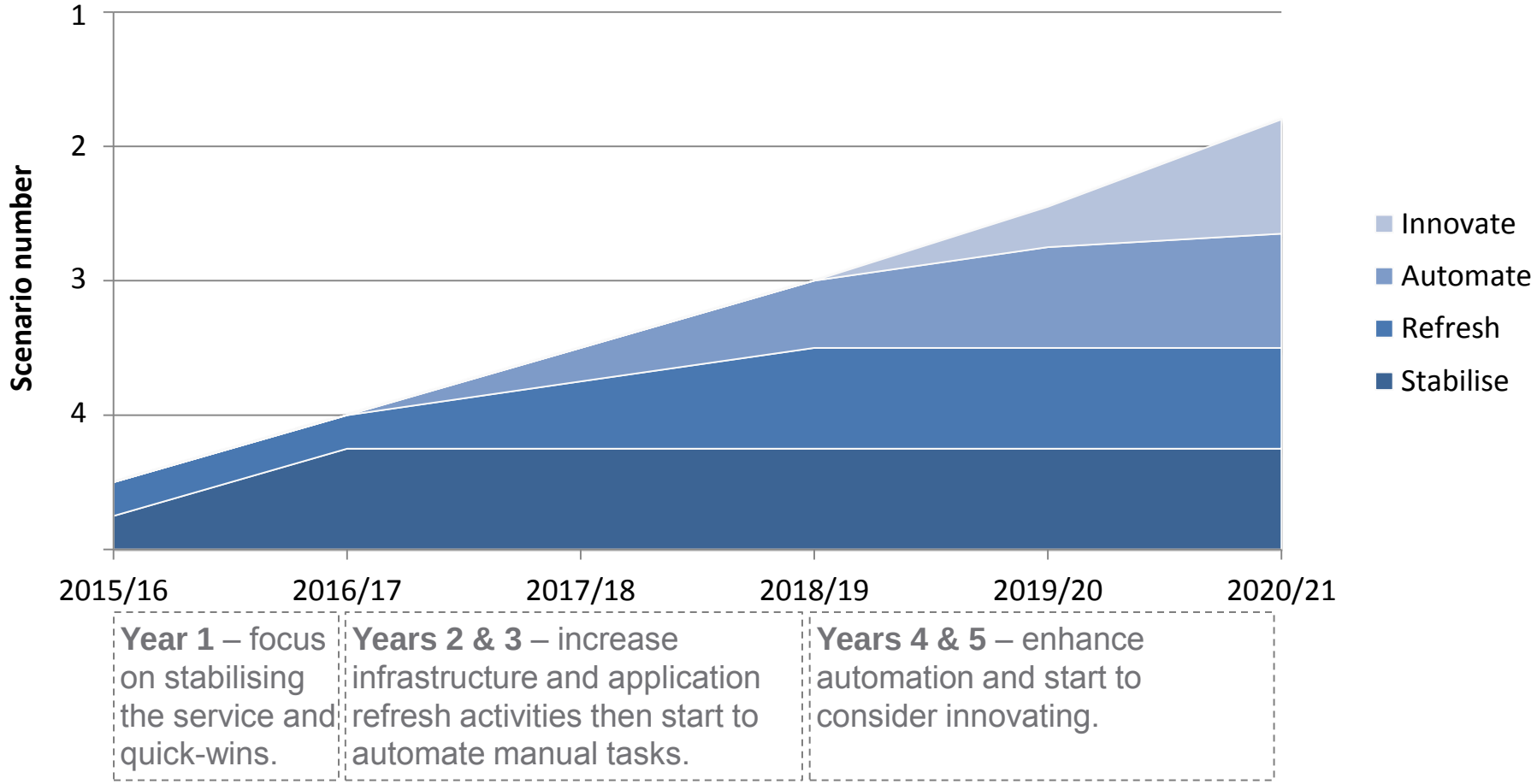
IM&T would operating as a low cost support function and provide stable services to the business.

The choice of scenario also has organisational and cost implications

	Organisational	Cost
Scenario 1: A leading clinical organisation	Truly transformational; including all of e-Ambulance services and focus being on the highest quality of care and most efficient services. Very substantial organisational change and growth required.	• All of the Capital budget will be required (more than £68MM over 5 years) • Additional organisational change will be required, potentially increasing run rates by 50%
Scenario 2: LAS transforming itself through larger projects	IM&T function grows to support more substantial change and is reorganised around projects of work to support new activities. Organisation see substantial improvements not just within operational performance but also within quality of care delivery.	• Substantial capital spend including substantial parts of e-Ambulance and future control centre upgrades and changes (approx £30-40MM over 5 years) • Increasing run by 25% to support new programmes
Scenario 3: An efficient logistics organisation	IM&T function is reduced in line with trust wide cost savings of 5% and reorganised to meet some small change programmes. Organisation see improvements in resilience and sustainability and some improvements in operational efficiency but no new quality of care improvements.	• Small amount of additional capital spend on efficiency programmes only (approx £10-20MM over 5 years) • Reduce run rates by 5% year on year
Scenario 4: Minimum viable service	IM&T function is reduced in line with trust wide cost savings of 5% and reorganised to be a pure support function centred around the resilience of IT. Organisation see improvements in resilience and sustainability but no new features or IT capabilities.	• Capital spend only on “Sustainability and Resilience” reduced to required programmes only (approx. £5-10MM over 5 years) • Reduce run rates by 5% year on year

The EMT aspire to reach scenario 1. Given budgetary constraints and technical debt, the foundations will need to be set before moving towards this.

The service offered by IM&T will improve over the 5 year period, focussing initially on stabilising and moving towards innovating. For further detail please refer to the Strategy Roadmap.



Year 1 – FY15/16

During year one IM&T will focus on stabilising the service provided to the business. This will include both the resilience of the technology and the support provided.

Business

- Respond at the minimal level required to drivers from outside LAS. Review & enhance the proof of Concept Board to capture and prioritise business needs
- Rationalise the service portfolio by cutting low priority services, freeing capacity for additional services in future
- Gain business buy-in to focus on stabilisation
- Prioritise business requests for future implementation and understand the resource and capability required to deliver
- Select quick-wins to improve confidence in IM&T and deliver early benefit

Technology

- Agree the strategic roadmap of business and technology change that supports achieving "stability" as agreed by the EMT
- Invest time and funding in improving infrastructure resilience
- Improve the service provided to the business through the service desk, both speed of resolving issues and the quality of communication
- Start to refresh key end-of-life infrastructure and applications
- Define the enterprise architecture of today and describe the required future state

Management

- Understand what is being delivered in IM&T in both projects and business-as-usual activity
- Set KPIs to monitor the improvement in performance and put in place a process for making these visible to the business
- Examine the IM&T operating model and org structure to ensure suitable skills and resilience are in place
- Define a robust financial plan for Year 1 and beyond
- Address the priority capability gaps in Strategy, Enterprise Architecture, Project Management and Business Relationship Management

There are also three cross cutting areas:

Managing the service - KPIs should be agreed with the EMT and progress against these made visible. This governance structure should also prioritise IM&T activity and new requests to align with business strategy on an ongoing basis. The procedure for escalations should be defined and agreed. Governance should also ensure that it is clear what the IM&T team are working on at any point in time.

Governance structure – A defined governance structure should agree the strategy, prioritise project delivery on an ongoing basis and manage alignment with the strategy business view.

Project engagement – All projects should be owned by the business. Definition and implementation of projects including IT should be performed as a joint activity between the business and IM&T, with the business owning the budget. This will ensure that the business are aware of the benefits, input to the requirements and the appropriate business change and training is carried out. IM&T will innovate to give ideas then provide options and costs to meet the business' requirements.

There are a number of actions which could deliver rapid benefits

Action	Benefit
Implement Business Relationship Management within IM&T. Each should align to an LAS organisational area, attend planning meetings, service reviews and commence design of Service Level Agreements.	Improved relationship between IM&T and the business and a single IM&T point of contact for the business.
Implement self-service with the Service Desk to improve processing of basic calls and voice services.	Streamlined call handling and lower support cost.
Implement System Centre Configuration Manager such that a complete picture of the infrastructure is available and Component Failure Impact Analysis (CFIA) can be undertaken prior to changes being made.	Reduce risk of infrastructure changes being made.
Basic CFIA process to determine critical infrastructure points of potential failure. The initial target should be the email infrastructure.	Target infrastructure improvements to reduce risk of failure.
Address critical audit findings and address network and security issues. Prevent deployment of software other than through controlled processes managed by IM&T.	Reduced security risk and potential negative impact on operations.
Create a basic capacity plan across all domains (business engagement, applications, infrastructure and support).	Identify and address areas where capacity is running out before these have an operational impact.
Cease nugatory/low value activities and those that don't support stabilisation.	Create capacity within IM&T to work on new projects requested by the business.
Refocus IM&T staff on controls and processes – determine the urgent versus requested changes	Greater control over IM&T activities to optimise use of time and improve delivery.
Create specific, measurable, achievable, realistic and time-bound objectives for all IM&T areas.	Buy-in from IM&T staff for improvement and clear direction to reach business goals.
Deliver current changes that add value or visibility in a professional manner.	Improve business confidence in IM&T and provide early business benefit.

Years 2 & 3 – FY16/17 & 17/18

During years two and three IM&T will initially focus on refreshing infrastructure and applications then start to automate manual business processes to improve operational efficiency.

Business

- Work closely with the business to understand areas of manual work which would benefit from automation and look carefully at the cost/benefit of each area
- Align with strategic business plans

Technology

- Refresh end-of-life infrastructure to decrease technical debt
- Refresh end-of-life applications, improving supportability and the functionality provided
- Start to automate less complex business processes

Management

- Review the sourcing of development and ongoing support to increase capacity for automation and future innovation
- Build the skills required for delivery such as project management and architecture
- Ensure that the focus on refresh does not detract from progress made on service stabilisation

Years 4 & 5 – FY18/19 & 19/20

During years four and five IM&T will continue to automate areas of manual activity and start to innovate by providing new capabilities for the business.

Business

- Continued business engagement to prioritise and understand requirements for automation projects
- Joint working on the feasibility of innovation projects

Technology

- Take on more complex automation projects
- Look at initially small scale innovation projects
- IM&T starts to take technology to the business which is likely to offer benefit

Management

- Make any changes required to the sourcing of development and ongoing support
- Review the success of the strategy and roadmap to feed into the next strategy

Summary actions and decisions for EMT and IM&T

This strategy and associated roadmap has set out a vision for IM&T over the coming years. The Trust Board is asked to ratify the content of this strategy and should be looking for EMT to take the following actions:

1. EMT to give IM&T the mandate to progress with a clear business priority.
2. IM&T should put deadlines on the immediate actions, assign owners and communicate the short-term plan to EMT
3. IM&T should establish a more detailed mid-term budget for the next financial year (FY 15/16). This may require iteration to produce an acceptable funding profile.
4. There should be an iterative process in which EMT members confirm and agree the roadmap based on the initial version provided. This should include the prioritisation of activities and likely timescales. IM&T should support this by providing impact analysis of EMT decisions.
5. IM&T should review all activity currently being performed and engage with the business to confirm the impact of stopping each. Activities with little or no value should be stopped.

London Ambulance Service NHS
NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**24th March 2015**
Document Title:	**Board Statements and Monitor Compliance**
Report Author(s):	**Sandra Adams**
Presented by:	**Sandra Adams**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
History:	**Compliance review at the Executive Management Team – 18th March 2015**
Status:	**For Approval**

Background/Purpose

The Trust Board is held to account by the NHS Trust Development Authority (TDA) for compliance with the provider licence requirements and Board statements. The Executive Management Team reviewed the evidence available against each statement at its meeting on 18th March 2015 and can confirm that the Trust Board can report compliance with each statement and requirement with the exception of the following:

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

The Board is unable to declare compliance with this statement having carefully reviewed performance since quarter one, together with current trending information for activity and capacity during the year. We are working closely with NHS England and local commissioners in the development of an investment case for 2015/16 and beyond that is being designed by McKinsey, aimed at reducing the Trust's utilisation rate and improving performance. The TDA are being kept fully informed on progress.

Action required

To note the assurance from the Executive Management Team on compliance with Board Statements and Monitor Compliance and to approve the submission and exception report for March 2015.

Assurance

Compliance schedule reviewed by the Executive Management Team on 18th March 2015.

Key implications and risks arising from this paper	
Clinical and Quality	**None**
Performance	**Category A8 and A19 performance in 2014/15**
Financial	**Penalties associated with the above**
Legal	**None**
Equality and Diversity	**None**
Reputation	**Potential media attention associated with performance targets**
Other	**None**
This paper supports the achievement of the following 2014/15 objectives	
Improve patient care	√
Improve recruitment and retention	
Implement the modernisation programme	
Achieve sustainable performance	
Develop our 111 service	
Simplify our business processes	√
Increase organisational effectiveness and development	√

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**24th March 2015**
Document Title:	**Trust Secretary Report**
Report Author(s):	**Sandra Adams**
Presented by:	**Sandra Adams**
Contact Details:	**sandra.adams@lond-amb.nhs.uk**
History:	**N/A**
Status:	**For information**

Background/Purpose

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

Tenders received

One new tender has been received since 27th January 2015:

1. Lambourne End Transmitter Site
   Tenders received from:
   - Kevin Miller
   - Waters and Harrington
2. There have been no new entries to the Register for the use of the Trust Seal since 27th January 2015.

Action required

To be advised of the tenders received and entered into the tender book and the use of the Trust Seal since 27th January 2015 and to be assured of compliance with Standing Orders and Standing Financial Instructions.

Assurance

Compliance with Standing Orders and Standing Financial Instructions.

Key implications and risks arising from this paper	
Clinical and Quality	**None**
Performance	**None**
Financial	**Controls and mitigations against any risk: Compliance with Standing Orders and SFIs; 2014/15 Financial Plan**
Legal	**Controls and mitigations against any risk: Compliance with Standing Orders and SFIs**
Equality and Diversity	**None**
Reputation	**None**
Other	**Controls and mitigations against any risk: Compliance with Standing Orders and SFIs**
This paper supports the achievement of the following 2014/15 objectives	
Improve patient care	
Improve recruitment and retention	
Implement the modernisation programme	
Achieve sustainable performance	
Develop our 111 service	
Simplify our business processes	
Increase organisational effectiveness and development	

TRUST BOARD FORWARD PLANNER 2015

24th March 2015

Standing Items	Quality Governance and Risk	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman Report from Chief Executive	**Integrated Board Performance Report** **Clinical Directors' Joint Report** **Audit Committee Assurance Report** **BAF and Corporate Risk Register** **Finance Report M11** **Report from Finance and Investment Committee**	2015/16 Integrated Business Plan and 5-year workforce and finance plan Retention Strategy - approval	Board Declarations Report from Trust Secretary Trust Board Forward Planner Register of interests	Finance and Investment Committee on 19th March 2015 Audit Committee on 2nd February 2015	

2nd June 2015

Standing Items	Annual Reporting	Quality Assurance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman Report from Chief Executive	**Annual Report and Accounts 2014/15 including Annual Governance Statement** **Quality Account 2014/15 for approval** **Audit Committee Assurance Report** **Annual Report of the Audit Committee 2014/15** **BAF and Corporate Risk Register** **Patient Voice and Service Experience Annual Report 2014/15** **Infection Prevention and Control Annual Report 2014/15** **Annual Safeguarding Report 2014/15**	Integrated Board Performance Report Clinical Directors' Joint Report Quality Governance Committee Assurance Report Finance Report Report from Finance and Investment Committee Progress report on CQC Chief Inspector of Hospitals planned inspection	2015/16 Corporate Objectives	Board Declarations Report from Trust Secretary Trust Board Forward Planner	Quality Governance Committee on 14th April 2015 Finance and Investment Committee on 21st May 2015 Audit Committee on 21st May 2015	

28th July 2015

Standing Items	Quality Assurance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Staff Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman Report from Chief Executive	**Integrated Board Performance Report** **Clinical Directors' Joint Report** **Quality Committee Assurance Report** **BAF and Corporate Risk Register** **Finance Report M3** **Report from Finance and Investment Committee** **Outcome of the CQC Chief Inspector of Hospitals planned inspection**	Q1 Business Plan review	Annual Equality Report 2014/15 Board Declarations Report from Trust Secretary Trust Board Forward Planner	Quality Governance Committee on 14th July 2015 Finance and Investment Committee on 23rd July 2015	

29th September 2014

Standing Items	Quality Governance and Risk	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman Report from Chief Executive	**Integrated Board Performance Report** **Clinical Directors' Joint Report** **Audit Committee Assurance Report** **Annual Audit Letter 2014/15** **BAF and Corporate Risk Register** **Finance Report M5** **Report from Finance and Investment Committee**	Business planning 16/17	Board Declarations Report from Trust Secretary Trust Board Forward Planner	Finance and Investment Committee on 24th September 2015 Audit Committee on 7th September 2015	

24th November 2014

Standing Items	Quality Assurance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Staff Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman Report from Chief Executive	**Integrated Board Performance Report** **Clinical Directors' Joint Report** **Quality Governance Committee Assurance Report** **Audit Committee Assurance Report** **BAF and Corporate Risk Register** **Finance Report M7** **Report from Finance and Investment Committee**	6 month review of business plan	Board Declarations Report from Trust Secretary Trust Board Forward Planner Performance Reporting compliance statement	Quality Governance Committee on 13th October 2015 Finance and Investment Committee on 19th November 2015 Audit Committee on 9th November 2015	

2015 Meetings Calendar

Committee	Chair	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Timings
Trust Board	Trust Chair	**27**		**24**			**2**	**28**		**29**		**24**		9.00 - 14.00
Board Strategy and Planning	Trust Chair		**24**		**28**		**30**				**27**		**15**	9.00 - 16.00
Annual General Meeting	Trust Chair									**29**				14.00 - 15.30
Annual C/Funds Committee	Non-executive director													
Remuneration Committee	Trust Chair													
Audit Committee	John Jones		**2**		**17**	**21**	**1**			**7**		**9**		14.00 - 17.00
Finance and Investment Committee	Nick Martin	**26**		**19**		**21**		**23**		**24**		**19**		14.00 - 17.00
Quality Governance Committee	Bob McFarland	**13**			**14**			**14**			**13**			14.00 - 17.00
Clinical Safety, Development and Effectiveness Committee	Clinical Directors	**20**	**17**	**17**	**21**	**19**	**16**	**21**	**18**	**22**	**20**	**17**	**22**	14.00 - 16.00
Executive Management Team (EMT)	CE	**Every Wednesday 9.00 - 12.00**												9.00 - 12.00

London Ambulance Service NHS Trust

Report to:	**London Ambulance Service Trust Board**
Date of meeting:	**24th March 2015**
Document Title:	**Register of Interests – March 2015**
Report Author(s):	**Sandra Adams**
Presented by:	**Sandra Adams**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
History:	**N/A**
Status:	**For information and assurance**

Background/Purpose

Register of Interests – Section 15 of the Standing Orders, Reservation and Delegation of Powers of the Trust Board Directors; supported by Appendix VII, Section 7, Standards of Business Conduct.

1. Standing Orders require all staff to declare any interests where they or a close relative, partner or associate has a controlling, or significant, or financial interest in a business, or any other activity, which may compete for a contract to supply goods or services to the Trust. It is the responsibility of the Trust Secretary to maintain the Register of Interests and, for assurance purposes, the Register is refreshed annually. This exercise commenced in February 2015 with an addendum sent out in March 2015 on the advice of the auditors to incorporate 'familiar relationships' in the declaration.

To date, 197 managers and senior managers have submitted declaration forms.

2. Section 15 of the Standing Orders refers specifically to Board Directors and the Trust Board can take assurance that:

- 15.2: Board directors and officers are invited to declare any new or undeclared interests at the commencement of all meetings of the Trust Board. This has been extended to Trust Board committees and the Executive Management Team;
- 15.3: Board directors have registered on appointment, and provided an annual update as a minimum, any significant pecuniary or other interest material and relevant to the business of the Trust.

On the advice of the auditors a further addendum was sent out in March 2015 to incorporate 'familiar relationships' in the declaration.

All directors have submitted declaration forms in 2015.

The next version of the declaration form will be updated to incorporate the advice from the auditors.

Action required

To review the Register of Interests for information and assurance purposes.

Assurance
In accordance with Standing Orders the Register of Interests has been refreshed an updated and all managers, senior managers and directors have subsequently been advised of the additional requirement to incorporate 'familiar relationships'.

Key implications and risks arising from this paper	
Clinical and Quality	**N/A**
Performance	**N/A**
Financial	**Potential risk if not declared**
Legal	**Potential risk if not declared**
Equality and Diversity	**N/A**
Reputation	**Potential risk if not declared**
Other	
This paper supports the achievement of the following 2014/15 objectives	
Improve patient care	**N/A**
Improve recruitment and retention	**N/A**
Implement the modernisation programme	**N/A**
Achieve sustainable performance	**N/A**
Develop our 111 service	**N/A**
Simplify our business processes	√
Increase organisational effectiveness and development	√

Trust Board Register of Interest - February 2015

Name	Date	Nil declaration	Interest declared	1. Directorships, including non-executive Directorship helds in private companies or PLCs	2. Ownership or partnership or private companies, businesses or consultancies likely or possibly seeking to do business with the Trust	3. Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the Trust	4. A position of authority in a charity or voluntary body in the field of healthcare or social services	5. Any material connections with a voluntary or other body contracting for services with NHS organisation	6. Any other commercial interests in a decision before a meeting of the Trust Board
Richard Hunt	04/03/2015		✓	Director of Maven Executive Coaching and Mentoring	Director of Attan Partners Ltd				
Jessica Cecil	25/02/2015		✓				On the advisory board of IntoUniversity, a charity aimed at getting disadvantaged young people to university	One sister is an NHS physiotherapist who also sees patients privately; another sister is a public health reseracher at Imperial College.	
John Jones	04/02/2015	✓							
Fergus Cass	04/03/2015		✓	Book Aid International - Charity - Trustee; Hospices of Hope - Charity - Trustee; Hospices of Hope Trading Limited - Charity related chain of shops - Chair Melton Court Parking Limited: company managing parking spaces at block where I live: Director			As noted above, I am a trustee of Hospices of Hope, a charity supporting hospice care in Romania and neighbouring countries		
Nicholas Martin	24/02/2015		✓	Cambridge Guarantee Holdings (Director); A2Dominion Housing Association (Director)			Chair, City of Westminster College		
Robert McFarland	05/02/2015	✓					Trustee and Chair of the European Doctor's Orchestra.		
Theo de Pencier	04/03/2015		✓	Freight Transport Association (FTA) - Chief Executive	LAS are members of FTA and from time to time purchase services/goods. I am not an owner or partner in FTA.			Other NHS Trusts are also members of FTA and from time to time purchase services/goods.	
Sandra Adams	04/02/2015	✓							
Karen Broughton	05/02/2015	✓							
Andrew Grimshaw	05/02/2015		✓	Director of LSO Consulting Ltd.					
Charlotte Gawne	17/03/2015		✓	Director – Vannin Consulting (currently a dormant IT consultancy)					
Jason Killens	10/02/2015	✓							
Fionna Moore	05/03/2015		✓	Medical Director, Location Medical Services.			Member Executive Committee, Resuscitation Council (UK)		
Paul Woodrow	10/02/2015	✓							
Mark Whitbread	09/03/2015	✓							
Zoe Packman	09/03/2015		✓					Honorary senior clinical fellow, Kingston University and St George's University of London	
Fenella Wigley	14/02/2015		✓				Regional Professional Lead for Doctors - St John Ambulance London Region		Expert Clinical Advisor to UKBA; Consultant in Emergency Medicine, Barts Health NHS Trust