London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD TO BE HELD IN PUBLIC ON TUESDAY 28TH JANUARY 2014 AT 09.30 – 11.30 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 received from:			
	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 20th December 2013** To approve the minutes of the meeting held on 20th December 2013	Approval	RH	TAB 1
09.35	4.	**Matters arising** To review the action schedule arising from previous meetings	Information	RH	TAB 2
09.40	5.	**Report from the Trust Chairman** To receive a report from the Trust Chairman on key activities since the last meeting	Information	RH	ORAL
QUALITY GOVERNANCE AND PERFORMANCE REPORTING					
09.45	6.	**Quality Report** 6.1 Quality Dashboard 6.2 Clinical Quality and Patient Safety Report	Assurance	SL FM	TAB 3
10.00	7.	**Integrated Board Performance Report** To receive the integrated board performance report	Information	PW	TAB 4
10.15	8.	**Finance Report** 8.1 Finance Report M9 8.2 Report from Finance and Investment Committee on 24th January 2014	Information	AG	TAB 5
10.25	9.	**Review of Demand Management Plan** To note the completion of the review of the Demand Management Plan (DMP) and the drafting of a revised plan, now the Surge Plan, to manage peaks in activity	Information	JK	TAB 6
BUSINESS ITEMS					
10.30	10.	**Report from Chief Executive** To receive a report from the Chief Executive	Information	AR	TAB 7

10.40	11.	**Update on Operating Model and Strategy** To receive an update on the process timeline and submissions	Information	KB	TAB 8
10.50	12.	**Modernisation Programme** To receive an update on the Modernisation Programme	Information	JC	ORAL
11.00	13.	**Board Declarations – self certification, compliance and board statements** To approve the submission of the Board declarations for December 2013	Approval	SA	TAB 9
	14.	**Report from Trust Secretary** To receive a report on use of the Trust Seal and tenders received.	Information	SA	TAB 10
	15.	**Forward Planner** To receive the Trust Board forward planner	Information	SA	TAB 11
11.10	16.	**Patient Story** To hear an account of a patient story		SL	
	17.	**Questions from members of the public**		RH	
	18.	**Any other business**			
11.30	19.	**Date of next meeting** The date of the next Trust Board meeting is 25th March 2014			

LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING
Part I

DRAFT Minutes of the meeting held on Tuesday 20th December 2013 at 09:00 a.m.
in the Conference Room, Fielden House, 28 London Bridge Street, London SE1 9SG

****

Present:	
Richard Hunt	Chairman
Ann Radmore	Chief Executive
Jessica Cecil	Non-Executive Director
Roy Griffins	Non-Executive Director
Andrew Grimshaw	Director of Finance and Performance
John Jones	Non-Executive Director
Jason Killens	Director of Operations
Nick Martin	Non-Executive Director
Bob McFarland	Non-Executive Director
Fionna Moore	Medical Director
Caroline Silver	Non-Executive Director
In Attendance:	
Sandra Adams	Director of Corporate Affairs
Karen Broughton	Director of Strategy and Transformation
Jane Chalmers	Director of Modernisation
Tony Crabtree	Acting Director of Workforce
Mike Evans	Interim Director of Business Development
Angie Patton	Head of Communications
Vic Wynn	Acting Director of Information Management and Technology
Members of the Public:	
Malcolm Alexander	Chair of the Patients' Forum
Evening Standard reporter	Member of the public

****

160. Welcome and Apologies

160.1 The Chair welcomed Karen Broughton to her first Trust Board meeting.

160.2 Apologies had been received from Steve Lennox, Francesca Guy, Charlotte Gawne and Paul Woodrow.

161. Staff Story

161.1 The Board welcomed Ardaman Gill to the meeting. Gill was employed as a fleet multi-skilled technician in the Fleet Support department at Fulham and he was attending the meeting to give his perspective on working for the LAS. Gill was clear that his role had an impact on delivering a service to patients and supporting Trust staff. He talked regularly to paramedic staff.

161.2 In response to questions from Board members, Gill confirmed that newer fleet would be beneficial. Both cars and ambulances were heavily utilised which had an impact on the vehicles and replacement of parts for older models was costly.

161.3 Gill confirmed that he would seek out his manager if he wanted more information about the service

or to be kept up to date but in response to a question about discussion forums, he suggested that there was insufficient time to stop for such meetings.

161.4 He thought it would be good to have all staff undertaking regular training but understood there was an associated cost which perhaps had an impact on the amount of training there used to be, often over a number of days, compared to now – hours rather than days. Gill knew about the Modernisation Programme 'A Time for Change' and recognised that things had to change however he would have liked to have been able to get more involved in the discussions.

161.5 Andrew Grimshaw confirmed that 6-8 additional posts were being recruited to support the workload in the workshops; plus equipment was being replaced and a programme of fleet replacement was planned. Gill confirmed that there was no additional capacity at Fulham and they were already servicing more than 100 vehicles and taking on work from other workshops. Gill was asked what one thing he wanted the LAS to do and he responded that he would want to see new vehicles and greater communication with senior management.

161.6 The Chairman thanked Gill for attending the meeting and sharing his views with Board members.

161.7 (Caroline Silver left the meeting.)

162. Declarations of Interest

162.1 None declared.

163. Minutes of the Part I meeting held on 26th November 2013

163.1 Against Minute 143.9 it was noted that daily monitoring was now in place.

163.2 Subject to that note the Trust Board approved the Minutes of 26th November 2013.

164. Matters Arising

164.1 **131.3:** This was on the agenda for discussion today.

164.2 **34.3 and 106.3:** Andrew Grimshaw confirmed that both items were being worked on and would be reported to the next Finance and Investment Committee before being brought back to the Board in January 2014.

> **ACTION:** AG to present a proposal for measuring value for money and a paper on non-productive time to the next Finance and Investment Committee before the Trust Board meeting in January.
>
> **DATE OF COMPLETION:** 28th January 2014

164.3 **120.10 and 141.5:** Ann Radmore reported that she had written to colleagues in the other ambulance service trusts asking if they would share Category C performance data. There was no requirement for figures to be published. Bob McFarland confirmed that this had also been discussed at the Quality Committee when it had been noted that each Trust measured Category C performance differently.

164.4 **145.2:** Sandra Adams and Francesca Guy would schedule risk management into a session of the Strategy Review and Planning Committee.

ACTION: SA/FG to schedule risk management into a session of the Strategy Review and Planning Committee.

DATE OF COMPLETION: 28th January 2014

164.5 **149.11:** Jason Killens reported that the LAS did not own or operate any vehicle that 'caged' a patient however some PTS contracts did require transportation of patients who presented a risk to themselves or others and under such circumstances the LAS used a third party provider.

164.6 Malcolm Alexander responded that this presented dignity and safety issues for patients, for example if the vehicle crashed and the patient could not get out.

164.7 Ann Radmore stated that the executive team would provide information on the specification for this part of the service contract and this would be reported to the Quality Committee.

ACTION: JK to provide information to the Quality Committee on the specification for third party providers for the transportation of patients who presented a risk to themselves or others.

DATE OF COMPLETION: 26th February 2013

164.8 The Chair thanked Malcolm Alexander for raising an issue on which the Trust Board had previously been unsighted.

165. <u>Report from the Trust Chairman</u>

165.1 The Chair reported that the appointments process for non-executive directors had been completed with two positive recommendations being made to the NHS Trust Development Authority (TDA): Theo de Pencier, Chief Executive of the Freight Transport Association, who had strong commercial experience; and Fergus Cass, previously a non-executive director of NHS North West where he had also been the Chair of the Audit Committee, and had previously been with Unilever. The Chair was waiting for confirmation of the appointments from the TDA and he was looking forward to welcoming them to the Trust Board. The Chair confirmed that Caroline Silver and Roy Griffins would complete their second terms of office in the New Year.

165.2 The Chair had attended a meeting with Martin Flaherty and Martyn Salter at Association of Ambulance Chief Executives (AACE) to discuss commercial opportunities. Subsequent to this he had been asked to join the committee which was starting up in the New Year. The Chair would consider any potential conflict of interest as part of this and he would be discussing issues with Mike Evans.

165.3 The Chair had attended a Board Leadership programme event at which David Flory and Matthew Kershaw were speaking about the challenges facing the NHS at a macro level. The picture for 2014/15 and 2015/16 had been described along with the challenges the health network faced.

165.4 Both the Chair and Nick Martin had attended a non-executive directors' event run by the FTN. The Chair was considering inviting one of the speakers to a future Strategy Review and Planning meeting as the event had presented the macro picture for the NHS and the need for good governance and an effective Board, and developing the requirements in preparation for Foundation Trust licence.

165.5 The Chair made reference to the Better Care Fund and this having a significant effect on the NHS as funding transfers to local authorities. He suggested this be considered in the context of the

Trust's strategy discussions. Ann Radmore said that she would speak to Simon Weldon, NHS England (London) about him speaking to the Trust Board.

ACTION: AR to ask Simon Weldon to present to the next meeting of the Trust Board.

DATE OF COMPLETION: 28th January 2014

Proposal for a Commendation Certificate/Commendation for members of the public

165.6 The Chairman talked to the proposal which would be awarded by the Chief Executive to a member of the public whose contribution to the outcome of a patient's condition/care was deemed crucial or whose actions had assisted a member of staff in a hazardous/threatening situation.

165.7 The Trust Board approved the proposal for implementation from 1st April 2014.

166. Quality Report

Quality Report

166.1 Fionna Moore took the report on behalf of Steve Lennox who was on annual leave. Overall the level of quality was being maintained.

166.2 The Chair asked whether there were any trends arising from serious incidents (SIs). Fionna reported that 8 had been declared in the month and she had met with Steve, Sandra and Tony to review the metrics on SIs, risks, incidents, problematic inquests and complaints and to determine whether there was a rising tide. No specific themes or concerns had been identified but the group had agreed to meet regularly now to monitor more closely, in particular on the delays to C2 patients, and to ensure there was greater governance focus on these areas.

166.3 The Chair expressed concern about the the increase in SIs continuing but Fionna assured him that this was being monitored and the Trust remained in the upper quartile for many of the indicators. Ann Radmore confirmed that the executive team was monitoring SIs and Bob McFarland reported that the Quality Committee was also content with this approach.

166.4 Ann Radmore referred to the Clwyd Review on Complaints Management and reported that she had asked Steve Lennox and Gary Bassett to bring a report to the Trust Board in the first quarter of 2014/15. An initial review suggested little needed changing from current practice.

ACTION: Steve Lennox to present a report to the Trust Board on the Clwyd Review on Complaints Management.

DATE OF COMPLETION: 24th June 2014

166.5 John Jones asked about the deep cleaning target in infection control. Bob McFarland responded that the Quality Committee had been informed that work was underway to improve practice and Andrew Grimshaw added that he had instigated a review of the Make Ready contract.

166.6 In response to a question about missing equipment, Jason Killens confirmed that a census had been undertaken on 12th December and the outcomes were being reviewed. The senior management team had committed to purchase equipment to the value of £200k and a process was being implemented to collect equipment left at hospital. Jason reported that he had also raised this issue with approximately 500 staff this week, emphasising the need to look after and return

equipment, and raising the profile on this issue. Ann Radmore stated that the LAS was starting to see the impact of personal issue equipment, for example seeing a much more sustained position of testing blood on scene. Funding had been identified and plans put in place for the roll-out of personal issue thermometers in 2014. Staff feedback on personal issue equipment was positive.

166.7 The Chair commented on an inconsistency with reporting on appropriate care pathways and the patient experience and the referrals from the Clinical Hub (CHUB). Ann Radmore responded that sometimes the conversation did not meet the patient's expectations, which could result in disappointment or frustration, for example if they wished to go to hospital but the paramedics recommended a different outcome. Work was underway with senior staff about how to communicate messages. 'Intelligent conveyance' was showing that both patients and staff were receptive to alternative hospitals or destinations however it was still early days on this.

166.8 Jason Killens commented on the Pathfinder training that was currently underway for Paramedics with 500 first responders receiving the training for the on-scene decision-making tool. This included enhanced use of appropriate care pathways, reduced conveyance to emergency departments, and fewer multiple responses for appropriate calls.

Clinical quality and patient safety report

166.9 Fionna Moore reported that the new National Limb Fracture Clinical Performance Indicator had been rolled out nationally and showed the LAS at the bottom of the table. This was not a cause for concern as the Trust was not seeing the evidence in the emergency departments however the lower limb fracture CPI had been highlighted to Team Leaders in order to improve both standards of care and documentation.

166.10 Attention was drawn to the reduction in CPI completion which was probably due to deployment of Team Leaders to front line care. The Mental Health CPI was at its highest rate yet.

166.11 There had been two reportable controlled drugs issues since the last meeting of the Trust Board. One involved the loss of two ampoules of morphine at Camden station and the second at Whipps Cross where a box of ten ampoules of morphine had been found sealed and intact beside the controlled drugs safe which had been left open. The circumstances of the second incident were not yet clear but the Metropolitan Police controlled drugs liaison officer had been asked to investigate further. In both incidents it was thought that CCTV would greatly aid the investigation.

166.12 (Caroline Silver returned to the meeting)

166.13 As a result of a number of incidents involving adrenaline being administered intravenously instead of intramuscularly, the Trust had asked the supplying pharmacy to label the ampoules differently in future stating 'intramuscular USE ONLY'.

166.14 The revalidation of doctors exercise had shown that two doctors had failed to engage in the process so this would be followed up in writing by Fionna Moore advising them that the evidence submitted to date would not support their revalidation and asking them to make contact.

166.15 With effect from 1st December 2013 the Trust had fully rolled out the 2013 JRCALC UK Ambulance Services Clinical Practice Guidelines having trained over 60% of operational staff on their usage.

166.16 The Chair asked whether the CPI for Mental Health could be recalibrated now as, although the Trust had reached the highest completion rate yet, it was still shown as red RAG which undervalued the improvement made. Ann Radmore suggested the use of improvement arrows. Andrew Grimshaw reported that he had instigated a review of performance metrics ready for 2014/15 and this would include absolute and trajectory measurements. Karen Broughton suggested this included

thresholds. Paul Woodrow was working on the performance information and how it was presented. The Chair suggested that this was an opportunity to make the information as meaningful as possible.

166.17 In summary, Ann Radmore commented that the Trust was now seeing a combination of factors coming together since Summer 2013 and in particular the impact from July/August onwards. Decisions had been made about how best to deploy resources, including Team Leaders, to front line care, rather than focus on CPI completion.

167. Integrated Board Performance Report

167.1 Andrew Grimshaw presented the report and confirmed that performance was broadly consistent with previous months.

167.2 Key highlights:

- Category A performance remained below target for the fifth consecutive month and discussions were underway with commissioners and NHS England (London) regarding a trajectory to recover the position;
- Serious incidents were at the highest level reported in month however the number of new complaints had reduced in month;
- Category C response times remained below expectations and this continued to represent a risk to patient safety due to extended response times;
- Significant progress had been made with CSR training with 1906 staff having received their core skills refresher training by the end of November 2013;
- Financial position showed a favourable variance of £48k to plan and was broadly on track. The position did not yet include the risk of penalties if the Trust failed to achieve the A8 target;
- The capital position was being closely managed to ensure the plan was completed. £8-8.5m was committed and Andrew would be talking to the Chair of the Finance and Investment Committee about spending the residual amount on additional vehicles.

167.3 Ann Radmore commented that the Trust needed to become much smarter on how it spent capital, because although we start the year with a clear plan we were then slow to implement it. Andrew confirmed that this was being worked on.

167.4 The Chair stated that, if looked at objectively, finance was on target but performance, workforce and quality were not. Ann Radmore confirmed that that was an accurate reflection of the position and the Trust was in a very tight and finely balanced position. Deployment of the additional funding from the government would only just help the Trust achieve performance levels.

167.5 Andrew Grimshaw tabled performance information which showed that the LAS was getting to 75% of Category A patients within 8 minutes and 15 seconds and to 98.7% within 15 minutes. This demonstrated there was not a significant body of long waits in this category; the quality report confirmed this and also that it was not presenting a safety concern. Caroline Silver commented that these metrics should be shown in future including the cost of meeting the target and reducing the 15 seconds, and it would be useful to put these figures in the public domain so that the public had a better understanding of our performance.

167.6 (JC joined the meeting).

167.7 Bob McFarland suggested that acknowledgement should also be given to the fact that pushing more resource into meeting Category A took the resource from Category C.

167.8 Andrew Grimshaw reminded the Board that it had previously discussed that the financial position would not be compromised to achieve the target if it was assured that patient safety was not of concern. The Chair confirmed that the extraordinary meeting in October had focussed on performance and the position the Trust was in and the actions required to address this. The key issue was that raised by Caroline. The daily report looked at how we achieved 75% and maintained patient safety. Fifteen seconds vs minutes presented different pictures. Both the Chair and Ann Radmore said that they did not accept the current level of performance and the executive had been charged with achieving A8, balanced with patient safety. It was also to be recognised that if the LAS did not meet the target the penalty regime of £5m on Red 1 and £5m on Red 2 responses would apply.

167.9 In response to a question from Bob McFarland about the predicted year end position, Ann Radmore confirmed that this was contingent on the allocation of funding.

168. Finance Report

168.1 Andrew Grimshaw reported that this was broadly on target with a small in-month deficit but overall £43k favourable year to date. He reminded the Board that the year-end position remained a surplus of £262k.

168.2 John Jones asked how precarious the position was and how non-recurrent support was impacting on the financial position. Andrew Grimshaw responded that there were some timing issues and capital spend was slow, and the overall position was tight.

169. Quality Committee Assurance Report

169.1 Bob McFarland reported from the meeting held the previous week and he had taken over as the Chair of the Quality Committee. Bob was working out how to make the committee contribute effectively to the Trust Board. Dates for 2014 had been fixed and the timing of these with the Clinical Quality Safety and Effectiveness Committee and the Trust Board would help.

169.2 The Director of Quality from the North West London Clinical Commissioning Group was to be invited to attend meetings, and steps were being taken to recruit a patient representative. The newly-appointed LAS Director of Paramedic Education and Development would be invited to attend the meeting at key points in the year.

169.3 The committee had received a presentation from the South East London 111 team and had noted the successful transition across to LAS. Quality issues would in future be reported to the committee. It was noted too that after the first month of operation, the service was meeting the metrics agreed with commissioners.

169.4 The Chair asked whether the committee had identified any cause for concern and Bob McFarland confirmed that there was nothing further than that which had already been discussed in the meeting today.

170. Francis and Berwick Update

170.1 Ann Radmore presented this item on behalf of Steve Lennox. The paper provided a progress update since the Board discussion in September when it had been agreed that the overall goal should be for the LAS to become a learning organisation and therefore focus on two strategic areas of work:

- Strengthening the patient voice; and
- Strengthening the staff voice and empowering the workforce.

170.2 This was not intended to be a checklist but to become part of the Trust's 2020 strategy and a core component of Trust culture and how we do things. A range of actions were identified in the Next Steps of the paper and included building on the staff engagement work started by Listening into Action, and involving patients in the strategy and in building the philosophy of 'no decision about me, without me' and understanding what this meant for the services the Trust provided. The Trust needed to explore new opportunities for patient engagement, for example through Healthwatch and local acute providers; through better use of technology; and engagement with the Third sector.

170.3 Caroline Silver asked for clarification about the supervisory layer referred to in point 12. Jason Killens responded that this referred to creating space, capability, capacity, and the right environment, for Team Leaders to deliver supervision effectively. Ann Radmore added that a strategy for training, development and leadership needed to be developed in 2014 for Clinical Team Leaders and above. A new organisational structure for Operations would need to identify an assessment of gaps in capability that needed to be addressed so that managers could discharge their roles effectively. The Chair supported this, saying that the advice elsewhere for facing the challenges ahead for the NHS, and in particular in the context of Francis and Berwick, was not to continue to do the same things in the same way.

171. <u>Report from Chief Executive</u>

171.1 Ann Radmore presented her report and referenced the following:

- NHS England had published the assurance framework for CCGs but had not approved the changes to the allocation process;
- All 3 London training boards (LETBs) had agreed to provide additional funding support to the LAS to be spent by year end 2013/14, and all 3 were actively engaging in discussions with the LAS on funding for 2014/15;
- Following the Glasgow police helicopter crash assurance had been sought on the London Air Ambulance and the position would be kept under review;
- Following her visit to the North East Ambulance Service in November, Ann planned to visit other ambulance services;
- Ann Radmore and Jason Killens had attended the meeting of the London Assembly Budget and Performance Committee on 17th December where the discussion had ranged from broad strategy to detail on how calls were handled in the control room. Ann Radmore reported that the committee supported the LAS being the cornerstone of the NHS in London and that the LAS worked closely with the other emergency services and had been looking at opportunities for greater collaboration between the three services. The London Assembly had a broader understanding now of what the LAS did and that only 10% of our responses were with fire and police;
- The Keogh review made specific reference to the role of the paramedic and widening the scope of practice;
- It was to be noted that the LAS ran 10 Joint Response Units (JRUs) in London but this was not funded by the NHS. The Metropolitan Police Service wanted this rolled out across other areas but we have had to clear that this is not our role and we are not funded to do so.

171.2 Ann Radmore confirmed that a letter had been sent to the Chair of the Greater London Authority Police and Crime Committee regarding a number of inaccurate statements that had been made at a meeting in November.

172. <u>Modernisation Programme</u>

172.1 Jane Chalmers gave an oral update on the programme and tabled a project summary showing that all projects were either on track or had been delivered. Areas rated amber RAG were mainly related

to the workforce model going forward and these were likely to be back on track by April 2014. Nick Martin asked how far behind the Trust was on the original programme and Jane Chalmers confirmed this to be 3-4 months although much of the work had been undertaken concurrently and had been pushed ahead rather than waiting for other areas to happen. It was noted that Paramedic recruitment did not form part of the programme but a similar report would be brought to the January Board.

ACTION: David Prince to provide the Trust Board with a report on Paramedic recruitment.

DATE OF COMPLETION: 28th January 2014

172.2 Ann Radmore gave an update on the recruitment of A&E support staff. Most had joined the service as they saw it as a route through to becoming a Paramedic and therefore thought needed to be given to the training and development ladder for this. There could be an opportunity here to build our own internal pipeline for developing a Paramedic workforce.

172.3 The Chair asked whether the development of a clinical career structure within the LAS has had an effect as yet. Fionna Moore responded that with the recent recruitment drive internally for the Advanced Paramedic Practitioner role, 250 packs had been requested and 70 applications received for 12 posts. The next tranche of posts would be advertised externally as well as within the LAS and the aim was to recruit 36 Advanced Paramedic Practitioners over the next 3 years. Over time, progression would become a reality as people move up and create vacancies which in turn would allow other staff to move up.

173. Charitable Funds Annual Report and Accounts 2012/13

173.1 Tony Crabtree presented the item confirming that the Charitable Funds Committee approved the accounts at its meeting in November for submission by 31st January 2014. Caroline Silver confirmed that the Audit Committee had discussed and agreed to an independent examination of the accounts rather than an audit.

173.2 Caroline Silver confirmed that the main expenditure was against the unrestricted funds and this comprised the long service awards and general amenities. There was one restricted fund which was the voluntary responder charity. The unrestricted fund had been run down over the years and the Trust Board would need to consider the future of the charitable funds.

173.3 The Trust Board approved the Annual Report and Accounts for 2012/13.

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

174.1 Sandra Adams presented the exception report for November 2013 and drew the Board's attention in particular to the paragraph against Board Statement 10 and ongoing compliance with all existing targets. Karen Broughton asked what the implications would be of making this statement and Sandra confirmed that this formed part of the TDA's performance monitoring and would be consistent with the position we had been discussing with them already and that had been discussed earlier in the Board meeting. Caroline Silver confirmed that this represented a factual non-compliance statement. It was agreed that the statement would reference absolute commitment by the Board to doing everything it could to achieve the targets and the Chair would sign this off on behalf of the Trust Board.

ACTION: SA to amend the board statement with RH's agreement and to submit to the TDA.

DATE OF COMPLETION: 20th December 2013

175. Report from Trust Secretary

175.1 There was no report submitted this month.

176. Forward Planner

176.1 The dates for 2014 had been confirmed. The Chair proposed that the start time of the meeting in future should be 9.30am for Part 1 but with 9.00am meeting for the Chairman and non-executive directors. This was agreed.

177. Any other business

177.1 There were no items of other business.

178. Questions from members of the Public

178.1 Malcolm Alexander had submitted a number of questions by email the day before the meeting and it had been agreed with him that a response would be sent in early January 2014.

178.2 The Part I meeting was formally closed.

179. Date of next meeting

179.1 The next meeting of the Trust Board is on Tuesday 28th January 2014.

……
Signed by the Chair

ACTIONS

from the Meeting of the Trust Board held on 20th December 2013

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
25/09/12	**131.3**	MD to write an explanation on the roles of the two LAS charities.	**AG**	AG/SA to review all aspects of charitable funds and to report back to the Trust Board in November 2013.
26/11/13	**141.5**	AR to ask Chief Executives at other ambulance trusts whether they would be willing to share Category C performance data.	**AR**	AR to raise at AACE meeting on 23rd January.
26/11/13	**149.9**	SL to consider whether the Trust would refer cases to the Mental Health Expert Safety Group of NHS England to get support for better provision of emergency mental health care.	**SL**	Our Mental Health Advisor is exploring how this group links with provider services as we understand it is mainly set up to influence commissioners. If we find there are pathways for a direct dialogue with providers we will engage with this group.
26/11/13	**149.11**	JK to provide confirmation that the LAS did not own, operate or hold contracts with any vehicle that caged a patient or restrained them in any way.	**JK**	JK to provide an update to the Quality Committee.
20/12/13	**164.2**	AG to present a proposal for measuring value for money and a paper on non-productive time to the next Finance and Investment Committee before the Trust Board meeting in January.	**AG**	
20/12/13	**164.7**	JK to provide information to the Quality Committee on the specification for third party providers for the transportation of patients who presented a risk to themselves or others.	**JK**	On agenda for 26th February.
20/12/13	**165.5**	AR to ask Simon Weldon to present to a future Trust Board or Strategy Review and Planning Committee meeting.	**AR**	

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
20/12/13	**166.4**	Steve Lennox to present a report to the Trust Board on the Clwyd Review on Complaints Management.	**SL**	Scheduled for March.
20/12/13	**172.1**	David Prince to provide the Trust Board with a report on Paramedic recruitment.	**DP**	
20/12/13	**174.1**	SA to amend the board statement with RH's agreement and to submit to the TDA.	**SA**	

ACTIONS

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
26/03/13	**34.3**	EMT to develop an index for measuring value for money.	**AG/EMT**	Action closed.
23/07/13	**106.3**	AG to present a paper on non-productive time to a future Part II Trust Board meeting.	**AG**	Action closed.
26/11/13	**145.2**	FG/SA to schedule a focussed session on risk management at a future Strategy Review and Planning Committee meeting.	**FG/SA**	Action complete.
20/12/13	**164.4**	SA/FG to schedule risk management into a session of the Strategy Review and Planning Committee.	**SA/FG**	Action complete.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 28 JANUARY 2014

PAPER FOR INFORMATION

Document Title:	**Quality Report (Dashboard)**
Report Author(s):	**Steve Lennox, Director of Nursing and Quality**
Lead Director:	**Steve Lennox, Director of Nursing and Quality**
Contact Details:	**Steve.Lennox@Lond-Amb.nhs.uk**
Why is this coming to the Trust Board?	**Inform Trust Board current position against quality measures**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**Assure the Trust Board that the same levels of quality (within the monitored domains of the dashboard) are being maintained.**

Key issues and risks arising from this paper

Quality performance appears to be stable but there has been a slight increase in the vacancy rate across the organisation. Performance for Cat C was slightly up but still below the aspirant levels.

Executive Summary

The dashboard is a barometer of quality and provides one piece of assurance regarding the level of quality the service is providing. Other elements of assurance include, Assurance from the Quality Committee, Trust Board Members Observational Ride Outs, Patient Stories and Clinical Report.

This quality report suggests that overall the same level of quality is being maintained. The indicators of amber or red RAG rating are;

Cat A8 (Red 1) RAG Rated RED

Please see performance reporting.

STEMI Care AMBER

We still have issues with the analgesic aspect of the care bundle. We have tried to reinforce the messages but there has been little sustained improvement. We will continue to message.

Stroke care 60 Minutes AMBER

Stroke Care AMBER

There are some improvements as a result of the personal issue equipment but these are not yet captured in the DH data set (three months behind). Therefore, the improvements have not yet appeared in the data set.

Not Conveyed hear & Treat AMBER
This deterioration is due to the changes taking place in CTA. We expect the position to change in December.

Not Conveyed see & Treat RED
Waiting to se how improvements in hear and treat affect see and treat. We expect a decline in compliance with this indicator.

Clinical Performance Indicators AMBER
PRF copy left with patient, ethnicity coding, Stroke –time of onset, final set of observations are below the 95% level. Overall there is a slight drop in CPI for November. Potentially a sign of the Winter pressures.

Incidents AMBER
The number of SIs reported was again above the level expected. We have changed the data set to be date incident occurred rather than date reported but there is a renewed focus on SI reporting and the rise could be suggestive of better reporting systems. This will continue to be monitored.

Lost Property AMBER
Lost property disappointingly remains amber

Re-contact Rate See & Treat AMBER
This continues to rise slightly but is still below other services. No real explanation but there appears to be no link to complaints.

Experience of People Subject to delay AMBER
This reducing and is potentially linked to the improvements in ring backs. This is being monitored at the Learning From Experience Committee.

Infection Control – Cleaning RED
The target is for all vehicles to be deep cleaned within 6 weeks. The compliance figure was not met but more recent figures suggest that this has now been significantly improved.

Cat C
Please see performance reporting.

Supervision OWR –RED
OWR has fallen back due to the challenges with capacity.

Vacancy Factor RED
This still represents the biggest risk to quality. Being monitored through modernisation work and winter planning.

CPI Feedback
The capacity challenges are now manifesting in the CPI feedback given to staff. This is not consistent with last year. Areas have been reminded of the importance of maintaining CPI feedback.

Therefore, our areas of quality improvement remain as outlined within our Quality Account.

- Attitude & behaviour
- Experience of patients receiving a delay
- Experience of patients on an ACP
- Missing Equipment

Attachments

Dashboard

****

Quality Strategy

This paper supports the following domains of the quality strategy

- ☒ Staff/Workforce
- ☒ Performance
- ☒ Environment
- ☒ Experience
- ☒ Helping People
- ☒ Quality of Life
- ☒ Preventing Death

LAS Strategic Goals and Priorities

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

LAS Strategic Goals

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

2013/14 Priorities

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

Has an Equality Analysis been carried out?

- ☐ Yes
- ☒ No

Key issues from the assessment:

1. Quality Dashboard for December (November & August) 2013

	November 2013		OLDER (August)	
Domain 1. Preventing people from dying prematurely				
DH	Red 1 (A8)	↑	DH Outcome from cardiac arrest	↓
DH	Red 2 (A8)	↑	DH Return of spontaneous circulation	↑
LAS	Basic Life Support	↓	DH STEMI Care	↓
			DH Stroke Care	↓
Domain 2. Enhancing quality of life for people with long-term conditions				
DH	Not conveyed to A&E	↓		
LAS	Clinical Performance Indicators	↔		
Domain 3. Helping people to recover from episodes of ill health or following injury				
DH	Time to Treatment	↓		
LAS	Airway Management	↔		
Domain 4. Ensuring people have a positive experience of care				
DH	Service Experience	↑		
LAS	Incidents	↑		
LAS	Lost Property	↓		
DH	Time taken to Answer 999	↔		
DH	Re Contact Rate	↓		
DH	calls Abandoned	↔		
LAS	Experience (delay)	↑		
LAS	Attitude & Behaviour	↑		
LAS	Experience (ACP)	↑		
Domain 5. Treating & caring for people in a safe environment and protecting them from avoidable harm				
LAS	Infection Control	↑		
LAS	Safeguarding	↑		
DH	A19	↑		
LAS	C1	↑		
LAS	C2	↑		
LAS	C3	↑		
LAS	C4	↑		
LAS	Handover at Hospital	↓		
Domain 6. Caring for the workforce				
LAS	Supervision of staff	↓	LAS Sickness	↓
LAS	CPI Feedback Sessions	↓	LAS Temperature Check N/A	N/A
LAS	priority Training	↔		
LAS	Vacancy factor	↓		
LAS	3rd Party Providers	↑		

2. Comparison Table

2.1 The following table identifies the Department of Health Indicators and our ranking against other Ambulance Trusts and our direction of travel. Our lowest and highest compliance scores are also illustrated.

2.2 The GREEN shading represents where the Trust is in the upper quartile when compared to other services. We are upper quartile in 22 (last report 22) out of 46 areas.

	May Data for July Trust Board					YTD
	Comp liance	Rank	Lowest	Highest	Comp liance	Rank
A8 R1 Response Time	75.10%	7	71.70%	81.90%	76.30%	6
A8 R2 Response Time	71.00%	9	67.10%	81.50%	73.60%	3
A19 Response Time	97.60%	1	96.70%	99.00%	97.80%	1
ROSC (all)	33.10%	4	26.10%	36.40%	30.20%	4
ROSC (Utstein)	62.00%	2	45.70%	68.10%	59.00%	2
Time Taken to Answer 50th Percentile	0.00	1	0.00	0.00	0.00	1
Time Taken to Answer 95th Percentile	1.00	1	29	0.01	0.01	1
Time Taken to Answer 99th Percentile	0.06	1	1.46	0.02	0.09	1
Time to Treatment 50th Percentile	6.24	9	6.11	5.36	6.06	8
Time to Treatment 95th Percentile	15.60	2	16.90	12.70	14.53	2
Time to Treatment 99th Percentile	24.36	2	19.40	27.30	23.32	2
Outcome from cardiac Arrest Survival	10.50%	6	6.30%	11.40%	8.80%	5
Outcome from cardiac Arrest Survival (Utstein)	37.00%	2	16.30%	37.00%	27.60%	4
STEMI Outcome 150 minutes	90.10%	3	84.30%	95.20%	92.60%	3
STEMI Outcome Care Bundle	77.60%	7	63.10%	79.00%	77.70%	6
Stroke Outcome 60 minutes	68.80%	4	61.60%	75.80%	68.30%	4
Stroke Care Outcome Bundle	93.30%	11	92.10%	95.70%	94.10%	9
Calls Closed with CTA	4.70%	6	4.50%	6.90%	4.80%	6
Non A&E	31.10%	8	26.60%	33.30%	31.50%	4
Re Contact rate CTA	2.20%	2	3.40%	2.10%	2.60%	1
Re Contact rate See & Treat	7.10%	10	6.60%	4.90%	6.70%	11
Re Contact rate Frequent callers	2.00%	5	2.50%	2.61%	2.18%	5
999 Calls Abandoned	0.00%	1	0.00%	0.10%	0.02%	1
Service Experience						

3. Conclusions

3.1 The DH dashboard is stable. The previous report indicated a meeting was to be held to look at a number of the internal indicators more closely within the context of a rise in SIs and complaints. This concluded that there was no evidence to suggest any significant new quality issues but this would be further reviewed.

3.2 Otherwise the dashboard is relatively stable within the context of operational challenges.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 28TH JANUARY 2013

PAPER FOR INFORMATION

Document Title:	**Clinical Quality and Patient Safety Report**
Report Author(s):	**Fionna Moore / Steve Lennox**
Lead Director:	**Fionna Moore / Steve Lennox**
Contact Details:	
Why is this coming to the Trust Board?	**Information only**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other: Elements of this report have been presented to other groups
Recommendation for the Trust Board:	**For noting only.**

Key issues and risks arising from this paper

- Clinical Performance Indicator audit remains below 75%. There is a risk that the Trust will not be able to robustly evidence the quality of care delivered to patients. This also impacts on the ability to provide operational staff with meaningful feedback about individual clinical practice.

Executive Summary

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

- **Demand Management Plan:** Early implementation of Surge Amber. Increased use of DMP D. No escalation of DMP past stage D.
- **Clinical Performance Indicators:** CPI completion rate remains low. Overall CPI compliance remains >95%, except for mental health (89%).
- **Clinical Audit & Research:** An interim Clinical & Audit Activity report has been released by CARU.
- **Prevention of Future Deaths Reports:** The Trust has not received any Prevention of Future Deaths Reports (formerly Rule 43 Reports) from HM Coroner since the last Trust Board report.

- **Medicines Management:** There have been no reportable controlled drugs incidents or notification of drug errors since the last Trust Board report. There has been one Unannounced Visit from a Metropolitan Police Controlled Drugs Liaison Officer. This inspection revealed compliance with controlled drug policy and law.

- **High Risk Register:** There are a total of 326 addresses on the Locality Alert Register (the number lowest to-date). There has been a significant reduction in the number of high risk address notifications from the Metropolitan Police.

- **Complaints:** There has been a decrease in the number of complaints received by PED. 44% of complaints related to response delays.

- **Advanced Paramedic Practitioner (APP):** The first 12 APPs have now been recruited.

Attachments
None

****

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

☒ Staff/Workforce
☒ Performance
☐ Environment
☒ Experience
☒ Helping People
☐ Quality of Life
☐ Preventing Death

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

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

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

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

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

Equality Analysis

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

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST

Clinical Quality & Patient Safety Report – January 2014

Clinical Directors' Joint Report

Quality Domain 1: Preventing people from dying prematurely

Clinical Audit and Research

The interim Clinical Audit and Research Activity Update has been released by CARU (Appendix 1). The report details information on progress and activities in:

- Clinical audit
- Research
- Publications and conference presentations

The results of the Paediatric Febrile Convulsion Clinical Performance Indicator Audit (Cycle 11, September 2013) have been published by the National Ambulance Clinical Quality Group (NASCQG). This is the first cycle since the National Ambulance Services Medical Directors (NASMeD) approved the recommendation from NASCQG to continue febrile convulsion as a CPI, following two pilot cycles. The Trust achieved an overall compliance of 56.3% against the CPI, ranking 9th out of all 11 Ambulance Trusts. Aspects of care that the Trust had the lowest compliance against were recording of blood glucose and temperature.

The Monthly Cardiac Arrest and ST-Elevation Myocardial Infarction Reports (Cardiac Care Pack) for November 2013 have been published. The full report can be accessed at:

X:\Clinical Audit & Research Unit\Cardiac Reports\Cardiac Care Pack - Monthly Reports\April '13- March '14

Key Findings:

- Defibrillator data download rate remains at less than 1%.
- 1 in 3 cardiac arrest patients that had resuscitation commenced gained and sustained ROSC (Return of Spontaneous Circulation) until arrival at hospital.
- 99% of STEMI patients were transported to the most appropriate destination.
- Overall call to arrival at hospital time for STEMI has increased from 66 to 91 minutes over the past two months.
- The percentage of patients who received a complete care bundle (aspirin, GTN, two pain assessments and analgesia) decreased from 77% to 75%. The primary reason for a full care bundle not being provided remains the analgesia component.

The Clinical and Quality Directorate continue to publicise the message to expedite transfer to hospital for all time critical patients, via the Team Leader/Paramedic Manager Clinical Module, Intern courses and articles published in the Clinical Update journal.

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.

There were 16 Alerts issued in December. All have been reviewed by Safety and Risk and none have any relevance to the Trust.

Quality Domain 2: Enhancing quality of life for people with long-term conditions

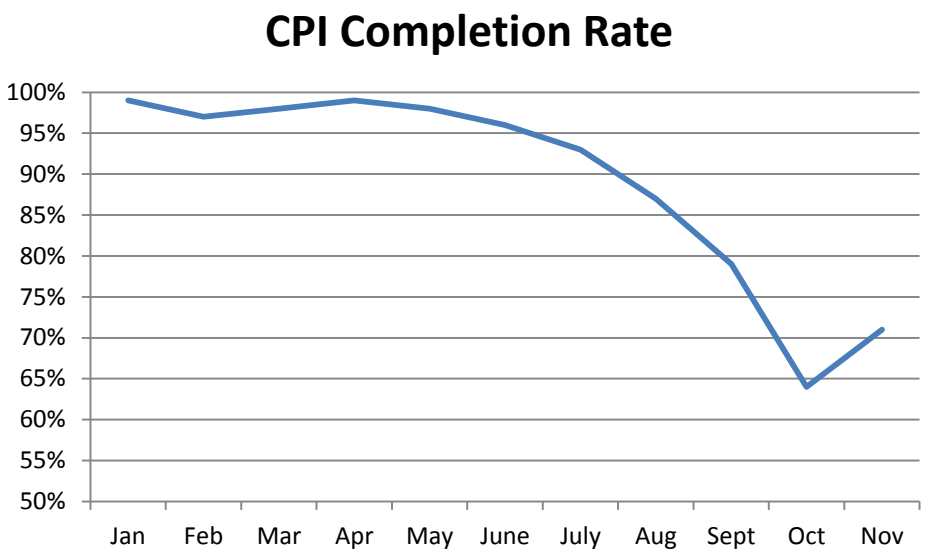
No update since the last Trust Board report.

Quality Domain 3: Helping people to recover from episodes of ill health or following injury

Clinical Performance Indicator completion and compliance

CPI completion rate increased in November; the first time in the past six months. Only 10 Complexes achieved >95% completion rate. Due to increased operational focus by Team Leaders to improve category A performance, there is a significant risk that CPI compliance will not recover to >95% before the end of the financial year.

CPI compliance remains >95% against all clinical care standards (except mental health).



Full CPI reports can be accessed at: Clinical Audit & Research Unit\Clinical Performance Indicators (CPIs)\Monthly Team Leader CPI reports\2013-14\Monthly Reports 2013-14

CPI Completion January to November 2013

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

CPI Compliance November 2013

Area	Cardiac Arrest	Glycaemic Emergencies	ACS	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	99%	97%	97%	97%	91%	98%	97%
South	96%	97%	95%	97%	89%	97%	97%
West	97%	98%	97%	96%	89%	97%	98%
LAS Total	**97%**	**97%**	**96%**	**96%**	**89%**	**97%**	**97%**

CPI Compliance October 2013

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

The Trust is below the expected number of CPI feedback sessions. 3327 (out of an expected 3640▲) CPI feedback sessions have been completed year-to-date.

▲ Expected target is based on each member of staff receiving two face-to-face feedback sessions a year. The value is calculated using ESR and CPI database data.

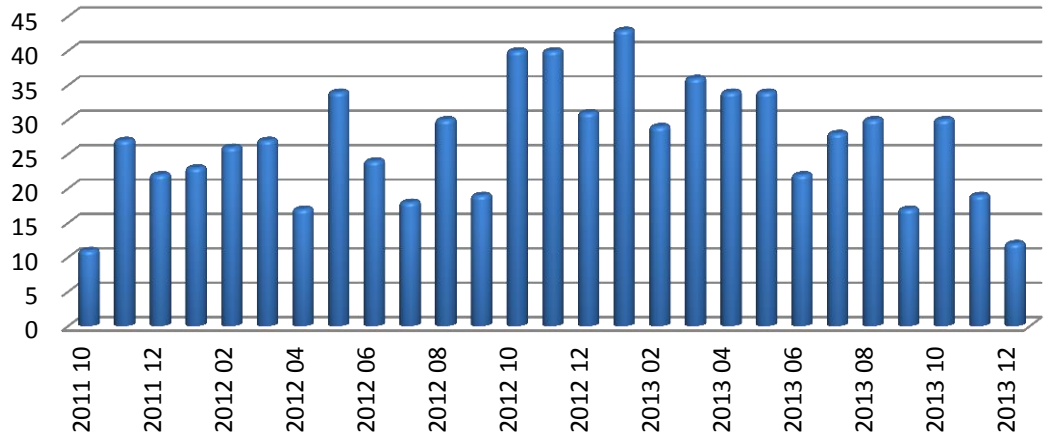
Quality Domain 4: Ensuring people have a positive experience of care

Patient Experiences

Complaint Volumes

The number of complaints this month totalled 82, reflecting a seasonal decrease. Of these 38 related to delays (44%). During December, complaints about staff conduct were the lowest since October 2010.

Conduct complaints by month - October 2010 to December 2013



11 complaints involved other Trusts/agencies including 5 x Acute Trusts, 4 x 111 provider, 1 LAS111, and 1 Serious Incident considerative. This case, C8550, was declared a Serious Incident on 13 December – patient was not immediately immobilised and is now paralysed. C8601 is the first complaint that involves the LAS 111 service and the out of hours deputising service.

Complaint Themes

Complaints relating to delay (38) and staff conduct (12) continue to be the main themes. 2 complaints are the result of complaints via social media which is a new category and will result in an increase in complaints in the future.

10 complaints relate to non-conveyance. Of these, one did not relate to LAS - external PTS provider. 8 were triaged as Category C4. One patient was conveyed by a taxi service on behalf of the LAS, the taxi company have since reimbursed the patient with the taxi fare which was charged by mistake – DMP D in place at the time of this call.

The following table shows the complaint subjects May to December 2013

Complaints by subject	May	June	July	Aug	Sept	Oct	Nov	Dec
Delay	37	29	38	30	50	53	41	38
Conduct	26	18	22	27	16	30	19	12
Road handling	12	8	15	12	9	10	8	9
Non-conveyance	0	6	5	5	7	8	11	10
Not our service	1	7	4	4	1	1	1	2
Treatment	2	3	4	4	5	13	11	6
Patient Injury/Damage to Property	0	0	3	0	1	4	2	1
High Risk Address Referral	1	0	1	3	1	2	2	1
Conveyance	2	2	0	4	2	3	1	2
Clinical Incident/Equipment	0	0	0	1	0	1	0	1
Assisting with external agency	0	0	0	0	2	0	2	0
Totals:	**81**	**73**	**92**	**90**	**94**	**125**	**98**	**82**

Emerging themes
Almost entirely the same as previously reported; delay and poor staff attitude the major sources of complaint. There has also been a continuing small rise in complaints about non-conveyance.

Performance/Quality
111 cases were closed during December. This is a 35% increase in closure rates over November (72/111). As at 7 January, 197 complaints remain open or re-opened over 221 in December. This represents an increase in closed cases reflecting the slight decrease in complaints received in this month and a revision in practice in PED whereby one member of staff is currently managing all the PALS cases.

The current stage audit of complaints evidences that 39% of all 'open' complaints are currently awaiting a Quality Assurances report, 16% are awaiting Operational input, 13% are currently being drafted by the case officer and 11% are in the approval process. The QA Manager is currently fast tracking QA reports where less than 2 x 999 calls have been received, this has improved throughput over preceding months.

Current stage of monthly complaints received	**Overall**	**November**	**December**
Allocated	11	6	7
Awaiting input from complainant	6	5	1
Awaiting Clinical Opinion	7	2	1
Awaiting input from other agency	5	2	2
Awaiting Operational Input	32	24	13
Awaiting QA Report	76	37	33
Awaiting Allocation	6	0	0
Comeback Response with Executive Office	0	0	0
Draft Response with Executive Office	23	1	1
Draft Response with involved parties	0	0	0
Draft Response with PED Management	4	0	2
Draft response with PED Officer	27	18	6
No further action	0	1	6
Response sent	0	2	10
Totals:	**197**	**98**	**82**

Closure rates for 2013 are set out in the table below. This table evidences that cases are being closed quicker with less open for more than 60 days.

Total complaints

Month	0-25	0-35	0-40	0-45	0-60	0-80	0-100	Total	Total complaints received
2013 01	23	10	6	10	20	12	7	88	88
2013 02	22	7	5	11	15	8	1	69	69
2013 03	35	10	5	14	18	3	3	88	88
2013 04	32	10	9	14	16	5	0	86	86
2013 05	21	10	7	9	16	13	4	80	81
2013 06	30	7	4	4	14	10	4	73	73
2013 07	34	7	8	11	22	6	1	89	92
2013 08	27	5	9	21	19	5	2	88	90
2013 09	20	4	9	24	28	6	0	91	94
2013 10	23	8	8	15	35	0	0	89	125
2013 11	16	5	0	0	0	0	0	21	98
2013 12	16	0	0	0	0	0	0	16	82
Totals:	**299**	**83**	**70**	**133**	**203**	**68**	**22**	**878**	**1066**

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

Month	0-25	0-35	Closed within 35 days by month
2013 01	23	10	33
2013 02	22	7	29
2013 03	35	10	45
2013 04	32	10	42
2013 05	21	10	31
2013 06	30	7	37
2013 07	34	7	41
2013 08	27	5	32
2013 09	20	4	24
2013 10	23	8	31
2013 11	16	5	21
2013 12	16	0	16
Totals:	**299**	**83**	**382**

It should be emphasised that a true reflection of response times cannot be calculated until the furthest timescale (i.e. 35 days working days have elapsed) = 28 January 2014

'Comeback' Activity

Year	Numbers of comeback responses recorded
09/10	10
10/11	2
11/12	20
12/13	43
13/14 (to date)	25
Totals:	**100**

There are currently 3 cases re-opened in December where the complainant was not satisfied with the initial response. In one case C8126, the family have asked to listen to the tape recordings of the 999 calls, the second has asked for a copy of the tape recording and the final case is from a patient who has cited a further case of staff smoking on duty.

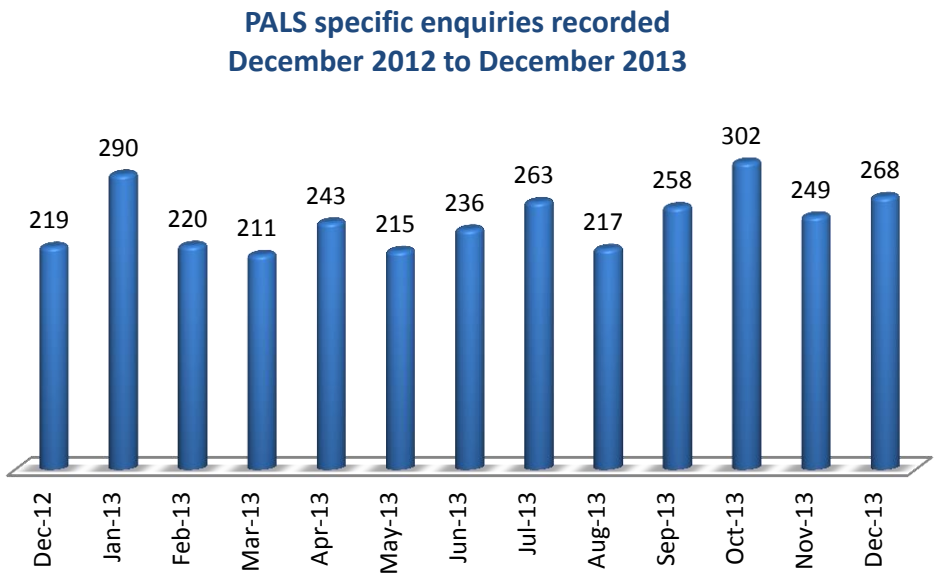
Health Service Ombudsman

Datix Reference	Current status	Outcome
C6786	File requested 30 Sept 2013	File sent 04 Oct 2013 - outcome awaited
C7169	File requested 18 Oct 2013	HSC to investigate way in which disciplinary was managed
C7319	File requested by HSC 21 Oct 2013	File sent 11 Nov 2013 - outcome awaited
C7417	Further details requested by PHSO > further local resolution	Further letter to family 29 August 2013 - PED file sent 06 Dec 2013
C7642	Scope of enquiry expanded by PHSO	HSC not to investigate - closed
C7771	File requested 23 Dec 2013	File sent 03 Jan 2014
C7874	File requested by HSC 04 Oct 2013	File sent 23 October 2013 - HSC request for further details - provided
C7893	File requested by HSC 22 November 2013	File sent 23 Nov 2013 -acknowledged 05 Dec 2013
C7988	file requested by HSC 10 October 2013	File sent 21 October 2013 - acknowledged 30 Oct 2013
C8004	File requested by HSC 31 Oct 2013	File sent 05 November 2013 - acknowledged 18 Nov 2013
C8032	file requested by HSC 06 Dec 2013	File sent 09 Dec 2013 - acknowledged 09 Dec 2013
C8064	File requested by HSC 04 Dec 2013	File sent 04 Dec 2013 - acknowledged 04 Dec 2013

In December, the PHSO monthly newsletter[1] discussed the progress on the new initiative to carry out more investigations and resolve more complaints. This has resulted in a fourfold increase in the numbers of cases they are investigating (869 since April 2013), the downside of which is that this has resulted in a lengthier process whilst staff are redeployed to carry out the investigations.

PALS

PALS enquiries increased to 268 in December above the monthly average of 246. Of these 26 remain open, including patient requests for medical records, requests for information when CommandPoint was down, other agencies seeking clarification of actions (e.g. H&S Executive, Care Homes etc.) and specific information where collaboration has been sought with other agencies/departments.



The total PALS enquiries received in the past 6 years is as follows:

Financial Year	Total PALS
2008/09	5606
2009/10	5674
2010/11	6031
2011/12	6264
2012/13	5714
2013/14 (to 31 Dec 2013)	4369
Totals:	**33658**

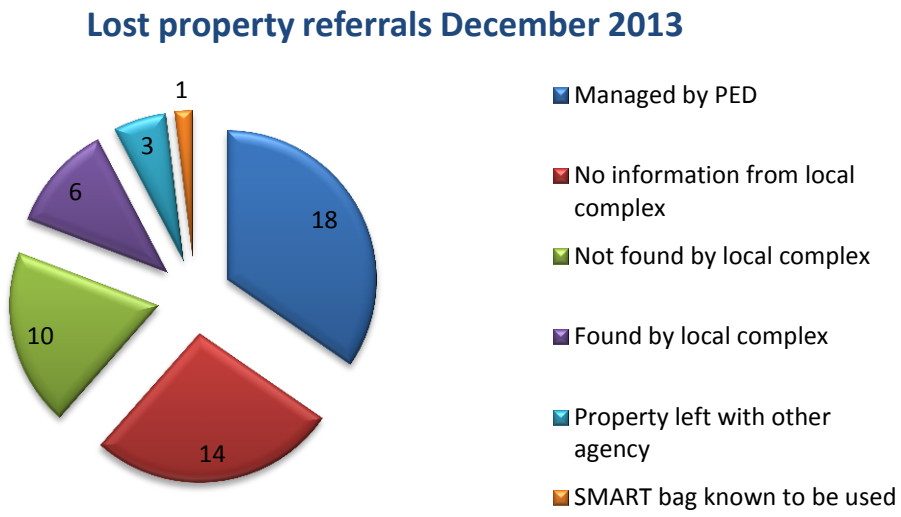
[1]http://www.ombudsman.org.uk/__data/assets/pdf_file/0020/23807/PHSO_Resolve_E-bulletin_Dec_2013.pdf

PALS Themes
Consistent themes about destination hospital, medical record requests and requests about policy and procedure.

PALS by subject	Totals
Information/Enquiries	200
Lost Property	52
Other – Incident reports etc	13
Appreciation	3
Total	**268**

Lost property
52 lost property cases were received. 34 were managed via the shared facility. Of the remaining 18, this includes cases resolved on the day by PED staff, where items were found locally and a number of cases where property was traced by local staff and entered in Datix.

Of the 34 local referrals, 6 items were found – representing circa 17%. Of the remaining enquiries, 3 items were handed to hospital staff, the police or were not taken to hospital by the crew. No information is recorded regarding 14 items, 10 items were not traced at all.



Quality Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

Serious Incidents

A review of SI reporting to EMT and Trust board is being undertaken by the Interim Head of Governance. It is the intention to create a quarterly report, detailing not only the number of SIs declared and not declared to NHS England (London), but also incident themes.

NHS Central Alerting System (CAS)

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

There were 16 Alerts issued in December. All have been reviewed by Safety and Risk and none have any relevance to the Trust.

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 2013/14.

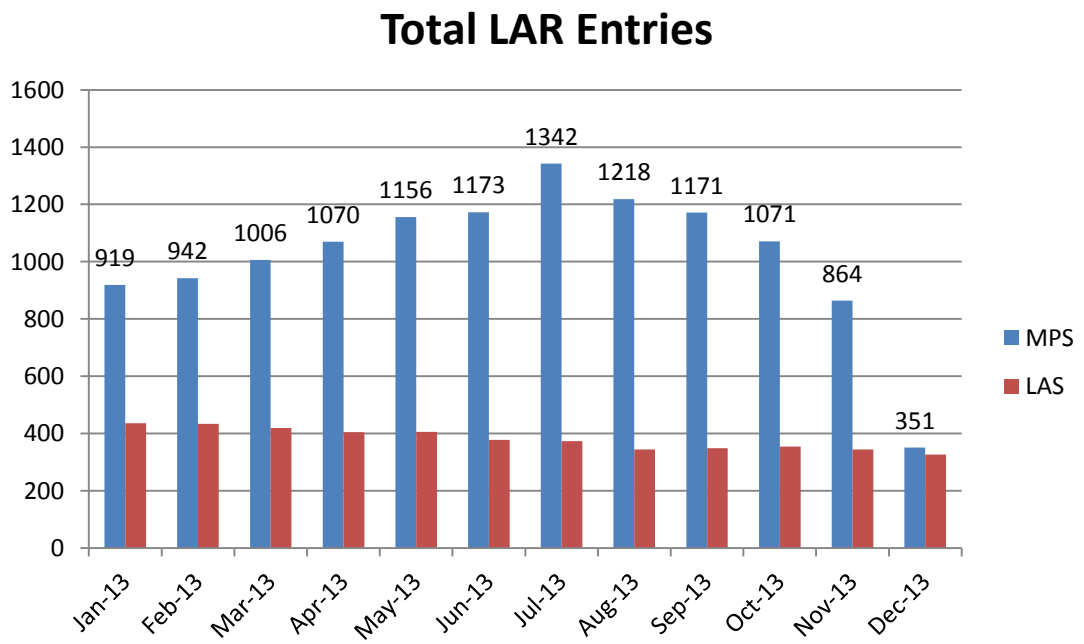
NICE Guidance

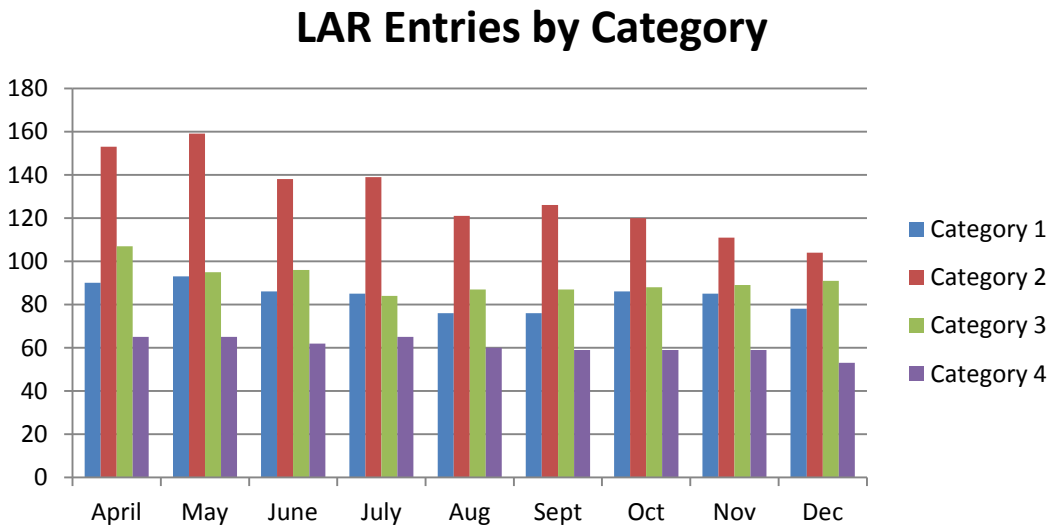
No NICE guidance, which has relevance to the Trust, has been issued since the last Trust Board report.

Locality Alert Register

There are currently **326** addresses on the Locality Alert Register (LAR). This is the lowest number to-date. These are broken down as follows:

CATEGORY 1: 78
CATEGORY 2: 104
CATEGORY 3: 91
CATEGORY 4: 53





There has been a significant reduction of high risk address notifications from the Metropolitan Police, following protracted discussions between the MPS and Management Information. The MPS completed an audit of all high risk notifications sent to the Trust, which resulted in the removal of over 500 addresses. A new system, which requires the MPS to assess if there is any specific threat to other agencies, has also been introduced. This has resulted in a reduction in the number of new locality alerts and improvement in the quality of risk information provided by the MPS.

The Trust now has notification of **351** high risk addresses from the Metropolitan Police.

Demand Management Plan

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

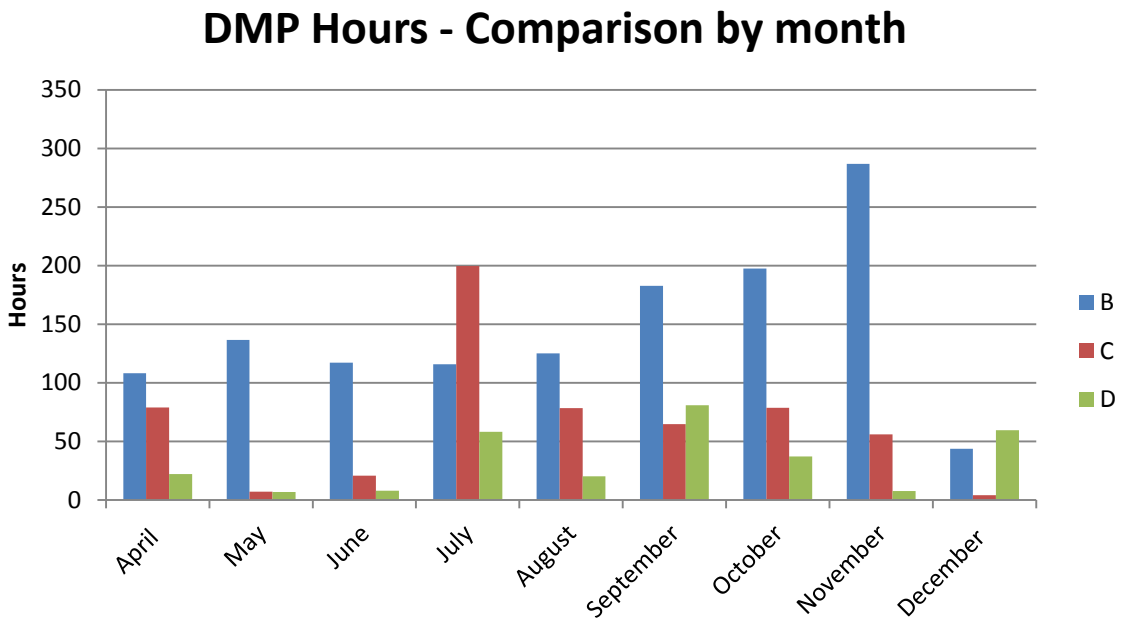
DMP enables the LAS to prioritise higher MPDS category calls, to ensure those patients with the most serious conditions or in greatest need continue to receive a response. Escalating stages of DMP (A-H) decreases the response to lower call categories. The risk is mitigated by increased clinical involvement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

Early implementation of Surge Amber was invoked on 19th December 2013.

As a result of the early implementation of Surge Amber, DMP data reporting is affected. In practical terms, the first stage of DMP that can be invoked, which operates at a higher level than Surge Amber, is DMP D.

DMP use May - November 2013

Month	Number of occasions DMP invoked	Stage B (hours)	Stage C (hours)	Stage D (hours)	Stage >D (hours)	Ambulances reprioritised
June	19	117.25	20.75	7.75	0	3532
July	17	115.75	199.75	58.25	0	4403
August	24	125	78.25	20.25	0	3771
September	27	182.75	64.75	80.75	0	4003
October	20	197.5	78.5	37	0	3240
November	25	286.75	56	7.5	0	2068
December	15	43.75	4	59.5	0	6395



Medicines Management

There have been no mandatory reportable controlled drugs (CD) incidents or notification of drug errors since the last report to Trust Board.

There has been an Unannounced Visit by the Metropolitan Police Controlled Drugs Liaison Officer to Whipps Cross Ambulance Station on Wednesday 15th January 2014. (This was in response to an incident that occurred in December 2013, where a box of morphine ampoules was found outside of the CD Safe. The incident was reported to the NHS England (London Region) LIN Group and the Metropolitan Police). A report of the visit was received on Friday 17th January 2014. All CD Registers and associated paperwork were found to be in order and complaint with Trust policy.

The Trust Risk Register for Medicines Management has been reviewed and actions updated.

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

The Trust has received no Prevention of Future Deaths Reports (previously Rule 43 Report) since the last Trust Board report.

Infection Prevention & Control

Some audit data for hand hygiene, vehicle, and premises cleaning were missing from complexes due to REAP 4, with one missing for 3 months (Barnehurst) and 4 (Hillingdon, City and Hackney, Newham, Bromley) for the last 2 months.

Hand Hygiene compliance remains consistently high at 100%.

CSR training compliance continues to improve, a cumulative total 63% at the end of December, with some variance from 20.3% (Oval) to 77.9% (Romford) in complexes.

AOM Premises cleaning audits and Lakethorne monthly average data are demonstrating compliance at each complex (85%), however Lakethorne has targeted 8 individual sites for further improvement (Barnehurst, Becontree, Bounds Green, Edmonton, Fort Street, Leabridge Road, Mayday Hut, Waterloo CRU). Cleaning of A&E vehicles is not at the level expected in some areas. However, collective KPI based on overall compliance including PTS cars was achieved at over 90%. There is a need to review KPIs for 2014/2015 during contract review.

Incident reporting: Staff exposure to sharps and BBV exposure - there are 3 Razor injuries (1 clean/2 dirty), 3 used sharps injury, a BBV exposure in the eye (spit from IVDU); 1 TB transfer without appropriate PPE used; and in January, 4 members of staff exposed to meningococcal meningitis (all treated).
Current work themes:

- An external review undertaken in November highlighted significant compliance and some development areas in Cleaning, Policies and SOPs, Team management, Communication, Training and Learning, Equipment and uniforms, OH and inoculation injuries. The 2014/2015 IPC plan will address these areas; compliance will require engagement of all internal services within LAS.

- Alternative audit data capture system was explored and a 6-month pilot for the use of Doc-Works will begin at the end of February 2014 in 5-6 sites; pilot approved by DIPC and IMT. There may be a cost implication if the system is evaluated as effective of approximately £6k per year.

- Quarterly audits and on–going ad hoc inspection visits are highlighting gaps in practice:
    - Uniform disposal
    - Linen and blankets pinch points
    - Equipment cleaning
    - Consistent standard of cleanliness – garages and ambulance
    - Waste streaming
    - And need for all teams understand accountability responsibility and to work together

- Infection control refresher training continues, subject to REAP levels constraint. An IPC strategy has been drafted to include patient facing and non-patient facing staff and content are being aligned to Skills for Health, and enhanced to address other areas such as waste streaming, cleaning, PPE and aseptic competencies. There is currently no data for non-patient facing and contractor staff which will be part of the 2014/15 plan.

1908 staff have now received the influenza vaccination; 46% (1908) operational staff and 40% non-operational staff.

Rising Tide

Advanced Paramedic Practitioners

The first 12 Advanced Paramedic Practitioners (APPs) have been recruited following an application and assessment process. The Advanced Paramedics will now undertake further education (including Masters level modules at the University of Hertfordshire) to increase their scope of practice in assessment and interventions. It is planned that the new APPs will be operational from 1st April 2014.

Fionna Moore	**Steve Lennox**
Medical Director	**Director of Nursing & Quality**

Appendix 1

LAS Clinical Audit and Research Activity Update September to December 2013

Please refer to the previous update provided in September 2013. This document reflects changes since the previous updates therefore any projects that are being undertaken but have had no significant updates are not included.

Clinical Audit Activity Update

Core Clinical Audits	
A further review of the clinical audit work plan for 2013-14 has been undertaken and one new project has been added: Re-contact. The See & Treat clinical audit has been put on hold to allow for winter pressure to pass before facilitating focus groups with staff and the Joint Response Unit clinical audit sample size has been reduced to allow some extra capacity for the new project. These changes were agreed by Chair's action. One of the two clinical audit posts is currently vacant.	
Overdose Status: Report disseminated Report date: October 2013	In the first six months of 2013 there were four serious incidents involving patients who had taken an overdose, raising concerns that these patients are waiting too long for ambulance. This clinical audit examined the LAS's response to 50 patients who had taken an intentional overdose. Almost half of the patients triaged as category C waited more than 30 minutes for a response. In order to ensure that these patients do not deteriorate whilst waiting for a response during periods of high demand, an implementation plan is being developed for periods of high demand, ensuring overdose patients receive an enhanced clinical assessment and, where necessary, are prioritised to ensure a timely response. Overall average on scene time was 27 minutes, but times ranged from 3 minutes to 150 minutes. Whilst it is understood that the on scene management of this group of patients can be complex and challenging, crews have been reminded through articles in the Clinical Update and RIB that delays could impact administration of activated charcoal at hospital. In addition, two further projects will be conducted: a study to determine whether pre-hospital administration of activated charcoal is feasible, and an in-depth clinical audit examining the appropriateness of triage, on-scene management and clinical outcomes for these patients.
Anaphylaxis	Given the number of patients in the adrenaline re-audit (released in June) who received adrenaline when it was not indicated, a further baseline clinical audit was conducted to determine whether there are also patients who should have received adrenaline and did not (specifically anaphylaxis). This clinical audit examined the care provided to 207 patients who presented to the LAS in the first week of July 2013 with symptoms of an allergic reaction or anaphylaxis. Adrenaline was only indicated for a small number of these patients. Despite this small number, less than half of those for whom it was indicated received it in line with guidelines. All patients for whom adrenaline was administered received it via the correct route; however there were some patients who received an incorrect dose and some who did not receive adrenaline at all, despite clear documented symptoms of anaphylaxis. There were also a few patients who received adrenaline without any clear indications for its administration recorded. Staff have been reminded of the indications for intramuscular adrenaline (1:1000) and the risk to patients if it is not administered when indicated (as well as the requirement to clearly document any contraindications to indicated interventions).

Status: Report disseminated Report date: November 2013	The correct dosage for intramuscular adrenaline (1:1000) administration, including post-EpiPen administration have also been included in a Clinical RIB reminder, and posters and a Clinical Update article will be produced to communicate the findings of the clinical audit. The above reminders will also be proposed to the Training Services Committee for inclusion in Core Skills Refresher (2014/15).
Hydrocortisone Status: Report disseminated Report date: November 2013	The LAS attend high numbers of calls for symptoms related to asthma. The recognition and diagnosis of severe and life-threatening asthma can be challenging, but failure to recognise severity can lead to inappropriate management, and ultimately patient deterioration. There are anecdotal concerns that even when indicated, hydrocortisone (a steroid treatment for severe and life-threatening asthma) is suspected to be underused. This clinical audit examined the care provided to 135 patients who presented to the LAS acute severe or life threatening asthma. The clinical audit findings showed only a very small number of patients with signs or symptoms of acute severe or life threatening asthma are administered hydrocortisone. It is thought there may be some confusion regarding the time parameter included in the 2006 JRCALC Guidelines (in use at the time of this clinical audit), which states that hydrocortisone is only indicated where call to hospital time is greater than 30 minutes. This has only been removed from one section of the 2013 Guidelines therefore we have clarified this with the publishers who have confirmed that hydrocortisone should be given sooner rather than later and the time parameter no longer applies. A survey will also be sent to staff to determine why hydrocortisone is being underused in the LAS. In addition, oral prednisolone (another steroid) is being considered as an alternative to hydrocortisone as this is easier to administer. Of the very small number of patients who were administered hydrocortisone, most received it by the correct route and dose. Staff have still been reminded of the correct route and doses (which have been revised in the 2013 Guidelines) as well as the indications for administration of hydrocortisone by a message in the Clinical RIB. Posters will also be sent to ambulance stations and an article written for the Clinical Update. The findings and key messages of this clinical audit were also summarised for Clinical Paramedic Managers and Team Leaders in the Clinical Development Module and the wording of the hydrocortisone aspect of care in the Difficulty in Breathing Clinical Performance Indicator (CPI) has been amended to ensure that missed hydrocortisone administrations are fed back to staff.
Police Attendance Status: Data collection Expected date of dissemination: March 2014	The LAS received an inquest outcome letter that recommended review of PRFs generated from consultations where the police are also present or have been called by the LAS for assistance. This clinical audit aims to assess the level of clinical risk associated with calls where both the LAS and the Metropolitan Police Service (MPS) attend and the patient is not conveyed to hospital. The clinical audit focuses on the level of clinical assessment undertaken and the appropriateness of the management plan for 250 patients attended in September 2013 where both the MPS and the LAS were in attendance.
UCC Usage at King Georges' Hospital Ilford Status: Data collection Expected date of dissemination: March 2014	A clinical audit was conducted in September 2012 assessing if it would have been more appropriate to convey patients to an Appropriate Care Pathway (ACP) rather than Kingston Emergency Department (ED). The clinical audit found that all patients were appropriately conveyed to the ED. While some patients would have been suitable for ACP, they were closer in distance to the ED meaning the conveyance decision made by staff was appropriate. A second Clinical Audit focused on the Urgent Care Centre (UCC) co-located at King Georges' Hospital will provide further information regarding the appropriateness of conveyance decision making by staff when the ED and UCC are equidistant.

Re-contact Status: Data collection Expected date of dissemination: April 2014	The National Ambulance Non-Conveyance Audit (NANA) raised concerns that following a 999 call to the LAS for a patient that was not conveyed to hospital, a second 999 call was made as the patient died within 24 hours. This project aims to determine whether or not this was an isolated incident and to inform the LAS of the level of risk in terms of frequency of occurrence regarding any cases where non-conveyance may have resulted in severe harm or death.

Continual Audit Activity	
Cardiac Care	Release of the ST Segment Elevation Myocardial Infarction (STEMI) Annual Report 2012/13 has been delayed until December 2013 due to resourcing issues. Three Cardiac Care Packs have been released within the LAS reporting data from August to October 2013. Of particular concern from these care packs is the increasing time spent on scene for STEMI patients, which is in excess of 40 minutes on average, and the defibrillator download rate falling to 1%. Ambulance Quality Indicator (AQI) data for May to July 2013 has been submitted to NHS England to deadline. For the cardiac arrest indicators, the average ROSC at hospital rate was 30% and survival to discharge was 8% for the overall group of patients. For the Utstein group of patients, there was large variation with ROSC rates ranging from 55% to 68% but survival to discharge rates were fairly consistent ranging from 24% to 27%. For the STEMI indicators, performance for the '999 call to pPCI within 150 minutes' indicator continued to be greater than 90%. Delivery of the care bundle (aspirin, GTN, two pain scores and analgesia) has increased to 78%, which is a considerable improvement from 67% in 2012-13. This is likely to be a result of changes to the national definitions to allow exceptions to GTN delivery if the patient does not have cardiac chest pain and a continued focus by the LAS to improve the delivery of analgesia.
Stroke Care	The Stroke Annual Report has been delayed indefinitely due to resourcing issues. Three Stroke Care Packs have been released within the LAS reporting data from August to October 2013. Crews continue to transport patients appropriately to HASUs and journey times are averaging 15 minutes. However, time spent on-scene continues to be longer than the recommended 30 minutes, and have remained so for the last 6 months, with just over half of crews managing to meet this target. The AQI data for May to July 2013 was submitted to deadline. The proportion of patients potentially eligible for thrombolysis conveyed to a HASU within 60 minutes of the 999 call was 68%, which is on par with 2012-13 performance. The LAS's delivery of the stroke care bundle is consistently averaging 94% each month. Complex management teams have been tasked to improve the stroke care bundle as part of their objectives for 2013/14.

Clinical Performance Indicators (CPIs)	
Clinical Performance Indicators (CPIs)	CPIs are used within the LAS to monitor general documentation and the standard of care delivered by crews. The CPIs enable the LAS to measure the extent to which guidelines for specific clinical conditions are followed and to provide individualised clinical feedback to staff on a twice-yearly basis. The percentage of CPI audits completed by Team Leaders has been decreasing since May. In October the LAS completion rate was just 64%, the lowest in four years. This decrease may be attributed to increased demand on the Service resulting in Team Leaders undertaking operational duties in place of office duties.

	A high level of general documentation and patient care continues to be maintained for acute coronary syndrome, cardiac arrest, difficulty in breathing stroke and non-conveyed patients. Documentation of the care provided to patients who have diagnosed psychiatric problems continues to slowly improve and is now at 91%, its highest since the Mental Health CPI was introduced in April 2012. Just over halfway through the financial year, over a third of complexes are meeting their staff feedback targets. Further work needs to be done across the LAS to ensure that more face-to-face feedback sessions are delivered.

National Clinical Audits	
National CPIs: ▪ Hypoglycaemia ▪ Asthma ▪ Suspected fracture (pilot) ▪ Febrile convulsions (pilot)	The National CPIs measure and compare the care provided to patients by the eleven ambulances services in England. National CPI data is used by the Care Quality Commission (CQC) to assess whether the LAS have met their Quality and Risk Profiling targets. We are awaiting the release of the final version of the cycle eleven report (which summarises data collected from June – September 2013). We have been undertaking quality improvement work to investigate possible reasons that the LAS perform poorly compared to other ambulance services regarding immobilisation of limb recorded under the Suspected Fracture National CPI. Following further review of the patient report forms (PRFs), it was identified that a possible reason for staff not immobilising patients is that they may be treating the patients for a sprain/strain rather than suspected fractures and therefore using the incorrect code. Questionnaires were sent to three complexes to obtain staff views on immobilisation. Most staff were confident immobilising patients with a suspected fracture, although some did not feel they had sufficient training (A&E Support and a first year Student Paramedic). Staff agreed they would immobilise a fracture even if it was not obvious (including suspected strains). Staff stated that immobilisation equipment was not always available when needed, but if it was safe to do so, they would improvise using other kit. Most staff agreed they would always document immobilisation in the free text and/or the lifting and immobilisation section of the patient report form. However reasons for not immobilising a suspected fracture below the knee were: patient refusal (including splinting increasing the patient's pain), lack of equipment, positioning of the patient's leg and as manual immobilisation was easier. From cycle twelve, the Suspected Fracture National CPI is being expanded to include all suspected single limb fractures below the knee or below the elbow.

Research Activity Update

Research funding applications

FAST2
An application, led by Rachael Fothergill and supported by Melanie Edwards as co-applicant, was submitted to the NIHR Research for Patient Benefit (RFPB) programme, to investigate whether a modification of the FAST would improve pre-hospital recognition of stroke by ambulance clinicians. This was a proposed follow on study to the ISRAS project. Unfortunately this application was unsuccessful. We will continue to pursue alternative sources of funding.

ResQpod
An LAS application led by Rachael Fothergill, and supported by Mark Whitbread as co-applicant, was submitted to the Resuscitation Council UK in August 2013. The proposed study aimed to investigate the impact of the CardioPump device on survival to hospital discharge following out-of-hospital cardiac arrest. Unfortunately this application was unsuccessful. The decision has now been made to carry out a feasibility study without external funding.

Alternatives to face to face contact
An outline application led by Mary Halter at St George's and supported by Rachael Fothergill as co-applicant, for a collaborative study which aims to assess the impact of the introduction of hear and treat submitted to NIHR Health Services and Delivery Research (HS&DR) has been successful. A full application will now be submitted in January.

rAAA Triage Tool
An application has been submitted to the Health Foundations' Shine funding call for a collaborative study led by Alan Karthy at St George's; to validate a pre-hospital triage tool for ruptured Abdominal Aortic aneurysm (rAAA). The intention of the study is to develop an electronic risk scoring system that could be loaded onto the Mobile Data Terminal (MDT) and/or a smartphone app. Rachael Fothergill, Fionna Moore, Mark Whitbread and Michael Daminani are co-applicants for this project. An initial application to the Wellcome Trust was unsuccessful. Two further applications for this project will be submitted to NIHR RfPB in January 2014 and the British Heart Foundation (BHF) in the near future.

Variation in non-conveyance
An outline application was submitted to the NIHR in October for a collaborative study lead by Niro Sirwardena at East Midlands Ambulance Service. This study aims to examine the reasons for the variation in non-conveyance rates and re-contact rates between UK ambulance services. If successful, a full application will be submitted in January 2014.

ParaNEWS
An application for a collaborative study led by Niro Sirwardena at East Midlands Ambulance Service and supported by Rachael Fothergill as co-applicant, which aims to validate the National Early Warning Scores in a prehospital setting has been submitted to the NIHR Health Services and Delivery Research (HS &DR) programme. If successful a smartphone app would be developed for study paramedics to use.

Active research projects:

Lead Site	Study Details	Update
Harefield Hospital	**DANCE (High Risk ACS)**: Direct Angioplasty for Non-St-Elevation Acute Coronary Events. Chief Investigator: Dr Miles Dalby (Harefield Hospital) LAS Principal Investigator: Mark Whitbread Recruitment period: 18/10/2010 – 29/11/2013 Funding: Abbott Laboratories Limited and Daiichi Sankyo UK Limited Sponsor: Royal Brompton and Harefield Trust R&D approval date: July 2010 Adopted onto the NIHR portfolio	This randomised controlled pilot study compares immediate assessment and treatment (angiogram +/- PCI within 90 mins) with standard care for patients with high risk non-ST-elevation acute coronary syndromes. Approximately 200 staff were trained and participated in the trial. All Heart Attack Centres (HACs) in London were active in the study. 108 patients were recruited to the trial (target n=200). The decision was taken by the trial steering group to end recruitment to the trial on the 29th November 2013 due to the low recruitment figures. Follow up data is expected to be gathered by January 2014.
Barts Health NHS Trust	**Paramedic SVT**: Safety and efficacy of Paramedic treatment for regular supraventricular tachycardia (SVT) Chief Investigator: Prof Richard Schilling (Bart's and The London) LAS Principal Investigator: Mark Whitbread Recruitment period: 31/11/2010 – ongoing Funding: British Heart Foundation Sponsor: Barts Health NHS Trust Trust R&D approval date: October 2010	This randomised controlled trial investigates whether trained paramedics can safely treat and non-convey patients with SVT. Patients are randomly allocated to either receive paramedic treatment with adenosine on scene plus referral to heart rhythm specialist, or are directly conveyed to their local emergency department (standard treatment). Protocol training for ambulance crews was completed in all areas in April 2012. Approximately 75 Paramedics are involved in the trial. 84 patients have been recruited to the study to date (target n=90). The recruitment period has been extended until the recruitment target is met.

LAS	**AMICABLE** Chief Investigator: Tim Edwards (LAS) LAS Supervisor: Emma Williams Data collection period: 09/2013-07/2015 Sponsor: University of Hertfordshire Trust R&D approval date: July 2013	This prospective observational study aims to investigate the impact of pre-hospital airway management strategies on mortality and morbidity in cardiac arrest patients who experience return of spontaneous circulation and are transferred directly to a heart attack centre. Data collection has begun and the first patient outcome has been followed up.
LAS	**Exercise-related sudden cardiac arrest** Chief Investigator: Melanie Edwards Sponsor: LAS	This is a retrospective analysis of cases where cardiac arrest occurred during or after exercise to investigate incidence of, and factors related to survival from, exercise-related cardiac arrest. Data analysis has been completed and the findings are being drafted for publication. The abstract was selected for a "Stand up science" presentation at the London Trauma Conference in December 2013.
LAS	**Stroke Mimics** Chief Investigator: Melanie Edwards Sponsor: LAS	This is a paper using data collected during the ISRAS study that investigates 1) the incidence of stroke mimics, 2) the diagnoses of stroke mimics, and 3) differences in response of stroke and mimics to the ROSIER assessment tool. Data analysis has been completed and the findings are being drafted for publication.
Durham University	**Professionalism** Chief Investigator: Dr Jan Illing (Durham University) LAS Supervisor: Melanie Edwards Recruitment period: 09/2012-11/2012 Funder: Health and Care Professions Council Sponsor: Durham University	The study aims to examine what professionalism means to trainee healthcare professionals, and how it may be related to their conscientiousness in training and in initial career progress. Trust R&D approval was issued in May 2011 but recruitment to the study did not start until September 2012. Recruitment to the study has now finished, with 94 LAS staff recruited to the project (target n=100). An interim report was received in October 2013. This interim report explores whether it is possible to develop a questionnaire to explore professionalism as a multidimensional construct.

Swansea University	**An Investigation of RCT Implementation in Pre-Hospital Emergency Care** Chief Investigator: Gareth Thomas LAS Supervisor: Gurkamal Virdi Recruitment period: April 2012- November 2013 Funder: National Institute for Social Care and Health Research (NISCHR) Sponsor: Swansea University	This study aims to investigate the factors affecting implementation of random control trials in pre-hospital emergency care, and the barriers and facilitators to the number, progress, and quality of trials. Trust R&D approval was issued in November 2011. All interviews have been completed for each case study. This project has now been put on hold until November 2014.

Student BSc/MSc Projects:

Universita del Piemonte Orientale (Italy) & Vrije Universiteit Brussel (Belgium)	**Antidote use and medical management of chemical incidents casualties** Student: Dr Wui Ling Chan Recruitment period: July-August 2013 Trust R&D approval date: June 2013	This student questionnaire study aims to evaluate emergency responders' knowledge of medical management and use of antidotes in chemical incidents casualties. 54 members of staff were recruited.
City University	**Blue light responders, evacuation and pets** Student: Karen Hetherington Recruitment period: June – July 2013 Trust R&D approval date: June 2013	This student questionnaire study aimed to investigate whether pet owners respond differently to non-pet owners when asked to evacuate their homes. Staff from the LAS, metropolitan police and fire brigade were been invited to participate. 16 members of staff completed the questionnaire and made up 55% of all respondents in the questionnaire (target n=70). The final report was received in November 2013.

Northumbria University	**Consultant Paramedics** Chief Investigator: Andrew Hodge (Northumbria University) LAS Supervisor: Melanie Edwards Recruitment period: June 2013 Sponsor: Northumbria University Trust R&D approval date: April 2013	This study aimed to evaluate the Consultant Paramedic role by i) assessing the perceived effectiveness of the Consultant Paramedic role against the core functions required for the role and skills and attributes required by a band 8 role, ii) exploring the factors associated with success and challenges to performing an effective Consultant Paramedic role, and iii) understanding the difference between the Consultant Paramedics activities across the UK. Interviews were completed in June 2013. The final report was received in October 2013. The report suggests that Consultant Paramedics are integral to clinical leadership within the paramedic profession. Balancing retention of clinical skills and appearing visible to staff whilst providing leadership were identified as challenges to the role. The traditional operational structure was deemed to be a conflict to clinical leadership structure.

Publications since September 2013

Published (LAS authors in bold)

Title: Survival of resuscitated cardiac arrest patients with ST-elevation myocardial infarction (STEMI) conveyed directly to a Heart Attack Centre by ambulance clinicians
Authors: **Fothergill R, Watson L, Virdi G, Moore F, Whitbread M**
Journal: Resuscitation, 2013, http://dx.doi.org/10.1016/j.resuscitation.2013.09.010

Title: The role of the emergency services in the optimisation of primary angioplasty: experience from London and the Heart Attack Team
Authors: Dalby M, **Whitbread M**
Journal: EuroIntervention, 2013, 9, 4, 517-523

Title: Examining the use of the Recognition of Stroke in the Emergency Room (ROSIER) stroke assessment tool in the pre-hospital setting.
Authors: **R Fothergill**, J Williams, **M Edwards**, I Russell, P Gompertz
Journal: Stroke, 2013, 44(11): DOI: 10.1161/STROKEAHA.13.000851

Submitted Publications pending decision (LAS authors in bold)

Title: Development of a Complex Intervention in the Emergency Care of Falls for Evaluation: Implementation of the MRC Guidance
Authors: Chatter R, Snooks H, Mason S, Halter M, Sirwardena N, Hutchings H, Whitfield, **Fothergill R**, Koniotou M, Wilson L.
Journal: BMC Medical Research Methodology

Title: A Clinical Audit of the Pre-Hospital Paediatric Respiratory Assessment in London
Authors: **Clark S, Shaw J, Wrigley F**
Journal: Journal of Paramedic Practice

Title: Impact of Extreme weather on Response Times in London
Authors: Thornes J.
Journal: Ambulance Today

Title: Frequent callers to the ambulance service: patient profiling and impact of case management on patient utilisation of the ambulance service
Authors: **Edwards M, Bassett G, Sinden L, Fothergill R**
Journal: Emergency Medicine Journal

Accepted Publications – in press (LAS authors in bold)

Title: Spotlight on Research: Implementation of a mechanical chest compression device
Authors: **Watson L**
Journal: Journal of Paramedic Practice

Conference Presentations (LAS authors in bold)

Title: The student experience of university paramedic education and training: from classroom learning to situational understanding
Authors: Donaghy J
Conference: 19th Qualitative Health Research Conference, Halifax, Canada, November 2013

Title: Exercise-related sudden cardiac arrest in London: Incidence, survival, and bystander response

Authors: **Edwards M**
Conference: London Trauma Conference, London, December 2013
Conference Abstract Submissions (LAS authors in bold)

Title: Does use of the Recognition Of Stroke In the Emergency Room stroke assessment tool enhance stroke recognition by ambulance clinicians?
Authors: **Fothergill R**, Williams J, **Edwards M**, Russell I, Gompertz P
Conference: 999 EMS Forum, Sheffield, 19th February 2014

Title: Increases in survival from out-of-hospital cardiac arrest: A five year study
Authors: **Fothergill R, Watson L, Chamberlain D, Virdi G, Moore F, Whitbread M**
Conference: 999 EMS Forum, Sheffield, 19th February 2014

Title: Survival of resuscitated cardiac arrest patients with ST-Elevation Myocardial Infarction (STEMI) conveyed directly to a Heart Attack Centre by ambulance clinicians
Authors: **Fothergill R, Watson L, Virdi G, Moore F, Whitbread M**
Conference: 999 EMS Forum, Sheffield, 19th February 2014

Title: Exercise-related sudden cardiac arrest in London: Incidence, survival, and bystander response
Authors: **Edwards M, Fothergill R**
Conference: 999 EMS Forum, Sheffield, 19th February 2014

Title: Frequent callers to the ambulance service: patient profiling and impact of case management on patient utilisation of the ambulance service
Authors: **Edwards M**, **Bassett G, Sinden L, Fothergill R**
Conference: 999 EMS Forum, Sheffield, 19th February 2014

Title: Clinical audit making a difference: Clinical Performance Indicators in the London Ambulance Service NHS Trust
Authors: Shaw J, Salvidge H, Virdi G, Fothergill R
Conference: Clinical Audit for Improvement, 26-27th February 2014

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 28TH JANUARY 2014

PAPER FOR INFORMATION

Document Title:	**Integrated Board Performance Report**
Report Author(s):	**Paul Woodrow, Director of Performance**
Lead Director:	**Paul Woodrow, Director of Performance**
Contact Details:	**paul.woodrow@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To provide the Board with an integrated view on performance.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**The Trust Board is requested to note this paper.**

Key issues and risks arising from this paper

This paper provides a summary of the Trust's performance across a range of quality, performance, workforce and finance metrics.

- Quality: Delays in Cat C calls remain cause of concern. The number of complaints is still above target, SIs have reduced but remain above target.
- Performance: Activity levels remain within contracted levels, performance improved in December but remained below the 75% target.
- Workforce: Turnover and vacancy factor continue to be the priority. Sickness levels have reduced but remain off target.
- Value for Money: Additional resources secured to support A8. Failure to achieve could result in a penalty.

Executive Summary

Attachments

Performance Report M09

****

Quality Strategy

This paper supports the following domains of the quality strategy

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

LAS Strategic Goals and Priorities

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

LAS Strategic Goals

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

2013/14 Priorities

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

Has an Equality Analysis been carried out?

☐ Yes
☒ No

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST
INTEGRATED PERFORMANCE REPORT 2013/14: DECEMBER 2013 (MONTH 09)

Quality Exceptions	!	**Delays in Cat C calls remain cause of concern. Number of complaints is still above target, SIs have reduced but remain above target**
Performance Exceptions	!	**Activity levels remain within contracted levels, performance improved in December but remained below the 75% target**
Workforce Exceptions	!	**Turnover and vacancy factor continue to be the priority. Sickness levels have reduced but remain off target**
Value for Money Exceptions	!	**Additional resources secured to support A8. Failure to achieve could result in a penalty.**

Summary commentary

Category A performance was again below the 75% national threshold for December, however, the revised trajectory for December as part of the Winter sustainability plan was set for 70% and we over achieved against that target and improved overall Category A performance against the previous month. Red 1 performance was slightly under the 75% threshold for the month but remains on track to deliver for the year, Red 1 also showed a month on month increase. A revised trajectory has been agreed and an associated action plan has been enacted to deliver the Red 2 target by year end. Cat C response times remain below expectations with a slight decrease in C1 performance in month and static C2 performance from the previous month. This continues to represent a risk to patient safety due to extended response times. Activity remained within contracted levels throughout the month. New Years Day was the busiest day ever in the Trust, we responded to 1807 Category A calls and over 3,700 total incidents. The Trust also responded to a Major Incident in Central London on the 19 December and conveyed 80 patients, as well as also responding to a decared Serious Incident on the 20 December in South London where we conveyed c30 patients. EOC also enacted Operational Procedure 066 on the 25 December and in the early hours of 26 December. The Trust remains on track to deliver its planned £0.3m surplus, Cost Improvements are slightly off track YTD (£0.1m) but the expectation is that £9.8m will be delivered. YTD Capital Remains underspent but this will accelerate through Q4 and theTrust will be at or very close to its £10.3m target. The Trust's cash balance is above plan due to receipt of CBRN (£7.2m) in December combined with lower than expected Capital spend. Overall, the Trust expects to achieve a 3 (Good) rating on the Monitor Financial Risk Ratings used in assessing FTs financial performance.Workforce: Workforce measures show a dcrease in the level of sickness in both measures. Turnover remains at above 10%. With vacancies remaining overall static in month at 9.7% across the Trust. Workforce metrics remain a major concern for the Trust and represent a significant risk to performance, safety and finance. Increasing recruitment and retention levels are a key priority for EMT.CSR training remains static due to our planned temporary cessation of training during December as part of the Christmas and New Year Service delivery plan. To date 1906 staff have received their CSR training. CSR training will recommence in January 2014.

QUALITY

	Quality measures	Target	Current month	Previous month	Monthly Trend
1	Serious Incidents declared	1	4	7	↓ !
2	Complaints received	69	82	98	↓ !
3	999 Call Answering - 5 secs	95.0%	97.9%	99.0%	↓
4	NHS111 Call Answering- 60secs	95.0%	98.0%	N/A	↑
5	NHS 111 Transfer rate to 999	10.0%	9.0%	N/A	↔
6	CPI compliance	95.0%	71.0%	64.0%	↑
7	Infection control - hand hygiene	100.0%	100.0%	98.0%	↑
8	Category C1 (20 mins)	75.0%	66.7%	67.2%	↓ !
9	Category C2 (30 mins)	75.0%	61.2%	61.2%	↔ !
10	Flu vaccination uptake ops %	75.0%	46.0%	N/A	↑

PERFORMANCE / ACTIVITY

	Performance / activity measures	Target	Current month	Previous month	Monthly Trend
1	Category A - Red 2 performance	75.0%	71.6%	71.0%	↑ !
2	Category A - Red 1 performance	75.0%	74.8%	74.2%	↑
3	FRU A8 Performance	85.0%	72.0%	72.0%	↔ !
4	Trust A19 Performance	95.0%	97.1%	98.2%	↓
5	Cat A total incidents	43,165	41,104	38,159	↓
6	Cat A (red 1) incidents	N/A	1,311	1,190	↓
7	Cat A (red 2) incidents	N/A	39,793	36,969	↓
8	Total incidents	93,873	91,204	89,860	↓
9	Demand Management Plan (A)	90%	29%	42%	↓ !
10	Clinical Hub H&T discharges	TBC	9,440	N/A	↑

WORKFORCE

	Workforce measures	Target	Current month	Previous month	Monthly Trend
1	Staff Turnover	8.5%	10.3%	10.1%	↑ !
2	Vacancies (%)	5.0%	9.7%	9.7%	↔ !
3	Vacancies (WTE)	241	484	472	↑ !
4	Sickness all staff	5.5%	5.8%	6.2%	↓ !
5	Frontline sickness	5.5%	6.2%	6.8%	↓ !
6	CSR 2013 Delivery - % of est	90.0%	63.0%	63.0%	↔

VALUE FOR MONEY

		Target	Current month	Previous month	Year end forecast
1	EBITDA (£000)	13,935	13,308	11,097	Amber
2	Net surplus (£000)	438	470	369	Green
3	Cost Improvement Programme (£	6,293	6,206	5,171	Green
4	Capital expenditure (£000)	6,497	2,339	2,076	Green
5	Monitor FRR	3	3	3	Green
6	Cash balance (£000)	14,944	25,417	17,849	Green

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 28TH JANUARY 2014

PAPER FOR INFORMATION

Document Title:	**Finance Report Month 9: December 2013**
Report Author(s):	**Andrew Grimshaw, Director of Finance and Performance**
Lead Director:	**Andrew Grimshaw, Director of Finance and Performance**
Contact Details:	**andrew.grimshaw@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To provide and update on the Trust's financial position**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Learning from Experience Group ☒ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To note the report**
Key issues and risks arising from this paper	
Executive Summary In month the Trust reported on plan. YTD the Trust is on plan. The Trust still expects to deliver its £0.3m year end surplus position.	
Attachments Finance Report Month 9: December 2013	

****

Quality Strategy

This paper supports the following domains of the quality strategy

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

LAS Strategic Goals and Priorities

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

LAS Strategic Goals

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

2013/14 Priorities

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

Has an Equality Analysis been carried out?

- ☐ Yes
- ☒ No

Key issues from the assessment:

London Ambulance Service NHS Trust
Finance Report - Part 1 - 2013/14
Month 9: December

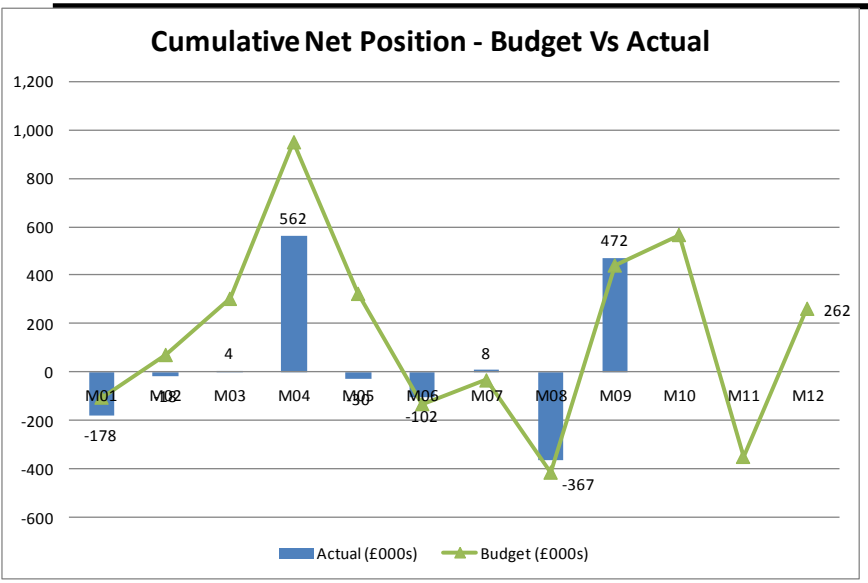
EMT – 22nd January 2014
Board – 28th January 2014

Andrew Grimshaw
Finance Director

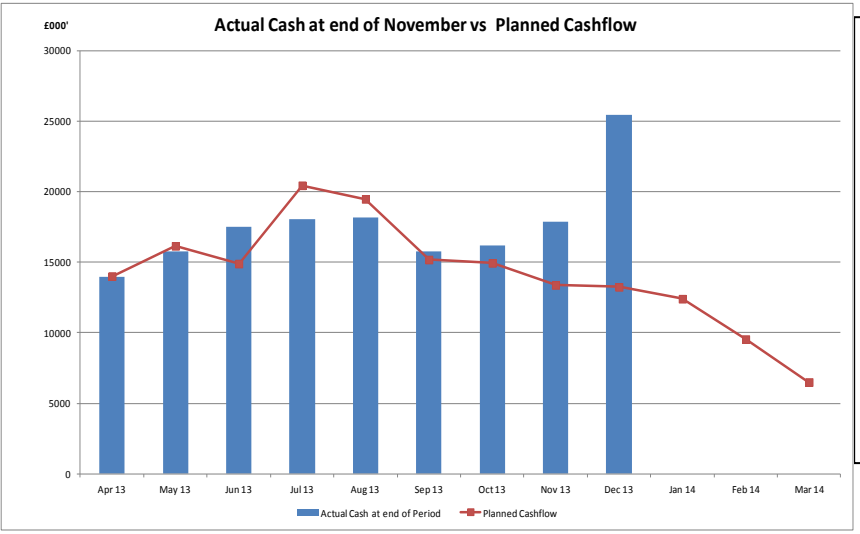
Executive Summary

Financial Indicator	Summary Performance	Current month	Previous month
Surplus	In month the Trust reported on plan. YTD the Trust is on plan. The Trust still expects to deliver its £0.3m year end surplus position. The risk to maintaining the YTD plan position is driven by a number of factors including excess relief costs in operational staff groups. This has meant additional usage of premium resource such as overtime and private ambulance services. It is important to note that the forecast also considers the Trust's downside scenario whereby the CAT A Red 1 (£5.0m) and Hospital Turnaround penalties (£0.3m) would be incurred. In this scenario the Trust would deliver a deficit of £5.1m	**GREEN**	**GREEN**
Income	Income is £0.5m favourable in month and £0.5m adverse YTD. Risks to the full year position include a shortfall in core income (currently managed through reserves), and Hospital Turnaround Penalties (YTD £0.1m impact adverse). Mitigation has been seen in the form of better than expected PTS performance (£0.4m), additional A&E Journeys (£0.5m) and 111 income (£1.5m). Winter pressures funding of £1.4m has also been accounted for offset against specific projects.	**GREEN**	**GREEN**
Expenditure	In month spend is £0.5m adverse, YTD there is a favourable variance of £0.8m; this is driven by ongoing vacancies in substantive establishment (e.g. admin and clerical and frontline). Also 111 costs amounting to £1.5m have been included (offsets with Income). Winter Pressures related project costs have also been included (£1.4m) Operational Pay is currently £2.0m adverse YTD when 3rd Party and Incentives are included. The Trust has received additional winter funding to support this additional pressure The modernisation programme will address the current inefficiencies in front line delivery.	**AMBER**	**AMBER**
CIPs	Currently reporting (£0.1m) behind schedule YTD due to start up delays. Additional PMO support is in place to support the delivery of CIPs and further opportunities are being realised.	**AMBER**	**AMBER**
Balance Sheet	Overall no major concerns at this stage, The land and buildings were revalued as at 1st April 2013 by the district valuer. The impact on the balance sheet was a £1.9m increase on non current assets, a £1.6m increase in the revaluation reserve and a £0.3m impairment credit to the statement of comprehensive income.	**GREEN**	**GREEN**
Cashflow	Cash is £12.3m above plan. This is mainly due to an increase in trade and other creditors, a decrease in borrowings and debtors and lower than planned capital expenditure. Plans are in place to manage cash in line with the EFL.	**GREEN**	**GREEN**

Executive Summary - Key Financial Metrics



Description	2013/14 - Month 9			Year to Date			FY 2013/14
	Budg	Act	Var	Budg	Act	Var	Budg
	£000	£000	£000 fav (adv)	£000	£000	£000 fav (adv)	£000
Dept Health							
Surplus / (Deficits)	856	839	(17)	438	470	31	262
EFL	127	(7,687)	(7,814)	(8,382)	(21,022)	(12,640)	(2,288)
CRL	873	263	(610)	6,498	2,339	(4,159)	10,250
Suppliers paid within 30 days - NHS	95%	88%	-7.0%	95%	85%	-10.0%	95%
Suppliers paid within 30 days - Non NHS	95%	60%	-35.0%	95%	65%	-30.0%	95%
Monitor							
EBITDA %	9.1%	8.0%	-1.1%	6.3%	6.0%	-0.3%	6.3%
EBITDA on plan	2,480	2,211	(269)	13,935	13,308	(627)	0
Net Surplus	856	839	(17)	438	470	31	262
Return on Assets	2.95%	2.07%	-0.9%	2.95%	2.07%	-0.9%	3.56%
Liquidity Days	(8.62)	(8.56)	0.1	(8.62)	(8.56)	0.1	(8.63)
Monitor FRR net rating		3			3		



- In month on plan.
- Year to date on plan; Ongoing pressures:
  - Management of operational staff – especially relief factor
  - CIP delivery
- Cash is £12.3m above plan. This is mainly due to an increase in trade and other creditors offset by a decrease in borrowings and debtors and lower than planned capital expenditure.
- The EFL variance is due to higher than planned cash balance and a reduction in borrowing.
- The Trust would expect to score an FRR of 3 against the current Monitor metrics.
- CRL position – The Capital plan is currently £4.8m behind plan due to programme delays but the full Capital allocation of £10.3m is still expected to be spent

Statement of Comprehensive Income

2013/14 - Month 9			Description	Year to Date			FY 2013/14	
Budg	Act	Var		Budg	Act	Var	Budg	Fcast
£000	£000	£000 fav/(adv)		£000	£000	£000 fav/(adv)	£000	£000
			Income					
23,164	23,147	(17)	Income from Activities	197,161	197,020	(141)	262,415	
4,091	4,631	540	Other Operating Income	25,749	25,362	(388)	35,772	
27,255	**27,778**	**523**	**Subtotal**	**222,911**	**222,382**	**(529)**	**298,187**	
			Operating Expense					
19,033	18,520	513	Pay	162,703	156,176	6,526	218,834	
5,742	7,047	(1,305)	Non Pay	46,273	52,898	(6,624)	60,646	
24,775	**25,567**	**(792)**	**Subtotal**	**208,976**	**209,074**	**(98)**	**279,479**	
2,480	**2,211**	**(269)**	**EBITDA**	**13,935**	**13,308**	**(627)**	**18,708**	
9.1%	8.0%	1.1%	**EBITDA margin**	6.3%	6.0%	0.3%	6.3%	
			Depreciation & Financial					
1,252	1,116	136	Depreciation	10,153	9,885	268	13,990	
326	230	96	PDC Dividend	2,936	2,720	216	3,915	
45	25	20	Interest	408	233	175	540	
1,624	**1,372**	**252**	**Subtotal**	**13,496**	**12,838**	**658**	**18,446**	
856	**839**	**(17)**	**Net Surplus/(Deficit)**	**438**	**470**	**31**	**262**	
3.1%	3.0%	0.1%	**Net margin**	0.2%	0.2%	0.0%	0.1%	

- The YTD trend has improved and is on plan
- Income is adverse due to lower than planned central income (£3.4m) and Hospital Turnaround Penalties (£0.1m), offset by improved PTS performance (£0.4m), A&E journeys (£0.5m) , 111 related income (£1.5m), winter pressures income (£1.4m) and staff recharges (£0.1m)
- Pay is showing a favourable position overall (£6.5m) due to vacancies across the trust. However, frontline pay (including PAS usage and Incentives) is showing £2.0m overspend YTD. A major factor in the total frontline cost overspend is the management of relief which is running significantly higher than plan
- Non Pay is £1.6m adverse YTD (when PAS is excluded)
- Depreciation and Financial Charges are on track

- *Note: The reported position excludes a 12/13 year end impairment correction of £336k. This is excluded from the Trust 13/14 financial performance total reported to the NTDA and so it is excluded here.*

Divisional Expenditure (excludes Income)

2013/14 - Month 9			Description	Year to Date			FY 2013/14	
Budg	Act	Var		Budg	Act	Var	Budg	Fcast
£000	£000	£000 fav/(adv)		£000	£000	£000 fav/(adv)	£000	£000
			Operational					
14,430	15,052	(621)	A&E	129,623	128,599	1,024	173,072	
2,492	2,453	39	EOC	20,616	19,254	1,362	27,492	
2,111	2,110	1	Operational Support	16,732	16,796	(64)	22,746	
19,033	**19,615**	**(582)**	**Subtotal**	**166,971**	**164,649**	**2,322**	**223,311**	
511	**571**	**(60)**	**PTS**	**4,775**	**5,004**	**(229)**	**6,372**	
			Support Services					
342	310	32	Chief Executive	3,115	3,064	52	4,141	
1,361	648	713	111 Project	1,361	1,406	(45)	3,211	
252	108	144	Corporate Services	2,268	2,136	132	3,074	
793	855	(61)	Estates	7,363	7,369	(6)	9,743	
177	54	123	Strategic Development	1,641	1,489	152	2,172	
212	210	2	Finance	1,840	1,847	(6)	2,514	
1,632	2,528	(896)	Central Corporate	13,947	17,016	(3,069)	17,327	
12	(7)	20	Central Income	110	83	27	147	
982	950	32	IM&T	8,626	8,402	224	11,786	
865	750	116	HR & OD	8,426	7,538	889	11,428	
106	97	9	Healthcare Promotion & Quality	957	870	87	1,278	
0	149	(149)	Transformation & Strategy	0	149	(149)	0	
119	102	17	Medical	1,071	890	182	1,422	
6,855	**6,753**	**102**	**Subtotal**	**50,726**	**52,259**	**(1,533)**	**68,243**	
26,399	**26,939**	**(540)**	**TOTAL**	**222,472**	**221,912**	**560**	**297,925**	
27,255	*27,778*	*523*	*Income Memorandum*	*222,911*	*222,382*	*(529)*	*298,187*	
856	***839***	***(17)***	***NET POSITION MEMORANDUM***	***438***	***470***	***31***	***262***	

The divisional structure will be adjusted to incorporate the new corporate structure as required.

- The main driver of performance is the Operational division; this represents 75% of total expenditure.
- The main reason for Operational budget being favourable to plan relates to
  - Ongoing EOC vacancies (e.g. CHUB)
  - Ongoing underspends in frontline pay
  - Operational Support – has seen increases in vehicle spend plus allocations for its CIP programme for which there is some slippage.
- PTS is broadly on plan overall (additional income is more than offsetting additional spend)
- The 111 Programme is now included. 111 will report a small surplus as agreed with Commissioners
- Within support services
  - Central Corporate includes the adverse reserves position supporting income shortfalls and projected increases in non pay spend
  - HR & OD is favourable primarily because of vacancies across the department (including training officers)and delays in spend in the modernisation programme.
  - IM&T is showing a favourable position due to the identification of corrections required to telephony costs.

Statement of Financial Position: YTD

	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Dec-13		
	Act	Act	Act	Act	Act	Act	Act	Act	Act	Act	Plan	Var	%
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000			
Non Current Assets													
Property, Plant & Equip	119,021	118,240	117,414	119,201	118,434	117,675	117,021	116,362	115,935	114,382	116,421	(2,039)	-1.75%
Intangible Assets	13,628	13,478	13,328	13,061	12,869	12,690	12,864	12,663	12,663	12,663	12,573	90	0.72%
Trade & Other Receivables	0	0	0	0	0	0	0	0	0	0	0	0	
Subtotal	132,649	131,718	130,742	132,262	131,303	130,365	129,885	129,025	128,598	127,045	128,994	(1,949)	-1.04%
Current Assets													
Inventories	3,264	3,176	3,310	3,217	3,248	3,280	3,311	3,247	3,208	3,263	3,264	(1)	-0.03%
Trade & Other Receivables	16,075	18,604	15,797	14,875	15,267	15,972	16,670	18,602	20,836	17,800	14,892	2,908	19.53%
Cash & cash equivalents	5,500	13,968	15,747	17,486	18,028	18,164	15,770	16,171	17,849	25,518	13,243	12,275	92.69%
Total Current Assets	24,839	35,748	34,854	35,578	36,543	37,416	35,751	38,020	41,893	46,581	31,399	15,182	112.18%
Total Assets	157,488	167,466	165,596	167,840	167,846	167,781	165,636	167,045	170,491	173,626	160,393	13,233	8.25%
Current Liabilities													
Trade and Other Payables	(24,546)	(34,792)	(32,694)	(33,091)	(32,613)	(32,861)	(31,553)	(33,021)	(36,788)	(39,123)	(28,314)	(10,809)	38.17%
Provisions	(2,098)	(1,000)	(1,000)	(2,098)	(2,098)	(2,098)	(1,908)	(1,908)	(1,908)	(1,908)	(1,281)	(627)	48.95%
Borrowings	(309)	(263)	(263)	(263)	(263)	(263)	(263)	(263)	(263)	(263)	(229)	(34)	14.85%
Working Capital Loan - DH	0	0	0	0	0	0	0	0	0	0	0	0	
Capital Investment Loan - DH	(1,244)	(1,244)	(1,244)	(1,244)	(1,244)	(1,244)	(1,244)	(1,244)	(1,244)	(1,244)	(1,244)	0	0.00%
Net Current Liabilities)	(28,197)	(37,299)	(35,201)	(36,696)	(36,218)	(36,466)	(34,968)	(36,436)	(40,203)	(42,538)	(31,068)	(11,470)	38.17%
Non Current Assets plus/less net current assets/Liabilities	129,291	130,167	130,395	131,144	131,628	131,315	130,668	130,609	130,288	131,088	129,325	1,763	150.36%
Non Current Liabilities													
Trade and Other Payables	0	0	0	0	0	0	0	0	0	0	0	0	
Provisions	(8,731)	(9,766)	(9,853)	(8,839)	(8,816)	(8,862)	(9,144)	(9,021)	(9,081)	(9,114)	(8,882)	(232)	2.61%
Borrowings	(641)	(661)	(641)	(427)	(377)	(380)	(379)	(330)	(323)	(305)	(641)	336	-52.42%
Working Capital Loan - DH	0	0	0	0	0	0	0	0	0	0	0	0	
Capital Investment Loan - DH	(4,343)	(4,343)	(4,343)	(4,343)	(4,343)	(4,343)	(3,721)	(3,721)	(3,721)	(3,721)	(3,721)	0	0.00%
Total Non Current Liabilities	(13,715)	(14,770)	(14,837)	(13,609)	(13,536)	(13,585)	(13,244)	(13,072)	(13,125)	(13,140)	(13,244)	104	0.00%
Total Assets Employed	115,576	115,397	115,558	117,535	118,092	117,730	117,424	117,537	117,163	117,948	116,081	1,867	149.32%
Financed by Taxpayers Equity													
Public Dividend Capital	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	0	0.00%
Retained Earnings	20,053	19,874	20,035	20,395	20,952	20,590	20,284	20,397	20,023	20,808	20,558	250	1.22%
Revaluation Reserve	33,426	33,426	33,426	35,043	35,043	35,043	35,043	35,043	35,043	35,043	33,426	1,617	4.84%
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	0	0.00%
Total Taxpayers Equity	115,576	115,397	115,558	117,535	118,092	117,730	117,424	117,537	117,163	117,948	116,081	1,867	6.05%

> Non current assets stand at £128.6m.

Variance on non current assets
The land & buildings have been revalued as at 1st April 2013, by the district valuer this resulted in an overall increase on land and buildings of £1.9m. The capital programme is £3.5m behind plan.

Current assets are £41.9m

Variance on current assets

> Cash position as at November is 17.8m, this is £4.5m above planned. This is due to higher than planned creditor balances, a delay in capital spend offset by a higher than planned debtor balances

> Receivables (debtors) are £1.6m above plan , Accrued Income £3.1m higher than planned and prepayments are £1.8m above plan.

> Receivables (Debtors) comprise principally trade debtors £12.7m, prepayments £5.1m and accrued income £3.1m.

Current Liabilities are £40.2m

> Current Liabilities comprise principally trade payables (creditors) £8.8m, Accruals £4.9m, Deferred Income £5.3m, Other Creditors £13.7m, HMRC £4.1m, Borrowings £1.5m and provisions £1.9m.

Variance on current liabilities
Current liabilities were higher than planned due to higher trade & other creditors £9.4m, provisions £0.6m and lower than planned accrual £1.4m balances. The trust has a high volume of unapproved invoices and is accruing for the ORH transitional costs. Deferred Income is £0.5m lower than planned.

> Borrowings - No new loans have been taken out during the year. In June the trust returned 50 old ambulances that were surplus to requirements. A cost benefit analysis showed it was cheaper to terminate the leases early than to continue to maintain them to the end of the contract.

> The revaluation reserve has increased by £1.6m as a result of the revaluation of land and buildings

Cashflow Statement YTD

	In Month Movement									YTD Move	YTD Plan	Var
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Dec-13	Dec-13	Dec-13
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual			
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Opening Balance	5,500	13,968	15,747	17,486	18,028	18,164	15,770	16,171	17,849	**5,500**	**5,500**	**0**
Operating Surplus	1,187	1,625	1,488	1,997	1,133	651	1,539	998	2,156	12,774	13,850	(1,076)
(Increase)/decrease in current assets	(2,441)	2,673	1,015	(423)	(737)	(729)	(1,868)	(2,195)	2,981	(1,724)	1,395	(3,119)
Increase/(decrease) in current liabilities	9,316	(2,420)	1,008	101	(22)	245	1,226	3,536	2,017	15,007	2,084	12,923
Increase/(decrease) in provisions	1,035	87	(1,014)	(36)	(27)	75	(139)	37	16	34	151	(117)
Net cash inflow/(outflow) from operating activities	9,097	1,965	2,497	1,639	347	242	758	2,376	7,170	26,091	17,480	8,611
Cashflow inflow/outflow from operating activities	**9,097**	**1,965**	**2,497**	**1,639**	**347**	**242**	**758**	**2,376**	**7,170**	**26,091**	**17,480**	**8,611**
Returns on investments and servicing finance	(13)	(11)	(11)	(8)	(8)	(8)	(2)	(7)	(8)	(76)	(110)	34
Capital Expenditure	(590)	(155)	(533)	(1,039)	(206)	(43)	(306)	(684)	525	(3,031)	(6,961)	3,930
Dividend paid	0	0	0	0	0	(1,962)	0	0	0	(1,962)	(1,963)	1
Financing obtained	0	0	0	0	0	0	0	0	0	0	0	0
Financing repaid	(26)	(20)	(214)	(50)	3	(623)	(49)	(7)	(18)	(1,004)	(703)	(301)
Cashflow inflow/outflow from financing	**(629)**	**(186)**	**(758)**	**(1,097)**	**(211)**	**(2,636)**	**(357)**	**(698)**	**499**	**(6,073)**	(9,737)	**3,664**
Movement	8,468	1,779	1,739	542	136	(2,394)	401	1,678	7,669	20,018	7,743	12,275
Closing Cash Balance	**13,968**	**15,747**	**17,486**	**18,028**	**18,164**	**15,770**	**16,171**	**17,849**	**25,518**	**25,518**	**13,243**	**12,275**

The cash balance as at December 2013 is £25.5m, this is £12.3m above plan.

Variance on current assets is (£3.1m)
> Current assets movement was lower than planned due to increase in prepayments (£2.6m), lower decrease in accrued income (£5.4m) and a lower increase debtors £4.9m.

Variance on current liabilities is £12.9m
> Current liabilities movement was higher than planned due to increase in trade & other creditors £14.6m and decrease in accruals (£1.1m). The trust has a high volume of unapproved invoices. Deferred Income increase was (£0.6m) lower than planned.

Variance on Capital Expenditure is £3.9m
> The lower than planned Capital Expenditure payments is due to slippage on the capital programme. Capital Expenditure payments total £3.0m in year.

> Financing, the Trust paid £0.3m in loan principle and termination costs on its finance leases in year. In June the trust return 50 old ambulances that we surplus to requirement. A cost benefit analysis showed it was cheaper to terminate the leases early that to continue to maintain them to the end of the contract.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 28TH JANUARY 2014

PAPER FOR ~~APPROVAL/~~INFORMATION

Document Title:	**Review of Demand Management Plan**
Report Author(s):	**Jason Killens**
Lead Director:	**Jason Killens**
Contact Details:	**Jason.killens@londonambulance.nhs.uk**
Why is this coming to the Trust Board?	**Information – routine review of Demand Management Plan**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	1. Note the completion of the review of the Demand Management Plan (DMP) and the drafting of a revised plan, now the Surge Plan, to manage peaks in activity

Key issues and risks arising from this paper

The review of the Demand Management Plan incorporates lessons identified through its period of operation since 2011 and introduced revised methodology to manage surges in activity where demand outstrips available supply through the use of recognised triage process.

Executive Summary

The Demand Management Plan (DMP) was last reviewed in September 2011 (version 7). A recent root and branch review, incorporating best practice, lessons identified and changes to our model of response in that period such as the clinical hub replacing CTA, has now been completed.

The resulting Surge Plan builds on the principles of the previous DMP and seeks to protect responses to the most serious emergency calls, using the telephone triage process to identify such patients, whilst progressively restricting the responses made to less serious calls as demand outstrips available supply.

Attachments

Nil

****

Quality Strategy

This paper supports the following domains of the quality strategy

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

LAS Strategic Goals and Priorities

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

LAS Strategic Goals

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

2013/14 Priorities

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

Has an Equality Analysis been carried out?

- ☐ Yes
- ☒ No

Key issues from the assessment:

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 28TH JANUARY 2014

PAPER FOR INFORMATION

Document Title:	**Report from the Chief Executive**
Report Author(s):	**Ann Radmore, Chief Executive**
Lead Director:	**N/A**
Contact Details:	**ann.radmore@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**The CEO provides an update to the Board on key areas.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**Information only.**
Key issues and risks arising from this paper	

Executive Summary

The report covers the following items:

1. Secretary of State Jeremy Hunt Message to NHS Staff
2. Securing sustainability: NHS TDA publishes planning guidance 2014/15 – 2018/19
3. Pan London Group Emergency Services Mobile Communications Project (ESMCP)
4. Stonewall Top 100 Employees
5. Norwegian Air Ambulance
6. BBC 1 – Sunday Politics Show – Sunday 12 January 2014
7. Chief Executive visit to Yorkshire Ambulance Service
8. National Education & Training Paramedic Steering Group
9. Listening into Action (LiA) End of Year 1 Event

Attachments

Report from Chief Executive – January 2014

****

Quality Strategy

This paper supports the following domains of the quality strategy

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

LAS Strategic Goals and Priorities

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

LAS Strategic Goals

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

2013/14 Priorities

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

Has an Equality Analysis been carried out?

- ☐ Yes
- ☒ No

Key issues from the assessment:

CHIEF EXECUTIVE REPORT FOR THE LONDON AMBULANCE SERVICE TRUST BOARD MEETING HELD ON 28 JANUARY 2014

1. Secretary of State Jeremy Hunt Message to NHS Staff

On the 10 January 2014 a message to all NHS Staff from the Secretary of State, Jeremy Hunt was published.

The full message can be viewed here:
https://www.gov.uk/government/speeches/jeremy-hunt-new-year-message-to-nhs-staff

2. Securing sustainability: NHS TDA publishes planning guidance 2014/15 – 2018/19

On 23 December the NHS Trust Development Authority (NTDA) published guidance for NHS Trust Boards to help them plan the long term delivery of their services for patients.

The full guidance document **Securing sustainability: NHS TDA publishes planning guidance 2014/15 – 2018/19** can be viewed here:http://www.ntda.nhs.uk/wp-content/uploads/2013/12/tda_planning_2013_final-4.pdf

Further details on the planning guidance will be provided in item 12 of the agenda

3. Pan London Group Emergency Services Mobile Communications Project (ESMCP)

The pan London ESMCP group held its second meeting on 10 Jan 2014. The group comprises representatives from the London Ambulance Service, the Metropolitan Police Service and the London Fire Brigade. The purpose of the group is to ensure that the London element of the new national radio system is procured and implemented in London in a way which ensures interoperability between the 3 services.

4. Stonewall Top 100 Employees

The Service has been named amongst Britain's top 20 most gay-friendly places to work achieving a 19th placing out of 100.

The Service, which achieved 94th place in 2012 and 22nd in 2013, was rated the second highest NHS organisation in the list and is one of only two ambulance trusts to make the top 100.

The LAS press release can be found here:
http://www.londonambulance.nhs.uk/news/news_releases_and_statements/top_20_best_gay-friendly_work.aspx

5. Norwegian Air Ambulance

Following the tragic news of the air ambulance fatal accident in Norway the following message was sent on behalf of the service by Dr Fionna Moore;

> All of the staff at London Ambulance Service were deeply shocked and saddened to learn of the crash involving your aircraft and of the fatal consequences for members of the crew. May I convey the sincere condolences of the Service to you, your colleagues and those members of the Emergency Services involved.

6. BBC 1 – Sunday Politics Show – Sunday 12 January 2014

Dr Fionna Moore took part in an interview on the London element of the Sunday Politics Show where she discussed the use of the Demand Management Plan by the Service.

7. Chief Executive visit to Yorkshire Ambulance Service

The Chief Executive was welcomed to the Yorkshire Ambulance Service on 7 January 2014 and discussed a wide range of issues.

8. National Education & Training Paramedic Steering Group

The Chief Executive is one of two ambulance trust CEs (the other being the Chief Executive of South East Coast Ambulance Service) who have been invited to be members of the National Education & Training Paramedic Steering Group to represent all ambulance trusts.

The group is chaired by Patrick Mitchell, Director of National Programmes, Health Education England

The role of the steering group includes:

- Considering and reviewing the Paramedic Evidence Based Education Project (PEEP) report recommendations
- Agreeing sub sets of work from the PEEP review and action plans for implementation
- Agreeing interim recommendations for the Director of Education and Quality to consider prior to presenting recommendations to Health Education England Executive
- If agreed by HEE monitoring progress on the implementation of the recommendations and ensuring national coordination

A copy of the executive summary of the PEEP report is attached as an appendix to this report.

9 Listening into Action (LiA) End of Year 1 Event

On the Monday 20 January 2014 a LiA 'End of Year 1 Event' was held. This event allowed staff from across the Trust to ‘showcase’ the work they had done on their individual LiA projects and to take questions from the audience.
The projects which were showcased’ were:

Communications
111 Feedback
Refreshments at Hospital
Health Care Professional Engagement
Medical Priority Despatch System (MPDS)
Learn About Each Other
Recognition of Excellence

The event was attended Board members, LiA Sponsor Group members and a number of invited guests

Ann Radmore
Chief Executive
22 January 2014

Allied Health Solutions

Enterprise Innovation Partnership

Paramedic Evidence Based Education Project (PEEP)

Executive Summary and Summary of Recommendations

bucks new university

August 2013

Maximising paramedics' contribution to the delivery of high quality and cost effective patient care.

ACKNOWLEDGEMENTS

The commissioners and Allied Health Solutions wish to formally acknowledge the contribution of all those who willingly gave of their time and agreed to be interviewed as part of this study. Thanks also go to the Project Advisory Board members and staff at the study sites across the United Kingdom.

Particular thanks go to Jim Petter, the College of Paramedics' Director of Professional Standards at the time this study was commissioned.

The study was commissioned by the Department of Health (England) National Allied Health Professional Advisory Board co-chaired by Lisa Hughes and Professor Ieuan Ellis and funded by the College of Paramedics. However, the views expressed are those of the authors alone.

This report has been authored by:

Professor Mary Lovegrove OBE*
June Davis*

*Director, Allied Health Solutions

Executive Summary

The increase in attention that the education and training of paramedics has received in recent years led the National Allied Health Professional Advisory Board, England, to commission this study. Our aim has been to develop an evidence based business case, for the College of Paramedics, to progress the strategic direction of the standardisation of education and training for this key workforce.

As a consequence of local influence and local funding decisions between education commissioners, education providers, and their partner ambulance services, there are various education and funding models in place across the United Kingdom (UK). This situation is considered to be a critical risk for the profession, especially when combined with the concerns about financial sustainability and a potential for continued inconsistencies, particularly in England. This Paramedic Evidence-Based Education Project (PEEP) has attempted to address these issues.

This report presents the findings of this study and chronicles the existing evidence to support the future direction of paramedic education and training.

Samples of representatives of stakeholder organisations from each of the four nations of the UK were invited to take part in this study. We spoke to representatives of patients who receive care from paramedics; senior managers with responsibility for developing the paramedic workforce; managers who develop and guide clinical policy; education and training providers to the paramedic workforce; paramedics, and students. In addition, a one day summit was held by the Department of Health in England for a UK wide invited group of participants. This provided considerable insight into the whole systems approach that needs to be taken to progress the standardisation of the education and training of the paramedic workforce.

The potential contribution that a well-educated and highly trained paramedic workforce can make to healthcare, through its unique field of practice that intersects healthcare, public health, social care and public safety, has yet to be fully appreciated and understood. Paramedics are very well regarded by the general population. A closer engagement of this workforce with pre-hospital urgent care, and prevention of hospital admission, should be of benefit to the wider community.

The emerging consensus is that paramedics are autonomous professionals at the point of registration and well placed to effectively deliver a patient led, out of hospital urgent care service. To enable this situation to be realised, a more robust education and training system needs to be in place. The current education and training model, in England, is locally determined, resulting in very different student experiences, and different levels of learning outcomes achieved at the point of registration.

While this is not a definitive study, it highlights the need for the standardisation of approach to education and training, and to developing a clear framework that will enable this to happen. This study highlights a number of areas in the education and training of paramedics that could be developed, and also proposes a model that leads to an all graduate paramedic profession by 2019. The proposed model attempts to address the key stages required to ensure all key stakeholders are empowered to engage and inform the development of a unified approach. The result should be an education and development framework for paramedics that is sustainable. It is recognised that many may contend

that this timeframe is far too long. However, a carefully staged approach is strongly recommended, and it is proposed that the College of Paramedics establishes a UK wide stakeholder steering group, to take the development systematically through the identified stages.

One key deliverable is to raise the minimum threshold entry onto the Paramedic Register, of the Health Care Professions Council, so that all student paramedics enrol on programmes leading to a minimum award of a diploma in higher education (DipHE), by September 2015. This requires the education sector to reflect on the appropriateness of the use of a foundation degree, or an apprenticeship model, for developing the paramedic workforce, as currently these two models of education and training are also used to develop the healthcare support workforce. Post-registration and continuing professional and personal development (CPPD) opportunities should be readily available to all paramedics, who wish to achieve the new minimum threshold, or prepare themselves for an all graduate profession.

The current funding model to support the students is very varied and favours those who can financially support themselves through their training. While this might be financially advantageous to the service it does not promote fair or widened access to the profession. The findings of this study indicate that the most appropriate funding model for England is the Higher Education England (HEE) /Local Education and Training Board (LETB) commissioned model with access to bursary support in line with other NHS non-medical trainees. This would provide security of supply to the service and the higher education (HE) sector; a national overview of numbers in training; and enable prospective students from diverse backgrounds to apply to train as paramedics. It would also further the discussion about bursary support and a clinical tariff for training the students. The governance of this funding model also quality assures the clinical learning environment which is fundamental to a standardised approach to developing the paramedic workforce.

During the study we found some excellent examples of true partnership working for the benefit of the paramedic student. For example, the Scottish model of the Ambulance Service sponsoring an Academy linked to Glasgow Caledonian University. Another example of how the ambulance service, the commissioners and the education providers work well together is Health Education North West (HENW). Effective partnership working is essential. Arrangements need to be in place to enable the student and the qualified paramedic to receive timely feedback on their clinical decisions to enable them to further develop their knowledge and skills.

In relation to the curriculum review, some of the interviewees reported that the curriculum should include more leadership skills development and improved learning outcomes about dementia and mental health challenges. A matter of concern for the education sector and the profession is how to enhance the multi-professional learning opportunities for the students. All participants in the study recognised the importance of time spent in the clinical learning environment and many of them questioned whether two academic years was sufficient to gain the clinical experience required.

The myriad and complexity of the paramedic education and training models in England will continue until there is an agreed consensus, which requires investment of time and resources. One approach to resolving this situation is to appoint, to a full time role, somebody who would work in partnership with Health Education England and the Local Education and Training Boards; the Ambulance Services in England; the Northern Ireland Ambulance Service; the Scottish Ambulance Service and the Welsh Ambulance Service.

Summary of Recommendations

1.0 Standardised approach to education and training

There should be a standardised approach to all aspects of education and training for paramedics.

1.1 Nationally agreed approach to commissioning and funding

a) There should be a nationally agreed commissioning and funding model for pre-registration paramedic education based on core principles:
   - Equivalent opportunities to access education and training as compared to other non-medical healthcare professionals.
   - Equity of access to funding.
   - Transparent, affordable and sustainable.

b) There should be a standardised approach to paramedic education funding in England based on Multi-professional Education and Training (MPET) including the clinical education tariff.

c) Ambulance services, education commissioners and education providers should agree a regional tri-partite approach to apply a nationally agreed funding model.

d) Commissioners of pre-registration education and training programmes should add paramedic pre-registration programmes to existing National Standard Contracts between commissioners and the education providers.

e) The emergency driving requirement should be the responsibility of the ambulance services not individual students.

1.2 Access to bursary funding

Paramedic students should have access to student bursaries in line with students of other non-medical professions.

1.3 Models of pre-registration education and training

The education providers should review the academic awards offered to paramedic students and bring them in line with the other non-medical professions, particularly Allied Health Professionals (AHPs). The use of the foundation degree as the main award leading to qualification as a paramedic should be discontinued.

2.0 Pre-registration education development model leading to an all graduate profession

The College of Paramedics in partnership with National Education Lead Bodies should agree an achievable pre-registration development model. The model should take the paramedic profession to an all graduate status by 2019.

The stages of development should include, in addition to recommendation 1.2 and 1.3 above, the following steps:

- Review of agreed scope of practice.
- Review of Standards of Proficiency.
- Evaluate education and development opportunities for the existing workforce.
- Embed a whole systems approach to enhance the learning environment for the student paramedic.

3.0 Knowledge and skills enhancement

There are a number of areas in the curricular where the education sector and service sectors working in partnership should enhance the curricular and the effectiveness of the learning environment.

3.1 Content

Suggested additions to the pre-registration and where appropriate post-registration curricular include:

- Dementia and mental health awareness.
- Clinical leadership skills.
- Multi-professional learning opportunities.
- Integrated Care.
- End of Life Care.
- Inclusion Health.

3.2 Clinical Decision Making

The ambulance trusts should review how they support pre-registration paramedics to obtain the appropriate level of clinical decision making skills. The process by which students and qualified paramedics receive timely feedback for clinical decisions should be improved.

4.0 Partnership model

A UK wide approach should be taken to developing a clear strategy for an all systems partnership model to support the future development of the paramedic workforce.

5.0 Paramedic leadership for England

Health Education England in partnership with NHS England and the College of Paramedics should appoint a national lead for education and training of paramedics. This national lead would have the responsibility for standardising the education and training of paramedics in England. They would also work with their counterparts in Northern Ireland, Scotland and Wales to share best practice in paramedic education and training across the UK.

6.0 Standardised approach to identification

To help the patient, service users and the general public, the ambulance services in partnership with the College of Paramedics, should take a standardised approach to the identity of the paramedic profession, including who wears the 'green uniform' and what titles the specialist and advanced paramedic practitioner are given.

Contact Us

Director

June Davis
07719 302382
Junedavis@alliedhealthsolutions.co.uk

Director

Professor Mary Lovegrove OBE
07715620020
Marylovegrove@alliedhealthsolutions.co.uk

Allied Health Solutions

Enterprise Innovation Partnership

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 28 JANUARY 2014

PAPER FOR INFORMATION

Document Title:	**Update on Operating Plan and Strategy**
Report Author(s):	**Karen Broughton**
Lead Director:	**Karen Broughton**
Contact Details:	**Karen.broughton@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To update the Board on progress with the Trust's Operating Plan and 5 year strategy.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**The Board is asked to note the progress on the Operating Plan and 5 year Strategy.**

Key issues and risks arising from this paper

There is a requirement for the Trust to develop a 2 year Operating Plan and 5 year Strategy.

Executive Summary

Over the past few months, the Trust Board has given direction and attention to the creation of a new strategy to take the London Ambulance Service forward to 2020. In December 2013, the Trust received national guidance on the requirement to produce a 2 year Operating Plan as well as a 5 year Strategic Plan.

This paper seeks to update the Trust Board on the progress toward completion of the 2 year operating plan and 5 year strategic plan.

Attachments

Appendix A provides key dates and steps to achieve delivery of the Operating Plan and Strategy.

****

Quality Strategy

This paper supports the following domains of the quality strategy

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

LAS Strategic Goals and Priorities

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

LAS Strategic Goals

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

2013/14 Priorities

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

Has an Equality Analysis been carried out?

☐ Yes
√ No

Key issues from the assessment: n/a at this stage

LONDON AMBULANCE SERVICE TRUST BOARD

28 JANUARY 2014

Update on Operating Plan and Strategy

1. Introduction

Over the past few months, the Trust Board has given direction and attention to the creation of a new strategy to take the organisation forward to 2020.

To date we have undertaken a number of engagement activities with patients, patient groups, stakeholders, staff, Trust Board members and Executive Management Team (EMT) members to: consider the current and changing NHS context; consider current LAS services and the increasing demands on them; gain initial views on strategic priorities for the next 5 years.

During this initial engagement phase the Trust received national guidance on the requirement to produce a 2 year operating plan as well as a 5 year strategic plan. These two documents support the development of our 2020 strategy.

This paper seeks to update the Trust Board on the progress towards completion of the 2 year Operating Plan and 5 year Strategic Plan.

2. National Requirements

On 23 December 2013, the Trust Development Authority (TDA) issued *Securing Sustainability Planning Guidance for NHS Trust Boards 2014/15 - 2018/19.* This document set out the requirement on Trust's to produce a 2 year Operating Plans for 2014/15 to 2015/16 and a 5 year Strategic Plan (2014/15 to 2018/19). Both the Operating Plan and the 5 year Strategic Plan have prescribed structures and inputs.

Throughout the *Securing Sustainability Planning Guidance* there is strong emphasis on the Trust Board's overview and assurance mechanisms across a number of organisational dimensions, as well as a significant focus on quality of care.

The guidance set an initial deadline of 13 January 2014 for the completion of a number of financial and workforce planning templates for 2014/15, as well as our performance against a range of areas outlined in a planning checklist. Copies of these documents can be made available to Board Members if requested.

3. 2 year Operating Plan progress and key dates

The Trust submitted its first draft of the Operating Plan on 13 January 2014. This consisted of:

- **Financial Plan** which consisted of a number of templates identifying: Income and expenditure plans; capital and cash plan; source and application of funds; cost improvement programme
- **Workforce Plan** which showed: whole time equivalents planned at 31 March in each year of the plan; pay bill, bank and agency spend in each year of the plan; analysis of whole time equivalents and workforce spend for each main staff group; bridge analysis of changes in whole time equivalents

- **Planning checklist** which required completion across a number of areas: quality and workforce; finance; Quality, Innovation, Productivity and Prevention (QIPP); innovation; sustainability.

The Finance and Investment Committee considered the draft Financial Plan, and the key financial planning assumptions, at its meeting on 24 January 2014

Feedback on the first draft of the Operating Plan will be provided by the TDA by the end of January 2014. We will take account of this feedback to produce the next Operating Plan draft on 5 March 2014, and the final draft on 4 April 2014. As part of each submission we will amend our initial templates, as well as producing a written Operating Plan and a 6 page summary plan.

4. 5 year Strategy update progress and key dates

A number of engagement activities have been held with patients, patient groups, stakeholders, staff, members of the Trust Board and the EMT to consider our strategy and priorities for the next 5 years. Inputs from these activities have been used to give consideration to the Trust's mission, vision, values and priorities for the years ahead. These will be further developed over the forthcoming weeks to create our 2 year Operating Plan and 5 year Strategic Plan.

The EMT has a further dedicated session on the 3 February 2014 to take this work forward and the Trust Board has dedicated time at its Strategy and Planning on 25 February 2014. Communications will continue individually with Board Members outside formal meetings. Additional meetings for the Trust Board and EMT consideration of the Strategy are currently being planned as is the next phase of external engagement activities.

Our full 5 year Strategy must be submitted to the TDA by 20 June 2014 and will include a 5 year: long term financial model and integrated business plan; activity plan; workforce plan; and a strategic plan summary.

5. Development Support Plan

The final national requirement is for the Trust to identify its development requirements and supports plans to ensure delivery of the operating plan and strategy. We will undertake a review of our development requirements during June-mid Sept in order that we can submit our development plan to the TDA by 30 September 2014.

6. Next Steps

Initial planning of the steps required to complete the 2 year Operating Plan and 5 year Strategic Plan have been considered and are provided in Appendix A for information (attached). This plan will be refined as we go forward.

7. Recommendations

The Board is asked to note progress towards the Operating Plan and 5 year Strategic Plan.

Karen Broughton
Director of Transformation and Strategy
21 January 2014

London Ambulance Service NHS Trust

Operating Plan and 5 Year Plan

Planning process

21/01/2014

Delivery the 2 year Operating Plan

Planning process: January – March 2013

January

- Continue to review potential 2014/15 QIPP schemes
- Continue work on defining the revised workforce plan
- Trust Board engagement on next stage of Operating Plan; and Trust Board meeting 28 January
- Meeting with commissioners to continue negotiations on 14/15 contracting round – weekly throughout Jan/Feb/March
- Assistant Director level working group established to focus on bringing together elements of Operating Plan and 5 Year Strategy
- Executive Director leads to begin to draft of their parts of Operating Plan
- Finance and Investment Committee considers work to-date on Operating Plan and QIPP Plan
- Fortnightly progress reports to EMT

Delivery the 2 year Operating Plan

Planning process: January – March 2013

February	• 3 February – Strategy session with EMT to consider current operating plan submission and 5 year strategy development • 5 February – Monthly Commissioning meeting • Continue engagement with patients and stakeholders on LAS's 2020 Strategy • Weekly Assistant Director meetings held and progress continued • Draft Annual workforce plan for 2014-16 • Director of Nursing and Medical Director review workforce plan and QIPP plans prior to Board sign off • Fortnightly progress reports to EMT • Meeting with commissioners to continue negotiations on 14/15 contracting round – weekly throughout Jan/Feb/March • 26 February - Quality Committees to consider emerging QIPP plan and Operating Plan • 25 February – Trust Board Strategy and Planning session: final review of contract position; agree 1st draft of operating plan: consider emerging QIPP plan • 28 February - QIPP plan draft finalised following comments and feedback from Quality Committee • 28 February - Final contract agreed with commissioners • If necessary, additional meetings of the Board will be put in place to continue engagement

Delivery the 2 year Operating Plan

Planning process: January – March 2013

March

- 5 March – Full 1st draft Operating Plan submitted to TDA (post contract sign off)
- Continue engagement with patients and stakeholders on LAS's 2020 Strategy
- Meeting with commissioners to continue negotiations on 14/15 contracting round – if required and unable to reach agreement at 28 February
- Finalise Annual workforce plan for 2014-16
- Weekly Assistant Director meetings held and progress continued
- Review Finance and activity plans based on final contract agreement
- Director of Nursing and Medical Director review workforce plan and QIPP plans prior to Board sign off
- Review final finance and performance out turn
- Fortnightly progress reports to EMT
- 20 March – Finance and Investment Committee review and sign off QIPP Plans and Operating Plan
- 25 March - Trust Board Meeting to approve Operating Plan and QIPP Plan
- If necessary, additional meetings of the Board will be put in place to continue engagement

5 Year Plan

Planning process

April – June 2014

- 4 April – submit final full Operating Plan to TDA
- Formal engagement with the Trust Board will be as follows:
  - 29 April – Trust Board - Board Strategy and Planning Session
  - 4 June – Trust Board – review penultimate draft of 5 year plan alongside 2020 Strategy
  - 24 June – Trust Board agree 2020 Strategy
- Continue engagement with patients and stakeholders on LAS's 2020 Strategy and 5 Year Plan
- Meeting with commissioners on a monthly basis to manage contract performance
- Weekly Assistant Director meetings held and progress continued
- Review Finance and activity plans based on final contract agreement
- Fortnightly progress reports to EMT
- QIPP Delivery Board reviewing progress towards QIPP schemes
- Additionally in the period April to June, the 5 year plan will be reviewed at Finance and Investment (on 22 May) and Quality Committees (on 23 April and 18 Jun)
- If necessary, additional meetings of the Board will be put in place to continue engagement
- There will be extensive internal and external engagement with stakeholders throughout this period. The nature and shape of this engagement will to an extent depend on the work undertaken in January to March so exact details cannot be described at this stage.
- TBA but before 20 June – Trust Board to meet to review final draft of 5 year plan
- 20 June – Submit 5 year plan, LTFM and IBP to TDA

Delivering development support plan

July – Sept 2014

The Trust will analyse and critically evaluate:

- Our development support needs in order to ensure that we deliver the 2 year operating plan and the 5 year strategic plan both of which will in turn enable the Trust to deliver its 2020 strategy.
- Our development support plan will identify; priority areas for action, what development support is required over what timescale, clarity on the outcomes which are required and the timescales within which they need to be delivered.

This work will be led by the Director of Transformation and Strategy whose portfolio includes organisational development but support will be drawn from across the Trust and views and feedback will be sought from both internal and external stakeholders.

Formal engagement with the Trust Board will be as follows:

29 July – Trust Board – update on progress
2 September - Board Strategy and Planning Session – penultimate draft of development support plan for review and comment
30 Sept – Trust Board approves development support plan prior to submission

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 28TH JANUARY 2014

PAPER FOR APPROVAL

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

Key issues and risks arising from this paper

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

Executive Summary

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

1. Board statements

Board statement 10 requires the Board to sign off that: it is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.
Following discussion at the Board meeting in December a statement of non-compliance was submitted. The position now is as follows:

A winter sustainability action plan has been developed and additional funding from the NHS has been secured to deliver the actions contained within the plan. A revised trajectory to ensure the Trust achieves both the Red1 & Red 2 target has been submitted to the TDA, NHS England (London) and our commissioners. Based on the revised trajectory performance in December markedly improved and the Trust has been achieving the 75% standard against both targets routinely since the beginning of January 2014.

The Board is therefore asked to approve an unqualified compliance statement for December 2013.

2. Monitor Compliance

The Monitor Compliance document refers to the conditions within the new provider licence which comes into effect from 1st April 2014 but against which we are being monitored now.
http://www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-8

The Board is asked to confirm that these conditions were met in December 2013.

Attachments

None.

****

Quality Strategy

This paper supports the following domains of the quality strategy

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

LAS Strategic Goals and Priorities

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

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

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

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

Key issues from the assessment:

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 28TH JANUARY 2014

Compliance with Standing Orders and Standing Financial Instructions

Document Title:	**Trust Secretary Report**
Report Author(s):	**Francesca Guy, Committee Secretary**
Lead Director:	**Sandra Adams, Director of Corporate Services**
Contact Details:	**francesca.guy@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Compliance with Standing Orders**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To be advised of the tenders received and entered into the tender book and the use of the Trust Seal since 19th November 2013 and to be assured of compliance with Standing Orders and Standing Financial Instructions**

Key issues and risks arising from this paper

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

Executive Summary

One new tender has been received since 19th November 2013 for the replacement of Vehicle Hoists in 8 LAS workshops. Tenders received and opened on 23rd December 2013:

- Straightset Ltd
- Gemco
- JHM Butt and Company Ltd

There has been one new entry to the register for the use of the Trust Seal since 19th November 2013:

The Trust Seal was used on 17th December 2013 for the licence to underlet basement rooms 32 and 35 and Suite 2D, Third Floor Premises, County House, 221 – 224 Beckenham Road, Beckenham BR3 4UF.

Attachments

None.

****

Quality Strategy

This paper supports the following domains of the quality strategy

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

LAS Strategic Goals and Priorities

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

LAS Strategic Goals

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

2013/14 Priorities

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

Has an Equality Analysis been carried out?

- ☐ Yes
- ☒ No

Key issues from the assessment:

London Ambulance Service NHS
NHS Trust

TRUST BOARD FORWARD PLANNER 2014

25th March 2014

Standing Items	Quality Governance and Risk	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Staff Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman FT Update	**Integrated Board Performance Report** **Quality Dashboard** **Clinical Quality and Patient Safety Report (including serious incidents update)** **Quality Committee Assurance Report** **Audit Committee Assurance Report** **BAF and Corporate Risk Register – Quarter 4 documents** **Finance Report** **Report from Finance and Investment Committee** **Risk Management Strategy and Policy review** **Clwyd Report**	Report from Chief Executive Officer Modernisation Programme 2014/15 Operating Plan sign off 2014/15 Corporate Objectives sign off 2014/15 Equality Objectives sign off Staff Survey results IBP/LTFM sign off Enabling Strategies Christmas Day incident final report Proposal to Increase the number of Non-Executive Directors	Board Declarations Report from Trust Secretary Trust Board Forward Planner	Audit Committee on 3rd February 2014 Finance and Investment Committee on 20th March 2014	

3rd June 2014

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 FT Update	**Annual Report and Accounts 2013/14** **Quality Account 2013/14 for approval** **Audit Committee Assurance Report** **BAF and Corporate Risk Register – Quarter 1 documents**	Integrated Board Performance Report Quality Dashboard Clinical Quality and Patient Safety Report (including serious incidents update) Quality Committee Assurance Report Finance Report Report from Finance and Investment Committee	Report from Chief Executive Officer Modernisation Programme Presentation from AACE	Board Declarations Report from Trust Secretary Trust Board Forward Planner	Audit Committee on 22nd May 2014 and 2nd June 2014 Finance and Investment Committee on 15th May 2014	Fionna Moore

24th June 2014

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

29th July 2014

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

30th September 2014

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

25th November 2014

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

16th December 2014

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

2014 Meetings Calendar

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