Trust Board Papers - 29th January 2013

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London Ambulance Service NHS Trust

MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD
TO BE HELD IN PUBLIC ON TUESDAY 29TH JANUARY 2013 AT 09.00 – 11.30
CONFERENCE ROOM, 220 WATERLOO ROAD, LONDON SE1 8SD

AGENDA: PUBLIC SESSION

	ITEM	SUBJECT	LEAD	TAB
	1.	**Welcome and apologies for absence** Apologies received from: Caroline Silver		
9.00	2.	**Patient Story** To hear an account of a patient experience	SL	Oral
9.10	3.	**Declarations of Interest** To request and record any notifications of declarations of interest in relation to today's agenda	RH	
	4.	**Minutes of the Part I meeting held on 27th November 2012** To approve the minutes of the meeting held on 27th November 2012	RH	TAB 1
9.15	5.	**Matters arising** To review the action schedule arising from previous meetings	RH	TAB 2
9.20	6.	**Report from Chairman** To receive a report from the Trust Chairman on key activities since the last meeting	RH	ORAL
	QUALITY, GOVERNANCE AND RISK			
9.25	7.	**Quality Dashboard** To receive the most recent Quality dashboard	SL	TAB 3
9.35	8.	**Clinical Quality and Patient Safety Report** To receive the monthly report on clinical quality and patient safety	FM/SL	TAB 4
9.40	9.	**Quality Committee Assurance Report** To receive a report from the Quality Committee meeting on 13th December 2012	BM	TAB 5
9.45	10.	**Integrated Board Performance Report** To receive the integrated board performance report	AR	TAB 6
9.55	11.	**Quarter 4 Performance** To receive assurance on progress against the action plan	JK/ PW	TAB 7
10.05	12.	**Care Quality Commission Report and Action Plan** To receive the report from the CQC compliance inspection and the internal action plan	SA	TAB 8

	STRATEGIC AND BUSINESS PLANNING			
10.15	13.	**2013/14 Business Plan Submission** To discuss the first cut 2013/14 business plan submission	SA/ AG	TAB 9
10.30	14.	**Clinical Quality Strategy** To approve the clinical quality strategy	FM/SL	TAB 10
10.45	15.	**Report from Chief Executive Officer** To receive a report from the Chief Executive Officer	AR	TAB 11
10.55	16.	**2012 Olympic Games End Report** To receive the 2012 Olympic Games End Report	JK	TAB 12
11.00	17.	**Foundation Trust Project** To receive an update on progress on the project to take forward the Foundation Trust application	SA	TAB 13
	GOVERNANCE			
11.05	18.	**Finance and Investment Committee Report** To receive a report from the Finance and Investment Committee meeting on 15th January 2013	RH	ORAL
11.10	19.	**Update on Information Governance** To receive an update on Information Governance	PS	TAB 14
	BUSINESS ITEMS			
11.15	20.	**Report from Trust Secretary** To receive the report from the Trust Secretary on tenders received and the use of the Trust Seal	SA	TAB 15
	21.	**Forward Planner** To receive the Trust Board forward planner	SA	TAB 16
	22.	**Any other business**	RH	
	23.	**Questions from members of the public**	RH	
11.30	24.	**Date of next meeting** The next meeting of the Trust Board will take place on Tuesday 26th March 2013		

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING
Part I

DRAFT Minutes of the meeting held on Tuesday 27th November 2012 at 9:00 a.m.
in the Conference Room, 220 Waterloo Road, London SE1 8SD

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Present:	
Richard Hunt	Trust Chair
Mike Dinan	Director of Finance
Martin Flaherty	Acting Chief Executive
Roy Griffins	Non-Executive Director
Caron Hitchen	Director of Workforce
Brian Huckett	Non-Executive Director
Steve Lennox	Director of Quality and Health Promotion
Beryl Magrath	Non-Executive Director
Nick Martin	Non-Executive Director
Fionna Moore	Medical Director
Caroline Silver	Non-Executive Director
In Attendance:	
Sandra Adams	Director of Corporate Services
Francesca Guy	Committee Secretary (minutes)
John Jones	Associate Non-Executive Director
Jason Killens	Deputy Director of Operations
Angie Patton	Head of Communications
Ann Radmore	Chief Executive Designate
Peter Suter	Director of Information Management and Technology
Paul Woodrow	Deputy Director of Operations
Members of the Public:	
Neil Kennett-Brown	North West London Commissioning Partnership
Malcolm Alexander	LAS Patients' Forum
Paul Webbewood	Member of the public
Sonia Blackwood	Member of the public

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138. Welcome and Apologies

138.1 Apologies had been received from Jessica Cecil.

138.2 The Chair welcomed John Jones to his first Trust Board meeting. Ann Radmore, Chief Executive Designate, would be joining the meeting later.

139. Patient Story

139.1 The Trust Board was joined by the mother of a patient who gave an account of her son's experiences being treated by the LAS.

139.2 The Trust Board thanked the patient's mother for joining the meeting. The Chair asked for Steve Lennox to follow up with the crew involved and for an update to be given at the next meeting on what action had been taken.

ACTION: SL to follow up with the crew involved in the Patient's story and to provide an update at the next Trust Board meeting on what action had been taken.

DATE OF COMPLETION: 29th January 2013

139.3 Steve Lennox confirmed that a Patient Specific Protocol was being developed for this patient, which would help to improve his treatment going forward.

140. Declarations of Interest

140.1 There were no declarations of interest.

141. Minutes of the Part I meeting held on 25th September 2012

141.1 The minutes of the Part I meeting on 25th September 2012 were approved.

142. Matters Arising

142.1 The following actions and matters arising were discussed:

142.2 **123.3:** Steve Lennox confirmed that he had explained in the Quality Dashboard Report that the targets were aspirational. Action complete.

142.3 **123.4:** Plans for Christmas and New Year had been added to the Trust Board forward planner. Action complete.

142.4 **123.5:** Steve Lennox confirmed that he had reviewed the action owners in the Quality Report in light of changes to the senior management team. Action complete.

142.5 **124.6:** Peter Suter confirmed that he had arranged for the Management Information Team to meet with the Patients' Forum to address their concerns about the High Risk Register. Action complete.

142.6 **124.8:** Peter Suter reported that, since 1st April 2012, there had been 1915 calls to addresses on the High Risk Address Register, of which 230 had flagged been flagged by the Metropolitan Police Service. Action complete.

142.7 **128.3:** The top 5 lessons learnt from the 2012 Olympic Games were included in the Chief Operating Officer's report. Action complete.

142.8 **131.3:** Mike Dinan stated that the action to write an explanation of the two LAS charities was outstanding and would first be presented to the Finance and Investment Committee. Outstanding.

142.9 **134.2:** Peter Suter stated that the action to explore options for the Trust Board to use iPads or alternative devices for Trust Board meetings would be discussed further in the Part II meeting.

142.10 **135.1:** The Chair stated that he had drawn up a proposal for the Trust to award a commendation to a member of public who had assisted the service. This would be discussed further at the Strategy Review and Planning Committee meeting in December.

143. Report from the Chairman

143.1 The Chair reported that he had recently attended a meeting of acute trust chairs at which they had

received a presentation on the expected future commissioning structure.

143.2 The Chair stated that it would be an interesting period for the Trust moving forward with the appointment of Ann Radmore as Chief Executive Officer. The focus would be on engagement with key stakeholders and this would be discussed at the Strategy Review and Planning Committee meeting in December.

143.3 Sandra Adams added that she had discussed with Ann Radmore the role non-executive directors could play in engaging with key stakeholders.

144. Quality Dashboard and Action Plan

144.1 Steve Lennox reported that the Quality Dashboard had returned to the pre-Olympics position. This reflected the pressure in the system, although LAS still performed well against other ambulance trusts nationally.

144.2 Steve reported that he had attended a meeting for clinical and quality directors held by the NHS Trust Development Authority who had indicated that they did not want to see a RAG rated scorecard and instead wanted to see fewer indicators reviewed in greater detail. Steve would therefore need to review the format of the scorecard with Fionna Moore.

144.3 Steve added that the action plan for the Quality Dashboard now sat at an area level and was therefore not included in the Trust Board pack.

144.4 The Chair asked for the use of acronyms in this report to be minimised, particularly as this was a public document.

144.5 The Patients' Forum had submitted a question to ask whether it was the intention of the Trust Board to develop 'Service Experience Indicators', in view of Monitor's commitment to strengthening patient involvement in quality improvement and decision making. Steve Lennox responded that he had met with the Chair of the Patients' Forum and had discussed how best to use the forum to obtain feedback directly from patients.

145. Clinical Quality and Patient Safety Report

145.1 Fionna Moore reported the following:

- There had been an increase in Clinical Performance Indicator (CPI) performance reporting, which was at the highest level it had been for some time. The south area in particular were to be congratulated in improving its CPI completion rates;
- The LAS no longer recorded missing equipment as an exception for CPIs and crews had been encouraged to report missing equipment via the formal incident reporting process;
- The Royal College of Physicians had developed a National Early Warning Score (NEWS) to standardise the assessment of acute-illness severity across the NHS. Currently, no early warning system had been validated in pre-hospital care and this could present a potential audit opportunity.

145.2 Beryl Magrath congratulated the Trust for the increase in CPI performance reporting.

145.3 The Chair noted that the Mental Health CPI was consistently rated red and asked how this would be addressed. Steve responded that this was a new CPI and therefore the current levels of compliance were as expected. Steve expected to see compliance rates improve over time as this CPI became embedded.

145.4 Roy Griffins commented that this report was very helpful and substantiated the issues highlighted in the Quality Report, particularly with regards to the increase in the number of complaints regarding delays. Steve Lennox acknowledged that complaints about delays had shown an increase, as had complaints relating to attitude and behaviour, although this was still relatively low. An action plan was in place to address attitude and behaviour which would be monitored by the Learning from Experience Group going forward.

145.5 Beryl Magrath commented that attitude and behaviour was a key issue and was much more common than acknowledged. Steve responded that, even including those complaints where attitude and behaviour was cited as a secondary issue, the Trust did not receive a significant number of these types of complaints. Martin stated that the Trust took these complaints seriously and followed up with the members of staff involved.

145.6 The Chair stated that complaints were an early warning sign about key issues and the Trust Board therefore needed to be satisfied that this was not an early warning sign. Martin acknowledged that increased pressure and delays to patients could lead to an increase in attitude and behaviour issues. The trend would be monitored and reviewed.

145.7 The Patients' Forum had submitted a question asking the Trust Board to confirm that the Trust had adopted the Health Service Commissioner's guidance 'Driving improvement and learning from NHS complaints information' published in March 2011. Steve confirmed that the Trust did follow the guidelines and had one of the lowest levels nationally of complaints investigated by healthcare commissioners, which indicated that complaints were being managed well.

146. <u>Quality Committee Assurance Report</u>

146.1 Beryl Magrath stated that the Quality Committee wished to bring to the attention of the Trust Board its concern about the combined effect of the Cost Improvement Programme which had led to increased pressure in the system manifested by delays, particularly to Category C patients, cancelled training and increased use of the Demand Management Plan.

146.2 The Chair asked Nick Martin, as a new member of the Quality Committee, whether he agreed with these comments about increased pressure on the system. Nick Martin confirmed that he supported these comments but was assured by the fact that the governance structure was set up to ensure that these issues were identified.

146.3 In response to a question from the Chair, Beryl stated that the attendance at the Quality Committee was good and Paul Woodrow now attended as the representative from Operations.

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

147.1 Sandra Adams stated that the Board Assurance Framework reflected both the reports from the Quality Committee and the Audit Committee. Sandra reported the following:

- No new risks were opened in the quarter and none were closed;
- The principal risks section had been updated, particularly the key controls and actions;
- There were two areas to be risk assessed: delays to Category C patients and the governance of the Locality Alert Register (formerly the High Risk Register);
- The CQC had undertaken an unannounced visit earlier in the month and the draft report was expected this week. One issue had been identified relating to missing equipment, although the CQC had taken some assurance that an action plan was in place to address this;
- There were two risks concerning the Board which had come through the Audit Committee and Trust Board in recent months. The Risk, Compliance and Assurance Group had agreed the rating for these which would not place them on the Board Assurance Framework or

Corporate Risk Register. Sandra however was proposing that these should be kept visible through the Board Assurance Framework and reviewed as necessary.

147.2 Nick Martin expressed surprise that the two new risks on the risk register relating to changes at board level had not been rated higher, as this would be the case in the private sector. Caroline Silver agreed with this comment and stated that these risks added to the overall picture of strain on the organisation.

147.3 Roy Griffins agreed with this point, but was assured that these risks would remain visible to the Trust Board at their current level. Roy reported that he had been on a rideout recently and stated that the changes at management level had filtered through to frontline crews. Sandra stated that these risks would be added to the risk focus section of the Board Assurance Framework under strategic risk 4.

147.4 The Chair stated that the Board Assurance Framework gave the Trust Board reassurance that the governance structure was capturing key issues and risks. The Trust Board now needed to discuss what action should be taken to address these risks. This would be taken forward to a Strategy Review and Planning Committee meeting.

148. <u>Audit Committee Assurance Report</u>

148.1 Caroline Silver reported that the meeting on 5th November had been the annual internal meeting of the Audit Committee, which was not attended by either external audit or internal audit. Caroline noted the following points:

- The meeting was joined by representatives from East Lancashire Financial Services (ELFS) and their internal auditors. The Committee was encouraged that the outsourcing arrangements with ELFS were working well. Some minor issues had been identified, but these were as expected;
- The Audit Committee discussed the report from the Quality Committee and was assured by the fact that the governance structure was working effectively to identify key organisational risks. However, the Audit Committee was concerned about the content of the report and wanted to bring these concerns to the attention of the Trust Board;
- The Trust was currently in the process of tendering for internal audit and local counter fraud services;
- The Committee reviewed the report into the accounting errors at Croydon PCT and was assured that the finance team had reviewed the recommendations in the report.

148.2 Mike Dinan reported that since the meeting of the Audit Committee some additional concerns had been identified in relation to the outsourcing arrangements. These were not significant however and would be followed up by the Finance and Investment Committee.

148.3 John Jones stated that he thought that the process was working well in terms of providing assurance to the Trust Board and the key to that was having the chair of the Quality Committee in attendance at the Audit Committee.

148.4 The Trust Board had received a question from the Patients' Forum asking for confirmation that all entrants on the Location Alert Register (formerly High Risk Register) had now received a letter inviting them to contact the LAS if they wished to object to their placement on the register. Fionna responded that the Trust was working its way through the register and was sending letters out in a rolling programme.

149. Executive Directors Report

Chief Operating Officer's Report

149.1 Martin Flaherty reported that the red flags highlighted in this report correlated with those raised in other reports:

- The Trust was meeting its Category A target, but this was against a background of increased workload. Category A activity had increased by 13.5% in comparison with last year;
- Call taking performance was just under target;
- Utilisation levels had increased month on month, particularly at weekends;
- Use of the Demand Management Plan had increased and had been escalated to level D on a number of occasions;
- Student paramedic training was continuing as planned and CSR training was picking up;
- The Winter Plan had been submitted to the commissioners and had received a green rating, but there is a general concern about winter across London;
- The lessons learnt from the 2012 Olympic Games were included in the report. The post-games report was currently being drafted and would be published in January 2013;
- New FRUs continue to arrive and all 30 were expected by the end of November 2012. 34 more FRUs to be purchased.

ACTION: FG to add the 2012 Olympic Post-Games Report to the Trust Board forward planner for January.

DATE OF COMPLETION: 11th December 2012

149.2 The Patients' Forum asked how confident the Board was that the LAS had enough fully trained frontline staff to meet increased demand in relation to patients with life-threatening conditions. Martin Flaherty responded that resources were targeted towards higher acuity patients, but this inevitably had an impact on Category C patients. This would be considered in the capacity review currently being undertaken by ORH.

Report from the Director of Finance

149.3 Mike Dinan reported that the Trust was reporting a deficit of £183k for the month against a planned surplus of £190k. Year to date the Trust was reporting a deficit of £445k against a planned surplus of £675k. Overtime and third party expenditure had increased and there had been some slippage against the delivery of the CQUINs. The Cost Improvement Programme was on track.

149.4 Mike reported that the Trust had received a clear response that there would be no additional funding available for the Queen's Diamond Jubilee and this had therefore been taken out of the forecast. The Chair commented that this would be discussed in further detail in the Part II meeting.

Report from the Director of Workforce

149.5 Caron Hitchen reported that the key item to bring to the attention of the Trust Board was sickness absence levels. This was currently only just within target and was likely to get worse moving into the winter months. This was reflective of pressures in the system and was something that the Trust Board should continue to monitor.

149.6 Caron reported that the data for PDR completion in operational areas was incomplete. PDR completion rates in operational areas was not at an acceptable level but there were significant

constraints with high levels of utilisation and high levels of training being delivered to student paramedics.

149.7 Roy Griffins noted that turnover had shown a further increase and asked whether this was significant. Caron responded that there had been some increase in turnover, partly due the student paramedic attrition rate, but this was still within the normal trend.

149.8 Caron reported that a conscious decision had been made to recruit more heavily to frontline posts. Up to 100 apprentice paramedics had been recruited, who would have an initial 9 weeks' of training before becoming operational.

149.9 The Patients' Forum asked the Trust Board whether it was satisfied that appropriate measures were being taken to ensure that LAS's percentage of paramedics of black and other minority ethnic heritage, matches the diversity of London's population. Caron responded that the measurement of only paramedics, especially when going back to 2004, was not a particularly good measure as at that time only 29% of frontline staff delivering care to patients were paramedics. Over the period in question our frontline BME staff had increased from 4.32% to 5.82%. Clearly the LAS would like to see a greater representation and was focused on achieving this. It was worth noting that 9.17% of our recently-recruited Student paramedics were from BME backgrounds. It was also worth noting that the number of BME paramedics employed (including student paramedics about to qualify) had increased since 2004 by 269%.

149.10 Caron reported that, in terms of scrutiny of LAS employment practices, the Trust was confident that these had "passed muster" and this was supported by the fact the LAS was currently included in the top 100 employers index with Stonewall. The Trust had also gained assurance from the implementation of the national Equality Delivery System and the Equality and Inclusion Strategy. The Equality and Human Rights Commission had also confirmed that the Trust's employment practices were open and inclusive.

150. <u>Report from Chief Executive Officer</u>

150.1 Ann Radmore joined the meeting.

150.2 Martin Flaherty reported that the principle challenge was to deliver a high quality service against a backdrop of high levels of demand. This would be discussed further in the Part II meeting. Martin noted the following:

- The Foundation Trust application was progressing and a new version of the Tripartite Formal Agreement was due to be signed off by 7th December when the Trust would be meeting with NHS London and the NHS Trust Development Authority to discuss the application;
- The LAS Strategic Commissioning Board had taken place on 26th November. The purpose of the meeting was to provide a clearer understanding of how the Trust would be commissioned going forward;
- The Trust would be appointing an interim Director of Finance and the interviews were due to take place next Friday;
- The Trust would continue to be involved in discussions around reconfiguration, which would form part of the capacity modelling going forward;
- With regards to the key priorities for 2012/13, there was increased concern about Category C performance and some aspects of CQUIN achievement;
- Action had been taken after the technical issues experienced in early October to improve the resilience of the fallback arrangements.

150.3 Beryl Magrath asked whether the technical issues in October were connected to the risk that

messages exchanged between MDTs and CommandPoint could become out of sequence. Peter Suter confirmed that these were separate issues. An alarm system was in place to alert the Control Room when messages had gone out of sequence. Northrop Grumman was also working on a technical fix which would take three to four months to implement.

151. Performance Reporting Compliance Statement

151.1 Peter Suter reported that this was the yearly return which detailed compliance with performance reporting standards. Martin Flaherty confirmed that the KA34 yearly return no longer existed, however ambulance trusts had opted to adhere to the previous guidelines issued by the Department of Health.

151.2 The Trust Board noted the Performance Reporting Compliance Statement.

152. Report from Trust Secretary

152.1 Sandra Adams noted that one tender had been received since the last meeting for the refurbishment and reconfiguration of Barnehurst Ambulance Station. An additional tender had been received after the papers had been circulated, the details of which would be included in the next report to the Trust Board.

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

153. Forward Planner

153.1 The Chair asked the Trust Board whether it would like to continue to with the forward planner in its current format. The Trust Board agreed that this was a useful way of ensuring information was fed across the key committees.

154. Any other business

154.1 There were no items of other business.

155. Questions from members of the Public

155.1 Paul Webbewood stated that he was concerned about the impact of the south east London reconfiguration and people locally were concerned about the risk of patients dying in ambulances due to increased journey times. Fionna Moore responded that those patients who were critically ill or injured were currently conveyed to Kings College Hospital and therefore the closure of Lewisham Hospital emergency department would not have a direct impact on the patient journey. However, the LAS was concerned that increased pressures on emergency departments would have an impact on patient experience.

155.2 Fionna stated that the LAS sat on one of the clinical advisory groups and was working closely with the sector to understand the implications of closing the emergency department at Lewisham Hospital. There was an assumption that a large number of patients would be seen by the urgent care centre at Lewisham Hospital. Martin Flaherty added that changes in patient flows and extended travel times would be taken into account by the ORH capacity review.

155.3 Nick Martin asked whether the Trust had been proactive with regards to this issue. Martin confirmed that the Trust had been proactive and would look to understand the impact across London as a whole. Neil Kennett-Brown stated that commissioners were looking at service reconfigurations to ensure that there were consistent standards across London.

155.4 Neil Kennett-Brown noted that the capacity modelling exercise was a good piece of collaborative work. The outcome of this was not yet known, but would need to be communicated jointly to the wider system.

156. <u>Date of next meeting</u>

156.1 The Strategy Review and Planning Committee will be meeting on Tuesday 11th December 2012.

156.2 The next meeting of the Trust Board will take place on Tuesday 29th January 2013.

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Signed by the Chair

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ACTIONS
from the Meeting of the Trust Board of Directors of
LONDON AMBULANCE SERVICE NHS TRUST
held on 27th November 2012

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
28/06/11	**67.3**	RH to discuss world cities benchmarking with FM.	**RH/FM**	FM to attend Eagles summit in February 2013.
29/05/12	**46.3**	LB to publish patient story in the GP newsletter.	**LB**	Action taken forward by Emma Williams. To be published in the January 2013 newsletter.
26/06/12	**74.12**	RH/SA to discuss how to build in staff presentations into the Trust Board forward planner.	**RH/SA**	To be explored as part of a wider programme of staff engagement, linking to Board development.
21/08/12	**102.7**	SL to review attendance at the Safeguarding Committee.	**SL**	Attendance was reviewed at the Safeguarding Committee meeting on 4th October and a revised membership was agreed. Action complete.
25/09/12	**126.7**	MF to put forward a proposal to the Risk, Compliance and Assurance Group to consider an additional risk for Category C patients.	**PW**	Action being taken forward by Paul Woodrow.
25/09/12	**131.3**	MD to write an explanation on the roles of the two LAS charities.	**AG**	Outstanding. Action to be taken forward by AG.
25/09/12	**135.1**	Trust Chair to develop a proposal for the Trust to award a commendation to a member of the public who had assisted the service.	**RH**	RH to discuss with AR.
27/11/12	**139.2**	SL to follow up with the crew involved in the Patient's story and to provide an update at the next Trust Board meeting on what action had been taken.	**SL**	A reflective meeting with the crew involved is being arranged.

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
27/11/12	**149.1**	FG to add the 2012 Olympic Post-Games Report to the Trust Board forward planner for January.	**FG**	On the agenda for the meeting on 29th January 2013. Action complete.

CLOSED ACTIONS

25/09/12	**123.3**	SL to explain in the Quality Dashboard Report to the Trust Board that the targets were aspirational.	**SL**	Action complete.
25/09/12	**123.4**	FG to add a presentation on plans for the Christmas and New Year period to the Trust Board forward planner.	**FG**	Action complete.
25/09/12	**123.5**	SL to review the action owners on the Quality Report action plan in light of changes to the senior management team.	**SL**	Action complete.
25/09/12	**124.6**	PS to arrange for the MI Team to meet with members of the Patients' Forum to address their concerns about the High Risk Register.	**PS**	Action complete.
25/09/12	**124.8**	PS to provide figures on how many high risk addresses the Trust had attended.	**PS**	Since 1st April 2012, there have been 1915 calls to addresses on the High Risk Register, of which 230 were MPS flagged addresses. Action complete.
25/09/12	**128.3**	FG to add Top 5 lessons learnt from the 2012 Olympic Games to the Trust Board forward planner for December 2012.	**FG**	Included in the COO report to the November Trust Board. Action complete.
25/09/12	**134.2**	PS to explore options for the Trust Board to use iPads or alternative devices for Trust Board meetings.	**PS**	Discussed in the Part II Trust Board meeting. Action complete.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29 JANUARY 2013

PAPER FOR DISCUSSION

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

Key issues and risks arising from this paper

This report identifies that the LAS remains one of the top performing Ambulance Trusts in the country when using the DH indicators as the measure. We have maintained our 3rd ranking.

Executive Summary

There are three components to the Quality Dashboard & Action Plan

1. **Quality Dashboard (July 2012)**

The dashboard illustrates the Trusts performance for November 2012 against the identified Quality Measures. The challenge and discussion for each indicator has been undertaken at SMG where a Full Quality report supported the dashboard.

The dashboard illustrates 34 measures for quality and reveals 11 Green measures 12 Amber measures and 11 Red measures. This month has seen a refresh of the dashboard and three measures have been reviewed and Missing Documentation has been removed at the suggestion of the Quality Committee as assurance has been found from other sources. Right Place, Right Time and The Response Time measure have also been removed as these measures have not been developed to measure anything beyond a basic measure.

2. **DH Quality Measures (Comparison)**

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

Some of the 11 DH measures (service experience has been excluded) are made up of a number of indicators. A8 is broken into Red 1 and Red 2.

This month the Trust is at the very top in 7 of the indicators.

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

Isle of Wight 11 (25%)
Great Western 7 (16%)
London 7 (16%)
East of England 4 (9%)
South Central 3 (7%)
Yorkshire 2 (4.5%)
North West 2 (4.5%)
South East Coast 2 (4.5%)
South Western 2 (4.5%)
East Midlands 2 (4.5%)
West Midlands 2 (4.5%)
North East 0 (0%)

3. Quality Action Plan

The action plans have now been devolved to a local level. Each area now has a quality action plan and progress is monitored at CQSEC

4. Revision of the Dashboard

The dashboard has been reconfigured to incorporate the guidance within the National Quality Board's publication "Quality in the new Health System; Maintaining and improving quality from April 2013". These domains are also replicated within the NHS Outcomes framework. This moves the dashboard away from the Maslow principle on which it was initially based but maintains a domain approach to classifying the measures.

Attachments

1. **Quality dashboard**
2. **DH Quality Measures (Comparison)**

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Quality Strategy

This paper supports the following domains of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes

✓ No

Key issues from the assessment:

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Quality Dashboard for October 2012

Domain 1. Preventing people from dying prematurely

Preventing Death

Outcome from Cardiac Arrest	On Scene Time	Return of Spontaneous Circulation	STEMI Care	Stroke Care	Basic Life Support
Green	Amber	Green	Red	Green	Green

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

Quality of Life

Not Conveyed to A&E	Clinical Performance Indicators	CQUIN Diabetes Care
Amber	Amber	Amber

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

Helping People

Time to Treatment	Airway Management	CQUIN Alcohol Related Harm
Green	Red	Amber

Domain 4. Ensuring people have a positive experience of care

Experience

Service Experience	Incidents	Lost Property	Time Taken to Answer 999 Calls	Re-Contact Rate	CQUIN Mental Health Care
Amber	Amber	Amber	Green	Amber	Amber

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

Environment

Infection Control	Safeguarding
Red	Amber

Domain 6. Time in which it takes for patients to receive assistance and be handed over

Performance

A8 Response Time	A19 Response Time	C1 Response Time	C2 Response Time	C3 Response Time	C4 Response Time	Arrival at Hospital to Handover
Red	Green	Red	Red	Red	Amber	Red

Domain 7. Caring for the workforce

Staff/Workforce

% of staff Receiving Supervision	% of X2 CPI Feedback Sessions	% of priority training commitments delivered (CSR)	Vacancy Factor	3rd Party Providers	Sickness (Always a Month behined)	-Temperature Check (Quarterly June)
Red	Green	Red	Green	Red	Green	Green

Comparison Table

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

The GREEN shading represents where the Trust is in the upper quartile when compared to other services.

	March (December)			Year to Date	
	Compliance	Rank	Direction of Travel (Compliance)	Compliance	Rank
A8 R1 Response Time	74%	9	↓	77.4%	4
A8 R2 Response Time	73,5%	11	↓	76.2%	9
A19 Response Time	97.8%	3	↓	98.2%	1
ROSC (all)	36.4%	3	↑	30.4%	2
ROSC (Utstein)	61%	4	↓	53.4%	3
Time Taken to Answer 50th Percentile	0	1	↔	0	1
Time Taken to Answer 95th Percentile	1.0	1	↔	0.09	5
Time Taken to Answer 99th Percentile	0.36	2	↓	1.01	7
Time to Treatment 50th Percentile	6.0m	10	↓	5.49	6
Time to Treatment 95th Percentile	15.06m	2	↓	14.18	2
Time to Treatment 99th Percentile	22.4m	5	↑	22.33	3
Outcome from cardiac Arrest Survival	8.8%	7	↑	7.3	7
Outcome from cardiac Arrest Survival (Utstein)	22,9%	8	↑	23.3	4
STEMI Outcome 150 minutes	84.3%	10	↓	92.1%	3
STEMI Outcome Care Bundle	68.9%	10	↓	69.4%	12
Stroke Outcome 60 minutes	75.8%	5	↑	70.8%	4
Stroke Care Outcome Bundle	95.1%	8	↓	94.9%	7
Calls Closed with CTA	5.3%	8	↓	5.6%	8
Non A&E	33.3%	9	↑	32%	9
Re Contact rate CTA	3.2%	2	↓	3%	2
Re Contact rate See & Treat	5.6%	8	↓	5.2%	5
Re Contact rate Frequent callers	2.6%	5	↓	2.6%	5
999 Calls Abandoned	0.1%	1	↔	0.1%	1
Service Experience	No measure				

Conclusions

This dashboard has seen a further drop in compliance and the dashboard is revealing the tension between capacity, safety and quality. However, the evidence suggests that safety is being maintained during this challenging time.

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London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH JANUARY 2013

PAPER FOR DISCUSSION

Document Title:	**Clinical Quality and Patient Safety Report**
Report Author(s):	**Dr Fionna Moore / Steve Lennox**
Lead Director:	**Dr Fionna Moore / Steve Lennox**
Contact Details:	**fionna.moore@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**For Information**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☒ Other : Elements of this report have been presented at EMT, Quality Committee and CQSEC
Recommendation for the Trust Board:	**For Information**

Key issues and risks arising from this paper

- An increased use of DMP during November and December, including an increased use of DMP stage D. Also of note, the longest continuous use of DMP this year.
- The services highest ever CPI compliance rate has been noted. However, the mental health CPI continues to have the services lowest compliance.
- The number of entries on the Locality Alert Register has reduced. However, alerts from the Metropolitan Police Service continue to increase.
- There have been no reportable controlled drugs incidents.
- There have been no new Rule 43 Reports received by the Trust.
- Increasing number of complaints received by PED, surround delays and driving standards amongst others.
- The Clinical Audit and Research Unit Quarterly activity report has been released. There was a clinical audit of immediate inter-hospital transfers by the London Ambulance Service

Executive Summary

This report is structured around the quality domains of the quality dashboard. However, it also reports on issues wider than this.
The Trust can take limited assurance that a high quality and safe clinical service is provided to its patients. There is real concern over the high utilisation rate and increasing call numbers seen by the Trust. There is also concern that should this continue, there will be delays in introducing the new national Clinical Guidelines and other training and implementation planned over the following months.

Attachments

Appendix 1: The clinical audit of immediate inter-hospital transfers by the London Ambulance Service.

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

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

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

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

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

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

Equality Impact Assessment

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

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST

Clinical Quality & Patient Safety Report – January 2013

Clinical Directors' Joint Report

1. Summary

This report is structured using the Quality Domains of the Quality Dashboard. However, it also reports on issues wider than those measures.

This report identifies both successes and areas for improvement. The Trust Board can take limited assurances that the service is maintaining a high quality service to its patients. There is real concern over the high utilisation rate and increasing call numbers seen by the Trust in recent months. There is also concern that if this continues, there will be delays in introducing the new National Clinical Guidelines and other training and implementation planned over the following months.

2. Quality Domains

Quality Domain 3: Clinical Intervention

Removal of exceptions for missing or faulty equipment

Following the removal of the exception for missing or faulty equipment, reported on in the last Clinical Quality and Patient Safety Report, a significant increase in the completion of LA52's was noted. Since the change, there have been 599 LA52's submitted for this reason. It was hoped that the numbers would decrease, but unfortunately this has not been the case and numbers remain As a result, a medical directorate bulletin was released on 14th January 2013; requesting that staff record missing equipment on an LA154, but complete an LA52 in the event that the missing equipment has a clinical impact. It is hoped that by the next Clinical Quality and Patient Safety Report the number of LA52's completed for this reason will have reduced.

Clinical Performance Indicators (CPIs)

In November 2012, the highest ever CPI audit completion rate was achieved by the Trust (98%) and above the 95% target. This was achieved in a month which saw increasing demand and escalation of DMP. The Mental Health CPI continues to have the lowest overall compliance; there has been an improvement in the use of the capacity tool, however compliance with regard to considering a safeguarding referral has reduced.

Full CPI reports can be accessed at: X:\Clinical Audit & Research Unit\Clinical Performance Indicators (CPIs)\Monthly Team Leader CPI reports\2012-13\Monthly Reports 2012-13

Table 1. CPI Completion March to November 2012

Area	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.
East	95%	82%	82%	79%	72%	88%	96%	97%
South	67%	46%	42%	62%	87%	99%	98%	98%
West	100%	93%	88%	92%	98%	98%	97%	99%
LAS	**86%**	**72%**	**70%**	**77%**	**87%**	**96%**	**97%**	**98%**

Table 2. CPI Compliance November 2012

	Cardiac Arrest	Glycaemic Emergencies	ACS (Including MI)	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	97%	97%	96%	97%	89%	97%	97%
South	97%	98%	97%	98%	91%	97%	98%
West	98%	98%	97%	98%	89%	97%	98%
LAS Total	**97%**	**98%**	**97%**	**98%**	**89%**	**97%**	**98%**

Table 3. CPI Compliance October 2012

	Cardiac Arrest	Difficulty in Breathing	ACS (Including MI)	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	97%	94%	96%	96%	88%	97%	98%
South	98%	96%	97%	98%	91%	97%	98%
West	98%	95%	97%	98%	91%	97%	98%
LAS Total	**98%**	**95%**	**96%**	**97%**	**90%**	**96%**	**98%**

Table 4. CPI Compliance September 2012

	Cardiac Arrest	Glycaemic Emergencies	ACS (Including MI)	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	98%	98%	96%	97%	90%	96%	97%
South	97%	98%	96%	98%	87%	95%	98%
West	98%	98%	97%	98%	89%	97%	98%
LAS Total	**97%**	**97%**	**96%**	**98%**	**88%**	**96%**	**98%**

Cardiac Care

Para SVT: This initiative continues to be on target. To date, 64 patients have been successfully recruited to the trial and no adverse incidents have been reported.

High Risk ACS: The high risk ACS guidelines have been well received in the East Area, the first to go live with this pathway. To date we have taken approximately 2-4 patients per week to a high risk ACS centre from this area. The West Area will come on board with the

pathways next, and is planned for February. There is no date set at present for the go live of the South Area.

Emergency Arrhythmias: A great deal of work has been completed on this project. The trial is estimated to commence in February. The trial area will be in the north of London, but the specifics have yet to be decided.

Team Leader Updates

Two team leader update days are planned during February. Plans for these days are in progress, but the cardiac topics above will be discussed on these days so that all team leaders are aware of the updates and changes to the care we provide these groups of patients. Also planned for inclusion will be an update on the amended major trauma triage tool, the paediatric trauma triage tool, and the new JRCALC guidelines due for release in April.

Quality Domain 4: Safety

Safeguarding

Clarification has been sought from Commissioners on the expectations of Sir David Nicholson's letter received in November on celebrities and safeguarding. The letter was intended to prompt organisations to consider "untouchables" who work in a voluntary capacity within NHS Trusts, for example as charity patrons. The Trust's two safeguarding leads have undertaken a gap analysis regarding volunteers and will undertake a similar exercise regarding celebrities. The Trust's Commissioners have reported back to the Commissioning Board the action that we (and all other providers) have taken.

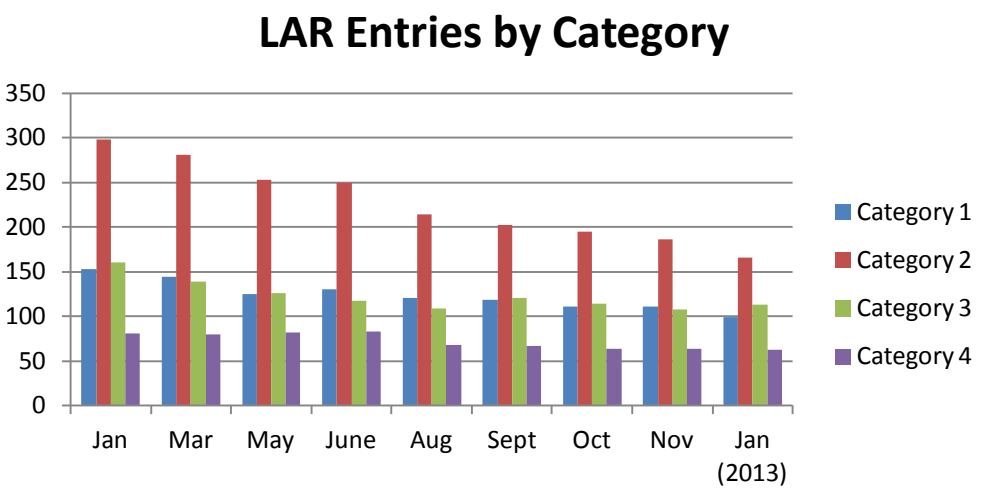
NHS Central Alerting System (CAS)

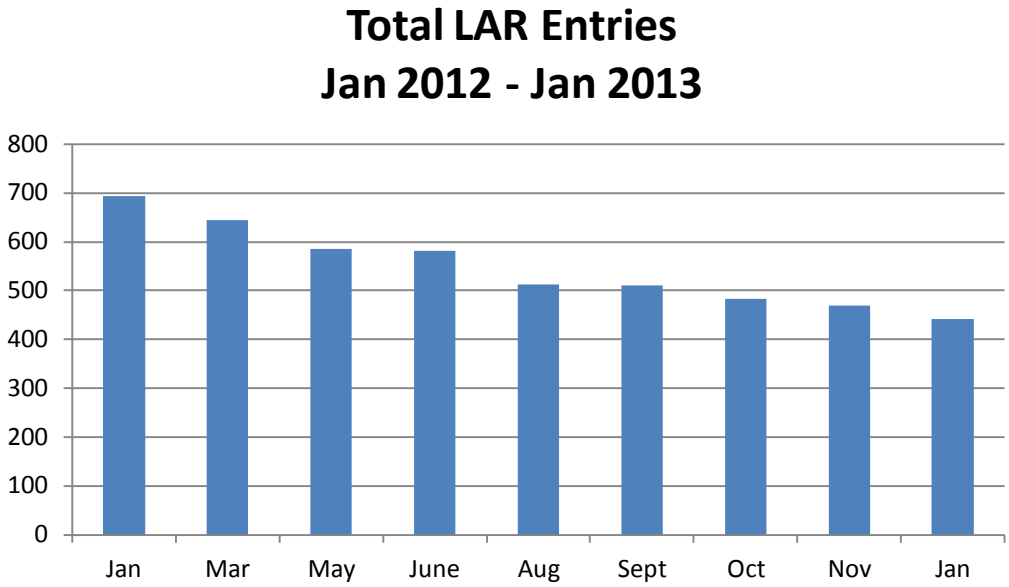
There have been 11 Central Alerting System reports released for the period 15th November 2012 to 15th January 2013. One alert (MDA/2013/002) relates to medical oxygen cylinders filled to a higher pressure (200 bar) than the normal pressure (137 bar). These cylinders are in use in one hospital Trust on a trial basis but there is a risk they will be moved out of that trust in error during patient transport journeys or discharge. This could lead to damage to devices attached to the higher pressure cylinders. Any associated risk to the LAS is being assessed. All other alerts have been acknowledged by the trust, but none apply to it.

Locality Alert Register (formally High Risk Register)

There are currently **441** addresses on the register, broken down as follows:

CATEGORY 1: **99**
CAT EGORY 2: **166**
CATEGORY 3: **113**
CATEGORY 4: **63**





The Trust has notification of 919 high risk addresses from the Metropolitan Police. The only addresses which are queried on receipt are healthcare providers or hospitals. The wording of the actual flag has also been amended and now advises the crew to make a dynamic risk assessment on arrival, but does not provide any specific information.

Demand Management Plan

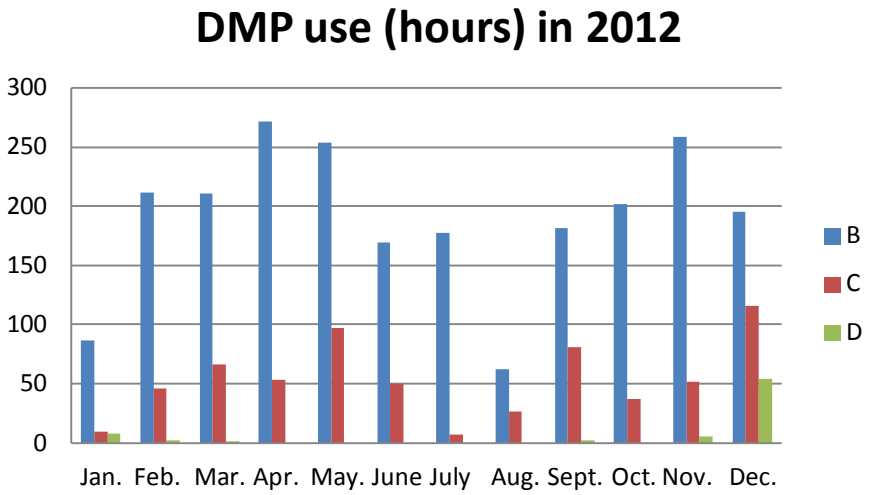
The purpose of DMP is to provide the Trust with structured risk mitigating options to respond to demand at times when it exceeds the capacity of the service to provide a timely response. It provides a framework in which Control Services are able to respond to periods of high pressure, due to unforeseen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

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

clinical and operational review as the plan is escalated. There is a significant level of clinical risk related to the stage of the DMP invoked.

Month	Number of Occasions	Stage B (in hours)	Stage C (in hours)	Stage D (in hours)	Stage >D (in hours)	Ambulances reprioritised	No-send at point of contact
November	30	258.75	52	5.75	0	629	579
December	24	195.25	116	54.25	0	3463	2470

November and in particular December saw a marked increase in the use of DMP. DMP level D was in use fourteen times during December, and on two occasions was in place continuously for more than 8 hours. Also of note during December, the longest continuous period of DMP being in place for the past 12 months was noted, lasting 40 hours, 15 minutes.



Christmas and New Year Working

Over the Christmas and New Year period, it was recognised by the Trust that there was likely to be a rise in the number of calls received, at a time when resourcing was challenged. The Trust wrote a strategy plan to prepare for the anticipated rise in calls, with the aim to continue providing a safe and resilient service for our patients, responding to the high priority calls in a timely manner. For the period outlined in the documents, calls with a lower priority after an MPDS triage were advised on alternative pathways for help. All the calls which were triaged to self refer to their GP or NHS Direct were clinically reviewed before closing off the LAS system. Any call where there was a clinical concern received a call back from an LAS clinician. LAS clinicians also called back other lower priority calls to promote the use of for example, walk in centres and minor injury units.

Serious Incidents

Since the last report to the Trust Board, thirty incidents were referred to the Serious Incident Group, three of which were declared with NHS London.

1. Delayed response to a call via the MPS CADLink. Concerns were raised by the Control Services Operations Centre Manager (OCM - Acting AOM on duty) that updated information on a patient's condition was either not seen or not acted upon, which resulted in a response time of 72 minutes to a patient who had fallen in the street. The patient went into cardiac arrest before the Ambulance arrived, with the Metropolitan Police Service performing CPR until the ambulance arrived. STEIS 2012-28602

2. Complaint regarding an ambulance failing to arrive. A patient went into labour and her husband called for an ambulance. Despite a number of follow up calls an ambulance failed to arrive, so the patient's partner took her to hospital. On arrival, the patient was found to have suffered a suspected 'placental abruption'. STEIS 2012-31319

3. Delayed response to cardiac arrest at a Mental Health hospital. On the initial 999 call, the patient was complaining of Chest Pain and difficulty breathing. At the time of the call, the Emergency Control Room was operating on Demand Management Stage D and no ambulance was available to send. The patient subsequently went into cardiac arrest. On the crews arrival, which was well over an hour after Origin Time, there was a further delay getting into the hospital and to the patient due to a door security locking system. The crew eventually gained access by a member of staff. However the resuscitation attempt was unsuccessful. STEIS 2012 31326

The above incidents are all under investigation at the time of writing.

Medicines Management

There have been no reportable controlled drugs incidents since the last report. Extensive enquiries into how a vial of morphine appeared in a Technician Drug pack have failed to discover where it came from. The incident, and all subsequent actions, has been reported to the INWL LIN Group. (Quarter 3 report submitted on 1st January 2013.)

There have been no unannounced visits by the Metropolitan Police. The MMG Chair is arranging a meeting to take place within the next few weeks to discuss the Metropolitan Police CDLO interface for the forthcoming year.

There are two areas of note requiring attention:

1. Logistics

Problems with the new invoicing and payment system (ELFS) has twice, in the last few months, meant that Frimley Park Hospital Pharmacy have had to chase payments from the LAS. In a second incident, drug stocks were withheld from the LAS for a number of days, until payment was processed. (At one point the LAS owed *circa* £150 in unpaid drugs bills). The problem was dealt swiftly by the Finance Directorate, but the ELFS system, in respect of drugs, would appear to need further work. Logistics and Finance are working to improve this.

2. Controlled Drugs (CD) Safe System

This system is now several years old. During the 2013/14 financial year, proposals will be put forward to modernise/ update the whole CD storage system. This will be concurrent with a review of the drug bag system, as there are significant interdependencies. The Chair of MMG will be setting up meetings with the Head of Logistics, The Metropolitan Police CDLO Team and others to scope out the project.

Rule 43 Reports

The Trust has not received any new Rule 43 reports. There have been no rule 43 reports for any other NHS Trusts which could impact on the London Ambulance Service.

Quality Domain 5: Clinical Outcomes

Nothing of note to report

Quality Domain 6: Dignity

Nothing of note to report

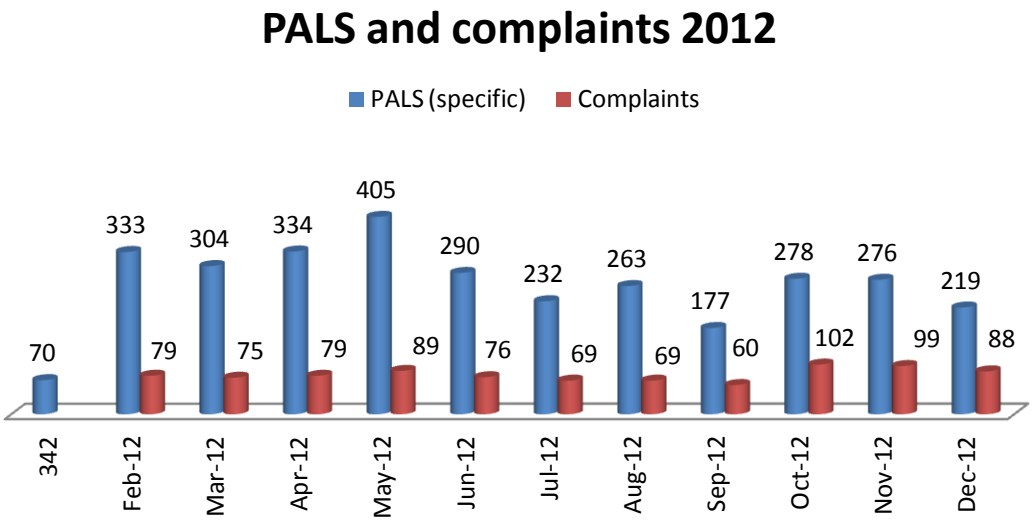
Quality Domain 7: Satisfaction

The Patient Experience Department continues to face challenges of increased demand and fewer staff resources, particularly affecting the PCAT team where a skeleton service is now operating. This is due to a combination of reduced resourcing via CIP, maternity leave, study placement and sickness and special leave absence.

Introduction

The recent increase in complaints continues with an 11% increase over annual average [88 against 78 per month). However, the month of December shows a small decrease in both complaints and PALS enquires.

The following graph illustrates the month on month volume of complaints and PALS enquiries.



Complaints – Emerging Themes

As reported within the previous Board report the main driver for the rise in volume was an increase in the number of complaints that report "delay" as the main complaint. This

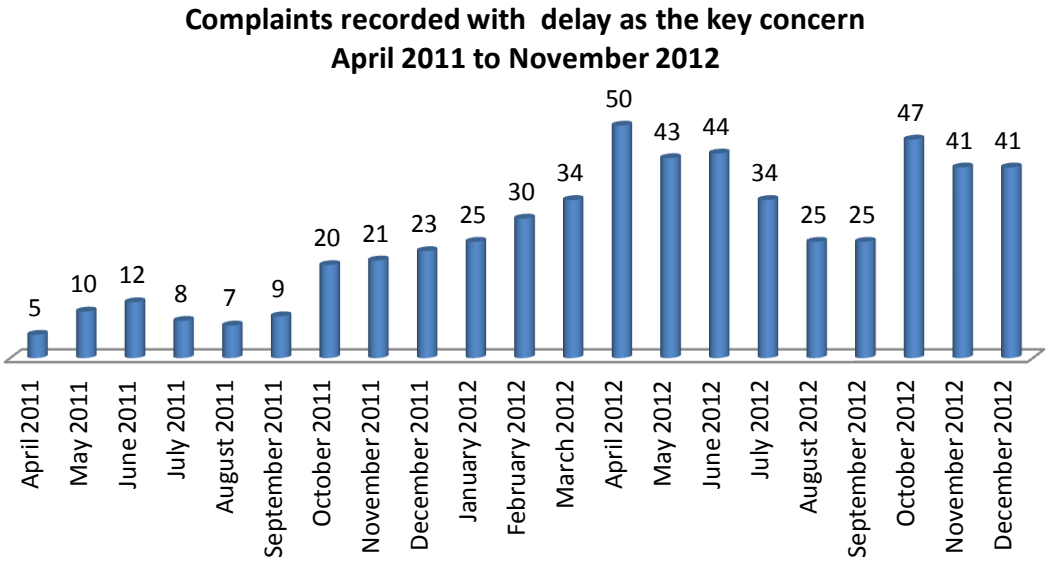
remains the most common theme in December with Attitude & Behaviour remaining the second most common theme and road handling remaining third.

The following table illustrates the most common themes and the volume of complaints associated with those themes.

Complaints by Subject (primary)	Totals
Delay	41
Attitude and behaviour	24
Road handling	8
Non-conveyance	6
Treatment	4
Patient Injury or Damage to Property	2
Conveyance	1
High Risk Address Referral	1
Not our service	1
Totals:	**88**

Delay

The number of complaints that the Trust receives has shown a steady increase during 2012 although the final two months of the year showed a very slight decrease. However, delay represents 46.5% of the total complaint volume.



Similar to previous months, where a 999 call is triaged at C2 and DMPB is in place, there is an increased likelihood of a complaint. During December 7 complaints matched this criteria. At DMPC, this witnessed 9% of delay complaints in November and 27% in December.

The following tables illustrate the relationship between DMP and complaints.

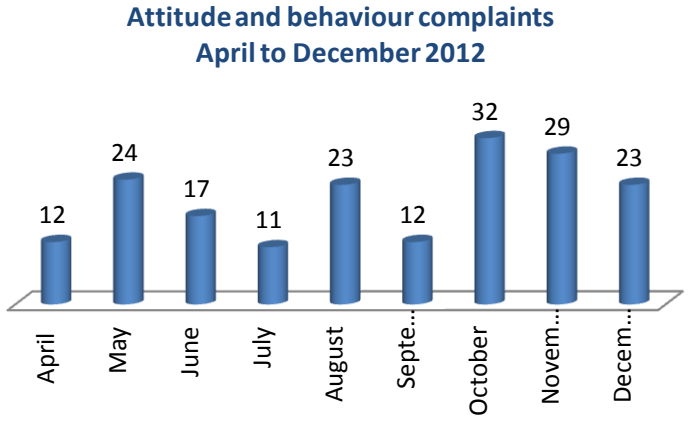
DMP in place	Number of delay complaints
DMPA	10
DMPB	18
DMPC	11
DMPD	2
Total	**41**

Category of call	Number of delay complaints
Red 2	1
C1	2
C2	20
C3	9
C4	9
Total	**41**

Attitude & Behaviour

Attitude & behaviour remains the second most common theme emerging from complaints although the final two months of 2012 have seen a decline in the number of complaints with this as a theme.

The following graph illustrates the number by month.



Road handling

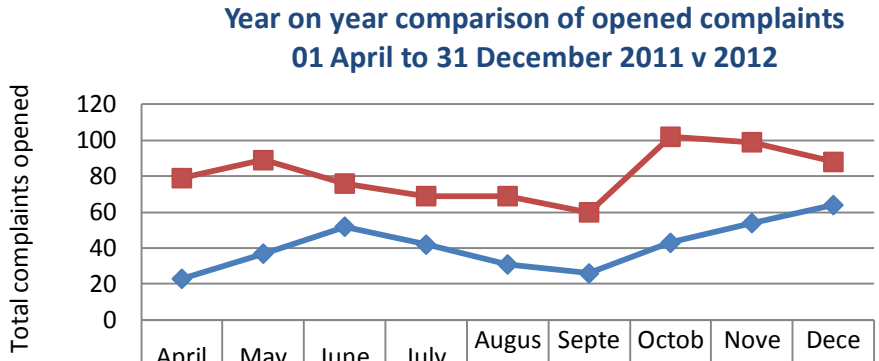
The third most frequent theme is “road handling”. This has been a fairly frequent theme for some time and is not an emerging concern. Plans are in place to manage this issue differently as the nature of the complaint differently and to ask the local areas to lead on any concerns.

This particular theme is difficult for the Trust to address on a corporate level and whilst there could be learning for the individual drivers it is often difficult to identify the individuals unless precise location and time details are given. Therefore, the EMT have agreed that the patient

experience team are removing this cause from the central corporate work stream and the management of such cases will pass to local operational management.

Complaints Management

The Trust is currently receiving up to 5 complaints per working day; there was an 11% increase in complaints (month on month) during December, this trend seems likely to continue with high operational demand expected into 2013.



	April	May	June	July	August	September	October	November	December
01 April 2011 to 30 November 2011	23	37	52	42	31	26	43	54	64
01 April 2012 to 30 November 2012	79	89	76	69	69	60	102	99	88

The following table illustrates the number of complaints successfully closed against their allocated closure time in the last 3 months of 2012. 54% of the complaints have been completed on time (although some of the outstanding complaints that arrived in December and still within their time frame are included in the denominator value)

Response time allocated October 2012 to December 2012	No. of complaints	Closed within time frame
Complaint 25 days	10	10
Complaint 35 days	272	144
Complaint 40 days	6	2
Complaint 45 Days (SI)	1	0
Totals	289	156

In November 2012, 26% more complaints were closed than in the previous year (97 v 72). This improvement has not been able to be maintained in December as a result of the staff shortages. 154 cases currently await conclusion including a small number of cases re-opened following a further approach from the complainant after the substantive response. This total also includes 24 cases that have exceeded the 35 day target.

PALS

PALS data is more spurious than complaints, the 2011 data shows a slight downward trend and 2012 illustrates two periods of reduced activity. The dip in May/June 2012 may relate to the extended Bank Holiday period during the Jubilee celebrations and the August/September 2012 dip as a result of the Olympics. The decline in incoming enquiries during the Christmas period is a seasonal trend.

There has been marginal increases in safeguarding issues although this continues to rise. The department has seen a significant increase in the numbers of general enquiries recently with the closure of the HQ switchboard.

There has also been a significant increase in the approaches from Solicitors for medical records (25% year on year) with no signs of this abating.

The following table illustrates the themes arising from PALS enquiries within the month of December.

Total PALS analysis

Total PALS by subject	December 2012
Information/Enquiries	148
Medical Records	100
Lost Property	43
Safeguarding Children	28
Safeguarding Adults	27
Request for Witness Statement	8
Appreciation	5
Frequent Callers	5
Incident Report - Other	4
Incident Report - A&E	3
Clinical	2
Conveyance	2
Delay	2
External Incident Report - EOC	2
Access	1
Incident Report - GP Surgery	1
Policy/ Procedure	1
Road Traffic Collision/RTC	1
Social Services	1
Totals:	**384**

The most common issue beyond a simple enquiry remains lost property.

The Trust revised the method of managing lost property enquiries in November, early evidence has indicated that despite a period of uncertainty, local staff are adhering to the new guidelines. There has also been increased interest in the SMARTbag™ scheme, and the benefits of using the property bags, resulting in an article being added to the RIB. ADOs have supported the new arrangements.

There were 43 lost property enquiries recorded in PALS for December, of those 34 were referred to local stations in line with the new process. Of those, 19 have recorded outcomes. An audit of the first three months of the trial will be undertaken to evaluate which areas are complying and whether there has been an impact on the use of the SMARTbag™

Incident reports

The patient experience team manage external agency reports and LA52 reports about external agencies. There were 10 of these during December including the following:

1. Report by the local CIO about a midwifery staff at an ante natal clinic who were evidently encouraging maternity patients to call 999 when in labour. (P48334). Liaison was arranged involving the Trust's Consultant Midwife, resulting in agreed process with the Practice Manager.

2. NHS Direct requested an evaluation of a call referred to them by EOC which was provided by the Quality Assurance Team (P47815).

3. A crew raised concerns at the gravity of a young child they attended at a GP surgery. (P47448). The Medical Directorate contacted the surgery and after a practice clinical meeting, a decision was made by the GP to purchase an oxygen saturation monitor to enhance future clinical assessments of patients awaiting an ambulance.

Action being taken

The quarterly integrated report outlines the actions being taken as a result of patient feedback but the Quality Committee have approved the proposal to relaunch the Learning from Experience Committee to focus on improving the experience for four specific areas;

- Delay
- Attitude & Behaviour
- Misisng Equipment
- Alternative Care Pathways

The committee will try and support a solution for these issues but will primarily focus on improving the experience of patients who are experiencing one of these issues. For example trying to improve the informationa nd explanation offered to patients who experience a delay at the time.
The Director of Operations has supported the proposal that the Assistant Director of Operations should take a lead role on these improvement initiatives. Therefore, the membership and structure of the committee will also be relaunched to reflect this.

3. Quality Priorities

Mental Health

Lord Adebowale met with the Director of Health promotion & Quality as part of the Met Police 136 Review. The report is due for publication in March but early indicators suggest the report will make comment and potential recommendations regarding the delay that 136 patients experience from the Trust. The Clinical Advisor for Mental Health will look at this in more detail in order to ensure we are prepared for publication and have identified opportunities for improvement.

4. Clinical Audit & Research (CARU)

The Clinical Audit and Research Unit (CARU) produce quarterly activity updates summarising the progress of projects being undertaken within or facilitated by the unit. The Clinical Audit Activity update summarises the key changes in core clinical audits, continual audit activity, clinical performance indicators (CPIs) and national clinical audits. The Research Activity Update outlines new research projects and changes to active research and non-research projects, as well as any publications.

The full report for October to December 2012 can be accessed at: X:\Clinical Audit & Research Unit\Clinical Audit & Research Steering Group (CARSG) Documents\Clinical Audit & Research Updates\2012.

A clinical audit report examining immediate inter-hospital transfers has been published. A summary of the audit report is included as Appendix 1.

5. Rising Tide

Public Health

The Trust was a little later than last year in commencing the flu programme due to the delay caused by the Games. However, uptake has improved and now 34% of the clinical workforce has taken up the vaccine. Bromley (55%), Fulham (63%), Camden (74%) and Hillingdon (50%) are all showing good compliance with Barnehurst (4%) and Oval (12%) being particularly poor. This has been raised with the management team for the South and for discussion at the business meeting.

The Norovirus activity shows a continuing downward trend within London but the numbers are still relatively high. This is causing capacity problems in a number of our Acute Trusts and this has a knock on effect within their Accident & Emergency departments.

Fionna Moore
Medical Director

Steve Lennox
Director of Quality & Health Promotion

18th January 2013

Clinical audit of immediate inter-hospital transfers by the London Ambulance Service
November 2012

Executive Summary

Background

In addition to responding to 999 calls from members of the public in an emergency situation, the London Ambulance Service NHS Trust (LAS) also transfers patients between hospitals and other healthcare locations. This clinical audit concentrates on immediate inter-hospital transfers (when a patient is being transferred for life or limb saving treatment). Calls triaged as an immediate inter-hospital transfer require an ambulance response within one hour of the call and, depending on the clinical condition of the patient, may require an ambulance crew of a particular skill level.
There is a potential clinical risk when ambulance crews are dispatched to an immediate inter-hospital transfer without the appropriate skills to manage the patients' clinical condition. Therefore this clinical audit was undertaken to assess the potential clinical risk and other anecdotal concerns resulting from discussions between Emergency Medical Dispatchers (EMDs) and hospital staff as to: what constitutes an immediate inter-hospital transfer; whether a Health Care Professional (HCP) escort from the hospital should accompany the patient, and which transfers should be undertaken by the LAS and which should be undertaken by the hospitals' contracted Patient Transfer Service (PTS).

Methodology

This clinical audit was undertaken using a retrospective sample of immediate inter-hospital transfer calls from January 2012. A sample of 192 calls was selected using cluster sampling, 158 of which were clinically reviewed due to the variation and complexity of the calls.

Results

There was a wide variation in the frequency of questions asked by EMDs during the calls. Despite this variation, 90% of calls were still correctly categorised as an immediate inter-hospital transfer. The length of the calls ranged from 2 minutes 19 seconds to 24 minutes 22 seconds, with longer calls often resulting from a further discussion with the Clinical Support Desk (CSD). CSD provided advice for 61% of calls in the sample, however there was no documentation on the CSD log of the advice provided during 28% of these calls.
The LAS dispatched an ambulance crew with the appropriate skill level based on the patients' reported condition for 91% of calls and the ambulance arrived within one hour of the call in 82% of the immediate inter-hospital transfers, thereby meeting the time target for this patient group.
52% of patients had two full sets of observations documented. An additional 24% of patients had one full set of observations documented. For the remaining 24% of patients at least one full set of observations was not documented. If an HCP escort accepts primacy of care, their name, position and confirmation of accepting primacy should be recorded on the patient report form. This was only documented for one patient.

Recommendations

The LAS should ensure that:

- All required information is sourced during the initial call to enable correct call categorisation and resource allocation by working with other UK ambulance services

to review suitability of protocol 35 for usage in assessing inter-hospital transfers and communicating to EMDs the importance of following protocols.

- The Clinical Support Desk record all advice given and escalate calls appropriately to an on-call advisor when necessary.
- Hospital staff are aware of the LAS criteria for inter-hospital transfers and their responsibility to escort the patient by reviewing and reissuing the inter-hospitals transfers flowchart.
- EOC call-takers, call-taking managers, Operation Centre Managers and CSD staff are updated of ongoing changes by ensuring training documents are reviewed, updated and issued to reflect relevant changes in the transfer process.
- Ambulance crews are aware of the importance of undertaking and documenting two sets of full observations for hospital transfer patients. An article for the Clinical Update should be written and a poster issued to ambulance stations to raise awareness.
- Recommendations evidencing improvements in patient care by conducting a re-audit

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London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH JANUARY 2013

PAPER FOR DISCUSSION

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

Key issues and risks arising from this paper

Two red flags were raised at the meeting relating to the gradual deterioration in workforce and performance indicators, as a result of the operational pressures of matching capacity to demand.

Executive Summary

The last meeting of the Quality Committee took place on 13th December 2012 and the attached report provides a summary of the meeting. It is also intended to provide assurance to Board members on the quality and safety of services.

Two red flags were raised at the meeting relating to the gradual deterioration in workforce and performance indicators, as a result of the operational pressures of matching capacity to demand. These were reflected in the Quality Report and the report on the Cost Improvement Plan, as well as other reports to the Quality Committee.

Attachments

Report from the Quality Committee held on 13th December 2013

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Quality Strategy

This paper supports the following domains of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Analysis

Has an Equality Analysis been carried out?

☐ Yes
☒ No

Key issues from the assessment:

Report from the QC following the meeting held on 13th December 2012

Overview

The two red flags raised at the meeting concerned the gradual deterioration in workforce and performance indicators, as a result of the operational pressures of matching capacity to demand. These were highlighted in the Quality Report and the report on CIP projects, but were themes in the majority of other reports to the Committee. Delays, cancelled training with the implementation of REAP 4 and use of DMP all contribute. The safety of patients has to take precedence.

Risks to the LAS

- Targets for staff CPI feedback, PDRs and OWR will all be missed to varying degrees(CO5 & CO6)
- Increased use of 3rd party front line provision(could affect all strategic goals)
- The safety and care of Cat C patients (CO2, CO3 & CO4)
- Service experience (Strategic goal 1 & CO9)
- Long hospital handover times, especially in SE London (Strategic goal 1 & CO7)
- Non achievement of Q4 performance targets (CO3 & CO4)
- Lost patient property (Strategic goal 1)
- Poor levels of quality assurance in EOC (could affect all strategic goals)
- CQC reported a moderate compliance breach for equipment availability , also highlighted by crew reports on LA52s, and a minor breach for staffing (CO4)
- Fire risk assessments by Internal Audit have identified significant weaknesses (could affect all strategic goals)
- Home to base mileage payments for lease car holders-not paid as business mileage-CIP B2-4 (CO7)
- Obstetric emergencies and the care bariatric patients are commonly associated with clinical incidents, SIs & complaints (CO1 & 2)
- High levels of DMP and delay or non-dispatch of a mobile resource(CO1, CO2, CO3, CO4)

The Quality Committee received assurance from :

- Although the Quality Dashboard gives a red RAG rating to lost prfs; work done in South Area, using dip sampling, had shown that often a CAD number was issued before a patient was seen and the resource was cancelled. Clinicians who review complaints say that they have never had any problem in locating a prf. This item was therefore removed from the Quality Dashboard.
- New prf boxes are now ordered and some have been installed
- The number of addresses on the Locality Alert Register has again fallen

- Internal Audit report appropriate for the QC
- Finishing the Student Paramedic training remains a priority for the Trust (it was postponed last year). 319 will have qualified between April 2012 & April 2013
- 110 EMTs have successfully completed the APL Paramedic course in the last year
- The subgroups reporting to CQSEC are making good progress in reporting against the CQC criteria
- The Learning from Experience Report will now focus on 4 themes for improvement
    a. Delay
    b. Attitude & Behaviour
    c. Missing Equipment
    d. Alternative Care Pathways

  The TORs & membership of the group have been revised

- An Individual Learning Account (ILA) for staff is to be introduced in April. Staff will attend training on non-duty days
- The Clinical Team Leader trial has commenced in New Malden with a support car available to crews
- Risk Profile triangulates with the Quality Dashboard

Beryl Magrath Chairman QC

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH JANUARY 2013

PAPER FOR DISCUSSION

Document Title:	**Integrated Performance Report**
Report Author(s):	**Christine Kane**
Lead Director:	**Paul Woodrow**
Contact Details:	
Why is this coming to the Trust Board?	**To provide the Trust Board with an integrated view on the key aspects of the Trust's performance; Caring for patients, Service Delivery, Caring for staff and Value for money.**
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 continued high levels of activity and the associated impact on performance.** **2. Note the action plan in place to secure the delivery of the Cat A target.** **3. Note the financial position, and the reduction in forecast surplus.** 4. **Note the importance of securing an appropriate settlement for 2013/14.**

Key issues and risks arising from this paper

In 2012/13 the Trust continues to see activity levels in excess of volumes included within the contract, with average daily calls up 21.4% and Category A incidents up 13.7%. This has been partially offset by a reduction in Category C incidents, down 11%. It must be noted that this reduction was achieved through increased enactment of the Trust Demand Management Plan (DMP) The Trust remains at REAP 4.

The high levels of activity continue to drive high operational utilisation rates and this is creating pressure on waiting times particularly for lower acuity patients. The Trust has seen increases in both complaints and serious incidents across December, up 10% on the rolling yearly average. The need to maximise clinical staff towards patient facing duties remains high with an associated impact on training and development being undertaken. Sickness is also increasing.

Additional funding, £6.2m has been secured to support winter pressures and the delivery of the Category A target across the year. This has enabled the Trust to commission additional overtime and contractor capacity to help address the demand pressures. Activity has marginally reduced but remains above contracted levels on all metrics. Service delivery levels are now on track to deliver

the required year end position. This is contingent on maintaining performance above 80% for the remainder of the year.

Despite the additional funding the financial position remains under significant pressure; the forecast outturn is currently £0.3m, £2.8m lower than plan. The continued high demand and failure to secure the full value of CQUINs being the major contributory factors. A range of control measures have been introduced to ensure the Trust achieves the current forecast outturn, these are detailed in the Month 09 Finance Report.

Planning for 2013/14 has started. This is initially focused on the recommendations contained within the ORH report. Securing an appropriate agreement in respect of this report will be key to informing the basis of the activity, performance and financial settlement for 2013/14.

Executive Summary

Attachments

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Quality Strategy

This paper supports the following domains of the quality strategy

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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:

Integrated Trust Performance Report December 2012

Attachment 1

Caring for Patients during their Journey

How do we care for our patients?

* First Contact (Call Answering)	95.1%
* Treatment (CPI)	98.7%
* Clinical Outcomes	97%
* Patient Safety Index	158
* Patient Wellbeing	Amber
* Service Experience	Amber

Service Delivery

Evidencing Delivery of the Response model

Performance Indicators	*Actual*	*YTD/2011*
* Cat A Target (75%)	67.2%	73.9%
* Cat C1 Target (90%)	69.0%	78.0%
* Cat C2 Target (90%)	60.2%	73.1%
* Ambulance Utilisation*	89.2%	87.4%
* FRU Utilisation*	55.0%	47%
* Complaints/Serious Incidents	88	80

*Utilisation % compared to 2011-12

Daily Performance & Activity — REAP 4

	Nov	Dec	MoM	Y2Y
Av. Daily Call Volume	4656	5214	12%	21.4%
Peak Daily Call Vol.	5151	6164	16%	28.4%
Cat A Incidents	36701	42173	15%	13.7%
Cat C1 & 2 Incidents	28725	27815	-3%	7%
Cat C3 & 4 Incidents	25269	22906	-9%	-18%
Total Incidents	*90695*	*92894*	*2%*	*1.8%*
DMP Stage A	55%	26.4%	-28%	-35%
DMP Stage B	38%	28.5%	-9%	-5%
DMP Stage C/D	7%	38.0%	31%	34%
Percentage > REAP 3	100%	100%	0%	10%

Care for Staff - Workforce Report

How will we sustain change and improve?

Performance Indicators		*T/C*
* Staff Sickness Levels	5.53%	---
* Staff Core Skills Training	0%	3.1
* Staff Development (PDR)	35%	2.5
* Staff Retention	8.9%	2.8
* Staff Safety & Wellbeing	102	3.2
* Staff Satisfaction	3.4	

Value for Money - November 2012

Evidencing stewardship of the public purse (YTD)

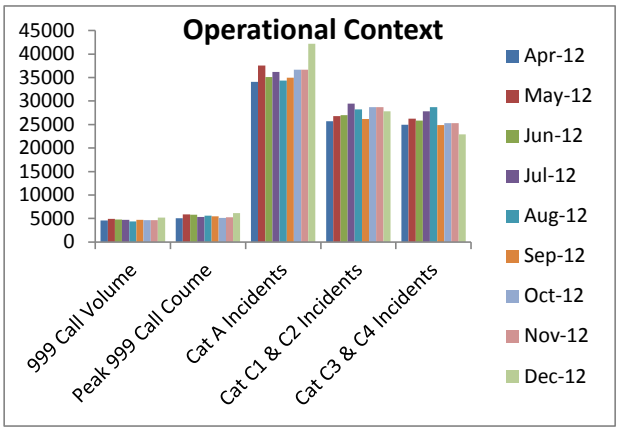
* Financial EBITDA	9,407
* Net Surplus	(2,014)
* Cost Improvement Programme	7,485
* CQUINs	867
* Monitor Net Rating (FRR)	2
* Carbon Reduction Plan	Green

1. Operational Context

Attachment 2

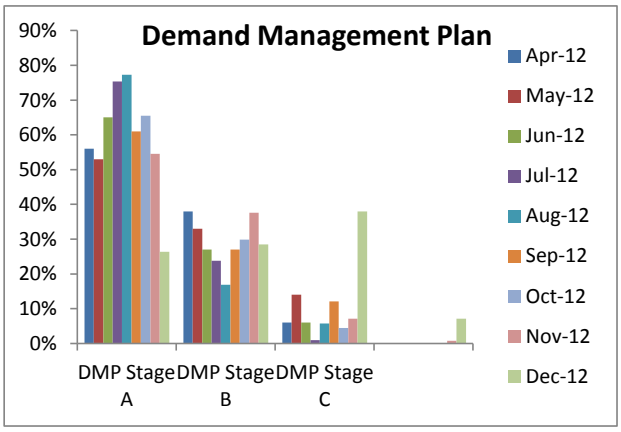
Daily Performance & Activity	Nov	Dec	MoM	REAP 4 Y2Y
Av. Daily Vol.	4656	5214	12%	21.4%
Peak Daily Vol.	5151	6164	16%	28.4%
Cat A Calls	36701	42173	15%	13.7%
Cat C1 & 2 Calls	28725	27815	-3%	6.6%
Cat C3 & 4 Calls	25269	22906	-9%	-18.3%
Total Incidents	*90695*	*92894*	*2%*	*1.8%*
DMP Stage A	55%	26%	-28%	-35%
DMP Stage B	38%	29%	-9%	-5%
DMP Stage C	7%	38%	31%	34%
Percentage >	100%	100%	0%	10%

November 2012 Report	Oct	Nov	MoM	REAP 3 Y2Y
Av. Daily Vol.	4656	4656	0%	8.4%
Peak Daily Vol.	5151	5298	3%	10%
Cat A Calls	36701	35936	-2%	13%
Cat C1 & 2 Calls	28725	27791	-3%	12%
Cat C3 & 4 Calls	25269	24837	-2%	-11%
Total Incidents	*90695*	*88564*	*-2%*	*4.6%*
DMP Stage A	66%	54.5%	-11%	-29%
DMP Stage B	30%	37.6%	8%	25%
DMP Stage C	5%	7.1%	3%	3%
Percentage > REAP	100%	100%	0%	10%



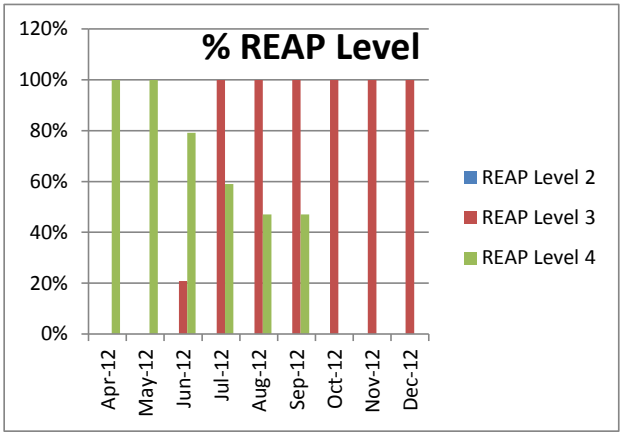
Total incidents continue to increase with the month of December seeing an overall growth of 3.0% in comparison to December 2011. The Trust overall category A demand remains challenging with an overall growth rate of 14.4% over the same financial period last year. This equates to an additional 42,049 more category A incidents, with total incidents at 3.6% up on the same period last year, which equates to an additional 28,735 more incidents year to date.

999 call volume continue to increase this year with the month of December seeing an additional 16,655 calls enter the system, this equates to a growth of 11.5% in-comparison to last December. Year to date total call volume has seen an overall growth of 9.1% above the same period last year, this equates to an additional 111,777 calls being handled within EOC.



As demand and call volumes continue to increase the additional pressures compel the Trust to implement the Trust's Demand Management Plan (DMP).

The month of December saw normal operations (DMP Stage A) in operation 26.4% (from 55% in November), escalation to DMP Stage B for 28.5% (from 38% in November) and escalation to DMP Stages C&D for 38% (from 7% in November).



REAP levels had remained at level 3 throughout the financial year, but were raised to level 4 on 10th December as the Trust experienced its busiest week in the history of the LAS for calls categorised as immediately life threatening with over 9000 such calls, up 500 from the previous week.

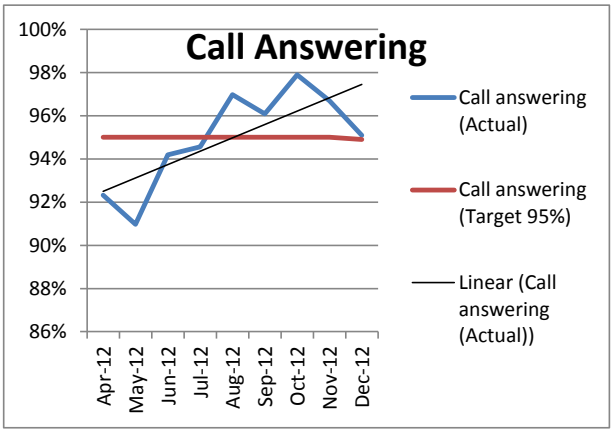
REAP 4 continued throughout December.

2. Care for Patients

Attachment 2

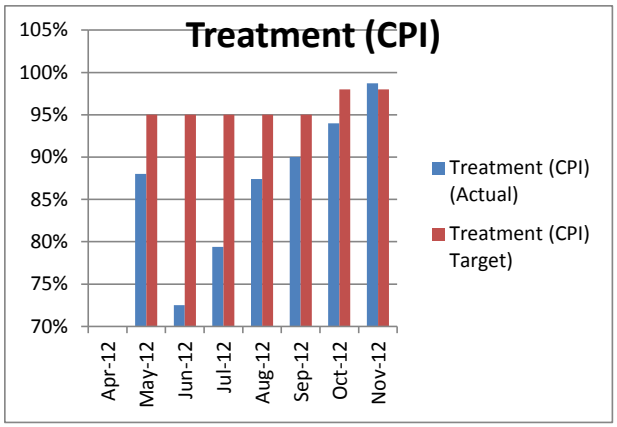
Caring for Patients during their Journey	
* First Contact (Call Answering)	95.1%
* Treatment (CPI)	98.7%
* Clinical Outcomes	97%
* Patient Safety Index	158
* Patient Wellbeing	Amber
* Service Experience	Amber

November 2012 Report	
* First Contact (Call Answering)	96.7%
* Treatment (CPI)	90.0%
* Clinical Outcomes	96%
* Patient Safety Index	156
* Patient Wellbeing	Green
* Service Experience	Green



999 call volume continues to increase this year with the month of December seeing an additional 16,655 calls enter the system, this equates to a growth of 11.5% in comparison to last December. Year to date total call volume has seen an overall growth of 9.1% above the same period last year, this equates to an additional 111,777 calls being handled within EOC.

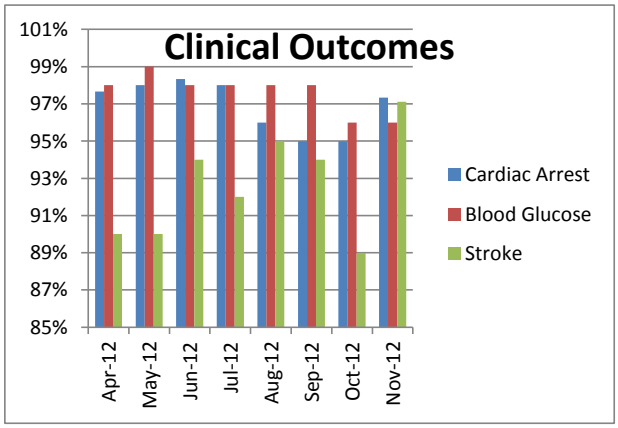
Calls answered within 5 seconds for the month of December achieved 95.1% with the year to date sitting at 94.9%. We remain 1st when comparing ourselves with other providers for 999 calls answered at the 95th percentile



We expect a 95% feedback rate for the Clinical Performance Indicators. For the month of November the compliance was 98.7%.

This measure had been RAG rated red since April 2012. However, the compliance figure continued to improve and has hit the 95% target.

This is a significant achievement by the operational areas who were experiencing severe pressures in November.

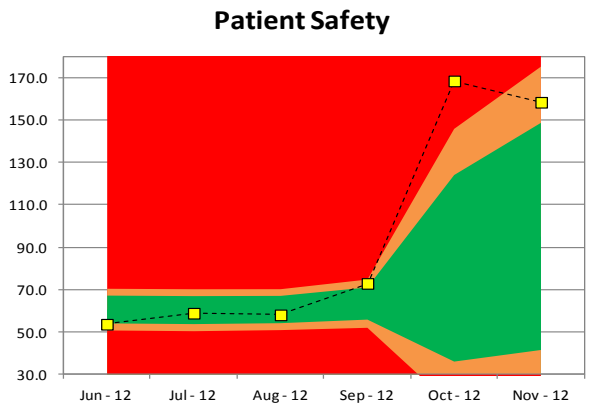


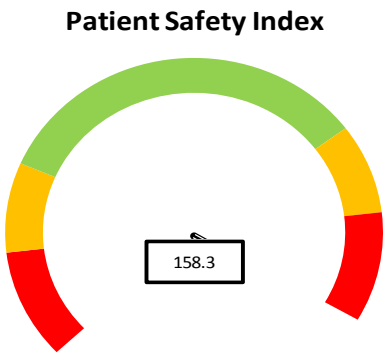
This is a composite measure and is now made up of 11 indicators obtained from CARU audits

Overall the compliance is high and this month there are 7 green indicators with drug administration documentation remaining green for two consecutive months.

The figures do not meet the national standards for 4 as they need to be 95% to be compliant.

This measure has been given an AMBER RAG rating as 4 of the indicators remain amber.





Patient Safety Index: The Patient Safety Index (number of patient safety incidents reported per 100,000 hours worked) is reported as AMBER in November. The Trust had previously seen a steep rise in incident forms being submitted due to the changes made in recording missing equipment. Therefore the rise in rate reflects a single issue that is being addressed by operations and being monitored by the Learning from Experience Committee.

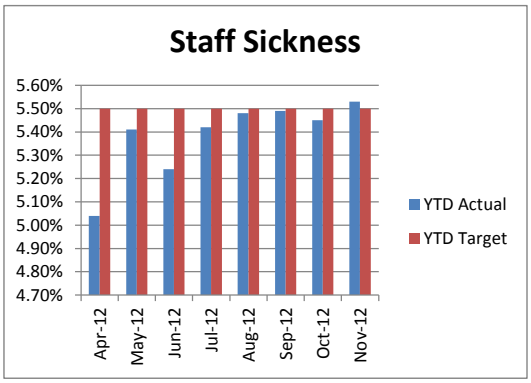
Service Experience: This measure is a DH measure. However, it is not clearly defined and there is little guidance as to what is expected. We have usually awarded ourselves a Green rating as we have a strong
Integrated Risk Report and a subsequent action plan on improving experience which is being used throughout the governance structure. However, the Trust has seen a significant rise in complaints during the last quarter of 2012. Therefore, an AMBER RAG rating has been awarded to reflect the rise in dissatisfaction.

3. Care for Staff

Attachment 2

Care for Staff - Workforce Report		
How will we sustain change and improve?		
Performance Indicators		***T/C***
* Staff Sickness Levels	5.53%	---
* Staff Core Skills Training	0%	3.1
* Staff Development (PDR)	35%	2.5
* Staff Retention	8.9%	2.8
* Staff Safety & Wellbeing	102	3.2
* Staff Satisfaction	3.4	

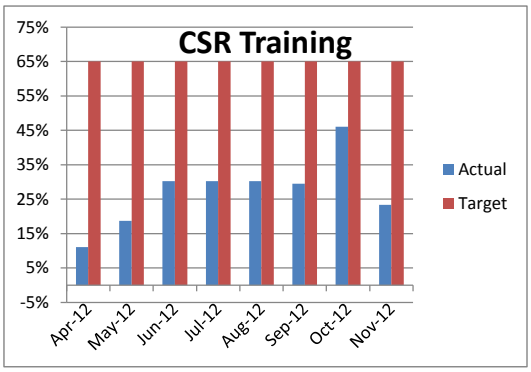
November 2012 Report		
How will we sustain change and improve?		
Performance Indicators		*T/C*
* Staff Sickness Levels	5.49%	---
* Staff Core Skills Training	21%	3.1
* Staff Development (PDR)	35%	2.5
* Staff Retention	8.2%	2.8
* Staff Safety & Wellbeing	67	3.2
* Staff Satisfaction	3.4	



October Report

Sickness absence YTD for 12/13 has now exceeded the target for the year of 5.5% as we enter the winter period. Close attention continues to be paid to absence management arrangements, and the RAG rated audits continue to show that, in the main, all absence is being managed in accordance with the Managing Attendance Policy (MAP).

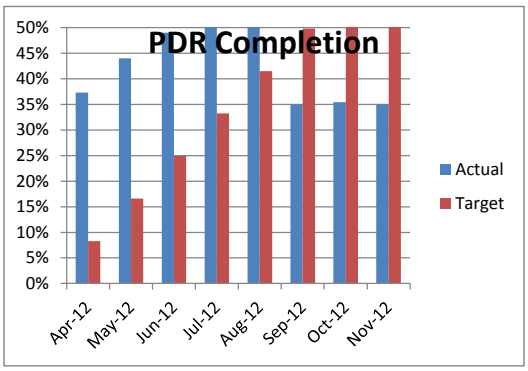
As previously reported, joint work between Operations and HR senior teams has been launched to review all aspects of sickness absence and management processes.



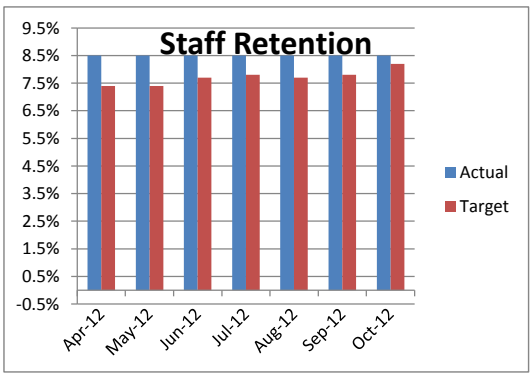
The original CQUIN targets for CSR 1, CSR 2 and CSR 3 were 60% by the end of the year but there were also milestones against each of the quarters. The demands made by the Olympic Games made it difficult to release staff in the usual manner and
therefore the Trust will not meet the Quarterly targets of the CQUIN.

However, the Training & Strategy Group made the decision to focus on CSR 1 training post Olympic Games.

This means the CQUIN measure for CSR 2 & 3 will not be met.

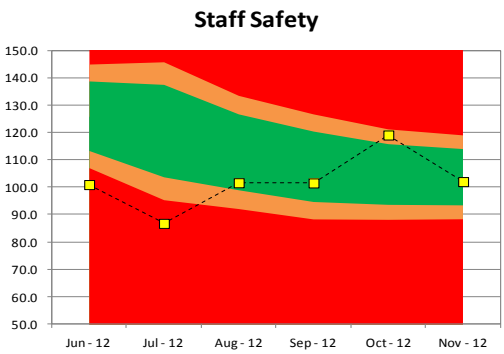


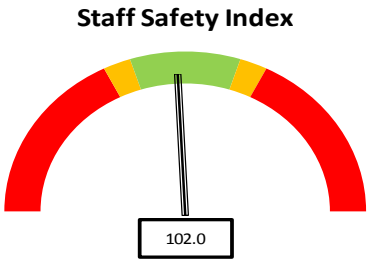
The PDR completion percentage of 35.4% does not include targets from South and East area, but PDRs have been completed there.



This is measured by staff retention/turnover percentages from a rolling twelve month period. The target is 8.5%, with a RAG rating of amber if the figure is between 8.5% and 8.9%; red if the value is above 9%.

In November, the value was 8.9%, which is RAG rated Amber.





Incident Reporting:

Reported Incident Levels

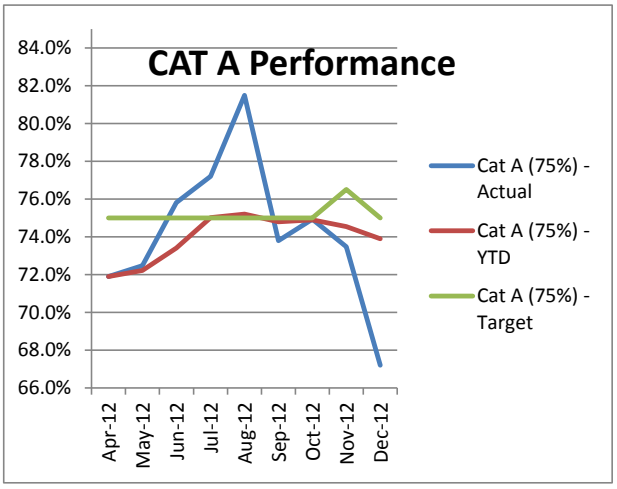
The Staff Safety Index (number of staff safety incidents reported per 100,000 hours worked) is reported as GREEN

4. Service Delivery

Attachment 2

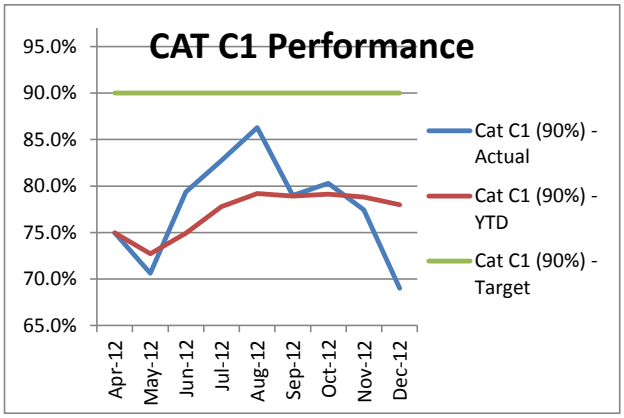
Service Delivery		
Evidencing Delivery of the Response model		
Performance Indicators	***Actual***	***YTD/Pr***
∗ Cat A Target (75%)	67.2%	73.9%
∗ Cat C1 Target (90%)	69.0%	78.0%
∗ Cat C2 Target (90%)	60.2%	73.1%
∗ Ambulance Utilisation (55%)	89.2%	87.4%
∗ FRU Utilisation (40%)	55.0%	47%
∗ Complaints/Serious Incidents	88	79.583

November 2012 Report		
Evidencing Delivery of the Response model		
Performance Indicators	***Actual***	***YTD/Pr***
∗ Cat A Target (75%)	73.5%	74.6%
∗ Cat C1 Target (90%)	77.4%	78.8%
∗ Cat C2 Target (90%)	69.3%	74.5%
∗ Ambulance Utilisation (55%)	88.4%	83.3%
∗ FRU Utilisation (40%)	47.4%	40%
∗ Complaints/Serious Incidents	100	70



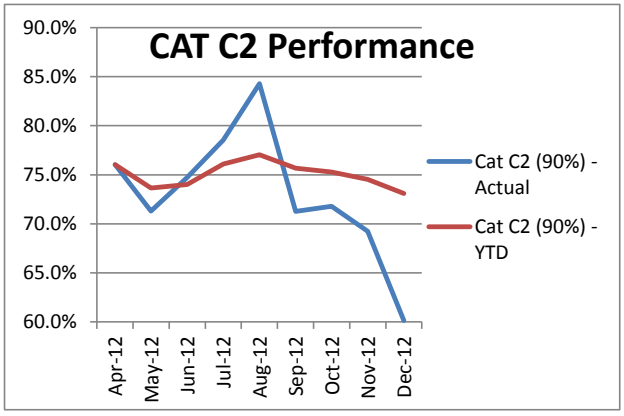
The month of December saw the Trust achieve 67.2% for category A8 performance. It is disappointing to note that this falls below the National Key Standard for A8 and below the trajectory target of 72% submitted to our commissioners. The YTD position of 73.9% remains below the commissioner's trajectory of 74.5%.

Category A incident demand for the month of December ended 18.0% above the same period last year, this equates to an additional 6,434 incidents. Some days in December recorded Category A activity up 30% on the same dates in 2011. Week ending 23 Dec 2012 was the busiest Category A week in LAS history, and is the first time Category A activity has peaked at over 10,000 for the week.

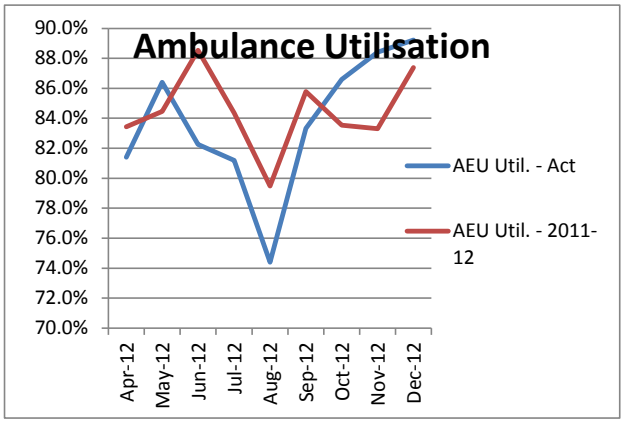


We aim to respond to our category C1 patients within 20 minutes and our target is that we will achieve this 90% of the time.

Category C1 performance was recorded as 69% in December, with a year to date value of 78%

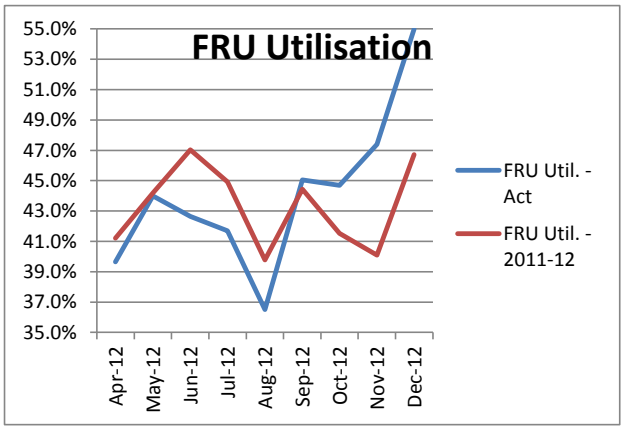


Category C2 performance for December was 69.3%, with a year to date value of 73.1%

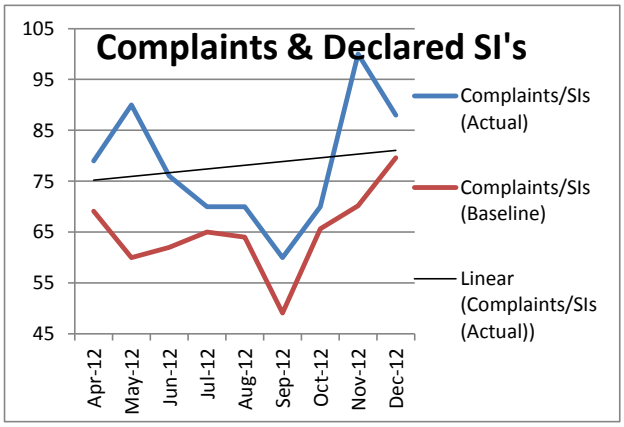


The utilisation graphs now show a comparison with 2011-12.

Utilisation rates for ambulances in December averaged 85% and peaked at 93%, meaning that we simply did not have sufficient capacity to respond to the levels of activity we experienced. This inevitably led to calls being held without resource being available to dispatch. A temperature gauge to the challenges this presented in December was our level of DMP utilisation.



FRU utilisation in December was 54.98%



Tthe Trust has seen a significant rise in complaints during the last quarter of 2012. Therefore, an AMBER RAG rating has been awarded to reflect the rise in dissatisfaction.

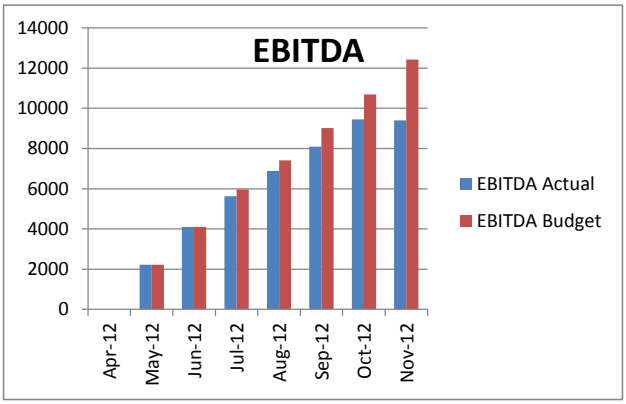
A summary of complaints and Serious Incidents is now provided to the ADOs on a weekly basis.

5. Value for Money

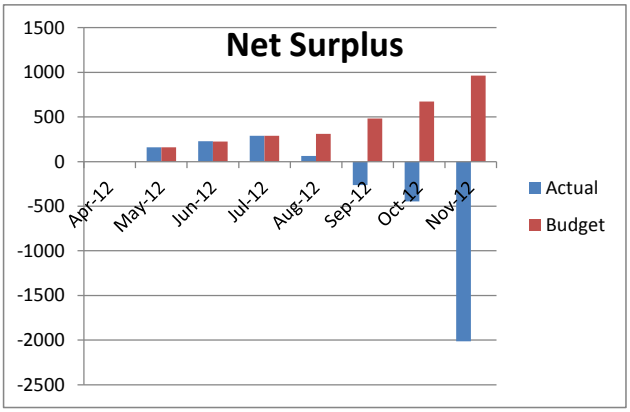
Attachment 2

Value for Money (November)	
Evidencing stewardship of the public purse (YTD)	
* Financial EBITDA	9,407
* Net Surplus	(2,014)
* Cost Improvement Programme	7,485
* CQUINs	867
* Monitor Net Rating (FRR)	2
* Carbon Reduction Plan	Green

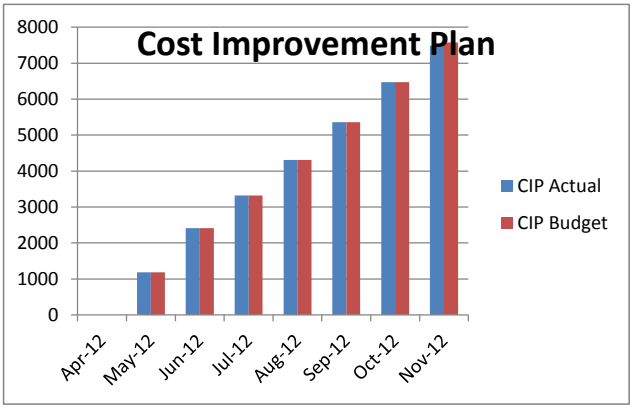
October 2012 Report	
Evidencing stewardship of the public purse (YTD)	
* Financial EBITDA	9,451
* Net Surplus	(446)
* Cost Improvement Programme	6,469
* CQUINs	867
* Monitor Net Rating (FRR)	2
* Carbon Reduction Plan	Green



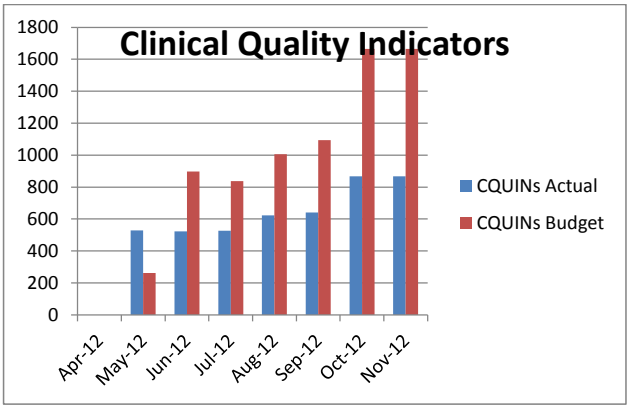
EBITDA is currently behind plan due to pay & non pay expenditure exceeding plan and slippage on depreciation



The Trust is reporting a deficit of £1.6m for the month against a planned surplus of £250k - a variance of £1.8m.

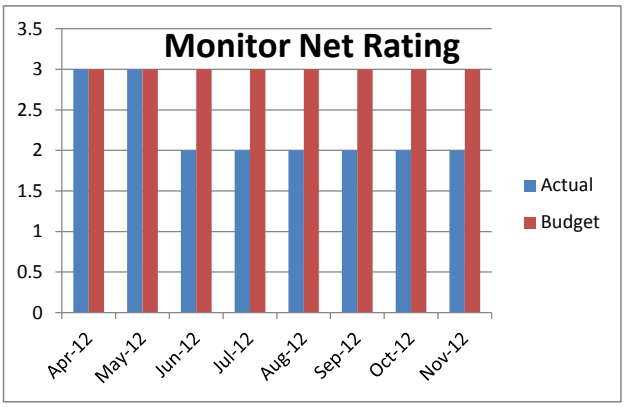


CIP is not on track year to date and is not forecast to achieve plan at year end



Additional support for Queens Diamond Jubilee has been refused by NWLCH.
No Additional income has been accrued in period 8.

Current unearned CQUIN is forecast to be £1.9 million and Red Rated.



The Monitor Net Rating remains at 2 due to the liquidity

Carbon Footprint Report:

Interim Report 2012-13

The review of the Trust's overall carbon footprint at month 6 indicated that the Trust is on track to deliver circa 4% carbon savings this year, this is dependent on all things remaining equal in terms of procurement as it is the key component of the Trust's carbon footprint.

Fuel:

Diesel usage has increased compared to the same period 2011/12 by 2.3%; year on year the number of incidents has risen by 5.4%. Petrol consumption has fallen by 39% due to all the petrol cars being withdrawn from the Fleet; the motorcycle unit is currently the sole consumer of petrol.

Compared to 2011/12 the Trust is conveying less patients; 2% increase in non conveyance compared to last year. There is increased utilisation of the Cycle Response Unit, with an increase of approx 29% compared to activations in the same period 2011/12; on average about 50% of the incidents attended by CRU are resolved at scene.

However we are resolving fewer calls using Hear & Treat compared to the same period last year by circa 2% (YTD Dec 2011 (43078) compared to YTD Dec 2012 (42033).

There are a number of initiatives in the pipeline to decrease our fuel consumption e.g the Trust is testing an on-board telemetric device in March to evaluate its potential benefits. This was scheduled to take place in December but has been delayed for a number of reasons, one of which is vehicle availability. There are continuing efforts to improve the level of Hear and Treat and See and Treat, which are reported elsewhere ie Chief Executive's monthly progress report or the IPB Programme report

Energy:

Year to date electricity consumption is approx 28% less than 2011/12; but gas consumption has increased by approx 35%, due in large part to a cold wet summer (2012 was officially the UK's second wettest year on record.

There are ongoing efforts to implement energy saving measures across the Estate, from replacing old inefficient boilers to installing efficient lighting in garages ensuring that lighting is not used when there is sufficient daylight. Work has been undertaken by the Estates team to 'cleanse' the data regarding energy consumption has to date our data regarding usage has largely being based on estimates. Estates are currently engaged in finalizing the Re-Fit contract thereby delivering a reduction in energy consumption in 2012/13. .

Procurement: the available data suggests that at month 6 the Trust's carbon footprint is less than the same period last year. The new system has measured the carbon footprint of purchases and given a figure of 11,766 tCO2 e. A member of the Medical Directorate is working closely with the Procurement team to review our medical equipment purchases, rationalising purchases whilst ensuring that clinical standards are upheld and achieving significant savings.

Recycling: for the year to date the data indicates that there has been an improvement in the percentage of recycling undertaken 44% (12/13) compared to 36% (11/12). It has been noted that the clinical waste is approx 8% less than last year although incidents has increased by approx 5.4%; this has been flagged up with Education and an investigation is being undertaken. It may be that crews are disposing of clinical waste whilst at hospitals.

Attachment 3

Quadrant	Performance Indicator	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Care for patients	**Description**	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Call Answering (Actual)	Call answering (Actual)	92%	91%	94%	95%	97%	96.09%	98%	97%	95%			
Call Answering (Target)	Call answering (Target 95%)	95%	95%	95%	95%	95%	95%	95%	95%	95%			
Treatment (CPI) (Actual)	Treatment (CPI) (Actual)		88%	73%	79%	87%	90%	94%	98.7%				
Treatment (CPI) Target)	Treatment (CPI) Target)		95%	95%	95%	95%	95%	98%	98%				
Clinical Outcomes	Cardiac Arrest	98%	98%	98%	98%	96%	95%	95%	97%				
Clinical Outcomes	Blood Glucose	98%	99%	98%	98%	98%	98%	96%	96%				
Clinical Outcomes	Stroke	90%	90%	94%	92%	95%	94%	89%	97%				
Clinical Outcomes	Aggregate	95%	96%	96%	96%	96%	96%	93%	97%				
Patient Safety Index (Actual)	Clinical & Non-Clinical Incidents raised by staff/100,000 hours worked	54	53	51	52	53	69	165	158				
Patient Safety Index (Target)	Clinical & Non-Clinical Incidents raised by staff/100,000 hours worked	59	58	57	58	60	99						
Patient Wellbeing	Actions arising from the Learning from Experiences Report		Green	Green	Green	Green							
Quality Barometer	Quality Dashboard		Green	Green	Green	Green							
Care for Staff	**Description**	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Staff Sickness (Actual)	YTD Actual	5.04%	5.41%	5.24%	5.42%	5.48%	5.49%	5.45%	5.53%				
Staff Sickness (Target)	YTD Target	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%
Actual	Actual Percentage of staff receiving CSR 1, 2 and 3 training against plan	11%	19%	30%	30%	30%	30%	46%	23%	0%			
Target	Target Percentage of staff receiving CPR 1, 2 and 3 training against plan	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%
Actual	Percentage of staff who have completed Performance Development Plans	37%	44%	49%	54%	54%	35%	35%	35%				
Target	Percentage of staff who have completed Performance Development Plans	8%	17%	25%	33%	42%	50%	58%	66%	75%	83%	91%	100%
Actual	Staff Retention Target YTD Turnover	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%
Target	Staff Retention Actual YTD Turnover	7.4%	7.4%	7.7%	7.8%	7.7%	7.8%	8.2%	8.9%				
Actual	SSI - LHC, Physical & Verbal Abuse incidents/100,000 hours worked - Actual	142	129	100	86	105	105	120	102				
Target	SSI - LHC, Physical & Verbal Abuse incidents/100,000 hours worked - Target	69	69	68	65	113	158						
Service Delivery	**Description**	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Cat A Target Performance (75%)	Cat A (75%) - Actual	71.9%	72.5%	75.8%	77.2%	81.5%	73.8%	74.9%	73.5%	67.2%			
Cat A Target Performance (75%)	Cat A (75%) - YTD	71.9%	72.2%	73.4%	75.0%	75.2%	74.8%	74.9%	74.6%	73.9%			
Cat A Target Performance (75%)	Cat A (75%) - Target	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	76.5%	75.0%			
Cat C1 Target (90%)	Cat C1 (90%) - Actual	75.0%	70.6%	79.4%	82.7%	86.3%	79.0%	80.3%	77.4%	69.0%			
Cat C1 Target (90%)	Cat C1 (90%) - YTD	75.0%	72.7%	74.9%	77.8%	79.2%	78.9%	79.1%	78.8%	78.0%			
Cat C1 Target (90%)	Cat C1 (90%) - Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%			
Cat C2 Target (90%)	Cat C2 (90%) - Actual	76.0%	71.3%	74.7%	78.6%	84.3%	71.3%	71.8%	69.3%	60.2%			
Cat C2 Target (90%)	Cat C2 (90%) - YTD	76.0%	73.7%	74.0%	76.1%	77.0%	75.7%	75.3%	74.5%	73.1%			
Cat C2 Target (90%)	Cat C2 (90%) - Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%			
Ambulance Utilisation (55%)	AEU Util. - Act	81.4%	86.4%	82.3%	81.2%	74.4%	83.3%	86.6%	88.4%	89.2%			
Ambulance Utilisation (55%)	AEU Util. - 2011-12	83.4%	84.5%	88.5%	84.4%	79.5%	85.8%	83.5%	83.3%	87.4%			
FRU Utilisation (40%)	FRU Util. - Act	39.7%	44.0%	42.64%	41.7%	36.50%	45.05%	44.7%	47.40%	54.98%			
FRU Utilisation (40%)	FRU Util. - 2011-12	41.2%	44.2%	47.0%	44.9%	40%	44%	42%	40.10%	46.72%			
Number of Complaints received	Complaints/SIs (Actual)	79	90	76	70	70	60	70	100	88			
Number of Complaints received	Complaints/SIs (Baseline)	69	60	62	65	64	49	66	70	80			
Value for Money	**Description**	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Financial EBITDA	EBITDA Actual		2216	4104	5628	6884	8096	9451	9407				
Financial EBITDA	EBITDA Budget		2216	4104	5966	7416	9015	10692	12429	14574	16675	18827	21992
Net Surplus	Actual		161	226	288	63	-262	-446	-2014				
Net Surplus	Budget		159	223	289	312	484	674	964	1357	1855	2404	3116
Cost Improvement Programme	CIP Actual		1179	2407	3321	4308	5354	6469	7485				
Cost Improvement Programme	CIP Budget		1179	2407	3321	4308	5354	6469	7579	8718	10134	11550	13594
CQUINs	CQUINs Actual		528	523	527	623	640	867	867				
CQUINs	CQUINs Budget		262	898	837	1006	1093	1664	1664	3510	4490	5470	6448
Monitor Net Rating (FRR)	Actual	3	3	2	2	2	2	2	2				
Monitor Net Rating (FRR)	Budget	3	3	3	3	3	3	3	3	3	3	3	3
Carbon Reduction Plan	Carbon Reduction Plan		Amber			Green	Green	Green	Green				
Operational Context	**Description**	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
999 Call Volume	Average # 999 calls	4585	4914	4761	4727	4402	4704	4656	4656	5214			
Peak 999 Call Coume	Peak # of calls	5081	5884	5809	5320	5619	5490	5151	5298	6164			
Cat A Incidents	CAT A	34083	37547	35119	36167	34374	34985	36701	36701	42173			
Cat C1 & C2 Incidents	CAT C1 & C2	25688	26782	27002	29471	28214	26176	28725	28725	27815			
Cat C3 & C4 Incidents	CAT C3 & C4	24955	26259	25820	27820	28670	24866	25269	25269	22906			
DMP Stage A	% month DMP A	56%	53%	65%	75%	77%	61%	66%	55%	26%			
DMP Stage B	% month DMP B	38%	33%	27%	24%	17%	27%	30%	38%	29%			
DMP Stage C	% month DMP C	6%	14%	6%	0.93%	5.80%	12%	5%	7.10%	38%			
DMP Stage D	% month DMP D								0.80%	7.10%			
REAP Level (Target)	REAP Target 75% @ Level 2	75%	75%	75%	75%	75%	75%	75%	75%				
REAP Level (Actual)	REAP Level 2	0%	0%	0%	0%	0%	0%	0%	0%				
REAP Level 3+	REAP Level 3	0%	0%	21%	100%	100%	100%	100%	100%	100%			
REAP Level 4+	REAP Level 4	100%	100%	79%	59%	47.06%	47.06%						

Integrated Trust Performance Report - Explanation of each measure

1. Operational Context

Av. Daily Vol.				REAP 3
Peak Daily Vol.	Nov	Dec	MoM	Y2Y
999 Call volume	4656	5214	12%	21.4%
Peak 999 Call	5151	6164	16%	28.4%
Cat A Calls	36701	42173	15%	13.7%
Cat C1 & 2 Calls	28725	41177	-3%	6.6%
Cat C3 & 4 Calls	25269	22906	-9%	-18.3%
DMP Stage A	55%	26%	-28%	-35.3%
DMP Stage B	38%	29%	-9%	-5%
DMP Stage C	7%	38%	31%	34%
% > REAP 3	100%	100%	0%	10%

Call Volumes

The report shows the average and peak number of calls per day and comparative figures from the previous month (in blue). The percentage increase/decrease YTD and comparison with the same month in the previous year is also shown.

The report shows the total number of Category A, Category C1 and C2, and Category C3 and C4 calls responded to during the month and the percentage increase/decrease on the same month in the previous year.

Demand Management Plan

The report shows the percentage of hours where the Trust's Demand Management Plan (DMP) stages were invoked in the Emergency Control Room and the percentage increase/decrease on the same month in the previous year. N.b. This does not apply for May, as DMP was not fully introduced in May 2011.

REAP Level

The report shows the current REAP level and the percentage of time that the Trust has operated at or above REAP 3.

2. Care for Patients

Caring for Patients during their Journey	
How do we care for our patients?	
* First Contact (Call Answering)	95.1%
* Treatment (CPI)	98.7%
* Clinical Outcomes	97%
* Patient Safety Index	158
* Patient Wellbeing	Amber
* Service Experience	Amber

First Contact (Call Answering)

First contact with a patient affects their entire experience. Did we answer the call quickly, did we listen to them and/or did we give them the correct information to manage their expectations?

This is measured by the percentage of calls answered within 5 seconds against a national target of 95%.

Treatment (CPI)

Did we correctly assess and treat our patients?

This is measured from the clinical outcomes from the CARU CPI Audit report, and is graded as Red, Amber or Green from the Quality Dashboard. N.b. This indicator appears within this report for the first time since October 2011.

Clinical Outcomes

Did our patients have a positive outcome?

This is an aggregate measure from the audit of specific patient clinical outcomes: cardiac arrest; STEMI; Stroke; Diabetes etc as defined in the Quality Dashboard Clinical Performance Indicators.

Patient Safety

How have we ensured patient safety?

This is measured by the total number of clinical and non clinical incidents raised by staff, against the number of hours worked, effectively the rate of clinical and non clinical incidents per 100,000 hours worked – a Patient Safety Index. The target is based on averages over the previous 12 months to show variance against the mean.

The target is based on a rolling 12 month average, and RAG rated the standard deviation against the mean – Green = < ± 1 STD, Amber < ± 1.5 STD, Red > ± 2 STD.

Patient Wellbeing

How have we ensured that patient's concerns and complaints are acted upon?

This is a measure of progress against the actions arising from the Learning from Experience Report.

Clinical Quality/Barometer – Service Experience

This is a DH measure. However, it is not clearly defined and there is little guidance as to what is expected. We have awarded ourselves a GREEN rating as we now have a strong Integrated Risk Report and a subsequent action plan on improving experience which is being used throughout the governance structure.

3. Care for Staff

Care for Staff - Workforce Report		
How will we sustain change and improve?		
Performance Indicators		***T/C***
* Staff Sickness Levels	5.53%	---
* Staff Core Skills Training	0%	3.1
* Staff Development (PDR)	35%	2.5
* Staff Retention	8.9%	2.8
* Staff Safety & Wellbeing	102	3.2
* Staff Satisfaction	3.4	

This information is obtained from the Workforce report submitted by the Human Resources Department and the quarterly Staff Temperature Check survey. Statistics on complaints and Serious Incidents are obtained from the Governance and Compliance department.

Staff Availability

This is calculated from YTD sickness levels, which have a target of 5.5%. The RAG rating is <5.5% Green and >5.5% Red.

Staff Training

The percentage of staff attending Core Skills Refresher (CSR) levels 1, 2 and 3 training against plan.

The Clinical Quality Indicators (CQUIN) target is for 65% of eligible staff to attend CSR training between January 2012 and February 2013. The Trust's approved Training plan meets these requirements, but it has been agreed that training will be suspended between May and September 2012 to ensure that adequate resources are available for the Olympics and Paralympics. The Trust's Training plan will, therefore, be recalibrated in October 2012. This will be reflected in the Integrated Report.

The quality barometer is the response to the Temperature Check question: "I am given access to the information I need to do a good job".

Staff Development

How are we ensuring that staff are provided with appropriate development opportunities?

This is measured by the number of staff who have completed Performance Development Plans (PDRs) against plan. The measure is a cumulative percentage across the year.

The quality barometer is how staff feel that they are being developed, based on the aggregate score for specific questions in the Staff Temperature Check survey; "I am given opportunities to develop my knowledge and skills"; and "I have access to the equipment I need to do a good job".

Staff Retention

How are we ensuring that staff are managed well?

This is measured by staff retention/turnover percentages from a rolling twelve month period. The target is 8.5%, with the RAG rating of Amber if the figure is between 8.5% and 9% and Red if the value is above 9%.

The quality barometer is how staff feel that they are being managed, based on the aggregate score for specific questions in the Staff Temperature Check survey; "The LAS values employee suggestions for improvement"; "My manager shows appreciation for the work I do"; "There is a spirit of cooperation amongst my colleagues"; and "My manager shows me the support that I need to do my job well".

Staff Safety and Wellbeing

How are we ensuring that staff are safe at work?

This is measured by the number of lifting, handling & carrying (LFC), physical (PV) and non-physical abuse (NPA) incidents raised by staff, against the number of hours worked, effectively the rate of incidents per 100,000 hours worked – a Staff Safety Index.

The target is based on a rolling 12 month average, and RAG rated the standard deviation against the mean – Green = < ± 1 STD, Amber < ± 1.5 STD, Red > ± 2 STD.

Staff Satisfaction

The quality barometer is how staff feel about working for the LAS, based on the aggregate score for specific questions in the Staff Temperature Check survey: "I enjoy working for the LAS"; "I am proud of the quality of care the LAS provides"; "I believe I can make a difference to the success of the LAS" and "I am happy with my work/life balance".

The RAG scoring mechanism is Red <3, Amber 3-3.5, Green >3.5.

4. Service Delivery Quadrant

Service Delivery		
Evidencing Delivery of the Response model		
Performance Indicators	***Actual***	***YTD/Pr***
* Cat A Target (75%)	67.2%	73.9%
* Cat C1 Target (90%)	69.0%	78.0%
* Cat C2 Target (90%)	60.2%	73.1%
* Ambulance Utilisation (55%)	89.2%	87.4%
* FRU Utilisation (40%)	55.0%	47%
* Complaints/Serious Incidents	88	80

Cat A & C Target Performance

How is the Trust performing against targets?
This is measured by the percentage of Category A calls responded to in 8 minutes, and the percentage of Category C1 and C2 calls responded to in 30 minutes. The report shows actual figures for the month and the year to date, or the previous month where applicable (for Complaints/Serious Incidents).

Utilisation

The report shows the monthly and year to date utilisation percentages for ambulances (55% target) and fast response vehicles (40% target).

Quality Barometer

The quality barometer for the Response Model Delivery quadrant is the number of complaints received about the Trust plus the number of serious incidents declared with NHS London. The average number of complaints received per day has risen from 1.5 in 2010 to 1.8 in 2011 and now stands at 2.0 for the last twelve months. The Trust declares an average of 1.4 Serious Incidents per month. The RAG Rating for this measure is therefore < 63 – 65 (Green), 65 – 75 (Amber) and >75 (Red).

5. Value for Money Quadrant

Value for Money	
Evidencing stewardship of the public purse (YTD)	
* Financial EBITDA	9,407
* Net Surplus	(2,014)
* Cost Improvement Programme	7,485
* CQUINs	867
* Monitor Net Rating (FRR)	2
* Carbon Reduction Plan	Green

This information is obtained from the Finance Department, and all values are RAG rated against the annual forecast. The values submitted are Financial EBITDA; Net surplus, Cost Improvement Plan, CQUINs and the Monitor Net Rating (FRR).

The report also includes a RAG rating on overall performance on carbon reduction, based on energy and fuel consumption, vehicle savings and recycling.

There is a separate Carbon Reduction dashboard which is submitted to the Finance and Investment Committee half-yearly, with the next meeting scheduled for September 2012. Plans are also in place to publish the Carbon Reduction dashboard on the Pulse in Q2 2012.

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London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29 JANUARY 2013

PAPER FOR NOTING

Document Title:	**Q4 recovery and winter funding action plan 2012/13 v1.3**
Report Author(s):	**Paul Woodrow**
Lead Director:	**Paul Woodrow** - Director of Service Delivery (South Thames)
Contact Details:	Paul.Woodrow@lond-amb.nhs.uk
Why is this coming to the Trust Board?	**For information**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other
Recommendation for the Trust Board:	The Trust Board to receive assurance on progress against the action plan.

Key issues and risks arising from this paper

Contractual £5m penalty for failing to deliver 75% A8 for the year and a reputational risk of failing to hit the A8 target.

Executive Summary

The Q4 recovery and winter funding action plan is attached which sets out the actions to be taken to improve performance delivery in Q4 in line with the following key objectives:

1. The safe management of more calls in control services preventing the allocation of resources where possible.
2. Increased frontline capacity across key dates and times to reduce patient waiting time, improve quality and patient safety.

Attachments

Q4 recovery and winter funding action plan 2012/13 v1.3

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Quality Strategy

This paper supports the following domains of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

- ☒ That we fail to effectively fulfil 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

Q4 recovery and winter funding action plan 2012/13

As LAS enters Q4 2012/13 A8 performance sits at 73.7% for the year to date. With a year end target of 75% a planned and sustained performance recovery across Q4 is now required where by the year to date A8 performance delivery will be improved and in doing so avoiding the contractual £5m penalty for failing to deliver 75% A8 for the year together with managing the reputational risk of failing to hit the A8 target.

As at 3 January daily A8 performance of 79% is required across each and every day of Q4 to deliver a year end position of 75%. This is a significant challenge for the Trust and is one of the deeper recoveries we have found ourselves in across the last decade. Delivery on target does remain possible whoever it does require us to be absolutely focused on delivery across Q4. Measures within this plan are designed to aid recovery whilst balancing this with a need to maintain local autonomy. Leadership at a local level is crucial to our success and it is therefore important that all staff are aware of the depth of the recovery and what they need to do to support it. In the event that sufficient progress is not made across the first two weeks of January the plan and its associated actions will be critically reviewed with a view to more stringent requirements being placed on delivery with 24 hour centrally based supervision of delivery.

Recovery actions across Q4 in this plan are combined with the requirements of the recently awarded winter funding bids whereby LAS has received additional funding to support the delivery of core services across the winter and to the end of Q4 2012/13. This is against a backdrop of sustained increase in demand upon LAS during 2012/13. The funding totals £6.2m and following a successful bidding process has been allocated to support two key objectives. These are:

1. **The safe management of more calls in control services preventing the allocation of resources where possible**
2. **Increased frontline capacity across key dates and times to reduce patient waiting time, improve quality and patient safety**

Some of the actions noted below have been agreed with commissioners as those that LAS will enact as part of the winter funding bids whilst others are required to support the recovery effort. Compliance to these actions will be monitored weekly.

London Ambulance Service NHS Trust

Q4 recovery and winter funding action plan 2012/13

Ref	Action	Impact/Benefit	Owner	Sub action progress update	Notes/Comments
1	**Additional Frontline Capacity** Bringing total ambulance cover up to 33k hours per week in order to maintain LAS performance over known high demand periods.	Improved A8 Improved C performance Reduction in response times Reduced use of DMP and associated clinical risk (to be shown as percentage use reduction across Q4 from Q3) Increased resilience to peaks in demand	JK	PAS contracts drafted and daily provision from each firm confirmed Contracts on track to be signed by 7 January with provision commencing immediately	 tele conf notes_201212_jk.doc
			GH	GH drafting LAS incentive package to target key dates and times and include productivity commitment to reduce HTT to 14 minute average –package to run for all of Q4 and provide long range incentive payment	Bulletin to be issued by Friday 4 January
		Increase in deployed frontline hours	KM/PMcK/KB	Brief and deploy all cluster training officers to rosters providing AEU/FRU cover (shifts could be undertaken where trained on CHUB/MET DG)	CH to ensure Fulham Training don't require/use trainers
		Reduced abstractions and increased frontline hours	BO'N	Defer all training other than SP2 and APP planned activity (potential daily planned abstraction cap to be agreed)	GH to monitor and ensure compliance
			CH	Recruit to full establishment across Q4	
			VC/JD	Recruit and secure deployment of all transfers and bank applications	Note to recruitment seeking support for entry of bank and transfer candidates sent (JK). Additional advert being run in NHS Jobs for registered Paramedics on 17th Jan 2013 for 2 weeks

2	**Increased Hear & Treat** Increasing capacity within Clinical Telephone Advice in order to optimise the number of lower acuity calls appropriately not receiving an ambulance response.	1188 additional ambulance no sends a month Approximately 808 saved ED conveyances Deploy 10 nurses (5 a day, 6 days a week)	CHm/NA	CHm to deliver 2 x cohorts of 5 nurses for interview/training in January	Nurses supplied through agency via JK
		Improved CTA efficiency	NA/CHm	Maintain PSIAM call handling time average of 24 minutes	
		Improved re-triage, no send rates and more appropriate care for patient with AEU being available respond to other incidents	RW	Progress towards ORH capacity review required C4 re-triage rates of 53% of all C4 calls re-triaged with no send rate of 25% (of the 53%)	Update received 09.01.2013
3	**Managing MPS Demand** Strengthening MPS call handling and response activity	45% no send rate on MPS assessed calls A reduction in ambulance sends and consequent conveyances as a result of calls received from the MPS Improved response to MPS calls and reduced likelihood of issues leading to escalation by MPS (over 15 week period to year end)	SMcI	Deploy JRU to top 10 MPS volume boroughs to LAS through CO response cars	 JRU PPMASTER.pptx
			PD	EMD x 4 and CHUB staff (and others that are suitable) x 2 to provide Thursday, Friday and Saturday 16/04 re-triage	PD lead from 14.01.2013

4	**Strengthening Clinical Hub** Matching capacity with demand in order to reduce the number of low acuity C category calls dispatched	Additional 780 ambulance no sends a month Equating to approximately 414 saved ED conveyances a month Improved re-triage, no send rates and more appropriate care for patient with AEU being available respond to other incidents	CHm/NA	Deploy 1 additional WTE on CHUB 24/7 delivering additional 26 no send in Jan, 28 in Feb and 26 in March per day 5 WTE to ideally come from Clinical Tutors (KM to lead with PLMs to identify candidates)	To be base lined from average no sends per day across Nov and Dec 2012
			RW	Progress towards ORH capacity review required C3 re-triage rates of 36% of all C3 calls re-triaged with no send rate of 20% (of the 36%)	
5	**See Treat and Refer** Additional resourcing within the clinical hub in order to provide capacity to offer enhanced clinical support to frontline crews	During periods of increased pressure at specific ED's take direct action to reduce AEU attendance through directing from EOC crews to ACPs where appropriate or supporting self care	FW	One extra person on CCD to actively manage flow of patients inbound to EDs with resus pressures	Mon, Fri, Sat 12/24 shifts

6	**Improved deployment** Introduce revised ORH active area cover deployments points	Improved geographical deployment of available resources and reduce mobilisation and response times	KC (plus area PIMs)	Implement use of new tier 1 and tier 2 points from Monday 21 January	EOC PIM KC • The new Tier 1 & Tier 2 points have been loaded onto Geotracker • Staff training has been cascaded • Improved geographical deployment of available resources and reduce mobilisation and response times • The new node points have been shared with each FRU team on complex and copies of the geographical locations of the points are in each of the FRUS for future reference • A consolidated list of the West area node points has been drawn up translating the points into more recognisable road junctions to aid the introduction process and provide clarity to the FRU staff. • A degree of trepidation exists within the area as we go live with the new data as many of the previously used and believed to be tried and tested points do not feature in as essential or desirable node points. The FRU performance will remain under close scrutiny following the go live date on the 21st January 2013 • • We are on track to go live on Monday the 21st January

7	**Improved operational efficiency** More efficient use of existing resources	Reduced MAR and release of existing deployed hours to respond to incidents	JK	Introduce interim revised response model as identified in ORH capacity modelling	Requires further scoping to assess achievability
		Release of existing deployed hours to respond to incidents	EP/KB	Reduce VOR to 5.1% by end Q4	
		Improved senior oversight and direction of immediate actions to improve efficiency	PW	Introduce twice daily service delivery review conference call operating 7 days a week	RW, KM, PMcK, KB, JH to chair on rotation (cover to be agreed by chairs) by telephone
		Release of existing deployed hours to respond to incidents	GH	Reduce HTT to 14 minute average through efficiency requirement in operational incentive package	
		Reduced turnaround time	KM, PMcK, KB	Consider placing HLO's at known problematic EDs to aid crew turnaround and use of ACPs and so on at peak times (11/21 Mon, Tues and Fri)	EDs to be focused on: St George's Tooting Mayday Kingston PRUH QMIL King's College UCH Whipps Cross Newham King George's Ilford Queen's Romford
		Longer range ability to plan for shortfalls in cover and peaks in demand	GH	Resource centre to plan relief staff 6/52 ahead	
		Less on the day hours produced loss due to pairing of single staff	GH	Resource centre to reduce single staffed losses from XX to XX	
		Reduced HTT releasing	PIMs	All Ops staff with HTT average across 3	WEST PIM PC

		capacity to respond to calls		months in excess of 17 minutes to have individual action plan tailored to reduce to <15 minutes by end February	• Assurance have been received that all complexes have a robust plan in place to manage outliers in terms of HTT across all complexes. These action plans and the resulting performance improvement will be reviewed in complex 1-2-1 meetings with the PIM
		Reduced abstractions due to attendance issues	PIMs	Compare U/A and LA51(a) payment/non payment across complexes/watches	
		Reduced abstractions due to attendance issues	CH	Monthly peer review of attendance management processes across areas	More thought on actions for long term absence and approach from OHD
		Ensure compliance with existing AfC requirements	Senior HR managers in area	Review unsocial hours payments to ensure compliance with hours worked	
		Increase in deployed hours	TC	All senior staff side reps to provide 50% time AEU/FRU deployment	
		Improved oversight and direction of immediate actions to improve efficiency	AK	Establish interim daily co-ordination centre to support planning	MI, RC, S/O representation to be secured (PW)
		Improved efficiency through support to frontline operations in necessary roles	AK	Identify definitive list and ensure suitable deployment to support recovery of all restricted duties staff	
		Increase in deployed hours	KM, PMcK, KB, JK, PW	Operational managers who are clinically qualified to complete minimum of 2 operational AEU/FRU/CHUB/CSD/MPS DG shifts per month	Those who are non clinical to support delivery in some other way as agreed with ADO WEST PIM PC • Operational managers where clinically able to provide 2 operational shifts per month • All available AOMs have completed at least one operational shift during the month to date of

					January with further shifts planned to meet the required number.
		More appropriate dispatch to Category A calls	RW/FM	Explore options around earlier dispatch in the call cycle and introducing new questioning of callers to identify non Cat A incidents prior to dispatch	09.01.2013 – RW yet to meet with FM

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8	**Other necessary actions**		PW, JK	Confirm operational managers arrangements for bank holidays	
			PIMs	Set and agreed complex level A8 improvement trajectories	Consider local supporting recovery plans needing to be consistent in approach regarding resource dispatch and EOC actions WEST PIM PC • Set and agree complex level A8 improvement trajectories. • The trajectories have been set and form part o the West Area Q4 plan, these are to be review against performance return on a weekly basis the PIM and Complex AOM
			AK	Ensure compliance with REAP 3/4 actions as necessary	
			JK	Progress roster reviews in line with new roster key	Briefing to senior Ops team set up for January
			JK, PW	Design and implement new relief management arrangements for all new entrants	Briefing to senior Ops team set up for January
			CH	Rest break, AAC and annual leave arrangements revised and implemented	CQUIN 7 requirements
			BO'N	Clinical Tutors to provide 1 x 12/20 hrs and 1 x 08/18 hrs 7 days a week support to EBS RST activity	
			CH	6 WTE seconded from non Ops teams to provide 1 additional support person 24/7 on CSD supporting ED capacity management	
			AP	Develop a Trust wide communications plan for Q4 setting out performance recovery, demand management and other related topics	Activity consider development of "misuse" video as in SCAS
			JK/PW	Consider use of MDT messaging to advise of increased pressure/change in DMP level raising awareness of pressures	
			PS	In order to maximise the availability of CP and other mission critical EOC systems minimise any changes, testing or reconfiguration work to those that are	

				absolutely operationally essential. Postpone where possible change type activities to the next financial year.	

Key to action delivery

	Actions total
Complete	
On track	
Some slippage – likely to deliver on plan	
Off plan – unlikely to deliver as planned	

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH JANUARY 2013

PAPER FOR DISCUSSION

Document Title:	**Care Quality Commission Inspection report and LAS action plans**
Report Author(s):	**Sandra Adams**
Lead Director:	**Sandra Adams**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Regulatory report on standards of care and safety within the LAS**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☐ Other
Recommendation for the Trust Board:	**To consider the findings of the compliance inspection and to agree the process for monitoring the action plans**

Key issues and risks arising from this paper

- CQC reviewed 6 standards, of which the Trust met four.
- Regulation 16, Outcome 11 – safety, availability and suitability of equipment – moderate impact – 'not all ambulances were equipped to meet the care needs of the people using the service'.
- Regulation 22, Outcome 13 – staffing – minor impact - 'the provider had failed to ensure that there were a sufficient number of suitably qualified, skilled and experienced persons employed to meet the demands placed on the service. This had led to delays in responding to calls for an ambulance and a reduction in staff achieving mandatory training updates'.
- Action plans have been prepared and submitted to the CQC on 4th January 2013 and, following discussion at the Executive Management Team on 16th January, the responsible directors have been asked to identify risks, blockages and any investment requirements by February.
- Risk 355, risk of staff not receiving clinical or mandatory training, pertains to Outcome 13; risk 362 pertains to the tracking of medical devices/equipment; and risk 303 to the unavailability of equipment.
- Media interest following the publication of the report on the CQC website, particularly on staffing levels.

Executive Summary

- The CQC undertook an unannounced inspection on 14th and 15th November. This included interviews with staff at HQ, observing call handling in the Control Room, and visiting two complex sites and meeting staff. The inspectors looked at personal care or treatment records and observed how people were being cared for and they talked to people using the service.

- They found that the service was facing a higher demand than it could meet, leading to delays in sending a vehicle response to less urgent calls. They also found that the service was experiencing difficulty in ensuring that each ambulance had appropriate equipment to meet people's needs.
- They also found that people using the service were satisfied with the care given.
- Regulation 16 – equipment: the action plan focuses on vehicle-based equipment, portable equipment and personal issue equipment. The key actions include completion of the asset tracking project and monitoring contractor compliance with the process and vehicle inventory management, and reviewing the supply of portable equipment. Actions are due for completion by 30th April 2013 and the plan identifies the potential risks to service users if this action is not completed.
- Regulation 22 – staffing: the recruitment plan is progressing for 2012/13 and will deliver a vacancy rate of <2% by April 2013; the final cohorts of student paramedics will provide more qualified paramedic staff to deliver patient care on completion of their training; the capacity review will inform the workforce plan and future recruitment requirements for the next 5 years. An A&E Resource group meets fortnightly to review progress against the plan. Resourcing levels will increase and this will have a positive impact over the coming months.

Attachments
Action plans for Regulations 16 and 22.
CQC inspection report previously circulated to Trust Board members and is published on the CQC website.

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

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

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

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

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

☒ That we fail to effectively fulfil 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 – in draft form and due to be reviewed for initial screening. Draft identified that there was no positive
☐ or neutral impact on any of the protected characteristic groups.
No

Key issues from the assessment:

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Report on actions you plan to take to meet CQC essential standards

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RRU
Our reference	INS1-514094890
Location name	London Ambulance Service NHS Trust
Provider name	London Ambulance Service NHS Trust

Regulated Activities	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	**Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety, availability and suitability of equipment**
	How the regulation was not being met:
	Ambulances were not all suitably equipped to meet the care needs of people using the service.
Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	

The Trust will ensure that appropriate equipment is provided on all front-line vehicles. Essential medical equipment can be separated into three key groups: vehicle-based, portable, and personal-issue.

1. Vehicle-based equipment

This is equipment which does not routinely move between vehicles. The Trust works to a defined list of 12 essential items (a copy of this is attached). Every item of equipment on the Trust's asset register that corresponds with this list is currently being brought into a barcode-based asset tracking system. This piece of work commenced in October 2012 and at the time of writing approximately 12,000 individual pieces of equipment had been barcoded and scanned for the first time. This represents roughly 85% of the total inventory. The project will not be complete until 100% of assets are brought into the system. This is due for completion by end of January 2013. Once this work is complete, a true dynamic picture of equipment allocation and lifecycle will be available across the Trust. This will assist in the identification of shortfalls, quality assurance of the equipment issue process and the holding to account of staff responsible for the equipping of vehicles.

The Trust's vehicle preparation contractor is primarily responsible for the proper provision of this equipment. The equipment is checked on a nightly basis as part of the vehicle preparation ('make ready') activities carried out by the contractor, Initial Healthcare. The implementation of the asset tracking system is the primary objective in this part of the contract. Once full implementation has been achieved then the Trust will move to a 'business as usual' phase of the contract in which the contractor will be expected to achieve 100% of the 12 essential items on every ambulance on every occasion. This will be monitored as part of the routine monthly KPI review.

2. Portable equipment

There are three key items of 'portable' equipment that are relevant.
- Blood glucose monitoring device ('BM kit')
- Tympanic (in-ear) thermometer
- Sphygmomanometer

At present these items are provided for staff in a vehicle-based equipment pack known colloquially as the 'red bag'. This pack also contains other non-clinical items including Airwave radio handsets.

- BM kits
The supply of this item of equipment is currently subject to a competitive tendering exercise. At the time of writing, responses have been received and an evaluation is due to take place in the first week of January 2013. Thereafter the Trust will conduct a one-month trial of selected devices with a view to implementation of the new product in March or April 2013. The evaluation of the responses to the tendering exercise will influence the long-term approach to this key item of equipment. However part of the decision-making process will consider whether to personally issue this item to every member of operational staff. This will include a cost-benefit analysis. Also open for consideration will be the introduction of a disposable BM kit, the adoption of which would ultimately discharge the question of how to manage the provision of this piece of equipment save for the need to ensure an adequate supply in stores.

- Tympanic Thermometer
The intention is to review the provision of this device in line with the outcome of the BM kit tendering exercise. If the decision is made to personally issue BM kits to all staff, this will in turn shape any decision on the future supply of thermometers. Whilst the two items perform different roles, their comparable size, functionality and importance as diagnostic devices mean it is sensible to treat them on a similar basis from a Logistics perspective. Therefore a decision will be taken by the end of April 2013, in line with the conclusion of the BM kit tendering exercise.

- Sphygmomanometer
The clinical audit process does not indicate any particular shortage of this item of equipment. As well as being provided as a portable item it is also available on ambulances as an accessory to the Lifepak 12 or Lifepak 15 defibrillator and monitoring devices. Nonetheless its supply will also be reviewed in conjunction with the Thermometer and BM Kit as previously noted.

- Pulse oximeter
At present there are two types of pulse oximeter in use within the Trust. A standalone “Nonin” finger probe, suitable for most patients except the very young, is in use on most of the Trust’s Fast Response Units (FRUs). A separate device which connects to the Lifepak 12 or Lifepak 15 defibrillator / monitor is in routine use on the ambulance fleet. All vehicles carry an adult finger probe and some additionally carry a paediatric device. The Trust has recently committed to the purchase of new combined adult / paediatric “Nonin” devices to be supplied to all ambulances in the Fleet. This will take place across the final quarter of 2012/13. Once implemented, the new device will be added to the asset tracking scheme and will become subject to the scrutiny outlined in the previous section.

3. Personal-issue equipment
The only item of personal-issue equipment currently in regular use is the stethoscope. Most items of equipment that staff carry amongst their personal kit are single-use items such as a laryngoscope. Consequently there is no current plan to review existing items

of personal-issue equipment; however as previously noted, some additional items may be added to the personal-issue manifest as reviews are conducted.

Summary of key actions

- Complete implementation of asset tracking project (by end of January 2013)
- Begin to monitor contractor's compliance with asset tracking process and vehicle inventory management (from February 2013)
- Review portable equipment supply (April 2013)

Who is responsible for the action?	ADO Fleet & Logistics
How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place?	

1. Implementation of asset tracking project.
   There is a dedicated project manager overseeing the implementation of this work by the contractor. The project manager conducts weekly project review meetings where the contractor is scrutinised on its progress. This has shown itself to be an effective method of holding the contractor to account for delivery.

2. Monitor contractor's compliance with asset tracking process and vehicle inventory management.
   The Trust already employs a dedicated Contract Manager overseeing the Vehicle Preparation contract. This individual already holds the contractor to account successfully in respect of those elements of the contract that are already fully implemented. In addition, KPIs are already reported monthly to the Trust Senior Management Group and board with full commentary, facilitating proper scrutiny and transparency. Once asset tracking becomes a 'business as usual' activity, operational managers will have routine access to a Management Information portal enabling them to monitor the supply and turnover of equipment relevant at local level.

3. Review portable equipment supply
   Any review will be a multi-disciplinary exercise involving key colleagues from Operations, the Medical Directorate and Education & Development, amongst others. The Purchasing Department will provide expert input in respect of the procurement and contractual aspects. Once any changes have been made, critical reviews at 3, 6 and 12 month stages will verify that any planned improvements have been achieved. Direct feedback from operational staff will additionally inform the process of review.

Who is responsible?	ADO Fleet & Logistics
What resources (if any) are needed to implement the change(s) and are these resources available?	

There is no foreseen requirement for additional resources at this stage. The review of the supply of BM Kits and thermometers may indicate a requirement for investment beyond the current level and if this is the case, an appropriate case for funding will be prepared and submitted for approval.

Date actions will be completed:	By end of April 2013
How will not meeting this regulation until this date affect people who use the service(s)?	
There is a risk that a) a complete diagnosis or b) the full range of possible interventions may be compromised by the absence of items of equipment. Nonetheless the occurrence of incidents relating to the unavailability of equipment is minimal and the management of equipment is demonstrating consistent improvements. The action plan detailed above is one part in a range of measures in Logistics designed to maintain an excellent standard of care.	
Completed by (please print name(s) in full)	EDWARD POTTER
Position(s)	Assistant Director of Operations – Fleet & Logistics
Date	31st December 2012

Regulated Activities	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing
	How the regulation was not being met:
	The provider had failed to ensure that there were a sufficient number of suitably qualified, skilled and experienced persons employed to meet the demands placed on the service. This had led to delays in responding to calls for an ambulance and a reduction in staff achieving mandatory training updates.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1. We continue to progress our recruitment plan for 2012/13. This is on track to deliver a vacancy factor of under 2% by April 2013.

2. We are currently completing the final cohorts of our Student Paramedic training which will reduce and ultimately remove the high abstraction levels resulting from this training by quarter 4 and provide more qualified paramedic staff to delivery of patient care.

3. We are currently undertaking a full capacity review. The outcome of this will inform the workforce plan and future recruitment requirements for 2013-2018.

Who is responsible for the action?	Director of Workforce

How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place?

We have an "A&E Resources Group" chaired by the Director of Workforce which meets every 2 weeks to track progress against the above.

The workforce plan (with associated recruitment and training plan) for 2013 – 2018 will reflect the outcome of the comprehensive capacity review specifically modeling workforce requirements with demand to ensure provision of resource against expected demand is sustainably achieved.

Who is responsible?	Director of Workforce

What resources (if any) are needed to implement the change(s) and are these resources available?

Actual resources required will be determined and reported through the capacity review. This review is jointly owned by the LAS and our commissioners and will inform the commissioning discussions for next year and beyond.

Date actions will be completed:	1. April 2013 2. March 2013 3. Workforce plan will be developed by March 2013 with implementation on-going thereafter

How will not meeting this regulation until this date affect people who use the service(s)?	
As reported in the CQC report this currently has minor impact. Resourcing levels will increase prior to the completion dates identified and therefore this impact is likely to improve prior to these dates.	
Completed by (please print name(s) in full)	Caron Hitchen
Position(s)	Director of Workforce
Date	28 December 2012

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London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH JANUARY 2013

PAPER FOR DISCUSSION

Document Title:	**2013/14 business plan**
Report Author(s):	**Sandra Adams**
Lead Director:	**Sandra Adams/Andrew Grimshaw**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To advise the Trust Board of the process for the development, approval and submission of the 2013/14 business 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:	To understand the 2013/14 business planning process and the support and sign off required by the Trust Board through to final submission on 5th April 2013

Key issues and risks arising from this paper

The NTDA have published the planning and technical guidance for the preparation and submission of the 2013/14 business plans. The attached document summarises the planning guidance. Key issues are:

- The outcome of the capacity review in terms of commissioner investment and the level of efficiency required by the Trust over and above the national 4% efficiency to meet any gap: using all efficiencies delivered as part of the ORH capacity review to support the cost of this seriously limits the Trust's ability to deliver the national savings requirement of 4 percent.
- Achieving successful contract outcomes for 2013/14 within the required timeframe.
- Ensuring consistency with the Integrated Business Plan and Long Tem Financial Model – the NHS Trust Development Authority require 2013/14 plans to reflect the 1st year of the longer term strategy.
- Sign off by the Medical and Nursing directors on the workforce plan, CIPs; assessment by them of the quality and productivity plans; presentation by them to the Board of the quality impact assessment of the 3 plans referred to here, in public, for consideration and endorsement.
- 1st cut submission to the NHS Trust Development Authority (NTDA) by 25th January to include: workforce plans, financial plans, planning checklist (self assessment of compliance), and an overarching presentation.
- Final submission by 5th April 2013. Trust Board approval on 26th March.

Executive Summary

The planning guidance sets out the expectations for Trusts to deliver a **fully integrated plan**

focussing on high quality services, living within resources available, and creating business processes to underpin future sustainability, in the medium-long term as well as the year ahead.

Trust Boards will fully endorse the plans submitted for 13/14 which are underpinned by proper clinical governance processes and represent absolute commitment from the Trust to deliver in 2013/14 and beyond.

The Board should note in particular the three clear focus areas of quality, delivery and sustainability as outlined on page 1 of the summary document. Four sections then follow on the content of the integrated plan: high quality services; core standards; workforce; and finance. Underpinning this are the contract system and CQUINs.

The Trust is asked to identify 5 key areas of delivery where there is significant variation from the top performers in the NHS. The 5 proposed areas that would then be signposted in the strategies can be linked to the CQC outcomes, the staff survey and to feedback from patients/service users and from our staff. For example: organisational culture – high morale linked to high quality service provision and outcomes as evidenced by the CQC report for December 2012, and from the annual staff survey; also signposting staff engagement and communication; commitment to training thereby equipping our staff with the skills they need to provide high standards of care. Using clinical quality indicators to benchmark where we need to improve the standard of care for urgent/category C patients. Using the CQC outcomes and regulations to confirm where we know there to be issues such as not having the right equipment in the right place at the right time to do the job required and then ensuring that where we have committed to take action, we see this through and are able to evidence the impact. We also need to recognise that some of these issues can be improved within the coming year however some areas, such as organisational culture, take more time to develop and take effect and we need to commit to such a programme over the strategic period.

We are also asked to identify 3-6 areas of high priority support and development needs. This is likely to be based on the board and senior management development programme that supports delivery of the Trust's strategic goals over the next 5 years.

The 1st cut submission is being submitted on 25th January and the high level/key messages within this will be discussed with the Board on 29th January.

Attachments

Summary of NHS Trust Development Authority Business Planning Guidance

****

Quality Strategy

This paper supports the following domains of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

☒ That we fail to effectively fulfil 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 however this will be undertaken on the final draft of the 2013/14 business plan.

Key issues from the assessment:

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Summary of TDA 2013/14 Planning Guidance: Towards High Quality, Sustainable services

Sets out the expectations for Trusts to deliver a **fully integrated plan** focussing on high quality services, living within resources available, and creating business processes to underpin future sustainability, in the medium-long term as well as the year ahead.

Governance: Trust Boards will fully endorse the plans submitted for 13/14 which are underpinned by proper clinical governance processes and represent absolute commitment from the Trust to deliver in 2013/14 and beyond. [Trust Board 29th January and 26th March]

'A relentless focus on consistently delivering core standards, improving the quality of services provided and creating sustainability through sound finance and business planning.'[1]

Clear expectations that there will be an integrated approach to planning that combines the following 3 key focus areas:

- **Quality** – agreed CQUIN schemes will be delivered in full and the basic standards on quality adhered to: the rights and pledges within the NHS Constitution; the Mandate to the NCB; and the NHS Outcomes Framework 2013/14. The new National Quality Dashboard will incorporate all of the key indicators that the Trust Board should be monitoring to ensure 'that they are attaining the high levels of quality needed to deliver against the standards set out in the *NHS Constitution* and their progress towards delivering against the '*NHS Outcomes Framework*.' Add to this the *Quality Governance Framework*. [2]
  These three things are designed to help the Trust Board deliver high quality services for patients and their communities.
- **Delivery** – all core standards are met and all contracts delivered in full.
- **Sustainability** – the Trust shows an improvement trajectory for surpluses and financial risk ratings for 2013/14 linked to the overall LTFM medium to long term financial plans.

Plans for 2013/14 must show a clear strategy to deliver against each of the key areas of quality, finance and performance, wrapped up in the medium to long term plan outlining the improvement process we will deliver against to achieve FT status.

1. Delivering an integrated plan: high quality services (page 12):- delivering the standards within the NHS Constitution; the NHS Outcomes Framework and the Quality Governance Framework. [Steve Lennox/Fionna Moore]
Leadership for quality – Board members should be actively engaged on quality with strong governance systems underpinning this. Plans will need to show evidence that the Trust can deliver:

- A **coherent clinical strategy** supporting the provision of high quality care. [requires TB sign off on 29th January 13]
- Evidence of a culture that promotes safety; with evidence of improvement in services for patients and the support for staff [reference RSM Tenon Quality Governance Framework. report from August 12]

[1] NHS Trust Development Authority – Towards High Quality, Sustainable Services: planning guidance for NHS Trust Boards for 2013/14
[2] See final page for links to relevant documents

- Evidence of the assessment of quality and productivity plans, CIPs and workforce plans by the Medical and Nursing directors; presentation of their (the directors) quality impact assessment to the Board in public for consideration and endorsement. [TB 29th January and 26th March; Quality Committee 20th February]
- A commitment to supporting prevention.

Every NHS Trust is expected to identify 5 key areas of delivery where it significantly varies from the top performers and to set out an improvement plan to bridge the gap in the coming year. The National Quality Dashboard will allow the Trust to look at variation and trends and to benchmark with peer organisations and to intelligently use available data to identify areas for improvement. The TDA will work with us (ambulance trusts) to identify quality indicators that demonstrate effective and safe services that meet patients' expectations. [TB 26th March]

2. Delivering an integrated plan: core standards (page 15):- all plans are expected to show credible and clear approach to delivering against all pre-existing operational performance standards: Cat A8 and 19 for us. Where failing to deliver core standards, the Trust will be expected to have an improvement plan with clear timescales agreed for implementation and delivery. [TB 29th January and 26th March] [Paul Woodrow/Jason Killens]

3. Delivering an integrated plan: workforce (page 17):- a motivated workforce, clear about the organisation's objectives and with a defined role to play in delivering better care, will help to ensure high standards. The Trust is expected to have the processes in place to ensure staffing levels are sufficient to deliver safe, high quality and cost effective care. [Caron Hitchen/Paul Woodrow]

The Trust Board is expected to be able to assure the TDA that:

- They have approved the workforce plan, including the period 2013/14
- The workforce plan has been approved by the Medical and Nursing directors prior to sign off by the Board [TB 29th January and 26th March]

For other workforce assurance requirements, see the Schedule.

Staffing levels, appropriate training, clarity on the Trust's objectives and purpose are intended to help staff have confidence in their work to improve patient care. National staff survey outcomes will be featured in the TDA's performance indicators.

Health Education England will be using NHS provider workforce plans to inform their programme of work and will be responsible for 'ensuring that education, training and workforce development drive the highest public health and patient outcomes.' These **education and training priorities** are to be incorporated into the Trust's plan. [Workforce and OD strategy for sign off by TB on 29th January]

The TDA's expectation is that we can demonstrate through our plans that we are managing the workforce in a way consistent with commissioning requirements and internal savings plans, and that all workforce plans have been '*quality assured for their impact on patient care and endorsed by the Medical and Nursing directors who must confirm that the clinical staffing profile is commensurate with the delivery of safe care.'*

The **national workforce assurance tool** will be rolled out later in 2013 so the Trust is required to familiarise itself with this.

4. Delivering an integrated plan (page 18): finance:- the operating plan for 13/14 and the planned surplus must be consistent with the LTFM and the Trust must have a defined and measurable improvement trajectory in line with the IBP. [IBP and LTFM to TB 26th March] [Andrew Grimshaw/Amanda Cant/Ambreen Mahmood]

- Provider efficiency requirement in the tariff is -4% and pay and prices confirmed at 2.7% giving a net tariff deflator of -1.3% forming the base case assumption for discussion on non-tariff services. The change for tariff services will be -1.1%.
- CQUIN is set at 2.5% of contract value and once agreed with the commissioner is expected to be fully implemented.
- The TDA expects NHS Trusts to implement changes to the scope and structure of business rules in the PbR guidance for 13/14 (subject to provisions of the NHS PbR code of conduct).
- Where an NHS Trust is being reimbursed at less than 100% of the national tariff it is expected that they will be engaged in reinvestment decisions which are intended to be jointly owned by providers and commissioners from 13/14.
- Integrated plans need to include outputs from 2011/12 to 2014/15 so as to put 2013/14 plans into context.
- 3 main factors driving efficiency requirements: tariff deflator; commissioner QIPP schemes in excess of the tariff deflator; and internal Trust factors including costs in excess of inflation funding in the tariff and any undelivered efficiency brought forward from previous years.
- Capital plans will be an update on plans agreed in 12/13 reflecting any changes in the overall strategy or affordability that would lead to changes in the previously agreed plan.
- Cash requirements will be identified in the LTFM and financial plans should be consistent with the cash position.
- QIPP end state needs to be well described.
- Clear clinical sign off process for the CIP.

NHS Trusts will be expected to comply with some FT provider license conditions from April 2013. Probably the following: conditions on pricing – providing data to support the development of the tariff prices and comply with broader tariff rules; and conditions on choice, competition and integration ensuring a consistent approach across the sector. We will need to understand more about this from the TDA as to how it will apply to the LAS. (page 11)

5. Contract and payment system (page 22): it is recommended that, to provide stability, providers and commissioners agree a contract extension of 18 months from the date of FT authorisation. [Jason Killens/Sonia Blackwood/Amanda Cant]

- Assessment and mitigation of in-year risk will be key to delivering high quality and sustainable care in 13/14 so each contract must articulate a risk management strategy. The TDA will provide a checklist to use in the contracting process when assessing the requirements of commissioner QIPP and other key areas of risk assessment and mitigation.
- Contracts must be signed by 31st March 2013.
- No NHS Trust should plan for failure and therefore should not plan for application of any mandatory penalties.

[TB 26th March; Finance & Investment Committee 15th January & 12th March]

6. CQUINS (page 23): the value to be earned in 13/14 remains 2.5% on top of the value of all services commissioned through the NHS Standard Contract. One fifth of CQUIN payment (0.5%) will be in line with national goals on:

- Friends and family test – this won't apply to us so we may be commissioned to demonstrate regular feedback from patients.
- Improvement against NHS Safety Thermometer – ambulance services are excluded from the NST survey.
- Improving dementia care.
- Venous thromboembolism (VTE) – see above re NST.

Provider financial plans need to include the income expected from CQUIN and any associated costs with delivering the schemes. Schemes need to be well defined. [Jason Killens/Steve Lennox/Emma Williams]

Reference also made to Innovation, Health and Wealth and becoming active partners in Academic Health Science Networks. This will need to be discussed with the TDA as to how it might apply and where we would fit in.

7. Support and development (page 24) – each Trust is asked to identify 3-6 high priority support and development needs that are required to achieve their goals. The TDA will then work with Trusts during 13/14 to ensure these needs are met. [Sandra Adams/Caron Hitchen/Ann Radmore]

Support may be available through the NHS Leadership Academy, the Improvement Body, clinical networks and senates, peer support and access to expertise for example.

References:

NHS Constitution http://www.dh.gov.uk/health/search?q=nhs%20constitution

Mandate for the National Commissioning Board
https://www.wp.dh.gov.uk/publications/files/2012/11/mandate.pdf

NHS Outcomes Framework 2013/14
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131700

National Quality Dashboard – nothing yet available but browsing DH and National Quality Board pages may be helpful

Quality Governance Framework http://www.monitor-nhsft.gov.uk/our-publications/browse-category/guidance-foundation-trusts/mandatory-guidance/quality-governance-fr

Health Education England http://www.dh.gov.uk/health/2012/06/introducing-hee/

Innovation, Health and Wealth, DH 2011
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131299

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH JANUARY 2013

PAPER FOR APPROVAL

Document Title:	**Clinical & Quality Strategy**
Report Author(s):	**Fionna Moore and Steve Lennox**
Lead Director:	**Fionna Moore and Steve Lennox**
Contact Details:	**Patricia.turner@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**This is a key strategy for the period 2013-2018 requiring approval from the Trust Board**
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: Trust Board – August 2012; and joint SMG/ADG workshop in November 2012
Recommendation for the Trust Board:	To approve the strategy

Key issues and risks arising from this paper

The strategy presented to the Trust Board reflects the key clinical quality priorities at the current time and replaces the former Quality Strategy. This Clinical and Quality Strategy outlines how our care and treatment will support the realisation of our vision and our five year strategy.

Executive Summary

The Clinical and Quality Strategy outlines how our care and treatment will support the realisation of our vision and our five year strategy. It uses the 2011 National Commissioning Board publication "Our Culture of Compassionate Care – Creating a Vision for Nurses, Midwives and Care Staff" as a framework. This document, whilst not necessarily written specifically for paramedics, has relevance in that it appeals to all professions where care is a key clinical intervention.

The document identifies six core values or behaviours that are essential in order to deliver a high standard of care. These are:

- Care
- Compassion
- Competence
- Communication
- Courage
- Commitment

These are closely aligned to the critical values of the Trust and we will consider how we can promote these within the delivery of the Clinical & Quality strategy.

The publication identifies six areas where it is necessary to commit further action in order to make a

difference. These are:

- Helping people to stay independent, maximising wellbeing and maximising outcomes.
- Working with people to provide a positive experience of care.
- Delivering high quality care and measuring impact.
- Building and strengthening leadership.
- Ensuring we have the right staff, with the right skills, in the right place.
- Supporting positive staff experience

The Clinical and Quality Strategy uses these six areas as themes for the specific objectives.

These elements apply to all our core services, whether it be patient transport services, call handling, urgent care or our main accident and emergency service. Our ability to deliver in these six elements will also guide our decisions on whether to venture into new territory such as delivering 111 services. We simply aspire to be the best in all that we do.

The Clinical and Quality Strategy is supported by the other enabling strategies but with a particularly strong relationship with the workforce strategy. The need to ensure we have the very best work force is an essential component to being a world leader in pre-hospital care.

Attachments
None – presentation to be given

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Quality Strategy
This paper supports the following domains of the quality strategy
All are supported
☐ Staff/Workforce
☐ Performance
☐ Clinical Intervention
☐ Safety
☐ Clinical Outcomes
☐ Dignity
☐ Satisfaction

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

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

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

☒ That we fail to effectively fulfil 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
☒ Not at this stage
Key issues from the assessment:

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29 JANUARY 2013

PAPER FOR INFORMATION

Document Title:	**Chief Executive Report**
Report Author(s):	**Ann Radmore**
Lead Director:	**N/A**
Contact Details:	**-**
Why is this coming to the Trust Board?	**To update the Board on key developments affecting the Trust**
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 ☐ Other
Recommendation for the Trust Board:	That the Board note my report
Key issues and risks arising from this paper	
Executive Summary - not required	
Attachments - 3 page briefing	

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

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

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

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

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

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

Equality Impact Assessment

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

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING 29 JANUARY 2013
CHIEF EXECUTIVE'S REPORT

1. Service Delivery issues

Capacity Plan and 13/14 contract

The ORH capacity plan is now finalised and will be moving into the next stage which is contract negotiation for 2013/14. There will be intensive negotiations over the next month with a target date for contract signature by the end of February.

The key balancing assumptions are that the LAS embraces the key issues of efficiency and workforce modernisation and the commissioners are able to invest sufficiently to enable the LAS to modernise and sustain the new model and demand.

Performance in Q4

The service needs to respond to a challenging position for the final quarter to ensure safe and consistent service across London.

Additional short term funding of £6.2m has been provided by commissioners to enable the service to put more capacity in the control room and a significant amount out on the road. There is a strong focus on utilising this funding to ease the pressure on the service, reduce risk and delivery of the 75% target.

Helicopter crash in Vauxhall

On 18th January the service responded to an incident in Vauxhall where a helicopter crashed resulting in two fatalities. The staff at the incident responded in an exemplary way whilst the rest of London continued to receive a strong response across the period.

2. Priority Focus

The Board has been advised over 12/13 on the key priorities identified as Trust Board, SMG and business as usual priorities.

The Executive Management Team (previously known as SMG) has identified key priorities for the last three months of this financial year as:

EMT PRIORITIES FOR Q4 (Updated 16 Jan 13)	
Priority	**Dir Lead**
Clinical Safety and Hitting 75%	FM/PW/JK
Delivering 12/13 Finances inc CQUINS	AG
Contract for 13/14 inc CQUINs and LTFM	JK
13/14 Business Plan inc IBP	SA
Budget setting for 13/14	AG
Achievement of FT milestones	SA
Workforce Modernisation Plan - Prep Work	CH
Bow to Go Live (East)	PS
Strategic Comms Plan	AP
Understanding of commissioning	AR
Strategic Networking Plan	JC
Revised Management Structure	AR
Asses Implications of Francis Report	SL
Preparation for TSA Decision	JK
EMT Phase 1 Development	All plus HealthSkills
Board Phase 1 Development	SA
Scoping Transformation Programme	AR plus EMT

3. National/Policy issues

3.1 Everyone counts: Planning for Patients 2013/14. Since the last board meeting the National Commissioning Board has issued its planning guidance for 2013/14.
http://www.commissioningboard.nhs.uk/everyonecounts/

The NHS Confederation summary identifies key issues
http://www.nhsconfed.org/priorities/latestnews/Pages/NHS-Commissioning-Board-planning-guidance-201314-our-reaction.aspx

And the 5 "offers"

1. Move toward seven-day a week working for routine NHS Services
2. Greater transparency and choice for patients
3. More patient participation
4. Better data to support the drive to improve services

5. Higher standards and safer care will be of relevance to the service as we develop plans for 13/14 and beyond.

3.2 Review of Urgent and Emergency Services

The NCB has launched a review of urgent and emergency services in England to be led by Sir Bruce Keogh, Medical Director. The review will report in Spring 2013.

4. Healthcare Delivery change in London

The Trust special administration has now reported to the Secretary of State for Health on the South London hospital situation. This report recommends a series of changes including Queen Elizabeth Woolwich and Lewisham operating as one Trust and the closure of A & E and maternity services. The LAS contributed to consultation highlighting predicted effects to our service.

Ann Radmore
Chief Executive

21 January 2013

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London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29 JANUARY 2013

PAPER FOR INFORMATION

Document Title:	**London Ambulance Service 2012 Post-Games Report**
Report Author(s):	**Anna Parry, Lyn Sugg, Peter Thorpe**
Lead Director:	**Martin Flaherty, Jason Killens**
Contact Details:	**anna.parry@aace.org.uk /07785 243 992**
Why is this coming to the Trust Board?	**For information as requested by the Trust Board.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Finance and Investment Committee ☒ Other
Recommendation for the Trust Board:	**To note the report**

Key issues and risks arising from this paper

N/A

Executive Summary

1.1 Introduction

London was awarded the 2012 Olympic and Paralympic Games on 6 July 2007. The London Ambulance Service NHS Trust (LAS) supported London's 2012 Games Bid prior to its award, and planned and delivered high quality emergency medical services to the Games and the rest of London in summer 2012. The LAS also contributed to the safety and security of the 2012 Games operating within a multi-agency environment both before and during Games-time.
To ensure the organisation was fully and robustly prepared, an Olympic Games Planning Office was formed in 2007 and a comprehensive five-year programme initiated: the London 2012 Olympic and Paralympic Programme. The Office of Government Commerce Projects in a Controlled Environment 2 (PRINCE2) and Managing Successful Programmes (MSP) methodologies were used.

1.2 Objectives

- To deliver an appropriate level of care for all the local communities and Olympic and Paralympic related patient populations during the 2012 Games
- To be an active partner in the planning and delivery of a safe and secure 2012 Games

The overarching requirement on the Organising Committee of the Olympic Games in relation to

medical provision (as cited in the International Olympic Committee (IOC) Olympic Games Medical Services, Technical Manual, November 2005) was to:-

'ensure that the level of medical services to the community is not compromised during the Games-time. Capacity issues must be addressed during the planning phases to ensure optimal use of community-based health resources and appropriate level of care for the community and Olympic related patient populations.'

This also underpinned the LAS's 2012 Games Programme.

1.3 Key products/deliverables

The key products planned for and delivered during the Olympic Programme were:-

- Command and control structure: internal and external
- Operational and contingency plans with corresponding testing and exercise programme
- 220 pre-planned aid (PPA) staff from English ambulance services accredited and trained and a comparable number of LAS staff
- 2012 Games training programme: operational; event management; communications delivered to 2012 Games cohort (500+)
- Olympic Deployment Centre (ODC) including catering and transport to venues
- Information Management and Technology infrastructure: Event Control Room (mandate was in part 2012 Games); Forward Command Points in all 2012 Games venues; Olympic Deployment Centre; Olympic Information Unit
- Sixty-six fully equipped additional ambulances
- Accommodation for PPA staff including catering, welfare and transport to/from ODC

1.4 Games-time Operations

The LAS, supported by other English ambulance trusts, delivered emergency medical services to spectators and athletes in 2012 Games venues within river, central, park and urban zones. Simultaneously, a high level of service delivery was achieved across London.

The LAS successfully fulfilled its role as a key partner in delivering a safe and secure 2012 Games. During Games-time, it had significant input into the 'Health' response to the National Olympic Co-ordination Centre working with other ambulance services to provide a 24-hour-a-day Health response to national Command, Control and Co-ordination. This involved representation on all safety and security issues whilst working with the Department of Health (DH) 2012 Games Response Cell and the National Ambulance Coordination Centre.

1.5 Key Legacy Benefits

The legacy impact of the LAS's planning for and participation in the 2012 Games is far-reaching and extensive. The key legacy benefits identified are outlined below:-

- **PPA:** relationships with other trusts have been enhanced significantly during the 2012 Games. English ambulance services successfully demonstrated their ability to competently provide emergency medical services together. This has enhanced the services' combined capacity to respond to planned and unplanned events in the future.
- **Multi-agency working:** relationships were enhanced considerably with other emergency services, health services and Local Authorities throughout the planning and delivery stages of the 2012 Games. This strengthening will improve future multi-agency working providing an effective model for partnership-working for both short and sustained periods of activity.
- **Training delivery:** this was commended by PPA and LAS staff, who felt that they embarked upon their respective Games-time roles fully prepared and well-trained. This will be of benefit to staff in their business-as-usual posts at their respective trusts.
- **Event Control:** although this was not part of the LAS's Olympic Programme, its development was necessary for the 2012 Games. It was therefore an important enabler and its production was a key interdependency. This fully tested facility is now available for the

management of all planned and unplanned major events in the capital.

- **Venue design:** LAS input was made into all the new venue designs for the 2012 Games with public health and emergency service requirements factored into planning. This provides a legacy benefit for those venues that will be remaining in use.
- **Staff morale:** feedback from staff about their participation in the 2012 Games was almost without exception positive. LAS and PPA staff embraced the opportunity to be involved in a once in a lifetime event and approached it with professionalism and commitment.
- **Commissioning:** once an approach to commissioning had been determined and a framework agreed, the relationship between the LAS and its commissioners, in addition to NHS London and the DH, was proactive and positive. Funding requirements were outlined, challenged, refined and ultimately met.
- **Working differently:** non-operational support staff and managers were given the opportunity to undertake new roles in different working environments; they proved themselves highly motivated and capable, enhancing organisational capacity for the future.

Attachments

None. A presentation on the key elements of the report will be given at the Trust Board on 29th January. The full report is available on request – please email francesca.guy@lond-amb.nhs.uk

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Quality Strategy

This paper supports the following domains of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

☒ That we fail to effectively fulfil 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:

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London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH JANUARY 2013

PAPER FOR REVIEW

Document Title:	**Foundation Trust project**
Report Author(s):	**Sandra Adams**
Lead Director:	**Sandra Adams**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To advise the Trust Board on progress against the key milestones in the foundation trust application**
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. To review the progress against the key milestones towards achieving foundation trust status in 2014; 2. To confirm that board members will give their time and commitment to the process.

Key issues and risks arising from this paper

- On schedule against the milestones agreed in the accountability agreement and Tripartite Formal Agreement (TFA).
- Key documents for Board approval this month are: strategies for Clinical Quality, Workforce and Estates.
- Progress against the 2012/13 Board Governance Assurance Framework (BGAF) action plan is monitored monthly and 7 out of the 12 areas are now complete. KPMG commence the refresh review in February 13.
- The board development programme is on schedule and work continues with Healthskills to develop the Board, executive and senior management teams.
- Monthly single operating submissions are made to NHS London and we will continue to be Red RAG rated until April 13 as the TFA is not yet signed by the NTDA. The Board should note that this has been signed off by the cluster and had been reviewed by NHS London ready for sign-off before the process changed. Sign-off will take place once the 2013/14 business planning and contract process is completed.
- Contract negotiations for 2013/14 are underway and will inform the next draft of the Integrated Business Plan (IBP) and Long Term Financial Model (LTFM) which will be brought to the Trust Board for approval on 26th March 2013 prior to submission to the NHS Trust Development Authority.
- The Foundation Trust project supports the application process and the governance arrangements are being updated to reflect changes to the Trust Board and to external stakeholders who will need to be engaged in the process.
- The Trust is aiming for formal submission to the NHS Trust Development Authority (NTDA) in October 2013 and onward submission to Monitor in December 2013.

- Key issues and risks include the capacity of the executive management team to manage the timeline over the next 3 months alongside the 2013/14 contract negotiations and business planning submission, all of which occur simultaneously and inform the longer term strategy and the application.
- Alongside these activities we will be managing the refresh reviews for Board and Quality Governance and the 1st stage due diligence governance review.
- Substantial board time and individual board member time and commitment is required to support this process through to a successful application.

Executive Summary

The LAS is commencing a new application to become an NHS foundation trust following its review meeting with NHS London and the NTDA in December 2012. Over the next 3 months the Trust has key milestones to achieve in terms of 2013/14 contracts and business planning, the 5-year IBP and financial model and associated documents, and independent assessment on board governance, quality governance and 1st stage due diligence governance review.

The board development programme continues and is being overlaid with the external programme led by Healthskills which is aimed at developing the Board, executive management and senior management teams as future leaders of the LAS as an NHS foundation trust.

Arrangements are being finalised with the three external consultancy firms who will be undertaking board and quality governance refresh reviews and 1st stage due diligence. These will require individual board member time and this is to be scheduled in for February and March.

The Trust Board will receive presentations on the Clinical Quality, Workforce and Estates strategies, building on the strategic direction approved by the Board in August 2012, for approval.

A new Project Initiation Document is being drafted for approval by the Executive Management Team in February taking into account a new FT application and new Board members and external stakeholders.

In summary, the Trust is on track against the key milestones outlined in the attached document. Board members will need to give their support, time and commitment to the process to ensure the Trust succeeds with its application in late 2013.

Attachments

FT accountability agreement – deliverables – January 13

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Quality Strategy

This paper supports the following domains of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

☐ That we fail to effectively fulfil 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 – an EA was undertaken on the previous IBP. This will need to be refreshed once the next version is drafted.

Key issues from the assessment:
No positive or adverse impact identified.

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FOUNDATION TRUST ASSURANCE				Executive team responsibility	Governance
Development Phase					
SHA introductory meeting with Trust to agree entry into FT Pipeline (**Gateway 1**)	**12/13**	**Q3**	**7/12/12**	**SA**	
TFA Governance Arrangements agreed by Trust Board	**12/13**	**Q3**	**27/11/2012**	**SA**	**Trust Board**
BGAF Self Assessment completed by Trust in 2011/12 and independently assessed. Action plan implemented – see below.	**12/13**	**Q3**	**20/11/2012**	**SA**	**Trust Board** **SMG**
BGAF action plans developed and agreed by Trust Board – ongoing monitoring	**12/13**	**Q4**	**January 13**	**SA**	**Trust Board 29/1/13**
Board Development and Performance Monitoring Programme agreed by Trust Board – ongoing monitoring	**12/13**	**Q4**	**January 13**	**SA**	**Trust Board 29/1/13**
Trust Self Assessment against Monitor's Quality Governance framework complete and agreed by Trust Board - ongoing	**12/13**	**Q4**	**January 13**	**SL**	**Quality Committee 20/2/13**
Quality governance action plans developed and agreed by Trust Board - ongoing	**12/13**	**Q4**	**January 13**	**SL**	**Quality Committee 20/2/13**
Clinical/Quality Strategy approved by Trust Board	**12/13**	**Q4**	**January 13**	**FM/SL**	**Trust Board 29/1/13**
Estates Strategy approved by Trust Board	**12/13**	**Q4**	**January 13**	**SA**	**Trust Board 29/1/13**
Workforce and OD Strategy approved by Trust Board	**12/13**	**Q4**	**January 13**	**CH**	**Trust Board 29/1/13**
Service Contract agreed between Trust and Commissioner	**12/13**	**Q4**	**March 13**	**JK**	**Trust Board 26/3/13**
Updated IBP, LTFM, Implied Efficiency, Initial CIP programme and initial downside modeling with mitigations and enabling strategies, ready for HDD1, to be sent to NTDA.	**12/13**	**Q4**	**March 13**	**SA/AG**	**Trust Board 26/3/13**

Consultation document approved by Trust Board	**13/14**	**Q1**	**April 13**	**SA**	**Review at SRP 30/4/13**
Response to consultation document approved by Trust Board	**13/14**	**Q3**	**September 13**	**SA**	
Membership strategy approved by Trust Board	**12/13**	**Q4**	**January 13**	**SA**	**Trust Board – 26/3/13**
Council of Governors, elections and appointment process developed and approved by Trust Board	**13/14**	**Q3**	**September 13**	**SA**	
Constitution updated	**13/14**	**Q3**	**September 13**	**SA**	
Monitor Board self certification assessment and action plans - Working Capital review, Board statement Clinical quality, service performance and Board Statement of quality governance Arrangements – this is monitored monthly through the SOM 2 oversight process	**12/13**	**Q2**	**Commenced August 12**	**SA/AR**	**Ongoing**
Assessment and Sign-Off Phase					
IBP – Formal submission to NTDA approved by Trust Board including supporting enabling strategies	**13/14**	**Q4**	**March 13**	**SA**	**Trust Board – 26/3/13**
LTFM - Formal submission to NTDA approved by Trust Board	**13/14**	**Q4**	**March 13**	**AG**	**Trust Board – 26/3/13**
Implied Efficiency submission to NTDA approved by Trust Board for Base Case and Mitigated Downside case	**13/14**	**Q4**	**March 13**	**AG**	**Trust Board – 26/3/13**
Initial CIP Programme submission to NTDA - 5 years, approved by Trust Board	**13/14**	**Q4**	**March 13**	**AG**	**Trust Board – 26/3/13**
Initial Trust Base Case assumptions and QIPP and approved by Trust Board	**13/14**	**Q4**	**March 13**	**AG**	**Trust Board – 26/3/13**
Initial Trust Downside assumptions modeled and approved by Trust Board including mitigations	**13/14**	**Q4**	**March 13**	**AG**	**Trust Board – 26/3/13**

BGAF Independent Supplier Report*	**13/14**	**Q1**	**April 13**	**SA**	**Trust Board – 26/3/13**
Trust BGAF action plan updated post independent review and approved by Trust Board	**13/14**	**Q1**	**May 13**	**SA**	**Trust Board – 4/6/13**
Independent Account HDD1 Report	**13/14**	**Q1**	**April 13**	**SA**	
Trust HDD1 action plan approved by Trust Board	**13/14**	**Q1**	**May 13**	**SA**	**Trust Board – 4/6/13**
Quality Governance Independent Review Report	**13/14**	**Q1**	**April 13**	**SL**	
Trust Quality Governance action plan updated post independent review and approved by Trust Board	**13/14**	**Q1**	**May 13**	**SL**	**Trust Board – 4/6/13**
Public Consultation - May to July 2013	**13/14**	**Q2**	**July 13**	**AP**	**Review – SRP 30/4/13**
NTDA Quality & Safety Gateway Review Start	**13/14**	**Q1**	**June 13**	**SL**	***TBC***
Formal submission of documents to NTDA to inform the Readiness Review meeting – IBP/LTFM/Implied Efficiency/CIPs/Downside & Mitigations/Independent Assessments and all enabling strategies.	**13/14**	**Q1**	**June 13**	**SA**	**Trust Board 25/6/13**
FT Readiness meeting (**Gateway 2**)	**13/14**	**Q2**	**July 13**		
NTDA agrees to the commencement of HDD2	**13/14**	**Q2**	**August 13**	**SA**	
Independent Accountant HDD2 Report	**13/14**	**Q2**	**August 13**	**AG/SA**	**Trust Board 24/9/13**
Trust HDD2 action plan developed and approved by Trust Board	**13/14**	**Q2**	**September 13**	**AG**	**Trust Board 24/9/13**
Commissioner convergence letter	**13/14**	**Q3**	**September 13**	**LB**	
Constitution- legal opinion obtained and approved by Trust Board – refresh just prior to submission to NTDA	**13/14**	**Q3**	**September 13**	**SA**	**Trust Board 24/9/13**
Monitor Board self certifications - Working Capital review, Board statement Clinical quality, service performance and Board Statement of quality governance Arrangements	**13/14**	**Q3**	**September 13**	**SA**	**Trust Board 24/9/13**
NTDA Quality & Safety Gateway Review End	**13/14**	**Q3**	**October 13**	**SL**	**SRP review 22/10/13**
IBP/LTFM/Implied Efficiency updated for NTDA B2B	**13/14**	**Q3**	**October 13**	**SA/AG**	

submitted to NTDA (**Gateway 3**)						
Gateway includes Final downside/mitigation modeling with CIPs and PIDs and Final CIP Programme with full PIDs for 24 month rolling programme; working capital review		**13/14**	**Q3**	**October 13**	**AG**	
NTDA Approval Phase						
Successful NTDA Board to Board (**Gateway 4**)	**13/14**	**Q3**	**Nov 13**		**RH/SA**	
NTDA governance processes to approve application (**Gateway 5**)	**13/14**	**Q3**	**Dec 13**		**SA**	

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29 JANUARY 2013

PAPER FOR DISCUSSION

Document Title:	**Update of Information Governance**
Report Author(s):	**Peter Suter**
Lead Director:	**Peter Suter**
Contact Details:	**02077832044**
Why is this coming to the Trust Board?	**To enable the board to obtain assurance on Information Governance**
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 ☐ Other
Recommendation for the Trust Board:	The Trust Board note the contents of this report and seek any further reassurances they require.

Key issues and risks arising from this paper

There are no specific risks identified. The Trust board need to satisfy themselves with the arrangements that are currently implemented.

Executive Summary

The objective of this paper is to provide an update on the current status of Information Governance within the Trust. It provides an overview of Information Governance, outlines the respective roles and responsibilities, provides details of the activities and progress made with areas that come under the term Information Governance, and details current priorities.

Attachments

Appendix1: IGG Terms of reference
Appendix 2: IGG Policies and Procedures.

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Quality Strategy

This paper supports the following domains of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

- ☐ Yes
- ☒ No

Key issues from the assessment:

TRUST BOARD 29 JANUARY 2013

UPDATE ON INFORMATION GOVERNANCE

1. INTRODUCTION

1.1 The objective of this paper is to provide an update on the current status of Information Governance within the Trust. It provides an overview of Information Governance, outlines the respective roles and responsibilities, provides details of the activities and progress made with areas that come under the term Information Governance, and details current priorities.

1.2 Information Governance is an umbrella term describing how the Trust provides a consistent, organised, and safe approach to the handling and management of corporate and personal information. It covers data quality, management and security. By necessity it includes the mandated requirements of the Caldicott principles, Information Security Management (ISO/IEC 17799 / ISO/IEC 27001), The Data Protection Act 1998, The Freedom of Information Act 2000, the Information Governance Toolkit and records management requirements (as defined by the CQC Essential Standards, the Public Records Act, and the DH Records Management Code of Practice).

2. THE LAS INFORMATION GOVERNANCE FRAMEWORK

2.1 Information Governance is managed on behalf of the Trust by the IGG (Information Governance Group); terms of reference are attached at appendix 1. Specific LAS roles and responsibilities for Information Governance are set out in the table below:

POSITION	RESPONSIBILITIES
CEO	Accounting officer*, the CEO has ultimate responsibility for Information Governance
Director of Information Management & Technology	SIRO* (Senior Information Risk Owner)
Medical Director	Caldicott Guardian*: responsible for issues related to patient confidentiality
Director of Corporate Services	All aspects of Governance & Compliance
Information Governance Manager	Information Governance Toolkit, Freedom of Information, Data Protection, Access to Health Records, Records Management and Data Quality.
Information Security Manager	Information processing systems against information security controls and technical controls.
Nominated Senior Managers	Information Asset Owners* (IAOs)
Nominated staff	Information Asset Administrators (IAAs) – support IAOs in the day to day management of Information Assets such as databases, and ensure policies and procedures are adhered to.
Nominated staff	Freedom of Information Act Coordinators.
All Staff	To work within the LAS policies & procedures for Information Governance.

These are mandated roles

2.2 The trust has developed a range of appropriate policies and procedures that cover all aspects of Information Governance. These are reviewed in a regular programme by the IGG and a full list is included at Appendix 2 of this paper.

3. TRAINING AND AWARENESS

3.1 A key component of effective information governance is training and awareness of staff and is a high priority for the trust. All new staff are provided with face to face training as part of their two initial Corporate Induction days. Information Governance is also included in the local induction checklist that is undertaken by managers with their new staff.

3.2 Additionally, all staff are required to complete either the 'Introduction to Information Governance' module if they handle personal information or the 'Information Governance: Beginners Guide' module of the Connecting for Health Information Governance Training Tool. Additional training is provided for specific roles such as the IAOs. A total of nearly 3,400 staff successfully passed these modules during 2011/12 and staff who completed their training a year ago are now undertaking the refresher module.

4. THE INFORMATION GOVERNANCETOOLKIT.

4.1 The Information Governance Toolkit is a performance tool produced by the Department of Health (DH) that is revised and reissued each year. It draws together the legal rules and central guidance as a set of information governance requirements. Each NHS organisation is required to carry out self-assessments of their compliance against the IG requirements that are compliance audited by the Internal Auditors. The target is to achieve a compliance of at least 75%, maintaining Level 2 for each requirement.

4.2 Over the last three years considerable focus has been made on the IG Toolkit to ensure a continual improvement in its scoring;

- 2009/10 – 41%
- 2010/11 – 61%
- 2011/12 – 79%

4.3 A plan is currently being developed to ensure that the Trust meets the mandated training requirement for the 12/13 submission. This has to take into account the current difficulties in releasing frontline staff due to operational pressures. It will be subject to verification by the internal auditors.

5. INFORMATION SECURITY & CYBER PROTECTION

5.1 Information Security is the protection of LAS information and the systems that store, process and transport it. The sensitive nature of LAS operations requires that information systems are protected in terms of confidentiality, integrity and availability, not only to ensure compliance with the legal, regulatory and contractual requirements, but also to maintain the reputation of the LAS with patients, partners, staff, the NHS, stakeholders and the general public.

5.2 The Trust has implemented a range of measures to secure its information. For obvious reasons, specific details are not given here. However they include firewalls, network configuration and segregation, anti-virus protection, regular patch updates and encryption. Regular environmental scanning also takes place to access threats that are being constantly identified. Compliance reporting is part of the regular IGG agenda. Detailed risk assessments of each system that handles sensitive data are currently being undertaken.

6. INCIDENTS

6.1 In the last financial year the Trust declared 6 Information Serious Incidents one of which was declared to the Information Commissioner. These have included the loss of Patient Report Forms and a witness statement, SMS texts sent to the wrong mobile number, an email that inadvertently disclosed other email addresses, and documents sent to the wrong address.

6.2 As we move to more mobile technologies there have been more lost or stolen equipment, however the encryption tools have ensured that no LAS data has been lost. Many minor incidents the Trust experiences are the result of internal users not following the Acceptable Use Policy; a situation that will be improved by better quality training and awareness.

7. FREEDOM OF INFORMATION

7.1 The Information Governance Manager has responsibility for managing Freedom of Information requests. FoI Co-ordinators and other staff provide support for the timely provision of information and this has been a significant contribution towards ensuring that all requests have been responded to within the statutory period of 20 working days. The number of requests have increased recently (22 received in October, and 29 in November) although during the past year the average has been 16 per month.

7.2 Subjects have ranged from enquiries about the vehicle fleet, supply contracts, and staffing, to aspects of Control Services operations, the effects of NHS reconfiguration in London, and planning for the Olympics. The Director of Corporate Services is responsible for the application of exemptions and overseeing appeals.

8. DATA PROTECTION

8.1 Currently there is a focus to improve the co-ordination of Data Protection Subject Access Requests in order to provide the necessary assurance of compliance. Further work will be carried out over the next few months, in particular with regard to training staff who handle subject access requests.

8.2 Work has been completed to ensure that the LAS website is compliant with the requirements of the Information Commissioner following new legislation which requires the informed consent of website users before cookie data may be collected and stored.

9. EXTERNAL ACTIVITIES

9.1 The LAS is a member of the London Social Care and NHS Information Governance Group and the London Caldicott Guardian Forum. The Information Governance Manager also attends the national Ambulance Information Governance Leads Group which meets 2-3 times a year.

9.2 The Trust has also joined the Information Security for London Forum, a body whose membership includes 28 London Councils and the London Fire Brigade. This information exchange was created with the support of the Centre for the Protection of Critical National Security (CPNI) and CESG and will give LAS access to HMG advice and tools.

10. CURRENT IG PRIORITIES

10.1 The main priorities for Information Governance over the next 12 months are as follows;

10.2 Consolidate the new activities which have led to the current Information Governance Toolkit satisfactory rating and improve the score where feasible.

10.3 Review the use of the security software to optimise our solutions and economise on current technology overlaps.

10.4 Implement a security awareness campaign to improve user knowledge and behaviour. This will include more helpful “how to” guides that will make it easier for staff to follow our best practice e.g. transferring information.

10.5 Embed the role of the Information Asset Owners across the Trust and complete the development of the Information Asset Register.

10.6 Ensure that NHSmail or equivalent secure email is rolled out to all relevant staff so that all personal identifiable information sent outside the Trust is transferred in a secure manner.

10.7 Electronic Document Management Project

10.8 Review process and responsibilities for handling Data Protection Subject Access Requests.

10.9 Continue and enhance the programme of Information Governance training for staff across the Trust tailoring specific training where required.

11. RECOMMENDATION

11.1 The Trust Board note the contents of this report and seek any further reassurances they require.

Peter Suter
Director of Information Management & Technology

APPENDIX 1:

Terms of Reference

Information Governance Group

1. AUTHORITY

The constitution and terms of reference of the Information Governance Group shall be set out below and subject to amendment when directed and agreed by the Risk Compliance and Assurance Group (RCAG).

The Group is authorised by RCAG to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Group.

The Group is authorised by RCAG to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2. PURPOSE

Information Governance provides a framework to bring together the requirements, standards and best practice that apply to the handling of corporate and personal information. It covers data quality, Caldicott principles, Information Security Management (ISO/IEC 17799 / ISO/IEC 27001), The Data Protection Act 1998, The Freedom of Information Act 2000, the Information Governance Toolkit and records management requirements as defined by the CQC Essential Standards, the Public Records Act, and the DH Records Management Code of Practice.

The Information Governance Group is the management forum that will ensure that there is clear direction and visible management support for Information Governance initiatives within the LAS.

It will promote best practice within the organisation through appropriate direction and resourcing.

It will also act as a cross-functional forum of senior management representatives from relevant parts of the organization to co-ordinate the implementation of Information Governance controls.

3. RESPONSIBILITY

1. Pro-actively manage and support Information Governance throughout the Trust by:
    - 1.1 Ensuring that appropriate policies and procedures are developed, approved, implemented and reviewed.
    - 1.2 Ensuring that specific roles and responsibilities for information governance are in place.
    - 1.3 Developing, supporting and monitoring major initiatives, processes, and systems to enhance and ensure compliance with information governance.
    - 1.4 Promoting management support for, and staff awareness of, information governance.
    - 1.5 Reviewing information governance audit findings and ensuring that appropriate actions are taken.
    - 1.6 Reviewing IG incidents and serious incidents, ensuring that appropriate actions are taken.
    - 1.6 Coordinating and approving the annual LAS Information Governance Toolkit submission.

2. Ensure that effective information security is in place across the Trust by:
    - 2.1 Promoting information security awareness and best practice
    - 2.2 Assessing the adequacy and co-ordinating the implementation of specific information security controls for new systems or services.
    - 2.3 Reviewing and monitoring information security incidents and weaknesses.

3. Support, monitor and review Trust-wide records and information management initiatives including the Records Management Strategy.

4. Monitor information, and information management systems confidentiality, integrity and availability by:

4.1 Identifying, managing and reviewing Information risks across the Service and supporting the implementation of any required controls.
4.2 Ensuring that Business Continuity plans are in place which will support continued provision of information and systems.
4.3 Receive and review Internal Audit reports on IG and monitor progress with actions taken to address recommendations.

4. MEMBERSHIP

The Group will be chaired by the Senior Information Risk Owner (SIRO) and the Caldicott Guardian and Director of Corporate Services will be joint Vice-Chair.

Membership will comprise the following executive officers:

- Director of IM&T (SIRO) – Chair
- Medical Director (Caldicott Guardian)-Vice Chair
- Director of Corporate Services – Vice Chair
- Assistant Director Corporate Services
- Head of Management Information
- Head of IM&T Infrastructure
- Information Governance Manager
- Information Security Manager
- Deputy Head of IM&T Infrastructure
- Representative from A&E Operations
- Senior HR Manager

The Medical Director sends her Staff Officer to formally act on her behalf.

Members may send deputies to attend if necessary provided these are empowered to make decisions.

Representatives from other departments/Directorates may be asked to attend to facilitate discussion and progress with specific items.

5. ACCOUNTABILITY

The Information Governance Group will be accountable to the Risk Compliance and Assurance Group.

6. REPORTING

The minutes of the Information Governance Group will be formally recorded by the Personal Assistant to the Director of Information Management and Technology and the approved minutes submitted to RCAG.

The Chair of the Information Governance Group will draw to the attention of RCAG any issues which require disclosure.

7. ADMINISTRATION

Secretarial support will be provided by the Personal Assistant to the Director of Information Management and Technology and will include the agreement of the agenda with the Chair and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward;

The agenda and papers will be distributed at least 48 hours before each meeting;

Papers tabled will be at the discretion of the Chair.

8. QUORUM

A quorum for each meeting will be the Chair or Vice-Chair, one of the Information Governance Manager or Information Security Manager and two additional members.

9. FREQUENCY

The Group will meet monthly, or as appropriate.

10. REVIEW OF TERMS OF REFERENCE

The Information Governance Group will review these terms of reference at least annually from the date of agreement.

11. Monitoring

The IGG will review the effectiveness of its performance within these Terms of Reference annually.

APPENDIX 2:

Information Governance Policies and Procedures

TP009	Policy for Access to Health Records, Disclosure of Patient Information, Protection and Use of Patient Information	
TP012	Data Protection Policy	
TP017	Procedure for Health Records Used Generated and Stored by the LAS	
TP022	Freedom of Information and Environmental Information Regulations Policy	
TP024	Procedure for Managing Patient Confidentiality When Dealing with the Media	
TP029	Records Management and Information Lifecycle Policy	
TP030	Retention and Disposal Policy and Procedure	
TP038	Patch Management Policy	
TP046	Registration Policy and Procedure	
TP047	Electronic Information Handling Procedure	
TP048	Information Security Policy	
TP059	Information Governance and Privacy Impact Assessment Policy and Procedure for new Processes, Services and Systems	
TP060	Policy for the Acceptable Use of IT and Communications Systems	
TP061	Safe Haven Policy and Procedure	
TP062	Information Governance Policy	
TP072	Confidentiality Audit Procedure	
TP080	Policy for Use of Social Media	

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London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 29TH JANUARY 2013

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 ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	**To be advised of the tenders received and entered into the tender book and the use of the Trust Seal since 28th November 2012 and to be assured of compliance with Standing Orders and Standing Financial Instructions**

Key issues and risks arising from this paper

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

Executive Summary

Three tenders have been received, opened and entered into the tender book since 28th November 2012:

- Internal audit:
  Tenders received and opened on 30th November 2012
  Chantrey Vellacott DFK
  Deloitte and Touche
  KPMG
  Parkhill
  RSM Tenon
  SCA.
- Counter Fraud:
  Same as above.
- Complete solution for the testing of Capillary Blood Glucose
  Tenders received and opened on 21st December 2012
  Abbott Diabetes Care (division of Abbott Laboratories Limited)
  LifeScan
  Nipro
  Nova Biomedical
  Roche Diagnostics Limited

There have been no new entries to the Register for the Use of the Trust Seal since 28th November 2012.

Attachments

None.

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

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

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

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

Risk Implications
This paper links to the following strategic risks:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?
Yes
No

Key issues from the assessment:

TRUST BOARD FORWARD PLANNER 2013

26th March 2013

Standing Items	Quality Governance and Risk	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman FT Update	**Quality Dashboard and Action Plan** **Clinical Quality and Patient Safety Report** **Quality Committee Assurance Report** **BAF and Corporate Risk Register – Quarter 4 documents** **Risk Management Strategy and Policy review** **Audit Committee Assurance Report** **Reports from Executive Directors (COO, DoF, DoHR)**	Report from Chief Executive Officer 2013/14 Annual Business Plan sign off 2013/14 Corporate Objectives sign off 2013/14 Equality Objectives sign off Draft IBP/LTFM for approval	Membership Strategy Report from Finance and Investment Committee Report from Trust Secretary Trust Board Forward Planner	Audit Committee - 4th March Finance and Investment Committee - 12th March Quality Committee – 20th February	

4th June 2013

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 2012/13** **Draft Quality Account 2012/13** **Audit Committee Assurance Report**	Quality Dashboard and Action Plan Clinical Quality and Patient Safety Report Quality Committee Assurance Report Reports from Executive Directors (COO, DoF, DoHR)	Report from Chief Executive Officer HDD1 Action Plans for approval BGAF and QGF Action Plans for approval IBP/LTFM final approval prior to submission to NTDA	Report from Finance and Investment Committee Annual Equality Report 2012/13 Update on Information Governance Report from Trust Secretary Trust Board Forward Planner	Audit Committee - 13th May Finance and Investment Committee – 14th May Quality Committee – 24th April	Caroline Silver John Jones

25th June 2013

Standing Items	Quality Governance and Risk	Quality Assurance/Annual Reporting	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	**Quality Dashboard and Action Plan** **Clinical Quality and Patient Safety Report** **Quality Committee Assurance Report** **BAF and Corporate Risk Register – Quarter 1 documents** **Audit Committee Assurance Report** **Reports from Executive Directors (COO, DoF, DoHR)**	**Quality Account 2012/13 for approval**	Report from Chief Executive Officer	Report from Trust Secretary Trust Board Forward Planner	Audit Committee - 3rd June Quality Committee – 19th June	Steve Lennox

23rd July 2013

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	**Quality Dashboard and Action Plan** **Clinical Quality and Patient Safety Report** **Quality Committee Assurance Report** **Reports from Executive Directors (COO, DoF, DoHR)** **Annual Infection Prevention and Control Report 2012/13** **Annual Patient Experiences Report 2012/13** **Annual Safeguarding Report 2012/13**	Report from Chief Executive Officer Outcome reports on public consultation to receive and approve	Report from Finance and Investment Committee Annual Corporate Social Responsibility Report Report from Trust Secretary Trust Board Forward Planner	Finance and Investment Committee – 9th July Quality Committee – 21st August	

24th September 2013

Standing Items	Quality Governance and Risk	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman FT Update	**Quality Dashboard and Action Plan** **Clinical Quality and Patient Safety Report** **BAF and Corporate Risk Register – Quarter 2 documents** **Audit Committee Assurance Report** **Annual Report of the Audit Committee** **Reports from Executive Directors (COO, DoF, DoHR)**	Report from Chief Executive Officer HDD2 Report and Action Plan	Report from Finance and Investment Committee Report from Trust Secretary Trust Board Forward Planner	Audit Committee - 2nd September Finance and Investment Committee – 10th September	

26th November 2013

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	**Quality Dashboard and Action Plan** **Clinical Quality and Patient Safety Report** **Quality Committee Assurance Report** **Audit Committee Assurance Report** **Reports from Executive Directors (COO, DoF, DoHR)**	Report from Chief Executive Officer	Report from Finance and Investment Committee Report from Trust Secretary Trust Board Forward Planner Performance Reporting compliance statement	Audit Committee - 4th November Finance and Investment Committee – 12th November Quality Committee – 23rd October	

17th December 2013

Standing Items	Quality Governance and Risk	Strategic and Business Planning	Governance	Sub-Committee meetings during this period	Apologies
Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman FT Update	**Quality Dashboard and Action Plan** **Clinical Quality and Patient Safety Report** **Quality Committee Assurance Report** **BAF and Corporate Risk Register – Quarter 3 documents** **Reports from Executive Directors (COO, DoF, DoHR)**		Report from Trust Secretary Trust Board Forward Planner	Quality Committee – 11th December	

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