LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING
Part I

DRAFT Minutes of the meeting held on Tuesday 26th March 2013 at 9:00 a.m.
in the Conference Room, 220 Waterloo Road, London SE1 8SD

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Present:	
Richard Hunt	Trust Chair
Ann Radmore	Chief Executive Officer
Jessica Cecil	Non-Executive Director
Roy Griffins	Non-Executive Director
Andrew Grimshaw	Director of Finance
John Jones	Non-Executive Director
Beryl Magrath	Non-Executive Director
Nick Martin	Non-Executive Director
In Attendance:	
Sandra Adams	Director of Corporate Services
Francesca Guy	Committee Secretary (minutes)
Jason Killens	Director of Service Delivery (North Thames)
Bob McFarland	Associate Non-Executive Director
Angie Patton	Head of Communications
Peter Suter	Director of Information Management and Technology
Paul Woodrow	Director of Service Delivery (South Thames)
Fenella Wrigley	Deputy Medical Director
Members of the Public:	
Mark Docherty	NHS North West London
Anne Tofts	Healthskills
Jessica Thom	Member of the Public
Matthew Pountney	Member of the Public
Richard Kingham	Paramedic LAS

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25. Welcome and Apologies

25.1 Apologies had been received from Fionna Moore, Steve Lennox, Caron Hitchen, Caroline Silver and Jane Chalmers. Fenella Wrigley attended the meeting on behalf of Fionna Moore.

25.2 The Chair welcomed Bob McFarland to his first LAS Trust Board meeting as Associate Non-Executive Director. The Chair also welcomed Mark Docherty to the meeting.

25.3 The Chair also noted that this was Beryl Magrath's last formal Trust Board meeting as she had come to the end of her 8 year tenure as a Non-Executive Director. Beryl would, however, be attending the Strategy Review and Planning Committee meeting in April.

25.4 The Chair noted that Peter Suter would also be leaving the organisation in June.

26. Patient Story

26.1 The Trust Board was joined by Jessica Thom who gave an account of her experiences living with

Tourette's Syndrome. Jessica was joined by her Personal Assistant, Matthew Pountney and LAS Paramedic, Richard Kingham.

26.2 Jessica explained that she was the founder of Touretteshero, an organisation which aimed to raise awareness of Tourette's and celebrate its humour and creativity, and had written a book entitled 'Welcome to Biscuitland'.

26.3 Jessica reported that overall her experiences of the LAS had been very positive, although there had been some instances where the crew had made assumptions about what she was able to understand. Jessica stated that the factors which helped to make her experiences with the LAS positive included: help arriving quickly; good communication and use of humour; understanding of her communications system; her carers being listened to; and clear information about what was going to happen next.

26.4 Jessica expressed concern that funding cuts to social support and preventative health services for disabled people would lead to increasing demands on the LAS. Jessica thanked the LAS for delivering a service in challenging circumstances.

26.5 The Chair thanked Jessica for telling her story to the Trust Board.

26.6 Beryl Magrath asked how Jessica got to sleep at night. Jessica responded that she took melatonin and used a weighted blanket to help lessen her tics at night. Getting to sleep used to be a big problem, but it had improved recently.

26.7 Ann Radmore asked how LAS staff would react to calls made by bystanders on behalf of Jessica. Fenella Wrigley responded that these calls would be taken through the usual triage system and an additional question would be asked about whether the patient was wearing an alert bracelet or had any additional information on their person.

26.8 The Chair asked whether there was anything that the LAS could do to improve its service. Jessica responded that overall her experience of the LAS had been very positive, but she thought that the situation might become more challenging over the next few years with cuts to the NHS. Jessica urged the LAS to continue to be mindful of disabled people in this challenging environment,

27. Declarations of Interest

27.1 There were no declarations of interest.

28. Minutes of the Part I meeting held on 29th January 2013

28.1 The minutes of the Part I meeting held on 29th January 2013 were approved.

29. Matters Arising

29.1 The following matters arising were discussed:

29.2 **15.4:** Fionna Moore had written to Keith Willett to offer assistance with the review. Roy Griffins was keen that the LAS' involvement with the review was pursued. Ann Radmore responded that currently the remit of the review did not include pre-hospital care, but nevertheless that the LAS would continue to seek involvement.

29.3 **17.3:** Sandra Adams reported that she was currently in discussion with the NTDA regarding the timeline of the Foundation Trust application. Ann Radmore added that there was no longer a requirement for all NHS Trusts to be authorised as Foundation Trusts by a defined deadline.

29.4 **18.1:** The Chair reported that Nick Martin would chair the Finance and Investment Committee going forward and the terms of reference would be updated to reflect this.

30. Report from the Chairman

30.1 The Trust Board noted the report from the Chairman.

31. Integrated Board Performance Report

31.1 Andrew Grimshaw reported that he and Paul had reviewed the format of the integrated board performance report. The following key points were noted:

- Category A and C performance had seen an improvement as a result of additional funding, although Category C performance was still not at the desired level. This was reflected in the number of complaints and serious incidents involving Category C patients. Overall, however the Trust had seen a decrease in both complaints and serious incidents in Q4;
- Sickness levels had shown an increase and staff turnover continued to be above target levels, reflecting the high levels of workload;
- The Trust was currently in surplus due to the additional income received from NHS London and was on track to achieve the revised surplus of £260k;
- Overall the increased pressures on the organisation had had an impact on both the quality of care provided and the Trust's financial position.

31.2 John Jones asked whether the Trust Board should consider setting a target for complaints and serious incidents. Ann Radmore responded that she would expect to see the current level of serious incidents continue as this demonstrated that the Trust was managing incidents appropriately. Fenella Wrigley suggested that the Trust should also monitor near miss incidents as these provided valuable information on any emerging themes and trends.

31.3 Jessica Cecil commented that the revised format of the integrated board performance report was very helpful as it was now easier to see the correlations between the different matrices. Jessica noted that use of the Demand Management Plan had decreased in February and asked whether this had led to increased levels of staff training being delivered. Andrew Grimshaw responded that the Trust would need to source more staff in order to deliver increased levels of training and therefore decreased use of the Demand Management Plan had not had a significant impact.

31.4 Beryl Magrath expressed concern that near misses were underreported and suggested that this was linked to the culture of the NHS. Staff should be encouraged to report near misses and be assured that they would not be disciplined as a result. Paul Woodrow added that greater clinical support was needed in the field to support staff to report errors and near misses.

31.5 Ann Radmore stated that from April 2013 the Trust aspired to deliver a level of quality which would allow the desired levels of training to be delivered. Levels of training provided a useful barometer to measure whether the Trust was providing a quality service.

31.6 The Chair suggested that the integrated board performance report could be displayed electronically at future meetings to allow the Trust Board to review the most up to date information.

32. Quality Report

Quality Dashboard

32.1 Fenella Wrigley reported that the quality dashboard was based on January data and therefore it did

not reflect the additional funding received from NHS London. Fenella noted the following:

- Hear and treat had an inverse impact on see and treat. Increased levels of hear and treat activity meant that patients who were attended by a crew were less suitable for see and treat and appropriate care pathways and therefore the proportion of patients who required conveyance to an emergency department tended to increase;
- On scene times had shown an increase due to the focus on reducing hospital turnaround times. Crews had been reminded that paperwork should be completed on arrival at hospital for those patients who were critically unwell or injured;
- The Clinical Quality, Safety and Effectiveness Committee was working to improve airway management;
- The Patient Experiences Department was working to improve the number of lost property incidents, although it was acknowledged that the number of incidents was relatively small.

32.2 Roy Griffins welcomed the narrative on the red rated measures, however he stated that it would be useful to have a value judgement about whether these were of concern. The Chair stated that the narrative also needed to differentiate between safety and quality.

32.3 Jessica Cecil commented that it was encouraging to note that the LAS was performing well against other ambulance trusts in the majority of indicators, with the exception of STEMI and stroke care. Fenella responded that this was due to the fact that the LAS followed the JRCALC guidelines for the administration of analgesia to STEMI patients, rather than the Department of Health guidelines. The guidance for analgesia was being revised and was close to being agreed nationally which should have an impact on LAS performance against this indicator. In order to provide internal assurance, the Clinical Audit and Research team had undertaken some analysis of analgesia for patients with a pain score of over 3. Poor performance against the stroke care indicator was due to the fact that crews were not documenting each individual element of the FAST test. This should improve with clinical team leaders in place who would be able to provide more face to face feedback.

32.4 Beryl Magrath asked whether staff had received sufficient training to be confident in leaving patients at home. Fenella Wrigley responded that enhanced assessment training had been rolled out in some areas, although staff also needed experience as well as training. Crews had been provided with a flow chart for the use of appropriate care pathways and this had improved usage, although it was not possible to provide a flow chart for every condition. The Trust was also looking to introduce Pathfinder which was a pre-hospital tool that supported decision making and would cover all illnesses.

32.5 Nick Martin asked whether there was a qualitative way to look at comparisons with other ambulance trusts. Fenella Wrigley agreed to feed this comment back to Steve Lennox.

ACTION: FW to ask SL to consider whether there was a qualitative way to monitor comparisons with other ambulance trusts.

DATE OF COMPLETION: 4th June 2013

32.6 The Chair suggested that the Trust Board might wish to consider setting a board aspirational target for the quality dashboard eg having 50% of indicators rated green. The Executive Management Team was asked to consider this.

ACTION: EMT to consider setting a board aspirational target for the quality dashboard.

DATE OF COMPLETION: 4th June 2013

Clinical Quality and Patient Safety Report

32.7 Fenella Wrigley reported the following:

- Clinical Performance Indicator (CPI) completion rates remained the highest that the Trust had ever seen. Compliance rates were also high, with the exception of the Mental Health CPI. A strategy was being developed to improve compliance rates with this CPI;
- The review of the Locality Alert Register was ongoing and the number of addresses continued to decrease;
- There had been one reportable controlled drugs incident involving the loss of morphine, which had been investigated. A recent unexpected visit by the Metropolitan Police Service, however, showed a significant improvement in the management of drugs;
- The Trust had received one Rule 43 report, relating to a delay in attending a patient who had taken an overdose;
- The Trust had received an increasing number of complaints regarding delays.

32.8 Beryl Magrath noted that 111 activity showed an increase at weekends and asked whether this was indicative of difficulties in accessing medical care at the weekend. Jason Killens responded that last week was the first week that all sites had gone live and activity would continue to be monitored. There were concerns about the increase in the rate of conversion of calls to ambulances at the weekend and this could be linked to inability to access out of hours provision. This would be analysed in more depth once the Trust had a month's worth of data. The Trust was currently in further discussions with commissioners about what was driving demand nationally.

32.9 Nick Martin asked why the number of complaints had shown an increase in October. Fenella responded that this was mostly due to delays caused by decreased resourcing levels following the Olympic Games.

33. Quality Committee Assurance Report

33.1 Beryl Magrath commented that a summary and short report had been provided of the key areas of discussion at the Quality Committee meeting on 20th February 2013. Beryl reported that the same issues remained relating to high utilisation and limited capacity, which had had an impact on release of staff for training, operational workforce reviews and personal development. Given this, and the fact that Category C times were too long, the Quality Committee was not able to give the Trust Board complete assurance on the quality of care provided, in all circumstances (including Category C).

33.2 The Quality Committee also discussed the following:

- The development of the Clinical Hub;
- The STEMI and Stroke Annual Reports for 2012/13, which underlined the significant amount of good work done by LAS staff in these areas of critical care;
- A report from the Risk, Compliance and Assurance Group, which highlighted that a long standing action to replace PRF boxes was yet to be completed;
- The Internal Audit Work Plan for 2012/13. The Quality Committee had significant input into this work plan;
- The Francis Report. The Quality Committee had requested this report to come to the Trust Board.

33.3 The Chair noted that the Quality Committee was unable to give the Trust Board complete assurance on the quality of care provided and asked whether this was due to current circumstances or whether there were any new issues that the Trust Board should recognise. Beryl confirmed that it was due to the existing issues of high utilisation and limited capacity. Ann Radmore commented that progress had been made against some of these issues and this would be discussed further in the Part II meeting.

34. Board Assurance Framework and Corporate Risk Register

34.1 Sandra Adams reported that the Board Assurance Framework had been updated to reflect the year end position but also to set the scene for 2013/14. Three new risks had been added to the Board Assurance Framework: one relating to high risk addresses referred from the Metropolitan Police Service; the second relating to Category C performance; and a third relating to compliance with the information governance toolkit. Sandra added that the Risk, Compliance and Assurance Group did a thorough job of reviewing the risk register at each meeting.

34.2 Jessica Cecil asked what the deadline was for completing the mitigating actions for the top-rated risk [risk 368 – there is a risk that messages exchanged between MDTs and the CommandPoint CAD system may become out of sequence, cross one another while one is being processed or a job being 'cycled' through to closure in error by an A&E resource. This may result in an open event being closed in the CAD system erroneously, leading to a patient not receiving a response from the LAS and their condition deteriorating, possibly resulting in serious injury or death]. Peter Suter responded that the software was due to be delivered in April 2013 and would be tested in May for release in late May/early June. In the meantime the mitigating measures would continue to be checked to ensure that they were effective.

34.3 The Chair commented that the Trust Board needed to understand how the Trust would deliver value for money and suggested that an index should be developed to monitor this.

ACTION: EMT to develop an index for measuring value for money.

DATE OF COMPLETION: 4th June 2013

35. Finance Update

Finance Report (Month 11)

35.1 Andrew Grimshaw reported that the Trust was on track to deliver the revised surplus of £260k. An increase in activity had led to an increase in expenditure, which was supported by additional funding from NHS London. The Cost Improvement Programme (CIP) continued to be delivered in line with the plan, although Andrew would look to review the CIP reporting. Capital expenditure remained behind plan. Andrew reported that the Trust was on track to deliver its EFL, but would undershoot its CRL, albeit within acceptable limits.

Report fro Finance and Investment Committee

35.2 The Chair reported that the last meeting of the Finance and Investment Committee had focussed on the uncertainty of the year end position, which had since been resolved. The membership and terms of reference of the Finance and Investment Committee would be revised with Nick Martin taking over as chair. The Committee would have a greater focus on cash management and capital going forward.

36. Francis Report

36.1 Sandra Adams recommended that Trust Board members read as a minimum the executive summary of the Francis Report and the statements of evidence. Sandra stated that the key themes were culture; putting patients first; monitoring of compliance with fundamental standards; accountability of board level directors; effective complaints and incidents process; real involvement of patients and public; openness, transparency and candour; caring, compassionate and considerate nursing and leadership. Sandra stated that pages 5 and 6 of the paper detailed the LAS's response to the Francis Report, which included three recommendations for the Trust Board's approval. A progress report would be presented to the Trust Board in July.

36.2 Ann Radmore stated that the Francis Report was the most important reflection on the NHS in the past decade and therefore the Trust needed to take its time to respond. The LAS would need to undertake a gap analysis and draw up an action plan to address any gaps identified. The organisation also needed to retest its values and behaviours and ensure that openness and honesty were embedded in these as well as showing compassion in every interaction. The Trust Board needed to consider what it could do and how it could influence others.

36.3 The Chair stated that he would like to see this remain on the Trust Board agenda on a monthly basis.

ACTION: FG to add an update on the actions to address the recommendations made in the Francis Report to the Trust Board forward planner.

DATE OF COMPLETION: 4th June 2013

36.4 Roy Griffins stated that he supported this response and would like to be included in the discussions with Steve Lennox. Beryl Magrath agreed with this point and suggested that the Trust Board also needed to hear staff stories as well as patient stories, as staff would provide a source of valuable information. Ann Radmore agreed to follow this up with Steve Lennox.

ACTION: AR to discuss with SL how to incorporate staff stories into the Trust Board agenda.

DATE OF COMPLETION: 4th June 2013

36.5 Ann Radmore stated that the Trust would also need to consider how it interacted with Healthwatch and the local authorities.

36.6 The Chair suggested that the Trust Board hold a facilitated Strategy Review and Planning discussion focusing on the characteristics of a 'weak' board, the culture of the organisation and establishing aspirational board challenges/objectives.

ACTION: SA to arrange facilitated Strategy Review and Planning session to discuss the recommendations from the Francis Report relating to organisational culture and board characteristics.

DATE OF COMPLETION: 23rd July 2013

36.7 The Trust Board agreed the recommendations as set out in the paper.

37. Duty of Candour and Being Open Policy

37.1 Sandra Adams reported that it was now a contractual duty for NHS trusts to have a Duty of Candour and this had been incorporated into the updated Being Open policy. More work needed to be done to understand the number of incidents to which this duty would apply and the executive team had expressed some reservation about how this would be resourced. One option was to develop a specialist team to liaise with families in the same way that the police did. The Trust Board was therefore asked to approve the policy and note that there was further work to do to fully implement the policy.

37.2 Roy Griffins stated that the Trust already performed well in this area and that it would be useful to understand what extra burden the implementation of this policy would put on this organisation. Sandra responded that this was something that was yet to be worked through.

37.3 The Chair commented that the essence of Being Open was intangible and that it would be useful to have a paragraph which described the key principles.

ACTION: SA to ask Carmel Dodson-Brown to draft a brief explanation of the key principles of Being Open.

DATE OF COMPLETION: 4th June 2013

37.4 The Chair asked whether the staff survey included a question about whether staff felt confident to raise concerns and report near misses. Ann responded that the Trust was unable to influence the questions of the staff survey, but that there were two existing questions which touched on this.

37.5 Fenella stated that it was also important to ensure that staff understood how to report near misses. Beryl Magrath suggested that this was something that could be covered in the staff induction.

ACTION: CH to ensure that the reporting of near misses was covered in the staff induction.

DATE OF COMPLETION: 4th June 2013

37.6 Subject to these comments, the Trust Board approved the Duty of Candour and Being Open Policy.

38. Staff Engagement and Communication

38.1 Ann Radmore stated that the LAS had had the opportunity to join Listening Into Action, which aimed to put staff at the centre of organisational change. This initiative started with several 'big conversations', in which staff would be encouraged to discuss any blockages to delivering care and be empowered to help find the solutions. Listening Into Action would also provide a platform to discuss the LAS strategy with staff. Ann stated that she anticipated that it would be uncomfortable for senior teams, but it represented a key step in moving to a different relationship with staff. The advertisement for the role of Listening Into Action lead had received a significant response, which was encouraging.

38.2 Nick Martin asked whether this would be externally administered. Ann Radmore responded that it would be run and led internally and that the team that would be leading on it were both paramedics.

38.3 Nick asked whether it was worth considering anonymous responses from staff. Ann responded that a number of surveys would be taken as part of the initiative, all of which would be anonymous.

39. Membership Strategy

39.1 Sandra Adams reported that some minor changes had been made to the Membership Strategy to reflect the changes to the NHS structure. Sandra reported that the Trust now had circa 8000 public members and it was anticipated that this would reach 10k next year. The Trust would therefore need to take stock and consider how membership would be managed going forward.

39.2 Sandra added that consideration also needed to be given to how to involve FT members in committees and also how to engage with governors. The possibility of appointing a CCG governor had been discussed previously. Ann Radmore commented that other trusts had moved away from this model due to conflicts of interest. Sandra Adams agreed to take soundings from other foundation trusts about whether they had appointed a CCG governor.

ACTION: SA to take soundings from other foundation trusts about whether they had appointed a CCG governor.

DATE OF COMPLETION: 4th June 2013

The Trust Board approved the Membership Strategy.

40. Action Plan from November 30th 2011

40.1 Jason Killens explained that this action plan had been drawn up following the day of industrial action on 30th November 2011. Of the 26 actions, 5 were currently outstanding and Jason gave an update on progress against each of these actions.

41. Proposal for the Handling of Low Acuity Calls

41.1 Jason Killens stated that the Trust Board's approval was sought for the proposal for transferring calls that had previously been passed to NHS Direct to 111. The preferred option was to develop a warm transfer which would enable LAS to transfer the call electronically to 111. However this would take some time to implement and in the meantime EOC staff would be asked to use a script to ensure that the caller was aware that an ambulance would not be sent and to advise the caller to call 111.

41.2 Roy Griffins noted that there would be some exceptions where callers would receive enhanced assessment through Clinical Telephone Advice and asked whether the Trust could bear this additional activity. Jason Killens responded that activity would not be higher than current levels and if anything it would be less due to the fact that 111 assessed patients from two years old.

41.3 Beryl Magrath asked whether the LAS would be able to retriage calls referred back from 111. Fenella Wrigley responded that the LAS would be able to undertake enhanced clinical assessment by a clinician, but would not be able to retriage the patient.

41.4 The Trust Board approved the proposal for the handling of low acuity calls following the closure of NHS Direct and the implementation of pan-London 111 Service.

42. 2013/14 Contract Position

42.1 Jason Killens reported that significant progress had been made with the 2013/14 contract negotiations and two costed options had been developed with the commissioners' support for the implementation of the capacity review recommendations. Jason reported that the Trust should be

in a position to agree the 2013/14 contract within the next few days.

42.2 John Jones asked whether the negotiations included commitment for future years. Jason confirmed that it did include commitment for future years and this would be discussed further in the Part II meeting.

43. 2013/14 Budget and Operating Plan

43.1 Andrew Grimshaw reported that an interim budget and operating plan was in place. The Chair noted that this represented significant progress since the last Finance and Investment Committee meeting.

44. Board Governance Assurance Framework Refresh Review

44.1 Fleur Nieboer and Neil Thomas joined the Trust Board to update the Trust Board on the initial outcome of the recent Board Governance Assurance Framework Refresh Review. Fleur explained that they would be completing the remaining interviews within the next few weeks and finalising the report in April.

44.2 Fleur reported that the Trust had made significant progress since the last review in 2012, particularly around the formalisation of processes, and that it was not anticipated that that there would be any red or amber/red rated indicators this time round.

44.3 Fleur reported that, of the amber/green rated indicators, a number of these related to the transitional period that the Trust Board was currently undergoing. The Chair agreed that until this had settled, it was difficult to assess how well the Trust Board was performing against these indicators, although it was anticipated that these indicators would turn green with the passage of time. The Chair added that the Trust Board also needed to be satisfied with the way in which it handled change as it was likely that there would be further changes.

44.4 Fleur reported that board performance reporting had moved on significantly since the last review, although there was still some duplication of information. It was anticipated that this would be resolved by September 2013.

44.5 Progress had also been made with the strategy, although again there was more work to do. The Chair commented that it was usual for a new Chief Executive Officer to review the strategy.

44.6 Neil Thomas stated that overall good progress had been made and work was already underway against those indicators that were rated amber/green. KPMG's view was therefore that there was no need to undertake a further re-run of this process.

44.7 The Chair thanked Fleur and Neil for the way in which they had conducted the review and stated that this was something that the Trust Board would keep on its agenda.

45. Report from Chief Executive Officer

45.1 Ann Radmore noted that her report to the Trust Board included a summary of recent changes to the NHS system. The LAS Quality Account would need to be reviewed by Southwark Healthwatch given that the LAS headquarters buildings fall under its boundaries.

45.2 The Chair stated that he would like a presentation at a future Trust Board meeting on the role of Health and Wellbeing Boards.

ACTION: FG to add a presentation on the role of Health and Wellbeing Boards to the Trust Board forward planner.

DATE OF COMPLETION: 4th June 2013

45.3 Jessica Cecil added that she would like to understand the role of the NHS Trust Development Agency and its impact on the LAS. Ann Radmore agreed to send Jessica her previous presentation on the structure.

ACTION: AR to send JC her presentation on the structure of the NHS Trust Development Agency.

DATE OF COMPLETION: 4th June 2013

46. Report from Trust Secretary

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

47. Forward Planner

47.1 The Chair stated that the forward planner needed to include other aspects of board development and to include the dates of future meetings to ensure Trust Board members' commitment to these dates. The Chair also stated that consideration should be given to moving the start of the meeting to 10.00.

48. Any other business

48.1 There were no items of other business.

49. Questions from members of the Public

49.1 The LAS Patients' Forum had submitted a number of questions:

49.2 1) Richard Hunt kindly wrote to the Forum on November 6th confirming that the LAS Board will ensure that any follow-ups to patient's stories are clearly identified, along with minuted comments and that a six monthly review of the patient stories will be undertaken, together with any follow up action requested by the Board. Can the Board let the Forum know if there is any information available on the outcomes so far from any of the stories presented to LAS Board meetings?

49.3 Steve Lennox had submitted a response that the patient story had been introduced to the Trust Board as a way of bringing the patient experience right into the Board room. The two clinical directors identified patients that would give the board an insight into the wide range of issues that patients face. The stories were not identified based on a prioritisation process therefore the Board was reluctant to escalate an action plan at Board level which might actually not be as significant as an action plan that was being managed locally.

49.4 However, the Trust Board did ask at each Board meeting if there were any unresolved issues arising from the presentation at the previous Trust Board and if the actions suggested had been closed. To date the additional actions had included; holding a reflective exercise with the clinical staff, developing a patient specific protocol and writing a further apology on behalf of the Board. All these had been concluded.

49.5 2) The Forum is very pleased that the LAS Board is committed to the Health Service Commissioners guidance 'Driving improvement and learning from NHS complaints information' published in March 2011. Can the board provide evidence of outcomes associated with the implementation of this guidance?

49.6 Steve Lennox had submitted a response that the LAS reported all learning through the Integrated report which was presented to Quality Committee, EMT, Learning from Experience and the commissioner Quality group. The Forum was represented at the Learning From Experience Committee and had the opportunity to influence the report at that forum.

49.7 The Trust had reshaped the report to strengthen the evidence of what we had changed based on the learning from complaints but we recognised that this still needed further strengthening. In addition, we were currently undertaking further review following the publication of the Francis Report.

49.8 3) Is the Board satisfied with the clinical case and safeguards for patient safety in respect of the recommendations of the TSA, Sir Bruce Keogh and Jeremy Hunt for South London Healthcare Trust and the plan for Lewisham A&E, and are adequate resources available for implementation of a safe and clinically effective service?

49.9 Ann Radmore stated that the reconfiguration in South London was subject to judicial review.

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

50.1 The next Trust Board meeting will take place on Tuesday 4th June 2013.

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Signed by the Chair

ACTIONS

from the Meeting of the Trust Board held on 26th March 2013

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
25/09/12	**131.3**	MD to write an explanation on the roles of the two LAS charities.	**AG**	AG/SA to review all aspects of charitable funds and to report back to the Trust Board.
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.
29/01/13	**14.5**	FM/SL to brief the Greater London Authority on the key elements of the Clinical Quality Strategy.	**FM/SL**	Updated strategy to be incorporated into the Integrated Business Plan.
29/01/13	**15.4**	FM/AR to write to Sir Bruce Keogh to ask the LAS to be involved with the review of urgent and emergency services.	**FM/AR**	FM has written to Professor Keith Willett, Chair of Domain 3 (Urgent and Emergency Care) within the NHS Commissioning Board, offering to assist with the review. No response has been received as yet.
26/03/13	**32.5**	FW to ask SL to consider whether there was a qualitative way to monitor comparisons with other ambulance trusts.	**SL**	There is no structure currently in place, although SL is exploring options to do this on a quarterly basis.
26/03/13	**32.6**	EMT to consider setting a board aspirational target for the quality dashboard eg having 50% of indicators rated green.	**SL**	The Trust's aspiration is to be in the upper quartile for all indicators.
26/03/13	**34.3**	EMT to develop an index for measuring value for money.	**AG/EMT**	Proposal to be presented to the Trust Board at end June, following discussion at the Finance and Investment Committee.
26/03/13	**36.4**	AR to discuss with SL how to incorporate staff stories into the Trust Board agenda.	**AR**	Underway.

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
26/03/13	**36.6**	SA to arrange facilitated Strategy Review and Planning session to discuss the recommendations from the Francis Report relating to organisational culture and board characteristics.	**SA**	Scheduled for the SRP meeting on 10th September 2013.
26/03/13	**37.3**	SA to ask Carmel Dodson-Brown to draft a brief explanation of the key principles of Being Open.	**SA**	Included in the Trust Board pack. Action complete.
26/03/13	**37.5**	CH to ensure that the reporting of near misses was covered in the staff induction.	**CH**	Action taken forward by TC.
26/03/13	**39.2**	SA to take soundings from other foundation trusts about whether they had appointed a CCG governor.	**SA**	North East Ambulance Service FT, South East Ambulance Service FT and South Central Ambulance Service FT do not have a CCG governor. South West Ambulance Service FT has 2 appointed governors from CCGs.
26/03/13	**45.2**	FG to add a presentation on the role of Health and Wellbeing Boards to the Trust Board forward planner.	**FG**	To be arranged.
26/03/13	**45.3**	AR to send JC her presentation on the structure of the NHS Trust Development Agency.	**AR**	

CLOSED ACTIONS

28/06/11	**67.3**	RH to discuss world cities benchmarking with FM.	**RH/FM**	FM to attend Eagles summit in February 2013. Action complete.
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. Action superseded by 36.4.

29/01/13	**07.5**	JK/PW to look into the possibility of monitoring call close down rates for individuals in the control room.	**JK/PW**	Discuss with RW. Integrated performance pack to be developed to include this data.
29/01/13	**08.2**	JK/PW to monitor the increase in resourcing and its impact on patient experience.	**JK/PW**	Action complete.
29/01/13	**14.2**	FM/SL to include reference to EOC and PTS staff in the Clinical and Quality Strategy.	**FM/SL**	The Clinical and Quality Strategy is currently being revised and updated. Action complete.
29/01/13	**17.3**	SA to present the Foundation Trust timeline to the Trust Board at each meeting.	**SA**	SA is in discussion with the NTDA regarding the timeline of the Foundation Trust application. There is no longer a requirement for all NHS Trusts to be authorised as Foundation Trusts by a defined deadline. Action complete.
26/03/13	**36.3**	FG to add an update on the actions to address the recommendations made in the Francis Report to the Trust Board forward planner.	**FG**	Added to the Trust Board forward planner for 23rd July 2013. Action complete.

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The Principles of *Being open*

In January 2009, the Department of Health launched The NHS Constitution for England this incorporates the principles of *Being open*. It is essential that a *Being open* policy meets the needs of the local organisation however, a number of legal and regulatory requirements must also be taken into account. The standards of openness outlined in the framework have been included in the Trust policies to ensure compliance with the accreditation and external assessment processes.

- National Health Service Litigation Authority
- Care Quality Commission
- NHS Contract

Open and effective communication with patients should begin at the start of their care and continue throughout their time within the healthcare system. This should be no different when a patient safety incident occurs. *Being open* when things go wrong is key to the partnership between patients and those who provide their care. Openness about what happened and discussing patient safety incidents promptly, fully and compassionately can help patients cope better with the after-effects. Patient safety incidents also incur extra costs through litigation and further treatment; openness and honesty can help prevent such events becoming formal complaints and litigation claims.
Staff may also be unclear about who should talk to patients when things go wrong and what they should say; there is the fear that they might upset the patient, say the wrong things, make the situation worse and admit liability. The Trust *Being open* policy sets out the process of communication with patients, and raising awareness about this, will provide staff with the confidence to communicate effectively following an incident.

The following ten principles underpin *Being open;*

1. **Acknowledgement** – when the Trust becomes aware of patient safety incidents the NHS contract stipulates that patients and carers should be informed if they have been involved in a moderate, serious or declared serious incident.

2. **Truthfulness, timeliness and clarity of communication** - Patients should be provided with a step-by-step explanation of what happened, that considers their individual needs and is delivered openly. Communication should also be timely; patients, their families and carers should be provided with information about what happened as soon as practicable. It is also essential that any information given is based solely on the facts known at the time. Healthcare professionals should explain that new information may emerge as an incident investigation is undertaken, and that patients, families and carers will be kept up-to-date with the progress of the investigation.

3. **Apology** - Patients, their families and carers should receive a meaningful apology – one that is *a sincere expression of sorrow or regret* for the harm that has resulted from a patient safety incident. This should be in the form of an appropriately worded and agreed manner of apology as early as possible. The Trust decides on the most appropriate member of staff to give both verbal and written apologies to patients, their families and carers. The decision should consider seniority, relationship to the patient, and experience and expertise in the type of patient safety incident that has occurred. Verbal apologies are essential because they allow face-to-face contact between the patient, their family and carers and the healthcare team. This should be given as soon as staff are aware an incident has occurred. A written apology, which clearly states the healthcare organisation is sorry for the suffering and distress resulting from the incident, must also be given.

4. **Recognising patient and carer expectations –** both should be treated sympathetically, with respect and consideration. They should also be provided with support in a manner appropriate to their needs. This involves consideration of special circumstances that can include a patient requiring additional support, such as an independent patient advocate or a translator.

5. **Professional support -** Healthcare organisations must create an environment in which all staff, whether directly employed or independent contractors, are encouraged to report patient safety incidents. Staff should feel supported throughout the incident investigation process because they too may have been traumatised by being involved. They should not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or any threat to their registration. To ensure a robust and consistent approach to incident investigation, healthcare organisations are advised to use the NRLS's Incident Decision Tree.

6. **Risk management and systems improvement** - Every healthcare organisation's *Being open* policy should be integrated into local incident reporting and risk management policies and processes. *Being open* is one part of an integrated approach to improving patient safety following a patient safety incident. It should be embedded in an overarching approach to risk management that includes local and national incident reporting and analysis of incidents using Root Cause Analysis.

7. **Multi-disciplinary responsibility -** The Trust policy on openness applies to all staff that have key roles in the patient's care, most healthcare provision is through multidisciplinary teams. This should be reflected in the way that patients, their families and carers are communicated with when things go wrong. This will ensure that the *Being open* process is consistent with the philosophy that incidents usually result from systems failures and rarely from the actions of an individual.

8. **Clinical Governance -** *Being open* requires the support of patient safety and quality improvement processes through clinical governance frameworks in which patient safety incidents are investigated and analysed to find out what can be done to prevent their recurrence. These findings should be disseminated to healthcare professionals so that they can learn from patient safety incidents.

9. **Confidentiality** - Communications with parties outside of the investigation team should also be on a strictly need to-know basis and, where practicable, records should be anonymous. It is good practice to inform the patient, their family and carers about who will be involved in the investigation before it takes place, and give them the opportunity to raise any objections.

10. **Continuity of care** - Patients are entitled to expect that they will continue to receive care and should be treated with dignity, respect and compassion. If a patient expresses a preference for their healthcare needs to be taken over by another team, the appropriate arrangements should be made.

[i]

[i] *Being open* – Communicating patient safety incidents with patients, their families and carers. National Patient Safety Agency. November 2009.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 4TH JUNE 2013

PAPER FOR INFORMATION

Document Title:	**Chairman's report**
Report Author(s):	**Trust Chairman**
Lead Director:	**N/A**
Contact Details:	**marilyn.cameron@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:	**To note the report**

Key issues and risks arising from this paper
N/A

Executive Summary
Since the last meeting, I have interviewed a prospective NED, met Trevor Jones, Chair of SCAS, participated in two teleconferences, one with UKTI and one on 111. We had a visit from a group of Russian local government officials to the LAS and I attended an LAS leadership meeting and a commemoration service. I met with Odgers Berndtson to review recruitment at the LAS over the last 12 months. I have completed personal assessments and one to one meetings for all NEDs. I met with David Jervis and discussed a survey for AACE and attended the ALF conference. I also had a meeting with Mike O'Donovan, Chair of Heatherwood and Wexham NHS Trust.

Attachments
None.

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

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

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

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

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

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

Equality Analysis

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

Key issues from the assessment:

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 4 JUNE 2013

PAPER FOR NOTING

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:	Note the report

Key issues and risks arising from this paper

The current quality dashboard suggests a stable position against the indicators.
.

Executive Summary

There are three components to the Quality Dashboard

1. Quality Dashboard

The dashboard illustrates the Trusts performance for March 2013 against the identified Quality Measures. The challenge and discussion for each indicator has been undertaken at SMG.

The dashboard illustrates 34 measures for quality and reveals 11 Green measures 6 Amber measures and 17 Red measures.

The Trust Board requested a short commentary regarding RED indicators.

On Scene Time

The three time critical conditions (cardiac, trauma and stroke) all have various elements of the pathway measured. This is included in the dashboard to monitor the effects of pressure on the entire patient pathway. On scene times are currently at 40 minutes with a target of 30 minutes. There is little change and no increase.

STEMI Care

This is Red due to the issues we have previously raised regarding analgesia. No new clinical concerns.

Not conveyed See & Treat
We aim to treat approximately 32% of patients through See and Treat. The figure of 29.6% was slightly below the expected level but is not a clinical concern.

Diabetes & Alcohol
The RAG rating reflects the CQUIN work. We made less referrals than expected for alcohol and diabetes alternative care pathways. These indicators will now be removed from the scorecard and replaced with the 2013 priorities.

Airway Management
The indicators are in the main as expected but the RAG status reflects compliance with one indicator and that is regarding the recording of End Tidal C02 at the time of intubation. This is being addressed by the areas and is showing some signs of improvement. 92% for March

Infection Control
The infection control indicator is RAG rated red due to statutory training compliance and a drop in Cleaning compliance which has been actioned.

Safeguarding
The safeguarding indicator is Rag rated red due to statutory and mandatory training compliance.

Cat C Response Times
We are underperforming with category C and this is addressed in other Board reports

Handover Time
The dashboard reports the time it takes us to receive a handover. This is a national issue that is being addressed by national influencers.

Supervision & Training
Staff are not currently receiving the level of OWR that has been set. There were 88 OWR sessions in March compared to a target of 200. Similalrly the training commitments were not delivered but this has been previously discussed at Trust Board.

3rd Party Providers and Sickness
We have set a compliance level of 8% of the work to be provided by 3rd party and the month of January this was 8.58%, just over the level. No significant clinical issues. Sickness was also just above the compliance level of 5.5% at 5.8%

Vacancy factor
For the first time since the introduction of the quality dashboard turnover has met the threshold with a figure of 8.8% against a target of 8%.

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.

This month the Trust is at the very top in 10 of the indicators.

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

****

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

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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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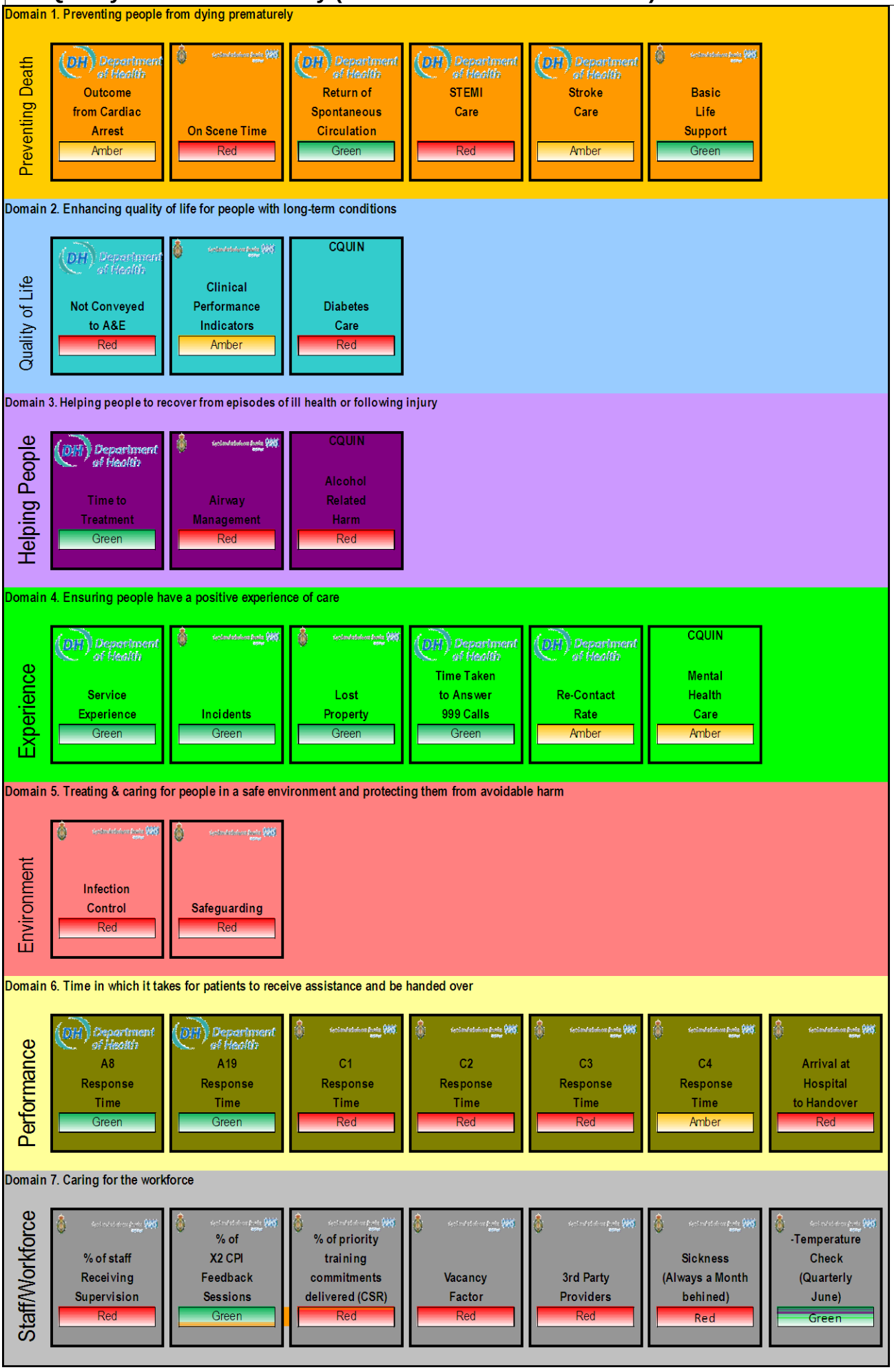
1. Quality Dashboard for May (March & December Measures) 2013



2. Comparison Table

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

2.2 The GREEN shading represents where the Trust is in the upper quartile when compared to other services. We are upper quartile in 25 (last report 22) out of 46 areas.

	March (January Data)					YTD	
	Compliance	Rank	Lowest	Highest	Direction of Travel	Compliance	Rank
A8 R1 Response Time	81.9%	1	71.70%	81.9%	↑	77.7%	4
A8 R2 Response Time	78.40%	2	67.10%	81.50%	↓	76.30%	5
A19 Response Time	98.50%	1	96.70%	99.00%	↔	98.2%	1
ROSC (all)	30%	2	27.30%	36.40%	↓	30.9%	2
ROSC (Utstein)	54.8%	1	45.70%	63.60%	↓	54.9%	2
Time Taken to Answer 50th Percentile	0.00%	1	0.00%	0.00%	↔	0.00%	1
Time Taken to Answer 95th Percentile	0.01	1	29	0.01	↑	0.07%	2
Time Taken to Answer 99th Percentile	0.05	1	1.46	0.02	↑	0.51	5
Time to Treatment 50th Percentile	5.36%	4	6.11%	5.36%	↔	5.49%	7
Time to Treatment 95th Percentile	13.18%	1	16.90%	12.70%	↓	14.10%	2
Time to Treatment 99th Percentile	20.12%	1	19.40%	27.30%	↑	22.23%	2
Outcome from cardiac Arrest Survival	6.30%	6	6.30%	11.40%	↔	8.0%	4
Outcome from cardiac Arrest Survival (Utstein)	21.6%	4	16.30%	37.00%	↓	31.2%	1
STEMI Outcome 150 minutes	91.5%	3	84.30%	94.90%	↑	91.7%	3
STEMI Outcome Care Bundle	66%	10	63.10%	69.20%	↑	67.3%	12
Stroke Outcome 60 minutes	61.6%	3	61.6%	75.80%	↓	67.8%	4
Stroke Care Outcome Bundle	92.8%	11	92.10%	95.70%	↑	94.1%	10
Calls Closed with CTA	6.3%	5	5.30%	6.90%	↓	5.90%	8
Non A&E	26.6%	8	26.6%	33.30%	↓	31.3%	9
Re Contact rate CTA	2.9%	1	3.40%	2.20%	↓	2.9%	2
Re Contact rate See & Treat	6.1%	6	6.1%	4.90%	↓	5.4%	6
Re Contact rate Frequent callers	2.3%	4	2.5%	2.61%	↑	2.5%	5
999 Calls Abandoned	0.0%	1	0.0%	0.10%	↑	0.1%	1
Service Experience							

3. Conclusions

3.1 This dashboard has seen an improvement in compliance.

3.2 There are no new issues revealed within the dashboard but some of the clinical measures remain just below the trajectory we have set although again we do reasonably well when drawing comparisons with other services. In conclusion the dashboard suggests that all ambulance services have found some challenge in delivering a high quality service within the context of increased demand across winter.

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London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 4TH JUNE 2013

PAPER FOR INFORMATION

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

Key issues and risks arising from this paper

- CPI completion rates remain the high.
- The Mental Health CPI continues to be the low achieving.
- Total Locality Alert Register entries have increased slightly since the last report, but not to a level of concern. The addresses received from the Metropolitan Police Service continue to rise each month.
- There has been one reportable controlled drugs incident since the last report, involving the loss of two morphine sulphate ampoules possibly at a hospital. The ampoules have not been found, but the investigation complied with policy.
- The Trust has not received any Rule 43 recommendations since the last report to Trust Board

Executive Summary

The report is structured around the quality domains of the quality dashboard but also reports on issues wider than the quality measures. This report identifies areas of improvement required as well as successes. The Trust Board can take some assurance that the service is maintaining high levels of care to it's patients. However, there are also concerns surrounding the high utilisation rates, and the new National Clinical Guidelines. The initial go-live of the guidelines has been delayed due to the number of staff that would have been trained by the initial go-live date.

Attachments

Appendix 1: Nice Quality Standards (Supporting people to live well with dementia)

****

Quality Strategy

This paper supports the following domains of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☒ No

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST

Clinical Quality & Patient Safety Report – May 2013

Clinical Directors' Joint Report

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 where improvement is required. The Trust Board can take some assurance that the service is maintaining a high quality service to its patients. However, there is concern over utilisation and increasing call numbers seen by the Trust in recent months. This concern is coupled with the need for training time and the introduction of the new National Clinical Guidelines and drugs which are due to be released. Without appropriate training time, the release of the guidelines will have to be stalled, as will the implementation of the new drugs the Trust is adopting. This will impact on the care that is provided to our patients.

Quality Domains

Quality Domain 1: Preventing People from Dying Prematurely

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 most recent Cardiac Care Pack (Monthly Cardiac Arrest and ST-Elevation Myocardial Infarction Report April 2013) has been published. The full report can be found at:

Clinical Audit & Research Unit\Cardiac Reports\Cardiac Care Pack - Monthly Reports\April '12-March '13\Cardiac Care Pack (March '13).pdf

The most recent Stroke Care Pack (monthly report April 2013) has been published. The full report can be found at:

X:\Clinical Audit & Research Unit\Stroke Reports\Monthly Reports\April '12-Mar '13\Stroke Care Pack (March '13).pdf

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

Mental Health

The Independent Commission on MH and Policing report was published on 10 May that identifies issues with the commissioning of transport for mental health patients under section 136/135. The following recommendation was made for the ambulance service.

Recommendation 23:
NHS England should work with Clinical Commissioning Groups, health and wellbeing boards and the CQC to ensure that:
No person is transferred in a police van to hospital;
Funds are made available through an appropriate dedicated response for mental health, for instance provision of a dedicated paramedic in a car; and

The Trust will need to consider its response in due course

End of Life Care

The 2011-12 CQUIN for End of Life Care identified a training need for staff to have the confidence and appropriate training to be able to deal with this group of patients in a way that was best for them. A training package was written and agreed following the need being identified. However, the roll out of this training was delayed. Consequently, very few operational staff have received this.

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

Clinical Performance Indicator completion and compliance

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

CPI completion April 2012 to January 2013

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

CPI Compliance March 2013

Area	Cardiac Arrest	Difficulty Breathing	ACS (Including MI)	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	97%	97%	97%	96%	86%	97%	97%
South	98%	98%	97%	98%	88%	97%	98%
West	98%	98%	97%	98%	89%	97%	98%
LAS Total	**98%**	**97%**	**97%**	**97%**	**88%**	**97%**	**98%**

CPI Compliance February 2013

Area	Cardiac Arrest	Difficulty Breathing	ACS (Including MI)	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	97%	94%	95%	96%	88%	97%	97%
South	98%	96%	97%	98%	86%	96%	98%
West	98%	96%	97%	98%	91%	97%	98%
LAS Total	**98%**	**95%**	**97%**	**97%**	**88%**	**97%**	**98%**

Cardiac Care

ParaSVT

This research project continues to go well, only 16 patients left to complete the study. The project continues to see no adverse incidents.

Some general discussions will be required following the successful recruitment of all patients to see if we continue post research project.

High Risk ACS

This initiative is now pan London and appears to be working well.

Resuscitation

Following a recent visit to Lund University to meet with Prof. Stig Steen a number of minor changes are being made to LAS resuscitation guidelines

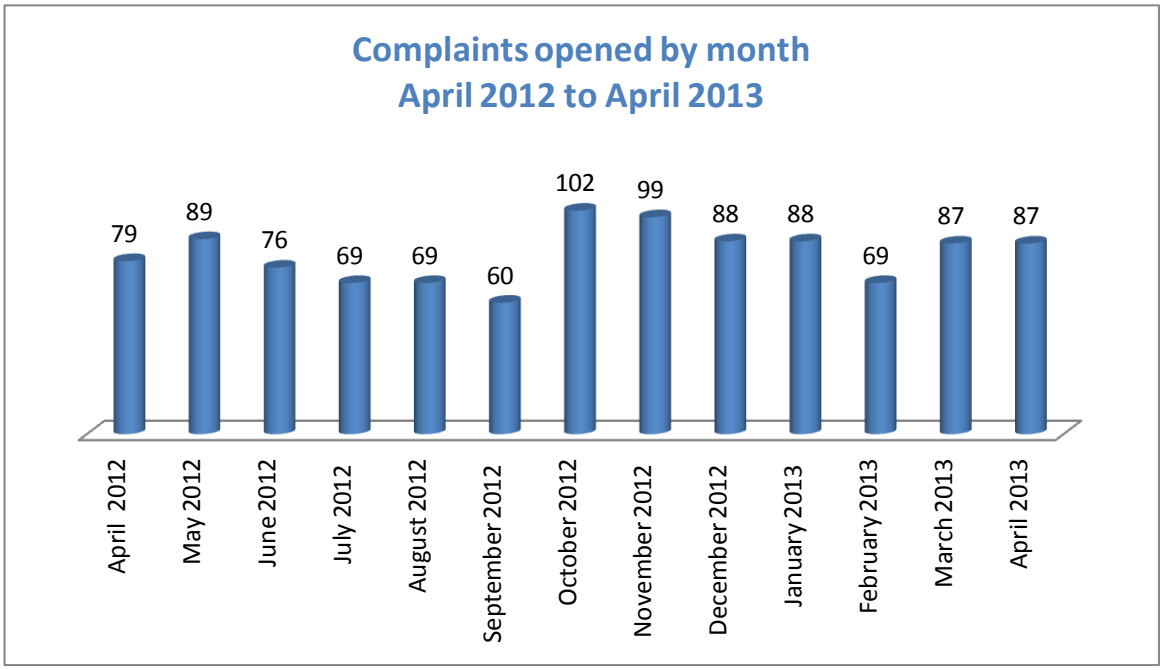
Quality Domain 4: Ensuring people have a positive experience of care

Patient Experiences

COMPLAINTS

Complaints for April remained static at 87. The monthly average for 2012/13 was 81 complaints per month; this was lower than expected as a result of reduced volumes during the Olympic Games period when complaints averaged 66 per month between July - September.

During April, 19 complaints involved other Trusts/agencies including 9 Acute Trusts, 4 x 111 providers and the remainder including GPs and Mental Health services. As at 8 May 157 complaints remain open or re-opened. 92 cases were closed Complainants are advised by email or telephone call whenever a delay in responding is anticipated.



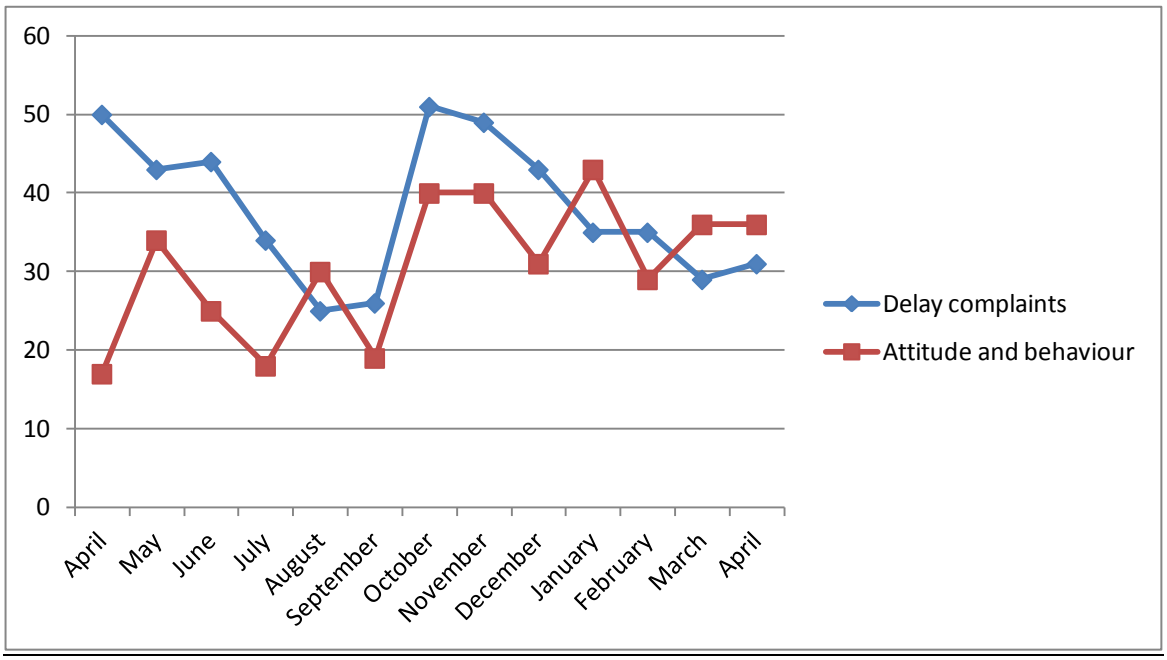
The latest benchmarking data available for 2011/12 indicates that LAS received 25% of all complaints to ambulance Trusts during the period. However, a number of Trusts have not as yet filed data (for example South East Coast, South Central and East of England) which affects the overall picture. This is summarised in the following table.

Numbers of complaints received		
Trust	**2010/2011**	**2011/2012**
London Ambulance	514	673
North West	482	386
Great Western	282	383
West Midlands	273	313
North East	210	300
East Midlands	228	252
South Coast	121	169
Northern Ireland	98	98
Yorkshire	67	82
Totals	2275	2656

Complaint Themes – Main themes

Complaints relating to the delay and staff attitude & behaviour continue to be the dominant themes.

The following graph demonstrates the trend in the delay and attitude and behaviour themes. The third most frequent theme is road handling. During 2012 - 2013 there were 100 such complaints of which 45% related to siren noise and 15% were not LAS vehicles.



Complaint Themes – Other themes

Locality Information

A new theme for 2012/13 involves concerns raised by patients challenging their inclusion to the Locality Information System – currently 16. Outcomes have encouraged more rigorous liaison with the police and we are advised a new process will be implemented by the police in due course.

However, almost every case has been referred back to the local complex to undertake further work, especially in relation to a care plan approach.

The following table illustrates the main themes arising from complaints.

Complaint subject	**subject during 01/04/12 to 30/04/13**	**Apr-13**
Delay	441	30
Attitude and behaviour	288	21
Road handling	95	10
Non-conveyance	76	7
Treatment	75	10
Conveyance	31	3
Locality Information Register	16	2

Patient Injury or Damage to Property	16	1
Not our service	14	3
Clinical Incident	6	0
Aggravating Factors	3	0
Clinical Equipment	1	0
Totals:	**1062**	**87**

Complaint Themes –Case Examples

Recorded message

Use of the recorded message by EOC is a routine subject of complaint, with one caller saying they were left feeling vulnerable and isolated. (C7803). The Control Services governance team have been asked to consider checking whether a patient is alone when using the recorded messages.

Call triage

The call triage system MPDS was also the subject of a complaint (C7785) from a doctor calling on behalf of himself when he suffered an injury which was bleeding heavily. Due to the way in which the call was managed (C4); the doctor was advised to make his own way to hospital. The Quality Assurance evaluation found that the call handler should have used the manual 'shift option' to select 'serious bleed' (C2). The revised version (12.2) will automatically upgrade such calls and discussion is taking place between QA and IM&T to about possible changes to CommandPoint, although this would have a cost implication.

End of life care/DNAR

Several complaints were received involving end of life care. For example, the family of a dementia patient with a terminal illness who was a resident at a care home were distressed when, after unsuccessful resuscitation, the patient was left *in situ* on the floor. (C7757) We found that the crew should not have applied protocol so literally and it would have been reasonable to consider returning the patient to bed. Local liaison was also recommended with the care home.

In another case, despite a DNAR in place, the volume of demand to the Trust caused information not being made quickly available to a voluntary ambulance responder and a resuscitation attempt was made. (C7703). The palliative plan arrangements only became apparent thereafter. CQD will be liaising with local palliative care leads towards establishing improved guidance and ensuring relatives are aware of what to do in the event of a patient's death. The project lead for voluntary responder practitioners will highlight the management of patients with end of life care plans.

In a further case, a patient, who had a DNAR in place, had died, thus an approach was made to the GP to attend to certify an expected death. (C7697) Unfortunately, the GP was unable to attend for some time and EOC erroneously arranged for the police to attend to release the ambulance crew from the scene. The police are only usually required to attend an unexpected death and the family were concerned that the police treated the incident as a crime scene. It has been identified that when such calls are passed to the police, the menu, under the heading '*deceased – responsible adult on scene*' does not include 'expected death'. This issue has been drawn to the attention of our EOC Quality Manager and a bulletin is also being produced for dissemination to all EOC staff to try to prevent the unnecessary activation of the police to such incidents.

Mental health patients

Following a number of complaints regarding the management of 999 calls to patients with mental health problems or suicidal ideation (C7004), EOC have prepared a revised process for the dispatch of LAS vehicles which now need to be booked once a Mental Health Assessment is under way and it is clear that the needs of the patient have been identified.

EMDs also now check if the patient is on their own and note 'ALONE' in the free text area of the call event log. When a response is delayed, these calls are then prioritised for ring back and if no contact is made; a series of checks takes place in EOC. Where a suicidal patient calls back to cancel the request for help, although an adult with capacity can refuse treatment, the assessment of their capacity cannot be undertaken by telephone and the call must not be closed.

Complaint Answering

Closure rates year on year (below) show that in 2012 this was 43% closed within time frame and 42% in 2013 although a 35 day minimum has now been allocated, so this is not directly comparable. Similarly, a true reflection of response times cannot be calculated until the furthest timescale (i.e. 35 days working days have elapsed) = 25 May 2013.

Response time allocated February to April 2012	Number of complaints opened this period	Closed within time frame
Complaint 25 days	151	76
Complaint 30 days	15	8
Complaint 35 days	35	3
Complaint 40 days	29	12
Complaint 45 days	3	2
Totals:	**233**	**101**

Response time allocated February to April 2013	Number of complaints opened this period	Closed within time frame
Complaint 25 days	5	5
Complaint 35 days	232	97
Complaint 40 days	5	1
Complaint 45 days	1	0
Totals:	**243**	**103**

Comeback responses

We have received more repeat complaints this year than in previous years; as illustrated in the following table.

Year	Numbers of comeback responses recorded
09/10	9
10/11	4
11/12	12
12/13	37
13/14	2
Totals:	**64**

In April 2013 there were 2 comebacks.

Datix	Complaint summary	Outcome	Comeback outcome
7193	Complaint regarding siren noise	Regular complainant regarding siren noise.	Suggested that the enquirer raises his concerns with the HSO
7611	Complaint from patient concerned that information regarding her condition was shared with her GP	Explanation of role of Referral Support Team and that the crew believed that the patient supported passing details to her GP.	Patient believed that LAS had breached patient confidentiality. Apprised of s.30 of the DPA and advised to contact her GP regarding the deletion of the record

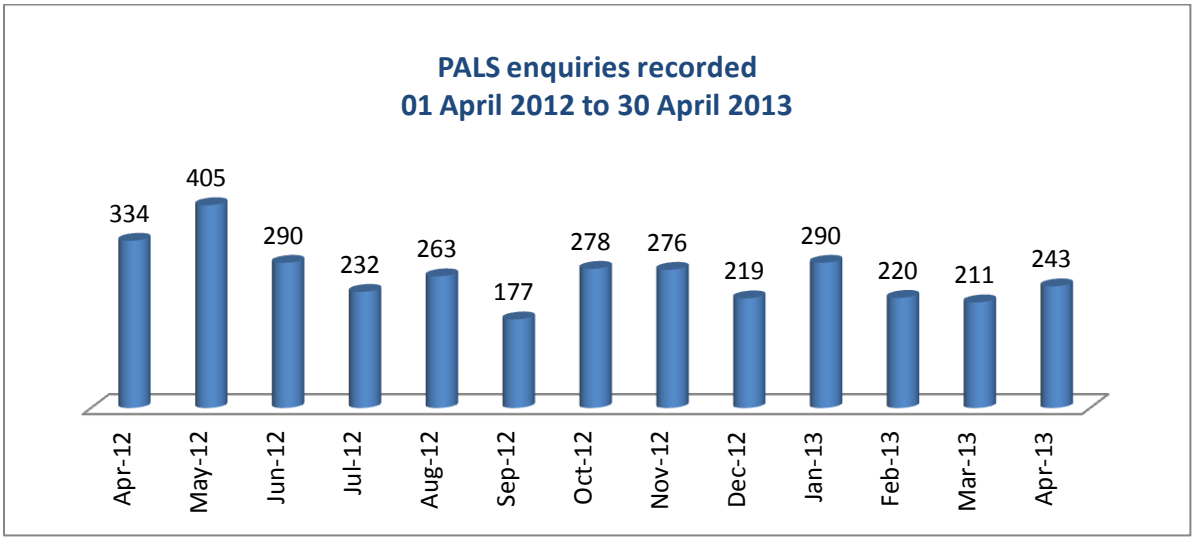
Health Service Ombudsman

The Ombudsman has announced that they will be investigating more cases – we will be monitoring this in the next few months as this may impact on the time factor in the preparation of submissions. We currently have 6 cases from April with the Ombudsman.
More complex analysis of HSC cases will be prepared on a quarterly basis from Q1 2013/14.

PALS

PALS Volume

The number of PALS enquiries remains stable with less incident report investigations due to improved signpost changes on the LAS website. There was a slight increase in April over March; general enquiries continue to be about destination hospital, medical record requests, event information and requests for defibrillator training.
Lost property in April accounted for 55 requests - of those 47 were referred to local stations. The new system is functioning well. Only 8 referrals do not have a recorded outcome. The Performance Improvement Managers now have access to the lost property spreadsheet as part of their Quality of Care objective for 2013/14 to monitor lost property and the use of SMARTbags™.
PED will also be providing monthly data to support the information required to monitor complaint resolution.



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

Financial Year	Total PALS
08/09	5606
09/10	5674
10/11	6031
11/12	6264
12/13	5714
13/14 (to date)	505
Totals:	**29794**

PALS Themes

The PALS network website no longer functions but sharing of information is being maintained through LinkedIn and local networks.

PALS April 2013	Total
Information/Enquiries	167
Lost Property	55
Clinical	5
Appreciation	3
External Incident Report - LAS Crew	2
Incident Report - A&E	2
Incident reports	7
Patient Injury or Damage to Property	2
Totals:	**243**

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

Safeguarding

There are no new safeguarding matters to report.

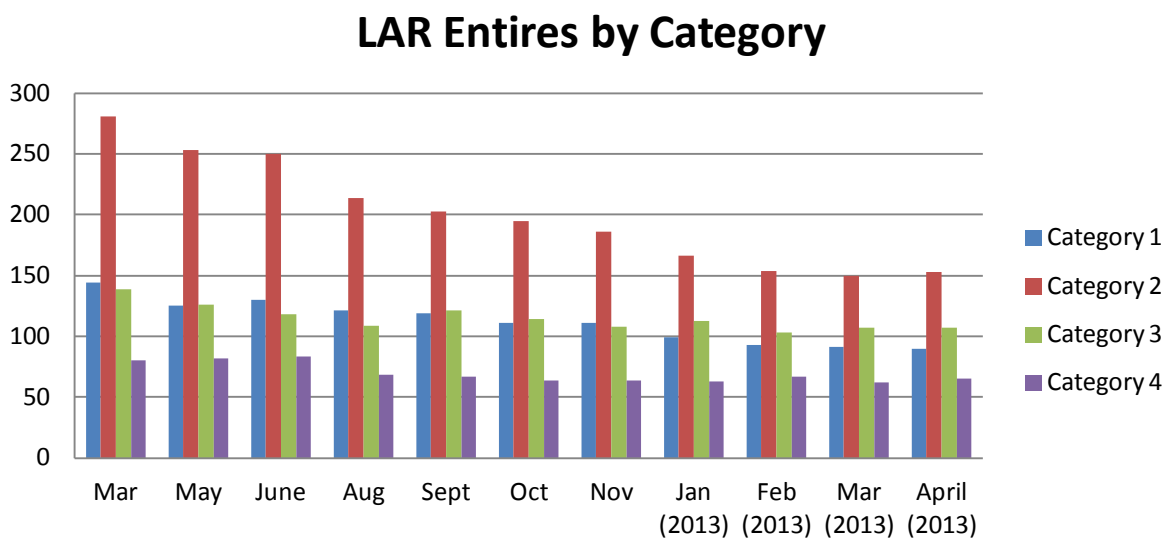
NHS Central Alerting System (CAS)

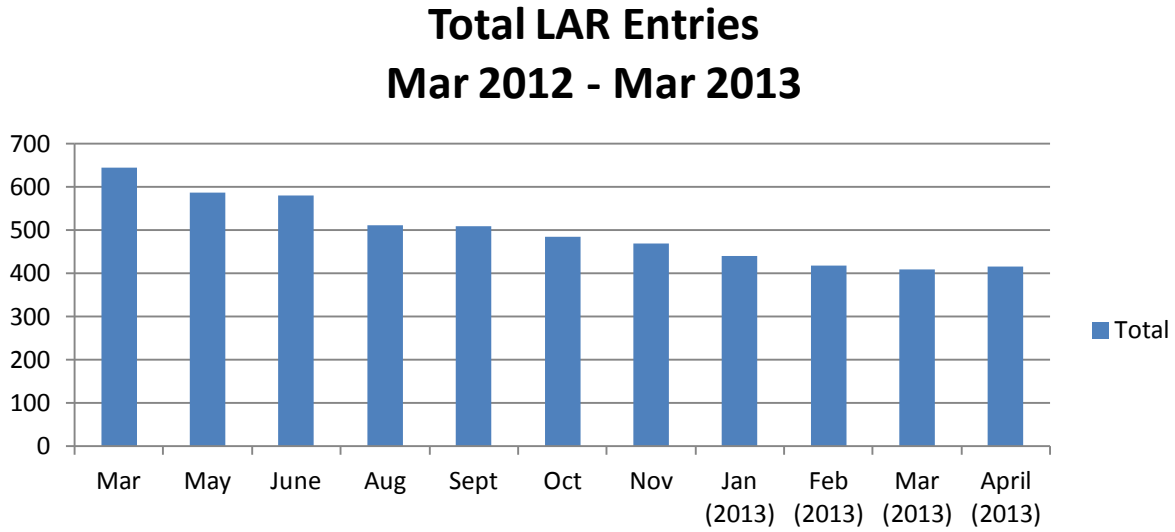
There have been 11 Central Alerting System reports during March. Of these, only one may have relevance and is currently being assessed by the Safety and Risk department. This alert surrounds the use of detergent and disinfectant wipes on reusable medical devices with plastic surfaces. The other CAS reports were acknowledged but not relevant to the Trust.

Locality Alert Register

There are currently 415 LAS addresses on the system. They are broken down as follows:

CATEGORY 1: 90
CAT EGORY 2: 153
CATEGORY 3: 107
CATEGORY 4: 65





The Trust has notification of 1184 high risk addresses from the Metropolitan Police. Crews are reminded to complete a dynamic risk assessment on their arrival to the address. The number of addresses received from the Metropolitan Police has risen considerably since January 2013.

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.

DMP use during March to April 2013 (Winter working arrangements in place throughout March 2013)

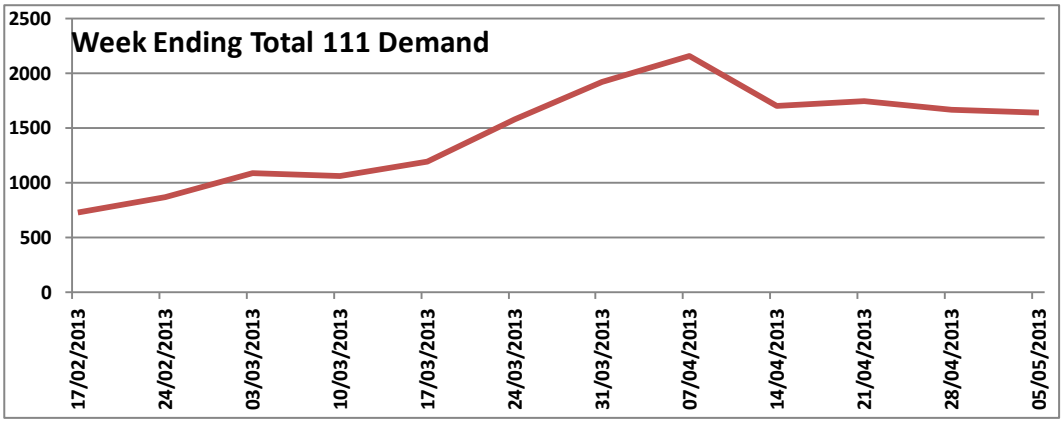
Month	Number of Occasions	Stage B (in hours)	Stage C (in hours)	Stage D (in hours)	Stage >D (in hours)	Ambulances reprioritised	No-send at point of contact
March	6	0	0	15.25	0	3988	783
April	209	108	79	22	0	409	1139

111 System Implementation

NHS 111 is now live across most London sites with Lewisham Southwark and Lambeth expected to launch this month.

Modelling based on national activity shows a projected incident rate for NHS 111 calls at 10% of total projected 2013/14 activity on 122,000 incidents.

Activity for May is showing a marginal decrease when compared April.



111 activity currently accounts for 8% of all 999 incidents with circa 55% being converted to category A incidents.

Weekend activity accounts for over 10% of 111 activity with some weekend day seeing up to 12% of total activity.

Serious Incidents

Since the last report to Trust Board, there have been 20 potential serious incidents reported. Of these, 4 have been declared and are under investigation.

The first incident (61235/13997) was raised by West London Mental Health NHS Trust. It surrounds the death of two of their patients who had waited for an extended time for an ambulance following

999 calls made by a mental health worker on behalf of patients. The first died from an overdose, and the second following a fire.

The second incident (I60785 STEIS 2013 11798) surrounds a patient who fell from a trolley bed and sustained an injury to her head which required treatment.

The third declared incident (I60864 STEIS 2013 11934) involves a crew who were responding under emergency conditions to a R2 event. En-route to the call the ambulance struck a pedestrian who sustained head and abdominal injuries. The black box recording from the time of the impact showed that although the blue lights were activated, the sirens were not.

The last incident that has been declared (I61165 STEIS 2013 12920) involves a crew who remained on scene at a call for an extended period of time (1hr 53 minutes). Whilst on scene, the patient deteriorated and had a cardiac arrest. He subsequently died.

Medicines Management

There has been one reportable controlled drugs incident since the last report to Trust Board. This incident involved the loss of two ampoules of morphine sulphate by a member of staff from Isleworth Station on 5th April 2013. The details of the loss were reported immediately to all the correct authorities and the LAS Policy on reporting and investigating the loss was complied with. The paramedic advised that she lost the morphine pouch and the ampoules when she used the toilets at Charing Cross Hospital. She did not realise she had lost the pouch until later that shift. On discovering the loss she reported it immediately, and the loss was reported to the Police. Charing Cross Hospital were contacted and also visited but the pouch has not been handed in anywhere. The investigation is satisfied that this was a genuine loss and that whilst the member of staff accepts the loss is absolutely her fault, it is felt that this was a genuine mistake and had been dealt with as such. The incident, and all subsequent actions, will be reported to the INWL LIN Group in the Quarter 1 report to be submitted on 1st July 2013. There will be a previous bulletin re-issued reminding staff about ensuring they are aware of the exact physical location of their morphine at all times.

The Medicines Management Group met on 27th March 2013. The main items discussed were the introduction of the four new JRCALC Drugs, ensuring that Frimley Pharmacy were aware of the proposed "start Date" (1st July). *Apropos* this action, all supplies are being readied, Logistics Depot at Deptford are aware of their actions, the training packages are written and David Whitmore and Mark Faulkner have personally carried out the "Train the Trainer" events for the new drugs. The date of the next MMG is 10th July 2013.

Rule 43 Reports

The Trust has not received any rule 43 recommendations since the last report presented to the Trust Board. There have not been any relevant recommendations given to other Trusts that the London Ambulance Service could learn from.

Quality Priorities

The Quality Account has identified the Quality Improvement areas for 2013/14

- Service Modernisation
- Improving the care of less urgent patients by;
    - Reducing the number of complaints associated with poor attitude & behaviour
    - Improving the experience of patients subjected to a delay
    - Improving the experience of patients referred to alternative care pathways
    - Reduce the incidence of missing equipment

These will be added to the Quality dashboard to provide an indication of progress in addressing these areas.

Rising Tide

Public Health

The Trust's infection control audit results have been published. More detail will be contained within the annual infection control report but the annual audit cycle has revealed. That compliance with current IPC guidelines; overall the Trust average is 85% compliant. This figure is a good indicator that as a Trust we have successful and effective systems in place to comply with current guidelines and procedures.

This does not however account for one complex scoring as low as 65% (32% below their own self-audit) whilst a neighbouring complex in the same sector was compliant at 98% (11% over their own self-audit).

The audit revealed that there are some issues with the management of food in local fridges; particularly in management offices. This will be addressed locally.

Clinical Professional Issues

2013 Clinical Practice Guidelines / Training

The 2013 clinical practice guidelines have been received by the Trust. All team leaders and training officers should now have their personal copies. The rest are being disseminated to clinical staff in the coming weeks. Due to the updates, and the addition of four new drugs that the Trust will move to, (tranexamic acid, intravenous paracetamol, oral dexamethasone and ondansetron) all patient facing/clinical staff will require a training session to enable them to appropriately follow the new guidelines.

The planned go-live for the new guidelines is 1st October 2013, with the update being completed within the CSR training which it is hoped will commence on 28th May. A minimum number of staff will be required to have undertaken this training prior to the guidelines being adopted, so that the move to them is done in a safe manner, with patient care being of the utmost importance. It is suggested that a minimum of 1920 staff, equating to approximately 60% should be trained on the updated guidelines and new drugs prior to go-live. If this is not possible, this date may well have to be pushed back which essentially will affect the care that is provided to our patients.

April 2013 NICE Guidance

The April 2013 Guidelines discuss the importance of 'supporting people to live well with dementia' (QS30) Please see appendix 1.
There are a number of salient points which the Trust could adopt, although not aimed at Ambulance Trusts, which could provide a better level of care to this patient group. Of particular importance is developing multi-agency dementia partnerships which will aim to improve the care provided and the ways these patients are assessed and treated.

Fionna Moore	**Steve Lennox**
Medical Director	**Director of Quality & Health Promotion**

Sheffield Clinical Commissioning Group
NICE Quality Standards Summary for
Supporting people to live well with dementia (QS30)
April 2013

Sheffield Clinical Commissioning Group

APPENDIX 1

Please refer to the detail contained within the NICE support for commissioners
http://publications.nice.org.uk/support-for-commissioning-dementia-care-cmg48

Statements	Commissioning and resource impact	Local Costing Implications	Associated NICE Guidance
Integrated care and service provision	**Commissioning impact:** Use a whole-systems approach to commissioning. Develop integrated health and social care needs assessments and commissioning plans. Integrate commissioning functions across health and social care where possible. Involve the public, people with dementia, their carers and families when commissioning services. Develop local multi-agency dementia partnerships. Use a long-term conditions approach to supporting people with dementia. Ensure that commissioning plans promote personalised care. Ensure that all health and social care professionals who may come into contact with people with dementia are aware of the condition and where people can access diagnosis. Commission multi-agency teams. **Estimated resource impact:** There may be costs for awareness raising training for staff, and developing skills, knowledge and continued professional development of health and social care professionals. There may be savings from more efficient systems and procedures, disinvestment from ineffective practice and having single assessment points and records leading to reduced duplication of duties and economies of scale.		QS1 QS13 CG42 TA217
Early identification, assessment and diagnosis	**Commissioning impact:** Agree a local target to increase the proportion of people with dementia who receive an early diagnosis. Commission a dementia diagnosis service. Ensure initial management of dementia includes information about the condition, and equal consideration of medical and social components of care. Develop a 'single point of information' on local dementia care and services.		

Statements	Commissioning and resource impact	Local Costing Implications	Associated NICE Guidance
	Estimated resource impact: There may be additional costs resulting from a possible increase in the use of services that support people with dementia and their carers.		
Promoting choice	**Commissioning impact:** Clearly define who is responsible for: Initiating a care plan Initiating a carers assessment The periodic review of the care plan, and review when a person's circumstances have changed Care coordination Supporting people to make advance care plans for end of life. Ensure there is access to independent advocacy services for vulnerable people with dementia **Estimated resource impact:** There may be additional resources required to support people with dementia and their carers to develop Advance Care Plans.		
Promoting independence	**Commissioning impact:** Ask community and residential providers to demonstrate that they enable people with dementia to participate in leisure activities, maintain relationships and contribute to the local community. Invest in support for people to live independently with dementia. **Estimated resource impact:** There may be costs associated with adaptations to housing and the environment, meeting the needs of daily living and supporting people to participate in leisure activities and the community. However promoting independence may delay or reduce the need for avoidable residential care home costs and hospital admissions.		
Providing support	**Commissioning impact:** Have plans to increase access to behaviour and social interventions for people with		

Statements	Commissioning and resource impact	Local Costing Implications	Associated NICE Guidance
	dementia, which can reduce inappropriate use of antipsychotic drugs. Commission mental health liaison services in hospitals. **Estimated resource impact:** There may be potential savings resulting from a reduction in inappropriate use of anti-psychotic drugs and a reduction in secondary care costs (unplanned hospital admissions and length of stay in hospital). You may use the commissioning tool to estimate potential saving. Each 10% reduction in unplanned hospital admissions may save £14,000 per 100,000 population. *Additional investment in behavioural and social interventions may be required to support a reduction in the use of antipsychotic drugs.*		
Palliative and end of life care	**Commissioning impact:** Make end of life care commissioners aware of the specific needs of people with dementia. Support primary care to identify people with dementia who should be added to primary care palliative care registers. **Estimated resource impact:** No additional costs anticipated.		
Support for carers	**Commissioning impact:** Ensure that carers assessment are routinely offered at the time of diagnosis. Commission a range of respite services for carers of people with dementia. Ensure local capacity in services that can provide emotional, psychological and social support to carers. **Estimated resource impact:** There may be costs to fund respite services and tailored interventions such as self-help, short-term psychotherapy or CBT. See costing work for NICE clinical guideline 42 for more information on costs.		

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London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE
FINANCE & INVESTMENT COMMITEE

DATE: 4TH JUNE 2013

PAPER FOR APPROVAL

Document Title:	**2013/14 Financial Plan update**
Report Author(s):	**Interim Director of Finance**
Lead Director:	**Andrew Grimshaw**
Contact Details:	**Andrew.Grimshaw@lond-amb.nhs.uk**
Why is this coming to 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 ☐ Other
Recommendation for the Trust Board:	The Trust Board is requested to note this paper.
Executive Summary This paper provides a summary of work being undertaken to finalise the 2013/14 Financial plan as approved at the March meeting of the Trust Board.	
Key issues for the Trust Board The FIC is requested to note the action plan.	
Attachments	

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Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper links to the following strategic risks:

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

NHS Constitution

This paper supports the following principles that guide the NHS:

☐ 1. The NHS provides a comprehensive service, available to all
☐ 2. Access to NHS services is based on clinical need, not an individual's ability to pay
☐ 3. The NHS aspires to the highest standards of excellence and professionalism
☐ 4. NHS services must reflect the needs and preferences of patients, their families and their carers
☒ 5. The NHS works across organisational boundaries and in partnership with other organisations in the
☐ interest of patients, local communities and the wider population
☒ 6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
☒ 7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☒ No

Key issues from the assessment:

London Ambulance Service NHS Trust
Trust Board
04th June 2013.

2013/14 Financial Plan update

This paper provides an update on the interim financial plan agreed by the Trust Board in March 2013 together with the steps underway to finalise this.

The Board is requested to note the actions being taken and the timeline for presenting a finalised report to the Board for Approval.

Divisional Budgets

The Finance Dept continues to work with divisional management teams to review all budgets to ensure they are adequate and appropriately structured. This work involves detailed individual budget review meetings with executive leads and other appropriate staff. The intention being to ensure transparency of budgets and to have clear agreement and sign off that the allocated resources are available and managers understand their budget responsibilities.

To date the majority of divisions have been reviewed in detail and follow up meetings have been arranged where necessary. The aim is to provide assurance, and evidence of sign up to the June Finance Committee meeting to enable a final budget position to be presented to the late June Trust Board meeting.

To date no significant issues have been identified that challenge the interim financial plan as presented.

Action: Finance Director to complete budget review for June FIC.

Service Developments.

As part of the interim financial plan provision was made for service developments and the need to invest in quality during 2013/14. To date none of these funds have been allocated, although it is likely that some costs are being incurred as some issues are embedded within divisional budgets; for example the retention of long term vacant posts has been requested to be made as a service development, some of these posts were filled during the budget setting process or since.

As part of the budget reviews all bids for service developments are being revisited to ensure they are necessary, accurate and the timing of the cost is understood. While this work is removing and or reducing some service developments it is also identifying a range of issues that were not identified in the original budget setting work. The overall total value of requests remains in excess of the funds put aside for this purpose. As originally indicated a process of prioritisation will need to be undertaken to ensure that available resources are effectively focused. This work will be undertaken via the Senior Management team.

Action: Finance Director to agree timescale and process of review with SMT to ensure work concluded before the end of June 2013.

Cost Improvement Programme.

Work continues to identify the full vale of savings required for 2013/14, £9.8m. A detailed paper on progress was presented to the May meeting of the FIC. Further work is necessary as not all plans are finalised.

Additional support has been engaged to support the identification and delivery of CIP activities across the Trust, and steps are being taken to ensure programme governance is clear. A detailed paper will be provided to the June FIC.

The NTDA has requested a detailed presentation of CIPs by the end of June 2013, with the expectation this has been signed off by the Trust Board. Work is in hand to enable this to be completed for review by both the FIC and TB in June.

Action: 1). Finance Director to provide a detailed CIP paper to the June FIC.
2). Finance Director to provide a CIP update for NTDA to be reviewed by Trust Board

Capital expenditure

The capital plan remains at £10.0m. Since the interim financial plan was agreed by the Trust Board in March a range of new capital pressures have been identified, these are not significant but require the review of the previously presented prioritisation. This work is being progressed and the aim is to provide an updated capital plan to the FIC and Trust Board in June as part of the overall final financial plan refresh.

Action: Finance Director to present revised capital plan to June FIC and TB.

Presentation of the financial plan to the NTDA

The Trust has already submitted it financial plan to the NTDA at the end of April. An update was requested by the 24th May to reflect some minor technical corrections; there were no changes to the main position as agreed by the Board in March.

The finalisation of the overall financial plan will need to be maintained within the totals previously presented to the NTDA. This is not seen as a major risk given the reserves set aside for service developments. A revised plan and profile will be presented to the FIC in June.

Conclusion

The Trust Board is requested to note the actions being undertaken to conclude the 2013/14 financial plan. A final financial plan will be presented for review and approval at the late June meeting of the Trust Board.

Finance Director
28th May 2013.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 4TH JUNE 2013

PAPER TO PROVIDE ASSURANCE TO THE TRUST BOARD

Document Title:	**Audit Committee Assurance Report**
Report Author(s):	**Caroline Silver, Chair of the Audit Committee**
Lead Director:	**N/A**
Contact Details:	
Why is this coming to the Trust Board?	**To receive an update on the key items of discussion at the Audit Committee meeting on 13th May 2013 and to receive assurance from the Committee.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Other
Recommendation for the Trust Board:	**To note the report**

Key issues and risks arising from this paper

None.

Executive Summary

It is the role of the Audit Committee to focus on the controls and related assurances that underpin the achievement of the Trust's objectives and the processes by which the risks to achieving these objectives are managed. The purpose of this report is to assure the Trust Board of the effectiveness of the Trust's systems of integrated governance, risk management and internal control, and is based on the Trust's key sources of assurance as identified in the Trust's Board Assurance Framework (section C of the Board Assurance Framework).

Attachments

Report from the Audit Committee meeting on 13th May 2013. A verbal report of the meeting on 3rd June will be provided by the Chair of the Audit Committee at the Trust Board meeting.

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

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

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

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

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

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

Equality Impact Assessment

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

Key issues from the assessment:

Report from the Audit Committee on 13th May 2013

STRATEGIC RISKS

1. There is a risk that we fail to effectively fulfil responsibilities to deliver high quality and safe care
2. There is a risk that we cannot maintain and deliver the core service along with the performance expected.
3. There is a risk that we are unable to match financial resources with priorities.
4. There is a risk that our strategic direction and the pace of innovation to achieve this are compromised.

ASSURANCES AND CONTROLS

It is the role of the Audit Committee to focus on the controls and related assurances that underpin the achievement of the Trust's objectives and the processes by which the risks to achieving these objectives are managed. The purpose of this report is to assure the Trust Board of the effectiveness of the Trust's systems of integrated governance, risk management and internal control, and is based on the Trust's key sources of assurance as identified in the Trust's Board Assurance Framework (section C of the Board Assurance Framework).

The following controls are in place to support the management and mitigation of our strategic risks and these are referenced against each control as appropriate (eg SR 1.2.3.4).

Annual Governance Statement (SR 1.2.3.4)

The Audit Committee reviewed and commented on the draft Annual Governance Statement to be included in the Annual Report for 2012/13. The Trust does not have a letter of representation from Peter Bradley, however the Audit Committee agreed that, as the Trust Board had had overall responsibility during this period, there was sufficient assurance in place for Ann Radmore to sign the Annual Governance Statement.

At the meeting on 4th June, the Chair of the Audit Committee is required to provide the Trust Board with assurance on the effectiveness of the Trust's systems of integrated governance, risk management and internal control, based on the key sources of assurance identified in the board assurance framework.

Draft Annual Report 2012/13 (SR 1.2.3.4)

The Audit Committee reviewed and commented on the draft Annual Report for 2012/13. The final version will be signed off by the Audit Committee on 3rd June and presented to the Trust Board on 4th June for final approval.

Year End External Audit (SR 2)

The Audit Committee held an additional meeting on 18th April to review and approve the draft accounts for 2012/13 prior to submission to the auditors.

At the meeting on 13th May, the Audit Committee was assured that the external audit was progressing well, with no significant issues or adjustments to be made. The final accounts for 2012/13 will be signed off by the Audit Committee on 3rd June and presented to the Trust Board on 4th June for final approval.

Internal Audit Annual Report 2012/13 including Head of Internal Audit Opinion (SR 1.2.3.4)

The Head of Internal Audit Opinion is as follows:

> Based on the work undertaken in 2012/2013, significant assurance can be given that there is a sound system of internal control which is designed to meet the organisation's objectives, and that controls are being consistently applied in all the areas reviewed.

The Audit Committee is assured by the statement and noted the significant progress that has been made to strengthen internal controls, including risk management. This was the last meeting attended by RSM Tenon. From 1st April 2013, the Internal Audit and Local Counter Fraud services will be provided by KPMG.

Draft Strategic and Operational Internal Audit Plan 2013 – 2015 (SR 1.2.3.4)

The Audit Committee reviewed and commented on the Draft Strategic and Operational Internal Audit Plan for 2013 – 2015. An updated plan will be presented to the Audit Committee on 3rd June for approval.

Local Counter Fraud Specialist Work Plan 2013/14 (SR 3)

The Audit Committee approved the Local Counter Fraud Specialist Work Plan for 2013/14.

Date of next meeting

The Audit Committee is holding an additional meeting on 3rd June. The Chair of the Audit Committee will provide an oral update on the key items of discussion.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 4 JUNE 2013

PAPER FOR APPROVAL

Document Title:	**Annual Report 2012/13**
Report Author(s):	**Sandra Adams/Alex Bass**
Lead Director:	**Sandra Adams, Director of Corporate Services**
Contact Details:	**sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To obtain approval for the annual report**
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:	**That the Trust Board approves the annual report**

Key issues and risks arising from this paper

None.

Executive Summary

- As an NHS organisation, we have a statutory duty to publish, as a single document, an annual report and accounts to include the annual report; the remuneration report; a statement of the Accounting Officer's responsibilities; a governance statement; the primary financial statements and notes and the audit opinion and report.
- The minimum content for the annual report is set out in the Department of Health's NHS Finance manual (Manual for accounts chapter 2).
- This year the Service's annual report focuses on meeting the minimum requirements for content.
- The Trust Board is asked to approve the annual report.
- The annual report will then be combined into one document with the accounts to be submitted to the auditors, and published on the Service's website along with the Quality Account.
- An annual review, based on the format of the Ambulance News newspaper, will be produced for the Service's wider stakeholder base and will be published prior to the AGM in September.
- Both the annual report and annual review will be presented at the AGM in September.

Attachments

Draft copy of the 2012/13 annual report.

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

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

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

Annual Report
2012/13

Contents

Who we are

The London Ambulance Service NHS Trust is the busiest emergency ambulance service in the UK providing healthcare that is free to patients at the point of delivery. We are also the only London-wide NHS trust.

Our main role is to respond to emergency 999 calls, getting medical help to patients who have serious or life-threatening injuries or illnesses as quickly as possible.

However, many of our patients have less serious illnesses or injuries, and do not need to be sent an ambulance on blue lights and sirens. Often these patients will receive more appropriate care somewhere other than at hospital and so we provide a range of care to them, recognising that many have complex problems or long-term medical conditions.

We also run a patient transport service which provides pre-arranged transportation for patients to and from their hospital appointments. In addition, we manage the emergency bed service, a bed-finding system for NHS healthcare professionals who need to make arrangements for their seriously-ill patients.

We are led by a Trust Board which comprises a non-executive chairman, six non-executive directors and six executive directors, including the Chief Executive.

As an integral part of the NHS in London, we work closely with hospitals and other healthcare professionals, as well as with other emergency services. We are also central to planning for, and responding to, large-scale events or major incidents in the capital.

We have over 4,500 staff who work across a wide range of roles. We serve more than eight million people who live and work in the London area. This covers about 620 square miles, from Heathrow in the west to Upminster in the east, and from Enfield in the north to Purley in the south.

In 2012/13 we handled over 1.7 million emergency calls from across London and attended more than one million incidents.

We are committed to developing and improving the service we provide to the people who live in, work in, and visit London.

Chairman Richard Hunt's views

What was your impression of how the Service coped with two of the biggest events – the Queen's Diamond Jubilee celebrations and the Olympics?

They were the standout events in a busy year, and it was very pleasing that all the planning and preparation that went into them paid off. Both will live long in the memory, and I was very proud of what we contributed and were able to achieve.

The Olympics and Paralympics in particular were the culmination of many years of hard work. As important as the fact that we were able to play our part in caring for those who needed treatment at Games venues, we also maintained our service to patients across the rest of London, and met our commitments in that regard as well.

How do you think the Service performed overall during 2012/13?

As well as Olympics and the Jubilee, it was a year of change – not least in seeing both our Chief Executive and two other senior directors leave us for new opportunities elsewhere.

In light of that, and the ever increasing workload, we did well to once again achieve our main performance target and in doing so reach more of the most seriously ill and injured patients more quickly.

Having said that, we know that there are things that we need to change in order to move on and deal with ever increasing demand and continue to improve what we are doing. I would like to send my thanks to all colleagues in the Service for the part they played in delivering both event and day-to-day performance during a remarkable and challenging year.

What has been the impact of the ongoing financial savings plan?

It was a very difficult year for us financially and delivering on our planned budget proved even more challenging than we had expected it to be.

Our priority was to do all we could to protect patient care despite our financial challenges, and this led to greater levels of spending in some areas than we had budgeted for.

We have received additional funding from 2013/14 from the clinical commissioning groups to help increase our frontline staffing levels, but are fully aware that we need to continue to make savings in other parts of the Service and have to spend every penny carefully.

When do you now hope to become a foundation trust?

We are continuing with our plans to be licensed to operate as an NHS foundation trust and are working with the newly-formed NHS Trust Development Authority on building a new timeline towards a new application in 2014/15. However, our governance processes and ways of working will increasingly be brought in line with those required of a foundation trust over the coming months.

Chief Executive Ann Radmore's views

What have been your first impressions of the Service since taking up your post in January?

I have been very impressed with the compassion and commitment I've seen in staff across the organisation. I have spent time in our control rooms, with frontline crews and a number of support departments, and it is clear that people are very proud to work for us and want to do all they can for the benefit of our patients.

What do you see as the main challenges over the next 12 months?

We have reached the point where we have to make changes to the way we work in order to be able to provide all our patients with a safe and high-quality service in the future. At the same time, we also have to improve the working lives of our staff.

We are providing a good level of service to people with life-threatening illnesses and injuries, but some who have less serious conditions have been having to wait longer for our help than they should.

With the support of funding to help increase our frontline staffing levels, we are going to have to start to work differently and more efficiently to be able to respond to everyone who calls us.

In terms of plans to modernise the organisation, what will be the benefits for patients?

The changes we will be making will include ensuring rosters for frontline staff are more closely aligned with our patterns of demand and changing our annual leave arrangements – meaning patients will receive more appropriate and timely treatment from us, leading to better outcomes for them.

We are also being very mindful of the findings of the Francis Report into Mid Staffordshire NHS Foundation Trust, and what learning we can take from its recommendations.

How do see you see changes to the wider NHS, such as those to A&E departments, impacting on the Service?

One of the big changes is that we are now commissioned directly by GPs who want a more local service which reflects how they see the priorities for their patients in a particular area.

In terms of reconfiguration programmes, we continue to support proposals that will lead to better clinical care and the changing face of the NHS in London. Our commissioners also recognise that we will need additional investment to help manage increasing demand created as a result of local NHS changes.

Directors' Report

Our vision and strategic goals

Our vision is to be a world-class service, meeting the needs of the public and our patients, with staff who are well-trained, caring, enthusiastic and proud of the job they do.

We want to deliver the highest standards of healthcare and contribute towards Londoners having health outcomes that are among the best in the world.

Our strategic goals are:

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

These are supported by a number of corporate objectives, details of which can be found in the following pages of this report.

In the longer term, we believe that we will be better placed to achieve our goals by becoming an NHS foundation trust.

This will bring benefits in terms of making us more accountable to our patients and the communities we serve, giving us greater financial freedom and providing more opportunities for longer term planning.

We are now working with the newly-formed NHS Trust Development Authority on a timeline for this process.

Our achievements during 2012/13

Strategic goal: Improve the quality of care we provide to our patients

Our staff are often the first point of contact for people in the capital who want medical help, and so we have an important role to play in improving the health outcomes of patients in London.

Our objectives are:

- To improve the experience and outcomes for patients who are critically ill or injured
- To improve the experience and provide more appropriate care for patients with less serious illnesses or injuries
- To meet response times routinely, and
- To meet all other quality, regulatory and performance targets.

During the year we continued to provide very good care to our most seriously ill and injured patients, but at the same time recognise that we need to improve our response to some of our patients with less serious conditions.

2012/13 was the second year when we and other ambulance services across the country were measured against a range of clinical indicators, which as well as covering traditional time-based targets also look in more detail at the quality of care provided to patients. The indicators include outcomes for stroke and cardiac patients, as well as the number of patients cared for without needing to be taken to hospital.

Our Quality Account reports in detail on the progress we made in improving the quality of care we provide to our patients.

The year also saw the publication of the Francis Report into the failings at the Mid Staffordshire NHS Foundation Trust. It was published following a public inquiry into much higher than expected death rates at the hospital and raised issues around patient care which require serious consideration by all NHS organisations. We are considering all the Report's recommendations, identifying those that are relevant to us, and using these to improve and develop our service.

At the end of April 2013, we also announced plans for a programme of modernisation to help improve quality of care, patient experience and waiting times. At the time of writing, staff had been asked for their views on the details of these plans.

Below are detailed some of the key achievements from the 2012/13 year, including examples of how patients have benefited from our care.

- ***Improving the experience and outcomes for patients who are critically ill or injured***

  Trauma care: Our staff continued to take patients with life-threatening injuries, such as those sustained in serious road traffic incidents or stab or gunshot wounds, to one of four specialist centres in the capital. These are open round the clock, with expert clinicians available to provide the best possible care.

Priscila's story

One example of a patient who has benefited from receiving specialist care is Priscila Currie, who suffered serious leg and arm injuries following a road traffic collision in 2010.

Our staff who attended her assessed that she should be taken to the nearest trauma centre at the Royal London Hospital, rather than the local A&E department.

She underwent surgery but made a full recovery and, following the experience of the care she received, has since joined the Service as a student paramedic.

Cardiac care – heart attack: There are eight specialist centres in London where patients who are diagnosed as suffering a common type of heart attack, known as an ST-elevation myocardial infarction, can be taken directly by ambulance staff. They can then undergo primary angioplasty, a procedure which involves inflating a balloon inside an artery to clear the blockage that has caused the heart attack.

One of the national clinical indicators looks at the percentage of those who receive this treatment within two and a half hours of the 999 call being received. The Service's latest available figure, from April to December 2012, was 91.7 per cent[1].

Full year figures for 2011/12 – published in our heart attack annual report at the end of 2012 – showed that the quickest of these so called 'call to balloon' times was just 42 minutes.

Bhupen's story

In December, Bhupen Mistry met up with Emergency Medical Technician James Dixon, who treated him after he suffered a heart attack in January 2012. James and his crewmate bypassed local A&E departments to take Bhupen to the heart attack centre at Hammersmith Hospital.
After undergoing primary angioplasty, he was discharged just two days later.

Cardiac care – cardiac arrest: Thanks to the quality of care provided by our staff, the survival rates of patients who suffer an out-of-hospital cardiac arrest continue to rate as some of the highest in the country, and our published figures are also among the best in the world.

[1] This figure is provisional, base d on data available on 3 May 2013

Statistics for the period from April to December 2012 show that 27.3 per cent[2] of patients whose hearts stopped beating, at home or in public, were resuscitated and discharged from hospital.
The last whole year figures were for 2011/12, when the figure was 31.7 per cent – double that of just three years before.

Ian's story

Among patients whose lives were saved was 50-year-old Ian Brown, who suffered a cardiac arrest while on a construction site in May 2012.
Colleagues immediately called 999 and began to give rescue breaths and chest compressions before our staff arrived within five minutes and gave three shocks with a defibrillator – a machine used to restart the heart. Paramedic Adrian Thatcher said: "His workmates helped to save his life by starting CPR so quickly, and we then diagnosed that he'd had a heart attack that led to the cardiac arrest and took him straight to the specialist centre at King's College Hospital."

Through working with the British Heart Foundation, we are now responsible for nearly 1,000 defibrillators available in public places across the capital.

These include tourist attractions, airports and train stations and, in December, 16 of the machines were installed in the Houses of Parliament.

During the year, we also trained more than 17,000 members of the public in cardio-pulmonary resuscitation – a simple life-saving technique which involves giving chest compressions and rescue breaths to someone whose heart has stopped beating.

We currently manage 55 community responder and co-responder schemes in London whereby volunteers are trained to attend emergency calls in their local area and provide first aid to patients until an ambulance arrives. We now have 968 trained volunteers within these schemes.

Stroke care: We take patients who we diagnose with stroke symptoms directly to one of eight specialist stroke centres in London. Here they have rapid access to life-saving treatment which can increase their chances of survival and cut the risk of long-term disability caused by a stroke – which occurs when the blood supply to part of the brain is cut off.

We took just under 9,500 stroke patients to a hyper acute stroke unit during the year, equating to around 95 per cent of all stroke patients who we attended.[3]

One of the national indicators measures the percentage of stroke patients who arrive at a specialist centre within 60 minutes of us receiving the 999 call. Figures available for the first nine months of last year show that we achieved this in 67.8 per cent of cases. Although this represents an improvement on last year (from 65.1 per cent), we will continue to work to improve this figure.

[2] This figure is provisional, based on data available on 3 May 2013
[3] This figure is provisonal, based on data available on 21 May 2013

Peter's story

Teacher Peter Banks was able to return to work during the year after suffering a stroke in January 2012.
After carrying out an assessment, staff took him to the hyper-acute stroke unit at Charing Cross Hospital where he received thrombolysis – a clot busting drug to restore the flow of blood to the brain. He was allowed home five days later.

- ***Improving the experience and providing more appropriate care for patients with less serious illnesses and injuries***

  During 2012/13, we treated a wide range of patients presenting with less serious conditions.

  Taking patients to the right place of care: As part of a wider NHS response to managing patients with less serious conditions, we continued our work to identify suitable alternative destinations where appropriate care can be provided away from the traditional hospital environment.

  These include minor injuries units, urgent care centres and walk-in centres, some of the latter being provided as part of the services at some larger GP practices. Frontline staff have received training and guidance to enable them to better assess minor injuries, illnesses and conditions, and from this decide on the appropriate destination for patients.

  Clinical telephone advice: Our clinical telephone advisors helped 68,479 patients over the phone, slightly down from 70,842 in the previous year but up from 50,058 in 2010/11.

  This way of responding to those with less serious illnesses and injuries was supported by the development of a new clinical hub in our main control room, supporting both call takers and frontline staff.

  Care for elderly fallers: Every month we respond to around 6,500 people aged 65 and above who have had a non-traumatic fall – usually a slip or stumble – at home. Since the introduction of a system to refer patients who did not need hospital treatment to their GP, we have referred an average of around 1,200 patients each month, and are continuing to encourage staff to use the system so that the GP can take steps to help prevent the patients falling again in the future.

  Care of mental health patients: We have been working with the nine mental health trusts across London to develop arrangements so that any mental health patients who we attend can be taken to the right place for treatment, rather than unnecessarily transporting them to an emergency department.

  The last of these came into operation in March and should help ensure patients receive continuity of care.

We also continued to examine complaints with a mental health component, and where possible are meeting with mental health trusts to agree personalised care plans for their patients, and the options available to them apart from calling for an ambulance.

End-of-life care: We continued to work with both NHS and hospice-based end-of-life care providers to provide appropriate care and support. We also continued to develop staff skills, training and competencies, the way we collate patient information and how we communicate with local providers of end-of-life care services.

Patients with pre-arranged hospital appointments: As well as a response to emergency calls, we offer pre-arranged transport for patients to and from their hospital appointments.

During last year, we carried out 177,379 of these journeys last year, compared to 180,004 in 2011/12.

We delivered patients to hospital on time for 92 per cent of the journeys – compared with 92 per cent the year before, and 90 per cent in 2010/11. And we departed hospital on time in 94 per cent of cases. This compares with 93 per cent in 2011/12, and 95 per cent in the year before that.

Ninety seven per cent of our patients had a journey time of less than an hour, an increase from 95 per cent delivered in the previous three years.

Our total number of contracts at the end of the year stood at 17, down from 20 last year. The reduction is the result of the continuing realignment of the NHS operating structure, with smaller contracts being merged into geographical groups with a lead commissioning body. We expect to see this trend continue throughout 2013/14.

- ***Meeting response times routinely***

  Demand on our service continues to increase, and 2012/13 was busier than ever.

  We received a total of 1,708,597 emergency calls during the year, an increase of 6.4 per cent on the 1,605,956 in 2011/12.

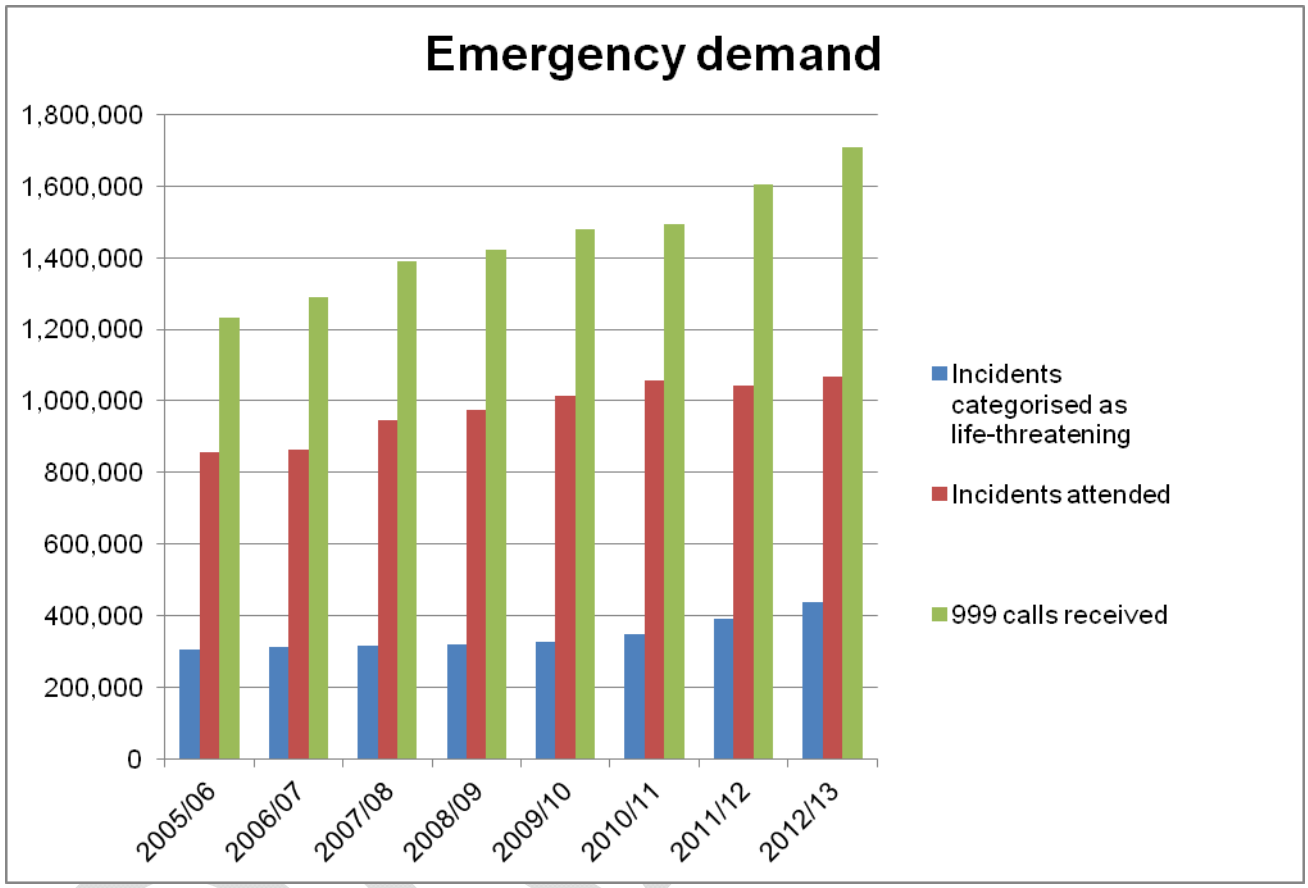
  Of all the calls we handled last year, we responded to 1,068,338 emergency incidents, up from 1,041,739 the year before.

  We took marginally more patients to a hospital accident and emergency department – 747,630 compared to 735,270 the year before. However, we also conveyed more people to an appropriate care centre such as a minor injuries unit – 89,996 compared to 74,127 in 2011/12 and 27,578 the year before that. In 250,185 cases, our staff attended a patient but did not take them anywhere for further medical treatment.

  Despite a busy year, we achieved the national response time targets to reach:

  - 75 per cent of Category A (life-threatening) calls within eight minutes
  - 95 per cent of Category A calls within 19 minutes

The number of life-threatening (Category A) calls received during 2012/13 increased by 12.8 per cent (465,197 calls were received compared to 412,426 in 2011/12).
We attended 438,067 of these incidents, compared to 390,229 in 2011/12, and we reached 75.41 per cent (330,366) of these patients within eight minutes – the tenth year in a row that we have achieved this national response time target.
We reached 98.16 per cent (430,010) of Category A patients within 19 minutes, against the target of 95 per cent.



All other calls fall into one of four C categories. We received 1,242,284 calls to Category C (lower priority) patients last year, up from 1,155,909 in 2011/12. Of these, 642,438 received an ambulance response, compared to 628,687 the previous year, and we reached 86.48 per cent of these patients within our target time of 60 minutes. This was down from 91.04 per cent in 2011/12, and was reflective of the difficulties we faced in providing a good level of service to all of our less seriously ill and injured patients.

- ***Meeting all other quality, regulatory and performance requirements***

We achieved unconditional registration in March 2010 with the Care Quality Commission (CQC) which we maintained in 2010/11.

Further to a routine visit to the Service at the end of March 2012, detailed in last year's report, the CQC also carried out to further inspections, in June and November.

The latter of these identified two areas of concern. The first was against regulation 16 (safety, availability and suitably of equipment), finding that 'ambulances were not all suitably equipped to meet the care needs of the people using the service. The other

was around staffing, and that 'we had failed to ensure that there were a sufficient number of suitably qualified, skilled and experienced persons employed to meet demands on the service'. This has led to delays in responding to calls for an ambulance and a reduction in staff achieving mandatory updates.
Action plans on both were submitted to the CQC in January 2013.

We achieved full compliance when we were reassessed at level 1 of the NHS Litigation Authority risk management standards for ambulance trusts in October 2012.

The Director of Health Promotion and Quality is the lead for infection prevention and control and has strengthened our monitoring and audit processes for compliance with the hygiene code regulations. A scorecard is presented each month showing performance against key infection prevention and control indicators.

Strategic goal: Deliver care with a highly skilled and representative workforce

We want all staff on the frontline to have the skills to assess and treat a wide range of conditions, and those in other functions have the right skills to support them.

We also want to improve the diversity of our workforce, and focus on engaging with our staff more so that they are motivated and feel valued, and have a greater say in how we improve our service.

To achieve this goal we will:

- develop our staff so that they have the skills and confidence they need to deliver high quality care to a diverse population, and
- engage with our staff to improve patient care and productivity.

- ***Developing our staff so that they have the skills and confidence they need to deliver high quality care to a diverse population***

  Our workforce: At the end of March 2013, we had a workforce of 4,614 staff.

  As part of our savings plan, we reduced our workforce by a total of 194 posts during the year, of which 90 were from the frontline with the remainder from support departments. And over the course of the year, a total of 447 people left the Service – a turnover rate of 9.6 per cent, compared to 7.1 per cent last year.

  More student paramedics qualified during the year after completing their three-year training programme, while almost 100 apprentice paramedics started working for us as part of a five-year course run in partnership with the Open University.

  After working with our commissioners to identify what capacity we need to meet future increases in demand, we are now finalising our plans to recruit additional staff in the coming year.

  The rate of sickness among our staff for 2012/13 was 5.84 per cent, against a target of 5.5 per cent. This compares with a sickness rate of 5.32 per cent in the previous year.

In relation to severance payments, no employees left the Service under terms that required Treasury approval last year.

Our approach to equality and inclusion: We welcome our obligations under equalities legislation, including the Equality Act 2010. Our aim is to ensure that equality and inclusion is integral to everything we do.

We welcome people to our organisation from any background, who are committed to providing high-quality care that meets the needs of the diverse communities we serve. We aim to provide innovative and responsive healthcare which meets the needs of all these communities, providing better healthcare for all.

Our policy is to treat everyone fairly and without discrimination, and we want to ensure that:

- patients and customers receive fair and equal access to our healthcare service
- everyone is treated with dignity and respect
- staff experience fairness and equality of opportunity and treatment in their workplace.

We want to be an employer of choice, and to attract the best and most talented people from all walks of life to a career where they can develop to their full potential.

As an employer, we are focusing on:

- celebrating and encouraging the diversity of our workforce and creating a working environment where everyone feels included and appreciated for their work
- promoting and providing training and employment opportunities regardless of age, disability, gender reassignment, marital status, pregnancy or maternity, race, religion or belief, sex, sexual orientation or any other aspect of an individual person's background
- fostering creativeness and innovation in our working environment, so that all staff can deliver to the best of their ability and help us take forward our equality and inclusion goals.

During the year, we took 22nd place in the charity Stonewall's Top 100 Employers list – up from 94th place in the previous year. We were also recognised in the top 10 of their Healthcare Equality Index. Both were significant achievements and recognition of our inclusive policies and support networks for staff. As well as a Lesbian, Gay, Bisexual and Transgender Forum, we also have a very active Deaf Awareness Forum.

In terms of disabled employees, we are members of the Employers' Forum on Disability as well as Carers UK. We have signed up to the Two Ticks 'positive about disabled people scheme' and our diversity forum for disabled people and carers, known as Enable, provides staff with a voice on policy and decision-making for our disabled employees and staff who are carers, including their involvement as 'critical friends' in our equality analysis.

We are also members of Opportunity Now, a membership organisation representing employers who want to transform the workplace by ensuring inclusiveness for women;

and we are members of Race for Opportunity which is a race diversity campaign committed to improving employment opportunities for ethnic minorities across the UK.

- ***Engaging with our staff to improve patient care and productivity***

We recognise that an engaged workforce is key to improving our services and productivity, and we are committed to communicating and engaging with staff to achieve this.

Our staff engagement score last year, informed by the NHS staff survey, was 3.21 (based on a score range from 1 to 5). This was calculated from findings related to staff members' perceived ability to contribute to improvements at work; their willingness to recommend the Service as a place to work or receive treatment; and the extent to which they feel motivated and engaged with their work.

Although this was up from 3.15 in 2011, it compared with a national ambulance trust average of 3.27 (up from 3.23 last year).

Staff survey findings: The 2012 survey highlighted some improvements on the previous year, such as reductions in the number of staff reporting they cannot meet conflicting demands on their time at work and those who felt they were not able to do their work to a standard they were pleased with.

However, the results also showed a number of areas of concern. These included increases in the percentage of staff who felt unwell due to work-related stress, and the number saying they had received health and safety training in the previous year was significantly lower compared to other ambulance trusts.

Following publication of the results in February, departments and station complexes have developed plans to try to address some of the main issues identified by their respective groups of staff.

Listening into Action: In March this year, we signed up to be part of Listening into Action, which is already being used by a number of other trusts across the country to change the way they listen to and involve staff.

Led by the Chief Executive, it is an approach designed to bring about positive change through collaboration with staff and will be taking place through 2013/14.

Staff conferences: There was a programme of internal conferences throughout the year which provided staff with an opportunity to hear about our future plans, and to raise issues that matter to them.
In total, 11 events were held for managers, support staff and team leaders.

Unlike in previous years, however, there were no local consultation meetings as the timing for these coincided with the departure of the former Chief Executive. It is though planned to hold these meetings again in late summer and early autumn 2013.

Opportunities for giving feedback and sharing ideas: We continued to use 'temperature check' surveys for staff to give feedback and suggestions on how to make improvements for the benefit of patients and their own working lives.

Our first mobile app, developed through the course of the year with funding from the strategic health authority, has been built based on suggestions of content from staff and should be launched in summer 2013.
Total Reward Statements - providing health service staff with personalised information on the value of their employment package, pension and other benefits available to them - will be rolled out across the NHS after feedback from our staff helped in the development of the statements.

Health and well-being: Our LINC (Listening, Informal, Non-judgemental, Confidential) peer support worker initiative marked its tenth year this year. The informal, voluntary network now has 110 trained staff who can listen to and support Service colleagues on issues from work-related stress to family and social problems.

Partnership working with the unions: We continued to use our long-established partnership working arrangements with our trade union colleagues, with a formal consultation and negotiation framework in place.

We consulted on the major issues, opportunities and challenges facing the Service, and we plan to maintain these working relationships when we become a foundation trust.

The staff side to the Staff Council, the senior consultative group within our Service, has been offered and accepted a governor seat as part of the planning process for foundation trust status.

Representation on our Council of Governors: When we achieve foundation trust status, staff will be able to stand for election to our Council of Governors. We are proposing three seats for staff representatives. This is separate from, and in addition to, the seat for a staff side representative from the Staff Council.

Strategic goal: Provide value for money

It continues to be very important that we provide Londoners with a service that represents value for money.

To achieve this goal we will:

- use our resources efficiently and effectively, and
- maintain service performance during major events, both planned and unplanned – which last year included the 2012 Games.

- ***Using our resources efficiently and effectively***

Our aim has been to maintain safe levels of patient care despite having to make savings over this period.

We achieved our target of making savings of £12.5 million during the year, after also achieving our target of £15m in 2011/12. Both were achieved through reducing pay costs through reduced head count and making savings in areas of non-pay.

To help cope with very high levels of demand during the winter months – when calls to the most seriously ill and injured patients rose by around 14 per cent on the same period in 2011/12 – we received £6.2 million of additional funding as part of £57 million allocated to the NHS in London.

- ***Maintain service performance during major events, both planned and unplanned including the 2012 Games***

As well as the day-to-day demand, we have to be ready to deal with both planned events and larger emergency incidents.

In a normal year, these include New Year's Eve celebrations, the London Marathon and the Notting Hill Carnival. 2012 was even more significant for the capital, with the Queen's Diamond Jubilee followed by the Olympic and Paralympic Games.

Jubilee celebrations: More than 200 staff covered the central London area as over 1.5 million people attended events connected with the Queen's Diamond Jubilee celebrations over four days in June last year.

Working with volunteers from St John Ambulance and the Red Cross, we treated 1,151 patients for a range of injuries and illnesses. The Sunday, which saw the Thames River Pageant taking place, proved to be the busiest day for us, with those treated including a number of people from the flotilla suffering from the effects of the cold and wet weather.

London 2012: The Games were the culmination of more than five years of planning and preparation for us, and we played an important role in their success.

Our focus was to maintain our service to Londoners while providing medical care to patients at Games venues and associated events.

To help achieve this, around 400 frontline staff were dedicated to the Games, with half of these coming from other NHS ambulance services.

All of those involved received additional specialist training - including in disability awareness - while those from outside London also spent an extra two days familiarising themselves with our vehicles, equipment, policies and protocols.

In addition to people treated by volunteers working for the London Organising Committee of the Olympic and Paralympic Games (LOCOG), staff at the Games venues treated approximately 1,250 patients – 850 from the Olympics and 400 during the Paralympics. Around 670 of these were either taken to one of the pre-selected hospitals used for patients or a polyclinic set up at the Olympic Park.

As well as being able to meet the demands of the Games, we were able to offer a high level of service and patient care across the rest of the capital. During the competitions, crews reached an average of nearly 83 per cent of the most seriously ill and injured patients within eight minutes.

Major incident planning: During the year, we published our revised major incident plan which outlines the operational steps we will take in the event of a major or

catastrophic incident occurring. It incorporated learning from a number of issues that were highlighted during the inquests into the 2005 London bombings.

Governance of our organisation

Our Trust Board manages risk through our risk management policy and strategy, corporate risk register and board assurance framework.

The board assurance framework and corporate risk register are presented to the Trust Board each quarter, and further scrutiny is applied through the Quality and Audit Committees. The risk register is reviewed in detail by the Risk Compliance and Assurance group on a quarterly basis.

Full details can be found in our governance statement on page 24 of this document.

Our use of feedback to make improvements

Feedback from patients, their families and the public is an important way of helping to improve our services.

One of the most valuable forms of feedback we receive is through complaints, of which we received 976 during the year, up from 673 in 2011/12.

This significant increase reflected some of the difficulties we faced in terms of an above expected rise in demand, with the most frequent cause for complaint being a delay in staff attending patients.

During the year, we reviewed the way in which our Learning from Experience Group and processes work, to take greater account of what patients have to tell us and also issues arising from complaints.

This includes inviting a patient or a relative to speak at each public meeting of our trust board about their own experiences of using our service.

Our Patient Experiences Department also received more than 5,700 general enquiries. A significant number of these concerned lost property, and we have made changes to the way this system is managed to help make it easier for patients to track down missing items.

We continue to liaise more and more with other agencies to promote safeguarding of both adults and children.

Principles for Remedy

We manage our complaints handling process as promoted by in the good practice guidance of the Principles of Remedy. This includes:

- All complaint responses include reference to, and contact details for, the Parliamentary and Health Service Ombudsman.
- Our website and operational vehicles carry details of how to make a complaint about the service or experience received.

- Numbers and themes of complaints are provided in a monthly clinical quality and safety report to the Trust Board, which is discussed in the Part One of the meeting.
- The Learning from Experience Group reviews the themes and issues emerging from complaints and the action then taken to improve service and the experience of patients

Our plans to reduce our carbon footprint

We remain committed to making improvements in all aspects of our environmental performance.

Environmental monitoring and reporting enables us to quantify the environmental and social effects of delivering our service; to improve both our management of any associated adverse environmental and social impact, and our overall environmental performance; and to work towards achieving the targets in the NHS Carbon Reduction Strategy.

In 2012, the Carbon Trust reviewed and approved our five-year carbon management plan which sets out how we will reduce our carbon footprint as part of our contribution to tackling climate change. A carbon footprint is measured in tonnes of carbon dioxide equivalent (tCO2e). This is based on a baseline for the Service of 62,776 tonnes CO2e that was calculated in 2010/11.

There are three areas in which we will focus our activity – fuel consumption, energy use and procurement. We aim to reduce our energy and fuel consumption by 25 per cent over the five-year period, and by focusing on procurement we will cut indirect emissions from products and services by 10 per cent. It is envisaged that this will achieve total costs savings of over £5.5m. As the data we are using becomes more reliable, we are able to better assess our carbon footprint and to identify areas where additional efforts are required.

The overall trajectory is downwards from the baseline figure of 62,776 tCO2e – a reduction of 34 per cent achieved primarily from a reduction in procurement spend and fuel.

Fuel consumption: Our core business means that we have high levels of fuel consumption. In 2012/13 we used over 4.2 million litres of fuel, compared to 4.3 million litres in 2011/12 – meaning that despite an increase of more than 2.5 per cent in incidents attended, we used approximately five per cent less fuel.

In September, we met Transport for London's deadline for ensuring that our fleet is compliant with Low Emissions Zone (LEZ). In addition, after switching to a new supplier, 95 per cent of our engine parts are now recycled, with an average of 20 engines replaced each year.

Energy use: Although over half of our 70 ambulance stations are more than 50 years old, when measured against other ambulance services we score well in our energy consumption per metre. In 2012/13 our average daily consumption of gas and electricity for all our properties saw an estimated decrease of three per cent compared to usage in 2011/12. During the year we also recycled 93 per cent of our waste.

Procurement: The overall trend is downwards from the baseline of circa 43,969tCO2e to 24,730tCO2e. Comparing expenditure in 2012/13 against that in the baseline year reveals a significant decrease in the amount spent on consultancy, mobile calls and rental, rent and service charges and computer hardware.

Environmental impact performance indicators

Area		Non financial data 2010/11 (baseline)	Non financial data 2011/12 Year 0	Non financial data 2012/13 Year 1		Financial data 2010/11 '000	Financial data 2011/12 '000	Financial data 2012/13 '000
Finite resources	Water	**57**	**53**	60	Water cost	**97,189**	**91345**	**102,028**[1]
	Electricity	**3,913**	4,289	4,203[2]	Electricity cost	**1,055,486**	**1054406**	**Final financial figures not yet available**
	Gas	**1,515**	492	708[2]	Gas cost			
	Fuel	12,387	12,082	11,519	Fuel cost	5,846,323	5383166	4,316,464
Procurement	Procurement	44,904[3]	**19,285,**	**24,730,**		74,524,230	**56,084,612**	**68,651,920**
TOTAL		62,776	36,201	41,220		81,523,228	62,613,529	

1. Total expenditure on water for 2012/13 – figure given is the known expenditure to date.
2. Total expenditure on energy consumption not available as yet, carbon footprint estimated from data available from 33 per cent of metered estate tracked over the year.
3. The carbon footprint for procurement in 2011/12 and 2012/13 has been estimated by assigning DEFRA emission factors per pound of spend against individual cost centres. This is an improvement on the method used in 2011 to estimate the baseline figure for 2010/11.

Looking ahead to this and future years, our environmental priorities will include:

- Further investment in energy conservation works to reduce carbon emissions from energy use across our estate
- Continuing to raise staff environmental awareness
- Reviewing procurement arrangements to identify opportunities for carbon reduction and cost savings
- Working with suppliers to minimise waste and identify opportunities for associated carbon reduction.

Changes to the London healthcare system

The Health and Social Care Act 2012 came into effect on 1 April 2013 and signalled significant changes to the management of NHS services in London. We are now commissioned by 32 clinical commissioning groups and this is co-ordinated through the North West London Commissioning Support Unit.

London's strategic health authority was disestablished on 31 March 2013 and we are now performance managed through the NHS Trust Development Authority, who will also support us through the foundation trust application process.

NHS England (London) co-ordinates the commissioning arrangements across London and holds the 32 clinical commissioning groups accountable.

Monitor has now extended its role to regulating all providers of NHS services and we will be applying for a provider licence during 2013/14, to come into effect from 1 April 2014.

Our Trust Board

In 2012/13 our Trust Board was made up of 13 members – a non-executive chairman, six of the Service's executive directors (including the Chief Executive), and six non-executive directors.

The Chief Executive and the other executive directors are appointed through a process of open advertising and formal selection interview. The non-executive directors are appointed by the same method, previously through the Appointments Commission and as from October 2012 through the NHS Trust Development Authority. All executive appointments are permanent and subject to normal terms and conditions of employment.

There were a number of changes to the Trust Board during the year. Peter Bradley left as Chief Executive Officer in September 2012 to take up the post of Chief Executive Officer with St John Ambulance Service, New Zealand. Martin Flaherty, Chief Operating Officer, acted up as Chief Executive Officer until 6 January 2013 when he retired from the Service. Ann Radmore was appointed as Chief Executive Officer in October 2012 and took up the post on 7 January 2013.

Michael Dinan, Director of Finance, left the Service on 18 January 2013 and Andrew Grimshaw was appointed as Interim Director of Finance from January 2013 and subsequently as substantive Director of Finance with effect from July 2013.

Murziline Parchment left the position of non-executive director in September 2012 and Nicholas Martin was appointed as non-executive director from 1 October 2012.

Brian Huckett left the position of non-executive director in December 2012 and John Jones took up the role on 1 January 2013.

We appointed a clinical associate non-executive director, Robert McFarland, who will take up the position on 1 May 2013. Dr Beryl Magrath completed her second term of office as non-executive director on 31 March 2013.

The Board has six formal sub-committees: the Strategy Review and Planning Committee, the Quality Committee, the Audit Committee, the Finance and Investment Committee, the Remuneration and Nominations Committee and the Charitable Funds Committee.

The Strategy Review and Planning Committee is made up of all the board members and is chaired by the Chairman.

Four non-executive directors and the Chief Executive make up the membership of the Quality Committee, which was chaired during the year by non-executive director Dr Beryl Magrath.

The membership of the Audit Committee comprises three non-executive directors and is chaired by non-executive director Caroline Silver, who also chairs our Charitable Funds Committee.

The Finance and Investment Committee was chaired by the Chairman (to 31 March 2013) and has three non-executive directors, three executive directors and three directors as its members. The Remuneration and Nominations Committee, also chaired by the Chairman, comprises all non-executive directors.

Non-executive directors

Richard Hunt CBE joined us as Chairman in July 2009. He was formerly the International President of the Chartered Institute of Logistics and Transport, and has experience extending across the aviation, logistics, international oil and brewing sectors. Richard is a former Chief Executive of Aviance Ltd which handles logistics at UK airports, and he was Chief Executive of EXEL Logistics Europe, the largest UK transport and logistics business. He has also served as a non-executive on the Highways Agency Advisory Board. Richard was appointed CBE for services to logistics and transport in the 2004 New Year Honours.

Dr Beryl Magrath MBE took up her post as non-executive director in 2005, and was chair of our Quality Committee. She is a former consultant anaesthetist and previously worked at Bromley Hospitals NHS Trust in Kent. She was a founder of South Bromley HospisCare in 1984 and was medical director of Bromley Hospitals NHS Trust between 1992 and 2000. Beryl is Vice Chairman of Governors for Castlecombe primary school in Bromley. She completed her second term of office as a non-executive director in March.

Caroline Silver took up her post as a non-executive director with us in March 2006 and is chair of our Audit Committee and the Charitable Funds Committee. A chartered accountant by background, she is a partner and Managing Director of Moelis and Company, an independent investment banking firm. Prior to that, Caroline spent 20 years in major international investment banks, where her roles included Vice Chairman of Bank of America Merrill Lynch EMEA Investment Banking and Vice Chairman of Morgan Stanley's global Investment Banking Division. She is a specialist in advising clients on international mergers, acquisitions and financings, particularly in the financial services and healthcare sectors. Caroline started her career as a chartered accountant with Price Waterhouse (now PWC).

Roy Griffins CB took up his post as a non-executive director in March 2006. He is chairman of London City Airport and an independent member of Camden's Standards Committee. He is also a non-executive director of NHS Blood and Transplant. Roy has had a 30-year career in the British civil and diplomatic service, and was the UK's director of civil aviation between 1999 and 2004, and director-general of Airports Council International Europe from 2004 to 2006. Roy is a member of the Audit and Quality Committees, and is also our Deputy Chairman.

Jessica Cecil took up her post on 1 December 2010. She has over 20 years of experience working in broadcasting on flagship television programmes such as *Newsnight*, *Panorama* and *Tomorrow's World*. She is now Head of the Director General's Office at the BBC, responsible for strategic projects, senior stakeholder management and running the major boards of the corporation on his behalf. Jessica is the senior independent non-executive director.

John Jones started as an associate non-executive director in October 2012, and took up his substantive role on 1 January 2013. He has 17 years' experience at board level in the NHS and has held a number of executive finance director positions. As a Director of Finance with Hertfordshire Partnership NHS Foundation Trust, John helped them to attain foundation trust status. John is a member of the Chartered Institute of Management Accountants and the Chartered Institute of Public Finance and Accountancy. He is a member of the Audit Committee, and Finance and Investment Committee.

Brian Huckett left his position as a non-executive director in December 2012 having reached the end of his second term of office.

Nicholas Martin took up his post in October 2012, and is a member of the quality committee. He has 30 years' experience of corporate finance advising a wide range of companies from different sectors. He has served on a number of boards and governing bodies in executive and non-executive roles, including Cambridge University, Hammersmith Hospitals NHS Trust, NHS City & Hackney Primary Care Trust and NHS Haringey Primary Care Trust. He is a barrister, a Chartered Fellow of the Chartered Institute of Securities & Investment, and a former Cabinet Special Adviser.

Nicholas replaced **Murziline Parchment,** who stepped down from her position in September 2012 after joining the Board in September 2011.

Executive directors

Chief Executive Ann Radmore joined the Service in January 2013 after working as Chief Executive of NHS South West London where she led the establishment of the South West London Cluster in early 2010. Ann was previously Chief Executive of NHS Wandsworth and led the trust out of financial difficulties into a high performing primary care trust. After graduating from Cambridge University, Ann joined the NHS in 1983 as a national management trainee. She has worked in both specialist teaching and acute hospital and community settings as well as commissioning and a strategic health authority and has managed a wide range of clinical and support services. She has led two major hospital redevelopments, one in Greenwich and one at Queen Mary's Roehampton. Ann also led the Londonwide implementation of the ground-breaking stroke and cardiovascular models – which significantly improved outcomes for patients through specialist units.

She replaced **Peter Bradley CBE,** who left the Service in September 2012 to become Chief Executive of St John in New Zealand.

Director of Finance Andrew Grimshaw initially joined the Service on an interim basis in January 2013 and was appointed to the permanent post in March. Having joined the NHS as a trainee accountant in 1989, he has worked at district general hospitals, specialist and teaching hospitals throughout his career. He has worked as a Director of Finance since 2004 both for NHS trusts and foundation trusts.
He took over from **Michael Dinan** after he left the Service in January.

Director of Health Promotion and Quality Steve Lennox was appointed as an executive director in January 2011, after joining us in September 2010. He was previously a member of the Chief Nurse's healthcare-associated infections and cleanliness team at the Department of Health where he worked at a national level with acute trusts, mental health trusts and ambulance trusts. A Registered General Nurse and a Registered Mental Nurse, Steve has worked in a variety of different clinical fields including HIV, critical care and neurosurgery.

Director of Workforce Caron Hitchen was appointed in May 2005. Caron is a qualified nurse, and her career has been predominantly NHS-based. She worked for five years at Mayday Hospital NHS Trust as Director of Human Resources and, prior to that, she spent seven years in human resources management roles at Ealing Hospital NHS Trust.

Medical Director Dr Fionna Moore was appointed in December 1997 and was made an executive director in September 2000. She chairs our clinical, quality safety and effectiveness committee, and clinical audit and research group. Fionna has more than 21 years' experience as a consultant in emergency medicine, currently with Charing Cross Hospital and previously at University College and John Radcliffe Hospitals. She is a BASICS doctor and holds a fellowship in immediate medical care from the Faculty of Pre-Hospital Care of the Royal College of Surgeons Edinburgh. In 2009, Dr Moore was appointed Trauma Director for London.

The Trust Board is supported by other non-voting directors and one senior manager who attends the Board meetings.

Director of Information Management and Technology Peter Suter was appointed in November 2004, after serving as Head of Information Technology at Sussex Police for 10 years. Before that, he had worked for Siemens-Nixdorf, GEC in South Africa, and BT. He is joint chair of the Information Governance Committee. Peter holds a BSc in Information Technology from the Open University.

Director of Corporate Services Sandra Adams took up her post in July 2009. Sandra joined us from Moorfields Eye Hospital NHS Foundation Trust, where she held the post of Director of Corporate Governance and had project managed the application to become one of the first NHS foundation trusts in the country. Sandra had previously worked in commissioning of acute services, and in a number of community and hospital posts, including managing acute service reconfiguration in south west London.

Director of Strategy and Planning Lizzy Bovill joined the Service as an assistant director of operations in 2008, moving from Guy's and St Thomas' NHS Foundation Trust. Her career to date has focused on general management and service improvement roles both in large teaching hospitals, specialist networks and the voluntary sector. Lizzy's current role includes managing and delivering the range of contracts held by the Service with our commissioners, leading on commercial and strategic developments, stakeholder and partner management within and external to the NHS and delivering demand management initiatives.

Head of Communications Angie Patton joined the Service in 2002, having previously worked for seven years with Hertfordshire Constabulary, latterly as Head of Communication. Prior to starting her career in public relations, Angie worked for National Power plc and Vickers Shipbuilding and Engineering.

As part of an interim six month executive management structure that was put in place by the new Chief Executive, from January 2013, three further directors also attend board meetings:

Director of Service Delivery (North Thames) Jason Killens has 16 years' experience working in both clinical and senior management posts. His current responsibilities include the strategic planning and command of major public events, and he was the Service's Strategic Commander for the Queen's Diamond Jubilee celebrations and the 2012 Olympic and Paralympic Games.

Director of Service Delivery (South Thames) Paul Woodrow joined the Service in 1991. His career has included time spent working as a paramedic – including a secondment on London's Air Ambulance – and clinical team leader. He has since held a number of managerial positions with responsibility for the operational delivery and

performance. Before taking up his current post, Paul completed secondments with NHS London and Great Western Ambulance Service.

Director of Modernisation Jane Chalmers joined the Service in January 2013. Her first career was in the Royal Air Force, where she trained as an air traffic controller and then completed a number of senior appointments. These included roles in national and multi-national strategic communication, strategic planning and commanding the training school which trained all the air traffic controllers and operations officers for the RAF and the Royal Navy. Since leaving the RAF, Jane has worked in the public sector and took up her first role in the NHS in 2009. She has been a programme manager for a reconfiguration programme and for the re-organisation programme which planned and delivered the transition of five primary care trusts into one cluster. Latterly she was the Director of the Chief Executive's office in NHS South West London.

Meetings

The Board meets in public eight times a year on Tuesdays from 9am in the conference room at our headquarters. Details of the meetings are published on our website at www.londonambulance.nhs.uk

We comply with the code of practice on openness in the NHS and our Trust Board meetings are always open to the public, with time set aside for their questions at the beginning and end of the meetings.

Directors' interests

A register is held of directors' interests. This is available on request from the Director of Corporate Services.

Governance Statement

Scope of responsibility

The Board is accountable for internal control and, as Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

As Accountable Officer I have overall accountability for having a robust risk management system in place which is supported by a governance structure (please figures one and two), processes and monitoring arrangements, and an assurance and risk management framework. These arrangements are documented in the Risk Management Policy and Strategy which defines risk as anything threatening the achievement of our strategic objectives. It defines the ownership and subsequent management of the identified risks and the responsibilities of individuals and it describes the Trust Board's corporate responsibility for the system of internal control and robust risk management.

As part of London's local health economy we work with our partners to minimise the risks to patient care. To do so we meet routinely with our lead commissioners and with the performance team at NHS London in order to progress and maintain the key performance targets set for ambulance services.

We work in partnership with health and social care organisations in the development and provision of emergency and urgent healthcare across London. In 2012/2013 this included service developments in the care provided to diabetic patients and the weekend opening of the Soho Alcohol Recovery Centre. We increased the number of calls we handled and resolve through hear and treat and we worked with emergency departments and NHS London to improve the handover of patients from our service into an acute healthcare setting. We continued to consolidate our cardiac referral pathways and developed bypass criteria for patients who have suffered acute stroke and major trauma, so that they can receive the highest standards of care in specialist centres.

We provided care and treatment to patients at various events during the Queen's Diamond Jubilee Celebrations in June 2012. We successfully implemented the Olympic delivery plan, providing increased resources to the Olympics and Paralympics whilst maintaining a safe service to London residents and visitors. We actively engaged with a wide range of stakeholders across London which has been particularly important during the transition phase of the implementation of the Health and Social Care Act in the NHS. We undertook approximately 1,086 patient and public involvement events including local community and foundation trust membership events, all of which were well received by those attending.

Our governance framework

I can confirm that arrangements in place for the discharge of statutory functions have been checked for any irregularities and that they are legally compliant. The governance structure underpinning these arrangements is described below. These include the arrangements in

place for the Trust Board to govern and manage the organisation through a committee structure that covers a range of functions.

Each board committee is chaired by a non-executive director. Membership of the Remuneration and Nomination, and Audit committees is non-executive only with executives in attendance where relevant and required. The Quality Committee is chaired by a non-executive director. The governance structure was fully reviewed in July 2012 along with the annual effectiveness review of the Trust Board, its reporting committees and the quality, safety and risk-related committees: Risk Compliance and Assurance, Clinical Quality Safety & Effectiveness, and Learning from Experience.

No further changes were made to the governance structure and the Trust Board continued to take assurance from this throughout 2012/13. Our Chair and Director of Corporate Services undertake a post-Board review each month to ensure the agenda has been covered, sufficient time allotted to agenda items and effective contribution and scrutiny given. The Board was formally observed on at least one occasion during the year and feedback has been built into subsequent board meetings and taken up with individual board members where appropriate.

The annual Board effectiveness review comprises the Corporate Governance Code and other recommended good practice on Board governance, such as Monitor's Code of Governance. The Trust Board reviewed its effectiveness in July 2012, based on the 2010 Code and there were no areas of non-compliance to report. The review identified an overall rating of 'good' and areas where further development was required: strategic planning and review, annual appraisal and time commitment for non-executive directors. These reflected the independent board governance assurance framework review for which an action plan is in place and has been progressed. Aspects of the review were refreshed in February 2013 with positive assurance that progress was being made. The Board development programme also addresses some of the areas.

Attendance by Board members at Trust Board meetings is recorded in the minutes and included in the annual effectiveness review. Attendance at key board committees is also monitored and recorded by the Committee Secretariat (see figures two to seven).

The Trust Board understands its responsibilities for discharging the statutory functions and takes assurance from the Audit Committee that systems are in place and that these are legally compliant.

The Chair of the Audit Committee provides a report to the next meeting of the Trust Board. This report includes a summary of the business discussed and the assurances received from the executive, the internal and external auditors and from counter fraud. The role of the Audit Committee is to focus on the controls and related assurance that underpin the achievement of our objectives and the processes by which the risks to achieving these objectives are managed. At the Trust Board meeting on 4 June 2013 the Audit Committee chair provided assurance to the Board of the effectiveness of our systems of integrated governance, risk management and internal control, based on the key sources of assurance identified in the board assurance framework. Throughout the year, the committee assesses the appropriateness and effectiveness of the corporate processes around risk identification and management, as reflected in the corporate risk register. The committee meets five times during the year with one meeting held without the internal or external auditors present.

The Chair of the Quality Committee provides a report to the next meeting of the Trust Board. This report includes the committee's assessment of quality and risk as taken from the reports and evidence presented to the committee, and from quarterly review of the board assurance framework and corporate risk register. The committee also reviews the cost improvement programme to seek assurance that there is no detrimental impact on patient and staff safety and the quality of services provided as a result of the programme. At the Trust Board meeting on 26 March 2013 the Quality Committee chair provided assurance on the quality and safety of service provision, including the supporting clinical, information and corporate governance framework. The committee meets five times during the year.

The Chair of the Finance and Investment Committee provides a report to the next meeting of the Trust Board. The committee provides assurance on the scrutiny of current finance and investment issues based on the reports and evidence presented to it throughout the year. At the Trust Board meeting the chair of the committee reported on the cash position, cash management, liquidity, CIP progress, and capital expenditure. The committee meets five times during the year.

The Trust Board works within the remit of the Standing Orders and Standing Financial Instructions and Scheme of Delegation and each of these has been reviewed and updated during 2012/13. We have prepared our constitution, governance rationale and standing orders in readiness for foundation trust status and will update these prior to application. The constitution will be updated in 2013/14 to reflect Monitor's Model Core Constitution and therefore the requirements of the Health and Social Care Act 2012. The governance rationale meets the requirements of Monitor's Code of Governance and will be updated in 2013/14.

We were subject to a number of external independent reviews during 2012/13. KPMG undertook the Board Governance Assurance Framework review; RSM Tenon undertook a review against Monitor's Quality Governance Framework. The incoming Director of Finance commissioned an independent baseline financial review by Grant Thornton, incorporating cash planning, cash forecasting, income and expenditure, and capital expenditure.

Once a review is completed we implement an action plan to address areas requiring development and these are then monitored by the Executive Management Team, the Trust Board and the relevant Board committee. The potential scope and impact of the recommendations of the Francis Report and Winterbourne review have been presented to the Trust Board.

We received unconditional registration from the Care Quality Commission (CQC) in March 2010 to provide the following regulated activities:

- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury
- Diagnostic and screening procedures.

The CQC undertook an unannounced compliance inspection in November 2012. Two areas for improvement were identified and action plans have been implemented to address the following: Outcome 11:- Safety, availability and suitability of equipment - moderate impact on patient safety and care; and Outcome 13:- Staffing – minor impact on patient safety and care.

We can confirm that all premises which we own, occupy or manage had fire risk assessments that complied with the Regulatory Reform (Fire Safety) Order 2005. We also achieved compliance with the Department of Health Fire Safety Policy.

Risk assessment

The Risk Management Policy and Strategy defines the risk management process which specifies the way risk (or change in risk) is identified, assessed and managed through controls. We were reassessed at level one of the NHSLA risk management standards for ambulance trusts and are fully compliant. We are working towards level two.

The Risk Management Policy and Strategy describes the process for embedding risk management throughout the Trust and during 2012/13 we made further progress with developing and managing local risk register processes. Risks can be escalated to the Risk Compliance Assurance Group (RCAG) for discussion and addition to the corporate risk register if required. We have also aligned project management risks with the corporate risk register. The policy and strategy have been updated and re-formatted in line with NHSLA requirements. A risk maturity audit was undertaken by the internal auditors who report compliance and recommend strategies for embedding the framework within the Trust. The audit showed that our risk maturity was increasing with more emphasis on risk management approaches being built into normal business processes.

Patient and staff safety and other incidents are reported in accordance with the incident reporting procedure and are then scored, either by local managers or by the risk and safety team, using the NPSA risk severity matrix. Action is then taken to control, manage or mitigate the risk and depending upon the score the risk may be added to the corporate register for review by the RCAG or monitored at a local level. A Serious Incident Group meets weekly to review any serious incidents that need investigating and may need to be formally declared as Serious Incidents.

New risks with a net severity rating of High >15 are added to the corporate risk register and the board assurance framework which are reviewed by the Trust Board on a quarterly basis. The following risks were added in 2012/13:

- ID 355 – Mandatory training

There is a risk of staff not receiving clinical and non-clinical mandatory training.

- ID 368 – CommandPoint and mobile data terminal messaging

There is a risk that messages between mobile data terminals in vehicles and the CommandPoint CAD system become out of sequence, cross one another while one is being processed or a job is being ‘cycled’ through to closure in error.

- ID 378 – Locality Alert Register

There is a risk that insufficient information is contained within Metropolitan Police Service referrals for inclusion in our locality alert register.

- ID 379 – Category C calls – delayed or inappropriate responses

There is a risk that calls received and triaged as Category C, subdivided into C1, C2, C3 and C4, could receive a delayed or inappropriate response because of increased levels of Category A demand.

- ID 371 – Level 2 information governance toolkit – risk due to lack of training

There is a risk that we will not continue to maintain Level 2 for IG Toolkit Requirement 112 because operational staff will not have completed their online IG refresher training.

There were two risks assessed below the threshold for the board assurance framework but being kept visible to the Trust Board and these concerned the changes to Board membership during 2012/13 and into 2013/14 and the potential impact of these on a) our governance, and b) signing off the strategy.

There were 11 lapses of data security in 2012/13 but none reached the threshold for reporting to the Information Commissioner.

We have undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

To provide increased resilience and reduce the risk of service failure a second control room has been opened at Bow. This will allow for some transition of call taking should the Emergency Control room at Waterloo become inoperable. We now have two control rooms in operation.

We continued to make significant progress against the Information Governance toolkit in-year achieving 82 per cent at the required Level 2 standards.

The risk and control framework

Systems are in place to monitor compliance throughout the year and to address any emerging gaps or risks. The board assurance framework shows the linkages between the strategic goals for the next five years and the most significant strategic risks to the achievement of these. This is mapped to the key risks the Trust Board chose to focus on during the year as well as the top risks on the corporate risk register. The board assurance framework is mapped to the Care Quality Commission's outcomes and requirements. The Quality Committee reviews the board assurance framework and corporate risk register quarterly as does the Trust Board. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Risk Compliance and Assurance Group reviews the corporate risk register in detail at each meeting, adding 17 risks and archiving 24 risks during 2012/13. The Audit Committee assess the effectiveness of the corporate risk register annually. The Trust Board, Quality Committee and Executive Management Team receive a quality dashboard showing monthly performance and any identified risks, from which they seek improvements and mitigations.

The local counter fraud specialist (LCFS) attends four meetings of the Audit Committee per year and monthly executive counter fraud meetings. During 2012/13 we undertook a procurement exercise for local counter fraud services and the contract was awarded to KPMG from 1 April 2013.

The Internal Auditors attend four meetings of the Audit Committee per year and work closely with the Governance and Compliance team to execute the annual audit workplan. Internal audit also attend meetings of the Quality Committee and the committee has input to the development of the annual audit workplan. This work is also informed by the executive team.

During 2012/13 we undertook a procurement exercise for internal audit services and the contract was awarded to KPMG from 1 April 2013.

KPMG will manage the transition from RSM Tenon to the new contract in the first quarter of 2013/14.

The Audit Commission ceased to provide external audit services during 2012/13. The Department of Health awarded the contract to Price Waterhouse Cooper and this took effect during 2012/13.

Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work of the internal auditors, clinical audit and our executive management team who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the Quality Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of the effectiveness of the system of internal control by the Board, the Audit Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Significant issues

We declared 16 serious incidents to NHS London and the Commissioners in 2012/13. Thematically, four were related to maternity calls and nine were delays in responding to patients, while there was one each relating to equipment, a road traffic incident and the response to an incident also involving the police.

With our lead commissioners, we recognised the increasing gap between demand and the available resources and jointly commissioned ORH Limited, a company specialising in planning and modelling, to undertake a capacity review. This was reported in January 2013 and has informed the contract for 2013/14 including identifying risk sharing arrangements and mitigating actions. This is incorporated in our modernisation programme that commences in May 2013.

As a result of the mitigating actions we took to ensure resources were available to meet the increasing demand on services during 2012/13, we sought and gained approval from NHS London to reduce the control total from £3.2m to £262k. We therefore failed to meet the 2012/13 financial plan. We also undershot on our Capital Resourcing Limit and failed to deliver CQUINs to an approximate value of £3m. The Grant Thornton review was commissioned to undertake a baseline financial review incorporating cash planning and forecasting, income and expenditure and capital expenditure, the outcome of which will inform future financial planning and management.

Our organisation underwent several Board changes during 2012/13. Peter Bradley left the post of Chief Executive on 10 September 2012 and Martin Flaherty was acting Chief Executive until 6 January 2013. I took over the position of Chief Executive on 7 January 2013. Michael Dinan left the post of Director of Finance on 20 January 2013 and Andrew Grimshaw was appointed as interim Director of Finance for a period of six months. Mr Grimshaw was subsequently appointed to the substantive post and will assume the role permanently from July 2013.

Letters of representation were obtained from Martin Flaherty and Michael Dinan confirming that, to the best of their knowledge, there were no significant issues arising during their period of office in 2012/13. My statement therefore as Accountable Officer pertains to the period 7 January – 31 March 2013. This was discussed by the Audit Committee and assurance given that the Trust Board is accountable for internal control with responsibility delegated to Peter Bradley as Chief Executive during the period 1 April – 10 September 2012. The Board is unaware of any significant issues other than those stated in the narrative above.

Head of Internal Audit opinion
Based on the work undertaken in 2012/13, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Accountable Officer : Ann Radmore, Chief Executive

Organisation: London Ambulance Service NHS Trust

Signature:

Date:

Figure 1

Governance Structure – February 2013

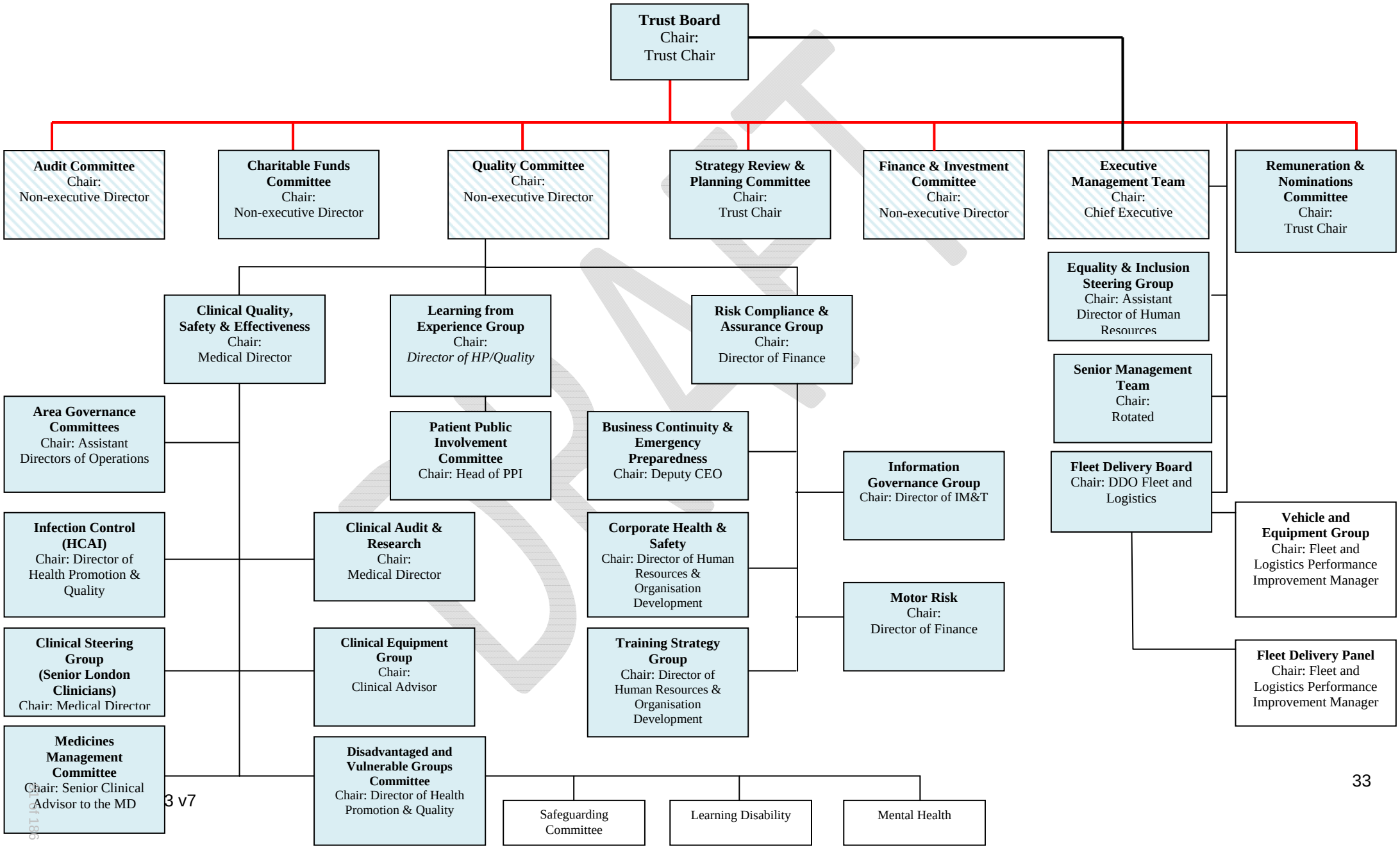


Figure 2 - Committee membership

Formal Trust Board committee	Chair	Current members
Audit committee	Non-executive director, Caroline Silver	Brian Huckett (non-executive director) – to 31/12/12 Roy Griffins (non-executive director) John Jones (non-executive director) – from 1/1/13
Charitable funds committee	Non-executive director, Caroline Silver	Caron Hitchen (executive director)
Quality committee	Non-executive director, Dr Beryl Magrath MBE	Roy Griffins (non-executive director) Peter Bradley (Chief Executive) Jessica Cecil (non-executive director) Murziline Parchment (non-executive director) – to 30/9/12 Nick Martin (non-executive director) – from 1/10/12
Finance & investment committee	Trust Chair, Richard Hunt, CBE	Non-executive director member of the audit committee Non-executive director member of the quality committee Executive directors – Finance, Workforce, Corporate Services *, Health Promotion & Quality, Strategy & Planning * *Non-voting directors
Strategy review and planning committee	Trust Chair, Richard Hunt CBE	All board directors, voting and non-voting.
Remuneration and Nomination committee	Trust Chair, Richard Hunt CBE	All non-executive members of the Trust Board

Figure 3 – Attendance at Trust Board meetings

	29 May 2012	26 June 2012	21 August 2012	25 September 2012	27 November 2012	29 January 2013	26 March 2013	Comments
Trust Board members (voting)								
Richard Hunt (Non-Executive Chair)	x	✓	✓	✓	✓	✓	✓	
Peter Bradley (Chief Executive)	✓	✓	✓					Left in September 2012
Jessica Cecil (Non-Executive Director)	✓	x	✓	✓	x	✓	✓	
Mike Dinan (Director of Finance)	✓	✓	✓	✓	✓			Left in January 2013
Martin Flaherty (Chief Operating Officer)	✓	✓	✓	✓	✓			Left in January 2013
Roy Griffins (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	
Andrew Grimshaw (Director of Finance)						✓	✓	Joined in January 2013
Caron Hitchen (Director of Workforce)	✓	✓	✓	✓	✓	✓	x	
Brian Huckett (Non-Executive Director)	✓	✓	x	✓	✓			Left in December 2012
John Jones (Non-Executive Director)					✓	x	✓	Joined in January 2013
Steve Lennox (Director of Health Promotion and Quality)	✓	x	✓	✓	✓	✓	x	
Ann Radmore (Chief Executive)					✓	✓	✓	Joined in January 2013
Beryl Magrath (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	
Nick Martin (Non-Executive Director)					✓	✓	✓	Joined in October 2012
Fionna Moore (Medical Director)	✓	✓	✓	✓	✓	✓	x	
Murziline Parchment (Non-Executive Director)	✓	✓	x	✓				Left in September 2012
Caroline Silver (Non-Executive Director)	x	✓	x	✓	✓	x	x	
Non-voting								
Sandra Adams (Director of Corporate Services)	✓	✓	✓	✓	✓	✓	✓	
Lizzy Bovill (Director of Strategy and Planning)	✓	✓	✓					Maternity leave from September 2012
Jane Chalmers (Director of Modernisation)						✓	x	Joined in January 2013
Bob McFarland (Associate Non-Executive Director)							✓	Joined in March 2013
Jason Killens (Director of Service Delivery, North Thames)					✓	✓	✓	Commenced role of Director of Service Delivery in September 2012
Angie Patton (Head of Communications)	x	x	✓	✓	✓	✓	✓	
Peter Suter (Director of Information Management and Technology)	✓	✓	x	✓	✓	✓	✓	
Paul Woodrow (Director of Service Delivery, South Thames)					✓	✓	✓	Commenced role of Director of Service Delivery in September 2012

Figure 4 – Attendance at Quality Committee meetings

	25 April 2012	20 June 2012	15 August 2012	24 October 2012	13 December 2012	20 February 2013	Comments
Quality Committee members							
Beryl Magrath	✓	✓	✓	✓	✓	✓	
Jessica Cecil	✓	✓	✓	x	x	✓	
Roy Griffins	✓	✓	x	✓	✓	✓	
Nick Martin				✓	✓	✓	
Murziline Parchment	✓	x	x				Left in September 2012
Peter Bradley	x	x	✓				Left in September 2012
Attending							
Sandra Adams (Director of Corporate Services)	✓	✓	x	✓	✓	✓	
Mike Dinan (Director of Finance)	✓	✓	x	✓	x		Left in January 2013
Martin Flaherty (Chief Operating Officer)	x	x	x	x	x		Left in January 2013
Caron Hitchen (Director of Human Resources and Organisation Development)	✓	✓	✓	✓	✓	✓	
Steve Lennox (Director of Health Promotion and Quality)	✓	x	✓	✓	✓	✓	
Fionna Moore (Medical Director)	✓	x	✓	✓	✓	x	
Paul Woodrow (Director of Service Delivery)	x	✓	✓	✓	✓	x	

Figure 5 – Attendance at Audit Committee meetings

	5 March 2012	14 May 2012	1 June 2012	3 September 2012	5 November 2012	Comments
Audit Committee members						
Caroline Silver (Non-Executive Director)	✓	✓	✓	✓	✓	
Roy Griffins (Non- Executive Director)	✓	✓	✓	✓	✓	
Brian Huckett (Non-Executive Director)	✓	✓	x	✓	x	
Attending						
Peter Bradley (Chief Executive)	x	x	✓	x		Left in September 2012
Mike Dinan (Director of Finance)	✓	✓	✓	✓	✓	
Sandra Adams (Director of Corporate Services)	✓	✓	✓	✓	✓	

Figure 6 – Attendance at Strategy Review and Planning Committee meetings

	24 April 2012	24 July 2012	23 October 2012	11 December 2012	Comments
Trust Board members (voting)					
Richard Hunt (Non-Executive Chair)	✓	✓	✓	✓	
Peter Bradley (Chief Executive)	✓	✓			Left in September 2012
Jessica Cecil (Non-Executive Director)	✓	x	x	✓	
Mike Dinan (Director of Finance)	✓	✓	✓	✓	
Martin Flaherty (Chief Operating Officer)	✓	✓	✓	✓	
Roy Griffins (Non-Executive Director)	✓	x	✓	x	
Caron Hitchen (Director of Workforce)	✓	✓	✓	✓	
Brian Huckett (Non-Executive Director)	✓	x	✓	✓	
John Jones (Non-Executive Director)			✓	✓	Joined as Associate Non-Executive Director in October 2012
Steve Lennox (Director of Health Promotion and Quality)	✓	✓	x	✓	
Ann Radmore (Chief Executive)				✓	Joined in January 2013
Beryl Magrath (Non-Executive Director)	✓	✓	✓	✓	
Nick Martin (Non-Executive Director)			x	✓	Joined in October 2012
Fionna Moore (Medical Director)	✓	✓	✓	✓	
Murziline Parchment (Non-Executive Director)	✓	✓			Left in September 2012
Caroline Silver (Non-Executive Director)	x	x	✓	✓	
Non-voting					
Sandra Adams (Director of Corporate Services)	✓	✓	✓	✓	
Lizzy Bovill (Director of Strategy and Planning)	✓	✓			Maternity leave from September 2012
Jason Killens (Director of Service Delivery, North Thames)			✓	x	Commenced role of Director of Service Delivery in September 2012
Angie Patton (Head of Communications)	✓	✓	✓	✓	
Peter Suter (Director of Information Management and Technology)	✓	✓	x	✓	
Paul Woodrow (Director of Service Delivery, South Thames)			✓	x	Commenced role of Director of Service Delivery in September 2012

Figure 7 – Attendance at Finance and Investment Committee meetings

	15 May 2012	10 July 2012	18 September 2012	13 November 2012	12 March 2013	Comments
Quality Committee members						
Richard Hunt (Non-Executive Director)	✓	✓	✓	✓	✓	
Jessica Cecil (Non-Executive Director)	✓	✓	x	x		
Brian Huckett (Non-Executive Director)	✓	✓	✓	✓		Left in December 2012
John Jones (Non-Executive Director)				✓	✓	Joined as Associate Non-Executive Director in October 2012
Beryl Magrath (Non-Executive Director)	✓	✓	✓	✓	✓	
Nick Martin (Non-Executive Director)				✓	✓	
Attending						
Sandra Adams (Director of Corporate Services)	✓	✓	✓	✓	✓	
Lizzy Bovill (Director of Strategy and Planning)	✓	✓				Maternity leave from September 2012
Mike Dinan (Director of Finance)	✓	x	✓	✓		Left in January 2013
Andrew Grimshaw (Director of Finance)					✓	Joined in January 2013
Caron Hitchen (Director of Human Resources and Organisation Development)	x	✓	x	✓	✓	
Steve Lennox (Director of Health Promotion and Quality)	x	✓	✓	✓	x	
Ann Radmore (Chief Executive)					✓	Joined in January 2013

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 4 JUNE 2013

PAPER FOR INFORMATION

Document Title:	**Quality Account**
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?	**Mandatory Report to Trust Board on Quality**
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 (Commissioners Clinical Quality Group)
Recommendation for the Trust Board:	**Note the report**

Key issues and risks arising from this paper

The Trust is required to produce an Annual Quality Account for publication on the Trust's web site and on NHS Choices. This sits alongside the Annual Report & Financial Accounts and primarily reports against quality improvement targets set in the previous year.

Executive Summary

The Trust is required to produce an annual Quality Account giving both a retrospective account of the year's performance against a range of quality indicators and measures, and also a prospective indication of priorities for quality improvement for the coming year

Production of a Quality Account is a mandatory requirement.

The report identifies that the Trust achieved the majority of quality improvement targets is set itself in 2012/13. In some instances the success measures did not meet the threshold within the CQUIN payment framework. Nevertheless all improvement work was attempted during the year.

This report has been distributed to the key stakeholders; Commissioners, Southwark Healthwatch and Hillingdon Scrutiny Committee) for their comments. These will be incorporated into the final version that will be submitted to the following Trust Board for approval before final publication.

Attachments

1. **Quality Account**

****

Quality Strategy

This paper supports the following domains of the quality strategy

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

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

- ☐ Yes
- ✓ No

Key issues from the assessment:

London Ambulance Service NHS
NHS Trust

Annual Quality Account
2012/13
The annual quality report

The London Ambulance Service NHS Trust
Annual Quality Account 2012/13

An account on the quality of service provided by the Trust and the identification of improvement priorities for 2013/14

Incorporating an end of year review of the DH Ambulance Quality Indicators

Contents

Introduction

Statement on Quality from the Chief Executive

Welcome to the fourth London Ambulance Service NHS Trust Quality Account. I came into post in January 2013 and I am proud to take over from Peter Bradley, the previous Chief Executive, who led the organisation through a significant improvement during his more than ten years in the service.

In an ever changing NHS I believe we can now build upon recent successes and the current high level of public confidence and capture the opportunities of increasingly professional and skilled staff to work within the new NHS and improve the way urgent and emergency care is provided to Londoners.

As you may be aware, NHS organisations are required to produce an annual Quality Account. The purpose of the document is to report on the quality of our services and the care we provide. We are accountable to our patients and this is one of the mechanisms that we use to answer that accountability. Therefore, the Quality Account is primarily written for a patient audience but it is also used by the Department of Health and has specific aspects that are required for their reporting arrangements.

We report on the progress we have made on the improvement areas we identified in last year's report and we also discuss our performance against the national quality indicators for ambulance services. We also use a number of other measures, such as complaints, to give the reader a more complete picture of quality.

The past year has arguably been the most challenging and exciting in our history. In a single year we saw London host the two biggest events ever performed in the capital. The first was the Diamond Jubilee held predominately on the River Thames and later in the year London hosted the Olympic Games. These gave us the opportunity to demonstrate one of our real strengths: our ability to provide business as usual to Londoners and simultaneously respond to the needs of planned events that change our operating environment. Our ability to do this is truly world class and this was highlighted as one of our quality targets for last year.

The preparations for the two world events were more time consuming than we anticipated but they brought great benefit to us and to London. London proved to the world what a great city London is to live and to work and we are proud to have played our small part in this unique event. In addition, we managed to improve in a number of our quality indicators and we met our most challenging performance target of reaching 75% of people within 8 minutes for the tenth consecutive year. But there are also areas where we failed to make the improvements that we wished to see. In particular we saw our ability to address peoples needs and discharge them on scene reduce. This resulted in taking a greater percentage to accident and

emergency departments than we would have expected.

We have seen demand increase by 6.4% and in particular the proportion of calls that result in a category A response, our highest priority level, has risen by 12.2% and this may offer some explanation as to why we took more people to accident and emergency. This rise in demand has given us a real challenge in meeting the needs of our patients in the lower priority categories and we have decided to focus on this group of patients for our Quality Improvement priorities in 2013-2015. Some of the specific improvement priorities are highlighted later in this Quality Account. We are proposing some significant changes that will bring dramatic quality improvements to this group of patients and allow us to improve the speed of our response. We know that from talking to patients and service users that the length of time it takes us to respond is the single most important issue. This will be another step in creating a world class service for London.

To the best of my knowledge, the measures reported within this Quality Account are true and accurate and reflect the services we provide.

Ann Radmore
Chief Executive

What is a Quality Account?

The purpose of the Quality Account

In 2009, as part of the Department of Health's drive to ensure quality receives equal status to finance and to also promote a greater degree of transparency, all NHS Trusts have been required to publish a Quality Account.

The Quality Account is required to follow a template and report on a set of mandatory items. It is divided into three distinct sections:

Section 1 contains a statement on quality from the Chief Executive Officer and this introduction.

Section 2 looks back at the previous year and reports against a set of mandatory measures. The section also reports progress made against the priorities we identified for improvement in the 2012-2013 Quality Account.

Section 3 looks forward to the year ahead and identifies new priorities for improvement.

Individual Trusts are able to report over and above the minimum requirements but they should represent a true reflection of quality.

Once produced, the Quality Account should have the same value and status within the organisation as the annual financial accounts and the same degree of rigor and challenge should be applied whilst being created and approved.

Once published staff, the public, and patients can access the Quality Account on line and use this to help set local priorities or identify areas for further challenge and scrutiny.

How are patients, the public, staff and commissioners, involved in designing a Quality Account?

It is fundamental to the process that patients and staff are involved in the development of the quality account and especially in the identification of the improvement priorities for the coming year.

Patients, carers and members of the public

This year, new DH guidance firmly identifies which statutory patient and public organisation needs to be approached in order to provide formal feedback. The guidance states that the "Health Watch" covering the geographical area of the health provider's headquarters is responsible. Therefore, for 2012/13 we have worked with Southwark "Health Watch" in obtaining the views of patients, carers and members of the public.

In addition, as an aspirant Foundation Trust we have a members group which has a membership of over 8,000 who are representative of our patient group. We regularly hold meetings and towards the end of 2012 we started to make suggestions regarding quality priorities for 2013/14 at the member's events. On 25 March 2013 we held a member's event dedicated to "Quality and Innovation". At this event we

specifically fed back on our progress on our 2011/12 improvements and responded to a question an answer session on quality issues.

As part of our public facing work with our public education team we routinely ask for feedback on what our improvement priorities should be. This year we asked 62 patients about our priorities and asked them what the most important things are that we need to get right first time.

Overwhelmingly the most important thing for the public is that we respond quickly. This is at the point of call answering and a clinical team arriving on scene. Other important themes include our staff being skilled and courteous.

In April 2013 we also presented the main issues within this Quality Account to the Hillingdon External Services Scrutiny Committee.

Staff

Our main forums for obtaining the views of our workforce are via manager's meetings and through the staff in year surveys. These do not exclude other opportunities such as Executive ride outs when members of the Trust Board observe patient care and actively seek the views of staff.

In addition, feedback on quality also passes through the area governance meetings where staff can feed quality concerns into a local forum that reports centrally up to the Quality committee and Trust Board.

The Trust Board

During the course of the year the Executive Management Team and the Trust Board review the priorities identified within the Quality Account alongside wider quality measures every month via a Quality dashboard. It is important to note that this Quality Account is an annual summary of the whole 2012/13 period. Members of the Trust Board, Operational Managers and other staff are involved in measuring and monitoring quality every month.

Commissioners

The Trust meets with commissioners in the form of the Clinical Quality Group. This has representation from the various clinical commissioning groups and representatives from the Trust and at every meeting we review the identified priorities and the remainder of the Quality Dashboard.

In addition, we have frequent review meetings with our lead commissioner in year to discuss issues such as Serious Incidents and performance.

Our Vision and Values

Our strategic direction and the values we uphold

Our vision is to be a world class service, meeting the needs of the public and our patients, with staff who are well trained, caring, enthusiastic and proud of the job they do.

We want to deliver the highest standards of healthcare and contribute towards Londoners having health outcomes that are among the best in the world.

Our strategic goals are:

To improve the quality of care we provide our patients

We will achieve this through the following objectives

- To improve the experience and outcomes for patients who are critically ill or injured
- To improve the experience and provide more appropriate care for patients with less serious illness or injuries
- To meet response times routinely, and
- To meet all other quality, regulatory and performance targets

To deliver care with a highly skilled and representative workforce

We will achieve this through the following objectives

- Develop our staff so that they have the skills and confidence they need to deliver high quality care to a diverse population
- Engage with our staff to improve patient care and productivity

To provide value for money

We will achieve this through the following objectives

- Use our resources efficiently and effectively
- Maintain service performance during major events, both planned and unplanned including the 2012 Games

Our 2012/13 Annual Report outlines some of the progress that we have made in meeting these objectives and is designed to compliment, rather than repeat, this Quality Account..

Our values

The values that we uphold as an organisation remain the same. We have seven values that underpin the culture of the London Ambulance Service and these are also known as our CRITICAL values from the acronym that they reveal.

These cultural values are:

Clinical excellence

We will demonstrate total commitment to the provision of the highest standards of patient care. Our services and activities will be ethical, kind, compassionate, considerate and appropriate to patients' needs

Respect and courtesy

We will value diversity and will treat everyone as they would wish to be treated, with respect and courtesy

Integrity
We will observe high standards of behaviour and conduct, making sure we are honest, open and genuine at all times and ready to stand up for what is right

Teamwork
We will promote teamwork by taking the views of others into account. We will take genuine interest in those who we work with, offering support, guidance and encouragement when it is needed

Innovation and flexibility
We will continuously look for better ways of doing things, encourage initiative, learn from mistakes, monitor how things are going and be prepared to change when we need to

Communication –
We will make ourselves available to those who need to speak to us and communicate face to face whenever we can, listening carefully to what is said to us and making sure that those we work with are kept up to date and understand what is going on

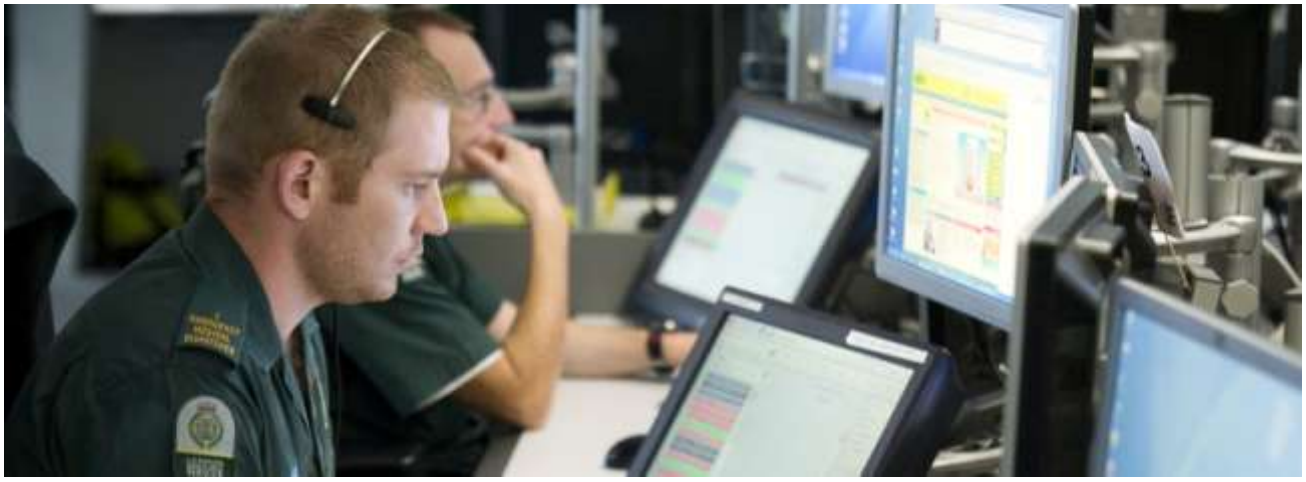
Accept responsibility
We will be responsible for our own decisions and actions as we strive to constantly improve

Leadership and direction
We will demonstrate energy, drive and determination especially when things get difficult, and always lead by example.

We believe that our strategic goals and our values provide a platform on which we can achieve or vision to be a world class service. Our vision is an aspiration that we use to determine our direction of travel. Work undertaken during the year has revealed great diversity throughout the world's ambulance services with different operating models and different quality measures and where there are common measures the data is not comparable due to a range of factors. However, we are giving some thought as to what milestones we can use to measure our ability to declare ourselves as a world class service. We will outline our thoughts within our new Clinical and Quality Strategy.

Prioritising Quality

How do we prioritise quality and identify our priorities



We believe that our patients are the key stone in our ability to monitor quality. However, as we provide services to a wide geographical area with no defined catchment our ability to engage a wide variety of patients in our work is challenging.

The Patient Voice

Whilst, we have had some success this year and this Quality Account does report on a specific feedback project we need to test a model that supports engagement at a local level that maximises the role of our Community Involvement Officers.

We remain committed to working with our patients and are looking for opportunities for more inclusion and have added a regular "patient voice" item to our Learning from Experience Committee and will be inviting patient representation to our Quality Committee during 2013.

The Staff Voice

The annual Healthcare Commission Staff Survey highlights the importance of staff engagement and satisfaction.

High Quality Care for All (2008) stresses the importance of empowering staff, giving them the skills to provide a high quality service as practitioners, partners and leaders. Staff need to be supported to innovate to improve quality and this is echoed in the findings identified within the Francis Report (2013).

We run an annual survey and regular in year surveys to measure staff satisfaction and collect feedback. In addition the Chief Executive and senior managers regularly undertake observational shift to work alongside staff to hear their issues first hand.

The role of the Trust Board

The Trust Board is accountable for ensuring the Trust consistently provides a safe and high quality service and this is demonstrated by the following

- Nominating a Director responsible for bringing quality issues to the attention of the Trust Board and acting as the custodian to quality issues.

- Prioritising quality on the agenda by ensuring these are, whenever possible, placed at the top of the agenda

- Devoting the majority of its time discussing and acting on quality issues and the factors that influence quality

- Having a Board level committee, with the same status (and linked to) as the audit committee, dedicated to quality monitoring

- Monitors the quality of care provided across all our services and routinely measuring and benchmarking services internally and externally where this information is available

- Proactively looking at any risks to quality and taking prompt mitigating action

- Challenging poor performance or variation in quality and recognising quality improvement.

- Building a culture of listening, transparency and accountability. Listening to concerns from patients, carers and staff. The Trust Board now invites a patient to recount their experience to every Trust Board meeting.

- Working to ensure our workforce is motivated as possible and enabled to deliver quality care.

Our Commissioners

The system for commissioning healthcare is evolving and on April 1 2013 changed to become clinically led and locally determined. Once the new system becomes familiar with the opportunities this brings for driving local improvements we expect to see local quality targets emerging.

For the time being we expect to continue with the current model of a single commissioner who commissions us on behalf of London. We currently work with our commissioner to identify what quality measures we need to routinely report. These are then reported to the Quality Group which has representation from the new local commissioners.

The Influence of Government Policy

For the past 3 years the Department of Health has published an NHS Outcomes Framework. This gives guidance to the wider NHS on what quality outcomes have been identified as critical to achieving the national priorities for health improvement.

The current framework was initially developed in December 2010, following public consultation, and has been updated and refreshed since its initial publication.

The Indicators in the NHS Outcomes Framework are grouped around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. For each domain, there are a small number of overarching indicators followed by a number of improvement areas. They primarily focus on improving health and reducing health inequalities:

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long term conditions
Domain 3	Helping people to recover from episodes of ill health or following injury
Domain 4	Ensuring that people have a positive experience of care
Domain 5	Treating and caring for people in a safe environment; and protecting them from avoidable harm

This definition supports the view that high quality care comprises: effectiveness, patient experience and safety. Consequently in order to use a single framework when talking about quality we have aligned our quality indicators within these domains. However, we have also retained our workforce indicators as a sixth domain as we believe our workforce is a critical element to maintaining quality.

From April 2013 provider Trusts will be required to publish quality measures in a way that will enable direct comparisons to be made with other Trusts via a mandated quality dashboard. This will not initially apply to Ambulance Trusts as they already report comparative information to the DH. However, it is likely that ambulances will be incorporated into the dashboards to allow local issues to be highlighted. This may mean that we need to adjust our current quality measures once there is clarification.

The national reporting has a different approach to quality and the DH has agreed not to set national targets or thresholds associated with each quality measure but to allow the measures to be interpreted locally. We have taken this a step further and are no longer focussing on achieving a target but are turning our attention to the number of patients that did not receive a particular standard. For example, if the 95% target of patients received the right care following a stroke is achieved we now asking how many people did not receive the right care following their stroke and why. This work is

in development and we are starting to collect and audit information differently so that we can report this for the majority of our indicators.

The Expectations of our Regulators

Our regulator is the Care Quality Commission (CQC). They are responsible for setting the minimum standards for quality and safety that people have a right to expect whenever they receive care; Organisations that consistently meet these expectations are then registered with the CQC and are able to provide care to NHS funded patients.

The CQC then monitor the provision of healthcare at these registered providers using a variety of measures that include unannounced inspections and other methods of data gathering.

The CQC have had a difficult year and have completely re-evaluated and refreshed the way that they will inspect healthcare providers. From April 1 the inspection and regulation of care services will ask the following questions about services.

- Are they safe?
- Are they effective?
- Are they caring?
- Are they well led?
- Are they responsive to people's needs?

They are planning to appoint a Chief Inspector of Hospitals, and a Chief Inspector of Social Care and Support, and are also considering the appointment of a chief inspector for primary and integrated care.

The CQC will be moving towards inspections being determined by the 'risk' involved. By this they mean the quality and safety of a service, and the type of care being provided. They will inspect services more often where there is a high risk of harm to people who use them, and where people are vulnerable because of their circumstances, such as services caring for people with learning disabilities, those caring for people in their own homes, and those caring for people with mental health issues.

The CQC intend to develop new fundamental standards that focus on the new five areas, working with the public, people who use services, carers, providers and professionals.

The Trust Development Authority

The Trust Development Authority (TDA) is a new organisation aimed at ensuring all NHS provider Trusts who are not Foundations Trusts have a facilitated transition to being able to register with Monitor and become a Foundation Trust. They have created a quality directorate at the very centre of their organisation, which is designed to give locally-focussed Delivery and Development Teams guidance on the key measures for success. Undoubtedly as 2013 progresses we will become more aware of the quality expectations of the TDA and will need to incorporate these within our quality plans for the coming year.

Review of the Year 2012/13

Quality in general

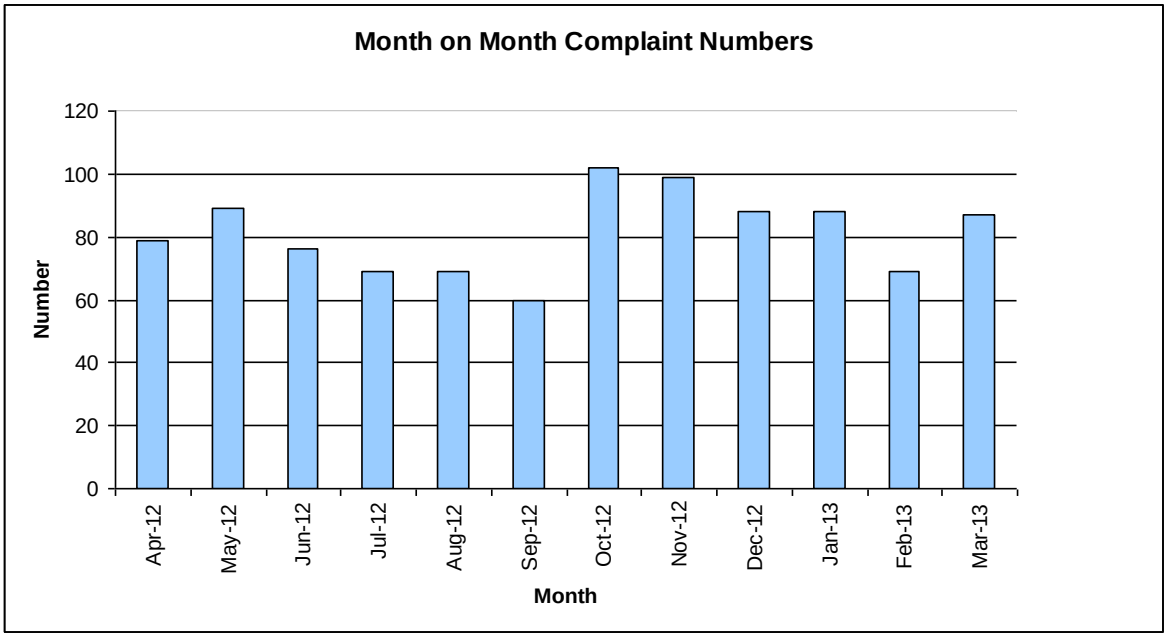
We use a wide range of indicators to give us a measure of the level of quality we are offering and these are specifically reported later in the Quality Account. However, we also use a range of routine indicators to help triangulate the information. Some of these are reported within this section..

Complaints

We have seen an increase in complaints during 2012/13 compared to the previous year.

The main theme has been delays in the ambulance being dispatched, especially to patients triaged within our medium priority level which we call C1 and C2. This undoubtedly reflects the increased activity to the Trust with demand continuing to rise year on year.

For each of complaint that we receive we undertake a comprehensive explanation which includes, if necessary, a quality assurance evaluation of the emergency call received. This allows us to identify whether the 999 call was handled appropriately and to determine if the caller received the correct information. In the majority of cases the call was handled correctly and the cause of the poor patient experience was purely down to us being unable to match the demand with an available resource.



We also continued to receive complaints about poor staff attitude and behaviour. The most likely cause for a complaint of this nature is when our clinical staff challenge the patient about the validity of their 999 call. Similarly we also receive complaints when our call takers refer patients to telephone advice rather than a face to face response. This is a difficult situation for the Trust as we have a responsibility to use our resources appropriately. However, we are developing a plan to try and reduce the unhappiness experienced by patients when we do not respond in the way they expect.

We have made concentrated efforts this year to learn from patient feedback about a wide range of issues relating to the 999 call management function. This has included changing the information we give to 999 callers.

We have also identified from complaints that we receive poor information from some community alarm providers when a patient activates their alarm. This is usually because the provider is remote from the patient and many authorities now use the 999 as the default response to an alarm activation.

During 2012/13 we had 29 cases progress to the Health Service Ombudsman for further enquiry. 1 of these was subject to further investigation suggesting that the quality of our complaint response is of a good standard. However, in that 1 case the recommendation was made that we need to improve our maintenance of chronological records when we meet with complainants.

Serious Incidents

We had 1,708,597 calls for assistance in 2012/13 and 16 resulted in a serious incident. This is a low ration to our work. However, we must ensure we learn all the lessons that are contained within all serious incidents.

There are no overall themes. However, we deliver 1,000 babies a year and considering all of these are out of the planned environment some do result in difficulties. Therefore we had a number of serious incidents regarding challenged labour last year.

We had a number of serious incidents where patients had been categorised correctly but due to the demand on the service we had been unable to give a response within the target time. This is unsatisfactory and we are in discussion with our commissioners on how we can ensure we respond appropriately to all calls and this forms the basis of our improvement priorities for 2013/14.

Patient Feedback

In 2012/13 we agreed with our commissioners to undertake a major satisfaction survey of patients who have not been conveyed to hospital, to elicit information about their experience. The project also asked clinicians and call answering staff about their experience of making decisions not to convey patients to hospital, and the factors that affect their decisions.

We approached 599 patients and 178 took up the opportunity to give feedback and 116 members of staff participated in the feedback.

On the whole patients were happy with the service being provided although the patients receiving hear and treat reported slightly less satisfaction than the patients receiving see and treat. Some respondents had concerns about the validity of assessing patients over the phone and then about the way that they were spoken to by Trust staff. Amongst the see and treat patients it was attitude that contributed to the lower satisfaction.

However, only 4% of the patients reported that the call taker had been poor when asked about courtesy and the score was 3% for ambulance staff. However, 1% reported that they hadn't been involved as much as they wished during hear and treat but this was 5% for see and treat.

Patients gave positive comments on the way that they were treated and some of the quotes include

"Always calming, reassuring and helpful"

"They keep you calm and do everything for you"

"I have always received excellent care from the ambulance service and am most grateful to them. They do a fantastic job"

Some patients also took the opportunity to give feedback that identified the need to improve. These included

"I have called for an ambulance twice for my illness and both times an ambulance has not been dispatched. It amazes me how a grading system determines if an ambulance comes to you or not. I feel this would only encourage people to exaggerate their symptoms. My illness led to hospital treatment, MRI scans, more treatment and now on going with the GP. An ambulance should have been sent"

The exercise revealed that some patients call 999 as they are unaware of the alternatives that are available; such as out of hours GP services. For others, they had dialled 999 because they believed the ambulance staff would be able to administer pain relief.

With regards to our staff the exercise revealed that our staff may not be clear about policies or guidelines that relate to non-conveyance and staff were asking for greater clarity. Interestingly, staff who used to be part of our Emergency Car Practitioner team seemed to be more confident about leaving patients at home but there was a call for more training in managing the less urgent patients and the alternatives that may be available.

Staff Survey

A total of 1,659 London Ambulance Service staff completed the 2012 NHS Staff Survey, a response rate of 37%. The survey enables staff to provide feedback on their experience of working for the Trust.

The results show a number of improvements from the 2011 survey, which include:

- A 10% reduction in staff reporting that communication between senior management and staff is not effective
- The number of staff reporting that they cannot meet conflicting demands on their time at work has fallen by 8%
- The number of staff who felt they were not able to do their job to a standard they are were pleased with fell by 5%

However, the following areas have been identified as areas requiring action:

- The number of respondents reporting that there are not enough staff at the Trust to do their job properly rose by 10%
- The number of staff reporting that that they have experienced harassment, bullying or abuse from patients rose by 19%
- The percentage of staff who felt unwell as a result of work-related stress increased by 10%
- The percentage of staff who reported that they are not able to make improvements in their area of work increased by 10%

A Trust wide action plan has been produced to tackle the areas of concern. Actions include increasing face-to-face communication between senior management and staff, through road shows and listening events which will encourage staff to share their ideas. In addition access to health, wellbeing and stress management support is to be improved and recruitment is underway to significantly increase clinical staffing levels. The plan is supplemented by actions agreed at ambulance station and department level, based on local results breakdowns.

A summary of the Trust's results can be found on the Department of Health's website, although it should be noted that this report is based only on a small sample of the total respondents."

The 2012/13 Quality Indicators

2012/13 saw the Ambulance Quality Indicators (AQIs) have their second year. They were introduced in April 2011 for all ambulance services in England and look at the quality of care provided as well as the speed of response to patients.

The indicators are specific to the ambulance service but are designed to be read alongside the indicators for Acute Trusts that have Accident & Emergency departments. They measure elements of patient safety and patient outcomes

Constantly monitoring our performance is essential and it is a vital indicator of how well we respond to patients' needs and how we can maintain and improve our standards of care. Response times remain important for the most seriously ill patients and all NHS ambulance services must respond to

75% of calls to life-threatening emergencies within 8 minutes and 95% of these calls within 19 minutes. These two time related indicators form part of our contract and have penalties associated with under performance.

Our 2012/13 Quality Priorities

Progress against our improvement priorities

Last year we used six main pieces of work to inform the selection of our quality improvement priorities. These were 1) the NHS Operating Framework 2) patient ideas 3) staff ideas 4) learning from incidents 5) commissioning intentions and 6) the quality indicators.

From this analysis we identified the four areas as;

- Mental health care
- Alcohol related harm
- Maintaining quality during the Olympics
- Treatment and care of Diabetes

Mental Health Care

In recognition of the vital role we play in the emergency and urgent care of patients with mental health conditions we identified mental health care as an area for quality improvement in the previous year and decided to continue this work in 2012/13.

Building upon the success of the previous year we identified four specific areas for action which are outlined below. We have had mixed results this year. Undoubtedly the care of mental health patients has continued to progress and we are increasingly being seen by other NHS organisers as a mental health provider. As a result of our work we now have stronger networks and our liaison with the London Mental Health Trusts has considerably improved.

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

We incorporated mental health training within the third day of our statutory and mandatory training programme. This approach would ensure that every clinician would receive an update during 2012/13.

To support this training and also ensure that the classroom time was maximised we also asked our clinical staff to complete the on line mental health package prior to attending the classroom training.

Unfortunately the rise in Category A demand made it extremely difficult for us to deliver all of our training aspirations within 2012/13. As soon as it became apparent that we would be unable to deliver on all our training objectives we had to reprioritise. Unsurprisingly we had to focus on preparing our staff for the Olympic Games. Nevertheless, mental health training remains part of our statutory and mandatory training and has been rolled into 2013/14.

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

In 2012 we appointed a Clinical Advisor for Mental Health. We believe we are the only Ambulance Trust to make such an appointment and this role is central in our ability to advance the support available to our clinical staff. The post holder is prioritising our team of clinical advisors but this has taken longer than initially anticipated due to changes we are making within our support team and also due to the limited training opportunities within the past year. This has been rolled into 2013.14.

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

As we had undertaken a patient feedback exercise with patients with general mental health disorders in the previous year we decided to focus on a different group of mental health patients in 2012/13 and decided to incorporate a satisfaction element into our alcohol recovery service which is reported within the next section.

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

There are 11 NHS Trusts that provide mental health care to Londoners. During 2012 we completed the negotiation of mental health care pathways with all of these providers and implemented them in March 2013.

This means that all the mental health providers will now accept a referral from a paramedic for patients with chronic mental health conditions and have agreed that we can access their out of hour teams for additional support or advice. This means that once these agreements are embedded within our clinical practice we should convey less patients to an accident and emergency department.

Our base line figure for 2011/12 shows that we conveyed 12,833 patients to accident and emergency with mental health conditions. It is important to remember that for some of these patients the accident and emergency department would be an appropriate choice and we are unlikely to see reductions in large numbers. Nevertheless, for a significant number of patients with chronic conditions, such as dementia and depression we should see improved mental health care.

Alcohol Related Harm.

Alcohol continues to receive widespread media attention and it is a high priority across London for a number of other organisations; such as the office of the London Mayor and we identified as a priority as it features consistently across all the six elements we used to identify our priorities.

We broke the improvement area into two main work streams 1) Our alcohol recovery service and 2) health promotion and this was supported by the CQUIN reward framework which was used to support the implementation of this objective.

Alcohol Recovery Service

In order that we can meet the resourcing challenge of managing large numbers of intoxicated patients at weekends we use our Alternative Response Vehicle which we established 6 years ago. These vehicles can carry up to 5 patients at one time and convey intoxicated patients to Emergency Departments. This helps us to ensure front line ambulance resources can attend other emergency calls and also allows the clinicians who work on the Alternative Response Vehicle to develop expert skills and confidence in caring for what can be a challenging group of patients.

In 2010 we developed this model further and commenced the Soho Alcohol Recovery Centre pilot. This was an innovative alternative care pathway for patients with alcohol intoxication where intoxicated patients were brought to this centre where they received care until it was safe to discharge them back into the community. The pilot initially ran over the Christmas and New Year period in 2010 and 2011. Last year we agreed with our commissioners to run this service over all weekends and to evaluate this as part of our quality improvement priorities for 2012/13 with 2 specific actions for us to report against.

Action area 5**:** To undertake a comprehensive audit of the alcohol recovery service that considers the benefits to patients and the health economy

Action area 6: To make recommendations to our commissioners on the future delivery model for alcohol

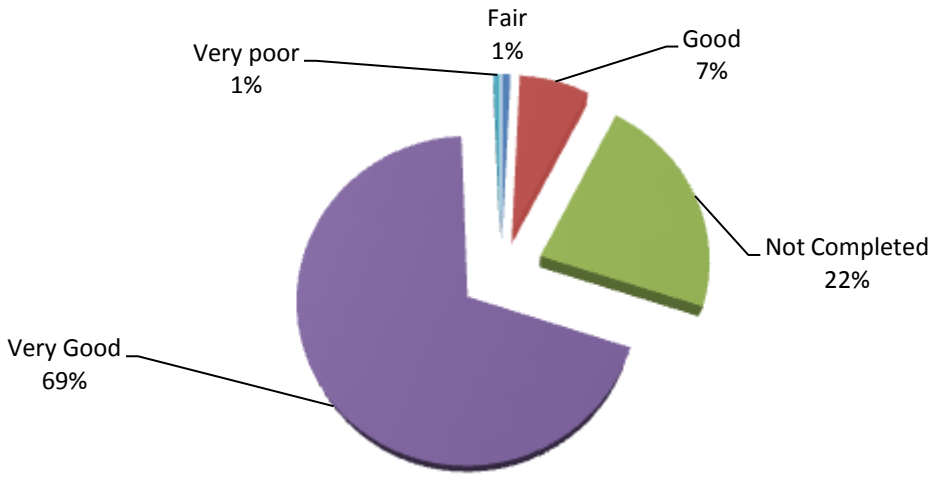
We successfully ran the project for the whole of the commissioned period and submitted a full evaluation report to our commissioners so therefore achieved both of the improvement areas identified.

During the course of the project the numbers attending the service fluctuated from less than 5 to more than 40 over a weekend period. However, the vast majority of weekends saw more than 20 patients use the service. This means that we regularly prevented more than 20 patients every weekend being taken to St Thomas' Accident and Emergency department.

We evaluated the quality of the service offered to patients by asking for an evaluation questionnaire to be completed. The results were overwhelmingly positive. 22% of patients declined to complete the questionnaire whilst 69% of patients stating their service experience was very good.

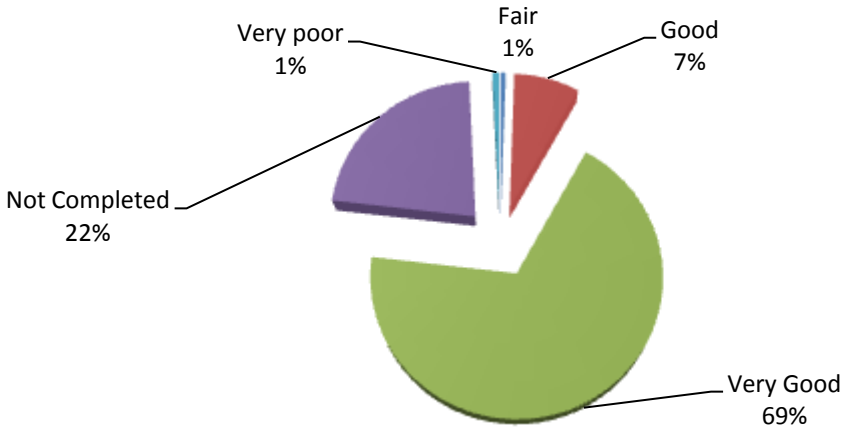
The following chart illustrates the experience rated from very good to very poor.

Respondent's Overall Satisfaction with the SARC



We also evaluated a number of other elements. Worth noting in this Quality Account is the satisfaction regarding the information provided on discharge. Once again 69% of patients said the information was very good with only 1% stating that it was poor. This is illustrated in the following chart.

Respondent's Satisfaction with Information Provided



Overall we believe the alternative management of intoxicated patients has been a success and our commissioner has agreed to extend the service into 2013/14 to give time to evaluate the cost effectiveness of the service and secure sustained commissioning for the service

Health Promotion

We agreed with our commissioners to use our work with alcohol to test new ground in health promotion. We have been undertaking health promotion in areas of emergency care for a number of years. For example, we undertake health check schemes at shopping centres and participate in gun/knife crime prevention work.

However, we do not routinely participate in the "every contact is a health promotion opportunity" concept. Whilst we support the notion that all health care professionals should maximise any contact with patients as an opportunity to share knowledge and health promotion advice we have not routinely incorporated this into practice. This quality improvement priority was our first attempt and we set two specific action points.

Action point 7: To identify three ambulance stations where we can introduce an alcohol assessment protocol nd,

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

Three complexes (Camden, Islington and Croydon) were identified as pilot sites to receive training in the use of an alcohol assessment tool called AUDIT-C and to deliver alcohol information leaflets to those screening positive. These three complexes were selected on the basis of their high level of exposure to alcohol related incidents and due to their history of activity and involvement in the subject area.

The AUDIT-C (Alcohol Use Disorders Identification Test Consumption questions) is a validated questionnaire that is designed to detect those at higher risk of hazardous or harmful drinking. Those scoring 5 or above out of a maximum possible 12 are deemed to have screened positive for higher risk drinking and therefore may benefit from further screening alcohol advice and brief interventions.

Technically the specific action points were achieved. However, the results were disappointing with a disappointing low number of patients receiving the assessment. We had predicted up to 3000 patients per quarter would be screened but we didn't see numbers go beyond 200.

The staff evaluation as part of the scheme revealed that the majority of our clinical workforce (76%) did not feel this type of assessment was appropriate to their role. This clearly needs further exploration and discussion and in the short term we have decided not to continue this piece of work until we have the opportunity to consider the

wider role of our clinicians in health promotion.

Maintaining Quality During the Olympics

In recognition that the public were concerned about the Olympic and Paralympic period we explicitly identified maintaining quality as one of our quality improvement priorities for 2012/13.

We were committed to ensuring that London received a normal service during the Games and we proposed to put into place a number of measures that would maximise our ability to deliver a normal service.

We identified three strategic objectives for the Olympic period:

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

To support the delivery of these three objectives we identified five specific action points.

Action point 9: We will deliver our action plan to manage these times. In addition, we will establish a weekly Olympic demand and capacity review meeting to review the latest position and initiate actions as required. A Group was established to provide the strategy and oversight to ensure that the Trust was prepared and able to maintain service delivery throughout the period of the Olympics and Para-Olympics. The main objective of the group was to Preserve lives and protect patient care throughout the Olympic period as well as ensure sufficient assets and management functionality is available to manage core activity in preparation for restoration of the new normality. The group provided central leadership where appropriate resolving any risks and issues, enabling the Trust to manage business as usual.

An action log was created and was in place throughout the Games period. All actions were assigned and had responsible owners and deadlines by which they needed to be discharged. This encouraged operational ownership and accountability.

Action point 10: We will implement a new model of clinical support that will provide greater flexibility and strengthen our ability to meet the additional demands of the Games.

To ensure clinical support for control room staff and our frontline crews a bespoke clinical hub was established within our main control room at Waterloo. This hub was staffed with highly skilled and experienced Paramedics who were trained in the use of an enhanced clinical assessment software tool.

These paramedics also provided additional capacity to our existing cohort of clinical telephone advisors and enabled us to conduct higher levels of hear and treat to appropriate groups of patients identified through our initial triage process as having minor injuries or illnesses that did not warrant the attendance of an ambulance. This initiative continued post Olympic Games and the expansion of our hear and treat service has now been formally funded by our commissioners.

Action point 11: We will explore the possibility of using flexible staff to support the call handling agents and will ensure the governance and quality issues are addressed.

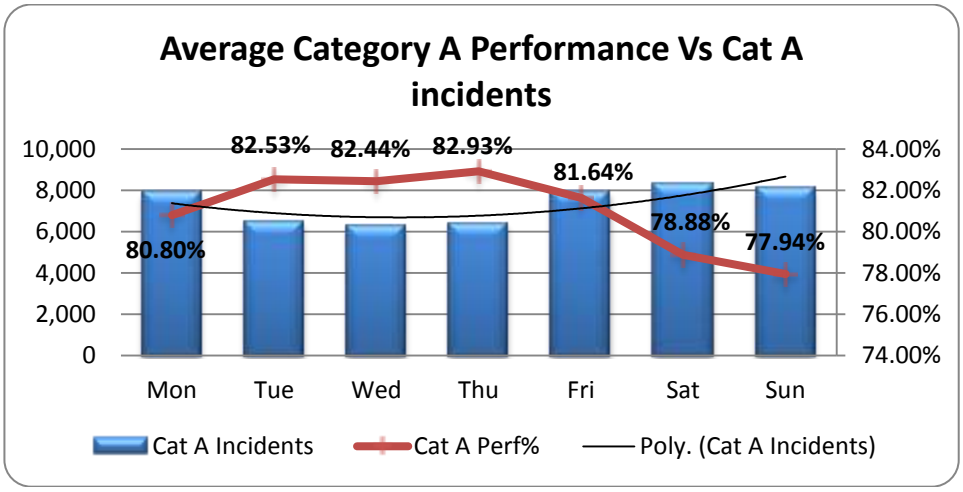
With demand on the Service expected to increase during the Games, Support services staff were asked to play their part to assist frontline colleagues during the Games. Staff, who are not expected to see an increase in their workload during the Games, were asked to volunteer for a variety of roles, freeing up more A&E operations staff to treat patients.

Action point 12: These messages will be communicated as required and need to be reinforced by robust local messages.

Key messages were communicated to staff on a daily basis, covering clinical updates and information briefings. Teleconferences were held in a supportive environment encouraging problem solving from all involved as well as sharing good practice across all areas.

Action point 13: Identify the quality indicators to monitor in real time during the period of the 2012 Games.

We maintained our performance over the Olympic Games period and provided an excellent service to the rest of London. This is illustrated in the following graph.



Treatment and Care of Diabetes

We decided to continue to focus on long-term conditions and build upon our success with our "falls" priority in the previous year. We identified diabetes as a priority area for 2012/13 and this was supported by the CQUIN reward framework which was used to support the implementation of this objective. In particular, those patients who suffered a hypoglycaemic episode and recovered, and also those patients over 40 years of age who on a random blood sugar testing have been identified as having a raised blood sugar level.

We identified one specific action point;

Action point 14: Develop a protocol and training for our clinical staff that supports patients with a reading of 8mm to be referred, when appropriate, to their GP.

We decided to develop a new protocol for appropriate advice and onward referral of patients found to have a raised blood sugar level. The aim of the project was to prevent long term complications; improving long term health care, related costs and reducing associated morbidity.

Unfortunately we did not see the number of referrals that we anticipated but the results were very positive.

- 93% of GPs found the hyperglycaemia referral pathway either quite or very helpful.
- 95.5% of patients who were indicated to have follow up blood tests received them.

In addition we developed a project for a reduced blood sugar level. The aim of the project was to develop and implement a London specific pathway for the onward referral of insulin dependent diabetic patients who have recovered post treatment from an episode of hypoglycaemia and are remaining in the community. By integrating pre-existing systems along with using GPs as a single point of access for onward referrals, a new referral pathway was developed to ensure best practice and launched in October 2012.

The pathway was successfully launched and has been received positively by all involved. The implications of operational pressures and subsequent launch delays along with an inconstant approach to staff training resulted in missed trajectory targets. However, the 2 hour welfare check had a 90% success rate and of those patients receiving a subsequent ambulance response 20% required additional medical assistance proving the robust nature of the system. Similarly of the referrals made to GP's 78% received additional follow up with 50% resulting in further intervention.

Technically we achieved the action point but as we did not achieve the referral numbers that were anticipated we failed to meet the threshold of the CQUIN.

Summary of achievements

2012/13 was a mixed year for meeting the specific quality improvement priorities. These are summarised in the following table;

	Achieved	Partially Achieved	Not Achieved
Action area 1: To make mental health training mandatory for all our clinical staff and ensure at least 60% of the relevant workforce receives the face-to-face element of training in the coming year.			✓
Action area 2: To ensure 100% of our permanent clinical advisors have an advanced understanding of mental health.		✓	
Action area 3: To undertake further engagement activities with mental health patients that gives us patient feedback on experience and satisfaction.	✓		
Action area 4**:** To role out the agreed care pathways across the whole Trust.	✓		
Action area 5: To undertake a comprehensive audit of the alcohol recovery service that considers the benefits to patients and the health economy	✓		
Action area 6**:** To make recommendations to our commissioners on the future delivery model for alcohol	✓		
Action point 7**:** To identify three ambulance stations where we can introduce an alcohol assessment protocol.	✓		
Action point 8: To identify what course of action can be taken when a patient triggers the assessment.	✓		
Action point 9: We will deliver our action plan to manage these times. In addition, we will establish a weekly Olympic demand and capacity review meeting to review the latest position and initiate actions as required.	✓		
Action point 10**:** We will implement a new model of clinical support that will provide greater flexibility and strengthen our ability to meet the additional demands of the Games.	✓		
Action point 11: We will explore the possibility of using flexible staff to support the call handling agents and will ensure the governance and quality issues are addressed.	✓		
Action point 12: These messages will be communicated as required and need to be reinforced by robust local messages	✓		
Action point 13**:** Identify the quality indicators to monitor in real time during the period of the 2012 Games	✓		
Action point 14**:** Develop a protocol and training for our clinical staff that supports patients with a reading of 8mm to be referred, when appropriate, to their GP.		✓	

Mandatory Assurance Statements

The mandatory statements as mandated by the DH

Statement Area 1: Data review
During 2012/2013 the London Ambulance Service NHS Trust provided three NHS services and has reviewed the data available to them on the quality of care in all three of these NHS services.

Statement Area 2: Income
The income generated by the NHS services reviewed in 2012-2013 represents 100 per cent of the total income generated from the provision of NHS services by the London Ambulance Service NHS Trust for 2012-2013.

Statement Area 3: Clinical audit
During 2012-2013, three national clinical audits and no national confidential enquiries covered NHS services that the London Ambulance Service NHS Trust provides. During that period, the London Ambulance Service NHS Trust participated in 100% of national clinical audits, which it was eligible to participate in.

The national clinical audits that the London Ambulance Service NHS Trust was eligible to participate in during 2012/13 are as follows:

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

The national clinical audits that the London Ambulance Service NHS Trust participated in during 2012/13 are as follows:

- Department of Health Ambulance Clinical Quality Indicators:
  - Outcome from cardiac arrest –ROSC
  - Outcome from cardiac arrest – Survival to discharge
  - Outcome from acute STEMI
  - Outcome from stroke
- National CPI programme:
  - Hypoglycaemia
  - Asthma
  - Lower leg fracture
  - Febrile convulsion
- NANA

The national clinical audits that the London Ambulance Service NHS Trust participated in, and for which data collection was completed during 2012/13 are listed below alongside the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of that audit.

National Clinical Audit	Number of cases eligible for inclusion	Number of cases submitted	Percentage of cases submitted
DH ACQI: Outcome from cardiac arrest – ROSC a) Overall group b) Utstein comparator group	a) 2790 b) 368	a) 2790 b) 368	100%
DH ACQI: Outcome from cardiac arrest – Survival to discharge a) Overall group b) Utstein comparator group	a) 2725 b) 344	a) 2725 b) 344	100%
DH ACQI: Outcome from acute STEMI a) Thrombolysis delivered within 60 minutes of call b) Primary percutaneous coronary intervention (PPCI) delivered within 150 minutes of call. c) Care bundle delivered (includes provision of GTN, aspirin, two pain assessments and analgesia)	a) 1 b) 929 c) 1745	a) 1 b) 929 c) 1745	100%
DH ACQI: Outcome from stroke a) Face Arm Speech Test (FAST) positive stroke patients potentially eligible for thrombolysis, who arrive at a hyper acute stroke centre within 60 minutes of call. b) Care bundle delivered (includes assessment of FAST, blood pressure and blood glucose)	a) 3888 b) 6637	a) 3888 b) 6637	100%
National CPI: Hypoglycaemia a) Blood glucose before treatment b) Blood glucose after treatment c) Treatment for hypoglycaemia recorded (oral carbohydrates, glucagons, IV glucose) d) Direct referral made to an appropriate health professional e) Care bundle	600	600	100%
National CPI: Asthma a) Respiratory rate recorded b) PEFR recorded (before treatment) c) SpO_2 recorded (before treatment) d) Beta-2 agonist recorded e) Oxygen administered f) Care bundle	900	900	100%
National CPI: Lower leg fracture a) Two pain scores recorded b) Analgesia administered c) SpO_2 recorded (before treatment) d) Oxygen administered e) Immobilisation of limb recorded f) Assessment of circulation distal to fracture recorded g) Care bundle	58	58	100%
National CPI: Febrile convulsion a) Blood glucose recorded (before treatment) b) Temperature recorded (before treatment) c) SpO_2 recorded (before treatment) d) Oxygen administered e) Anti convulsant administered f) Temperature management g) Appropriate discharge pathway recorded h) Care bundle	145	145	100%
NANA: a snapshot audit of ambulance non-conveyance practice for 999 calls attended on the 24th October 2012 for a 24 hour period; including re-attendance within the subsequent 24 hour period a) Patient demographics b) Highest level of clinician at scene c) Patient Assessment d) Intervention e) Reason for non-conveyance f) Safety netting	23	23	100%

In addition, the London Ambulance Service NHS Trust undertakes a programme of local Clinical Performance Indicators that monitors the care provide to seven patient groups (see box below) and quality assures the documentation on 2.5% of all clinical records completed. We also undertake four continuous audits that monitor the care provided to every patient who suffers a cardiac arrest, STEMI or stroke, or who have been involved in a major trauma incident.

Information: Clinical Performance Indicators (CPIs) are designed to bring continual improvement to the clinical care provided by the London Ambulance Service NHS Trust. They focus on clinical areas where there is strong evidence of the care that leads to the best outcome for patients, or where there is a clinical risk associated with the patient group. The areas of care included are: acute coronary syndrome, cardiac arrest, difficulty in breathing, glycaemic emergency, stroke, mental health, patients that are treated and left at scene (non-conveyed) and general documentation. The delivery of care to these patients groups is routinely fed back to staff on a one-on-one basis by clinical supervisors so that staff are able to discuss how they can improve their performance. This process has led to clear documented improvements in care since its introduction.

The report of two national clinical audits were reviewed by the provider in 2012/13 and the London Ambulance Service NHS Trust intends to take the following actions to improve the quality of healthcare provided:

- Raise awareness of the STEMI care bundle by developing an acute coronary syndrome aide memoire to highlight all elements of the care bundle as well as ECG interpretation and the correct pathways for this group of patients
- Raise awareness of the stroke care bundle by creating a multimedia training package in collaboration with other NHS Trusts
- Increase the number of referral routes for diabetic patients in London by introducing direct referrals and follow up care
- Increase the proportion of patients presenting with asthma who have their oxygen saturation level measured before treatment by introducing portable oxygen saturation monitors with both adult and paediatric probes
- Increase the number of patients with asthma who have their peak flow rate measured before treatment by asking staff for their ideas for improvement and implementing these actions as appropriate

The reports of ten local clinical audits were reviewed by the provider in 2012-2013 and the London Ambulance Service NHS Trust intends to take the following actions to improve the quality of healthcare provided:

Mental Health Care

- Ensure staff are familiar with the definition of the terms ‘neglect’ and ‘vulnerable adult’ by providing training to staff.
- Clarify the indications for, and the use of, the capacity tool by reviewing the core skills refresher training.
- Identify whether a patient’s condition has previously been diagnosed by amending the patient report form to prompt staff to document the name of the patient’s GP or other current health care professional such as a psychiatric nurse.
- Introduce a risk assessment tool that can be used by staff attending patients who present with a mental health disorder.
- Monitor and improve the care given to patients with a mental health disorder by introducing a new CPI and providing feedback to staff.

Paediatric pain re-audit

- Make it easier for staff to administer larger doses of paracetamol to older children by revising the presentation of liquid suspension paracetamol.
- Incorporate paediatric pain management into pain training sessions to educate staff in the appropriate techniques for children experiencing pain and the correct doses of analgesia.
- Review the paediatric immobilisation training to ensure staff are educated in the immobilisation options available.

Assessment of paediatrics patients with pyrexia

- Assess whether leaving patients at home when their medical history indicates conveyance presents a serious risk to the patient by reviewing identified cases and feeding back to staff if necessary.

- Remind staff of the current guidelines and protocols for assessing and treating paediatric patients with pyrexia by issuing a poster to all ambulance stations and writing an article for the London Ambulance Service Clinical Update.
- Ensure training on paediatric care delivered to staff includes the importance of making a direct GP referral when paediatric patients are not conveyed, and taking two sets of observations 20 minutes apart.

Paediatric respiratory assessment

- Advocate the necessity of infant respiratory assessment by incorporating paediatric respiratory assessments into the core skills refresher training and the CPIs.
- Determine whether there is a shortage of oxygen saturation probes in specific areas of London and investigate if documentation regarding shortages is provided elsewhere by reviewing further records.
- Review the scale of the equipment concerns on the risk register.

Sudden Unexpected Death in Infants, Children and Adolescents

- Display posters on all ambulance stations to remind staff of the importance of documenting the receiving clinicians name for children who have died unexpectedly.
- Increase use of the 'Child at risk/in need report form (LA279)' by renaming it to reflect its additional use as a notification of contact form and designing a safeguarding memory aide that explains when an LA279 should be completed.
- Evaluate the LA279 referral process by conducting a trial to receive this information via the telephone.
- Determine whether it is possible to store LA279s electronically to ensure information is easily accessible and that storage complies with the LAS Records Management and Information Lifecycle Policy.
- Improve joint compliance to the 'Working Together to Safeguard Children' guidelines by communicating the results of this clinical audit with London Safeguarding Children Boards.

Alcohol intoxication

- Publish an article in the Clinical Update and produce posters for every ambulance station that remind staff of the importance of eliciting a full and accurate history for this patient group.

Alternative care pathway (ACP) use

- Publish an article in the Clinical Update and produce posters for every ambulance station that encourage staff to consider conveying a patient to an ACP if it will not prolong journey time greatly, even if the ACP is further away than the nearest Emergency Department.

Immediate inter-hospital transfers

- Ensure all necessary information is sourced during the initial call by working with other UK ambulance services to review the suitability of Medical Priority Dispatch System Protocol 35 for inter-hospital transfer calls and communicating to Emergency Medical Dispatchers the importance of following protocols.
- Ensure the Clinical Support Desk (CSD) record all advice given and escalate calls appropriately to on-call advisor when necessary by implementing quality assurance process to monitor the CSD log.
- Remind hospital staff of the criteria for inter-hospital transfers and their responsibility to provide an appropriate escort for the patient by reviewing and reissuing the inter-hospital transfers flow chart.

Transient loss of consciousness

- Educate staff in the pathology of T-LOC and encourage them to convey patients to hospital, or refer them directly to their GP, by reviewing current training packages, running a T-LOC study day and producing a prompt card.
- Assist staff to recognise the ECG findings specific to T-LOC by validating a mnemonic with the important ECG abnormalities.
- Prompt staff to explain 'other abnormality' and family history by adding another box to the patient report form.

Obstetrics emergencies

- Review current training packages and deliver a series of maternity update teaching sessions to remind staff of the importance of documenting all relevant information on the patient report form.
- Inform staff that any new skills learnt should not interfere with LAS taught skills by writing a Clinical Update article to remind staff of their training obligations.

- Develop an aide memoire to remind staff of the procedure for managing obstetric/obstetric emergency patients.
- Demonstrate the frequency of midwife non-attendance by sharing the clinical audit findings with the London Heads of Midwifery and Local Supervising Authority Midwifery Officer.

Statement Area 4: Research

The number of patients receiving NHS services provided or sub-contracted by the London Ambulance Service NHS Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 284.

Participation in clinical research demonstrates the London Ambulance Service NHS Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff keep up to date with the latest possible treatment options and active participation in research leads to improved patient outcomes.

The London Ambulance Service NHS Trust was involved in conducting three clinical research studies in pre-hospital care during 2012/13 There were 417 clinical staff participating in research approved by a research ethics committee at the London Ambulance Service NHS Trust during 2012/13. These staff participated in research covering two medical specialties. These were:

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

It is important to note that as well as recruiting patients we also conducted research involving staff and student paramedics as participants. These recruitment numbers have not been included in the 284 figure above, which only includes patient numbers. The total number of LAS staff and student paramedics participating in research as participants in 2012/13 was 581.

The number of participants and the number of staff involved in conducting all types of studies in the LAS during 2012/13 are displayed in the following table

.

Study name 2012/13	Participants recruited	LAS clinical staff involved
NHS REC approved studies involving patients		
Care of older people who fall: evaluation of the clinical and cost effectiveness of new protocols for emergency ambulance paramedics to assess and refer to the appropriate community based care (SAFER2)	284	87
High Risk Acute Coronary Syndrome (ACS) (*formerly known as 'DANCE'*)	100	250
Safety and Efficacy of Paramedic treatment of regular Supraventricular Tachycardia (ParaSVT)	32	80
Studies involving LAS staff and student paramedics as participants (not requiring NHS REC review)*		
Identifying emergency personnel at risk of post traumatic stress disorder (PTSD)	390 (in follow-up)	-
Professionalism and conscientiousness of trainee health professionals	94	-
The use of Section 136 of the UK mental health act in SW London	4	1
A Critical Discourse Analysis of Paramedics' talk about their administration of analgesia to patients who are cognitively impaired	12	1
Are psychological and emotional welfare measures in the UK proportional to the levels of stress experienced by responders after a disaster?	1	-
Identification of emergency and urgent care system characteristics affecting preventable unplanned admission rates	2	-
An Exploration of the Practice Placement Experience of Higher Education Student Paramedics within UK ambulance services	37	1
Occupational Stress in the Ambulance Service: a Cross-Cultural Investigation of Psychological wellbeing	11	-
The student experience of university paramedic education/training – from classroom learning to situational understanding	13	-
A case study of the English Ambulance Services	16	1

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

It is important to note that in addition to the above mentioned research projects, the LAS also undertakes a number of descriptive, feasibility and evaluation projects to provide evidence of the best ways to treat patients and to achieve the best possible outcomes.

In the last three years, twelve publications have resulted from our involvement in research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS. The publications have been published in journals including, in 2011: *'Complexity of the decision-making process of ambulance staff for assessment and referral of older patients who have fallen: a qualitative study'* published in the Emergency Medicine Journal, and in 2012: *'Predicting non-cardiac aetiology: a strategy to allocate rescue breathing during bystander CPR'* published in Resuscitation, and '*Support and Assessment for Fall Emergency Referrals (SAFER2) research protocol: cluster randomised trial of the clinical and cost effectiveness of new protocols for emergency ambulance paramedics to assess and refer to appropriate community based care'* published in the British Medical Journal. Our engagement with clinical research also demonstrates the London Ambulance Service NHS Trust's commitment to testing and offering the latest medical treatments and techniques.

Other activities which demonstrate our commitment to research as a driver for improving the quality of care and the patient experience include our Journal Clubs and Advice Surgeries. During 2012/13, we held three Journal Clubs for ambulance clinicians through which they appraised published papers that discussed renal colic, pre-eclampsia, paediatric pain management, paediatric respiratory assessment, pre-hospital triage of trauma, specialist response to out-of-hospital cardiac arrest, and acute respiratory failure. Through our monthly Advice Surgeries we provide guidance to staff interested in undertaking research and help them to develop new research protocols. In addition, journal contents pages are circulated to all staff on a monthly basis to enable them to keep up to date with published literature and emerging research evidence, and findings from our research studies are disseminated to them via the quarterly Clinical Update Bulletin.

We have an extensive collaboration portfolio for the forthcoming 2013/14 period, which includes the following studies:

- High Risk ACS (*formerly known as 'DANCE'*): Pilot RCT comparing direct angioplasty for non-ST-elevation acute coronary events vs. conventional management.
- Safety and Efficacy of Paramedic treatment of regular Supraventricular Tachycardia (ParaSVT): RCT comparing the safety and efficacy of paramedic treatment of regular supraventricular tachycardia using pre-hospital administration of adenosine vs. conventional management.
- Care of older people who fall: evaluation of the clinical and cost effectiveness of new protocols for emergency ambulance paramedics to assess and refer to the appropriate community based care (SAFER 2): Cluster RCT comparing the clinical and cost effectiveness of new protocols for ambulance workers to assess and refer elderly fallers to appropriate community based care vs. conventional practice.
- Identifying emergency personnel at risk of post traumatic stress disorder (PTSD): Longitudinal study investigating risk factors of post-traumatic stress disorder in student paramedics.
- Assessment of call handling speed and equity of calls from non-English speaking callers to a large metropolitan Ambulance Service: An investigation into whether call handling speed and allocated response differs between English and non-English speaking callers.
- rAAA: Modelling retrospective data for patients with a ruptured aortic abdominal or thoracic aortic aneurysm (rAAA) and control cases (other emergencies) to develop a pre-hospital triage tool to aid identification of rAAA
- Stroke mimics: An investigation of the incidence and diagnoses of stroke mimics, and differences in responses of strokes and mimics to the ROSIER assessment tool
- IMPROVE: Investigation of whether endovascular repair compared with open surgical repair reduces the mortality from ruptured abdominal aortic aneurysm
- Exercise-related sudden cardiac arrest in London: A retrospective analysis of cases where cardiac arrest occurred during or after exercise to investigate incidence of, and factors related to survival from, exercise-related cardiac arrest
- Direct conveyance of cardiac arrest STEMI patients to HACs: A retrospective analysis of survival in cardiac arrest patients with ST-elevation conveyed to a Heart Attack Centre (HAC)
- Direct conveyance of non-STEMI cardiac arrest patients to HACs: A retrospective analysis of survival in cardiac arrest patients without ST-elevation conveyed to a Heart Attack Centre (HAC)
- Risk of sudden cardiac death in epilepsy: A retrospective analysis of data from patients in cardiac arrest with a history of epilepsy to identify whether patients with epilepsy are at higher risk of cardiac arrest.
- Ethnicity and survival from cardiac arrest: A retrospective analysis investigating the relationship between ethnicity and survival from cardiac arrest
- Out-of-Hospital Cardiac Arrest Outcomes project: Development of a national cardiac arrest registry and use of statistical modelling to understand variability in outcomes and contributory factors to survival
- An Explorative Assessment of London's 999 Frequent Callers and the Effectiveness of Interventional Strategies Employed by the London Ambulance Service's Patient Centred Action team: A retrospective analysis aiming to i) profile this group of patients, ii) examine the impact of the LAS Patient Centred Action Team's interventional strategies on frequent caller behaviour

In addition to the above, we have developed a number of research protocols for which we are awaiting external funding decisions.

Ambulance Quality Indicators Care Bundle

The percentage of patients with a pre-hospital clinical impression of ST elevation myocardial infarction (STEMI) and suspected stroke who received an appropriate care bundle

The London Ambulance Service NHS Trust submitted the following information regarding the provision of an appropriate care bundle to STEMI and stroke patients to NHS England for the reporting period 2012-13 and 2011-12:

	2012-13 *		2011-12	
	LAS average	**National average** (Range)	**LAS average**	**National average** (Range)
STEMI patients	67.5	74.1 (67.5 - 93)	61.7	77.6 (59.6 - 93.2)
Stroke patients	94.2	94.2 (90.4 - 100)	91.3	95.6 (85.9 - 98.9)

- *At the point of preparation of this Quality Account, NHS England reported data for April to November 2012.*

The London Ambulance Service NHS Trust considers that the data in the table above is as described for the following reasons: this data is captured by the LAS from clinical records completed by ambulance staff attending patients as part of ongoing clinical quality monitoring in line with the technical guidance for the Ambulance Quality Indicators and reported directly to NHS England.

The London Ambulance Service NHS Trust has taken the following actions to improve the percentage of patients with a pre-hospital clinical impression of ST elevation myocardial infarction (STEMI) and suspected stroke who received an appropriate care bundle, and so the quality of its services, by:

- Improving clinical education provided to staff through materials such as clinical podcasts and other multimedia packages, training updates with associated aide memoires, bulletins and newsletters
- Ensuring that staff have the necessary equipment to perform patient assessments
- Reviewed pain management practices to enhance the analgesia component of the STEMI care bundle and introduced clear guidelines for step-wise pain management using a pain assessment tool to assess the severity of the patient's pain and treat with pain relief as appropriate.

Statement Area 5: CQUINS

A proportion of the London Ambulance Service NHS Trust's income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between London Ambulance Service NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the commissioning for Quality and Innovation payment framework.

The details of the agreed goals for 2012/13 are as follows:

1. ED Conveyance & Appropriate care pathways (ACPs):
i. Increased see and treat/refer rates (no convey) (maximum £373,427, achieved £15,559)
ii. Increased use of ACPs (conveyance to destinations alternative to emergency departments (maximum £311,189, achieved £49,790)
iii. Reduction in Emergency Department conveyance rate (maximum £373,427, achieved £156,839)
2. Hear and Treat resolution (no convey) via clinical telephone advice:
i. (maximum £497,402, achieved £295,264)
3. Improved management of long term conditions – diabetes:
i. Patients having hypoglycaemic episodes (maximum £248,951, achieved £99,580)
ii. Patients with undiagnosed diabetes with raised blood glucose levels (maximum £248,951, achieved ££99,5800
4. Improved management of patients with alcohol related needs/health promotion
i. Alcohol recovery centres (maximum £560,140, achieved £535,245)
ii. Alcohol health promotion (maximum £ 373,427, achieved £186,713)
5. Data sharing and improvement in data capture:
i. NHS number collection – 5 sites piloting different methods (maximum £497,902, achieved £497,902)
ii. Patient level data shared with LAS commissioning team (£497,902, achieved £497,902)

iii. Frequent caller data – sharing cluster based data (£248,951, achieved £128, 210)
6. 4 patient experience based activities:
i. A focus on calls receiving a long response and those involving bariatric patients (maximum £186,713, achieved £111,010)
ii. Use of the emergency & urgent care toolkit as an audit system in the Clinical Hub (maximum £186,713, achieved £186,713)
iii. Feedback from non-conveyed patients (maximum £186,713, achieved £186,713)
iv. Compliance against core skills refresher training (maximum £186,713, achieved £18,671)
7. Workforce changes:
i. Implementation of new rest break policy (maximum £497,902, achieved £0)
ii. Complete a roster review (maximum £497,902, achieved £497,902)
iii. Implement a new annual leave process/policy (maximum £248,951, achieved £248,951)

The details of the agreed goals for 2013/14 are as follows:

Workforce Changes
1. Workforce skill mix: Delivery of training to support 2-tier working
Detail: This is measured by the percentage of A&E support staff that have commenced the conversion course to enable front-line working (excluding those who may not be eligible through sickness, maternity or other issues, as well as recognising there may be some staff who may not be capable of achieving the required standards).
£1,740,331

2. Roster development across all areas/teams: Development of new roster patterns for all appropriate complexes and teams
Detail: Achievement will be measured against the development of a full set of new rosters that are in line with ORH modelling results. Note that this is not about implementation of these rosters. £2,370,886

Efficiencies
1. Enhanced clinical triage process implemented: Recruitment of additional staff within the Clinical Hub to the new role which is targeted to deliver hear and treat
Detail: The achievement measure is completion of the recruitment process to fill the Clinical Hub positions.
£781,888

2. New response model implemented: Full implementation of CommandPoint changes to dispatch protocols to support the changes to a 2-tier working
Detail: This has a simple measure of achievement – whether it is implemented or not within the agreed timescale. £807,110

Staff Engagement
1. Engagement exercise and communications strategy delivered: Completion of a series of staff engagement events including delivery of a comprehensive information pack to staff
Detail: This is recognised as an ongoing process which will involve regular checkpoint reports to the steering group.
£605,333

Statement Area 6: Care Quality Commission
The London Ambulance Service NHS Trust is required to register with the Care Quality Commission and its current registration status is “registered”. The London Ambulance Service NHS Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against The London Ambulance Service NHS Trust during 2012/13.

The London Ambulance Service NHS Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2012/13.

Statement Area 7 Data Quality
The London Ambulance Service NHS Trust will be taking the following actions to improve data quality:

At the time of writing the Quality Account the Trust was in discussion with the internal auditors as to what aspects would feature within the audit programme. Data Quality will feature in at least one audit project.

Statement Area 8 NHS Number and General Medical Practice Code Validity
The London Ambulance Service NHS Trust was not required to submit records during 2012/13 to the Secondary Uses service for inclusion in the Hospital Episode Statistics

which are included in the latest published data.

The London Ambulance Service NHS Trust was not required to submit records during 2012/13 using patients' valid General Medical Practice Code

Statement area 9 Information Governance Toolkit Attainment Levels

The London Ambulance Service NHS Trust Information Governance Assessment Report score overall score for 2012/13 was 82% and was graded at level 2.

Statement area 10 Payment by results

The London Ambulance Service NHS Trust was not subject to the Payment by Results clinical coding audit during 2012/13 by the Audit Commission

Ambulance Quality Indicators

A review of the 2012/13 Quality Indicators

2012/13 was the second year of the national ambulance quality indicators. These are a set of measures that allow individual Ambulance Trusts to look where they lie in comparison with other NHS ambulance providers.

It is not always possible to draw direct comparisons as services differ slightly across the country but it allows Ambulance Trusts to use the information analytically.

The following graphs illustrate the London Ambulance Service NHS Trust year end position in all 12 quality measures. However, not all the measures include a whole year of data as some of the measures required extensive data quality checking therefore the data for those includes data from April to December 2012.

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

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

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

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

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

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

		Numerator	Incidents	%
East Midlands Ambulance Service	93.8	732	780	93.8
East of England Ambulance Service	91.9	682	742	91.9
Great Western Ambulance Service	89.9	328	365	89.9
Isle of Wight	57.1	8	14	57.1
London Ambulance Service	91.7	959	1,046	91.7
North East Ambulance Service	90.2	788	874	90.2
North West Ambulance Service	87.1	990	1,137	87.1
South Central Ambulance Service	89.9	596	663	89.9
South East Coast Ambulance Service	88.0	508	577	88.0
South Western Ambulance Service	82.4	490	595	82.4
West Midlands Ambulance Service	84.0	673	801	84.0
Yorkshire Ambulance Service	82.5	898	1,089	82.5
Overall for period	**Higher is better**	7,652	**8,683**	**88.1**

Our compliance was 91.9% last year and this year we are at 91.7% suggesting a stable performance with this quality indicator.

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

		Numerator	Incidents	%
East Midlands Ambulance Service	75.3	782	1,038	75.3
East of England Ambulance Service	83.2	1,023	1,229	83.2
Great Western Ambulance Service	94.1	332	353	94.1
Isle of Wight	88.2	30	34	88.2
London Ambulance Service	67.3	1,349	2,004	67.3
North East Ambulance Service	84.7	553	653	84.7
North West Ambulance Service	83.1	1,529	1,840	83.1
South Central Ambulance Service	68.5	686	1,001	68.5
South East Coast Ambulance Service	77.4	656	847	77.4
South Western Ambulance Service	82.9	1,126	1,358	82.9
West Midlands Ambulance Service	72.4	639	883	72.4
Yorkshire Ambulance Service	78.8	928	1,178	78.8
Overall for period	**Higher is better**	9,633	**12,418**	**77.6**

Our compliance is 67.3% and last year our compliance was 59.5% suggesting we have made improvements in this quality indicator.

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

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

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

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

		Numerator	Incidents	%
East Midlands Ambulance Service	17.5	398	2,270	17.5
East of England Ambulance Service	21.7	512	2,358	21.7
Great Western Ambulance Service	26.4	257	973	26.4
Isle of Wight	23.6	17	72	23.6
London Ambulance Service	30.9	1,008	3,264	30.9
North East Ambulance Service	24.6	310	1,261	24.6
North West Ambulance Service	26.7	772	2,886	26.7
South Central Ambulance Service	35.8	314	876	35.8
South East Coast Ambulance Service	25.1	475	1,891	25.1
South Western Ambulance Service	25.0	429	1,713	25.0
West Midlands Ambulance Service	27.6	474	1,718	27.6
Yorkshire Ambulance Service	21.4	485	2,270	21.4
Overall for period	**Higher is better**	5,451	**21,552**	**25.3**

Residents and visitors to London appear to continue to have a good outcome with 30.9% of all cardiac arrests having a pulse, or heartbeat, on arrival at hospital. Last year our compliance was 29.4% suggesting a stable performance.

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

		Numerator	Incidents	%
East Midlands Ambulance Service	40.2	158	393	40.2
East of England Ambulance Service	52.6	173	329	52.6
Great Western Ambulance Service	55.3	78	141	55.3
Isle of Wight	37.5	3	8	37.5
London Ambulance Service	54.9	225	410	54.9
North East Ambulance Service	49.4	88	178	49.4
North West Ambulance Service	45.3	175	386	45.3
South Central Ambulance Service	49.5	49	99	49.5
South East Coast Ambulance Service	45.9	119	259	45.9
South Western Ambulance Service	40.1	103	257	40.1
West Midlands Ambulance Service	40.6	88	217	40.6
Yorkshire Ambulance Service	46.0	159	346	46.0
Overall for period	**Higher is better**	1,418	**3,023**	**46.9**

London has the highest number of witnessed arrests and again the table shows a good outcome with 54.9% of witnessed cardiac arrests having a pulse or heartbeat on arrival at hospital. Last year our compliance was 53.7% suggesting a stable performance.

Measure 3. Outcome from cardiac arrest - survival to discharge

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

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

		Numerator	Incidents	%
East Midlands Ambulance Service	7.8	172	2,192	7.8
East of England Ambulance Service	6.0	137	2,295	6.0
Great Western Ambulance Service	10.8	105	973	10.8
Isle of Wight	4.2	3	72	4.2
London Ambulance Service	8.0	256	3,189	8.0
North East Ambulance Service	6.1	75	1,221	6.1
North West Ambulance Service	7.5	176	2,350	7.5
South Central Ambulance Service	15.0	119	794	15.0
South East Coast Ambulance Service	6.1	110	1,809	6.1
South Western Ambulance Service	8.8	150	1,699	8.8
West Midlands Ambulance Service	7.0	121	1,718	7.0
Yorkshire Ambulance Service	8.0	178	2,238	8.0
Overall for period	**Higher is better**	1,602	**20,550**	**7.8**

This shows that 8.0% of all patients who had a cardiac arrest in the London region survived to be discharged from hospital. Last year our compliance was 9.5% suggesting a slight drop in performance across London but the numbers are not large enough to draw any clinical conclusions.

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

		Numerator	Incidents	%
East Midlands Ambulance Service	11.6	42	361	11.6
East of England Ambulance Service	24.3	73	300	24.3
Great Western Ambulance Service	31.9	45	141	31.9
Isle of Wight	42.9	3	7	42.9
London Ambulance Service	27.3	104	381	27.3
North East Ambulance Service	25.1	42	167	25.1
North West Ambulance Service	19.9	57	286	19.9
South Central Ambulance Service	20.7	19	92	20.7
South East Coast Ambulance Service	16.7	39	233	16.7
South Western Ambulance Service	22.4	57	255	22.4
West Midlands Ambulance Service	13.7	28	204	13.7
Yorkshire Ambulance Service	28.1	94	335	28.1
Overall for period	**Higher is better**	603	**2,762**	**21.8**

This graph really demonstrates the benefits to outcome when a cardiac arrest is witnessed as this shows that 27.3% of all patients who had a cardiac arrest witnessed in the London region survived to be discharged from hospital and is regarded as a better indicator than the previous element (element 1 graph 6). Last year the compliance was 30.3% suggesting a slight drop in performance across London but the numbers are not large enough to draw any clinical conclusions.

Measure 4. Outcome following stroke for ambulance patients

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

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

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

		Numerator	Incidents	%
East Midlands Ambulance Service	48.2	443	919	48.2
East of England Ambulance Service	47.6	1,008	2,119	47.6
Great Western Ambulance Service	61.9	447	722	61.9
Isle of Wight	68.1	62	91	68.1
London Ambulance Service	67.8	3,002	4,425	67.8
North East Ambulance Service	78.5	1,210	1,541	78.5
North West Ambulance Service	79.9	2,420	3,028	79.9
South Central Ambulance Service	49.0	702	1,432	49.0
South East Coast Ambulance Service	61.6	2,276	3,693	61.6
South Western Ambulance Service	53.9	1,110	2,061	53.9
West Midlands Ambulance Service	64.2	1,132	1,763	64.2
Yorkshire Ambulance Service	64.8	2,177	3,359	64.8
Overall for period	**Higher is better**	15,989	**25,153**	**63.6**

Our compliance this year is 68.1% and last year our compliance was 65.1% suggesting a small improvement. However the actual number of patients conveyed within 60 minutes last year was 2,590 and this year the number of patients conveyed within 60 minutes was 3,002. We can not draw any clinical conclusions from the increase.

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

		Numerator	Incidents	%
East Midlands Ambulance Service	96.0	7,268	7,574	96.0
East of England Ambulance Service	95.7	5,311	5,552	95.7
Great Western Ambulance Service	100.0	1,215	1,215	100.0
Isle of Wight	93.7	388	414	93.7
London Ambulance Service	94.1	7,131	7,581	94.1
North East Ambulance Service	97.2	2,998	3,083	97.2
North West Ambulance Service	99.0	8,205	8,285	99.0
South Central Ambulance Service	97.0	4,705	4,852	97.0
South East Coast Ambulance Service	90.7	4,915	5,416	90.7
South Western Ambulance Service	95.5	5,207	5,450	95.5
West Midlands Ambulance Service	94.6	5,702	6,027	94.6
Yorkshire Ambulance Service	94.6	6,071	6,418	94.6
Overall for period	**Higher is better**	59,116	**61,867**	**95.6**

Our compliance this year is 94.1% and last year our compliance was 90.0% suggesting a slight improvement.

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

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

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

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

		Numerator	Calls	%
East Midlands Ambulance Service	7.0	43,083	612,765	7.0
East of England Ambulance Service	6.7	46,091	690,612	6.7
Great Western Ambulance Service	7.2	13,705	189,037	7.2
Isle of Wight	8.2	1,731	21,050	8.2
London Ambulance Service	5.9	68,479	1,156,289	5.9
North East Ambulance Service	4.0	13,292	329,795	4.0
North West Ambulance Service	3.5	29,905	862,887	3.5
South Central Ambulance Service	4.9	19,414	396,342	4.9
South East Coast Ambulance Service	9.7	55,709	574,218	9.7
South Western Ambulance Service	6.4	26,576	413,211	6.4
West Midlands Ambulance Service	6.6	50,876	775,045	6.6
Yorkshire Ambulance Service	4.9	30,030	609,607	4.9
Overall for period	**Higher is better**	398,891	**6,630,858**	**6.0**

Our compliance is 5.9%. Last year our compliance was 6.4% suggesting we conveyed a greater proportion of patients to accident and emergency this year.

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

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

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

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

		Numerator	Incidents	%
East Midlands Ambulance Service	3.	1,481	43,083	3.4
East of England Ambulance Service	15.4	7,080	46,091	15.4
Great Western Ambulance Service	10.9	1,489	13,705	10.9
Isle of Wight	2	45	1,731	2.6
London Ambulance Service	2	2,002	68,479	2.9
North East Ambulance Service	15.8	2,101	13,292	15.8
North West Ambulance Service	31.2	9,316	29,905	31.2
South Central Ambulance Service	18.7	3,623	19,414	18.7
South East Coast Ambulance Service	13.0	7,243	55,709	13.0
South Western Ambulance Service	15.6	4,137	26,576	15.6
West Midlands Ambulance Service	14.8	7,532	50,876	14.8
Yorkshire Ambulance Service	19.7	5,906	30,030	19.7
Overall for period	**Lower is better**	51,955	**398,891**	**13.0**

The compliance this year is 2.9% and last year our compliance was 5.2% suggesting an improved position and sustaining our position of the second lowest re-contact rate following telephone advice.

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

	Numerator	Incidents	%
East Midlands Ambulance Service	11,449	180,424	6.3
East of England Ambulance Service	20,249	262,465	7.7
Great Western Ambulance Service	2,919	73,429	4.0
Isle of Wight	143	5,968	2.4
London Ambulance Service	13,444	249,071	5.4
North East Ambulance Service	3,597	72,106	5.0
North West Ambulance Service	10,827	168,212	6.4
South Central Ambulance Service	11,376	161,717	7.0
South East Coast Ambulance Service	9,001	189,797	4.7
South Western Ambulance Service	11,608	175,415	6.6
West Midlands Ambulance Service	13,454	256,511	5.2
Yorkshire Ambulance Service	10,872	127,619	8.5
Overall for period **Lower is better**	118,939	**1,922,734**	**6.2**

Our compliance this year is 5.4% and last year our compliance was 4.3% suggesting a small increase.

Measure 7. Call abandonment rate

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

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

	Numerator	Calls	%
East Midlands Ambulance Service	6,059	685,921	0.9
East of England Ambulance Service	6,071	938,821	0.6
Great Western Ambulance Service	1,888	307,881	0.6
Isle of Wight	367	23,484	1.6
London Ambulance Service	1,805	1,588,181	0.1
North East Ambulance Service	11,044	504,420	2.2
North West Ambulance Service	31,269	1,085,945	2.9
South Central Ambulance Service	9,871	448,143	2.2
South East Coast Ambulance Service	20,367	622,060	3.3
South Western Ambulance Service	6,732	577,698	1.2
West Midlands Ambulance Service	9,032	955,998	0.9
Yorkshire Ambulance Service	18,971	806,347	2.4
Overall for period **Lower is better**	123,476	**8,544,899**	**1.4**

Our compliance is 0.1% the same as last year. This is the lowest rate across the country.

Time to answer calls

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

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

There is no comparison graph available for this measure as the results are not statistically significant. However, our performance is monitored at three intervals; 1) 50th percentile where we achieve a rate of 0.0 seconds 2) 95th percentile where we achieve a rate of 0.07 seconds and 3) the 99th percentile where we achieve a rate of 0.51 seconds.

Measure 8. Service experience

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

There is no mandatory element and each individual Trust is able to decide how they meet the expectations of this measure. The London Ambulance Service NHS Trust now produce a quarterly Service Experience report that brings together all the elements of patient experience and patient feedback.

Measure 9. Category A 8 minute response time

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

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

		Numerator	Incidents	%
East Midlands Ambulance Service	76.4	28,286	37,026	76.4
East of England Ambulance Service	75.0	28,580	38,131	75.0
Great Western Ambulance	76.8	13,898	18,108	76.8
Isle of Wight	77.3	952	1,231	77.3
London Ambulance Service	72.3	76,999	106,431	72.3
North East Ambulance	75.9	19,255	25,367	75.9
North West Ambulance Service	76.8	48,701	63,434	76.8
South Central Ambulance Service	74.7	12,848	17,190	74.7
South East Coast Ambulance Service	77.9	35,807	45,938	77.9
South Western Ambulance Service	75.8	18,642	24,578	75.8
West Midlands Ambulance Service	75.9	42,132	55,526	75.9
Yorkshire Ambulance Service	77.3	33,877	43,804	77.3
Overall for period	**Higher is better**	359,977	**476,764**	**75.5**

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

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

		Numerator	Incidents	%
East Midlands Ambulance Service	91.9	215,045	234,120	91.9
East of England Ambulance Service	93.5	224,981	240,553	93.5
Great Western Ambulance	95.7	88,459	92,436	95.7
Isle of Wight	97.4	7,194	7,385	97.4
London Ambulance Service	98.2	426,863	434,815	98.2
North East Ambulance	97.0	153,956	158,743	97.0
North West Ambulance Service	95.1	366,781	385,645	95.1
South Central Ambulance Service	95.0	107,561	113,222	95.0
South East Coast Ambulance Service	97.3	258,582	265,693	97.3
South Western Ambulance Service	95.4	163,511	171,465	95.4
West Midlands Ambulance Service	97.3	334,002	343,269	97.3
Yorkshire Ambulance Service	97.0	257,058	265,071	97.0
Overall for period	**Higher is better**	2,603,993	**2,712,417**	**96.0**

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

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

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

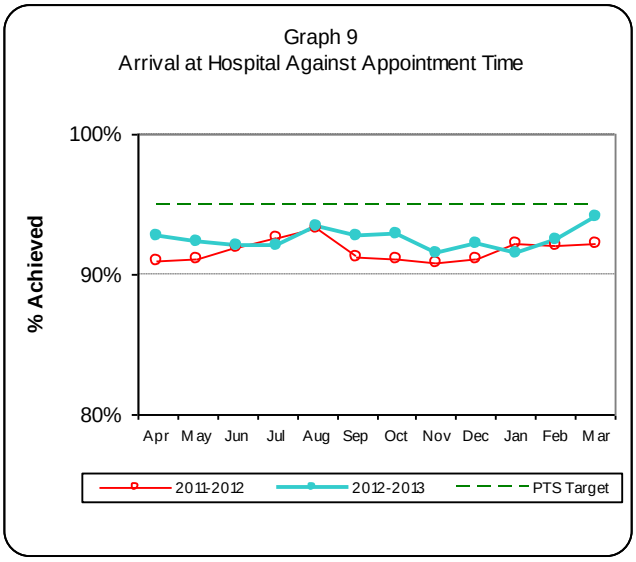
No Graph Time to treatment by an ambulance-dispatched health professional (Year end position)

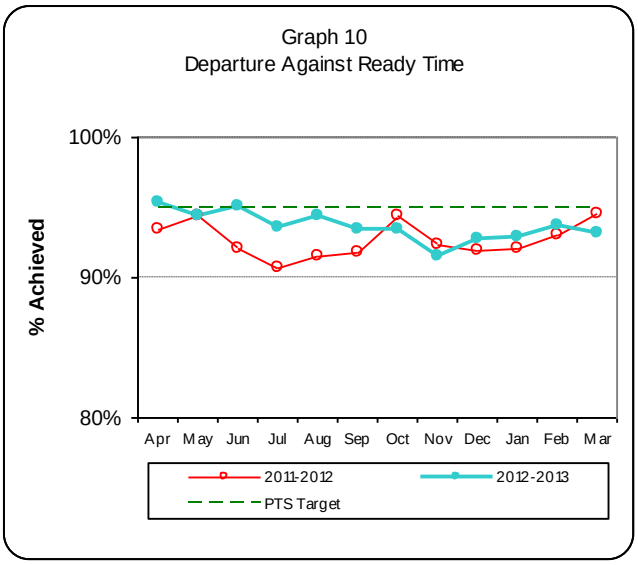
There is no comparison graph available for this measure as the results are not statistically significant. However, our performance is monitored at three intervals; 1) 50th percentile where we achieve a rate of 5.49 minutes 2) 95th percentile where we achieve a rate of 14.10 minutes and 3) the 99th percentile where we achieve a rate of 22.23 minutes. These figures are consistent with other ambulance services.

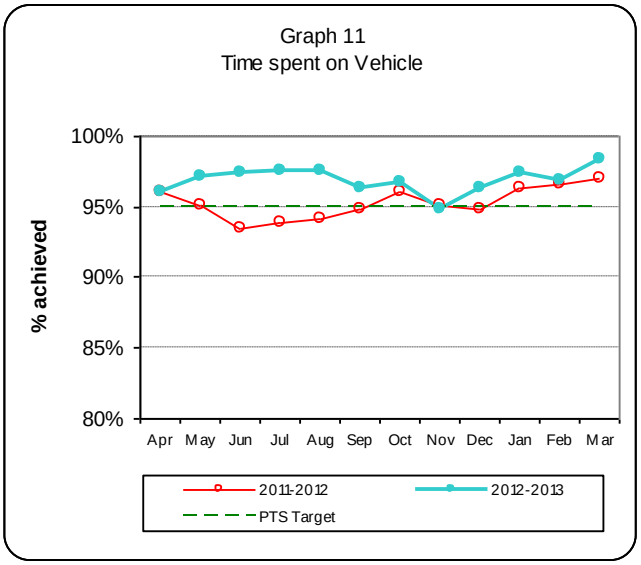
Patient Transport Services

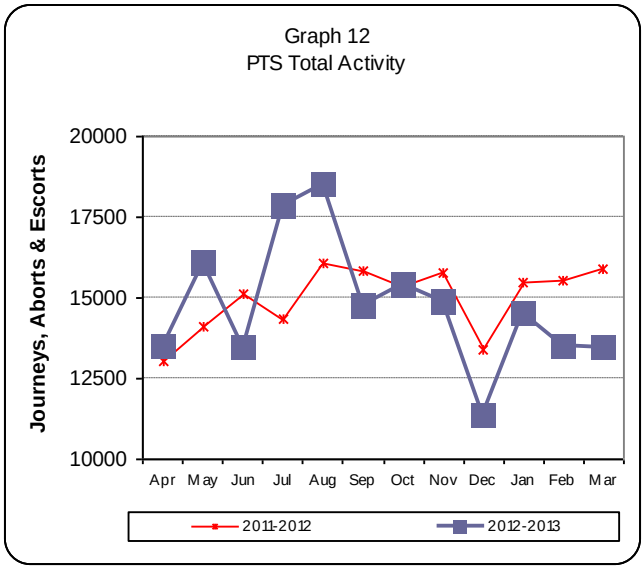
We are commissioned by a number of London NHS trusts and PCTs to provide non-emergency patient transport for patients attending hospital or clinic appointments carried out by, or on behalf of, the contracting trust/PCT. Each contract is specific to the requirements of the individual organisation and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

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









2013/14 Quality Priorities

Our improvement priorities for the coming year

With a rise in over 100,000 calls in 2012/13 and with 47,000 of these being category A calls we have found it increasingly difficult to meet the expectations of our lower priority. Our resources are always directed towards the higher priority patients which means at times of high category A demand, such as late evening, these patients wait an unacceptable length of time.

We have agreed with our commissioners that we need to focus our improvement work on our less urgent patients in 2013/14. However, the programme of work required to make the necessary improvements is so complex that we have agreed that these improvements should span a number of years.

Fundamentally we need to improve the way that we use our resources. At peak times we simply do not have enough staff who are available and consequently patients have to wait until our clinical staff have finished with the previous patient. This means some patients can wait for a long time.

Our commissioners have invested in the service this year and this investment will allow us to increase the number of staff that we employ. However, this is not the whole story. Over time we have become increasingly inefficient and our current operating model is not allowing us to use our resources in the most effective way.

Therefore we have proposed a number of changes that will lead to a modernisation of the service.

Service Modernisation

At the time of writing the quality account our proposals are with our staff for consultation and it would be inappropriate to outline each individual project here as an agreed improvement priority as the detail may change.

However, each of the individual proposals will help us support a workforce that is more skilled and is less constrained by current practices and the operating model. If successful our vision for 2015 includes the following;

- Each patient who rings 999 will have a response within 1 hour. Either by telephone assessment or by a clinician attending to them directly.
- Our working rosters will enable us to match ambulance availability with 999 call demand.
- We will have established close working relationships with clinical commissioning groups to identify gaps in service and improve access to appropriate healthcare options.
- Patients will experience a seamless referral to appropriate providers, for example, NHS 111, crisis and falls teams.
- Every patient who requires a face to face assessment will be attended within an hour by a paramedic with enhanced assessment skills who has the right training and experienced clinical support.

- On scene senior clinical support will be provided to staff where needed.
- Staff will benefit from an embedded clinical career structure, education and regular meaningful feedback and appraisals.
- We will be less reliant on private and voluntary ambulance services as we will have recruited more staff.

The implementation of the modernisation programme is one of our four main priorities for 2013/14.

Priorities for 2013/14

We have identified four priority areas for 2013/14.

- The implementation of the modernisation agenda.
- To improve communication and engagement
- Sustain performance to ensure a safe service to patients
- Build a sustainable financial position for 2014/15 and beyond

We will work with the Trust Board to identify what specific projects and measures need to be identified to ensure success in each area.

Improving the care of less urgent patients

Our modernisation programme is focussed on making the changes necessary to improve services for our lower category patients. However we have agreed to focus our broader quality work on this group of patients and our Quality Committee has tasked the Learning from Experience Committee to try and make four specific improvements.

Attitude and Behaviour

We employ excellent staff and we are proud of the job that we do. Occasionally we receive complaints where the patient, or carer, has found the need to cite attitude or behaviour as a reason for having a poor experience of our service.

In 2012/13 we received 288 complaints regarding attitude and behaviour.

On examination of the complaints these are almost exclusively from our lower category calls and are most likely to occur when our staff challenge the reason for calling an ambulance. We will look at this issue further during 2013/14 with the intention of lowering the number of complaints on this issue.

Improving the Experience of Patients subjected to a Delay

Our modernisation programme will allow us to eventually improve the delay. However, we want to explore if we can improve the experience of patients who have a delay. Last year we had 441 complaints regarding a delay.

Waiting for a clinician to arrive having made a 999 call is stressful. Whilst we may not have categorised certain calls as a high priority we recognise for those at the scene they require assistance quickly.

Some patients tell us that they would like to receive information about how long they may have to wait so that they can make a choice. This is extremely difficult for us to do but we will look at ways to see if we can improve the experience of patients who are subject to a delay.

Improving the Experience of Patients Referred to Alternative Care Pathways

There is a perception that a 999 call will automatically result in conveyance to accident & emergency. This is no longer the case and with our staff becoming more advanced in their clinical skills we are able to resolve a number of calls without the need to convey a patient to accident & emergency. For some patients we are able to offer an alternative such as an urgent care centre or local district services.

This is not always what is expected and can lead to dissatisfaction. We need to build upon our 2012/13 satisfaction survey of patients who have not been conveyed to hospital and ensure we implement the service experience improvements identified from that work.

Equipment

The nature of our mobile service means we can accidentally leave equipment at the roadside or in patient's home which means it may not be available for the next patient. This does not affect our bulky life saving equipment but smaller items such as blood testing kits or equipment used in patient assessment.

This issue was identified in our 2012 Care Quality Commission inspection and we agreed to look for methods that would reduce the incidence of lost equipment.

If we can make significant improvements in this area we will improve the assessment we are able to offer our patients, improve our staff's satisfaction in their ability to do a good job and improve the pressure on our finances.

Stakeholder Comments

The feedback we have received on this Quality Account

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 4TH JUNE 2013

PAPER FOR INFORMATION

Document Title:	**Report from the Chief Executive**
Report Author(s):	**Ann Radmore**
Lead Director:	**N/A**
Contact Details:	**gill.cristiani@lond-amb.nhs.uk**
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 - 2 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

4th June 2013

REPORT FROM THE CHIEF EXECUTIVE

1. The Care Bill (HL) 2013-14

1.1 A Bill has been introduced into parliament to reform the law relating to care and support for adults and the law relating to support for carers, to make provision about safeguarding adults from abuse or neglect, to make provision about care standards, to establish and make provision about Health Education England, to establish and make provision about the Health Research Authority, and for connected purposes.

1.2 The first reading of the Bill took place on 9th May and the second reading is scheduled for 21st May when there will be a general debate on all aspects of the Bill.

1.3 Part 2 of the Bill concerns care standards and covers Trust Special Administration; licence conditions for foundation trusts; governance and duties for the Care Quality Commission.

1.4 Part 3 Chapter 1 proposes the establishment, role and responsibilities of Health Education England; the establishment of Local Education and Training Boards (LETB).

2. Update on the Listening into Action (LiA) Programme

2.1 Since the last Board meeting on 26 March, five 'big conversation' events with staff have taken place. Approximately 250 staff attended these events, with a good mix of operational, control and corporate service staff. At each event, the staff worked in table groups and were posed three questions relating to; barriers preventing them from doing their job properly, aspirations of what change would make the biggest impact, and from this, what clear tangible actions could be undertaken to make the changes needed. Feedback from the events was very positive, and in particular many individuals commented on how they really enjoyed having an opportunity to meet staff from a range of other departments within the LAS.

2.2 The LiA team are now collating the comments and feedback from the events and identifying which 'actions' may be suitable for quick wins or one of the ten team projects which the Trust would wish to take forward. In the next few weeks, the Sponsor Group[1], will be reviewing the proposals put forward by the LiA team and will agree which quick wins and projects should be taken forward into the next phase which is about working through to completion the ideas and projects.

2.3 A briefing on the work to be undertaken in the next phase will be provided at the Board meeting on June 25th.

[1] Chaired by Chief Executive and consisting of staff drawn from all levels and departments of the Trust

3. Delivering High Quality Care for Patients: the Accountability Framework for NHS Trust Boards

3.1 The NHS Trust Development Authority (NTDA) published the accountability framework for NHS Trust Boards in April 2013.

3.2 The framework sets out a clear set of rules within which NHS Trusts are expected to operate and describes how the NTDA will work with Trusts on every aspect of the business. This includes how the Board will be held to account, the type of support that can be expected from the NTDA, and the achievement of Foundation Trust status.

3.3 The framework describes the models for oversight, development and support, and approvals. Monthly monitoring is a key component of the oversight model and commenced from May 2013 (April submission) through a series of Board declarations and compliance statements. These are covered in a separate agenda item on the Board agenda.

3.4 Further details of the framework can be found at:
http://www.ntda.nhs.uk/wp-content/uploads/2012/04/framework_050413_web.pdf .

4. External conference

4.1 Ambulance Leadership Forum
The 2013 Ambulance Leadership Forum Conference (21 to 22 May) was attended by the Chairman and several members of the Executive and Senior Management Teams. This was a good opportunity to share learning and build relationship with colleagues from other ambulance services both UK based and overseas.

5. Visits to Dubai and India

5.1 During May two members of the Trust's business development team visited India as part of a UK Trade and Investment (UKTI) and Healthcare UK healthcare delegation focusing on primary healthcare. This followed a previous visit in January and the Prime Ministers recent visit highlighting the UK and Indian health care development partnership. LAS was the only ambulance service to be represented in the delegation that also included other NHS provider organisations (acute trusts) and private sector providers. It should be noted that 80% of all health spending in India takes place in the private sector with less than half of the country has a state provided ambulance service. The delegation met with state and private sector providers in two Indian states.

5.2 In Maharashtra (Mumbai) meetings took place with a number of private sector hospitals. Here the LAS team made initial contact with key personnel responsible for the provision of hospital specific ambulance services. Discussions around quality assurance, disaster preparedness, paramedic training and clinical development took place. Follow up contact has been made with a view to developing relationships and opportunities for LAS commercial consultancy effort in the future.

5.3 The second leg of the trade mission took the delegation to Tamil Nadu (Chennai) where further meetings took place that were facilitated by UKTI and the British Deputy High Commission. In addition the LAS team also took part in a facilitated introductory session with over 30 health providers who had specifically requested to meet representatives from LAS. Of note two key contacts were made with KPMG India and Tata Consultancy Services where follow up conversations have begun with a view to partnership in health consultancy. It is envisaged that LAS could provide EMS sector specific consultancy support to wider health consultancy projects undertaken by each or similar organisations.

5.4 Following the formal healthcare mission LAS travelled to Trivandrum (Kerala) where meetings took place with our in country partner. Wording for a revised MOU, building on the previous one, has been agreed with Zigitza Healthcare (ZHL) that provides greater opportunity for LAS to benefit from commercial opportunities with our in country partner. Meetings were held with the National Rural Health Mission (NRHM) and Kerala Medical Services Corporation (KMSC) with a view to developing partnerships to deliver disaster preparedness training and EMS quality improvement. Follow up discussions have commenced with NRHM and KMSC.

5.5 The final leg of the delegation (whilst routing back to London) took LAS to Dubai and Ajman in United Arab Emirates (UAE). In Dubai LAS met with representatives from Dubai Corporation of Ambulance Services (DCAS) who whilst currently being the providers of event, PTS and emergency ambulance cover are looking to outsource the provision of services and become a regulator for such. Our Indian partner, ZHL are in the final stages of a commercial arrangement for the provision of event and PTS services and have requested our support in the provision of quality assurance for these services. Meetings also took place with the DCAS training lead with specific interest in the provision of MIMMS courses and the development of links with higher education institutes for Paramedic development. In Ajman, LAS met with Police chiefs who currently provide ambulance services (this is the case in all UAE emirates save for Dubai). Consideration is being given to outsourcing the provision of ambulance services in Ajman and LAS consultancy opportunities were tabled. Follow up discussions continue in regards these opportunities.

6. Participation in Exercises

6.1 Members of the Service have recently taken part in 2 training exercises. The first of these was conducted in partnership with colleagues from the other London based emergency services in late April. The second took place in Staffordshire in early May and was a joint exercise with England's nine other ambulance services, several police forces, fire and rescue services, air ambulances, the military and voluntary groups.

7. Information Governance Update

7.1 This is an update on Information Governance, an area that remains a priority focus for the Trust, and the work of the Information Governance Group (IGG) that meets on a monthly basis to oversee and manage all IG issues. Looking back over the year 12/13 the LAS received 206 FoI requests, an average of 17 a month. This compares with 190 received during 2011-12, an increase of 8.5%. Subjects have been wide-ranging, from hospital handover delays and use of private ambulance services to enquiries about the vehicle fleet, supply contracts, and staffing. There have been 11 Information incidents but none has been declared a serious incident nor needed to be declared to the Information Commissioner. These have included the loss of encrypted laptops and Patient Report Forms, inappropriate access to network folders and use of email, and non-adherence to correct procedures.

7.2 With an increased emphasis on the need to increase the level of information sharing between organisations in the health and social care sector, whilst at the same time ensuring that effective governance controls are in place, the LAS have introduced a Sharing Agreement document. This was ratified by the IGG in February 2013. This use of this document will assist in monitoring who the LAS share data with, what they use it for, and how it is stored and eventually destroyed.

7.3 A new project has been formed to introduce an Electronic Document Records Management System in the Trust. This is necessary in order to meet legislative requirements on disclosure and Freedom of Information, and Information Governance

Toolkit requirements for the management and control of our unstructured data. Such a system will enable the Trust to find, manage and store its information more effectively and create efficiency improvements and savings. We are still in the early stages of the project but the business case has been written and is currently under further development.

7.4 Finally, there is good news on the Information Governance toolkit (IGT), the national benchmark for IG assurance. The Performance Update for V.10 of the Toolkit was submitted at the end of October and an audit was carried out on the evidence provided by the internal auditors in December 2012. The Trust submission on 28th March 2013 achieved a score of 82%, that has since been checked and validated by our auditors. This is a significant achievement for the Trust.

Ann Radmore
Chief Executive

May 2013

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 4 JUNE 2013

PAPER FOR INFORMATION

Document Title:	**Update on Modernisation Programme**
Report Author(s):	**Jane Chalmers, Director of Modernisation**
Lead Director:	**Ann Radmore, Chief Executive**
Contact Details:	**jane.chalmers@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Routine Update**
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 Note**

Key issues and risks arising from this paper

Nil

Executive Summary

This paper covers the activities which have taken place in relation to the Modernisation Programme since the last Trust Board meeting on 26 March 2013.

Attachments

Update on Modernisation Programme

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Quality Strategy

This paper supports the following domains of the quality strategy

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

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:

Trust Board Update – Modernisation Programme

This update covers the activities which have taken place in relation to the Modernisation Programme since the last Trust Board meeting on 26 March 2013.

Launch of the Programme

On 24 April, following a meeting of the Trust Board it was agreed that the Modernisation Programme would be 'launched' as planned on 25 April. Also on 24 April, in preparation for the formal launch on 25 April, a series of briefings for managers and Trade Union colleagues were held.

The Programme was formally launched on 25 April, with staff being notified electronically at 1000 and press releases and notes to stakeholders being sent out from 1100 onwards on that day. Staff were also sent copies of the booklet 'Our plans to improve the care we provide to patients' with their payslips and a dedicated page was set up on the internal website

Consultation

A consultation period with staff commenced immediately and ran until 24 May. As part of this consultation process, 5 roadshows were held across London to brief staff on the proposals and answer any questions they may have had and receive their feedback on the proposals. These roadshows were attended by approximately 370 staff. Additionally, a dedicated @modernisation inbox was set up to receive staff feedback and they were also able to feedback via a comments sheet at the back of the booklet they received.

A frequently asked questions (FAQs) document was developed for the launch and has been updated regularly based on the questions raised in the responses from staff during the consultation. The updated FAQs are being shared with staff via the weekly Routine information Bulletin and are also available on the internal website. This document will continue to be updated throughout the life of programme

During the consultation period a meeting took place between senior management and Trade Union representatives to discuss the proposals.

Next Steps

Responses received during the consultation period are now being collated and reviewed. A response to consultation will be published in the next 2 weeks.

The Programme now moves to the implementation and delivery phase and detailed planning and activities have now commenced for each of the projects. The programme structure and governance is being revised and updated to ensure that it is 'fit for purpose' for the next phase. Details of this will be provided at the Board meeting to be held on 25 June.

Further meetings with Trade Union colleagues are already planned for June and are being planned to take place on a regular basis throughout the implementation and delivery phase

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London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 4TH JUNE 2013

PAPER FOR APPROVAL

Document Title:	**Board declarations – self certification, compliance and board statements**
Report Author(s):	**Sandra Adams**
Lead Director:	**Richard Hunt/Ann Radmore**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Briefing the Trust Board on the new accountability framework and self certification requirements for submission to the NHS Trust Development Authority**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Executive Management Team ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☒ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	To approve a) Retrospectively, the first self certification and board statements submitted on 16th May 2013 b) The process for reviewing and approving future monthly declarations

Key issues and risks arising from this paper

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

Executive Summary

The NHS Trust Development Authority (NTDA) published 'Delivering High Quality Care for Patients: the Accountability Framework for NHS Trust Boards' in April 2013 and a brief headline note was sent to Board members on 16th May. The oversight model from the NTDA includes the monthly submission of a series of Board declarations, the first of these being sent out in template form on 9th May for submission by 17th May. The first drafts of these declarations were reviewed and approved subject to agreed changes, by the Finance and Investment Committee on behalf of the Trust Board, on 14th May.

Two monthly self certification documents are attached:

1. Compliance Monitor

The Compliance Monitor document refers to the conditions within the new provider licence which comes into effect from 1st April 2014 but against which we are being monitored now. The Board will receive a separate briefing on this in future months however the link to the conditions is here: http://www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-8 and Board members could review in particular

section 4 and the annex for more information about the conditions.

In terms of compliance, we declared compliance against all conditions with the exception of:

G4 – fit and proper persons as governors and directors: condition G4.3 will require amendment to executive director contracts;
C2 – competition oversight: the Trust Board has yet to discuss and consider competition regulation in the new NHS environment and this will be added to the board development or strategy sessions being planned for 2013/14.

2. Board Statements

This declaration is a series of statements against clinical quality, finance and governance. The description of each statement is included in the document and further detail can be found in the Accountability Framework.

We declared compliance against all with the exception of:

Clinical quality 2: CQC compliance: we identified this as a risk as the Trust is in the process of implementing the action plans to address the minor and moderate non-compliance issues addressed by the CQC in December 2012. A meeting is planned with the CQC for 11th June to discuss progress.

The Board is asked to retrospectively approve these submissions.

Following discussion at the Finance and Investment Committee it was suggested that a proposal was brought to the Trust Board on the process for reviewing and signing off the monthly submissions. Submissions are made to the NTDA on or around the 17th of each month for the previous month. The April 2013 submission was required by 17th May.

The proposal is as follows:

- Where there is a Board meeting then the statements for that current month will be reviewed by the Board for sign off and submission two weeks later. For example, the June 2013 statements will be reviewed at the 25th June Board meeting.
- Where there is not a Board meeting in the month, authority for review and sign off will be delegated to the relevant Board committee. The Board is asked to consider whether the Executive Management Team is the appropriate committee for this.
- The Board should note that it is unlikely that the compliance position against any of the statements will change from one month to the next. The proposal is that an exception report is sent out to Trust Board during the month where there is a risk of, or actual, non-compliance against a licence condition or a Board statement.
- The Board undertakes a half-year review of compliance against all conditions and statements and this will be scheduled into the forward planner.

The Trust Board is asked to approve this process.

Attachments

Monthly self-certification requirements – Compliance Monitor
Monthly self-certification requirements – Board statements

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Quality Strategy

This paper supports the following domains of the quality strategy

All domains are supported

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

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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NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Compliance Monitor

Monthly Data.

CONTACT INFORMATION:

Enter Your Name: Sandra Adams

Enter Your Email Address: sandra.adams@lond-amb.nhs.uk

Full Telephone Number: 02077832045 Tel Extension:

SELF-CERTIFICATION DETAILS:

Select Your Trust: London Ambulance Service NHS Trust

Submission Date: 16/05/2013 Reporting Year: 2013/14

Select the Month

- (•) April
- ( ) May
- ( ) June
- ( ) July
- ( ) August
- ( ) September
- ( ) October
- ( ) November
- ( ) December
- ( ) January
- ( ) February
- ( ) March

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

1. **Condition G4** – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions).
2. **Condition G5** – Having regard to monitor Guidance.
3. **Condition G7** – Registration with the Care Quality Commission.
4. **Condition G8** – Patient eligibility and selection criteria.

5. **Condition P1** – Recording of information.
6. **Condition P2** – Provision of information.
7. **Condition P3** – Assurance report on submissions to Monitor.
8. **Condition P4** – Compliance with the National Tariff.
9. **Condition P5** – Constructive engagement concerning local tariff modifications.

10. **Condition C1** – The right of patients to make choices.
11. **Condition C2** – Competition oversight.

12. **Condition IC1** – Provision of integrated care.

Further guidance can be found in Monitor's response to the statutory consultation on the new NHS provider licence: The new NHS Provider Licence

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

		Comment where non-compliant or at risk of non-compliance
1. Condition G4 Fit and proper persons as Governors and Directors.	No	Condition G4.3 will require amendment to Executive director contracts/job descriptions
		Timescale for compliance: 30/09/2013
2. Condition G5 Having regard to monitor Guidance.	Yes	
		Timescale for compliance:
3. Condition G7 Registration with the Care Quality Commission.	Yes	
		Timescale for compliance:
		Comment where non-compliant or at risk of non-compliance
4. Condition G8 Patient eligibility and selection criteria.	Yes	
		Timescale for compliance:

		Comment where non-compliant or at risk of non-compliance
5. Condition P1 Recording of information.	Yes	
		Timescale for compliance:
6. Condition P2 Provision of information.	Yes	
		Timescale for compliance:
7. Condition P3 Assurance report on submissions to Monitor.	Yes	
		Timescale for compliance:
8. Condition P4 Compliance with the National Tariff.	Yes	When published and applicable to ambulance services
		Timescale for compliance:

		Comment where non-compliant or at risk of non-compliance
9. Condition P5 Constructive engagement concerning local tariff modifications.	Yes	
		Timescale for compliance:

		Comment where non-compliant or at risk of non-compliance
10. Condition C1 The right of patients to make choices.	Yes	
		Timescale for compliance:
11. Condition C2 Competition oversight.	No	The Trust Board has yet to consider this condition
		Timescale for compliance: 31/10/2013
12. Condition IC1 Provision of integrated care.	Yes	
		Timescale for compliance:

Submit

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Board Statements

Monthly Data.

CONTACT INFORMATION:

Enter Your Name: Sandra Adams

Enter Your Email Address: sandra.adams@lond-amb.nhs.uk

Full Telephone Number: 02077832045 Tel Extension:

SELF-CERTIFICATION DETAILS:

Select Your Trust: London Ambulance Service NHS Trust

Submission Date: 16/05/2013 Reporting Year: 2013/14

Select the Month

- (•) April
- ( ) May
- ( ) June
- ( ) July
- ( ) August
- ( ) September
- ( ) October
- ( ) November
- ( ) December
- ( ) January
- ( ) February
- ( ) March

BOARD STATEMENTS:

CLINICAL QUALITY
FINANCE
GOVERNANCE

The NHS TDA's role is to ensure, on behalf of the Secretary of State, that aspirant FTs are ready to proceed for assessment by Monitor. As such, the processes outlined here replace those previously undertaken by both SHAs and the Department of Health.

In line with the recommendations of the Mid Staffordshire Public Inquiry, the achievement of FT status will only be possible for NHS Trusts that are delivering the key fundamentals of clinical quality, good patient experience, and national and local standards and targets, within the available financial envelope.

BOARD STATEMENTS:

For CLINICAL QUALITY, that

1. The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

1. CLINICAL QUALITY Indicate compliance.	Yes
Timescale for compliance:	
RESPONSE:	
Comment where non-compliant or at risk of non-compliance	

BOARD STATEMENTS:

For CLINICAL QUALITY, that

2. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

2. CLINICAL QUALITY Indicate compliance.	Risk
Timescale for compliance:	30/09/2013
RESPONSE: Comment where non-compliant or at risk of non-compliance	The Trust is implementing its action plans addressing the moderate and minor non-compliance issues raised by the CQC in December 2012. There are no restrictions or notices placed upon the Trust.

BOARD STATEMENTS:

For CLINICAL QUALITY, that

3. The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.

3. CLINICAL QUALITY Indicate compliance.	Yes
Timescale for compliance:	
RESPONSE: Comment where non-compliant or at risk of non-compliance	

BOARD STATEMENTS:

For FINANCE, that

4. The board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.

4. FINANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

5. The board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.

5. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

6. All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.

6. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

7. The board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.

7. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

8. The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.

8. GOVERNANCE Indicate compliance.	Yes
Timescale for compliance:	
RESPONSE: Comment where non-compliant or at risk of non-compliance	

BOARD STATEMENTS:

For GOVERNANCE, that

9. An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).

9. GOVERNANCE Indicate compliance.	Yes
Timescale for compliance:	
RESPONSE: Comment where non-compliant or at risk of non-compliance	

BOARD STATEMENTS:

For GOVERNANCE, that

10. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.

10. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

11. The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.

11. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

12. The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.

12. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

13. The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.

13. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

14. The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.

14. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

Submit

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London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 4TH JUNE 2013

PAPER FOR INFORMATION

Document Title:	**Internal Audit and Local Counter Fraud Specialist**
Report Author(s):	**Sandra Adams, Director of Corporate Services**
Lead Director:	**Sandra Adams, Director of Corporate Services**
Contact Details:	**sandra.adams@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 ☐ Finance and Investment Committee ☐ Other:
Recommendation for the Trust Board:	**To note that KPMG has been awarded the contracts for Internal Audit and Local Counter Fraud services**

Key issues and risks arising from this paper

High quality, value for money internal audit and local counter fraud services are essential for testing, monitoring and ensuring the effectiveness of the Trust's internal controls and risk management processes.

Executive Summary

The London Ambulance Service's Internal Audit and Local Counter Fraud contract with RSM Tenon expired on 1st April 2013. A procurement exercise was run to ensure there is adequate cover for the new financial year.

The Trust applied a framework agreement that set out terms and conditions under which individual contracts could be awarded and a mini competition was then undertaken detailing the specific requirements of the Trust, against which the suppliers' bids were evaluated. The mini competition was issued to all suppliers on the framework in two Lots. Lot 1: Internal Audit. Lot 2: Counter Fraud. The two Lots were awarded independently. Bids were evaluated on the Most Economically Advantageous Tender (MEAT) basis.

Internal Audit

There were seven suppliers under the Framework Agreement and all were invited, of which six suppliers responded.

Although KPMG's bid was not the lowest value, the quality of their written submission provided the evaluation panel with full confidence in their ability to successfully implement the contract, as per the specification. Their combined Technical and Commercial scores ranked them first in terms of the MEAT evaluation. In particular, the panel were impressed with the way in which risk would be identified and incorporated into the Internal Audit reports. Also, the skills and qualifications of the

specific staff who will be running the LAS contract inspired full confidence in panel. KPMG scored maximum marks in this section and set themselves apart in comparison with the second and third placed providers.

Local Counter Fraud

There were seven suppliers under the Framework Agreement and all were invited, of which six suppliers responded.

Although KPMG's bid was not the lowest in price, the quality of their written submission provided the evaluation panel with full confidence in their ability to successfully implement the contract, as per the specification. Their combined Technical and Commercial scores ranked them first in terms of the MEAT evaluation criteria. In particular, the panel were impressed with the methods that KPMG planned to use to re-launch the Counter Fraud service, and the way in which this would be publicised throughout the Service. KPMG's knowledge of the risks facing the London Ambulance Service was very thorough. The handover plan that was detailed during the presentations provided great assurance to the panel. Their intended use of Staff Forums for feedback also ensured the company scored highly.

The recommendation to award KPMG the contracts for Internal Audit and Local Counter Fraud Services was agreed by the Chair of the Audit Committee and the Executive Management Team. The Trust Board is asked to note this update.

Attachments
None.

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

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

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

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 4TH JUNE 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 19th March 2013 and to be assured of compliance with Standing Orders and Standing Financial Instructions**

Key issues and risks arising from this paper

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

Executive Summary

Three tenders have been received, opened and entered into the tender book since 19th March 2013:

- Provision of Waste Services (General and Clinical Waste):
  Tenders received and opened on 21st May 2013

  Lot 1 General Waste:
  Biffa
  Bywaters
  DS Smith Recycling
  Grundon
  SITA
  Veolia
  Viridor

  Lot 2 Clinical Waste:
  Grundon
  GW Butler
  Medisort
  PHS

SITA
SRCL
Tradebe

There has been one new entry to the Register for the Use of the Trust Seal since 31st January 2013 for the lease dated 14th December 2011 made between Brixton Ltd and London Ambulance Service in respect of Unit 14 Deptford Trading Estate, London SE8.

Attachments

None.

****

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

25th June 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** **Serious Incident Update** **Quality Committee Assurance Report** **BAF and Corporate Risk Register – Quarter 1 documents** **Audit Committee Assurance Report** **Reports from Executive Directors (COO, DoF, DoHR)**	Report from Chief Executive Officer	Report from Trust Secretary Trust Board Forward Planner	Audit Committee - 3rd June Quality Committee – 19th June	Steve Lennox Richard Hunt – meeting to be chaired by Roy Griffins. Meeting to close at 13.00

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** **Serious Incident Update** **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** **Francis Report Progress Update**	Report from Chief Executive Officer Outcome reports on public consultation to receive and approve	Report from Finance and Investment Committee Annual Equality Report 2012/13 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** **Serious Incident Update** **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** **Serious Incident Update** **Quality Committee Assurance Report** **Audit Committee Assurance Report** **Reports from Executive Directors (COO, DoF, DoHR)** **Update on Safeguarding (Alan Tayler and Lysa Walder to attend)**	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** **Serious Incident Update** **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	

MEETINGS CALENDAR FOR 2014

Committee	Chair	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Timings
Trust Board	Trust Chair	**28**		**25**			**3 & 24**	**22**		**23**		**25**	**16**	9.00 - 14.00 (followed by a board development session 14.00 - 16.00)
Strategy Review and Planning	Trust Chair		**25**		**29**					**2**	**28**			9.00 - 14.00 (followed by a board development session 14.00 - 16.00)
Annual General Meeting	Trust Chair									**23**				14.00 - 15.30
Annual C/Funds Committee	Caroline Silver (NED)													
Remuneration Committee	Trust Chair						**3**							14.00 - 15.00
Audit Committee	Caroline Silver (NED)			**x**		**x**	**x**			**x**		**x**		TBC
Finance and Investment Committee	Trust Chair	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	TBC
Quality Committee	Beryl McGrath (NED)		**x**		**x**		**x**		**x**		**x**		**x**	TBC (usually third Wednesday of the month)
Clinical Quality Safety and Effectiveness Committee	Medical Director	**x**		**x**		**x**		**x**		**x**		**x**		TBC (usually third week of the month)
Learning From Experience Group	Director of Quality and Health Promotion		**x**			**x**			**x**			**x**		TBC (usually first week of the month)
Risk Compliance & Assurance Group (RCAG)	Director of Finance	**x**		**x**		**x**		**x**		**x**		**x**		TBC (usually first/second week of month)
Executive Management Team (EMT)	CEO	**Every Wednesday 9.00 - 11.00**												9.00 - 11.00