



**MEETING OF THE LONDON AMBULANCE SERVICE NHS TRUST BOARD  
TO BE HELD IN PUBLIC ON TUESDAY 27<sup>th</sup> NOVEMBER 2012 AT 09.00 – 11.30  
CONFERENCE ROOM, 220 WATERLOO ROAD, LONDON SE1 8SD**

**AGENDA: PUBLIC SESSION**

ITEM	SUBJECT	LEAD	TAB
1.	<b>Welcome and apologies for absence</b> Apologies received from:		
2.	<b>Patient Story – 10.30 – 11am</b> To hear an account of a patient experience	SL	Oral
3.	<b>Declarations of Interest</b> To request and record any notifications of declarations of interest in relation to today's agenda	RH	
4.	<b>Minutes of the Part I meeting held on 25<sup>th</sup> September 2012</b> To approve the minutes of the meeting held on 25 <sup>th</sup> September 2012	RH	TAB 1
5.	<b>Matters arising</b> To review the action schedule arising from previous meetings	RH	TAB 2
6.	<b>Report from Chairman</b> To receive a report from the Trust Chairman on key activities since the last meeting	RH	TAB 3
<b>QUALITY GOVERNANCE AND RISK</b>			
7.	<b>Quality Dashboard and Action Plan</b> To receive the most recent Quality dashboard and progress against the Quality Action Plan	SL	TAB 4
8.	<b>Clinical Quality and Patient Safety Report</b> To receive the monthly report on clinical quality and patient safety	FM/SL	TAB 5
9.	<b>Quality Committee Assurance Report</b> To receive a report from the Quality Committee meeting on 24 <sup>th</sup> October 2012	BM	TAB 6
10.	<b>Board Assurance Framework and Corporate Risk Register</b> To receive the Q3 documents	SA	TAB 7
11.	<b>Audit Committee Assurance Report</b> To receive a report from the Audit Committee meeting on 5 <sup>th</sup> November 2012	CS	TAB 8
12.	<b>Executive Directors Report</b> 12.1 Chief Operating Officer, to receive the integrated board performance report 12.2 Director of Finance, to receive the report on financial performance for month 7, including the cost improvement programme 12.3 Director of Human Resources and Organisation Development, to receive a report on workforce	MF MD CH	TAB 9

<b>STRATEGIC AND BUSINESS PLANNING</b>			
13.	<b>Report from Chief Executive Officer</b> To receive a report from the Chief Executive Officer	MF	TAB 10
<b>GOVERNANCE</b>			
14.	<b>Performance Reporting Compliance Statement</b> To note the annual performance reporting compliance statement	PS	TAB 11
<b>BUSINESS ITEMS</b>			
15.	<b>Report from Trust Secretary</b> To receive the report from the Trust Secretary on tenders received and the use of the Trust Seal	SA	TAB 12
16.	<b>Forward Planner</b> To note the Trust Board forward planner	SA	TAB 13
17.	<b>Any other business</b>	RH	
18.	<b>Questions from members of the public</b>	RH	
19.	<b>Date of next meeting</b> The next meeting of the Trust Board will take place on Tuesday 29 <sup>th</sup> January 2013		

**LONDON AMBULANCE SERVICE NHS TRUST**

**TRUST BOARD MEETING  
Part I**

DRAFT Minutes of the meeting held on Tuesday 25<sup>th</sup> September 2012 at 9:00 a.m.  
in the Conference Room, 220 Waterloo Road, London SE1 8SD

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**Present:**

Richard Hunt	Trust Chair
Jessica Cecil	Non-Executive Director
Mike Dinan	Director of Finance
Martin Flaherty	Acting Chief Executive
Roy Griffins	Non-Executive Director
Caron Hitchen	Director of Workforce
Brian Hockett	Non-Executive Director
Steve Lennox	Director of Quality and Health Promotion
Beryl Magrath	Non-Executive Director
Fionna Moore	Medical Director
Murziline Parchment	Non-Executive Director
Caroline Silver	Non-Executive Director

**In Attendance:**

Sandra Adams	Director of Corporate Services
Francesca Guy	Committee Secretary (minutes)
Angie Patton	Head of Communications
Peter Suter	Director of Information Management and Technology

**Members of the Public:**

Deane Kennett	North West London Commissioning Partnership
Malcolm Alexander	LAS Patients' Forum
Lisa Dickinson	Transport Operations Centre Group Manager, Patient Transport Services

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**117. Welcome and Apologies**

- 117.1 No apologies had been received.
- 117.2 The Chair noted that Malcolm Alexander was the new chair of the LAS Patients' Forum and would be attending the Trust Board meetings from now on. Malcolm had sent in a number of questions to the Trust Board that would be addressed throughout the course of the meeting.

**118. Patient Story**

- 118.1 Steve Lennox reported that the purpose of the patient story was for the Trust Board to consider a wide range of issues and that he had not been able to find an appropriate story for today's meeting. Steve had therefore agreed with the Chair not to have a patient story at this meeting.
- 118.2 Steve confirmed that, following the patient story heard at the last Trust Board meeting, a reflective exercise had been undertaken with the members of staff involved, which they had found to be very beneficial. The LAS had also signed up to the NHS London dementia improvement programme to develop current practice and service provision for dementia patients.

118.3 The Chair agreed that the patient stories should be varied and therefore he had been happy not to include one on today's agenda. He would like to see future patient stories highlight any actions that had been taken to address the issues raised.

118.4 Roy Griffins stated that he had an example of a patient story which related to the handling of a Category C patient. He did not want to share this directly with the Trust Board or raise a complaint, but thought that this was something that the Trust could learn from and should be fed into the system. Steve Lennox suggested that Roy follow this up with Gary Bassett. The Chair agreed that these types of experiences should be fed into the system.

**119. Declarations of Interest**

119.1 There were no declarations of interest.

**120. Minutes of the Part I meeting held on 21<sup>st</sup> August 2012**

120.1 The minutes of the Part I meeting held on 21<sup>st</sup> August 2012 were approved.

**121. Matters Arising**

121.1 The following matters arising were discussed:

121.2 **112.5:** The Chair stated that he would follow up with Martin Flaherty the outstanding actions arising from the National Audit Office report.

121.3 **28.7:** Attitude and behaviour would be discussed under the Patient Experiences item.

121.4 All actions from the previous meeting had been completed.

**122. Report from the Chairman**

122.1 The Chair reported that recent activity had focussed on the transition for Martin Flaherty into the role of acting Chief Executive, following Peter Bradley's departure. This transition had gone smoothly and the Chair had set up regular one to one meetings with Martin.

122.2 The Chair had also attended an Association of Ambulance Chief Executive's (AACE) meeting between the Trust Chairs and Chief Executives. Ambulance service chairs had agreed to use AACE as the prime representative body with effect from 1<sup>st</sup> April 2013. This was a positive move, which would allow a more operational focus. This would not, however, end the relationship with the NHS Confederation, although notice would be given terminating from 1<sup>st</sup> April 2013 membership of the ASN.

122.3 The recruitment process for a new Chief Executive was ongoing and a shortlist had been drawn up. Candidates would be required to give a presentation next Monday, which would be followed by the formal interviews on Friday 5<sup>th</sup> October. The interview panel would comprise the Chair, Caroline Silver, Jessica Cecil and Ruth Carnall.

122.4 The Chair gave an update on recruitment for new non-executive directors and reported that the Trust had received 27 interested applicants, two of which were appointable for the finance role. It was proposed that one would be appointed immediately and the other offered a designate role, with a view to becoming a full member once a vacancy arose. The Chair reported that unfortunately the Trust had not been able to appoint to the clinical non-executive role. Steve Lennox asked whether there was an opportunity to appoint a paramedic to this role, given that Peter Bradley and Martin Flaherty would be leaving the Trust. The Chair agreed with this suggestion, but stated that non-

executive directors were not permitted to be currently employed by the NHS.

**123. Quality Dashboard and Action Plan**

- 123.1 Steve Lennox stated that this report showed the strongest position for the Trust thus far and built on last month's results. SMG had discussed the format of the report at its last meeting and had agreed more information was required on Category C performance, which Steve would look to include in the next report.
- 123.2 Beryl Magrath asked whether it was possible for the data in the report to be more current. Steve responded that the data was generated by the Department of Health and he was therefore unable to change this, but acknowledged that when the report was discussed by SMG the figures were more recent.
- 123.3 Beryl noted that the targets contained within the Quality Report were aspirational and asked whether this could place the Trust at a disadvantage. Fionna Moore responded that the targets defined the direction of travel for the Trust and enabled the Trust to identify any slippage against this. The Chair agreed with setting aspirational targets, but asked Steve to describe this process in more detail in the report to the Trust Board.

**ACTION:** SL to explain in the Quality Dashboard Report to the Trust Board that the targets were aspirational.

**DATE OF COMPLETION:** 27<sup>th</sup> November 2012

- 123.4 The Chair asked whether there was any action that needed to be taken now in advance of the Christmas and New Year period. Angie Patton responded that the Communications Team had already been working on the key messages for the public. The Chair asked for a presentation on plans for the Christmas and New Year period, particularly as alcohol had been identified as a health promotion priority.

**ACTION:** FG to add a presentation on plans for the Christmas and New Year period to the Trust Board forward planner.

**DATE OF COMPLETION:** 23<sup>rd</sup> October 2012

- 123.5 Roy Griffins noted that the action owners on the action plan would need to be reviewed in light of the changes to the senior management team.

**ACTION:** SL to review the action owners on the Quality Report action plan in light of changes to the senior management team.

**DATE OF COMPLETION:** 27<sup>th</sup> November 2012

**124. Clinical Quality and Patient Safety Report**

- 124.1 Fionna Moore reported the following:

- CPI completion rates had recovered, with the West Area showing steady performance. The Mental Health CPI had been introduced in April 2012 and was included in CSR training. It

- was therefore anticipated that compliance against this CPI would improve;
- The implementation of a new clinical pathway to transport high risk acute coronary syndrome patients directly to a Heart Attack Centre had been delayed due to a number of centres not being ready;
- There had been a continuing decrease in the number of high risk addresses contained within the High Risk Register;
- There had been a decrease in the use of the Demand Management Plan (DMP) over the reporting period, with August seeing the lowest use of DMP in 2012;
- A snapshot audit had been undertaken on 200 patients managed in December 2011, which highlighted the importance crews gave to handling alcohol patients and the need to undertake an assessment to determine whether there were any underlying conditions such as a head injury or hypoglycaemia.

- 124.2 Jessica Cecil asked for an update on South Area CPI completion. Fiona responded that the South Area had been less successful in finding people to assist Team Leaders in CPI completion, but that an action plan had been put in place to address this.
- 124.3 Jessica asked how much the decrease in the use of the DMP was due to additional resourcing over the Olympics. Fiona responded that the Trust had been very well staffed over the Olympics, with fewer abstractions and this had contributed to the decreased use of DMP.
- 124.4 Beryl Magrath noted that the Cardiac Arrest Annual Report 201/12 demonstrated that the LAS was world class and stated that staff should be thanked for their contribution to achieving these results.
- 124.5 Beryl asked whether there were plans to put tympanic thermometers into the red bag. Fiona confirmed that this was the intention but reported that the red bags had been more effective in some complexes than others. Paul Woodrow and Ed Potter were looking at how this process could be improved further.
- 124.6 The Chair noted that the Patients' Forum had submitted a question to the Trust Board asking whether all entrants on the High Risk Register had been notified and been given a chance to appeal against the entry and what protection had been given to people living adjacent to high risk addresses. Peter Suter responded that there had been significant focus on the High Risk Register and that a process was in place to inform all entrants. Crews had been trained to undertake a dynamic risk assessment for both patients on the register and those living nearby. Peter stated that he would be happy for the Management Information team to meet with the Patients' Forum to address their concerns in more detail.

**ACTION:** PS to arrange for the MI Team to meet with members of the Patients' Forum to address their concerns about the High Risk Register.

**DATE OF COMPLETION:** 23<sup>rd</sup> October 2012

- 124.7 Martin stated that it was necessary for the Trust to have the High Risk Register in place in order to protect both crews and patients, but crews had moved away from a position where they automatically waited outside high risk addresses. The process for the management of the register had been reviewed and was now more robust, but Martin acknowledged that this would always be problematic.
- 124.8 The Chair asked Peter Suter to provide figures on how many high risk addresses the Trust had attended.

**ACTION:** PS to provide figures on how many high risk addresses the Trust had attended.

**DATE OF COMPLETION:** 27<sup>th</sup> November 2012

**125. Annual Patient Experiences Report 2011/12**

- 125.1 Steve Lennox reported that it was a statutory requirement for the Trust to produce an annual complaints report, although the Trust Board received a monthly update on complaints and therefore the themes and trends should not be new to the Board. The key themes were delay, attitude and behaviour and non-conveyance. Lost property had also emerged as a key trend in PALS activity and this was partly due to the Trust being unable to demonstrate that it had not lost patient property, rather than actual cases of lost property.
- 125.2 A discussion followed about the public perception that ambulances automatically transported patients to an Emergency Department. Steve Lennox commented that the national message on this was weak and that the Trust often received complaints from patients who had not been transported to hospital. The Chair commented that this was a strategic communications issue and asked whether this should be addressed with Simon Weldon at the Strategy Review and Planning Committee. The Communications team had focussed on messages around non-conveyance, but it was suggested that both the LAS Community Involvement Officers and the Association of Ambulance Chief Executives could have a role in disseminating this message further, both locally and nationally.

**126. Board Assurance Framework and Corporate Risk Register**

- 126.1 Sandra Adams reported that the Board Assurance Framework had been updated to reflect recommendations made by RSM Tenon to strengthen the assurances and to reflect the discussion at the Strategy Review and Planning Committee on strategic risks. Sandra stated that the Trust did not currently have an articulated risk for Category C patients and might therefore need to consider this.
- 126.2 The Trust Board reviewed section D of the Board Assurance Framework which set out the principal risks for the Trust.
- 126.3 Sandra reported that a new risk had been added to this section (368) relating to messages exchanged between MDTs and the CommandPoint CAD system. Peter Suter stated that there was a risk that MDT messages could go out of sequence and he was currently working with Northrop Grumman to develop a technical solution, which would take approximately 3 months to complete. There was currently a manual alert system in place to alert people if this occurred.
- 126.4 Murziline Parchment commented that the mitigation of a number of the strategic and principal risks relied heavily on the ORH review and she assumed therefore that the update at the Strategy Review and Planning Committee would take this into account.
- 126.5 Roy Griffins commented that he liked the format and presentation of the Board Assurance Framework and had found it useful that the information was up to date.
- 126.6 Sandra referred to a question that had been submitted by the Patients' Forum that asked whether the Trust Board had considered the risks relating to the changes to the wider healthcare system and the potential fragmentation of commissioning. Sandra stated that the Trust did not have a risk that was expressed in this way, but that this issue sat behind a number of other risks and CQUINs. The Trust would continue to work with the commissioners to mitigate the impact of this risk.

126.7 Sandra added that the corporate risk register had been fully reviewed and was up to date. She reiterated the need to consider an additional risk for Category C patients, which would be followed up by the Risk, Compliance and Assurance Group.

**ACTION:** MF to put forward a proposal to the Risk, Compliance and Assurance Group to consider an additional risk for Category C patients.

**DATE OF COMPLETION:** 14<sup>th</sup> January 2013

**127. Audit Committee Assurance Report**

127.1 Caroline Silver reported the following:

- The meeting on 3<sup>rd</sup> September was the last that would be attended by the Audit Commission. Caroline had met with representatives from Price Waterhouse Coopers and was confident that the LAS would be able to develop a constructive relationship with its new external auditors. Price Waterhouse Coopers were scheduled to attend the next Audit Committee meeting in November;
- The Audit Committee had discussed the risk register and had agreed that the Trust needed to undertake regular horizon scanning to ensure that all risks had been captured. The Committee had also suggested that the risk target levels needed to be reviewed;
- Reports had been received from the Finance and Investment Committee and the Quality Committee and the relationship between the committees seemed to be working well;
- Amendments to the Standing Orders and the Standing Financial Instructions were approved to ensure that they were brought into line with the Bribery Act;
- The Charitable Funds Annual Report and Accounts for 2011/12 were approved. The Audit Committee recommended that the Trust Board revisit its policy to run down the fund as it looked likely that the fund would run down entirely over the course of the next five years;
- The Committee received a progress report from Internal Audit. Overall the Committee was satisfied with the way in which internal audit was working and the Trust Board could take assurance that it was materially more robust than it had been and continued to improve. Caroline commended the Audit and Compliance Manager, Frances Wood, to the Trust Board;
- The Committee received a progress report from the Local Counter Fraud Specialist and was satisfied that this work was on track.

127.2 Roy Griffins noted that he had found the format of the report very useful. Roy added that the previous external auditors had done a very good job and he wanted the Trust Board to acknowledge this.

**128. Executive Directors Report**

**Chief Operating Officer's Report**

128.1 Martin Flaherty reported the following:

- August had seen an ongoing increase in call volume and Category A workload. Category A calls were now up by 15.8%;
- Utilisation levels had decreased during the Olympic Games period, but had started to rise again in September;
- Resourcing challenges were rising again in September and take up of overtime was slow;
- Waiting times for Category C patients had shown an improvement in July and August due to improved resourcing. DMP utilisation had also decreased over this period;

- The year to date position for Category A8 was 75.2% and Category A19 was 98.4%.

- 128.2 Martin added that the Olympics Games 2012 delivery had been an overwhelming success. Performance had been stable and staff had been given rest breaks and had finished their shifts on time. A temporary Forecast and Planning Office had operated over the Olympic period and it was planned that elements of this would be taken forward into day to day planning. The way in which the Trust worked with other ambulance trusts had also been effective and it was planned that this would continue.
- 128.3 The Chair requested a session at the December meeting of the Trust Board on the top five lessons learnt from the Olympics.

**ACTION:** FG to add Top 5 lessons learnt from the 2012 Olympic Games to the Trust Board forward planner for December 2012.

**DATE OF COMPLETION:** 27<sup>th</sup> November 2012

- 128.4 Murziline Parchment stated that it was interesting to see what the Trust could achieve given additional resources. Martin agreed with this comment and stated that this would feed into the ORH capacity review. Martin also wanted to acknowledge the contribution of Patient Transport Services to the smooth running of the Olympics.
- 128.5 Martin reported that the Integrated Board Performance Report had been further developed and asked the Trust Board whether it wanted to continue to receive the Chief Operating Officer's report alongside this report. The Trust Board agreed that the narrative in the Chief Operating Officer's report was informative and helped the Trust Board to understand the figures contained within the Integrated Board Performance Report.
- 128.6 Beryl Magrath asked whether there was a risk that the Trust was overtriaging Category A calls. Martin responded that yesterday 66% of all incoming call volume was triaged as Category A, which therefore suggested that there was a potential problem with overtriaging and this would be looked into further. The Trust was still focussed on using MPDS, but there was still a debate to be had in the future regarding NHS Pathways.

Report from the Director of Finance

- 128.7 Mike Dinan reported that this had been a challenging month and the Trust had reported a deficit of £226k for the month against a planned surplus of £24k, he was confident however that this position was recoverable. Mike reported that the Cost Improvement Programme was on track.
- 128.8 Mike reported that there was a potential risk on the revenue side given that additional funding for the Queen's Diamond Jubilee and the Olympics had not yet been received. There was also a risk of non-achievement of some of the CQUINs.
- 128.9 The Patients' Forum had submitted a question about what consideration had been given to the impact of Payment By Results. Mike responded that the Trust had been shadowing Payment by Results with the commissioners and that it represented both an opportunity and a threat. The risks would therefore need to be managed appropriately.

Report from the Director of Workforce

- 128.10 Caron Hitchen stated that there was some duplication with the Integrated Board Performance Report and suggested that in future this report concentrate on progress against the delivery of the

five year workforce strategy.

128.11 Caron reported the following:

- Sickness absence was only just within target and had exceeded the target last month. Benchmarking data showed that no ambulance trust nationally was achieving less than 5% and half were over 6%. However the LAS had set itself a target of 5.5% and this was therefore a risk;
- Training had been suspended over the Olympic period and a fuller update on training was provided in the Integrated Board Performance Report.

128.12 The Chair noted that there had been 50 leavers in June and asked whether there was a reason for this. Caron responded that a number of frontline staff had left to join other ambulance trusts and although this trend was higher than normal, it was not significant.

128.13 Caron stated that there was a risk however that staff would leave to join overseas ambulance services. Martin reported that four to five senior staff members had left to work at the ambulance service in Qatar and were looking to recruit further from the LAS. Caron stated that the apprentice paramedic programme provided an opportunity to recruit a larger number of staff directly into operational posts and therefore provided some mitigation for this risk. The Chair stated that the risk of staff transferring to Qatar needed to be considered as a strategic issue.

## **129. Report from Chief Executive Officer**

129.1 Martin Flaherty reported that the Trust Board's focus so far this year had been on embedding CommandPoint and on successfully delivering care to patients over the Queen's Diamond Jubilee weekend and during the 2012 London Olympics and Paralympics. CommandPoint was now fully embedded and the Trust Board would be required in due course to approve the removal of CTAK as the backup system. Martin was also pleased to report that the Trust had safely delivered the Olympic games, the Notting Hill Carnival and the Paralympic Games. Olympic service delivery had been an exemplary piece of planning and delivery.

129.2 Martin reported the following:

- He and Sandra Adams had met with Alwen Williams, who would be responsible for taking the remaining London trusts through to FT authorisation. This had been a positive meeting and had resulted in a revised Tripartite Formal Agreement, which was currently going through the approval process;
- The LAS continued to be involved in discussions across London relating to proposals for hospital configurations;
- He had met with Anne Rainsberry and had discussed the future arrangements for LAS commissioning. Simon Weldon had agreed to present to the Strategy Review and Planning Committee meeting in October on the commissioning landscape both in London and nationally.

129.3 Martin provided an update against the key priorities for 2012/13 and stated that these were broadly on track with the exception of the second control room at Bow, which had been rescheduled to go live on 19<sup>th</sup> November 2012.

129.4 The Chair commented that he would like the Trust to consider different methods of communication, including social media. The Chair was also keen to ensure that the Trust was part of the commissioning arrangements as they developed.

129.5 Caron Hitchen referred to a question that had been submitted by the Patients' Forum about

workforce transformation and the impact this would have on patients. Caron stated that workforce modernisation was a key priority area for the Trust and would be looking to take this forward.

129.6 The Chair wanted to acknowledge that Martin had transitioned into the role of Acting Chief Executive very well and thanked Martin for ensuring that this transition had gone smoothly.

**130. Update on ORH Capacity Review**

130.1 Martin Flaherty reported that ORH had been invited to the Strategy Review and Planning Committee meeting in October to provide a fuller update on the capacity review. The Chair noted that it might be necessary to limit the agenda of the SRP meeting to a few key items to ensure that this was discussed adequately.

130.2 Martin reported that the terms of reference for the review had been agreed and a steering group had been set up, which was chaired by Simon Weldon. The Steering Group was still in the process of agreeing some of the assumptions, but had made good progress against other elements. Overall, the review was on track to report in mid-December 2012.

130.3 The Chair commented that the review had taken a long time to complete. Martin responded that it had become a bigger piece of work than was originally anticipated, but that he was confident that the outcome of this review would feed into the commissioning round for 2012/13, providing the final report was received by mid-December.

130.4 Murziline Parchment left the meeting.

**131. Charitable Funds Annual Report and Accounts 2011/12**

131.1 Mike Dinan explained that the Trust Board was asked to approve the Charitable Funds Annual Report and Accounts for 2011/12, which had already been reviewed by the Charitable Funds Committee and the Audit Committee. Mike added that the Trust Board was also asked to review its policy to run down the fund as the impact of this policy had become more evident in recent years given the downturn in the economy and the resulting lower return on investments. Caroline Silver agreed that she had thought it necessary to ensure that the Trust Board were aware of this.

131.2 Trust Board members agreed that there was no alternative but to run down the funds, but that careful consideration would be required as to how this would be communicated to staff. Peter Suter commented that it was important not to underestimate the impact this would have on staff. Caroline commented that the Trust Board might need to consider whether to provide these services by alternative means.

131.3 Caroline added that the Trust had established a different charity for community first responders and stated that there was potential for confusion around the roles of these two charities. Mike Dinan was asked to write an explanation on the role of the two charities.

**ACTION:** MD to write an explanation on the roles of the two LAS charities.

**DATE OF COMPLETION:** 27<sup>th</sup> November 2012

131.4 The Trust Board approved the Charitable Funds Annual Report and Accounts for 2011/12 and reconfirmed its policy to run down the fund, recognising that this would need to be communicated carefully to members of staff.

### **132. Report from Finance and Investment Committee**

132.1 The Chair reported that the Finance and Investment Committee had met last week and had discussed the following:

- An update on the Olympics budget;
- Long Term Financial Model;
- The outcome of shadowing Payment by Results and the next steps;
- Sale and Leaseback of vehicles. This was the last of the four sale and leaseback cases;
- Business case for the West Area Workshop;
- Liquidity and working capital report. The Trust was required to have a working capital facility in advance of submitting its FT application and this discussion would therefore need to come back to the Trust Board;
- Year to date financial position including a new format for the CIP report, which allowed for a more clinical focus;
- Financial risks;
- Approval of the purchase of AEDs and refurbishment of BETs vehicles.

132.2 The Chair reported that overall the Committee was in better shape and that his intention would be to step down as chair once the new non-executive directors had settled into their roles with the LAS.

### **133. Report from Trust Secretary**

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

### **134. Forward Planner**

134.1 The Chair commented that he had found last Monday's conference call with the Trust Board very useful and that he would consider arranging more of these. Trust Board members agreed that it was a useful way to catch up in between Trust Board meetings.

134.2 The Chair also stated that the Trust Board needed to consider involving people remotely and moving towards a paperless way of working. Caroline Silver welcomed this proposal, particularly as there were occasions when she had been unable to attend the Trust Board meeting in person, but would have liked to have participated in the discussion. Caroline suggested that the Trust should consider using iPads for Trust Board meetings. Peter Suter was asked to follow this up.

**ACTION:** PS to explore options for the Trust Board to use iPads or alternative devices for Trust Board meetings.

**DATE OF COMPLETION:** 27<sup>th</sup> November 2012

### **135. Any other business**

135.1 The Chair asked whether it was possible for the Trust to give a commendation to a member of the public who had assisted the service by, for example, performing CPR on a patient. Angie Patton responded that she had looked into this and agreed that this would be a positive initiative and was something that the police service did. The Chair agreed to develop a proposal for the December Trust Board meeting.

**ACTION:** Trust Chair to develop a proposal for the Trust to award a commendation to a member of the public who had assisted the service.

**DATE OF COMPLETION:** 11<sup>th</sup> December 2012

135.2 The Chair reported that Murziline Parchment had decided to stand down as a non-executive director as she had found it difficult to commit to the time required for the role.

135.3 The Trust Board congratulated Lizzy Bovill on the birth of her daughter yesterday.

**136. Questions from members of the Public**

136.1 The Chair of the Patients' Forum had submitted a number of questions prior to the meeting, which had been addressed during the course of the meeting. There were no other questions from members of the public.

**137. Date of next meeting**

137.1 The next meeting of the Trust Board will take place on Tuesday 27<sup>th</sup> November 2012

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Signed by the Chair

**ACTIONS**  
from the Meeting of the Trust Board of Directors of  
**LONDON AMBULANCE SERVICE NHS TRUST**  
held on 25<sup>th</sup> September 2012

<u>Meeting Date</u>	<u>Minute Date</u>	<u>Action Details</u>	<u>Responsibility</u>	<u>Progress and outcome</u>
28/06/11	<u>67.3</u>	<b><u>Chairman's Report</u></b> RH to discuss world cities benchmarking with FM.	<b>RH/FM</b>	Eagles were looking to share best practice in cardiac care.  Canadian and Australasian Ambulance Services were looking to set up a benchmarking group.
27/09/11	<u>112.5</u>	RH/PB to meet to discuss whether there was anything further the Trust could be doing to meet the recommendations made by the NAO report.	<b>RH/MF</b>	Chair to follow up with Martin Flaherty the outstanding actions arising from the National Audit Office report.
29/05/12	<u>46.3</u>	LB to publish patient story in the GP newsletter.	<b>LB</b>	GP story has been postponed until September as we have prioritised demand management messages for the Olympic period in the July edition.
26/06/12	<u>74.12</u>	RH/SA to discuss how to build in staff presentations into the Trust Board forward planner.	<b>RH/SA</b>	Outstanding.
21/08/12	<u>102.7</u>	SL to review attendance at the Safeguarding Committee.	<b>SL</b>	To be undertaken at the next Safeguarding Committee meeting on 4 <sup>th</sup> October 2012.
25/09/12	<u>123.3</u>	SL to explain in the Quality Dashboard Report to the Trust Board that the targets were aspirational.	<b>SL</b>	

<u>Meeting Date</u>	<u>Minute Date</u>	<u>Action Details</u>	<u>Responsibility</u>	<u>Progress and outcome</u>
25/09/12	<u>123.4</u>	FG to add a presentation on plans for the Christmas and New Year period to the Trust Board forward planner.	<b>FG</b>	
25/09/12	<u>123.5</u>	SL to review the action owners on the Quality Report action plan in light of changes to the senior management team.	<b>SL</b>	
25/09/12	<u>124.6</u>	PS to arrange for the MI Team to meet with members of the Patients' Forum to address their concerns about the High Risk Register.	<b>PS</b>	
25/09/12	<u>124.8</u>	PS to provide figures on how many high risk addresses the Trust had attended.	<b>PS</b>	
25/09/12	<u>126.7</u>	MF to put forward a proposal to the Risk, Compliance and Assurance Group to consider an additional risk for Category C patients.	<b>MF</b>	
25/09/12	<u>128.3</u>	FG to add Top 5 lessons learnt from the 2012 Olympic Games to the Trust Board forward planner for December 2012.	<b>FG</b>	
25/09/12	<u>131.3</u>	MD to write an explanation on the roles of the two LAS charities.	<b>MD</b>	
25/09/12	<u>134.2</u>	PS to explore options for the Trust Board to use iPads or alternative devices for Trust Board meetings.	<b>PS</b>	
25/09/12	<u>135.1</u>	Trust Chair to develop a proposal for the Trust to award a commendation to a member of the public who had assisted the service.	<b>RH</b>	

## CLOSED ACTIONS

<b>27/03/12</b>	<b><u>28.7</u></b>	RH to discuss with PB his experiences of tackling attitude and behaviour issues.	<b>RH</b>	Discussed as part of the Patient Experiences item at the September Trust Board meeting. Action complete.
<b>26/06/12</b>	<b><u>84.5</u></b>	MF to report to the Trust Board on the findings of the ORH capacity review and specifically the number of calls received from other healthcare providers.	<b>MF</b>	On agenda for September Trust Board meeting.
<b>21/08/12</b>	<b><u>98.2</u></b>	SA/FG to add a discussion on double dispatch to the Trust Board forward planner.	<b>SA/FG</b>	Added to forward planner for November 2012.
<b>21/08/12</b>	<b><u>101.4</u></b>	SL to include an explanation in the quality dashboard to the Trust Board about how the Trust's quality priorities were monitored.	<b>SL</b>	To be included in September's dashboard.
<b>21/08/12</b>	<b><u>102.4</u></b>	SA/FG to add safeguarding to the Trust Board forward planner.	<b>SA/FG</b>	Added to forward planner for February 2013 Strategy Review and Planning Committee.
<b>21/08/12</b>	<b><u>105.4</u></b>	FG to add a presentation on PPI and PE to the Trust Board forward planner.	<b>FG</b>	Added to forward planner for November 2012.
<b>21/08/12</b>	<b><u>105.6</u></b>	MF to provide an interim report on the ORH capacity review at the September Trust Board meeting.	<b>MF</b>	On agenda for September Trust Board meeting.
<b>21/08/12</b>	<b><u>109.6</u></b>	SA/FG to add succession planning to the Trust Board forward planner.	<b>SA/FG</b>	Added to the forward planner for October Strategy Review and Planning Committee.



## LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 27<sup>TH</sup> NOVEMBER 2012

### PAPER FOR NOTING/APPROVAL

<b>Document Title:</b>	<b>Chairman's report</b>
<b>Report Author(s):</b>	<b>Richard Hunt</b>
<b>Lead Director:</b>	
<b>Contact Details:</b>	
<b>Why is this coming to the Trust Board?</b>	<b>For information</b>
<b>This paper has been previously presented to:</b>	<input type="checkbox"/> Strategy Review and Planning Committee <input type="checkbox"/> Senior Management Group <input type="checkbox"/> Quality Committee <input type="checkbox"/> Audit Committee <input type="checkbox"/> Clinical Quality Safety and Effectiveness Committee <input type="checkbox"/> Risk Compliance and Assurance Group <input type="checkbox"/> Learning from Experience Group <input type="checkbox"/> Finance and Investment Committee <input type="checkbox"/> Other
<b>Recommendation for the Trust Board:</b>	
<b>Key issues and risks arising from this paper</b>	
<p>During the period under review, I attended a stakeholder event for the CEO candidates, a day for the interviews themselves and subsequent decision making. I met with the Chair of NHS London, Professor Mike Spyer, twice on the subject of board changes and the FT process. I had a meeting with Anne Tofts of Healthskills, as part of our board development programme and the 360 exercise. I met with Jim Myers of Northrop Grumman, Chris Hutchison, the LINC representative of the LAS and had an external meeting with NED Jessica Cecil. After the appointment of two new Non Executive Directors, I had introductory meetings with both Nick Martin and John Jones. I have also had two meetings with our new CEO designate, Ann Radmore.</p> <p>I attended the board meeting of the Ambulance Service Network, Finance and Investment Committee, a meeting with British Airways (together with Martin Flaherty, Jason Killens and Paul Woodrow) about rostering, was an attendee at the ASN conference and made a conference call, together with Jason Killens, on international opportunities for the LAS.</p> <p>I was invited to the Post Olympic Games reception and the Celebration of long service awards ceremony.</p>	
<b>Attachments</b>	



**LONDON AMBULANCE SERVICE TRUST BOARD**

**DATE: 27 NOVEMBER 2012**

**PAPER FOR NOTING**

<b>Document Title:</b>	<b>Quality Dashboard</b>
<b>Report Author(s):</b>	<b>Steve Lennox</b>
<b>Lead Director:</b>	<b>Steve Lennox</b>
<b>Contact Details:</b>	<b>Steve.lennox@lond-amb.nhs.uk</b>
<b>Why is this coming to the Trust Board?</b>	<b>Inform Trust Board current position against quality measures</b>
<b>This paper has been previously presented to:</b>	<input type="checkbox"/> Strategy Review and Planning Committee <input checked="" type="checkbox"/> Senior Management Group <input type="checkbox"/> Quality Committee <input type="checkbox"/> Audit Committee <input type="checkbox"/> Clinical Quality Safety and Effectiveness Committee <input type="checkbox"/> Risk Compliance and Assurance Group <input type="checkbox"/> Learning from Experience Group <input type="checkbox"/> Other
<b>Recommendation for the Trust Board:</b>	Note the report
<b>Key issues and risks arising from this paper</b> This report identifies that the LAS remains one of the top performing Ambulance Trusts in the country when using the DH indicators as the measure. In reality we have moved from our usual 1 <sup>st</sup> and 2 <sup>nd</sup> ranking to 3 <sup>rd</sup> . Great Western appears to have had a particularly successful month.	
<b>Executive Summary</b> There are three components to the Quality Dashboard & Action Plan	
<b>1. Quality Dashboard (July 2012)</b> The dashboard illustrates the Trusts performance for September 2012 against the identified Quality Measures. The challenge and discussion for each indicator has been undertaken at SMG where a Full Quality report supported the dashboard.  The July dashboard illustrates 38 measures for quality and reveals 15 Green measures (15 last month) 10 Amber measures (7 last month) and 12 Red measures (15 last month), and 1 not populated. This is the strongest dashboard presented to date.	
<b>2. DH Quality Measures (Comparison)</b> The DH mandatory quality measures have been lifted from the dashboard in order to offer a comparison across all other ambulance services. Some of the DH indicators appear Red on the dashboard as we have set ourselves tough SMART targets but appear more favourable when comparing against other services as there is no associated SMART target when making comparisons.  Some of the 11 DH measures (service experience has been excluded) are made up of a number of indicators. A8 is broken into Red 1 and Red 2.	

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

The following table illustrates the number of top performing measures each Ambulance Trust has in the 43 information points (not all comparisons are drawn from statistically significant data therefore, this is merely a discussion point).

- Isle of Wight 10 (23%)
- Great Western 8 (19%)
- London 7 (16%)
- Yorkshire 4 (9%)
- South Central 4 (9%)
- East of England 4 (9%)
- North West 3 (7%)
- South East Coast 2 (5%)
- South Western 1 (2%)
- North East 0 (0%)
- East Midlands 0 (0%)
- West Midlands 0 (0%)

### 3. Quality Action Plan

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

#### 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

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:

# Quality Dashboard for September 2012

Satisfaction	Incidents Green	Service Experience Green					
Dignity	999 Calls Abandoned Green	Lost Property Green	2012 Quality Priority Mental Health Care Amber	2012 Quality Priority Alcohol Related Harm Amber			
Clinical Outcomes	Outcome from Cardiac Arrest (Survival) Green	Infection Control Red	Not Conveyed to A&E Red	Re-Contact Rate Green			
Safety	Appropriate Response Times Amber	Safeguarding Green	Right Place, Right Time, Right Person Amber	On Scene Time Amber	Time Taken to Answer 999 Calls Green	Time to Treatment Green	Missing Documentation Red
Clinical Intervention	Return of Spontaneous Circulation Green	STEMI Care (Time & Care Bundle) Red	Stroke Care (Time & Care Bundle) Amber	Airway Management Red	Basic Life Support Green	Clinical Performance Indicators Amber	2012 Quality Priority Diabetes Care Green
Performance	A8 Response Time Red	A19 Response Time Green	C1 Response Time Red	C2 Response Time Red	C3 Response Time Red	C4 Response Time Amber	Arrival at Hospital to Handover Red
Staff/Workforce	% of staff Receiving Supervision Red	% of Staff Receiving X2 CPI Feedback Sessions Red	% of priority training commitments delivered (CSR) Amber	Vacancy Factor Green	3rd Party Providers Red	Sickness (Always a Month behind) Green	Staff Morale - Temperature Check (Quarterly June) Green

## Comparison Table

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

The **GREEN** shading represents where the Trust is in the upper quartile when compared to other services. In May we were upper quartile in 20 (last month 18) out of 42 areas (A8 not yet reported by DH).

	March (December)			Year to Date	
	Compliance	Rank	Direction of Travel (Compliance)	Compliance	Rank
A8 Response Time					
A19 Response Time	98%	1	↓	97.2%	1
ROSC (all)	28.4%	3	↑	28.2%	2
ROSC (Utstein)	50%	3	↑	47.8%	6
Time Taken to Answer 50 <sup>th</sup> Percentile	0	1	↔	0	1
Time Taken to Answer 95 <sup>th</sup> Percentile	0.01	1	↔	0.124	7
Time Taken to Answer 99 <sup>th</sup> Percentile	0.42	3	↓	1.11	8
Time to Treatment 50 <sup>th</sup> Percentile	6.0m	10	↓	5.46	7
Time to Treatment 95 <sup>th</sup> Percentile	14.54m	3	↓	14.11	2
Time to Treatment 99 <sup>th</sup> Percentile	23.42m	4	↓	22.29	3
Outcome from cardiac Arrest Survival	7.2%	8	↓	7.1	6
Outcome from cardiac Arrest Survival (Utstein)	26.5%	3	↑	24.6	3
STEMI Outcome 150 minutes	92.9%	4	↓	94.3%	1
STEMI Outcome Care Bundle	68.6%	10	↔	69.6%	11
Stroke Outcome 60 minutes	72.3%	4	↑	69.4%	4
Stroke Care Outcome Bundle	93.7%	9	↓	94.7%	7
Calls Closed with CTA	5.5%	8	↓	5.3%	9
Non A&E	32%	9	↓	32%	9
Re Contact rate CTA	2.8%	1	↓	2.9%	2
Re Contact rate See & Treat	4.5%	8	↔	4.3%	2
Re Contact rate Frequent callers	2.6%	5	↑	2.6%	4
999 Calls Abandoned	0.1%	1	↔	0.1%	1
Service Experience	No measure				

## **Conclusions**

This dashboard has seen a drop in compliance. This was expected as the post Olympic annual leave and extractions from training took effect. However, the workforce indicators are a concern and it is a possibility that the staff morale and capacity issues will lead to a drop in quality within the higher level domains. It is recommended that the Trust give the workforce issues further consideration.



**LONDON AMBULANCE SERVICE TRUST BOARD**

**DATE: 27<sup>TH</sup> NOVEMBER 2012**

**PAPER FOR NOTING/APPROVAL**

<b>Document Title:</b>	<b>Clinical Quality &amp; Patient Safety Report</b>
<b>Report Author(s):</b>	<b>Joint Clinical Directors' Report</b>
<b>Lead Director:</b>	<b>Fionna Moore and Steve Lennox</b>
<b>Contact Details:</b>	
<b>Why is this coming to the Trust Board?</b>	<b>For information</b>
<b>This paper has been previously presented to:</b>	<input type="checkbox"/> Strategy Review and Planning Committee <input type="checkbox"/> Senior Management Group <input type="checkbox"/> Quality Committee <input type="checkbox"/> Audit Committee <input type="checkbox"/> Clinical Quality Safety and Effectiveness Committee <input type="checkbox"/> Risk Compliance and Assurance Group <input type="checkbox"/> Learning from Experience Group <input checked="" type="checkbox"/> Other: Elements of this report have been presented at SMG, Quality Committee, and CQSEC
<b>Recommendation for the Trust Board:</b>	For information
<b>Key issues and risks arising from this paper</b> <ul style="list-style-type: none"> <li>• Increase in CPI audit (96%). CPI compliance remains &gt;95% except for mental health. High compliance in Cycle 9 of the national Hypoglycaemia CPI.</li> <li>• National Early Warning Score report published by Royal College of Physicians. CQD examining possible use of early warning scores by Ambulance Services.</li> <li>• Continued decrease in the number of entries on the Locality Alert Register, now the lowest since MI took management of the register.</li> <li>• Increased use of DMP B since end of Olympic and Paralympic Games. DMP was escalated to stage D in September for the first time since March 2012.</li> <li>• One reportable Controlled Drugs incident involving the loss of morphine. One on-going investigation into the appearance of an ampoule of morphine in a General Drug pack.</li> <li>• No new Rule 43 Reports have been received by the Trust.</li> <li>• Increasing number of complaints about ambulance delays, received by PED.</li> <li>• Two Clinical Audit reports published by CARU</li> </ul>	
<b>Executive Summary</b> This is the sixth edition of a revised clinical report. The report is structured around the quality domains of the quality dashboard but also reports on issues wider than the quality measures. Overall this report provides assurance that a high quality and safe clinical service is provided.	
<b>Attachments</b> <b>Appendix 1:</b> Clinical Audit Examining the Assessment of Intoxicated Patients by the London Ambulance Service (Summary).	

**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:

# Clinical Quality & Patient Safety Report – November 2012

## Clinical Directors' Joint Report

### 1. Quality Domains

#### Quality Domain 3: Clinical Intervention

##### Removal of exceptions for missing or faulty equipment

CPI data from all ambulance services in England is reported to the Department of Health (DH) as part of their Care Quality Indicators and used for national comparative purposes. For several years the LAS has awarded exceptions for missing or faulty equipment, and has been the only UK ambulance service to do so. This has resulted in different figures being reported locally and nationally for this time period. Under the instruction of the DH, it is not acceptable to award equipment-related exceptions and from 1st October 2012 the LAS is no longer able to allocate exceptions for missing or faulty equipment, irrespective of whether a LA52 has been completed. If equipment is missing or faulty, patients may not receive the best possible care.

##### Clinical Performance Indicators (CPIs)

Team Leader CPI completion rate increased to **96%** in September. Twenty three complexes achieved or exceeded the 95% audit target. Overall compliance against all clinical care standards remains consistently high at 95%; the Trust target is 100%. The exception to this remains the mental health CPI.

3053 (out of an expected 3384) CPI feedback sessions have been undertaken by Team Leaders this year.

Table 1. CPI completion February to September 2012

Area	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.
East	86%	94%	95%	82%	82%	79%	72%	88%
South	83%	78%	67%	46%	42%	62%	87%	99%
West	84%	96%	100%	93%	88%	92%	98%	98%
<b>LAS Total</b>	<b>84%</b>	<b>89%</b>	<b>86%</b>	<b>72%</b>	<b>70%</b>	<b>77%</b>	<b>87%</b>	<b>96%</b>

Table 2. CPI Compliance September 2012

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

Table 3. CPI Compliance August 2012

	Cardiac Arrest	Difficulty in Breathing	ACS (Including MI)	Stroke	Mental Health	Non-Conveyed	1 in 40 PRF
East	98%	95%	97%	98%	91%	95%	97%
South	97%	95%	96%	97%	86%	95%	98%
West	98%	96%	97%	98%	86%	97%	97%
<b>LAS Total</b>	<b>98%</b>	<b>95%</b>	<b>96%</b>	<b>98%</b>	<b>87%</b>	<b>96%</b>	<b>97%</b>

## CPI Cycle 9

The first element of Cycle 9 of the National CPI audit (Hypoglycaemia) has been published by the National Ambulance Service Clinical Quality Group. The audit report identifies that the Trust has improved overall compliance against the care bundle. Of note, compliance against the criterion H4 (direct referral of patients to an appropriate healthcare professional) has increased from 64.7% (Cycle 8) to 88.7%. This is the highest compliance nationally.

### Cardiac Care

**Para-SVT** - This trial continues to go extremely well and now has over 60 patients recruited (90 required). The research trial was presented at the Heart Rhythm UK conference in September.

**High Risk ACS** - A new pathway to transport high risk Acute Coronary Syndrome (ACS) patients directly to a Heart Attack Centre, went live on the 22<sup>nd</sup> October 2012. Patients with chest pain and evidence of ischemia on a 12 lead ECG will now be able to be transported directly to the London Chest Hospital, in addition to patients meeting STEMI criteria.

**Improving Cardiac Arrest Survival** - Team Leader training has been completed at Oval, Deptford and Waterloo complexes, in order to deliver therapeutic hypothermia to patients post cardiac arrest. The Trust is now awaiting King's College Hospital to confirm a date for the trial to start.

**Arrhythmias** - Progress is being made to set up a pathway to transport patients with high risk arrhythmias directly to specialist centres. High risk arrhythmias are defined as:

- ICD (implantable cardiac defibrillator) activation twice in 24 hours
- Ventricular Tachycardia (VT)
- Complete (Third degree) Heart Block

### **National Early Warning Score (NEWS)**

The Royal College of Physicians (RCP) has published a report about standardising the assessment of acute-illness severity in the NHS, by developing a National Early Warning Score (NEWS). The concept of an early warning scoring system is to enable identification of acutely unwell or deteriorating patients by assessing six specific physiological parameters. Each parameter is allocated a score reflecting the magnitude of deviation from a 'normal' value. The higher the score, the higher the clinical acuity (Appendix 1).

The report recommends that the routine clinical assessment of patients (>16 years of age) should be standardised across the NHS with the routine recording of a minimum clinical data set of physiological parameters resulting in a National Early Warning Score (NEWS). The National Institute of Clinical Excellence has also advocated the use of early warning scores.

To-date, no early warning system has been validated for pre-hospital use, however a number of UK ambulance Trusts are using different early warning score systems. The RCP report recommends that NEWS should be considered by ambulance services, to improve the communication of acute-illness severity to receiving hospitals. The Clinical and Quality Directorate has reviewed and is considering the report and the potential implications for clinical practice within the LAS.

An executive summary of the report 'National Early Warning Score (NEWS): Standardising the assessment of acute-illness severity in the NHS' is included as Appendix 2.

### **Quality Domain 4: Safety**

#### **Safeguarding**

There is a separate paper to SMG regarding the Self Assessment for Adults. However, the safeguarding lead for adults has now been appointed and will work full time until the end of the year, at which point they will work part time in the role. The Safeguarding team is currently very disparate in geography and it is imperative that this team are located within the same locality. This is currently being considered.

#### **Risk to Bariatric Patients**

There is increased focus on the Trust's ability to respond to bariatric patients, this is a particular concern where the patient is time-critical. To mitigate the risk, the Trust now ensures that there are three fully equipped and staffed PTS bariatric resources available 12

hours a day, five days a week. Out-of-hours, a bariatric response is provided by private ambulance services; however immediate availability of a resource is not always possible. A Medical Directorate bulletin was released on 15<sup>th</sup> October, which provides guidance on patient management and how to access appropriate resources.

### **NHS Central Alerting System (CAS)**

23 CAS Alerts have been released for the period 13<sup>th</sup> September - 15<sup>th</sup> November 2012. All have been acknowledged by the Trust. One alert (MDA/2012/075) identifies a risk of anaphylactic reaction to chlorhexidine (a commonly used antiseptic). The Trust currently uses chlorhexidine to cleanse skin prior to IV cannulation. An article highlighting the risk of anaphylaxis will be published in the next Clinical Update (December 2012). No other alerts required any action.

### **Locality Alert Register (formally High Risk Register)**

There are currently **469** addresses on the register, broken down as follows:

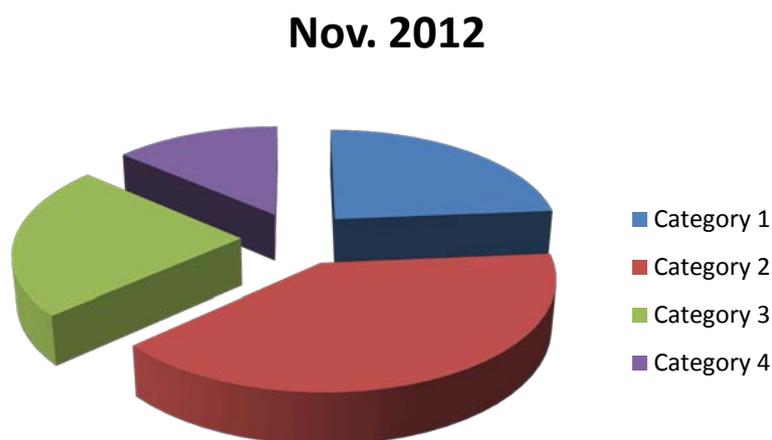
CATEGORY 1: **111**

CATEGORY 2: **186**

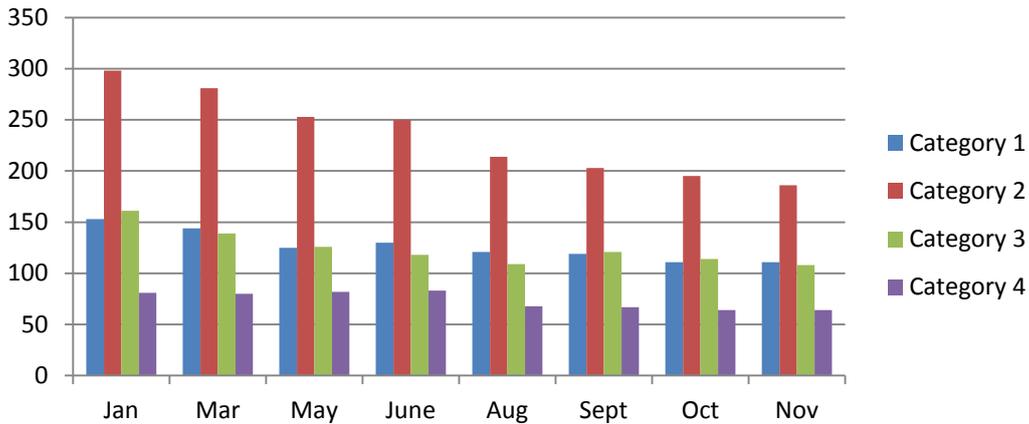
CATEGORY 3: **108**

CATEGORY 4: **64**

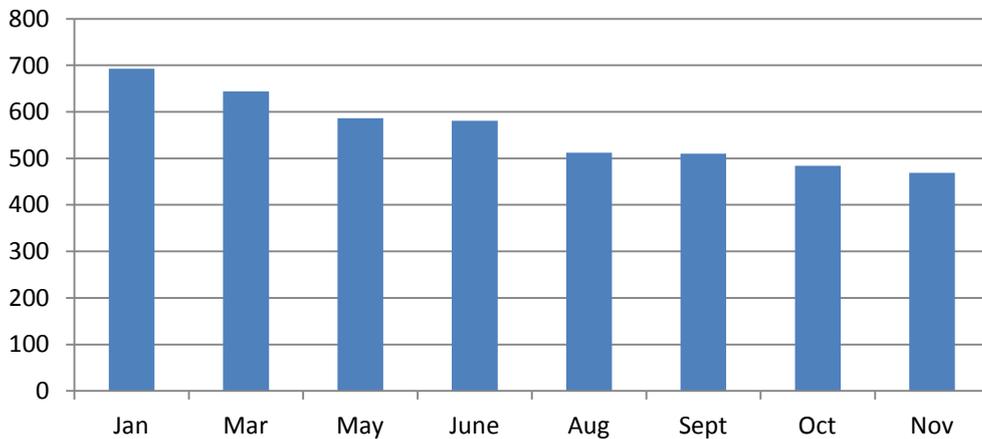
There has been a demonstrable decrease in the number of high risk addresses over the past nine months. **This is the lowest number of LAR entries since MI took over the management of the register.** The Trust has notification of 766 high risk addresses from the Metropolitan Police.



## LAR Entries by Category (2012)



## Total LAR Entries (2012)



### 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 was invoked on **29 separate occasions** and in place for a total duration of **239 hours** in October 2012.

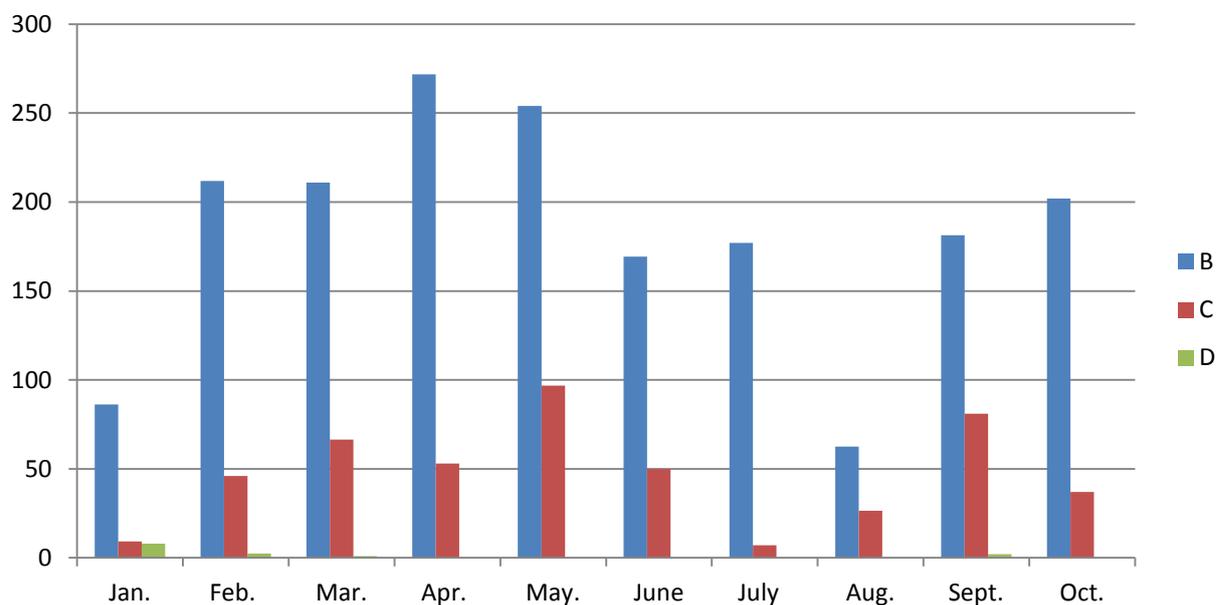
Stage **B** was in place 35 times for a total duration of **202 hours**.

Stage **C** was in place 8 times for a total duration of **37 hours**.

There was no escalation of DMP past stage C in October.

There were **319 ambulances reprioritised** in October.

### DMP use (hours) in 2012



### Medicines Management

There has been one reportable controlled drugs incident since the last Trust Board report. This occurred at Isleworth Ambulance Station. The incident involved a Paramedic who lost one of ampoules of morphine, almost certainly whilst treating a patient. The loss was reported as soon as it was discovered and a very robust investigation was undertaken by a local DSO. Unfortunately the missing ampoule was not recovered. All relevant parties were informed as per LAS policy. The NW London Controlled Drugs Local Intelligence Network (LIN) has been informed, as has the Metropolitan Police CD Liaison Officer. Local advice and guidance has been issued.

Two other incidents were reported to the LAS AO and Senior Clinical Adviser, but were not escalated to the LIN and / or Metropolitan Police CDLO, involving 'temporary' mislaying of morphine ampoules. Once again, robust investigations took place at Complex / Area level and the appropriate actions completed.

An investigation is being undertaken following the appearance of one ampoule of morphine sulphate that was discovered in a Technician Drug Pack. The pack had been returned to Logistics for re-filling on 2<sup>nd</sup> November 2012. Since the 28th September 2012, six stations have had use of this drug pack (Mottingham, Romford, North Kensington, Chase Farm, Westminster, & South Croydon). At the time of writing this report, all except South Croydon and Westminster had been contacted and morphine supplies verified / tallied etc. Investigations continue.

The Senior Clinical Advisor attended the Part one meeting of the NHS NW London Controlled Drugs Local Intelligence Network (LIN) on 20<sup>th</sup> September 2012. The purpose was to meet the new Accountable Officer for NW London and to inform the LIN of changes made to LAS CD policy and procedure. NW London LIN are satisfied with our policy and procedures.

There have been no Unannounced Visits by the Metropolitan Police.

The new presentation of sodium chloride for IV infusion is now fully in circulation, with no problems reported back to the MMG, or the Medical Directorate.

Two pertinent issues were indentified at the last Medicines Management Group meeting on 17<sup>th</sup> October 2012:

1. At the time of the meeting the LAS owed Frimley Park Pharmacy £77k in unpaid bills, (£14.5K of it unpaid at 60 -90 days and £54K at over 90 days). The problems were felt to be the new e-Proc system. Work has been undertaken by Logistics with ELFS and Frimley Park to expedite the matter and it now appears to have been resolved.
2. Supplies of atropine 1mg / 10ml manufactured by Mini-Jet will become limited until March / April 2013. Therefore it has been agreed with Frimley Park Pharmacy to purchase a product made by Aurum which is 1mg / 5ml, (This is the fall back presentation and has been used by LAS before). If the Trust needs to use this presentation, a note will be placed in the drug packs warning staff.

### **Rule 43 Reports**

The Trust has not received any new Rule 43 reports.

### **Quality Domain 5: Clinical Outcomes**

Nothing to report.

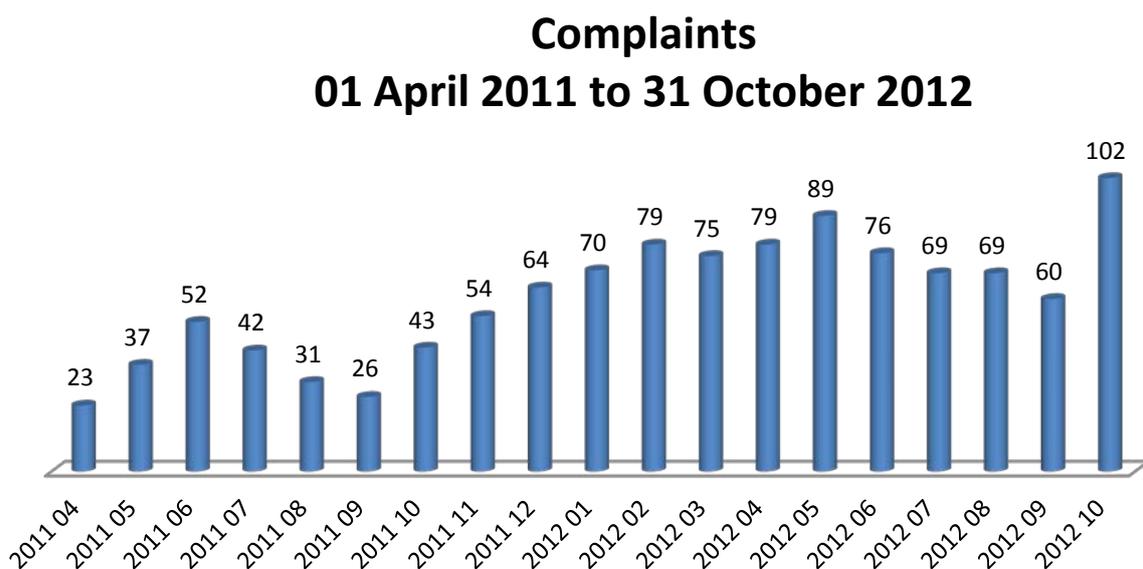
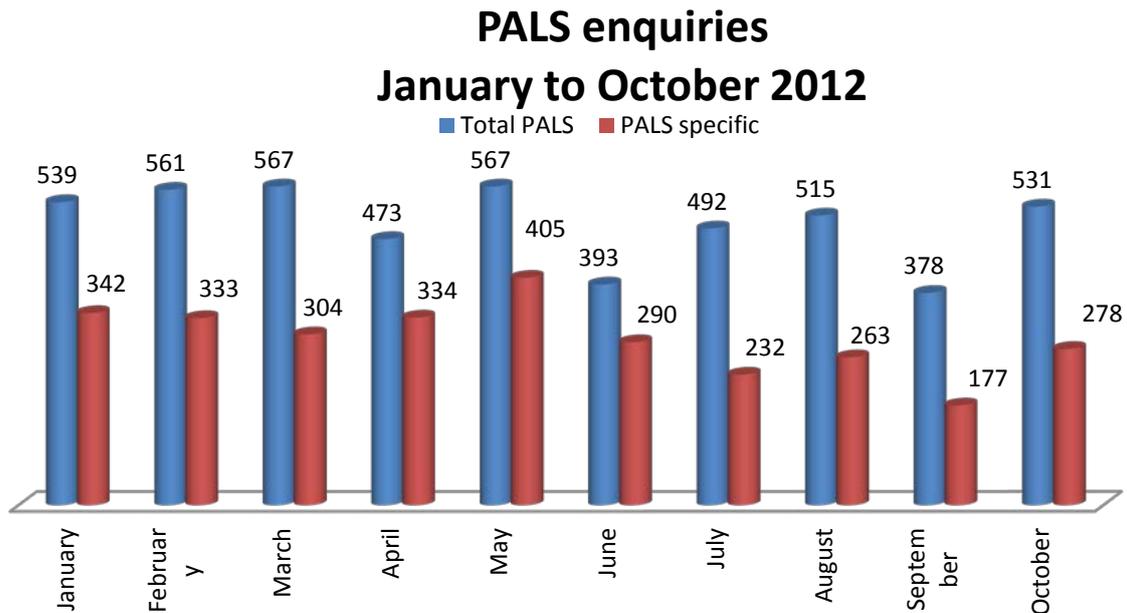
### **Quality Domain 6: Dignity**

Nothing to report.

## Quality Domain 7: Satisfaction

### Complaints

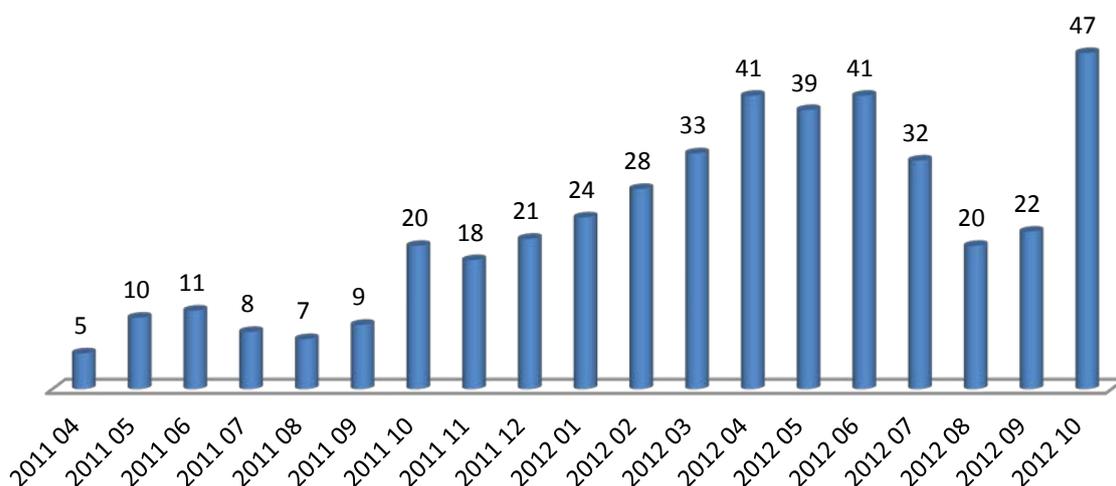
PALS has seen a 29% increase in activity, including a 36% increase in PALS specific cases. Complaints reached an all time high of 102 (+41% compared with September). Although call rates for the month were only 2% higher than previous months. The following two graphs illustrate the rise in both PALS and Complaints volume during the course of the year.



## Delay

The main driver for the rise appears to be delay. The number of complaints that the Trust is receiving for complaints relating to a delay has increased considerably. The following graph illustrates a drop for the Olympic period but an increase over time.

**Complaints recorded with delay as the key concern  
01 April 2011 to 31 October 2012**



There is also a change in that an increased number of the complaints about delay are about a real delay rather than the ambulance taking longer than the public believe it should. The issue of delay is clearly closely monitored and cases are frequently explored for analysis by the staff members in EOC.

An analysis of the complaints where delay is the key theme is as follows:

<b>Delay complaints</b>			
<b>DMP in place</b>	<b>Number</b>	<b>Category of call</b>	<b>Number</b>
DMP A	16	Red	2
DMP B	21	C1	1
DMP C	7	C2	24
Other (not coded)	3	C3	8
		C4	9
		Other (further details awaited)	3
<b>Total</b>	<b>47</b>		<b>47</b>

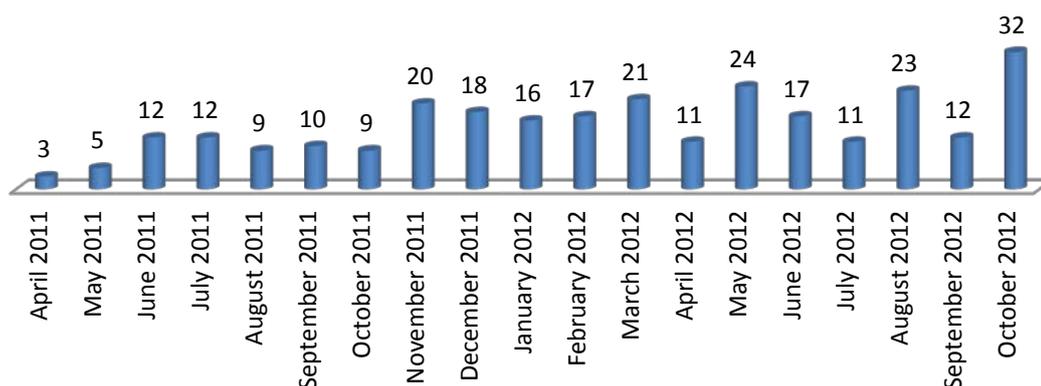
Note: The DMP stage in place does not necessarily correlate to the category of the call that is the subject of the complaint.

The emergency theme is that the Trust is more likely to receive a complaint about the delay in an ambulance attending when the call is triaged at C2 and/or DMP B is in place. One complaint (C7359) relates to the delay in dispatching an ambulance to a Red 2 call when DMP C was in place. The family have a child with an ongoing condition and had been advised by the hospital to take the child to hospital as soon as possible. A doctor attended the family home and after waiting over an hour for an ambulance, a decision was made in conjunction with the doctor to convey the child by car. PED are assisting the Acute Trust who are hosting the complaint.

### Attitude & Behaviour

When looking deeper into complaint themes there is little variation from month to month with attitude and behaviour being cited as the second most common theme. In October there were 32 complaints regarding attitude and behaviour. The following graph reveals the trend in those complaints with attitude and behaviour as their main theme.

**Complaints where Attitude and behaviour is the key concern  
01 April 2011 to 31 October 2012**



Whilst there is a small rise in October this is not significant at this stage with the chart showing no overall trend. Therefore this theme remains fairly static.

However, this month the team have broken the attitude and behaviour complaints into themes and the following table illustrates the main issue.

Complaints where attitude and behaviour were cited	Total
Attitude	69
Inappropriate Comments	52
Lack of concern/compassion	48
Behaviour	46
Rudeness or obscene comments to patient/family/public	27
Other issues (wrong hospital, refusal to carry patient, DMP etc)	25
Alleged delay	18

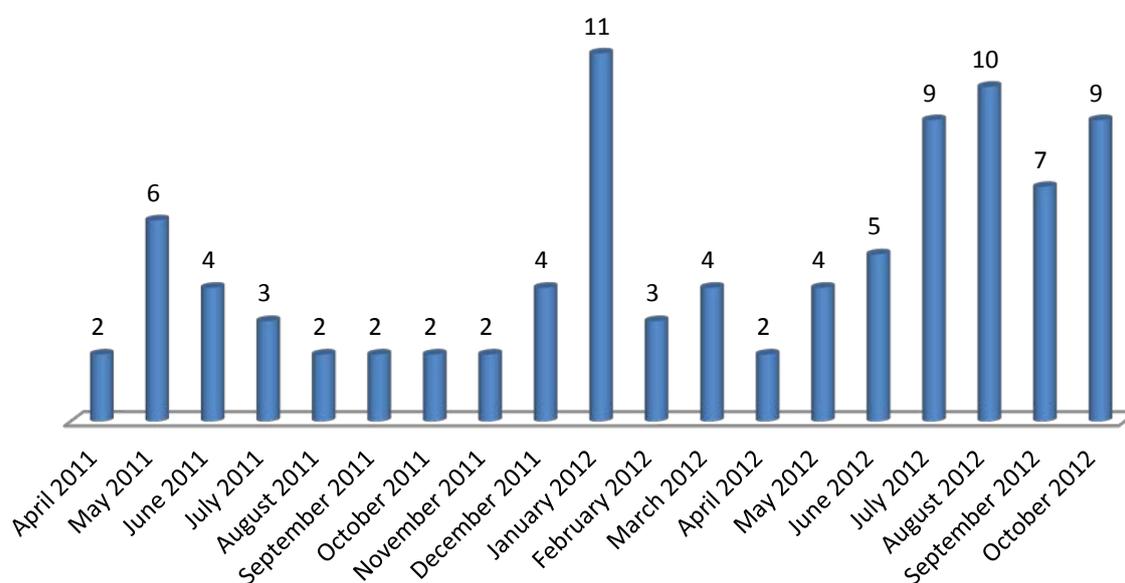
No/poor communication	17
No / inappropriate clinical assessment	15
Not listening to wishes of patient/family	9
Call not re-triaged	6
Inappropriate walking of patient	6
Geriatric	5
Reluctant to convey to hosp. or tried to persuade not to attend	4
Rudeness to other health care professionals	4
<b>Total where sub subject recorded</b>	<b>351</b>

All the complaints regarding attitude and behaviour are specifically drawn to the attention of the Assistant Directors of Operations for their personal consideration and for them to undertake any potential linking of cases. The Director of Health Promotion & Quality also takes an interest in those cases that are of most concern.

### Road Handling

The third most frequent theme is road handling. There were 9 complaints in October regarding road handling.

### Complaints where road handling was the key concern 01 April 2011 to 31 October 2012



The LAS has a robust driver training programme for all operational staff to ensure the safety of patients, the public, and themselves when driving to emergencies and transporting patients to hospital. The Trust is responsible for promoting safe driving practice and our driving courses are conducted to national standards.

Ambulance staff are given detailed information on exemptions from road laws appropriate to the ambulance service work and any incidents of drivers speeding or running on red lights are generally reported to the Service by the Metropolitan Police Service. Driving standards are outlined in Trust Policy TP065 'Conduct on the Road Procedure'.

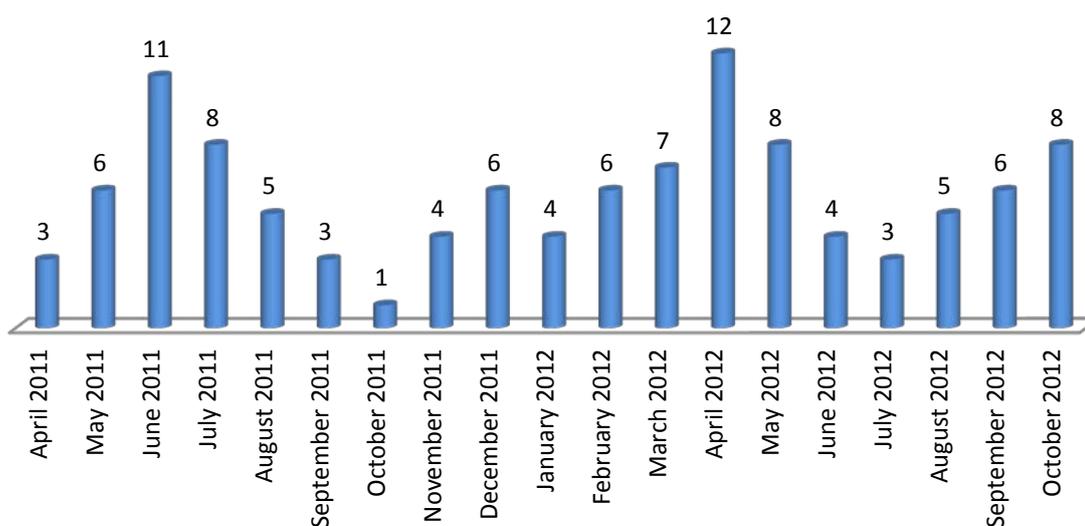
However, despite such preventative measures, recently we have seen a marked increase in the numbers of complaints involving driving incidents.

During the period 01 April 2008 to 31 October 2012 there have been 196 complaints about driving standards.

### Non Conveyance

Finally, the fourth most frequent reason is regarding Non-Conveyance. In October there were 8 complaints regarding non conveyance. The following graph illustrates the trend over time.

**Complaints regarding non-conveyance issues  
01 April 2011 to 31 October 2012**



2 complaints related to referrals to NHS Direct where DMP was in place and the patient was advised to make their own way to hospital (C7289 and C7354). The following table illustrates the complaints about non conveyance regarding capacity pressure and category of call.

Non conveyed			
DMP in place	Number	Category of call	Number
DMP A	5	C2	1
DMP B	2	C3	2
DMP C	1	C4	4

		Other	1
<b>Totals</b>	<b>8</b>		<b>8</b>

### **Ombudsman**

No case records were requested by the Ombudsman in October.

### **Serious Incidents**

One case was declared as a Serious Incident and involves the transfer of a patient from one hospital to another. a number of health care providers. The SI outcome report is currently awaited (C7343).

### **Closure Rate**

At the completion of the Olympic Games, the dept has renewed management team availability and better monitoring and an encouraging case review focus by officers has brought about an improved closure rate during October.

<b>Complaints closed January to October 2012</b>	<b>Total</b>
January	60
February	59
March	55
April	67
May	88
June	74
July	80
August	105
September	45
October	90
<b>Totals:</b>	<b>723</b>

As at 6 November a total of 135 complaints remain open or re-opened following a further approach from the complainant after the substantive response has been completed.

## PALS Themes

The following table reveals the most frequent issues being raised at a PALS level.

<b>October PALS</b>	<b>Numbers</b>
Information/Enquiries	181
Medical Records	153
Lost Property	61
Safeguarding Children	44
Safeguarding Adults	38
Frequent Callers	16
Clinical	5
Delay	5
Policy/ Procedure	4
Access	3
Communication	3
Conveyance	3
External Incident Report – EOC	3
Incident Report – Other	3
Appreciation	2
Incident Report - GP Surgery	2
Request for Witness Statement	2
Non-physical abuse	1
Explanation of Events	1
Other	1
<b>Total</b>	<b>531</b>

Of the 61 lost property enquiries, only 9 items were found (15%). A revised process has been prepared that will be rolled out in November 2012. Other Ambulance Trusts have expressed an interest in the SMART bags and the process used by LAS.

### **Other activity:**

The head of Department and the AOM Control services gave a presentation at HMC.

Departmental managers attended a national conference outlining proposed changes to the complaints procedure.

## 2. Quality Priorities

### Mental Health

There are currently two external reviews being conducted regarding mental health in which we are participating.

- 1) Section 136 Review. This has been commissioned by the CEO for Mental health group and is aimed at scoping the issues and developing some pan London and local agreements.
- 2) Review of Death in Custody. We have been asked to participate in the Met Review of deaths in custody. We remain unsighted on the scope of this project but have been asked to share our policies with the reviewers.

## 3. Clinical Audit & Research (CARU)

Two clinical audit reports have been published in September and November 2012.

### **Clinical audit of patients conveyed to Kingston Emergency Department by the London Ambulance Service that may have been suitable for an alternative care pathway (September 2012)**

This clinical audit aimed to identify whether LAS ambulance staff are conveying ACP suitable patients to the most appropriate destination. Specifically, this clinical audit aimed to establish whether patients conveyed to Kingston Hospital ED may have been suitable for treatment at the nearby Queen Mary's Hospital MIU. From 9th to 15th May 2011 259 patients were conveyed to Kingston Hospital ED during Queen Mary's Hospital MIU opening hours. Of these, 95 patients were identified as presenting with an illness or injury suitable for conveyance to an MIU. A clinical review of the patient report forms was completed to determine if the patient's clinical condition was suitable for treatment by an MIU and if the staff skill level allowed for this decision making. The location of the patient was also considered.

Of the 95 patients identified as having an illness or injury suitable for conveyance to an MIU, nine were referred to Kingston Hospital by another healthcare professional. Of the remaining 86 patients, clinical review of the patient report form revealed only nine (10%) patients had an injury or condition that could have been treated at the MIU. Further investigation of the location of these nine patients showed all were closer to Kingston Hospital than to the MIU.

This clinical audit found every patient in the sample was appropriately conveyed to Kingston ED. Most patients' clinical condition was not appropriate for treatment at the MIU, however there was a small number of patients who could have been treated at the MIU but were closer to Kingston Hospital.

## **Clinical audit of immediate inter-hospital transfers by the London Ambulance Service (November 2012)**

### **Background**

In addition to responding to 999 calls from members of the public in an emergency situation, the London Ambulance Service NHS Trust (LAS) also transfers patients between hospitals and other healthcare locations. This clinical audit concentrates on immediate inter-hospital transfers (when a patient is being transferred for life or limb saving treatment). Calls triaged as an immediate inter-hospital transfer require an ambulance response within one hour of the call and, depending on the clinical condition of the patient, may require an ambulance crew of a particular skill level.

There is a potential clinical risk when ambulance crews are dispatched to an immediate inter-hospital transfer without the appropriate skills to manage the patients' clinical condition. Therefore this clinical audit was undertaken to assess the potential clinical risk and other anecdotal concerns resulting from discussions between Emergency Medical Dispatchers (EMDs) and hospital staff as to: what constitutes an immediate inter-hospital transfer; whether a Health Care Professional (HCP) escort from the hospital should accompany the patient, and which transfers should be undertaken by the LAS and which should be undertaken by the hospitals' contracted Patient Transfer Service (PTS).

### **Methodology**

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

### **Results**

There was a wide variation in the frequency of questions asked by EMDs during the calls. Despite this variation, 90% of calls were still correctly categorised as an immediate inter-hospital transfer. The length of the calls ranged from 2 minutes 19 seconds to 24 minutes 22 seconds, with longer calls often resulting from a further discussion with the Clinical Support Desk (CSD). CSD provided advice for 61% of calls in the sample, however there was no documentation on the CSD log of the advice provided during 28% of these calls.

The LAS dispatched an ambulance crew with the appropriate skill level based on the patients' reported condition for 91% of calls and the ambulance arrived within one hour of the call in 82% of the immediate inter-hospital transfers, thereby meeting the time target for this patient group.

52% of patients had two full sets of observations documented. An additional 24% of patients had one full set of observations documented. For the remaining 24% of patients at least one full set of observations was not documented. If an HCP escort accepts primacy of care, their name, position and confirmation of accepting primacy should be recorded on the patient report form. This was only documented for one patient.

## Recommendations

- All required information is sourced during the initial call to enable correct call categorisation and resource allocation by working with other UK ambulance services to review suitability of protocol 35 for usage in assessing inter-hospital transfers and communicating to EMDs the importance of following protocols
- The Clinical Support Desk record all advice given and escalate calls appropriately to an on-call advisor when necessary
- Hospital staff are aware of the LAS criteria for inter-hospital transfers and their responsibility to escort the patient by reviewing and reissuing the inter-hospitals transfers flowchart
- EOC call-takers, call-taking managers, Operation Centre Managers and CSD staff are updated of ongoing changes by ensuring training documents are reviewed, updated and issued to reflect relevant changes in the transfer process
- Ambulance crews are aware of the importance of undertaking and documenting two sets of full observations for hospital transfer patients. An article for the Clinical Update should be written and a poster issued to ambulance stations to raise awareness
- Recommendations evidencing improvements in patient care by conducting a re-audit

## 4. Rising Tide

Nothing to report.

## 5. Cost Improvement Programme

A new process has been designed to provide structured reports to the Quality Committee for CIP. CIP monitoring for 2012-13 will be undertaken via assurance statements provided by the clinical lead for each initiative, identifying any actual or potential adverse effect on clinical care and any monitoring processes that are in place.

## 6. Other areas

Nothing to report.

**Fionna Moore**  
Medical Director

**Steve Lennox**  
Director of Quality & Health Promotion

**16<sup>th</sup> November 2012**

PHYSIOLOGICAL PARAMETERS	3	2	1	0	1	2	3
Respiration Rate	≤8		9 - 11	12 - 20		21 - 24	≥25
Oxygen Saturations	≤91	92 - 93	94 - 95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0		35.1 - 36.0	36.1 - 38.0	38.1 - 39.0	≥39.1	
Systolic BP	≤90	91 - 100	101 - 110	111 - 219			≥220
Heart Rate	≤40		41 - 50	51 - 90	91 - 110	111 - 130	≥131
Level of Consciousness				A			V, P, or U

\*The NEWS initiative flowed from the Royal College of Physicians' NEWSDIG, and was jointly developed and funded in collaboration with the Royal College of Physicians, Royal College of Nursing, National Outreach Forum and NHS Training for Innovation.



Training for Innovation

NEW scores	Clinical risk
0	Low
Aggregate 1–4	
<b>RED score*</b> (Individual parameter scoring 3)	Medium
Aggregate 5–6	
Aggregate 7 or more	High

## Executive summary

### Background

Early detection, timeliness and competency of clinical response are a triad of determinants of clinical outcome in people with acute illness. Numerous recent national reports on acute clinical care have advocated the use of so-called ‘early warning scores’ (EWS), ie ‘track-and-trigger systems’ to efficiently identify and respond to patients who present with or develop acute illness. A number of EWS systems are currently in use across the NHS, however, the approach is not standardised. This variation in methodology and approach can result in a lack of familiarity with local systems when staff move between clinical areas/hospitals – the various EWS systems are not necessarily equivalent or interchangeable. Put simply, when assessing acutely ill patients using these various scores, we are not speaking the same language and this can lead to a lack of consistency in the approach to detection and response to acute illness. This lack of standardisation also bedevils attempts to embed a culture of training and education in the assessment and response to acute illness for all grades of healthcare professionals across the NHS. Building upon recommendations in the RCP’s Acute Medicine Task Force report *Acute medical care: the right person, in the right setting – first time*, published in 2007, the RCP commissioned a multidisciplinary group to develop a National Early Warning Score (NEWS).

### Remit

The remit of this group was to develop a NEWS system that could be adopted across the NHS to provide a standardised track-and-trigger system for acute illness in people presenting to, or within hospitals. The remit also included the need for recommendations on the urgency of the clinical response required, the clinical competency of the clinical responders and the most appropriate environment for ongoing clinical care, according to the NEWS.

### National Early Warning Score

The NEWS, like many existing EWS systems, is based on a simple scoring system in which a score is allocated to physiological measurements already undertaken when patients present to, or are being monitored in hospital. Six simple physiological parameters form the basis of the scoring system:

- i) respiratory rate
- ii) oxygen saturations
- iii) temperature
- iv) systolic blood pressure
- v) pulse rate
- vi) level of consciousness.

A score is allocated to each as they are measured, the magnitude of the score reflecting how extreme the parameter varies from the norm. The score is then aggregated. The score is uplifted for people requiring oxygen. It is important to emphasise that these parameters are already routinely measured in hospitals and recorded on the clinical chart.

## Evaluation of NEWS

During its development, the NEWS was evaluated against a variety of other early warning systems currently in use. NEWS was shown to be as good at discriminating risk of acute mortality as the best of existing systems and better than others. Furthermore, at the recommended trigger levels for a clinical alert, NEWS is more sensitive than most existing systems. This means NEWS will provide an enhanced level of surveillance and clinical review of patients with greater specificity in identifying those at risk of clinical deterioration. Experience of the use of NEWS in clinical practice will allow ongoing evaluation of its performance and refinement, if required.

## Using NEWS

This report advocates that the NEWS should be used to standardise the assessment of acute-illness severity when patients present acutely to hospital and also in the prehospital assessment ie by primary care and the ambulance services. It is also recommended that the NEWS is used as a surveillance system for all patients in hospitals, tracking their clinical condition, alerting the clinical team to any clinical deterioration and triggering a timely clinical response.

## The NEWS clinical observations chart

To facilitate standardisation and a national unified approach, a colour-coded clinical chart has been developed which we propose is used across the NHS to record routine clinical data and track a patient's clinical condition. This tracking system will alert the clinical team to any untoward clinical deterioration and also clinical recovery. This in turn should determine the urgency and scale of the clinical response.

## Clinical response to NEWS

Depending on the NEWS score, the report provides recommendations for the frequency of clinical monitoring, the urgency of clinical review and the competency requirements of the clinical team needed to undertake that review. The report emphasises the importance of ensuring that acute care response teams with the appropriate competencies in acute clinical care are clearly defined, free of other clinical responsibilities and available 24/7 in acute hospitals. Furthermore, for those patients with the highest NEWS score, ie the most seriously ill, the report provides recommendations regarding the most appropriate clinical environment for ongoing critical care.

The NEWS provides the basis for a unified and systematic approach to the first assessment of acutely ill patients and a simple track-and-trigger system for monitoring clinical progress for all patients in hospitals. This is allied to recommendations on the urgency and competency of the clinical response, as well as the most appropriate environment for ongoing care of the most acutely ill patients. In so doing, the NEWS provides a template for the staff and infrastructure requirements for modern acute clinical care.

## NEWS and training and education

The NEWS provides the basis for standardising the training and credentialing of all staff engaged in the care of patients in hospitals and the prehospital assessment of patients. We recommend that this should also be extended to undergraduate education of medical, nursing and allied healthcare professionals.

## **NEWS, national clinical outcomes data and research and innovation**

Finally, adopting NEWS nationally would also provide valuable standardised data on regional variations in illness severity and resource requirements, as well as objective measurements of illness severity and clinical outcomes – the latter providing an invaluable research resource to evaluate the efficacy of new systems of care and interventions.

## **Conclusion**

The key message from this report is the potential for the NEWS to drive a step change improvement in safety and clinical outcomes for acutely ill patients in our hospitals by standardising the assessment and scoring of simple physiological parameters and adopting this approach across the NHS.



**LONDON AMBULANCE SERVICE TRUST BOARD**

**DATE: 27<sup>TH</sup> NOVEMBER 2012**

**PAPER FOR NOTING/APPROVAL**

<b>Document Title:</b>	<b>Quality Committee Assurance Report</b>
<b>Report Author(s):</b>	<b>Beryl Magrath, Chair of the Quality Committee</b>
<b>Lead Director:</b>	<b>N/A</b>
<b>Contact Details:</b>	
<b>Why is this coming to the Trust Board?</b>	<b>To understand the topics of discussion at the Quality Committee and the issues as well as gaining assurance from the committee</b>
<b>This paper has been previously presented to:</b>	<input type="checkbox"/> Strategy Review and Planning Committee <input type="checkbox"/> Senior Management Group <input type="checkbox"/> Quality Committee <input type="checkbox"/> Audit Committee <input type="checkbox"/> Clinical Quality Safety and Effectiveness Committee <input type="checkbox"/> Risk Compliance and Assurance Group <input type="checkbox"/> Learning from Experience Group <input type="checkbox"/> Finance and Investment Committee <input type="checkbox"/> Other
<b>Recommendation for the Trust Board:</b>	<b>To take assurance from the report on the governance of quality and safety</b>
<b>Key issues and risks arising from this paper</b>	
N/A	
<b>Executive Summary</b>	
<p>The last meeting of the Quality Committee took place on 24<sup>th</sup> October and the attached report provides a summary of the meeting. It is also intended to provide assurance to Board members on the quality and safety of services.</p> <p>One red flag issue was raised and this was then reflected in the Audit Committee on 5<sup>th</sup> November. There is no specific evidence that the quality and safety of service is being detrimentally affected however there are growing concerns that the combined effect of DMP, CIP, cancelled training and delays is causing pressure on resourcing and capacity.</p> <p>The remainder of the report provides assurance based on the feedback from committees. Of note are:</p> <ul style="list-style-type: none"> <li>a) Clinical Audit Annual Report</li> <li>b) CPI monitoring</li> <li>c) NHSLA level 1</li> <li>d) Locality alert register</li> </ul>	

## Attachments

Report from the Quality Committee held on 24<sup>th</sup> October 2012.

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### Quality Strategy

This paper supports the following domains of the quality strategy

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

### Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

### Risk Implications

This paper supports the mitigation of the following strategic risks:

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

### Equality Analysis

Has an Equality Analysis been carried out?

- Yes
- No

Key issues from the assessment:

## Report from the QC following the meeting held on 24<sup>th</sup> October 2012

### Overview

The red flag raised at the meeting concerned the combined effect of all the CIP projects. Delay, cancelled training and use of DMP mean that the Directors who countersign the package of CIP projects cannot support a further reduction in clinical headcount until systems and processes have been maximised to release capacity. At present there is no concrete evidence that quality and safety have been jeopardised, but the rising Category A and the removal of posts is, at times, having an impact on resourcing. The implementation of DMP is managing the risk at the time, but this impacts particularly on Category C patients

### Quality Indicators

#### Introduction

This report covers the Olympic period and is the strongest since its implementation. In the National Ambulance Quality Indicators the LAS is in the upper quartile for 13 out of 22 indicators and in the bottom quartile for 3 out of 22 indicators.

Using the June 2012 Quality Dashboard Indicators, the following give cause for concern:

1. The percentage of staff CPI audit feedback sessions which has improved from 72.5% in June to 79.4% in June-target is 95% (CO5 & CO6)
2. There was a major increase in 3<sup>rd</sup> party providers, which was planned & associated with the Olympics (CO1, CO2 & CO5)
3. Despite the additional support from other Services and 3<sup>rd</sup> party providers the Category C1 & C2 response times had improved, Category C3 only achieved a 77.9% response-target 90%. The Category C action plan will be available by the end of November.
4. No hospital achieved 100% turnaround time within 15 minutes, particularly poor in ONEL & SEL and worst in Croydon (CO1 & CO2)
5. Missing documentation continues to be an issue and may be related to inaccurate data recording

The Quality Committee received assurance from :

1. CQSEC-The subgroups are making progress against their work plans
2. The RSM Tenon work plan following the Quality Governance Review is being implemented
3. The Clinical Audit Annual Report covered the whole spectrum of work undertaken by CARU. In the last two years:

- 14 clinical audits have been done,

- The routine monitoring of CPIs and feed-back given
  - National Performance Indicators
  - ASCQI
  - MINAP
  - Clinical audit training in audit & research
  - Research
  - T/L training
4. Progress report on clinical audits
  5. Progress report from Internal Audit
  6. Quality Risk Profile triangulates with the Quality Dashboard
  7. The achievement of NHSLA Level 1. The LAS was found to be compliant with 50 out of 50 risk management standards. There is also good evidence in place for Level 2, which will be undertaken within the next year
  8. RCAG. The BAF has been updated. The reporting groups are making progress with work plans
  9. The High Risk Register (Locality alert register) now has the fewest number of flagged addresses. Letters are being written to individuals on the HRR. 10 complaints have been received. There remains a problem with MPS flagged addresses. A HRR workshop highlighted the real risk of violence to our staff involving weapons. The HRR policy is being reviewed by the ADG



## LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 27<sup>TH</sup> NOVEMBER 2012

### GOVERNANCE

<b>Document Title:</b>	<b>Board Assurance Framework – Q3 – October – December 2012</b>
<b>Report Author(s):</b>	<b>Sandra Adams</b>
<b>Lead Director:</b>	<b>Sandra Adams</b>
<b>Contact Details:</b>	<b>Sandra.adams@lond-amb.nhs.uk</b>
<b>Why is this coming to the Trust Board?</b>	<b>Good governance – providing assurance to the Trust Board on the identification and management of risk and the sources of assurance that these are effective.</b>
<b>This paper has been previously presented to:</b>	<input type="checkbox"/> Strategy Review and Planning Committee <input type="checkbox"/> Senior Management Group <input type="checkbox"/> Quality Committee <input type="checkbox"/> Audit Committee <input type="checkbox"/> Clinical Quality Safety and Effectiveness Committee <input type="checkbox"/> Risk Compliance and Assurance Group <input type="checkbox"/> Learning from Experience Group <input type="checkbox"/> Finance and Investment Committee <input type="checkbox"/> Other
<b>Recommendation for the Trust Board:</b>	<b>To review the key risks and mitigations in place to manage these and to confirm whether there is sufficient assurance in place for these.</b>
<b>Key issues and risks arising from this paper</b> a) No new risks added in the quarter b) No risks closed in the quarter c) One key themed risk is still being articulated and assessed – Category C response d) The CQC undertook an unannounced compliance inspection against 4 outcomes e) There are greater links now between the BAF risks and the sources of assurance.	
<b>Executive Summary</b> The commentary on page 1 highlights that there were no risks opened or closed during the quarter however there are risks still to be identified – the level and quality of service provided to category C calls, and the governance of the locality alert register. Two risks with a more strategic element were identified by the Audit Committee and supported by the Trust Board, concerning the changes within the Trust’s governance arrangements. These have been articulated and assessed and, although neither reaches the threshold for inclusion in the BAF, they can be kept visible through the BAF. A key source of assurance about the controls in place to manage any anticipated effect will be the independent review of the board governance assurance framework in March/April 2013.  The CQC undertook an unannounced compliance inspection on 14 <sup>th</sup> November and the draft report is expected by week ending 23 <sup>rd</sup> November. This will provide a key source of assurance of the effectiveness of the controls in place to manage safety, quality and risk and the report should be available for the Quality Committee to review on 11 <sup>th</sup> December.	

**Attachments**

**Board Assurance Framework – November 2012**

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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**

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**Risk Implications**

This paper supports the mitigation of the following strategic risks:

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

**Equality Analysis**

Has an Equality Analysis been carried out?

- Yes
- No

Key issues from the assessment:

## Board assurance framework November 2012

**The Board Assurance Framework (BAF)** comprises the principal risks facing the Trust in 2012/13 and looking ahead within the strategic period 2012-17 thereby mirroring the integrated business plan. The BAF is structured as follows:

**Section A:** Trust Vision – strategic goals – corporate objectives – strategic risks

**Section B:** The key risk themes identified by the Trust Board for focus over the next two years. This section now includes the sources of assurance.

**Section C:** Key sources of assurance common to most corporate risks

**Section D:** The principal risks with relevant controls, assurances, gaps and action planned, each mapped to the corporate objectives and the requirements of the Care Quality Commission. Principal risks as defined here are those that have a gross severity rating (likelihood x impact) of >20, and a corresponding net rating of >15 as at 2<sup>nd</sup> November 2012.

### Commentary:

#### Risks closed since Q2 BAF:

There were no risks closed on the BAF.

#### Risks opened in Q3 BAF:

There are no new risks on the BAF in this quarter.

The Audit Committee and then the Trust Board raised the issue of risks associated with the foundation trust application process, specifically relating to changes to the Trust Board and the impact of changes on the ownership of the strategy. These risks were articulated by the Director of Corporate Services based on the Audit Committee discussion. These were tied into the FT application project risk register before being assessed and agreed by the Risk Compliance and Assurance Group on 8<sup>th</sup> October.

**Risk 369:** there is a risk that the governance of the Trust may be adversely affected by changes at Trust Board level. Gross impact – Major/Gross likelihood – Possible = 12.

**Risk 370:** there is a risk that the development and sign off of the 5-year strategy may be impeded by changes within key board roles. Gross impact – Major/Gross likelihood – Possible = 12.

These risks have been included in the Tripartite Formal Agreement that has been signed off by the cluster and is currently with NHS London. Neither risk is incorporated in the BAF as they do not reach the threshold however they are included here to ensure board visibility. Both risks are supported by mitigating actions and these can be reviewed on page 10 of the risk register. Further assurance will be gained when the board governance assurance framework review is refreshed in March 2013.

#### Risks identified but not yet fully articulated:

Category C – the potential impact of demand on the level and quality of service provided to urgent care patients.

Locality Alert Register (LAR) – formerly known as the High Risk Register: the Trust Board can take assurance that a number of risks have now been identified and articulated as part of the governance processes being developed to manage the LAR. These were reviewed by RCAG in October and require further definition and review of the risk grading. It is likely that several will have a gross rating of >15 and therefore appear in the Q4 BAF.

## **Board assurance framework November 2012**

All operational risks on the corporate/trust registers were reviewed by RCAG in July 2012. Those operational risks on the BAF have existed for several years and are still 'live'. This indicates a level of tolerance of risks and the RCAG recommended keeping these visible for the foreseeable future. The Trust risk register was fully updated in September 2012. The risk module on Datix (risk management system) will be implemented in January 2013 from which risk reports will in future be generated. The module allows local risk registers to be linked to the corporate risk register and BAF thereby bringing greater integration in risk reporting.

The CQC undertook an unannounced compliance review on 14<sup>th</sup> November 2012. This was focused on 4 outcomes: Consent; Care and Welfare of people who use services; Staffing; and Assessing and monitoring the quality of service provision. The inspectors also asked for evidence of specific actions that we had been taking for Infection Prevention & Control and Safeguarding. The draft report is due with the Trust in the week ending 23<sup>rd</sup> November. Following factual accuracy checking the final report should be available for the Quality Committee on 11<sup>th</sup> December. This will be a key assurance report.

The BAF now includes more substantial information about assurances. The key sources of assurance are indicated in Section C and this has been followed through into Section B – Risk themes – and against each of the risks on the BAF. This allows board members to see where they should be able to seek assurance on the management and mitigation of key risks.

Risks are monitored by the Risk Compliance and Assurance Group (RCAG) throughout the year and can only be added, amended or downgraded and removed from the corporate risk register on presentation to and approval by the RCAG. The Quality Committee will review the BAF and corporate risk register during the year and the Audit Committee will review the effectiveness of the control systems in place to manage risk.

**Board assurance framework  
November 2012**

**Section A**

**Trust Vision: '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.'**

<b>Strategic Goal 1</b>	<b>To continually improve our delivery of safe and high quality patient care using all appropriate pathways</b>
<b>Strategic Goal 2</b>	<b>To have staff who are skilled, confident, motivated and feel valued and who work in a safe environment</b>
<b>Strategic Goal 3</b>	<b>To be efficient and productive in delivering our commitments and to continually improve</b>

**This is then translated into the strategic goals and corporate objectives covering the period 2012-2017.**

<b>Strategic Goal</b>	<b>Key Corporate Objectives</b>	<b>Abbrev.</b>	<b>Strategic risk</b>
<b>Improve the quality of care we provide to patients</b>	To improve outcomes for patients who are critically ill or injured	CO1	1 & 2
	To provide more appropriate care for patients with less serious illness and injuries	CO2	1 & 2
	To meet response time targets routinely	CO3	1 & 2
	To meet all other regulatory and performance targets	CO4	2 & 4
<b>Deliver care with a highly skilled and representative workforce</b>	To develop staff so they have the skills and confidence they need to deliver high quality care to a diverse population	CO5	1
	To create a productive and supportive working environment where staff feel safe, valued and influential	CO6	All
<b>Deliver value for money</b>	To use resources more efficiently and effectively	CO7	3

**Board assurance framework  
November 2012**

Strategic Goal	Key Corporate Objectives	Abbrev.	Strategic risk
	To maintain service performance during major events, both planned and unplanned, including the 2012 Games	CO8	1, 2 & 3
	To improve engagement with key stakeholders	CO9	4

		Strategic Goals			Risk themes
		1. To improve the quality of care we provide to patients – improving our delivery of safe and high-quality care using all appropriate pathways	2. Deliver care with a highly-skilled and representative workforce – having staff who are skilled, confident, motivated, feel valued and who work in a safe environment	3. Deliver value for money – being efficient and productive in delivering our commitments to continually improve	
Strategic Risks	1. There is a risk that we fail to effectively fulfill responsibilities to deliver high quality and safe care	Strong link	Strong link	Strong link	BAU risks – quality Cat C and non-conveyance Clinical supervision and training Obstetrics
	2. There is a risk that we cannot maintain and deliver the core service along with the performance expected	Strong link	Moderate link	Strong link	BAU risks – performance; quality; finance Demand management

**Board assurance framework  
November 2012**

		Strategic Goals			Risk themes
	3. There is a risk that we are unable to match financial resources with priorities	Strong link	Moderate link	Strong link	BAU risks – financial; quality
	4. There is a risk that our strategic direction and the pace of innovation to achieve this are compromised	Strong link	Moderate link	Strong link	Cat C and non-conveyance

**Board assurance framework  
November 2012**

**Section B: risk themes**

**The Trust Board reviewed the risk focus areas (themes) and identified the following for focus in the next two years:**

Strategic Risk	Causes	Risk focus BAF Yes/No	Mitigating actions	Sources of assurance
<p><b>1.</b> There is a risk that we fail to effectively fulfill responsibilities to deliver high quality and safe care.</p>	<p>Failure to recognise specific and serious clinical issues; staff not receiving clinical training and development which impacts on their ability to carry out their role effectively;</p>	<p><b>Themes:</b> Category C and non-conveyance; Obstetrics; Clinical supervision, education and training. <b>BAF? Yes:</b> Risk 31 – maternity care; Risk 355 – clinical and non-clinical mandatory training; Risk 22 – comprehensive assessment/non-conveyance; <b>BAF? No:</b> Impact on Category C patients of meeting 75% Category A within the context of rising demand.</p>	<p>Programme of clinical and non-clinical mandatory training supported by PDR/OWR and clinical supervision; Review of incidents and complaints so that errors are addressed and learnt from; Networking with maternity units; Partnership working within the local health economy to manage capacity and direct responses accordingly – jointly commissioned capacity review in Autumn 2012. Further mitigations to be considered.</p>	<p>Quality dashboard - clinical quality indicators Risk registers CPI compliance Clinical quality and safety report Quarterly integrated risk report Risk indicators: incidents, SIs, complaints &amp; PALs, legal, inquests Clinical audit Internal audit report on training Integrated performance report Quality Committee report to the Trust Board Commissioners' clinical quality group Care Quality Commission registration &amp; QRP NHSLA level 1 (minimum) Quality Governance Framework score of 3.0</p>

**Board assurance framework  
November 2012**

Strategic Risk	Causes	Risk focus BAF Yes/No	Mitigating actions	Sources of assurance
<p>2. There is a risk that we cannot maintain and deliver the core service along with the performance expected</p>	<p>Increasing demand; funding levels within the local health economy and a focus on 'more for less'; lack of capacity within the healthcare system.</p>	<p><b>Themes:</b> Business as usual; DMP/demand. <b>BAF? Yes</b> Risk 265 – matching resources to demand; Risk 269 – staff changeover times; Risk 329 – financial penalties due to non-achievement of contractually agreed targets; <b>BAF? No</b> Impact on Category C patients of meeting 75% Category A within the context of rising demand</p>	<p>Strong cost improvement programme and focus on gaining efficiencies and driving up productivity; Service delivery model becomes the golden thread of the 5-year strategy; Partnership working within the local health economy to manage capacity and direct responses accordingly – jointly commissioned capacity review in Autumn 2012. Further mitigations to be considered.</p>	<p>Trust Finance Board report Cost Improvement Programme report to Quality Committee &amp; Finance &amp; Investment Committee Integrated performance report Integrated risk report 5-year strategic plan Risk registers Quality dashboard with clinical quality indicators Care Quality Commission registration &amp; QRP Commissioning monitoring meetings + clinical quality group</p>

**Board assurance framework  
November 2012**

<b>Strategic Risk</b>	<b>Causes</b>	<b>Risk focus BAF Yes/No</b>	<b>Mitigating actions</b>	<b>Sources of assurance</b>
3. There is a risk that we are unable to match financial resources with priorities	Funding levels within the local health economy;	<p><b>Themes:</b> Business as usual; DMP/demand.</p> <p><b>BAF? Yes</b> Risk 265 - matching resources to demand;</p>	<p>Strong cost improvement programme and focus on gaining efficiencies and driving up productivity;</p> <p>Partnership working within the local health economy to manage capacity and direct responses accordingly – jointly commissioned capacity review in Autumn 2012. Further mitigations to be considered.</p>	<p>Trust Finance Board report</p> <p>Cost Improvement Programme report to Quality Committee &amp; Finance &amp; Investment Committee</p> <p>Quality dashboard with clinical quality indicators</p> <p>Contract with commissioners</p> <p>External audit opinion</p> <p>Head of internal audit opinion</p> <p>Quality Governance Framework</p>

**Board assurance framework  
November 2012**

Strategic Risk	Causes	Risk focus BAF Yes/No	Mitigating actions	Sources of assurance
<p>4. There is a risk that our strategic direction and the pace of innovation to achieve this are compromised</p>	<p>Changes within London's health economy and infrastructure create a lack of overall strategic direction or conflicts within the system; we are unable to clearly articulate a strategy; management focus on delivering day to day performance; lack of headroom to release staff from core duties to undertake training and development/to transform the workforce.</p>	<p>No</p>	<p>Clearly articulated strategic direction with planned developments across three to five years</p> <p>Implementation of the service delivery model</p> <p>Implementation of stakeholder engagement and communications strategy</p> <p>Ensure that partnerships within London's health economy ( LHE) are maintained to support the development of appropriate clinical pathways and utilisation of the LHE</p>	<p>5-year strategy and financial strategy</p> <p>IBP/LTFM</p> <p>Cost Improvement Programme</p> <p>Integrated performance report</p> <p>Strategy Review and Planning group papers</p> <p>Commissioner support</p> <p>Board Governance Assurance Framework</p> <p>Quality Governance Framework</p> <p>Due diligence reports</p>

**Board assurance framework  
November 2012**

**Section C – Key sources of assurance**

Committee minutes and papers	External	Internal
<b>Trust Board</b>	Care Quality Commission; NHS London; London Assembly; Externally commissioned reports eg National Audit Office – Transforming NHS Ambulance Services; Quality Governance Framework; Board governance assurance framework.	Corporate risk register; Board assurance framework; Annual review of effectiveness of the Board and supporting committees; Annual Governance Statement; Annual reports – safeguarding/infection prevention and control/complaints management/corporate social responsibility; Integrated performance report: Monthly board reports from the COO, Director of Finance, Medical director, Director of Workforce, Trust Secretary; Board Governance Memorandum.
<b>Quality Committee</b>	Care Quality Commission registration; DH Clinical Quality Indicators; CQC quality risk profile; Quality Governance Framework; Board assurance framework.	Corporate risk register; Local risk registers; Audit recommendations progress report; Clinical audit report; Cost improvement programme reports; Minutes of RCAG, LfE, CQSEC; Quality indicators dashboard; Integrated risk management report; Observational ride-outs.
<b>Audit Committee</b>	NHS Litigation Authority level assessment of risk management standards; Head of Internal Audit Opinion; External Audit opinion.	Audit recommendations progress reports; Governance Statement; Report from Chair of the Quality Committee.
<b>Finance and Investment Committee</b>	Independent working capital assessment Due diligence reports	LTFM reports; CQUIN and contract monitoring; Cost Improvement Programme reports; Monthly finance board reports; Finance risk report.
<b>Risk Compliance &amp; Assurance Group</b>	Internal audit reports and recommendations; CQC quality risk profile.	Audit recommendations progress report Local risk registers; Risk register process and reports.

**Board assurance framework  
November 2012**

<b>Clinical Quality Safety &amp; Effectiveness Committee</b>	Cluster clinical quality group minutes	Clinical risk register Infection control dashboard Safeguarding dashboard Clinical quality indicators Clinical audit
<b>Learning from Experience Group</b>	CQC registration Ombudsman reports Coroner Rule 43 reports	Integrated risk management report; Action plans and outcome reports from investigations (serious incidents, complaints, Rule 43 etc).
<b>Senior Management Group</b>	Internal audit reports CQC quality risk profile Patient Forum and LINKS feedback Members' feedback from events	Risk registers; Audit recommendations progress report; Patient experiences report; Performance reports; SMART targets/balanced scorecard; Serious Incident reports.

**Board assurance framework  
November 2012**

**Section D: Principal Risks**

Each of the principal risks has been mapped to at least one corporate objective and wherever possible to the Care Quality Commission's registration requirements.

Principal risk and headline	Corporate objective	Risk score	CQC map	Key controls	Assurance on controls			Action plan	Responsible officer	Net	Target
					Positive assurance	Gaps in controls	Gaps in assurance				
<p><b>368 - 27<sup>th</sup> July 2012</b> 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&amp;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</p> <p><b>Sources of assurance:</b> Risk register; integrated board performance report and integrated risk report</p>	C03 C04 C07	25	N/A	Software adaptation; manual alert systems;	Weekly director oversight – CP problem management review; Monitoring incidents – CP senior user group	None identified	None identified	Technical solutions under development	PS	15	5

**Board assurance framework  
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<p><b>265 – 31<sup>st</sup> July 2006</b> Service performance may be affected by the inability to match resource to demand</p> <p><b>Update: potential underlying causes/source of risk</b> identified as reductions in front line establishment in 11/12 and 12/13 CIP and the current vacancy factor against establishment.</p> <p><b>Sources of assurance:</b> RCAG review 9/7/12 Risk remains at current level pending action</p> <p>Daily operational reports.</p> <p>See BAF section B</p>	<p>C03 C05 C07</p>	<p align="center">20</p>	<p align="center">16</p>	<p>Ongoing recruitment; Use of VAS and PAS in peak demand; Agreed ToR for capacity review with commissioners Operational weekly demand and capacity review group; A&amp;E resourcing group set up in Sept 12, chaired by Director of Workforce</p>	<p>Operational weekly demand and capacity review group; SMG weekly and monthly performance reports; Integrated board performance report</p>		<p>ORH capacity review underway and due to report in December 12; implement outcomes of the review; Modelling undertaken by the weekly group</p>	<p align="center"><b>MF</b></p>	<p align="center">16</p>	<p align="center">12</p>
<p><b>31 – 14<sup>th</sup> November 2002</b> There is a risk that the control and operational staff may fail to recognise serious maternity issues or fail to apply correct guidelines which may lead to serious adverse patient outcomes in maternity cases.</p> <p><b>Sources of</b></p>	<p>C01 C02 C05 C06</p>	<p align="center">20</p>	<p align="center">6 16 14</p>	<p>The Medical Director attends NPSA's Obstetric Pan London Forum. LAS Consultant Midwife provides advice to Control Services, Legal Services,</p>	<p>CQSEC minutes Integrated risk report – incidents, SIs, claims and inquests</p>		<p>Modifications to the safe triage of women in early labour flow-chart - ongoing and complete Sept 2012; Monitoring the delivery of the CPD obstetrics module. Re-</p>	<p align="center"><b>FM</b></p>	<p align="center">16</p>	<p align="center">12</p>

**Board assurance framework  
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<p><b>assurance:</b> RCAG review 9/7/12 Risk remains at current level pending action</p> <p>Weekly serious incident review group; ADG monitoring SI action plans See BAF section B</p>			<p>Patient Experience, and Education and Development. Reports on all the reported incidents concerning obstetric cases are presented to the Clinical Quality Safety and Effectiveness Committee- Report produced in Feb 2012. Training by Consultant midwife to complexes with workshops and a number of complexes have made local arrangements for midwives to deliver training sessions. Maternity care updates and ongoing training through direct contact and articles in the Clinical Update. CTA now have</p>				<p>review planned June 2012. Actions relating to current SI recommendations; Completion of SI investigations;</p>			
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**Board assurance framework  
November 2012**

				maternity pathway to assist with triage of women in labour. Liaison with Trust midwifery units. <b>Flow chart now in use in CTA</b>						
<b>355 – 23<sup>rd</sup> November 2011</b> Staff not receiving clinical and non-clinical mandatory training  <b>Sources of assurance:</b> Risk reviewed on 28/5/12 – RCAG confirmed  <b>CQC compliance review – November 12</b>  BAF Section B	C01 C02 C03 C05 C06 C07	20	12 14	1. PDR / KSF Agreed rostered training days. 2. Dedicated tutors. 3. Paramedic registration. 4. Weekly Operational demand capacity meetings. 5. Cluster arrangements in place on all complexes. 6. TNA updated and published May 2012	Clinical quality indicators; Quality dashboard; Clinical quality and safety monthly board report; Training records.		Launch workbook for IP&C – <b>April 13</b>  <b>Completion of OLM pilot Oct 2012?</b>	<b>CH</b>	16	8
<b>269 – 8<sup>th</sup> December 2006</b> At staff changeover times, LAS performance falls as it takes longer to reach patients.	C01 C02 C03 C04 C07 C08	20	16	Daily rest break allocation to reduce losses at shift change over.  Bridging shifts	Integrated board performance report;  Weekly operational demand and		Implement changes to rest break Complete the capacity review and implement outcomes.	<b>MF</b>	16	8

**Board assurance framework  
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<p><b>Update: underlying cause/source of risk:</b> current rest break agreement permits staff to conclude shift by up to 30 minutes early where no rest break given by EOC</p> <p><b>Sources of assurance:</b> Risk reviewed on 8/7/12 by RCAG</p> <p>BAF Section B</p>				<p>with VAS and PAS</p> <p>Staggered shifts included in roster reviews</p>	<p>capacity review group monitors performance and identifies actions.</p>			<p>Ongoing roster reviews.</p> <p>Rota changes to be implemented as a result of ORH review stage 1</p>			
<p><b>327 – 12<sup>th</sup> October 2009</b></p> <p>Re-use of linen/infection prevention and control guidelines</p> <p><b>Sources of assurance:</b> Risk reviewed by IP&amp;C committee on 30/7/12.</p> <p>IP&amp;C dashboard</p> <p>IP&amp;C minutes</p> <p>Clinical quality and safety report to Trust Board</p> <p>CQC registration &amp; compliance review – November 12</p>	C04	20	8	<p>Adequate supply of blankets; Increased availability of blankets for A&amp;E crews; Improved collection of soiled blankets from hospitals and non-contract laundries; Reduction in blanket loss.</p>	<p>IP&amp;C committee – action plan in place; risk register; Reports to Quality Committee, CQSEC and Trust Board; IP&amp;C dashboard.</p>	Blankets not always available;	Full understanding of the scale of the problem and therefore a strategic solution in place	<p>a) Audit blanket usage as part of hand hygiene auditing.</p> <p>b) developing options paper to agree strategic direction.</p> <p>c) QPIMS to address compliance of single use locally. DIPC to present at conferences. Continue to audit.</p> <p>d) Small sub group to be formed to</p>	SL	16	6

**Board assurance framework  
November 2012**

								discuss options paper and endorse recommendations			
<p><b>22 – 14<sup>th</sup> November 2002</b></p> <p>Failure to clinically assess comprehensively may result in inappropriate conveyance or treatment</p> <p><b>Sources of assurance:</b> Risk reviewed on 31/5/12 and confirmed by RCAG on 9/7/12.</p> <p>SI weekly review group; inquests; integrated risk report;</p> <p><b>CQC compliance review – November 12</b></p> <p>See BAF Section B</p>	C01 C02 C05 C08	20	16 13 14	Enhanced patient assessment course for paramedics and reflective practice and includes a supervision element. Training Strategy Group monitor the level of training delivery; CPIs monitor level of assessment provided; LA52 reporting and review at CQSE; Operational workplace review includes ride outs; Closed round table reviews and reflective practice; Clinical updates from the Medical	Incident reporting; Operational workplace reviews; CQSE papers and minutes; Reporting of incidents via EBS shows improved take-up with this on LA52s.	Planned CPD delivery affected by operational pressures; Delays in incident reporting; impact of operational pressures on EBS pilot.	Review of effectiveness of incident reporting;	To review the effectiveness of the existing incident reporting system. Re-launch the pilot scheme in Whipps X complex with staff contacting EBU via their airways radio. EBU will record incidents directly onto an electronic version of the existing LA52.	<b>FM</b>	15	9





**LONDON AMBULANCE SERVICE TRUST BOARD**

**DATE: 27<sup>TH</sup> NOVEMBER 2012**

**PAPER FOR NOTING/APPROVAL**

<b>Document Title:</b>	Trust Risk Register
<b>Report Author(s):</b>	Frances Wood
<b>Lead Director:</b>	Sandra Adams
<b>Contact Details:</b>	<a href="mailto:Frances.wood@lond-amb.nhs.uk">Frances.wood@lond-amb.nhs.uk</a>
<b>Why is this coming to the Trust Board?</b>	To provide assurance to the Trust Board that the risk identification and management process is operating effectively within the Trust.
<b>This paper has been previously presented to:</b>	<input type="checkbox"/> Strategy Review and Planning Committee <input type="checkbox"/> Senior Management Group <input type="checkbox"/> Quality Committee <input checked="" type="checkbox"/> Audit Committee <input type="checkbox"/> Clinical Quality Safety and Effectiveness Committee <input checked="" type="checkbox"/> Risk Compliance and Assurance Group <input type="checkbox"/> Learning from Experience Group <input type="checkbox"/> Finance and Investment Committee <input type="checkbox"/> Other
<b>Recommendation for the Trust Board:</b>	To receive an update on the Trust Risk Register including changes made at the Risk Compliance and Assurance Group Meeting in October 2012.
<b>Key issues and risks arising from this paper:</b>	
<p>The following risks were approved by the Risk Compliance and Assurance Group for archiving as they had reached their target level:</p> <ul style="list-style-type: none"> <li>• 323 - There is a risk that the audit programme is not sufficiently robust to identify to identify infection control issues across the Trust (Target Rating of risk was Minor x Possible = Moderate 6).</li> <li>• 173 - There is a risk to staff, patients and the organisation of staff working excessive overtime/hours in breach of the Working Time Directive (Target Rating of risk was Major x Rare = Moderate 4).</li> <li>• 181 - There is a risk of injury to staff from slips, trips and falls on LAS premises during the course of their duties (Target Rating of risk was Minor x Unlikely = Moderate 4).</li> <li>• 363 - There is a risk that there will be increased sickness and absence amongst staff as a consequence of support service staff headcount reductions with associated anxiety and increased workloads for those remaining leading to increased stress (Target Rating of risk was Moderately x Unlikely = Moderate 6).</li> </ul> <p>The following new risks were discussed by the Risk Compliance and Assurance Group and were approved for addition to the Trust Risk Register:</p> <ul style="list-style-type: none"> <li>• There is a risk that the governance of the Trust may be adversely affected by changes at Trust Board level. This is now listed as risk number 369 on the Trust Risk Register with a current scoring of Major x Possible = Significant 12.</li> </ul>	

- *There is a risk that the development and sign off of the 5-year strategy may be impeded by changes within key board roles. This is now listed as risk number 370 on the Trust Risk Register with a current scoring of Major x Possible = Significant 12.*

The target rating of the following risk was discussed and reviewed by the Risk Compliance and Assurance Group:

- 351 - There is a risk that operational staff may be verbally abused. The consequences being an increase in staff absence through stress, and an adverse impact on staff moral/ service/ patient care. The target rating was re-graded from Minor x Rare = Low 2 to Negligible x Possible = Low 3.

### **Executive Summary**

The Trust Risk Register was reviewed in Q3 by the Risk Owners and Action Owners and was updated and presented to the Risk Compliance Group in October 2012 for review and approval of submitted new risks, risks to be archived and risks presented for re-grading.

The attached Trust Risk Register has been updated to reflect the new risks that were approved and the scoring of re-graded risks. Risks that were approved for archiving have been placed on the archived risk register.

The Trust Risk Register will be reviewed again in Q4 by the Risk Owners and Action Owners and will be presented to the Risk Compliance and Assurance Group in January 2013 for review and approval.

### **Attachments**

**Trust Risk Register – November 2012**

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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 TRUST BOARD

DATE: 27<sup>TH</sup> NOVEMBER 2012

### PAPER TO PROVIDE ASSURANCE TO THE TRUST BOARD

<b>Document Title:</b>	<b>Audit Committee Assurance Report</b>
<b>Report Author(s):</b>	<b>Caroline Silver, Chair of the Audit Committee</b>
<b>Lead Director:</b>	<b>N/A</b>
<b>Contact Details:</b>	
<b>Why is this coming to the Trust Board?</b>	<b>To receive an update on the key items of discussion at the Audit Committee meeting on 5<sup>th</sup> November 2012 and to receive assurance from the Committee.</b>
<b>This paper has been previously presented to:</b>	<input type="checkbox"/> Strategy Review and Planning Committee <input type="checkbox"/> Senior Management Group <input type="checkbox"/> Quality Committee <input type="checkbox"/> Audit Committee <input type="checkbox"/> Clinical Quality Safety and Effectiveness Committee <input type="checkbox"/> Risk Compliance and Assurance Group <input type="checkbox"/> Learning from Experience Group <input type="checkbox"/> Other
<b>Recommendation for the Trust Board:</b>	<b>To note the report</b>
<b>Key issues and risks arising from this paper</b>  At the Audit Committee meeting on 5 <sup>th</sup> November 2012, a number of risks to the Trust's key sources of assurances were identified. These risks, together with the mitigating actions, are detailed in the attached report.	
<b>Executive Summary</b>  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).	
<b>Attachments</b>  Report from the Audit Committee meeting on 5 <sup>th</sup> November 2012.	

**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 5<sup>th</sup> November 2012

### 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 which are referenced against each control as appropriate (eg SR 1.2.3.4).

This meeting was the annual internal meeting of the Audit Committee and was therefore not attended by representatives from external audit, internal audit and local counter fraud.

#### ***Financial Services Update – East Lancashire Financial Services (ELFS) (SR 3)***

The Audit Committee was joined by Kathryn Brown, the Deputy Director Shared Services at ELFS and their internal audit manager, Margaret Wood from Audit North West, to provide an outline of the internal audit approach for ELFS. ELFS is the outsourced provider of certain finance functions, the same giving recently been transferred to them from LAS in-house staff.

The Audit Committee is assured that Audit North West has not identified any significant issues with ELFS's systems of internal control. Any weaknesses identified by Audit North West in the LAS's system of internal control will be notified to the LAS Audit and Compliance Manager and the Chair of the Audit Committee, together with a series of recommendations to action.

The Head of Financial Services was asked to draw up a timetable of information required for the close of the statutory accounts so that this could be aligned with ELFS's internal and external audit programme.

The Audit Committee asked ELFS for an overview of the success or otherwise of the outsourcing, and to identify any issues or significant matters arising. ELFS commented that the widely distributed nature of LAS services had been a challenge for ELFS, which had not encountered this previously. Also, around the topic of accounts payable. However, in general progress was to plan and as expected. The Audit Committee further asked the finance team at LAS to raise any questions and/or concerns that they had regarding outsourcing, of which there were none brought to the committee's attention.

Overall, the Audit Committee is assured that the outsourcing of financial services to ELFS is being embedded effectively.

#### ***NHSLA Level 1 Assessment Outcome (SR 1.2.3.4)***

The NHSLA level 1 assessment took place on 11<sup>th</sup> October and the LAS achieved compliance with all 50 of the risk management standards. This is a significant achievement which sets a strong foundation to progress to level 2 assessment in autumn 2013. The Audit Committee is assured that Governance and Compliance Team will continue to monitor progress towards level 2.

#### ***Internal Audit (SR 1.2.3.4)***

### *Internal Audit Recommendations Progress Report*

The Audit Committee received an update on internal audit recommendations and is assured that internal audit activity has started to increase again following the 2012 Olympics. Overall, the process is working well, however the Risk, Compliance and Assurance Group is due to review the process in January 2013 and will report back to the Audit Committee.

### *Review of the Effectiveness of Internal Audit and Local Counter Fraud Services*

The Audit Committee is required to undertake an annual assessment of internal audit and local counter fraud services which is based on the NHS Audit Committee Handbook self-assessment checklist and the Key Performance Indicators. Overall, the Audit Committee is satisfied with the service currently provided by RSM Tenon and there are some good examples where external audit findings have fed into internal audit work, particularly with regards to missing medical devices. The Audit Committee regularly receives reports from internal audit and local counter fraud and quality assures these by questioning both the audit approach and the findings.

Going forward, the internal auditors will also rely on the external audit arrangements at ELFS and this will therefore need to be considered in next year's review.

### *Update on the tender process for internal audit and local counter fraud specialist*

The contract with RSM Tenon to provide internal audit and counter fraud services comes to an end in April 2013, having already been extended and the Audit Committee agreed at its meeting on 5<sup>th</sup> March 2012 to pursue a tender process for both these services. The tender specifications are in the process of being finalised and will shortly be distributed to the suppliers on the Commercial Solutions Framework. The tender responses will be evaluated against set criteria by the Director of Finance, the Director of Corporate Services, the Audit and Compliance Manager and a member of the procurement team. These suppliers will then be invited to present to a panel which will comprise of the above and the Chair of the Audit Committee.

### ***Standing Orders and Standing Financial Instructions (SR 3)***

The Audit Committee was asked to note proposed changes to the Trust's Scheme of Delegation in relation to delegated approval limits. The Audit Committee is assured that budget holders have received appropriate training and that arrangements are in place to ensure that this training is refreshed on an annual basis.

### ***Report from the Finance and Investment Committee (SR 2.3.4)***

The Audit Committee received a report from the Director of Finance on the key areas of discussion at the recent Finance and Investment Committee on 18<sup>th</sup> September 2012. A full report has already been provided to the Trust Board at its meeting in September.

### ***Report from the Quality Committee (SR 1.2)***

The Quality Committee has raised a red flag concerning the combined effect of the Cost Improvement Programme projects. The Quality Committee receives a report with assurance statements from the clinical leads for each of the CIP projects and an overview from the three responsible directors (Director of Quality and Health Promotion, Director of Workforce and Director of Finance). Whilst the responsible directors are content that none of the CIP projects are individually having an impact on patient care, they are concerned that the combined effect of the CIP is resulting in increased pressure in the system, manifested by delays, cancelled training and increased use of the Demand Management Plan. They therefore are not able to support a further headcount reduction in frontline services, a view which is endorsed by the Quality Committee.

The Audit Committee found this to be a very useful update and demonstrates that the governance structure is working effectively to identify key organisational risks. However, the content of the report is of concern and the Audit Committee would like to bring this to the attention of the Trust Board.

### ***Independent Report and Action Plan into Croydon PCT***

The Audit Committee discussed the report of the independent review commissioned by NHS London into financial management and corporate governance arrangements at NHS Croydon for the period relating to the 2010-11 Annual Accounts. The finance team has reviewed the recommendations in the report and identified LAS assurance against these.

A contributing factor to the accounting errors identified was the transition to South West London Cluster and the subsequent changes in personnel. The Audit Committee received assurance that this risk has been considered in relation to LAS and that, although there are a number of personnel changes at management level, there is sufficient continuity within the finance team to mitigate this risk. Financial reporting is also important to enable the Trust Board and Finance and Investment Committee to identify any mismatch in accounting.

### **RISKS TO ASSURANCES AND CONTROLS**

<b>Risk</b>	<b>Mitigation given</b>
<b>1<sup>st</sup> June 2012</b>	
Missing equipment	<ul style="list-style-type: none"> <li>▪ The Audit Committee will continue to focus on this issue in 2012/13;</li> <li>▪ The Audit Commission will flag this as an issue to the incoming external auditors, Price Waterhouse Coopers, as part of their handover;</li> <li>▪ The Chair of the Audit Committee to meeting with the incoming external auditors;</li> <li>▪ Audit Committee received an update on the asset tracking part of the new Make Ready Contract at the meeting on 5<sup>th</sup> November.</li> </ul>
<b>3<sup>rd</sup> September 2012</b>	
Risk of knowledge loss due to the transfer of LAS external audit services to PWC	<ul style="list-style-type: none"> <li>▪ PWC have access to five years' of the Trust's audit files and the Audit Commission have written a comprehensive briefing note.</li> <li>▪ PWC have been given the opportunity to meet with the outgoing external auditors</li> </ul>
<b>5<sup>th</sup> November 2012</b>	
Combined effect of the CIP resulting in increased pressure in the system	<ul style="list-style-type: none"> <li>▪ Trust Board to discuss this issue in relation to LAS strategy</li> </ul>



## LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 27<sup>TH</sup> NOVEMBER 2012

### PAPER FOR NOTING/APPROVAL

<b>Document Title:</b>	<b>Chief Operating Officer's Report</b>
<b>Report Author(s):</b>	<b>Martin Flaherty</b>
<b>Lead Director:</b>	<b>Martin Flaherty</b>
<b>Contact Details:</b>	<b>0207-7832039</b>
<b>Why is this coming to the Trust Board?</b>	<b>For noting</b>
<b>This paper has been previously presented to:</b>	<input type="checkbox"/> Strategy Review and Planning Committee <input type="checkbox"/> Senior Management Group <input type="checkbox"/> Quality Committee <input type="checkbox"/> Audit Committee <input type="checkbox"/> Clinical Quality Safety and Effectiveness Committee <input type="checkbox"/> Risk Compliance and Assurance Group <input type="checkbox"/> Learning from Experience Group <input type="checkbox"/> Other
<b>Recommendation for the Trust Board:</b>	The Board is asked to Note the paper
<b>Key issues and risks arising from this paper</b> <ul style="list-style-type: none"><li>• Ongoing high incoming 999 call volume and high Cat A workload</li><li>• Establishment of a Task &amp; Finish Group to develop a Red 1 Action Plan</li><li>• Increased utilisation during October of 3.1% in comparison to last year</li><li>• FRU utilisation growth of 3.5% in comparison to last year</li><li>• Resourcing challenges are rising due to increasing training abstractions which were suspended during the Olympic Games</li><li>• Overtime uptake is slow leading to the introduction of an additional incentive scheme to particularly bolster our weekend staffing</li><li>• Waiting times for Cat C patients remain an area of concern especially at weekends.</li></ul>	
<b>Executive Summary</b> <p>The paper provides an update on the following key areas:</p> <ol style="list-style-type: none"><li>1.A&amp;E Service Delivery</li><li>2.Post Olympic Games Update</li><li>3.Emergency Preparedness</li><li>4.Fleet and Logistics</li><li>5.PTS</li></ol>	

## Key messages

- The ytd position on Cat A8 minutes is 74.9% and on Cat A19 is 98.2%
- The Trust continues to experience high levels of demand with 999 calls now up 9.3%, Cat A calls up 13.65% and overall incidents up 3.65% when compared to the same period last year.
- Calls answered within 5 seconds or less for the month of October achieved 97.9%
- Ambulance utilisation for October reached 86.6% an increase of 3.1% for the same period last year
- Event planning for NYE is well underway
- The LAS Winter Plan submitted to NHSL obtaining a Green rating
- The introduction of 30 new FRUs to be deployed by end of November 2012
- Nearly 2000 additional blankets circulated around the service in preparation for winter
- Vehicle preparation contract showing further improvements.
- Short Term Recovery Plan to reduce VOR of FRUs introduced successfully
- PTS unsuccessful in the tender for Hillingdon Hospital however LAS were successful bidder in regards of quality but third most expensive
- LAS and Initial submitted a joint bid for West Middlesex Hospital NEPTS

## Attachments

Chief Operating Officer's Report November 2012  
Integrated Trust performance Report November 2012

### 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 27<sup>TH</sup> NOVEMBER 2012**  
**CHIEF OPERATING OFFICERS REPORT**

**1. A&E SERVICE DELIVERY**

Accident & Emergency Services performance and activity (please see attached integrated performance report for October 2012)

**Overview**

The table below sets out the A&E performance against the key standards for Category A for September through to 11 November 2012 together with the current year to date (YTD) position.

Category	Cat A8	Cat A19	C1
<b>Key Standard</b>	<b>75%</b>	<b>95%</b>	<b>93%</b>
September	73.8%	98.0%	73.4%
October	74.9%	97.9%	77.0%
November *11	75.4%	97.9%	78.4%
<b>YTD</b>	<b>74.9%</b>	<b>98.2%</b>	<b>79.1%</b>

The month of October saw the Trust achieve 74.9% for category A8 performance. This meant that the Trust marginally fell below the national key standard of 75% for category A8 performance, and below the trajectory target of 77.5% submitted to our commissioners. It is extremely disappointing to report that for the second month in succession we have been unable to achieve the A8 national standard and commissioner’s trajectory. Our commissioners confirmed with us in October that they would not serve a contract query notice for the month of September. They have also given us encouraging signs that they will resist from issuing a notice in relation to our October performance. At the time of writing no contract query notice has been received. On a positive note our A8 year to date (YTD) trajectory remains on track. The A8 YTD position as of the end of October stood at 74.9% against an agreed position of 74.6%. Red 1 performance for the month of October finished at 77%, this is a 3.5% improvement on the September position. Richard Webber, Head of Control Services has been requested by me to establish a task and finish group to develop a Red 1 action plan and trajectory to ensure we deliver the 80% performance standard by year end. The action plan has been agreed and work has begun to discharge the actions within the timescales set.

These levels of performance have been achieved against the continual backdrop this year of activity growth above agreed contracted thresholds, both for A8 and total incidents. The current position shows A8 activity having increased by 13.65% over the same period last year. Total incidents have also increased by 3.65% compared to last year. These percentage increases equate to a significant increase in the numbers of incidents attended compared to the same period last year. 999 call volumes have also significantly increased with the current year to date position demonstrating a 9.3% increase over the same period last year. Calls answered within 5 seconds or less for the month of October achieved 97.9% with the year to date sitting at 94.8% marginally below the 95% threshold. During the month of October we produced c130k hours of frontline ambulance cover supplemented by c60k of FRU cover.

Pre-planned overtime within A&E operations for October was just over 32k hours, we have had to once again introduce an additional incentive scheme to increase the uptake of overtime. The latest scheme that was introduced was to particularly bolster our weekend staffing with the greatest incentive for night shifts being offered. We were also heavily reliant on third party private ambulance provision throughout the month of October. PAS contributed 6,585 cover hours to the total frontline ambulance hours produced in the month. This level of PAS provision which is vital at present to provide the required capacity to meet activity projections clearly has a significant financial implication for the Trust. Despite all of these actions we still struggled to provide the core amount of resourcing to match our demand.

Frontline ambulance utilisation for the month of October reached 86.6% this is an increase of 3.1% based on the same month last year. This increase in utilisation is despite a 2% increase in the number of frontline ambulance hours being produced in comparison to last October. FRU utilisation in October saw an overall growth of 3.5% to 45% in comparison to the same period last year, despite the Trust producing an additional 2.4% of FRU hours. A&E support utilisation saw the greatest increase with October ending at 68.7% an increase of 12% in-comparison to last October, whilst producing an additional 645 hours. October saw the Trust produce an additional 5,798 hours in comparison to last October with total utilisation increasing from 63.3% to 65.4% which clearly demonstrates the additional pressures the Trust is attempting to absorb.

Another gauge used to monitor the activity pressures is the utilisation rate of our demand management plan (DMP). In the month of October we operated at DMP level A for 54% of the total hours in the month. This demonstrates that for 46% of the total hours of the month we hit the triggers to escalate the DMP level. In the month of October we enacted DMP level B for over 317 hours and DMP level C for over 20 hours.

Despite SMG agreeing to commence SP2 Paramedic training at the conclusion of the London 2012 Games it is important to emphasise the very real challenges this is providing the operations directorate. In October there were c3, 800 episodes of pre-planned training peaking at 194 a day in the middle of October. We also commenced CSR training in line with the commitment to resume this after the Games period. To try to reduce the operational impact of this training we have identified all staff groups that do not require abstracting from frontline duty are currently being planned on to CSR courses. Over 350 staff have received their CSR1 update since we recommenced the delivery of this training. The month of November will see pre-planned SP2 and CSR training deliver a total of 3,312 episodes of training, peaking at 174 per day from 19<sup>th</sup> November to 30<sup>th</sup> November 2012. As a result of the continuing challenges with our ability to provide sufficient capacity all other abstractions are subject to the closest scrutiny and any that are identified as not being critical are being cancelled. The Trust's REAP level is reviewed weekly and as a result we have been unable to lower the REAP level from level 3.

## **2. Winter Planning**

The LAS 'winter plan' was submitted to NHSL in October for final approval and obtained a Green rating as part of the NHSL and commissioners joint assurance framework. A number of events have been planned across London to test the system wide London plans. Planning continues for the Christmas period and AOM Trevor Hubbard is leading a group in the development of that plan. The operational plan will be published in mid December. New Years Eve like previous years will also have

a bespoke operational plan. This is an event that the Trust is well versed at planning for and this year ACAO John Pooley is the Trust Gold for the event. Once again the operational plan will be ready for publishing in mid December. The LAS is also taking part in the twice weekly NHSL winter pressures teleconferences. Operational areas are also participating in Cluster teleconferences relating to winter planning and pressures. Internally there is a robust review of internal demand and capacity, this meeting takes place every Monday and reviews demand and capacity projections and makes recommendations on actions to be taken based on their analysis. Assistant Directors of Operations attend this together with representatives from MI and Resourcing.

### **3. Emergency Preparedness**

The London SHA and PCT's are commencing the transformation to the NHS Commissioning Board Emergency Preparedness, Resilience and Response structure (EPRR). Last month a new Deputy Director (Nicky Smith) for EPRR was appointed. In early October a workshop was held to provide an update to the London NHS Community on the proposed EPRR arrangements. This looks significantly different to that we have seen within the NHS in London and will consolidate the EPRR function for London into one team. It will focus on three geographical area teams (North West, North East and South) of 4 staff along with several key central functions: Resilience Development Manager, London Resilience Team liaison, Influenza and Horizon Scanning, Capacity Surge Manager, EPRR Education and Business Continuity Management. During the coming months there will be a series of Assurance exercises taking place to ensure the new structure can operate effectively in the new world of the NHS. The LAS EP team is engaged in all aspects of the assurance process and I will provide further updates as work progresses.

The printed versions of the LAS Major Incident Plan should start to arrive in the next couple of weeks and will be distributed across the trust. The six new Emergency Support Vehicles have been delivered and commissioned and the old outdated vehicles are in the process of being decommissioned.

The Guy Fawkes weekend saw a large number of public firework displays across London, plans were in place to provide oversight of the events and they proceeded with minimal disruption. Event planning for New Years Eve is well underway and making good progress and specific planning for any potential adverse weather is well underway within the operational areas including a refresh of the area and central plan. Additional 4x4 vehicles have been allocated to the operational areas as part of our overall winter planning process.

### **Post Olympics Games update**

Work continues on developing the Trust's post Games report. The report which is the final objective of the Olympic Games Planning Office team is a consolidation and amalgamation of all the post Games activity to date. It will reflect on all of the key activities as part of the Trust's overall preparations for the London 2012 Games including, pre-planning, programme management, financial management, operational delivery of the games, contingency planning and maintaining service delivery to the people of London throughout the entire Games period. All heads of the key Olympic work streams are making contributions to the overarching report. The report will be published in January 2013.

Since the conclusion of the Games there have been an array of official debriefs with all LAS strategic and tactical commanders, LAS staff both involved in the delivery of the Games and maintaining service delivery. There were comprehensive de-briefs involving all of the Pre-planned aid staff from

across the country that contributed to the management and delivery of the Games. Senior Managers from the LAS gave comprehensive presentations at a national post Games conference hosted by AACE and held in London on the 19 October.

#### **4. Olympic Games activity**

Olympics (16 July to 12 August 2012)

320 Venue conveyances

235 Other (live site, last mile and transport hub) conveyances

555 TOTAL OLYMPIC CONVEYANCES

485 venue responses

907 TOTAL OLYMPIC RESPONSES

#### **Paralympics (27 August to 9 September)**

118 Venue conveyances

97 Other (live site, last mile and transport hub) conveyances

215 TOTAL PARALYMPIC CONVEYANCES

169 Venue responses

389 TOTAL CONVEYANCES

#### **Maintaining Service Delivery (23 July to 09 September)**

54,997 Category A Incidents – Cat A performance 80.30%

2,077 Red 1 incidents – performance 80.12%

#### **5. Lessons identified from Olympic Games planning**

##### **Short notice additional requirements not fully anticipated**

- The number of dynamic resourcing changes that required action both pre-Games and during the Games were under estimated and the number of dedicated resource Co-ordinators deployed to the ODC became overwhelmed at times. This was quickly resolved with assistance from the MSD team providing additional support to the resourcing function.

##### **Training venue commitments pre-games not fully anticipated and advised late to LOCOG**

- The requirement of LAS resources to be deployed to Training venues changed considerably with very little notice at times during the run up to both the Olympics and Paralympics. This meant that Olympic cohort staff had to be abstracted from core

resourcing earlier than planned to meet these commitments. This also added further pressure on the Olympic resource Co-ordinators.

### **Access, accreditation and VAPs**

- The LAS requested that all zone and venue Commanders were provided with accreditation passes for all areas and all venues to give flexibility. This request was declined and the top-up passes used to give the flexibility did not arrive until 48 hours prior to the commencement of the Olympic and Paralympic Games. There was also a shortage of top-up passes which also limited flexibility. Vehicle passes were also allocated to vehicles via the registration number which also proved problematic particularly when vehicles developed any kind of fault it was not possible to bring in a relief vehicle. There were also some minor issues with overzealous G4S staff that were quickly resolved.

### **Clarity on responsibility for the last mile**

- The definition of the 'last mile' is the distance between the Olympic venue and the nearest public transport hub. The Government published a 30 page document on the overall management of this area immediately outside of the venues. The document did not however provide sufficient clarity on health provision and which body was responsible for the provision thereof. This created additional resourcing demands across all venues and placed additional complexity into the rostering arrangements for ambulance staff.

### **Pre deployment training and exercising with LOCOG in venues lacking**

- There would have been real benefits in undertaking pre-deployment training with LOCOG medical volunteers and ambulance staff to enable working relationships to be developed at an earlier stage and also gain a greater mutual understanding of how each of the groups operated within their own recognized policies, procedures and guidelines. There were also plans for LOCOG medical and ambulance staff to carry out daily drills and joint briefings within venues. This did not happen consistently across venues, if it had of done it would have helped to avoid some of the early misunderstandings between the two groups of staff at specific venues.

## **Lessons identified from Maintaining Service Delivery**

### **Alignment of the Olympic delivery and MSD work streams**

- There would have been a benefit in these two critical delivery work streams aligning themselves more closely earlier on in the process. It became evident as we drew closer to the Games there were areas of significant overlap that would have been better explored jointly rather than in isolation.

### **MSD planning should have commenced earlier in the overall planning cycle**

- Some of the initiatives implemented to assist the MSD work stream would have delivered greater benefits if there had been more time to implement them earlier. There were also inequities in the number of managers abstracted to the Olympic cohort from

each operational area which left disproportionate shortages of management cover in certain places. This would have been avoided if the two delivery arms had commenced planning at the same time.

#### **Additional familiarisation and training for Team Leaders**

- Team Leaders principally were used to provide the additional management capacity on complexes to ensure the day to day running and management of core business. There were some elements of this role where they would have not had previous exposure and some felt uncomfortable with dealing with certain types of issues. The lack of additional training was principally caused by a lack of capacity to release them for any additional training and because of the tight delivery timescales of the operational delivery. Earlier planning would have assisted in facilitating these needs.

The lessons identified will be covered in more detail in the post Games report and there are mechanisms in place to ensure we both learn from these as well as the areas of best practice that were also identified.

## **6. Fleet & Logistics**

### **Fleet**

The introduction of 30 new Skoda FRUs into the Fleet continues, which by the end of October 12 were in routine operational use with a further eight on Trust premises at various stages of the commissioning process. All 30 are expected to be fully deployed by the end of November 2012. The supply chain was briefly interrupted following the identification of a further defect in the electrical system, affecting the transmission of speed pulse data into the satellite navigation device; this has now been resolved thanks to robust partnership working by the converter, AES, and the Trust's communications maintenance provider, Telent. Phase two, which incorporates 34 further cars, will commence following a competitive tendering exercise owing to the need to spread FRU conversion work across more than one supplier, for resilience reasons.

### **Logistics**

October signified the first full month in which asset tracking data was captured by the Vehicle Preparation supplier, Initial Healthcare. The quality of the data is now being reviewed; in particular ensuring that serial numbers for each item of equipment have been correctly recorded in the new database. Training for Equipment Support Personnel based at the central store takes place in November.

Nearly 2,000 additional blankets were circulated around the Service last month as winter approaches. Whilst the percentage collected from stations and hospitals also increased, nearly 3,000 still remained "lost" in the system (uncollected). The Logistics Department has now been able to direct additional resource at hospital liaison to assist in the recovery of blankets. In addition, proposals are being prepared to facilitate the one for one swapping of blankets at Emergency Departments and other acute destinations.

Performance on drug bag packing, daily station visits and return of drugs orders remains robust.

Scoping work continues for a network of area equipment hubs with efforts ongoing to secure suitable space. The next phase of the work, once sites are established, will be to introduce an access control system before formally launching the new arrangements to Operations.

### **Vehicle Preparation**

Following the appointment of a new General Manager by the supplier, and the implementation of new staff rotas, the nightly “clean and stock” metrics have shown further improvement – to 80% of available vehicles. This remains below the contracted standard, and as a result financial penalties will be applied, but there is nonetheless a material improvement which demonstrates progress. Deep cleaning of vehicles to plan also showed an excellent improvement in scoring 95% on Ambulances and 100% on FRU’s and PTS vehicles.

The Trust’s Contract Manager is now focusing on complexes with particularly acute challenges in Vehicle Preparation performance, with a number of recovery plans now in effect. This engagement with complex management teams is essential to the successful implementation of the new contract and the ongoing drive to boost operational confidence in the product.

### **Fleet and Logistics Department Performance**

There was a 0.10% increase in vehicle-attributable VOR during the month. This can mainly be attributed to time spent in Workshops. There was a significant increase in FRU downtime caused by major mechanical faults (gear boxes, engine failures, transmission problems). A significant push on ambulance servicing as well as technician vacancy levels also had a minor impact. Fleet stability did suffer a reduction (to 56%) which can be partly linked to the increased Workshop VOR. A short term recovery plan was implemented at the end of the month which saw the closure of three fleet workshops to everything except planned FRU repair work. This had a swift and positive impact on FRU availability levels.

Vehicles sourced on time for start of shift increased to 89% for the month, a 2% increase on September and above target. This was supported by robust work in reducing the number of unequipped vehicles each day.

Work will continue throughout November to finalise major changes to the flexible fleet scheme, and to bring FRU resourcing into the Vehicle Resource Centre in time for the closure of the Area Delivery Units.

Ambulance servicing showed an encouraging improvement to 65% completed to plan (on time), an increase of 20% on the previous month. Sustained effort is now being applied to ensure that ambulance servicing schedules are maintained at a consistent level. FRU car servicing remained below target at 28% against plan. With the addition of new cars into the fleet and work in hand to take the daily resourcing of FRU’s into the VRC , additional impetus can be given to drive sustained improvement. Overall fleet availability showed a slight drop for the month but remained above 85%. This is consistent with the increased workshop VOR figure.

## **7. Patient Transport Service**

### **Commercial**

The following gives an update on commercial activity within PTS:

- Hillingdon Hospital NHS Foundation Trust NEPTS and Courier:
  - The LAS were unsuccessful in winning this tender.
  - 6 providers were considered and LAS and three others were taken through to the presentation stage.
  - The LAS scored more than the successful bidder on quality however were the third most expensive.
- West Middlesex Hospital NEPTS.
  - Initial has now submitted this joint bid with LAS.

### **Performance**

Activity rose in October to 15,382. This is a return to expected levels and is in line with October 2011.

The quality indicators for September were:

- Arrival Time: 93% remained the same as previous month.
- Departure Time: 93% dropped 1% from September.
- Time on Vehicle: 97% dropped by 1%, remains above the 95% target.

**Martin Flaherty**

**Chief Operating Officer/Deputy CEO**



LONDON AMBULANCE SERVICE TRUST BOARD

27-Nov-12

PAPER FOR: NOTING/APPROVAL/**DISCUSSION THEN APPROVAL**

<b>Document Title:</b>	<b>Integrated Trust Performance Report</b>
<b>Report Author(s):</b>	<b>Christine Kane/Martin Flaherty</b>
<b>Lead Director:</b>	<b>Martin Flaherty</b>
<b>Contact Details:</b>	<b>N/A</b>
<b>This paper has been previously presented to:</b>	<input type="checkbox"/> Strategy Review and Planning Committee <input checked="" type="checkbox"/> Senior Management Group <input type="checkbox"/> Quality Committee <input type="checkbox"/> Audit Committee <input type="checkbox"/> Clinical Quality Safety and Effectiveness <input type="checkbox"/> Risk Compliance and Assurance Group <input type="checkbox"/> Learning from Experience Group <input type="checkbox"/> Other
	That concerns arising from the Workforce, Clinical Quality and Operations reports are discussed and updates made prior to the report being submitted to the Trust Board in November 2012.

**Key issues and risks arising from this paper**

**Operational Performance:**

The month of October saw the Trust achieve 74.9% for category A8 performance. This meant that the Trust marginally fell below the national key standard of 75% for category A8 performance, and below the trajectory target of 77.5% submitted to our commissioners. It is extremely disappointing to report that for the second month in succession we have been unable to achieve the A8 national standard and commissioner's trajectory. Our commissioners confirmed with us in October that they would not serve a contract query notice for the month of September. They have also given us encouraging signs that they will resist from issuing a notice in relation to our October performance. At the time of writing no contract query notice has been received. On a positive note our A8 year to date (YTD) trajectory remains on track. The A8 YTD position as of the end of October stood at 74.9% against an agreed position of 74.6%. Red 1 performance for the month of October finished at 77%, this is a 3.5% improvement on the September position. Richard Webber, Head of Control Services has been requested by me to establish a task and finish group to develop a Red 1 action plan and trajectory to ensure we deliver the 80% performance standard by year end. The action plan has been agreed and work has begun to discharge the actions within the timescales set.

These levels of performance have been achieved against the continual backdrop this year of activity growth above agreed contracted thresholds, both for A8 and total incidents. The current position shows A8 activity having increased by 13.65%, with total incidents increased by 3.65% compared to the same period last year; this equates to a significant increase in the numbers of incidents attended compared to the same period last year. 999 call volumes have also significantly increased with the current year to date position demonstrating a 9.3% increase over the same period last year. Calls answered within 5 seconds or less for the month of October achieved 97.9% with the year to date sitting at 94.8% marginally below the 95% threshold.

During the month of October we produced c130k hours of frontline ambulance cover supplemented by c60k of FRU cover. Pre-planned overtime within A&E operations for October was just over 32k hours, we have had to once again introduce an additional incentive scheme to increase the uptake of overtime. The latest scheme that was introduced was to particularly bolster our weekend staffing with the greatest incentive for night shifts being offered. We were also heavily reliant on third party private ambulance provision throughout the month of October. PAS contributed 6,585 cover hours to the total frontline ambulance hours produced in the month. This level of PAS provision which is vital at present to provide the required capacity to meet activity projections clearly has a significant financial implication for the Trust. Despite all of these actions we still struggled to provide the core amount of resourcing to match our demand.

**Training and Supervision:**

Despite SMG agreeing to commence SP2 Paramedic training at the conclusion of the London 2012 Games it is important to emphasise the very real challenges this is providing the operations directorate. In October there were c3,800 episodes of pre-planned training peaking at 194 a day in the middle of October. We also commenced CSR training in line with the commitment to resume this after the Games period. To try to reduce the operational impact of this training we have identified all staff groups that do not require abstracting from frontline duty are currently being planned on to CSR courses. Over 350 staff have received their CSR1 update since we recommenced the delivery of this training. The month of November will see pre-planned SP2 and CSR training deliver a total of 3,312 episodes of training, peaking at 174 per day from 19th November to 30th November 2012. As a result of the continuing challenges with our ability to provide sufficient capacity all other abstractions are subject to the closest scrutiny and any that are identified as not being critical are being cancelled. The Trust's REAP level is reviewed weekly and as a result we have been unable to lower the REAP level from level 3.

**Attachment 2** provides a short narrative of the position for each measure for the year to date.

**Attachment 3** provides a RAG rated summary of the underlying performance indicators.

**Attachment 4** provides an explanation for each measure and this will be included in the report each month.

**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

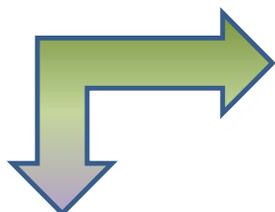
**Equality Impact Assessment**

Has an Equality Impact Assessment been carried out?

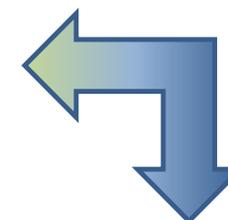
- Yes
- No

# Integrated Trust Performance Report October 2012

Attachment 1



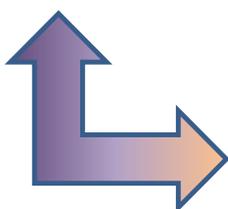
Caring for Patients during their Journey	
<i>How do we care for our patients?</i>	
* First Contact (Call Answering)	97.9%
* Treatment (CPI)	90.0%
* Clinical Outcomes	96%
* Patient Safety Index	134
* Patient Wellbeing	Green
* Service Experience	Green



Service Delivery		
<i>Evidencing Delivery of the Response model</i>		
<b>Performance Indicators</b>	<b>Actual</b>	<b>YTD/2011</b>
* Cat A Target (75%)	74.9%	74.9%
* Cat C1 Target (90%)	80.3%	79.1%
* Cat C2 Target (90%)	71.8%	75.3%
* Ambulance Utilisation*	86.6%	83.5%
* FRU Utilisation*	44.7%	42%
<small>*Utilisation % compared to 2011-12</small>		
* Complaints/Serious Incidents	70	60

Daily Performance & Activity					REAP 3
	Sept	Oct	MoM	Y2Y	
Av. Daily Call Volume	4704	4656	-1%	4.7%	
Peak Daily Call Vol.	5490	5151	-7%	-9%	
Cat A Incidents	34985	36701	5%	10.1%	
Cat C1 & 2 Incidents	26176	28725	9%	11%	
Cat C3 & 4 Incidents	24866	25269	2%	-10%	
<b>Total Incidents</b>	<b>86027</b>	<b>90695</b>	<b>5%</b>	<b>3.7%</b>	
DMP Stage A	61%	66%	5%	-15%	
DMP Stage B	27%	30%	3%	17%	
DMP Stage C/D	12%	5%	-8%	-2%	
Percentage > REAP 3	100%	100%	0%	10%	

Care for Staff - Workforce Report		
<i>How will we sustain change and improve?</i>		
<b>Performance Indicators</b>		<b>T/C</b>
* Staff Sickness Levels	5.49%	---
* Staff Core Skills Training	46%	3.1
* Staff Development (PDR)	35%	2.5
* Staff Retention	8.2%	2.8
* Staff Safety & Wellbeing	79	3.2
* Staff Satisfaction	3.4	



Value for Money - September 2012	
<i>Evidencing stewardship of the public purse (YTD)</i>	
* Financial EBITDA	8,096
* Net Surplus	(262)
* Cost Improvement Programme	5,354
* CQUINs	640
* Monitor Net Rating (FRR)	2
* Carbon Reduction Plan	A > G

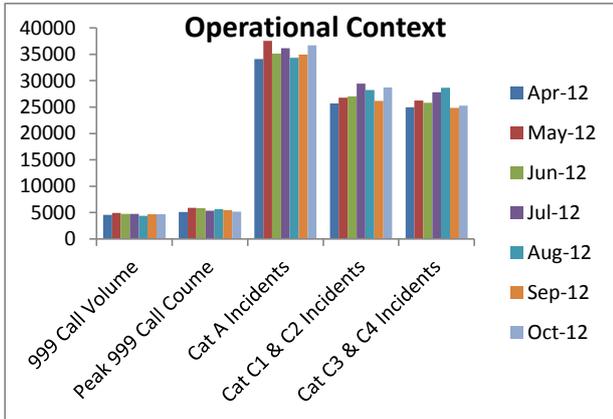


# 1. Operational Context

# Attachment 2

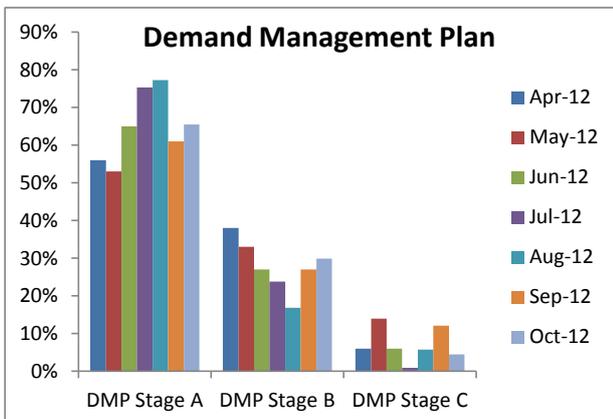
Daily Performance & Activity				REAP 3	
	Sept	Oct	MoM	Y2Y	
Av. Daily Vol.	4704	4656	-1%	4.7%	
Peak Daily Vol.	5490	5151	-7%	-9.5%	
Cat A Calls	34985	36701	5%	10.1%	
Cat C1 & 2 Calls	26176	28725	9%	10.6%	
Cat C3 & 4 Calls	24866	25269	2%	-10.3%	
<b>Total Incidents</b>	<b>86027</b>	<b>90695</b>	<b>5%</b>	<b>3.7%</b>	
DMP Stage A	61%	66%	5%	-15%	
DMP Stage B	27%	30%	3%	17%	
DMP Stage C	12%	5%	-8%	-2%	
Percentage >	100%	100%	0%	10%	

September 2012 Report			REAP 3	
	Aug	Sept	MoM	Y2Y
Av. Daily Vol.	4402	4704	6%	7%
Peak Daily Vol.	5619	5490	-2%	4%
Cat A Calls	34374	34985	2%	11%
Cat C1 & 2 Calls	28214	26176	-8%	8%
Cat C3 & 4 Calls	28670	24866	-15%	-9%
<b>Total Incidents</b>	<b>91258</b>	<b>86027</b>	<b>-6%</b>	<b>4%</b>
DMP Stage A	77%	61%	-16%	-12%
DMP Stage B	17%	27%	10%	9%
DMP Stage C	6%	12%	6%	3%
Percentage > REAP	100%	100%	0%	10%



999 total call volume continue to rise this year with the month of October seeing an additional 3.228 calls enter the system, this equates to a growth of 3.65% in-comparison to last October. The Trust overall Category A demand remains challenging with an overall growth rate of 10.1% over the same financial period last year.

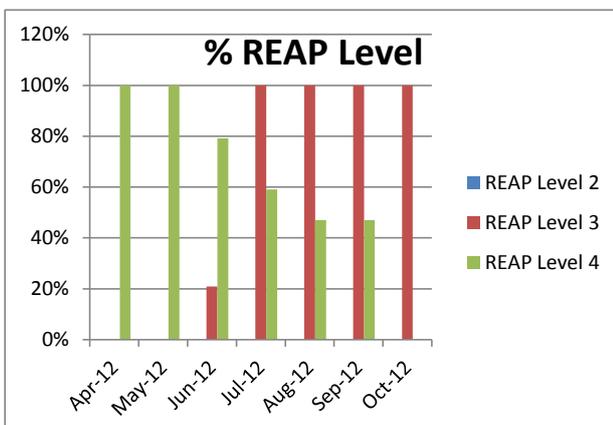
Category C1/C2 calls were up 9% and C3/C4 calls up 2% from the previous month, with year on year comparison showing an increase in C1/C2 of 10.6%.



Another gauge used to monitor the activity pressures is the utilisation rate of our demand management plan (DMP).

In the month of October we operated at DMP level A for 64% of the total hours in the month. This demonstrates that for 31% of the total hours of the month we hit the triggers to escalate the DMP level.

In the month of October we enacted DMP level B over 232 hours and DMP level C for over 30 hours.



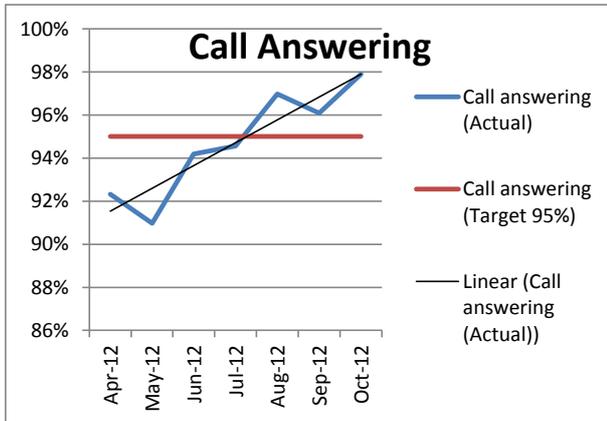
REAP levels have remained at level 3 throughout the financial year.

## 2. Care for Patients

## Attachment 2

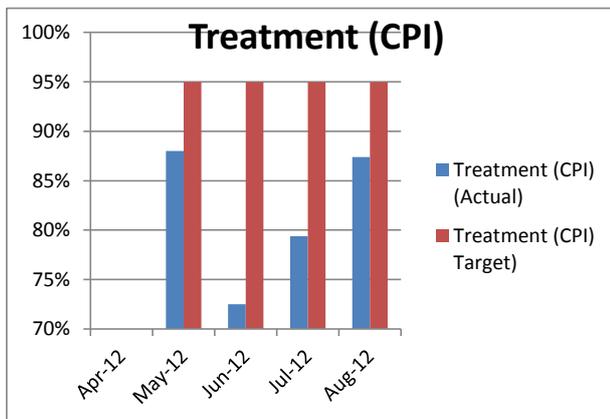
Caring for Patients during their Journey	
* First Contact (Call Answering)	97.9%
* Treatment (CPI)	90.0%
* Clinical Outcomes	96%
* Patient Safety Index	134
* Patient Wellbeing	Green
* Service Experience	Green

September 2012 Report	
* First Contact (Call Answering)	96.1%
* Treatment (CPI)	87.4%
* Clinical Outcomes	96%
* Patient Safety Index	56
* Patient Wellbeing	Green
* Service Experience	Green



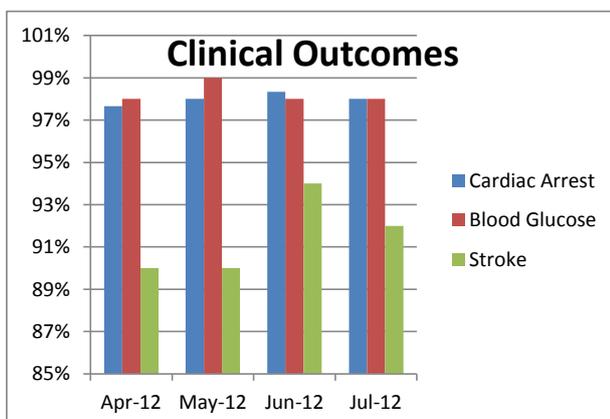
Calls answered within 5 seconds or less for the month of October achieved 97.9% with the year to date sitting at 94.8% marginally below the 95% threshold.

During the month of October we produced c130k hours of frontline ambulance cover supplemented by c60k of FRU cover.

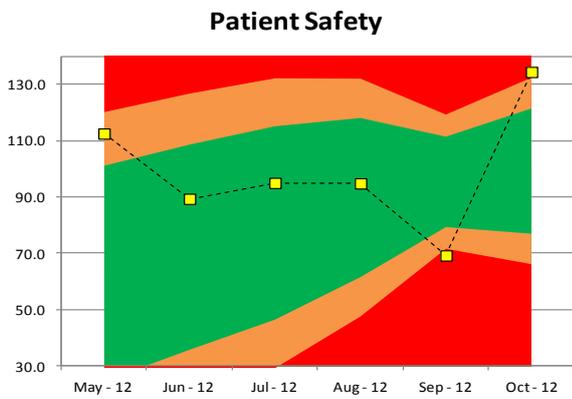


We expect a 95% feedback rate for the Clinical Performance Indicators. For the month of September the compliance was 90%. This measure is RAG rated RED.

This measure has been RAG rated red since April 2012. However, the compliance figure is improving and the CPI graph showing CPI feedback compliance (See Quality Report p4) has a correlation with Olympic pressures. It is expected that CPI compliance will return to levels above 95% very soon.



Overall the compliance is high and this month there are still 6 green indicators. The figures do not meet the national standards for 5 as they need to be 95% to be compliant. However, the amber indicators are the same month in and month out; these areas are not showing signs of improvement. This measure has been given an AMBER RAG rating as 5 of the indicators remain amber.



**Patient Safety Index:** The Patient Safety Index (PSI) has been consistently within the GREEN zone since the beginning of the year, moving briefly into AMBER in April May where there was an increased number of clinical incidents reported per 100,000 hours worked. In September, the Patient Safety Index moved into the low red zone due to a reduction in reported patient safety incidents. However, in October, the number of incidents relating to missing equipment, specifically missing medical devices, such as tympanics, BM kits and pulse oxymeters has increased by 1163%. This is as a result of changes in National Clinical Performance Indicators, whereby missing equipment is no longer an exception, and staff have been submitting incident reports to mitigate a reduction in compliance in the overall CPI.

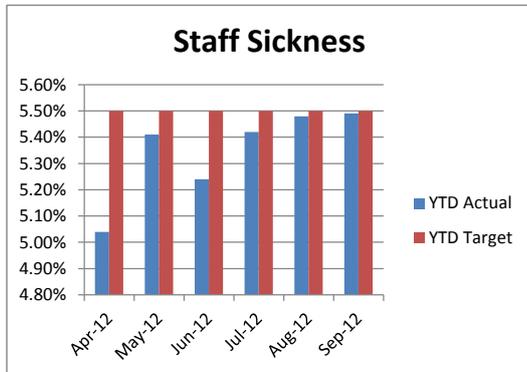
Actions have been put in place by local management to improve the availability of equipment. This includes the introduction of a quarterly audit and tasking Performance Improvement Managers to oversee the equipment replacement process. The Trust is also looking at the procurement of personal issue disposable BM kits.

**Service Experience:** We have awarded ourselves a GREEN rating as we now have a strong Integrated Risk Report and a subsequent action plan on improving experience which is being used throughout the governance structure.

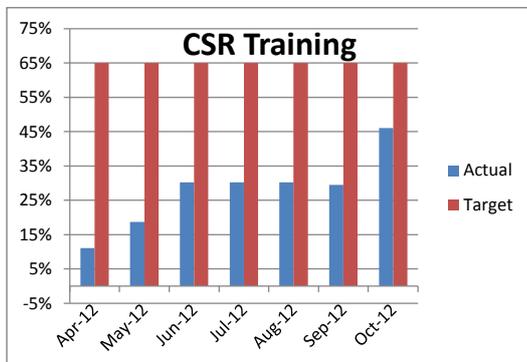
### 3. Care for Staff

Care for Staff - Workforce Report		
How will we sustain change and improve?		
Performance Indicators		T/C
* Staff Sickness Levels	5.49%	---
* Staff Core Skills Training	46%	3.1
* Staff Development (PDR)	35%	2.5
* Staff Retention	8.2%	2.8
* Staff Safety & Wellbeing	79	3.2
* Staff Satisfaction	3.4	

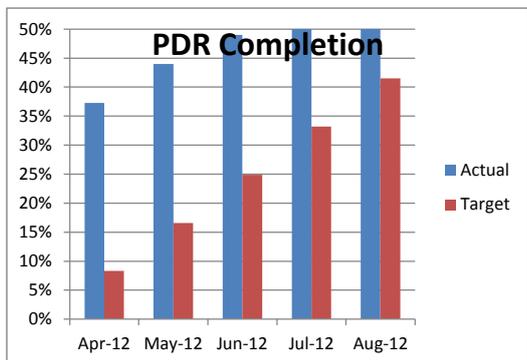
September 2012 Report		
How will we sustain change and improve?		
Performance Indicators		T/C
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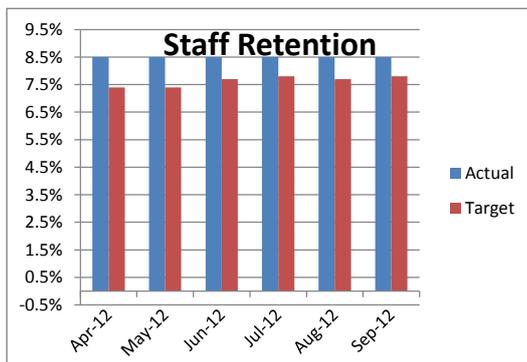
Sickness absence YTD for 12/13 now stands at 5.45%, remaining ahead of the year end figure for 11/12, but still meeting the 12/13 target of 5.5% or below. The RAG rated audits continue to show that, in the main, all absence is being managed appropriately and in accordance with the Managing Attendance Policy (MAP). As previously reported, joint work between Operations and HR senior teams has been launched to review all aspects of sickness absence and management processes, with a second workshop to consider the strategic approach to attendance management to be held this month.



The original CQUIN targets for CSR 1, CSR 2 and CSR 3 were 60% by the end of the year but there were also milestones against each of the quarters. The demands made by the Olympic Games made it difficult to release staff in the usual manner and therefore the Trust will not meet the Quarterly targets of the CQUIN. However, the Training & Strategy Group made the decision to focus on CSR 1 training post Olympic Games. This means the CQUIN measure for CSR 2 & 3 will not be met. The AMBER rating is given to reflect the CQUIN position for CSR 2 & 3 but it is anticipated that CSR 1 will be recovered to 60% by the end of the year. October course capacity 638, 303 staff booked, 295 attended (46%).

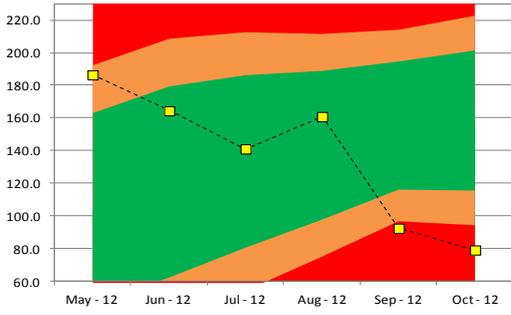


The PDR completion percentage of 35.4% does not include targets from South and East area, but PDRs have been completed there.

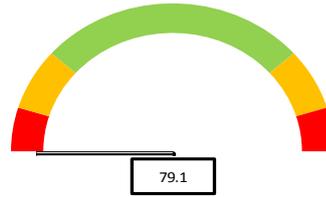


Staff retention remains close to the target of 8.5%.

**Staff Safety**



**Staff Safety Index**



**Incident Reporting:**

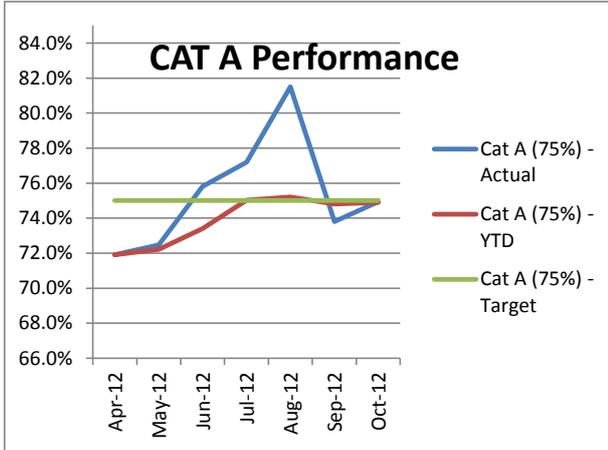
**Reported Incident Levels**

The Staff Safety Index (number of staff safety incidents reported per 100,000 hours worked) has fallen into the RED zone for the last two months, and now stands at 79.1 against an expected lower range of 118. This may be explained by the fact that October saw a 1,163% increase in the number of patient safety incidents.

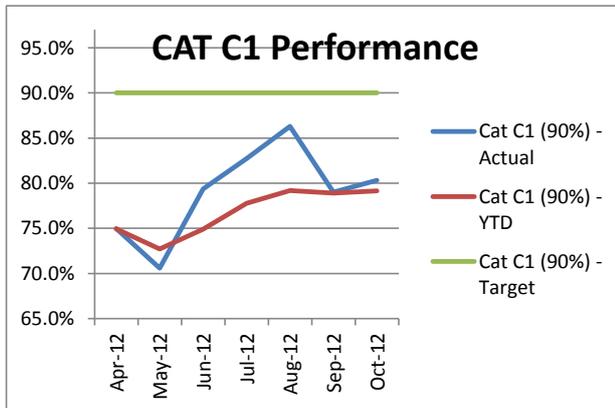
## 4. Service Delivery

Service Delivery		
Evidencing Delivery of the Response model		
Performance Indicators	Actual	YTD/Pr
* Cat A Target (75%)	74.9%	74.9%
* Cat C1 Target (90%)	80.3%	79.1%
* Cat C2 Target (90%)	71.8%	75.3%
* Ambulance Utilisation (55%)	86.6%	83.5%
* FRU Utilisation (40%)	44.7%	42%
* Complaints/Serious Incidents	70	60

September 2012 Report		
Evidencing Delivery of the Response model		
Performance Indicators	Actual	YTD/Pr
* Cat A Target (75%)	73.8%	74.8%
* Cat C1 Target (90%)	79.0%	78.9%
* Cat C2 Target (90%)	71.3%	75.7%
* Ambulance Utilisation (55%)	83.3%	85.8%
* FRU Utilisation (40%)	45%	44%
* Complaints/Serious Incidents	60	70

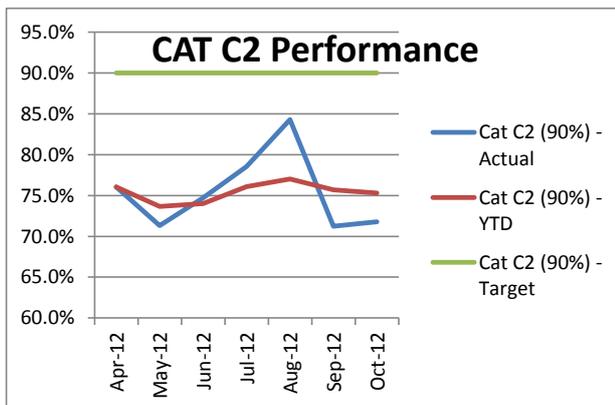


The month of October saw the Trust achieve 74.9% for category A8 performance. This meant that the Trust marginally fell below the national key standard of 75% for category A8 performance, and below the trajectory target of 77.5% submitted to our commissioners. It is extremely disappointing to report that for the second month in succession we have been unable to achieve the A8 national standard and commissioner's trajectory. On a positive note our A8 year to date (YTD) trajectory remains on track. The A8 YTD position as of the end of October stood at 74.9% against an agreed position of 74.6%. Red 1 performance for the month of October finished at 77%, this is a 3.5% improvement on the September position.

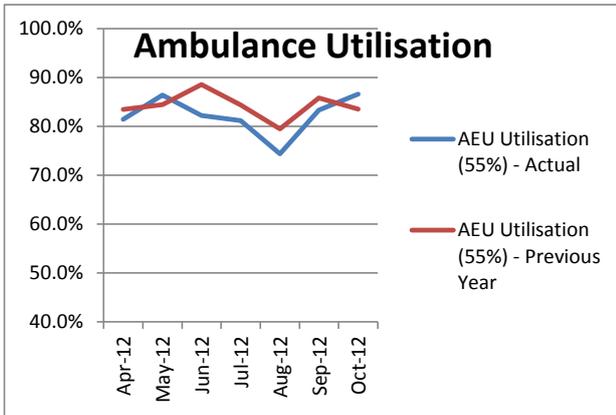


Category C1 has marginally improved in October, reaching 80.3% against the locally agreed target of 90%.

The quality report notes the longest waits for an ambulance to C1 calls were 14.6 and 6.4 hours, both of which involved the Metropolitan Police (see Quality Report). The most significant delay in terms of the impact on the patient's condition was a 3.3 hour delay for an elderly patient, where her friend reported that her condition had changed.



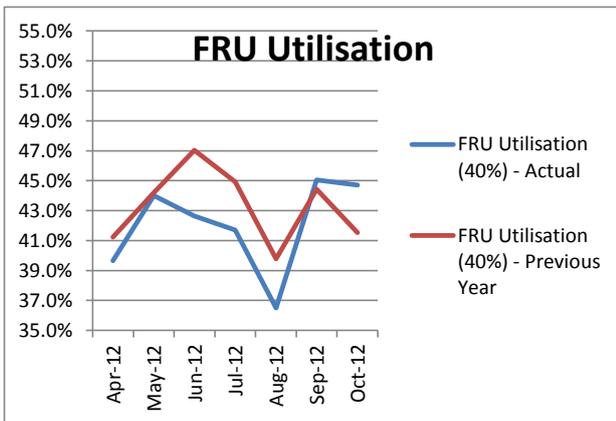
Category C2 performance was 71.8% - our lowest compliance since April 2012. The longest 10 waits in the C2 category in August ranged from 36 to 6.1 hours; the 36 hrs wait is not regarding a specific patient but is a potential fire arms case here we were asked to stand by. This is the case for four of the other longest waits. There are no significant clinical cases within the remaining five cases although it is worth noting that three of the cases delayed beyond six hours were mental health patients; two of which were reporting suicidal thoughts. The Trust's Clinical Advisor for Mental Health is working with CSD and Control to look at the way we manage patients expressing suicidal thoughts.



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

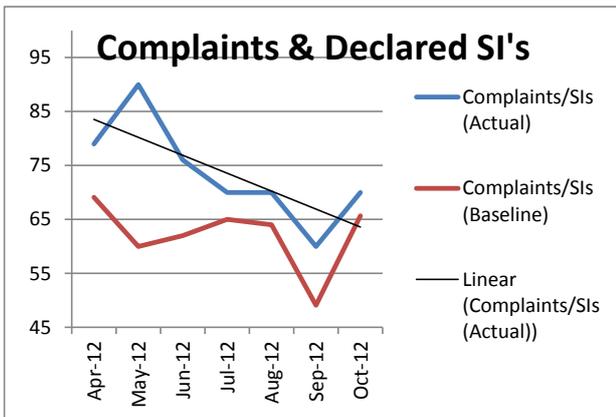
Frontline ambulance utilisation for the month of October reached 86.6% this is an increase of 3.1% based on the same month last year. This increase in utilisation is despite a 2% increase in the number of frontline ambulance hours being produced in comparison to last October.

FRU utilisation in October saw an overall growth of 3.5% to 45% in comparison to the same period last year, despite the Trust producing an additional 2.4% of FRU hours.



A&E support utilisation saw the greatest increase with October ending at 68.7% an increase of 12% in-comparison to last October, whilst producing an additional 645 hours.

October saw the Trust produce an additional 5,798 hours in comparison to last October with total utilisation increasing from 63.3% to 65.4% which clearly demonstrates the additional pressures the Trust is attempting to absorb.



The number of complaints received is running at 18% above the expected baseline (rolling average over the previous 12 months).

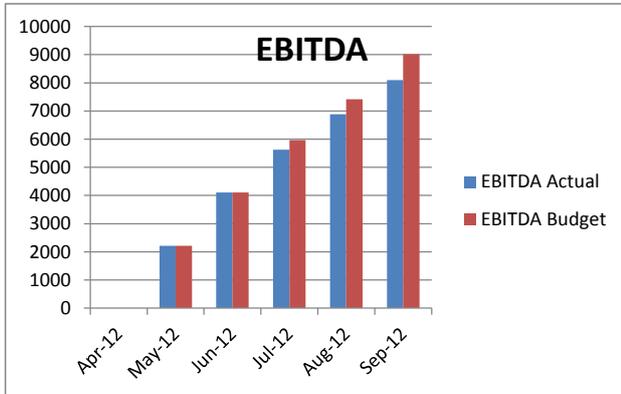
A summary of complaints and Serious Incidents is now provided to the ADOs on a weekly basis.

## 5. Value for Money

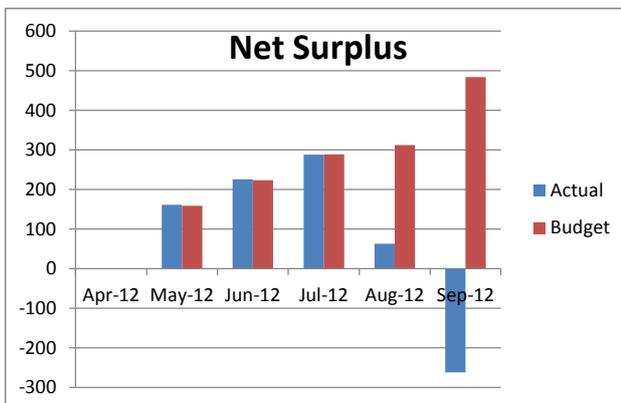
Attachment 2

Value for Money (September)	
<b>Evidencing stewardship of the public purse (YTD)</b>	
* Financial EBITDA	8,096
* Net Surplus	-262
* Cost Improvement Programme	5,354
* CQUINs	640
* Monitor Net Rating (FRR)	2
* Carbon Reduction Plan	
	A > G

August 2012 Report	
<b>Evidencing stewardship of the public purse (YTD)</b>	
* Financial EBITDA	6,884
* Net Surplus	63
* Cost Improvement Programme	4,308
* CQUINs	623
* Monitor Net Rating (FRR)	2
* Carbon Reduction Plan	
	A < G



EBITDA - Is currently behind plan due to pay & non pay expenditure exceeding plan and slippage on depreciation.



Surplus - is behind plan by £746k while forecast to achieve control total of £3,093k. A recovery plan is being developed to return the trust to planned trajectory.



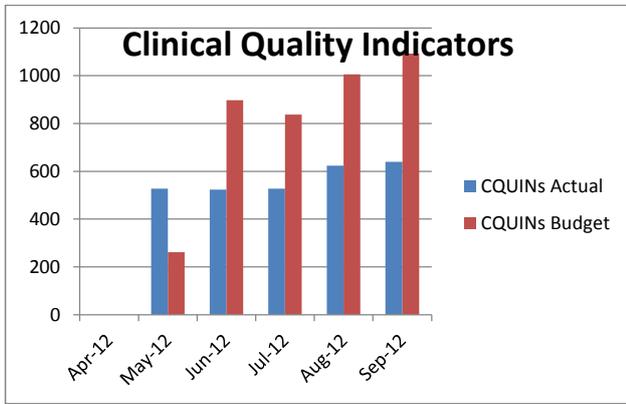
**Process Management:** Higher than planned to offset delays in Resource Mgt and Other programmes.

**Resource Management:** Control CIP under achieved due to increased overtime use as a result of the implementation of CommandPoint.

**Other Op Pay:** The revised rest break policy has not been issued or implemented, impacting on subsistence payments

**Support Services Staffing:** Support Services pay is under review regarding the mix of post reduction and vacancy management

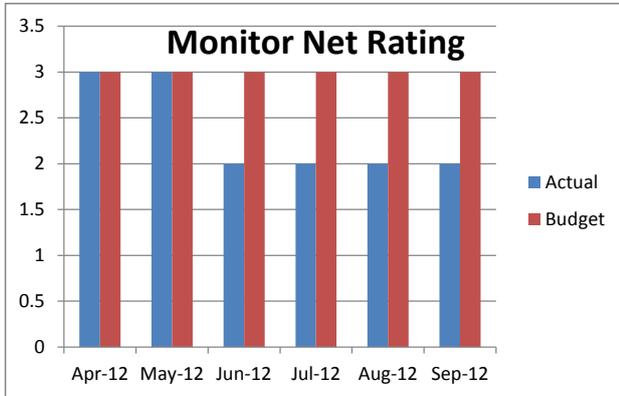
**Other Non Pay:** Annual leave calculation highlights no reduction in Annual Leave accrual. This is offset by over achievement in other non-pay CIP programmes



The Trusts CQUIN Income risk is disclosed excluding the £1.5 million risk reserve held within the Trusts expenditure reserves.

Current high risk forecast (£1,236K) is within the available risk reserve therefore is forecast to not impact on the Trusts overall position.

High and Medium risk CQUINs now total £3.1 million which is outside available reserves.



The Monitor Net Rating remains at 2 due to the liquidity

## **Carbon Footprint Report:**

### ***Interim Report 2012-13***

The data year to date suggests that the Trust is on track to deliver circa 4% carbon savings this year, this is dependent on all things remaining equal in terms of procurement as it is the key component of the Trust's carbon footprint.

#### **Fuel: [GREEN]**

Fuel consumption has increased compared to the same period 2011/12 by 3.8%, in line with increase in demand.

Compared to 2011/12 the Trust is conveying less patients and resolving more incidents at scene; the PCT Sep report has 30.02% of incidents not being conveyed. There is increased utilization of the Cycle Response Unit, with an increase of 42% compared to activations in the same period 2011/12 and on average about 50% of the incidents attended by CRU are resolved at scene.

However we are resolving fewer calls using Hear & Treat compared to the same period last year by circa 7% (YTD Sep 2011 (32844) compared to YTD Sep 2012 (30,715). There are a number of initiatives in the pipeline to decrease our fuel consumption e.g the Trust is testing an on-board telematics device in November to evaluate its potential benefits.

#### **Energy: [AMBER]**

Year to date electricity consumption is less than 2011/12; but gas consumption has increased, reflecting in part a cold summer and the change in usage of Bow to a 24/7 office following VRC's relocation there earlier in the year. There is no gas data for October as new AMR metres are being installed and we are awaiting bills.

There are ongoing efforts to implement energy saving measures across the Estate, from replacing old inefficient boilers to installing efficient lighting in garages ensuring that lighting is not used when there is sufficient daylight. Work has been undertaken by the Estates team to 'cleanse' the data regarding energy consumption has to date our data regarding usage has largely being based on estimates.

**Procurement: [GREEN]** the available data suggests that year to date the Trust's carbon footprint is less than the same period last year. The new system has measured the carbon footprint of purchases and given a figure of 11,766 tCO<sub>2</sub> e. A member of the Medical Directorate is working closely with the Procurement team to review our medical equipment purchases, rationalizing purchases whilst ensuring that clinical standards are upheld and achieving significant savings.

											Attachment 3				
Quadrant	Performance Indicator	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13		
<b>Care for patients</b>	<b>Description</b>	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13		
Call Answering (Actual)	Call answering (Actual)	92%	91%	94%	95%	97%	96.09%	98%							
Call Answering (Target)	Call answering (Target 95%)	95%	95%	95%	95%	95%	95%	95%							
Treatment (CPI) (Actual)	Treatment (CPI) (Actual)		88%	73%	79%	87%	90%								
Treatment (CPI) Target)	Treatment (CPI) Target)		95%	95%	95%	95%	95%								
Clinical Outcomes	Cardiac Arrest	98%	98%	98%	98%	96%	95%								
Clinical Outcomes	Blood Glucose	98%	99%	98%	98%	98%	98%								
Clinical Outcomes	Stroke	90%	90%	94%	92%	95%	94%								
Clinical Outcomes	Aggregate	95%	96%	96%	96%	96%	96%								
Patient Safety Index (Actual)	Clinical & Non-Clinical Incidents raised by staff/100,000 hours worked	68	67	53	53	69	134								
Patient Safety Index (Target)	Clinical & Non-Clinical Incidents raised by staff/100,000 hours worked	59	58	57	58	60	99								
Patient Wellbeing	Actions arising from the Learning from Experiences Report		Green	Green	Green	Green									
Quality Barometer	Quality Dashboard		Green	Green	Green	Green									
<b>Care for Staff</b>	<b>Description</b>	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13		
Staff Sickness (Actual)	YTD Actual	5.04%	5.41%	5.24%	5.42%	5.48%	5.49%	5.45%							
Staff Sickness (Target)	YTD Target	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%	5.50%		
Actual	Actual Percentage of staff receiving CSR 1, 2 and 3 training against plan	11%	19%	30%	30%	30%	30%	46%							
Target	Target Percentage of staff receiving CPR 1, 2 and 3 training against plan	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%		
Actual	Percentage of staff who have completed Performance Development Plans	37%	44%	49%	54%	54%	35%	35%							
Target	Percentage of staff who have completed Performance Development Plans	8%	17%	25%	33%	42%	50%	58%	66%	75%	83%	91%	100%		
Actual	Staff Retention Actual YTD Turnover	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%	8.5%		
Target	Staff Retention Target YTD Turnover	7.4%	7.4%	7.7%	7.8%	7.7%	7.8%	8.2%							
Actual	SSI - LHC, Physical & Verbal Abuse incidents/100,000 hours worked - Actual	59	63	56	42	98	79								
Target	SSI - LHC, Physical & Verbal Abuse incidents/100,000 hours worked - Target	69	69	68	65	113	158								
<b>Service Delivery</b>	<b>Description</b>	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13		
Cat A Target Performance (75%)	Cat A (75%) - Actual	71.9%	72.5%	75.8%	77.2%	81.5%	73.8%	74.9%							
Cat A Target Performance (75%)	Cat A (75%) - YTD	71.9%	72.2%	73.4%	75.0%	75.2%	74.8%	74.9%							
Cat A Target Performance (75%)	Cat A (75%) - Target	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%							
Cat C1 Target (90%)	Cat C1 (90%) - Actual	75.0%	70.6%	79.4%	82.7%	86.3%	79.0%	80.3%							
Cat C1 Target (90%)	Cat C1 (90%) - YTD	75.0%	72.7%	74.9%	77.8%	79.2%	78.9%	79.1%							
Cat C1 Target (90%)	Cat C1 (90%) - Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%							
Cat C2 Target (90%)	Cat C2 (90%) - Actual	76.0%	71.3%	74.7%	78.6%	84.3%	71.3%	71.8%							
Cat C2 Target (90%)	Cat C2 (90%) - YTD	76.0%	73.7%	74.0%	76.1%	77.0%	75.7%	75.3%							
Cat C2 Target (90%)	Cat C2 (90%) - Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%							
Ambulance Utilisation (55%)	AEU Utilisation (55%) - Actual	81.4%	86.4%	82.3%	81.2%	74.4%	83.3%	86.6%							
Ambulance Utilisation (55%)	AEU Utilisation (55%) - Previous Year	83.4%	84.5%	88.5%	84.4%	79.5%	85.8%	83.5%							
FRU Utilisation (40%)	FRU Utilisation (40%) - Actual	39.7%	44.0%	42.64%	41.7%	36.50%	45.05%	44.7%							
FRU Utilisation (40%)	FRU Utilisation (40%) - Previous Year	41.2%	44.2%	47.0%	44.9%	40%	44%	42%							
Number of Complaints received	Complaints/Slis (Actual)	79	90	76	70	70	60	70							
Number of Complaints received	Complaints/Slis (Baseline)	69	60	62	65	64	49	66							
<b>Value for Money</b>	<b>Description</b>	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13		
Financial EBITDA	EBITDA Actual		2216	4104	5628	6884	8096								
Financial EBITDA	EBITDA Budget		2216	4104	5966	7416	9015	10733	12581	14574	16675	18827	21992		
Net Surplus	Actual		161	226	288	63	-262								
Net Surplus	Budget		159	223	289	312	484	724	968	1357	1855	2404	3116		
Cost Improvement Programme	CIP Actual		1179	2407	3321	4308	5354								
Cost Improvement Programme	CIP Budget		1179	2407	3321	4308	5354	6149	7359	8718	10134	11550	13594		
CQUINs	CQUINs Actual		528	523	527	623	640								
CQUINs	CQUINs Budget		262	898	837	1006	1093	2613	3062	3510	4490	5470	6448		
Monitor Net Rating (FRR)	Actual	3	3	2	2	2	2								
Monitor Net Rating (FRR)	Budget	3	3	3	3	3	3	3	3	3	3	3	3		
Carbon Reduction Plan	Carbon Reduction Plan		Amber			Green	Green								
<b>Operational Context</b>	<b>Description</b>	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13		
999 Call Volume	Average # 999 calls	4585	4914	4761	4727	4402	4704	4656							
Peak 999 Call Coume	Peak # of calls	5081	5884	5809	5320	5619	5490	5151							
Cat A Incidents	CAT A	34083	37547	35119	36167	34374	34985	36701							
Cat C1 & C2 Incidents	CAT C1 & C2	25688	26782	27002	29471	28214	26176	28725							
Cat C3 & C4 Incidents	CAT C3 & C4	24955	26259	25820	27820	28670	24866	25269							
DMP Stage A	% month DMP A	56%	53%	65%	75%	77%	61%	66%							
DMP Stage B	% month DMP B	38%	33%	27%	24%	17%	27%	30%							
DMP Stage C	% month DMP C	6%	14%	6%	0.93%	5.80%	12%	5%							
REAP Level (Target)	REAP Target 75% @ Level 2	75%	75%	75%	75%	75%	75%								
REAP Level (Actual)	REAP Level 2	0%	0%	0%	0%	0%	0%								
REAP Level 3+	REAP Level 3	0%	0%	21%	100%	100%	100%	100%							
REAP Level 4+	REAP Level 4	100%	100%	79%	59%	47.06%	47.06%								

## Integrated Trust Performance Report - Explanation of each measure

### 1. Operational Context

Av. Daily Vol.	REAP 3			
Peak Daily Vol.	Sept	Oct	MoM	Y2Y
999 Call volume	4704	4656	-1%	4.7%
Peak 999 Call	5490	5151	-7%	-9.5%
Cat A Calls	34985	36701	5%	10.1%
Cat C1 & 2 Calls	26176	41177	9%	10.6%
Cat C3 & 4 Calls	24866	25269	2%	-10.3%
DMP Stage A	61%	66%	2%	-15%
DMP Stage B	27%	30%	-7%	12%
DMP Stage C	12%	5%	5%	3%
% > REAP 3	100%	100%	12%	-35%

#### Call Volumes

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

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

#### Demand Management Plan

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

#### REAP Level

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

### 2. Care for Patients

Caring for Patients during their Journey	
How do we care for our patients?	
* First Contact (Call Answering)	97.9%
* Treatment (CPI)	90.0%
* Clinical Outcomes	96%
* Patient Safety Index	134
* Patient Wellbeing	Green
* Service Experience	Green

#### First Contact (Call Answering)

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

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

#### Treatment (CPI)

Did we correctly assess and treat our patients?

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

#### Clinical Outcomes

Did our patients have a positive outcome?

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

#### Patient Safety

How have we ensured patient safety?

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

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

### Patient Wellbeing

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

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

### Clinical Quality/Barometer – Service Experience

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

## 3. Care for Staff

Care for Staff - Workforce Report		
How will we sustain change and improve?		
Performance Indicators		T/C
* Staff Sickness Levels	5.49%	---
* Staff Core Skills Training	46%	3.1
* Staff Development (PDR)	35%	2.5
* Staff Retention	8.2%	2.8
* Staff Safety & Wellbeing	79	3.2
* Staff Satisfaction	3.4	

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

### Staff Availability

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

### Staff Training

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

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

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

### Staff Development

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

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

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

### Staff Retention

How are we ensuring that staff are managed well?

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

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

### Staff Safety and Wellbeing

How are we ensuring that staff are safe at work?

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

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

### Staff Satisfaction

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

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

## 4. Service Delivery Quadrant

Service Delivery		
<i>Evidencing Delivery of the Response model</i>		
Performance Indicators	Actual	YTD/Pr
* Cat A Target (75%)	74.9%	74.9%
* Cat C1 Target (90%)	80.3%	79.1%
* Cat C2 Target (90%)	71.8%	75.3%
* Ambulance Utilisation (55%)	86.6%	83.5%
* FRU Utilisation (40%)	44.7%	42%
* Complaints/Serious Incidents	70	60

### Cat A & C Target Performance

How is the Trust performing against targets?

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

### Utilisation

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

### Quality Barometer

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

## 5. Value for Money Quadrant

Value for Money	
<i>Evidencing stewardship of the public purse (YTD)</i>	
* Financial EBITDA	8,096
* Net Surplus	-262
* Cost Improvement Programme	5,354
* CQUINs	640
* Monitor Net Rating (FRR)	2
* Carbon Reduction Plan	A > G

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

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

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



## LONDON AMBULANCE SERVICE TRUST BOARD

Month 7 - September 2012

### PAPER FOR REVIEW

<b>Document Title:</b>	<b>Trust Finance Board Report</b>
<b>Report Author(s):</b>	Fatima Kazmi
<b>Lead Director:</b>	Mike Dinan
<b>Contact Details:</b>	Michael.Dinan@lond-amb.nhs.uk
<b>Why is this coming to the Trust Board?</b>	Monthly Trust Financial Review
<b>This paper has been previously presented to:</b>	Senior Management Group
<b>Recommendation for the Trust Board:</b>	<ul style="list-style-type: none"><li>• The committee is asked to comment on the information included within the month 7 report.</li></ul>
<b>Executive Summary/key issues for the Trust Board</b>	
<p>The Trust is reporting a deficit of £183k for the month against a planned surplus of £190k - a variance of £374k. YTD the Trust is in a deficit of £445k against a planned surplus of £675k - a variance of £1.1m. The Cash position remains on track.</p> <p>The Capital position is underspent by £2.0m y.t.d. The Trust is behind on both actual EBITDA and on its planned net surplus. The forecast control total for 2012/13 of £3.1m is in line with the plan. The trust has developed a financial recovery plan for review at the Trust Board on 27/11/11 . The key financial risks to delivery are:</p> <ul style="list-style-type: none"><li>- Continued unfunded increases in demand.</li><li>- The receipts of 690k of QDJ</li><li>- achievement of £5.7m CQUINS</li><li>- delivery on all operational KPIs and avoidance of any financial KPIs</li></ul>	
<p>CIP is on track year to date and forecast to achieve plan at year end.</p>	
<p>From a DH compliance perspective, the CRL is forecasting a £2m underspend and EFL is forecast to be in line with the plan. The CRL is behind due to delay in the Fast Response Vehicle replacement programme and delays in Estate project. The current slippage is likely to continue until year end.</p>	
<b>Attachments</b>	

### Corporate Objectives 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
- ✓ 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?

No

Key issues from the assessment:

Key issues from the assessment:

## COMMENTARY - MONTH 7

### Result

The LAS made a loss of £184k for the month. This compared to a loss of £324k for month 6.

Ytd, the cumulative loss is £446k compared to budgeted surplus of 674k.

The forecast for the year is a surplus of £3,092k. This is in line with the budgeted control total.

Forecast EBITDA is £1.2m below budget at 7.0% of income or £20.5m. This compares to £18.6m (6.6%) for 2011/12

The variance in EBITDA is primarily driven by

- Additional Income (Olympics, RTA & QDJ)
- Additional pay costs (Overtime)
- Additional 3<sup>rd</sup> party expense

The CIP is forecast to deliver savings of £12.5m.

The Trust is on track to achieve a Financial Risk Rating of 3.

### Income

For the month, overall income was £24,812k. This was £1.1m above plan

Key driver was the billing of the Olympics contingency which has been agreed with PCTs.

Ytd, total income is up £3,849k vs budget.

- Additional agreed Olympic income (Contingency, ODA & b/fwd)
- QDJ accrual
- RTA income calculated from DH data

For 2011/12, the forecast income is £291,630k which is £2,666k above budget

In the forecast, the positive ytd variance is offset by a provision of £1,769k for CQUIN not delivered.

Other than for March 2013 when the balance of the CQUIN is billed, the forecast average monthly income of £23.5m is expected to be reasonably consistent.

The LAS has not heard back from the Dr Anne Rainsberry on the QDJ income and has followed up with another letter.

The forecast still assumes that this commitment for support for additional activity outside of the core A&E contract will be honoured.

### Expense

For the month, total operating expense was £23,457k (m6 £23,664k) and total expense was £24,994k (m6 £25,201k).

- Total Pay decreased by £287k
- A&E pay increased by £349k, driven by increased base staffing and overtime
- This was offset by reduction in other overtime £339k and Agency cost £217kk
- Non pay increased by £79k
- Third party expense increased by £355k, caused by an increase in monthly operating expenditure (£200k) and invoices relating to previous months (£155k)
- Staff related pay reduced by £1m as the due to the high costs of the Olympic payments in m6.

Ytd, total operating expense was ££5,090k above budget and total expense was £4,969k above budget.

Total Pay costs are £2,060k over plan

- Increased A&E overtime spend of £4,352
- Other overtime up by £825k
- Both overtime overspends are driven by increased activity and are , in part , funded by additional income for the Olympics and QDJ
- Additional activity, particularly regarding Category A is resulting in the Trust absorbing c. £1.5m in increased activity without additional funding
- Increased agency spend of £1,011k is offset by an under spend of £1,803k in Corporate Support pay . Vacancies are not being filled by permanent staff.

Ytd Non pay is £3,033k above budget.

- 3<sup>rd</sup> party expense driven by increased demand and Olympic contingency cover is up £2,586
- Staff related payment are up £1,897k caused by additional Olympic requirements and increased A&E demand
- Other Non Pay controls are offsetting the overspends in 3<sup>rd</sup> party and staff related costs

For 2012/13, the forecast total operating expense is £289m which is £2.8m above budget.

Adjusting for the Olympics, total expense is up 1% on 2011/12 in a period where A&E calls are up 9.3%, CatA incidents are up 13.2% and overall demand is up 3.5%

Forecast average payroll expense is £17m per month for the remaining 5 months of 2012/13.

Overtime spend has been re-profiled in line with the updated workforce plan and the need to deliver on the Financial Recovery Plan

Forecast monthly average non pay cost of £4.7m for rest of the year is in line with previous years and reflects the post Olympics business.

- 3<sup>rd</sup> party expense has been reduced in line with the Financial recovery plan
- All other discretionary expense is subject to tight financial controls

#### **Cost Improvement Programme (CIP)**

Ytd, the CIP is on track

- Slippages in rest breaks (£572k)
- Offset by additional non Pay Savings and non recurrent savings in Corporate Support

The Director of Finance has implemented a continuous review of all of the existing CIP projects.

#### **Balance Sheet & Cash flow**

Total Assets Employed by the LAS of £114m is unchanged from m4. Forecast total assets employed is £118m.

Trust on track to deliver a return on assets of 6.84% for the year compared to a plan of 6.6%

The capital plan is under spent by £2m on its capital plan ytd. This is caused by a delay in fleet, estates and IM&T hardware projects

Forecast capital expenditure of £11.9m is projected to be below the plan or CRL of £2.4m.

The Finance & Investment Committee and SMG continue to closely monitor capital spend.

Cash balances were £6.4m at the end of m7. The forecast cash balance for m12 remains £5.5m. Key elements of the forecast include:

- Delivery of forecast EBITDA (£20.5m)
- Capital plan delivered

#### **Better Payment Practice Code (BPPC)**

Ytd performance for supplier payments is Non NHS (80%) and NHS (53%) which is behind the required 95%.

This metric is being tracked by the department to improve performance.

#### **Financial Risks**

Key financial risks remain

- Continued high demand
- Unachieved CQUIN
- Failure to deliver the CIP
- Overtime and third party expense control
- QDJ income

A worse case scenario has been developed identifying a £2.9m risk to the current forecast.

Existing controls plus the application of the Financial Recovery Plan are expected to mitigate this risk.

#### **Financial Recovery Plan (FRP)**

An FRP was developed to deliver the planned £3.1m surplus.

The FRP underpins the forecast. It will be further reviewed at the Trust Board on 27/11/12, taking account of continued increased demand and operating pressures

**Mike Dinan**

**Director of Finance**

**November 2012**

**London Ambulance Service  
Summary Financial Compliance 2012/13 - Month 7**

Month 7 - October 2012				Description	Year to Date				FY 2012/13			
Budg	Act	Var	%		Budg	Act	Var	%	Budg	Fcast	Var	%
£000	£000	£000			£000	£000	£000		£000	£000	£000	
<b>Dept Health</b>												
190	(184)	374	-203.3%	Surplus	674	(446)	1,120	-251.1%	3,092	3,092	0	0.0%
(727)	647	(1,374)	-212.4%	EFL	(759)	(2,238)	1,479	-66.1%	(1,998)	(1,999)	1	-0.1%
1,455	344	1,111	76.4%	CRL	7,555	5,441	2,114	28.0%	12,400	11,934	466	3.9%
95	58	37	63.8%	Suppliers paid within 30 days - NHS	95	53	42	79.2%	95	58	37	63.8%
95	73	22	30.1%	Suppliers paid within 30 days - Non NHS	95	80	15	18.8%	95	83	12	14.5%
<b>Monitor</b>												
7.1%	5.5%	2%	29.7%	EBITDA %	6.3%	5.5%	1%	15.7%	7.5%	7.0%	0%	6.9%
190	(184)	374	-203.3%	Net Surplus	674	(446)	1,120	-251.1%	3,092	3,092	0%	0.0%
2.45%	2.46%	0%	-0.4%	Return on Assets	2.45%	2.46%	0%	-0.4%	5.71%	5.70%	0%	0.0%
(10.29)	(9.97)	(0)	3.3%	Liquidity Days	(10.29)	(9.97)	(0)	3.3%	(10.38)	(10.26)	(0)	1.1%
	2			Monitor net rating		2				2		

**Commentary**

Surplus - is behind plan by £1.1m while forecast to achieve control total of £3,093k. A recovery plan has been developed to return the trust to planned trajectory during Q3.

EFL - Forecast for the year in line with Plan, y.t.d variance due to the higher than planned cash balance at the end of month 7.

CRL - Year to date behind plan due to delayed delivery of Fast Response Vehicles and slippage in the Estates programme.

'BPPC - the trust recommenced reporting against the BPPC from month 5 after the new financial services arrangements were implemented.

EBITDA - Is currently behind plan due to pay & non pay expenditure exceeding plan and slippage on depreciation.

Return on Assets is in line with plan.

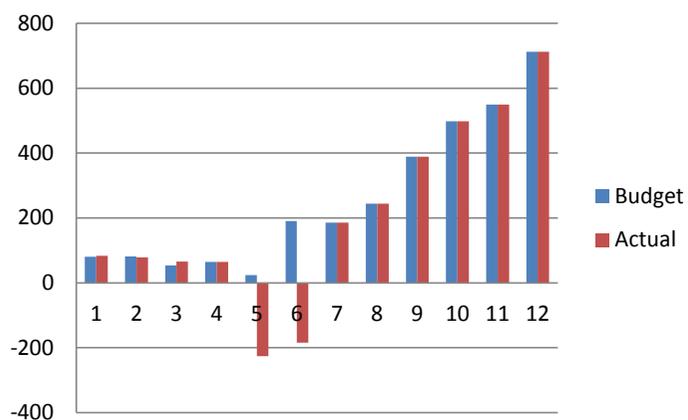
Liquidity - Whilst this currently shows a Rating of 1. When a Working Capital Loan facility of £22.3m is added, this will increase to 3.

Monitor net rating - Currently 2 due to Liquidity.

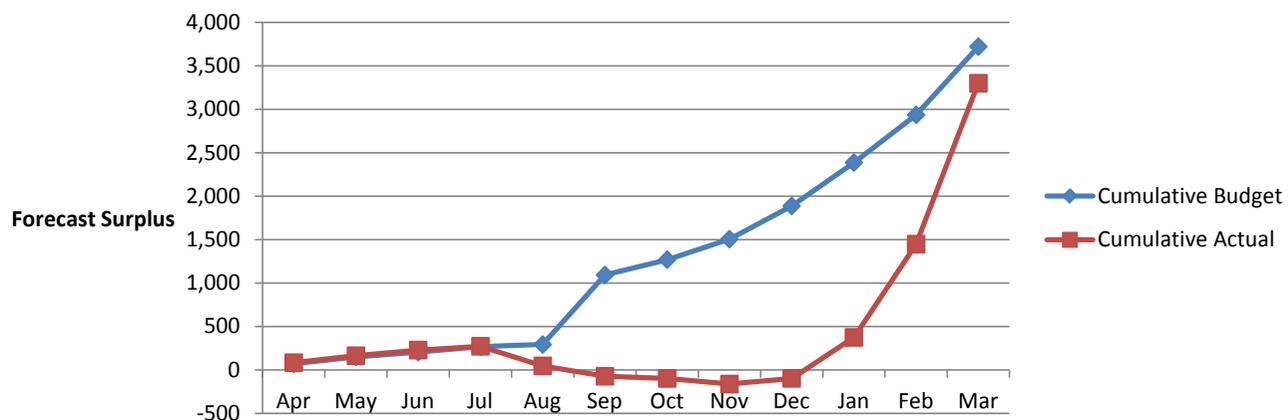
## London Ambulance Service Summary Financial Information 2012/13 - Month 7

Month 7 - October 2012				Description	Year to Date				FY 2012/13			
Budg	Act	Var	%		Budg	Act	Var	%	Budg	Fcast	Var	%
£000	£000	£000			£000	£000	£000		£000	£000	£000	
23,697	24,812	1,115	-4.5%	Income	168,902	172,751	3,849	-2.2%	288,963	291,650	2,687	-0.9%
1,678	1,355	(323)	23.8%	EBITDA	10,692	9,451	(1,241)	13.1%	21,746	20,534	(1,212)	5.9%
7.1%	5.5%	2%	29.7%	EBITDA %	6.3%	5.5%	1%	15.9%	7.5%	7.0%	0%	6.9%
190	(184)	374	-203.3%	Net Surplus	674	(446)	1,120	-251.1%	3,092	3,092	0	0.0%
0.8%	-0.7%	2%	-208.1%	Net margin %	0.4%	-0.3%	1%	-254.6%	1.1%	1.1%	0%	0.9%
1,664	867	797	91.9%	CQUIN	1,664	867	797	91.9%	6,202	4,433	1,769	39.9%
924	924	0	0.0%	CIP	6,469	6,469	0	0.0%	12,498	12,498	0	0.0%
7,175	7,175	0	0.0%	Cash balance	7,175	7,175	0	0.0%	5,500	5,500	0	0.0%
				Net Current Assets less								
(7,057)	(9,190)	2,133	-23.2%	Current Liabilities	(7,057)	(9,190)	2,133	-23.2%	(3,406)	(6,556)	3,150	-48.0%
114,848	114,848	0	0.0%	Total Assets Employed	114,848	114,848	0	0.0%	118,207	118,207	0	0.0%
2.45%	2.46%	(0)	-0.4%	Return on Assets	2.45%	2.46%	(0)	-0.4%	5.71%	5.70%	0	0.0%

### Net Surplus Budget vs Actual



### Cumulative Net Surplus £ Budget v. Actual



**London Ambulance Service  
Summary Revenue 2012/13 - Month 7**

Month 7 - October 2012				Description	Year to Date				FY 2012/13			
Budg	Act	Var	%		Budg	Act	Var	%	Budg	Fcast	Var	%
£000	£000	£000			£000	£000	£000		£000	£000	£000	
				<b>Income</b>								
22,419	22,690	271	-1.2%	Emergency & Urgent care	156,982	158,693	1,711	-1.1%	272,251	272,559	308	-0.1%
1,278	2,122	844	-39.8%	Other	11,920	14,058	2,138	-15.2%	16,712	19,091	2,379	-12.5%
<b>23,697</b>	<b>24,812</b>	<b>1,115</b>	<b>-4.5%</b>	<b>Subtotal</b>	<b>168,902</b>	<b>172,751</b>	<b>3,849</b>	<b>-2.2%</b>	<b>288,963</b>	<b>291,650</b>	<b>2,687</b>	<b>-0.9%</b>
				<b>Operating Expense</b>								
16,938	17,141	(203)	-1.2%	Pay	121,193	123,725	(2,532)	-2.0%	205,053	208,157	(3,104)	-1.5%
5,081	6,316	(1,235)	-19.6%	Non Pay	37,017	39,575	(2,558)	-6.5%	62,164	62,959	(795)	-1.3%
<b>22,019</b>	<b>23,457</b>	<b>(1,438)</b>	<b>-6.1%</b>	<b>Subtotal</b>	<b>158,210</b>	<b>163,300</b>	<b>(5,090)</b>	<b>-3.1%</b>	<b>267,217</b>	<b>271,116</b>	<b>(3,899)</b>	<b>-1.4%</b>
<b>1,678</b>	<b>1,355</b>	<b>(323)</b>	<b>23.8%</b>	<b>EBITDA</b>	<b>10,692</b>	<b>9,451</b>	<b>(1,241)</b>	<b>13.1%</b>	<b>21,746</b>	<b>20,534</b>	<b>(1,212)</b>	<b>5.9%</b>
7.1%	5.5%	1.6%	29.7%	<b>EBITDA margin</b>	6.3%	5.5%	0.9%	15.7%	7.5%	7.0%	0.5%	6.9%
				<b>Depreciation &amp; Financial</b>								
1,094	1,186	(92)	-7.8%	Depreciation	7,261	7,318	(57)	-0.8%	13,927	13,116	811	6.2%
326	326	0	0.0%	PDC Dividend	2,284	2,284	0	0.0%	3,915	3,916	(1)	0.0%
68	27	41	151.9%	Interest	473	295	178	60.3%	812	503	309	61.4%
1,488	1,539	(51)	-3.3%	<b>Subtotal</b>	<b>10,018</b>	<b>9,897</b>	<b>121</b>	<b>1.2%</b>	<b>18,654</b>	<b>17,535</b>	<b>1,119</b>	<b>6.4%</b>
<b>190</b>	<b>(184)</b>	<b>374</b>	<b>0</b>	<b>Net Surplus/(Deficit)</b>	<b>674</b>	<b>(446)</b>	<b>(1,362)</b>	<b>0</b>	<b>3,092</b>	<b>3,092</b>	<b>0</b>	<b>(0)</b>
0.8%	-0.7%	1.5%	-208.1%	<b>Net margin</b>	0.4%	-0.3%	0.7%	-254.6%	1.1%	1.1%	0.0%	0.9%

**Commentary (items over 100k only)**

Income - Additional support for Queens Diamond Jubilee has been discussed with NWLCH. Additional income accrued as a result. Also the DH requested additional dedicated resourcing for the 2012 Olympics which has also been accrued c£1m. Current unearned CQUIN is forecast to be £1.8 million.

Expenditure – Pay is over spent y.t.d due to additional overtime expense driven by an increase in Cat A demand of 13.6% and additional Queens Diamond Jubilee workload. Average monthly spend of £17.6m is forecast to reduce to £16m in the second half of the year.

Expenditure – Non pay - Spending on third party transport to support patient care and staff related expenses have been offset by CIP reductions in other non pay categories including leasing costs.

EBITDA - Actual EBITDA and margin are below plan due to increased non pay expenditure in Q1 & Q2.

**London Ambulance Service**  
**Summary Financial Risk 2012/13 - Month 7**

	Gross Risk				Net	Not Inc	Notes
	Value	Impact	Likelihood	Rating	Value	Forecast	
	£000			£000	£000	£000	
<b>Income</b>							
CQUIN	6,225	5	3	15	1,769	0	Based on high risk items in monthly commissioners report
Contract Penalty	10,179	5	3	15	0		Cat A currently at 74.7% ytd.
Contract Non Recurrent Funds	2,400	3	4	12	400	400	Based on changed hospital turnaround risk in relation to cluster performance, total £1.5m at risk current est worst perf, £500k
QDJ Income	690	3	5	15		511	Additional Support for QDJ accrued.
Olympics	1,000	3	3	9	0		Additional dedicated resources for 2012 Olympics accrued
<b>Subtotal</b>	<b>20,794</b>				<b>2,169</b>	<b>911</b>	
<b>Expense</b>							
CIP not achieved	12,498	5	3	15	312	0	2.5% of gross value
Overtime control	8,004	5	3	15	800	0	10% of gross value. Offset by Base Pay
Annual leave benefit accrual	1,200	3	2	6	0	0	Monthly monitoring in place - residual risk based on current movement
Economic - Fuel/Rates	574	3	3	9	0	0	50% of gross value
Other Expense	1,333	3	3	9	0	500	0.5% of operating expense (gross). 25% assumed net.
Continued Clinical Operating Pressure	1,500	4	3	12	0	1500	
<b>Subtotal</b>	<b>25,109</b>				<b>1,113</b>	<b>2,000</b>	
<b>Other</b>							
PTS profitability	163	3	3	9	0	0	
Impact of 111	6,362	5	2	10	0	0	1% of operating expense (gross). 0% assumed net
Unexpected events	0	2	2	4	0	0	
<b>Subtotal</b>	<b>6,525</b>				<b>0</b>	<b>0</b>	
<b>TOTAL</b>	<b>52,428</b>				<b>3,282</b>	<b>2,911</b>	

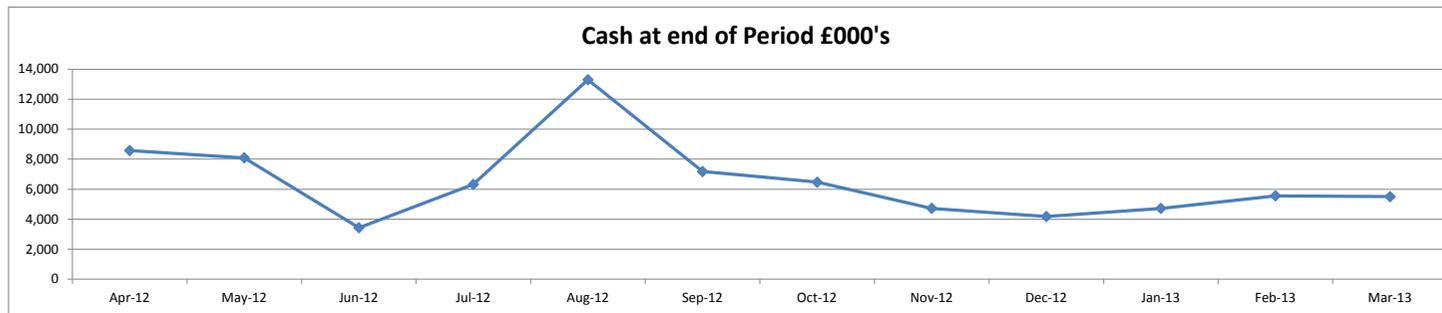
**London Ambulance Service  
Summary Expense Trend 2012/13 - Month 7**

		Monthly Performance												Quarterly Performance				
		Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	12/13	Q1	Q2	Q3	Q4
		Act	Act	Act	Act	Act	Act	Act	Fcast	Fcast	Fcast	Fcast	Fcast	Total	Act	Act	Fcast	Fcast
		£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
<b>Payroll</b>																		
Crew staff - base	BP01	10,194	10,193	10,087	10,009	10,057	9,954	10,164	10,551	10,551	10,542	10,542	9,942	122,784	30,474	30,019	31,266	31,025
Crew staff - overtime	BP02	1,064	1,115	2,195	1,931	2,297	1,010	1,149	823	823	523	523	523	13,974	4,374	5,238	2,794	1,568
<b>Subtotal</b>		<b>11,258</b>	<b>11,308</b>	<b>12,281</b>	<b>11,939</b>	<b>12,354</b>	<b>10,964</b>	<b>11,313</b>	<b>11,374</b>	<b>11,373</b>	<b>11,065</b>	<b>11,064</b>	<b>10,464</b>	<b>136,758</b>	<b>34,848</b>	<b>35,258</b>	<b>34,060</b>	<b>32,593</b>
A&E Mgt	BP04	1,215	1,182	1,227	1,287	1,277	1,294	1,254	1,296	1,293	1,245	1,245	1,234	15,048	3,624	3,858	3,843	3,723
EOC	BP05	974	970	982	954	1,006	996	974	953	953	953	953	953	11,621	2,926	2,956	2,880	2,859
Operational Support	BP06	294	303	294	257	274	220	271	280	280	280	280	280	3,314	891	751	831	840
HART/EPU		363	439	415	467	399	399	402	402	403	411	412	412	4,924	1,217	1,265	1,207	1,235
PTS	BP07	337	345	344	329	319	330	342	348	348	348	348	348	4,084	1,026	978	1,037	1,044
Support Services	BP08	2,401	2,399	2,360	2,356	2,300	2,427	2,342	2,333	2,340	2,352	2,352	2,352	28,313	7,159	7,082	7,015	7,057
Other Overtime	BP09	203	188	148	91	59	394	55	161	161	161	161	169	1,950	539	544	377	490
Agency	BP10	217	192	226	93	54	407	190	67	59	61	61	61	1,688	635	554	317	182
<b>Total Payroll</b>		<b>17,262</b>	<b>17,326</b>	<b>18,277</b>	<b>17,773</b>	<b>18,041</b>	<b>17,430</b>	<b>17,143</b>	<b>17,214</b>	<b>17,210</b>	<b>16,875</b>	<b>16,875</b>	<b>16,273</b>	<b>207,700</b>	<b>52,865</b>	<b>53,245</b>	<b>51,567</b>	<b>50,024</b>
<b>Non Pay</b>																		
Staff related	BN01	588	786	530	738	1,234	1,823	800	548	544	533	533	532	9,190	1,904	3,796	1,891	1,598
Med equip, Csmbles & drugs	BN02	698	592	705	425	575	650	491	474	447	445	445	200	6,147	1,995	1,650	1,413	1,090
Vehicle leasing	BN03	256	301	117	257	357	349	301	148	149	150	151	2,685	675	962	598	450	
Fuel & Oil	BN04	532	547	477	477	526	480	505	502	502	502	502	6,052	1,556	1,482	1,508	1,505	
Vehicle Maintenance	BN05	477	746	627	781	788	220	598	598	598	598	1,356	7,986	1,850	1,789	1,794	2,552	
Vehicle Insurance	BN07	(102)	503	(87)	(558)	462	116	371	202	202	202	202	1,718	314	21	776	607	
3rd Party transport *1	BN08	268	328	352	723	614	378	733	176	173	173	176	4,269	948	1,714	1,082	524	
Accommodation & Estates	BN09	1,124	1,124	1,147	1,293	1,215	1,177	1,037	985	990	986	991	13,020	3,395	3,684	3,012	2,928	
IT & Telecoms	BN10	808	683	622	921	498	905	944	730	730	729	722	9,013	2,112	2,323	2,403	2,174	
Finance & legal	BN11	566	(291)	(667)	781	58	(174)	251	11	11	8	9	611	(392)	664	273	66	
Consultancy	BN12	69	60	38	8	(10)	62	122	62	48	64	48	619	167	60	232	160	
Other Non Pay	BN13	168	201	288	206	(48)	248	160	219	120	150	150	2,011	656	406	499	449	
<b>Subtotal</b>		<b>5,452</b>	<b>5,581</b>	<b>4,149</b>	<b>6,053</b>	<b>6,267</b>	<b>6,234</b>	<b>6,313</b>	<b>4,655</b>	<b>4,513</b>	<b>4,540</b>	<b>4,527</b>	<b>5,038</b>	<b>63,320</b>	<b>15,181</b>	<b>18,553</b>	<b>15,481</b>	<b>14,105</b>
<b>Depreciation</b>																		
Other	BD03	909	395	1,447	1,096	1,117	1,168	1,186	1,160	1,220	1,138	1,141	1,141	13,116	2,751	3,381	3,565	3,419
<b>Subtotal</b>		<b>909</b>	<b>395</b>	<b>1,447</b>	<b>1,096</b>	<b>1,117</b>	<b>1,168</b>	<b>1,186</b>	<b>1,160</b>	<b>1,220</b>	<b>1,138</b>	<b>1,141</b>	<b>1,141</b>	<b>13,116</b>	<b>2,751</b>	<b>3,381</b>	<b>3,565</b>	<b>3,419</b>
<b>Financial</b>																		
PDC dividend	BF01	326	326	326	326	326	327	326	326	326	326	326	326	3,916	979	979	979	979
Interest	BF02	58	41	50	19	38	42	27	42	42	42	42	42	483	149	98	111	125
<b>Subtotal</b>		<b>384</b>	<b>368</b>	<b>376</b>	<b>345</b>	<b>364</b>	<b>369</b>	<b>353</b>	<b>368</b>	<b>368</b>	<b>368</b>	<b>368</b>	<b>368</b>	<b>4,399</b>	<b>1,128</b>	<b>1,078</b>	<b>1,090</b>	<b>1,104</b>
<b>TOTAL</b>		<b>24,007</b>	<b>23,670</b>	<b>24,248</b>	<b>25,267</b>	<b>25,788</b>	<b>25,201</b>	<b>24,994</b>	<b>23,396</b>	<b>23,311</b>	<b>22,921</b>	<b>22,911</b>	<b>22,820</b>	<b>288,536</b>	<b>71,925</b>	<b>76,256</b>	<b>71,702</b>	<b>68,652</b>
Total Income		(24,088)	(23,749)	(24,312)	(25,331)	(25,562)	(24,877)	(24,811)	(23,480)	(23,390)	(23,782)	(23,578)	(24,669)	(291,630)	(72,150)	(75,769)	(71,681)	(72,029)
Run rate		(81)	(79)	(64)	(64)	226	324	184	(84)	(79)	(860)	(667)	(1,849)					
YTD		(81)	(161)	(225)	(288)	(62)	262	446	362	283	(577)	(1,244)	(3,094)					
<b>Memo</b>																		
A&E Third Party transport	BN08	21	26	30	31	16	37	77	40	40	40	40	40	438	77	84	157	120

**London Ambulance Service  
Summary Cashflow 2012/13 - Month 7**

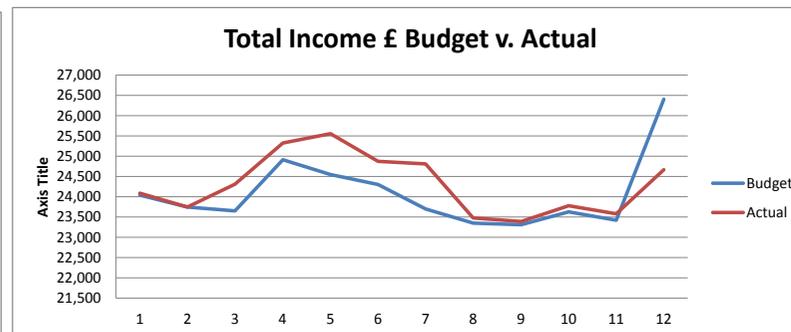
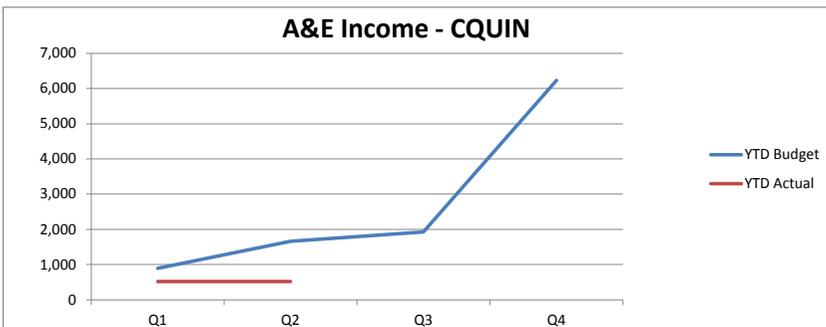
\* cash flow forecast arising from accounting forecast

	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
	Actual £000	Actual £000	Actual £000	Actual £000	Actual £000	Actual £000	Fcast £000	Fcast £000	Fcast £000	Fcast £000	Fcast £000	Fcast £000
<b>Opening Balance</b>	5,250	8,578	8,091	3,429	6,323	13,298	7,175	6,464	4,723	4,177	4,719	5,559
<b>Cash receipts</b>												
PCTs	23,925	24,476	23,967	21,558	32,295	24,581	25,985	23,311	23,018	23,444	23,218	24,846
Other Income	393	408	627	716	290	472	422	345	427	345	427	349
PDC Drawdown	0	0	0	0	0	0	0	0	0	0	0	0
Capital Receipts	0	0	0	0	0	0	0	0	0	0	0	0
Interest Received	3	4	3	21	4	4	7	7	6	5	5	5
VAT	229	464	294	412	162	421	250	250	250	250	250	250
Repaid Investments	0	0	0	0	0	0	0	0	0	0	0	0
Other Receipts	0	0	0	0	0	0	0	0	0	0	0	0
<b>Total receipts</b>	<b>24,550</b>	<b>25,352</b>	<b>24,891</b>	<b>22,707</b>	<b>32,751</b>	<b>25,478</b>	<b>26,664</b>	<b>23,913</b>	<b>23,701</b>	<b>24,044</b>	<b>23,900</b>	<b>25,450</b>
<b>Cash Payments</b>												
Payroll	(10,251)	(9,988)	(10,988)	(10,360)	(10,226)	(9,392)	(10,182)	(10,156)	(10,155)	(9,961)	(9,957)	(9,596)
PAYE/NIC	(5,745)	(7,180)	(7,335)	(7,272)	(7,700)	(7,682)	(7,148)	(7,029)	(7,058)	(7,056)	(6,919)	(6,919)
Suppliers	(2,303)	(5,944)	(8,359)	(2,055)	(7,593)	(8,806)	(9,603)	(8,413)	(6,706)	(6,300)	(5,423)	(5,456)
Capital Expenditure	(2,880)	(2,674)	(2,834)	(100)	(229)	(3,059)	(427)	(30)	(300)	(157)	(733)	(936)
Interest Payable	(43)	(53)	(37)	(26)	(28)	(31)	(15)	(26)	(28)	(28)	(28)	(22)
PDC dividends	0	0	0	0	0	(2,009)	0	0	0	0	0	(1,958)
Loan repayment	0	0	0	0	0	(622)	0	0	0	0	0	(622)
Investments	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	0
<b>Total Payments</b>	<b>(21,222)</b>	<b>(25,839)</b>	<b>(29,553)</b>	<b>(19,813)</b>	<b>(25,776)</b>	<b>(31,601)</b>	<b>(27,375)</b>	<b>(25,654)</b>	<b>(24,247)</b>	<b>(23,502)</b>	<b>(23,060)</b>	<b>(25,509)</b>
<b>Net Inflows/(Outflows)</b>	<b>3,328</b>	<b>(487)</b>	<b>(4,662)</b>	<b>2,894</b>	<b>6,975</b>	<b>(6,123)</b>	<b>(711)</b>	<b>(1,741)</b>	<b>(546)</b>	<b>542</b>	<b>840</b>	<b>(59)</b>
<b>Closing Balance</b>	<b>8,578</b>	<b>8,091</b>	<b>3,429</b>	<b>6,323</b>	<b>13,298</b>	<b>7,175</b>	<b>6,464</b>	<b>4,723</b>	<b>4,177</b>	<b>4,719</b>	<b>5,559</b>	<b>5,500</b>
<b>Revenue Reconciliation</b>												
Cashflow from Operating Activities	6,353	2,233	(1,735)	2,385	7,248	(387)	(209)	(1,668)	(200)	750	1,619	3,497
Cashflow from Investing Activities	(2,852)	(2,699)	(2,844)	531	(253)	(5,095)	(438)	(54)	(326)	(184)	(759)	(2,914)
Cashflow from Financing Activities	(173)	(21)	(83)	(22)	(20)	(641)	(64)	(19)	(20)	(24)	(20)	(642)
<b>Net Inflow/outflow</b>	<b>3,328</b>	<b>(487)</b>	<b>(4,662)</b>	<b>2,894</b>	<b>6,975</b>	<b>(6,123)</b>	<b>(711)</b>	<b>(1,741)</b>	<b>(546)</b>	<b>542</b>	<b>840</b>	<b>(59)</b>
<i>Cash at beginning of Period</i>	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
<i>Cash at end of Period</i>	5,250	8,578	8,091	3,429	6,323	13,298	7,175	6,464	4,723	4,177	4,719	5,559
	8,578	8,091	3,429	6,323	13,298	7,175	6,464	4,723	4,177	4,719	5,559	5,500



**London Ambulance Service  
Summary Income 2012/13 - Month 7**

Month 7 - October 2012				Description	Year to Date (Q2)				FY 2012/13				% Act	
Budg	Act	Var	%		Budg	Act	Var	%	Budg	Fcast	Var	%		
£000	£000	£000			£000	£000	£000		£000	£000	£000			
19,255	20,052	797	-4.0%	BI01	Base	145,078	145,868	790	-0.5%	248,106	248,094	(12)	0.0%	85.9%
1,664	867	(797)	91.9%		CQUIN*	1,664	867	(797)	91.9%	6,202	4,433	(1,769)	39.9%	2.1%
<b>20,919</b>	<b>20,919</b>	<b>0</b>	<b>0.0%</b>		<b>Subtotal (PCT)</b>	<b>146,742</b>	<b>146,735</b>	<b>(7)</b>	<b>0.0%</b>	<b>254,308</b>	<b>252,527</b>	<b>(1,781)</b>	<b>0.7%</b>	<b>88.0%</b>
<b>Specialised Services</b>														
631	642	11	-1.7%	BI02	CBRN	4,416	4,495	79	-1.8%	7,570	7,706	136	-1.8%	2.6%
591	679	88	-13.0%	BI04	HART	4,136	4,301	165	-3.8%	7,090	7,373	283	-3.8%	2.5%
44	44	0	0.0%		MERIT	58	58	0	0.0%	350	350	0	0.0%	0.1%
<b>1,266</b>	<b>1,365</b>	<b>99</b>	<b>-7.3%</b>		<b>Subtotal</b>	<b>8,610</b>	<b>8,854</b>	<b>244</b>	<b>-2.8%</b>	<b>15,010</b>	<b>15,429</b>	<b>419</b>	<b>-2.7%</b>	<b>5.2%</b>
<b>Commercial</b>														
546	535	(11)	2.1%	BI08	PTS	3,799	3,839	40	-1.0%	6,502	6,511	9	-0.1%	2.3%
71	74	3	-4.1%	BI09	BETS/SCBU	483	480	(3)	0.6%	836	826	(10)	1.2%	0.3%
55	55	0	0.0%	BI15	BAA	387	391	4	-1.0%	663	668	5	-0.7%	0.2%
86	132	46	-34.8%	BI14	Stadia	604	500	(104)	20.8%	1,036	1,057	21	-2.0%	0.4%
3	0	(3)		BI16	Training	28	5	(23)	460.0%	45	9	(36)	400.0%	0.0%
15	39	24	-61.5%	BI10	Other Commercial	105	131	26	-19.8%	181	130	(51)	39.2%	0.1%
<b>776</b>	<b>835</b>	<b>59</b>	<b>-7.1%</b>		<b>Subtotal</b>	<b>5,406</b>	<b>5,346</b>	<b>(60)</b>	<b>1.1%</b>	<b>9,263</b>	<b>9,201</b>	<b>(62)</b>	<b>0.7%</b>	<b>3.2%</b>
<b>Info. Services &amp; Research</b>														
92	92	0	0.0%	BI06	EBS	647	647	0	0.0%	1,109	1,109	0	0.0%	0.4%
14	11	(3)	27.3%	BI07	Research	98	62	(36)	58.1%	168	116	(52)	44.8%	0.1%
<b>106</b>	<b>103</b>	<b>(3)</b>	<b>2.9%</b>		<b>Subtotal</b>	<b>745</b>	<b>709</b>	<b>(36)</b>	<b>5.1%</b>	<b>1,277</b>	<b>1,225</b>	<b>(52)</b>	<b>4.2%</b>	<b>0.4%</b>
<b>Other</b>														
56	108	52	-48.1%	BI03	RTA	455	1,231	776	-63.0%	835	1,711	876	-51.2%	0.3%
35	62	27	-43.5%	BI11	MPET	247	284	37	-13.0%	424	594	170	-28.6%	0.1%
472	1,310	838	-64.0%	BI13	Olympics 2012	6,047	8,190	2,143	-26.2%	6,851	8,995	2,144	-23.8%	2.4%
66	109	44	-40.0%	BI05	Other	708	1,458	750	-51.4%	996	1,948	952	-48.9%	0.3%
<b>629</b>	<b>1,589</b>	<b>961</b>	<b>-60.5%</b>		<b>Subtotal</b>	<b>7,457</b>	<b>11,163</b>	<b>3,706</b>	<b>-33.2%</b>	<b>9,106</b>	<b>13,248</b>	<b>4,142</b>	<b>-31.3%</b>	<b>3.2%</b>
<b>23,696</b>	<b>24,811</b>	<b>1,116</b>	<b>-4.5%</b>		<b>TOTAL</b>	<b>168,960</b>	<b>172,807</b>	<b>3,847</b>	<b>-2.2%</b>	<b>288,964</b>	<b>291,630</b>	<b>2,666</b>	<b>-0.9%</b>	<b>100.0%</b>



\*CQUIN The Trusts CQUIN Income risk is disclosed excluding the £1.5 million risk reserve held within the Trusts expenditure reserves. Current high risk forecast (£1.7m) is within the available risk reserve therefore is forecast to not impact on the Trusts overall position. High and Medium risk CQUINs now total £3.1 million which is outside available reserves.

**London Ambulance Service  
Summary Expense 2012/13 - Month 7**

Month 7 - October 2012				Year to Date				FY 2012/13				%	M6 2011/12		FY 2011/12	
Budg	Act	Var	%	Budg	Act	Var	%	Budg	Fcast	Var	%		Act	YTD	Act	
£000	£000	£000		£000	£000	£000		£000	£000	£000			£000	£000		
10,428	10,249	179	1.7%	BP01	Payroll											
579	1,039	(460)	-44.3%	BP02/BP09	Crew staff - base	72,150	70,907	1,243	1.8%	123,417	123,530	(113)	-0.1%	43.2%	65,068	123,862
					Crew staff - overtime	6,019	10,371	(4,352)	-42.0%	9,165	13,173	(4,008)	-30.4%	3.2%	2,992	10,480
<b>11,007</b>	<b>11,288</b>	<b>(281)</b>	<b>-2.5%</b>		<b>Subtotal</b>	<b>78,169</b>	<b>81,278</b>	<b>(3,109)</b>	<b>-3.8%</b>	<b>132,582</b>	<b>136,703</b>	<b>(4,121)</b>	<b>-3.0%</b>	<b>46.4%</b>	<b>68,060</b>	<b>134,342</b>
1,201	1,238	(37)	-3.0%	BP04	A&E Mgt	9,439	8,719	720	8.3%	15,313	14,945	368	2.5%	5.4%	7,044	14,474
1,016	974	42	4.3%	BP05	EOC	7,277	6,855	422	6.2%	12,271	11,620	651	5.6%	4.3%	6,102	11,461
270	271	(1)	-0.4%	BP06	Operational Support	2,117	1,916	201	10.5%	3,582	3,317	265	8.0%	1.3%	2,095	3,748
402	496	(94)	-19.0%		HART/EPU	2,790	3,217	(427)	-13.3%	4,831	5,539	(708)	-12.8%	1.7%		4,685
353	342	11	3.2%	BP07	PTS	2,512	2,346	166	7.1%	4,276	4,084	192	4.7%	1.5%	2,454	4,438
2,612	2,289	323	14.1%	BP08	Support Services	18,192	16,389	1,803	11.0%	31,155	27,838	3,317	11.9%	10.9%	15,278	28,324
41	55	(14)	-25.5%	BP09	Other Overtime	327	1,152	(825)	-71.6%	533	1,964	(1,431)	-72.9%	0.2%	190	1,686
35	190	(155)	-81.6%	BP10	Agency	368	1,379	(1,011)	-73.3%	511	1,657	(1,146)	-69.2%	0.2%	134	2,147
<b>16,937</b>	<b>17,143</b>	<b>(206)</b>	<b>-1.2%</b>		<b>Total Payroll</b>	<b>121,191</b>	<b>123,251</b>	<b>(2,060)</b>	<b>-1.7%</b>	<b>205,054</b>	<b>207,667</b>	<b>(2,613)</b>	<b>-1.3%</b>	<b>71.7%</b>	<b>101,357</b>	<b>205,305</b>
					<b>Non Pay</b>											
558	800	(242)	-30.2%	BN01	Staff related	4,606	6,503	(1,897)	-29.2%	6,867	9,194	(2,327)	-25.3%	2.4%	3,123	7,105
426	491	(65)	-13.3%	BN02	Med equip, Csmbls & drugs	4,598	4,010	588	14.7%	6,987	6,021	967	16.1%	2.4%	2,981	5,715
317	301	16	5.4%	BN03	Vehicle leasing	2,050	1,938	112	5.8%	3,639	2,684	955	35.6%	1.3%	740	2,470
477	505	(28)	-5.5%	BN04	Fuel & Oil	3,349	3,543	(194)	-5.5%	5,743	6,051	(308)	-5.1%	2.0%	2,974	6,156
626	598	29	4.8%	BN05	Vehicle Maintenance	4,132	4,237	(105)	-2.5%	7,793	7,986	(193)	-2.4%	2.7%	3,804	7,392
135	371	(236)	-63.7%	BN07	Vehicle Insurance	1,268	706	563	79.7%	2,229	1,718	512	29.8%	0.8%	811	1,880
64	733	(669)	-91.3%	BN08	3rd Party transport	811	3,397	(2,586)	-76.1%	1,131	4,270	(3,139)	-73.5%	0.4%	293	1,233
1,287	1,037	249	24.0%	BN09	Accommodation & Estates	8,266	8,117	149	1.8%	13,748	13,078	670	5.1%	4.8%	6,584	12,713
707	944	(237)	-25.1%	BN10	IT & Telecoms	5,326	5,380	(55)	-1.0%	8,776	9,138	(362)	-4.0%	3.1%	3,981	7,474
37	251	(214)	-85.2%	BN11	Finance & legal	177	522	(345)	-66.1%	2,024	610	1,414	231.7%	0.7%	1,103	2,446
25	122	(97)	-79.5%	BN12	Consultancy	234	350	(116)	-33.1%	355	619	(264)	-42.7%	0.1%	346	863
423	160	263	164.8%	BN13	Other Non Pay	2,201	1,347	854	63.3%	2,872	2,137	735	34.4%	1.0%	985	2,312
<b>5,081</b>	<b>6,312</b>	<b>(1,231)</b>	<b>-19.5%</b>		<b>Subtotal</b>	<b>37,017</b>	<b>40,050</b>	<b>(3,033)</b>	<b>-7.6%</b>	<b>62,164</b>	<b>63,505</b>	<b>(1,341)</b>	<b>-2.1%</b>	<b>21.7%</b>	<b>27,725</b>	<b>57,759</b>
					<b>Depreciation</b>											
290	192	98	51.3%	BD03	Other	2,041	1,302	739	56.8%	2,489	2,245	244	10.9%	0.9%	6,335	5,173
586	739	(153)	-20.7%	BD01	Fleet	4,183	4,768	(585)	-12.3%	8,851	8,379	473	5.6%	3.1%	0	1,760
222	255	(34)	-13.2%	BD02	IT	1,038	1,247	(209)	-16.7%	2,586	2,493	93	3.7%	0.9%	0	4,497
<b>1,098</b>	<b>1,186</b>	<b>(88)</b>	<b>-7.4%</b>		<b>Subtotal</b>	<b>7,263</b>	<b>7,318</b>	<b>(55)</b>	<b>-0.8%</b>	<b>13,926</b>	<b>13,116</b>	<b>810</b>	<b>6.2%</b>	<b>4.9%</b>	<b>6,335</b>	<b>11,430</b>
					<b>Financial</b>											
326	326	0	0.0%	BF01	PDC dividend	2,284	2,284	0	0.0%	3,915	3,916	(1)	0.0%	1.4%	1,916	3,884
68	27	41	151.9%	BF02	Interest	473	295	178	60.3%	812	503	309	61.4%	0.3%	790	578
<b>394</b>	<b>353</b>	<b>41</b>	<b>11.6%</b>		<b>Subtotal</b>	<b>2,757</b>	<b>2,579</b>	<b>178</b>	<b>6.9%</b>	<b>4,727</b>	<b>4,419</b>	<b>308</b>	<b>7.0%</b>	<b>1.7%</b>	<b>2,706</b>	<b>4,462</b>
<b>23,510</b>	<b>24,994</b>	<b>(1,484)</b>	<b>-5.9%</b>		<b>TOTAL</b>	<b>168,227</b>	<b>173,198</b>	<b>(4,970)</b>	<b>-2.9%</b>	<b>285,871</b>	<b>288,707</b>	<b>(2,836)</b>	<b>-1.0%</b>	<b>100.0%</b>	<b>138,123</b>	<b>278,956</b>

**Commentary (items over 50k only)**

Crew staff - base - Vacancies higher than budgeted. However, this is partially offset by Overtime in order to maintain produced hours for frontline staff.  
Crew staff - overtime is above projections. The overtime has been increased to help manage increase Cat A demand. In addition to covering the Queens Jubilee Celebrations. Additional income of c£690k is included in the year to date position to cover the Queens Jubilee Expenditure only.

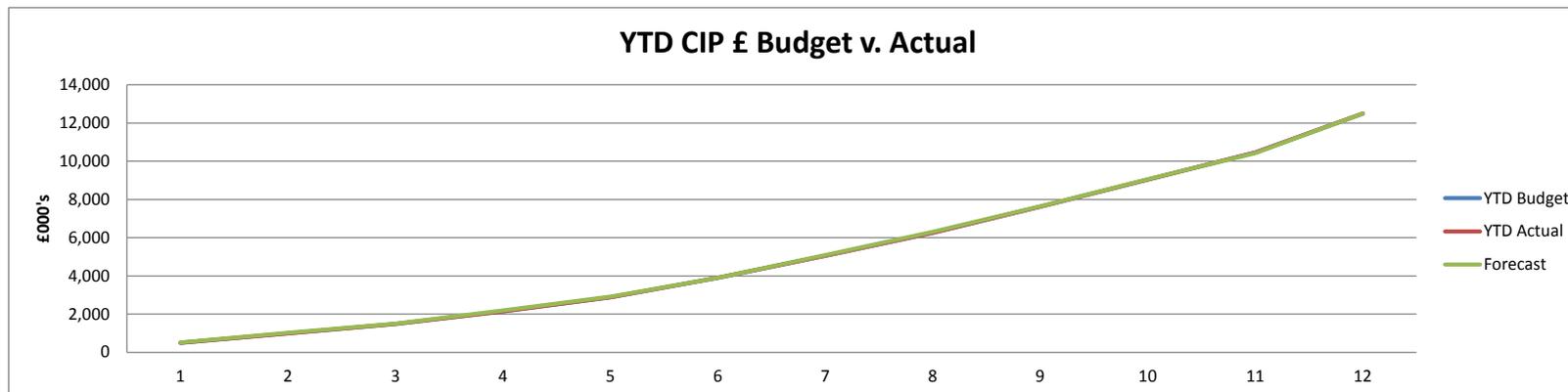
Support Services - Due to a number of vacancies in Corporate Areas, which will be reviewed by the support services review panel before recruitment commences.  
Other overtime - EOC overtime higher than expected due to double time paid at weekends.  
Agency - Higher than anticipated Agency usage due to unfilled vacancies in corporate support areas.  
Staff related - Uniform protective clothing purchases higher than expected  
Fuel & Oil - Fuel consumption continues to increase in line with demand.  
Vehicle Maintenance - Higher than anticipated Maintenance Costs.  
Vehicle Insurance - Actual claims significantly lower than Estimate based on 2011-12 outturn.  
3rd Party transport - Due to demand pressures, greater usage of 3rd Party has been hired.  
Accommodation & Estates - As per budget run rate  
IT & Telecoms - As per anticipated Computer Software and Maintenance charges.  
Finance & legal - year to date adjustment relates to a reversing credit for lease items. The forecast year end position reflects increased spending on staff injury benefit.  
Consultancy - Cost of FT work completed by KPMG  
Other Non Pay - CQUIN reserve adjustment to reflect current high risk projects.  
Depreciation - Lower than anticipated year to date. Forecast to break even at year end.

**London Ambulance Service  
Summary Cost Improvement Programme 2012/13 - Month 7**

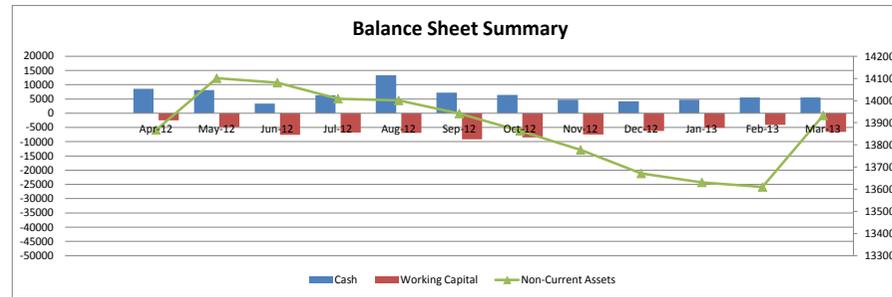
Month 7 - October 2012				Description	Year to Date				FY 2012/13				% Act
Budg	Act	Var	%		Budg	Act	Var	%	Budg	Fcast	Var	%	
£000	£000	£000			£000	£000	£000		£000	£000	£000		
				<b>Operational Pay</b>									
291	291	0	100.0%	Process Mgt	2,036	2,036	0	100.0%	3,821	3,821	0	100.0%	30.6%
91	9	(82)	10.3%	Resource Mgt	638	66	(572)	866.7%	1,579	1,276	(303)	80.8%	12.6%
57	30	(27)	52.4%	Other	397	208	(189)	90.9%	739	114	(625)	15.4%	5.9%
<b>439</b>	<b>330</b>	<b>(109)</b>	<b>75.2%</b>	<b>Subtotal</b>	<b>3,071</b>	<b>2,310</b>	<b>(761)</b>	<b>32.9%</b>	<b>6,139</b>	<b>5,211</b>	<b>(928)</b>	<b>84.9%</b>	<b>49.1%</b>
				<b>Support Service Pay</b>									
165	88	(77)	53.4%	Support Service staffing	1,158	618	(540)	87.4%	2,113	2,113	(0)	100.0%	16.9%
<b>165</b>	<b>88</b>	<b>(77)</b>	<b>53.4%</b>	<b>Subtotal</b>	<b>1,158</b>	<b>618</b>	<b>(540)</b>	<b>87.4%</b>	<b>2,113</b>	<b>2,113</b>	<b>(0)</b>	<b>100.0%</b>	<b>16.9%</b>
				<b>Non Pay</b>									
20	21	1	103.6%	Estates	139	144	5	-3.5%	163	163	0	100.0%	1.3%
300	485	185	161.7%	Other Non Pay	2,101	3,397	1,296	-38.2%	4,082	5,011	929	122.7%	32.7%
<b>320</b>	<b>506</b>	<b>186</b>	<b>158.1%</b>	<b>Subtotal</b>	<b>2,240</b>	<b>3,541</b>	<b>1,301</b>	<b>-36.7%</b>	<b>4,245</b>	<b>5,174</b>	<b>929</b>	<b>121.9%</b>	<b>34.0%</b>
<b>924</b>	<b>924</b>	<b>0</b>	<b>100.0%</b>	<b>TOTAL</b>	<b>6,469</b>	<b>6,469</b>	<b>0</b>	<b>0.0%</b>	<b>12,498</b>	<b>12,498</b>	<b>(0)</b>	<b>100.0%</b>	<b>100.0%</b>

**Commentary**

<i>Process Mgt</i>	Higher than planned to offset delays in Resource Mgt and Other programme
<i>Resource Mgt</i>	Control CIP under achieved due to increased overtime use as a result of the implementation of Command Point
<i>Other Op Pay</i>	Revised rest break policy has not been issued or implemented, impacting on subsistence payments
<i>Support Service staffing</i>	Support Services Pay is underreview regarding mix of post reduction and vacancy management.
<i>Other Non Pay</i>	Offset by over achievement in other non pay CIP programs



**London Ambulance Service  
Summary Balance Sheet 2012/13 - Month 7**



	Monthly Performance												Mar-13				
	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Plan	Var	%	
	Act	Act	Act	Act	Act	Act	Act	Fcast	Fcast	Fcast	Fcast	Fcast	Fcast				
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000			
<b>Non Current Assets</b>																	
Property, Plant & Equip	123,055	122,755	124,239	123,955	123,215	123,148	122,133	121,291	120,431	119,368	118,963	118,758	121,987	119,940	(2,047)	-1.71%	
Intangible Assets	15,033	14,964	14,941	14,918	14,918	14,918	14,918	14,918	14,918	14,918	14,918	14,918	14,918	14,964	46	0.31%	
Trade & Other Receivables	1,770	956	1,829	1,934	1,950	1,942	2,362	2,423	2,423	2,423	2,423	2,423	2,423	956	(1,467)	-153.45%	
<b>Subtotal</b>	<b>139,858</b>	<b>138,675</b>	<b>141,009</b>	<b>140,807</b>	<b>140,083</b>	<b>140,008</b>	<b>139,413</b>	<b>138,632</b>	<b>137,772</b>	<b>136,709</b>	<b>136,304</b>	<b>136,099</b>	<b>139,328</b>	<b>135,860</b>	<b>(3,468)</b>	<b>-154.85%</b>	
<b>Current Assets</b>																	
Inventories	2,812	3,044	3,047	3,137	3,022	3,319	3,595	3,669	3,669	3,669	3,669	3,669	3,669	3,044	(625)	-20.53%	
Trade & Other Receivables	11,940	18,989	16,621	14,589	22,088	14,911	12,035	10,108	9,677	9,368	9,107	8,787	8,008	14,263	6,255	43.85%	
Cash & cash equivalents	5,250	8,578	8,091	3,429	6,323	13,298	7,175	6,464	4,723	4,177	4,719	5,559	5,500	5,500	0	0.00%	
<b>Total Current Assets</b>	<b>20,002</b>	<b>30,611</b>	<b>27,759</b>	<b>21,155</b>	<b>31,433</b>	<b>31,528</b>	<b>22,805</b>	<b>20,241</b>	<b>18,069</b>	<b>17,214</b>	<b>17,495</b>	<b>18,015</b>	<b>17,177</b>	<b>22,807</b>	<b>5,630</b>	<b>23.32%</b>	
<b>Total Assets</b>	<b>159,860</b>	<b>169,286</b>	<b>168,768</b>	<b>161,962</b>	<b>171,516</b>	<b>171,536</b>	<b>162,218</b>	<b>158,873</b>	<b>155,841</b>	<b>153,923</b>	<b>153,799</b>	<b>154,114</b>	<b>156,505</b>	<b>158,667</b>	<b>2,162</b>	<b>1.36%</b>	
<b>Current Liabilities</b>																	
Trade and Other Payables	(21,364)	(30,779)	(30,327)	(26,494)	(36,007)	(36,219)	(30,854)	(27,667)	(24,501)	(22,456)	(21,560)	(21,159)	(22,168)	(24,516)	(2,348)	9.58%	
Provisions	0	0	0	0	0	0	0	0	0	0	0	0	0	(1,150)	(1,150)		
Borrowings	(1,268)	(1,095)	(1,074)	(967)	(945)	(925)	(519)	(424)	(405)	(385)	(361)	(341)	(321)	(453)	(132)	29.14%	
Working Capital Loan - DH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Capital Investment Loan - DH	(1,244)	(1,244)	(1,244)	(1,244)	(1,244)	(1,244)	(622)	(622)	(622)	(622)	(622)	(622)	(1,244)	(1,244)	0	0.00%	
<b>Net Current Liabilities</b>	<b>(23,876)</b>	<b>(33,118)</b>	<b>(32,645)</b>	<b>(28,705)</b>	<b>(38,196)</b>	<b>(38,388)</b>	<b>(31,995)</b>	<b>(28,713)</b>	<b>(25,528)</b>	<b>(23,463)</b>	<b>(22,543)</b>	<b>(22,122)</b>	<b>(23,733)</b>	<b>(27,363)</b>	<b>(3,630)</b>	<b>9.58%</b>	
<b>Non Current Assets plus/less net current assets/Liabilities</b>	<b>135,984</b>	<b>136,168</b>	<b>136,123</b>	<b>133,257</b>	<b>133,320</b>	<b>133,148</b>	<b>130,223</b>	<b>130,160</b>	<b>130,313</b>	<b>130,460</b>	<b>131,256</b>	<b>131,992</b>	<b>132,772</b>	<b>(4,556)</b>	<b>2,000</b>	<b>32.90%</b>	
<b>Non Current Liabilities</b>																	
Trade and Other Payables	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Provisions	(9,154)	(9,256)	(9,133)	(9,210)	(9,210)	(9,262)	(9,147)	(9,265)	(9,334)	(9,402)	(9,338)	(9,407)	(9,581)	(8,221)	1,360	-16.54%	
Borrowings	(6,130)	(6,130)	(6,130)	(3,124)	(3,124)	(3,124)	(641)	(641)	(641)	(641)	(641)	(641)	(641)	(534)	107	-20.04%	
Working Capital Loan - DH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Capital Investment Loan - DH	(5,587)	(5,587)	(5,587)	(5,587)	(5,587)	(5,587)	(5,587)	(5,587)	(5,587)	(5,587)	(5,587)	(5,587)	(4,343)	(4,343)	0	0.00%	
<b>Total Non Current Liabilities</b>	<b>(20,871)</b>	<b>(20,973)</b>	<b>(20,850)</b>	<b>(17,921)</b>	<b>(17,921)</b>	<b>(17,973)</b>	<b>(15,375)</b>	<b>(15,493)</b>	<b>(15,562)</b>	<b>(15,630)</b>	<b>(15,566)</b>	<b>(15,635)</b>	<b>(14,565)</b>	<b>(13,098)</b>	<b>1,467</b>	<b>0.00%</b>	
<b>Total Assets Employed</b>	<b>115,113</b>	<b>115,195</b>	<b>115,273</b>	<b>115,336</b>	<b>115,399</b>	<b>115,175</b>	<b>114,848</b>	<b>114,667</b>	<b>114,751</b>	<b>114,830</b>	<b>115,690</b>	<b>116,357</b>	<b>118,207</b>	<b>118,206</b>	<b>(1)</b>	<b>-121.95%</b>	
<b>Financed by Taxpayers Equity</b>																	
Public Dividend Capital	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	0	0.00%	
Retained Earnings	19,304	19,386	19,464	19,527	19,590	19,366	19,039	18,858	18,942	19,021	19,881	20,548	22,398	22,397	(1)	0.00%	
Revaluation Reserve	33,712	33,712	33,712	33,712	33,712	33,712	33,712	33,712	33,712	33,712	33,712	33,712	33,712	33,712	0	0.00%	
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	0	0.00%	
<b>Total Taxpayers Equity</b>	<b>115,113</b>	<b>115,195</b>	<b>115,273</b>	<b>115,336</b>	<b>115,399</b>	<b>115,175</b>	<b>114,848</b>	<b>114,667</b>	<b>114,751</b>	<b>114,830</b>	<b>115,690</b>	<b>116,357</b>	<b>118,207</b>	<b>118,206</b>	<b>(1)</b>	<b>0.00%</b>	
	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
<b>Budgeted</b>																	
Current Assets		30,612	30,172	27,772	27,193	27,065	23,384	23,686	24,344	24,315	25,294	26,601	22,807	22,807			
Current liabilities		(33,348)	(33,430)	(34,298)	(32,688)	(31,823)	(30,441)	(30,866)	(30,852)	(29,614)	(29,836)	(30,213)	(26,213)	(26,213)			
<b>Net Current Assets less Current Liabilities</b>		<b>(2,736)</b>	<b>(3,258)</b>	<b>(6,526)</b>	<b>(5,495)</b>	<b>(4,758)</b>	<b>(7,057)</b>	<b>(7,180)</b>	<b>(6,508)</b>	<b>(5,299)</b>	<b>(4,542)</b>	<b>(3,612)</b>	<b>(3,406)</b>	<b>(3,406)</b>			
<b>Total Assets Employed</b>		<b>115,195</b>	<b>115,273</b>	<b>115,336</b>	<b>115,399</b>	<b>115,175</b>	<b>114,848</b>	<b>114,667</b>	<b>114,751</b>	<b>114,830</b>	<b>115,690</b>	<b>116,357</b>	<b>118,207</b>	<b>118,206</b>			
Cash Balance		8,578	8,091	3,429	6,323	13,298	7,175	6,464	4,723	4,177	4,719	5,559	5,500	5,500			

**London Ambulance Service  
Summary Capital 2012/13 - Month 7**

Month 7 - October 2012				Description	Year to Date				FY 2012/13				%
Budg	Act	Var	%		Budg	Act	Var	%	Budg	Fcast	Var	%	Act
£000	£000	£000			£000	£000	£000		£000	£000	£000		
0	285	(285)	0.0%	<b>General</b>									
				Other	0	331	(331)	0.0%	0	331	(331)	0.0%	0.0%
<b>0</b>	<b>285</b>	<b>(285)</b>	<b>0%</b>	<b>Subtotal</b>	<b>0</b>	<b>331</b>	<b>(331)</b>	<b>0%</b>	<b>0</b>	<b>331</b>	<b>(331)</b>	<b>0%</b>	<b>0%</b>
				<b>Fleet</b>									
0	(40)	40	0.0%	DCA	1,769	4,326	(2,557)	-144.5%	1,803	4,401	(2,598)	-144.1%	14.5%
100	0	100	100.0%	LP 15	450	0	450	100.0%	1,048	794	254	24.2%	8.5%
483	0	483	0.0%	FRU	1,931	(223)	2,154	111.5%	2,747	798	1,949	71.0%	22.2%
79	40	39	0.0%	PTS	106	40	66	62.3%	500	791	(291)	-58.2%	4.0%
0	0	0		RBS DCA	2,549	2,513	36	1.4%	2,549	2,513	36	1.4%	
58	0	58	0.0%	Other Fleet	916	140	776	84.7%	1,091	1,158	(67)	-6.1%	8.8%
<b>720</b>	<b>0</b>	<b>720</b>	<b>100%</b>	<b>Subtotal</b>	<b>7,721</b>	<b>6,796</b>	<b>925</b>	<b>215%</b>	<b>9,738</b>	<b>10,455</b>	<b>(717)</b>	<b>-112%</b>	<b>58%</b>
				<b>Estates</b>									
0	0	0	0.0%	New	0	13	(13)	0.0%	1,997	1,760	237	11.9%	16.1%
0	28	(28)	0.0%	Refurb	480	348	132	27.5%	480	553	(73)	-15.2%	3.9%
50	16	34	68.0%	Other	219	36	183	83.6%	468	482	(14)	-3.0%	3.8%
<b>50</b>	<b>44</b>	<b>6</b>	<b>68%</b>	<b>Subtotal</b>	<b>699</b>	<b>397</b>	<b>302</b>	<b>111%</b>	<b>2,945</b>	<b>2,795</b>	<b>150</b>	<b>-6%</b>	<b>24%</b>
				<b>IM&amp;T</b>									
430	0	430	0.0%	Hardware	1,022	98	924	90.4%	1,545	412	1,133	73.3%	12.5%
255	15	240	0.0%	Software	441	147	294	66.7%	500	269	231	46.2%	4.0%
<b>685</b>	<b>15</b>	<b>670</b>	<b>0%</b>	<b>Subtotal</b>	<b>1,463</b>	<b>245</b>	<b>1,218</b>	<b>157%</b>	<b>2,045</b>	<b>681</b>	<b>1,364</b>	<b>120%</b>	<b>16%</b>
<b>1,455</b>	<b>344</b>	<b>1,111</b>	<b>0%</b>	<b>Gross Capital Expenditure</b>	<b>9,883</b>	<b>7,769</b>	<b>2,114</b>	<b>157%</b>	<b>14,728</b>	<b>14,262</b>	<b>466</b>	<b>120%</b>	<b>16%</b>
				<b>Disposals</b>									
0	0	0	0.0%	Estates	0	0	0	0.0%	0	0	0	0.0%	0.0%
0	0	0	0.0%	Fleet	(2,328)	(2,328)	0	0.0%	(2,328)	(2,328)	0	0.0%	-18.8%
<b>0</b>	<b>0</b>	<b>0</b>	<b>0%</b>	<b>Subtotal</b>	<b>(2,328)</b>	<b>(2,328)</b>	<b>0</b>	<b>0%</b>	<b>(2,328)</b>	<b>(2,328)</b>	<b>0</b>	<b>0%</b>	<b>-19%</b>
<b>1,455</b>	<b>344</b>	<b>1,111</b>	<b>0%</b>	<b>Net Capital Expenditure</b>	<b>7,555</b>	<b>5,441</b>	<b>2,114</b>	<b>0%</b>	<b>12,400</b>	<b>11,934</b>	<b>466</b>	<b>0%</b>	<b>-19%</b>

**Commentary**

LP 15	Purchase delayed awaiting outcome of Ambulance and FRU procurement strategy
<b>Fleet</b>	
DCA	Overspend due to the purchase of 22 DCAs originally planned to be leased. After a financial lease vs buy analysis, it was felt that the Trust would get better value for money through purchasing.
FRU	Underspent as the decision has now been made to lease the FRUs rather than purchase. This underspend will therefore offset the DCA purchase, following a financial lease vs buy analysis.
Other Fleet	This category is made up of the DSO, ESV and ECV projects. ESV and ECV conversion slots slipped to priorities DCAs.
<b>IM&amp;T</b>	
Software	The IM&T capital replacement programme has slipped into Q3 & Q4 of 2012-13.
Estates	Slippage on estate modernisation programme forecast prior to year end.

**London Ambulance Service  
Summary Divisional Expense 2012/13 - Month 7**

Month 7 - October 2012				Description	Year to Date				FY 2012/13				%
Budg	Act	Var	%		Budg	Act	Var	%	Budg	Fcast	Var	%	Act
£000	£000	£000			£000	£000	£000		£000	£000	£000		
				<b>Operational</b>									
14,911	15,746	(835)	-5.3%	A&E	101,689	104,887	(3,198)	-3.0%	174,370	178,961	(4,591)	-2.6%	61.0%
1,952	1,842	110	6.0%	EOC	13,903	14,234	(331)	-2.3%	23,335	24,731	(1,396)	-5.6%	8.2%
1,392	1,275	117	9.2%	Operational Support	10,947	11,353	(406)	-3.6%	18,695	18,917	(222)	-1.2%	6.5%
<b>18,255</b>	<b>18,863</b>	<b>(608)</b>	<b>-3.2%</b>	<b>Subtotal</b>	<b>126,539</b>	<b>130,474</b>	<b>(3,935)</b>	<b>-9.0%</b>	<b>216,400</b>	<b>222,609</b>	<b>(6,209)</b>	<b>-9.4%</b>	<b>75.7%</b>
<b>492</b>	<b>535</b>	<b>(43)</b>	<b>-8.0%</b>	<b>PTS</b>	<b>3,621</b>	<b>3,618</b>	<b>3</b>	<b>0.1%</b>	<b>6,082</b>	<b>6,116</b>	<b>(34)</b>	<b>-0.6%</b>	<b>2.1%</b>
				<b>Support Services</b>									
377	1,187	(810)	-68.2%	Chief Executive (Olympics)	8,910	10,933	(2,023)	-18.5%	10,576	12,643	(2,067)	-16.3%	3.7%
347	245	102	41.6%	Corporate Services	2,394	2,308	86	3.7%	4,125	3,911	214	5.5%	1.4%
208	193	15	7.8%	Strategic Development	1,345	1,160	185	15.9%	2,302	1,944	358	18.4%	0.8%
1,714	1,612	102	6.3%	Finance	10,582	10,030	552	5.5%	19,625	16,304	3,321	20.4%	6.9%
1,073	1,185	(112)	-9.5%	IM&T	7,350	7,521	(171)	-2.3%	13,960	13,441	519	3.9%	4.9%
827	996	(169)	-17.0%	HR & OD	6,024	5,816	208	3.6%	10,273	9,438	835	8.8%	3.6%
90	81	9	11.1%	Healthcare Promotion & Quality	630	577	53	9.2%	1,082	1,018	64	6.3%	0.4%
122	99	23	23.2%	Medical	833	761	72	9.5%	1,443	1,288	155	12.0%	0.5%
<b>4,758</b>	<b>5,598</b>	<b>(840)</b>	<b>-15.0%</b>	<b>Subtotal</b>	<b>38,068</b>	<b>39,106</b>	<b>(1,038)</b>	<b>-2.7%</b>	<b>63,386</b>	<b>59,987</b>	<b>3,399</b>	<b>5.7%</b>	<b>22.2%</b>
<b>23,505</b>	<b>24,996</b>	<b>(1,491)</b>	<b>-6.0%</b>	<b>TOTAL</b>	<b>168,228</b>	<b>173,198</b>	<b>(4,970)</b>	<b>-2.9%</b>	<b>285,868</b>	<b>288,712</b>	<b>(2,844)</b>	<b>-1.0%</b>	<b>100.0%</b>

**Commentary (items over 50k only)**

*A&E - Increased use of Third Party Providers due to demand pressures and increase in overtime.*

*EOC - Overtime forecast to be higher than budgeted due to Command Point implementation.*

*Corporate Services - Significant number of vacancies to being reviewed as part of CIP.*

*Finance - underspend relates to the release of CQUIN expenditure reserve to offset income reduction.*

*IM&T - Higher than planned ytd due to Command Point costs; Invoices from BT (which are under investigation); CTACK tools being continued*

*CE - Additional third party provider costs relating to the Olympics off set by additional Income*

**London Ambulance Service  
Summary Staffing 2012/13 - Month 7**

Month 7 - October 2012					Description	FY 2012/13				%
Budg	Act	Var	%	Fcast		Plan	Variance	%	Act	
Est.	In Post					Est.	In Post			
					<b>Operational</b>					
BP01	3,101.18	2,984.70	116.48	3.9%	A&E	3,101.18	3,101.18	0.00	0.0%	66.2%
BP05	381.91	349.48	32.43	9.3%	EOC	381.91	381.91	0.00	0.0%	8.2%
BP06	271.83	240.50	31.33	13.0%	Operational Support	271.83	271.83	0.00	0.0%	5.8%
BP04	228.40	230.02	-1.61	-0.7%	Operational Management	228.40	228.40	0.00	0.0%	4.9%
HART/	99.40	96.00	3.40	3.5%	HART/EPU	99.40	99.40	0.00	0.0%	2.1%
	<b>4,082.72</b>	<b>3,900.69</b>	<b>182.03</b>	<b>4.7%</b>	<b>Subtotal</b>	<b>4,082.72</b>	<b>3,983.32</b>	<b>0.00</b>	<b>2.5%</b>	<b>87.2%</b>
					<b>Operational</b>					
BP07	147.51	136.73	10.78	<b>7.9%</b>	PTS operational	147.51	147.51	0.00	0.0%	3.2%
BP07	12.00	8.50	3.50	<b>41.2%</b>	PTS Management	12.00	12.00	0.00	0.0%	0.3%
	<b>159.51</b>	<b>145.23</b>	<b>14.28</b>	<b>9.8%</b>	<b>Subtotal</b>	<b>159.51</b>	<b>159.51</b>	<b>0.00</b>	<b>0.0%</b>	<b>3.4%</b>
					<b>Support Services</b>					
S1	31.08	31.31	-0.23	-0.7%	Chief Executive	31.08	31.08	0.00	0.0%	0.7%
S29	31.76	30.15	1.61	5.3%	Corporate Services	31.76	31.76	0.00	0.0%	0.7%
S26	34.00	27.00	7.00	25.9%	Strategic Development	34.00	34.00	0.00	0.0%	0.7%
S3	49.21	41.93	7.28	17.4%	Finance	49.21	49.21	0.00	0.0%	1.1%
S6	87.48	77.48	10.00	12.9%	IM&T	87.48	87.48	0.00	0.0%	1.9%
S4	162.74	148.13	14.61	9.9%	HR & OD	162.74	162.74	0.00	0.0%	3.5%
S81	18.67	17.77	0.90	5.0%	Healthcare Promotion & Quality	18.67	18.67	0.00	0.0%	0.4%
S8	24.40	18.80	5.60	29.8%	Medical	24.40	24.40	0.00	0.0%	0.5%
	<b>439.34</b>	<b>392.57</b>	<b>46.77</b>	<b>11.9%</b>	<b>Subtotal</b>	<b>439.34</b>	<b>439.34</b>	<b>0.00</b>	<b>0.0%</b>	<b>9.4%</b>
	<b>4,681.57</b>	<b>4,438.49</b>	<b>243.08</b>	<b>0.26</b>	<b>Total</b>	<b>4,681.57</b>	<b>4,582.17</b>	<b>0.00</b>	<b>0.02</b>	<b>1.00</b>
					<b>DH Classification</b>					
	3,813.32	3,629.22	184.10	5.1%	Ambulance staff	3,813.32	3,813.32	0.00	0.0%	81.5%
	601.34	580.13	21.21	3.7%	Managers & Senior Managers	601.34	601.34	0.00	0.0%	12.8%
	266.91	229.15	37.76	16.5%	Admin & Estates	266.91	266.91	0.00	0.0%	5.7%
	<b>4,681.57</b>	<b>4,438.49</b>	<b>243.08</b>	<b>5.5%</b>	<b>TOTAL</b>	<b>4,681.57</b>	<b>4,681.57</b>	<b>0.00</b>	<b>0.0%</b>	<b>100.0%</b>

**Commentary**

*There were 252.08 vacancies across the organisation at the end of Month 7, mainly Ambulance staff and in back office functions budget establishment is exclusive of overtime wte.*

Operational Management Includes EOC and A&E Management

**London Ambulance Service**  
**Summary Finance KPIs Trend 2012/13 - Month 7**

	Outturn 2011-12	Monthly Performance											
		Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
		Act	Act	Act	Act	Act	Act	Act	Fcast	Fcast	Fcast	Fcast	Fcast
Income £	281,708	24,088	23,747	24,312	25,351	25,562	24,877	24,812	23,362	23,322	23,624	23,424	26,342
EBITDA £	18,643	1,376	840	1,888	1,525	1,255	1,213	1,355	1,848	1,993	2,101	2,152	3,165
EBITDA %	6.6%	5.7%	3.5%	7.8%	6.0%	4.9%	4.9%	5.5%	7.9%	8.5%	8.9%	9.2%	12.0%
Net Surplus £	2,751	83	78	65	64	(226)	(324)	(184)	244	389	498	549	712
Net margin %	1.0%	0.3%	0.3%	0.3%	0.3%	-0.9%	-1.3%	-0.7%	1.0%	1.7%	2.1%	2.3%	2.7%
CQUIN £	2,681	794	74	523	527	623	640	867	449	448	980	980	978
CIP £	14,871	393	786	1,228	830	1,077	1,338	924	1,210	1,359	1,416	1,416	2,044
Capital £	6,709	3,071	2,370	607	607	1,047	154	344	822	429	867	867	1,966
Cash balance £	5,250	8,578	8,091	3,429	6,323	13,298	7,176	6,464	4,723	4,177	4,719	5,559	5,500
Net Current Assets less Liabilities £	(4,781)	(2,507)	(4,886)	(7,550)	(6,763)	(6,860)	(9,187)	(8,472)	(7,459)	(6,249)	(5,048)	(4,107)	(6,556)
Return On Assets %	5.42%	0.33%	0.66%	0.66%	0.66%	1.62%	2.04%	2.46%	2.93%	3.51%	4.18%	4.88%	5.70%
Liquidity days	(9.66)	(10.28)	(10.35)	(10.29)	(10.15)	(10.03)	(9.98)	(9.97)	(10.04)	(10.09)	(10.16)	(10.21)	(10.26)
Monitor net rating	2	2	2	2	2	2	2	2					
A&E Trade Receivables : 60 days	(171)	202	(349)	(428)	709	967	810	462					
PTS Trade Receivables : 60 days	522	504	436	487									
Other Trade Receivables : 60 days	64	84	79	189	650	263	300	167					
Total Trade Receivables : 90 days	343	292	254	20	624	869	707	631					
Trade Payables : 90 days	(10)	(9)	4	(15)	11	54	203	151					

Note - July - October A&E Trade Receivables Figures include PTS Trade Receivables, were are working with ELFS to design a report to split this information.



**LONDON AMBULANCE SERVICE TRUST BOARD**

**DATE: 27 NOVEMBER 2012**

**PAPER FOR NOTING**

<b>Document Title:</b>	<b>Workforce Report</b>
<b>Report Author(s):</b>	<b>Caron Hitchen</b>
<b>Lead Director:</b>	<b>Caron Hitchen</b>
<b>Contact Details:</b>	<a href="mailto:caronhitchen@lond-amb.nhs.uk">caronhitchen@lond-amb.nhs.uk</a>
<b>Why is this coming to the Trust Board?</b>	<b>This is a regular report to the Trust Board detailing key workforce indicators providing assurance to the Board on workforce issues.</b>
<b>This paper has been previously presented to:</b>	<input type="checkbox"/> Strategy Review and Planning Committee <input checked="" type="checkbox"/> Senior Management Group <input type="checkbox"/> Quality Committee <input type="checkbox"/> Audit Committee <input type="checkbox"/> Clinical Quality Safety and Effectiveness Committee <input type="checkbox"/> Risk Compliance and Assurance Group <input type="checkbox"/> Learning from Experience Group <input type="checkbox"/> Other
<b>Recommendation for the Trust Board:</b>	<b>To receive the report</b>
<b>Key issues and risks arising from this paper</b> Sickness absence will continue to be monitored closely and managed robustly to maintain satisfactory levels.	
<b>Executive Summary</b>  Key headlines from the Workforce report are:  <u>Sickness absence</u> Year to date sickness absence level is 5.45% as at September, which remains just within target (5.5%). Sickness absence levels for the month of September are reported at 5.49%. Whilst both indicators are just within our set target of 5.5% we would normally expect to see some increase in levels of absence as we enter the winter months.  <u>Vacancies and Turnover</u>  Vacancy levels for frontline staffing at 31 October 2012 were 103wte. with 88 wte due to join Operational staffing over the remainder of the year (and a further 48 due out of training into Operations in April having been recruited in January). The A&E Resources group now meets every 2 weeks to maintain progress against current recruitment and training plans together with preparing for 2013/14 resourcing requirements.  Turnover for the 12 months to September 2012 shows a further increase at 8.2%. This YTD figure is higher than we have seen in previous years partly due to the outsourcing of part of the finance function earlier.	

PDR completion for 12/13

All but one Corporate Support functions are reporting 100% completion with IM&T at over 90%.

Data for operational areas is currently incomplete and work is underway with ADOs to ensure accurate data for the end of Q3. It should be noted that Student Paramedic staff and newly appointed Apprentice Paramedic receive on-going appraisal and assessment as part of their training and we will need to ensure this is captured in the data.

Health and Safety Incidents

Whilst the format of the Health and Safety report to Trust Board is currently being reviewed we continue to see a general downward trend on reporting of key health and safety incident categories.

Employee relations

The report indicates continued high levels of “case management” of attendance cases together with a consistent level of non clinical disciplinary cases. Nothing to report by exception.

**Attachments**

- 1. Workforce data report

\*\*\*\*\*

**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 (N/A)

Key issues from the assessment:



London Ambulance Service  
NHS Trust

# **Workforce Summary for Trust Board**

## **November 2012**

## Workforce Report

Current Month

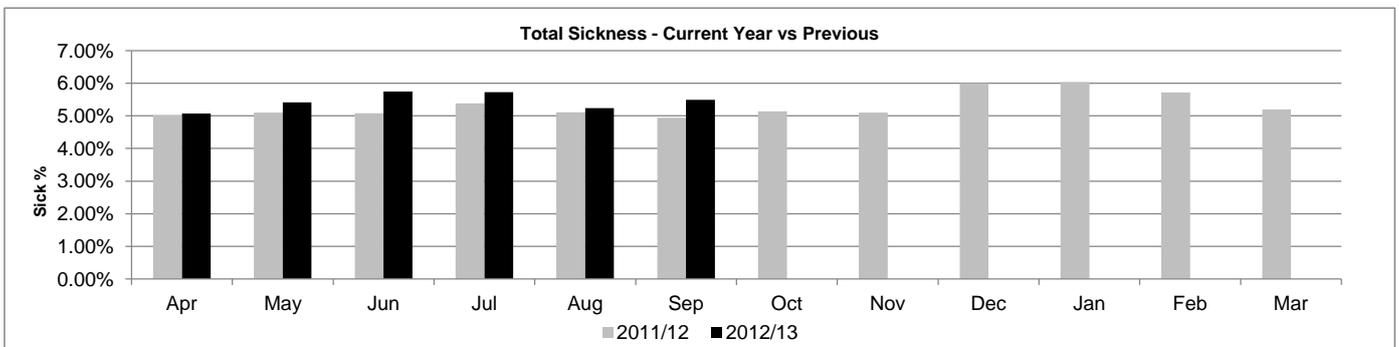
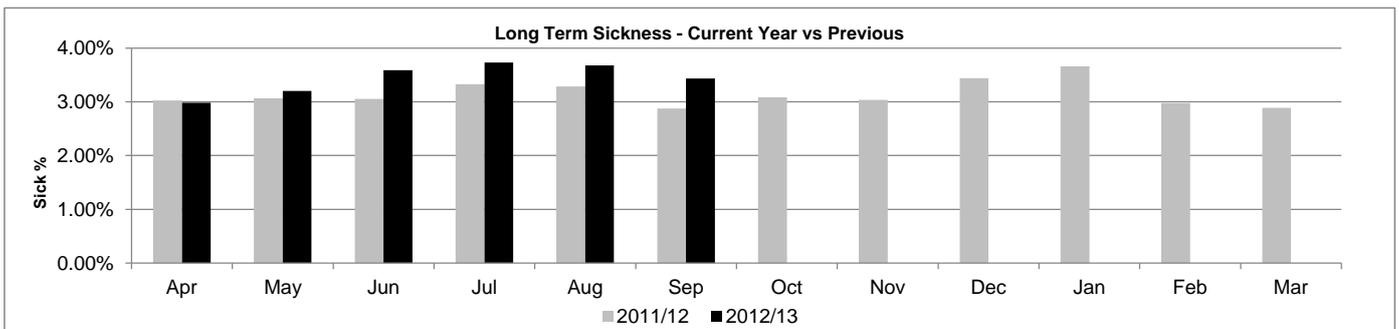
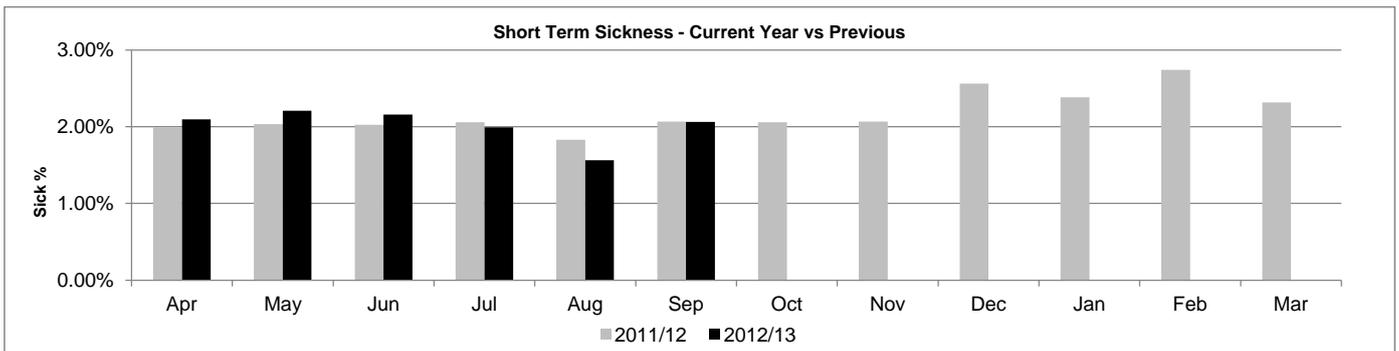
Oct-12

Sickness Month

Sep-12

## Trust Summary

### Sickness Absence



Sickness 2011/12  
YTD Sickness

5.32%
5.45%

Current WTE  
Current Headcount

4412.98
4639.00

NB Secondments and Acting Up Included in Totals

Total Sickness

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2011/12	5.01%	5.10%	5.08%	5.39%	5.11%	4.94%	5.14%	5.10%	6.00%	6.04%	5.71%	5.20%
2012/13	5.08%	5.41%	5.75%	5.72%	5.24%	5.49%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Unauthorised Absence

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2011/12	163.00	167.00	161.00	192.00	171.00	164.00	161.00	312.00	98.00	167.00	179.00	168.00
2012/13	148.00	137.00	144.00	156.00	126.00	128.00	139.00	0.00	0.00	0.00	0.00	0.00

## Narrative

### Sickness

Sickness for the Trust rose slightly in September to 5.49%. Although this remains lower than the level in the two months immediately preceding the Olympic and Paralympic Games, it should be noted that the early part of the month was still covered by Games-related resourcing and attendance bonus payments. In terms of length of absence, short term was almost unchanged but long term increased. Sickness absence YTD for 12/13 now stands at 5.45%, remaining ahead of the year end figure for 11/12, but still meeting the 12/13 target of 5.5% or below. The RAG rated audits continue to show that, in the main, all absence is being managed appropriately and in accordance with the Managing Attendance Policy (MAP). As previously reported, joint work between Operations and HR senior teams has been launched to review all aspects of sickness absence and management processes, with a second workshop to consider the strategic approach to attendance management to be held this month.

### Unauthorised Absences

This figure shows the number of instances when staff have reported unable to attend work at short notice for reasons other than their own sickness, or when they have not reported for work. Depending on the reason, the absence may be converted into annual leave or un/paid special leave or remain an unpaid and unauthorised absence. Disciplinary action may result. The figure for the Trust as a whole for October showed a slight increase, but is still down on the same period on 2011.

# Workforce Report

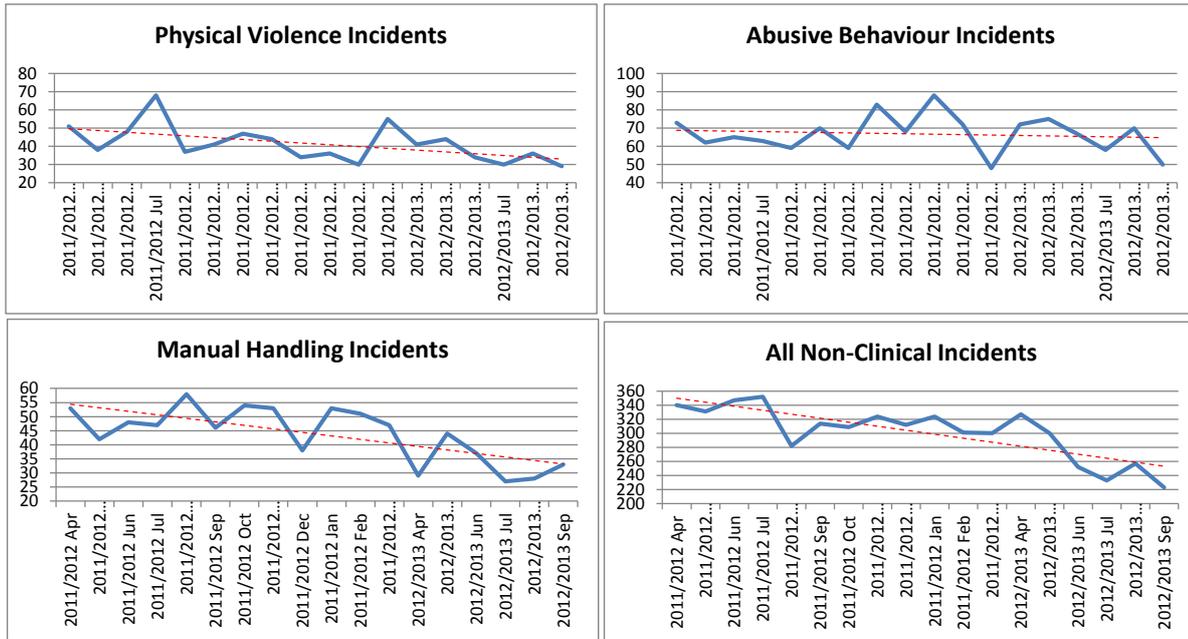
Current Month

Sep-12

Report under review

## Trust Summary

### Health & Safety Issues



*Note - Due to the delay in receiving incidents reports, the majority of reported incidents within October have yet to arrive at Safety and Risk.*

Incident reporting trends are shown above for information. The format and content of this element of the workforce report is currently under review and will recommence in January 2013.

## Workforce Report

Current Month      Oct-12

### Trust Summary

#### Vacancies & Turnover

	Funded WTE	Inpost WTE	Variance
Trust Total	4629.37	4419.54	-209.83
<b>Directorate</b>			
A&E Operations	3458.02	3294.65	-163.37
Chief Executive	16.60	15.29	-1.31
Control Services	462.75	395.56	-67.19
Corporate Services Directorate	32.13	30.13	-2.00
Finance & Business Planning Directorate	54.20	41.93	-12.27
Health Promotion & Quality	18.87	17.77	-1.10
Information Management & Technology Directorate	87.48	78.48	-9.00
Medical Directorate	27.20	18.21	-8.99
Operational Support	134.43	113.85	-20.58
Patient Transport Service	142.21	141.23	-0.98
Strategy & Business Development	43.00	30.00	-13.00
Trust Board	5.00	4.00	-1.00
Workforce Directorate	178.22	178.30	+0.08

	Est.	In Post	Var.
T/L Paramedic	197.65	189.52	-8.13
Paramedic	1252.15	1459.17	+207.02
Apprentice Paramedic	80.00	51.00	-29.00
Student Paramedic 1	0.00	0.00	+0.00
Student Paramedic 2	25.00	3.00	-22.00
Student Paramedic 3	320.00	179.84	-172.16
Student Paramedic 4	61.00	77.00	+16.00
EMT 1	18.61	17.61	-1.00
EMT 2-4	863.44	769.68	-93.76
A&E Support	333.53	301.90	-31.63
<b>TOTAL</b>	<b>3151.00</b>	<b>3048.00</b>	<b>-103.00</b>

### Turnover

2011/12	7.1%	Apr-11 to Mar-12
2012/13	8.2%	12 Months up to Oct-12

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
<b>No. Leavers (Headcount)</b>												
2011/12	22.00	36.00	33.00	28.00	34.00	30.00	23.00	21.00	26.00	35.00	28.00	28.00
2012/13	34.00	34.00	50.00	27.00	32.00	37.00	35.00	0.00	0.00	0.00	0.00	0.00
<b>No. Starters (Headcount)</b>												
2011/12	6.00	7.00	7.00	21.00	7.00	32.00	50.00	8.00	15.00	4.00	6.00	3.00
2012/13	20.00	5.00	18.00	28.00	5.00	49.00	51.00	0.00	0.00	0.00	0.00	0.00

NB: Inpost figures are based on individuals substantive post not their seconded/acting up post.

## Workforce Report

Current Month

Oct-12

## Trust Summary

### Employee Relations Data

	Attendance	Grievances	Capabilities	Disciplinary (Clinical)	Disciplinary (Non Clinical)
<b>Current Case Total</b>	593 (498)	7 (11)	3 (3)	5 (2)	40 (39)

<b>Current Employment Tribunal Cases</b>	9 (10)
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<b>Current Suspensions</b>	11 (11)
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### Narrative

The figure for the previous month appears in brackets.

#### **Attendance**

These figures and the audit results mentioned previously continue to demonstrate the focus on attendance management has been sustained.

#### **Grievances**

As reported previously, it must be expected that as managers increase the focus on all facets of performance, this figure will be higher than previously seen. Nevertheless, given the number of employees, this number still remains low.

#### **Disciplinary**

The ratio of clinical to non-clinical cases continues to show that clinical issues are rarely dealt with under the disciplinary procedure.

#### **Employment Tribunals**

One claim has been dismissed; one claim has been withdrawn; one new claim has been lodged.

## PDR completions in 2012/13

Area / Directorate / Dept	No to be done	No done	% completed 12/13	% completed 11/12	Difference +/-
West*	960	14	1.5	38.8	- 37.3
South*	tbc	39	tbc	6.9	tbc
East*	tbc	33	tbc	33.1	tbc
Control Services	521	212	40.7	74.3	- 34.3
Sub total	1481	298	20.1	32.0	- 11.9
PTS	151	63	41.7	53.2	- 11.5
IM&T	77	70	90.9	99.0	- 8.1
Operational Support	118	59	50.0	66.3	- 16.3
Medical	25	25	100.0	100.0	0.0
Communications	12	12	100.0	94.1	+ 5.9
Corporate Services	29	29	100.0	94.6	+ 5.4
Strategic Development	6	6	100.0	N/A	N/A
Workforce	137	137	100.0	100.0	0.0
Finance and Business Planning incl Estates	35	35	100.0	82.4	17.6
Sub total	590	436	73.9	76.5	- 2.6
Total	2071	734	35.4	54.0	18.6

As at 8 Nov 2012



**LONDON AMBULANCE SERVICE TRUST BOARD**

**DATE: 27 NOVEMBER 2012**

**PAPER FOR NOTING**

<b>Document Title:</b>	<b>Chief Executive Report</b>
<b>Report Author(s):</b>	<b>Martin Flaherty</b>
<b>Lead Director:</b>	<b>N/A</b>
<b>Contact Details:</b>	<b>-</b>
<b>Why is this coming to the Trust Board?</b>	<b>To update the Board on key developments affecting the Trust</b>
<b>This paper has been previously presented to:</b>	<input type="checkbox"/> Strategy Review and Planning Committee <input type="checkbox"/> Senior Management Group <input type="checkbox"/> Quality Committee <input type="checkbox"/> Audit Committee <input type="checkbox"/> Clinical Quality Safety and Effectiveness Committee <input type="checkbox"/> Risk Compliance and Assurance Group <input type="checkbox"/> Learning from Experience Group <input type="checkbox"/> Other
<b>Recommendation for the Trust Board:</b>	<b>That the Board note my report</b>
<b>Key issues and risks arising from this paper</b>  The Board is asked to note the issues raised around waiting times for Cat C patients and capacity issues in general and debate these more fully within the performance sustainability section of Part 2	
<b>Executive Summary</b>	N/A
<b>Attachments</b>	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 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 27 NOVEMBER 2012**

### **CHIEF EXECUTIVE'S REPORT**

#### **1. SERVICE UPDATE**

This first section of my report focuses on the key focus areas for the Trust Board during 2012/2103 which are; Delivery of a high quality service; leading transformation and influencing the delivery of healthcare in London. (see attached pyramid diagram).

#### **Delivery of high quality and safe service**

At the Board in September I advised that we had safely delivered the Olympic and Paralympic Games whilst maintaining an excellent level of service to Londoner's throughout that period.

Since the last Board we have been engaged on a wide ranging series of debriefs both internally and with external partners across the health service and our fellow emergency services. The ambulance sector also held a national post games conference in October to ensure that lessons identified were shared across the ambulance sector.

Finally the Trust hosted a celebration event on November 13<sup>th</sup> for members of staff from across the service and a large cohort of pre-planned aid staff from across the country. The event was very well received and allowed us to thank staff for the magnificent efforts they all made in delivering the games.

The COO report contains an update on activity levels and lessons identified during the Games and a comprehensive post games report is in the final stages of production and will be shared with the Board in January before being published widely.

With the above events behind us we turn to concentrating on the remainder of the year and the priorities here are clearly to maintain a high quality and safe service against a background of unrelenting demand increases and a need to deliver substantial training commitments with a constrained resource pool. As indicated in the COO report this is continuing to prove immensely challenging.

The overriding issues affecting quality here is an inability to always provide sufficient resource to deal with the incoming demand. This coupled with the very high utilisation levels is increasing pressure within the service and at times leads to unacceptable delays for some lower category patients. The problem is particularly acute at weekends and to a lesser extent weekday evenings . The long term capacity issues are being dealt with within the Joint LAS and Commissioner led Capacity Review which is progressing well but which will inevitably take a significant time to deliver tangible capacity increases. In the interim the Trust continues to manage the difficult situation dynamically both in terms of adding additional resource where possible and managing the demand proactively through use of DMP. It is clear however that this is adding to the stress levels of front line ambulance staff and control room staff and I will be asking the Board to debate this more fully later in the meeting to ensure that we have absolute clarity on the issues and the measures being taken to mitigate them wherever possible.

## **Lead Transformation**

The Boards focus here continues to be dominated by the need to progress our Foundation Trust application. At the last Board I reported that the Initial 'kick-off' meeting with the Trust Development Authority lead Alwen Williams and her team was scheduled for mid November. This has now been rescheduled for 7<sup>th</sup> December following difficulties with TDA availability. This is the first milestone of our new application.

The TFA has been reviewed and signed off by the cluster however Alwen Williams has expressed some concerns to our regarding the timelines and work required to consolidate the Board given the large number of executive and non executive changes. We await final feedback from the TDA team on this and other issues before we are able to finalise and resubmit the TFA in readiness for 7<sup>th</sup> December.

The Single Operating Model (SOM) submissions for October and November show the Trust as RED rated as we have not achieved a fully signed off TFA however this is well understood by all parties due to the rescheduling of the first milestone.

The Director of Corporate Services can provide a fuller update as required during Part 2 of the Board meeting.

We will be attending a Strategic Commissioning Board on 26<sup>th</sup> November led by our existing commissioners and this is designed to be a transition/handover from the 'old' commissioning representatives to the new CCG/CSS model. We will use the meeting to both set out our vision and strategy going forward and to explore how best to engage fully with the new commissioning environment.

We are actively engaged in appointing an interim FD and final interviews for this post will take place on 30<sup>th</sup> November. We will run the appointment process for the substantive role in parallel utilising a suitable executive search agency.

Other priority areas for transformation are those relating to modernisation of working practices and work is ongoing to move this forward. We are engaged in a series of meetings with senior trade union colleagues over the next few weeks to discuss the way forward and have also had some helpful discussions with commissioners regarding the related CQUIN items. The Board will have the opportunity to discuss these in more detail in part two of today's meeting within the general IR update.

## **Influence the delivery of healthcare in London**

*(see stakeholder engagement section also)*

The LAS continues to be involved in discussions across London relating to proposals for hospital reconfigurations to ensure we can continue to deliver a high quality service to our emergency and urgent care patients in the future. The known changes to hospital reconfiguration for 13/14 have been modelled within the ORH work and changes taking place in subsequent years will form part of the sensitivity analysis for those years. One trend which is emerging is a significant increase in requests for ambulance responses generated by Health Care Professionals in those areas where an A&E Department has been re-categorised or closed.

We continue to try to better understand the causes of the relentless demand increases we are experiencing and updated the Board once again at the SRP meeting in October with regard to our latest findings. We are sharing this work with our commissioners and will work together to develop joint strategies to attempt to control some of the incoming demand as best we can.

## **2. KEY PRIORITIES 2012/2013 – MONTH 7 UPDATE**

At the end of the last financial year, the Board agreed its key priorities for 2012/2013 and we split our approach and focus in three ways –i) Board priority areas, as outlined in the first part of my report, ii) SMG objectives and finally iii) Business as Usual (BAU) activities. The attached pyramid diagram was used to illustrate this. The first section of my report updates the Board as to where we are against the key focus areas at month 7.

- **SMG Objectives**

As agreed with the Board before the new financial year started, the SMG agreed a smaller number of priorities for 2012/2013. Eleven in all and these are attached to the back of the pyramid diagram as a reminder. Current progress shows that most are on track to be delivered by the end of the financial year, however there remain significant risks with the specific components of the workforce modernisation objective; with improving waiting times for Category C patients (Category A workload dependent); and delivering the levels of hear and treat and see and treat to achieve CQUIN income. Of these I feel that improving waiting times for Cat C patients is the most problematical given the increases in demand and the related capacity issues. CQUIN achievement is also an issue with the trust currently making a provision of 1.7m for the unachieved element.

- **Business as Usual activities**

These remain broadly on track with the exception of some aspects of training delivery and PDR delivery. Again these are related to the ongoing capacity issues.

## **3. Strategic Development Programme**

We have reviewed the way in which the Trust will manage strategic development programmes defined within the IBP going forward. The new Strategic Development Programme has now been launched with the legacy projects handed over from the three previous programmes (Patients, Workforce and Value for Money) which closed in July.

At the present time thirty two projects have been handed over but five are suspended until the ORH report has been received (and may be combined into one project) and five more are earmarked for 2013/14. The progress of those earmarked for 2013/14 will depend on the outcome of the current strategy development and business planning work being undertaken to further develop the five year strategy and 2013/14 Operating Plan and Budget.

In terms of projects currently live the following points are of note regarding progress:

- Control Room (Bow as a 'hot' control)\_ - Problems with disaster recovery testing in October led to postponement of the first live use of Bow from November 2012 until February 2013;
- Resource Centre Consolidation - Delivered. All three resource centres moved into Bow on 20th October;

- Workshop Rationalisation - Delays have occurred due to the requirement to re-submit the business case to the SHA for approval. This has been significantly revised and updated. Delays have also occurred in negotiating the lease agreement with the developer.
- Support Services non-pay reductions\_- The procurement department have, to date, generated well over £250k of new savings this year with a further £300k likely from current negotiations with suppliers. When these are added to the full year effect of 2011/12's price reductions delivery of the price component of savings are on track with overall non-pay spend reduced in line with the CIP.
- HQ - Annex Rationalisation (short term)\_- The realisation that the Loman Street 4th floor lease expires in November 2013 will delay delivery of the projected savings by 8 months. Although the delay in surrendering the 4th floor will mean that the Trust will not realise the anticipated savings, the continued use of it will enable works to proceed at HQ (if SMG agree to the proposed changes to 3rd Floor HQ).

#### **4. INFORMATION MANAGEMENT AND TECHNOLOGY**

##### **FALLBACK TESTING**

- 4.1 As part of the preparation work to bring Bow live as a second Control Room a series of resilience tests have taken place, the first of which was overnight on 2/3 October. This exercised the Control Room procedure to work on paper (OP66), and a simultaneous technical test of the fallback arrangements for the MDT (Mobile Data Terminal) infrastructure. However there were technical problems that meant it was not possible to return to normal operations at 05:00 as planned. The control room had to continue working on paper until 14:30 when full computerised services were restored. The OP66 procedure worked well for both the planned and extended time on paper operations.
- 4.2 The fault lay within the MDT infrastructure that is part of the original CAD environment, internally developed by the LAS (not part of the CommandPoint system). Two problems occurred. Firstly the test to connect to the Bow systems was unsuccessful and secondly when the connection was re-established to HQ, the system was flooded with multiple MDT messages making it totally unusable. The technical team worked through to find a resolution that was neither obvious, nor was it apparent what was causing it. By 10:00 they managed to remove the massive backlog of messages in the system identifying a further problem of the multiple generation of messages coming in from the MDTs on the live vehicle fleet. There was no known reason why this was occurring and several hours were spent analysing and breaking down various aspects of the problem. Finally by 12:30 a resolution was found, tested and a recommendation made to GOLD at 13:15 to move back to full computerised operations. This was ratified at the 14:00 Gold meeting, the first live call was taken on CommandPoint at 14:40, with auto despatch being turned on at 15:30.

4.3 Due to the extended, unplanned time on paper operations, the Medical Directorate reviewed calls to identify those patients who might have been put at risk through delays in dispatch and response. The overall conclusion of the Medical Director was that: 'Despite some lengthy delays in dispatch and response we have not, to date identified any patients who experienced significant deterioration as a result of period of unplanned paper based dispatch on 3<sup>rd</sup> October 2012. Nor has the Trust experienced any adverse publicity or complaints relating to the delays. However there were patients who received an unacceptable level of care as a result of the failure to return full system based working, following the testing of the technical resilience arrangements for MDT's in the early hours of 3<sup>rd</sup> October 2012'.

4.4 As a result of this problem, a new operational procedure was developed to allow the Control Room to operate with full computerised operations but without MDT's. This is known as OP 68 and was tested during the second resilience test on 6/7 November. During this test, full computerised systems were left in place, but MDTs were disconnected. This meant that there was no auto despatch and all calls were manually despatched using the Airwave radio system. The test proved successful and MDTs were reconnected to CommandPoint as planned.

4.5 In parallel to other activities, detailed technical work took place in the test environment to identify the issue (but not the root cause) of the problems encountered on 2/3 October. Based on this work, the third test took place on 13/14 November and re-ran the test that failed on 2/3 October. Once again the control Room reverted to paper operations (OP66), technical fall back tests were executed and the MDTs reconnected to CommandPoint without the problems that previously occurred.

4.6 The conclusion of these tests has enhanced the resilience, and assurance of the fallback arrangements. Further work is planned at the end of November to exercise operating some elements of the Control Room from Bow. This is in preparation for the first stage of brining Bow live as a second control room in February next year.

## **5. STAKEHOLDER ENGAGEMENT & PATIENT AND PUBLIC INVOLVEMENT**

- There are 930 events on the PPI and Public Education activity database for 2012 so far. We are able to meet over 75% of requests, approximately 80 per month across the Service. Recent events have included a knife crime awareness talks, "Safe Drive, Stay Alive" (a road safety initiative), school visits and hospital open days. We have also taken part in activities for specific groups, such as those with autism and in schools for disabled children.
- The PPI & Public Education Department is leading on a CQUIN designed to elicit views of patients who were not conveyed to hospital between April and June this year. We are also asking staff about their experiences of leaving patients at home, and the factors affecting their decisions to convey patients to hospital or leave them at home.

So far the responses from patients are generally positive. Staff highlight the importance of training, and the lack of other services available out of hours. The full report will be available in February.

- Discussions are progressing with Picker Europe and the CQC about the development of a national ambulance patient survey in 2013/14, focusing on 'hear and treat.' Picker have consulted with colleagues in ambulance trusts and are devising a method by which comparative data might be collected. A data sampling pilot is to take place at the end of November/early December.
- The Trust held its most recent Community Event in Southgate on 3<sup>rd</sup> November. The event was a huge success, with a wide range of stalls focusing on different aspects of health care. Over 330 members of the public attended. The next event will be held in Croydon, early in 2013.
- This year's Public Education Staff Development Programme took place in the last week of October, with 11 delegates. The course covered topics such as the policies and support available for staff taking part in public education, communication and key messages, how to answer difficult questions, understanding diversity, presentation skills and lesson planning. Feedback from the course was excellent, and the next programme is planned for 2013. In the meantime, there are plans to provide elements of the programme to a wider group of staff.

## **Communication and engagement**

**Appointment of new Chief Executive:** Ann Radmore was announced as the Service's new Chief Executive in early October. Ann, who is currently the Chief Executive of NHS South West London, will take up her new role on 7 January 2013.

Ann has already started a programme of meetings with key stakeholders and has taken opportunities to meet staff, including a visit to the control room, an ambulance ride-out in Romford and attendance at an event to recognise staff's contribution to the Games.

**Reconfiguration:** The impact on the Service of proposed changes to NHS services across different parts of London continues to receive interest from stakeholders and media. The London Assembly has invited a representative from the Service to a meeting of the Health and Environment committee in December to discuss the issue of A&E closures across London; the Service has provided the London Assembly with an initial position statement. The Mail on Sunday has been running a campaign about the proposed A&E closures in north west London, and on two occasions has reported on the potential impact on ambulance journey times. A consultation launched by the Trust Special Administrator which proposes the closure of Lewisham's A&E department has also started to trigger concerns from local residents about longer journey times.

## **Staff recognition**

**Games 'thank you' event:** Athletes Liam Phillips and Martine Wright were special guests at an event on 13 November to mark ambulance staff's contribution to the success of the 2012 Olympic and Paralympic Games. Both athletes expressed their thanks to staff and presented certificates to representatives of different staff groups who played a role in the Games. Other guest speakers who shared messages of thanks included David Zideman who was the clinical lead for emergency medical services for the Games, Chairman Richard Hunt, Chief Executive Martin Flaherty and newly appointed Chief Executive Ann Radmore. Over 200 members of staff from across the Service attended the event.

**Long service recognition:** Thirty-five members of staff, with a combined 780 years of service, were recognised at a ceremony in October. Twenty-three members of staff received

awards for their 20 years of service, and 12 retirees were recognised. Stories about individuals were covered in local media across London.

## **Social media**

**#999ambulance:** A Twitter session was run from the control room on 4 October from 12pm to midnight during which time all the calls handled by two call takers (over two six hour shifts) were tweeted, as well as facts and figures and advice on how to use the 999 ambulance service. The aim was to give the public an insight into what happens when they call 999, educate the public about the correct use of the 999 system, increase the number of followers on the Service's Twitter site, and direct traffic to the website including pages with health promotion.

Over the 12-hour period, information was tweeted about 77 different incidents, with patient confidentiality being maintained. The Service posted 334 tweets in total, 210 of which were replies to questions and direct health messages in response to calls.

Many of the people who interacted with the Service were healthcare professionals, celebrities, journalists and members of the public, and the number of followers grew from 12,200 to 13,200 during this time. Posts were retweeted further to thousands more people, and many positive messages were received about the initiative. Asked afterwards, control room staff thought it was a good thing to do, and that it helped people understand the 999 system.

Visits to the Service's website doubled (2,200 visitors over 12 hours), with an increase in visits to pages about working with the Service and stroke care. A short film about 999 access for deaf people was promoted and subsequently received 900 hits on the Service's YouTube site.

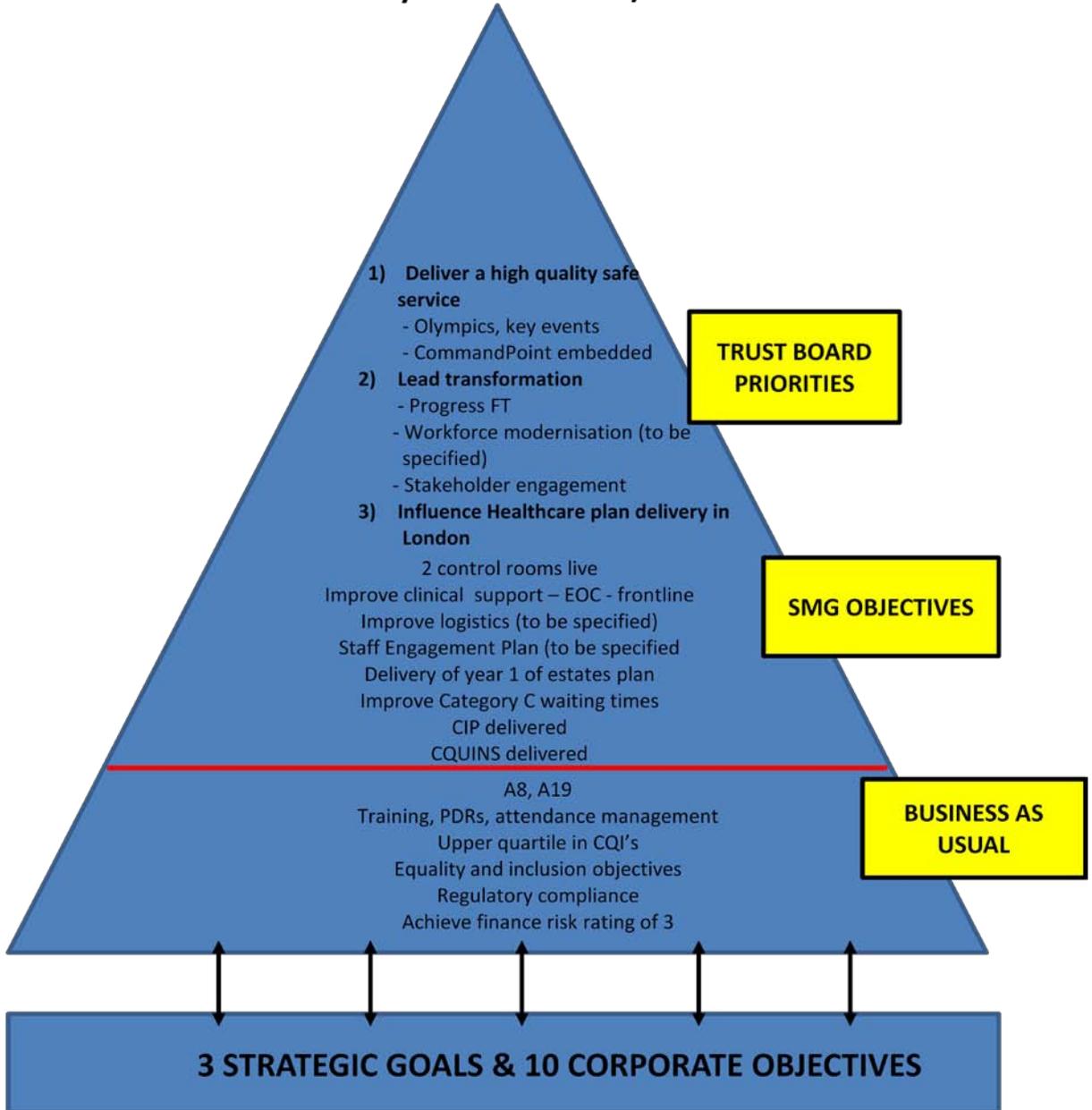
The Tweetathon coincided with a recruitment drive for call takers, and the opportunity to work in this role was promoted. In the period 1 to 19 October, 377 applications were received for this role – more than double that received during each of the previous three recruitment drives.

## **Media**

**Delay stories:** Regional and national media reported on a 23-minute ambulance response to a police officer who collapsed and died after chasing a suspect. The delay occurred after the Service was given the wrong address for the incident and initially sent resources to Belsize Park. When the ambulance crew was unable to locate the patient, the caller was called back and resources were redirected to Belsize Park Gardens. A 54-minute response to a hit-and-run victim was reported in the News Shopper (Bromley).

**Martin Flaherty**  
**Acting CEO**

# LAS Key Priorities 2012/2013



## 2012/2013 SMG objectives (Month 7)

1. Improve operational support including the optimal availability of vehicles, equipment and supplies which will be measured by achievement of agreed trajectories reported to Trust board, a reduction in VOR to 3.5%, increased staff satisfaction evidenced by feedback from staff and see a fall in reported equipment shortages. **ON TRACK**
2. Bow control running live and operating in a similar way to that at Waterloo.  
**ON TRACK OVERALL BUT RESCHEDULING OF INITIAL MOVE TO BOW TO FEBRUARY 13**
3. Continue with FT application work and embed governance and quality frameworks **ON TRACK ALBEIT IT AGAINST A REVISED SOM TIMELINE TO RUN FOR 12 MONTHS FROM INITIATION MEETING WITH THE TDA ON 7<sup>TH</sup> DECEMBER. REVISED TFA STILL WITH TDA AND AWAITING FEEDBACK PRIOR TO RESUBMISSION.**
4. Deliver £12.5m Cost Improvement Programme **ON TRACK**
5. Complete engagement over estates strategy and deliver year one of the estates plan **ON TRACK**
6. Deliver workforce modernisation initiatives **SOME SLIPPAGE BUT ON TRACK TO DELIVER ANNUAL LEAVE AND REST BREAKS. ROSTER CHANGES AND SKILL MIX NOW IMPACTED BY DELAYS IN CAPACITY WORK COMPLETION AND DISCUSSIONS WITH TRADE UNIONS REGARDING OVERALL PACKAGE .(PART 2 DISCUSSION)**
7. Deliver 2012/2013 stakeholder engagement plan **ON TRACK**
8. Improve clinical support in EOC and in the field through the establishment of a clinical hub in EOC and through implementing the new Team Leader job description **ON TRACK**
9. Improve waiting times for all categories of Category C patients. **SIGNIFICANT SLIPPAGE AND CONCERN THAT NO SUSTAINABLE PROGRESS WILL BE DELIVERED IN YEAR DUE TO DEMAD AND CAPACITY ISSUES.**
10. Deliver agreed CQUINS **SOME SIGNIFICANT SLIPPAGE**
11. Successfully deliver safe and effective pre hospital care at the 2012 Olympics and other key events. **DELIVERED**



**LONDON AMBULANCE SERVICE TRUST BOARD**

**DATE: 27<sup>TH</sup> NOVEMBER 2012**

**PAPER FOR NOTING**

<b>Document Title:</b>	<b>Performance Reporting Compliance Statement</b>
<b>Report Author(s):</b>	<b>Sue Meehan</b>
<b>Lead Director:</b>	<b>Peter Suter</b>
<b>Contact Details:</b>	<b>07766445364</b>
<b>Why is this coming to the Trust Board?</b>	This is a yearly return that is presented to the Board.
<b>This paper has been previously presented to:</b>	<input type="checkbox"/> Strategy Review and Planning Committee <input checked="" type="checkbox"/> Senior Management Group <input type="checkbox"/> Quality Committee <input type="checkbox"/> Audit Committee <input type="checkbox"/> Clinical Quality Safety and Effectiveness Committee <input type="checkbox"/> Risk Compliance and Assurance Group <input type="checkbox"/> Learning from Experience Group <input type="checkbox"/> Other
<b>Recommendation for the Trust Board:</b>	To note the paper.
<b>Key issues and risks arising from this paper</b>	
The 11/12 compliance paper was presented and approved by the Trust board in September 2011. The compliance details, as specified within the paper, were met.	
<b>Executive Summary</b>	
This paper describes the rules on how the LAS captures, records and calculates performance information. It also includes information on how various systems are synchronised and other general issues associated with measurement of performance standards. The paper incorporates LAS compliance with previous guidance issued by the DH Information Centre for the KA34 yearly return (version 11/12 final guidance) and the ambulance quality indicators. It also confirms that LAS reporting procedures conform with the additional operational clarification provided by the National Directors of Operations Group (NDOG).	
<b>Attachments</b>	
Appendix 1: Glossary of Terms Appendix 2: Technical specifications Appendix 3: KA34 Guidance 11/12 (This has been included as the ambulance quality indicators still refer to this guidance, although the KA34 has been discontinued from 2012/13) Appendix 4: NDOG Operational Clarification Appendix 5: MPS matrix	

**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:

**PERFORMANCE REPORTING COMPLIANCE STATEMENT**

**AMBULANCE QUALITY INDICATORS 2012/13**

## **1 Background**

This paper describes the rules on how the LAS captures, records and calculates performance information. It also includes information on how various systems are synchronised and other general issues associated with measurement of performance standards. The paper incorporates LAS compliance with previous guidance issued by the DH Information Centre for the KA34 yearly return (version 11/12 final guidance) and the ambulance quality indicators. It also confirms that LAS reporting procedures conform with the additional operational clarification provided by the National Directors of Operations Group (NDOG). There are five appendices to this paper:

Appendix 1: Glossary of Terms

Appendix 2: Technical specifications

Appendix 3: KA34 Guidance 11/12 (This has been included as the ambulance quality indicators still refer to this guidance, although the KA34 has been discontinued from 2012/13)

Appendix 4: NDOG Operational Clarification

Appendix 5: MPS matrix

Ambulance Quality Indicators 12/13 guidance is available from the following website

<http://transparency.dh.gov.uk/2012/06/19/ambqguidance/>

## **2 Compliance with KA34 20011/12 Guidance**

The 11/12 compliance paper was presented and approved by the Trust board in September 2011. The compliance details, as specified within the paper, were met.

## **3 Computer Aided Despatch systems**

The Computer Aided Despatch (CAD) system CTAK was replaced by CommandPoint during March 2012.

## **4 Clock synchronisation**

The Computer Aided Despatch systems both use Network Time Protocol (NTP) to synchronise their internal clock to internal NTP servers which receive a combination of time references from the Global Positioning System (GPS) space-based global navigation satellite system and public time servers on the Internet. The combination provides resilience with a precision is between 15 and 3 microseconds. This is a constant procedure (i.e. not a scheduled process) as the servers have permanent access to the GPS receiving devices and the Internet for this protocol.

The current SatNav software allows the MDT clock to be set accurately down to milliseconds. The MDT synchronises the clock every time it starts up, this is every time it has been switched off manually or when it switches off automatically because it hasn't been used for more than 30 minutes. It also synchronises every hour on the hour.

## 5 Call connect time

The call connect time is taken from when the call hits the telephone switch. CommandPoint detects the call arrival and time stamps it instantly. This process is an accepted industry standard. The time stamp is stored by the Calling Line Identity (CLI) process.

## 6 Clock start times (call connect)

- **Calls generated by a 999 call**

The clock start time (call connect) is when the call is presented to the control room telephone switch. This is time stamped in CommandPoint.

This is the start time used for Category RI and C calls. From 1 June 2012 R2 calls clock start times are based on either vehicle despatched, got chief complaint or + 60 seconds from call connect, whichever is the earliest.

- **Running calls (LAS emergency responder who comes across an incident)**

The clock start time for running calls is when the LAS responder contacts the control room to inform them that they are dealing with a running call. These calls are entered into the CAD system by the dispatchers and are treated in the same manner as an emergency call through the 999 system..

- **Calls taken during CAD downtime**

The time is taken from the clocks on the EOC wall, synchronised to the national time standard currently broadcast from Anthorn in Cumbria (formerly Rugby). There are no seconds displayed.

## 7 Arrival times

- Arrival times for all categories of calls are generated from automatic status reporting at scene based on a vehicle being within 200m of the original incident location (NDOG).
- If the automatic status reporting time is not available, then the MDT “red at scene” button press time is used. If neither of these times is available the PRF time is used.
- PRF times are used for those calls that are not generated from a 999 call e.g. “footprint” calls. These calls will be added into the database manually within Management Information, based entirely on data from the PRF.
- Currently the LAS does not operate the front end model where they wait for confirmation from the initial responder that an ambulance is required. An ambulance routinely forms part of the initial response and is not requested as described in the KA34 guidance.

*“Category A: .....Presenting conditions, which require a fully equipped ambulance vehicle to attend the incident, must have an ambulance vehicle arrive within 19 minutes of the request for transport being made in 95% of cases, unless the control room decides that an ambulance is not required”.*

## **8 Changing incident attributes such as AMPDS code or system generated time stamps**

In CommandPoint the determinant is recorded from ProQA, and the category of the call for the purpose of performance reporting comes from this field. If required, calls would be upgraded or downgraded by changing the Event Type, which would change the priority level within CommandPoint, but this would not affect the category used for performance reporting. If ProQA is re-launched after the call has been completed then it is possible to change the determinant, however for reporting purposes this would be ignored. It is not possible to change timestamps within CommandPoint. The last determinant before arrival at scene is the one used for reporting purposes.

In July 2012 the Clinical Hub was introduced in EOC. Part of the role of the clinical hub is to ring back Red 2 calls to carry out a more detailed assessment of the patient's condition. These calls may be downgraded to Category C as part of the assessment. The category of these calls will be retrospectively changed during the data quality process as described in section 12

## **9 MPS calls**

Incidents received through the MPS link are time stamped when the call hits the LAS server. The calls are categorised in accordance with the matrix in Appendix 5 as there are no AMPDS codes. For performance purposes they are categorised as either Category A for R1/2 calls or Category C for C1/2/3 calls

## **10 Calls during CAD downtime**

Calls taken during CAD downtime are manually allocated an AMPDS code. However, this code is not entered into the performance database and all calls are categorised as Category C2.

## **11 Cross border calls**

The KA34 return states the following:

*“Each NHS Ambulance Service is responsible for reporting on the performance of all emergency calls for which it receives the initial call. This includes calls received by a Service that relate to incidents occurring outside its recognised boundary and calls relating to incidents within or outside its boundary that are subsequently transferred to another Service for response.*

*An Ambulance Service should not report, or report on the performance relating to any incident where another Ambulance Service received the initial call, even if the call was transferred to and dealt with by that Ambulance Service. Trusts responsible for dealing with any cross-border calls should advise the trusts who received the initial call of all appropriate clock start times for performance reporting purposes.”*

Calls transferred to the LAS from other ambulance services are excluded from the performance calculations.

## **12 Ambulance Quality Indicators Return**

There has been one major change in 1 June 2012 where the call start time for red 2 calls has been changed.

The IM&T Management Information Department is responsible for providing the statistical returns and ensuring that the LAS complies with the Department of Health Guidance and NDOG guidance. There is a two stage process of conformance checking the data in terms of validation and verification as defined in the following two sections:

**Stage 1: Data Validation - for data to be valid it must obey given rules.**

CAT A & CAT C calls recorded in the performance database must conform to the rules (i.e. what a CAT A & CAT C call is) as defined in the 12/13 Ambulance Quality Indicators guidance. Category C calls are further split into four sub groups C1-4. By this process of checking;

- Red 2 calls may be re-categorised to Category C as part the assessment carried out by the clinical hub. This process will only apply to calls that have been rung back before arrival at the scene, and regardless of whether the response time has been hit or missed.
- Test calls will not be counted.
- Equipment pick-up calls will not be counted.
- Critical inter-hospital transfer calls made by a health care professional that have not gone through AMPDS will be categorised as Category A.
- Non-critical inter-hospital transfer calls made by a health care professional that have not gone through AMPDS will be categorised as Category C4.
- Calls made by a healthcare professional that have not gone through AMPDS (that should be Card 35) will be categorised as a Category C4.
- Running calls (hence do not go through AMPDS) will be categorised as Category A. (NDOG).
- The KA34 guidance explicitly allows certain types of calls to be re-categorised as Cat C4 for reporting purposes. Clearly this approach was to acknowledge the difficulty of hitting a response time in certain circumstances. In particular;
  - Hang-ups before coding is complete (i.e. before the determinant is obtained)
  - Caller not with patient and unable to give details
  - Caller refuses to give details (the definition of refuses is taken from the Oxford English dictionary to mean unwillingness or inability)

Current LAS dispatching regimes allow calls to be despatched immediately on basic information, reducing the impact of these problems. Therefore in the spirit of the guidance this rule is only applied to these three types of calls not met within the target.

- Where a call is via a translation bureau (e.g. language line or hearing impaired access service), the rule defined above applies. In addition each call suitable for re-categorisation to Cat C4 will be individually validated to ascertain if there were delays in obtaining the call details. Only those calls where there is clearly a delay associated with the caller's inability to give details will be re-categorised as Cat C4.
- City police arrival times are added to the database for Category A calls as an approved first responder equipped with a defibrillator (KA34).

All calls within the performance database will be validated in this way.

**Stage 2: Data Verification – the process to ensure that valid data is correct and accurate.**

With regard to the KA34 and Ambulance Quality Indicators, this is to ensure that the stated times are accurate and can be substantiated from a defined source. The process will be to verify the database in the following sequence:

Stage 2.1: Zero response - the following groups of **Category A** calls will have a zero response applied to them.

- Static defibrillator locations including hospitals, GP surgeries, airports, railway and underground stations, prisons, police stations, leisure centres, museums, theatres, stores and other locations where a healthcare professional is at the location of the incident, equipped with a defibrillator and deemed clinically appropriate to respond by the trust (KA34, NDOG).
- Events – all calls within event footprints (NDOG).
- Running calls (NDOG).
- Transported transfer - calls to meet helicopters or other modes of transport where a health care professional is already on board, arriving with a patient to be transferred on to a hospital (NDOG).
- BETS calls – calls to a hospital to collect and transfer a baby to another hospital (KA34, NDOG).

Stage 2.2: RVPs – rendezvous point

For Cat A a RVP location is a pre-arrival rendezvous point deemed appropriate for the safety of the ambulance crew.

- Under CommandPoint the incident location is put as a secondary location, with the RVP point being the event location. This means that the correct time (ie RVP time) is picked up automatically (KA34).
- Where there is a call to an incoming aircraft, train, coach or boat providing the ambulance service approved response is at the RVP by the ETA of the aircraft, train, coach or boat the response will be zeroed (NDOG).

Stage 2.3: Automatic Time stamp

All remaining Cat A calls that have been automatically time stamped will not be further verified regardless of whether they meet the target (Cat A 8 minute). The basis for this decision is that as there is no human intervention in this process, the room for error is deemed negligible.

Stage 2.4: Manual Time stamp

All remaining Cat A calls that are either MDT button pressed or manually entered (for whatever reason) will be further verified. This will be irrespective of whether or not they are within the performance target and manually adjusted if errors are found. The basis for this decision is to remove possible errors introduced by human intervention.

**Records will be kept of any adjustments that are made.**

**Recommendation.**

The Trust Board to note the contents of this paper.

**Sue Meehan  
Head of Management Information**

**Peter Suter  
Director of IM&T**

**September 2012**

## **APPENDIX 1: GLOSSARY OF TERMS**

### **CLI Calling Line Identity**

Details of the telephone number are passed from the caller, via the telephone company (e.g. BT) to the LAS.

### **KA34**

DH guidance for completion of KA34.

### **LAS emergency responder**

Emergency vehicle (includes car or bike), approved LAS first responder equipped with a defibrillator.

### **MSF ("Rugby time")**

UK national time standard transmitted by the atomic clock run by the National Physical Laboratory in Teddington, but transmitted from a site near Anthorn, Cumbria. This clock is one of the synchronised official UTC clocks. The wall clocks in EOC are synchronised using this signal.

### **NDOG**

Best practice set of guidelines agreed by the National Directors of Operations Group.

### **NTP Network Time Protocol**

This is the system by which internet servers synchronise each other to UTC. Every computer connected to the internet can synchronise its clock with this signal, using a number of public time servers run by the American military. All our servers are using this method to keep in synch.

### **UTC Universal Time Co-ordinated**

The internationally agreed time standard set by synchronised atomic clocks run by several countries.

**APPENDIX 2: TECHNICAL SPECIFICATIONS**

<b>Time stamp</b>	<b>Definition</b>	<b>CAD database field</b>	<b>Clock used</b>	<b>How synchronised</b>	<b>KA34 compliant</b>
Call connected Command Point	When the call arrives on the telephone switch	CAD_ROW_DBASQ.asqdate	Command Point Server	NTP using the LAS NTP stratum 1 servers (using GPS as stratum 0 clock for synchronisation)	Yes
Call answered Command Point	When the call is answered by the call taker	CAD_ROW_DBASQ.answerdate	Command Point Server	Same as call connected CommandPoint	Not applicable
Arrived at scene (Auto status)	When the vehicle arrives within 200m of the incident using AVLS	Log record	CTAK server	Same as below	Yes
Arrived at scene (MDT)	This is when the crew press the MDT button to indicate the resource has arrived at the patient's location	log_entry.param1 where record_type=6 and param=3	MDT	MDTs synchronise with the SatNav clock when they start up and then every hour on the hour. The accuracy is within milliseconds. The SatNav uses GPS time.	Yes



## Appendix 3



### AMBULANCE SERVICES:

#### DATA REPORTING REQUIREMENTS FOR THE COMPLETION OF KA34, 2011-12

## 1. INTRODUCTION

- 1.1 The information obtained from the KA34 is analysed by individual ambulance service providers to show volume of service and performance against required standards; including clinical quality indicators. This information is published each month by the Information Centre for Health and Social Care (IC), with a further conclusive annual bulletin being published. The most recent annual statistical bulletin “Ambulance services, England: 2010-11”, is available on the IC website. ([www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/ambulance](http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/ambulance))
- 1.2 The KA34 reporting template for 2011-12 is enclosed at the end of this guidance document. It is planned to publish information derived from the returns made by the ambulance services on an annual basis.

**Important note: The principal changes to the guidance for 2011-12 reporting are:**

- A) **Removal of the Category B, 19-minute ambulance response time requirement. This has meant that the term ‘Category B’ has been removed and the guidance and collection form has been amended to reflect this.**

**To note: that some re-numbering of sections has been required to allow changes to be made to this guidance.**

- 1.3 NHS Ambulance Trusts use different types of technical solutions to quickly identify the location of a caller, to dispatch an emergency response and to record electronically the various stages of the call management cycle, including the stopping of the clock.
- 1.4 It is expected that ambulance services will have robust governance arrangements, including data management protocols, in place to assure their Board and independent auditors that all performance data submitted as part of this return is measured and recorded in accordance with this guidance.

## 2. AMBULANCE RESPONSE TIME REQUIREMENTS

- 2.1 National response times standards for emergency and urgent ambulance services have been set since 1974. The NHS Executive Review of Ambulance Performance Standards introduced revised standards following publication in July 1996. The following revised targets were issued to ambulance services in Executive Letter EL(96)87, as amended by the Department of Health’s letters to all Chief Executives dated 10 September 2004, 28 September 2004 and 2 March 2006, and most recently via the NHS Operating Framework 2011-12.
  - 2.1.1 **Category A:** presenting conditions, which may be immediately life threatening and should receive an emergency response within 8 minutes irrespective of location in 75% of cases.

Presenting conditions, which require a fully equipped ambulance vehicle to attend the incident, must have an ambulance vehicle arrive within 19 minutes of the request for transport being made in 95% of cases, unless the control room decides that an ambulance is not required.

**2.1.2 Category C:** presenting conditions which are not immediately life threatening. For these calls the response time standards are not set nationally but are locally determined.

### **3. DEFINITIONS FOR COMPLETION OF KA34**

#### **3.1 Part 1 - Emergency calls:**

**3.1.1** Ambulance services use two approved call prioritisation systems (the Medical Priority Dispatch System and NHS Pathways) to map codes that comprise of categories A, and C. The call determinates under all categorisation codes are reviewed annually and, if appropriate, revised lists are issued accordingly (see Department of Health weblink to Annexed list at end of this guidance document).

**3.1.2** Although the vast majority of calls can be categorised using the Annexed list, some calls remain that the Annex does not deal with:

- (a) Duplicate or multiple calls to an incident where a response has already been activated. All of these calls should be categorised in the same way as the original call that activated the response
- (b) Hang-ups before coding is complete  
Caller not with patient and unable to give details  
Caller refuses to give details  
Hoax calls where response not activated  
Response cancelled before coding is complete (e.g. patient recovers)

All of these should be counted as category C calls

**3.1.3** Once a category (A or C) is determined and a response is activated, the priority given should not subsequently be altered for reporting purposes. For operational reasons, a service may subsequently upgrade or downgrade the category, but reporting should remain against the code that was in place within the CAD record prior to the arrival of a first response arriving on scene.

**3.1.4** In line 01 on KA34, all emergency calls are to be counted, even if multiple calls are received for a single incident (see also 2.1.4)

#### **3.2 Resolving Category C calls through telephone advice**

**3.2.1** Where a call is determined as Category C and the most appropriate response is through clinical advice to be provided over the phone (with no ambulance response required), and calls are dealt with by a healthcare professional accountable to the Trust or passed to another organisation working with the Trust through an agreed contract or Service Level Agreement (agreed and governed through the Trust Board) and recorded in line 07 of the KA34 return. Calls defined under section 3.1.2 of this guidance should be excluded when recording in line 07.

**3.2.2** Only successfully completed calls that have been dealt with by the healthcare professional, to whom the call was transferred to, should be recorded in line 07 of the KA34 return. A

successfully completed call is one where advice has been given with any appropriate action being agreed with the patient and where no further response is required from the ambulance service.

### **3.3 Incidents**

- 3.3.1 For purposes of reporting performance, each incident responded to should be counted only once (except for line 01), regardless of how many ambulances or other emergency responses are despatched to the incident.

### **3.4 Patient Destinations and Patient Journeys**

- 3.4.1 Each patient conveyed is counted as an individual patient destination. Similarly, each patient who is treated at the scene of an incident without requiring onward conveyance is counted as an individual treatment at the scene.

#### ***Part 2 – Emergency Patient Destinations:***

- 3.4.2 **Disaggregation of emergency patient destinations** - include only those patients conveyed as a result of a 999 call made by a member of the public or organisation, or as a result of being categorised as an emergency following a referral by a health care professional.
- 3.4.3 **Emergency patient journeys to Type 1 and 2 A&E** (as defined in the NHS Data Dictionary) – include those emergency patient journeys provided by the Trust where a patient is transported to a Type 1 or Type 2 A&E department only.
- 3.4.4 **Emergency patient journeys to a destination other than Type 1 and 2 A&E** – include those emergency patient journeys provided by the Trust where a patient is transported to all other destinations other than Type 1 or 2 A&E departments. An example of this could be conveying a patient to a minor injuries unit or a Walk-in Centre, a specialist stroke or cardiac centre, GP service or any other health or social care service.
- 3.4.5 **Treatment at the scene** – include those patients who were treated at the scene by the ambulance service and as a result of that treatment did not require onward transportation for further treatment. If, as part of that treatment, the ambulance trust staff arranged, for example, an appointment for the patient at a GP surgery or a follow-up home visit from a health professional that should also be counted as treatment at the scene. Responses where ambulance trust staff attended an incident and advice was given but no clinical intervention was necessary with no onward transportation required, then that should also be included as treatment at the scene.

#### ***Part 3 – Patient Journeys: Non-urgent***

- 3.4.6 The following provides a more detailed clarification of what should be included in Part 3 'Patient Journeys: Non-Urgent' section of the KA34 return:
- 3.4.7 **Special patient journeys** - include those patient journeys provided by the Trust where punctuality is of paramount importance and late arrival beyond the prescribed time could be detrimental to the patient's medical condition. An example of this is a transfer between hospitals where a serious or critically ill patient requires specialist facilities not available at the transferring hospital and where treatment is required en route.
- 3.4.8 **Planned/ non-emergency patient journeys** - include all other patient journeys by the Trust. These are for any patients not given emergency or special priority (e.g. most journeys for outpatient appointments, hospital admissions and discharges of a routine nature, including transport to and from other healthcare facilities).

### **3.5 Timing of emergency response times – clock start and stop**

- 3.5.1** In order to calculate the response time the “clock starts” when the call is presented to the control room telephone switch. This will be the case for all calls received on control room telephone lines; from dedicated 999 lines or otherwise. For calls that are electronically transferred to the computer aided dispatch (CAD) system from another CAD the clock starts immediately when that call record is first received by an ambulance trust system.
- 3.5.2** The "clock stops" when the first emergency response vehicle arrives at the scene of the incident. To clarify, a legitimate clock stop position can include the response arriving at a pre-arrival rendezvous point when one has been determined as appropriate for the safety of ambulance staff in agreement with the control room. For example, a rendezvous point could be agreed for the following situations:
- Information has been received relating to the given location that the patient is violent and police or other further assistance is required.
  - Information has been received that the operational incident because of its nature is unsafe for ambulance staff to enter.
- 3.5.3** A response within 8 minutes means 8 minutes 0 seconds (i.e. 480 seconds) or less. Similarly, 19 minutes means 19 minutes 0 seconds or less.

#### ***Category A 19-minute transport request***

- 3.5.4** Whichever is the earlier, the clock starts when either
- the initial responder makes a request for transport to the control room, or
  - the information received from the 999 caller indicates that transport is needed, in which case the clock starts as per 3.5.1.

### **3.6 Emergency response**

- 3.6.1** For the purposes of the Category A 8-minute standard, an emergency response may only be by:
- An emergency ambulance; or
  - A rapid response vehicle equipped with a defibrillator to provide treatment at the scene; or
  - An approved first responder equipped with a defibrillator, who is accountable to the ambulance service; or when a healthcare professional is at the location of the incident, equipped with a defibrillator and deemed clinically appropriate to respond by the trust. A first responder is not a substitute for an ambulance response and an ambulance response should be dispatched to all calls attended by an approved first responder.
- 3.6.2** For the purposes of the Category A 19-minute standard, transport is defined as a fully equipped ambulance vehicle (car or ambulance) able to transport the patient in a clinically safe manner.

### **3.7 Cross-border Calls**

- 3.7.1** A cross-border call/incident should be reported by only one Ambulance Service.
- 3.7.2** Each NHS Ambulance Service is responsible for reporting on the performance of all emergency calls for which it receives the initial call. This includes calls received by a Service that relate to incidents occurring outside its recognised boundary and calls

relating to incidents within or outside its boundary that are subsequently transferred to another Service for response.

- 3.7.3** An Ambulance Service should not report, or report on the performance relating to, any incident where another Ambulance Service received the initial call, even if the call was transferred to and dealt with by that Ambulance Service. Trusts responsible for dealing with any cross-border calls should advise the Trusts who received the initial call of all appropriate clock start times for performance reporting purposes.
- 3.7.4** Where an NHS Ambulance Service asks another NHS Ambulance Service to undertake a call on its behalf, the responsibility for dealing with the call in the most appropriate way passes to the Ambulance Service once it has accepted it.

#### **4. COMPLETING THE KA34 RETURN**

##### **4.1 Part 1: Emergency calls**

###### **Line 01 on KA34: Total number of emergency calls**

- 4.1.1** Record in column 1 on KA34 the total number of emergency calls where the incident is classified as immediately life-threatening (Category A), in column 2 on KA34 the total number of emergency calls where the incident is classified as category C.
- 4.1.2** If there have been multiple calls to an incident, all calls should be recorded in this line. Include non-urgent transport requests, which, after interrogation and the agreement of the caller, are treated as either Category A, or C calls.

###### **Lines 02 to 07 on KA34: Emergency responses**

- 4.1.3** In **Line 02** on KA34 record the total number of incidents, which resulted in an emergency response arriving at the scene. **If there have been multiple calls to a single incident, only one incident should be recorded.** A separate entry should be made for each of the categories A and C.
- 4.1.4** In **Line 03** on KA34 record the total number of Category A incidents, which resulted in an emergency response arriving at the scene of the incident within 8 minutes. A response within eight minutes means eight minutes zero seconds or less. Note that this detail is not required for category C incidents.

###### **RESPONSE PERFORMANCE FOR CATEGORY A INCIDENTS AT 8 MINUTES IS CALCULATED AS FOLLOWS:**

<p>Emergency responses within 8 minutes (Line 03)</p> <hr/> <p>Total number of incidents with an emergency responses (Line 02)</p>
--

- 4.1.5** In **Line 04** on KA34, record the total number of calls where, following the arrival of a rapid response vehicle or an approved responder at the scene, the control room **subsequently** decided that a fully equipped ambulance vehicle would not be required for category A calls. Note that this detail is not required for category C.

4.1.6 In **Line 05** on KA34, record the total number of incidents that resulted in the arrival of a fully equipped ambulance vehicle (car or ambulance) able to transport the patient. Note that this detail is not required for category C.

**NOTE:** The number of emergency incidents resulting in the arrival of an emergency response (line 02) can be split into:

- (i) those where an emergency response arrived and the control room subsequently decided that a fully equipped ambulance vehicle (car or ambulance) was not needed (line 04 on KA34),
- (ii) those where a fully equipped ambulance vehicle (car or ambulance) able to transport the patient was needed (line 05 on KA34).

For Category A, the total of lines 04 and 05 on KA34 should therefore equal the number recorded in line 02 on KA34.

4.1.7 In **Line 06** on KA34, record the total number of incidents that resulted in the arrival of an ambulance response within 19 minutes, as per section 3.6.2 . For Category A incidents, the timing starts when a request for transport is made (see 3.5.4). Note that this detail not required for category C

**NOTE:** only the first ambulance response to arrive at the scene of the incident should be included in lines 05 or 06 where more than one ambulance response has been despatched.

**RESPONSE PERFORMANCE FOR CATEGORY A INCIDENTS AT 19 MINUTES IS CALCULATED AS FOLLOWS:**

Total number of incidents with an ambulance response arriving within 19 minutes (Line 06)
—————
Total number of incidents with ambulance response arriving (Line 05)

4.1.8 In **line 07** on KA34, record the total number of successfully completed Category C calls that have been resolved by a designated healthcare professional providing telephone advice (see section. 3.2.)

**4.2 Parts 2 and 3: Emergency Patient Destinations and Patient Journeys**

4.2.1 Count each patient conveyed as an individual patient destination (part 2) or as an individual patient journey (part 3).

**Part 2: Emergency Patient Destinations**

4.2.2 Record the number of patient journeys separately for Categories A and C arising from emergency and urgent calls into the following three destination categories (see section 3.4.2):

- Patient journeys to Type 1 and 2 A&E
- Patient journeys to a destination other than Type 1 and 2 A&E.
- Treatment at the scene

### **Part 3: Patient Journeys - Non-urgent**

**4.2.3** Record here the total number of patient journeys other than emergency, include special and planned journeys.

#### **ANNEX**

The call categorisation codes that comprise Categories A and C are set out at

[www.dh.gov.uk/en/Healthcare/Urgentandemergency/DH\\_113435](http://www.dh.gov.uk/en/Healthcare/Urgentandemergency/DH_113435)

The code lists are reviewed annually by the Emergency Call Prioritisation Advisory Group (ECPAG) and, if appropriate, revised lists will be issued accordingly.

**TEMPLATE OF FORM : Ambulance Services KA34**

	1	2
	Category A: Immediately Life Threatening Calls	Category C: Locally Managed <b>Non</b> - Immediately Life Threatening Calls
<b>Part 1 - Emergency Calls</b>		
01. Total number of emergency calls		
02. Number of calls resulting in an emergency response arriving at the scene of the incident		
03. Number of calls resulting in an emergency response arriving at the scene of the incident within 8 minutes		
04. Number of calls where following the arrival of an emergency response no ambulance is required		
05. Number of calls resulting in an ambulance able to transport the patient arriving at the scene of the incident		
06. Number of calls resulting in an ambulance arriving at the scene of the incident within 19 minutes		
07. Number of calls resolved through telephone advice only		
<b>Part 2 - Emergency Patient Destinations</b>		
08. Total number of emergency patient journeys to Type 1 and 2 A&E destinations		
09. Total number of emergency patient journeys to a destination other than Type 1 and 2 A&E		
10. Total number of patients treated at the scene only		
	Special Journeys	Planned Journeys
<b>Part 3 - Patient Journeys: Non-urgent</b>		
11. Total number of special/planned journeys		
<p>Please record in the box below any factors that may have significantly increased or decreased the figures from the previous year</p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>		
<p>Many thanks for taking the time to complete this survey.</p>		



## **APPENDIX 4: NDOG OPERATIONAL CLARIFICATION**

### **Stopping the clock for category A and B calls in a consistent way in all English Ambulance Services.**

#### **Background -**

When the Directors of Operations and performance leads met on the 19<sup>th</sup> January 2007 it was apparent that ambulance services were treating some operational incidents in a different way regarding clock start/stop.

Organisations were reporting clock start and stop within the guidance issued by the DH; however they were often presented with other Operational incidents which required a common and consistent approach around clock start/stop.

The Director of Operations and Performance leads for Ambulance Services have therefore recommended in this document a number of clock start/stop points for ambulance Trusts to put in place with immediate effect.

The group also recommended that existing performance data for ambulance Trusts is retrospectively adjusted from 1<sup>st</sup> July 2006 to reflect the suggested clock start/stop points in this document.

#### **Suggested Clock start/stop-**

*Please note: that 01 refers to validated ambulance service response/responder at the location given by the caller and therefore call within the 8/19 minute standard will be met.*

##### **1. Patients in Transit**

This refers to patients travelling in bound to a location by train, coach, boat and aircraft and providing the ambulance service approved response is at the RVP of the location given by the estimated time of arrival of the patient the clock starts when the patient arrives and is stopped with a 01 code.

##### **2. Special Events**

When the NHS Ambulance Service has been asked to provide medical cover at a special event and has trained personnel at the location of the event in the use of a defibrillator, the 01 code may be applied to all calls received within the event itself. Those calls which fall outside of the perimeter of the special event are to be responded to normally by the local ambulance service.

Calls which arise from a special event should be entered on a Patient Report Form and retrospectively prioritised before being entered into the CAD system. The CAD record must be made within 36 hours of the event closing.

##### **3. Inter-hospital transfers**

When a request is received through the 999 system to transfer a patient from one Healthcare facility to another and the ambulance service has confirmed that the centre requesting the transfer has a defibrillator at the location and someone is trained in its use, MPDS card 33 should be used and the 01 code applied to the call.

4. GP surgeries/Walk in Centres/Minor Injury Units

As above, but without the use of card 33.

5. Prisons/Secure Detention Units

If the ambulance service receives a call through the 999 system to attend a Prison or secure unit the clock stops when the ambulance response arrives at the agreed RVP.

If the ambulance service have trained personnel within the unit and have provided a defibrillator and have confirmed at the time of the call that both are present then the 01 code can be applied to the call.

6. Running Calls

To default to a Category A and the 01 code is applied.

**Hayden Newton**  
**National Ambulance Performance Implementation Lead**  
**20<sup>th</sup> January 2007.**

**Appendix 5 MPS Matrix**

## Proposed MPS Matrix for Call Categorisation

New Proposed Matrix for MPS Call Categorisation								
Ambulance Request						Stand By	Information	Category
Breathing	Conscious	Chest Pain	Stab/Shot	Severe Bleed	Under 2yrs			
No								Red1
Yes/Unk	No							Red2
Yes/Unk	Yes/Unk	Yes						Red2
Yes/Unk	Yes/Unk	No/Unk	YES					C1EM
Yes/Unk	Yes/Unk	No/Unk	No/Unk	Yes				C1EM
Yes/Unk	Yes/Unk	No/Unk	No/Unk	No/Unk	Yes			C2EM
Yes/Unk	Yes/Unk	No/Unk	No/Unk	No/Unk	No/Unk			C3EM
<b>No Patient Details</b>						Yes		C3EM
						No	Yes	C3EM

1



## LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 27<sup>TH</sup> NOVEMBER 2012

### Compliance with Standing Orders and Standing Financial Instructions

<b>Document Title:</b>	<b>Trust Secretary Report</b>
<b>Report Author(s):</b>	<b>Francesca Guy, Committee Secretary</b>
<b>Lead Director:</b>	<b>Sandra Adams, Director of Corporate Services</b>
<b>Contact Details:</b>	<a href="mailto:francesca.guy@lond-amb.nhs.uk">francesca.guy@lond-amb.nhs.uk</a>
<b>Why is this coming to the Trust Board?</b>	<b>Compliance with Standing Orders</b>
<b>This paper has been previously presented to:</b>	<input type="checkbox"/> Strategy Review and Planning Committee <input type="checkbox"/> Senior Management Group <input type="checkbox"/> Quality Committee <input type="checkbox"/> Audit Committee <input type="checkbox"/> Clinical Quality Safety and Effectiveness Group <input type="checkbox"/> Risk Compliance and Assurance Group <input type="checkbox"/> Other
<b>Recommendation for the Trust Board:</b>	<b>To be advised of the tenders received and entered into the tender book and the use of the Trust Seal since 18<sup>th</sup> September 2012 and to be assured of compliance with Standing Orders and Standing Financial Instructions</b>
<b>Key issues and risks arising from this paper</b>  This report is intended to inform the Trust Board about key transactions thereby ensuring compliance with Standing Orders and Standing Financial Instructions.	
<b>Executive Summary</b>  One tender has been received, opened and entered into the tender book since 18 <sup>th</sup> September 2012: <ul style="list-style-type: none"><li>▪ Refurbishment and Reconfiguration of Barnehurst Ambulance Station Tenders received and opened by Bravo Solutions on 5<sup>th</sup> November 2012 Coniston Ltd Form Ltd Millane Contracts Ltd Warwick Avenue Ltd SCG Contracting Ltd</li></ul> There have been no new entries to the Register for the Use of the Trust Seal since 23 <sup>rd</sup> August 2012.	
<b>Attachments</b>  None.	

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**Quality Strategy**

This paper supports the following domains of the quality strategy

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

**Strategic Goals 2010 – 13**

This paper supports the achievement of the following corporate objectives:

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

**Risk Implications**

This paper links to the following strategic risks:

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

**Equality Impact Assessment**

Has an Equality Impact Assessment been carried out?

- Yes
- No

Key issues from the assessment:



### TRUST BOARD FORWARD PLANNER 2013

	Standing Items	Quality Assurance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period
<b>29<sup>th</sup> January Trust Board</b>	Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman FT Update	<b>Quality Dashboard and Action Plan</b>  <b>Clinical Quality and Patient Safety Report</b>  <b>Reports from Executive Directors (COO, DoF, DoHR)</b>	Report from Chief Executive Officer  2013/14 Annual Business Plan  2013/14 Corporate Objectives  2013/14 Equality Objectives	Report from Finance and Investment Committee  Update on Information Governance  Report from Trust Secretary  Trust Board Forward Planner	Finance and Investment Committee - 15 <sup>th</sup> January
<b>26<sup>th</sup> February Strategy Review and Planning Committee</b>	Safeguarding FT Update				

	Standing Items	Quality Governance and Risk	Strategic and Business Planning	Governance	Sub-Committee meetings during this period
<b>26<sup>th</sup> March Trust Board</b>	<p>Patient Story</p> <p>Declarations of Interest</p> <p>Minutes of the previous meeting</p> <p>Matters arising</p> <p>Report from the Trust Chairman</p> <p>FT Update</p>	<p><b>Quality Dashboard and Action Plan</b></p> <p><b>Clinical Quality and Patient Safety Report</b></p> <p><b>Quality Committee Assurance Report</b></p> <p><b>BAF and Corporate Risk Register – Quarter 4 documents</b></p> <p><b>Risk Management Strategy and Policy review</b></p> <p><b>Audit Committee Assurance Report</b></p> <p><b>Reports from Executive Directors (COO, DoF, DoHR)</b></p>	<p>Report from Chief Executive Officer</p> <p>2013/14 Annual Business Plan sign off</p> <p>2013/14 Corporate Objectives sign off</p> <p>2013/14 Equality Objectives sign off</p> <p>Draft IBP/LTFM for approval</p>	<p>Report from Finance and Investment Committee</p> <p>Report from Trust Secretary</p> <p>Trust Board Forward Planner</p>	<p>Audit Committee - 4<sup>th</sup> March</p> <p>Finance and Investment Committee - 12<sup>th</sup> March</p> <p>Quality Committee – 20<sup>th</sup> February</p>
<b>30<sup>th</sup> April Strategy, Review and Planning Committee</b>	<p>Final review of key FT application documents</p> <p>Reports on Board Governance Assurance Framework, Quality Governance and HDD1</p> <p>Public Consultation Documents for approval</p>				

	Standing Items	Annual Reporting	Quality Assurance	Strategic and Business Planning	Governance	Sub-Committee meetings during this period
<b>28<sup>th</sup> May</b>  <b>Trust Board</b>	Patient Story  Declarations of Interest  Minutes of the previous meeting  Matters arising  Report from the Trust Chairman  FT Update	<b>Annual Report and Accounts 2012/13</b>  <b>Draft Quality Account 2012/13</b>  <b>Audit Committee Assurance Report</b>	Quality Dashboard and Action Plan  Clinical Quality and Patient Safety Report  Quality Committee Assurance Report  Reports from Executive Directors (COO, DoF, DoHR)	Report from Chief Executive Officer	Report from Finance and Investment Committee  Annual Equality Report 2012/13  Update on Information Governance  Report from Trust Secretary  Trust Board Forward Planner	Audit Committee - 13 <sup>th</sup> May  Finance and Investment Committee – 14 <sup>th</sup> May  Quality Committee – 24 <sup>th</sup> April
	Standing Items	Quality Governance and Risk	Quality Assurance/Annual Reporting	Strategic and Business Planning	Governance	Sub-Committee meetings during this period
<b>25<sup>th</sup> June</b>  <b>Trust Board</b>  <b>Apologies: Steve Lennox</b>	Patient Story  Declarations of Interest  Minutes of the previous meeting  Matters arising  Report from the Trust Chairman  FT Update	<b>Quality Dashboard and Action Plan</b>  <b>Clinical Quality and Patient Safety Report</b>  <b>Quality Committee Assurance Report</b>  <b>BAF and Corporate Risk Register – Quarter 1 documents</b>  <b>Audit Committee Assurance Report</b>  <b>Reports from Executive Directors (COO, DoF, DoHR)</b>	<b>Quality Account 2012/13 for approval</b>	Report from Chief Executive Officer	Report from Trust Secretary  Trust Board Forward Planner	Audit Committee - 3 <sup>rd</sup> June  Quality Committee – 19 <sup>th</sup> June

<b>23<sup>rd</sup> July</b>  <b>Strategy, Review and Planning Committee</b>	Committee Effectiveness Review  IBP/LTFM sign off  FT Update				
	<b>Standing Items</b>	<b>Quality Assurance</b>	<b>Strategic and Business Planning</b>	<b>Governance</b>	<b>Sub-Committee meetings during this period</b>
<b>20<sup>th</sup> August</b>  <b>Trust Board</b>	Patient Story  Declarations of Interest  Minutes of the previous meeting  Matters arising  Report from the Trust Chairman  FT Update	<b>Quality Dashboard and Action Plan</b>  <b>Clinical Quality and Patient Safety Report</b>  <b>Quality Committee Assurance Report</b>  <b>Reports from Executive Directors (COO, DoF, DoHR)</b>  <b>Annual Infection Prevention and Control Report 2012/13</b>  <b>Annual Patient Experiences Report 2012/13</b>  <b>Annual Safeguarding Report 2012/13</b>	Report from Chief Executive Officer  Outcome reports on public consultation to receive and approve	Report from Finance and Investment Committee  Annual Corporate Social Responsibility Report  Report from Trust Secretary  Trust Board Forward Planner	Finance and Investment Committee – 9 <sup>th</sup> July  Quality Committee – 21 <sup>st</sup> August

	Standing Items	Quality Governance and Risk	Strategic and Business Planning	Governance	Sub-Committee meetings during this period
<b>24<sup>th</sup> September</b>  <b>Trust Board</b>	Patient Story  Declarations of Interest  Minutes of the previous meeting  Matters arising  Report from the Trust Chairman  FT Update	<b>Quality Dashboard and Action Plan</b>  <b>Clinical Quality and Patient Safety Report</b>  <b>BAF and Corporate Risk Register – Quarter 2 documents</b>  <b>Audit Committee Assurance Report</b>  <b>Annual Report of the Audit Committee</b>  <b>Reports from Executive Directors (COO, DoF, DoHR)</b>	Report from Chief Executive Officer	Report from Finance and Investment Committee  Report from Trust Secretary  Trust Board Forward Planner	Audit Committee - 2 <sup>nd</sup> September  Finance and Investment Committee – 10 <sup>th</sup> September
<b>22<sup>nd</sup> October</b>  <b>Strategy, Review and Planning Committee</b>	FT Update				

	<b>Standing Items</b>	<b>Quality Assurance</b>	<b>Strategic and Business Planning</b>	<b>Governance</b>	<b>Sub-Committee meetings during this period</b>
<b>26<sup>th</sup> November Trust Board</b>	Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman FT Update	<b>Quality Dashboard and Action Plan</b>  <b>Clinical Quality and Patient Safety Report</b>  <b>Quality Committee Assurance Report</b>  <b>Audit Committee Assurance Report</b>  <b>Reports from Executive Directors (COO, DoF, DoHR)</b>	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 - 4 <sup>th</sup> November  Finance and Investment Committee – 12 <sup>th</sup> November  Quality Committee – 23 <sup>rd</sup> October
	<b>Standing Items</b>	<b>Quality Governance and Risk</b>	<b>Strategic and Business Planning</b>	<b>Governance</b>	<b>Sub-Committee meetings during this period</b>
<b>17<sup>th</sup> December Trust Board</b>	Patient Story Declarations of Interest Minutes of the previous meeting Matters arising Report from the Trust Chairman FT Update	<b>Quality Dashboard and Action Plan</b>  <b>Clinical Quality and Patient Safety Report</b>  <b>Quality Committee Assurance Report</b>  <b>BAF and Corporate Risk Register – Quarter 3 documents</b>  <b>Reports from Executive Directors (COO, DoF, DoHR)</b>		Report from Trust Secretary  Trust Board Forward Planner	Quality Committee – 11 <sup>th</sup> December