London Ambulance Service NHS
NHS Trust

TRUST BOARD

Meeting to be held at 10.00am on Thursday 3rd February 2011
Conference Room, LAS Headquarters, 220 Waterloo Road, London SE1 8SD

Peter Bradley
Chief Executive Officer

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AGENDA

			TAB
1.	**Welcome and apologies for absence**		
2.	**Minutes of the Part I meeting held on 14th December 2010** To approve the minutes of the meeting held on 14th December 2010		TAB 1
3.	**Matters arising** 3.1 Actions from previous meetings	All	TAB 2
4.	**Report from Sub-Committees** To receive a report from the following Committees 4.1 Quality Committee on 14th December 2010		TAB 3
5.	**Chairman's Report** To receive a report from the Trust Chairman on key activities	RH	TAB 4
6.	**Update from executive directors** To receive reports from Executive Directors on any additional key matters 6.1 Chief Executive Officer, including balanced scorecard, new risks and performance reports 6.2 Finance Director	 PB MD	 TAB 5 TAB 6
7.	**Clinical quality and patient safety report** To receive the monthly report on clinical quality and patient safety	FM	TAB 7
8.	**Update on Patients with Learning Difficulties** To receive an update on activity in relation to patients with learning difficulties	SL	TAB 8

STRATEGIC AND BUSINESS PLANNING

9.	**CommandPoint Update** To receive an update on the CommandPoint project	PS	TAB 9

| 10. | **Business Planning and Commissioning 2011/12**
To receive a presentation of the process and timetable for 2011/12 | MD/
LB | TAB 10 |
| 11. | **Estates Strategy** | MD | TAB 11
Pack B |

FOUNDATION TRUST PROCESS

12.	**Historical Due Diligence Closure Report and minutes from the meeting on 30th November 2010** 11.1 To approve the minutes of the meeting held post-Trust Board on 30th November 11.2 To receive a progress report on Stage 2 Historical Due Diligence	SA	TAB 12
13.	**Integrated Business Plan and Long Term Financial Model** To approve Version 5.0 of the Integrated Business Plan and Long Term Financial Model prior to submission	SA/ MD	TAB 13 Pack B
14.	**Lessons learned from recent NHS Foundation Trust applicants** To consider Monitor's document on the lessons learned from recent foundation trust applicants and to consider a number of key questions as part of the internal assurance process	SA	TAB 14
15.	**Board declarations/self certification as part of the documentation required for the Foundation Trust application** To consider the board statements for self certification in preparation for the application and for SHA assurance processes	SA	TAB 15

GOVERNANCE

16.	**Patient Experience Annual Report 2009/10** To receive the annual report on patient experiences for the period April 2009 to March 2010	SA	TAB 16
17.	**Report from Trust Secretary** To receive the report from the Trust Secretary on tenders received and the use of the Trust Seal	SA	TAB 17
18.	**Forward Planner** To review the Trust Board forward planner and agree items for future meetings	SA	TAB 18
19.	**Questions from members of the public**		
20.	**Any other business**		
21.	**Date of next meeting**		

The next meeting in public of the **Trust Board** will be held on Tuesday 29th March 2011.
There will be a meeting of the **Strategy Review and Planning Committee** on Tuesday 1st March 2011.

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING
Part I

Minutes of the meeting held on Tuesday 14th December 2010 at 10:00 a.m.
in the Conference Room, LAS HQ, 220 Waterloo Road, London SE1 8SD

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Present:

Richard Hunt	Chair
Peter Bradley	Chief Executive Officer
Jessica Cecil	Non-Executive Director
Mike Dinan	Director of Finance
Roy Griffins	Non-Executive Director
Caron Hitchen	Director of Human Resources and Organisation Development
Brian Huckett	Non-Executive Director
Beryl Magrath	Non-Executive Director
Fionna Moore	Medical Director
Nigel Walmsley	Non-Executive Director

In Attendance:

Sandra Adams	Director of Corporate Services
Lizzy Bovill	Deputy Director of Strategic Development
Francesca Guy	Committee Secretary (minutes)
Steve Lennox	Director of Health Promotion and Quality
Christine McMahon	Project Manager, Governance and Compliance Team
Peter Suter	Director of Information Management and Technology
Richard Webber	Director of Operations

Members of the Public:

Joseph Healy	Chair of Patients Forum
Neil Kennett-Brown	North West London Commissioning Partnership

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		Action
155/10.	**Welcome and Apologies**	

Apologies had been received from Caroline Silver and Angie Patton.

156/10.	**Minutes of the Part I meeting held on 30th November 2010**

The following amendments were agreed: **FG**

- Minute 138/10, page 4: The Trust Board agreed that it would be useful to hold a workshop on the balanced scorecard at a future meeting or Strategy Review and Planning meeting. Caron Hitchen agreed to add this to the Board Development Plan; **CH**
- Minute 139/10: An action point to be added for appropriate staff to meet to develop a strategy for medicines management;
- Minutes 145/10: An amendment to the paragraph regarding the ethnicity section of the membership strategy.

Subject to these amendments, the minutes of the meeting held on 30th November 2010 were approved.

157/10. Matters Arising

The following matters arising were discussed:

- 102/10: Sandra reported that the draft Constitution and the Standing Orders were currently being reviewed by lawyers;
- 97/10: Mike Dinan agreed to circulate the age profile of the fleet to the Trust Board prior to the next Trust Board meeting; **MD**
- 117/10: Mike Dinan confirmed that agency spend included temporary staff and consultancy;
- 117/10: It was agreed that it was the responsibility of the Trust Board to hold the Trust to each line of the budget. The Cost Improvement Plan would be monitored line by line also;
- 135/10: The DVD on treating patients experiencing excited delirium had been copied and distributed to all complexes. There was a delay however in staff viewing the DVD due to the equipment available at stations, but this was being followed up by the Information Management and Technology department. An e-learning package was being developed;
- 138/10: Caron Hitchen reported that there was currently no update on causes of sickness amongst Patient Transport Services staff. Nigel Walmsley requested more contextual information to support the figures; **CH**
- 145/10: Sandra Adams responded that the membership strategy would be updated as part of the ongoing work on the Integrated Business Plan.

Additional actions were agreed from the meeting on 30th November, to be added to the minutes and the action schedule:

- Appropriate staff to meet to discuss the development of a strategy for medicines management; **FM**
- Performance statistics to be benchmarked and contextualised. **RW**

Joseph Healy reported that the Patients' Forum had raised a query regarding the Safeguarding Committee, which had not met for some time. Steve Lennox responded that a recent meeting had been cancelled and had been rescheduled for early January 2011.

Beryl Magrath asked whether the LAS undertook any joint working with the London Metropolitan Police. Fionna Moore responded that the Trust was currently working on training with the Metropolitan Police on public order deployment.

The Chair requested that the remaining actions on the action schedule be completed by the next Trust Board meeting. **All**

The Chair noted that the Business Case for the Single Tender Authority for Mobile Data Terminals had not previously been included in the Trust Board forward planner and asked therefore whether the forward planner was detailed enough, particularly with regards to financial matters. It was the responsibility of all Trust Board members to ensure that relevant items were included in the forward planner. **All**

158/10. Chairman's Report

The Chair reported that he had made a presentation about the LAS to the last London PCT chairs meeting, and had covered performance, current status and the Foundation Trust application.

The Chair would be attending Board meetings of other NHS trusts as part of his development and would be looking to attend the board meetings of South East Coast Ambulance Trust and Mid-Staffordshire in the near future. The Chair would also be attending the board meeting of NHS London.

159/10. **Update from Executive Directors**

<u>Chief Executive Officer</u>

Peter Bradley reported the following:

- An announcement would be made on Friday 17th December 2010 that the Category B target would be removed and performance measurement would move towards clinical outcomes. It was likely that this announcement would attract media interest;
- Work on the Category A target (clock change) would be submitted to the Secretary of State in January 2011 for approval;
- The Quality, Innovation, Prevention and Productivity (QIPP) plan would be submitted to PCTs and NHS London as part of the quality agenda;
- Work was continuing on the application for Foundation Trust status and the letter of convergence was needed from commissioners by Friday 17th December 2010. More work needed to be done to develop the Cost Improvement Plan;
- Penalty negotiations needed to be resolved as quickly as possible to allow for future planning and financial performance needed to be sustained for the rest of 2010/11;
- The Trust had recently received two awards; one for clinical innovation in the treatment of stroke patients and one for ambulance staff at Greenwich complex for admission avoidance;
- Following his secondment to the Irish Ambulance Service, Martin Flaherty would take up the temporary position of acting CEO of Great Western Ambulance Service and would therefore not return to the LAS until December 2011. The Trust Board agreed that Mike Dinan would take the role of acting CEO during the period of Peter Bradley's annual leave in January 2011;
- The staff survey was now closed and had a 35% completion rate, which was comparable to last year;
- A message would be sent to all staff regarding potential staff reductions and the implications of this.

<u>Director of Finance</u>

Mike Dinan explained that, as the Trust Board meeting was earlier in the month than usual, the Finance Report was not yet finalised but would be circulated to the Trust Board by the end of the week and he would be happy to hold a conference call then to discuss. The Chair requested that if, in the future, the finalised report was not available, the Trust Board be provided with headline figures.

MD

Mike Dinan reported the following:

- The Trust had made a £501k loss for this month against a forecast of £520k;
- The year to date surplus was £543k against a forecast of £526k;
- The Trust would therefore need to break even for the rest of the year;
- The year end forecast would not be amended at this stage;
- Overtime hours might need to be increased during the Christmas period and the student protests.

Brian Huckett asked for an update on unresolved issues such as contract penalties. Mike Dinan responded that he had estimated a sum for this and was meeting commissioners on 14th December 2010.

Richard Webber gave an update on performance:

- The Trust lost 0.5% on performance on 30th November for the month of November due to the snow. This was against a year to date figure on 29th November of 75%;
- Performance was at 64% for the first week of December and 67% for the second week of December. Performance was now just below 66% for the month,
- Last week was the busiest week on record with 21,600 calls received and 1100 Category A responses per day;
- Extra staffing was required last week, with significantly more car hours and good ambulance cover;
- There was currently significant pressure on the whole system with 200+ hospital-related delays, and most other ambulance trusts nationally were in the same position;
- It was expected that next week would see a further increase in demand with additional student protests and more snow forecast both of which were becoming a drain on resources, particularly if they continued;
- The LAS had seen a significant increase in respiratory problems and some cases of swine flu and noro-virus.

Fionna Moore added that the demand management plan had been updated and had been used aggressively during times of extreme demand and had been in use 14 out of the last 15 days. The plan could only be put into action on approval by the Gold Medic. The demand management plan required additional clinical support for the control room in order to minimise clinical risk.

Lizzy Bovill commented that additional planning would be required for the Christmas period when many GP surgeries would be closed. It was expected that the LAS would be especially busy over this period.

Nigel Walmsley asked whether the increase in demand was due to high levels of sickness in the community or cut backs in the wider system. Fionna Moore responded that both were contributory factors, but that the service had in particular received an increase in calls from elderly patients with respiratory problems. Thirteen out of nineteen ECMO beds in the country were in use. Fionna added that she had never seen demand at this level and the system was experiencing pressures at hospitals that was very rarely seen.

160/10. Clinical Quality and Patient Safety Report

Fionna Moore reported the following:

- The Trust was working to introduce resuscitation guidelines which had been published in October. Training sessions would commence in January 2011;
- National changes to call categorisation would come into effect following the removal of the Category B target. The Trust was currently preparing for these changes and in particular looking at the high end of B determinants to assess those that may need an A response;
- There were no new issues to report with regards to medicines management. The Trust would continue to pursue a vehicle-based solution to medicines management, but this would take some time to implement. Unannounced station

visits were underway to check controlled drug management;

- With regards to Infection Prevention and Control, there were instances of norovirus in the community which had led to some hospital wards being shut. Seasonal flu and the H1N1 virus were also present;
- All staff had been offered a vaccination against seasonal flu.

Joseph Healy asked what procedure was followed when someone within a kettle contacted the LAS [kettling is the term used to corral students undertaking protests whereby the Police keep small groups confined, releasing them at intervals]. Fionna Moore responded that the LAS had been in discussion with the Metropolitan Police regarding the potential risks of following this tactic. The police had their own medics within the containing group who could provide First Aid. The LAS had a dedicated resource in the Control Room for this type of incident and two specially trained public order teams with 6 to 8 staff in each.

161/10.   Balanced Scorecard

Christine McMahon joined the meeting to give a presentation on the balanced scorecard. Christine reported that data was now being collected in a more timely manner, but that the balanced scorecard was 95 % complete and still work in progress. The SMG had agreed the format of the balanced scorecard and any further changes would be approved by SMG only. The SMG was now using this as a performance guide. It was agreed that the Trust Board would have a workshop on the balanced scorecard in January or February.   **CMc**

Christine McMahon explained that in the future the Trust Board would be provided with a hard copy of the balanced scorecard in the papers for each Trust Board meeting. The Trust Board would be able to access the balanced scorecard online prior to the meeting in order to drill further down into the detail than the paper copy alone would allow. It was suggested that the Trust Board discuss the balanced scorecard in more detail at Strategy Review and Planning meetings. Christine added that the Associate Directors Group would be reviewing those areas which were rated as red and the actions to address these issues.

Roy Griffins asked about the relationship between the corporate balanced scorecard and the Quality Risk Profile. Christine McMahon responded that an additional module would be created on Performance Accelerator which would measure the Trust against external regulations.

Beryl Magrath commented that it would be useful to look at high level indicators in order to benchmark against other ambulance trusts nationally or ambulance trusts in other world cities.

162/10.   2011/12 Planning Process

Quality, Innovation, Prevention and Productivity (QIPP)

Lizzy Bovill explained that the Quality, Innovation, Prevention and Productivity (QIPP) plan was a Department of Health initiative for NHS trusts to deliver cost savings without compromising clinical quality. Each NHS trust would be required to submit a QIPP plan which would be amalgamated into a whole sector plan.

Lizzy explained that the QIPP plan had been based on the Integrated Business Plan and the delivery of corporate objective 2. The QIPP plan was also aligned with the current Cost Improvement Plan. Lizzy added that the QIPP plan had been reviewed in detail by Fionna Moore and Steve Lennox.

The Trust Board approved the QIPP plan subject to any comments received from the Trust

Board in the next two weeks.

Cost Improvement Programme 2011/12 – 2012/13

Mike Dinan reported that the Cost Improvement Programme (CIP) 2011/12 – 2112/13 had been revised to £55,702 million from a previous plan of £58.7 million, following feedback from HDD1. The pay/non-pay split had been revised with 80% coming from increase productivity in pay areas. The Long Term Financial Model was being revised to reflect month 8.

The Trust Board had been provided with an example of the project documentation which would be completed for each initiative. By the time of the next Trust Board meeting all documentation would be complete.

Sandra Adams reported that the second phase of Historical Due Diligence 2 would commence in early January 2011. Mike Dinan added that the documentation required by the auditors would be ready by the end of the week and would demonstrate the progress made in the development of the CIP. A meeting with the SHA and Grant Thornton on 20th December was key to the process.

Beryl Magrath commented that it would be useful to include a box on the initiative analysis on clinical impact.   **MD**

Mike Dinan had also provided the Trust Board with an overview of the governance structure for the CIP. The Chair asked the Trust Board members to read through this document and give any feedback to Sandra Adams by the end of the week.   **All**

Richard Webber commented that the Trust Board needed to consider the challenges to delivering the CIP and the interdependencies in the system. The Trust Board should also compare its CIP with that of other ambulance trusts.

Steve Lennox commented that the CIP, corporate balanced scorecard and clinical and quality indicators should be considered. He and Fionna Moore would identify which clinical indicators were relevant. This point should be included in the governance process.

163/10.   Business Case for Single Tender Authority for Mobile Data Terminals

Peter Suter reported that the Mobile Data Terminals (MDTs) were now five years old and required replacing. A plan was in place to replace the existing fleet which would require the supply of new MDTs, screens and SatNav units.

The Chair noted that the total project cost was £1.34 million and asked whether this had been included in the budget and whether it was necessary to proceed with this purchase at this time. Mike Dinan responded that this had been budgeted and had been included within the capital plan and revenue plan.

In response to questions from the Trust Board, Peter Suter stated that the production time for MDTs was eight weeks and the units would be introduced over a period of six months. This technology was not currently used by other ambulance trusts, but was used by the police.

Nigel Walmsley asked whether there were any lessons learnt to ensure that the Trust did not get tied into a single supplier in the future. Peter Suter responded that it had been a useful lesson to learn.

The Trust Board approved the single tender action for the purchase of mobile data terminals.

164/10. **Integrated Business Plan and Long Term Financial Model**

Integrated Business Plan

Sandra Adams reported that the Integrated Business Plan (IBP) had been updated in response to comments received from NHS London.

Beryl Magrath asked whether, in light of the recent increase in demand, the forecast increase in incidents was realistic. Peter Bradley responded that views varied between too conservative or ambitious. The plan was transformational and relied on whole systems sequencing.

Neil Kennett-Brown, the lead commissioner, was of the opinion that the call figure of 2.8% growth was too ambitious and that the Trust needed to reconsider how the number of calls received was converted to incidents and conveyances (the incident response). Peter Bradley commented that the number of second calls had dropped as response times had improved, but that the initial call volume was still high and increasing.

Sandra Adams drew attention to paragraph 9.2.7 of the IBP regarding strategic decision-making within the Trust. Sandra stated that the Council of Governors and the Trust Board performed different roles and therefore it was not appropriate that the Council of Governors meeting would become the public Board meeting.

The Trust Board was in agreement that it was important to be as transparent as possible, but retain the right to hold part II meetings when necessary. Peter Suter commented that there was a difference between a public meeting, where members of the public could ask questions and a meeting held in public, where members of the public could attend and listen to the debate. This distinction needed to be made.

Long Term Financial Model

An update on the Long Term Financial Model would be provided at the next meeting of the Trust Board. **MD**

165/10. **Action plan from historical due diligence**

Sandra Adams reported that she would be receiving feedback following the observed meeting of the Trust Board, but initial indications were that there were no causes for concern.

Sandra noted that there were a number of items on the HDD action plan which were complete and a number which would be discussed at today's meeting. Overall, good progress had been made against the action plan.

Peter Bradley added that he, Sandra Adams and Mike Dinan would be meeting with representatives from NHS London and Grant Thornton to receive feedback. If their opinion was that the LAS had not made progress with the issues identified, the timetable would be delayed. Sandra Adams commented that NHS London had been supportive, but the LAS needed to give assurance that they had made progress on three key issues.

The Chair commented that the next critical milestone was the ability to commence HDD 2 at the beginning of January 2011. The sentiment from the Trust Board was to adhere to

the original timescale to achieve Foundation Trust status in September 2011.

166/10. <u>**CommandPoint Update**</u>

Peter Suter updated the Trust Board on personnel issues within the CommandPoint project team. As such, Jonathan Nevison would take on the role of project manager and this position would be reviewed at the end of January 2011. Peter Suter noted the following:

- Two half day briefing sessions for LAS Senior Managers and Board Members had taken place in November;
- The overall budget was on track;
- The high-level plan would be reviewed regarding those actions assigned to the Deputy CEO,
- The Trust Board would be asked for final approval to go live at its meeting on 24th May 2010.

Peter Suter reported that it was unrealistic to expect the system to go live without any defects, but a process was in place to agree those faults with which the system would go live.

Jessica Cecil asked whether there was any significant risk attached to the change of project manager at this stage in the project. Peter Suter responded that there had been a consistent project consultant throughout the project, together with a senior technical lead and the Information Management and Technology team. It was hoped therefore that this risk could be managed.

167/10. <u>**Clinical Response Model**</u>

Caron Hitchen reported that it was a recommendation from HDD stage 1 to assure the Trust Board on the evaluation process and the anticipated benefits for the Clinical Response Model. Caron reported the following:

- Full evaluation of the model would commence in January 2011;
- The evaluation would review whether the CRM had achieved its original objectives and how the CRM could become more effective and efficient;
- Recommendations arising from the evaluation would inform the final design of the model and the phasing of roll-out.

Roy Griffins noted that the governance of the evaluation plan stopped at the project board level. As the CRM was fundamental to the achievement of the Business Plan, the Trust Board and the Quality Committee needed to be assured that the CRM delivered what was set out in the business plan.

Beryl Magrath responded that an update on the CRM was a regular item at the Quality Committee, however it would be useful to see a current risk assessment. Caron Hitchen responded that a risk assessment had been undertaken as part of the project management and this would be reported to the Trust Board.

Richard Webber commented that the final evaluation report should be presented to the Trust Board. **CH**

168/10. <u>**Governance Structure**</u>

Sandra Adams reported that Grant Thornton had recommended that the Trust Board undertake a six month review of the governance structure. In addition to this, a recommendation was made that the Trust established a Finance and Investment Committee. This had been added to the structure chart.

Steve Lennox noted that a new committee for vulnerable and disadvantaged groups had been established, into which the safeguarding and mental health groups reported. Sandra agreed to update the chart to reflect this.

SA

Subject to this comment, the Trust Board approved the governance arrangements and revised committee structure.

169/10. Board Development Programme

Caron Hitchen reported that recommendations had been made following the first stage of the HDD process to inform the Trust Board development requirements. As such, the Board development plan had been updated to include the following:

- How to best meet development needs in relation to the Foundation Trust process;
- Preparation for the SHA board to board meeting;
- Mock Monitor board to board meeting in May 2011.

The plan would also be updated to include the workshop on the balanced scorecard, as discussed earlier. This plan would need to be developed into a board development programme to submit to NHS London.

The Chair commented that the plan should also include the attendance of Trust Board members at board meetings of other NHS trusts.

CH

Peter Bradley asked Trust Board members to send any additions to Caron Hitchen.

All

170/10. Board Process Review

Sandra Adams reported that, following the first stage of HDD, recommendations were made that the Trust Board review the information provided to the Trust Board in order to assess the level of compliance with good practice governance guidance.

The Chair commented that this was an ongoing area of focus for the Trust Board and that, although progress had been made, more needed to be done to ensure the right level of information and consistency. The Chair added that it would be useful to see how other Trust Boards operated in this respect.

It was agreed that the Chair and Sandra Adams would discuss this further outside of the meeting.

SA/RH

171/10. Forward Planner

The Trust Board noted the forward planner.

172/10. Questions from members of the public

There were no questions from members of the public.

173/10 **Any other business**

Jessica Cecil asked when the Trust Board would be receiving the next version of the Integrated Business Plan. Sandra Adams responded that the IBP would be updated and circulated in early January. The final version of the IBP would be submitted to the Secretary of State by 1st March 2011.   **SA**

It was noted that Jessica Cecil's appointment as non-executive director took effect from 1st December 2010.

174/10. **Date of next meeting**

Thursday 3rd February 2010

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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 14th December 2010

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
20/09/09	102/10	**Proposed governance arrangements and draft constitution for the LAS NHS Foundation Trust** Further discussion to be held at the Service Development Committee in October with an update to the November Board meeting.	SA	**Open**
31/08/10	97/10	**Matters Arising** The Chair asked that the Trust Board be provided with an age profile of the fleet.	MD	**Mike Dinan agreed to circulate the age profile of the fleet to the Trust Board prior to the next Trust Board meeting**
30/11/10	135/10	**Matters Arising** Angie Patton and Fionna Moore to follow up on the action to ensure that the joint LAS/Metropolitan Police DVD which gave guidance on protecting the safety and well being of persons taken into police custody was copied and distributed.	AP/FM	**Complete**
30/11/10	138/10	**Update from Chief Executive Officer** Caron Hitchen agreed to find out more information on the causes of sickness amongst Patient Transport Staff.	CH	**Caron Hitchen reported that there was currently no update on causes of sickness amongst Patient Transport Services staff. Nigel Walmsley requested more contextual information to support the figures.**

30/11/10	145/10	**Membership Strategy**		
		Sandra Adams and Steve Lennox to discuss the ethnicity section of the membership strategy.	**SA/SL**	**Complete**
		Sandra Adams to review the age brackets in the membership strategy.	**SA**	**Complete**
		Sandra Adams to amend working on page 3 to reflect comments from the Chair.	**SA**	**Complete**
14/12/10	156/10	**Minutes of the meeting held on 30th November 2010**		
		The minutes were agreed subject to a few amendments	**FG**	**Complete**
		The Trust Board agreed that it would be useful to hold a workshop on the balanced scorecard at a future meeting or Strategy Review and Planning meeting. Caron Hitchen agreed to add this to the Board Development Plan	**CH**	
14/12/10	157/10	**Matters Arising**		
		Additional actions were agreed from the meeting on 30th November, to be added to the minutes and the action schedule:		
		• Appropriate staff to meet to discuss the development of a strategy for medicines management; • Performance statistics to be benchmarked and contextualised.	**FM** **RW**	**Complete**
		The Chair requested that the remaining actions on the action schedule be completed by the next Trust Board meeting.	**ALL**	
14/12/10	159/10	**Update from the Executive Directors**		
		The Chair requested that if, in the future, the finalised report was not available, the Trust Board be provided with headline figures.	**MD**	**Complete**
14/12/10	161/10	**Balanced Scorecard**		
		It was agreed that the Trust Board would have a workshop on the balanced scorecard in January or February.	**CMc**	**Dates to be confirmed**

14/12/10	162/10	**Cost Improvement Programme 2011/12 – 2012/13** Beryl Magrath commented that it would be useful to include a box on the initiative analysis on clinical impact. The Chair asked the Trust Board members to read through this document and give any feedback to Sandra Adams by the end of the week.	**MD** **ALL**	**Complete**
14/12/10	164/10	**Long Term Financial Model** An update on the Long Term Financial Model would be provided at the next meeting of the Trust Board.	**MD**	**Trust Board meeting 03/02/11**
14/12/10	167/10	**Clinical Response Model** Richard Webber commented that the final evaluation report should be presented to the Trust Board.	**CH**	**Complete – Forward Planner 11/12**
14/12/10	168/10	**Governance Structure** Steve Lennox noted that a new committee for vulnerable and disadvantaged groups had been established, into which the safeguarding and mental health groups reported. Sandra agreed to update the chart to reflect this.	**SA**	**Complete**
14/12/10	169/10	**Board Development Programme** The Chair commented that the plan should also include the attendance of Trust Board members at board meetings of other NHS trusts. Peter Bradley asked Trust Board members to send any additions to Caron Hitchen.	**CH** **ALL**	**Complete** **Complete**
14/12/10	170/10	**Board Process Review** It was agreed that the Chair and Sandra Adams would discuss the Board process review further outside of the meeting.	**SA/RH**	**Complete**

14/12/10	173/10	**Any Other Business** Sandra Adams responded that the IBP would be updated and circulated in early January.	**SA**	**Complete**

LONDON AMBULANCE SERVICE TRUST BOARD

3rd FEBRUARY 2011

PAPER FOR NOTING

Document Title:	**Report from Sub-Committees: Quality Committee on 14th December 2010**
Report Author(s):	**Beryl Magrath, Non-Executive Director**
Lead Director:	
Contact Details:	
Why is this coming to the Trust Board?	**To provide the Trust Board with an update on the key topics of discussion at the recent Quality Committee meeting**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☒ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	To note the report

Executive Summary

- RCAG Noted that an SPPP for call recording in EBS has been approved. To date there has been no call recording by EBS; this is now important with the increasing and diverse work undertaken by EBS. The amendments to the Risk Register were noted, also the hope that local risk registers would be in place by March 2011. It was noted that the Director of IM&T had reported that 75% staff would be trained in version 8 of the IG toolkit by March 2011.

- Mid Staffs Update the Director of Health Promotion & Quality presented a paper demonstrating how the LAS developing quality portfolio will strengthen the Trust's position, using the themes of the lessons learned from the recommendations arising from the Mid Staffs report

- Audit Update The QC received an update of audits undertaken by the Internal Auditors with the contemporary RAG ratings & was pleased to note that the action plans were up to date. The CEO pointed out that the issues highlighted regarding HART were not major and were being addressed. A focus presentation on HART & CBRN is scheduled for the February QC meeting. It was agreed that CARU would be asked to present clinical audit findings at a future meeting

- Quality Risk Profile The Director of Corporate Services presented the Quality Risk Profile, which is sent to Trusts on a monthly basis, to enable staff to review trends in performance. The 5 key sources of information are 1) The NHSLA risk management standards and the CQC staff survey key findings 2) Staff satisfaction with the quality of work & the care they are able to deliver 3) Job satisfaction 4) Staff recommending the Trust as a place to work & receive treatment 5) % staff experiencing discrimination at work in the last 12 months. A risk estimate is given for the 5 essential standards. It was noted that LAS scored green for 2) only; amber for 1), 3) & 4) and red for 5). The red section was entirely devoted to IG which is under review by the Information Governance Group. The QC noted that much of the information was out of date

(although the data emanates from the LAS) as it takes time to pass through the systems of the various regulatory bodies. Some data seemed to be contradictory (item nos. 8042 & 8041). Some was irrelevant. It is to be hoped that this will improve in future reports.

- Focus Section. The Director of IM&T together with Assistant Director of Operations (EOC) John Hopson went over the safeguards put in place to minimise the disruption to the quality of patient care during the transfer from CTAK to Commandpoint. There has been considerable preparation beforehand, learning from previous experience and that of other emergency services. These include only cutting over to the CAD system (no other software changes); extensive training in call and dispatch followed by an exam, with mandatory, trainer monitored "sandpit" training for al staff to ensure retention of skills & dry runs. On the night cut over would be CTAK>paper>swing interfaces to Commandpoint>live to Commandpoint, if Commandpoint fails this would be reversed. EOC would be staffed to ORHD standards with extra managers. For the subsequent 10/52 there would be a minimum of 8 floorwalkers/watch (1 training officer, 1 level 1 work based trainer, 1 level 2 work based trainer [sandpit] and 5 level 3 work based trainers) and the Project Team would be on site and sleep locally for 10 days. There would also be 1 super user/watch and Northrop Grummond 24/7 Helpline desk. There would be no overt press publicity, but question would be answered if requests were made. The Quality Committee can assure the Trust Board that every conceivable effort has been made to ensure the minimum of disruption to the quality of patient care during the transfer from CTAK to Command point.
- Forward Planner It was agreed that monthly meetings would be timetabled, but cancelled if there were insufficient items for the agenda

Key issues for the Trust Board

Attachments
None

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

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

Risk Implications
This paper links to the following strategic risks:

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

NHS Constitution
This paper supports the following principles that guide the NHS:

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

☐	7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

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

Key issues from the assessment:

LONDON AMBULANCE SERVICE TRUST BOARD

3ᴿᴰ FEBRUARY 2011

PAPER FOR NOTING

Document Title:	**Chairman's Report**
Report Author(s):	**Richard Hunt**
Lead Director:	**Richard Hunt**
Contact Details:	
Why is this coming to the Trust Board?	**As a formal record of the Chairman's activities since the last Board meeting**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	To note the report

Executive Summary

Over the period since the last Trust Board the Chairman visited Command Point and went with Peter Bradley to the GLA to visit James Cleverly. He was visited by Mike O'Donovan, the Chairman of Central London Community Healthcare who reports to Peter Molyneux, Chairman of the NW Sector PCT who was taken round EOC and UOC. He had a meeting with Peter Suter at Northrop Grumman and Nick Fairholme (with David Sutton), who is the acting Managing Director of Surface Transport for TfL. He attended the board meeting in Tunbridge Wells of South East Coast Ambulance Service. The Chairman also has routine weekly meetings with the Chief Executive with a focus on performance, Cat B penalty payment and Foundation Trust application. He also has routine meetings with the Director of Operations.

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

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Equality Impact Assessment

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

Key issues from the assessment:

LONDON AMBULANCE SERVICE TRUST BOARD

3RD FEBRUARY 2011

PAPER FOR NOTING

Document Title:	**Chief Executive's Report**
Report Author(s):	**SMG for Peter Bradley**
Lead Director:	**Peter Bradley, Chief Executive Officer**
Contact Details:	
Why is this coming to the Trust Board?	**For information and noting**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	To note the report

Executive Summary

- Detailed negotiations relating to the settlement of the financial penalties and outstanding performance payments continue with the North West London Commissioners;

- The development of 111 initiatives across London and discussions with NHS Direct and NHS London continue;

- As agreed at the December Trust Board new risks added to the corporate risk register will be reported each month followed by a quarterly review of the register and the board assurance framework. The Risk Compliance and Assurance Group agreed the addition of several new risks which are outlined in the report;

- The balanced scorecard is attached and demonstrates progress against the Corporate Objectives;

- December has been the most challenging month so far for the LAS. The overall workload has been the highest we have ever experienced alongside a spike in flu, snow and ice, demonstrations and prolonged cold weather. Whilst the Category A performance target was not achieved, it is important to note that the time it took us to reach 75% of our Cat A patients was still under 10 minutes, which despite the issues highlighted above is still a significant achievement;

- The new format workforce report is attached. It shows sickness levels by directorate, split into short and long term (long term = > 4 weeks); unauthorised absences; staff turnover for the Trust and vacancies against funded establishment by directorate*; employees relations

activity; and PDR completion rates.

Key issues for the Trust Board

- Performance remains challenging and all efforts are focused on building on the improvements of the last few weeks
- Negotiations continue regarding contractual penalties and CQUIN payments for 2010/11
- We are working with other health partners across London to mitigate winter/seasonal pressures and maintain patient safety

Attachments

- Performance data pack
- Balanced Score Card
- Workforce Report December 2010

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

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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 3 FEBRUARY 2011
CHIEF EXECUTIVE'S REPORT

1. **COMMISSIONING AND BUSINESS DEVELOPMENT**

Detailed negotiations relating to the settlement of the financial penalties and outstanding performance payments continues with the North West London Commissioners .These are conversations take place in the context of the requirement to reach a settlement that will secure our year end position and support both our Category A recovery and our Foundation Trust application. Further meetings are underway to negotiate the LAS contract for 2011/12 including the adoption of the new national targets and CQUINS which will focus on increasing the use of appropriate care pathways, in line with our business plan, reducing conveyance to A&E and increasing partnership working and case management of patients with other agencies such as GPs.

The development of 111 initiatives across London and discussions with NHS Direct and NHS London continue. A visit is planned to Nottingham in early February to see and learn from the new 111 pilot that has been created between NHS D, GPOOH and East Midlands ambulance.

There will be a brief presentation during the board meeting on 3rd February to provide board members with an up to date position on the commissioning negotiations and to outline the business planning and budget process that will be undertaken over the coming weeks.

2. **SERVICE IMPROVEMENT PROGRAMME**

The service improvement programme (SIP2012) is progressing according to plan with all but 3 out of the 67 initiatives on track. The three which are identified as being of 'red' status (i.e. not on track and cause for concern) are:

- Clinical Development, Leadership and Workforce Programme - learning management system;
- Performance and Service Delivery Programme - e-PRF, Roster Review.

These projects are the subject of SMG and programme level attention to bring them back on track. SMG have decided that the above two programmes which along with the Olympics constitute the current service improvement programme should close at the end of March 2011 and be replaced with three new programmes aligned to the Patient, Employee and Value for Money Strategic Goals of the Trust. These together with the Olympics programme will constitute a new Integrated Business Plan (IBP) Delivery Programme. This will be the vehicle for the service development activity required to achieve the SMART targets identified in the IBP. It is envisaged that closure reports on the two current programmes will be presented to the Board in May 2011.

3. RISKS

As agreed at the December Trust Board new risks added to the corporate risk register will be reported each month followed by a quarterly review of the register and the board assurance framework. The Risk Compliance and Assurance Group agreed the addition of the following risks to the register on 10th January 2011:

ID	Risk Description	Risk Grading	Risk Impact + Risk Likelihood
337	**There is a risk that there will be a delay in the future roll out of the Clinical Response Model due to potential changes needed to be implemented to CommandPoint.**	**High 16**	[Major (4)+Likely (4)]
338	**Staff working on cars (FRUs and CAUs) are at risk of accident due to the need to read and manually action the MDT whilst driving at speed through traffic.**	**High 16**	[Major (4)+Likely (4)]
339	**The potential lack of technician drug packs for use by operational staff causes a risk to providing clinical care for patients. Bags are not always available for use by staff at commencement of shift. This may lead to vehicles being deficient of drugs for all or part of a shift.**	**Significant 12**	[Moderate (3)+Likely (4)]
340	**There is a risk that the Service will suffer a significant detrimental impact to the resource capacity of the Training schedule through travel disruption due to bad weather or industrial action by travel operatives, leading to reduced attendance at training; or cancellation or postponement of the training schedule; resulting in an extension of the training period and a delay in the date of Go Live, causing a cost and time overrun.**	**Significant 12**	[Major (4)+Possible (3)]
341	**There is a risk that the Trust will be unable to receive sufficient 'engineering information' from all MDT devices across all LAS vehicles completing the roll out of MDT/2 to all necessary vehicles before CommandPoint Go Live. This will cause unacceptable compromises to the capability to identify, diagnose and/or rectify any related faults that may occur (or produce essential near real time management information) requiring CommandPoint Go Live to be delayed thus causing the project a time and cost overrun.**	**High 16**	[Major (4)+Likely (4)]

4. BALANCED SCORECARD

Attached is a report presenting progress to date in respect of the Corporate Objectives. The Balanced Scorecard is 96% complete with work outstanding in respect of: CO2 "percentage of total incidents resolved through CTA, NHSD" is reported on monthly basis. There is currently a misalignment between the target set and what is being reported on as the latter does not include non-conveyed. A meeting had been arranged recently to resolve the issue but had to be rescheduled to late January and so the 'live' presentation should reflect the outcome of that discussion.

C05 "Percentage of NWOW staff attending WOW training days" following the recruitment of NWOW clinical tutors work is being undertaken to validate the training needs analysis before finalising the training programme. Once the training plan is finalised there will be monthly updates provided as to the progress of the implementation which will probably cross over into 2011/12.

On a positive note, the clinical indicators demonstrate that where the Trust is able to gather information with regard to outcomes, there is good work being undertaken by front line colleagues.   SMG recently discussed the poor response to the infection control audits and undertook to ensure that the appropriate steps were taken to ensure that there is an improvement for Quarter 4.

Unfortunately colleagues have not been able to include commentary in every instance where actual has been less than target. Discussions are ongoing with colleagues to ensure that this is done in a timely fashion.   Nevertheless the predominance of reds for Operational Performance Indicators on the Balanced Scorecard vividly highlights the pressure the Trust faced in December which was reflected in the fact that REAP level 4 was declared.

Training sessions will be offered to members of the Trust Board to coincide with the Trust Board's meeting on 3rd February and any board committees scheduled to take place in February.

5. SERVICE DELIVERY

Accident & Emergency service performance and activity (see attached information pack)

The table below sets out the A&E performance against the key standards for this financial year (2010/11), the complete validated performance for both November and December and the un-validated performance for the first 24 days of January.

	CAT A8	CAT A19	CAT B19	CAT C60
Standard	**75%**	**95%**	**95%**	**90%**
2010/11 yr to date	73.7%	98.9%	88.7%	89.6%
November	74.5%	98.9%	88.3%	88.6%
December	62.3%	96.9%	70.5%	76.6%
January (to 24th)	76.2%	98.5%	83.7%	87.7%

   *** Estimated prior to data validation**

December has been the most challenging month so far for the LAS. The overall workload has been the highest we have ever experienced alongside a spike in flu, snow and ice, demonstrations and prolonged cold weather. The LAS has been very closely involved with supporting the rest of the health economy by co-ordinating hospital capacity issues via the new Capacity Management System (CMS), participating in numerous teleconferences daily and providing regular reports and updates 7 days a week. We have also placed Operational Managers in A&E Departments across London to provide support for extended hours every day and have arranged for the redirecting of patients from one Trust to another on several occasions to try to even out demand and reduce pressure in the system.

Whilst the Category A performance target was not achieved, it is important to note that the time it took us to reach 75% of our Cat A patients was still under 10 minutes, which despite the issues highlighted above is still a significant achievement.

A review of the last calendar year shows that out of 1,050,666 incidents responded to, the Trust reached nearly 68,500 more patients (+6.5%) in the target time than the previous year- that's 187 more patients every day reached within national performance standard times.

Demand in December saw some significant spikes with LAS having 4 days with demand in excess of previous New Years Eve nights. On the Friday before Christmas we took 6,681 calls with an hourly peak of 400 calls and on New Years Eve we took 7,455 calls with one hour see us receive 700, 999 calls. This is significantly higher than anticipated with a normal day seeing us take 150 calls an hour and 3,500 a day with real spikes concentrated over a few hours. This increased activity caused a fall in Emergency call answering within 5 seconds to 89.3%% for December, down from November when the Trust achieved 96.1%. I am pleased to be able to report that this has improved significantly in January and we are over 97% for January.

The average number of incidents LAS responded to each day in December was 3,065 (an overall increase over last December of 4.4%). However this is considerably below the true demand and the acuity of the increasing demand is reflected in the growth of Category A by 13.7% and Category B by 13.6% in comparison to December 2009. Category A activity averaged 1,143 with some days exceeding 1300. During the periods of overwhelming demand in December the Trust utilised the Demand Management Plan (DMP) to protect patient care. With the implementation of DMP we recommended alternative care pathways to a number of patients that under normal operating arrangements would have had an Ambulance dispatched. As a direct consequence we did not send an Ambulance to an additional 3,000 incidents during December.

Ambulance Utilisation for December has seen an increase to 80.7 % in comparison to November's 75.9%. FRU utilisation has seen the same pattern emerge for the month of December finishing at 51.7% compared to Novembers 45%. The driver behind the increase in both FRU & Ambulance utilisation is very high demand- the highest the trust has ever received- coupled with elongated hospital handover time and is significantly above the ideal of 55% for Ambulances and 40% for Cars.

A total of 264,811 Ambulance Hours resourcing were produced for November and December this year, which was a reduction of 0.6% against the same period last year. FRU hours produced for November and December increased by 8% compared to the same period last year; with November seeing an increase of 13% and December an increase of 3.5%. It is worth noting that the actual overtime spend for November and December 2010 was a 42% decrease when compared to the same period last year. This is as a direct result of the increase in staffing and means that we are much less reliant on

overtime uptake and that the cover is being provided more in line with the demand profile. In addition to the front-line cover provided, there have been 114 planned training courses during these two months covering core skills refreshers, 2 A&E Support courses, 58 Paramedic development courses and further Practice Placement educator modules.

A number of new rosters were implemented in the first 10 days of January which means that there are now over 80% of stations working new, demand compliant rotas. Progress continues against the implementation plan for the remaining new rosters and we now anticipate closure of this project by the end of February.

The first phase of the Clinical Response Model (CRM) began on 20th October. The concept is aimed at only dispatching a Car to calls with an Ambulance only dispatched immediately on Category A calls. For all other calls an on-scene patient assessment should take place first, with an Ambulance only sent when requested by the car on scene who has confirmed that a patient does require transportation. The first main station to go live was Barnehurst and it was followed by Greenwich at the end of November. Bromley was scheduled to go live in early January, following which an evaluation was to be completed. In order to support this model the automated dispatch was disabled and there was a relatively significant drop in performance. We have now reinstated the electronic dispatch and are tasking the cars mostly to Category A calls in order to support the Trust Category A performance recovery. However it is intended that, where possible, the benefits of the project which are around reducing unnecessary hospital conveyances, accessing more care in the community and reducing double sends should still be achievable.

Following requests from Acute Trusts to be notified when LAS ambulances are en route to them; the LAS has developed The Hospital Based Alert and Handover System. This is an in house development that takes information from the LAS CTAK system and provides real time information to Acute Trusts showing ambulances en route to them along with a provisional estimate of arrival time. This allows the EDs to prepare for the arrival of ambulances and potentially improve the patient experience. A further advantage of the system is that data capturing the actual patient handover time can also be gathered in real time. Currently we rely on retrospective scanning of PRFs, which leads to a 10-12 day delay in reporting this important information.

An initial 'proof of concept' trial was started in June 2010. Following evaluation of this improvements were made to the system and plans made to roll out pan London. Prior to this roll out infrastructure changes were required to increase server capacity. This was achieved late last year with roll out planned to be completed by January, 2011. The system is now operational at the majority of London hospitals, with 6 sites left to introduce the system. Of these sites, 3 have a planned start date of 2nd Feb and the remaining 3 should go live during February.

Efforts were maintained during December and January to reduce the number of patients conveyed inappropriately to an A&E. In December LAS secured additional determinants that could be suitably managed by NHS Direct and over 1,000 additional calls were passed during this time. In addition we have doubled the number of patients conveyed to a walk in centre, minor injuries unit or urgent care centre since Feb 2010. Training has now been delivered to team leaders across London's West and East Sectors and South is planned to be undertaken shortly. This training will then be cascaded to frontline staff to aid them in identifying suitable patients for management using an appropriate care pathway.

The average total hospital turnaround time spiked at its highest year to date position at 34.5 minutes during the week ending the 9th January. The arrival to handover figures averaged at 17.5mins in December, 5 mins longer than the April 2010 position. Over

December and early January we saw multiple vehicles queuing outside A&Es for extensive periods as crews were delayed handing over as a result of hospital capacity issues. Managers were deployed to all A&Es across London and senior management resources were utilised to secure resolution to the delays as quickly as possible. In December 479 patient handovers were declared as Serious Incidents to acutes across the capital as the patient had waited in excess of an hour to be handed over to the department. As we move through January most of the significant hospital problems have improved from the situation in December, but are still trending at over 100 a week. We continue to work with the NHS London sector Chief Executives to resolve this issue. In comparison the handover to green time continues to reduce and is currently at 16.8mins with a number of complexes successfully reaching the 15mins target.

The current version of the Demand Management Plan (DMP) was approved for use by SMG in September 2010. It built on the previous over capacity plan that did not provide clear procedures for the management of emergency calls when demand outstrips capacity. The previous plan also did not set out a framework for authorisation nor did it set out review requirements. Since its approval the plan has been used extensively during December and early January as detailed earlier. In early January a cross directorate review took place. This review sought feedback to identify lessons from the use of the plan at all stages up to and including stage "F" during the six weeks of almost daily use in the weeks preceding the review. The review considered each level of the DMP together with the authority levels for activation and the review periods. The review group concluded that the plan has delivered what we had intended it to in a safe way commensurate with the prevailing circumstances at the time of activation. However, with the benefit of use and review we were able to enhance the options available thus making the plan more flexible and adaptable for the presenting circumstances.

A revised version of the plan has now been agreed with the SMG that includes the items identified during the review. Trust Board are now asked to note the revised DMP, noting the following key changes from the previous version:

- Review periods for stage C have been increased from a maximum of 2 hours to a maximum of 4 hours
- Stage C now encompasses all green (Category C) calls although it maintains the clinical exceptions for those aged under 5 or over 69 (and others deemed appropriate in the circumstances by the Medical Director or nominated deputy)
- CTA (clinical telephone advice) remains an option for call handling from stage C however the revised plan now formally introduces the requirement for a clinical sector (CD) to be established from stage D staffed by suitably trained Paramedics or medical directorate staff to review calls that do not receive an immediate dispatch
- A new stage has been introduced at F/G to enable the splitting of amber (Category B) calls and to ensure that in only the most severe of circumstances service is withheld from red (Category A) calls

From stage E the plan recognises the significant nature of the circumstances that the Trust will be facing when it is necessary to enact this stage (or above) of DMP. It is therefore required that at the time of activation or prior to this the Trust raises its REAP level and declares an internal major incident to maximise operational resourcing to respond to the prevailing circumstances. It is recognised that this plan will require further review after April 2011 when national changes to the classification of Category B calls come into effect.

All 65 of the new Mercedes ambulances ordered through McNeillies have now been delivered and are in service. This has allowed us to remove the remaining LDV ambulance from service by Christmas Eve as planned. The provision of winter tyres for AEUs and FRUs had been completed ahead of plan and, crucially before the cold spell. Positive feedback has been received from crews about the improved traction during the snow and ice.

Stocks of new linen blankets have been added to the system, 5,000 since November with a further 4,000 by the end of January. As well as the stocks of our traditional branded blankets, 6,000 alternative blankets have been delivered to stations since the beginning of November, with 9,000 more to be issued over the next four weeks. In total there were 24,000 additional blankets in the system. In December we changed our laundry provider to Sunlight who cover the majority of acute London hospitals. We are now receiving an enhanced service with collections being made 7 days a week from our store at Deptford and they will be collecting our dirty blankets direct from hospitals as part of their regular collections, increasing the overall number of hospital collections each week. It is anticipated that these actions will resolve most of the blanket issues frequently raised.

A project is ongoing, due for completion during February, to realign the deployment of the AEU fleet with the new rotas introduced earlier this year and to stabilise the fleet. This will result in a portion of the fleet assigned to stations and the rest being moved between stations to match shift patterns and support overtime and events requirements. This will give a sense of ownership back to stations for the vehicles and the equipment on them.

During February we will be rolling out a new diagnostic pack, which will contain Blood Glucose Monitoring kits, Tympanic thermometers and BP monitors. These will be managed by local management on station in the same way as drug packs. We expect to see a much greater ownership and accountability for the packs and a significant reduction in the losses of these key items of equipment.

The Make Ready trials at the Royal London, Newham General and Homerton hospitals have commenced. Vehicles are cleaned and re-equipped with medical consumables during patient handover. Early feedback has been positive. There have been an encouraging number of responses to the Make Ready contract tender in all 3 areas (vehicle cleaning/equipping, vehicle movements, premises cleaning). Assessments will commence in January.   .

With new and emerging threats to London and the UK, the EPU has been heavily involved in the planning, preparation, development and training of operational staff to ensure the LAS is prepared to respond to those new challenges. Aspects of this work have been developed on a national level, with the Emergency Preparedness Unit (EPU) actively involved.

During November the EPU completed the operational manager's updates for emergency planning and counter terrorism incidents, with over 120 managers attending. The Control Service training for staff operating in the Incident Control Room has taken place, and to date over 40 staff have been trained to be able to operate the room when it is opened to manage an incident. The first round of MERIT training took place in November, which is for medical teams that would assist the LAS on the scene of any future large incidents and there are further courses scheduled for February.

During the next three months and beyond it will be an exceptionally busy time for the emergency planning team, with planning for the Virgin London Marathon in mid March and the Royal Wedding of Prince William and Kate Middleton in April. A series of further student demonstrations will take place during January and March, which could see around 300,000 people taking to the streets in protest at the Austerity measures and student fees

increase. The EPU will continue to develop the trusts response for new and emerging threats and the challenges that we may face.

The EPU continues to work though the actions of the National Emergency Preparedness audit with the actions due to be completed by the end of March 2011. The EPU has reviewed the trusts Major Incident and special contingencies Plans and the revised version awaits the outcome of the inquest into the July 7th Bombings as it is likely that further recommendations will me made.

In order to support the LAS delivering Category A performance for the year, a Performance Recovery Plan focussing on 10 key items was launched in late December. Progress against the key items is monitored weekly with some quite encouraging early improvement already noted. The plan has now been shared with our lead commissioners, the SHA and the DH.

6. PATIENT TRANSPORT SERVICE

Commercial

On 5th January 2011, the LAS were asked to present to the following group of Trusts as part of the procurement programme for non-emergency PTS:

- Croydon PCT
- The Royal Brompton NHS Foundation Trust
- St Georges Healthcare NHS Trust
- Epsom & St Helier University Hospitals NHS Trust
- Wandsworth Teaching PCT (currently held by LAS)

As a consequence, we were shortlisted and have made further presentations to the Royal Brompton and St Georges Healthcare, including Wandsworth PCT, on 11th January and 19th January respectively. The Royal Brompton is considering bids from the LAS and one other supplier, whilst St Georges and Wandsworth are considering bids from us and two other suppliers.

We understand that we will be asked to present again to Epsom and St Helier at some later point in January 2011.

There has been some delay with the process for the other Trusts included in phase 3 of the procurement process. We understand that some Trusts are now considering joining the UCLH tender process which is being conducted outside of the LPP programme. Consequently we wait to hear about our tenders for:

- Chelsea & Westminster Hospital NHS Foundation Trust
- Guy's and St Thomas' NHS Foundation Trust (High Dependency Transfers only)
- Richmond & Twickenham PCT (currently held by the LAS)
- Royal Free Hampstead NHS Trust
- Royal Marsden NHS Foundation Trust
- Whittington Hospital NHS Foundation Trust

Operations

- Rotas

  PTS has been reviewing its rota's and with effect from 1 January 2011, staff working across West London, have moved across onto new rota lines. The purpose of the changes is to ensure better utilisation of vehicles and staff, as well

introduce a consistent, pan-London, working pattern. Benefits should include the elimination of third party usage, reduction in overtime and implementation of PROMIS to bring about better recording.

Work is now commencing to implement these changes for staff working in East of London.

- Vehicles

Following the loss of South London Healthcare contract, associated vehicles have been redistributed amongst the remaining contracts. This has provided the opportunity to decommission our 2002 Movanoes and LDV vehicles. In December 20 vehicles were returned to the leasing company, with a further batch of 16 in January and 15 in February, planned.

Performance

Activity in December fell by 11,000 journeys in December 2010. PTS had forecast to lose approximately 8,000 journeys which was associated with the South London Healthcare contract. However, activity was also affected by the closure of clinics as a result of the snow and the lengthy Christmas period.

The quality standards for December 2010 were:

- Arrival Time: 88%
- Departure Time: 95%
- Time on Vehicle: 94%

7.   **HUMAN RESOURCES**

Workforce Plan implementation

The A&E funded establishment for 2010/11 is 3433. Vacancies as at the 31 December 2010 are reported at 127wte against this establishment.

Forecasted recruitment activity provides for 45 wte A&E Support staff between December and March (including 2 additional training courses introduced in January and February). Taking anticipated leavers into account, the end of year position will be on plan, with circa 120 vacancies.

Recruitment to the Emergency Operations Centre is now complete with sufficient staffing to meet the requirements of CommandPoint implementation. No further recruitment training will be undertaken until after CommandPoint go-live.

Workforce information

The new format workforce report is attached. It shows sickness levels by directorate, split into short and long term (long term = > 4 weeks); unauthorised absences; staff turnover for the Trust and vacancies against funded establishment by directorate*; employees relations activity; and PDR completion rates.

* It should be noted that the vacancy figures by directorate in this report should be viewed with caution as further reconciliation work is required.

Unauthorised absence is regarded as any absence which is reported at short notice for a reason other than sickness and has therefore not been authorised. This absence may

retrospectively be converted into authorised leave (annual or paid/unpaid special leave) or remain unauthorised and unpaid.

Sickness levels for the Trust in November are reported at 5.3%. This is an increase on October which was reported at 5.09%. Increases are seen across most areas of the Trust.

PTS absence however has reduced from a high of 7.93% in September to 6.27% in November and Operational Support has seen a significant reduction in absence levels to 3.66%.

Fluctuations in absence levels in the smaller directorates should be viewed with caution, as only a small change in the number of staff on sickness absence produces a marked difference in the percentage levels reported. Further investigation has shown this to be the case in Operational Support which the Trust Board asked to be investigated.

Year to date absence is currently at 5.13% against a target of 4.5%.

The extraordinary high level of unauthorised absence in December was due to the weather conditions.

Staff turnover remains within expected parameters and in line with workforce planning projections at 7.2% for the year Oct 09 to Nov 10. The increase numbers of leavers in November was due to the transfer of South London PTS contract.

Training and Education

The Trust is on track to meet the 13 key training commitments published in January 2010. In particular, to date, c1,700 front line staff have accessed training in Core Skills Refresher (CSR). This is against a plan of 1,330 for the whole year.

In addition, the Trust continues with its:
- 3 year training programme of over 700 Student Paramedics
- Provision for Emergency Medical Technicians to become Paramedics
- A&E Support training

The Trust has developed and introduced a learning website, through which staff can access all information relating to training together with links into the new e-learning facility. Obstetrics and mental Health packages were identified as priority areas for development and are now available via e-learning.

New Ways of Working

The second wave of the New Ways of Working Workstream continues to progress across five further complexes, including Bromley, Greenwich, Camden, Friern Barnet and Islington Complexes. Progress in the following key areas has been made:

Clinical development
Progress: - All wave 1 and 2 complexes (7 complexes, 14 Clinical Tutors) now have 2 Clinical Tutors based at each Complex.   - All wave 2 complexes have completed or nearing completion of the Training Needs Analysis.   - A period of verification will be undertaken with staff confirming the training information is correct.   - Each wave 2 complex has received delivery of the training equipment purchased.

- Level 3 patient assessment training is being delivered to paramedics at Bromley and Greenwich Complexes to support the Clinical Response Model.

Next steps:
- Verification of Training Needs Analysis results.
- Development of a training delivery plan defining timeframes and allocation of courses.

Leadership development:

Progress:
- Progress has been limited due to the impact of REAP (level 4), winter pressures and Christmas. This has impacted the ability to arrange meetings / time with complex management teams.
- Peer and self assessment not commenced due to emphasis on operational duties.

Next steps:
- Identify alternate ways to meet with complex managers i.e. via a ride-out.
- Management teams across South Complexes will be supporting each other, particularly those involved in the South East. This should allow South East complexes (Barnehurst, Bromley & Greenwich) to focus on project work and allowing time to progress leadership development.

External linkages

Progress:
- Recruitment to the Community Involvement Posts is well underway and due for completion in February 2011.

Next steps:
- Appointment of successful candidates

Estates & IM&T

Progress:
- IM&T requirements have been defined and ordered for all complexes and should be available by February allowing access to e-learning and staff development.
- 2 of 5 wave 2 complexes will require estate modifications and have prepared plans with associated costs.
- Barnehurst complex were due to commence the refurbishment works from January 11. This is now planned from February 2011 due to awaiting the results of the tender process in January and confirmation of start date from the agreed contractor.

Team based working

Progress:
- All wave 2 complexes are developing potential models for team based working on their complex.
- A total of 10 candidates were successful at interview for wave 2 complexes following the recent Team Leader recruitment campaign.

Next steps:
- All complexes to continue to review TBW options with a view to narrowing down and refining chosen options.
- Commence Team Leader course.

Communications and staff engagement

Progress:
- All wave 2 complexes continue to lead on a range of communication activities including updating notice boards, sending letters to staff (staff recognition and updates), newsletters and bulletins, to ensure staff receive regular updates on news and progress with NWOW.
- Most complexes now have several staff forums set up and aligned to the 7 project areas to encourage staff engagement in NWOW.

Workforce transformation – Clinical Response Model (CRM)

To date, a lot of excellent work has been undertaken both in the control room and by complex staff to begin to introduce the clinical response model (CRM) in Barnehurst and more recently Greenwich. The full evaluation of the model was due to commence on 12 January with Bromley complex joining the project. In light of a number of factors, it has been decided however to defer full implementation of CRM in the South East sector and the associated evaluation until April 2011 to allow for appropriate focus on recovery of Category A performance for the year.

The planning and training activity both within operations and the Emergency Operations Centre is continuing however. In addition, operational staff within South East London are actively being encouraged to continue to use the patient referral protocols and fully utilise appropriate care pathways.

This decision should not have a detrimental impact on plans for future rollout following the full evaluation and associated recommendations, as this would not occur in any event until after the implementation of CommandPoint in June 2011.

Partnership working, staff engagement and joint consultative arrangements

Following the Coalition Government's decision to implement a two-year pay freeze across the NHS, in January NHS Employers announced that national discussions were underway to investigate the possibility of introducing an enabling agreement that would allow local partnerships to agree on a freeze in payment of increments for the next two years. In return, local employers would guarantee that there would be no compulsory redundancies for staff in pay bands 1 to 6 and, essentially, give a commitment to do all possible to avoid compulsory redundancies for staff in bands 7 and above. It can be reported however that all key national unions such as RCN and Unison have now rejected the proposals.

Occupational Health

The contract with Atos Healthcare to provide occupational health and counselling services terminated on 30 November 2010 following a decision by the Trust not to take up the option of a two year extension provided for within the contract.

A new model of counselling provision has been introduced, using a network of practitioners experienced in dealing with trauma, managed by the staff support team and supported by a Trust based Senior Counsellor.

Occupational health and physiotherapy services have been put out to tender, and panel evaluations will take place in February ahead of formal selection and appointment of a new provider or providers in March 2011. Meanwhile, Guys and St Thomas' NHS Foundation Trust has been appointed to provide occupational health services on an interim basis, effective from 1 December 2010. Feedback to date about the quality and responsiveness of service provision across the range of services (occupational health, physiotherapy and counselling) has been very positive.

8.   **COMPLAINTS, PALS ENQUIRIES AND SERIOUS INCIDENTS**

The following tables summarise the numbers and categories of complaints and PALs enquiries received in December 2010 and also the number of serious incidents reviewed in the period. These will be reported monthly in future but more detailed analysis will be reviewed by the Quality Committee.

PALS by Subject December 2010	Number
Information/Enquiries	202
Lost Property	66
Communication	13
Delay	11
Other	8
Appreciation	3
Clinical	3
Patient Injury or Damage to Property	3
Non-conveyance	2
Physical Violence	1
Conveyance	1
Non-physical abuse	1
Dignity and Privacy	1
PALS total:	315

Complaints by Subject December 2010	Number
Non-physical abuse	11
Delay	9
Non-conveyance	7
Treatment	3
Patient Injury or Damage to Property	2
Road handling	1
Total complaints received:	33

Serious Incidents considered	3
Serious Incidents declared	0

9.   **COMMUNICATIONS AND ENGAGEMENT**

Public education:

Recent public education activities have included:

- School and college visits, and talks for scout and cub groups
- Health education sessions in Tower Hamlets
- Knife crime events
- Road safety events, including Safe Drive Stay Alive
- Talks for religious communities, e.g. mosques, the London Muslim Centre and a Faith in Health event
- Visits to care homes
- Emergency Services days
- Junior Citizen schemes
- Christmas markets
- Message in a Bottle event

The PPI and Public Education team keep a record of the time staff spend taking part in public education activities, often in their own time. A recognition scheme has been introduced, with certificates being given to staff who spent over 25, 50 and 100 hours involved in public education activities during 2010. 43 certificates were produced for staff, 10 of whom had contributed over 100 hours of their time and were also given a leather A4 sized folder, embossed with a thank you message.

Over 50 members of staff have been invited to take part in the next development programme, which will be held in May.

The Public Education Strategy has almost all been delivered now, and it has been agreed that any outstanding elements – plus future developments – will be included in the new Health Promotion Strategy.

Community Events:

The first of a series of community events in the Trust's Foundation Trust constituencies will be held in Enfield on 19th March.

New Ways of Working:

Recruitment has commenced for five Community Involvement Officer posts who will be based at the NWOW sites of Camden, Islington, Friern Barnet, Bromley and Greenwich.

Museum:

Richard Walker (Public Education & Media Resources Manager) is leading a project to make best use of the historic collection. With the help of the Head of Estates, a site has been identified on which all the vehicles can be kept under cover. The Chairman has offered his support in taking forward plans for the rest of the collection, and a workshop-style meeting is being planned to develop a strategy for this.

Category C group:

The Category C group met in early January and agreed to develop a new discussion paper, outlining the current issues affecting Category C patients and making recommendations, rather than focusing on the issues raised over two years ago. There have been a number of changes in service provision since the survey was carried out, and it was felt that the plan needed to be updated to reflect these.

Media

Alcohol-related calls: Between late November and New Year, we reached an estimated audience of over 15 million people with proactive media work focussing on the festive increase in demand and alcohol-related calls, and the impact of the cold weather.

Observational shifts at the Liverpool St and West End treatment centres, as well as with frontline ambulance crews and the central London 'booze bus', were arranged for ITV London, BBC London, Sky News, the Evening Standard and the Independent newspaper.

The Evening Standard, local newspapers and regional television news also covered the cold weather and the effect the snow had on the Service, reporting on the increase in 999 calls and rise in slips, trips and falls.

Key messages included top tips to stay safe on a night out, how to take care in the cold weather, what we were doing to ease the pressure on the Service and how people could access healthcare without calling 999.

7 July bombings inquests: Following the last written update to the November Trust Board meeting, staff gave evidence relating to the Edgware Road, Russell Square and King's Cross sites before Christmas, and further witnesses who responded to the bus bombing at Tavistock Square attended the inquests at the end of January.

The media has continued to report some of the evidence staff have given, and the witnesses have been supported to allow the media to film and photograph them for use in any news reports.

Evidence relating to the Service's overall response to the bombings is due to be heard in early March and the inquests are expected to be concluded by the end of that month.

Other issues: A reunion between a member of staff and a Crawley Town steward was reported on the front page of the Crawley and Horley Observer in January. Off-duty staff member Josef Kane resuscitated Terry Marshall when he collapsed at a football game in November.

An incident in which a woman died after being attacked by a dog led to a number of media calls before Christmas; the incident received widespread national coverage.

Peter Bradley CBE
Chief Executive Officer

24 January 2011

London Ambulance Service
NHS Trust

Information Pack for Trust Board

December 10

*** Please note we have no hospital data for Dec as we are still processing PRF's
** No CTA / NHSD figures for December

London Ambulance Service NHS Trust
Accident and Emergency Service
Activity / Call Process -
December 2010

Graph 1
Average number of Cat A, B & C incidents per day

138 more incidents per day (Apr- Dec) 10/11

2009/2010   2010/2011

Graph 2
Average number of Cat A incidents per day

44 more incidents per day (Apr - Dec) 10/11

2009/2010   2010/2011

Graph 3
Average number of Cat B incidents per day

40 more incidents per day (Apr - Dec) 10/11

2009/2010   2010/2011

Graph 4
Average number of Cat C incidents per day

54 more incidents per day (Apr - Dec) 10/11

2009/2010   2010/2011

Graph 5
Average number of 999 calls received per day

-65 fewer calls per day (Apr - Dec) 10/11)

2009/2010   2010/2011

Graph 6
No of incidents conveyed

09/10 Conveyances   10/11 Conveyances
"09-10 Incidents"   10-11 incidents

London Ambulance Service NHS Trust
Accident and Emergency Service
Performance - December 2010

Graph 7
Category A 8 minute performance

73.72%%
YTD 10/11
(Apr - Jan
23rd)

Target 75%   2009/2010   2010/2011
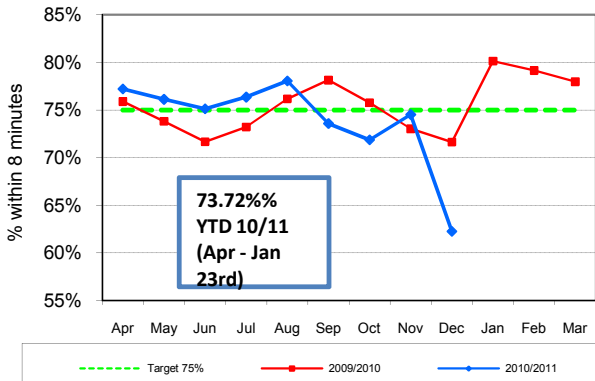
Graph 8
Category A 19 minute performance

98.91% YTD
(Apr - Jan
23rd)10/11

Target 95%   2009/2010   2010/2011
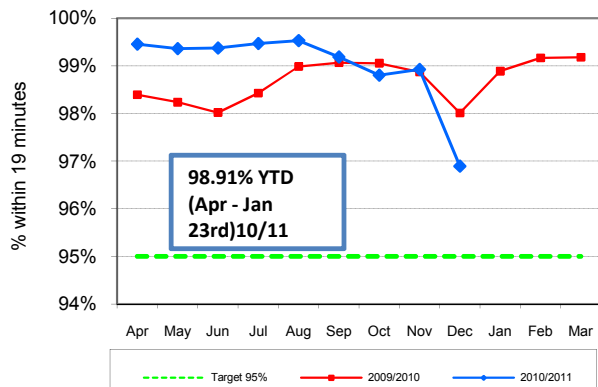
Graph 9
Category B 19 minute performance

88.69% YTD
(Apr - Jan
23rd)10/11

Target 95%   2009/2010   2010/2011
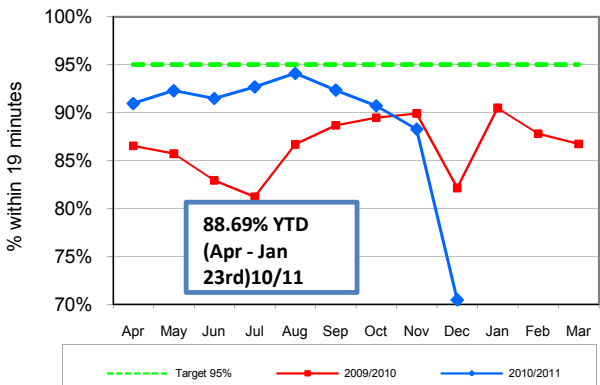
Graph 10
Category C incidents (excluding card 35) responded to within 1 hour (call connect to arrive scene)

89.57% YTD
(Apr - Jan
23rd)10/11

2009/2010   2010/2011
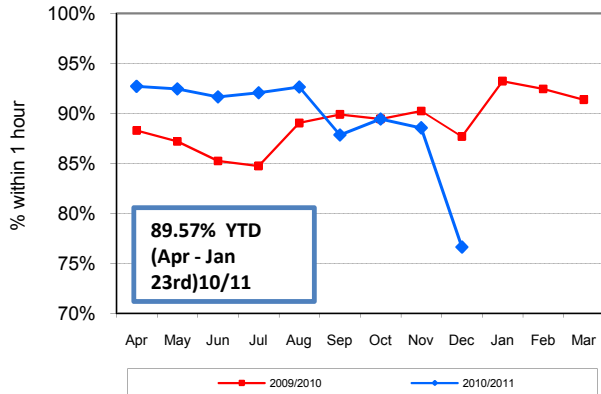
Graph 11
Percentage of calls answered within 5 seconds

93.82% YTD (Apr
- Dec) 10/11

Target 95%   2009/2010   2010/2011
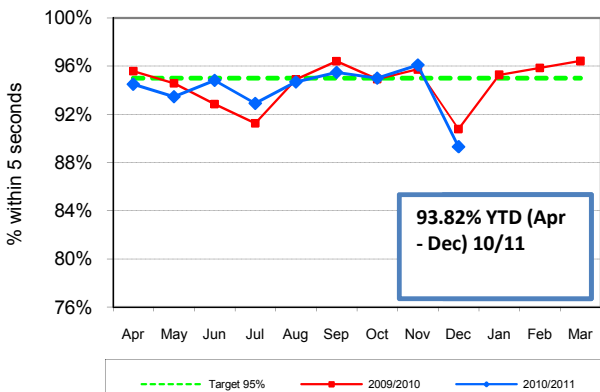
Graph 12
Rest Breaks Given
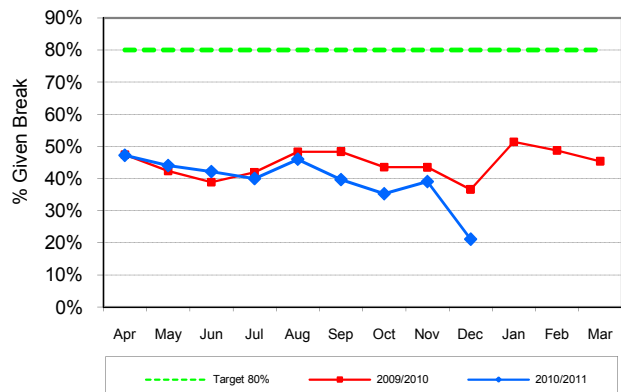
Target 80%   2009/2010   2010/2011

London Ambulance Service NHS Trust
Accident and Emergency Service
Performance - December 2010

Graph 13
Category A 8 minute performance

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target 75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
2010/2011	77.2%	76.1%	75.1%	76.4%	78.0%	73.58%	71.87%	74.52%	62.26%			
Cat A trajectory (10/11)	77.0%	78.0%	76.0%	77.0%	78.0%	79.0%	77.0%	77.0%	75.0%	77.0%	76.0%	76.0%
2009/2010	75.9%	73.8%	71.7%	73.2%	76.2%	78.1%	75.8%	73.0%	71.6%	80.1%	79.2%	78.0%
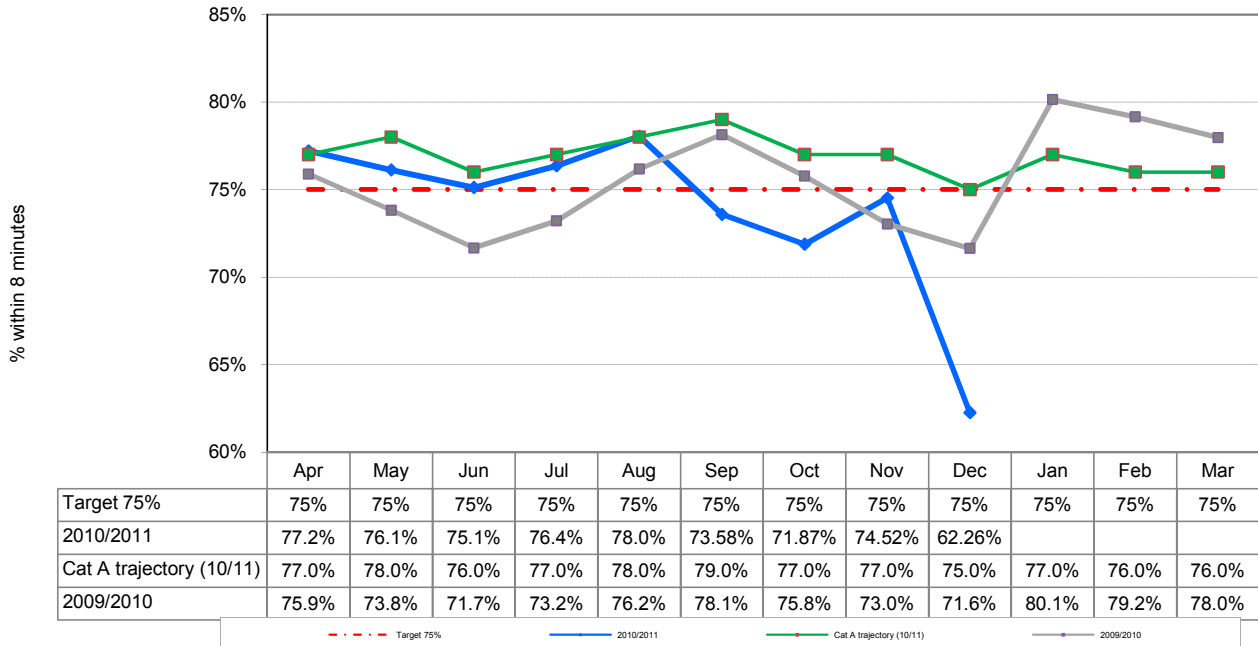
Graph 14
Category B 19 minute performance
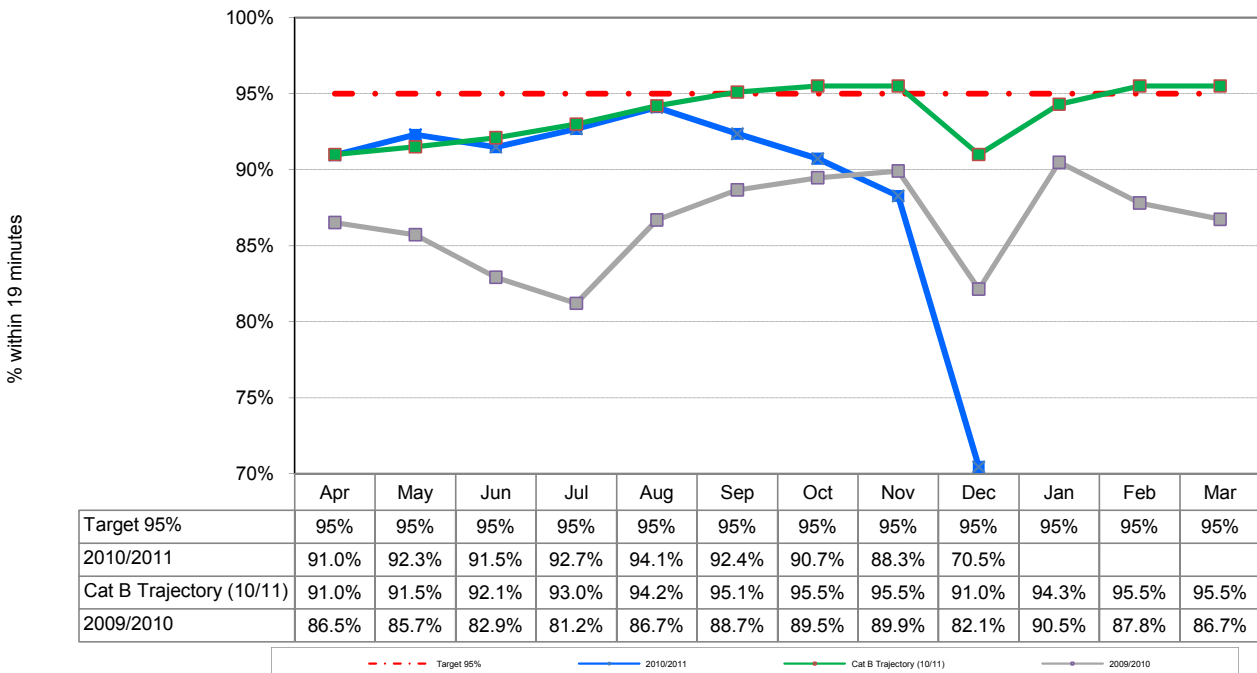
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target 95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
2010/2011	91.0%	92.3%	91.5%	92.7%	94.1%	92.4%	90.7%	88.3%	70.5%			
Cat B Trajectory (10/11)	91.0%	91.5%	92.1%	93.0%	94.2%	95.1%	95.5%	95.5%	91.0%	94.3%	95.5%	95.5%
2009/2010	86.5%	85.7%	82.9%	81.2%	86.7%	88.7%	89.5%	89.9%	82.1%	90.5%	87.8%	86.7%

London Ambulance Service NHS Trust
Accident and Emergency Service
Efficiency and Effectiveness - December 2010

Graph 15
Ambulance Hours average available per day
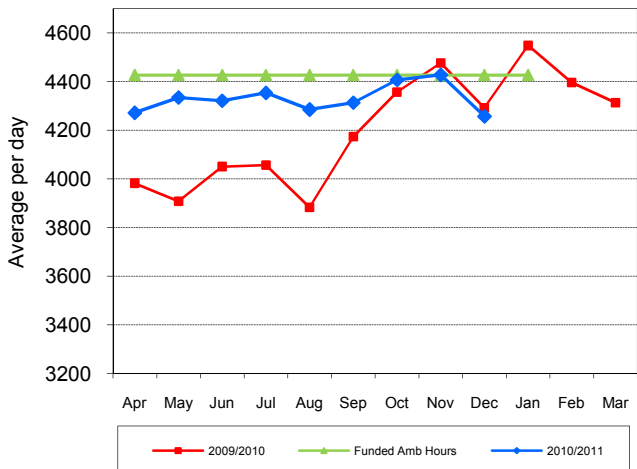
Graph 16
FRU hours average available per day
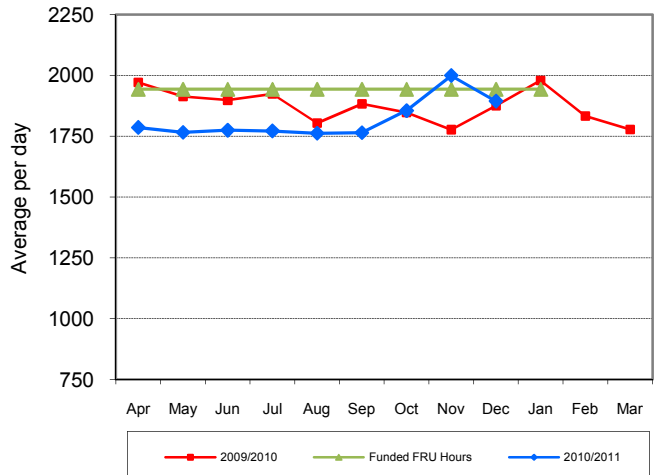
LAS hours in the day Compliant to ORH
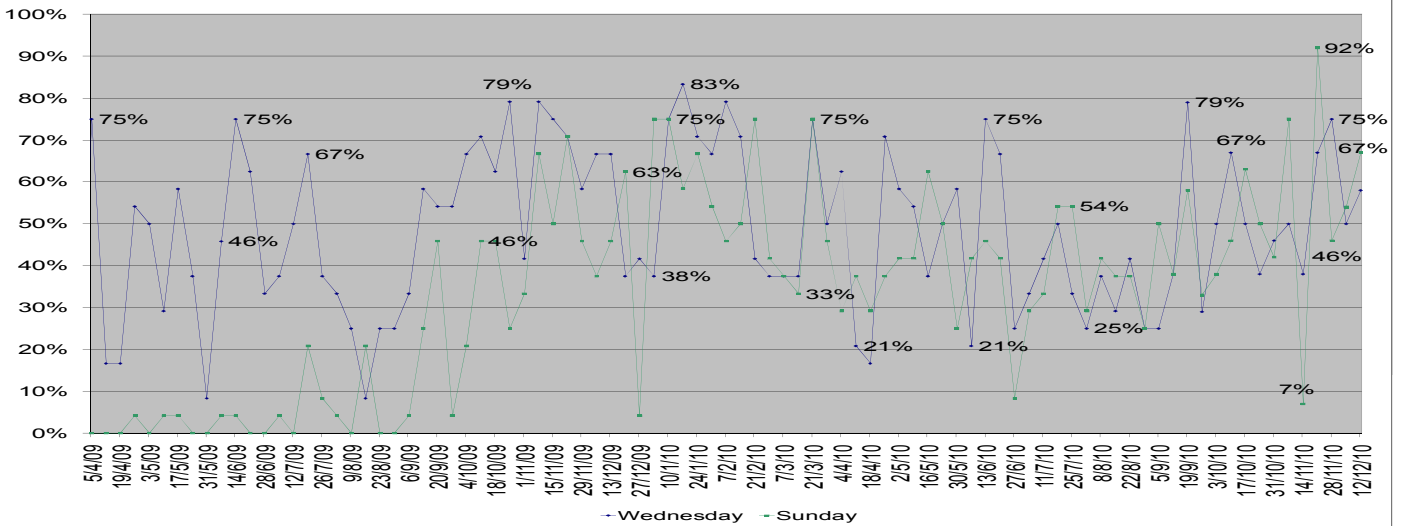
Graph 17
UOC Hours average available per day
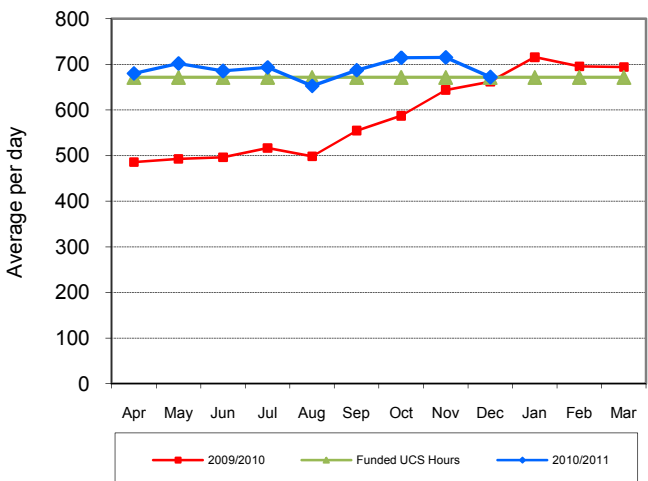
Graph 18
All Vehicle Hours average available per day

Please be aware that the funded hrs include more vehicle types than those above
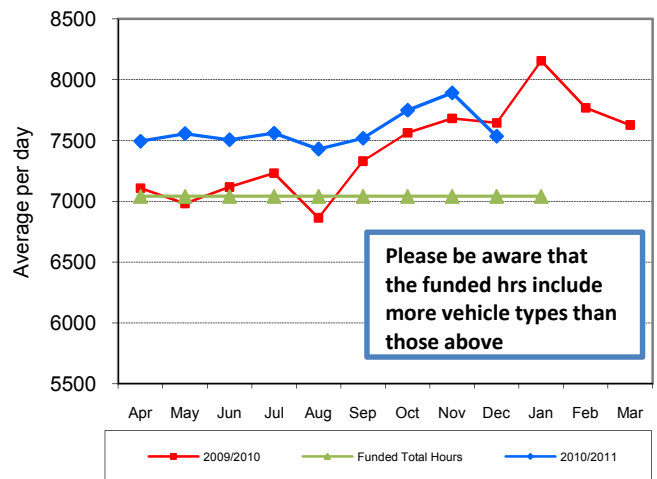
includes other vehicle types other than those above

London Ambulance Service NHS Trust
Accident and Emergency Service
Efficiency and Effectiveness - December 2010

Graph 19
FRU Utilisation

Utilisation %

2009/2010   2010/2011
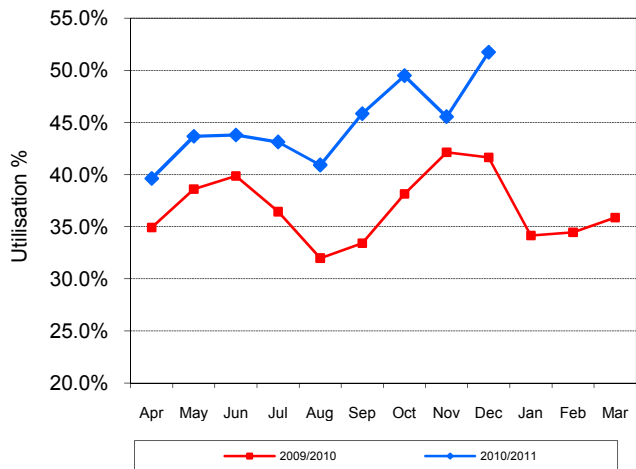
Graph 20
Ambulance Utilisation

Utilisation %

2009/2010   2010/2011
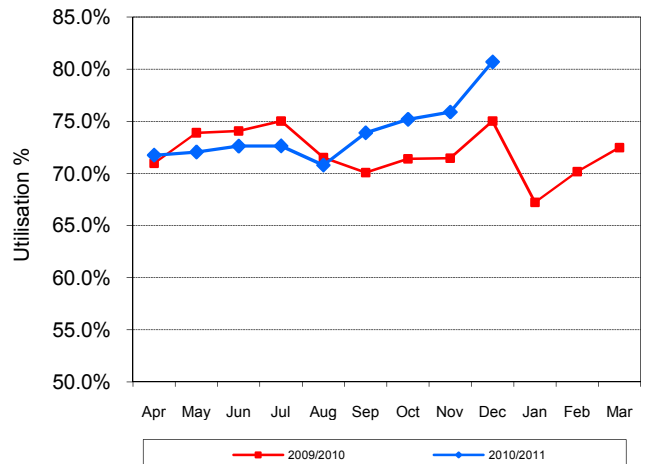
Graph 21
EOC hours staffed per day

Average per day

2009/2010   2010/2011
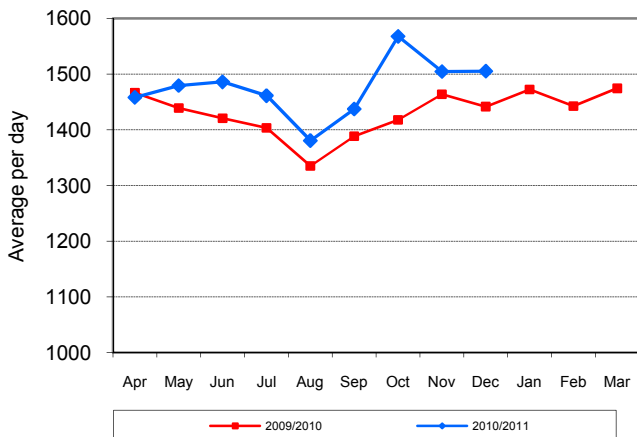
Graph 22
Average hospital turnaround time

Minutes

2009/2010   2010/2011
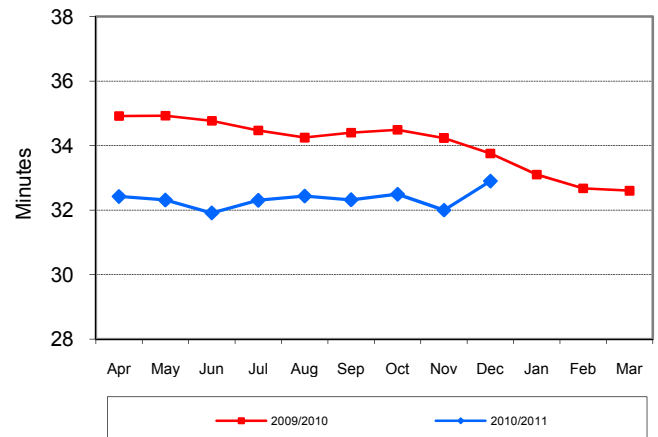
Graph 23
Average Arrival at Hospital to Handover (Mins)

Minutes

2009/2010   2010/2011
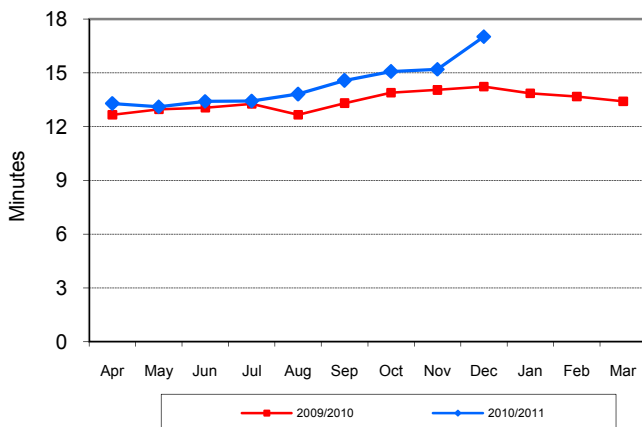
Graph 24
Average Handover to Green (Mins)

Minutes

2009/2010   2010/2011
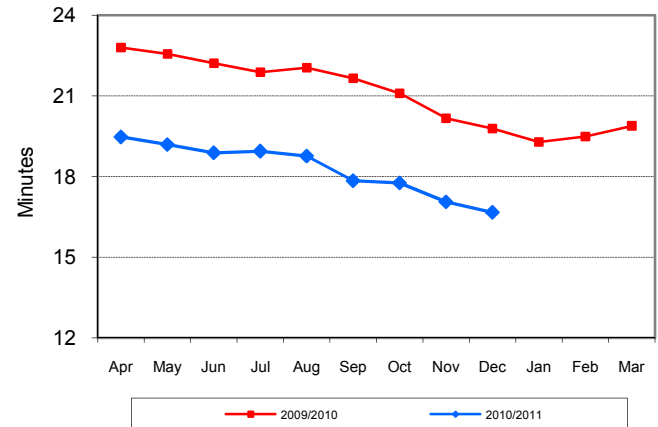
London Ambulance Service NHS Trust
Patient Transport Service
Activity and Performance - December 2010

Graph 25
Arrival at Hospital Against Appointment Time
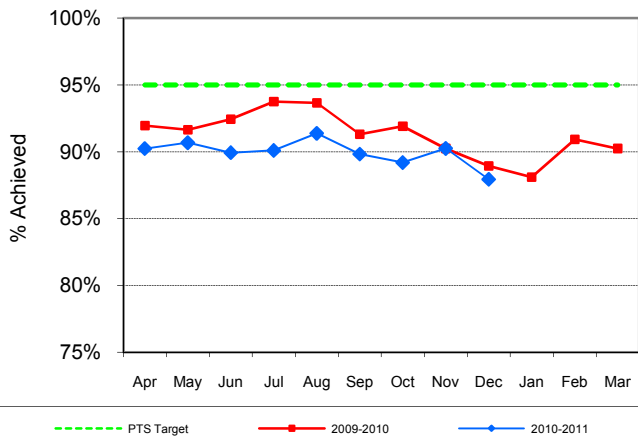
Graph 26
Departure Against Ready Time
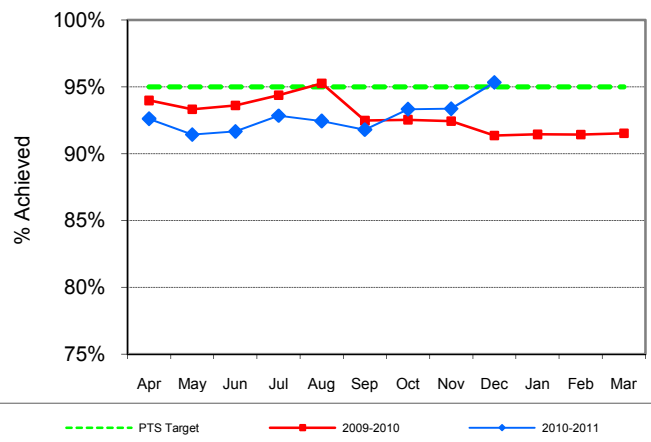
Graph 27
Time spent on Vehicle
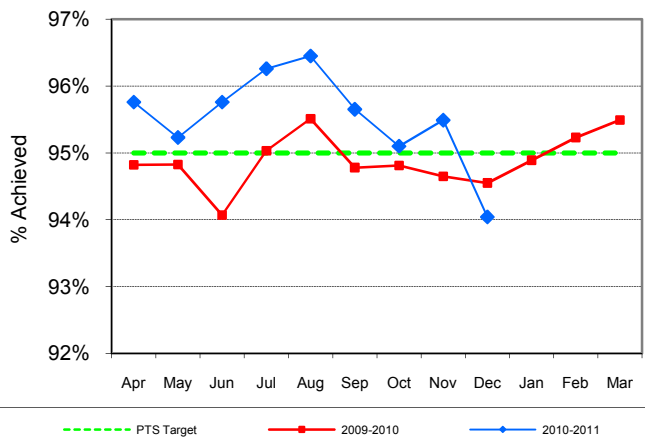
Graph 28
PTS Total Activity
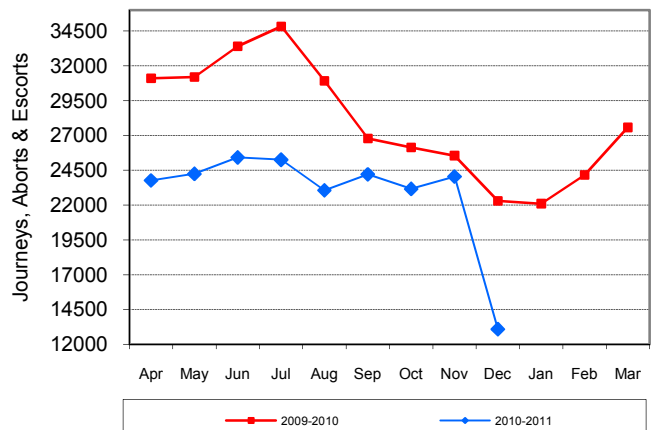
London Ambulance Service NHS Trust
Accident and Emergency Service
UOC Effectiveness - December 2010
Incident information is based on responses where a vehicle has arrived on scene for dispatches occuring during UOC operational hours (0700 -02259)

Graph 29
CAT A, B & C Workload by Urgent Care Vehicles average incidents per day

Graph 30
CTA/NHSD Ambulances saved

Graph 31
UOC Utilisation

Graph 32
Green resolution - December 2010

Graph 33
Safeguarding children and adults

Graph 34
Patients conveyed to Non A&E Departments - LAS
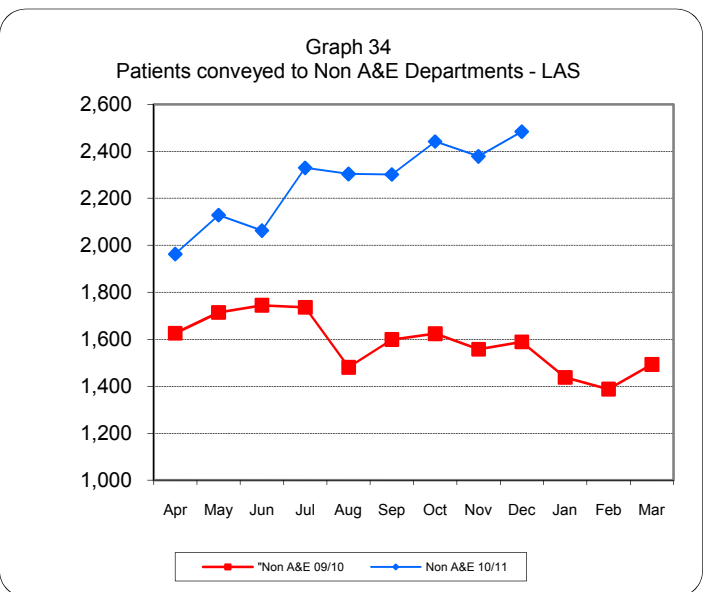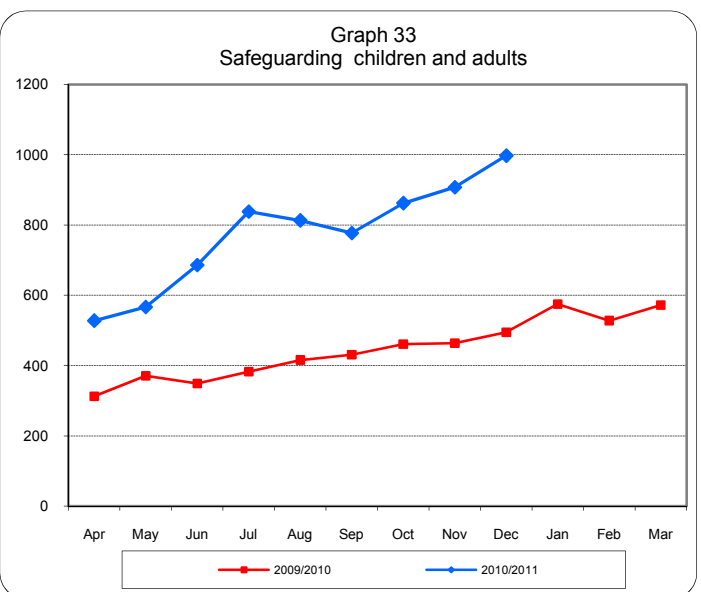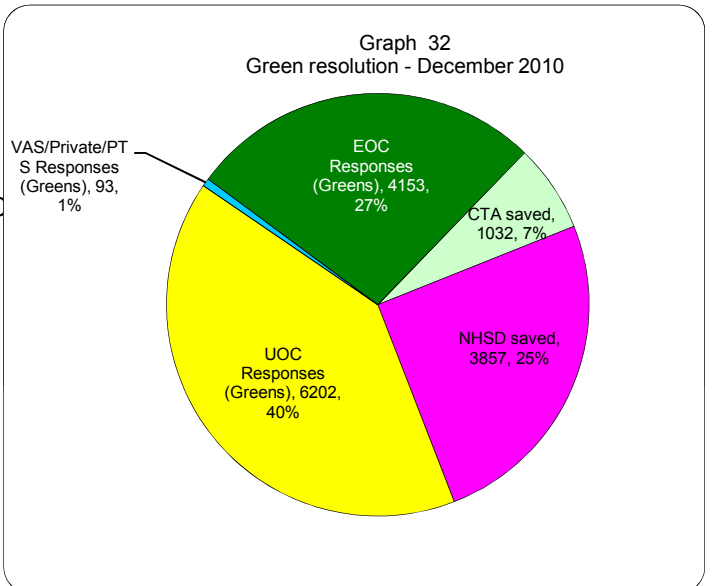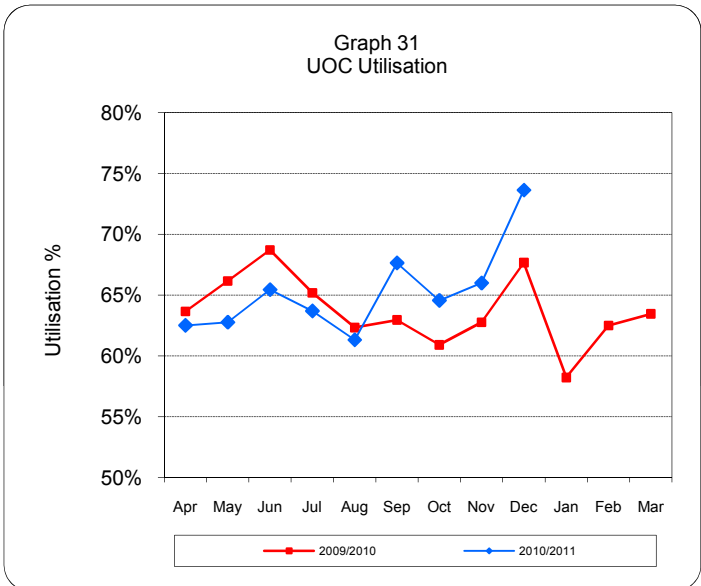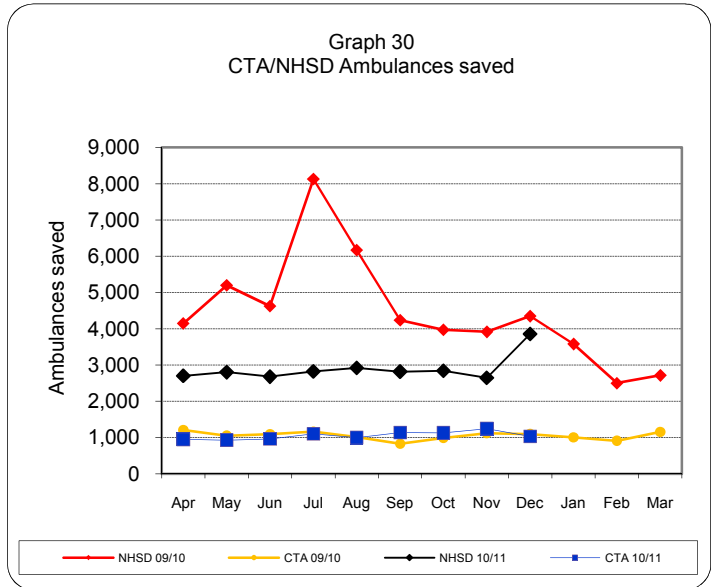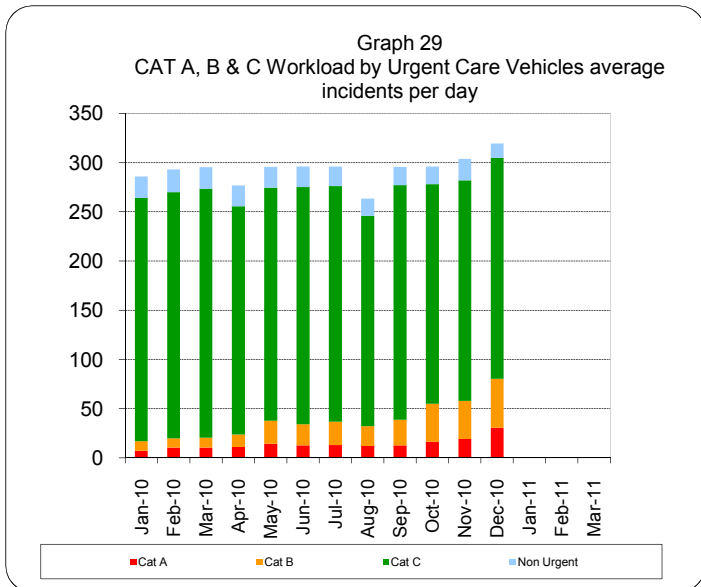
Balanced Scorecard Supporting Indicators

Accountability		PI	May 10			Jun 10			Jul 10			Aug 10			Sep 10			Oct 10			Nov 10			Dec 10			Jan 11			Feb 11			Mar 11			PI Actual
Owner	Sponsor	PI Target Name	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	Commentary
Care for patients																																				
CO1. % of FAST positive patients taken to appropriate specialist centres																																				
Gurkamal Virdi	Fionna Moore	% of FAST positive patients taken to appropriate specialist centres	0	57	▷G	90	95	▽G	90	95	▷G	90	95	▷G	90		▷?	90		▷?	90		▷?	90		▷?	90		▷?	90		▷?	90		▷?	2011-01-10 GV: 90% of FAST positive patients were conveyed directly to a HASU and a further 5% of FAST positive patients were appropriately transported to the nearest A&E. Therefore, 95% of patients were conveyed to an appropriate facility. This is encouraging as phase 2 of the stroke pathway went live on 19th July and there has been an increase use of HASU's by 19% as a result.
CO1. Improved outcome following STEMI																																				
Gurkamal Virdi	Fionna Moore	% of STEMI patients taken to specialist cardiac centres	90		▷?	90		▷?	90	91	▷G	90	93	△G	90	90	▽G	90	96	△G	90	91	▽G	90		▷?	90		▷?	90		▷?			▷?	GV 2011-01-10: In November, 91% of patients were taken directly to a Cath Lab, which is an decrease of 5% from the previous month. A further 7% of patients were appropriately transported to A&E. Therefore, 98% of patients were conveyed to an appropriate facility in November.

Accountability		PI	May 10			Jun 10			Jul 10			Aug 10			Sep 10			Oct 10			Nov 10			Dec 10			Jan 11			Feb 11			Mar 11			PI Actual
Owner	Sponsor	PI Target Name	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	Commentary
CO1. Increase in survival rates for trauma patients																																				
Gurkamal Virdi	Fionna Moore	% of appropriate patients taken to major trauma centres	90	96	▼G	90	99	△G	90	96	▼G	90		▷?	90		▷?	90		▷?	90		▷?	90		▷?	90		▷?	90		▷?	90		▷?	▷? GV 2011-01-10: For July 2010, 96% of major trauma patients were appropriately conveyed to a MTC or a local trauma unit (A&E). This exceeds the target set for the LAS of 90% conveyance of major trauma patients to an appropriate facility. NB: data capture is currently 4 months in arrears; this is a result of additional data sourcing processes entailed as a result of low levels of documentation of destination codes.
CO1. Survival rate for out of hospital cardiac arrest																																				
Gurkamal Virdi	Fionna Moore	% patients with presumed cardiac aetiology who have a return of spontaneous circulation (ROSC) sustained to hospital (LAS overall) GV	23		▷?	23		▷?	23	23	▷G	23	26	△G	23	25	▼G	23	26	△G	23	32	△G	23		▷?	23		▷?	23		▷?	23		▷?	▷?
Gurkamal Virdi	Fionna Moore	Number of defibrillators in public places CHS	10	4	▼R	17	7	▼R	17	9	△R	17	12	△R	20	14	▼R	25	22	△R	30	26	▼R	34	26	▼R	40		▷?	45		▷?	53		▷?	▷? CHS 10/01/11 - existing plans still in place but timetable has slipped over last few weeks. Review of plan on 11/01/11.

Accountability		PI	May 10			Jun 10			Jul 10			Aug 10			Sep 10			Oct 10			Nov 10			Dec 10			Jan 11			Feb 11			Mar 11			PI Actual
Owner	Sponsor	PI Target Name	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	Commentary
Gurkamal Virdi	Fionna Moore	Number of people trained by the Trust under the community responder scheme CHS	20	24	△G	30	24	▽R	40	24	▽R	40	42	△G	50	54	△G	60	78	△G	70	85	△G	75	99	△G	85		▷?	95		▷?	100		▷?	
Gurkamal Virdi	Fionna Moore	Number of people trained to use defibrillators CHS	100	100	△G	150	164	△G	160	210	△G	160	235	△G	210	315	△G	260	362	▽G	300	410	△G	320	474	△G	370		▷?	420		▷?	483		▷?	
CO2. Increased use of appropriate care pathways																																				
Emma Williams	Lizzy Bovill	% of complexes with new Clinical Response Model in place BON	0		▷?	0		▷?	0		▷?	0		▷?	0		▷?	1		▷?	2		▷?	2		▷?	3		▷?	3		▷?	3		▷?	-
Emma Williams	Lizzy Bovill	Number of of falls referred to established pathway EW	100	114	△G	100	120	△G	100	131	△G	100	113	▽G	100	137	△G	100	176	△G	100	206	△G	100		▷?	100		▷?	100		▷?	100		▷?	
Emma Williams	Lizzy Bovill	Number of patients referred to a community provider EW	200	989	△G	200	1015	△G	200	1088	△G	200	1174	△G	200	1101	▽G	200	1346	△G	200	1286	▽G	200		▷?	200		▷?	200		▷?	200		▷?	
Emma Williams	Lizzy Bovill	The % of total incidents resolved through CTA, NHSD SW	33		▷?	33		▷?	33		▷?	33		▷?	33		▷?	33	4.30	▷R	33	4.40	▲R	33		▷?	33		▷?	33		▷?	33		▷?	SW 10/01/11: NB: resolved by CTA + resolved by NHSD + Cases not conveyed year to date fig is 27%. Milestone to be reviewed w/c 17/01/11 with LB and CMC as it does the current measurement does not reflect the title and reporting data

Accountability		PI	May 10			Jun 10			Jul 10			Aug 10			Sep 10			Oct 10			Nov 10			Dec 10			Jan 11			Feb 11			Mar 11			PI Actual
Owner	Sponsor	PI Target Name	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	Commentary
CO2. Increased use of appropriate care pathways PART 2																																				
Stephen Hines	Fionna Moore	End of Life care target - 50% processed in 72 hours SH	50		▷?	50		▷?	50		▷?	50		▷?	50	98	▷G	50	70	▽G	50	95	△G	50	91	▽G	50		▷?	50		▷?	50		▷?	SH 10/1/11 229 added, with delays on approx 20. Paul Tattam added temporary flags on christmas eve / day to avoid problems
Stephen Hines	Fionna Moore	Patient Specific Protocols target - 75% processed within 48 hrs SH	75		▷?	75		▷?	75		▷?	75		▷?	75	77	▷G	75	100	△G	75	100	▷G	75	64	▽R	75		▷?	75		▷?	75		▷?	SH 10/1/11 9 out of 25 new PSPs had significant delays in getting the first letter out. This was predominanty due to DMP
CO3. Meet locally agreed Category C response target																																				
Jason Killens	Richard Webber	Meet locally agreed Category C (30 minute callback) response target	90	97.30	▽G	90	96.60	▽G	90	96	△G	90	97.50	△G	90	96.60	▽G	90	96.78	△G	90	95	▽G	90	78.70	▽R	90		▷?	90		▷?	90		▷?	RLH 10/01/2011 Disappointing not to achieve the category C 30 minute call back milestone, demand for December was challenging due to adverse weather, Swine Flu and Student Demonstrations. The Trust utilised the DMP (Demand Management Plan) to protect Category A Life-threatening calls. With the implementation of DMP (B) Category C calls, the milestone change from a 30 minute ring back to 60 minute ring back; this meant the Trust achieved 98%.

| Accountability | | PI | May 10 | | | Jun 10 | | | Jul 10 | | | Aug 10 | | | Sep 10 | | | Oct 10 | | | Nov 10 | | | Dec 10 | | | Jan 11 | | | Feb 11 | | | Mar 11 | | | PI Actual |
Owner	Sponsor	PI Target Name	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	Commentary
Jason Killens	Richard Webber	Meet locally agreed Category C (60 minute ambulance response target)	90	92.50	▽G	90	91.70	▽G	90	92.10	△G	90	92.60	△G	90	89	▽R	90	89.40	△R	90	88.50	▽R	90	76.50	▽R	90		▷?	90		▷?	90		▷?	RLH 10/1/2011 December's incident demand across the Trust finished at c4.5%, with both Category A & B seeing a 13% increase in comparison to December 2010. The Trust implemented DMP to protect Category A life-threatening calls. The Trust focused our service users towards Clinical Telephone Advise (CTA) or alternative care pathway such as NHS Direct. Category C60 remains achievable, up to and inclusive of 31st December YTD performance sits at 89.1%

CO3. Meet the Category A (8 and 19 minutes) response time target

Owner	Sponsor	PI Target Name	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	Commentary
Jason Killens	Richard Webber	% Calls answered in 5 seconds ----- PW	95	93.45	▽R	95	94.82	△R	95	92.91	▽R	95	93.60	△R	95	95.30	△G	95	95.80	△G	95	95.90	△G	95	89.30	▽R	95		▷?	95		▷?	95		▷?	
Jason Killens	Richard Webber	% of Category A activation within 45 seconds ------ JB (PW)	60	45	▽R	60	45.30	△R	60	45.60	△R	60	45.50	▽R	60	63.40	△G	60	60.84	▽G	60	66.60	△G	60	46.10	▽R	60		▷?	60		▷?	60		▷?	
Jason Killens	Richard Webber	Achievement of Cat A (19 minutes) ---- CD	95		▷?	95		▷?	95		▷?	95	77.90	▷R	95	99.10	△G	95	98.70	▽G	95	98.90	△G	95	96.80	▽G	95		▷?	95		▷?	95		▷?	
Jason Killens	Richard Webber	Achievement of Cat A (8 minutes) ---- CD	78	76.12	▽R	76	75.12	△R	77		▷?	78	99.51	△G	79	73.40	▽R	77	71.70	△R	77	74.30	△R	75	61.80	▽R	77		▷?	76		▷?	76		▷?	
Jason Killens	Richard Webber	AEU mobilisation from station less than 30% ---- CD	30	21.50	△G	30	21	△G	30	25	▽G	30	29	▽G	30	22.70	△G	30	25	▽G	30	21.40	△G	30	0	△G	30		▷?	30		▷?	30		▷?	

Accountability		PI	May 10			Jun 10			Jul 10			Aug 10			Sep 10			Oct 10			Nov 10			Dec 10			Jan 11			Feb 11			Mar 11			PI Actual
Owner	Sponsor	PI Target Name	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	Commentary
Jason Killens	Richard Webber	Ambulance mobilisation <208sec Average ------ CD	208	102.50	△G	208	111.80	▽G	208	114.30	▽G	208	110.40	△G	208	140	▽G	208	234	▼R	208	233	▲R	208		▷?	208		▷?	208		▷?	208		▷?	CPD 04/12/10 Continuing to reduce the mobilisation from station will in turn reduce the mobilisation average.
Jason Killens	Richard Webber	Ambulance utilisation of 55% ------- CD	55	72	▼R	55	72.60	▼R	55	71.70	△R	55	75.20	▼R	55	76.80	▼R	55	77.60	▼R	55	81	▼R	55	85.20	▼R	55		▷?	55		▷?	55		▷?	
Jason Killens	Richard Webber	FRU mobilisation <134 sec Average ------ CD	134		▷?	134		▷?	134	85.90	▷G	134	107	▽G	134	101	△G	134	105	▽G	134	77	△G	134	137	▼R	134		▷?	134		▷?	134		▷?	
Jason Killens	Richard Webber	FRU mobilisation from station less than 25% ------- CD	25		▷?	25		▷?	25	26	▷R	25	28	▼R	25		▷?	25	25	△G	25	25	▷G	25	22.80	△G	25		▷?	25		▷?	25		▷?	
Jason Killens	Richard Webber	FRU utilisation of 40% ------ CD	40	43.70	▼R	40	43.80	▼R	40	42.50	▲R	40		▷?	40	46.20	▼R	40	47.80	▼R	40	48.40	▼R	40	54.90	▼R	40		▷?	40		▷?	40		▷?	
Jason Killens	Richard Webber	Job cycle time (incl. hospital turnaround) 66 minutes ----- CD	66		▷?	66		▷?	66		▷?	66	64	▷G	66	65	▽G	66	66	▽G	66	67	▼R	66	69	▼R	66		▷?	66		▷?	66		▷?	
Jason Killens	Richard Webber	Proportion of the year below REAP level 1 & 2 combined --- CD	75		▷?	75		▷?	75		▷?	75		▷?	75	85	▷G	75	78.10	▽G	75	69.40	▼R	75		▷?	75		▷?	75		▷?	75		▷?	CPD 04/12/10 25 weeks of or 36 we have been at level 2 or below

performance accelerator

Accountability		PI	May 10			Jun 10			Jul 10			Aug 10			Sep 10			Oct 10			Nov 10			Dec 10			Jan 11			Feb 11			Mar 11			PI Actual
Owner	Sponsor	PI Target Name	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	Commentary
Jason Killens	Richard Webber	Staffing total hours produced as per contract (AEU) ---- AK	100		▷ ?	100		▷ ?	100		▷ ?	100		▷ ?	100	88.60	▶ R	100	99.50	▲ R	100	100	▲ G	100	96.20	▼ R	100		▷ ?	100		▷ ?	100		▷ ?	AK 10/01/11 A number of key issues for not meeting this target can be highlighted as follows; Adverse weather conditions, large Service commitment to Public Order events, reduction in overtime and no encentive scheme, rising sickness and unathourised abscence. I have placed an amber Rag as we will need to control the number of abstractions in the last quarter.
Jason Killens	Richard Webber	Staffing total hours produced as per contract (All) ----- AK	100		▷ ?	100		▷ ?	100		▷ ?	100		▷ ?	100	87.90	▶ R	100	96.80	▲ R	100	112.10	▲ G	100	107.30	▼ G	100		▷ ?	100		▷ ?	100		▷ ?	AK - 10/01/11 The trust has continued to acheive this target and I am positive that this will be acheived for financial year end.

Accountability		PI	May 10			Jun 10			Jul 10			Aug 10			Sep 10			Oct 10			Nov 10			Dec 10			Jan 11			Feb 11			Mar 11			PI Actual
Owner	Sponsor	PI Target Name	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	Commentary
Jason Killens	Richard Webber	Staffing total hours produced as per contract (FRU) -- -- AK	100		▷?	100		▷?	100		▷?	100		▷?	100	90.80	▷R	100	86.80	▼R	100	95.40	▲R	100	93	▼R	100		▷?	100		▷?	100		▷?	AK 10/01/11 The introduction of the CRM trial in the SE has made us accomdate staff on their orginal rostas rather than the CRM. There is also eveidence that there are a greater number of core cor FRU rostas that are not fully resourced, the appetite for FRU work is low, coupled with the number of FRUs being used for the CRM trial means that Team Leaders are often without FRUs.
Jason Killens	Richard Webber	Staffing total hours produced as per contract (UC) ----- AK	100		▷?	100		▷?	100		▷?	100		▷?	100	87.10	▷R	100	108	▲G	100	108	▷G	100	102.30	▼G	100		▷?	100		▷?	100		▷?	
Jason Killens	Richard Webber	VOR % ----- CV	12		▷?	12		▷?	12		▷?	12	11	▷G	12	10	▲G	12	4.90	▲G	12	11.50	▼G	12	9.70	▲G	12	9.70	▷G	12		▷?	12		▷?	

CO3. Meet the Category B (19 minutes) response time target

Owner	Sponsor	PI Target Name	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	Commentary
Jason Killens	Richard Webber	% Category B activation of 90 seconds - JB (PW)	70	66	▲R	70	69.50	▲R	70	70.30	▲G	70	72.70	▲G	70	71.44	▼G	70	68.93	▼R	70	62.59	▼R	70		▷?	70		▷?	70		▷?	70		▷?	JB 07/12/10 FRU's are no longer being utilised for CAT B and there was a CTAK System Crash during November
Jason Killens	Richard Webber	Achievement of Cat B (19 minutes) - CD		92.30	▷?		91.48	▷?	86	92.68	▷G	86.5	93.97	▲G	93	92.10	▼R	90	90.30	▲G	91.5	88.10	▼R	94	70.30	▼R	95		▷?	95		▷?	95		▷?	CPD 11/01/11 The service was under extreme pressures due to increased call volume and adverse weather enacting DMP on a number of occassions up to including F with REAP 5.

Accountability		PI	May 10			Jun 10			Jul 10			Aug 10			Sep 10			Oct 10			Nov 10			Dec 10			Jan 11			Feb 11			Mar 11			PI Actual
Owner	Sponsor	PI Target Name	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	Commentary
CO4. Meet Health & Safety target																																				
John Selby	Caron Hitchen	Meet Health & Safety target - % H&S incidents reported within 7 days	35	34.15	▲R	35	30.72	▼R	35	33.64	▲R	35	35.93	▲G	35	55.50	▲G	38	33.10	▼R	40	36	▲R	43	47.60	▲G	45		▷?	48		▷?	53		▷?	
CO4. Meet Infection control target - Compliance on Infection Control Audit																																				
Trevor Hubbard	Steve Lennox	Compliance with guidelines as % of all	85	84.20	▲R	85	86.10	▲G	85		▷?	85	92.50	▲G	85	85.60	▼G	85	90	▲G	85	88.40	▼G	85	87.70	▼G	85		▷?	85		▷?	85		▷?	TH 10/1/11 Overall compliance against the audit is 87.7% for those audits completed which is improved on Q2
Trevor Hubbard	Steve Lennox	Infection control audits as per plan - complexes to undertake infection control audit, quarterly returns will be received over the 3 month period	20	23	▲G	36	36	▼G	20	7	▼R	20	2	▼R	36	52	▲G	20	9	▼R	20	9	▷R	36	45	▲G	20		▷?	20		▷?	36		▷?	TH 10/01/11 45 audits received for final month of Q3. Total audits received 62 out of 76 which is 81.5% completion. This is the 3rd quarter where completion levels have been below the 95% and i am concerned that with increasing performance pressures the focus on audits for Q4 will not be there and we will again fall behind in this.
CO4. Meet patient report form completion target																																				
Jason Killens	Richard Webber	Meet patient report form completion target - % PRFs received within 7 days	95		▷?	95		▷?	95		▷?	95	99.30	▷G	95	98.90	▼G	95	98.70	▼G	95	98.30	▼G	95	96.30	▼G	95		▷?	95		▷?	95		▷?	

Accountability		PI	May 10			Jun 10			Jul 10			Aug 10			Sep 10			Oct 10			Nov 10			Dec 10			Jan 11			Feb 11			Mar 11			PI Actual
Owner	Sponsor	PI Target Name	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	Commentary
Good for staff																																				
CO5. Increase in staff confidence levels																																				
Jason Killens	Richard Webber	% of non-operational staff receiving PDR sessions per annum ----- AB	90		?	90		?	90		?	90		?	90		?	90	72	G	90	72	G	90	77	G	90		?	90		?	90		?	AB 04.01.11 The figures indicate that there is still work to be done in the larger depts - PTS (53%) Operational Support (66%)
Jason Killens	Richard Webber	% of operational staff receiving PDR sessions per annum ---- AK	10		?	20		?	30		?	30		?	40	39	R	50	34	R	60	28	R	60	47	R	70	47	R	80		?	90		?	AK 10.01.11 There has been no progress on this target due to REAP 4 actions, this objective will remain increasingly difficult to achieve in the last quarter as abstractions peak as SP3 enter their 12 week conversion to attain Paramedic qualification.
Jason Killens	Richard Webber	% of operational staff who have a workplace performance review twice per year ---- AK	10		?	20		?	30		?	30		?	40	10	R	50	11	R	60	8	R	60	8	R	70		?	80		?	90		?	AK 10.01.11 The weather, student protesets and performance challenges in December has meant that this taregt could not progress.
Jason Killens	Richard Webber	% of operational staff who have two CPI feedback sessions per year ---- JD + CD	95	116	G	95	108	G	95	102	G	95	113	G	95	115	G	95	115	G	95	113	G	95		?	95		?	95		?	95		?	
Jason Killens	Richard Webber	Complexes with NWoW in place ----- HL	2		?	2		?	2		?	2		?	2		?	2		?	2	2	G	2	2	G	2		?	2		?	7		?	HL 05.01.10 (updated)
Jason Killens	Richard Webber	CPI Completed as % of plan ---- JD + CD	75	89	G	75	74	R	75	80	G	75	89	G	75	89	G	75	84	G	75	84	G	75		?	75		?	75		?			?	

Accountability		PI	May 10			Jun 10			Jul 10			Aug 10			Sep 10			Oct 10			Nov 10			Dec 10			Jan 11			Feb 11			Mar 11			PI Actual
Owner	Sponsor	PI Target Name	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	Commentary
Jason Killens	Richard Webber	CPI compliance with guidelines as a % of all ---- JD + CD	95	94	R	95	94	R	95	95	G	95	94	R	95	94	R	95	94	R	95	95	G	95		?	95		?	95		?	95		?		?	
CO5. Increase in staff skill levels																																				
Ann Ball	Caron Hitchen	% of NW0W staff attending NWoW training days ---- HL			?			?			?			?			?			?			?			?			?			?			?			-
Ann Ball	Caron Hitchen	% of staff attending training courses against places available ---- JH + GH	70	83.80	G	70	79	G	70	76.50	G	70	68.50	R	70	70	G	70	79	G	70	70.70	G	70	67.20	R	70		?	70		?	70		?		?	JH: 2011/01/10: EMT4 - Patient Assessment Element (one day), 3 courses cancelled, 1 course cancelled due to the adverse weather conditions and 2 courses cancelled due to low staff bookings
Ann Ball	Caron Hitchen	Number of (not qualified) Student paramedics in training ---- AB	664	704	G	664	704	G	664	704	G	664	704	G	664	695	G	664	686	G	664	691	G	664	684	G	664		?	664		?	664		?		?	
Ann Ball	Caron Hitchen	Proportion of annual priority training commitments delivered ---- JH + GH	111		?	111		?	111		?	111		?	111	236	G	111	161	G	111	120	G	111	3	R	111		?	111		?	109		?		?	JH: 2011/01/10: 72 places planned (6 one day courses), 3 places booked 3 attended. 48 places (4 courses) cancelled due to operational directive. 12 places (1 course) cancelled due to low staff bookings. RAG Green target for financial year 1331 exceeded to 1661.

Owner	Sponsor	PI Target Name	G (May 10)	Actual (May 10)	V (May 10)	G (Jun 10)	Actual (Jun 10)	V (Jun 10)	G (Jul 10)	Actual (Jul 10)	V (Jul 10)	G (Aug 10)	Actual (Aug 10)	V (Aug 10)	G (Sep 10)	Actual (Sep 10)	V (Sep 10)	G (Oct 10)	Actual (Oct 10)	V (Oct 10)	G (Nov 10)	Actual (Nov 10)	V (Nov 10)	G (Dec 10)	Actual (Dec 10)	V (Dec 10)	G (Jan 11)	Actual (Jan 11)	V (Jan 11)	G (Feb 11)	Actual (Feb 11)	V (Feb 11)	G (Mar 11)	Actual (Mar 11)	V (Mar 11)	PI Actual / Commentary
CO6 ANNUAL MEASURE. Increase representation of staff from minority ethnic																																				
Ann Ball	Caron Hitchen	(ANNUAL) Increased proportion of BME staff progressed			▷?			▷?			▷?			▷?			▷?			▷?			▷?			▷?			▷?			▷?			▷?	▷? -
Ann Ball	Caron Hitchen	(ANNUAL) Increased proportion of BME staff recruited			▷?			▷?			▷?			▷?			▷?			▷?			▷?			▷?			▷?			▷?			▷?	▷? -
Ann Ball	Caron Hitchen	(ANNUAL) Increased proportion of BME staff retained			▷?			▷?			▷?			▷?			▷?			▷?			▷?			▷?			▷?			▷?			▷?	▷? -
CO7. Trust sickness levels																																				
Ann Ball	Caron Hitchen	Reduce sickness levels across the Trust	4.50	5.08	▼R	4.50	4.65	▲B	4.50	5.22	▼R	4.50	5.47	▼R	4.50	5.15	▲R	4.50	5.19	▼R	4.50	5.30	▼R	4.50		▷?	4.50		▷?	4.50		▷?	4.50		▷?	▷? AB 04.01.11 Refreshed figure for Oct = 5.09%. FYTD = 5.13%. Audits continue to show good management of attendance.
CO7. Improve clinical leadership through NWoW implementation																																				
Helen Lew	Caron Hitchen	Proportion of NWoW complexes with full establishment of clinical tutors (team leaders to be included when numbers confirmed) HL			▷?			▷?			▷?			▷?	4	4	▷G	8	8	▷G	14	12	▲G	14	14	▼G	14		▷?	14		▷?	14		▷?	▷? HL (05.01.11). All 7 NWOW complexes now have confirmed Clinical Tutors. Friern Barnet is the last complex to have their CTs comence on the 6th and 31st january 2011.
CO7. Lower vacancy rates to 4%																																				
Ann Ball	Richard Webber	Control Services staff vacancy %	3		▷?	3		▷?	3		▷?	3	3.97	▼R	3	6.10	▼R	3	5.40	▲R	3	5.10	▲R	3	6.40	▼R	3		▷?	3		▷?	3		▷?	▷? AB 10.01.11 32.17 wte above establishment. No further recruitment planned for 10/11

Accountability		PI	May 10			Jun 10			Jul 10			Aug 10			Sep 10			Oct 10			Nov 10			Dec 10			Jan 11			Feb 11			Mar 11			PI Actual
Owner	Sponsor	PI Target Name	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	Commentary
Ann Ball	Richard Webber	Front-line staff vacancy %	4		▷?	4		▷?	4		▷?	4	4.95	▷R	4	5	▽R	4	4.30	△R	4	3.04	△G	4	3.70	▽G	4		▷?	4		▷?	4		▷?	AB 10.01.11 127.1 wte vacancies. A&E Support courses (15 places per course) planned for Jan, Feb and Mar.
Ann Ball	Richard Webber	Support services vacancy %	3		▷?	3		▷?	3		▷?	3		▷?	3		▷?	3	0	▷G	3	11.74	▽R	3	11.50	△R	3		▷?	3		▷?	3		▷?	AB 10.01.11 Vacancies in support services are being reviewed and held as part of the CIP.
Value for taxpayers																																				
CO8. ANNUAL MEASURE Resources ALE																																				
Martyn Salter	Michael Dinan	ANNUAL ALE score of Excellent	15		▷?	25		▷?	35		▷?	40		▷?	50		▷?	60		▷?	70		▷?	75		▷?	80		▷?	90		▷?	100		▷?	-
CO8. More efficient use of fleet																																				
Jason Killens	Richard Webber	% AEU fleet available to operations	88		▷?	88		▷?	88		▷?	88	89	▷G	88	90	△G	88	89	▽G	88	88.50	▽G	88	89.10	△G	88		▷?	88		▷?	88		▷?	
Jason Killens	Richard Webber	Fleet plan - mercedes in fleet	1		▷?	10		▷?	21		▷?	30	30	▷G	39	39	▷G	51	51	▷G	63	62	▽R	72	65	▽R	81		▷?	89		▷?	89		▷?	CV Further vehicles (24 from UVM) will not commence delivery until February 2011

Accountability		PI	May 10			Jun 10			Jul 10			Aug 10			Sep 10			Oct 10			Nov 10			Dec 10			Jan 11			Feb 11			Mar 11			PI Actual
Owner	Sponsor	PI Target Name	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	Commentary
CO8. Reduce carbon footprint																																				
Christine McMahon	Michael Dinan	% of carbon reduction			▷?			▷?			▷?			▷?	50	56	▷G	60	63	▽G	65	66	▽G	75	75	▽G	80		▷?	90		▷?	100		▷?	10/01/11: the Trust's carbon footprint based on utilities and fuel has been calculated for 2007/08 (10,442,280); it will be very challenging for the Trust to acheive the NHS target of reducing the footprint by 10% by 2015. The 2010/11 Management Action Plan is mostly being implemented. It has proved quite challenging to gather data in respect of the agreed quarterly KPIs. Consideration is being given to strengthen the reference to carbon reduction in the Trust's business case template . The Trust has applied to work with the Carbon Trust - NHS Carbon Management programme in 2011.
CO8. Reduction in the cost base (CIP)																																				
Andrew Bell	Michael Dinan	CIP forecast vs plan - year end target is £18m			▷?			▷?			▷?			▷?	18439	18233	▷G	18439	18439	▽G	18439	18439	▷G	18439	18439	▷G	18439		▷?	18439		▷?	18439		▷?	
Andrew Bell	Michael Dinan	CIP realised (£)	1620		▷?	2430		▷?	4125		▷?	5820	5616	▷R	7516	8517	△G	9336	9929	▽G	11157	11846	△G	12978	13120	▽G	14798		▷?	16619		▷?	18439		▷?	

Accountability		PI	May 10			Jun 10			Jul 10			Aug 10			Sep 10			Oct 10			Nov 10			Dec 10			Jan 11			Feb 11			Mar 11			PI Actual
Owner	Sponsor	PI Target Name	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	Commentary
CO8. Resources Estates																																				
Martin Nelhams	Michael Dinan	% completion of Estates strategy objectives completed	100		▷ ?	100		▷ ?	100		▷ ?	100		▷ ?	100		▷ ?	100	33	▶R	100	33	▶R	100	33	▶R	100		▷ ?	100		▷ ?	100		▷ ?	MN 07/01/2011: The Estate strategy is still in a draft formatt and there has been no public consultation. No further work on the controls rooms project has been undertaken. The Business case for the West workshop has been delayed and will go to the January TB. HART East is due for completion Feb 2011. The site for HART west has been secured and the specification for refurbishment has been completed. A project board for the Enfield/Haringey super station has been established.
Martin Nelhams	Michael Dinan	Estates capital spend as % of plan			▷ ?			▷ ?	30		▷ ?	38	34	▶R	47	50	▲G	56	58	▼G	65	80	▲G	74	92	▲G	82		▷ ?	91		▷ ?	100		▷ ?	
CO8. Resources Financial																																				
Andrew Bell	Michael Dinan	Capital Cost Absorption rate			▷ ?			▷ ?			▷ ?			▷ ?			▷ ?			▷ ?			▷ ?			▷ ?			▷ ?			▷ ?			▷ ?	not available yet
Andrew Bell	Michael Dinan	Capital Resource Limit (CRL)	18.42		▷ ?	18.42		▷ ?	18.42		▷ ?	18.42	16.99	▶G	18.42	15909	▼R	18.42	16246	▼R	18.42	16898	▼R	18.42	16898	▶R	18.42		▷ ?	18.42		▷ ?	18.42		▷ ?	AJB 2011-01-12 Based on M08 but not expected to change materially. Spend remains within agreed limits.
Andrew Bell	Michael Dinan	Control Surplus/ (Deficit)	502		▷ ?	502		▷ ?	502		▷ ?	502	526	▶G	502	526	▶G	502	526	▶G	502	526	▶G	502	501	▼R	502		▷ ?	502		▷ ?	502		▷ ?	

Accountability		PI	May 10			Jun 10			Jul 10			Aug 10			Sep 10			Oct 10			Nov 10			Dec 10			Jan 11			Feb 11			Mar 11			PI Actual
Owner	Sponsor	PI Target Name	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	Commentary
Andrew Bell	Michael Dinan	Cumulative Net surplus	935	316	▼R	1166	1126	▲R	1300	1510	▲G	1338	1848	▲G	1213	1646	▼G	1074	1042	▼R	948	543	▼R	826	-1138	▼R	713		?	607		?	502		?	AJB 2011-01-12 YTD has accounted for spend of £1.2m Command point training that was forecast to start in January. Thus, there is a negative year to date swing but not Full year effect.
Andrew Bell	Michael Dinan	EBITDA %	9.13	7.28	▲R	8.80	7.43	▲R	8.69	7.32	▷R	8.54	7.23	▲R	8.33	7	▼R	8.20	6	▼R	8.11	6	▲R	8.04	5	▼R	8.01		?	7.99		?	7.98		?	2011-01-12 EBITDA is not being achieved as there has been an in year switch which has reduced depreciation but increased other non pay which has reduced the EBITDA %
Andrew Bell	Michael Dinan	External Financing Limit (EFL)	260000		?	260000		?	260000		?	260000	260000	▷G	260000	260000	▷G	260000	260000	▷G	260000	260000	▷G	260000	260000	▷G	260000		?	260000		?	260000		?	
Andrew Bell	Michael Dinan	Liquidity Ratio	15		?	15		?	15		?	15		?	15	1	▷G	15	1	▷G	15	-67	▲G	15	-2	▷G	15		?	15		?	15		?	AJB 2011-01-01 Liquidity is based on the Month 8 Balance Sheet and is not expected to change materially at Month 9. 15 days is the Monitor target for cash cover.
Andrew Bell	Michael Dinan	Net Surplus/ (Deficit) - after Impairments	502		?	502		?	502		?	502	526	▷G	502	526	▷G	502	526	▷G	502	526	▷G	502	501	▼R	502		?	502		?	502		?	AJB 2011-01-12 Remains on target
Andrew Bell	Michael Dinan	Return on Assets (RoA)	3.42		?	3.42		?	3.42		?	3.42		?	3.42	3	▷G	3.42	3	▷G	3.42	5	▼R	3.42	5	▷R	3.42		?	3.42		?	3.42		?	AJB 2011-01-12 this is based on Month 8 as balance sheet has not yet been updated but is not expected to change materially
Andrew Bell	Michael Dinan	To process at least 95% of bills by value within 30 days	95		?	95		?	95		?	95	89	▷R	95	90	▲R	95	91	▲R	95	90	▼R	95	90	▷R	95		?	95		?	95		?	AJB 2011-01-12 Based on M08 but not expected to change materially. the trust is not expected to meet national targets in 2010/11

Accountability		PI	May 10			Jun 10			Jul 10			Aug 10			Sep 10			Oct 10			Nov 10			Dec 10			Jan 11			Feb 11			Mar 11			PI Actual
Owner	Sponsor	PI Target Name	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	G	Actual	V	Commentary
Andrew Bell	Michael Dinan	To process at least 95% of bills by volume within 30 days	95		?	95		?	95		?	95		?	95	84	R	95	85	R	95	85	R	95	85	R	95		?	95		?	95		?	AJB 2011-01-12 Based on M08 but not expected to change materially. the trust is not expected to meet national targets in 2010/11
CO8. Resources IM&T																																				
John Downard	Peter Suter	CommandPoint - CAD 2010 Milestones - % Complete JN	42		?	42		?	50		?	42	42	G	59	59	G	59	59	G	59	59	G	67	67	G	75		?	83		?			?	JN 4/1/10: Project management handover included a complete inventory check of all products and milestones marked as delivered in Stage 5. PM is happy the status is as recorded.
John Downard	Peter Suter	Target availability CAD environment as a whole	99	96.54	R	99	98.88	R	99	98.35	R	99	99.41	G	99	99.89	G	99	97.10	R	99	99.85	G	99	99.02	G	99		?	99		?	99		?	MPS CADlink disruptions.
John Downard	Peter Suter	Target availability CTAK core functionality	99.80	99.67	R	99.80	99.95	G	99.80	99.80	G	99.80	99.93	G	99.80	99.96	G	99.80	98.99	R	99.80	99.89	G	99.80	99.69	R	99.80		?	99.80		?	99.80		?	Corruption of the main user account file required a system restart (14/12). Full deployment of XC mapping caused some disruption but highlighted a configuration error which was then quickly resolved.

performance accelerator

London Ambulance Service
NHS Trust

Workforce report for Trust Board

January 2011

Workforce Report

Current Month	Dec-10	Sickness Month	Nov-10

Trust Summary

Sickness Absence
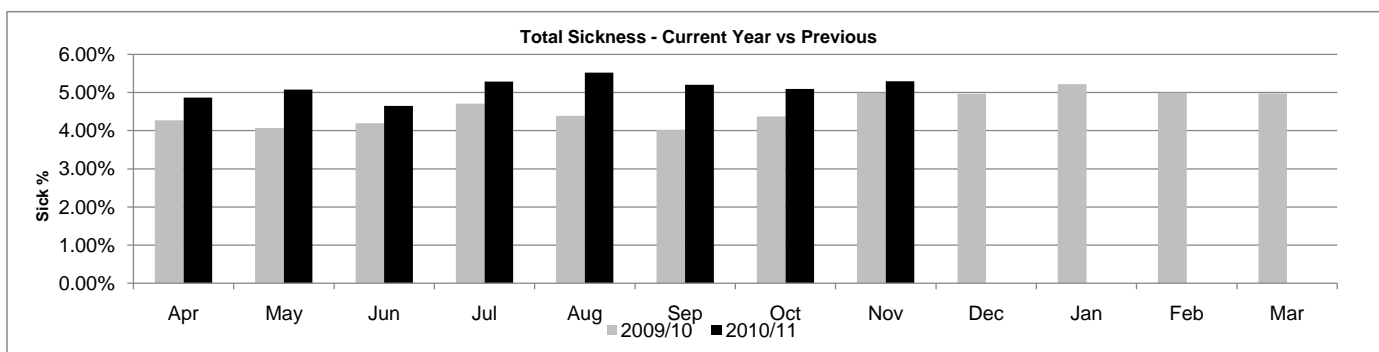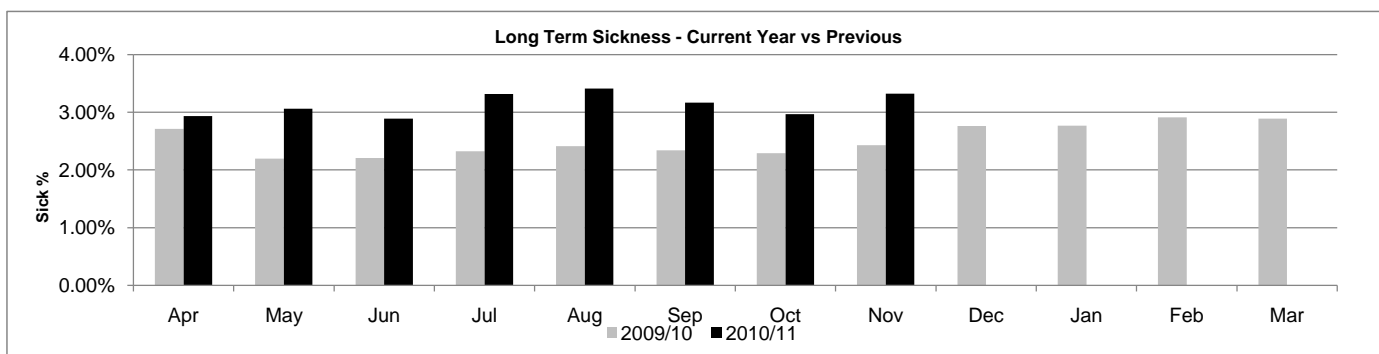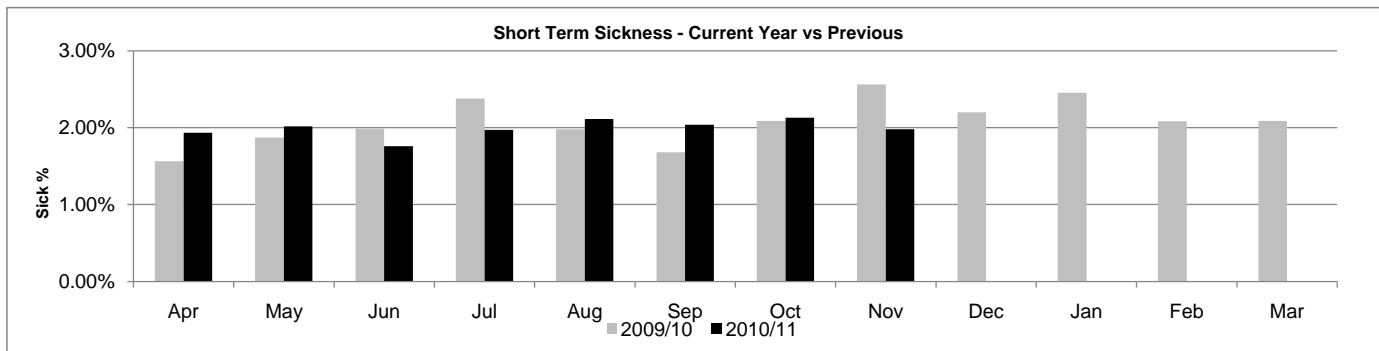
Short Term Sickness - Current Year vs Previous

Long Term Sickness - Current Year vs Previous

Total Sickness - Current Year vs Previous

Sickness 2009/10	4.61%	Current WTE	4782.12	NB Secondments and Acting Up Included in Totals
YTD Sickness	5.13%	Current Headcount	4998.00	

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2009/10	4.27%	4.07%	4.19%	4.70%	4.39%	4.02%	4.37%	4.99%	4.96%	5.22%	4.99%	4.98%
2010/11	4.87%	5.08%	4.65%	5.29%	5.52%	5.20%	5.09%	5.30%	0.00%	0.00%	0.00%	0.00%

Unauthorised Absence	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2009/10	130.00	99.00	128.00	149.00	132.00	132.00	118.00	157.00	239.00	201.00	118.00	139.00
2010/11	263.00	210.00	167.00	178.00	136.00	197.00	169.00	197.00	377.00	0.00	0.00	0.00

Narrative

Sickness

The Trust summary show that sickness absence for the financial year to November was 0.52% above last year's outturn figure and 0.63% above target (4.5%). The figures indicate that the increase has been primarily in long term absence, which monitoring suggests is being managed well; the length of the absence being dictated by the nature of the condition. Recent experience suggests that staff are waiting longer for hopsital treatment which may impact on long term absence in the future especially with the change in NHS waiting time targets. This will be monitored. No trends in the increase of specific reasons for absence have yet been identified.

Unauthorised Absences

This figure shows the number of instances when staff have reported as 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 these absences may be converted into annual leave or un/paid special leave or remain an unpaid unauthorised absence. Disciplinary action may result. Next month's report will show unauthorised absences by Area, with specific commentary.

Workforce Report

Current Month	Dec-10	Sickness Month	Nov-10

A&E Operations Areas

Sickness Absence
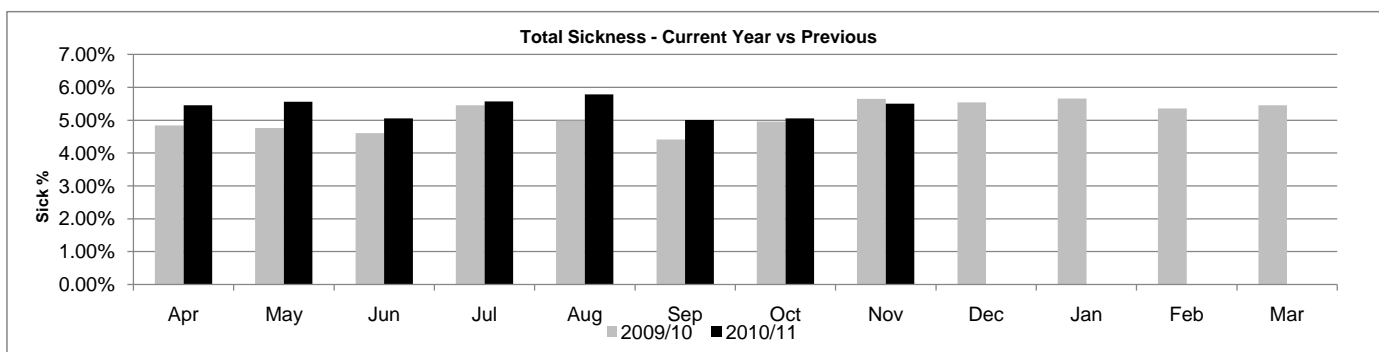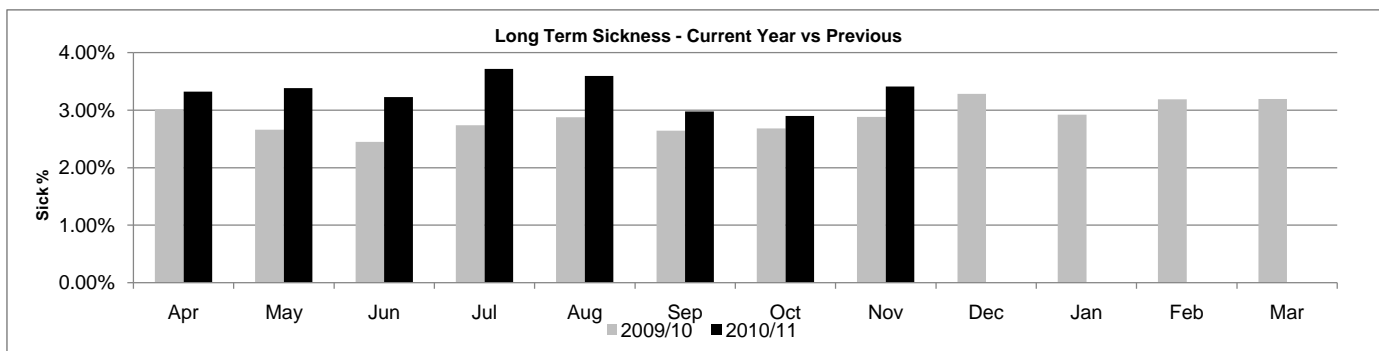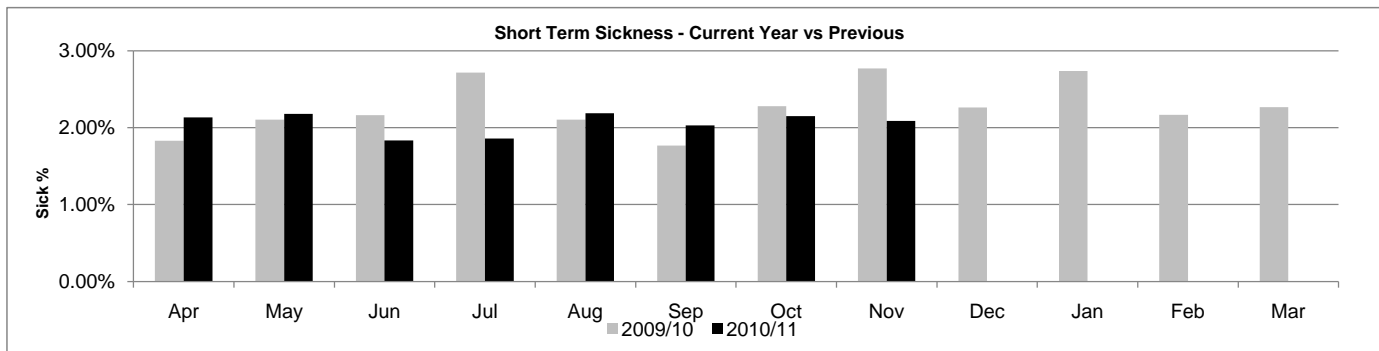
Short Term Sickness - Current Year vs Previous

Long Term Sickness - Current Year vs Previous

Total Sickness - Current Year vs Previous

Sickness 2009/10	5.15%	Current WTE	3308.46	NB Secondments and Acting Up Included in Totals
YTD Sickness	5.37%	Current Headcount	3458.00	

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2009/10	4.84%	4.76%	4.61%	5.46%	4.98%	4.41%	4.96%	5.65%	5.55%	5.66%	5.36%	5.46%
2010/11	5.45%	5.57%	5.06%	5.58%	5.79%	5.00%	5.05%	5.50%	0.00%	0.00%	0.00%	0.00%

Unauthorised Absence	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2009/10	128.00	99.00	126.00	149.00	132.00	131.00	116.00	156.00	238.00	198.00	114.00	135.00
2010/11	247.00	193.00	148.00	163.00	115.00	167.00	141.00	174.00	329.00	0.00	0.00	0.00

Narrative

West: November long term absence was greater than short term; mainly due to injuries (at work) and at that time colds/flu had not really had an impact. The trend, however, is upwards with West sickness increasing to 6.3% at the end of December and a spike in short term sickness with flu and respiratory infections starting to feature. In regards to long term absence, the West currently has 25 people absent due to injuries. These include back injuries, broken bones and shoulder problems. Although these cases are being managed well, some will be protracted due to the nature of the illness or injury.

South: Figures for the current financial year indicate a slight increase in absence compared to the previous year. Monthly audits of attendance management are ongoing. Some of the audits that were completed in November indicated that further management action was required and this has been addressed with the managers concerned. In total, 23 people across the South area were absent with long-term absence issues during November. These were mainly musculo-skeletal injuries and were being managed appropriately. It is expected that the absence figures for December will show an increase on that of November due to the apparent prevalence of flu/'flu like' illnesses.

East: Total sickness increased by nearly 18.1% between October and November. This increase is comprised of an increase in short-term sickness of 12.2% and an increase in long-term sickness of 28.5%. Increases have continued into December with overall East Area sickness increasing by almost 23.3% over November and was 8.0% of rostered hours. Whilst long-term sickness increased by 12.3% over November, short-term sickness increased by 30.2% for the month. In December short-term sickness alone was responsible for a sickness rate of nearly 5.2%. This is evidenced by the significant increase in cold/'flu absences reported. Sick-card audits in the East Area are conducted on a monthly basis and all produce a 'green' result. Sickness is being managed well.
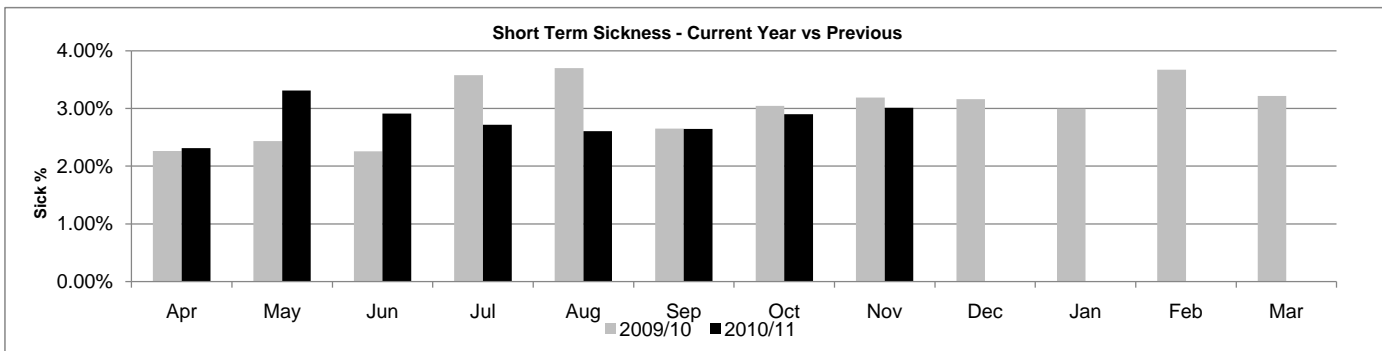
Workforce Report

Current Month	Dec-10	Sickness Month	Nov-10

Control Services

Sickness Absence
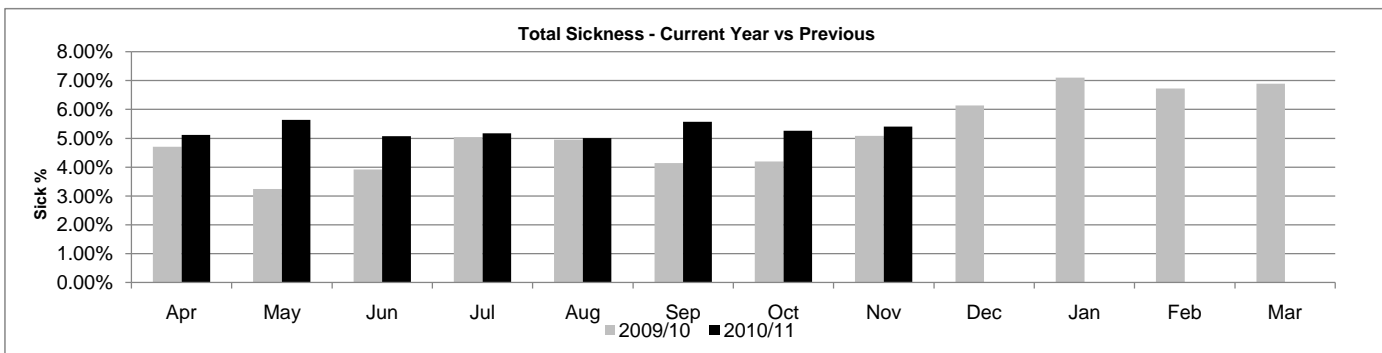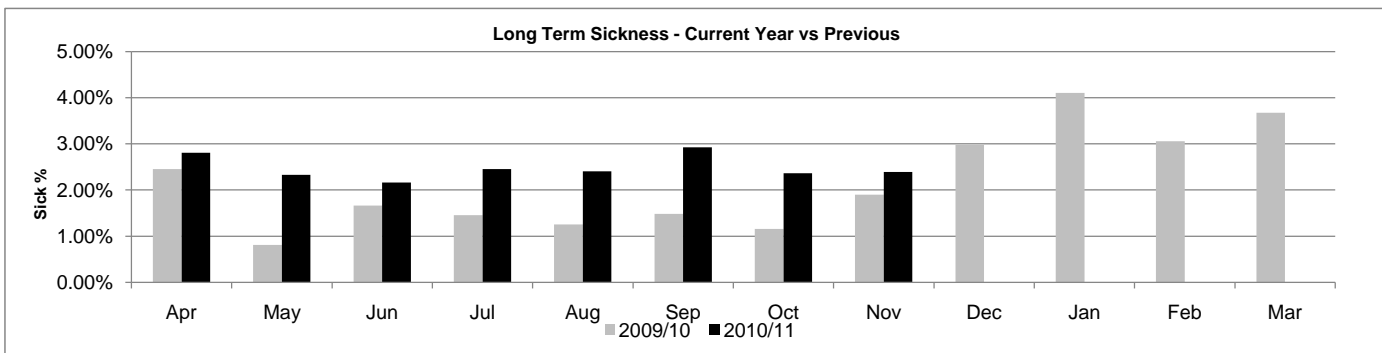
Short Term Sickness - Current Year vs Previous

Long Term Sickness - Current Year vs Previous

Total Sickness - Current Year vs Previous

Sickness 2009/10	5.19%	Current WTE	442.18	NB Secondments and Acting Up Included in Totals
YTD Sickness	5.28%	Current Headcount	465.00	

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2009/10	4.71%	3.25%	3.92%	5.03%	4.95%	4.14%	4.20%	5.09%	6.14%	7.10%	6.72%	6.89%
2010/11	5.12%	5.64%	5.07%	5.17%	5.01%	5.57%	5.27%	5.40%	0.00%	0.00%	0.00%	0.00%

Unauthorised Absence	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2009/10	2.00	0.00	2.00	0.00	0.00	1.00	2.00	1.00	1.00	3.00	4.00	4.00
2010/11	16.00	17.00	19.00	15.00	21.00	30.00	28.00	23.00	48.00	0.00	0.00	0.00

Narrative

Sickness for Control Services has remained fairly static April to November (5.12 lowest to 5.64 highest). November's figures show a slight increase in short term sickness October to November (but a drop from 2009) with no change in long term absence month on month, but an increase year on year. In November the 'cold/flu season had not impacted. December's figures will show a more significant rise.

In November 12 people were on long term sickness absence. This figure has increased as people on short term absence move into long term at 4 weeks.

Audits and monitoring indicate that in the main absence is being managed in accordance with the MAP.

Detail regarding the management of U/As will be included next month.

Workforce Report

Current Month	**Dec-10**	**Sickness Month**	**Nov-10**

Human Resources & Organisation Dev Directorate

Sickness Absence

Short Term Sickness - Current Year vs Previous

Long Term Sickness - Current Year vs Previous

Total Sickness - Current Year vs Previous

Sickness 2009/10	1.88%	**Current WTE**	251.15	**NB Secondments and Acting Up Included in Totals**
YTD Sickness	2.84%	**Current Headcount**	263.00	

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2009/10	0.85%	1.06%	1.64%	1.38%	1.41%	1.22%	1.30%	1.83%	2.95%	3.12%	2.84%	3.16%
2010/11	2.03%	2.70%	2.52%	3.12%	3.29%	4.34%	3.44%	2.14%	0.00%	0.00%	0.00%	0.00%

Narrative

Short-term absence
The level of short term sickness has decreased steadily since August 2010 with 8 members of staff absent for short periods during the month of November. This is being managed appropriately.

Long term absence
The level of long-term absence has reduced since September 2010 with three members of staff absent in the month of November. All cases are being managed appropriately.

Workforce Report

Current Month   Dec-10   **Sickness Month**   Nov-10

Finance & Business Planning Directorate

Sickness Absence
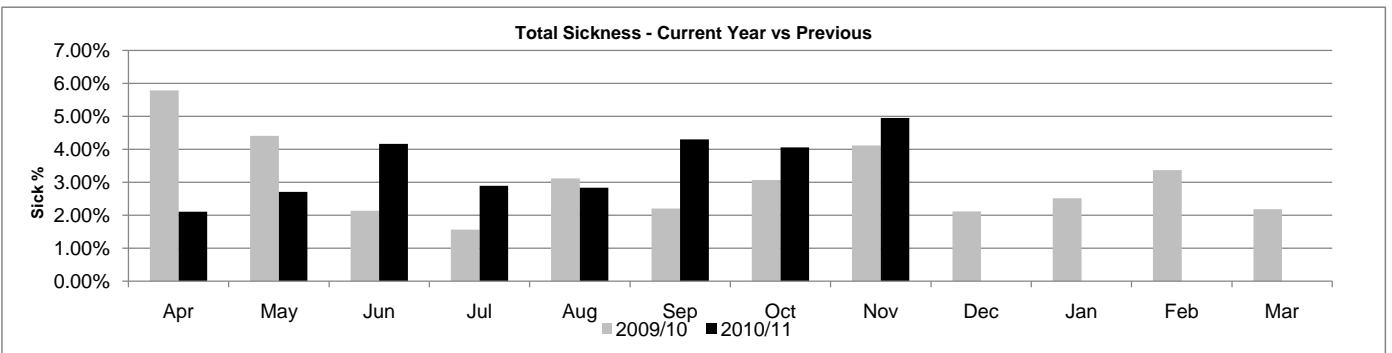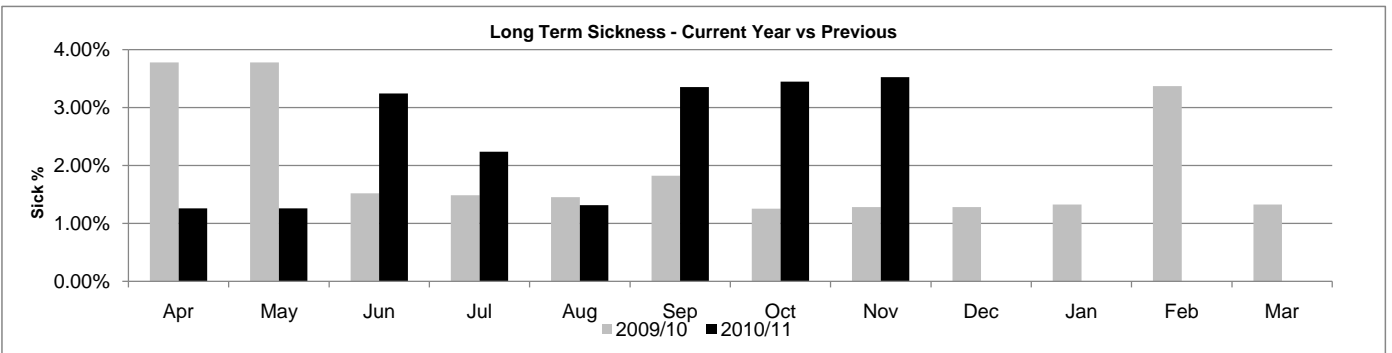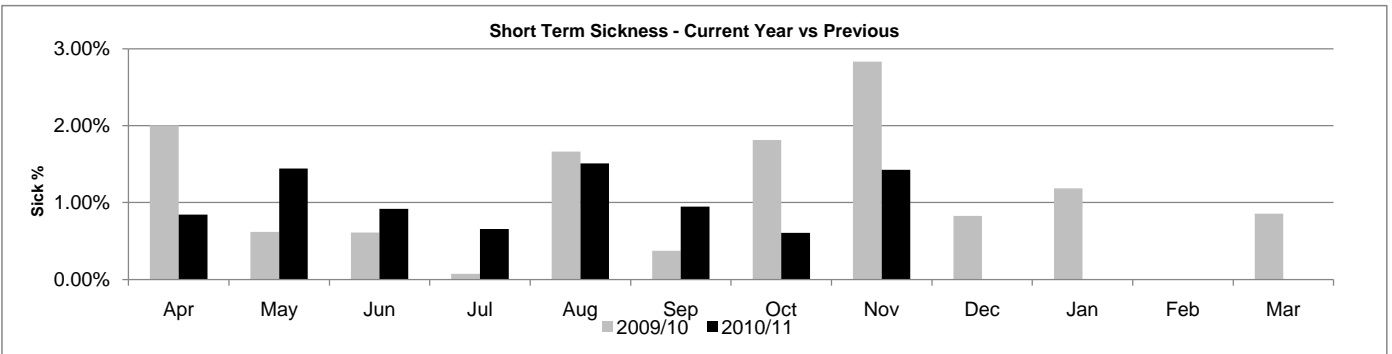
Short Term Sickness - Current Year vs Previous

Long Term Sickness - Current Year vs Previous

Total Sickness - Current Year vs Previous

Sickness 2009/10	3.04%	Current WTE	46.78
YTD Sickness	3.47%	Current Headcount	49.00

NB Secondments and Acting Up Included in Totals

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2009/10	5.78%	4.40%	2.13%	1.56%	3.12%	2.20%	3.07%	4.11%	2.11%	2.51%	3.37%	2.18%
2010/11	2.10%	2.70%	4.16%	2.89%	2.83%	4.30%	4.06%	4.95%	0.00%	0.00%	0.00%	0.00%

Narrative

Short-term sickness
Short-term absence increased slightly during November with 4 members of staff absent for short periods of time.

Long term sickness
Long term absence has increased. The contract of one person on long term sickness was terminated on the 30th November 2010. Two members of staff are absent; one through (work related) stress and the other following a trip abroad

Workforce Report

Current Month	Dec-10	Sickness Month	Nov-10

Information Management & Technology Directorate

Sickness Absence

Short Term Sickness - Current Year vs Previous

Long Term Sickness - Current Year vs Previous

Total Sickness - Current Year vs Previous

Sickness 2009/10	1.74%	Current WTE	78.53	NB Secondments and Acting Up Included in Totals
YTD Sickness	1.65%	Current Headcount	80.00	

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2009/10	1.80%	0.68%	1.50%	2.14%	2.85%	1.90%	2.21%	0.99%	0.59%	2.73%	2.22%	1.33%
2010/11	1.53%	1.55%	2.08%	0.93%	2.56%	1.75%	1.36%	1.40%	0.00%	0.00%	0.00%	0.00%

Narrative

Short-term sickness
Short term sickness has reduced with 6 members of staff absent for short periods during the month of November. Audits indicate that absence is being managed in accordance with MAP.

Long term absence
One member of staff commenced long term sickness during the month of November. this case is being managed appropriately.

Workforce Report

Current Month   **Dec-10**   **Sickness Month**   **Nov-10**

Corporate Services Directorate

Sickness Absence
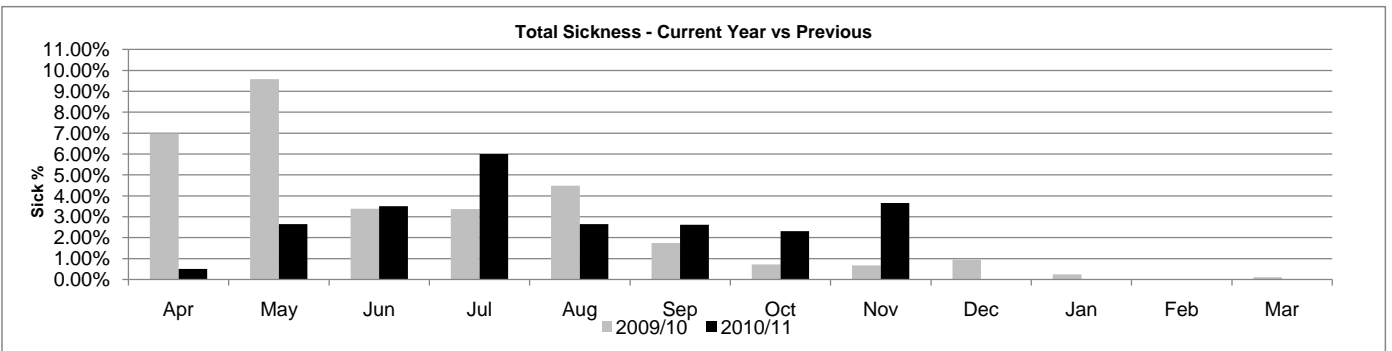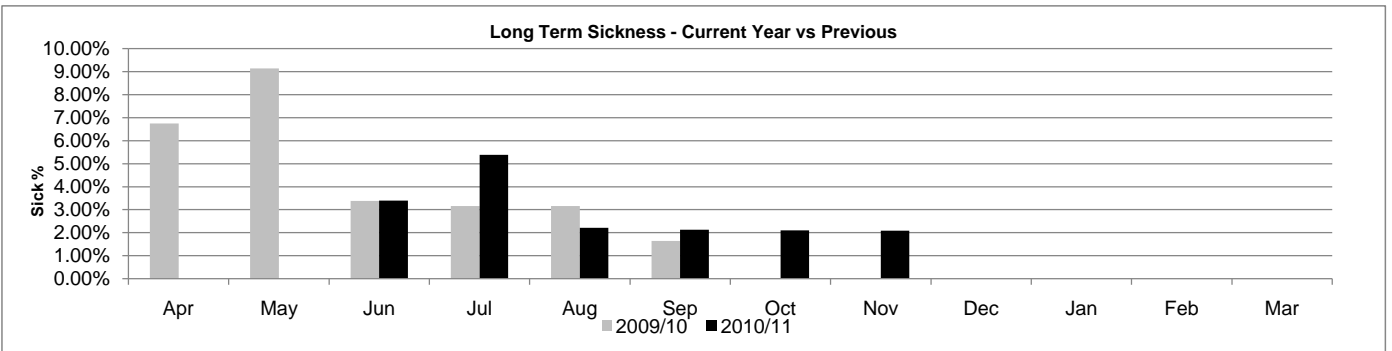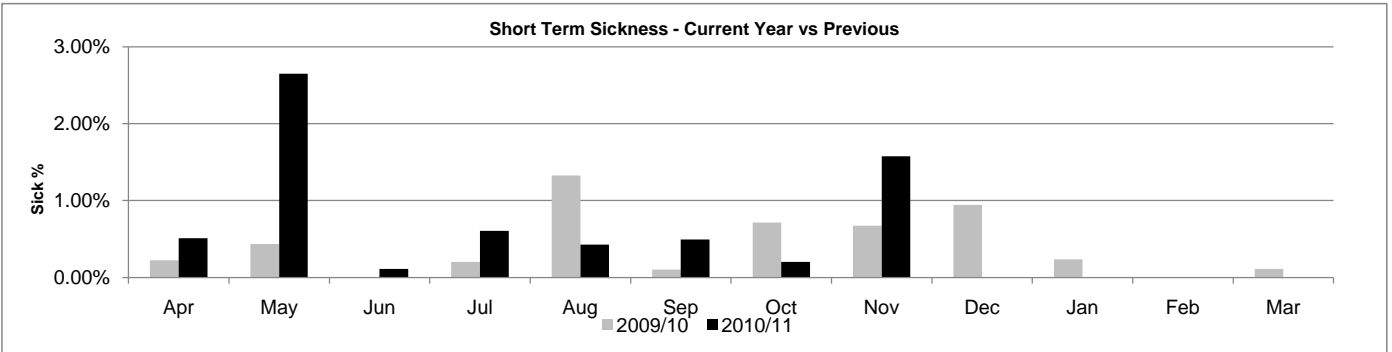
Short Term Sickness - Current Year vs Previous

Long Term Sickness - Current Year vs Previous

Total Sickness - Current Year vs Previous

Sickness 2009/10	2.72%	**Current WTE**	47.93	**NB Secondments and Acting Up Included in Totals**		
YTD Sickness	3.11%	**Current Headcount**	49.00			

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2009/10	6.98%	9.58%	3.38%	3.37%	4.49%	1.74%	0.71%	0.68%	0.95%	0.24%	0.00%	0.11%
2010/11	0.51%	2.65%	3.51%	5.99%	2.65%	2.62%	2.31%	3.66%	0.00%	0.00%	0.00%	0.00%

Narrative

Short term sickness
Short term absence has increased with 5 members of staff absent for short periods during the month of November. This appears to be due to seasonal colds and flu

Long-term sickness
The one member of staff on long term sickness resigned w.e.f. 30th November 2010

Workforce Report

Current Month   **Dec-10**   **Sickness Month**   **Nov-10**

Medical Directorate

Sickness Absence

Short Term Sickness - Current Year vs Previous

Long Term Sickness - Current Year vs Previous

Total Sickness - Current Year vs Previous
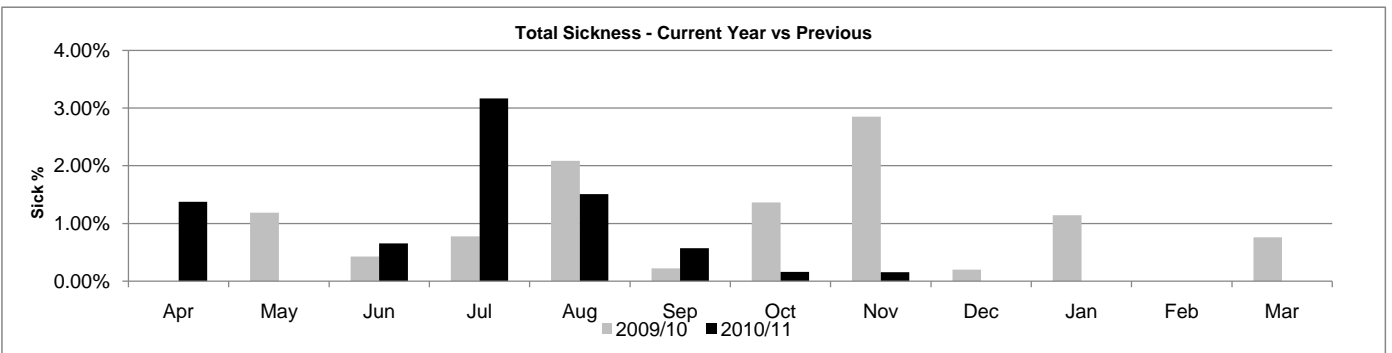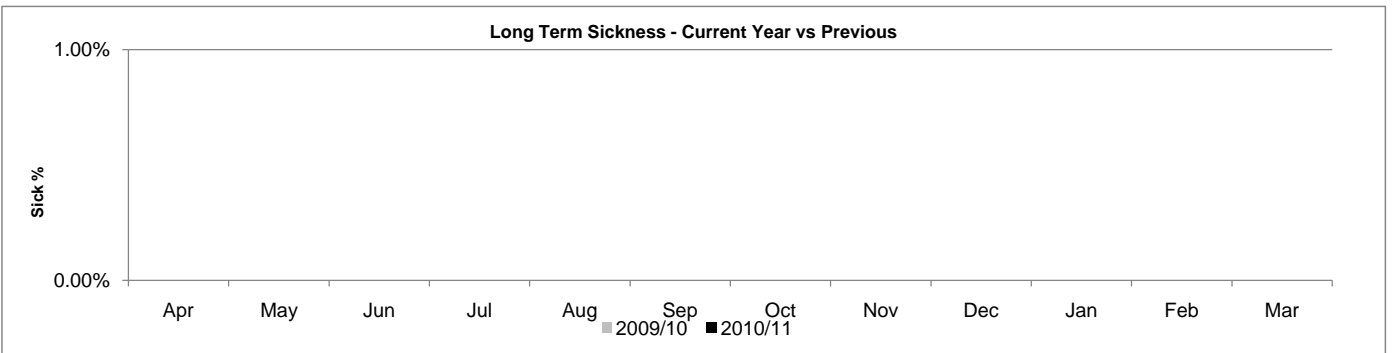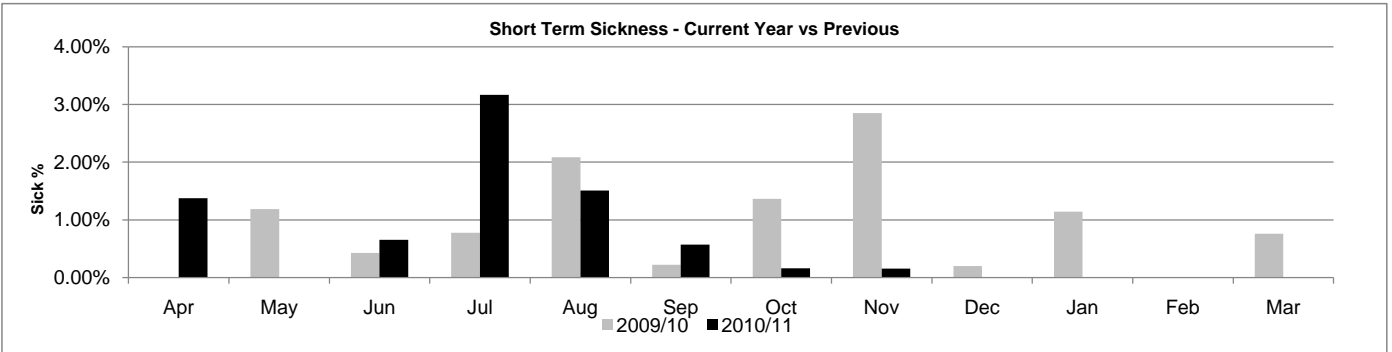
Sickness 2009/10	0.93%	**Current WTE**	21.42	**NB Secondments and Acting Up Included in Totals**
YTD Sickness	0.97%	**Current Headcount**	23.00	

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2009/10	0.00%	1.19%	0.43%	0.78%	2.09%	0.22%	1.36%	2.85%	0.20%	1.14%	0.00%	0.76%
2010/11	1.37%	0.00%	0.65%	3.17%	1.51%	0.57%	0.16%	0.16%	0.00%	0.00%	0.00%	0.00%

Narrative

Short-term sickness
One member of staff absent during the month of November

Long term sickness
None

Workforce Report

Current Month	**Dec-10**	**Sickness Month**	**Nov-10**

Chief Executive

Sickness Absence
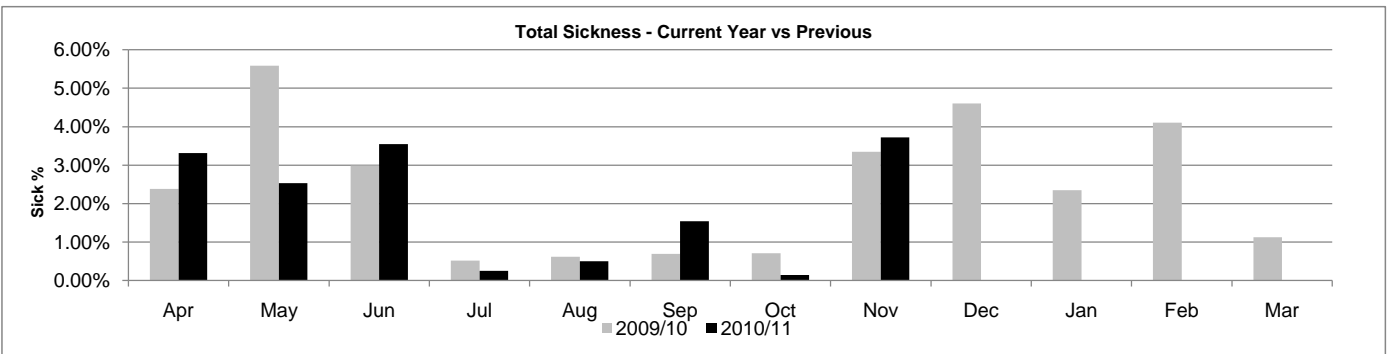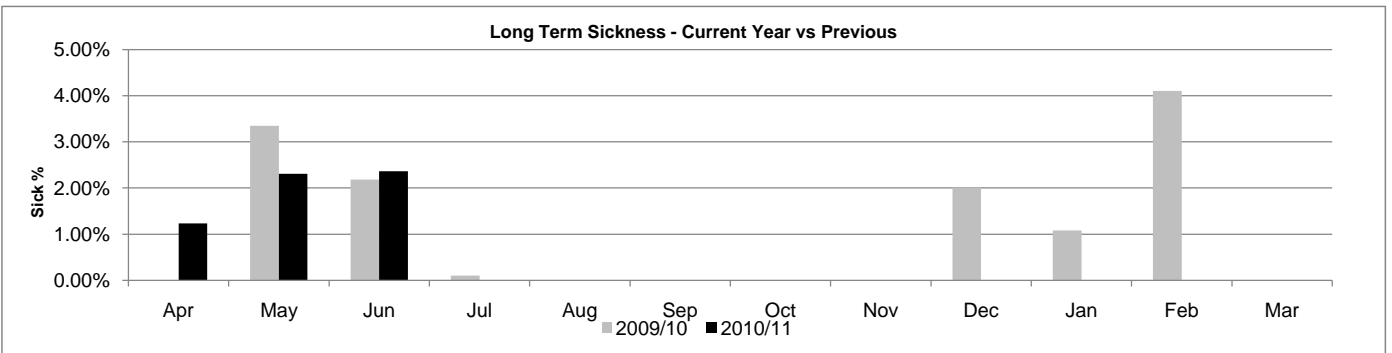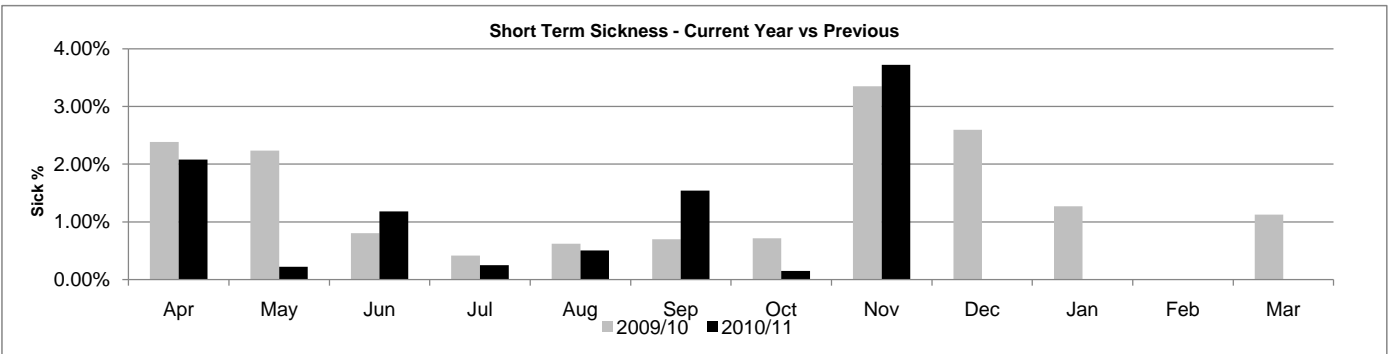
Short Term Sickness - Current Year vs Previous

Long Term Sickness - Current Year vs Previous

Total Sickness - Current Year vs Previous

Sickness 2009/10	2.40%	**Current WTE**	20.61	**NB Secondments and Acting Up Included in Totals**
YTD Sickness	2.18%	**Current Headcount**	21.00	

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2009/10	2.38%	5.58%	2.99%	0.52%	0.62%	0.70%	0.71%	3.35%	4.60%	2.35%	4.10%	1.12%
2010/11	3.31%	2.53%	3.55%	0.25%	0.50%	1.54%	0.15%	3.72%	0.00%	0.00%	0.00%	0.00%

Narrative

Short term sickness
One member of staff absent for one day

Long term sickness
none

Workforce Report

Current Month	Dec-10	Sickness Month	Nov-10

Patient Transport Service

Sickness Absence
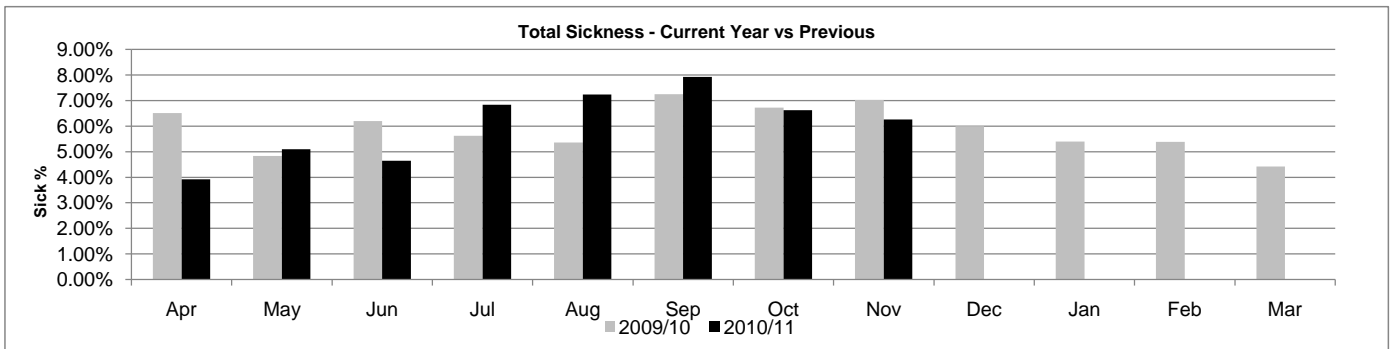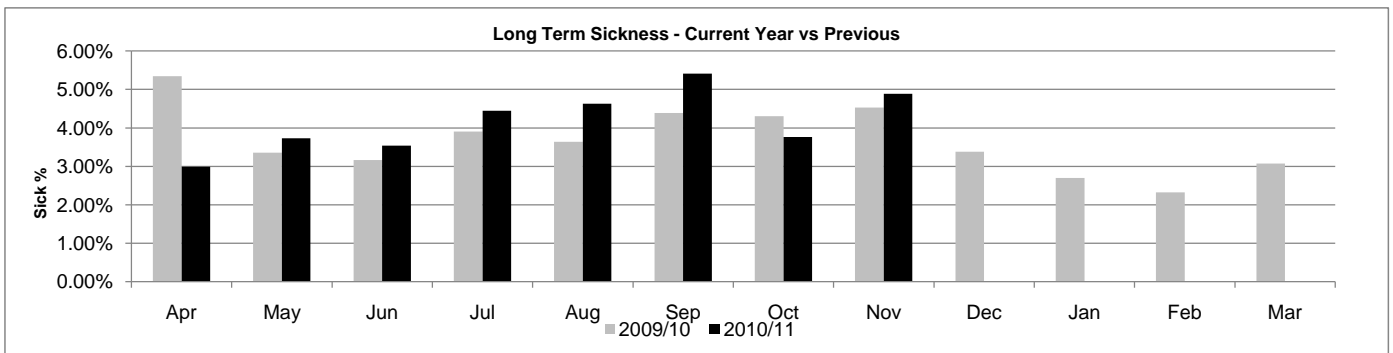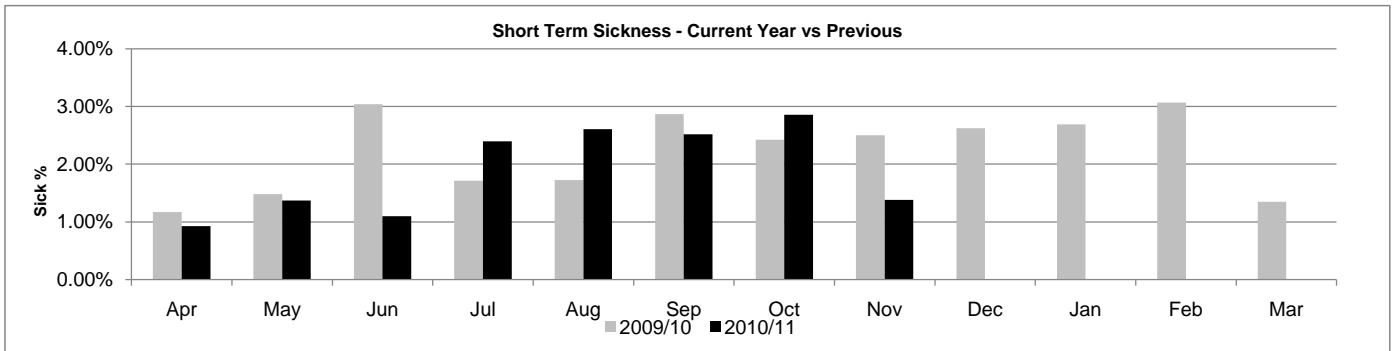
Short Term Sickness - Current Year vs Previous

2009/10 2010/11

Long Term Sickness - Current Year vs Previous

2009/10 2010/11

Total Sickness - Current Year vs Previous

2009/10 2010/11

Sickness 2009/10	5.89%	Current WTE	191.45	NB Secondments and Acting Up Included in Totals
YTD Sickness	6.03%	Current Headcount	201.00	

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2009/10	6.51%	4.84%	6.20%	5.62%	5.36%	7.25%	6.72%	7.03%	6.01%	5.39%	5.39%	4.42%
2010/11	3.92%	5.10%	4.64%	6.84%	7.23%	7.93%	6.62%	6.27%	0.00%	0.00%	0.00%	0.00%

Narrative

Short term sickness
Short term sickness has reduced significantly since July 2010, having peaked in October. Audits indicate that attendance is being managed in accordance with MAP.

Long term sickness
Six members of staff were on long term sickness in November. One member of staff is currently on notice following a capability hearing, two have returned to work in January 2011, three are being actively managed in accordance with policy.

Current Month	**Dec-10**	**Sickness Month**	**Nov-10**

Operational Support

Sickness Absence

Short Term Sickness - Current Year vs Previous

Long Term Sickness - Current Year vs Previous

Total Sickness - Current Year vs Previous
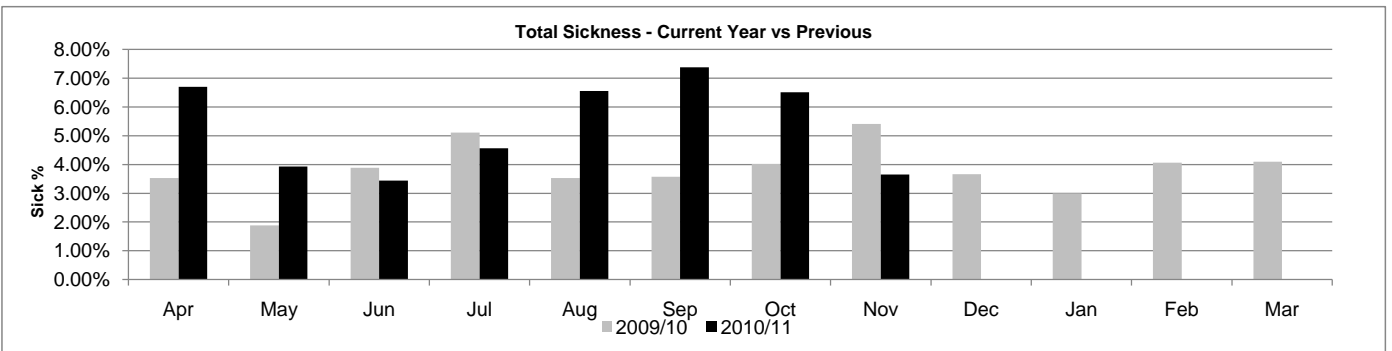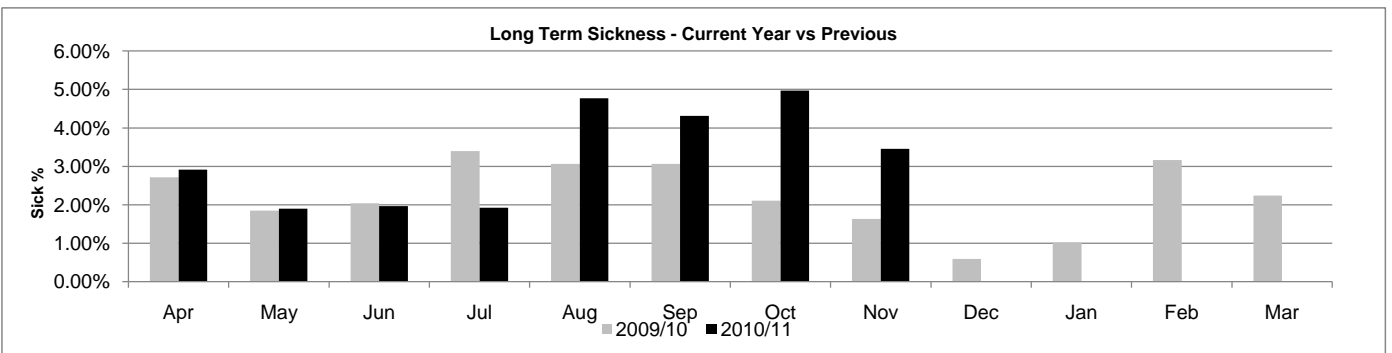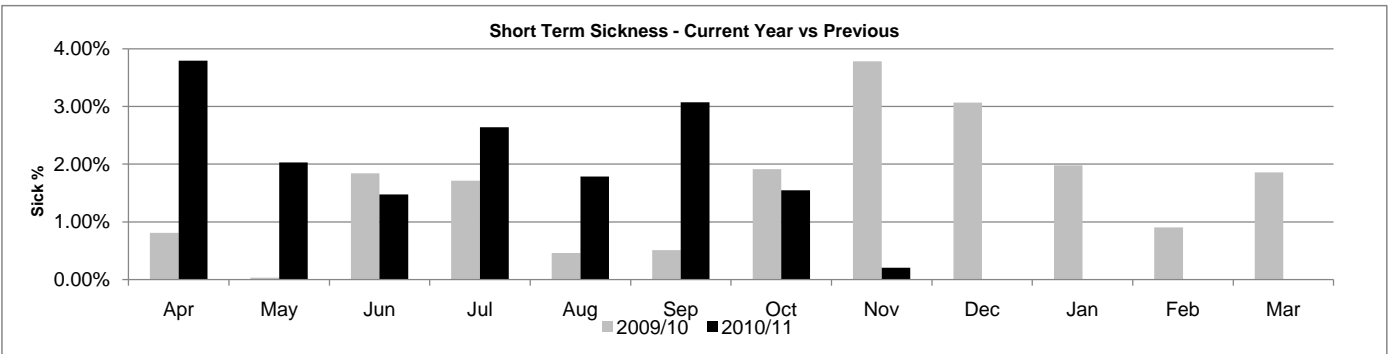
Sickness 2009/10	3.81%	**Current WTE**	114.85	**NB Secondments and Acting Up Included in Totals**
YTD Sickness	5.36%	**Current Headcount**	116.00	

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2009/10	3.53%	1.88%	3.88%	5.11%	3.53%	3.58%	4.02%	5.42%	3.66%	3.00%	4.07%	4.09%
2010/11	6.70%	3.93%	3.44%	4.57%	6.55%	7.38%	6.52%	3.66%	0.00%	0.00%	0.00%	0.00%

Narrative

Short term sickness
10 staff absent for short periods during November

Long term sickness
5 staff absent during the month; 1 in the process of applying for Ill Health Retirement; papers being prepared for one attendance capability; one 'planned' absence

Workforce Report

Current Month   **Dec-10**

Trust Summary

Health & Safety Issues

Manual Handling Injuries - Current Year vs Previous

■ 2009/10 ■ 2010/11

Non Physical Abuse - Current Year vs Previous

■ 2009/10 ■ 2010/11

Physical Violence - Current Year vs Previous

■ 2009/10 ■ 2010/11
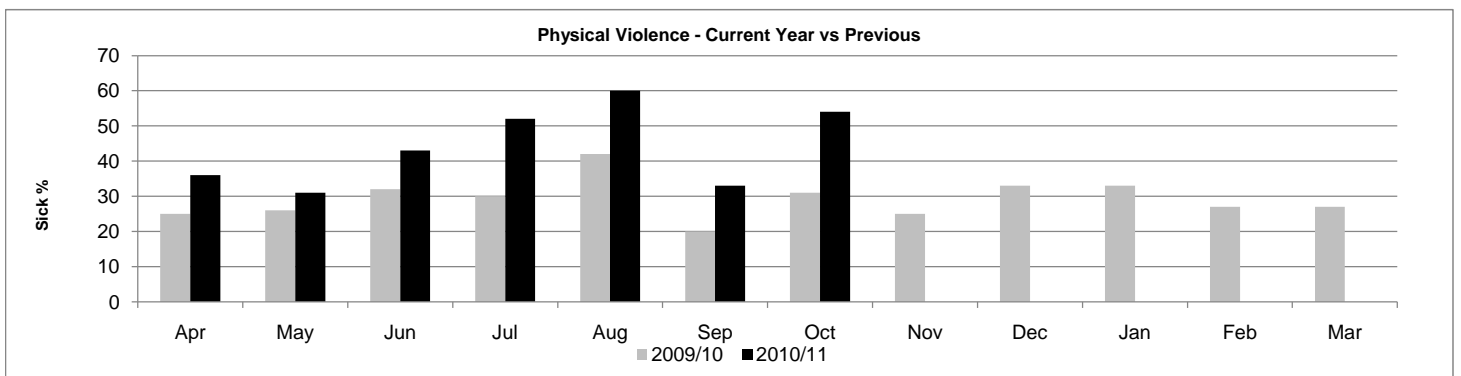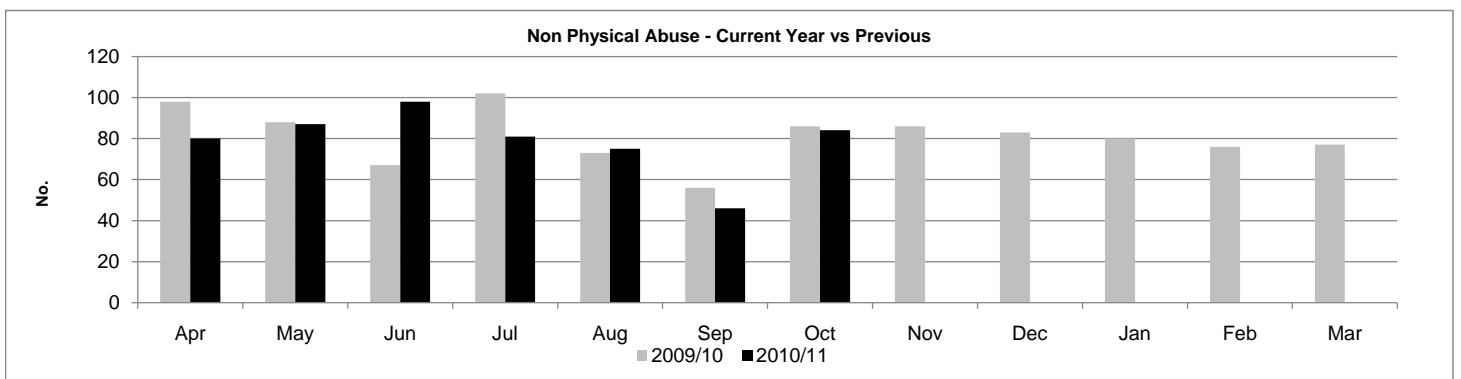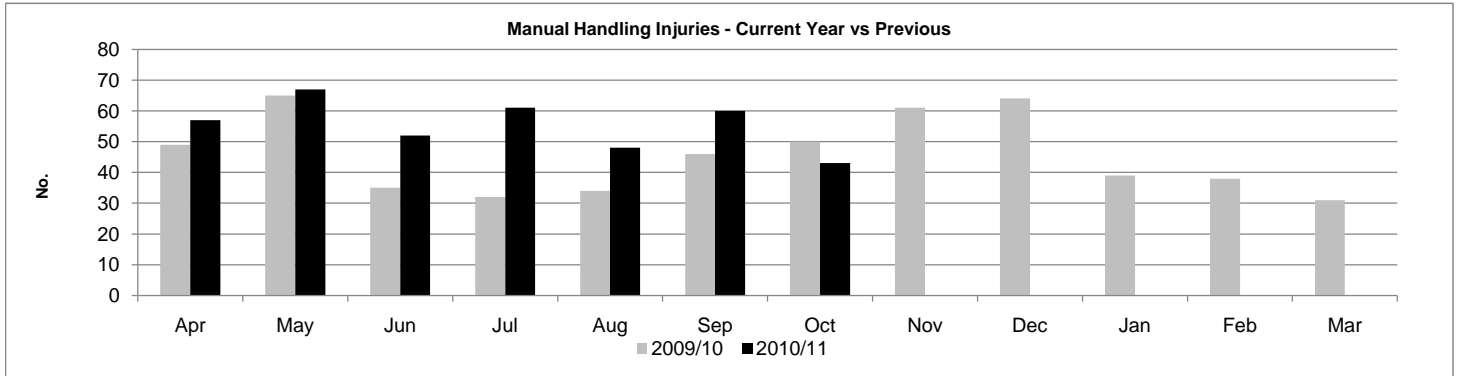
Narrative

Historically there is a lag between date of incident and date of receipt at Safety and Risk. ADOs routinely receive reports detailing such delays.

Faxing of incident reports has been trialled abd has improved timeliness in the pilot areas. The formal review of incident reporting will also review the whole process, and a pilot involving East Central and telephone reporting to EBS, aiming to get as near as possible to real-time reporting, will commence in January 2011.

Overall, reporting trend-lines show a general decline (improvement) in reports of adverse incidents in lifting and carrrying and non-physical abuse, but increases in reports of physical violence. This may reflect the work undertaken by the Local Security Management Specialist in raising awareness and also in building links with local police in the Boroughs, particularly since his permanent appointment to the role. This category will be carefully monitored.

Workforce Report

Current Month   **Dec-10**

Trust Summary

Vacancies & Turnover

	Funded WTE	Inpost WTE	Variance
Trust Total	4969.59	4707.64	-261.95
Directorate			
A&E Operations Areas	3433.87	3305.90	-127.97
Chief Executive	18.55	14.61	-3.94
Control Services	404.73	438.24	+33.51
Corporate Services Directorate	56.56	46.93	-9.63
Finance & Business Planning Directorate	54.35	47.13	-7.22
Health Promotion & Quality	2.00	1.00	-1.00
Human Resources & Organisation Dev Directorate	258.92	231.93	-26.99
Information Management & Technology Directorate	98.98	78.53	-20.45
Medical Directorate	26.80	20.21	-6.59
Operational Support	120.86	112.85	-8.01
Patient Transport Service	212.64	158.27	-54.37
Trust Board	7.00	7.00	+0.00

Turnover

2009/10	6.2%	Apr-09 to Mar-10
2010/11	7.1%	12 Months up to Dec-10

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No. Leavers (FTE)												
2009/10	19.00	27.00	19.00	19.00	30.00	29.00	24.00	25.00	21.00	20.00	28.00	35.00
2010/11	44.00	32.00	11.00	27.00	28.00	34.00	22.00	52.00	18.00	0.00	0.00	0.00
No. Starters (FTE)												
2009/10	82.00	59.00	53.00	59.00	43.00	147.00	81.00	90.00	5.00	103.00	56.00	64.00
2010/11	10.00	6.00	28.00	21.00	13.00	70.00	37.00	62.00	6.00	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   **Dec-10**

Trust Summary

Employee Relations Data

	Attendance	Grievances	Capabilities	Discipliary (Clinical)	Discipliary (Non Clinical)
Current Case Total	288	15	5	0	13

Current Employment Tribual Cases	12		**Current Suspensions**	9

Narrative

As these figures have not been reported on a monthly basis before now, it is not possible to evidence if current levels of activity are normal or abnormal.
Attendance
This figure represents all employees who are being managed under various stages of the MAP, including long term sickness cases which are being considered in terms of capability (health).
Capabilities
This figure represents cases which are being dealt with under the Performance Capability policy.
Disciplinary
Although the perception remains that staff are disciplined for clinical errors, this data, which we do know is typical demonstrates that a disciplinary case concerning clincal matters is not commonplace.
Employment Tribunal
Two of these cases are equal pay claims which were lodged in 2007. Of the remaining 10, five were lodged in the first half of 2010.
Suspensions
The longest suspension dates from the end of September 2011. This case and one other have since come to closure with dismissals taking place.
Hearing for two other cases have already been scheduled for January

Workforce Report

Current Month   **Dec-10**

Trust Summary

PDR Completion Rates

Area / Directorate / Dept	No. to be done	No. done	% Comleted
West	857	574	67.0%
South	1147	503	43.9%
East	1043	248	23.8%
Control Services	596	183	30.7%
Sub Total	3643	1508	41.4%
PTS	220	117	53.2%
IM&T	80	77	96.3%
Operational Support	104	69	66.3%
Medical	23	23	100.0%
Communications	17	16	94.1%
Corporate Services	37	35	94.6%
HR and OD	149	142	95.3%
Finance & Business Planning incl Estates	51	42	82.4%
Sub Total	681	521	76.5%
Total	4324	2029	46.9%

NB figures currently based on HR PDR completion spreadsheet

London Ambulance Service **NHS**

NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

M09 December

PAPER FOR REVIEW

Document Title:	**M09 December - Financial Review**
Report Author(s):	Andy Bell
Lead Director:	Mike Dinan
Contact Details:	Michael.Dinan@lond-amb.nhs.uk
Why is this coming to the Trust Board?	Monthly Trust Financial Review
This paper has been previously presented to:	Senior Management Group
Recommendation for the Trust Board:	To be noted
Executive Summary/key issues for the Trust Board	

- Overall the Trust remains on track to meet its year end control target of a £501k surplus. CIP remains on target to be achieved and the Financial risk remain the same as Month 8. The Cash and Capital position remain on track as per the November Board papers.

The In Month position for the Trust is a £542k loss against a forecast loss of £454k.

- In Month 9, the Trust received additional income from Department of Health for maintenance of mass casualty vehicles of £241.5k. This additional income is offset by increases in expenditure to provide additional resilience in order to meet National targets.

- The Trust's deficit was higher than forecast mainly due to a £124k adjustment on previously recognised profit on sale and leaseback transaction.

- Pay expenditure has reduced due to departure of PTS staff.

- Non pay spend has increased due to higher spend incurred in Staff Related expenditure and Medical Consumables in line with increase in demand.

YTD the trust is reporting a breakeven against a plan surplus of £826k.

The Trust is expected to record a surplus of £501k for the year.

- Overall Trust Expenditure has increased by £235k from £23,779k to £24,014k. Pay has dropped by £154k

- Additional Overtime has been forecast in January and February due to continuing operational pressures and to meet performance target and demand. In line with this, Fuel has also been adjusted upwards to reflect the increase in activity.

- The Trust forecast outturn position includes a net penalty and with held CQUIN of £700k. This has yet to be agreed with PCT Commissioners

The Identified Financial Risk for the Trust has been identified as £1.32m. The current forecast includes a provision of £700k relating to PCT penalties and CQUIN adjustments.

The CIP Program is currently on track to deliver £18.3m savings (Page 8).

- £13.6m of original CIP will be delivered as planned which will be the largest CIP ever achieved by LAS.

- The CIP program is currently on track to deliver the full £18.4m savings program. Further work on achieving Subsistence and Non frontline payroll savings are ongoing.

Capital funding is forecast to be £16.11m. This is in line with the CRL .

Current cash position is £2.2m.

London Ambulance Service NHS

NHS Trust

Trust Board - Financial Review

Month Ending 31st December 2010 - (Month 9)

Report Contents

LAS Financial Review - Financial Summary

Month Ending 31st December 2010 - (Month 9)

Month M09 December				Summary	Ytd M09 December				2010/11			
Act £000	Plan £000	Diff £000	%		Act £000	Plan £000	Diff £000	%	Fcast £000	Plan £000	Diff £000	%
				Income								
21,737	21,578	159	0.7%	A&E	193,330	194,198	-868	-0.4%	259,079	258,931	148	0.1%
1,735	1,847	-112	-6.1%	Other	18,574	16,626	1,949	11.7%	23,122	22,167	954	4.3%
23,472	**23,425**	**47**	**0.2%**	**Total**	**211,904**	**210,824**	**1,080**	**0.5%**	**282,201**	**281,098**	**1,103**	**0.4%**
				Operating Expense								
17,305	17,080	225	1.3%	Pay	157,325	152,125	5,200	3.4%	207,982	203,752	4,230	2.1%
5,320	4,589	731	15.9%	Non Pay	42,422	41,744	678	1.6%	57,125	54,926	2,199	4.0%
22,625	**21,669**	**956**	**4.4%**	**Total**	**199,746**	**193,869**	**5,877**	**3.0%**	**265,107**	**258,678**	**6,429**	**2.5%**
847	1,756	-909	-51.7%	**EBITDA**	12,158	16,955	-4,797	-28.3%	17,094	22,420	-5,326	-23.8%
3.61%	7.50%	-3.89%	-51.8%	EBITDA %	5.74%	8.04%	-2.30%	-28.7%	6.06%	7.98%	-1.92%	-24.1%
1,389	1,878	-489	-26.0%	**Depreciation, Dividend & Interest**	12,158	16,129	-3,971	-24.6%	16,593	21,918	-5,326	-24.3%
-542	-122	-420	344.1%	**Net Surplus/(Deficit)**	0	826	-826	-100.0%	501	502	-1	-0.2%
-2.31%	-0.52%	-1.79%	343.2%	Net Margin	0.00%	0.39%	-0.39%	-100.0%	0.18%	0.18%	0.00%	-0.6%
0	0	0	#DIV/0!	Impairment	0	0	0	#DIV/0!	0	0	0	#DIV/0!
-542	-122	-420	344.1%	**Net Surplus/ (Loss) After Impairment**	0	826	-826	-100.0%	501	502	-1	-0.2%
				Average Capital Employed	109,319	109,578	-259	-0.2%	111,454	109,578	1,876	1.7%
				Return on Assets	5.17%	5.85%	-0.68%		5.17%	5.85%	-0.68%	

LAS Financial Review - Financial Performance Indicator

Month Ending 31st December 2010 - (Month 9)

| Key Financial Performance Targets	Performance				Forecast				Status		
	Ytd Position				2010/11						
	Act	Plan	Diff	%	Fcast	Plan	Diff	%	Current	Trend	Forecast
	£000	£000	£000		£000	£000	£000		(YTD)		
1. EBITDA *Monitor*	12,158	16,955	(4,797)	-28.3%	17,094	22,420	(5,326)	-23.8%	↓	↑	↓
2. EBITDA % *Monitor*	5.74%	8.04%	-2.30%	-29%	6.06%	7.98%	-1.92%	-24.1%	↓	↓	↓
3. Control Surplus/(Deficit) *NHSL*	0	826	(826)	-100%	501	502	(1)	-0.3%	↓	↑	↔
4. Net Surplus/(Deficit) - after Impairments *Monitor/DH*	0	826	(826)	-100%	501	502	(1)	-0.3%	↓	↑	↔
5. Cost Improvement Program (CIP) *NHSL*	13,120	12,978	142	1%	18,439	18,439	(0)	0.0%	↑	↑	↔
6. Return on Assets (RoA) *Monitor - Net Surplus less PDC, Impairment & Gains/(loss) on disposal / Ave. Total Assets employed (less interest bearing borrowings*	5.17%	5.85%	-0.68%	-12%	5.17%	5.85%	-0.68%	-11.6%	↓		↓
7. Capital Resource Limit (CRL) *DH*	13,814	13,814	0	0%	16,107	18,419	(2,312)	-12.6%	↔		↓
8. External Financing Limit (EFL) *DH*	(260)	(260)	0	0%	(260)	(260)	0	0.0%	↔		↔
9. Liquidity Ratio *Monitor - Numbers of Days liquid asset cover for Trust Total Operating Expenditure*	(2.09)	15.00	(17)	-114%	(8.22)	15.00	(23.22)	-154.8%	↓		↓
10. To process at least 95% of bills by value within 30 days *DH*	90%	95%	-5%	-5%	90%	95%	-5%	-5.3%	↓		↓
11. To process at least 95% of bills by volume within 30 days *DH*	85%	95%	-10%	-10%	86%	95%	-9%	-9.5%	↓		↓
12. LAS Trust Management Costs *DH - Calculated as % of Total LAS Income (Excl. MPET)*	6.7%	7.0%	-0.3%	-4%	6.7%	7.0%	-0.3%	-4.4%	↔		↔

- The Reduction against plan of EBITDA % is largely due to increasing Operating cost pressures particularly in non frontline pay and non pay items such as vehicle maintenance, subsistence and make ready. This has eroded the trusts actual EBITDA margin.
- The LAS Trust Management costs have been calculated on the basis of the M09 Financial Position and will be reviewed on an ongoing basis.

KEY

↓	Target below expected levels attention required
↑	Target exceeded
↔	Target within tolerable range

Cumulative Net Surplus


Key Financial Trends
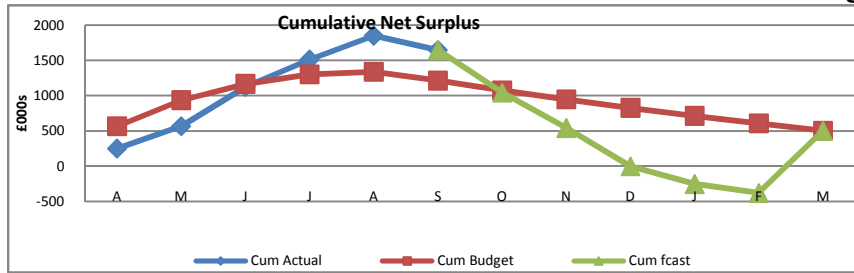
The Trust is currently on track to achieve it's year end surplus position of £526k. The sharp increase in surplus in March is the achievement of £1.8m worth of witheld CQUIN revenue
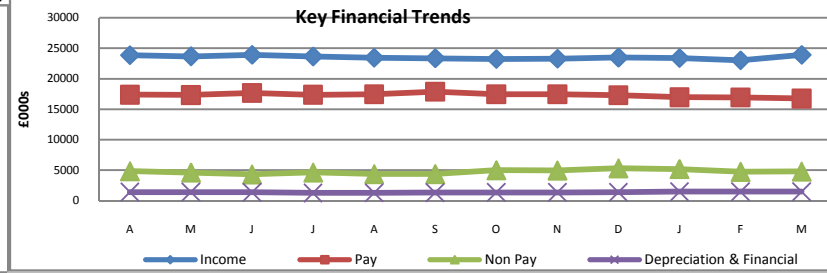
Key Financial Trends are broadly stable with planned decrease in income in Q2 due to the loss of MPET and steady increases in depreciation as the asset base grows

Cumulative CIP

Balance Sheet Summary
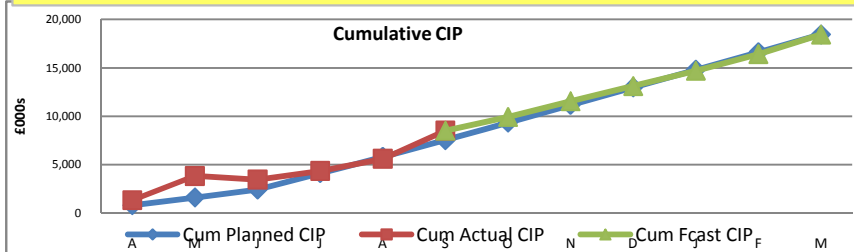
The Trust is in line to achieve it's CIP but there is a risk around structural change CIPs such as reduction of agency staff and reducing subsistence payments. However, additional savings against budget due to lower than expected spend on A&E staffing has offset this.
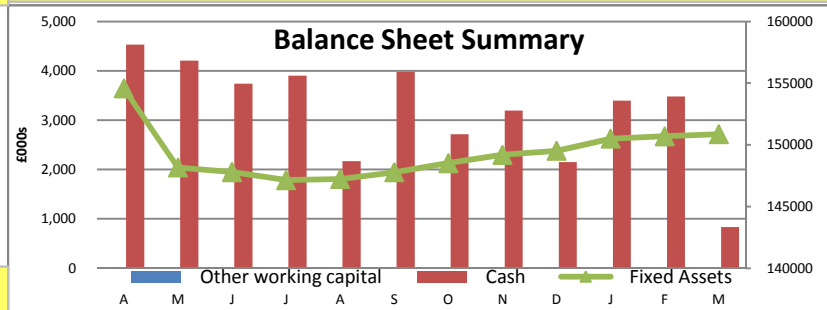
The Balance sheet remains in line with expected forecast.

Other Trend Information

	April	May	June	July	August	September	October	November	December	January	February	March	Average
A&E Cost Analysis													
A&E Cost per Head per month (£s)	1.7	1.8	1.8	1.8	1.7	1.9	1.8	1.8	1.8	1.7	1.7	1.7	1.8
EOC Cost Per Call & Response per month (£s)	4.5	4.7	4.4	4.4	4.2	4.6	4.7	4.8	4.8	4.1	4.4	4.4	4.5
A&E Cost Per Incident (£s) per month	169.5	171.5	171.4	159.2	174.1	184.5	168.8	171.7	165.5	163.8	177.0	155.1	170.0
A&E Cost Per Day (£000s)	479.2	481.4	496.4	468.9	468.3	512.3	491.8	502.8	489.9	467.9	504.9	452.1	485.9
Activity Analysis													
Incidents per WTE per month	17.8	18.4	18.5	19.4	17.7	17.6	19.0	18.4	19.4	18.7	16.9	19.2	18.5
Responses per Incident per month	1.5	1.3	1.5	1.3	1.5	1.5	1.4	1.3	1.3	1.4	1.6	1.5	1.4
Calls per WTE per month	24.5	26.2	28.3	28.7	31.2	26.9	25.5	27.8	27.7	29.7	26.1	23.9	27.6
% Overtime to Total Payroll	6.9%	6.9%	7.0%	6.3%	6.7%	7.7%	6.8%	6.4%	6.5%	4.7%	4.5%	3.4%	0.1
Total Frontline Staff WTE	3,447	3,410	3,407	3,398	3,377	3,374	3,402	3,416	3,377	3,386	3,385	3,352	3,399
Total Control Services Staff WTE	472	470	465	476	488	501	506	517	513	507	513	509	492
Total Operational Support Staff WTE	93	93	92	92	93	95	96	96	96	95	95	95	94
Total Management Staff WTE	222	216	210	221	224	223	219	218	216	217	216	215	219
Total Other Corporate Support Staff WTE	523	531	533	528	528	529	526	527	527	530	529	528	528
Total LAS Staff WTE	4,756	4,720	4,706	4,715	4,709	4,722	4,749	4,774	4,728	4,735	4,738	4,699	4,731
Ratio of Non Corporate Staff to Corporate Staff	8.1	7.9	7.8	7.9	7.9	7.9	8.0	8.1	8.0	7.9	8.0	7.9	8.0

LAS Financial Review - Income & Expense Trend

Month Ending 31st December 2010 - (Month 9)

	Apr-10 Actual	May-10 Actual	Jun-10 Actual	Jul-10 Actual	Aug-10 Actual	Sep-10 Actual	Oct-10 Actual	Nov-10 Actual	Dec-10 Actual	Jan-11 Fcast	Feb-11 Fcast	Mar-11 Fcast	2010/2011 Fcast	2010/2011 Budget	Diff	%
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	
Income	(23,877)	(23,675)	(23,912)	(23,655)	(23,451)	(23,353)	(23,231)	(23,278)	(23,472)	(23,370)	(23,020)	(23,907)	(282,201)	(281,098)	(1,103)	0.4%
Payroll (£k)																
A&E Frontline	10,478	10,460	10,535	10,488	10,468	10,598	10,601	10,630	10,616	10,641	10,664	10,671	126,852	132,724	(5,872)	-4.4%
A&E Overtime	1,048	1,039	1,049	950	1,042	1,238	1,045	950	969	712	673	494	11,210	5,485	5,725	104.4%
A&E Incentive	3	1	0	0	1	0	2	0	0	0	0	0	7	0	7	#DIV/0!
A&E Management	1,227	1,218	1,175	1,241	1,212	1,214	1,228	1,244	1,198	1,188	1,188	1,188	14,522	13,398	1,123	8.4%
EOC	950	951	952	959	989	1,017	1,007	1,023	1,026	1,010	1,005	999	11,887	10,512	1,376	13.1%
Operational Support	297	291	251	289	298	298	301	302	299	308	308	308	3,549	4,023	(474)	-11.8%
PTS	562	543	527	517	531	525	508	495	415	410	410	410	5,852	5,168	684	13.2%
Corporate Support	2,218	2,236	2,400	2,252	2,284	2,280	2,185	2,227	2,222	2,289	2,308	2,312	27,215	29,686	(2,471)	-8.3%
Other Overtime	161	158	189	146	135	138	148	169	153	83	83	83	1,648	765	882	115.3%
Agency	448	442	582	533	503	556	440	419	406	323	294	294	5,240	1,991	3,249	163.2%
Total	**17,390**	**17,339**	**17,662**	**17,375**	**17,464**	**17,865**	**17,466**	**17,459**	**17,305**	**16,964**	**16,934**	**16,760**	**207,982**	**203,752**	**4,230**	**2.1%**
Non Pay																
Staff Related	530	492	655	600	507	605	551	596	716	620	558	564	6,993	6,906	87	1.3%
Consumables, Medical Equip & Drugs	488	631	626	666	370	559	647	491	593	597	479	498	6,646	5,971	676	11.3%
Vehicle Leasing	78	96	120	202	172	138	135	134	153	128	121	121	1,598	2,447	(849)	-34.7%
Fuel & Oil	454	471	454	463	422	433	487	533	567	516	466	486	5,753	6,026	(274)	-4.5%
Vehicle Maintenance	397	804	557	561	613	864	760	945	658	455	294	323	7,233	6,050	1,183	19.6%
Other Automotive	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	#DIV/0!
Vehicle Insurance	175	223	221	229	166	(126)	159	56	52	159	159	159	1,629	1,577	53	3.3%
3rd Party Transport	102	49	64	86	69	59	57	71	55	41	41	41	735	351	384	109.3%
Accommodation & Estates	991	1,094	1,028	1,057	953	1,105	1,046	939	1,210	997	1,004	991	12,415	11,707	708	6.0%
IT & Telecoms	723	717	377	656	624	359	599	705	701	773	727	730	7,694	8,958	(1,264)	-14.1%
Finance & Legal	751	(144)	(1)	162	239	149	216	335	264	305	300	295	2,871	326	2,544	779.7%
Consultancy	12	(4)	42	119	108	73	67	64	68	424	425	425	1,824	1,972	(148)	-7.5%
Other	130	184	174	(174)	131	152	279	94	283	164	161	156	1,734	2,635	(900)	-34.2%
Subtotal	**4,830**	**4,614**	**4,317**	**4,628**	**4,374**	**4,370**	**5,005**	**4,964**	**5,320**	**5,180**	**4,735**	**4,789**	**57,125**	**54,926**	**2,199**	**4.0%**
Depreciation																
Fleet	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	#DIV/0!
IT	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	#DIV/0!
Other	992	992	967	877	868	885	950	947	977	1,065	1,065	1,065	11,651	15,283	(3,632)	-23.8%
Subtotal	**992**	**992**	**967**	**877**	**868**	**885**	**950**	**947**	**977**	**1,065**	**1,065**	**1,065**	**11,651**	**15,283**	**(3,632)**	**-23.8%**
Financial																
Dividend	314	314	314	294	309	340	314	314	314	314	314	314	3,772	4,588	(816)	-17.8%
Interest	101	99	92	97	98	96	97	95	97	99	99	99	1,170	2,047	(877)	-42.9%
Subtotal	**415**	**414**	**406**	**391**	**407**	**435**	**412**	**409**	**412**	**413**	**413**	**413**	**4,942**	**6,635**	**(1,693)**	**-25.5%**
Total Expense	**23,628**	**23,358**	**23,352**	**23,271**	**23,113**	**23,555**	**23,833**	**23,779**	**24,014**	**23,622**	**23,147**	**23,027**	**281,700**	**280,596**	**1,103**	**0.4%**
Net Surplus	**(250)**	**(316)**	**(560)**	**(384)**	**(338)**	**202**	**602**	**501**	**542**	**252**	**127**	**(880)**	**(501)**	**(502)**	**1**	**0**
Cumulative Surplus	**(250)**	**(566)**	**(1,126)**	**(1,510)**	**(1,848)**	**(1,645)**	**(1,043)**	**(542)**	**(0)**	**251**	**379**	**(501)**	**(501)**	**(502)**		

LAS Financial Review - CIP Summary

Month Ending 31st December 2010 - (Month 9)

Key CIP Programs	Performance Ytd Position				Forecast 2010/11				Status		
	Act £000	Plan £000	Diff £000	%	Fcast £000	Plan £000	Diff £000	%	Current	Forecast	
1. A&E Incentive	3,021	3,029	(7)	99.8%	3,021	3,029	(7)	99.8%	↔	↔	Delivered
2. Agency Cost	49	2,835	(2,786)	1.7%	1,003	4,252	(3,249)	23.6%	↓	↓	All agency staffing reviewed by SMG. Agreed plan to remove all Non vacancy agency staff (except those specifically funded by projects). SMG are reviewing this monthly.
3. A&E Subsistence	(172)	1,122	(1,294)	-15.4%	(102)	1,682	(1,784)	-6.0%	↓	↓	In order to meet the current subsistence outturn target Subsistence needs to be reduced by £62k per month from an average of £200k per month - this is approximately a saving of a third
4. Third Party Transport	1,045	1,229	(184)	85.0%	1,797	1,844	(47)	97.5%	↓	↔	Underachievement on 3rd Party YTD is offset by additional income generated by PTS ECJs of approx £100k per month. Therefore the CIP is being achieved.
5. Non Frontline Payroll	752	945	(192)	79.7%	1,273	1,605	(331)	79.3%	↓	↓	37 posts have been identified and removed. A change to the date for CommandPoint implementation has deferred reduction in EOC posts
6. Non Pay / Procurement	5,026	3,819	1,207	131.6%	6,477	6,028	450	107.5%	↑	↑	On Track
7. Pay - Other	3,399	0	3,399	#DIV/0!	4,969	0	4,969	#DIV/0!	↑	↑	Additional Vacancies held against A&E Staffing above projection due to lower levels of permanent recruitment than expected.
8. Other	0	0	0	#DIV/0!	0	0	0	#DIV/0!	↔	↔	
Total	13,120	12,978	142	101%	18,439	18,439	(0)	100.0%	↔	↔	Trust on Target to deliver planned total

KEY:

CIP Target being exceeded	↑
CIP Target not being achieved	↓
CIP on Target	↔

LAS Financial Review - Capital Summary

Month Ending 31st December 2010 - (Month 9)

Projects	Ytd Position 9				Forecast 2010/11				Status 2010/11
	Act £000	Plan £000	Diff £000	%	Act £000	Plan £000	Diff £000	%	
1. CommandPoint	2,305	2,554	249	10%	2,793	3,406	(613)	-18%	↓
2. IM&T - Other	1,233	1,314	81	6%	1,808	1,751	57	3%	↔
3. Fleet - DCA	3,930	4,100	170	4%	5,083	5,467	(384)	-7%	↓
4. Fleet - FRU	117	99	(18)	-18%	117	132	(15)	-11%	↔
5. Fleet - Other	261	3,171	2,910	92%	3,289	4,228	(938)	-22%	↓
6. Estates - West Workshop	0	15	15	100%	20	20	0	0%	↔
7. Estates - HART East	560	473	(87)	-18%	631	631	0	0%	↔
8. Estates - Hart West	0	0	0	0%	20	0	20	0%	↔
9. Estates - Other	1,567	1,235	(332)	-27%	1,955	1,647	308	19%	↑
10. Clinical Equipment	0	0	0	0%	0	0	0	0%	↔
11. Other Projects	0	0	0	0%	0	0	0	0%	↔
12. Fleet - Finance Lease	0	5,240	5,240	100%	6,987	6,987	0	0%	↔
13. Disposals	(5,946)	(4,947)	999	-20%	(6,596)	(6,596)	0	0%	↔
14. Unallocated Funds	0	560	560	100%	0	747	(747)	-100%	↓
Total	4,027	13,814	9,787	71%	16,107	18,419	(2,312)	-13%	↓

KEY:

↔	Capital Program on Target
↓	Capital Program Underspend - Requires attention
↑	Capital Program Overspend - Requires attention

	Month Act	Month Budget	%		Ytd Act	Ytd Budget	Diff	%		Ytd 0910	Diff	%		2010/2011 Fcast	2010/2011 Budget	Diff	%
	£000	£000			£000	£000	£000			£000	£000			£000	£000	£000	
Income																	
A&E	21,737	21,578	0.7%		193,330	194,198	(868)	-0.4%		188,704	4,626	2.5%		259,079	258,931	148	0.1%
Other	1,735	1,847	-6.1%		18,574	16,626	1,949	11.7%		21,238	(2,663)	-12.5%		23,122	22,167	954	4.3%
Total	23,472	23,425	0.2%		211,904	210,824	1,080	19413.0%		209,942	1,963	0.9%		282,201	281,098	1,103	0.4%
Operating Expense																	
Pay	17,305	17,080	1.3%		157,325	152,125	5,200	3.4%		153,009	4,316	2.8%		207,982	203,752	4,230	2.1%
Non Pay	5,320	4,589	15.9%		42,422	41,744	678	1.6%		44,309	(1,887)	-4.3%		57,125	54,926	2,199	4.0%
Total	22,625	21,669	4.4%		199,746	193,869	5,877	3198.6%		197,318	2,429	1.2%		265,107	258,678	6,429	2.5%
EBITDA	847	1,756	-51.7%		12,158	16,955	(4,797)	-453.5%		12,624	(466)	-3.7%		17,094	22,420	(5,326)	-23.8%
EBITDA %	3.6%	7.5%	-51.8%		5.7%	8.0%	-2%	-448.9%		6.0%	-0.3%	-4.6%		6.1%	8.0%	-1.9%	-24.1%
Depreciation, Dividend & Interest	1,389	1,878	-26.0%		12,158	16,129	(3,971)	-24.6%		12,288	(130)	-1.1%		16,593	21,918	(5,326)	-24.3%
								-									
Net Surplus/(Deficit)	(542)	(122)	344.1%		0	826	(826)	-200.0%		336 -	336	-2.6%		501	502 -	1	-0.2%
Net Margin	-2.3%	-0.5%	343.2%		0.0%	0.4%	-0.4%	-200.0%		0.2%	-0.2%	-4.6%		0.2%	0.2%	0.0%	-0.6%
Impairments	0	0	#DIV/0!		0	0	0	#DIV/0!		0	0	#DIV/0!		0	0	0	#DIV/0!
Net Surplus after Impairment	(542)	(122)	344.1%		0	826	(826)	-200.0%		336 -	336	#DIV/0!		501	502 -	1	-0.2%
Income																	
Non Current Assets					150,508	152,901	(2,393)	-1.6%		131,406	19,102	14.5%		152,405	152,901	(496)	-0.3%
Cash					2,153	2,979	(826)	-27.7%		5,141	(2,988)	-58.1%		836	2,979	(2,142)	-71.9%
Working Capital					(2,377)	(9,903)	7,526	-76.0%		(1,538)	(839)	54.6%		(2,540)	(9,903)	7,362	-74.3%
Non Current Liabilities					(40,965)	(36,399)	(4,567)	12.5%		(41,767)	802	-1.9%		(39,247)	(36,399)	(2,849)	7.8%
Capital Employed					109,319	109,578	(259)	0%		93,242	16,077	17.2%		111,454	109,578	1,876	2%
Average Capital Employed					109,319	109,578	(259)	-0.2%		69,932	39,388	56.3%		111,454	109,578	1,876	1.7%
Return on Assets					5.17%	5.85%	#DIV/0!	-11.6%		0.5%	0	975.9%		5.17%	5.85%	-0.7%	-11.6%

LAS Financial Review - Balance Sheet

Month Ending 31st December 2010 - (Month 9)

	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
	Actual	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Forecast*	*Forecast*	*Forecast*	
Non-Current Assets														
Intangible assets	12,639	12,604	12,604	12,182	12,244	12,273	12,851	13,014	13,159	14,490	14,490	14,490	14,490	
Property, Plant and Equipment	131,434	125,054	124,671	124,427	124,450	124,959	125,210	125,689	125,853	125,502	125,692	125,860	127,399	
Trade and Other Receivables	10,503	10,513	10,527	10,534	10,544	10,548	10,458	10,492	10,504	10,516	10,516	10,516	10,516	
Total Non-Current Assets	154,576	148,171	147,802	147,143	147,238	147,780	148,519	149,195	149,516	150,508	150,698	150,866	152,405	
Current Assets														
Inventories	2,783	2,728	2,701	2,686	2,672	2,739	2,746	2,718	2,722	2,724	2,724	2,724	2,724	Trade Debtors
NHS Trade Receivables	3,122	10,903	9,332	2,886	2,438	11,542	5,421	5,620	3,032	3,156	3,646	3,611	2,500	A&E £128k > 60 days (4.14%), Nov £2k > 60 days (0.06%)
Non NHS Trade Receivables	0	0	0	0	0	0	0	0	0	0	0	0	0	PTS £633k > 60 days (20.43%), Nov £619k > 60 days (20.75
Other Receivables	8,202	6,595	7,308	8,237	7,554	7,599	7,669	7,637	7,671	7,955	7,955	7,955	4,010	
Accrued Income	1,897	4,503	4,641	6,138	8,302	4,477	5,224	5,395	6,241	5,176	5,676	5,876	3,552	
Prepayments	3,249	1,933	2,775	4,200	3,670	3,355	3,474	2,993	3,016	4,091	3,691	3,291	2,891	
Investments	0	0	0	0	0	0	0	0	0	0	0	0	0	
Cash and Cash Equivalents	5,141	4,533	4,208	3,737	3,903	2,169	3,977	2,716	3,196	2,153	3,396	3,481	836	
Current Assets	24,394	31,195	30,965	27,884	28,539	31,881	28,511	27,079	25,878	25,255	27,088	26,938	16,513	
Non-Current Assets Held for Sale	650	650	650	650	650	650	650	650	650	650	650	650	0	
Total Current Assets	25,044	31,845	31,615	28,534	29,189	32,531	29,161	27,729	26,528	25,905	27,738	27,588	16,513	
Total Assets	179,620	180,016	179,417	175,677	176,427	180,311	177,680	176,924	176,044	176,413	178,436	178,454	168,918	
Current Liabilities														
Bank Overdraft	0	0	0	0	0	0	0	0	0	0	0	0	0	Trade Creditors
NHS Trade Payables	336	340	321	242	347	220	228	668	736	797	2,601	2,654	2,109	NHS PSPP - This month (42%), Nov (80%), Ytd (80%)
Non NHS Trade Payables	7,682	6,786	10,241	8,779	6,727	5,745	6,263	6,359	6,301	8,116	7,616	7,956	4,276	Non NHS PSPP - This month (73%), Nov (90%), Ytd (84%)
Other Payables	6,854	8,782	9,036	9,020	8,757	8,881	9,106	9,101	9,076	9,177	8,034	8,181	7,511	
PDC Dividend Liabilities	200	514	828	1,142	1,436	1,745	30	344	658	972	1,286	1,600	0	
Capital Liabilities	8,610	4,873	3,190	586	360	416	544	892	557	238	1,293	1,276	1,640	
Accruals	1,217	5,044	1,828	2,022	4,646	4,243	2,961	3,071	3,334	3,771	3,771	3,771	2,671	
Deferred Income	124	91	306	80	198	4,701	4,165	3,375	2,815	1,575	911	246	10	
DH Capital Loan Principal Repayment	1,244	1,244	1,244	1,244	1,244	1,244	622	622	622	622	622	622	0	
Borrowings	3,503	3,398	3,213	2,713	2,528	2,483	1,983	1,272	1,228	861	561	455	0	
Provisions for Liabilities & Charges	0	0	0	0	0	0	0	0	0	0	0	0	0	
Total Current Liabilities	29,770	31,072	30,207	25,828	26,243	29,678	25,902	25,704	25,327	26,129	26,695	26,761	18,217	
Net Current Assets/(Liabilities)	(4,726)	773	1,408	2,706	2,946	2,853	3,259	2,025	1,201	(224)	1,043	827	(1,704)	
Total Assets less Current Liabilities	149,850	148,944	149,210	149,849	150,184	150,633	151,778	151,220	150,717	150,284	151,741	151,693	150,701	
Non-Current Liabilities														
DH Capital Loan Principal Repayment	8,075	8,075	8,075	8,075	8,075	8,075	8,075	8,075	8,075	8,075	8,075	8,075	8,075	
Borrowings	21,560	21,560	21,560	21,560	21,560	21,620	21,620	21,620	21,620	21,667	21,667	21,667	21,667	
Other Financial Liabilities	0	0	0	0	0	0	0	0	0	0	0	0	0	
Provisions for Liabilities & Charges	10,888	10,982	10,932	11,011	10,967	11,018	11,116	11,162	11,161	11,223	11,301	11,380	9,505	
Total Non-Current Liabilities	40,523	40,617	40,567	40,646	40,602	40,713	40,811	40,857	40,856	40,965	41,043	41,122	39,247	
Total Assets Employed	109,327	108,327	108,643	109,203	109,582	109,920	110,967	110,363	109,861	109,319	110,698	110,571	111,454	
Financed By Taxpayers' Equity														
Public Dividend Capital	60,885	60,885	60,885	60,885	60,885	60,885	60,885	60,885	60,885	60,885	62,516	62,516	62,516	
Revaluation Reserve	35,914	35,487	35,487	35,487	35,911	35,911	35,911	35,911	35,911	35,911	35,911	35,911	35,911	
Donated Asset Reserve	4	4	4	4	4	4	4	3	3	3	3	3	3	
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	
Retained Earnings	12,943	12,370	12,686	13,246	13,201	13,539	14,586	13,983	13,481	12,939	12,687	12,560	13,443	
Total Taxpayers' Equity	109,327	108,327	108,643	109,203	109,582	109,920	110,967	110,363	109,861	109,319	110,698	110,571	111,454	

LAS Financial Review - Cashflow

Cashflow Statement
Month Ending 31st December 2010 - (Month 9)

	Apr-10 £'000s Actual	May-10 £'000s Actual	Jun-10 £'000s Actual	Jul-10 £'000s Actual	Aug-10 £'000s Actual	Sep-10 £'000s Actual	Oct-10 £'000s Actual	Nov-10 £'000s Actual	Dec-10 £'000s Actual	Jan-11 £'000s Forecast	Feb-11 £'000s Forecast	Mar-11 £'000s Forecast	Total £'000s
Operating Activities													
Operating surplus/(deficit)	664	730	1,000	395	745	233	(192)	(92)	(9)	161	286	1,297	5,218
Depreciation and amortisation	992	992	967	877	868	885	950	947	977	1,065	1,065	1,066	11,651
Impairments and reversals	0	0	0	0	0	0	0	0	0	0	0	0	0
Transfer from the donated asset reserve	0	0	0	0	0	0	(1)	0	0	0	0	0	(1)
Interest Paid	(114)	(115)	(109)	(113)	(113)	(113)	(113)	(110)	(112)	(114)	(114)	(111)	(1,351)
Dividend Paid	0	0	0	0	0	(2,055)	0	0	0	0	0	(1,917)	(3,972)
(Increase)/Decrease in Inventories	55	27	15	14	(67)	(7)	28	(4)	(2)	0	0	0	59
(Increase)/Decrease in NHS Trade Receivables	(7,781)	1,571	6,446	448	(9,104)	6,121	(199)	2,588	(124)	(490)	35	1,111	622
(Increase)/Decrease in Long Term Receivables	0	0	0	0	0	90	(34)	(12)	(12)	0	0	0	32
(Increase)/Decrease in Non NHS Trade Receivables	0	0	0	0	0	0	0	0	0	0	0	0	0
(Increase)/Decrease in Other Receivables	1,607	(713)	(929)	683	(45)	(70)	32	(34)	(284)	0	0	3,945	4,192
(Increase)/Decrease in Accrued Income	(2,606)	(138)	(1,497)	(2,164)	3,825	(747)	(171)	(846)	1,065	(500)	(200)	2,324	(1,655)
(Increase)/Decrease in Prepayments	1,316	(842)	(1,425)	530	315	(119)	481	(23)	(1,075)	400	400	400	358
Increase/(Decrease) in Trade Payables	4	(19)	(79)	105	(127)	8	440	68	61	1,804	53	(545)	1,773
Increase/(Decrease) in Other Payables	5,182	3,720	(7,020)	(2,406)	(905)	151	(86)	(242)	571	(1,657)	473	(4,363)	(6,582)
Increase/(Decrease) in Payments on Account	0	0	0	0	0	0	0	0	0	0	0	0	0
Increase/(Decrease) in Accruals	3,827	(3,216)	194	2,624	(403)	(32)	110	263	437	0	0	(1,100)	2,704
Increase/(Decrease) in Deferred Income	(33)	215	(226)	118	4,503	(536)	(790)	(560)	(1,240)	(664)	(665)	(236)	(114)
Increase/(Decrease) in Provisions & Liabilities	94	(50)	79	(44)	51	98	46	(1)	62	78	79	(1,875)	(1,383)
Net Cash inflow/outflow from operating activities	3,207	2,162	(2,584)	1,067	(457)	3,907	501	1,942	315	83	1,412	(4)	11,551
Cashflows from Investing Activites													
Interest received	27	29	31	30	29	31	30	28	28	29	29	27	348
(Payments) for property, plant & equipment	(3,737)	(2,331)	(3,327)	(1,126)	(1,321)	(1,008)	(1,081)	(1,446)	(945)	(200)	(1,250)	(2,241)	(20,013)
Proceeds from disposal of property, plant & equipment	0	0	5,909	380	0	0	0	0	(121)	0	0	650	6,818
(Payments) for intangible assets	0	0	0	0	0	0	0	0	0	0	0	0	0
Proceeds from disposal of intangible assets	0	0	0	0	0	0	0	0	0	0	0	0	0
(Payments) for investment with DH	0	0	0	0	0	0	0	0	0	0	0	0	0
(Payments) for other financial assets	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Cash inflow/outflow from investing activities	(3,710)	(2,302)	2,613	(716)	(1,292)	(977)	(1,051)	(1,418)	(1,038)	(171)	(1,221)	(1,564)	(12,847)
Net Cash inflow/outflow before financing	(503)	(140)	29	351	(1,749)	2,930	(550)	524	(723)	(88)	191	(1,568)	(1,296)
Cashflows from Financing Activites													
Public Dividend Capital Received	0	0	0	0	0	0	0	0	0	1,631	0	0	1,631
Public Dividend Capital Repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
Loans received from DH	0	0	0	0	0	0	0	0	0	0	0	0	0
Loans principal repaid to DH	0	0	0	0	0	(622)	0	0	0	0	0	(622)	(1,244)
Loans received from Salix Finance	0	0	0	0	60	0	0	0	47	0	0	0	107
Capital element of finance lease	(105)	(185)	(500)	(185)	(45)	(500)	(711)	(44)	(367)	(300)	(106)	(455)	(3,503)
Net Cashflow inflow/(outflow) from financing	(105)	(185)	(500)	(185)	15	(1,122)	(711)	(44)	(320)	1,331	(106)	(1,077)	(3,009)
Increase/(decrease) in cash & cash equivalents	(608)	(325)	(471)	166	(1,734)	1,808	(1,261)	480	(1,043)	1,243	85	(2,645)	(4,305)
Cash, cash equivalents and bank overdrafts at 010410	5,141												
Cash, cash equivalents and bank overdrafts at 310311	4,533	4,208	3,737	3,903	2,169	3,977	2,716	3,196	2,153	3,396	3,481	836	(4,305)

LAS Financial Review - Income Summary
Month Ending 31st December 2010 - (Month 9)

Month Act	Month Budget	%		Ytd Act	Ytd Budget	Diff	%	2010/2011 Fcast	2010/2011 Budget	Diff	%
£000	£000			£000	£000	£000		£000	£000	£000	
			Emergency Delivery								
20,708	20,863	-0.7%	PCT Commissioned	186,374	187,767	(1,393)	-0.7%	249,840	250,357	(517)	-0.2%
642	620	3.5%	CBRN	5,780	5,584	196	3.5%	7,706	7,445	261	3.5%
387	94	310.9%	RTA	1,176	847	329	38.9%	1,533	1,129	404	35.8%
21,737	**21,578**	0.7%	**Subtotal**	**193,330**	**194,198**	**(868)**	-0.4%	**259,079**	**258,931**	**148**	0.1%
			Specialised Services								
741	581	27.6%	HART	5,224	5,230	(6)	-0.1%	6,965	6,974	(9)	-0.1%
3	3	3.2%	HEMS	30	30	0	0.9%	40	39	0	0.6%
745	**584**	27.4%	**Subtotal**	**5,254**	**5,260**	**(6)**	-0.1%	**7,005**	**7,013**	**(8)**	-0.1%
			Information Services & Research								
94	92	1.6%	EBS	829	829	0	0.0%	1,104	1,106	1	-0.1%
36	13	177.5%	Research	212	117	95	81.3%	274	156	118	75.4%
130	**105**	23.4%	**Subtotal**	**1,042**	**946**	**96**	10.1%	**1,379**	**1,262**	**119**	9.2%
			Patient Transport Services								
491	598	-17.8%	PTS	6,584	5,383	1,201	22.3%	8,050	7,177	873	12.2%
64	80	-20.2%	BETS & SCBU	576	719	(144)	-20.0%	766	959	(193)	-20.1%
29	46	-36.8%	A&E Long Distance	206	413	(206)	-50.0%	290	550	(261)	-47.4%
584	**724**	-19.3%	**Subtotal**	**7,366**	**6,515**	**851**	13.1%	**9,106**	**8,687**	**419**	4.8%
			NHS London								
(7)	213	-103.5%	MPET	2,641	1,913	728	38.1%	2,666	2,550	116	4.5%
0	0	#DIV/0!	Other Education	0	0	0	#DIV/0!	0	0	0	#DIV/0!
62	70	-10.8%	Olympics 2012	581	626	(45)	-7.2%	767	835	(68)	-8.1%
55	**282**	-80.6%	**Subtotal**	**3,222**	**2,539**	**683**	26.9%	**3,433**	**3,385**	**48**	1.4%
			Commercial								
71	77	-7.9%	Stadia	728	689	39	5.7%	963	919	44	4.8%
52	52	0.0%	BAA	469	469	0	0.0%	625	625	0	0.0%
7	1	421.3%	Training	38	11	27	242.1%	38	15	23	156.6%
129	**130**	-0.6%	**Subtotal**	**1,236**	**1,169**	**66**	5.7%	**1,627**	**1,559**	**68**	4.4%
93	22	324.8%	**Other**	456	196	259	132.0%	573	262	311	118.8%
23,472	**23,425**	0.2%	**Total**	**211,904**	**210,824**	**1,080**	0.5%	**282,201**	**281,098**	**1,105**	0.4%

LAS Financial Review - Expense Summary

Month Ending 31st December 2010 - (Month 9)

Month Act	Month Budget	%		Ytd Act	Ytd Budget	Diff	%	Ytd 0910	Diff	%		2010/2011 Fcast	2010/2011 Budget	Diff	%
£000	£000			£000	£000	£000		£000	£000			£000	£000	£000	
			Income												
21,737	21,578	0.7%	A&E	193,330	194,198	(868)	-0.4%	188,704	4,626	2.5%		259,079	258,931	148	0.1%
1,735	1,847	-6.1%	Other	18,574	16,626	1,949	11.7%	21,238	(2,663)	-12.5%		23,122	22,167	954	4.3%
23,472	**23,425**	**0.2%**	**Total**	**211,904**	**210,824**	**1,080**	**0.5%**	**209,942**	**1,963**	**0.9%**		**282,201**	**281,098**	**1,103**	**0.4%**
			Payroll (£k)												
10,616	11,192	-5.1%	A&E Sectors	94,876	98,778	(3,902)	-4.0%	86,815	8,061	9.3%		126,852	132,724	(5,872)	-4.4%
969	458	111.6%	A&E Overtime	9,330	4,096	5,235	127.8%	11,437	(2,107)	-18.4%		11,210	5,485	5,725	104.4%
0	0	#DIV/0!	A&E Incentive	7	0	7	#DIV/0!	2,864	(2,856)	-99.8%		7	0	7	#DIV/0!
1,198	1,115	7.4%	A&E Management	10,957	10,054	902	9.0%	9,980	976	9.8%		14,522	13,398	1,123	8.4%
1,026	850	20.8%	EOC	8,873	7,963	910	11.4%	8,099	773	9.5%		11,887	10,512	1,376	13.1%
299	336	-11.1%	Operational Support	2,626	3,014	(389)	-12.9%	2,483	143	5.8%		3,549	4,023	(474)	-11.8%
415	432	-3.9%	PTS	4,624	3,872	751	19.4%	4,996	(372)	-7.5%		5,852	5,168	684	13.2%
2,222	2,485	-10.6%	Corporate Support	20,305	22,229	(1,924)	-8.7%	18,376	1,930	10.5%		27,215	29,686	(2,471)	-8.3%
153	64	140.5%	Other Overtime	1,397	574	823	143.4%	2,015	(617)	-30.6%		1,648	765	882	115.3%
406	149	173.0%	Agency	4,330	1,544	2,786	180.4%	5,944	(1,614)	-27.2%		5,240	1,991	3,249	163.2%
17,305	**17,080**	**1.3%**	**Total**	**157,325**	**152,125**	**5,200**	**3.4%**	**153,009**	**4,316**	**2.8%**		**207,982**	**203,752**	**4,230**	**2.1%**
			Non Pay												
716	523	36.8%	Staff Related	5,250	5,336	(86)	-1.6%	5,522	(271)	-4.9%		6,993	6,906	87	1.3%
593	497	19.4%	Consumables, Medical Equip & Drugs	5,073	4,480	592	13.2%	5,322	(249)	-4.7%		6,646	5,971	676	11.3%
153	204	-24.7%	Vehicle Leasing	1,229	1,836	(608)	-33.1%	473	755	159.7%		1,598	2,447	(849)	-34.7%
567	502	12.9%	Fuel & Oil	4,285	4,520	(235)	-5.2%	3,520	765	21.7%		5,753	6,026	(274)	-4.5%
658	498	32.1%	Vehicle Maintenance	6,161	4,556	1,605	35.2%	4,539	1,622	35.7%		7,233	6,050	1,183	19.6%
52	130	-60.4%	Vehicle Insurance	1,153	1,186	(33)	-2.8%	1,198	(45)	-3.8%		1,629	1,577	53	3.3%
55	14	291.0%	3rd Party Transport	612	309	303	97.9%	1,791	(1,179)	-65.8%		735	351	384	109.3%
1,210	938	29.1%	Accomodation & Estates	9,423	8,894	529	5.9%	9,463	(40)	-0.4%		12,415	11,707	708	6.0%
701	730	-4.0%	IT & Telecoms	5,462	6,767	(1,305)	-19.3%	6,311	(848)	-13.4%		7,694	8,958	(1,264)	-14.1%
264	182	45.1%	Finance & Legal	1,972	364	1,608	441.7%	2,762	(790)	-28.6%		2,871	326	2,544	779.7%
68	160	-57.5%	Consultancy	549	1,491	(942)	-63.2%	1,344	(795)	-59.1%		1,824	1,972	(148)	-7.5%
283	210	34.6%	Other	1,253	2,004	(750)	-37.4%	2,064	(811)	-39.3%		1,734	2,635	(900)	-34.2%
5,320	**4,589**	**15.9%**	**Subtotal**	**42,422**	**41,744**	**678**	**1.6%**	**44,309**	**(1,887)**	**-4.3%**		**57,125**	**54,926**	**2,199**	**4.0%**
			Depreciation												
0	0	#DIV/0!	Fleet	0	0	0	#DIV/0!	0	0	#DIV/0!		0	0	0	#DIV/0!
0	0	#DIV/0!	IT	0	0	0	#DIV/0!	0	0	#DIV/0!		0	0	0	#DIV/0!
977	1,325	-26.2%	Other	8,456	11,153	(2,697)	-24.2%	9,034	(578)	-6.4%		11,651	15,283	(3,632)	-23.8%
977	**1,325**	**-26.2%**	**Subtotal**	**8,456**	**11,153**	**(2,697)**	**-24.2%**	**9,034**	**(578)**	**-6.4%**		**11,651**	**15,283**	**(3,632)**	**-23.8%**
			Financial												
314	382	-17.8%	Dividend	2,829	3,441	(612)	-17.8%	2,520	309	12.3%		3,772	4,588	(816)	-17.8%
97	171	-42.9%	Interest	873	1,535	(662)	-43.1%	734	139	18.9%		1,170	2,047	(877)	-42.9%
412	**553**	**-25.5%**	**Subtotal**	**3,702**	**4,976**	**(1,274)**	**-25.6%**	**3,254**	**448**	**13.8%**		**4,942**	**6,635**	**(1,693)**	**-25.5%**
24,014	**23,547**	**2.0%**	**Total Expense**	**211,904**	**209,998**	**1,906**	**0.9%**	**209,606**	**2,298**	**1.1%**		**281,700**	**280,596**	**1,103**	**0.4%**

LAS Financial Review - Divisional Summary
Month Ending 31st December 2010 - (Month 9)

Month Act	Month Budget	%		Ytd Act	Ytd Budget	Diff	%	2010/2011 Fcast	2010/2011 Budget	Diff	%
£000	£000			£000	£000	£000		£000	£000	£000	
			Operations								
			A&E Sector Services								
14,807	**14,304**	**32%**	- Subtotal	**128,565**	**125,340**	**(3,225)**	2.6%	**170,787**	**168,535**	**(2,251)**	1.3%
			Control Services								
2,098	**1,599**	31%	- Subtotal	**17,552**	**15,022**	**(2,530)**	16.8%	**23,327**	**19,819**	**(3,508)**	17.7%
			Operational Support								
1,406	**1,278**	10%	- Subtotal	**14,490**	**11,987**	**(2,503)**	20.9%	**18,881**	**15,821**	**(3,060)**	19.3%
			Total Operations								
18,311	**17,181**	7%	- Subtotal	**160,607**	**152,349**	**(8,258)**	5.4%	**212,996**	**204,176**	**(8,820)**	4.3%
			Patient Transport Services (PTS)								
630	**579**	9%	- Subtotal	**6,450**	**5,383**	**(1,067)**	19.8%	**8,028**	**7,122**	**(906)**	12.7%
			Corporate Directorates								
			Chief Executive								
446	**449**	-1%	- Subtotal	**3,520**	**3,890**	**370**	-9.5%	**4,675**	**5,236**	**561**	-10.7%
			Corporate Services								
374	**359**	4%	- Subtotal	**3,426**	**3,411**	**(16)**	0.5%	**4,574**	**4,488**	**(85)**	1.9%
			Strategic Development								
180	**168**	7%	- Subtotal	**1,603**	**1,471**	**(131)**	8.9%	**2,138**	**1,976**	**(162)**	8.2%
			Finance & Estates								
1,701	**2,105**	-19%	- Subtotal	**13,317**	**17,005**	**3,687**	-21.7%	**17,511**	**22,842**	**5,330**	-23.3%
			Human Resources & Training								
1,055	**1,259**	-16%	- Subtotal	**11,855**	**12,992**	**1,137**	-8.8%	**15,146**	**16,919**	**1,773**	-10.5%
			IM & T								
1,219	**1,326**	-8%	- Subtotal	**10,205**	**12,420**	**2,215**	-17.8%	**15,363**	**16,399**	**1,035**	-6.3%
			Healthcare Promotion & Quality								
10	**0**	#DIV/0!	- Subtotal	**10**	**0**	**(10)**	#DIV/0!	**10**	**0**	**(10)**	#DIV/0!
			Medical								
84	**121**	-30%	- Subtotal	**907**	**1,076**	**169**	-15.7%	**1,256**	**1,438**	**183**	-12.7%
			Total Corporate Directorates								
5,071	**5,786**	-12%	- Subtotal	**44,843**	**52,265**	**7,422**	-14.2%	**60,673**	**69,298**	**8,625**	-12.4%
			Total LAS								
24,012	**23,547**	2%	- Total LAS	**211,901**	**209,998**	**(1,903)**	0.9%	**281,697**	**280,596**	**(1,101)**	0.4%

LONDON AMBULANCE SERVICE TRUST BOARD

3RD FEBRUARY 2011

PAPER FOR NOTING

Document Title:	Clinical Quality and Patient Safety Report
Report Author(s):	Dr Fionna Moore
Lead Director:	Dr Fionna Moore
Contact Details:	LAS HQ
Why is this coming to the Trust Board?	For information and noting
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☒ Other **Elements of this report have been discussed at CQSEC, CARSG and SMG**
Recommendation for the Trust Board:	That the Board considers and notes the report

Executive Summary/key issues for the Trust Board

Safety: 2 new SIs declared, 1 relating to non conveyance and one to concerns over treatment and the level of patient supervision

Clinical and cost effectiveness:

1. CPI performance now at 76% for the last month (December). Target 95%. 8 Complexes achieved 95% and 4 100%. Feedback targets for the year to date exceeded.
2. Update on the clinical issues relating to cardiac care, stroke, trauma and the use of the Demand Management Plan.
3. Report on National Clinical performance Indicators cycles 3 and 4; good overall progress but concerns over scores in the 'care bundles' for cardiac arrest, STEMI and asthma. Also referrals for hypoglycaemic patients who are not conveyed to hospital
4. **U**pdate on progress against Infection Prevention and Control provided.

Governance:

1. Limited assurance provided on the management of medicines, including both Controlled and General Drug issues. 1 incidents relating to Controlled Drugs reported.
2. Feedback provided from the recent unannounced audits of Controlled Drugs arrangements at 4 Complexes.

Care environment and amenities:

Infection Prevention and Control:
Update provided on progress against the priorities identified for the current work plan

Public Health:
Update provided on the current influenza outbreak.

Attachments
Main report with 1 appendix (Clinical Audit report on National CPIs, cycles 3 and 4)

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

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

Risk Implications
This paper links to the following strategic risks:

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

NHS Constitution
This paper supports the following principles that guide the NHS:

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

Equality Impact Assessment

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

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board 3rd February 2011

Clinical Quality and Patient Safety Report

Safety

1.1   Update on Serious Untoward Incidents (SIs)

Two new SIs have been declared and twenty four potential incidents have considered since my last report in December 2010. One declared case relates to the non conveyance of a young woman who subsequently died and the other to concerns around the treatment and supervision of care provided to a patient who deteriorated and subsequently suffered a cardiac arrest while in our care.

1.2   Central Alerting System (CAS) formerly the Safety Alert Broadcasting System (SABS):

The Central Alerting System (CAS) is contributed to by the Medicines and Healthcare Products Regulatory Agency (MHRA), the National Patient Safety Agency (NPSA) and the Chief Medical Officer. When a CAS alert is issued the LAS is required to inform the MHRA of the actions that it has taken to comply with the alert. If no action is deemed necessary a "nil" return is still required.

23 alerts were received from 15th November 2010 – 20th January 2011. All alerts were acknowledged; one relating to possible counterfeit saturation probes and one relating to umbilical cord clamps are being assessed for relevance.

1.3   Safeguarding

The Trust is participating in a review from the SHA Safeguarding Improvement Team on January 26 which will involve a thorough examination of Trust processes and a series of 1:1 interviews. The review will form a gap analysis which will help the Trust to understand its position against compliance with current recommendations. A full report will be provided to the Board as part of the annual Safeguarding report at the earliest opportunity.

Clinical and Cost Effectiveness

2.1   Clinical Performance Indicator completion and compliance

The current target for CPI completion is **95%.** The most recent figures (December) show an overall completion rate of **76%;** the lowest figure since June. Eight Complexes achieved 95%, four of which and HART achieved

100%. Raising the REAP level to 3, and then to 4 in December, is the most likely explanations for decline in the last three month's figures. (diagram 1)

Diagram 1. CPI completion June to December 2010

Area	August	Sept.	Oct.	Nov.	Dec.
East	89%	89%	79%	86%	87%
South	85%	91%	87%	77%	62%
West	94%	88%	87%	92%	83%
LAS	**89%**	**89%**	**84%**	**84%**	**76%**

In terms of compliance (the appropriate documentation of aspects of care or valid exceptions to care) the LAS achieved or exceeded 95% compliance to 5 out of 7 CPIs. Of these, compliance rates for the Cardiac Arrest, ACS, Stroke and Glycaemic Emergencies CPIs remained consistent with those in November.
The South Area achieved 95% compliance or higher for all 7 CPIs in December, In addition, the South Area achieved the highest compliance to the Non Conveyed CPI this year, with 95%. The East and West Areas each achieved 95% compliance or higher for 5 out of 7 CPIs, with the West Area achieving the highest compliance to the ACS CPI this year, at 97%.
HART, as well as **Greenwich, Hanwell** and **Wimbledon** Complexes, achieved 95% compliance or higher in all seven CPIs. The 100% compliance target was met for the Cardiac Arrest CPI by **Newham** Complex as well as **HART**.

For the year 2010 to date, Team Leaders across the LAS have delivered 4624 feedback sessions, exceeding their target for the year so far (4410). This has been achieved by the West Area has exceeded its target (based on each member of staff receiving two feedback sessions per year) as both the East and South Areas have struggled to deliver sessions during December.

2.2   Clinical Update

2.2.1 Cardiac Care

Cardiac related research projects:

The Adenosine research project on the pre hospital management of supraventricular tachycardias started in November; a total of 60 paramedics from East Area Complexes (Newham, Romford and Whipps Cross) were trained by Professor Richard Schilling (London Chest Hospital). To date three patients have been identified - one has been enrolled into the transport to A&E arm i.e. so far no drug has been given. A further 30 paramedics will

undergo training in early February so that 90 staff within the East Area will be carrying the drug.

The 'DANCE' study started and four patients successfully enrolled (of 8 possible) to date. (This is the trial involving NSTEMI patients being identified and transported to Harefield Heart Attack Centre for urgent, rather than emergency angioplasty.)

Cardiac arrest:

Return of spontaneous circulation (ROSC)
CQUINs target ROSC (at any point) is 30%: October 2010 32%
ROSC sustained to hospital: October 2010 23%
Ongoing Issues: Downloads of data from defibrillators is extremely low (currently fluctuating between 9 – 13% per month). A solution to resolve this issue should be in place by Quarter 4.

Resuscitation Guidelines:

The new LAS resuscitation guidelines will shortly be released with a plan to have staff training completed by the 31st March (if possible) ready to go live as of the 1st April. Staff will be permitted to use the new guidelines as soon as they are trained.
4 sessions are planned for Training Officers (4th & 11th January) and six days for Team Leaders running from late January through to the end of February

Equipment:

Ring magnets (for the deactivation of internal defibrillators) are being rolled out across the Trust.

2.2.2 Stroke

Summary from Stroke Care Pack (August 2010) X:\Clinical Audit & Research Unit\Stroke reports

• *During August 2010 the LAS attended 621 stroke patients. This is an increase of 40 patients from the last month.*
• *95% of patients were conveyed to an appropriate facility. Of those patients that were conveyed appropriately 90% were taken directly to a HASU with a further 5% of patients appropriately transported to the nearest A&E.*
• *The average response time was 8 minutes for patients who were allocated Category A and Category B responses.*
• *The average journey time from scene to hospital was 19 minutes.*
• *In 92% of patients either the time of the onset of stroke symptoms or 'time unknown' was recorded on the PRF.*
• *100% of stroke patients had their blood pressure measured and 99% had their blood glucose assessed.*
• *94% of stroke patients had their oxygen saturation measured.*

Through NHS London, there appears to have been significant interest from local groups (NHS and political) around journey times from the Barnet area. Fears about extended journey times in this area have not been confirmed.

The London stroke system has a thrombolysis rate of over 12%, which is comparable with that in any major city, and significantly greater than anywhere else in the UK.

ISRAS trial (ROSIER) progressing well – over 100 patients recruited, and there has been a shift in the way that consent will be gained, meaning that a higher number of patients will be eligible. Approval has been given for an extension to the current data capture period

Areas highlighted to SMG: TIA – some patients with mild symptoms are still being taken to local hospitals even though technically they are still FAST+ and should be taken to a HASU. We are working with the Department of Education and Development to ensure that the message is clear at the point of teaching.

St Thomas' – Still lags behind in terms of numbers of patients being admitted (36 patients in August against 91 to Northwick Park and Charing Cross). We have suggested to the networks that they advise local Emergency Departments to transfer patients here rather than to King's.

PRUH – HASU still not open. We believe that this will be sometime in the next few months. We agree with the Stroke Network that a staged opening (i.e. daytime hours) will probably not be feasible.

Trials relating to stroke and falls
ISRAS / ROSIER – progressing well, with over 100 patients enrolled.

SAFER2 (NIHR funded multicentre study evaluating the impact of falls protocols). Advert in this week's RIB for volunteers to take part in either trial or control arm. Complexes have yet to be randomised, so we are unsure where we will have to not roll-out the falls training part of the clinical training.

Issues highlighted to SMG: poor recruitment to the study across all study sites has led the project lead (Professor Helen Snooks) to propose a £50 bonus to all paramedics who sign up to the study. This initiative has received approval from the overseeing MREC. SMG has expressed concerns about this approach and has suggested an alternative, with individual Complexes being rewarded for their involvement.

2.2.3 Trauma
Details available in the Trauma Care pack for June 2010 available on
X:\Clinical Audit & Research Unit\Trauma reports\May '10 - March '11
We are exceeding the target of 90% of patients being taken to an appropriate facility (94% in May, 96% in June). We are averaging mean journey times of 16 minutes against a 45 minute target which demonstrates excellent performance.

<u>Clinical issues:</u>
- A small but significant number of patients were taken inappropriately to a MTC, as they did not meet the clinical criteria.
- Pain relief was appropriately administered, or a valid exception documented in 76% of patients.
- 18 patients with isolated head injuries were conveyed to the three designated trauma units with appropriate neurosurgical facilities.
- 9 patients were appropriately conveyed to St Mary's by crews from the West Area with penetrating chest or neck trauma; the only major trauma injuries the hospital was accepting at the time of this report.
- The MTC at Imperial (on the St Mary's site) opened 08:00 to 19:00 hrs on 1st December. It will be live 24/7 from 10th January 2011.

Issues highlighted to SMG: Crew documentation of Major Trauma Centre (MTC) destination codes is extremely poor. For example, in June only 25 of the 280 major trauma PRFs had a MTC destination code.

2.2.4 Clinical Implications of the Demand Management Plan (DMP)

Has been successfully used on an almost daily basis, for at least some hours of each day from 5th December to early January on occasions when demand has outstripped resources.

Main reasons for use:

- Snow
- Flu like illness where access to GP / NHSD overwhelmed over bank holidays
- Alcohol related calls (Parties pre Christmas and NYE)
- Operational staffing issues (especially over Christmas Day and Boxing day)

Levels C and D been used – level C works well when the tide rises slowly but with sudden surges eg NYE and snow the plan needed to go in at D

There is a significant clinical risk associated with implementing the plan, especially at level D – which stops the immediate despatch to Amber and Green calls and uses 'No send' for Green omegas. In view of flu and associated high risk groups some amendments have been made to ensure that high risk patients are not missed eg pregnant women, children under 5 and those patients with associated co-morbidities.

When levels C or D are implemented there is the option to set up a 'Clinical Decision (CD) sector' so all Amber calls can be gathered and reviewed by paramedics and then sent to an appropriate place eg sector where ambulance dispatch is obviously needed, amber 2's to CTA (increased call back time to 2 hours and not using PSIAM) or Clinical Support Desk (CSD)

for Amber 1s for clinical review. (We have tried it the other way around - all calls go to sector and then the area controller moved them to CD, but this was not effective as sick patients who obviously needed a response were bounced across when vehicles were available. Green calls went direct to CTA / NHSD.

NHSD have had very long call back times - up to 12 hours at times so their ability to help has been limited.

Clinical staffing to maintain safety:

This has depended heavily on 2 or 3 CSD trained staff - one to manage core enquiry work from crews, one to manage interhospital transfers and HCP calls and one to manage and oversee the CD sector. A clinical floor walker has been used to support call handlers.
Ring backs (to check on patient welfare and safety can, and should be done by Team Leaders or other suitably trained paramedics eg HEMS, Public Order Team (very helpful on NYE), HART, ECPs etc. These people do not need to be formally CSD trained as they are making a clinical assessment of the patient rather than giving advice / guidance to colleagues. Issues around the deployment of Team Leaders have been the most stressful part of the DMP for both Gold Medic, Gold Doctor and AOM ops and AOM EOC. Some staff groups have been very helpful in particular Medical Directorate, Public Order team, Bank CSD, ECP leads.

In summary:

- DMP has been introduced successfully though there are a few changes needed to make following this period of very intensive use. The fundamental aim of maintaining clinical safety is manageable at levels C and D and no substantial changes are envisaged.
- Level F presents more challenges and carries very substantial risk. It was used once, on NYE, when the call rate was at an unprecedented level and 400 calls were being held.
- The frequency of implementation of the plan needs to be monitored bearing in mind the potential and unquantified clinical risk that it brings.
- Better communication with GPs is needed to ask them to use other methods of transporting patients eg patient seen by GP and sent home to collect belongings and then call 999.
- Main clinical risk area has been elderly patients remaining on the floor and interhospital transfers (6 incidents have come to light to date - 4 resolved and 2 being reviewed this week)

Issues highlighted to SMG: Support is required for the training and use of a much larger pool of Team Leaders. We cannot keep relying on the Medical Directorate or small number of CSD bank paramedics - they are needed to cover core CSD work. We also need to review the clinical input to the DMP.

The need to remind Commissioners of the potential clinical risk that the LAS carries each time the DMP is implemented.

2.2.5 Paediatrics

The clinical expert panel convened by the Medical Directorate to consider issues around non conveyance of children under the age of 2 years was due to meet on 24th November. This meeting has been deferred due to both operational pressures and limited progress in providing additional equipment for frontline staff.

2.3   Summaries of clinical audit or research projects that are currently being undertaken by the Clinical Audit & Research Unit:
.
A summary of the findings Summary of Findings from Cycles Three and Four of the National Clinical Performance Indicators is included under Appendix 1.

The Board will note the LAS continued to score highly in most National CPI indicators in Cycles Three and Four; however there remain some areas for improvement. In particular scores on the care bundles, where a number of indicators are considered together and each element must be delivered to count as a positive delivery of the bundles, were poor for STEMI, cardiac arrest and asthma. We also scored poorly on referral of hypoglycaemic patients who were not conveyed to hospital.

Governance

3. Medicines management update

3.1 Untoward incidents: One instance of the loss of a controlled drug has been reported since my last report where two ampoules of morphine are unaccounted for. This is currently under investigation but would appear to be a counting and documentation error.
No instances of loss or misuse of other drugs has been reported

3.2 Medicines Management Group (MMG) update
The primary function of the MMG is to ensure that high quality patient care is being delivered by the London Ambulance Service NHS Trust through effective use and management of medicines. The MMG also looks at all aspects of the introduction of proposed new drugs, as well as reviewing existing drugs.

The fourth meeting of the MMG for 2010 / 11 took place on 15th December 2010. The meeting focussed primarily on:

- Governance structures for Controlled Drugs following receipt of the report on the unannounced visits that took place on the 18th November 2010
- Improving the governance regarding the Paramedic and General Drugs Bags.

- Financial case for the introduction of a pre-filled saline syringe for flushing cannulae (covered in report to Clinical Quality, Safety and Effectiveness Committee)
- Further discussion on feasibility trial of using IV paracetamol. (covered in report to Clinical Quality, Safety and Effectiveness Committee)

Governance structures for Controlled Drugs following receipt of the report from the Metropolitan Police Controlled Drug Unit on the unannounced visits on the 18th November 2010.

Four Complexes (Romford, Greenwich, Camden & New Malden) received unannounced visits. As a result the following recommendations have been considered:

Authorised Signatory Forms: These need to be more accessible to the inspecting teams. A solution acceptable to both parties is being progressed so that the sheets are placed into a pocket at the rear of a properly printed and bound booklet kept in the Administration Office of the Main Station for the Complex. On the Satellite Stations there is no need for the Authorised Signatory Sheet to be in the booklet so the booklet could be kept within the CD Safe.

CD Cabinets: All were found to be locked, secure and in good order. However the method of Code Change Notification was not sufficiently secure. An alternative suggestion is to be trialled.

CD Order Books: On three of the four Complexes the order books were in good order. At one Complex some orders had been signed for by a non authorised person.

CD Registers: In the main all the CD Registers were in good order. However at one Complex the CD Register did not detail an incoming order correctly and at another Complex there was one complete page missed out.

PRF Completion / Recording CD usage – wastage: on too many occasions the reconciliation of the CD Register for used / wasted morphine is not being undertaken correctly. An alternative suggestion is to be trialled

The report was anonymised and shared with all AOMs, DSOs and Team Leaders. It will be discussed at the next AOM Meeting where the Chair of MMG will progress this work.

Improving the governance regarding the Paramedic and General Drugs Bags

Logistics are currently looking at a bar coding system that can be used for both stock control at Deptford Logistics as well as Stock Control at Station level. The longer term aim would be to integrate the ID / Swipe Card system with barcode reading CD stock control / Paramedic Drug Bag Control.

This approach was supported by the whole MMG which acknowledged the review of drug bags work already underway but recommended that this work should be accelerated with a definitive, costed solution within, if at all possible, 6 months.

The above points were fully supported by Clinical Quality Safety and Effectiveness Committee at their meeting of the 18th January 2011.

Patient Focus

The Patient Experience Report is included under agenda item 18 of the Trust Board report.

The Medical Directorate will be assisting the membership team in the London Ambulance Service Emergency Heart Care Event 'An evening with us' on Thursday 27th January, to demonstrate our progress in cardiac arrest survival and the management of heart attacks in London.

Accessible and Responsive Care

Nothing further to report

Care Environment and Amenities

6.1   Infection Prevention and Control Update

The Trust is now currently collecting results for premises and vehicle audits, make ready deep cleaning audits, and hand hygiene compliance but the suite of data are not currently being considered alongside each other. The infection control team are developing a new balance scorecard for infection prevention and control that captures all of the information available. This will be piloted at the next infection prevention and control meeting scheduled for 18 February. In addition, the area Performance Improvement Managers are taking on the responsibility for driving improvements in infection control and as such will be reporting progress to the infection control committee.
The biggest gap in data, and therefore assurance, is currently hand hygiene compliance. Out of the 8 Acute Trusts invited to audit our staff only St George's has commenced regular audits and the results are a disappointing 21%. A plan has been put into place to escalate the speed at which the other 7 Trusts join the audit process and be supporting the auditing of areas through the use of staff currently on a phased return to work. Training for this staff group is on February 4. In addition the Trust will undertake an awareness raising exercise which will be supported by the visible auditing.
Current results for the areas are as follows.

	East	West	South
Premises Audit	88.6% (63% return)	87.2% (95.4% return)	85.5% (82.1% return)
Deep Clean	70% (within 8 weeks)	82% (within 8 weeks)	63% (within 8 weeks)
Hand Hygiene	-	-	21% (St George's)

Public Health

7.1 Trends in influenza and influenza-like illness

Current Picture

As of 19.01.2011 the HPA weekly report shows influenza activity in a slight decline with GP consultation rates dropping across the UK, but still above threshold levels. According to the Q Surveillance sentinel surveillance scheme, influenza activity in England, Wales and Northern Ireland decreased from 81.3 per 100,000 in week 1 to 57.4 per 100,000 in week 2. Activity in London also decreased in week 2 (57.5 per 100,000 from 78.2 per 100,000 in week 1), and is now equal to the national average.

Since October, 254 influenza related deaths have been reported, an increase on the previous week again due to the backlog from the holidays. The all cause death rate in the UK continues to be above the predicted (10,000/wk) and upper limits (11,000/wk) and increasing (currently 12,644/wk), mainly due to the recent cold weather and circulating respiratory viruses.
Generally a gradual decline in flu activity and data still catching up from Christmas; our own call data supports the general decline in activity however there are still a lot of very sick people out in the NHS in London with approximately 81 people in critical care across London with Flu related illnesses 65 of these people in the 14-64 age range.

7.2 Flu vaccination update

1195 staff vaccinated so far, with areas planning clinics for this week so that figure will increase next week.

Recommendation

That the Board notes the report

Fionna Moore,
Medical Director

26th January 2011

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Appendix 1

Clinical Audit & Research Summary Reports for the Trust Board

Authors: Joanna Day, Frances Sheridan
Clinical Audit & Research Unit, Medical Directorate

National Clinical Performance Indicators: Summary of Findings from Cycles Three and Four

Introduction

National Clinical Performance Indicators (CPIs) are a measure by which all ambulance services in England are able to compare their performance against one another, enabling identification of clinical areas for improvement.

The National CPIs are facilitated by the National Ambulance Services Clinical Quality Group (NASCQG) and look at five clinical areas: ST-elevation myocardial infarction (STEMI), Cardiac Arrest, Stroke, Hypoglycaemia and Asthma. The evaluation of each clinical area is repeated in 6 month cycles. Four cycles have now been completed.

Results

The table below shows LAS compliance against each of the National CPIs from Cycles Three and Four of the National CPI programme, alongside national averages.

Indicator	Cycle 3		Cycle 4	
	LAS Compliance	**National Average Compliance**	**LAS Compliance**	**National Average Compliance**
STEMI				
Two pain scores recorded*	84%	72%	82%	78%
Morphine given	61%	55%	69%	65%
Aspirin administration*	97%	87%	99%	94%
GTN administration*	92%	81%	91%	90%
Analgesia given*	49%	54%	55%	66%
[Pilot] Oxygen saturation recorded	99%	90%	99%	94%
[Pilot] Care bundle a	42%	45%	41%	53%

Stroke				
FAST assessment*	95%	93%	96%	95%
Blood glucose measurement*	94%	89%	97%	91%
Blood pressure measurement*	99%	99%	100%	98%
[Pilot] Time of onset of stroke recorded	63%	51%	67%	67%
[Pilot] Care bundle a	88%	83%	93%	86%
Cardiac Arrest				
ROSC on arrival at hospital	22%	25%	20%	19%
Defibrillator on scene*	95%	98%	94%	95%
Time to respond ≤ 4 b minutes*	18%	27%	14%	24%
ROSC at hospital from initial rhythm VF/VT	40%	41%	33%	29%
[Pilot] Care bundle a	17%	27%	13%	23%
Hypoglycaemia				
Blood glucose measured before treatment*	100%	98%	99%	99%
Blood glucose measured after treatment*	96%	97%	95%	97%
Treatment recorded*	98%	97%	97%	97%
[Pilot] Direct referral made to an appropriate health professional	7%	27%	5%	19%
[Pilot] Care bundle a	94%	92%	92%	92%

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Asthma				
Respiratory rate recorded*	100%	98%	99%	99%
Peak flow recorded (before treatment)*	57%	32%	52%	42%
Oxygen saturation recorded (before treatment)*	78%	89%	75%	91%
Beta 2 agonist given*	97%	92%	98%	96%
Oxygen administered	95%	89%	96%	92%
[Pilot] Care bundle [a]	51%	28%	47%	40%

[a] *The care bundles assess the number of patients that received a combination of indicators for a National CPI. The indicators which make up the care bundles are indicated by an asterisk (*).*

[b] *Call start to arrive scene*

Discussion

The LAS continued to score highly in most National CPI indicators in Cycles Three and Four; however there remain some areas for improvement.

In Cycle Four, 16 of the 20 indicators had a score above, or similar to, the national average. Peak flow recorded before treatment for patients suffering from asthma was particularly well documented with a compliance score for the LAS 10% above the national average. Four areas in Cycle Four scored lower than the national average; recording oxygen saturation before treatment for asthma patients again is an area of concern with the compliance score in Cycle Four being 16% below the national average.

When comparing LAS compliance for Cycles Three and Four, the majority of the indicators that were assessed scored higher than, or were similar to, the national average. Substantial improvement was achieved in the LAS's treatment of STEMI patients, with the compliance score for administering analgesia rising by 6% and morphine rising 8%. This improvement may be due to a poster campaign implemented by the Clinical Audit and Research Unit encouraging analgesia administration, particularly morphine, to STEMI patients. Although this is an improvement for the Service, the LAS compliance score for providing analgesia to STEMI patients is still below the national average and improvement should still be encouraged.

The LAS continues to score highly in several indicators: FAST assessment and blood pressure measurement for stroke patients; defibrillator on scene for

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cardiac arrest patients; blood glucose measured before and after treatment and treatment recorded for hypoglycaemic patients; respiratory rate recorded and beta 2 agonist given for patients suffering from asthma, consistently achieving over 90% in all four cycles.

During Cycle's Three and Four NASCQG introduced eight pilot indicators including: care bundles for each National CPI, and three new indicators: Oxygen saturation recorded for STEMI patients; Time of onset of stroke recorded, and Direct referral made to an appropriate health professional for hypoglycaemic patients. In both cycles the LAS had above the national average compliance for five of the eight measures. The LAS performed particularly well when recording oxygen saturation for STEMI patients, this observation was taken 99% of the time in both cycles. In Cycle Three the LAS achieved a compliance score 10% above the national average for recording time of onset of stroke. However, the LAS Cardiac Arrest care bundle compliance score was below the national average in both cycles, as was direct referrals for hypoglycaemic patients. The LAS STEMI care bundle score was below the national average compliance in Cycle Four.

Summary

For most of the indicators in Cycle Four the LAS had a score above, or similar to, the national average including some indicators that far exceeded it. However, there were some indicators where the LAS scored poorly in comparison to the national average, such as recording oxygen saturation before treatment for asthma patients. This is an area of concern. The majority of scores were consistent with, or higher than, Cycle Three with a great improvement in the administration of analgesia to STEMI patients. This remains an area of concern despite the improvement.

The pilot indicators introduced in Cycle Three were again assessed in Cycle Four and the LAS achieved above the national average compliance for most indicators. However, the STEMI and Cardiac Arrest care bundles and documentation of direct referrals for hypoglycaemic patients were below the national average compliance in Cycle Four.

LONDON AMBULANCE SERVICE TRUST BOARD

3RD FEBRUARY 2011

PAPER FOR NOTING

Document Title:	**Learning Disability Report**
Report Author(s):	**Steve Lennox**
Lead Director:	**Steve Lennox**
Contact Details:	**020 77832299**
Why is this coming to the Trust Board?	**Letter from David Nicholson asked Boards to consider their position regarding patients with a Learning Disability**
This paper has been previously presented to:	☐Strategy Review and Planning Committee ☒Senior Management Group ☐Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☒Other (Learning Disability Group)
Recommendation for the Trust Board:	Note the report

Executive Summary

This short report is prompted by David Nicholson's letter (October 2010) asking all Trust Boards to consider their position regarding the care of patients with Learning Disabilities. His letter identifies two specific points for Boards to report on but the opportunity has been taken to report on a wider set of indicators than those highlighted in David Nicholson's letter.

The reported indictors are
Two indicators in David Nicholson's letter (2 Green status)
Six Care Quality Commission Outcomes (1 Green, 2 Amber, 3 Red status)
Four recommendations in the report healthcare for all (2 Amber, 2 Red status)

This is supported by an Action Plan that is being monitored by the learning Disability group.

Key issues for the Trust Board

The Trust needs to progress two key actions;
  1) Recording of disability on the Patient Report form
  2) Recording of disability when patients feedback (especially complaints)
This will allow the Trust to look at information and indicators in greater detail.

Attachments

Report with appendices (David Nicholson's Letter and the Action Plan)

****

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

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

Risk Implications
This paper links to the following strategic risks:

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

NHS Constitution
This paper supports the following principles that guide the NHS:

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

Equality Impact Assessment

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

Key issues from the assessment:

However, the trust Equality lead is a member of the Learning Disability Group.

LEARNING DISABILITY UPDATE

1. **INTRODUCTION**

   1.1. The issues of care and quality facing patients with learning disability have been receiving increased attention since the publication of the Mencap report Treat Me Right (2004). The report presented a strong case to suggest the NHS had a poor track record of caring for people with learning disabilities.

   1.2. This was followed by a number of subsequent reports from different organisations suggesting that the NHS had made little progress since Mencap had raised the issue.

   1.3. In 2007 there was a high profile report from the Healthcare Commission into the care and treatment of patients with learning disabilities at Sutton and Merton Primary Care Trust. This significantly raised the profile of learning disability within the regulatory authority.

   1.4. Healthcare for All (2008) was commissioned by Patricia Hewitt. The NHS, the Department of Health and the regulatory authority all faced severe criticism. This led to David Nicholson writing to all Trust Boards in 2008 asking them to urgently review the recommendations.

   1.5. However, despite the heightened awareness, along with the NHS, the regulatory authority came under continued criticism within the Six Lives Report (2009) produced by the Parliamentary and Health Service Ombudsman.

   1.6. In July 2010 David Nicholson wrote to Chief Executives again. On this occasion it was reinforcing the work required from the Mental Capacity Act

   1.7. A progress report on Six Lives was published in October 2010. This recognised that there was significant progress but there was work still to do. Consequently, David Nicholson wrote to Chief Executives for a third time (the letter is within appendix I) asking for Trust Boards to assure themselves that the law is being followed in two specific areas;
   - Making 'reasonable adjustments' in line with the Disability Discrimination Act (2005) and now the Equality Act (2010)
   - Assessing capacity, gaining consent and best interest decision making in line with the Mental Capacity Act 2006

   1.8. Consequently Learning Disability is receiving an increased focus with the Care Quality Commission and within the Department of Health.

   1.9. This short report RAG rates the Trust on all of the recent high profile measures (David Nicholson's Letter, Care Quality Commission Outcomes and Healthcare for All). The ratings have been applied following discussion at the Learning Disability Group which has representation from MENCAP. They may appear disappointing however the fact the Trust has a dedicated group driving a Learning Disability work plan places the Trust in a stronger position than many other Trusts. In addition many of the lower ratings are as a direct result

of two single gaps; 1) the Trust does not currently record disability at the point of care and 2) the trust does not record disability when patients provide feedback (specifically complaints). Both of these points are within the action plan and once implemented will considerably improve the trusts position.

2. DAVID NICHOLSON'S LETTER 2010

2.1. The Learning Disability group met on 11 November and specifically considered the two points within David Nicholson's letter. The group RAG rated the Trust green for both points.

2.2. The following details the committee's assessment.

Point 1
Making 'reasonable adjustments' in line with the Disability Discrimination Act (2005) and now the Equality Act (2010)

RAG Rated   Green

Evidence
The Trust has a Policy Statement of Duties to Patients (revised in 2010) which clearly sets out the expectations of staff to treat patients as individuals. The Trust has in place an Equality & Inclusion Strategy 2010-2013 which outlines the Equality Impact Assessment process and the use of critical friends. In addition, the Trust retains its accreditation for Positive About Disabled People. However, the committee highlights that the majority of evidence is process based and the Trust needs to move towards the monitoring of outcome in order to strengthen assurance. The need for being outcome focussed is receiving specific attention within the learning disability action plan.

Point 2
Assessing capacity, gaining consent and best interest decision making in line with the Mental Capacity Act 2006

RAG Rated   Green

Evidence
The Trust has a Policy for Consent to Examination or Treatment (revised 2010) which outlines the responsibilities within the Mental Capacity Act and contains specific forms to document the occasions when the patient does not have the capacity to provide consent.

3. CARE QUALITY COMMISSION OUTCOMES

3.1. The Learning Disability Group evaluated the Trust's position against the Care Quality Commission Outcomes in the January meeting. This was undertaken through discussion and challenge.

3.2. There are no specific indicators focussed on patients with learning difficulties although there are references to vulnerable groups within the Care Quality Commission Outcomes. Instead the committee discussed how the Trust would evidence that the standards were being applied to this particular group of patients.

3.3. The RAG rating is not necessarily a reflection of the Trusts overall compliance with the outcomes; just this particular group.

3.4. The following Care Quality Commission Outcomes have been RAG rated. Any gaps in assurance or clinical practice have been added to the Learning Disability Action Plan (Appendix II)

Outcome 1
Respecting and involving people who use services

RAG Rated   🟧 Amber

Evidence Gap
The group members were confident that through their own experiences of observational "ride outs" that respect was given to all patient groups and the membership discussed a number of practice examples. However, the Trust is not in a position to be able to evidence this as the trust is not currently recording disability information when patients feedback. However, the Trust could evidence examples where people with learning disability have been specifically consulted and the Director of Health Promotion and Quality is meeting members of MENCAP in February to specifically discuss the needs of this group of patients.

Outcome 2
Consent to care and treatment

RAG Rated   🟥 Red

Evidence Gap
Whilst scoring green against David Nicholson's second point for procedures and processes the Trust has not undertaken an examination of compliance with policy.

Outcome 4
Care and welfare of people who use services

RAG Rated   🟥 Red

Evidence Gap
The significant gap is that the Trust does not currently record disability on the Patient Report Form and therefore can not look at outcome measures for this group of patients.

Outcome 6
Cooperating with other providers

RAG Rated   🟥 Red

Evidence Gap
The Trust is unable to evidence that disability is part of the handover. Adding this information to the Patient Report Form will enhance the Trust's ability to evidence this outcome.

Outcome 7
Safeguarding people who use services from abuse

RAG Rated   🟩 Green

Evidence
The Trust is in a strong position when evidencing safeguarding referrals and compliance with safeguarding training.

Outcome 16
Assessing and monitoring the quality of service provision

RAG Rated ⬛ Amber

Evidence Gap
Again the gaps are regarding the Trust not recording disability on the patient report form or when receiving feedback.

4. RECOMMENDATIONS FROM HEALTHCARE FOR ALL
4.1. There are four main recommendations arising from the Healthcare for All (2008) report for consideration by Acute NHS Providers. These were RAG rated by the Learning Disability group at the November meeting.

4.2. The following details the committee's assessment.

Recommendation 2
All health care organisations should ensure that they collect the data and information necessary to allow people with learning disability to be identified by the health service and their pathways of care tracked

RAG Rated ⬛ Red

Evidence Gap
Again the gaps are regarding the Trust not recording disability on the patient report form or when receiving feedback.

Recommendation 10
All Trust Boards should demonstrate in routine public reports that they have effective systems in place to deliver effective, 'reasonably adjusted' health services. This should include arrangements to provide advocacy for all those who need it, and arrangements to secure effective representation on PALs from all.

RAG Rated ⬛ Red

Evidence Gap
Again the gaps are regarding the Trust not recording disability on the patient report form or when receiving feedback.

Recommendation 9
Section 242 of the National Health Service Act 2006 requires NHS bodies to involve and consult patients and the public in the planning and development of services, and in decisions affecting the operation of services. All Trust Boards should ensure that the views and interests of people with learning disabilities and their carers are included

RAG Rated ⬛ Amber

Evidence Gap
The evidence gap is similar to that reported for the Care Quality commission Outcome 1.

Recommendation 3
Family and other carers should be involved as a matter of course as partners in the provision of treatment and care, unless good reason is given, and Trust Boards should ensure that

reasonable adjustments are made to enable and support carers to do this effectively. This will include the provision of information, but may also involve practical support and service co-ordination

RAG Rated   🟧 Amber

Evidence Gap
The group membership was confident that carers and partners were involved in the clinical setting. However, the Amber rating reflects the fact that the Trust can not evidence that suitable adjustments take place.

5. NEXT STEPS

5.1. An action has been assembled and was reviewed in January 2011. Delivery of the action points will form the core business of the group and progress will be reported to the Clinical Quality, Safety and Effectiveness Committee.

5.2. A number of the action points may require investment in order to progress full delivery. It has been agreed by the group to deliver each objective as far as possible and issues of funding will be brought to the attention of the Senior Management Team as they arise.

5.3. The action plan is enclosed in Appendix II.

APPENDIX I

DH Department of Health

From the Office of Sir David Nicholson KCB CBE
Chief Executive of the NHS in England

TO:
All Chief Executives in NHS Trusts in England
All Chief Executives in NHS Foundation Trusts in England
All Chief Executives in Primary Care Trusts in England
All Chief Executives in Strategic Health Authorities in England
All Chief Executives of Independent Providers

Richmond House
79 Whitehall
London
SW1A 2NS
Tel: 020 7210 5142
Fax: 020 7210 5409
david.nicholson@dh.gsi.gov.uk

CC:
All Chairs of NHS organisations in England
All Chief Executives of Local Authorities in England
Monitor
Care Quality Commission
Local Government Association

Gateway ref: 14769

14 October 2010

Dear colleague,

Publication of 'Six Lives' progress report

In March 2009 the Parliamentary and Health Service Ombudsman and Local Government Ombudsman published 'Six Lives: The provision of public services to people with learning disabilities', an investigation into the deaths of six people with learning disabilities who were in the care of the NHS. Their report contained serious criticism of the way public services responded to the needs of people with learning disabilities:

> 'The investigation reports...show the devastating impact of organisation behaviour which does not adapt to individual needs, or even consistently follow procedures designed to maintain a basic quality of service for everyone. They identify a lack of leadership and a failure to understand the law in relation to disability discrimination and human rights. This led to situations in which people with learning disabilities were treated less favourably than others, resulting in prolonged suffering and inappropriate care' ('Six Lives')

'Six Lives' included a series of recommendations, one of which was for the Department of Health to support implementation and publish a progress report outlining what had been done. This progress report was published today. I would like to thank colleagues whose support in sharing information enabled us to assess

where we are. You can read the full report on the DH website at
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyA
ndGuidance/DH_120251
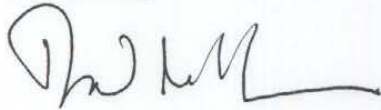
This report recognises that much work has been done in some organisations to
improve health care for people with learning disabilities, and progress has been
made, but good work is not embedded everywhere and serious concerns remain.
These concerns particularly centre on how far the law is being followed in terms of:
- making 'reasonable adjustments' in line with the Disability Discrimination Act
  2005 and now the Equality Act 2010
- assessing capacity, gaining consent and best interest decision making in line
  with the Mental Capacity Act 2006

As set out in my letter of 29 June 2009[1] and 13 July 2010[2], it is essential for the NHS
to make reasonable adjustments for people with learning disabilities and ensure
they are following correct processes for people who may lack the capacity to make
particular decisions about their care and treatment

I would like to ask all Boards to assure themselves that their staff are following the
law in these areas with all those in their care. I would also ask Boards to consider
how to maintain progress in improving the health care of people with learning
disabilities. If we ensure our services are getting it right for people with learning
disabilities, they will have the patient-centred approach that will improve care and
treatment for all.

Yours faithfully,

Sir David Nicholson KCB CBE
NHS Chief Executive

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[1] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_0
86604.pdf
[2] http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/D
H_117412

APPENDIX II

Learning Disability Group Trust Action Plan Created Sept 2010 Updated January 2011

Delivery Plan

Summary of Workstreams and Status

20 January 2011

Workstream	R.A.G.	R.A.G.	R.A.G
	09/10	11/10	20/01
Workstream 1. Improving access to information about LAS for people with learning disabilities (CQC Outcome 1).	🟥	🟧	🟩
Workstream 2. Improve staff education and training on learning disabilities and provide aids and techniques for staff when dealing with learning disabled patients (Healthcare for All Recommendation 10. CQC Outcome 2, 3 and 7).	🟥	🟩	🟩
Workstream 3. Introduce data capture of disabled people accessing our services (Healthcare for All Recommendation 2. CQC Outcome 7 &16).	🟥	🟥	🟧
Workstream 4. Improve partnership working with learning disabled groups (Healthcare for All Recommendation 9 & 3. CQC Outcome 6)	🟥	🟩	🟩
Workstream 5. Assurance regarding CQC requirements	🟥	🟥	🟥

APPENDIX II

Learning Disability Group Trust Action Plan Created Sept 2010 Updated January 2011

Workstream 1. Improving access to information about LAS for people with learning disabilities. (CQC Outcome 1)								
Objective	Current State	Action	Imp' Lead	Operational Lead and involved individuals	Date of Completion	Current Risk	Measure of Success	Evidence
1.1 Producing DVD on role of LAS	Agreed with Bexleyheath Mencap commitment to develop	Producing DVD on role of LAS	Margaret Vander	Alan Taylor/ Richard Walker	June 2011		When fully produced and available	DVD
1.2 Review and improve external website	Suggested current web site is not compliant with best practice	Review external web site and identify gaps in best practice	Angie Patton	Vicky Hirst/ Jenny Round	January 2011		Know where we are not compliant with best practice	Website review
1.3 Easy read version of choose well	Reviewed by Learning disabled group to be considered at materials sub group for next steps	Develop an easy read version of Choose well	Angie Patton	Jenny Round	~~January 2011~~ April 2011		When fully produced and available	Leaflet available
1.4 Telephone prompt card	Reviewed by Learning disabled group. With Paul Constantinou	Develop a telephone prompt card	Margaret Vander	Ruth Lewis	April 2011		When fully produced and available	Leaflet available

Update 11 November 2010

1.1 Outline of DVD agreed. Alan agreed to lead and feedback. June appears a sensible completion date.

1.2 Bexleyheath "Respect" user group agreed to take part. External review of website scored as orange. "Respect" raised issues on font and videos. Agreed that we need to undertake a small gap analysis in order to understand where it could be improved in order to guide an informed decision.

1.3 Easy read version of Choose Well completed. Just need to check it fulfils requirements.

1.4 Telephone prompt card currently being reviewed by Bexleyheath Mencap

APPENDIX II

Learning Disability Group Trust Action Plan Created Sept 2010 Updated January 2011

Update 20 January 2011
1.2 Written report completed. Need to identify any opportunities for "Easy read2 insertion, especially at the complaints page. Bexlyheath "Respect" have helped develop the DVD that will be uploaded onto the web site.
1.3 Quote for production supplied. To be reviewed when 1.4 is delivered to avoid duplication.
1.4 Reviewed by MENCAP and sent to K-International and it has expanded to 8 pages (but very good) copy to be brought to the next meeting

APPENDIX II

Learning Disability Group Trust Action Plan Created Sept 2010 Updated January 2011

Workstream 2. Improve staff education and training on learning disabilities and provide aids and techniques for staff when dealing with learning disabled patients. (Healthcare for All Recommendation 10. CQC 2, 3 & 7)								
Objective	**Current State**	**Action**	**Imp' Lead**	**Operational Lead and involved individuals**	**Date of Completion**	**Current Risk**	**Measure of Success**	**Evidence**
2.1 To develop learning disability training to staff involved in the 2012 Games	Working with Mencap to produce Package. Mencap to deliver Train the trainer package to Training officer, who will then train staff	Develop Olympic training package	Keith Miller	Alan Taylor	April 2011		When staff trained and good feedback received	Power point produced working on DVD
2.2 Introduce learning disability training to all new staff internally and via university	Discussion had with Keith and Paul once final sessions produced by Mencap will share with both and submit to Training services group	Submit finished sessions to leads for consideration	Keith Miller	Alan Taylor	June 2011		Once agreed and included in programme	
2.3 Introduce learning disability CPD training	Discussion had with Keith and once final sessions produced by Mencap will share with both and submit to Training services group	Submit finished sessions to training services group	Caron Hitchen	Keith Miller	June 2011		~~Have priority known across the Trust~~ Agreement to have on Core Skills Refresher	
2.4 To develop aids to support staff when communicating with patients with a learning disability	Working with the clear communications people to produce pocket book for a trail/review	Develop pocket communication book	Peter Thorpe	Alan Taylor/ Daryl Mohammed	March 2011		~~Up to development stage~~ Printed by March '11	
		Identify funding for subsequent print runs		Steve Lennox	April 2011		Funding identified and allocated in budget	
		Develop communication	Angie Patton	Jenny Round	March 2011		Piece appears in LAS news	

Learning Disability Group Trust Action Plan Created Sept 2010 Updated January 2011

		piece for LAS news to accompany the launch						
2.5 To develop training aids to support staff training	Filmed with Bexleyheath Respect group. Being edited	Develop LD awareness DVD for staff	Peter Thorpe	Richard Walker/ Alan Taylor	March 2011		When complete and signed of by clinical workgroup	
2.6 Improve the understanding of staff when caring for patients with learning disability	Leaflet produced for review by Mencap/ LD group/clinical work group	~~Develop a learning disability leaflet for staff~~ To develop information for staff	Peter Thorpe	Alan Taylor/ Daryl Mohammed	March 2011		When complete and signed of by clinical workgroup	To go into Medical Directorate Update

Update 11 November 2010
2.1 Being developed in conjunction with Mencap
2.2 Agreement in principle to introducing disability training into new training programmes formalise once complete
2.3 LD as CPD needs profile and need to be made higher priority. Presentation to equality and inclusion group (AT)
2.4 Pocket book underway need to agree funds with Olympics and with SMG for continued funding
2.5 DVD underway awaiting editing
2.6 Draft of leaflet produced for review by Mencap and Learning Disability group

Update 20 January 2011
2.0 All on track
2.6 Changed following discussion from a leaflet to producing information in the form of a Medical Directorate Bulletin.

APPENDIX II

Learning Disability Group Trust Action Plan Created Sept 2010 Updated January 2011

Workstream 3. Introduce data capture of disabled people accessing our services. (Healthcare for All Recommendation 2. CQC Outcome 7 &16).								
Objective	**Current State**	**Action**	**Imp' Lead**	**Operational Lead and involved individuals**	**Date of Completion**	**Current Risk**	**Measure of Success**	**Evidence**
3.1 Introduce disability box on PRF	PRF does not allow staff to identify any of the known disadvantaged groups	To consider how the Trust can start to capture this data	Fionna Moore	Mark Faulkner	April 2011	🟧	Capturing data routinely	
3.2 Disability data capture for non clinical relationships				Janice Markey			**Being monitored by Equality Inclusion Steering Group**	
3.3 Capture complaints and thanks from disabled people	Trust is currently not able to identify complaints from disadvantaged groups	To consider how the Trust can start to capture this data	Gary Bassett	Clive Palmer		🟥		

Update 11 November 2010
3.1 This is going to be a significant challenge but we need to move towards collecting this information. To be discussed outside of the meeting.
3.2 Janice Markey agreed to take this objective to the Equality, Inclusion Steering Group. To be removed from Action Plan.
3.3 No progress on data capture from complaints. Clive suggested Gary should attend the next meeting for a wider discussion.

Update 20 January 2011
3.1 Progress made. Mark is testing that the scanning captures the modifications to the PRF.
3.3 PRF changes will assist as PRFs can be checked for complaints but Patient Experience team also to consider the use of the Equality Monitoring form.

Learning Disability Group Trust Action Plan Created Sept 2010 Updated January 2011

Workstream 4. Improve partnership working with learning disabled groups (Healthcare for All Recommendation 9 & 3. CQC Outcome 6)								
Objective	**Current State**	**Action**	**Imp' Lead**	**Operational Lead and involved individuals**	**Date of Completion**	**Current Risk**	**Measure of Success**	**Evidence**
4.1 Community involvement officers to establish local links with LD groups	Not able to evidence involvement of people with learning Disability	CIO to meet local groups to develop local initiatives	Richard Webber	Jason Killens	~~January 2011~~ April 2011		Involvement is part of routine work	
4.2 Engage local groups with development of learning materials		Involve Bexleyheath "Respect" in reviewing materials and taking part in DVD.	Keith Miller	Alan Taylor	February 2011			
		~~Involve Southwark LD partnership board in quality assurance of work~~		~~All~~			**Removed**	
		LD group to consider how best to engage with all the LD partnership boards London.		Janice Markey Carmel Dodson-Brown			Work in partnership with Equality & Inclusion Steering Group	
		Invite a member of MENCAP HQ to the Learning Disability group		Alan Taylor			Achieved	
Update 11 November 2010 **4.1** CIO meeting local groups to develop local initiatives. Steve Lennox to contact Jason Killens. **4.2** Involve Southwark LD partnership board contacted re quality assurance of work – no reply to requests so agreed to remove the action point. A member of Mencap HQ attends the learning disability work group. Janice Markey and Steve Lennox to follow up the discussion on how the Trust can engage with LD Partnership Boards. It was suggested that the Trust could hold an annual/biannual presentation to key stakeholders.								

APPENDIX II

Learning Disability Group Trust Action Plan Created Sept 2010 Updated January 2011

Update 20 January 2011
4.1 Changed at Jason's request
4.2 "Respect" involved in DVD development (action point 1.1). Carmel added to action point as she agreed to identify the pan London opportunities. Janice is going to include Learning Disability groups in the review of the Equality Strategy in June/July

Learning Disability Group Trust Action Plan Created Sept 2010 Updated January 2011

Workstream 5. Confirm CQC requirements								
Objective	**Current State**	**Action**	**Imp' Lead**	**Operational Lead and involved individuals**	**Date of Completion**	**Current Risk**	**Measure of Success**	**Evidence**
5.1 Confirm the exact requirements on the LAS to meet the CQC requirements (2009 and current)	Unaware if current practice and actions meet CQC expectations.	Carmel to review current Action Plan and give guidance on expectations	Sandra Adams	Carmel Dodson-Brown		🟩	Completed	
5.2 Consider additional items that it would be right to undertake so as to not just meet the minimum requirements		Group to consider what additional items are the 'right' thing to be undertaking		All		🟩	Completed	
5.3 To be able to demonstrate compliance with CQC Outcome 1 "Respecting and involving people who use services"	Group confident that observation of clinical practice would reveal good practice but unable to assure that this is the case	Need to have system for recording all examples of involvement with patients that have a Learning Disability	Margaret Vander	Ruth Lewis	April 2011	🟧	Recorded in the minutes of the committee (and centrally in patient engagement team)	Notes within minutes
		Capture complaints and thanks from people with a learning disability				🟥	**Being captured by Action Point 3.3**	
5.4 To be able to demonstrate compliance with CQC Outcome 2 "Consent to care & treatment""	Robust policy in place but unable to demonstrate compliance	Consider auditing practice regarding compliance	Fionna Moore	Daryl Mohammed	August 2011	🟥	Improved awareness regarding compliance with policy	

Learning Disability Group Trust Action Plan Created Sept 2010 Updated January 2011

5.5 To be able to demonstrate compliance with CQC Outcome 4 "Care and welfare of people who use services"	Group not confident that observation of clinical practice would reveal compliance with CQC standards	Capture disability data on PRF so this can be crossed referenced with outcomes				🟧	**Being captured by Action Point 3.1**	
		Capture complaints and thanks from people with a learning disability				🟥	**Being captured by Action Point 3.3**	
		To consider how to drop key CQC observations into workforce reviews and evidence these		Steve Lennox	April 2011	🟧	Evidence contained within workforce reviews	
5.6 To be able to demonstrate compliance with CQC Outcome 6 "Co-operating with other providers"	Group confident that observation of clinical practice would reveal good practice but unable to assure that this is the case	Group need to consider in more detail how the Trust can demonstrate compliance with this	Sandra Adams	Carmel Dodson-Brown		🟧		
5.7 To be able to demonstrate compliance with CQC Outcome 7 "safeguarding people who use services from abuse"	Compliant	Compliant				🟩	Compliant	
5.8 To be able to demonstrate compliance with CQC Outcome 16 "Assessing and monitoring the quality of service provision"	Group confident that observation of clinical practice would reveal good practice but unable to assure that this is the case	Capture disability data on PRF so this can be crossed referenced with outcomes				🟧	**Being captured by Action Point 3.1**	

APPENDIX II

**Learning Disability Group Trust Action Plan Created Sept 2010 Updated January 2011**

		Capture complaints and thanks from people with a learning disability					**Being captured by Action Point 3.3**	
		Meet with service users and discuss service quality		Steve Lennox	February 2011			Record of discussions

Update 11th November 2010
5.1 Operational lead changed to Carmel Dodson-Brown. Carmel not present and will be asked for her opinion.
5.2 Item not discussed as out of time

Update 20 January 2011
5.0 Review through discussion and challenge of our ability to demonstrate compliance with the 6 relevant CQC Outcomes. Additions to action plan made following discussion**.**

LONDON AMBULANCE SERVICE TRUST BOARD

3RD FEBRUARY 2011

PAPER FOR NOTING

Document Title:	**CommandPoint update**
Report Author(s):	**Peter Suter**
Lead Director:	**Peter Suter**
Contact Details:	**02077832044**
Why is this coming to the Trust Board?	**To provide the Trust Board with an update on the CommandPoint project**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	

Executive Summary: The Project is on track for go-live on 8 June 2011. The final software release (known as release 1.1) passed FAT testing on 17 December as planned. Final bug fixing is underway, as with any product of this nature, the system will go live with known, non service effecting bugs in the system.

Key issues for the Trust Board
To be aware of the risks and issues that the project is currently managing.

Attachments
CommandPoint Project Update: February 2011

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

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

Risk Implications
This paper links to the following strategic risks:

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

NHS Constitution

This paper supports the following principles that guide the NHS:

☒ 1. The NHS provides a comprehensive service, available to all
☐ 2. Access to NHS services is based on clinical need, not an individual's ability to pay
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☐ 4. NHS services must reflect the needs and preferences of patients, their families and their carers
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☒ 6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
☐ 7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

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

Key issues from the assessment:
None.

COMMANDPOINT PROJECT UPDATE: FEBRUARY 2011

1.   SUMMARY

1.1   Delivery is currently on track for go-live on 8 June 2011.

1.2   Nick Evans, CommandPoint project manager is currently not at work due to a family bereavement. In order to ensure focus and progress of the project, LAS Programme Manager Jonathan Nevison took over as CommandPoint project manager on 13 December 2010. This change in the project management team took place at the stage boundary between testing and transition. Jonathan has revisited the entire configuration file for the testing stage in a governance exercise, to provide assurance of robust stage 5 product delivery. The project consultant provided continuity of handover between the project managers, across this boundary.

1.3   Northrop Grumman have completed development of CommandPoint Release 1.1. Factory Testing of Release 1.1 commenced as scheduled on 13 December and completed on 17 December. Three members of the LAS project team attended Chantilly (USA) to witness this testing. Due to weather conditions they experienced some problems on their return trip, but did eventually arrive back in the UK on 23 December. The project has moved from stage 5 (testing) into the penultimate stage 6 (migration).

1.4   Detailed programme reviews have been a consistent part of the project controls for some time. This an opportunity for the Project Executives, Project Managers and senior project staff to meet in a 'sleeves rolled up manner' and review the project at whatever detail is required. The last review took place via teleconference on 17 December; further reviews are scheduled through to go live. They have proved a useful discipline within the overall project governance structure.

1.5   The first staff training courses commenced as planned on 6 January. There are two training rooms, each running two x three day courses over six days each week. The current schedule will complete call taking & despatch courses by 20 April, and all other training by mid May, allowing about 3 weeks contingency before 8 June. To date training is going well, with positive feedback received from students.

1.6   Skills fade from the early training courses will be prevented with skills maintenance training and a skills maintenance lab has been provisioned in UOC to enable this. The lab went live on 10 January 2011 and staff are being released from the control room to spend time in there keeping their CommandPoint skills fresh. This is a vital component (from lessons learnt from other organisations) in the overall training strategy.

1.7   Contract modification negotiations have proved extremely challenging for the contract team. Modification 8 has now been signed and work is ongoing to complete modification 9. It is important to note that the actual project work has continued in parallel and schedule has not been adversely affected due to this work.

1.8   While not formally a risk, close attention is being paid to Cat A performance recovery activities to ensure there are no conflicts with CommandPoint project requirements.

2.   WORK PLANNED FOR NEXT PERIOD

2.1   Having now completed FAT for 1.1 a prioritised fault list for the system has been prepared. There are 4 priorities of faults:

	Description	Acceptable for Go live
P1	CRITICAL - Prevents a critical element of the system from functioning or may result in loss or corruption of data or loss of service or degraded system.	0
P2	MAJOR - A non-mission critical element of the system is not functioning. A workaround is not available.	0
P3	MINOR – A fault in a non-critical element of the system. A workaround is available that enables normal operation of the system	negotiable
P4	COSMETIC – Cosmetic issues only. No workaround required.	negotiable

2.2   The focus is to now review all the P3 & P4 faults and agree which ones will be resolved prior to go live, and which ones are acceptable for go live. In order to achieve this a more detailed impact assessment has been designed as follows:

- Each P3 and P4 fault is assessed for potential impact on ease of operation, patient safety and crew safety and a 1 (minimal) to 3 (potentially severe) rating applied in each of these three areas.

- The three ratings are added together to provide an overall impact grading between 3 (low) and 9 (high).

2.3   A review group led by the senior users have applied this grading to each fault and NG have been asked to work to resolve as many faults as realistically possible (starting at level 9). Planning assumption is to resolve all faults somewhere around level 6 and above. It is anticipated that the open fault list would be in the region of between 100 and 150 at the time of go live (this includes a large number of cosmetic issues).

2.4   The Installation and initiation of 'Site Integration Testing' and 'User Acceptance Testing' of release 1.1 commenced on 17 January 2011 and is running to plan.

2.5   Detailed work is underway for the Transition plan. This includes detailed technical and operational cut-over and roll back scenarios and response plans; technical and operational dry run schedules; technical and operational briefings pre- post- and during transition.

2.6   Further development of 'Reference Data Products.' This series of products provides all of the configuration data for CommandPoint. All of the static data (e.g., location addresses) required for go-live has now been loaded, apart from the response profile rules which are subject to change under the new Cat B regime and are on hold awaiting further clarification (see 5.4 below). Some of these sets, however, are dynamic, for example user names. Collection of these sets is initiated, with plans in place between now and go-live to pull together this data and load it. Other reference data sets relate to functionality not currently available under CTAK. 'Activity Pattern Monitor Rules', for example, can be set up with

parameters to provide alerts if statistically significant swings occur across a range of different indicators, including call volumes by area, determinant types or multiple dispatches to single incidents. Work is underway to develop the use of these in conjunction with the business change management arrangements for the project.

3.   TIMETABLE

3.1   The transition is planned to take place between midnight and 07:00 hours on Wednesday 8 June 2011. An outline plan detailing the key milestones is attached at Appendix 1.

4.   FUTRE COMMANDPOINT RELEASES

4.1   Consideration needs to be given to the future, long term direction of CommandPoint Development. From a LAS perspective, it is reasonable to assume that there may need to be:

- A bespoke interface developed to pass calls to another agency

- A bespoke interface developed to an alternative triage software

- Implementation of essential functions identified once experience gained on release 1.1

- Changes required to accommodate CRM

4.2   At this time however, not all of these requirements are clear, particularly the significant interface developments. Consideration needs to be given to a potential timetable for this work. NG have indicated a 9 month cycle for further bespoke developments - this indicates decisions in March if the LAS require a release 1.2 in January 2012. There will also be budgetary implications for this work.

4.3   Taking a longer term view, CommandPoint is a standard product used by a number of US based emergency services. The NG approach is that all developments are built into the core product and made available to all users. From a strategic perspective, the LAS should consider limiting bespoke LAS development to release 1.2 and then moving towards working with the standard product. In this way, bug fixes and developments would be considered across all users and the LAS would obtain the benefit of using a standard product and being part of an international user group steering the products future development.

4.4   The preferred direction of travel is migrate toward the LAS using a standard product and then influencing developments through an international user group. This would probably be post a LAS release 1.2 of the product.

5.   RISKS & ISSUES

5.1   Risks are recorded in the Project Risk Log. A weekly report is provided to the Project Executive highlighting the most significant risks. These risks are listed in Appendix 2.

5.2   Risk 117 relates to the reconfiguration required within EOC. The amalgamation of all resources within a geographical area under a single controller is an essential requirement for CommandPoint. This work is being planned and overseen by the ADO for Control Services. Given the significance, the Trust Board need to be aware of this risk.

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5.5 Issues are recorded in the Project Issue Log and mitigation discussed in the fortnightly checkpoint meetings. These issues are listed in Appendix 3. One issue is brought to Trust boards attention.

5.6 Issue 123 was raised this period relating to the changes arising from end of the Cat B target and the new categorisation of calls into Red and Green. There are two sub-issues affecting the response profile rules is CommandPoint:

- How the response rules change, i.e., are there any determinants to which we no longer send as the first response (we telephone triage) or to which we might send different responses (e.g., an FRU/MRU/CRU instead of an AEU)

- How the priority rating will change for the Amber 1 and 2 determinants. In other words, those that will go up to red (Cat A), and those that go down to green (no response target.)

6. OVERVIEW OF 2010/11 BUDGET

6.1 The project remains within the overall budget agreed by the Trust Board. Some spend profiling has been amended due to the movement of the go-live date to 8 June 2011. Details of the 2011/12 budget has yet to be agreed but will be funded from within the Contingency Reserve. High level details are shown in the table below.

| | FBC Approval (Issue 3.1) | Budget Adjustments | Revised Budget | Previous Years Spend | Current Year | | Future Years | Total Project | |
					Spend	Forecast		Spend	Variance
Capital Northrop Grumman Costs	8,315	751	9,066	7,495	597	571	403	9,066	(0)
LAS Costs	5,897	(245)	5,651	3,843	1,023	777		5,643	9
Total Capital	14,212	505	14,717	11,338	1,620	1,348	403	14,709	8
Revenue Northrop Grumman Costs	1,493	(375)	1,118		1,118			1,118	(0)
LAS Costs	4,592	(1,396)	3,196	936	1,251	906		3,093	103
Total Revenue	6,085	(1,771)	4,314	936	2,369	906	0	4,211	103
Project Board Budget	**20,296**	**(1,265)**	**19,031**	**12,274**	**3,989**	**2,254**	**403**	**18,920**	**111**
Contingency	5,228	(190)	5,039	0	0	0	0	0	5,039
Total	**25,525**	**(1,455)**	**24,070**	**12,274**	**3,989**	**2,254**	**403**	**18,920**	**5,150**

7.   RECOMMENDATION

7.1   The Trust Board are asked to note the contents of this report and progress of the CommandPoint Project.

Peter Suter
Project Executive
Director of Information Management & Technology

APPENDIX 1: Key Milestones.

CommandPoint- High Level Plan			
Description	**Deliverables**	**Plan Date**	**Progress/Rev**
User Acceptance Testing	Complete second iteration	22/10/10	Completed for R1.0 R1.1 to commencing by end Jan.
Pilot Course	Running the pilot course for End Users. This will trial the course content and training material. Following completion, the training materials will be finalised.	29/11/10	Complete for CT and DP courses, CTA still to do.
FAT 1.1	Commence FAT of Release 1.1 (Note this is not on the critical path)	13/12/10	Complete
Commence Pre Go-Live User Training	15 week programme, to train all control services staff.	6/1/11	Underway.
Gateway 4	Full gateway review to assess readiness to go live	TBC/2/11	Planned for 14/3/11
Release 1.1	Release 1.1 used in training.	22/2/11	Deferred to April 2011
Complete Pre Go-Live User Training	All staff trained in their primary job function (Call Taking or Dispatch). A number of staff on each watch trained in both Call Taking and Dispatch Functions.	20/4/11	On target
Final preparation	Final technical and operational preparations for transition to CommandPoint.	21/4/11	Underway
Transition Date	The actual go live date for CommandPoint.	8/6/11	
+60 Days	Post go live focus to ensure; Bug fixes Embedded working practices Return operational performance back to previous levels	7/8/11	
Release 1.2	The current plan has a requirement to build an interface to PSIAM for CTA. The details of this work and timetable have yet to be specified.	TBC	
Post Go-Live Training	Follow-up training to ensure that all staff have received training in both Call Taking and Dispatch Functions	TBC	
Project closure	Formal closure and handover to in-life team.	TBC	

Appendix 2: Most Significant Risks

Risk Id P / I	Title	Score	Owner	Description
117 **4/5**	FRU Desk / UOC Changes in Control Services	20	Fiona Carleton	There is a risk that a reconfiguration of the dispatch or call taking functions of the Emergency Operations Centre (EOC) (For instance to accommodate the disestablishment of the Fast Response Unit (FRU) Desk and Urgent Operations Centre (UOC)) is not controlled by the Operations Change Management Group, resulting in a delay to the date of Go Live, causing a cost and time overrun.
118 **4/5**	MDT2: Lack of MDT engineering information	20	John Downard	There is a risk that the Trust will be unable to receive sufficient 'engineering information' from all MDT devices across all LAS vehicles equipped with an MDT, due to a delay (for whatever reason) in completing the roll out of MDT/2 to all necessary vehicles before CommandPoint Go Live. This will cause unacceptable compromises to the capability to identify, diagnose and/or rectify any related faults that may occur (or produce essential near real time management information) requiring CommandPoint Go Live to be delayed thus causing the project a time and cost overrun.
72 **3/5**	Inadequate / insufficient end-user training	15	Keith Miller	There is a risk that the training provided to CAD users will be inadequate or insufficient, leading to the users not being able to use the system effectively and causing a cost/time overrun (from Lessons Learned, x ref 1&5)
94 **3/5**	Significant Service Impact Interrupts or Delays Training	15	John Hopson	There is a risk that the Service will suffer a significant detrimental impact to the resource capacity of the Control Room (for example, through increased REAP level, high volume sickness, major incident) leading to reduced attendance at training; or the cancellation or postponement of the training schedule, resulting in an extension of the training period and a delay in the date of Go Live, causing a cost and time overrun.
112 3/4	Release 1.1 development	12	John Downard	There is a risk that Northrop Grumman encounters unforeseen difficulties during the development and testing of CommandPoint Release 1.1, resulting in a need for additional unplanned development work, causing time and/or cost overrun.
68 2/5	Total failure of CTAK system	10	Peter Suter	There is a risk that the CTAK system will suffer a total failure beyond the capacity of realistically available technical resources, leading to a need to accelerate the procurement and implementation of an interim solution, causing a 'piecemeal' implementation of various available components of the new system as and when available until full introduction achieved, resulting in additional cost of suppliers and potentially extending timescales.
78 2/5	Failure of new CAD system during implementation	10	John Downard	There is a risk that the new CAD system fails during implementation, leading to unplanned remedial work and possible delay to the project and/or cost overrun.

Risk Id	Title	Score	Owner	Description
P / I				
85 2/5	Power Supply to HQ insufficient	10	John Downard	There is a risk that the power supplies to LAS Headquarters are inadequate to support the operation of all components of the new CAD system (including control room and data centre hardware) leading to the need for unplanned remedial work and causing time and cost overruns.
119 **2/5**	Significant Service Impact Interrupts or Delays Implementation	10	Peter Suter	There is a risk that if an unforeseen occurrence happens during the period prior to Go Live, of such seriousness that it results in diverting resources and/or facilities that are essential to conduct of cut over and / or go live causing the planned date for the events to be postponed resulting is a time and cost overrun.
99 3/3	Staff fail to attend training	9	John Hopson	There is a risk that some staff, for any reason, and without prior notification/agreement with Resource Centre, will not be able to attend the initial training course for which they are scheduled, leading to an extension of the training period, a delay in the date of implementation, resulting in a cost and time overrun.
100 **3/3**	User Acceptance Testing exceeds allocated time	9	Jonathan Nevison	There is a risk that user acceptance testing will exceed the time allocated in order to complete testing to the agreed contractual criteria resulting in a time and/or cost overrun and increased risk of failure of a critical part of the system.
120 **2/4**	Travel Disruption to Training Schedule	8	Keith Miller	There is a risk that the Service will suffer a significant detrimental impact to the resource capacity of the Training schedule through travel disruption due to bad weather or industrial action by travel operatives, leading to reduced attendance at training; or the cancellation or postponement of the training schedule, resulting in an extension of the training period and a delay in the date of Go Live, causing a cost and time overrun.
117	MDT Status Updates	Critical	John Downard	CommandPoint and Mobile Data Terminals both hold information relating to the status of a resource. Under certain conditions, this information can become 'out of sync', where the status recorded on the MDT does not match that recorded on CommandPoint.
120	Performance Testing of Northgate XC Router	Critical	John Downard	The Northgate XC Routing Server process will be used for the first time by the LAS during CommandPoint Go-live. CommandPoint will significantly increase the load on the XC Routing server. In order to reduce risk of failure of the XC routing server performance tests should be carried out to ascertain the viability of running the CommandPoint specific XC Routing on the current hardware and software configuration.
123	Re-prioritisation of Cat B calls in Response Profile Rules	Critical	Jonathan Nevison	Changes to the categorisation of old Amber 1 and 2 MPDS determinants may have an effect on the RPR model agreed with the DDO and DMD. As these rule took some months to develop there is concern that this could impact on go live.

Appendix 3: Most Significant Issues

ID	Title	Impact	Owner	Description
128	Address field delimiters	Critical	Jonathan Nevison	Concatenation of address fields by CommandPoint, from the CLI telephone address data capture in the interface, for onward transmission to the gazetteer does NOT currently include commas as line delimiters. The gazetteer is not reliably returning map locations as a consequence. This is not recognised as a 'bug' by NG as this specification was not made sufficiently clear in the relevant Interface Control Document and is therefore currently considered an enhancement request subject to request for change, by the supplier.
097	1.0 FAT Test Report Findings	High	Colin Strugnell	Unexpected high numbers of P2 & 3 failures and auto dispatch functionality not as as anticipated
104	Availability of Met-CAD Interface for Testing	High	Les Taylor	Difficulties with Met/CAD LAS interface for SIT testing
108	Venue for Skills Maintenance Training	High	Jonathan Nevison	Change of intended venue from ICR HQ to UOC - required an exception plan to prepare for the training
112	Adequacy of CommandPoint Hardware Environments	High	John Downard	2 concerns by NG - 1 -clearing space around the cabinets 2 - temp conditions in server room
118	Operational Development Initiatives	High	Steven Kime	Operational development initiatives that have come about since the specification of R1.1 will not be reflected in CommandPoint.
119	Readiness of desktop environment for Command Point.	High	Les Taylor	Storage securing & installation on 3rd screens, monitor screen arms and hard drives needs to be added to a new product, Desktop Build Plan.
122	SBR Tenancy - Invocation of Break Clause	High	Jonathan Nevison	Tenancy break clasue imminent query retain or invoke
065	Data Manager Resources	Mod	John Downard	Resource to maintain reference data notified as insufficient according to NG
068	Locality Information Database	Mod	Steven Kime	Process for updating locality info to CAD is unclear
116	CRM Implications	Mod	John Downard	Testing and rollout of the clinical response model (CRM) project will nessessitate the operation of two versions of the response profile rules (8.5.13) simultaneously (RPR for BAU and CRM response groups.) RPR for CRM will be a dependancy upon its successful operation once CP is live. Resolution of the issue requires that changes to the RPR are developed by the CRM project and developed within product 8.5.13 by the CP project. Full CP functionality to support CRM will only be delivered with RFC126 (log writing capability)
011	CAD 2010 and Caldicott	Low	Paul Newman	Does this project raise, or could it raise any issue of concern which should be discussed or agreed with or brought to the attention of the Caldicott Guardian?
037	Rolling list of potential related initiatives	Low	Jonathan Nevison	Tracking and monitoring of related initiatives
043	Relocation Test & Training Environments	Low	John Downard	Once the Project has finished with the test and training environments they must be relocated from their temporary accommodation. The degree to which the suppliers and/or the LAS contribute to this work needs to be clarified and, if necessary, the subject should be raised during negotiation and included within the Final Tender from suppliers

ID	Title	Impact	Owner	Description
049	32 SBR Air Conditioning	Low	John Hopson	AC not sufficient in SBR. Needs to be tested and repaired.
086	Benefit B3 - Reduced Corporate Risk	Low	Paul Newman	Misalignment between the measurement (B3) of the benefit and the current/new process implemented in Service Desk
111	LVM Synchronisation between HQ & Bow	Low	John Downard	There are no updating procedures from the LVM database at HQ and at Bow

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

3ʳᴰ FEBRUARY 2011

PAPER FOR APPROVAL

Document Title:	**Business Planning and Contracting**
Report Author(s):	**Mike Dinan and Lizzy Bovill**
Lead Director:	**Lizzy Bovill**
Contact Details:	**Lizzy.bovill@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To ensure board input and agreement to contract position for 2011/12**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other ADG
Recommendation for the Trust Board:	To support position presented

Executive Summary/key issues for the Trust Board

The presentation to the board will cover the latest position on:

- Financial penalty negotiations with our lead commissioners are currently being finalised. The financial impact of the outcome of these discussions will have an impact on our year end position.
- Negotiations for LAS contract 2011/12 – outline of current position, areas of focus and areas of convergance and divergence with the commissioners,
- The business planning and budget setting

Attachments - none

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Strategic Goals 2010 – 13
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☒ To improve our delivery of safe and high quality patient care using all available pathways
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☒ 7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

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

Key issues from the assessment:

LONDON AMBULANCE SERVICE TRUST BOARD

3RD FEBRUARY 2011

PAPER FOR NOTING

Document Title:	**Estate Strategy**
Report Author(s):	**Martin nelhams**
Lead Director:	**Michael Dinan**
Contact Details:	**Martin.Nelhams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**For Trust Board Approval**
This paper has been previously presented to:	strategy Review and Planning Committee ☒ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	To approve the Estate Strategy

Executive Summary

1. The way in which the London Ambulance Service delivers urgent and emergency health care has changed significantly in recent years. Whilst facing the challenges of tougher response time targets, year-on-year increases in demand and tougher infection control guidance, the organisation has worked hard to provide care that is better tailored to the needs of all its patients. Looking ahead, the Service needs to ensure it has the right infrastructure to support the development of its services in the future.

2. A key area for change is the ambulance station estate. Numbering some 70 disparate properties (the Service's total estate comprises 96 sites), it is a portfolio that is recognised within the Service as being out-of-date, mainly in the wrong location and inadequate in terms of facilities and space for a modern ambulance service. In particular, lack of on-site management presence in many stations is considered a barrier to the people management aspect so essential to effect wider change management. In short, the Service is operating from an inefficient legacy estate.

3. This is closely followed by the control centre estate. Here the problem is different. The technology is modern and effective but there are issues with resilience with the majority of activity taking place in a single location with back-up facilities which do not mirror the main control room.

4. A preliminary property strategy for the operational estate has been developed that focuses on the ambulance station and the control centre but also considers other property types and uses, especially where such uses impact on the future shape or content of ambulance stations. It has been assumed that active area cover - the system whereby ambulance crews and single responders are placed on standby at strategic locations rather than waiting for calls at their ambulance station - will become the norm. The place of work for frontline staff will be the vehicle itself; the ambulance station becoming the "mother ship" for crew signing-on/off, rest breaks, training, staff management etc. The focus should therefore be on the human dimension rather than the ambulance station being a vehicle garage with supplementary facilities. This is not to discount the importance of the ambulance station playing a role in fleet management; rather it is to change the emphasis towards the crews.

5. In formulating the estates strategy, regard has been given to other parallel strategies (e.g. vehicle

workshops) that are in various stages of development and has endeavoured, wherever possible, to anticipate the likely outcomes. Consideration has also been given to the changing training requirements.

6.   Consideration has been given to a number of options with a conclusion that the Service should migrate towards having a smaller number of larger ambulance stations with better facilities. For the purposes of the strategy, a range of nine to 12 stations has been used which could provide the optimum blend between operational efficiency and the critical mass to sustain certain key on-site functions. This number would equate to three to four in each of the Service's three sector areas in the east, south, and west. This number is for illustrative purposes only and it should be recognised that a strategy to migrate to fewer sites is likely to take at least 10 years given the nature of the property market.

7.   Assuming 12 such stations, the design template for each station would accommodate the needs to support approximately 35 vehicles divided into five key components: crew facilities, management/administration, training, storage and vehicle preparation.   The space allowances recognise the demands of the shift system and that activity levels will be higher at crew change-over time.

   (i)   *Crew facilities* include signing on/off and briefing, showers and locker room, an area for dirty disposal that meets infection prevention and control guidance, catering facilities, parking and improved hand hygiene facilities. Catering comprises a kitchen, vending machine, drinks dispenser and space at table to eat; it does not include a staffed canteen facility. In addition there will be IT facilities to allow crews to access e-mail/internet and carry out on-line training. On-site parking will be provided for approximately 80 private cars; one per shift member plus some spares to manage capacity at shift changeover and for visitors/people with disabilities etc.

   (ii)   *Management/Administration facilities* include space for the ambulance operations manager, the duty station officer, team leaders, trainers, and support staff such as administration together with meeting rooms etc.

   (iii) Each station will include a *training* room supplemented by on-line training facilities. This will facilitate the proposal to build training into the rosters and avoid the need for staff to travel elsewhere. The training room can also be used for other functions .e.g. school visits.

   (iv)   To minimise waste it is proposed that *storage* space be provided not just for day-to-day consumables but also for daily signing-out of valuable items such as crew radios, defibrillators as well as controlled drugs. Compliance with infection control guidance regarding the storage of consumables and equipment will be given the highest priority and the complexity of storage implies a dedicated stores administrator.

   (v)   *Vehicle preparation* includes stores and vehicle preparations ("make ready"), cleaning and minor on-site mechanical work to complement the major centralised workshops. It includes facilities to accommodate a small number of vehicles under cover for make ready etc. with the residue being parked outside but with access to charging points.

8.   A smaller number of larger ambulance stations presents various challenges. Location is critical. Stations need to be sited within the Greater London Authority area, inside the M25 and close by major arterial roads to facilitate access to active area cover deployment spots and return to the station for the shift rest break. Equally, they need to be accessible by staff. In an ideal world, considerable reliance would be placed on access to public transport. However, the nature of shift work, the radial nature of most public sector routes and the potential micro-location of the station will result in the majority of staff using private vehicles to get to work. Proximity to public transport is therefore a desirable rather than an absolute.

9.   Equally, the larger ambulance station with its increased parking requirement for both ambulances and private vehicles will require a quantum leap in footprint. Site availability is already a constraint; adoption of the larger ambulance station will be likely to push their location further from the centre. However, the use of active area cover mitigates any impact on patient care as ambulance staff are located at strategic locations. There is a high probability that the industrial estate will be the favoured location where space, access and value combine to the optimum. Security and resilience will be key issues to address.

10. Whilst the estates strategy does not cover implementation or affordability, consideration has been given to a number of options – to build a bespoke facility or to convert an existing building; to use the Service's own financial resources or to enter into some form of public/private partnership arrangement. Whichever route is adopted, it recommended that the Service pilots the concept of the larger ambulance station, perhaps one in each of the sector areas, to test and develop both the

concept and the method of implementation. This would involve close cooperation with staff and unions and could in itself be used as a major example of positive change management.

11. The strategy has been based on the assumption that active area cover will become the norm. This raises the question of whether the ambulance stations will need to be supplemented by fixed satellites where crews can await calls, take rest breaks etc. It was concluded that mobile deployment and the fluid nature of demand should not require fixed satellite points. Crews will have access to such facilities during their daily visits to hospitals and that there is also scope for them to use public facilities (e.g. coffee shops) on an informal basis. However, this can be tested as part of the pilot exercise.

12. There may be pressure to retain a number of existing sites to supplement the larger ambulance stations, perhaps as satellites. The need for these will emerge, or not, but affordability of the new strategy will be influenced by the potential for disposal receipts and revenue savings through rationalisation of the ambulance estate.

13. With regard to **control centres**, it is clear that operating principally from a single building that has low levels of security and which is located in the flood plain does not provide an adequate level of resilience and there are challenges to managing infectious illness such as flu within a densely populated single space.

14. The strategy here is to migrate to two independent control centres with a third control centre used for training purposes. Each control centre should be capable of meeting 100 per cent of demand but normal operations will be split equally between the two centres. Other functions such as the resource/vehicle resource centres could also be relocated to the control room sites which may result in efficiencies being made.

15. A central London location is not required on operational grounds. Alternative locations have not been determined but an analysis of control centre staff home addresses suggest that locations below a north-east/south-west transect through London are likely to maximise staff retention.

16. An outline business case for **fleet workshops** to be centralised in two or three locations has already been approved. The new ambulance stations therefore assume only minor maintenance functions (e.g. oil/battery/bulb checks) and some make ready; the rest being undertaken at the workshops.

17. A preferred option for the provision of **training** has not been determined as a strategy for future training requirements and delivery has yet to be developed. However, some provision at the new ambulance stations has been assumed and this could potentially release some existing facilities.

18. There may be scope to re-evaluate the need for a central **storage** facility (currently at Deptford) by reviewing whether manufacturers and suppliers can supply directly to the larger ambulance stations and whether there is a need for bulk deliveries to be broken down and repackaged within the service. This may result in Deptford being released for disposal.

19. The strategy has also considered the **Patient Transport Service (PTS)** and its impact on larger ambulance stations. PTS is differentiated by the fact that, with certain exceptions, it provides services procured via relatively short term competitively tendered contracts through a different and separate vehicle fleet of some 170 vehicles. The overnight/weekend vehicle parking requirements change according to the scale and location of the contracts currently in force. Unlike the 24/7 nature of the emergency response service, operations are principally 8am to 5pm, five days a week.

20. PTS could, in effect, be a separate standalone business with no major operational or clinical requirement to be co-located with emergency response vehicles saves for the fact that its staff members are part of the Service and that physical separation does not encourage a sense of common identity.

21. The weakness of the current PTS model has been recognised and the NHS may recast the way that contracts are structured to allow a better matching of contractual length and property liability. Whilst there may be merit in increasing the footprint of certain ambulance stations to permit PTS overnight parking and shared facilities, the reality is that it will be difficult to anticipate which stations should be thus extended. An alternative might be to create one PTS enabled ambulance station in each sector area. Pending clarity on the new model, consideration should be given by the Service to procure PTS space requirements independently to the ambulance stations but keep the situation under review.

22. If the ambulance station and control room strategies are implemented, a large proportion of the existing **HQ building** in Waterloo Road will be located elsewhere. The building itself is outdated and is complicated by a flying freehold of residential accommodation to the rear. The opportunity should be taken, once the control centre and ambulance station are provided elsewhere, to both reprovide the facility and take the opportunity to co-locate the other administrative functions currently at Fielden House, Pocock Street and Loman Street.

23. The new HQ could either be provided as part of a redevelopment of the site or relocated elsewhere. There is no reason why normal commercial space could not be leased on the open-market. This would obviate a double decant and provide the opportunity to sell the existing site raising a capital receipt to help fund implementation of the wider strategy.

24. Where do the priorities lie? The first priority should be the provision of new control centres as it is perceived that this is where the Service is exposed to the greatest operational risk. This is closely followed by the introduction of fewer larger ambulance stations where significant change is required to improve efficiency and to allow effective change.

25. Whilst the strategy considers the likely space requirements for the principal functions and sets out an indicative cost range for each, no consideration has been given at this point to affordability in general, the likely extent and timing of receipts from the disposal of facilities and alternative implementation options. This would form the next phase of the study if the general principles were accepted, but indicative costs for the next five years are set out below. There would be Capital receipts, but this is difficult to quantify at the moment and would be set out in more detail in the business case for each project.

Description	2011/12	2012/13	2013/14	2014/15	2015/16
Ambulance station-East reconfiguration 1	750,000				
Ambulance station – West reconfiguration 2		750,000			
Ambulance station South reconfiguration 3			750,000		
Ambulance station East reconfiguration 4				750,000	
Ambulance station West reconfiguration 5					750,000
Fleet 1 reconfiguration	1,000,000				
Fleet 2 reconfiguration		1,000,000			
HART 2 site West	1,000,000				
New control rooms			2,000,000	4,000,000	4,000,000
Estate Maintenance	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000
Total	3,750,000	2,750,000	3,750,000	5,750,000	5,750,000

26. The Service has already started some of the projects that this document refers to:

   ▪ A project board has been established for the new control rooms and an outline business case is currently being produced. It is anticipated that at least one new control room will be well on the way to being opened within the next three years.

   ▪ The full business case for a new workshop is due to be approved by the board at which time premises can be secured and the work to open the new workshop started.

   ▪ Business cases for the development of larger ambulance stations in each area are currently being prepared, with the one for a new station in the east area due to go to the board shortly. It is anticipated that the first of the new stations will be open in the next 24 months.

   ▪ Premises for a HART facility in the East area has been secured and is due to open in January 2011.

   ▪ A new event control has been developed at Devon's road, opening in October 2010.

27. The Service will consult on the proposals outlined within its estates strategy specifically with local groups that may be affected by any change and Patients forums/Linc, PCT's, NHS London, Unions and the Staff Council and other stakeholders.

   27.1 On a London wide basis the Service will share the contents of the Strategy with NHS London as part of its Integrated Business plan and its Foundation Trust application process. Other stakeholders and Commissioners will also be consulted on the proposals outlined in the

	Strategy.
27.2	At a local level the Service will consult with the local community/Patients Forum through community engagements events. It will contact other stakeholders such as PCT's, Local authorities, LFEPA, MPS and local NHS Trusts and GP's to keep them informed of any changes. The Business case process will ensure that at each stage consultation is carried out and recorded.

Key issues for the Trust Board

Attachments
Estate Strategy and appendices.

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

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

Risk Implications
This paper links to the following strategic risks:

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

NHS Constitution
This paper supports the following principles that guide the NHS:

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

Equality Impact Assessment

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

Key issues from the assessment:

LONDON AMBULANCE SERVICE TRUST BOARD

3RD FEBRUARY 2011

PAPER FOR NOTING

Document Title:	**Historical Due Diligence (HDD) Closure Report and minutes from the meeting held on 30th November 2010**
Report Author(s):	**Sandra Adams**
Lead Director:	**Sandra Adams**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**As a formal record of the receipt of the Stage 1 closure report for Historical Due Diligence and to receive assurance on the progress being made with the due diligence action plan.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	To note the progress made since Stage 1 and to discuss the issues arising from Stage 2 which will be available at the time of the meeting

Executive Summary

1. Giles Newman from Grant Thornton presented the report on the Stage 1 HDD Preliminary review and reporting procedures highlighting the key issues that would require attention before Stages 2 and 3 commenced:
   - Detailed cost improvement programme;
   - Reasonableness of the downside case with mitigations;
   - Risk management principally relating to the detailed cost improvement programme and the overall risks facing the organisation including the local health economy, short term liquidity and funding for the 2012 Olympic Games.

A number of other areas concerning corporate governance, high level controls and financial reporting and control were given an amber rating.

Out of 44 items for action, 15 would have to be progressed by early January 2011 if Stage 2 HDD was to commence on schedule. A report was made to the Trust Board on 14th December 2010 confirming progress with several items and a further meeting was held with the SHA and Grant Thornton on 20th December to provide assurance of the progress made. It was agreed at this meeting to proceed to Stage 2 on 10th January 2011.

A copy of the updated action plan is attached for information.

2. From late December through to mid-January the Finance and Corporate Services teams have been providing evidence and supporting information for Stage 2 due diligence. The Grant Thornton team were on-site for 2 weeks and were due to provide the draft report on Monday 24th January 2011. At the time of writing this report there are a number of outstanding issues

that mean the HDD Stage 2 report has not been finalised and the clearance meeting has not taken place. An update will be given on these issues at the Trust Board meeting.

Key issues for the Trust Board
Significant progress has been made with the recommended actions from Stage 1 due diligence leading to the commencement of Stage 2 in early January 2011.

The closure report for Stage 2 has yet to be finalised but the position on this will be clearer by the time of the Trust Board meeting.

Attachments
Minutes of the meeting held on 30th November 2010
FRP (due diligence) action plan – updated 20th January 2011

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

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Risk Implications
This paper links to the following strategic risks:

☐ There is a risk that we fail to effectively fulfil care/safety responsibilities
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☒ 7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

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

Key issues from the assessment:

LONDON AMBULANCE SERVICE TRUST BOARD

3RD FEBRUARY 2011

PAPER FOR APPROVAL

Document Title:	**Integrated business plan and long term financial model – Version 5**
Report Author(s):	Sandra Adams/Christine McMahon and contributors
Lead Director:	Sandra Adams
Contact Details:	Christine.mcmahon@lond-amb.nhs.uk
Why is this coming to the Trust Board?	**For approval prior to submission to the Strategic Health Authority in preparation for the formal application to the Secretary of State for Health**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☒ Other Circulated to Trust Board members on 18th January 2011 and reviewed at previous Trust Board and Strategy Review and Planning meetings.
Recommendation for the Trust Board:	To note and approve the responses to comments on version 4; To approve Version 5 of the Integrated Business Plan incorporating the long term financial model.

Executive Summary

The attached version 5 of the Integrated Business Plan incorporates any remaining comments from the SHA, principally on Chapter 6 relating to the long term financial model and the comments received from Board members since 18th January 2011.

On approval by the Trust Board, Version 5 will be submitted to NHS London (the SHA) for final comment prior to a) the Board to Board, and b) final updates and then submission (Version 6) to the SHA as part of the formal foundation trust application.

Trust Board members are asked to note that the Estates Strategy is also on the agenda for formal approval and the updated executive summary will form Chapter 11 of the IBP.

The IBP is a work in progress and will continue to be updated through to formal application to Monitor and possibly during the Monitor assessment process.

Key issues for the Trust Board

Work in progress includes the following:
- The SMART matrix – a number of queries raised are being considered and SMG will review when it meets 16th February;
- Further work being undertaken re. incorpating feedback stakeholder

- Figures 29 etc relating to performance will be updated to reflect 10/11 performance to 31/01/11.
- Further work required on the financial scenarios.

Attachments
Executive summary of work in progress and changes made since Version 4;
Version 5 of the Integrated Business Plan incorporating the long term financial model.

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

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☒ 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
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☒ 7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

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

Key issues from the assessment:

LONDON AMBULANCE SERVICE TRUST BOARD

3RD FEBRUARY 2011

PAPER FOR DISCUSSION

Document Title:	**Lessons learned from recent NHS foundation trust applicants - Monitor**
Report Author(s):	**Sandra Adams**
Lead Director:	**Sandra Adams**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**For the Trust Board to consider the lessons of previous FT applicants and any action we may need to take.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	• To consider the lessons learned from recent FT applicants; • To consider the questions listed below for discussion.

Executive Summary

1. This is a useful document for considering the lessons learned from recent applicants, focussing on 4 areas:-
   - An effective trust board
   - Strategic business planning
   - Service performance
   - Financial governance
   - Assessing quality governance

Listed below are a number of key questions that have arisen from Monitor's assessment of previous FT applicants that the Trust Board may wish to now consider.

Key issues for the Trust Board

Key questions arising that we should consider:-
- Is the board capable of operating the LAS as an autonomous foundation trust? (page 2, Role of the Trust Board);
- Is board governance effective and can the board identify and mitigate the future risks to service and financial performance? (page 3, Transparency of board reporting);
- Are future plans comprehensive, have the financial and quality impacts been carefully considered, and have plans been tested and challenged internally and with commissioners? (page 3, Strategic business planning);
- Has the board considered the impact of changes to the commissioning landscape on the future plans of the LAS (page 3, as above);
- Are the risks associated with the contract with commissioners understood in detail and has there been full board involvement and discussion prior to signing the contract? (page 4,

Contracting and risk);
- Are the activity and income assumptions in the LTFM in line with PCT commissioning intentions or views of affordable growth levels? (page 4, Commissioning intentions);
- Has the CIP had clinical input and support and has a full risk assessment of the potential impact of quality and safety of services been considered? (page 4&5, CIP and the link to quality);
  And, is there strong governance over the development and delivery of plans?
- Do we have credible mitigation plans in place to be able to demonstrate financial viability? (page 5, Downside planning and mitigation plans);
  And, is there clear board and clinical ownership of the mitigation plans? (as above, page 6);
- Can we demonstrate that the board accurately understand the quality of care the LAS provides and that this is a corporate responsibility? (page 7, Monitor's approach to quality governance);
- Can we demonstrate that we have reviewed the recommendations from reports and inquiries into other NHS trusts to ensure we benefit from the lessons learned? (page 7, as above).

Attachments
Monitor's document – 10th January 2011.

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

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☐ 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

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Equality Impact Assessment

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

Key issues from the assessment:

Lessons learned from recent NHS foundation trust applications

10 January 2011

Monitor
Independent Regulator
of NHS Foundation Trusts

Lessons learned from recent NHS foundation trust applications

Monitor periodically reviews recent assessments of applications for foundation trust status to identify the reasons why some have been unsuccessful. This short report sets out some of the lessons learned from applicants who have been deferred, rejected or have postponed their application.

By sharing these learnings we hope to increase understanding of our expectations, and also improve the efficiency of the application process for all involved. This document complements the approach outlined in the publication *Applying for NHS Foundation Trust Status: Guide for Applicants* (November 2008) and our amendments to the guide published in July 2010.

Main themes

We continue to view the principle of board accountability as absolutely central to becoming a successful NHS foundation trust and many of the themes we have identified in this report reflect this. There are also themes emerging including the way in which boards approach quality and their priorities for improvement and the impact of the economic environment.

In this report, we have summarised the lessons learned under four key headings, with a final section which provides an update on our approach to assessing quality governance:

1. An effective trust board
    - Role of the trust board
    - Self-certification
    - Transparency of board reporting (financial and non-financial)

2. Strategic business planning
    - Contracting and risk
    - Commissioning intentions
    - Cost improvement plans (CIPs) and the link to quality
    - Downside planning and mitigation plans
    - Estates

3. Service performance
    - Performance against targets and indicators

4. Financial governance
    - Accounting policies
    - Historical due diligence recommendations
    - Private patient income

5. Assessing quality governance
    - Monitor's approach to quality governance
    - Quality performance thresholds

While the headings above are distinct, it is a combination of behaviours and processes which need to be considered together when assessing whether

governance structures are sufficiently robust to assure the delivery of a financially sustainable organisation which is focused on the quality of care it provides.

1) An effective trust board

Boards of NHS foundation trusts are given greater autonomy to manage their organisations, giving them greater flexibility to meet local needs and improve care for local populations. This goal can only be delivered if boards step up to that challenge and take advantage of the freedoms NHS foundation trust status provides.

Role of the trust board

Although the assessment process is rigorous, and requires a high level of planning and information, there is one fundamental question we ask: is the board capable of operating this organisation as an autonomous foundation trust? Our requirements about the broader governance of the trust, its business plan and future strategy, all contribute to reaching a conclusion on that question.

That's why the way a board operates is so crucial to our assessment decision. We will look at a range of indicators including:

a) the board's composition;

b) the dynamics between executive and non-executive (striking the right balance between challenge and support to the executive team);

c) their approach to quality;

d) their ability to understand and put in place a long-term business strategy;

e) their ability to measure and compare their performance against others and set goals for improvement; and

f) their ability to identify and mitigate risk.

Self-certification

One of the key regulatory principles underlying Monitor's *Compliance Framework* is proportionate, risk-based regulation, with a reliance on self-certification by each foundation trust in key areas. To test whether we can rely on future self-certifications under the compliance regime, we ask boards to self-certify a range of statements during the assessment process. We then explore the basis for the board's self-certification in each area, to test whether the statements have been made on the basis of a satisfactory process and appropriate evidence (i.e. that the board has made the statements after due and careful enquiry). Issues uncovered in recent assessments related to:

- absence of key members of the board when reviewing the self-certification;

- lack of clarity on the evidence available to support each statement or reliance on outdated data; and

- amendments to the wording of the self-certification declarations, i.e. effectively caveating the relevant statement;

Where we judge that a board does not have a robust process for self-certification, or where it has not sought appropriate assurance that the available evidence supports the statements made, we will question how the trust would function as a foundation trust under the compliance regime.

Transparency of board reporting (financial and non-financial)

We place considerable importance on the level and quality of information provided to the board. Effective governance is essential for an NHS foundation trust and as part of this it is vital that the board receives the right information to enable it to monitor its performance in an effective way. The adequacy of board reporting is tested both by the independent accountants, through their work on financial reporting procedures, and by the Monitor assessment team.

Examples of issues from recent assessments that led Monitor to question board governance include:

- targets and standard performance being reported without clear explanations for areas of underperformance and/or a lack of projected future performance expectations; and

- outturn financial position and CIP achievement being masked by reversals of provisions or reserves, and changes to the assumptions underpinning forecast cash balances not being adequately explained.

The above issues have led Monitor to question the board's ability to identify and mitigate the future risks to service and financial performance.

2) Strategic business planning

A major indicator of whether a board is capable of operating as an NHS foundation trust is their ability to think strategically about the future of the trust. Boards must have a vision for the future improvement of healthcare for the communities they serve and have a good grasp of the opportunities and challenges that exist, in both the medium and long term. This should be captured in comprehensive plans, where both the financial and quality impacts of those plans have been carefully considered. All future plans should be tested and challenged within the trust and with commissioners.

With the current financial pressures, commissioning budgets will be under significant pressure for the foreseeable future with low income uplifts and expected increases in demand for services. The *Operating Framework 2010-11* and *Revision to the Operating Framework* both included measures which increase trusts' exposure to activity risk (emergency activity above base line paid at 30% of tariff; hospitals being responsible for patients for the 30 days after discharge) and payment risk (best practice tariffs; income uplifts linked to measurable quality and outcomes). These risks did not change significantly in the *Operating Framework 2011-12.*

Additionally, in light of the Government's long-term vision for the future of the NHS set out in *Liberating the NHS: Legislative Framework and Next Steps*, which includes plans to change the commissioning landscape, trust boards will need to consider the impact of these changes on their future plans. Applicants should expect to be

challenged on what work they are doing to understand the future risks to their business plan in light of these changes.

Areas of concern from recent assessments that have led to deferrals and postponements are set out below.

Contracting and risk

As a consequence of the financial environment and changing contracting rules for this year, we have seen a trend towards risk sharing and other arrangements with commissioners. While trusts need to take a commercial approach to contracting, it is important that risks associated with each agreement are understood in detail and that there has been full board involvement and discussion prior to contract signing.

Some of these agreements place activity risk on trusts, often based on demand management plans which aim to remove or deflect the activity from the acute provider. In these situations, trusts need to have strategies in place for handling demand management failure. Likewise, discussions should be based on a full understanding of the trust's marginal cost structure and the level of flexibility available if activity levels diverge significantly from forecasts.

Without evidence of sufficient board challenge in areas of key risk, we have been concerned about the applicant's ability to operate as an autonomous organisation.

Commissioning intentions

Monitor has also been presented with a number of business plans where the activity and income assumptions contained in the long-term financial model were not in line with the relevant primary care trusts' commissioning intentions or views of affordable growth levels. In cases where demographic and other factors drive significant increases in activity, the trust and its local health economy partners should work in partnership to develop plans to manage the demand in the most cost-effective way.

Where there is a discrepancy between affordability in the local health economy and applicant trust plans, we will reflect such risks in our sensitivity analysis of the trust's plans (i.e. balancing the risk of demand management failure with commissioner payment risk). Such sensitivities have caused some applicants to need more time to develop robust mitigation strategies.

Cost improvement plans (CIPs) and the link to quality

A well-developed CIP has been the cornerstone of recent successful applications for NHS foundation trust status. We expect to see robust, detailed plans for the first two to three years of the business plan (including implementation plans) and a set of plausible key themes in outer years. However, such plans cannot stand in isolation but need to be understood in the context of the wider organisation and competing non-financial priorities. We will look for evidence that the plans have clinical input and support and that a full risk assessment of the potential impact on quality and safety of services has been considered. We will also seek to understand how the Board will monitor the risks to quality on an ongoing basis to ensure that corrective action can be implemented in a timely manner to address any quality concerns (e.g. the development of early warning indicators and post-implementation impact assessments).

Where applicants often fall short is in demonstrating a sufficiently thorough understanding of the underlying drivers of their cost base, and the evidence to underpin the achievement of significant efficiency improvements. This includes (but is not limited to):

- fully understanding the combined impact of schemes on the trust's headcount;

- having reliable and tested service-line management information available at a granular level;

- understanding the trust's skill mix and how it compares to peers;

- having a comprehensive understanding of marginal cost data; and

- showing an understanding of benchmarking data for key operational measures (e.g. length of stay, day case rate, bed occupancy, nurse to bed ratio, EBITDA margin).

Finally, we look for strong governance over the generation and delivery of plans. A historical track record of CIP delivery can support our assessment of future CIP achievement. Where poor historical achievement is identified, the onus will be on applicants to demonstrate what has changed in the development of future plans that will reverse the historical trend. Conversely where significant costs have been taken out in the past, applicants will be challenged on how they are assured that further cost reductions can be implemented without an undue impact on quality, and how this will be monitored.

Good practice includes:

- a lead person and timescales for each component of the programme;

- clinical engagement at all stages of the process;

- a robust set of early warning indicators to identify clinical risk which is reported throughout the organisation;

- risk-rating likelihood of achievement and impact on quality; and

- a structured impact assessment of each scheme.

Amendments to Applying for NHS Foundation Trust Status - Guide for Applicants (July 2010) provides further guidance on developing cost improvement plans in Appendix B14.

Downside planning and mitigation plans

Being able to demonstrate that a set of credible mitigation plans are in place is likely to be key to demonstrating financial viability for future applicants. In this respect it is important that trusts have:

(a) a clear view of future risks through their risk management systems and a robust contingency planning process for identifying possible solutions; and

(b) tested their base case financial assumptions with a challenging downside scenario and developed mitigation plans which can respond to risks in the environment.

In terms of development process and planning, the same points apply as to the CIP point above: the suggested mitigations need to be more than just a list of ideas. It should be a prioritised plan with detailed implementation plans and consideration of timescales (including an assessment of the need for consultation and/or negotiation), where the potential impact on quality has been considered (additional to CIPs, not in isolation) and where there is clear board and clinical ownership.

Estates

A contributing factor to a number of deferrals and postponements is related to estate issues. A number of trusts did not have estate strategies that were sufficiently developed for Monitor's Board to feel comfortable that risks and issues relating to often complex and ageing estates were being tracked and dealt with appropriately. Having significant levels of backlog maintenance is a considerable drain on cash resources and we expect affected trusts to present coherent and credible strategies for addressing the backlog within a reasonable timeframe.

3) Service performance

Applicants will be aware that Monitor's assessment approach to service performance mirrors that of the *Compliance Framework* in respect of targets and indicators. Whilst the criteria for service performance are clear from the *Guide for Applicants,* we have identified governance concerns where applicants have not addressed performance issues against particular targets. Failure to address performance within a reasonable timeframe has led us to question the board's effectiveness and hence the ability to operate as an autonomous organisation. While individual targets (A&E and 18 weeks) have been amended this year, the principles remain and we will always expect trusts to drive towards good performance and have regard to the quality and access wishes of their local population and patient groups.

4) Financial governance

Accounting policies

It is important that key changes to accounting treatment are agreed with the external auditor prior to submission of the trust's integrated business plan and long-term financial model. Monitor and the independent accounting firm will assess the governance arrangements applicants have gone through to agree material changes to accounting policies; for example appropriate auditor sign-off for material asset write downs or changes to policies on asset lives.

A small number of applicants with large PFI schemes also failed to demonstrate a detailed understanding of the financial implications of their PFI scheme under IFRS and were not able to confidently support the accounting treatment of the scheme which had been put forward to Monitor in the long-term financial model.

Historical due diligence (HDD) recommendations

The work undertaken by the independent accounting firm prior to a trust's referral to Monitor is intended to be challenging and developmental, with progress culminating in the HDD report. Where the HDD report makes further recommendations for improvement, it is Monitor's assumption that trusts will address those, or be well advanced in doing so, prior to the kick-off of the assessment process. Failure to address recommendations has led to delays in authorisation decisions as the independent accounting firms have required further evidence to be able to sign their financial reporting procedures opinion.

Private patient income (PPI)

The PPI cap is set by legislation and forms part of a trust's terms of authorisation. Any breach of the PPI cap is also a breach of a trust's authorisation and Monitor does not have flexibility in this area. Where applicants have been generating private patient income in excess of the cap as NHS trusts, they need to demonstrate that credible plans are in place to reduce the income below the cap once foundation trust status is achieved. For the avoidance of doubt, during a trust's first year as a foundation trust, the cap only applies to the months when it is an NHS foundation trust. A pro-rata cap will be set for the first year.

Although changes to the cap form part of current proposals for legislation (described in the Government's consultation response document *Liberating the NHS: Legislative Framework and Next Steps*), the current cap will continue to apply until new legislation comes into effect.

)) Assessing quality governance

In addition to the lessons learned highlighted above there are further areas to highlight:

Monitor's approach to quality governance

Monitor has adopted a revised framework for assessing quality governance. This is outlined in the *Amendments to Applying for NHS Foundation Trust Status - Guide for Applicants* published in July 2010, including an outline of transitional arrangements. Applicants should start to prepare their board memorandum now, in order to identify gaps in good practice and implement action plans where necessary.

We are looking for evidence that boards accurately understand the quality of the care their organisation provides, and that this is seen as a responsibility of the entire board, not only the medical and nursing directors. Trusts should be committed to continuous quality improvement, and have put in place the tools to address poor performance. There should be a culture where the quality of patient care (clinical effectiveness, safety and patient experience) is the primary concern of all staff.

Furthermore, trusts should also demonstrate that they have reviewed recommendations from reports and inquiries into other NHS trusts, in order to ensure that they benefit from the lessons learned.

Quality performance thresholds

The quality performance threshold is detailed in *Amendments to Applying for NHS Foundation Trust Status - Guide for Applicants* published in July 2010. Applicants should be aware that if the Care Quality Commission or the Department of Health is

unable to provide the relevant letters of assurance as set out in section 5.7.5 and 5.7.6 to the guide, this is likely to lead to a postponement of the application.

Conclusion

The points in this report should be considered in conjunction with Monitor's requirements in the *Guide for Applicants*. You may also like to review our previous letters to applicant trusts on lessons learned which are available on our website:

- *Lessons learned from Group 1* (April 2004); and

- *Lessons Learned from Wave* 2 *(*August 2006).

If you have any questions on the topics raised in this report please speak to the Senior Assessment Manager assigned to your application or, in the case of future applicants, please email enquiries@monitor-nhsft.gov.uk.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

3rd February 2011

PAPER FOR CONSIDERATION

Document Title:	**Draft statements – self certification in preparation for the foundation trust application**
Report Author(s):	**Sandra Adams**
Lead Director:	**Sandra Adams**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**In preparation for the SHA assurance process and the FT application**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	To consider the board statements that we will be required to submit with the foundation trust application and to identify any areas of concern that need to be addressed within the next two weeks.

Executive Summary

As part of the application, and then on an annual basis, the Trust Board will be required to submit signed self declarations and board statements providing assurance of the following:

- Clinical quality
- Service performance
- Other risk management processes
- Board roles, structure and capacity.

In addition to this is the statement on quality governance arrangements and the board memorandum (see pages 3 - 5).

The key requirements of assurance for quality governance are highlighted on page 6 followed by Monitor's definition of quality governance as demonstrated in their published framework. This will be discussed in more detail through the Quality Committee and evidenced in the future Quality Strategy but it is important for the Trust Board to note the minimum requirements for our FT application.

Key issues for the Trust Board

- To understand the requirements for self-certification and to provide assurance that the board statements can be signed and submitted during the FT application process.

- The Strategic Health Authority will wish to have assurance that the Trust Board has considered the compliance requirements prior to supporting the Trust's application to become an NHS foundation trust.

Attachments
Board statements – self certification

****

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

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

Risk Implications
This paper links to the following strategic risks:

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

NHS Constitution
This paper supports the following principles that guide the NHS:

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

Equality Impact Assessment

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

Key issues from the assessment:

Board Statements – self certification

1. Board statements required in the application to Monitor are aligned to the annual self-certification statement in Monitor's Compliance Framework in force at the time of authorisation. These statements are as follows and wording in *italics* indicate the proposed changes to the 2011/12 Compliance Framework:

The board is required to confirm the following:

Clinical quality
The board is satisfied that, to the best of its knowledge and using its own processes *and having regard to Monitor's Quality Governance Framework* (supported by Care Quality Commission information, *its own information on serious incidents, patterns of complaints,* and including any further metrics it chooses to adopt), its aspirant NHS foundation trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients;

The board to the best of its knowledge and using its own processes, it is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements; and

Processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.

Service performance
The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds), and commits to comply with all known targets going forwards.

Other risk management processes
Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner;

All recommendations to the board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned;

The necessary planning, performance management and risk management processes are in place to deliver the business plan;

A Statement of Internal Control ("SIC") is in place, and the aspirant NHS foundation trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to most up to date guidance from HM Treasury (http://www.hm-treasury.gov.uk);

The Trust has achieved a minimum of Level 2 performance against the requirements of their Information Governance Statement of Compliance (IGSoC) in the Department of Health's Information Governance Toolkit; and

All key risks to compliance with their Authorisation have been identified and addressed.

Board roles, structures and capacity

The board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the board;

The board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability;

The selection process and training programmes in place ensure that the non-executive directors have appropriate experience and skills;

The management team have the capability and experience necessary to deliver the business plan; and

The management structure in place is adequate to deliver the business plan.

Signed for and on behalf of the board:

Title:

Date:

Trust:

2. The following section is the **Proforma Board Statement on Quality Governance Arrangements and table of contents for Board Memorandum as required by Monitor for an FT application:**

(to be typed on applicant letterhead)

Private and confidential

Monitor – Independent Regulator of NHS foundation trusts

[Date]

[NHS trust]

Quality Governance
In connection with the application of [NAME OF THE TRUST] for NHS foundation trust status, the board of directors confirm that:
• The board is satisfied that, to the best of its knowledge and using its own processes (supported by Care Quality Commission information and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective leadership arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients, including:
- Ensuring required standards are achieved (internal and external)
- Investigating and taking action on substandard performance
- Planning and managing continuous improvement
- Identifying, sharing and ensuring delivery of best-practice
- Identifying and managing risks to quality of care

• This encompasses an assurance that due consideration has been given to the quality implications of future plans (including service redesigns, service developments and cost improvement plans) and that processes are in place to monitor their ongoing impact on quality and take subsequent action as necessary to ensure quality is maintained

The basis of the board of directors confirmation is set out in the attached board memorandum, dated [DATE].

For and on behalf of the board of directors [.....] NHS Trust

Board memorandum
This is a Word document which summarises the applicant's responses to the 10 questions posed by the quality governance framework by reference to good practice as set out in Appendix B14 (**Applying for NHS Foundation Trust Status - Guide for Applicants (published July 2010).** Applicants are not expected to display every element of good practice. As a general rule applicants should either describe how they comply with good practice or explain how and why they take a different approach.
The preparation of the board memorandum and the information therein are the responsibility of the directors.

A sample table of contents is provided below

1. Executive summary and conclusion

2. Strategy

A) Does quality drive the trust's strategy?
• description of Board‟s quality strategy;
• detail of quality goals and how they have been developed and communicated across the trust;

B) Is the Board sufficiently aware of potential risks to quality?
• description of Board‟s approach to assessing initiatives for their impact on quality;
• description of how the Board is assured that the CIPs do not compromise the trust‟s ability to meet required quality standards;
• description of how financial and operational initiatives are monitored for ongoing impact on quality (e.g. service redesigns, service developments).

3. Capabilities and culture

A) Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?
• overview of leadership arrangements;
• description of board‟s approach to challenging quality performance;
• skills assessment review;

B) Does the Board promote a quality-focused culture throughout the trust?
• explanation of the mechanisms used to drive quality agenda and promote an open culture;
• description of how the trust learns from incidents and complaints.

4. Processes and structures

A) Are there clear roles and accountabilities in relation to quality governance?
• description of roles and committee structures and how responsibilities are cascaded through the organisation;

B) Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?
• description of arrangements in place to escalate issues;
• description of how staff can raise concerns and issues;
• approach to clinical audit and how information is used to drive quality;
• internal audit approach to quality governance arrangements; and
• description of how the organisation acted on feedback received, including the resolution of complaints.

C) Does the Board actively engage patients, staff and other key stakeholders on quality?
• description of how the Board engages with patients, staff and stakeholders.

5. Measurement

A) Is appropriate quality information being analysed and challenged?
• process adopted by the Board to select relevant quality information, details of what is reviewed;
• details of how quality performance information reviewed by the Board is backed up by more granular information;

B) Is the Board assured of the robustness of the quality information?
• details of Board‟s approach to assuring data quality;
• how internal audit is used to review robustness of data and a description of how findings are followed up;

C) Is quality information being used effectively?
• examples of how quality information has led to improvements in quality;
• details of targets set and performance against targets.

6. Factual accuracy

3. **In addition to these statements:**

- 'Applicants are required to have a quality governance score of less than 4 with an overriding rule that none of the four categories of the Quality Governance Framework to be entirely Amber/Red rated;

- demonstrate the following quality performance threshold:
  a. they are registered without compliance conditions;
  b. they continue to meet the quality threshold set by the Department of Health at the time of Secretary of State referral;
  c. the CQC's current judgement of compliance against registration shows;

    i. the overall level of concern is no worse than moderate concerns and high confidence in capacity;
    ii. the CQC is not conducting or about to conduct a responsive review into compliance and no enforcement/investigation activity is ongoing or planned including preliminary investigations into mortality outliers and;

  d. have a minimum governance rating of amber/green (as defined in Chapter 2 of the Compliance Framework)' (see link below)

http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/guidance-foundation-trusts/mandatory-guidance/compliance-frame-0

4. **To assist further with this the Guide for Applicants includes the following:**

Appendix B14: Definition of Quality Governance and example good practice under the Quality Governance Framework

Our definition of quality governance is as follows:

Quality governance is the combination of structures and processes at and below board level to lead on trust-wide quality performance including:
☐ ensuring required standards are achieved
☐ investigating and taking action on sub-standard performance
☐ planning and driving continuous improvement
☐ identifying, sharing and ensuring delivery of best-practice
☐ identifying and managing risks to quality of care

Quality Governance Framework:

Strategy	Capabilities and Culture	Processes and Structures	Measurement
1A Does quality drive the trust's strategy?	**2A** Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?	**3A** Are there clear roles and accountabilities in relation to quality governance?	**4A** Is appropriate quality information being analysed and challenged?
1B Is the Board sufficiently aware of potential risks to quality?	**2B** Does the Board promote a quality-focused culture throughout the Trust?	**3B** Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?	**4B** Is the Board assured of the robustness of the quality information?
		3C Does the Board actively engage patients, staff and other key stakeholders on quality?	**4C** Is quality information used effectively?

LONDON AMBULANCE SERVICE TRUST BOARD

3RD FEBRUARY 2011

PAPER FOR NOTING

Document Title:	**Annual report of the Patient Experiences department 2009/10**
Report Author(s):	**Gary Bassett, Head of Patient Experiences**
Lead Director:	**Sandra Adams**
Contact Details:	**Gary.bassett@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Requirement for an annual report on patient experiences to be made to the Trust Board**
This paper has been previously presented to:	☐Strategy Review and Planning Committee ☒Senior Management Group ☐Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	To note the content of the report and the case studies in appendix A; To note the planned changes to reporting from January 2011.

Executive Summary

It is a legal requirement that the Trust Board receives an annual report on complaints management. Within the LAS complaints are managed and reported through the Patient Experiences department who also co-ordinate PALS, Freedom of Information, SUI, and safeguarding activity. The attached report covers the year 2009/10 and although it is being reviewed considerably later in the year than preferred, it gives a good baseline for future trend reporting and analysis of a number of indicators of the patient experience.

The second report attached is the half year report for 2010/11. This is will be discussed with the Quarter 3 report for the Quality Committee on 2nd February 2011.

From January 2011, a summary of the number of complaints and PALS enquiries is to be incorporated in the Chief Executive's report along with any emerging issues.

Key issues for the Trust Board

- The volume of complaints and PALS enquiries increased by 2% in 2009/10 against an increase in ambulance activity of 3.5% over the same period;
- Key themes continue to be staff attitude and behaviour and delays in dispatch for the non-urgent (Green/Category C calls), however a new theme was that of the referral of calls to NHS Direct. Once this emerged as an issue action was taken with staff in the control centre concerning the information given to callers who were being referred to NHS Direct and this subsequently resulted in a reduction in those types of complaints;
- For 2010/11 the key emerging themes again concern changes to the way we respond to incidents and calls, namely the use of appropriate care pathways. There is an increasing trend in the number of complaints about this and how staff, whether through the control

centre or the operational crew, communicate the use of pathways. Further discussion is needed on this internally to ensure that we are giving the right messages to our staff so that they can communicate effectively with patients about the change in response;

- Complaints activity should be reported to the Trust Board routinely and was a key learning point from the Mid-Staffordshire NHS foundation trust inquiry report. We will increasingly be asked to evidence discussions at Board-level about complaints and how any associated risks are then managed and lessons learnt.

(Please note that there is a small discrepancy in total numbers compared to the breakdown by department and area in both reports that needs further analysis)

Attachments

Annual report 2009/10

Half year activity and trends for complaints and PALS activity 2010/11

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Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper links to the following strategic risks:

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

NHS Constitution

This paper supports the following principles that guide the NHS:

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☐ 4. NHS services must reflect the needs and preferences of patients, their families and their carers
☐ 5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
☐ 6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
☒ 7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

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

Key issues from the assessment:

Complaints and PALS activity

April – September 2010

Patient Experiences Department

Quarterly Report April to September 2010

1. Activity Summary

- **Totals [1]**

Q1 – Q2	PALS	COMP	Total
2010_11	2977	309	3286

- **Summary Activity by Month**

By Area

AREA	Apr	May	Jun	Jul	Aug	Sep	Grand Total
EAST							
PALS	77	72	105	103	83	108	548
COMP	9	2	17	13	6	20	67
East Total	**109**	**117**	**174**	**169**	**127**	**168**	**864**
SOUTH							
PALS	74	85	111	115	120	118	623
COMP	4	10	14	18	25	31	102
South Total	**116**	**120**	**156**	**174**	**175**	**182**	**923**
WEST							
PALS	71	75	90	87	85	122	530
COMP	4	4	6	23	3	18	58
West Total	**94**	**104**	**112**	**139**	**107**	**171**	**727**
Grand Total	**319**	**341**	**442**	**482**	**409**	**521**	**2514**

Key: COMP   Complaints
         PALS   PALS enquiries

By Department

Department	Apr	May	Jun	Jul	Aug	Sep	Grand Total
Emergency Operations Centre							
PALS	16	16	14	24	10	9	89
COMP	5	10	11	15	4	8	53
EOC Total	**26**	**27**	**29**	**45**	**15**	**24**	**166**
Patient Transport Services							
PALS	2	3	4	3	5	5	22
COMP	3	4	1		3	7	18

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[1] To note the small discrepancy between total numbers and the detailed breakdown by area and department that needs further analysis

Patient Experiences Department

Quarterly Report April to September 2010

PTS Total	**5**	**7**	**6**	**4**	**8**	**13**	**43**
Urgent Care Services							
PALS	1		4		3		8
COMP			1				1
UCS Total	**1**		**6**	**1**	**3**		**11**
Sub Total	**32**	**34**	**41**	**50**	**26**	**37**	**220**

Other

Department	Apr	May	Jun	Jul	Aug	Sep	Grand Total
HQ	**24**	**15**	**38**	**24**	**43**	**43**	**187**
MAIAT		**1**	**1**			**1**	**3**
NOS	**6**	**6**	**10**	**9**	**9**	**9**	**49**
UK	**54**	**26**	**62**	**55**	**46**	**66**	**309**
VAS			**1**	**1**			**2**
HEMS	**2**						**2**
Other Total	**86**	**48**	**112**	**89**	**98**	**119**	**552**

By subject

Subject	PALS	COMP	Total
Access	19		
Aggregating Factors	1	4	
Appreciation	23		
Physical Violence	1		
Clinical Equipment	2	1	
Clinical Incident	42		
Communication	27		
Conveyance	18	7	
Delay	21	44	
Sirens	23		
Dignity & Privacy	2		
Non-Clinical Equipment	1		
Frequent Callers			
Incident Report Other			
Lost Property	312		
Non Conveyance	10	30	
Not our Service		7	
Attitude & Behaviour		150	
Patient Injuries	7	3	
Patient Protocol	37		
Referred to Local Authority	1		
Road Handling		22	
Road Traffic Accident	10		

Patient Experiences Department

Quarterly Report April to September 2010

Safeguarding Other Agencies	4		
Safeguarding - Hospital Referral			
Safeguarding - MPS Referral			
Safeguarding - Social Services Referral	1		
Social Services	20		
SUI Considerative	9		
Hospital Delays	1		
Treatment		41	41
Sub Total	**592**	**309**	

General Enquiries

Subject	PALS	COMP	Total
Witness Statements	21		
Miscellaneous	60		
Explanation of Events	15		
Information	1037		
Medical Records	588		
Other	18		
Grand Total	**1739**	**0**	

2. **Emerging Trends**

    a. Delays to calls triaged at a Green level of priority continue to feature;

    b. Regular features at times of increased demand:

    - delays in responding to Amber calls

    - re-triage omitted at repeat or ETA calls

    - Green call 30 minute call back not undertaken;

    c. Staff attitude and behaviour remains a constant source of patient dissatisfaction. Noticeably, patients being advised of appropriate care pathways is an increasing issue within this context;

    d. The number of cases involving the referral of patients to NHS Direct has slowed from 2009/10;

    e. Increase in incident reports from GP practices in relation to difficulties in arranging an ambulance (lack of awareness of the triage system);

    f. Reluctance of maternity units to release a midwife to assist ambulance staff; the notion of geographical catchments and shortage of staff feature prominently.

Gary Bassett
Head of Patient Experiences

Appendix A – Case Studies

1. A General Practitioner visited a patient at the request of her carer as she was unresponsive. After assessing the patient, the GP asked a neighbour to call 999 and returned to the surgery. The crew noted that on their arrival the patient appeared to have suffered from rigor mortis and raised concerns that the GP was not at the scene to provide a handover. The surgery have agreed that in future visiting GP's will take a summary of the patient's medical notes to the scene, will make all 999 calls themselves and await the ambulance crew for clinical handover.

2. A GP raised concerns that the ambulance staff failed to recognise the significance of a high temperature and elevated pulse rate and erroneously advised the child's mother to administer flu remedies and rest, thus delaying appropriate treatment being facilitated. This incident has raised a number of learning points around the assessment of febrile illness and consideration of the underlying causes of that illness. This incident will be used as a case study for a future clinical update.

3. A patient called 999 for damaged knee ligaments and was referred to NHS Direct who declined to arrange an ambulance. The call was incorrectly referred back to East of England Ambulance Service. The quality assurance evaluation identified shortcomings in the management of both the original 999 call and the call managed by East of England in that they were incorrectly triaged. The first call handler selected an incorrect protocol and omitted to observe protocol instructions regarding the triage of distal injuries. The call should have been triaged using the 'traumatic injuries' protocol and an override facility used to upgrade the call from a 'Green' to an 'Amber' priority. This solution has been put in place until a proposal for change submitted to the NAED regarding the triage of some distal injuries has been formally ratified. The second call (passed from East of England) was similarly under-triaged as a 'Green' priority with the correct protocol once again not adhered to.

4. Concerns were raised by the patient's wife who was concerned that the attending ambulance crew mistook her husband's symptoms as drunkenness. He was diagnosed with a stroke and her GP advised her that he would have benefited from direct referral to an HASU. The crew undertook a reflective practice exercise to recognise the FAST and ROSIER protocols

5. Concerns were raised by the CCD that an Acute Trust were refusing to accept a patient who matched the FAST protocol but presented with a low GCS. This was raised by the Medical Directorate with the Trust who agreed that the patient would have benefited from conveyance to their HASU. It has been agreed that the Stroke and Cardiac network would contact all EDs on HASU sites reminding them that the LAS will be bringing patients to them from longer distances, and that it is up to the crews to decide whether or not the patient is safe for transfer. EDs will also be

reminded that they cannot refuse a priority alert unless they have declared a major incident.

6. EOC incorrectly triaged a 999 call by using an incorrect chief complaint and recommended that the patient make their own way to the local Minor Injuries Unit. It transpired that EOC had incorrect opening times for the MIU which was closed when the patient arrived. A reflective practice exercise was undertaken with the call handler and EOC have been asked to update their MIU details.

7. A patient's family were concerned that there was a communication failure with PTS and transport did not arrive, resulting in the patient missing an important appointment. The Day Controller had been trying to ensure all the planned patient journeys were covered due to staff absences which resulted in a delay in contacting the patient's care home. The local PTS Manager s agreed that the TOC Day Controller will make contact with all ambulance staff as they commence operational duty, and any delays in confirming that a member of ambulance staff has arrived to work will be referred to a PTS Operations Manager. If staff report sick or do not arrive, the patient journeys involved will be allocated to another manager to liaise with the patients and clinics accordingly.

8. A Call handler omitted to ask several key questions which caused under triage of the 999 call. The call was passed to NHS Direct. The call handler undertook a reflective training exercise.

9. A 999 call was received from a patient suffering from sciatica who was unhappy at the treatment provided and attitude of the ambulance crew. They did not fully appreciate the differential diagnosis that could have applied and had not recorded whether any consideration was given to offering any form of pain relief. Regarding the unhelpful attitude they presented, the ambulance staff explained that it was their intention to provide the patient with sufficient information in order that he could make an informed decision about the care pathways available to him. An apology was offered together with an explanation of care pathway practice. A local training officer will also facilitate a reflective practice exercise with the staff involved. This will focus on the comprehensive patient assessment of back injuries.

10. A patient called 999 following a fall at home. The call was triaged as requiring a green response. The patient waited for 3 hours due to significant demand and eventually cancelled her request. The patient was advised of the measures being taken to improve performance and that her experience would be made available to the Group specifically established to consider improvements to Green call management.

11. Staff raised concerns that a GP over-triaged the presenting symptoms of a patient causing incorrect information to be passed by surgery staff to EOC. The GP was contacted and clarification was provided of the triage level for patients

presenting with cauda equine syndrome. This condition would normally attract an Amber level of response. The GP has been asked to ensure that his staff provide comprehensive details of patients when making 999 calls and local ambulance staff will be familiarised with this condition.

12. A member of the public reported the dangerous actions of an ambulance vehicle which was identified as one used as flexible fleet support. This incident highlighted the importance of signing support vehicles in and out at complexes to identify users.

13. A 999 call was referred to an outer counties ambulance service. Concerns were raised that full details were not passed to them about the mental health problems of the patient. The outer counties service failed to ring the patient back and downgraded the call. An ambulance was not provided and the patient later committed suicide. Subsequently, the outer county ambulance service have asked that full details are included in any calls passed to them; they will also change their policy so that any mental health patient is rung back by a clinician.

14. Concerns were raised by a family when the 999 call made in respect of a child's fall from a trampoline was triaged as the lowest category although the patient had ongoing heart problems. It was agreed that the patient's address would be highlighted as part of a care plan and similarly the outer counties ambulance service would also consider the same as the address is outside the LAS boundary.

15. A patient believed that the Fast Responder discouraged him from attending hospital as the FRU was of the opinion that the medication prescribed had not had sufficient time to act. Medical opinion supported the patient should have been conveyed to hospital. The FRU undertook a reflective practice exercise focussing on patient assessment.

16. This case highlighted Operational 'Policy (Ambulance Response in Circumstances of Close Personal Relationships' Ref). A member of staff attended a call to a patient who was known to them but with whom there had been a family rift. The crew were unaware of the situation until they arrived at the scene. Both EOC and Operational staff were reminded of the requirements and implementation of the apposite procedure.

17. Concerns were raised by a care home manager about the delay in providing an ambulance to a patient who had fallen and suffered an arm injury. EOC staff were reminded of the requirement to appraise callers of the reasons for the delay and the importance of obtaining regular updates on the patient's condition.

18. A patient's relative was unhappy with the attitude of the attending staff who commented that the patient could have been conveyed to hospital in the family car. The patient was experiencing a stroke. An apology was offered together with an

explanation of alternative pathway practice and additional training in patient assessment arranged for the crew.

19. The patient's family were concerned that the patient, who was the victim of an assault, was not treated with sympathy and compassion by the crew. The crew undertook an operational workplace exercise involving the importance of non-verbal body language and patient assurance techniques..

20. A 999 call was triaged as a green response and referred to NHS Direct. There was some confusion over the category of the call at the time and the call handler selected an incorrect determinant. NHS Direct referred the call back to LAS and this time the call handler was persuaded to upgrade the call based on the opinion of the NHSD Nurse rather than on the presenting condition of the patient. Both members of staff have been made aware of the call management shortcomings.

Patient Experiences

Annual Report 2009/10

Contents

1 Introduction

New complaints management legislation was introduced in April 2009 representing the full implementation of the *Making Experiences Count* (MEC*)* programme.

This has required a period of transition for all health and social care agencies in embedding the new arrangements and the LAS Patient Experiences department (PED) has been at an advantage having been a pilot site for the MEC initiative, with a structural model in place that extends across all feedback mechanisms. The Head of PED was invited to present about the establishment of this integrated approach at a number of conferences hosted by the Department of Health and independent providers and it has since become apparent that many Trusts throughout the UK are now working to this model.

The PED has developed a much closer professional relationship with the Independent Complaints Advocacy Service, who have facilitated a number of local resolution meetings, contributed to policy reviews and equality impact assessments as well as participating in the Trust's governance mechanisms.

In terms of PALS, complaints and incident reports, the volume of demand (6138) was comparable with 2008/09(6017) however the work in resolving individual cases has greatly increased by virtue of an holistic approach and a substantial increase in the number of local resolution meetings.

The Health Service Commissioner considered 49 cases for the year but none were taken forward as an Ombudsman's investigation which is a reflection of the quality and standard of the Trust's processes for Complaints Management and the diligence of the PED in putting these into practice.

The PED also manage requests made under the Freedom of Information Act 2000 and co-ordinates safeguarding activity and the investigation of serious incidents. This report incorporates narrative on frequent caller activity and the work of the Patient Centred Action Team (PCAT).

2 Regulatory Changes

Financial redress can now be made to complainants without recourse to legal action by virtue of the *Local Authority Social Services and NHS Complaints Regulations (2009).* The Ombudsman made clear her expectation that there is an obligation to '*put the complainant back in the position they were in before they experienced the problems they encountered'.* This means that there is an obligation to consider financial redress much more widely, although, as matters stand, the Trust has no designated fund for this purpose and costs are borne by local operational budgets. Arrangements have been put into place to enable coordination of decision making in this respect between the Head of PED, local management teams and senior managers.

The regulations now further determine that where an issue is raised orally but is unable to be resolved within the next working day, such instances must be technically recorded as a complaint. Work was undertaken to enable case management categorisation of each

relevant PALS case, where recourse is offered to the Ombudsman. This should not, however, be viewed as a negative development in that MEC determines a focus on the issue raised, rather than the mechanism used to raise it; moreover, offering recourse in this manner both negates replication of process and affords the service-user greater opportunity for resolution.

A further change is that where a complaint gives rise to either legal action or the invocation of the Trust's disciplinary procedure, a response must still be made to the complainant. The PED continues to offer advice to the respective departments involved on a case-by-case basis.

3. Overview

3.1 Totals and Comparison with Previous Year

The total number of PALS and Complaints cases was 6138, which breaks down to 5682 PALS enquiries and 456 Complaints, a slight increase (2%) on the previous year. This should be seen in the context of an increase of 3.5% ambulance activity in the same period and therefore indicates that the level and quality of service has not deteriorated despite the increased volume of work.

Year	PALS	COMP	Grand Total
2009-10	5682	456	6138
2008-09	5606	405	6011

Please note that there is a discrepancy of approximately 700 in the total numbers reported for 2009/10 compared with the detailed breakdown in section 3.2. This requires further analysis but does not detract at this stage from the overall impressions given on complaints and PALS activity.

3.2 Summary activity by month

3.2.1 By Area

Area	Type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Grand Total
East	COMP	2	6	9	7	7	8	5	4	4	6	5	12	75
	PAL	62	63	52	54	55	56	91	72	66	68	107	108	854
East Total		64	69	61	61	62	64	96	76	70	74	112	120	929
South	COMP	6	2	6	13	9	8	5	8	9	11	10	12	99
	PAL	73	88	78	97	78	66	99	124	112	81	106	135	1137
South Total		79	90	84	110	87	74	104	132	121	92	116	147	1236
West	COMP	5	4	8	9	7	10	4	4	5	6	10	9	81
	PAL	58	56	67	67	56	66	72	88	73	50	79	105	837
West Total		63	60	75	76	63	76	76	92	78	56	89	114	918
Grand Total		**206**	**219**	**220**	**247**	**212**	**214**	**276**	**188**	**168**	**222**	**317**	**381**	**3083**

Annual Report 2009/10

Key: COMP   Complaints
      PALS   PALS enquiries

3.2.3 By department

Sector	Type	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Grand Total
PALS	COMP						1							1
	PALS	88	86	139	127	36	5							481
PALS Total		88	86	139	127	36	6							482
EOC	COMP	14	9	14	21	16	15	14	19	14	11	6	11	164
	PALS	13	21	21	20	12	20	10	13	20	12	16	25	203
EOC Total		27	30	35	41	28	35	24	32	34	23	22	36	367
HEMS	PALS			3			1			2				6
HEMS Total				3			1			2				6
HQ	COMP		1		1	1						1		4
	PALS	35	25	29	30	28	39	33	31	18	24	34	62	388
HQ Total		35	26	29	31	29	39	33	31	18	24	35	62	392
Multi Agency Initial Assessment Team (MAIAT) inc HART	PALS			1										1
MAIAT Total				1										1
Not Our Service (NOS)	COMP	3	4	1	3	2	1					1		15
	PALS	8	11	13	4	6	11	10	8	7	4	5	6	93
														108
PTS	COMP	3	2	2			1		2		2	1	1	14
	PALS	3	4	1	6	2	5	4		3	3	1	2	34
PTS Total		6	6	3	6	2	6	4	2	3	5	2	3	48
Urgent Care Service (UCS)	COMP						1		1				1	3
	PALS	1	2	3	3		1	1				1	1	13
UCS Total		1	2	3	3		2	1	1			1	2	16
UK	PALS	18	18	26	17	75	83	118	148	96	152	109	76	936
UK Total		18	18	26	17	75	83	118	148	96	152	109	76	936
Voluntary Ambulance Service Total												1	1	2
Grand Total		175	168	239	225	170	172	180	214	153	204	169	179	2358

3.2.4 By subject

Code	COMP	PALS	Grand Total
Access		28	28
Aggregating Factors	2	9	11
Appreciation		76	76
Attitude & Behaviour	147	26	173
Clinical Equipment	5	7	12
Clinical Incident	2	77	79
Communication		36	36
Conveyance	19	42	61
Delay	91	99	190
Driving	23	37	60
Explanation of Events		90	90
Frequent Callers			0
Information	1	2166	2167
Locality Information	2	13	15
Lost Property	1	703	704
Medical Records		400	400
Non Clinical Equipment		3	3
Non-Conveyance	75	33	108
Not Our Service	14	11	25
Other		49	49
Patient Specific Protocol		16	16
Policy & Procedure		59	59
Referred Local Authority		1	1
Safeguarding			0
Serious Untoward Incident	1	49	50*
Social Services		175	175
Solicitors Enquiry		735	735
Treatment	66	1	67
Unknown		5	5
Use of Sirens	7	30	37
Dignity & Privacy		1	1
Grand Total	**456**	**4977**	**5433**

* Refers to the number of incidents considered as potential serious untoward incidents

4. Emerging Trends

4.1 Unsurprisingly, complaints and PALS activity increases following periods of high operational demand, with delays in dispatch a continuing theme as are delays to calls that were triaged as Green (category C – neither life threatening or serious). The PED

continues to contribute to the work being taken forward by the Category C action planning group which is focussed on improving the experience of Category C patients.

4.2 Staff attitude and behaviour remain a constant source of patient dissatisfaction. A proposal is being considered to undertake a Trust-wide survey which will explore the potential relationship between staff behaviours and corporate messages. It has also been proposed to identify and explore any trends that may be emerging relating to staff groups, age, experience and duration of shift at the time of any given reported incident.

4.3 The most significant new source of patient dissatisfaction was the referral of patients to NHS Direct (NHSD).

Type	Clinical	Delay	Non-Conveyance	Attitude & Behaviour	Other	Grand Total
PALS	8	14	11	3	9	45
COMP	5	9	40	13	4	71
Grand Total	13	23	51	16	13	116
% of Total	12.6%	22.3%	49.5%	15.5%	12.6%	100.0%

Note - 70 cases involving NHSD were received between February - April 2009, outwith the indicated data for 2009/10, the scheme having being introduced in February 2009.

During 2009/10, the NHSD scheme represented 14.7% of all complaints and the source of most patient dissatisfaction (13.3%), however the decision to pass selected lower priority calls to NHSD has to be seen in the context of managing an increasing demand on the ambulance service. In 2009/10 over 64,000 calls were selected and transferred each week with 83% then resolved by telephone advice rather than vehicle dispatch. Since initiating this referral process the LAS has worked closely with NHSD to improve communications between the two organisations. The trends identified in the next sections highlight the areas where work has been undertaken with a subsequent decrease in complaints or expressions of dissatisfaction.

5. NHS Direct - identified trends

- 999 calls that are passed to NHS Direct and then referred to a GP resulting in a further 999 call and an ambulance being dispatched may lead to the perception of 'NHS pass the parcel' with a delay in the patient receiving appropriate treatment and ultimately, no saving in resources. Each individual case has been analysed to identify where lessons can be learned.

- Patient and public expectations that placing a 999 call will result in ambulance being dispatched: increased publicity about the scheme may influence this.

- Confusion due to the instruction protocol that did not make it clear that a caller was being referred to NHSD: revised instruction guidance has now been devised and implemented leading to a reduction in this type of complaint.

- The scheme does not enable systematic identification of incidents where a patient has sought advice from NHSD before placing a 999 call, which can result in the patient being referred back to NHSD. This matter is subject to continuing discussions with NHSD.

- There have been instances where NHSD operatives have taken a view that the main objective of the scheme is to prevent an ambulance being dispatched rather than achieve the most appropriate care pathway. Following discussions with NHSD, instances of this nature have reduced significantly.

- Failure by LAS call handlers to adhere to Patient Specific Protocol or Individual Dispatch Protocol (care plan) instructions potentially leading to a significant clinical risk and inappropriate patient management. This can often undermine multi-disciplinary working to achieve emergency care management and there are currently no existing systemic arrangements in place to counter this call management omission although it should be noted that this is not restricted to passing calls to NHSD. A Team Brief has been issued to all Control Services staff and a technical solution is being progressed with the Information Management &Technology department.

- Referrals can result in sub-optimal care in relation to specific conditions, for example patients presenting with testicular torsion or patients living with cancer. These matters are being taken forward by the Medical Directorate. Arrangements have also been put into place to exclude patients aged under 5 years or over 70 years from the referral scheme, irrespective of their presenting symptoms, save a small tranche of patients presenting with specific clinical symptoms.

6. NHSD governance issues

- A comprehensive evaluation has yet to be completed, although some expansion of the scheme to include some types of calls historically categorised at Amber

(category B) priority level has been introduced. Close liaison continues with the Medical Directorate to identify and take action on any individual cases or trends.

- A draft enhanced protocol to enable joint complaint management was presented to NHSD but agreement has yet to be reached. This remains the subject of discussions between the Trust and NHSD at a senior level. A mechanism for NHSD to offer incident reports in relation to 999 referrals that they consider were not appropriate for whatever reason has however been introduced and is managed by Control Services.

- Information has not as yet been sent to all PCTs and local authorities for dissemination to GP practices and social care providers' pan-London. It is intended that information about the scheme will be published on the Trust website to clarify the 999 call management processes.

7. Governance

- The Feedback Learning & Improvements Group (FLIG) was established to consider emerging themes and issues of significance arising from service-user, stakeholder and staff feedback. The work of the Group involved analysis of individual incidents of particular importance to patient care and the manner of service delivery, and ensuring the implementation of recommendations arising from action plans relating to Serious Incidents (previously known as Serious Untoward Incidents) for example.

- Following a review of the Trust's governance structure the group has been replaced by the Learning From Experience Group which is building upon the governance processes established by FLIG.

- We continue to develop information about the department and the work streams the department has responsibility for, by publishing a range of information on the Trust website[1]. This information is interlinked to illustrate correlations between the differing mechanisms of service user and stakeholder feedback[2]. A key component is the publication of anonymised case examples to illustrate learning on an individual, Trust-wide and health and social care economy basis[3]. This is also consistent with the Trust's commitment to openness and transparency and has received wide approval.

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[1] http://www.londonambulance.nhs.uk/talking_with_us/enquiries,_feedback_and_compla.aspx

[2] http://www.londonambulance.nhs.uk/about_us/what_we_do/making_your_experiences_count/using_feedback.aspx

[3] http://www.londonambulance.nhs.uk/about_us/what_we_do/making_your_experiences_count/examples_of_learning.aspx

8. Community Liaison - Patient Centred Action Team (PCAT)

The PCA team manages cases of frequent callers to the LAS and continues to develop individual care plans and explore alternative care pathways through a multi-agency approach. Although invariably labour intensive, the work of the team continues to have a significant effect in reducing or preventing call volumes; some 121 cases were resolved during 2009/10, representing a conservative estimation of a reduction of 14,520 x 999 calls. Case study examples are published on the Trust website[4].

The PCAT has developed a category list to identify the type of user by the Trust resources they employ. This includes organisations as well as individuals and some patients may fall into more than one category:

- FC1 – calls to Emergency Operations Centre only

- FC2 – assisted but not conveyed

- FC3 – taken to an Emergency Department (ED)

- FC4 – hoax caller

- FC5 – self present at an ED, no LAS involvement.

Analysis of frequent caller activity in the year is as follows:

Impact on Performance and Resources – 3 month snapshot: A trial snapshot was undertaken of frequent calls in order to illustrate the impact frequent callers have on LAS operational targets and the difficulty in devising a performance management model. This has sought to demonstrate the impact on operational and EOC resources over a three month period.

Call volume: The total number of 999 calls made was 295 and this includes repeated calls regarding the same incident.

Taken to A&E: The total number of calls where the patient was taken to A&E was 109.

FRU (Fast Response Unit) sent: The total number of FRUs used was 54.

Ambulance attendance: The total number of ambulances used was 171.

Ambulance shifts lost: A 'shift' is classed as 10 calls attended by an ambulance (the average amount of calls an ambulance crew on a 12 hour shift will attend). The total number of whole 'shifts' lost was 17.

999/EOC call time: The amount of time from 'call connect' to 'call ended' that each frequent call of each frequent caller took; many frequent callers will continually call back; sometimes over 5 times after making an initial call. The total amount of EOC time used was just over 19 hours.
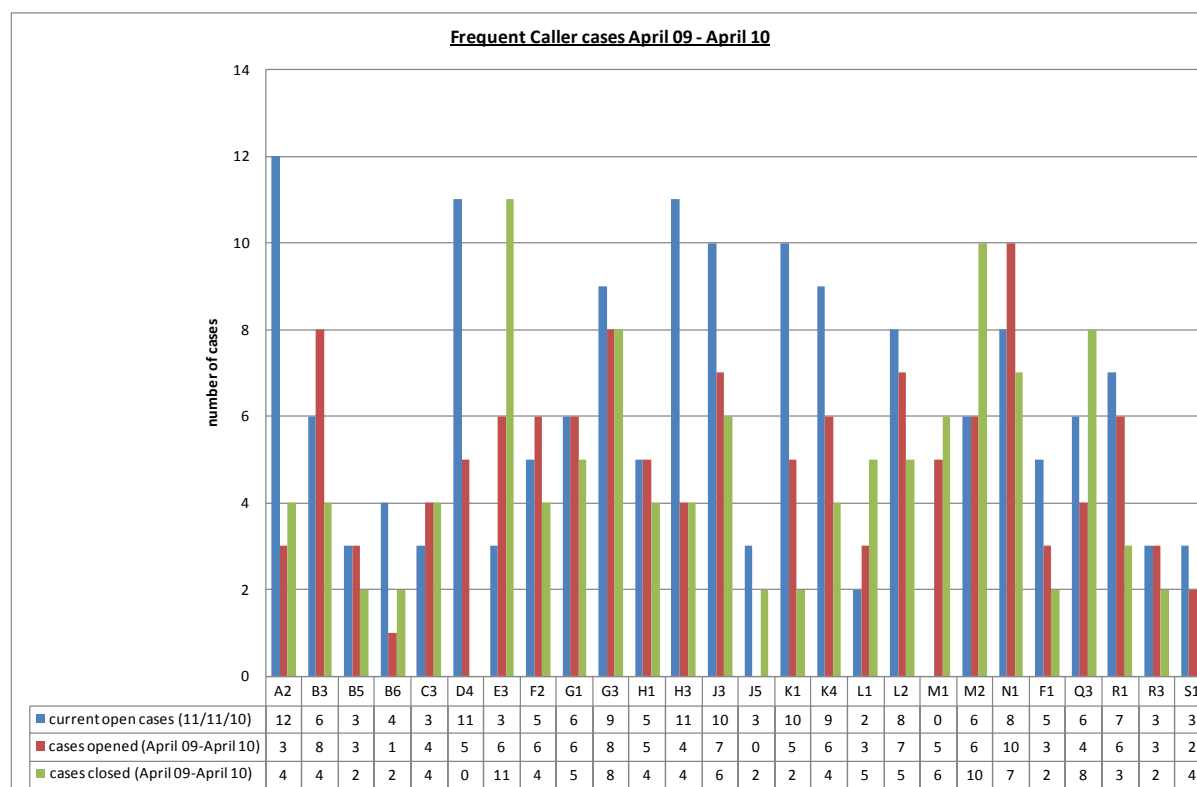

4

http://www.londonambulance.nhs.uk/health_professionals/caring_for_frequent_callers/case_studies.aspx

Patient referred by NHSD/CTA: As indicated, NHS Direct has recently been inappropriately utilised to manage a small number of calls from 'frequent callers'. Significantly, the vast majority of patients so referred were suffering from a mental health issue. From analysis, it is clear that referrals made to NHSD in this way have not prevented the patients referred from calling 999 again on a regular and consistent basis, and in some instances this has undermined and damaged complex care arrangements negotiated with a wide range of other health and social care practitioners.

Current cases by ambulance Complex:

Frequent Caller cases April 09 - April 10

	A2	B3	B5	B6	C3	D4	E3	F2	G1	G3	H1	H3	J3	J5	K1	K4	L1	L2	M1	M2	N1	F1	Q3	R1	R3	S1
current open cases (11/11/10)	12	6	3	4	3	11	3	5	6	9	5	11	10	3	10	9	2	8	0	6	8	5	6	7	3	3
cases opened (April 09-April 10)	3	8	3	1	4	5	6	6	6	8	5	4	7	0	5	6	3	7	5	6	10	3	4	6	3	2
cases closed (April 09-April 10)	4	4	2	2	4	0	11	4	5	8	4	4	6	2	2	4	5	5	6	10	7	2	8	3	2	4

The number of current 'open' cases at the end of the period, 158, is average at any given point and reflects the scale of the challenge in managing these cases.

It is Trust policy to involve ambulance complexes in the management of this patient cohort and 22 out of the 26 complexes currently have a dedicated champion. Where case conferences are held these tend to be successful but the process is time-consuming. Many of the patients are especially challenging to primary and secondary care and often involve patients with mental health issues.

Liaising with Care Homes: The team has identified that agencies and organisations, as well as individuals, can be identified as 'frequent callers': data showing the top 100 phone numbers calling 999 indicated that some residential and nursing homes use the Trust far more frequently than expected for their size and for the type of resident. PCAT has expanded its remit to work with these agencies with the aim of reviewing their policies to reduce call volumes.

The team has also highlighted other establishments (ice rinks, supermarkets) where the 999 call volume appears disproportionately high and the team has started to work with them in order to establish, for instance, whether their policies on first-aid have an over-reliance on the 999 service. Similarly, work has been undertaken with a number of hostels to improve management of a patient group who are, by definition, frequently transient.

Additional Triggers: A number of incidents were reported by ambulance staff as incident reports which involved difficulties such as;

- Difficulty gaining access to patients;
- A lack of clinical information being made available at handover;
- Inadequate recording of advance decisions and associated understanding of the Mental Capacity Act provisions;
- Misunderstandings of the emergency care role (eg; in respect of lifting fallen patients).
- Failure to consider care pathway alternatives

The Training: Following an incident in a South London care home belonging to a major provider PCAT, the local ambulance complex management team and the care provider's development manager discussed the potential for staff training. This led to a 'Managing Emergencies' module which was integrated into an in-service training session delivered by the provider. PCAT and the local management team presented 5 sessions in four different care facilities owned by this provider and each session was attended by approximately up to 10 care workers. The presentation covered a number of topics:

- Background information
- Manner of response
- Call volumes – highlighting the difference between call levels and incidents attended.
- Importance of CPR
- Indications for calling 999 especially after a fall.
- Calling 999
- When 999 may not be necessary
- Alternative Pathways
- Preparing for the arrival of LAS.

This was followed by CPR training and allied topics. Feedback from the care staff who participated has been favourable. Amongst the feedback from participants the following is a typical comment:

"I have found these sessions to have had a positive effect on our staff team. Individuals have stated that they feel more confident to know when to call an emergency ambulance."

Early indications are that there has been a reduction in call volumes from this care provider.

Further Initiatives: Contact has also been made with a PCT leading to liaison with another care home provider to arrange a similar training session. Discussions are also underway with another major care provider.

It is proposed to disseminate the PowerPoint presentation to all ambulance complexes so that they can consider local initiatives to offer training to care home providers and similar agencies, for example Housing with Extra Care.

Compliance with the requirement for completion of an FOI request within 20 days has deteriorated in recent years to 79%. The main reason for this has been a lack of assistance from some Trust departments in making the information available and not all departments have had a dedicated FOA contact in place. This has since been addressed with directors and through the Information Governance Group.

The vast majority of requests made under FOIA are unnecessary given that the LAS are happy to accommodate requests in the course of usual business to both PED and Communications departments. Requests can be refused as is shown in the tables above

9. Summary

In summary the Patient Experiences Department has managed an increased volume of activity during the year and has introduced improved working practices in many instances, either through internal processes or by working in partnership with LAS staff and external agencies.

Gary Bassett

Head of Patient Experiences

November 2010

Appendix A – Case Studies

1. A Cardiologist requested the ECG rhythm strip for a patient who had suffered a cardiac arrest. This was urgent to assist the cardiologist decide whether to implant a 'mini-defibrillator'. After considerable effort the correct ECG was located. This however raised the issue of data being unavailable because, for example, memory cards become full and are not replaced; data is not downloaded promptly; cards are mislaid or have been incorrectly applied within the defibrillator. This matter was referred to the Trust's cardiac lead, Education & Development and Operational Support departments to improve methods of data collection.

2. A GP surgery did not provide a clinical handover of care when an ambulance crew attended a very unwell child. The patient was also left without clinical supervision for some considerable while both before and after a GP was able to assess him, despite clinically serious symptoms being reported. The incident was raised with the GP surgery who later advised of improved arrangements in these respects.

3. A District Nurse administered insulin to a diabetic patient with a very low blood glucose level. The advice obtained from the Medical Directorate was that this represented a potentially severe risk, the appropriate management being to administer glucose orally. Concerns were also raised that District Nurses do not routinely carry glucagon during the course of administering giving insulin to patients in the community. The local community nursing provider was alerted to take local action and raise the generic issue with the Strategic Health Authority.

4. A patient incurred an accidental penetrating injury at home. The 999 call was referred to NHS Direct, who were unable to conduct an assessment as by this time the patient had felt compelled to make his own way to hospital, the call back message from NHS Direct being left on the patient's ansaphone facility.

    A quality assurance review of the 999 call management revealed that the incident had been incorrectly triaged, the call handler mistakenly selecting the inappropriate 'chief complaint' protocol. A reflective practice exercise was arranged and the patient was provided with a full explanation of the triage system, what had gone wrong in this case and the action that had been taken to prevent re-occurrence

5. A patient aged 14 presented at hospital with a septal abscess which required emergency drainage. It transpired that the patient had been attended by ambulance staff the previous day but they had not recognised the significance of the patient's presentation, including a high temperature, the patient being left in the care of his mother with advice to administer flu remedies. The incident raised a number of learning points around the assessment of febrile illness; the ambulance staff concerned took part in a reflective practice exercise. The local management team also undertook to liaise with the Trust's GP lead to undertake dedicated training for all complex staff.

6. A mother placed a 999 call after her four year old daughter had fallen from a trampoline. The child was at that time awaiting heart repair surgery for a number of serious heart defects. A delay ensued in an ambulance attending and the child's mother was subsequently alarmed at discovering that the incident had been designated a lower emergency response priority. An explanation of the triage system was provided clarifying that this is based on immediate presentation rather than the unquantifiable risk of deterioration. Arrangements were however made to devise an emergency care plan held against the patient's address in the event of any future 999 call.

7. An MP expressed concerns that a patient who had experienced a knee injury had been referred to NHS Direct and then another ambulance Trust only for her to be once again referred for an ambulance to be arranged by the LAS. She had also been advised to make her own way to hospital and it was only on challenging this that an ambulance was eventually arranged. The quality assurance evaluation conducted by the respective agencies involved identified that that all the call handlers involved had (to varying extents) failed to adhere to protocol. The call handlers subsequently took part in a reflective practice exercise hosted by each agency. The LAS also re-issued a bulletin offering guidance about the triage of distal injuries.

8. A patient's mother was offered incorrect information about the destination hospital her son had been conveyed to. She incurred unnecessary travel expenses and inconvenience accordingly. An explanation and apology was offered and reimbursement of the costs incurred made.

9. A hospital Minor Injury Unit (MIU) expressed concerns that staff had been advised to contact the hospital Patient Transport Service provider following a request to arrange the transfer of a patient with a possible spinal injury to another acute Trust A&E department. Clarification of the apposite procedures was provided to the MIU, covering the differing types of process according to the nature of the patient's presentation and purpose of the transfer; the investigation also identified some gaps in guidance which resulted in amendments to the call management protocol in relation to ambulance requests from MIUs.

10. A woman spontaneously went into labour at home (BBA) but the baby presented in the breech position and unfortunately the foetal head became trapped in the maternal pelvis and contractions ceased. The attending ambulance staff experienced difficulties in arranging a midwife to attend as the hospital considered the patient to be outside their geographical area of responsibility. The crew were eventually able to deliver the baby and conveyed the mother and child to hospital. This matter was raised with the hospital involved and referred to the Nursing & Midwifery Council. The incident also gave rise to a review by the LAS Consultant Midwife of the clinical telephone advice algorithm used by the Clinical Coordination Desk in relation to a breech birth where the baby's head is trapped and the mother is not experiencing contractions.

11. Concerns were raised that the treatment provided by an ambulance crew may have contributed patient's demise. The patient had presented with   symptoms of a headache and visual disturbances. Two doses of adrenaline were administered when the patient collapsed with a suspected allergic response. A subsequent CT scan indicated a large subarachnoid hemorrhage.   A clinical review was undertaken by the Trust's Medical Directorate which offered clarification of the treatment provided and confirmed that the administration of adrenaline would not have affected the patient outcome.

12. Concerns were raised by a 999 caller who had become understandably frustrated that a well-known landmark could seemingly not be located by the call handler. An explanation was offered that whilst the Trust's gazetteer system can identify most locations, it is reliant on information about precise road junctions in order to achieve a match; further that whilst call handlers cannot be aware of landmarks familiar to callers, these are used as additional information to assist the assigned ambulance staff in the case of any difficulties or system failures. An apology was however offered with an explanation of the improvements being implemented to the gazetteer system, including a facility to match a location from the full post code and the alternative sources of assistance available to call handlers to verify a location, including map reference resources and liaison with the Metropolitan Police.

13. A child experiencing a potential anaphylaxis shock was not treated by the attending ambulance staff, who explained to the patient's mother that they were not authorised to administer a patient's own medication, leaving the patient's mother to give the injection herself.   Based on clinical advice from the Medical Directorate, it was confirmed that Adrenaline should have been given from the crew's supply or the patient's Epipen.utilised. Guidance was issued in Clinical Bulletins confirming the position that ambulance staff are authorised to administer a patient's prescribed medication, should the need arise.

14. A governance review was undertaken following the management of a patient presenting with sepsis at a care facility. The information provided by the referring clinician did not reflect the seriousness of the patient's condition; the clinician had also not remained on scene to monitor the patient who was held to critically unwell. A member of the Medical Directorate liaised with the GP deputising service involved so that the clinician was able to learn from the shortcomings in this management of the patient; revised guidance was also issued by the GP deputising service in relation to best practice in supervising a patient until the arrival of ambulance staff and facilitating a handover of care.

15. An agency who provide specialised residential care for patients with neurological conditions, the majority of whom have significant spinal injury, sought to clarify recognition of Autonomic Dysreflexia as a medical emergency. A member of the Medical Directorate liaised with the agency concerned and advice was subsequently disseminated to enable the establishment of specific care plans for individuals within this patient group. An article to raise awareness across the Trust was also published.

Selective PCAT Case Examples

16. Disabled 47 yr old man living alone, a wheelchair user. 999 calls given as having fallen out of his wheelchair. Over a nine month period 209 999 calls were made but with conveyance being deemed necessary on only 8 occasions. Ambulances were often dispatched because the call handlers experience difficulties in understanding the patient's impaired speech. The care package was provided by the local council Adult Community Services included 3 x domiciliary care per day. Following liaison with the GP, who had also experienced significant demand from the patient, PCAT arranged a strategy discussion and were able to advise the local authority care manager of the possibility of an application to the Independent Living Fund in order to increase the resources available to the patient. Following such an application, additional funds were made available using the direct payment facility so that the patient was able to employ a care worker of his own choice. The volume of 999 calls has subsequently been reduced to one or two per month.

17. 82 year old disabled man living in large nursing home in north London. He has very poor mobility partly, he alleges, as a result of earlier hospital treatment. He is an anxious and sometimes demanding patient. Despite having a call system in his room to enable him to request assistance from the care home staff, he has called 999 over 100 times in 6 months. Following liaison with the care home manager and a meeting with the patient and his son PCAT were able to establish that he calls 999 because he feels that the care home staff do not respond to his needs quickly enough and he also seeks the reassurance because ambulance staff carry out full clinical observations. With the agreement of the home staff and his family a care plan is in place so that a resource is not dispatched but EOC staff call the home to inform them of what has occurred. As a result there has been a reduction in the number of ambulances dispatched.

18. 50 year old woman with history of mental illness, alcohol abuse and self harming frequently called 999 threatening to self harm or expressing suicidal ideation. Following liaison with the local mental health provider's Crisis Intervention Team, a case conference was held together with local police community safety officers to plan the patient's discharge from a small residential unit. The patient agreed to call 24/7 mental health team number rather than 999 when she was feeling distressed. Care plan locality information was affected to ensure the mental health team are notified in the event of a 999 call. There has been a significant reduction in 999 calls since but monitoring continues.

19. Concerns were raised by Clinical Support Desk and local ambulance staff regarding a elderly obese patient (30+ stone) who had placed 200 x 99s calls over a 12 month period, mainly in relation to experiencing falls or catheter problems. The patient usually declined conveyance to hospital and was only actually taken to an ED on 5 occasions. The patient was reported as verbally and physically abusive and made sexual advances to female crew staff. PCAT made contact with the GP, and after the patient's admission to hospital liaison ensued with the hospital. It was agreed that the patient would not be discharged until an increased care package could be implemented. This was achieved and in the three months following the patient's discharge, the volume of 999 calls has been reduced to 3, each call being made by a carer rather than the patient.

London Ambulance Service **NHS**

NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

3ᴿᴰ FEBRUARY 2011

PAPER FOR NOTING

Document Title:	**Trust Secretary report**
Report Author(s):	**Sandra Adams**
Lead Director:	**Sandra Adams**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Compliance with Standing Orders**
This paper has been previously presented to:	☐Strategy Review and Planning Committee ☐Senior Management Group ☐Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	**To note the tenders received and entered into the tender book since 30ᵗʰ November 2010 and the use of the Trust Seal**

Executive Summary

Two tenders have been received, opened and entered into the tender book since 30ᵗʰ November 2010:

- Sale of Park Royal Ambulance Station
  Tenders received and opened on 12ᵗʰ January 2011:
  Chancery Gate
  Double 4 Ltd
  Memory Crystal.
- Logistics Vehicle Conversion
  Tenders received and opened via Bravo Solutions on 27ᵗʰ January 2011:
  Bott Ltd
  S. MacNeillie & Son
  Wilker UK Ltd.

There has been one entry to the Register for the Use of the Trust Seal:

- Alterations to 889 Brewery Road, London N7 9NT.

Key issues for the Trust Board
To note the report

Attachments
N/A

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

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

Risk Implications

This paper links to the following strategic risks:

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

NHS Constitution

This paper supports the following principles that guide the NHS:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐	Yes
☒	No

Key issues from the assessment:

LONDON AMBULANCE SERVICE TRUST BOARD

3RD FEBRUARY 2011

PAPER FOR NOTING

Document Title:	**Trust Board Forward Planner**
Report Author(s):	**Sandra Adams, Director of Corporate Services**
Lead Director:	**Sandra Adams, Director of Corporate Services**
Contact Details:	**0207 783 2045**
Why is this coming to the Trust Board?	**To ensure that key issues are discussed by the Trust Board and that Trust Board members are fully engaged with the agenda planning process.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	To note the Trust Board forward planner for the coming year and to identify any areas for discussion for future agenda items
Executive Summary To note the Trust Board forward planner for the coming year and to identify any areas for discussion for future agenda items.	
Key issues for the Trust Board N/A	
Attachments Trust Board forward planner.	

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Strategic Goals 2010 – 13   This paper supports the achievement of the following corporate objectives: ☒ To have staff who are skilled, confident, motivated and feel valued and work in a safe environment   ☒ To improve our delivery of safe and high quality patient care using all available pathways   ☒ To be efficient and productive in delivering our commitments and to continually improve
Risk Implications   This paper links to the following strategic risks: ☒ There is a risk that we fail to effectively fulfil care/safety responsibilities   ☒ There is a risk that we cannot maintain and deliver the core service along with the performance expected   ☒ There is a risk that we are unable to match financial resources with priorities   ☒ There is a risk that our strategic direction and pace of innovation to achieve this are compromised

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☒ 6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
☒ 7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

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

Key issues from the assessment:

TB FORWARD PLANNER

Date	Strategic and Business Planning	Items for approval (eg Policies and Business Cases)	Performance and Other	Governance	Standing Items
3rd February 2011 TB	Formal IBP and LTFM sign off pre-submission	CommandPoint Update (PS)	Quality Indicators Dashboard (SL)	Patient Experience Report (SA)	Report from CEO including balanced scorecard and performance reports
SMG 12 Jan	Business Planning and Contracting 2011/12		Update on Patients with Learning Disabilities (SL)	Key risks (SA)	Report from Finance Director
	Update on Clinical Response Model (CH)			HDD Closure Report and minutes from the meeting on 30th November	Report from Sub-Committees
				Foundation Trust application documents including quality and performance compliance requirements	Clinical Quality and Patient Safety Report
				Board Declarations/self certification	Report from Trust Secretary
1 March 2011 TB	Approve FT application	CommandPoint Update		Key risks	Report from CEO including balanced scorecard and performance reports
SMG 16 Feb	Annual Business Plan and Budget			Safeguarding Declaration	Report from Finance Director
	Corporate objectives			Board Assurance Framework	Report from Sub-Committees
	Cycle Response Unit (Tom Lynch)				Clinical Quality and Patient Safety Report
	Update on Clinical Response Model				Report from Trust Secretary
29 March 2011 TB	Annual Business Plan and Budget	CommandPoint Update		Risk management policy and strategy review	Report from CEO including balanced scorecard and performance reports
SMG 16 Mar				Annual Review of Standing Orders and Standing Financial Instructions	Report from Finance Director
				BAF and Risk Register	Report from Sub-Committees

TB FORWARD PLANNER

					Clinical Quality and Patient Safety Report
					Report from Trust Secretary
26 April 2011 SRP	Review of balanced scorecard			Governance structure review	
SMG 13 April					
24 May 2011 TB	FT application update	CommandPoint Update		2010/11 Annual Report and Accounts (including Quality Report)	Report from CEO including balanced scorecard and performance reports
SMG 11 May				KA34 Compliance Statement	Report from Finance Director
				2010/11 Annual Infection Prevention and Control Report	Report from Sub-Committees
				Q4 integrated governance and finance declaration	Clinical Quality and Patient Safety Report
				2009/10 Annual Equality Report	
				Corporate Social Responsibility Report 2010/11	Report from Trust Secretary
				Key risks	
28 June 2011 TB	FT application update	CommandPoint Update		Audit Committee Annual Report 2010/11	Report from CEO including balanced scorecard and performance reports
SMG 15 June				Patient Experience and Complaints Report	Report from Finance Director
				Audit and Research Annual Report	Report from Sub-Committees
				BAF and corporate risk register	Clinical Quality and Patient Safety Report
					Report from Trust Secretary
26 July 2011 SRP	Review of balanced scorecard				

TB FORWARD PLANNER

SMG 13 July					
23 Aug 2011 TB	FT application update			Q1 integrated governance and finance declaration	Report from CEO including balanced scorecard and performance reports
SMG 10 August				Key risks	Report from Finance Director
					Report from Sub-Committees
					Clinical Quality and Patient Safety Report
					Report from Trust Secretary
27 Sept 2011 TB	FT application update			Annual Trust Board effectiveness Review 2010/11	Report from CEO including balanced scorecard and performance reports
SMG 14 Sept				BAF and risk register	Report from Finance Director
					Report from Sub-Committees
					Clinical Quality and Patient Safety Report
					Report from Trust Secretary
1 November 2011 SRP awayday - all day	Review of balanced scorecard				
29 Nov 2011 TB				Q2 integrated governance and finance declaration to Monitor	Report from CEO including balanced scorecard and performance reports
SMG 9 Nov				Patient and Complaints Experience Report	Report from Finance Director

TB FORWARD PLANNER

				Key risks	Report from Sub-Committees
					Clinical Quality and Patient Safety Report
					Report from Trust Secretary
13 Dec 2011 **TB**				Charitable Funds Annual Report and Accounts 2010/11	Report from CEO including balanced scorecard and performance reports
SMG 7 Dec				BAF and corporate risk register	Report from Finance Director
					Report from Sub-Committees
					Clinical Quality and Patient Safety Report
					Report from Trust Secretary