London Ambulance Service NHS
NHS Trust

TRUST BOARD

Meeting to be held at 10.00am on Tuesday 24th May 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 29th March 2011** To approve the minutes of the meeting held on 29th March 2011		TAB 1
3.	**Matters arising**	All	TAB 2
	3.1 Actions from previous meetings 3.2 To receive a presentation on the results of the staff survey	CH	Presentation
4.	**Report from Sub-Committees** To receive a report from the following Committees		
	4.1 Quality Committee on 27th April 2011 4.1 Audit Committee on 17th May 2011	BM CS	TAB 3 Oral
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 Director of Finance 6.3 Balanced Scorecard on Infection Prevention and Control	PB MD SL	TAB 5 To follow TAB 6
7.	**Clinical quality and patient safety report** To receive the monthly report on clinical quality and patient safety	FM	TAB 7

STRATEGIC AND BUSINESS PLANNING

8.	**CommandPoint** To receive assurance on readiness and give authority to go live on 8th June 2011	PS	TAB 8

9.	**2010/11 Annual Report and Accounts** To note the 2011/12 Annual Report and Accounts	MD	TAB 9
10.	**Cost Improvement Plan 2011/12** To receive an update on progress against the Cost Improvement Plan for 2011/12	MD	TAB 10
11.	**Future Financial Services Outline Business Case** To approve the outline business case for future financial services	MD	TAB 11
12.	**Quality Account 2010/11** To discuss the content of the Quality Account for 2010/11	SL	TAB 12
13.	**Service Improvement Programme Closure Report** To note the Service Programme Closure report	SA	TAB 13

FOUNDATION TRUST PROCESS

14.	**Foundation Trust Update** To receive an oral report on progress towards the Board to Board and submission of application to the Department of Health	SA	Oral

GOVERNANCE

15.	**Report from Trust Secretary** To receive the report from the Trust Secretary on tenders received and the use of the Trust Seal	SA	TAB 14
16.	**Forward Planner** To review the Trust Board forward planner and agree items for future meetings	SA	TAB 15
17.	**Questions from members of the public**		
18.	**Any other business**		
19.	**Date of next meeting** The next Trust Board meeting will be held on Tuesday 28th June at 10.00		

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING
Part I

DRAFT Minutes of the meeting held on Tuesday 29th March 2011 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
Steve Lennox	Director of Health Promotion and Quality
Beryl Magrath	Non-Executive Director
Fionna Moore	Medical Director
Caroline Silver	Non-Executive Director
Nigel Walmsley	Non-Executive Director
In Attendance:	
Sandra Adams	Director of Corporate Services
John Hopson	Assistant Director Of Operations (EOC)
Mary John	Payroll Manager (observing)
Rachel Love	Management Information Analyst (observing)
Jonathan Nevison	Project Manager, CommandPoint
Angie Patton	Head of Communications
Eric Roberts	Unison Branch Secretary
Peter Suter	Director of Information Management and Technology
Richard Webber	Director of Operations
Members of the Public:	
Carrie Armitage	
Richard Berry	Scrutiny Manager, Health and Public Service Committee, London Assembly
Joseph Healy	Patients Forum
Alan Lacombie	Northrop Grumman

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22. Welcome and Apologies

22.1 Apologies had been received from Lizzy Bovill.

23. Minutes of the Part I meeting held on 3rd February 2011

23.1 The minutes of the meeting held on 3rd February 2011 were approved.

24. Matters Arising

24.1 97/10: Mike Dinan had circulated the age profile of the fleet to members of the Trust Board. This action was complete.

24.2 03.5: Mike Dinan had provided the Trust Board with a break down of agency spend. This action was complete.

24.3 06.7: Sandra Adams reported that the revised wording for risk 338 would be presented to the next Risk, Compliance and Assurance Group meeting for approval.

24.4 11.3: With regards to the operating cost implications of the Estates Strategy, Mike Dinan reported that this would come through to the Trust Board in the form of individual business cases and the refresh of the Integrated Business Plan (IBP).

24.5 16.2: Sandra Adams confirmed that complaints data was now included in the CEO report and that a quarterly report on trend data would be provided to the Trust Board. Sandra was in the process of setting up a system to regularly review complaints and responses and proposed that a non-executive director undertake ad hoc sampling of completed complaints.

24.6 16.3: Sandra Adams confirmed that PALS data was incorporated in the complaints report and PALS was managed by the same team.

24.7 19.1: Angie Patton reported that case studies of patients who had received better clinical care as a result of being referred to an appropriate care pathway would be incorporated into community newspapers and the LAS website.

24.8 The Chair stated that any reports provided to this meeting of the Trust Board for noting would be taken as read. The Chair requested that any highlight reports focus on key issues, particularly risks and concerns about issues that might develop.

25. Report from Sub- Committees

Quality Committee on 2nd February 2011 and 1st March 2011

25.1 Beryl Magrath reported that at its last meeting, the Quality Committee had noted that there might be a conflict of interest between operational turnaround targets and time taken to fulfil hand hygiene compliance. Beryl Magrath had requested that the executive team look into this further and report back to the Quality Committee.

25.2 Beryl Magrath also noted that the Quality Committee should be a key part of the monitoring system of the Cost Improvement Plan.

ACTION: MD to ensure that the Quality Committee was incorporated into the monitoring of the Cost Improvement Plan.

DATE OF COMPLETION: 24th May 2011

25.3 In response to a question from the Chair, Beryl Magrath commented that she was assured that the Quality Committee was making progress and was achieving what it was established to do.

Audit Committee on 7th March 2011

25.4 Caroline Silver tabled a report on the Audit Committee meeting on 7th March 2011. Areas discussed included the review of the processes around the risk register which was becoming a more effective and dynamic document. The Audit Committee found no issues of concern around the risk management processes. Caroline Silver reported that there were no material counter fraud issues to raise.

25.5 The Audit Committee asked the Quality Committee to review the risks around the implementation of CommandPoint.

ACTION: SA/FG to add the review of the risks around the implementation of CommandPoint to the forward planner of the Quality Committee.

DATE OF COMPLETION: 27th April 2011

25.6 The Chair asked whether the relationship between the Audit Committee and the Quality Committee was working effectively and whether there was clarity about the roles of the two committees. Caroline responded that both committees had discussed this issue in depth and, whilst there were initial concerns that the roles of the two committees might overlap, the relationship was now working effectively. Caroline commented that the Quality Committee was meeting more frequently to accommodate the number of agenda items which had been identified. Beryl Magrath also attended Audit Committee meetings and the strength and level of Beryl's input should not be underestimated.

25.7 Beryl Magrath commented that she was currently trying to keep Quality Committee meetings to two hours, but they occasionally overran due to some agenda items requiring more attention. Caron Hitchen added that when the Quality Committee was first established, there was concern regarding the overlap of responsibilities with other committees, but she was now reassured that this was working effectively. Caron commented that the Quality Committee would need to consider the quality impact of the Cost Improvement Plan.

ACTION: SA/FG to add CIP to the forward planner of the Quality Committee.

DATE OF COMPLETION: 24th May 2011

25.8 The Trust Board would also need to consider how to make best use of the Quality Committee, Audit Committee and Finance and Investment Committee in the future, although this would be addressed in the annual governance review.

26. Chairman's Report

26.1 The Trust Board noted the Chairman's Report.

26.2 The Chair suggested that the wording in the risk implications section of the Trust Board front sheet be reconsidered.

ACTION: FG/SA to review the wording in the risk implications section of the Trust Board front sheet.

DATE OF COMPLETION: 24th May 2011

27. Update from Executive Directors

Chief Executive Officer

27.1 The Chair congratulated the executive team for the achievement of the 75% target for category A for the year 2010/11 and recognised that this had been a challenge, particularly in the last few months.

27.2 Peter Bradley noted the following:

- With regards to performance targets, both Category A8 and A19 had been met. Although the Category B target had not been achieved, 2010/11 had seen the best year for Category B performance, with thousands more patients reached within the 19 minute target than ever before. 95% of calls had been answered within 5 seconds;
- Funding for 2011/12 was close to being agreed. Funding for 2012 Olympics and HART was being worked through with the commissioners and the Department of Health;
- Penalty negotiations had yet to be resolved, despite holding a number of meetings with the commissioners. This would have an impact on the Trust's year end position and would be discussed further in the Part II meeting;
- The staff survey results had shown some significant improvements, particularly with regards to training and appraisal. A detailed report would be brought to the Trust Board at a future meeting;
- The Chair and Chief Executive would be attending a scrutiny review meeting at the London Assembly on 6th April;
- The verdict on the 7/7 inquests was due to be given on 6th May. The Trust would ensure that it was in a position to respond to the verdict and the resulting media interest;
- The Audit Commission's review of Ambulance Trusts was due to be published on 11th May and was likely to be submitted to the Public Accounts Committee;
- Richard Webber was currently developing the performance plan for the first quarter. The Trust needed to secure good performance in the first two months in order to prepare for the likely drop in performance following the implementation of CommandPoint in June 2011. The Bank Holidays in May and August, the Royal Wedding and protest marches would also have an impact on performance and would need to be taken into account.

27.3 The key issues were:

- Finalising the Foundation Trust timeline and in particular the date of the Board to Board meeting with the SHA;
- Communicating the key messages of the Cost Improvement Plan. A bulletin would be circulated which would inform all staff that the number of staff would be reduced by 160 in 2011/12. Discussions would be held with staff, unions and management over the next few weeks regarding the best way to manage this;
- Category B changes which would come into effect on 18th April and would be replaced by clinical quality indicators. It was agreed that Richard Webber would provide the Trust Board with a presentation on the Category B changes at the next meeting;
- The Trust was pushing hard for the changes to clock start call connect and would be submitting a paper to the Department of Health in April.

ACTION: RW to provide the Trust Board with a presentation on the Category B changes.

DATE OF COMPLETION: 24th May 2011

27.4 The Chair noted that some items would be discussed in detail later on the agenda but recognised the positive contributions of staff and others over the past year. It was difficult to maintain a view of the bigger picture at times, but overall the service had reached more patients within faster response times over the past year than in previous years. This was an achievement to be recognised.

27.5 Beryl Magrath congratulated staff for achieving the Category A target despite the last few difficult months. Beryl noted that the Trust had experienced a 2% growth in Category A activity last year which was more than the 1.8% forecast in the Integrated Business Plan (IBP). Peter Bradley responded that the IBP predicted a 2.8% growth in the number of 999 calls received which would translate to a 1.8% growth in the number of incidents. Richard Webber added that it was expected

that the Trust would experience an overall increase in activity of 4.5% and would have to respond by providing more telephone advice and conveying fewer, less urgent patients.

27.6 Jessica Cecil noted that current staff sickness absence was at 5.2% and that the results of the staff survey showed that a significant number of staff felt under pressure to come to work despite not feeling well enough. Caron Hitchen responded that staff absence was managed robustly under the attendance management policy. Staff perception about not feeling well enough to attend work might differ depending on their role.

27.7 In response to a question regarding Operational Workforce Reviews, Caron Hitchen reported that they were introduced in October 2010. PDRs were currently at 47%, however this should start to show an improvement.

27.8 It was agreed that the Trust Board receive a presentation on the results of the staff survey at its next meeting.

ACTION: CH to provide the Trust Board with a presentation on the results of the staff survey.

DATE OF COMPLETION: 24th May 2011

27.9 Roy Griffins asked whether the review by the National Audit Office would include handover times at accident and emergency departments. Peter Bradley responded that it was likely that the report would put some economic value on lost hours at hospital.

27.10 Joseph Healy asked whether the Patients Forum could have a copy of the staff survey report.

ACTION: CH to send a copy of the staff survey report to Joseph Healy.

DATE OF COMPLETION: 24th May 2011

Director of Finance

27.11 Mike Dinan reported the following:

- The in month position for the Trust was a £70k surplus against a loss of £282k. The Trust was on track for a control total of £500k, subject to decisions on penalties;
- Income had increased in month 11 due to changes in the accounting treatment of RTA income and better performance in PTS as a result of a price uplift. The Audit Committee would review RTA annually in future;
- The overtime control total was met in February and was likely to be so for March;
- Operation Plato revenue was due to be received which would meet the costs of establishing additional resilience;
- The Trust had delivered nearly £13.5 million recurrent costs savings, which was one of the largest cost improvement plans delivered in London.

27.12 Brian Huckett noted that £3 million of the budget was on agency spend (£1 million in Operations and £2 million in Information Management and Technology). Mike Dinan responded that it was likely that this figure would remain the same next year for Operations, but that IM&T agency spend would reduce.

27.13 Jessica Cecil congratulated the executive team for the achievement of the £13 million cost improvement plan, which should provide substantial evidence for the long term financial model in the future.

27.14 The Trust Board noted the Report from the Director of Finance.

Balanced Scorecard on Infection Prevention and Control

27.15 It was agreed that the balanced scorecard on infection prevention and control would be presented to every meeting of the Trust Board and a detailed plan would be reviewed by the Quality Committee until sufficient assurance had been provided to the Trust Board that this issue could be de-escalated. Steve Lennox noted the following:

- Hand hygiene remained a concern. The Trust had recently commenced a second round of hand hygiene auditing at accident and emergency departments whereby practice would be observed and corrected where necessary;
- Training data had improved and would be reported differently from April 2011 to provide more accurate figures;
- A plan was in place to improve deep cleaning of vehicles which was starting to have an impact. Audits would be undertaken on two aspects of compliance (fleeces and reuse of blankets);
- The overall amber rating reflected the improvements in practice seen in recent months. It was interesting to note that the improvement in training in the South Area had not yet had the anticipated impact on compliance.

27.16 Joseph Healy congratulated Steve Lennox for the improvements that had been seen in Infection Prevention and Control and asked that Steve Lennox give a presentation to the Patients Forum on blanket use.

ACTION: SL to give a presentation to the Patients Forum on blanket use.

DATE OF COMPLETION: 24th May 2011

28. Clinical Quality and Patient Safety Report

28.1 Fionna Moore reported the following:

- Three new serious incidents had been declared, one relating to the referral of a patient with mental health problems and two relating to the loss of patient identifiable data;
- CPI performance had improved for the month of February and it was expected to continue to improve following the Category B changes;
- The DANCE study was likely to become influential as many of the Heart Attack Centres wished to be involved;
- Three audits had been undertaken:
    - Use of adrenaline as a treatment for asthma and anaphylaxis;
    - Use of salbutamol. This was a snapshot audit on 50 patients and the findings showed that it was generally appropriately used, although some areas of concern were identified;
    - Management of patients with sickle cell disease. The findings showed that there had been an improvement in the care given to this group of patients, in particular the speed of response and the administration of pain relief;
- Compliance with the Controlled Drugs policy was still an area of concern, but was being managed;
- The JRCALC Guidelines Sub-committee's recommendation for the addition of both IV paracetamol (analgesic) and ondansetron (anti-emetic) had been approved.

28.2 Beryl Magrath congratulated the LAS on its presentation to the London Trauma Office conference.

28.3 Beryl Magrath commented that the use of the morphine belt needed to be publicised to ensure that the message was heard by staff.

28.4 Beryl Magrath expressed concern that, if the Clinical Audit and Research Unit become more involved in audits to support the Integrated Business Plan, fewer snapshot audits would be undertaken.

28.5 Joseph Healy commented that the management of controlled drugs was an issue and referred specifically to the report on the reluctance of the CPS to prosecute. Caroline Silver responded that the Metropolitan Police Service audited controlled drugs issues and this had therefore now come off the Audit Committee agenda. Fionna Moore added that out of 2000 doses of morphine administrated in a month, three doses had been lost since the last report to the Trust Board. These incidents were taken very seriously and were followed up appropriately. The Metropolitan Police also undertook unannounced inspections to provide assurance on our controlled drugs processes.

29. <u>CommandPoint Update</u>

29.1 Peter Suter reported that Trust Board approval would be sought on 24th May for CommandPoint go-live. Peter Suter made the following comments:

- The project remained on track for go live on 8th June 2011;
- User Acceptance Testing had finished on 28th February 2011 as planned;
- The full list of test problem observations ('bugs') had been set out in the report to the Trust Board. All bugs had been rated with an impact score of 1 to 10 and those with an impact score of 6 or higher would be corrected prior to go live. The report to the Trust Board on 24th May would include an assessment from the Senior Users that they were satisfied with the correction of the bugs;
- The Gateway Review had been completed. There was currently no consistency of view on the impact that implementation would have on the Trust performance. Peter Suter and Richard Webber were currently working through estimates and work was underway to mitigate any risks to performance;
- The Project Manager at Northrop Grumman had recently resigned but would be replaced. The Senior Technical Manager and other personnel had been consistent throughout the course of the project and therefore this did not represent a major risk to the project.

29.2 Carrie Armitage reported that over the last four years, the project had really come together. There had been a marked change over the last six months in the project plan and delivery and Carrie was assured that everything would be in place for 8th June. Carrie reported that a good relationship between the LAS and Northrop Grumman had been established and an exemplary approach to some of the technical delivery had been demonstrated.

29.3 Carrie stated that the Trust now needed to start engaging with the commissioners and wider stakeholders who had an interest in the Trust's performance and to manage the inevitable dip in performance. Carrie's view was that the bug list demonstrated how comprehensive the testing had been.

29.4 Carrie advised the Trust Board that on 24th May, no one would be able to give the Trust Board a hundred per cent assurance, but that the Trust Board would need to consider what 'good enough' looked like and how it would be managed.

29.5 Alan Lacombie from Northrop Grumman reinforced Carrie's comments about the good working relationship between LAS and Northrop Grumman. He had found the relationship to be open, honest and constructive. Alan reported that an independent risk review had been undertaken and nothing was captured that was not already in the project risks and issues register. This confirmed

that the LAS was well-positioned for transition on 8th June.

29.6 Brian Huckett commented that staff who had undertaken training on the new system had given very positive feedback. Refresher training was also underway.

29.7 Peter Suter confirmed that the actions and lessons learnt from the 1992 implementation had been reviewed to ensure that the same mistakes would not be repeated. Peter Suter would be recommending that there was independent assurance of this for the Trust Board.

29.8 The Chair asked how external events would be handled on the night of the transition. Peter Suter responded that the Trust Board had agreed that Martin Flaherty, Deputy Chief Executive, would be the lead person responsible for overseeing the transition, including external events and whether these could be managed.

29.9 Caron Hitchen asked how the Trust Board could be assured that the impact rating of the bugs was correct and those of a lower rating were not in fact showstoppers. John Hopson responded that the impact rating was based on patient safety, crew safety and performance to ensure that there was no adverse effect on patient care. Senior users would be asked to review bugs again before 24th May in order to give the Trust Board assurance that those bugs which required fixing before go live had indeed been fixed. Senior users would also be asked to assess the impact of those bugs which had been deemed as acceptable for go live.

29.10 Roy Griffins commented on the programme and budget control and in particular the comment in Carrie Armitage's assurance report about the ring-fenced contingency funds. Mike Dinan responded that the budget was in place but there was a commercial risk post implementation of having to maintain an off-shelf/slightly customised product within usual budget planning.

29.11 Roy Griffins also raised a concern about the possible overlap of concentration on the Foundation Trust application and the implementation of CommandPoint. Peter Bradley responded that different people were involved in both projects and therefore he was confident that this would not pose a risk.

29.12 Beryl Magrath asked what progress had been made on the reconfiguration of the Control Room to be compliant with CommandPoint. Peter Suter responded that business processes were being improved, led by Fiona Carleton. Carrie Armitage added that the timing had been good with Fiona Carleton coming in now and managing the set up, processes and software.

29.13 Caroline Silver asked what would cause Peter Suter to lose sleep. Peter Suter responded that the risks were set out in the project risks and issues register. The key issue for him was the technical release of the software and ensuring that it was operating as it should. Mike Dinan added that knowing what was 'good enough' was important as was having confidence in command and control.

29.14 Jessica Cecil asked how confident users were in operating the new system. Carrie Armitage responded that confidence would come with use of the system. Staff would initially be slower at operating the new system, but this did not represent a significant risk in Carrie's view. Richard Webber added that it would take time for staff to familiarise themselves with the new system and that this would have an impact on performance. The Trust had modelled a prediction of the impact on performance.

30. <u>2011/12 Annual Business Plan and Budget</u>

30.1 Mike Dinan had circulated the 2011/12 Annual Business Plan and Budget to the Trust Board on 24th March 2011. Mike drew attention to the income summary (appendix A1) and made the following comments:

- £284 million income overall;
- CBRN income was held flat. The lack of a service level agreement remained a concern;
- The commissioners now accept that they have the funding for HART and would pass this on to the LAS;
- Property leases remained the only issue of concern;
- Red flag issues in the audit report had been addressed;
- PTS income was down from last year due to lost contracts;
- Written assurance was currently being sought on MPET funding as this remained a risk;
- There was a risk that the LAS would not receive the level of funding for the Olympics and therefore the level of support would have to drop;
- Other income had also decreased. For example, no funding was assumed for PLATO in 11/12.

30.2 There followed a discussion about the funding for Olympics. Mike Dinan commented that the funding for the Olympics covered planning and exercises. If the level of funding was reduced then the number of exercises would also have to be reduced. Phasing into the final year was an option or reviewing the level of support. Mike Dinan reported that another funding bid had been submitted.

30.3 Mike Dinan stated that the Finance team had been prudent with regards to the expectation of the level of funding the Trust was likely to receive. £2 million was the minimum for which the planning role could be undertaken. The Chair commented that the Trust had no option but to carry this risk as for MPET. If the Trust has acted properly and prepared for what was needed, if we did not receive the level of funding expected, the Trust could only mitigate associated risks to an extent, but could not eliminate the risk entirely.

30.4 Mike Dinan drew attention to the key points of the expense summary (appendix A2):

- Pay budget had dropped by £5 million;
- Non-pay had dropped by 3%;
- Provision for CQUIN and KPIs had been made and the CIP increased accordingly;
- Deliberately ringfencing some money to deal with the first quarter issues resulting from the implementation of CommandPoint and for the infrastructure for improving patient care;
- Overall, expenditure was held flat;
- Surplus of £2.7 million planned is necessary to help manage risks that might occur during the year.

30.5 The Trust Board approved the budget for 2011/12.

31. <u>Cost Improvement Plan</u>

31.1 Mike noted the key points of the Cost Improvement Plan (appendix B):

- Planned CIP for 11/12 is £14.8 million;
- £13.3 million had been identified, removed or planned in budgets already;
- A further £1.4 million was to be confirmed once 10/11 was locked down;
- 160 posts were to be removed in 11/12;
- Projects were in place to manage the cost savings;
- Non-pay reductions had already been realised in the main, eg a reduction in audit fees.

31.2 The Chair noted that £14 million of CIP had been allocated across the executives and, as it was the Trust Board's responsibility to approve the budget, the non-executives would need assurance that the executive directors were fully committed to delivering the CIP. Peter Bradley responded that a more robust process had been put in place this year, particularly as this year the CIP affected staff numbers. Peter Bradley gave the Trust Board assurance that the executive directors were committed to delivering the agreed CIP. Caroline Silver agreed that the process improved every

year.

31.3 Eric Roberts commented that he did not feel it necessary to attend the Trust Board routinely as senior management was open with staff and union representatives and he always received Trust Board papers. However, approximately 3500 members of staff were trade union members and had a right to be heard when a major decision was being made. The LAS was experiencing a reduction in funding for the first time in years and a reduction in the number of posts after a year on year increase. Staffside was opposed to these cuts and would do all it could in and outside of the service to prevent them. Eric recognised that this was not the Trust Board's doing, but the decision about how to deal with it was the Trust Board's. Eric urged the Trust Board to think very carefully about the impact the CIP would have on staff and the service.

31.4 The Chair thanked Eric for his comments which helped to add perspective to the task the Trust Board had to undertake. Caron Hitchen added that executive management and the Trust Board had held numerous discussions in developing the CIP and recognised that the world was different.

32. Control Room

32.1 The Trust Board was asked to support the proposal for a second live Control Room at Bow. As demonstrated by the UPS fire in October 2010, the current arrangements were not sufficient for long term business continuity arrangements.

32.2 Peter Suter confirmed that the costs were not yet known but would be developed as part of the planning. The Trust Board was asked at this time for approval of the direction of travel.

32.3 The Trust Board approved the direction of travel but recognised that there was further work to be done to develop this proposal.

33. Timelines for Foundation Trust application

33.1 The Chair expressed some disappointment that the dates for the Trust's FT application had shifted once again. This was particularly difficult given the commitment made to the Secretary of State last year. The Chair was also concerned that these changes were being made without full engagement with the Trust Board. Given the commitment made at the last Trust Board meeting this was, in his view, bad practice as these changes had been made without the prior agreement of the Trust Board.

33.2 The Chair stated that the Trust Board now needed to focus on May and the Board to Board meeting, although it was recognised that the Board to Board meeting was now likely to take place in late May, rather than early May. The Trust Board supported this approach.

33.3 Caron Hitchen asked whether, if the SHA still had concerns after that meeting, they could be addressed without having to hold another Board to Board meeting. Peter Bradley responded that it would depend on the issues raised.

33.4 The Trust Board agreed that it remained committed to the process. The next step was to get confirmation from the SHA on the Board to Board meeting date.

34. Governance Rationale

34.1 Joseph Healy asked that the timescales from the opening of the nominations to the closing of the voting process be reviewed, as it was the view of the Patients' Forum that this was currently too short.

ACTION: SA to review the timescales for the voting process.

DATE OF COMPLETION: 24th May 2011

34.2 Subject to this comment, the Trust Board noted the update to the Governance Rationale.

35. Historical Due Diligence stage 2 update

35.1 Sandra Adams reported that, since the Trust Board papers were circulated, the SHA had asked that HDD2 be revisited formally by Grant Thornton. Progress had been made against the actions identified and it was anticipated that this would be reflected in the review week commencing 11th April. The draft report would then be available for the Strategy Review and Planning Committee to review on 26th April before its submission to the SHA.

36. Long Term Financial Model – downside scenario

36.1 This would be discussed in Part II of the Trust Board meeting.

37. Caldicott Guardian

37.1 The Trust Board approved the appointment of the Medical Director to the role of Caldicott Guardian.

38. Board Assurance Framework and Corporate Risk Register

38.1 Sandra Adams gave an update on key changes to the Board Assurance Framework and Corporate Risk Register. The Board Assurance Framework and Corporate Risk Register would be reviewed by the Risk, Compliance and Assurance Group at its next meeting in April.

38.2 The Chair opened a discussion about the risk and assurance process and whether this should be a subject for future discussions at a Strategy, Review and Planning Committee meeting. Caroline Silver commented that both the Audit Committee and Quality Committee had a role in the risk process. This process was currently working well and should give assurance to the Trust Board. The Trust Board Chair was welcome to attend a future Quality Committee meeting if he felt that this would provide additional assurance.

38.3 Caroline confirmed that those risks which had reached their target rating were kept under review even though they had been moved to a dormant risk register. The internal auditor also made judgements on the Trust's risk awareness and identified areas of risk through other reviews.

38.4 The Chair noted the progress made on the Board Assurance Framework and the Corporate Risk Register. This was now a living document.

39. Report from Trust Secretary

39.1 The Board noted the Report from the Trust Secretary.

39.2 Caron Hitchen reported that Occupational Health and Physiotherapy Services had since been awarded to Guys and St Thomas' NHS Foundation Trust.

40. Forward Planner

40.1 Two items had been added to the Trust Board forward planner:

- Presentation on the Category B changes;

- Presentation on the results of the Staff survey.

ACTION: SA/FG to add items to the Trust Board forward planner.

DATE OF COMPLETION: 24th May 2011

40.2 The Chair and Sandra Adams would review the forward planner for the year ahead and into 2012.

ACTION: SA and RH to review the Trust Board forward planner for the year ahead and into 2012.

DATE OF COMPLETION: 24th May 2011

41. Questions from members of the public

41.1 There were no questions from members of the public.

42. Any other business

42.1 The Chair noted that this was the last meeting for Nigel Walmsley. Nigel had made a positive contribution to the Trust Board from which others had learnt. Nigel wished the Trust Board and the LAS every good fortune.

43. Date of next meeting

43.1 The next meeting of the Trust Board is on 24th May 2011. The next meeting of the Strategy, Review and Planning meeting is on 26th April 2011.

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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 29th March 2011

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**	**Final documents to come to the Trust Board on 28th June 2011**
31/08/10	**97/10**	**Matters Arising** The Chair asked that the Trust Board be provided with an age profile of the fleet.	**MD**	**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.**
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**
03/02/11	**03.5**	**Matters Arising** MD to provide the Trust Board with a break down of agency spend.	**MD**	**Complete.**

03/02/11	**06.7**	**Update from Executive Directors** SA to revise the wording of new risk 338 and to include mitigating actions of new risks in the CEO report to the Trust Board.	**SA**	**Risk reviewed by Richard Webber on 24th March 2011.**
03/02/11	**11.3**	**Estates Strategy** MD to provide the Trust Board with operating cost implications of the Estates Strategy.	**MD**	**This would come to the Trust Board in the form of individual business cases and the refresh of the IBP.**
03/02/11	**16.2**	**Patient Experience Annual Report 2009/10** RH and SA to discuss how often the Trust Board is to receive an update on patient experience and whether to review individual complaints in detail.	**SA/RH**	**Complaints data is now included in the CEO report and a quarterly report on trend data would be provided to the Trust Board. It was proposed that a non-executive director undertake ad hoc sampling of completed complaints. Action complete.**
03/02/11	**16.3**	**Patient Experience Annual Report 2009/10** SA to consider how information from PALS would be fed into the complaints process.	**SA**	**PALS data was incorporated in the complaints report and PALS was managed by the same team. Action complete.**
03/02/11	**19.1**	**Questions from members of the public** AP to look into publicising case studies of patients who had received better clinical care as a result of being referred to an appropriate care pathway.	**AP**	**Underway**
29/03/11	**25.2**	**Report from the Quality Committee** MD to ensure that the Quality Committee was incorporated into the monitoring of the Cost Improvement Plan.	**MD**	
29/03/11	**25.5**	SA/FG to add the review of the risks around the implementation of CommandPoint to the forward planner of the Quality Committee.	**SA/FG**	**Discussed at the Quality Committee meeting on 27th April. Action complete.**

29/03/11	**25.7**	SA/FG to add CIP to the forward planner of the Quality Committee.	**SA/FG**	**Action complete.**
29/03/11	**26.2**	**Chairman's Report** FG/SA to review the wording in the risk implications section of the Trust Board front sheet.	**FG/SA**	**Action complete.**
29/03/11	**27.3**	**Update from Executive Directors** RW to provide the Trust Board with a presentation on the Category B changes.	**RW**	**Provided at the SRP meeting on 26th April. Action complete.**
29/03/11	**27.8**	CH to provide the Trust Board with a presentation on the results of the staff survey.	**CH**	**On agenda for 29th March 2011. Action complete.**
29/03/11	**27.10**	CH to send a copy of the staff survey report to Joseph Healy.	**CH**	
29/03/11	**27.16**	SL to give a presentation to the Patients Forum on blanket use.	**SL**	
29/03/11	**31.4**	**Cost Improvement Plan** SA to review the timescales for the voting process as stated in the governance rationale and constitution.	**SA**	**This has been reviewed. Election timetable is stated in the model constitution and remains at 40 days. The LAS will work with prospective governors in the run-up to the elections to ensure they are as prepared as possible for the nominations process.**
29/03/11	**40.1**	**Forward Planner** SA/FG to add items to the Trust Board forward planner. ▪ Presentation on the Category B changes; ▪ Presentation on the results of the Staff survey.	**SA/FG**	**Action complete.**
29/03/11	**40.2**	SA and RH to review the Trust Board forward planner for the year ahead and into 2012.	**SA/RH**	**To be reviewed and to take account of the 2011/12 priorities. SA and RH are meeting on 6th June.**

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

24TH MAY 2011

PAPER FOR NOTING

Document Title:	**Briefing on the recent Quality Committee meetings**
Report Author(s):	**Beryl Magrath**
Lead Director:	**Beryl Magrath**
Contact Details:	-
Why is this coming to the Trust Board?	**To inform the Trust Board of the business covered by the Quality Committee**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☒ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	**To note the scope of the discussion and the key areas highlighted below.**

Executive Summary

- Incident Reporting It is acknowledged that incidents are under-reported using the LA52. As the LA52 form is currently undergoing revision, the Quality Committee asked whether it was possible to consider how anonymous reporting could be achieved. The issue with anonymous reporting is that feedback to individual members of staff is difficult.
- There was some anxiety from Quality Committee members that an integrated report incorporating complaints, legal cases, SIs, incidents, .problematic inquests etc. was not yet available.
- CQSEC The need to align meetings, in order that feeder groups could report was noted. Medicines Management was rated amber, but was being closely monitored and was improving. A presentation was made by the Emergency Response Volunteers (who are all blue light trained professionals) with a proposal in principle to increase the drugs and equipment available to them. This was agreed subject to public consultation.
- Safeguarding The RAG rating had shown a deterioration following the visit of the Safeguarding Improvement Team. Further objectives had been added to the action plan. It was also noted that although all front-line staff had received Level 2 training, the standard of that training was unclear, but was meeting compliance regulations. Additionally, all other staff, including members of the Trust Board should receive Level 1 training; this had not yet occurred.
- Infection Prevention and Control There had been improvements in hand hygiene compliance, with regular audits raising the profile. Deep cleaning had significantly improved, as had the use of fresh blankets for each patient. Patient Transport Services are now incorporated into the infection control balanced scorecard. There was considerable discussion as to why the RAG rating remained red and when this was likely to improve. The Director of Heath Promotion and Quality indicated that the ideal for hand hygiene was 100%, but this was unlikely to ever be achieved. It was agreed that he would produce a trajectory for achieving (say) 80% by December 2011.
- Quality Risk Profile It was noted that the LAS was red RAG rated for the Information Governance Toolkit, but this should improve when the 2010/2011 figures had worked through

the system.

- CommandPoint Update Gold Command are overseeing the transition to CommandPoint and it would be their decision on the 8th of June to go live, which would ensure that the transition was clinically-focussed and operationally-led. The technical interface had been trialled at Bow and some problems were identified. The cutover had been practised; three vehicles had taken dummy calls from CommandPoint; there have been four planned exercises with each Watch and there are four more planned. The biggest risk identified was with the MPS/CAD interface (about 30% of calls received come through this link) as cooperation had not been good. The second risk was the Airwave interface, but this had improved following the table-top exercise. The third risk was the reorganisation of the Control Room-now under way.
- Audit Update The Quality Committee noted that there had been a great improvement in the audit process in the last few months. It was agreed that the CEO would be able to provide assurance to the Quality Committee if audit recommendations were not on track. The HART recommendations were still not fully implemented. A full West Team was not yet recruited as the new premises in Isleworth will not be finished until August. It is clearly important that there are two fully functioning HART Teams available for 2012 Olympics.
- Quality Account The Quality Committee was asked to approve the draft Quality Account, which had been circulated prior to the meeting as it was due to be circulated to stakeholders in the next week. It was approved subject to a number of amendments.
- Emergency Bed Service Alan Hay, the EBS Manager reported that the services provided currently include:
    - GP referral of patients into a receiving hospital. Currently 90% of patients are conveyed to an EBS suggested unit;
    - Safeguarding referrals. All EBS staff have received Level 3 training and the number of referrals made have increased exponentially. However at present there is minimal feedback from social services;
    - Capacity management system (CMS), a new system since last year. 70% updates are within 2-3 hours, which is a great improvement on their original paper based system;
    - Two new services were being trialled incident reporting (East) and a falls referral service in the West, which is to be introduced in South and East areas later in 2011.
- It was noted GP engagement events were being organised to build relationships with GPs. It is likely that the capacity of EBS to absorb the falls referral service will be too stretched & require additional resources.
- Clinical Audit and Research The Medical Director gave a presentation on the structure and current activity of CARU.

Key issues for the Trust Board
As above.

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 NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 24TH MAY 2011

PAPER FOR NOTING

Document Title:	**Chairman's report**
Report Author(s):	**Richard Hunt**
Lead Director:	**-**
Contact Details:	**-**
Why is this coming to the Trust Board?	**To provide the Trust Board with an update of key activities since the last Trust Board meeting on 29th March 2011**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Other
Recommendation for the Trust Board:	**To note the report**

Executive Summary

The Chair has attended the following meetings:

- Greater London Assembly scrutiny meeting at City Hall;
- Trust Board development sessions;
- Ambulance Service Network board meeting;
- Ambulance Chairs' meeting;
- A meeting with Professor Mike Spyer, Acting Chairman of NHS London.

The Chair has met with the following at the LAS:

- Jo Webber of the ASN;
- Sir Nigel Essenhigh of Northrop Grumman;
- Phil Thompson of UNISON.

The Chair also gave a lecture in Paris on the LAS to the Sapeurs Pompiers de Paris.

Key issues for the Trust Board

None.

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
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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
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 16 MAY 2011

PAPER FOR NOTING

Document Title:	**Chief Executive's Report**
Report Author(s):	**Senior Managers Group 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 Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Other
Recommendation for the Trust Board:	**To note the report**

Executive Summary

- Agreement on the A&E contract for 2011/12 has been reached
- A key commitment is the introduction of NHS Pathways to enable efficient use of a Directory of Service
- 3 new programmes make up the IBP Delivery Programme aligned with the Trust's 3 strategic goals
- Consideration of new Risk Register items are detailed
- CAT A performance for last year turned out at 75.14% and in April 77.7%,
- Overall growth in incidents for last year was 4.5% (Cat A 5.8%)
- Category B targets have been replaced with Quality Indicators whilst the four new category C areas allowed for restructuring of response profiles in line with the IBP
- Overtime spend for April showed a 14% reduction on last year despite double bank Holidays and the Royal wedding
- Progress continues in reducing handover to green time but average arrival to handover continues to increase
- Preparations for Command Point implementation are on track
- A New Dispatch Model has successfully been introduced into control services.
- Call taking was transferred to Bow on May 3rd following an Internal Major Incident caused by flooding at HQ
- The Royal Wedding saw the deployment of over 200 LAS staff, was impeccably planed for and there was no adverse impact on performance elsewhere in London.
- Sickness absence in the Trust fell last month- the year closed at 5.27% against a target of

4.5%

- LAS staff side have responded to the Trust's CIP & the Joint Secretaries have agreed to meet every two weeks to progress issues
- The service continues with patient involvement & public education activities - over 320 since January.
- Media coverage regarding the trust's CIP was generally balanced
- 7th July bombing inquests; the verdicts contained seven recommendations relating to work of the Service

Key issues for the Trust Board

It has been a very busy period for the LAS. Year end for the finance team, achieving 75% Category A; introducing the new clinical quality indicators to replace Category B; negotiating and signing off the 2011/2012 A&E contract; dealing with the largest public event – the Royal Wedding, in over a decade; publishing our five year cost improvement programme and dealing with the internal and external communications; dealing with the outcome and subsequent media interest over the 7/7 Coroners verdict and progressing our Foundation Trust application. The Trust Board are asked to note the activities we have been involved in over recent weeks and to note my gratitude for the excellent work colleagues have done over this particularly busy time. Next is Command Point.

Attachments

- Balanced Scorecard
- Performance data pack
- Workforce Report

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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 supports the mitigation of the following strategic risks:

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

NHS Constitution

This paper supports the following principles that guide the NHS:

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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 24 MAY 2011
CHIEF EXECUTIVE'S REPORT

1. COMMISSIONING AND BUSINESS DEVELOPMENT

Strategic Development

The contract between London Ambulance Service NHS Trust and North West London Commissioning Partnership (on behalf of the PCTs of London) has been agreed and signed for 2011/12. This contract includes 1.5% of incentives (CQUINs) to continuously improve patient care. Particular areas of focus for 2011/12 will be increasing the appropriate use of the wider London health system such as urgent care centres and referring patients to their GPs where clinically appropriate. In addition we are focusing on ensuring patients at the end of their lives receive care in accordance with their care plan wherever possible and improving the care we provide for patients with mental health conditions. The ambition is to provide the highest standards of patient care whilst ensuring the most appropriate use of the health care services in London. Staff will be supported and trained to enable them to make appropriate clinical decisions. During April final project plans and timelines have been created to ensure that progress toward the delivery of all our contract targets can be appropriately tracked. In addition meetings have been held with staff and management teams to identify potential barriers to delivery and mitigating actions.

A key commitment for LAS over the coming year is the introduction of NHS Pathways within LAS. This will enable LAS to efficiently use the Directory of Services and enable patients who present with appropriate conditions to be referred to community or primary care services. In addition it will enable us to work with 111 providers in London to ensure that patients who require an ambulance will receive one without delay. Finally we have submitted a tender to Connecting for Health to be a licensed NHS Pathways trainer, building on the excellent training services we provide in house for our control centres. The outcome of this will not be known until the end of June 2011.

2. SERVICE IMPROVEMENT PROGRAMME

The SIP programmes (Clinical Development and Performance and Service Delivery) have now closed (see closure report elsewhere on the agenda) and the three new programmes which make up the new overall IBP Delivery Programme are being developed in line with the IBP and SMART targets. These new programmes are aligned to the three Strategic Goals of the Trust:

- Patient Care Programme- SRO Steve Lennox
- Workforce and OD Programme – SRO Caron Hitchen
- Value for Money (VfM) Programme – SRO Mike Dinan

Although CIP projects are overseen from the VfM Programme the projects are delivered across the three programmes as besides contributing to cost base reduction they also contribute to achievement of other non-CIP SMART targets alined to all three of the goals. Future progress reporting will be undertaken using

Performance Accelerator and through the CEO report to Trust Board. The position regarding development of the new programmes is as follows:

- CIP projects have been prioritised with an initial focus on validating the savings.
- Programme boards are set up for the end of May beginning of June
- Performance Accelerator is being developed and loaded with projects, these will be reported from June using this platform

3. NEW 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 Risk Register and the Board Assurance Framework. The Risk Compliance and Assurance Group will be considering the addition of the following risks to the Corporate Risk Register at its meeting on 16th May 2011:

Risk Description	Risk Grading/ Score	Risk Impact + Risk Likelihood
There is a risk of staff not recognising safeguarding indicators and therefore failing to make a timely referral.	**High 16**	[Major (4) + Likely (4)]
Unable to assure that the current taxi contract accommodates the guidelines for regulated activity (safeguarding).	**High 15**	[Moderate (3) + Almost Certain (5)]
The Trust currently receives a sum of £7.7m non recurring funding to maintain a CBRN (Decontamination) Response. There is a risk that the funding may not continue. The funding is used to fund 143 WTE and the hours required for annual CBRN training.	**Significant 10**	[Catastrophic (5) + Unlikely (2)]
The Trust is committed to having 2 full strength HART's by April 2010. Due to recruitment difficulties, there is a risk that the West Team may not be at full strength by that date.	**Significant 8**	[Major (4) + Unlikely (2)]
There is a risk that the working processes in the dispatch or call taking functions of the Emergency Operations Centre (EOC) do not align with those required by Command Point, causing a delay to the date of Go Live, causing a cost and time overrun.	**High 20**	[Catastrophic (5) + Likely (4)]
There is a risk that patients may not receive the	**Significant**	[Major (4) +

Risk Description	Risk Grading/ Score	Risk Impact + Risk Likelihood
treatment/care they require due to poor awareness of the Clinical Coordination Desk amongst crews and lack of adherence to the new system.	**12**	Possible (3)]
There is a risk that the Clinical Coordination Desk may not be able to coordinate demand across London's specialist centres due to lack of information provided by neighbouring ambulance trusts when bringing patients to London Centres.	**Significant 9**	[Moderate (3) + Possible (3)]
There is a risk that the Clinical Coordination Desk will not be able to operate effectively due to a lack of suitably trained staff in EOC where existing trained staff have been re-deployed to other projects.	**Significant 9**	[Moderate (3) + Possible (3)]

4. BALANCED SCORECARD

This financial year end report provides the status of the performance indicators supporting the Trust's 2010-11 Corporate Objectives (CO).
The Trust met or exceeded all CO1 and CO2 targets focussed on improving outcomes for patients who are critically ill or injured and in providing more appropriate care for less seriously ill patients. The Trust also met Cat A (8 minute) and Cat A (19 min) call answering and activation targets. Corporate Objectives for Cat A, implementing trauma and stroke strategies and to refer more patients to appropriate alternative pathways were thus achieved.

However, the focus on achieving targets for Cat A calls has impacted the Trust's ability to achieve Cat B (19 min) target of 90% (CO3). Targets to limit the percentage of vehicles mobilised from station were achieved and also the ORH overall recommended times for mobilisation of <208 seconds for ambulances, and <134 seconds for FRUs were achieved. From a promising start in the first three months of the year, job cycle times were not met for the last five months of the year. During the past financial year the Trust recorded REAP level 1 for 12 weeks and level 2 for 13 weeks giving a total of 25 weeks or 48.1% over the year. Staffing hours targets were consistently met and showing an upward trend for All, FRU and UC categories, but targets for the AEU category were not achieved for five of the six months for which data was provided. REAP levels are cited as a constraint to achieving staff workplace performance reviews, with 8% operational staff having bi-annual reviews versus a target of 80%.

The target of 2 complexes adopting NWoW by Feb-11 was achieved and wave 2 is currently live across 5 complexes (CO5). Work continues to introduce NWoW through project and business change activity, although REAP/winter pressures and performance recovery focus have impacted on local delivery, and are continually monitored at sector project boards and by the NWoW workstream board. The target

of 14 NWoW complexes with a full establishment of clinical tutors was achieved within the first three months. Staff training targets were met, as were CPI completion and compliance targets.

The CommandPoint (CO8) project remains on target for go live 08 June 2011, with the project being externally assured as 'Green-Amber'. As of 01-Apr-11, all critical milestones are delivered or on track to be delivered on time.
SMG are reviewing the 2011-12 Performance Indicators supporting the Integrated Business Plan. New indicators being considered are: Clinical Quality Indicators (CQI) to measure patient treatment and outcomes (CO1), drilling down into STEMI, ROSC and introducing survival to discharge (Utstein) targets; new CAT A and CAT C response and CTA assessment targets (CO3); the implementation of the Equality & Inclusion plan (CO6); PTS profitability (CO8); measures to ensure no decrease in service during major events and incidents (CO9). Also being considered by SMG are targets to measure and ultimately improve Londoners' perceptions of the service (C10).

5. SERVICE DELIVERY

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

Performance Overview (Graphs 1, 2, 3, 7, 8 & 13)

The table below sets out the A&E performance against the key standards for the last financial year (2010/11) and the first 6 weeks of this year. The performance for last year and April are validated and for the first 12 days of May are an estimate.

	Cat A8	**Cat A19**	**Cat B19**	**Cat C60**
Key Standard	**75%**	**95%**	**95%**	**90%**
Mar-11	79.6%	99.6%	79.5%	88.3%
2010-11 Year End figures	75.14%	99.1%	87.4%	89.5%
Apr-11	77.7%	99.3%		
*May (to 12th)	77.2%	99.4%		

**** Estimated prior to data validation***

I am pleased to report that the Trust performed very well for Category A performance for the month of March 2011; ending on 79.6% and meaning the trust achieved above the National key standard ending the year on 75.14%. Category A & B incident demand for the month of March continued to increase above the Trust forecast and expectations with a growth of 7.5% for Category A and 8.1% for Category B. Total incidents growth for 2010/11 by category of call finished higher than the Trust forecast. The Trust saw an overall growth in all three Incident categories with a cumulative growth of 4.5%, the largest growth being Category A 5.8% followed by Category B 5.3% and Category C 1.2%.

The Trust has previously agreed a trajectory for performance this year with the Commissioners. In order to mitigate the forecast dip in performance associated with the

implementation of a new control system, we had intended to over perform for the first 2 months of the year by delivering 79.5 against Category A. It is thus disappointing to note that whilst we are at 77.6% for the year so far, and so above the national standard, we have not delivered in line with the agreed trajectory.

As from the 1st April 2011 the Category B national target was removed and Clinical Quality Indicators implemented to ensure a more appropriate focus on clinical outcomes as opposed to time based targets. There are also locally agreed time based responses that are agreed with Commissioners and the Trust has had to restructure its response profiles. Category A remains unchanged, but the Trust has had to plan for the introduction of four new categories of calls known as C1, C2, C3 and C4. The new Categories allow for greater utilisation of Hear and Treat as opposed to sending a vehicle to calls received; which is in line with the Trusts IBP and CIP. The LAS formally implemented the changes at 0300 on the 19th April so this will be a part month in terms of the benefits achieved. The number of calls resolved by NHSD has remained the same but there has been an improvement in calls resolved by CTA from c30 per day to up to 50 per day. Work is underway to better understand what can be achieved and then produce an improvement trajectory so that we can track the delivery of the optimum number of calls that can be resolved by telephone advice.

Category A remains a nationally agreed key standard of responding to 75% of potentially life-threatening calls within eight minutes. It is estimated that the total incident responses, measured as Category Red 1 and Red 2, will now be slightly increased to 37.5% of the total incident workload as a result of now appropriately grading calls received from the Police via the Cadlink.

The new locally agreed responses C1, C2, C3 & C4 have a different response profile according to the patients described condition, which will become far more effectively implemented when the Response Profiles go live in Command Point. In preparation for this we have individually programmed specific response profiles for all 1,885 call determinants.

Call Answering (Graph 5 & 6)

The percentage of calls answered within 5 seconds for 2010/11 ended on 94.62%; just short of the 95% target. It is important to note that this is an improvement in comparison to 2009/10 which ended at 94.43%, whilst answering an additional c7,670 calls in 2010/11. The percentage of calls answered within 5 seconds for April 2011 ended at 94.1% and we anticipate achieving this more consistently once Command Point has been implemented.

Rest Breaks (Graph 12)

The number of rest breaks allocated in April 2011 finished at 33% a marginal growth of 2% against March 2011. Rest breaks remain a key area of focus and we are disappointed to see no significant improvement in the percentage allocated. The Trust introduced a break plan to spread the allocation of breaks across the day, reducing the end of shift losses with the outcome of better performance at shift changeover. Although the rest break initiative is still in its infancy the Trust has seen some encouraging signs. The Operational Partnership Forum has continued to try to amend the existing policy to aid break allocation, however this is being met by some resistance and so the matter has been escalated within the agreed consultative framework.

Call Taking Resolution (Graph 31)

On the 11th April 2011 the Trust went live with the NHSD link which allows us to refer calls to them via a web link. Expectations are that the new system, which ends the current practice of telephone handover, will be more effective and quicker which will free capacity and allow

greater availability of our clinically trained staff to process more calls. Although we will not see an increase in numbers passed to NHSD, as the agreed call groups have not changed, the process has become more streamlined. The month of April saw the Trust pass a total of 5,047 calls to NHSD of which 2,067 or 41% were passed via the new NHSD transfer link. NHSD resolved over 4000 calls.

In addition the LAS Call Telephone Advisors saved over 1,000 dispatches by telephone resolution. The number of calls resolved as a result of DMP implementation was about 200. As a consequence the total number of calls resolved by telephone advice for the month was just under 5,500.

Resourcing (Graphs 14, 15, 16, 17 & 18)

The Trust produced 122,904 ambulance hours resourcing for April this year which was 4,002 hours less than for the same period last year; a 3.15% reduction. FRU hours produced for April increased by 17% to 58,025 hours compared to 49,523 hours for the same period last year. Appetite for covering FRUs seems to have started to improve as we draw nearer to summer and we anticipate a further improvement in the second quarter as new Paramedics graduate in greater numbers from Hannibal House. The Trust produced 23,876 ambulance hours for Urgent Care vehicles in April this year, exceeding the hours produced last year by 3,005.

Actual planned overtime spend for April was 26,557hours. This is a decrease of 14% compared to the same period last year when we spent circa 31K hours on planned overtime. This has been a considerable achievement taking into account our strategic intent not to offer any more overtime incentive scheme, balanced against a double bank holiday including the Royal Wedding.

Hospital Handover/Turnaround (Graphs 22, 23 & 24)

The Trust continues to work relentlessly to reduce both the average patient handover to green and average hospital turnaround times in order to increase the resources available to respond to calls. I am glad to report that both of these targets have seen a further reduction. On the 16th April 2010 the Trust average patient handover to green time was 19.3 minutes and for the weekending 1st May 2011 the Trust achieved 15.6 minutes, the lowest time we have seen since the increased focus on this area, with 9 Complexes below the 15 minutes target- 6 of which are in the West.

On the weekending the 9th May 2010 the average hospital turnaround time was reported at 32.4 minutes, week ending the 8th May 2011 the Trust reported 31.9 a marginal improvement. However this remains above the target recommended previously of 28 minutes.

It is disappointing to report that the average arrival to patient handover continues to increase. From weekending the 02nd May 2010 the Trust has seen a cumulative increase from 13.6 minutes to 16.0 minutes for weekending 1st May 2011- an increase of 2.4 minutes. The increase in average arrival to patient handover is getting further from the 12 minutes target, which is inhibiting the achievement of the necessary frontline efficiencies.

Control Services (Graph 6, 47, 48, 49, 50 & 51)

The Department of Education & Development within Control Services continues to carry out a structured Training regime for the Trust's new CAD system Commandpoint with training undertaken at Southwark Bridge Road. The scheduled courses for established staff range from a 3 day comprehensive course to a 1 day bridging course tailored specifically for

support staff working within EOC. All staff have undertaken either a Call Taking or Dispatch course with 23% of staff being dual trained in both areas; with the remainder to be trained post Go-Live. On completion of their course staff undertake a maintenance training programme and are allocated 20 minutes every shift they work in a simulated environment based in the former UOC and are supported by a Work Based Trainer.

When Commandpoint goes live all staff will be supported by a nominated Training lead and a team of 7 Work Based Trainers per Watch for a duration of between 5 to 10 weeks within EOC.

On May 4th at 07:00, Control Services launched its New Dispatch Model (NDM). This model sees Control Services adopt new operating processes for its dispatch function. Whilst the configuration of Commandpoint acted as catalyst for this change, Control Services have used it to introduce increased efficiencies, remove competing demands from allocators and to improve the delivery of key CIP initiatives such as rest break allocation and management of VOR (Vehicle Off Road).

The NDM moves EOC away from the concept of specialist desks such as the FRU desk and instead has one member of staff allocating all resources available within one complex whether they be solo responders (CRUs, MRUs, CFRs or FRUs) or Ambulances- A&E and UCS. The task of resource allocation sits across a larger number of EOC staff with each allocator having an equitable and manageable number of resources, so as to optimise deployment decisions. The NDM also aligns itself more readily to the Clinical Response Model and it is an expected consequence of NDM that there will be a reduction in double sends. It appears as though the increase in talkgroups has also beneficially led to a reduction in the reported waits for crews to a response from control.

There has also been a Dispatch and Distribution Support desk (DDS) set up which amalgamates several key Control functions that were previously discharged from disparate parts of the Control Room. Previously, those staff allocating resources also had responsibility for the deployment of these vehicles onto Active Area Cover alongside dealing with VOR and finally break allocation- ancillary (yet critical) tasks which are completely at odds with the primary function of allocating jobs as quickly as possible (a significant factor in the low level of breaks currently secured). All of these functions have now transferred to the DDS whose increased focus and active management of VOR, AAC and Breaks should deliver improved performance across all 3 metrics. In addition, those allocating are only ever presented with available resources and are not asked to juggle the competing needs of break allocation, VOR and AAC. DDS also track hospital delays and focuses on crew turnarounds as well as logging all hospital breaches.

The new arrangements should also provide greater opportunities for proper oversight and accountability against various key metrics and allow for Individual performance Management to be effectively implemented into dispatch.

In the first week of operation, comparative data shows that performance has not dipped at all. With a performance cell in situ 24/7 for the first 10 days, we are dynamically capturing all breaches and categorising them, so that trends are identified and recommendations for continuous improvement made.

On Tuesday 3rd May (the main day back to work following the second of 2 successive bank holidays), there was a flood in the call taking area of EOC caused from a burst radiator in an office directly above. This meant that 2 of the 3 call taking “clusters” had to be evacuated and the staff transported rapidly to the Fall Back Control Room at Bow. Meanwhile, a group of call takers continued to operate from the central bank of desks, meaning that call response was maintained without interruption throughout the incident. Given the severity of

the situation and the potential impact of it, an internal major incident was declared just after 0620 hours. The Call taking staff from the day Watch (D) were all taken across to Bow and the call taking operation was run from Bow for the entire day shift. Some call taking staff were returned to HQ at around 1430 hours and a two site operation for call taking was in place until the night Watch took over at 1900hrs.

The morning transition from HQ to Bow was seamless in terms of call handling performance being maintained. A return to normality was achieved with all night staff reporting to Waterloo and all call taking activity returning to HQ. That said, it was without question a difficult environment for both managers and staff to endeavour to sustain a level of service to patients during a time of flooding – and supports further the benefits of operating from 2 live control rooms.

Fleet & Logistics (Graph 52 & 53)

Analysis of the reasons why so many Airwave radio handsets were being reported lost or misplaced shows that the problem was due to a number of causes. These included a lack of personal accountability, effective tracking, reporting and continuity in an environment of fluid movement with respect both staff and fleet. It was evident that the problems associated with this also related to a number of other key items of equipment and the approach taken was to address them collectively. There has been a review of the Airwave policy, design of a continuity and tracking process, the vehicle Daily Movement sheet (LA1), signing out of drugs, Paediatric equipment and specialist drug administration (EZIO) kits being revised as well as s need to capture information more appropriate to today's operating environment.

A vehicle pack has now been designed and produced which contains the fuel card, map book, statutory check sheet, essential paperwork, MOT, insurance, accident reporting, Airwave handsets and Diagnostic packs. The keys are attached to the outside of the pack and it requires signing in and out by anyone who moves a vehicle and there is a unique number tag sealed when not in use, or when access to the contents is not necessary. All information is recorded on the revised LA1 which has an audit process now built in for the administration and management teams. The removal of keys from vehicles is to focus on reducing the risk of misappropriation of our vehicles from LAS premises. A pilot will run for the month of June in the West area led by PIM Kevin Brown and will be supported by activity from the airwave team, fleet, logistics, staff side and health and safety representative and managers who will address the challenge together

There has been a review of the day to day fleet planning process and changes made to give the VRC visibility up to seven days ahead. The benefit will be to become more efficient in our movement of the flexible fleet portion of the AEU fleet, which will go live during May. We have been operating with AEUs individually assigned to station for some time now and we have commenced a review to check that vehicles are still deployed in the optimum way. This may result in some reassignment of vehicles and a great proportion of the fleet assigned to station.

Fourteen of the twenty four ex UVM Ambulances have now been delivered to the LAS and nine of the fifteen Volvo response cars have now been fully commissioned and are operational.

A personal fuel card trial has been ongoing for a month now and, apart from some minor teething issues with PIN numbers, everything appears to be running well. There are no exceptions being highlighted on BP transactions. The next step is to check transactions against receipts, to check that individuals and stations are following procedures correctly.

In terms of Make Ready, the tender documentation inviting the short-listed applicants "to participate" has been issued. The tender had continued to be delayed due to additional requirements requested by Procurement and further involvement by Capsticks (purchasing law consultants). It is estimated that a contract award will now not take place until December 2011 or January 2012.

Tighter management of the existing contract has continued to see improvements in deep cleaning. The addition of a resource attached to the VRC (paid for by the contractor LSS) has allowed for the momentum to remain with most evenings seeing more than the target number of vehicles being cleaned. This has proven a valuable lesson to be taken forward into the next contract. Increased auditing has been carried out by the Infection Prevention and Control Team which has backed up the good work being carried out.

Emergency Preparedness

In terms of Emergency Preparedness, Operational commander courses continue to take place and to date 48 staff have been trained from the DSO and Training Officer group. Four one day conferences are planned for later this month and early next month to bring local managers up to speed on the current and emerging threats. The LAS with also host a lessons learned seminar in early June for the National Ambulance Service Trusts.

The London Marathon took place on the 17th April, with over 30,000 runners taking part and 120 LAS operational and control staff and Manager deployed. Casualty numbers were lower than previous years. The planned Mayday demonstrations at the beginning of 2nd May passed without issue and minimal deployments were made based upon the intelligence picture received from the Met Police

Now that the coroner has delivered her verdict for the inquests for 7th July 2005 bombings, work is now underway to finalise the Major Incident Plan for publication.

Royal Wedding

On Friday 29th April HRH Prince William married Catherine Middleton at Westminster Abbey. The event ceremony took place at 11am and followed a car processions along the ceremonial route involving all of the senior Royals. Following the service a state coach procession took place from Westminster Abbey to Buckingham Palace. The route was lined by member of the three military services and saw one million members of the public gather in central London to watch the events. This was the largest public event in the UK within the last decade and saw over 200 LAS staff deployed across the period of the event who were joined by nearly 1k volunteers for St John Ambulance and the British Red Cross. A balcony appearance at Buckingham Palace of the newly weds along with the Royal family together with a military fly past drew the events to a close. In addition, special events and attractions were also staged in Hyde Park (for 200k), St James's Park and at Trafalgar Square. St John Ambulance, British Red Cross and LAS worked in partnership in the delivery of a joined up pre-hospital health provision for this event. A little under 450 casualties were treated across the entire event area with in excess of 35 of these being conveyed to central London hospitals. As a result of the impeccable planning that had taken place we not only effectively covered the event but ensured that the provision to the rest of London was not adversely impacted and in fact delivered higher levels of performance pan London than usual.

The lessons learnt going forward are that:

- A briefing officer is required for events where multiple on the day briefings are required to take place as it is not practical for Silver to undertake them all due to other event pressures.
- We need to limit the number of resources on any command channel to no more than 25 to 30.
- We need to ensure the availability of accurate information regarding 'branded' events is available (such as street events in this case) so that appropriate responses can be considered where services may be impacted by the event.

6. PATIENT TRANSPORT SERVICE

Commercial

Following resubmissions of bids under LPP Phase 3 we are waiting to hear further of the following outstanding bids:

- Epsom & St Helier University Hospitals NHS Trust
- Richmond and Twickenham PCT
- Sutton and Merton PCT
- Croydon PCT
- Wandsworth Teaching PCT (currently held by LAS)
- Chelsea & Westminster Hospital NHS Foundation Trust
- Guy's and St Thomas' NHS Foundation Trust (High Dependency Transfers only)
- Royal Free Hampstead NHS Trust
- Royal Marsden NHS Foundation Trust
- Whittington Hospital NHS Foundation Trust

Following our resubmissions the LPP has now announced the award of one of the contracts in which the LAS was unsuccessful. This was:

St Georges Healthcare – Awarded to Group 4 (Current Provider) LAS 3rd

We have received detailed feedback on our bid and clarification on points raised in the feedback. This was very close with only three points between the winning bidder and the LAS. The LAS bid was more expensive.

We have been requested to present to Guy's and St Thomas' NHS Foundation Trust (High Dependency Transfers only) on the 19th May 2011 having made their shortlist for presentations.

Outside of the LPP we have submitted a bid to provide PTS to Queen Mary Roehampton Hospital on behalf of their PFI Provider Sodexo. We have been successful and selected as their preferred bidder. Transfer to LAS would take place at the end of July 2011 and the current provider M&L staff (12) would TUPE into the LAS at that time.

Operations

- Rotas

.We have now started the process of reviewing and implementing new rotas for PTS staff working in East London. 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. PTS staff in West London are all now working on new 5 day rotas.

- Vehicles

A total of 46 2002 Movanos and LDV vehicles have now been decommissioned and returned to the leasing company as planned, following the loss of the South London Healthcare contract. This will leave a final batch of 16 vehicles to be decommissioned and returned in May 2011. (With the award of the Sodexo contract we will retain 7 of these in the short term to allow for delivery of new replacement vehicles). In April, 10 new Zafira Cars were commissioned and brought into service replacing 10 x "03" plate vehicles.
PTS will then have a fleet of 129 vehicles.

- Communications

During March and April our Work Based Trainer has been delivering two modules of training to all road staff on Stroke and Bariatric Vehicle and Equipment training.

- Performance

Activity in April fell to 13,062 patient journeys as a result of the Bank Holiday weekends with only 18 working days in the month, from the previous month high of 16,589 patient journeys in March. February's activity had been 14,493 patient journeys.

The quality standards for April 2011 were:

- Arrival Time: 91%
- Departure Time: 93%
- Time on Vehicle: 96%

7. HUMAN RESOURCES

Workforce information

Sickness absence

Sickness absence reported in March has decreased for the Trust overall to 5.09% for the month. This closes the year at 5.27% against the target of 4.5%.

A&E operational Areas overall achieved a sickness absence level of 4.97% for the month of March, down from a high of 6.52% in December and the lowest level in the year.

The spike of 11.86% in PTS in February has begun to decrease (10.78% in March). The short term absence which shot up in February has now returned to more normal

levels appears to have been linked to Colds/Flu and outbreaks of Norovirus and D&V on a number of sites. Once this trend had been identified further Infection Control advice was issued to all PTS staff advising of dangers and requirements of good Infection Control. There ahs also been an increase in long term absence which is being appropriately managed using existing Trust policy.

The national benchmarking report for sickness absence across all Ambulance Trusts is not yet available beyond December 2010.

Vacancies and Turnover

With budgets being finalised for 2011/12 for the Trust and associated establishments agreed, ESR establishment will need to be reconciled to reflect this.

From weekly operational staff in post figures, it can however be reported that as at 2.5.11, frontline staffing was 3280 wte against a revised establishment of 3301 (vacancy level of 21wte). The Trust anticipates the recruitment of c60 newly qualified paramedic from the annual university outturn in the autumn.

EOC (call taking and dispatch) remains 20wte above establishment prior to implementation of CommandPoint.

Turnover in April is relatively low at 19 compared to a monthly average of 29 in 2010/11. Average numbers for last year were however somewhat inflated by student paramedic attrition. The turnover trend will be monitored to assess any impact on CIP assumptions.

Employee Relations

Employee relations activity appears to have stabilised in April with no major shift in level of activity in any of the areas.

PDR completion

Electronic recording of PDR completion commenced in April. It will no doubt take time for managers to become familiar with the new recording system and regular (monthly) reminders will be sent to managers in this respect to ensure accurate, live PDR reporting.

Health Safety and Risk – incident reporting

As part of the over-arching review of incident reporting, a pilot has been running in East Central Sector. Instead of completing a paper form in triplicate, staff use Airwave telephony to report adverse incidents to staff in the Emergency Bed Service, who take and clarify the required details. At the Complex which has particularly been the focus for this initiative, most incidents have been reported on the day they have occurred and there has also been an increase in the level of reporting. The pilot is to be extended to adjacent complexes and also formally evaluated in the coming weeks to assess benefits and feasibility of implementing a programme to introduce a similar system Trust wide, subject to resource and cost implications against benefits.

Training and Education

The main area of activity in April has been focussed on the significant numbers of Student Paramedics now receiving the Paramedic element of their training. Training commitments fro 2011/12 will be agreed by June 2011.

Work continues on finalising the options for future Higher Education level Paramedic training supporting all access routes (Direct entry, A&E Support advancement, Emergency Medical Technician conversion and upgrading IHCD paramedic qualification to diploma). Options are scheduled to be presented to the Senior Management Group in June 2011.

Workforce transformation

All key workstreams supporting the Trust's workforce transformation agenda are currently being reviewed and consolidated under one programme to ensure all relevant interdependencies are managed appropriately. This includes New Ways of Working, Clinical Response Model and Clinical Career Structure together with supporting projects to deliver the A&E management restructure and the Estates Strategy. The Trust is still on track to introduce the Clinical Response Model in September 2011.

Partnership working

The LAS staff side have responded to the Trust's Cost Improvement programme as follows:

"…….All the Trade Unions within the Staff Council are very concerned about the contents within the CIP and of the implications for the Service and our members.

We are all together in strongly condemning the level of cuts being forced upon our Service, both financial, and human.

We believe that this will take our Service backwards and start to destroy the good work that, collectively, we have all done in the last decade.

We would hope to see that our concerns and views are taken on board and that the Trust Board reconsider the severity of the post reductions being planned….."

We will continue to work with staff side in implementing the CIP and considering any potential alternative areas for cost savings which may be identified.

The Joint Secretaries have agreed to meet every two weeks to provide a regular opportunity for discussion about progress and any issues arising. This will also be a standing item on the Staff Council and the frequency of these meetings is also to be reviewed.

The Terms and Conditions Sub-group of the Staff Council has been established, This is a sub-committee of the Staff Council and will consult upon HR policy and procedures; local application of DH or NHS policies, and changes required by legislative change.

Wellbeing

As previously reported, Guy's and St Thomas' Foundation Trust is now formally contracted to provide occupational health services and early feedback on service provision has been very positive. The new physiotherapy service, also with Guy's, begins on 1 June.

Staff Engagement

A pilot Team Briefing system has been launched. Initially in Human Resources and Finance Directorates, this is now to be extended to Fleet and Logistics from May 2011. The pilot will be reviewed and evaluated before further roll out across the Trust.

8. COMPLAINTS, PALS ENQUIRIES AND SERIOUS INCIDENTS

PALS by Subject (primary) and Received	Number	Category
Information/Enquiries	160	PALS
Lost Property	40	PALS
Clinical	6	PALS
Appreciation	5	PALS
Delay	4	PALS
Policy/ Procedure	4	PALS
Communication	3	PALS
Non-physical abuse	3	PALS
Conveyance	2	PALS
Explanation of Events	2	PALS
Other	2	PALS
Dignity and Privacy	1	PALS
Non-conveyance	1	PALS
Road Traffic Collision/RTC	1	PALS
Totals:	234	

Category of enquiry	**January**	**February**	**March**	**April**
PALS	**303**	**344**	**487**	**278**
Incident reports	**5**	**22**	**9**	**2**
Solicitor requests	**78**	**76**	**90**	**54**
Safeguarding	**48**	**44**	**56**	**44**
Serious Incidents	**9**	**6**	**4**	**7**
Frequent Callers	**12**	**11**	**22**	**16**
Totals	**455**	**503**	**668**	**401**

Trend analysis: The rise in calls in March was due to PALS staff recording the PTS incident line enquiries. There were only 16 working days in April, which has resulted in fewer enquiries to the duty line and less lost property enquiries.

Complaints by subject	January	February	March	April
Treatment	17	8	9	6
Delay	15	13	7	5
Non-conveyance	12	4	6	3
Road handling	5	5	4	3
Non-physical abuse	3	10	5	3
Aggravating Factors	1	0	0	0
Conveyance	1	3	1	1
Not our service	1	0	1	2
Patient Injury or Damage to Property	1	0	0	0
Clinical Incident	0	1	0	0
Totals:	**56**	**44**	**33**	**23**

9. COMMUNICATIONS AND ENGAGEMENT

PPI and Public Education activity report

Service Experience:

- The Head of PPI & Public Education has been working with the Director of Quality & Health Promotion and others to ensure that the Service is able to provide a quarterly report and evidence for the new "service experience" quality indicator.

- The Category C group is in the final stages of developing a new paper, for submission to the Quality Committee. This brings the issues affecting Category C patients up to date, and makes recommendations for improving the care provided to this group of people.

- The Head of PPI & Public Education is working with colleagues to ensure that patient experience is captured in a variety of service developments, e.g. appropriate care pathways and the clinical response model.

Public Education:

- An eight-day Public Education Staff Development Programme is being run during May, with 11 participants. The programme provides participants with opportunities to improve their skills and knowledge, in order to make the most of their involvement in public education activities.

- John Wright has been seconded from the Patient Experiences Team to focus on developing the Trust's involvement in knife crime initiatives across London. He has been running regular hard-hitting sessions with youth offending teams, pupil referral units and schools / colleges, talking about the consequences of carrying knives.

- Following focus group discussions with people with learning disabilities, the Service has produced a booklet in easy-read text, explaining what people should do when they are ill, what services are available, and what to expect if they call 999.

- As the Public Education Strategy has now mostly been completed, it has been agreed that the Head of PPI & Public Education will work with the Director of Quality & Health Promotion to produce a new joint strategy or action plan covering both health promotion and public education.

New Ways of Working:

Four Community Involvement Officers have been appointed for the latest New Ways of Working complexes, and are settling into their roles. The Head of PPI & Public Education continues to run monthly network meetings for them, so that they can come together regularly and share their experiences and ideas.

Community Events:

The first of a series of community events in the Trust's Foundation Trust constituencies was held in Enfield on 19th March. Approximately 150 people attended and it was thought to have gone very well. A smaller event was held in Bexley in March, with a larger one planned for the summer.

Other PPI and public education activities:

Over 320 patient involvement and public education activities have been recorded on the database since January. For the period since the last report, these have included:

- School visits (all ages)
- Learning disabilities events and visits
- Knife crime events for youth offending teams, pupil referral units and other groups
- Basic life support training, including AED familiarisation and Heartstart courses
- Seminar for FT members on cardiac care
- Consultation meetings with Age Concern, MENCAP and other voluntary sector organisations about quality indicators
- The opening of a new sheltered housing scheme for older people
- Visits to care homes and talks to groups of older people, e.g. a retirement talk, Kensington & Chelsea over 50s group
- Junior Citizen Schemes
- Hosting a visit for a group of Norwegian students
- Careers events
- Public Services Days and Business Forums
- Brownies, guides, cubs and scouts visits
- Talks and displays at community events, e.g. Sunali Gardens, Stratford Spring Festival, Enfield Community Event
- Talks to groups of first aiders, e.g. about appropriate care pathways
- Health workshops and events, e.g. an event focusing on diabetes and stroke
- Talks and mock interviews for young people via the Prince's Trust
- Workshops for people in the Tamil and Polish communities
- Displays at shopping centres
- Safer Citizen scheme for deaf and hearing-impaired children

Reputation and issues management

Cost improvement plan: The Service announced its five-year cost improvement plan in early April to make savings of £53m. Staff were briefed face-to-face at conferences and by

their line managers, with supporting messages shared through bulletins and other internal communication channels.

I gave an exclusive interview to the Evening Standard about the plans, and a news release was then issued to local, regional and national broadcast and print media. I gave further interviews to BBC London TV, BBC London radio, LBC radio, London Tonight and the Health Service Journal.

The announcement received the following coverage:

- A neutral announcement on Sky News, BBC news, ITN News and Channel 4 News.
- Regional and national radio coverage on nine stations including BBC Radio 4 and 5.
- Six national newspapers featured the story with the Guardian putting it on the front page.
- Regional media coverage in the Herald, Leicester Mercury and City AM as well as the Evening Standard
- The story was carried on 14 websites including national and local newspaper sites as well as trade union sites.
- Fifteen local newspapers carried the story with follow-up coverage the following week and letters from readers.

Coverage continues to trickle in as references are made to the savings in wider NHS stories. The Service has also received parliamentary questions and letters from MPs.

On the whole coverage was balanced and included the Service's key messages as well as negative comments from union representatives. Media organisations that interviewed me included more key messages and stories were more favourable.

Circulation and viewing figures showed that the story attracted the following approximate audience / readers:

National and regional print	7,000,000
Local print media	380,000
Regional TV	1,250,000
BBC national news	4,000,000
ITV national news	4,000,000

7 July bombings inquests verdicts: Lady Justice Hallett delivered her verdicts on 6 May at the end of six-months of proceedings at the Royal Courts of Justice. In her ruling, she said that the 52 victims of the 2005 London bombings could not have been saved whatever time the emergency services had arrived.

She praised the work of staff who dealt with the incidents, but she also highlighted some of the issues with the emergency response of the Service and other agencies involved and made nine recommendations intended to prevent loss of life in the future.

Seven of the recommendations relate to the work of the Service:

- The London Resilience Team - which was set up after the 9/11 attacks in the US to plan for emergencies in the capital - should review inter-agency training of frontline staff for dealing with major incidents, particularly with reference to the Underground
- The way that Transport for London is alerted to major incidents declared by the emergency services on the Tube, and how it informs other agencies about emergencies on the network, should be reviewed

- Transport for London and the London Resilience Team should examine how a common rendezvous point for the emergency services is established at the scene of a major incident
- There should be a review of how the emergency services confirm that the power to Tube tracks has been turned off and it is safe to go on to them
- Transport for London should consider whether first aid kits can be carried on Tube trains, and whether the stretchers stored at Tube stations are suitable
- The Service and the London Air Ambulance should review training of staff in dealing with large numbers of casualties, in particular to make clear that the process of triage does not exclude giving immediate medical aid.
- The Department of Health, the Mayor of London and other relevant bodies should look at the funding and capabilities of the London Air Ambulance and the Medical Emergency Response Incident Teams (MERIT).

Following the delivery of the verdicts and recommendations the emergency services coordinated a series of statements to the media outside the court on behalf of each organisation. As Chief Executive I spoke on behalf of the Service, and my statement was widely broadcast by national media throughout the day.

A more detailed statement was released the same afternoon, which recognised the issues that had been faced on 7 July 2005 and outlined and some of the main changes and developments made since that time. This was shared with all national and local media, key stakeholders and other interested parties, and also published on the website.

A series of interviews were given during the afternoon, including live interviews on BBC Radio London, LBC and two on Radio Five Live, and a pre-recorded interview for BBC News. Additionally, pre-verdict filming to demonstrate changes that had been made had been facilitated for Channel 4 News, BBC London and London Tonight, and some of this footage featured in their evening bulletins.

There was significant national newspaper coverage the following day. While some of these stories included information from the Service's statement, they also reflected the reactions of the victims' families and some of the evidence that had been heard throughout the inquests about the emergency response on the day of the bombings.

The Service has until 1 July (56 days from the delivery of the verdicts on 6 May) to respond to the recommendations made in the coroner's report.

Changes to performance targets and introduction of clinical indicators: Information about the removal of the Category B response time target and the introduction of new call categories and clinical indicators was shared with both staff and the public.

A detailed article was published in LAS News, supported by bulletins, to inform staff about the changes. Externally, the Spring issue of Ambulance News – which is issued to some 20,000 stakeholders including foundation trust members, key stakeholders and GP surgeries – included a front page story about the changes, and a news release was issued to all London newspapers and broadcasters. Additionally, the Service's website was updated to include information about the new call categories and the clinical indicators, with this also being highlighted on the homepage.

External scrutiny

Review of the London Ambulance Service by the London Assembly's Health and

Public Services Committee: Chairman Richard Hunt and Chief Executive Peter Bradley were quizzed on the challenges facing the Service at a London Assembly review in April. This was the second meeting to look at both the operational and strategic issues facing the service.

Representatives from the Health and Public Services committee posed questions about performance targets and how patient demand can be managed among other things. Chair and Assembly Member, James Cleverly, thanked the service for attending and added "the first review was one of the most interesting scrutiny meetings we have had."

Finance Director Mike Dinan is going to City Hall in May to discuss the Service's cost improvement plans.

Media

High-risk register: The story of a woman who lived at an address flagged on the Service's high-risk register and who was apparently left brain damaged after waiting over 100 minutes for an ambulance parked around the corner was featured in national and regional newspapers, and regional TV and radio. The Service issued a statement and gave inteviews to BBC Radio London Drivetime and The Ken Livingston and David Mellor Show on LBC Radio.

Assualt sentence: The Mirror covered the sentencing of a drunk patient who bit and severly injured a student paramedic's finger while she was treating him in Shoreditch last July. The man was given a 36-week suspended sentence, 180 hours' community service and was ordered to pay £7,500 compenstation to our staff member and £1,000 prosecution costs by a judge at Snaresbrook Crown Court on 5 May.

Royal Wedding: Health messages were issued for people planning to go to the Royal Wedding and an interview was given to LBC radio with messages broadcast in hourly news bulletins. Figures of numbers of patients treated over the event period were also issued to the media. The Evening Standard and Uxbridge Gazette (front page) covered an alternative Royal Wedding story whereby a quick-thinking crew ensured another groom didn't miss his wedding that day. Staff were called to a man with serious back pain who was due to get married four hours later. If they had given him morphine and taken him to hospital he would have missed his wedding, so through the control room they contacted a local BASICS doctor to administer some stronger pain relief and took him to his wedding by ambulance.

Chief Executive's charity - MERU

Funds raised at London Marathon: Fifteen members of staff ran the London Marathon last month and raised nearly £12,000 for MERU. The runners received coverage in local papers and Homerton Student Paramedic Luke Collyer, who dragged two huge tyres along the route, was mentioned in an Evening Standard article.

The Service has already exceeded the two-year fundraising target of £25,000, with staff raising £30,692 to date. Future fundraising events include a trip to Mongolia to deliver ambulances, a masked ball and a carol concert.

Peter Bradley CBE
Chief Executive Officer

17 May 2011

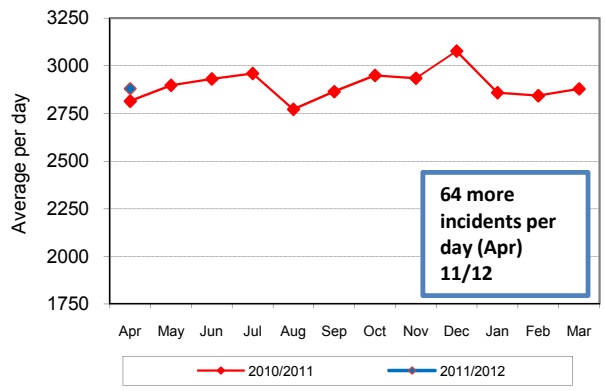
London Ambulance Service
NHS Trust

Information Pack for Trust Board

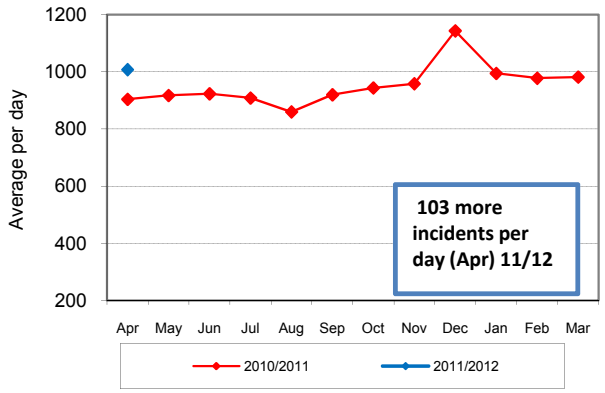
April 2011

London Ambulance Service NHS Trust
Accident and Emergency Service
Activity / Call Process -
April 2011

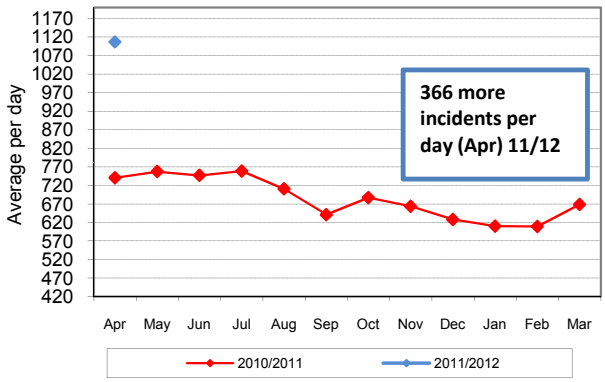
Graph 1
Average number of Total incidents per day



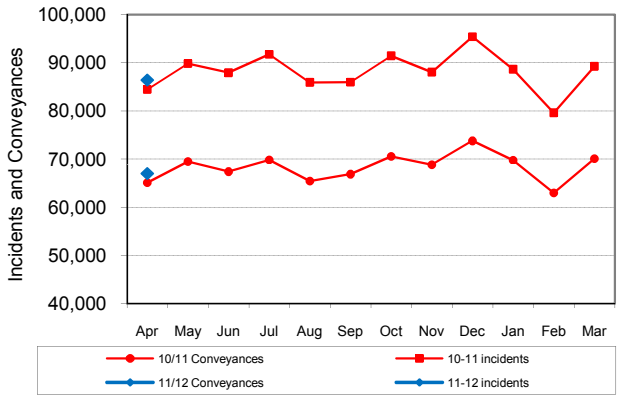
Graph 2
Average number of Cat A incidents per day



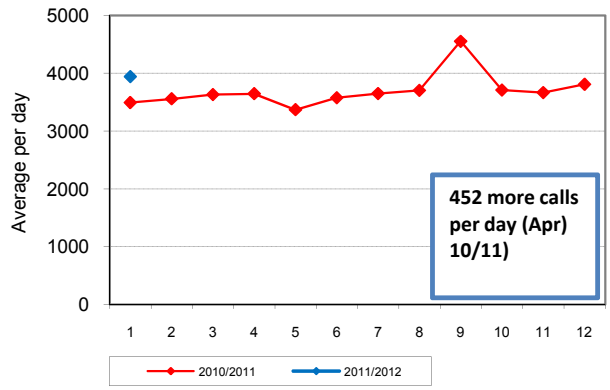
Graph 3
Average number of Cat C incidents per day



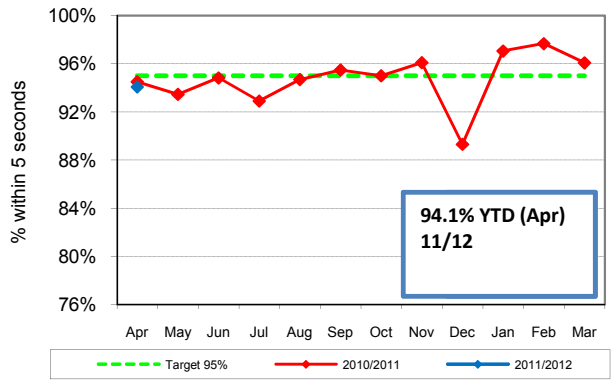
Graph 4
No of incidents conveyed



Graph 5
Average number of 999 calls received per day

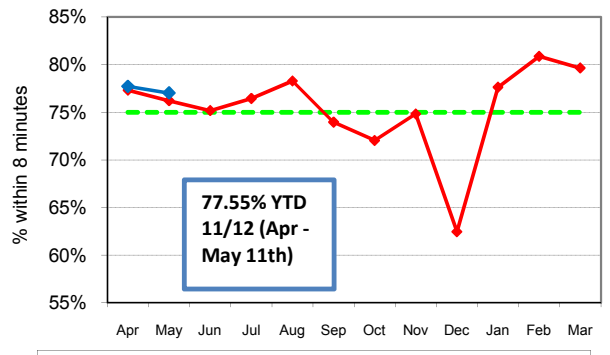


Graph 6
Percentage of calls answered within 5 seconds

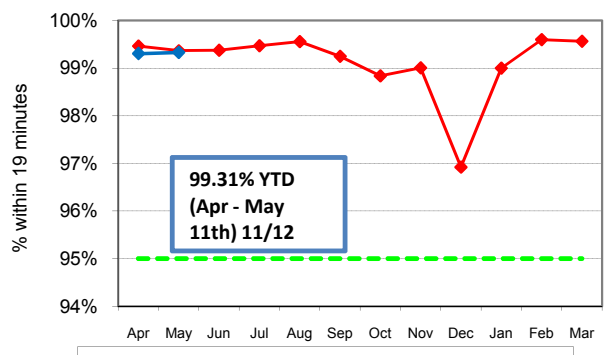


London Ambulance Service NHS Trust
Accident and Emergency Service
Performance - April 2011

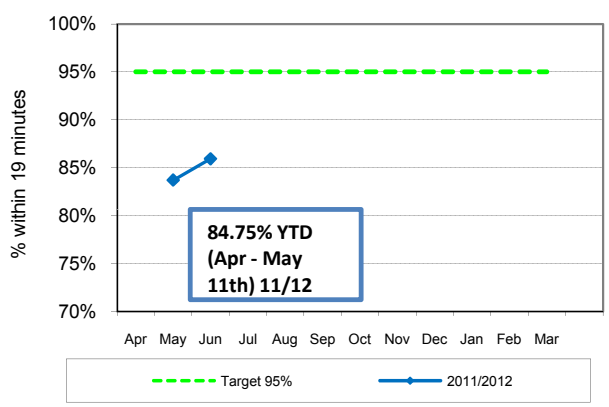
Graph 7
Category A 8 minute performance



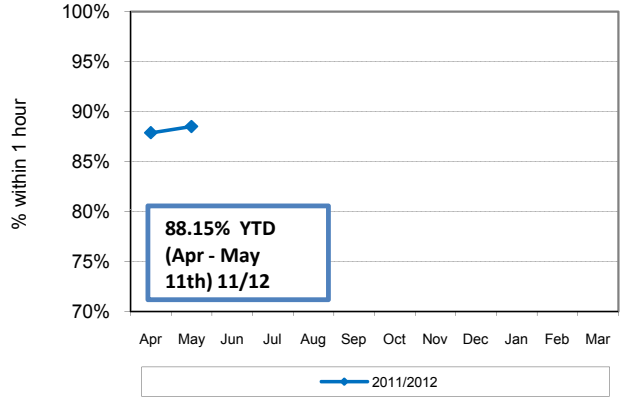
Graph 8
Category A 19 minute performance



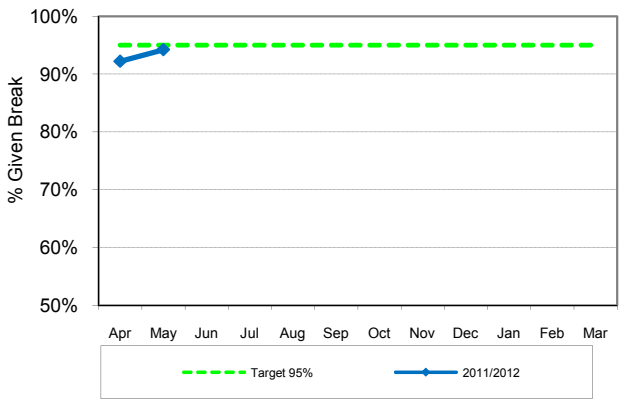
Graph 9
Category C1 20 minute performance



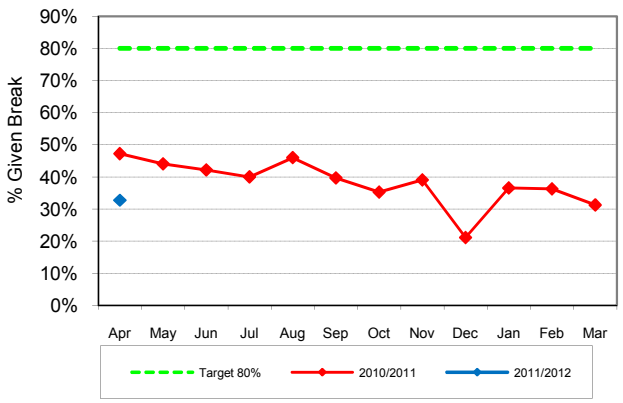
Graph 10
Category C2 30 minute performance



Graph 11
Cat C incidents 60 Minute Performance

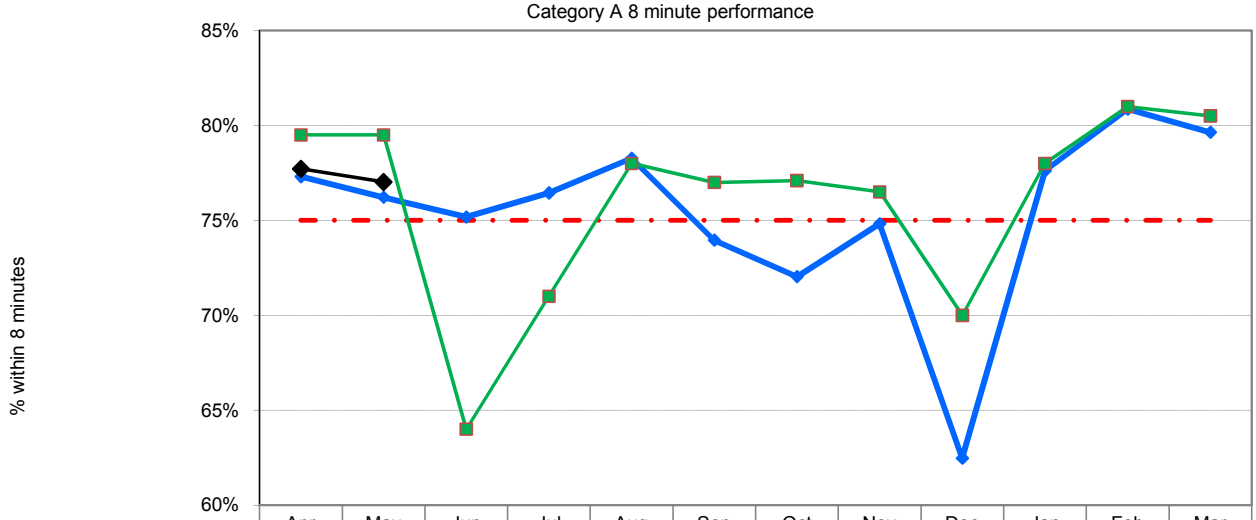


Graph 12
Rest Breaks Given



London Ambulance Service NHS Trust
Accident and Emergency Service
Performance - April 2011

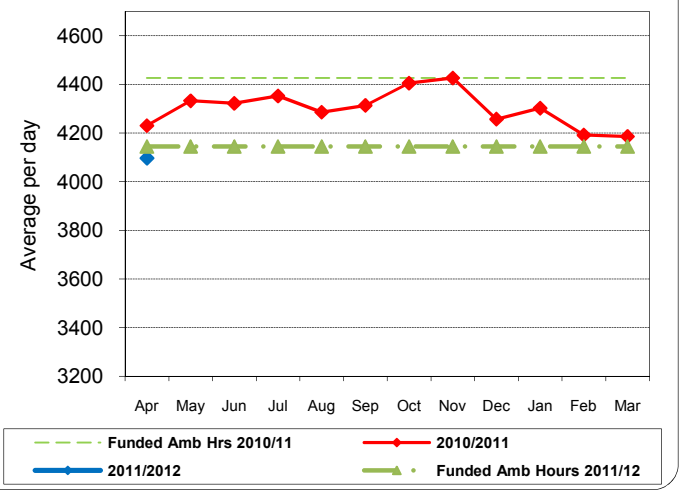
Graph 13
Category A 8 minute performance



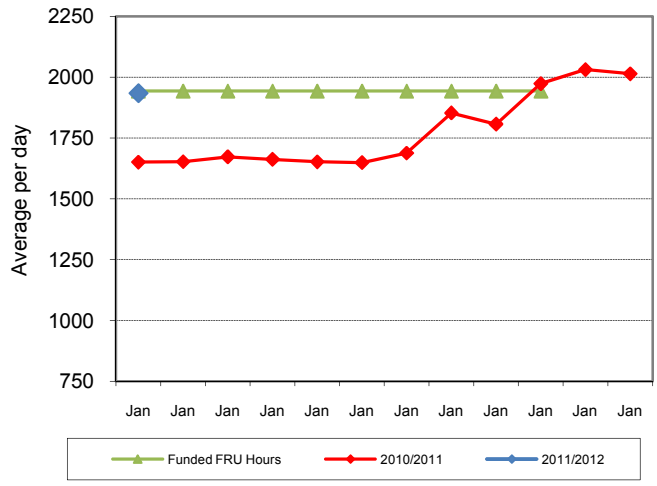
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target 75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
2010/2011	77.3%	76.2%	75.2%	76.4%	78.3%	74.0%	72.0%	74.8%	62.5%	77.6%	80.9%	79.6%
Cat A trajectory (11/12)	79.5%	79.5%	64.0%	71.0%	78.0%	77.0%	77.1%	76.5%	70.0%	78.0%	81.0%	80.5%
2011/2012	77.7%	77.0%										

London Ambulance Service NHS Trust
Accident and Emergency Service
Efficiency and Effectiveness - April 2011

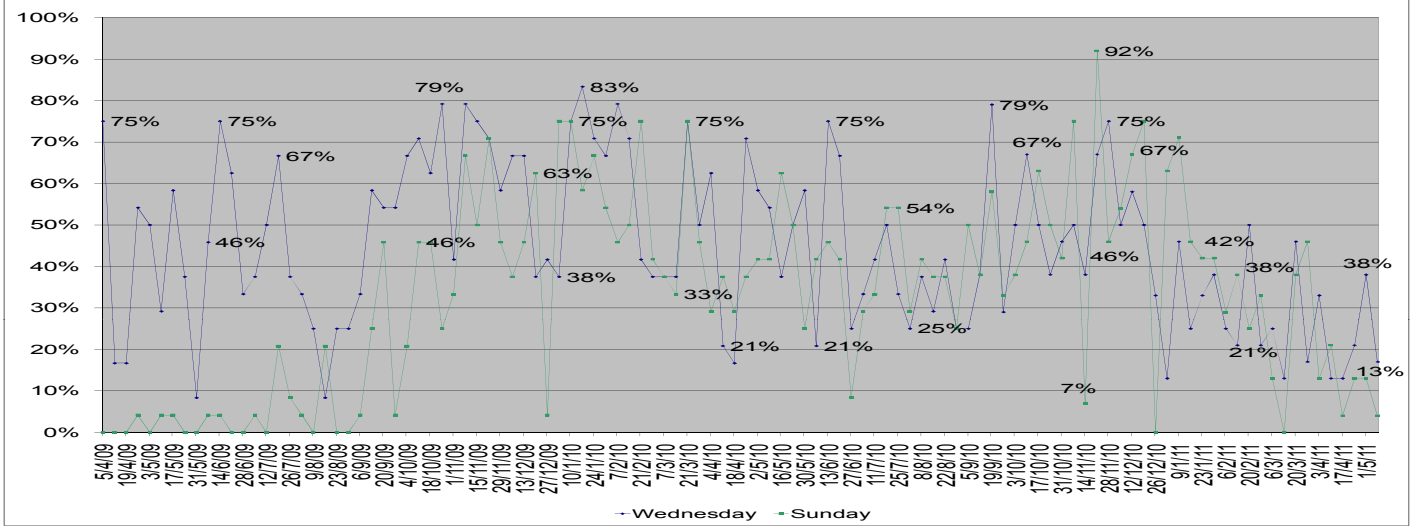
Graph 14
Ambulance Hours average available per day



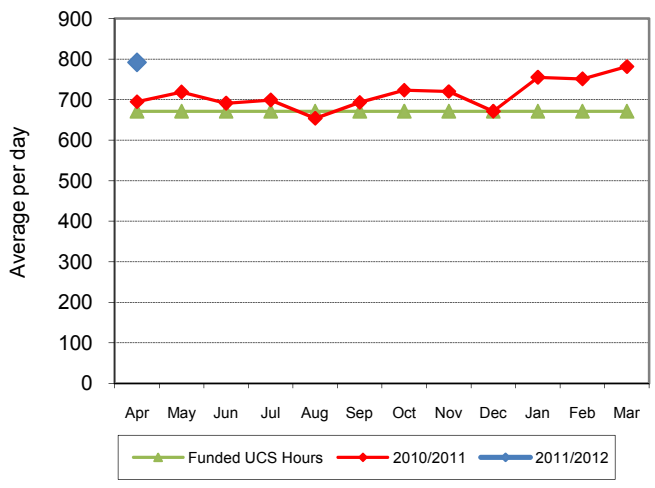
Graph 15
FRU hours average available per day



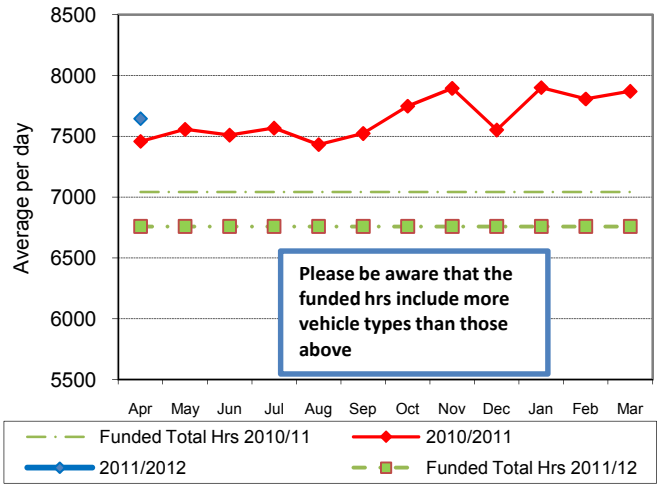
LAS hours in the day Compliant to ORH



Graph 17
UOC Hours average available per day



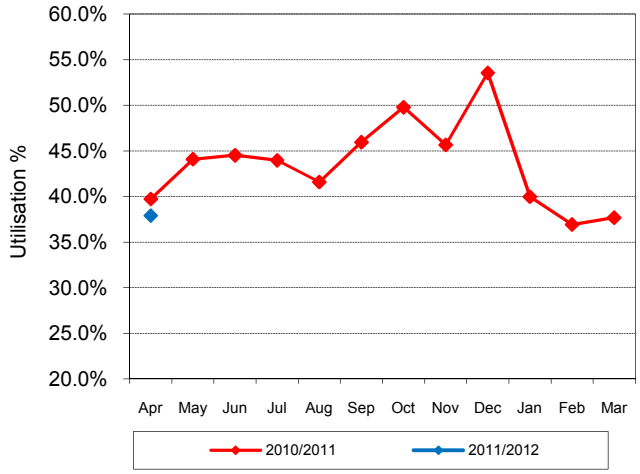
Graph 18
All Vehicle Hours average available per day



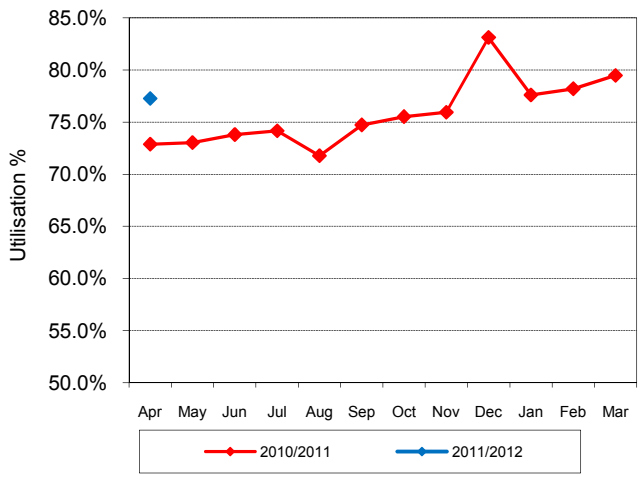
includes other vehicle types other than those above

London Ambulance Service NHS Trust
Accident and Emergency Service
Efficiency and Effectiveness - April 2011

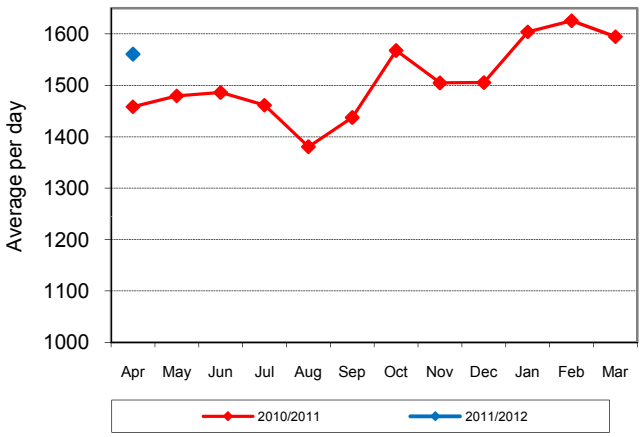
Graph 19
FRU Utilisation



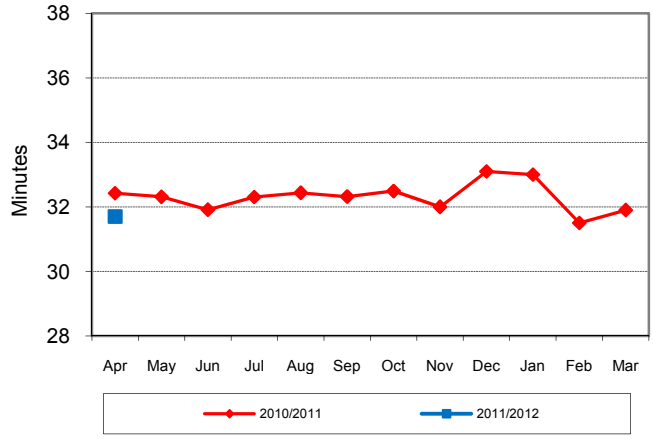
Graph 20
Ambulance Utilisation



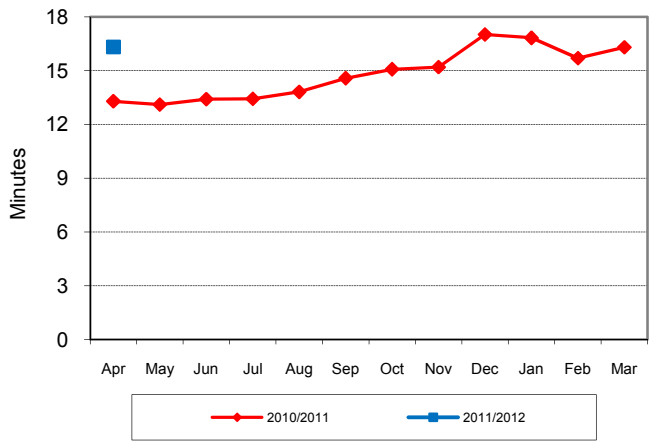
Graph 21
EOC hours staffed per day



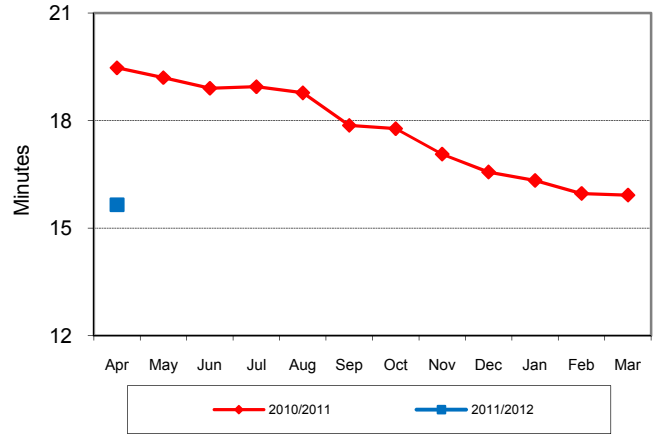
Graph 22
Average hospital turnaround time



Graph 23
Average Arrival at Hospital to Handover (Mins)

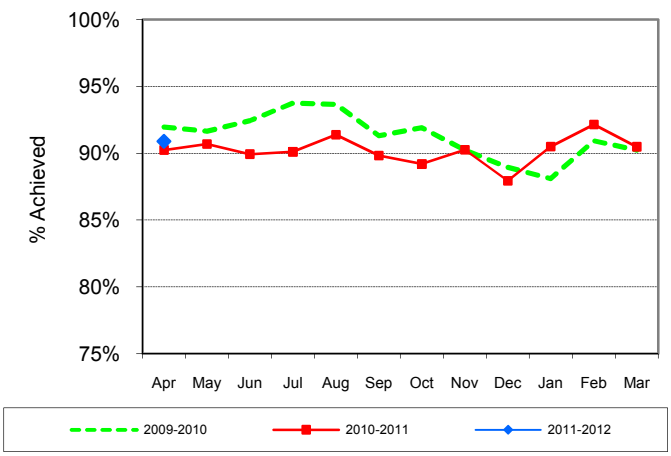


Graph 24
Average Handover to Green (Mins)

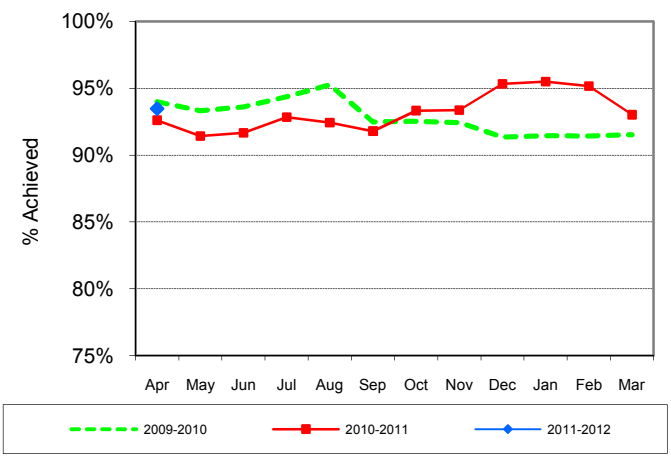


London Ambulance Service NHS Trust
Patient Transport Service
Activity and Performance - April 2011

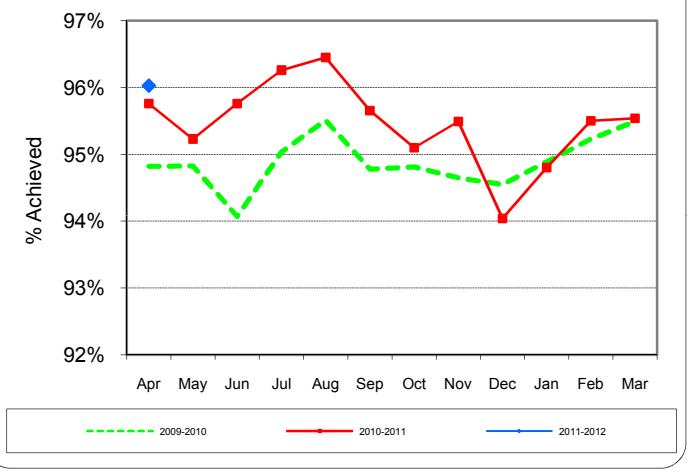
Graph 25
Arrival at Hospital Against Appointment Time



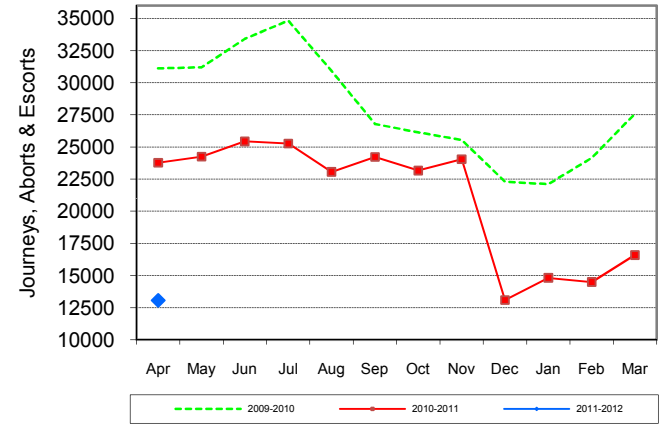
Graph 26
Departure Against Ready Time



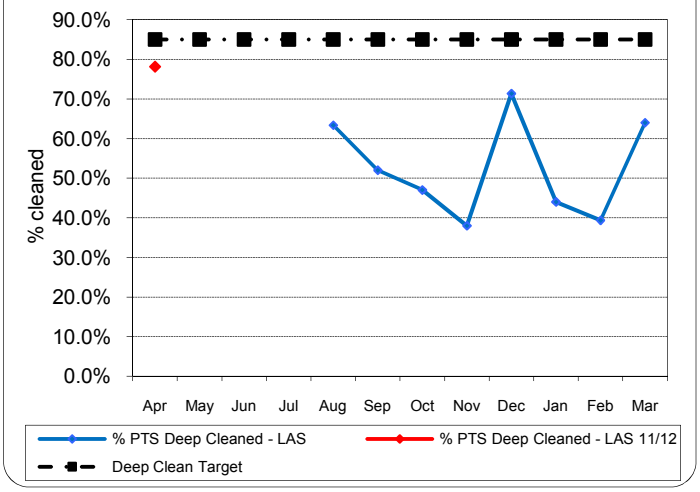
Graph 27
Time spent on Vehicle



Graph 28
PTS Total Activity



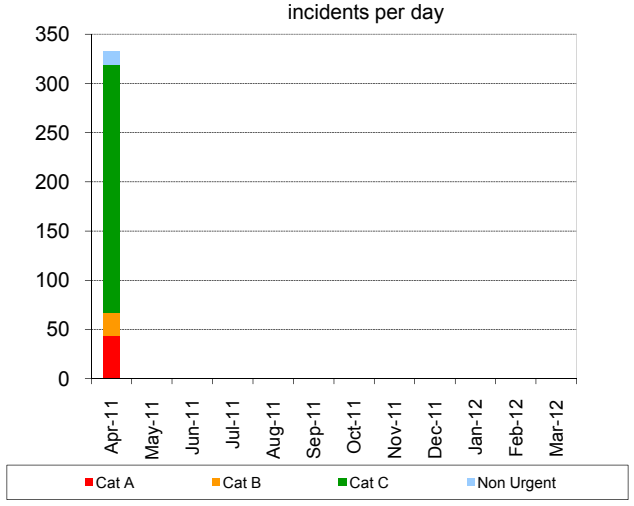
Graph 29
Deep Clean - PTS (17 weeks) - LAS



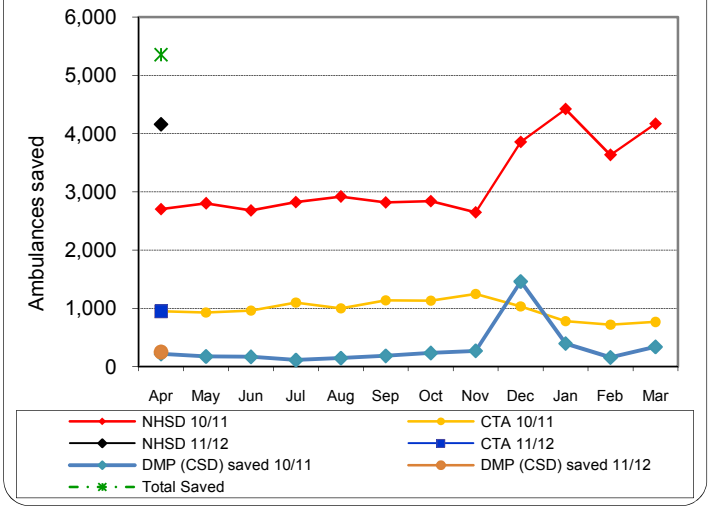
London Ambulance Service NHS Trust
Accident and Emergency Service
UOC Effectiveness - April 2011

Incident information is based on responses where a vehicle has arrived on scene for dispatches occuring during UOC operational hours (0700 -02259)

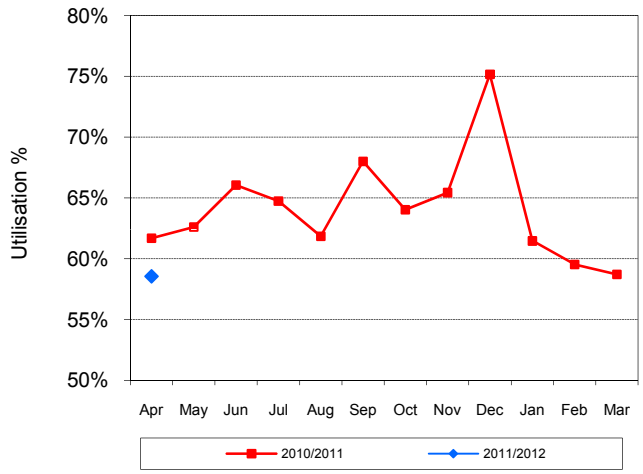
Graph 30
CAT A, B & C Workload by Urgent Care Vehicles average incidents per day



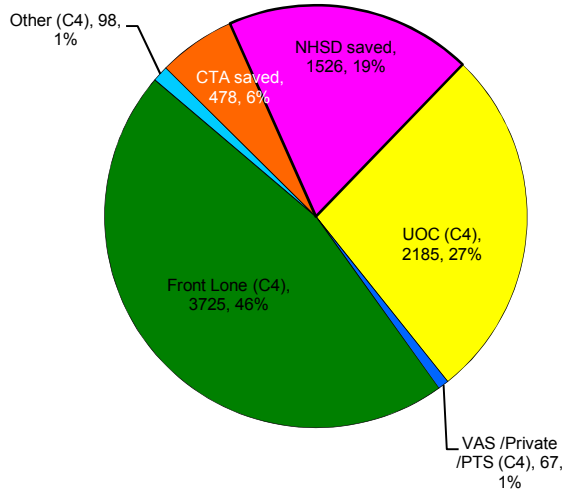
Graph 31
CTA/NHSD/DMP Ambulances saved



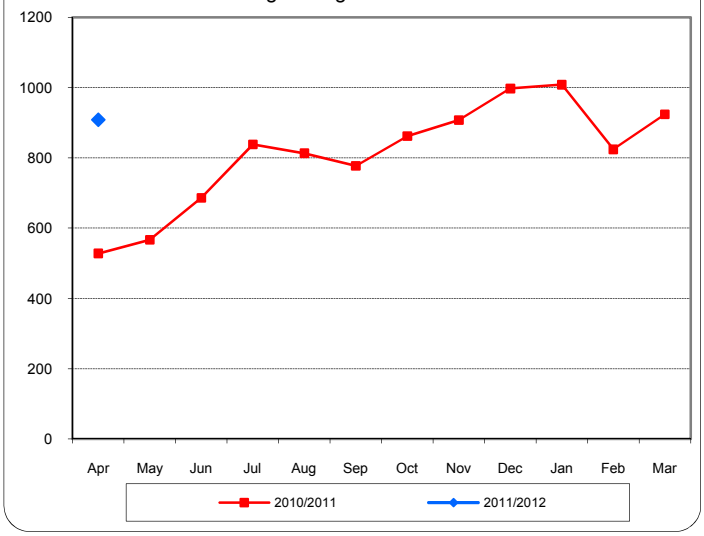
Graph 32
UOC Utilisation



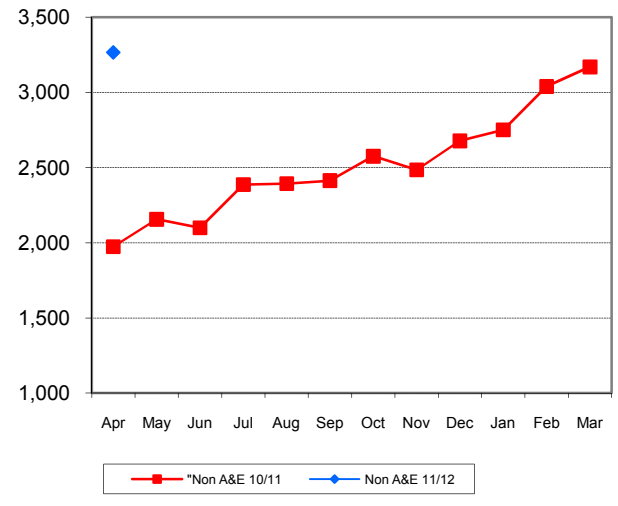
Graph 33
C4 resolution - April 19th to April 30th



Graph 34
Safeguarding children and adults

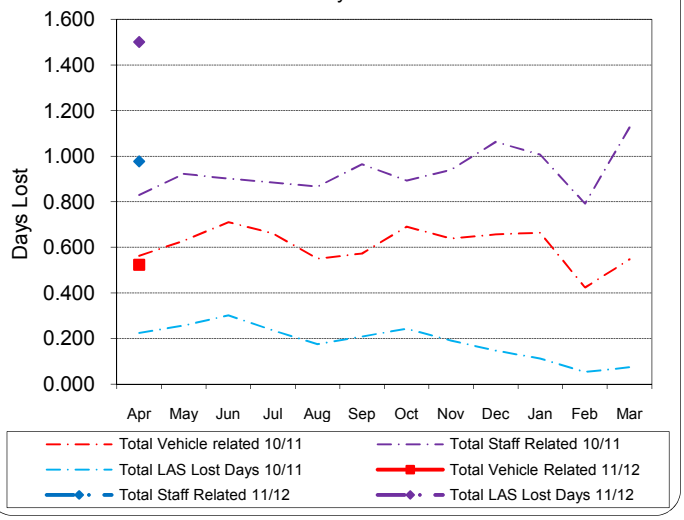


Graph 35
Patients conveyed to Non A&E Departments - LAS

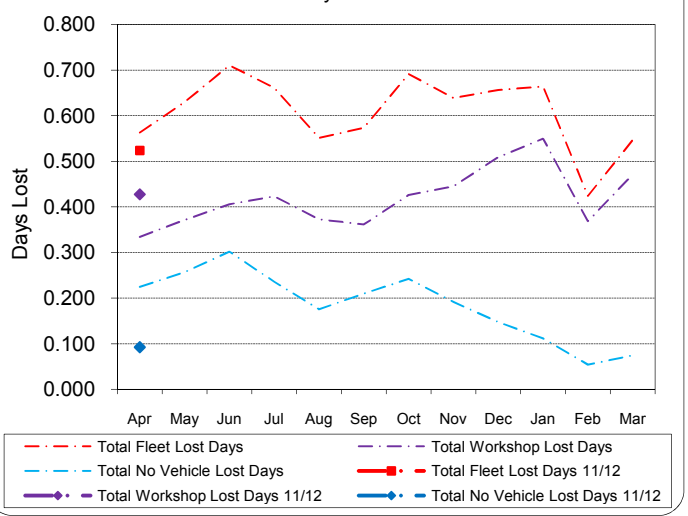


London Ambulance Service NHS Trust
Accident and Emergency Service
SMG Pack - Fleet and Logistics - April 2011

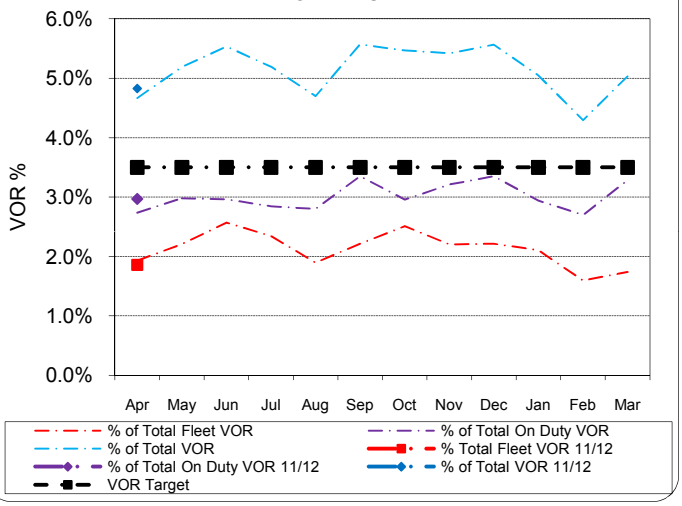
Graph 47
AEU Lost Days - LAS



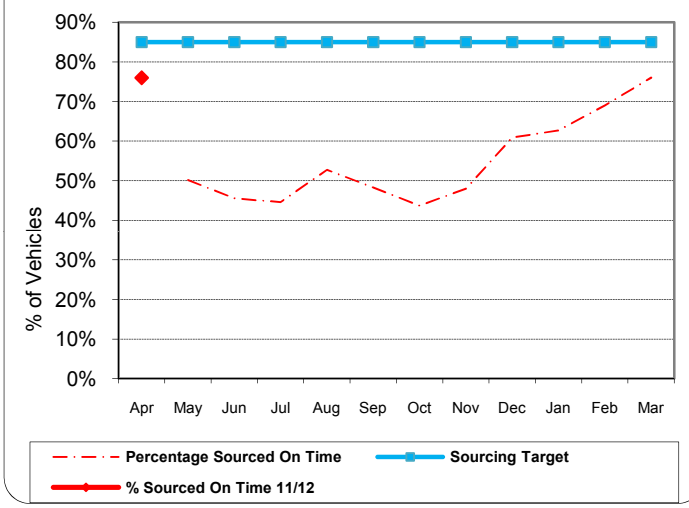
Graph 48
AEU Lost Days - Fleet Breakdown



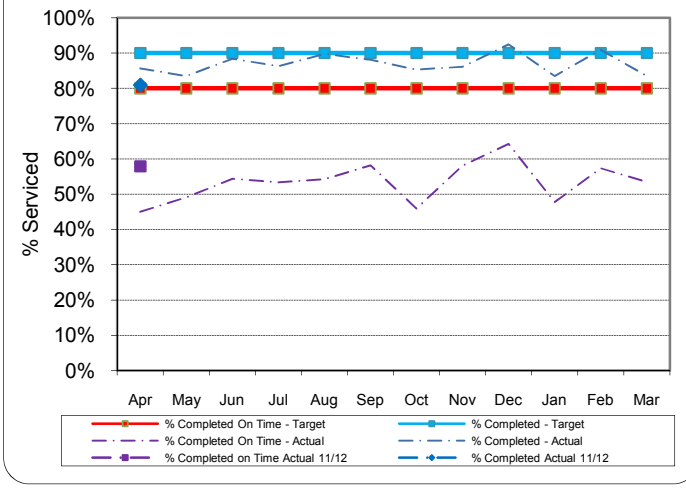
Graph 49
VOR - LAS



Graph 50
Vehicles Sourced -% within 30mins of shift start

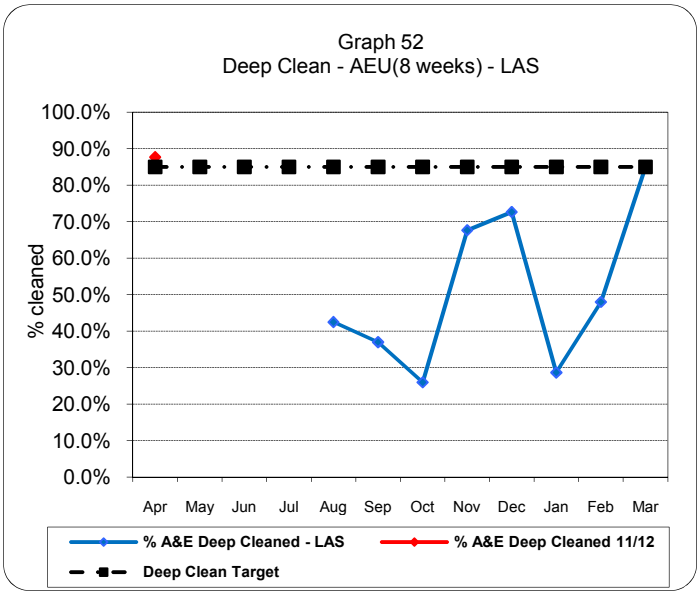


Graph 51
Servicing Performance - LAS

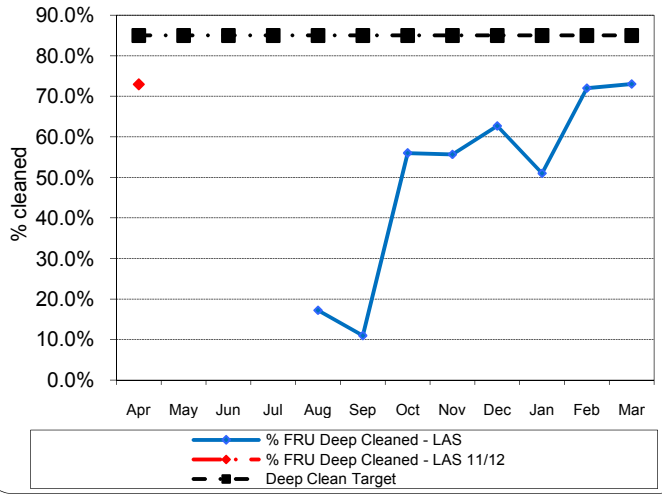


London Ambulance Service NHS Trust
Accident and Emergency Service
SMG Pack - Fleet and Logistics - April 2011

Graph 52
Deep Clean - AEU(8 weeks) - LAS



Graph 53
Deep Clean - FRU (13 weeks) - LAS



London Ambulance Service
NHS Trust

HR Summary for Trust Board

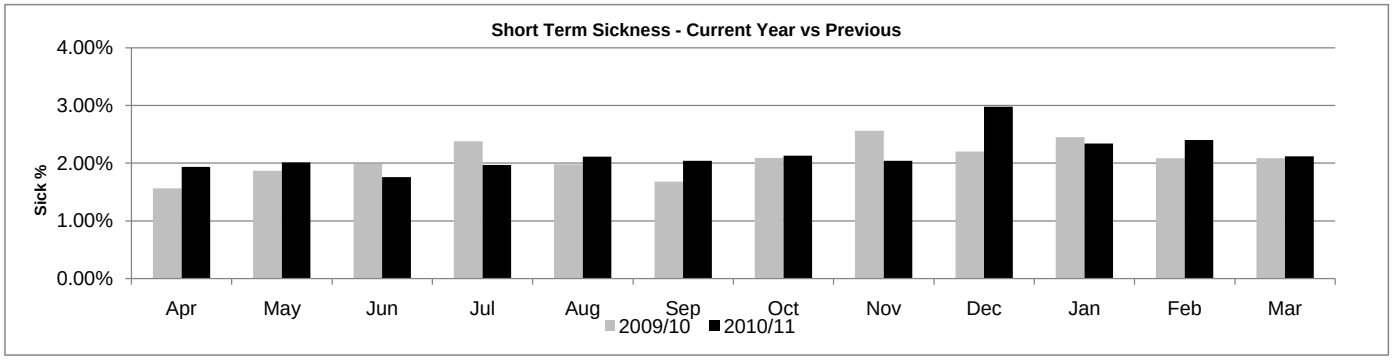
April 2011

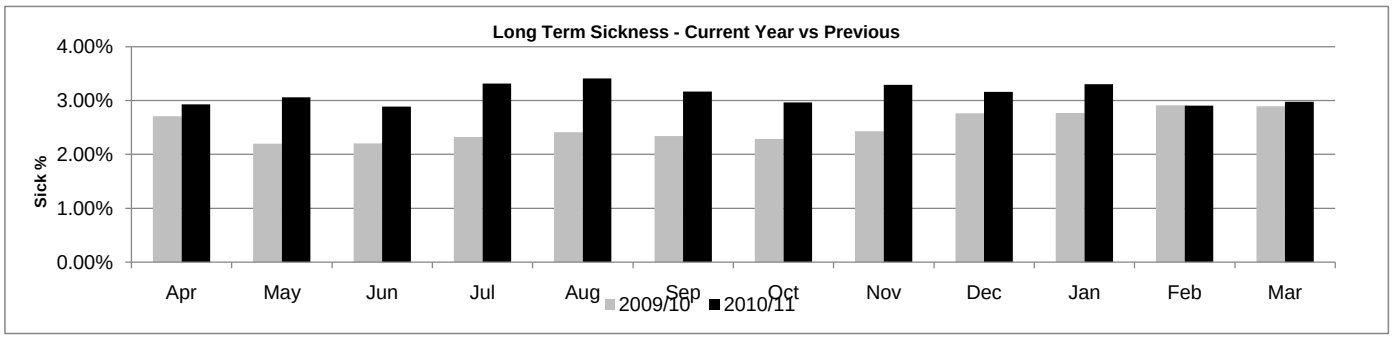
Workforce Report

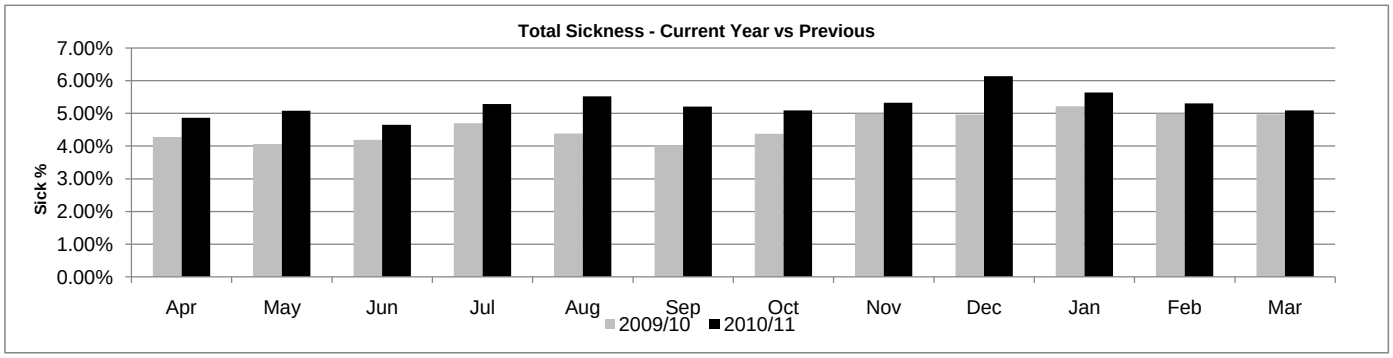
Current Month Mar-11 **Sickness Month** Mar-11

Trust Summary

Sickness Absence







Sickness 2009/10	4.61%	**Current WTE**	4728.79
YTD Sickness	5.27%	**Current Headcount**	4946.00

NB Secondments and Acting Up Included in Totals

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2009/10	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%	5.33%	6.13%	5.64%	5.30%	5.09%

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	388.00	190.00	142.00	175.00

Narrative

Sickness

As last month. the Trust summary continues to show a decrease in sickness absence month on month from December and year to date now also shows a marginal decrease to 5.27%. The Trust therefore clsoes the year 0.77% above the 4.5% target. Long term absence remained broadly static and short term absence decreased slightly since February. As will be seen from the more detailed analysis to follow, the RAG rated audits continue to show that, in the main, all absence is being managed appropriately.

Unauthorised Absences

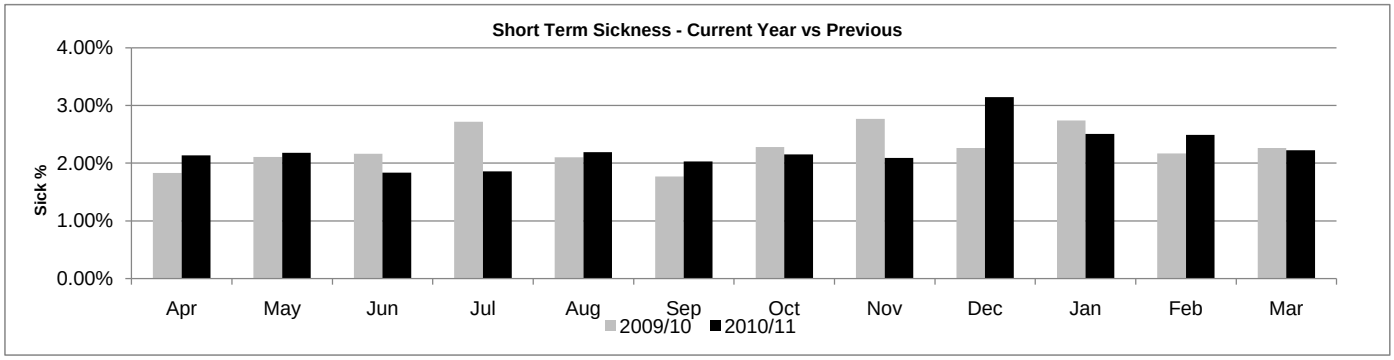
This figure shows the number of instances when staff have reported unable to attend work at short notice for reasons other than their own sickness or when they have not reported for work. Depending on the reason, the absence may be converted into annual leave or un/paid special leave or an unpaid absence. Disciplinary action may result. It is disappointing to see a rise February to March. These figures are actuals, therefore the year on year figure will be affected by the growth/differences in the establishment.

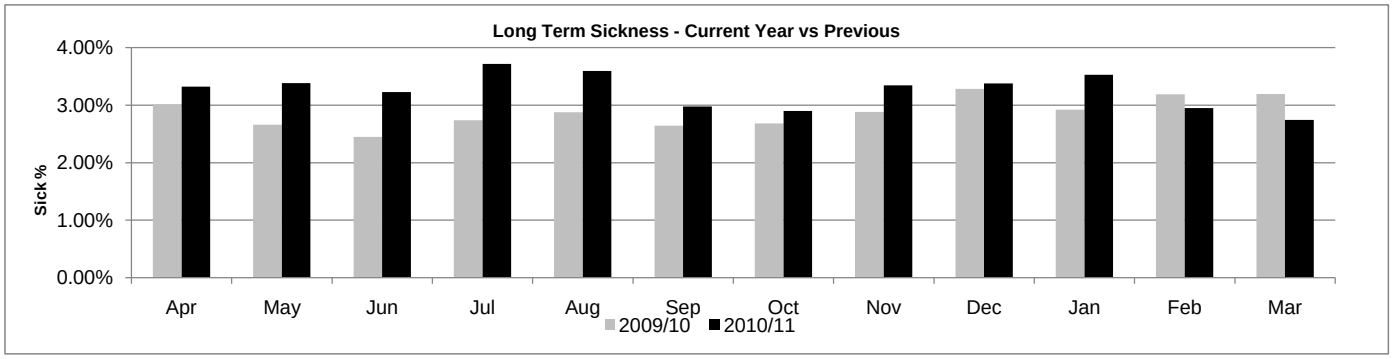
Workforce Report

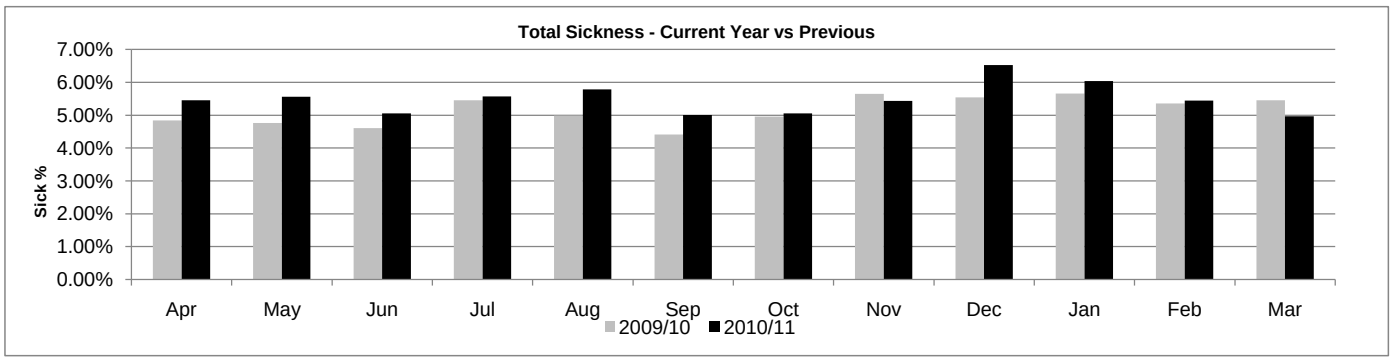
Current Month **Mar-11** **Sickness Month** **Mar-11**

A&E Operations Areas

Sickness Absence







Sickness 2009/10	5.15%	**Current WTE**	3301.88
YTD Sickness	5.50%	**Current Headcount**	3454.00

NB Secondments and Acting Up Included in Totals

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2009/10	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%	5.44%	6.52%	6.04%	5.44%	4.97%

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	340.00	148.00	108.00	147.00

Narrative

Sickness

Operational sickness continued the downward trend started after the December peak. The percentage decrease in sickness in A&E Areas (January to February) of 0.7%, exceeds slightly that across the Trust as a whole of 0.43%. However year on year the figure for February 2011 is slightly above that for 2010. The year to date figure for A&E Areas is 1.05% above target. Again reflecting the whole-trust figures, short term absence increased and there was a decrease in long term sickness. As will be seen in the commentary for each Area, the RAG rated process audits continue to show good management of attendance.

Unauthorised Absence

The figure for unauthorised absence in A&E Areas in March returned to the same level as January.

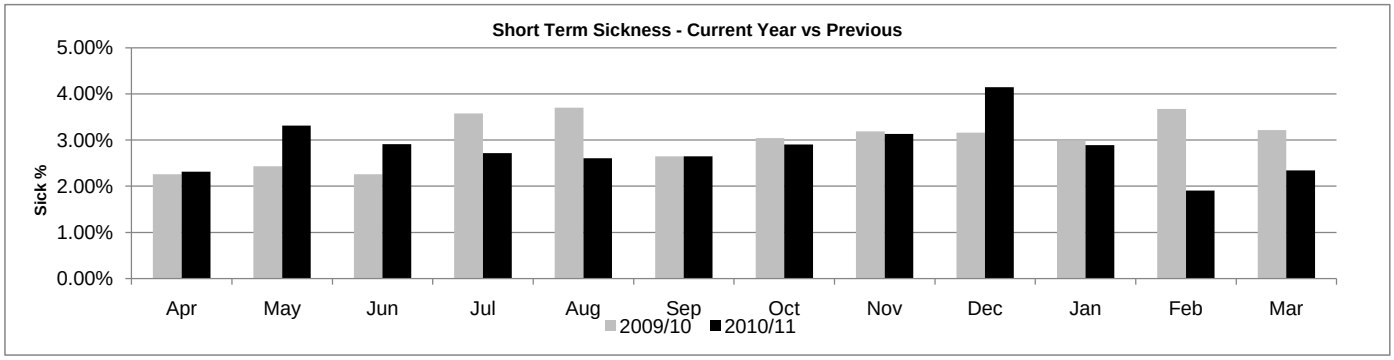
Please see the following pages for the figures for each Area.

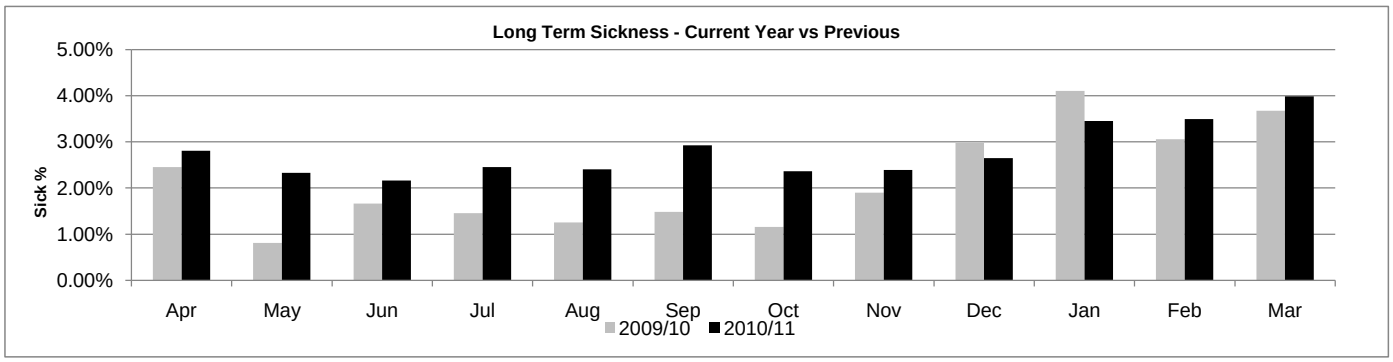
Workforce Report

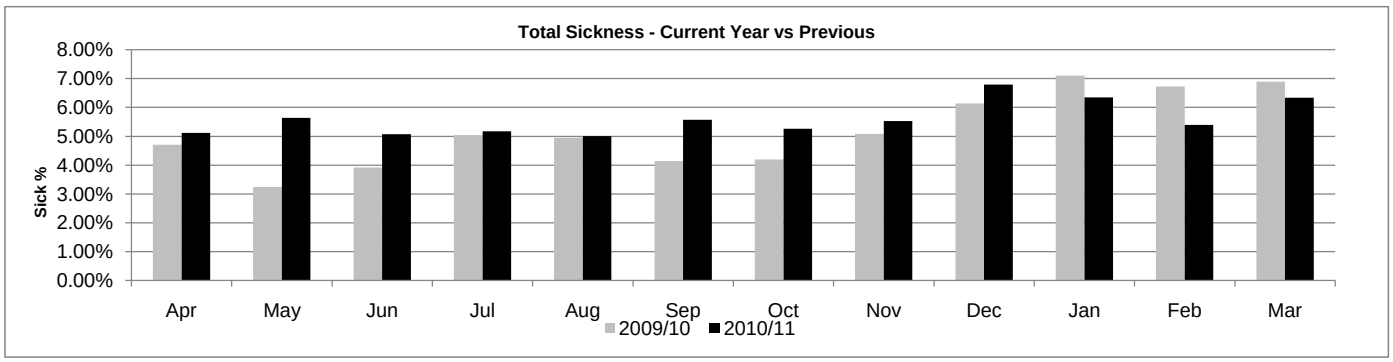
Current Month **Mar-11** **Sickness Month** **Mar-11**

Control Services

Sickness Absence







Sickness 2009/10	5.19%	**Current WTE**	429.34
YTD Sickness	5.61%	**Current Headcount**	453.00

NB Secondments and Acting Up Included in Totals

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2009/10	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%	5.52%	6.79%	6.35%	5.40%	6.33%

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	42.00	34.00	28.00

Narrative

Long-term absence has increased in comparison with the same point of the previous year, short term absence has increased since February 2011, however total sickness is marginally lower in comparison with the same point of the previous year.

Audit checks continue to be undertaken on a regular basis. The results are good and the necessary feedback has been provided to line managers. Long term absence also continues to be addressed, with a number of employees being referred to hearing in the coming months for consideration of dismissal.

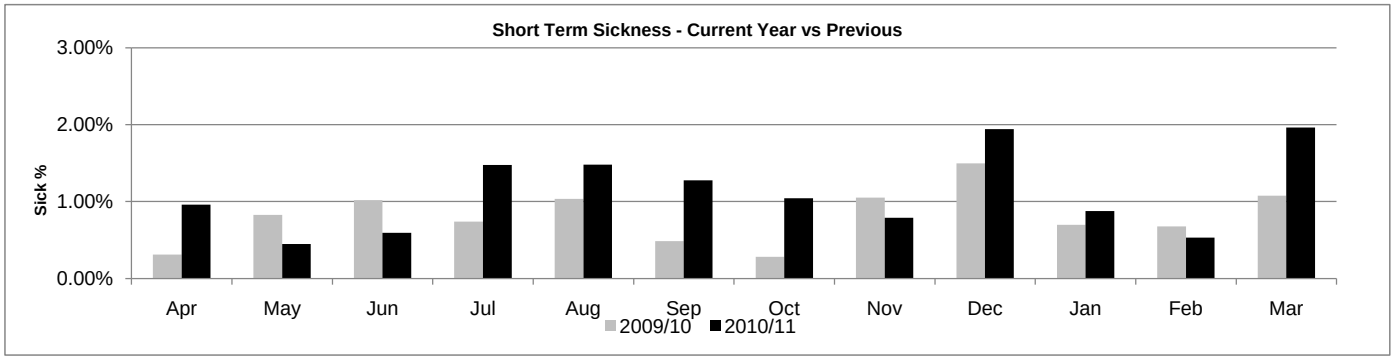
Unauthorised Absences
Although still high the figure continues to fall since the December high. Control Services continues to manage robustly unauthorised absences as the figures show.

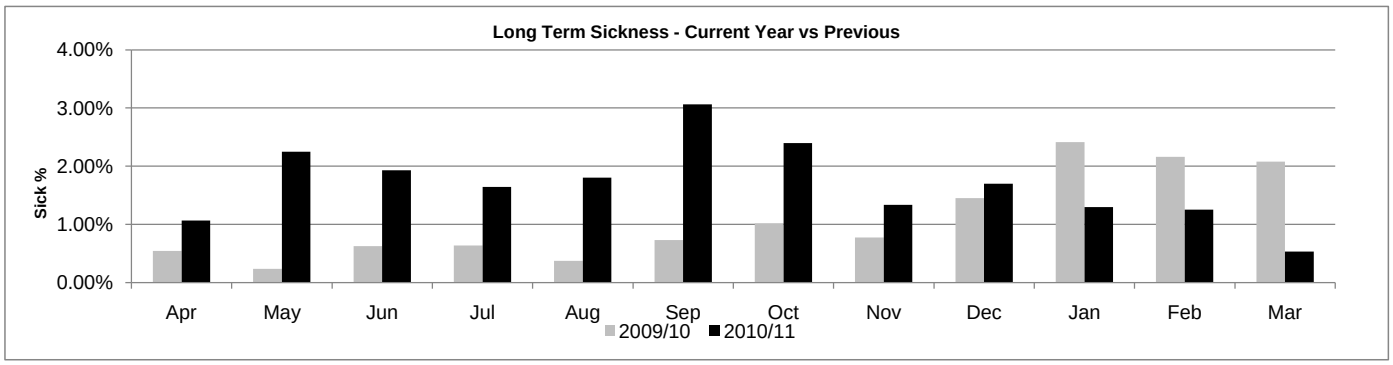
Workforce Report

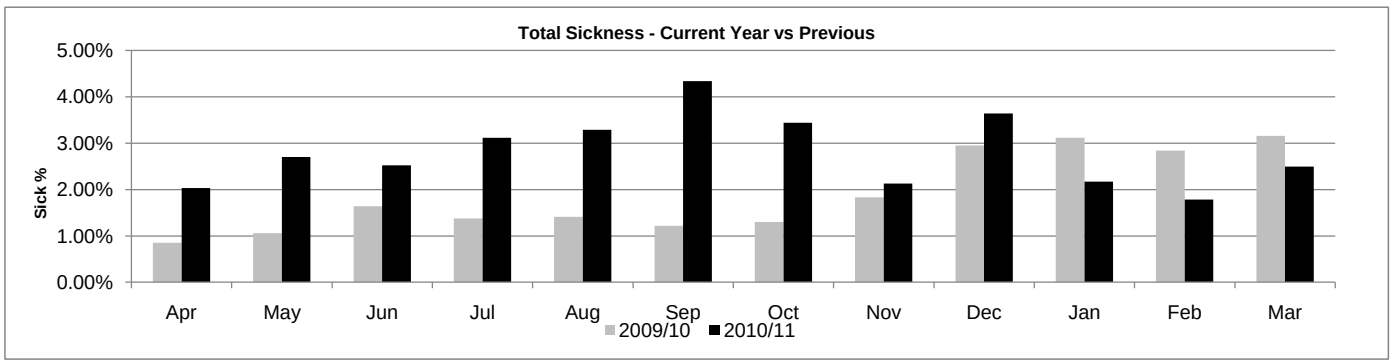
Current Month **Mar-11** **Sickness Month** **Mar-11**

Human Resources & Organisation Dev Directorate

Sickness Absence







Sickness 2009/10	1.88%	**Current WTE**	242.68
YTD Sickness	2.75%	**Current Headcount**	253.00

NB Secondments and Acting Up Included in Totals

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2009/10	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%	2.13%	3.64%	2.17%	1.79%	2.50%

Narrative

Short term absence increased with 11 members of staff absent over the month.

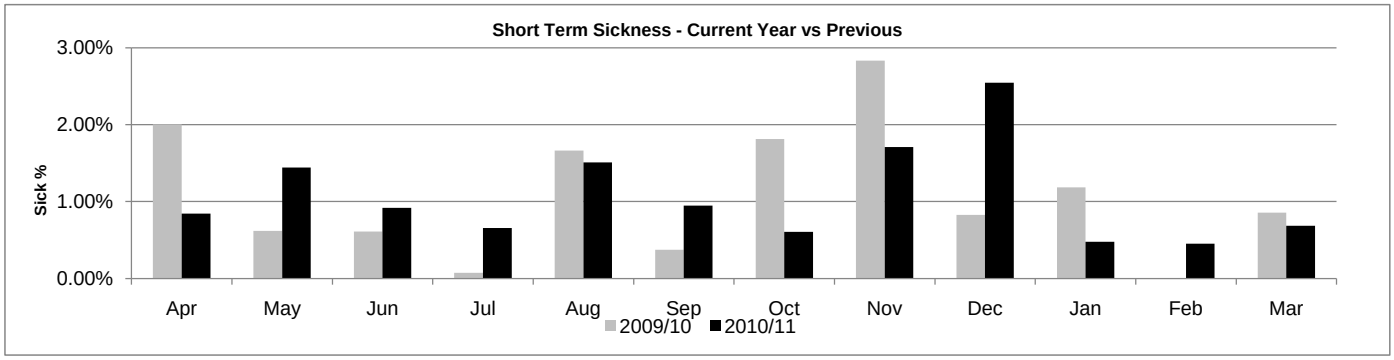
Long term sickness : 2 staff absent, both cases being actively manged by manager and HR.

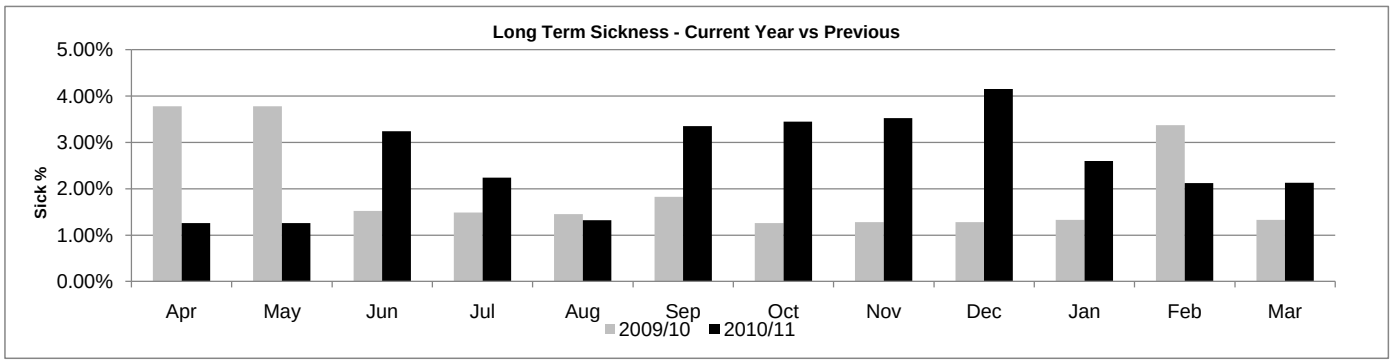
Workforce Report

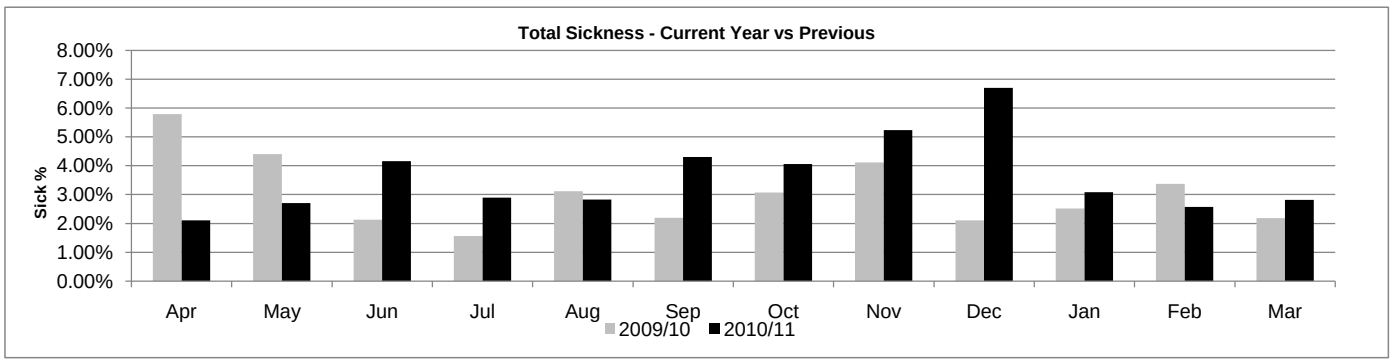
Current Month Mar-11 **Sickness Month** Mar-11

Finance & Business Planning Directorate

Sickness Absence







Sickness 2009/10	3.04%	**Current WTE**	46.93	**NB Secondments and Acting Up Included in Totals**
YTD Sickness	3.61%	**Current Headcount**	49.00	

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%	5.23%	6.70%	3.08%	2.58%	2.82%

Narrative

Short term sickness has risen marginally with 7 members of staff absent for a total of 13 days over the month.

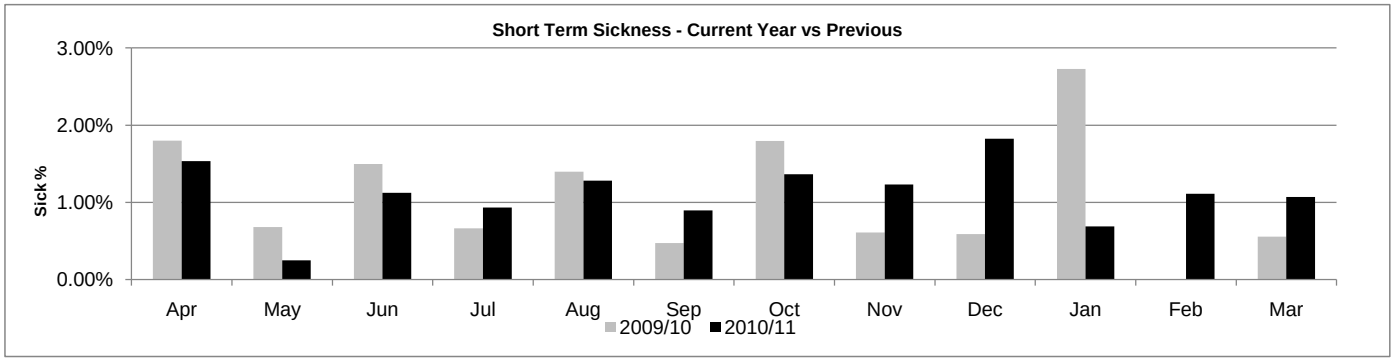
2 staff on long term absence; both cases being managed by manager/union/OH/HR involvement as required.

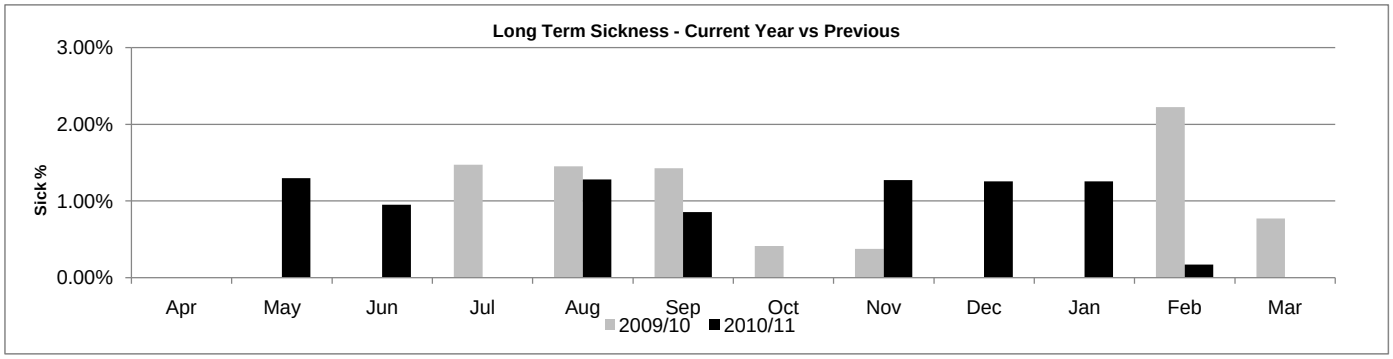
Workforce Report

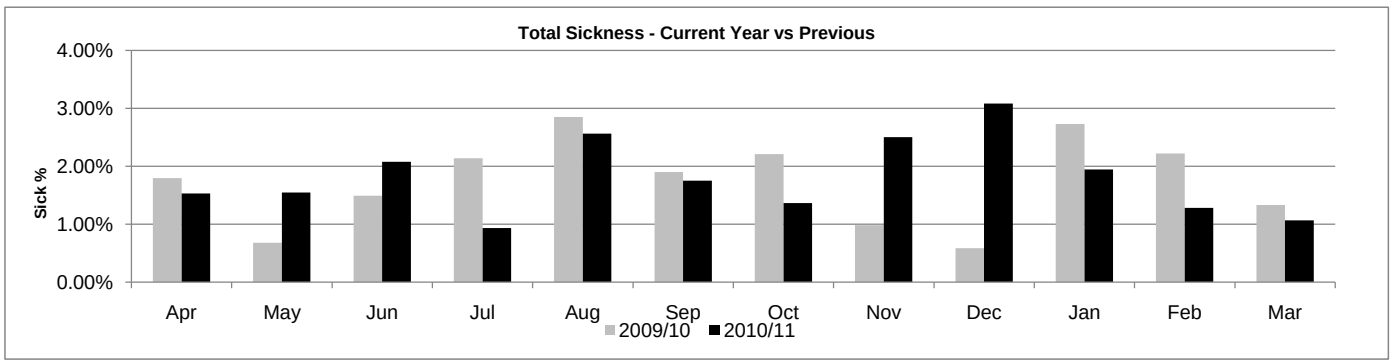
Current Month **Mar-11** **Sickness Month** **Mar-11**

Information Management & Technology Directorate

Sickness Absence







Sickness 2009/10	1.74%	**Current WTE**	84.53
YTD Sickness	1.80%	**Current Headcount**	86.00

NB Secondments and Acting Up Included in Totals

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2009/10	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%	2.50%	3.08%	1.95%	1.28%	1.07%

Narrative

6 members of staff absent during March - including one absent for 3 weeks and one for 2 weeks.

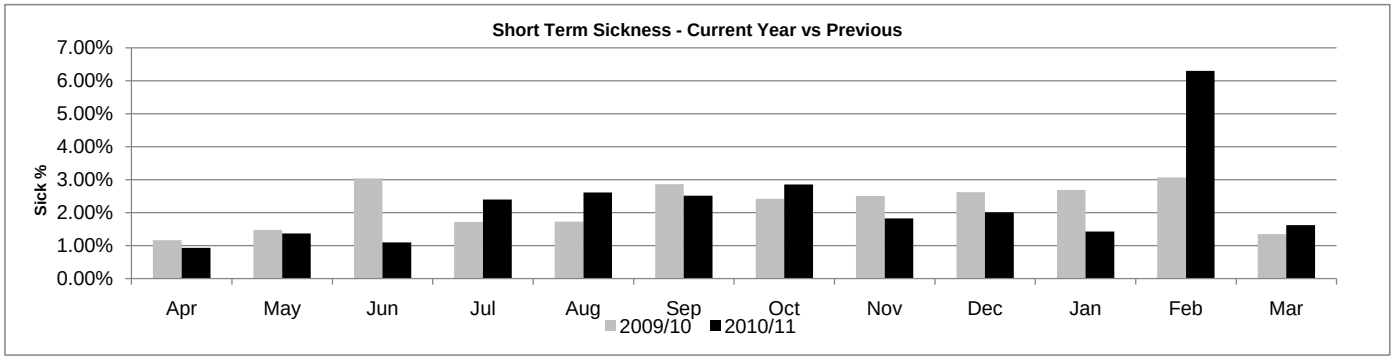
No long term sickness absence.

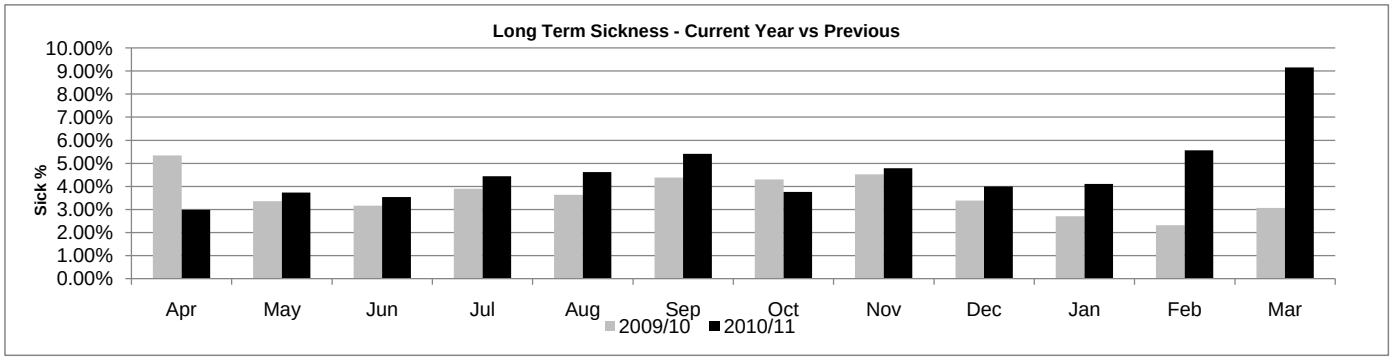
Workforce Report

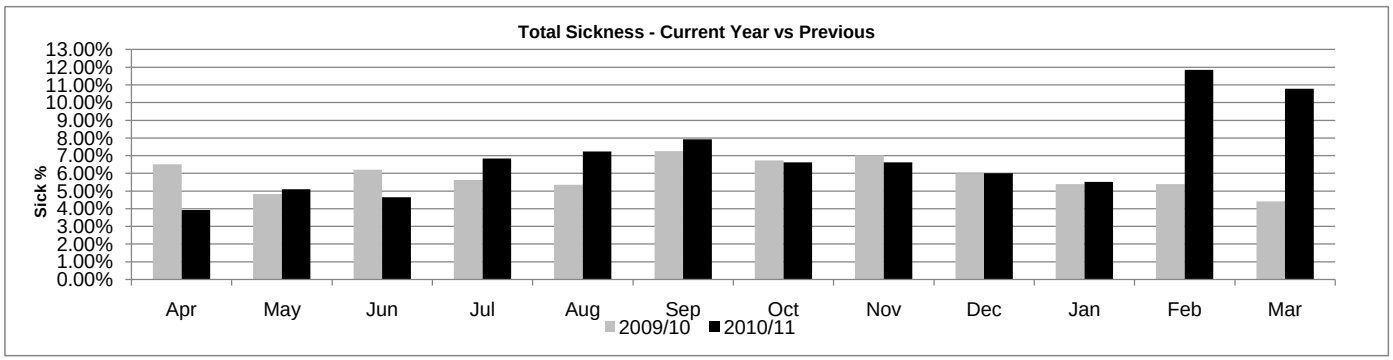
Current Month **Mar-11** **Sickness Month** **Mar-11**

Patient Transport Service

Sickness Absence







Sickness 2009/10	5.89%	**Current WTE**	159.74	**NB Secondments and Acting Up Included in Totals**
YTD Sickness	6.74%	**Current Headcount**	167.00	

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%	6.61%	6.00%	5.52%	11.86%	10.78%

Narrative

Sickness remains high within PTS with a high number of long term sick absences. All of these are being closely managed by the PTS Operations team and local HR Managers both on a weekly basis and at the Monthly audit with HR. We are taking action as soon as a trigger is reached and we are utilising the capability and failure to attend work processes in addition to MAP where appropriate. For example, with the exception of one member of staff, each of the Central staff who transferred back to PTS Management on 12th January 2011 are now on an informal warning, one has resigned as a result of close management and one is being considered for capability and will be referred for a formal warning on their return.

In the two operational areas the breakdown of numbers are:

East: 7 x Long Term 6 x Short Term (Of the long term sick one member of staff returned in April, one resigned)
West: 11 x Long Term 3 x Short Term (Five of the west long term sick returned to work in April)
Managers: 1 x Long Term 1 x Short Term

The Short Term figure which shot up in February has now returned to more normal levels appears to have been linked to Colds/Flu and outbreaks of Norovirus and D&V on a number of sites. Once the trend had been identified we issued further Infection Control advice to all PTS staff advising of dangers and requirements of good Infection Control.

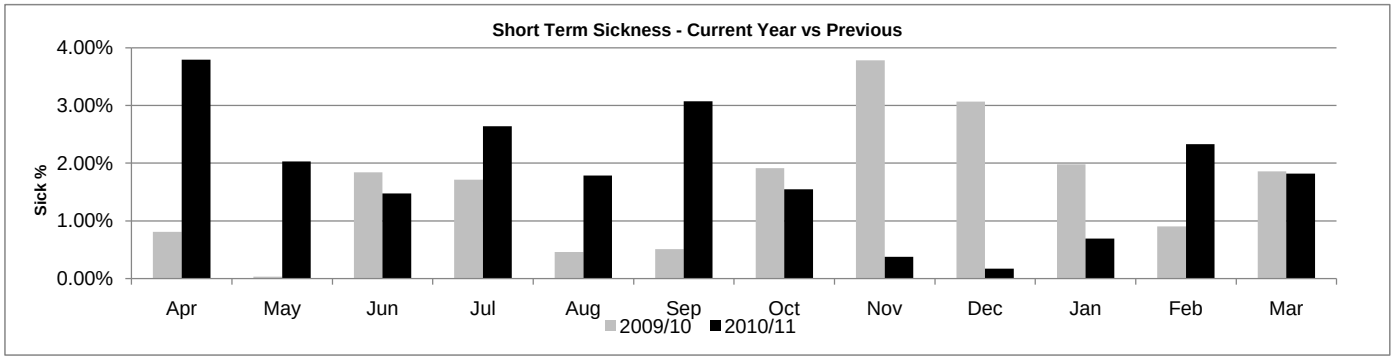
In the last two months we have seen a total of 7 PTS staff leave the service through retirement/resignation.

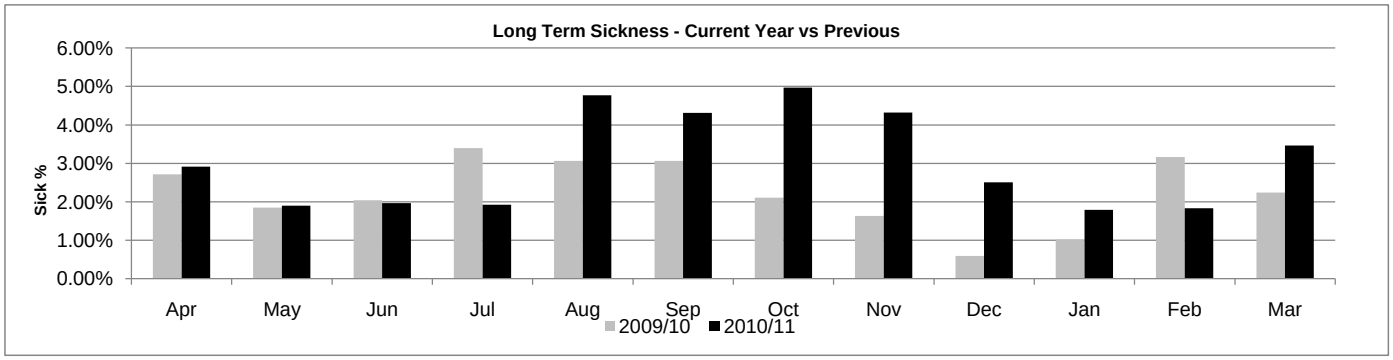
Workforce Report

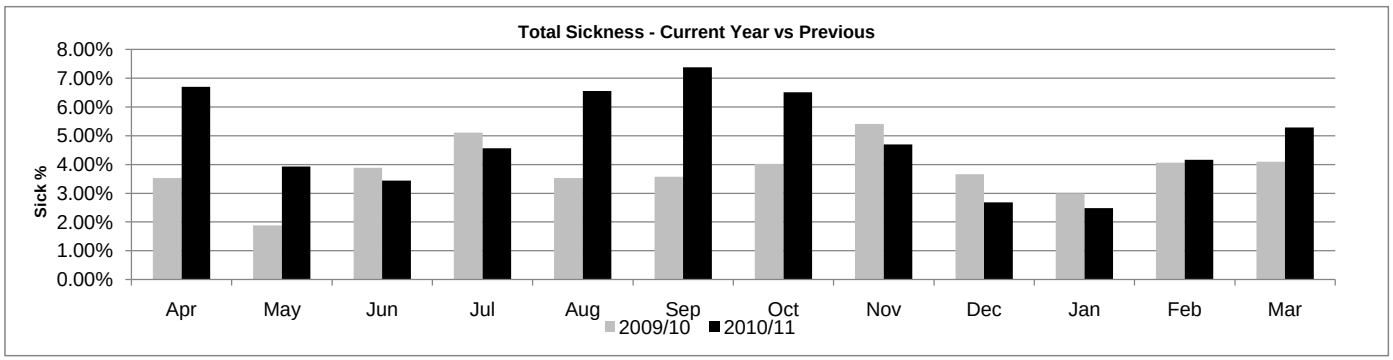
Current Month **Mar-11** **Sickness Month** **Mar-11**

Operational Support

Sickness Absence







Sickness 2009/10	3.81%	**Current WTE**	109.85	**NB Secondments and Acting Up Included in Totals**
YTD Sickness	4.87%	**Current Headcount**	111.00	

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%	4.70%	2.68%	2.48%	4.17%	5.29%

Narrative

Decrease in short term absence for the month with 15 staff absent for a total of 24 days + 2 absent for two weeks each

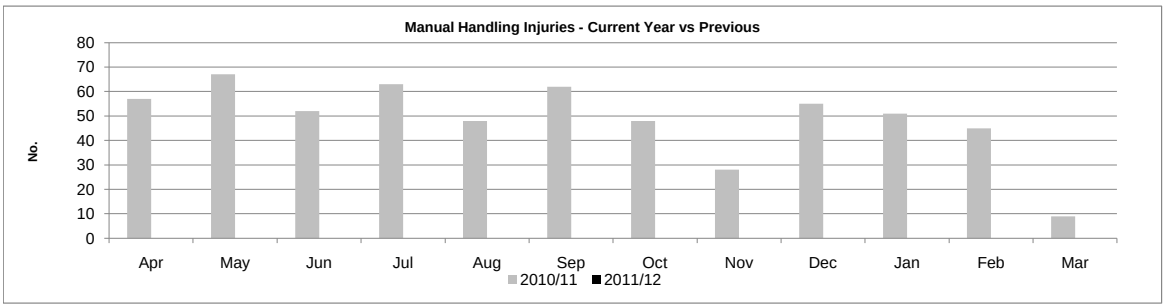
3 staff on long term absence one as a result of complications following surgery; 1 application for Ill Health Retirement , and 1 to attend capability attendance hearing

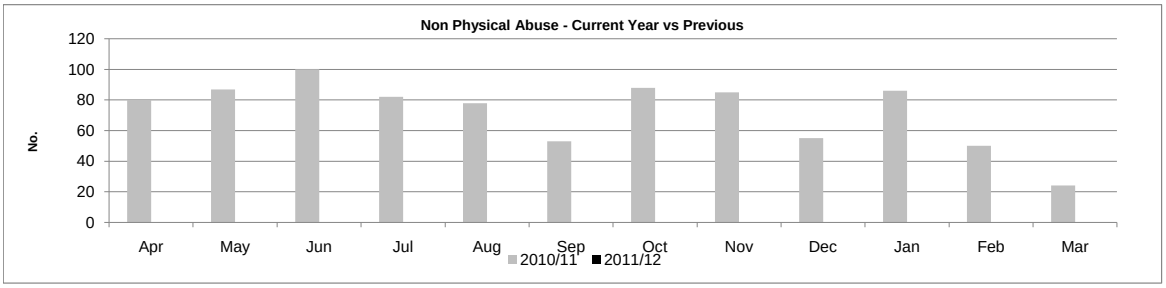
Workforce Report

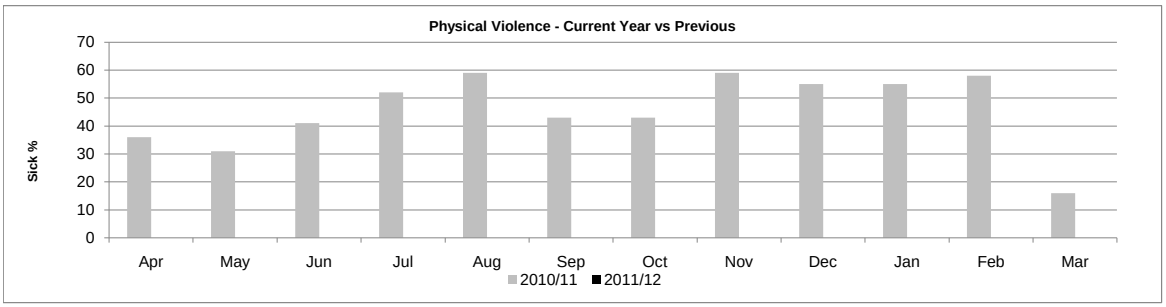
Current Month **Apr-11**

Trust Summary

Health & Safety Issues





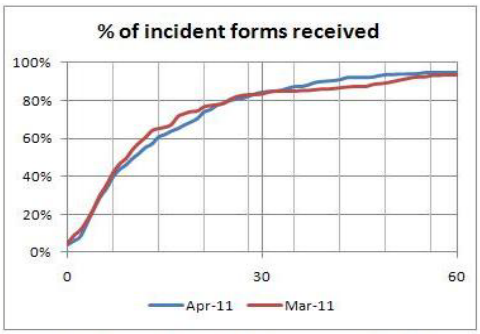


Narrative

The above reported incident data is accurate as of forms received by the 3rd May 2011.
The first figures for the 2011/2012 financial year are low compared to 2010/2011, due to the delay in incident forms reaching the safety and risk department. During the month of April 2011, approximately 84% of forms were received within 30 days, which is identical to March 2011. More up-to-date figures (within 95%) will be available in the next month's update.

Days	Jan-11	Feb-11	Mar-11	Apr-11
0	0%	1%	5%	4%
30	77%	82%	84%	84%
60	94%	91%	94%	95%
90	97%	94%	96%	97%

An audit took place of the received Physical Violence figures for quarters 3 and 4 of 2010/2011, and many incidents were downgraded to Non-Physical Abuse in line with NHS Protect definitions of Physical Assault. The new figures are shown in the table above.
Preliminary results from the Incident Reporting Pilot Trial show an increase in incidents reported on the incident date. This is mirrored
Based upon April 2011 figures, we can predict that all of the four major categories are down compared to fy2010/2011.



Workforce Report

Current Month **Apr-11**

Trust Summary

Vacancies & Turnover

	Funded WTE	Inpost WTE	Variance
Trust Total	4649.20	4703.53	+54.33
Directorate			
A&E Operations Areas	3225.98	3316.79	+90.81
Chief Executive	16.61	15.61	-1.00
Control Services	437.28	430.94	-6.34
Corporate Services Directorate	49.93	49.93	+0.00
Finance & Business Planning Directorate	59.20	46.93	-12.27
Health Promotion & Quality	2.00	2.00	+0.00
Human Resources & Organisation Dev Directorate	195.17	224.28	+29.11
Information Management & Technology Directorate	87.53	82.53	-5.00
Medical Directorate	23.20	20.21	-2.99
Operational Support	128.86	106.43	-22.43
Patient Transport Service	153.44	158.74	+5.30
Trust Board	6.00	6.00	+0.00

Turnover

2010/11	7.1%	Apr-10 to Mar-11
2011/12	6.6%	12 Months up to Apr-11

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No. Leavers (FTE)												
2010/11	44.00	32.00	11.00	27.00	28.00	34.00	22.00	52.00	18.00	26.00	24.00	34.00
2011/12	19.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
No. Starters (FTE)												
2010/11	10.00	6.00	28.00	21.00	13.00	70.00	37.00	62.00	6.00	24.00	25.00	23.00
2011/12	4.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

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

Workforce Report

Current Month **Apr-11**

Trust Summary

Employee Relations Data

	Attendance	Grievances	Capabilities	Discipliary (Clinical)	Discipliary (Non Clinical)
Current Case Total	541 (551)	13 (16)	2 (2)	2 (3)	21 (26)

Current Employment Tribual Cases	15 (16)

Current Suspensions	7 (11)

Narrative

The figure for the previous month appears in brackets.

Attendance
Reporting issues now believed to be resolved

Capabilities
Taking into account the size of the total workforce, this figure continues to be very low.

Disciplinary
The ratio of clinical to non-clinical cases remains low.

Employment Tribunal
During April one new claim were lodged and two claims were withdrawn by the Claimants.

Suspensions
The longest suspension dates from the end of October. The hearing for this case was scheduled and postponed at the member of staff's request. A new date is being arranged.

Workforce Report

Current Month **Apr-11**

Trust Summary

PDR Completion Rates

Area / Directorate / Dept	No. to be done	No. done	% Comleted
West	1038	1	0.1%
South	1342	0	0.0%
East	1074	21	2.0%
Control Services	453	1	0.2%
Sub Total	3907	23	0.6%
PTS	167	0	0.0%
IM&T	86	1	1.2%
Operational Support	111	0	0.0%
Medical	25	2	8.0%
Chief Exec/Communications	22	0	0.0%
Corporate Services	49	0	0.0%
HR and OD	253	17	6.7%
Finance & Business Planning incl Estates	49	0	0.0%
Sub Total	762	20	2.6%
Total	4669	43	0.9%

NB figures are reset wef 1 April 2011

Date 11 April 2011

London Ambulance Service NHS Trust

BALANCED SCORECARD SUPPORTING INDICATORS

PI Name	Apr 2010		May 2010		Jun 2010		Jul 2010		Aug 2010		Sep 2010		Oct 2010		Nov 2010		Dec 2010		Jan 2011		Feb 2011		Mar 2011	
Care for patients																								
CO1. % of FAST positive patients taken to																								
% of FAST positive patients taken to appropriate specialist centres	0		0	57	90	95	90	95	90	95	90	97	90	97	90	96	90		90		90		90	
CO1. Improved outcome following STEMI																								
% of STEMI patients taken to specialist cardiac centres	90		90		90		90	91	90	93	90	90	90	96	90	91	90	94	90	95	90			
CO1. Increase in survival rates for trauma																								
% of appropriate patients taken to major trauma centres	0		90	96	90	99	90	96	90	96	90	99	90		90		90		90		90		90	
CO1. Survival rate for out of hospital																								
% patients with presumed cardiac aetiology who have a	23		23		23		23	23	23	26	23	25	23	26	23	32	23	25	23	30	23	23	23	
Number of defibrillators in public places CHS	5	0	10	4	17	7	17	9	17	12	20	14	25	22	30	26	34	26	40	42	45	49	53	53
Number of people trained by the Trust under the	10	10	20	24	30	24	40	24	40	42	50	54	60	78	70	85	75	99	85	99	95	109	100	127
Number of people trained to use defibrillators CHS	50	20	100	100	150	164	160	210	160	235	210	315	260	362	300	410	320	474	370	545	420	580	483	654
CO2. Increased use of appropriate care																								
% of complexes with new Clinical Response Model in	0		0		0		0		0		0		1		2		2		3		3		3	
Number of of falls referred to established pathway EW	100	105	100	114	100	120	100	131	100	113	100	137	100	176	100	206	100	223	100	214	100	205	100	
Number of patients referred to a community provider	200	932	200	989	200	1015	200	1088	200	1174	200	1101	200	1346	200	1249	200	1939	200	1594	200	2100	200	
The % of total incidents resolved through CTA, NHSD	33		33		33		33		33		33		33	4	33	4	33		33	0	33		33	
CO2. Increased use of appropriate care																								
End of Life care target - 50% processed in 72 hours SH	50		50		50		50		50		50	98	50	70	50	95	50	91	50	99	50	94	50	100
Patient Specific Protocols target -75% processed within	75		75		75		75		75		75	77	75	100	75	100	75	64	75	93	75	86	75	88
CO3. Meet locally agreed Category C																								
Meet locally agreed Category C (30 minute callback)	90	98	90	97	90	97	90	96	90	98	90	97	90	97	90	95	90	79	90	95	90	96	90	97
Meet locally agreed Category C (60 minute ambulance	90	93	90	93	90	92	90	92	90	93	90	89	90	89	90	89	90	77	90	89	90	90	90	88
CO3. Meet the Category A (8 and 19																								
% Calls answered in 5 seconds ----- PW	95	95	95	93	95	95	95	93	95	94	95	95	95	96	95	96	95	89	95	97	95	98	95	97
% of Category A activation within 45 seconds ------	60	46	60	45	60	45	60	46	60	46	60	63	60	61	60	67	60	46	60	63	60	68	60	65
Achievement of Cat A (19 minutes) ----- CD	95		95		95		95		95	78	95	99	95	99	95	99	95	97	95	99	95	100	95	100
Achievement of Cat A (8 minutes) ------ CD	77	77	78	76	76	75	77		78	100	79	73	77	72	77	74	75	62	77	77	76	81	76	79
AEU mobilisation from station less than 30% ---- CD	30	23	30	22	30	21	30	25	30	29	30	23	30	25	30	21	30	0	30	20	30	18	30	18
Ambulance mobilisation <208sec Average ------ CD	208	104	208	103	208	112	208	114	208	110	208	140	208	234	208	233	208		208		208		208	
Ambulance utilisation of 55% ------- CD	55	72	55	72	55	73	55	72	55	75	55	77	55	78	55	81	55	85	55	80	55	81	55	81
FRU mobilisation <134 sec Average ------ CD	134		134		134		134	86	134	107	134	101	134	105	134	77	134	137	134	78	134	57	134	67
FRU mobilisation from station less than 25% -------	25		25		25		25	26	25	28	25		25	25	25	25	25	23	25	24	25	24	25	23
FRU utilisation of 40% ------ CD	40	40	40	44	40	44	40	43	40		40	46	40	48	40	48	40	55	40	40	40	37	40	38
Job cycle time (incl. hospital turnaround) 66 minutes ----	66		66		66		66		66	64	66	65	66	66	66	67	66	69	66	68	66	67	66	67
Proportion of the year below REAP level 1 & 2 combined	75		75		75		75		75		75	85	75	78	75	69	75		75		75		75	
Staffing total hours produced as per contract (AEU) ----	100		100		100		100		100		100	89	100	100	100	100	100	96	100	95	100	95	100	95
Staffing total hours produced as per contract (All) -----	100		100		100		100		100		100	88	100	97	100	112	100	107	100	112	100	111	100	112
Staffing total hours produced as per contract (FRU) ----	100		100		100		100		100		100	91	100	87	100	95	100	93	100	106	100	105	100	104
Staffing total hours produced as per contract (UC) -----	100		100		100		100		100		100	87	100	108	100	108	100	102	100	115	100	115	100	118
VOR % ----- CV	12		12		12		12		12	11	12	10	12	5	12	12	12	10	12	12	12	12	12	5

BALANCED SCORECARD SUPPORTING INDICATORS

CO3. Meet the Category B (19 minutes)																								
% Category B activation of 90 seconds - JB (PW)	70	62	70	66	70	70	70	70	70	73	70	71	70	69	70	63	70		70		70	74	70	
Achievement of Cat B (19 minutes) - CD		91		92		91	86	93	87	94	93	92	90	90	92	88	94	70	95	84	95	83	95	79
CO4. Meet Health & Safety target																								
Meet Health & Safety target - % H&S incidents reported	35	34	35	34	35	31	35	34	35	36	35	56	38	33	40	36	43	48	45	30	48	35	53	41
CO4. Meet Infection control target -																								
Compliance with guidelines as % of all	85	79	85	84	85	86	85		85	93	85	86	85	90	85	88	85	88	85	91	85	89	85	89
Infection control audits as per plan - complexes to	20	14	20	23	36	36	20	7	20	2	36	52	20	9	20	9	36	45	20	10	20	25	36	36
CO4. Meet patient report form completion																								
Meet patient report form completion target - % PRFs	95		95		95		95		95	99	95	99	95	99	95	98	95	96	95	99	95	98	95	98
Good for staff																								
CO5. Increase in staff confidence levels																								
% of non-operational staff receiving PDR sessions per	90		90		90		90		90		90		90	72	90	72	90	77	90		90	77	90	77
% of operational staff receiving PDR sessions per	0		10		20		30		30		40	39	50	34	60	28	60	47	70	47	80	47	90	47
% of operational staff who have a workplace	0		10		20		30		30		40	10	50	11	60	8	60	8	70	8	80	8	90	8
% of operational staff who have two CPI feedback	95	93	95	116	95	108	95	102	95	113	95	115	95	115	95	113	95	105	95	104	95	104	95	
Complexes with NWoW in place ----- HL	2		2		2		2		2		2		2		2	2	2	2	2	2	2	2	7	2
CPI Completed as % of plan ---- JD + CD	75	93	75	89	75	74	75	80	75	89	75	89	75	84	75	84	75	76	75	74	75	74		
CPI compliance with guidelines as a % of all ---- JD +	95		95	94	95	94	95	95	95	94	95	94	95	94	95	95	95	95	95	95	95	95	95	
CO5. Increase in staff skill levels																								
% of NW0W staff attending NWoW training days ----																								
% of staff attending training courses against places	70	73	70	84	70	79	70	77	70	69	70	70	70	79	70	71	70	67	70	86	70	88	70	80
Number of (not qualified) Student paramedics in training	664	704	664	704	664	704	664	704	664	704	664	695	664	686	664	691	664	684	664	682	664	678	664	676
Proportion of annual priority training commitments	111		111		111		111		111		111	236	111	161	111	120	111	3	111	53	111	75	109	0
CO6 ANNUAL MEASURE. Increase																								
(ANNUAL) Increased proportion of BME staff																								
(ANNUAL) Increased proportion of BME staff recruited																								
(ANNUAL) Increased proportion of BME staff retained																								
CO7. Trust sickness levels																								
Reduce sickness levels across the Trust	5		5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	6	5	6	5		5	
CO7. Improve clinical leadership through																								
Proportion of NWoW complexes with full establishment											4	4	8	8	14	12	14	14	14	14	14	14	14	14
CO7. Lower vacancy rates to 4%																								
Control Services staff vacancy %	3		3		3		3		3	4	3	6	3	5	3	5	3	6	3	5	3	5	3	3
Front-line staff vacancy %	4		4		4		4		4	5	4	5	4	4	4	3	4	4	4	4	4	4	4	4
Support services vacancy %	3		3		3		3		3		3		3	0	3	12	3	12	3	11	3		3	11

BALANCED SCORECARD SUPPORTING INDICATORS

Value for taxpayers																								
CO8. ANNUAL MEASURE Resources ALE																								
ANNUAL ALE score of Excellent	10		15		25		35		40		50		60		70		75		80		90		100	
CO8. More efficient use of fleet																								
% AEU fleet available to operations	88		88		88		88		88	89	88	90	88	89	88	89	88	89	88	88	88	88	88	
Fleet plan - mercedes in fleet	0		1		10		21		30	30	39	39	51	51	63	62	72	65	81	65	89	65	89	
CO8. Reduce carbon footprint																								
% of carbon reduction											50	56	60	63	65	66	75	75	80	75	90	80	100	85
CO8. Reduction in the cost base (CIP)																								
CIP forecast vs plan - year end target is 18m											####	18233	####	18439	####	18439	####	18439	####	18439	####	18439	####	
CIP realised ( )	810		1620		2430		4125		5820	5616	7516	8517	9336	9929	####	11846	####	13120	####	14985	####	16549	####	
CO8. Resources Estates																								
% completion of Estates strategy objectives completed	100		100		100		100		100		100		100	33	100	33	100	33	100	45	100	60	100	60
Estates capital spend as % of plan							30		38	34	47	50	56	58	65	80	74	92	82	93	91		100	
CO8. Resources Financial																								
Capital Cost Absorption rate																								
Capital Resource Limit (CRL)	18		18		18		18		18	17	18	15	18	16	18	17	18	17	18	17	18	16	18	
Control Surplus/ (Deficit)	502		502		502		502		502	526	502	526	502	526	502	526	502	501	502	502	502	502	502	
Cumulative Net surplus	567	250	935	316	1166	1126	1300	1510	1338	1848	1213	1646	1074	1042	948	543	826	(1138)	713	69	607	140	502	
EBITDA %	10	7	9	7	9	7	9	7	9	7	8	7	8	6	8	6	8	5	8	6	8	6	8	
External Financing Limit (EFL)	####		####		#####		####		####	#####	####	#####	####	#####	####	#####	####	#####	####	#####	####	#####	####	
Liquidity Ratio	15		15		15		15		15		15	1	15	1	15	(67)	15	(2)	15	(1)	15	(55)	15	
Net Surplus/(Deficit) - after Impairments	502		502		502		502		502	526	502	526	502	526	502	526	502	501	502	502	502	502	502	
Return on Assets (RoA)	3		3		3		3		3		3	3	3	3	3	5	3	5	3	5	3	5	3	
To process at least 95% of bills by value within 30 days	95		95		95		95		95	89	95	90	95	91	95	90	95	90	95	90	95	90	95	
To process at least 95% of bills by volume within 30 days	95		95		95		95		95		95	84	95	85	95	85	95	85	95	85	95	84	95	
CO8. Resources IM&T																								
CommandPoint - CAD 2010 Milestones - % Complete	42		42		42		50		42	42	59	59	59	59	59	59	67	67	75	75	83	83		83
Target availability CAD environment as a whole	99		99	97	99	99	99	98	99	99	99	100	99	97	99	100	99	99	99	98	99	100	99	96
Target availability CTAK core functionality	100		100	100	100	100	100	100	100	100	100	100	100	99	100	100	100	100	100	100	100	100	100	100

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 24TH MAY 2011

PAPER FOR NOTING

Document Title:	**Infection Control Update**
Report Author(s):	**Steve Lennox**
Lead Director:	**Steve Lennox**
Contact Details:	**0207 7832 299**
Why is this coming to the Trust Board?	**It was agreed by the Trust Board to escalate the reporting of infection control**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Senior Management Group ☒ Quality Committee ☐ Audit Committee ☒ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Other
Recommendation for the Trust Board:	**To note the Infection Control Update**

Executive Summary

At the March Trust Board meeting it was agreed to escalate the reporting of Infection Control. This means the Board will receive the balance scorecard (along with the Senior Management Group) at each Board Meeting and the Quality committee will oversee the delivery of the action plan with updates at each Quality Committee Meeting.

The Balance scorecard enclosed is the scorecard for the end of April 2011. The most recent update will be circulated at the Board meeting.

Areas for highlighting

1. **Hand Hygiene.** This is improving. Compliance is still poor but improving. 18 Complexes have improved (with Friern Barnet improving from 13% to 63%). 7 remaining the same and 1 complex deteriorating (Brent from 64% to 56%).

   The Quality Committee has been asked for a trajectory to act as an indication as to when the issue can be de-escalated. This will be compiled shortly.

2. **Training.** The picture for training is mixed with some complexes (particularly in the South) performing well. The complexes are below their required levels and this is being addressed by the Local Performance Improvement Managers.

3. **Cleaning.** This has improved dramatically. All but 3 complexes are now compliant with the 8 week standard. This is still a focussed area of attention to ensure sustainability is maintained.

4. **Feedback.** Patient feedback is not currently a concern. Sharps incidents will be added to the scorecard as an indication of practice.

5. **Policy.** This remains below standard but again improvements are being seen. However, as the current audits involve bare below the elbows and blanket usage this could be due to improved weather conditions.

Overall the scorecard reveals an improving picture but it is recommended that this remains an escalated issue and the Board receives the scorecard at the next Board Meeting.

Key issues for the Trust Board

Infection Control is a key requirement with care Quality Commission registration.

Attachments

Infection Control Balanced Scorecard for April 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 supports the mitigation of the following strategic risks:

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

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:

Balance Scorecard March 2011 Infection Prevention & Control

IPC Dashboard April 2011

		Hand Hygiene			Training		Cleaning/Environment					Feedback	Policy	
	Complex	Hand Hygiene Hospital	Hand Hygiene Complex	Hand Hygiene Other	Hand Hygiene Training	Infection Control Training	Vehicle Audits (Returns)	Premises Audits (Returns)	Quarterly Audit compliance	Deep Clean	ICT Team Inspection	Complaints Incidents	Uniform compliance	Blanket re-use
Last Date of Data Set		Apr-11	Apr-11	Apr-11	Feb-11	Feb-11	Apr-11	Apr-11	Apr-11	Apr-11	Apr-11	Mar-11	Apr-11	Apr-11
West	Brent	56%				59%		20	85%	95%	100%	0	100%	0%
West	Camden	50%				43%	84	5	84%	75%		0	57%	100%
West	Friern Barnet	63%		25%		62%	8	17	85%	72%		0	50%	0%
West	Fulham	53%				72%	53	45	93%	88%		0	75%	100%
West	Hanwell	46%	83.00%		1%	71%	27	5	74%	100%		0	93%	33%
West	Hillingdon	48%				43%	34	1	81%	80%		0	8%	100%
West	Isleworth	37%				58%	37	36	98%	93%		0	50%	0%
West	Pinner	70%				64%	5	32	94%	100%	100%	0	80%	50%
East	Chase Farm			40%		94%			94%	100%		0	80%	50%
East	Edmonton	63%			1%	61%	17	4	82%	82%		0	29%	100%
East	Homerton	45%				69%	9	12	91%	94%		1	25%	83%
East	Islington	56%				87%		8	90%	100%		0	78%	60%
East	Newham	67%		43%		69%		2	96%	100%	71%	1	59%	100%
East	Romford	45%				62%	99	47	96%	94%		0	20%	0%
East	Tower Hamlets	43%			1%	83%		2	91%	67%		0	59%	40%
East	Whipps Cross	67%			1%	69%	1	3	80%	100%	55%	0	65%	62%
South	Barnehurst	33%				94%	4		84%	91%		0	0%	
South	Bromley	62%				63%			54%	93%	50%	0	63%	100%
South	Croydon	47%				75%		7	84%	90%		0	12%	
South	Deptford	58%				80%		8	94%	80%	75%	0	75%	100%
South	Greenwich	50%		33%		118%	2		87%	93%	100%	0	75%	100%
South	New Malden	24%				71%	97	49	91%	93%		0	41%	
South	Oval	58%		47%		123%		29	94%	100%	75%	0	73%	75%
South	St Helier	61%				80%	13	13	90%	93%		0	50%	100%
South	Waterloo	54%				97%		1	95%	94%	40%	0	44%	0%
South	Wimbledon	71%				67%	10	16	97%	80%		0	100%	75%
LAS	PTS	35%										0	16%	
	COLUMN TOTAL													

LAS TOTAL	Hand Hygiene	Training	Cleaning/Environment	Feedback	Policy

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 24TH MAY 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:	**fionna.moore@lond-amb.nhs.uk**
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 Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☒ Other **Elements of this report have been discussed at CQSEC, Quality Committee CARSG and SMG**
Recommendation for the Trust Board:	**To note the report**

Executive Summary/key issues for the Trust Board

Safety:

1. 5 new SIs declared, 1 relating to delay in attending a patient involved in an RTC; 1 relating to the assessment of a patient with mental health presentation; 1 relating to delays in attending a patient on the High Risk Register and two relating to ambulances (one fire and one which ran out of fuel).
2. Update provided on the review of implementing changes to the High Risk Register procedure.

Clinical and cost effectiveness:

1. CPI performance now at 84% for the last month (January). Target 95%. 13 Complexes achieved 100% and 16 achieved 95%. Feedback targets for the year to date exceeded.
2. Update on the initial LAS Research Conference, on progress with the ISRAS and SAFER 2 studies.
3. Summary of findings from cycle 5 of the national Clinical Performance Indicator (CPI) report

Governance:

1. Limited assurance provided on the management of medicines, including both Controlled and General Drug issues. 2 incidents relating to Controlled Drugs reported.
2. Feedback provided from the progress made by the Medicines Management Group

Attachments

Main report with 1 appendix (Clinical Audit report on cycle 5 of the national CPI report

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Strategic Goals 2010 – 13

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Risk Implications

This paper supports the mitigation of the following strategic risks:

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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 24th May 2011

Clinical Quality and Patient Safety Report

Safety

1.1 Update on Serious Untoward Incidents (SIs)

Five new SIs have been declared since my last report in March. One of these related to delays in attending a cyclist involved in an RTC who subsequently died. One to a delay in attending a patient identified as being on the High Risk Register. One to a patient who presented with mental health issues, was assessed on two occasions but not conveyed. Sadly he was subsequently found hanged. The other two relate to ambulances; one where an ambulance caught fire and one where a vehicle ran out of fuel while conveying a patient with chest pain (there were, in addition, clinical concerns around the handover in this case.)

.

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.

14 alerts were received from 14th March - 10th May 2011. All alerts were acknowledged; one, relating to insulin passports is being assessed for relevance.

1.3 High Risk Register

The High Risk Register remains a significant risk to the Trust. The Head of Management Information has headed a review of the implementation of the new procedure which will evidence reasons for inclusion on the register. Progress is as follows:

1. 25/26 station complexes have been visited. The final one is next week. Each station has been trained in the new procedure, received the new forms and re-categorised the existing High Risk Register request form (LA277). Where appropriate forms for review have been left with the station for them to carry out further investigation.

2. Some stations still have these reviews outstanding. However a target to return the forms within 6 weeks of the meeting has been set and outstanding reviews are being followed up. A few stations are still using the old forms despite requesting them not to do so. In the event that they use the old forms these are returned to the station for transfer onto the appropriate form.

3. To date seven complexes (Chase Farm, Tower Hamlets, Deptford, Hanwell, Camden, Friern Barnet and Brent) have specified a specific HRR champion to assist with the process. The Assistant Directors of Operations have been

asked to encourage other Complexes in their Areas to assist in identifying champions.

4. There remain a few outstanding queries where stations have categorised the LA277 incorrectly and these have then been returned to the complex, for review and return to Management Information. As an example of good practice the West Area detailed their staff officer to assist with this process. This has been very successful as it is very time consuming to continually chase outstanding queries.

5. The next stage will be to start writing to the addresses. The plan is that Management Information team request the HRR champion to come to Bow to review all the recent LA277s and carry out a "mini" review on each one. The HRR champion will then be asked to confirm that they are happy for letters to be sent to all the addresses on the register. This will take some time to roll out as there is only one member of staff in MI for this task but the plan is to start this next week with Chase Farm, followed by Tower Hamlets.

Clinical and Cost Effectiveness

2.1 Clinical Performance Indicator completion and compliance

The current target for CPI completion is **95%.** The most recent figures (March) show an overall completion rate of **84%** which is a marked improvement on the previous months. In addition sixteen Complexes achieved over 95%, and thirteen achieved 100%. The East Area achieved their highest overall completion this year, with 5 out of 8 Complexes achieving 100%, and were the only Area to meet the 95% completion target for any CPIs. The East Area also achieved their highest completion this year to the Non Conveyed and 1 in 20 CPIs.

Diagram 1. CPI completion November 2010 to March 2011

Area	Nov.	Dec.	Jan	Feb	March
East	86%	87%	71%	83%	92%
South	77%	62%	69%	64/%	79%
West	92%	83%	83%	77%	82%
LAS	**84%**	**76%**	**74%**	**74%**	**84%**

In terms of **compliance** (the appropriate documentation of aspects of care or valid exceptions to care) the LAS, South and West Areas achieved at least 95% compliance to 6 out of 7 CPIs. The LAS as a whole needs to improve compliance to the Non Conveyed CPI, as this is consistently the CPI with the lowest compliance rate across the Service.

The East Area achieved at least 95% compliance to 4 out of 7 CPIs and had the lowest compliance of all the Areas to the ACS, Difficulty in Breathing and Non Conveyed CPIs. However, 7 out of 8 Complexes in the East Area achieved at least 95% compliance to the Glycaemic Emergencies CPI.
The South Area achieved their highest compliance this year to the Cardiac Arrest and 1 in 20 CPIs, at 98% and 97% respectively, with all but one Complex in the South Area achieving at least 95% compliance to the Cardiac Arrest CPI.

In the West Area, at least 95% compliance was achieved by 7 out of 8 Complexes to the Cardiac Arrest and Stroke CPIs and by all Complexes to the Glycaemic Emergencies CPI.

Croydon, Greenwich, Hanwell and **St. Helier Complexes** were the only Complexes to achieve at least 95% compliance to all 7 CPIs, while 100% compliance to any of the CPIs was only achieved by **HART** and **St. Helier Complex**.

The LAS and the West Area managed to exceed their **feedback session targets** for the year.

The East Area increased the number of feedback sessions undertaken in March and exceeded their monthly target but failed to quite meet their target for the year. While the South Area increased the number of feedback sessions undertaken in March, they did not meet their monthly target or their feedback session target for the year.

City & Hackney Complex undertook nearly 3 times more feedback sessions than their expected target this month, while **Brent, Camden, Edmonton, Fulham, Greenwich, Hanwell, Isleworth, Pinner**, **Romford** and **Whipps Cross Complexes** completed the next highest number of feedback sessions in March.

2.2 Clinical Update

2.2.1 LAS' First Annual Research Conference

On 4th May 2011 the Trust hosted its first research conference 'from Research to Clinical Practice; how Research in the LAS influences patient care'. No other ambulance service in the UK has held such an event. Presenters included Professor Douglas Chamberlain, delivering a lecture on the history of Ambulance Services in the UK, research collaborators from Universities and Hospitals across the UK as well as the Medical Director of the Emergency Medical Services, New York Fire Department.

83 members of LAS staff attended, of whom 50% were front line staff, in addition to Clinical Tutors and members of the Medical Directorate. Feedback has been very positive and we hope that this event will be repeated on an annual basis.

2.2.2 Stroke and Falls

ISRAS trial (ROSIER):

At the meeting of the National Institute for Health Research with the Thames Stroke Research Network on 10th May the LAS won an award for the ISRAS Study for the highest recruitment to a single study. Furthermore, the LAS is placed the third highest recruiting site for stroke research within the Thames Stroke Research Network, just behind UCLH and Oxford Radcliffe (an excellent result considering the size and resources of the other two organisations).

SAFER 2 (NIHR funded multicentre study evaluating the impact of falls protocols).

An LAS paramedic has been recruited as Research Support Officer to drive forward the training and implementation of this study. Although the LAS has recruited a significant number of paramedics to the study we are lagging behind the Welsh

Ambulance Service and East Midlands Ambulance Service in rolling out the pilot study.

2.2.3 Emergency Response Vehicle

The issue of extending the drugs available to staff from the Emergency Response Vehicle, (known locally as FR81) to include the treatment of patients with aspirin and salbutamol, was raised at the Clinical Quality, Safety and Effectiveness Committee in March. This vehicle is crewed by Community First Responders trained to the First Person on Scene FPOS (Intermediate) course, the majority of whom are serving with either the Royal Air Force or the Police. Members of the Committee wished to ensure that the views of the public had been sought before recommending that the LAS support this change

The Director of Health Promotion and Quality attended the Hillingdon Overview and Scrutiny Committee on 26th April. Previous minutes are freely available online and to the public via the Hillingdon Council Website under the Health Scrutiny Minutes where the issue and role of FR81 is discussed openly. Indeed the scrutiny commission meeting is open to the public and is well attended and in the 2 years FR81 has been operating the local AOM has not received a single enquiry about it. Further to that in 2010 Hillingdon Council sponsored FR81 and purchased the vehicle they use to perform their duties. The car is dual badged as working in partnership with the LAS but the predominant badge on the car is that of the Hillingdon Council crest making it clear that the council has funded the operation of that vehicle. This would suggest that there must have been due process involved and again public involvement.

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 from Cycle Five of the National Clinical Performance Indicators is included under Appendix 1.

The National Clinical Performance Indicators (CPIs) measure and compare the care provided to patients by the twelve ambulances services in England. They focus on five clinical areas: ST-elevation myocardial infarction (STEMI), Cardiac Arrest, Stroke, Hypoglycaemia and Asthma.
The issues highlighted in this summary reflect, in particular, the need to focus on recording pain relief in STEMI, appropriate referral of patients left at home following treatment for hypoglycaemia and capturing the initial oxygen saturation levels in patients treated for asthma.

Governance

3. Update on Medicines Management.

There has been no meeting of the Medicines Management Group since the last report to the Trust Board. The first meeting of the MMG for 2011 / 12 is due to take place on 18th May 2011. Thus this part of the report remains unchanged from that submitted in April 2011.

Incidents involving Controlled Drugs (CD) and other drugs. Central Alert System (CAS)

Since the last report there have been two reported incidents involving Controlled Drugs (CD), no incidents involving other drugs and no alerts via the CAS system involving drugs.

One incident involves a possible break in at Bounds Green Ambulance Station, on 11th April 2011, and the theft of four ampoules of morphine sulphate. (No other equipment / items are reported stolen / loss during this incident).

A paramedic returning to Bounds Green Ambulance Station reported finding the main entrance to the station open and the door to the CD Safe open. Upon checking the CD Register against the stock in the CD Safe it was discovered that four ampoules could not be accounted for. Potentially there were fifteen ampoules in the safe that could have been stolen / taken. The Metropolitan Police were informed immediately and are conducting a burglary enquiry via the local CID unit. The LAS Accountable Officer has ensured that the Metropolitan Police Controlled Drugs Liaison Unit has been informed, and they will assist both the CID and LAS internal investigation(s). Investigations are currently still ongoing with no obvious culprit identified. It has to also be considered that this is some form of cover up for an earlier mistake – though the evidence for this is very circumstantial.

The second incident occurred on 10th April 2011 at Fulham Ambulance Station, and the possible loss of an ampoule of morphine.

In this incident a DSO accessing the CD Safe in the morning noticed that there was an ampoule of naloxone in the CD Safe. This therefore made the count of ampoules wrong. Investigations were undertaken and there was no explanation as to where the ampoule of naloxone had come from, or any evidence to suggest who might have placed it in the CD Safe. The Metropolitan Police at Fulham were informed, as well as the Met Police CD Liaison Officer for the LAS. At the time of writing this report the matter has not been resolved and enquiries are still ongoing.

Update on "The Kent Incident"

This incident is being reported on to the Board much more fully through the 'Learning from Experiences' Group. However, it is apposite to report here that two major learning points from this incident in terms of medicines management are that:

- The LAS must look at denying access to drug stores, both CDs and "general drugs", through the use of swipe card access linked to a CCTV system and better station security.

- The LAS is costing a system that would use a separate bag to contain the drugs diazepam, (both IV and rectal), and oral morphine. This bag would be signed for in a separate register, but the bags could be contained within the CD Safes. All the other drugs both "general" and "paramedic" would, for the foreseeable future, continue to be packaged in their current bags. The cost of this system would be in the region of £7.5K - £10K. However this still needs further consideration, in order to ensure that any implementation dovetails with future requirements for drug bags.

Peer Audit of CD Processes

The South Area has been trialling a system of peer review of each others' CD processes. In essence this means that one Station Management Team will audit another Complexes' CD management system, very much in the manner of the Metropolitan Police unannounced visit system. Due to the success of this trial, it is envisaged that this will be rolled out across all Complexes in the near future.

Met Police CD Liaison Officer Team (CDLOT)

The Senior Clinical Adviser to the Medical Director met with Detective Sergeant Dancy of the Met Pol CDLOT on 10th May 2011. This meeting was to discuss how the unannounced visits would be conducted over the following twelve months. Also discussed were the issues highlighted from the Kent Incident.

The possibility that the Met Pol CDLOT could present at paramedic training sessions, Senior Managers and Managers Conferences, to highlight the issues around CD management was raised. An e-learning package could be put together for use via the LAS e-learning website. Mr. Whitmore will take these discussions forward with the appropriate LAS Departments.

Overall cost of LAS drugs budget

The Head of Procurement and the Senior Clinical Adviser to the Medical Director are continuing to work with our pharmacy supplier – Frimley Park Pharmacy to see where savings can be made on the costs of medications. In addition they will be doing further work to prepare a tender proposal for medicines supply to the LAS within the next 18 months, (the current contract with Frimley Park Pharmacy is drawing to its end).

Patient Focus

The Medical Directorate will assist the FT membership team in the London Ambulance Service Emergency Stroke Care Event 'An evening with us' on Tuesday 24th May, demonstrating our progress in identifying stroke patients and conveying those with the resent onset of symptoms. As with the cardiac care evening a patient who suffered a stroke will tell their story and link this with the LAS and London Stroke Network strategy.

Accessible and Responsive Care

Nothing further to report

Care Environment and Amenities

6.1 Infection Prevention and Control Update

This item is covered under a separate agenda item.

Public Health

Nothing further to report

Recommendation

That the Board notes the report

Fionna Moore,
Medical Director

16th May 2011

Appendix 1

Clinical Audit & Research Summary Reports for the Trust Board

National Clinical Performance Indicators: Summary of Findings from Cycle Five

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

Introduction

The National Clinical Performance Indicators (CPIs) measure and compare the care provided to patients by the twelve ambulances services in England. They focus on five clinical areas: ST-elevation myocardial infarction (STEMI), Cardiac Arrest, Stroke, Hypoglycaemia and Asthma.

Results

Despite improvement following the awareness campaign, when compared to other ambulance services, the LAS continued to perform poorly when administering analgesia (morphine and/or entonox) to STEMI patients. The Service also saw a decline in the percentage of patients receiving aspirin and glyceryl trinitrate (GTN). In May 2010 the Service recorded oxygen saturation for 100% of this patient group, improving on the high standard set in cycles three and four, when this pilot indicator was introduced. The decline in pain management meant that when care provided to STEMI patients was assessed as a whole, the LAS ranked eleventh out of the twelve ambulance services in England.

In June 2010 the LAS continued to have proportionately more patients in cardiac arrest with return of spontaneous circulation (ROSC) sustained to hospital, than most of the other ambulance services. Despite this the LAS remains within the bottom three ambulance services for the level of overall care provided to patients in cardiac arrest. This is due to the low number of patients for whom an advanced life support (ALS) provider was in attendance and those reached within the four minute target.

The July 2010 cycle five data for stroke patients showed a decline in the percentage of patients who had their blood glucose and blood pressure recorded as well as those for whom FAST (face arm speech test) was documented. The Service remained average or above compared to other ambulance services for these indicators, but dropped from ranking first and second place in cycle one. The percentage of patients for whom time of onset of stroke was recorded varied greatly across the different services; this is an area of care the LAS should explore as knowing time of onset could greatly affect the stroke referral pathways for patients (introduced in 2010). The Service continued its quality improvement activity for this patient group introducing the LAS stroke CPI, stroke database, and participating in the national ‘Know Your Blood Pressure’ campaign.

August 2010 data for hypoglycaemia patients showed an improvement in the percentage for whom treatment was recorded, following a steady decline since cycle one. The decline in percentage of patients for whom blood glucose was measured, both before and after treatment, continued. Since the cycle three introduction of direct referrals as an indicator, when the LAS ranked twelfth, the Service has

progressed to eighth place; however the percentage of patients directly referred has reduced.

The fifth cycle of data, collected from September 2010, continues to show the Service as one of the best in the country at recording respiratory rate and peak flow before treatment, for asthma patients. In cycles four and five the LAS ranked twelfth for recording oxygen saturation before treatment, despite this being introduced as a compulsory observation on the new patient report form (PRF). The percentage of patients administered treatment, beta-2 agonist and oxygen has also declined since the cycle three introduction of these indicators. This has had an impact on the overall care the patients received, which has also declined.

Summary

On the whole the Service is doing well in the overall care provided to stroke and asthma patients. Worryingly, over the five national CPI cycles, the LAS performance has declined compared to other ambulance services. Improvements are needed in the care provided to STEMI patients, particularly in relation to pain management. The Service should further investigate direct referrals for hypoglycaemia patients. Staff should also be encouraged to document the time of onset of stroke if known, as this will help inform their decision regarding which stroke pathway to follow.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

24 MAY 2011

PAPER FOR DECISION

Document Title:	**CommandPoint Update**
Report Author(s):	**Peter Suter**
Lead Director:	**Peter Suter**
Contact Details:	**peter.suter@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**Decision for the Trust board to authorise the transition to CommandPoint.**
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
Recommendation for the Trust Board:	**The Trust Board is asked to:** • **accept the contents of this report.** • **give authority to proceed with transition to CommandPoint as planned.** • **delegate authority to the Deputy Chief Executive to oversee the actual transition on behalf of the Trust Board**

Executive Summary

The project remains on track for go live on 8 June 2011. There are two papers attached;

- Update from Project Executive, including the request for authority to proceed.
- Report from the consultant providing independent Project Assurance, specifically referencing the Page report. The conclusion is supportive of the project proceeding to go live.

All the system testing has been completed satisfactorily, outstanding bugs are appended to this report. All planned training has been completed successfully. Updates on both of these aspects of the project have been regularly reported to the Trust Board.

Key issues for the Trust Board

To be satisfied that the project is ready to go live.

Attachments

CommandPoint Project Update – May 2011
CommandPoint Project Assurance Report

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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:

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

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:
None.

COMMANDPOINT PROJECT UPDATE: MAY 2011

1. OBJECTIVE

1.1 The objective of this paper is to seek authority from the Trust Board to proceed with Transition to CommandPoint as planned on 8 June 2011.

2. SUMMARY OF CURRENT POSITION

2.2 In line with previous reports, the project is currently on track for go-live on 8 June 2011. All the system testing has been completed satisfactorily, outstanding bugs (at the time of producing this report) are appended to this report. All planned training has been completed successfully. Updates on both of these aspects of the project have been regularly reported to the Trust Board.

3. TRANSITION PREPARATION - DRY RUN SCHEDULE

3.1 The aim of transition is to ensure a successful technical and operational migration from the live operational use of CTAK to the live operational use of the new CommandPoint CAD system. To maintain operational use over a period of time and at a level of performance sufficient for the LAS Trust Board to formally agree the 'Acceptance' of the new system from the project.

3.2 Part of the transition planning has been a series of dry run events to practice all aspects of the transition. These are briefly detailed below:

Dry Run A	Initial Tabletop exercise for the Gold group
Dry run B	Interface cutover and roll back at bow. CommandPoint brought live in Bow and either connected to live interfaces or simulators.
Dry run C	Cutover and rollback in HQ while EOC ran on paper. All technical aspects of system actually connected together in the live environment. The technical cutover and rollback scripts were performed within the time allowed in the schedule. In fact the room was returned to CTAK operations earlier than planned. Alongside the technical rehearsal a linked Gold command group table top exercise also took place, rehearsing the communications between these two important constituencies during cutover.
Dry run D*	Simulated live running in Bow with E watch – this being the first live use dry run with staff operating CommandPoint. This involved mirroring live calls taken in Waterloo in inputting them in CommandPoint at Bow. A key result from this event is that the call taking part of the simulation were able to keep up with their colleagues working on CTAK, and put in a 'call-connect to determinant' mean performance of 98 seconds; very close to the average performance in the control room. Usual statistics health warnings apply here, small sample of call handlers and calls, but never-the-less a very encouraging result
Dry run E	Table top exercise for both Gold groups.
Dry run F	The full dress rehearsal, event F, is scheduled for the night of 16th into 17th of May. This is with E watch who will actually take the system live on 8 June.
Dry run G	G1/G2/G3 – control room dry run – based on dry run D
Dry run H	Interface cutover and rollback at HQ.

3.3 Following the success of dry run D*, and the evident value the control room staff took from it, the project is running another 3 of these events during May to be offered to A, B and C watches as dry run event G. These watches are not currently involved in formal dry runs. These 'sand-pit days' will give them an opportunity to practise their call taking and dispatch skills for far longer periods than the 20 minutes allowed in skills maintenance and should be a great confidence booster, as well as providing more go live readiness in the control room staff.

4. GO LIVE ASSURANCE

4.1 Go live assurance to the Trust board is made up of a number of different aspects:

- Regular reports to the Trust board
- Gateway reviews
- Independent assurance from Carrie Armitage
- Independent assessment of lessons learnt from the Page report.
- Details of outstanding faults, risks & issues as appended to this report.
- Project planning - Readiness review checklist, detailed transition plans – both technical operational.
- Assurance from Senior Users.

5. RISKS & ISSUES

5.1 Current risks with a high impact score are outlined in appendix B, together with the mitigating actions. The project team are satisfied that all risks are sufficiently mitigated to provide go live assurance, but a final update will be given at the Trust Board meeting.

5.2 Those issues remaining with critical or major impact are outlined in appendix C, together with resolving actions. Again, the project team are satisfied that all issues are sufficiently resolved to provide go live assurance.

6. OUTSTANDING BUGS/OBSERVATIONS

6.1 All outstanding bugs and workarounds are outlined in appendix D There are no outstanding P1 or P2 bugs. The outstanding P3 & P4 bugs have all been graded, as previously described, from 1 to 9 (highest impact) and there are workarounds in place for all of them.

6.2 The senior users have reviewed all the outstanding bugs and are satisfied that;

- it is safe to go live with the known and accepted bugs
- the workarounds are appropriate
- the sum of the outstanding bugs and workarounds do not make the system unusable.

6.3 The lead Senior User will be in attendance at the Trust Board meeting to address any questions that the Trust Board may have.

7. SUCCESS CRITERIA

7.1 The overall success criteria will be the ability to transition to CommandPoint and stay live without the need to cut back to CTAK. This will be set in the context of maintaining patient safety, meeting operational performance targets for CAT A and maintaining similar performance for CAT C to that previously recorded prior to Transition.

8. BUDGET

8.1 The project remains within budget. High level details are provided in the table below.

£000s	FBC Approval (Issue 3.1)	Budget Adjustments	Revised Budget	Previous Years Spend	Current Year (2011/12)		Total Project	
					Spend	Forecast	Spend	Variance
Capital								
Northrop Grumman Costs	8,315	1,018	9,333	8,717		617	9,333	0
LAS Costs	5,897	(41)	5,855	5,125		517	5,642	213
Total Capital	14,212	977	15,189	13,842	0	1,134	14,975	213
Revenue								
Northrop Grumman Costs	1,493	(375)	1,118	1,118			1,118	(0)
LAS Costs	4,592	(1,252)	3,340	2,241		468	2,709	631
Total Revenue	6,085	(1,627)	4,458	3,359	0	468	3,827	631
Project Board Budget	**20,296**	**(650)**	**19,647**	**17,201**	**0**	**1,602**	**18,803**	**844**
Contingency	5,228	(792)	4,437	0	0	0	0	4,437
Total	**25,525**	**(1,441)**	**24,083**	**17,201**	**0**	**1,602**	**18,803**	**5,281**

9. RECOMMENDATIONS

9.1 The Trust Board are asked to accept the contents of this report.
9.2 To give authority to proceed with transition to CommandPoint as planned.
9.3 To delegate authority to the Deputy Chief Executive to oversee the actual transition on behalf of the Trust Board.

Peter Suter
Project Executive
Director of Information Management & Technology

Appendix A: Milestone Progress

CommandPoint- High Level Milestone Plan			
Description	**Deliverables**	**Plan Date**	**Progress/Rev**
User Acceptance Testing	Complete second iteration	22/10/10	Complete
Pilot Course	Running the pilot courses for End Users. These will trial the course content and training material. Following completion, the training materials will be finalised.	29/11/10	Complete
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	Complete
Gateway 4	Full gateway review to assess readiness to go live	TBC/3/11	Complete
Release 1.1	Release 1.1 used in training.	22/2/11	Complete
Dry Run Event A	Gold group table top exercise	10/3/11	Complete
Dry Run Event B	Interface cutover and rollback from Bow	23/3/11	Complete
Dry Run Event C	Interface cutover and rollback from HQ with simultaneous Gold table top	13/4/11	Complete
Dry Run Event D	Live use dry run with first live use watch from simulators at Bow	20/4/11	Complete
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	Complete
Final preparation	Final technical and operational preparations for transition to CommandPoint.	21/4/11	Complete
Dry Run Event E	Further Gold and shadow Gold table top	10/5/11	Complete
Dry Run Event F	Full control staff dress rehearsal at Bow	16/5/11	Planned
Dry Run Event G1	Control staff sandpit dry run	18/5/11	Planned
Dry Run Event G2	Control staff sandpit dry run	25/5/11	Planned
Dry Run Event G3	Control staff sandpit dry run	31/5/11	Planned
Dry Run Event H	Interface cutover and rollback from HQ	2/6/11	Planned
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	TBC	

	CTA. The details of this work and timetable have yet to be specified.		
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.	30/9/2011	

Appendix B: Most Significant Risks

Risk Id P / I	Title	Owner	Description	update	Overview
105 4 / 4 **Target:** **0 / 0**	Met CAD Interface	John Downard	There is a risk that Northrop Grumman encounter unforeseen difficulties during the development and testing of the Met CAD interface, resulting in a need for additional unplanned development work, causing time and/or cost overrun.	04/05/11	Complicated interface to test due to the coordination required between LAS and Met. Police. Progress to date: • SIT tests validated that events can be sent to and received from CommandPoint and Met CAD • Network changes made by Met CAD firewall • Initial interface test run on 04/05/11 Still outstanding: • Full integration test between CommandPoint and Met CAD • Met CAD test not submitted to LAS • Met have not signed off LAS test scripts. An area of concern due to the late testing of the interface in a close approximation to the production environment.
128 3 / 4 **Target:** **0 / 0**	New workstation layout not acceptable to staff	Jonathan Nevison	There is a risk that the workstation layout for CommandPoint is not acceptable in terms of health and safety by the staff, requiring a re-evaluation and re-configuration of the layout causing a time and/or cost overrun.	04/05/11	• 24/03/11 DSE Assessment by Health & Safety • Final Report produced 28/04/11 • Initial concerns identified: 1. Potentially excessive lateral head movement for three screens. 2. Some ICCS terminals are not near enough to reach without using arms at full length • **6/4 meeting at Bow with SBFI to assess requirements. EOC not considered a risk by SBFI due to the size of desks. FBC requires changes to monitor arms.** ICCS terminal positions need to be in the correct place or extended monitor arms used and CAD monitors left at head height when the re-fit takes place in May.

Risk Id	Title	Owner	Description		
P / I				**update**	**Overview**
072 **2 / 5** **Target:** **2 / 4**	Inadequate / insufficient end-user training	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)	15/03/11	The capability of users will not be fully appreciated until full live use. To mitigate against this, a comprehensive training package has been initiated: • Extensive functional training for all users • Maintenance skills training • Refresher course planned • Constant monitoring of feedback for courses from users, managers and staff side has led to minor reviews and amendments to the training approach • Control room staff at Cut Over and go Live involved in dry run events for further exposure • Sandpit at Bow for A,B and C Watches to be planned. • Aspiration to give all staff some “Dry run” experience to live calls. The scale of continued attention to training quality and efficiency, over many months, reduces the probability of the risk to low. However, the impact, should the risk occur, is recognised as being more difficult to determine. The eventual numbers of well trained staff and expert support results in the target impact score of 4 (High)

Risk Id P / I	Title	Owner	Description	update	Overview
78 **2 / 5** **Target: PB accepted risk 28/04/11**	Failure of new CAD system during implementation	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.	15/04/11	Significant work has gone into testing. However, no matter what scale of testing is done there remains a residual risk of failure at Cut Over and go Live. Activities that have occurred thus far: • FAT (Factory Acceptance Testing) for several releases. • SIT (Site integration testing) for several releases. • Extensive UAT (User Acceptance testing) in both test and training environments • Protracted use within the training environment • Dry run exercises against both FBC and EOC environments The risk to the project remains because 2 priority 2 (High) known bugs exist which are being addressed and are subject of late patches Whilst effort is applied to reduce the probability of this risk, the impact cannot be reduced and will always be Very High.
119 **2 / 5** **Target: PB Accepted risk 28/04/11**	Significant Service Impact Interrupts or Delays Implementation	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.	13/12/10	Producing a contingency plan for the period prior to the advertised go live date.(For example a major incident just before go live). Request made to EPU for planned events around Go Live dates. **Outstanding on the Contingency plan:** • Refine the detail in the Transition Stage Plan so that we can accurately predict what tasks need to be re-run and what are still to be done and how long they will take (In actual time). • Estimate what contingency there is in the elapsed times. • Before implementation of CommandPoint, determine the expected values of the delaying factors.

Risk Id P / I	Title	Owner	Description	update	Overview
92 **3 / 3** **Target: PB Accepted risk 28/04/11**	Loss of key personnel	Jonathan Nevison	There is a risk that key personnel may become unavailable due to unforeseen events, for example accident or illness, causing a lack of knowledge and capability in areas crucial to the success of the project, resulting in delay to the project whilst a replacement resource is identified and recruited.	11/03/11	Risk probability increased due to MDT aspects now in scope and single point of expertise – mitigated by additional resource sharing and shadowing. • Technical team shadowed each other during Dry Run Events B and C for the Cut over activities. • Technical scripts produced and in a common environment for all in team to use. • Technical Rotas being defined and agreed that reduce the single points of failure caused by individuals working excessive hours.
117 **3/3** **Target: 2 / 3**	Activities in Control services are not compliant with CommandPoint processing requirements	Fiona Carleton	There is a risk that the working processes in the dispatch or call taking functions of the Emergency Operations Centre (EOC) do not align with those required by CommandPoint (For instance to accommodate the Fast Response Unit (FRU) Desk activities on Dispatch Groups) causing a delay to the date of Go Live, causing a cost and time overrun.	31/03/11	The Plan is to adopt new layout of the room, new working processes and new language as of 4th May • Additional ICCS positions requested by Project team. Unlikely to be granted. • 6th South pilot run and reviewed with CommandPoint PM. • Have recommended a “mode” for working that is being actively consulted on. • Future Proofing Dispatch Working group meeting fortnightly. • CSCB group meeting regularly, with CommandPoint project represented at the meeting. All CTAK changes being logged. • Agreed change control protocol for CommandPoint. Probability needs to aim for a 2 for this risk to be accepted by the project before cutover.

Appendix C: Most Significant Issues

ID	Title	Impact	Owner	Description
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. This has potential patient safety implications. There are also a number of other less significant MDT issues that together contribute to a serious functionality issue between MDTs and CommandPoint. **All fixes will be applied to MDT 1 and 2 before go-live**
120	Performance Testing of Northgate XC Router	Critical	John Downard	The Northgate XC Routing Server has failed performance tests at load. **Fixed and tested**
131	Software Patches Not Reflected on CommandPoint Client Image	Critical	Jonathan Nevison	The latest version of CommandPoint software (R1.1.1) has now been tested against the bug fixes, and unfortunately a number of other bugs have come to light. In order to fix these bugs a new release of the CommandPoint client will be required, however the retro-fitted hard drives have already proceeded using the old client version. **Client upgrades are taking place on remaining dry runs.**
129	Dispatch Course Too Short	High	Keith Miller	Student feedback from the dispatch courses delivered at SBR is indicating that the time allowed in the syllabus for the students to assimilate the information on the course is insufficient and that some students are leaving the course not having enough time to meet the course objectives. **Resolved – dispatch course adapted. All missing learning points addressed in maintenance.**
130	Maintenance Training Not Testing Enough	High	Keith Miller	The issue was raised that a group of AOM's within Control Services had a lack of confidence that the current maintenance training regime would adequately prepare staff for the live operation of CommandPoint, particularly in terms of operating the system

				under pressure **Addressed – SMT now redesigned.**
104	Availability of Met-CAD Interface for Testing	High	Les Taylor	Difficulties with Met/CAD LAS interface for SIT testing **Addressed – MET CAD testing nearing completion (verbal update.)**

Appendix D – Open Bugs and Workarounds

ID#	Pri	short_desc	Impact	Notes/Workaround
796	P2	EO - Unable to edit event. States event is not active.	10	Fixed and closed
795	P2	MIS - Acd time not being populated for events when CTI message 3 is received before message 2	10	Fixed and closed
784	P2	Manual Editing EMD data does not send MDT Update	10	Fixed and closed
773	P2	EVA - EMD Tab - Breathing, Conscious and age values not affecting Prioity	10	Fixed and closed
691	P2	Daylight Saving Hours Inconsistencies	10	Fix should be OK - more tests to do.
824	P3	Agency wide DGP setting does not isloate units from auto dispatch and dispatch recommendations when they are assigned to a DGP where agency wide is unchecked	9	Affects management of events and/or major incidents. Logging unit off then on again with auto-dispatch switched off. Resource needs to be made unavailable
826	P4	XEC - ExtCADAstReason value not displayed in event chronology. Coresponding AssistanceReqd value description is incorrectly displayed instead	9	workaround add reason narrative to text in request or in misc comment after
818	P3	EVA - event cancelled by dispatcher whilst EVA still open - Dispatcher only receives first update admin message	9	Commitment to waiting for END to be typed.
816	P3	EO - Incorrect priority displayed on PE monitor when priority is manually changed (not event type) prior to closing the event.	9	workaround on 777 will fix this
814	P4	ED - Remarks Summary Tab displayed unexpectedly.	9	Fix should be OK - more tests to do.
777	P3	Event Type marked for teleserve - TE to Loc DGP - Edit event - call transfers back to teleserve DGP	9	workaround CTA to EOC - CTA change event type and return to EOC - training for CTA.
774	P4	Auto dispatch - Chronology displays incorrect "dispatched as" value when a unit is dispatched for a capability	9	Fixed and closed

731	P3	EVA - Teleserve event type entered with unit assigned - Call Taker unable to update event.	9	Workaround identified and into training (check box and dispatch pick it up)
656	P3	Airwave device not recieving 'Loc Comments' in Dispatch message	9	Escalated to NG as a high priority to fix - to be repaired in patch 3
579	P3	EU - Unwanted tabs displayed in event update which have been removed from ED via CONS	9	Escalated to NG as a high priority to fix - to be repaired in patch 3
779	P3	MDT Update Filter	9	Config Issue
786	P3	IOI info contines to be tagged when reusing an Event Entry form	7	No workaround needed
771	P3	Event Edit - EMD Button remains enabled when edit complete	7	No workaround needed
744	P4	MDT - Dispatch Message - Location Comment pushed onto third line.	7	Joe to insert a field delimiter to repair
723	P3	Event copy - Enter EMD data manually - ED entered event does display EMD tab	7	Workaround identified and into training - simple but does create duplicate ProQA care numbers
801	P3	MIS UAT Issues	6	Not a control room issue
638	P3	Data Integrity - updating an event in DTF can result in old data being updated as new	6	Not a significant issue if the data is entered
822	P3	MDT 2 Defaults to last event screen	5	Joe F to comment
752	P3	ED - Suggestion Panel - AVRR Tab - Proposed units - no qualifiers or capability displayed	5	Info can be accessed from a different tab (AVRR) needs comms through training
751	P3	ED - Suggestion Panel - Resource Def Tab lite incorrectly when awaiting AVRR response	5	Workaround - this is a flase flag that more resources are needed, but the correct information can be seen within the event
749	P3	HPOM did not show message when LVM line stopped	5	Admin/Technical support - no impact on control services
747	P3	DGP - Temp Sector - TCML workstation being assigned allows last user to ASX DGP	5	Allows last user on DG to log out. CTAK works this way now, as long as the event controller has control over it. Workaround not needed.
736	P3	EVA - 2 case numbers (ProQA) issued to the same event	5	No functional implications, therefore no workaround
694	P3	ProQa delivered data not displayed in EMD tab	5	Data in available in ProQA. ProQA tools are available.

587	P3	EVA - Transport Tab - Contact Type - Unable to enter data without a destination	5	Workaround - data needs to go into contact name,# and type fields to dispatch
544	P4	SIT Airwave: Map not centering on Emergency Button	5	Workaround in the room - DIBA returns Googlemap window behind the OCM desk where this is needed.
289	P3	MCFG, PE, Filer By, Available Data Items does not include HoldingFlag	5	Held events are left on the list - no workaround
727	P3	Special Character mapping on the MetCAD interface	4	# shows instead of £ - unlikely to arise in a CAD message anyway
675	P3	Rest Window Remaining Column displays wrong value	4	The value is calculated to the end of the restbreak window - needs a little mental arithmetic
528	P4	FAT 2: MDT not displaing the Chief Complaint	4	Mostly fixed - NFA. Leaves update button hilit before its ready
797	P4	AVRR request - unhelpful message when AVRR finds no units as RSP is already met	3	
742	P3	Roster form lock up if using wildcard search to search for all entries	3	Covered in training - do not use open wildcard to search
735	P4	EVA - EMD Tab - Map reference not populated if ProQA is not used	3	Map reference not to come from EMD
734	P4	EVA - EMD Tab - Map Reference doesn't update when location is changed	3	Workaround in place. Training continue to use geo map reference
725	P3	Data Load Utility Tool - Roster - Cycle length and number of personnel not imported	3	Re-test - should be fixed
702	P3	Situation Plan Step Details, added comments not recorded in chronology	3	Comments appear in plan not chronology. Use misc comments as workaround
701	P3	EMD Tab,Patient Name field,cleared with ProQa delivery	3	Re-test - should be fixed
700	P3	Situation Plan Step Detail - Successful completion of step does not move focus to next step	3	Minimal impact No Further Action
695	P3	Situation Plan Details - Execute form. The execute and undo button sometimes requires 2 pushes to activate.	3	Minimal impact No Further Action
693	P3	EMD tab, Response to Key question field, incorrect data displayed from ProQa	3	Minimal impact No Further Action
692	P3	EMD Tab, Response to Key Questions field, Missing/incorrect data	3	Minimal impact No Further Action

686	P4	ED - Chronology Max form - event segments not in reverse order as defined by DOS EventHistChronology	3	Irritating for user, but the list may be re-sorted as required
678	P3	SMS dispatch messages being received 3 times on mobile phone	3	Not able to re-test, awaiting SMS interface change
658	P3	Only first view of IOI record recorded in the chronology	3	Not capturing review of IOI data - potentially higher safety risk?
594	P4	ED/USUG - docked form not always "on top"	3	Workaround: Manage windows and don't move form
557	P3	RDM execution does not display a corresponding event/unit history segment and comments if present	3	Workaround: Capture action on misc comment
540	P4	UTU command not updating Unit Type on Active Unit status monitor	3	Exceptional - no worksaround required
513	P4	FAT 2: Entire IOI record sent to MDT	3	Potential safety issue (priority not scored appropriately) truncates IOI detail and may hide essential info. Escalated to NG - to be repaired in patch 3.
491	P3	Default Roster's Date/Time/Key Fields can not be changed	3	Cant change end date. Workaround create a new roster and copy to extend it.
799	P3	Startup of CommandPoint client after Restart	2	Khawar working on script for this
780	P3	Questionable location field erroneously populated	2	
764	P4	MET CAD: Single patient has additional empty urgent remarks for 2nd patient	2	Blank urgent remarks not sent to MDT therefore not too big an issue
757	P3	CL and AP commands not working with Easting/Northing	2	No further action
756	P3	ED - Suggestion Panel - Static recommended units not displayed	2	Re-test - should be fixed
755	P3	UQ form status drop down only has ATP, RA or RNA	2	Not current CTAK functionality
720	P3	XC - Status Alert fires incorrectly when event updated (no change of status)	2	Irritation. No Workaround
712	P4	Capability assigned to UNT or AST record - Roster logs on unit - Capability is not displayed with the log on segment	2	Workaround. Don't assign before log on.

707	P4	ED - Dispatch Recommendation - Alternative Units not displayed correctly	2	Refresh of screen when scrolling - colour change.
703	P3	Info record viewed, LID segement added to chronology, unable to query LOC ID number	2	Woraround to view IOI data - runs out after 3 months
685	P4	ED - Chronology - after clock change segments times not displayed in correct order	2	Error affecting display in chronology only manifests on clock change
680	P3	IGP - When executed success message delivered but was not successful	2	Workaround cut and paste macros from gen info
677	P3	Audit trail doesn't record tagged IOI messages sent to crews	2	Sent is assumed OK. Failures are logged.
676	P3	Not all segments recorded as CAD to CAD with filter	2	Filter inconsistent. Workaround - locate by sorting.
672	P3	Trigger to send email of updated event to assigned units not firing	2	Email dispatch is not used.
665	P3	NOVEH & NOBLS (OOS event) commands not working	2	Workaorund in place
652	P3	HOT mode - Comment added - Cursors moves to EMD Tab, # patients field	2	Workaround, re-position cursor
651	P3	NAE - Trigger 'Command' not firing	2	Not CTAK functionality
647	P3	ProQa case entry - Number patients 'Unknown' - CAD displays 255	2	MDT workaround
640	P3	Dimmed Mapping icon reappears when unit changes to TA	2	Resources dissapearing from map. Zoom out to locate
635	P3	Unable to filter event chronology on EMD filter	2	Filter inconsistent. Workaround - locate by sorting.
633	P3	IOI Form, Priority is invalid	2	H/M/L priority don't work. Leave priority as event type
609	P4	US Phone Number format on PER	2	Not using
600	P3	UAT: SpellChecker	2	Spell checker inconsistant
599	P3	UAT: AE monitor filter	2	Dodges filter - workaround use sort instead.

597	P3	XC Mapping - Move to feature not updating unit position	2	no work around
595	P3	XC Mapping - Georfences - Message to CAD when resource triggers an exit geofence message	2	Pre-set messages come up instead of NIS text
559	P3	Comments entered with RDM command not stored in event/unit history or sent to MDT	2	per 557 - capture action as a misc comment
555	P4	SIT PerfMon - negative number in availability report	2	IM&T issue
552	P3	SIT Email Unable to send NOT	2	Email dispatch is not used.
546	P3	Notify Icon displays incorrect count after last notfication viewed via Notification Button on ED form	2	Cosmetic - freezes at 1
313	P3	EQ, Event Query Tab, Satus, unable to display DDC	2	Not current CTAK functionality
291	P3	AU monitor, Filter, status, no statuses are available for selection.	2	Filter inconsistent. Workaround - locate by sorting.
280	P3	CAD Configurator - Regions - Windows not positioning as set at logon	2	Window position. Irritation only.
239	P3	Status Notes word wrapping not functioning	2	Not using at go live
231	P3	Caller Address Label is not consistent in EVA and ED forms	2	Cosmetic
223	P3	ViewedFlag on Pending Incidents monitor not in the Filter By tab for selection	2	Filter inconsistent. Workaround - locate by sorting.
825	P4	IOI record sent to MDT sends LOT code and not description	1	locality type code (about 10) which are abbrv get sent e.g., CREWRISK, SAFEHAVN, PALLCARE
827	P4	Erroneous data in the Escorted By field on new version of MDT1	1	Not populated by CAD?
800	P3	MIS Transfer Interval can be up to 4 mins when set to 1 min	1	The MIS is not used for reporting 'live' data and there is a clear understanding that these reports are not up-to-the-minute.
785	P3	No Segemnt History for viewed IOI events	1	not an issue in normal operation

783	P4	Poor Grammar in Roster Failure Alert Message	1	
778	P3	Hold Event Cancel can be executed by Non Controlling dispatcher	1	
770	P4	MDT - Urgent Remarks - all previous messages appended to end of new message with no delimeter between them.	1	Not expected to be an issue in live. No workaround req.
761	P4	LI command with B/ and E/ - Entry in roster is not logged against user in the history tab	1	shows incorrect user name
740	P3	Crew Details not logged for new shift when returning vehicle late back	1	Functionality not used
726	P3	Inavlid date string error when adding a Status Note	1	Status notes not used
724	P4	Auto eventry entry - E911 form - Lat Long should be displayed as Easting and Northing	1	Not used
721	P4	Detailed event print display - Hold for unit and personnel not displaying date	1	Unlikely to print this
717	P4	RAR form closed unexpectantley when removing time periods	1	CAD Config (users wont see)
716	P4	DOS - BetterDriveTime - Value description incorrect	1	CAD Config (users wont see)
705	P4	CONS - Dispatch Recommendation Form - Reset default button not functioning	1	CAD Config (users wont see)
681	P3	DOS params EventNearByTime and EventDupsByTime set to 0	1	Workaround - find by query on date
679	P3	cmd - SIT command - context Yes - event number still required when executing command	1	Enter event number into form rather than auto populate. This is best practise anyway.
671	P4	MDT failure message contains a mis-spelling	1	Typo - cosmetic
650	P4	ES - Tab order excludes 'Urgent Information' check box	1	Use Hot key or mouse
648	P4	A selection of forms eg UH, OPD not controlled by Configurator in Regions	1	Pop up window covers dashboard. Window can be moved.

645	P4	ED - Disposition Tab - Non Convey reason from MDT not stamping Unit ID in Unit column	1	Non-convey comes over as a code
641	P4	EVA - Alt Q moving cursor to Caller field	1	Hot key issue. Alt + Q hard coded
612	P4	Calltaker able to access mon command	1	Workaround - isolated by work station configuration
603	P3	UAT: Alphanumeric passwords	1	Password rules cant be enforced (letters and numbers)
582	P3	CMD - ESA command cannot be copied	1	ESA now named 'BLUE'
577	P4	Configurator - Global Controls - All EMD Tab label names unable to be altered	1	Spelling mistake
537	P4	EMD Tab - DDC for Conscious and Breathing does not contain description for the Value	1	NFA - abbreviations taught on course
533	P4	FAT 2: The DLS activation date not recognised	1	No user sees this
493	P3	MCFG, AU monitor, all filter by options are ignored and incomplete	1	Workaround pre-define filters and leave. Will reset on reboot, (needs 1-2 min to redefine)
481	P4	SRP form assistant drop down should contain code & description only	1	surplus info, not a functional problem
478	P4	LAS Date Forrmat OPT definition default	1	Never seen by users
465	P4	Roster: Additional messages sent	1	Beneficial leaves messages to say users are logging in
461	P4	Auto Dispatch: Incorrect Message	1	Wording a little unclear
438	P4	MDC recall and resend:The SH form entries are not displayed in reverse chronological order	1	Not in common use (OCM) form needs resorting each time you use it.
433	P4	facility Forms & Real Time Transactions: When entering a remark in the FAC form an changing the status of the hospitall to closed, when tabbing out of the status, remarks entered are cleared	1	Complete form in correct order or remarks are deleted. *Emphasise in training
415	P4	Gazetteer:Location information form didnâ€™t close when undocked	1	Need to close both forms

410	P4	Event Display Duplicate: ONS and ENR not displayed on newly create filter type	1	Filter inconsistent. Workaround - locate by sorting.
408	P4	Event Display Duplicate: chronology failed to display the specified segments for the new default activity type code.	1	Filters cant be changed but default is functional
386	P4	CAD to CAD:Map ref stored in correct box	1	Should be fixed - retest
379	P4	CAD to CAD:Request for assistance box cant hold all characters sent	1	Workaround - scroll available
372	P4	Auto Dispatch: message RE auto dispatch	1	Message not clear. Fix expected
359	P4	Date Format:MISTRAIN input agency is not valid"	1	Not an issue - agency not used
358	P4	Performance Monitoring Execution 11/1/10: Display artifact	1	No user sees this
343	P4	CTI Interface: E911 field not long enough for all information	1	Information can be viewed other ways
290	P4	Hold Event for time in future, Display the event. Event status should display HLD	1	Alternative search via EQ
243	P3	Unit Recommendation - not displaying additional capability 'or's'	1	Not current CTAK functionality
234	P3	Drop down list not displayed in DOS AllowMultiLogon	1	Feature not used

May 11

CommandPoint Project Assurance

Prepared by Carrie Armitage

Between 1987 and 1992 the London Ambulance Service undertook to implement a CAD (Computer Aided Dispatch) system. There were in fact two unsuccessful projects both of which attempted to computerise the manual call taking and dispatch processes. After the failure of the second project, an independent enquiry was set up to analyse the reasons for failure. The enquiry was led by Don Page, then Chief Executive of South Yorkshire Metropolitan Ambulance and Paramedic Service NHS Trust and produced a report in early 1993 known as the Page Report.

This report for the London Ambulance Service Trust Board reviews the transition preparation to implement CommandPoint, a replacement CAD system against the recommendations set out in the Page Report. This was one of the recommendations of the OGC Gateway™ Review carried out in March 2011.

2 COMMANDPOINT PROJECT ASSURANCE/1993 PAGE REPORT

Background

Between 1987 and 1992 the London Ambulance Service undertook to implement a CAD (Computer Aided Dispatch) system. There were in fact two unsuccessful projects both of which attempted to computerise the manual call taking and dispatch processes. After the failure of the second project, an independent enquiry was set up to analyse the reasons for failure. The enquiry team was led by Don Page, then Chief Executive of South Yorkshire Metropolitan Ambulance and Paramedic Service NHS Trust and produced a report in 1993 known as the Page Report.

The terms of reference for the enquiry were:

> *"to examine the operation of the CAD system, including:*
>
> *a) The circumstances surrounding its failures on Monday and Tuesday 26 and 27 October and Wednesday 4 November 1992*
> *b) The process of its procurement*
>
> *and to identify the lessons to be learned for the operation and management of the London Ambulance Service against the imperatives of delivering service at the required standard, demonstrating good working relationships and restoring public confidence"*

This report has been commissioned in direct response to a recommendation from the recent OGC Gateway™ Review report: "*The Trust Board should review transition preparation against the Page enquiry recommendations to provide additional assurance".* The report is an assessment of the state of readiness for the London Ambulance Service to implement CommandPoint, a replacement CAD system with particular reference to the lessons learned and the recommendations set out in the Page Report. However, this report has not revisited the procurement process for CommandPoint, which has been the subject of previous OGC Gateway™ Reviews and previous project assurance reports. Nor does this report address the wider Trust management recommendations which were part of the Page Report.

This report focuses on the technical robustness of the product and the operational readiness of the service to go-live with the new CAD system on 8 June 2011 in relation to the lessons learnt from the Page report.

There are major differences between the circumstances prevailing at the time of the 1992 implementation and today:

- In 1992 the plan was to move from a wholly manual system to total automation in one phase. Today LAS already operate a CAD system (known

as CTAK) which was developed in-house and consequently the service has over 20 years of experience in the operation of automated call taking and dispatch systems.

- The 1992 system was considered to be a pioneering new system, which was written specifically for LAS. The proposed new CAD system, CommandPoint is a package solution (which has undergone some bespoke modification for LAS), but nonetheless is implemented in several major metropolitan emergency services in the USA including North West Chicago and Sedgewick County, Philadelphia.
- The 1992 system required changes in the operational method of working for ambulance crews, which is not the case for the introduction of CommandPoint.
- In 1992, according to the Page Report, following a major management restructuring exercise in 1991, there were serious industrial relations problems within LAS which affected staff attitudes to the new system.

Structure of the report

I have grouped the recommendations of the Page Report into three main categories

- Technical problems and failures
- Operational problems and failures
- Project management problems and failures

Technical assurance

The Page Report identifies several areas of technical failure during the project.

a) The software or application was considered to be incomplete with known “bugs” and processes which led to inaccurate or incomplete data.
b) The technical infrastructure, the hardware, computers and servers, on which the application software depended, had not been thoroughly load tested. Indeed the fall back option to a second server had not been tested at all, and subsequently was found to have been incorrectly implemented.
c) There were known outstanding problems with data transmission to the mobile data terminals (MDTs) in the vehicles.

Taking each point in turn:

a) CommandPoint has been thoroughly and rigorously tested at all stages of the project. All releases of the application software have undergone factory acceptance testing (FAT) in the USA by the supplier, Northrop Grumman,

witnessed by LAS test manager and users. The purpose of FAT testing is to test the functionality of an application as opposed to its internal structures and software programming. For this project it has involved running a series of tests on CommandPoint designed to demonstrate that the system will operate as specified by LAS. The output of these FAT tests are a pass/fail status. The test environment was designed to be identical, or as close as possible, to the anticipated LAS environment. The initial FAT tests on the first release of software were started in January 2010 but were delayed by several weeks before achieving a satisfactory pass status. The second sets of FAT tests on Release 1.1 (which is the version of the software which will be at the core of the go-live system) were completed successfully and on time in December 2010.

Following each FAT testing the implementation of the application on LAS hardware in the UK was subjected to extensive site integration testing (SIT) which also tested the interfaces with other systems and applications. All interfaces have been successfully tested with the exception of that to the Metropolitan Police Service.

The final stage of testing is user acceptance testing (UAT) in which users, subject matter experts (SMEs) and the LAS test manager and his team have subjected the application to as close a simulation to real-life usage as possible through a series of structured tests. When problems/bugs are identified these are logged and given a severity rating as defined in the contract. The project has carried out UAT in a systematic and rigorous manner and there is a well documented record and system for managing all bugs and errors with associated fixes and outcomes. The severity rating attached to each bug is agreed by the Senior User and members of the operational team. Currently there are still some priority 2 (P2) bugs which will require fixing prior to go-live. Release 1.1.3 which fixes these P2 bugs has been released to test this week. There is always a risk that a new release may introduce additional new problems and indeed the last release introduced some new P3 bugs. The definition of a P3 problem is one which will not prevent the system from working, i.e. there is an agreed workaround but that it will require to be fixed in an early release post-go-live. A significant number of P3 bugs have been fixed during UAT. At the last Project Board there was some discussion about the more recent P3 bugs there needs to be

agreement on the categorisation and severity of these between the Project Director and the Senior User prior to go-live.

In summary, there are still some outstanding problems with the application – but there is an agreed process for assessment of the severity of any problem and any potential work-around or solution which involves the Senior User and members of the operational team. There is a clear schedule of all known issues and bugs and this forms part of the go-live checklist which will provide the final assessment prior to the go-live decision.

b) The system has also been load tested up to 1100 calls per hour which is at least 4 x times more than the current highest call volumes. The load testing for the Northgate XC routing server is still outstanding but I am assured there are plans in place to load test this server before go-live.

The fall back option to the backup data centre in Bow has been tested and the transition plan takes account of the process for operational fall-back to the Bow facility should this be required.

c) In a separate project MDT units in vehicles have been undergoing an upgrade to new hardware units (MDT2) combined with a MDT software upgrade. New MDT2 units have been successfully tested with CommandPoint.

The Page Report identified that in 1992 there were faults in the “hand shaking” routines between MDTs and the despatch systems where the system could show a different status. Also crews were incorrectly not pressing the correct status buttons.

This issue appears to have re-surfaced during the CommandPoint implementation in a slightly different guise, but nonetheless it must be resolved prior to go-live. It is only a problem with the older MDT1 units and IM&T have provided a software patch which is currently in test to resolve the problem. There remain circa 400 older MDT1 units which have not yet been replaced and which therefore require a software patch upgrade prior to go-live. The aim is to have patched as many of the MDT1 units as possible prior to go-live, but an operational assessment indicates that if there are a few remaining units outstanding (vehicles may be off the road, in maintenance etc) this would not be a show stopper.

In addition CommandPoint requires crews to use some different terminology and a communications plan is in place to address this. However, there still appears to be a certain “them and us” between control room staff and ambulance crews and the Board should consider if all necessary operational and management actions have been taken.

In all there are four outstanding concerns/issues, all of which have plans for resolution, which must be addressed prior to go-live:

1. Interface with Met Police successfully tested
2. Interface with MDT units – Software patch applied to older MDT1 units
3. Successful load testing of Northgate XC Router.
4. All priority 2 (P2) known bugs fixed and tested and an agreed assessment of all P3 & P4 bugs. This assessment should highlight the priority P3 faults which have a high severity grade within the P3 category and an agreed workaround solution for these P3 faults.

Operational assurance

The Page Report identified the following areas of concern during the 1992 implementation. *“Satisfactory implementation of the system would require changes to a number of existing working practices. Senior management believed that implementation of the system would, in itself, bring about these changes. In fact many staff found it to be an operational “strait jacket” within which they still tried to operate local flexibility. This caused further confusion within the system.”*

The report also identified poor communications between staff and staff associations and a lack of ownership by management and staff both in the control centre and the ambulance crews. The report concluded that the staff probably had not been sufficiently involved in the setting of the requirement specification or in the revised operational methods of working.

The training for the 1992 system was considered inadequate and carried out too far in advance, which led to “skills decay” by the time staff were expected to use the system.

Overall the operational issues with the 1992 implementation can be summarised as:

- Poor user involvement in the initial specification and lack of ownership of the solution.
- Poor staff relations and poor communication.
- Inadequate training.

- Big bang approach from a manual system to an automated system with concurrent changes to working practices at the same time as the introduction of technology.

This project has been aware of these past failures since its inception and has ensured that at all stages the lessons learned from the 1992 implementation have been embedded in the CommandPoint project.

The role of the Senior User on the Project Board has been undertaken by Assistant Director of Operations John Hopson since the outset of the project, providing consistent and effective user input at a senior level throughout the procurement and implementation phase. John has also led the communication work stream with staff and made sure that the appropriate users have been involved at all stages of the project. There is a remarkable sense of staff ownership of CommandPoint and the feedback from training courses and from staff-side representatives is extremely positive. Users have been involved throughout the process, evaluating the functionality, testing the software and providing valuable feedback to the design of the training programme.

Initially this project had a clearly stated objective to upgrade the existing CTAK CAD technology and not to introduce any changes to working practices. This was based on the lessons learned from the 1992 implementation. However, it was essential to test CommandPoint against the current working practices prior to the implementation. This has been led by Assistant Director of Operations Fiona Carleton and as a consequence some changes to the layout of the Control Room and to some working practices have been made.

In my view this has been wholly appropriate, well managed and well-timed, with the changes to the Control Room and process being implemented four weeks prior to go-live to make sure they are embedded prior to the technology change. It appears that these changes in the Control Room have not led to any particular degradation of performance despite the new ways of working still requiring operators to use the old CTAK system. It has certainly mitigated the effects of changing working practices simultaneously with the introduction of new technology. It is important to note that these operational changes are relatively minor, are based on sound reasons which were already being considered for operational efficiency and are in no way comparable to the 1992 “big bang” changes from manual to automated processes.

There may still be a degradation in performance immediately post-go-live as operators adjust to the unfamiliarity of CommandPoint, but this is an inevitable effect

in any major introduction of new technology and typically lasts between one and two months.

The training programme has been exemplary and thorough with all staff who are eligible and available (i.e. there are some staff on maternity/sick leave) trained and achieved 85% competency and greater. The Page Report was critical of training skills fade during the period prior to implementation. The CommandPoint project has allowed a 5 week consolidation period at the end of the training and users have had input into the content of the maintenance training leading to a more scenario based approach which staff have found helpful. At the end of shifts staff have paid time allocated to maintain their skills and this is recorded to ensure that all staff keep their skills refreshed.

The dry run events to simulate cut-over have been successful and given staff the opportunity to experience the system in a “live” environment. Further dry run events (sand-pit days) in May will enable A, B and C watches to also experience the system in the “live” environment, which will further build skills and confidence in preparation for the real event.

The dry runs have also successfully tested cut-over and roll-back processes.

There is a complete Cut-over Readiness Checklist which constitutes the final confirmation for readiness which will be signed off by Deputy Chief Executive Martin Flaherty as the ultimate agreement for go-live. It is comprehensive and clearly sets out owners and criteria/expectations for Yes/No. The checklist is intended to give an accurate status prior to go-live which will enable the Deputy Chief Executive to take a balanced and informed view of the overall status. It is never possible for such a large and complex project to have 100% assurance that all is complete and without issue – and in the end this will be a judgement call on the part of Gold Command. However, the checklist is comprehensive (over 350 items) and the approach is robust and auditable. The Trust Board may wish to have input into how the judgement on what is “good enough” from the check list is made.

Overall the project has covered all the lessons learned from the previous 1992 implementation in terms of user engagement, working practices, training, communication and staff relations.

Project management

The Page Report had some serious criticisms of the project management and engagement of LAS senior directors and management.

The previous unsuccessful 1992 implementation was considered to have been over ambitious, expecting to deliver to unrealistic time-scales driven by operational requirements to achieve performance targets, adopted a “big-bang” approach with untested software and solutions from a small systems house with no experience in this field.

The CommandPoint project has procured a system from a world-class systems house. Northrop Grumman is a leading global security company providing innovative systems, products and solutions in aerospace, electronics, information systems, and technical services to government and commercial customers worldwide with considerable experience in implementation of emergency services CAD systems. Whilst there has been some bespoke development work to meet specific LAS requirements, this has not been disproportionate.

The transition and cut-over plans are detailed, well-tested and have a fully tested roll-back plan.

The 1992 implementation was characterised by an overwhelming need to implement a computerised system within a very ambitious timescale. This was expected to deliver performance improvements to meet pressing operational performance targets and consequently delivery milestones were considered to be unmoveable. If anything, the CommandPoint project has been characterised by a conservative approach to timescales, ensuring quality has not been compromised through a need to meet milestones at all costs. Most of the major project delays were in the early stages of the project during the procurement phase with only a short delay of some four months in the implementation phase. Despite these delays the project is still within the original project budget.

One of the recommendations of the Page Report was that there should be a senior IT executive at Board level. LAS now has a Director of IM&T at Board level who has provided the necessary senior ownership, direction and expertise throughout the project. The project has been led by a qualified PRINCE project manager and has been supported consistently throughout by a highly experienced project consultant. In addition LAS has engaged the services of an external Project Assurance Consultant who has provided regular reviews to the non-executive director charged with a special interest in the project. The project has also been subjected to external review via the OGC Gateway™ Review process and in the last Gateway 4 Readiness for Service, carried out in March 2011 achieved an amber/green rating which indicates a likely successful delivery.

Conclusion

The OGC Gateway™ Review recommended the LAS Trust Board should seek additional assurance that the CommandPoint project transition preparation has taken into account all the Page Report recommendations. This review concludes that although there are significant differences between the circumstances prevailing at the time of the 1992 implementation and today, nonetheless the project has systematically considered all of the previous lessons learned and has adopted appropriate strategies and mitigating actions to ensure that the failures in the software, operational activity and management will not occur this time. Staff engagement, communication and training have been thorough and any changes in working practice have been implemented in advance and well received by operational staff.

In addition the project has also considered lessons learned from other ambulance service deployments.

The transition planning and dry runs which have taken place in the past two months have provided the Project Board with sufficient assurance to recommend to the Trust Board on 24 May that the go-live should progress as planned. I am confident that the transition and cut-over will be successful and that CommandPoint will deliver a robust and modern operational environment for the Control Room operations.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 24TH MAY 2011

PAPER FOR NOTING

Document Title:	**2010/11 Annual Report and Accounts**
Report Author(s):	**Aiden Brisland/Michael John**
Lead Director:	**Mike Dinan, Finance Director**
Contact Details:	**michael.dinan@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To provide the Trust Board with progress to date in the preparation of the annual report 2010/11 and to provide an opportunity to comment.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☒ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Other
Recommendation for the Trust Board:	**To note progress to date in the preparation of the annual report 2010/11 and provide comment on the current content by the stated deadline.**

Executive Summary

- As an NHS organisation, we have a statutory requirement to publish, as a single document, an annual report and accounts to include the annual report; the remuneration report; a statement of the Accounting Officer's responsibilities; a statement on internal control; the primary financial statements and notes and the audit opinion and report.
- The minimum content for the annual report is set out in the Department of Health's NHS Finance manual (Manual for accounts chapter 2).
- This year the Service's annual report focuses on meeting the minimum requirements for content.
- In providing comment on the current draft of the Annual Report, the Trust Board is asked to note that comments shared from the Audit Committee on 17 May have not yet been incorporated.
- All comments to be received by close of play on Thursday 26 May and to be incorporated into the final draft that will be presented to the Audit Committee on 6 June for approval.
- The annual report will be published on the Service's website along with the Quality Account at the end of June.
- An annual review, based on the format of the Ambulance News newspaper, will be produced for the Service's wider stakeholder base and this will be published prior to the AGM in September.
- Both the annual report and the annual review will be presented at the AGM in September.

Key issues for the Trust Board

The annual report has been reviewed by the Audit Committee on 17th May and will be submitted to the Committee for approval on 6th June. The deadline for comments is close of play on 26th May.

Attachments
2010/11 Annual Report and Account

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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 supports the mitigation of the following strategic risks:

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

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
NHS Trust

Annual Report

2010/11

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Who we are

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

As the mobile arm of the health service in the capital, our main role is to respond to emergency 999 calls, getting medical help to patients who have serious or life-threatening injuries or illnesses as quickly as possible.

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

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

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

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

We have almost 5,000 staff, who work across a wide range of roles. We serve more than seven-and-a-half million people who live and work in the London area. This covers about 620 square miles, from Heathrow in the west to Upminster in the east, and from Enfield in the north to Purley in the south.

In 2010/11 we handled over 1.5 million emergency calls from across London and attended more than one million incidents.

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

Our Trust Board

Our Trust Board is made up of 13 members – a non-executive chairman, six of the Service's executive directors (including the Chief Executive), and six non-executive directors.

The Chief Executive and the other executive directors are appointed through a process of open advertising and formal selection interview. The non-executive directors are appointed by the same method but independently through the Appointments Commission. All executive appointments are permanent and subject to normal terms and conditions of employment.

The Board has five formal sub-committees: the Strategy Review and Planning Group, the Quality Committee, the Audit Committee, the Remuneration Committee and the Charitable Funds Committee. A new committee, Finance & Investment, will be introduced from April 2011.

The membership of the Strategy Review and Planning Group is made up of all the board members and is chaired by the Trust Chair.

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

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

The Remuneration Committee comprises all non-executive directors and is chaired by the Trust Chair.

Non-executive directors

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

Brian Huckett is a former director of finance and information technology with Visa International, where he helped to bring card-based banking services to people in the developing worlds of Africa, the Middle East, and Eastern Europe. He has previously worked for TSB Bank, PA Management Consultants, and a variety of international construction companies. Brian is a member of the Audit Committee.

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

Sarah Waller CBE stepped down as a non-executive director at the end of November 2010, after serving on our Trust Board since December 2000.

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

Roy Griffins CB took up his post as a non-executive director in March 2006. He is chairman of London City Airport and of the Channel Tunnel Intergovernmental Commission. He has had a 30-

year career in the British civil and diplomatic service, and was the UK's director of civil aviation between 1999 and 2004, and director-general of Airports Council International Europe from 2004 to 2006. Roy is a member of the Audit and Quality Committees.

Nigel Walmsley took up his post in March 2010. He is currently Chairman of the Broadcast Audience Research Board (BARB) – the research company which measures television viewing – as well as being a member of the Advertising Standards Authority and non-executive director of Passenger Focus, the statutory consumer voice of rail and bus passengers. Nigel was a member of the Quality Committee and stood down as a non-executive director at the end of March 2011. It is expected that this post will be filled during the forthcoming financial year (2011/12).

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

Executive directors

Chief Executive Peter Bradley CBE joined the London Ambulance Service in May 1996 as Director of Operations and was appointed Chief Executive and Chief Ambulance Officer in 2000. He has worked for 20 years in a variety of posts with ambulance services in New Zealand and was awarded the CBE in the 2005 New Year Honours. In his part-time role for the Department of Health as National Ambulance Advisor, he led the strategic review of NHS ambulance services, the findings of which were published in June 2005.

Deputy Chief Executive Martin Flaherty OBE joined the Service in 1979. His career has included time spent as a paramedic, followed by 20 years as a manager in a variety of positions. He became an executive director in April 2005 and was responsible for coordinating the emergency medical response to the 7 July bombings that year. He was awarded an OBE in the 2006 New Year Honours and became Deputy Chief Executive in May 2009. From July 2010 to January 2011 Martin was on secondment with the HSE National Ambulance Service in Ireland where he acted as interim Chief Executive. He is currently on secondment with the Great Western Ambulance Service where he has been interim Chief Executive since February 2011.

Director of Finance Michael Dinan joined us in November 2004. He had worked for 13 years for United Parcel Service in a variety of positions including Group Finance Director for the European logistics business. Michael is a member of the Chartered Institute of Management Accountants (CIMA).

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

Director of Human Resources and Organisation Development Caron Hitchen was appointed in May 2005. Caron is a qualified nurse, and her career has been predominantly NHS-based. She

worked for five years at Mayday Hospital NHS Trust as Director of Human Resources and, prior to that, she spent seven years in human resources management roles at Ealing Hospital NHS Trust.

Medical Director Dr Fionna Moore was appointed in December 1997 and was made an executive director in September 2000. She also chairs our clinical steering group and clinical audit and research group. Fionna has more than 20 years' experience as a consultant in emergency medicine, currently with Charing Cross Hospital and previously at University College and John Radcliffe Hospitals. She is a BASICS doctor and holds a fellowship in immediate medical care from the Faculty of Pre-Hospital Care of the Royal College of Surgeons Edinburgh. In 2009, Dr Moore was appointed Trauma Director for London.

The Trust Board is supported by four other directors who are non-voting directors.

Directors

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

Director of Operations Richard Webber first joined the London Ambulance Service in 1991. His operational career saw him working as a paramedic, training manager and latterly as an operational manager until he left in 2000. He then worked for another ambulance trust, a strategic health authority, and a large acute trust before rejoining us in 2005. After periods heading up the east area and then Control Services, he became Director of Operations in May 2009.

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

Director of Service Development Kathy Jones left the Service in May 2010, after joining us from the South West Thames Health Authority in September 1993. Kathy became the Director of Service Development in 2005.

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

Meetings

The Board meets in public eight times a year on Tuesdays from 10am in the conference room at our headquarters. Details of the meetings are published on our website at www.londonambulance.nhs.uk

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

Directors' interests

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

Chairman's views

What have been the highlights from last year?

We handled more 999 calls than ever before last year and highlights included meeting the Category A performance standard of reaching 75 per cent of seriously ill or injured patients within eight minutes – reaching 40,000 more of these patients than the previous year within the national time target – despite experiencing the busiest day, week and month in our history.

In addition, our Category B performance of responding to 95 per cent of patients in a non life-threatening condition within 19 minutes was our highest ever achieved.

Last year was also the first year of operation for the new London-wide trauma and stroke networks. Both are proving to be major successes, improving patient outcomes and, crucially, saving more lives.

I am also pleased that we received a European control centre of the year award and the Cabinet Office Customer Service Excellence Award, recognising the hard work of our staff who answer 999 calls and help to dispatch ambulances.

What impact will the proposed NHS reforms have on the Trust?

As we start the new financial year this will be one of the key questions. At the time of writing uncertainties remain over how some aspects of the reforms will work in practice. For example it is unclear how GPs will assume and manage the responsibility for commissioning our services and we look forward to this being clarified over the forthcoming months. However, I am confident that we will continue to focus on meeting patients' needs and expectations while responding to the reconfiguration of the NHS in London, and of course nationally, as we are required to do.

How will the Trust maintain levels of patient care when significant financial savings have to be made across the NHS?

We will not compromise our focus on patient care, even though we have to make financial savings. Quality and safety in the care we provide are at the very heart of what we do – we will do everything we can to ensure this does not change.

We are managing our approach to financial savings through a comprehensive cost improvement programme and this is monitored on a monthly basis by the Trust Board. We have a good track record of delivering savings and we fully expect this to continue.

How is the Trust's application to become a foundation trust progressing and what benefits will this status bring?

This has been a demanding project but we remain on track to become a foundation trust by the end of 2011 or early 2012. We have made considerable progress over the last 12 months, but there has been some slippage in our original timeline – due to the thoroughness of the process – which can only be of benefit in the longer term.

From our point of view, the additional freedoms to manage our affairs and to manage our funding and finances are key benefits. We are keen to ensure that our application has a trouble free route through the process, although ideally, as I write this, we would like to be a few months further ahead.

Nevertheless, we are pleased to have around 5,000 public members of the London Ambulance Service and a similar number of staff members. This will give us the opportunity to engage more directly with our potential users and ensure we develop the Service in a way that reflects patients' needs.

Chief Executive's views

What improvements have patients seen in the care they receive from the capital's ambulance service over the last year?

More patients have had their 999 call answered more quickly than ever before, and more patients have received an emergency ambulance more quickly than ever before. In addition, we have continued to improve care for our patients suffering from major trauma, stroke, heart attack and cardiac arrest. We have also continued to improve the end-of-life care for patients and our infection control procedures.

What have been the Trust's biggest challenges over the last 12 months? How did you cope and what lessons did you learn?

The biggest challenges we have faced have been the volume of demand on our service and working to a much tighter budget than in previous years, while at the same time achieving the national ambulance response target of reaching 75 per cent of seriously ill or injured patients (Category A) within eight minutes. This has been achieved by sheer hard work, determination and the goodwill of staff and managers across the Service.

The key lesson is that we have to take the pressure off our service by using the new target changes to best effect. That means providing much more clinical telephone advice and increasing our use of the community health services and referral services that are available in London.

What benefit will the removal of the time targets for responding to seriously ill and injured patients have?

The main benefit will be that we will have the flexibility to provide a more appropriate response to our patients. Rather than having to send an ambulance to every patient, we will be able to undertake a more thorough telephone assessment and then agree the most appropriate care pathway such as clinical advice over the telephone, a GP referral or an ambulance if it is decided that is the best course of action.

We will also be able to focus more on improving patient outcomes by measuring a range of clinical quality indicators and comparing ourselves with other ambulance services in England. We will now be judged on how well patients recover, rather than on just how quickly we can get to them.

What are your priorities for this year?

We need to implement our new call-handling system safely and effectively, finalise our preparations for the Olympic and Paralympic Games, implement the new clinical quality indicators safely and achieve foundation trust status.

We have to do all this while delivering a challenging cost improvement programme and at the same time ensuring that we maintain a high level of service for all our patients.

Will the Trust be ready for the Olympic and Paralympic Games next year?

Yes we will. We have a very good track record of dealing with large scale events, whether it is New Year's Eve, G20, the London Marathon or the Notting Hill Carnival. While I recognise that this is on a much bigger scale than anything we have done before, our planning team have done a first-class job and I know that all our staff involved during the Games will show the world what a professional, high-quality service we have.

Directors' Report

Our strategic goals

We want to provide our patients with the highest quality of care that will contribute towards Londoners having health outcomes that are amongst the best in the world.

Over the next five years, our strategic goals are:

- to improve the quality of care we provide to our patients, whatever their clinical need, so that they get the best health outcome
- to develop our staff so that they have the skills and confidence to provide the high-quality care that our patients expect and deserve, and
- to provide value for money.

We believe that we will be better placed to achieve our goals by becoming an NHS foundation trust.

This status will:

- give us more freedom to develop our services
- enable our patients, staff and local communities to have a greater say in how we develop and deliver our services, and
- give us more freedom in how we use our money.

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

We have an important role to play in improving the health outcomes of patients in London.

As a 24/7 pan-London healthcare provider, we are often the first point of contact for people who want medical help, whether it is an emergency or a less serious condition. Our response will determine whether they get the right treatment to meet their needs.

To achieve this goal we will:

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

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

We know that to enable us to provide a quality service, our staff need to be highly-skilled, confident and motivated. They should also be representative of the communities we serve.

We will continue to invest in their development so that staff on the frontline have the skills to assess and treat a wide range of conditions, and those in other functions have the right skills to support them.

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

To achieve this goal we will:

- develop our staff so that they have the skills and confidence they need to do their job
- improve the diversity of our workforce, and
- engage with our staff to improve patient care and productivity.

Strategic goal: Provide value for money

It is extremely important that we provide Londoners with a service that represents value for money.

It currently costs residents £30 each per year for their ambulance service. This is less per head of population than most other ambulance services in the country, but in the future we will need to provide a better service for less money.

To achieve this goal we will:

- use our resources efficiently and effectively
- maintain service performance during major events, both planned and unplanned including the 2012 Games, and
- improve engagement with key stakeholders.

We work with a wide range of stakeholders, from local involvement networks and the London Ambulance Service Patients' Forum to the Strategic Health Authority and our commissioners. Many of our stakeholders have contributed to the development of our strategic plan and will play a crucial role in its delivery.

Achievements during 2010/11

Clinical developments

We attended more patients than ever before in 2010/11, responding to more than one million incidents.

Over the last year we have continued to improve the care we provide to our patients, whether they have life-threatening conditions or less serious illnesses or injuries.

Stroke care

The Service has continued to support the development of the London stroke networks. In February 2010, we started taking patients with very early stroke symptoms directly to one of eight hyperacute stroke units (HASUs) – specialist centres where early, consultant-led assessment, diagnosis and treatment is started within minutes of arrival. In July 2010, this was extended to all patients with a stroke, regardless of where they live or work in London. Audit data has shown our staff consistently transport over 95 per cent of suspected stroke patients to an appropriate destination.

Despite the longer distances to be travelled, the average journey time to hospital is under 20 minutes.

In November 2010, the North West London Stroke and Cardiac Network and Imperial College Healthcare NHS Trust hosted a stroke training day attended by over 80 Service staff.

Trauma care

Three specialist major trauma centres went live in April 2010, and a fourth in December 2010. The centres are equipped to deal with patients who suffer life-threatening injuries, including amputations or gunshot wounds. They have a specialist consultant on site to manage these patients 24/7. Patients with less serious injuries such as a fractured hip or ankle, or minor head injuries are treated at their local trauma unit.

Our staff have been trained in the use of a triage system that helps to ensure that the most seriously injured patients are taken to a major trauma centre. Although identifying these patients is often very difficult, the initial results are very promising, with nearly half of all patients taken to one of these specialist centres having significant injury. This compares well with international standards. Although patients are often bypassing their local hospital, the vast majority of ambulance journey times for major trauma patients are below 45 minutes, with a median time of 13.4 minutes.

The system is already benefiting patients, with an additional 37 survivors across London in the first six months since the system went live, compared to the expected number of survivors.

Cardiac care

We have continued to improve the care we provide to patients who suffer a heart attack (caused by a blockage of blood flow to the heart) or cardiac arrest (when the heart stops beating).

More patients who suffer heart attacks are being taken to specialist centres than ever before. Our latest figures show that 1,779 patients who were diagnosed as suffering from a common type of heart attack, known as an ST-elevation myocardial infarction, were taken directly to a cardiac catheter laboratory in 2009/10. This is an increase of 11 per cent on the year before. These patients were taken to specialist centres to enable them to be given primary angioplasty, a procedure which involves inflating a balloon inside an artery to enable a blockage to be cleared.

Latest figures for cardiac arrests also show that Londoners whose hearts stop beating in public are over eight times more likely to survive than 10 years ago. This survival rate of 21.5 per cent is up from just 2.5 per cent in 1998/99 and an increase from 15.2 per cent in 2007/08. The improvement in cardiac arrest survival rates reflects a wide range of developments in the care and treatment of cardiac patients in the capital.

We now have 39 community responder and co-responder schemes in place whereby volunteers are trained to attend emergency calls in their local area and provide first aid to patients until an ambulance arrives. In the last year 109 volunteers have been trained.

We also have over 500 defibrillators – machines that are used to re-start a patient's heart with an electric shock – in almost 200 public places including tourist attractions, airports and train stations. And we have trained thousands of people working in these areas in their use. In the last year 49 defibrillators have been sited and 1,080 people have been trained or re-trained.

Mental health care

There is a higher prevalence of people with mental health conditions in London than elsewhere in the country and consequently mental health 999 emergencies are jobs frequently covered by the Service. As a result we are committed to making improvements to the quality of service we provide to this group of patients.

People with mental health conditions can have a range of complex needs and care packages are frequently dependent upon a number of different provider organisations. Some patients may be refugees and face language and cultural barriers. In addition, London's population is very mobile and mental health patients can access healthcare at any location making crisis planning extremely challenging.

In 2010/11 we explored some of these issues and held detailed discussions with commissioners and have developed a mental health action plan that will help drive improvements during 2011/12. The action plan is broken down into a number of work streams that include areas that have a relationship with mental health such as alcohol consumption and dementia.

By offering more mental health clinical support to our staff and changing the way we view mental health, we hope to improve the overall patient experience.

End-of-life care

Supporting end-of-life care strategies across London is a growing priority for the Service and fits with ongoing strategic developments including identifying and making use of appropriate health care centres other than hospital emergency departments (alternative care pathways) and giving people a choice about where they die.

We will continue to work with both NHS and hospice-based end-of-life care providers. To provide end-of-life care support that is fit for purpose we will continue to develop staff skills, training and competencies, the way we collate patient information and how we communicate with local providers of end-of-life care services.

We are currently working on a project with St Thomas' Hospital to make sure patients under its care on an end-of-life care programme are appropriately managed and looked after by our staff following a 999 call.

Care for patients with less serious conditions

During 2010/11 we developed our work to look at how we treat patients presenting with less serious conditions.

Our clinical telephone advisors helped 49,931 patients over the phone, an increase from 47,180 last year. Of these patients, 23 per cent were assessed as not needing an ambulance to attend them in person. We also referred 46,054 calls to NHS Direct for their advisers to call back patients and provide them with clinical help over the telephone.

As part of a wider NHS response to managing patients with less serious conditions, work has also been done to identify suitable alternative destinations where care can be provided away from the traditional hospital environment. These include minor injuries units, urgent care centres and walk-in

centres, some of the latter being provided as part of the services at some larger GP practices. Currently there are 50 of these alternative destinations, and we are working with each service provider to encourage our staff to use the facilities, as well as with the services themselves to give them a better understanding about how we work. Frontline staff are receiving training to enable them to better assess minor injuries, illnesses and conditions, and from this decide on the appropriate destination for patients.

In addition, we have started some work relating to elderly patients who have fallen with the overall aim to have a much higher level of GP engagement with us when managing their ongoing care.

Provision of pre-arranged patient transport

As well as our 999 service, we offer pre-arranged transport for patients to and from their hospital appointments. We carried out 204,454 of these journeys last year.

We delivered patients to hospital on time in 90 per cent of the journeys, compared with 92 per cent the year before, and 90 per cent in 2008/09. We departed hospital on time in 95 per cent of cases. This compares with 93 per cent in 2009/10, and 92 per cent in the year before that.

Ninety-five per cent of our patients had a journey time less than an hour. This was the same as the previous two years.

During the year, we did not commence any new contracts and stopped providing services for the South London Healthcare NHS Trust in December 2010.

Our total number of contracts at the end of the year stood at 19.

Performance against government targets

In 2010/11 we received a total of 1,494,207 emergency calls, compared to 1,480,275 in 2009/10. And we responded to 1,058,132 emergency incidents, up from 1,012,927 the year before. The total of emergency calls received per year has increased by 21 per cent over the last six years.

We conveyed 812,592 patients to hospital, compared to 762,192 the year before, and 3,711 to an appropriate care centre such as a minor injuries unit. We also gave clinical advice over the phone to 49,931 patients with minor illnesses or injuries.

During the year we also faced some major challenges such as the re-emergence of swine flu (H1N1) in winter along with adverse weather conditions and student protests. Despite this we achieved two of the government response time targets, and improved our performance against the third.

In 2010/11, the targets were to reach:

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

The number of life-threatening calls received during 2010/11 increased by over five per cent. We attended 347,675 of these incidents – compared to 328,616 the year before. We responded to 75.14 per cent of these types of calls within eight minutes. This is a similar achievement to 2009/10.

We reached 96 per cent of Category A incidents within 19 minutes, exceeding the target of 95 per cent. However, this is slightly below our performance in 2009/10, when we reached over 98 per cent of patients within this time.

We saw incidents involving patients with serious but not life-threatening conditions increase by over five per cent during the 12-month period, which was an additional 23,014 incidents compared with the year before. Unfortunately, although our performance against the Category B target improved during the year, we were unable to achieve the 95 per cent target. We responded to 85.3 per cent of these calls within 19 minutes; this compares with 85.8 per cent in 2009/10.

The Category B performance standard is being replaced in 2011/12 with clinical indicators. This set of indicators and measures will be based around the following:

- Cardiac arrest survival rate
- Cardiac and stroke outcomes
- Mortality rates from discharge
- Call handling/clinical telephone advice/NHS Direct
- Patient experiences
- Time of treatment (for patients in an immediately life-threatening condition waiting longer than eight minutes)
- Patient's safety while in our care.

Emergency demand						
	2005/06	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2010/11**
999 calls received	1,231,572	1,288,819	1,389,660	1,423,496	1,480,275	1,494,207
Incidents attended	856,659	865,537	945,776	973,908	1,012,927	1,058,132
Incidents categorised as life-threatening	305,300	312,377	315,744	319,677	328,616	347,675

New call-handling system

We are implementing a new system for handling 999 calls and dispatching staff and vehicles.

The new system, CommandPoint, is expected to go live in June 2011 following comprehensive testing and staff training.

The system will improve our ability to handle 999 calls and meet the challenges of population growth in the capital and ever-increasing demand on our service.

Regulation

For two years in a row the Audit Commission has rated the overall management of our finances at

level 4 – the highest rating possible. We have also achieved unconditional registration in March 2010 with the Care Quality Commission which we maintained in 2010/11.

The new Director of Health Promotion and Quality is the lead for infection prevention and control and has strengthened our monitoring and audit processes for compliance with the hygiene code regulations.

We were reassessed at level 1 of the NHS Litigation Authority risk management standards for ambulance trusts in October 2010 and achieved this with a much improved score on the 2008 assessment.

An action plan was successfully implemented in March 2010 to address the improvement notice from the Health and Safety Executive concerning refresher training for manual handling and this led to the notice being removed in June 2010.

Governance and risk

Our Trust Board manages risk through the risk management policy and strategy, corporate risk register and board assurance framework, all of which were reviewed during 2010/11. We have revised the board assurance framework and increased the frequency of review by the Quality Committee and the Trust Board. We have added to this the key risk areas that the Trust Board identified for a focus during the year and this has contributed to greater scrutiny of the risks on the corporate register.

The new governance structure was implemented in April 2010 and the Trust Board undertook an interim review of this in December. No significant changes were made and the structure will be fully reviewed in April 2011.

From November 2010 to January 2011 our governance and financial reporting processes were scrutinised by independent accountants as part of the due diligence process in preparation for our foundation trust application. We have implemented an action plan to address the issues arising from this and we are now looking ahead to being authorised as an NHS foundation trust in late 2011.

How we prepare for emergencies

We have to be prepared for anything that may happen in the capital, whether it is a planned event or an unplanned emergency.

Our major incident plan outlines the operational steps we will take in the event of a major or catastrophic incident occurring. This plan has been written in conjunction with all our partner agencies in the capital.

We also have plans in place to ensure we are as prepared as possible for large-scale events such as New Year's Eve, the London Marathon, the Notting Hill Carnival and many other smaller events.

To help us prepare for the unexpected, we regularly take part in major incident exercises with other agencies and successfully managed the medical provision at a number of central London demonstrations and events during 2010/11.

We have a specially-trained team to treat patients in the 'hot zone', or hazardous area, at serious or major incidents. The hazardous area response team (HART) is also equipped to deal with large numbers of casualties at incidents. We also have teams that are trained to work within crowded and often challenging environments such as football matches and demonstrations.

Improving our service through feedback

We believe in taking account of all of the feedback we receive, including complaints. We believe the issues raised are more important than the process which is used to report an incident, and by treating all of the feedback we receive seriously we can gain a better picture of any emerging trends and incidents of particular importance to patient care.

The most important issue from our point of view is that, once feedback from patients has been received and looked into, we are able to address the causes of any poor experience so that we can manage similar situations better in the future.

Every year we receive approximately 500 complaints and around 6,000 enquiries to our patient experiences department, including approximately 200 incident reports from other health and social care agencies.

We remain committed to safety and public accountability by being open about matters when something goes wrong and using all feedback as a learning opportunity to encourage change and improve practice. We believe feedback can be used to improve the NHS and social care as a whole and we are exploring ways in which we can share lessons learned with all UK ambulance services.

As best practice we now publish case studies on our website at www.londonambulance.nhs.uk under *About us > What we do > Making your experiences count.*

We also continue to use a care plan approach so that we can tailor the needs of patients to an individual care programme matched to their needs. This is especially helpful in not only meeting the needs of patients but in managing demand more effectively. You can find out more about our patient centred action team at www.londonambulance.nhs.uk under *Health professionals > Caring for frequent callers*.

We are also pleased to be increasingly involved in liaising with other agencies to promote safeguarding of both adults and children. More information is available on our website at www.londonambulance.nhs.uk/health_professionals.aspx

Our workforce

We have continued to revise the skills profile of our workforce. A two-year major recruitment drive between 2008 and 2010 saw our workforce grow significantly with over 700 people joining us in the new role of student paramedic. This programme has had a very low attrition rate and we currently employ 677 student paramedics. At the end of 2010/11, 63 students had qualified as full paramedics and we expect a further 373 to qualify next year and 265 in 2012/13. Our recruitment activity in 2010/11 has also ensured that staffing levels in control services – where staff answer 999 calls and dispatch ambulances – will meet the additional demands on resources during the implementation of the new call handling system, CommandPoint.

There has been a significant rise in the quantity of training delivered this year and we have rolled out in the region of 6,000 units of clinical training to staff across a range of subject areas.

The rate of sickness among our staff for the 2010 calendar year (January to December 2010) was 5.2 per cent.

How we inform and consult with our staff

Staff communication and consultation: We recognise that an engaged workforce is key to improving services and productivity, and we are committed to communicating and consulting with staff to achieve this. A formal staff engagement strategy has been developed, and approved by the Trust Board, to support and further develop the long-standing partnership agreement with the recognised trade unions.

Partnership working with the unions: We have long-established partnership working arrangements with our trade union colleagues, with a formal consultation and negotiation framework in place. This relationship has been strengthened over recent years as we have worked together on major change programmes, including the implementation of Agenda for Change terms and conditions, and new cover arrangements for frontline staff that places them where historical data indicates the next 999 call will come from. The staff side to the Staff Council, the senior consultative group within our Service, has been offered and accepted a governor seat as part of the planning process for foundation trust status. New partnership arrangements for health and safety have also been agreed.

We have continued to consult on the major issues, opportunities and challenges facing the Service. For example, we will continue to hold joint partnership events to foster the agreements and involve more representatives in our planning and preparation for the Olympic and Paralympic Games. This approach will support and supplement the established formal diarised meetings at corporate and local level. We plan to maintain these working relationships when we become a foundation trust.

Staff conferences and consultation meetings: Another effective way in which we engage with staff is through our programme of internal conferences and consultation meetings. Conferences with different staff groups take place throughout the year, and every 18 months our Chief Executive and Medical Director hold consultation meetings at local level, visiting some 30 ambulance stations, as well as fleet workshops, and meeting with patient transport service staff and other staff groups. These meetings have provided a key opportunity for staff to offer their views on what we should be focusing on, and have influenced service strategy.

Health and well-being: We have developed a health and well-being strategy, approved by our Trust Board. Arrangements for occupational health and counselling services have been reviewed, and a new model of counselling, introduced by way of a network of selected counsellors experienced in trauma as well as work-place counselling, has been agreed. A new provider of occupational health and physiotherapy services has been selected and health and safety training for managers and staff has been enhanced. The LINC (Listening, Informal, Non-judgemental, Confidential) peer support worker initiative received national recognition, being awarded second place in the ‘stress’ category of the annual Healthcare People Management Association awards for best practice in human resources.

Following a planned visit and inspection by the Health and Safety Executive, we were served with a formal improvement notice in spring 2010, and the Executive also issued a report which commented

upon and made recommendations about arrangements for the management of health and safety in the Service. The improvement notice related to refresher training for operational staff, and gave a three-month period within which to demonstrate compliance. The notice was lifted on time and at the earliest opportunity, and the Executive has declared itself happy with progress against the report and recommendations. This work continues.

New ways of working initiative: We have an initiative to develop clinical leadership at local level which will improve the care we give to patients and improve job satisfaction for staff. Two operational sites have successfully implemented new ways of working, and a further five are currently focussed on achieving these objectives. Staff at all levels locally are being actively engaged and encouraged to contribute to this work which ranges from improving clinical training and leadership skills to introducing team based working with supporting rotas and increasing community engagement. This initiative will roll out across all local operational areas in over the next two years

Staff survey: We send the annual NHS staff survey to all members of staff, rather than the sample required for the purpose of the national survey. This has enabled us to get a better picture of staff views and concerns across the organisation. The results are fed back to each directorate, and local action plans are developed to address any key issues.

Staff involvement in policy development: There are a number of examples where staff have been directly involved in influencing how we deliver our service, for example how we report concerns about vulnerable adults and children, the introduction of a bicycle ambulance in central London, the launch of the media-dubbed ‘booze bus’ that deals with alcohol-related calls, and the development of a pan-London programme whereby patients diagnosed with a heart attack are taken directly to one of eight heart attack centres in the capital where they receive specialist treatment. Staff have also been involved in the development of key strategies relating to mental health, long-term conditions, older people and public education.

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

Our approach to equality and inclusion

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

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

It is our policy to treat everyone fairly and without discrimination. Specifically, we aim to ensure that:

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

All of our staff are expected to promote these values at all times and behaviour that does not meet this standard is addressed.

As a provider of healthcare to the people living, working in and visiting our capital city, we seek to provide care, which addresses the individual needs of our diverse patients and customers.

We aim to ensure that:

- our patients and customers are aware of our services and that those services are accessible to all
- our public buildings and information are accessible to all
- we enable all our diverse communities in London to be involved in the development and monitoring of our policies and services.

We aim to become an employer of choice for those who want to make London a safer and healthier place for all. We want to attract the best and most talented people from all walks of life to rewarding and challenging career opportunities, where they can develop their potential to the benefit of their fellow staff, patients and customers.

Our aims are to:

- celebrate and encourage the diversity of our workforce and to create a working environment where everyone feels included and appreciated for their work
- promote and provide our training and employment opportunities regardless of age, disability, gender reassignment, marital status, pregnancy or maternity, race, religion or belief, sex, sexual orientation or any other aspect of an individual person's background
- foster creativeness and innovation in our working environment, to ensure that each member of staff can give of their best and move our Service forward in our equality and inclusion goals.

As a procurer of goods and services, we are committed to:

- ensuring that contractors from whom we procure goods and services are aligned with our equality and inclusion values
- actively considering supplier diversity as a key aspect in our contract management.

Our policy in relation to disabled employees

We are a member organisation of the Employers' Forum on Disability as well as of Carers UK. We have signed up to the Two Ticks ‘positive about disabled people’ scheme and have established a new staff diversity forum for disabled people and carers, known as Enable. This will provide an active voice on policy and decision-making for our disabled employees and staff who are carers, including their involvement as ‘critical friends’ in our equality analysis. Members of Enable will also lead and participate in relevant engagement events on behalf of the organisation.

Severance payments

No employees left the Service under terms that required Treasury approval.

Sustainability

In March 2010 our Trust Board approved a carbon reduction policy committing us to reducing our 2007 carbon footprint by 10 per cent by 2015. A number of initiatives have now been implemented to help reduce our carbon footprint.

- During 2010/11 we modernised our ambulance fleet with new ambulances that are 100 per cent more fuel efficient than older models. The new vehicles are capable of covering an average of 18 miles per gallon compared to 9 miles per gallon for the older ambulances. The new vehicles are also almost 90 per cent recyclable (by weight). We are also investigating the possibility of adding electric or hybrid vehicles to our fleet of non-emergency vehicles.
- Twenty five per cent of our energy is now supplied from green sources. We have also managed to cut energy consumption across our estate through garage lighting projects, the replacement of 20 life-expired boilers over the last three years and the installation of smart meters for electricity and gas.
- A number of paper-based processes have been moved to web-based systems (such as expenses claims) helping us to reduce the amount of paper we use.
- We have continued to encourage recycling across the organisation.
- A teleconferencing facility is now routinely used across the Service, cutting down on unnecessary journeys between sites.
- We have amended our template for business cases to include an environmental impact assessment that addresses carbon reduction.
- We successfully applied to take part in the Carbon Trust's public sector carbon management programme which starts in 2011/12. This will further support us in meeting the target of reducing our 2007 carbon footprint by 10 per cent by 2015.

2010/11 financial summary statements

Financial review

We fulfilled four of its statutory financial duties in 2010/2011:

The figures given for periods prior to 2010/11 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

Income and Expenditure £000s

	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
Surplus/deficit(-) in year	332	1,258	113	398	725	-420	687
Cumulative surplus/deficit(-)	75	1,333	1,446	1,844	2,569	2,149	2,836
Cumulative deficit permitted (0.5%)	-963	-1,080	-1,080	-1,180	-1,308	-1,399	-1,418

The surplus in 2010/2011meant that the cumulative position improved for the 10th year running, and remained well within the limit of 0.5 per cent of turnover permitted by the Department of Health.

1. On income and expenditure we reported a surplus of £687,000 for the year, and therefore did better than the break-even target set by the Department of Health for 2010/2011.

2. We had a £75,000 undershoot against our external financing limit (EFL) for the year, which we are permitted to do.

3. A return on assets (the capital cost absorption duty**)** of 3.5 per cent was achieved. This was within the permitted range of 3.0 per cent to 4.0 per cent.

4. In the capital programme £15.1m was spent on a range of projects, including ambulances, new technology projects and projects to improve the estate. Overall we under spent by £8,918,000 against our capital resource limit, which we are permitted to do.

We were able to pay 84 per cent of our non-NHS and NHS trade invoices respectively within 30 days, which was below the 95 per cent target set by the Department of Health.

Balance sheet

The largest item on the balance sheet is £143 million of fixed assets (£144 million in 2009/10) comprising land, buildings, plant and machinery, information technology, fixtures and intangibles. We fund the investment in capital assets through our capital programme. In 2010/11, we invested £15.2 million (£25.6 million in 2009/10). The most significant additions were related to the project to replace the emergency operations centre computer system, Mercedes ambulances and hazardous area response team (HART) vehicles.

We have a net working capital of -£3.8 million (-£6.7 million in 2009/10) and long-term creditors and provisions of £32.9 million (£38.6 million in 2009/10). We had £872,000 cash in the bank as at 31 March 2011 (£5.1 million in 2009/10).

We obtained and fully drew down a £10 million loan from the Department of Health to fund capital expenditures in 2009/10. The loan is spread over eight years with an average fixed interest rate of 2.65 per cent (£265,000) per annum.

In 2010/11, we obtained a loan of £107,000 from SALIX Finance Ltd to support our capital investment in technical measures to improve energy efficiency. The loan was drawn down in August and December 2010 for £60,000 and £47,000 respectively. It is an interest free, unsecured loan with two to five year repayment terms.

Our assets are ultimately owned by the public and the taxpayers' equity section of the balance sheet shows the component elements. Public dividend capital is £62.5 million (£60.9 million in 2009/10) of the equity – this represents the Department of Health's investment in us and annual dividends are payable on this sum. A further £35.7 million (£35.9 million in 2009/10) is held in a revaluation reserve representing the accumulated decrease in value of our estate.

Pension Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme and the accounting policy is set out in note 11 to the full Annual Accounts. The Remuneration report sets out information on the pension benefits of directors.

Financial Plan 2011/12

We have formally submitted a plan for 2011/12 that takes into account planned contracted income levels and the expenditure budgets that have been set for the new financial year. The plan is set to deliver a surplus of £2.7m.

Detailed financial planning work is in progress in preparation for our foundation trust application.

Financial risk

We monitor financial risk through the assurance framework and risk management processes as detailed in the statement of internal control included in the financial statements.

International Financial Reporting Standards (IFRS)

The Treasury has announced that public sector bodies are required to prepare their accounts under International Financial Reporting Statements (IFRSs) from 2009/10. It was the first year that we have prepared our accounts under IFRSs, resulting in the rework of 2008/09 results to act as prior year comparators in the 2009/10 accounts.

Professional valuation was carried out by the District Valuers of the Revenue and Customs Government Department on 31 March 2011 for all land and buildings. The net gain and loss on revaluation and impairments was £1,125,000 and £160,000 respectively.

IAS 19 requires us to accrue for remuneration earned but not yet taken. In this instance, we have made an accrual for annual leave of £3,521,000 for the current financial year (£1,321,000 in 2009/10).

Subsequent events after the balance sheet date

There was no important event occurring after the financial year end that has a material effect on the 2010/2011 financial statements.

Other information

The Audit Commission was our external auditor for the year ending 31 March 2011. We paid the Audit Commission £170,000 (£155,000 in 2009/10) for audit services relating to the statutory audit. All issues relating to financial audit and financial governance are overseen by our audit committee.

The financial statements for the year follow. These are summary financial statements extracted from the full accounts, which are available free of charge from the Financial Controller who can be contacted at the address given at the end of this annual report.

Independent auditor's statement to the Board of Directors of London Ambulance Service NHS Trust

I have examined the summary financial statements which comprises vision and values, who we are, Chairman's views, Chief Executive's views, building on success, patients, people, performance, the Trust Board, and the financial summary statements, set out on pages 23 to 25.

This report is made solely to the Board of Directors of London Ambulance Service NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 49 of the Statement of Responsibilities of Auditors and of Audited Bodies prepared by the Audit Commission.

Respective responsibilities of directors and auditor

The Directors are responsible for preparing the annual report.

My responsibility is to report to you my opinion on the consistency of the summary financial statement within the annual report with the statutory financial statements.

I also read the other information contained in the annual report and consider the implications for my report if I become aware of any misstatements or material inconsistencies with the summary financial statement.

Basis of audit opinion

I conducted my work in accordance with Bulletin 1999/6 'The auditors' statement on the summary financial statement' issued by the Auditing Practices Board. My report on the statutory financial statements describes the basis of our audit opinion on those financial statements.

Opinion

In my opinion the summary financial statement is consistent with the statutory financial statements of the Trust for the year ended 31 March 2011.

…….
Philip Johnstone, District Auditor
Audit Commission, 1st Floor, Millbank Tower, London. SW1P 4QP
xx June 2011

Related party transactions

During the year none of the Department of Health Ministers, trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with London Ambulance Service NHS Trust.

The Department of Health is regarded as a related party. In 2009/10 London Ambulance Service NHS Trust obtained a £10m capital investment loan from the Department and the current outstanding loan is £8,075k. It also had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

	2010/11 Payments to Related Party £000	**2010/11** Receipts from Related Party £000	**2010/11** Amounts owed to Related Party £000	**2010/11** Amounts due from Related Party £000
Department of Health	966	7,396	0	130
London Strategic Health Authority	4	5,193	0	216
Richmond & Twickenham PCT	0	4,628	0	182
Westminster PCT	4	21,477	0	139
Tower Hamlets PCT	0	23,122	0	174
London Primary Care Trusts	49	210,222	24	3,945
Whipps Cross University Hospital NHS Trust	0	1,213	0	231
South London Healthcare NHS Trust	0	2,720	6	0
South West London and St Georges Mental Health NHS Trust	3	1,005	0	0
NHS Litigation Authority	614	0	1	0
NHS Business Service Authority	717	0	25	0

	2009/10 Payments to Related Party £000	2009/10 Receipts from Related Party £000	2009/10 Amounts owed to Related Party £000	2009/10 Amounts due from Related Party £000
London Strategic Health Authority	11	6,034	0	3,087
Richmond & Twickenham PCT	0	12,628	0	227
London Primary Care Trusts	127	244,124	19	2,094
Whipps Cross University Hospital NHS Trust	0	1,431	0	102
South London Healthcare NHS Trust	0	2,751	1	500
South West London and St Georges Mental Health NHS Trust	2	1,006	3	0
NHS Litigation Authority	689	0	1	0
NHS Business Service Authority	755	0	15	255

For 2010/11 Westminster PCT was the host PCT (2009/10 Richmond & Twickenham PCT).
We received an administration fee of £2,500 (2009/10 £2,500) from the London Ambulance Service Charitable Funds.

The London Ambulance NHS Trust is the corporate trustee of the funds

Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of the NHS has designated that the Chief Executive should be our Accountable Officer. The relevant responsibilities of accountable officers are set out in the Accountable Officers Memorandum issued by the Department of Health. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to us;
- our expenditure and income has been applied to the purposes intended by Parliament and conforms to the authorities which govern them;
- effective and sound financial management systems are in place; and
- our annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an accountable officer.

Signed

Peter Bradley
Chief Executive
Xx June 2011

Statement of Directors' responsibilities in respect of the accounts

The directors are required under the national Health Services Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of our state of affairs and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on the consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent; and

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding our assets and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board
Signed

Peter Bradley
Chief Executive
Xx June 2011

Mike Dinan
Finance Director
Xx June 2011-05-12

STATEMENT ON INTERNAL CONTROLS 2010/11

1. Scope of Responsibility

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

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

As part of London's local health economy we work with our partners to minimise the risks to patient care. To do so we meet routinely with our lead commissioners and with the performance team at NHS London, and strive to meet and maintain the key performance targets set for ambulance services. We work in partnership with health and social care organisations in the development and provision of emergency and urgent healthcare across London. In 2010/11 this has included the development of pathways for stroke, cardiac and major trauma care across London, as well as developing pathways for urgent and emergency care in local areas. In the past year we have consolidated our cardiac referral pathways and developed bypass criteria for patients who have suffered acute stroke and major trauma, so that they can receive the highest standards of care in specialist centres.

2. The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives; and
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in the London Ambulance Service NHS Trust for the year ending 31 March 2011 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

The management of risk is delegated by the Trust Board to the Chief Executive as Accountable Officer and to two board committees: Audit and Quality. An executive committee, Risk Compliance &

Assurance (RCAG), is chaired by the Director of Finance with delegated authority from the Trust Board and the Quality Committee to take an overview of our risk management activities.

Risks are separated into the following groups: strategic, corporate, clinical, governance, financial, human resources, health and safety, business continuity, information management and technology, infection control, logistics, operational, and reputational. Management of risks is delegated to directors:

- Director of Finance – financial risk management.
- Medical Director – clinical quality, safety and effectiveness (and risks associated with infection prevention and control and safeguarding up to September 2010).
- Director of Human Resources & Organisational Development – operational risk management such as health and safety, occupational health, training, and human resources.
- Director of Operations – operational risk management such as frontline ambulance services and control rooms which could impact upon patient care.
- Director of Information Management & Technology – information management and technology, and information risk management.
- Director of Corporate Services – corporate risk management such as regulation and compliance, and overall responsibility for ensuring that corporate risk processes and controls are in place.
- Director of Health Promotion & Quality – risks concerning infection prevention and control and safeguarding (since September 2010).

The Directors of Finance and Corporate Services routinely attend the Audit Committee. Three committees – Risk Compliance and Assurance, Clinical Safety & Effectiveness, and Learning from Experience – report to the Quality Committee which is attended by the chairs. The Director of Health Promotion & Quality is the nominated executive for infection prevention and control and also for safeguarding, the Director of Human Resources and Organisation Development is the nominated director for security management, and the Director of Information Management & Technology is the senior information risk owner reporting to the Trust Board.

A mandatory training plan is in place for our employees. This was assessed by the NHSLA in October 2010 and the standard was achieved at level one. New staff attend a corporate induction which covers the basic risk and safety management responsibilities and includes basic information governance principles such as data protection and confidentiality. Staff are trained to the level and for the areas appropriate to their role. The regular Service-wide bulletin system is used to communicate changes to practice and there are clinical and training updates published for all staff via the intranet. Individual managers are responsible for ensuring their staff receive such information and undertake the training and development required for them to safely undertake their role.

The risk management and governance structure was implemented in April 2010 and an interim review was undertaken in December 2010. The chairman of the Trust Board seeks assurance at each meeting from the chairs of the Audit and Quality committees that the arrangements are working effectively. The structure will be reviewed early in 2011/12 to ensure that it is working effectively for the Trust Board and that it minimises the risks facing us and our ability to meet our strategic goals.

4. The risk and control framework

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

The Risk Management Policy and Strategy describes the process for embedding risk management throughout the trust and during 2009/10 we introduced the risk register procedure to support this process.

Incidents are reported in accordance with the incident reporting procedure and are then scored, either by local managers or by the risk and safety team, using the NPSA risk severity matrix. Action is then taken to control, manage or mitigate the risk and depending upon the score the risk may be added to the corporate register for review by the RCAG or monitored at a local level.

Following an inspection in 2009/10 against the requirements of the 'Code of Practice for health and adult social care on the prevention and control of infections and related guidance' under the Health and Social Care Act 2008, we implemented a number of recommendations and a 12-point action plan which has been managed throughout the year. Improved audit practices are now in place and providing assurance of compliance as well as identifying areas that require more focus.

We received unconditional registration from the CQC in March 2010 to provide the following regulated activities:

- transport services, triage and medical advice provided remotely;
- treatment of disease, disorder or injury; and
- diagnostic and screening procedures.

Systems are in place to monitor compliance throughout the year and to address any emerging gaps or risks. The board assurance framework has been further developed during the year to show the linkages between the strategic goals for the next five years and the most significant strategic risks to the achievement of these. This is mapped to the key risks the Trust Board chose to focus on during the year as well as the top risks on the corporate risk register. The board assurance framework is mapped to the care Quality Commission's outcomes and requirements. The Quality Committee reviews the board assurance framework and corporate risk register quarterly as does the Trust Board. The Risk Compliance and Assurance Group review the corporate risk register in detail at each meeting.

Control measures are in place to ensure that all of our obligations under equality, diversity and human rights legislation are complied with.

As an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employers' contributions and payments in to the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

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

Actions have been taken in the following areas to strengthen control and minimise risk:

Human resources and organisation development

- We have worked to ensure compliance with the Equality Act 2010.
- Our senior management-led Equality & Diversity Steering Group is functioning well.
- The number of frontline staff delivering patient care increased by 421 to improve achievement of the Category A and B targets.

Clinical care

- We have acquired 390 new model defibrillators to help support the improvement in the cardiac survival rate in London.
- We continue to provide cardio-pulmonary resuscitation (CPR) training to the public and businesses.
- We have improved the delivery of our clinical care fleet with the acquisition of 72 modern ambulances as part of a rolling programme.
- Clinical care pathways are being developed to support emergency and urgent healthcare across London.
- Training is in place to support the conveyance of major trauma, stroke and cardiac patients to specialist units, bypassing local hospitals, where appropriate
- Management of controlled drugs:
    - Following an audit review undertaken on 2008/09, the auditors undertook a further review in July 2009 and found a number of control weaknesses leading to an audit opinion of 'limited assurance'. We have implemented a robust action plan and progress has been made in the latter part of the year. As a result of the audit opinion, our Trust Board considered there to be insufficient evidence against the core standard for medicines management in the December 2009 declaration. Over the past year we have worked closely with the Metropolitan Police Controlled Drugs Unit to undertake unannounced inspections. We have also introduced a system of peer review which is being rolled out across the Service. The Trust Board has since received evidence of progress made and has the assurance that there are no significant lapses that could cause a risk to patient safety. The BAF identifies the gaps in controls and assurance specifically as failure to comply with policies and procedures relating to the management of controlled drugs but has assurance that the underpinning policies are sound.
- Medical devices: an audit identified a number of weaknesses in respect of stock holding, reporting of losses and monitoring of losses of these items of equipment. An action plan is being prepared to address and resolve these issues.

Control Services

- During the peak in swine flu-related calls we worked closely with NHS Direct to ensure that ambulances were despatched appropriately.
- The expansion of the clinical support function which supports decision making by frontline staff, and the capacity management of specialist units specifically relating to major trauma, stroke and cardiac care.
- Resilience in our control room has been improved with the deployment of increased resources to meet demand.
- Pressure levels within our resourcing escalatory action plan were refined during the year, and contingency plans developed in the event of significantly higher demand as a result of swine flu.

Information Management and Technology

- We protect data through administrative and technical controls.
- Administrative controls include:
  - data handling policies;
  - regulatory compliance, e.g. Caldicott recommendations, NHS Code of Practice, Data Protection Act 1998, Freedom of Information Act 2001and ISO 27001; and
  - employee background checks.
- Technical controls include:
  - edge security, e.g. firewalls and content filtering appliances;
  - access control mechanisms;
  - laptop encryption; and
  - removable media encryption.
- Work in implementing the new computer aided dispatch system, which will significantly enhance resilience and capability, remains on track for implementation in June 2011.
- The creation of a dedicated event control room was completed to plan. This facility provides coordination support to annual events such as the London Marathon and the Notting Hill Carnival.

Business Continuity

- Our programme of testing departmental plans has continued.
- We held a pandemic flu business continuity workshop during the year and as a result of this a business continuity departmental flu plan document was put in place.
- A business continuity plan for ambulance station complexes has been developed which will include adverse weather considerations.
- Work on developing fuel resilience has taken place.
- Training for both operational and support staff has been under development and for the latter has been delivered as part of a one-day refresher course.

Accounting

- The control weakness listed in 2009/10 has been fully resolved and we have assurance that all journals have been uploaded and posted by different people through out 2010/11.
- The outstanding audit points suggest that during 2010/11 there was a systematic weakness in relation to all budget holders signing off budgets at the earliest opportunity. This control weakness was addressed by November 2010.

Public Involvement

- Complaints, incidents, patient experiences and claims are all indicators of risk and are managed and reported in line with our policy. We operate a policy of openness and transparency and seek to engage the public in resolving issues and managing risks. We work in partnership with the LAS Patients' Forum to consider issues of concern about service provision. The Learning from Experience group has been developing the reporting process for integrated review and learning from complaints, patient experiences, incidents, claims and inquests, and the Trust Board receives a monthly summary of complaints activity.

Information Governance

- Records management (patient report forms):
    - Internal audit undertook a review of patient record forms and identified that these were not being completed in accordance with our policy in certain cases and that this was not being followed up at a local level. The completeness of patient report forms is monitored at station and complex level and the management of clinical records is a theme throughout the clinical programme training. The risk of unauthorised access has been reduced by repairing and purchasing new red and black patient report form boxes which are used for the collection and transporting of patient identifiable information.

- A serious incident involving the theft of an unencrypted lap top which contained patient information was reported to the Information Commissioners Office in February 2011. A second serious incident report was submitted in March following the theft of patient information from one of our vehicles. We are liaising closely with the Information Commissioner's Office while both incidents are being investigated.

Control Issues

The Head of Internal Audit's opinion is as follows:
Based on the work undertaken in 2010/11, significant assurance can be given that there is a generally sound system of internal control, designed to meet our objectives, and that controls are generally being applied consistently. However, some weakness in the design of controls, and the inconsistent application of controls put the achievement of particular objectives at risk. The key risks and issues are:

Hazardous Area Response Team (HART): Our audit of the HART team identified a number of significant weaknesses with regards to the establishment of the team, including the establishment of processes for stock checking and fleet management, and the delivery of the estates projects to enable suitable accommodation to be established for the housing of the East and West teams.

Of the 10 recommendations made, 18 action items were identified. By the time of reporting, eight had been completed with the remaining 10 progressing to plan.

5. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by bodies such as external auditors, registration under the Care Quality Commission, and the Health and Safety Executive.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Audit and Quality Committee, and the Risk Compliance and Assurance Group. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust Board delegates authority for risk management to two committees:

- Audit Committee.
- Quality Committee.

The Chairs of these committees provide a verbal report to the Trust Board following the most recent meeting providing assurance on risk management and the effectiveness of the systems and controls that are in place.

The Audit Committee advises the Board about how well we are operating the risk management system. To carry out this responsibility it receives reports from the Chief Executive and from both internal and external audit when they review risk management systems and processes.

The Quality Committee provides assurance to the Trust Board and to the Audit Committee on quality, safety and risk management.

The Risk Compliance and Assurance Group has delegated responsibility for taking a general overview of all our risk management activities and to pick up any specific risk management issues which are not covered by the specific Audit and Quality Committees. This committee also receives a report on the management of all identified high priority risks that have been identified by our systems and processes.

The Trust Board receives regular reports from the Director of Finance and the Medical Director, and my report as Chief Executive provides assurance about the performance of the organisation and any key strategic, regulatory or compliance issues arising during the reporting period. The Trust Board receives a quarterly report on clinical quality and patient safety.

In addition, the Trust Board receives an annual report from the Audit Committee and on Equality and Inclusion, and routine reports from patient experiences.

With the exception of the internal control issues that I have outlined in this statement, my review confirms that the London Ambulance Service NHS Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

Peter Bradley
Chief Executive Officer
XX June 2011

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2011

	2010/11	2009/10
	£000	£000
Revenue		
Revenue from patient care activities	**280,304**	269,557
Other operating revenue	**3,313**	10,307
Operating expenses	**(279,541)**	(275,633)
Operating surplus (deficit)	**4,076**	4,231
Finance costs:		
Investment revenue	**823**	577
Other gains and (losses)	**1,068**	(128)
Finance costs	**(1,508)**	(1,540)
Surplus/(deficit) for the financial year	**4,459**	3,140
Public dividend capital dividends payable	**(3,772)**	(3,560)
Retained surplus/(deficit) for the year	**687**	(420)
Other comprehensive income		
Impairments and reversals	**(160)**	(10,692)
Gains on revaluations	**1,125**	15,315
Receipt of donated/government granted assets	**0**	0
Net gains/(losses) on available for sale financial assets	**0**	0
Reclassification adjustments:		
- Transfers from donated and government grant reserves	**(2)**	(2)
- On disposal of available for sale financial assets	**0**	0
Total comprehensive income for the year	**1,650**	**4,201**

All income and expenditure is derived from continuing operations.

Reported NHS financial performance position [Adjusted retained surplus/(deficit)]

Retained surplus/(deficit) for the year	**687**
IFRIC 12 adjustment	**0**
Impairments	**303**
Reported NHS financial performance position [Adjusted retained surplus/(deficit)]	**990**

A trust's reported NHS financial performance position is derived from its retained surplus/(deficit), but adjusted for the following:

a) Impairments to Fixed Assets. 2009/10 was the final year for organisations to revalue their assets to a Modern Equivalent Asset (MEA) basis of valuation. An impairment charge is not considered part of the organisation's operating position.
b) The revenue cost of bringing PFI assets onto the balance sheet (due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009/10). NHS trusts' financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring

departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to PFI, which has no cash impact and is not chargeable for overall budgeting purposes, should be reported as technical. This additional cost is not considered part of the organisation's operating position.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2011

	31 March 2011 £000	31 March 2010 £000
Non-current assets		
Property, plant and equipment	**128,044**	131,434
Intangible assets	**14,479**	12,639
Investment property	**0**	0
Other financial assets	**0**	0
Trade and other receivables	**6,753**	10,526
Total non-current assets	**149,276**	154,599
Current assets		
Inventories	**2,571**	2,783
Trade and other receivables	**20,342**	16,448
Other financial assets	**0**	0
Other current assets	**0**	0
Cash and cash equivalents	**872**	5,141
	23,785	24,372
Non-current assets held for sale	**650**	650
Total current assets	**24,435**	25,022
Total assets	**173,711**	179,621
Current liabilities		
Trade and other payables	**(21,952)**	(25,026)
Other liabilities	**0**	0
Borrowings	**(4,847)**	(4,748)
Other financial liabilities	**0**	0
Provisions	**(1,418)**	(1,938)
Net current assets/(liabilities)	**(3,782)**	(6,690)
Total assets less current liabilities	**145,494**	147,909
Non-current liabilities		
Borrowings	**(24,931)**	(29,633)
Trade and other payables	**0**	0
Other financial liabilities	**0**	0
Provisions	**(7,955)**	(8,949)
Other liabilities	**0**	0
Total assets employed	**112,608**	109,327
Financed by taxpayers' equity:		
Public dividend capital	**62,516**	60,885
Retained earnings	**14,796**	12,943
Revaluation reserve	**35,713**	35,914
Donated asset reserve	**2**	4
Government grant reserve	**0**	0
Other reserves	**(419)**	(419)
Total Taxpayers' Equity	**112,608**	109,327

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Government grant reserve	Other reserves	Total
	£000	£000	£000	£000	£000	£000	£000
Balance at 31 March 2009							
As previously stated	57,523	12,609	32,045	6	0	(419)	101,764
Prior Period Adjustment	0	0	0	0	0	0	0
Restated balance	57,523	12,609	32,045	6	0	(419)	101,764
Changes in taxpayers' equity for 2009/10							
Total comprehensive income for the year:							
Retained surplus/(deficit) for the year	0	(420)	0	0	0	0	(420)
Transfers between reserves	0	754	(754)	0	0	0	0
Impairments and reversals	0	0	(10,692)	0	0	0	(10,692)
Net gain on revaluation of property, plant, equipment	0	0	15,315	0	0	0	15,315
Net gain on revaluation of intangible assets	0	0	0	0	0	0	0
Net gain on revaluation of financial assets	0	0	0	0	0	0	0
Receipt of donated/government granted assets	0	0	0	0	0	0	0
Net gain/loss on other reserves (e.g. defined benefit pension scheme)	0	0	0	0	0	0	0
Movements in other reserves	0	0	0	0	0	0	0
Reclassification adjustments:							
- transfers from donated asset/government grant reserve	0	0	0	(2)	0	0	(2)
- on disposal of available for sale financial assets	0	0	0	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0	0	0	0
Originating capital for Trust establishment in year	0	0	0	0	0	0	0
New PDC received	3,362	0	0	0	0	0	3,362
PDC repaid in year	0	0	0	0	0	0	0
PDC written off	0	0	0	0	0	0	0
Other movements in PDC in year	0	0	0	0	0	0	0
Balance at 31 March 2010	60,885	12,943	35,914	4	0	(419)	109,327

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY (Continued)

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Government grant reserve	Other reserves	Total
	£000	£000	£000	£000	£000	£000	£000
Changes in taxpayers' equity for 2010/11							
Balance at 1 April 2010	60,885	12,943	35,914	4	0	(419)	109,327
Total Comprehensive Income for the year							
Retained surplus/(deficit) for the year	0	687	0	0	0	0	687
Transfers between reserves	0	1,166	(1,166)	0	0	0	0
Impairments and reversals	0	0	(160)	0	0	0	(160)
Net gain on revaluation of property, plant, equipment	0	0	1,125	0	0	0	1,125
Net gain on revaluation of intangible assets	0	0	0	0	0	0	0
Net gain on revaluation of financial assets	0	0	0	0	0	0	0
Net gain on revaluation of non current assets held for sale	0	0	0	0	0	0	0
Receipt of donated/government granted assets	0	0	0	0	0	0	0
Net gain/loss on other reserves (e.g. defined benefit pension scheme)	0	0	0	0	0	0	0
Movements in other reserves	0	0	0	0	0	0	0
Reclassification adjustments:							
- transfers from donated asset/government grant reserve	0	0	0	(2)	0	0	(2)
- on disposal of available for sale financial assets	0	0	0	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0	0	0	0
Originating capital for Trust establishment in year	0	0	0	0	0	0	0
New PDC received	1,631	0	0	0	0	0	1,631
PDC repaid in year	0	0	0	0	0	0	0
PDC written off	0	0	0	0	0	0	0
Other movements in PDC in year	0	0	0	0	0	0	0
Balance at 31 March 2011	62,516	14,796	35,713	2	0	(419)	112,608

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2011

	2010/11 £000	2009/10 £000
Cash flows from operating activities		
Operating surplus/(deficit)	**4,076**	4,231
Depreciation and amortisation	**11,713**	12,002
Impairments and reversals	**303**	1,845
Net foreign exchange gains/(losses)	**0**	0
Transfer from donated asset reserve	**(2)**	(2)
Transfer from government grant reserve	**0**	0
Interest paid	**(1,341)**	(1,366)
Dividends paid	**(3,972)**	(3,360)
(Increase)/decrease in inventories	**212**	(183)
(Increase)/decrease in trade and other receivables	**386**	(1,136)
(Increase)/decrease in other current assets	**0**	0
Increase/(decrease) in trade and other payables	**2,622**	1,130
Increase/(decrease) in other current liabilities	**0**	0
Increase/(decrease) in provisions	**(1,680)**	(1,217)
Net cash inflow/(outflow) from operating activities	**12,317**	11,944
Cash flows from investing activities		
Interest received	**61**	53
(Payments) for property, plant and equipment	**(15,006)**	(15,064)
Proceeds from disposal of plant, property and equipment	**7,018**	323
(Payments) for intangible assets	**(5,686)**	(3,867)
Proceeds from disposal of intangible assets	**0**	0
(Payments) for investments with DH	**0**	0
(Payments) for other investments	**0**	0
Proceeds from disposal of investments with DH	**0**	0
Proceeds from disposal of other financial assets	**0**	0
Revenue rental income	**0**	0
Net cash inflow/(outflow) from investing activities	**(13,613)**	**(18,555)**
Net cash inflow/(outflow) before financing	**(1,296)**	(6,611)
Cash flows from financing activities		
Public dividend capital received	**1,631**	3,362
Public dividend capital repaid	**0**	0
Loans received from the DH	**0**	10,000
Other loans received	**107**	0
Loans repaid to the DH	**(1,244)**	(681)
Other loans repaid	**0**	0
Other capital receipts	**0**	0
Capital element of finance leases and PFI	**(3,443)**	(3,522)
Net cash inflow/(outflow) from financing	**(2,949)**	9,159
Net increase/(decrease) in cash and cash equivalents	**(4,245)**	2,548
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year	**5,081**	2,533
Effect of exchange rate changes on the balance of cash held in foreign currencies	**0**	0
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	**836**	5,081

Remuneration report

Our Remuneration Committee consists of the Chairman and the six non-executive directors. The Chief Executive is usually in attendance but is not present when his own remuneration is discussed.

The Remuneration Committee is responsible for advising the Board about appropriate remunerations and terms of service for the Chief Executive and executive directors. It makes recommendations to the Board on all aspects of salary, provisions for other benefits, including pensions and cars, as well as arrangements for termination of employment and other contractual terms.

In formulating their recommendations to the Board, the Committee takes into account a number of factors, including the requirement of the role, the performance of the individuals, market rates, affordability, and the NHS Very Senior Managers Pay Framework.

Executive directors are subject to normal terms and conditions of employment. They are employed on permanent contracts which can be terminated by either party with six months' notice.

Their performance is assessed against individually set objectives and monitored through an appraisal process.

For the purposes of this report, the disclosure of remuneration to senior managers is limited to our executive and non-executive directors. Details of remuneration, including salaries and pension entitlements, are published on page 45**.**

The appointment and remuneration of the Chairman and the non-executive directors are set nationally. Non-executive directors are normally appointed for a period of four years and usually serve two terms in office.

The information contained below in the Salary and Pension Entitlement of Senior Managers has been audited by our External Auditors.

Salary and pension entitlements of senior managers

A) Remuneration

Name and Title	2010-11			2009-10		
	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Benefits in Kind Rounded to the nearest £100	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Benefits in Kind Rounded to the nearest £100
Richard Hunt, Chairman	£20,001-£25,000	£0		£15,001-£20,000	£0	
Caroline Silver, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Beryl Magrath, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Brian Huckett, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Jessica Cecil, Non-Executive Director	£0-£5,000	£0		-	-	
Nigel Walmsley, Non-Executive Director	£5,001-£10,000	£0		£0-£5,000	£0	
Roy Griffins, Non-Executive Director	£5,001-£10,000	£0		£5,001-£10,000	£0	
Sarah Waller, Non-Executive Director	£0-£5,000	£0		£5,001-£10,000	£0	
* Peter Bradley, Chief Executive	£110,001-£115,000	£0	£2,277	£110,001-£115,000	£0	£3,448
Michael Dinan, Director of Finance	£115,001-£120,000	£0		£115,001-£120,000	£0	
**Martin Flaherty, Director of Operations	£50,001-£55,000	£0	£1,326	£115,001-£120,000	£0	£1,300
Caron Hitchen, Director of Human Resources	£100,001-£105,000	£0		£100,001-£105,000	£0	
Stephen Lennox, Director of Health Promotion & Quality	£5,001-£10,000	£0		-	-	
*** Fionna Moore, Medical Director	£70,001-£75,000	£0		£70,001-£75,000	£0	

The figures shown under the heading 'benefit in kind' refer to the provision of lease cars.

* Excludes remuneration recharged to the Department of Health for role as National Ambulance Advisor.
** Martin Flaherty was on a secondment to the Irish Ambulance Service from July 2010 to January 2011 and to Great Western Ambulance Service NHS Trust since February 2011.
*** Fiona Moore is an employee of Imperial College Healthcare NHS Trust who works part-time for the London Ambulance Service as Medical Director.
Sarah Waller and Nigel Walmsley resigned as non-executive director in November 2010 and March 2011 respectively.
Jessica Cecil was appointed as a non-executive director on 1December 2010.
Stephen Lennox was appointed as Executive Director of Health Promotion & Quality in January 2011.

Salary and pension entitlements of senior managers (continued)

B) Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2,500)	Lump sum at aged 60 related to real increase in pension (bands of £2,500)	Total accrued pension at age 60 at 31 March 2011 (bands of £5,000)	Lump sum at age 60 at related to accrued pension at 31 March 2011 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2011	Cash Equivalent Transfer Value at 31 March 2010	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension To nearest £100
Richard Hunt, Chairman	**	**	**	**	**	**	**	
Caroline Silver, Non-Executive Director	**	**	**	**	**	**	**	
Beryl Magrath, Non-Executive Director	**	**	**	**	**	**	**	
Brian Huckett, Non-Executive Director	**	**	**	**	**	**	**	
Jessica Cecil, Non-Executive Director	**	**	**	**	**	**	**	
Nigel Walmsley, Non-Executive Director	**	**	**	**	**	**	**	
Roy Griffins, Non-Executive Director	**	**	**	**	**	**	**	
Sarah Waller, Non-Executive Director	**	**	**	**	**	**	**	
Peter Bradley, Chief Executive	£0-£2,500	£2,501-£5,000	£10,001-£15,000	£35,001-£40,000	£297,431	£288,254	£6,424	
Michael Dinan, Director of Finance	£0-£2,500	£2,501-£5,000	£5,001-£10,000	£25,001-£30,000	£146,122	£139,828	£4,406	
Martin Flaherty, Director of Operations	£0-£2,500	£5,001-£7,500	£15,001-£20,000	£55,001-£60,000	£374,101	£366,768	£5,133	
Caron Hitchen, Director of Human Resources	£0-£2,500	£2,501-£5,000	£25,001-£30,000	£80,001-£85,000	£441,267	£471,771	-£21,353	
Stephen Lennox, Director of Healthcare Promotion ++	£0	£0	£0	£0	£0	£0	£0	
Fionna Moore, Medical Director	£0-£2,500	£2,501-£5,000	£45,001-£50,000	£140,001-£145,000	£1,137,365	£1,137,365	£0	

** As non-executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive members.
++ Pending information from Pension Agency.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV – this reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

C) Expenses 2010/11

Name and Title	Travel - UK	Travel - Overseas	Provision of Lease Cars	Mobile Phones	Subscription	Hospitality	Total
	£	£	£	£	£	£	£
Richard Hunt, Chairman	3,405	-	-	-	-	16	**3,421**
Beryl Magrath, Non-Executive Director	113	-	-	-	-	-	**113**
Sarah Waller, Non-Executive Director	-	-	-	-	-	-	**-**
Roy Griffins, Non-Executive Director	-	-	-	-	-	-	**-**
Brian Huckett, Non-Executive Director	-	-	-	-	-	-	**-**
Caroline Silver, Non-Executive Director	-	-	-	-	-	-	**-**
Nigel Walmsley, Non-Executive Director	-	-	-	-	-	-	**-**
Jessica Cecil, Non-Executive Director	-	-	-	-	-	-	**-**
Peter Bradley, Chief Executive	3,084	-	6,272	729	-	139	**10,224**
Michael Dinan, Director of Finance	604	-	-	486	-	349	**1,439**
Martin Flaherty, Director of Operations	34	-	7,344	-	-	-	**7,378**
Caron Hitchen, Director of Human Resources	616	511	-	457	143	-	**1,727**
Fionna Moore, Medical Director	-	-	1,996	799	-	-	**2,795**
Stephen Lennox, Director of Health Promotion & Quality	-	-	-	-	-	-	**-**
Total	**7,856**	**511**	**15,612**	**2,471**	**143**	**504**	**27,097**

Sarah Waller resigned as a non-executive director on 30 November 2010 and Jessica Cecil was appointed as a non-executive director on 1 December 2010.
Stephen Lennox was appointed as Director of Health Promotion & Quality in January 2011.
The Trust Board approves all travel outside of the European Community.

The above expense figures have not been audited.

Reporting of other compensation schemes – exit packages 2010/11

NHS Body		**London Ambulance Service NHS Trust**			
	a	b	c	d	e
1	**Exit package cost band (including any special payment element)**	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band (total cost)**	**Number of departures included in (b) and (c) where special payment element (totalled))**
2	**<£20,001**	0	0	0	0
3	**£20,001 - £40,000**	0	1	1 (£40,000)	0
4	**£40,001 - £100,000**	1	0	1 (£87,000)	0
5	**£100,001 - £150,000**	1	0	1 (£136,000)	0
6	**£150,001 - £200,000**	0	0	0	0
7	**Total number of exit packages by type (total cost)**	3 (£223,000)	1 (£40,000)		
8				**Total number (and cost) of exit packages**	**Total number of special payments (and total cost of special payment element)**
				3 (£263,000)	0

Management costs

	2010/11 £000	**2009/10** £000
Management costs	18,921	19,300
Income	281,197	271,143

Better payment practice code – measure of compliance

	2010/11		2009/10	
	Number	**£000**	Number	£000
Total non-NHS trade invoices paid in the year	**62,654**	**83,829**	64,530	87,130
Total non NHS trade invoices paid within target	**52,816**	**75,015**	55,518	80,160
Percentage of non-NHS trade invoices paid within target	**84%**	**89%**	86%	92%
Total NHS trade invoices paid in the year	**421**	**4,379**	525	3,038
Total NHS trade invoices paid within target	**352**	**3,392**	459	2,606
Percentage of NHS trade invoices paid within target	**84%**	**77%**	87%	86%

The Better Payment Practice Code requires us to aim to pay all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

EXTERNAL FINANCING

We are given an external financing limit which it is permitted to undershoot.

	£000	**2010/11** **£000**	2009/10 £000
External financing limit		**1,371**	18,423
Cash flow financing	1,296		6,611
Finance leases taken out in the year	0		0
Other capital receipts	0		0
External financing requirement		**1,296**	6,611
Undershoot/(overshoot)		**75**	11,812

This summary financial statement does not contain sufficient information to allow as full an understanding of our results and state of affairs nor of our policies and arrangements concerning directors' remuneration as would be provided by the full annual accounts and reports. Where more detailed information is required a copy of our full accounts and reports are obtainable free of charge.

A copy of our full accounts is available from the Financial Controller at the following address:

Financial Controller
Finance Department
London Ambulance Service NHS Trust
220 Waterloo Road
London
SE1 8SD

Explanation of statutory financial duties

Break-even duty

We are required to break-even on our income and expenditure account taking one year with another.

External financing limit (EFL)

The external financing limit (EFL) is the means by which the Treasury via the NHSE controls public expenditure in NHS trusts. This is an absolute financial duty, with a maximum tolerance of only 0.5 per cent of turnover under the agreed limit. There is no tolerance above the EFL target without prior notification and agreement.

Most of the money spent by us is generated from our service agreements for patient care and income generation (income from operations). The EFL determines how much more (or less) cash than is generated from its operations we can spend in a year.

Each year, each individual NHS trust is allocated an EFL as part of the national public expenditure planning process. We have a statutory duty to maintain net external financing within its approved EFL.

Capital resourcing limit (CRL)

The CRL is part of the resource accounting and budgeting arrangements in the NHS and its purpose is to ensure that resources allocated by the government for capital spending are used for capital, rather than to support revenue budgets. All NHS bodies have a capital resource limit. The CRL is accruals based as opposed to the cash-based EFL in NHS trusts.

Underspends against the CRL are permitted and overspends against the CRL are not permitted.

A capital resource limit controls the amounts of capital expenditure that a NHS body may incur in the financial year.

Capital Cost Absorption Duty

The financial regime of NHS trusts recognises that there is a cost associated with the maintenance of the capital value of the organisation. We are required to absorb the cost of capital at a rate of 3.5 per cent of average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital, bears to the average relevant net assets of the trust. To meet this duty we must achieve a rate between 3.0 per cent and 4.0 per cent.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 24TH MAY 2011

PAPER FOR NOTING

Document Title:	**Cost Improvement Programme – Progress to Date**
Report Author(s):	**Martyn Salter**
Lead Director:	**Mike Dinan**
Contact Details:	**0207 783 2715**
Why is this coming to the Trust Board?	**To update the Board on progress in delivering the 2011/12 Cost Improvement Programme.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Other
Recommendation for the Trust Board:	**To note progress to date and next steps in delivering the Cost Improvement Programme**

Executive Summary

This paper sets out progress since the Trust Board approved the Cost Improvement Programme for 2011/12 and the following five years. It also sets out the actions that will be taken over the next couple of months.

Key issues for the Trust Board

Good progress has been made toward delivering the 2011/12 Cost Improvement Programme.

Attachments

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Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper supports the mitigation of the following strategic risks:

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

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
☐ 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

Cost Improvement Programme – Progress to Date

1. Introduction

1.1. This paper sets out progress since the Trust Board approved the CIP for 2011/12 and the following 5 years. It also sets out the actions that will be taken over the next couple of months.

2. Progress since last Report

2.1. Process

2.1.1. Since the Board meeting at the end of March, the following actions have taken place:

- All CIP projects have been allocated into one of the IBPD programmes and the associated portfolios.
- Project executives and, in most cases, project managers have been identified, reporting to the relevant CIP Sponsor.
- All projects have now been entered into Performance Accelerator and the relevant guidance produced for project managers (owners), project executives (sponsors), clinical leads and finance leads.
- All CIPs have been removed from budgets.
- Process for monitoring the CIP has been agreed between the CIP lead and finance staff.
- Dashboards delivered within PA to report, on screen, progress of CIP.

2.2. Project Management

2.2.1. For many of the projects delivering savings in the current year meetings have taken place between the relevant programme manager and project manager or project executive and progress is being made to deliver the agreed milestones. Evidence of this includes:

- Notification of the cessation of managers overtime payments.
- Meetings between procurement and departments to coordinate negotiations to reduce contract prices and scope of e-series catalogues.
- Production of the business case exploring future arrangements for the delivery of financial services.

2.2.2. In some cases the summary PIDs previously produced have been replaced with more comprehensive documents providing greater detail and guidance for project managers.

2.2.3. Programme managers are encouraging project teams to review risk and issue logs, updating them where necessary.

2.3. Delivery

2.3.1. Although the Month 1 financial results are not available at the time of writing it is anticipates that there will not be a material variance against plan at the end of the month, given budgets were reduced by the value of the CIP.

2.4. Discussions are taking place to identify further initiatives which will close the gap and cover for any slippage in delivering the agreed savings. This will include exploring how some of the increased cost identified at the 2010/11year end, e.g. annual leave accrual, could be reversed in 20911/12.

3. Next Steps

3.1. The following activities are currently taking place or are planned for the remainder of this month:

- Training of all project managers, project executives, clinical leads and finance leads so they can complete the monthly update reports using PA. (The first of these reports is due on the 1st June 2011.) This will allow programme managers sufficient time to take any corrective action and produce reports for the SMG meeting.
- Loading of Month 1 actual savings into PA along with target and actual non-financial KPIs.
- Producing the suite of reports which will be used each month to report progress on delivering the CIP (and IBPD).
- Delivery of project milestones.
- Produce routine reports on progress for the Trust Board, SMG and ADG.

3.2. Following final agreement of the governance surrounding the IBPD programmes the three programme managers will need to finalise the sequencing of projects and identify any interdependency or capacity issues not already known. There may also need to be some further work to ensure effective alignment between the programmes and management of the CIP.

M. J. Salter
Corporate Processes Programme Manager
19 May, 2011

MJS/TB Report 20110524.docx

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 24TH MAY 2011

PAPER FOR APPROVAL

Document Title:	**Future Financial Services OBC**
Report Author(s):	**Amanda Cant**
Lead Director:	**Michael Dinan**
Contact Details:	**0207 783 2764 (or internal 1122764)**
Why is this coming to the Trust Board?	**For approval to proceed to procurement**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Other
Recommendation for the Trust Board:	**The Trust board are asked to approve the future financial services proceeding to procurement.**

Executive Summary

The Board approved cost improvement programme includes project F2-2 – Financial Services Review. It is estimated this might deliver up to £250k per annum of recurrent savings for the London Ambulance Service.

The outline business case will come to the Board in part II exploring the options for future financial services using the 5 business case model.

Since the 'Credit Crunch' the public sector has been under pressure to reduce support services costs as part of a government drive to reduce the Public Sector Borrowing Requirement.

This is reflected in the Department of Health (DH) and Commissioners' requirement for the LAS to reduce costs by 4% recurrently in 2011/12 and over the next 4 years. As part of the Cost Improvement Programme, a benchmarking exercise has been carried out with NHS Shared Services Bureau (NHS SBS)[1]. The exercise demonstrated that there were significant potential savings to be achieved by changing the Trust's processes, staffing and systems around Financial Services.

This business case considers the most cost efficient methods of delivering core financial and procurement services including accounts payable and receivable, financial system management, cash flow, reconciliations and tax returns.

The business case has been prepared to explore the trust needs to ensure value for money over its use of public funds.

[1] NHS SBS is a joint venture between the department of health and a private company called Xsansa. NHS SBS provide financial services to over 100 NHS Bodies national wide. It is likely they would be interested in provided financial services to the London Ambulance Services.

The Board is asked to approve proceeding to tendering to any willing provider.

Stake holder and Staff consultation in line with managing change will be undertaken through out the life of the project.

Key issues for the Trust Board

Risk Description	Corporate Objective	Risk Category	Date Opened	Gross Impact	Gross Like-lihood	Gross Rating	Existing Controls (Already In Place)	Risk Owner	Date Risk Last Updated	Net Impact	Net Like-lihood	Net Rating
There is a risk shared service providers will be less flexiblity and adaptable than current in house service	19	Finance	01/03/2011	Moderate	Likely	12	1. System design phase to ensure clear shared understanding of business requirements	Meena Shah		Moderate	Likely	12
End users will resist direct input of data in to the finance system	19	Finance	01/03/2011	Moderate	Unlikely	6	1. Develop realistic training plan for end users	Andy Bell		Moderate	Unlikely	6
Deliverablity of change without additional restructuring costs	19	Finance	01/03/2011	Major	Possible	12	1. Consider deliverability and restructuring costs	Michael John		Major	Possible	12
Patient care may be impacted if suppliers are not paid in a timely basis as a result of financial services transfer	19	Finance	01/03/2011	Moderate	Unlikely	6	1. Ensure any approved supplier has rapid payment facility	Ken Thompson		Moderate	Rare	3
There is a risk tendering will not deliver the anticipated savings.	19	Finance	01/03/2011	Moderate	Possible	9	1. There is no obligation to proceed with submitted tenders	Amanda Cant		Moderate	Unlikely	6
Redundancies will arise from outsourcing financial services. This may lead to industrial unrest and reputational damage	19	Finance	01/03/2011	Moderate	Unlikely	6	1. Redundancies will be minimised via inclusion of Tupe rights in tendering specifications	Judy Brown		Moderate	Rare	3

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:

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

NHS Constitution

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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
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 24TH MAY 2011

PAPER FOR DISCUSSION

Document Title:	**Quality Account 2010-2011**
Report Author(s):	**Steve Lennox**
Lead Director:	**Steve Lennox**
Contact Details:	**Stephen.lennox@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**For discussion**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☒ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Other
Recommendation for the Trust Board:	**To discuss the content of the Quality Account**

Executive Summary:

This is the consultation version of the Quality Account. The assurance process obligates us to share a draft report with stakeholders and incorporate their comments within the final version that is published on NHS Choices website and submitted to the Secretary of State.

The final version will be tabled at the Board in June for approval before submission.

However, the DH time frame does not give the June Board (28 June) the opportunity to shape the final version (submission 30 June). Therefore, the draft is presented at the May Board in advance notice and for the opportunity for Board members to comment.

The Quality Account was presented to the April Quality Committee for approval prior to circulation to stakeholders.

Key issues for the Trust Board:

The quality priorities for 2011-2012. Mental health, End of Life, Appropriate Care Pathways and the Quality dashboard.

Attachments:

Quality Account 2010 - 2011

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Strategic Goals 2010 – 13

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This paper supports the mitigation of the following strategic risks:

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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
NHS Trust

Quality Account 2010-2011

- Vision
- Priorities
- Quality Statements
- Looking Back
- Stakeholder Feedback
- Summary

Contents

Section 1: Introductions

Section 2: Part A Quality Priorities

Section 2 Part B Quality Statements

Section 3 Looking Back

Section 4 Stakeholders Comments

Section 5 Summary

Section 1. Introductions

Statement by the Chief Executive

Statement by the Chief Executive

The London Ambulance Service NHS Trust is the busiest ambulance service in the country responding to the emergency needs of up to 8 million London residents, commuters and tourists. We help patients of all ages who require unplanned assistance for all health conditions, including trauma, cardiac emergency, mental health, maternity and stroke. The work we do really is varied and can range from dealing with a major incident, providing clinical support to mass gatherings such as the Papal Visit to helping vulnerable elderly patients in their homes who have had a fall.. In addition, we also provide a transport service for patients who require assistance in travelling to various hospitals and clinics. and run the Emergency Bed Service that includes as one of its roles reporting on hospital A&E capacity across the Capital.

This past year has been a challenging year for us. We saw the coldest winter in a lifetime which affected the health needs in London and also brought on adverse driving conditions through persistent low temperatures. We also saw a large number of demonstrations and public events which required our clinical support. These changes, amongst others, resulted in the highest number of 999 calls requesting assistance that we have ever received with 1,500,000 calls made during 2010-2011.

Whilst it was challenging we successfully met our most significant quality standard set by the Department of Health; to reach 75% of our patients with a potentially life threatening condition within 8 minutes and 95% within 19 minutes. Unfortunately, we didn't meet the Department of health standard for our less urgent patients. The standard is to reach 95% of those cases within 19 minutes and we achieved 87%. This is disappointing. But speed is not always the priority with this group of patients and whilst we will endeavour to improve our response times this quality standard is replaced next year with more meaningful clinical outcome measures which we will report on next year.

We are committed to providing our patients with the best possible clinical outcomes and experience. Safety and quality are at the very top of our priority list and our vision is to be a world class service.

This, our second ever Quality Account, reports on some of the progress we are making in achieving our vision. Last year we identified a number of quality areas where we would make improvements and this report describes the progress we have made. In addition, we identify new priorities for the coming year and will report on their progress in next year's Quality Account.

The account reports on a number of successes. However, we are not complacent and recognise that further improvements can always be made. We want to raise the profile of the patient voice and improve our understanding of what it is like to be a patient who uses our service. For this reason we are moving towards quality indicators that are described and presented in a way that are meaningful to the public and that will over time provide greater transparency and accountability for what we do. This is reflected in the style of this account. We have tried to make it more accessible to patients and welcome patient feedback on the report or their experience of our service.

To the best of my knowledge the information contained in this report is accurate and reflects a true account of our service

Peter Bradley CBE

Chief Executive

Introduction

The London Ambulance Service NHS Trust is the only NHS Trust that serves the whole of London. Our role is to provide healthcare that is free to patients at the point of delivery in an out of hospital environment

This year, like every year, has been an interesting and challenging year. There have been a number of high profile activities that have looked at the quality of our service. All Ambulance Trusts participated in a National Audit Office review and the results will be published in 2011-2012. We have been reviewed by the Greater London Authority and are awaiting their conclusion. Most significantly is the outcome of the inquest led by the Right Honourable Lady Justice Hallett into the London Bombings of 7 July 2005. Her conclusions will be published in early May 2011.

However, as a result of our own learning we have already implemented a number of quality improvements. For example, we now establish an event control room when necessary and have implemented a second Hazardous Area Response Team that can respond to events involving hazardous materials or environments.

We now also have an Urban Search & Rescue team which consists of specially trained staff who are able to respond to patients in challenging and hard to reach environments such as places of height and depth.

These developments have been very positive in improving the quality service we provide. However, we regularly face significant operational challenges and our ability to respond rapidly requests for help is our priority and is monitored continuously by the Strategic Health Authority, Primary care Trusts, and the Department of Health. We view the speed of our response as the cornerstone of our ability to demonstrate to everyone that we place safety and quality at the very top of our list of priorities.

But speed of response is only one small component of safety and quality. Other elements are indentified in this, our second ever, Quality Account which presents other information for patients, the public, and the Trust Board on safety and quality.

The structure of the Quality Account requires us to identify a number of key priorities for the coming year and to report on the progress against the priorities we set in last year's Quality Account.

In addition, we have included short quality reports from some of our service areas where quality priorities were not explicitly identified within last year's Quality Account (for example, Patient Transport).

Section 1. Introductions

Vision & Values

Our Vision is:

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

As an NHS trust we developed seven values that underpinned the culture of the London Ambulance Service and these became our CRITICAL values, representing the culture of the organisation and reflecting the values enshrined in the NHS Constitution. These cultural values are:

- **Clinical excellence** – we will demonstrate total commitment to the provision of the highest standards of patient care. Our services and activities will be ethical, kind, compassionate, considerate and appropriate to patients' needs;
- **Respect and courtesy** – we will value diversity and will treat everyone as they would wish to be treated, with respect and courtesy;
- **Integrity** – we will observe high standards of behaviour and conduct, making sure we are honest, open and genuine at all times and ready to stand up for what is right;
- **Teamwork** – we will promote teamwork by taking the views of others into account. We will take genuine interest in those who we work with, offering support, guidance and encouragement when it is needed;
- **Innovation and flexibility** – we will continuously look for better ways of doing things, encourage initiative, learn from mistakes, monitor how things are going and be prepared to change when we need to;
- **Communication** – we will make ourselves available to those who need to speak to us and communicate face to face whenever we can, listening carefully to what is said to us and making sure that those we work with are kept up to date and understand what is going on;
- **Accept responsibility** – we will be responsible for our own decisions and actions as we strive to constantly improve;
- **Leadership and direction** – we will demonstrate energy, drive and determination especially when things get difficult, and always lead by example.

We identified a number of factors that would assist us in delivering our long term vision. These were the following.

1. **Service Improvement Programme (SIP)** the aim of our service improvement programme is to bring about change in terms of service, performance and culture and achieve the SMART targets. The service development plans are integrated within the Service Improvement Programme
2. **SMART targets:** The achievement of these Specific, Measurable, Attainable, Relevant, and Time-bound targets signifies achievement of our corporate objectives..
3. **Corporate objectives:** The collective achievement of these objectives signifies achievement of our strategic goals.
4. **Strategic goals:** The collective achievement of these goals signifies progress made towards our vision..

Corporate Objectives

We have 10 corporate objectives and these are identified within the service so those relating to safety and quality are listed first

1. To improve outcomes for patients who are critically ill or injured

2. To provide more appropriate care for patients with less serious illness or injury

3. To meet response times routinely

4. To meet other regulatory and performance targets

5. To develop staff so they have the skills and confidence they need to do their job

6. To improve the diversity of the workforce

7. To create a productive and supportive working environment where staff feel safe, valued and influential

8. To use resources more efficiently and effectively

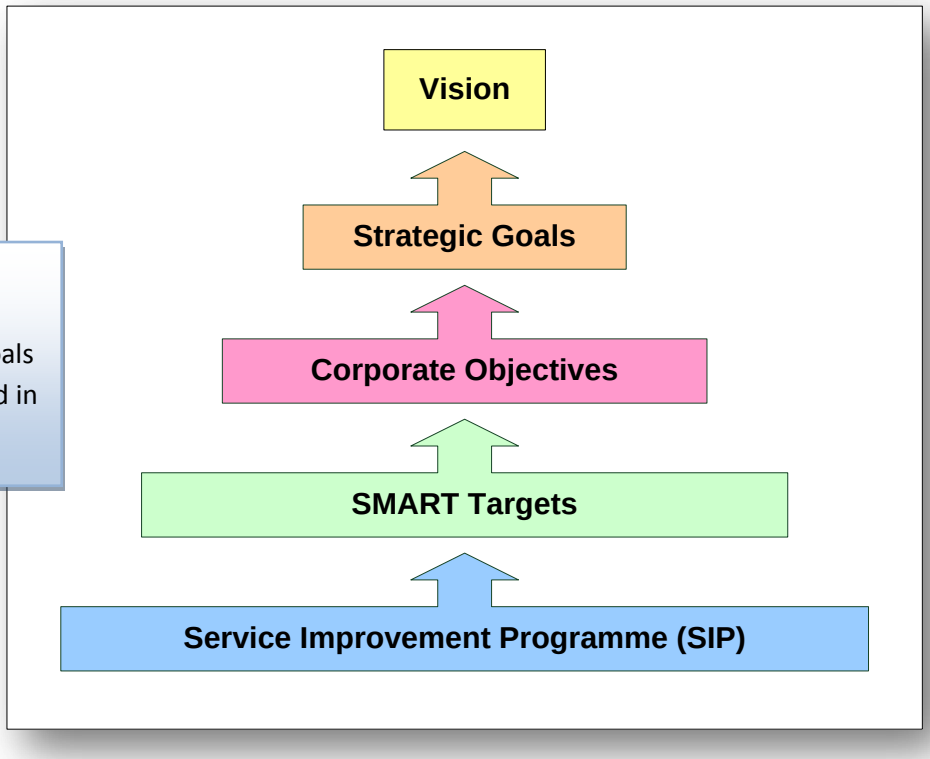
9. To maintain service performance during major events, both planned and unplanned, including the 2012 games

10. To improve engagement with stakeholders

Our Strategic Goals are;

- **Improve the quality of care we provide to patients : to improve our delivery of safe and high quality patient care using all appropriate pathways**
- **Deliver care with a highly skilled and representative workforce: to have staff who are skilled, confident, motivated, feel valued and who work in a safe environment**
- **Deliver value for money: to be efficient and productive in delivering our commitments and to continually improve**

Illustration to show how our strategy and goals were structured in 2010-2011



Writing the Quality Account

We have actively met with a number of patient groups to ask how we are doing and to ask what our quality priorities should be for 2011-2012

We believe that in order for us to accurately know how well we are doing it is fundamental for us to ask our patients. Whilst we recognise that we can make improvements in how we consult and have learnt lessons for next year it was the over riding principle that this account should reflect the views of patients.

In addition, we believe that patients should be invited to help us identify our quality priorities for 2011-2012.

Therefore, we invited a number of patient groups to participate in a series of focus groups. There were no specific factors for identifying the patient groups that we approached except we targeted groups that represented patients who could use our services regularly (such as support groups for patients with chronic disease).

Not all of the groups we approached responded. However, we were able to meet with The Sickle Cell Society, The London Gay, Bisexual and Transgender Group of Age Concern, the London Older People's Forum, MENCAP and a number of patient groups that had been specifically created for patient education.

The meetings were well attended and the feedback was very positive. Overwhelmingly the common theme was the need to respond quickly to emergency requests and this remains a Trust priority for 2011-2012.

The quality priorities for 2011-2012 emerged from the focus groups and all focus groups identified the need to consider some of the quality issues for patients who need assistance but do not fall into our emergency category. This is a fundamental component of the quality priorities for this year.

The focus groups were supported by an invitation for our Foundation Trust membership to make quality suggestions via a designated e-mail box. In addition, the Director of Health Promotion & Quality undertook a number of interviews with patients that had used our services.

On completion of the Quality Account a number of stakeholders were invited to make comments on the report and their feedback is contained within the report.

How is the Trust Prioritising Quality?

Quality is at the heart of the Trust's business and we are continuously looking at ways in which we can improve our services or improve the outcome for patients.

Our Trust Board receives information on quality at every board meeting and a number of our non executive directors are members of other committees where quality is a significant part of the committee's work plan.

However, quality is the responsibility of all Trust staff and each of the Trust's three areas has a governance mechanism for monitoring the quality of the service we provide and for monitoring any action taken to improve.

We have started to develop a new quality dashboard that will help the organisation monitor quality more consistency and this will sit alongside the Trust's well established performance dashboard.

However, we know there is further work for us to do. We have identified the further development of the quality dashboard as one of our key quality improvement priorities for 2011-2012 but we also need to consider how we structure the feedback that we receive from patients and how we evidence that this has led to us making improvements to our service. We have strong and valuable links with the London Ambulance Patient Forum who are represented at various committees but we also need to consider how else we can involve patients. This will be a key component of a new quality indicator on the dashboard called "Service Experience".

In addition, we need to improve the way we learn and share the learning from serious incidents. Our service covers a large geographical area and we need to be confident that lessons learned in one area of London are shared across our teams regardless of their location.

We have actively embedded quality within the core business of the Trust and in 2010 established a Board Level Quality Committee that is chaired by a non executive director

In 2010 we developed a new quality strategy that brings together clinical research, audit, incidents and quality improvements into a single work stream

In 2010 we appointed a Director of Health Promotion & Quality onto the executive team. This is a clinical post and the post holder is responsible for assuring the Board on quality matters

Further Improvements we need to make to our quality processes include the following

1. We need to embed the quality dashboard

2. We need to improve the way we structure and use feedback from patients

3. We need to improve the way we learn and share the learning from serious incidents

Introduction to Looking Forward

In December 2010 the Department of Health published the Operating Framework for 2011-2012. The framework is used to identify a number of areas that the NHS has to address as a whole and the quality section should be used to inform the quality priorities of all NHS organisations. Trusts are of course free to make additional priorities but there is an expectation that the national priorities will be addressed through local quality work.

This year, as we try to drive improvements against a backdrop of wider financial constraints, the Operating Framework asks us to consider quality in the wider context of health care and identify areas where our actions may release benefits across the NHS as a whole. This is called the "Quality, Innovation, Productivity and Prevention Plan (QIPP) and all NHS organisations are expected to have a plan in place.

We have developed a comprehensive QIPP plan that identifies a number of areas such as health promotion and the development of our workforce. However, the main focus of our QIPP plan is for us to reduce the number of patients we take to accident & emergency who could have their care needs met directly by us or by referral to another provider. This brings enormous benefits to patients as it could avoid an unnecessary period of hospital care and the disruption that is associated by hospitalisation. For the health system it releases benefits by reducing the demand on hospital assessment beds and minimising unnecessary hospitalisation.

The importance of this is reflected in our local Commissioning for Quality and Innovation (CQUIN) payment framework. This scheme allows our commissioners to financially reward us for achieving a successful change. Reducing the number of patients we take to accident & emergency is the largest of the five measures in our CQUIN scheme for 2011-2012.

The Quality Account asks us to take all of this into consideration and identify a small number of quality priorities for 2011-2012 that will lead our quality improvement agenda.

The Operating Framework alone identifies 15 subject areas that are relevant to the services we provide and there are also a number of local priorities.

In order to get this right we asked our patients through the quality work identified in the previous section of this Quality Account.

We then prioritised these against the national and local drivers and have identified four specific areas of quality improvement for 2011-2012.

The four areas are;

- Improving Mental health care
- Improving End of Life Care
- Improving the care for patients who have fallen
- Developing a quality dashboard

Having applied this selection process we are confident that these are the right areas for 2011-2012. They are reflected within the national Operating Framework, our QIPP plan, and our CQUIN scheme. They are consistent with our Strategic Goals and we know they are of importance to patients.

The following few pages outline the case for inclusion in more detail and highlight each example with a case study. This is then followed by an explanation as to what improvements we intend to make in each of the four areas

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1. Improving Mental Health Care

Through our accident and emergency work we are known as an acute provider but our work in response to a psychiatric emergency is often less well known. Consequently our links and knowledge of London's complex mental health services are not as strong as they are with accident and emergency departments.

In addition, calls for assistance with mental health problems represent approximately 9% of our work but we recognise that it has not received proportional attention in our service improvement work.

Mental health is a national priority. It is specifically highlighted in the Operating Framework and appears in our CQUIN scheme from our commissioners. We know from our discussions with patients that they widely support us in making improvements in this area.

However, this is not an easy area for improvement work. Unlike accident and emergency services mental health care is provided differently across London and there are a variety of access points. In addition, mental health patients often travel away from home and can present in crisis away from their care provider. Despite these challenges we have the ambition to make significant improvements to the patient experience.

We have also included a work stream on Dementia Care. This is to reflect the priority that this is given within the Operating Framework

Our improvement priorities for mental health are identified later in this report.

Case Study

Carol was in her early twenties and standing on the edge of a roof threatening to jump. Concerned passers by called 999 and asked for the police and an ambulance.

Ordinarily this challenging situation could result in the police applying an order under The Mental health Act and us being obligated to transfer the patient to accident & emergency for a mental health assessment.

In Carol's case we had already established good links with the local mental health team and had previously agreed that we could directly access their skills.

When we spoke to Carol it became apparent that she didn't wish to jump but she did need assistance. We took the decision that this situation did not need police intervention and carol did not need to be conveyed to accident & emergency. Instead, we contacted the local psychiatric liaison service who arranged a mental health assessment.

This avoided Carol being taken to accident & emergency and the intervention of the police. This was only possible because of our relationship with the local mental health team.

2. End of Life Care

We recognise that the end of life can be a very distressing time for all involved. This is particularly the case when patients who have expressed a particular preference to end their life at home can not have their wish fulfilled.

This can happen when patients, friends or family call us for assistance. When we arrive we have very little information available to us and inevitably our desire to minimise the distress means we transport the patient to accident and emergency for a medical opinion. This is clearly not always the best action to take.

End of Life Care is also a national priority. It is specifically highlighted in the Operating Framework and also appears in our CQUIN scheme.

A number of patients groups were specifically interested in this aspect of our work and appreciated how instrumental the ambulance service is in ensuring the preferences expressed by patients are maintained. This area of work was wholly endorsed by our patient groups.

Case Study

We were called to a young lady who was experiencing severe pain and distress. Silvia had lung cancer that, over time, had extended into her bones and she had also recently developed renal failure.

She had already been identified to us through the End of Life project work so we already had all the important information on her care plan. We also had all the relevant healthcare contact details to hand.

On arrival our clinical staff were able to assess and identify Silvia's main concerns.

Medications had already been prescribed and were in the house for other healthcare professionals to use. Our clinical staff administered the necessary drugs for Silvia's immediate symptom control. We then arranged further care and follow up visits by a specialist palliative care team.

Silvia died peacefully later that night, in accordance with her own wishes, in her own bed with her family beside her. Without the sharing of information from the outset our clinical staff would have had limited options and Silvia could have been taken to hospital.

3. Patients who have fallen

Patients who have fallen is not specifically identified as a national priority within the Operating Framework. However, it is a local priority.

Inevitably with a population the size of London we receive a significant number of calls regarding patients who have fallen. Every month approximately 6500 people aged 65years or over call an ambulance having fallen. The majority of these incidents occur in the patient's own home. Currently, 67% of these patients are conveyed to hospital, 29% are assisted and treated on scene, and the remaining 4% are referred to other services.

With a year-on-year increase in the percentage of over 65s within the population, it is predicted that the numbers of people who fall will continue to increase. Some will obviously require transportation to accident and emergency but we need to undertake further work with those groups where an immediate hospital assessment is not necessary.

This is an important part of our QIPP Plan as there are opportunities to increase the proportion of patients that we don't take to accident and emergency by working with this group. Also, there are opportunities for us to improve the way we communicate our actions with other healthcare providers; particularly when we decide not to convey a patient to accident and emergency following a fall. This is a specific measure within our CQUIN scheme.

Case Study

Having an agreed process in place can make a real difference to patient care. Some care homes have residents with low needs and therefore have limited clinical expertise.

On Christmas Day Emily was in a care home and fell. The staff in the care home had to adhere to their policy which states the need to call 999 and ask for an ambulance.

We had an agreed protocol in place with the Primary Care Provider and were able to contact the GP ourselves.

Emily was pleasantly surprised that the GP came out for a visit and referred Emily directly to a falls team.

This prevented Emily from having to be transported to Accident & Emergency and wait for her assessment away from friends and relatives.

4. Development of a Quality Dashboard

It is important that we also focus some attention on the wider quality measures identified within the Operating Framework and are able to demonstrate wider quality improvements. Therefore, whilst they will not have a dedicated work stream to support implementation, the dashboard will capture a number of the other priorities and these are outlined in our Quality Strategy.

Our patient groups were supportive of us developing wider measures and we agreed that we would make these available to patients in due course.

In addition, the quality dashboard will be an important part of our portfolio of evidence when meeting with commissioners and they are also supportive of this development.

5. Last Years Priorities (2010-2011)

There is one final area for consideration. This is the on going work from the priorities identified last year.

In 2010-2012 we identified six priority areas. These were as follows;

1. **Improving Cardiac care**
2. **Improving Trauma Care**
3. **Implementing Alternative Care Pathways**
4. **Improving Stroke Care**
5. **Developing the Quality Dashboard**
6. **Freeing ambulances for care**

Unsurprisingly whilst this report highlights the successes there are a number of further improvements that can be made. In addition, 3 of the areas are explicitly identified within this year's Operating Framework. Therefore, we also commit ourselves to a continuation in making improvements in these essential areas of quality. The areas for improvements are identified later in this report.

Mental Health care

Quote to be included from received comments

Mental Health (quality domain: patient safety)

We have agreed our improvement strategy for mental health with our commissioners and will launch our mental health group early in 2011-2012.

Whilst our lead Director has a mental health qualification we will also need to recruit a mental health expert to lead some of the improvement work and we will do this early in 2011-2012.

We will need to work in collaboration with other NHS Trusts and with our commissioners to ensure we make meaningful improvements to the quality of service we provide.

Patient feedback is also essential and we will engage with patient representation to ensure we are making the right improvements.

Improvements we need to make to mental health care include the following.

1. Improving the skill and competence in our clinical staff

2. Participate in whole system transformation work with partner organisations

3. Improve the advice and support available to our clinical staff

4. Improve the actual clinical intervention we provide mental health patients

5. Improve our governance and safeguarding arrangements with mental health patients

6. Improve the care of patients with dementia

7. Consider how we can use health promotion work with mental health patients

8. Improve the management of alcohol related harm

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Section 2. Looking Forward

End of Life care

"Patients should be allowed to choose to die at home and the London Ambulance Service should support their decision by offering them all the assistance they possibly can'"

Minority Ethnic Elder's Group of the London Older People's Forum

End of Life (quality domain: patient experience)

The ability to support end of life care strategies across London is a growing priority for the Trust and fits with other ongoing strategic developments including the development of Appropriate Care Pathways and the development of a Single Point of Access.

Last year we worked collaboratively with Guy's and St Thomas' Hospital Charity on end of life care. The project required us to share the decisions patients had made about their End of Life Care and for us to ensure these wishes were taken into consideration along the whole care pathway.

The Trust will build upon this work and continue to work with other End of Life Care providers in jointly providing that care. In order to provide fit for purpose end of life care support in the community the Trust will develop a number of quality improvements.

Further Improvements we need to make to end of life care include the following.

1. Improve the skills and competence of our clinical staff

2. Having and sharing the information about a patient's current care preferences

3. Clarifying how we obtain clinical support from local providers

4. Improve the confidence in the systems so we can handover care

5. Having knowledge on what action to take when agreed care provision breaks down

6. Improve the knowledge in the dying process

7. Improve the ability of clinical staff to make an examination and assessment

8. Improve the knowledge of drug use in out of hospital end of life care

9. Understand the challenges associated with end of life care for people with dementia

Patients who have Fallen

Quote to be included from received comments

Falls (quality domain: clinical effectiveness)

It is recognised by clinicians that there are a multitude of causes that can lead to an individual sustaining a fall, ranging from physiological changes related to the aging processes, acute medical episodes and slips or trips on furnishings (or pets)! However, in order to establish the underlying cause of the fall, an in-depth history and a full physical assessment must be undertaken on each patient. Together these provide the clinician with the knowledge that enables them to construct a management plan to address patient's individual needs.

Historically, there has been no linking mechanism between our services and the wider GP community to share information about patients who have fallen but have not been taken to hospital. During the financial year 2010-2011, a small working group was tasked to review our management of elderly patients who have fallen. It became clear that there were two strands of work to be undertaken 1) providing additional training for all operational staff and enabling our staff to understand the possible causes and management options for elderly people who fall and 2) relating to stakeholder engagement including GPs, out-of-hours services, and community care services providing specialist care for patients who have fallen.

Further Improvements we need to make to the way we care for patients who have fallen include the following.

1. We will develop further the tool to assist our clinicians in decision making and make this more widely available to staff.

2. We will implement training so that staff are familiar with the developed tool.

3. We will improve our monthly referral rates following agreed falls protocol (back to GP) for uninjured people who have fallen.

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Implementing a Quality Dashboard

Insert quote saying why the dashboard is important

Quality Dashboard (quality domain: all three domains)

During 2010-2011 we started to develop a quality dashboard that will strengthen the way we assure ourselves that we are delivering on quality. The dashboard will regularly present the outcomes against a number of quality measures such as Infection Control and Patient experience.

For 2010-2011 the majority of the developmental work was focussed around the implementation of new measures from the Department of Health. However, as we progress through 2011-2012 we will implement additional indicators so that we have a more complete picture.

These additional quality measures have been identified through an analysis of our incidents and through discussions at a number of patient focus groups.

Further Improvements we need to make to the development of our quality dashboard include the following.

1. Implementing the use of the dashboard through our quality governance structure.

2. The implementation of the additional quality measures identified within our quality strategy.

3. To continue listening to patients so that we can identify new measures to replace measures that consistently demonstrate success.

2009-2010 Priorities

Last Year's Priorities

In section 3 of this Quality Account we report the improvements made against last year's quality priorities. These are large pieces of work and, just like the mental health priority we have identified for next year, require us to work in partnership with other providers.

Consequently some of the work is continuing. It would be wrong to cease the improvement work on the grounds we have entered a new year. Therefore, we make the commitment to continue to drive the improvements in those areas alongside the new improvements we have identified for next year. In essence, our quality improvement programme has significantly enlarged.

The improvements for patients in those priority areas will be monitored via new indicators on the quality dashboard. This will allow the Trust to corporately monitor, and then learn and share, the local improvement work.

Within the Quality Account we have also asked each of our service areas to contribute by identifying the quality improvements they made to their services areas last year and to specifically identify quality improvement areas for this year. These will be monitored through the local governance work and the service areas will be asked to report their improvements in next year's Quality Account.

Assurance Statements

Section B: Statements Relating to the Quality of Services (mandated)

The Department of Health identifies a number of mandatory statements that the Quality Account must report upon. These are predominately regarding data, audit and research and are as follows;

Statement Area 1: Data Review

During 2010-2011 the London Ambulance Service NHS Trust provided three NHS services. The London Ambulance Services NHS Trust has reviewed all the data available to them on the quality of care in all three of these services.

Statement Area 2: Income

The income generated by the NHS services reviewed in 2010-2011 represents 100 per cent of the total income generated from the provision of NHS services by the London Ambulance Service NHS Trust for 2010-2011.

Statement Area 3: Clinical Audit

During 2010-2011, one national clinical audit and one national confidential enquiry covered NHS services that the London Ambulance Service NHS Trust provides. During that period the London Ambulance Service NHS Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the London Ambulance Service NHS Trust was **eligible to participate in** during 2010-2011 are as follows;

- National Clinical Performance Indicators programme covering:
  - ST-elevated myocardial infarction (STEMI)
  - Cardiac arrest
  - Stroke
  - Hypoglycaemia
  - Asthma
- Centre for Maternal and Child Enquiries (CMACE formerly the Confidential Enquiry into Maternal and Child Health): Confidential Enquiry into Head Injury in Children.

Statement Area 3: Clinical Audit Continued

The national clinical audits and national confidential enquiries that the London Ambulance Service NHS Trust **participated in** during 2010-2011 are as follows;

- National Clinical Performance Indicators programme covering:
  - STEMI
  - Cardiac arrest
  - Stroke
  - Hypoglycaemia
  - Asthma
- CMACE: Confidential Enquiry into Head Injury in Children.

The national clinical audits and national confidential enquiries that the London Ambulance Service NHS Trust participated in, and for which data collection was completed during 2010-2011 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

- National Clinical Performance Indicators programme covering:
  - STEMI (100%)
  - Cardiac arrest (100%)
  - Stroke (100%)
  - Hypoglycaemia (100%)
  - Asthma (100%)
- CMACE: Confidential Enquiry into Head Injury in Children (100% for the cases for which the London Ambulance Service NHS Trust has been given full details)

Statement Area 3: Clinical Audit Continued

The report of one national clinical audit was reviewed by the provider in 2010-2011 and the actions that the London Ambulance Service NHS Trust intends to take are outlined in the Research & Audit Section.

The reports of eight local clinical audits were reviewed by the provider in 2010-2011 and the actions the London Ambulance Service NHS Trust intends to take are outlined in the research & Audit section.

There are two additional mandatory statements reported in the Audit & Research section of this report

Statement Area 4: Research

The number of patients receiving NHS Services provided or sub contracted by the London Ambulance Service NHS Trust in 2010-2011 that were recruited during that period to participate in research approved by a research ethics committee was 164.

Statement Area 5: CQUINs

A proportion of the London Ambulance Service NHS Trust income in 2010-2011 was conditional on achieving quality improvement and innovation goals agreed between the London Ambulance Service NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services through the Commissioning for Quality and Innovation (CQUIN) payment framework. The details of the agreed goals for 2010-2011 are as follows.

1a.Care Pathway role description and names of champions. £0.5m Achieved

1b. care Pathway action plan by complex / sector £0.5m Achieved

1c. Monthly Care Pathway reports £0.5m Achieved

1d.Reduce conveyance rate to hospital A&E departments £0.5m Not Achieved

1e. Increase rate of usage of Clinical Telephone Advice, NHS Direct and not-conveyed cases. £0.75m Not Achieved

2a. Response time to Cardiac Arrest. Percentage of patients returned to spontaneous circulation (ROSC). Percentage of ST Elevated Myocardial Infarction patients taken to catheter labs £0.25m Achieved

2b. Percentage of stroke patients taken to Hyper Acute Stroke Units. Percentage of trauma patients taken to Major Trauma Units. £0.25m Achieved

2c Establish falls referral pathways and refer patients. Establish & Refer. £0.25m Partially Achieved

Statement Area 5: CQUINs Continued

The details of the agreed goals for 2011-2012 are as follows.

1a. Reducing conveyance rate to A/E services. £1m

1b. Hear & Treat resolution (no convey) via Clinical Telephone Advice & NHS Direct. £0.75m

1c. Implementation of NHS Pathways in Clinical Telephone Advice. £0.75m

1d. Clinical Performance Indicator non conveyed. £0.25m

2a. Falls & Older People referrals to GPs. £0.25m

3a. End of Life Care patients held on our system. £1.25m

3b. End of Life Care usage of register by our staff to affect outcome 0.125m

4a. Mental Health service improvement plan, including outcome of wider mental health review. £0.125m

4b. Development of MH protocols for direct access to MH crisis teams. £0.25m

5a. Whole system clinical group - established & effective including joint review of referral, treatment & discharge protocols, including specific review of protocol frequent callers, metropolitan police & high referring/call locations. £0.125m

5b. Whole system clinical incident reporting & resolution. £0.25m

Statement Area 6: Care Quality Commission

The London Ambulance Service NHS Trust is required to register with the Care Quality Commission and its current registration status is "registered". The London Ambulance Service NHS Trust has no conditions placed on its registration.

The London Ambulance Service NHS Trust has not participated in special reviews or investigations by the Care Quality Commission during the reporting period.

Statement Area 7: Data Quality

The London Ambulance Service NHS Trust will be taking the following actions to improve data quality.

Data quality is an integral part of the data capture process. There is a data quality team in the department of Management Information with a specific responsibility for ensuring that data quality remains a priority for the Trust. All Accident &Emergency records are processed through an in house data quality system which checks data inconsistencies, records outside certain parameters, and the system also checks against a set of rules agreed by the Trust Board.

In addition to this there is a facility available to all staff which allows individual records to be flagged for checking by the data quality team. The data quality system is ever evolving where more "rules" are added to it on an ongoing basis to continually improve the quality of the data.

Team leaders also carry out CPIs (clinical performance indicators) on patient report forms against an agreed set of criteria. This is led by the Clinical Audit and Research Unit.

Statement Area 8: NHS Number and General Medical Practice Code Validity

The London Ambulance Service NHS Trust was not required to submit records during 2010-2011 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The London Ambulance Service NHS Trust was not required to submit records during 2010-2011 using patient's valid General Medical Practice Code.

Statement Area 9: Information Governance Toolkit attainment levels

The London Ambulance Service NHS Trust Information Governance Assessment Report score overall score for 2010-2011 was 61% and was graded amber from the Information Governance Toolkit Grading Scheme.

Statement Area 10: Payment by Results

The London Ambulance Service NHS Trust was not subject to the Payment by Results clinical coding audit during 2010-2011 by the Audit Commission.

Introduction to Looking Back

The following pages present the progress made against the priorities that we identified in 2010-2011.

Last year our strategic vision was; **to meet the needs of the public and our patients, with staff who are well trained, caring, enthusiastic and proud of the job they do.**

Against this vision we mapped a number of service objectives that would help us deliver the quality improvements in order for us to achieve our vision.

These service priorities were;

- Improve cardiac care
- Implement stroke and trauma strategies
- Make demonstrable progress with implementing appropriate care pathways
- Develop and publish a clinical dashboard to better inform the public about quality of care
- Improve operational support including the optimal availability of vehicles, equipment and supplies

The following section presents our quality improvements against each of these five areas (except Stroke and Trauma work is reported separately within this Quality Account).

In addition, the following service areas have reported their quality improvements

- Emergency Operations Centre
- Patient Transport Services
- Emergency Bed Services
- Clinical Audit and Research

Accident & Emergency: Improving Cardiac Care

During 2010-2011 we developed further the cardiac model, implemented in 2006-2007 (which identified 8 specialist heart Attack Centres in London) and achieved the following.

The survival rate from cardiac arrest has risen dramatically from 4.2% to 21.5% in the past 11 years.

We took 11% more patients (1779 patients) to specialist units in 2009-2010 that the previous year.

In September 2010 the guidelines were expanded to accept a wider range of patients directly into the Heart Attack Centres.

The terms cardiac arrest and heart attack can be confusing. For the purpose of the Quality Account a cardiac arrest refers to the event which causes the heart to stop beating and a heart attack is the death of heart muscle.

Patients diagnosed with a common type of heart attack, known as an ST elevation myocardial infarction, have been taken directly to one of eight designated Heart Attack Centres for angioplasty, 24 hours a day, since March 2006. These patients are taken to specialist centres to enable them to be given primary angioplasty, a procedure which involves inflating a balloon inside an artery to enable a blockage to be cleared.

How have we developed what we do since 2006?

We have become more experienced in identifying the correct patients. Feedback from all eight Heart Attack Centres has revealed that 80 per cent of the patients we suspected as having this type of heart attack were correctly diagnosed, an extremely respectable diagnosis rate. The majority of the remaining 20 per cent were deemed to have associated high risk cardiac problems.

We now produce world class survival rates from cardiac arrest that occur in the out of hospital setting. Last year resuscitation was attempted on over 4,000 patients.

How do we continue to learn from the experience of the Network?

Representatives from our service attend monthly meetings held at many of the Heart Attack Centres. These meetings provide an opportunity to discuss patients individually, particularly regarding delays incurred or questions relating to diagnosis. Any issues are fed back to frontline staff and station management and training needs addressed. Incidents and issues are monitored for trends and appropriate action taken where necessary.

What changes to clinical practice have taken place during 2010-2011?

Therapeutic hypothermia is now known to improve outcomes in specific groups of patients. This has been introduced in certain areas to assess the feasibility of the wider implementation in the pre-hospital setting.

In addition, we have a number of research areas looking at how we can make further improvements. For example, in October 2010 in conjunction with Barts and the London NHS Trust we commenced a new research study. The objective of this study is to determine the feasibility of pre hospital administration of adenosine (to patients with very rapid heart

rhythm) by paramedics and subsequent referral to an electrophysiologist bypassing the need to attend the Emergency Department. This is the first such trial within the UK.

How have we improved the speed in which cardiac arrest patients receive assistance?

We know that early defibrillation is a significant factor to making a recovery. However, we are developing opportunities where cardiac arrest patients can receive defibrillation even before we arrive on scene.

The Service is now responsible for 520 Automatic External Defibrillators at over 192 different sites. Over 4600 members of the public have been trained in their use and approximately 3000 refresher training sessions were delivered. This initiative has, since 2005 produced 28 survivors from cardiac arrest.

In addition, our Community Resuscitation Team continue to train members of the public in cardio-pulmonary resuscitation and have trained over 6900 members of the public in the last year and over 60,800 people to date. The Schools and Events team travel around the capital teaching school children how and when to call for an ambulance and perform resuscitation.

How have we kept our staff up to date with developments in cardiac care?

In 2010-2011 Team Leaders received a two week 'clinical leads update course' covering various aspects of cardiac care and resuscitation. Intensive resuscitation training was also delivered on our paramedic courses.

Due to the rapid advancement of cardiac care within the service and the amount of information needed to keep staff up to date, numbered information sheets entitled 'cardiac information circulars' were developed. These circulars can be easily located on the intranet and provide guidance on a range of cardiac care topics. For the last two years, a quarterly 'Clinical Update' publication has been circulated to staff along with their personal copy of the Trust News. This has contained information on resuscitation and cardiac care in addition to other clinical topics.

The afore mentioned successes relating to cardiac arrest survival and STEMI care have been the result of several factors, which include the implementation of a detailed service wide 'cardiac care strategy', appointment of a dedicated 'cardiac lead', the hard work of frontline staff and stringent audit of data.

It is important however, that we continue to strive to provide high quality evidence based care, and continue to increase survival rates year upon year.

Further Improvements we need to make in order to improve cardiac care include the following.

1. Due to the abundance of data indicating the benefits of therapeutic hypothermia, and the fact that it is recommended in the 2010 Resuscitation Council UK guidelines, this treatment will be rolled out pan London as soon as the most feasible means of instigating hypothermia is determined.

2. Enable the downloading of information from defibrillators to be made as accessible as possible

Accident & Emergency: Improving Trauma Care

During 2010-2011 London dramatically reorganised the way emergency trauma care is delivered within London.

The new system saw the implementation of 4 Trauma Networks. Each network has a hospital designated as a Major Trauma Centre and a number of other hospitals supporting them as trauma units.

Patients identified as having major injuries are taken directly to one of the four Major Trauma Centres bypassing local hospitals. This gives patients rapid access to a specialist and experienced trauma team

The location of the Major Trauma Centres should ensure that no patient should be more than 45 minutes away from a Major Trauma Centre

The management of patients with major trauma has been identified as an area for improvement for well over 20 years. Studies have revealed that poor airway management and failure to recognise and control haemorrhage as major factors are areas of care that need improving.

The report “Trauma, Who Cares” in 2007 highlighted the lack of progress, and in particular identified shortcomings in the pre-hospital management of these patients.

In addition, there has been significant learning from the experience of managing the military casualties in Iraq and Afghanistan. The National Audit Report (2010) reported the progress made in caring for military casualties and this was in stark contrast to the National Audit Office report on the management of major trauma in civilian practice.

These reports were the subject of scrutiny by the Public Accounts Committee and led to the Chief Executive of the NHS including major trauma care in the 2011 Operating Framework, and requiring all Strategic Health Authorities to have robust plans in place for regionalised trauma care by the end of 2011.

London has been ahead of the recommendations and has implemented the new system ahead of other areas in the country.

How do we ensure our clinical staff take the patient to the right hospital?

Clearly the decision on which patients should be taken where is critically important. Our staff make decisions based on their assessment but this is supported by a tool known as the Major Trauma Field Decision Tree,

The tool consists of 4 steps; any patient who triggers steps 1 or 2 is taken direct to an Major Trauma Centre whilst patients who trigger steps 3 and 4 are discussed with the experienced trauma Paramedic staff on our Clinical Coordination Desk.

How long is it taking to get patients to get to the right hospital?

The changes do not affect the speed in which we arrive on scene. Journey times to the Major Trauma Centres have been short with the average time from leaving the scene being14 minutes.

How do we know the changes have benefitted patients?

All data regarding trauma is submitted to the Trauma Audit and Research Network. This is a national trauma database which collates all the relevant information. Approximately 10 patients sustain severe injuries each day in London.

Evidence from Victoria, in Australia, suggests that it can take up to 5 to 7 years to collect enough data to identify the improved outcomes. However, we know that key factors that play a part in contributing to patient outcomes (such as access to CT scanning) have improved significantly through the implementation of the changes.

The London Trauma Office published its first half yearly report in January 2011, with evidence that 37 additional survivors had been identified as a result of the implemented changes.

Further Improvements we need to make to the care of trauma patients include the following.

1. Evidence suggests that the Major Trauma Field Decision Tree is currently over sensitive and may be taking more patients than necessary to Major Trauma Centres. This needs reviewing in 2011-2012

2. In conjunction with the London Trauma Office work is ongoing to develop a triage tool suitable for paediatric patients.

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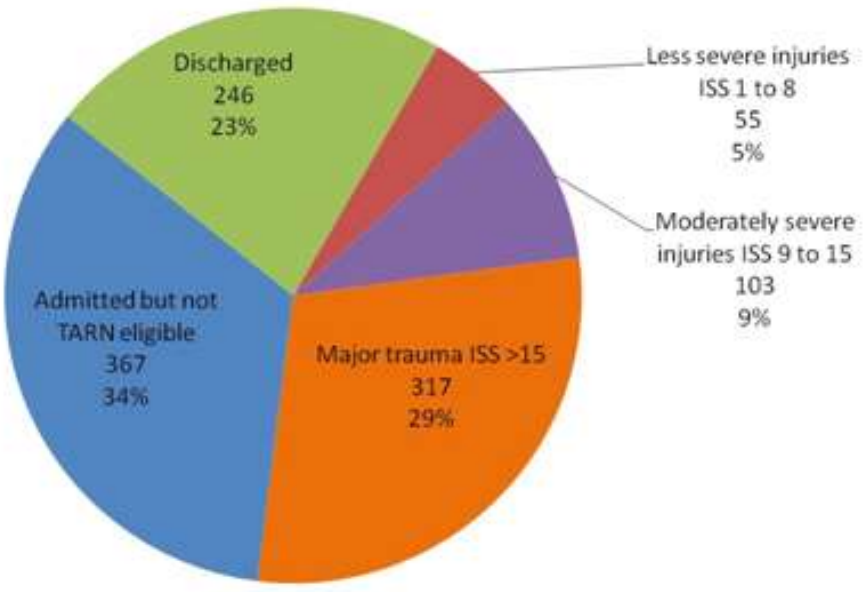
Outcomes of all Major Trauma Centres Triage Tool Positive Patients From 6 April 2010 to 31 July 2010 (total number 1,088)

Figure 1 demonstrates the severity of injuries found on over 1000 patients from the 4 months following 'go live', with 29% of patients having major trauma (ISS >15), and a further 9% having moderately serious injuries (ISS 9 – 15).



Accident & Emergency: Alternative and Appropriate Care Pathways

In 2010-2011 we developed two large Alternative or Appropriate Care Pathways. A Stroke pathway and a Major Trauma pathway

We have also developed a range of local pathways that prevent the need to take patients to Accident & Emergency.

A number of reports have been published, particularly 'A Framework for Action' by Professor Lord Darzi and 'Taking Healthcare to the Patient: Transforming NHS Ambulance Services' by Peter Bradley both of which make it clear that the ambulance service needs to have a far greater level of integration with other services to provide enhanced patient care.

The terms 'Alternative Care Pathway' or 'Appropriate Care Pathway', is used to describe a specific service or unit that has agreed to receive patients presenting with a clearly define condition directly from us and where this has been constructed into a formal framework between the relevant parties. Without this agreement the patients would usually have been taken to Accident & Emergency.

What new pathways have been developed in 2010-2011?

Two pan-London Alternative Care Pathways have been developed:

- Stroke Alternative Care Pathway introduced from February 2010, where patients testing positive for possible Acute Stroke are taken directly to Hyper-Acute Stroke Units.
- Major Trauma Alternative Care Pathway introduced in April 2010, where those patients who have sustained significant traumatic injuries (as assessed using a decision tree) are conveyed to one of four Major Trauma Centres.

How has this benefitted the patients?

We have not specifically evaluated the introduction of alternative care pathways but have received some positive feedback from patients and will explore this further in 2011-2012.

What else have we done to develop alternative care pathways?

Over the past few years, a number of Walk-in Centres and minor Injury Units have been developed, sometimes on the site of previous Accident & Emergency Departments. These units are usually nurse-led and specialise in the less serious conditions. A 'core' list of basic conditions that could be accepted by all such centres was developed by us. Overall this has been a success, and with more Urgent Care Centres opening over the forthcoming year, this approach will continue.

On a more local basis, some community services have approached our local management teams in order to demonstrate the benefits of us having direct access to their services (where a patient may be able to receive excellent definitive care in the community). In these cases the Care Pathway is developed on this local level, with support from a central team who will have final verification at a strategic level. There have been some real successes in these local pathways, where due to their nature, the local ownership has resulted in real engagement with local staff.

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Further Improvements we need to make to the development of alternative or appropriate care pathways include.

1. There are further opportunities to develop the care pathways and this has been identified as a specific quality priority for 2011-2012

2. We will continue to explore opportunities within Urgent Care Centres

3. We will look for ways to obtain patient feedback on how the pathways benefit patients.

Accident & Emergency: Improving Stroke care

In 2010-2011 we implemented a whole new approach to stroke care which involved taking patients with a suspected stroke directly to a specialist centre bypassing local Accident & Emergency departments.

We have continually monitored the impact this has had on patient outcomes

Stroke has been identified as the second largest cause of death in London, and the largest cause of adult disability. Approximately 11 000 Londoners suffer a stroke every year. Through NHS London, we have been involved in reforming stroke care across the capital from the beginning of the project.

What changes have taken place to stroke care in 2010-2011?

From February 2010, we started to take all patients with a new-onset positive stroke test to their nearest Hyper Acute Stroke Unit, provided that they could be transported there within three hours of the onset of symptoms. This arrangement allowed the Hyper Acute Stroke Units to run-up to full capacity, whilst delivering thrombolysis to those patients that needed it most.

Later in the year the time frame was increased from three hours to four and a half hours. All patients with symptoms suggesting a new stroke are now taken to a Hyper Acute Stroke Unit.

How have we kept our clinical staff up to date with the changes to stoke care?

All appropriate staff were trained before the go live phase but since then we have published articles on stroke and Transient Ischaemic Attacks which have appeared in our clinical updates for staff. Stroke has also featured in our publication the LAS News

In November, the North-West London Stroke and Cardiac Network and Imperial Healthcare NHS Trust hosted a Clinical Education day for our staff. Speakers included network leads and senior clinicians addressing key issues on stroke prevention and acute treatment. Almost 100 people attended and feedback was overwhelmingly excellent. We plan to hold a similar event later this year.

Many staff have also had the opportunity to spend time in local Hyper Acute Stroke Units shadowing clinical staff, and feedback indicates that this is a very useful experience.

How do we monitor the capacity of beds in the Hyper Acute Stroke Units?

In order to monitor capacity and balance flows of patients (to maximise available bed-space) the Clinical Coordination Desk was set up. Sitting alongside the Clinical Support Desk, this has played a vital role in coordinating patient movements across all Hyper Acute Stroke Units, and providing decision support for clinical crews faced with patients with unusual signs and symptoms.

How have these changes benefitted patients?

Clinical Audit of our stroke care started in May 2010. Since this time, we have been able to demonstrate that ambulance crews consistently triage stroke patients to an appropriate hospital over 90% of the time.

Ambulance journey times to scene have also consistently been within the appropriate target. On scene time averages at 33 minutes, although this is somewhat shifted by a number of difficult removals; journey time to hospital is 18 minutes on average, across London, which is well within the limits agreed at the time the project was set up. The average call-to-ED time is just over 60 minutes.

Feedback from all the Hyper Acute Stroke Units and the networks has been very complimentary. They attribute the success of the stroke project in part to our ability to get patients directly to specialist centres. We have had several excellent patient testimonials, including a speaker who commented that “the competence of the LAS crews gave him confidence in the whole stroke service”.

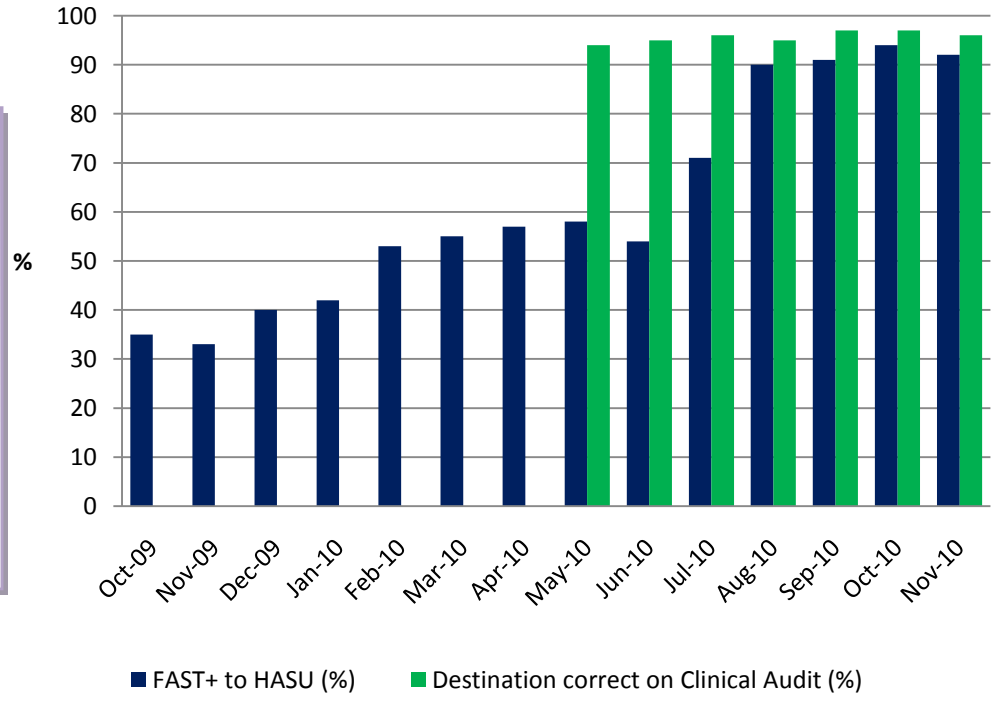
In a little over a year, the London Stroke System has developed into a system with one of the highest thrombolysis rates in the world. Over 80% of patients spend more than 90% of their hospital stay on a dedicated stroke ward and 85% of TIA patients have their treatment commenced within 24 hours of symptom onset. Length of stay continues to drop, and over 30% of patients are discharged home from a HASU. The Critical Transfer and Repatriation systems are working well.

Further Improvements we need to make to improving stroke care include.

1. Supporting the final Hyper Acute Stroke Unit to open

2. The bed capacity had initially appeared to be more than needed. However the final months of the year saw units reporting zero bed status. This has meant ambulance crews being re-routed to more distant Hyper Acute Stroke Units. We will support the Network in reviewing the arrangements

Graph 1. Patients conveyed directly to a HASU and those conveyed to an appropriate destination following clinical audit



All Areas: Implementing a Quality Dashboard

In 2010-2011 we put in place the processes necessary for implementation of the new quality indicators from April 2011

We have identified a number of additional quality indicators for inclusion in a wider quality dashboard

We have developed a new Quality Strategy that outlines the direction of our future quality work and how the quality dashboard will look following implementation in 2011-2012

In The Quality Account 2009-2010 we reported that the Department of Health were introducing a set of new quality indicators during 2010-2011. These were launched in April 2011 but much of the quality dashboard work in 2009-2010 was spent preparing for these new measures.

However, we have taken the opportunity to expand the dashboard so that it goes beyond the minimum data and gives the trust a better measure of how we are delivering on quality.

How have we implemented the new Quality Measures from the Department of Health?

There are 12 quality measures for implementation. These are comprehensive and many have sub levels. Consequently there are actually 20 measures which require data collection and publication.

We will be required to publish the data on our web site alongside the equivalent data from other Ambulance Trusts. This is so the public and commissioners can benchmark our service against that of similar providers.

The data collection has commenced and the dashboard will be published in 2011-2012.

What other quality indicators are we considering?

Our discussions with patient groups and an analysis of our complaints and incidents have revealed a number of additional quality measures. Some of these are developments of work we were already measuring such as Safeguarding and Infection Control. Other indicators are new such as the recording of lost property or equipment availability.

How has our Quality Strategy assisted us in Improving Quality?

Whilst we have a Director with specific responsibility for Quality it is everyone's responsibility. Consequently the improvement work sits across a number of directorates. For example, the clinical audit team report to the Medical Director and the patient experience team report to the Director of Corporate Services. The report brings together all the essential components into a cohesive strategy to ensure all the work streams are striving to deliver the same improvement priorities.

Further Improvements we need to make to the development of our quality dashboard were identified in section 2 but include the following.

1. Implementing the use of the dashboard through our quality governance structure

2. The implementation of the additional quality measures identified within our quality strategy

3. To continue listening to patients so that we can identify new measures to replace measures that consistently demonstrate success

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Operational Support: Freeing Ambulances for Care

In 2010-2011 we reviewed our blanket management processes to ensure we had adequate supply for the winter months

We made improvements in equipment availability for our clinical staff

We have improved the availability of vehicles

Throughout 2010/11 there have been a number of initiatives to improve the effectiveness of the Fleet and Logistics Department and improve the service given to Frontline Operations.

What specific improvements have we made in 2010-2011?

A review of the management of blankets was undertaken and its recommendations approved by the Senior Management Group. The result was a significant increase in the number of blankets in the system, prior to the bad weather in December. The new process takes account of blanket losses and replacements as well as aligning laundering with Primary Care Trusts to reduce the number of blankets being collected and returned to us.

Diagnostic Packs, containing Blood Glucose Monitoring kits, tympanic thermometers and sphygmomanometers were introduced along with a robust control system to reduce the number of losses and to ensure 100% availability to frontline crews.

This was coupled with the introduction of Managers Drug Packs, to improve the availability of Paramedic Drug Packs and reduce the wastage and loss of out of date drugs.

What improvements were made to vehicle availability in 2010-2011?

A number of initiatives were undertaken to improve vehicle availability during the year. The flexible fleet concept was challenged and deployment of the fleet brought into line with rostas. As a result 75% of the fleet is now assigned to a specific station and only 25% being moved between stations to meet peaks and troughs of demand throughout the week.

Aligning the fleet back to stations has had a number of positive impacts, there is a clear sense of ownership by station crews which in turn has meant that equipment is staying with the vehicle and vehicles do not have to be re-equipped each time they move. Serving performance is improving as it is easier to withdraw a vehicle from use to undertake safety checks.

What improvements have been made to cleaning?

Deep cleaning performance is beginning to improve as it is easier for the deep cleaning crews to locate vehicles. By the end of the 2010-2011 period we were able to report significant improvements in our compliance with our deep cleaning standards.

What impact have these improvements had on Freeing Ambulances for Care?

These initiatives have all contributed to improved performance by Fleet and Logistics and this can be demonstrated through the changes in the main Key Performance Indicator for Fleet and Logistics with vehicles off the road falling from 5.5% in June 2010 to 4.3% in February 2011.

Further Improvements we need to make to operational support include.

1. We will continue to drive down times when vehicles are of the road for avoidable circumstances

2. We will look at the times that mechanical or equipment repair result in lost vehicle availability

3. We will continue to drive down the length of unnecessary delay during the transfer of care between our Trust and other Trusts

Emergency Operations Centre; Quality Improvements

In 2010-2011 we have been preparing for the implementation of our new Computer Aided Dispatch System

We have developed a Demand Management Programme that ensures safety and quality at times of high demand.

We won control room of the year in this years Emergency Services Awards

This has been a busy year for our Emergency Operations Centre as we move towards the complex change in our computer systems.

How have we been preparing for the changes to our Computer Aided Dispatch System?

This goes live on June 8th, 2011. Therefore, as this represents a significant risk and challenge for the organisation most of 2010 has been about ensuring the quality implementation of the new system.

We have ensured that there are the right number of trainers in place to support the comprehensive training schedule from Jan 2011 until the go live date. In addition, recruitment had to be front-loaded to support the number of people removed from "Business as Usual" to support the delivery of the system (called CommandPoint).

What other developments have taken place during 2010-2011?

Early 2010 saw the successful release of version 12.1 of our Medical Priority Dispatch System into the control room. This meant our triage system was updated to ensure the latest standards and learning was incorporated into our processes.

We are beginning to fully use software which allows us to more accurately predict call volumes and understand our staffing requirements.

In addition, the new radio system "Airwave" was the subject of training for control room staff alongside the requirement to "balance" the skills mix within Control Services between those able to take calls and those able to dispatch vehicles.

Special funding was secured in order to host "Watch Away Days" at which all of our 400+ staff had the opportunity to undertake training to help them manage change. With such a significant change agenda for control services it prompted staff to consider how they, and colleagues, might react to change and how they could best equip themselves to cope.

How did we ensure our staff were kept up to date?

A training plan has seen all control staff scheduled for dispatch and/or call taking training for the CommandPoint. Maintenance training commenced with vigour and sees every member of control staff spending 20 minutes of every rostered shift working on CommandPoint. Such is the dynamic and responsive nature of this training that its content has already been modified to provide a more "simulated" set of workplace scenarios.

The 2010-2011 winter brought bad weather which saw unprecedented demand for our services. What did we do to ensure quality and safety was maintained?

Managing demand safely and effectively when the service is placed under significant pressure – i.e. snow events, New Year's Eve has been formalised and enhanced with the development of

The Demand Management Programme. Complete with task cards, for every role in Control Services, it offers a pre-defined manner in which to prioritise demand and allocate resources accordingly. In particular, this has seen increased use of clinicians in the control rooms who play a key clinical role to ensure safety of calls awaiting a response within the Demand Management Programme.

In addition, the Clinical Support Desk has been continuing to support ever increasing volumes of Patient Specific Protocols and supporting the End of Life initiative in allowing people to die at home.

Given the demand pressures the Clinical Support Desk has also been key in assisting with assessing inter-hospital transfers and health care professional requests for conveyance.

In order to support the new network of Trauma specialist units & Hyper Acute Stroke Units our Control Services created the Clinical Coordination Desk to liaise between crews and hospitals alike to ensure appropriate referrals and effective utilisation of this service.

How has our work been recognised?

In doing all of the above, Control Services won the Control Room of the Year at the Emergency Service Awards 2011. What's more, having been awarded the Customer Services Excellence Award (the government standard) in 2010 making us the first Ambulance Trust to receive it we have just had confirmation following this year's inspection of our right to retain it for a further year.

Further Improvements we need to make to our Emergency Operations Centre include.

1. Implement and embed CommandPoint

2. Embed new ways of working in dispatch

3. Understand impact of the new Department of Health code changes

4. Focus on developing our Hear & Treat Activities to optimise response to certain categories of calls

5. Introduce a new system for supporting our Clinical Telephone Advice

6. Move to dual control rooms

7. Support the re-launch of our Clinical Response Model

8. Continue to plan for the Olympics

Patient Transport Services: Quality Improvements

In 2010-2011 we invested in training for our staff

We took delivery of a number of new vehicles

We have improved our performance against all three quality indicators of our contracts

Patient transport is an important part of our core business and whilst this service has its own dedicated management team it is fully integrated into our quality governance processes.

How did we keep our Patient Transport Staff up to date with changes?

Last year we developed two specific posts of full time Patient Transport Services Work Based Trainers and successfully appointed into one of the posts.

The new Work based Trainer has been delivering refresher training on key topics such as resuscitation and defibrillation as well as rolling out new core skills of Airwave radio procedure Personal Digital Assistants and bariatric vehicle training. Along side this we have been developing the monthly training schedule which will be re-launched in April 2011 with the topic of Stroke Test.

What have we done to update our vehicles?

During 2010 we took delivery of fifty three new vehicles comprising of twenty five sitting case vehicles, twenty five stretcher vehicles (to a modified design) and three specialist bariatric vehicles. These new additions to our fleet, along with the commencement of disposal of sixty older sitting case and minibus vehicles has seen the average age of our fleet fall from 7 years old at the beginning of the year to 3.5 years old by the end.

How have the new vehicles benefited patients?

These new vehicles bring enhancements to patient and passenger safety and comfort such as all new wheelchair capable vehicles having the facility to offer all wheelchair occupants a three point seatbelt (with upper anchor point), previously this was only available for the primary wheelchair position while the secondary wheelchair position lacked the upper anchor point.

The addition to the fleet of three specialist bariatric vehicles capable of conveying patients weighing up to 318Kg (50st) has provided added levels of both patient and staff safety. These vehicles are equipped with high capacity stretcher trolleys, specialist bariatric wheelchairs and automated stair climbers as well as kerb and threshold ramps.

How have we performed against our contracted quality standards?

There are three Key Performance Measures that are common across all contacts and that are also reported on internally. These are:

Appointment Time. This is the arrival of a patient for their appointment within a time window as specified by the Trust

Ready Time. This is the collection of a patient after their appointment within a time window specified by the Trust

Time on Vehicle. This is the amount of time a patient spends from collection to drop off against a target specified by the trust

Year on year we have seen a steady rise in our performance in all three of these targets (as shown in the chart below), this is set against a backdrop of the changing nature of healthcare provision within London with such as the marked increase in on the day bookings where the patients is required to be collected within one hour of the request being made.

Table. To illustrate performance against the quality indicators in the contract.

Quality Standard	Appointment Time	Ready Time	Time on Vehicle
2008/2009	90.49%	92.40 %	94.86 %
2009/2010	91.58%	93.03 %	94.98 %
2010/2011	92.01%	95.20 %	95.50 %

Further Improvements we need to make to our patient Transport Services include.

1. Continuing to lower the age of the fleet to a projected 1.2 years old by the end of 2011

2. We will see enhancements to the equipment carried on our bariatric vehicles as well as the introduction of a bariatric support vehicle. This will provide additional specialist equipment such a hoist, lifting cushions and a variety of ramps for the most challenging situations

Emergency Bed Services: Quality Improvements

We have achieved a number of staff development opportunities.

We have improved our process for safeguarding referrals

We have developed the work of the team

We are strengthening incident reporting

The Emergency Bed Service provides a co-ordination service for London on the availability of specialist beds. In addition, the service provides a number of co-ordination functions within the Trust.

How did we develop our staff last year?

A variety of training and development opportunities were achieved. These included the accreditation of our Operations Manager by the British Psychological Society in intermediate level B psychometric training. One staff member being selected for the Stonewall Management Training Course and one staff member being accepted for the Princes Trust Course. In addition we have completed a number of internal courses across the team.

How have we strengthened safeguarding?

We have continued to improve the safeguarding process. We are now dealing with around 1,000 referrals a month, virtually all of which are referred to a social services professional within an hour.

We have developed and continue to improve our reporting suite so that we are now able to provide detailed reports of delays in referral, and feedback received, to complex and borough level. We are circulating these reports and addressing these issues both through area governance meetings and external forums such as London Safeguarding Adults Network.

We have commenced an audit so that we can understand some of the variation in referral rates across London and hope to assist in managing such variation out of the system.

How have we expanded the work of the Emergency Bed Services Team?

We have recently commenced a pilot in NW London whereby we have worked with Connecting for Health colleagues to design a web-based system.

In May last year we commenced a service whereby we collect and share information about capacity in Hyper Acute Stroke Units. This information is used by control services to optimise the capacity, ensuring that patients accessing this time-critical pathway go to the most appropriate unit.

In January we commenced a service whereby we act as the central point for maternity services to declare their status under the Maternity Alert Policy. This information is shared with control services colleagues and others in the maternity community to support protocols aimed at optimising maternity capacity, both operationally via divert decisions, and also at a strategic level by providing the medical directorate with historical data about declarations.

In the autumn we introduced a web-based information system which allows Acute Trusts to enter data on pressure and capacity within the unit and then displays that data in such a way that users are able to assess capacity across London.

How are we strengthening Incident reporting?

March saw the implementation of a pilot to take our Incident Reports direct from clinical staff via the airwave phones. The aim is twofold:

- To improve the speed and robustness of the onward referral process, ensuring that all report forms are referred to the appropriate person quickly with an audit trail and accountability.
- To make it easier and faster for clinical staff to report incidents, improving both crew and patient safety.

Further Improvements we need to make to our Emergency Bed Service include

1. Roll out the incident reporting and critical care pilot work

2. Introduce a falls referrals support service

3. Implement call voice recording for safeguarding referrals.

Clinical Audit & Research

The work of the clinical audit and research team is integral to the quality agenda and they play a significant role in monitoring our adherence to quality standards and in identifying any issues from a range of audits that are undertaken through the year.

Clinical Audit

Mandatory Statement 3 (continued from section 2); National Clinical Audit

The report of one national clinical audit was reviewed by the provider in 2010-2011 and the London Ambulance Service NHS Trust intends to take the following actions to improve the quality of healthcare provided;

- Increase the proportion of patients presenting with a STEMI who receive pain-relieving medicine.
- Increase the number of referral routes for diabetic patients in London.
- Increase the proportion of patients presenting with asthma who have their oxygen saturation level measured before treatment.

Mandatory Statement 3 (continued from section 2); Local Clinical Audit

The reports of eight local clinical audits were reviewed by the provider in 2010-2011 and the London Ambulance Service NHS Trust intends to take the following actions to improve the quality of healthcare provided;

Clinical audit of obstetric patients transported by the London Ambulance Service

- Remind crews to exercise caution when attending all obstetrics cases, as ambulance services have only limited capabilities in identifying and managing obstetric abnormalities.
- Remind crews of the importance of taking more than one set of observations, as time allows, to detect any changes in the woman's condition. This is especially important in cases where the woman presents with frank bleeding and severe, continuous abdominal pain.
- Produce a memory aide listing the key questions to ask and document for routine pregnancies, to include: history of the presenting pregnancy, history of previous pregnancies and live births, estimated date of delivery, the pain score and whether entonox administration is required. In addition, it will contain a reminder of when women should be conveyed to their booked maternity unit, the nearest maternity unit or to an emergency department.
- Remind crews to document an estimated volume of blood loss when a woman presents with bleeding, or a reason why this could not be documented.
- Work with maternity units and Healthcare for London to ensure dedicated emergency alert lines are placed in each unit.
- Explore ways of encouraging the further education of ante-natal women about what constitutes normal signs of labour and what constitutes signs of potential complications to help them to know when to call an ambulance.

Clinical audit of the care provided to patients under one year old left at scene by the London Ambulance Service

- Update London Ambulance Service NHS Trust protocols so all children younger than two years old attended by the London Ambulance Service NHS Trust are conveyed to hospital, and where a child aged between two and five years old is not conveyed to hospital the attending crew refer the patient to their GP for follow up.

Clinical audit of airway management in the London Ambulance Service

- Remind crews to document all aspects of care on the patient report form, including the use of a bougie.
- Remind crews to evidence patency and effectiveness of both endotracheal intubation and laryngeal mask airway placement through documenting end tidal

- carbon dioxide readings (ETCO2) and additional methods of verification.
- Remind crews of the importance of documenting oxygen administration, including the time at which this was commenced.
- Provide guidance on the management of the airway in patients with a tracheotomy as part of the airway management training.

Clinical audit of the use of adrenaline (1:1,000) in the London Ambulance Service

- Remind crews the indications for adrenaline (1:1,000) and contraindication for patients with chronic obstructive pulmonary disease.
- Remind crews of the correct doses of adrenaline (1:1,000) administration, with emphasis given to the side-effects and possible dangers of incorrect administration.
- Provide guidance to crews regarding the dosage of adrenaline (1:1,000) that should be administered following the use of an Epipen.

A baseline clinical audit examining the use of Salbutamol in the London Ambulance Service

- Remind crews of the clinically valid exceptions for taking a peak flow reading and its' importance to clinical care.
- Remind crews of the guidelines regarding en-route treatment for patients with life threatening or acute severe asthma.

A re-audit of the management of sickle cell crisis in the London Ambulance Service

- Communicate guidelines followed by the London Ambulance Service to hospitals.
- Update training slides with the new guidelines for treating patients in sickle cell crisis.
- Remind crews that a carry chair or trolley bed should always be used so that the patient's condition is not exacerbated.
- Remind crews that oxygen saturation readings should be checked regularly and oxygen administered, if required, to help stop tissue hypoxia and reduce cell clumping.
- Remind crews that oramorph is recommended for patients in sickle cell crisis experiencing severe pain.
- Remind crews that an ECG must be taken to rule out any cardiac causes when a patient reports chest pain.

Recognition of Life Extinct by the London Ambulance Service

- Remind crews that for patients eligible for resuscitation, they should perform advanced life support for at least 20 minutes and recognise life as extinct only if the patient has been in continuous asystole throughout.
- Remind crews of the importance of documenting all drugs and treatments given to the patient, including the documentation of oxygen administration, if a resuscitation attempt is made.
- Consolidate all current guidelines, procedures, bulletins and updates into one document to contain all necessary information related to recognition of life extinct, and provide clear instructions on how to complete the recognition of life extinct form.
- Ensure paperwork is secured so all sheets additional to the patient report form is collated and scanned together.
- Improve legibility of the recognition of life extinct form and add version numbers to allow for identification of the most recent form.

Clinical audit of the care given to patients treated for epileptic seizure by the London Ambulance Service

- Continue to ensure that a Paramedic response is available to allow for automatic dispatch to patients who are still reported as having a seizure at the time the 999 call ends.
- Ask Paramedics to consider if they are prepared should a patient have a further seizure en-route to hospital, including: if they are going to escort the crew; if they have already placed a line whether it is secure; if they have access to rectal diazepam and whether someone is available to help them should they need to roll the patient should it be necessary to administer this, and if the patient is on the trolley bed (not the chair) in the ambulance.
- Remind crews of the need to exclude other causes of seizure such as hypoglycaemia and cardiac arrhythmias.
- Remind crews of the indications for diazepam administration.

Mandatory Statement 11 Clinical Audit Reports that have been discussed by the Trust Board

The results of 10 local clinical audits were presented to the Trust Board. The arising recommendations to improve patient care or compliance with guidelines are included in each of the reports. These reports are then disseminated to staff via our Team Leaders.

The Subjects discussed were;

Emergency oxygen therapy

Stroke care

Trauma care

Care of obstetric patients

Naloxone (drug used to counter the effects of opiates)

Stroke

Trauma (additional data as the systems and data collection matured)

Adrenaline 1 in 1,000

Salbutamol

Care of patients with sickle cell disease

The results of national audits were discussed on 4 occasions and these were regarding the national clinical performance indicators. The arising recommendations to improve patient care or compliance with guidelines are included in each of the reports. These reports are then disseminated to staff via our Team Leaders.

Clinical Research

The vast majority of the 164 patients recruited into research programmes were from a Stroke study “Improving Stroke Recognition by Ambulance Services: use of the Recognition Of Stroke In the Emergency Room assessment (ROSIER) tool”. This is an LAS led research project funded by The Stroke Association and adopted on to the National Institute for Health Research portfolio.

It is important to note that as well as recruiting patients we also recruit staff and student paramedics. These recruitment numbers have not been included in the 164 figure that only records patient numbers.

Additionally, we have an extensive collaboration portfolio that for the 2011/12 period includes the following studies:

- DANCE (High Risk Acute Coronary Syndrome): Direct Angioplasty for Non-St-Elevation Acute Coronary Events
- Paramedic SVT: Safety and efficacy of Paramedic treatment of regular supraventricular tachycardia (pre-hospital administration of Adenosine).
- SAFER 2: Care of older people who fall: an evaluation of the clinical and cost-effectiveness of new protocols for emergency ambulance personnel to assess and refer to appropriate community based care.
- Smart-CPR (Cardio Pulmonary Resuscitation).
- Identification of stroke symptoms in alert patients who fall without injury.
- PTSD: Identifying Emergency Personnel at Risk of Post-Traumatic Stress Disorder.
- Cardioprotection Study: Cardioprotective benefits of remote ischemic post-conditioning. The investigation involves the application of a blood pressure cuff to treat myocardial ischemia reperfusion injury.
- Psychosocial Tools.
- ASCQI: Ambulance Service Clinician Quality Improvement Survey .
- QSN: Quality and Safety in the NHS: Evaluating Progress, Problems and Promise.
- An exploration of attitudes towards young people who self-harm and an investigation into the care they receive in hospital emergency departments.

In addition to research projects the R&D team also authorise a number of data requests and evaluation studies. Some of the current active evaluation studies include:

- Can ultrasound paramedics be taught and retain the skills necessary to identify the myocardium using the subxiphoid approach?
- Ambulance personnel’s reaction to epileptic seizures.
- Evaluation of airway management in simulated chemical, biological, radiological and nuclear (CBRN) environments.

Stakeholders

Comments and feedback from stakeholders to be added.

Summary

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

24TH MAY 2011

PAPER FOR NOTING

Document Title:	**Service Improvement Programme (SIP) Closure Report**
Report Author(s):	**Martin Brand, Johnny Pigott**
Lead Director:	**Sandra Adams, Director of Corporate Services**
Contact Details:	**martin.brand@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To report on the benefits realised, lessons learned and transition arrangements to the new IBP Delivery Programme**
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 benefits realised, lessons learned and transition arrangements.**

Executive Summary

Following decision to close SIP 2012 and initiate a new service improvement programme, the IBP Delivery Programme, a combined closure report has produced for the two constituent programmes that make up the SIP (Clinical Development, Leadership and Workforce and Performance and Service Delivery). Benefits realised over the two year life of these programmes (April 2009 to March 2011), lessons learned and transition arrangements for projects that are not closed have been documented.

Key issues for the Trust Board

To note the benefits, lessons and transition arrangements.

Went well

1. Of the 86 projects initiated within the programmes' existence the vast majority have been delivered as planned.
2. Progress reporting based on milestones conforms to best practice and was widely used.
3. The SIP allowed a margin of innovation and flexibility with people empowered to deliver their projects rather than following an overly bureaucratic documentation process.

Improvement opportunities

1. An inconsistent approach to benefit realisation and business change management.
2. There is still a tendency towards functional silo working.
3. Project progress reporting was a time consuming and labour intensive with several different variants of monthly reports required by different bodies.

Attachments

Summary of the Closure Report (appendices giving project level detail are available in the backup papers).

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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:

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

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 at programme level through the March 2008 EIA public consultation event at the Oval and as applicable at individual project level

☐ No

Key issues from the assessment:
Various –there are many different projects within the overall service improvement programme

London Ambulance Service NHS Trust

Service Improvement Programme Closure Report

April 2011

1. EXECUTIVE SUMMARY

This is the Programme Closure Report for the Clinical Development, Leadership & Workforce, and Performance and Service Delivery Programmes of the Service Improvement Programme. The Senior Management Group decided that the current SIP should close and the new Integrated Business Plan Delivery Programme (IBP programme) replace it. The Olympics Programme will migrate into the new IBP Programme and is unaffected.

This report describes the benefits realised and the lessons learned over the period these programmes were operational, April 2009 to March 2011. It also outlines transition arrangements for those projects, risks, issues and interdependencies that remain live as at the 31 March 2011, as well as benefits still to be realised.

Key Lessons- Learnt

Went well

1. Of the 86 projects initiated within the programmes' existence the vast majority have been delivered as planned.
2. Progress reporting based on milestones conforms to best practice and was widely used.
3. The SIP allowed a margin of innovation and flexibility with people empowered to deliver their projects rather than following an overly bureaucratic documentation process.

Improvement opportunities

1. An inconsistent approach to benefit realisation and business change management.
2. There is still a tendency towards functional silo working.
3. Project progress reporting was a time consuming and labour intensive with several different variants of monthly reports required by different bodies.

Next Steps

1. SMG members are asked to note the closure report for the SIP 2012.
2. Programme boards for the three new programmes have been set up in May where the scope and deliverables of the programmes will be agreed.
3. The blueprint that sits below the Integrated Business Plan will be developed for the programmes to provide the agreed view of the future in terms of what the programmes will deliver up and until 2015.
4. The programme structures and governance will be developed through May and June.
5. All projects will be scoped and set up in Performance Accelerator and reported on through this system, a phase approach is to be adopted:
    1. CIP project and projects rolled over from the old programmes will be prioritised
    2. New projects will be scoped, project managers identified, and put on PA as and when they are initiated.
6. A further up-date on the new programmes will be provided at the next SMG meeting.

2. PURPOSE

This is the Programme Closure Report for two of the three programmes that have constituted the overall service improvement programme (SIP) for the London Ambulance Service NHS Trust (LAS) over the period April 2009 to March 2011.

Following the Trust Board's decision to apply for Foundation Trust status the Senior Management Group decided that the current SIP should close. It is to be replaced with a new Integrated Business Plan Delivery Programme (IBP programme). Of the three constituent sub-programmes of the SIP the 'Olympics Programme' will migrate into the new IBP Programme. However the 'Clinical Development, Leadership and Workforce Programme' and the 'Performance and Service Delivery Programme' have come to a natural end point and will close. A natural end point has come about in that most of the projects have closed and the benefits have either been realised or are in the process of being realised through business as usual activity.

This report focuses on the status of projects progressed under the governance of the two closing programmes in terms of either what they have delivered or for those still on-going identification of where they migrate to under the new IBP Programme structure. Significant lessons learned of sufficient significance at the programme and project levels are also referred to.

3. OVERVIEW

2.1 Benefit realised

Below is a summary of the benefits that have been realised by the two programmes, for the full benefit report see the appendices:

Clinical Development, Leadership and Workforce Programme

Workstream	**Benefit Summary (for detail see appendix 1)**
OD & People	• **Improved access to learning** through e-learning site o Registered users:123 o 10 Courses on LAS Live o Assessments Attempted: 76 o Assessments Passed: 51 • **Improved access to development opportunities** and utilisation of talent through the talent management programme – 4 participants undertaking a range of self-directed learning, including delivery of PIPs (potential cost savings of £100k for BETS). • **Improved ability to meet ORH modelling** requirements, a 24% increase in frontline staff since 2007/08 (706 staff), there by contributing towards operational performance, reducing overtime payments and reducing sickness. • **Improved access to targeted develop** through the coaching programme that

	has delivered over 576 hours of coaching delivered by accredited coaches from within the LAS on specific performance goals. • **Improved Staff Satisfaction -** 3.12 (2009/10) increased to 3.17 (20010/11) which is a statistically significant increase. • **Improved Staff Engagement** - 3.24 (2009/10) increased to 3.28 (2010/11).
NWoW	• **Increased use of ACPs:** Significant increase in ACP usage on NWOW complexes; usage has doubled at Chase Farm and trebled at Barnehurst. Both complexes ACP usage has exceeded the LAS average (2.5 – 3.5%). • **More engagement with the community:** Regular coordinated borough events have increased engagement and strengthen working relationships with local community. The number of borough events attended by staff and the CIO at NWOW complexes range from 3-10 per month. This is a significant increase with comparison to non-NWOW complexes. • **Improved communication:** Staff involvement and engagement is at the heart of NWOW, both Chase Farm and Barnehurst have seen a significant increase in the percentage of staff that feel involved in changes that affect their work . Both Chase Farm and Barnehurst are above the LAS average (below 20%). • **Improved patient care experience:** Through training, support and communication, the percentage of staff who feel happy with the standard of care provided to patients / service users has significantly increased on both NWOW complexes to over 80%. This is above the LAS average. • **Improved capability to deal with work related demands:** Providing the right support, guidance and leadership on Complex to crews has seen the percentage of staff able to do their job to a standard they are personally pleased increase at Chase Farm to 56%, which is above the LAS average.
HFL	• **Improved appropriate conveyance for major trauma patients -** 97% (August 2010) of major trauma patients were appropriately conveyed to a MTC or a local trauma unit (A&E), which exceeds the target set for the LAS of 90% conveyance of major trauma patients to an appropriate facility. • **Improved appropriate conveyance for stroke patients November 96%** (n=643)of patients appropriate facility, with **92%** (n=614) of patients taken directly to a HASU and **4%** (n=29) appropriately transported to the nearest A&E. • **Improve use of appropriate care pathways** - Average ACP usage has increased slightly from around 1% to 2%, however this varies greatly by complex and area. Most complexes report usage of 1.5% contrasted with a small number reporting 4% for the financial year to December 2010.

Performance and Service Development Programme

Workstream	Benefit Summary (for detail see appendix 2)
Technology	• LARP project near completion enabling decommissioning of old analogue radios and masts which when completed will realise cost savings of £475k pa providing a better communication system for crews. • PTS Mobile Data system has enabled improvement in KPIs now running at 90% plus, also improved management information for LAS and hospital clients. • Timely access to accurate information with 'single version of the truth' provided for LAS by Data Warehouse project. • CommandPoint, e-PRF and SMS Text messaging projects to be completed.
Operations: Production	• 527 community responders trained • 570 static defibs in place • Improved relationships with Acute Trusts through Hospital Turn-around projects with better communication and action regarding delays. • 83% of new staff rotas in place across the Service. • Better staff deployment through resourcing to ORH • Plan, 'mobile office' for DSOs and action on patient handover times.
Operations: Distribution	• Reduced mobilisation times for ambulances to 153.2 seconds (baseline 209 secs.) and FRUs 132.7 secs. (baseline 136 secs.). • Improved performance reporting to give 24/7 oversight. • Re-location of UOC staff into Control Services. • Improved use of Active Area Cover.
Operations: Infrastructure	• New Event Control room operational for major events increasing resilience and capacity and saving £110k pa. • Provision of new front line vehicles in accordance with the Vehicle procurement Plan. • Roll out of 7 day extended hours rotas across vehicle workshops. • Establishment of the Vehicle Resource Centre to maximise available resources. • Work to secure and build new workshops with one operational in the West supported by two mobile workshops in 2012. VOR reduced, 75% of faults repaired remotely and 90% of vehicle servicing carried out according to schedule.
Corporate Processes and Governance	• New purchasing software releasing cash benefits from decommissioning of legacy systems with improved KPI performance in purchase-to pay process. • Improved investigation and reporting of road traffic collisions from use of Incident Data Recorders. • Reduction in overtime payroll errors and reduced administrative overheads from use of ProMis for overtime management and processing of claims. • Improved missing PRF rates from review and change of PRF processes. • Reduced overhead required to manage expenses as a consequence of Electronic Expenses system. • Improved controls over access to national IT applications, patient and staff confidential data due to implementation of NHS smart cards.
Foundation Trust	• IBP and LTFM produced • Membership of 9669 (4808 public, 4861 staff) • Public consultation undertaken • Due Diligence underway for FT application submission in 2011.

2.1 Lessons learnt and recommendations.

The table below describes the principal programme level lessons learnt looking across the Clinical Development, Leadership and Workforce and the Performance and Service Delivery Programmes. It also identifies recommendations to be carried forward into the new IBP Delivery Programme arising from closure of the Service Improvement Programme. Selected project level lessons learnt are identified in the tables in Appendix 1 (Clinical Development) and Appendix 2 (Performance and Service Delivery) which outline each project progressed since April 2009. Also identified are the status of each project and the benefits realised (where applicable).

No.	**Nature of lesson learned** (went well; improvement on previous situation; was lacking; went badly)	**Description of lesson learned**	**Recommendations for future enhancement/modification**
1	Improvement on previous situation	There is more work to be done in securing support from other departments to deliver aspect of projects, particularly when there are competing priorities. There is still a tendency towards functional silo working although this is much better than it used to be. The focus on workstreams re-enforced functional silo working.	Early engagement, membership on relevant grounds, boards, clear terms of engagement protocols, use of work packages.
2	Was lacking	The majority of the work was delivered and managed at the workstream level reducing the role of programme boards. At times this resulting in a lack of cohesion and direction at the programme board level.	A cleared focus by SROs and programme boards on benefits realisation. Under the IBP Programme while directors have portfolios of projects they are responsible for as functional heads they are delivering these to contribute to achievement of SMART target benefits against the corporate Outcome Indicators. The role of the programme board is to hold directors to account for the delivery of the projects in their portfolios so that the benefits are realised corporately.
3	Was lacking	An inconsistent approach to benefit realisation and business change management.	The benefits realisation process needs to be consistently followed for all projects in the IBP Programme with benefits clearly identified at the start through benefits profiles identifying contribution to Outcome Indicators and documented in PIDs. SROs and programme managers have a particular role in focusing on

			benefits.
4	Went well	The SIP allowed a margin of innovation and flexibility with people empowered to deliver their projects rather than following an overly bureaucratic documentation process. This took place within a standardised set of templates available which allowed people to use a 'lite' version of documentation if appropriate to the project.	The policy of having 'lite' and a full versions of documentation should continue. While people should be required to use the standardised templates available on Process Central they should be free to choose which is appropriate to their individual project in consultation with the project executive and PCMO staff.
5	Was lacking	There was insufficient capacity to deliver the change required within the planned timeframe. The work was often done by managesr on top of their 'day jobs' which caused slippage. This was particularly the case when REAP levels were high. Although attempt was made to distinguish projects driven by time from those driven by resource, in practice resource availability determines speed of progress in nearly all cases.	Be clear at the initiation stage which projects are really driven by time and will have resource made available as required (and ring fenced) and which are driven by resource availability and any consequent slippage is acceptable. There is a need to avoid the pretence that projects are driven by time when actually they are driven by resource which leads to 'heroic planning' which is not grounded in capacity to deliver.
6	Was lacking	Project progress reporting was a time consuming and labour intensive process on a monthly basis. In the latter part of the period several different variants of the monthly progress reports were required by different bodies (project boards, programme boards, SMG, SSG and Trust Board). All required the full data gathering exercise but some only wanted to see summary data.	Progress reporting needs to be electronically based with data input just once at the project level which can then be viewed in different ways – by programme, portfolio or by CIP. The decision to focus the IBP Delivery programme on the Outcome Indicators linked to corporate objectives and strategic goals but the reality that the Trust is functionally organised makes electronic based reporting essential as hardcopy reporting would become an intensive, expensive and very time consuming industry detracting from actual project delivery.
7	Went well	Progress reporting based on milestones conforms to best practice and was widely used. This was a significant improvement on the situation previously where progress reporting was done on the basis of percentage of work complete, often not based on a milestone plan.	Planning at the strategic level for projects and programmes should continue to focus on milestone delivery related to activity outputs. Performance management should continue to be based on milestone achievement with a realisation that in principle not all milestones will be achieved as planned in the time schedule because of the capacity issues described in number five above.

3 .PROGRAMME TRANSITION

3.1 Process

The three new IBP Delivery Programmes, Patient, Workforce & OD, and Value for Money will go live during April 2011. Currently each programme is being defined, the governance arrangements agreed and a programme plan developed.

Part of this programme definition stage includes the scoping of projects, allocation of resources and budgets, and development of individual project plans. Each of these projects are to be set up in Performance Accelerator (PA), which will be the future mechanism for SMG and the programme boards to monitor the progress of the project and benefits linked to each programme.

The first new programme reports will be for May 20111 and will use PA as the vehicle to report on progress.

3.2 Project Transition

The projects with in the current programmes are in variety of stages, from closed and benefits being realised, in the business change phase, or still in the enabler phase, and will be managed in the following ways:

- Those closed projects are reported in the body of the closure report with a benefits and lessons learnt report;
- Those that are due to close shortly, either enabler or business changes, will not carry across into the new programmes but will be managed until their completion by the project boards. However, benefits that were identified to be delivered by these projects will be carried over into the new programmes.
- Those that are starting or still have the majority of the project to be delivered will be carried across into the new programme structures.

Below is a summary of the projects contained within the Clinical Development, Leadership and Workforce and Performance and Service Delivery Programmes and the intended action for each:

Clinical development, Leadership and Workforce Programme

Project	Status	Action	New Programme
OD & People			
Workforce Plan Implementation	Closed	In Closure report	NA
Coaching & Mentoring	Closed	In Closure report	NA
Performance Management	Open	Carry over	Workforce & OD
Talent Management	Closed	In Closure report	NA
E-learning	Closed	In Closure report	NA
Learning Management Systems	Open	Carry over	Workforce & OD
Standards of Paramedic Education	Open	Carry over	Workforce & OD
Clinical Response Model	Open	Carry over	Patient
Staff Well-Being	Near close	In Closure report	NA
Staff Engagement	Near close	In Closure report	NA
Team Working	Open	Carry over	Workforce & OD
KSF / PDR	Open	Carry over	Workforce & OD
NWoW			
Barnehurst	Closed	In Closure report	NA
Camden	Closed	In Closure report	NA
Greenwich	Open	Carry over	Workforce & OD
Friern Barnet	Open	Carry over	Workforce & OD
Bromley	Open	Carry over	Workforce & OD
Islington	Open	Carry over	Workforce & OD
Chase Farm	Open	Carry over	Workforce & OD
HFL			
Stroke	Closed	In closure report	NA
Major Trauma	Closed	In Closure report	NA
Appropriate Care Pathways	Open	Carry over	Patient
Stakeholder Engagement	Open	Carry over	Value for Money

Performance and Service Delivery programme

Project	Status	Action	New programme
Technology			
Command Point	Open	Carry over	Patient Care
Data Warehouse	Closed	In closure report	N/A
LARP (Radio Project)	Open	Carry over	N/A
PTS Mobile Data	Closed	In closure report	N/A
TEASHIP	Open	Carry over	Patient Care
ePRF	Suspended	In closure report	N/A
Operations - Production			
First and co-responders	Closed	In closure report	N/A
Static defribrillator	Open	Carry over	N/A
Hospital turnaround (phase 1)	Closed	In closure report	N/A
Roster reviews	Open	Carry over	Patient care
Annual leave	Closed	In closure report	N/A

Resourcing to ORH plan across 168 hours	Closed	In closure report	N/A
Mobile office	Closed	In closure report	N/A
Hospital based alert	Open	Carry over	Patient care
CMS implementation	Open	Carry over	Patient care
Operations -Distribution			
Performance oversight	Closed	In closure report	N/A
Single responders	Closed	In closure report	N/A
Urgent care despatching	Closed	In closure report	N/A
Ambulance activation reduction	Closed	In closure report	N/A
FRU activation reduction	Closed	In closure report	N/A
Active area cover	Closed	In closure report	N/A
Rest breaks	Open	Carry over	Patient care
Future proofing control delivery	Open	Carry over	Patient care
Operations - Infrastructure			
Vehicle fleet procurement	Open	Carry over	VfM
Event control rooms	Closed	In closure report	N/A
Logistics & fleet review	Closed	In closure report	N/A
Emergency preparedness review	Closed	In closure report	N/A
New workshop commissioning	Open	Carry over	VfM
Contol rooms	Open	Carry over	Patient care
Real time fleet management information	Open	Carry over	VfM
Corporate Processes and Governance			
Performance measurement	Open - Due closure 30/4/11	In closure report	N/A
Meeting Room Booking System	Closed	In closure report	N/A
FISC Roll out	Closed	In closure report	N/A
Fleet Strategy and Workshop Review	Closed	In closure report	N/A
Flexible Fleet Management	Closed	In closure report	N/A
Incident Data Records - Phase I	Closed	In closure report	N/A
Incident Data Recorders Phase II	Closed	In closure report	N/A
Staff Administration	Closed	In closure report	N/A
VRC Improvement	Closed	In closure report	N/A
Replacement Budget Setting & Forecasting System	Closed	In closure report	N/A
Map all Processes	Closed	In closure report	N/A
PRF Handling and Processing	Closed	In closure report	N/A
The Intelligent Trust	Abandoned	In closure report	N/A
Electronic Expenses	Open		
Inventory Management	Abandoned	In closure report	N/A
Starters, Movers & Leavers	Open	Carry over	VfM
Staff Admin Phase 2	Open	Carry over	VfM
GRS Upgrade	Open	Carry over	VfM

User Identity Management	Open	Carry over	VfM
Driving Licence Checks	Open	Carry over	VfM
ESR Self Service	Abandoned	In closure report	N/A
Benchmark Financial Services	Closed	In closure report	N/A
Benchmark Payroll	Open	Carry over	VfM
Incident Reporting (LA52)	Open	Carry over	VfM
Vehicle Off Road Process Improvement	Open	Carry over	VfM
RTC reporting	Open	Carry over	VfM
Agency Staff Process Improvement	Open	Carry over	VfM
Foundation Trust			
Business plan	Open	Carry over	Patient care
Governance & membership	Open	Carry over	Patient care
Communication & consultation	Open	Carry over	Patient care
Business strategy & marketing	Open	Carry over	Patient care
HR & organisation development	Open	Carry over	Patient care
Finance	Open	Carry over	Patient care
Commissioning engagement	Open	Carry over	Patient care

3.2 Risk/Issues/Interdependencies

Programme level risks, issues and interdependencies that remain open when SIP programmes close will be allocated to the appropriate IBP Delivery programmes as a handover. This will be managed by the PCMO with risks and issues handed over, logged on the appropriate Risk and Issue Logs for the new sub-programmes to review at the inaugural programme board meetings.

Project level risks for projects which migrate into a new programme will continue to be owned by the project boards, executives and managers who will not automatically change as a consequence of the altered programme governance arrangements. The only change will be the escalation path from project to programme level should this be necessary. Escalation will in future be to the relevant programme board and SRO under the IBP Delivery programme structure.

3.3 Management of Benefits 11/12

During the development phase of the three new programmes, benefit maps will be developed that align those benefits to be realised with the programme objectives and identified projects. These maps help to shape the programme mandates. A mapping exercise to link those benefits from the SIP maps to the new programme maps has been

undertaken and benefits transferred across and validated.

Where projects have recently, or are soon to close, there may be benefits identified and carried over from the old programmes that need to be monitored but where the new programmes will not be delivering a specific project. Other new projects will have benefits identified and developed as part of the overall programme development work.

Irrespective of whether a benefit is carried over from the old programmes, or developed in the new programmes, each programme will agree a benefit map that forms the basis of the programme boundary for their benefits and projects to be delivered. Each benefit in these maps will be developed and a benefit owner responsible for their delivery identified. Measures will be identified and agreed that will form the basis for tracking each benefit. Where possible these will be measures used for existing targets such as the balanced score card, CQUIN targets or quality measures, this will ensure the process is manageable and consistent.

Once developed, the benefits will feed into a benefit plan that sets out when and where project delivery will feed into the realisation of benefits, the timescales and process for reporting on benefits, as well as baseline and agreed target values. All benefits will be reported through Performance Accelerator at SMG and the programme boards, supported by a governance framework to manage benefit delivery and ownership.

4. NEXT STEPS

7. SMG members are asked to note the closure report for the SIP 2012.
8. Programme boards for the three new programmes have been set up in May where the scope and deliverables of the programmes will be agreed.
9. The blueprint that sits below the Integrated Business Plan will be developed for the programmes to provide the agreed view of the future in terms of what the programmes will deliver up and until 2015.
10. The programme structures and governance will be developed through May and June.
11. All projects will be scoped and set up in Performance Accelerator and reported on through this system, a phase approach is to be adopted:
    1. CIP project and projects rolled over from the old programmes will be prioritised
    2. New projects will be scoped, project managers identified, and put on PA as and when they are initiated.
12. A further up-date on the new programmes will be provided at the next SMG meeting.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

24TH MAY 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 and the use of the Trust Seal since 29th March 2011**

Executive Summary

Two tenders have been received, opened and entered into the tender book since 29th March 2011:

- Refurbishment of the new HART west site at Isleworth
  Tenders received and opened on 5th April 2011:
  Millane Contract Services Ltd
  Coniston Ltd
  Warwick Avenue
  Marbank Construction Ltd
  Vinci Facilities
- Risk Management System
  Tenders received and opened via Bravo Solutions on 11th May 2011:
  Datix
  Ulysses

There has been one entry to the Register for the Use of the Trust Seal:

- Unit 28 Bermondsey Trading Estate – lease renewal

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:

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

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
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

24TH MAY 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
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Risk Implications
This paper links to the following strategic risks:

☒ 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:

TB FORWARD PLANNER

Date	Strategic and Business Planning	Items for approval (eg Policies and Business Cases)	Performance and Other	Governance	Standing Items	Apologies	Committee dates
28 June 2011 TB	FT application update	CommandPoint Update		Audit Committee Annual Report 2010/11	Report from CEO including balanced scorecard and performance reports		Audit 6th June
				2010/11 Annual Infection Prevention and Control Report	Report from Finance Director		
				Corporate Social Responsibility Report 2010/11	Report from Sub-Committees		
SMG 15 June	Cost Improvement Programme			Patient Experience and Complaints Report 2010/11	Clinical Quality and Patient Safety Report		CQSE 7th June
				Audit and Research Annual Report 2010/11	Report from Trust Secretary		
				BAF and corporate risk register			
				KA34 Compliance Statement			
26 July 2011 SRP	Review of balanced scorecard			Bribery Act training (Hayley England)			Qual 6th July
SMG 13 July	Cost Improvement Programme Q1 review						RCAG 11th July
23 Aug 2011 TB	FT application update			Q1 integrated governance and finance declaration	Report from CEO including balanced scorecard and performance reports		CQSE 2nd Aug
SMG 10 August				Key risks	Report from Finance Director		LFE 9th Aug
					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		Qual 7th Sept
SMG 14 Sept				BAF and risk register	Report from Finance Director		Audit 12th Sept
				2009/10 Annual Equality Report	Report from Sub-Committees		
					Clinical Quality and Patient Safety Report		

TB FORWARD PLANNER

					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		RCAG 10th Oct
SMG 9 Nov				Patient and Complaints Experience Report	Report from Finance Director		CQSE 26 Oct
				Key risks	Report from Sub-Committees		Qual 2nd Nov
					Clinical Quality and Patient Safety Report		Audit 7th Nov
					Report from Trust Secretary		LFE 15th Nov
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		