London Ambulance Service NHS
NHS Trust

TRUST BOARD

Meeting to be held at 10.00am on Tuesday 23rd August 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** Roy Griffins Brian Huckett		
2.	**Minutes of the Part I meeting held on 28th June 2011** To approve the minutes of the meeting held on 28th June 2011		TAB 1
3.	**Matters arising** Actions from previous meetings	All	TAB 2
4.	**Report from Sub-Committees** To receive a report from the following Committees		TAB 3
	4.1 Quality Committee 4th July 2011	BM	
	4.2 Finance and Investment Committee 5th July 2011	RH	
	4.3 Strategy Review and Planning Committee on 26th July 2011	RH	
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, serious incidents and performance reports	PB	TAB 5
	6.2 Director of Finance	MD	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.	**Cost Improvement Programme Quarter 1 Update** To receive an update on quarter 1 progress against the Cost Improvement Programme	MD	TAB 8
9.	**CommandPoint Update** To receive an update on CommandPoint	PS	TAB 9

FOUNDATION TRUST PROCESS

10.	**Foundation Trust Update** To receive a report on the current position with the application	SA	TAB 10

GOVERNANCE

11.	**Annual Review**	AP	To be tabled
12.	**Bribery Act Update** To receive an update on the implications of the Bribery Act	MD	TAB 11
13.	**Report from Trust Secretary** To receive the report from the Trust Secretary on tenders received and the use of the Trust Seal	SA	TAB 12
14.	**Forward Planner** To review the forward planner for the Trust Board and agree items for future meetings	SA	TAB 13
15.	**Any other business**		
16.	**Questions from members of the public**		
17.	**Date of next meeting** The next meeting of the Trust Board will take place on Tuesday 27th September 2011		

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING
Part I

DRAFT Minutes of the meeting held on Tuesday 28th June 2011 at 09:00 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

In Attendance:

Sandra Adams	Director of Corporate Services
Carrie Armitage	
Ken Beedle	Northrop Grumman
Fiona Carleton	Assistant Director of Operations (EOC)
Lizzy Bovill	Deputy Director of Strategic Development
Martin Flaherty	Deputy Chief Executive
Francesca Guy	Committee Secretary (minutes)
John Hopson	Assistant Director Of Operations (EOC)
Cheryl Janey	Northrop Grumman
Alan Leckenby	Northrop Grumman
Jonathan Nevison	Project Manager, CommandPoint
Russ Obert	Northrop Grumman
Angie Patton	Head of Communications
Peter Suter	Director of Information Management and Technology
Ken Uffelman	Northrop Grumman
Karen Williams	Northrop Grumman
Richard Webber	Director of Operations

Members of the Public:

Barry Silverman	Patients Forum
Neil Kennett-Brown	North West London Commissioning Partnership

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63. Welcome and Apologies

63.1 Apologies had been received from Caroline Silver.

64. Minutes of the Part I meeting held on Tuesday 24th June 2011

64.1 The minutes of the Part I meeting held on Tuesday 24th June 2011 were approved.

65. Matters Arising

65.1 The following matters arising were considered:

65.2 **46.12:** Francesca Guy confirmed that the staff survey action plans had been added to the Strategy Review and Planning Committee forward planner. This action was complete.

65.3 **47.5:** Sandra Adams reported that an update on serious incidents would be included in the Chief Executive's Report to the Trust Board. Serious incident reporting and management was also now on the Quality Committee's agenda as a regular item. This action was complete.

65.4 **55.3:** Steve Lennox reported that the final version of the Quality Account for 2010/11 was included in the Trust Board's pack for today for approval. This action was complete.

65.5 **59.2:** Sandra Adams reported that the Trust Board's forward planner had been updated with items identified at the last Trust Board meeting. Sandra and the Chair would discuss the Trust Board's forward planner on an ongoing basis. This action was complete.

66. Report from Sub- Committees

Quality Committee on 24th May 2011

66.1 Beryl Magrath reported the following:

- The Quality Committee heard a report from the Chair of the Learning from Experience Group and noted that the LA52 incident reporting form was in the process of being reviewed. A pilot was ongoing of electronic reporting through the Emergency Bed Service (EBS) in four complexes. It was intended that this pilot would be rolled-out Trust-wide. The Learning from Experience Group would also be reviewing the governance processes around Serious Incidents;
- The Quality Committee reviewed the integrated report for the first time. The report had been structured around the patient's journey, which the Quality Committee agreed was a useful way of presenting information. There was some discussion around staff ability to check vehicle and equipment and the Quality Committee suggested that this should be factored into the shift time. The Quality Committee also discussed attitude and behaviour complaints, lost property and claims. The Committee noted that information on claims was not currently linked to incidents and complaints and that this should be addressed with the new risk management system. Overall, the Quality Committee felt that the integrated report was a good start, but that the data needed to improve as does learning from incidents;
- The Quality Committee reviewed the Infection, Prevention and Control dashboard and noted the improvements, although recognised that hand hygiene, uniform compliance and blanket audits still needed attention. The Quality Committee agreed the recommendation, which would be put forward to the Trust Board at today's meeting, to de-escalate the reporting of infection prevention and control from the Trust Board;
- The Quality Risk Profile was reviewed and the Quality Committee noted that the IG Toolkit compliance assessment score was 61%. There was a target of 95% to reach by October 2011;
- The Quality Committee reviewed its terms of reference and agreed to invite Caron Hitchen as a member of the Committee, particularly as there were a number of HR issues which would affect the quality of service provided by the Trust;
- David Leach, from the CBRN/HART team, joined the meeting to give an update on progress against the internal audit recommendations. The Quality Committee was assured that the issues highlighted in the internal audit report were being addressed, although the full west team was six members short and the accommodation in Isleworth would not be finished until September 2011 at the earliest.

66.2 The Chair commented that the Quality Committee had a good focus on the 'micro' issues, but needed to now consider some of the 'macro' issues. He suggested that he and Beryl Magrath meet

to discuss how the Quality Committee would address this in order to provide sufficient assurance to the Trust Board, particularly as the Quality Committee was pivotal to the Trust Board and the overall governance structure.

ACTION: RH and BM to meet to discuss the Quality Committee's agenda.

DATE OF COMPLETION: 23rd August 2011

66.3 Roy Griffins agreed that this would be useful, particularly as the Quality Committee's agenda was so large. He suggested that the Quality Committee needed to make better use of its sub-groups and become more of an oversight Committee rather than delving into the detail. Jessica Cecil added that clinical assurance was at the heart of the LAS, but the Trust Board might need to consider setting some boundaries around this. Mike Dinan agreed in principle, but cautioned that there was a risk that the Trust Board might lose sight of something important if the Quality Committee only received summary information. The Chair of the Quality Committee would therefore need to exercise discretion in deciding which issues would require a more detailed discussion.

66.4 Peter Bradley commented that it would be useful to have a one page position statement on quality. It was clear that improvements had been seen in infection, prevention and control and management of medicines, but there were still some outstanding issues such as learning from incidents and vehicle and equipment. The Trust Board needed to be clear what these remaining issues were.

ACTION: SL to write a one page position statement on quality.

DATE OF COMPLETION: 23rd August 2011

Audit Committee on 6th June 2011

66.5 As Caroline Silver had been unable to attend the meeting, she had sent an update on the Audit Committee meeting to Sandra Adams. The following points were noted:

- Approval of the 2010/11 Annual Report and Accounts was an important part of the Audit Committee's business. In particular, there was considerable discussion of one item raised on Friday 3rd June by the external auditors, which related to the testing of plant, machinery and equipment. A defibrillator (value £3k) could not be located despite extensive searching. The Audit Commission suggested adjusting an extrapolated figure of £371k across the entire P&E asset base. This was discussed extensively, both in terms of the 10/11 Report and Accounts, but also in terms of the loss of the asset, given that control of physical property / the asset register was one of the Trust's ongoing challenges. It was concluded unanimously by the Committee that we would not adjust the accounts due to the fact that the amount was an extrapolation only and we had not adjusted for similar items previously. The external auditors were content with this. It was suggested however that when interim work was undertaken, there be some work on the asset register at that point to provide further comfort. Following this discussion, the 2010/11 Annual Report and Accounts were approved.
- The Audit Committee also noted that the lost defibrillator did not appear to have been tested since 2009 and this provoked a discussion around testing which was more quality and patient safety oriented than financial. SMG representatives and the Chair of the Audit Committee agreed to bring this to the attention of the Quality Committee;
- The Committee reviewed the High Risks on the Risk Register. Frances Wood and Sandra Adams were questioned about the processes around the Register. In general, the Committee felt that the Risk Register continued to improve in terms of relevance, use and

content;

- No issues from Counter Fraud were discussed, although it was pleasing to note a more successful trend line with the CPP in terms of prosecutions resulting. It was suggested that good news stories be published in LAS News;
- The Audit Committee was presented with some of its annual governance statements, which it took away for completion off-line;
- The work performed by internal audit, and planned to be performed, was discussed. It was noted that this year the Quality Committee was not involved at a sufficiently early stage to give meaningful input to the direction of internal audit's work. It was agreed that this would be rectified in future and the committee's earlier involvement sought;
- In Beryl McGrath's absence, Roy provided the Audit Committee with an update on the most recent Quality Committee meeting;
- The Committee received a briefing on the scope of the Bribery Act, and would encourage all Board members to be familiar with this far-reaching piece of legislation;
- Frances Wood provided the Committee with a detailed view of the progress on the Audit Recommendations report. There had been significant progress on this over the last 12 months both in terms of dealing with the recommendations but also in the format and utility of reporting;
- The Committee thanked Mike Dinan, Michael John and the team for all the hard work around the year end process, which the External Auditors commented had gone smoothly and professionally.

66.6 The next meeting of the Committee would be on Monday 12th September.

66.7 Roy Griffins wanted assurance that the Trust would consider how it would track equipment moving forward. Richard Webber responded that a project was due to commence shortly which would review the asset tracking systems. Mike Dinan reported that over the next two weeks, effort would be made to find the lost defibrillator. Richard Webber and Mike Dinan would also be meeting to discuss the servicing of equipment, which was a higher priority.

ACTION: RW/MD to update the Trust Board on plans to address the tracking and servicing of equipment.

DATE OF COMPLETION: 23rd August 2011

67. Chairman's Report

67.1 The Chair noted that staff had volunteered on a sponsored basis to drive six LDV ambulances to the capital of Mongolia.

67.2 The Chair reported the following:

- The Chair had recently met with NHS London and had sought clarification for the further delay to the board to board meeting. They explained that they required the Audit Committee Chair to attend and confirmed that the delay was not linked to the failure of the cutover to CommandPoint;
- The Chair had attended the Ambulance Leadership Forum and had heard presentations from ambulance services in New York and Christchurch about their experiences in the 11th September attacks and the recent earthquakes in New Zealand. The Chair commented that it had been humbling to hear of their experiences.

67.3 Richard Webber stated that some of the clinical presentations that had been given at the Ambulance Leadership Forum demonstrated that the LAS was ahead of the game in many respects. The Chair felt that there would be benefits to establishing a world city ambulance forum,

through which basic information could be shared and he would discuss this further with Fionna Moore.

ACTION: RH to discuss world cities benchmarking with FM.

DATE OF COMPLETION: 27th September 2011

68. Update from Executive Directors

Chief Executive Officer

68.1 Peter Bradley reported the following:

- LAS had been successful in tendering to Connecting for Health to become an authorised NHS Pathways training provider. This was a good service development for the Trust;
- The National Audit Office (NAO) report had been published and it was recommended that the Trust Board discuss this at the Strategy, Review and Planning Committee meeting on 26th July;
- A new report was published on behalf of the Association of Ambulance Chief Executives entitled *Taking Healthcare to the Patient 2.* This report offered some counter arguments to the criticisms in the NAO report and would be made available to the Public Accounts Committee;
- The Trust Board would be kept updated as to the status of CommandPoint. The key issues were the timing of the future implementation and keeping staff trained and up to standard in the intervening period;
- There were some concerns that the Trust was behind on its Cost Improvement Programme and the Trust Board would need to assure itself that the slippage could be recovered. There was a particular concern regarding Patient Transport Services but it was hoped that a more favourable position would be reported next week;
- Work was ongoing to review the governance arrangements around serious incidents, including investigations, reports and lessons learnt. This would form part of the CEO report from now on.
- Category A performance was at 76.1% for this quarter and it was unlikely that the Trust would achieve 75% for June. This was largely due to the recent hot weather which had caused a spike in demand. There were currently insufficient ambulances on the road and this was due to fewer overtime hours, fewer members of staff and high levels of training (both rostered and discretionary). SMG recognised that it needed to get a better grasp on abstractions;
- The review by the Greater London Authority was finished and a report was likely to be published in September 2011;
- There was some concern that the board to board meeting with the SHA would be further delayed and the LAS would need to push hard to get a new date agreed.

68.2 Roy Griffins commented that the Trust Board needed to continue to focus on the 'day job'. He expressed some concern about the demand levels and asked whether the demand forecast in the Integrated Business Plan (IBP) was an accurate reflection of reality. Peter Bradley responded that overall demand was in line with the IBP but that the volume of Category A calls received was particularly challenging.

68.3 Jessica Cecil noted that that average arrival to patient handover time needed to improve. Richard Webber responded that work was going ahead at sector level to address this.

68.4 Beryl Magrath asked whether the new dispatch model had had an adverse impact on performance. Richard Webber responded that the new dispatch model had been a significant success and

feedback from staff had been positive. The only slight downside was the merging of urgent care resources which as a result was occasionally used inappropriately, but this issue was being addressed.

68.5 Beryl Magrath asked why the number of available ambulance hours had dropped. Peter Bradley responded that better control of training and abstractions was needed. The Chair commented that it was the responsibility of the Non-Executive Directors to hold the executive to account and as such he wanted to see the steps that would be taken to address this issue. The Trust Board needed to be alerted of any early warning signs that targets would be missed together with an action plan as to how this would be addressed. Caron Hitchen stated that the Trust was currently in a unique position with regards to training, but recognised that action needed to be taken to mitigate this risk.

Director of Finance

68.6 Mike Dinan reported the following:

- The month 2 position for the Trust was £245k surplus against a plan surplus of £526k;
- There were some concerns regarding income including Patient Transport Services and RTA. RTA was particularly difficult to plan and forecast;
- A&E overtime was above budget due to ongoing operational pressures but this was not an area of undue concern;
- The Trust had entered into a new leasing arrangement for 71 of its ambulances resulting in an increase in vehicle leasing of £130k.

68.7 Mike Dinan noted that progress against the Cost Improvement Programme was detailed in appendices 5 and 6 of his report. Mike drew attention to the following:

- The agency staff programme had shown some slippage but it was likely that the position would be recovered shortly;
- The biggest risk for the programme was the 'unidentified', the value of which was £1.4 million for the year. This would be the focus in the coming months.

68.8 Mike Dinan proposed that the details of the Cost Improvement Programme would be reviewed by the Finance and Investment Committee and reported to the Trust Board.

ACTION: MD to add Cost Improvement Programme as a standing agenda item for the Finance & Investment Committee

DATE OF COMPLETION: 13th September 2011

68.9 Roy Griffins asked whether there had been any material financial impact of the failure of CommandPoint. Mike Dinan responded that no financial impact had yet been felt, but the most significant financial variable would be ensuring that staff were trained until the next implementation. The longer this was delayed, the more cost would be incurred.

68.10 Roy Griffins commented that it would be useful to discuss the Cost Improvement Programme at the Strategy, Review and Planning Committee awayday. Sandra Adams added that there was an issue about how the quality and safety impacts of the Cost Improvement Plan would be monitored on an ongoing basis and how quality indicators would be identified.

ACTION: FG to add CIP to the forward planner for the Strategy Review and Planning Committee.

DATE OF COMPLETION: 26th July 2011

Balanced Scorecard on Infection Prevention and Control

68.11 Steve Lennox reported that the balanced scorecard on infection prevention and control showed continuous improvement for all areas, including hand hygiene. The balanced scorecard had been presented to the Quality Committee with a recommendation to de-escalate from the Trust Board. It was proposed that the Quality Committee would continue to review the balanced scorecard at each meeting and an exception report be included in the Chief Executive Officer's report to the Trust Board.

68.12 Roy Griffins commented that he was pleased to see this progress but asked for a target level of acceptability and how far we currently were from achieving this.

ACTION: SL to identify a target level of acceptability.

DATE OF COMPLETION: 23rd August 2011

68.13 Steve Lennox added that clinical staff had been very responsive and it had been useful to have had infection prevention and control reported to the Trust Board.

68.14 The Trust Board agreed to de-escalate the infection prevention and control balanced scorecard from the Trust Board and noted that it would be kept under continuous review by the Quality Committee.

69. Clinical Quality and Patient Safety Report

69.1 Fionna Moore reported the following:

- Progress had been made with the High Risk Register which had been reduced to under 800 addresses. The processes around managing the High Risk Register had also been tightened up;
- CPI completion continued to improve, although none of the areas had achieved the feedback target for the year to date;
- No adverse incidents to report in relation to medicines management;
- Slow progress had been made with the DANCE study, but it was agreed that this was the right thing to do;
- A survey had been undertaken of all UK ambulance trusts to ascertain whether they had revised their practice in line with the JRCALC oxygen therapy guidance. Work would be undertaken with leaders in clinical care to get the assurance that the training reflected the update in guidelines;
- The LAS faced significant risk to its reputation over the SAFER2 trial. Recruitment for a project researcher was underway.

69.2 Beryl Magrath noted that there was an issue with crew not recording the correct destination code on documentation and asked how this would be addressed. Fionna Moore responded that coding was brought up at team leader meetings particularly as this was critical to achieving CQUINs. Lizzy Bovill added that the coding was in the process of being revised to make it more logical and it was hoped that this would improve accurate usage of codes. Crews often recorded a patient as being taken to an A&E department when often this was not the end destination for the patient. This was a key learning point for staff.

69.3 There followed a discussion about the lack of outcome data from hospitals. Fionna Moore stated that some of the comments in the NAO report could add some weight to this argument. Beryl Magrath suggested that this issue needed to be pushed at CEO or department level.

70. 2010/11 Annual Report and Accounts

70.1 Mike Dinan reported that the draft 2010/11 Annual Report and Accounts had been reviewed by the Audit Committee and the Trust Board. The final Report and Accounts had been approved by the Audit Committee at its meeting on 6th June. They would also be presented to the Annual General Meeting in September.

70.2 Roy Griffins gave assurance to the Trust Board that the 2010/11 Annual Report and Accounts had been reviewed in detail by the Audit Committee and recommended their approval by the Trust Board.

70.3 The Trust Board approved the 2010/11 Annual Report and Accounts.

71. Cost Improvement Programme 2011/12

71.1 The Cost Improvement Programme had been discussed as part of the report from the Director of Finance. [DN: See paragraph 68.7]

72. Response to the Coroner's Rule 43 Report from the 7/7 London Bombings Inquests

72.1 Angie Patton explained that the coroner had requested that the response to the Rule 43 Report from the 7/7 London Bombings Inquests remain confidential at this stage. As such, this agenda item would be dealt with in the Part II meeting of the Trust Board.

73. Foundation Trust Update

73.1 Sandra Adams reported that the board to board meeting with the SHA had been postponed and they were looking to agree a new date as soon as possible. Sandra therefore asked for the Trust Board members to send her their availability over the coming months.

ACTION: Trust Board members to send their availability over the coming months to Sandra Adams.

DATE OF COMPLETION: 8th July 2011

73.2 Peter Bradley commented that it would be desirable to get a few dates from the SHA.

ACTION: SA to ask SHA for a few possible dates for the board to board meeting.

DATE OF COMPLETION: 8th July 2011

73.3 Sandra had fed back to the SHA that the requirement of the Audit Committee Chair to attend the board to board meeting was not written down in any of the guidance and that the Trust had taken steps to cover any gaps during this process. With regards to CommandPoint, the SHA was looking for assurance that action had been taken to address remaining bugs and that an action plan to implementation was in place. The Chair commented that he had agreed to keep in contact with Mike Spyer at NHS London, particularly with regards to CommandPoint, although Mr Spier did not view CommandPoint as a showstopper at this stage. The Chair suggested that it might be helpful for him to write a letter to Mike Spyer emphasising the Trust's state of preparedness for the board to board meeting and the feeling of the Trust Board.

ACTION: RH to write a letter to Mike Spyer, NHS London, emphasising the Trust's state of preparedness for the board to board meeting and the feeling of the Trust Board.

DATE OF COMPLETION: 26th July 2011

73.4 The Chair reported that he would be proceeding with the recruitment to fill the Non-Executive Director vacancy on the Trust Board. It had previously been agreed that the position would remain vacant until after the Foundation Trust process had been completed but due to the delay in the timescales, it had been agreed to proceed with recruitment.

73.5 Roy Griffins commented that the Trust Board had agreed unanimously to pursue Foundation Trust status and that the Trust Board should continue in this process in good faith.

73.6 The Chair agreed to write a follow up letter to the Secretary of State confirming the new timescale.

ACTION: RH to write a letter to the Secretary of State confirming the new timescale to achieve Foundation Trust status.

DATE OF COMPLETION: 23rd August 2011

74. Draft Constitution for the London Ambulance Service NHS Foundation Trust

74.1 Sandra Adams reported that applicants for Foundation Trust status were required to be legally constituted and to meet the requirements of Schedule 7 of the 2006 NHS Act. The Trust Board was therefore asked to approve the draft constitution.

74.2 Roy Griffins stated that he would like the Trust Board to discuss the ramifications of the proposed constitution and the new duties of the Non-Executive Directors prior to approval. Sandra Adams responded that Capsticks were due to attend the Strategy Review and Planning Committee meeting on 26th July to give an update on this. Sandra added that the governance rationale had been discussed by the Trust Board a number of times and the constitution reflected legal requirements and the content of the governance rationale. Therefore the draft constitution was not new to the Trust Board.

74.3 Trust Board members were keen to fully discuss the implications of the constitution and governance rationale and as such the Trust Board agreed to delegate the approval of the constitution to the Strategy Review and Planning Committee which would be meeting on 26th July 2011. Sandra confirmed that postponing the approval of the constitution would not affect the board to board meeting with the SHA as the draft constitution formed part of the Integrated Business Plan.

75. Quality Account 2010/11

75.1 Steve Lennox commented that the Quality Account should be given the same weighting and gravitas as the Annual Report and Accounts and the draft version had been presented to the Trust Board at its last meeting on 24th May. This version of the report incorporated feedback from stakeholders and the Patients' Forum.

75.2 The Chair commented that this was a very informative document and he was likely to use it as a reference guide, particularly in preparation for Foundation Trust status. The Chair thanked the Patients' Forum for their input.

75.3 The Trust Board approved the Quality Account 2010/11.

76. 2010/11 Annual Infection Prevention and Control Report

76.1 Steve Lennox reported that it was a requirement of the CQC to produce an annual Infection Prevention and Control Report.

76.2 The Trust Board approved the 2010/11 Annual Infection Prevention and Control Report.

77. 2010/11 Safeguarding Report

77.1 Steve Lennox reported that it was a requirement of the CQC to produce an annual Safeguarding Report and noted that good progress had been made with regards to safeguarding particularly following the visit from the SHA's Safeguarding Improvement Team in January 2011. Steve added that the balanced scorecard for safeguarding was work in progress, but a system was now in place to monitor safeguarding activity.

77.2 Roy Griffins commented that he would like to see SMG approve this type of report prior to Quality Committee/Trust Board approval. Steve Lennox responded that the work outlined in the report was not new to SMG and SMG regularly received updates on safeguarding activity.

77.3 The Trust Board approved the 2010/11 Safeguarding Report.

78. Board Assurance Framework and Corporate Risk Register

78.1 Sandra Adams reported that a recommendation from the due diligence process was that the Trust Board reviewed the Board Assurance Framework and Corporate Risk Register every quarter. Sandra suggested that any issues which the Trust Board would like to see discussed in more detail be incorporated into the forward planner of the Quality Committee.

78.2 Sandra explained that, as part of the review of the governance processes around incident reporting and serious incident management, the linkages between risks and reported incidents would be reviewed.

78.3 The Chair suggested that it would be useful for the Trust Board to hold a workshop on the Board Assurance Framework and Corporate Risk Register in preparation for the board to board meeting.

78.4 The Trust Board noted the updated Risk Register and Board Assurance Framework.

79. Terms of Reference for the Nominations and Remuneration Committee

79.1 Sandra Adams explained that Monitor's Code of Governance for NHS Foundation Trusts set out a requirement to integrate formally the nominations process into the governance structure. The recommendation was to establish a combined Nominations and Remuneration Committee and the Trust Board was asked to approve the Committee's terms of reference which were based on the existing terms of reference for the Remuneration Committee.

79.2 The Trust Board approved the terms of reference for the Nominations and Remuneration Committee.

80. Research Capabilities Statement

80.1 Fionna Moore reported that the LAS was required by the National Institute of Health Research to submit a research capabilities statement, which outlined the capability and ongoing projects of the research arm of the Clinical Audit and Research Team.

80.2 The Trust Board approved the Research Capabilities Statement.

81. CommandPoint Update

81.1 The following people joined the Trust Board meeting for this agenda item:

John Hopson, Assistant Director of Operations, Control Services
Fiona Carleton, Assistant Director of Operations, EOC
Jonathan Nevison, Project Manager, CommandPoint
Karen Williams, CEO, Northrop Grumman
Alan Leckenby, Northrop Grumman
Russ Obert, Northrop Grumman
Ken Uffelman, Northrop Grumman
Cheryl Janey, Northrop Grumman
Ken Beedle, Northrop Grumman

81.2 The Chair opened the discussion by stating that there had been unexpected problems with the cutover to CommandPoint, despite careful and extensive planning. The cutback to CTAK had been managed well and normal operation was resumed in the early hours of 9th June. The Trust Board now needed to understand the root cause of the failure of CommandPoint and what lessons could be learnt from this experience.

81.3 Peter Suter reported that the initial cutover to CommandPoint had been successful and the system went live at 05.00 on 8th June, however at 10.07 the control room reverted to paper due to technical problems. The decision was made, in consultation with Martin Flaherty and Richard Webber, to remain on paper until later that evening when the system was cutback to CTAK.

81.4 Peter reported that as a result, two serious incidents had been declared. One in relation to the failure of CommandPoint and one relating to a specific patient issue.

81.5 The LAS and Northrop Grumman had identified four key issues that had caused the problem, three of which were performance related and the other functional. These were:

- CPU utilisation was reached before the cutover was terminated. Northrop Grumman had identified five factors which had contributed to this;
- Intermittently the software responsible for controlling communication between the server and workstations would fail and then restart resulting in a temporary disconnection for some of the workstations. Microsoft had found a resolution for this problem and it should be resolved within the next few days;
- Some workstations were flickering. This was due to coding problems;
- Issues with automatically assigning vehicles to incidents.

81.6 Peter Suter added that all the faults with the coding were within the bespoke aspects of the system. The interfacing between the systems worked, but testing had failed to identify how they would behave in a live environment. The testing in Chantilly had not been sufficient, although it was recognised that it was difficult to replicate a live environment.

81.7 Peter Suter reported that Northrop Grumman had estimated that all four issues identified would be resolved within a couple of weeks. However, the users had had a difficult five hours using the system and therefore, in order to restore the users' confidence, all remaining bugs needed to be fixed prior to go-live. The Project Board had reviewed the approach to transition and had agreed that, with the experience that was now had, the 'flip flop' testing method would be preferable. The concept of parallel running was also being considered. Peter stated that it was not possible at this stage to confirm the new date for transition and any decision that needed to be made would come back to the Trust Board for approval.

81.8 Karen Williams stated that Northrop Grumman was committed to making CommandPoint a success. Three out of four of the problem areas had now been resolved and Northrop Grumman was working with Microsoft to resolve the remaining issue. Northrop Grumman was in the process of designing a corrective action plan and had established an independent review board to review the work done and the next steps going forward. This would include reviewing user feedback together with the list of changes to the system and understanding the initial testing environment and what elements would need to be enhanced. The performance test laboratory had been updated and Northrop Grumman would work with LAS to get this right. Karen gave assurance to the Trust Board that Northrop Grumman took this commitment very seriously and had dedicated significant resources to this investigation.

81.9 Richard Webber supported Peter Suter's earlier comments that all remaining bugs would need to be fixed prior to go live and he requested assurance from Northrop Grumman that these bugs would be remedied.

81.10 Beryl Magrath asked how long a delay would result in staff needing to undertake additional training. Peter Suter responded that the dry runs had been very popular and that these, together with additional classroom refresher courses would need to be considered once the new timetable was agreed.

81.11 Brian Huckett asked how long would be needed for the retesting of CommandPoint. Peter Suter responded that this had not yet been agreed and neither had the scope of the additional fixes. Martin Flaherty added that the Trust had not been particularly busy at the time that the system failed and therefore the test environment needed to take into account periods of high demand.

81.12 Jessica Cecil asked what affect this delay had on other LAS initiatives and wider issues. Peter Suter responded that the impact would be on the Clinical Response Model, NHS Pathways and accepting calls from other NHS Pathway providers. Additionally, resources would continue to be focussed on CommandPoint which might otherwise have been focussed on other projects.

81.13 Caron Hitchen asked, given the testing had now been found to be inadequate, what key enhancements would be made to the testing environment. Karen Williams responded that the testing would now include flipping in and flipping out as it was now recognised that testing in a live environment was invaluable. Lizzy Bovill commented that clinical assurance would be needed around this type of testing and that this would need to be clearly understood before the testing stage.

81.14 Mike Dinan stated that the expectation was that this product would be delivered. There had been a problem with Northrop Grumman's internal testing which had delivered a product which did not work. The Trust now needed assurance that the product that it had bought would be what was delivered.

81.15 Fiona Carleton stated that the disappointment of the team was enormous and it was therefore now important that the product functioned as it should. Fiona reiterated the earlier point that the smaller issues needed to be resolved in order to restore the users' confidence, including those things that previously did not seem important. Roy Griffins endorsed this point and stated that to fail for a second time would be much more serious. The confidence and goodwill of staff were required to ensure that this was a success. John Hopson agreed that the damage done to staff confidence could not be underestimated and that it would not be advisable to go live for a second time with workarounds.

81.16 Northrop Grumman noted these points and it was agreed that they would attend the Strategy Review and Planning Committee awayday on 26th July to give an update on progress towards implementation and to address the concerns raised.

82. Report from Trust Secretary

82.1 Sandra Adams noted that one tender had been received and entered into the tender book since 24th May 2011 for cleaning offices and ambulance stations.

82.2 The Trust Board noted the Report from the Trust Secretary.

83. Forward Planner

83.1 The Chair noted that the Trust Board was faced with a large agenda and that it was important to take a step back and review the ongoing 'business as usual' agenda and the total performance around quality, finance, human resources and information technology.

83.2 The Trust Board agreed to add a discussion on the National Audit Office report to the forward planner for the Strategy Review and Planning Committee awayday on 26th July 2011.

ACTION: FG to add the National Audit Office report to the forward planner for the Strategy Review and Planning Committee awayday on 26th July 2011.

DATE OF COMPLETION: 8th July 2011

83.3 The Trust Board noted the forward planner.

84. Any other business

84.1 The Chair reported that he had begun the process of recruitment to the non-executive director vacancy and would keep the Trust Board updated on any progress made.

85. Questions from members of the public

85.1 Barry Silverman commented that the annual report set out the Trust's approach to disabled employees and yet the conference room did not have a hearing induction loop system. Barry commented that other requirements may be needed and the Trust Board might wish to consider conducting a disability audit. The Patients Forum had made a number of comments on diversity but there had not been an improvement on this over a number of years. Barry asked what action the Trust Board was taking to address this situation.

85.2 The Chair responded that the Trust Board was clear that it needed to make steps to improve equality and diversity and it was hoped that there would be an opportunity to make a step in the right direction with the recruitment for the vacancy for a new non-executive director. However the outcome of the recruitment process was not yet known and the panel would choose the best candidate for the role.

85.3 Caron Hitchen added that the Equality and Inclusion Steering Group was regularly attended by representatives from the Patients' Forum and therefore the Patients' Forum should be cognisant of the Equality and Inclusion Strategy and action plan. The Equality and Human Rights Commission had also written a letter of support to the Trust for the action plan and approach taken.

85.4 Barry Silverman also asked what the relationship between the governors and the Trust Board would be, as set out in the constitution and what, for example, would happen if the governing bodies failed to reach an agreement. Barry suggested that the constitution needed to be stress-tested against these types of scenarios.

85.5 Neil Kennett-Brown wanted assurance that the Trust Board would continue to focus on important

pieces of work despite the ongoing issues with regards to CommandPoint. The Chair responded that throughout today's discussion the Trust Board had highlighted the fact that it recognised that there was a wider agenda which required attention and the Trust Board would take the necessary time to discuss this.

86. Date of next meeting

86.1 The next meeting of the Strategy Review and Planning Committee meeting was on Tuesday 26th July. The next meeting of the Trust Board was on Tuesday 23rd August 2011.

ACTIONS
from the Meeting of the Trust Board of Directors of
LONDON AMBULANCE SERVICE NHS TRUST
held on 28th June 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**	**The draft constitution is in line with Monitor's model constitution and with current legislation. Legal advice is that we should not make any changes to the constitution until the Health Bill becomes law and we will discuss then with Capsticks any changes that may have to be made.**
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	**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.**
28/06/11	**66.2**	**Report from Sub- Committees** RH and BM to meet to discuss the Quality Committee's agenda.	**RH/BM**	**Action complete.**
28/06/11	**66.7**	**Report from Sub- Committees** RW/MD to update the Trust Board on plans to address the tracking and servicing of equipment.	**RW/MD**	
28/06/11	**67.3**	**Chairman's Report** RH to discuss world cities benchmarking with FM.	**RH/FM**	

28/06/11	**68.12**	**Update from Executive Directors** SL to identify a target level of acceptability for the quality indicators for infection control.	**SL**	**Underway.**
28/06/11	**73.3**	**Foundation Trust Update** RH to write a letter to Mike Spyer, NHS London, emphasising the Trust's state of preparedness for the board to board meeting and the feeling of the Trust Board.	**RH**	**Action complete.**
28/06/11	**73.6**	**Foundation Trust Update** RH to write a letter to the Secretary of State confirming the new timescale to achieve Foundation Trust status.	**RH**	**Letter to Secretary of State confirming the FT application timeline is on hold until satisfactory completion of the board to board.**

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 23RD AUGUST 2011

PAPER FOR NOTING

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

Executive Summary

The Finance and Investment Committee is still developing its agenda, its process and way of working. The Committee last met on 5th July and discussed the following:

- Month 2 Capital Outturn Report
- Cost Improvement Plan
- Remount/Lease Update
- Liquidity Briefing
- Patient Transport Services
- West Area Workshop Update
- NHS Pathways

Key issues for the Trust Board

As above.

Attachments

The minutes of the Finance and Investment Committee meeting on 5th July are included in the papers for Part II.

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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

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☒ 6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
☒ 7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☒ No

Key issues from the assessment:

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 23RD AUGUST 2011

PAPER FOR NOTING

Document Title:	**Update from the Strategy Review and Planning Committee Away Day on 26th July 2011**
Report Author(s):	**Richard Hunt**
Lead Director:	**-**
Contact Details:	
Why is this coming to the Trust Board?	**To update the Trust Board of the items discussed and the actions agreed at the Strategy Review and Planning Committee meeting on 26th July 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 Strategy Review and Planning Committee (SRP) held an away day on 26th July 2011. The Committee discussed progress against 2011/12 priorities and corporate objectives and noted that the key areas of focus in the coming months were Category A performance; financial targets (Cost Improvement Programme and income and expenditure); Foundation Trust application and CommandPoint.

SRP also discussed the National Audit Office report *Transforming NHS Ambulance Services*, the Quality Strategy, Staff Survey Action Plans and Governance Review. SRP received a presentation from Capsticks on the implications of the Health Bill.

Key issues for the Trust Board

What action does the Trust Board need to take with the information provided?

To note the report and in particular the actions which have been identified to address the key issues as outlined in the section below.

Are there any areas which are a potential cause for concern?
Please note the following**:**

- Operational performance re trajectory
- YTD month 3 – financial position vs plan
- Foundation trust application – time line
- CommandPoint review and implementation

Performance

LAS has been issued with a performance notice for failure to achieve the trajectory submitted to the commissioners. Performance needs to improve to allow for the expected increase in demand over the winter months and the implementation of CommandPoint, during this financial year.

Finance

The Trust is £1489k behind plan at month 3. This is largely due to the following:

- Income has decreased as a result of reduction in PTS and RTA income;
- A&E overtime remains above budget due to continuing operational pressures;
- A&E management and EOC overtime remain above budget;
- Estimated costs of road traffic accidents has doubled in the first quarter of the year, resulting in an increase in vehicle insurance. If this continues, the expenditure will pose a further £1.7m financial risk to the Trust.

The Cost Improvement Programme (CIP) is £1.1m behind plan at month 3. An additional £800k has been added to the CIP as a result of the year end agreement with the commissioners.

Foundation Trust application

The SHA Board to Board meeting has been postponed to 7th October 2011. The historical due diligence review undertaken in January and April 2011 will need to be refreshed before our application is submitted to the Department of Health. A financial recovery plan and downside cases and mitigations are essential for Board governance, sign off and submission to NHS London and the Cluster Finance Director. The SHA will also want to see that the Trust Board had gone through the appropriate steps to assure itself for readiness for CommandPoint go-live and what steps the Trust Board will now take to assure itself on the agreement of the second go-live date.

CommandPoint

It was likely that the implementation of CommandPoint will be delayed until early next year. This will have an impact on the five-year strategic and financial plans, including the implementation of the Clinical Response Model, 111 non-emergency contact number and NHS Pathways.

A serious incident has been declared for the overall failure of the CommandPoint implementation in June 2011 and the final investigation report will be shared with the Trust Board at its meeting at the end of September 2011.

What are the key actions to mitigate any concerns?

- Identify the actions required to ensure that there are sufficient resources to meet performance targets.
- Financial recovery plan and downside cases and mitigation programme to be reviewed, signed off and monitored by the Trust Board.
- Board development sessions throughout September to prepare board members for the Board to Board meeting.
- Trust Board to understand what implications the delay in the implementation of CommandPoint would have on the 5-year strategic and financial plans and what impact this would have.

How does the Trust Board draw assurance?

- Trust Board to scrutinise and challenge financial and performance information leading to agreement on recovery plans.
- Revised performance trajectory submitted to commissioners.
- Trust Board and SMG to continue to review performance on a monthly basis.

- Trust Board and SMG to continue to review financial performance on a monthly basis.
- Detailed directorate-level reports on the Cost Improvement Plan to be submitted to the Finance and Investment Committee.
- Detailed progress reports on CommandPoint to be presented to the Trust Board.
- CommandPoint Serious Incident investigation report to be presented to the Trust Board at its meeting on 27th September 2011.

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 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
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Equality Impact Assessment

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

Key issues from the assessment: None required

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 23RD AUGUST 2011

PAPER FOR NOTING

Document Title:	**Report from the Quality Committee**
Report Author(s):	**Beryl Magrath**
Lead Director:	**-**
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 Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Other
Recommendation for the Trust Board:	**To note the scope of the discussion and the key areas highlighted below.**

Executive Summary

Overleaf, please find the new style report from the Quality Committee, which highlights risks to the Trust and assurances given to the Committee.

The following risks are drawn to your attention:

- The availability of equipment for use by front-line staff
- Two SIs were declared where patients were not thoroughly assessed. The question was asked whether the advent of the 1000 newly qualified paramedics, qualifying in the next 2 years, would pose a risk, particularly if they were used as single responders.
- The delay in implementing the CRM, following the delay in CommandPoint, as this was a key enabler of the IBP
- Concerns about managing the governance processes around the high risk register. There is one recent SI relating to this
- Concern was expressed that with the escalation of REAP levels, governance meetings such as that relating to infection, prevention and control, were cancelled, when a higher risk existed.

Key issues for the Trust Board

As above.

Attachments

Report from the Quality Committee held on 6th July 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
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Risk Implications

This paper supports the mitigation of the following strategic risks:

☒ That we fail to effectively fulfil care/safety responsibilities
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Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☒ No

Key issues from the assessment:

Report from the Quality Committee held on 6th July 2011

Risk area	Risk register reference	Board assurance framework	Assurance received/action identified to receive assurance at future meeting
Strategic risk 1 – there is a risk that we fail to effectively fulfil care and safety responsibilities			
Availability of equipment for use by front line staff	250, 312, 303, 339, 304, 72, 186	250 – out of date paediatric equipment. Corporate objective 1 – to improve outcomes for patients who are critically ill or injured	Action: risk 250 to be reviewed
Servicing of defibrillators	186, 303, 304		
2 Serious Incidents were declared when patients were not clinically assessed appropriately and thoroughly. The question was asked whether the advent of newly qualified paramedics would pose a risk, particularly if they were rostered as single responders	22	22 – failure to clinically assess comprehensively may result in inappropriate conveyance or treatment Corporate objective 1 (as above); CO2 – to provide more appropriate care for patients with less serious illness CO5 – to develop staff so that they have the skills and confidence they need to do their job CO8 – to use resources efficiently and effectively	
The current taxi contract is not fully compliant with the safeguarding legislation	344	344 – unable to assure that the current taxi contract accommodates the guidelines for regulated activity CO4 – to meet all other regulatory and performance targets	
RCAG highlighted the lack of a comprehensive asset management system	272, 72		

That staff who work unsocial hours are unable to access core training	252 relates	CO5	
An SI was declared concerning patients presenting with behavioural disturbances	9, 138		
2 Serious incidents concerning the loss of patient identifiable information were reported to the Information Commissioner	20		
It was noted that the new driving policies covered the statutory checks to be carried out on a vehicle before leaving an ambulance station but not the equipment and clinical checks	312, 350		
At CQSEC there were a number of queries concerning the governance of BASICS			
The Learning from Experience Group highlighted a backlog of investigations into serious incidents	7		SHA quality and safety assurance gateway review; Workflow processes for managing serious incidents; Learning from Rule 43 Coroner reports; Commitment to remove backlog by 30/9/11
There are concerns about managing the governance processes around the high risk register. There is 1 SI related to this.	7		

The quality measures in place for the education of 1000 new trainee paramedics and the efforts made to mitigate the lack of practical experience.	294 Also strategic risks 4 & 1		
Strategic risk 2 – there is a risk that we cannot maintain and deliver core service along with the performance expected			
Concern was expressed that with the escalation of REAP, meetings relating to infection prevention & control were cancelled, when a higher risk existed	322, 223 Also strategic risk 1		Infection prevention and control annual report 2010/11; Also discussed at CQSE about the need for area governance groups to still meet at times of high pressure and therefore potentially greater risk
The need for ongoing training for FRU drivers	9		
The use of the Demand Management Plan where, as the Plan escalated, ambulance resources were saved for the most serious patients. It was mitigated by having a clinical floor walker (FM or FW), increased use of the CCD and CTA. There had been 1 Serious Incident (at level F) who had deteriorated more rapidly than expected	265, 222	265 – performance affected by inability to match resource to demand CO3 – to meet response times routinely CO5 CO8	Action: Future agenda item for the CQSE committee

Report from the Quality Committee held on 6th July 2011

Strategic risk 3 – there is a risk that we are unable to match financial resources with priorities			
The non-recurrent funding of £7.7m which funds 143 WTE staff and acknowledges the Trust's contribution to CBRN	345	345 – as per the risk area in column 1 CO4	
Strategic risk 4 – there is a risk that our strategic direction and the pace of innovation to achieve this are compromised			
The delay in implementing the CRM, following the delay in CommandPoint, as this was a key enabler for the IBP	337, 294, 340 Also strategic risk 2	337 – as per the risk area in column 1 CO1 CO2 CO3 CO5 CO8	
CQC Quality Risk Profile highlighted the LAS lack of disabled parking spaces, however the existing ambulance stations were not able to provide these. New estate would take into account the relevant legislation	179		
Areas where assurance was given on a range of quality and safety issues			
Safeguarding annual report 2010/11	Clinical governance arrangements for the CIP programme	Infection Prevention & Control Annual Report 2010/2011	The workflow progress on Serious Incidents
The NHS London Safety and Quality Gateway Review meeting on 6th July			

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 23RD AUGUST 2011

PAPER FOR NOTING

Document Title:	**Chairman's Report**
Report Author(s):	**Trust Chairman**
Lead Director:	**-**
Contact Details:	**-**
Why is this coming to the Trust Board?	**To receive a report from the Trust Chairman on key activities.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Learning from Experience Group ☐ Other
Recommendation for the Trust Board:	**The Trust Board is asked to note the report.**

Executive Summary

Below is a summary of the Chairman's activity since the last Trust Board meeting.

Key issues for the Trust Board

Activity for the last few weeks has focussed on:

a) Attendance at the NHS Confederation conference in Manchester. Useful networking; contact made with CEO of Care UK with follow up meeting arranged. Once again, a conference of this scale amongst many others seems to be a rather old-fashioned approach compared to other commercial sectors. Three day conferences involving thousands of attendees have, in my view, questionable value. Was anything new learned? The presentation by the Secretary of State did not seem to go down well with many delegates. Why are there so many conferences in and around the whole NHS?

b) I have arranged meetings with all the new PCT cluster Chairs in London (6) and have been pleased that they have responded readily to the invitation for a meeting and, in most cases, have elected to come to us at the LAS. One meeting is outstanding with a date fixed for 13th September. All meetings were very positive. I have suggested that it might be useful for me to attend the cluster chairs' meeting with SHA London Chairman Mike Spyer.

c) Over the period we have built on the ambulance trust chairs meetings by holding teleconference calls to finalise a position on the 111 programme. We were able to quickly establish both momentum and agreement around this but I have to note that this was not sustained and thus far has not produced a positive outcome. We sought a meeting with the Secretary of State or Sir David Nicholson, neither of which were achieved. As an exercise I will be reviewing this with other

Ambulance Trust colleagues who clearly, together with the ASN, are not effective as a lobbying group.

d) I was invited to attend a full day procurement workshop run by the Department of Health with presentations from Sir David Nicholson and Jim Easton. It appears the NHS starts from the relatively low base in terms of the procurement process and effectiveness.

e) As a follow up to above and as a result of various input I gave during the workshop, Tim Kempster, who works in this area at the DH, came to see me for a follow up discussion!

f) We have progressed the appointment of a new Non Executive Director. I am expecting the Appointments Commission to formalise the appointment of Murziline Parchment with effect from 1st September. Murziline has a legal background and has been heavily involved in London through local authorities and the London Assembly.

g) I was invited to attend the GLA Conservative members' reception, met the mayor briefly and followed up a conversation regarding our cycle response unit with an invitation to visit the LAS.

Attachments

None.

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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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Equality Impact Assessment

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

Key issues from the assessment:
None required.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 23RD AUGUST 2011

PAPER FOR NOTING

Document Title:	**Chief Executive's Report**
Report Author(s):	**SMG for Peter Bradley**
Lead Director:	**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:	**The Trust Board is asked to note the report.**

Executive Summary

When I last addressed the Trust Board in July, I highlighted five inter linked areas that required specific attention. CommandPoint; our Foundation Trust application; Category A performance; our Cost Improvement Programme and our year to date financial position/achieving our control total. In addition to the usual updates from my team, which are attached, below I provide a brief update on these five areas.

Commandpoint

Good progress continues to be made in dealing with both the outstanding bugs and enhancements to the software and the number continues to reduce each week. Resolving these, coupled with a much stronger testing environment both here and in the US are significant for when we go live. The key issue for the Board to consider will be the options around when to go live and the pros and cons around the options.

Foundation Trust application

We have had confirmation that our board to board with the SHA will now be held on the 7th of October. It is pleasing that this date now seems firm. We have much to do in the coming weeks to prepare for this including getting our financial recovery plan signed off by the Board (at this meeting) and further work on our downside scenarios and mitigations – to be signed off

by the Board ahead of the board to board. We will also need to have a refresh of the HDD 2 process during September and October. The Board will need to discuss our preparatory work for the board to board and the timing and content of any sessions we hold.

Category A performance

The performance notice issued by Commissioners has been lifted and the LAS continues to build on its year to date category A performance. At the time of writing we are 76.3% for the year. This needs to be above 77% to allow for the winter period and for an in year Commandpoint go live. Helpfully, through our good work to increase hear and treat and see and treat the number of overall incidents we have attended this year has remained more or less flat when compared to last year (999 calls have still increased), however the significant rise in Category A incidents is cause for concern.

Cost Improvement Programme & YTD financial position

Work is still ongoing to ensure each directorate's unidentified savings (by line item) are identified and this will be completed in the next week. We are £1m behind with our CIP at month 4 and work continues in earnest to get back on track. We are still forecasting to achieve our full £15.9m CIP for 2011/2012. In terms of our overall month 4 financial position, we made 425k surplus and our ytd position is now 530k and we are still forecasting to achieve our end of year control total of £2.7m. Our financial recovery plan outlines the steps we are taking to ensure this is delivered.

Concluding comments

Overall we are in a better position than we were a month ago. Performance has improved, as has our financial position, we have a date for our Board to Board, we are making good progress with our CQUINs and most importantly our cardiac arrest survival figures for 2010/2011 are our best ever. Great news. However much still needs to be done over the next two to three months to secure both our financial position and performance going forward.

During September, I along with the Medical Director, will be holding our annual 26 consultation meetings at ambulance stations across London and we will also be holding three managers conferences. These will be important sessions for not only sharing our plans but also hearing from staff.

Over the last two weeks LAS staff have responded magnificently to the challenges faced during the riots. Frontline staff, our EPU team, specialist responders, managers, control room staff to our communications team, all have done a great job in difficult circumstances and I am pleased that this has been acknowledged by a range of people.

National activities

Over the last two months or so my national work has included:

- Interview panel for EMAS CEO
- Continuing to support EMAS with their performance improvement plans
- Undertaking a review of performance at NWAS Ambulance Service and East of England Ambulance Service
- Establishing the Association of Ambulance Chief Executives (AACE)
- Publishing Taking Healthcare to the Patient 2
- Speaking at the YAS Ambulance Service senior managers conference
- Working to secure a change to the call connect start time for Category A
- Overseeing the first round of nominations for the Queens Ambulance Medal

- Preparing responses to NAO report and giving evidence at PAC hearing

Attachments

- Balanced Scorecard
- Performance data pack

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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 TRUST
TRUST BOARD MEETING 23 AUGUST 2011
CHIEF EXECUTIVE'S REPORT

1. COMMISSIONING AND BUSINESS DEVELOPMENT

The LAS has maintained Category A (YTD) performance above the national standard since 1 April, however in July 2011 LAS received a performance notice from our commissioners relating to underperformance against trajectory for Cat A in April and May 2011 and failing to reach the national standard in June. A remedial action plan has subsequently been agreed with commissioners, with a revised trajectory given CommandPoint did not go live in June. This notice was cancelled at the end of July. In relation to contractual indicators we continue to meet the requirements of the other key performance indicators and are performing well against the CQUIN targets. Of note is the substantial increase in the use of hear and treat and of fallers we have referred to their GP, where clinically appropriate. These improvements continue to demonstrate our development of appropriate care pathways and increased efficiency across the Service.

The business development team continue to support the delivery of the 111 pilots across London and to develop our own options around becoming a 111 provider. Following on from the successful tender to become an NHS Pathways training organisation in Q1 we will be enabling the training of our staff in September. This will allow us to offer training in NHS Pathways on a commercial basis from October onwards should we wish to. In addition to this the team are working on the service development areas aligned with the Integrated Business Plan.

2. INTEGRATED BUSINESS PLAN (IBP) DELIVERY PROGRAMME

Following initiation of the three new programmes which make up the IBP Delivery Programme (Patient Care [SRO Steve Lennox]; Value for Money [SRO Mike Dinan]; Workforce and OD [SRO Caron Hitchen]) work has been progressing to scope the constituent projects and their benefits. Discussions concerning clinical assurance are progressing for CIP projects relevant to their stage of development. Key points of note are:

- **Patient Care Programme** (twelve projects) - A workaround to be ready for taking calls from 111 pilot sites direct into Despatch without further Triage is being progressed. In terms of being in a position to utilise NHS Pathways in CTA by February 2012 workarounds are also being investigated. It is now felt that it will not be possible to bring NHS Pathways into CTA in advance of having it in EOC (residing on CommandPoint as a host system). Workarounds being considered are the use of ADASTRA or cloud technology enabling the LAS to use NHS Pathways hosted by another Ambulance Trust;

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- **Value for Money Programme** (thirty three projects) - Of the projects within the programme three are not due to start yet, one is in the initiation stage and two are 'Red' (i.e. 'Real time fleet management information' and 'Reduce use of agency staff'). With regard to the first, a new project manager has been appointed to complete the project and ensure the benefits are realised. The Agency Staff project is 'Red' because the numbers are not reducing in line with plan and this is covered off later in the Board Agenda.

- **Workforce and OD Programme** (sixteen projects) **-** The first meeting of the Delivery Board took place on the 25th August to agree the scope of the five projects which form SMG priority 10 for 2011/12 and begin to integrate them. Key outcomes were a proposal to launch the Clinical Response Model (CRM) in October or November 2011 as well as agreement to take the Estates proposal to the September Trust Board. The status of the CRM project remains 'Red' because the go-live proposal has not been finally agreed. 'New Ways of Working' (NWoW) wave 2 complexes are continuing to progress although the likely completion date in now December.

3. BALANCED SCORECARD (see attached information pack)

The new Balanced Scorecard is now fully operational and, excluding Finance figures, which are typically not available until the third week of the following month, was 87% complete for July.

The presentation of the information in the balance scorecard pack is now much more useable and the plan from next month is to provide meaningful explanations and actions for those indicators that are significantly off track.

Infection Control

Status: Amber RAG rating

At the previous Board meeting it was agreed to return the detailed reporting of Infection Control back to the Quality Committee. However, in light of the fact this has only recently been an escalated issue it was also agreed that a brief status update is to be given within the Chief Executive's Report.

Overall the scorecard illustrates a continuing improvement. Hand Hygiene continues to improve with 16 of the 18 complexes audited in July showing they are above the 70% trajectory for the month.

The east area is the weakest area. The Performance Improvement Manager for the east outlined the actions the east were taking in order to improve compliance at the July Infection Prevention & Control Committee. The responsible director and AOM will continue to monitor compliance.

More detail is provided within the Medical Directors Report this month.

4. 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 Category A for June and July and the first 15 days of August 2011.

	Cat A8	Cat A19
Key Standard	**75%**	**95%**
June 2011	**74.1%**	**99.3%**
July 2011	**76.8%**	**99.4%**
August (to15th)	**75.3%**	**98.9%**

It is pleasing to report that the Trust achieved the National key standard for Category A performance for the month of July ending on 76.8% (above the agreed trajectory), with the YTD Category A performance sitting at 76.3%. Performance fell back slightly in August due to the spikes in activity caused by the hot weather and the special arrangements that were required as a result of the public disorder. During the public disorder we had to remove single responders for periods of time and on other days mobilise them from stations instead of cover points.

Category A Incident demand has continued in the same vein as experienced in the previous months, with July showing an overall growth of 14.5% in-comparison to last year, which is the largest growth since March 2006. Category A YTD continues to grow with an overall growth of 10.7%. There were some changes made to the coding of Police calls at the start of the year, but these have had an impact of less than 3% of the total increase so there has been an overall step change in Cat A demand of above 7% so far this year and work is underway to understand the causes. Overall incident demand for July was 3.3% less than last year, with a total incident demand reduction YTD of 1.6% as a result of improvements to hear and treat.

Call Answering (Graph 5 & 6)

Call answering performance (95% of calls answered within 5 seconds) has improved through June and July 2011 and now stands at 94.3% with over 95% performance returned in July. This is an area of huge focus for Control Services over the next few months and excellent work is taking place on each team to improve both quality and productivity. There is considerable work ongoing to replicate best practice across the teams and it is clear that there is scope for further productivity improvement which will further improve call handling performance.

This improvement has occurred against a backdrop of continued increasing 999 call volume and the ongoing challenge presented by the continued need for CommandPoint training and before roster reviews take effect and align them more closely to demand.

Rest Breaks (Graph 12)

July saw a marginal increase in rest breaks allocated on the previous month. The rest break allocation plan recently introduced into EOC and managed by a small and dedicated team of staff ensures that where demand and capacity permit crews are allocated a rest break during the time window during their shift where a break can be given. The number of attempts to allocate breaks has increased and while utilisation remains high (84% AEU and 45% FRU in July) the allocation of rest breaks continues to be a challenge.

Discussion with staff side continues over the plans to implement revised rest break arrangements.

Call Taking Resolution (Graph 31)

The Trust has been working hard on improving the number of calls saved through LAS CTA using PSIAM. I can confirm that since February 2011 the Trust has seen a month on month improvement on saved journeys with July saving 1,307 front line journeys. It is also worth noting that for the months of May, June and July the average calls passed through PSIAM equated to 5,803, saving 21.5% or 1,247 journeys per month. NHSD no sends for the month of July finished on 4,419 which equates to 84% of all calls passed. This means that for July there were a total of just over 6,000 calls resolved by telephone.

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

The Trust produced 125,054 Front line ambulance hours resourcing for July this year which was 9,863 hours less than for the same period last year; a 7.3% reduction. FRU hours produced for July increased by 12.7% to 58,069 hours compared to 51,228 hours for the same period last year. As predicted appetite for covering FRUs has improved as we have drawn into the summer period and we anticipate a further improvement in the second quarter as new Paramedics graduate in greater numbers from Hannibal House. The Trust produced 25,469 ambulance hours for Urgent Care vehicles in July this year, exceeding the hours produced last year by 3,722.

Actual planned overtime spend for July was 35,759 hours. This is a decrease of 7% compared to the same period last year when we spent circa 38K hours on planned overtime. This has been a considerable achievement taking into account the significant number of staff abstractions to SP2 development and Paramedic training. However the overtime spend is above that profiled and so work is underway to reduce abstractions enabling the production of more hours from core staffing thus relying less on overtime.

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

The Trust continues to work with commissioners and acute hospital trusts 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. At the end of June 2011 the inclusion criteria for data was changed which resulted in more records being included that had previously been excluded from reporting. While this has not affected the overall hospital handover time, it has shown a slight reduction in the hospital element by circa 30 seconds but increased the LAS element by a similar amount.

For June ‘10 the average hospital turnaround time was 31.9 mins and for June ‘11 32.6 mins. The average arrival to patient handover times for the same dates was 12.8 mins and 16.4 mins respectively. Similarly the average patient handover to green time was 19.6 mins in June’10 and 16.6 mins in June ’11. As a result of our ongoing concerns and representations about the increase in the arrival to patient handover, NHS London has now raised this as an area of concern and appointed a Senior Responsible Officer to oversee an improvement plan. This has so far involved a number of workshops (also attended by LAS) and a requirement for action plans to be produced by all acute sites, demonstrating how the KPIs in relation to patient handover will be achieved.

The June LAS performance against the KPIs in this area against trajectory are as follows:-

Handover to Green within 15 minutes - trajectory 51% - performance 53.3%
Handover to Green within 30 minutes – trajectory 95% - performance 93.3%
Data completeness – trajectory 77% - performance 85.3%

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

CommandPoint continues to take up a huge amount of senior management time in Control Services however some good work has been carried out since June 2011. As the Senior Users on the CP Project Board Fiona Carleton, John Hopson and Paul Cassidy have been closely involved in working with NG to solve some of the issues that came out of the go-live of June 8th. This work will continue to ensure that when we are in a position to go-live next time the system will be fit for purpose, stable and able to enhance overall performance.

Analysis of performance over the last few months shows that the New Dispatch Model introduced into EOC in preparation for CommandPoint remains fundamentally sound. Analysis of volumes and productivity does show that there is room for improvement and on this basis we envisage changing the model by combining a number of smaller complexes with Allocators running these combined complexes. This proposal has been agreed at ADO level and by the control services (CS) senior management team and currently sits with our CS staff side colleagues.

Following on publication of "Taking Healthcare to the Patient 2" Control Services were asked to trial a change to clock start in EOC. A number of meetings were held out of which came a suite of proposed changes to current dispatch practice and process and a trial was held between midnight on the 8th August and midnight 10th August. The main elements to the trial were a change in clock start for Red 2 calls to vehicle assigned, chief complaint, final determinant or 60 seconds, whichever occurred first. There was no change to clock start for Red 1 calls, our highest priority of patient. To aid the trial a change was made to our automatic dispatch process for Ambulances (FREDA) and a move away from allocation on address (pre-empting) by EOC staff.

Performance for both Red 1 and Red 2 calls remained stable however as expected we saw the number of cancellations received by frontline staff drop markedly and the number of calls receiving multiple resources drop. Both of these areas are of huge benefit to the Trust as the level of cancellation seen through pre-emption was unsustainable from a frontline perspective and the National Audit Office highlighted the need for us to see fewer multiple dispatch calls to aid our efficiency as a Service.

Feedback from staff both on the frontline and in EOC has been universally positive and the data returned from the Trial so positive that we have decided to maintain the changes that were made for the Trial after its end. Pre-emption will now only occur as a default allocating tool when volumes increase to such an extent that we would need to ensure crews are allocated to calls ASAP.

It is very much hoped that the success of the Trial that was held in EOC will influence the national agenda around a change to clock start which can only be good news for each and every Ambulance Trust.

Fleet & Logistics (Graph 52 & 53)

The number of days lost due to vehicles being off the road (VOR) increased slightly in July from 1.62 to 1.63 days. However, when looking at the breakdown, Fleet VOR has increased by 0.01 days and On-Duty has remained static. Against the same period in 2010, Fleet VOR has fallen by 0.08 days and On-Duty VOR has increased by 0.17 days. The review of the responsibilities and effectiveness of the Area Delivery Units (ADUs), DDS (CSU) in EOC and VRC is ongoing, project managed by Kevin Canavan. The aim is to set up a single coordinated unit with the responsibility and authority to

effectively mange all VOR and focus on reducing it. We expect this consolidate function to be operational by the end of November.

Vehicle sourcing fell from 80% to 75% for the period. There is still a long way to go and the focus remains on stabilising the fleet and proactively planning vehicle movements rather than reacting to changes in manning.

Make Ready has remained steady for the period, and performance management continues with the current provider. Deep cleaning performance remains above target for AEUs and has remained static at 92% of the fleet within their deep clean interval. The number of FRUs overdue for deep cleaning has reduced by 2%. PTS deep cleaning performance has improved with a fall of 12% in the number of vehicles overdue for deep cleaning.

Emergency Preparedness

The National Police Improvement Agency carried out a structured de-briefing course for a range of staff from various disciplines within the trust. 38 staff are now trained and certificated to carry out structured debriefing following an incident or event, which will assist the Emergency Planning team with the process of capturing any lesson that are identified in future incidents

The work on the new HART West site continues to make good progress and is due to be commissioned in early September. Recruitment continues to increase the staff levels to full establishment at both East (currently 39) and West (currently 37) sites.

The funding for the replacement of the Emergency Support Vehicles (x4) and Emergency Control Vehicles (x2) has been agreed, the process to commission these assets has now begun and we expect to bring these vehicles into service within 6 months.

Planning is underway for a number of events such as the Olympic test events and Notting Hill Carnival over the August bank holiday weekend.

Public disorder

On the evening of Saturday 6th August serious public disorder broke out in Tottenham following the shooting of a local resident by Police. The disorder originated after a peaceful demonstration outside Tottenham Police Station and rapidly spread through the local area with numerous commercial and domestic premises being set alight. There were running street battles between protestors and Police with missiles being thrown and weapons used.

As a result of this disorder LAS gold command was activated, strategic intentions set with supporting tactical plans and specialist public order trained and equipped staff deployed to the scene. LAS implemented special arrangements to manage the ongoing disorder that included the withdrawal of solo responding from the borough to protect staff safety.

Core business activity across London was significantly above plan for the evening and together with the additional activity associated with the riot in Tottenham a major incident was declared at 0216 hours. Level D of the demand management plan (DMP) was also invoked.

Following the Tottenham riot on Saturday evening looting, arson and violent disorder spread across London on Sunday and Monday. Special arrangements were developed and extended across London to enable the ongoing provision of service as incidents developed.

LAS have continued to work with and support other emergency services, stakeholders and partners since the disorder began. We have an ongoing resourcing plan in place that is supported by rostered on duty strategic leadership, tactical command and specially trained and equipped staff.

5. PATIENT TRANSPORT SERVICE

Financial Recovery Plan

PTS income and expenditure are not where we projected them to at the end of month 4 and a recovery plan has been drawn up to ensure the position is recovered as soon as possible.

Performance

Activity in July fell to 14,350 from 15,123 patient journeys in June. Overall activity continues to be lower as a result of the effects of tight activity control from all Trusts in response to current financial constraints, as compared to previous highest month's activity of 16,589 patient journeys achieved in March 2011.

The quality standards for July 2011 were:

- Arrival Time: 93%
- Departure Time: 91%
- Time on Vehicle: 94%

Commercial

We continue to wait to hear further on the submitted bids to the following Trusts under LPP Phase 3. We believe the delay in awarding on these bids is due to the continuing uncertainty re the current reorganisation of the NHS:

- 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) Presentation made 19th May 2011 having made shortlist.
- Royal Free Hampstead NHS Trust
- Royal Marsden NHS Foundation Trust
- Whittington Hospital NHS Foundation Trust

We have been advised that LPP Phase 4 will be released in August 2011 and will involve up to 15 NHS Trusts mainly based in the North East of London.

Outside of the LPP the following work is being undertaken:

We started the new contract on the 25th July 2011 to provide PTS to Queen Mary Roehampton Hospital on behalf of their PFI Provider Sodexo. There was a smooth transition of the contract with no reported issues. 11 of the previous provider M&L staff TUPE'd into the LAS and spent 3 days in Induction training in their first week and are now being supported by PTS work base trainers on their return to contract work.

We presented to Lewisham Hospital along with their potential PFI Provider Sodexo in a joint bid for PTS work included within the PFI services tender for the hospital.

We are waiting for the technical specification where we expressed our interest in a new tender issued on OJEC for London Barts NHS Trust for High Dependency Transfers only.

Operations

- Communications

  During June and July we have held a number of staff consultation meetings Pan London advising current position and changes required in line with the PTS Savings Action Plan.

  We held a successful Open Day at Queen Mary Roehampton advising the Trust staff and patients of the changes they would experience when the PTS service transfers to the LAS. This was well received by the Trust.

  Our Work Based Trainer has been delivering the next module of refresher training to all road staff on Wheelchair Harnessing & Securing.

6. HUMAN RESOURCES

Workforce information

Highlights from the attached workforce information report are:

Sickness absence

A validation exercise for sickness year to date has been undertaken. This has resulted in a slight revision downwards in some of the figures reported. Sickness absence reported in June was 5.12% compared to 5.10% (adjusted) in May. The year to date figure stands at 5.08%. The Trust target is to achieve a maximum absence level of 5% for the year.

A&E operational Areas overall achieved a sickness absence level of 5.03% for the month of June, remaining almost static and below the average for the Trust. East Area still remained below the target level at 4.98% (South 5.04% and West 5.07%).

PTS sickness in June remained high and static. Long-term absence remained high, but all cases are being managed appropriately through the MAP.

Comparative sickness figures for 2010/11 for English ambulance services have just been made available. It was very pleasing to note that the LAS figure was lowest at 5.24%. The highest figure was 6.49%.

Vacancies and Turnover

The reconciliation of ESR establishment, following the changes agreed through budget setting and those associated with the Cost Improvement Plan, remains incomplete but progress is being made.

From weekly operational staff in post data, it can be reported that as at 31.07.11, frontline staffing was 3231 wte against an establishment of 3301 wte (vacancy level of 70 wte). We have an anticipated recruitment to c60 university paramedics in late autumn.

Turnover in July was within normal range as was the reported year to date levels.

PDR completion

Although the figures for July show a very slight improvement in completion rates in most areas, there remains a concern that not all PDR activity is being recorded through the electronic route. Managers have been reminded of the process to be used.

It should be recognised that some PDR completion is undertaken on a rolling year rather than fiscal year and will therefore not be recorded until later in the year.

Health Safety and Risk – incident reporting

The Trust will be meeting with the Health and Safety Executive on 26 August to discuss progress since the HSE inspection last year and plans for the Olympics. We will also discuss issues raised in a recent letter from the HSE following contact by a member of staff. These issues are, airwave radios, carry chair trial and arrangements for the Corporate Health and Safety Group (which is scheduled to be re-launched in its new format on 15 September). The HSE have been advised of existing management arrangements for each of these issues prior to the meeting.

Incident reporting pilot

The pilot trial is continuing, and a decision has been reached to continue the trial until further notice. There have been some issues over inputting incident data and receipt of management sections of the reports, but these are being addressed. There are also reported incidents of Airwave radio signal dropout. This is being addressed by EBS requesting on receipt of the initial call, that crew staff provide a return contact number. EBS report dropout incidents to IM&T for their investigation. Finally, due to the low uptake of the concept among some of the original trial Complexes, it is intended to extend the trial to Whipps Cross Complex once the above issues have been rectified.

Manual Handling

The number of reported manual handling incident remains low compared to this point in 2010/11. The chair transporter trial remains on going, with the agreement to extend it until the end Dec 2011.

Abusive Behaviour

The number of reported incidents of verbal or threatened abuse remains below the number reported in 2010/11.

Physical Assault and Security

The number of reported incidents is slightly higher compared to this point in 2010/11, however the number of incidents has fallen since April and is now at the approximate average of last year.

Prosecutions include: A New Addington man has been sentenced to 17 months in jail after a road traffic incident which injured a paramedic from Croydon in May. He was also prosecuted for a string of other driving offences. Additionally in April, a paramedic from Hanwell was assaulted by a male with mental health issues in Hillingdon Hospital. The man pleaded guilty to common assault and was given a £25 fine and was ordered to pay £125 compensation.

Training and Education

The main area of activity in July has been to continue to deliver the Paramedic skills elements of training to the significant numbers of Student Paramedics. Currently, between 150 and 200 students per day are moving through this final part of the programme. In the year to date 101 Student Paramedics have qualified and are in the process of registering with the Health Professions Council.

The three one day modules delivering Core Skills Refresher (CSR) have been designed and agreed. Delivery had to be suspended temporarily in order to undertake work to strengthen the staff allocation processes. We now have data showing by Area how many staff on any given day have a rostered training day. We are, in most cases, able to break this down by Complex too. Planning is now aligned to the actual number of staff available for training on any given day. The programme delivery has also been altered so each CSR module will run for three months. This approach helps us to optimise uptake, as at the end of each quarter we can drill down to individuals and target CSR training to those who have not completed within the quarter. This has resulted in a change to the data collection, as we no longer show incremental month by month achievement on score cards such as infection control. Instead we will provide the majority of data in a single quarter. There may be small changes as we ensure those who did not complete, do access their CSR at a later date.

Work continues on the introduction of Higher Education pathways for Paramedic Registration. The Open University (OU) Paramedic course for A&E Support has been launched. The pathway for Emergency Medical Technicians requires further work and will be launched shortly. Further work is being undertaken to identify if the OU can also provide modules for existing Paramedics to gain a Higher Education award.

Partnership working

The Joint Secretaries continue to meet on a regular basis to ensure that strong communication channels are maintained. The scheduled programme of Staff Council and Operational Partnership Forum meetings continue. The revised Corporate Health and Safety Group has arranged its first joint meeting for 15 September, and the new Operational Health and Safety Partnership Forum will be established shortly after that first meeting, once union membership is confirmed.

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

Wellbeing

The Staff Support team continues to be active, through Linc and the counselling service, in assisting staff who have been involved in traumatic incidents, including recent deaths in service. Linc worker visibility and availability was also maintained and promoted during the recent civil unrest.

Involvement in pan-London and national wellbeing initiatives continues to build. Since the last report, the Assistant Director, Employee Support Services has been invited to chair the NHS London Heath and Wellbeing group and has been accepted as a management side member of NHS Employers' Partnership for Occupational Safety and Health in Healthcare (POSHH).

Staff Engagement

An evaluation of a new Team Briefing system, which has been piloted in Human Resources, Finance and Fleet and Logistics, is now complete. The results are currently being analysed in order to inform a roll out into other areas of the Trust.

A staff suggestion scheme, "change one thing" has now been launched. This is open to all staff who have an idea which they think could improve the working lives of LAS staff or the experiences of LAS patients. 18 ideas were submitted within the first two weeks of the launch of the scheme at the end of July. All of the ideas received are to be reviewed by the Staff Engagement Steering Group after which feasible ideas will be passed to the Associate Directors' Group for a decision on implementation. Staff will be kept updated on the progress of their ideas.

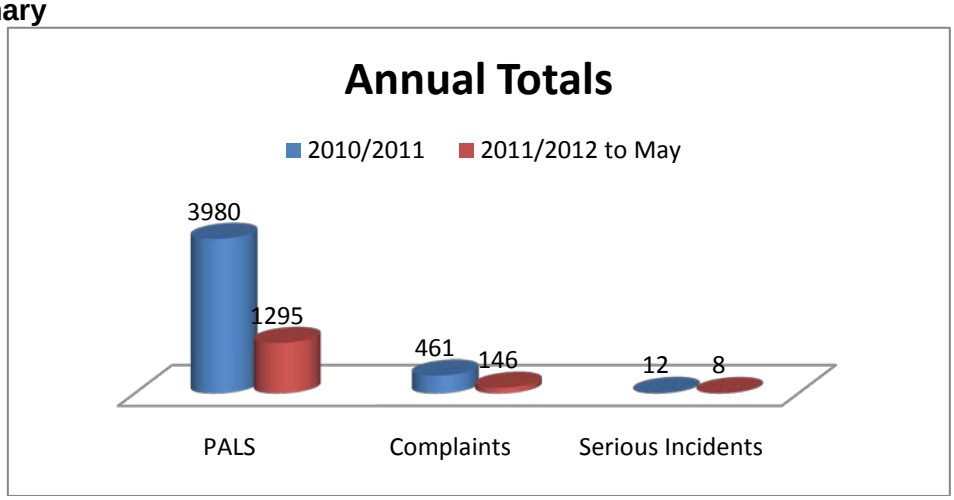
The first "temperature check" survey, designed to measure staff satisfaction and engagement at regular intervals, opened for two weeks in June. 629 staff, predominantly from the A&E Operations directorate, completed the online survey. The results have been published on the Pulse (intranet) along with information on work underway to address the weakest results. The next "temperature check" will be conducted in September and we will report back to the Board following these results.

The Service's staff engagement work continues to be recognised as good practice. A case study on the Trust has been published in July's edition of the IDS HR Studies journal and NHS Employers reference our staff involvement successes in their recently launched staff engagement toolkit. In addition, following the launch of the government backed Employee Engagement Task Force, the Trust has been invited to be part of the practitioners' group supporting this work.

7. COMPLAINTS, PALS ENQUIRIES AND SERIOUS INCIDENTS

This report provides a basic update on the Trust's position with regards to serious incidents, complaints and PALS activity, specifically focussing on activity during July 2011. To provide some context I have included a running total of activity to date along with a comparison to 2010/2011.

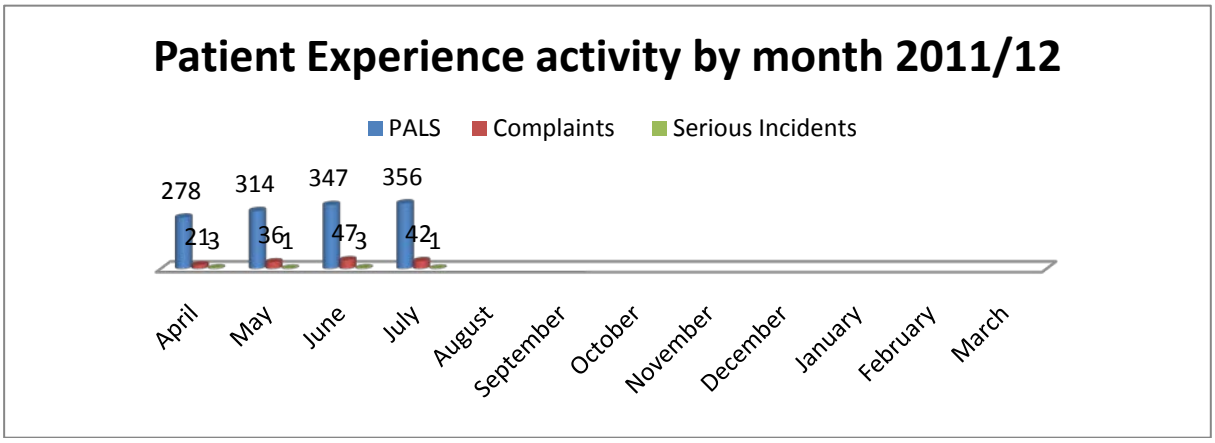
Summary



During 2010/11 figures for PALS included all activity recorded within the PALS module on Datix, including Frequent Callers, Safeguarding and requests for medical records/witness statements. It was decided that this would be reported via other mechanisms during 2011/12, therefore the comparison above is not like, for like. Based on figures from April to July 2011, on average the Frequent Callers, Safeguarding and requests for medical records/witness statements accounts for 37% activity reported in the PALS module, leaving an average of 63% representing true PALS activity.

Therefore, on average during 2010/11 there were 209 PALS case per month compared to (on average) 324 per month during 2011/12, which represents a 55% increase in PALS workload.

Complaints received per month, on average during 2010/11 was 38, thus far for 2011/12, the average is 36.



Complaints and PALS

The highest causes of complaint; non – physical abuse, conveyance and delay, remain the same as last month. There were 11 complaints related to calls either where no ambulance was sent or the call was managed by CTA or NHS Direct.

Complaints July 2011	
Non-physical abuse	15
Non-conveyance	8
Delay	7
Treatment	4
Conveyance	3
Road handling	3
Not our service	1
Patient Injury or Damage to Property	1
Totals:	42

Complaints and PALS activity has increased month on month during 2011/12. This table excludes safeguarding activity, frequent caller case loads/enquiries and requests for witness statements and medical records.

PALS July 2011	
Information/Enquiries	232
Lost Property	67
Clinical	8
Appreciation	7
Communication	7
Conveyance	6
Policy/ Procedure	5
Road Traffic Collision/RTC	3
Access	2
Delay	2
Explanation of Events	2
External Incident Report - LAS Crew	2
Non-conveyance	2
Other	2
Social Services	2
External Incident Report - EOC	1
Helpline Request	1
Incident Report - CATH Lab	1
Incident Report EOC	1
Information Technology	1
Non-physical abuse	1
Patient Injury or Damage to Property	1
Totals:	**356**

PALS enquiries which take two days or longer to resolve must be treated as a complaint given the provisions of Section 8 of The Local Authority Social Services and NHS Complaints (England) Regulations (2009). One PALS case was offered recourse to the Health Service Ombudsman, during July.

Serious Incidents

The table below lists the serious incidents which were declared by the LAS to NHS London during July.

ID	StEIS	Description	Incident Date	Received
39688	2011_13249	Member of staff (FRU) physically and verbally assaulted by a patient in the vehicle.	11/07/11	13/07/11

8. COMMUNICATIONS AND ENGAGEMENT

PPI and Public Education activity report

Patient and Public Involvement:

- The next "Members' Meet" is being held for prospective Foundation Trust governors on 14th September. It will focus on how 999 calls are prioritised and how non-life threatening emergency calls are managed in the LAS, including the use of appropriate care pathways.

- Another Foundation Trust event is being organised for October, which will be open to anyone interested in becoming a member, as well as those who have already become members. This event will focus on the Trust's patient involvement and public education work.

- The Patient & Public Involvement Committee met in July and received updates from the Chair of the Patients' Forum as well as from the Head of PPI & Public Education and one of the PPI & Public Education Co-ordinators, and the Foundation Trust Membership Manager.

Public Education:

- The next Public Education Staff Development Programme is planned for seven days in September and October 2011. This programme provides participants with opportunities to improve their skills and knowledge, in order to make the most of their involvement in public education activities. Applications for the autumn programme are currently being processed

Community Involvement Officers:

- The Head of PPI & Public Education is working with the NWOW Workstream Manager to produce an 'options' paper for the roll-out of Community Involvement Officers. This is soon to be discussed by the Programme Board.

- Planning is underway to recruit to the currently vacant CIO post at Friern Barnet.

- The monthly network meetings for the CIOs continue, with recent discussions about the role of the CIOs in managing frequent callers, the High Risk Register and Safeguarding.

Other PPI and public education activities:

Over 600 patient involvement and public education activities have been recorded on the database since January. For the period since the last report, these have included:

- RAF Northolt 'families day'
- The Great Tooting Ambulance Pull
- School visits for children of all ages, to children at after-school clubs, and scout and cub groups
- Talks to college first-aiders
- Attendance at Patients' Forum meetings
- Heartstart and Train the Trainer sessions
- Ambulance station and EOC visits
- A visit to a mosque and another to a group in a Tamil community
- Knife crime sessions at pupil referral units (attended by children who have been excluded from school) and youth offending teams
- Summer fetes, fairs and fun days, including the Newham Show
- Presentation to staff at the British Library
- Careers events and events for young people, including those at the Prince's Trust
- Basic Life Support sessions in Tower Hamlets (as part of the Tower Hamlets Project)
- Open days at St. George's Hospital and the Royal Free Hospital
- Junior Citizen Schemes in Redbridge, Greenwich, Haringey, Ealing and Southall, Hounslow, Waltham Forest and Enfield.
- Talks at luncheon clubs, residents' associations and community centres
- Child safety events
- Road safety events, e.g. Driven by Consequences in Bromley
- "How to Save a Life" at Heathrow Airport
- Prison Me No Way in Newham and in Chingford
- PTS awareness day at Queen Mary's Hospital, Roehampton
- Community events in Sidcup

Reputation and issues management

London disorder: Statements on casualty figures and on the difficult conditions staff worked under during the London disorder were issued and were picked up by a wide range of national and regional media, for example the Evening Standard, BBC website, Sky News, Radio 5 Live and the Guardian.

Follow-up requests were received from various media and the Deputy Director of Operations Jason Killens gave an interview to LBC Radio on the Tuesday, Channel 4 News filmed in the incident control room, and BBC London TV interviewed an Oval crew who had experienced the difficult conditions first hand on the Monday night.

Staff were kept up to date and messages of thanks were passed on through the intranet, the weekly routine information bulletin and other bulletins.

Almost 150 members of the public got in touch to show their support to staff via Twitter and Facebook.

Media

Feature on Radio Five Live: A positive eight-minute feature was broadcast on Radio Five Live after reporter Lesley Ashmall went on a ride out with a crew from Greenwich to experience first hand the pressures on the Service. She was particularly surprised to discover the volume of lower priority calls the Service receives which she described as shocking. She interviewed a family to ask why they had called an ambulance for a minor illness and also visited the control room and interviewed Chief Executive Peter Bradley.

Sky News report about disciplinary procedures: The Service was mentioned in a Sky News report about how ambulance services will often not inform families of patients who have died when the staff involved are subject to disciplinary procedures. It was subsequently clarified that, under the serious incident policy which was updated last year, the Service will make every effort to ensure that people involved will now be informed at the earliest opportunity.

Provision of decommissioned ambulances to Mongolia: Staff were interviewed live on BBC London radio as they set off to drive six decommissioned ambulances to Mongolia where the vehicles would be donated to the country's developing ambulance service. Articles about individual volunteers appeared in around 10 other local newspapers ahead of the trip and one volunteer was interviewed on Radio Jackie (SW London). During the trip, the teams' blog received over 10,000 page views. The teams reached Monglia's capital on the morning of 10 August.

Sentence for New Addington man: A local newspaper reported on the sentencing of a New Addington man who injured a member of staff. Croydon paramedic David Sangster suffered a fractured shoulder and whiplash and had to take six weeks off work to recover after his fast response vehicle was driven into by Darren Henry. Mr Henry pleaded guilty to a number of driving offences at Croydon Crown Court and, due to previous motoring convictions, received a 17-month prison sentence.

Abusive caller in Ilford: An Ilford pensioner who was found guilty of making malicious calls to a Service enquiry line received coverage in the local newspaper. Patient service staff received more than 50 abusive calls from David Morse between 2008 and 2010. Despite pleading not guilty Mr Morse was fined £500 and given a two year conditional discharge.

Participation at Pride London: The Pink Paper online covered the London Ambulance Service's attendance at Pride London in July. The story included photos of staff and ambulances as well as quotes from Ambulance Operations Manager Trevor Hubbard.

Peter Bradley CBE
Chief Executive Officer

15 August 2011

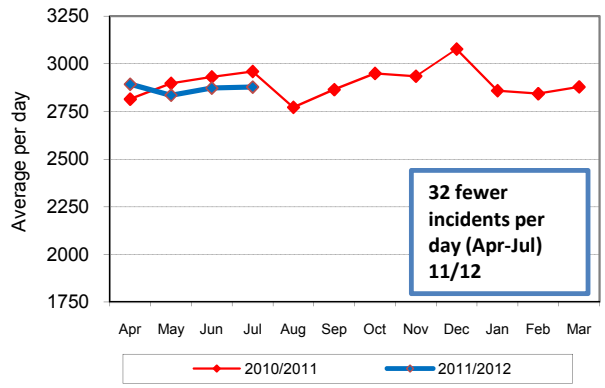
London Ambulance Service
NHS Trust

Information Pack for Trust Board

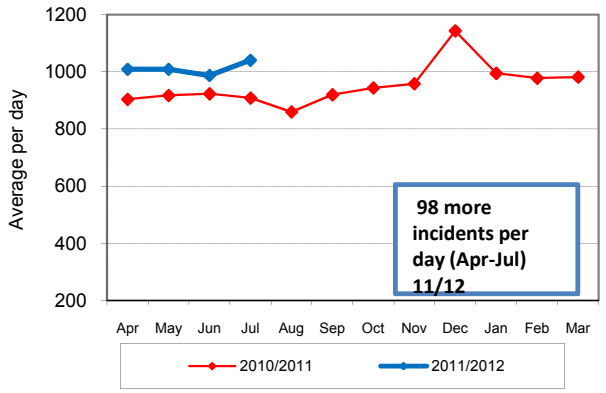
July 2011

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

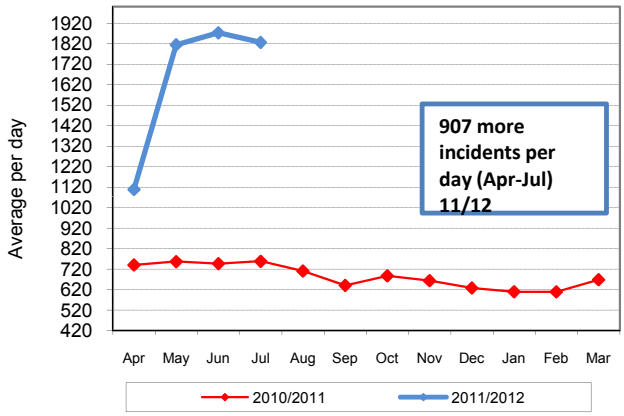
Graph 1
Average number of Total incidents per day



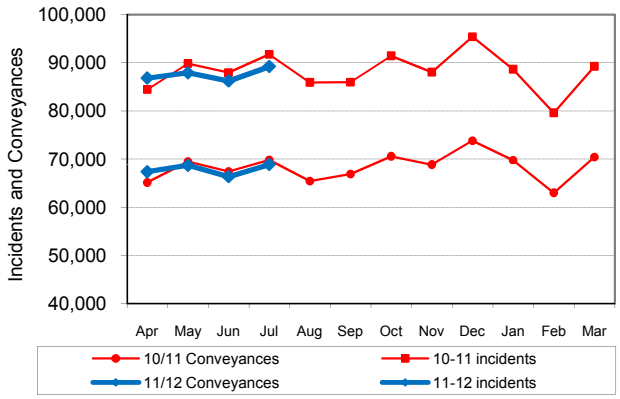
Graph 2
Average number of Cat A incidents per day



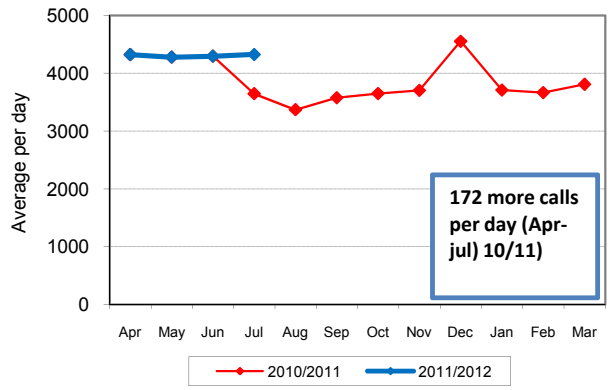
Graph 3
Average number of Cat C incidents per day



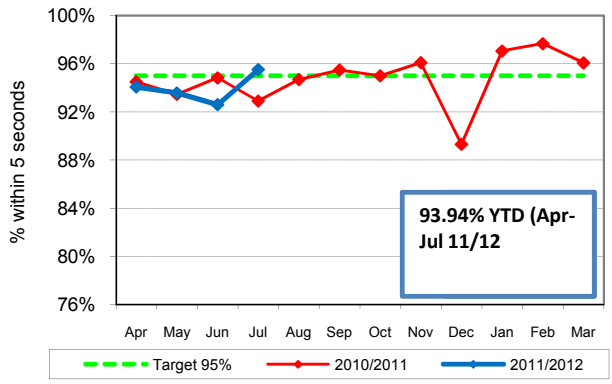
Graph 4
No of incidents conveyed



Graph 5
Average number of 999 (+ MPS) calls received per day

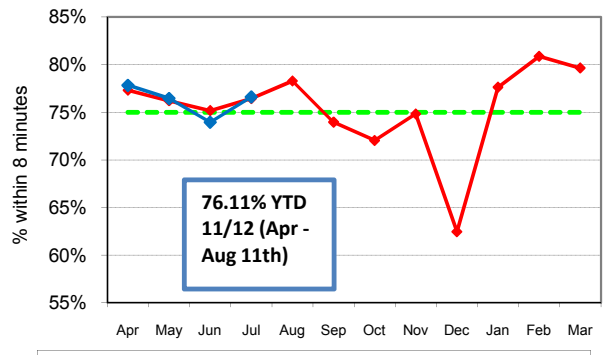


Graph 6
Percentage of calls answered within 5 seconds

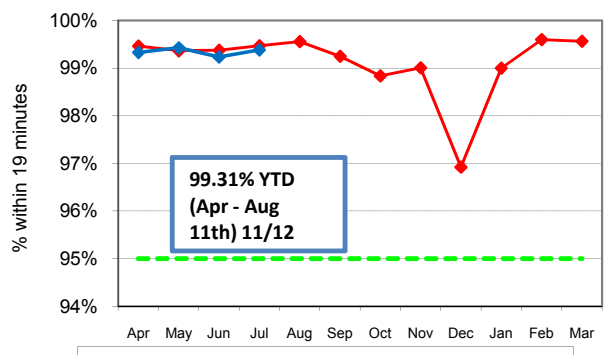


London Ambulance Service NHS Trust
Accident and Emergency Service
Performance - July 2011

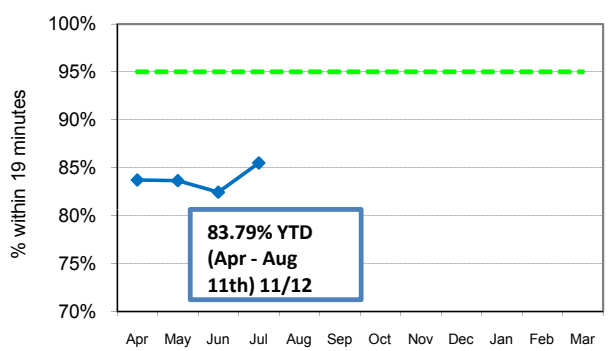
Graph 7
Category A 8 minute performance



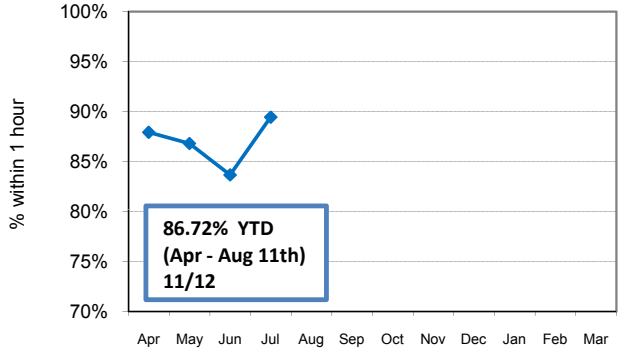
Graph 8
Category A 19 minute performance



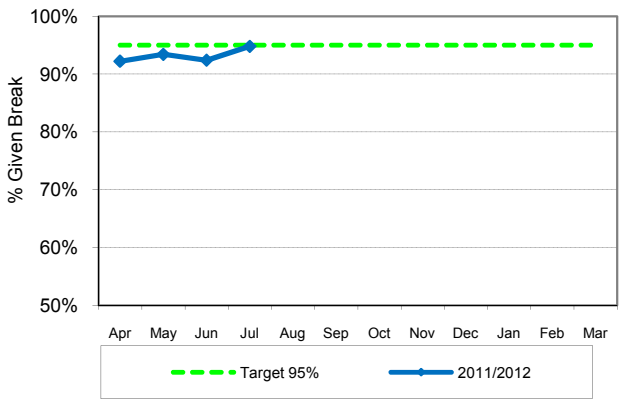
Graph 9
Category C1 20 minute performance



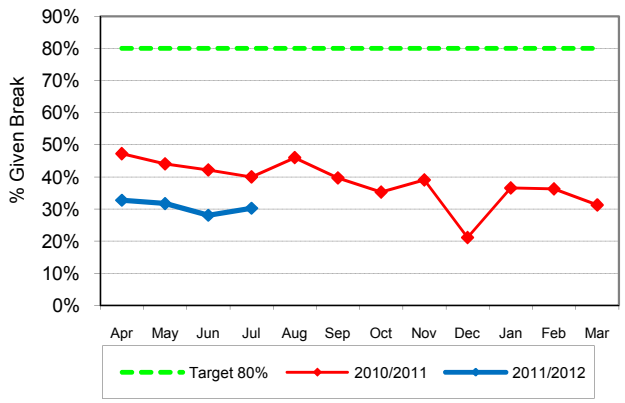
Graph 10
Category C2 30 minute performance



Graph 11
Cat C incidents 60 Minute Performance

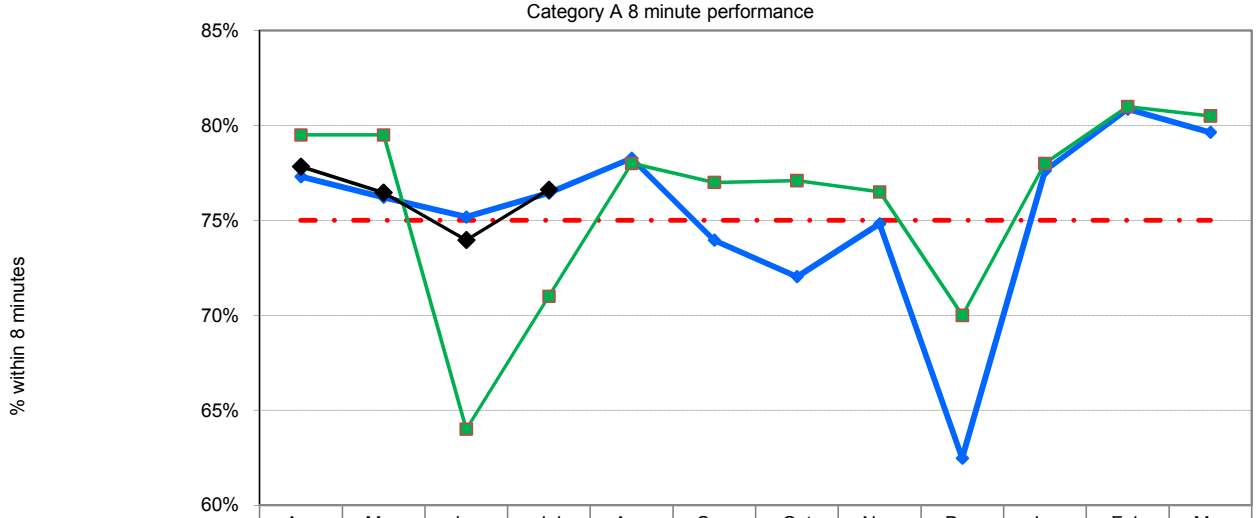


Graph 12
Rest Breaks Given



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

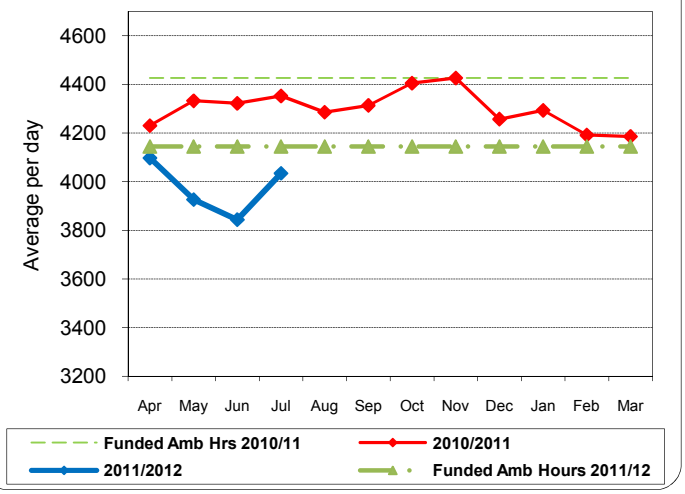
Graph 13
Category A 8 minute performance



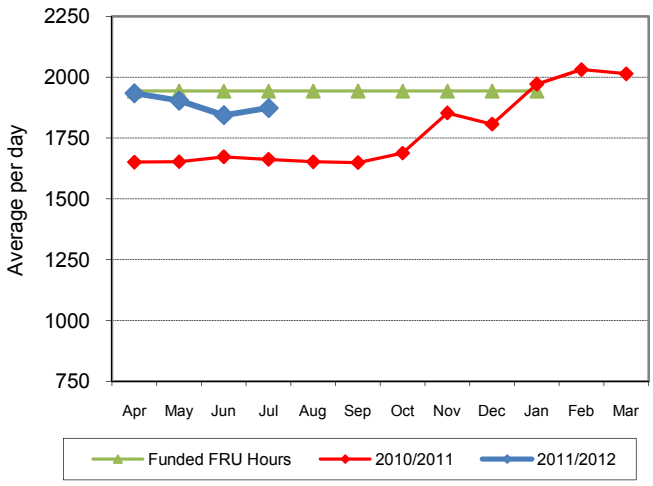
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target 75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
2010/2011	77.3%	76.2%	75.2%	76.4%	78.3%	74.0%	72.0%	74.8%	62.5%	77.6%	80.9%	79.6%
Cat A trajectory (11/12)	79.5%	79.5%	64.0%	71.0%	78.0%	77.0%	77.1%	76.5%	70.0%	78.0%	81.0%	80.5%
2011/2012	77.8%	76.5%	74.0%	76.6%								

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

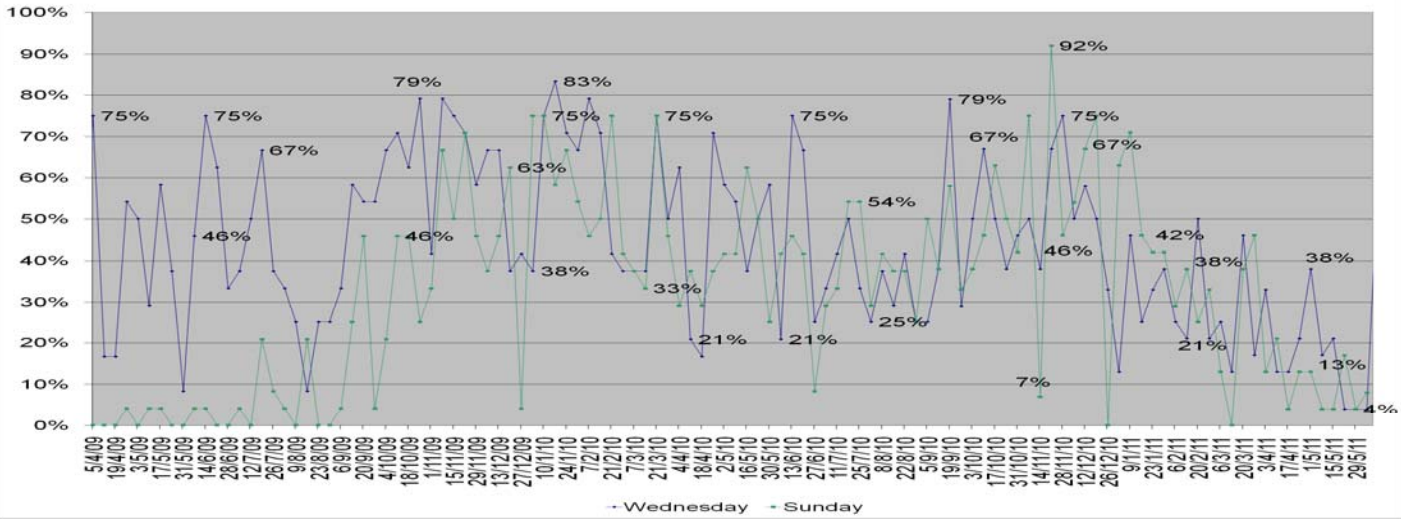
Graph 14
Ambulance Hours average available per day



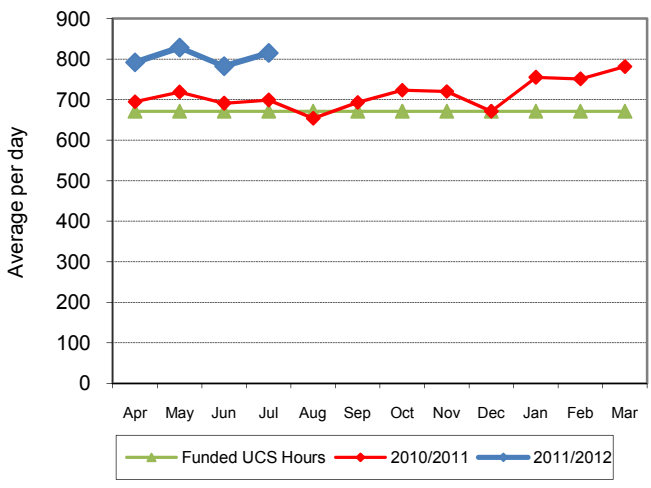
Graph 15
FRU hours average available per day



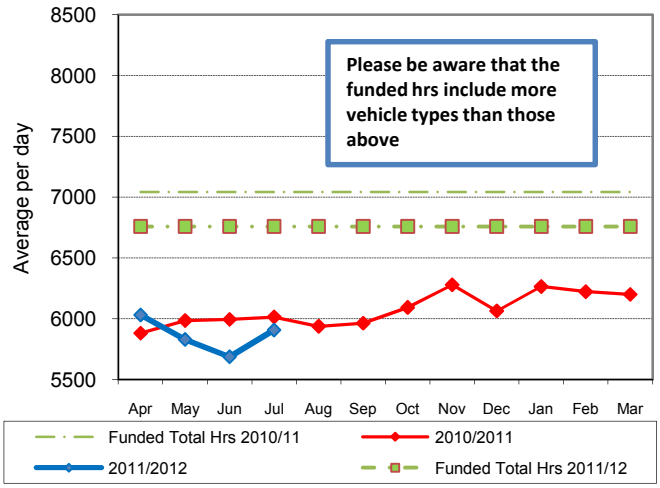
LAS hours in the day Compliant to ORH



Graph 17
UOC Hours average available per day



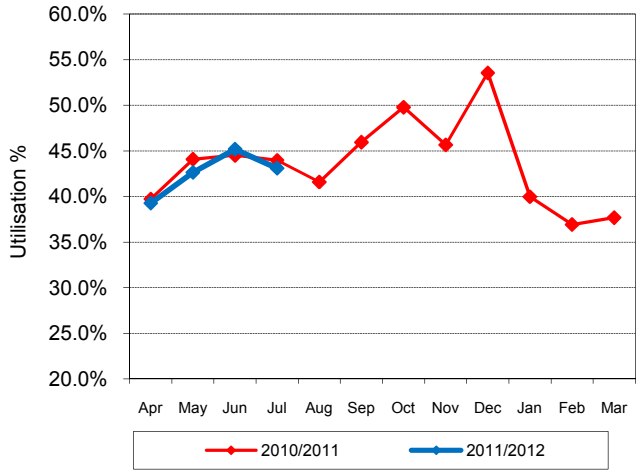
Graph 18
All Vehicle Hours average available per day



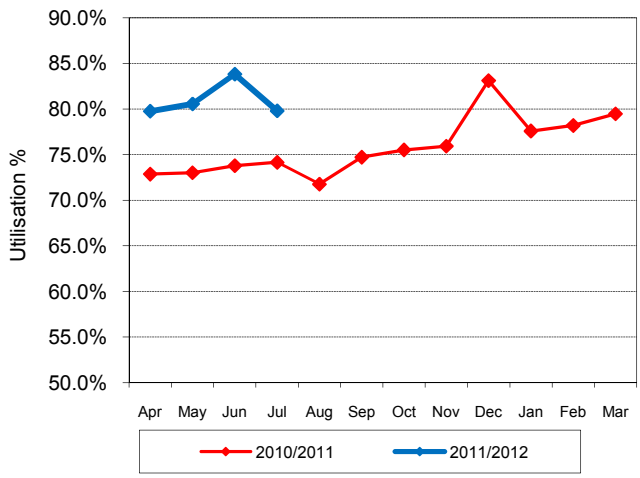
includes other vehicle types other than those above

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

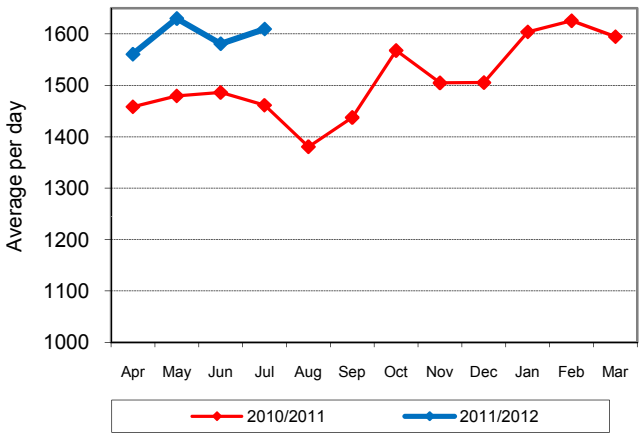
Graph 19
FRU Utilisation



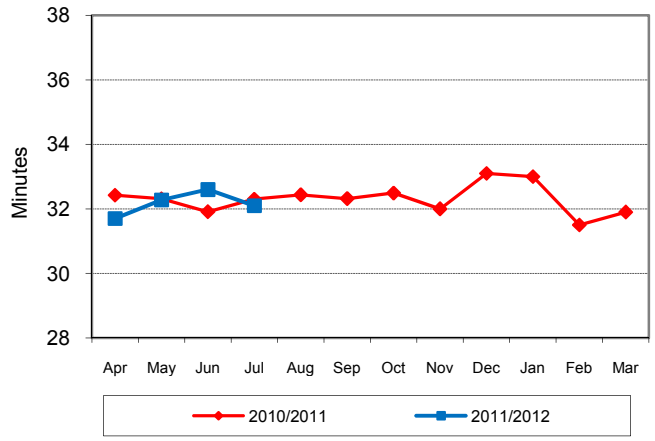
Graph 20
Ambulance Utilisation



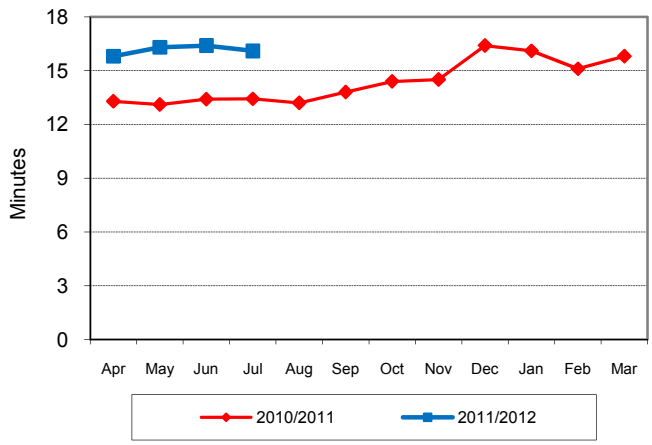
Graph 21
EOC hours staffed per day



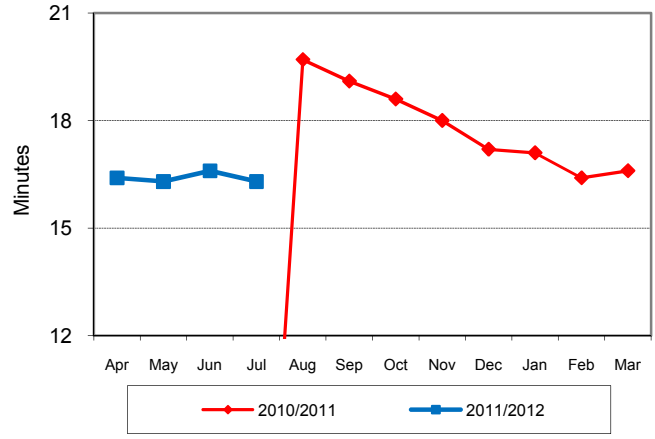
Graph 22
Average hospital turnaround time



Graph 23
Average Arrival at Hospital to Handover (Mins)

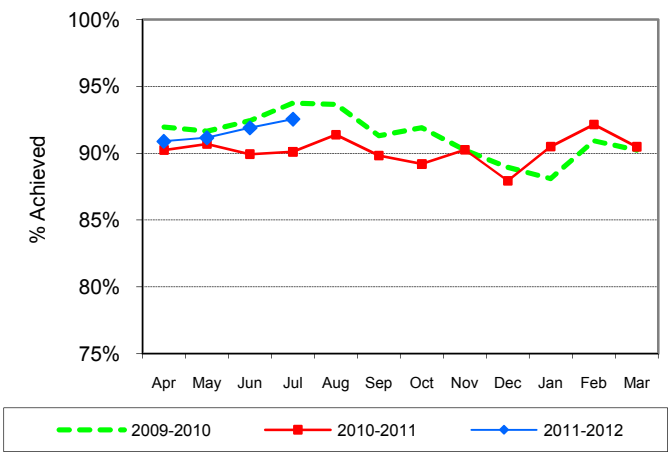


Graph 24
Average Handover to Green (Mins)

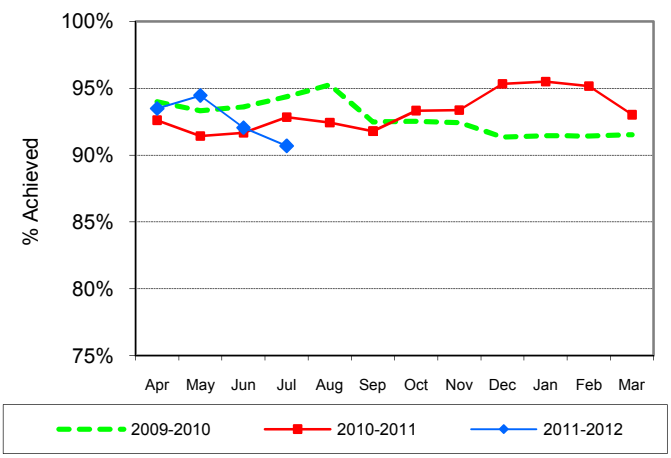


London Ambulance Service NHS Trust
Patient Transport Service
Activity and Performance - July 2011

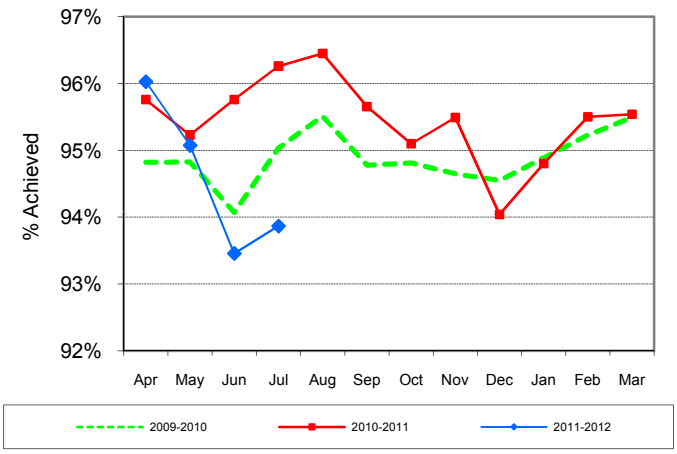
Graph 25
Arrival at Hospital Against Appointment Time



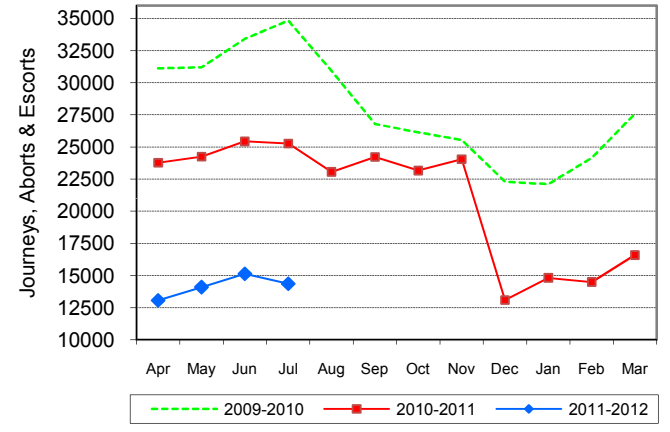
Graph 26
Departure Against Ready Time



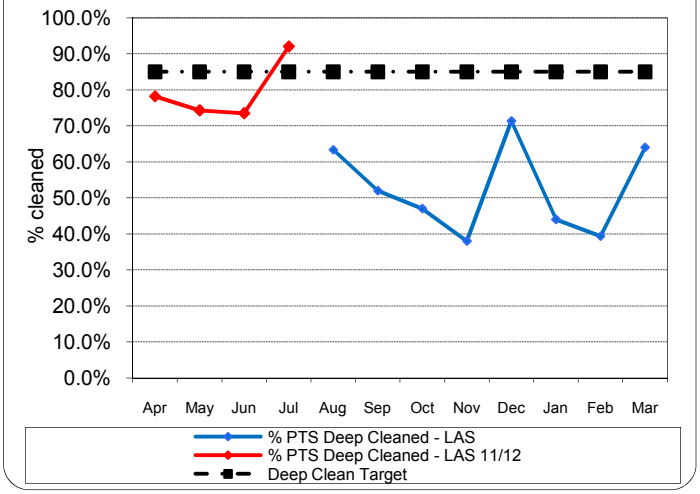
Graph 27
Time spent on Vehicle



Graph 28
PTS Total Activity



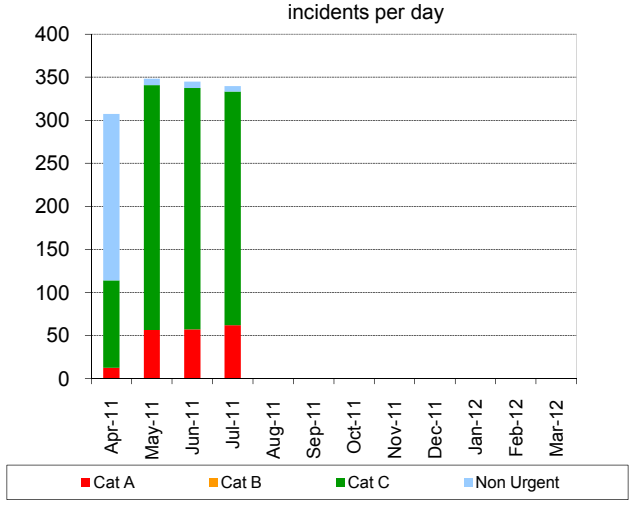
Graph 29
Deep Clean - PTS (17 weeks) - LAS



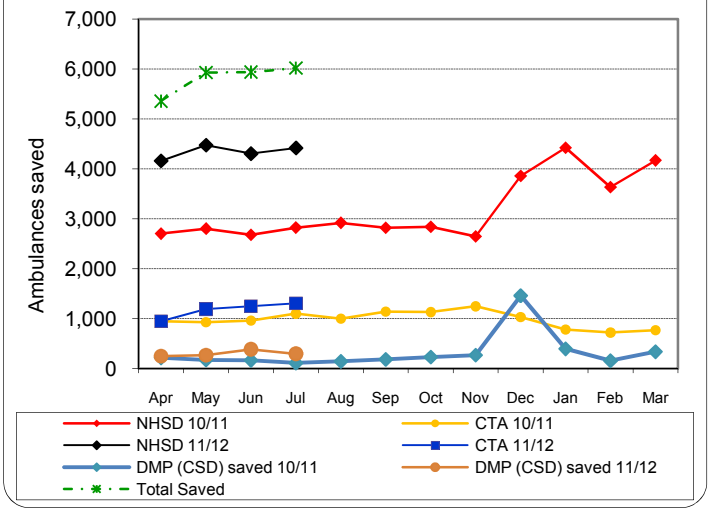
London Ambulance Service NHS Trust
Accident and Emergency Service
UOC Effectiveness - July 2011

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

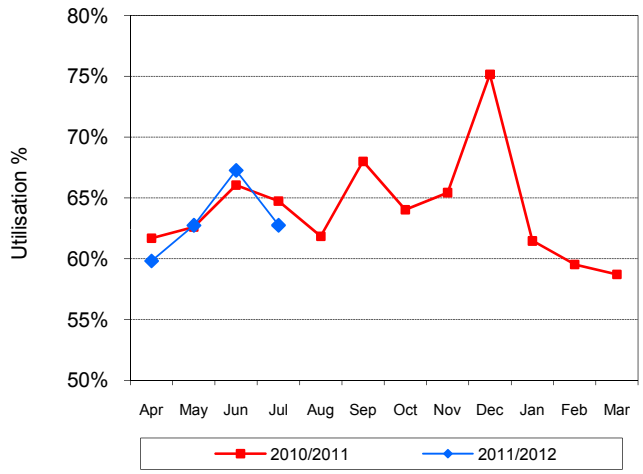
Graph 30
CAT A, B & C Workload by Urgent Care Vehicles average incidents per day



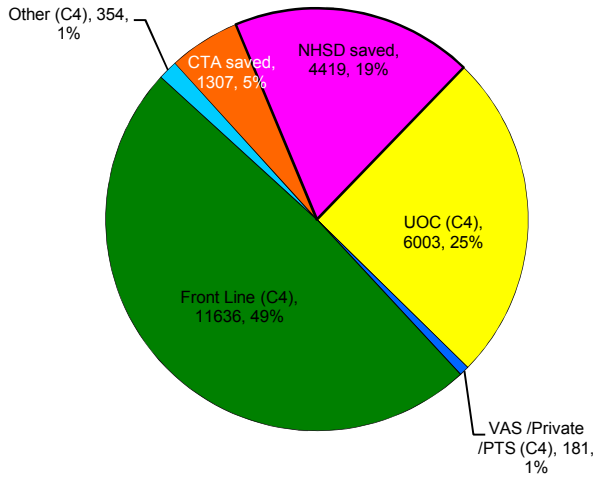
Graph 31
CTA/NHSD/DMP Ambulances saved



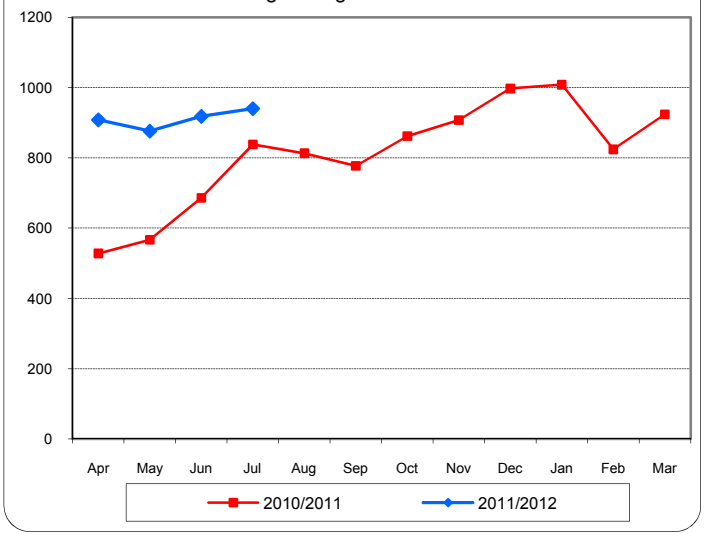
Graph 32
UOC Utilisation



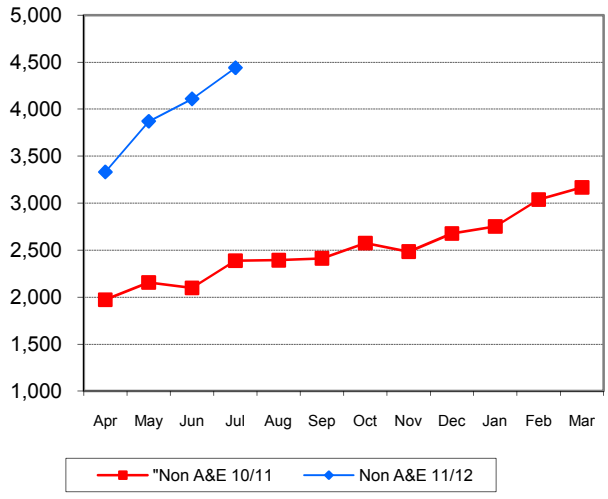
Graph 33
C4 resolution - July 2011



Graph 34
Safeguarding children and adults

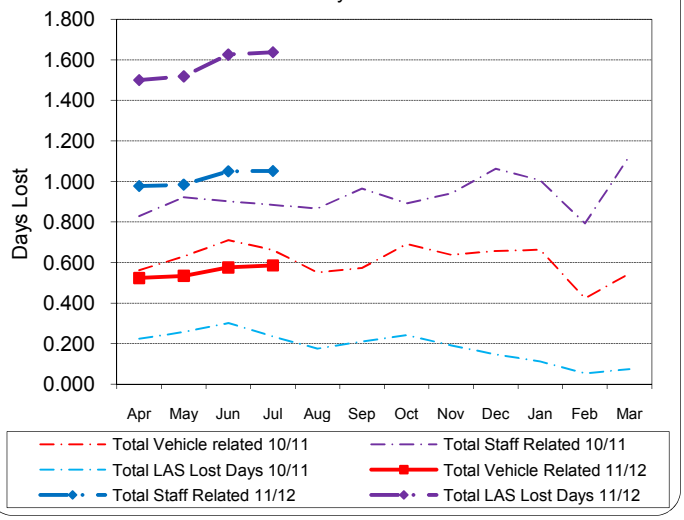


Graph 35
Patients conveyed to Non A&E Departments - LAS

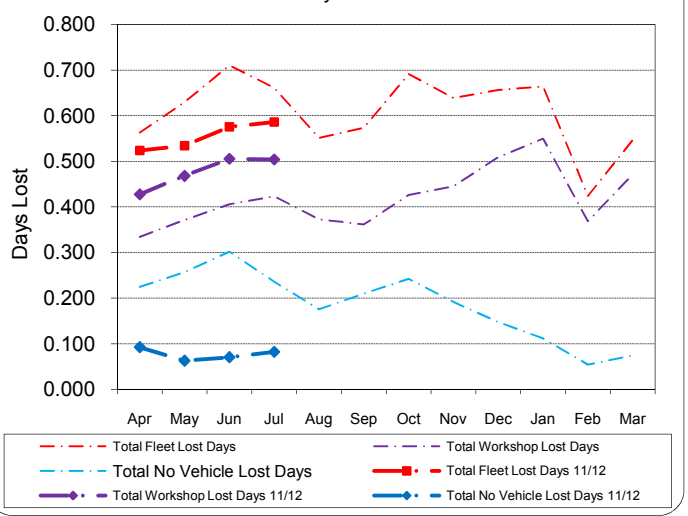


London Ambulance Service NHS Trust
Accident and Emergency Service
SMG Pack - Fleet and Logistics - July 2011

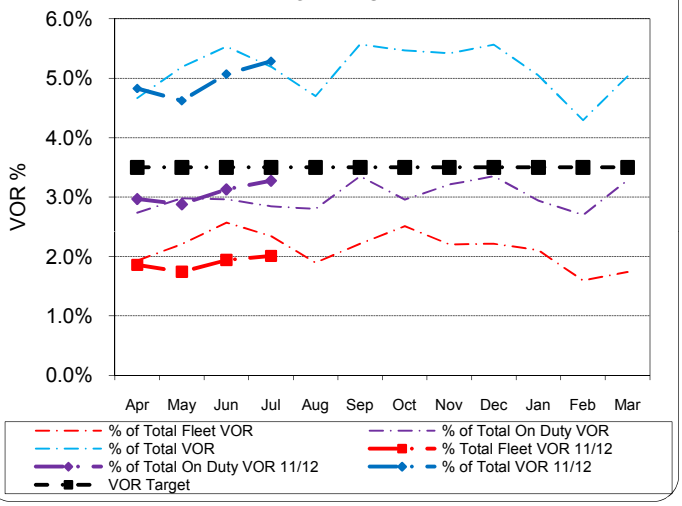
Graph 47
AEU Lost Days - LAS



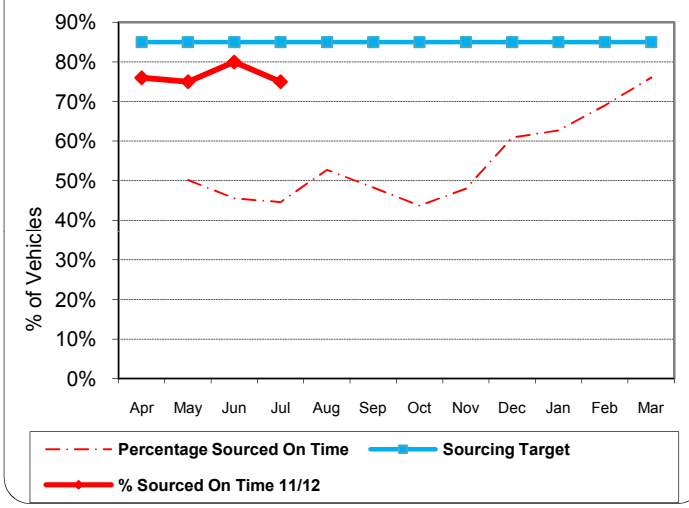
Graph 48
AEU Lost Days - Fleet Breakdown



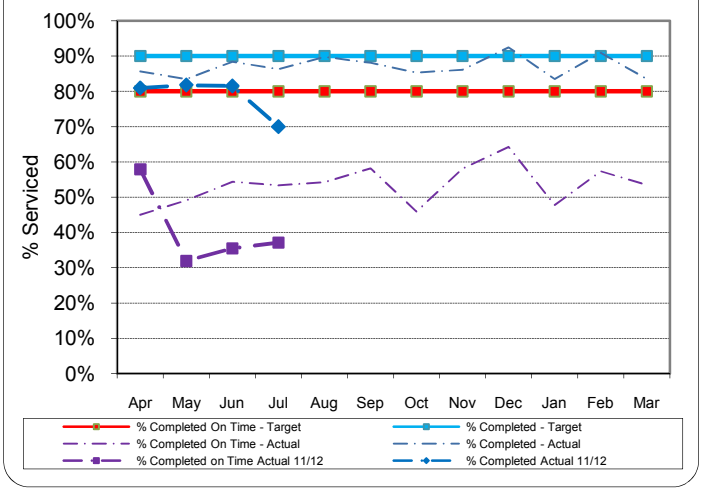
Graph 49
VOR - LAS



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

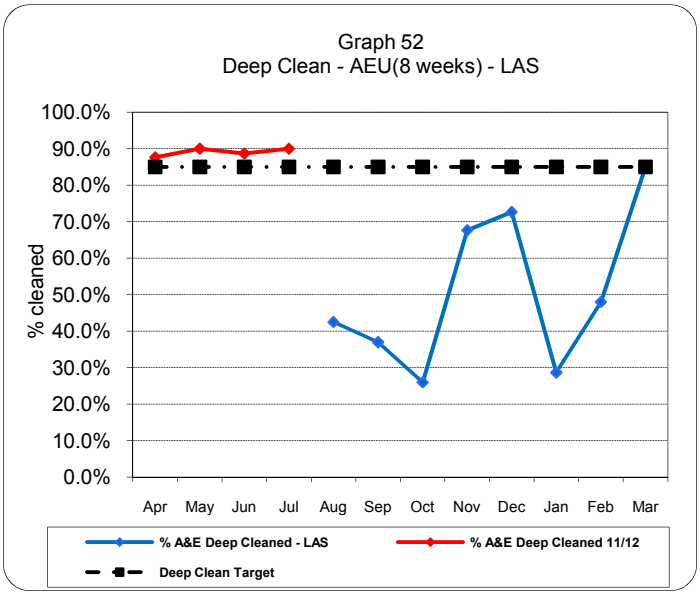


Graph 51
Servicing Performance - LAS

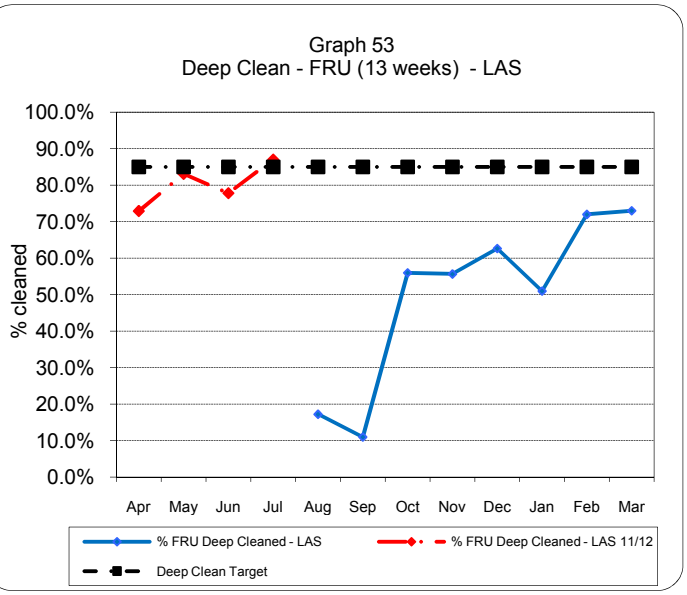


London Ambulance Service NHS Trust
Accident and Emergency Service
SMG Pack - Fleet and Logistics - July 2011

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

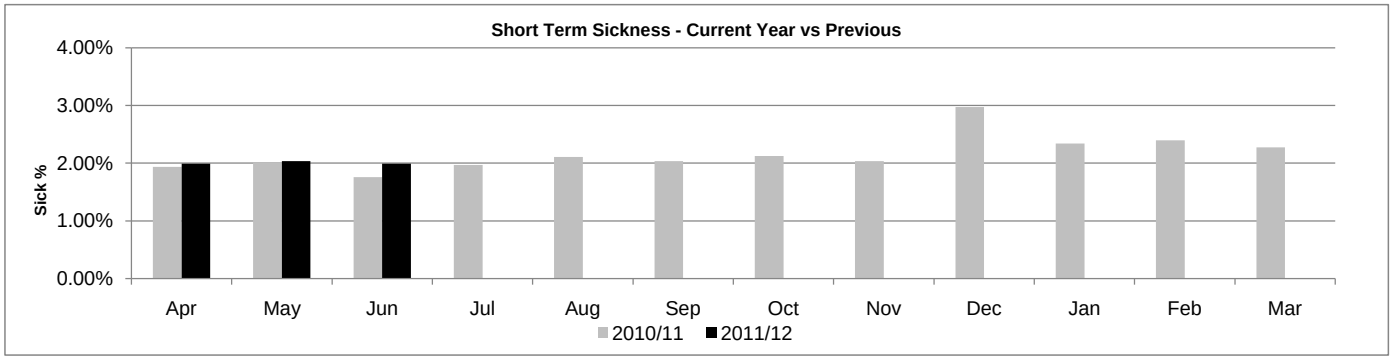
July 2011

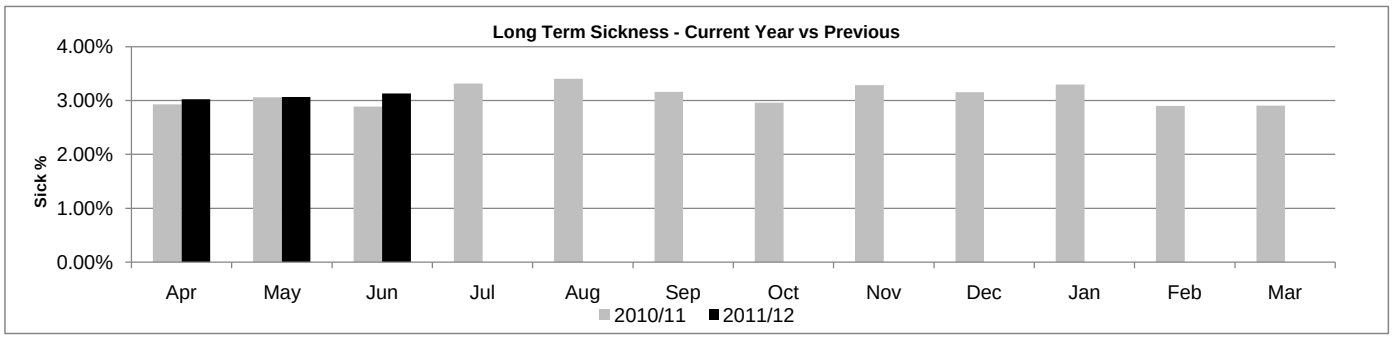
Workforce Report

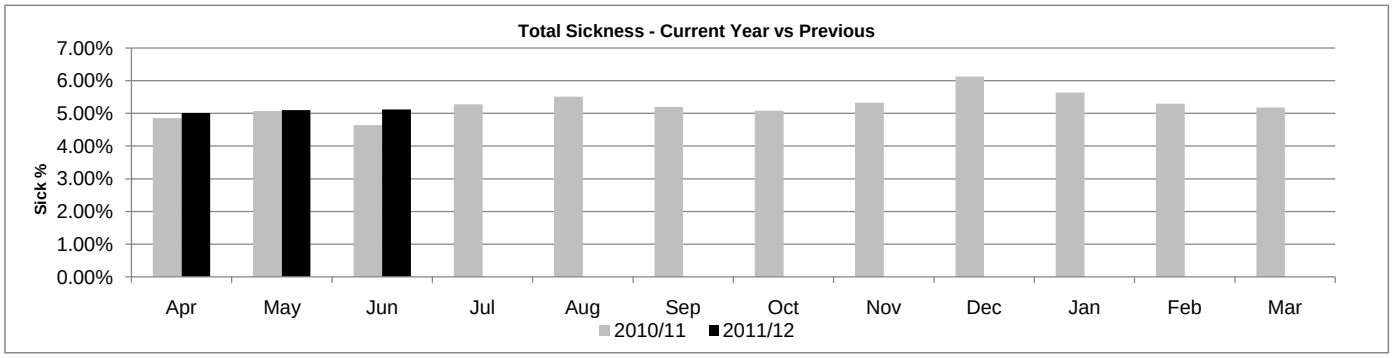
Current Month **Jul-11** **Sickness Month** **Jun-11**

Trust Summary

Sickness Absence







Sickness 2010/11	5.27%	**Current WTE**	4653.25
YTD Sickness	5.08%	**Current Headcount**	4871.00

NB Secondments and Acting Up Included in Totals

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	4.86%	5.07%	4.64%	5.28%	5.51%	5.20%	5.08%	5.32%	6.13%	5.64%	5.30%	5.18%
2011/12	5.01%	5.10%	5.12%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Unauthorised Absence	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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
2011/12	163.00	167.00	160.00	192.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Narrative

Sickness
A validation exercise for sickness year to date has been undertaken. This has resulted in a slight reduction in the figures reported. The new figures show that the monthly total (May to June) has remain almost static and YTD remains above the target for 2011/12 of 5% or below. The ratio of short- to long-term absence was largley unchanged. As previously reported, the RAG rated audits continue to show that, in the main, all absence is being managed appropriately. In June ratings have not been green, this has been due to managers not completely all follow up actions from the previous audit. There have been mitigating factors, including management vacancies coupled with many actions required.

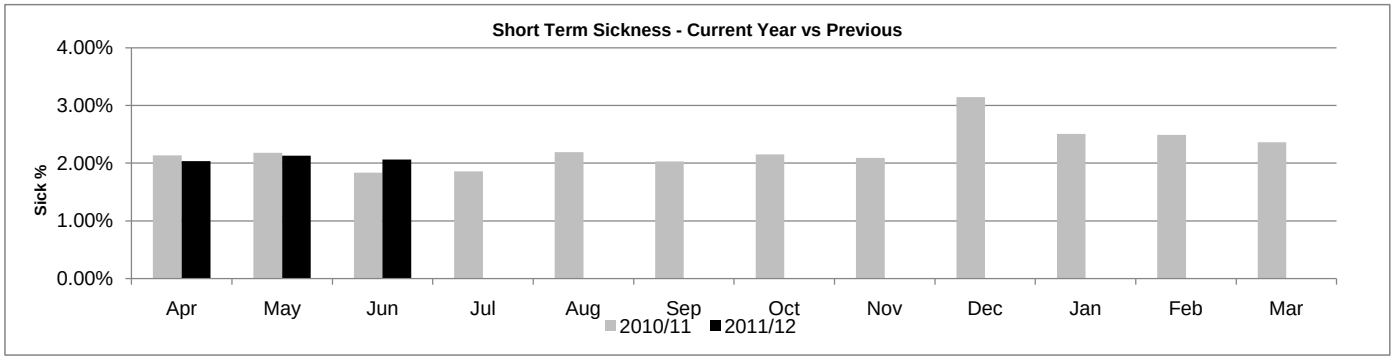
Unauthorised Absences
This figure shows the number of instances when staff have reported unable to attend work at short notice for reasons other than their own sickness or when they have not reported for work. Depending on the reason, the absence may be converted into annual leave or un/paid special leave or remain an unpaid unauthorised absence. Disciplinary action may result. The figure for July shows a significant increase on that for the previous year and month. These figures are actuals, and therefore will be affected by the differences in the number of staff in post.

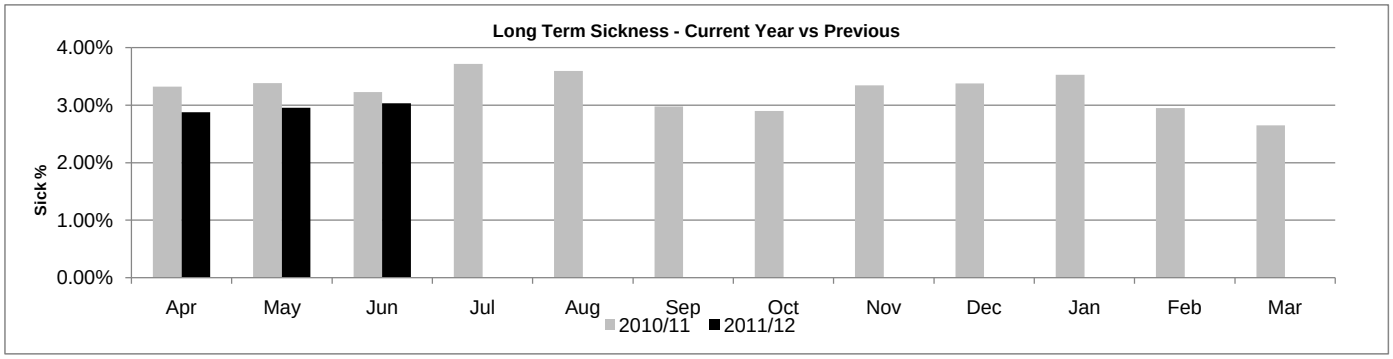
Workforce Report

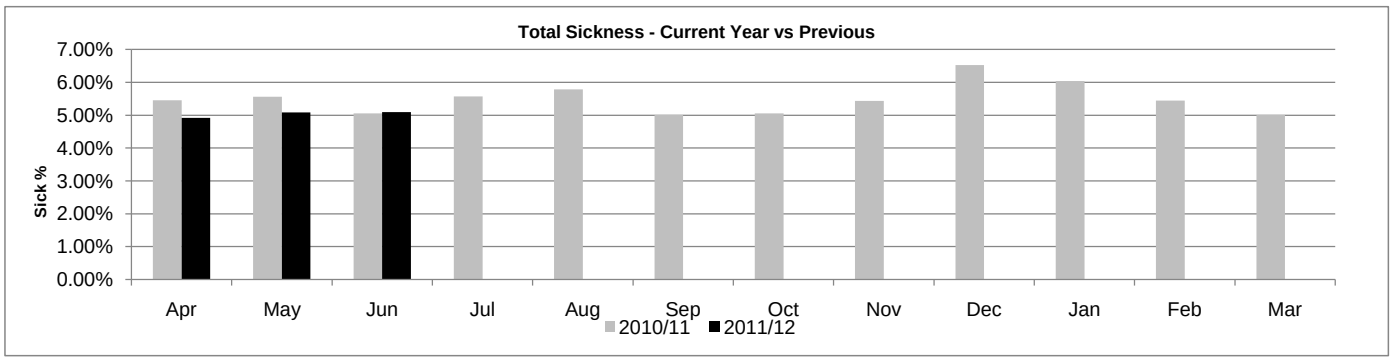
Current Month **Jul-11** **Sickness Month** **Jun-11**

A&E Operations Areas

Sickness Absence







Sickness 2010/11	5.50%	**Current WTE**	3279.42
YTD Sickness	5.03%	**Current Headcount**	3432.00

NB Secondments and Acting Up Included in Totals

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	5.45%	5.57%	5.06%	5.58%	5.79%	5.00%	5.05%	5.44%	6.52%	6.04%	5.44%	5.01%
2011/12	4.91%	5.08%	5.10%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Unauthorised Absence	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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
2011/12	141.00	144.00	135.00	162.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Narrative

Sickness
Sickness in the Areas was almost static May to June and just above the figure for the previous year. Unusually, the total figures for all Areas remains just below the Trust total for the month of June and YTD. During June one person in Areas was given notice for capability (health); four people were referred for hearings; two people on long-term sickness resigned; a total of 104 long-term sickness cases were active; 27 people returned to work following long-term absences; 53 members of staff were subject to formal warnings under the Managing Attendance Policy (MAP). On the last day of June at total of 133 members of staff were absent due to sickness, compared with 147 on the last day of May.

Audits of application of the MAP have raised no cause for concern. Two Complexes received red audits in June because outstanding actions had not been completed within the agreed timeframe.

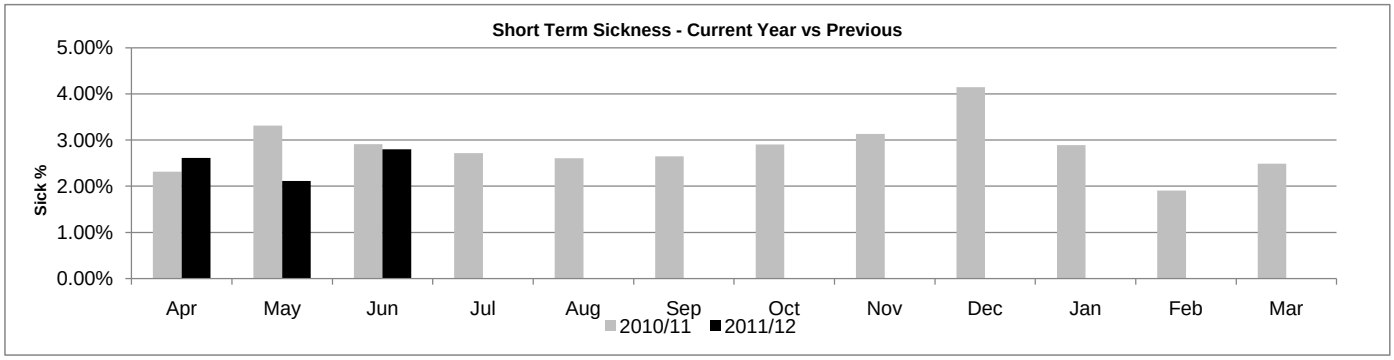
Unauthorised Absences
The figure for U/As increased significantly June to July, most markedly in South Area. A possible explanation for this might be that there were three specific staff related episodes which had a negative impact on morale.

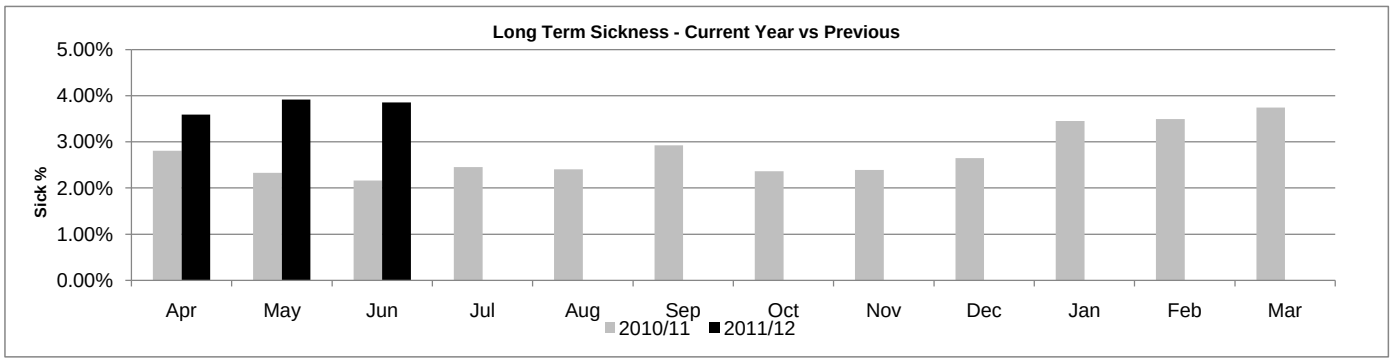
Workforce Report

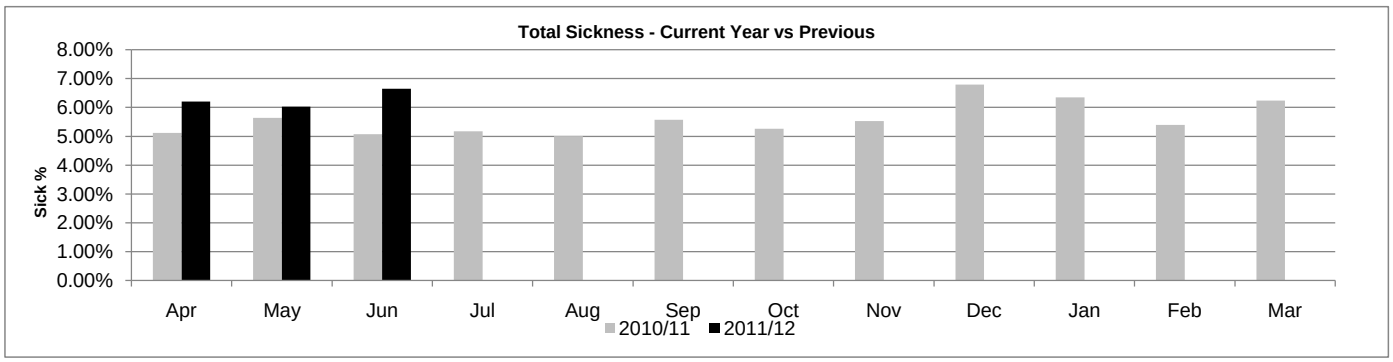
Current Month **Jul-11** **Sickness Month** **Jun-11**

Control Services

Sickness Absence







Sickness 2010/11	5.60%	**Current WTE**	440.52	**NB Secondments and Acting Up Included in Totals**	
YTD Sickness	6.29%	**Current Headcount**	464.00		

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	5.12%	5.64%	5.07%	5.17%	5.01%	5.57%	5.27%	5.52%	6.79%	6.35%	5.40%	6.23%
2011/12	6.20%	6.03%	6.65%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Unauthorised Absence	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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
2011/12	22.00	23.00	25.00	30.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Narrative

Sickness
After the decrease April to May, short-term sickness increased in June, to the highest level so far this year. It should be noted that June was the month in which implementation of CommandPoint was attempted.

28 long-term sickness cases were being managed during June; 7 people reached the four-week trigger in month and 5 returned to work. All Watch attendance audits were green. 16 people were on formal MAP warnings; 2 were dismissed for capability (health); 1 was referred for a hearing; 2 people on long-term sickness resigned and moved into their notice period. On the last day of June 43 were absent due to sickness, compared to 40 in May.

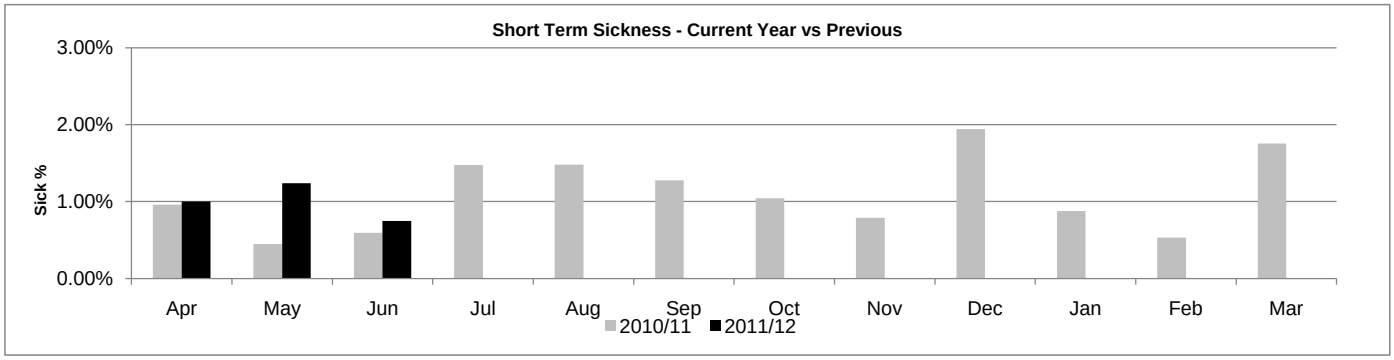
Unauthorised Absences
U/As remain high and initiatives are being discussed to address this. U/As remain a focus of management attention.

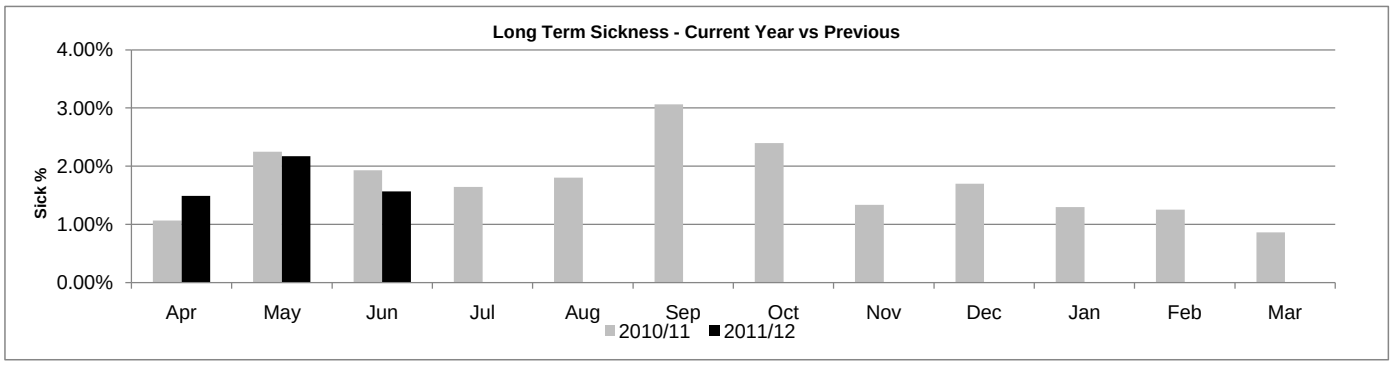
Workforce Report

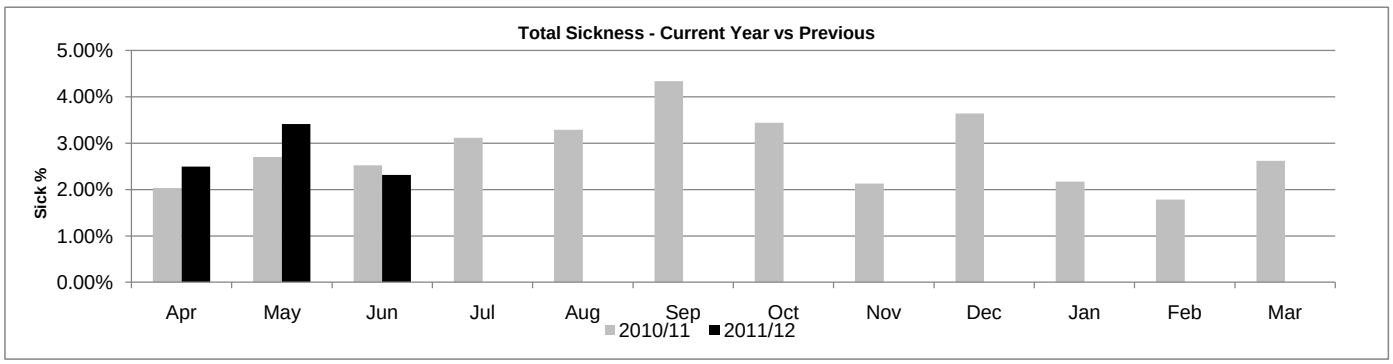
Current Month **Jul-11** **Sickness Month** **Jun-11**

Human Resources & Organisation Dev Directorate

Sickness Absence







Sickness 2010/11	2.76%	**Current WTE**	182.28
YTD Sickness	2.76%	**Current Headcount**	193.00

NB Secondments and Acting Up Included in Totals

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	2.03%	2.70%	2.52%	3.12%	3.29%	4.34%	3.44%	2.13%	3.64%	2.17%	1.79%	2.62%
2011/12	2.49%	3.41%	2.31%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Narrative

Short-term
Eight people in the HR and OD directorate had episodes of short-term sickness totalling 47 days during June; one being for surgery and post-operative re-couperation; one was pregnancy related and maternity leave then commenced.

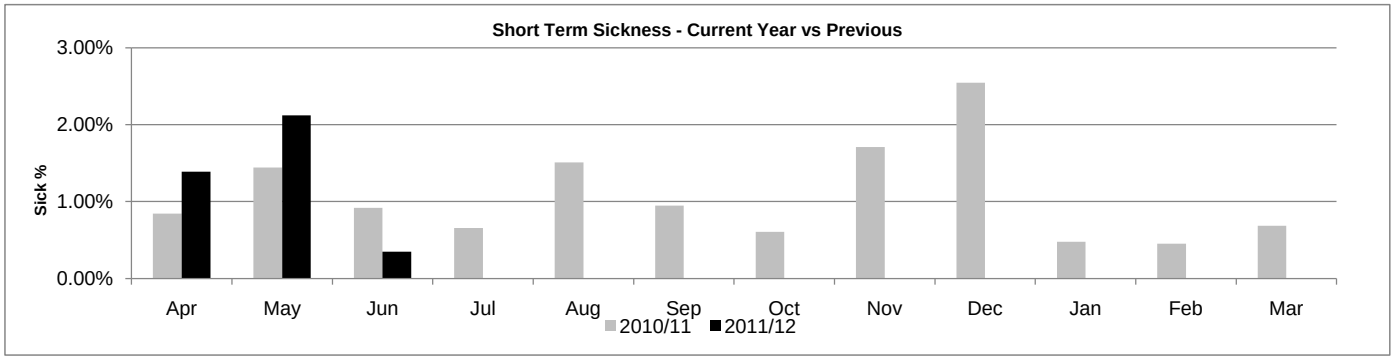
Long-term
4 long-term cases were being managed in June. We now have a return to work date of 04.09.11 for one. The others are being managed appropriately.

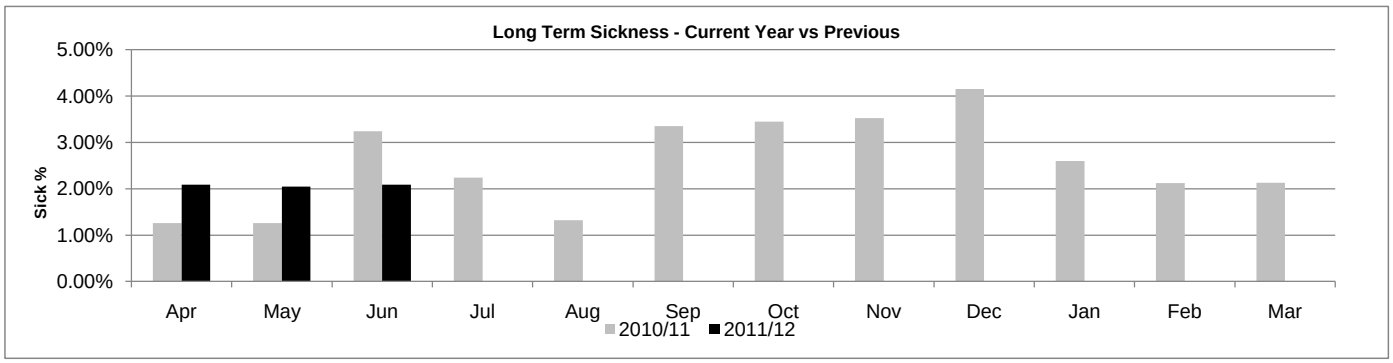
Workforce Report

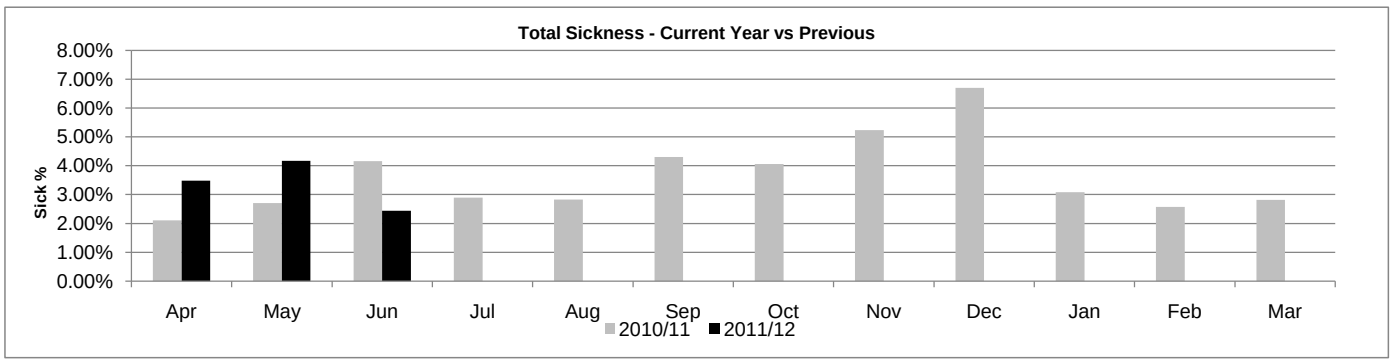
Current Month **Jul-11** **Sickness Month** **Jun-11**

Finance & Business Planning Directorate

Sickness Absence







Sickness 2010/11	3.61%	**Current WTE**	47.93	**NB Secondments and Acting Up Included in Totals**
YTD Sickness	3.37%	**Current Headcount**	50.00	

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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%
2011/12	3.48%	4.17%	2.43%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Narrative

Short-term
Four people had episodes of short-term sickness totalling 5 days during June.

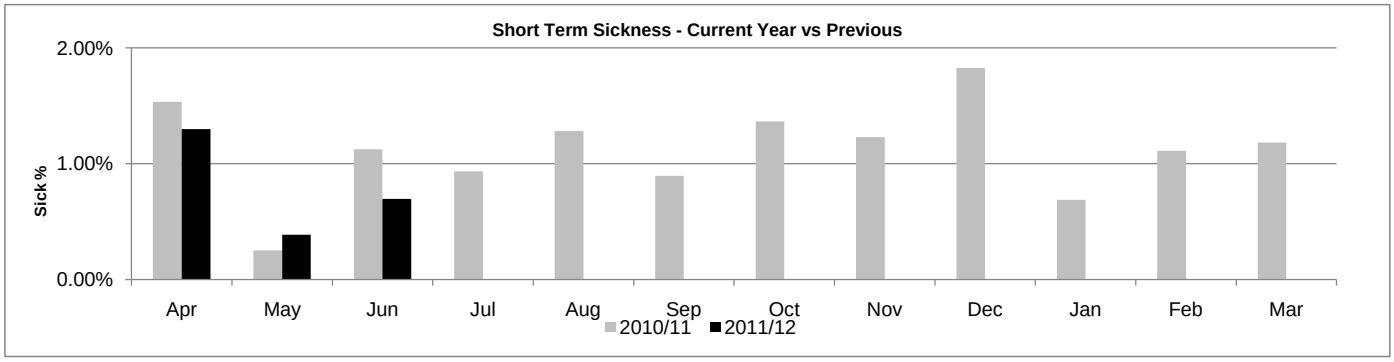
Long-term
One person was on long-term sick leave in June, for whom an exit strategy has now been agreed. It is expected that their service will end in August.

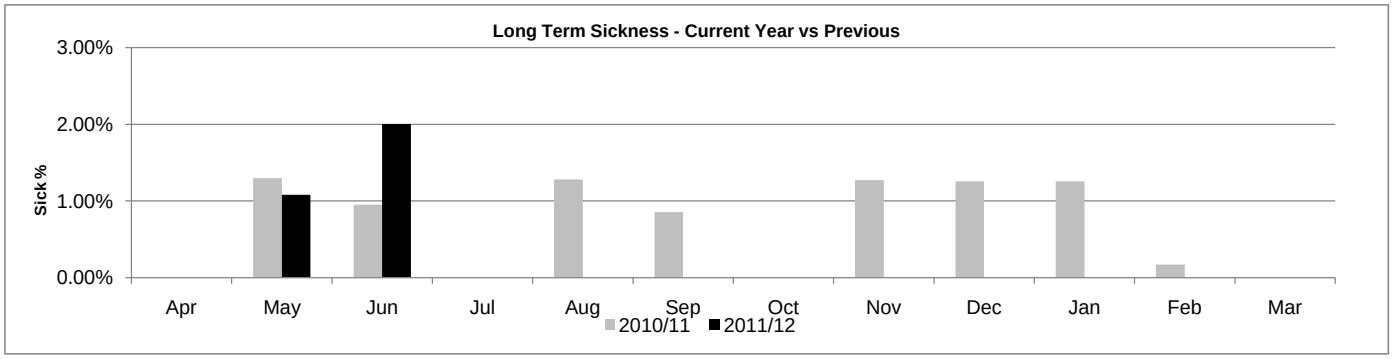
Workforce Report

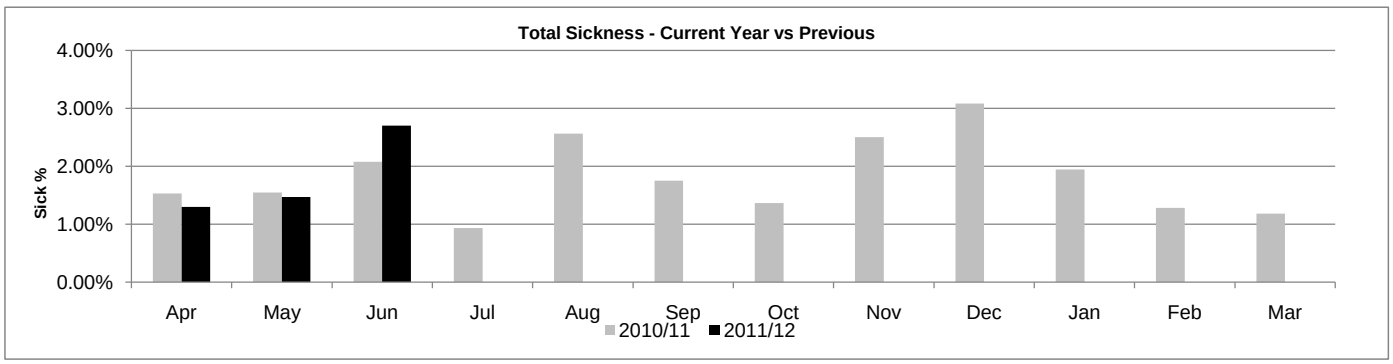
Current Month **Jul-11** **Sickness Month** **Jun-11**

Information Management & Technology Directorate

Sickness Absence







Sickness 2010/11	1.81%	**Current WTE**	81.42
YTD Sickness	1.81%	**Current Headcount**	83.00

NB Secondments and Acting Up Included in Totals

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	1.53%	1.55%	2.08%	0.93%	2.56%	1.75%	1.36%	2.50%	3.08%	1.95%	1.28%	1.18%
2011/12	1.30%	1.47%	2.70%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Narrative

Short-term
Seven people had episodes of short-term sickness totalling 16 days during June. Two individuals were absent for two episodes.

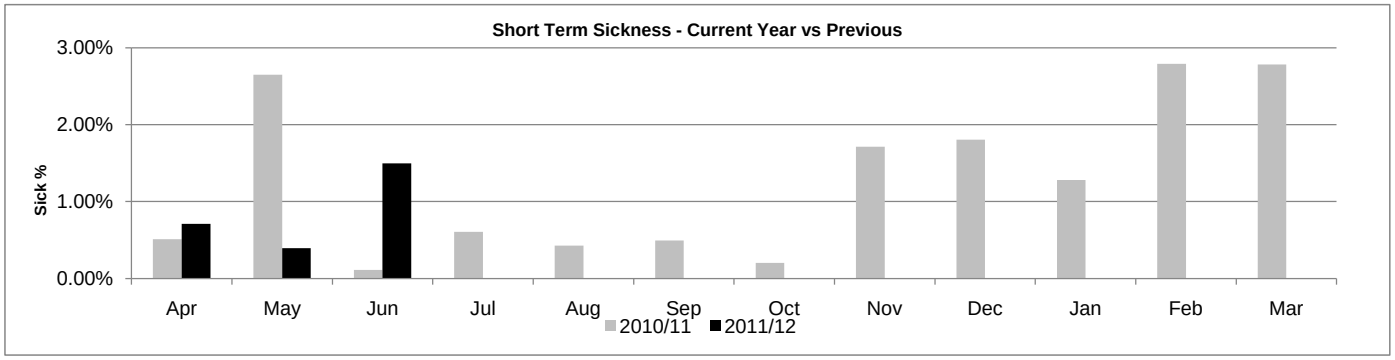
Long-term
Two people were on long-term sick leave; one has since returned to work.

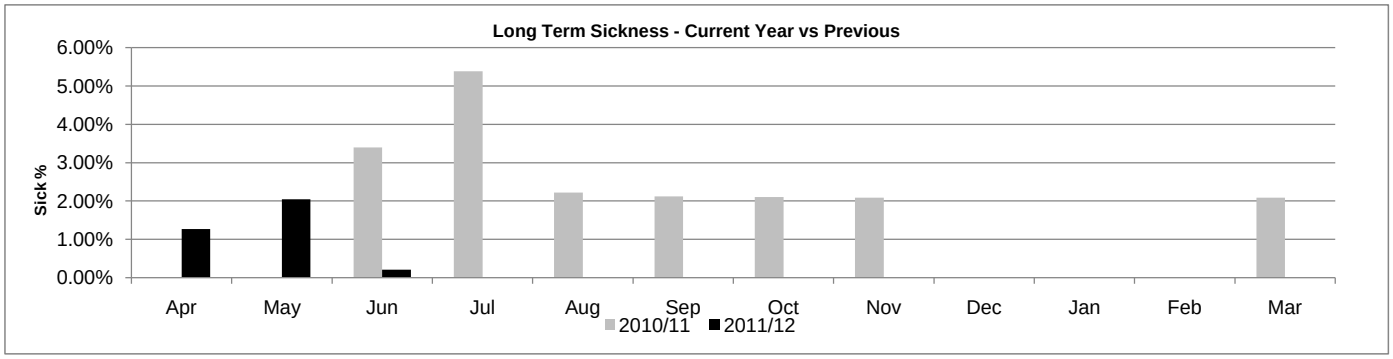
Workforce Report

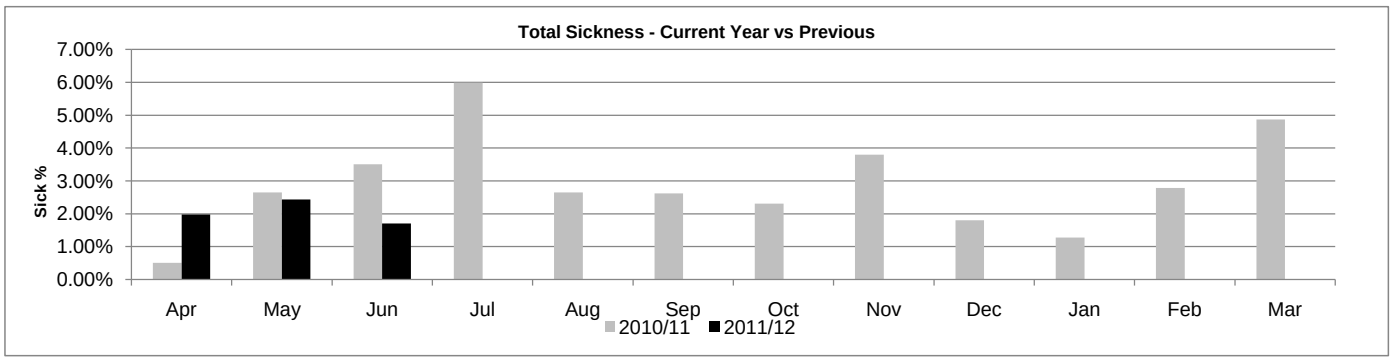
Current Month **Jul-11** **Sickness Month** **Jun-11**

Corporate Services Directorate

Sickness Absence







Sickness 2010/11	2.97%	**Current WTE**	48.93	**NB Secondments and Acting Up Included in Totals**
YTD Sickness	2.04%	**Current Headcount**	50.00	

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	0.51%	2.65%	3.51%	5.99%	2.65%	2.62%	2.31%	3.80%	1.80%	1.28%	2.79%	4.87%
2011/12	1.98%	2.44%	1.70%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Narrative

Short-term
Six people had episodes of short-term sickness totalling 22 days during June.

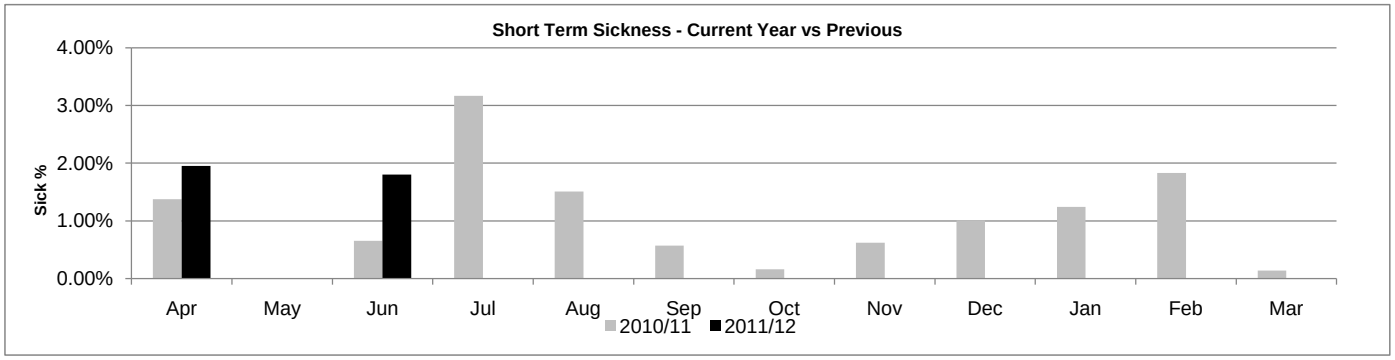
Long-term
One person moved into long-term sick leave and a return to work schedule has been agreed.

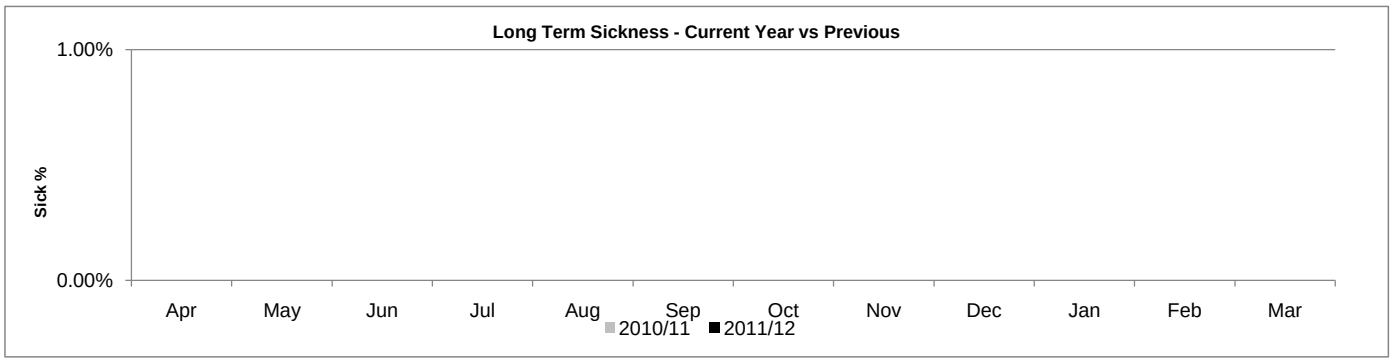
Workforce Report

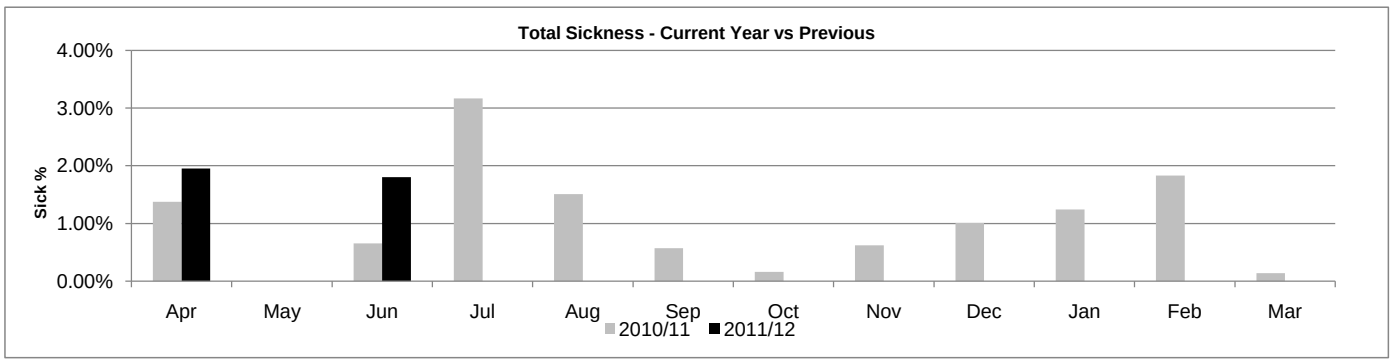
Current Month **Jul-11** **Sickness Month** **Jun-11**

Medical Directorate

Sickness Absence







Sickness 2010/11	1.03%	**Current WTE**	22.21	**NB Secondments and Acting Up Included in Totals**
YTD Sickness	1.25%	**Current Headcount**	24.00	

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	1.37%	0.00%	0.65%	3.17%	1.51%	0.57%	0.16%	0.62%	1.01%	1.24%	1.83%	0.14%
2011/12	1.95%	0.00%	1.80%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Narrative

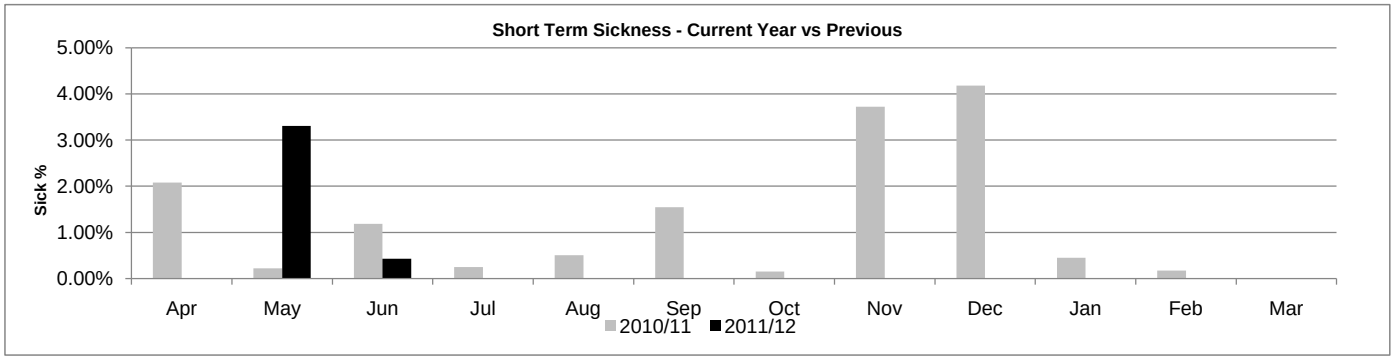
Short-term
Six people had episodes of short-term sickness totalling 12 days during June.

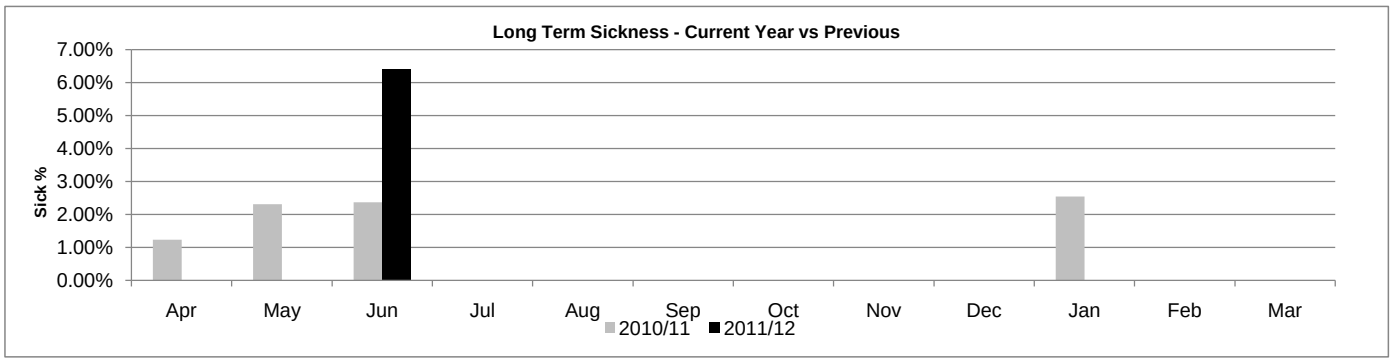
Workforce Report

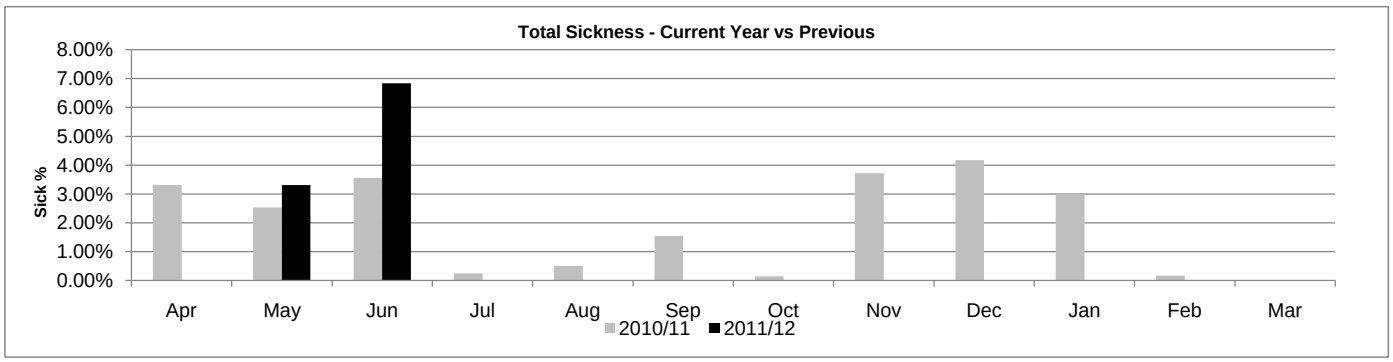
Current Month **Jul-11** **Sickness Month** **Jun-11**

Chief Executive

Sickness Absence







Sickness 2010/11	2.15%	**Current WTE**	15.61	**NB Secondments and Acting Up Included in Totals**
YTD Sickness	3.36%	**Current Headcount**	16.00	

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	3.31%	2.53%	3.55%	0.25%	0.50%	1.54%	0.15%	3.72%	4.18%	2.99%	0.17%	0.00%
2011/12	0.00%	3.31%	6.83%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Narrative

Short-term
One member of staff was absent for two days.

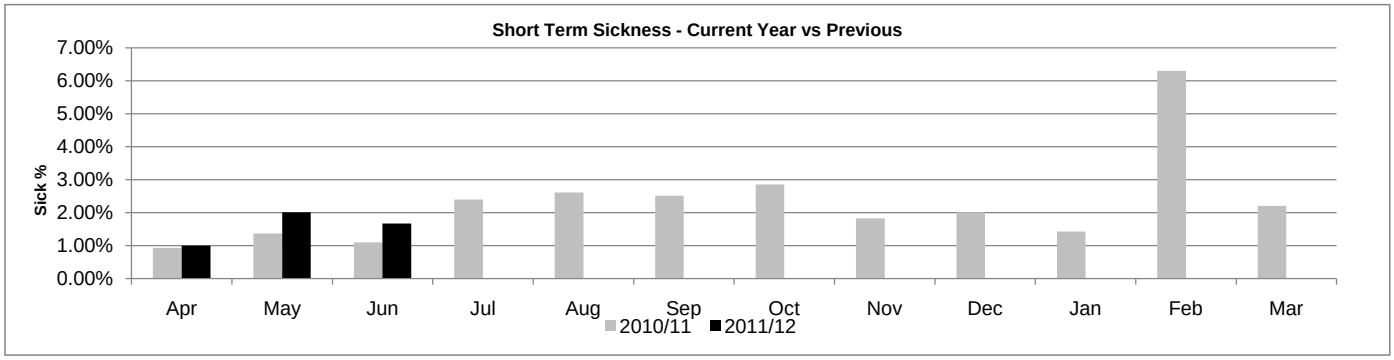
Long-term
One person was absent for the entire month and returned to work on 05.07.11.

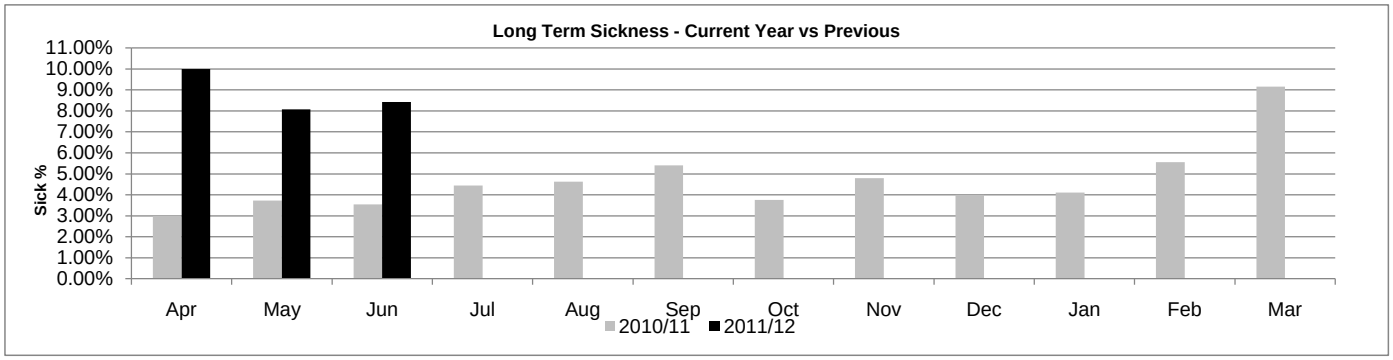
Workforce Report

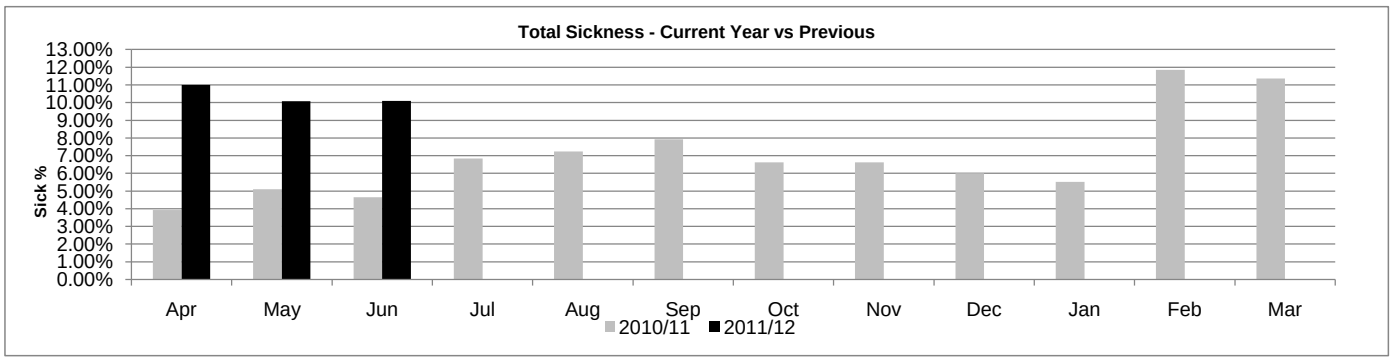
Current Month **Jul-11** **Sickness Month** **Jun-11**

Patient Transport Service

Sickness Absence







Sickness 2010/11	6.78%	**Current WTE**	153.74	**NB Secondments and Acting Up Included in Totals**	
YTD Sickness	10.39%	**Current Headcount**	161.00		

Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	3.92%	5.10%	4.64%	6.84%	7.23%	7.93%	6.62%	6.61%	6.00%	5.52%	11.86%	11.36%
2011/12	11.00%	10.08%	10.09%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Narrative

Sickness still remains high in PTS due to 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. The breakdown is as follows:

East: 4 x long-term (static from last month) - 3 of these cases are expected not to return, either through retirement or resignation.
1 x short-term (down from 2)

West: 8 x long-term (up from 5) - these cases are being managed appropriately.
2 x short -term

Managers: 1 x Long Term 1 x Short Term (same as last month)

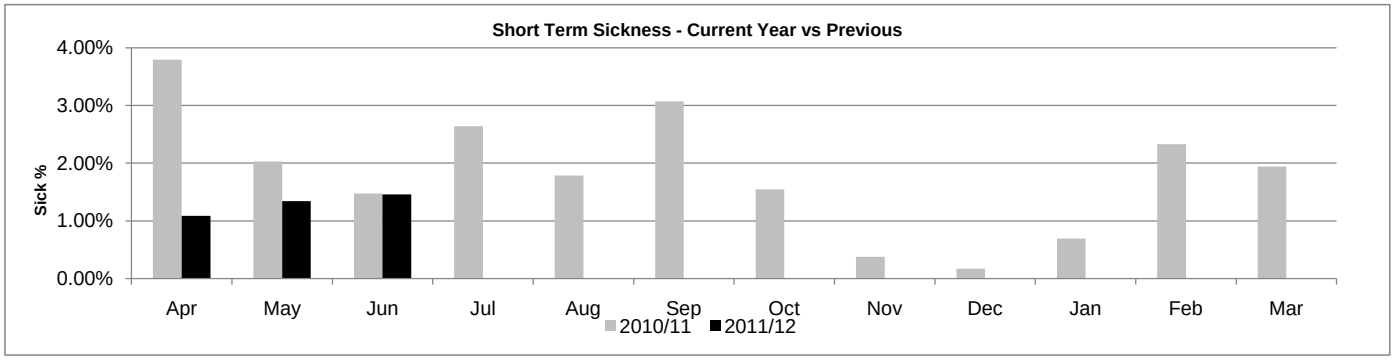
Short-term sickness is being well managed with only four staff off at the time of reporting.

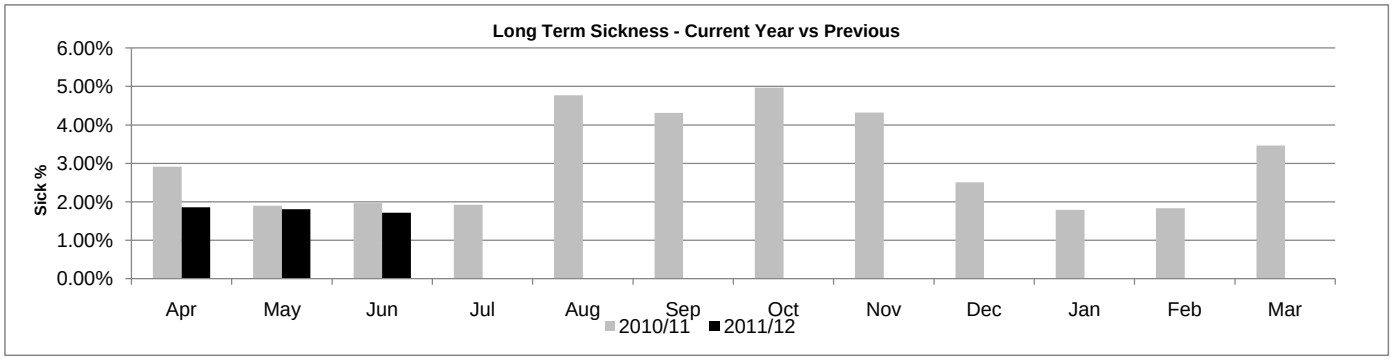
Workforce Report

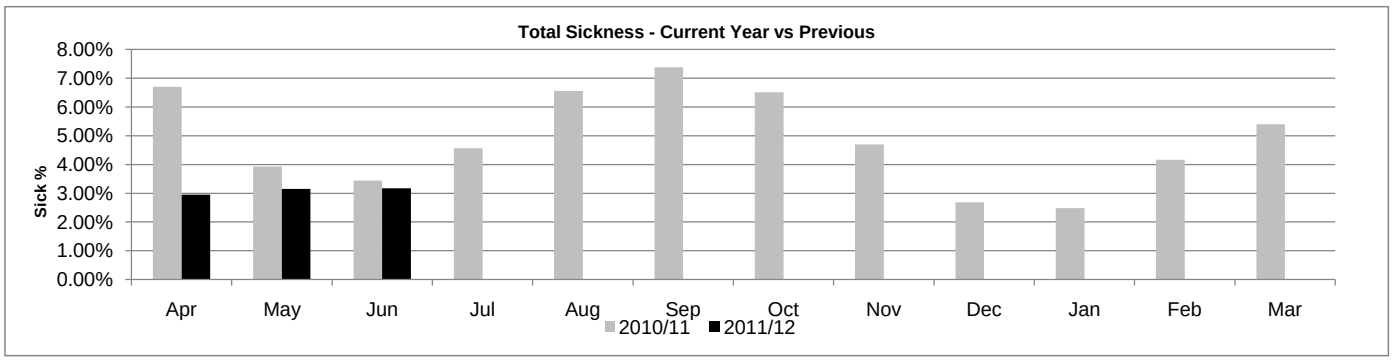
Current Month **Jul-11** **Sickness Month** **Jun-11**

Operational Support

Sickness Absence







Sickness 2010/11	4.88%	**Current WTE**	116.43	**NB Secondments and Acting Up Included in Totals**
YTD Sickness	3.10%	**Current Headcount**	117.00	

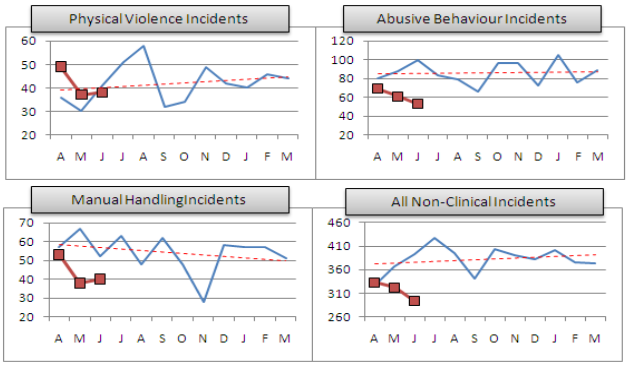
Total Sickness	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010/11	6.70%	3.93%	3.44%	4.57%	6.55%	7.38%	6.52%	4.70%	2.68%	2.48%	4.17%	5.40%
2011/12	2.95%	3.15%	3.18%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Narrative

Short-term
12 members of staff had episodes of short-term absence in June. Four attended meetings to discuss their (poor) level of attendance and receive alerts that if there is no improvement MAP warnings will follow.

Long-term
Two people are on long-term sickness absence. In one case, an application for ill-health retirement has been accepted.

HEALTH SAFETY AND RISK REPORT



Note: Due to the delay in receiving reported incidents, the figures for June 2011 may not be fully complete. Note that all collated figures are based 1 month in ar

Manual Handling Update
The numbers of lifting, handling and carrying incidents remain low compared to 2010/11. This is across all 3 areas, with the South Area having the lowest amoun reported Manual Handling incidents in June 2011. (East Area: 1617, South Area: 1112, West Area; 1315)

The chair transporter trial is still ongoing, with the length of the trial having been extended to allow for further evaluation.

Abusive Behaviour Update

The numbers of incidents where staff are verbally abused or threatened has fallen consistently below the number reported in 2010/11. The largest change is in t Area, which has fallen from 28 incidents in May 2011 to 25 in June 2011. (East Area: 28, South Area: 13, West Area; 14 15)

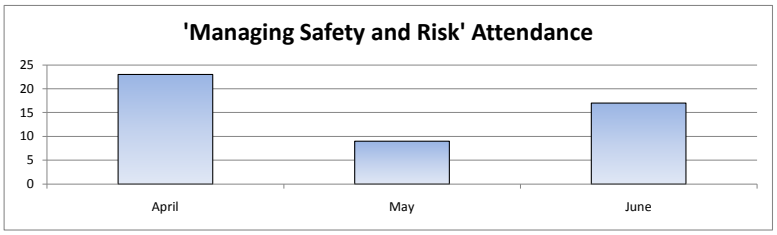
Physical Assault and Security Update

The numbers of reported physical abuse is slightly higher compared to this point in 2010/11; however the numbers of reported incidents have fallen since April a now at the approximate average of last year. The West Area saw a fall from 16 incidents in May 2011 to 10 12 incidents in June 2011, however there was a slight the East and South Areas. (East Area: 15 18, South Area: 13 14, West Area; 10 12)

A New Addington man has been sentences to 17 months in jail after a road traffic incident which injured David Sangster (Paramedic) from Croydon in May. He w prosecuted for a string of other driving offences.

In April, Liam Kenny (Paramedic) from Hanwell was assaulted by a male with mental health issues in Hillingdon Hospital. The man pleaded guilty to common assa was given a £25 fine and was ordered to pay £125 compensation.

Health and Safety Training Update
During May 2011, 28 members of operational staff have received refresher training in Conflict Resolution, delivered in-house. 1x Managing Safety and Risk cours cancelled in May, and 1x course was cancelled in July due to low delegate numbers. Since April 2011, 49 members of staff have attended the Managing Safety an training course.

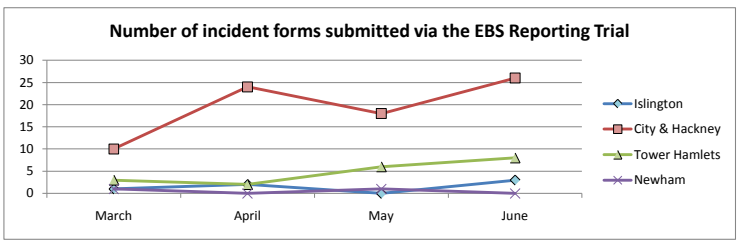


EBS Reporting Trial
Due to the success of the pilot trial on the complexes that have been actively participating, a decision has been reached to continue the trial until further notice.

There have been some issues over the management section of the report not being sent to Health, Safety and Risk but these appear to be related to the Excel fo that was produced in-house. There are also reported issues regarding the reliability of the Airwave radios where the signal repeatedly drops out while in use. The issues are under investigation.

Due to the low update of the concept among some of the original trial complexes, it is intended to extend the trial to Whipps Cross Complex once the above issu have been rectified.

Due to the rapid receipt of these forms, we have up-to-date information on the numbers of forms submitted to us via the EBS reporting trial.



All data accurate on the 22nd July 2011

Workforce Report

Current Month **Jul-11**

Trust Summary

Vacancies & Turnover

	Funded WTE	Inpost WTE	Variance
Trust Total	4642.93	4638.59	-4.34
Directorate			
A&E Operations Areas	3225.76	3298.84	+73.08
Chief Executive	16.61	15.61	-1.00
Control Services	437.28	438.37	+1.09
Corporate Services Directorate	53.93	49.93	-4.00
Finance & Business Planning Directorate	58.20	51.93	-6.27
Health Promotion & Quality	2.00	2.00	+0.00
Human Resources & Organisation Dev Directorate	183.12	160.28	-22.84
Information Management & Technology Directorate	87.53	81.42	-6.11
Medical Directorate	24.20	19.21	-4.99
Operational Support	129.86	117.43	-12.43
Patient Transport Service	153.44	150.74	-2.70
Trust Board	6.00	6.00	+0.00

Turnover

2010/11	7.1%	Apr-10 to Mar-11
2011/12	7.2%	12 Months up to Jul-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	22.00	36.00	33.00	24.00	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	6.00	7.00	7.00	9.00	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 **Jul-11**

Trust Summary

Employee Relations Data

	Attendance	Grievances	Capabilities	Disciplinary (Clinical)	Disciplinary (Non Clinical)
Current Case Total	677 (590)*	18 (7)	0 (1)	2 (1)	36 (16)

Current Employment Tribunal Cases	8 (11)

Current Suspensions	4 (5)

Narrative

* The figure for the previous month appears in brackets. Given the significant increase in a number of categories from June to July a validity check will be undertaken to ensure that all closed cases are marked as such and therefore not included in the count.

Attendance

This figure continues to rise month on month to a new high as the focus on robust attendance management remains a high priority.

Grievances

Assuming the figures are correct, it must be expected that as managers increase the focus on all facets of performance this figure will continue rise. Nevertheless, given the number of employees, this number remains low.

Capabilities given the number of employees, this number remains low.

Disciplinaries

This count shows a marked increase in cases. In the past the similarity between the disciplinary case count and the number of people suspended has led to concerns that lower level misdemeanours were not being addressed. If these figures are correct they could indicate an improvement in that situation.

Employment Tribunals

Three cases were closed in July - two withdrawn and one settled. No new claims were lodged.

Workforce Report

Current Month **Jul-11**

Trust Summary

PDR Completion Rates

Area / Directorate / Dept	No. to be done in Year	No. Done	No. Done (Previous Month)	% Complete	% Complete (Previous Month)
A&E Operations East	983	83	*67*	8.4%	6.8%
A&E Operations South	1332	28	*27*	2.1%	2.0%
A&E Operations West	1136	61	*53*	5.4%	4.7%
Chief Executive	16	6	*6*	37.5%	37.5%
Control Services	461	0	*0*	0.0%	0.0%
Corporate Services Director	51	24	*22*	47.1%	43.1%
Deputy Director Operations	143	19	*19*	13.3%	13.3%
Finance & Business Plannin	54	18	*18*	33.3%	33.3%
Health Promotion & Quality	2	1	*1*	50.0%	50.0%
Human Resources & Organi	171	78	*75*	45.6%	43.9%
Information Management &	83	17	*16*	20.5%	19.3%
Medical Directorate	21	6	*6*	28.6%	28.6%
Operational Support	118	14	*8*	11.9%	6.8%
Patient Transport Service	158	4	*3*	2.5%	1.9%
Trust Board	6	5	*5*	83.3%	83.3%
Urgent Care Service	119	2	*2*	1.7%	1.7%
Total	**4854**	**366**	***328***	**7.5%**	**6.8%**

NB: Figures based on appraisers' input into database

APRIL TO JULY 2011

Care for patients - SQU Indicators	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Commentary
CO2 - SQU03_01 - Call abandonment rate									
C2.1.1 Number of calls abandoned before call answered	0.12	0.10	0.12	0.10	0.12	0.10	0.12	0.09	PC 05/08/11. The Trust continues to achieve this target
CO2 - SQU03_02 - Re-contact rate following discharge of care									
C2.2.1 Calls closed with telephone advice where recontact is within 24 hour		2		3.03	15.2	2.80		4.13	National targets not available for June
C2.2.2 Treated and discharged at scene where recontact is within 24 hours		2		4.27	3.7	3.80		3.69	National targets not available for June
C2.2.3 Calls from patients for whom a locally agreed frequent caller procedure is in place		0		0.45	0.6	3.00		2.95	National targets not available for June
C2.2.4 Number of patients with a frequent caller procedure in place							40%	33%	Prior to the introduction of this indicator a requirement for each frequent caller to have a 'plan' did not exist; there is no benchmarking data available from the DH or guidance on what a frequent calle plan should consist of. Therefore, we are now in the process of devising a document which will become the 'frequent caller plan'. The current caseline is based upon the number of frequent callers who have a definitive plan to address their needs, beyond informing their GP or other lead agency. The aim is to roll out the new frequent caller plan by end September 2011, with a view to transferring existing plans into this format and gradually increasing the number of frequent callers with a plan to 40% by 31 March 2012.
CO1 - SQU03_03 - Outcome from Cardiac Arrest - ROSC									
C1.1.1 ROSC time of arrival at hospital (Utstein comparator group)	50	43	50	68	50	66	50		Target Achieved
C1.1.2 ROSC time of arrival at hospital (overall)	24	27	24	31	24	31	24		Target consistantly achieved
C1.1.3 % of patients with ROSC who get appropriate therapeutic hypothermia	1		1		1		1		
C1.1.4 % patients with presumed cardiac aetiology who have a return of spontaneous	24	27	24	33	24	32	24		Target consistantly achieved

APRIL TO JULY 2011

	Apr 2011		May 2011		Jun 2011		Jul 2011		
Care for patients - SQU Indicators	Target	Actual	Target	Actual	Target	Actual	Target	Actual	**Commentary**
CO10. SQU03_04 Service Experience									
C10.1.1 Increase in number of Londoners who feel informed about the Service.									The Learning from Experience group will review the Q1 integrated report on 9th August from which it can start to develop focus areas for service experience. Structure changes mean that the Patient Experiences team will lead on service experience and on non-declared serious incidents (graded 8-14). Governance & Compliance will lead on serious incidents graded 15 and over.
C10.1.2 Increase in number of Londoners satisfied with way staff do their job v other									
C10.1.3 Increase in number of Londoners prepared to speak highly of Service (advocacy									
C10.1.4 Increase in proportion of stakeholders who feel their understanding of the service									
C10.1.5 Increase in proportion of stakeholders who speak highly of the service without being asked (advocacy level).									
CO1 - SQU03_05 - Outcome from acute STEMI									
C1.2.1 % of STEMI patients taken to specialist cardiac centres, primary angioplasty					84				Figures for April
C1.2.2 % of patients with STEMI who receive an appropriate care bundle	63	75	63	78	63	72	63		Gv 2011-08-05: In June, 32% of patients received the full care bundle, with a further 40% classed as having valid exceptions to full provision. In total, 72% of patients were provided with the full care bundle or met the criteria for having valid exceptions to its provision.
CO1 - SQU03_06 - Outcome from Stroke									
C1.4.1 % of FAST positive patients who arrive at hyperacute stroke centre within 60					58	64			Figures relate to April 2011
C1.4.2 % of stroke patients who receive appropriate care bundle					95	96			GV 2011-06-23: Data is on track for release in line with the DH deadline of 21st August.
CO1 - SQU03_06 - Outcome from Trauma									
C1.3.1 % of appropriate patients taken to major trauma centres	90		90		90		90		GV 2011-06-23: Data is behind by 6 months. CARU are using resources within the team & restricted duties staff where available to process data but this is not sufficient. As such, SMG agreed a temp post to support data capture. The reasons for delay are due to lengthy processes required to build a full picture of the number of major trauma cases as a result of poor coding on PRFs, incomplete logs from CCD resulting in the need for hospital data to supplement gaps. Until these issues are resolved CARU needs continued support in the form of additional resources.

APRIL TO JULY 2011

	Apr 2011		May 2011		Jun 2011		Jul 2011		
Care for patients - SQU Indicators	Target	Actual	Target	Actual	Target	Actual	Target	Actual	**Commentary**
CO1 - SQU03_07 - Outcome from Cardiac Arrest - Survival to									
C1.5.1 Outcome from cardiac arrest - survival to discharge (overall survival rate)	8		8		8		8		GV 2011-06-23: Data is on track for release in line with the DH deadline of 21st August.
C1.5.2 Outcome from cardiac arrest - survival to Discharge Utstein Commparator Group Survival Rate	22		22		22		22		GV 2011-06-23: Data is on track for release in line with the DH deadline of 21st August.
C1.5.3 Number of defibrillators in public places	575	579	580	588	585	598	590	600	Progressing slightly better than planned
C1.5.4 Number of people trained by the Trust under the community responder scheme	536	545	545	554	554	571	563	585	Progressing slightly better than planned
C1.5.5 Number of people trained to use defibrillators	6713	6766	6755	6892	6797	6930	6839	7032	Progressing slightly better than planned
CO3 - SQU03_08 - Time to answer call									
C3.1.1 % Calls answered in 5 seconds	95	94	95	94	95	93	95	96	SH 02/08/1 Continued to achieve
CO3 - SQU03_09 - Time to arrival									
C3.2.1 % Time to arrival of ambulance-dispatched health professional for life-threatening calls (CAT A 8 min)	5.8	5.6	5.9		6.2		6.1		Figures not provided since April 2011
CO3 - SQU03_10 - Calls closed with CTA or managed without									
C3.3.1 % of complexes with new Clinical Response Model in place	3		3		3		3		Information not provided
C3.3.2 Achievement of Cat C1 (20 minutes)	90.0	83.7	90.0		90.0	82.4	90.0	85.5	SH 02/08/11 Target not achieved due to month of July seeing high demand in Cat A life-threaning calls of c14.6% which has impacted on Cat C1
C3.3.3 Achievement of Cat C2 (20 minutes)	90.0	87.9	90.0		90.0	83.7	90.0	83.7	RH 08/07/2011 The month of June saw the Trust continuing to concentrate on Category A life-threatening calls due to the higher than expected category A demand.
C3.3.4 Meet agree C3 response target (CTA or face/face assessment 20 minutes)	90		90	90.1	90	88	90	86	SW 05/08/11 June saw exceptional demands for the Trust and as a result has impacted on our ability to attain this measure. MI have produced the data. This measure includes calls from MPS but EXCLUDES Card 35 and AS3 non urgent request as the times for response are often over 60 minutes
C3.3.5 Meet agreed C4 response target CTA 60 minutes	90		90	96.9	90	95.9	90	94.9	SW 05/08/11 June saw exceptional demands for the Trust. MI have produced the data. This measure includes calls from MPS but EXCLUDES Card 35 and AS3 non urgent request as the times for response are often over 60 minutes

APRIL TO JULY 2011

Care for patients	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Commentary
CO2 - Appropriate Care - End of Life Care Pathways									
C2.8.3 End of Life care target - 50% processed in 72 hours	75	60	75	50	75		75		SH 27/7/11 Delays caused by staff absence at Bow.
CO2 - Appropriate Care - Patient Specific Protocols									
C2.8.4 Patient Specific Protocols target -75% processed within 48 hrs	80		80	70	80		80		SH 27/7/11 Delays caused by Command Point preparation
Care for patients - HQU Indicators									
CO3 - HQU03_01 - Category A 8 minute response time									
C3.4.1 Achievement of Cat A (8 minutes)	75	78	75	76	75	74	75	77	RH02/08/2011 Continuing to achieve
CO3 - HQU03_02 - Category A 8 and 19 min response time									
C3.5.1 % of Category A activation within 45 seconds	60	61	60	64	60	63	60	64	SH02/08/11 Continued to achieve
C3.5.2 FRU mobilisation <134 sec Average	136	136	136	69	136	80	136	61	Target achieved
C3.5.3 Ambulance mobilisation <208sec Average	209	209	209	153	209	168	209	168	RH 08/07/2011 Continue to achieve
C3.5.4 FRU mobilisation from station less than 25%	25	24	25	23	25	23	25	23	SH02/011 Continued to achieve
C3.5.5 AEU mobilisation from station less than 30%	30	17	30	17	30	16	30	16	SH02/08/11 Continued to achieve owing to higher Utilisation
C3.5.6 FRU utilisation of 40%	40	41	40	44	40	47	40	45	SH 02/0/8 Utilisation continues to be off-track due to July Cat A life threatening calls incident demand growth for July 14.6%
C3.5.7 Ambulance utilisation of 55%	55	84	55	84	55	88	55	84	SH 02/0/8 Utilisation continues to be off-track due to July Cat A life threatening calls incident demand growth for July 14.6%
C3.5.8 Achievement of Cat A (19 minutes)	95	99	95	99	95	99	95	99	SH0208/11 Continued to achieve
CO3 - HQU03_02 - Category A 8 and 19 min response time [Staffing]									
C3.6.1 Job cycle time (incl. hospital turnaround) 66 minutes	66.0	66.0	66.0	66.2	66.0	67.1	66.0	66.3	Target met for July
C3.6.2 Proportion of the year below REAP level 1 & 2 combined	75	0	75	75	75	6	75		RH 08/07/2011 the Trust for the Month of June remained at REAP 3 and at one point REAP4 due to the high category A demand. This has now pushed the percentage down to 6%
C3.6.3 VOR 2	4	4	4	4	4	4	4	5	
C3.6.4 Staffing total hours produced as per contract (All)	100.0	119.7	100.0	123.8	100.0	124.0	100.0	106.7	
C3.6.5A Staffing total hours produced as per contract (AEU)	100.0	109.2	100.0	104.9	100.0	111.0	100.0	91.1	
C3.6.5F Staffing total hours produced as per contract (FRU)	100.0	111.6	100.0	114.0	100.0	106.0	100.0	96.4	
C3.6.5U Staffing total hours produced as per contract (UC)	100.0	123.8	100.0	136.0	100.0	124.0	100.0	122.4	

APRIL TO JULY 2011

	Apr 2011		May 2011		Jun 2011		Jul 2011		
Care for patients	Target	Actual	Target	Actual	Target	Actual	Target	Actual	**Commentary**
CO4 - Meet Health & Safety Target									
C4.1.1 Meet Health & Safety target - % H&S incidents reported within 7 days	53	40	56	43	58	43	61	50	AK 02-08-2011: The number of incident reports submitted within 7 days of incident are still below the milestone, however there has been an increase since last month to our highest figure to date. Overall: East Area (62.6%, 163 forms), South Area (39.8%, 98 forms), West Area (37.7%, 114 forms)
CO4 - Meet Patient Report Form completion target									
C4.2.1 Meet patient report form completion target - % PRFs processed at MI within 7 days	95.0	98.3	95.0	97.5	95.0	99.2	95.0	99.3	SH02/08/11 Continued to achieve
Good for staff									
CO5 - Increase in staff confidence levels (Non-Operational) Caron									
C5.1.1 % of non-operational staff receiving PDR sessions per annum	90		90		90	17	90		05.07.11 Some larger depts/ directorates operate a system of delivering PDRs in a rolling programme over 12 months. Nevertheless this figure is lower than would be expected for the Q1. Managers will be reminded of the reporting process to ensure accurate data collection.
CO5 - Increase in staff confidence levels (Operational) Richard									
C5.1.2 % of operational staff receiving PDR sessions per annum	90	41	90		90	370	90		06/08/11: Since April the Service have undertaken 370 staff PDRs. The process of how this is captured has been redefined and all line managers can upload completed PDRs via the intranet, this remains a challenge operationally and competes now with CSR courses and numerous local incentives, large abstarctions and hence the challenge to produce good performance remains the greatest challenge.
C5.1.3 % of operational staff who have a workplace performance review twice per year	90	87	90		90	25	90		06/08/11: This target has not progressed, we may need to consider how this is being captured and consider any shift undertaken by a Team Leader with any staff to be included as an operational rideout?
C5.1.4 % of operational staff who have two CPI feedback sessions per year	95	62	95	89	95	84	95		Information not provided
C5.1.6 CPI Completed as % of plan	80	81	80	83	80	77	80		Information not provided
C5.1.7 CPI compliance with guidelines as a % of all	95	95	95	95	95	95	95		Information not provided

APRIL TO JULY 2011

	Apr 2011		May 2011		Jun 2011		Jul 2011		
Good for staff	Target	Actual	Target	Actual	Target	Actual	Target	Actual	**Commentary**
CO5 - Increase in staff skill levels									
C5.2.1 Total NW0W training hours delivered								10204	(HL 01.08.11) 50% of NWOW training delivered to date (10,204 hours delivered from a total of 20, 413 to be delivered).
C5.2.2 % of staff attending training courses against places available	80	89	80	90	80	80	80	83	2011-08-04 JH:this information is only up until 22nd July. Will update when I have remaining information sent to me, which has been requested.
C5.2.3 Number of student paramedics who have completed their training	37		9		72	30	92	25	2011-08-04 JH: this information is only up until 22nd July. Will update when I have remaining information sent to me, which has been requested.
C5.2.4 Proportion of annual priority training commitments delivered	80	0	80	0	80	42	80	33	2011-08-04 JH: 33% Attendance against planned up to 22nd July- in context this only equates to 24 students places planned with take up being only 8 staff -defferal of csr courses continued in July due to supporting operational resilence and also allowing resource department team time to establish process for booking staff who are on rostered training days only. This target does not take into account NWOW established sites who are completing this
CO6. Implement Equality & Inclusion									
C6.1.1 Implement Equality & Inclusion Action Plan									Ongoing implementation of actions in year 1/2 of Equality & Inclusion Strategy Action Plan; new Corporate Equalities Induction Training materials provided, Train the Trainer workshops provided and Equalities Induction session launched in corporate Induction session July 4; Positive Action Strategy approved by Equality & Inclusion Steering Group; Equality Analysis proforma and guidance, updated in line with Equality Act 2010; training on Equality Act 2010 and disability equality commissioned - to be rolled out from October 2011. Some actions in Equality & Inclusion Strategy Action Plan delayed to await outcome of Public Sector Duty and Specific Regulations.

APRIL TO JULY 2011

	Apr 2011		May 2011		Jun 2011		Jul 2011		
Value for taxpayers	Target	Actual	Target	Actual	Target	Actual	Target	Actual	**Commentary**
CO8. Facilities (EBITDA)									
C8.1.3 Estates capital spend as % of plan	2		3		15		28		Information not provided
C8.1.4 % completion of Estates strategy objectives completed	95		95		95		95		Information not provided
C8.7.1 CAD core system availability *(CommandPoint Measure)	99.8	100.0	99.8	100.0	99.8	100.0	99.8	100.0	
C8.7.2 Target availability CAD environment as a whole	99.00	99.57	99.00	99.23	99.00	99.40	99.00	98.75	
CO8. Financial (EBITDA)									
C8.2.11 Liquidity Ratio	15	7	15	7	15	4	15		
C8.2.12 Net Surplus/(Deficit) - after Impairments	1	1	1	1	1	1	1		
C8.2.13 Return on Assets (RoA)	6	8	6	7	6	6	6		
C8.2.14 To process at least 95% of bills by value within 30 days	95	89	95	89	95	89	95		
C8.2.15 To process at least 95% of bills by volume within 30 days	95	85	95	85	95	85	95		
C8.2.3 Capital Resource Limit (CRL)	10	9	10	9	10	9	10		
C8.2.4 Control Surplus/ (Deficit)	2713	2718	2713	2493	2713	2412	2713		
C8.2.5 Cumulative Net surplus	551	776	526	776	503	105	324		
C8.2.6 EBITDA %	8	8	8	8	8	6	8		
C8.2.7 External Financing Limit (EFL)									Information not available
C8.4.1 100% completion of carbon reduction management plan by 31 March 2012		0		0	10	10	20		CMc 08/07/11: internal launch of the CT NHS Carbon Mgt Programme was held on 6th June, faciliated by Carbon Trust representative and attended by the majority of the Project Board & Project team. The carbon management plan has been drafted and will be shared with the Project Board & team prior to submission to the Carbon Trust. In addition work is also being undertaken in respect of the Carbon Management Strategy baseline for submission end of July 2011.
CO8. More efficient use of fleet									
C8.3.1 % AEU fleet available to operations	88	96	88	96	88		88		22/11/2011 RH Continue to achieve milestone
CO8. Reduction in the cost base									
C8.5.1 CIP forecast vs plan - year end target is 18m	15	14800	15	14089	15	16	15		
C8.5.2 YTD CIP Achieved (000's)	1129	834	1129	1102	1129	0	1246		
C8.6.4 PTS Profitability	31		60		89		118		
CO9. Trust performance maintained during major events									
C9.1.1 No decrease in CAT A (8 minute) response times during planned major events	75	76	75	76	75	74	75	77	
C9.2.1 No decrease in CAT A (8 minute) response times during unplanned major incidents	65	76	65	76	65	74	65	77	
C9.3.1 No decrease in CAT A (8 minute) response times during the Olympics &	75	76	75	76	75	74	75	77	

APRIL TO JULY 2011

	Apr 2011		May 2011		Jun 2011		Jul 2011		
CQUINS	Target	Actual	Target	Actual	Target	Actual	Target	Actual	**Commentary**
CO2 - CQUIN-01 - Reducing conveyance rate to A/E services									
C2.3.1 % of patients not conveyed to an ED	73.7	73.5	73.4	73.4	73.1	71.8	72.7		Reduction on May's figure by 1.6%. The majority of this from an increase in referrals to ACPs and an increase in 'other' call type (cancellations, no trace, gone before arrival, multiple sends)
CO2 - CQUIN-2A - Hear & Treat resolution (no convey) via CTA &									
C2.4.1 The number of incidents resolved through CTA	755	1187	755	1463	755	2016	780		DoH Returns not available for July
C2.4.2 The number of incidents resolved through NHSD	4278	4748	4278	4325	4278	4305	4420		DoH Returns not available for July
C2.4.3 The number of incidents resolved through % Vehicles Saved	5033	6211	5033	5788	5033	6321	5200		DoH Returns not available for July
CO2 - CQUIN-2B - Implementation of NHS Pathways in CTA									
C2.5.1 Formal LAS sign-off & Commitment to implement NHSPathways by April 2011									Draft reports developed which identify breakdown of hear and treat call resolution, volumes of calls to CTA and onwards to NHSD, looks at workload for A&E support by call category. Trajectory completed and well on target to achieve required
C2.5.2 Action Plan to achieve NHS Pathways in CTA and ambulance dispatch by May									
C2.5.3 Live call receiving from NHS Pathways (111 pilots) to enable immediate ambulance									
C2.5.4 CTA implemented NHS Pathways triage tool (PSIAM phased out) by Feb 2012									
C2.5.5 LAS enabled to search & use the DOS by Feb 2012									
C2.5.6 Agreement to move to NHS Pathways to replace AMPDS by April 2013									
CO2 - CQUIN-3 - CPI non-conveyed									
C2.6.1 Completion of non-conveyed CPI	85	85	85	89	85	82	85		Failed to meet target but due to being at REAP 3+ during June this negated this part of the CQUIN
C2.6.2 Compliance to care for non-conveyed patients	94	90	94	94	94	93	95		Decreased by 1% from last month
CO2 - CQUIN-4 - Falls & Older People referrals to GP									
C2.7.1 Number of of falls referred to GP	378	125	378	389	378	583	662		
CO2 - CQUIN-5A - End of Life Care Pathways									
C2.8.1 EOLC patients held on LAS systems - Number of EOL plans held					0				Without CommandPoint - unable to create an 'EOLC' flag, also issues identifying EOLC lists - NHSL currently tendering for bespoke pan-London system; also engaging with initial 111 pilots (Hillingdon, LCW & ONEL, but with limited success)

APRIL TO JULY 2011

	Apr 2011		May 2011		Jun 2011		Jul 2011		
CQUINS	Target	Actual	Target	Actual	Target	Actual	Target	Actual	**Commentary**
CO2 - CQUIN-5B - End of Life Care Pathways									
C2.8.2 EOLC patients held on LAS systems - Number of incidents where specific feedback from crews/control on application of EOLC agreed pathway									Information not available
CO2 - CQUIN-6A - Mental Health Pathways									
C2.9.1 Mental Health service improvement plan, including outcome of MH review									Information not available
CO2 - CQUIN-6B - Mental Health Pathways									
C2.9.2 Development of Mental Health protocols for direct access to MH crisis teams									Information not available
CO2 - CQUIN-7A - Whole system clinical issue resolution									
C2.10.1 Establish effective whole system clinical group									Information not available
CO2 - CQUIN-7B - Whole system clinical issue resolution									
C2.10.2 Whole system clinical incident reporting & resolution									Information not available

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

M04 July

PAPER FOR REVIEW

Document Title:	**M04 July - Financial Review**
Report Author(s):	Andy Bell
Lead Director:	Mike Dinan
Contact Details:	Michael.Dinan@lond-amb.nhs.uk
Why is this coming to the Trust Board?	Monthly Trust Financial Review
This paper has been previously presented to:	Senior Management Group
Recommendation for the Trust Board:	• The committee is asked to comment on the information included within the month 4 report and the actions being taken to safeguard the trusts' position against plan. • The committee is asked to approve the three fully mitigated financial risks being removed from the financial risk register.

Executive Summary/key issues for the Trust Board

The LAS made a surplus of £425k for the month. This compared to a loss of £671k for m3 and a forecast surplus of £123k for the month.
YTD the trust is reporting a £530k surplus against a plan surplus of £1,856k. A Financial Recovery Plan has been developed which incorporates the existing CIP to deliver the required annual surplus of £2.7m.
Forecast EBITDA is £2.5m below budget at 7.2% of income or £20.3m. This compares to £17.2m for 2010/11.
The CIP is £496k behind the ytd plan. Specific actions are being taken by SMG to recover the postion by year end
The Department of Health has set the CRL for 2011/12 at £9,112k. The Trust is planning to fully utilise the allocated capital funding. The YTD position is a favourable variance of £319k due to Fleet Projects being ahead of plan.
The Year end cash position is forecast to be £5.3m. The YTD position is an unfavourable of £3.4m against plan. The unfavourable variance is due to CBRN income only received in Month 5 offsetting against advance receipt of HART Income.

LONDON AMBULANCE SERVICE NHS TRUST
MONTH 4 FINANCE & CONTRACTUAL PERFORMANCE REPORT
PERIOD ENDING 31st JULY 2011

Result

The LAS made a surplus of £425k for the month. This compared to a loss of £671k for m3 and a forecast surplus of £123k for the month.

Ytd, the surplus is £530k compared to budget of £1,856k.

The forecast for the year is a surplus of £2,736. This is in line with the budgeted control total.

Forecast EBITDA is £2.5m below budget at 7.2% of income or £20.3m. This compares to £17.2m for 2010/11.

- Income shortfalls in A&E penalty, RTA and PTS are the primary drivers
- Non pay gains offset an overspend in pay

YTD CIP is £496k behind plan but expected to be delivered by year end.

The Department of Health has set the CRL for 2011/12 at £9,112k. The Trust is planning to fully utilise the allocated capital funding. The YTD position is a favourable variance of £319k due to Fleet Projects being ahead of plan.

Income

For the month, overall income was £23,479k. This was £419k up on m3 and £48k up on budget.

- Q1 income impacted by application of £800k penalty for 2010/11 (£267k per month)
- Ytd income also reduced by £74k per month for a reduction in expected RTA income

Ytd, total income is down £1,139k vs budget.

- Impact of A&E penalty (£800k) and RTA Income (£298k)
- PTS income down £307k vs budget

For 2011/12, the forecast income is £280,500k which is £2,518k below budget

- 2010/11 penalty £803k
- RTA £895k
- PTS £1,008k
- Run rate of £23m per month is expected is be reasonably consistent
- No additional income forecast at this stage for August unrest in London
- No penalties forecast for A&E income

Expense

For the month, total operating expense was £21,729k (m3 £22,390k) and total expense was £23,054k (m3 £23,732k).

- Payroll expense was down £284k due to reduced agency expense (£130k) and reduced other overtime (£57k)
- Agency expense fell by £130k. Correcting for an overaccrual in m3, the actual cost was £200k in the month.
- Overtime was £256k above forecast due a higher level of abstractions

Ytd, total operating expense was £600k above budget and total expense was £196k above budget.

- Pay cost is £1,289k over budget but £988 below the same period in 2010/11.
- Increased overtime spend of £1,289k over budget
- Non pay is £688k below budget and £469k below 2010/11 where both the specific CIP activity and general cost controls are delivering sustained reductions.
- Depreciation is £415k below budget due to slippage in the capital plan.
- Average monthly operating expense is £21,675k and total expense £23,013k

For 2011/12, the forecast total operating expense is £260,196k which is in line with budget and £6,261k below 2010/11.

- Forecast average payroll expense is £17m per month for the remaining 8 months of 2011/12. This is line with the current run rate.
- Overtime spend has been re-profiled in line with the updated workforce plan.
- Forecast total payroll expense is £6,284k below payroll cost for 2010/11.
- Non Pay expense is forecast to be £1,149k below budget and adjusting for income provisions £1m below 2010/11
- Forecast monthly average non pay cost of £4.8m for rest of the year is in line with the current run rate (£4.5m) and the CIP.

Depreciation, Dividend & Interest expense is forecast to be £2.6m below budget and £1.4 higher than 2010/11.

- Depreciation is forecast to be £415 k below budget for 4 months due to the delay in implementing CommandPoint
- Slippage in the rest of the capital plan (Estates and Fleet) are also included in the forecast.

Cost Improvement Programme (CIP)

- At the end of Month 4 there is a shortfall against plan of £496k but, by taking the corrective action identified in the CIP report, the forecast for the year-end will be achieved.
- Director of Finance is conducting a CIP review of all projects.

Capital

The actual forecast capital spend for 2011/12 is estimated to be £8.4m against a Capital budget of £9.1m. There is an overall slippage against plan of £0.7m

- The capital plan also provides for income from the sale of Park Royal in September.

Balance Sheet & Cashflow

Cashflow remains strong with m4 closing cash balance of £4.7m.

Average capital employed was £113m.

Financial Risk

The Trust's financial risk has reduced from last month from £10.3m in Month 3 to £9.5m in Month 4 this is due to:

- A £771k reduction in CBRN Income risk as all income has now been receipted.
- A £200k reduction in PTS profitability risk due to securing a new contract.
- This has been offset by an £500k increase in A&E Operational risk related to forecast overtime usage.

London Ambulance Service NHS
NHS Trust

Trust Board - Financial Review

Month Ending 31st July 2011 - (Month 4)

Report Contents

LAS Financial Review - Financial Snapshot

APPENDIX 1

Month Ending 31st July 2011 - (Month 4)

NHS Trust Statutory Financial Duties	Forecast	Direction of Travel	Commentary
Income & Expenditure against plan	↓	←	Assessment based on achievement of the financial plan for the year
External Financing Limit (EFL)	↔	→	Assessment based on achievement of the financial plan for the year
Capital Resource Limit (CRL)	↓	←	Assessment based on achievement of the financial plan for the year
Return on Assets	↔	→	Assessment based on achievement of the financial plan for the year
CIP	↓	←	The Trust is expected to deliver a CIP of £15.9m for the year. At month 4 the trust is behind plan.

NHS Financial Performance Framework	Forecast Score	Status	Direction of Travel	Commentary
Initial Planning (Planned I&E Surplus Margin)	3	G	→	The planned I&E surplus is in line with SHA expectations
Year to Date Performance (YTD I&E Surplus Margin)	3	G	→	Year to date Operating Surplus is at variance to plan less than 3% of Income (1.4%)
Forecast Outturn Performance (Forecast I&E Surplus Margin)	3	G	→	Forecast surplus with variance from plan of less than 3% of Forecast Income (0.001%)
Underlying Financial Position (Underlying I&E Surplus Margin)	3	G	→	Underlying breakeven or surplus position
Better Payment Practice Code (95% bills paid within 30 days)	2	A	→	Bills paid within 30 days for the year to date to 80% of NHS suppliers and 89% non NHS suppliers
Balance Sheet Efficiency (Liquidity)	2	A	→	Current assets (stocks, debtors and cash) over current liabilities (amount owing < one year) less than 1 but greater than 0.5
LAS Trust Management Costs (% of Total LAS Income (Excl. MPET))	N/A	G	→	Management costs (excluding MPET) is 6.73% of Income
Overall	3	G	→	**Trust is rated as Performing**

Monitor Financial Risk Rating	Forecast Score	Status	Direction of Travel	Commentary
Achievement of plan (EBITDA achieved compared to plan)	3	A	→	Better than 70% achievement against planned EBITDA margin
Underlying Performance (EBITDA margin)	3	A	→	The EBITDA margin required is 5% for 3 and 9% for 4 (current forecast is 7.2%)
Financial Efficiency (Return on assets and I&E margin)	4	G	→	Return on Assets is forecast at 6.6% and I&E surplus margin is forecast at 1%
Liquidity (Liquid assets / operating expenditure)	3	A	→	Liquid asset cover less than15 days, assumes 30 day working facility
Overall	4	G	→	**The Trust is targeting score of 4 for 2011/12**

Income and Expenditure

The year to date I&E position is a surplus of £530k, behind plan by £1.3m due to overspend on A&E Overtime and reduction in RTA and PTS Income. Recovery plan has been devised to ensure the Trust remains on track financially for the rest of the year.

Capital

The Trust is forecasting to meet its Capital Resource Limit (CRL) for the year.

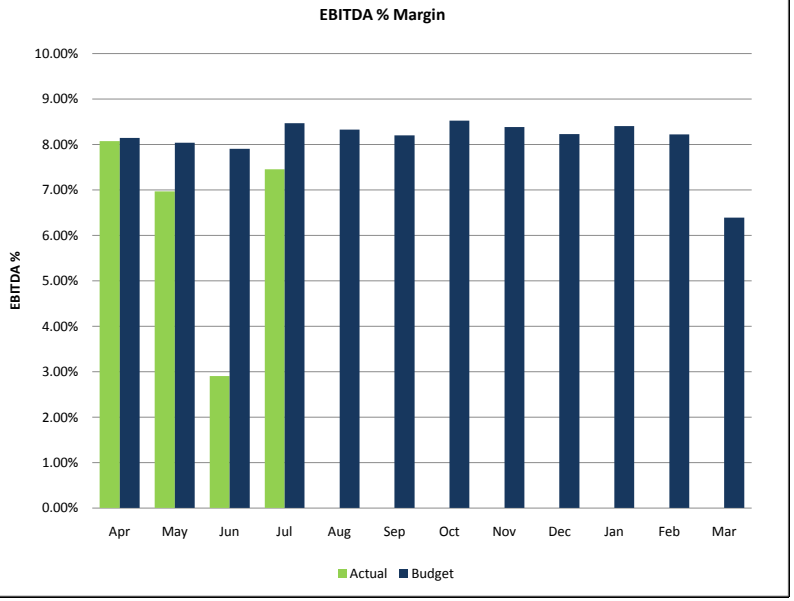
Cash

The Trust is forecasting to meet the External Financing Limit (EFL) for the year.

Financial Risk Rating

Monitor Financial Risk Rating forecast is for performance equivalent to a rating of 4. Monitor assesses financial risk on a scale from 1 (high risk) to 5 (low risk).

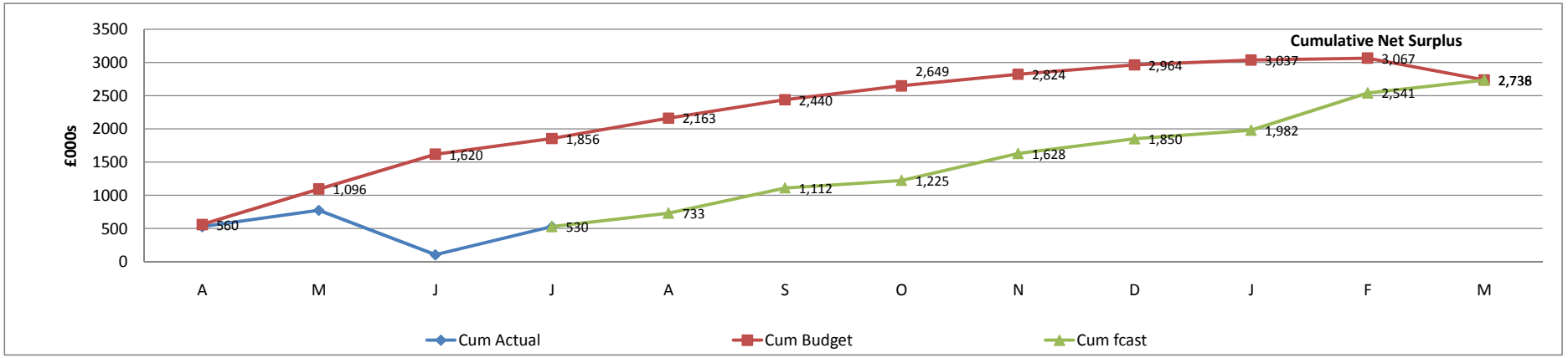
Income & Expenditure	Current Month			Year to Date			Annual	
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget
	£000	£000	£000	£000	£000	£000	£000	£000
Income								
A&E	(20,852)	(20,853)	(1)	(82,610)	(83,413)	(803)	(251,285)	(252,088)
HART/CBRN	(1,255)	(1,234)	21	(4,955)	(4,934)	21	(14,824)	(14,803)
Olympics	(114)	(114)	0	(455)	(455)	0	(1,365)	(1,365)
PTS	(516)	(568)	(52)	(1,964)	(2,272)	(307)	(5,807)	(6,815)
Other	(742)	(662)	80	(2,599)	(2,649)	(50)	(7,219)	(7,947)
Total Income	**(23,479)**	**(23,431)**	**48**	**(92,583)**	**(93,723)**	**(1,139)**	**(280,500)**	**(283,018)**
Pay Expenditure								
Frontline	10,584	10,762	179	42,632	43,318	686	128,286	131,821
Other	5,237	5,583	346	20,964	21,923	959	62,807	65,539
Overtime	1,198	515	(683)	4,246	2,152	(2,095)	10,970	5,337
Agency	174	19	(155)	936	96	(840)	2,105	250
Total Pay	**17,193**	**16,880**	**(313)**	**68,778**	**67,489**	**(1,289)**	**204,168**	**202,947**
Medical Consumables	491	498	7	1,948	1,991	43	5,878	5,973
Vehicle	1,045	891	(154)	4,405	3,564	(841)	12,397	10,691
Fuel & Oil	550	496	(55)	2,022	1,983	(40)	5,916	5,949
Accommodation and Estates	1,009	1,079	70	4,014	4,399	386	12,549	12,880
Other	1,441	1,603	162	5,531	6,671	1,140	19,288	21,684
Finance Costs	383	556	173	1,523	1,804	281	4,488	5,412
Depreciation	943	1,192	249	3,833	3,966	133	13,081	14,744
Total Non Pay	**5,862**	**6,315**	**454**	**23,276**	**24,379**	**1,103**	**73,596**	**77,333**
Total Expenditure	**23,054**	**23,195**	**141**	**92,054**	**91,867**	**(187)**	**277,764**	**280,280**
EBITDA	**(1,750)**	**(1,984)**	**(234)**	**(5,886)**	**(7,626)**	**(1,741)**	**(20,305)**	**(22,894)**
Surplus / (Deficit)	**(425)**	**(236)**	**189**	**(530)**	**(1,856)**	**(1,326)**	**(2,736)**	**(2,738)**



LAS Financial Review - Financial Summary

APPENDIX 2

Month Ending 31st July 2011 - (Month 4)



	Month Act	Month Budget	Month Variance	%	Ytd Act	Ytd Budget	Diff	%	Ytd 1011	Diff	%	2011/12 Fcast	2011/12 Budget	Diff	%
	£000	£000			£000	£000	£000		£000	£000		£000	£000	£000	
Income															
A&E	21,536	21,671	(135)	-0.6%	85,487	86,684	(1,197)	-1.4%	85,766	(279)	-0.3%	260,107	261,901	(1,794)	-0.7%
Other	1,943	1,760	183	10.4%	7,097	7,039	58	0.8%	9,354	(2,257)	-24.1%	20,394	21,117	(724)	-3.4%
Total	23,479	23,431	48	0.2%	92,583	93,723	(1,139)	-8325.0%	95,119	(2,536)	-2.7%	280,500	283,018	(2,518)	-0.9%
Operating Expense															
Pay	17,193	16,880	313	1.9%	68,778	67,489	(1,289)	1.9%	69,766	(988)	-1.4%	204,168	202,947	1,221	0.6%
Non Pay	4,536	4,567	(31)	-0.7%	17,920	18,608	688	-3.7%	18,389	(469)	-2.6%	56,028	57,177	(1,149)	-2.0%
Total	21,729	21,447	282	1.3%	86,698	86,097	(601)	-14424.1%	88,155	(1,457)	-1.7%	260,196	260,124	72	0.0%
EBITDA	1,750	1,984	(234)	-11.8%	5,886	7,626	(1,741)	-538.1%	6,964	(1,079)	-15.5%	20,305	22,894	(2,589)	-11.3%
EBITDA %	7.5%	8.5%	-486.1%	-12.0%	6.4%	8.1%	-2%	-557.2%	7.3%	-1.0%	-13.2%	7.2%	8.1%	-0.9%	-10.5%
Depreciation, Dividend & Interest	1,325	1,748	(423)	-24.2%	5,356	5,771	(415)	-7.2%	5,455	(99)	-1.8%	17,569	20,156	(2,588)	-12.8%
Net Surplus/(Deficit)	425	236	189	80.1%	530	1,856	(1,326)	-239.9%	1,510	- 980	-13.7%	2,736	2,738	- 2	-0.1%
Net Margin	1.8%	1.0%	392.2%	79.7%	0.6%	2.0%	-1.4%	-240.6%	1.6%	-1.0%	-13.2%	1.0%	1.0%	0.0%	0.8%
Impairments	0	0	0	#DIV/0!	0	0	0	#DIV/0!	0	0	#DIV/0!	0	0	0	#DIV/0!
Net Surplus after Impairment	425	236	189	80.1%	530	1,856	(1,326)	-239.9%	1,510	- 980	#DIV/0!	2,736	2,738	- 2	-0.1%
Income															
Non Current Assets					144,887	143,882	1,005	0.7%	140,717	4,170	3.0%	141,611	143,882	(2,271)	-1.6%
Cash					4,720	8,152	(3,432)	-42.1%	4,209	511	12.1%	5,250	5,250	0	0.0%
Working Capital					(8,964)	(5,383)	(3,581)	66.5%	5,529	(14,493)	-262.1%	(11,765)	(5,383)	(6,382)	118.6%
Non Current Liabilities					(27,493)	(28,403)	910	-3.2%	(41,811)	14,318	-34.2%	(19,740)	(28,403)	8,663	-30.5%
Capital Employed					113,150	118,248	(5,098)	-4%	108,644	4,506	4.1%	115,356	115,346	10	0%
Average Capital Employed					113,150	118,248	(5,098)	-4.3%	108,486	4,665	4.3%	115,356	118,248	(2,892)	-2.4%
Return on Assets												6.59%	6.51%	0.1%	1.3%

LAS Financial Review - Income & Expense Trend

APPENDIX 3

Month Ending 31st July 2011 - (Month 4)

	Apr-10 Actual	May-10 Actual	Jun-10 Actual	Jul-10 Actual	Aug-10 Fcast	Sep-10 Fcast	Oct-10 Fcast	Nov-10 Fcast	Dec-10 Fcast	Jan-11 Fcast	Feb-11 Fcast	Mar-11 Fcast	2011/2012 Fcast	2011/2012 Budget	Diff	%
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	
Income	**(23,354)**	**(22,690)**	**(23,060)**	**(23,479)**	**(23,329)**	**(23,323)**	**(23,241)**	**(23,251)**	**(23,217)**	**(23,217)**	**(23,237)**	**(25,102)**	**(280,500)**	**(283,018)**	**2,518**	**-0.9%**
Payroll (£k)																
A&E Frontline	10,733	10,675	10,640	10,584	10,584	10,647	10,725	10,763	10,748	10,733	10,726	10,729	128,286	131,821	(3,535)	-2.7%
A&E Overtime	857	648	1,075	1,062	1,006	748	857	562	777	661	257	1,216	9,727	4,957	4,769	96.2%
A&E Management	1,240	1,257	1,205	1,204	1,217	1,224	1,234	1,234	1,235	1,231	1,231	1,231	14,743	14,078	664	4.7%
EOC	975	977	959	947	936	929	939	932	925	917	910	903	11,249	12,053	(805)	-6.7%
Operational Support	288	296	311	315	317	317	317	317	317	317	317	317	3,745	4,210	(464)	-11.0%
PTS	390	388	388	381	382	380	300	299	295	291	291	290	4,073	4,611	(538)	-11.7%
Corporate Support	2,286	2,369	2,399	2,390	2,397	2,416	2,458	2,462	2,446	2,458	2,464	2,453	28,997	30,586	(1,588)	-5.2%
Other Overtime	130	146	193	136	155	139	64	64	54	54	54	54	1,243	380	863	227.2%
Agency	217	237	308	174	205	173	139	139	127	127	125	132	2,105	250	1,855	741.9%
Total	**17,115**	**16,993**	**17,477**	**17,193**	**17,198**	**16,974**	**17,032**	**16,772**	**16,924**	**16,790**	**16,374**	**17,326**	**204,168**	**202,947**	**1,221**	**0.6%**
Non Pay																
Staff Related	441	630	578	546	538	557	564	456	461	454	486	477	6,188	6,236	(48)	-0.8%
Consumables, Medical Equip & Drugs	479	430	548	491	475	498	498	498	498	485	485	493	5,878	5,973	(95)	-1.6%
Vehicle Leasing	123	253	328	241	236	236	236	236	236	236	236	236	2,836	1,459	1,376	94.3%
Fuel & Oil	504	492	476	550	496	491	484	484	484	484	484	484	5,916	5,949	(32)	-0.5%
Vehicle Maintenance	619	647	702	783	630	630	630	629	626	626	626	626	7,775	7,609	167	2.2%
Other Automotive	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	#DIV/0!
Vehicle Insurance	179	138	370	22	135	135	135	135	135	135	135	135	1,786	1,623	163	10.1%
3rd Party Transport	42	70	61	98	42	42	34	29	29	29	29	29	533	585	(52)	-8.9%
Accommodation & Estates	1,080	913	1,011	1,009	1,053	1,053	1,061	1,073	1,073	1,070	1,070	1,082	12,549	12,880	(331)	-2.6%
IT & Telecoms	564	628	609	530	680	671	660	671	668	669	679	672	7,701	7,968	(266)	-3.3%
Finance & Legal	152	(270)	(10)	87	113	118	81	143	123	163	144	1,454	2,300	4,264	(1,963)	-46.0%
Consultancy	58	69	86	41	52	52	52	52	62	52	34	4	614	614	(0)	-0.1%
Other	112	115	153	139	158	167	171	179	191	189	192	185	1,952	2,018	(66)	-3.3%
Subtotal	**4,354**	**4,116**	**4,913**	**4,536**	**4,608**	**4,650**	**4,606**	**4,585**	**4,586**	**4,593**	**4,601**	**5,878**	**56,028**	**57,177**	**(1,149)**	**-2.0%**
Depreciation																
Fleet	476	477	0	0	0	0	0	0	0	0	0	0	952	0	952	#DIV/0!
IT	140	140	0	0	0	0	0	0	0	0	0	0	280	0	280	#DIV/0!
Other	347	348	963	943	946	946	1,117	1,117	1,117	1,335	1,335	1,335	11,848	14,744	(2,896)	-19.6%
Subtotal	**962**	**965**	**963**	**943**	**946**	**946**	**1,117**	**1,117**	**1,117**	**1,335**	**1,335**	**1,335**	**13,081**	**14,744**	**(1,663)**	**-11.3%**
Financial																
Dividend	319	319	319	319	319	319	319	319	319	319	319	319	3,832	3,832	0	0.0%
Interest	72	51	59	63	55	54	54	54	48	49	48	48	656	1,580	(925)	-58.5%
Subtotal	**392**	**370**	**378**	**383**	**374**	**374**	**373**	**374**	**368**	**368**	**367**	**367**	**4,488**	**5,412**	**(925)**	**-17.1%**
Total Expense	**22,823**	**22,445**	**23,732**	**23,054**	**23,126**	**22,943**	**23,129**	**22,848**	**22,995**	**23,086**	**22,677**	**24,907**	**277,764**	**280,280**	**(2,516)**	**-0.9%**
Net Surplus	**(531)**	**(245)**	**671**	**(425)**	**(203)**	**(380)**	**(113)**	**(404)**	**(222)**	**(131)**	**(559)**	**(195)**	**(2,736)**	**(2,738)**	**2**	**(0)**
Cumulative Surplus	**(531)**	**(776)**	**(105)**	**(530)**	**(733)**	**(1,112)**	**(1,225)**	**(1,628)**	**(1,850)**	**(1,982)**	**(2,541)**	**(2,736)**	**(2,736)**	**(2,738)**		

LAS Financial Review - Worst Case Scenario

APPENDIX 4

Month Ending 31st July 2011 - (Month 4)

	2011/2012 Base Case Fcast	2011/2012 Worst Case Fcast	Diff	%	2011/2012 Budget
	£000	£000	£000		£000
Income	**(280,500)**	**(274,170)**	**6,330**	**-2.3%**	**(283,018)**
Payroll (£k)					
A&E Frontline	128,286	128,286	0	0.0%	131,821
A&E Overtime	9,727	11,138	1,411	14.5%	4,957
A&E Management	14,743	14,743	0	0.0%	14,078
EOC	11,249	11,249	0	0.0%	12,053
Operational Support	3,745	3,745	0	0.0%	4,210
PTS	4,073	4,073	0	0.0%	4,611
Corporate Support	28,997	28,997	0	0.0%	30,586
Other Overtime	1,243	1,243	0	0.0%	380
Agency	2,105	2,105	0	0.0%	250
Total	**204,168**	**205,579**	**1,411**	**0.7%**	**202,947**
Non Pay					
Staff Related	6,188	6,188	0	0.0%	6,236
Consumables, Medical Equip & Drugs	5,878	5,878	0	0.0%	5,973
Vehicle Leasing	2,836	3,079	243	8.6%	1,459
Fuel & Oil	5,916	5,916	0	0.0%	5,949
Vehicle Maintenance	7,775	7,775	0	0.0%	7,609
Other Automotive	0	0	0	#DIV/0!	0
Vehicle Insurance	1,786	1,786	0	0.0%	1,623
3rd Party Transport	533	533	0	0.0%	585
Accommodation & Estates	12,549	12,549	0	0.0%	12,880
IT & Telecoms	7,701	7,701	0	0.0%	7,968
Finance & Legal	2,300	2,300	0	0.0%	4,264
Consultancy	614	614	0	0.0%	614
Other	1,952	3,436	1,484	76.0%	2,018
Subtotal	**56,028**	**57,755**	**1,727**	**3.0%**	**57,177**
Depreciation					
Fleet	952	952	0	0.0%	0
IT	280	280	0	0.0%	0
Other	11,848	11,848	0	0.0%	14,744
Subtotal	**13,081**	**13,081**	**0**	**0.0%**	**14,744**
Financial					
Dividend	3,832	3,832	0	0.0%	3,832
Interest	656	656	0	0.0%	1,580
Subtotal	**4,488**	**4,488**	**0**	**0.0%**	**5,412**
Total Expense	**277,764**	**280,903**	**3,138**	**1.1%**	**280,280**
Net Surplus/ (Deficit)	**(2,736)**	**6,732**	**9,468**	**(0)**	**(2,738)**
Cumulative Surplus	**(2,736)**	**6,732**			**(2,738)**

LAS Financial Review - CIP Summary

APPENDIX 5

Month Ending 31st July 2011 - (Month 4)

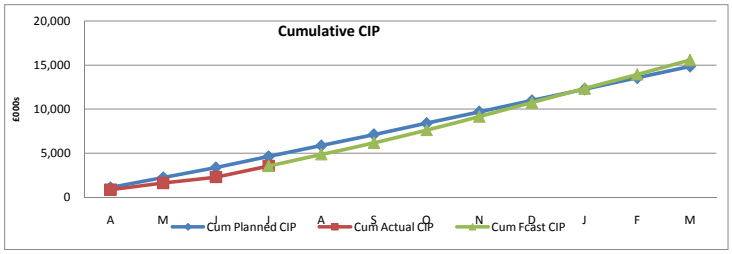
Key CIP Programs	Performance Ytd Position				Forecast 2011/12				Status	
	Act £000	Plan £000	Diff £000	%	Fcast £000	Plan £000	Diff £000	%	Current	Forecast
Front Line staffing - Process Management	2,014	1,729	285	116.5%	6,881	5,187	1,694	132.7%	↑	↑
Front Line staffing - Resource Management	164	89	75	184.8%	800	800	0	100.0%	↔	↔
Fleet optimisation	101	28	73	361.1%	263	251	12	104.8%	↔	↔
Support Services - Pay	206	206	0	100.2%	617	617	(0)	100.0%	↔	↔
Support Services - Agency	365	794	(429)	46.0%	1,395	2,381	(986)	58.6%	↓	↓
Support Services - Non Pay	872	990	(118)	88.1%	2,816	2,970	(154)	94.8%	↓	↓
Support Services - IM&T	279	298	(20)	93.4%	865	895	(30)	96.7%	↔	↔
PTS	(4)	6	(10)	-62.1%	668	268	400	249.0%	↔	↑
Subtotal	**3,997**	**4,139**	**(143)**	**96.6%**	**14,306**	**13,369**	**937**	**107.0%**	↓	↑
Unidentified	126	480	(354)	26.3%	1,302	1,439	(137)	90.5%	↓	↓
Other - Annual Leave Policy	11	11	0	100.0%	32	32	(0)	99.2%	↔	↔
Total	**4,133**	**4,630**	**(496)**	**89.3%**	**15,640**	**14,840**	**800**	**105.4%**	↓	↑

KEY:

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

Front Line Staffing - Process Management :
- CIP identified in this line only include the reduction of Frontline posts by 132wte. It does not include overspend on Overtime and over establishment of A&E Management.

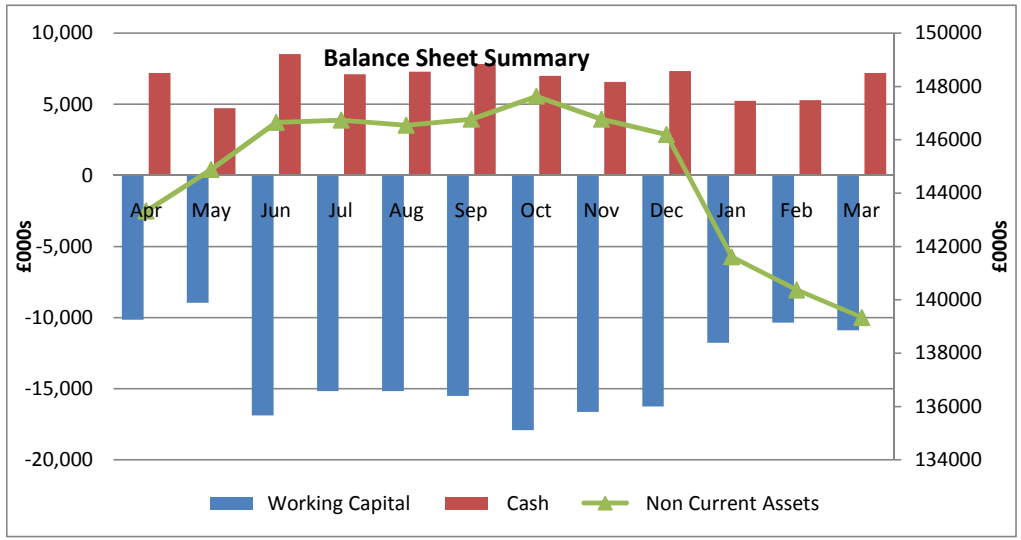
Other :
- Included in Other is £800k further CIP to be identified relating to Year-End Agreement with PCT (amounting to £533k in M02). This is expected to be achieved in Month 12 through amendments in annual leave policy.
- Also included £1.7m of unidentified CIP.

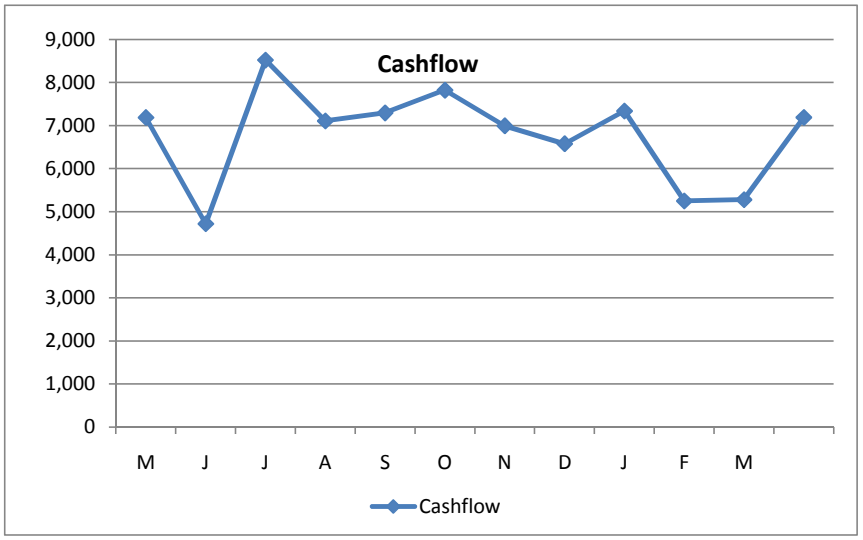


LAS Financial Review - Balance Sheet & Cashflow

APPENDIX 6

Month Ending 31st July 2011 - (Month 4)





Trade Debtors	A&E £1329k > 60 days (61.14%), May £185k > 60 days (9.03%)
	PTS £421k > 60 days (19.39%), May £311k > 60 days (15.16%)
Trade Creditors	NHS PSPP - This month (94%), June (66%), Ytd (80%)
	Non NHS PSPP - This month (92%), June (88%), Ytd (89%)

Key Balance Sheet Items				
	Current		**Year End**	
	£000s		**£000s**	
Cash	4,720		5,250	
Working Capital	(8,964)		(11,765)	

	Jun-11 £'000s Actual	Jul-11 £'000s Actual	Aug-11 £'000s Fcast	Sep-11 £'000s Fcast	Oct-11 £'000s Fcast	Nov-11 £'000s Fcast	Dec-11 £'000s Fcast	Jan-12 £'000s Fcast	Feb-12 £'000s Fcast	Mar-12 £'000s Fcast	Apr-12 £'000s Fcast	May-12 £'000s Fcast	Jun-12 £'000s Fcast
Non-Current Assets	143,330	144,887	146,654	146,738	146,545	146,773	147,627	146,767	146,192	141,611	140,374	139,338	140,486
Current Assets	25,444	31,334	24,920	21,855	21,136	20,661	17,451	16,434	16,799	19,294	19,385	21,294	20,378
Total Assets	**168,774**	**176,221**	**171,574**	**168,593**	**167,681**	**167,434**	**165,078**	**163,201**	**162,991**	**160,905**	**159,759**	**160,632**	**160,864**
Current Liabilities	(28,407)	(35,578)	(33,284)	(29,915)	(29,003)	(28,344)	(28,371)	(26,476)	(25,699)	(25,809)	(24,465)	(25,004)	(27,410)
Net Current Assets/(Liabilities)	**(2,963)**	**(4,244)**	**(8,364)**	**(8,060)**	**(7,867)**	**(7,683)**	**(10,920)**	**(10,042)**	**(8,900)**	**(6,515)**	**(5,080)**	**(3,710)**	**(7,032)**
Total Assets less Current Liabilities	**140,367**	**140,643**	**138,290**	**138,678**	**138,678**	**139,090**	**136,707**	**136,725**	**137,292**	**135,096**	**135,294**	**135,628**	**133,454**
Total Non-Current Liabilities	27,642	27,493	24,937	24,945	24,832	24,840	22,235	22,122	22,130	19,740	19,660	19,716	17,264
Total Assets Employed	**112,725**	**113,150**	**113,353**	**113,733**	**113,846**	**114,250**	**114,472**	**114,603**	**115,162**	**115,356**	**115,634**	**115,912**	**116,190**
Total Taxpayers' Equity	**112,725**	**113,150**	**113,353**	**113,733**	**113,846**	**114,250**	**114,472**	**114,603**	**115,162**	**115,356**	**115,634**	**115,912**	**116,190**
Cashflow	**7,186**	**4,720**	**8,522**	**7,108**	**7,297**	**7,821**	**6,994**	**6,577**	**7,340**	**5,250**	**5,279**	**7,188**	**8,209**

LAS Financial Review - Capital Summary

APPENDIX 7

Month Ending 31st July 2011 - (Month 4)

Projects	Ytd Position Month 4				Capital plan 2011/12				Status	
	Act £000	Plan £000	Diff £000	%	Act £000	Plan £000	Diff £000	%	2011/12	Project
Capital programme - Information Technology	1,485	2,565	1,080	0%	3,734	3,845	111	3%	↔	↓
Capital programme - Estates	393	427	34	0%	911	1,500	589	39%	↓	↓
Capital programme - Fleet	2,890	1,391	(1,499)	0%	7,739	8,265	526	6%	↓	↔
Capital programme - Equipment ***	0	0	0	0%	986	0	(986)	0%	↑	↔
Capital programme - Disposals NBV	(6,678)	(6,738)	(60)	0%	(7,328)	(6,738)	589	0%	↓	↔
Capital programme - Unallocated funds	0	764	764	0%	2,374	2,240	(134)	-6%	↔	↔
Total	(1,910)	(1,591)	319	-20%	8,417	9,112	695	8%	↓	↓

KEY:

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

Capital Plan M4

> The Trust is negotiating with the auditors the accounting treatment of Sale and lease back of ambulances with Singer Healthcare Finance Ltd. The Trust is hoping that the new lease will be treated as an operating lease.

> There is a new Capital project for 80 defibrillators, it will be funded from the under spend due to capital project slippage. To be reviewed by Finance Investment Committee in September. ***

> The Trust has exchanged contracts for the Sale of Park Royal and completion is scheduled for 21st September 2011.

LAS Financial Review - Income Summary

APPENDIX 8

Month Ending 31st July 2011 - (Month 4)

Month Act	Month Budget	%		Ytd Act	Ytd Budget	Diff	%	2011/2012 Fcast	2011/2012 Budget	Diff	%
£000	£000			£000	£000	£000		£000	£000	£000	
			Emergency Delivery								
20,852	20,853	0.0%	PCT Commissioned	82,610	83,413	(803)	-1.0%	251,285	252,088	(803)	-0.3%
642	642	0.0%	CBRN	2,473	2,569	(96)	-3.7%	7,610	7,706	(96)	-1.2%
42	176	-76.3%	RTA	404	702	(298)	-42.5%	1,211	2,106	(895)	-42.5%
21,536	**21,671**	-0.6%	**Subtotal**	**85,487**	**86,684**	**(1,197)**	-1.4%	**260,107**	**261,901**	**(1,794)**	-0.7%
			Specialised Services								
613	591	3.6%	HART	2,482	2,366	116	4.9%	7,213	7,097	116	1.6%
3	3	3.3%	HEMS	14	13	0	3.3%	40	39	0	1.1%
616	**595**	3.6%	**Subtotal**	**2,496**	**2,379**	**117**	4.9%	**7,253**	**7,137**	**117**	1.6%
			Information Services & Research								
93	92	0.4%	EBS	370	369	2	0.4%	1,107	1,106	1	0.1%
2	18	-87.4%	Research	(28)	72	(100)	-139.2%	42	216	(174)	-80.5%
95	**110**	-13.9%	**Subtotal**	**342**	**441**	**(99)**	-22.4%	**1,149**	**1,322**	**(173)**	-13.0%
			Patient Transport Services								
516	568	-9.2%	PTS	1,964	2,272	(307)	-13.5%	5,807	6,815	(1,008)	-14.8%
88	66	33.9%	BETS & SCBU	275	263	12	4.4%	801	789	12	1.5%
12	20	-40.0%	A&E Long Distance	105	80	25	30.8%	286	240	46	19.3%
616	**654**	-5.8%	**Subtotal**	**2,344**	**2,615**	**(271)**	-10.4%	**6,895**	**7,844**	**(950)**	-12.1%
			NHS London								
102	104	-2.0%	MPET	408	417	(8)	-2.0%	1,250	1,250	0	0.0%
0	0	#DIV/0!	Other Education	0	0	0	#DIV/0!	0	0	0	#DIV/0!
114	114	0.0%	Olympics 2012	455	455	0	0.0%	1,365	1,365	0	0.0%
216	**218**	-0.9%	**Subtotal**	**863**	**872**	**(8)**	-0.9%	**2,615**	**2,615**	**0**	0.0%
			Commercial								
194	83	133.4%	Stadia	348	333	15	4.4%	1,015	1,000	15	1.5%
55	52	6.1%	BAA	221	208	13	6.1%	663	625	38	6.1%
5	1	471.1%	Training	13	4	9	236.9%	14	11	3	23.9%
255	**136**	87.1%	**Subtotal**	**582**	**545**	**36**	6.7%	**1,692**	**1,636**	**56**	3.4%
145	47	208.3%	**Other**	470	188	282	150.3%	790	564	226	40.1%
23,479	**23,431**	0.2%	**Total**	**92,583**	**93,723**	**(1,139)**	-1.2%	**280,500**	**283,018**	**(2,518)**	-0.9%

LAS Financial Review - Rolling Balance Sheet

APPENDIX 9

Month Ending 31st July 2011 - (Month 4)

	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
Non-Current Assets	*Actual*	*Actual*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	
Intangible assets	14,696	14,842	14,842	14,842	14,842	14,842	14,842	14,842	14,842	14,842	14,842	14,842	14,842	
Property, Plant and Equipment	120,648	121,958	123,711	123,833	123,626	123,840	124,680	123,857	123,269	123,685	122,483	121,431	122,564	
Trade and Other Receivables	7,986	8,087	8,101	8,063	8,077	8,091	8,105	8,068	8,081	3,084	3,049	3,065	3,080	
Total Non-Current Assets	143,330	144,887	146,654	146,738	146,545	146,773	147,627	146,767	146,192	141,611	140,374	139,338	140,486	
Current Assets														
Inventories	2,584	2,590	2,590	2,590	2,590	2,590	2,590	2,590	2,590	2,590	2,590	2,590	2,590	Trade Debtors
NHS Trade Receivables	4,844	12,274	4,159	3,658	3,250	2,751	2,748	2,648	2,750	2,536	2,598	2,598	2,598	A&E £1329k > 60 days (61.14%), May £185k > 60 days (9.03%)
Non NHS Trade Receivables	0	0	0	0	0	0	0	0	0	0	0	0	0	PTS £421k > 60 days (19.39%), May £311k > 60 days (15.16%)
Other Receivables	5,991	6,445	4,544	4,244	3,944	3,644	1,464	1,164	864	5,763	5,763	5,763	3,825	
Accrued Income	27	150	150	150	150	150	150	150	150	150	150	150	150	
Prepayments	4,162	4,505	4,305	4,105	3,905	3,705	3,505	3,305	3,105	3,005	3,005	3,005	3,005	
Investments	0	0	0	0	0	0	0	0	0	0	0	0	1	
Cash and Cash Equivalents	7,186	4,720	8,522	7,108	7,297	7,821	6,994	6,577	7,340	5,250	5,279	7,188	8,209	
Current Assets	24,794	30,684	24,270	21,855	21,136	20,661	17,451	16,434	16,799	19,294	19,385	21,294	20,378	
Non-Current Assets Held for Sale	650	650	650	0	0	0	0	0	0	0	0	0	0	
Total Current Assets	25,444	31,334	24,920	21,855	21,136	20,661	17,451	16,434	16,799	19,294	19,385	21,294	20,378	
Total Assets	168,774	176,221	171,574	168,593	167,681	167,434	165,078	163,201	162,991	160,905	159,759	160,632	160,864	
Current Liabilities														
Bank Overdraft	0	0	0	0	0	0	0	0	0	0	0	0	0	Trade Creditors
Non NHS Trade Payables	5,608	6,825	6,459	6,208	6,068	6,043	6,042	6,049	6,058	6,036	8,029	8,198	8,198	NHS PSPP - This month (94%), June (66%), Ytd (80%)
NHS Trade Payables	224	268	258	248	238	228	218	208	198	188	188	188	188	Non NHS PSPP - This month (92%), June (88%), Ytd (89%)
Other Payables	9,049	9,135	8,837	8,843	8,767	8,558	8,522	8,366	8,091	8,372	8,186	8,186	8,186	
PDC Dividend Liabilities	957	1,276	1,595	0	319	638	957	1,276	1,595	0	316	632	948	
Capital Liabilities	272	215	1,714	1,982	2,092	2,423	3,380	2,392	2,639	3,395	24	174	2,359	
Accruals	4,771	4,970	4,920	4,820	4,770	4,770	4,770	4,720	4,670	4,620	4,620	4,620	4,620	
Deferred Income	3,944	9,288	6,344	5,438	4,532	3,626	2,720	1,814	908	0	0	0	0	
DH Capital Loan Principal Repayment	1,244	1,244	1,244	622	622	622	622	622	622	1,244	1,244	1,244	1,244	
Borrowings	1,538	1,557	1,113	954	795	636	340	229	118	1,154	1,058	962	866	
Provisions for Liabilities & Charges	800	800	800	800	800	800	800	800	800	800	800	800	801	
Total Current Liabilities	28,407	35,578	33,284	29,915	29,003	28,344	28,371	26,476	25,699	25,809	24,465	25,004	27,410	
Net Current Assets/(Liabilities)	(2,963)	(4,244)	(8,364)	(8,060)	(7,867)	(7,683)	(10,920)	(10,042)	(8,900)	(6,515)	(5,080)	(3,710)	(7,032)	
Total Assets less Current Liabilities	140,367	140,643	138,290	138,678	138,678	139,090	136,707	136,725	137,292	135,096	135,294	135,628	133,454	
Non-Current Liabilities														
DH Capital Loan Principal Repayment	6,831	6,831	6,831	6,831	6,831	6,831	6,831	6,831	6,831	5,587	5,587	5,587	5,587	
Borrowings	12,312	12,312	9,748	9,748	9,748	9,748	7,135	7,135	7,135	5,981	5,981	5,981	3,468	
Other Financial Liabilities	0	0	0	0	0	0	0	0	0	0	0	0	1	
Provisions for Liabilities & Charges	8,499	8,350	8,358	8,366	8,253	8,261	8,269	8,156	8,164	8,172	8,092	8,148	8,208	
Total Non-Current Liabilities	27,642	27,493	24,937	24,945	24,832	24,840	22,235	22,122	22,130	19,740	19,660	19,716	17,264	
Total Assets Employed	112,725	113,150	113,353	113,733	113,846	114,250	114,472	114,603	115,162	115,356	115,634	115,912	116,190	
Financed By Taxpayers' Equity														
Public Dividend Capital	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	62,516	
Revaluation Reserve	35,672	35,672	35,672	35,672	35,672	35,672	35,672	35,672	35,672	35,672	35,672	35,672	35,672	
Donated Asset Reserve	0	0	0	0	0	0	0	0	0	0	0	0	0	
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	
Retained Earnings	14,956	15,381	15,584	15,964	16,077	16,481	16,703	16,834	17,393	17,587	17,865	18,143	18,421	
Total Taxpayers' Equity	112,725	113,150	113,353	113,733	113,846	114,250	114,472	114,603	115,162	115,356	115,634	115,912	116,190	

LAS Financial Review - Rolling Cashflow

Cashflow Statement

Month Ending 31st July 2011 - (Month 4)

APPENDIX 10

	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-11	Jun-11
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
	Actual	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*
Operating Activities												
Operating surplus/(deficit)	807	577	753	486	777	590	499	927	563	687	687	687
Depreciation and amortisation	943	946	946	1,117	1,117	1,117	1,335	1,335	1,335	1,226	1,226	1,226
Impairments and reversals	0	0	0	0	0	0	0	0	0	0	0	0
Transfer from the donated asset reserve	0	0	0	0	0	0	0	0	0	0	0	0
Interest Paid	(67)	(57)	(57)	(57)	(56)	(47)	(47)	(47)	(46)	(77)	(77)	(77)
Dividend Paid	0	0	(1,914)	0	0	0	0	0	(1,914)	0	0	0
(Increase)/Decrease in Inventories	(6)	0	0	0	0	0	0	0	0	0	0	0
(Increase)/Decrease in NHS Trade Receivables	(7,430)	8,115	501	408	499	3	100	(102)	214	(62)	0	0
(Increase)/Decrease in Long Term Receivables	11	(14)	38	(14)	(14)	(14)	37	(13)	98	35	(16)	(15)
(Increase)/Decrease in Non NHS Trade Receivables	(112)	0	0	0	0	0	0	0	4,899	0	0	0
(Increase)/Decrease in Other Receivables	(454)	1,901	300	300	300	2,180	300	300	(4,899)	0	0	1,938
(Increase)/Decrease in Accrued Income	(123)	0	0	0	0	0	0	0	0	0	0	0
(Increase)/Decrease in Prepayments	(343)	200	200	200	200	200	200	200	100	0	0	0
Increase/(Decrease) in Trade Payables	1,217	(366)	(251)	(140)	(25)	(1)	7	9	(22)	1,993	169	0
Increase/(Decrease) in Other Payables	112	(325)	(21)	(103)	(236)	(63)	(183)	(302)	254	(206)	(20)	(20)
Increase/(Decrease) in Payments on Account	0	0	0	0	0	0	0	0	0	0	0	0
Increase/(Decrease) in Accruals	199	(50)	(100)	(50)	0	0	(50)	(50)	(50)	0	0	0
Increase/(Decrease) in Deferred Income	5,344	(2,944)	(906)	(906)	(906)	(906)	(906)	(906)	(908)	0	0	0
Increase/(Decrease) in Provisions & Liabilities	(149)	8	8	(113)	8	8	(113)	8	8	(80)	56	61
Net Cash inflow/outflow from operating activities	(51)	7,991	(503)	1,128	1,664	3,067	1,179	1,359	(368)	3,516	2,025	3,800
Cashflows from Investing Activites												
Interest received	22	19	20	20	19	15	15	15	13	4	4	4
(Payments) for property, plant & equipment	(2,310)	(1,200)	(800)	(800)	(1,000)	(1,000)	(1,500)	(500)	(995)	(3,395)	(24)	(174)
Proceeds from disposal of property, plant & equipment	0	0	650	0	0	0	0	0	0	0	0	0
(Payments) for intangible assets	(146)	0	0	0	0	0	0	0	0	0	0	0
Proceeds from disposal of intangible assets	0	0	0	0	0	0	0	0	0	0	0	0
(Payments) for investment with DH	0	0	0	0	0	0	0	0	0	0	0	0
(Payments) for other financial assets	0	0	0	0	0	0	0	0	0	0	0	0
Net Cash inflow/outflow from investing activities	(2,434)	(1,181)	(130)	(780)	(981)	(985)	(1,485)	(485)	(982)	(3,391)	(20)	(170)
Net Cash inflow/outflow before financing	(2,485)	6,810	(633)	348	683	2,082	(306)	874	(1,350)	125	2,005	3,630
Cashflows from Financing Activites												
Public Dividend Capital Received	0	0	0	0	0	0	0	0	0	0	0	0
Public Dividend Capital Repaid	0	0	0	0	0	0	0	0	0	0	0	0
Loans received from DH	0	0	0	0	0	0	0	0	0	0	0	0
Loans principal repaid to DH	0	0	(622)	0	0	0	0	0	(622)	0	0	0
Loans received from Salix Finance	0	0	0	0	0	0	0	0	0	0	0	0
Capital element of finance lease	19	(3,008)	(159)	(159)	(159)	(2,909)	(111)	(111)	(118)	(96)	(96)	(2,609)
Net Cashflow inflow/(outflow) from financing	19	(3,008)	(781)	(159)	(159)	(2,909)	(111)	(111)	(740)	(96)	(96)	(2,609)
Increase/(decrease) in cash & cash equivalents	(2,466)	3,802	(1,414)	189	524	(827)	(417)	763	(2,090)	29	1,909	1,021
Cash, cash equivalents and bank overdrafts at 310511												
Cash, cash equivalents and bank overdrafts at 310512	4,720	8,522	7,108	7,297	7,821	6,994	6,577	7,340	5,250	5,279	7,188	8,209

LAS Financial Review - Financial Risks

APPENDIX 11

Month Ending 31st July 2011 - (Month 4)

Key Financial Risks	Gross Risk				Net	Status	Comment
	Value £000	Impact	Likelihood	Rating	Value £000		
1. Penalty Charge - Category A Target	10,104	5	2	10	4,978	A	M3 in month performance is below trajectory on Cat A 8 mins. Year to date we are on track for all.
2. CQUIN	3,730	3	4	12	1,052	A	M4 highlights slippage on A1 ACP conveyance, 5a EOLC, 6a Mental health plan and 6b protocol establishment with Health Providers
3. CBRN Income	7,706	4	1	4	0	G	Allocation received from Westminster PCT
6. CIP Delivery	14,840	5	3	15	1,484	R	Month 4 CIP is behind plan
7. Economic Cost Pressures (Fuel, Rates, etc)	250	3	3	9	0	G	M4 ytd on track
8. Low Emmission Zone	1200	3	4	12	0	A	Awaiting written confirmation from GLC that LAS has one year implementation extension
9. EOC/Command Point	542	3	4	12	0	A	M4 over £100k year to date overspend
11. Depreciation	1197	3	1	3	243	A	Finance & Investment committee approved lease amendments. Residual risk arises from difference between operating lease costs and deprecation.
12. A&E Operational	3028	4	3	12	1,411	R	Operational financial risk arising from increased overtime.
13. PTS Profitability	1,000	3	3	9	300	A	Contract have been tendered and the outcome remains uncertain. Non contract income targets is not being met.
Total	53,308				9,468		

KEY:	
G	**Green - Minimal or No Financial Risk at Present**
A	**Amber - Moderate level of risk requiring attention**
R	**Red - Significant Level of risk requiring corrective action**

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 23RD AUGUST 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:	
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:	**That the Board considers and notes this report**

Executive Summary/key issues for the Trust Board

Safety:

1. Further update provided on the review of implementing changes to the High Risk Register procedure.
2. Further progress in implementing safeguarding measures.

Clinical and cost effectiveness:

1. CPI performance now at 83% for May and 77% for June target 95%. 12 Complexes achieved 100% in May and 10 in June. There is an increasing trend for feedback to staff to be provided as a report, rather than through face to face feedback. The current REAP level has contributed to this.
2. Survival to discharge for out of hospital cardiac arrest has increased to 22.8% for the Utstein cohort of patients, a further improvement on the previous year. Overall survival remains at 8%.
3. We remain on track to report progress against the national quality indicators, due August 2011.

Governance:

1. Limited assurance provided on the management of medicines, including both Controlled and General Drug issues. No incidents relating to Controlled Drugs, or other drugs to report. However, an unannounced visit to 4 Complexes by the Controlled Drugs Liaison Team have again highlighted shortcomings in the implementation of the Controlled Drugs Procedure.

Care Environment and Amenities

1. Sustained improvement in reporting against the Infection Control Scorecard. Compliance figures for hand hygiene remain below satisfactory levels. The current operational pressures limit clinical staff undertaking audits as they are involved in delivering direct patient care.

Attachments

The Cardiac Arrest Annual Report 2010/2011 is included in full under appendix 1.

****

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 TRUST

Trust Board 23rd August 2011

Clinical Quality and Patient Safety Report

Safety

1.1 Update on Serious Incidents (SIs)

Information on SIs is now provided within the Chief Executive's report.
The national Directors of Clinical Care (DOCC) Group now share the learning from SIs as well as discussing any Rule 43 requests made to their services at their monthly meetings.

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.

25 alerts were received from 14th June – 12th August 2011. All alerts were acknowledged; one, relating to the recall of 28% Venturi masks manufactured between July 2009 and April 2010, is subject to ongoing investigation. Information is awaited from two Complexes before the alert can be closed.

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:

There are currently 688 addresses on the register (down from 796 in June 2011). Of those the figures split by category as follows:

Category 1:	149
Category 2:	311
Category 3:	167
Category 4:	61

There are now no outstanding cases for inclusion.

A senior manager has been assigned to lead on the operational input into the group undertaking a weekly review of cases suggested for inclusion on the register and will lead the review of the procedure.

Key for categories

"1" is the most serious type of incident where a member of staff has actually been the subject of physical violence;

"2" is where there has been (a) a specific threat of use of a weapon or (b) where there has been verbal abuse with intimidation or (c) where there has been verbal abuse aggravated by being based on the grounds of race, religion or sexual orientation;

"3" is where a member of staff has been verbally abused;

"4" is where a medical condition was a major factor in the incident (procedure says that for Cat 4 address appropriate care management must always be agreed with other health and social care managers).

1.4 Safeguarding

The annual report for Safeguarding was reported at the June Board meeting.
All three work streams are now in place 1) Safeguarding children & adults, 2) Mental health and 3) Learning disability. The parent Committee for Vulnerable and Disadvantaged groups will now be established and this committee will offer external scrutiny to our three existing action plans.
The safeguarding action plan is going to be amended following our self assessment for safeguarding adults. The Department of Health requested the completion of a gap analysis and our return has been submitted to NHS London which illustrates a moderate position against the expected standards. The revealed gaps will be turned into actions on the current safeguarding action plan.
The recruitment to a safeguarding children lead is progressing. It is expected to have made an appointment by the end of September 2011.
The balance scorecard for safeguarding is currently in its second iteration and compliance is good with regards to referrals and policy. The organisations still needs to improve attendance at local Safeguarding Boards and our position across London is currently being mapped onto the scorecard.

Clinical and Cost Effectiveness

2.1 Clinical Performance Indicator completion and compliance

The current target for CPI completion is **95%.** The most recent figures (May and June) show overall completion rates of **83 and 77%.** In May twelve Complexes achieved 100%; in June ten achieved this. The East Area remains the highest performer.

Diagram 1. CPI completion November 2010 to June 2011

Area	Dec	Jan	Feb	March	April	May	June
East	87%	71%	83%	92%	94%	88%	89%
South	62%	69%	64/%	79%	69%	83%	73%
West	83%	83%	77%	82%	83%	79%	71%
LAS	**76%**	**74%**	**74%**	**84%**	**81%**	**83%**	**77%**

Across the LAS, the level of documentation of specific areas of care given to Non Conveyed patients remains a cause for concern, particularly in undertaking a final set of basic observations and leaving a copy of the PRF with the patient.
Similarly, there is room for improvement in level of documentation audited under the 1 in 20 CPI, particularly in recording the ethnicity code and drug administration details.

It is of concern that feedback on CPIs is infrequently delivered face to face. As the LAS remains at REAP 3 or 4 there is much less opportunity for Team Leaders to meet with their staff.

2.2 Clinical Update

Survival from out of hospital cardiac arrest

Survival from out of hospital cardiac arrest has increased to 22.8% for 2010 -2011. This is a further improvement on the previous year (21.5%) and maintains the annual increase that we have seen since we initially started collecting the data in 1998 when the figure was 4%. This figure looks at a subset of patients, those whose arrest is believed to be from a cardiac cause, was bystander witnessed and where the rhythm is amenable to a shock from a defibrillator. For all patients where resuscitation is attempted the survival remains 8%.

The report also highlights the increase in survival of those patients whose cardiac arrest was witnessed by LAS staff, where the survival has increased to 55.6% for the Utstein comparator group, and to 15.6% overall.

Since September 2010 those patients with a cardiac arrest of presumed cardiac origin, who have a return of spontaneous circulation and evidence of specific changes on their ECG, are now taken direct to one of the 8 Heart Attack Centres. These patients have an even greater chance of survival (72%). The LAS is the only ambulance service in the UK to use this particular pathway.

This report signals a fantastic achievement for the LAS and reflects improvements in all the stages of managing this group of patients, from identification in the Control Room, the dispatch of appropriate resources, through the resuscitation attempt, to stabilisation and conveyance to hospital. It is also pleasing to note the reduction in missing data in this year's report. This represents both the tireless efforts of staff in CARU who follow up each case, and also the much improved cooperation from the receiving hospitals in supplying data on this group of patients.

The full report can be viewed on: X:\Clinical Audit & Research Unit\Cardiac Reports\Annual Reports\Cardiac Arrest Annual Reports\LAS Cardiac Arrest Annual Report 2010-2011.pdf and is included under Appendix 1.

Cardiac Care projects

We are involved in a number of exciting and ground breaking projects, including a trial of an anti arrhythmic drug in patients with a very fast heart rate (para SVT study), therapeutic hypothermia in cardiac arrest, the DANCE study in North West London. Unfortunately progress with these initiatives is suffering from limitations on releasing staff for training; hopefully this will change as and when the current REAP level is reduced.

From September the LAS will be commissioned to undertake the urgent transfer of patients with non ST elevation acute coronary syndrome (NSTEACS) to the nearest Heart Attack Centre. This will be a pan London initiative by the end of this financial year and has the support of both the cardiac networks and the Commissioners.

We have some concerns around the accuracy of crews' interpretation of 12 lead ECGs when diagnosing STEMIs. There is anecdotal evidence that levels have fallen to below 90%. Many staff have not received refresher training, however this is planned for the third tranche of Core Skills Refresher training.

2.3 Summaries of clinical audit or research projects that are currently being undertaken by the Clinical Audit & Research Unit:

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Cardiac Arrest Annual Report 2010/2011 is included under Appendix 1.

The LAS is on track to upload the indicators relating to Cardiac Arrest, STEMI and Stroke patients on UNIFY2 is **21st August 2011 for incidents from April 2011.** The reporting deadline for these areas provides for a three month time lag to allow Ambulance Services sufficient time to capture data from PRF's, hospitals and national registries

Governance

3. Update on Medicines Management.

Since my last report there has been no reported incident involving controlled drugs (CD), no incidents involving other drugs and no alerts via the CAS system involving drugs.

The Controlled Drugs Liaison Team (CDLT) of the Metropolitan Police conducted unannounced visits to four LAS sites on 7th July 2011. Issues found were non compliance to CD Safe code changes, inadequate Daily Audit Checks being documented and poor compliance to the completion of the CD Register. An action plan has been produced, and all Complexes are to report progress against that plan to the Accountable Officer by the end of August 2011.

NHS Protect will visit the LAS Accountable Officer, her staff and the Metropolitan Police CDLT on 17th August 2011. They are visiting all Ambulance Services in England to collate and promulgate areas of good practice, with a view to producing a Good Practice Guide for the Ambulance Service in relation to Controlled Drugs. It is

acknowledged that some areas of the Controlled Drugs legislation / regulation / guidance are not as clear for Ambulance Services as for other parts of the Health Service.

The most recent meeting of the Medicines Management Group on 13th July 2011 was only attended by three members (David Whitmore (Chair), Steven Cook – LAS Pharmacy Adviser and Frances Wood), thus the meeting was not quorate. However Steven Cook gave a verbal report from the National Ambulance Pharmacy Advisers Group.

Patient Focus

Nothing further to report

Accessible and Responsive Care

Nothing further to report

Care Environment and Amenities

6.1 Infection Prevention and Control

The annual report for Infection Prevention and Control was reported at the June Board meeting.
The Infection Prevention and Control Committee met on 4 August 2011 and despite REAP level 4 there was a good attendance at the committee meeting with all areas except the South represented. The attendance together with the sustained improvements revealed in the Infection Control Scorecard suggests that Infection Control is receiving the highest priority across the Trust.
However, whilst the Trust continues to demonstrate improvements the compliance figures are still below satisfactory levels for hand hygiene and the area Performance Improvement Managers each have a plan in which to drive further improvements. The issue is now also captured within area governance reports although there are opportunities to strengthen the detail of the reporting.
The recent performance pressures have generated considerable debate regarding the auditing of infection control practice. At times of high pressure clinical staff do not have the capacity to continue monitoring the audit cycle as they are required for direct patient care. This is at a time when it is even more important to audit practice. At CQSE it was agreed to approach Acute Trust Directors of Infection Prevention and Control to see if Acute Accident & Emergency staff could assist in auditing our practice. A pilot at St George's and King's College Hospital has been reasonably successful at sending regular audit data.
Infection Control continues to be monitored at the trust Quality Committee.

Public Health

Nothing further to report

Recommendation

That the Board notes the report

Fionna Moore
Medical Director
14th August 2011

London Ambulance Service NHS Trust

Cardiac Arrest Annual Report: 2010/11

July 2011

Authors: Lynne Watson and Gurkamal Virdi
Clinical Audit & Research Unit
Medical Directorate

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Table of Contents

1. Introduction

From 1st April 2010 to 31st March 2011, the London Ambulance Service NHS Trust (LAS) attended 9,948 patients who experienced an out-of-hospital cardiac arrest.

Clinical, operational and demographic information relating to each patient was collected and analysed by the Clinical Audit and Research Unit. This information was sourced from completed Patient Report Forms (PRFs), Emergency Operations Centre (EOC) records, Mobile Data Terminals (MDTs) and defibrillator data files. All patients who were conveyed to hospital following ongoing resuscitation attempts were traced and survival outcomes obtained from national databases and hospital sources where possible.

There have been a number of changes in policy and protocol which have directly influenced the treatment received by cardiac arrest patients during 2010/11. Firstly, in December 2010, the European Resuscitation Council updated the existing resuscitation guidelines, which helped inform the LAS's treatment procedures. Specifically, the LAS has encouraged the use of defibrillators in manual mode, removed atropine from the cardiac arrest protocol and reiterated the need to enhance post resuscitation care of patients on scene to ensure that the patient is stable prior to conveyance to hospital. Secondly, from September 2010, a new pathway was established whereby a specific group of cardiac arrest patients were conveyed directly to a Heart Attack Centre (cardiac catheter laboratory). Finally, in response to the recommendations made by the Joint Royal Colleges Ambulance Liaison Committees Airway Management Group, the LAS issued guidance regarding the direction of airway management in June 2010. This outlines training requirements and skill maintenance necessary to perform intubations at an adequate skill level and challenges surrounding this. It states that "the focus will be on the use of [supraglottic airway devices]" but "[endotracheal] intubation can still be carried out although serious consideration should be given to the use of a [supraglottic airway device] as the first line management when providing an advanced airway."

This report presents the out-of-hospital cardiac arrest survival rates for patients in London. The LAS calculates two types of cardiac arrest survival figure: an overall survival rate and an Utstein[1,2] survival rate. The overall survival rate is based on those patients who had resuscitation attempted following an out-of-hospital cardiac arrest regardless of all factors. The Utstein survival calculation is conducted on a smaller sub-group of patients who have an arrest of presumed cardiac cause. This is an internationally validated method for calculating out-of-hospital cardiac arrest survival rates that allows for comparisons to be made between Emergency Medical Services. This calculation is the number of patients discharged alive as a proportion of the number of patients who had resuscitation attempted following a cardiac arrest of a presumed cardiac cause, where the arrest

was bystander witnessed and the initial arrest rhythm was shockable (Ventricular Fibrillation (VF) or pulseless Ventricular Tachycardia (VT)). Throughout this report the term Utstein refers to the above comparator group of patients only.

This report provides figures for the LAS as a whole, however, rates of ROSC achieved at any point, ROSC sustained to hospital and overall survival for each Complex are provided in Appendix 1. Data on ROSC and survival is also broken down by hospital and Primary Care Trust (PCT) in Appendices 2 and 3 respectively. Detailed information relating specifically to cardiac arrest patients under the age of 18 years is presented in Appendix 6.

2. Cause of Arrest

During 2010/11, the LAS attended a total of 9,948 out-of-hospital cardiac arrest patients. Of these, it was deemed that 5,693 (57.2%) patients were not suitable for resuscitation upon arrival of ambulance crews. Resuscitation was commenced for 4,255 (42.8%) patients in total: 3,336 arrests were due to a presumed cardiac cause, 293 were the result of a traumatic event, and a further 626 arrests were due to other causes (e.g. respiratory disease, drug overdose).

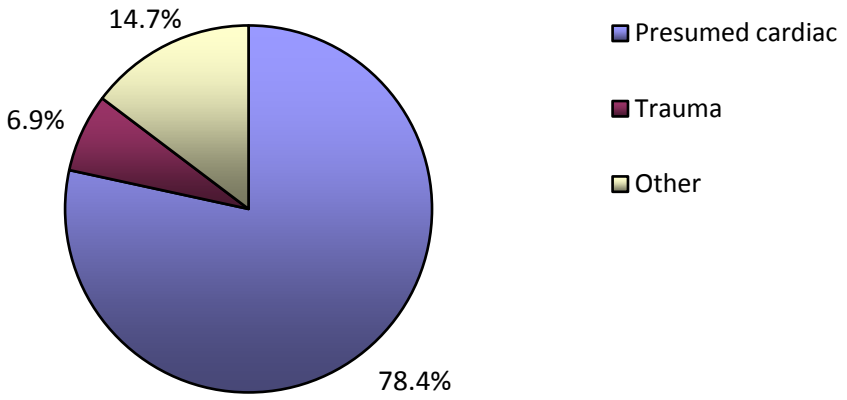


Figure 1 – Cause of arrest

3. Profile of Arrest

3.1. Resuscitation Not Attempted

Of the 5,693 cardiac arrests where a full resuscitation cycle was not undertaken, 98.6% (n=5,614) of patients were deceased upon the arrival of ambulance crews, while a further 79 patients had a Do Not Attempt Resuscitation (DNAR) order in place. The average age of patients was 70 years, the

majority were male (59.9%; n=3,410) and arrests most frequently occurred in a private location (94.3%; n=5,367).

3.2. Resuscitation Attempted

Table 1 shows the profile of cardiac arrest patients, where resuscitation was commenced (regardless of the cause of arrest).

Resuscitation Attempted	
Patient Demographics	
Number of cases:	4,255
Average age:	65 (0-102) years
Gender:	Male (64%; n=2,741) Female (36%; n=1,513); Not documented (0%; n=1)
Average age by gender:	Male (63 years) Female (69 years)
Ethnicity[+]:	White (61.9%) Mixed (0.4%) Asian/ British Asian (6.7%) Black/Black British (6.3%) Other Ethnic Group (3.1%) Unable to obtain (17.5%) Not documented (4.1%)
Event Information	
Most common day:	Saturday (15.4%; n=657)
Most common month:	December (10.6%; n=452)
Location:	Private (78%; n=3,320) Public (21.9%; n=931) Not documented (0.1%; n=4)
Witnessed^:	Bystander (41.8%; n=1,779) Not witnessed (36.9%; n=1,572) Crew witnessed (20.6%; n=877) Not documented (0.6%; n=27)
Bystander CPR:	36% (n=1,533)
Initial presenting rhythm:	Asystole (50.4%; n=2,146) VF/ pulseless VT (21.1%; n=899) PEA (26.9%; n=1,143) Not documented (1.6%; n=67)
ROSC:	32% (n=1,361)
ROSC sustained to hospital:	24.7% (n=1,051)

Table 1 – Profile of cardiac arrests in London for all patients where resuscitation was attempted

[+] Due to the nature and condition of cardiac arrests, patients are often unable to provide ethnicity information. Crews therefore document on the PRF that they are unable to obtain this information.
^ Due to rounding, percentages will not equal 100%

4. Presumed Cardiac Aetiology

The following section focuses only on those cardiac arrests of a presumed cardiac cause (n=3,336) irrespective of all factors (e.g. witnessed, bystander CPR, initial rhythm).

4.1. Patient Demographics

The majority of cardiac arrest patients were male (64% vs. 36% female). Ages ranged from 0 – 102 years, with an average of 68. As seen previously, females were older than males by an average of six years (72 vs. 66 years respectively). The distribution of age groups is shown in Figure 2 below.

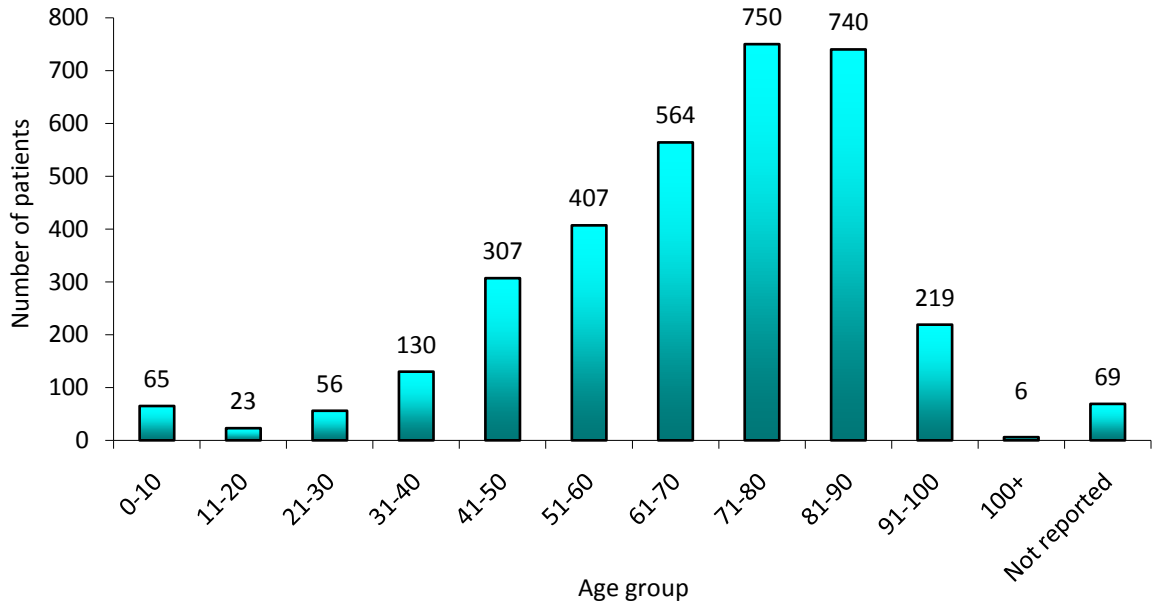


Figure 2 – Age groups of patients

4.2. Day and Month of Cardiac Arrest

Cardiac arrests of presumed cardiac cause most frequently occurred on a Monday (15.5%; n=517) and least frequently on a Friday (13.1%; n=438). The greatest number of arrests occurred during the month of December (10.8%; n=361), with the least number of cardiac arrests in July (n=230; 6.9%).

4.3. Location

A greater number of cardiac arrests of presumed cardiac cause occurred in a private, residential location (79%; n=2,637). Of which, 2,256 were in the home and 381 in a care home facility. 20.8% (n=695) of arrests occurred in a public place. In just 0.1% (n=4) of cases, there was no indication as to the location of the arrest.

Location	n	%[^]
Private		
Home	2,256	67.7
Care Home	381	11.4
Public		
Work	71	2.1
Street	310	9.3
GP Surgery	14	0.4
Other public	300	9.0

Table 2 – Location of cardiac arrests

Furthermore, of the 300 arrests that occurred within the other public location category, the ten most common locations have been broken down by frequency in Table 3 below.

Other public	n	%
Underground/ Rail/ Bus	55	18.3
Shop	44	14.7
Hospital/ Walk in centre	38	12.7
Leisure centre/ Sports facility	33	11.0
Airport	26	8.7
Hotel/ Hostel	14	4.7
Public House/ Club	14	4.7
Place of worship	11	3.7
Parkland/ Woodland	10	3.3
Restaurant	8	2.7

Table 3 – Breakdown of top ten other public locations

[^] Due to rounding, percentages will not equal 100%

4.4. Response Times

Following the triage of a 999 call, a response category is allocated in line with Department of Health (DH) definitions. Internally, the LAS further allocate colour coded response categories (red, amber or green) with levels of 1, 2 and 3 to describe the priority within the category. 60.4% (n=2014) of cardiac arrests were allocated a Red 1 category, the highest priority, at the point of the 999 call.

Ambulance response times for all 3,336 patients are displayed in Table 4. Response times achieved in 2009/10 have also been included for the purpose of comparison. The average 999 call to arrival on scene interval remains consistent with that reported in 2008/09 and 2009/10 at seven minutes. The average on scene time has increased by four minutes to 49 minutes and the average 999 call to arrival at hospital interval has increased by eight minutes to 60 minutes. In addition, the average overall job cycle time has increased by 12 minutes to 125 minutes.

Time Interval	2010/11 Average Time (mins.)	2009/10 Average Time (mins.)
999 (Call Connect)* - arrival on scene	7	7
On scene time	49	45
999 (Call Connect)* - arrival at hospital	60	52
Job cycle (Call Connect* - green∞)	125	113

** Call Connect refers to the time that the call was connected to the ambulance service.*
∞ Green is the time at which the crew have completed the job and are available for the next call.

Table 4 – Response times for those cardiac arrests of a presumed cardiac cause

This year we have also looked at response times for the group of patients whose arrest was due to a presumed cardiac cause, where the arrest was bystander witnessed and where the initial rhythm was VF or pulseless VT (i.e. the Utstein comparator group). The response times for this group are displayed in Table 5.

Time Interval	2010/11 Average Time (mins.)
999 (Call Connect)* - arrival on scene	6
999 (Call Connect)* - 1st LAS defibrillation	11
Arrival at scene - 1st LAS defibrillation	4
999 (Call Connect)* - arrival at hospital	57
Job cycle (Call Connect* - green∞)	124

** Call Connect refers to the time that the call was connected to the ambulance service.*
∞ Green time is the time at which the crew have completed the job and are available for the next call.

Table 5 – Response times for the Utstein comparator group

4.5. Witnessed Arrest

In line with previous years, almost half of all cardiac arrests (44.1%; n=1,471) of a presumed cardiac cause were bystander witnessed (either seen or heard) and a further 19.2% (n=640) were witnessed by an LAS crew. In 36.2% (n=1,209) of patients the cardiac arrest was not witnessed and in 0.5% (n=16) of cases there was no indication as to whether the cardiac arrest was witnessed or not. Cardiac arrests were more frequently witnessed in a private location (71.4%; n=1,051). Appendix 4 provides further information on the impact of witnessed arrests on ROSC and survival figures.

4.6. Bystander CPR

For just over one third of patients (36.7%; n=1,223) bystander CPR was undertaken prior to the arrival of an LAS crew. Bystander CPR was more frequently commenced when the cardiac arrest was witnessed rather than un-witnessed (61% vs. 39%). Additionally, bystander CPR was also more common when the arrest occurred in a private location compared to those arrests that occurred in public (70% vs. 30%). Of interest, the work place was the most likely location for a bystander to perform CPR (62%). These figures are consistent with those seen in previous years. Appendix 4 provides further information on the relationship between bystander CPR, ROSC and survival rates.

4.7. Initial Presenting Rhythm

As detailed in previous reports, almost half of all cardiac arrest patients presented to LAS ambulance crews with an asystolic heart rhythm (47.6%; n=1,589). Additionally, 25.5% (n=851) of patients presented with an initial rhythm of VF or pulseless VT. Pulseless Electrical Activity (PEA) accounted for a further 25.9% (n=863). In 1% (n=33) of cases PRFs did not give any indication as to the patient's initial arrest rhythm. Appendix 4 provides further information on each initial presenting rhythm and its impact on both ROSC and survival figures.

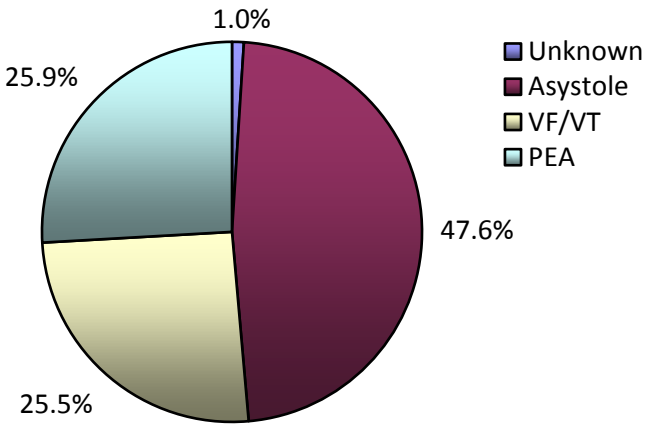


Figure 3 – Initial presenting rhythm

4.8. Return of Spontaneous Circulation (ROSC)

In just over one third of patients (33.5%; n=1,116) ROSC was achieved at some point whilst in the care of LAS crews. Just under three quarters of these patients collapsed in a private location (74.6%; n=832) and 74.3% (n=829) had an arrest that was witnessed either by a bystander or an LAS crew. In addition, 38.8% (n=433) of patients in whom ROSC was achieved (at any point) received bystander CPR; a 4% increase on last year. Where ROSC was achieved, the majority of patients presented with an initial arrest rhythm of VF/ pulseless VT (44.5%, n=497).

Where ROSC was achieved (n=1,116), it was sustained to arrival at hospital in 865 cases (77.5%). Therefore, of the total population of 3,336 cardiac arrest patients, 25.9% (n=865) had a return of spontaneous circulation present on arrival at hospital; this figure represents an increase of 2% from that reported in 2009/10.

The graph below demonstrates the year on year increases in both ROSC achieved at some point whilst in LAS care and ROSC sustained to hospital.

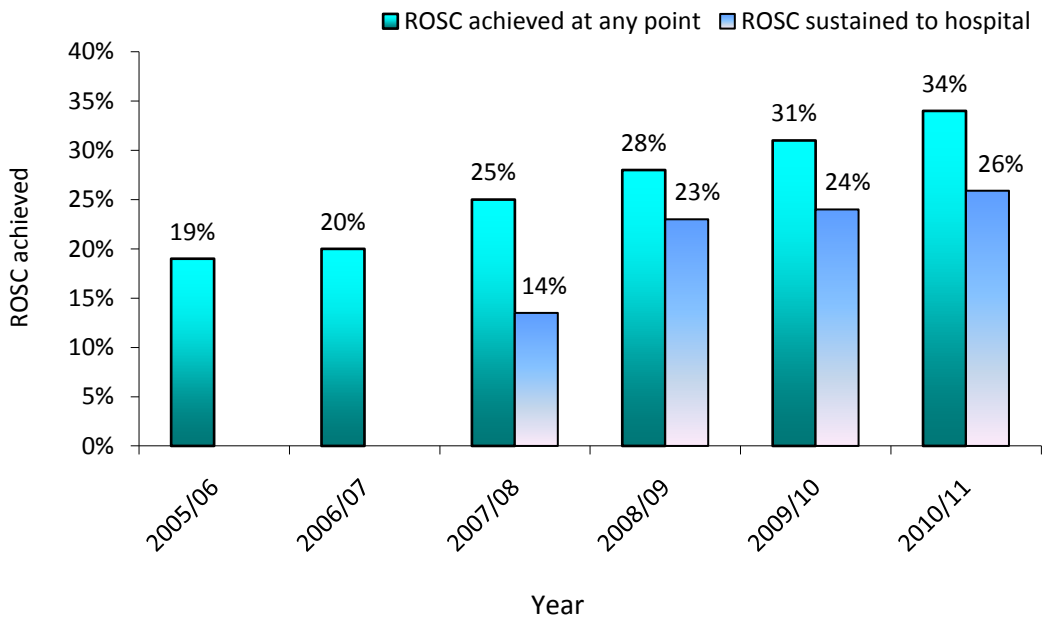


Figure 4 – Percentage of patients with ROSC by year

4.9. Airway Management

Airway management includes either endotracheal tube intubation or supraglottic airway device (SGA) placement (such as Laryngeal Mask Airway™ or I-gel™). Trained Paramedics are able to perform both interventions, whereas recently qualified Paramedics and Level 4 Emergency Medical Technicians (EMT) are able to place SGA's only. During 2010/11, there were 2,241 cases where resuscitation was attempted and a Paramedic or Level 4 EMT was present. In 83% of cases at least one successful airway management intervention was undertaken. For the purpose of comparison, numbers of intubations and SGA's placed in 2009/10 are included in brackets in Table 6 below.

Airway Management	
Number of successful intubations*	1,826 (1,935)
Number of SGA's placed*	1,149 (674)
Percentage of patients who were intubated, had an SGA placed, or both	83%

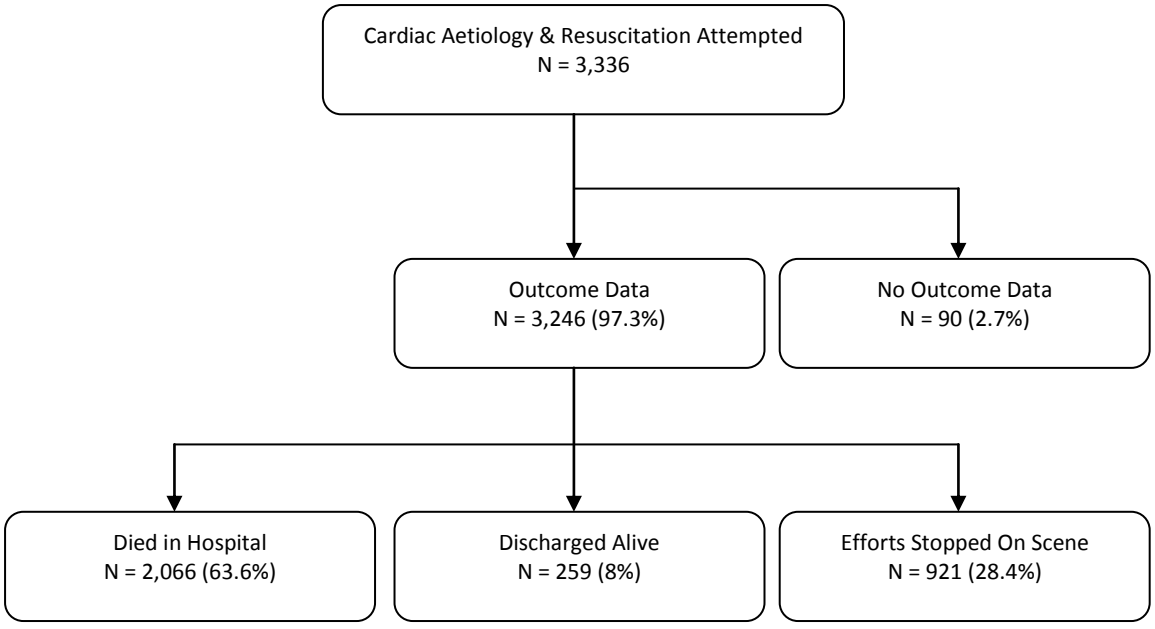
** In some cases a patient may have been intubated and had an SGA placed prior or subsequent to intubation; these cases have been included and reported in both intubation and SGA data.*

Table 6 – Airway management

4.10. Survival Calculations

4.10.1. Overall Survival Rate

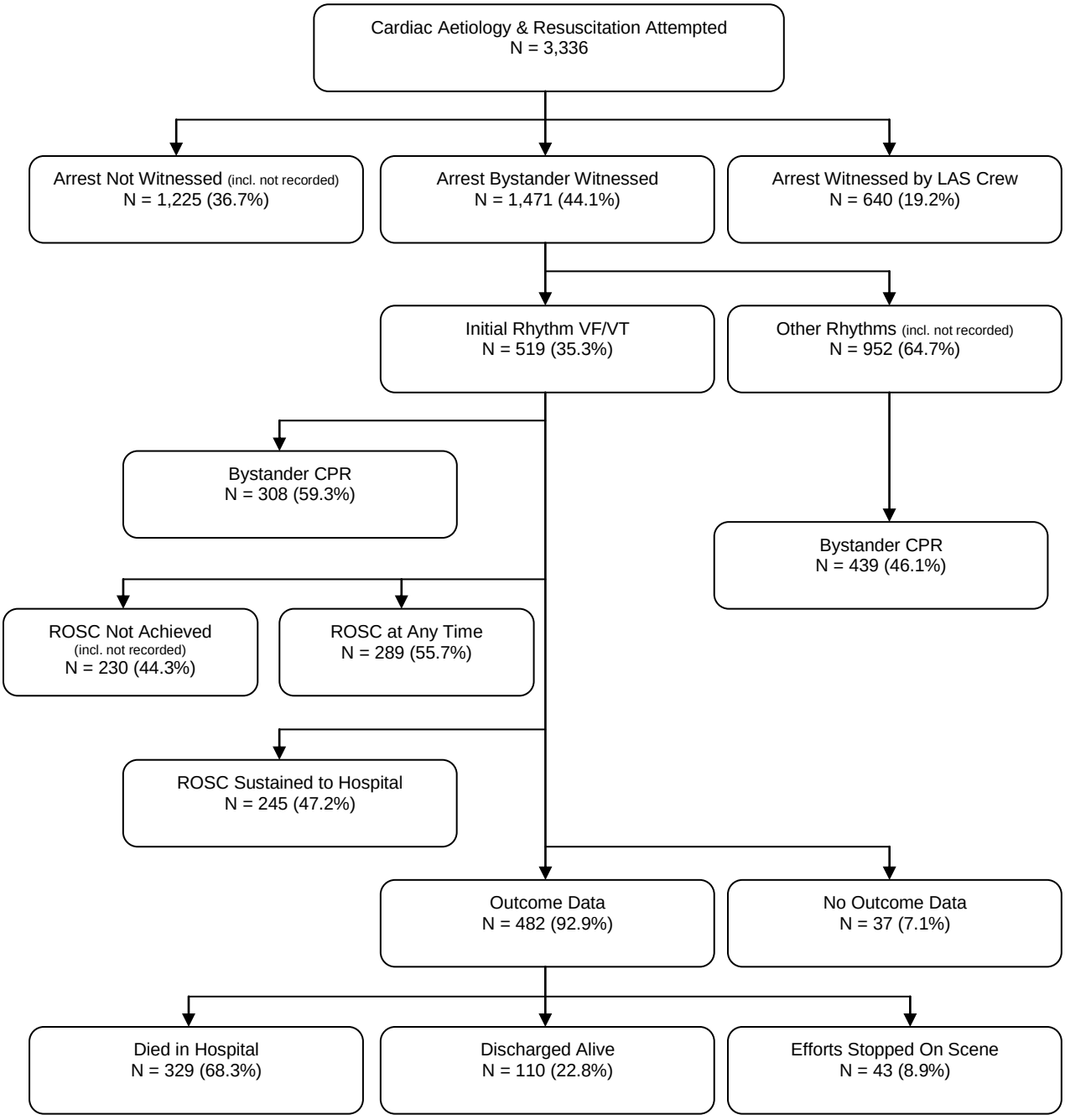
The overall survival rate is based on those patients who had resuscitation attempted by the LAS following an out-of-hospital cardiac arrest of a presumed cardiac cause irrespective of all factors. The overall survival rate for 2010/11 is 8%.



Overall Survival Rate: (259/3,246) = 8%

4.10.2. Utstein Survival Rate

The Utstein calculation is the number of patients discharged alive divided by the number of patients who had resuscitation attempted following a cardiac arrest of a presumed cardiac aetiology, where the arrest was bystander witnessed and the initial arrest rhythm was VF or pulseless VT. Patients for whom outcomes could not be traced (n=37) were excluded from the survival figure. Therefore, the valid denominator for the 2010/11 Utstein survival calculation is 482. The LAS Utstein survival rate for 2010/11 is 22.8%.



Utstein Survival Rate: (110/482) = 22.8%

Excluding 2007/08, Utstein survival rates have increased year on year as demonstrated in Figure 5 below.

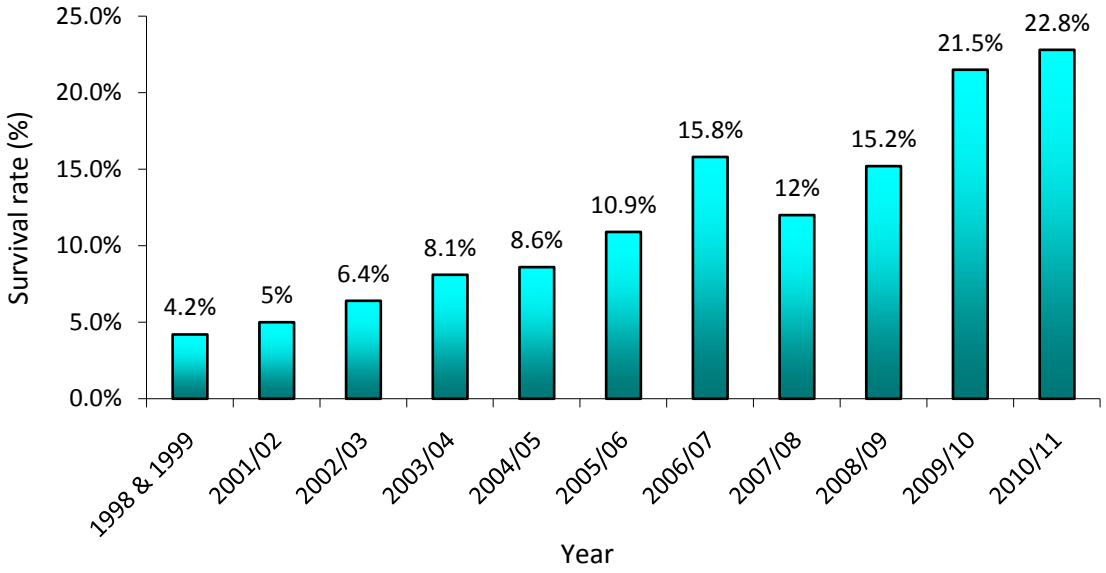


Figure 5 – Utstein survival rate by year

4.10.3. Survival from LAS Crew Witnessed Cardiac Arrests Only

Survival is higher in cardiac arrests that were witnessed by ambulance crews as these patients would be expected to receive immediate interventions. Arrests witnessed by LAS crews accounted for 19.2% (n=640) of all out-of-hospital cardiac arrests of presumed cardiac cause during 2010/11; the table below details the outcomes for this group of patients. As 23 patients could not be traced to hospital, the valid denominator for overall survival is 617 and 144 for the Utstein comparator group (presumed cardiac cause, crew witnessed and initial rhythm of VF/pulseless VT).

Outcome	n	%
Died on scene	60	9.7
Died in hospital	461	74.7
Overall survival rate	96/617	15.6
Utstein survival rate	80/144	55.6

Table 7 – Overall and Utstein survival from crew witnessed arrests

5. Trauma

During 2010/11, there were 293 patients whose cardiac arrest was the result of a traumatic event. Road traffic accidents and other traumatic incidents (e.g. fall from height, assault) were the most frequent cause of the traumatic event (see Table 8 below).

Trauma		
Cause	**n**	**%**
Road traffic accident	81	28%
Hanging	61	21%
Stabbing	33	11%
Drowning/Submersion	17	6%
Shooting	12	4%
Electrocution	7	2%
Other	82	28%

Table 8 – Cause of traumatic event

Of the 293 patients, over two thirds of these patients were male (78.2% vs. 21.8%) and the average age of patients was 40, with the greatest number of arrests occurring in the 21 - 30 year old age group. The majority of cardiac arrests of a traumatic cause occurred on the street (45%; n=132), closely followed by a private home location (35%; n=102). London's Air Ambulance (HEMS) were present on scene in 51% of cases (n=149). An initial presenting shockable heart rhythm (VF or pulseless VT) was only present in 4.4% (n=13) of cases.

For patients where trauma was the cause of the cardiac arrest, outcomes could not be traced in 15 cases and therefore the valid denominator is 278. The overall survival rate for this group of patients is 2.9% (n=8).

6. Other (non-cardiac) Cause

626 patients had a cardiac arrest that, due to its cause, was classified as other. This category includes causes such as drug overdose, respiratory disease and other non-cardiac related causes. Within this group, 92% (n=578) of arrests occurred within a private location, nearly two thirds (59.9%; n=375) of patients presented with an asystolic heart rhythm and 30% (n=190) of patients received bystander CPR prior to the arrival of the LAS.

7. Direct Conveyance to Heart Attack Centre

In September 2010, a new pathway was implemented for cardiac arrest patients, who had been stabilised on scene by crews, to be conveyed to one of eight Heart Attack Centres in London. The eligibility criteria for this pathway is: patients aged 18 years or over, ROSC achieved after an initial rhythm of VF or pulseless VT, evidence of ST-elevation on a 12 lead ECG and where the cause of arrest was believed to be cardiac in origin.

Figure 6 below shows the number of patients taken to a Heart Attack Centre and those that survived to hospital discharge. For more information on these patients, see Appendix 2.

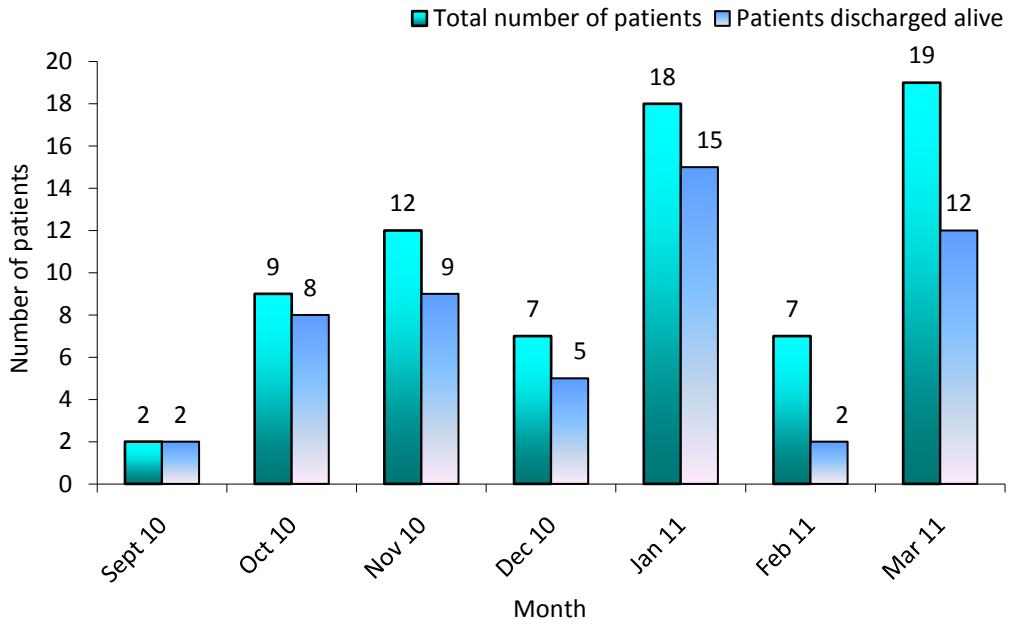


Figure 6 – Number and survival to discharge for patients conveyed directly to Heart Attack Centres

8. Survival from Defibrillators in Public Places

During 2010/11, defibrillators situated in public places were deployed a total of 25 times. Detailed information for this group of patients can be viewed in Appendix 5. Outcomes were obtained for all 25 patients; of these eight patients survived to hospital discharge resulting in an overall survival rate of 32% (n=8/25), a decrease of 1% on 2009/10. Due to the small numbers within this group, an Utstein survival calculation is not appropriate.

9. Discussion

For the third consecutive year, the LAS has seen an increase in the Utstein survival rate with the 2010/11 figure of 22.8% being the highest rate achieved by the LAS to date. The increase of 1.3% from 21.5% in 2009/10 continues the positive trend that is emerging. The overall survival rate of 8% has remained consistent with that reported last year for those arrests that occurred due to a presumed cardiac cause. In addition, a considerable increase of 9.3% has been seen in the Utstein survival rate of those cardiac arrests that were witnessed by LAS crews, where the survival rate has increased from 46.3% in 2009/10 to 55.6% in 2010/11.

Many factors outlined in this report have remained in line with those figures reported in 2009/10. Patient demographics, proportions of witnessed arrests, rates of bystander CPR, arrest location and initial presenting rhythms have all remained fairly consistent. Changes can however be seen in response times; while call to arrival at scene is identical to that reported in 2009/10 (7 minutes), call to first LAS defibrillation (for patients in the Utstein comparator group) has increased by one minute to 11 minutes. Similarly, both call to arrival at hospital and overall job cycle have seen noticeable increases (of 8 minutes and 12 minutes respectively). These are in part due to improvements made in the management of cardiac arrest patients through efforts to achieve ROSC and stabilise patients before conveyance to hospital. When comparing figures to those of 2009/10, rates of conveyance for those patients in whom ROSC was never achieved at any point has decreased by 10% (49% vs. 39% respectively) and the number of patients who were recognised as life extinct on scene by LAS crews has increased by approximately 10%. This clearly demonstrates that increasingly patients are being conveyed to hospital where appropriate and that resuscitation is being ceased where it is unsuccessful, which may in turn be reflected in the increase in response times for this reporting period.

During 2010, cardiac care initiatives and changes in protocol were introduced that may have had a direct impact on the increase seen in the Utstein survival rate. In September 2010, the decision was made to convey patients with ROSC following an arrest of a presumed cardiac cause, where the initial presenting rhythm was VF or pulseless VT and ST-elevation was clearly showing on a 12 lead ECG, directly to a Heart Attack Centre. This has enabled those patients who suffered a cardiac arrest due to a blocked coronary artery (i.e. a potentially reversible cause) to gain immediate access to primary angioplasty where appropriate. This change is reflected in the increased number of patients conveyed directly to a Heart Attack Centre (as seen in Appendix 2) and may go some way to accounting for the increase in survival. It may also have impacted on the 999 call to arrival at

hospital response time as conveying a patient to the nearest Heart Attack Centre may involve a longer journey time than conveying to the nearest hospital Accident & Emergency department.

Furthermore, in December 2010, in line with the release of the European Resuscitation Council's changes to existing resuscitation guidelines the LAS released a cardiac care circular providing an update on basic and advanced life support guidelines. Among the changes contained within this document were: using a defibrillator in manual mode allowing for a reduced break in chest compressions and the withdrawal of atropine in all cardiac arrests. Again, these changes in combination with other factors may also have contributed to the increase in survival.

At a Complex level there still remains great variation in the overall survival rates achieved by individual Complexes, with figures ranging from 1.8% through to 15.2%. It is important to note that although the number of Complexes that achieved an overall survival rate higher than that of the LAS wide figure (8%) has decreased, the number of Complexes with an overall survival rate greater than 10% has increased, with eight Complexes now exceeding this figure (Hillingdon, Pinner, City and Hackney, Edmonton, Islington, New Malden, Oval and Waterloo).

An important next step in improving survival from an out-of-hospital cardiac arrest relies on an increase being made to the number of defibrillator data files which are downloaded and saved either from FR2 data cards or using the Lifepak 1000. For 2010/11, the download rate ranges from 7% to 17%, which is substantially lower than the 100% target. Download analysis should be performed whenever possible from electronic cards or the Lifepak 1000 and these files should be analysed and findings fed back to crews, to allow for further improvements in care to be made. In addition, the LAS should continue to pursue options for pre-hospital therapeutic hypothermia in light of recent of National Institute of Health and Clinical Excellence guidelines[3] recommending commencement of induced hypothermia as soon as possible after the cardiac arrest has occurred.

There are two further trends which have continued during this reporting period, the first of which is the support given by London hospitals in providing the LAS with timely and detailed patient outcome information. This has allowed the LAS to obtain 97.3% of all patient outcomes, with the remaining 2.7% largely made up of those patients for whom little or no personal information could be obtained. Secondly, the quality of PRF documentation completed by LAS crews has also continued to improve. In many areas the percentage of missing information is as little as 1% or less. This is a substantial achievement and has enabled the most robust dataset to date to be compiled.

To conclude, the increases seen in survival to hospital discharge and rates of ROSC illustrate the continual improvements that are being made by the LAS to strengthen the cardiac care that patients receive. In addition, further initiatives such as pre-hospital therapeutic hypothermia in combination with improved PRF documentation and an increased number of defibrillator data downloads are expected to aid this improvement further.

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3. National Institute for Health and Clinical Excellence. Therapeutic hypothermia following cardiac arrest. National Institute for Health and Clinical Excellence, 2011; 386.

Appendix 1: ROSC and Survival per Complex 2010/11

Complex	Number of patients	ROSC		ROSC sustained to hospital		Overall survival where ROSC was sustained to hospital %	Overall survival %
		N	%	N	%		
West							
Brent	181	60	33	44	24	27.5 (11/40)	6.2 (11/177)
Camden	87	30	35	24	28	17.4 (4/23)	4.7 (4/85)
Friern Barnet	130	42	32	31	24	29 (9/31)	8.5 (11/130)
Fulham	102	32	31	25	25	26.1 (6/23)	8 (8/100)
Hanwell	147	47	32	39	27	27.8 (10/36)	7 (10/143)
Hillingdon	153	56	37	38	25	45.9 (17/37)	11.3 (17/151)
Isleworth	126	51	41	44	35	20 (8/40)	6.6 (8/122)
Pinner	195	69	35	56	29	35.7 (20/56)	10.3 (20/195)
East							
Chase Farm	85	26	31	16	19	43.8 (7/16)	8.2 (7/85)
City and Hackney	112	35	31	27	24	45.8 (11/24)	15 (16/107)
Edmonton	145	57	39	45	31	38.6 (17/44)	13.5 (19/141)
Islington	76	32	42	26	34	36 (9/25)	12.2 (9/74)
Newham	116	34	29	26	22	30.4 (7/23)	6.3 (7/111)
Romford	175	50	29	42	24	6.3 (2/32)	1.8 (3/165)
Tower Hamlets	104	27	26	23	22	26.3 (5/19)	7.1 (7/99)
Whipps Cross	171	56	33	41	24	27 (10/37)	7.3 (12/165)
South							
Barnehurst	163	49	30	36	22	24.1 (7/29)	5.1 (8/156)
Bromley	149	45	30	32	22	27.6 (8/29)	5.5 (8/145)
Croydon	205	66	32	55	27	26.4 (14/53)	7.5 (15/200)
Deptford	59	21	36	15	25	16.7 (2/12)	3.6 (2/56)
Greenwich	141	38	27	29	21	7.1 (2/28)	2.1 (3/140)
New Malden	99	47	48	36	36	41.7 (15/36)	15.2 (15/99)
Oval	73	24	33	22	30	38.1 (8/21)	11.1 (8/72)
St.Helier	127	42	33	30	24	37.9 (11/29)	9.1 (11/121)
Waterloo	108	34	32	28	26	50 (13/26)	12.3 (13/106)
Wimbledon	107	46	43	35	33	22.6 (7/31)	6.9 (7/101)
West	1121	387	35	301	27	29.7 (85/286)	8.1 (89/1103)
East	984	317	32	246	25	30.9 (68/220)	8.4 (80/947)
South	1231	412	33	318	26	29.6 (87/294)	7.5 (90/1196)
LAS-Wide	**3336**	**1116**	**33**	**865**	**26**	**30 (240/800)**	**8 (259/3246)**

Appendix 2: ROSC and Survival per Hospital 2010/11

Hospital	Number of patients	Number of patient outcomes	Missing patient outcomes %	ROSC		ROSC sustained to hospital		Overall survival Where ROSC sustained to hospital %	Overall survival %
				N	%	N	%		
Barnet General	63	63	0	26	41	20	32	20 (4/20)	7.9 (5/63)
Central Middlesex	45	43	4	14	31	8	18	0 (0/7)	0 (0/43)
Charing Cross	40	40	0	14	35	13	33	30.8 (4/13)	12.5 (5/40)
Chase Farm	43	40	7	20	47	13	30	15.4 (2/13)	5 (2/40)
Chelsea & Westminster	39	39	0	20	51	13	33	15.4 (2/13)	7.7 (3/39)
Darent Valley	13	13	0	3	23	3	23	33.3 (1/3)	7.7 (1/13)
Ealing	61	59	3	28	46	23	38	23.8 (5/21)	8.5 (5/59)
Hammersmith	38	36	5	29	76	26	68	37.5 (9/24)	25 (9/36)
Hillingdon	101	100	1	54	54	35	35	37.1 (13/35)	14 (14/100)
Homerton	48	47	2	17	35	11	23	50 (5/10)	14.9 (7/47)
Kings College	77	75	3	28	36	22	29	33.3 (7/21)	10.7 (8/75)
King Georges Ilford	63	58	8	31	49	22	35	11.1 (2/18)	3.4 (2/58)
Kingston	74	73	1	41	55	34	46	23.5 (8/34)	11 (8/73)
Lewisham	82	82	0	28	34	24	29	12.5 (3/24)	4.9 (4/82)
Mayday	135	133	1	57	42	46	34	17.8 (8/45)	6 (8/133)
Newham General	94	88	6	32	34	24	26	20 (4/20)	4.5 (4/88)
North Middlesex	81	79	2	40	49	29	36	29.6 (8/27)	10.1 (8/79)
Northwick Park	129	129	0	63	49	50	39	30 (15/50)	11.6 (15/129)
Princess Royal Farnborough	77	73	5	33	43	20	26	6.3 (1/16)	1.4 (1/73)
Queen Elizabeth	111	105	5	52	47	35	32	13.8 (4/29)	3.8 (4/105)
Queen Mary's Sidcup	28	27	4	8	29	8	29	14.3 (1/7)	3.7 (1/27)
Queens Romford	135	122	10	43	32	36	27	0 (0/24)	0 (0/122)
Royal Free	83	81	2	47	57	38	46	22.2 (8/36)	9.9 (8/81)
Royal London	53	49	8	23	43	18	34	25 (4/16)	14.3 (7/49)
St Georges Tooting	113	104	8	64	57	47	42	36.6 (15/41)	15.4 (16/104)
St. Helier	58	51	12	21	36	13	22	41.7 (5/12)	9.8 (5/51)
St Mary's Paddington	50	48	4	14	28	9	18	42.9 (3/7)	6.3 (3/48)
St Thomas's	90	86	4	41	46	32	36	37.9 (11/29)	12.8 (11/86)
University College London	50	49	2	25	50	22	44	31.8 (7/22)	14.3 (7/49)
West Middlesex	81	78	4	41	51	35	43	18.8 (6/32)	7.7 (6/78)
Whipps Cross	97	97	0	36	37	27	28	14.8 (4/27)	6.2 (6/97)
Whittington	56	55	2	19	34	16	29	20 (3/15)	7.3 (4/55)
Other Hospitals	8	8	0	3	38	1	13	0 (0/1)	0 (0/8)

Appendix 2: ROSC and Survival per Hospital continued…

Heart Attack Centre	Number of patients	Number of patient outcomes	Missing patient outcomes %	ROSC		ROSC sustained to hospital		Overall survival where ROSC sustained to hospital %	Overall survival %
				N	%	N	%		
Hammersmith Heart Attack Centre	7	6	14	7	100	7	100	66.7 (4/6)	66.7 (4/6)
Harefield Heart Attack Centre	14	13	7	14	100	13	93	75 (9/12)	69.2 (9/13)
Kings College Heart Attack Centre	12	12	0	12	100	12	100	58.3 (7/12)	58.3 (7/12)
London Chest Heart Attack Centre	30	30	0	29	97	26	87	76.9 (20/26)	80 (24/30)
Royal Free Heart Attack Centre	9	9	0	9	100	9	100	100 (9/9)	100 (9/9)
St Georges Heart Attack Centre	9	8	11	9	100	9	100	87.5 (7/8)	87.5 (7/8)
St Thomas's Heart Attack Centre	5	4	20	5	100	4	80	66.7 (2/3)	50 (2/4)
The Heart Heart Attack Centre	14	14	0	14	100	12	86	83.3 (10/12)	71.4 (10/14)

Appendix 3: ROSC and Survival per Primary Care Trust (of the hospital) 2010/11

PCT of hospital	Number of patients	Number of patient outcomes	Missing patient outcomes %	ROSC		ROSC sustained to hospital		Overall survival where ROSC sustained to hospital %	Overall survival %
				N	%	N	%		
Barnet	63	63	0	26	41	20	32	20 (4/20)	7.9 (5/63)
Bexley	28	27	4	8	29	8	29	14.3 (1/7)	3.7 (1/27)
Brent	174	172	1	77	44	58	33	26.3 (15/57)	8.7 (15/172)
Bromley	77	73	5	33	43	20	26	6.3 (1/16)	1.4 (1/73)
Camden	142	139	2	81	57	69	49	35.8 (24/67)	17.3 (24/139)
City & Hackney	49	48	2	18	37	12	25	45.5 (5/11)	14.6 (7/48)
Croydon	135	133	1	57	42	46	34	17.8 (8/45)	6 (8/133)
Ealing	61	59	3	28	46	23	38	23.8 (5/21)	8.5 (5/59)
Enfield	124	119	4	60	48	42	34	25 (10/40)	8.4 (10/119)
Greenwich	111	105	5	52	47	35	32	13.8 (4/29)	3.8 (4/105)
Hammersmith & Fulham	85	82	4	50	59	46	54	39.5 (17/43)	22 (18/82)
Havering	135	122	10	43	32	36	27	0 (0/24)	0 (0/122)
Hillingdon	115	113	2	68	59	48	42	46.8 (22/47)	20.4 (23/113)
Hounslow	81	78	4	41	51	35	43	18.8 (6/32)	7.7 (6/78)
Islington	56	55	2	19	34	16	29	20 (3/15)	7.3 (4/55)
Kensington & Chelsea	39	39	0	20	51	13	33	15.4 (2/13)	7.7 (3/39)
Kingston	74	73	1	41	55	34	46	23.5 (8/34)	11 (8/73)
Lambeth	184	177	4	86	47	70	38	41.5 (27/65)	15.8 (28/177)
Lewisham	82	82	0	28	34	24	29	12.5 (3/24)	4.9 (4/82)
Merton & Sutton	58	51	12	21	36	13	22	41.7 (5/12)	9.8 (5/51)
Newham	94	88	6	32	34	24	26	20 (4/20)	4.5 (4/88)
Redbridge	63	58	8	31	49	22	35	11.1 (2/18)	3.4 (2/58)
Tower Hamlets	83	79	5	52	63	44	53	57.1 (24/42)	39.2 (31/79)
Waltham Forest	97	97	0	36	37	27	28	14.8 (4/27)	6.2 (6/97)
Wandsworth	122	112	8	73	60	56	46	44.9 (22/49)	20.5 (23/112)
Westminster	64	62	3	28	44	21	33	68.4 (13/19)	21 (13/62)
Out of London	20	20	0	5	25	3	15	33.3 (1/3)	5 (1/20)

Appendix 4: Bystander CPR, ROSC, ROSC sustained to hospital and overall survival by patient group 2010/11

Resus Attempted

Patient group	Bystander CPR	ROSC	ROSC sustained to hospital	Overall survival
Location				
Home	29.9%	31.0%	23.8%	6.2%
Care Home	45.6%	30.8%	23%	1.1%
Work	60.2%	41%	30.1%	19.2%
Street	41.4%	30.2%	23.6%	11.7%
GP Surgery	55.6%	50%	33.3%	12.5%
Other	58.2%	41%	33.8%	17.3%
Initial presenting rhythm				
Asystole	39.0%	21.8%	15.7%	1.4%
PEA	24.8%	29.7%	22.2%	3.1%
VF/VT	43.9%	57.2%	47.1%	25.9%
Witnessed				
Bystander	49.7%	38.1%	29.6%	8.9%
Crew	-	35.9%	28.7%	14.1%
Not witnessed	40.5%	22.8%	16.7%	2.2%
Bystander CPR				
No	-	29.1%	21.5%	4.1%
Yes	-	33.2%	26.3%	7.5%

Presumed Cardiac Only

Patient group	Bystander CPR	ROSC	ROSC sustained to hospital	Overall survival
Location				
Home	29.9%	31.7%	24.4%	6.1%
Care Home	47.2%	30.7%	22.6%	0.8%
Work	62%	43.7%	32.4%	21.2%
Street	43.5%	35.5%	28.7%	15.5%
GP Surgery	57.1%	50%	42.9%	16.7%
Other	59.7%	45%	37%	20.8%
Initial presenting rhythm				
Asystole	39.3%	21.5%	15.3%	1.3%
PEA	24.2%	30.1%	22.5%	2.2%
VF/VT	44.5%	58.4%	48.3%	26.5%
Witnessed				
Bystander	50.8%	39.1%	30.5%	9.6%
Crew	-	39.7%	32.2%	15.6%
Not witnessed	38.9%	23.2%	17%	2.3%
Bystander CPR				
No	-	29.1%	21.4%	4%
Yes	-	35.4%	28.2%	8.7%

Appendix 5: Defibrillators in public places

The table below provides details on all 25 cases in which a Public Access Defibrillator was deployed.

Public Access Defibrillation	
Patient Demographics	
Number of cases:	25
Average age:	67 (40 - 89 years)
Gender:	Male (96%); Female (4%)
Event Information	
Incident location:	Airport 28% (n=7) Public Transport 36% (n=9) Leisure centre 4% (n=1) Shopping centre 8% (n=2) Other location 20% (n=5) Workplace 4% (n=1)
Bystander witnessed:	(92%; n=23)
Bystander CPR:	80% (n=20)
Initial rhythm (as recorded by public defibrillator):	VF/VT (84%; n=21) Non-shockable (16%; n=4)
Average number (and range) of PAD shocks*:	2 (1-7) shocks
ROSC:	40% (n=10)
Overall survival:	32% (8/25)

** Where initial rhythm was VF/pulseless VT*

Appendix 6: Key findings for patients under 18 years

In 2010/11, a total of 179 patients under the age of 18 had a cardiac arrest. Resuscitation was attempted for 153 (85.5%) patients, of these 85 (55.6%) were presumed to be due to a cardiac cause, 17 (11.1%) were thought to be due to trauma and 51 (33.3%) were due to another non cardiac cause.

	Presumed cardiac	Trauma	Other (non-cardiac)
Cardiac arrests: *n*	**85**	**17**	**51**
Gender: *n (%)*			
Male	48 (56.5)	12 (70.6)	28 (54.9)
Female	37 (43.5)	5 (29.4)	22 (43.1)
Not known	-	-	1 (2)
Ethnicity^: *n (%)*			
White	28 (32.9)	7 (41.2)	20 (39.2)
Mixed	1 (1.2)	-	1 (2)
Asian/ British Asian	9 (10.6)	-	3 (5.9)
Black/ Black British	13 (15.3)	3 (17.6)	12 (23.5)
Other Ethnic Group	7 (8.2)	1 (5.9)	3 (5.9)
Unable to obtain	24 (28.2)	6 (35.3)	10 (19.6)
Not documented	3 (3.5)	-	2 (3.9)
Presenting cardiac rhythm: *n (%)*			
VF/VT	9 (10.6)	-	3 (5.9)
PEA	8 (9.4)	9 (52.9)	6 (11.8)
Asystole	59 (69.4)	7 (41.2)	35 (68.6)
Not known	9 (10.6)	1 (5.9)	7 (13.7)
Arrest witnessed: *n (%)*			
Bystander	24 (28.2)	5 (29.4)	16 (31.4)
EMS personnel	5 (5.9)	1 (5.9)	7 (13.7)
Not witnessed	56 (65.9)	11 (64.7)	27 (52.9)
Not known	-	-	1 (2)
Bystander CPR: *n (%)*			
Yes	37 (43.5)	12 (70.6)	18 (35.3)
No	48 (56.5)	5 (29.4)	33 (64.7)
Arrest location: *n (%)*			
Public	12 (14.1)	9 (52.9)	2 (3.9)
Private	73 (85.9)	8 (47.1)	49 (96.1)
Other public location: *n (%)*			
Airport	2 (2.4)	-	-
Hotel/ Hostel	-	-	1 (2)
Leisure centre	1 (1.2)	1 (5.9)	-
Parkland/ Woodland	2 (2.4)	-	-
River	-	1 (5.9)	-
School	4 (4.7)	-	-
Shop	-	1 (5.9)	-
ROSC^: *n (%)*			
Yes	13 (15.3)	2 (11.8)	8 (15.7)
No	70 (82.4)	15 (88.2)	43 (84.3)
Not known	2 (2.4)	-	-
ROSC sustained to hospital: *n (%)*			
Yes	12 (14.1)	1 (5.9)	8 (15.7)
No	71 (83.5)	16 (94.1)	43 (84.3)
Not known	2 (2.4)	-	-
Overall Survival: *% (n)*	**5 (4/80)**	**5.9 (1/17)**	**10.9 (5/46)**

^ Due to rounding percentages will not equal 100%

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 23RD AUGUST 2011

PAPER FOR NOTING

Document Title:	**2011/12 Cost Improvement Programme – Progress to 31st July 2011**
Report Author(s):	**Martyn Salter**
Lead Director:	**Michael Dinan**
Contact Details:	**0207 783 2715**
Why is this coming to the Trust Board?	**Routine Monthly Report**
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 Board are asked to note the contents of the report and the corrective action being taken to deliver the CIP by the financial year end.**

Executive Summary

At the end of Month 4 there is a shortfall against the CIP plan of £496k but, by taking the corrective action identified in Section 5, the forecast for the year-end is that the CIP will be achieved.

Key issues for the Trust Board

To note the corrective action being taken to ensure the CIP is achieved by the year end.

Attachments

The report '2011/12 Cost Improvement Programme – Progress to 31st July 2011'

****

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 TRUST

2011/12 Cost Improvement Programme – Progress to 31st July 2011

1. Introduction

1.1. This report sets out the progress to achieving the 2011/12 CIP for the four months to 31st July2011 and the actions required to bring the delivery back on track.

1.2. The current CIP totals £15,640k, comprising £14,840k agreed as part of the 2011/12 budgets together with a further £800k required to deliver the surplus agreed with the NHSL and commissioners. Fuller details are set out in the table below:

	£000s
Originally Agreed CIP	13,369
Unidentified CIP included in directorate budgets[1]	1,439
Annual Leave policy	32
CIP included in Budgets	**14,840**
CIP required for commissioners year end agreement	800
Total CIP	**15,640**

2. Financial Results as at 31st July 2011 (Month 4)

2.1. **Appendix 1**, attached, shows a high level breakdown of the delivery of the CIP for the three months ended 31st July 2011. This indicates that there is a shortfall against plan of £496k at the end of Month 4. The under achievement against plan has reduced.

2.2. The annual planned CIP, as shown in **Appendix 1** is £14,840k, being the figure agreed with the SHA at the commencement of the financial year and were removed from budgets. Further savings are required to allow the Trust to achieve its agreed 'control total'. The total CIP required, which it is forecast to be delivered, is £15,640k.

3. Key Issues

3.1. At the end of July 2011, the main concerns are:

- Reduced Use of Agency Staff is still under achieving against the plan, although at a considerable lower rate than in previous months. This is

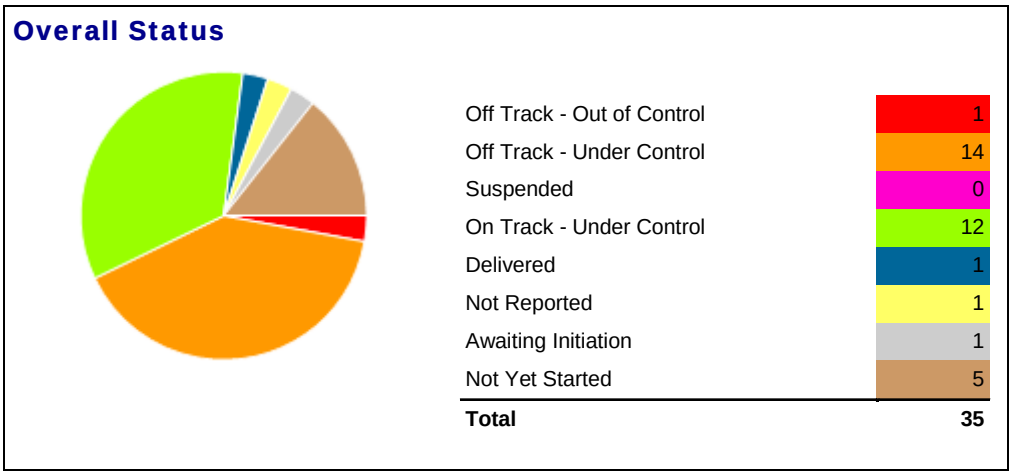
[1] Unidentified CIPs are those where the details of how the savings will be made have not been agreed between the relevant director and the finance department.

compensated by vacant posts within the various support service departments.

- The unidentified CIP included in directorate budgets shows significant under achievement against the plan. At the end of July 2011 only £250k of the savings has been identified.
- Projects to deliver productivity improvements are not delivering sufficient non-financial benefits to offset the impact of the reduced manning consequent upon the removal of posts at the commencement of the financial year, e.g. percentage of patients not conveyed to A&E. This in turn is leading to manning and performance issues.

4. Project Performance

4.1. Shows the CIP Project Status Report. The project status of all the CIP projects as at 31st July 2011 is summarised in the figure below.



4.2. Of the project not yet started, two are of concern as they should be delivering productivity gains in the current year to match the savings withdrawn from budgets. The Make Ready project is marked as 'Off Track – Out of Control' because the project manager has significant concerns relating to the level of savings achievable this financial year, based on the indicative tender responses.

4.3. Staff from the medical directorate continue to provide clinical oversight on all the projects.

5. Required Actions

5.1. To address the under achievement of savings against the planned target the following actions will be taken over the next month:

- Action within directorates needs to take place to drive down the use of

agency staff to the irreducible minimum.

- A detailed analysis of non-pay is being carried out by the DoF to identify savings and corrective action agreed will be taken by Month 5.
- Directors will agree the delivery plan, for the unidentified CIP, which will then be removed from individual budget lines before the Month 5 report.
- All currently vacant posts will be reviewed and unless recruitment to the post is agreed will be disestablished.

5.2. Project managers, supported by project executives, will work to deliver:

- The non-financial benefits for each project, which will allow for improved front-line productivity. Where non-financial KPIs have not bee identified project teams will do so.

5.3. It is proposed that the Finance and Investment committee will carry out a fuller review at its September meeting.

6. Conclusions

6.1. At the end of Month 4 there is a shortfall against plan of £496k but, by taking the corrective action identified in section 5, the forecast for the year-end can be achieved.

7. Recommendations

7.1. The Board are asked to note the contents of the report and the corrective action being taken to deliver the CIP by the financial year end.

Michael Dinan
Executive Director Finance
17 August, 2011

APPENDIX 1

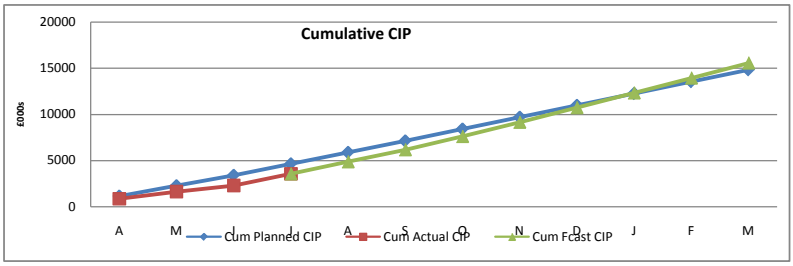
Month Ending 31st July 2011 - (Month 4)

Key CIP Programs	Performance Ytd Position				Forecast 2011/12				Status	
	Act £000	Plan £000	Diff £000	%	Fcast £000	Plan £000	Diff £000	%	Current	Forecast
Front Line staffing - Process Management	2,014	1,729	285	116.5%	6,881	5,187	1,694	132.7%	↑	↑
Front Line staffing - Resource Management	164	89	75	184.8%	800	800	0	100.0%	↔	↔
Fleet optimisation	101	28	73	361.1%	263	251	12	104.8%	↔	↔
Support Services - Pay	206	206	0	100.2%	617	617	(0)	100.0%	↔	↔
Support Services - Agency	365	794	(429)	46.0%	1,395	2,381	(986)	58.6%	↓	↓
Support Services - Non Pay	872	990	(118)	88.1%	2,816	2,970	(154)	94.8%	↓	↓
Support Services - IM&T	279	298	(20)	93.4%	865	895	(30)	96.7%	↔	↔
PTS	(4)	6	(10)	-62.1%	668	268	400	249.0%	↔	↑
Subtotal	**3,997**	**4,139**	(143)	96.6%	**14,306**	**13,369**	**937**	**107.0%**	↓	↑
Unidentified	126	480	(354)	26.3%	1,302	1,439	(137)	90.5%	↓	↓
Other - Annual Leave Policy	11	11	0	100.0%	32	32	(0)	99.2%	↔	↔
Total	**4,133**	**4,630**	(496)	89.3%	**15,640**	**14,840**	800	105.4%	↓	↑

KEY:

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

Front Line Staffing - Process Management :
- CIP identified in this line only include the reduction of Frontline posts by 132wte. It does not include overspend on Overtime and over establishment of A&E Management.



London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD (pt 1)

23 AUGUST 2011

PAPER FOR DECISION

Document Title:	**CommandPoint Update**
Report Author(s):	**Peter Suter, Director of Information Management and Technology**
Lead Director:	**Peter Suter, Director of Information Management and Technology**
Contact Details:	**peter.suter@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To provide an update of progress on the CommandPoint Project.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group
Recommendation for the Trust Board:	**The Trust Board are asked to note the contents of this report.**

Executive Summary

The objective of this paper is to provide an update of progress on the CommandPoint project.

Key issues for the Trust Board

Progress to date and the considerations for the next go live.

Attachments

CommandPoint Project Update August 2011

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Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper links to the following strategic risks:

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

NHS Constitution

This paper supports the following principles that guide the NHS:

☐ 1. The NHS provides a comprehensive service, available to all
☐ 2. Access to NHS services is based on clinical need, not an individual's ability to pay
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☐ 4. NHS services must reflect the needs and preferences of patients, their families and their carers
☐ 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

Trust Board 23 August 2011 (part 1)

1. OBJECTIVE

1.1 The objective of this paper is to provide an update of progress on the CommandPoint Project.

2. SUMMARY OF PROGRESS SINCE LAST REPORT

2.1 The four core faults that caused the system failure on 8 June have been rectified and the corrected version of the software released to the LAS. This has been installed in the LAS test environment where NG has demonstrated the fixes. This was done by, where possible, first reproducing the faults on the 8 June version of the software and then showing that the same circumstances do not produce those faults in the rectified version. Further evidence that all the faults are fixed will be sought during subsequent testing and dry run phases.

2.2 As previously reported there are a number of other items that have been identified as requiring resolution before the next go live. The last report to the Trust Board (SRP meeting in July) quantified this as 150. 90 of these were defined as bugs and as of 8 August, 44 have been completed and testing is currently underway. For completeness it should also be reported that there are 16 items (in addition to the 150) that are the responsibility of the LAS to resolve (e.g. some issues with MDT messages) and work in hand to address these.

2.3 The remaining 60 items (of the 150) were quickly reduced to 34 (due to duplicates, items combined, items not reproducible and moved to watch lists), and were defined as enhancements. This term should be interpreted as descriptive of the type of work required to fix the items; the LAS had not identified 34 new functions required as enhancements.

2.4 The assumed nature of the work required to resolve these other 34 items caused the initial timeline to map out to an unacceptable date in July 2012. The main cause for this was high level planning assumptions associated with each item. In order to address this NG developers flew to the UK and engaged in a detailed workshop with the LAS to clarify each item. The LAS team was led by Senior User ADO John Hopson supported by subject matter experts from the Project Team and staff seconded from the control room (who had not previously been involved with the project). This work allowed clarification and compromises on delivery details in order to simplify the development work required. As a result, a further 8 items were removed (work included in other items) and a new baseline of 116 items has been agreed:

- 103 Bugs
- 7 items that can be resolved with design notes, instead of full design documentation.
- 6 items requiring full design documentation

2.5 Ed Sturms, one of NG's Vice Presidents has been assigned full time as NG's Project Executive. His role is to lead all the NG resources necessary to bring the LAS fully live. Ed was originally involved with the tender stage of the project and is known to the LAS. I see this as a positive enhancement to the project structure.

2.6 As well as supporting the NG activities, the LAS Project Team have continued to work on progressing the following:

- Developing a new project plan to minimise the timeline required from NG delivery to live use
- With input from the external test consultant, developing a new detailed test plan
- Progressing Management Information changes to minimise the impact when CommandPoint goes live
- Developing the training plans that will be critical to a successful go live

3. REVIEW OF 8 JUNE PROBLEMS

3.1 The analysis of what went wrong on 8 June and why it went wrong has been completed. This can be summarised into three key areas:

3.2 Firstly there were four critical technical faults (not identified during testing) that caused the system to fail five hours after going live. Had this not occurred, and the system remained live, the operational experience would have been considerably different. Other issues identified would probably have been dealt with through emergency patch releases and there would have been a greater acceptance of system work arounds and compromises.

3.3 The detailed root cause reports of the four critical faults have been previously presented by NG to the Trust board. NG have also been very open in their response, acknowledging that with hindsight they did not do enough to fully assess and understand how the LAS would use CommandPoint™ in live operation. That is why certain elements of testing were not comprehensive enough to identify the fault conditions that existed.

3.4 Secondly, Operational users had accepted both a number of workarounds for known problems and some functionality that would be delivered in later releases. The five hours of live use identified that some of the workarounds were more complex than anticipated, and potentially some of the later release functionality proved to be more important than had been previously accepted. Clearly there is conjecture around these points as the user experience was set against a very difficult background caused by the four critical faults.

3.5 Thirdly, as anticipated there were a number of new bugs discovered during go live, that have now added to the number of items that need to be resolved. It is this collective number of items requiring resolution and the damage to user confidence that is crucial to the next go live planning.

4. GO LIVE CONSIDERATIONS

4.1 In considering the timetable for the next go live there are several factors for consideration:

Assurance

4.2 The software released for go live will undergo a vigorous test regime, from both the NG and LAS perspective. This will include an independent assessment by the test consultant brought in from the CfH programme.

4.3 The biggest problem faced on 8 June was that the NG performance test environment did not sufficiently resemble the complexity and loading of the operation LAS environment. Lessons have been learnt to inform current plans, however a differential between the test and live environments will always exist.

4.4 In order to address this differential, at NG's request, the LAS have redeveloped a number of the interface simulators. This will enable NG to include more realistic operational performance loading into their enhanced performance test environment. The advanced simulators are also installed in the LAS test environment to support dry run testing.

4.5 The approach to the next go live will also include a schedule of live tests. It this way the LAS will switch from CTAK to CommandPoint™ for up to 6 hours and then switch back to CTAK. This sequence could be repeated several times and would be used to give overall assurance and confidence in the system.

4.6 This approach is influencing the release schedule of the system for go live. The first release is V1.2, the functionality of which has been agreed by Senior Users as being acceptable for live running for up to six hours. The second release is V1.3 that will contain resolutions to all the 116 issues.

External pressures

4.7 There are many conflicting pressures on the timetable to go live, the main ones are:

- Winter pressures, especially Christmas and New Years Eve.
- Impact on operational performance and ability to hit the Cat A performance target. Whenever CommandPoint goes live, there will be degradation in operational performance.
- User confidence if the system does not have the full complement of issues resolved prior to go live.
- The Olympics that commence in London on 27 July 2012.
- The Queens Diamond Jubilee celebration in June 2012.
- Negative publicity the longer it takes to bring CommandPoint live.
- Delivery of Bow & HQ as live control rooms requires CommandPoint to be live in HQ first.
- Development of 111 services requires CommandPoint to be live and an interface developed to receive calls from external service providers.
- CRM requires CommandPoint to be live and an additional enhancement implemented
- At go live there will always be new issues that are discovered - this is normal with any new system. A period of up to 3 months dealing with new issues, patch releases and workarounds would be a reasonable planning assumption. Conceptually this is no different from 8 June or any date that is selected. However, the less the known faults at go live, the lower the risk and the better the chances of a lesser impact on operational performance.

5. GO LIVE OPTIONS

5.1 There are conflicting pressures between the time required to resolve all the outstanding items and the operational demands of Olympics and jubilee celebrations. Detailed plans and options are currently under consideration and are subject to commercial sensitivity.

6. BUDGET

6.1 The project budget is currently under detailed review due to the project delay. Details will be presented in the next report.

7. RECOMMENDATIONS

7.1 The Trust Board are asked to note the contents of this report.

Peter Suter
Project Executive
Director of Information Management & Technology

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 23RD AUGUST 2011

PROGRESS REPORT

Document Title:	**Progress report on the LAS application to become an NHS Foundation Trust**
Report Author(s):	**Sandra Adams**
Lead Director:	**Sandra Adams**
Contact Details:	**Sandra.adams@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To update the Board on a key strategic development**
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 be aware of the progress the Trust needs to make before the Board to Board meeting on 7th October and prior to submission of the application to the Department of Health on 1st December 2011**

Executive Summary

- The Board to Board meeting with NHS London is confirmed for 2.00pm on Friday 7th October 2011.
- The historical due diligence (HDD) review undertaken in January and April 2011 will need to be refreshed before our application is submitted to the Department of Health (DH).
- Key to a successful application at DH and Monitor stage are our ability to demonstrate that the LAS NHS foundation trust will be legally constituted, financially viable and well governed
- The Tripartite Formal Agreement (TFA) between the LAS, NHS London and the DH has to be updated and re-submitted by 19th August showing the revised timeline.
- Key to our preparation for the Board to Board and HDD2 is a financial recovery plan reviewed and signed off by the Trust Board and finalising the downside cases and mitigation plans.
- Board development sessions are planned throughout September and will focus on finance, quality, performance, CommandPoint, risk and assurance. These reflect the likely areas of challenge at the meeting on 7th October.

Key issues for the Trust Board

- It is important to maintain momentum and focus on the timeline and the actions we need to take and to assure ourselves about for the Board to Board and then formal submission to DH.
- The draft constitution, appended to the Integrated Business Plan, is in line with Monitor's model constitution and with current legislation. Legal advice is that we should not make any changes to the constitution until the Health Bill becomes law and we will discuss then with Capsticks any changes that may have to be made.

- South West Ambulance Service NHS foundation trust hosted a day of presentations for other ambulance trusts on the lessons learnt through the Monitor stages of the application. This was very useful as we start to prepare for the next stages. A summary of the submissions we are required to make to Monitor is attached for information in advance of key items, such as the Board Memorandum and self-certification statements, coming to the Board for discussion and approval.

What action does the Trust Board need to take with the information provided?

- To understand the requirements from the Trust prior to the Board to Board and submission to the DH.
- To prepare individually for the Board to Board meeting and to identify any areas that board members wish to understand further through the Board development sessions.
- To consider the 3 key areas of assurance at the Monitor stage of the application process.

Are there any areas which are a cause for concern?

- Timeline for HDD2 stage 2 review of Month 6 financial results is tight in order for NHS London to process our application through their internal governance prior to submission to DH on 1st December 2011.
- Financial recovery plan and downside cases and mitigations are essential for Board governance, sign off and submission to NHS London and the Cluster Finance Director.
- The decision regarding the next go live date for CommandPoint and the plans to support this process and provide assurance to the Trust Board, and the implications of this on the 5-year strategic and financial plans.

What are the key actions to mitigate any concerns?

- Financial recovery plan and downside cases and mitigation programme to be reviewed, signed off and monitored by the Trust Board.
- Board development session throughout September to prepare board members for 7th October.
- Board agreement on the next steps towards CommandPoint implementation.

How does the Trust Board draw assurance?

- Scrutiny and challenge on financial and performance information leading to agreement on recovery plans.
- Outcome of HDD2 refresh in September and October/November.
- DH sign-off the Tripartite Formal Agreement
- Submission of the foundation trust application to the DH on 1st December 2011.

Attachments
Summary of submissions for Monitor's assessment phase

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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 principles that guide the NHS and enshrined within the NHS Constitution.

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☒ Yes - On the Integrated Business Plan

☐ No

Key issues from the assessment:

None.

Summary of submissions to Monitor during the assessment phase of the foundation trust application

Legally constituted	• Constitution including election rules – appendix 3 of the IBP • Summary of statutory consultation process – appendix 4 of the IBP • Membership strategy – appendix 5 of the IBP • Update on implementation of membership strategy • Details of electoral process and report on initial elections
Financially viable	• Final IBP • Financial model incorporating long-term financial projections and working capital projections (ie 5-year annual projections and two year monthly working capital projections) • Working capital board statement and board memorandum • Schedule of services
Well governed	• Final IBP • Governance arrangements and rationale – appendix 2 of the IBP • Membership strategy – appendix 5 of the IBP • Update on implementation of membership strategy • Details of electoral process and report on initial elections • Register of directors' interests • Register of governors' interests • Third party inspectorate reports • Self-certification statements and supporting evidence • Direct evidence on - Performance management - Risk management - Targets and standards

Note:

Integrated business plan includes:

- Long term financial model
- Governance rationale
- Model core constitution
- Consultation response and staff engagement
- Membership strategy.

Self-certification statements:

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

- Proforma Board Statement on Quality Governance

Sandra Adams, Director of Corporate Services August 2011

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

DATE: 23 AUGUST 2011

PAPER FOR NOTING

Document Title:	**Bribery Act 2010 Briefing**
Report Author(s):	**Hayley England, Local Counter Fraud Specialist**
Lead Director:	**Michael Dinan, Director of Finance**
Contact Details:	**07736108950, hayley.england@rsmtenon.com**
Why is this coming to the Trust Board?	**To provide awareness of the new legislation and the implications this has for the Trust**
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 briefing on the Bribery Act 2010**

Executive Summary

This paper has been produced to provide the Trust Board with an awareness of the effects of the Bribery Act 2010 including descriptions of the key offences and defences, the adequate procedures expected to be absorbed into the Trust's existing governance arrangements and the progress to date of its implementation.

Key issues for the Trust Board

Provide awareness of the legislation, t
he ramifications of not having adequate procedures in place to prevent bribery occurring and the risks associated with this.

Attachments

RSM Tenon Bribery Act Briefing
A presentation will be delivered at the Board meeting to accompany this briefing.

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Strategic Goals 2010 – 13

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Risk Implications

This paper supports the mitigation of the following strategic risks:

- ☐ That we fail to effectively fulfil care/safety responsibilities
- ☐ That we cannot maintain and deliver the core service along with the performance expected
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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:

The Anti-Bribery Policy has been assessed and is applicable to all staff.

RSM Tenon

BRIBERY ACT BRIEFING

The Bribery Act will be implemented on 1 July 2011.

The Bribery Act reforms criminal law to provide a new, modern and comprehensive scheme of bribery offences that will enable courts and prosecutors to respond more effectively to bribery in the UK or abroad. As part of the implementation of the Act, the Ministry of Justice also revealed the statutory guidance on the adequate procedures required for businesses to avail themselves of a statutory defence to the corporate offence included in the Act.

The Act covers a wide range of both direct and indirect bribery offences, whether or not involving a public official, in the UK or abroad. This includes offences committed by individuals and corporate offences applicable to corporates and partnerships. Penalties for non-compliance with the Act are serious.

In the context of the legislation, a 'corporate'is defined as any organisation that has some element of business activity, irrespective to what happens to any profit. Even if not deemed as a corporate, it is important from an ethical and governance stance that organisations ensure relevant policies and processes dovetail with the requirements of the Bribery Act and that they are aware of the obligations also placed upon suppliers and contractors with which they do business.

KEY FACTS OF THE BRIBERY ACT

The Bribery Act 2010:

- Provides a more effective legal framework to combat bribery in the public and private sectors;
- Replaces the disjointed and complex offences of common law and those in the Prevention of Corruption Acts 1889-1916, which will be rescinded;
- Creates two general offences covering the offering, promising or giving of an advantage, and requesting, agreeing to receive, or acceptance of an advantage;
- Introduces a corporate offence of failure to prevent bribery by persons working on behalf of an organisation. Organisations may avoid conviction if they can show that they have adequate procedures in place to prevent bribery;
- Makes it a criminal offence to give, promise or offer a bribe and to receive or accept a bribe either at home or abroad. Measures also cover bribery of a foreign public official;
- Increases the maximum penalty for bribery from seven to ten years imprisonment, with an unlimited fine;
- Requires the Secretary of State to publish guidance about procedures that relevant commercial organisations can put in place to prevent prosecution for the corporate offence; and
- Helps tackle the threat that bribery poses to economic progress and development around the world.

ADEQUATE BRIBERY PREVENTION PROCEDURES

As stated, it is a complete defence if the organisation can show that it has adequate bribery prevention procedures in place. The Ministry of Justice Guidance was issued on 30 March 2011 and set out six principles to be implemented to prevent a finding of negligently failing to prevent a bribe. These are as follows:

- **Principle 1 – Proportionate procedures:** A commercial organisation's procedures to prevent bribery by persons associated with it are proportionate to the bribery risks it faces and to the nature, scale and complexity of the commercial organisation's activities. They are also clear, practical, accessible, effectively implemented and enforced.
- **Principle 2 – Top level commitment:** The top level management of a commercial organisation (be it a board of directors, the owners or any other equivalent body or person) are committed to preventing bribery by persons associated with it. They foster a culture within the organisation in which bribery is never acceptable.
- **Principle 3 – Risk Assessment:** The commercial organisation assesses the nature and extent of its exposure to potential external and internal risks of bribery on its behalf by persons associated with it. The assessment is periodic, informed and documented.
- **Principle 4 – Due diligence:** The commercial organisation applies due diligence procedures, taking a proportionate and risk based approach, in respect of persons who perform or will perform services for or on behalf of the organisation, in order to mitigate identified bribery risks.
- **Principle 5 – Communication (including training):** The commercial organisation seeks to ensure that its bribery prevention policies and procedures are embedded and understood throughout the organisation through internal and external communication, including training that is proportionate to the risks it faces.
- **Principle 6 – Monitoring and review:** The commercial organisation monitors and reviews procedures designed to prevent bribery by persons associated with it and makes improvements where necessary.

WHAT ARE WE DOING?

The London Ambulance Service, in conjunction with the Local Counter Fraud Specialist (LCFS), has taken a robust and proactive approach to the requirements of the Act. The Trust already has strong governance arrangements in place that will meet many of the key work streams needed to achieve compliance. To further strengthen our approach, the LCFS has undertaken a full operational Fraud Risk Assessment which reviewed a number of activities affected by the implementation of the Act.

From this assessment, a number of recommendations were made to assist in the Trust becoming compliant.Key work streams for the Trust to address to assist in being compliant include, but are not limited to:

- The Trust Board should take responsibility for Anti-Bribery and Corruption to ensure the message is communicated from the 'top down.' Information can be provided to the Board in the form of bespoke training
- Formal Nomination of a Senior Compliance Officer
- Adoption of an E-learning Package which is heavily publicised to facilitate training through all levels of the organisation
- Article in the RIB
- Inclusion of the legislation within the existing fraud presentations provided to key groups as well as at inductions. This will include refreshing all counter fraud literature
- Trust assessment of operational risks specific to the organisation – potentially through the Risk Compliance Assurance Group

- Bespoke training to key risk groups – Finance /Payroll / Procurement / IM&T / Estates / Stores / Legal
- Ensure adoption of the Anti-Bribery Policy post-assurance testing from the Legal Department and the policy inserts provided for the relevant policies
- Training to PTS as commercial arm of LAS
- Regular and risk-based checks and auditing in key risk areas to ensure continued monitoring of risk and record keeping
- Continued use of procurement and contract management procedures to minimise the opportunity for corruption by subcontractors and suppliers
- Review of sole supplier waivers to actively consider the risk that this process may be used to circumvent tendering exercises, which could be used to mask bribery and corruption
- Review of due diligence in place for engaging consultants. This could include making enquiries through business associations, or internet searches and following up any business references and financial statements
- Counter Fraud Review of all standard contracts used for suppliers or engaging consultants to seek assurance that they reflect a commitment to zero tolerance of bribery, set clear criteria for provision of bona fide hospitality and define in detail the basis of remuneration, including expenses
- Design of key guidance points on preventing bribery for its staff involved in bidding for business and when engaging consultants
- Having a standard item regularly on the SMG meetings within the risk areas identified to periodically emphasise the relevant policies and procedures

RSM Tenon will continue to provide updates, guidance, support and assistance in relation to ensure adequate procedures are addressed in relation to the Bribery Act 2010.

Hayley England
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London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

23RD AUGUST 2011

Compliance with Standing Orders and Standing Financial Instructions

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 be advised of the tenders received and entered into the tender book and the use of the Trust Seal since 28th June 2011 and to be assured of compliance with Standing Orders and Standing Financial Instructions**

Executive Summary

Three tenders have been received, opened and entered into the tender book since 28th June 2011:

- Analogue Radio Site Equipment Removal
  Tenders received and opened via Bravo Solutions on 7th July 2011:
  Argiva Ltd
  Avatar Electrical Ltd
  Communication and Technology Services Ltd..
- 24-hour support and maintenance of vehicle based ICT
  Tenders received and opened via Bravo Solutions on 7th July 2011
  Telent Technology Services Ltd.
- Purchase of Park Royal
  Tenders received and opened via Bravo Solutions on 8th July 2011
  Wrenbridge
  National Bank of Dubai
  Memory Crystal
  Chancerygate.

  The amounts of each tender can be made available to the Trust Board in Part II of the Trust Board meeting.

There has been one entry to the Register for the Use of the Trust Seal on27th July 2011:

- Lease renewals for North Woolwich Road and Fort Street
  JT Downey (Investments) Ltd and London Ambulance Service NHS Trust

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

Attachments
N/A

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Strategic Goals 2010 – 13
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Risk Implications
This paper links to the following strategic risks:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?
Yes
No

Key issues from the assessment:

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

23RD AUGUST 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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Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☐ No

Key issues from the assessment:

TB FORWARD PLANNER

	2010/11 Budget for approval	Service-wide Rota project		Balanced scorecard	Full update on core standards compliance 2009/10		
Date	**Strategic and Business Planning**	**Items for approval (eg Policies and Business Cases)**	**Performance and Other**	**Governance**	**Standing Items**	**Apologies**	**Committee dates**
27 Sept 2011 TB	FT application update		Clinical Quality Dashboard (SL)	Annual Trust Board effectiveness Review 2010/11	Report from CEO including balanced scorecard and performance reports		Qual 7th Sept
SMG 14 Sept	CommandPoint Update			BAF and risk register	Report from Finance Director		Audit 12th Sept
	CommandPoint Serious Incident report			2009/10 Annual Equality Report	Report from Sub-Committees		Finance & Investment 13th September
	Development of 111			KA34 Compliance Statement	Clinical Quality and Patient Safety Report		
				Corporate Social Responsibility Report (CMc)			
				Patient Experience Annual Report (SA)	Report from Trust Secretary		
1 November 2011 SRP awayday - all day	Review of balanced scorecard			Board statements and self declarations			
	Outsourcing						
	Presentation on NWoW, CRM, Estates, A&E management restructure and clinical management structure						
29 Nov 2011 TB				Q2 cost improvement plan	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
							Finance & Investment 28th November
13 Dec 2011 TB			7/7 progress report	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		

Presentations
Approval
Compliance
FT items