London Ambulance Service NHS
NHS Trust

TRUST BOARD

Meeting to be held at 10.00am on Tuesday 26th January 2010
Conference Room, LAS Headquarters, 220 Waterloo Road, London SE1 8SD

Peter Bradley
Chief Executive Officer

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AGENDA

			Tab
1.	**Welcome & Apologies** To note the apologies from Fionna Moore, Medical Director, and to welcome Fenella Wrigley, Assistant Medical Director		
2.	**Minutes of the Part I meeting held on 24th November 2009**		
	To approve the minutes of the meeting held on 24th November 2009		1
3.	**Matters Arising** – Action log register		2
	3.1 Silvertown Olympic site – to receive an update on the position with the draft lease	MD	
	3.2 Audit Committee minutes and annual report	SA	
	3.3 Service improvement programme	CH/MF	
	3.4 CAD 2010 progress report	PS/PB	
4.	**Formal reports from sub-committees**		
	4.1 Clinical Governance Committee		
	To receive an oral report of the meeting held on 25th January 2010	BM	Oral
5.	**Chairman's Update**	RH	Oral
6.	**Report of Chief Executive Officer**	PB	3
7.	**Report of Finance Director** 7.1 To receive a report on financial performance for month 9 and the projected year end position	MD	4
	7.2 CIP development		
	7.3 Fleet update and business cases for approval		Oral

8.	**Clinical quality & patient safety report** **To receive the report and to note the following items:** 8.1 Safeguarding declaration – to receive a copy of the revised declaration published on 31st December 2009	FW	5 6
	8.2 Infection prevention and control – to receive an update on progress against the action plan		Oral
	8.3 Patient safety – to receive an update on compliance with the Care Quality Commission registration requirements		Oral
	8.4 Medicines management/controlled drugs management – to receive an update on progress with the action plan		Oral
	8.5 Patient experience report – part 2	MF	7
9.	**Care Quality Commission registration requirements** To receive and approve the registration submission	SA	8
10.	**Risk management arrangements** 10.1 To receive an update on the development of the Strategic Risk Register and Assurance Framework	SA	9
	10.2 To note the updated risk register		10
	10.3 To discuss and approve the revised committee structure		11
11.	**Strategy & planning** 11.1 Strategic goals and objectives – for approval	KJ	12
	11.2 Corporate objectives – for approval	KJ	13
	11.3 Draft business plan 2010/11 including the 1st cut submission to NHS London – for discussion	MD	14
	11.4 Estates strategy	MD	Oral
12.	**Application process for becoming an NHS Foundation Trust** 12.1 Membership strategy To discuss and approve staff side representation on the Council of Governors	SA	Oral
	12.2 Integrated business plan To receive an update on progress with the development of the Integrated Business Plan	SA	Oral
	12.3 Long term financial model To receive an update on progress with the Long term financial model	MD	See item 11. 3
13.	**Service improvement programme update** 13.1 Progress report	KJ	Oral
	13.2 Olympic and Paralympic games	MF	15
	13.3 Clinical education – developing a new pathway	CH	16

14.	**Quarter 3 Integrated governance and finance declaration** To note the Q3 declaration submitted to NHS London on 14th January 2010	SA/MD	17
15.	**ALE 2009/10**		
	15.1 To receive and discuss 'Taking it on Trust' – checklist for Boards	SA	18
	15.3 To nominate Board responsibilities for Security Management: a) Executive director (voting) and b) Non-Executive director	PB/RH	19
16.	**Report of Trust Secretary**		
	16.1 To note the use of the Trust Seal and tenders received	SA	20
	16.2 To note the Trust Board and Service Development Committee forward planner from January to December 2010	SA	21
17.	**Presentation on Out of Hospital Cardiac Survival figures 2008/09** Presenter: Lynne Watson – Cardiac Data Officer		
18.	**Presentation to Joan Mager, CEO, Richmond & Twickenham Primary Care Trust**	PB	Oral
19.	**Questions from Members of the Public**		
20.	**Any Other Business**		
21.	**Date of next meeting**		
	The next meeting of the Trust Board of Directors will be held on Tuesday 30th March 2010.		

ACTIONS
from the Meeting of the Trust Board of Directors of
LONDON AMBULANCE SERVICE NHS TRUST
held on 24th November 2009

MINUTE NO.	PART I MEETING	RESPONSIBILITY	DATE
77/09 **112/09**	Balanced scorecard For the Board to discuss the scorecard at its next meeting.	**Director of Finance (to be included in the Chief Executive's report)**	**26th January 2010**
85/09 **117/09**	Audit recommendations on drug controls Assurance to be given at the next Board meeting on progress with the action plan.	**Medical Director (to be included in the Clinical quality & patient safety report)**	**26th January 2010**
106/09 **112/09**	Silvertown Olympic site Update on review of the draft lease.	**Director of Finance**	**26th January 2010**
113/09	Audit committee minutes and annual report To be circulated.	**Director of Corporate Services**	**26th January 2010**
121/09	Service Improvement Programme a) Annual leave project:- provide an update at the next Board meeting. b) To provide updates the status of the referral pathways and New Ways of Working projects. c) CAD 2010 – Chief Executive's report to include progress towards the 1st major milestone.	**Director of Human Resources and Organisational Development/** **Deputy Chief Executive** **Chief Executive**	**26th January 2010**

122/09	Membership strategy Confirm whether other NHSFTs have staff side representation on the Council of Governors	**Director of Corporate Services (to be included in the NHSFT item)**	**26th January 2010**
124/09	Use of the Trust Seal Confirm the use and legal standing of the Trust Seal	**Director of Corporate Services (to be included in the report of the Trust Secretary)**	**26th January 2010**

LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING 26 JANUARY 2009
CHIEF EXECUTIVES REPORT

1. SERVICE DEVELOPMENT

An internal board has been established with oversight of the Healthcare for London workstream. The workstream board has a specific focus on the establishment of the constituent projects, their management and control, and their successful delivery into the service.

Current position:

Stroke & Major Trauma

Operational Research in Health (ORH) have submitted their draft report. Their modelling has suggested that the impact on LAS performance of delivering the two pathways is small and can be mitigated by deploying the following resources:

Major Trauma
- 24 Vehicle Hours per Week (VHPW), at each of Poplar, Battersea and Fulham Ambulance Stations, on a Friday and Saturday night, between 2000-0800.
- Requires 5.00 Whole Time Equivalent (WTE) staff

Stroke
- 30 VHPW at each of Edmonton, Barnehurst and Hillingdon Ambulance Stations, deployed Monday-Friday, 0800-1400.
- Requires 6.50 WTE staff

A communications plan has been developed to ensure all staff are aware of the impact the changes in stroke and trauma care will have on the LAS.

A Clinical Coordination Desk Project Board has been set up with the intention of ensuring LAS is well placed coordinate the flow of patients to all specialist centres and A&E departments. SMG approved the corresponding funding in December.

Resource within CARU has been assigned to develop the major trauma and stroke audit systems and a project plan is currently being developed to support this.

A finance report has been developed for commissioners outlining spend to date on HfL.

Stroke

LAS continue to work closely with Healthcare for London to implement the two stage transition to the full stroke model. From February 2010 all Face/Arms/Speech test positive (FAST+) patients who can be conveyed to a Hyper Acute Stroke Unit (HASU) within to arrive within 3 hours of onset of symptoms will be conveyed in this manner. This will be expanded to include all FAST+ patients, excluding those in South East London, from April 2010. South East London will follow suit once the HASU at Princess Royal University Hospital (Bromley) opens early 2011.

Cardiac and Stroke Network Directors reaffirmed their commitment to the first part of this timetable at a meeting on 13th January 2010.

LAS will accelerate the coordination role offered by Emergency Bed Service (EBS), currently being trialled in South East London, so that some of its features can be implemented across London to assist with the first stage of implementation.

It is expected that continued pressure will need to be applied if the April deadlines are to be met as well.

Trauma

Major Trauma Centres based at The Royal London Hospital, Kings College Hospital and St Georges Hospital will go live in April 2010, with a fourth centre at St Mary's Paddington scheduled to go live in October 2010. The LAS is confident we will be able to respond to this effectively.

The LAS continue to work closely with the London Trauma Office and trauma networks across London to develop robust implementation plans.

The final cohort of team leaders have embarked on the two-week clinical update which has a focus on crews' roles in delivering the Major Trauma proposals, specifically their use of the LAS's trauma decision tree (developed with designated Major Trauma Centres).

Unscheduled Care

Our commissioners' transformational team are now taking an interest in the development of a pan-London "directory of services" – a tool for identifying the community services available for patients who do not need the emergency department. This interest may help to accelerate this development.

2. SERVICE DELIVERY

Accident & Emergency service performance and activity

The table below sets out the A&E performance against the key standards for the year to date (2009/10), the complete validated performance for November and December and the un-validated performance for the first 16 days of January. The 1st of the month was New Years Day with exceptional demand. If that were to be excluded then Category A performance for the month would be above 80% and Category B performance would have been 91.1%.

	CAT A8	CAT A19	CAT B19
Standard	**75%**	**95%**	**95%**
2009/10 YTD	74.4%	98.5%	86.1%
November 2009	72.9%	98.9%	89.9%

December 2009	71.5%	98.0%	82.2%
January 2010 (to 16th)*	78.4%	98.4%	89.9%

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

Demand on the LAS continues to rise with overall activity up. The incoming call demand remains at about 6% above the previous year and responses up about 4%. Activity rose by 4.6% in October, 5.1 % in November and 1.4% in December, as compared to the previous year. Year to date there has been an increase in Category A8 activity of 2.7% and Category B activity of 4.8%. Resource utilisation continues to be an area of further concern. It has risen again in December with utilisation hitting 75% for the month which is a further deterioration against the ideal of 55%.

December was the busiest ever month for the LAS, with a daily average number of responses of above 2,900 per day (in excess of 91,000 calls for the month). This meant that for the fist time ever the LAS responded to in excess of 1 Million calls in a year- with the millionth call being received in the early hours of the 31st December. New Years Day started exceptionally busy with the peak hourly demand experienced at 1am when over 700 calls were taken as compared to a norm of 150-200. Over the course of the day 7,136 calls were taken, exceeding the previous year by 1,000 calls and Millennium Eve which was 1,300 calls quieter.

We are continuing to note that demand is presenting in surges at different times from previously which has caused exceptionally high volume hours which are resulting in high utilisation levels and poor performance.

999 call answering performance has been reasonable with 95.7% answered within 5 seconds in November and a slight deterioration in December with 90.8% answered in 5 seconds. As incoming call levels have fallen in January, the call answering performance has improved and is now back over 95%.

We produced circa 267,259 Ambulance Hours of resourcing for November and December this year which was circa 13,143 hrs more than for the same period last year and both months showing an increase in Ambulance hours. This 5.2% increase resulted in seven of the nine weeks having Ambulance resourcing at more than 30,000 hours. For January we are already seeing an even further improvement with 2 weeks at 32,000 hours.

FRV hours produced for November and December decreased by circa 7% to 111,436hrs compared to 120,366hrs for the same period as last year. This is made up of a decrease of 4000hrs in November and a decrease of 4846hrs in December. One contributing factor was the stopping of the FRV bonus scheme in October and the unwillingness of staff to work on FRVs. The introduction of an FRV shift bonus and an overtime enhancement during specific days in December has improved staffing to a more acceptable level and resulted in the improvements seen.

Pure overtime spend for this period compared to last year (without enhancements or bonuses) decreased by circa 25% to 86,453hrs which is as to be expected with the additional numbers of staff now on frontline duties.

Over the past few weeks the Emergency Planning Department has been extremely busy preparing and then enacting plans to deal with the adverse weather. Part of the planning has involved the negotiating of a number of loan four wheel drive vehicles from Land Rover, Mitsubishi and Paragon Fleet Solutions who all very kindly loaned vehicles for the use of the LAS. To ensure that we could facilitate our staff getting to work we identified a number of muster points across the areas and hired in 4x4 vehicles. These vehicles were also available to attend calls in cases where we experienced difficulties in getting to some call locations.

During the worst of the weather, we hired a number of hotel rooms for use by staff and managers that may have experienced problems getting to and from work. This meant that they were available at the start of their shift and helped us to provide an effective service. There have been a number of daily conference calls both within the trust and with other Health partners and the SHA to provide updates, share information amongst the key players and enact various closures and diverts. The development of the Strategic Adverse Weather Plan that covered all aspects of the service including

Overall Planning was a great success. LAS staff made great efforts to attend work and as a result the performance delivered during the period was amongst the best in the country with the not insignificant issues effectively managed as best we could.

One of the key objectives for LAS for 2009/10 was to reduce the total hospital turnaround time by 5mins across London. Currently the average total turnaround time in London is 33.7mins, a 1.2min reduction since April 09. However this hides a distinct variation in performance towards this target between the acute Trusts and LAS.

Over the last few months we have continued to work closely with NHS London and the acute Trusts to improve hospital turnaround. Delays within emergency departments continue to increase across London. During the week ending 27th December the average arrival to patient handover time across London had risen to 14.7 minutes, a 15% rise since April 09, with handover exceeding 15mins on average 36% of the time. Handover delays exceeding an hour are declared as potential SUIs for the Trust who have been unable to receive the patient, over 100 potential Serious Untoward Incidents (SUIs) were declared across London over the Christmas period. Work is currently underway to develop key performance indicators (KPIs) for acute Trusts with the commissioners to ensure the appropriate performance management of handover delays in 2010/11.

The patient handover to crew becoming available has reduced by three minutes to 19.8 mins, a 15% decrease since April 09, and in line with the improvement trajectory agreed with the SHA in November. An additional 2 mins is required in order to meet our stretching intention of reducing patient handover to green time to 18mins by end of March 2010.

The key focus for the remaining quarter is to further improve Category A and B performance, reduce hospital turnaround and to prepare for next year and the financial challenges that will bring. The staffing prediction is consistently above plan and work is underway to ensure that all necessary efficiency measures are achieved and then sustained so that we end the year in as strong a position as possible. We are on track to ensure that the LAS delivers Category A8 performance above target for the year and improves on Category B performance.

2.1 PATIENT TRANSPORT SERVICE

Commercial

The deadline for submission of tenders under the London Procurement Programme was extended due to a failure by commissioners to respond to clarification questions. The new deadlines were the 23rd December 2009 for South London Healthcare NHS Trust and 20th January 2010 for all other contracts.

The LAS has submitted its bid to the South London Healthcare NHS Trust. Further submissions are being made for the following contracts, in line with the revised deadline:

- Barnet and Chase Farm Hospitals NHS Trust;
- City and Hackney PCT;
- Ealing PCT;
- Hillingdon PCT;
- Newham University Hospitals NHS Trust, including Newham PCT and East London Foundation Trust;
- North Middlesex University Hospital NHS Trust;
- North West London Hospitals NHS Trust;
- Tower Hamlets PCT.

Outside of the above programme, Imperial College Healthcare NHS Trust has invited the LAS to submit a preliminary qualifying questionnaire (PQQ) for the provision of PTS. These services cover, Charring Cross, Hammersmith and St Mary's Hospitals. The PQQ has been submitted and we wait to see if we are invited to participate further in the tender process.

Operations

The final PTS consultation meeting was held at New Malden Ambulance Station on 12 January 2010. Main issues raised at the consultation meetings were:

- PTS staff attending cat C calls which were assessed as PTS suitable and finding a different response was required;
- Timing and likelihood of replacement vehicles;
- Some initial teething problems with PDAs; and
- Concerns that planners centred in the new Transport Operations Centres would lose their local geographical knowledge of the areas they planned.

All issues raised from the consultation meetings are to form the basis of a PTS action plan which will be updated and issued to all PTS staff on a regular basis.

PTS Operations Managers have now received training on PDAs and Airwave radios so that they can cascade this to operational staff. Both of these programmes have been ongoing through December but have slowed due to staff absence over the Christmas period. By cascading training, we will accelerate the roll out of both devises, which will be completed before the end of February 2010.

In September 2009, the dedicated PTS crews being put forward to undertake pts suitable Cat C calls, were put under control of the UOC Allocators, to increase utilisation. Unfortunately, the number of journeys fell and with effect from 11 January 2010, this resource has been brought back under PTS control. The intention is to bring the number of calls back up to the previous level of approximately 20 calls per day. Work is underway to see if this function can be moved to the PTS Transport Operations Centres. This will allow greater co-ordination with the core PTS resource and numbers of UOC calls can increased to reach the target of 50 per day.

Performance

Following the period of snow before Christmas and the subsequent break, PTS activity fell to 22,304 journeys, its lowest number for 3 years. With core income increasingly being based on price per patient movement, this has had a dramatic effect on December's financial return.

Again due to the weather and Christmas period we saw a change in our normal pattern of work. There was a dramatic shift away from scheduled appointments and an increased demand from our Acute Hospital customers to deal with on the day discharges. Consequently, we have seen a small dip in the quality standards which were:

- Arrival time: 89%
- Departure time: 91%
- Time on Vehicle: 95%

3. HUMAN RESOURCES

Workforce Plan implementation

The report for A&E staff in post against funded establishment (now increased to 3353) shows a vacancy level of 167 wte. at 31.12.09. With all remaining training places fully allocated we remain on track to have recruited to full establishment by the end of March 2010.

From 1 April to 31 December 2009, 444 staff have successfully completed their initial training and transferred to operations. In addition 50 graduate Paramedics have commenced employment providing a total of 494 total operational staff (384 net additional staff when accounting for turnover).

Recruitment to Emergency Operations Centre staff has now delivered against the increased establishment for 2009/10 in preparation for the implementation of the CAD 2010 project.

All other general recruitment is has continued as required.

Workforce information

The attached workforce report shows the regular workforce information giving sickness levels, staff turnover and A&E staff in post against funded establishment.

Trust sickness levels for November have increased to 5%. The report also now includes the year to date figure which, for 2009/10, is within target at 4.39% (target is below 5% for the year as a whole).

Staff turnover has fallen slightly again to the lowest level within this year at 5.09%.

Development of the MPET funding SLA

The Trust is still awaiting completion of the formal contract for MPET funding for the recruitment and training of 377 Student Paramedics and 121 A&E Support staff. We have however received verbal confirmation that full funding against actual activity for this training will be received from the SHA thus removing the £1m risk against this training activity. This will be confirmed in writing

Partnership working, staff engagement and joint consultative arrangements

Field work on the NHS staff survey closed in December and published results are expected from the contractor in February. The formal results taken from the sample survey and published nationally, with full comparison ratings, will be published in March. The Staff Survey Steering Group has not met since the survey closed, but will re-convene to begin to consider the 2009 results in late February to analyse and support the production of a trust action plan.

The current Partnership agreement covers the period 2007-2010. Work on revisiting and renewing this agreement will commence shortly, and this will incorporate partnership working principles specific to the Trust's joint heath and safety management and consultation arrangements.

Health and Safety

Reported levels of adverse incidents for the calendar year to date against the key categories of clinical incidents, manual handling incidents, and physical and non-physical assault are included in the table below.

	Lifting/Handling/Carrying	Clinical Incident	Non Physical Abuse	Physical Violence	Total
Jan-09	46	74	67	33	220
Feb	42	47	83	23	195
Mar	40	56	85	29	210
Apr	48	79	101	21	249
May	60	96	88	23	267
Jun	32	89	61	29	211
Jul	26	80	86	22	214
Aug	32	65	67	40	204
Sep	33	68	54	18	173
Oct	49	93	81	29	252
Nov	43	85	64	16	208
Totals:	451	832	837	283	2403

The Health and Safety team continues to work with local managers to encourage timely reporting of all incidents. In addition, a Trust-wide review of all incident reporting arrangements has been agreed, and this project will commence its work in February/March. Representation will include all parts of the service along with staff side.

Formal proposals for the new Health and Safety partnership structures will be taken to the Staff Council meeting in February. Staff side seats on the Corporate Health and Safety Group will be allocated to the recognised trade unions, and a new Operational health and Safety Partnership Forum will be established to provide a focus for trust-wide operational health and safety issues. This will enable the Corporate group to better fulfil its strategic remit.

As previously reported the Trust expects the Health and Safety Executive to undertake an inspection as part of its general employer scrutiny responsibilities in March 2010. The outcome of this inspection will be reported to a future meeting of the Trust Board.

Disciplinary Appeals and Employment Tribunals

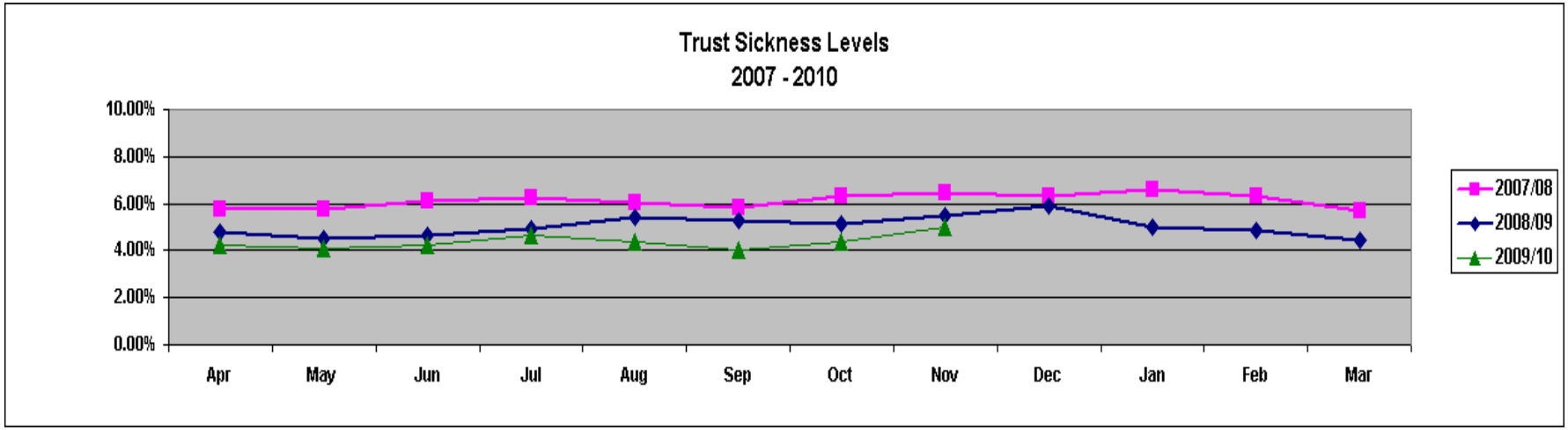
Since the last Trust Board meeting, 2 appeals against dismissal have been heard with the following timescales:

Case No.	Date of appeal letter	Hearing date	Further comments
1	10.9.09	26.11.09	
2	23.10.09	18.12.09	

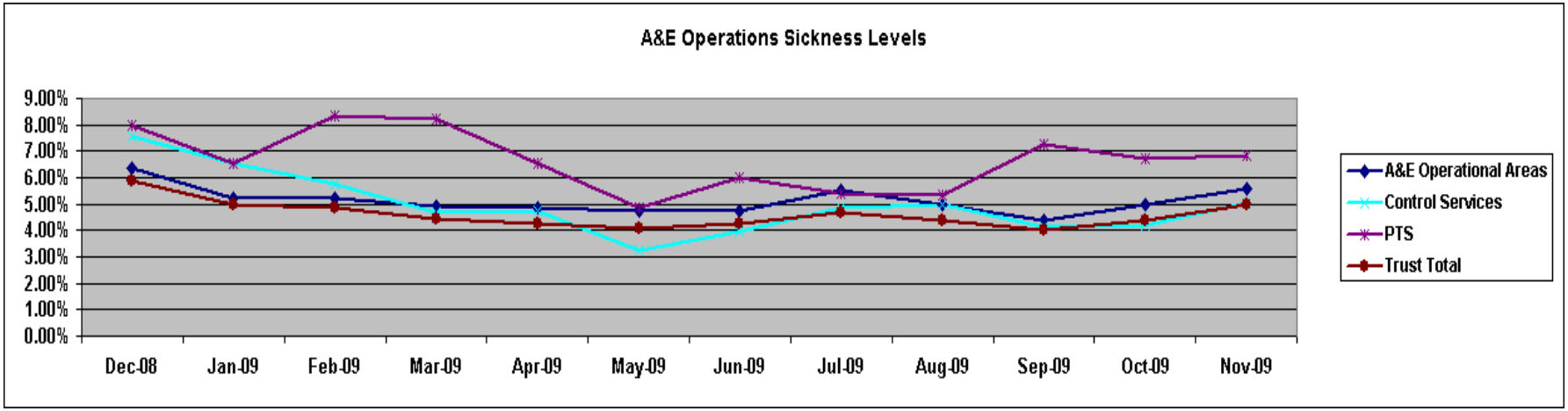
The Trust has had no Employment Tribunal case progress to full hearing in the period since the last Trust Board.

Trust Sickness Levels

Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2007/08	5.73%	5.73%	6.10%	6.25%	6.05%	5.80%	6.33%	6.47%	6.34%	6.61%	6.32%	5.66%
2008/09	4.79%	4.49%	4.64%	4.96%	5.41%	5.26%	5.12%	5.50%	5.89%	5.01%	4.87%	4.44%
2009/10	4.27%	4.07%	4.24%	4.66%	4.39%	4.03%	4.39%	5.00%				



A&E Operational Areas	6.35%	5.23%	5.21%	4.91%	4.84%	4.76%	4.72%	5.51%	4.98%	4.41%	4.96%	5.60%	5.11%
Control Services	7.55%	6.52%	5.76%	4.70%	4.71%	3.25%	3.95%	4.84%	4.95%	4.14%	4.20%	5.05%	4.95%
PTS	7.98%	6.57%	8.35%	8.23%	6.51%	4.84%	6.02%	5.39%	5.36%	7.25%	6.72%	6.87%	6.68%
Trust Total	**5.89%**	**5.01%**	**4.87%**	**4.44%**	**4.27%**	**4.07%**	**4.24%**	**4.66%**	**4.39%**	**4.03%**	**4.39%**	**5.00%**	**4.61%**



Staff Turnover

Staff Groups	Feb-08/Jan-09	Mar-08/Feb-09	Apr-08/Mar-09	May-08/Apr-09	Jun-08/May-09	Jul-08/Jun-09	Aug-08/Jul-09	Sep-08/Aug-09	Oct-08/Sep-09	Nov-08/Oct-09	Dec-08/Nov-09	Jan-09/Dec-09
A & C	15.14%	14.51%	14.06%	12.62%	12.30%	11.56%	10.03%	10.91%	9.94%	9.55%	8.70%	8.62%
A & E	5.51%	5.45%	5.10%	4.99%	4.86%	4.50%	4.34%	4.59%	4.49%	4.36%	4.28%	4.29%
CTA	6.97%	7.32%	7.69%	2.50%	2.56%	2.44%	4.88%	2.38%	4.26%	4.35%	3.92%	4.35%
EOC Watch Staff	11.52%	11.47%	10.76%	9.97%	10.00%	9.55%	10.54%	10.10%	9.30%	8.87%	8.91%	8.78%
Fleet	14.00%	13.46%	13.21%	10.53%	8.62%	8.47%	8.47%	8.62%	8.62%	3.45%	1.79%	1.72%
PTS	12.98%	12.13%	10.92%	9.27%	9.39%	9.05%	8.64%	8.68%	7.50%	6.25%	6.84%	6.47%
Resource Staff	0.00%	2.04%	4.26%	4.17%	4.17%	4.17%	4.17%	4.17%	8.33%	8.51%	7.84%	8.51%
SMP	6.77%	6.75%	6.94%	5.84%	5.47%	5.24%	5.43%	5.05%	5.15%	4.92%	4.42%	4.26%
Trust Total	**7.30%**	**7.18%**	**6.82%**	**6.32%**	**6.14%**	**5.77%**	**5.64%**	**5.78%**	**5.58%**	**5.28%**	**5.12%**	**5.09%**

A&E Establishment as at December 2009

Position Titles	Staff in post(Fte)	Funded Est.	Variance		Leavers
Team Leader Paramedic	166.04	194.00	27.96		0.00
ECP	66.41	74.00	7.59		0.00
Paramedic	899.57	1047.00	147.43		0.00
EMT 2-4	1167.68	956.00	-211.68		2.50
Student Paramedic 1	208.00	404.00	-154.00		8.00
Student Paramedic 2	350.00				2.00
Student Paramedic 3	20.00	300.00	280.00		0.00
EMT 1	20.64	328.00	59.30		0.00
A&E Support	248.06				2.00
EMD1	113.44	54.00	-59.44		2.00
EMD2	97.83	90.55	-7.28		0.00
EMD3	78.64	100.76	22.12		0.00
EMD Allocator	66.72	78.00	11.28		0.00
CTA	39.23	50.00	10.77		0.00
Total	**3542.26**	**3676.31**	**134.05**		**16.50**

4. IM & T Update

IM&T Customer Survey

One of the SMG objectives this year (number 25) is to improve IM&T Customer Service. This was set against the benchmark of the first IM&T Customer Survey that was undertaken in September 2008. The headline results were that 59% of respondents rated the IM&T service between satisfactory and very good, with 41% rating the service as poor.

As a result of this feedback, the IM&T Senior Management Team implemented a Service Improvement Plan with the aim to achieve at least a 75% satisfaction rating (satisfactory and above) by the time the survey was re-run in September 2009. The results from this second survey have now been released.

Firstly, the number and demographics of the respondents are comparable between the two surveys:

Staff Group	**2009/10**	**2008/09**
Support staff	97 (43%)	69 (29%)
Attendee at Managers Conference	59 (26%)	89 (38%)
Attendee at Senior Managers' conference	33 (15%)	51 (22%)
Paramedic / Technician	35 (16%	25 (11%)
Total number of respondents	**224**	**234**

Secondly, in terms of the overall results, the target of 75% has been exceeded: 96% of staff who responded, rate the service as between satisfactory and very good. The comparative results between years are detailed below:

	2009/10 (%)	2008/09 (%)
Excellent	17	5
Very Good	35	12
Good	29	17
Satisfactory	15	26
Poor	4	41

This is a very positive result, demonstrating that the SMG objective has been achieved. Work is now underway analysing the detail of the results and feedback to input into the IM&T Directorate's Objectives for 2010/11.

Airwave

As previously reported, A&E Operations is now fully live on Airwave and as reported below, the usage over New Year's Eve proved successful. The final deployment of the project is to bring it live within PTS. There has been some delay due to co-ordination with the roll out of the MDT 'lite' solution as well as performance pressures. There is, however, a plan in place to complete all of PTS by Friday 19 February 2010. Work is underway to close the project by the end of the financial year and hand over to the 'inlife' team.

CommandPoint Update

A full update on the project, previously referred to as CAD 2010, to replace CTAK with CommandPoint was provided at the November 2009 Trust Board meeting. The following is a brief update on the project, specifically reporting issues that were raised in the previous report:

Interface Simulators: The problems previously reported with the interface simulators that were causing delay to NG have now been resolved. Some problems remain, but they are being dealt with by the respective project teams.

FAT (Factory Acceptance Testing) of Release 1.0: This remains scheduled for February 2010. NG has reported that all code is now written and undergoing internal review. A team led by John Downard, (IM&T Head of Software Development & support) will travel to Chantilly, USA and witness the FAT process. The formal FAT reporting will be during March 2010, allowing at least a verbal update to the next Trust Board meeting.

Request for Changes: At the time of writing, work is still continuing in relation to the two outstanding interfaces for PSIAM and LVM (Least Vehicle Movements). Of these two, there is now some concern regarding the PSIAM interface and the ability to release this for go-live. If necessary, the contingency would be to move it to the first post go-live release of CommandPoint.

The overall approach to manage the integration of the Request for Changes for go-live on 22 February 2011 is by way of release 1.1 of the system. Detailed planning is underway in terms of HW, SW and people resources for this release as the additional testing and training will coincide with UAT (User Acceptance Testing) and TTT (Train The Trainer).

Change in Project Manager:

It was reported that Northrop Grumman had announced the resignation of their Project Manager. This matter has now been resolved and John Hopkins, a UK based NG employee, has taken over and is now working from the LAS project offices at Southwark Street.

Individual risks for each of the Interfaces: Following on from discussions with Carrie Armitage, the Trust Board's external consultant, the suggestion regarding risk assessing each interface separately has been implemented. While it will increase overhead on the project team, it has been decided that that the benefits are worthwhile.

Planning & co-ordination: Ken Uffelman, responsible Director within NG and Peter Suter meet again at the end of January 2010 to conduct another full review of the project and associated schedule. This is the second in an ongoing schedule allowing both SROs close co-ordination with the project managers. Tom Shelman, Northrop Grumman's VP and General Manager, has arranged to meet with Richard Hunt, to continue executive level dialog.

Noting the concern regarding the PSIAM interface, the overall assessment is that the project remains on track for a cut-over on 22 February 2011. A full project update, including results of the FAT testing will be given at the March 2010 Trust Board.

New Year's Eve 2009

As on previous years, New Year's Eve was a significant event in terms of IM&T support. Although VHF radios were used for the overall LAS command channel, Airwave was widely deployed and performed well, with no significant problems reported. Given the reports of recent years, where there have been significant Airwave problems, this is extremely positive. It has provided a level of confidence to fully utilise Airwave for future major pre-planned events.

From an overall IM&T perspective, there were no indications that the date change from 2009 to 2010 should have caused any difficulties. However, there was one problem in relation to the interface between CTAK (the CAD system) and ProQA (the Triage system). Shortly after midnight a problem manifested that started to cause call taking screens to lock up. Given the unknown nature of the problem, EOC decided to revert to paper at approximately 00:15. On-site IM&T support identified a problem with the Pro-QA interface and after disabling this, EOC reverted back to CTAK at approximately 01:15, but using the fall back system of card based AMPDS for call triage. This process proved extremely effective, allowing the call management to continue with minimal disruption.

IM&T support continued to work on the problem through the night, endeavouring to decode the interface between the two systems in order to rectify the problem. At 08:00 the decision was taken to rest the IM&T night staff (in particular the CTAK systems specialist) and resume again at 16:00. During the day additional support was made available from Priority Solutions, (the suppliers of Pro-QA). By 20:00 the problem had been identified and a solution developed and tested. However, given that the use of manual cards was proving extremely effective, the decision was made to begin implementation the following day. This proved successful and by 10:00 on Saturday 2 January, the fully automated link between CTAK and AMPDS was restored and has remained stable since.

The route cause of the problem was the date coding within the CTAK side of the CTAK–PSIAM interface. When it was originally implemented in 2000, the design utilised a combination of the date and the CTAK call number to uniquely identify each call passed across the interface. However, a single digit was encoded to represent the date; hence the problem when the date changed from 2009 to 2010. There were no other date related problems with any IM&T systems.

5. COMMUNICATIONS

Issues management

Managing demand: A programme of communication activity has taken place during the Christmas/winter period to help ease demand. As part of this, the Service has signed up to the national NHS 'Choose Well' initiative which focuses on educating people to choose the right NHS treatment for their needs.

Choose Well campaign: The Service, on behalf of ambulance services nationally, has negotiated with the DH to allow advertising of the 'choose well' messages on emergency ambulances. Ads will start to appear on the side of new Mercedes vehicles in London by the end of January. A leaflet has also been produced outlining how people can get the right NHS treatment this winter – 40,000 copies are being distributed on A&E ambulances and patient transport vehicles, and by post to LINks and members. The choose well messaging is being integrated into all media communication relating to demand.

Alcohol-related calls over the festive period: Proactive media work on this issue has led to extensive media coverage. The focus of attention during the office party season was the

treatment centre set up at Liverpool Street station, which was covered by media including BBC London television and radio, Sky News and The Sun. The Evening Standard ran a story ahead of its opening, and later published an article after a reporter spent a shift on a central London booze bus. Sky News also spent New Year's Eve on one of the booze buses.
A number of local newspapers ran articles detailing the latest figures on alcohol-related calls and the impact they have on the Service's ability to respond to other emergency incidents.

Approximately 19 minutes of radio and TV airtime was given to this issue, and total media coverage reached an estimated eight million people. The London Ambulance Service was given 38 name checks in over 32 media pieces.

Cold weather: In the week before Christmas, attention switched to a large rise in demand that led to the Service managing its busiest ever weekend and to snow that then fell across the capital during the Monday evening rush hour.
Live interviews were carried out with LBC and BBC London radio. The Independent newspaper also ran an extensive feature in its weekend magazine following a ride-out with a crew from Camden station.

Into January, further coverage was generated during a prolonged cold snap which saw further snow falls. Messages were again put out asking the public to consider other healthcare options before calling for an ambulance, leading to further regional TV and radio interviews, as well as coverage in the Evening Standard. Coverage was achieved in 10 media pieces, with 13 name checks and over 19 minutes of broadcast coverage. Messages reached an estimated 3.5 million people.

Twitter: The Service launched its official Twitter page to coincide with winter and Christmas pressures. Updates with key messages have been published on a regular basis, and can be found at http://twitter.com/ldn_ambulance.

Swine flu: Internal communication has recently focused on encouraging staff to have the seasonal flu and the swine flu vaccinations. Messages have been promoted through existing channels, and at 11 January 1643 staff had received the seasonal flu jab and 799 the H1N1 jab.

Stakeholder engagement

New community newspaper: The Service issued its first community newspaper, Ambulance News, in December. The quarterly paper provides people in the capital with news on what is happening in their ambulance service, as well as health advice and foundation trust membership updates. It is issued to members (including staff), MPs, primary care trusts, LINks, GP surgeries and A&E departments, and other key stakeholders.

Foundation trust consultation: The findings of the Service's consultation on its plans to become a foundation trust have been published. Over 1800 members of the public were spoken to during the consultation period; all staff were encouraged to give feedback; and the plans were sent to over 2000 partner organisations for comment. There were a total of 350 formal responses to the consultation, and these influenced a number of changes to the original proposals. All primary care trusts have been informed of the key changes, and these were reported in Ambulance News and LAS News. The evaluation can be found on the website at www.londonambulance.nhs.uk/ft.

Consultation meetings: The Chief Executive and Medical Director have completed their consultation meetings. A response to key issues raised at A&E meetings has been published on the intranet. Feedback and action plans are being developed from the patient transport service and control services meetings, and an additional meeting is to be held in February with operational support staff.

A survey is currently being carried out to seek staff views on the consultation meetings; the findings will influence the approach to be taken in the future.

Staff recognition

Chief Ambulance Officer commendations: At the beginning of December, eight members of staff were recognised for going above and beyond the call of duty – a story that was picked up by several local papers. Paramedics Madeline Basford-Herd, Janet Clennell and Matthew Miles, along with Emergency Medical Technician Frank Samaras received Chief Ambulance Officer commendations. Emergency Medical Technicians Reyed Budaly, Mark White, Peter Knight and Student Paramedic Sarah Simms received Assistant Director of Operations commendations.

Media

The Service's latest cardiac arrest survival rate figure was reported in the Evening Standard and featured in the South London Press with a patient case study.

A delay in Kingston was reported in the Surrey Comet after a young woman fell on ice and waited over an hour for an ambulance. The Service was exceptionally busy at the time (Sunday 20 December) and it proved to be the second busiest weekend on record. The Chair of the Patient's Forum, Malcolm Alexander, was approached for a comment.

Health for North East London's consultation on plans to replace the A&E department at King George Hospital with an urgent care centre, amongst other changes, has attracted a lot of attention from local residents, politicians, community groups and media in Redbridge.

PPI activity report

Public education:

- The public education staff development programme which took place in October and November has been evaluated, and minor adjustments have been made for the next group. The next programme is being planned for June and July 2010. Work is also underway to get the programme accredited.

- New resources are being developed to give out to young people at knife and gun crime events, and for people with learning disabilities to remind them what to do when they are ill.

Category C Service User Survey:

- A draft action plan has been developed and work is underway to link actions and activities to existing programmes in the Service Improvement Programme where possible. It is hoped that a final version of the action plan and accompanying recommendations will be submitted to SMG for approval.

New Ways of Working:

- John Carmichael, who previously worked at Moorfields NHS Foundation Trust, has been appointed to the post of Community Involvement Officer at Chase Farm. He is due to start work in February.

Translation and Interpreting services:

- The Equality and Inclusion Manager is currently reviewing the Trust's translation and interpreting services, and is developing a new policy in this area. The Chair of the Patients' Forum is involved in this area of work.

Local Involvement Networks:

- A meeting has been held between local LAS managers and Local Involvement Network (LINk) representatives in Hillingdon and Hounslow boroughs. It is hoped that there will be many opportunities for joint working with the LINks in these areas and others across London.

Patient Care Conference:

- The Patient Care Conference will be held on Wednesday 27th January at the Emirates stadium. Over 160 participants are expected to attend. The theme of the conference is 'engagement' – of staff, partner organisations and patients. The conference will be a mixture of plenary and break-out sessions.

Museum:

- A feasibility study for a joint 'blue light services' museum has recently been produced, and is under discussion between all the emergency services and the GLA. There is generally a high level of commitment to making this exciting proposal come to fruition, and further talks are expected in the near future.

6. BALANCED SCORECARD

In the latest version of the Balanced Scorecard (December 2009) the names of Owners and their commentary have been included (where a commentary has been written). There are on-going efforts to encourage Owners to complete the monthly update. The report is reviewed by the Senior Management Group on a monthly basis. A few of the measures are a month behind as raw data needs to be further analysed, e.g. A1 (ROSC); A4 (Non-conveyance) and C1 (Clinical Performance Indicators) and C3 (Health & Safety). There are also a few measures where there is no data available or a written commentary; this is being addressed with the Owners and Sponsors. Approximately 50% of the actual data is uploaded automatically at the beginning of each month; efforts are continuing to automate data where possible.

In terms of performance it is apparent that the cardiac survival rates (ROSC) have shown a steady improvement in 2009-10, as has actual operational training days and CAD 2010. Areas of concern include: national response targets; the completion of the Clinical Performance Indicators; produced hours and fleet.

The Trust Board is asked to note that the Infection control measure is updated quarterly following the completion of quarterly infection control audits. The Balanced Scorecard report in February will include the outcome of the audit undertaken October-December 2009.

Peter Bradley CBE
Chief Executive Officer

19 January 2010

London Ambulance Service NHS Trust

Balanced Scorecard 09/10 year to date overview

Balanced Scorecard 09/10 report giving a year to date overview of all PIs and their status plus owners

PI	PI Actual		Accountability	Apr 09		May 09		Jun 09		Jul 09		Aug 09		Sep 09		Oct 09		Nov 09		Dec 09		Jan 10		Feb 10		Mar 10		PI Actual
Measures	R	V	Owner	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	Comments
A. OUTCOMES (What we want to achieve)																												
A01. Cardiac survival rates																												
A1.1 Percentage of patients with presumed cardiac aetiology who have a return of spontaneous circulation (ROSC) sustained to hospital		G	Gurkamal Virdi	13.5		13.5	20	13.5	22.2	13.5	22.2	13.5	26.8	13.5	25.1	13.5		13.5		13.5	23	13.5		13.5		13.5		The rate of Return of Spontaneous Circulation sustained to hospital for cardiac arrest patients whose arrest is of presumed cardiac aetiology where resuscitation is attempted has increased considerably oever the last year. Please note, the data presented is the latest available; there is a month's lag between the cardiac arrest incident and the processing of the Patient Report Form, from its scanning at Management Information to the data then being audited by the Clinical Audit and Research Unit.
A02. Stroke																												
A2.1 To be determined post April 2010		?	Gurkamal Virdi																									-
A03. Trauma																												
A3.1 To be determined post April 2010		?	Gurkamal Virdi																									-
A04. Non conveyance																												
A4.1 A&E non conveyance		G	Sue Watkins	31200	23076	31200	24828	31200	25132	31200	29031	31200	24965	31200	20759	31200	38570	31200	39779	31200		31200		31200		31200		
A4.2 % total demand non conveyed		?	Sue Watkins		28		29		29		32		30		25		44		45									
A4.3 % suitable completed patient episodes managed through Clinical Telephone Advice		R	Sue Watkins	80	20	80	19	80	20	80	19	80	20	80	18	80	17	80		80		80		80		80		CTA - still under establishment. Course planned for 18th January 2010 and this course has currently 11 people allocated. This should dramatically enhance the current CTA establishment, taking it to it's highest ever number of approx 56 WTE. Continued recruitment in place, and appears to be going well. UOC implemented a recovery plan September 2009 due to poor utilisation figures and poor allocation of rest breaks for crews. Detailed analysis took place as to what the reasons were for poor utilisation.
B. CUSTOMERS / STAKEHOLDERS (What we need to do for our customers)																												
B01. National response targets																												
B1.1 % Category A calls within 8 minutes		R	Jason Killens	76	75	74	73	71	71	72	72	74	75	78	77	79	75	76.5	72	75.5	71	75.5		76		77		SK.05.01.10 A8 performance has been affected by adverse weather throughout the month. SK.05.01.10 Additional resources now focussed on Category A calls, this will likely have a negative impact upon B19 performance. SK.05.01.10 Throughout the month, decisions have been taken to lift and lower the REAP levels from 3 to 4 to 5 and back now to 4. In most, this has been down to adverse weather conditions in and around London, but also to cope with increasing seasonal demand.
B1.2 % Category A calls within 19 minutes		G	Jason Killens	95	98	95	98	95	97	95	98	95	98	95	98	95	98	95	98	95	97	95		95		95		A19 continues to perform comfortably above the 95% threshold,
B1.3 % Category B calls within 19 minutes		R	Jason Killens	87	86	86	85	83	82	86	81	87	86	93	88	95	89	91.5	89	94	82	95		95		95		B19 has proved challenging for the month of Decemeber as a response to focussing resources on Category A calls.
B02. Infection control																												
B2.1 Compliance on Infection Control Audit		?	Trevor Hubbard													85		85		85		85		85		85		Agreement on Chemex as provider for cleaning solution pan london for 1 year contract from dat of final install expected Feb 10 Linen issues no further forward.
B03. Call answering																												
B3.1 % Calls answered in 5 seconds		R	Phil Flower	95	95	95	94	95	92	95	91	95	94	95	95	95	94	95	95	95	90	95		95		95		Call taking performance has been mainatained although there were some difficulties in the Month of August due to numbers of stafff being on Holiday. Growth in call demand continues to be circa 4.6% pa. Managing demand in the event of a flu pandemic. Action plans in place to recruit and train additional staff and to recall staff with call taking experience Possible ipact of flu remains of concern
B04. Financial balance																												
B4.1 Cumulative Net surplus		G	Asif Islam	-286	-286	-235	-235	208	208	-249	-249	-482	-482	-628	-425	-229		-71		448	336	-328		-313		517		AI 19/01/10:Additional winter pressure and demand led to higher overtime and associated costs.Forecast reduced to £1.4M
B4.2 EBITDA margin %		R	Asif Islam	5.5	5	9.1	9	5.3	5	5.1	5	8	8	8.5	7	7.2		6.6		5.5	6	8		8		4.5		AI 19/01/10 : EBITDA Margin not an area of concern
C. INTERNAL PROCESSES (What we need to do well to reach our goals)																												
C01. CPI																												
C1.1 CPI completed as % of plan		R	Jason Killens	95	40	95	46	95	35	95	29	95	35	95	43	95	46	95	43	95		95		95		95		November CPI Report - LAS achieved 43% CPI completion (down from 46% in October).
C1.2 Compliance with guidelines as a % of all		R	Jason Killens	100	93	100	93	100	93	100	93	100	93	100	95	100	95	100	95	100		100		100		100		current REAP Level limits availability of Team Leader to provide office hours and complete CPI Reports. This may continue for some time.
C02. Patient reporting																												
C2.1 %PRFs received within 7 days		G	Jason Killens	95	95	95	96	95	94	95	98	95	97	95	95	95	95	95	97	95	95	95		95		95		
C03. Health & Safety																												
C3.1 Number of H&S incidents		G	John Selby	266	249	275	267	266	211	275	214	275	192	266	170	275	249	266	201	275		275		248		275		AK 08-01-2010: There was an increase in the average delay between incident date and the date received by Safety and Risk, from 19.5 days (October 09) to 38.6 days (November 09). This is due to a large number of forms submitted by various complexes (Brent, Deptford, New Malden, Newham, St Helier) which were more than 400 days since the incident. This may be spun positively, considering that it shows these complexes are beginning to put reliable methods in place which are finding these forms. Removing these outliers, the median delay is 14.0 days, down from a median of 14.4 in October.

London Ambulance Service NHS Trust

Balanced Scorecard 09/10 year to date overview

Balanced Scorecard 09/10 report giving a year to date overview of all PIs and their status plus owners

PI	PI Actual		Accountability	Apr 09		May 09		Jun 09		Jul 09		Aug 09		Sep 09		Oct 09		Nov 09		Dec 09		Jan 10		Feb 10		Mar 10		PI Actual
Measures	R	V	Owner	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	Comments
C04. Produced hours																												
C4.1 Average Daily - Produced hours - AEUs		R	Gareth Hughes	4684	3982	4684	3908	4684	4051	4684	4057	4684	3882	4684	4174	4684	4375	4426	4476	4426	4293	4426		4426		4426		
C4.2 Average Daily - Produced hours - FRUs		R	Gareth Hughes	1943	1971	1943	1913	1943	1898	1943	1924	1943	1804	1943	1883	1943	1849	1943	1777	1943	1875	1943		1943		1943		
C4.3 Average Daily - Produced hours - Other		G	Gareth Hughes	475	621	475	644	475	638	475	674	475	636	475	695	475	772	671	783	671	798	671		671		671		
C4.4 Produced hours as % of plan		R	Gareth Hughes	100	92	100	90	100	90	100	91	100	87	100	93	100	91	100	89	100	91	100		100		100		
C05. Productive hours																												
C5.1 Hours produced as % hours paid		R	Gareth Hughes	68	76.4	68	74.3	68	74.3	68	73.4	68	69.8	68	73.4	68	74.7	68	73	68	8	68		68		68		
C5.2 Non operational staff % time lost through sickness		G	Gareth Hughes	5	3	5	2	5	2	5	2	5	3	5		5		5		5		5		5		5		
C06. Job cycle times																												
C6.1 Job cycle time: Cat A		G	Jason Killens	65	58	65	65	65	65	65	65	65	65	65	49	65	49	65	49	65	49	65		65		65		Continue to achieve targets as directed
C6.2 Job cycle time: Cat B		G	Jason Killens	73	60	73	73	73	73	73	73	73	73	73	88	73	43	73	47	73	44	73		73		73		
C6.3 Job cycle time: Cat C		G	Jason Killens	66	72	66	66	66	66	66	66	66	66	66	46	66	43	66	38	66	38	66		66		66		
C6.4 Job cycle time: Trust Average		?	Jason Killens		61		61		62		62		62				45		45		44							
C07. Activation																												
C7.1 Average AEU activation times (seconds)		?	Phil Flower	234	232	234	234	234	234	234	234	234	234	234		234	174	234		234		234		234		234		Call demand and adverse weather have degraded performance in december.
C7.2 Average FRU activation times (seconds)		G	Phil Flower	126	151	126	126	126	126	126	126	126	126	126	78	126	74	126	72	126	71	126		126		126		The re introduction of the FRU desk has seen a steady improvement in FRU activations and assocaited performance.
C08. Recruitment																												
C8.1 Student paramedics in training		R	Ann Ball	277	277	275	275	251	251	259	259	264	264	249	444	228		237	204	215		245		235		176		Target allows for attrition during course, therefore shortfall not a cause for concern. 12 places remain to filled on the Student Paramedic course commencing 29.03.10. All other places filled. All A&E Support courses full to Mar 2010 EMD recruitment to increased establishment to support CAD 2010 training achieved
C8.2 Crew staff vacancy %		R	Ann Ball	12	12	11	10	10	10	9	9	9	8	6	8	5		2	4.9	2								On track for achievement of target by final end date
C8.3 Control Services staff vacancy %		G	Ann Ball	9	9	7	7	5	4	8	7	4	4	4	2	4		4	1.3	-2		-2		-2		-2		
C09. CTAK availability																												
C9.1 CAD System availability (unplanned downtime)		G	John Downard	99.8	99.95	99.8	100	99.8	99.91	99.8	100	99.8	99.12	99.8	100	99.8	99.8	99.8	100	99.8	100	99.8		99.8		99.8		CTAK core functionality remained stable through December however the planned FBC testing did affect FRED/FREDA. Also availabilty of the MPS CADlink was affected when their planned DR testing over ran.
C9.2 CAD System Environment availability (unplanned downtime)		G	John Downard	99	94.78	99	97.61	99	90.22	99	97	99	97.67	99	97.78	99	98.73	99	99.57	99	99.72	99		99		99		
C10. Number of RTAs																												
C10.1 Number of RTAs		R	Nicola Foad	133	95	133	126	133	123	133	142	133	100	133	134	133	142	133	148	133	160	133		133		133		The variance from the target will be reported to the next Motor Risk Group meeting and to the Area Governance meetings. The variance from target was discussed at Motor Risk Group meeting on 3/12/2009 and the Deputy Director of Operations submitted a SPPP (bid for funding) to recruit staff to adjudicate and follow up on RTCs. The recent bad weather is likely to have caused a further increase in the number of RTCs.
D. RESOURCES, LEARNING AND GROWTH (What we need to enhance to succeed)																												
D01. Training																												
D1.1 Actual operational training days as per plan		?	Keith Miller	76	28	92	76	176	49	102	47	0	34	236	115	58	130	36	83		45							KM 2010-01/13. Clinical update course provided 26 places but accomodated 28 students. PPED course provided 48 places of which 17 where taken up. 1 course cancelled due to operational pressures
D1.2 % of staff who have an operational workplace performance review twice per year		?	Keith Miller		17		14		14		15		13		12.5				8.2		0							KM 2010-01/13. No OWR recorded on Promis query due to increased performance pressures
D1.3 % of EOC staff who complete re-registration on MPDS		?	Keith Miller		4		5		17		4		10	5		6		2		6		11		14		15		
D02. Fleet																												
D2.1 Average VOR per day		R	Christopher Vale		191		199		251		235		222		269	114	299	134	301	120	299	102			128		103		
D2.2 % AEU fleet available to operations		?	Christopher Vale		97		97		96		96		96		95		95		95		95							
D2.3 Mercedes AEU in fleet		?	Christopher Vale	281	247	295	249	309	266	323	278	337	281	349	291		297		307		307							
D03. CAD2010																												
D3.1 CAD 2010 Milestones - % complete		G	Nick Evans	14.29	14.29	21.43	14.29	28.57	28.57	28.57	28.57	28.57	28.57	28.57	28.57	35.71	35.71	35.71	35.71	35.71	35.71	42.86		42.86		42.86		Next milestone will be reached on completion of Factory Acceptance Testing during March 2010. NE 8/1/10 Outstanding contractNE 8/1/10 Outstanding RFCs for PSIAM and LVM interfaces NE 8/1/10 CommandPoint hardware needs to be relocated prior to Site Integration Testing. LAS IM&T need to relocate other servers in order to allow this modifications executed.
D04. Airwave																												
D4.1 Airwave implementation - % of units operational		R	Vic Wynn					24	15	47	31	75	54	89	85	100	87	100		100		100		100		100		West☐118☐117☐99% NW☐117☐115☐98% E Cent☐98☐96☐98% NEast☐115☐106☐92% SEast☐168☐139☐83% SWest☐168☐152☐90% PTS☐196☐124☐63%
D05. Staff survey																												
D5.1 Staff survey action plan milestones - % complete		R	Kelly O'Brien															50	50	55		60	50	70		100		January SSSG meeting has been postponed until February. KOB 2010-01-08 A draft copy of the post survey communications plan has been created. The January SSSG meeting is postponed until February to ensure maximum attendance/participation. This means that there will be a very minor delay to agreeing the action plan, this will not be significant to overall progress.
D06. Estates plan																												

London Ambulance Service NHS Trust

Balanced Scorecard 09/10 year to date overview

Balanced Scorecard 09/10 report giving a year to date overview of all PIs and their status plus owners

PI	PI Actual		Accountability	Apr 09		May 09		Jun 09		Jul 09		Aug 09		Sep 09		Oct 09		Nov 09		Dec 09		Jan 10		Feb 10		Mar 10		PI Actual
Measures	R	V	Owner	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	TRG	Actual	Comments
D6.1 Estates capital spend as % of plan	?	G	Martin Nelhams	0.3	0.3	0.3	0.3	3.6	3	7.8	7	-0.2	-1	7.3	22	26	34	42.8	20	59.6	20	78.9		68.5		100		First report Willesden ambulance station - contracts for sale have exchanged, completion Feb 10. HART East - Cody Road Planning acheived, lease negotiations ongoing. West Area workshop - Business case to be approved. Event control - User brief verbally agreed, formal approval required. Office moves to be finalised. New Control rooms - First Project board held. New HQ - No progress.
D07. Cost Improvement Programme																												
D7.1 CIP realised	G	R	Asif Islam	207	207	207	207	207	207	147	147	107	107	6392		836		829		564	1074	702		689		712		AI 19/01/10: CIP achieved YTD £9.7M. Pressure on savings in overime , incentive agency and subsistence

Legend

RAG Status - Owner Generated

- Red RAG Status represents a high level of concern
- Amber RAG Status represents a possible issue for concern
- Green RAG Status represents on track
- RAG Status Not Set

PI Variance - System Generated

- Red Variance Indicator
- Amber Variance Indicator
- Green Variance Indicator
- Variance Not Set

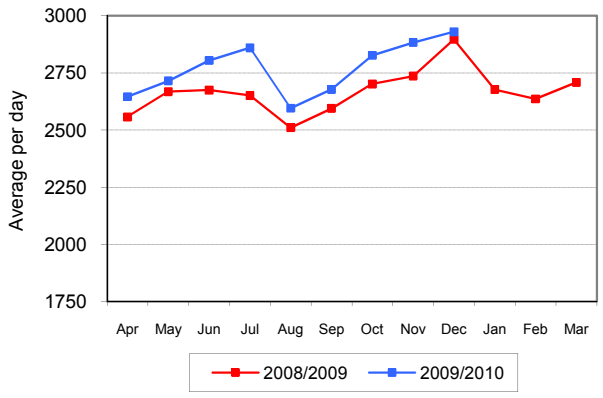
London Ambulance Service
NHS Trust

Information Pack for Trust Board

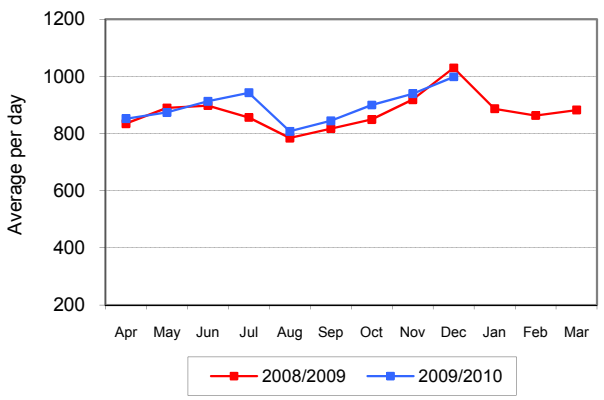
December 2009

London Ambulance Service NHS Trust
Accident and Emergency Service
Activity - December 2009

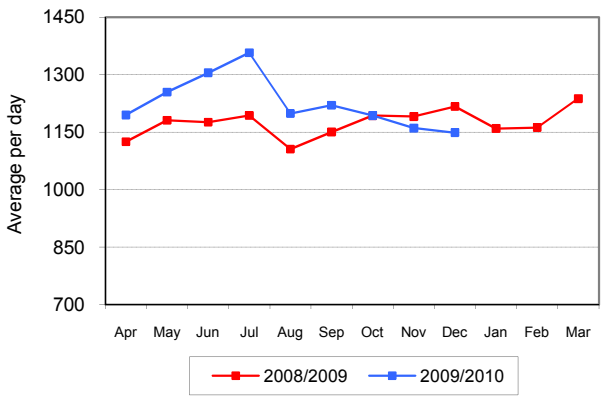
Graph 1
Average number of Cat A, B & C incidents per day



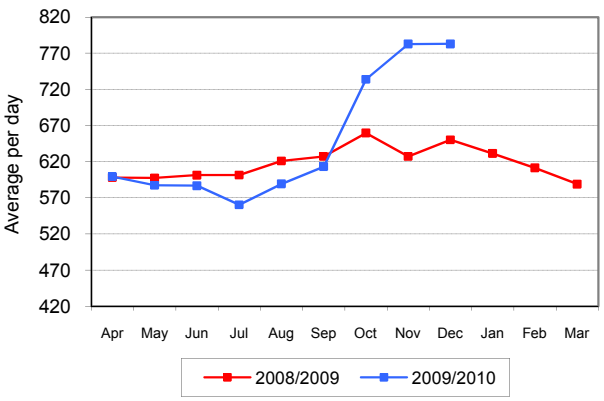
Graph 2
Average number of Cat A incidents per day



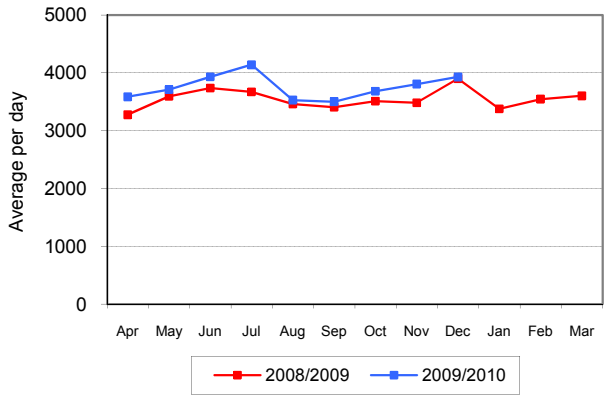
Graph 3
Average number of Cat B incidents per day



Graph 4
Average number of Cat C incidents per day

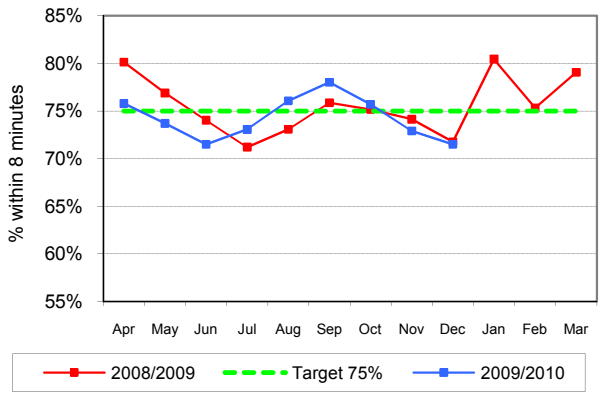


Graph 5
Average number of 999 calls received per day

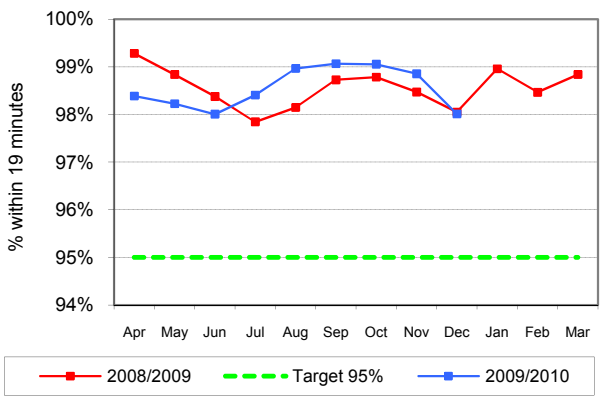


London Ambulance Service NHS Trust
Accident and Emergency Service
Performance - December 2009

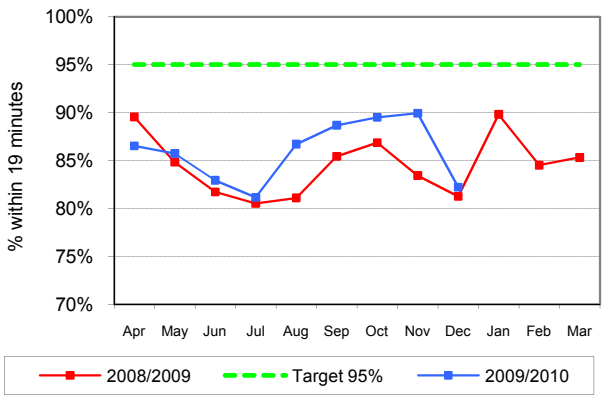
Graph 6
Category A 8 minute performance



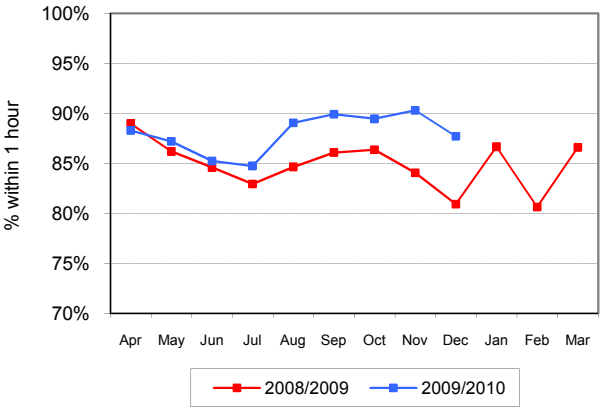
Graph 7
Category A 19 minute performance



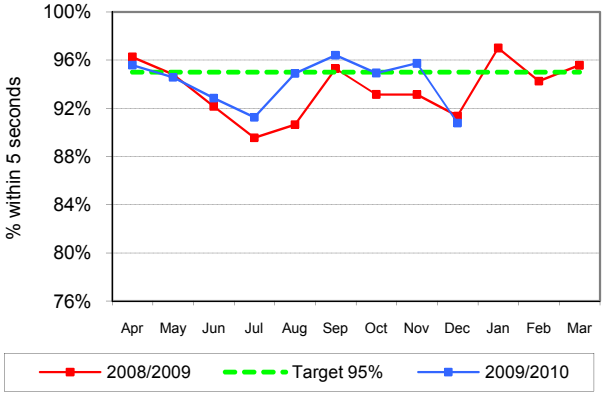
Graph 8
Category B 19 minute performance



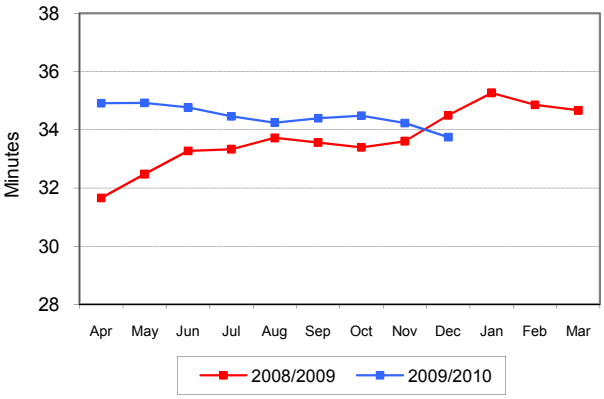
Graph 9
Category C incidents (excluding card 35) responded to within 1 hour (call connect to arrive scene)



Graph 10
Percentage of calls answered within 5 seconds

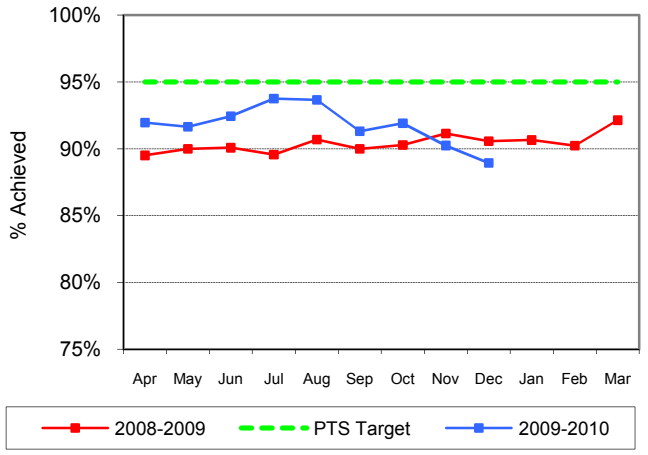


Graph 11
Average hospital turnaround time

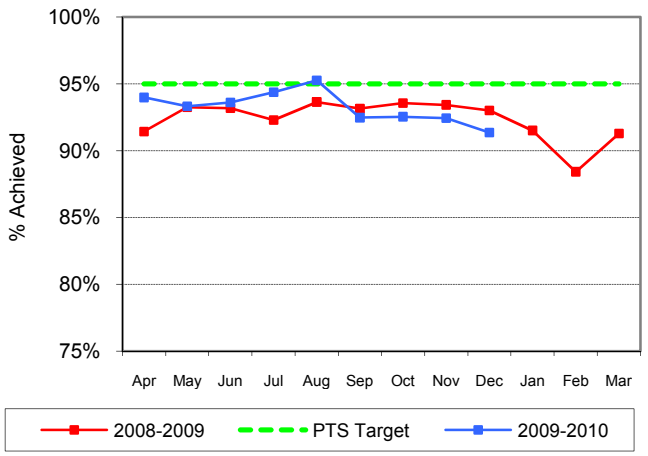


London Ambulance Service NHS Trust
Patient Transport Service
Activity and Performance - December 2009

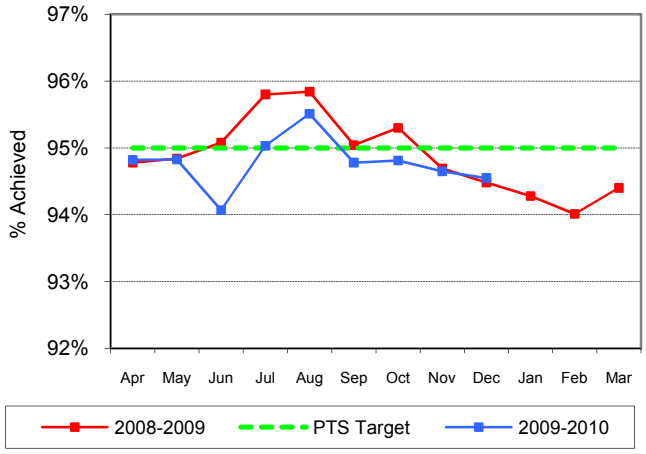
Graph 12
Arrival at Hospital Against Appointment Time



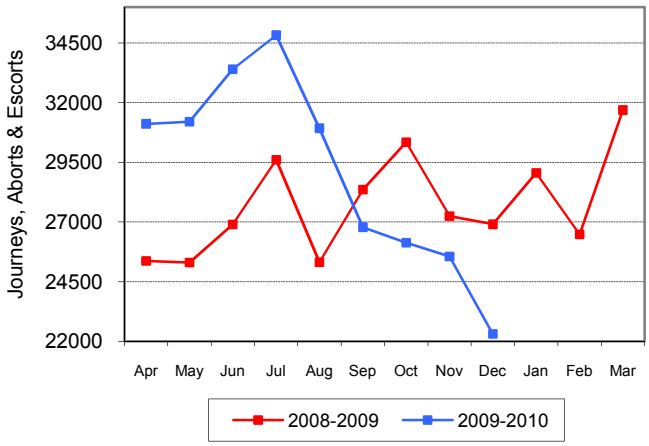
Graph 13
Departure Against Ready Time



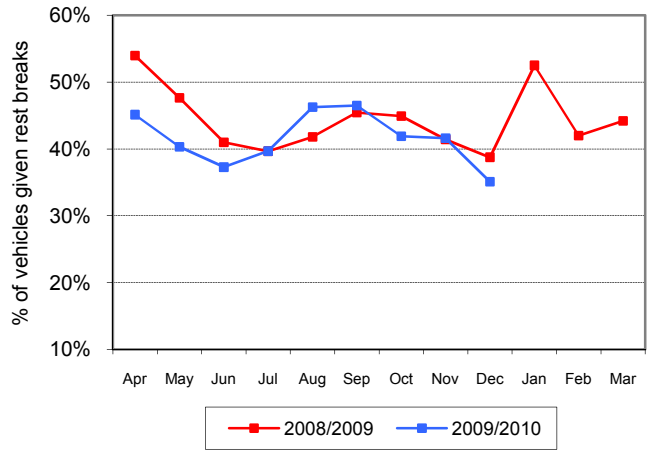
Graph 14
Time spent on Vehicle



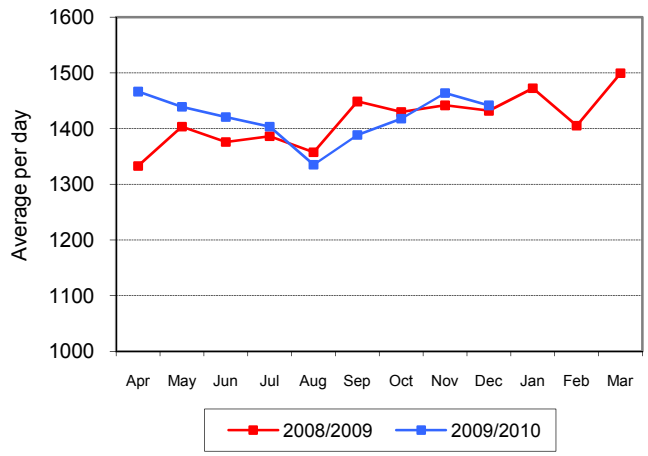
Graph 15
PTS Total Activity



Graph 16
% of vehicles given a rest break

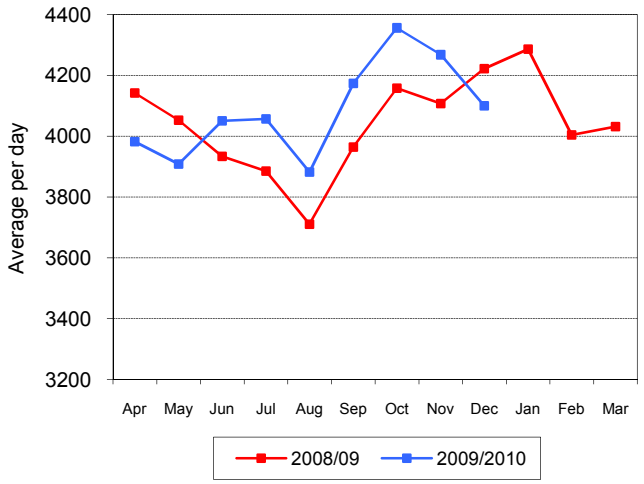


Graph 17
EOC hours staffed per day

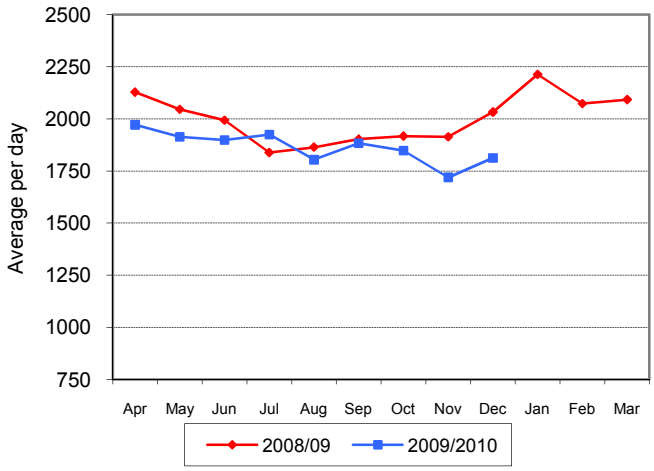


London Ambulance Service NHS Trust
Accident and Emergency Service
Resourcing and Rest Breaks - December 2009

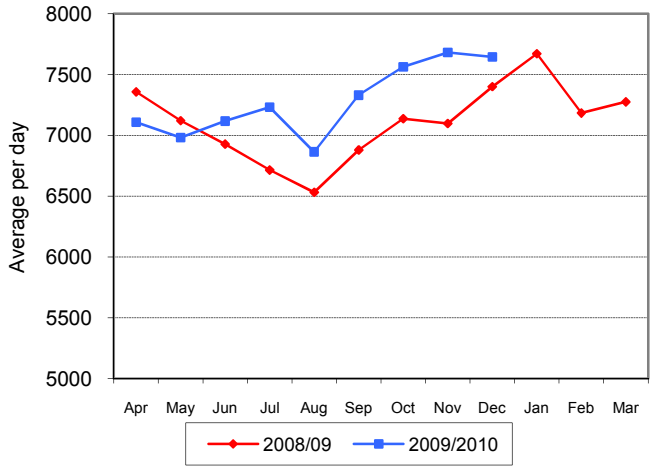
Graph 18
Ambulance Hours average available per day



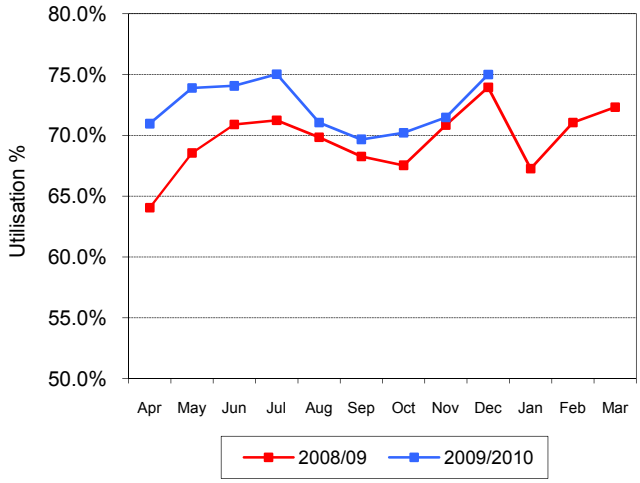
Graph 19
FRU hours average available per day



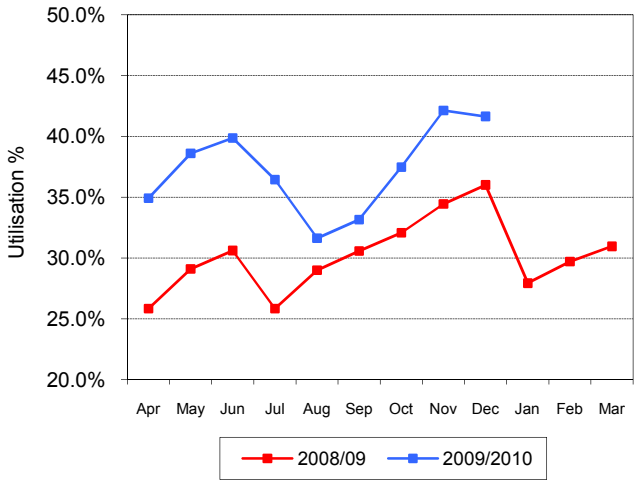
Graph 20
All Vehicle Hours average available per day



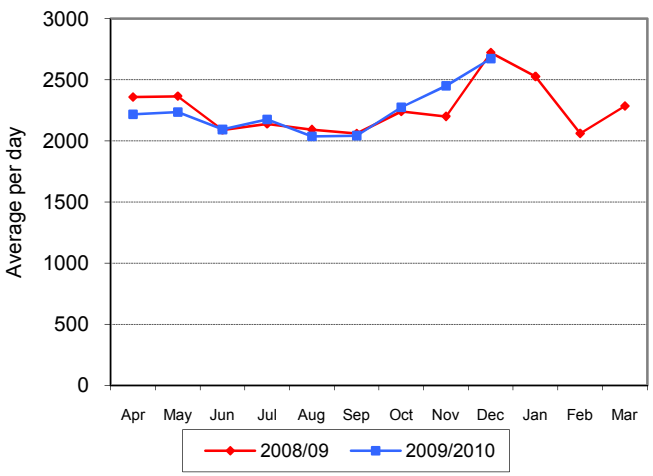
Graph 21
Ambulance Utilisation



Graph 22
FRU Utilisation

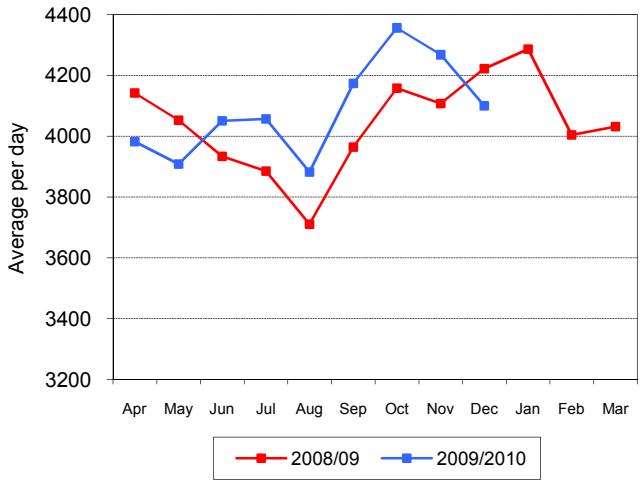


Graph 23
EBS Activity

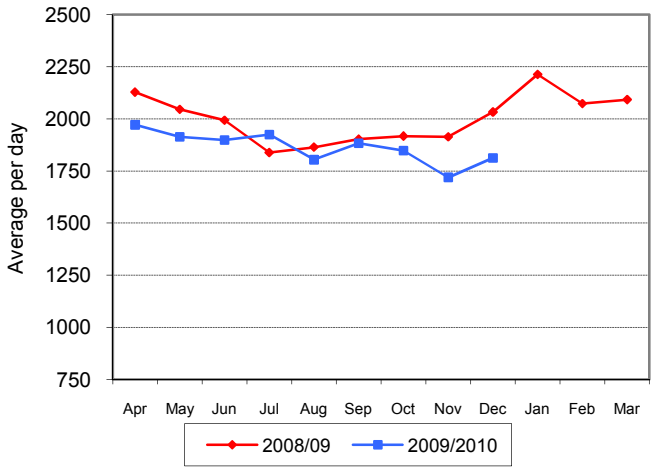


London Ambulance Service NHS Trust
Accident and Emergency Service
Resourcing and Rest Breaks - December 2009

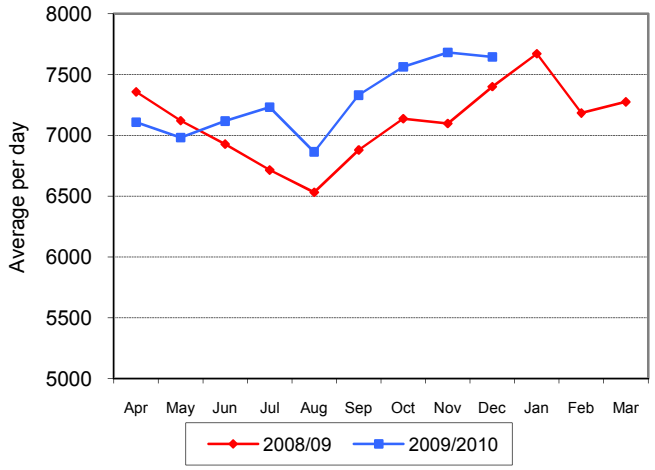
Graph 18
Ambulance Hours average available per day



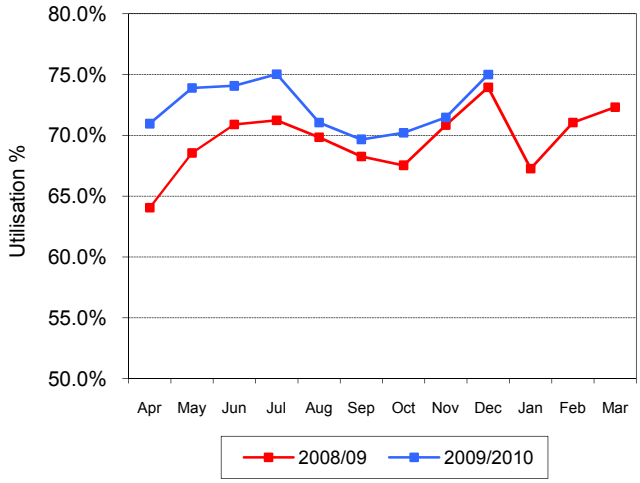
Graph 19
FRU hours average available per day



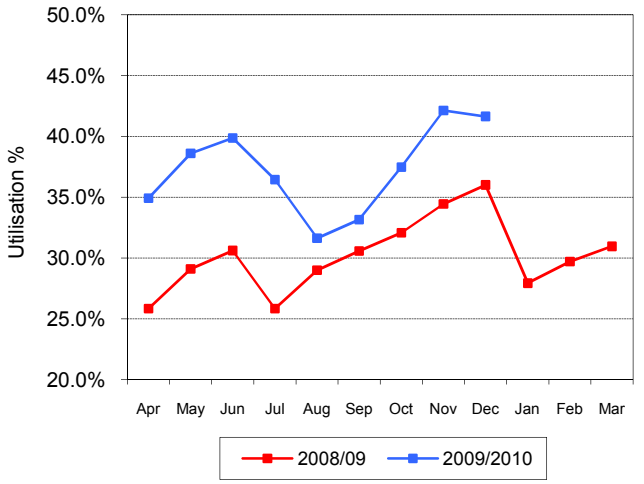
Graph 20
All Vehicle Hours average available per day



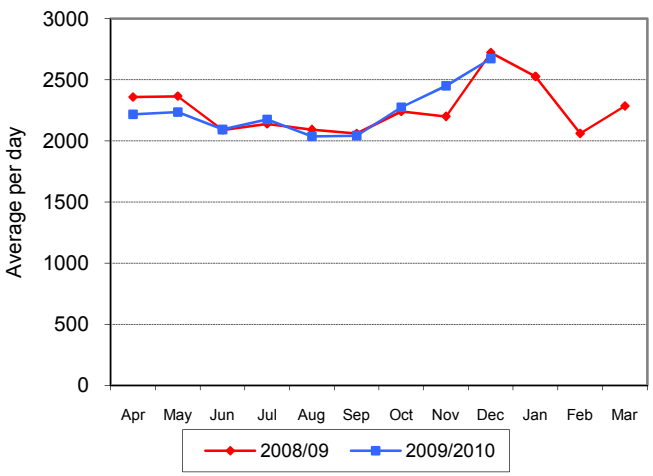
Graph 21
Ambulance Utilisation



Graph 22
FRU Utilisation

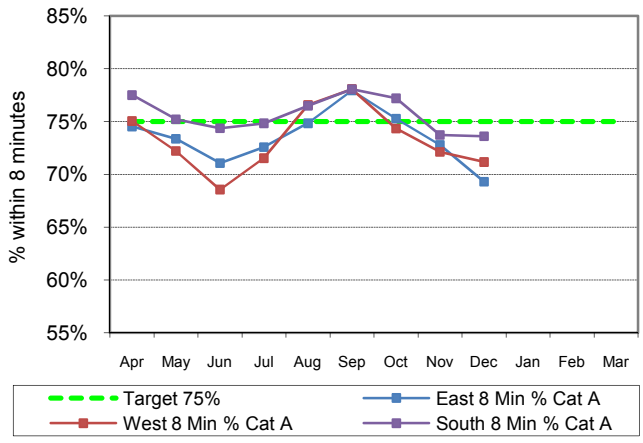


Graph 23
EBS Activity

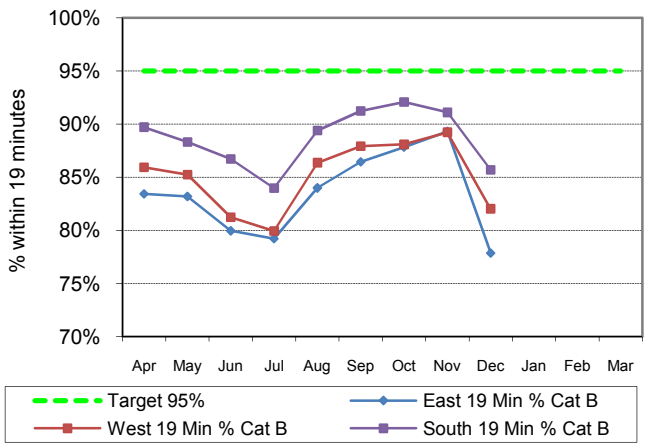


London Ambulance Service NHS Trust
Accident and Emergency Service
Area Performance / Staffing / Utilisation - December 2009

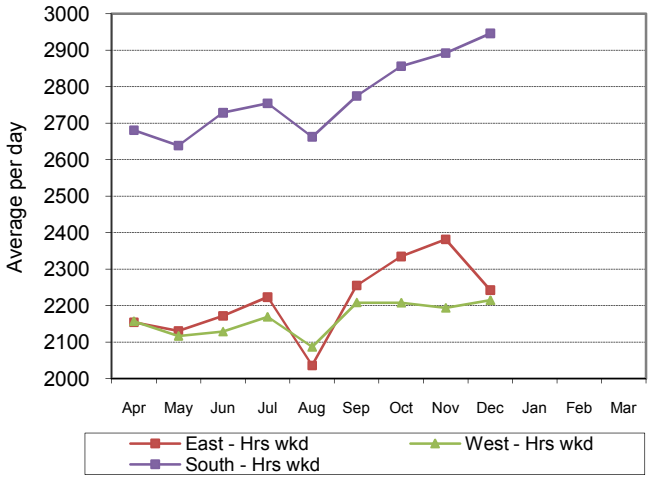
Graph 24
Area Category A 8 minute performance



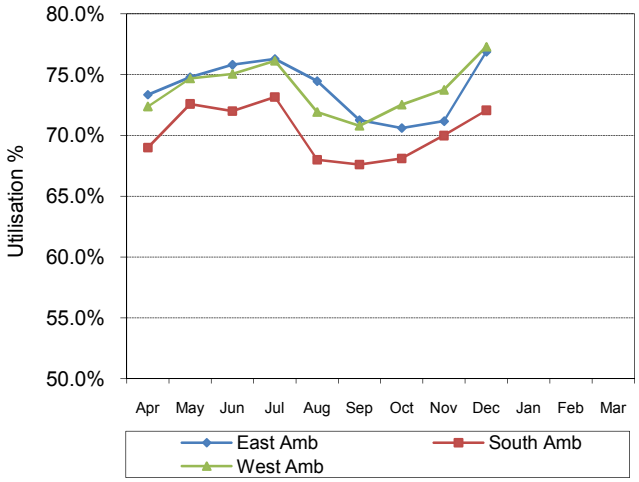
Graph 25
Area Category B 19 minute performance



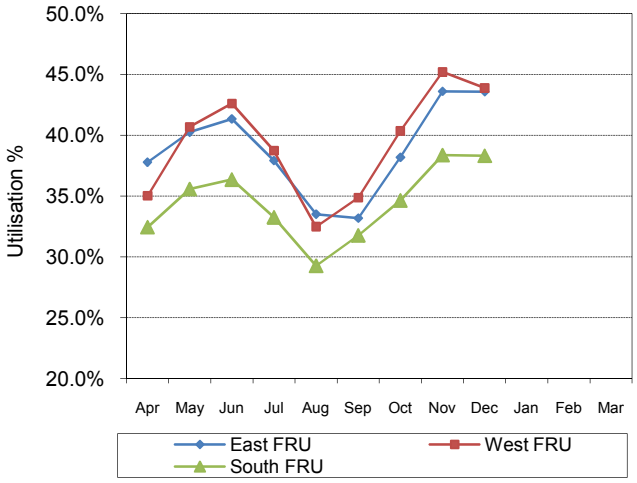
Graph 26
Area All Vehicle Hours average available per day



Graph 27
Area Ambulance Utilisation



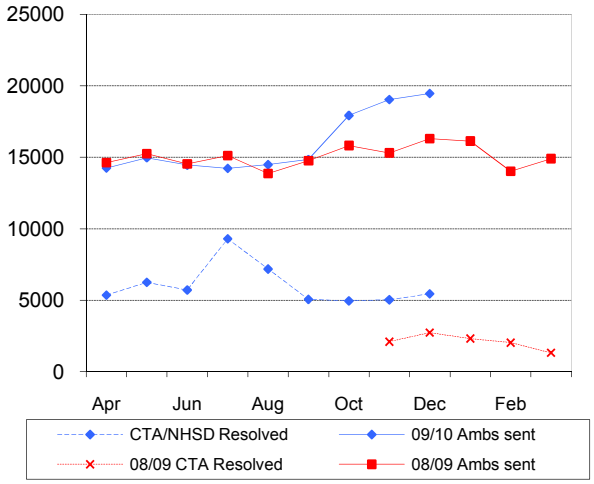
Graph 28
Area FRU Utilisation



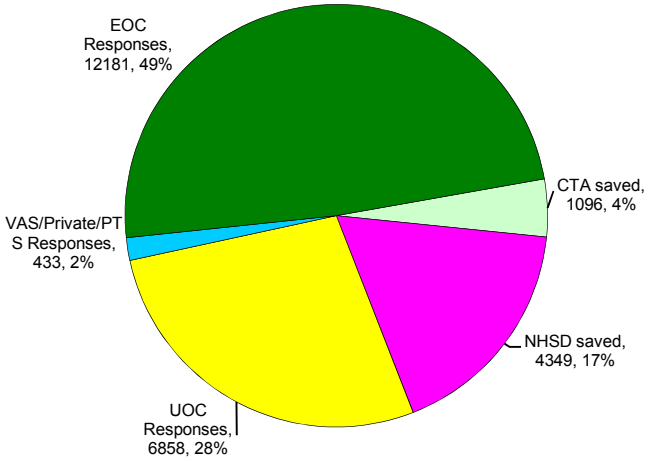
London Ambulance Service NHS Trust
Accident and Emergency Service
Cat C Resolution / EBS measures - December 2009

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

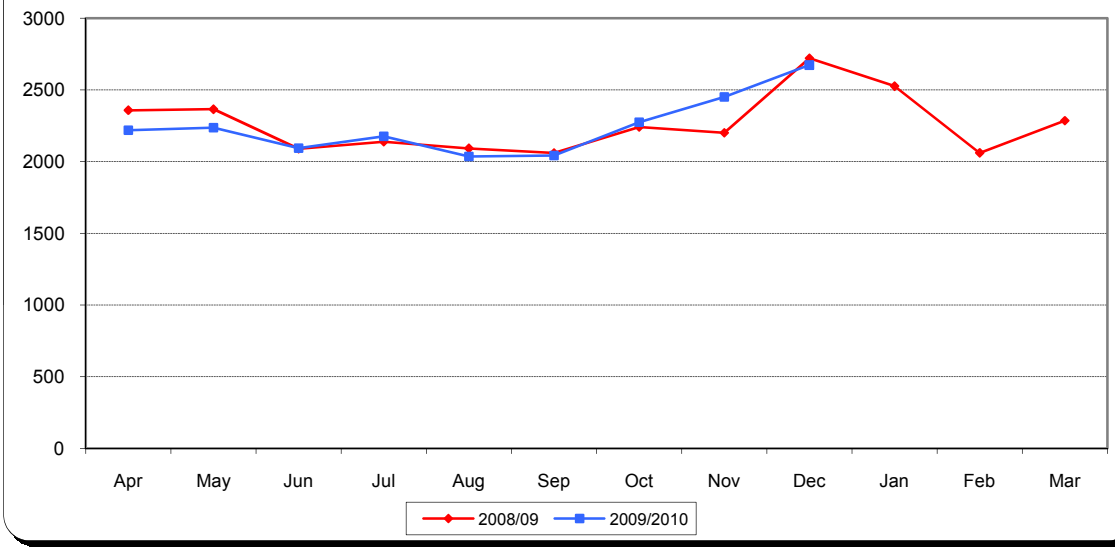
Graph 24
Cat C resolution by Month



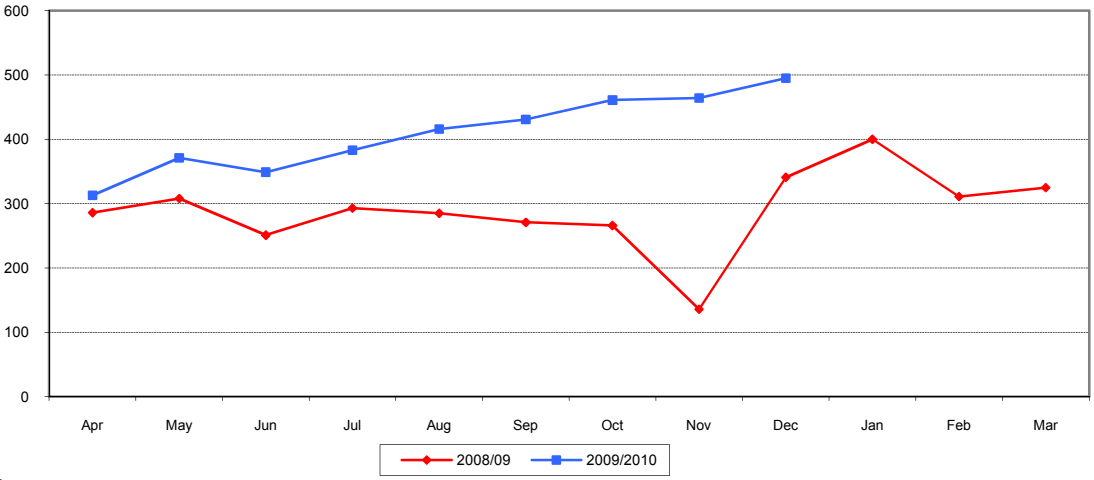
Graph 25
Cat C resolution - December 2009



Total EBS Activity per month



Safeguarding



TRUST BOARD M09 December

Document Title	**M09 - Finance Board Pack**
Report Author(s)	**Finance Department**
Lead Director	**Mike Dinan**
Contact Details	**0207 7463 2585**
Aim	**Information**

Key Issues for the Board

The result for the month is a deficit of £663k. The year to date result shows a surplus of £336k. The full year result is forecast to be a surplus of £1411k. Total average monthly cost year to date was £23289k and Total average monthly cost for the full year is forecast to be £23326k.

Mitigating Actions (Controls)

Monitoring of expenditure and associated cost improvement plans . Intervention as required.

Recommendations to the Board

To note the contents of this report.

Equality Impact Assessment

Has an EIA been carried out?	No
(If not, state reasons)	Not relevant for this paper

Key Issues from Assessment

Risk Implications for the LAS (including clinical and financial consequences)

The key risks are around the achievement of the Cost Improvement Plan, the receipt of all budgeted income and the financial impact of responding to increased demand. Failure to achieve the financial targets set will impact on the standing of the LAS. The Trust has recognised an impairment effect of £1.3m. Whilst this is believed to be a prudent estimation a risk remains that when the formal valuation is completed the figure may be higher. Winter pressures have resulted in the reduction in the forecast surplus from £1.6m to £1.4m.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

Corporate Objectives that the report links to

Achieve financial targets including control total, PTS profitability and efficiency savings

LONDON AMBULANCE SERVICE NHS TRUST

FINANCE REPORT TO THE TRUST BOARD

For the Month Ending 31st December 2009 - (Month 9)

Contents:

LONDON AMBULANCE SERVICE NHS TRUST

Finance Report - Summary
For the Month Ending 31st December 2009 - (Month 9)

£000s

	JN THE MONTH			YEAR TO DATE				ANNUAL		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Total Income	23,261	23,469	(208)U	209,942	211,522	(1,580)U	(0.8%)U	281,328	281,930	(602)U
Total Operational Costs	22,354	22,824	470F	197,317	200,336	3,020F	1.5%F	263,188	267,371	4,184F
EBITDA	**907**	**645**	**262F**	**12,625**	**11,186**	**1,439F**	**0F**	**18,141**	**14,559**	**3,582F**
EBITDA Margin	***3.9%***	***2.7%***	**1.1%**	***6.0%***	***5.3%***	**0.7%**		***6.4%***	***5.2%***	**1.3%**
Depreciation & Interest	1,570	1,054	(516)U	12,289	9,489	(2,799)U	(22.8%)U	16,730	12,653	(4,077)U
Net *Surplus/(Deficit)*	**(663)**	**(409)**	**(254)U**	**336**	**1,696**	**(1,360)U**	**(404.2%)U**	**1,411**	**1,906**	**(256)U**
Net Margin	***-2.9%***	***-1.7%***	**-1.1%**	***0.2%***	***0.8%***	***-0.6%***		***0.5%***	***0.7%***	***-0.2%***

Financial Commentary

For the Month Ending 31st December 2009 - (Month 9)

Year to Date
For the year to date, income exceeds expenditure by £336k. The budgeted position is for income to exceed expenditure by £1696k, hence there is a year to date adverse variance of £1360k. This is mainly due to higher levels of third party provider usage, travel costs and subsistence associated with the increased demand in December PTS is reporting a profit to date of £113k

Month
In the month there is a £663k deficit against a budgeted deficit of £409k resulting in an adverse movement of £254k. This Variance is mainly due to higher levels of third party provider usage, travel costs and subsistence associated with the increased demand in December. The additional winter pressure resulted in higher than planned Overtime and associated incentive costs. 0

Forecast
The year end forecast is £1411k surplus against a budgeted surplus of £1906k. Winter pressures have resulted in the reduction of the forecast surplus from £1,600k to £1,400k

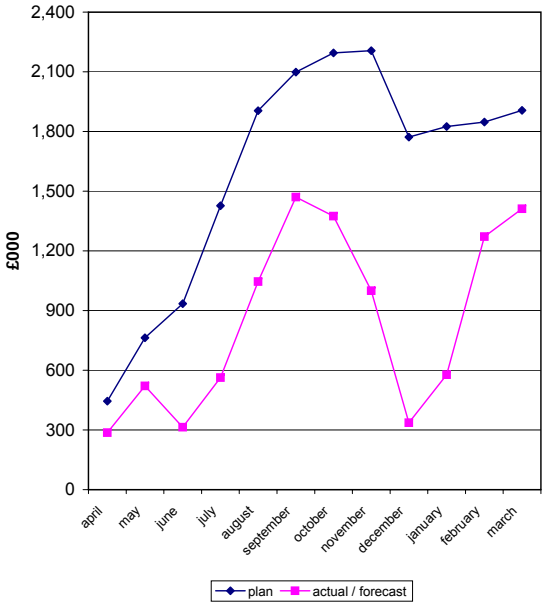
London Ambulance Service NHS Trust

Summary of Financial Performance

For the Month Ending 31st December 2009 - (Month 9)

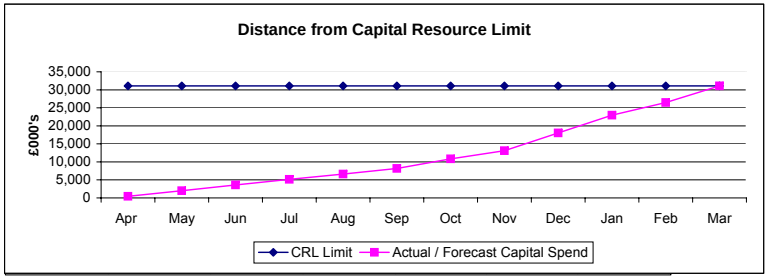
Income and Expenditure

Cumulative Net Financial Position

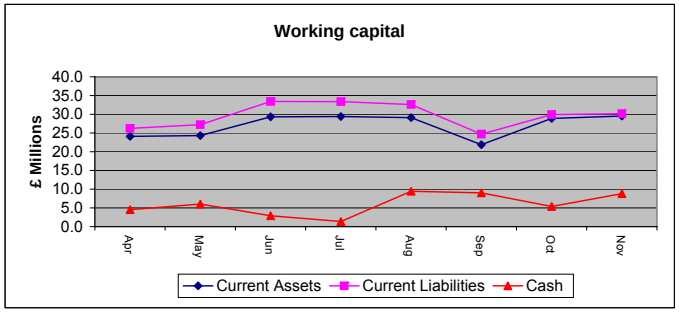


Balance Sheet

Distance from Capital Resource Limit



Working capital



Ratios	September	October	November	December	
Asset turnover ratio	2.07	2.05	2.04	2.09	●
Debtors % > 90 days	3.8%	5.3%	7.3%	12.6%	●
PSPP NHS	84%	84%	96%	80%	●
PSPP Non NHS	86%	86%	88%	85%	●

Key Financial Indicators

	Oct	Nov
A&E Overtime (£000) / Day (Month)	43	45
A&E Overtime (% of paybill)	7.95%	7.90%
Subsistence (£000) / Day (Month)	5.62	5.86
Subsistence per head £	38.24	37.89
Third Party Transport expenditure / Day (Month)	5,523	7,391
Total operational cost per incident	187	199
EBITDA Margin (YTD)	5.5%	4.4%
Net Margin (YTD) (% of Income)	0.8%	0.2%
Cat B performance (cumulative)	85.79%	86.25%

LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends
For the Month Ending 31st December 2009 - (Month 9)

£000s

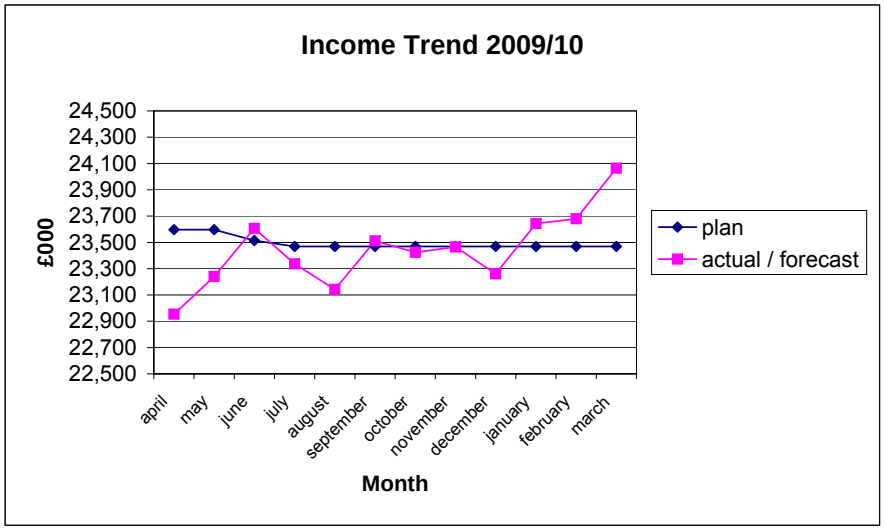
	MONTHLY SPEND												
	April	May	June	July	August	September	October	November	December	January	February	March	Total
	Actual	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Forecast*	*Forecast*	*Forecast*	
Income	**22,954**	**23,240**	**23,606**	**23,337**	**23,143**	**23,512**	**23,424**	**23,465**	**23,261**	**23,643**	**23,680**	**24,064**	**281,328**
Pay Expenditure													
A&E Operational Staff	9,143	9,201	9,318	9,474	9,433	9,604	9,635	9,769	9,849	9,966	10,084	10,232	115,707
Overtime	1,695	1,552	1,680	1,417	1,514	1,457	1,342	1,349	1,447	1,016	437	463	15,369
Overtime Incentives	443	781	513	415	178	317	7	15	194	87	26	0	2,977
A&E Management	1,023	1,024	1,072	1,023	1,031	1,088	1,114	1,189	1,189	1,207	1,212	1,211	13,384
EOC Staff	1,008	1,044	1,039	1,066	1,047	1,064	1,072	1,091	1,083	1,169	1,161	1,168	13,012
PTS Operational Staff	491	527	511	494	487	491	477	489	477	477	477	477	5,874
PTS Management	82	76	78	96	88	76	106	73	79	79	79	79	991
Corporate Support	2,855	2,965	2,813	2,925	2,990	3,025	3,134	3,105	2,989	3,024	3,019	3,028	35,872
Sub Total	**16,740**	**17,168**	**17,025**	**16,910**	**16,767**	**17,123**	**16,887**	**17,081**	**17,307**	**17,025**	**16,495**	**16,658**	**203,186**
Average Daily	*558*	*554*	*567*	*545*	*541*	*571*	*545*	*566*	*558*	*549*	*589*	*537*	*557*
Non-Pay Expenditure													
Staff Related	368	340	300	235	287	287	289	220	445	321	306	322	3,720
Subsistence	170	184	208	174	156	196	176	173	254	178	175	177	2,220
Training	131	158	70	167	51	26	146	158	154	167	152	146	1,525
Medical Consummables & Equipment	517	450	498	836	573	507	525	539	607	560	561	497	6,669
Drugs	3	33	44	29	17	37	39	36	35	39	38	38	383
Fuel & Oil	367	375	389	386	365	376	392	419	450	435	442	438	4,835
Third Party Transport	154	220	196	150	223	194	171	222	261	161	156	151	2,260
Vehicle Costs	902	107	1,004	753	767	706	633	936	403	708	750	745	8,414
Accomodation & Estates	1,018	1,019	1,082	1,138	947	894	1,172	1,050	1,145	1,110	1,180	1,261	13,017
Telecommunications	592	617	800	981	582	891	882	362	603	748	804	1,068	8,930
Depreciation	623	1,255	976	965	1,023	920	1,028	1,045	1,198	1,099	1,099	1,106	12,338
Other Expenses	727	464	732	398	549	559	813	1,236	634	479	456	924	7,972
Profit/(Loss) on Disposal FA	1	0	2	1	1	5	0	0	56	0	0	0	57
Sub Total	**5,566**	**5,223**	**6,296**	**6,211**	**5,540**	**5,600**	**6,266**	**6,395**	**6,245**	**6,005**	**6,119**	**6,873**	**72,340**
Average Daily	*186*	*168*	*210*	*200*	*179*	*187*	*202*	*234*	*201*	*194*	*219*	*222*	*198*
Financial Expenditure	**362**	**613**	**493**	**34**	**353**	**365**	**366**	**364**	**372**	**372**	**372**	**393**	**4,392**
Average Daily	*12*	*20*	*16*	*1*	*11*	*12*	*11*	*12*	*12*	*12*	*13*	*13*	*12*
Monthly Expenditure	**22,668**	**23,004**	**23,814**	**23,087**	**22,660**	**23,087**	**23,520**	**23,840**	**23,924**	**23,402**	**22,986**	**23,924**	**279,917**
Cumulative	**22,668**	**45,672**	**69,486**	**92,573**	**115,234**	**138,321**	**161,841**	**185,681**	**209,605**	**233,007**	**255,993**	**279,917**	
Monthly Net	**286**	**235**	**(208)**	**249**	**482**	**425**	**(96)**	**(375)**	**(663)**	**241**	**694**	**140**	**1,411**
Cumulative Net	**286**	**521**	**314**	**563**	**1,046**	**1,470**	**1,375**	**1,000**	**336**	**577**	**1,271**	**1,411**	
Impairment	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,306**	**105**

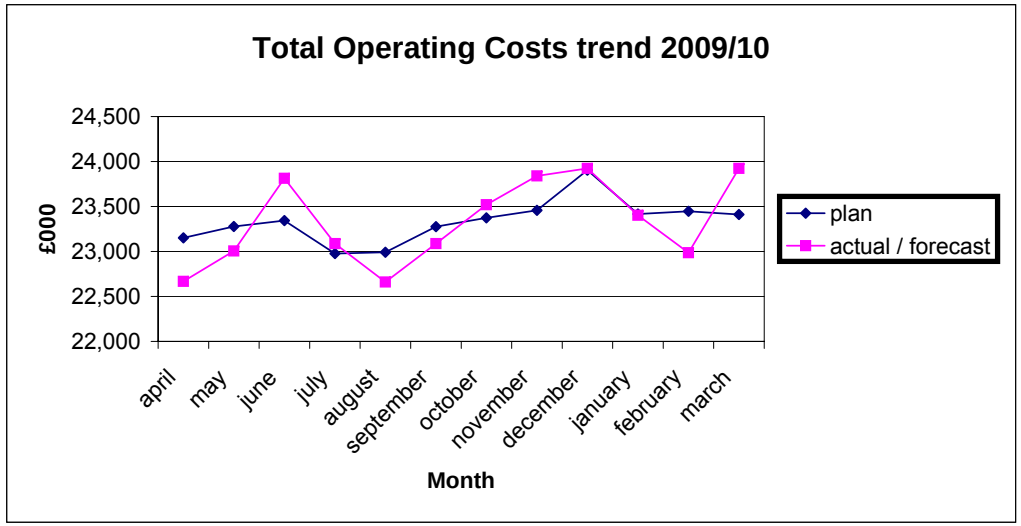
LONDON AMBULANCE SERVICE NHS TRUST
Forecast to Forecast Analysis
For the Month Ending 31st December 2009 - (Month 9)

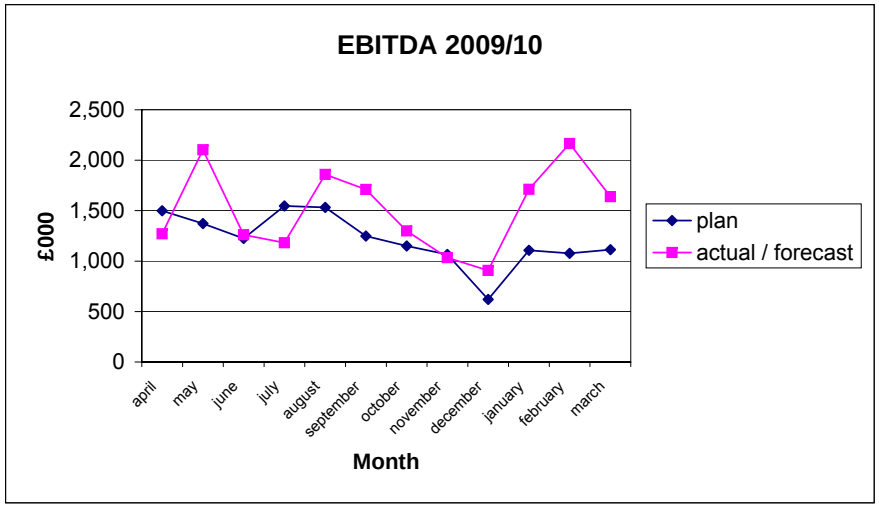
	Forecast Month 9	Forecast Month 8	Variance	
Income	**23,261**	**23,547**	**286**	**£200k in projected realisable HART income, £47k reduction in Olympics Income, £74k reduction in PTS income. £51k increase in RTA income**
Pay Expenditure				
A&E Operational Staff	9,849	9,815	34	Pay adjustments variance
Overtime Incentives	194	150	44	Incentives incurred in M09 exceeded forecast by £44k due to increased FRU shifts to meet demand and performance target
Overtime	1,447	1,156	291	Total overtime and incentives higher than planned of £334k. Overtime exceeded forecast by £289k which equates to additional usage of 13,762 unauthorised overtime hours at an average of £21/hr. In month, A&E increased overtime spend by £72k (3500 hours) and EOC by £8k (380 hours) over and above Month 8 spend
A&E Management	1,189	1,189	0	
EOC Staff	1,083	1,145	-62	11wte (11wte x £2.5k = £27.5k) of EMD1 started instead of 24wte planned in December (24wte x £2.5k = £60k). Other pay variance of £30k
PTS Operational Staff	477	479	-2	
PTS Management	79	112	-33	Planned recruitment of PTS staff not realised
Corporate Support	2,989	3,074	-85	Realised savings of £84k
Sub Total	**17,307**	**17,121**	**187**	
Average Daily	*558*	*552*		
Non-Pay Expenditure				
Staff Related	445	251	194	Higher than projected increase in spend
Subsistence	254	176	78	Additional winter pressure causing breaks to be interrupted and additional subsistence to be paid
Training	154	202	-48	fine
Medical Consumables & Equipment	607	538	69	Additional purchase of snow socks for A&E vehicles
Drugs	35	37	-2	
Fuel & Oil	450	418	32	Higher fuel usage in line with the increase in the number of incidents
Third Party Transport	261	190	71	Additional Third Party usage in line with demand pressures
Vehicle Costs	403	736	-333	Anticipated additional spend to keep vehicles on the road not realised
Accommodation & Estates	1,145	1,126	19	
Telecommunications	603	805	-202	Projected increase not realised in M09
Depreciation	1,198	1,033	165	Additional depreciation of HART vehicles and IT hardwares
Other Expenses	634	1,145	-511	Revision of income to forecast for HART and Olympics . YTD income revision for HART and Olympics adjusted to match YTD expenditure.
Profit/(Loss) on Disposal FA	56	0	56	Disposal of vehicles and stretchers at a loss
Sub Total	**6,245**	**6,657**	**-412**	
Average Daily	*201*	*215*		
Financial Expenditure	**372**	**356**	**16**	
Average Daily	*12*	*11*		
Total Expenditure	**23,924**	**24,134**	**-210**	
Monthly Net	**(663)**	**(587)**	**(76)**	
Impairment	**1,306**	**1,306**	**0**	Due to recent revaluation on the Trust's properties, impairment of £1.3m has been identified and recognised.

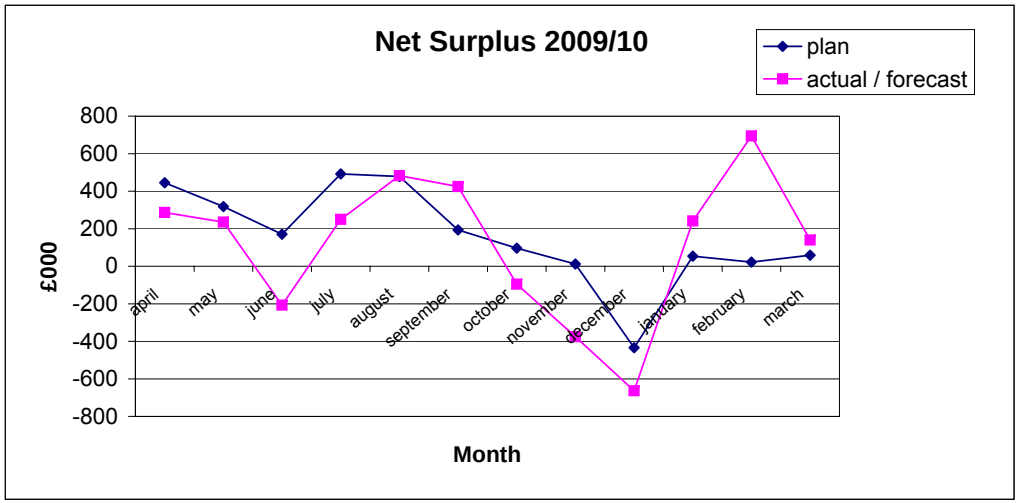
London Ambulance Service NHS Trust

For the Month Ending 31st December 2009 - (Month 9)









LONDON AMBULANCE SERVICE NHS TRUST

Analysis by Expense Type

For the Month Ending 31st December 2009 - (Month 9)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
Pay Expenditure										
A&E Operational Staff	9,849	10,352	503F	85,425	88,602	3,177F	3.7%F	115,707	119,869	4,161F
Overtime	1,447	1,526	79F	13,453	12,210	(1,242)U	(9.2%)U	15,369	15,140	(228)U
Overtime Incentives	194	0	(194)U	2,864	1,000	(1,864)U	(65.1%)U	2,977	1,000	(1,977)U
A&E Management	1,189	1,074	(115)U	9,754	9,445	(308)U	(3.2%)U	13,384	12,368	(1,015)U
EOC Staff	1,083	1,100	17F	9,514	9,615	101F	1.1%F	13,012	12,914	(98)U
PTS Operational Staff	477	448	(29)U	4,443	4,190	(253)U	(5.7%)U	5,874	5,534	(340)U
PTS Management	79	90	11F	754	818	63F	8.4%F	991	1,388	397F
Corporate Support	2,989	2,845	(144)U	26,801	25,495	(1,306)U	(4.9%)U	35,872	33,904	(1,968)U
	17,307	**17,435**	**128F**	**153,008**	**151,374**	**(1,633)U**	**(1.1%)U**	**203,186**	**202,118**	**(1,068)U**
Non-Pay Expenditure										
Staff Related	445	320	(125)U	2,771	2,879	108F	3.9%F	3,720	3,838	118F
Subsistence	254	121	(133)U	1,690	1,094	(597)U	(35.3%)U	2,220	1,458	(762)U
Training	154	208	54F	1,060	1,903	843F	79.5%F	1,525	2,520	995F
Medical Consumables & Equipment	607	497	(110)U	5,051	4,693	(358)U	(7.1%)U	383	420	38F
Drugs	35	35	0F	268	315	48F	17.8%F	6,669	6,088	(580)U
Fuel & Oil	450	377	(73)U	3,520	3,403	(117)U	(3.3%)U	4,835	4,534	(301)U
Third Party Transport	261	88	(173)U	1,792	791	(1,001)U	(55.9%)U	2,260	1,054	(1,206)U
Vehicle Costs	403	1,279	876F	6,211	11,445	5,235F	84.3%F	8,414	15,281	6,867F
Accommodation & Estates	1,145	886	(259)U	9,466	7,911	(1,555)U	(16.4%)U	13,017	10,665	(2,353)U
Telecommunications	603	719	116F	6,310	6,606	295F	4.7%F	8,930	8,746	(185)U
Depreciation	1,198	652	(546)U	9,034	5,866	(3,168)U	(35.1%)U	12,338	7,822	(4,516)U
Other Expenses	634	830	196F	6,113	7,659	1,546F	25.3%F	7,972	10,300	2,328F
Profit/(Loss) on Disposal FA	56	29	(27)U	57	263	206F	363.7%F	57	350	293F
	6,245	**6,041**	**(204)U**	**53,343**	**54,828**	**1,485F**	**2.8%F**	**72,340**	**73,075**	**735F**
Financial Expenditure	**372**	**403**	**31F**	**3,255**	**3,623**	**369F**	**11.3%F**	**4,392**	**4,831**	**439F**
Total Trust Expenditure	**23,924**	**23,879**	**(46)U**	**209,605**	**209,826**	**221F**	**0.1%F**	**279,917**	**280,024**	**107F**

LONDON AMBULANCE SERVICE NHS TRUST

Income & Expenditure - Analysis of Income
For the Month Ending 31st December 2009 - (Month 9)

£000s

	IN THE MONTH			*YEAR TO DATE*				*ANNUAL*		
	Actual	Budget	Variance	Actual	Budget	Variance	% Variance	Forecast	Budget	Variance
A&E Income										
A&E Services Contract	20,217	20,219	(2)U	181,949	181,970	(21)U	(0.4%)U	242,598	242,626	(28)U
HEMS Funding	11	11	0F	101	98	3F	3.6%F	135	131	5F
Emergency Bed Service	98	92	6F	836	829	7F	0.2%F	1,113	1,105	8F
CBRN Income	642	645	(2)U	5,780	5,801	(22)U	(0.4%)U	7,706	7,735	(29)U
BETS & SCBU Income	45	51	(6)U	430	460	(30)U	(6.0%)U	572	613	(42)U
A & E Long Distance Journey	54	33	21F	266	300	(34)U	(8.6%)U	350	400	(50)U
Stadia Attendance	52	85	(33)U	767	764	3F	3.0%F	1,029	1,019	10F
Heathrow BAA Contract	52	44	8F	635	399	236F	72.1%F	791	532	259F
PTS Income from FTs	69	27	43F	718	240	478F	206.6%F	985	320	665F
A&E Income from FTs	7	13	(5)U	99	113	(14)U	3.9%F	140	150	(10)U
Olympics Income	40	160	(120)U	396	1,440	(1,044)U	(71.9%)U	635	1,920	(1,285)U
HART Income	390	363	27F	1,986	3,268	(1,282)U	(46.0%)U	4,022	4,357	(335)U
Injury Recovery Income	156	77	79F	976	697	279F	41.2%F	1,290	929	361F
MPET Income	718	870	(153)U	7,782	7,832	(50)U	6.7%F	10,445	10,443	2F
	22,551	**22,690**	**139**	**202,720**	**204,210**	**(1,490)U**	**(0.9%)U**	**271,812**	**272,280**	**(468)U**
PTS Income	659	731	(72)U	6,858	6,875	(18)U	(0.9%)U	9,034	9,067	(33)U
Other Income	51	49	2F	364	437	(73)U	(14.4%)U	482	582	(100)U
Trust Result	**23,261**	**23,469**	**(208)U**	**209,941**	**211,522**	**(1,581)U**	**(0.8%)U**	**281,328**	**281,930**	**(602)U**

LONDON AMBULANCE SERVICE NHS TRUST

Expenditure Trends Including Last Year
For the Month Ending 31st December 2009 - (Month 9)

	November	December	January	February	March	April	May	June	July	August	September	October	November	December
											Current Year			
	Actual	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*
Income	**19,982**	**22,955**	**22,728**	**22,590**	**21,790**	**22,954**	**23,240**	**23,606**	**23,337**	**23,143**	**23,512**	**23,424**	**23,465**	**23,261**
Pay Expenditure														
A&E Operational Staff	8,474	8,624	8,677	8,624	8,880	9,143	9,201	9,318	9,474	9,433	9,604	9,635	9,769	9,849
Overtime	1,601	1,712	1,710	1,495	1,735	1,695	1,552	1,680	1,417	1,514	1,457	1,342	1,349	1,447
Overtime Incentives	596	848	1,753	893	274	443	781	513	415	178	317	7	15	194
A&E Management	970	1,024	1,001	980	1,001	1,023	1,024	1,072	1,023	1,031	1,088	1,114	1,189	1,189
EOC Staff	962	918	965	1,007	990	1,008	1,044	1,039	1,066	1,047	1,064	1,072	1,091	1,083
PTS Operational Staff	468	470	464	448	479	491	527	511	494	487	491	477	489	477
PTS Management	93	60	80	74	79	82	76	78	96	88	76	106	73	79
Corporate Support	2,781	2,687	2,804	2,431	3,600	2,855	2,965	2,813	2,925	2,990	3,025	3,134	3,105	2,989
Sub Total	**15,946**	**16,342**	**17,455**	**15,952**	**17,038**	**16,740**	**17,168**	**17,025**	**16,910**	**16,767**	**17,123**	**16,887**	**17,081**	**17,307**
Average Daily	*514*	*527*	*582*	*515*	*568*	*540*	*554*	*567*	*545*	*559*	*552*	*545*	*569*	*558*
Non-Pay Expenditure														
Staff Related	223	186	326	219	430	368	340	300	235	287	287	289	220	445
Subsistence	167	222	149	147	336	170	184	208	174	156	196	176	173	254
Training	10	131	167	120	262	131	158	70	167	51	26	146	158	154
Drugs	49	26	34	51	41	3	33	44	29	17	37	39	539	607
Medical Consumables & Equipment	374	494	526	396	367	517	450	498	836	573	507	525	36	35
Fuel & Oil	392	421	403	357	378	367	375	389	386	365	376	392	419	450
Third Party Transport	115	125	153	121	173	154	220	196	150	223	194	171	222	261
Vehicle Costs	1,017	1,153	1,225	836	1,507	902	107	1,004	753	767	706	633	936	403
Accommodation & Estates	938	1,052	1,013	1,085	1,187	1,018	1,019	1,082	1,138	947	894	1,172	1,050	1,145
Telecommunications	613	537	973	615	926	592	617	800	981	582	891	882	362	603
Depreciation	609	596	608	606	712	623	1,255	976	965	1,023	920	1,028	1,045	1,198
Other Expenses	394	477	621	392	750	727	464	732	398	549	559	813	1,236	634
Profit/(Loss) on Disposal FA	2	67	0	0	0	1	0	2	1	1	5	0	0	56
Sub Total	**4,897**	**5,489**	**6,197**	**4,942**	**5,664**	**5,566**	**5,223**	**6,296**	**6,211**	**5,540**	**5,600**	**6,266**	**6,395**	**6,245**
Average Daily	*158*	*177*	*207*	*159*	*189*	*180*	*168*	*210*	*200*	*185*	*181*	*202*	*213*	*201*
Financial Expenditure	**366**	**337**	**360**	**362**	**363**	**362**	**613**	**493**	**34**	**353**	**365**	**366**	**364**	**372**
Average Daily	*12*	*11*	*12*	*12*	*12*	*12*	*20*	*16*	*1*	*12*	*12*	*12*	*12*	*12*
Monthly	**21,210**	**22,168**	**24,012**	**21,256**	**23,064**	**22,668**	**23,004**	**23,814**	**23,087**	**22,660**	**23,087**	**23,520**	**23,840**	**23,924**

Capital Plan

For the Month Ending 31st December 2009 - (Month 9)

Cost Category	Note	Actuals YTD M09	Forecast M10-12	FYE Forecast YE	2009/10 BUDGET
Finance Lease - Ambulances		£0.00	£14,392,589.61	£14,392,589.61	£14,507,599.00
Fleet	1	£8,866,182.45	-£7,765,481.22	£1,100,701.23	£1,200,438.24
IM&T		£4,103,739.70	£5,259,639.99	£9,363,379.69	£9,241,846.68
Equipment		£1,714,908.00	£3,031,987.50	£4,746,895.50	£4,848,558.00
Estates		£333,049.60	£1,287,001.00	£1,620,050.60	£3,109,558.08
Total:		**£15,017,880**	**£16,205,737**	**£31,223,617**	**£32,908,000**

Original CRL:	**£16,000,000**
CRL Increase for HART Capital	**£3,362,000**
Current CRL:	**£19,362,000**
Variation to CRL:	**£13,546,000**
2 **Total CRL requested from DH for year (To be approved)**	**£32,908,000**

Spend in the month has been £2M because of the receipt of 41 Mercedes chassis.
Spend in the other areas has been negligible.
The Trust will spend over £16M in the last quarter . Notable items are defibs (£3M) CAD2010 (£3M)
27 ambulances (£3M) and the HART vehicles due in March (£1.6M)

1 Ambulances that will move to finance leases in the last quarter
2 CRL requested figure of £32,908,000 as at M6 submission to DH

LONDON AMBULANCE SERVICE NHS Trust

Statement of Financial Position

For the Month Ending 31st December 2009 - (Month 9)

	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Non-Current Assets	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Forecast*	*Forecast*	*Forecast*
Intangible assets	6,752	9,564	9,603	8,989	11,219	10,680	9,650	10,662	13,795	9,289	9,289	9,289	9,289
Property, Plant and Equipment	121,789	117,135	109,296	109,857	108,225	109,201	112,559	113,207	111,251	116,346	119,630	118,661	117,685
Trade and Other Receivables	12,462	12,484	12,507	12,654	12,716	12,781	12,751	12,815	12,075	10,434	10,497	10,560	10,528
Total Non-Current Assets	141,003	139,183	131,406	131,500	132,160	132,662	134,960	136,684	137,121	136,069	139,416	138,510	137,502
Current Assets													
Inventories	2,600	2,547	2,508	2,510	2,293	2,265	2,208	2,239	2,253	2,222	2,222	2,222	2,222
NHS Trade Receivables	2,773	4,339	1,680	8,978	10,641	2,003	5,734	5,230	271	2,645	4,926	5,422	4,800
Non NHS Trade Receivables	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Receivables	6,140	5,769	5,629	5,659	5,988	5,958	5,455	5,657	5,961	7,242	7,830	7,852	7,874
Accrued Income	0	3,619	5,638	6,034	5,996	6,905	3,447	5,626	5,455	6,126	5,526	5,526	5,399
Prepayments	4,561	3,329	2,843	3,221	3,223	2,552	3,017	3,909	3,353	3,751	3,751	3,051	2,751
Investments	0	0	0	0	0	8,900	9,800	4,999	6,000	7,500	11,000	9,500	0
Cash and Cash Equivalents	2,533	4,513	6,013	2,925	1,353	531	(797)	375	2,814	2,661	(3,923)	(1,360)	5,081
Current Assets	18,607	24,116	24,311	29,327	29,494	29,114	28,864	28,035	26,107	32,147	31,332	32,213	28,127
Non-Current Assets Held for Sale	0	1,700	1,700	1,709	1,709	1,709	1,709	1,709	1,709	950	950	950	650
Total Current Assets	18,607	25,816	26,011	31,036	31,203	30,823	30,573	29,744	27,816	33,097	32,282	33,163	28,777
Total Assets	159,610	164,999	157,417	162,536	163,363	163,485	165,533	166,428	164,937	169,166	171,698	171,673	166,279
Current Liabilities													
Bank Overdraft	0	0	0	0	0	0	0	0	0	0	0	0	0
Trade Payables	7,531	6,518	6,333	6,851	6,672	6,545	8,167	8,405	8,740	8,250	5,403	5,372	4,830
Other Liabilities	3,887	9,845	9,868	9,728	9,579	9,481	9,529	9,024	9,001	9,141	4,251	5,483	5,090
PDC Dividend Liabilities	0	350	820	1,230	1,120	1,400	(89)	191	471	751	1,031	1,311	0
Capital Liabilities	1,926	132	149	162	80	83	73	83	105	156	116	99	89
Accruals	3,571	4,290	5,305	5,164	4,651	5,048	2,560	3,313	3,602	3,723	3,123	3,073	2,673
Deferred Income	0	930	561	6,171	7,162	6,550	5,053	5,394	4,739	5,484	3,804	1,604	20
DH Capital Loan Principal Repayment	0	0	0	0	0	0	0	0	0	0	0	0	0
Borrowings	3,602	3,602	3,602	3,562	3,549	3,522	3,522	3,509	3,496	3,482	3,469	3,456	3,443
Other Financial Liabilities	0	0	0	0	0	0	0	0	0	0	0	0	0
Provisions for Liabilities & Charges	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Current Liabilities	20,517	25,667	26,638	32,868	32,813	32,629	28,815	29,919	30,154	30,987	21,197	20,398	16,145
Net Current Assets/(Liabilities)	(1,910)	149	(627)	(1,832)	(1,610)	(1,806)	1,758	(175)	(2,338)	2,110	11,085	12,765	12,632
Total Assets less Current Liabilities	139,093	139,332	130,779	129,668	130,550	130,856	136,718	136,509	134,783	138,179	150,501	151,275	150,134
Non-Current Liabilities													
DH Capital Loan Principal Repayment	0	0	0	0	1,000	1,000	4,941	4,941	4,941	9,941	9,878	9,878	9,319
Borrowings	25,002	25,002	25,002	24,141	23,856	23,567	23,280	22,994	22,707	22,421	30,955	30,669	30,383
Other Financial Liabilities	0	0	0	0	0	0	0	0	0	0	0	0	0
Provisions for Liabilities & Charges	11,931	11,884	11,832	11,789	11,707	11,820	11,903	12,016	10,952	10,968	11,216	11,582	11,145
Total Non-Current Liabilities	36,933	36,886	36,834	35,930	36,563	36,387	40,124	39,951	38,600	43,330	52,049	52,129	50,847
Total Assets Employed	102,160	102,446	93,945	93,738	93,987	94,469	96,594	96,558	96,183	94,849	98,452	99,146	99,287
Financed By Taxpayers' Equity													
Public Dividend Capital	57,523	57,523	57,523	57,523	57,523	57,523	57,523	57,523	57,523	57,523	60,885	60,885	60,885
Revaluation Reserve	32,810	33,129	24,394	24,348	24,348	24,348	26,805	26,047	26,047	25,227	25,227	25,227	25,227
Donated Asset Reserve	9	9	8	8	8	8	8	8	7	7	7	7	7
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)
Retained Earnings	12,237	12,204	12,439	12,278	12,527	13,009	12,677	13,399	13,025	12,511	12,752	13,446	13,587
Total Taxpayers' Equity	102,160	102,446	93,945	93,738	93,987	94,469	96,594	96,558	96,183	94,849	98,452	99,146	99,287
Control Total	0	0	0	0	0	0	0	0	0	0	0	0	0

LONDON AMBULANCE SERVICE NHS Trust

Cashflow Statement
For the Month Ending 31st December 2009 - (Month 9)

	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
	Actual	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Forecast*	*Forecast*	*Forecast*	
Operating Activities													
Operating surplus/(deficit)	648	848	281	213	835	795	271	(11)	(1,598)	613	1,066	533	4,494
Depreciation and amortisation	623	1,255	976	965	1,023	920	1,028	1,045	1,198	1,099	1,099	1,106	12,337
Impairments and reversals	0	0	0	0	0	0	0	0	0	0	0	0	0
Transfer from the donated asset reserve	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest Paid	0	(129)	(62)	(62)	(64)	(64)	(76)	(74)	(82)	(82)	(82)	(102)	(879)
Dividend Paid	0	0	0	0	0	(1,769)	0	0	0	0	0	(1,591)	(3,360)
(Increase)/Decrease in Inventories	53	39	(2)	217	28	57	(31)	(14)	31	0	0	0	378
(Increase)/Decrease in NHS Trade Receivables	(1,566)	2,659	(7,298)	(1,663)	8,638	(3,731)	504	4,959	(2,374)	(2,281)	(496)	622	(2,027)
(Increase)/Decrease in Long Term Receivables	(22)	(23)	(147)	(62)	(65)	30	(64)	740	1,641	(63)	(63)	32	1,934
(Increase)/Decrease in Non NHS Trade Receivables	0	0	0	0	0	0	0	0	0	0	0	0	0
(Increase)/Decrease in Other Receivables	371	140	(30)	(329)	30	503	(202)	(304)	(1,281)	(588)	(22)	(22)	(1,734)
(Increase)/Decrease in Accrued Income	(3,619)	(2,019)	(396)	38	(909)	3,458	(2,179)	171	(671)	600	0	127	(5,399)
(Increase)/Decrease in Prepayments	1,232	486	(378)	(2)	671	(465)	(892)	556	(398)	0	700	300	1,810
Increase/(Decrease) in Trade Payables	(1,013)	(185)	518	(179)	(127)	1,622	238	335	(490)	(2,847)	(31)	(542)	(2,701)
Increase/(Decrease) in Other Payables	5,944	(441)	457	415	400	(1,104)	(1,484)	(3,183)	(887)	(13,737)	1,205	(420)	(12,837)
Increase/(Decrease) in Payments on Account	0	0	0	0	0	0	0	0	0	0	0	0	0
Increase/(Decrease) in Accruals	719	1,015	(141)	(513)	397	(2,488)	753	289	121	(600)	(50)	(400)	(898)
Increase/(Decrease) in Deferred Income	930	(369)	5,610	991	(612)	(1,497)	341	(655)	745	(1,680)	(2,200)	(1,584)	20
Increase/(Decrease) in Provisions & Liabilities	(47)	(52)	(43)	(82)	113	83	113	(1,064)	16	248	366	(437)	(786)
Net Cash inflow/outflow from operating activities	4,253	3,224	(655)	(53)	10,358	(3,650)	(1,680)	2,790	(4,029)	(19,318)	1,492	(2,378)	(9,647)
Cashflows from Investing Activites													
Interest received	2	0	(6)	3	4	4	3	4	4	4	4	4	30
(Payments) for property, plant & equipment	(2,275)	(1,724)	(1,569)	(2,238)	(1,996)	(431)	(1,666)	933	(100)	(4,423)	(147)	(140)	(15,776)
Proceeds from disposal of property, plant & equipment	0	0	3	1	1	(5)	0	0	759	8,820	0	300	9,879
(Payments) for intangible assets	0	0	0	0	0	0	0	0	0	0	0	0	0
Proceeds from disposal of intangible assets	0	0	0	0	0	0	0	0	0	0	0	0	0
(Payments) for investment with DH	0	0	0	0	0	0	0	0	0	0	0	0	0
(Payments) for other financial assets	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Cash inflow/outflow from investing activities	(2,273)	(1,724)	(1,572)	(2,234)	(1,991)	(432)	(1,663)	937	663	4,401	(143)	164	(5,867)
Net Cash inflow/outflow before financing	1,980	1,500	(2,227)	(2,287)	8,367	(4,082)	(3,343)	3,727	(3,366)	(14,917)	1,349	(2,214)	(15,514)
Cashflows from Financing Activites													
Public Dividend Capital Received	0	0	0	0	0	0	0	0	0	3,362	0	0	3,362
Public Dividend Capital Repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
Loans received from DH	0	0	0	1,000	0	4,000	0	0	5,000	0	0	0	10,000
Loans principal repaid to DH	0	0	0	0	0	(59)	0	0	0	(63)	0	(559)	(681)
Capital element of finance lease	0	0	(861)	(285)	(289)	(287)	(286)	(287)	(286)	8,534	(286)	(286)	5,381
Net Cashflow inflow/(outflow) from financing	0	0	(861)	715	(289)	3,654	(286)	(287)	4,714	11,833	(286)	(845)	18,062
Increase/(decrease) in cash & cash equivalents	1,980	1,500	(3,088)	(1,572)	8,078	(428)	(3,629)	3,440	1,348	(3,084)	1,063	(3,059)	2,548
Cash, cash equivalents and bank overdrafts at 1.4.09	2,533												2,533
Cash, cash equivalents and bank overdrafts at 31.3.10	4,513	6,013	2,925	1,353	9,431	9,003	5,374	8,814	10,161	7,077	8,140	5,081	5,081

Financial Risks (To be included in new Risk Register)
For the Month Ending 31st December 2009 - (Month 9)

Risk	Gross Value £k	2009/10 Fcast £k	Impact	Likelihood	Score	Comments/Mitigation
A&E penalty	7,100	500	Major	Possible	12	Review with PCTs in light of increased activity and failure to achieve hospital tirnaround
A&E Variable Income	1,600	1,600	Major	Unlikely	8	On track
CIP	11,600	11,600	Major	Possible	12	Shortfall in existing CIP offset by other savings in forecast
Olympics 2012	650	-	Moderate	Unlikely	0	
Other Income (MPET, HART, CBRN)	21,200	1,000	Moderate	Unlikely	6	Better use of Service Line Reporting to identify risk with followup
Economic & Environment (Fuel, NHS cuts, Swine Flu)	500	400	Minor	Possible	6	Review monthly
Other Non Core Business Profitability (PTS, BAA, Stadia)	250	250	Insignificant	Unlikely	2	Better use of Service Line Reporting to identify risk with followup

Revised Cost Analysis Schedule
For the Month Ending 31st December 2009 - (Month 9)

	Plan £k	YTD CIP achieved £k	Forecast Achievement £k
Planned CIP			
Overtime Incentive	-6,100	-4,236	-4,123
A&E Overtime	-1,600	-82	-1,600
Agency	-2,000	330	587
Procurement	-600	221	229
Subsistence	-700	85	80
Other Corporate Processes	-400	-343	-400
Accident Damage	-200	-483	-200
A&E Vacancies	0	0	0
Total Planned	**-11,600**	**-4,508**	**-5,428**
Other Identified CIP			
Staffing Review		-3,177	-4,161
Estates Management		57	-293
Non Essential Project Review		-888	-1,428
Fuel & Oil		-257	-199
Vehicle Procurement Slippage		-148	-200
PDC Dividend Adjustment		-764	-1,018
Total Other Identified CIP	**0**	**-5,177**	**-7,300**
Grand Total	**-11,600**	**-9,685**	**-12,727**
% of Revised CIP achieved		**83%**	**110%**

Explanation of Impairment

Impairment of Assets 2009/10

London Ambulance Trust was required to apply indices provided by the Treasury to asset values at the end of 2008/9 which reduced the carrying of assets by £16.7M. The trust has arranged with the District Valuer to carry out a formal valuation of properties using MEA (Modern Equivalent Asset methodically) between November and December. In late August a directive from the Department of Health required Trusts to disclose any potential impairments in 2009/10 in the Month 6 returns, clearly before the completion formal valuation exercise. The Trust has applied indices from the District Valuer to apply to carrying values as an interim measure prior to the formal valuation. These indices suggest a generic fall in the value of property approximately of 12%. In the absence of a better alternative the Trust has applied these to the carrying value of property. The Trust Board is requested to note the following:

1) Any property specific impairment is first offset against the revaluation reserve for that property,
2) Any excess of impairment over revaluation reserve is charged to Income and Expenditure
3) The value of this excess has been estimated to be £1.3M for 2009/10 based on the indices provided
4) The impairment charge does not affect the control agreed for the Trust
5) The impairment charge is included within the calculation of the Trust's surplus /deficit reported for statutory accounting.

London Ambulance Service NHS Trust

TRUST BOARD - 26th January 2010

Document Title	**Clinical Quality and Patient Safety Report**
Report Author(s)	**Dr Fionna Moore, Medical Director**
Lead Director	
Contact Details	
Aim	**To provide the Board with evidence of progressing clinical quality and patient safety.**

Key Issues for the Board

The Medical Director's report has been renamed to ensure that greater assurance is provided on clinical quality matters and that patient safety issues are made more explicit. The report will continue to focus on the 7 Domains of Standards for Better Health.

Issues to highlight:

Domain 1 (**safety**): the Serious Untoward Policy is under revision. A retrospective review of incidents from 2009 has been undertaken with a representative of NHS London to ensure consistency.

The Policy for managing controlled drugs is under revision.

Domain 2 (**Clinical and cost effectiveness**): Survival from out of hospital cardiac arrest ahs increased significantly.

All Team Leaders will have completed a 2 week 'Clinical Update' course by the end of January.

Domain 3 (**Governance**): The Safeguarding declaration has been revised and expanded.

CQC registration : the Trust has adequate evidence of compliance against clinical outcomes with the possible exception of outcome 9 (management of medicines). The work being undertaken gives assurance that we will be compliant by 31st March 2010.

Domain 6 (**Infection prevention and control**): further progress recorded on a number of work streams.

Domain 7: (**Public Health**): Continuing reduction in cases of H1N1 influenza.

Mitigating Actions (Controls)

Recommendations to the Board

That the Board notes the report

Equality Impact Assessment

Has an EIA been carried out? N/A

(If not, state reasons)

Key Issues from Assessment

Risk Implications for the LAS (including clinical and financial consequences) Compliant with CAS reporting arrangements. Improved arrangements for the management of controlled drugs Clinical Update and Update from UOC addresses issues around vulnerable groups (elderly fallers, mental health patients) Infection Prevention and Control arrangements reported.
Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)
Corporate Objectives that the report links to Delivering high standards of clinical care Meeting the educational needs of the workforce Providing a safe environment for patients and staff Undertaking high quality audit and research studies

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board 26th January 2010

Clinical Quality and Patient Safety Report

Standards for Better Health

First Domain – Safety

Update on Serious Untoward Incidents (SUIs)

Following close liaison with NHS London, a draft revision of the SUI policy and practice guidance has been completed and has been made available to SMG under separate cover. This involves a departure from the Trust's historic practice and will emphasise the importance of Root Cause Analysis and embedding the learning from each incident into revised operational practice.

A SUI decision group has been established with a regular weekly slot for participants to consider any potential SUIs. Information relating to incidents for consideration is made available electronically in advance of these meetings within secure folders. 21 incidents have been considered during the interim change management period. It is likely that 5 will be retrospectively declared, at the suggestion of NHS London. New cases coming to light will be declared as the revised system is embedded. All declared SUIs will be reported to SMG and subsequently to the Trust Board.

Arrangements have been put into place for the management of SUIs declared by other Trusts about instances of a delayed handover of care at emergency departments. These have been published on the LAS website. Since the process was introduced this winter we have seen circa 50 such SUIs being declared by acute trusts across. London. Following agreement with NHS London such instances are processed with a reduced level of cross agency liaison to limit the impact on the LAS' workload.

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

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

23 alerts were received from 11th November 2009 to 11th January 2010. All alerts were acknowledged; two required actions have been completed, one relating to intra-aortic balloon pump harness and the other around the Lifepak CR defibrillator. One alert which requires further action relates to the National Patient Safety Agency 'Being open; communicating with patients, their families and carers following a patient safety incident.' The three alerts requiring action or further assessment referred to in the previous report have now been actioned.

Controlled Drugs Update

LIN Group Membership

Due to the change in Lead Commissioner arrangements, the LAS is now a member of the Westminster PCT LIN Group. This is chaired by Ann Duncan, Director of Integrated Governance at Westminster PCT. Quarter 3 report has been submitted and discussed at the recent LIN meeting; no issues were raised by the group as a result of this report.

Controlled Drugs within LAS

The deadlines set in Action Plan detailed in final version of the internal audit by Bentley Jennison (dated 19th December 2009) are being worked towards. It is anticipated that all actions will completed by 31st March 2010. *The importance of completing this piece of work is highlighted by the requirement to produce evidence of compliance for CQC registration referred to under section 3, Governance.*

The Senior Clinical Adviser met with SCD6 Drugs Directorate of the Metropolitan Police on 21st December 2009. At this meeting the Metropolitan Police did express their satisfaction with the base line procedures, like Bentley Jennison though they expressed concern as to adherence to the policies by staff. The Senior Clinical Adviser to the Medical Director and a member of SCD6 Drugs Directorate will be arranging a series of both announced & unannounced visits across the LAS during 2010 to monitor new policy and procedure, as well as to offer advice and guidance where it is required. As a result of this meeting the following actions have been decided upon:

- The LAS will move towards the carriage of morphine sulphate on the person at all times. This option has been costed and an SPPP submitted for approval by SMG on 13th Jan 2009.

- The LAS has appointed a person who is authorised by the LAS Authorised Officer (AO) to destroy out of date pharmaceuticals (DOOP), in particular out of date morphine sulphate. This person is the Corporate Logistics Manager. Any destructions will also be witnessed by the Metropolitan Police Drug Liaison Officer for the LAS. This has come about due to new regulations that essentially mean that our supplying pharmacy can no longer undertake this role.

- A solution is being sought for the disposal of the small amounts of morphine sulphate that are sometimes unused at the scene or in transit to hospital. Currently the advice, (originally agreed to by the Home Office in 2005), has been to squirt the unused amount onto blue roll towel and place that into the "sharps bin". The Metropolitan Police are now concerned with this approach, and have advised the use of "DOOP jars". The Senior Clinical Adviser is looking at the cost implications and feasibility of this. An SPPP has been submitted for approval at SMG 13th Jan 2009.

- Although not legally required, the LAS will, as an example of good practice, arrange for out of date diazepam and oromorph to be destroyed at the same time as any out of date morphine.

- The amount of diazepam carried in the paramedic drugs pack will be reduced from four ampoules to three. This is a result of looking at the actual usage of diazepam and the amount that is disposed of as "out of date". There is potential saving to the Trust here of £80 per week, (this is an estimated cost).

- The Controlled Drugs Register layout will be reviewed as well as the physical quality of the printing and binding. The newest batch is not at an acceptable standard. Solutions are being pursued.

- The Controlled Drugs Policy is being wholly re-written to take account of any new policy, procedures or paperwork that we are introducing.

Second domain – Clinical and Cost Effectiveness

Clinical Performance Indicator completion

The current target for CPI completion is 95%. The current unacceptably poor level of performance is partially due to REAP 4 being in place for a significant part of the quarter, but possibly also due to the lack of focus by Team Leaders and local management teams. On a positive note we have seen the overall completion rates gradually increase since August.

Area	CPI Completion				
	July	August	September	October	November
East	23%	20%	23%	31%	30%
South	30%	44%	46%	40%	45%
West	32%	36%	56%	40%	49%
LAS	**30%**	**36%**	**43%**	**37%**	**43%**

Clinical Update for Team Leaders

80 % of Team Leaders have now undertaken the two week 'Clinical Update' course. The final course will be completed by the end of January. Feedback from the participants has been very positive. All front line staff will have a three hour stand down before the 1st April to allow Team Leaders to disseminate the major trauma decision tool and to reinforce messages around new clinical guidelines and infection prevention and control.

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

- **Cardiac Arrest Annual Report 2008/09**

(Authors: Gurkamal Virdi, Lynne Watson and Dr Rachael Donohoe)

The outcomes from out of hospital cardiac arrest will be presented as a separate agenda item. The report highlights a further significant improvement in survival of all patients who have suffered an out of hospital cardiac arrest from 12 to 15.2% (Utstein figure) and 4.1 to 5.6% (overall).

- **Clinical Audit and Research Bulletin**

This bulletin, published 24th December 2009 is available via the following link:

<X:\Clinical Audit & Research Unit\Bulletins & Newsletters\CARU Bulletin\Issue 24-(Dec09) FINALx.pdf>

Copies will be tabled at the Board meeting.

Third Domain – Governance

Safeguarding update

The Trust has re issued a Declaration of Compliance on its website, http://www.londonambulance.nhs.uk/health_professionals/safeguarding-child_protection/safeguarding_children_declarat.aspx

This can be reviewed under Appendix 1.

Care Quality Commission Registration 2010

From April 2010 the regulation of health and adult social care will change. Legislation is bringing in a new registration system that applies to all regulated health and adult social care services. To register, providers need to demonstrate that they meet the new **Essential Standards of Quality and Safety** across all the services they provide.

These are grouped into 16 outcomes (and supporting prompts) in the following six key areas:

- Involvement and information
- Personalised care, treatment and support
- Safeguarding and safety
- Suitability of staffing
- Quality and management
- Suitability of management.

It is important that the Trust demonstrates that it has a strong system of clinical governance in place to achieve the outcomes/ prompts. The outcomes are detailed below:

Outcome 1: Respecting and involving people who use services
Outcome 2: Consent to care and treatment
Outcome 4: Care and welfare of people who use services
Outcome 6: Cooperating with other providers
Outcome 7: Safeguarding people who use services from abuse
Outcome 8: Cleanliness and infection control
Outcome 9: Management of medicines
Outcome 10: Safety and suitability of premises
Outcome 11: Safety, availability and suitability of equipment
Outcome 12: Requirements relating to workers
Outcome 13: Supporting workers
Outcome 14: Staffing

Outcome 16: Assessing and monitoring the quality of service provision
Outcome 17: Complaints
Outcome 21: Records.

These outcomes have some links with the SfBH core standards and wherever possible, the standards have been mapped to the outcomes.

The Medical Director is leading on the 6 highlighted outcomes. The Medical Directorate is working with the Head of Governance and the Governance Development Unit to identify the relevant evidence for each outcome to be compliant.

At present there is adequate evidence to declare compliance with all the clinical outcomes except **Outcome 9: Management of medicines – prompt 9B. "**Clear procedures followed in practice, monitored and reviewed for medicines handling that include obtaining, safe storage, prescribing, dispensing, preparation, administration, monitoring and disposal." This is based on an audit of controlled drugs by the Trust's internal auditors, who identified non-compliance with the management of controlled drugs, (Morphine) which may leave the system open to error or abuse. A robust action plan has been developed and the action plan is scheduled to be completed by 31st March 2010. An independent audit manager is engaged by the Trust to carry out spot audits on a regular basis to ensure that the actions put in place for the management of controlled drugs are working and effective.

Fourth Domain – Patient Focus

Patient Experience Report

This item is included as a separate agenda item.

Fifth Domain – Accessible and Responsive Care

Clinical Support Desk

The Clinical Support Desk has played a vital role in supporting the LAS during the recent inclement weather. Good staffing levels have been maintained to ensure that operational crews are well supported and that on the occasions when the Extreme Over Capacity Plan has been used that clinical risk is minimised.

Sixth Domain – Care Environment and Amenities

Update on progress with Infection Prevention and Control Action plan:

Key messages on progress since November 2009

The roll out of Chemex (a multi purpose cleaning agent) is now underway with 1 year contract and national cleaning procurement about to start.

We have negotiated a pilot blanket exchange trial with Sunlight Laundry and Chase Farm Hospital which will commence on 1st February

The tender process for both the laundry and cleaning contract has started

Vaccination programme – Seasonal flu now drawing to a close with good results, H1N1 still patient facing only – fair uptake so far; this issue will be the subject of a subsequent report for the Trust Board.

Training programme to be delivered to all operational staff before 1st April 2010 will include 1 hour of hand hygiene, aseptic non touch technique and the introduction of new Cannulation packs.

Champions training has been on hold due to REAP levels; this can now be rescheduled.

A form of words has been agreed describing all staff's responsibilities referring to infection prevention and control. This statement will be incorporated in all job descriptions, not just those relating to operational or front line staff.

Seventh Domain – Public Health

Pandemic Flu Update

We continue to see H1N1 flu numbers fall; across the country estimated swine flu cases remain low with the weekly influenza/influenza-like illness (ILI) consultation rates in England below baseline levels.

Recommendation

That the Board notes the report

Fionna Moore,
Medical Director

15th January 2010

Appendix 1

The London Ambulance Service NHS Trust works hard to ensure that all patients, including children, are cared for in a safe, secure and caring environment. As a result, a number of safeguarding children arrangements are in place.

1. London Ambulance Service meets statutory requirements and NHS Guidance in relation to Criminal Records Bureau (CRB) checks – all staff that have direct or indirect contact with children, including control services staff who manage 999 calls, undergo an enhanced level of assessment. Our policy on *Employment History and Reference Checks* may be accessed here. From 12 October 2009, increased safeguards have been introduced under the Vetting and Barring Scheme; for more information, see http://www.isa-gov.org.uk.

2. All the Trust's child protection policies and systems are up to date and robust and are reviewed on a regular basis, ultimately by the Trust Board. The last policy review occurred in September 2009 following consultation with local London Safeguarding Children Boards. Our policy may be accessed at http://www.londonambulance.nhs.uk/health_professionals/safeguarding-child_protection.aspx. The next policy review is scheduled for September 2010, unless national developments trigger this earlier.

For more information about London Safeguarding Children Boards, see http://www.londonscb.gov.uk/about_the_london_safeguarding_children_board/

3. The Trust has a robust system in place for reporting children for whom there are safeguarding concerns. Referrals are made to the relevant local authority. Details of this process are available at http://www.londonambulance.nhs.uk/health_professionals/safeguarding-child_protection/the_referral_process.aspx

Data about the number of referrals made can be accessed here.

Work is being undertaken to identify an audit of instances where children under two years of age are attended as a result of a 999 call but are not conveyed to hospital. This work was primarily identified in relation to clinical assessment issues and the communications chain. A pilot audit tested the suitability of the clinical audit standards in place. As a result, an expert working group involving a number of paediatric consultants from external agencies has been assembled to inform future clinical practice and establish the most suitable clinical audit criteria. A review of current equipment relating to under-one clinical assessment is also being undertaken.

4. The Trust has a strategy in place to deliver safeguarding training. This training is in accordance with guidance issued by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) who are responsible for reviewing national practice. – see

http://www2.warwick.ac.uk/fac/med/research/hsri/emergencycare/prehospitalcare/jrcalcstakeholderwebsite/guidelines/safeguarding_children.pdf

The Trust also has in place a *Policy for Paediatric Care*.

Our training regime also draws upon

- *Safeguarding Children & Young People: Roles & Competencies for Health Care Staff* (www.e-lfh.org.uk/projects/Safeguarding/Index.html)
- *Every Child Matters* - http://www.dcsf.gov.uk/everychildmatters/
- *London Child Protection Procedures* (www.londonscb.gov.uk)

An assessment based on the *Roles and Competences for Health Care Staff, Intercollegiate Document, April 2006* – see www.rcpch.ac.uk/doc.aspx?id_Resource=1535 - concluded that our training regime is equivalent to level two. An example of the desired learner outcomes may be accessed here

All eligible staff have undertaken relevant safeguarding training and this is regularly reviewed to ensure it is up to date.

Level one training is not currently delivered as staff in non-operational or other than dedicated positions do not have any contact with children/patients or involvement with safeguarding matters.

100% of new clinical staff who have joined the Trust since 2005 (1,379) have received safeguarding training. Of the remainder of clinical staff employed as at March 2009, (2,318) we estimate that the vast majority have received level two training (the target is 80%) either through initial training on joining the Service, undertaking paramedic training or continuing professional development. Work is underway to confirm how many of the total of our staff have received each element of this training and we will publish this here when this work is completed.

.

Level three training is not currently widely delivered other than to staff in dedicated positions. This is because by virtue of the nature of emergency care, ambulance services do not have the same type of involvement in safeguarding matters as other NHS Trusts. The Medical Director, and in her absence, the Assistant Medical Director (Control Services) and the Head of Patient Experiences, are exclusively responsible for the submission of safeguarding case reports to local Safeguarding Boards and other responsible agencies. All local safeguarding representatives and some staff who have a direct remit (see below) are expected to have an awareness of safeguarding practice equivalent to level three.

The last training review commenced in September 2009 as part of the safeguarding review being undertaken in conjunction with the National Ambulance Safeguarding Group. Proposals are being developed towards ensuring all UK ambulance services can put into place a common training programme and content. It is anticipated that these proposals will be made available to the Care Quality Commission who have a

responsibility to ensure NHS Trusts are compliant with benchmark standards that can be applied to ambulance Trusts.

The Trust is innovative in its approach to ensuring all our staff are conversant with safeguarding issues. By way of example, safeguarding practice was discussed by the Medical Director during the 2009 annual consultation programme at each of our 26 ambulance station complexes and with control room staff. Over 1,000 staff attended these meetings. This primarily involved practice guidance in relation to Sudden Unexpected Death in Infants, Children and Adolescents – please see http://www.londonambulance.nhs.uk/health_professionals/safeguarding-child_protection/suidca.aspx

Regular updates are also provided in the Trust's in-house magazine, which is personally made available to all Trust staff. For example, please see this article.

Whilst we believe exceptional circumstances apply, the Trust accepts that as matters stand and using the existing definitions, we are not fully compliant with the requirements in relation to the training aspect of safeguarding provision. We are however strongly committed to resolving what we consider to be an issue for all UK ambulance services via our involvement in the National Ambulance Safeguarding Group.

6. The Trust has named professionals who lead on issues in relation to safeguarding. They are clear about their role, have sufficient time and receive relevant support, and training, to undertake their roles, which includes close contact with other social and health care organisations. The total number of professionals in these roles is broken down by discipline as follows:

Consultant Doctor
The Medical Director is the Executive Director lead for Safeguarding Children and chairs the Safeguarding Group which reports to the Trust Board on safeguarding activity.

Administrative support:
Our Emergency Bed Service (EBS) administers safeguarding referrals made by ambulance staff in the course of emergency care activity. This is because this service is available 24/7 so that referrals can be actioned immediately. All members of EBS have these responsibilities. EBS has a staff team of 24. EBS also manages routine enquiries from safeguarding professionals in relation to referrals made by ambulance staff.

Patient Experiences Department (PED)
The Head of Patient Experiences is responsible for safeguarding work streams as part of the departmental portfolio. This generally involves strategic policy developments and more serious safeguarding cases, including the work related to Serious Case Reviews –

http://www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/seriouscasereviews/scrs/ - so that learning can be affected not only across the Trust, but all UK ambulance services and the wider health and social care economy. Specific examples of learning may be accessed at http://www.londonambulance.nhs.uk/health_professionals/safeguarding-child_protection/safeguarding_children_declarat/learning_from_safeguarding_iss.aspx

Data about PED safeguarding activity is available here and here.

A dedicated facility is available for safeguarding professionals to raise enquiries relating to referrals made by London Ambulance Service staff or any safeguarding matter – see http://www.londonambulance.nhs.uk/health_professionals/safeguarding-child_protection/the_referral_process.aspx.

PED have a staff team of 16, including a community social worker, who all have safeguarding within their responsibilities. Including the head of department, 5 staff have an enhanced role; this includes a specific Safeguarding Officer.

For more information about PED, see http://www.londonambulance.nhs.uk/about_us/what_we_do/making_your_experiences_count/patient_experiences_department.aspx

Clinical Support Desk (CSD)
This is a unique facility amongst UK ambulance services. CSD staff are experienced paramedics, trained in a wide variety of specialist areas and can provide support and advice to ambulance staff *in situ*. CSD is staffed 24/7 and has a permanent staff team of 7 who work on a rota basis. This is complimented by a cohort of Team Leaders who have been trained accordingly so that the desk can have increased resourcing as required.

The Medical Directorate (MD),
The MD comprises 10 specialist staff who are able to offer peer review advice. This includes five Doctors, two Senior Paramedics, two Clinical Advisors and a Consultant Midwife. The MD also facilitate a 24/7 'on call' facility.

7. The Trust Board takes the issue of safeguarding extremely seriously and receives regular reports on safeguarding children issues. An example can be found on page 76 of the November 2009 board papers. Following a change management review when PED were afforded responsibility for safeguarding from April 2009, an annual safeguarding report will be presented to the Trust Board. This will also be published on the Trust's website. The first annual report is scheduled to be completed in May 2010.

8. The Trust Board has robust audit programmes to assure that safeguarding systems and processes are working. This is maintained via the reporting mechanisms described.

Our Safeguarding Group, chaired by our Medical Director, takes lead responsibility for strategic policy and practice. For example, earlier this year we responded to the National Institute for Clinical Excellence consultation on child maltreatment - see http://www.londonambulance.nhs.uk/health_professionals/safeguarding-child_protection/consultation_on_child_maltreat.aspx

For more information, please see the Group's Terms of Reference and a recent example of meeting minutes.

Each ambulance station complex has a nominated Safeguarding Lead, usually the ambulance operations manager or a specified member of the management team, who has a responsibility to represent the Trust at serious case review meetings etc according to a particular local authority or primary care trust area.

The Head of PED also liaises with the 32 x local London Safeguarding Children Boards and NHS London on both individual cases and strategic issues.

London Ambulance Service NHS Trust

TRUST BOARD - 26 January 2010

Document Title	**Patient Experiences (PED) Summary Activity Report**
Report Author(s)	**Gary Bassett**
Lead Director	**Martin Flaherty**
Contact Details	
Aim	**To update the Board on PED activity April 09 to Dec 09**

Key Issues for the Board to Note

- The report gives a summary of total activity within the Patent Experiences Department (PED) for the period April to December 09 and shows this to be broadly commensurate with the same period in 08/09
- Section 2 describes some regulatory changes which the Board is asked to note
- Within Emerging trends in Section 4 the principle areas explored are:
  - the normal rise in delay complaints associated with the busy winter period
  - Staff attitude and behaviour remains a source of patient dissatisfaction
  - There are a number of concerns being raised about the referral of Cat C patients to NHSD. 70 issues have been raised form 45,000 calls passed to NHSD and whilst only a small percentage there are issues which need to be explored fully and addressed.
  - The identified issues from NHSD referrals are detailed within Sec 4.1
  - There are also some improvements required in the way the LAS works with NHSD to address identified issues and work is in hand to develop mechanisms to do so.
- The Board should be aware that the current SUI policy is under review and will be coming back to the Board for noting in March
- A new category of SUI associated with extended hospital delays is now in place where delays of more than 60 minutes to handover and offload a patient now require the hospital to declare the incident an SUI . Circa 50 such cases have been declared over the last two months.
- The Emergency Bed Service (EBS) has now assumed full responsibility for the administration of safeguarding referrals.
- The frequent caller unit is working well and continues to address frequent callers to reduce demands on the service. In addition the unit is also exploring organisations as well as individuals who seem to call 999 excessively to explore whether changes can be made through these organisations to reduce demand.

Mitigating Actions (Controls)

Recommendations to the Board

The Board is asked to note the report

Equality Impact Assessment

None in relation to this summary of activity. Impact assessments will be part of the evaluation of any new initiatives such as the ongoing referral of Cat C calls to NHDS**.**
Risk Implications for the LAS (including clinical and financial consequences) Clinical risk issues arising from emerging trends identified within this report to be managed by current risk procedures
Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing) **N/A to this summary of activity**
Corporate Objectives that the report links to General Governance Objectives

London Ambulance Service
NHS Trust

Patient Experiences

Summary Activity Report

April – December 2009

Table of Contents

1 Introduction

For the first time and henceforth, activity reports will now include Safeguarding and Community Liaison (Frequent Callers) to better reflect the totality of demand to the department.

In terms of complaints, PALS and incident reports, the volume of demand (4403) is comparable with the previous year (4626). However, the work in resolving individual cases has increased by virtue of the holistic approach determined by the *Making Experiences Count (MEC)* programme, not least involving an increased number of local resolution meetings. The year to date has also witnessed a greater frequency and improved relationship with Independent Complaints Advocacy Service, who have facilitated and participated in a number of meetings with complainants.

Whilst not necessarily an indication of success or failure, 12 cases have been considered by the Health Service Commissioner but none have been the subject of an Ombudsman's investigation. It is, however, pleasing that there have been no criticism or recommendations relating to complaints management.

The Head of Patient Experiences Department (PED) has been invited to present at a range of conferences, hosted by the Department of Health and independent providers about the manner in which the Trust has embraced the MEC programme. It is noticeable that many Trusts throughout the UK are now adhering to the structural model we initiated.

2 Regulatory Changes

The *Local Authority Social Services and NHS Complaints Regulations (2009)* now enable financial redress to be made without recourse to legal action. The Ombudsman has made clear her expectation that there is an obligation to put the complainant back in the position they were in before they experienced the problems they encountered. This means that there is an obligation to consider financial redress much more widely, although, as matters stand, there is no designated budget for this purpose and costs are being borne by local budgets.

The regulations now further determine that where an issue is raised orally but is unable to be resolved within the next working day, this must in each appropriate instance be recorded as a complaint. Work is underway to categorise each relevant PALS case accordingly, where recourse is offered to the Ombudsman. This should not, however, be viewed as a negative in that (a) MEC determines a focus on the issue raised, rather than the mechanism used to raise it, (b) offering recourse in this manner both negates replication of process and affords the service-user greater opportunity for resolution.

A further change is that where a complaint gives rise to either legal action or the invocation of the Trust's disciplinary procedure, a response to the complaint still has to be facilitated.

3 Summary Activity by Month

The following shows Patient Experiences department (PED) activity by mechanism and Trust Area, and those cases referred to other agencies (Not Our Service - NOS). 'UK' and 'HQ' represent cases relating to various Trust departments where it would be problematic to further divide these for the purpose of this report.

The table below shows the total cases to each area.

Category	Definition	Total
East Area	Cases relating to East Area	797
West Area	Cases relating to West Area	756
South Area	Cases relating to South Area	1039
EOC/UOC	Cases relating to Control Services	620
PED	PED	1094
NOS	Cases involving external providers rather than the LAS	97
	Total Number of Cases	**4403**

Key to the method of contact used by service-users and stakeholders in the following tables:

COMP	Complaints
PALS	Patient Advice and Liaison Service
IR	Incident Reports (completed by Trust staff)
IRE	External Incident Reports (completed by other health and social care practitioners)
SCAP	Safeguarding Children/Vulnerable Adults
FC	Frequent Callers

3.1 By Area

Sector	Type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
EAST	COMP	2	6	9	7	7	8	5	4	2	50
	PALS	62	63	52	54	55	58	94	77	66	581
	IR	4	5	8	6	13	8	8	14	3	69
	IRE	4			4		2	1	2	2	15
	SCAP	9	3	21	10	4					47
	FC	1	6	1	3	10	3	5	6		35
East Total		**82**	**83**	**91**	**84**	**89**	**79**	**113**	**103**	**73**	**797**
WEST	COMP	5	4	8	9	7	10	4	4	1	52
	PALS	58	56	67	67	56	67	76	85	72	604
	IR	3	6	9	1	8	9	4	7	3	50
	IRE	1	1	1	1	3	1		1	1	10
	SCAP	5	2	1	3	1	1				13
	FC	5	2	2	4	5	4	1	3	1	27
West Total		**77**	**71**	**88**	**85**	**80**	**92**	**85**	**100**	**78**	**756**
SOUTH	COMP	6	2	6	13	9	8	5	8	3	60
	PALS	74	91	78	98	80	68	106	124	117	836
	IR	5	2	8	3	2	7	7	8	3	45
	IRE	2	3	3	1	1	2	2	1	1	16
	SCAP	5	9	9	8	2	3				36
	FC	6	3	6	4	16	4	4		3	46
South Total		**98**	**110**	**110**	**127**	**110**	**92**	**124**	**141**	**127**	**1039**
Subtotal All Areas		**257**	**264**	**289**	**296**	**279**	**263**	**322**	**344**	**278**	**2592**

3.2 Other Trust departments

Sector	Type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
EOC	COMP	14	9	14	21	16	15	14	19	9	131
	PALS	13	21	21	20	12	20	10	14	11	142
	IR		3		2		1				6
	IRE	2		2	2		1		1	4	12
	SCAP				1						1
	FC				1			1			2
EOC Total		**29**	**33**	**37**	**47**	**28**	**37**	**25**	**34**	**24**	**294**
UOC	COMP						1		1		2
	PALS	1	2	3	3		1	1			11
UOC Total		**1**	**2**	**3**	**3**		**2**	**1**	**1**		**13**
PTS	COMP	3	2	2			1		2		10
	PALS	3	3	1	5	2	5	4		3	26
	IRE									1	1
	PTS		1		1						2
PTS Total		**6**	**6**	**3**	**6**	**2**	**6**	**4**	**2**	**4**	**39**
HQ	COMP		1		1	1					3
	PALS	35	25	29	30	28	39	33	30	16	265
	SCAP		1								1
	FC	3	1							1	5
HQ Total		**38**	**28**	**29**	**31**	**29**	**39**	**33**	**30**	**17**	**274**
Subtotal		**74**	**69**	**72**	**87**	**59**	**84**	**63**	**67**	**45**	**620**

3.3 PED and other miscellaneous services

Sector	Type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
PALS	COMP						1				1
	PALS	89	86	140	128	36	5				484
	IR				1						1
	IRE		1								1
	SCAP		1	1							2
PALS Total		**89**	**88**	**140**	**129**	**36**	**6**				**489**
UK	PALS	18	18	26	17	75	83	119	142	97	595
	IR					1					1
	IRE			1							1
	SCAP			1	1						2
UK Total		**18**	**18**	**28**	**18**	**76**	**83**	**119**	**142**	**97**	**599**
HEMS	PALS			3			1			2	6
HEMS Total				**3**			**1**			**2**	**6**
PED Subtotal		**107**	**106**	**172**	**147**	**112**	**90**	**119**	**142**	**99**	**1094**

3.4 Not Our Service

Sector	Type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
NOS	COMP	3	4	1	3	2	1				14
	PALS	8	11	13	4	6	11	10	8	7	78
	IR	2									2
	IRE								1		1
	SCAP			1							1
	FC							1			1
NOS Total		**13**	**15**	**15**	**7**	**8**	**12**	**11**	**9**	**7**	**97**

3.5 Totals

Sector	Type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total		**451**	**454**	**548**	**537**	**458**	**449**	**515**	**562**	**429**	**4403**

4 Emerging Trends

a) Unsurprisingly, activity increases following periods of high operational demand with delays in dispatch a continuing theme. Delays to calls triaged at a Green priority feature significantly. The department is contributing to the work being taken forward by the Cat C group accordingly.

b) Staff attitude and behaviour remains a constant source of patient dissatisfaction. A proposal is being taken forward with the Cat C group to undertake a Trust-wide survey which will explore the potential relationship between staff behaviours and corporate messages. It has also been proposed to explore profiling towards identifying any trends within staff groups according to age, experience and duration of shift at the time of any given reported incident. We hope to take a pilot forward in conjunction with the South Area.

c) By far the most significant new source of patient dissatisfaction is the NHS Direct (NHSD) referral scheme: The table below shows the 70 issues raised regarding NHSD referrals this year. It should be noted that since February 2009 the Trust has transferred approximately 45,000 Cat C calls to NHS Direct. The caveat is that many of the patient groups involved are generally regarded as 'hard to reach' and therefore may be reluctant to feed back on their experience, for example elderly patients, patients with mental health problems etc.

	Clinical	Delay	Non-Conv	Attitude	Ext Rept	Comms	Total
Complaint	2	7	25	5			**39**
PALS	4	7	10	4		1	**26**
Ext Report		1	1		3		**5**
Total	**6**	**15**	**36**	**9**	**3**	**1**	**70**
% of Total	**8.6%**	**21.4%**	**51.4%**	**12.9%**	**4.3%**	**1.4%**	**100.0%**

4.1 NHSD identified trends

1. A small number of 999 calls that are passed to NHSD and onwardly referred to a GP resulting in a further 999 call and an ambulance being dispatched. There is consequently a service user perception of 'NHS pass the parcel' with a delay in the patient receiving appropriate treatment and ultimately, no saving in resources. Each individual case has been analysed to identify

where lessons can be learned. For example, patients aged over 65 and under 5 are no longer included within the referral schema.

2. Patient and public expectations that placing a 999 call will result in ambulance being dispatched lead to complaints or PALS enquires at the Trust taking this course of action, to refer patients to NHSD. Increased publicity about the scheme may influence this.
3. We need to work harder to ensure that there is no confusion in the caller's mind when a decision is taken to transfer them to NHSD. Revised instructional guidance has now been devised for call takers.
4. The scheme does not enable systematic identification of situations where advice has already been sought from NHSD before a 999 call is made. This matter is subject to discussions with NHSD.
5. It is possible that NHSD operatives may take the view that their main objective is to prevent an ambulance being dispatched rather than achieve the most appropriate care pathway. This matter is similarly subject to discussions with NHSD.
6. There have been instances where callers have been transferred to HNSD when they already have Patient Specific Protocols or a specific care package for a frequent caller is in place. This is due to a failure by call handlers to recognise the locality information associated with the call. This increases clinical risk and inappropriate patient management, often undermining significant multi-disciplinary working. We still need to improve the briefing and technical support to call handlers to eliminate this risk. A Team Brief has been issued to all Control Services staff and an IT solution is being progressed with Information Management & Technology department.
7. Referrals can result in less than optimum care management in relation to a small number of specific patient groups, for example patients presenting with torsion symptoms or patients living with cancer. These matters are being taken forward by the Medical Directorate.

4.2 NHSD Governance issues

1. An evaluation has yet to be completed, although some expansion of the scheme to include some types of Amber calls has been introduced. Close liaison continues with the Medical Directorate to highlight and action any individual cases, trends and associated learning points.
2. A draft protocol to enable joint complaint management has now been presented to NHSD. This will also include a mechanism for NHSD to query referrals that they consider were not appropriate.
3. Information is being sent to all PCTs and local authorities for dissemination to GP practices and social care providers pan-London. It is also proposed to publish information about the scheme on the Trust website.

4. A detailed report giving a précis of each approach to the Trust will be made available for consideration within the scheme evaluation.

5 Governance

a) The Feedback Learning & Improvements Group (FLIG) has been established to consider emerging themes and issues of significance arising from service-user, stakeholder and staff feedback. The work of the Group also involves conducting an in-depth analysis of individual incidents of particular importance to patient care and the manner of service delivery. The group also ensures the implementation of recommendations arising from action plans in cases of particular importance to the Trust, for example Serious Untoward Incidents.

The group maintains a core membership, chaired by the Deputy Chief Executive. The Group also seeks to invite expertise from around the Trust, as required and applicable to the matters under discussion. The Group has now invited a representative from Independent Complaints Advocacy Service and the Patients' Forum to become core members.

b) We continue to develop the information about the department and the workstreams the department has responsibility for, by publishing a range of information on the Trust website[1]. This information is interlinked to illustrate correlations between the differing mechanisms of service-user and stakeholder feedback[2]. A key component is the publication of anonymised case examples to illustrate learning on an individual, Trust-wide and health and social care economy basis[3]. This is also consistent with the Trust's commitment to openness and transparency and has received wide approval.

c) From January 2008, regular reporting to Area Governance Groups will be much more detailed to reflect the totality of department activity. Similarly, revised policy and practice guidance on managing feedback is being drafted.

6 Serious untoward incidents (SUI)

a) Following close liaison with NHS London, a draft revision of the SUI policy and practice guidance has been completed and will be made available to the Trust Board under separate cover, when finalised. This involves a

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[1] http://www.londonambulance.nhs.uk/talking_with_us/enquiries,_feedback_and_compla.aspx

[2] http://www.londonambulance.nhs.uk/about_us/what_we_do/making_your_experiences_count/using_feedback.aspx

[3] http://www.londonambulance.nhs.uk/about_us/what_we_do/making_your_experiences_count/examples_of_learning.aspx

departure from the Trust's historic practice and will emphasise the importance of Root Cause Analysis and embedding the learning from each incident into revised operational practice.

b) An potential SUI consideration Group (SUIG) has been established consisting of the Head of Patient Experiences and four SMG directors and has a regular weekly slot to consider any potential SUIs. Information relating to incidents for consideration is made available electronically in advance of these meetings within secure folders.

c) 21 incidents have been considered during the interim change management period. It is likely that 5 will be retrospectively declared, at the suggestion of NHS London. New cases coming to light will be declared as the revised system is embedded. All declared SUIs will be reported to the Trust Board.

d) Arrangements have been put into place for the management of SUIs declared by other Trusts about instances of a delayed handover of care at emergency departments. These have been published on the Trust website[4] following agreement with NHS London. Such instances do not require joint declaration and are processed with a reduced level of cross agency liaison to limit the workload placed on the LAS. Since the process was introduced this winter we have seen circa 50 such SUIs being declared by acute trusts across London.

7 Safeguarding

a) The change management process whereby the Emergency Bed Service has assumed responsibility for the administration of referrals has been completed. Work is underway to identify instances of late referrals. Agreement has also been reached that completion of a referral is included within the call cycle. Data about the volume of referrals is available on the Trust's website[5]. It is envisaged that when sufficient data has been accumulated, analysis will be undertaken to identify any apparent trends taking into account regional demographics etc. This will be reported to Safeguarding Group and local area governance groups as well as the Trust Board as part of the Medical Director's regular reports on Safeguarding activity.

b) A revised Safeguarding Declaration has been completed at the behest of NHS London following liaison with the Department of Health and Care Quality Commission who asked that all NHS Trusts include an expanded

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4 http://www.londonambulance.nhs.uk/health_professionals/reporting_incidents_to_us/delayed_handover_of_care_at_em.aspx

5 http://www.londonambulance.nhs.uk/health_professionals/safeguarding-child_protection/safeguarding_children_declarat.aspx

and detailed statement against specific criteria. This was published on the Trust website[6] on 30 December 2009, within the requisite deadline.

Although exceptional circumstances apply, the Trust has declared non-compliance with the existing training standard. This matter is being taken forward by Safeguarding Group in conjunction with Education and Development department and via our involvement in the National Ambulance Safeguarding Group.

c) Detailed PED activity as regards those cases that have escalated to a more serious level is available on the Trust website[7]. This indicates that approximately only 50% of local Safeguarding Children's Boards (SCB) and local authority agencies involved with vulnerable adult investigations are inviting the LAS to contribute to Serious Case Reviews, strategy meetings etc. This matter is being taken forward through London SCB, the London Adult Protection Network and the Trust's Commissioners. A significant increase in demand may therefore be anticipated in 2010.

d) The Trust remains vulnerable to criticism for its inability to make available local representatives to attend local Safeguarding meetings, most often prompted by operational pressure. .

8 Community Liaison (Frequent Caller Unit)

The unit continues to explore alternative care pathways through a multi-agency approach. Although, invariably labour intensive, the work of the unit continues to have a significant effect in reducing or preventing call volumes; some 67 cases have been closed during the period. Case study examples have been published on the Trust website[8].

The unit has, however, identified that organisations as well as individuals can be identified as 'frequent callers'. Using data from Management Information, which detailed the top 100 phone numbers calling 999, this indicated that some residential and nursing homes use the LAS far more frequently than expected for their size and type of resident. The unit has expanded its remit to work with these agencies with the aim of reviewing their policies to reduce call volumes.

The unit has also highlighted other establishments (ice rinks, supermarkets) where the call volume to 999 appears disproportionately high. The unit is beginning to work with these organisations in order to establish, for instance, whether their policies on first-aid have an over-reliance on the 999 service. Similarly, work has been

[6] ibid

[7] Ibid

[8] http://www.londonambulance.nhs.uk/health_professionals/caring_for_frequent_callers/case_studies.aspx

undertaken with a number of hostels to improve management of a patient group who are, by definition, frequently transient.

Based on field experience, the unit has developed a category list to identify the type of frequent caller by the LAS resources they use. This includes organisations as well as individuals and some patients may fall into more than one category:

- FC1 – calls to EOC only
- FC2 – assisted but not conveyed
- FC3 – taken to an Emergency Department (ED)
- FC4 – hoax caller
- (FC5 – self presented at an ED, no LAS involvement)

Impact on Performance and Resources – 3 month snapshot

In order to illustrate the impact frequent callers have on LAS operational targets, and given the difficulty in devising a performance management model, a trial snapshot was recently conducted. This seeks to demonstrate the impact on operational and EOC resources over a three month period.

During this three month period identified cases generated the following activity:

Call volume

The total number of 999 calls made. This includes repeated calls regarding the same incident. The total number of calls was **295**

Taken to A&E

The total number of calls where the patient was taken to A&E was **109.**

FRU (Fast Response Unit) sent

The total number of FRUs used was **54.**

Ambulance attendance

The total number of ambulances used was **171.**

Ambulance shifts lost

A ‘shift’ is classed as 10 calls attended by an ambulance (the average amount of calls an ambulance crew on a 12 hour shift will attend).

The total number of whole ‘shifts’ lost is **17.**

999/EOC call time

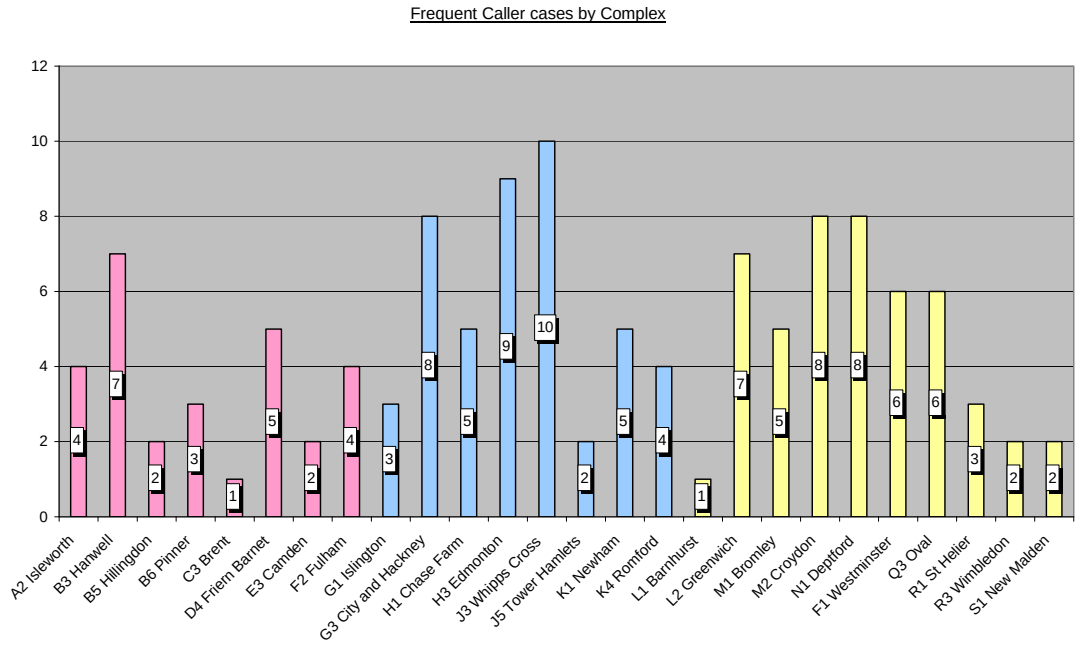
The amount of time from ‘call connect’ to ‘call ended’ that each call took; many frequent callers will continually call back, sometimes over 5 times after making an initial call.

The total amount of EOC time used was just over **19** hours.

Patient referred by NHSD/CTA

As indicated, NHS Direct has recently been inappropriately utilised to manage some calls from frequent callers. Significantly, the vast majority of patients so referred were suffering from a mental health issue. From an analysis, it is clear that referrals made to NHSD in this way have not prevented the patients referred from 'phoning 999 again on a regular and consistent basis, and in some instances, undermined and damaged complex care arrangements negotiated with a wide range of other health and social care practitioners.

Current frequent caller cases by ambulance Complex



Current Cases

Number of current 'open' cases: 128. NB: the average at any given time is 160.

Comprising of:

East Area 45

South Area 55

West Area 28

Trust policy as per OP/42, which seeks to involve ambulance complexes in the management of frequent caller cases has not been successful. Four of the twenty-six ambulance complexes currently do not have a dedicated Frequent Caller Representative (FCP) and while there are a few notable exceptions, the majority of complexes do not have any involvement with the management of cases.

In consequence, the Trust continues to manage patients of this nature in a less than optimum manner. This is of particular concern given correlations with practice in relation to the High Risk Register. Work is in hand to explore alternative approaches to resolve this issue, one of which could be to centralise follow up activity within the

Patient Experiences Department which would then require some additional resources to manage the workload.

9 Freedom of Information

The tables below indicate activity to date by source and primary department. It should be noted that the latter is somewhat unreliable given that an enquiry can affect the involvement of multiple Trust departments.

Type (Applicant)	On Time	25 Days	40 Days	> 40 Days	Total
Unspecified	7				**7**
Academic/Student	14			1	**15**
Clinician	4				**4**
Commercial	22	2	1		**25**
Employee	4	3		1	**8**
MP	12	4	1		**17**
Journalist	19	5	1	1	**26**
MOP	8				**8**
Other		1			**1**
Patient		1			**1**
Relative			1		**1**
Social Services	1				**1**
Voluntary Agency		1			**1**
Grand Total	**91**	**17**	**4**	**3**	**115**

Specialty	On Time	25 Days	40 Days	> 40 Days	Total
UOC	1				**1**
PED	6		1		**7**
Unspecified	2	1			**3**
A&E Development	2				**2**
Estates	2				**2**
Fleet	9	1		1	**11**
Finance	12	3	2	1	**18**
HQ Annexe	1				**1**
Mgmt Information	25	3	1		**29**
Other	12	5			**17**
HR	14	3			**17**
IM&T	4	1		1	**6**
Training	1				**1**
Grand Total	**91**	**17**	**4**	**3**	**115**

Exemptions have been applied on 12 occasions and Section 12 Fee Limit on 11 occasions.

The data reflects a completion rate of 79% within the legal timeframe (20 working days). This is a deteriorating situation and is usually due to delays in the supply of information from various departments across the Trust.

It was agreed that all departments would appoint a dedicated FOI representative who would be the principle contact for all FOI requests and would facilitate the timely provision of information. In many instances these staff have not been appointed and this must be resolved as a matter of urgency in early 2010.

Gary Bassett
Head of Patient Experiences.

London Ambulance Service NHS Trust

TRUST BOARD - 26th January 2010

Document Title	**Care Quality Commission registration requirements**
Report Author(s)	**Sandra Adams**
Lead Director	**Sandra Adams/Mike Dinan**
Contact Details	**020 7783 2045**
Aim	**To discuss and approve the submission for the Care Quality registration requirements – final document to be brought to the meeting**

Key Issues for the Board

- It is a legal requirement under the Health & Social Care Act 2008 that all providers of health services are registered to provide the service(s);
- Ambulance services are to be registered under the regulated activity of 'Transport services, triage and medical advice provided remotely;
- There are 16 quality & safety registration regulations where we are required to provide evidence of outcomes to demonstrate compliance; the guidance summary can be accessed from this link:

http://www.cqc.org.uk/_db/_documents/Summary_of_regulations_outcomes_and_judgement_framework_FINAL_081209.pdf

- Where possible we are using evidence from the 2009/10 core standards process to support the assessment and the standards for better health group have reviewed the evidence for each outcome;
- The Trust has received the Quality & Risk Profile (QRP) prepared by the CQC linking other sources of evidence to the registration requirements and we are focussing on those areas showing red or amber to ensure that action plans are in place and progress is being made to improve compliance; an example of this is item 19 on this agenda concerning Board responsibilities & security management;
- The registration process focuses on outcomes, for example the care, treatment and support people experience, whether this is safe and effective, and what the impact is for the individual;
- Registration can be without conditions, with conditions, or a refusal for all or part of the registration;
- The deadline for submission is 29th January 2010;
- The final review of evidence will take place on Friday 22nd January and the registration application will be brought to the Board on 26th January;
- At this stage we believe we are achieving compliance with most of the regulations and have evidence to support this;
- The regulations will in future form a key element of the quality, safety and risk agenda and will be routinely reviewed by the relevant committees within the risk management structure.

Mitigating Actions (Controls)

Risk management committee structure

Recommendations to the Board

To approve the final declaration on 26th January 2010 and to note the plans for ongoing monitoring and management of compliance with the regulations.

Equality Impact Assessment Has an EIA been carried out? (If not, state reasons) **Key Issues from Assessment** N/A at this stage
Risk Implications for the LAS (including clinical and financial consequences) N/A unless major con-compliance issues emerge in-year against a clinical quality or safety regulation.
Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing) Failure to be registered in full or part would be reported to NHS London and may result in a poorer governance rating and may also impact upon the NHSFT application
Corporate Objectives that the report links to Statutory/compliance requirements

London Ambulance Service NHS Trust
Trust Board
26th January 2010

Registration with the Care Quality Commission

From April 2010, providers of health and adult social care in England including NHS Ambulance Trusts which provide regulated activities, must be registered with the Care Quality Commission. **Essential Standards of Quality and Safety** provides guidance about compliance from the perspective of the patient. And the focus is on clinical outcomes and people's experience of quality and safety, rather than on an administrative and managerial task of compiling evidence about policies and process. When assessing a trust's application for registration CQC assessors and inspectors will use a tool called a 'quality and risk profile' that gathers information CQC holds relevant to registration.

There are 16 essential standards made up of the quality and safety of care regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009. These include:

Essential standards of quality and safety		
Outcome	**Regulation**	**Description**
1	17	Respecting and involving people who use services
2	18	Consent to care and treatment
4	9	Care and welfare of people who use services
5	14	Meeting nutritional needs
6	24	Cooperating with other providers
7	11	Safeguarding vulnerable people who use services
8	12	Cleanliness and infection control
9	13	Management of medicines
10	15	Safety and suitability of premises
11	16	Safety, availability and suitability of equipment
12	21	Requirements relating to workers
13	22	Staffing
14	23	Supporting workers
16	10	Assessing and monitoring the quality of service provision
17	19	Complaints
21	20	Records

Process
Due to the short timescales available to assimilate information, the Evidence Dossier used to support the October09 Standards for Better Health declaration will be the main reference source for the registration. Where gaps have been identified managers have provided additional supporting information. Meetings/ workshops were held with senior managers from Operations, Human Resources, Clinical and Support services .This high level information was presented to the SfBH group on 18th January 2010 to agree the level of compliance with the regulation outcomes. The recommendations will be presented to the Clinical Governance Committee on 25th

January and will go to the Trust Board on 26th January 2010 for approval before submission to CQC by 29th January 2010

As the Trust needs to evidence ongoing compliance further evidence will be collected after the submission date and on a continuing basis to ensure that the Trust have robust and verifiable measures for each outcome. This will be managed as part of the quality, safety and risk agenda through the committee structure and will be subject to ongoing review.

Once registration is submitted the CQC will evaluate each submission before 1st April 2010 and seek clarification from organisation if necessary. It is anticipated that the CQC will undertake spot checks, including the hygiene code, as well as more in-depth national assessments between February and April 2010.

Laila Abraham
Interim Head of Governance
18th January 2010

Provider registration

* Please confirm the name of your organisation

Application and declaration of compliance for registration as a health and adult social care provider.

Applications under section 11 of the Health and Social Care Act 2008

This application and declaration of compliance form is for registration with the Care Quality Commission. Registration entitles you to provide applicable regulated activities associated with health and social care. The complete list of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 can be found on our website at www.cqc.org.uk.

It is an offence under section 10 of the Health and Social Care Act 2008 to carry out a regulated activity without registering with the Care Quality Commission. You could be prosecuted and it could lead to your application being refused.

You should only use this form if you are an NHS provider currently registered for Health Care Associated Infection with the Commission. **It is not for use by healthcare providers who are registering for the first time.**

When completing the form you should also refer to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 and the guidance about compliance. These are available on our website at www.cqc.org.uk.

You must complete every field that is mandatory (marked with an asterisk). Other fields are optional but if you have this information available please provide it. We will reject an incomplete application and return it. If you need more space to answer any questions on this form, please complete the extra information text box at the end of the section 2.

While considering your application the Care Quality Commission is entitled to ask for further information and may arrange a site visit.

Please ensure that your completed application and declaration form does not contain any confidential personal information about patients or staff.

Statement on Data Protection Act 1998

The information you have provided in this form and any other information you submit in support of your application will be used by the Commission for the purposes of processing your application for registration, including fact verification, and matters connected with the Commission's statutory functions. The Commission may also share your information with third parties for the purposes of regulatory activity, law enforcement or any other purpose permitted by law.

The Commission will publish information on the Commissions website www.cqc.org.uk to enable the public to find and compare care services in their local area. The Commission may also be required to disclose your information pursuant to a request under access to information legislation, such as the Freedom of Information Act 2000.

Your information will be stored securely and held for the periods set out in the Commission's retention and disposal schedule.

Title	Applicant's First Name	Last Name

Who is the applicant?

This declaration must be signed by the applicant or by an individual duly authorised to sign on behalf of the organisation.

Date

* [] by clicking on this checkbox, you indicate your agreement that the information provided will be used as stated. If you do not agree then please contact the National Contact Centre on 03000 616161

Section 1 - Service Provider details

What is the service provider?

This is the legal entity or person(s) applying to register to provide the regulated activities. If you are an organisation it is the name of the company or trust.

Details of the service provider, including email address and main website (if applicable) will appear in the register that we are legally required to keep and make available to the public. The email address we require in this section is the general email address of the organisation, for example queries@nhstrust.org.uk. This should not be a personal email address unless it is this persons role to answer/redirect general queries from members of the public

1.0 Details of the Applicant

* Name of Service Provider	
* NHS Trust code	
* Address line 1	
Address line 2	
* Town/City	
* County	
* Postcode	
Business wide Email (if applicable)	
Website	
* Main Business Telephone (including extension)	
Business Fax	

Note: This address will be printed on the registration certificate and published on the internet as the provider details

Regulated Activities

What is a Regulated Activity?

Regulations set out the activities that trigger the need for you to register. The regulated activities are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009. If any of these activities are carried out, the providers of those activities must register with the Care Quality Commission.

[] Personal Care

[] Accommodation for persons who require nursing or personal care

[] Accommodation for persons who require treatment for substance misuse

[] Accommodation and nursing or personal care in the further education sector

[] Treatment of disease, disorder or injury

[] Assessment of medical treatment for persons detained under the Mental Health Act 1983

[] Surgical procedures

[] Diagnostic and screening procedures

[] Management of supply of blood and blood derived products etc.

[] Transport services, triage and medical advice provided remotely

[] Maternity and midwifery services

[] Termination of pregnancies

[] Services in slimming clinics

[] Nursing care

[] Family planning services

1.1 Details of the nominated individual

What is a Nominated Individual?

Each organisation applying for registration must nominate an individual to act as main point of contact for the CQC. They must be a director, manager or secretary of the organisation with responsibility for supervising the management of the regulated activity. ***It may be that you will want to appoint one nominated individual to cover one, several or all the regulated activities you provide. However, you must consider the need for that individual to fulfil the responsibility of supervising the management of the regulated activity****.*

The address of the nominated individual/s is their business address and contact telephone number. We also need the nominated individuals business email address for contact purposes.

Regulated Activity:	
* Title	
* First Name	
* Last Name	
* Job title in Organisation	
* Address line 1	
Address line 2	
* Town/city	
* County	
* Postcode	
* Nominated individual business email address	
* Nominated Individual Business telephone (including extension)	
Nominated Individual Business mobile	
Nominated Individual Business fax	

Section 2 - Other Information

What are the Invoice and financial contact details needed for?

There are no fees for registration with the Commission as you are already registered with us under the Health Care Associated Infections Regulations. However there will be annual fees, and we need to know who and where to send invoice and financial information. Please provide us with contact details of the appropriate person within the trust to contact about this and the invoice address.

2.0 Invoice and financial contact details

* Title	
* Contact First name	
* Last name	
* Job title in Organisation	
* Address line 1	
Address line 2	
* Town/city	
* County	
* Postcode	
* Business Wide Email	
* Business telephone (including extension)	
Business mobile	
Business Fax	

Section 2.1 - Statement of Purpose

All service providers (please see question 1.0 for definition of service provider) including NHS Trusts, are required by law to have a Statement of Purpose for each of the regulated activities they are registered for.

The aim of the Statement of Purpose is to provide information about:

- what you want to achieve in carrying out your regulated activity.

- the services you provide for the purpose of carrying out your regulated activity, and the locations from which you provide them. This information should be to a level of detail that enables us to have a good understanding about the specific nature of your services. For example, if you are registered for 'surgical procedures' your statement of purpose should define exactly what type of surgery this is, such as cardiac or neurosurgery, and whether this is for children as well as adults.

The Statement of Purpose must include the information set out in Schedule 3 of The Health and Social Care Act 2008 (Miscellaneous Provisions) Regulations 2010. We will require you to send us your Statement of Purpose once you are registered with us, or during our assessment of your application, if we need further clarity about the types of services you provide. You must notify us if you make any changes to your Statement of Purpose.

Section 2.2 - Information about Nominated Individuals

You are required by law either to supply this information (if the Commission requests it) or to have it available for us to see if we so wish. We are not asking you to submit this information now, but only to confirm that you have it available and that it is satisfactory. We may ask to see it in the future.

An enhanced Criminal Records Bureau check (Including information relevant to vulnerable children or adults) must be available. In order to be considered as satisfactory information this CRB must be less than one year old.

Evidence of proof of identity could be either a copy of your birth certificate or passport. Evidence of satisfactory conduct in relation to previous employment could be satisfactory references.

Documentary evidence of relevant qualifications could be certificates or other suitable evidence of your relevant professional qualifications.

A full employment history together with satisfactory written explanation for gaps in employment could be provided by a Curriculum Vitae.

***Please confirm that you have the following information available for the Nominated Individual/s applying for registration and that such full and satisfactory information is available if required by CQC.**

* Enhanced CRB (including information relevant to Vulnerable adults or children)

O Yes

O No

* Proof of identity including a recent photograph

O Yes

O No

* Satisfactory evidence of conduct in relevant previous employment where such employment was concerned with the provision of services relating to

a) health or social care; and/or

b) children or vulnerable adults

O Yes

O No

* Where a person has previously worked in a position whose duties involved work with vulnerable adults or children, verification so far as is reasonably practical of the reason why the position ended

O Yes

O No

* Documentary evidence of any relevant qualification

O Yes

O No

* A full employment history together with a satisfactory written explanation of any gaps in employment

O Yes

O No

* Satisfactory information about any physical or mental conditions which are relevant to the person's ability to carry on, manage or work for the purposes of, the regulated activity

O Yes

O No

*** 2.3 Respecting and involving people who use services**

How do you ensure the views and experiences of people who use services are listened to and acted upon when running your service/s?

- How have the views and experiences of people who use services, their carers and representatives influenced your service priorities and plans? **(Max 2000 characters)**	
- How have their views and experiences influenced how you deliver the services (across the range of regulated activities applying to register?) **(Max 2000 characters)**	
- What is the provider doing to increase the influence people have on planning or delivery of the services? **(Max 2000 characters)**	

*** 2.4 Equality, diversity and human rights**

How do you ensure people's equality, diversity and human rights are actively promoted in your services?

- How do you ensure that the promotion of equality, diversity and human rights influence your service priorities and plans?

(Max 2000 characters)

- How does the promotion of equality, diversity and human rights influence how you deliver services across the range of regulated activities you are applying to register?

(Max 2000 characters)

- What are you doing to increase the influence of equality, diversity and human rights issues on the planning and delivery of the services?

(Max 2000 characters)

2.5 Extra Information

Please complete this box if there is any additional information you wish to give us relating to this application:

(Max 2000 characters)

Location section

Application and declaration of compliance for registration as a health and adult social care provider.

Applications under section 11 of the Health and Social Care Act 2008

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It is an offence under section 10 of the Health and Social Care Act 2008 to carry out a regulated activity without registering with the Care Quality Commission. You could be prosecuted, and it could lead to your application being refused.

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You must complete every field that is mandatory (marked with an asterisk); other fields are optional but if you have this information available please provide it. We will reject an incomplete application and return it. The Care Quality Commission is entitled to ask for more information while considering your application or during a site visit.

Please ensure that your completed application and declaration form does not contain any confidential personal information about patients or staff.

Statement on Data Protection Act 1998

The information you have provided in this form and any other information you submit in support of your application will be used by the Commission for the purposes of processing your application for registration, including fact verification, and matters connected with the Commission's statutory functions. The Commission may also share your information with third parties for the purposes of regulatory activity, law enforcement or any other purpose permitted by law.

The Commission will publish information on the Commissions website www.cqc.org.uk to enable the public to find and compare care services in their local area. The Commission may also be required to disclose your information pursuant to a request under access to information legislation, such as the Freedom of Information Act 2000.

Your information will be stored securely and held for the periods set out in the Commission's retention and disposal schedule.

Title	Applicant's First Name	Last Name

Who is the Applicant?

This declaration must be signed by the applicant or by an individual duly authorised to sign on behalf of the organisation

* Date	

* [] by clicking on this checkbox, you indicate your agreement that the information provided will be used as stated. If you do not agree then please contact the National Contact Centre on 03000 616161

Section 3 - Regulated Activities and Locations

Please detail which regulated activities you undertake in your location for each service type.

What is a location?

A location is the place where regulated activities are provided and where a type of service is carried on. For example, a location could be each hospital run by the same NHS trust or each care home run by the same organisation. A location can cover an area - but it is the 'main address' from which the regulated activity is carried on, or carried on from (such as a hospital or domiciliary agency branch) that we expect to see in applications for registration. The term location is important because providers declare compliance against each regulated activity at each location.

* Name of location	
* NHS site code	
* Address line 1	
Address line 2	
* Town/city	
* County	
* Postcode	
* Business Wide Email	
Website	
* Business telephone (including extension)	
Business Fax	

*** Please select as many of the following options as provided by your location.**

Regulated Activities

What is a Regulated Activity?

Regulations set out the activities that trigger the need for you to register. The regulated activities are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009. If any of these activities are carried out, the providers of those activities must register with the Care Quality Commission.

[] Personal Care

[] Accommodation for persons who require nursing or personal care

[] Accommodation for persons who require treatment for substance misuse

[] Accommodation and nursing or personal care in the further education sector

[] Treatment of disease, disorder or injury

[] Assessment of medical treatment for persons detained under the Mental Health Act 1983

[] Surgical procedures

[] Diagnostic and screening procedures

[] Management of supply of blood and blood derived products etc.

[] Transport services, triage and medical advice provided remotely

[] Maternity and midwifery services

[] Termination of pregnancies

[] Services in slimming clinics

[] Nursing care

[] Family planning services

Service Type

What is a service type?

This section sets out the range of service type listings available and replicates the service types in the guidance about compliance. See the Guidance about Compliance for the full list. Please choose the types of service that best describes the service you provide (this should reflect those you identify in your statement of purpose). You can choose more than one service type. For example you may provide a care home and a domiciliary care agency, or if you are an acute hospital you may also provide a supporting diagnostic imaging service. For each of the service types that you choose, please state the regulated activities you provide at that location.

[] Acute Services

[] Prison Healthcare Services

[] Hospital services for people with mental health needs, learning disabilities and problems with substance misuse

[] Hospice services

[] Rehabilitation services

[] Long term conditions services

[] Residential substance misuse treatment and/or rehabilitation service

[] Hyperbaric Chamber

[] Community healthcare service

[] Community based services for people with mental health needs

[] Community based services for people with a learning disability

[] Community based services for people who misuse substances

[] Urgent care services

[] Doctors consultation service

[] Doctors treatment service

[] Mobile doctors service

[] Dental service

[] Diagnostic and/or screening service

[] Care home service without nursing

[] Care home service with nursing

[] Specialist college service

[] Domiciliary care service

[] Supported living service

[] Shared Lives

[] Extra Care housing services

[] NHS Ambulance service

[] Remote clinical advice service

[] Blood and Transplant service

Service User Band

(Which people you provide services to)

What is a service user band?

Describe the needs of the people who use your service. For example do you offer a service for people with mental health needs, dementia, older people, children (under the age of 18 years old) or people with learning or physical disability? You will need to ensure that these needs are the same as those listed in your statement of purpose.

[] Learning disabilities or autistic spectrum disorder

[] Older people

[] Younger adults

[] Children 0-3 years

[] Children 4-12 years

[] Children 13-18 years

[] Mental health

[] Physical disability

[] Sensory impairment

[] Dementia

[] People detained under the Mental Health Act

[] People who misuse drug and alcohol

[] People with an eating disorder

[] Whole Population

[] None of the above

Section 4 – Declaration of Compliance

Please complete this section for each location in which you carry out regulated activities and continue in the free text box at the end of the declaration if necessary. Please refer to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 for the legal requirements The guidance about compliance for providers illustrates how each of the regulations may be reliably met. Providers may decide on alternative approaches but should be prepared to justify and evidence to the Care Quality Commission how the chosen approach is equally or more effective in ensuring the regulations are met.

This form is asking you to declare whether you are fully compliant or non compliant with the Registration Regulations relevant to the regulated activities you provide. A provider who will be compliant with the registration regulations will meet the outcomes for people who use services as set out in the guidance about compliance. A provider who is non-compliant has not met elements of the registration regulations as described by the outcome statements in the guidance about compliance. Evidence to support the declaration must be available on request. You must complete a declaration of compliance for each location in which you wish to carry out regulated activities. For each of the regulations where you identify you are non compliant you will need to tell us:

- The ways in which you are non compliant
- What you will do to become compliant
- When you will become compliant
- How you will sustain your level of compliance

Locations and Regulated activities

Name of location	
NHS site code	
Address line 1	
Address line 2	
Town/city	
County	
Postcode	

The Service provider will be compliant on registration, or at the timescale specified in the action plan and will continue to be compliant with the registration regulations for each regulated activity undertaken at the location. The service provider will notify the commission of any changes in the status of their compliance.

Regulated Activity:

*** Regulations:**

	Compliant	Non Compliant
Regulation 9: Care and welfare of service users	O	O
Regulation 10: Assessing and monitoring the quality of service provision	O	O
Regulation 11: Safeguarding service users from abuse	O	O
Regulation 12: Cleanliness and infection control	O	O
Regulation 13: Management of medicines	O	O
Regulation 14: Meeting nutritional needs	O	O
Regulation 15: Safety and suitability of premises	O	O
Regulation 16: Safety, availability and suitability of equipment	O	O
Regulation 17: Respecting and involving service users	O	O
Regulation 18: Consent to care and treatment	O	O
Regulation 19: Complaints	O	O
Regulation 20: Records	O	O
Regulation 21: Requirements relating to workers	O	O
Regulation 22: Staffing	O	O
Regulation 23: Supporting workers	O	O
Regulation 24: Cooperating with other providers	O	O

Declaration of Compliance

What is a Declaration of Compliance?

Where you have declared non compliance you are required to complete an action plan telling us what measures you will take to be compliant with the Registration Regulations for each regulated activity. The Guidance about Compliance describes what compliance with the Regulations looks like and you should use the guidance to help you.

You have declared you are not compliant with <*specific Regulation*>. Describe in what ways you are not compliant **(Max 2000 characters)**	
What will you do to become compliant? **(Max 2000 characters)**	
When will you do this by?	
How will you make sure that you continue to be compliant? **(Max 2000 characters)**	

Declaration

Section 5 Provider Application declaration

This declaration must be signed by the applicant or by an individual duly authorised to sign on behalf of the organisation.

Before signing this declaration, you are advised to check that the regulated activities you have identified in Section 1 - Service Provider, correspond to those you have identified for each location in Section 3 - Regulated Activities and Locations

I hereby declare that the information detailed in this application is true and accurate.

I understand that Section 37 of the Health and Social Care Act 2008 makes it an offence to knowingly make a statement which is false or misleading in a material respect in this application, or in any of the documents submitted with this application. I understand that to knowingly make a false declaration could render me liable to prosecution and could lead to the refusal of this application.

I understand that non-compliance with the relevant legislation could lead to conditions being imposed on my registration. It may also lead to the refusal of my application or cancellation of registration if I do not comply once registered.

I have kept a copy for my records of all the documentation submitted for my application.

In making this application for registration with the Care Quality Commission, I agree to comply with the Health and Social Care Act 2008 and associated regulations.

From the date I send you this application and until you make a decision about it, I will let you know about any changes to the information I have supplied.

I confirm that I am aware of and will comply with the legislation and associated regulations. I will meet the outcomes in the Guidance about Compliance and understand that you may take this into account in decisions relating to my registration.

* I agree that the information contained in this form may be used as conditions of registration

O Yes

O No

* Has the Trust Board or equivalent discussed and agreed the content of the application and declaration

O Yes

O No

*** []** **Signed: (In signing the application form you are declaring that the information contained within it is true and accurate. Knowingly making a false declaration could render you liable to prosecution and lead to the refusal of the application.)**

* Title	
* Applicant First Name	
* Last name	
* Job title in Organisation	
Date	

In order for the form to be sent to CQC, you must click on 'Save and Quit' and press the 'Submit this form' button.

London Ambulance Service NHS
NHS Trust

TRUST BOARD - 26 January 2010

Document Title	**Strategic Risk Register and Board assurance framework – next steps**
Report Author(s)	**Sandra Adams**
Lead Director	**Sandra Adams**
Contact Details	**020 7783 2045**
Aim	**To update the Trust Board on the next steps from the strategic risk review**

Key Issues for the Board

- The strategic risks produced from the review session on 24th November were again reviewed by the Service Development Committee in December 2009 and recognised as work in progress;
- Board members have a further session planned for 26th January in order to confirm the strategic risks identified and agree the linkage between the strategic goals and risks;
- The next steps will be to:

a) agree executive ownership of each strategic risk
b) map each risk with existing controls and mitigating actions
c) determine the risk score or profile
d) agree further actions and controls required to mitigate the risk level further, and
e) identify the mechanisms for providing the Board with assurances that the risk is being appropriately managed.

Mitigating Actions (Controls)

Recommendations to the Board

To note the steps being taken to finalise the strategic risk review in order to manage and mitigate risks and provide the assurances to the Board in the future.

Equality Impact Assessment

Has an EIA been carried out?

(If not, state reasons)

Key Issues from Assessment

N/A

Risk Implications for the LAS (including clinical and financial consequence

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

The Trust Board needs a clear understanding of the risks facing the organisation and to have

assurance that controls and systems are in place and working effectively.
Corporate Objectives that the report links to Statutory & compliance requirements

London Ambulance Service NHS Trust

TRUST BOARD - 26th January 2010

Document Title	**Risk Register – 7th January 2010**
Report Author(s)	**Mark Bunkhall/Laila Abraham**
Lead Director	**Sandra Adams**
Contact Details	**020 7783 2045**
Aim	**To provide the Trust Board with an update on the Trust risk register and to note the actions to be taken**

Key Issues for the Board

- The risk register has been updated following review with responsible managers of actions and controls for individual risks;
- Those risks with gross and net ratings of red (severity score >12 currently) and amber (severity score > 8 currently) are shown;
- The Risk Compliance & Assurance group (RCAG) will review the register in more detail in conjunction with the strategic risks to be agreed by the board at its risk review meeting on 26th January
- Exception reports will be made to the Audit Committee in March 2010.

Mitigating Actions (Controls)

Management of the risk register through the RCAG with overview by the Audit Committee.

Recommendations to the Board

The Board is asked to note the updated information for the top 10 risks and the detailed review to be undertaken by the RCAG in February 2010.

Equality Impact Assessment

Has an EIA been carried out?

(If not, state reasons)

Key Issues from Assessment

N/A

Risk Implications for the LAS (including clinical and financial consequences)

Financial consequences of individual risks is not quantified on the register but will be contained in the detail in the relevant action plans.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

It is good governance practice for the Trust Board to see the risk register.

Corporate Objectives that the report links to

Statutory/compliance requirements

London Ambulance Service NHS
NHS Trust

TRUST BOARD - 26th January 2010

Document Title	**Proposed risk management committee structure**
Report Author(s)	**Sandra Adams**
Lead Director	**Sandra Adams**
Contact Details	**020 7783 2045**
Aim	**To strengthen the governance arrangements for quality, safety and risk management**

Key Issues for the Board

- Three key committees managing risk at Board level: Audit; Quality, Safety & Risk; and the Senior Management Group;
- The structure provides greater clarity on the roles and responsibilities of individual committees in the management of quality, safety & risk and will provide greater assurance for the Trust Board. The primary focus for each committee is underlined;
- Clinical governance remains a cornerstone of these arrangements and the structure is intended to strengthen this further. It will be the responsibility of the Chairs of the relevant committees to ensure that this happens and that support and guidance is available to the operational teams;
- There will be more focus on clinical safety and quality at an operational level with opportunities for the area teams to identify risks, solutions and outcomes within a supportive environment.

Mitigating Actions (Controls)

External governance guidance: 'Taking it on Trust: A review of how boards of NHS trusts and foundation trusts get their assurance' – The Audit Commission 2009; NHS Audit Committee handbook; Monitor (Independent regulator for NHS foundation Trusts) – guidance for governors and the Code of Governance (section F).

Recommendations to the Board

That the Trust Board recommends the proposed risk management committee structure and its implementation, with a review in 12 months time.

Equality Impact Assessment

Has an EIA been carried out?

(If not, state reasons)

Key Issues from Assessment

N/A

Risk Implications for the LAS (including clinical and financial consequences)

Potential clinical and financial risks from claims for example if the governance structure and agenda is not managed and issues fall through the gaps.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing) Potential implications for governance with the current structure and the increasing external agenda and focus on Trust Boards' responsibilities for risk management and assurance. An over-crowded agenda does not allow a focus on the key risk and governance issues and limits the level of assurance that can be given.
Corporate Objectives that the report links to Focus on clinical priorities; Statutory/compliance requirements;

Trust Board
26th January 2010
Proposed risk management committee structure

This document summarises the roles and reporting arrangements for the key risk committees within the proposed risk management structure. The intention is that the structure places more emphasis on – and provides the Trust Board with better assurance on - quality & safety, the management of risk, and the systems and processes to manage these. Further discussion is needed with individual leads/directors prior to finalising the structure, roles and responsibilities.

- **Audit Committee – Chair : Non-executive director**

The primary focus of the Audit Committee 'is to conclude upon the adequacy and effective operation of the organisation's overall internal control system. In performing that role, the committee's work will predominantly focus on the framework of risks, controls and related assurances underpinning the delivery of the organisation's objectives.' (Source – NHS Audit Committee Handbook)

Responsibilities include the relationships with internal and external auditors; counter fraud management, and monitoring the processes by which staff can raise concerns in confidence about possible improprieties in matters of financial reporting and control, clinical quality, patient safety and other matters.

Reporting arrangements: directly to the Trust Board of Directors; to the Quality, Safety and Risk Committee. There are no committees reporting to the Audit Committee.

- **Quality, Safety and Risk Committee – Chair: Non-executive director**

The primary focus of the committee will be to assure the Trust Board on clinical, corporate, information governance and compliance matters. It will review the Board Assurance Framework and Corporate (Trust) Risk Register and ensure that risk management is on the governance agenda throughout the organisation. Key agenda items would include overseeing the CQC registration process and the preparation for the NHSLA risk management inspection; seeking assurance from within the organisation that patient safety was being managed effectively; and that effective processes are in place to manage and monitor hygiene/infection control and safeguarding.

Reporting arrangements: directly to the Trust Board of Directors; to the Audit Committee. Committees reporting to the QSRC will be: Clinical Quality, Safety and Outcomes; Risk Compliance and Assurance Group; and Learning from Experience.

This committee would replace the Clinical Governance Committee as a formal board sub-committee but clinical governance will be a key element of the agenda.

- **Senior Management Group (SMG) – Chair: Chief Executive**

The SMG has overall responsibility for the day to day management of the organisation. The purpose of the SMG will be to manage the performance of the Trust within the strategic framework established by the Trust Board. The SMG will manage operational risk on behalf of the Trust Board and will ensure that structures and management arrangements are in place together with systems and processes for monitoring and reviewing all forms of risk throughout the Trust. The SMG will, at least annually, review the strategic risks facing the LAS and make recommendations to the Trust Board on any changes to those risks. It will also lead the CQC registration process each year and routinely review compliance with the requirements.

Reporting arrangements: directly to the Trust Board. If a Finance and Investment Committee is to be established, it is proposed that it would report directly to the SMG. The Equality & Inclusion Steering Group reports to SMG.

- **Risk Compliance and Assurance Group (RCAG) – Chair: Chief Executive**

The RCAG will be a sub-committee of the Quality, Safety & Risk Committee with responsibility for the operation and monitoring of all risk management processes and activities within the Trust, and for ensuring that the objectives of the Risk Management Policy and Strategy are achieved. The RCAG will oversee the implementation of the risk register procedure leading to the development of local risk registers supporting, and supported by, the corporate risk register and board assurance framework. The group will routinely review the corporate risk register and any proposed additions or deletions to this. The RCAG will also lead on the NHSLA risk management standards.

Responsibilities of the RCAG will include the following (note that many of these are functions and not committees or groups):

- Corporate health & safety
- Information governance including data quality & assurance
- Complaints & PALS
- Motor risk
- Incidents and SUIs
- Business continuity and emergency preparedness
- Claims and liabilities.

- **Clinical Quality, Safety and Outcomes Committee – Chair: Medical Director or nominated deputy**

A sub-committee of the Quality, Safety & Risk Committee, the principal responsibility for this committee is to oversee the arrangements within the Trust for managing clinical safety and quality. This will include clinical governance and clinical risk, as well as reviewing evidence and outcomes and developing or improving clinical practice. The committee will oversee the work of the clinical audit and research function ensuring that an audit programme is in place that supports the Trust's corporate objectives. The area governance committees (and potentially those established for A&E support/Control, and PTS) will report to this committee. The agenda will routinely include a focus

on a clinical issue/risk for discussion and recommendations for improving practice and this will be informed and led by the area committees. The committee will also review compliance with the CQC registration requirements and relevant NHSLA risk management standards. Evidence of measured outcomes and changes to practice where required are key elements of both the CQC and NHSLA standards.

- **Learning from Experience Group – Chair: Director of Health Promotion & Quality**

This will be a sub-committee of the Quality, Safety & Risk Committee, and will be responsible for the integrated review of incidents, complaints, and claims, in order to identify actual and emerging risk themes and to recommend changes to practice. There will be a direct relationship with clinical audit and research. This committee would replace the Feedback, Learning & Improvement Group.

The proposed structure includes a 'business group' reporting to the Clinical Quality, Safety & Outcomes committee. The intention is that this would be a time limited group that is formed to review a particular area of quality, safety or risk and to report and make recommendations to the committee. The membership of the group would reflect the issues under review and it is suggested that each topic is reviewed in a 3-month period and reports to the next meeting of the Clinical Quality, Safety & Outcomes committee. This committee can then provide assurance to the Board that a particular risk is being managed as well as providing guidance to the operational teams on clinical safety and quality.

Conclusion

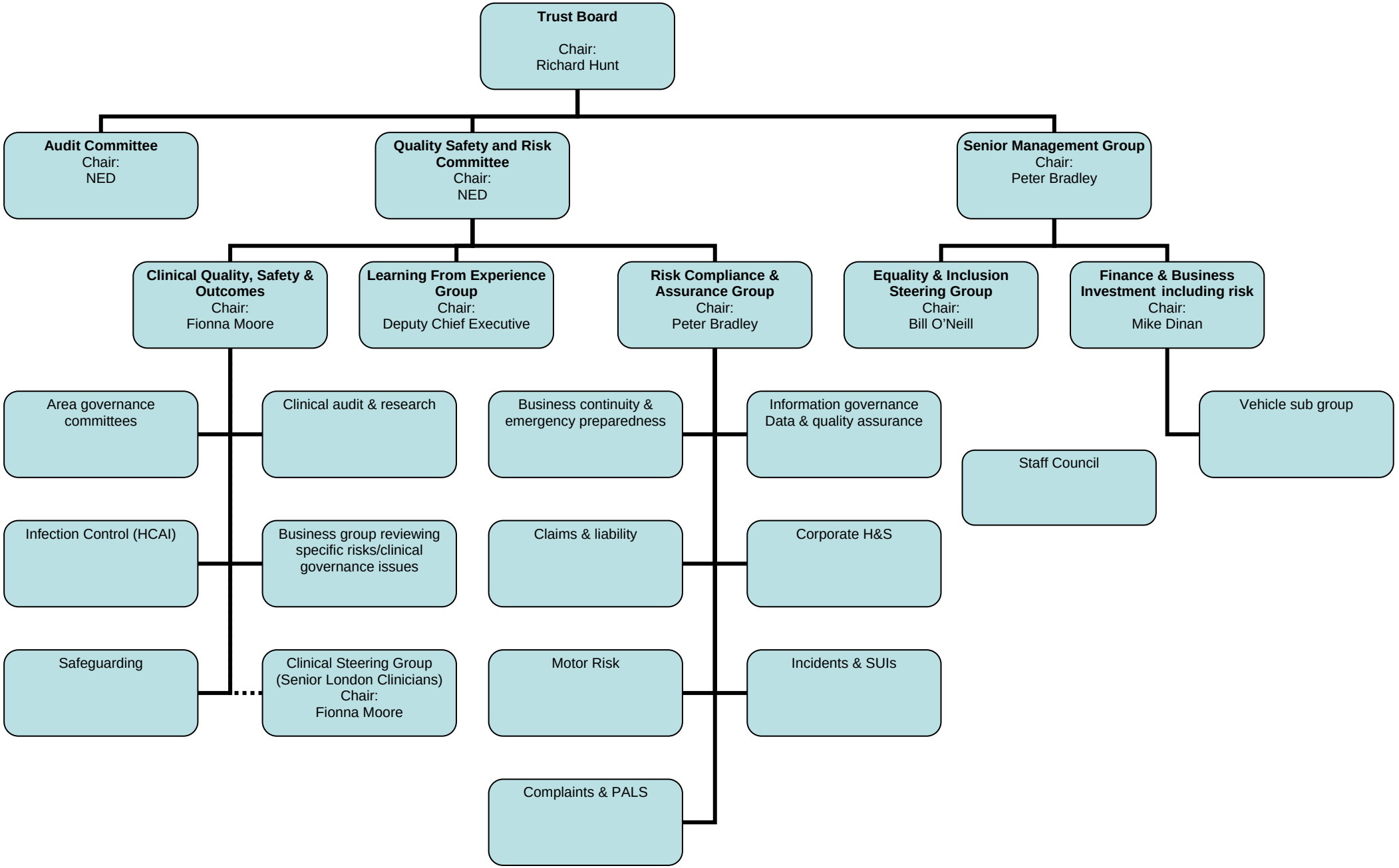
The proposed structure is a departure from that that has been in place for some years and it is intended to reflect the growing governance agenda requiring greater assurance for NHS Trust Boards on patient safety, quality of care and services, and the management of risk. There has been concern expressed by some board members that this will remove the focus on clinical governance, however the structure and the roles and responsibilities of the committees – in particular the Clinical Quality, Safety & Outcomes, and the board sub-committee for Quality, Safety & Risk – are intended to strengthen clinical governance arrangements and allow for a greater focus at the appropriate level in order to provide assurance to the Board.

Recommendation

That the Trust Board approves the proposed risk management committee structure and agree to its implementation, with a review in 12 months time.

Sandra Adams
Director of Corporate Services
19th January 2010

Proposed Risk Management Structure



London Ambulance Service NHS Trust

Strategic Goals, Corporate Objectives and Objectives for 2010-11

SDC 15.12.09

Kathy Jones
Director of Service Development

VISION

VALUES

Annual Board review

STRATEGIC GOALS

CORPORATE OBJECTIVES

ANNUAL OBJECTIVES delivered:

AS NORMAL BUSINESS

THROUGH THE SERVICE IMPROVEMENT PROGRAMME

Seven Strategic Goals

- To deliver safe and high quality healthcare
- To be efficient and productive, and continually improve
- To have staff who are skilled, confident, motivated and feel valued
- To improve outcomes for our sickest patients
- To provide appropriate responses for patients with less urgent need
- To be ready for major events; planned and unplanned
- To grow and innovate

To deliver safe and high quality healthcare – corporate objectives

- Meet response time targets routinely
- Provide regular and comprehensive Trust Board assurance on the safety and quality of the service delivered
- Ensure ownership of quality and safety at the front-line
- Have regular, comprehensive information on the clinical treatment delivered, that shows improvement
- Have regular, comprehensive information on the safety of care delivery, that shows improvement
- All staff trained according to mandatory requirements and assessed need
- Make specific improvements to the quality of care through CQUINs (Clinical Quality Innovations) agreed with Commissioners

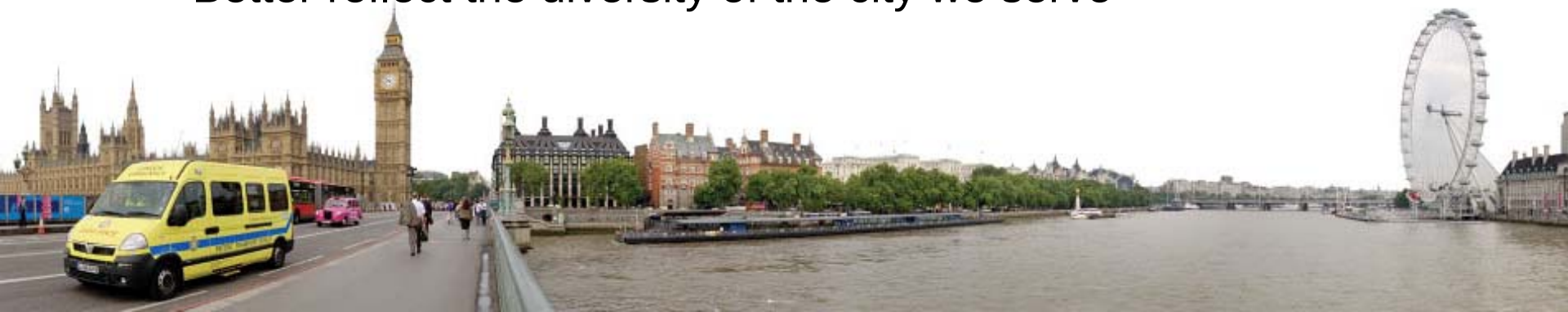
To be efficient and productive – corporate objectives

- Be in the upper quartile among ambulance services for key measures of productivity, efficiency and value for money
- Gain the right skill mix and deployment regime to maximise efficiency without compromising quality of care (all double-sending should be appropriate double-send)
- Demonstrate savings to the health economy from the delivery of appropriate care at home
- Constantly streamline processes
- Keep management/back office costs low (% turnover)
- Reduce our impact on the environment and contribute to sustainability
- Deliver Cost Improvements year on year

Staff who are skilled, confident, motivated and feel valued – corporate objectives

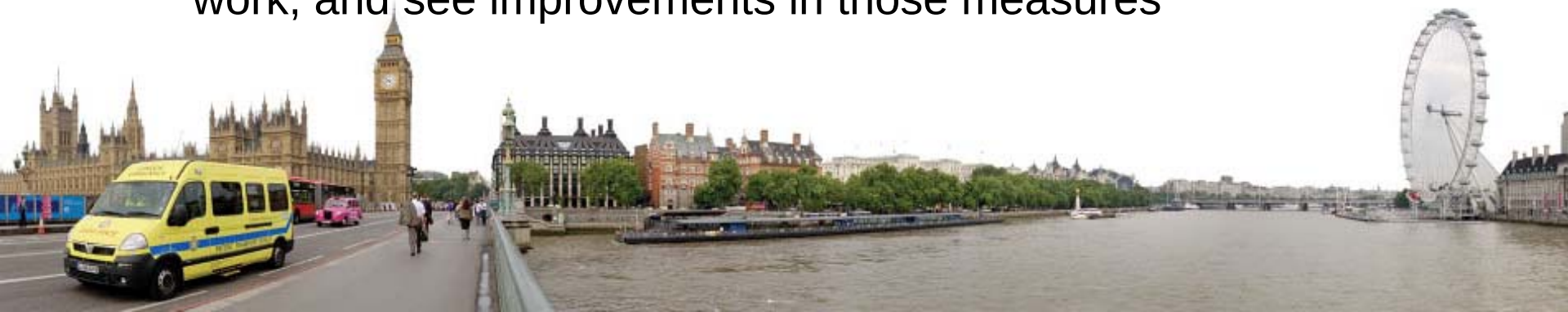
- All staff are appropriately trained for the job they do
- Staff feel that their opinions are valued and that they can influence
- All staff have personal development reviews and personal development plans
- Reward and recognise long service, quality of care and outstanding performance
- Provide a supportive working environment
- Better reflect the diversity of the city we serve

This wording isn't right. Any suggestions on what we should say in response to the knowledge that staff report high stress levels?



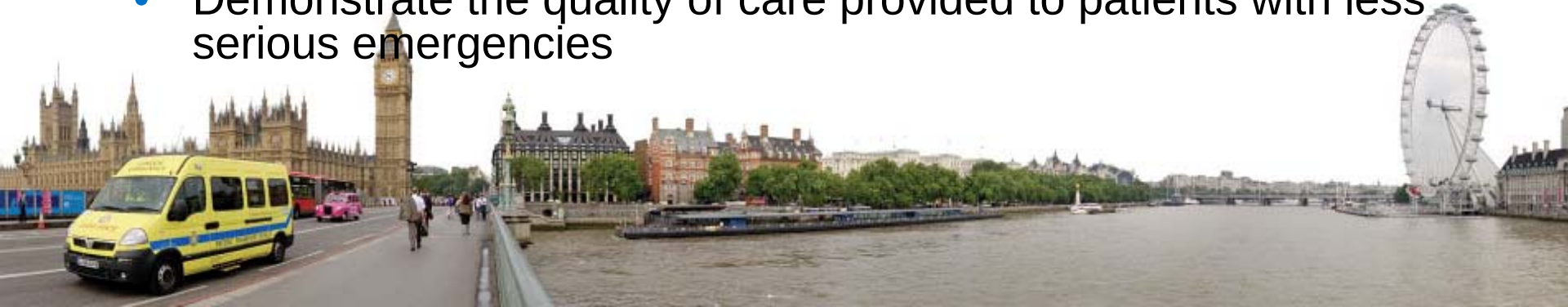
To improve outcomes for our sickest patients – corporate objectives

- Best in world outcomes from cardiac arrest, major trauma, stroke and myocardial infarction (+ serious vascular emergencies?)
- Take all life threatened patients to designated specialist centres where available
- Aim for four minute response time in cases of cardiac arrest (arrival of a trained and equipped individual)
- Measure that we use interventions that have been proved to work, and see improvements in those measures



To provide appropriate responses for patients with less urgent need – corporate objectives

- Deliver messages to public on appropriate use of the ambulance service
- Maximise numbers of appropriate patients receiving secondary telephone triage/advice
- Maximise numbers of appropriate patients receiving a response from someone with enhanced assessment and decision making training
- Maximise numbers of appropriate patients referred to a community based provider
- Maximise numbers of appropriate patients taken to place other than emergency department
- Demonstrate the quality of care provided to patients with less serious emergencies



To be ready for major events; planned and unplanned – corporate objectives

- Learn from all incidents, making changes to plans as a result, and testing any new arrangements
- Ensure all relevant staff are trained in major incident management as appropriate
- Secure resources in line with predicted demand
- Have capacity to run all planned major events without disruption to rest of operation
- Have contingency arrangements in place in event of disruption of operations (business continuity)
- Deliver an appropriate response to London during the Olympic and Paralympic games

To exploit market and collaborative opportunities arising from our position as the mobile arm of health in London – corporate objectives

- Gather, use and share information about the availability of healthcare services for our patients and for others' patients
- Play full role in illness prevention and health promotion
- Generate income to support core service delivery
- Communicate with and respond to key stakeholders in the health economy

Safety and quality objectives for 2010-11

- Gain unqualified CQC registration
- Hit all three national response time targets for the year
- Maintain ALE excellent rating and achieve CIP and control total
- Achieve level 2 NHSLA
- Refresh risk management arrangements
- Develop robust measures for assuring the Board on quality, safety and risk management

Efficiency and productivity objectives for 2010-11

- Open first super station and new workshop facility
- Introduce new rosters
- Introduce advanced paramedic role
- Plan for reductions in 2011-12

Workforce objectives for 2010-11

- Complete next NWOW roll out phase
- Deliver agreed training plan
- Introduce new paramedic practitioner role
- Deliver agreed elements of equality and diversity strategy
- Complete consultation meeting action plan

Clinical objectives for 2010-11

- Complete next NWOW roll out phase
- Deliver agreed training plan
- Introduce new paramedic practitioner role
- Refer more patients to appropriate alternatives
- Implement trauma and stroke strategies
- Develop and publish public health strategy and deliver year one activities
- Routinely report to the Board against specific and measureable clinical and quality outcomes

Resilience objectives for 2010-11

- CAD 2010 implementation
- Deliver agreed Olympics items
- Become a foundation trust
- Hit all three national response time targets for the year
- Maintain ALE excellent rating and achieve CIP and control total
- Demonstrate significant progress with improving logistics function

Innovation objectives for 2010-11

- Complete next NWOW roll out phase
- Introduce new paramedic practitioner role
- Implement trauma and stroke strategies
- Become a foundation trust
- Deliver agreed elements of London wide transformation programme

London Ambulance Service NHS
NHS Trust

TRUST BOARD - 26 January 2010

Document Title	**Development of the Trust's Annual Objectives**
Report Author(s)	**Martin Brand / Johnny Pigott**
Lead Director	**Kathy Jones**
Contact Details	
Aim	

Key Issues for the Board

This paper is a summary of the annual objectives that have been developed by SMG for 2010/11 and how they link in with the strategic goals. Where appropriate the objective has been defined as either business as usual or linked to one of the three programmes within the SIP. These have been discussed by the SMG and the following agreed:

- The lead Director for each objective;
- Which business area or programme it is aligned to;
- And whether it is a project, a business change or business as usual

This will enable the programme teams to meet with the relevant Director and begin to scope those areas defined as projects within the Service Improvement Programme in order to develop the programme plans for 2010/11. SMG members will also be able to share with their teams when planning the year and personal objectives.

Mitigating Actions (Controls)

Recommendations to the Board

The Board is asked to approve the corporate objectives and note the progress being made.

Equality Impact Assessment

Has an EIA been carried out?

(If not, state reasons)

Key Issues from Assessment

Risk Implications for the LAS (including clinical and financial consequences)

Any risks identified through this scoping process will be identified and managed through the programme and project risk management processes and through to the Trust risk register where appropriate.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing) Each of the programmes will begin to conduct Equality Impact Assessments as part of the development of the projects in order to understand their impact and address any issues through an action plan.
Corporate Objectives that the report links to

Strategic Goal	Corporate Objectives	Annual objectives (2010-11)	Programme	Workstream	Project Name	Cost	Status * New, being Scoped, Live	Lead Director for Objective	Project Year
To deliver safe and high quality healthcare	Meet response time targets as "business as usual"								
	Provide regular and comprehensive Trust Board assurance on the safety and quality of the service delivered	Gain unqualified CQC registration						Sandra Adams	
	Ensure ownership of quality and safety at the front-line	Introduce system of self and peer audit and monitoring	Clinical Development				New	Caron Hitchen	
		Apply for NHSLA Level 2						Sandra Adams	
		Meet CQC standards on safeguarding						Sandra Adams	
	Staff feel that their opinions are valued and that they can influence	Develop quality measures for logistics function	Performance & Service Delivery				New	Mike Dinan	
		Carry out user survey (if no CQC survey)						Sandra Adams	
		Review and refresh the risk register						Sandra Adams	
	Have regular, comprehensive information on the clinical treatment delivered	Meet targets for CPI completion						Richard Webber	
		Review all long patient waits						Richard Webber	
	Low level of vehicle accidents								
	All staff trained according to annual schedule								
	Respond to quality agenda as set by commissioners through CQUINs								
To be more efficient and productive	Be in the upper quartile among ambulance services for key measures of productivity and efficiency								
	Gain the right skill mix and deployment regime to maximise efficiency without compromising quality of care (all double-sending should be appropriate double-send)	Initial response project	Clinical Development	OD&P	Advanced Paramedic		Live	Caron Hitchen	
		Maximise CTA/NHSD	Performance & Service Delivery	TBD			New	Richard Webber	
		New rosters	Performance & Service Delivery	Production	Roster Review		Live	Richard Webber	
		NWOW roll-out	Clinical Development	NWoW	NWoW		Live	Martin Flaherty	
		Target for vehicle availability and hours produced						Richard Webber	
	Demonstrate savings to the health economy from the delivery of appropriate care at home								
	Minimise paperwork by making processes electronic	Corporate Processes workstream	Performance & Service Delivery	CPW	Staff Administration		**Live**	Mike Dinan	
			Performance & Service Delivery	CPW	Performance Measurement Phase 2		**Live**	Mike Dinan	
			Performance & Service Delivery	CPW	The Intelligent Trust		**Live**	Mike Dinan	
			Performance & Service Delivery	CPW	Electronic Expenses		**Live**	Mike Dinan	
			Performance & Service Delivery	CPW	Inventory Management		**Live**	Mike Dinan	
			Performance & Service Delivery	CPW	Incident Data Records		**Live**	Mike Dinan	

Strategic Goal	Corporate Objectives	Annual objectives (2010-11)	Programme	Workstream	Project Name	Cost	Status * New, being Scoped, Live	Lead Director for Objective	Project Year	
	Constantly streamline processes	"Productive ambulance station"	Performance & Service Delivery	TBD			new	Mike Dinan		
	Keep management/back office costs low (% turnover)									
	Always remember it is taxpayers' money	Instil responsibility for equipment	Clinical Development				New	Richard Webber		
	Reduce our impact on the environment									
	Deliver Cost Improvements year on year	CIP and control total						Mike Dinan		
		Carry out estates review and implement						Mike Dinan		
Staff who are skilled, confident, motivated and feel valued	All staff are appropriately trained for the job they do	Deliver training programme	Clinical Development	OD&P / NWoW	BAU?		BAU for 2010/11	Caron Hitchen		
		Develop first wave of initial responder paramedics	Clinical Development	Ops	Business changes from Advanced Paramedic Role / Implementation Project		New	Richard Webber		Should the word develop mean implement?
		Deliver referral pathway training	Clinical Development	HFL / OD&P	Referral Pathways		Live	Caron Hitchen or Kathy Jones?		Is this actually delivering the training & therefore a business change?
		Develop e-learning in the organisation	Clinical Development	OD&P	E-Learning		Live	Caron Hitchen		
	Staff feel that their opinions are valued and that they can influence	Develop staff engagement strategy	Clinical Development	OD&P	Staff Engagement		Live	Caron Hitchen		
	All staff have personal development reviews and personal development plans		Clinical Development	OD&P	Performance Mgt		Live	Caron Hitchen		
	Reward and recognise long service, quality of care and outstanding performance									
	Avoid unnecessary pressure on staff	Give rest breaks	Performance & Service Delivery	Distribution	Rest Breaks		live	Richard Webber		
		Reduce utilisation	Performance & Service Delivery	TBD			new	Richard Webber		Is this a project or business as usual?
	Reflect the diversity of the city we serve									
To improve outcomes for our sickest patients	Take all life threatened patients to designated specialist centres where available	Implement changes to stroke and trauma care, and monitor outcomes	Clinical Development	HFL	Major Trauma		Live	Richard Webber (Kathy Jones		KJ responsible for HFL implementation, RW for ensuring BCs.
	Take all life threatened patients to designated specialist centres where available	Implement changes to stroke and trauma care, and monitor outcomes	Clinical Development	HFL	Stroke		Live	Richard Webber (Kathy Jones		KJ responsible for HFL implementation, RW for ensuring BCs.
		Engage with vascular networks on proposals for specialist centres	Clinical Development					Kathy Jones		
		Engage with cardiac networks in plans for enhanced care for acute coronary syndromes	Clinical Development					Kathy Jones		
	Aim for four minute response time in cases of cardiac arrest	Report on response times to patients in cardiac arrest	Performance & Service Delivery	TBD			new	Richard Webber		

Strategic Goal	Corporate Objectives	Annual objectives (2010-11)	Programme	Workstream	Project Name	Cost	Status * New, being Scoped, Live	Lead Director for Objective	Project Year	
	Carry out evidence-based interventions for the sickest patients	CPAP.	Clinical Development					Fionna Moore		
		Cooling	Clinical Development					Fionna Moore		
To provide appropriate responses for patients with less urgent need	Deliver messages to public on appropriate use of the ambulance service									
	Maximise numbers of appropriate patients receiving secondary telephone triage/advice	Maximise CTA/NHSD	Performance & Service Delivery	TBD			new	Richard Webber		Is this project work or BAU?
	Maximise numbers of appropriate patients receiving a response from someone with enhanced assessment and decision making training	Initial response project	Clinical Development	OD&P	Advanced Paramedic		Live	Caron Hitchen		
		Deliver training in the use of referral pathways	Clinical Development	HFL / OD&P	Referral Pathways		Live	Caron Hitchen or Kathy Jones?		Is this actually delivering the training & therefore a business change?
	Maximise numbers of appropriate patients referred to a community based provider	Develop common set of referral pathways in each borough	Clinical Development	HFL	Referral Pathways		Live	Kathy Jones		
	Maximise numbers of appropriate patients taken to place other than emergency department									
	Demonstrate the quality of care provided to patients with less serious emergencies									
To be ready for major events; planned and unplanned	Learn from all incidents, making changes to plans as a result, and testing any new arrangements									
	Ensure all relevant staff are trained in major incident management as appropriate									
	Secure resources in line with predicted demand	Revisit vehicle requirements and deliver on plan	Performance & Service Delivery	Infrastructure			new	Richard Webber		
	Have capacity to run all planned major events without disruption to rest of operation	Implement Command Point	Performance & Service Delivery	Technology	CAD2010		live	Peter Suter		
		Build event control	Performance & Service Delivery	Infrastructure	Event Control Rooms		live	Martin Flaherty		
	Have contingency arrangements in place in event of disruption of operations (business continuity)	Arrangements with police service for back-up	Performance & Service Delivery	Distribution			new	Richard Webber		
	Deliver an appropriate response to London during the Olympic and Paralympic games	Secure funding	Olympics Programme					Martin Flaherty		
		Commence tranche 3 of olympic programme (testing and exercising)	Olympics Programme					Martin Flaherty		
	Be prepared for “rising tide” emergencies									
	Ensure security of buildings, vehicles, equipment etc.									
To exploit market and collaborative	Gather, use and share information about the availability of healthcare services for our patients and for others’ patients	Introduce a directory of services	Clinical Development	HFL	Directory of Services		Live	Kathy Jones		
	Play full role in illness prevention and health promotion	Extend opportunistic screening into blood pressure and other risk factors	Clinical Development				New	Richard Webber		Is this a simple training and instruction issue?

Strategic Goal	Corporate Objectives	Annual objectives (2010-11)	Programme	Workstream	Project Name	Cost	Status * New, being Scoped, Live	Lead Director for Objective	Project Year
opportunities arising from our position as the mobile arm of health in London		Develop means of communicating results of opportunistic screening	Clinical Development				New	Kathy Jones	
	Generate income to support core service delivery	X% target for extra income generation						Kathy Jones	
	Communicate with and respond to key stakeholders in the health economy	Develop stakeholder strategy	Clinical Development	HFL	Stakeholder Engagement		Live	Kathy Jones	
		Submit Foundation Trust Application	Performance & Service Delivery				Live	Sandra Adams	

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TRUST BOARD - 26 January 2010

Document Title	**Programme Progress report London 2012 Olympic Games**
Report Author(s)	**Peter Thorpe**
Lead Director	**Martin Flaherty**
Contact Details	
Aim	**The Board is asked to Note the report**

Key Issues for the Board to Note;

- Funding has been secured for the years 09/10 of 635k and 835k for the 2010/11 financial year.
- This is sufficient funding to cover this years expenditure but is circa 500k short in terms of the activity which was planned for 2010/11. Work is now in hand to amend the work plan and milestones associated with this year to ensure that expenditure is kept within these limits.
- There is still no allocated funding for the period of 2011/12 and the Games year of 2012/13. We are continuing to work with Commissioners, HNSL and DH to clarify how funding will be provided.
- All projects within Tranche 2 of the Olympics programme are either on track or within acceptable limits.
- We are now actively scoping the Testing and Exercising programme for the coming two years with partners. The first multi agency table top excersises will now take place in July 2010-01-15
- DH is leading on some modelling work to determine the impact on general 999 workload associated with the influx of visitors to London associated with the Games. This 'Games Effect' could add significant workload pressures which will need to be mitigated if performance to Londoners is not to suffer during the Games period.
- Work is ongoing to accurately map all the detailed resource requirements for LAS for each day of the Games period.
- The principle of the provision of mutual aid to LAS from other ambulance services across the UK has been accepted and DH have agreed to influence SHAs and Commissioners across the UK to facilitate this.
- The principle of the LAS growing its vehicle fleet temporarily to provide the additional vehicles required during the Games period has been accepted. Work is now in hand with commissioners and NHSL to agree the exact numbers required and how they will be provided.
- A new working group is being set up by NHSL to bring together LAS, Commissioners, NHSL , LOCOG and other players to resolve some of the outstanding issues. Its first meeting is scheduled for 21st January 2010

Mitigating Actions (Controls)

Recommendations to the Board

The board is asked to note the report

Equality Impact Assessment The 2012 programme has undertaken a full Equality Impact Assessment during Tranche 1 of the programme and this has been reviewed and acted upon for Tranche 2.
Risk Implications for the LAS (including clinical and financial consequences) There is an ongoing risk associated with failure to secure adequate funding for the years 2010/11 and 2012/13. This is being managed through the Risk and Issues processes within the programme. In addition we are working closely with NHSL, Commissioners and DH to find a solution.
Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)
Corporate Objectives that the report links to The 2012 programme is part of the Service Improvement Plan and as such is an integral part of the Trusts strategic objectives.

PROGRAMME PROGRESS REPORT FOR LONDON 2012 OLYMPIC AND PARALYMPIC PROGRAMME

PROGRAMME: London 2012 Olympic and Paralympic Programme

REPORTING PERIOD: 11/11/09 – 13/01/10

PROJECT STATUS SUMMARY: **4** ▲ **1** ▲ **0** ▲

Key

▲ **On track**

▲ **Not on track but in control**

▲ **Not on track and not in control**

Programme Summary

The following projects are currently live:

Olympic Programme: Tranche 2		
Operational Planning (Alan Palmer)	▲	**Page 3**
Workforce (Sandy Thompson)	▲	**Page 3**
Skills Acquisition (Alan Taylor)	▲	**Page 4**
Infrastructure and Support (Anna Parry)	▲	**Page 4**
Communication and Involvement (Sandy Thompson)	▲	**Page 5**
Commissioning Process (Anna Parry): CLOSED		**Page 6**

PROGRAMME SUMMARY

Progress:

- Command and Control Structure: agreed for internal and external circulation
- Scoping of LAS Scenario, Testing and Exercise Programme (STEP)
- Department of Health (DH) leading on further modeling of demand attributable to 'Games-effect' pan-London during Summer 2012; LAS inputting
- All contingency plans for Olympic construction site being reviewed; contingency planning for Stratford International Station to be included
- Selection process design for workforce commenced – discussions with HR
- Timetable for all LAS Staff Olympic training completed; deferred by 3 months due to concerns around command point completion; new date for training: June - November 2011
- Approach for training officers determined: their availability/training
- Process mapping of 'day in the life' of a paramedic during Games-time: completed for days 1 and 7; being completed for Games in its entirety
- Staff survey results collated – presentation to Programme Board 10/12

Upcoming tasks for this period:

- Populate Command and Control structure with leads for each venue and zone
- Further development of workforce roles and numbers for presentation to Directors of Operations by March 2010
- Commencement of training /educational session development in conjunction with specialists as appropriate
- Presentation of process mapping work to project boards and functional areas to inform further development of requirements, specifically for IM&T, Estates and Operational Support

Key issues, interdependencies and risks to note:

- Possible lack of HR resource going forward which could impact selection process and other HR related pieces or work required to deliver the this Workforce Project
- Current lack of IM&T resource resulting in slippage of milestone delivery in Infrastructure and Support; action plan produced detailing how this will be addressed by end of Feb 2010
- Awaiting decision re Trust approach to vehicles: will affect progression of Olympic planning

Communications:

- Update to National Directors of Operations re pre-planned aid requirement; commitment to provide roles and numbers by end of March 2010

T2P1: Operational Planning (PE: Peter Thorpe; PM: Alan Palmer)

Progress:

- Command and Control Structure: agreed for internal and external circulation.
- Scenario Testing and Exercise Programme (STEP) designed: Scoping being carried out looking at; Who, What, Where, When and How we should test and, risks to STEP.
- Event demand in urban domain during lockdown period V2: Department of Health (DH) to carry out further modelling.
- Venue specific contingency plans for construction phase V2: All contingency plans for Olympic construction site being reviewed. Contingency planning for Stratford International Station to be included.

Next steps:

- Command and Control Structure Agreed: Populate with leads for each venue and zone. Enhance urban zone details as they become available.
- Scenario Testing and Exercise Programme (STEP) designed: Fully scope and ensure fit for purpose.
- Event demand in urban domain during lockdown period V2: Any events notified to London Ambulance Service NHS Trust (LAS) to be risk assessed against relevant guidance.
- Venue specific contingency plans for construction phase V2: Modifications to be reviewed by Lyn Sugg and then sign off by service Head of Emergency Preparedness.

Risks and issues:

- No new risks or issues
- No changes to current risks/issues

T2P2: Workforce (PE: Peter Thorpe; PM: Sandy Thompson)

Progress:

- Commence selection process design: Initial discussions with Human Resource (HR) undertaken.
- HR issues re use of pre-planned aid: Peter Thorpe presented update to Directors of Operations meeting on 26 November 2009.

Next steps:

- Commence selection process design: Recruit HR resource to ensure process in place for summer 2010.
- HR issues re use of pre-planned aid: Continue to develop Olympic process mapping work in order to communicate numbers and roles required to other services by end March 2010.

Risks and issues:

- Possible lack of HR resource going forward which could impact selection process and other HR related pieces or work required to deliver the this project; mitigation: Possible use of new HR recruit to New Ways of Working (NWoW) role.

T2P3: Skills Acquisition (PE: Anna Parry; PM: Alan Taylor)

Progress:

- Commencement of training / educational session development: Clinical work group reviewed Autonomic Dysreflexia session. Event Work group developing achievement records. Royal National Institute for Deaf People (RNID) unable to develop bespoke session for LAS. Looking at alternative organisations to assist.
- Timetable for *all* LAS Staff Olympic training required: Project board have requested plan be deferred by 3 months due to concerns around command point completion. New date for training June - November 2011.
- Timetable for training the trainers (if preferred approach): Plan agreed by Keith Miller and Gill Heuchan (GH). GH to submit Strategic Planning Project Profiles (SPPPs) for Training Officers due to amount of core training to be undertaken
- Provisional timetable for induction/ training provision for staff from other UK ambulance services, volunteers and redeployed staff: Options for delivery are outlined in A2 until numbers, Trusts and approach known it is difficult to progress with timetable.

Next steps:

- Commencement of training /educational session development: Continue to review training sessions developed by specialists. Develop objectives and learner outcomes.
- Timetable for all LAS Staff Olympic training required: Gain agreement to plan from Gareth Hughes, Resource and Planning Ambulance Operations Manager (AOM). Amend milestone documentation to new timetable. Circulate to project board for agreement.
- Provisional timetable for induction/ training provision for staff from other UK ambulance services, volunteers and redeployed staff: Awaiting decisions on use of pre planned aid. Consider moving milestone to stage 3 later in 2010

Risks and issues:

- No new risks or issues
- No changes to current risks/issues

T2P4: Infrastructure and Support (PE: Peter Thorpe; PM: Anna Parry)

Progress:

- Ongoing discussion with Silvertown landlord regarding extension of existing lease/agreement of lease for additional premises; expectation that lease will be signed by 1 April 2010; agreement with ADO East that station will be vacated by 31 October 2011 for Olympic occupation
- Funding for technical specialist approved to lead on technical components in outstanding milestones and support business analysis work; production of action plan detailing how current slippage will be managed and IM&T component of project put back on track by February 2010
- Initial discussions with equipment suppliers re scope to loan key pieces of equipment – will depend upon direction determined with vehicles
- Initial scoping of functional areas (completed in conjunction with process mapping work) eg. catering, briefing, workshops etc

Next steps:
- Presentation of process mapping to IM&T and Operational Support to facilitate scoping of those functional areas: size, composition, incorporated processes
- Appointment of IM&T resource (see above)
- Decision regarding vehicle leasing/remounting to inform progression of equipment planning

Risks and issues:
- No new risks or issues
- No changes to current risks/issues

T2P5: Communication and Involvement (PE: Anna Parry; PM: Sandy Thompson)

Progress:
- Determine scope of usage for LAS teams re health promotion: Initial paper drafted by Richard Walker now reviewed and Richard is adding an 'Olympic initiative' table as an appendix to the document.
- Plan for communication re selection process: Initial meetings organised with Tony Crabtree / Eric Roberts / Eddie Brand

Next steps:
- Plan for communication re selection process: working with Communications and HR to ensure timely and relevant information communicated; source HR resource to work on this.

Risks and issues:
- No new risks or issues
- No changes to current risks/issues

T2P6: Commissioning Project (PE: Peter Thorpe; PM: Anna Parry)

- **Closed.**

Project Highlight Report

OVERVIEW OF OLYMPIC PROGRAMME TRANCHE 2 PROJECTS

T2P1: Operational Planning
Project Executive: Peter Thorpe; Project Manager: Alan Palmer
This project is focused on the operational components of LAS Olympic and Paralympic Games preparations. Incorporated in this project is the development of the Operational Plan and associated Contingency Plan for the London 2012 Olympic and Paralympic Games. Also encompassed within this project is the development of plans for implementation during the construction phase. A key area of focus will be the modeling of demand: in the Olympic and Paralympic venues, in relation to cultural events during the lockdown period, and that attributable to the 'Olympic effect' on London. The creation of the LAS Scenario Testing and Exercise Programme (STEP) sits within this project, and LAS participation in external STEP activity.

T2P2: Workforce
Project Executive: Peter Thorpe; Project Manager: Sandy Thompson
This project is focused on the refinement of workforce numbers and groups building on the work undertaken in Tranche 1. In response to the demand modeling undertaken in T2P1, this project will explore the supply options, considering Voluntary Aid Services, private providers, first responders etc, and determine how the LAS will meet the demand on its workforce during the Olympic and Paralympic Games. In addition, gold and silver officers will be 'selected' and a 'selection process' for the other staff groups required will commence.

T2P3: Skills Acquisition
Project Executive: Anna Parry; Project Manager: Alan Taylor
This project will build on the work undertaken in the Tranche 1 Clinical Skills Acquisition/Training Project further refining the areas where additional skills will be required for the Olympic and Paralympic Games. Operational, event management and clinical skills will be explored within this project. Furthermore, consideration of other training needs will occur with identification of the preferred mode/s of training provision and commencement of the skills acquisition programme.

T2P4: Infrastructure and Support
Project Executive: Peter Thorpe; Project Manager: Anna Parry
This project is comprised of three areas: Information Management and Technology (IM&T), Estates and Operational Support. Fundamental to the project is the development of additional event control capacity for the Olympic and Paralympic Games and the building/refurbishment of an Olympic complex. This will include the identification of sites for both, the building and equipping of the event control (including IM&T functionality) and the production of detailed plans for the Olympic complex. Also incorporated in the project are the finalisation of vehicle numbers/types and the commencement of any procurement / tendering process required.

T2P5: Communication and Involvement
Project Executive: Anna Parry; Project Manager: Sandy Thompson
This project focuses on communication with and involvement of staff, local communities and patients/public in London, including the development of a Stakeholder Management Strategy and a Communication and Engagement Strategic Plan. This project will oversee and co-ordinate the communication activity across Tranche 2 ensuring a joined-up and streamlined approach.

T2P6: Commissioning Project
Project Executive: Peter Thorpe; Project Manager: Anna Parry
This project has been introduced to oversee the production of the OIAMB outline business case and the subsequent commissioning process with NHS London and Richmond/Westminster PCT (i.e. lead PCT commissioner).

ACRONYM	FULL NAME / ORGANISATION
ACPO	Association of Chief Police Officers
AFA	Application for Financial Approval
ANICC	Ambulance National Information Co-ordination Centre
BAU	Business As Usual
BEMC	Beijing Emergency Medical Centre
BMHB	Beijing Municipal Health Bureau
BOCOG	Beijing Organising Committee of the Olympic Games
BRC	British Red Cross
BTP	British Transport Police
C&C	Command and Control
C2PR	Command, Control Resilience and Planning
Crone	Chemical Biological Radiological Nuclear and Explosives
CMO	Chief Medical Officer
COBR	Cabinet Office Briefing Room
CSP	Costed Security Plan
CT	Counter Terrorism
DCMS	Department for Culture, Media and Sport
DH	Department of Health
EOC	Emergency Operations Centre
EPB	Emergency Preparedness Board
EPU	Emergency Planning Unit
FNICC	Fire National Information Co-ordination Centre
GMP	Greater Manchester Police
GOE	Government Olympic Executive
HART	Hazardous Area Response Team
HMIC	Her Majesty's Inspectors of Constabulary
HPA	Health Protection Agency
HR	Human Resources
IM&T	Information Management and Technology
IOC	International Olympics Committee
JD	Job Description
JLAB	Joint Local Authority Building Control
LAS	London Ambulance Service
Links	Local Involvement Networks
LOCOG	London Organising Committee for the Olympic Games
LRRF	London Regional Resilience Forum
MOC	Main Olympic Control
MPS	Metropolitan Police Service
NHS	National Health Service
NHSL	NHS London
NICC	National Information Co-ordination Centre
NOCC	National Olympic Coordination Centre

NOP	National Operation Plan
NPIA	National Policing Improvement Agency
OBC	Outline Business Case
OCOG	Organising Committee of the Olympic Games
ODA	Olympic Delivery Authority
OGPO	Olympic Games Planning Office
OIAMB	Olympic Investment Appraisal and Monitoring Board
ORH	Operational Research in Health Limited
OSD	Olympic Security Directorate
PDF	Portable Document Format
PNICC	Police National Information Co-ordination Centre
PROMIS	Personnel Rostering Overtime Management Information System
REAP	Resourcing Escalatory Action Plan
SBU	Strategic Business Unit
SCC	Strategic Coordination Centre
SJA	St John Ambulance
SME	Subject Matter Experts
SOR	Special Operations Room (Call sign GT)
SPPP	Strategic Planning Project Profile
STEP	Scenario Testing and Exercise Planning
TCC	Transport Coordination Centre
TVP	Thames Valley Police
UOC	Urgent Operations Centre
VAS	Voluntary Aid Societies
VIP	Very Important Person

London Ambulance Service NHS
NHS Trust

TRUST BOARD - 26 January 2010

Document Title	**Clinical Education – Developing a New Pathway**
Report Author(s)	**Gill Heuchan, Assistant Director of Professional Education Development**
Lead Director	**Caron Hitchen, Director of Human Resources and Organisation Development**
Contact Details	**Caron.hitchen@lond-amb.nhs.uk**
Aim	**Inform the Trust Board of the plans to develop a minimum of Diploma level Paramedic clinical education. To gain support for fully progressing the recommendations.**

Key Issues for the Board

To support the future workforce plan, work has progressed in identifying potential approaches to clinical training, education and career progression in line with the move to a higher education model.

The full document can be accessed electronically and contains a set of case studies describing the potential future approaches allowing for:

- movement of A&E support staff through to diploma level paramedic training (via an apprenticeship/cadet approach).
- conversion of Emergency Medical Technician to diploma level paramedic.
- upgrade of existing IHCD paramedic to diploma level.
- direct entry university diploma paramedic.
- direct entry degree paramedic.

The attached Executive Summary provides background to this work together with summarising the recommendations which are currently being progressed for future delivery.

Mitigating Actions (Controls)

Recommendations to the Board

The Trust Board is asked to note and support the recommendations contained within the document and the further development of new models of clinical education provision.

Equality Impact Assessment

A full Equality Impact Assessment will be conducted for the recommendations which have been approved and the associated range of training programmes. The results of the assessment will be published on the Trust's public website. It should be noted that a principle intention of the recommendations made is to widen access to diploma level Paramedic training.

Key Issues from Assessment

Risk Implications for the LAS (including clinical and financial consequences)

There is a risk, particularly during the implementation phase, regarding the ability to recruit quickly (as we have recently) to respond to significant workforce growth.

Robust workforce planning (which is one of the recommendations made) will identify as accurately as possible future workforce requirements.

Move to a two year university diploma programme also reduces the lead in time for qualified staff thus further mitigating this risk.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

Corporate Objectives that the report links to

Recommendations made within this document fully meet the LAS objective to move to higher education clinical training model enhancing the level of training for registered paramedics.

London Ambulance Service NHS
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CLINICAL EDUCATION

DEVELOPING A NEW PATHWAY

Gill Heuchan
Assistant Director of
Professional Education Development
November 2009

EXECUTIVE SUMMARY

Introduction

The London Ambulance Service (LAS) Strategy 2006/07-2012/13 set out an ambitious programme of work to transform the delivery of ambulance services across London. As the only 24 hour mobile London wide organisation the LAS has a significant contribution to make to the healthcare of Londoners and those who visit the capital. These ambitions are crucial to the development of a service which not only supports the delivery of Healthcare for London but also anticipates the needs of London as a city combined with meeting the wide ranging needs of local populations.

The clinical care patients receive is directly related to the quality of the workforce. In order to achieve implementation of the key quality and service improvement initiatives the LAS recognises the need to ensure the workforce has the knowledge, skill, competence and confidence to deliver high quality care in new ways, as well as be engaged in continuous service and clinical quality improvement.

The report on the Strategic Review of Ambulance Services (Nicholl, Turner and Martin 2000) identified that the needs of patients could best be met by a higher level of paramedic practitioner. The London Ambulance Service has been developing paramedics along this academic pathway for the last twelve years alongside the traditional IHCD pathway. Currently approximately 30% of the LAS paramedics have a diploma/foundation degree or Bsc qualification.

Increasingly across the country the higher education route to qualification is being developed. The Department of Health issued guidance in 2008 for SHA's, PCT's and Ambulance services about the transition to an all Diploma qualification pathway for paramedics.

Increasingly paramedics are registering with the Health Professions Council (HPC) with a higher education qualification. The HPC have stated that once 51% f paramedics are registering with a higher education qualification they will review the minimum qualification for registration with a view to moving this to Foundation Degree/Diploma.

Current Position

Currently the LAS turnover is approximately 150 people per annum. The paramedic workforce numbers are sustained by a combination of pre-registration programmes:

- Higher Education, foundation degree, diploma and degree courses. The tuition for these courses is funded from HEFCE; students have to pay tuition fees. During the courses there is some paid employment with the LAS. These routes take 3-4 years from entry to qualification.

- EMT conversion to paramedic (IHCD) which is run by the LAS either as a full time 12 week programme or a 12 month part time programme. During the course the students are fully employed by the LAS and paid at their current salary, the LAS fund the tuition.

A workforce review identified a significant shortfall in paramedics; as a result the PCT's have commissioned a significant increase in the workforce numbers. In order to meet this commission the LAS is currently running a 3 year IHCD paramedic programme. The tuition elements are currently funded by MPET levy. There are significant periods of learning in the workplace as part of the programme, students are contracted by operations and are paid a salary throughout the programme. These students become available within the workforce 26 weeks after commencing the programme, their roles and responsibilities increase incrementally throughout the three years.

The intensive recruitment programme provides unique opportunity to implement the transition from IHCD to higher education programmes because the volume of new employees in the pipeline and the availability of these staff in the workforce early in their training programme.

The transition to an all diploma/degree registration relies on maintaining the workforce capacity whilst mapping the impact on other programmes for the current and future workforce, this includes:

- The entry/gateway points for new recruits, EMTs and those who may wish to APL to the programmes i.e. those from PTS or A&E support who wish to become paramedics;
- The step on and step off points;
- The continuing development programmes;
- The pathways for existing IHCD paramedics to achieve diplomas, foundation degrees or degrees, should they wish to do so.

This mapping and reconfiguration of the education pathways would create a skills escalator approach. This approach brings together key influences on education, practitioner and service quality, including:

- lifelong learning
- equality and diversity
- regulation
- recruitment and retention
- pay modernisation
- the careers framework
- the changing workforce

It is an approach the LAS has used in the past to develop staff as it can provide a structured programme of skills development with a variety of step on and step off points.

Shifting the minimum standards for registration, creates a shift in the expectations for academic underpinning to support more technical and specialist roles. The ongoing development of role types is a dynamic process to support delivery of Healthcare for London and is an integral part of the transformational workforce redesign process, which will ensure that staff are:

- Fit for purpose- meet the employer requirement;
- Fit for practice- achieve the regulatory requirement;
- Fit for award- achieve the educational requirement.

The skills escalator approach operates at all levels of the workforce and thus offers a powerful recruitment message of ongoing opportunity. It underpins and complements the succession planning and talent management programmes which focus at the senior/managerial levels of the organisation, providing equity across the grade and role boundaries.

Recommendations

In order to achieve the transition to a minimum diploma registration pathway the LAS needs to implement a number of interdependent workstreams. The recommendations identify the range of work to be undertaken as well as some areas where further scoping is required to fully understand the impact of the changes which are being proposed.

1. **Paramedic Students Direct entry-IHCD**

   i) Recruitment to the direct entry IHCD programme should cease at the earliest opportunity.

   ii) The content and costs of modules to award a diploma should be specified by the LAS in order to identify funding and contract the programmes for students to access an additional module post registration to achieve Diploma qualifications.

2. **Paramedic Students Direct entry-Diploma/Foundation Degree**

   i) The LAS should develop and seek approval for a 2 year academic programme with a 1 year preceptorship with the LAS.

   ii) The introduction of a 2+1 programme should be fully evaluated by theHEI provider to ensure that the quality of the practitioner is not compromised.

   iii) HEI's should be utilised by the LAS as the single point of direct entry for pre registration paramedic practice from 2011 at the latest, thus replacing the method of recruitment described in the item above.

iv) HEI student numbers should be scoped to determine the numbers required to maintain and develop the workforce over the next 5 years.

v) New contracts/ SLA's should be agreed with HEI's regarding the resourcing of tutorial support and venue support given by the LAS.

vi) Practice placement systems and processes should be reviewed and delivered in partnership with HEI's.

3. Paramedic Students Direct entry-Degree

i) The skills escalator career pathway should be redefined to reflect best utilisation and potential career pathway for a graduate paramedic.

ii) The LAS should consider and map the proportion of the workforce required at graduate level in order to meet the projected population needs.

4. EMT Conversion (Diploma/Foundation Degree)

i) The LAS should define the content and duration of a work based diploma programme.

ii) The LAS should deliver a modular based programme spread over a longer period (12 months) allowing for higher numbers to access with minimum disruption to operational cover.

iii) The LAS should seek accreditation of work based learning for EMT conversions**.**

5. A&E Support worker- Apprenticeship/Cadet Programme

i) The LAS should research and scope a work based programme for A&E support workers who aspire to become paramedics.

ii) The programme will be a 4 year diploma programme taking a work based cadet approach.

6. Existing IHCD paramedics

i) The LAS should develop pathways to develop existing paramedics to Diploma level as a work based programme.

ii) The pathway will include HEI modules / e-learning plus APEL of credits from the IHCD course.

7. Other Healthcare Professionals

i) The LAS should consider how it broadens its recruitment so it is based on skills rather than professional background.

ii) The LAS should consider developing accelerated programmes for those entering from other professional backgrounds.

8. Skills Escalator Approach

i) The LAS should ensure that the clinical education pathways, role and workforce development plans are framed utilising a skills escalator approach.

ii) In developing the educational pathway, consideration should be given to step on step off and step back arrangements.

9. Other Workstreams

i) The LAS should undertake further work to define the benefits and challenges of becoming a teaching organisation and determine if this is a development it wishes to initiate.

ii) The LAS should consider additional work programmes for control and non-clinical services to align the career pathways.

iii) The LAS should consider further work to identify opportunities for individuals to move from control to clinical career pathways and vice versa, as well as considering the potential to move from non-clinical to clinical career pathways.

Milestones and Reporting

There is a structured work programme to deliver these changes with defined milestones targets. Achievement of the milestones will be monitored and reported to the Clinical Education Steering Group, Training Strategy Group and the OD and People Workstream Board as well as SSG/SMG.

London Ambulance Service NHS
NHS Trust

TRUST BOARD - 26th January 2010

Document Title	**Quarter 3 Governance assessment**
Report Author(s)	**Sandra Adams**
Lead Director	**Sandra Adams**
Contact Details	**020 7783 2045**
Aim	**Compliance with the BHS London performance regime**

Key Issues for the Board

- 3rd quarter assessment of governance requirements submitted to NHS London on 14th January 2010;
- Board composition and process – Board vacancies identified: Non-Executive director and Director of Health Promotion – both soon to be recruited to;
- Board risk assurance framework has not been considered and approved within the quarter – this is due to the review of strategic risks that is underway currently;
- Clinical governance and performance management – two core standards declared in December 2009 as 'insufficient evidence': plans are in place to provide the Board with assurances of compliance by 31st March 2010;
- Safeguarding children – there have been 10 serious case reviews during the quarter, concerning 8 London boroughs; the named nurse safeguarding professional is not applicable to the LAS;
- Patient & staff involvement – category C and routine caller surveys are underway, and we have a programme of patient & public involvement for health promotion; the PTS routinely surveys its service users;
- Financial governance – there are no Better Care Better Value indicators applicable to the LAS however relevant measures are tacked through the board report and balanced scorecard each month;
- Financial management & forecasting – the trust has discussed the impact of increased activity with both NHS London and the lead commissioner and further analysis is underway; and
- The Trust was issued with a performance notice from its lead commissioner in December 2009 for failure to meet the Category B performance target.

The Trust achieved a green rating for its Quarter 2 assessment and should achieve this in Quarter 3 also.

Mitigating Actions (Controls)

Action is being taken to manage gaps in compliance as identified above.

Recommendations to the Board

To note the assessment of performance against governance requirements during the 3rd quarter: October – December 2009.

Equality Impact Assessment Has an EIA been carried out? (If not, state reasons) **Key Issues from Assessment** N/A
Risk Implications for the LAS (including clinical and financial consequences) No significant risks identified.
Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing) The Trust needs to maintain its green rating for the purposes of its NHSFT application and to avoid performance review measures.
Corporate Objectives that the report links to All.

Trusts - Quarterly Governance Assessment

This document is completed for all the functions of the Trust. Please indicate your answer to each question by ticking the box on the right hand side. Please add details in the comments field below if the response is **NO** to any statement. If the response is **NO** please also include in the comments field a timeline for compliance.

Trust name: London Ambulance Service NHS Trust

The Chair and Chief Executive on behalf of the Board are required to confirm that:

1) Board composition and processes	YES	NO
a) There have been no external or internal audit reports that raise issues of compliance within the last quarter.	√	
b) The Board currently has no vacancies for:		
I. non-executives		√
II. Executives		√
c) The Trust has met the deadline for all returns required by the SHA, Department of Health and other regulators.	√	
d) There is an organisation development programme in place, which includes developing talent and leadership and continuous development of staff. This will include signing up to local Learning and Development Agreements.	√	

Comments: Currently recruiting to the NED vacancy and soon to advertise for a Director of Health Promotion and Quality

2) Compliance with statutory duties		
a) The Trust has schemes and action plans in place to ensure that it complies with its statutory duties under equality legislation.	√	
b) The Trust has up to date HR information disclosing the diversity of the organisation's direct workforce.	√	
c) All services are compliant with the requirements under the European Working Time Directive.	√	
d) The Board Risk Assurance Framework has been formally considered and approved by the Board during the last quarter.		√

Comments: The Board is reviewing its strategic risks and is due to review the risk management arrangements and the BAF at its March 2010 meeting

3) External assessment		
a) There have been no clinical governance concerns raised by the CQC during the last quarter against any of the services the organisation provides.	√	
b) The Board received a formal report in the past quarter detailing the current and predicted CQC Quality of Services score.	√	
c) The Board received a formal report in the past quarter on the DH Performance Framework.	√	

Comments:

4) Commissioner – Provider relations		
a)	The Board received information in the past quarter detailing current and trend data on A&E and new outpatient attendances.	N/A☐ ☐
b)	The organisation can demonstrate that it is focussed on improving the productivity of its clinical workforce and can demonstrate that it has processes in place to show value for money.	√☐ ☐
c)	The Trust has robust and constructive relationships with all its providers, sector commissioners and Sector Acute Commissioning Unit.	√☐ ☐
d)	Provider and Commissioner financial quarterly projections reconcile.	√☐ ☐
Comments:		

5) Clinical governance and performance management		
a)	The organisation has been compliant with all CQC Core Standards during the last quarter.	☐ √☐
b)	The Trust has effective processes in place to address any clinical governance issues that have occurred in the last quarter that could impact on Core Standards.	√☐ ☐
c)	No services have been issued within an improvement notice by the CQC in the last quarter. Please give detail below of any improvement notices.	√☐ ☐
d)	No services have been issued with performance notices by other regulators.	√☐ ☐
e)	The Trust has met the SHA SUI reporting requirements in the last quarter.	√☐ ☐
f)	The Trust has had no incidents of 'Never Events' within the last quarter.	√☐ ☐
g)	The Board has received a report on patient safety incidents taken from the STEIS reporting system, including themes and lessons learnt, in the last quarter.	√☐ ☐
h)	The organisation has a clear strategy in place for improving clinical quality around patient safety, clinical effectiveness and patient experience that sets specific, measurable and challenging goals.	√☐ ☐
i)	The Board has received a report on clinical quality, including lessons learnt, in the last quarter.	√☐ ☐
j)	The Board has a corporate framework in place for the management and accountability of data quality.	√☐ ☐
k)	The Board has received a report on patient complaints, including themes and lessons learnt, in the last quarter.	√☐ ☐
Comments: Two core standards were declared as 'insufficient evidence' to provide assurance to the Board. Plans are in place to provide assurance by 31st March 2010.		

6) Emergency preparedness		
a)	The organisation has a robust Business Continuity Plan in place.	√☐ ☐
b)	There is a named Director in post responsible for:	
	I. emergency planning	√☐ ☐
	II. Flu.	√☐ ☐
c)	The organisation has a workforce plan to cover Flu.	√☐ ☐
Comments:		

7) Safeguarding children

a)	The Board has completed an urgent review of arrangements for Safeguarding children as set out in July 2009 letter from David Nicholson and published a corresponding declaration.	√☐ ☐
b)	The Board conducted a formal review of safeguarding arrangements in the last quarter.	√☐ ☐
c)	There have been no Serious Case reviews during the last quarter.	☐ √☐
d)	The Trust has a Board Level Director with responsibility for Safeguarding Children.	√☐ ☐
e)	The following safeguarding professionals are in post:	☐ √☐
I.	Named Nurse	√☐ ☐
II.	Named Doctor	√☐ ☐
III.	Named Midwife	√☐ ☐

Comments:

c) there have been 10 serious case reviews held during the quarter, across 8 London Boroughs

e) the named nurse position is not applicable to the LAS.

8) Patient and staff involvement

a)	The Trust has conducted local surveys of patients and the population in the last quarter.	√☐ ☐
b)	The Trust has a plan in place to address the areas of weakness identified in the Inpatient Survey.	N/A☐ ☐
c)	The Trust has a staff engagement policy in place.	☐ √☐

Comments:

a) surveys are in place for category C callers and routine callers. The Trust routinely engages with the local population through its health promotion work in local areas. The PTS service routinely surveys patients.

c) The draft strategy is due to be considered by the Trust Board in March 2010.

9) Business Strategy & Procurement

a)	The Trust has developed, with Board approval, a business strategy and business case for any material dis/investment of services and/or related assets [and in accordance with DH and NHS London requirements.	√☐ ☐
b)	Where material service changes are planned:	
I.	There has been formal engagement with Commissioners to assess the impact and to resolve any issues.	√☐ ☐
II.	There has been an assessment of the implications for the Trusts own services and of the financial implications and risks.	√☐ ☐
III.	The Trust has complied with national policies and guidelines, prevailing best practice and governance arrangements.	√☐ ☐
c)	All contracts with annual values over levels prescribed by OJEC have been signed off by all parties.	√☐ ☐

Comments:

10) Financial Governance

a)	The Board has developed and agreed a formal action plan to achieve an improvement in financial standing of at least one level in the ALE rating score, or maintain its standing if the maximum score	√☐ ☐

	has already been attained.	
b)	The Board, or its designated Finance Sub-Committee, and Executive team are fully engaged in monitoring the delivery of the planned improvements to ALE rating scores.	√☐ ☐
c)	The Trust has a plan to improve all Better Care Better Value indicators and the Board has monitored progress since the last quarter.	☐ √ ☐

Comments: There are currently no BCBV indicators relevant to ambulance trusts however relevant measures are tracked through the board report and balanced scorecard.

11) Financial Management and Forecasting

a)	The CIP has been monitored and risk-reviewed by the Board and the planned value for the quarter has been achieved or, if not achieved, there is a remedial plan in place.	√☐ ☐
b)	Where there are material changes in contracted volumes in the quarter, the trust has engaged in formal communication with the associated Sector Acute Commissioning organisation / PCT to agree relevant PCT activity levels and financial implications and to resolve any issues.	☐ √☐
c)	There is no expectation of significant additional working capital loan or temporary PDC requirements over and above plan.	√☐ ☐

Comments: The LAS has discussed the impact of increased activity in both calls received and incidents with both NHSL and the lead commissioner. Further analysis is required before resolution.

12) Other issues

Any other actual or potential issues not addressed in the questions above?

Comments: The Trust was issued with a performance notice from its Lead commissioner in December 2009 for failure to meet the Category B performance target. Discussions are underway.

Signed on behalf of the Board

Chief Executive and Accountable Officer	**Chair**
Peter Bradley	Richard Hunt

Date: 14th January 2010

London Ambulance Service NHS Trust

TRUST BOARD - 26th January 2010

Document Title	**Questions for Boards – 'Taking it on Trust; a review of how Boards of NHS Trusts and Foundation Trusts get their assurance'; Audit Commission 2009**
Report Author(s)	**Sandra Adams (for Questions for Boards)**
Lead Director	**Mike Dinan**
Contact Details	**020 7783 2045/2041**
Aim	**To complete and review the checklist for Board assurance as one of the governance requirements of ALE 2009/10**

Key Issues for the Board

- New requirement within ALE (Auditors Local Evaluation) 2009/10;
- The Audit Commission report discussed how 'ALE and other similar assessments could be strengthened to focus more on the effectiveness of risk management processes';
- 19 groups of questions (summarised below) each requiring details of the sources of evidence;

1) Strategic aims and objectives
2) Governance structures
3) Achieving objectives
4) Board meetings
5) Board operation and skills
6) Strategic risks
7) Management and monitoring of risk
8) Risk measurement
9) Risk culture
10) Use of internal audit
11) Compliance
12) Use of clinical audit
13) Sources of assurance
14) Board sub committees
15) Self declarations
16) Data quality – culture & responsibilities
17) Data quality – policies & training
18) Use of data
19) Data quality assurance

- The form is available at the following link:

http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/20090429takingitontrustchecklist.doc

- The executive team will complete the form for review and discussion at the Risk Compliance and Assurance Group, Service Development Committee (SDC) and Audit Committee meetings before final review and sign off by the Board on 30th March 2010.

Mitigating Actions (Controls)

NHSLA level one – October 2008

Core standards declaration and evidence 2009/10 – submitted December 2009

Recommendations to the Board

- To access the Questions via the link and to familiarise themselves with 'Taking it On Trust';
- To agree to the executive team completing the form and the subsequent discussion and sign off process including review by the SDC at its awayday on 3rd March.

Equality Impact Assessment

Has an EIA been carried out?

(If not, state reasons)

Key Issues from Assessment

N/A

Risk Implications for the LAS (including clinical and financial consequences)

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

- Impact upon ALE score for 2009/10
- Implications for governance assessment during the NHSFT application process

Corporate Objectives that the report links to

Statutory/compliance requirements

London Ambulance Service NHS Trust

TRUST BOARD - 26th January 2010

Document Title	**Board responsibilities for security management**
Report Author(s)	**Sandra Adams**
Lead Director	**Mike Dinan**
Contact Details	**020 7783 2041**
Aim	**To ensure compliance with the legal framework for security management services (SMS) within the NHS, including Secretary of State Directions 2004 (amended 2006) and NHS SMS guidance**

Key Issues for the Board

- All NHS bodies must designate an Executive (voting) director or Officer to the role of Security Management Director (SMD) to ensure that adequate security management provision is made within the Trust; for the LAS this is the Director of Finance;
- The Chair/Chief Executive of all NHS bodies must designate a non-executive (voting) Director or non-officer member to promote and champion security management work at Board level;
- The NED must give support and, where appropriate, challenge the SMD on issues relating to security management at executive board level;
- This also ensures compliance with Care Quality Commission registration requirements (regulation 15/outcome 10) and the core standards (C20a) and the Trust has been rated as red in the CQC Quality & Risk Profile due to not having designated the NED position.

Mitigating Actions (Controls)

SMS arrangements are in place within the organisation, led by the designated SMD.

Recommendations to the Board

To designate a non-executive director to promote and champion security management work at Board level.

Equality Impact Assessment

Has an EIA been carried out?

(If not, state reasons)

Key Issues from Assessment

N/A

Risk Implications for the LAS (including clinical and financial consequences)

Failure to designate an NED for this purpose will lead to non-compliance against the CQC's regulation 15/outcome 10 and may impact upon the Trust's application for registration in 2010/11.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

Governance – as above, and may impact upon the NHSFT application.
Corporate Objectives that the report links to **Statutory & compliance requirements.**

London Ambulance Service NHS Trust

TRUST BOARD - 26th January 2010

Document Title	**Report of the Trust Secretary**
Report Author(s)	**Sandra Adams**
Lead Director	**Sandra Adams**
Contact Details	**020 7783 2045**
Aim	**To note the receipt of tenders and the use of the Trust Seal in accordance with Standing Orders**

Key Issues for the Board

- 4 tenders received since the last Trust Board meeting;
- 2 entries in the register of the Trust Seal;
- The Seal is kept by the Trust Secretary in a secure place and a record is made in the register of every document sealed;
- Standing order 31: 'the fixing of the seal of the Trust shall be authenticated by the signature of the Chairman or some other such person authorised generally or specifically by the Trust for that purpose and one other director';
- The Seal is used as a necessary step in legal proceedings on behalf of the Trust and is most commonly used for executing documents such as formal contracts and lease agreements for example in land and estate transactions.
- Use of a seal helps to prevent any question of irregularity in such matters as there is only one seal available which is closely controlled by the Trust Secretary.

Mitigating Actions (Controls)

Standing Orders of the London Ambulance Service NHS Trust

Recommendations to the Board

To note the report of the Trust Secretary.

Equality Impact Assessment

Has an EIA been carried out?

(If not, state reasons)

Key Issues from Assessment

N/A

Risk Implications for the LAS (including clinical and financial consequences)

These would be assessed specifically for each tender or transaction.

Other Implications (including patient and public involvement/ legal/ governance/ diversity/ staffing)

Corporate governance requirements

Corporate Objectives that the report links to

Statutory/compliance requirements

London Ambulance Service NHS Trust
Trust Board of Directors
26th January 2010

Report of the Trust Secretary
Tenders received and the use of the Trust Seal

1. Introduction

1.1 In accordance with Standing Order 19, this report summarises tenders received and the names of those organisations tendering.

1.2 In accordance with Standing Order 31, this report summarises the entries in the register held by the Trust Secretary of documents sealed.

2. Tenders received

There have been 4 tenders received since the last Trust Board meeting.

2.1 Refurbishment of Tolworth Ambulance Station

Tenders received and opened on 14th December 2009:
Millane Construction Services Ltd
Coniston Construction Ltd
Lakehouse Contracts Ltd
Sibmar Construction Group
TCL Granby Ltd.

2.2 Vehicle conversion for 65 A&E ambulances

Tenders received and opened on 21st December 2009:
S.Macneillie & Son Ltd
U.V.Modular
WAS Vehicles UK Ltd
Wilker UK Ltd.

2.3 Talent Management Programme

Tenders received and opened on 22nd December 2009:
A&DC Ltd
Criterion Partnership Ltd
Jackson Samuel Ltd
Management Futures Ltd
Mirador
Denna PLC
SHL Group Ltd
Talent Q UK Ltd.

2.4 Managed Catering Services Ltd

Tenders received and opened on 31st December 2009:
Autograph Food Service
Harrison Catering Services Ltd
Pabulum Ltd.

3. Use of the Trust Seal

There have been two entries to the register:
Lease and license to carry out works relating to Units 1 & 2 Data Point, Cody Road, London E16 between London Ambulance Service NHS Trust and JRPA Estates Ltd; and

Sale of Willesden Ambulance Station – engrossments of legal and transfer charge between London Ambulance Service NHS Trust and Ealing land Ltd.

4. Recommendation

That the Trust Board note this report.

Sandra Adams
Director of Corporate Services
19th January 2010

London Ambulance Service NHS Trust

Summary of Cardiac Arrest Annual Report 2008-09

Lynne Watson
Cardiac Data Officer,
Clinical Audit & Research Unit, Medical Directorate

Cause of cardiac arrest

- The LAS attended 10,051 cardiac arrests in 2008-09.
- 5,910 patients were not resuscitated.
- 4,141 patients were resuscitated:
  - 3,266 arrests were due to a presumed cardiac cause
  - 270 cardiac arrests were related to trauma
  - 605 arrests were of a non-cardiac cause.

Key facts

- The average age of patients was 68 y/o and approx $^{2}/_{3}$ were male.
- Majority of arrests were in a private location (78%).
- Response times – Call connect:
  - 999 call to scene = 7 mins
  - 999 call to defib = 10 mins
  - 999 call to arrive hospital = 48 mins
  - Job cycle = 114 mins.

Key facts cont'd

- Witnessed arrest:
  - 1,437 (44%) of patients had their arrest witnessed by a bystander
  - LAS crews witnessed a further 545 (17%) of cardiac arrests.
- Bystander CPR was provided in 1,124 (34%) of cases.
- Initial Rhythm:
  - Almost half of patients presented in asystole
  - A quarter of patients (n=860) presented in VF/VT.

ROSC

- ROSC was achieved for 925 (28%) of patients at some point during treatment by the LAS.
- Of these, 740 (80%) sustained ROSC to hospital.
- This means that overall 23% of patients had sustained ROSC to hospital.

Survival Rates

- Utstein survival rate = 15.2% (64/422).
- Overall survival rate = 5.6% (164/2,923).
- Crew witnessed survival rate = 34.7% (41/118).

Summary

- Utstein Survival rate has increased from 12% to 15.2% and overall survival rate has increased from 4.1% to 5.6%.

- Rates of ROSC have also increased from 25% to 28% with 80% of these cases sustaining ROSC to hospital.