London Ambulance Service NHS
NHS Trust

TRUST BOARD

Meeting to be held at 10.00am on Tuesday 29th June 2010
Conference Room, LAS Headquarters, 220 Waterloo Road, London SE1 8SD

Peter Bradley
Chief Executive Officer

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AGENDA

			Tab	Time
1.	**Welcome and apologies for absence** To note the apologies from: Caron Hitchen Fionna Moore (David Whitmore to attend) Lizzy Bovill Sarah Waller			2
2.	**Minutes of the Part I meeting held on 25th May 2010** To approve the minutes of the meeting held on 25th May 2010		TAB 1	5
3.	**Matters arising** 3.1 Actions from previous meetings	All	TAB 2	5
4.	**Report from sub-committees** 4.1 To receive a report on key items of discussion at the Audit Committee meeting on 7th June 2010	CS	Oral	10
5.	**Chairman's Report** To receive a report from the Trust Chairman on key activities	RH	Oral	5
6.	**Update from executive directors** To receive reports from Executive Directors on key matters			
	6.1 Chief Executive Officer	PB	TAB 3	10
	6.2 Finance Director	MD	TAB 4	10
7.	**Clinical quality and patient safety report** To receive the monthly report on clinical quality and patient safety	DW	TAB 5	15
	STRATEGIC AND BUSINESS PLANNING			
8.	**New Ways of Working progress report** To receive a presentation on the progress of New Ways of Working	MF	Oral	30
9.	**Demand management** To receive a presentation on demand management	PB	TAB 6	40
10	**Lease for the reprovision of Purley Ambulance Station** To approve the lease for the reprovision of Purley Ambulance Station	MD	TAB 7	10

11	**Fleet Finance Update** To receive an update on the fleet	MD	Oral	5

GOVERNANCE

12.	**Annual Reporting** **12.1 Quality Account 2009/10** To approve the Quality Account for 2009/10	SA	TAB 8	5
	12.2 Annual Report and Accounts 2009/10 To note the approval process undertaken		Oral	5
13.	**NHS Foundation Trust application** To receive an update on the application process	SA	TAB 9	10
14.	**Infection Control Policy** To approve the Infection Control Policy	DW	TAB 10	10
15.	**Forward Planner** To review the Trust Board forward planner and agree items for future meetings	SA	TAB 11	2

16. **Any Other Business**

17. **Date of next meeting**

The next meeting of the Trust Board of Directors will be held on:

Tuesday 27th July Strategy Review and Planning
Tuesday 31st August Trust Board

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING
Part I

Minutes of the meeting held on Tuesday 25th May 2010 at 10:00 a.m.
in the Conference Room, LAS HQ, 220 Waterloo Road, London SE1 8SD

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Present:	
Richard Hunt	Chair
Peter Bradley	Chief Executive
Mike Dinan	Director of Finance
Martin Flaherty	Deputy Chief Executive
Roy Griffins	Non-Executive Director
Caron Hitchen	Director of Human Resources and Organisation Development
Brian Huckett	Non-Executive Director
Beryl Magrath	Non-Executive Director
Fionna Moore	Medical Director
Caroline Silver	Non-Executive Director
Sarah Waller	Non-Executive Director
Nigel Walmsley	Non-Executive Director
In Attendance:	
Sandra Adams	Director of Corporate Services
Malcolm Alexander	Chair of Patients Forum
Gary Bassett	Head of Patient Experience
Francesca Guy	Committee Secretary (minutes)
Kathy Jones	Director of Service Development
Neil Kennett-Brown	Director of LAS Commissioning (North West London Commissioning Partnership)
Angie Patton	Head of Communications
Peter Suter	Director of Information Management and Technology
Richard Webber	Director of Operations
John Wilkins	Interim NHSLA Project Lead

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52/10. Welcome and Apologies **Action**

The Chair welcomed everybody present to the meeting and acknowledged that this was Kathy Jones' last Trust Board meeting after 18 years with the Trust.

No apologies had been received.

53/10. Minutes of the Part I meeting held on 30th March 2010

Malcolm Alexander commented that an amendment should be made to paragraph 27/10.

Joe Haines (member of the public who had attended the meeting) had also requested that an amendment be made to paragraph 49/10 of the minutes to state that he had received a letter the week following his final interview in November 2009 which stated that he had a guaranteed place on the Student Paramedic program providing he passed the C1 driving test within 12 weeks of interview. **FG**

Subject to these amendments, the minutes of the Part 1 meeting held on 30th March 2010 were approved.

54/10. Matters Arising

The following matters arising were considered:

23/10 Minutes of the Part 1 meeting held on 26th January 2010. The suggested amendments had been made to the minutes.

27/10 Chief Executive Officer's Report. The presentation on demand management had been added to the Trust Board forward planner for June.

29/10 Clinical Quality and Patient Safety Report. The Strategy Review and Planning Group had discussed the findings of the Francis Report at their meeting on 27th April 2010.

33/10 West London Fleet Workshop Combined Business Case. This would be presented to the Trust Board for approval at their meeting in June.

34/10 West London HART Combined Business Case. This would be presented to the Trust Board for approval at their meeting in June.

38/10 Full update on core standards compliance 2009/10. This risk had been added to the corporate risk register.

39/10 Risk Management Structure. Sandra Adams confirmed that the Remuneration Committee had been added to the governance structure diagram.

40/10 Interim Risk Management Policy and Strategy. This action was complete.

41/10 Board Assurance Framework and Risk Register. The Risk Compliance and Assurance Group (RCAG) had reviewed the Board Assurance Framework and the risk register at their meeting on 17th May, the results of which would be discussed at today's meeting.

48/10 Forward Planner. The dates for the Quality Committee and Clinical Quality, Safety and Effectiveness Group meetings had been set for the year.

Caron Hitchen reported that the board development programme included a requirement for health and safety for Trust Board members. Caron had circulated guidance and asked for feedback from members and asked whether Trust Board members felt that it would be beneficial to hold a session on this. **All**

Beryl Magrath asked for an estimate of how much work-related injuries cost the Trust each year. Caron agreed to report back to the Trust Board on this. **CH**

55/10. Formal Reports from the sub-committees

4.1 Quality Committee

All were in agreement that the Trust Board should receive reports from its sub-committees at each of its meetings to allow effective operation of the integrated governance structure.

Beryl Magrath reported that the following was discussed at the inaugural meeting of the Quality Committee on 5th May 2010:

- The terms of reference for the Quality Committee. The Trust Board had

- The terms of reference of the Clinical Quality, Safety and Effectiveness Group, the Learning from Experience Group and the Risk Compliance and Assurance Group;
- The committee had agreed that the annual Quality Safety and Risk report to the Trust Board (as detailed in paragraph 5.4 of the terms of reference) should be the Quality Account;
- The quality indicators appropriate for an ambulance service. The Committee requested that each of the sub-groups develop quality indicators;
- The format of the meetings;
- The work plan for the rest of the year;
- The Quality Committee agreed that part of its role was to review the work plan of the clinical audit and internal audit.

Caroline Silver reported that she had been unable to attend the meeting, but hoped to attend alternate meetings of the Quality Committee where possible. Beryl would be attending the Audit Committee meeting on 7th June 2010. She and Beryl had discussed and agreed the informal and formal relationship between the two chairs.

56/10. Chairman's Report

The Chair reported the following:

- Appraisals for all directors had been completed;
- The Chair had met with Richard Sykes, Chair NHS London, who had given a positive opinion of the Trust. It was hoped that Richard Sykes would be visiting the London Ambulance Service in early June;
- The Chair had visited South East Coast Ambulance Service, which had a good relationship with the London Ambulance Service. He would be continuing to visit other ambulance services throughout the year;
- The replacement for Sarah Waller at the end of her tenure in November 2010 had yet to be finalised by the Appointments Commission.

57/10. Update from Executive Directors

Chief Executive Officer

Peter Bradley reported the following:

- The Trust was one of 13 NHS trusts and the only ambulance trust to receive a Customer Service Award. The Trust Board members expressed their thanks to members of staff involved;
- The Trust had recently lost the PTS contract which presented a problem to a number of staff. Peter Bradley commented that these staff had been proud to work for the London Ambulance Service but would have to transfer to a taxi company;
- There would be several management changes in the Trust over the coming months with Kathy Jones leaving the organisation at the end of this week and Martin Flaherty commencing his secondment as interim Chief Executive of the Irish Ambulance Service in July. The Trust had also re-advertised the role of the Director of Health Promotion and Quality;
- The Cost Improvement Plan was very stretching for this year and management costs would need to be reviewed with a view to reducing costs over the next 12 months;
- Simon Burns MP had been appointed as minister with responsibility for ambulance services. The minister would be looking to visit the Trust next week but the date had yet to be confirmed;

- Peter had circulated the key points of his conversation with Ruth Carnall to members of the Trust Board. There would be key changes in the NHS environment, particularly regarding reconfiguration and polyclinics;
- The new Secretary of State for Health was very well briefed and showed an eagerness to implement changes in the health service. The Trust needed to ensure it was in a position to influence policy decisions. The Chair asked whether recent messages from the new government affected any of the Trust's plans. In response, Peter Bradley stated that the Trust would be under increasing pressure to reduce support costs;
- The Trust had started the year well in terms of performance but would continue to be vulnerable to peaks in demand which therefore presented a risk to achieving targets and the contract. Yesterday had seen a 12 per cent increase in calls and last week had been the fifth busiest week for the Trust in five years. This highlighted the need for new ambulances in order to ensure performance remained on target throughout June. Mike Dinan reported that 65 new ambulances would be rolled out next week. Negotiations with UVM had resulted in the release of the 24 remaining ambulances;
- The Trust was continuing to negotiate with SHA with regards to MPET funding;
- Peter would be meeting with ECPs individually to discuss their future in the organisation. A paper would be presented to the June meeting of the Strategy Review and Planning Group. **PB**

Sarah Waller thanked Peter Bradley for his email which highlighted the key points of his discussion with Ruth Carnall and asked that Trust Board members continued to be kept informed in this way.

Sarah commented that the target of 55 per cent of staff given a rest break (graph 12 of the Information Pack) seemed low and had not been approved by the Trust Board. Moreover the Wellbeing Strategy did not make reference to rest breaks. Richard Webber responded that the target should be 80 per cent. He added that rest breaks continued to be an area of discussion and focus, but it would continue to be a difficulty. Crews received compensation in the form of time and money for not receiving a rest break and therefore there was a financial drive to improve this figure.

Beryl Magrath noted that the balanced scorecard showed that there continued to be a high number of road traffic accidents compared with that of other ambulance trusts. Mike Dinan responded that older vehicles tended to be more prone to accidents and therefore the number of accidents should decline as new vehicles were introduced into the fleet. The root cause of accidents was being analysed by the age of driver and length of service etc and the results would be reviewed by the Motor Risk Group.

In response to a query on infection control audits, Fionna Moore stated that she was currently working with complexes to ensure that infection control champions were given time to complete audits.

Beryl Magrath asked how the Trust had dealt with those members of staff whose travel arrangements had been delayed due to the volcanic ash cloud. Caron responded that, in line with other NHS trusts, staff had taken the additional time absent from work as annual leave or unpaid leave. The Trust did not currently use annualised hours but was looking into the benefits of this option.

Roy Griffins commented that it was likely that a health white paper would be published in six weeks and asked whether this would affect the Trust, particularly with regard to Taking Healthcare to the Patient, the Trust's contract with commissioners and the future of the B19 target. Peter Bradley responded that, in his opinion, the B19 target would be removed. It was also likely that an increased focus on alternative pathways would be seen and that the

NHS Direct and ambulance service telephone number would be combined. There had also been discussions around nationally-commissioned healthcare.

The Chair commented that the IBP would provide a vehicle by which to respond to the changes in the healthcare sector and the final discussions on the IBP would need to be informed by the changing policy environment. The Chair suggested that the Trust Board might need to arrange an additional meeting to discuss this in detail. The Chair was keen that the Trust did not lose focus from its programme of improvement during this time of change.

Malcolm Alexander asked for an update on the Cat B trial. Peter Bradley reported that the results of the trial indicated that some determinants could be safely moved to Cat C and that the Patients Forum would be consulted.

Beryl Magrath asked whether there was anything that would prevent the Trust from looking for sponsorship for e-PRF. Mike Dinan responded that there was nothing that would stop the Trust from looking for sponsorship, but that it would be difficult at this time.

Finance Director

Mike Dinan reported the following:

- The result for the month was a surplus of £250k. The variance between the actual surplus and the budgeted surplus of £710k was a result of a more prudent approach to cost assumptions and the phasing of the budget;
- The annual accounts for 2009/10 were still undergoing audit, but it was hoped that the final accounts would be available by the end of the week. The accounts would be circulated to the members of the Trust Board;
- The Cost Improvement Plan for month 1 had been achieved and agency spend in particular had seen a significant decrease.

Caroline Silver commented that good and realistic forecasting was essential and the Trust should consider the assessment of financial risk sensitivities around 2010/11 budgeting for the Audit Committee to consider.

The Chair commented that in the future the Trust Board would like to see more narrative in this report at the next Trust Board meeting. **MD**

58/10. Clinical Quality and Patient Safety Report

Fionna Moore reported the following:

- The Frequent Callers Unit had received a large volume of work with one patient in particular making over 70 calls over the Easter weekend. These patients often had a physical problem however, most had an overriding mental health problem. A part-time social worker had been employed to assist with these cases;
- CPI completion rates had shown a significant improvement in March 2010 and more feedback sessions had taken place.

Beryl Magrath noted the absence of a ‘blue light’ drivers training course for student paramedics. Richard Webber responded that this would expose the Trust to greater risk and that currently the Trust operated a mentoring programme on live cases with both cars and ambulances.

The Chair commented that the report was high quality, but was concerned about the level of information which was reported directly to the Trust Board. It was agreed that this information should be reviewed initially by the Quality Committee and escalated to the Trust Board where necessary.

Malcolm Alexander asked whether the lessons learnt from SUIs would be made available. Martin Flaherty responded that the recommendations would be reviewed initially by the Learning from Experience Committee and the Quality Committee, and escalated to the Trust Board.

59/10. 2010/11 Trust Objectives

Kathy Jones reported that the objectives for 2010/11 had been updated following previous discussions by the Trust Board. The most notable change was the reduction of seven strategic goals to three, which focused on the Trust's main stakeholder groups. The corporate goals had also been reduced to ten. Kathy stated that the objectives would inform the IBP and that the Service Improvement Plan must be the vehicle of the delivery of these goals.

Kathy reported that work was underway to develop measures to report on progress. The balanced scorecard would be adjusted to reflect these new measures.

The Chair commented that we would need to consider how progress against the objectives would be reported to the Trust Board. Individuals' objectives would need to be aligned with the corporate objectives. Furthermore the objectives might need to be revisited during the course of the year to reflect changes in the environment.

Sarah Waller asked that it be made clear that the corporate objectives were not listed in priority order.

60/10. Integrated Business Plan and Long Term Financial Model 2010/15

Integrated Business Plan

Sandra Adams explained that the IBP was a fundamental component of the application to the Secretary of State for Foundation Trust status. It was a core document on which the Trust Board would be challenged and therefore it was important that the Trust Board understood and contributed to the content of the IBP. Sandra explained that the IBP had been updated following the discussions at the Strategy Review and Planning meeting on 27th April and had been brought to the Trust Board today to generate a discussion on market assessment which would be incorporated into the next iteration of the plan.

In the discussion that followed, the following points were made:

- The environment within which the Trust operated could change dramatically over the next 6 months and in particular after the publication of the health white paper in six weeks;
- There was an assumption that demand would continue to rise. The Trust could undertake scenario planning for different percentages of demand increase and assess the implications;
- There were general trends which were not dependent on the white paper. For example, a rise in the profile of the organisation or an increase in access generally led to an increase in demand.

The Trust Board asked that the next iteration of the IBP be sent out to the Trust Board as soon as it was available. It was suggested that the Trust Board hold a separate session specifically to review and endorse the IBP. This could be following the next Trust Board meeting on 29th June 2010.

Peter Bradley commented that the timescale for applying for Foundation Trust status had been agreed and therefore it was important to set aside time to get this document right. The Department of Health demand toolkit would be useful in developing the document.

Long Term Financial Model

Mike Dinan tabled a paper on the Long Term Financial Model based on discussions so far with the commissioners. The next iteration would be circulated to the Trust Board as soon as it was ready.

Mike commented that the income was relative to that of other ambulance services, but below average per head and incident.

61/10. Board Assurance Framework and five key risks

Sandra Adams reported that the Risk Compliance and Assurance Group had undertaken a detailed review of the corporate risk register at their last meeting on 17th May 2010. Sandra reported that of the top ten risks reported in the board assurance framework, two were recommended for re-grading and removal from the corporate risk register, four required details to be updated to reflect action being taken, one was to be merged with other risks and one required the grading to be reviewed by the risk owner. The Governance and Compliance Team was currently working with risk owners to undertake this review and an up to date board assurance framework would be provided to the Trust Board in June.

Sandra reported, during the process of mapping risks to strategic objectives, it became apparent that the third strategic objective regarding the pace of innovation did not have any direct correlation with any of the strategic risks. RCAG had therefore made the recommendation that this risk be merged with strategic risk 5. The proposed new risk description is: There is a risk that our strategic direction and pace of innovation to achieve this are compromised.

RCAG had also considered the areas of risk focus for the Trust Board in 2010/11, which would not necessarily be the highest rating risks. These were:

- CPI and CPI feedback;
- Key clinical skills training;
- Demand management;
- Performance delivery against trajectories;
- CIP;
- KPIs;
- Clinical response model;
- Single point of access;
- Delivering Healthcare for London.

Sandra stated that it was yet to be decided the format of the report to the Trust Board. Roy Griffins commented that usually RCAG would report to the Quality Committee which would in turn report to the Trust Board. The Trust Board therefore needed to ensure that that the governance structure was working appropriately.

The Trust Board noted the ongoing review and updating of the risk register and agreed the

recommended risk areas for the Trust Board to focus on during 2010/11.

62/10. 2009/10 Annual Report and Accounts (incorporating Quality Report)

Mike Dinan reported that the final accounts would be presented to the Trust Board in June for approval.

A number of the non-executives reported that an out of date biography had been included in the annual report. Angie Patton agreed to ensure that this was updated. **AP**

Malcolm Alexander raised a query about how issues raised at AGMs were picked up. Caron Hitchen suggested that these people become members of the Trust.

63/10. KA34 Compliance Statement

There followed a discussion about whether it was necessary for the KA24 Compliance Statement to be presented to the Trust Board, in which it was reported that the Trust had been accused of being close to dishonesty in the past and therefore it was important to ensure that the process was as transparent as possible.

The Trust Board noted the KA34 Compliance Statement for 2010/11.

64/10. 2009/10 Annual Infection Prevention and Control Report

Fionna Moore reported that it was a statutory requirement from CQC to produce an annual infection prevention and control report which provides an overview of the Trust's infection control arrangements. Fionna confirmed that CQC had indicated that they would undertake another unannounced site visit.

Malcolm Alexander commented that it was important that frontline staff were clear of the role of CQC.

The Trust Board noted the Annual Infection Prevention and Control Report for 2009/10.

65/10. Quarter 4 integrated assurance return

Sandra Adams stated that it was important for the Trust Board to receive details of the assurance programme to which the Trust was subject by NHS London. This would become standard practice for the Board following a successful application for Foundation Trust status.

The Trust Board noted the Quarter 4 integrated assurance return which had been submitted to NHS London.

66/10. Corporate Social Responsibility Report

Martin Flaherty asked the Trust Board to note the contents of this report. He commented that the report detailed activities which had been undertaken throughout the year which showed that the Trust had made progress in this area. However more work could be done.

Beryl Magrath commented that in paragraph 2.10 of the report it should read that the new lease car policy includes a carbon dioxide limit, rather than a carbon monoxide limit. **MF**

A discussion followed about whether it was necessary to present the Corporate Social Responsibility Report to the Trust Board at a formal meeting and whether the report could

be made public by publishing it on the Trust's website. Sandra Adams expressed the opinion that the Trust Board did have an obligation to review the Corporate Social Responsibility Report and agreed to confirm this and come back to the Trust Board. **SA**

67/10. 2009/10 Annual Equality Report

Caron Hitchen reported that the Trust had a legal obligation to produce the annual equality report and publish the information publicly. However, Caron stated that the report could be published without it being presented formally to a Trust Board meeting and asked the Trust Board for their view.

Nigel Walmsley commented that papers for noting could be circulated via email and that Trust Board members could be invited to flag up any issues that they wish to be discussed at a Trust Board meeting.

Malcolm Alexander drew attention to the fact that the percentage of paramedics who were white had remained static for a number of years.

Subject to these comments, the Trust Board noted the 2009/10 Annual Equality Report.

68/10 NHS Values and NHS Constitution

Sandra Adams stated that this paper had been presented to the Trust Board following the request of the Strategy Review and Planning Group to publish the paper in a public forum.

Sarah Waller commented that the risk around non-conveyance should be included on the corporate risk register. **SA**

The Trust Board noted the noted its responsibility to have regard to the NHS Constitution in their decisions and actions and noted the discussion which took place at the Strategy Review and Planning Group meeting on 27th April 2010.

69/10. Report on the Francis Inquiry into the Mid-Staffordshire NHS Foundation Trust

Fionna Moore stated that this paper had been presented to the Trust Board following the request of the Strategy Review and Planning Group to publish the paper in a public forum.

The Trust Board noted the findings of the Francis Inquiry and the key points of discussion at the Strategy Review and Planning meeting on 27th April 2010.

70/10. Report from the Trust Secretary

Sandra Adams reported that the report from the Trust Secretary to the Trust Board was a requirement of the Standing Orders.

The Trust Board noted the report from the Trust Secretary.

71/10. Policies

John Wilkins and Gary Bassett joined the meeting for this agenda item.

Complaints and Feedback Policy

Martin Flaherty explained that this policy had been rewritten and incorporated information previously covered in two other documents regarding complaints management within the

Trust. The new policy also took account of new guidance and legislation.

Roy Griffins commented that it would be useful to include on the front sheet the governance groups which had previously reviewed and approved the policy prior to presentation to the Trust Board. Martin Flaherty responded that this policy had been reviewed and approved by SMG and had been subject to an equality impact assessment. It was an NHSLA requirement for the Trust Board to approve the policy.

Gary Bassett reported that the policy had been subject to equality impact assessment and a representative from the Independent Complaints Agency who had been involved in the assessment thought that it was the best complaints policy within the NHS.

The Trust Board approved the Complaints and Feedback Policy.

Serious Untoward Policy

Martin Flaherty reported that the Serious Untoward Policy had undergone the same process of approval as the Complaints and Feedback Policy. The policy had been revised to take into account updated guidance on the management of SUIs from both NHS London and the National Patient Safety Agency. It had also been updated to take into account the Trust's revised governance structure whereby SUIs would be reported through the Learning from Experience Group to the Quality Committee. The revised policy also gave more emphasis to the totality of SUIs and not just those which were clinically based.

Gary Bassett added that LAS was the only trust which had made a commitment to publish SUIs publicly. Peter Bradley commented that this corresponded with the new Secretary of State's desire for greater sharing of information.

The Trust Board approved the Complaints and Feedback Policy.

72/10. Strategies

Staff Engagement Strategy

Caron Hitchen commented that this was a key workforce strategy which responded to one of the four staff pledges contained within the NHS Constitution. The action plan for implementation of the strategy had been provided in pack B.

The Trust Board agreed that the strategy did not require overt attention from the Trust Board but that it should periodically review progress against the action plan.

The Trust Board approved the Staff Engagement Strategy.

Wellbeing Strategy

Caron Hitchen reported that this was a key workforce strategy which linked to key activities which the Trust undertook.

Beryl Magrath commented that it would be useful for the Trust Board to review the results of the pilots in control services.

Nigel Walmsley asked how much the strategy took to implement. Caron Hitchen responded that it was delivered within current budget but that she would provide more detail on the budget to the Trust Board.

Equality and Inclusion Strategy

Caron Hitchen reported that the strategy had been developed in preparation of the Equality Act 2010 and incorporated within its remit all six equality strands. Caron commented that the strategy was not limited to the workforce, but that workforce equality was a key element of the strategy. The strategy had been subject to consultation by the Equality Inclusion Steering Group and an action plan for its implementation had been included. Caron expressed the opinion that it was necessary for the Trust Board to approve the strategy due to its far-reaching implications.

The Trust Board approved the Equality and Inclusion Strategy.

Mental Health Strategy

Kathy Jones reported that the strategy had been developed in response to an internal audit recommendation. A number of the most difficult SUIs involved patients with mental health problems. The Trust Board had asked that Kathy present the strategy to the Board prior to her leaving the organisation.

Beryl Magrath commented that there were generally two types of patients with mental health problems: those in a crisis situation and those who required transport. Beryl commented that each sector should have a referral centre.

Kathy Jones responded that throughout the development of the strategy the appropriateness of the centres nominated in each of the sectors had been assessed and in some cases it was concluded that it was appropriate to convey patients to A&E.

Trust Board members were supportive of the strategy but were concerned about how the action plan would be taken forward, particularly in light of the fact that key members of staff had left the organisation or would be leaving shortly. Kathy Jones responded that it would be picked up as part of the appropriate care pathways project and the Mental Health Steering Group would continue to meet.

The Trust Board also agreed to set some time aside to discuss this at a future meeting. Malcolm Alexander added that the key themes of the debate at the conference last year should also be picked up.

The Trust Board approved the Mental Health Strategy with the caveat that there were further issues to be discussed.

73/10. Questions from Members of Public

There were no members of the public present at this meeting.

74/10. Forward Planner

The Chair requested that the Trust Board scrutinise the forward planner in light of the discussions which had taken place today and put forward items for future discussion. He stated that this was a live document and therefore Trust Board members did not need to wait to the following formal meeting to make a contribution.

75/10. Any other business

The Chair reiterated comments made by Trust Board members that they were happy to

receive papers and reports on issues as they arise, rather than waiting for a formal Trust Board meeting. Trust Board members would therefore be prepared for issues in advance of the meetings. Caroline Silver added that the Trust Board was currently going through a period of transition and would need to refine ways of working. Online and offline briefing would need to form part of this review.

The Chair added that the Trust Board needed to ensure that its meetings covered the right issues.

As this would be her last meeting at the Trust, the Chair made a presentation to Kathy Jones in recognition of her contribution to LAS during her 18 years of service.

76/10. <u>Date of next meeting</u>

The next Trust Board meeting would be held at 10.00 am on Tuesday 29th June 2010 in the Conference Room at LAS HQ. Sarah Waller gave her apologies for this meeting.

It was agreed that the non-executive directors would hold a session prior to this meeting. It had also been suggested that the Trust Board set some time aside after the meeting to discuss the IBP.

ACTIONS
from the Meeting of the Trust Board of Directors of
LONDON AMBULANCE SERVICE NHS TRUST
held on 25th May 2010

MINUTE NO.	PART I MEETING	RESPONSIBILITY	DATE
54/10	**Matters Arising** Caron Hitchen reported that the board development programme included a requirement for health and safety for Trust Board members. Caron had circulated guidance and asked for feedback from members and asked whether Trust Board members felt that it would be beneficial to hold a session on this.	**All**	
54/10	**Matters Arising** Beryl Magrath asked for an estimate of how much work-related injuries cost the Trust each year. Caron agreed to report back to the Trust Board on this.	**CH**	
57/10	**Update from Chief Executive Officer** A paper on ECPs would be presented to the June meeting of the Strategy Review and Planning Group.	**PB**	**SRP Forward Planner 27th July 2010**
57/10	**Update from Finance Director** The Chair commented that in the future the Trust Board would like to see more narrative in this report at the next Trust Board meeting.	**MD**	**29th June 2010**
62/10	**2009/10 Annual Report and Accounts (incorporating Quality Report)** Angie Patton agreed to ensure Trust Board members' biographies were up to date.	**AP**	**Complete**
66/10	**Corporate Social Responsibility Report** Beryl Magrath commented that in paragraph 2.10 of the report it should read that the new lease car policy includes a carbon dioxide limit, rather than a carbon monoxide limit.	**MF**	

66/10	**Corporate Social Responsibility Report** Sandra Adams expressed the opinion that the Trust Board did have an obligation to review the Corporate Social Responsibility Report and agreed to confirm this and come back to the Trust Board.	**SA**	
68/10	**NHS Values and NHS Constitution** Sarah Waller commented that the risk around non-conveyance should be included on the corporate risk register.	**SA**	**Complete**

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

29TH JUNE 2010

PAPER FOR NOTING

Document Title:	**Chief Executive report**
Report Author(s):	**Directors**
Lead Director:	**Peter Bradley**
Contact Details:	**peter.bradley@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**To inform the Trust Board of activities across the Trust**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	That the Trust Board notes the report

Executive Summary/key issues for the Trust Board

This report details activities across the Trust of interest to the Board:

- Changes to Trauma & Stroke care have started well
- Strategic goals, corporate and annual objectives have been updated
- Future reports to Trust Board on the SIP will be by exception
- Performance is good and against three of the Key performance measures is above the national standard and the fourth remains above the agreed trajectory**.**
- Demand is surprisingly high with May activity at 6.8% above last year's figure
- At the end of May the LAS experiencing its busiest week ever- responding to nearly 21,500 calls
- The spend on overtime in May decreased by 34% from last year and this is
- Over 500 staff have completed mandatory training in line with HSE requirements
- Work continues with staff side to implement new rotas. Currently we have 27/69 in place
- Work continues on a variety of initiatives to reduce hospital turnaround times.
- 5 fleet workshops 7 day weeks and extended hours
- The first MacNeillie ambulances have been delivered
- PTS were unsuccessful in their bid for the South London contract affecting 71 staff.
- CommandPoint remains on track for 2011 go-live with the precise details TBC. Factory

acceptance testing is formally completed allowing a 90% payment. Further assurance is expected in August. Budget details are contained in this report.

- Sickness level for April was 4.74% the best monthly level since Oct 09. The annual target is 4.5%
- A considerable shortfall remains in MPET funding
- The improvement notice issued by the Health & Safety Executive has been complied with a and therefore lifted as of 17th June
- A further annual Health & Safety action plan will reported to the Board in due course
- Further details of Health &Safety related reporting are contained in this report
- The new Minister of State for Health Simon Burns made a brief visit to LAS early in June.
- Recipients from the very successful Staff Awards night are detailed in this report
- Various service activities in public education are contained in this report
- Consultation on the development of our estates strategy will be run in conjunction with both FT and Olympics 2012 stakeholder activity.

Attachments

None

Corporate Objectives 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper links to the following strategic risks:

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

NHS Constitution

This paper supports the following principles that guide the NHS:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☒ No

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING 29 JUNE 2010
CHIEF EXECUTIVES REPORT

1. SERVICE DEVELOPMENT

Commissioning

We are currently refining the reporting arrangements against the new contract and a revised PCT pack has been developed. We have successfully delivered against the KPIs and CQUINs required to date. The only area of significant risk at present is performance against hospital turnaround targets.

Healthcare for London

Staff are now routinely taking stroke patients with onset of symptoms within the last three hours to hyper acute stroke units. From July 19th all patients with symptoms of a stroke will be conveyed to a HASU. Recent data for April and May demonstrates that we are currently taking nearly 70% of all patients who have suffered a stroke to a HASU.

Three major trauma centres have now opened in London and in the first 8 weeks approximately 540 patients were conveyed in accordance with the major trauma decision tool. The longest journey time was approximately 50 minutes with the majority being considerably less than this.

Strategic goals and annual objectives

Following the SMG awayday and discussion at the May Trust Board, the strategic goals, corporate and annual objectives have been updated and agreed by SMG and are now incorporated within the IBP. Work is progressing with the development of SMART targets to monitor achievement of objectives and these will be built into the balanced scorecard in the next few months in order to better inform both SMG and the Trust Board of progress towards the strategic goals.

Service Improvement Programme (SIP)

The detailed SIP report will no longer routinely be circulated to the board but will instead take the form of reporting by exception and when a significant stage has been reached that needs board discussion. A quarterly SIP update will be produced and made available to board members but the directors responsible for each of the 3 programmes will continue to give an overview routinely.

As reported previously there is steady progress with most projects but some may need to be reviewed once we have worked through our spending priorities. In summary eight enabling projects are identified as red (in several cases due to pending prioritisation decisions regarding funding):

- *Clinical Development, Leadership and Workforce Programme* - 'Learning Management Systems';

- *Performance and Service Delivery Programme* – 'e-PRF'; 'Annual Leave; 'Event Control'; 'The Intelligent Trust'; 'Inventory Management'; 'Asset Tracking'; 'Starters, Movers and Leavers'.

2. SERVICE DELIVERY

Accident & Emergency service performance and activity

The table below sets out the A&E performance against the key standards for this financial year (2010/11), the complete validated performance for May and the un-validated performance for the first 20 days of June.

	CAT A8	**CAT A19**	**CAT B19**	**CAT C60**
Standard	**75%**	**95%**	**95%**	**90%**
2010/11 yr to date	76.7%	99.4%	91.8%	92.5%
April 2010	77.2%	99.5%	91.0%	92.7%
May 2010	76.0%	99.4%	92.3%	92.4%
June 2010 (to 20th)*	76.8 %	99.4%	92.3 %	92.3 %

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

I am pleased to report that whilst performance for Category A for May was below the agreed trajectory, it remained above the National Standard. The performance for Category B was above the trajectory agreed with Commissioners and the SHA and was the best ever monthly performance for the LAS. Category C performance was again strong and is over 2% above the agreed level with Commissioners. The year to date position against three of the Key performance measures is above the national standard and the fourth remains above the agreed trajectory.

Demand on the LAS has continued to remain above the predicted growth level of 3.5%, with May activity at 6.8% above last year's figure. The overall activity for the year to date is now up by 6.6% with the Category A activity increasing by 5.4%. It is worth noting that the activity levels peaked in the last 2 weeks of May, with the LAS experiencing its busiest week ever- responding to nearly 21,500 calls. The most recent 4 week period has resulted in more incidents than during the peak of swine flu last June. This has resulted in Ambulance utilisation remaining above our ideal of 55%, with April at 71% and May rising to 73%.

Call answering performance for 999 calls answered within 5 seconds for May was 93.5% and for the current year is at 94.1%. This is a slight dip from April's figure, which is broadly as a result of the increased activity in May with a peak of 13,704 calls over the week end of the 22-24th May; the hottest days of the year so far. The increase in the call rate compared to April was an increase of 5.2%-5,551 calls. In addition to the high workload, there have been other reasons for the drop off in call-talking performance, the main one being the need to focus on mandatory training for existing staff. So far this year 174 out of the 270 staff who require it have undertaken MPDS (Call taking) re-certifications, with us on track to finish by August. In addition we have

trained a number of staff in the new radio system to support the expansion in radio talk-groups. To date a total of 255 staff have been trained and there are only 2 more courses for 30 staff planned in the next 2 months. In terms of the quality of call handling, the Quality Assurance compliance of the calls assessed has remained high with 96.2% compliance against the target of 95%.

We produced 134,293 Ambulance Hours resourcing for May this year which was 14,605 hrs more than for the same period last year. This is just over a 12% increase in DCA staffing. FRU hours produced for May decreased by circa 5.8% to 51,242 compared to 54,421 for the same period last year.

Actual planned overtime spend for May 2010 was circa 36.5K hrs. This is a decrease of circa 34% compared to the same period last year when we spent 55.8Khrs on planned overtime. The continued recruitment of additional staff has contributed to this reduction in overtime and also contributed to an increase in DCA production. There is still an increasing lack of appetite for staff to work on FRUs as well as the fact that Team Leaders, who often cover FRUs, are spending considerably more time undertaking their primary responsibilities of CPI completion, staff feedback and conducting Operational Workplace assessments so their input has also fallen. Over 500 staff have also completed a one day training course covering various mandatory training updates stipulated following the HSE visit.

We have previously doubled the number of Airwave Radio talk-groups across all of London from 6 Ambulance Talk groups to 12. This has been a key enabler for the telephone handshake elimination, which means that emergency calls are automatically electronically dispatched by FREDA using the SMS text facility, pan-London, directly to Airwave radio handsets. This has eliminated the need for a telephone call and has resulted in a reduction in activation times across all three operational areas.

There has been a successful trial of reporting resources arriving at the scene of incidents via the Airwave handsets on eight Motorcycle Response Units (MRUs). This has resulted in more accurate red at scene times and will reduce the need for manual updating of call logs. This will now be rolled out across all MRUs and CRUs over the next few weeks.

The rota project continues to make progress against the plan, but there have been some delays in the last month. There are now 27 of the 69 new rotas implemented across the Trust, which is lower than anticipated due to some stations not agreeing to 3am finishes. Work is underway with staff side to work together to resolve these issues and ensure that the cover provided meets the demand on an hour-by hour basis.

The Trust has undertaken some extensive planning for the 2010 World Cup that commenced with the first match on Friday 11th June. The planning approach has been driven by historical data setting out the impact on the LAS from previous international football tournaments, the impact that these have had on demand, performance and borough specific workload. We have also gathered intelligence from other sources that have helped inform our planning approach.

Our strategy is one of limiting the impact on core business and the wider health economy of increased demand for emergency ambulance services during the four week tournament. The planning has specifically targeted the England matches and those where international teams where London has significant numbers of residents from those countries. We have deployed at specific times additional call taking

capacity, dedicated resources for those areas where we expect a high density of patients who are heavily under the influence of alcohol, treatment centres in conjunction with voluntary aid partners, additional core resources and dedicated specially trained staff to deal with patients presenting in dense or hostile crowds.

We have worked with the regional media to ensure the public are aware of the increased pressure the LAS will be under during the period and to appeal to the public to use their ambulance service wisely.

A further test of our Fall Back Control (FBC) is planned for the early hours of the 30th June 2010. This exercise will test both the call taking function and all dispatch functions, including the Airwave radio system. Extensive preparations are taking place to ensure the control room fully replicates the new configuration of the Emergency Operations Centre (EOC) and that all aspects function as planned. We will report back to the Board on the outcome of the test.

Hospital Turnaround remains a key priority for delivery in 2010/11. Although we have not made the progress that we would have liked in this area to date, a number of additional pieces of work are being undertaken at a local level to support improvement. These include local meetings with union representatives to emphasise the necessity of reducing hospital turnaround by 3mins over the course of the year and the development and delivery of local action plans. Other contributing factors are the increase in overall activity, resulting in fewer opportunities to allocate rest breaks, and therefore increased likelihood of ad hoc breaks being taken at hospitals increasing turnaround time. Additional focus has been added in the control room to ensure crews are allocated breaks during quieter times to enable all staff to have planned down time. Local action plans have been provided for those complexes who have yet to see substantial improvement at a local level and these are being robustly performance managed by area teams. In addition we are taking the opportunity to learn from those complexes who are currently performing well in this area.

The new hospital handover alert system, a tool we have developed internally with our Management Information colleagues to support emergency departments to improve turnaround as well as our own, has now gone live on two sites. Whipps Cross and Charing Cross emergency departments both implemented this new system during the week commencing 7th June and so far the human and technical changes required are both working well. These include working with emergency department colleagues to identify where increased demand may result in delayed handover and creating proactive systems to manage this. Provided the proof of concept phase continues to be successful over the next few weeks a larger pilot is planned over the summer with full roll out due before the winter.

There are now 5 Fleet Workshops working 7 day rotas with extended hours of cover from Monday to Friday up until 10pm and from 7 am to 5pm on Saturdays, Sundays and Bank Holidays. We have now taken delivery of 3 new Ambulances from our new vehicle converters (MacNeillie's) and we are scheduled to continue at the rate of 2-3 per week from now on.

2.1 PATIENT TRANSPORT SERVICE

The loss of the South London Healthcare NHS PTS contract affects a total of 71 people. Initial group and individual 1 to 1 meetings have been held and staff are being advised of their rights under the Transfer of Undertaking (Protection of Employment) regulations 2006.

No official transfer date has been received from the customer. However, following a meeting with Savoy Ventures Limited, the successful bidder, we are working towards a handover date of 1 September 2010.

Activity increased by 500 journeys in May to 24,238. This remains approximately 2000 journeys less than predicted. Additional income has been generated to compensate via Extra Contractual Income.

Performance against the three main quality standards in May are shown below:

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

3. IM&T UPDATE

CommandPoint Project

The project remains on track for a go-live in 2011. It has commenced the second stage of testing , known as Site Integration Testing and involves the testing of the actual system interfaces on site in London with the live interfaces. To date, the work is progressing well.

1: Factory Acceptance Testing (FAT)

The first formal stage of testing, the Factory Acceptance Test was successfully completed on Monday 14 June. This completed a 2 stage process that was undertaken on NG premises in the USA and was witnessed by LAS staff. John Downard, Senior Technical for the project led the LAS team on site throughout the process. The functional testing results, compared to the contract were as follows:

	P1 (Critical)	P2 (Major)	P3 (Minor)	P4 (Cosmetic)
Contract	0	0	20	125
Results	0	0	16	40

This clearly constitutes a pass in terms of the contractual requirements for FAT.

As part of the SLA for the live system, CommandPoint has to be capable of certain performance criteria (e.g a throughput of 700 calls per hour). During the FAT process it was noted that certain aspects of the performance monitoring did not demonstrate this (although not technically a requirement of FAT). It was also noted that this may not be an issue with the CommandPoint system, but with the LAS systems to which it is interfaced. NG are investigating further and will produce a conclusive report that will isolate the issue(s) and identify the necessary action plan.

In the spirit of partnership and in order to maintain a clear focus on the future system requirements it has been agreed that while the LAS will issue the FAT pass certificate, we would holdback 10% of the FAT payment until NG produce a conclusive report into the performance issue. It is planned that the 90% payment will be made before the end of June, and the final 10% payment on production of the report during August 2010.

2: Timetable and Site Ingeneration Testing (SIT)

While work has been ongoing with FAT, a fundamental review of the project timetable has been undertaken. This includes allowances for the additional functionality that the LAS have requested and the delay caused by FAT. It also has looked to de-conflict certain areas of the current plan to allow more flexibility in the overall timetable. Final reviews are currently being undertaken with respective project teams to agree precise details and the new go-live date.

3: Budget

The overall financial data for the project is set out in the table below.

	2009/10		**2010/11**	**2011/12**
	Actual	Budget	Budget	Budget
	£000	£000	£000	£000
Capital	6,496	6,462	3,399	-
Revenue	520	974	2,479	3,665
Contingency	-	2,278	1,127	-

3.1: The spend for 2009/10 included an accrual for the FAT Milestone payment (£2,520k plus VAT), that was due in March 2010. The accrual was raised in recognition that Northrop Grumman had completed the work but that the number of bugs was greater than allowed in the contract. Based upon the final FAT results detailed above, the 90% payment will be £2.2M.

3.2: The budget for 2010/11 include a sum to cover the cost of LVM/Dynamic Deployment as it was known when the FBC was completed that this issue needed to be resolved but at the time of the tender no decision had been taken on the way forward.

3.3: The budget for 2010/11 and 2011/12 are based on the 22nd February 2011 cut-over date, so this will require reprofiling once the new timetable is finalised.

3.4: The budget for 2011/12 includes depreciation (£2,358k), internal financing charges (£420k) and loan interest (£263k). The only other large item is the service charge paid to Northrop Grumman (£236k).

3.5: The delay in producing the software and, consequent, delay in 'Cutover' will cost the project about £120k per month. The costs in EOC of the additional staff to cover the training and the Cutover period amount to a further £35k per month. However, this will almost totally be offset by significant reductions in depreciation and internal financing costs.

3.6: Notwithstanding the above the project is still well within the overall cost envelope set by the FBC as none of the contingency was used in 2008/09 or 2009/10.

3: CTAK Failure

For completeness, brief details of a CTAK failure are included within this section. On Wednesday 16 June, CTAK failed at 14:25, due to the nature of the failure, and immediate availability of IM&T staff, a fast restoration of service was achieved and service restored at 14:45. The cause of the problem was a problem within the Informix database. The suppliers IBM have acknowledged the issue and are undertaking further analysis.

4. HUMAN RESOURCES

Workforce Plan implementation

The A&E funded establishment for 2010/11 is 3433. Vacancies as at the 31 March 2010 are reported at 144wte. Recruitment to A&E Support staff is on track with all places filled until October 2010. University recruitment anticipated at 65wte will occur following completion of training from August onwards.

We still have 173 Student Paramedics to come out initial training between June and September.

Recruitment to the Emergency Operations Centre is on track with all but places allocated for the whole year.

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.

Sickness levels in April are reported at 4.74%. This is the best monthly level since October 2009 but is against an annual target of 4.5%. Trust managers will continue to focus on robust management of sickness absence supported by the Trust's wellbeing strategy to work towards achieving this target.

Staff turnover remains low at 5.64% for the year as at May 2010.

Development of the MPET funding SLA

The SHA have offered an allocation of £2.25m to support the ongoing salary costs of Student Paramedics in training across the three year programme. This is against an actual funding requirement of £5.3m. No SLA has yet been submitted by NHSL which we have requested as matter of urgency. The financial control total and internal savings requirements have been adjusted accordingly.

Partnership working, staff engagement and joint consultative arrangements

Following the most recent meeting of the Staff Council, a separate meeting with senior representatives was held to give a more detailed briefing and information regarding the current financial situation and pressures; procurement expenditure and arrangements; and potential options for the future estates strategy.

Consultation continues via the Operational Partnership Forum on a range of issues, including the roster review, active area cover arrangements, review of the rest break agreement and A&E Support/Urgent Operations Centre.

At the Healthcare People Management Association (HPMA) awards on 17 June the Trust was awarded Runner Up in the national finals of the Health and Safety Executive-sponsored award for best practice in managing workplace stress for the LINC peer support scheme.

This is a national (UK-wide) healthcare award, and the first time we have tried for an award for our staff support work. It represents well-deserved recognition of the great work of the Staff Support team and of all LINC workers. We were the only ambulance Trust to be nominated at the awards night.

Health and Safety

A formal update was sent on 16 June on the actions taken to respond to the Improvement Notice issued by the Health and Safety Executive following the formal inspection visit undertaken in March. On 17 June Mr John Crookes, HM Inspector of Health and Safety, advised that he was satisfied that compliance with the notice had been achieved and, consequently, the Notice would be lifted. A full and formal response was to follow.

As part of the on-going Trust response to the Improvement Notice and associated report and recommendations, a further meeting with Mr Crookes is to be arranged to provide detail of all actions taken to deal with his recommendations. As part of that process, the Health, Safety and Risk team will prepare an annual health and safety action plan, which will be reported to the Board.

Reported levels of adverse incidents for the 12-month period April 2009 to March 2010 against the key categories of clinical incidents, manual handling incidents, and physical and non-physical assault are included in the table below.

2009/10	Lifting Handling Carrying	Clinical Incident	Non Physical Abuse	Physical Violence	Total
Apr	52	85	109	22	268
May	66	102	104	26	298
Jun	39	97	78	33	247
Jul	31	94	106	29	260
Aug	35	74	79	41	229
Sep	47	83	67	24	221
Oct	62	114	93	35	304
Nov	63	131	93	35	329
Dec	48	109	80	35	272
Jan	39	119	80	33	271
Feb	38	134	73	27	282
Mar	31	116	75	27	249
Totals:	519	1026	972	337	3230

Over this period there is no reliable discernable trend in overall incident reporting, although in recent months there appears to have been a slight increase in clinical incidents and decrease in reports of non-physical abuse. These areas will be monitored closely to check the longer-term trends and investigate reasons for any changes.

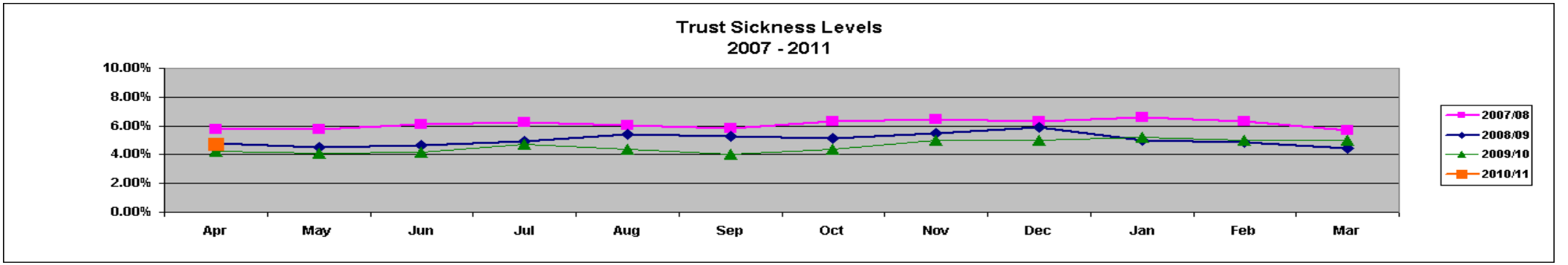
Concern remains that a small number (up to about 10 per month) of incident reports are subject to potentially significant delay in being received by the Health and Safety

team. The current review of incident reporting arrangements and processes will seek to improve this by, amongst other things, introducing electronic reporting arrangements. Meanwhile, the Health and Safety team continues to work with local managers to encourage timely reporting of all incidents, and where late reports are received, these are included in the above updated totals.

A formal meeting with the Medicines and Healthcare products Regulatory Agency (MHRA) has been held and agreement reached on a pilot scheme to improve reporting of notifiable incidents. Learning and outcomes will be shared nationally.

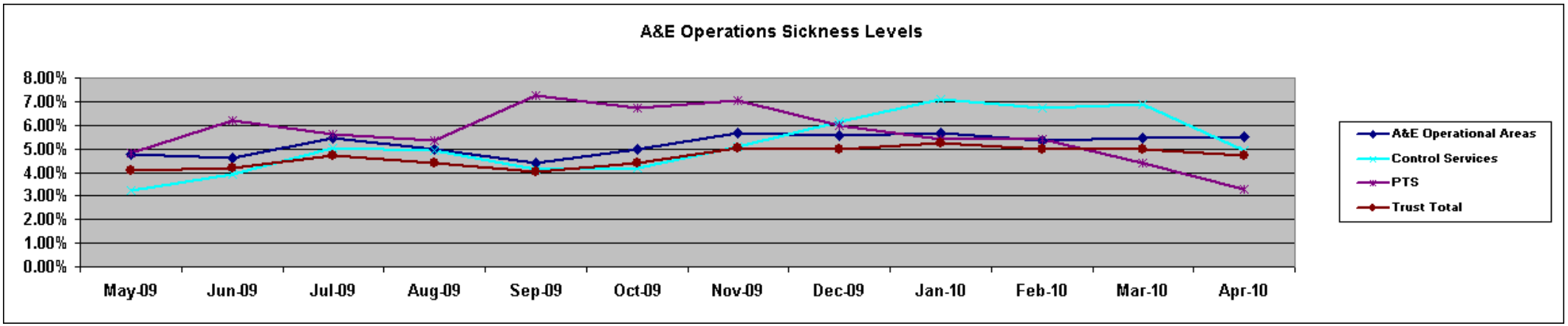
Trust Sickness Levels

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%	4.19%	4.70%	4.39%	4.03%	4.38%	5.01%	4.99%	5.24%	4.99%	4.98%
2010/11	4.74%											



A&E Ops Sickness Levels

	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	Calendar YTD	Financial YTD
A&E Operational Areas	4.76%	4.61%	5.46%	4.98%	4.41%	4.96%	5.65%	5.55%	5.66%	5.36%	5.46%	5.50%	5.20%	5.50%
Control Services	3.25%	3.92%	5.03%	4.95%	4.14%	4.20%	5.09%	6.14%	7.10%	6.72%	6.89%	4.95%	5.21%	4.95%
PTS	4.84%	6.20%	5.62%	5.36%	7.25%	6.72%	7.03%	6.01%	5.39%	5.39%	4.42%	3.26%	5.63%	3.26%
Trust Total	**4.07%**	**4.19%**	**4.70%**	**4.39%**	**4.03%**	**4.38%**	**5.01%**	**4.99%**	**5.24%**	**4.99%**	**4.98%**	**4.74%**	**4.64%**	**4.74%**



Staff Turnover

Staff Groups	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	Feb-09/Jan-10	Mar-09/Feb-10	Apr-09/Mar-10	May-09/Apr-10	Jun-09/May-10
A & C	11.56%	10.03%	10.91%	9.94%	9.55%	8.70%	8.62%	9.36%	9.38%	9.28%	9.48%	8.86%
A & E	4.50%	4.34%	4.59%	4.49%	4.36%	4.28%	4.29%	4.22%	4.29%	4.61%	4.93%	5.12%
CTA	2.44%	4.88%	2.38%	4.26%	4.35%	3.92%	4.35%	3.77%	4.00%	3.57%	3.64%	3.45%
EOC Watch Staff	9.55%	10.54%	10.10%	9.30%	8.87%	8.91%	8.78%	8.70%	8.54%	8.78%	9.16%	9.48%
Fleet	8.47%	8.47%	8.62%	8.62%	3.45%	1.79%	1.72%	1.79%	5.56%	8.77%	8.62%	10.53%
PTS	9.05%	8.64%	8.68%	7.50%	6.25%	6.84%	6.47%	5.65%	6.14%	6.67%	7.59%	7.62%
Resource Staff	4.17%	4.17%	4.17%	8.33%	8.51%	7.84%	8.51%	8.00%	6.12%	3.77%	5.66%	7.84%
SMP	5.24%	5.43%	5.05%	5.15%	4.92%	4.42%	4.26%	3.37%	3.16%	2.31%	2.74%	2.29%
Trust Total	**5.77%**	**5.64%**	**5.78%**	**5.58%**	**5.28%**	**5.12%**	**5.09%**	**4.95%**	**4.99%**	**5.18%**	**5.54%**	**5.64%**

A&E Establishment as at May 2010

Position Titles	Staff in post(Fte)	Funded Est.	Variance		Leavers
Team Leader Paramedic	164.83	194.00	29.17		1.00
ECP	64.96	74.00	9.04		0.00
Paramedic	899.84	1047.00	147.16		6.00
EMT 2-4	1097.34	956.00	-141.34		5.00
Student Paramedic 1	198.00	404.00	-188.00		3.00
Student Paramedic 2	394.00				0.00
Student Paramedic 3	114.00	300.00	185.00		0.00
Student Paramedic 4	1.00				0.00
EMT 1	20.64	328.00	28.30		0.00
A&E Support	279.06				2.00
EMD1	111.57	54.00	-57.57		1.00
EMD2	101.86	90.55	-11.31		1.00
EMD3	73.78	100.76	26.98		0.00
EMD Allocator	67.67	78.00	10.33		1.00
CTA	54.77	50.00	-4.77		0.00
Total	**3643.32**	**3676.31**	**32.99**		**20.00**

5. COMMUNICATIONS

Issues management

Demand management – World Cup: A media handling strategy has been developed to support the Service's planning for the World Cup.

Ahead of the first matches, messages around anticipated demand were issued to media, focussing on call rate figures from past tournaments and giving advice on how to choose the right NHS services. This generated coverage in local London papers and the Evening Standard. LBC did a pre-recorded interview with Deputy Director of Operations Jason Killens, and BBC Radio London interviewed Ambulance Operations Manager Gareth Hughes live on the drive time show.

Planned interviews for 18 June include ITV London – an interview with Jason Killens in the control room and filming on a 'booze bus', and BBC Radio London – a ride-out on the 'booze bus'.

Public affairs

Visit by new Minister of State for Health: Simon Burns MP visited the Service earlier this month. Mr Burns met with the Chief Executive and senior managers to discuss current issues before being given a tour of the Service's control rooms and meeting an ambulance crew. A news release was issued to London media and specialist publications following the visit.

London Assembly – Olympic planning: Chief Executive Peter Bradley and Head of Olympic Planning Peter Thorpe appeared alongside police and fire representatives at a London Assembly meeting looking at preparations for the Games in 2012. Issues discussed including staffing, the increase in demand, and the need to maintain business as usual to the rest of London. BBC London TV subsequently carried a report quoting the Service as being "disappointed" that St John Ambulance had not been chosen as the medical provider inside the venues.

Staff recognition

LAS Awards: Almost 250 staff attended the LAS Awards 2010 to celebrate the achievements of their colleagues. The event, held at the Grand Connaught Rooms on 10 June, recognised the work of staff who had been nominated by the people they work with.

Over dinner, patients were reunited with the crew staff who had treated them, before taking to the stage to hand over framed certificates to the winners and runners-up.

This year's award winners and highly commended were:

Accident & Emergency Person of the Year

Winners:	Peter Appleby, Emergency Care Practitioner, Friern Barnet and Rachael Yates, Team Leader, Camden
Highly commended:	Anthony Allen, Emergency Care Practitioner, West Ham

Control Services Person of the Year

Winner:	Mark Libby, Emergency Medical Dispatcher
Highly commended:	Kelly Williams, Emergency Medical Dispatcher Allocator

Manager of the Year
Winner: Paul Ward, Ambulance Operations Manager, Chase Farm
Highly commended: Tony O'Hanlon, Area Controller, Emergency Operations Centre

Patient Transport Service Person of the Year
Winner: Carol Norris, PTS Controller, Urgent Operations Centre
Highly commended: Chris Burry, PTS Team Leader, Greenwich

Support Services Person of the Year
Winner: Viv Bennett, Station Administrator, Deptford
Highly commended: Dave Lecomber, Logistics Support Officer, Waterloo HQ

Trainer of the Year
Winner: Andy Summers, Training Officer, Bromley
Highly commended: Chris Hawkswell, Training Officer, Bow

New Recruit of the Year
Winner: Anna Nguyen, Emergency Medical Dispatcher
Highly commended: Vinh Phan, Student Paramedic

Funeral of a member of staff: Around 200 people including family, friends and work colleagues attended the Service funeral of Simon Griffin this month. Simon, an emergency medical technician at Deptford, died at home on 11 May. Members of the motorcycle response unit escorted the funeral cortege and there was a fly-past by the air ambulance.

Media

The Edgware Times and Barnet Today reported on a complaint about the Service's handling of a 999 call in June 2009, which has been previously covered by the media. The call was correctly categorised as Category C, and referred to NHS Direct. An out-of-hours GP attended and called an ambulance, but the patient sadly subsequently died in hospital two days later.

PPI and Public Education activity report

Public education:

- The first module of the public education staff development programme took place from 7th to 10th June. Feedback was the best ever received for this course, and the participants are now looking forward to the next module in July. In Module 1 they had sessions on reflective practice, personality types, presentation skills, diversity, communication and key messages. One participant said "this is the best course I've ever done."

- Recent public education activities have included school visits and careers events, an open day for retired staff, basic life support training sessions in Tower Hamlets, crime prevention events, a synagogue visit, community events, pensioners forums, a family fun day and the annual charity 'ambulance pull' in Tooting.

- A DSO at Wimbledon, Taff Roberts, has acted as an advisor to a company which makes 'bag books', aimed at sensory-impaired children and young people. Members of the materials sub-group of the public education strategy steering group have now seen a prototype of the book, which tells a story about a child needing to call an

ambulance in a very original and multi-sensory way.

- The Service organised a multi-agency pan-London event focusing on knife crime reduction in early June. Key people across London who are working on knife crime initiatives came together at Millwall FC to share information and consider how to make a greater impact with their work across London. The event was attended by LAS staff and external partners in equal number, and a key note address was given by Neville Lawrence, father of Stephen Lawrence. A number of ideas about possible joint initiatives were expressed, and this work will be taken forward through the knife crime sub-group of the public education strategy steering group.

Prince's Trust:

- At the end of May an event was held, bringing together staff who had taken part in the Prince's Trust secondments and some of their line managers. The aim of the day was to give secondees an opportunity to talk about their experiences, and to consider how they may use their knowledge and experience to good effect now they are back in the Trust. A number of them attended the knife crime event mentioned above.

Patients' Forum:

- In mid-June a meeting was held with members of the Patients' Forum who have expressed an interest in doing observation shifts and station visits, to prepare them for this level of involvement in our front-line services. The meeting was attended by 10 Forum members.

Strategic Plan update – Consultation process

.

To further develop our draft strategic estates plan, we plan to consult extensively with a range of stakeholders including:

- PCTs
- Local authorities
- Patient groups
- Staff
- FT members

Over the next three months, we will run a series of events to engage and involve the relevant stakeholders from both a local and London perspective. We plan to combine this work with both FT and Olympics 2012 stakeholder activity.

We have already started the process with our staff representatives.

The clear aim of the strategy is to improve the quality of the estates infrastructure and align it with the planned, improved operating model.

Peter Bradley CBE
Chief Executive Officer

21 June 2010

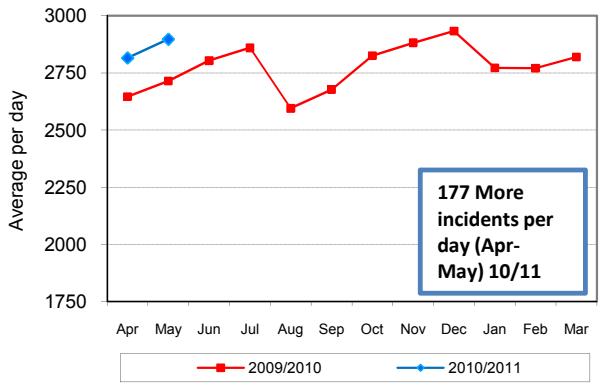
London Ambulance Service
NHS Trust

Information Pack for Trust Board

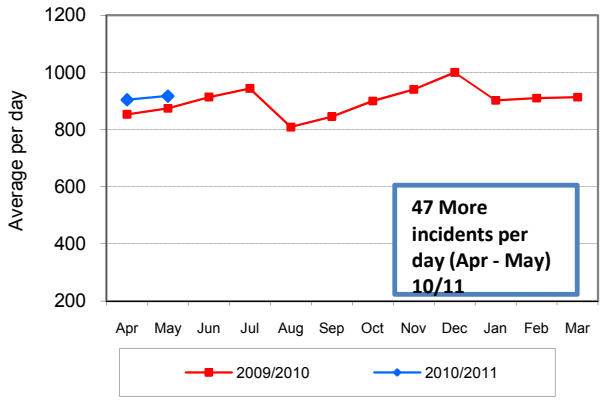
May 10

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

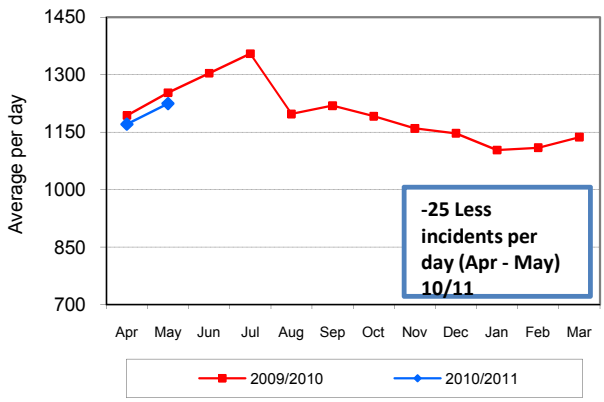
Graph 1
Average number of Cat A, B & C incidents per day



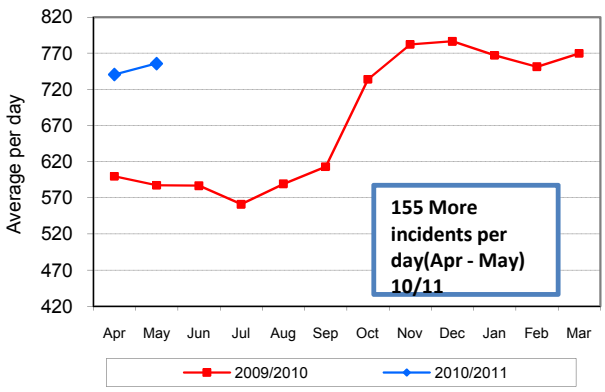
Graph 2
Average number of Cat A incidents per day



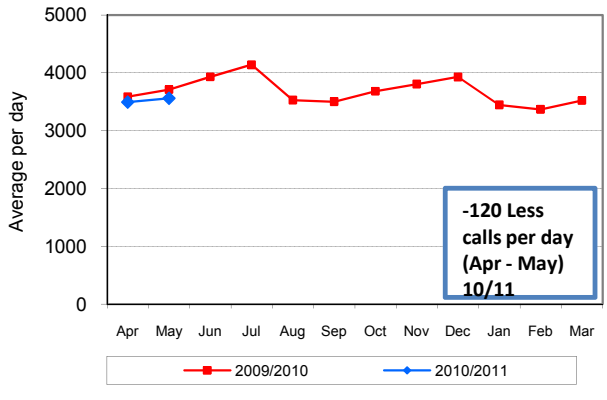
Graph 3
Average number of Cat B incidents per day



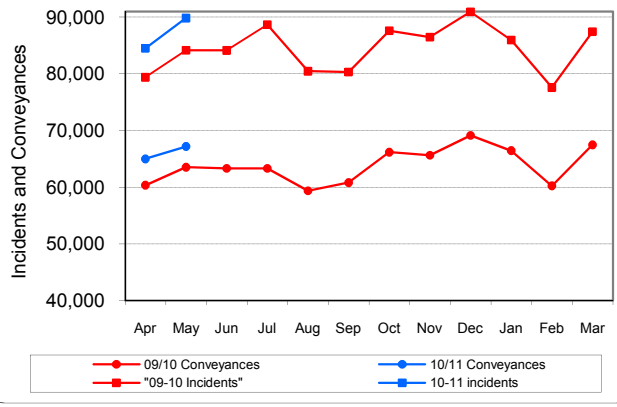
Graph 4
Average number of Cat C incidents per day



Graph 5
Average number of 999 calls received per day

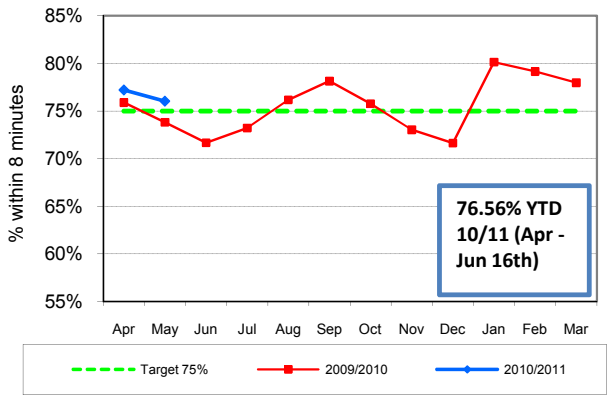


Graph 6
No of incidents conveyed

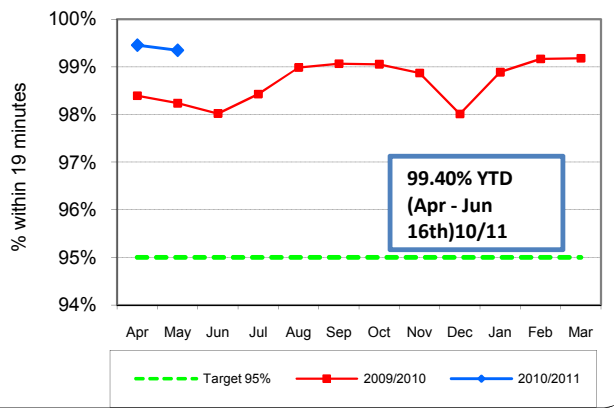


London Ambulance Service NHS Trust
Accident and Emergency Service
Performance - May 2010

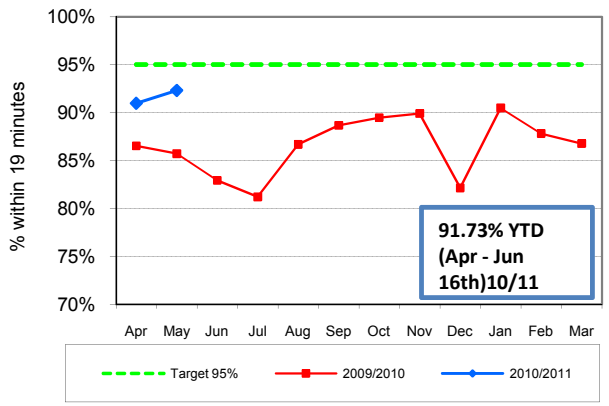
Graph 7
Category A 8 minute performance



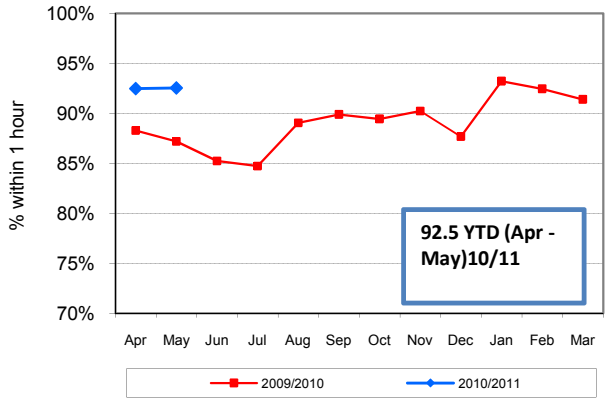
Graph 8
Category A 19 minute performance



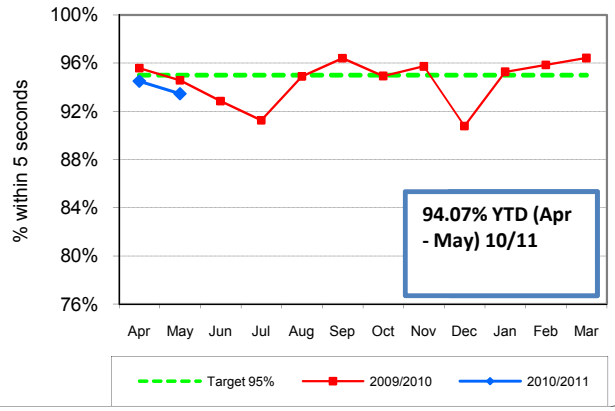
Graph 9
Category B 19 minute performance



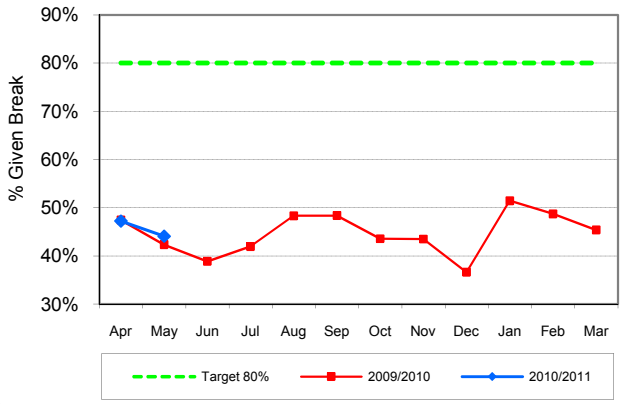
Graph 10
Category C incidents (excluding card 35) responded to within 1 hour (call connect to arrive scene)



Graph 11
Percentage of calls answered within 5 seconds

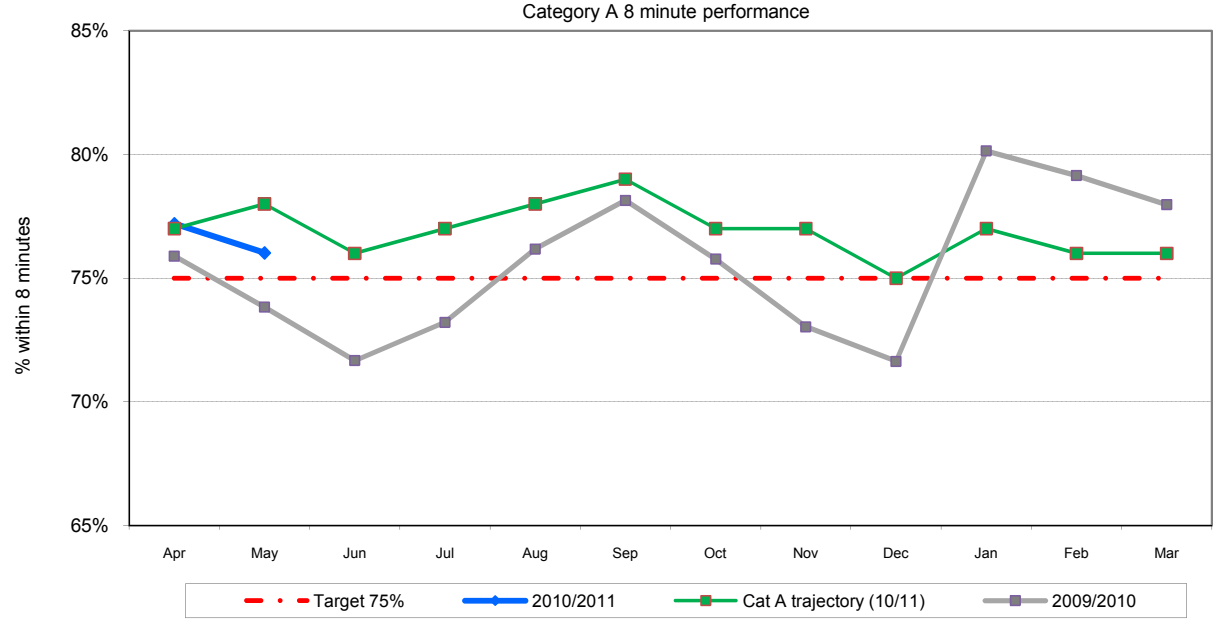


Graph 12
Rest Breaks Given

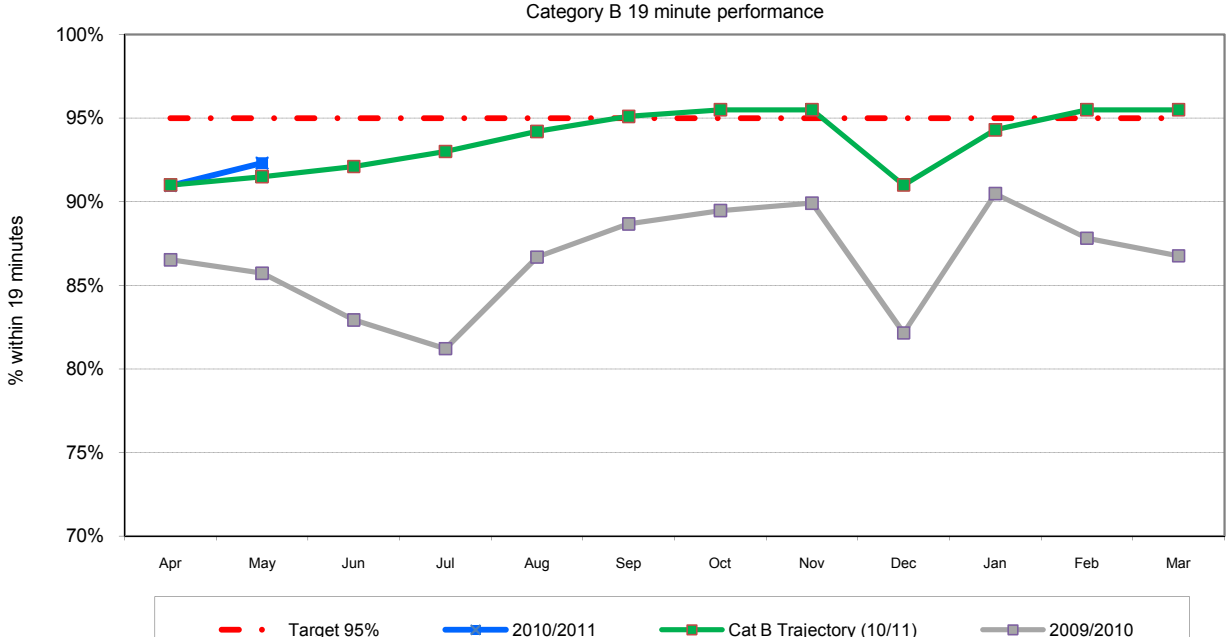


London Ambulance Service NHS Trust
Accident and Emergency Service
Performance - May 2010

Graph 13
Category A 8 minute performance

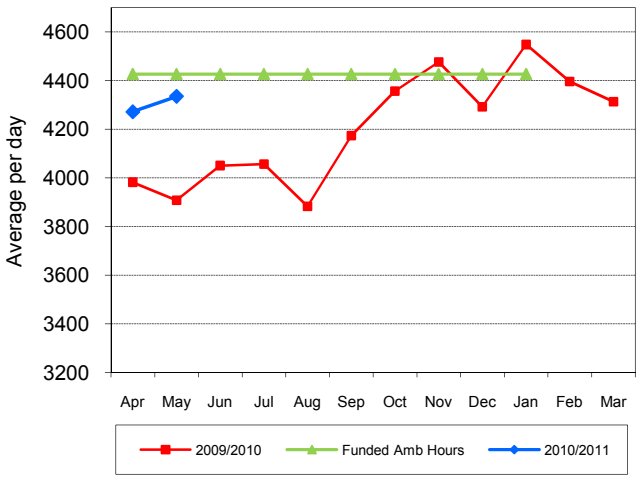


Graph 14
Category B 19 minute performance

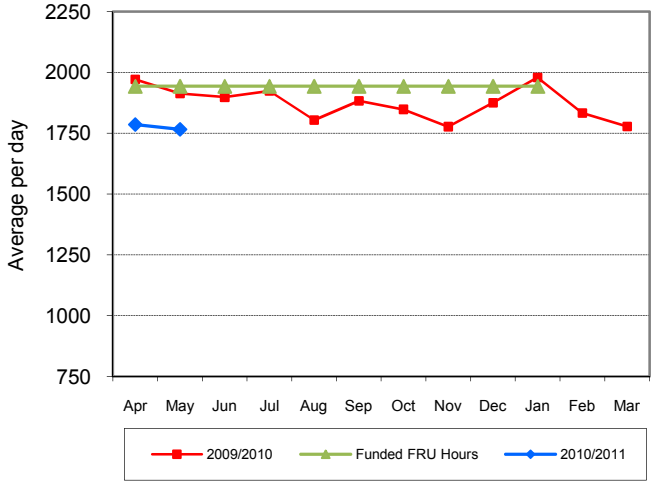


London Ambulance Service NHS Trust
Accident and Emergency Service
Efficiency and Effectiveness - May 2010

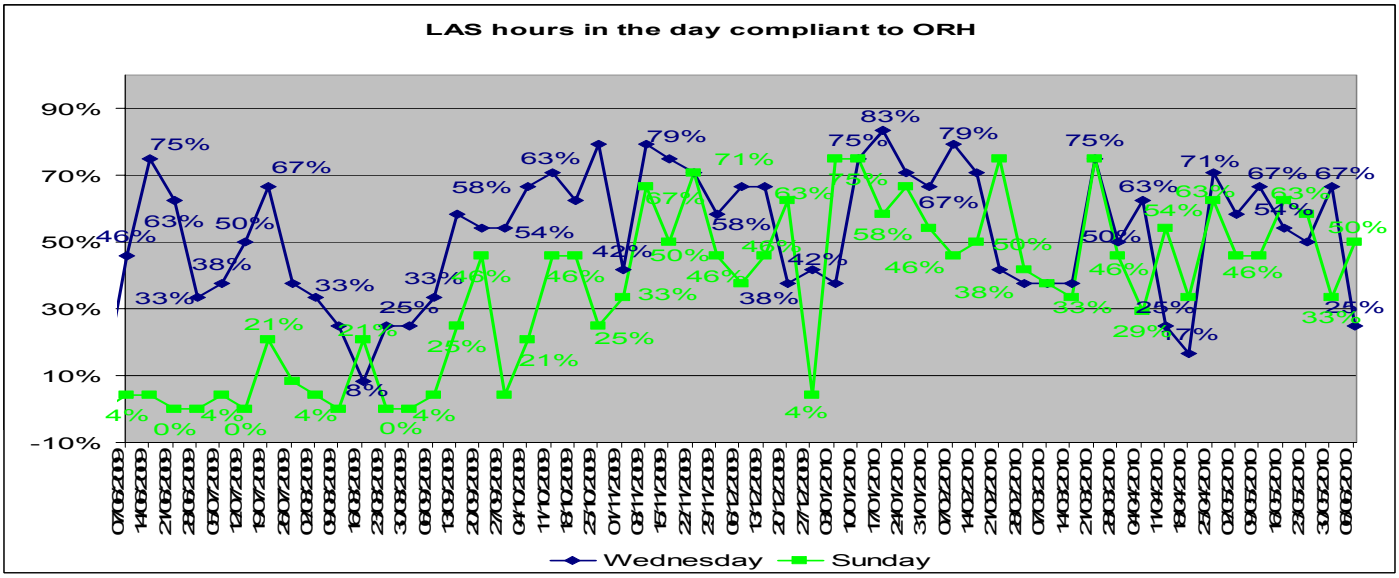
Graph 15
Ambulance Hours average available per day



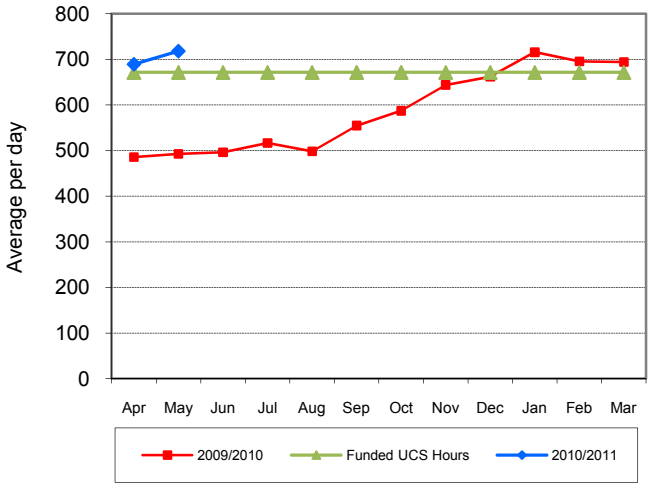
Graph 16
FRU hours average available per day



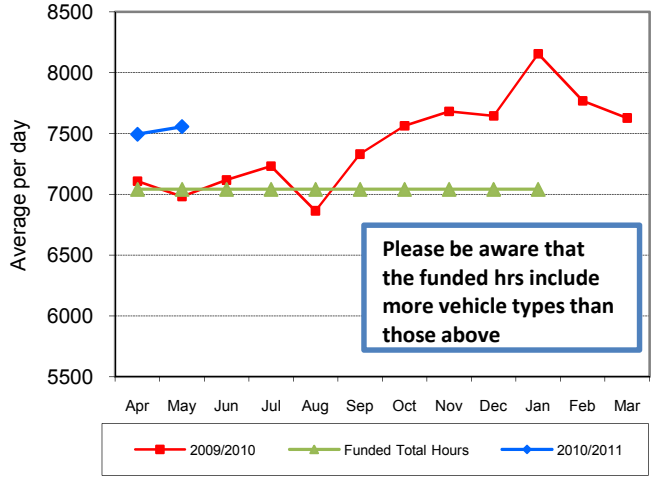
LAS hours in the day compliant to ORH



Graph 17
UOC Hours average available per day



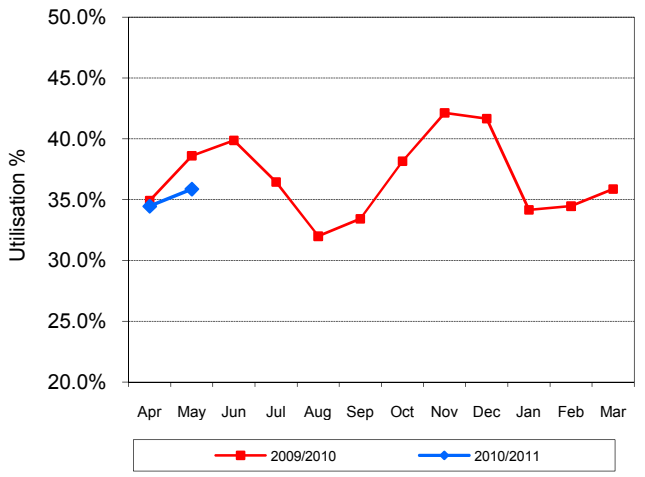
Graph 18
All Vehicle Hours average available per day



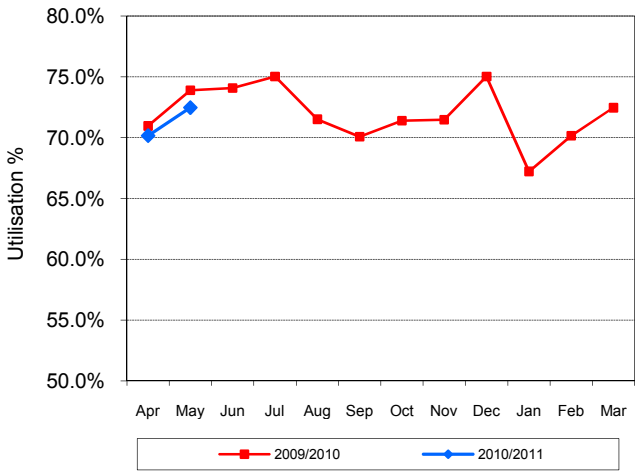
includes other vehicle types other than those

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

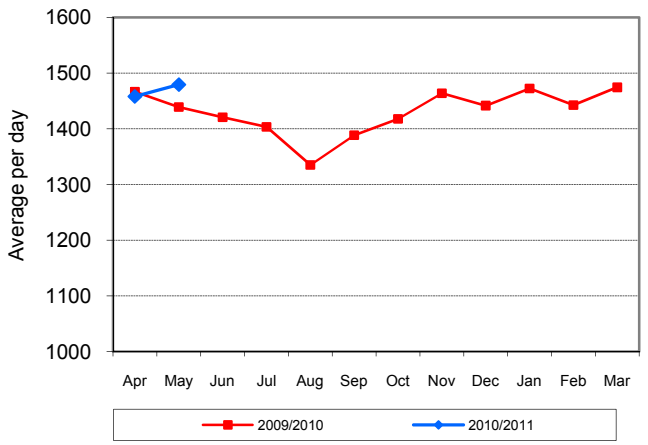
Graph 19
FRU Utilisation



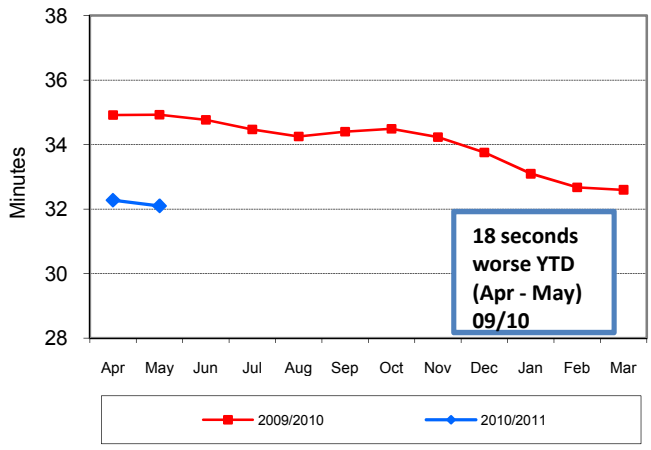
Graph 20
Ambulance Utilisation



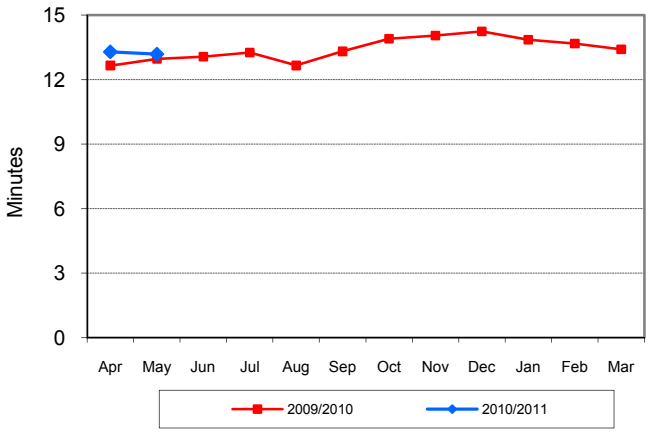
Graph 21
EOC hours staffed per day



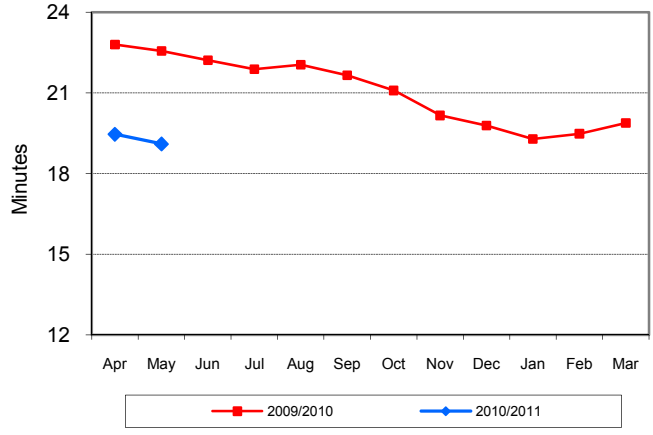
Graph 22
Average hospital turnaround time



Graph 23
Average Arrival at Hospital to Handover (Mins)

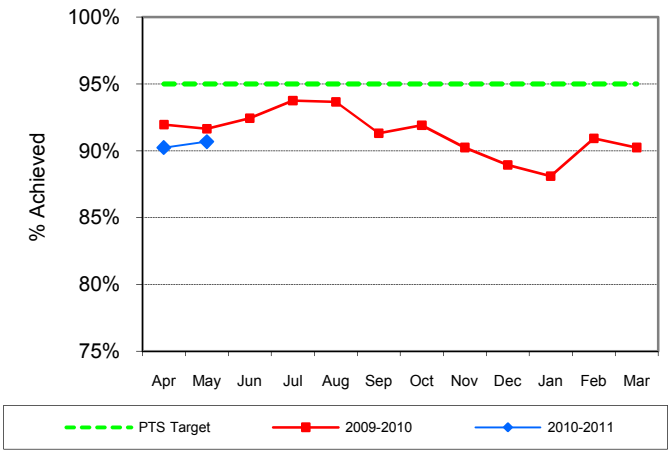


Graph 24
Average Handover to Green (Mins)

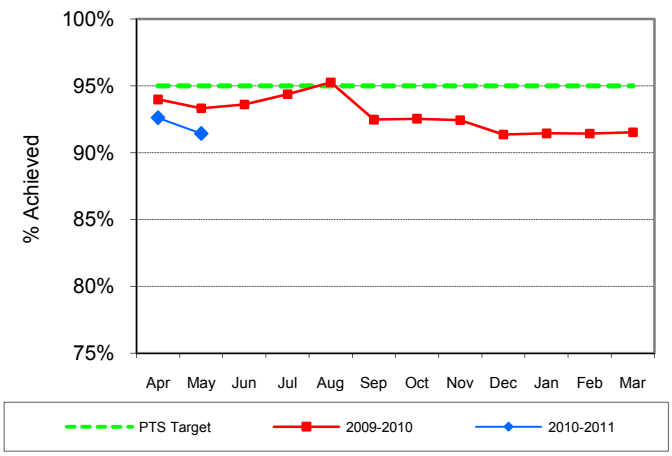


London Ambulance Service NHS Trust
Patient Transport Service
Activity and Performance - May 2010

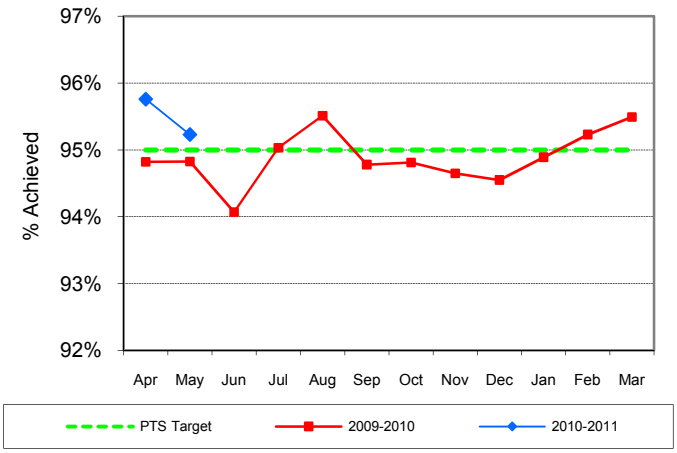
Graph 25
Arrival at Hospital Against Appointment Time



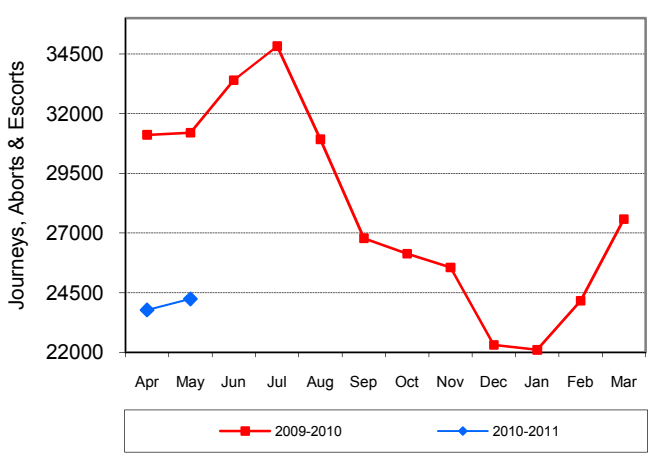
Graph 26
Departure Against Ready Time



Graph 27
Time spent on Vehicle



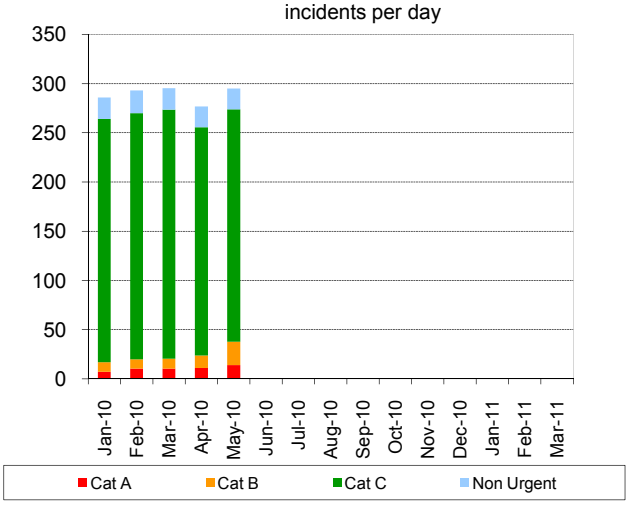
Graph 28
PTS Total Activity



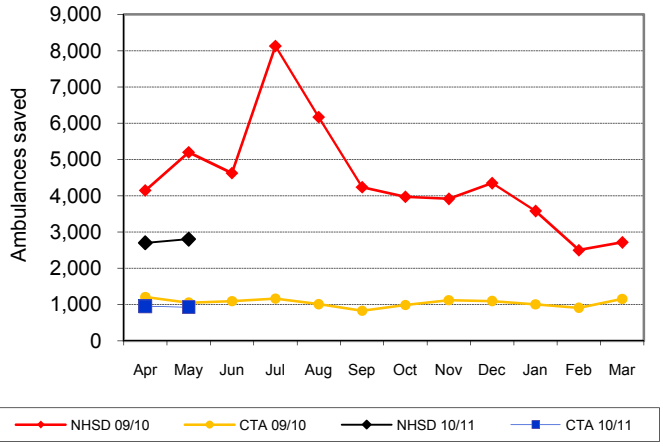
London Ambulance Service NHS Trust
Accident and Emergency Service
UOC Effectiveness - May 2010

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

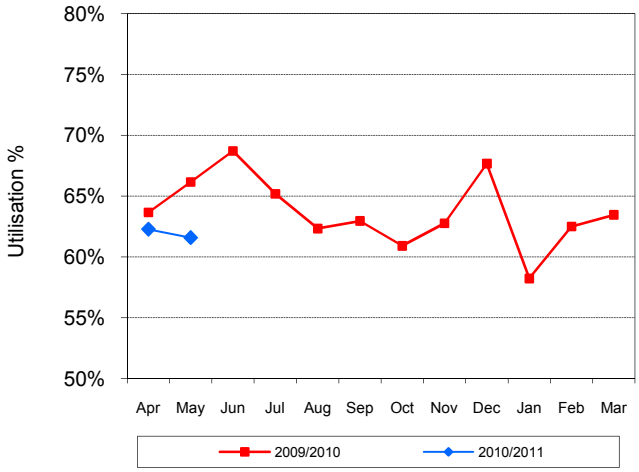
Graph 29
CAT A, B & C Workload by Urgent Care Vehicles average incidents per day



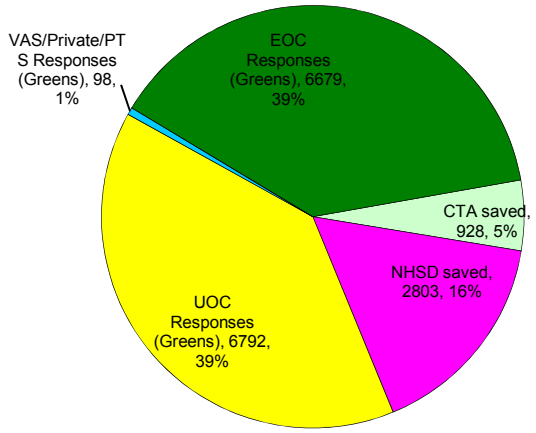
Graph 30
CTA/NHSD Ambulances saved



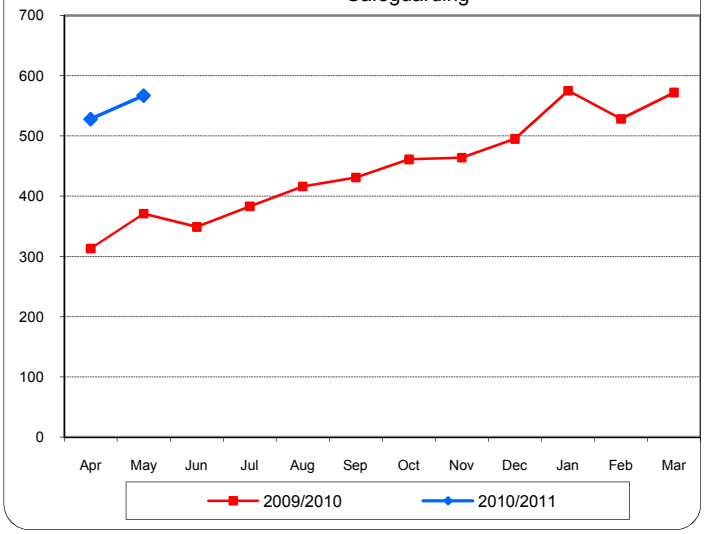
Graph 31
UOC Utilisation



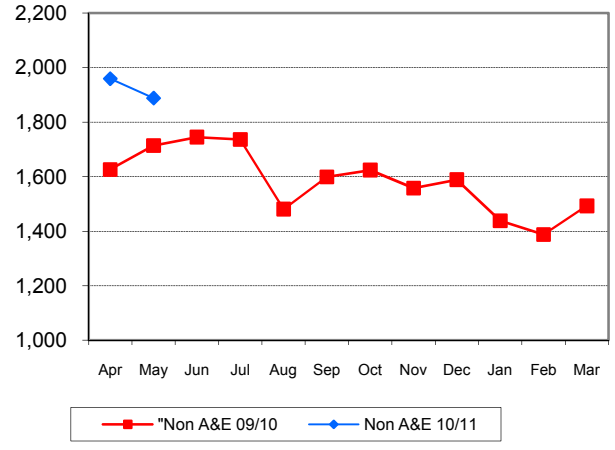
Graph 32
Green resolution - May 2010



Graph 33
Safeguarding



Graph 34
Patients conveyed to Non A&E hospital - LAS



London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

M02 May

PAPER FOR REVIEW

Document Title:	**M02 May - Financial Review**
Report Author(s):	Andy Bell
Lead Director:	Mike Dinan
Contact Details:	Michael.Dinan@lond-amb.nhs.uk
Why is this coming to the Trust Board?	Monthly Trust Financial Review
This paper has been previously presented to:	Senior Management Group
Recommendation for the Trust Board:	To be noted

Executive Summary/key issues for the Trust Board

- The in month position for the Trust is a £316k surplus against a planned surplus of £369k. The year to date position for the Trust as at 31st May 2010 is a £566k surplus against a planned surplus of £927k. The trust currently expects to achieve a forecast position of £517k surplus against a planned outturn of £503k surplus. The trust is on target to meet its financial control figure. Please refer to Page 3 in the board report for further detail.

- The current identified financial risk for the trust is £7.7m. This amount has not been recognised in the LAS financial forecast. For a detailed analysis of financial risk please see Page 6 in the board report.

- The CIP program is currently on track to deliver the full £18.6m savings program. Further work on achieving Subsistence and Non frontline payroll savings are ongoing. For more detail please see Page 7 of the board report.

- The LAS has not yet received final confirmation of available Capital funding for 2010/11. A planned figure of £22.7m will be used until confirmation is received. The Capital Plan can be found on Page 8 of the board report.

- The current cash position is £4.2m. This is mainly due to the receipt of £5.9m for the sale and lease back of ambulances. The Trust expects to make Command Point milestone payments in the coming period. Please see Page 9 for further information.

- The PTS year to date result is a £50k profit. This is broadly in line with the annual planned profit of £350k.The impact of the loss of the South East London Contract is currently being evaluated.

Attachments

Report Contents

Corporate Objectives 2010 – 13
This paper supports the achievement of the following corporate objectives:

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

Risk Implications
This paper links to the following strategic risks:

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

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

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

No

Key issues from the assessment:

LAS Financial Review - Financial Summary

Month Ending 31st May 2010 - (Month 2)

Month M02 May				Summary	Ytd M02 May				2010/11			
Act £000	Plan £000	Diff £000	%		Act £000	Plan £000	Diff £000	%	Act £000	Plan £000	Diff £000	%
				Income								
21,423	21,593	-170	-0.8%	A&E	42,846	43,186	-340	-0.8%	258,773	259,113	-340	-0.1%
2,252	1,750	502	28.7%	Other	4,707	3,501	1,206	34.4%	21,825	21,004	821	3.9%
23,675	**23,343**	**332**	**1.4%**	**Total**	**47,552**	**46,686**	**866**	**1.9%**	**280,598**	**280,117**	**481**	**0.2%**
				Operating Expense								
17,339	16,855	484	2.9%	Pay	34,729	33,521	1,208	3.6%	204,544	206,183	-1,639	-0.8%
4,614	4,445	169	3.8%	Non Pay	9,443	8,890	554	6.2%	55,391	53,338	2,054	3.9%
21,952	**21,300**	**652**	**3.1%**	**Total**	**44,173**	**42,411**	**1,762**	**4.2%**	**259,936**	**259,521**	**415**	**0.2%**
1,722	**2,043**	**-321**	**-15.7%**	**EBITDA**	**3,379**	**4,275**	**-896**	**-21.0%**	**20,662**	**20,596**	**66**	**0.3%**
7.28%	8.75%	-1.48%	-16.9%	EBITDA %	7.11%	9.16%	-2.05%	-22.4%	7.36%	7.35%	0.01%	0.1%
1,406	**1,674**	**-268**	**-16.0%**	**Depreciation, Dividend & Interest**	**2,814**	**3,349**	**-535**	**-16.0%**	**20,146**	**20,092**	**53**	**0.3%**
316	**369**	**-53**	**-14.2%**	**Net Surplus/(Deficit)**	**566**	**927**	**-361**	**-38.9%**	**517**	**503**	**13**	**2.6%**
1.34%	1.58%	-0.24%	-15.4%	Net Margin	1.19%	1.98%	-0.79%	-40.0%	0.18%	0.18%	0.00%	2.4%
0	0	0	#DIV/0!	Impairment	0	0	0	#DIV/0!	0	0	0	#DIV/0!
316	**369**	**-53**	**-14.2%**	**Net Surplus After Impairment**	**566**	**927**	**-361**	**-38.9%**	**517**	**503**	**13**	**2.6%**
				Average Capital Employed	**108,486**	**109,578**	**-1,093**	**-1.0%**	**108,585**	**109,578**	**-993**	**-0.9%**
				Return on Capital Employed	0.52%	0.85%	#DIV/0!	-38.3%	0.48%	0.46%	0.02%	3.5%

LAS Financial Review - Financial Performance Indicator

Month Ending 31st May 2010 - (Month 2)

Key Financial Performance Targets	Performance Ytd Position Act £000	Performance Ytd Position Plan £000	Performance Ytd Position Diff £000	Performance Ytd Position %	Forecast 2010/11 Act £000	Forecast 2010/11 Plan £000	Forecast 2010/11 Diff £000	Forecast 2010/11 %	Status Current (YTD)	Status Trend (compare to prev mth?)	Status Forecast
1. EBITDA *Monitor*	3,379	4,275	896	21.0%	20,662	20,596	(66)	-0.3%	↓	↑	↔
2. EBITDA % *Monitor*	7.11%	9.16%	2.05%	22%	7.36%	7.35%	-0.01%	-0.1%	↓	↑	↔
3. Control Surplus/(Deficit) *NHSL*	566	927	361	39%	517	502	(14)	-2.8%	↓	↑	↔
4. Net Surplus/(Deficit) - after Impairments *Monitor/DH*	566	927	361	39%	517	502	(14)	-2.8%	↓	↑	↔
5. Cost Improvement Program (CIP) *NHSL*	2,400	2,100	(300)	-14%	18,583	18,583	0	0.0%	↑		↔
6. Return on Assets (RoA) *Monitor*	0.52%	0.85%	0.32%	38%	0.48%	0.46%	-0.02%	-3.5%	↓		↔
8. Capital Resource Limit (CRL) *DH*	2,798	3,790	992	26%	16,788	16,788	0	0.0%	↓		↔
9. External Financing Limit (EFL) *DH*	(260)	(260)	0	0%	(260)	(260)	0	0.0%	↔		↔
10. Liquidity Ratio *Monitor*	0.97	1.50	0.53	36%	0.97	1.50	0.53	35.6%	↓		↓
11. To process at least 95% of bills by value within 30 days *DH*	68%	95%	27%	28%	90%	95%	5%	5.3%	↓		↓
12. To process at least 95% of bills by volume within 30 days DH	84%	95%	11%	12%	86%	95%	9%	9.5%	↓		↓
13. LAS Trust Management Costs *DH - Calculated as % of Total LAS Income (Excl. MPET)*	10.7%	7.0%	-4%	-53%	10.6%	7.0%	-4%	-52.0%	↓		↓

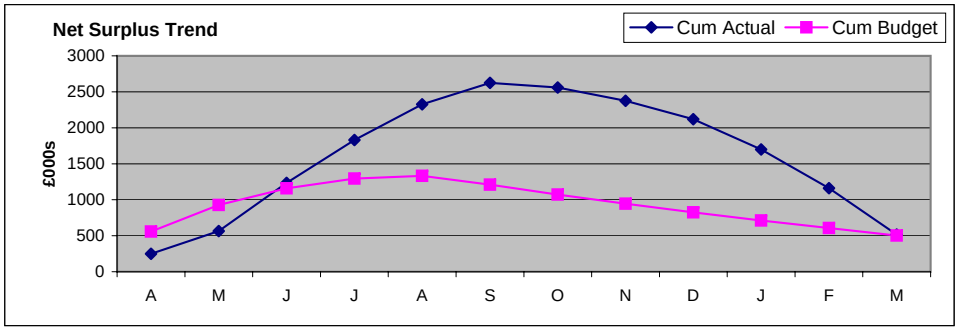
- LAS Trust Management Costs are currently calculated on an annual basis as part of the year end process. The figure provided YTD and forecast is based on estimates. The calculation will continue to be refined.

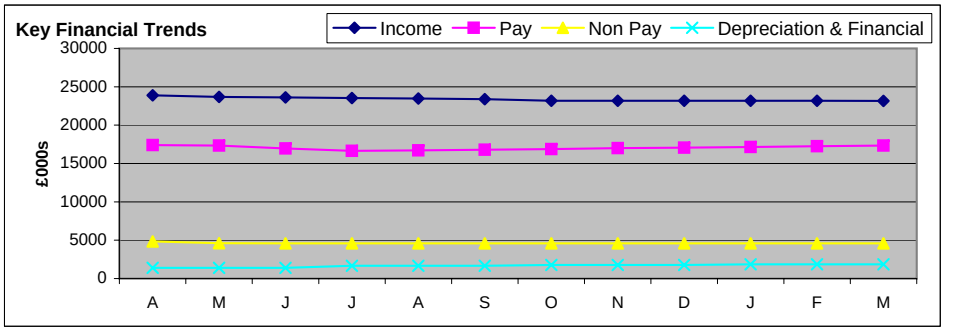
KEY

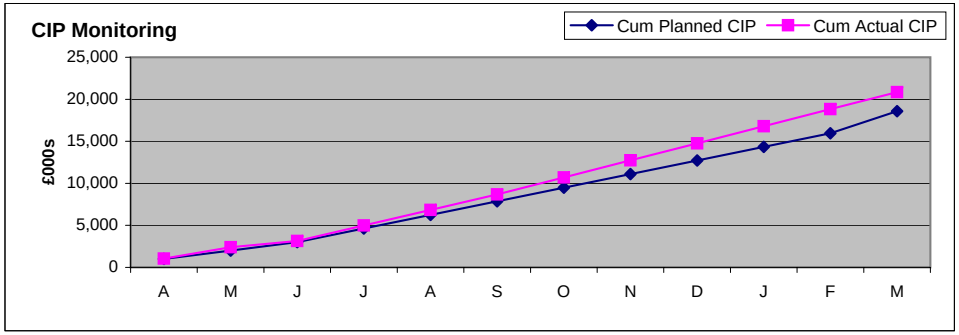
↓	Target below expected levels attention required
↑	Target exceeded
↔	Target within tolerable range

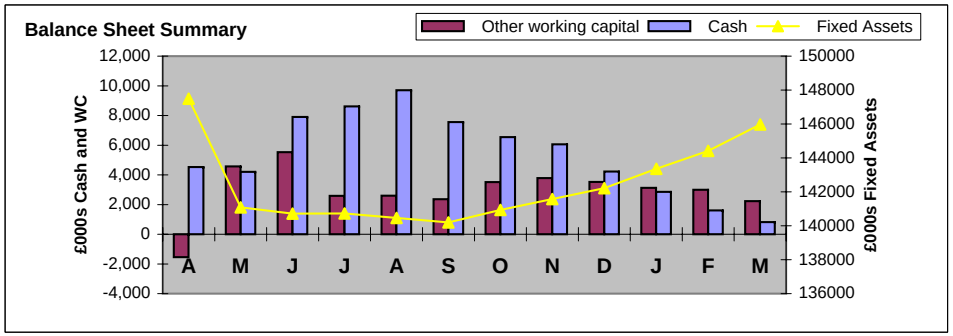
LAS Financial Review - Financial Analysis

Month Ending 31st May 2010 - (Month 2)









Other Trend Information

	April	May	June	July	August	September	October	November	December	January	February	March	Total	Average
A&E Cost per Head per month (£s)	1.7	1.8	1.7	1.7	1.7	1.7	1.8	1.8	1.8	1.8	1.8	1.8	21.2	1.8
EOC Cost Per Call & Response per month (£s)	4.5	4.7	4.3	4.3	3.9	4.2	4.3	4.3	4.3	3.9	4.2	4.3	51.1	4.3
A&E Cost Per Incident (£s) per month	169.6	171.5	165.8	156.0	171.9	174.0	161.0	164.7	157.6	169.0	189.1	168.7	2,018.9	168.2
A&E Cost Per Day (£000s)	479.3	481.5	480.0	459.4	462.4	483.3	469.0	489.4	476.5	482.7	539.4	491.8	5,794.6	482.9
Incidents per WTE per month	17.8	18.5	18.5	19.4	17.8	17.8	19.3	19.1	20.1	19.1	17.4	19.7	224.5	18.7
Responses per Incident per month	1.5	1.3	1.5	1.3	1.5	1.5	1.4	1.3	1.2	1.4	1.6	1.5	16.9	1.4
Calls per WTE per month	24.5	26.3	28.3	28.8	31.4	27.1	25.8	28.4	28.1	30.4	26.9	24.5	330.5	27.5
% Overtime to Total Payroll	7.0%	6.9%	6.2%	4.9%	4.8%	4.8%	4.1%	3.8%	3.5%	3.5%	3.5%	3.5%	0.6	0.0
Ratio of Frontline to Corporate Support Staff	8.1	8.1	8.2	8.2	8.3	8.4	8.5	8.5	8.6	8.6	8.6	8.7	100.7	8.4

LAS Financial Review - Financial Risks

Month Ending 31st May 2010 - (Month 2)

Key Financial Risks	Gross Risk				Net	Status	Comment
	Value £000	Impact	Likelihood	Rating	Value £000		
1. A&E Income - Activity decrease	5,102	4	1	4	0	G	m2 ytd activity up 7% YoY
2. A&E Income - CatA8 penalty	4,955	4	2	8	0	G	m2 performance 76% ytd
3. A&E Income - CatB19 penalty	4,955	4	4	16	2,123	R	m2 performance on trajectory. Net penalty based on both proportionality & caliberation
4. A&E Income - CatC (KPI)	4,955	4	2	8	1,239	R	m2 CTA and NHSD reports in development
5. A&E Income - LAS Patient handover (KPI)	1,635	3	2	6	818	A	m2 performance on revised trajectory
6. A&E Income - Clinical Performance Indicator (KPI)	1,635	3	2	6	0	G	m2 ytd on track
7. A&E Income - New Clinical Model (KPI)	1,635	3	3	9	818	A	m2 evaluation of Barnehurst trial in progress
8. A&E Income - Alternative Care Pathways (CQUIN)	2,973	4	2	8	743	A	m2 ytd on track
9. A&E Income - Cardiac, Stroke & Falls (CQUIN)	743	3	2	6	372	A	m2 dependent on availability of specialist units and falls services London-wide
10. CBRN Income	7,565	4	2	8	378	A	Net based on 5% slippage
11. HART Income	7,565	4	2	8	378	A	Net based on 5% slippage. Q1 billed and received
12. MPET Income	2,500	4	2	8	0	G	Letter from NHSL confirms amount. No slippage planned
10. CIP Delivery	17,583	4	3	12	879	A	m2 ytd on track. Net based on 5% slippage
11. Economic Cost Pressures (Fuel, Rates, etc)	1,000	3	3	9	0	G	m2 ytd on track
12. PTS Profitability	350	3	3	9	0	G	m2 ytd on track
Total	65,151				7,748		

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

LAS Financial Review - CIP Summary

Month Ending 31st May 2010 - (Month 2)

Key Financial Performance Targets	Performance Ytd Position Act £000	Plan £000	Diff £000	%	Forecast 2010/11 Act £000	Plan £000	Diff £000	%	Status Current	Trend	Forecast
1. A&E Incentive	2,019	2,019	0	0%	3,029	3,029	0	0%	↔		↔
2. Agency Cost	100	0	(100)	-100%	4,279	4,279	0	0%	↔		↔
3. A&E Subsistence	0	0	0	#DIV/0!	1,682	1,682	0	0%	↔		↔
4. Third Party Transport	200	0	(200)	-100%	1,844	1,844	0	0%	↑		↔
5. Non Frontline Payroll	81	81	0	0%	1,602	1,602	0	0%	↔		↔
6. Non Pay - Major Contract Review	0	0	0	#DIV/0!	1,285	1,285	0	0%	↔		↔
7. Non Pay - Activity Reduction	0	0	0	#DIV/0!	2,666	2,666	0	-100%	↔		↔
8. Non Pay - Other	0	0	0	#DIV/0!	2,198	2,198	0	-100%	↔		↔
9. A&E Pay - Other	0	0	0	#DIV/0!	0	0	0	#DIV/0!	↔		↔
10. Pay - Other	0	0	0	#DIV/0!	0	0	0	#DIV/0!	↔		↔
Total	2,400	2,100	(300)	-6%	18,583	18,583	0	-100%	↔		↔

- CIP is currently on plan with no incentives being allowed in the LAS in 2010/11.
- Early savings have been achieved in Agency due to the reduction of agency numbers in Q1
- Early savings have been achieved in Third Party due to the cancellation of all Third Party usage in A&E and the majority of Third Party in PTS in Q1. It should be noted that PTS Third Party should also be offset by ECJ Income.

KEY:

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

LAS Financial Review - Capital Summary

Month Ending 31st May 2010 - (Month 2)

Projects	Ytd Position m2				Forecast 2010/11				Project				Status	
	Act £000	Plan £000	Diff £000	%	Act £000	Plan £000	Diff £000	%	Act £000	Plan £000	Diff £000	%	2010/11	Project
1. CommandPoint	244	584	340	58%	3,378	3,500	(122)	-3%			0	#DIV/0!	↔	↔
2. IM&T - Other	502	166	(336)	-202%	1,182	993	189	19%			0	#DIV/0!	↔	↔
3. Fleet - DCA	(5,852)	1,886	7,738	410%	4,767	11,330	(6,563)	-58%			0	#DIV/0!	↓	↔
4. Fleet - FRU	0	234	234	100%	131	1,400	(1,269)	-91%			0	#DIV/0!	↓	↔
5. Fleet - Other	96	0	(96)	#DIV/0!	7,227	0	7,227	#DIV/0!			0	#DIV/0!	↑	↔
6. Estates - West Workshop	0	250	250	100%	0	1,500	(1,500)	-100%			0	#DIV/0!	↓	↔
7. Estates - HART East	13	110	97	88%	631	657	(26)	-4%			0	#DIV/0!	↔	↔
8. Estates - Hart West	0	138	138	100%	20	826	(806)	-98%			0	#DIV/0!	↓	↔
9. Estates - Other	23	266	243	91%	3,932	1,590	2,342	147%			0	#DIV/0!	↑	↔
10. Clinical Equipment	0	156	156	100%	938	938	0	0%			0	#DIV/0!	↔	↔
11. Other Projects	0	0	0	#DIV/0!	0	0	0	#DIV/0!			0	#DIV/0!	↔	↔
Total	(4,975)	3,790	8,765	231%	22,206	22,734	(528)	-2%	0	0	0	#DIV/0!	↓	↔
Capital Resource Limit (CRL)	2,798	3,790	992	26%	16,788	16,788	(933)	-6%	0	0	0	#DIV/0!	↔	↔
Variance	(7,773)	0	7,773	#DIV/0!	5,418	5,946	(2,056)	-35%	0	0	0	#DIV/0!	↓	↔

- Plan and CRL figure are based on 2010/11 final FiMs submission
- Project figures will be provided as model is developed
- The full year Fleet Capital spend has been reanalysed between Fleet - DCA and Fleet Other
- The YTD Fleet - DCA actual amount is skewed by the Sale and Leaseback funding for new ambulances this is due to fund new ambulances later in the year

KEY:

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

LAS Financial Review - Summary I&E & Balance Sheet

Month Ending 31st May 2010 - (Month 2)

	Month Act	Month Budget	%	Ytd Act	Ytd Budget	Diff	%	Ytd 0910	Diff	%	2010/2011 Fcast	2010/2011 Budget	Diff	%
	£000	£000		£000	£000	£000		£000	£000		£000	£000	£000	
Income														
A&E	21,423	21,593	-0.8%	42,846	43,186	(340)	-0.8%	41,330	1,516	3.7%	258,773	259,113	(340)	-0.1%
Other	2,252	1,750	28.7%	4,707	3,501	1,206	34.4%	4,864	(158)	-3.2%	21,825	21,004	821	3.9%
Total	23,675	23,343	1.4%	47,552	46,686	866	5291.3%	46,194	1,358	2.9%	280,598	280,117	481	0.2%
Operating Expense														
Pay	17,339	16,855	2.9%	34,729	33,521	1,208	3.6%	33,908	822	2.4%	204,544	206,183	(1,639)	-0.8%
Non Pay	4,614	4,445	3.8%	9,443	8,890	554	6.2%	8,910	533	6.0%	55,391	53,338	2,054	3.9%
Total	21,952	21,300	3.1%	44,173	42,411	1,762	2307.1%	42,818	1,355	3.2%	259,936	259,521	415	0.2%
EBITDA	1,722	2,043	-15.7%	3,379	4,275	(896)	-577.2%	3,376	4	0.1%	20,662	20,596	66	0.3%
EBITDA %	7.3%	8.8%	-16.9%	7.1%	9.2%	-2%	-546.5%	7.3%	-0.2%	-2.7%	7.4%	7.4%	0.0%	0.1%
Depreciation, Dividend & Interest	1,406	1,674	-16.0%	2,814	3,349	(535)	-16.0%	2,854	(40)	-1.4%	20,146	20,092	53	0.3%
Net Surplus/(Deficit)	316	369	-14.2%	566	927	- 361	-356.9%	522	44	1.5%	517	503	13	2.6%
Net Margin	1.3%	1.6%	-15.4%	1.2%	2.0%	-0.8%	-349.7%	1.1%	0.1%	-2.7%	0.2%	0.2%	0.0%	2.4%
Impairments	0	0	#DIV/0!	0	0	0	#DIV/0!	0	0	#DIV/0!	0	0	0	#DIV/0!
Net Surplus after Impairment	316	369	-14.2%	566	927	- 361	-356.9%	522	44	#DIV/0!	517	503	13	2.6%
Balance Sheet														
Non Current Assets				140,717	152,901	(12,184)	-8.0%	131,406	9,311	7.1%	149,521	152,901	(3,380)	-2.2%
Cash				4,209	2,979	1,231	41.3%	5,141	(932)	-18.1%	816	2,979	(2,162)	-72.6%
Working capital				5,529	(9,903)	15,432	-155.8%	(1,538)	7,067	-459.5%	(1,711)	(9,903)	8,191	-82.7%
Non Current Liabilities				(41,811)	(36,399)	(5,413)	14.9%	(41,767)	(44)	0.1%	(40,041)	(36,399)	(3,643)	10.0%
Capital Employed				108,644	109,578	(934)	-11832.1%	93,242	15,402	16.5%	108,585	109,578	(993)	-11135.0%
Average Capital Employed				108,486	109,578	(1,093)	-1.0%	15,540	92,945	598.1%	108,585	109,578	(993)	-0.9%
Return on Capital Employed				0.52%	0.85%	#DIV/0!	-38.3%	3.4%	(0)	-84.5%	0.48%	0.46%	0	3.5%

LAS Financial Review - Balance Sheet

Month Ending 31st May 2010 - (Month 2)

	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Non-Current Assets	*Actual*	*Actual*	*Actual*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*
Intangible assets	12,639	12,604	12,604	12,604	12,604	12,604	12,604	12,604	12,604	12,604	12,604	12,604	12,604
Property, Plant and Equipment	131,434	125,054	124,671	124,679	124,414	124,149	124,884	125,528	126,172	127,316	128,369	129,922	133,475
Trade and Other Receivables	3,418	3,428	3,442	3,442	3,442	3,442	3,442	3,442	3,442	3,442	3,442	3,442	3,442
Total Non-Current Assets	147,491	141,086	140,717	140,725	140,460	140,195	140,930	141,574	142,218	143,362	144,415	145,968	149,521
Current Assets													
Inventories	2,783	2,728	2,701	2,701	2,701	2,701	2,701	2,701	2,701	2,701	2,701	2,701	2,701
NHS Trade Receivables	10,207	19,827	19,124	13,173	13,163	13,158	13,148	13,128	13,128	13,128	13,128	13,128	13,126
Non NHS Trade Receivables	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Receivables	8,202	6,595	7,308	7,308	7,308	7,308	7,308	7,308	7,308	7,308	7,308	7,308	4,023
Accrued Income	1,897	2,664	1,934	1,934	1,934	1,934	1,934	1,934	1,934	1,934	1,934	1,934	1,934
Prepayments	3,249	1,933	2,775	2,775	2,775	2,775	2,775	2,775	2,775	2,775	2,775	2,775	2,775
Investments	0	0	0	0	0	0	0	0	0	0	0	0	0
Cash and Cash Equivalents	5,141	4,533	4,209	7,900	8,617	9,700	7,560	6,547	6,062	4,228	2,852	1,602	816
Current Assets	31,479	38,280	38,051	35,791	36,498	37,576	35,426	34,393	33,908	32,074	30,698	29,448	25,375
Non-Current Assets Held for Sale	650	650	650	650	650	650	650	650	650	650	650	650	0
Total Current Assets	32,129	38,930	38,701	36,441	37,148	38,226	36,076	35,043	34,558	32,724	31,348	30,098	25,375
Total Assets	179,620	180,016	179,418	177,166	177,608	178,421	177,006	176,617	176,776	176,086	175,763	176,066	174,896
Current Liabilities													
Bank Overdraft	0	0	0	0	0	0	0	0	0	0	0	0	0
Trade Payables	336	340	321	280	278	278	278	278	278	278	278	278	278
Other Liabilities	14,536	15,568	19,277	18,506	18,380	18,402	18,442	18,472	18,523	18,553	18,583	18,634	18,668
PDC Dividend Liabilities	200	514	828	1,142	1,456	1,770	0	314	628	942	1,256	1,570	0
Capital Liabilities	8,610	4,873	3,190	1,190	1,190	1,190	2,190	2,190	2,190	2,690	2,690	3,190	5,190
Accruals	1,217	5,044	1,828	1,828	1,828	1,828	1,828	1,828	1,828	1,828	1,828	1,828	1,828
Deferred Income	124	91	306	306	306	306	306	306	306	306	306	306	306
DH Capital Loan Principal Repayment	0	0	0	0	0	0	0	0	0	0	0	0	0
Borrowings	3,503	3,398	3,213	2,704	2,498	2,395	1,954	1,321	1,216	771	559	453	0
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	28,526	29,828	28,963	25,956	25,936	26,169	24,998	24,709	24,969	25,368	25,500	26,259	26,270
Net Current Assets/(Liabilities)	3,603	9,102	9,738	10,485	11,212	12,057	11,078	10,334	9,589	7,356	5,848	3,839	(895)
Total Assets less Current Liabilities	151,094	150,188	150,455	151,210	151,672	152,252	152,008	151,908	151,807	150,718	150,263	149,807	148,626
Non-Current Liabilities													
DH Capital Loan Principal Repayment	9,319	9,319	9,319	9,319	9,319	9,319	8,697	8,697	8,697	8,697	8,697	8,697	8,075
Borrowings	21,560	21,560	21,560	21,560	21,560	21,560	21,560	21,560	21,560	21,560	21,560	21,560	21,560
Other Financial Liabilities	0	0	0										
Provisions for Liabilities & Charges	10,888	10,982	10,932	11,017	10,882	10,967	11,052	11,017	11,102	10,271	10,236	10,321	10,406
Total Non-Current Liabilities	41,767	41,861	41,811	41,896	41,761	41,846	41,309	41,274	41,359	40,528	40,493	40,578	40,041
Total Assets Employed	109,327	108,327	108,644	109,314	109,911	110,406	110,699	110,634	110,448	110,190	109,770	109,229	108,585
Financed By Taxpayers' Equity													
Public Dividend Capital	60,885	60,885	60,885	60,885	60,885	60,885	60,885	60,885	60,885	60,885	60,885	60,885	60,885
Revaluation Reserve	35,914	35,487	35,487	35,487	35,487	35,487	35,487	35,487	35,487	35,487	35,487	35,487	35,487
Donated Asset Reserve	4	4	4	4	4	4	4	4	4	4	4	4	4
Other Reserves	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)	(419)
Retained Earnings	12,943	12,370	12,687	13,357	13,954	14,449	14,742	14,677	14,491	14,233	13,813	13,272	12,628
Total Taxpayers' Equity	109,327	108,327	108,644	109,314	109,911	110,406	110,699	110,634	110,448	110,190	109,770	109,229	108,585

LAS Financial Review - Cashflow

Month Ending 31st May 2010 - (Month 2)

	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
	Actual	*Actual*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	
Operating Activities													
Operating surplus/(deficit)	664	730	1,082	1,010	908	712	349	228	156	(6)	(127)	(230)	5,476
Depreciation and amortisation	992	992	992	1,265	1,265	1,265	1,356	1,356	1,356	1,447	1,447	1,447	15,180
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	(114)	(114)	(114)	(114)	(114)	(114)	(114)	(114)	(114)	(114)	(114)	(114)	(1,368)
Dividend Paid	0	0	0	0	0	(2,084)	0	0	0	0	0	(1,884)	(3,968)
(Increase)/Decrease in Inventories	55	27	0	0	0	0	0	0	0	0	0	0	82
(Increase)/Decrease in NHS Trade Receivables	(9,620)	703	5,951	10	5	10	20	0	0	0	0	2	(2,919)
(Increase)/Decrease in Long Term Receivables	(10)	(14)	0	0	0	0	0	0	0	0	0	0	(24)
(Increase)/Decrease in Non NHS Trade Receivables	0	0	0	0	0	0	0	0	0	0	0	0	0
(Increase)/Decrease in Other Receivables	1,607	(713)	0	0	0	0	0	0	0	0	0	3,285	4,179
(Increase)/Decrease in Accrued Income	(767)	730	0	0	0	0	0	0	0	0	0	0	(37)
(Increase)/Decrease in Prepayments	1,316	(842)	0	0	0	0	0	0	0	0	0	0	474
Increase/(Decrease) in Trade Payables	4	(19)	(41)	(2)	0	0	0	0	0	0	0	0	(58)
Increase/(Decrease) in Other Payables	5,192	3,734	(6,728)	(140)	8	26	16	37	16	16	37	20	2,234
Increase/(Decrease) in Payments on Account	0	0	0	0	0	0	0	0	0	0	0	0	0
Increase/(Decrease) in Accruals	3,827	(3,216)	0	0	0	0	0	0	0	0	0	0	611
Increase/(Decrease) in Deferred Income	(33)	215	0	0	0	0	0	0	0	0	0	0	182
Increase/(Decrease) in Provisions & Liabilities	94	(50)	85	(135)	85	85	(35)	85	(831)	(35)	85	85	(482)
Net Cash inflow/outflow from operating activities	3,207	2,163	1,227	1,894	2,157	(100)	1,592	1,592	583	1,308	1,328	2,611	19,562
Cashflows from Investing Activites													
Interest received	27	29	27	28	28	28	28	28	28	28	28	28	335
(Payments) for property, plant & equipment	(3,737)	(2,331)	(3,000)	(1,000)	(1,000)	(1,000)	(2,000)	(2,000)	(2,000)	(2,500)	(2,500)	(3,000)	(26,068)
Proceeds from disposal of property, plant & equipment	0	0	5,946	1	1	(5)	0	0	0	0	0	650	6,593
(Payments) for intangible assets	0	0	0	0	0	0	0	0	0	0	0	0	0
Proceeds from disposal of intangible assets	0	0	0	0	0	0	0	0	0	0	0	0	0
(Payments) for investment with DH	0	0	0	0	0	0	0	0	0	0	0	0	0
(Payments) for other financial assets	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Cash inflow/outflow from investing activities	(3,710)	(2,302)	2,973	(971)	(971)	(977)	(1,972)	(1,972)	(1,972)	(2,472)	(2,472)	(2,322)	(19,140)
Net Cash inflow/outflow before financing	(503)	(139)	4,200	923	1,186	(1,077)	(380)	(380)	(1,389)	(1,164)	(1,144)	289	422
Cashflows from Financing Activites													
Public Dividend Capital Received	0	0	0	0	0	0	0	0	0	0	0	0	0
Public Dividend Capital Repaid	0	0	0	0	0	0	0	0	0	0	0	0	0
Loans received from DH	0	0	0	0	0	0	0	0	0	0	0	0	0
Loans principal repaid to DH	0	0	0	0	0	(622)	0	0	0	0	0	(622)	(1,244)
Capital element of finance lease	(105)	(185)	(509)	(206)	(103)	(441)	(633)	(105)	(445)	(212)	(106)	(453)	(3,503)
Net Cashflow inflow/(outflow) from financing	(105)	(185)	(509)	(206)	(103)	(1,063)	(633)	(105)	(445)	(212)	(106)	(1,075)	(4,747)
Increase/(decrease) in cash & cash equivalents	(608)	(324)	3,691	717	1,083	(2,140)	(1,013)	(485)	(1,834)	(1,376)	(1,250)	(786)	(4,325)
Cash, cash equivalents and bank overdrafts at 1.4.09	5,141												
Cash, cash equivalents and bank overdrafts at 31.3.10	4,533	4,209	7,900	8,617	9,700	7,560	6,547	6,062	4,228	2,852	1,602	816	(4,325)

LAS Financial Review - Income Summary

Month Ending 31st May 2010 - (Month 2)

Month Act	Month Budget	%		Ytd Act	Ytd Budget	Diff	%	2010/2011 Fcast	2010/2011 Budget	Diff	%
£000	£000			£000	£000	£000		£000	£000	£000	
			Emergency Delivery								
20,708	20,863	-0.7%	PCT Commissioned	41,417	41,726	(309)	-0.7%	250,047	250,356	(309)	-0.1%
620	620	0.0%	CBRN	1,241	1,241	0	0.0%	7,445	7,445	0	0.0%
94	109	-13.9%	RTA	188	219	(30)	-13.9%	1,281	1,312	(30)	-2.3%
21,423	**21,593**	-0.8%	**Subtotal**	**42,846**	**43,186**	**(340)**	-0.8%	**258,773**	**259,113**	**(340)**	-0.1%
			Specialised Services								
581	447	29.9%	HART	1,162	895	268	29.9%	6,972	5,368	1,604	29.9%
3	11	-71.6%	HEMS	7	23	(16)	-71.6%	37	138	(101)	-73.5%
584	**459**	27.4%	**Subtotal**	**1,169**	**918**	**251**	27.4%	**7,009**	**5,506**	**1,503**	27.3%
			Information Services & Research								
92	83	10.6%	EBS	184	167	18	10.6%	1,004	1,000	1	0.4%
17	0	#DIV/0!	Research	35	0	35	#DIV/0!	35	0	35	#DIV/0!
109	**83**	31.2%	**Subtotal**	**219**	**167**	**53**	31.7%	**1,039**	**1,000**	**36**	3.9%
			Patient Transport Services								
731	598	22.2%	PTS	1,522	1,196	326	27.3%	7,503	7,177	326	4.5%
62	49	26.6%	BETS & SCBU	118	98	20	19.9%	708	590	118	19.9%
0	47	-100.0%	A&E Long Distance	1	94	(93)	-98.9%	201	563	(362)	-64.3%
793	**694**	14.2%	**Subtotal**	**1,641**	**1,388**	**253**	18.2%	**8,412**	**8,330**	**82**	1.0%
			NHS London								
540	260	107.5%	MPET	1,219	521	698	134.0%	2,519	3,125	(606)	-19.4%
0	0	#DIV/0!	Other Education	0	0	0	#DIV/0!	0	0	0	#DIV/0!
70	65	6.6%	Olympics 2012	139	131	9	6.6%	835	783	52	6.7%
610	**326**	87.3%	**Subtotal**	**1,358**	**651**	**706**	108.5%	**3,354**	**3,908**	**(554)**	-14.2%
			Commercial								
81	91	-10.7%	Stadia	157	183	(25)	-13.9%	947	1,095	(148)	-13.5%
52	59	-11.5%	BAA	104	118	(14)	-11.5%	624	706	(82)	-11.6%
5	0	#DIV/0!	Training	10	0	10	#DIV/0!	10	0	10	#DIV/0!
139	**150**	-7.6%	**Subtotal**	**272**	**300**	**(29)**	-9.5%	**1,582**	**1,801**	**(220)**	-12.2%
16	38	-57.1%	**Other**	47	76	(29)	-37.8%	429	458	(29)	-6.3%
23,675	**23,343**	1.4%	**Total**	**47,552**	**46,686**	**866**	1.9%	**280,598**	**280,117**	**478**	0.2%

LAS Financial Review - Expense Summary

Month Ending 31st May 2010 - (Month 2)

Month Act	Month Budget	%		Ytd Act	Ytd Budget	Diff	%	Ytd 0910	Diff	%	2010/2011 Fcast	2010/2011 Budget	Diff	%
£000	£000			£000	£000	£000		£000	£000		£000	£000	£000	
			Income											
21,423	21,593	-0.8%	A&E	42,846	43,186	(340)	-0.8%	41,330	1,516	3.7%	258,773	259,113	(340)	-0.1%
2,252	1,750	28.7%	Other	4,707	3,501	1,206	34.4%	4,864	(158)	-3.2%	21,825	21,004	821	3.9%
23,675	**23,343**	**1.4%**	**Total**	**47,552**	**46,686**	**866**	1.9%	**46,194**	**1,358**	2.9%	**280,598**	**280,117**	**481**	0.2%
			Payroll (£k)											
10,460	11,107	-5.8%	A&E Sectors	20,939	21,996	(1,057)	-4.8%	18,621	2,318	12.4%	131,964	138,775	(6,811)	-4.9%
1,040	462	124.8%	A&E Overtime	2,090	925	1,165	126.0%	2,749	(659)	-24.0%	8,240	4,933	3,307	67.1%
0	0	#DIV/0!	A&E Incentive	0	0	0	#DIV/0!	1,223	(1,223)	-100.0%	0	0	0	#DIV/0!
1,218	960	26.8%	A&E Management	2,445	1,930	515	26.7%	2,094	351	16.8%	14,550	11,035	3,515	31.9%
951	1,254	-24.2%	EOC	1,900	2,509	(608)	-24.2%	1,775	126	7.1%	11,443	15,051	(3,608)	-24.0%
291	288	0.9%	Operational Support	587	579	9	1.5%	607	(19)	-3.2%	3,334	3,326	9	0.3%
543	466	16.6%	PTS	1,105	931	174	18.6%	1,129	(23)	-2.1%	5,763	5,589	174	3.1%
2,236	2,026	10.4%	Corporate Support	4,453	4,069	384	9.4%	4,032	421	10.4%	24,364	23,979	384	1.6%
158	0	#DIV/0!	Other Overtime	319	0	319	#DIV/0!	498	(179)	-35.9%	1,389	0	1,389	#DIV/0!
442	291	51.9%	Agency	890	583	308	52.8%	1,181	(291)	-24.6%	3,497	3,495	2	0.1%
17,339	**16,855**	**2.9%**	**Total**	**34,729**	**33,521**	**1,208**	3.6%	**33,908**	**822**	2.4%	**204,544**	**206,183**	**(1,639)**	-0.8%
			Non Pay											
492	434	13.5%	Staff Related	1,022	867	155	17.9%	1,350	(328)	-24.3%	5,359	5,203	155	3.0%
631	557	13.2%	Consumables, Medical Equip & Drugs	1,118	1,114	4	0.4%	1,001	118	11.8%	6,690	6,686	4	0.1%
96	51	89.7%	Vehicle Leasing	174	102	73	71.6%	161	14	8.6%	683	610	73	11.9%
471	415	13.6%	Fuel & Oil	925	829	95	11.5%	742	182	24.5%	5,072	4,977	95	1.9%
804	500	60.8%	Vehicle Maintenance	1,201	1,001	201	20.0%	604	597	98.8%	6,205	6,004	201	3.3%
0	0	#DIV/0!	Other Automotive	0	0	0	#DIV/0!	0	0	#DIV/0!	0	0	0	#DIV/0!
223	127	75.5%	Vehicle Insurance	398	254	144	56.5%	244	153	62.8%	1,667	1,524	144	9.4%
49	11	332.6%	3rd Party Transport	150	23	128	567.7%	375	(224)	-59.9%	263	135	128	94.6%
1,094	1,151	-4.9%	Accomodation & Estates	2,085	2,302	(217)	-9.4%	2,034	51	2.5%	13,594	13,811	(217)	-1.6%
717	713	0.6%	IT & Telecoms	1,440	1,426	14	1.0%	1,210	231	19.1%	8,571	8,557	14	0.2%
(144)	127	-213.2%	Finance & Legal	608	254	354	139.4%	489	119	24.3%	3,377	1,523	1,854	121.7%
(4)	151	-102.6%	Consultancy	8	302	(294)	-97.4%	253	(245)	-97.0%	1,518	1,812	(294)	-16.2%
184	208	-11.7%	Other	314	416	(102)	-24.5%	449	(135)	-30.0%	2,394	2,496	(102)	-4.1%
4,614	**4,445**	**3.8%**	**Subtotal**	**9,443**	**8,890**	**554**	6.2%	**8,910**	**533**	6.0%	**55,391**	**53,338**	**2,054**	3.9%
			Depreciation											
0	0	#DIV/0!	Fleet	0	0	0	#DIV/0!	0	0	#DIV/0!	0	0	0	#DIV/0!
0	0	#DIV/0!	IT	0	0	0	#DIV/0!	0	0	#DIV/0!	0	0	0	#DIV/0!
992	1,265	-21.5%	Other	1,985	2,529	(545)	-21.5%	1,879	106	5.6%	15,177	15,175	2	0.0%
992	**1,265**	**-21.5%**	**Subtotal**	**1,985**	**2,529**	**(545)**	-21.5%	**1,879**	**106**	5.6%	**15,177**	**15,175**	**2**	0.0%
			Financial											
314	330	-4.7%	Dividend	629	660	(31)	-4.7%	820	(191)	-23.3%	3,769	3,960	(191)	-4.8%
99	80	24.7%	Interest	200	160	41	25.5%	155	45	29.3%	1,200	958	243	25.3%
414	**410**	**1.0%**	**Subtotal**	**829**	**820**	**9**	1.1%	**975**	**(146)**	-15.0%	**4,969**	**4,918**	**51**	1.0%
23,358	**22,974**	**1.7%**	**Total Expense**	**46,986**	**45,759**	**1,227**	2.7%	**45,672**	**1,314**	2.9%	**280,081**	**279,613**	**468**	0.2%

LAS Financial Review - Expense Trend

Month Ending 31st May 2010 - (Month 2)

	Apr-10 Act	May-10 Act	Jun-10 Act	Jul-10 Act	Aug-10 Act	Sep-10 Act	Oct-10 Act	Nov-10 Act	Dec-10 Act	Jan-11 Act	Feb-11 Act	Mar-11 Act	2010/2011 Fcast	2010/2011 Budget	Diff	%
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	
Payroll (£k)																
A&E Frontline	10,478	10,460	10,500	10,550	10,650	10,825	10,975	11,175	11,325	11,525	11,675	11,825	131,964	138,775	(6,811)	-4.9%
A&E Overtime	1,050	1,040	900	700	700	700	600	550	500	500	500	500	8,240	4,933	3,307	67.1%
A&E Incentive	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	#DIV/0!
A&E Management	1,227	1,218	1,251	1,242	1,233	1,224	1,215	1,206	1,197	1,188	1,179	1,170	14,550	11,035	3,515	31.9%
EOC	950	951	954	954	954	954	954	954	954	954	954	954	11,443	15,051	(3,608)	-24.0%
Operational Support	297	291	286	283	281	278	276	273	271	269	266	264	3,334	3,326	9	0.3%
PTS	562	543	466	466	466	466	466	466	466	466	466	466	5,763	5,589	174	3.1%
Corporate Support	2,218	2,236	2,008	1,991	1,974	1,956	2,040	2,023	2,006	1,988	1,971	1,953	24,364	23,979	384	1.6%
Other Overtime	161	158	150	120	100	100	100	100	100	100	100	100	1,389	0	1,389	#DIV/0!
Agency	448	442	442	350	350	300	250	250	250	150	150	115	3,497	3,495	2	0.1%
Total	**17,390**	**17,339**	**16,957**	**16,656**	**16,708**	**16,804**	**16,876**	**16,997**	**17,069**	**17,140**	**17,261**	**17,347**	**204,544**	**206,183**	**(1,639)**	**-0.8%**
Non Pay																
Staff Related	530	492	434	434	434	434	434	434	434	434	434	434	5,359	5,203	155	3.0%
Consumables, Medical Equip & Drugs	488	631	557	557	557	557	557	557	557	557	557	557	6,690	6,686	4	0.1%
Vehicle Leasing	78	96	51	51	51	51	51	51	51	51	51	51	683	610	73	11.9%
Fuel & Oil	454	471	415	415	415	415	415	415	415	415	415	415	5,072	4,977	95	1.9%
Vehicle Maintenance	397	804	500	500	500	500	500	500	500	500	500	500	6,205	6,004	201	3.3%
Other Automotive	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	#DIV/0!
Vehicle Insurance	175	223	127	127	127	127	127	127	127	127	127	127	1,667	1,524	144	9.4%
3rd Party Transport	102	49	11	11	11	11	11	11	11	11	11	11	263	135	128	94.6%
Accomodation & Estates	991	1,094	1,151	1,151	1,151	1,151	1,151	1,151	1,151	1,151	1,151	1,151	13,594	13,811	(217)	-1.6%
IT & Telecoms	723	717	713	713	713	713	713	713	713	713	713	713	8,571	8,557	14	0.2%
Finance & Legal	751	(144)	277	277	277	277	277	277	277	277	277	277	3,377	1,523	1,854	121.7%
Consultancy	12	(4)	151	151	151	151	151	151	151	151	151	151	1,518	1,812	(294)	-16.2%
Other	130	184	208	208	208	208	208	208	208	208	208	208	2,394	2,496	(102)	-4.1%
Subtotal	**4,830**	**4,614**	**4,595**	**4,595**	**4,595**	**4,595**	**4,595**	**4,595**	**4,595**	**4,595**	**4,595**	**4,595**	**55,391**	**53,338**	**2,054**	**3.9%**
Depreciation																
Fleet	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	#DIV/0!
IT	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	#DIV/0!
Other	992	992	992	1,265	1,265	1,265	1,356	1,356	1,356	1,447	1,447	1,447	15,177	15,175	2	0.0%
Subtotal	**992**	**992**	**992**	**1,265**	**1,265**	**1,265**	**1,356**	**1,356**	**1,356**	**1,447**	**1,447**	**1,447**	**15,177**	**15,175**	**2**	**0.0%**
Financial																
Dividend	314	314	314	314	314	314	314	314	314	314	314	314	3,769	3,960	(191)	-4.8%
Interest	101	99	100	100	100	100	100	100	100	100	100	100	1,200	958	243	25.3%
Subtotal	**415**	**414**	**414**	**414**	**414**	**414**	**414**	**414**	**414**	**414**	**414**	**414**	**4,969**	**4,918**	**51**	**1.0%**
Total Expense	**23,628**	**23,358**	**22,958**	**22,930**	**22,981**	**23,077**	**23,241**	**23,362**	**23,433**	**23,595**	**23,716**	**23,802**	**280,081**	**279,613**	**468**	**0.2%**

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

25th May 2010

PAPER FOR NOTING

Document Title:	**Clinical Quality and Patient Safety Report**
Report Author(s):	**Dr Fionna Moore**
Lead Director:	**Dr Fionna Moore**
Contact Details:	**LAS Headquarters, 220 Waterloo Road**
Why is this coming to the Trust Board?	**To provide the Board with evidence of progressing clinical quality and patient safety.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	The Trust Board is asked to note this report

Executive Summary/key issues for the Trust Board

Safety: No new SUIs declared; 7 incidents investigated

Clinical and cost effectiveness:

1. New arrangements for obtaining clinical advice from external experts described.
2. CPI performance now at 93% with 18 Complexes above 95% (April)
3. 'Improving outcomes from cardiac arrest'; pilot study described
4. Report on obstetric audit, including summary and recommendations
5. Improved arrangements for safeguarding arrangements described

Governance: report on unannounced inspections of Controlled Drugs arrangements by MPS

Care environment and amenities: progress on infection prevention and control with improved audit arrangements, review of category 3 procedures described.

Attachments

Main report with 2 appendices (Improving cardiac arrest survival and obstetric audit report)

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Corporate Objectives 2010 – 13

This paper supports the achievement of the following corporate objectives:

☒ To have staff who are skilled, confident, motivated and feel valued and work in a safe environment

☒ To improve our delivery of safe and high quality patient care using all available pathways
☒ To be efficient and productive in delivering our commitments and to continually improve

Risk Implications

This paper links to the following strategic risks:

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

NHS Constitution

This paper supports the following principles that guide the NHS:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☒ No

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board 29th June 2010

Clinical Quality and Patient Safety Report

Safety

1.1 Update on Serious Untoward Incidents (SUIs)

No new SUIs have been declared and 7 incidents have been given consideration as possible SUIs since my last update to the Board in May 2010.

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

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

12 alerts were received from 14th May to 14th June 2010. All alerts were acknowledged; none required action.

Clinical and Cost Effectiveness

2.1 Clinical Steering Group; arrangements for seeking external clinical advice

The LAS has a group of highly experienced and committed clinicians within the Clinical Steering Group who have met with us regularly over many years. This group goes back historically to the Local Ambulance Service Paramedic Steering Committee, which was a requirement of the IHCD, to assure the local implementation of clinical protocols and sign off training arrangements.

With the introduction of the Clinical Practice Guidelines for Use in UK Ambulance Services (the JRCALC Guidelines) the need for such advice has become much less. We have however always benefited from the ability to seek advice on a number of clinical topics from the group, who include nationally and internationally recognised experts in their fields.

It is becoming increasingly difficult to arrange quorate meetings in an environment where senior clinicians are increasingly committed to their host Trusts and to other projects. I am therefore proposing to disestablish the group in its current form and to set up a virtual group whereby the opinions and expertise of members of the group would remain available to us, without the need for formal meetings. The Terms of Reference of the Group would be changed to reflect this.

The Clinical Steering Group currently reports to the Clinical Quality, Safety and Effectiveness Committee, which can continue to request specialist and external advice, and ensure that such requests are formally minuted and the advice recorded.

2.2 Clinical Performance Indicator completion

The current target for CPI completion is **95%.** The April figures show a further dramatic improvement with **18 Complexes achieving 95% completion rates**. This is predominantly due to improvements made by the Clinical Audit and Research Unit whereby PRFs are electronically sorted and prepared for Team Leaders to audit, rather than relying on manual sorting. The improvements also reflect a period of more stable operational performance.

Diagram 1. CPI completion November to April 2009 / 2010

Area	November	December	January	March	April
East	30%	20%	23%	77%	86%
South	45%	44%	46%	82%	94%
West	49%	36%	56%	86%	98%
LAS	**43%**	**36%**	**43%**	**82%**	**93%**

For the year 2010 to date, Team Leaders across the LAS also gave 446 feedback sessions, which is 92% of the target. **Barnehurst**, **Camden**, **Edmonton**, **Hanwell, Hillingdon**, **Islington, Pinner** and **Waterloo** Complexes have met and exceeded their
individual feedback targets for the first month of the new year.

CARU, AOMs and their Team Leaders are to be congratulated on this marked recent and sustained improvement.

2.3 Improving Outcomes from Out of Hospital Cardiac Arrest

The LAS has been monitoring survival from out of hospital cardiac arrest for over ten years. We remain the only UK Ambulance Service to collect this data. We remain keen to improve on our current Utstein figure of 15.2%.

A proposed trial of a different protocol of resuscitation is outlined under Appendix 1. This paper has been prepared by Professor Douglas Chamberlain and Mark Whitbread, and builds on the experience of using the protocol in South east Coast Ambulance Service, which has consistently higher return of spontaneous circulation (ROSC) rates than any other UK ambulance service. This paper has been approved by both the Clinical Steering Group and the Senior Management Group.

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

A Summary of Findings from a Clinical Audit of the Care of Obstetrics Patients Transported by London Ambulance Service is included under Appendix 1.

2.5 Safeguarding update

Patient Experiences Department have undertaken a piece of work to revise the safeguarding process by abolishing the need for form completion by crews. Calls are now passed to EBS who will take details and forward to the relevant local authority. This should improve both the quality of referrals and their turn-around time. A reporting system has been put in place involving local authorities to improve feedback on referrals.

A recent Serious Case Review, involving a teenager with anorexia nervosa will be used as a case study to improve awareness that safeguarding is not confined to overt abuse.

Enfield Safeguarding Children Board (SCB) has expressed concern at our inability to send a local representative. It is likely that similar situations will become an even greater challenge for the Trust with the introduction of Vulnerable Adult Boards akin to SCBs.

Governance

3.1 Update on drug management; recent audit findings and progress

No incidents relating to loss, misuse or adverse effects of LAS drugs, including Controlled Drugs and those used under Patient Group Directions (PGDs) have been reported since my last report of May 2010.

3.2 Medicines management

Generic recommendations by MPS Controlled Drug Liaison Team as a result of Controlled Drug inspection at four LAS sites.

The Metropolitan Police Controlled Drug Liaison Team has made a series of unannounced inspections of our arrangements over the past month. Thus far 4 sites have been visited. In time all 26 Complexes will be inspected. The following summarises the findings to date:

FormLA227
The form should be more readily available for inspection if and when further inspections are completed.

Controlled Drugs Order Book
Reinforcement on current policy of the receiving of Controlled Drugs at LAS sites.
If no authorised signatory available all Controlled Drugs should be returned to Deptford and not left at the station.
Order book should be kept in AOM's office, but available for inspection.
Generally the ordering system worked and policy was properly adhered to.

Controlled Drugs Register
Reinforcement of current policy regarding Controlled Drug Registers
Ensure that Register is always kept in locked CD cabinet.
Updated Register at time of deposit and removal of Controlled Drugs
Ensure Controlled Drugs are always booked out singly
Controlled Drugs stock should be examined and checked by a clinically trained person and must completed daily.

Reinforce policy and or consider amending policy concerning witness signatures to ensure compliance of policy and accuracy of entries.

Clinical Records /Patient Report Form (PRF).
Consider amending policy regarding supervision / quality assurance of Clinical Records / PRF to ensure that the Clinical Records / PRF accurately reflects what is recorded in the Control Drugs Register.

Controlled Drugs Cabinet.
Strengthen policy regarding the circulation and knowledge of key codes. Combination codes should only be known to Paramedics who are stationed at the relevant site and not provided to Paramedics working at a site on a temporary basis. Consideration should be given to personally allocating a combination code to each Paramedic

Disposal of Residue Controlled Drugs.
Ensure details of wastage is documented on Clinical Records / PMR and witness signatures obtained.

Patient Focus

Nothing further to report

Accessible and Responsive Care

Nothing further to report

Care Environment and Amenities

6.1 Infection Prevention and Control Update

The Infection Prevention and Control Policy has been revised and is included as a separate agenda item. This revision is as a result of the need to meet NHSLA level 1 requirements which the policy had not met at the last review in November 2008. It is hoped that this will allow the Trust to achieve level 2 by the next NHSLA assessment in October 2010. The policy has been updated with current information and is part of the ongoing infection control programme work streams. An internal outbreak policy has also been produced which meets the HSC Act requirement and we have had the involvement of the HPA in assuring that it is appropriate.

Hygiene Code 2010 Performance Accelerator module is now live; it includes changes to the Health & Social Care Act 2008 with modifications to the criteria. There is an additional criterion which relates to Social Care.

Specific audit training has been provided to infection control champions in the South and East of London to ensure that completion and compliance is improved.

Quarterly audits for Q1 are much improved from the last financial year. Completion of audits is currently at 67% at all stations but this is expected to improve before quarter end. Compliance against the audits is improved with a change to the reporting this year, to identify trends and areas for corporate development. 63% of completed audits show full compliance (29 out of 46). Only 9 are not currently compliant. These

scores now form part of the balanced scorecard on a monthly basis with a target of 95% completion and 85% compliance.

The LAS Aseptic Non Touch Technique guideline has been accepted by the National ANTT programme as the first ambulance trust to comply with their guidelines to reduce HCAI and meets the Epic 2 guidelines. We have agreed all aspects of the care bundle and all staff had update training in January to March on ANTT in practice. The new PRF includes a section on cannula insertion under ANTT and will allow us to audit practice and identify future learning needs.

The management of Category 3 patients (those infectious diseases that require the routine application of special precautions and procedures, such as the viral haemorrhagic fevers) have been reviewed by the DH. The HART team will now undertake Category 3 transfers for the Trust, agreed at DH level by Russ Mansford and we have been able to test the response when conveying a patient in a planned journey from Luton Airport.

The infection control manual is currently under review with an expected end date of 4th August for sign off by the ICSG. A pocket guide will be written with key information for staff, agreed by staff side and training.
A watch procurement process is taking a little longer than expected but once completed will be rolled out as part of the 'bare below the elbows' and revised uniform policy for staff.

There are a number of tenders in progress which have an IPC involvement including:
Laundry Management
Premises Cleaning
Occupational Health
Vehicle
Movement
Vehicle Preparation & Cleaning

The Infection Control Steering Group is having an away day at Ilford Training School in early July to determine the priorities for 2010/11 and to identify 5 key themes for staff.

Public Health

Nothing further to report

Recommendation

That the Board notes the report

Fionna Moore,
Medical Director
18th June 2010

Appendix 1

LAS – Improving outcome from Out of Hospital Cardiac Arrest

Professor Douglas Chamberlain, Mark Whitbread

The London Ambulance Service responds to over 10.000 cardiac arrests annually undertaking Advanced Life support in approximately 50%.

The information set out in this document provides the LAS senior management with ways in which increased survival from cardiac arrest could be achieved

The plan would be to implement this at three Complexes across the service using larger Complexes with a reasonable incidence of cardiac arrest and access to hospitals able to provide a wide spectrum of care including full ITU facilities, CT scanning, angiography and cooling.

This implementation would require the 'buy in' of the senior management, station management and staff and would involve structured and regular stand down time to allow the education to take place.

Survival from Out-of-Hospital Cardiac Arrest

Introduction

Survival from out of hospital cardiac arrest varies very widely within all countries. This has been appreciated for many years: a report in 1990 cited the range of survival to discharge after resuscitation attempts from 29 cities that ranged from 2% to 25% for all cardiac rhythms and from 3% to 33% for cases showing ventricular fibrillation as first rhythm [1]. Moreover, centres with poor results tend not to report them with a resulting positive bias. No general improvement had been noted for 25 years or more, at least until recently [2].

The wide variation in results that have been noted even within countries is due not only to variations in facilities, procedures, training, and experience of prehospital emergency services but also to very large disparities in hospital survival from those admitted after return of spontaneous circulation has already been achieved. A recent American Heart Association policy statement [3] concluded that 'effective hospital-based interventions for out-of-hospital cardiac arrest exist but are used infrequently. Barriers to implementation of these interventions include lack of knowledge, experience, personnel, resources, and infrastructure.' The same situation exists in the United Kingdom [4], making a persuasive case for specialist cardiac arrest centres.

Steps for improving cardiac arrest:

The following are seen as important steps to improve survival from out-of-hospital cardiac arrest:

1. **Pre-arrival instructions:** Telephone pre-arrival instructions for adult cases judged to be cardiac in origin should be for compression-only for the first 6 minutes. Wherever possible, the rescuer should be prompted for the correct rate at 100 per minute (which can be achieved readily if there are two in attendance or if a mobile phone can be used in loudspeaker mode). The staff offering this guidance need a visible metronome (such as a visible electronic signal in a prominent position that can be seen by all staff). Staff should also be aware of, and listen out for, agonal breaths so that rescuers can be made aware that this is an indication to continue compressions, rather than to stop them.

2. **Use of manual defibrillation:** If AEDs are used, the manual mode can avoid the considerable loss in compression numbers that are inevitably caused by prompts. The adverse effects caused by the interruptions has been shown in an animal models [5]; In another study, a marked improvement in survival was shown when manual defibrillation was compared to an automated mode [6]. In clinical practice, responders using automated defibrillators were unable to use compressions for more than half the time [7], whilst in one centre the adoption of sequences of compressions with only minimal interruptions improved survival 3-fold [8]. Whilst the automated mode provides a reasonable strategy for those who are modestly trained, healthcare professionals can achieve more with a fully manual technique.

3. **Chest compressions**: Except for cases of VF/VT occurring when the defibrillator is immediately available, a sequence of compressions should be given before any attempt is made to defibrillate [9,10], as is optional under current Resuscitation Council Guidelines (2006). (See appendix 1). The compressions must be of good quality if the attainable benefit is to be realized. The optimal method is to give 100 compressions to optimise coronary flow [11] as soon as cardiac arrest is recognised (clinically rather than by ECG). With 2 operators, this can be occurring whilst the AED is made ready and pads are attached. A brief interval of 3 or 4 seconds is then taken to confirm the rhythm from the screen. For a non-shockable rhythm, conventional ERC guidelines are then followed but if a shockable rhythm is identified, another 100 compressions are given immediately. This sequence allows for the possibility that a non-shockable rhythm sometimes reverts to VF under the influence of compressions, and allows a few moments rest for the rescuer (or for another to take over).

4. **Reducing 'hands off' time**: With AEDs in manual mode, compressions can be continued during charging, as is also advised by the AHA for healthcare professionals. The shock button is pressed by the operator who is compressing the chest to avoid the risk of secondary shocks. This allows for the shortest possible interval between the last compression and the shock. Considerable experimental and human data [12] show that this is crucial for optimal rates of Return of Spontaneous Circulation (ROSC).

5. Compressions should be re-started within 3 seconds of the last compression. A sequence of 100 uninterrupted compressions is followed by a rhythm check. A previous clinical observational study using AEDs showed that the post shock delay to resumption of compressions averaged 29 seconds [13].

6. The use of a small metronome is strongly recommended so that compressions are given at 100 per minute (as in point 1 above); by guiding rate, audiotones can greatly increase indices of blood flow [14]. Most healthcare professionals compress far too rapidly very often to the extent that compressions are totally ineffective.

7. All paramedics and EMTs must be aware of the risks of excessive ventilation rates that achieve little but greatly reduce the blood flow on which recovery depends [15]. Ventilation rates should never exceed 12 per minute with the time taken for inflations minimised. "Breaths cost flow" and for several minutes are not necessary.

8. Crews should NOT move a patient who is still in a shockable rhythm unless the situation poses a serious safety risk. The perceived need for privacy is NOT a reason for moving a patient.

9. After ROSC, crews should stay on scene for 10 minutes observing the patient carefully. Many recurrent arrests occur during this time; further resuscitation attempts whilst a patient is being moved or transported are much less likely to be immediately successful than rapid defibrillation on scene.

10. Download analysis should be performed whenever possible from electronic cards or ECG data collected by other appropriate means [16]. These should be analysed and the findings made known to crews as feed-back reports.

11. For reasons cited in the introduction, survival is likely to be enhanced by taking patients who have regained a spontaneous circulation to designated 'cardiac arrest hospitals'.

12. Enthusiasm can be engendered not only by increasing success rates but also by regular meetings for reinforcement of the newly adopted principles, or feedback, for discussion, and also for providing increasing confidence in ECG interpretation. These can be on a voluntary basis; an important overall impact is made even if only small numbers can or do attend.

A section of an algorithm is shown in appendix 1 to demonstrate the principles outlined above.

Involvement of the Clinical Audit and Research unit (CARU)

Whilst this project does not meet the standard definitions of a research project, to ensure that the evaluation is robust and is of a high standard, data will be handled in accordance with best practice and research project management guidelines. This means that a systematic and rigorous approach will be adopted towards data collection, storage and reporting. All raw data will be collated by and stored within CARU, and will be archived for a minimum of five years upon project completion. Data will be entered onto a database by the Cardiac Researcher and verified and quality assured by an independent member of the CARU team. The Cardiac Researcher will analyse the data using a specialised statistical software package, utilising the advice of CARU's external consultant statistician as appropriate. The Cardiac Researcher will also be responsible for interpreting the results and making recommendations for the final report.

Proposed pilot LAS Complexes:

Three Complexes, one in each LAS geographical sector have been identified in relation to their 'feeder' hospital(s). The ultimate vision is that these hospitals will become 'cardiac arrest centres'. The three complexes proposed are:

Pinner (Pinner, Kenton and Wembley stations):
Pinner Complex was chosen for the West Sector due to the high number of cardiac arrests, reasonable ROSC/survival figures and presence of particularly enthusiastic staff.
The hospitals chosen as potential 'cardiac arrest centres' in that area are **Northwick Park** and **Harefield**.

Wimbledon (Wimbledon and Battersea stations):
Wimbledon Complex was selected to represent the South Sector due to the reasonable number of cardiac arrests and high ROSC/survival rates. **St Georges Hospital** is the chosen potential 'cardiac arrest centre'.

Tower Hamlets (Poplar and Silvertown):
Tower Hamlets Complex was chosen for the East Sector as it is staffed by young, enthusiastic paramedics and EMTs and has a relatively high 'ROSC sustained to hospital' rate, however the overall survival figure is 0%, making this an ideal Complex to attempt to increase overall survival. The hospitals identified as potential 'cardiac arrest centres' are the **Royal London** and **London Chest**.

Complex	No. of cardiac arrests	ROSC to hosp(%)	Overall survival (%)	Paras	EMTs	Team leaders	Ambulances	*FRUs
Pinner	174	22	7.9	49	43	7	19	6
Wimbledon	103	31	12.4	30 (+21 students)	31	7 (+1 sector trainer)	11	4
Tower Hamlets	70	24	0	39	20	3	9	5

*FRUs include Team Leader and DSO vehicles
N.B. Cardiac arrest data was taken from LAS cardiac arrest annual report 2008-09

References

1. Eisenberg MS, Horwood BT, Cummins RO, Reynolds-Haertle R, Hearne TR. Cardiac arrest and resuscitation: a tale of 29 cities. *Ann Emerg Med* 1990;19:179-86.

2. Sasson C, Rogers MA, Dahl J, Kallermann AL. Predictors of survival from out-of-hospital cardiac arrest: a systematic review and meta-analysis. *Circ Cardiovasc Qual Outcomes* 2010;3:63-81.

3. A Policy Statement From the American Heart Association. Regional Systems of Care for Out-of-Hospital Cardiac Arrest. *Circulation*. 2010;121:709-29.

4. Nolan J. Personnal communication (from National Cardiac Arrest Audit).

5. Yu T, Weil MH, Tang W et al. Adverse outcomes of interrupted precordial compression during automated defibrillation. *Circulation*. 2002;106:368-372.

6. Berg RA, Hilwid RW, Kern KB et al. Automated external defibrillation versus manuald for prolonged ventricular fibrillation: lethal delays of chest compressions before and after countershocks. *Ann Emerg Med.* 2003;42:458-467.
7. van Alem AP, Sanou BT, Koster RW. Interruption of cardiopulmonary resuscitation with the use of the automated external defibrillator in out-of-hospital cardiac arrest. *Ann Emerg Med.* 2003;42:449-457.

8. Bobrow BJ, Clark LL, Chikani V et al. Minimally interrupted cardiac resuscitation by emergency medical services for out-of-hospital cardiac arrest. *JAMA* 2008;299:1158-65.

9. Cobb LA, Fahrenbruch CE, Walsh TR et al. Influence of cardiopulmonary resuscitation prior to defibrillation in patients with out-of-hospital ventricular fibrillation. *JAMA*. 1999;281:1182-8.

10. Wik L, Hansen TB, Fylling F et al. Delaying defibrillation to give basic cardiopulmonary resuscitation to patients with out-of-hospital ventricular fibrillation: a randomized trial. *JAMA*. 2003;289:1389-95.

11. Ewy GA. Cardiocerebral resuscitation. The new cardiopulmonary resuscitation. *Circulation* 2005;111:2134-2142.

12. Edelsona DP, Abellaba BS, Kramer-Johansen J et al. Effects of compression depth and pre-shock pauses predict defibrillation failure during cardiac arrest. *Resuscitation* 2006;71:137-45.

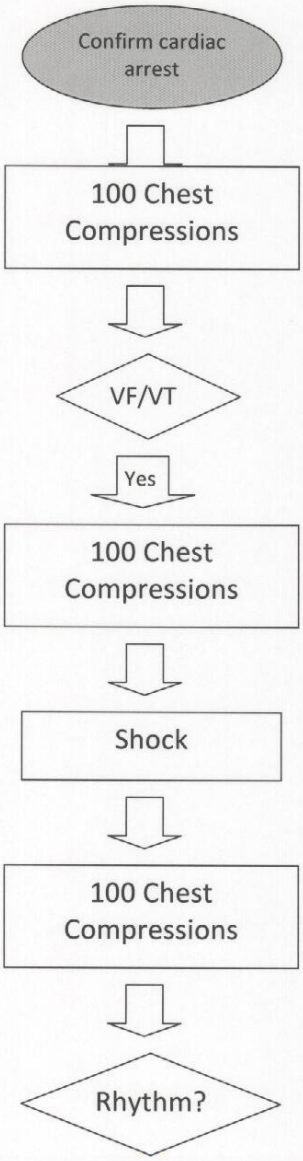
13. Rea TD, Shah S, Kudenchuk PJ et al. Automated external defibrillators: to what extent does the algorithm delay CPR? *Ann Emerg Med 2005*;46:132-41.

14. Kern KB, Sanders AB, Raife J et al. A study of chest compression rates during cardiopulmonary resuscitation in humans. The importance of rate-directed chest compressions. *Arch Intern Med* 1992 Jan;152(1):145-9.

15. Aufderheide TP, Sigurdsson G, Pirrallo RG et al. Hyperventilation-Induced hypotension during cardiopulmonary resuscitation. *Circulation* 2004;109:1960-5.

16. Chow-In Ko P, Chen W-J, Chih-Hao Lin C-H et al. Evaluating the quality of prehospital cardiopulmonary resuscitation by reviewing automated external defibrillator records and survival for out-of-hospital witnessed arrests. *Resuscitation* 2005;64:163-9.

Appendix 1


Confirm cardiac arrest
100 Chest Compressions
VF/VT
Yes
100 Chest Compressions
Shock
100 Chest Compressions
Rhythm?

7

Summary of Findings from a Clinical Audit of the Care of Obstetrics Patients Transported by London Ambulance Service

Authors: Stephen Gadd, Clinical Audit Manager
Gurkamal Virdi, Assistant Head of Clinical Audit & Research

Introduction

Obstetrics cases constitute approximately 2% of the London Ambulance Service NHS Trust (LAS) overall workload. The majority of obstetric cases require care for routine labour or an imminent birth; serious obstetric complications are a rare event. The rarity of serious complications presents an increased clinical risk to the Service through unfamiliarity and skill decay. Between 1991 and 2004, the LAS received 93 complaints related to obstetric incidents and nationally obstetric incidents are one of the top sources of litigation claims against ambulance services. A large-scale audit into obstetrics care has assessed the quality of care we are currently providing in London.

Method

This was a collaborative audit between the LAS and three maternity units: the Royal London, Homerton and St. George's. Crews submitted a midwife outcome form at handover to the maternity unit. The form was designed to capture the midwives' assessment of the woman and fetus. In addition, it captured whether they thought ambulance conveyance was appropriate, whether the woman required admission to the unit and whether the crews' patient records were accurate representations of the case in their opinions. Completed forms were collected by the Clinical Audit & Research Unit and the midwife outcome data compared to an assessment of the call tapes and the care given on scene by LAS crews. Call tapes were assessed using standard Advanced Medical Priority Dispatch System (AMPDS) case evaluation tools and the care given on scene assessed against audit standards derived from Joint Royal College Ambulance Liaison Committee (JRCALC) Clinical Practice Guidelines.

The second component of the project was to obtain the women's views of the care they received, their expectations and the circumstances which led to the ambulance being called, through a questionnaire. Ethical approval for the study was obtained because of this contact with a vulnerable group. As part of writing to the women, their consent to be included in the audit project was sought.

A total of 164 cases were included in the audit. Cases were categorised as routine (*n*=121) or emergency (*n*=43) based on the crew's documentation of illness code and supporting documentation.

Results

The emergency call

There was a clear correlation between calls allocated the highest LAS (Red) response, and calls identified by the crews as being emergencies. Emergency call tapes were reviewed and found to have an AMPDS case evaluation compliance score of 86% (AMPDS compliance score is 90%). The emergency medical dispatchers had an average customer service score of 99%.

Care by attending crews

LAS crew assessment of primary observations was very good, although assessment of secondary observations was so identified as an area for improvement. Areas of

documentation requiring improvement included recording the history of pregnancy, which was documented for only 64% of cases. The audit also found that only 73% of eligible women were offered entonox.

The types of obstetric complications that presented to the LAS during the audit were severe haemorrhage and continuous abdominal pain. Management of these patients was good, although documentation of blood loss volume and movement of the baby could be improved.

Conveyance
Patients are generally being conveyed appropriately according to the JRCALC Clinical Practice Guidelines. However, the use of pre-hospital alerts in cases with complications was not consistent.

Midwives were asked to document on the midwife outcome form whether they felt the woman required ambulance transportation. 35/130 responses to this question stated that ambulance transportation was required (27%); for obstetric emergency cases this figure rose to 18/31 cases with a response to this question (58%).

Questionnaire
After exclusions, for example if the woman was under 18, 150 questionnaires were sent and 27 people responded. The majority of respondents to the questionnaire stated they called an ambulance for normal presentations of labour. Women were asked if they were satisfied with the service they received: 85% of respondents stated they were completely satisfied. However, two respondents stated they were not satisfied and when asked to elaborate on reasons why described themes relating to staff attitude.

Summary
The majority of women presenting with normal obstetric conditions and obstetric complications in this audit received appropriate care from the LAS although specific areas of documentation were identified as requiring improvement. The responses to the questionnaires indicate that the majority of women in the audit were pleased with the care they received. The questionnaire responses also indicate the majority of women called an ambulance for normal presentations of labour. Recommendations have been formulated which include recommendations aimed at improving the care given to obstetric patients and exploring ways to further the education of ante-natal women about what constitutes normal and abnormal signs of labour.

Recommendations

- Crews should be reminded to exercise caution when attending all obstetrics cases, as ambulance services have only limited capabilities in identifying and managing obstetric abnormalities.

- Crews should be reminded of the importance of taking more than one set of observations, as time allows, to detect any changes in the woman's condition. This is especially important in cases where the woman presents with frank bleeding and severe, continuous abdominal pain.

- A memory aide should be produced listing the key questions to ask and document for routine pregnancies, to include: history of the presenting pregnancy, history of previous pregnancies and live births, estimated date of delivery, the pain score and whether entonox administration is required. In

- Crews should be reminded to document an estimated volume of blood loss when a woman presents with bleeding, or a reason why this could not be documented.

- The LAS continues to work with maternity units and Healthcare for London to ensure dedicated emergency alert lines are placed in each unit.

- The LAS should explore ways of encouraging the further education of ante-natal women about what constitutes normal signs of labour and what constitutes signs of potential complications to help them to know when to call an ambulance.

- Crews and call-takers should maintain a positive, polite and kind attitude when dealing with all Service users.

- Crews and call-takers should be commended that the majority of questionnaire respondents were very happy with the service they received.

- A further audit focusing on obstetric emergencies cases should be conducted in the future.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

29th June 2010

PAPER FOR NOTING

Document Title:	**Demand Management Presentation**
Report Author(s):	**Peter Bradley/Martin Flaherty**
Lead Director:	**N/A**
Contact Details:	**N/A**
Why is this coming to the Trust Board?	**The Trust Board requested an update on demand management at a previous Board meeting**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	The Board are asked to discuss and note the presentation

Executive Summary/key issues for the Trust Board

The presentation is split into two parts. Firstly Peter Bradley will talk about the findings from a piece of work commissioned last year by the Department of Health entitled *Tackling Demand Together*, a toolkit for improving urgent and emergency care services by understanding increases in 999 demand. Secondly, Martin Flaherty will update the Board on the work the LAS is doing to deal with demand in a different way.

Attachments

A hard copy of the slides will be made available to the Board members at the Board meeting

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Corporate Objectives 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper links to the following strategic risks:

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

NHS Constitution

This paper supports the following principles that guide the NHS:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☒ No

Key issues from the assessment:

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

29th June 2010

PAPER FOR APPROVAL

Document Title:	**Purley property lease**
Report Author(s):	**Martin Nelhams**
Lead Director:	**Mike Dinan**
Contact Details:	**Michael.dinan@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**All material leases require Trust Board approval**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☒ Trust Board (Jan 2007)
Recommendation for the Trust Board:	To approve the lease for the replacement of the Purley Ambulance Station

Executive Summary/key issues for the Trust Board

The Business case for the replacement of Purley Ambulance station was approved in January 2007. The case for change is based on the requirement for a new Ambulance station as the existing accommodation at Purley hospital is inadequate in terms of facilities and inappropriate being located on the first floor of the hospital. Purley hospital has also requested that the LAS vacate the premises.

The preferred option is to purchase an existing building and convert for use as an ambulance station. However, an extensive property search has not found any suitable sites for purchase. Leasehold premises have been located at 21 Ullswater Crescent, Ullswater Trading Estates, Coulsdon, Surrey CR5 2HR. The premises provide approx 200 m2 of office/storage space and 240 m2 of garage space for 3 ambulances and 1 RRV with external parking for circa 8 cars. Planning permission for the site for change of use to an Ambulance station has been granted. It is proposed to take a 10 year lease with a 5 year break option.

Capital costs of £80k and annual revenue costs of £45k are affordable.

The 5 break option allows the trust to develop its overall Estates strategy for South London without making a long term decision on a facility in the Croydon area

Attachments

None

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Corporate Objectives 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper links to the following strategic risks:

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

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

- ☐ Yes
- ☒ No

Key issues from the assessment:

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

29th June 2010

PAPER FOR APPROVAL

Document Title:	**Quality Account 2009/10**
Report Author(s):	**Rachel Jennings & Sandra Adams**
Lead Director:	**Sandra Adams**
Contact Details:	**020 7783 2045**
Why is this coming to the Trust Board?	**Legal requirement under the Health Act 2009 to publish an annual Quality Account:**
This paper has been previously presented to:	☒ Strategy Review and Planning Committee ☒ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	To approve the Quality Account for 2009/10

Executive Summary/key issues for the Trust Board

- Quality Accounts are annual reports to the public from providers of NHS healthcare services about the quality of services they provide;
- We should use the Quality Account to inform the public, patients and others on the areas where we are doing well, where we need to improve service quality, what our priorities are for the coming year, and how we have involved service users, staff and others in determining the priorities for improvement;
- The Trust Board is accountable for the Quality Account and must assure themselves and then state publicly within the document that the information presented is accurate;
- We have used the framework of the Department of Health toolkit for Quality Accounts to structure the document and have incorporated the required statements which are shaded in grey;
- We have incorporated the statement from the LAS Patients' Forum. This includes their comment regarding membership of the Quality Committee to which we have responded but not received a formal response;
- The Strategy, Review and Planning group reviewed an early draft and the Senior Management Group then reviewed a further document leading to the final version;
- The Quality Account will be published on our NHS Choices profile page and on our website. We will incorporate a summary of the account into the summary annual report and accounts which is due for publication in September in line with the AGM. We are also required to place a notice at 'the premises where your patients are receiving their healthcare services, stating where the Quality Account can be obtained'.

Attachments

Quality Account 2009/10

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Corporate Objectives 2010 – 13

This paper supports the achievement of the following corporate objectives:

☒ To have staff who are skilled, confident, motivated and feel valued and work in a safe environment
☒ To improve our delivery of safe and high quality patient care using all available pathways
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Risk Implications

This paper links to the following strategic risks:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☒ No

Key issues from the assessment:

London Ambulance Service NHS
NHS Trust

Quality Account 2009-10

PART ONE

The aim of this account is to provide easy access information about the quality of the services we provide. It defines how we measure quality and enables comparisons between services.

This is the first Quality Account for the London Ambulance Service NHS Trust and we hope that it assures the reader of the focus we have placed on assessing and improving the quality of our services during 2009/10.

In recent months the Trust's Board of Directors has introduced a new governance structure with a focus on quality, safety and effectiveness, and how we learn from experience and feedback.

The Board has made a commitment to quality improvement and places this high on the agenda as we progress towards becoming one of the first ambulance NHS foundation trusts and we are looking forward to greater engagement with our foundation trust members during the coming year.

During 2010/11 we will continue to work closely with the London Ambulance Service Patients' forum to address a number of the issues they raise in their commentary (Appendix one). We will also be planning our next Patient Care conference which was so well received in January 2010 and gave us invaluable feedback as well as contacts for future engagement

1. Introduction

1.1 The London Ambulance Service NHS Trust provides emergency and urgent care services for people who live, work and visit the capital. The population of more than 7.6 million[1] residents and an estimated one million daily visitors across 625 square miles of London is supported by over 5,000 staff located at 71 ambulance stations, strategically placed to ensure patients receive fast response.

1.2 Our **Vision** is **to meet the needs of the public and our patients, with staff who are well trained, caring, enthusiastic and proud of the job they do**. In the future there will be an increased focus on the quality of care provided by ambulance services and not just the speed of response[2]. Eventually this will result in the replacement of Category B response times, which are calls considered to be serious but not immediately life-threatening, with clinical and outcome indicators.

1.3 We work towards our Vision through the achievement of three strategic goals:

- **Care for patients:** to improve our delivery of safe and high quality patient care using all appropriate pathways:
- **Good for staff:** to have staff who are skilled, confident, motivated, feel valued and who work in a safe environment;
- **Value for money:** to be efficient and productive in delivering our commitments and to continually improve.

1.4 Underpinning the Vision and strategic goals are the eight CRITICAL values for the Trust, which reflect those of the NHS Constitution and Values. These cultural values are:

- **Clinical excellence**
- **Respect and courtesy**
- **Integrity**
- **Teamwork**
- **Innovation and flexibility**
- **Communication**
- **Accept responsibility**
- **Leadership and direction**

[1] Source: Office for National Statistics, Mid-2008 Population Estimates for UK, August 2008.
[2] Taking Healthcare to the Patient: Transforming NHS Ambulance Services. Department of Health 2005.

1.5 Our key quality priorities in 2009/10

We identified three key priorities in the quality of care we deliver to our patients. These are based on the three dimensions of quality: safety, effectiveness and patient experience[3]. Our priorities are as follows:

- Respond appropriately to our patients' needs
- Improve cardiac care outcomes
- Improve patient experiences.

1.6 Key Achievements in 2009/10

Clinical Practice Manager Mark Whitbread reached the finals of the 2009 NHS Leadership Awards for his work with cardiac care. Mark was one of three finalists out of 700 entrants in the Change Leader of the Year category. Mark was instrumental in setting up a network of eight specialist heart attack centres in the capital.

Our **Control Services** have been awarded a Customer Service Excellence Award, valid for three years, by the Cabinet Office. This followed a detailed external scrutiny of the service and it was deemed to provide service to a very high standard with some notable examples of good practice. The LAS is now one of only 16 NHS Organisations to receive this highly prestigious award and the first Ambulance Service.

We are involved in a number of **clinical audit** projects and are at the forefront of pre-hospital ambulance research at a national and local level. For example, we are nearing completion of the Smart Cardiopulmonary Resuscitation (CPR) project which is being undertaken in collaboration with New York's Emergency Medical Service. This project is looking at whether the survival rate from out-of hospital cardiac arrest can be improved by using an upgraded piece of software in the FR2 Automated External Defibrillator (AED).

In January 2010 we held a **Patient Care Conference** at the Emirates Stadium. This was well attended by patients, foundation trust members, voluntary groups, and stakeholders such as St John Ambulance and Community First Responders. This offered a superb opportunity for people to exchange views about their experiences and to contribute to future planning, including how the Quality Account should look this year.

[3] High Quality Care for All: NHS Next Stage Review Final Report. Department of Health 2008.

To the best of my knowledge the information contained in this document is accurate.

Signed:

Peter Bradley

Chief Executive Officer

June 2010

PART TWO

2. Priorities for quality improvement in 2009/10

This section describes the work we have undertaken in the past year to improve the quality of our services and to engage with others in doing so. We have focussed this section of the report on the three priority areas listed in 1.5 above and we have used case studies to illustrate progress where relevant.

2.1 Priority 1: Responding appropriately to our patients' needs

NHS Ambulance Trusts are required to achieve performance targets relating to speed of response and therefore improving our response times is a key objective for us. We also recognise however the importance of responding appropriately to all of our patients. Many patients who contact the ambulance service could receive care within the community, and many do not need to be treated in an emergency department and we are working with health and social care partners to address this for the future.

In order to effectively meet the needs of our patients, we have already introduced a number of additional response models.

- **Clinical telephone advice**

Calls to our control room that do not need an immediate ambulance response are passed to our clinical telephone advice team.

The team is made up of experienced medical technicians, paramedics and an emergency care practitioner and they establish what the best course of treatment is for the patient. This could be being cared for at home, or being referred to the local pharmacy, GP or walk-in centre.

The clinical telephone advice team dealt with around 47,000 calls during 2009/10. This is a significant decrease on the previous year due to the introduction of referrals to NHS Direct. On average 30% of these clinical telephone advice calls are dealt with without the need to send any vehicle to the patient, keeping ambulances free for those patients who really need them and ensuring that patients receive the most appropriate care.

Progress is monitored monthly and reported to the Trust Board. This is also a Key Performance Indicator (KPI) and CQUIN in our contract with commissioners.

- **Referrals to NHS Direct**

Certain calls that do not need an immediate ambulance response are passed to NHS Direct. This is a national nurse-led telephone helpline which provides healthcare advice 24 hours a day so that patients can manage problems at home or find out where to turn for the appropriate care. Referring these calls ensures optimal care is delivered to the patient.

In 2009/10 we referred 60,375 calls to NHS Direct. This is approximately 50% of calls to the Clinical Telephone Advice team.

Progress is monitored monthly and reported to the Trust Board. This is also a Key Performance Indicator (KPI) and CQUIN in our contract with commissioners.

- **Conveying patients to specialist units**

The provision of healthcare in London is changing and we have played a leading role working with Healthcare for London and other health partners to ensure we provide the best and most appropriate care for patients. Eight hyper-acute stroke centres and four major trauma centres have been approved in the capital and these specialist units will be linked to local units delivering general and rehabilitation care.

We already take our cardiac patients to specialist units and from April 2010 we started taking stroke and major trauma patients to specialist units.

Developing the new stroke and major trauma pathway has involved us producing new clinical decision trees to guide staff and setting up a Clinical Coordination desk to monitor decisions on major trauma and stroke patients in real time.

Progress is monitored monthly and reported to the Trust Board. This is also a CQUIN in our contract with commissioners.

- **Care pathways**

We know our patients prefer being treated in the community and are less likely to be repeat callers if they access a service which can manage their condition in the long term. Currently 60% of the patients we convey to Accident & Emergency (A&E) are not admitted. Therefore we are aiming to reduce unnecessary A&E admissions and prioritise care in the community so as to ensure we provide the most appropriate clinical care.

We currently have 56 referral pathways, including those to minor injury units and treatment centres, district nursing, mental health teams, falls teams and crisis teams for the homeless. The development of new pathways has been aided by the introduction of Community Involvement Officers at pilot sites as part of our New Ways of Working programme. These individuals support and facilitate local involvement, both with patients and the public and with partner organisations.

Since the utilisation and number of pathways available varies significantly across London the project to develop these pathways and increase their utilisation will continue next year. Unfortunately our Emergency Care Practitioner programme was decommissioned for 2010/11 however we intend to utilise these staff and their valuable skills and experience in supporting all our staff to increase their confidence in identifying patients whose presenting

complaint would be more suited to a care pathway rather than a conveyance to an emergency department.

This is monitored monthly and is a CQUIN in our contract with commissioners.

- **Improving response times**

We are providing better care and reaching more patients more quickly than ever before. However patients continue to wait longer for a response from us at weekends than at any other time. To improve this we are increasing the numbers of frontline staff and reviewing rosters to ensure staff availability. We are also investing in other resources to help us respond more quickly. Our use of fast response cars, motorcycles and bicycles means we can navigate London's busy roads, narrow streets and pedestrian areas much better than in an ambulance.

We have been training volunteers in local communities in basic life-saving skills so they can attend and treat patients with a life-threatening illness or injury while an ambulance is on the way. Six of these schemes were set up in the last year and we are planning to expand this to even more parts of London.

New technology has also played a part in reducing patient waiting times. We now use existing call data to predict where the next emergency call is likely to come from, meaning we can place ambulance crews closer to incoming 999 calls. Instead of our crews waiting for emergency calls at ambulance stations, they now provide cover from standby points within the community.

The system we use to automatically dispatch our ambulances continues to reduce the number of patients waiting for an emergency crew. The system won two top regional prizes last year at the NHS Innovator London Awards and the Health and Social Care awards in the Innovative Information and Communications Technology category.

2.2 Priority 2: Improving cardiac care outcomes

- **Rationale for prioritisation**

Responding to patients with cardiac conditions such as those experiencing a heart attack, or in cardiac arrest, is a core function of ambulance services and a clinical priority area for the London Ambulance Service. Clear guidelines for ambulance services are set out in the National Service Framework for coronary heart disease[4] and reducing morbidity and mortality from heart disease and related illness is a national priority[5].

Patients experiencing an ST-elevated myocardial infarction (STEMI), a common type of heart attack, have been shown to benefit from rapid definitive treatment at a specialist unit with 24/7 consultant presence, access to

[4] National Service Framework for Coronary Heart Disease. Department of Health 2000.
[5] Saving Lives: Our Healthier Nation. Department of Health 1999.

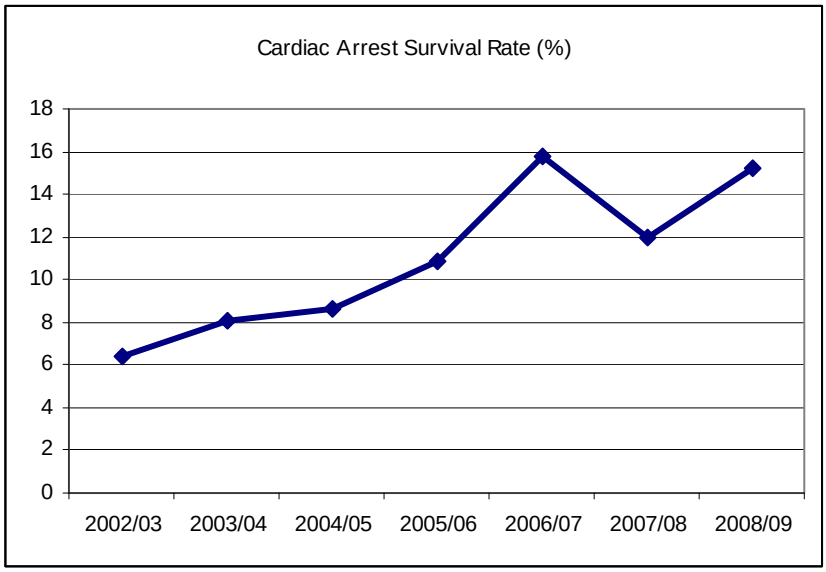
diagnostics, and early treatment[6]. We were the first ambulance service in the United Kingdom to directly convey STEMI patients to such specialist heart attack centres.

We attend more than 10,000 out-of hospital cardiac arrests per year. A cardiac arrest occurs when a person's heart stops beating meaning that blood and oxygen are no longer travelling round the body to vital organs. For each patient the administration of cardiopulmonary resuscitation (CPR) and the use of a defibrillator rapidly increases their chance of survival. There are now over 480 defibrillators in public places across London and we have trained more than 5,500 people to use these so they can begin life-saving procedures while our staff are on their way.

Our aims are to:

a) Increase survival to hospital discharge rates for patients who have suffered a cardiac arrest;

Cardiac arrest survival rate[7]:



b) Increase the number of STEMI patients conveyed directly to a specialist heart attack centre.

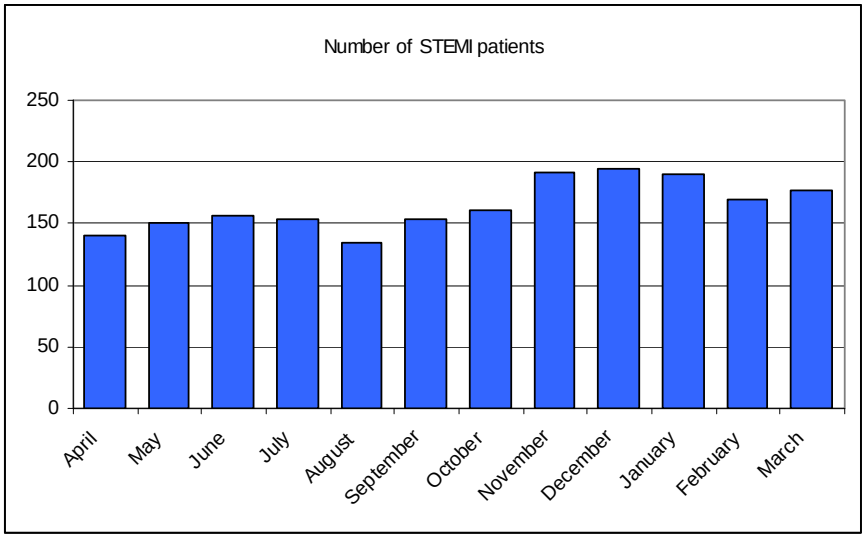
- In 2009/10 we attended 20% more STEMI patients that in 2008/09.

[6] PTCA reduces adverse cardiac outcomes and death better than thrombolytics after myocardial infarction. Keeley EC, Boura JA, Grines CL. Primary angioplasty versus intravenous thrombolytic therapy for acute myocardial infarction: a quantitative review of 23 randomised trials. Lancet 2003; 361:13–20

[7] The cardiac arrest survival figure is calculated using the Utstein method, which takes into account the number of patients discharged alive from hospital who had resuscitation attempted following a cardiac arrest of presumed cardiac aetiology, and who also had their arrest witnessed by a bystander and an initial cardiac rhythm of ventricular fibrillation or ventricular tachycardia.

- The average time spent on scene has increased from 33 minutes in 2008/9 to 36 minutes.
- The number of STEMI patients conveyed to A&E with no valid reason stated reduced from 3% in 2008/09 to 1%.

Direct conveyance of STEMI patients to heart attack centres:



- **Identified areas for improvement**

There are a number of actions we are taking to improve the number of STEMI patients who were conveyed to A&E with no valid reason stated.

- Improving the accuracy of recording on patient report forms and increasing the submission of defibrillator data.
- Delivering refresher training for frontline staff to increase their confidence in identifying STEMI patients and conveying them to a specialist unit.
- Producing communications to staff to put STEMI patient care in the spotlight.
- Improving the feedback to individual staff regarding patient outcomes. Knowing the improved outcome for patients can help give staff the confidence to bypass the local Accident and Emergency and instead convey the patient to the specialist unit.

- **Initiatives in 2009/10**

- A two week clinical update course for team leaders**.**
- The development and distribution of 12 lead electrocardiogram (ECG) summary cards. These are designed to assist staff in identifying a STEMI patient and the best destination for early treatment.
- Introduction of extra defibrillators in public places, along with the required training.

The clinical audit and research unit audit patient outcomes and this is fed back to staff as described above in a cycle of continuous improvement. Progress is routinely reported to the Trust Board through the clinical quality and patient safety report.

Case Study:

Cardiac care:

Tynisha Johnson-Ballantyne was with her mother, Yvonne, in Boots on Islington High Street in December when she suffered a cardiac arrest (her heart stopped beating) and she stopped breathing.

Once alerted by Yvonne, Boots staff called 999 for an ambulance and Pharmacist Krinal Shah started cardiopulmonary resuscitation (CPR). Krinal said: "I've taken a course in emergency life support, and I could immediately see that Tynisha was suffering from a cardiac arrest. I started to give her CPR while my colleagues called for an ambulance."

Within a few minutes two motorcycle paramedics and an ambulance crew were on the scene. "When we arrived we found Krinal giving CPR to good effect, which essentially kept Tynisha alive while we were on the way. Once there we used a defibrillator to deliver an electric shock to Tynisha's heart to start it again. It's a simple fact that if more people learnt basic life support then more people suffering cardiac arrests, young and old, would survive."

Tynisha was taken to University College Hospital for further treatment. Tynisha suffers from left ventricular hypertrophy, an enlarged heart, and was discharged from Great Ormond Street Hospital 14 days later with a pacemaker. Yvonne said: "I can't thank the ambulance staff enough; Tynisha wouldn't be here without them.

2.3 Priority 3: Improving the patient experience

In 2008 the Department of Health launched an early adopter programme for Making Experiences Count. This is a reform of the health and social care complaints system which was designed to provide a single, comprehensive complaints process across health and social care, focussed on locally resolving complaints with a more personal approach.

We were chosen to take part in the programme to develop a local approach to complaint resolution. Our patient experiences team is now the first point of contact for all comments, questions, feedback or concerns about the service or treatment delivered by us.

In 2009/10 our patient experiences team received 6,138 enquiries, varying from requests for medical records to issues about ambulance delays and the clinical care provided. This was a 10% increase on the previous year and included 456 complaints.

- **Frequent Callers**

We introduced a 'frequent callers unit' which is the first of its kind for an ambulance trust in the country. We define a frequent caller as a patient who has placed at least 10 emergency calls in a month. Although there are a relatively small number of frequent callers these patients make it harder for us to reach others with more serious or potentially life-threatening conditions. However we recognise that many of these patients have complex health and social needs and we therefore work closely with other health and social care organisations to ensure they receive the appropriate care and support.

The unit includes a dedicated social worker who advises on when and how best to intervene, as well as providing important advice on policy issues such as the Mental Health Act. The unit also works with GPs, primary care trusts and other health and social care professionals to try to understand and resolve the reasons why people may become frequent callers. The ultimate aim is to be able to develop an emergency care plan that helps the patient receive more appropriate care through alternative care pathways, which also helps to reduce pressure on the service.

As well as working with individuals the unit works with addresses we frequently receive calls from. These range from supermarkets and ice rinks to residential or nursing homes using the service more frequently than expected for their size and type of resident. The unit works with these organisations to review their first aid and care policies and ensure the service is only called when we are the most appropriate type of care.

- **Initiatives**

As part of the Making Experiences Count initiative we created a new Patient Experiences department which brings together all the feedback we receive from inside and outside of the Trust.

We use feedback as a learning opportunity and publish examples of changes made arising from service user feedback on our website.

Case Study:

Learning from feedback:
A patient under the care of a mental health unit was on 'home leave' and became unwell; the attending crew was unable to convey the patient to the unit as there was no direct care pathway agreement in place. The crew offered to take the patient to the local Accident and Emergency but the patient's mother felt this was totally inappropriate and chose to arrange for the patient to be taken another destination. As an outcome following review, the local ambulance manager agreed to ensure ambulance complex staff were familiar with referral guidelines with the local Mental Health Assessment Team and to raise this incident at a liaison meeting with the local mental health provider Trust, to achieve an improved care pathway.

Patients and the public are to be involved in newly-established Patient Environment Access Groups. These multi-disciplinary groups will focus on cleanliness and infection control, and will undertake inspection visits across London. Members of the London Ambulance Service Patients' Forum and Foundation Trust members will be invited to take part in this new initiative, which will be the first in an NHS ambulance service, and will include a full induction and training programme.

A group has been established to improve the service we provide to people with learning disabilities. The actions arising from this group are likely to include improved staff training and materials to support people with learning disabilities. We plan to involve people with learning disabilities in the development of the training programme and the supporting materials.

A public education action plan is being implemented for 2009-2011 and includes the introduction of a new risk assessment process for public events and working with teachers to develop materials for children. A number of new materials and resources have been designed and introduced ranging from lesson plans, presentations and display banners, through to give-away items such as pens, rulers, oyster-card holders and leaflets.

Case Study:

999 text trial
Hearing or speech-impaired Londoners can now access help during a medical or other emergency following the launch of a text-based service. 'emergencySMS' is currently being piloted nationally, and can be used by members of the public who have registered their mobile phone. To access help, users must send a text which includes which service is needed, a description of the problem and the location of the incident. When the message arrives in the emergency operations centre, the patient is triaged using text messages and the appropriate response is sent.

Patient experience and feedback, and patient & public involvement reports are made to the Trust Board twice a year.

2.4 Review of services

During 2009/10 the London Ambulance Service NHS Trust provided and/or sub-contracted one NHS service. The London Ambulance Service has reviewed all the data available to them on the quality of care of these NHS services.

The income generated by the NHS services reviewed in 2009/10 represents 96% of the total income generated from the provision of NHS services by the London Ambulance Service NHS Trust for 2009/10.

The Trust Board has received reports and presentations on a range of quality initiatives during the year as well as routine reporting data to provide assurance of progress being made.

The medical director's report has developed into a monthly report on clinical quality and patient safety, using the Care Quality Commission's 7 domains for core standards for better health to structure these reports. With effect from April 2010, the Trust Board established a new governance structure with an increasing focus on quality, safety, risk and effectiveness, incorporating the patient experience and how we learn from feedback and information.

The Trust Board reviewed the findings of the Francis Inquiry into the failings of Mid-Staffordshire NHS Foundation Trust and sought to assure itself of the robustness of systems within the London Ambulance Service. It also reviewed the requirements of the NHS Constitution and was satisfied that the CRITICAL values (see section one) met this.

Going forward, the Trust is implementing the strategies for Wellbeing and Staff Engagement, and for Equality and Inclusion. The Quality Committee will use the quality assurance framework produced by Monitor, independent regulator for NHS foundation trusts, to shape its assurance processes, and reporting against quality initiatives and progress will be enhanced on the board agenda.

2.5 Participation in clinical audits

During 2009/10 one national clinical audit and one national confidential enquiry covered NHS services that the London Ambulance Service NHS Trust provides.

During that period the London Ambulance Service NHS Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the London Ambulance Service NHS Trust was eligible to participate in during 2009/10 are as follows:

- National CPI programme covering:

- ST-elevated myocardial infarction (STEMI)
- Cardiac arrest
- Stroke
- Hypoglycaemia
- Asthma.
- Confidential enquiry into maternal, adolescent and child health.

The national clinical audits and national confidential enquiries that the London Ambulance Service NHS Trust participated in during 2009/10 are as follows:

- National Clinical Performance Indicators programme covering:
- ST-elevated myocardial infarction (STEMI)
- Cardiac arrest
- Stroke
- Hypoglycaemia
- Asthma.
- Confidential enquiry into maternal, adolescent and child health.

The national clinical audits and national confidential enquiries that the London Ambulance Service NHS Trust participated in, and for which data collection was completed during 2009/10, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

- National CPI programme covering:
  - ST-elevated myocardial infarction (STEMI) (100%)
  - Cardiac arrest (100%)
  - Stroke (100%)
  - Hypoglycaemia (100%)
  - Asthma (100%).
- Confidential enquiry into maternal, adolescent and child health (100% for the cases for which we have been given full details).

Information: Clinical Performance Indicators (CPIs) are a tool designed to bring continual improvement to the clinical care provided by the London Ambulance Service. They focus on clinical areas where there is strong evidence that following the correct practice leads to the best outcome for patients, or where there is a clinical risk associated with the patient group. The delivery of care in these areas is routinely audited by clinical leads, and the results of these audits are fed back to crew members on a one-on-one basis so they can make personalised recommendations on how they can improve performance. This process has led to clear improvements in care over time. For example, as a result of the CPI process one part of the Service has improved its documentation of whether cardiac arrest patients had a witnessed arrest by 33% since the beginning of the financial year.

The reports of one national clinical audit were reviewed by the provider in 2009/10 and London Ambulance Service intends to increase the proportion of patients presenting with an ST-elevated myocardial infarction (STEMI) who receive pain-relieving medicine which will improve the quality of healthcare provided:

- To increase the proportion of patients presenting with an ST-elevated myocardial infarction (STEMI) who receive pain-relieving medicine which will improve the quality of healthcare provided.

The reports of four clinical audits were reviewed by the provider in 2009/10 and the London Ambulance Service NHS Trust intends to take the following actions to improve the quality of healthcare provided:

Benzylpenicillin audit

- Increase compliance in documenting benzylpenicillin reconstitution and administration details
- Remind crews of the importance of rapid transportation of patients with suspected meningococcal septicaemia

Furosemide re-audit

Information: Furosemide is used to treat pulmonary oedema secondary to heart failure. The London Ambulance Service conducted a clinical audit into the use of this drug as research evidence suggests ambulance crews often give furosemide when it is not indicated. The audit found that patients given the drug had received thorough observations but in a large number of patients there was not sufficient documentation of signs, symptoms and history to warrant its use. As a result of this audit, we will continue to investigate alternative methods to treat this patient group and has launched an improvement campaign to underline the signs and symptoms of pulmonary oedema secondary to heart failure, and how to increase the likelihood of differentiating between this condition and those that present with similar symptoms.

- Provide staff with further training in the diagnosis of pulmonary oedema secondary to left ventricular failure;
- Increase the number of 12-Lead ECG readings acquired from patients presenting with suspected left ventricular failure and encourage documentation of exceptions;
- Ensure ambulance staff are familiar with the Joint Royal Colleges Ambulance Liaison Committee 2006 guidelines for furosemide administration;
- Investigate alternative techniques for the treatment of pulmonary oedema secondary to left ventricular failure in the pre-hospital environment.

Oxygen audit

- Increase ambulance staff awareness of the Joint Royal Colleges Ambulance Liaison Committee 2009 oxygen guidelines;

- Increase compliance to documenting oxygen dose and administration details.

Naloxone (Narcan) audit

- Increase the number of 12-Lead ECG readings acquired from patients with a physical dependency on narcotic drugs when administering naloxone;
- Confidential Enquiry into Maternal, Adolescent and Child Health: 100% for cases for which we have been given the full details.

2.6 Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the London Ambulance Service NHS Trust in 2009/10 that were recruited during that period to participate in research approved by a research ethics committee was 101.

Additional patients and employees were recruited to research studies conducted in collaboration with other organisations. For example 300 London Ambulance Service employees were recruited to a study identifying emergency personnel at risk of Post-Traumatic Stress Disorder.

2.7 Commissioning for Quality and Innovation

A proportion of London Ambulance Service income in 2009/10 was conditional on achieving quality improvement and innovation goals agreed between London Ambulance Service and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2009/10 and for the following 12 month period are available on request from Khaled Kassem-Toufic, Head of Business Development (contact email - khaled.kassem-toufic@lond-amb.nhs.uk)

2.8 What others say about the London Ambulance Service NHS Trust

- **Care Quality Commission**

London Ambulance Service is required to register with the Care Quality Commission and its current registration status is 'registered without conditions'.

The Care Quality Commission has not taken enforcement action against London Ambulance Service during 2009/10.

London Ambulance Service was inspected by the Care Quality Commission on 29th and 30th July 2009 on compliance with the code for prevention and control of infections. London Ambulance Service has implemented a 12-point action plan to address the requirements reported by the CQC, against which substantial progress is being made.

2.9 LAS Patients' Forum

We routinely engage with the LAS Patients' Forum and a number of members are active within committees and groups throughout the service contributing to policy and service development and improvement. Managers and staff from across the Trust also regularly attend Forum meetings and arrange additional events for members, such as the induction programme, station visits and ride-outs. Forum members also take part in events such as the Patient Care Conference and at this year's conference the Forum ran a break-out session. We consider the Patients' Forum to be a key partner in our developments.

In an extract from the LAS Patients' Forum annual report for 2009/10:

'In the view of the Forum, the LAS takes active steps to take account of the views and experiences of patients, users, carers and the local community including Local Involvement Networks (LINks).'

The Forum has produced a statement for inclusion in this Quality Account and we have provided this as Appendix A.

2.10 Data Quality

The London Ambulance Service NHS Trust did not submit records during 2009/10 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. This is not a requirement for ambulance services.

The London Ambulance Service NHS Trust score for 2009/10 for Information Quality and Records Management, assessed using the Information Governance Toolkit was 41%.

Action is underway to improve this score by the end of the first quarter of 2010/11.

The London Ambulance Service NHS Trust was not subject to the Payment by Results clinical coding audit during 2009/10 by the Audit Commission.

PART THREE

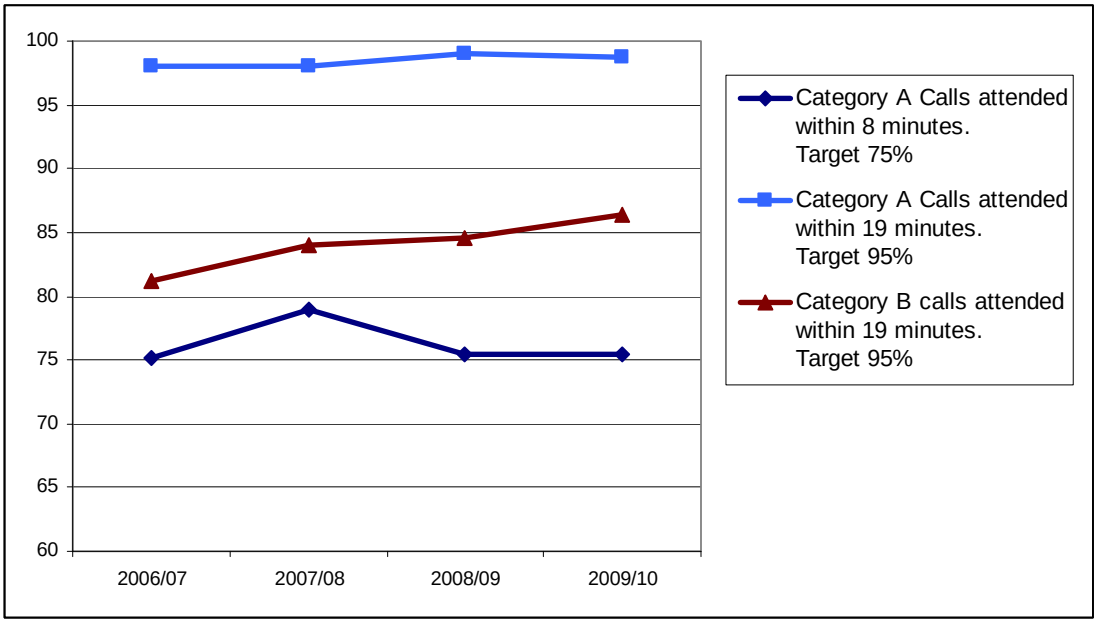
In this section we describe the quality of our services and how we have performed during 2009/10.

3.1 Performance against regulatory requirements

- Quality of financial management: we were rated 'excellent' for the way in which we managed our finances in 2008/09 under the Care Quality Commission's annual health check 'use of resources' assessment which was the highest of any ambulance service, and we expect to receive the same rating for 2009/10. This financial management rating is determined by the Auditors' Local Evaluation (ALE) which assesses how well NHS organisations manage and use their financial resources. We were the only ambulance service to achieve the maximum score of 4 in this assessment.

- Quality of care: we were rated 'fair' by the Care Quality Commission in 2008/09 for the quality of services provided to our local population. One of the reasons for this rating was our failure to reach 95% of Category B calls (categorised as serious illness or injury) in 19 minutes. This was due to high demand, particularly during the winter months, and for the first time the number of incidents we attended in one year exceeded 1 million. The high demand resulted in high ambulance utilisation meaning that fewer ambulances are available to respond to calls.

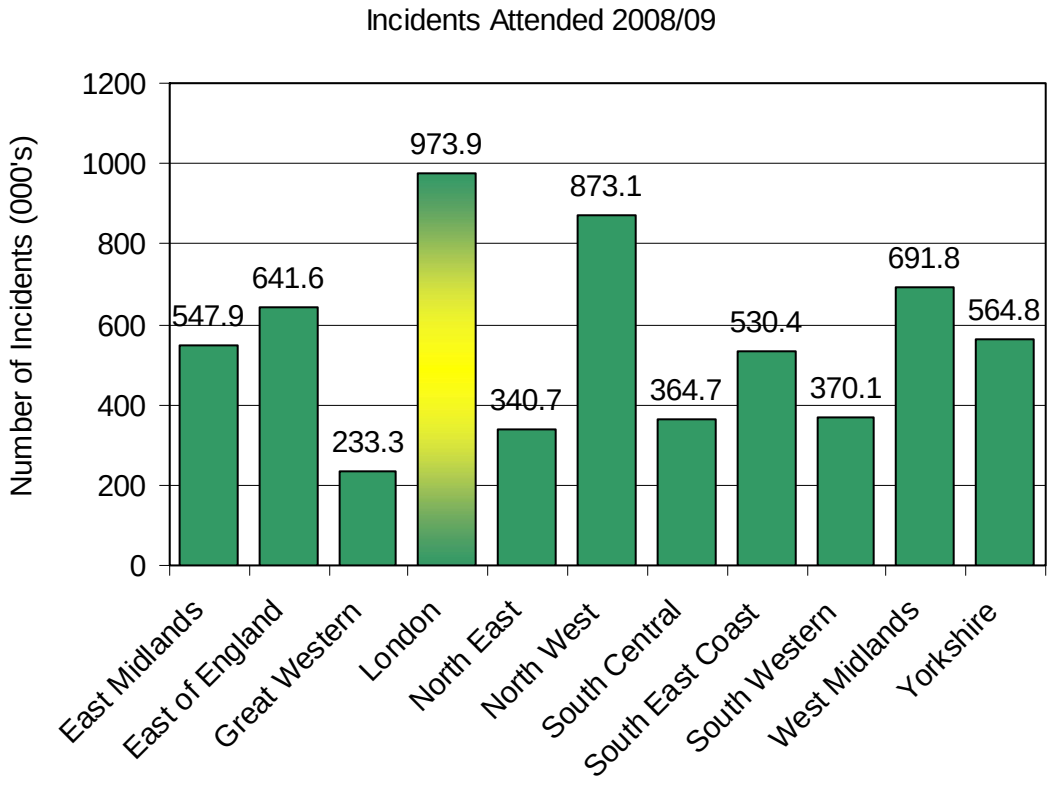
Graph showing performance against call response targets



- Level of performance: in 2009/10 our crews attended over 1 million incidents. This was more than any other ambulance trust. It was an increase of nearly four per cent on the previous year, of which over 330,000 incidents were Category A, where patients are assessed as being in an immediately life-threatening condition. The graph below shows how we performed in 2008/09 compared to other NHS ambulance service

trusts (comparative data for 2009/10 not yet available). We remain the busiest ambulance service in the UK.

Graph showing incidents attended, by NHS ambulance trust, in 2008/09



- Improving Category B response times: we will continue to recruit and train more frontline staff during 2010/11 and we will be receiving more ambulances. These ambulances will not only increase the number of vehicles available but also require less maintenance than the older vehicles and therefore spend more time on the road.

- Reducing hospital turnaround time and increasing the number of care pathways available: the hospital turnaround time is divided into two parts, including the time taken from arrival at the hospital to transferring the patient into the care of the hospital and the time taken from patient handover to the ambulance crew being available for the next call. Currently the average total turn around time is 32.9 minutes which is a 2 minute reduction since April 09. Throughout the year the London Ambulance component of the handover time, the second part, has reduced by 3.5 minutes to 19.3 minutes. We are aiming to reduce this to 15 minutes by the end of 2010/11 and will continue to work with all our health partners to reduce the total hospital turnaround time.

- Speed of response: from April 2008, the 'clock' used to measure the speed of response to a call also changed so that it started once the caller was

connected to the control room. Previously it started when the caller's telephone number and the patient's location and nature of their illness or injury had been established. The change means that recorded response times now start approximately two minutes earlier than they did, while the actual target of eight or nineteen minutes remains unchanged so patients are getting a better service from us.

- Patient experience: our patient experience score was over 90% but was rated as a fail by the Care Quality Commission when compared to other ambulance trusts. The score was determined by a national survey of Category C service users. Category C calls are those where the illness or injury is not considered to be serious or life-threatening.

  Although satisfaction levels were high and all ambulance trusts performed well in the survey, we scored slightly lower overall than other ambulance trusts. One example of where we scored lower was the length of time patients had to wait for a member of the ambulance service to arrive. However 97 per cent of respondents said that they had received a good, very good or excellent level of care from us. Being an outlier caused us to be the only ambulance trust to receive a rating of poor for patient experience in the Care Quality Commission assessment. A project group has been established to identify potential areas for improvement, and take forward actions and recommendations arising from the survey.

- Staff satisfaction: we were rated as being below average and have developed a plan to improve in specific areas. We have increased the level of training for operational staff during 2009/10 and will be implementing the Wellbeing and Staff Engagement strategies in the coming year.

Table showing 2009/10 performance against regulatory quality indicators

	2009/10
Safety Measures	
National Clinical Performance Indicators Overall Score	
% of Clinical Performance Indicators audits undertaken	45%
% of CPI elements of care delivered to the patient	94%
Clinical Outcome Measures	
% of STEMI patients taken to specialist centre or A&E with valid reason	97 %
Out-of-hospital cardiac arrest survival rate	15.2 %
Referral Pathway Utilisation (% of patients not conveyed to A&E)	36 %
Patient Experience Measures	
Category C User Satisfaction (% of respondents who said that they had received a good, very good or excellent level of care from us)	97%
Patient Transport Service User Satisfaction	

	Target	**2007/08**	**2008/09**	**2009/10**
Care Quality Commission Core Standards	N/A	Fully Met	Fully Met	N/A

Care Quality Commission Existing Commitments[8]	N/A	Almost Met	Partly Met	
Care Quality Commission National Priorities[9]	N/A	Excellent	Fair	
Category A within 8 minutes[10]	75%	79%	75.5%	75.5%
Category A within 19 minutes	95%	98%	99%	98.7%
Category B within 19 minutes	95%	84%	84.5%	86.4%

Note: The 2009/10 results for the indicators shaded in blue were not available at the time of publication of this document.

4. In summary

The London Ambulance Service NHS Trust has made a commitment to improving the quality, safety, and effectiveness of its services. The Quality Account for 2009/10 is intended to assure the reader of the progress we have made in the three priority areas during the year, and also or the improvements we have made in areas such as performance. In the coming year we have made further commitments to quality improvement and to learn more from feedback and experience on how we have performed and where we can do better. We have put in place the governance processes to support this and have made a commitment at Board level to ensure we have even more to report in next year's Quality Account.

Hard copies of the 2009/10 Quality Account can be obtained from:

Sandra Adams
Director of Corporate Services/Trust Secretary
Sandra.adams@lond-amb.nhs.uk
020 7783 2046

[8] Care Quality Commission Existing Commitments 2008/09 partly met as we failed to meet the target to reach 95% of Category B calls within 19 minutes.
[9] Care Quality Commission National Priorities 2008/09 scored as fair due to ratings of under achieved for staff satisfaction and fail for patient experiences. Rating of achieved for management of asthma, management of stroke and transient ischaemic attack, management of acute myocardial infarction, management of hypoglycaemia and management of cardiac arrest.
[10] Calls are classed as Category A where it is assessed there is an immediate threat to life. Serious incidents are prioritised as Category B and Category C calls are neither serious nor life-threatening.

Appendix One

Quality Accounts 2010 - statement

Patients' Forum Ambulance Services (London) Ltd

Forum Officers

Company Secretary: John Larkin

Chair:
Malcolm Alexander
30 Portland Rise
LONDON, N4 2PP
patientsforumLAS@aol.com -

0208-809 6551

Vice Chair:

Sister Josephine Udie
sisterjossi@hotmail.com

Vice Chair:
Joseph Healy
j-j@freezone.co.uk

Public Involvement

LAS has taken active steps to take account of views and experiences of patients, users, LINks and the Patients' Forum by:

- seeking views and taking them into account when planning services.
- carrying out consultations and discussions with patients, the Patients' Forum and LINks.
- Involving Patients' Forum/LINk members in the work of some LAS committees.

In 2010 the Forum was refused membership of the Quality Committee, which replaced the Governance Committee. Forum representatives had previously sat on the Governance committee and made active contributions.

LAS quality improvements sought by the Forum:

a) Publish information on the impact of public views and involvement on development of services, strategies and policies. Include responses to consultations.

b) Introduce a systematic approach to consulting Patients' Forum/LINks on new and revised policies and strategies.

c) Ensure LINks and the Patients' Forum continue to be given opportunities to contribute to decisions about planning and providing services, through representation on key committees and steering groups, co-designing services and delegating activities to users and community representative to reflect requirements in *Real Involvement* (DH)

Category A Responses

Carry out a retrospective study of the 4591 patients who were classified as Category A in 2009 who did not receive a Category A response, to assess outcomes for patients not receiving a Cat A response within 19 minutes.

Multi-disciplinary reviews of patients care

Arrange for all paramedics and technicians to meet with A&E/hospital clinical staff in formal multidisciplinary meetings, to review the care they have provided and to learn lessons from the clinical outcomes of patients who have been in their care.

Patient Transport Services

Adopt the Quality Standards for PTS developed by the Patients' Forum in collaboration with patients, LINks and voluntary sector groups.

Staff training

Ensure all completed staff training episodes are recorded, records kept updated and accessible for public scrutiny.

Communications with patients

Develop a programme to encourage Emergency Operations Centre staff who can speak more than one language, to qualify to practice clinically in these languages, to ensure that whenever possible all patients receive an appropriate and timely emergency service.

Diversity in the LAS workforce

Seek advice from the Equality and Human Rights Commission to enable the LAS to bring about a transformation in workforce diversity that reflects the population of London. Examine recruitment procedures and 'cultures' within the LAS to isolate factors, which prevent the development of a fully diverse LAS frontline work force and take urgent action to address significant findings.

Mental Health Care

Review care and treatment of people suffering from severe mental health problems taken from a public place or their home to a 'place of safety'. Assess clinical outcomes and the patient's views on the care received. Consider developing an expert cadre of paramedics trained as mental health practitioners.

Complaints and Incidents

Recommendations from each patient complaint to the LAS should be sent to the Patients Forum immediately after investigation. After six months the LAS should produce a report on implementation of each recommendation with evidence of impact, outcomes and enduring improvements to LAS services.

End 17/6/2010

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

29th June 2010

PAPER FOR NOTING

Document Title:	**NHS foundation trust application**
Report Author(s):	**Sandra Adams**
Lead Director:	**Sandra Adams**
Contact Details:	**020 7783 2045**
Why is this coming to the Trust Board?	**To update the board on the application process**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	To note the update on the NHS foundation trust application process

Executive Summary/key issues for the Trust Board

- The development of key components of the application process is progressing with the integrated business plan (IBP) being the principal document for submission later this year.
- The current timeline is: circulation of draft IBP in July 2010 to LAS staff council, NHS London's FT team and to commissioners for feedback; discussions with NHS London regarding the timing and process for historical due diligence of which there are two phases, taking us through to October 2010.
- After this part of the process we look to the PCTs for a letter of support and at the sector managing directors' meeting in early June there was agreement that they would consider the best process for providing this; once this is received and the Trust Board approves the final IBP and long term financial model we would ask the SHA to support submission of our application to the Secretary of State. At present we have timetabled this for November/December 2010.
- The Secretary of State review process takes 4 – 6 weeks and we would then be looking at the Monitor review process from February 2011. Once our application has been referred to Monitor we would start the nominations and election process for governors to sit of the Council of Governors.
- The Monitor review process takes 12 weeks so we may be looking at authorisation as an NHS ambulance foundation trust in May 2011.
- The FT project board meets monthly and we are in regular contact with NHS London's FT team who are represented on the project board, as is our lead commissioner.
- The draft IBP has been circulated to board members in advance of the board meeting and will be discussed in more detail in a board development session on the afternoon of 29th June prior to finalising the version that will be shared with key stakeholders (see bullet point 2 above).
- It is proposed that the strategy review and planning meeting on 27th July focuses solely on the IBP and financial model.

Attachments
N/A

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Corporate Objectives 2010 – 13
This paper supports the achievement of the following corporate objectives:

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

Risk Implications
This paper links to the following strategic risks:

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

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

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

Equality Impact Assessment

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

Key issues from the assessment:

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

29th June 2010

PAPER FOR APPROVAL

Document Title:	**Infection Prevention and Control Policy**
Report Author(s):	**Trevor Hubbard, AOM Infection Prevention and Control**
Lead Director:	**Dr Fionna Moore, Director of Infection Prevention and Control**
Contact Details:	**LAS Headquarters**
Why is this coming to the Trust Board?	**Statutory requirement**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☒ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	To approve the Infection Prevention and Control Policy
Executive Summary/key issues for the Trust Board This policy has undergone a major revision to meet NHSLA level 1 requirements which were not met at the last review in November 2008. It is hoped that this will allow the Trust to achieve level 2 by the next NHSLA assessment in October 2010. The policy has been updated with current information and is part of the ongoing infection control programme work streams.	
Attachments Infection Prevention and Control Policy	

****

Corporate Objectives 2010 – 13
This paper supports the achievement of the following corporate objectives:

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

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This paper links to the following strategic risks:

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

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☒ Yes
☐ No

Key issues from the assessment:
outcome A

London Ambulance Service NHS Trust

Infection Prevention and Control Policy

DOCUMENT PROFILE and CONTROL.

Purpose of the document: Provides a clear and comprehensive policy in order to assure infection control and decontamination arrangements throughout the Trust.

Sponsor Department: Medical Directorate

Author/Reviewer: AOM Infection Prevention & Control. To be reviewed by June 2013.

Document Status: Final

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
08/06/10	3.3	Records Manager	Reformatted
05/05/10	3.2	AOM Infection Prevention & Control	Major Revision. Added s8, 13; Amended introduction; objectives, responsibilities, s. 5, 7, 10, 11, 12; Appendix - membership; Expanded scope, s. 6, monitoring; Removed appendix II Infection Control Co-ordinator Job Description
12/12/08	3.1	Head of Records Management	Minor revision to s.7, para 10.
26/09/08	2.1	Head of Operational Support, Medical Director, Head of Governance	Revision
11/10/07	1.1	Head of Records Management	Revised
30/06/05	0.1		First draft

***Version Control Note:** All documents in development are indicated by minor versions i.e. 0.1; 0.2 etc. The first version of a document to be approved for release is given major version 1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved**.**

For Approval By:	**Date Approved**	**Version**
Clinical Quality, Safety & Effectiveness Committee		4.0
Clinical Governance Committee	12/11/08	3.0
Clinical Governance Committee	15/10/07	2.0
Chief Executive	10/05	1.0
Agreed by Trust Board (If appropriate):		

Published on:	Date	By	Dept
The Pulse	XX/XX/XX	Records Manager	CGT
LAS Website	XX/XX/XX	Records Manager	CGT
Announced on:	**Date**	**By**	**Dept**
The RIB		Records Manager	CGT

Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**
	Infection Control Manual	
	Health and Social Care Act 2008	
	ICSG Terms of Reference	
	National Patient Safety Agency (NPSA) Specification for the Cleaning of Vehicles and Premises	
	LAS Infection Control Quarterly Audit Tool	
	Vehicle Audit Tool	
	Premises Audit Tool	
	LAS Uniform and Work wear Policy	
	LAS Hand Hygiene Policy	
	LAS Decontamination Policy	
	Joint Royal Colleges Ambulance Liaison Committee Guidelines	
	ATOS Occupational Health Manual – Sharps and inoculation Injury	
	Department of Health Ambulance Guidelines	**2008**
	LAS Outbreak Policy	
	LAS Paramedic OSCE Pack	
	LAS Paramedic Education Airway Management	**2009**

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are not controlled nor substantive.

1. Introduction

This policy has been developed as part of the London Ambulance Service NHS Trust's (LAS) ongoing commitment to promote high standards of infection prevention & control throughout the organisation and to ensure that it complies with the Health and Social Care Act 2008 and its associated Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and CQC standard outcome/patient safety Related Guidance. It aims to minimise the risks of healthcare associated infection to all patients and members of our staff and ensures that so far as reasonably practicable patients, staff and other persons are protected against risks of acquiring Health Care Associated Infection through the provision of comprehensive training and appropriate care, in suitable facilities, consistent with good clinical practice. The Policy aims to ensure that patients with an infection, or who acquire an infection during treatment, are identified promptly and managed according to good clinical practice for the purpose of treatment and to reduce the risk of transmission.

The LAS sets out to achieve this by the continual review of its practices, utilising both audit and compliance monitoring processes to identify areas for further improvement. By analysing the resultant outcomes, the LAS seeks to constantly develop safer systems of work to maximise the wellbeing and safety of patients, as well as all of those involved in the delivery of our Service. The Public can get involved, by logging onto the LAS home webpage to see how and what the service is doing.

2. Scope

This Policy covers arrangements to ensure effective infection control in all aspects of the Trust's operations.

The Health and Social Care Act 2008 places a responsibility upon the LAS to deliver high quality infection, prevention and control practice throughout the organisation.

This policy applies to all relevant personnel employed by or that come into contact with the LAS, including patients, the public, contractors and voluntary staff.

3. Objectives

1. To confirm the Trust's commitment to the control of infection and to set the strategic direction for infection control initiatives.

2. To promote education and training in all aspects of infection control.

3. To reduce the risk of HCAI to patients and improve the safety of all persons who come into contact with the LAS.

4. Responsibilities

4.1 The Trust Board

The LAS NHS Trust Board is committed to and responsible for the control and prevention of infection. The Trust Board will ensure that by delivering appropriate management systems for infection prevention and control of infection are in place, patients, staff and other persons are protected against risks of acquiring healthcare associated infections through the provision of appropriate care, in suitable facilities, consistent with good clinical practice.

The Trust Board has overall responsibility for monitoring the effectiveness of infection control measures. It will monitor using the Assurance Framework, a programme of infection control audits on stations, the Annual Infection Control report and Infection Control updates contained within the Medical Director's reports.

4.2 Chief Executive Officer

The Chief Executive of the Trust has overall statutory responsibility. The Chief Executive delegates this responsibility to a Director for Infection Prevention and Control (DIPC), the Medical Director who is directly accountable to the Trust Board.

4.3 Director for Infection prevention and Control (DIPC)

It is the responsibility and role of the DIPC to:

- Report directly to the Chief Executive Officer, Senior Management Group (SMG) and the Trust Board to ensure that any changes in legislation or national guidance relating to infection control are made known to the organisation.
- Ensure that the Trust provides adequate resources to secure effective prevention and control of healthcare acquired infections.
- Ensure that the Trust implements an appropriate infection control infrastructure and infection control programmes.
- Ensure that appropriate actions relating to the prevention and control of infection are taken following recommendations from the SMG or Trust Board.
- Ensure that the Trust Board receives regular reports (including key performance indicator reports) with regards to infection control issues.
- Produce an Annual report on Infection Prevention and Control within the Trust as a public document

- Be responsible for the infection control team (ICT) within the Trust.

4.4 The Clinical Safety & Effectiveness Group

The Clinical Safety & Effectiveness Group is responsible for monitoring audits and the implementation of recommendations arising from them and any relevant issues relating to infection control, and feeding information into the Trust.

4.5 Infection Control Steering Group (ICSG)

The Infection Control Steering Group (ICSG) co-ordinates the development and implementation of infection prevention and control policy for the Trust. The Group will ensure that Department of Health guidelines, policy and initiatives are applied and developed. The group will oversee monitoring auditing activity and compliance and ensure effective liaison with the DIPC. The group will promote best practice in all areas of infection control and prevention.

Infection control will be monitored through the ICSG which 'aims to provide a robust mechanism for assuring infection control arrangements, providing advice on hygiene, infection prevention & control matters and establishing a framework for developing improvements in order to optimise patient care and staff safety.

The ICSG is chaired by the Head of Operational Support who is nominated by the Medical Director and meets on a quarterly basis. It reports through to the Trust Board via the Clinical Safety & Effectiveness Group and Group membership will comprise of appropriate management representation, staff representation and a specialist advisor on Infection Control (Appendix 1 - Terms of Reference).

4.6 Ambulance Operations Manager for Infection Prevention and Control

The AOM for IPC has delegated responsibility from the DIPC to provide infection control advice to all disciplines within the Ambulance Trust on a day to day basis.

- To advise on the management of patients with specific infections to minimise the risk of cross infection to other patients or staff.

- Through liaison arrangements, identify specific transportation requirements of patients with infection being discharged to the community in order to ensure good continuity between impatient and community services in the delivery of care and prevention of cross infection.

- To work with Head of Operational Support and Assistant Director of Corporate Services within the Trust to regularly appraise current infection prevention and control practices and to keep them updated.

- To interpret and explain reports or policy documents to Clinical Directorate staff.

- To work in liaison with the Emergency Planning Officer and Head of Records Management and Business Continuity in ensuring infection control is incorporated into major incident plans.

- To produce written reports on compliance with the Health & Social Care Act 2008 for the Care Quality commission registration requirements and ensure that accurate records are kept of all infection control audits and activities. Co-ordinate and implement annual Infection Control Programme.

- To assist in advising on and monitoring the implementation of infection control guidelines within the Trust in collaboration with fellow professionals and relevant staff.

- To advise line managers within the Trust on the implementation of agreed policies in their areas.

- To report to the Trust Infection Control Steering Group and other appropriate committees within the trust's Governance structure (outlined in TP005 Risk Management Policy) as necessary.

- To keep Senior Management updated on recent advances in infection control.

- To give infection control advice in the planning of new service upgrades to equipment and capital projects.

- To advise on new equipment in line with the Equipment Procurement Policy and advise on infection control and decontamination standards.

- To lead in the development and advice on the delivery of infection control audit tools across the Trust and implementation of audits.

- To critically appraise and evaluate infection control practices through the planned programme of audit and to feedback results to SMG and progress reports to the Infection Control Steering Group.

- Facilitate and participate in the evaluation, development, delivery and review of infection control educational sessions for staff on every ambulance station including induction and mandatory training sessions.

- To develop a system to encourage the work of infection control in conjunction with the Trust Clinical Leadership Project and Operational managers.

- Have an awareness of current research developments and statutory regulations

disseminating information as appropriate.

- Maintain close links with local Universities of education and provide training sessions/programmes as required.

- Provide educational input to patients and carers, to include health promotion.

- To undertake under the direction from the Head of Operational Support and Assistant Director of Corporate Services research for evidence based practice and clinical effectiveness and the planning of future services and training needs.

- To provide telephone advice on Infection Control as part of an on-call system.

4.7 Assistant Director of Corporate Services

The Assistant Director of Corporate Services will advise whether or not the LAS complies with external requirements, identifying gaps in compliance, and report to the ICSG and the Trust Board as appropriate.

The Audit Manager will also monitor Infection Control related risks and report them to the Risk Compliance and Assurance Group, including them on the Trust's assurance Framework as appropriate.

The Governance and Compliance Team is responsible for developing, in partnership with the Clinical Audit and Research Unit, appropriate audits.

4.8 Clinical Education and Training Manager

The Clinical Education and Training Manager has responsibility for ensuring that an Infection Control Training programme, including updates, is in place and is available to be delivered to all operational staff as required by Infection Control legislation and standards. This responsibility is in taken in consultation with the practice learning manager with IPC portfolio.

4.9 Practice Learning Manager

A Practice Learning Manager acts as the clinical link and associate clinical lead supporting the Head of Operational Support by communicating education and development issues into and from of the ICSG.

4.10 Ambulance Operations Managers and all Heads of Department

All Managers must ensure that infection prevention and control is an integral part of their everyday role; as stated in the Management of Health and Safety at Work

Regulations 1999. Their responsibilities should include:

- Ensuring that current legislative and mandatory requirements are met.
- Ensuring hat the LAS Infection Control Policy is made available to all staff and that it is maintained with necessary updates.
- Compliance with the LAS NHS Trust Infection Control Policy is monitored and where necessary, appropriate action is taken.
- Adequate liaison and consultation is maintained with the Safety Representatives and Infection Prevention and Control Champions for staff.
- Regular inspections of the workplace are undertaken and any defects identified are managed appropriately.
- Support is provided to ensure that continuous infection control audit can be undertaken and action plans implemented where required.
- Information on infection control related matters is disseminated to all staff.
- All reported incidents, including near misses in relation to infection control are sufficiently investigated with appropriate action taken to prevent reoccurrence.

4.11 Infection Control Champions

Infection control champions are department / complex based acting as local link workers for infection prevention and control. They work with the management team in ensuring compliance with statutory requirements and cascading information to peers relating to infection prevention and control practices.

IPC Champions undertake local audits of vehicles, premises and the department audit alongside local managers.

Champions will have additional training and development to fulfil their role within the department.

4.12 All Employees

The Health and Safety at Work Act 1974 also places duties upon Trust employees with regard to health, safety & welfare. Trust policies also require employees to take responsibility for their own and others safety. Therefore LAS NHS Trust staff must:

- Understand their responsibilities under this policy and related guidelines, to maintain and increase their knowledge of the subject relative to their role.

- Take reasonable care of their own safety and that of others who may be affected by their acts or omissions.

- Have due respect for any equipment provided in the interests of health, safety and welfare.

- Have available and wear the correct personal protective equipment when required and to immediately report any defects in such equipment.

- Ensure they maintain good personal hygiene at all times and to ensure the cleanliness of equipment and vehicles they use.

- To maximise the Trusts infection control procedure, no food and drink should be consumed in any patient-bearing areas of any Trust vehicle (i.e. the back of ambulances and rear seats of FRU's – Fast Response Units).

- Conform to LAS NHS Trust policies and procedures relating to infection control / incident reporting / investigation

- Ensure that any equipment for service, maintenance or repair that has been in contact with or has potentially been in contact with body fluids is cleaned and where necessary decontaminated, prior to being sent for service, maintenance or repair.

- Report all incidents including near misses, involving themselves or a patient in their care as per the LAS NHS Trust incident reporting procedure.

5. Education Training and Development

The Trust will ensure that all relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive adequate training, information and supervision in infection control practices applicable to their role. All staff, during their induction process will receive infection control awareness training. All operational staff will receive mandatory infection control training and refresher training on an annual basis.

All patient-facing staff will receive initial infection prevention and control training to enable them to safely care for patients and themselves. This will include as a minimum, training in universal precautions, hand hygiene, vehicle and equipment decontamination. Information leaflets, Posters and other training material will be made available for all staff in infection prevention and control.

The Trust training needs analysis for all staff will include infection prevention and control training is regularly reviewed and implemented across the Trust.

A record of all infection prevention and control training undertaken by all operational LAS staff will be retained through archived achievement records on Promis. Non operational staff training will be added to the Training Manager system. A quarterly report will be produced for the ICSG and for inclusion within the DIPC annual report to the Trust Board.

These records will be available for both internal and external scrutiny.

6. Audit

The Trust is active in maintaining appropriate policies and procedures required to ensure a safe environment for patients, staff and visitors. Infection control environmental audits performed throughout the Trust will support the effective implementation of these documents.

All Trust ambulance station premises and ambulance vehicles will be subjected to regular audit and inspection, to maintain compliance with the Health and Social Care Act 2008, NPSA Guidance for cleanliness.

The LAS Make Ready Audit is an assurance document which allows the Trust to scrutinise the work undertaken by contractors for our make ready service. This is a check of the vehicle to ensure that it is stocked and clean and is undertaken on a daily basis by crew staff with a representative number returned to the logistics department for record.

The Station Cleaning Audit form is similar in that it assures the Trust that the cleaning on station is to an acceptable standard. This is undertaken at each site every week.

The Trust's Infection Control Audit tool has been developed to review performance including:

- The general hygiene of ambulance stations, cooking/washing facilities, and food storage.
- The storage and disposal of clinical waste and sharps
- The storage of used linen
- The decontamination and cleanliness of ambulance vehicles and medical devices

Each premises and/or operational station will undertake an audit four times a year in line with the audit cycle. Each audit will generate an action plan that each manager will review and address any issues that arise. This will form part of the monthly complex

meeting agenda. Recurrent issues that have not been addressed will be escalated to the area Health and Safety meeting. Issues that cannot be addressed at area meetings will be reported to the Corporate Health and Safety Group.

Audits and their results will be recorded centrally and reported four times a year to the ICSG and to the Trust Board, via the Balanced Scorecard and to commissioners.

7. Infection Control Programme

An Infection Control Programme must be produced annually to maintain the Trusts' compliance with local and national infection prevention and control policy and to achieve compliance with the Health & Social Care Act 2008 in respect of IPC issues. The Programme's implementation and progress will be monitored by the ICSG and reported to the Clinical Safety & Effectiveness Group on a quarterly basis. The progress of the IPC programme will also be reported to commissioners in a monthly report.

8. Assurance Framework

The Trust will utilise the Dynamic Change Performance Accelerator governance tool to ensure that evidence is provided to support the Hygiene code Module within the system. The DIPC will maintain sponsorship of the module with key managers feeding evidence to support the Trust requirements under the Health & Social Care Act 2008 in respect of IPC issues.

9. Infection Control Procedures

The Trust has developed Infection Control procedures as set out in the LAS Infection Control Manual so that staff understand their personal responsibilities for controlling infection. The Manual provides information relating to the mechanisms involved in the spread of infection; personal hygiene; personal protective equipment; authorised cleaning materials; cleaning of vehicles and equipment and other issues such as the management of clinical waste and linen. The Trust reviews Infection Prevention and Control procedures annually to ensure that they continue to reflect best practice.

10. Cleaning products and contracts

Only cleaning products approved by the ICSG are to be used to clean and disinfect Trust premises and vehicles. Any sub - contracted work will include the requirement that only approved products are to be used.

The agreed Specification for the Cleaning of Trust Vehicles and Premises is adhered to when employing sub - contractors for any cleaning related work. The Trust will offer advice and guidance in respect of infection control arrangements where appropriate and monitor that the LAS Infection Control procedures are complied with. All current products should be detailed in the infection control manual and staff should comply with

Control of substances Hazardous to Health (COSHH) regulations in terms of chemical management.

11. Equipment

Any clinical equipment proposed to improve infection control arrangements will be evaluated through the Trust trial and acquisition processes. Staff side engagement will be secured through the ICSG and/or the Vehicle and Equipment Working Group as appropriate. The AOM IPC and PLM IPC will provide the lead on clinical advice to staff as appropriate.

12. Make Ready Scheme

Vehicles are cleaned, fully equipped and available for use through a make ready process. Performance of the Make Ready Contractors is monitored through the Make Ready Contract Group which oversees Key Performance Indicators as determined by the contract. The components of the Make Ready contract or any subsequent cleaning contract relating to Infection Control will be reported quarterly, using Key Performance Indicators, to the ICSG to monitor compliance to Infection Control standards.

Whilst daily routine cleaning of ambulances and regular deep cleaning of ambulances is a significant component of the scheme, the scheme is not a substitute for clinical staff being accountable for the consistent achievement of best infection control practice.

13. Communications

13.1 Information to staff

All information relating to infection prevention and control is available on the service intranet (the Pulse) and this is updated in the event of a change in policy, procedure or as a result of review or compliance. Changes to policy or procedure are communicated through the routine information bulletin (RIB) or as an Education and Development or Medical Directorate bulletin.

13.2 Information to patients and the public

All information relating to infection prevention and control is available on the service website and this is updated in the event of a change in policy, procedure or as a result of incidents or surveillance which may influence the reaction of the public in using the service. Patients and the public can obtain additional information through the Patient Experiences Department.

IMPLEMENTATION PLAN	
Intended Audience	All LAS Staff
Dissemination	Available to all staff on the Pulse and to the public on the LAS website.
Communications	Revised Policy and Procedure to be announced in the RIB and a link provided to the document.
Training	Training to be carried out as outlined in Section 5 of this Policy
Monitoring	To ensure adherence to this Policy the Audit Manager will undertake an annual programme of audits using the existing quarterly audit tool to take place in a sample of stations across the organisation. Monitoring of Audits with information on completion, compliance and common areas for improvement will be carried out by the ICSG as a standard agenda item at the quarterly meeting.

Appendix 1

Infection Control Steering Group Terms of Reference

The Infection Control Steering Group (ICSG) co-ordinates the development and implementation of infection prevention and control policy for the Trust. The Group will ensure that Department of Health guidelines and initiatives are applied and developed. The group will oversee auditing activity and ensure effective liaison with the Director responsible for infection control is maintained. The group will promote best practice in all areas of infection control.

Purpose

The aim of the ICSG is:

To provide a robust mechanism for assuring infection control arrangements, providing advice on hygiene, infection prevention & control matters and establishing a framework for developing improvements in order to optimise patient care and staff safety.

Scope

The ICSG is responsible for disseminating national policy in accordance with Department of Health ambulance service guidelines. Under the terms of the Health Act 2006 the group will agree and implement an annual infection control programme.

The group is responsible for the oversight of audit activity, promoting education and development, considering new products and facilities, and monitoring incidents and risks associated with infection control issues.

The group has no authority to approve new products (this falls to the Vehicle and Equipment Working Group) but can make recommendations. The group has no responsibility in the investigation of infection control related incidents (this falls to local complex management, the Medical Department, or Health and Safety Department) but can ask for further information/investigations if a significant infection risk is apparent or trends are developing.

Responsibilities

The tasks of the ICSG are to:

- Ensure that the Trust has sound control of infection arrangements and the availability of advice on infection control issues.

- Develop and implement an annual programme to provide a framework for improving infection control arrangements and regularly review progress and

advise the Trust on the most effective use of resources to improve infection control.

- Periodically review the Infection Control Policy and Manual of Procedures.

- Continuously improve infection control throughout the LAS so that staff recognise their responsibility for patient and staff safety.

- Provide a recognised body within the LAS for the co-ordination of infection control issues.

- Raise awareness of infection control issues and to provide recognised communication channels to staff and managers.

- Seek and promote evidence based practice in relation to infection control arrangements.

- Provide a mechanism to cement responsibilities in relation to infection control issues including the demonstration of Board level engagement.

- Develop arrangements for robust Infection Control audits, including management arrangements and staff compliance, and the formulation of remedial action plans.

- Identify preferred infection control products based on sound clinical or technical evidence.

- Monitor the LAS OHD Vaccination Policy. The policy explains how the requirements for vaccination are established, how initial vaccination is to be carried out and how staff will be recalled for booster vaccination in due course.

- Raise awareness of sharps and body fluid exposure procedures.

- Ensure that planned estates work takes account of Infection Control issues.

- Develop an evidence based programme of estates works to improve infection control arrangements.

Outcomes

The ICSG will develop an annual programme to improve hygiene, infection prevention and control arrangements to ensure that they meet the requirements of the Safety standard domain and related Standards that form part of the Care Quality registration requirements for NHS Trusts.

Membership

Membership of the Group comprises staff representatives, senior managers and other appropriate staff from across the Trust, and an advisor (internal and / or external) in infection control.

- Head of Operational Support (chair)
- Practice Learning Manager
- Senior Training Officer
- Assistant Director Employee Support Services
- AOM Infection Prevention & Control
- Staff Side representative
- Senior Safety & Risk Advisor
- Corporate Logistics Manager
- Facilities Manager
- Audit Manager

Meetings

The Team will meet quarterly and the quorum for meetings will be an infection control lead, a senior manager and educational / operational representatives

Reporting

The Minutes of each meeting are reported through to the Trust Board via the Clinical Safety and Effectiveness Group and the Medical Director who includes a summary of infection control matters within the formal report to the Board. The Group produces an Annual Report on behalf of the Medical Director to the Trust Board.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

29th June 2010

PAPER FOR NOTING

Document Title:	**Trust Board Forward Planner**
Report Author(s):	**Sandra Adams**
Lead Director:	**Sandra Adams**
Contact Details:	**0207 783 2045**
Why is this coming to the Trust Board?	**To ensure that key issues are discussed by the Trust Board and that Trust Board members are fully engaged with the agenda planning process.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	To note the Trust Board forward planner for the coming year and to identify any areas for discussion for future agenda items.
Executive Summary/key issues for the Trust Board To note the Trust Board forward planner for the coming year and to identify any areas for discussion for future agenda items.	
Attachments Trust Board forward planner.	

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Corporate Objectives 2010 – 13
This paper supports the achievement of the following corporate objectives:

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

Risk Implications
This paper links to the following strategic risks:

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

NHS Constitution

This paper supports the following principles that guide the NHS:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☒ No

Key issues from the assessment:

TB FORWARD PLANNER

Date	Strategic and Business Planning	Items for approval (eg Policies and Business Cases)	Performance and Other	Governance	Standing Items	Apologies	Committee dates
29 June 2010 TB	SIP Update	Estates Strategy and consultation process (MD)	Cat A and B Trajectory	Q1 governance & finance declaration	Report from CEO including balanced scorecards and performance report	Fionna Moore	Audit Committee 07/06/10 2.00 - 5.00pm
SMG 9th	New Ways of Working progress report			Board and sub-committee effectiveness review	Report from Finance Director (including risks around 10/11 KPIs)	Caron Hitchen	CQSE 18/06/10
	Improving survival rates from out of hospital cardiac arrest	Business Case for the Reprovision of Purley Ambulance Station		Demand Management Presentation (MF)	Report from sub-committees		
	Lessons Learnt: Adverse Weather and NYE	Infection Control Policy		Board Assurance Framework (SA)			
	Annual Report and Accounts				Clincal Quality and Patient Safety Report		
		Integrated Business Plan (SA)			Report from Trust Secretary		
27 July 2010 SRP	SIP Update			Constitution and governance arrangements		Fionna Moore	
SMG 14th	workforce update including NWOW, ECPs and the new clinical response model						SRP 7th 9am - 2pm
	IBP (to focus on market assessment)						Quality Committee 26/07/10
	External communication plan (AP)						
	Mental Health Strategy action plan						
	Cat B Trial and consultation						
31 Aug 2010 TB	CommandPoint Update (PS)	Being Open Policy (MD)	Cat A and B Trajectory	Patient Experience Report (GB)	Report from CEO including balanced scorecards and performance report		RCAG 23rd 2-5pm
	Response to Six Lives report (Daryl Mohammed)	A13/West London Workshop Business Case (MD)	Cat C Survey		Report from Finance Director		
		West London HART Business Case (MD)	PTS accounting issues		Report from sub-committees		
SMG 11th	SIP Update				Clincal Quality and Patient Safety Report		
					Report from Trust Secretary		

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28 Sept 2010 TB	CommandPoint Update (PS)		Cat A and B Trajectory	Q2 governance and finance declaration	Report from CEO including balanced scorecards and performance report		AGM 13th Audit Committee 2-5pm
SMG 14th			London Bombings inquest	Board assurance framework and corporate risk register - 6 month progress report (SA)	Report from Finance Director		SRP 8th 2-5pm
				Pressure surge assurance process	Report from sub-committees		Quality Committee 07/06/10
				Audit Committee Annual Report (SA)	Clincal Quality and Patient Safety Report		
	SIP Update				Report from Trust Secretary		
2nd November 2010 SRP awayday - all day			Cat A and B Trajectory				25/10/10 CQSE
SMG 14th							24/11/10 Quality Committee
30 Nov TB	CommandPoint Update (PS)		Cat A and B Trajectory		Report from CEO including balanced scorecards and performance report		8th Audit Committee
SMG 10th					Report from Finance Director		SRP 3rd 2-5pm
					Report from sub-committees		
					Clincal Quality and Patient Safety Report		
	SIP Update				Report from Trust Secretary		RCAG 22nd 2-5pm
14 Dec 2010 TB	Financial and commissioning intentions 2011/12		Cat A and B Trajectory	Q3 finance and governance declaration	Report from CEO including balanced scorecards and performance report	Fionna Moore tbc	
SMG 8th	CommandPoint Update (PS)				Report from Finance Director		
					Report from sub-committees		
					Clincal Quality and Patient Safety Report		
	SIP Update				Report from Trust Secretary		

Presentations
Approval
Compliance

TB FORWARD PLANNER

	Discussion items not yet allocated: 7/7 lessons learnt								