London Ambulance Service NHS
NHS Trust

# TRUST BOARD

**Meeting to be held at 10.00am on Tuesday 31st August 2010**
**Conference Room, LAS Headquarters, 220 Waterloo Road, London SE1 8SD**

**Peter Bradley**
**Chief Executive Officer**

**********

## AGENDA

| | | | Tab |
|---|---|---|---|
| 1. | **Welcome and apologies for absence** | | |
| 2. | **Minutes of the Part I meeting held on 29th June 2010**<br>To approve the minutes of the meeting held on 29th June 2010 | | TAB 1 |
| 3. | **Matters arising**<br>3.1 Actions from previous meetings | All | TAB 2 |
| 4. | **Report from sub-committees**<br>4.1 To receive a report on key items of discussion at the Quality Committee meeting on 26th July 2010 | BM | Oral |
| 5. | **Chairman's Report**<br>To receive a report from the Trust Chairman on key activities | RH | Oral |
| 6. | **Update from executive directors**<br>To receive reports from Executive Directors on key matters | | |
| | 6.1 Chief Executive Officer | PB | TAB 3 |
| | 6.2 Finance Director | MD | TAB 4 |
| 7. | **Clinical quality and patient safety report**<br>To receive the monthly report on clinical quality and patient safety | FM | TAB 5 |
| | **STRATEGIC AND BUSINESS PLANNING** | | |
| 8. | **Integrated Business Plan and Foundation Trust application Timeline**<br>To approve the draft Integrated Business Plan and the timeline for application to become an NHS foundation trust and to agree the most significant risks to this application as requested in the letter from NHS London | PB/ SA/ MD | TAB 6 |
| 9. | **Historical Due Diligence**<br>To brief the Trust Board on the process for historical due diligence | SA | TAB 7 |
| 10. | **Commissioning and the London Ambulance Service going forward**<br>To receive a presentation from Neil Kennett-Brown | NKB | Presentation |

| | | | |
|---|---|---|---|
| 11. | **Service Improvement Programme**<br>To provide the Trust Board with an update on progress on the Service Improvement Programme | | TAB 8 |

## GOVERNANCE

| | | | |
|---|---|---|---|
| 12. | **Board Committee Terms of Reference for approval**<br>The Terms of Reference for committees established by the Trust Board have been reviewed and are due for approval and incorporation within Standing Orders.<br>a) Remuneration committee<br>b) Strategy Review and Planning Group<br>c) Charitable Funds committee | SA | TAB 9 |
| 13. | **Report from the Trust Secretary**<br>To note the report from the Trust Secretary for the period since 25th May 2010 | SA | TAB 10 |
| 14. | **Forward Planner**<br>To review the Trust Board forward planner and agree items for future meetings | SA | TAB 11 |
| 15. | **Questions from members of the public** | | |
| 16. | **Any Other Business** | | |
| 17. | **Date of next meeting**<br>*The next meeting of the Trust Board of Directors will be held on:*<br>Tuesday 28th September 2010 | | |

**LONDON AMBULANCE SERVICE NHS TRUST**

**TRUST BOARD MEETING**
**Part I**

Minutes of the meeting held on Tuesday 29th June 2010 at 10:00 a.m.
in the Conference Room, LAS HQ, 220 Waterloo Road, London SE1 8SD

**********

| | |
|---|---|
| **Present:** | |
| Richard Hunt | Chair |
| Peter Bradley | Chief Executive Officer |
| Mike Dinan | Director of Finance |
| Martin Flaherty | Deputy Chief Executive |
| Roy Griffins | Non-Executive Director |
| Brian Huckett | Non-Executive Director |
| Beryl Magrath | Non-Executive Director |
| Caroline Silver | Non-Executive Director |
| Nigel Walmsley | Non-Executive Director |
| **In Attendance:** | |
| Sandra Adams | Director of Corporate Services |
| Andrew Bell | Head of Financial Management |
| Jessica Cecil | Associate Non-Executive Director |
| Tracey Freeman | Project Accountant |
| Francesca Guy | Committee Secretary (minutes) |
| Erin Heinrich | Foundation Trust Project Manager |
| Bill O'Neill | Assistant Director of Equality and Organisation Development |
| Peter Suter | Director of Information Management and Technology |
| Richard Webber | Director of Operations |
| David Whitmore | Senior Clinical Advisor |
| **Members of the Public:** | |
| Malcolm Alexander | Chair of Patients Forum |
| Gillian O'Malley | North West London Commissioning Partnership |
| | Virgin Media representative |

**********

**77/10. Welcome and Apologies** **Action**

Apologies had been received from Caron Hitchen, Fionna Moore, Lizzy Bovill and Sarah Waller.

**78/10. Minutes of the Part I meeting held on 25th May 2010**

Some minor amendments were made to the minutes of the meeting on 25th May 2010. Subject to these comments, the minutes were approved and would be signed by the chair. **FG**

**79/10. Matters Arising**

The following matters arising were considered:

**54/10 Matters Arising on 25th May 2010:** It was agreed that a session on health and safety for members of the Trust Board should be added to the forward planner. **CH/FG**

**54/10 Matters Arising on 25th May 2010:** Beryl Magrath asked for an estimate of how

much work-related injuries cost the Trust each year. This action was outstanding. **CH**

**57/10 Update from Chief Executive Officer:** A discussion on the future of ECPs had been added to the forward planner for the Strategy Review and Planning meeting on 27th July 2010. Peter Bradley reported that Fionna Moore, Martin Flaherty and Caron Hitchen had met with all 60 ECPs to discuss their options going forward.

**57/10 Update from Director of Finance:** The report from the Finance Director had been presented in a new format for this meeting.

**62/10Annual Report and Accounts (incorporating Quality Report):** The Annual Report and Accounts for 2009/10 had been submitted. The Trust Board would be asked to approve the Quality Account at today's meeting.

**66/10 Corporate Social Responsibility Report:** Martin Flaherty reported that the suggested amendment had been made to the report. Sandra Adams confirmed that Corporate Social Responsibility was a responsibility of the board.

**68/10 NHS Values and NHS Constitution:** Sandra Adams confirmed that the risk associated with non-conveyance had been added to the corporate risk register.

Nigel Walmsley commented that an action point under 72/10 regarding the cost of the Wellbeing Strategy had not been picked up on the action schedule. This action was outstanding. **CH**

The Chair commented that the format of the Trust Board forward planner had been updated to ensure that it was a live document to which Trust Board members provided regular input. He and Peter Bradley regularly discussed the forward planner and it was circulated to the Trust Board on a monthly basis.

**80/10. Formal Reports from the sub-committees**

Audit Committee

Caroline Silver noted the following:

- The Audit Committee received a written report from the chair of the Quality Committee as Beryl Magrath had been unable to attend the meeting in person. Both the chair of the Audit Committee and the chair of the Quality Committee agreed that regular communication between the two committees was vital to ensure the effectiveness of the new governance structure. The report from the Quality Committee identified two areas of potential risk around road traffic accidents and ambulance costs. It was agreed that these risks would be monitored by the Risk Compliance and Assurance Group and the Motor Risk Group;
- The Audit Committee noted five key organisational risks and discussed the process for monitoring risks and identifying new risks. One of the key methods of picking up new risks was through the minutes of the Trust Board meetings. Several risks had been identified at the last Trust Board meeting on 25th May and these centred around capital, the implementation of CommandPoint, infection control and demand management;
- The Audit Committee received a report from the Local Counter Fraud Specialist and had agreed that the Trust should budget for additional unplanned work, which was increasingly being proactively reported by members of staff;
- The Audit Commission had finalised the Trust's ALE assessment for the first three assessment areas: financial management, internal control and value for money. All

Key Lines of Enquiry including value for money remained as previously scored. The Audit Commission was currently completing their assessment of the final two Key Lines of Enquiry areas of financial reporting and financial standing;

- With regards to the Annual Governance Report from the Audit Commission, it was noted that the transfer to International Financial Reporting Standards had presented some additional challenges to the finalisation of the annual accounts, but that the Audit Commission was able to give an unqualified audit opinion;
- Some adjustments to the accounts were agreed. Some misstatements were considered but the Audit Committee agreed not to adjust the accounts in these cases. The Audit Commission was comfortable with this approach;
- A weakness with regards to the authorisation of journals had been identified by the Audit Commission, but after wider investigation, no further issues were identified that would affect the statement of accounts;
- The Audit Committee signed off on the letter of representation;
- The Audit Committee agreed the fees for the external audit for 2010/11, which were marginally reduced from last year;
- The Audit Committee discussed and approved the Annual Report and Accounts for 2009/10 and it was agreed that the governance structure should be reported as agreed by the Trust Board at 31st March 2010;
- The Audit Committee received a report from the internal auditors. RSM Tenon had given significant assurance that there was a sound system of internal control although four areas of weakness had been identified which were drug controls; patient transport services; records management and medical devices. These areas of weakness were being addressed by the Trust as a matter of priority. It was noted that the number of limited assurances given had increased from 2008/09 but that this was a reflection of management proactively using internal audit to address areas of concern. It was noted that the number of substantial assurances given had also increased;
- The Audit Committee reviewed progress against audit recommendations and asked that managers who consistently failed to meet their deadlines attend Audit Committee meetings to explain the cause of the delay. The Audit Committee were informed that the audit process was being reviewed and workshops would be held with managers;
- The Audit Committee agreed their terms of reference and reviewed the Audit Committee Annual Report. It was agreed that this would be put on hold pending the publication of the new audit committee handbook;
- The next meeting would be held on 7th September 2010.

In response to a question from the Chair, both Caroline Silver and Mike Dinan commented that they were happy with the way in which the Audit Committee was working and reported that the relationship with the external auditors had improved.

Beryl Magrath commented that the Audit Committee should play a role in bringing together the audit activity across the organisation eg drug audits and infection control audits.

Caroline Silver reported that NHS London did not currently have a chair for their Audit Committee and had asked other Audit Committee chairs in NHS organisations in London to take on this role. Caroline confirmed that she did not intend to take this position.

**81/10. <u>Chairman's Report</u>**

The Chair reported the following:

- This was Martin Flaherty's last Trust Board meeting with the London Ambulance Service for six months as he was due to start his secondment as Chief Executive of

the ambulance service in Ireland;

- The LAS awards night had been successful and had provided an opportunity to recognise the achievements made by staff;
- The Chair had attended a meeting with the chairs of the Metropolitan Police and the London Fire Brigade. It was agreed that this meeting would be reinstated as a regular meeting and the next meeting would be hosted by LAS;
- The Chair had attended a security oversight group for the 2012 Olympics and in response to his recommendation that the group should spend some time understanding the work that LAS was doing in preparation for the 2012 Olympics, the Trust had been asked to give a presentation at the next meeting;
- The Chair had met with the chair of NHS Direct and they had agreed that continued joint working was important;
- The Chair and Chief Executive had met with Pam Chesters of the Greater London Authority to ensure that the London Mayor was kept informed of the service provided by the Trust;
- The Chair had attended the NHS Confederation Conference at which Andrew Lansley had outlined the direction of travel with regards to GP commissioning;
- The Chair met with the chair of Northrop Grumman and had agreed to do so regularly.

**82/10. Update from Executive Directors**

Chief Executive Officer

Peter Bradley reported the following:

- The Trust was three months into the new commissioning arrangements and was currently on track to achieve the majority of KPIs and CQUINs. Hospital handover times however, remained at risk;
- The new government was not supportive of specific elements of Healthcare for London but did support the introduction of hyper acute stroke units and major trauma centres. From 19th July 2010, all patients with symptoms of a stroke would be conveyed to a HASU;
- The service strategic goals, corporate and annual objectives had been updated and finalised following comments made by the Trust Board and SMG;
- Performance had been good for the first quarter, but demand was increasing with May activity 6.8 per cent above last year's figure. 28th June was one of the busiest days on record and as a result of the high demand throughout the month the Trust would not achieve either category A or B trajectories for June. Demand had increased due to the recent hot weather and the World Cup. In response, the REAP level had been raised to 4 and the Trust hoped to see an improvement for July. In spite of these additional pressures, this was the best ever performance the Trust had seen;
- A Fall Back test would be taking place tomorrow night at Bow;
- The Patient Transport Service in South London would be transferring to the new company in September;
- Sickness levels remained low across the organisation;
- Funding for the training budget had been cut which meant that savings would need to be found elsewhere;
- The Health and Safety Executive notice had been lifted following evidence of increased training and the implementation of an comprehensive action plan;
- The healthcare white paper was due to be published shortly which would have implications for ambulance services across the country;
- The following weeks would see increased focus on the application for Foundation Trust status;

- The Trust would be undertaking a stakeholder perception survey carried out by MORI;
- The Trust had undergone much change in recent months with the introduction of radio dispatch and implementation of new rotas. 200 student paramedics were soon to join the workforce and new ambulances would also be released. Changes would also be seen with the introduction of the Clinical Response Model;
- CommandPoint remained on track for 2011 go-live date with factory acceptance testing formally completed. A 90 per cent payment of this milestone had been agreed.

The Chair noted the new coversheet used for Trust Board papers and welcomed the changes.

Beryl Magrath noted that the Trust was awarded runner up for the award for best practice in managing workplace stress at the Healthcare People Management Association awards and congratulated staff on this achievement.

Beryl Magrath also noted that there was an increasing lack of appetite of staff to work on fast response units. Peter Bradley responded that the introduction of the Clinical Response Model would help with this problem.

Beryl Magrath asked whether a record would be kept of the alternative care pathway used where patients were not conveyed to A&E. Peter Bradley responded that they would be providing more detail of alternative care pathway destinations in the future.

There followed a discussion about the likely contents of the healthcare white paper which was due to be published shortly. The Chair commented that it was important for the Trust to remain focused on the objectives for this year.

Director of Finance

Mike Dinan provided the Trust Board with an overview of the financial position for May, which showed a £316k surplus against a planned surplus of £369k. The Trust was currently on target to meet its financial control figure.

With regards to the Financial Performance Indicator, Mike Dinan noted that the Trust's management costs (eg non-frontline expenditure) would become increasingly important in the current economic and political climate and might be a subject of further discussion at a Strategy Review and Planning meeting.

The Chair asked about the impact of increasing demand on the financial position. Mike Dinan responded that currently costs associated with high demand were being absorbed, but might have an impact on the achievement of KPIs and CQUINs.

Mike Dinan also made the following points:

- There was no calibration with regards to the payment of the Cat B target;
- The cost improvement plan was a work in progress and the more difficult savings were yet to be made, particularly with regards to staffing;
- The departmental budget would be discussed at next month's meeting.

The Chair noted the improvements to this report and stated that more information would be available after the first quarter.

**83/10. Clinical Quality and Patient Safety Report**

David Whitmore reported that no SUIs had been declared since the last report to the Trust Board.

The Clinical Steering Group had been disestablished in its current form as its role was now obsolete following the introduction of the Clinical Practice Guidelines for Use in UK Ambulance Services and the establishment of new committees and groups which fulfilled many of the Clinical Steering Group's functions. However access to the advice of these clinicians remained valuable and Fionna Moore would be amending the terms of reference for this group to allow a virtual group without the need for formal meetings. Trust Board members were content that there was no longer a need for this group to meet formally. Martin Flaherty added that a national Directors of Clinical Care Group would also be established.

David Whitmore noted that CPI completion rates had seen a dramatic improvement following the implementation of an electronic system which reduced the workload of team leaders. Beryl Magrath acknowledged the improvement in CPI completion rates but noted that the East area remained behind the West and the South. Richard Webber responded that performance in the East had improved and would see further improvement by the end of the year.

David Whitmore reported that a trial would be undertaken of a different method of resuscitation for patients who had suffered a cardiac arrest. This proposal had been agreed by the SMG and Clinical Steering Group. Further details of the trial were outlined in the paper.

David Whitmore reported that the Metropolitan Policy Controlled Drug Liaison team had made a number of unannounced inspections and planned to make further inspections. Their overall opinion was that the Trust had good policies and procedures in place with regards to the handling of controlled drugs, but improvements needed to be made in the adherence to these policies by members of staff.

**84/10. New Ways of Working Progress Report**

Bill O'Neill joined the meeting for this agenda item to give an update on the progress at Barnehurst and Chase Farm complexes with regards to New Ways of Working.

- Training, education and development: Two dedicated Clinical Tutors had been appointed at each complex. Training plans incorporated demographic-specific training and areas suggested by members of staff;
- Leadership and Management: Management vacancies had been filled at Chase Farm complex, but changes were taking longer to implement at Barnehurst;
- Team based working: Members of staff had been grouped into teams each with a dedicated team leader. Each team would be responsible for its resourcing. Chase Farm had introduced a flexi week, which had worked well;
- External linkages: Dedicated Community Involvement Officers had been appointed at both complexes;
- Clinical response model: Barnehurst complex was involved in trialling the model which would be implemented at NWoW complexes once it had been fully evaluated;
- Logistics and technical support: There were training facilities at both sites to allow for refresher and update training to be undertaken locally;
- An evaluation of NWoW had been undertaken which had shown positive results. Both complexes would be NWoW business as usual as of July 2010;
- Going forward the next five complexes had been identified in the workplan as part of

a phased approach. Eventually all complexes would take part, although there would be a gap around the time of the 2012 Olympics;
- The clinical response model trials had shown a decrease in the number of patients conveyed to A&E and an increased use of alternative care pathways. A three month trial would be run at the NWoW sites from September 2010.

Martin Flaherty added that more work needed to be done in identifying the hard benefits, but that the key achievements were the new training arrangements and the replacement of the relief system.

Beryl Magrath asked whether there were any additional costs associated with NWoW. Bill O'Neill responded that it differed from complex to complex, but that the Community Involvement Officer represented the most significant additional cost. Martin Flaherty added that there might be a need in the future to increase the number of team leaders.

**85/10. <u>Demand Management</u>**

Peter Bradley gave a presentation on the increasing demand for the services provided by the London Ambulance Service and made the following points:

- Demand was increasing year on year with this year's month to date demand already surpassing last year's;
- Demand for the ambulance service was catching up with that of the police;
- There were several factors which had an impact on demand, including seasonal factors, social and attitudinal change, aging population, deprivation, frequent callers, alcohol and changes to patient care;
- The number of patients who were unconscious or passing out had increased which suggested an increase in the number of alcohol-related incidents. There had also been an increase in the number of falls;
- 20 – 29 year olds were the biggest users of the ambulance service and demand for ambulances services was generally greater in deprived areas;
- Long terms conditions which would impact demand were aging population and obesity.

Nigel Walmsley asked whether there was any correlation between the declining expectation that doctors make house calls and the increase in demand for ambulances. Caroline Silver added that there was a common perception that patients who arrive at A&E in an ambulance will jump the queue.

Martin Flaherty gave a presentation on the actions taken to manage demand:

- A Demand Management Group had been established to improve understanding of demand drivers;
- Some work had been undertaken to reduce incoming 999 demand including working with partners such as the Metropolitan Police, maternity units, GPs and care homes;
- Campaigns had been used with the aim of reducing demand, including the 'Choose well' campaign.

There followed a discussion about whether the campaigns were effective in reducing or managing demand. Martin Flaherty responded that the campaigns did not represent a large cost to the organisation but that advertising was generally more effective at driving up demand than reducing it.

Trust Board members made the following points about how demand might be managed more effectively:

- Clinicians in the Control Room;
- Development of the role of Appropriate Care Pathway Champions;
- Increased partnership working;
- Clinicians in all 5 BT centres.

The Chair commented that this was an important strategic issue for the Trust and the communications strategy was key.

**86/10. Lease for the Reprovision of Purley Ambulance Station**

Mike Dinan reported that all material leases required approval by the Trust Board. The existing accommodation at Purley hospital was not fit for purpose and leasehold premises had been located. Mike Dinan confirmed that the rent was competitive and the annual revenue costs of £45k were affordable.

Nigel Walsmley asked whether this was a fully repairing lease which Mike Dinan agreed to check. **MD**

The Trust Board approved the lease of the premises to replace Purley ambulance station.

**87/10. Fleet Finance Update**

Mike Dinan reported that 260 ambulance vehicles would be released in two tranches by October 2010. These included new ambulances from MacNeillies and UVM. Three bariatric vehicles would also be trialled in New Malden.

**88/10. Annual Reporting**

Quality Account 2009/10

Sandra Adams explained that it was a legal requirement under the Health Act 2009 to produce a Quality Account. This was the first Quality Account the Trust had produced and would be used to inform patients, staff and stakeholders of the Trust's success stories and any areas for improvement. The statements highlighted in grey indicated information that the Trust had a statutory obligation to provide. The Quality Account incorporated statements from key stakeholders including the Patients' Forum. Sandra had held a discussion with Malcolm Alexander who had agreed to amend the statement to give a more positive slant recognising the value of the work between the LAS and the forum.

Sandra Adams noted that there was some outstanding information to be received and it was agreed that David Whitmore would work with Sandra to eliminate these gaps. **SA/DW**

Sandra Adams informed the board that the Quality Account needed to be submitted to the Department of Health tomorrow and therefore needed to approved by the board today. Trust Board members recognised the time limitations but commented that next year the Quality Account should be considered first by the Quality Committee and presented to the Trust Board for approval in good time prior to submission to the Department of Health.

There followed a discussion about whether the Quality Account and the Annual Review should be combined. It was agreed that next year the content of the Quality Account would be included in the Annual Review.

Caroline Silver made some comments about the wording of some of the sections which Sandra agreed to update. **SA**

Subject to these comments, the Quality Account for 2009/10 was approved.

Annual Report and Accounts 2009/10

Sandra Adams reported that following the Trust Board meeting on 25th May 2010 and the Audit Committee meeting on 7th June 2010, the Annual Report and Accounts for 2009/10 had been circulated to the Trust Board. All comments made had been incorporated and the final report had been submitted to the auditors by the required deadline.

**89/10. NHS Foundation Trust Application**

Sandra Adams explained that her paper gave an overview of the Trust's status with regards to its application for Foundation Trust status. There had been some changes to original timescales and it was now likely that the Trust would be submitting an application in February 2011 which would be referred to Monitor in March 2011. The Monitor review process took 12 weeks and therefore it was hoped that the Trust would receive authorisation as an NHS ambulance Foundation Trust in May 2011.

The board noted that the closed session in the afternoon today would focus on the integrated business plan.

**90/10. Infection Control Policy**

David Whitmore explained that this policy had undergone extensive revision to meet NHSLA requirements. The Trust had introduced a 'no touch' technique and all staff had received training.

The updated policy had been approved by the Clinical Quality Safety and Effectiveness Committee at its meeting on 18th June 2010.

Roy Griffins acknowledged that this policy had been approved by the Clinical Quality Safety and Effectiveness Committee, but noted that in the future these policies should be presented to the Trust Board via the Quality Committee.

The Trust Board approved the Infection Control Policy.

**91/10. Forward Planner**

The Chair reiterated the fact that this was a live document which would be circulated to the Trust Board every month for their comment and suggestions. A number of items of discussion had been identified today for future meetings.

**92/10. Questions from members of the public**

There were no questions from members of the public.

**93/10 Any other business**

The Chair commented that this was Martin Flaherty's last Trust Board meeting with LAS prior to his six month secondment in Ireland as the Chief Executive of the ambulance services.

**94/10. Date of next meeting**

Strategy Review and Planning meeting on 27th July 2010.

**ACTIONS**
from the Meeting of the Trust Board of Directors of
**LONDON AMBULANCE SERVICE NHS TRUST**
**held on 29th June 2010**

| Meeting Date | Minute Date | Action Details | Responsibility | Progress and outcome |
|---|---|---|---|---|
| **20/09/09** | **101/09** | **LAS Foundation Trust Membership Strategy**<br>Discussion and final decision about union representation on the Council of Governors. | **SA** | **Open** |
| **20/09/09** | **102/10** | **Proposed governance arrangements and draft constitution for the LAS NHS Foundation Trust**<br>Further discussion to be held at the Service Development Committee in October with an update to the November Board meeting. | **SA** | **Open** |
| **25/05/10** | **54/10 & 79/10** | **Matters Arising**<br>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.<br><br>It was agreed that a session on health and safety for members of the Trust Board should be added to the forward planner. | **All** | **Added to TB agenda for November 2010** |
| **25/05/10** | **54/10** | **Matters Arising**<br>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** | |
| **25/05/10** | **66/10** | **Corporate Social Responsibility Report**<br>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** | **Incorporated within the Annual Report section on Sustainability** |

| | | | | |
|---|---|---|---|---|
| **25/05/10** | **72/10** | **Wellbeing Strategy**<br>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. | **CH** | |
| **29/06/10** | **86/10** | **Lease for the Reprovision of Purley Ambulance Station**<br>Nigel Walsmley asked whether this was a fully repairing lease which Mike Dinan agreed to check. | **MD** | |
| **29/06/10** | **88/10** | **Quality Account 2009/10**<br>Sandra Adams noted that there was some outstanding information to be received and it was agreed that David Whitmore would work with Sandra to eliminate these gaps. | **SA** | **Completed and submitted to Department of Health in June 2010** |
| **29/06/10** | **88/10** | **Quality Account 2009/10**<br>Caroline Silver made some comments about the wording of some of the sections which Sandra agreed to update. | **SA** | **As above** |

London Ambulance Service
NHS Trust

# Information Pack for Trust Board

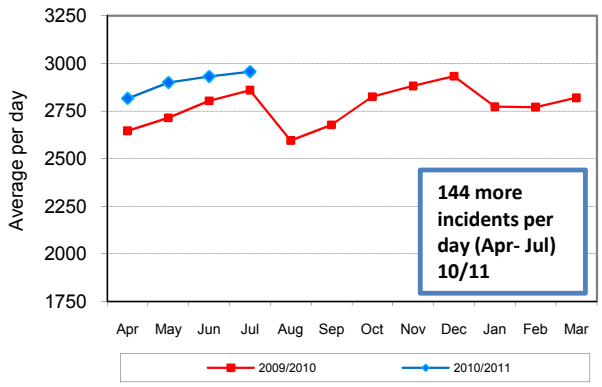
# July 10

**Please be aware we are still catching up on PRFs and we have no Hospital Data for july yet (would not be meaningful as limited info)

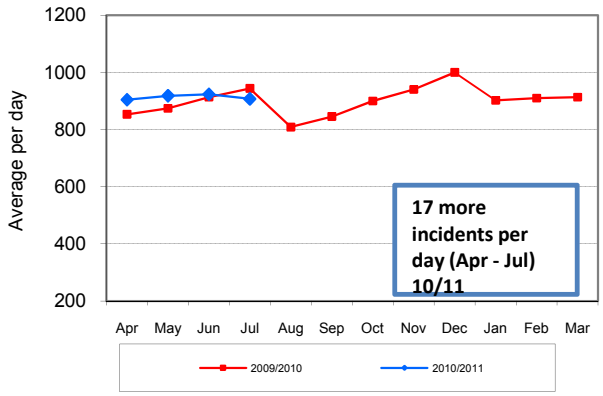
**Also LAS hours compliant to ORH awaiting new version

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

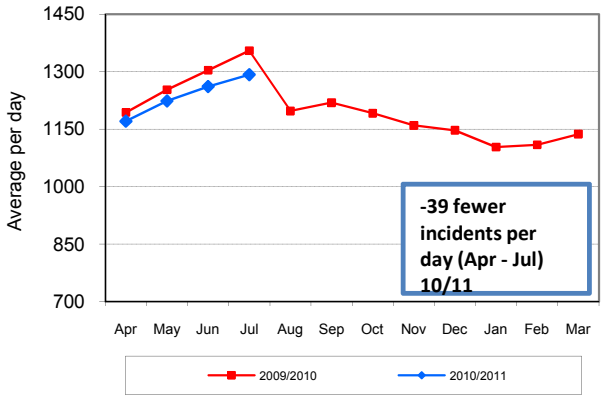
Graph 1
Average number of Cat A, B & C incidents per day



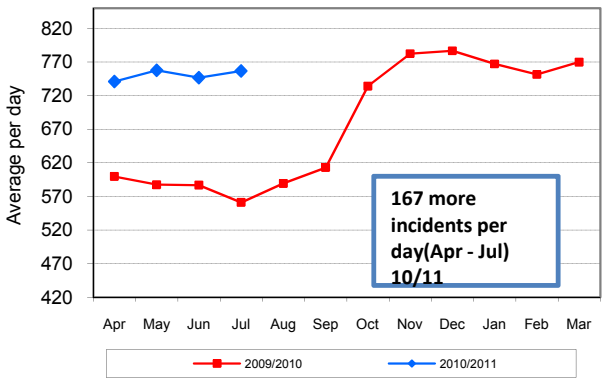

Graph 2
Average number of Cat A incidents per day



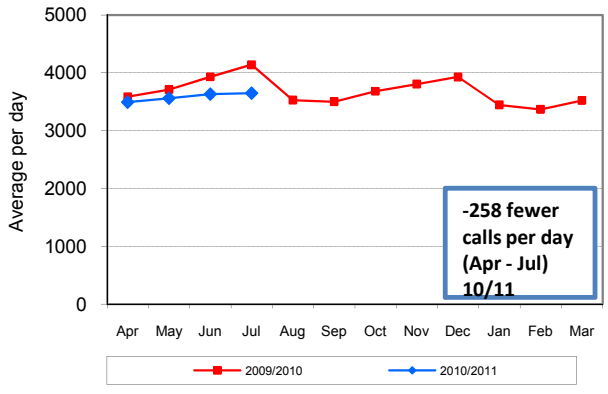

Graph 3
Average number of Cat B incidents per day



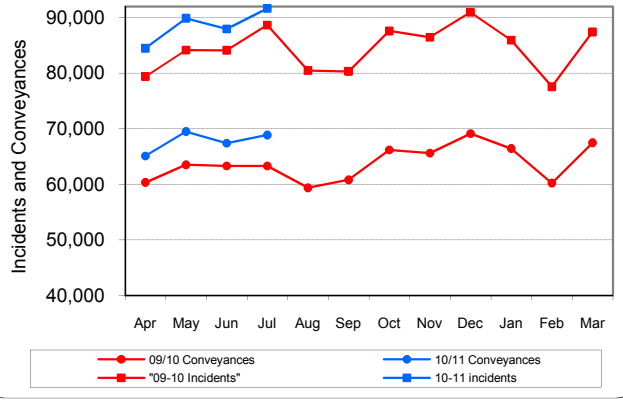

Graph 4
Average number of Cat C incidents per day




Graph 5
Average number of 999 calls received per day

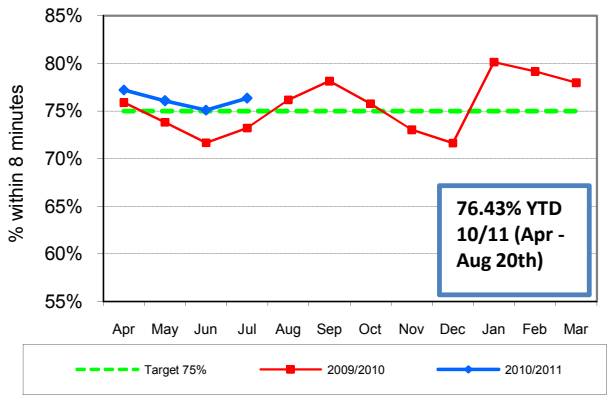



Graph 6
No of incidents conveyed

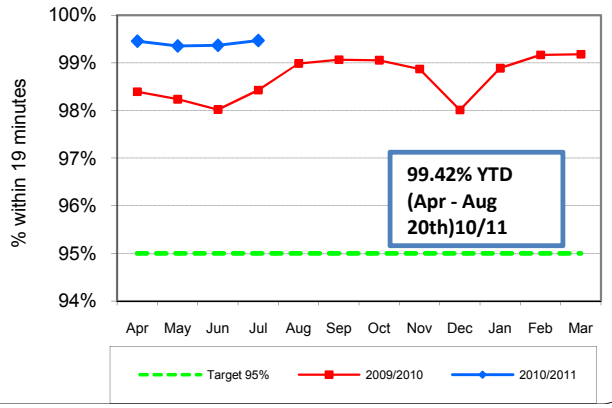


**London Ambulance Service NHS Trust**
**Accident and Emergency Service**
**Performance - July 2010**

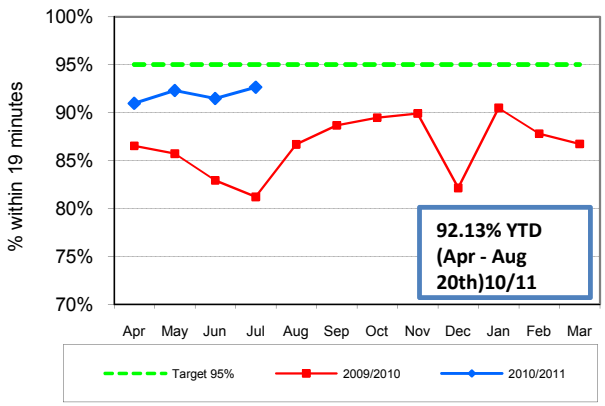
Graph 7
Category A 8 minute performance



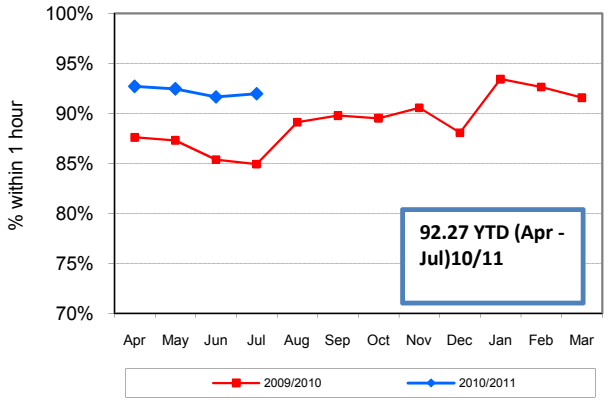

Graph 8
Category A 19 minute performance



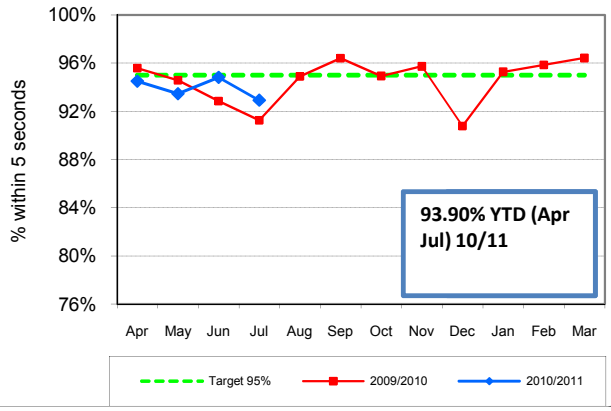

Graph 9
Category B 19 minute performance



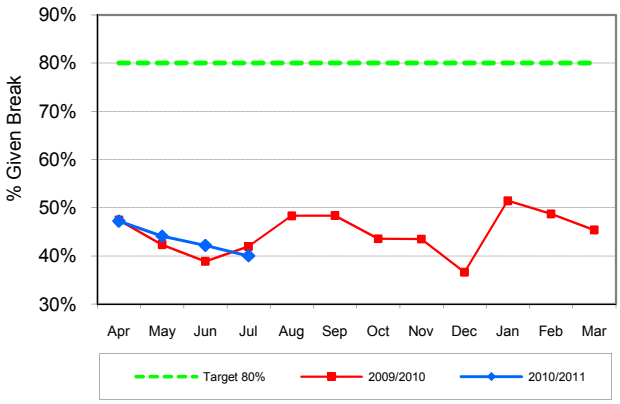

Graph 10
Category C incidents (excluding card 35) responded to within 1 hour (call connect to arrive scene)




Graph 11
Percentage of calls answered within 5 seconds

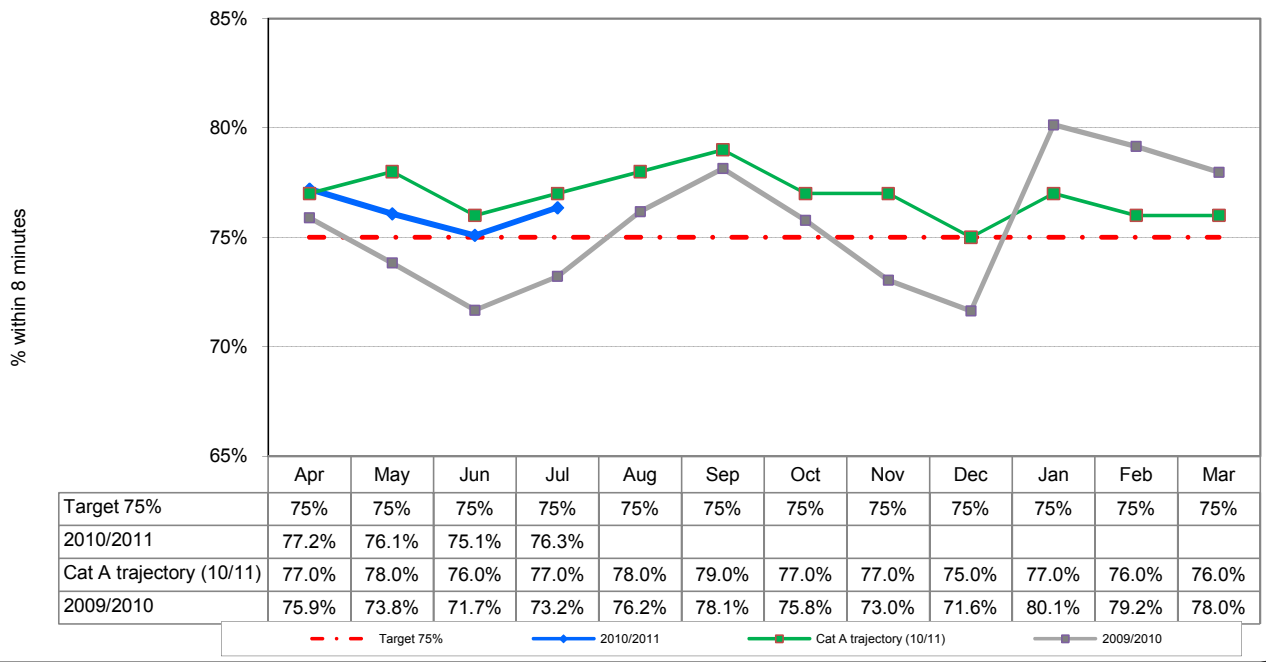



Graph 12
Rest Breaks Given



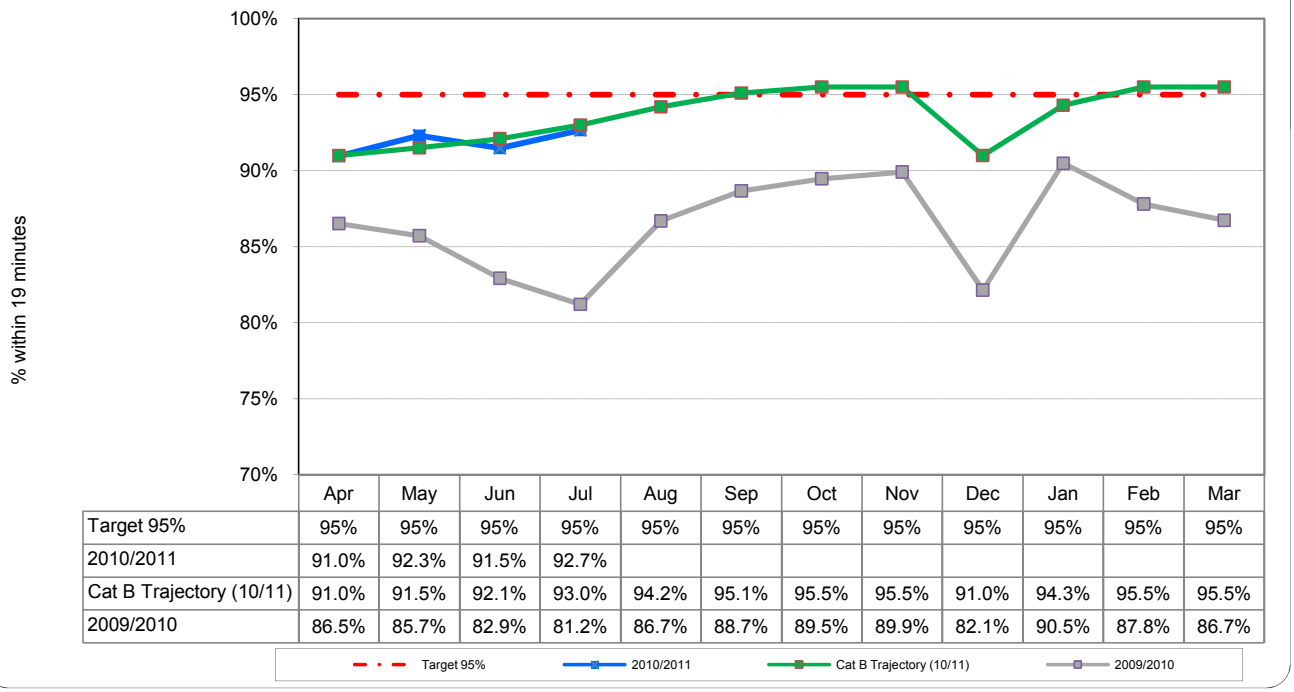
**London Ambulance Service NHS Trust**
**Accident and Emergency Service**
**Performance - July 2010**

Graph 13
Category A 8 minute performance




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Target 75% | 75% | 75% | 75% | 75% | 75% | 75% | 75% | 75% | 75% | 75% | 75% | 75% |
| 2010/2011 | 77.2% | 76.1% | 75.1% | 76.3% | | | | | | | | |
| Cat A trajectory (10/11) | 77.0% | 78.0% | 76.0% | 77.0% | 78.0% | 79.0% | 77.0% | 77.0% | 75.0% | 77.0% | 76.0% | 76.0% |
| 2009/2010 | 75.9% | 73.8% | 71.7% | 73.2% | 76.2% | 78.1% | 75.8% | 73.0% | 71.6% | 80.1% | 79.2% | 78.0% |

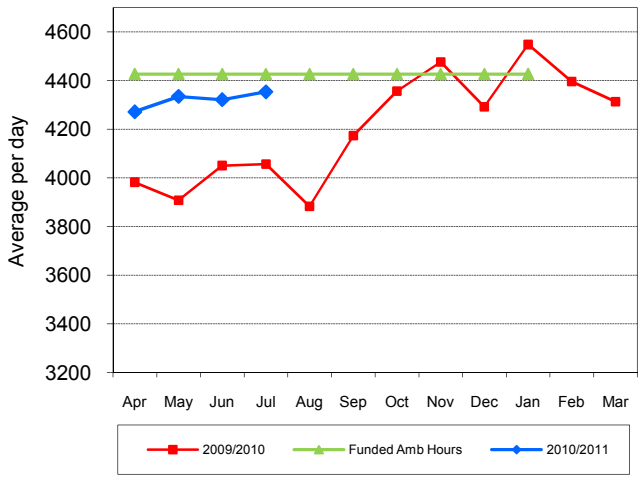
Graph 14
Category B 19 minute performance



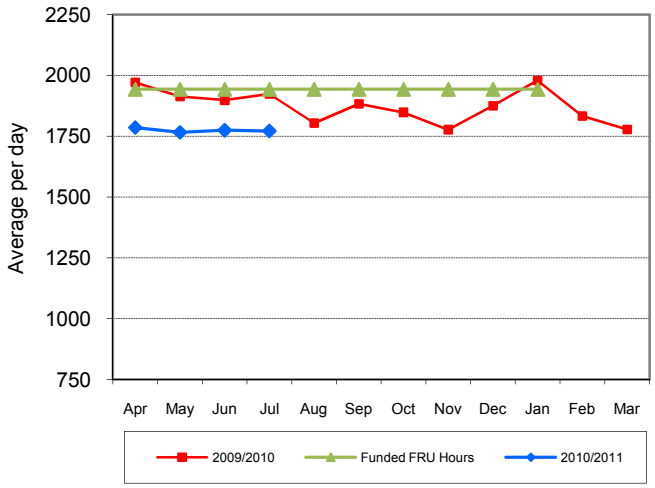

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Target 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |
| 2010/2011 | 91.0% | 92.3% | 91.5% | 92.7% | | | | | | | | |
| Cat B Trajectory (10/11) | 91.0% | 91.5% | 92.1% | 93.0% | 94.2% | 95.1% | 95.5% | 95.5% | 91.0% | 94.3% | 95.5% | 95.5% |
| 2009/2010 | 86.5% | 85.7% | 82.9% | 81.2% | 86.7% | 88.7% | 89.5% | 89.9% | 82.1% | 90.5% | 87.8% | 86.7% |

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

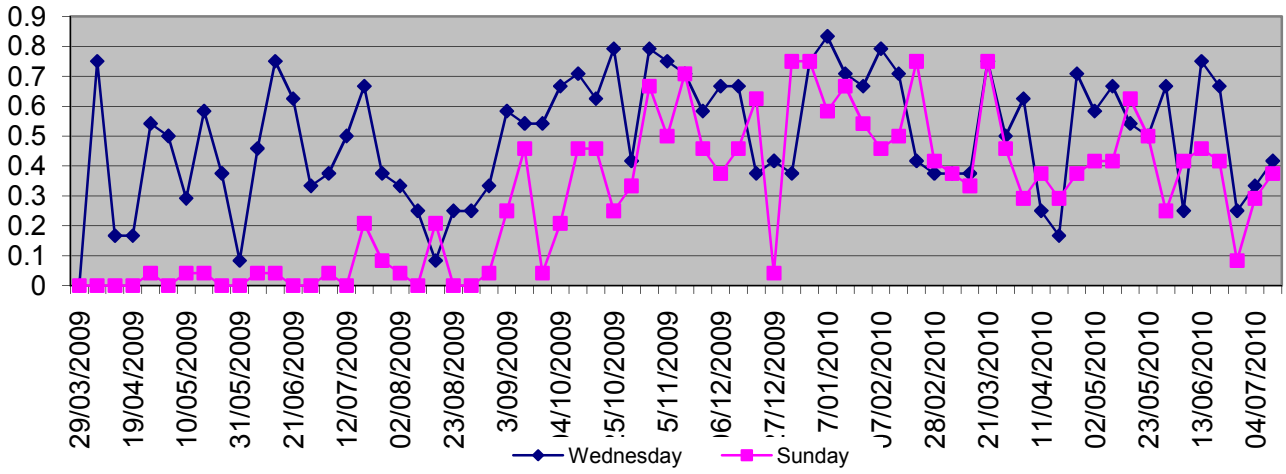
Graph 15
Ambulance Hours average available per day



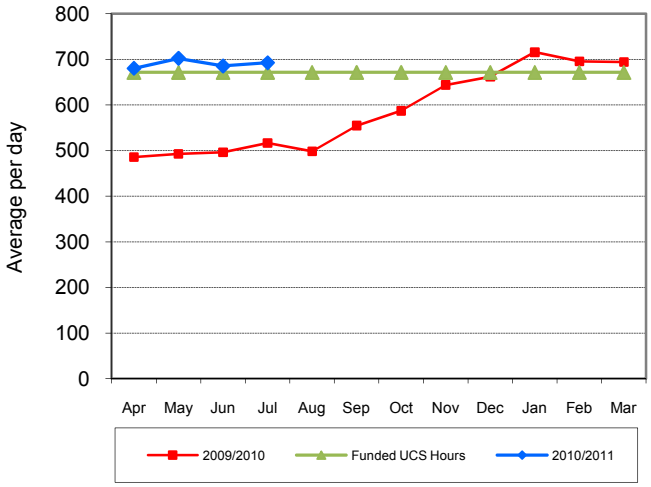

Graph 16
FRU hours average available per day



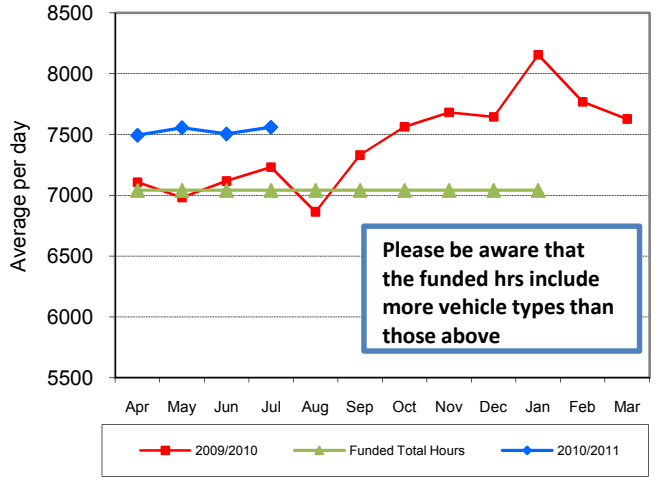

**LAS hours in the day Compliant to ORH**




Graph 17
UOC Hours average available per day



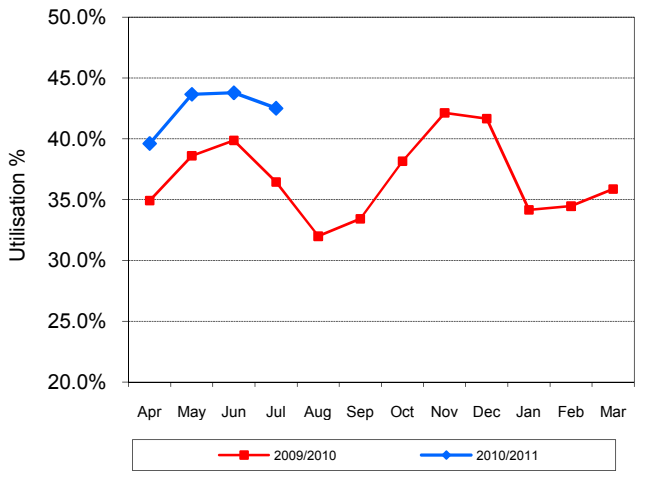

Graph 18
All Vehicle Hours average available per day



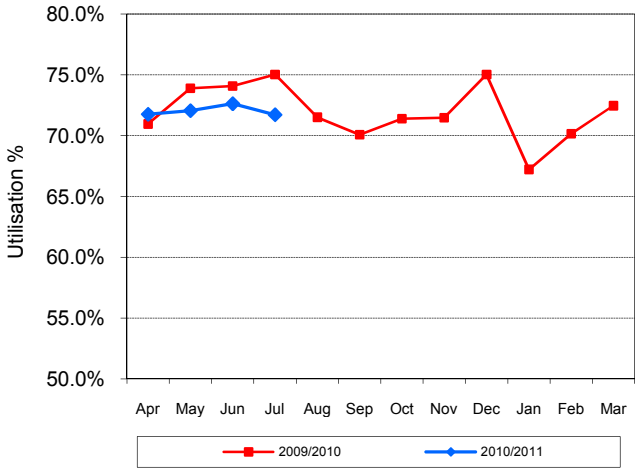

includes other vehicle types other than those above

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

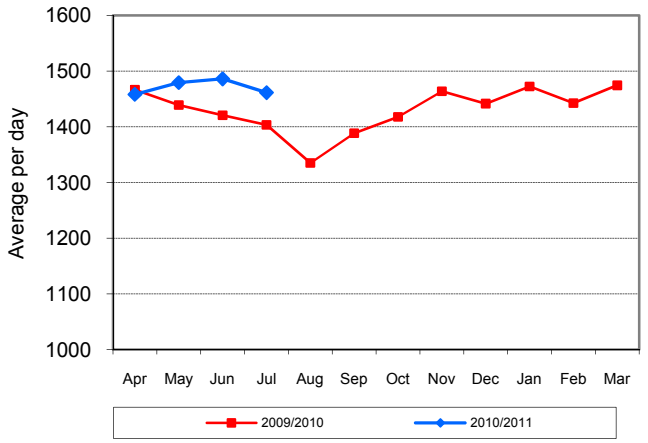
Graph 19
FRU Utilisation



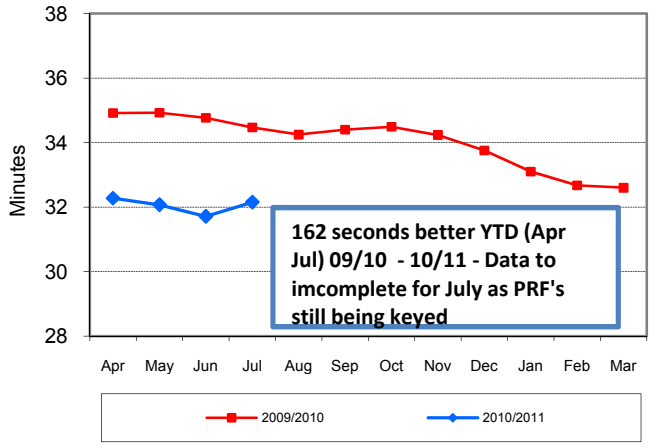

Graph 20
Ambulance Utilisation



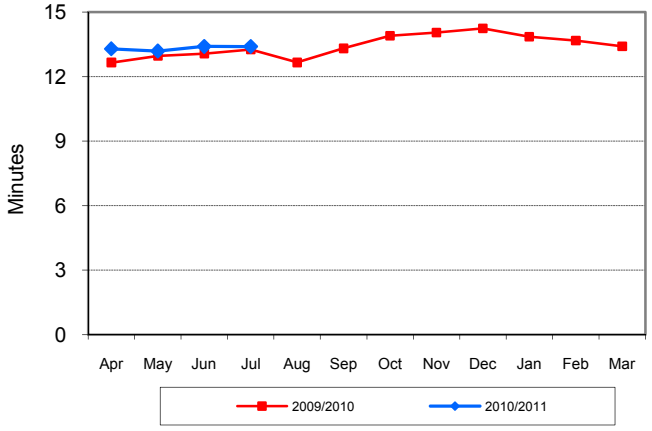

Graph 21
EOC hours staffed per day



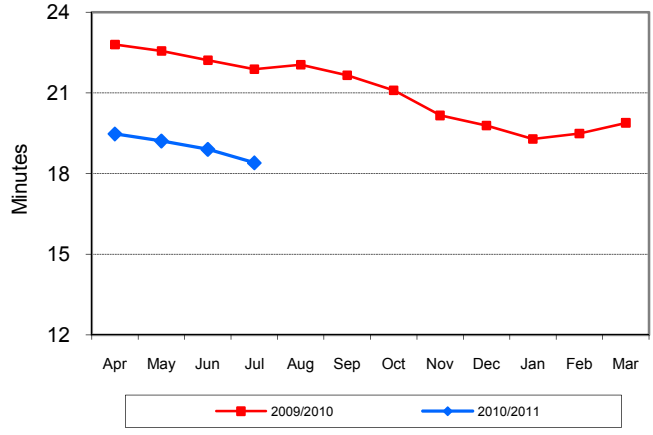

Graph 22
Average hospital turnaround time




Graph 23
Average Arrival at Hospital to Handover (Mins)

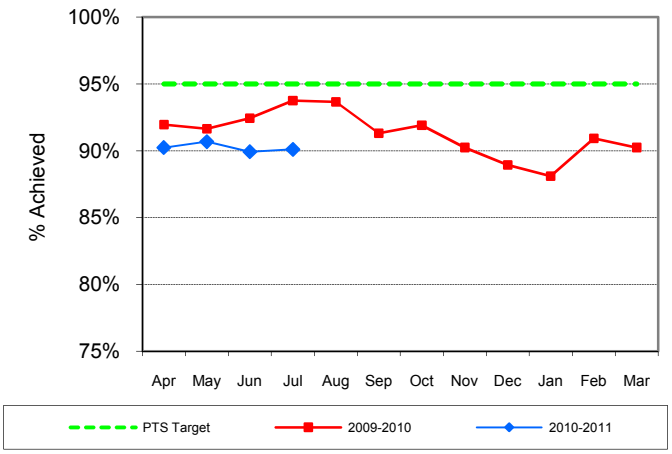



Graph 24
Average Handover to Green (Mins)

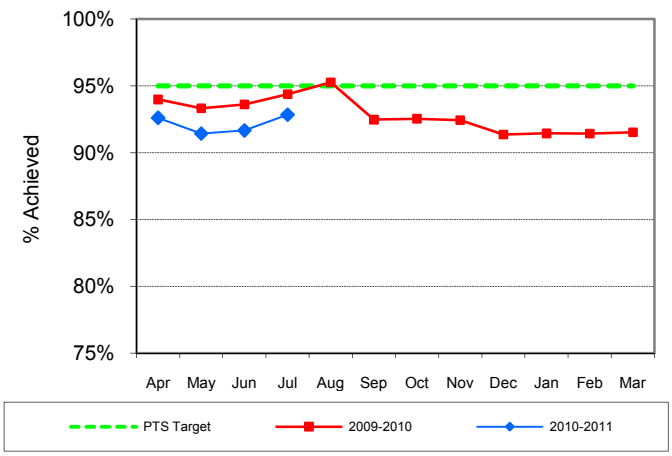


**London Ambulance Service NHS Trust**
**Patient Transport Service**
**Activity and Performance - July 2010**

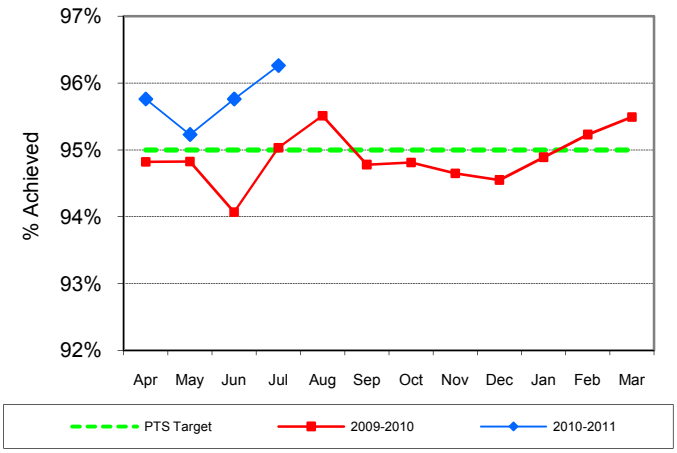
Graph 25
Arrival at Hospital Against Appointment Time



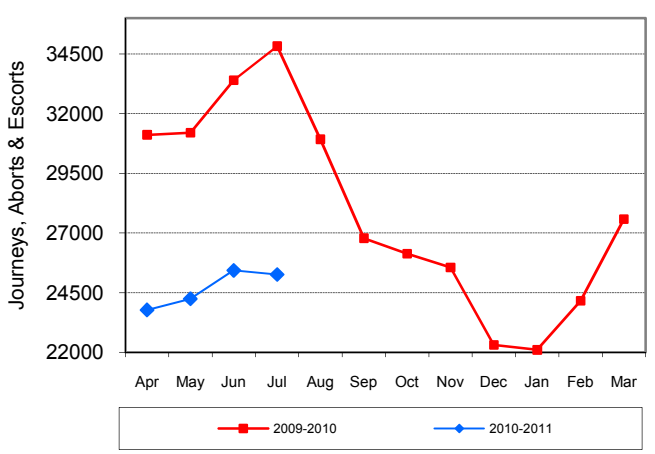

Graph 26
Departure Against Ready Time




Graph 27
Time spent on Vehicle



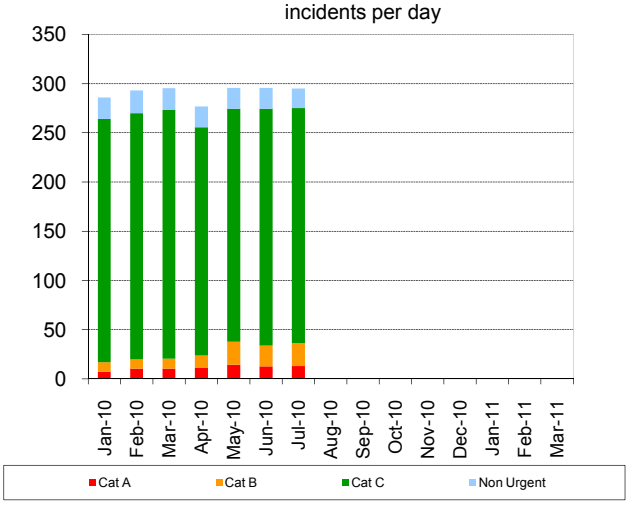

Graph 28
PTS Total Activity



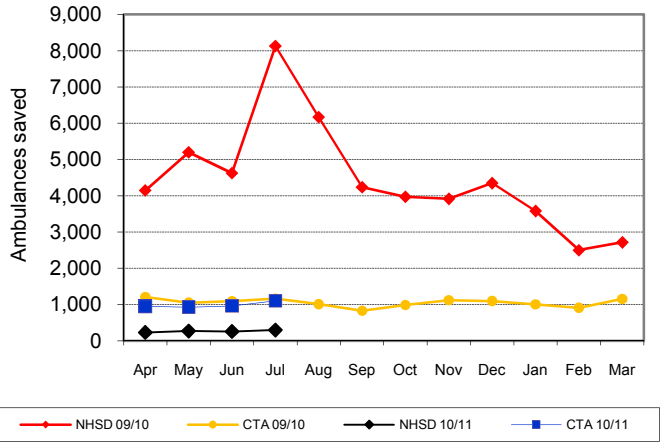
# London Ambulance Service NHS Trust
## Accident and Emergency Service
## UOC Effectiveness - July 2010

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

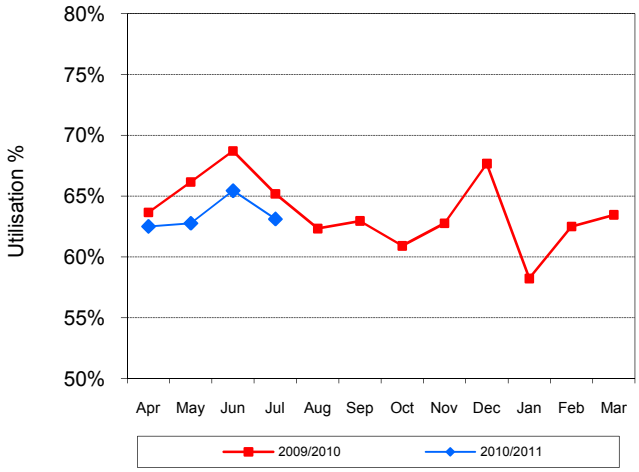
Graph 29
CAT A, B & C Workload by Urgent Care Vehicles average incidents per day



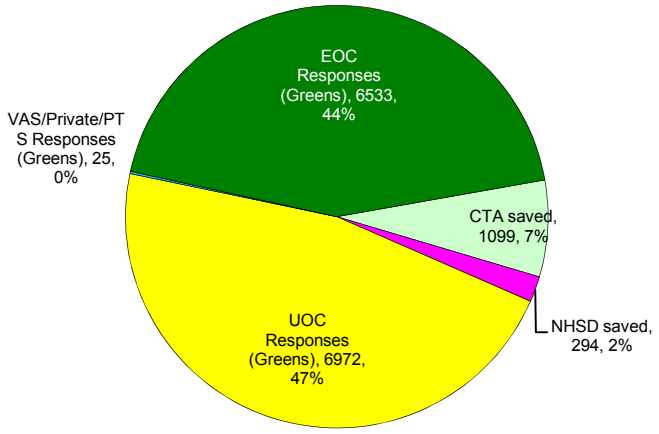

Graph 30
CTA/NHSD Ambulances saved



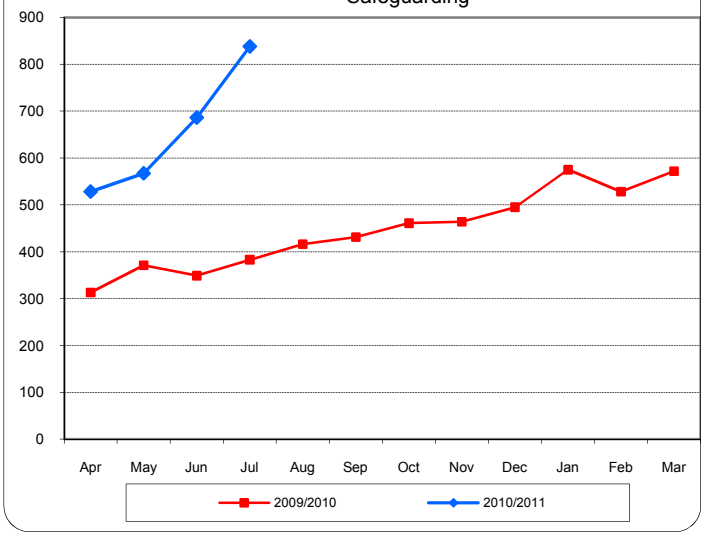

Graph 31
UOC Utilisation



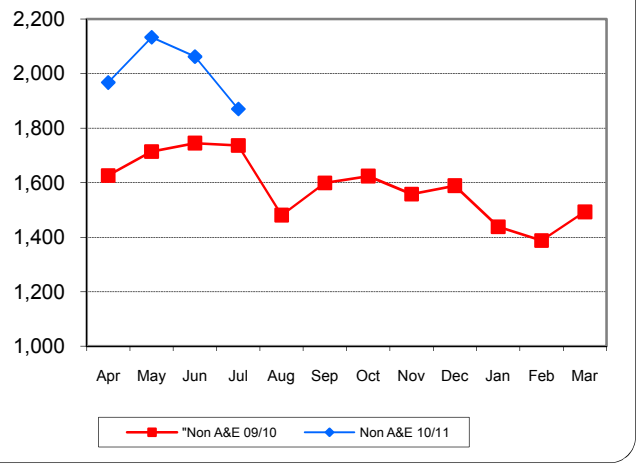

Graph 32
Green resolution - July 2010




Graph 33
Safeguarding




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



London Ambulance Service NHS
NHS Trust

# LONDON AMBULANCE SERVICE TRUST BOARD

## M04 July

**PAPER FOR REVIEW**

| | |
|---|---|
| **Document Title:** | **M04 July - Financial Review** |
| **Report Author(s):** | Andy Bell |
| **Lead Director:** | Mike Dinan |
| **Contact Details:** | Michael.Dinan@lond-amb.nhs.uk |
| **Why is this coming to the Trust Board?** | Monthly Trust Financial Review |
| **This paper has been previously presented to:** | Senior Management Group |
| **Recommendation for the Trust Board:** | To be noted |

**Executive Summary/key issues for the Trust Board**

- The in month position for the Trust is a £375k surplus against a planned surplus of £134k. The year to date position for the Trust as at 31st July 2010 is a £1501k surplus against a planned surplus of £1300k. The trust currently expects to achieve a forecast position of £527k surplus against a planned outturn of £502k 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 £4.8m. 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 £18.4m 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 currently has a Capital Resource Limit of £16.8m for 2010/11. The Capital Plan can be found on Page 8 of the board report.

- The current cash position is £3.8m. 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 £208k profit. This is broadly in line with the annual planned profit of £463k.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 July 2010 - (Month 4)**

| Month M04 July | | | | Summary | Ytd M04 July | | | | 2010/11 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Act £000 | Plan £000 | Diff £000 | % | | Act £000 | Plan £000 | Diff £000 | % | Fcast £000 | Plan £000 | Diff £000 | % |
| | | | | **Income** | | | | | | | | |
| 21,423 | 21,578 | -155 | -0.7% | A&E | 85,766 | 86,310 | -545 | -0.6% | 257,148 | 258,931 | -1,783 | -0.7% |
| 2,233 | 1,847 | 386 | 20.9% | Other | 9,354 | 7,389 | 1,965 | 26.6% | 22,646 | 22,167 | 479 | 2.2% |
| **23,656** | **23,425** | **231** | **1.0%** | **Total** | **95,120** | **93,699** | **1,420** | **1.5%** | **279,794** | **281,098** | **-1,304** | **-0.5%** |
| | | | | **Operating Expense** | | | | | | | | |
| 17,375 | 16,775 | 600 | 3.6% | Pay | 69,766 | 67,323 | 2,443 | 3.6% | 205,677 | 203,292 | 2,385 | 1.2% |
| 4,638 | 4,690 | -52 | -1.1% | Non Pay | 18,398 | 18,235 | 164 | 0.9% | 54,629 | 55,386 | -757 | -1.4% |
| **22,013** | **21,464** | **548** | **2.6%** | **Total** | **88,165** | **85,558** | **2,607** | **3.0%** | **260,306** | **258,678** | **1,628** | **0.6%** |
| **1,643** | **1,960** | **-317** | **-16.2%** | **EBITDA** | **6,955** | **8,141** | **-1,186** | **-14.6%** | **19,488** | **22,420** | **-2,932** | **-13.1%** |
| 6.95% | 8.37% | -1.42% | -17.0% | EBITDA % | 7.31% | 8.69% | -1.38% | -15.8% | 6.97% | 7.98% | -1.01% | -12.7% |
| **1,268** | **1,826** | **-558** | **-30.6%** | **Depreciation, Dividend & Interest** | **5,455** | **6,841** | **-1,387** | **-20.3%** | **18,961** | **21,918** | **-2,957** | **-13.5%** |
| **375** | **134** | **241** | **179.8%** | **Net Surplus/(Deficit)** | **1,501** | **1,300** | **201** | **15.4%** | **527** | **502** | **25** | **5.0%** |
| 1.59% | 0.57% | 1.01% | 177.1% | Net Margin | 1.58% | 1.39% | 0.19% | 13.7% | 0.19% | 0.18% | 0.01% | 5.5% |
| 0 | 0 | 0 | #DIV/0! | Impairment | 0 | 0 | 0 | #DIV/0! | 0 | 0 | 0 | #DIV/0! |
| **375** | **134** | **241** | **179.8%** | **Net Surplus/ (Loss) After Impairment** | **1,501** | **1,300** | **201** | **15.4%** | **527** | **502** | **25** | **5.0%** |
| | | | | **Average Capital Employed** | **108,937** | **109,578** | **-641** | **-0.6%** | **108,603** | **109,578** | **-975** | **-0.9%** |
| | | | | Return on Capital Employed | 1.38% | 1.19% | #DIV/0! | 16.1% | 0.49% | 0.46% | 0.03% | 5.9% |

# LAS Financial Review - Financial Performance Indicator

**Month Ending 31st July 2010 - (Month 4)**

| 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 Fcast £000 | Forecast 2010/11 Plan £000 | Forecast 2010/11 Diff £000 | Forecast 2010/11 % | Status Current (YTD) | Status Trend | Status Forecast |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. EBITDA<br>*Monitor* | 6,955 | 8,141 | 1,186 | 14.6% | 19,488 | 22,420 | 2,932 | 13.1% | ↓ | ↑ | ↓ |
| 2. EBITDA %<br>*Monitor* | 7.31% | 8.69% | 1.38% | 16% | 6.97% | 7.98% | 1.01% | 12.7% | ↓ | ↓ | ↓ |
| 3. Control Surplus/(Deficit)<br>*NHSL* | 1,501 | 1,300 | (201) | -15% | 527 | 502 | (25) | -4.9% | ↑ | ↑ | ↔ |
| 4. Net Surplus/(Deficit) - after Impairments<br>*Monitor/DH* | 1,501 | 1,300 | (201) | -15% | 527 | 502 | (25) | -4.9% | ↑ | ↑ | ↔ |
| 5. Cost Improvement Program (CIP)<br>*NHSL* | 4,358 | 4,125 | (233) | -6% | 18,440 | 18,439 | (0) | 0.0% | ↑ | | ↔ |
| 6. Return on Assets (RoA)<br>*Monitor* | 1.38% | 1.19% | -0.19% | -16% | 0.49% | 0.46% | -0.03% | -5.9% | ↑ | | ↔ |
| 8. Capital Resource Limit (CRL)<br>*DH* | 2,798 | 2,798 | 0 | 0% | 16,788 | 16,788 | 0 | 0.0% | ↔ | | ↔ |
| 9. External Financing Limit (EFL)<br>*DH* | (260) | (260) | 0 | 0% | (260) | (260) | 0 | 0.0% | ↔ | | ↔ |
| 10. Liquidity Ratio<br>*Monitor* | 1.11 | 1.50 | 0.39 | 26% | 0.67 | 1.50 | 0.83 | 55.7% | ↔ | | ↓ |
| 11. To process at least 95% of bills by value within 30 days<br>*DH* | 89% | 95% | 6% | 6% | 90% | 95% | 5% | 5.3% | ↓ | | ↓ |
| 12. To process at least 95% of bills by volume within 30 days<br>DH | 83% | 95% | 12% | 12% | 86% | 95% | 9% | 9.5% | ↓ | | ↓ |
| 13. LAS Trust Management Costs<br>*DH - Calculated as % of Total LAS Income (Excl. MPET)* | 7.0% | 7.0% | 0.0% | -1% | 7.1% | 7.0% | -0.1% | -1.0% | ↔ | | ↔ |

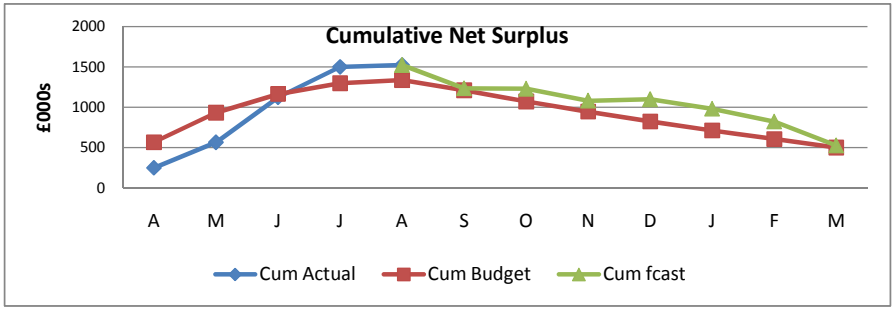
- The LAS Trust Management costs have been calculated on the basis of the 0910 year end exercise. Additional data such as audit fee, contracted out services and consultancy charges have been incorporated at 0910 levels.

**KEY**

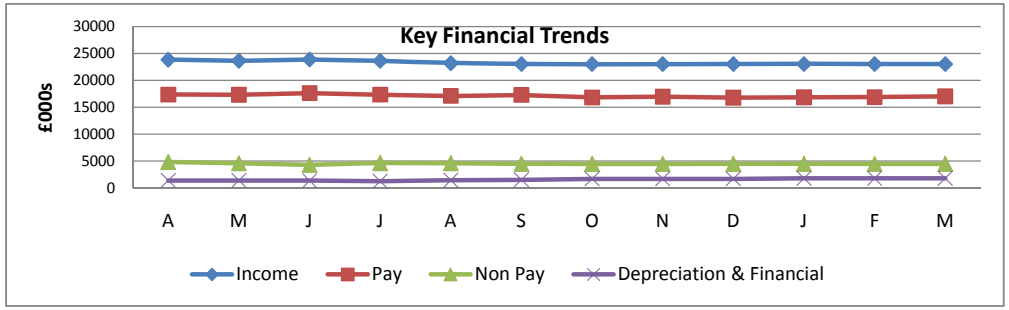
| | |
|---|---|
| ↓ | Target below expected levels attention required |
| ↑ | Target exceeded |
| ↔ | Target within tolerable range |

**LAS Financial Analysis**
**Financial Analysis**

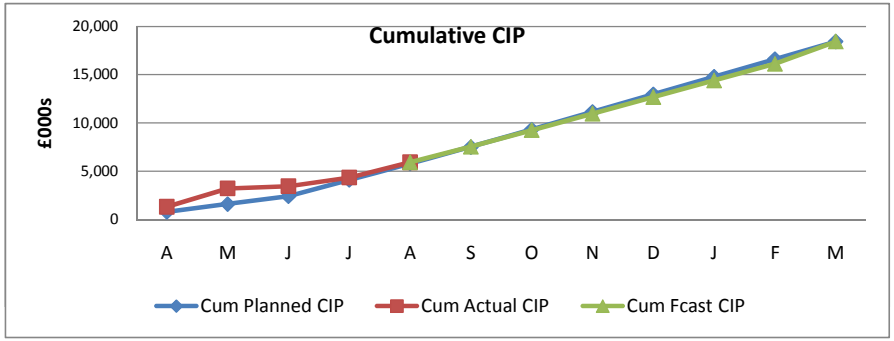
**Month Ending 31st July 2010 - (Month 4)**



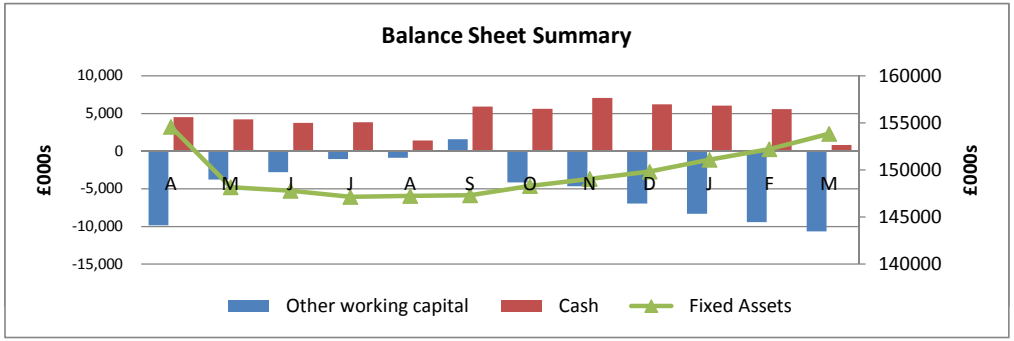

The Trust is currently on track to achieve it's year end surplus position of £502k




Key Financial Trends are broadly stable with planned decrease in income in Q2 due to the loss of MPET and steady increases in depreciation as the asset base grows




The is in line to achieve it's CIP but there is a risk around structural change CIPs such as reduction of agency staff and reducing subsistence payments.




The Balance sheet remains in line with expected forecast.

## Other Trend Information

| | April | May | June | July | August | September | October | November | December | January | February | March | Total | Average |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **A&E Cost Analysis** | | | | | | | | | | | | | | |
| A&E Cost per Head per month (£s) | 1.7 | 1.8 | 1.8 | 1.8 | 1.8 | 1.8 | 1.8 | 1.8 | 1.8 | 1.8 | 1.8 | 1.8 | 21.3 | 1.8 |
| EOC Cost Per Call & Response per month (£s) | 4.5 | 4.7 | 4.4 | 4.4 | 3.6 | 3.9 | 3.7 | 3.8 | 3.8 | 3.5 | 3.7 | 3.8 | 47.8 | 4.0 |
| A&E Cost Per Incident (£s) per month | 169.5 | 171.5 | 171.4 | 159.4 | 177.6 | 180.1 | 162.0 | 165.7 | 155.8 | 165.3 | 183.8 | 163.9 | 2,025.9 | 168.8 |
| A&E Cost Per Day (£000s) | 479.2 | 481.4 | 496.4 | 469.2 | 477.8 | 500.0 | 471.9 | 492.4 | 471.0 | 472.1 | 524.2 | 477.8 | 5,813.5 | 484.5 |
| **Activity Analysis** | | | | | | | | | | | | | | |
| Incidents per WTE per month | 17.8 | 18.4 | 18.5 | 19.4 | 17.4 | 17.4 | 18.9 | 18.6 | 19.6 | 18.6 | 16.8 | 19.0 | 220.5 | 18.4 |
| 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 | 26.2 | 28.3 | 28.7 | 30.7 | 26.5 | 25.3 | 27.8 | 27.4 | 29.5 | 26.1 | 23.7 | 324.7 | 27.1 |
| **Staffing** | | | | | | | | | | | | | | |
| % Overtime to Total Payroll | 6.9% | 6.9% | 7.0% | 6.3% | 6.3% | 6.3% | 3.1% | 3.1% | 3.2% | 3.2% | 3.2% | 3.2% | | 0.0 |
| Total Frontline Staff WTE | 4,155 | 4,111 | 4,097 | 4,109 | 4,088 | 4,103 | 4,094 | 4,096 | 4,084 | 4,071 | 4,058 | 4,056 | | 4,094 |
| Total Corporate Support Staff WTE | 601 | 609 | 609 | 606 | 691 | 689 | 689 | 688 | 688 | 688 | 688 | 688 | | 661 |
| Total LAS Staff WTE | 4,756 | 4,720 | 4,706 | 4,715 | 4,779 | 4,793 | 4,782 | 4,784 | 4,772 | 4,759 | 4,746 | 4,745 | | 4,755 |
| Ratio of Frontline to Corporate Support Staff | 6.9 | 6.8 | 6.7 | 6.8 | 5.9 | 6.0 | 5.9 | 5.9 | 5.9 | 5.9 | 5.9 | 5.9 | | 6.2 |

# LAS Financial Review - Financial Risks

**Month Ending 31st July 2010 - (Month 4)**

| 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 | m4 ytd activity up 5% |
| 2. A&E Income - CatA8 penalty | 4,955 | 4 | 2 | 8 | 0 | G | m4 performance 76% ytd |
| 3. A&E Income - CatB19 penalty | 4,955 | 4 | 4 | 16 | 1,652 | R | m4 performance on trajectory. Net penalty based on both proportionality & caliberation |
| 4. A&E Income - CatC (KPI) | 4,955 | 4 | 2 | 8 | 0 | G | m4 CTA and NHSD performance well above target |
| 5. A&E Income - LAS Patient handover (KPI) | 1,635 | 3 | 2 | 6 | 545 | A | m4 performance on revised trajectory |
| 6. A&E Income - Clinical Performance Indicator (KPI) | 1,635 | 3 | 2 | 6 | 0 | G | m4 ytd on track |
| 7. A&E Income - New Clinical Model (KPI) | 1,635 | 3 | 3 | 9 | 0 | G | m4 evaluation of Barnehurst trial in progress |
| 8. A&E Income - Alternative Care Pathways (CQUIN) | 2,973 | 4 | 2 | 8 | 743 | A | m4 ytd on track |
| 9. A&E Income - Cardiac, Stroke & Falls (CQUIN) | 743 | 3 | 2 | 6 | 186 | A | m4 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 | m4 ytd on track. Net based on 5% slippage |
| 11. Economic Cost Pressures (Fuel, Rates, etc) | 1,000 | 3 | 3 | 9 | 0 | G | m4 ytd on track |
| 12. PTS Profitability | 350 | 3 | 3 | 9 | 0 | G | m4 ytd on track |
| Total | 65,151 | | | | 4,761 | | |

| 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 July 2010 - (Month 4)**

| Key Financial Performance Targets | Performance Ytd Position Act £000 | Plan £000 | Diff £000 | % | Forecast 2010/11 Fcast £000 | Plan £000 | Diff £000 | % | Status Current | Trend | Forecast |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. A&E Incentive | 3,025 | 3,029 | (4) | 0% | 3,025 | 3,029 | (4) | 0% | ↔ | | ↔ |
| 2. Agency Cost | 269 | 472 | (204) | 33% | 4,049 | 4,252 | (204) | 2% | ↓ | | ↓ |
| 3. A&E Subsistence | 14 | 187 | (173) | 271% | 1,509 | 1,682 | (173) | 6% | ↔ | | ↔ |
| 4. Third Party Transport | 217 | 205 | 13 | -3% | 1,856 | 1,844 | 13 | 0% | ↔ | | ↔ |
| 5. Non Frontline Payroll | (13) | 95 | (108) | #NUM! | 1,476 | 1,605 | (129) | 4% | ↓ | | ↓ |
| 6. Non Pay - Major Contract Review | 64 | 143 | (79) | 49% | 902 | 1,285 | (382) | 19% | ↓ | | ↓ |
| 7. Non Pay - Activity Reduction | 701 | 297 | 404 | -35% | 2,842 | 2,673 | 169 | -76% | ↑ | | ↑ |
| 8. Non Pay - Other | 82 | (302) | 384 | #NUM! | 2,782 | 2,071 | 711 | -49% | ↑ | | ↑ |
| 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 | 4,358 | 4,125 | 233 | -3% | 18,440 | 18,439 | 0 | -100% | ↔ | | ↔ |

- The YTD CIP is currently ahead of trajectory. This is due to the full achievement of the Overtime incentive CIP in Q1. The Trust has also achieved savings ahead of schedule due to lower than expected spend on identified Non Pay items.

- Overall the Trust is in line to achieve it's full annual CIP target.

- However, key targets around Agency Spend, Subsistence and Non Pay contracts are slipping behind schedule due to the structural adjustments required to make these savings

**KEY:**

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

# LAS Financial Review - Capital Summary

**Month Ending 31st July 2010 - (Month 4)**

| Projects | Ytd Position 4 | | | | Forecast 2010/11 | | | | Project Excluding 2010/11 | | | | Status | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Act £000 | Plan £000 | Diff £000 | % | Act £000 | Plan £000 | Diff £000 | % | Act £000 | Plan £000 | Diff £000 | % | 2010/11 | Project |
| 1. CommandPoint | (97) | 566 | 663 | 117% | 3,040 | 3,399 | (359) | -11% | 11,338 | 11,338 | (0) | 0% | ↓ | ↔ |
| 2. IM&T - Other | 460 | 182 | (277) | -152% | 4,126 | 1,094 | 3,032 | 277% | 2,117 | 2,371 | (254) | -11% | ↑ | ↓ |
| 3. Fleet - DCA | 912 | 911 | (1) | 0% | 6,794 | 5,467 | 1,328 | 24% | 10,905 | 5,439 | 5,467 | 101% | ↑ | ↑ |
| 4. Fleet - FRU | 88 | 22 | (65) | -297% | 136 | 132 | 4 | 3% | 11 | 20 | (9) | -47% | ↔ | ↔ |
| 5. Fleet - Other | 192 | 422 | 230 | 54% | 2,623 | 2,531 | 92 | 4% | 4,799 | 2,368 | 2,430 | 103% | ↔ | ↑ |
| 6. Estates - West Workshop | 0 | 0 | 0 | #DIV/0! | 0 | 0 | 0 | #DIV/0! | 0 | 0 | 0 | #DIV/0! | ↔ | ↔ |
| 7. Estates - HART East | 17 | 105 | 88 | 84% | 631 | 631 | (0) | 0% | 177 | 177 | 0 | 0% | ↔ | ↔ |
| 8. Estates - Hart West | 0 | 0 | 0 | #DIV/0! | 48 | 0 | 48 | #DIV/0! | 0 | 20 | (20) | -100% | ↔ | ↔ |
| 9. Estates - Other | 477 | 657 | 180 | 27% | 1,835 | 3,942 | (2,108) | -53% | 897 | (1,327) | 2,224 | -168% | ↓ | ↑ |
| 10. Clinical Equipment | 0 | 156 | 156 | 100% | 938 | 938 | 0 | 0% | 6,254 | 5,316 | 938 | 18% | ↔ | ↑ |
| 11. Other Projects | 0 | 0 | 0 | #DIV/0! | 0 | 0 | 0 | #DIV/0! | 0 | 0 | 0 | #DIV/0! | ↔ | ↔ |
| 12. Fleet - Finance Lease | 0 | 767 | 767 | 100% | 4,600 | 4,600 | 0 | 0% | 0 | (4,600) | 4,600 | -100% | ↔ | ↑ |
| 13. Disposals | 0 | (991) | (991) | 100% | (6,646) | (5,946) | (700) | 12% | 0 | 0 | 0 | #DIV/0! | ↓ | ↔ |
| Total Against Capital Resource Limit (CRL) | 2,049 | 2,798 | 749 | 27% | 18,124 | 16,788 | 1,336 | 8% | 36,499 | 21,123 | 15,376 | 73% | ↑ | ↑ |

**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 July 2010 - (Month 4)

| | 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 | 21,578 | -0.7% | 85,766 | 86,310 | (545) | -0.6% | 82,664 | 3,102 | 3.8% | 257,148 | 258,931 | (1,783) | -0.7% |
| Other | 2,233 | 1,847 | 20.9% | 9,354 | 7,389 | 1,965 | 26.6% | 10,473 | (1,119) | -10.7% | 22,646 | 22,167 | 479 | 2.2% |
| Total | 23,656 | 23,425 | 1.0% | 95,120 | 93,699 | 1,420 | 6496.4% | 93,137 | 1,983 | 2.1% | 279,794 | 281,098 | (1,304) | -0.5% |
| **Operating Expense** | | | | | | | | | | | | | | |
| Pay | 17,375 | 16,775 | 3.6% | 69,766 | 67,323 | 2,443 | 3.6% | 67,843 | 1,923 | 2.8% | 205,677 | 203,292 | 2,385 | 1.2% |
| Non Pay | 4,638 | 4,690 | -1.1% | 18,398 | 18,235 | 164 | 0.9% | 19,476 | (1,078) | -5.5% | 54,629 | 55,386 | (757) | -1.4% |
| Total | 22,013 | 21,464 | 2.6% | 88,165 | 85,558 | 2,607 | 3182.4% | 87,319 | 845 | 1.0% | 260,306 | 258,678 | 1,628 | 0.6% |
| **EBITDA** | 1,643 | 1,960 | -16.2% | 6,955 | 8,141 | (1,186) | -786.4% | 5,818 | 1,138 | 19.6% | 19,488 | 22,420 | (2,932) | -13.1% |
| EBITDA % | 6.9% | 8.4% | -17.0% | 7.3% | 8.7% | -1% | -731.1% | 6.2% | 1.1% | 17.1% | 7.0% | 8.0% | -1.0% | -12.7% |
| **Depreciation, Dividend & Interest** | 1,268 | 1,826 | -30.6% | 5,455 | 6,841 | (1,387) | -20.3% | 5,254 | 200 | 3.8% | 18,961 | 21,918 | (2,957) | -13.5% |
| | | | | | | - | | | | | | | | |
| **Net Surplus/(Deficit)** | 375 | 134 | 179.8% | 1,501 | 1,300 | 201 | 547.9% | 563 | 937 | 15.7% | 527 | 502 | 25 | 5.0% |
| Net Margin | 1.6% | 0.6% | 177.1% | 1.6% | 1.4% | 0.2% | 629.4% | 0.6% | 1.0% | 17.1% | 0.2% | 0.2% | 0.0% | 5.5% |
| Impairments | 0 | 0 | #DIV/0! | 0 | 0 | 0 | #DIV/0! | 0 | 0 | #DIV/0! | 0 | 0 | 0 | #DIV/0! |
| **Net Surplus after Impairment** | 375 | 134 | 179.8% | 1,501 | 1,300 | 201 | 547.9% | 563 | 937 | #DIV/0! | 527 | 502 | 25 | 5.0% |
| **Balance Sheet** | | | | | | | | | | | | | | |
| Non Current Assets | | | | 147,238 | 152,901 | (5,663) | -3.7% | 131,406 | 15,832 | 12.0% | 157,456 | 152,901 | 4,556 | 3.0% |
| Cash | | | | 3,837 | 2,979 | 859 | 28.8% | 5,141 | (1,304) | -25.4% | 836 | 2,979 | (2,142) | -71.9% |
| Working capital | | | | (899) | (9,903) | 9,004 | -90.9% | (1,538) | 639 | -41.5% | (9,762) | (9,903) | 140 | -1.4% |
| Non Current Liabilities | | | | (40,602) | (36,399) | (4,204) | 11.5% | (41,767) | 1,165 | -2.8% | (39,927) | (36,399) | (3,529) | 9.7% |
| Capital Employed | | | | 109,574 | 109,578 | (4) | 0% | 93,242 | 16,332 | 17.5% | 108,603 | 109,578 | (975) | -1% |
| Average Capital Employed | | | | 108,937 | 109,578 | (641) | -0.6% | 31,081 | 77,857 | 250.5% | 108,603 | 109,578 | (975) | -0.9% |
| Return on Capital Employed | | | | 1.38% | 1.19% | #DIV/0! | 16.1% | 1.8% | (0) | -24.0% | 0.49% | 0.46% | 0 | 5.9% |

# LAS Financial Review - Balance Sheet

**Month Ending 31st July 2010 - (Month 4)**

| | 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* | *Actual* | *Actual* | *Forecast* | *Forecast* | *Forecast* | *Forecast* | *Forecast* | *Forecast* | *Forecast* | *Forecast* |
| Intangible assets | 12,639 | 12,604 | 12,604 | 12,182 | 12,244 | 12,244 | 12,244 | 12,244 | 12,244 | 12,244 | 12,244 | 12,244 | 12,244 |
| Property, Plant and Equipment | 131,434 | 125,054 | 124,671 | 124,427 | 124,450 | 124,523 | 125,508 | 126,272 | 127,036 | 128,300 | 129,423 | 131,046 | 134,668 |
| Trade and Other Receivables | 10,503 | 10,513 | 10,527 | 10,534 | 10,544 | 10,544 | 10,544 | 10,544 | 10,544 | 10,544 | 10,544 | 10,544 | 10,544 |
| **Total Non-Current Assets** | 154,576 | 148,171 | 147,802 | 147,143 | 147,238 | 147,311 | 148,296 | 149,060 | 149,824 | 151,088 | 152,211 | 153,834 | 157,456 |
| **Current Assets** | | | | | | | | | | | | | |
| Inventories | 2,783 | 2,728 | 2,701 | 2,686 | 2,672 | 2,672 | 2,672 | 2,672 | 2,672 | 2,672 | 2,672 | 2,672 | 2,672 |
| NHS Trade Receivables | 3,122 | 10,903 | 9,332 | 2,886 | 2,438 | 10,395 | 4,043 | 4,023 | 4,023 | 4,023 | 4,023 | 4,023 | 4,023 |
| 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 | 8,237 | 7,554 | 7,554 | 7,554 | 7,554 | 7,554 | 7,554 | 7,554 | 7,554 | 3,232 |
| Accrued Income | 1,897 | 4,503 | 4,641 | 6,138 | 8,302 | 3,302 | 3,302 | 3,302 | 3,302 | 3,302 | 3,302 | 3,302 | 3,302 |
| Prepayments | 3,249 | 1,933 | 2,775 | 4,200 | 3,670 | 3,670 | 3,670 | 3,670 | 3,670 | 3,670 | 3,670 | 3,670 | 3,670 |
| Investments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Cash and Cash Equivalents | 5,141 | 4,533 | 4,209 | 3,738 | 3,837 | 1,398 | 5,900 | 5,614 | 7,080 | 6,234 | 6,059 | 5,572 | 836 |
| **Current Assets** | 24,394 | 31,195 | 30,966 | 27,885 | 28,473 | 28,991 | 27,141 | 26,835 | 28,301 | 27,455 | 27,280 | 26,793 | 17,735 |
| Non-Current Assets Held for Sale | 650 | 650 | 650 | 650 | 650 | 650 | 650 | 650 | 650 | 650 | 650 | 650 | 0 |
| **Total Current Assets** | 25,044 | 31,845 | 31,616 | 28,535 | 29,123 | 29,641 | 27,791 | 27,485 | 28,951 | 28,105 | 27,930 | 27,443 | 17,735 |
| **Total Assets** | 179,620 | 180,016 | 179,418 | 175,678 | 176,361 | 176,952 | 176,087 | 176,545 | 178,775 | 179,193 | 180,141 | 181,277 | 175,191 |
| **Current Liabilities** | | | | | | | | | | | | | |
| Bank Overdraft | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| NHS Trade Payables | 336 | 340 | 321 | 242 | 290 | 30 | 179 | 167 | 167 | 167 | 167 | 167 | 167 |
| Non NHS Trade Payables | 7,682 | 6,786 | 10,241 | 8,779 | 6,727 | 7,294 | 7,964 | 8,634 | 9,964 | 10,634 | 11,304 | 11,644 | 7,814 |
| Other Payables | 6,854 | 8,782 | 9,036 | 9,020 | 8,756 | 8,655 | 9,060 | 9,195 | 9,925 | 10,186 | 10,529 | 10,707 | 9,762 |
| PDC Dividend Liabilities | 200 | 514 | 828 | 1,142 | 1,436 | 1,818 | 0 | 382 | 764 | 1,146 | 1,528 | 1,910 | 0 |
| Capital Liabilities | 8,610 | 4,873 | 3,190 | 586 | 360 | 369 | 1,378 | 1,347 | 1,316 | 1,785 | 1,715 | 2,145 | 4,074 |
| Accruals | 1,217 | 5,044 | 1,828 | 2,022 | 4,646 | 4,646 | 4,646 | 4,646 | 4,646 | 4,646 | 4,646 | 4,646 | 4,646 |
| Deferred Income | 124 | 91 | 306 | 80 | 198 | 198 | 198 | 198 | 198 | 198 | 198 | 198 | 198 |
| DH Capital Loan Principal Repayment | 1,244 | 1,244 | 1,244 | 1,244 | 1,244 | 1,244 | 622 | 622 | 622 | 622 | 622 | 622 | 0 |
| Borrowings | 3,503 | 3,398 | 3,213 | 2,713 | 2,528 | 2,425 | 1,984 | 1,351 | 1,246 | 801 | 589 | 483 | 0 |
| Provisions for Liabilities & Charges | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Current Liabilities** | 29,770 | 31,072 | 30,207 | 25,828 | 26,185 | 26,679 | 26,031 | 26,542 | 28,848 | 30,185 | 31,298 | 32,522 | 26,661 |
| **Net Current Assets/(Liabilities)** | (4,726) | 773 | 1,409 | 2,707 | 2,938 | 2,962 | 1,760 | 943 | 103 | (2,080) | (3,368) | (5,079) | (8,926) |
| **Total Assets less Current Liabilities** | 149,850 | 148,944 | 149,211 | 149,850 | 150,176 | 150,273 | 150,056 | 150,003 | 149,927 | 149,008 | 148,843 | 148,755 | 148,530 |
| **Non-Current Liabilities** | | | | | | | | | | | | | |
| DH Capital Loan Principal Repayment | 8,075 | 8,075 | 8,075 | 8,075 | 8,075 | 8,075 | 8,075 | 8,075 | 8,075 | 8,075 | 8,075 | 8,075 | 8,075 |
| Borrowings | 21,560 | 21,560 | 21,560 | 21,560 | 21,560 | 21,560 | 21,560 | 21,560 | 21,560 | 21,560 | 21,560 | 21,560 | 21,560 |
| Other Financial Liabilities | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Provisions for Liabilities & Charges | 10,888 | 10,982 | 10,932 | 11,011 | 10,967 | 11,039 | 11,111 | 11,063 | 11,135 | 10,199 | 10,151 | 10,223 | 10,292 |
| **Total Non-Current Liabilities** | 40,523 | 40,617 | 40,567 | 40,646 | 40,602 | 40,674 | 40,746 | 40,698 | 40,770 | 39,834 | 39,786 | 39,858 | 39,927 |
| **Total Assets Employed** | 109,327 | 108,327 | 108,644 | 109,204 | 109,574 | 109,599 | 109,310 | 109,305 | 109,157 | 109,174 | 109,057 | 108,897 | 108,603 |
| **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 | 35,911 | 35,911 | 35,911 | 35,911 | 35,911 | 35,911 | 35,911 | 35,911 | 35,911 |
| Donated Asset Reserve | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 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 | 13,247 | 13,193 | 13,218 | 12,929 | 12,924 | 12,776 | 12,793 | 12,676 | 12,516 | 12,222 |

# LAS Financial Review - Cashflow

**Month Ending 31st July 2010 - (Month 4)**

| | 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* | *Actual* | *Forecast* | *Forecast* | *Forecast* | *Forecast* | *Forecast* | *Forecast* | *Forecast* | *Forecast* | *Forecast* | |
| **Operating Activities** | | | | | | | | | | | | | |
| ` | 664 | 730 | 1,000 | 453 | 526 | 212 | 496 | 353 | 518 | 384 | 341 | 211 | 5,888 |
| Depreciation and amortisation | 992 | 992 | 967 | 877 | 936 | 1,024 | 1,205 | 1,205 | 1,205 | 1,307 | 1,307 | 1,307 | 13,324 |
| 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) | (109) | (113) | (132) | (132) | (132) | (132) | (132) | (132) | (132) | (132) | (1,506) |
| Dividend Paid | 0 | 0 | 0 | 0 | 0 | (2,200) | 0 | 0 | 0 | 0 | 0 | (2,296) | (4,496) |
| (Increase)/Decrease in Inventories | 55 | 27 | 15 | 14 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 111 |
| (Increase)/Decrease in NHS Trade Receivables | (7,781) | 1,571 | 6,446 | 448 | (7,957) | 6,352 | 20 | 0 | 0 | 0 | 0 | 0 | (901) |
| (Increase)/Decrease in Long Term Receivables | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| (Increase)/Decrease in Non NHS Trade Receivables | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| (Increase)/Decrease in Other Receivables | 1,607 | (713) | (929) | 683 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4,322 | 4,970 |
| (Increase)/Decrease in Accrued Income | (2,606) | (138) | (1,497) | (2,164) | 5,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (1,405) |
| (Increase)/Decrease in Prepayments | 1,316 | (842) | (1,425) | 530 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (421) |
| Increase/(Decrease) in Trade Payables | 4 | (19) | (79) | 48 | (260) | 149 | (12) | 0 | 0 | 0 | 0 | 0 | (169) |
| Increase/(Decrease) in Other Payables | 5,182 | 3,720 | (7,020) | (2,407) | 452 | 1,061 | 791 | 2,046 | 917 | 999 | 504 | (4,789) | 1,456 |
| Increase/(Decrease) in Payments on Account | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Increase/(Decrease) in Accruals | 3,827 | (3,216) | 194 | 2,624 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3,429 |
| Increase/(Decrease) in Deferred Income | (33) | 215 | (226) | 118 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 74 |
| Increase/(Decrease) in Provisions & Liabilities | 94 | (50) | 79 | (44) | 72 | 72 | (48) | 72 | (936) | (48) | 72 | 69 | (596) |
| **Net Cash inflow/outflow from operating activities** | 3,207 | 2,163 | (2,584) | 1,067 | (1,363) | 6,538 | 2,320 | 3,544 | 1,572 | 2,510 | 2,092 | (1,308) | 19,758 |
| **Cashflows from Investing Activites** | | | | | | | | | | | | | |
| Interest received | 27 | 29 | 31 | 30 | 27 | 27 | 27 | 27 | 27 | 27 | 27 | 27 | 333 |
| (Payments) for property, plant & equipment | (3,737) | (2,331) | (3,327) | (1,126) | (1,000) | (1,000) | (2,000) | (2,000) | (2,000) | (2,500) | (2,500) | (3,000) | (26,521) |
| Proceeds from disposal of property, plant & equipment | 0 | 0 | 5,909 | 313 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 650 | 6,872 |
| (Payments) for intangible assets | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Proceeds from disposal of intangible assets | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| (Payments) for investment with DH | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| (Payments) for other financial assets | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Net Cash inflow/outflow from investing activities** | (3,710) | (2,302) | 2,613 | (783) | (973) | (973) | (1,973) | (1,973) | (1,973) | (2,473) | (2,473) | (2,323) | (19,316) |
| **Net Cash inflow/outflow before financing** | (503) | (139) | 29 | 284 | (2,336) | 5,565 | 347 | 1,571 | (401) | 37 | (381) | (3,631) | 442 |
| **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) | (500) | (185) | (103) | (441) | (633) | (105) | (445) | (212) | (106) | (483) | (3,503) |
| **Net Cashflow inflow/(outflow) from financing** | (105) | (185) | (500) | (185) | (103) | (1,063) | (633) | (105) | (445) | (212) | (106) | (1,105) | (4,747) |
| **Increase/(decrease) in cash & cash equivalents** | (608) | (324) | (471) | 99 | (2,439) | 4,502 | (286) | 1,466 | (846) | (175) | (487) | (4,736) | (4,305) |
| **Cash, cash equivalents and bank overdrafts at 010410** | 5,141 | | | | | | | | | | | | |
| **Cash, cash equivalents and bank overdrafts at 310311** | 4,533 | 4,209 | 3,738 | 3,837 | 1,398 | 5,900 | 5,614 | 7,080 | 6,234 | 6,059 | 5,572 | 836 | (4,305) |

# LAS Financial Review - Income Summary

**Month Ending 31st July 2010 - (Month 4)**

| 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 | 82,833 | 83,452 | (619) | -0.7% | 248,499 | 250,357 | (1,858) | -0.7% |
| 620 | 620 | 0.0% | CBRN | 2,482 | 2,482 | (0) | 0.0% | 7,445 | 7,445 | (0) | 0.0% |
| 94 | 94 | -0.1% | RTA | 451 | 376 | 74 | 19.8% | 1,204 | 1,129 | 74 | 6.6% |
| **21,423** | **21,578** | -0.7% | **Subtotal** | **85,766** | **86,310** | **(545)** | -0.6% | **257,148** | **258,931** | **(1,783)** | -0.7% |
| | | | **Specialised Services** | | | | | | | | |
| 581 | 581 | 0.0% | HART | 2,325 | 2,325 | (0) | 0.0% | 6,974 | 6,974 | (0) | 0.0% |
| 3 | 3 | -0.3% | HEMS | 13 | 13 | (0) | -0.3% | 39 | 39 | (0) | -0.1% |
| **584** | **584** | 0.0% | **Subtotal** | **2,338** | **2,338** | **(0)** | 0.0% | **7,013** | **7,013** | **(0)** | 0.0% |
| | | | **Information Services & Research** | | | | | | | | |
| 92 | 92 | 0.0% | EBS | 369 | 369 | 0 | 0.0% | 1,106 | 1,106 | 1 | 0.0% |
| 33 | 13 | 151.2% | Research | 86 | 52 | 34 | 65.9% | 191 | 156 | 34 | 22.0% |
| **125** | **105** | 18.8% | **Subtotal** | **455** | **421** | **34** | 8.2% | **1,296** | **1,262** | **35** | 2.7% |
| | | | **Patient Transport Services** | | | | | | | | |
| 766 | 598 | 28.0% | PTS | 3,041 | 2,392 | 648 | 27.1% | 7,826 | 7,177 | 648 | 9.0% |
| 48 | 80 | -40.4% | BETS & SCBU | 229 | 320 | (90) | -28.3% | 869 | 959 | (90) | -9.4% |
| 10 | 46 | -78.7% | A&E Long Distance | 62 | 183 | (121) | -66.2% | 429 | 550 | (121) | -22.1% |
| **823** | **724** | 13.7% | **Subtotal** | **3,332** | **2,896** | **436** | 15.1% | **9,123** | **8,687** | **436** | 5.0% |
| | | | **NHS London** | | | | | | | | |
| 405 | 213 | 90.7% | MPET | 2,213 | 850 | 1,363 | 160.4% | 2,447 | 2,550 | (103) | -4.0% |
| 0 | 0 | #DIV/0! | Other Education | 0 | 0 | 0 | #DIV/0! | 0 | 0 | 0 | #DIV/0! |
| 70 | 70 | 0.0% | Olympics 2012 | 278 | 278 | 0 | 0.0% | 835 | 835 | 0 | 0.0% |
| **475** | **282** | 68.3% | **Subtotal** | **2,492** | **1,128** | **1,363** | 120.8% | **3,282** | **3,385** | **(103)** | -3.0% |
| | | | **Commercial** | | | | | | | | |
| 91 | 77 | 18.4% | Stadia | 310 | 306 | 4 | 1.3% | 923 | 919 | 4 | 0.4% |
| 52 | 52 | 0.0% | BAA | 208 | 208 | 0 | 0.0% | 625 | 625 | 0 | 0.0% |
| (2) | 1 | -260.0% | Training | 10 | 5 | 5 | 98.1% | 20 | 15 | 5 | 32.7% |
| **141** | **130** | 8.4% | **Subtotal** | **529** | **520** | **9** | 1.7% | **1,568** | **1,559** | **9** | 0.6% |
| 85 | 22 | 288.7% | **Other** | 209 | 87 | 122 | 139.7% | 364 | 262 | 102 | 39.0% |
| **23,656** | **23,425** | 1.0% | **Total** | **95,120** | **93,699** | **1,420** | 1.5% | **279,794** | **281,098** | **(1,304)** | -0.5% |

# LAS Financial Review - Expense Summary

**Month Ending 31st July 2010 - (Month 4)**

| 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 | 21,578 | -0.7% | A&E | 85,766 | 86,310 | (545) | -0.6% | 82,664 | 3,102 | 3.8% | 257,148 | 258,931 | (1,783) | -0.7% |
| 2,233 | 1,847 | 20.9% | Other | 9,354 | 7,389 | 1,965 | 26.6% | 10,473 | (1,119) | -10.7% | 22,646 | 22,167 | 479 | 2.2% |
| **23,656** | **23,425** | **1.0%** | **Total** | **95,120** | **93,699** | **1,420** | 1.5% | **93,137** | **1,983** | 2.1% | **279,794** | **281,098** | **(1,304)** | -0.5% |
| | | | **Payroll (£k)** | | | | | | | | | | | |
| 10,488 | 10,881 | -3.6% | A&E Sectors | 41,962 | 43,469 | (1,507) | -3.5% | 37,710 | 4,253 | 11.3% | 129,649 | 132,786 | (3,136) | -2.4% |
| 950 | 453 | 109.7% | A&E Overtime | 4,085 | 1,817 | 2,268 | 124.8% | 5,385 | (1,299) | -24.1% | 8,864 | 5,485 | 3,379 | 61.6% |
| 0 | 0 | #DIV/0! | A&E Incentive | 4 | 0 | 4 | #DIV/0! | 2,152 | (2,148) | -99.8% | 4 | 0 | 4 | #DIV/0! |
| 1,241 | 1,115 | 11.3% | A&E Management | 4,861 | 4,449 | 412 | 9.3% | 4,258 | 604 | 14.2% | 14,079 | 13,334 | 745 | 5.6% |
| 959 | 907 | 5.7% | EOC | 3,811 | 3,621 | 190 | 5.3% | 3,583 | 229 | 6.4% | 10,745 | 10,555 | 190 | 1.8% |
| 289 | 334 | -13.6% | Operational Support | 1,128 | 1,336 | (208) | -15.6% | 1,098 | 30 | 2.7% | 3,814 | 4,023 | (208) | -5.2% |
| 517 | 430 | 20.3% | PTS | 2,149 | 1,718 | 432 | 25.1% | 2,239 | (90) | -4.0% | 5,645 | 5,168 | 477 | 9.2% |
| 2,252 | 2,443 | -7.8% | Corporate Support | 9,106 | 9,858 | (753) | -7.6% | 8,037 | 1,069 | 13.3% | 28,433 | 29,186 | (753) | -2.6% |
| 146 | 64 | 128.8% | Other Overtime | 654 | 255 | 399 | 156.4% | 959 | (305) | -31.8% | 1,247 | 765 | 482 | 62.9% |
| 533 | 149 | 258.2% | Agency | 2,005 | 800 | 1,206 | 150.8% | 2,424 | (419) | -17.3% | 3,196 | 1,991 | 1,206 | 60.6% |
| **17,375** | **16,775** | **3.6%** | **Total** | **69,766** | **67,323** | **2,443** | 3.6% | **67,843** | **1,923** | 2.8% | **205,677** | **203,292** | **2,385** | 1.2% |
| | | | **Non Pay** | | | | | | | | | | | |
| 600 | 522 | 14.9% | Staff Related | 2,277 | 2,718 | (441) | -16.2% | 2,503 | (226) | -9.0% | 6,469 | 6,893 | (423) | -6.1% |
| 676 | 497 | 36.2% | Consumables, Medical Equip & Drugs | 2,421 | 1,996 | 425 | 21.3% | 2,407 | 14 | 0.6% | 6,692 | 5,971 | 722 | 12.1% |
| 202 | 204 | -0.7% | Vehicle Leasing | 497 | 818 | (321) | -39.3% | 197 | 300 | 152.4% | 2,126 | 2,447 | (321) | -13.1% |
| 463 | 502 | -7.8% | Fuel & Oil | 1,842 | 2,009 | (168) | -8.3% | 1,518 | 324 | 21.3% | 5,859 | 6,026 | (168) | -2.8% |
| 561 | 499 | 12.5% | Vehicle Maintenance | 2,320 | 2,066 | 254 | 12.3% | 1,940 | 380 | 19.6% | 6,799 | 6,057 | 742 | 12.2% |
| 0 | 0 | #DIV/0! | Other Automotive | 0 | 0 | 0 | #DIV/0! | 0 | 0 | #DIV/0! | 0 | 0 | 0 | #DIV/0! |
| 229 | 130 | 75.6% | Vehicle Insurance | 847 | 535 | 311 | 58.2% | 630 | 217 | 34.5% | 1,888 | 1,577 | 311 | 19.8% |
| 86 | 14 | 515.8% | 3rd Party Transport | 301 | 239 | 62 | 25.8% | 721 | (420) | -58.3% | 413 | 351 | 62 | 17.6% |
| 1,057 | 938 | 12.8% | Accomodation & Estates | 4,170 | 4,206 | (36) | -0.9% | 4,254 | (84) | -2.0% | 11,974 | 11,707 | 267 | 2.3% |
| 656 | 730 | -10.1% | IT & Telecoms | 2,474 | 3,117 | (643) | -20.6% | 2,990 | (516) | -17.3% | 8,315 | 8,958 | (643) | -7.2% |
| 162 | 282 | -42.7% | Finance & Legal | 769 | (1,113) | 1,881 | -169.1% | 914 | (146) | -15.9% | 644 | 779 | (135) | -17.4% |
| 119 | 160 | -25.7% | Consultancy | 169 | 690 | (521) | -75.6% | 541 | (372) | -68.8% | 1,451 | 1,972 | (521) | -26.4% |
| (174) | 212 | -182.3% | Other | 313 | 953 | (640) | -67.1% | 862 | (549) | -63.7% | 1,998 | 2,648 | (650) | -24.5% |
| **4,638** | **4,690** | **-1.1%** | **Subtotal** | **18,398** | **18,235** | **164** | 0.9% | **19,476** | **(1,078)** | -5.5% | **54,629** | **55,386** | **(757)** | -1.4% |
| | | | **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! |
| 877 | 1,274 | -31.1% | Other | 3,828 | 4,630 | (802) | -17.3% | 3,820 | 8 | 0.2% | 13,325 | 15,283 | (1,959) | -12.8% |
| **877** | **1,274** | **-31.1%** | **Subtotal** | **3,828** | **4,630** | **(802)** | -17.3% | **3,820** | **8** | 0.2% | **13,325** | **15,283** | **(1,959)** | -12.8% |
| | | | **Financial** | | | | | | | | | | | |
| 294 | 382 | -23.1% | Dividend | 1,237 | 1,529 | (292) | -19.1% | 1,120 | 117 | 10.4% | 4,296 | 4,588 | (292) | -6.4% |
| 97 | 171 | -43.1% | Interest | 389 | 682 | (293) | -42.9% | 314 | 75 | 23.9% | 1,341 | 2,047 | (706) | -34.5% |
| **391** | **553** | **-29.3%** | **Subtotal** | **1,626** | **2,212** | **(585)** | -26.5% | **1,434** | **192** | 13.4% | **5,637** | **6,635** | **(998)** | -15.0% |
| **23,281** | **23,291** | **0.0%** | **Total Expense** | **93,619** | **92,399** | **1,220** | 1.3% | **92,573** | **1,046** | 1.1% | **279,267** | **280,596** | **(1,329)** | -0.5% |

# LAS Financial Review - Expense Trend

**Month Ending 31st July 2010 - (Month 4)**

| | Apr-10 Actual | May-10 Actual | Jun-10 Actual | Jul-10 Actual | Aug-10 Fcast | Sep-10 Fcast | Oct-10 Fcast | Nov-10 Fcast | Dec-10 Fcast | Jan-11 Fcast | Feb-11 Fcast | Mar-11 Fcast | 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 | 10,535 | 10,488 | 10,638 | 10,817 | 10,992 | 11,124 | 10,953 | 10,983 | 11,023 | 11,158 | 129,649 | 132,786 | (3,136) | -2.4% |
| A&E Overtime | 1,048 | 1,039 | 1,049 | 950 | 1,012 | 1,012 | 450 | 458 | 458 | 461 | 463 | 466 | 8,864 | 5,485 | 3,379 | 61.6% |
| A&E Incentive | 3 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 0 | 4 | #DIV/0! |
| A&E Management | 1,227 | 1,218 | 1,175 | 1,241 | 1,138 | 1,140 | 1,155 | 1,156 | 1,157 | 1,157 | 1,157 | 1,156 | 14,079 | 13,334 | 745 | 5.6% |
| EOC | 950 | 951 | 952 | 959 | 908 | 907 | 853 | 853 | 853 | 853 | 853 | 853 | 10,745 | 10,555 | 190 | 1.8% |
| Operational Support | 297 | 291 | 251 | 289 | 335 | 335 | 336 | 336 | 336 | 336 | 336 | 336 | 3,814 | 4,023 | (208) | -5.2% |
| PTS | 562 | 543 | 527 | 517 | 435 | 436 | 437 | 437 | 437 | 437 | 438 | 438 | 5,645 | 5,168 | 477 | 9.2% |
| Corporate Support | 2,218 | 2,236 | 2,400 | 2,252 | 2,445 | 2,444 | 2,403 | 2,404 | 2,407 | 2,408 | 2,408 | 2,408 | 28,433 | 29,186 | (753) | -2.6% |
| Other Overtime | 161 | 158 | 189 | 146 | 74 | 74 | 74 | 74 | 74 | 74 | 74 | 74 | 1,247 | 765 | 482 | 62.9% |
| Agency | 448 | 442 | 582 | 533 | 149 | 149 | 149 | 149 | 149 | 149 | 149 | 149 | 3,196 | 1,991 | 1,206 | 60.6% |
| **Total** | **17,390** | **17,339** | **17,662** | **17,375** | **17,135** | **17,313** | **16,848** | **16,991** | **16,826** | **16,858** | **16,901** | **17,038** | **205,677** | **203,292** | **2,385** | **1.2%** |
| **Non Pay** | | | | | | | | | | | | | | | | |
| Staff Related | 530 | 492 | 655 | 600 | 524 | 524 | 524 | 524 | 524 | 524 | 524 | 524 | 6,469 | 6,893 | (423) | -6.1% |
| Consumables, Medical Equip & Drugs | 488 | 631 | 626 | 676 | 534 | 534 | 534 | 534 | 534 | 534 | 534 | 534 | 6,692 | 5,971 | 722 | 12.1% |
| Vehicle Leasing | 78 | 96 | 120 | 202 | 204 | 204 | 204 | 204 | 204 | 204 | 204 | 204 | 2,126 | 2,447 | (321) | -13.1% |
| Fuel & Oil | 454 | 471 | 454 | 463 | 502 | 502 | 502 | 502 | 502 | 502 | 502 | 502 | 5,859 | 6,026 | (168) | -2.8% |
| Vehicle Maintenance | 397 | 804 | 557 | 561 | 560 | 560 | 560 | 560 | 560 | 560 | 560 | 560 | 6,799 | 6,057 | 742 | 12.2% |
| Other Automotive | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | #DIV/0! |
| Vehicle Insurance | 175 | 223 | 221 | 229 | 130 | 130 | 130 | 130 | 130 | 130 | 130 | 130 | 1,888 | 1,577 | 311 | 19.8% |
| 3rd Party Transport | 102 | 49 | 64 | 86 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 14 | 413 | 351 | 62 | 17.6% |
| Accomodation & Estates | 991 | 1,094 | 1,028 | 1,057 | 976 | 976 | 976 | 976 | 976 | 976 | 976 | 976 | 11,974 | 11,707 | 267 | 2.3% |
| IT & Telecoms | 723 | 717 | 377 | 656 | 730 | 730 | 730 | 730 | 730 | 730 | 730 | 730 | 8,315 | 8,958 | (643) | -7.2% |
| Finance & Legal | 752 | (144) | (2) | 162 | 97 | (32) | (32) | (32) | (32) | (32) | (32) | (32) | 644 | 779 | (135) | -17.4% |
| Consultancy | 12 | (4) | 42 | 119 | 160 | 160 | 160 | 160 | 160 | 160 | 160 | 160 | 1,451 | 1,972 | (521) | -26.4% |
| Other | 130 | 184 | 174 | (174) | 202 | 212 | 212 | 212 | 212 | 212 | 212 | 212 | 1,998 | 2,648 | (650) | -24.5% |
| **Subtotal** | **4,830** | **4,614** | **4,317** | **4,638** | **4,633** | **4,514** | **4,514** | **4,514** | **4,514** | **4,514** | **4,514** | **4,514** | **54,629** | **55,386** | **(757)** | **-1.4%** |
| **Depreciation** | | | | | | | | | | | | | | | | |
| Fleet | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | #DIV/0! |
| IT | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | #DIV/0! |
| Other | 992 | 992 | 967 | 877 | 936 | 1,024 | 1,205 | 1,205 | 1,205 | 1,307 | 1,307 | 1,307 | 13,325 | 15,283 | (1,959) | -12.8% |
| **Subtotal** | **992** | **992** | **967** | **877** | **936** | **1,024** | **1,205** | **1,205** | **1,205** | **1,307** | **1,307** | **1,307** | **13,325** | **15,283** | **(1,959)** | **-12.8%** |
| **Financial** | | | | | | | | | | | | | | | | |
| Dividend | 314 | 314 | 314 | 294 | 382 | 382 | 382 | 382 | 382 | 382 | 382 | 382 | 4,296 | 4,588 | (292) | -6.4% |
| Interest | 101 | 99 | 92 | 97 | 119 | 119 | 119 | 119 | 119 | 119 | 119 | 119 | 1,341 | 2,047 | (706) | -34.5% |
| **Subtotal** | **415** | **414** | **406** | **391** | **501** | **501** | **501** | **501** | **501** | **501** | **501** | **501** | **5,637** | **6,635** | **(998)** | **-15.0%** |
| **Total Expense** | **23,628** | **23,358** | **23,352** | **23,281** | **23,206** | **23,352** | **23,069** | **23,212** | **23,046** | **23,180** | **23,223** | **23,360** | **279,267** | **280,596** | **(1,329)** | **-0.5%** |

London Ambulance Service NHS
NHS Trust

# LONDON AMBULANCE SERVICE TRUST BOARD

**31ST AUGUST 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<br>☐ Senior Management Group<br>☐ Quality Committee<br>☐ Audit Committee<br>☐ Clinical Quality Safety and Effectiveness Group<br>☐ Risk Compliance and Assurance Group<br>☐ Other |
| **Recommendation for the Trust Board:** | The Trust Board is asked to note this report |

**Executive Summary/key issues for the Trust Board**

**Safety:** 1 SUI declared; 13 incidents investigated

**Clinical and cost effectiveness:**

**1.** Cardiac Arrest annual report for 2009/2010 published. Utstein figure now 21.5% and overall figure (all rhythms) 8%. This represents a significant increase on previous years' results.
**2.** CPI performance now at 89 and 74% for the last two months. Still room for improvement but overall increase in compliance compared with 2009. Feedback targets for the year to date exceeded.
**3.** Interim report on Clinical Audit and Research provided.
**4.** Arrangements for resubmitting Safeguarding declaration described. Update provided on progress towards achieving 85% compliance to level 2 safeguarding training.

**Governance:** Update provided on medicines management. 2 incidents involving Controlled Drugs; loss of 1 ampoule of morphine. New arrangements for staff to carry morphine described, along with initiatives for improving safety arrangements for managing fluids.

**Care environment and amenities:** progress on infection prevention and control with improved audit arrangements.

**Attachments**
Main report with 2 appendices (Interim Clinical Audit and Research report; Safeguarding figures)

**********

**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 31st August 2010**

**Clinical Quality and Patient Safety Report**

## Safety

### 1.1 Update on Serious Untoward Incidents (SUIs)

One new SUI has been declared and 13 other incidents have been given consideration as possible SUIs since my last update to the Board in June 2010. The new case relates to a an elderly patient assessed by a London Ambulance Service crew and left at home who deteriorated and died within a short period of time.

### 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.

22 alerts were received from 15th June – 19th August2010. All alerts were acknowledged; one required action, relating to securing medical gas cylinders, including cylinders on trolleys. This action has been completed.

## Clinical and Cost Effectiveness

### 2.1 Clinical Steering Group; arrangements for seeking external clinical advice

Further to my update in June we have received a positive response from clinicians asked to join the virtual Steering Group with new representations from respiratory medicine and End of Life Care, as well as continue support from existing members.

### 2.2 Clinical Performance Indicator completion

The current target for CPI completion is **95%.** The May figures show that the dramatic improvements achieved in March and April have been sustained, although an increase in the REAP level in June was reflected in a fall in completion for this month. The overall improvement 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, and we anticipate that completion figures will again improve, reflecting the reduction of the REAP level to 1.

**Diagram 1. CPI completion November to April 2009 / 2010**

| Area | November | December | January | March | April | May | June |
|---|---|---|---|---|---|---|---|
| East | 30% | 20% | 23% | 77% | 86% | 77% | 78% |
| South | 45% | 44% | 46% | 82% | 94% | 94% | 70% |
| West | 49% | 36% | 56% | 86% | 98% | 93% | 76% |
| **LAS** | **43%** | **36%** | **43%** | **82%** | **93%** | **89%** | **74%** |

For the year 2010 to date, Team Leaders across the LAS have delivered 1577 feedback sessions, exceeding their target for the year so far. The West and South Areas have both met and exceeded their targets (this figure is based on each member of staff receiving two feedback sessions per year). 12 Complexes have met their individual feedback targets for the year to date. Impressively, **Chase Farm, Croydon,**
**Edmonton**, **Greenwich** and **Hanwell** Complexes completed over 30 sessions each in June 2010.

CARU, AOMs and their Team Leaders are to be congratulated on maintaining the recent and sustained improvement, both in CPIs completed and feedback provided.

### 2.3 Improving Outcomes from Out of Hospital Cardiac Arrest

The LAS Cardiac Arrest report, published in July shows that survival to hospital discharge has increased to 21.5% for the group of patients whose arrest is believed to be cardiac in origin, whose arrest was witnessed and whose presenting rhythm was ventricular fibrillation (Utstein figure). For all patients on whom resuscitation was attempted the figure has risen to 8%. This is a tremendous achievement.

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

An interim update on Clinical Audit and Research activity is included Appendix 1.

### 2.5 Safeguarding update

The Patient Experience Department has been asked to complete a further safeguarding declaration by the Commissioners. This is very similar to the declarations that we are obliged to provide to every local safeguarding board (although to date we have only received two requests). These declarations only refer to safeguarding activity for children and not, as yet, to vulnerable adults as this does not currently have the same footing in statue. We propose to include safeguarding activity both in the number of referrals as well as the involvement in individual management reports and serious case reviews in the Area Governance reports. We will complete the declaration for Commissioners and place it on the website to serve as a definitive statement for local safeguarding boards. In addition Patient Experience will ensure that that actions and issues from serious case reviews and individual management reports are brought to the Safeguarding Group for opinion and action and that lessons identified are subsequently published on the website. One of the areas of weakness reported in our previous declaration related to the percentage of staff trained to Safeguarding at level 2. Since professional development for existing members of staff restarted, and taking into account student

paramedics, the Trust has increased the numbers of staff trained to 51% (target 85%). A further 560 places are planned between August and October 2010, which will increase the numbers to 69%.

Appendix 2 demonstrates the increase in Safeguarding referrals for both adults and children, both by Complex and Borough.

**Governance**

### 3.1 Update on drugs management

One incident relating to loss, but no incidents relating to 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 June 2010.

### 3.2 Medicines management update

There have been two Controlled Drugs (CD) incidents since the last report to the Trust Board. The first occurred at Walthamstow Ambulance Station on 5th July 2010 and the second on 13th Sept 2010 at Silverton Ambulance Station.

In the first incident it became apparent that the CD Safe was one ampoule (10 mg) of morphine sulphate short. All the correct actions were taken and an investigation undertaken. Despite an exhaustive investigation it was not possible to determine exactly where the loss occurred. However the investigation did reveal that the 24hr routine checks had not been completed on a couple of occasions in the week prior to the discovery. The Assistant Director of Operations for the Area and Ambulance Operations Manager for the Complex have again reminded all staff of their legal duties in relation to controlled drugs. The case has been discussed by the Senior Clinical Adviser to the Medical Director with both the Metropolitan Police CD Liaison Officer, and the NHS Counter Fraud Specialist assigned to the LAS. Given the unfortunate circumstances of the 24hr checks it has very reluctantly been accepted that, on this occasion we will not be able to ascertain where and by whom the loss was made.

In the second incident a person or person's unknown gained entry to Silvertown Ambulance Station, by an access method that was not overtly apparent. Having broken into a couple of office cabinets, possibly to find the access codes to the CD Safe, they then attempted to gain access by trying to defeat the numeric keypad on the CD Safe. The situation was discovered when a late turn crew came back to station. Again all relevant persons were informed. Due to the tampering with the keypad the safe "locked itself out". This meant that locksmith had to be called to bypass the keypad and normal locking mechanisms. On opening the safe all the stocks were present and correct. The case has been discussed by the Senior Clinical Adviser to the Medical Director with both the Metropolitan Police CD Liaison Officer, and the NHS Counter Fraud Specialist assigned to the LAS. Given the paucity of evidence it is difficult to come to any firm conclusions about the break in. This could have been a targeted break in – purely for CDs –but could equally have been an opportunistic event.

Medicines Management Group (MMG)

The second meeting of the MMG was held on 21st July 2010. The main action points from the meeting are:

- The LAS is actively costing out the use of pre-filled saline flush syringes. The potential benefits to the service will be in the area of increased infection control and in terms of ease of use.
- The LAS will be changing from double chamber blood administration sets to single chamber fluid administration sets. There is a cost saving of approx 65p per unit. As there are several thousand sets in circulation there will be a modest saving over time.
- The LAS will explore drawing draw up a PGD for the use of IV paracetamol, and then run a feasibility study in the NW Sector under the direction of the Assistant Medical Director – West Area. IV paracetamol is a well researched treatment for moderate to severe pain and can be used very safely in conjunction with morphine. The intention for the feasibility study is to use IV paracetamol as a first line drug in situations where morphine would otherwise have been used.
- To reduce the possibility of fluid error(s) we are exploring the feasibility of placing a 500ml bag of 10% dextrose into the general drugs bag. We would thus only ask paramedics to carry two 500ml bags of 0.9% saline in their paramedic kit. We are still attempting to source 250 ml bags of saline. We would also look to send back for refund the many unopened cases of 10% dextrose that are currently in various station fluid stores.
- Work has started on a complete overhaul of the “General” (“Technician”) and “Paramedic” drug bags. The aim to explore a better system of ordering, storing, packing, issuing and administration of all drugs by LAS Staff. This is a root and branch review and will take potentially 18months to complete. It is anticipated that there will be a short term spend to achieve a much longer term saving(s).
- All paramedics are being issued with a personal pouch in which to keep their morphine. With the issue of the pouch thee is an attendant letter from the Medical Director also re-iterating the main points to be adhered to when signing in / out morphine sulphate.

Unannounced Visits by Metropolitan Police

The Senior Clinical Adviser to the Medical Director had a meeting in late August with the Metropolitan Police CD liaison Officer to plan the next tranche of unannounced visits to Ambulance Complexes.

**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 first quarter infection control audits showed improved completion across all areas and included the education centres for the first time. The West Area had the highest figures with 100% completion. Overall compliance was just below the 85% target in all areas.

An away day for the Infection Control Steering Group (ICSG) was held in July. This included a presentation from the Assistant Clinical Director from South West Ambulance Service who have recently received a national award for their infection prevention and control programme.

The ISCG agreed 5 priorities for this year with another ongoing 7 areas for development.

5 priorities are:

Vehicle Cleaning
Training and Development
Infection Control Champions
Linen Management
The Management of Sharps

All these targets now have a designated lead from both management and staff side. These leads will work together to deliver on these targets and feed back progress to the ICSG. Progress will also be monitored through the SMART objectives.

A trial starting on 21st August will align deep cleans to the vehicle servicing schedule in an attempt to improve completion of both. This will start at Fulham with the intention of rolling out across the LAS, if successful.

Agreement has been reached with the Clinical Audit and Research Unit to start an audit on cannulation and risks of healthcare associated infection, now that the system of Aseptic Non Touch Technique along with cannulation packs have been introduced. The audit will compare cannulation undertaken in emergency versus non emergency situations on one hospital site over a 3 month period, (probably a combined HASU and MTC, but yet to be determined.)

We have developed patient information leaflets dealing with common HCAIs to be placed on the Trust website, alongside fact sheets on the intranet for the management of these infections by front line staff

**Public Health**

Nothing further to report

**Recommendation**

That the Board notes the report

Fionna Moore,
Medical Director
**21st August 2010**

**Appendix 1**

**LAS Clinical Audit and Research activity – interim update**
**March 2010 to June 2010**

This report provides an interim update on both the clinical audit and research activities of the London Ambulance Services (LAS). It is intended to keep members informed about any recent changes to our clinical audit and research activities. This is a summary of those projects with substantial changes. For more comprehensive details, please refer to the most recent pack from the last CARSG meeting.

## Clinical Audit Activity

| **Core Clinical Audits** | |
|---|---|
| Epilepsy | This project assessed LAS compliance to Joint Royal Colleges Ambulance Liaison Committee (JRCALC) convulsion guidelines for 200 patients in June 2009. Amendments to the report have been made following suggestions from CARSG. The report is awaiting final approval and consultation on recommendations prior to dissemination. |
| Obstetrics | The report for this large-scale audit project has now been disseminated. |
| Under-Ones Not Transported to Hospital | The Expert Working Group, consisting of London Paediatric Consultants and members of the Medical Directorate, met in May and has agreed changes to the management of paediatric patients which will be implemented shortly. The next Expert Working Group meeting will take place in November to monitor these changes and a full clinical audit will be conducted 6-12 months following this meeting. |
| Sickle Cell | The report for this project is in the final draft stages and it is anticipated this will be released by the end of July. |
| Hip and Pelvic Injuries | Outcome data has been received from one hospital and is expected from at least two more. These records have been traced on the LAS system and data entry has begun. |
| Oxygen | The oxygen baseline audit has been completed and released. A reminder for ambulance staff to familiarise themselves with the 2009 JRCALC oxygen guidelines has been drafted and is due to |

| | |
|---|---|
| | appear in September's Clinical Update. |
| Naloxone | The naloxone baseline audit report has been completed and disseminated. The report made the recommendation that ambulance staff should be reminded to assess patients for suspected cardiac arrhythmias; this has been communicated to the training school and an article has been drafted to feature in September's LAS Clinical Update. |
| Salbutamol | This audit will assess the use of salbutamol in the LAS. The data has been collected for this project and is currently under clinical review by an advisor the LAS medical director. |
| Glasgow Coma Score | The design for this project has been agreed; GCS documentation will be reviewed for 100 head injury cases. |
| **CHD Audit Activity** | |
| Cardiac Care Pack | Four Cardiac Care Packs (covering data from February 2010 to May 2010) have been disseminated across the Service. |
| **Team Leader Audit Activity** | |
| Clinical Performance Indicators (CPIs) | Since the launch of the updated CPI database, Team Leader completion rates have increased significantly, reaching a high of 93% in April of this year – the highest completion rate figure since CPIs began. Although lower service pressures have given Team Leaders more office time which has likely contributed to this improvement, the dramatic completion rate figures show the clear benefits of the latest database update. |
| **Collaborative Audits** | |
| National CPIs (Stroke, Hypoglycaemia, Asthma, Cardiac Arrest and STEMI) | Cycle 5 of the National CPI audit is underway. LAS performance was generally high across the National CPIs during Cycles 1, 2, 3 and 4.<br>Areas of LAS care where we performed less well in Cycle 4 (compared to other ambulance services in England) were: the administration of morphine to STEMI patients when indicated, taking a $Sp0_2$ reading before treatment for asthma and taking a BM after treatment for hypoglycaemia.<br><br>A campaign to increase the Service's administration of |

| | |
|---|---|
| | analgesia to STEMI patients where indicated took place across the LAS during October 2009 following comparatively low results for analgesia administration in Cycle 3. This led to some improvement in analgesia administration in Cycle 4, however further improvement can be made. CARU are working with LAS Team Leaders to encourage the highlighting of this aspect of care during CPI feedback sessions. |
| Centre for Maternal and Child Enquiries (formerly the Confidential Enquiry into Maternal and Child Health): Confidential Enquiry into Head Injury in Children | This project is ongoing. Details of the cases that CMACE require have now been received, and CARU are in the process of collecting and anonymising the patient notes. |

**Research activity**

| **Active research studies LAS-led** | |
|---|---|
| *Dispatcher Assisted Resuscitation Trial ('DART').*<br><br>Principal Investigator: Dr Rachael Donohoe (LAS)<br>Recruitment period: 21/12/2004 to 30/09/2008<br>Funding: Unfunded<br>Eligible for NIHR CRN Portfolio Adoption[1]: No | Analysis is complete. The paper has been accepted by the New England Journal of Medicine and it is due to be published imminently. |
| *Characteristics and Clinical Outcomes of Patients with Left Bundle Branch Block, referred by the Ambulance Service to a centre capable of primary percutaneous coronary intervention (PPCI).*<br><br>Principal Investigator: Dan Dutfield (LAS)<br>Recruitment period: 31/03/2010 – 31/01/2011<br>Funding: Unfunded<br>Eligible for NIHR CRN Portfolio Adoption: No | This is a retrospective analysis of data held on Myocardial Ischaemia National Audit Project (MINAP) database. Working in conjunction with Royal Brompton and Harefield.<br><br>The study is now ethically approved, with LAS R&D approval issued in June 2010. |
| *The ISRAS Study: Improving Stroke Recognition by Ambulance Services: use of the ROSIER assessment tool.*<br><br>Investigators: Dr Rachael Donohoe (LAS), Dr Patrick Gompertz (Barts and the London), Dr Fionna Moore (LAS), Mark Whitbread (LAS), Dr Julia Williams (University of Hertfordshire).<br>Recruitment period: 03/08/2009 - 02/08/2010<br>Funding: The Stroke Association<br>Eligible for NIHR CRN Portfolio Adoption: Yes | This study has been adopted onto the NIHR portfolio.<br><br>Recruitment began in January 2010 with 74 participants recruited so far. |

| **Collaborative studies** | |
|---|---|
| *Smart CPR.*<br><br>Investigators: Dr John Freese (Fire Department of New York), Dr Rachael Donohoe (LAS), Dawn Jorgenson (Philips Medical Systems), Mark | Data collection is complete and analysis is currently being undertaken. Nine abstracts have been submitted to the European Resuscitation Conference |

[1] The National Institute for Health Research (NIHR) Clinical Research Network (CRN) Coordinating Centre provides support to facilitate clinical trials and other well designed studies. Studies that are included in the NIHR CRN Portfolio will have access to infrastructure support and to NHS service support costs. Only those studies that are part of the NIHR CRN Portfolio will have access to infrastructure support, it is therefore crucial that all studies which are eligible are included/adopted to the Portfolio.

| | |
|---|---|
| Whitbread (LAS).<br>Recruitment period: 06/05/2006 – 30/06/2009 (subject to interim data analysis)<br>Funding: Philips Medical Systems (Seattle, USA)<br>Eligible for NIHR CRN Portfolio Adoption: No | which is being held in December. Full papers for publication are currently being drafted. |
| *SAFER 2: Care of older people who fall: an evaluation of the clinical and cost-effectiveness of new protocols for emergency ambulance personnel to assess and refer to appropriate community based care.*<br>Investigators: Prof. H Snooks (Swansea University); Mary Halter (Kingston and St George's University of London); Dr Rachael Donohoe (LAS), Prof. Niro Siriwardena (East Midlands Ambulance Service); Richard Whitfield (Welsh Ambulance Service).<br>Recruitment period:: 04/2010 - 01/2011<br>Funding: NIHR Health Technology Assessment (HTA)<br>Eligible for NIHR CRN Portfolio Adoption: Yes | This is an NIHR portfolio study. HTA funding of £1.3 million has been awarded, including £50,750 as project implementation costs for LAS.<br>LAS have requested a further £40,000 for service support costs from the North West London Comprehensive Local Research Network (CLRN), to recruit a paramedic for 12 months with the task of consenting patients.<br>The study will be undertaken in the North West area of London<br>The R&D governance checks have been performed.<br>It is anticipated that the project will go live in August. |
| *Paramedic SVT: Safety and efficacy of Paramedic treatment of regular supraventricular tachycardia (pre-hospital administration of Adenosine).*<br>Investigators: Dr Richard Schilling (Barts & The London); Mark Whitbread (LAS)<br>Recruitment period: 14 months – dates TBC<br>Funding: Unfunded<br>Eligible for NIHR CRN Portfolio Adoption: No | British Heart Foundation funding was granted. LAS will receive £16,000 over two years.<br>Training for ambulance crews is planned for October 2010. |
| *Identification of Stroke Symptoms in Alert Patients who Fall without Injury (stroke-fallers).*<br>Principal Investigator: Tracey Barron<br>Recruitment period:: TBC<br>Funding: International Academies of Emergency Dispatch<br>Eligible for NIHR CRN Portfolio Adoption: No | R&D approval was issued in June 2010. |
| *Direct Angioplasty for Non-St-Elevation Acute* | The study is awaiting adoption onto |

| | |
|---|---|
| *Coronary Events (DANCE).*<br><br>Investigators: Dr Miles Dalby (Royal Brompton & Harefield); Mark Whitbread (LAS)<br>Recruitment period: TBC<br>Funding: Abbott Laboratories Limited and Diichi Sabkyo UK Limited (still TBC)<br>Eligible for NIHR CRN Portfolio Adoption: Yes | NIHR portfolio<br><br>Contract has been agreed and signed. £40,000 will be available in funds: £20,000 now, and a further £20,000 upon completion of recruitment.<br><br>R&D approval was issued in July 2010.<br><br>The training of ambulance crews will begin in September at Pinner, Kenton and Hillingdon. |
| *Immediate Management of the Patient with aneurysm rupture: Open Versus Endovascular Repair ('IMPROVE').*<br><br>Investigators: Prof. Janet Powell (Imperial College, London); Dr Fionna Moore (LAS).<br>Recruitment period: 04/2009 – 04/2011<br>Funding: NIHR Health Technology Assessment<br>Eligible for NIHR CRN Portfolio Adoption: Yes | LAS crews are now bypassing the A&E at Mayday, Kingston and St Helier and taking patients with suspected ruptured abdominal aortic aneurysm, directly to St George's vascular centre.<br><br>Discussions with the Comprehensive Local Research Network (CLRN) are ongoing in regard to funding for excess treatment costs. We are awaiting updates for the study from Investigators. |

| **Externally-led research studies** | |
|---|---|
| *Understanding and improving the experience of parents and carers who need advice when a child has a fever.*<br><br>Principal Investigator: Prof. Terence Stephenson (University of Nottingham)<br>Recruitment period: 01/04/2009 – 31/05/2009<br>Funding: Department of Health<br>Eligible for NIHR CRN Portfolio Adoption: Yes | The study is now complete. The final report has been submitted to the LAS Trust R&D approval. |
| *iHealth Project: Observational Studies v2.0.*<br><br>Principal Investigator: Dr Roger Kneebone (Imperial College London)<br>Recruitment period: 01/11/2008 – 01/04/2010<br>Funding: Engineering and Physical Sciences Research Council and Medical Research Council<br>Eligible for NIHR CRN Portfolio Adoption: Yes | The project was abandoned due to lack of contact from the Investigator. |
| *A study investigating the cardioprotective benefits of remote ischemic post conditioning in different clinical settings of myocardial ischemia-reperfusion injury.* | The study encountered recruitment problem at Chase Farm because of low incidence. LAS have suggested using the Pinner to Royal Harefield route to circumvent the problem. We are awaiting an update from the PI. The |

| | |
|---|---|
| Principal Investigator: Jonathan Hasleton (Hatter Cardiovascular Institute)<br>Recruitment period: 09/06/2008 – 09/06-2010<br>Funding: Externally led project with no funding<br>Eligible for NIHR CRN Portfolio Adoption: No | LAS have provided average of transport times from incident to London catheter-labs. |
| *An exploration of attitudes towards young people who self-harm and an investigation into the care they receive in hospital emergency departments.*<br><br>Principal Investigator: Karen Cleaver (University of Greenwich)<br>Recruitment period: 25/02/08 – 30/06/2010<br>Funding: Unfunded (Academic Study)<br>Eligible for NIHR CRN Portfolio Adoption: No | The recruitment of paramedics to the study has been difficult so the sample size was reduced.<br><br>This was due for completion in July but the Principal Investigator is currently away on leave. |
| *Identifying Emergency Personnel at Risk of Post-Traumatic Stress Disorder (PTSD).*<br><br>Principal Investigator; Dr Jennifer Wild (Institute of Psychiatry)<br>Recruitment period: 30/01/2009 – 26/10/2012<br>Funding: Wellcome Trust<br>Eligible for NIHR CRN Portfolio Adoption: Yes | A trial monitoring audit was conducted with Dr Jennifer Wild of the Institute of Psychiatry on 22 June 2010 by Mike Gordon (LAS R&D Co-ordinator).<br><br>433 participants have been recruited so far. |

| **Non-research (requiring local R&D approval for governance purposes)** | |
|---|---|
| *Evaluation of Airway Management in simulated CBRN Environments.*<br><br>Investigator: Dr Jan Schumacher (Guy's and St. Thomas') | This study will determine the influence of Chemical, Biological, Radiological and Nuclear (CBRN) personal protective equipment on the performance of airway management.<br><br>The study plans to evaluate 20 participants from an ongoing training course within the LAS.<br><br>R&D approval was issued in March. |
| *Evaluation of paediatric life support in simulated CBRN environments*<br><br>Investigator: Dr Jan Schumacher (Guy's and St. Thomas') | This study will evaluate paediatric life support within a simulated Chemical, Biological, Radiological and Nuclear (CBRN) environment.<br><br>The study plans to evaluate 20 participants from an ongoing training course within the LAS.<br><br>R&D approval was issued in March. |
| Ambulance personnel's reactions to epileptic seizures<br><br>Investigator - Lisa Hollings (LAS) | Study was granted with R&D approval in May 2010. |

| | |
|---|---|
| Comparison between ECP and paramedics using pathway protocols in place<br><br>Investigator - Jane Worthington (LAS) | R&D approval was issued in April 2010. |
| Survey for frontline ambulance staff<br><br>Investigator - Chris Marshall (Social Research Institute) | R&D approval was issued in March 2010. |
| Dimensions of collaborative capability: study of ambulance services in southern England<br><br>Investigator – Martin Brand (LAS) | Awaiting application before processing R&D governance approval. |
| Randomised questionnaire for EOC callers<br><br>Investigator - Andy Heward (LAS) | R&D approval was issued in February 2010. |

**Publications**

- Rea TD, Fahrenbruch C, Culley L, Donohoe RT, Hambly C, Innes J, Bloomingdale M, Subido C, Romines S & Eisenberg M (2010) Randomized trial of CPR with chest compression alone versus chest compression plus rescue breathing. New England Journal of Medicine; *in press.*
- Halter M, Vernon S, Snooks H, Porter A, Close J, Moore F, Porsz S. (2010) Complexity of the decision-making process of ambulance staff for assessment and referral of older people who have fallen: a qualitative study. Emerg Med J.; *doi:10.1136/emj.2009.079566.*
- Siriwardena, NA, Shaw D, Donohoe R, Black S & Stephenson J (2010) Development and pilot of Clinical Performance Indicators for English Ambulance Services. Emergency Medical Journal; 27: 327-331
- Siriwardena, Donohoe R, Stephenson J & Philips P (2010) Supporting research and development in ambulance services: research for better healthcare in prehospital settings. Emergency Medical Journal; 27: 324-326
- Shah, SA; Bhopal, R; Gadd, S and Donohoe, R. (2010) Out of hospital Cardiac Arrest in South Asian and White populations in London: database evaluation of characteristics and outcome. Heart; 96: 27-29.
- Barratt H, Wilson M, Moore F, Raine R. (2010) The implications of the NICE guidelines on neurosurgical management for all severe head injuries: systematic review. Emerg Med J. 27:173-8
- Deakin CD, Clarke T, Nolan J, Zideman DA, Gwinnutt C, Moore F, Ward M, Keeble C, Blancke W. (2010) A critical reassessment of ambulance service airway management in prehospital care. Emerg Med J. 27:226-33.

**Submissions**

Rachael T Donohoe; Jennifer Innes; Stephen M Gadd; Mark Whitbread; Fionna Moore; Douglas Chamberlain. (2010) Characteristics of out-of-hospital cardiac arrest and factors associated with survival in London: A four-year study. Annals of Emergency Medicine (Submitted)

**Appendix 2**

**Safeguarding Charts**

**Figure 1: Overall safeguarding figures 2006 - 2010**

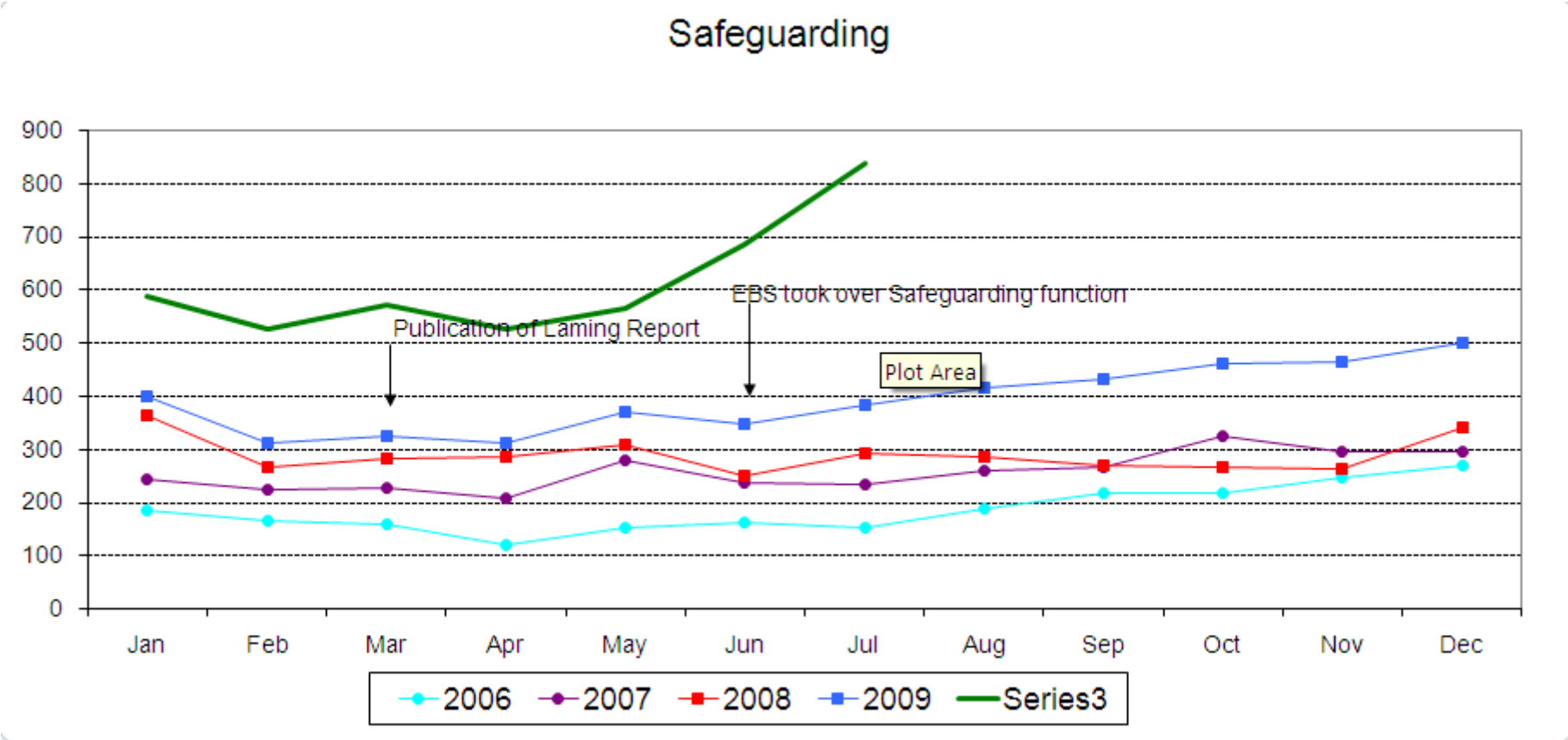


**Figure 2: Safeguarding Figures for May - July 2010**

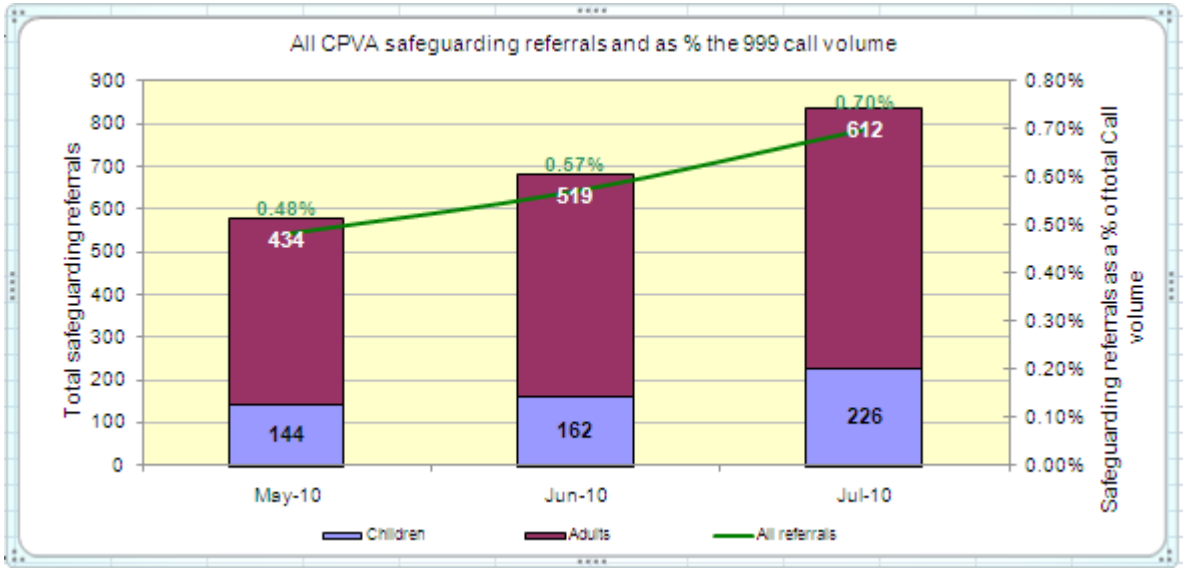


**Figure 3: Total safeguarding referrals made per borough**

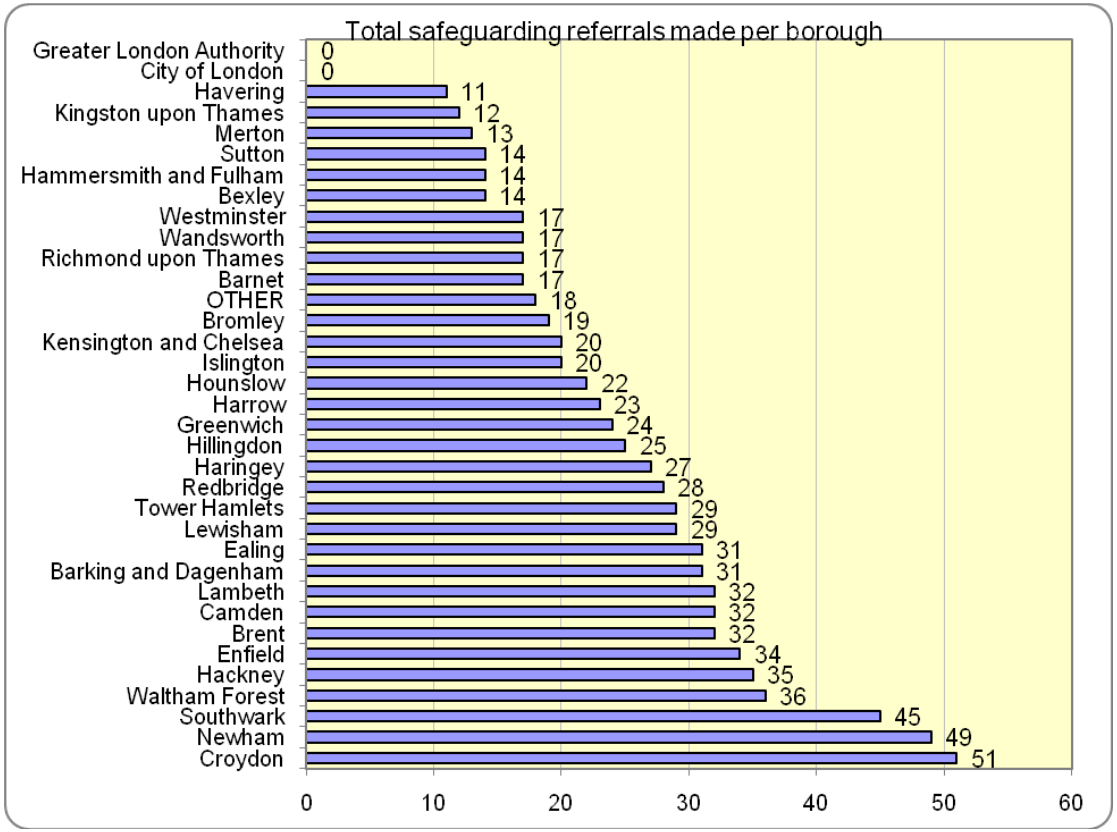


**Figure 4: Safeguarding referrals for adults July 2010**

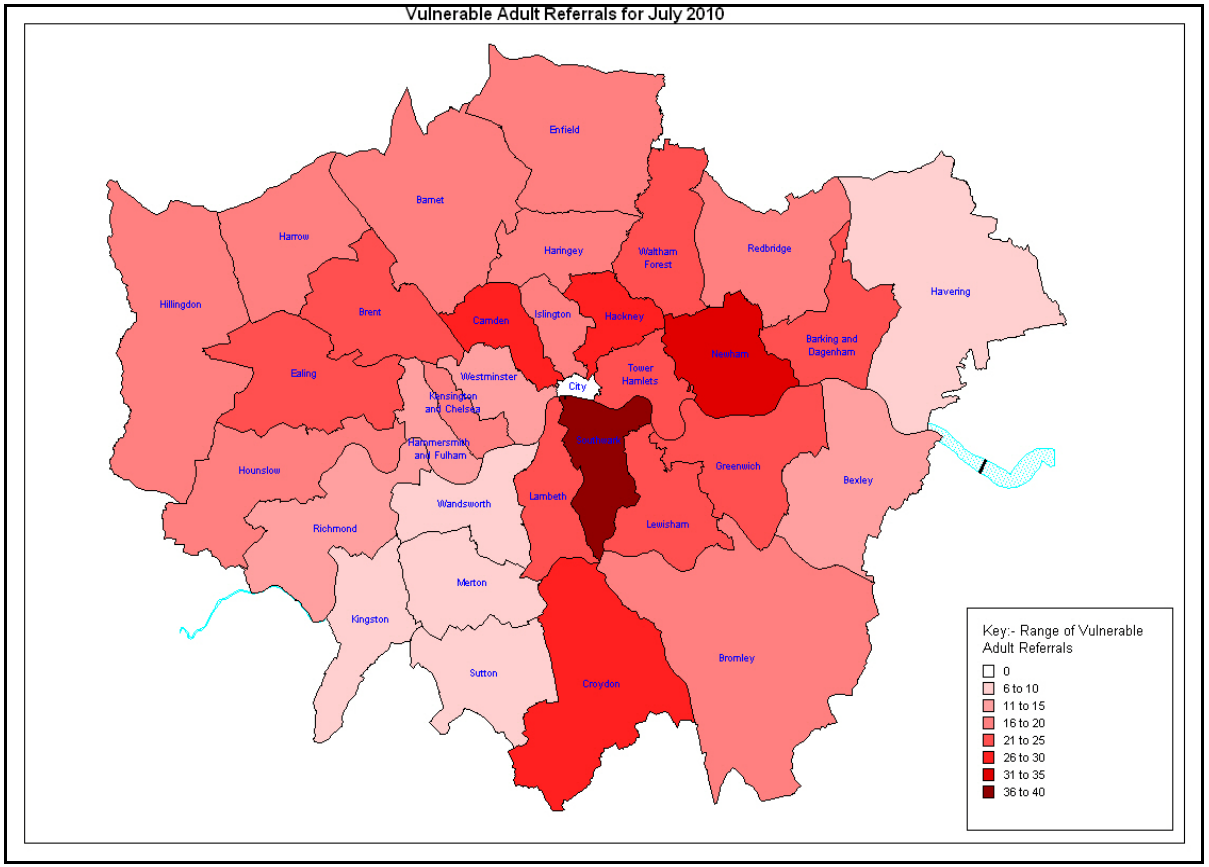
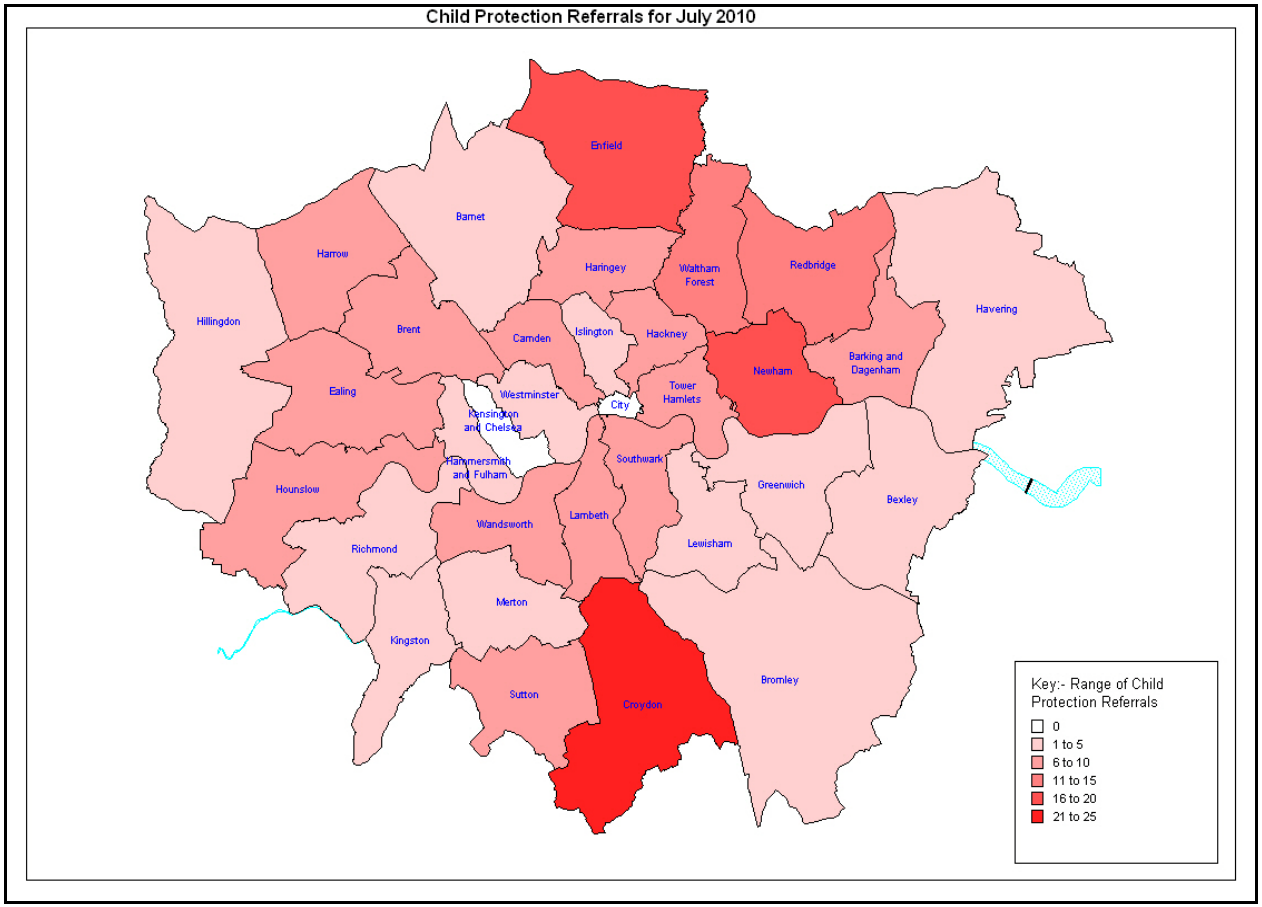


**Figure 5: Safeguarding referrals for children July 2010**



London Ambulance Service NHS
NHS Trust

# LONDON AMBULANCE SERVICE TRUST BOARD

**31st August 2010**

**PAPER FOR APPROVAL**

| | |
|---|---|
| **Document Title:** | **Integrated business plan and FT application timeline** |
| **Report Author(s):** | **Sandra Adams & Erin Heinrich** |
| **Lead Director:** | **Sandra Adams** |
| **Contact Details:** | **020 7783 2045** |
| **Why is this coming to the Trust Board?** | **Trust Board approval is required for the Integrated Business Plan and the application timeline** |
| **This paper has been previously presented to:** | ☒ Strategy Review and Planning Committee<br>☐ Senior Management Group<br>☐ Quality Committee<br>☐ Audit Committee<br>☐ Clinical Quality Safety and Effectiveness Group<br>☐ Risk Compliance and Assurance Group<br>☐ Other |
| **Recommendation for the Trust Board:** | a) To approve the draft Integrated Business Plan and the timeline for application to become an NHS foundation trust<br>b) To agree the most significant risks to this application as requested in the letter from NHS London |

**Executive Summary/key issues for the Trust Board**

The Integrated Business Plan (IBP), together with the Long Term Financial Model (LTFM), is the key document within our application to become an NHS foundation trust (FT). The Trust Board have seen previous versions of the draft and have agreed the strategic direction and service developments for the next 5 years and the full IBP is available to board members on request.

Story boards have been created to summarise the key content within the IBP and these are attached for review and comment. These form the basis of the discussion on 31st August and the Trust Board are asked to approve the draft IBP on the basis of these.

On approval of the IBP and LTFM, both will be sent to the FT support team at NHS London for formal review and feedback after which they will notify Grant Thornton, independent accountants, that we can commence historical due diligence (HDD). The timetable for this is October and provisional interview dates have been agreed with board members from 4th October. 1st stage HDD takes 3 weeks and the formal presentation to the Trust Board of the outcome from this is provisionally arranged for Thursday 21st October. The HDD process is outlined in a separate document on this agenda.

Provisional dates have also been set for interviews with NHS London's FT team as they will prepare board members for the HDD process and interviews. These are being planned for week commencing 27th September.

NHS London have written asking for formal confirmation of the Trust Board's endorsement of the current planned timeline: Secretary of State submission – 1st March 2011 and forecast FT licence date of 1st September 2011.

We are also asked to identify the most significant risks that we believe will prevent the Trust becoming an FT and the Trust Board is asked to consider this for discussion and agreement on 31st August.

**Attachments**

Story boards on the integrated business plan
Timeline on the application to become an NHS foundation trust
Letter from NHS London

**********

**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:

# LAS Foundation Trust Application - Story boards

# August Trust Board Meeting

## Story board 1 – The Trust's Vision and Strategy

### Strategy

To consolidate our position as the principle provider of emergency and urgent care in London, building on our strengths, and becoming more productive and efficient.

### Vision

To be a world class service, meeting the needs of the public and our patients, with staff who are well trained, caring, enthusiastic and proud of the job they do

### Values

**C**linical excellence

**R**espect and courtesy

**I**ntegrity

**T**eamwork

**I**nnovation & flexibility

**C**ommunication

**A**ccept responsibility

**L**eadership & direction

**Strategic and corporate objectives – how we will meet the strategic vision in the next five years**

| Strategic Goal | Key Corporate Objectives |
|---|---|
| Improve the quality of care we provide to patients - improving our delivery of safe and high quality patient care using all appropriate pathways | To improve outcomes for patients who are critically ill or injured |
| | To provide more appropriate care for patients with less serious illness and injuries |
| | To meet response time targets routinely |
| | To meet all other regulatory and performance targets |
| Deliver care with a highly skilled and representative workforce - having staff who are skilled, confident, motivated, feel valued and who work in safe environment | To develop staff so they have the skills and confidence they need to do their job |
| | To improve the diversity of the workforce |
| | To create a productive and supportive working environment where staff feel safe, valued and influential |
| Deliver value for money - being efficient and productive in delivering our commitments and to continually improve. | To use resources efficiently and effectively, and be in the top 25% of ambulance services on efficiency measures |
| | To maintain service performance during major events, both planned and unplanned, including the 2012 Games |
| | To improve engagement with key stakeholders |

## Strategic risks and mitigating actions

| Strategic Risk | Causes | Likelihood of risk occurring | Mitigating actions |
|---|---|---|---|
| **1.** There is a risk that we fail to effectively fulfil care and safety responsibilities | Insufficient clinical training and development for frontline staff; failure of infrastructure such as fleet or equipment; compromising safety in our efforts to achieve performance targets. | Unlikely | Clinical training and development strategy<br>Fleet strategy<br>New ways of working programme roll-out<br>Electronic patient record form |
| **2.** There is a risk that we cannot maintain and deliver the core service along with the performance expected | Reduced funding levels within the local health economy and a focus on 'more for less'; continued increase in demand and expectations for the service; lack of capacity within the healthcare system. | Possible | Strong cost improvement programme<br>Clinical response model<br>Partnership working within the local health economy to manage capacity and direct responses accordingly – appropriate care pathways; call handling and telephone advice |
| **3.** There is a risk that we are unable to match financial resources with priorities | Reduced funding levels within the local health economy; an over-ambitious transformation plan across London – too many priorities. | Possible | Clearly articulated strategic direction with planned developments across 3-5 years and using FT freedoms to support these<br>Strong cost improvement programme and focus on gaining efficiencies and driving up productivity<br>Implementation of the estates strategy |
| **4.** There is a risk that our strategic direction and the pace of innovation to achieve this are compromised. | Lack of certainty within the local health economy on strategic direction or the transformation programme; we are unable to clearly articulate a strategy; management focus on delivering day-to-day performance; lack of space to release staff from core duties to undertake training and development/to transform the workforce. | Unlikely | Clearly articulated strategic direction with planned developments across three to five years<br>Implementation of clinical response model |

# Story board 2 – What we do

## Profile of the London Ambulance Service

- We are the busiest free emergency ambulance service in the UK covering 625 square miles of Greater London, 32 London boroughs, six commissioning sectors incorporating 31 Primary Care Trusts.
- London has a resident population of 7.7 million which rises by approximately 800,000 commuters and visitors to the capital. During major events, and looking ahead to the 2012 Olympic and Paralympic Games, this can rise significantly beyond that figure and for extended periods.
- In 2009 we answered more than 1.48 million 999 emergency calls and responded to more than 1 million incidents.
- We employ approximately 5,000 staff, 80% of whom form the operational workforce – A&E support, advanced practitioners, community first responders, emergency medical technicians, paramedics, student paramedics and team leaders.
- Our call centre which handles more than 1.48 million calls per annum is divided into the Emergency Operations Centre (serious or life threatened calls), and the Urgent Operations Centre (dealing with patients with less serious conditions). Call handlers, clinical telephone advisors, and emergency medical dispatchers are amongst those providing these services.
- The non-operational workforce includes communications, corporate services, finance, fleet and logistics, human resources including education and development, information management and technology, medical, and operational administration and support.
- We have a fleet of 400 emergency ambulances, 200 fast response cars/units, 30 motorcycle response units and 60 cycle response units. In addition, the air ambulance (Helicopter Emergency Service - HEMS) is staffed by nine paramedics on annual secondment from the Service.

## The range of services

**Emergency and urgent healthcare access:** we answer requests for help of an emergency or urgent nature made via 999 calls and calls transferred by a dedicated computer link from the Metropolitan Police Service:

Calls are managed through software (the Medical Priority Dispatch System) operated by call handlers to allocate a determinant to the call which is then prioritised into one of the following three categories:

- Category A – life threatening which requires an 8 minute response;
- Category B – non life threatening but potentially serious which requires a 19 minute response; and
- Category C – neither serious nor life threatening requiring a 60 minute response.

**Emergency and urgent healthcare response:** frontline resources are sent to the majority of incidents but an ambulance is not sent to every 999 call:

- Category A – fast response unit backed up with an ambulance;

- Category B – ambulance, plus a fast response unit depending upon the nature of the illness or injury; and
- Category C – calls are triaged through one or more of the following: clinical review, detailed clinical assessment, clinical advice, referral to the appropriate care pathway, or resource sent. Some calls may be transferred to NHS Direct or our own clinical telephone advice team who undertake a detailed clinical assessment over the phone.

### Patient transport service (PTS) and clinical transfers

The Patient Transport Service provides pre-arranged transportation for patients to and from a hospital appointment and not requiring intensive clinical treatment or support;

Clinical transfers are provided for patients requiring additional clinical support in transit, including neonatal transfer (NTS) transporting babies from hospital to hospital on an emergency and booked (elective) basis using three specialised ambulance vehicles and trained staff; special care baby unit (SCBU) for baby ambulance transfers when NTS is not available or required, using regular ambulance vehicle and A&E operational staff; A&E long distance; inter-hospital transfers, for example from a hyper acute stroke unit (HASU) to an acute trust; and repatriation assistance.

**Specialist operational response:** the provision of emergency clinical response to incidents of a chemical, biological, radioactive and nuclear (CBRN) or other exceptionally hazardous nature, by staff with specialist training and equipment.

The Hazardous Area Response Team (HART) is a specialist team trained to provide life-saving care in hostile environments such as industrial accidents, natural disasters or terrorist incidents. The team is also capable of responding to CBRN incidents. Forty-two members of staff are HART trained and there is currently one team with a second due to be established in late 2010. Approximately 350 emergency medical technicians and paramedics have been trained in providing clinical decontamination in the event of a CBRN disaster.

The incident control and response suite is a dedicated facility for coordinating and managing responses to major incidents or emergencies within London. We also host a national coordination Centre for supporting large or prolonged incidents anywhere in the UK.

**Event management:** we plan for events ranging from the G20 Summit to the Notting Hill Carnival and the London Marathon, and are currently planning for the visit from the Pope in September 2010 and for the 2012 Olympic and Paralympic games. These require a high level of expertise in emergency planning and preparedness as well as resilience, and place additional demand upon the service.

**Public health and education:** we work with local communities, the public, and a range of agencies to provide and promote key health education messages and outcomes. These include running campaigns such as ‘Safe Drive, Stay Alive’; community education programmes such as community defibrillator training, resuscitation training and first responder training and support; health fairs to raise awareness of stroke; basic life support sessions; anti-knife and anti-gun crime events with the Metropolitan Police Service; and junior citizen programmes with local schools and colleges.

# Story board 3 – Who we are

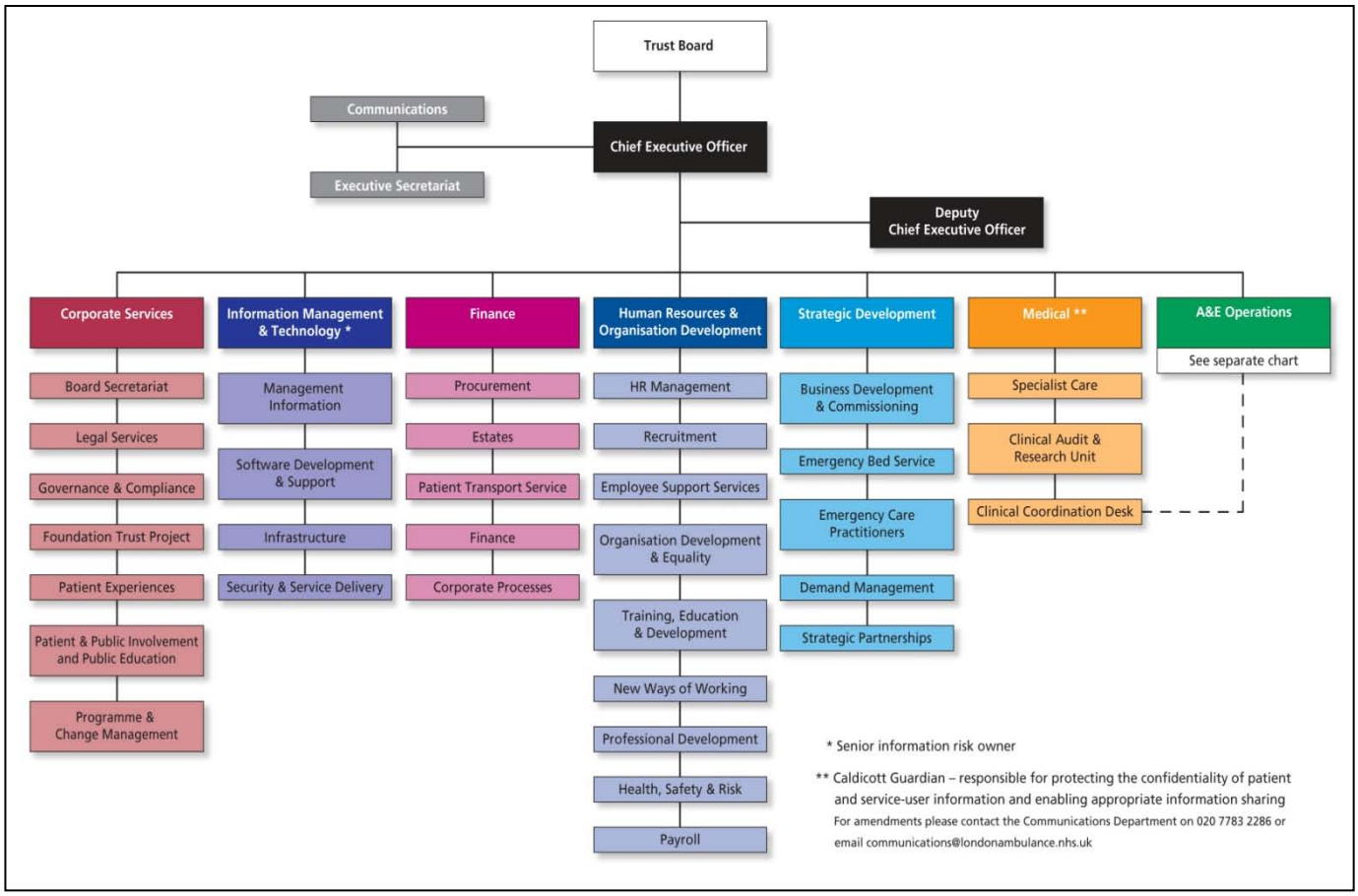
## Trust Board

Summary of board roles and responsibilities:

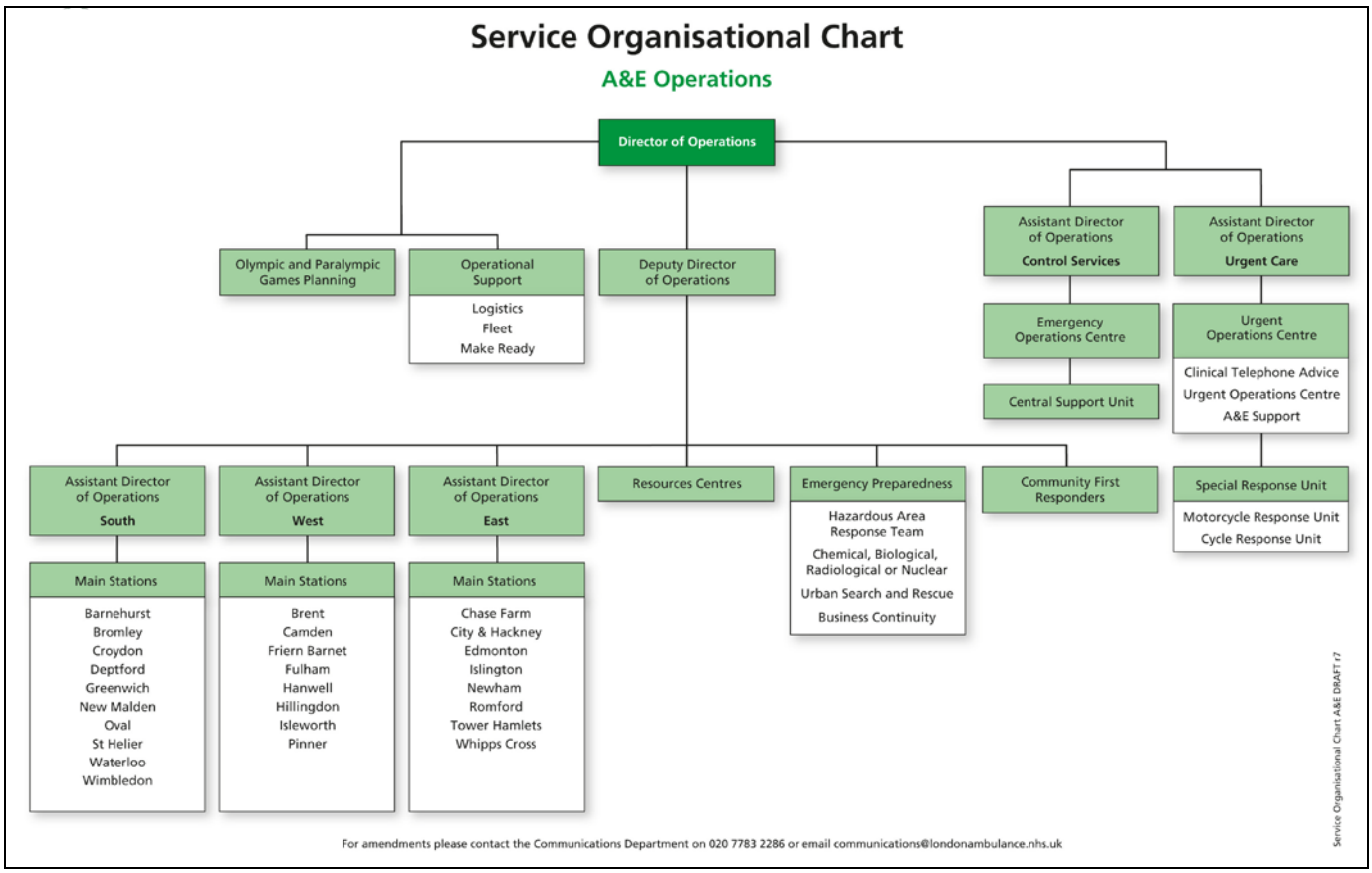
| Area of responsibility/ Strategic requirement | Non-Executive Director | Executive Director |
|---|---|---|
| | Richard Hunt CBE, Chairman | Peter Bradley CBE, Chief Executive Officer (CEO) |
| Finance | Caroline Silver, Chair of both the Audit committee and the Charitable Funds committee. | Mike Dinan, Director of Finance |
| Clinical and Service Quality | Dr Beryl Magrath MBE, Chair of the Quality committee and member of the Remuneration committee. | Dr Fionna Moore, Medical Director<br>Steve Lennox, Director of Health Promotion & Quality (registered nurse) |
| Management and Governance | Sarah Waller CBE, Vice chairman and member of the Quality and Remuneration committees.<br>Roy Griffins CB, Member of the Audit, Quality and Remuneration committees<br>Nigel Walmsley, Member of the Quality and Remuneration committees.<br>Jessica Cecil, Associate non-executive Director. Due to formally start from 1st December 2010. | Martin Flaherty OBE, Deputy Chief Executive<br>Caron Hitchen, Director of Human Resources and Organisational Development<br>Sandra Adams, Director of Corporate Services and Trust Secretary |
| Information Management & Technology | Brian Huckett, Member of the Audit and Remuneration Committees and non-executive lead for CommandPoint. | Peter Suter, Director of Information Management & Technology |
| A&E Operations | | Richard Webber, Director of Operations |
| Strategy | | Lizzy Bovill, Deputy director of strategic development |

## Management structure

- Managed by the Senior Management Group (SMG) comprising the following functional groups: A&E operations, communications, corporate services, finance, health promotion & quality, human resources & organisation development, IM&T, medical, and strategic development. The executive team is led by the Chief Executive and Deputy Chief Executive.
- Structure chart below identifies the reporting lines within each of the functions. The Health Promotion and Quality position is still to be added.



## Operational management structure



# Story board 4 – How we perform

## Operational performance

| Activity statistic | 2007/08 | 2008/09 | 2009/10 |
|---|---|---|---|
| Emergency and urgent calls received (calls) | 1,389,660 | 1,423,496 | 1,480,275 |
| Call yearly growth rate | 7.8% | 2.4% | 4.0% |
| Calls resulting in an emergency response arriving at the scene of the incident (Incidents) | 945,776 | 973,908 | 1,012,929 |
| Incident yearly growth rate | 9.3% | 3.0% | 4.0% |
| Incident to call ratio | 68:100 | 68:100 | 68:100 |
| Category A incidents | 315,744 | 319,677 | 328,616 |
| Category B incidents | 436,943 | 428,711 | 437,237 |
| Category C incidents | 193,089 | 225,520 | 247,076 |
| Category C calls initially transferred to clinical telephone advice team[1] | 47,479 | 121,464 | 139,136 |

## Commentary:

- Demand continues to grow, with both call and incident volume growing well above population growth (0.5%).
- We are providing increasing levels of advice to large numbers of 999 callers through the use of our own clinical telephone advisors and through our partnership with NHS Direct.
- Increasingly patients with critical illnesses or injuries (ie stroke, trauma and cardiac care) are being taken to specialist centres, and patients with more minor illnesses or injuries are either being treated over the telephone, treated at the scene and discharged, treated and referred to, or transported, to an alternative place of care.

[1] Note: The CTA deals with additional calls that are transferred or referred from other secondary sources, however due to the nature of these calls they are difficult to track and record.

## Target performance

| Category and time target | Target | Achieved | | | |
|---|---|---|---|---|---|
| | | 2007/8 | 2008/9 | 2009/10 | 2010/11 YTD[1] |
| Category A – 8 minutes | 75% | 79% | 75.5% | 75.5% | 76.3% |
| Category A – 19 minutes | 95% | 98% | 99.0% | 98.7% | 99.4% |
| Category B – 19 minutes | 95% | 84% | 84.5%[2] | 86.4% | 92.0% |
| Category C – 60 minutes | 90% | - | - | - | 92.3% |

## Commentary:

- We have more ambulance staff and control room staff than ever before which means patients are waiting shorter times for our help,
- Category A - our most important target is to get to those patients with an immediately life threatening condition within eight minutes, and we have achieved this for seven years in a row. This is due to significant investment by primary care trusts.
- Category B - we recognise we have to further improve our response to the biggest group of patients we attend, who don't have a life-threatening condition, but could still be seriously ill. We have seen year on year improvements in the speed of our response to these patients, and 2010/11 we will see our biggest ever improvement as all the new staff we have recruited and our new ambulances are out on the streets of London.

## Performance against response time targets compared with other ambulance trusts – 2009/10

| Statistics for 2009/10 | Target | London | South East Coast | South Central | East of England |
|---|---|---|---|---|---|
| Category A – 8 minute | 75.5% | 75.5% | 76.3% | 74.8% | 75.7% |
| Category A – 19 minute | 98.7% | 98.7% | 98.2% | 92.7% | 96.0% |
| Category B – 19 minute | 86.4% | 86.4% | 93.4% | 88.3% | 94.0% |

[1] As of 12th August 2010.
[2] In agreement with PCTs, this target was reduced to 90% for 2008/9 financial year only.

## Comparison of statistics and performance with other ambulance trusts – 2008/09

| Statistics for 2008/09 | London | South East Coast[1] | South Central[2] | East of England[3] |
|---|---|---|---|---|
| Population | 7.6 million | 4.5 million | 4.0 million | 5.6 million |
| Area | 625 sq m | 3,500 sq m | 3,554 sq m | 7,500 sq m |
| Staff | 4,500+ | 3,000+ | 2,300+ | 4,000+ |
| Number of calls | 1,480,275 | 619,222 | 494,716 | 778,099 |
| Number of incidents | 1,012,927 | 561,341 | 383,239 | 668,451 |
| Quality of services - Care Quality Commission rating | Fair | Fair | Weak | Fair |
| Financial management – Care Quality Commission rating | Excellent | Good | Good | Fair |

### Commentary:

- We handle by far the greatest number of calls and incidents, which can in part be attributed to the large population we serve;
- We resolve significantly more of our calls through telephone advice alone;
- We treat less patients on scene than other ambulance services. We will be addressing this issue through our clinical response model service development plan (see Page 16).
- We achieved the Category A eight-minute target despite facing extremely high demand levels;
- The Category B 19 minute target continues to be challenging for us and all other ambulance services across England. Demand for the emergency and urgent services continues to grow in excess of forecast, which places severe pressure on our resources and is reflected in our historical Category B 19 minute performance. We are currently achieving 92.3% on this target and are progressing towards achieving our locally agreed target of 93% for 2009/10.

In addition to these comparisons, the Trust was the only ambulance service in the whole of England to receive an 'Excellent' rating for financial management from the CQC Annual Healthcheck in 2008/09.

[1] Source: South East Coast Ambulance Service Annual Report 2008/9
[2] Source: South Central Ambulance Service Annual Report 2008/9
[3] Source: East of England Ambulance Service NHS Trust Annual Report 2008/9

## Financial performance

| Financial Performance | 2007/08 ('000) | 2008/09 ('000) | 2009/10 ('000) | 2010/11 ('000 forecast) |
|---|---|---|---|---|
| Income | £235,987 | £261,535 | £279,864 | £281,098 |
| Expenditure | £235,589 | £260,811 | £280,283 | £280,596 |
| EBITDA | £10,043 | £12,129 | £17,948 | £22,419 |
| EBITDA margin | 4.3% | 4.6% | 6.4% | 8.0% |
| Surplus/deficit for the period | - £398 | £724 | - £420 | £502 |
| Total Funds Employed | TBC | £101,800 | £112,900 | £113,900 |
| Reference Cost Index | TBC | 95 | 96 | 96 |

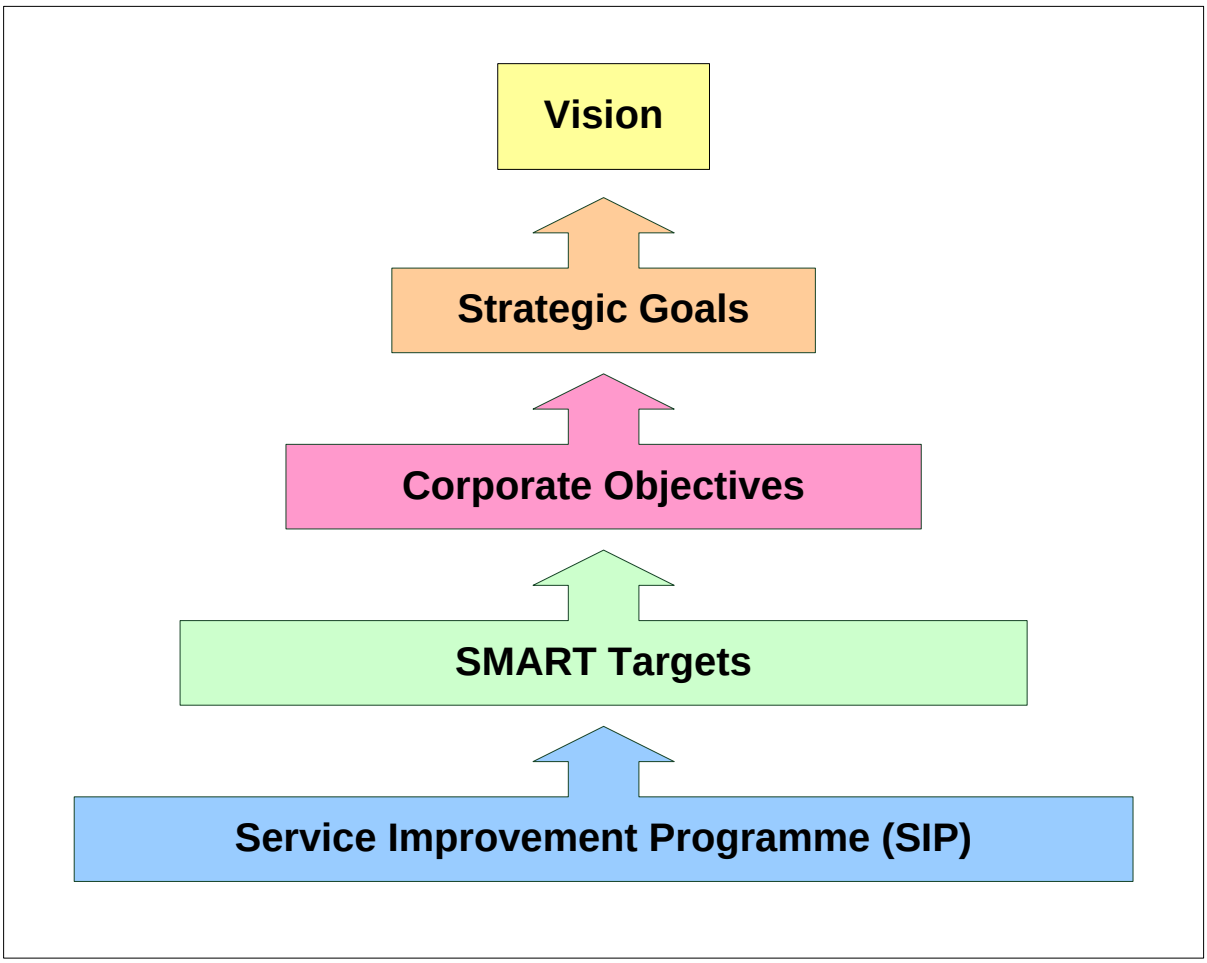
## Commentary:

- During the past three years we have dealt with increased activity ie calls and incidents.
- During the past three years income has grown by 21%. The main increase has been PCT-commissioned for emergency access and response.
- We have achieved our control and statutory surplus totals for the last seven years.
- Typically pay is 80% of the cost base and has increased in line with staff growth.
- On both a cost per head population (£28.55 in 2009/10) and on the national Reference Cost Index we cost less than the national average for ambulance services.
- For 2008/09 and 2009/10 the Audit Commission has certified us as Excellent in terms of use of resources (ALE).

# Story board 5 – Measuring success

The Trust will work towards our long-term vision by delivering the following:

1. **Service Improvement Programme:** The aim of the Trust's Service Improvement Programme is to bring about change to the Trust in terms of service, performance and culture and achieve the SMART targets.
2. **SMART Targets:** The achievement of these Specific, Measurable, Attainable, Relevant, and Time-bound targets signifies achievement of the Corporate Objectives. Some examples of SMART Targets are shown over page.
3. **Corporate Objectives:** The collective achievement of these objectives signifies achievement of the Strategic Goals.
4. **Strategic Goals:** The collective achievement of these goals signifies progress made towards the Vision.
5. **Vision.**



*** Note: Some of these targets are still in development ***

**Example: SMART targets for Corporate Objective 1**
**-To improve outcomes for patients who are critically ill or injured**

| Targets and measures | Directorate Responsible | Baseline | Target for 2010/11 | Target for 2012/13 | Target for 2014/15 |
|---|---|---|---|---|---|
| % patients with presumed cardiac aetiology who have a return of spontaneous circulation sustained to hospital | Medical | 23% | 24% | 25% | 26% |
| % Survival of cardiac arrest patients to hospital discharge[1] | Medical | 15.20% | >15% | >15% | >15% |
| % of STEMI[2] patients taken to specialist cardiac centres | Medical | 86% | 86% | TBC | TBC |
| % of appropriate patients taken to specialist stroke centres | Medical | 85% | >85% | >85% | >85% |
| % of appropriate patients taken to major trauma centres | Medical | Not available | 60% | 70% | 75% |
| Number of defibrillators in public places | Operations | 517 | 570 | TBC | TBC |
| Number of people trained by the Trust under the community responder scheme | Operations | 400 | 500 | 600 | 700 |
| Number of people trained to use defibrillators | Operations | 6,017 | 6,500 | TBC | TBC |

**Example: SMART target for Corporate Objective 2**
**- To provide more appropriate care for patients with less serious illnesses and injuries**

| Measure | Directorate Responsible | Baseline | Target for 2010/11 | Target for 2012/13 | Target for 2014/15 |
|---|---|---|---|---|---|
| % conveyance to Emergency Department | Medical, HR, Strategic Devpt. | 75% | 75% | 60% | 55% |

[1] Using Utstein guidelines.
[2] STEMI is an acronym meaning "ST segment elevation myocardial infarction," which is a type of heart attack.

# Story board 6 – Becoming an NHS foundation trust

## Why we want to become an NHS foundation trust (benefits)

This underpins our strategy for the next five years and it is fundamental to our achievement of our strategy and vision through stronger governance arrangements and partnership working, freedom to invest and innovate. This is supported further by the White Paper, Equity & excellence – Liberating the NHS, which proposes a framework within which we can reinvest any surplus and proceeds in the organisation and our services.

Becoming an NHS Foundation Trust (FT) is fundamental to achieving our vision and strategic goals and will lead to:

- Stronger governance arrangements: through more direct and relevant engagement with patients, the public, our staff, sharing a better understanding of the opportunities and challenges in meeting London's present and future health needs;
- Greater freedom to invest and innovate in services for the benefit of patients, the public and our staff, thereby maintaining the highest standards of modern and forward-thinking urgent and emergency healthcare;
- Greater freedom and flexibility to work in partnership across London's NHS healthcare system to plan, develop, improve and enhance high quality healthcare for the London community;
- Greater opportunities for longer term planning through clarity of vision and strategy, realised through working closely with partners such as GP consortia and the National Commissioning Board; and
- Recognition as an excellent organisation which has undergone the rigorous strategic and financial assessment process to become a NHS FT.

## What will be different?

- Engaging local people in the development of our strategic direction and how this will affect them will be the key to our future success as a NHS foundation trust;
- Working with the Council of Governors will add another dimension to the way the Board of Directors considers and determines the strategic direction;
    - The role of the governor is to support, challenge and hold to account the Board of Directors and to be the link between members and Board of Directors, and ensuring the Trust is accountable to local people;
- Being able to recruit and appoint our non-executive board members in conjunction with the governors.

## Cultural change

Becoming a NHS foundation trust FT will support our seven CRITICAL cultural values::

- **Clinical excellence** – greater freedom and flexibility to work in partnership across London's healthcare system, trying new and innovative ways of developing care pathways or different types of response.
- **Respect and courtesy** – we will value the diversity of our public members, staff members and governors and will treat all equally. We will actively recruit a diverse membership to reflect London's diverse population and we will respect and listen to incorporate their thoughts and values.
- **Integrity** – we will be more open about our decision-making and performance, publishing quarterly reports for review by Monitor, our members and the public. This openness will also be visible internally in communications with patients and staff.
- **Teamwork** – we will promote teamwork with the inclusion of public members, staff and stakeholders in our Council of Governors. We will offer support, guidance and encouragement to Governors so their views are heard and acted on.
- **Innovation and flexibility** – the ability to retain and reinvest surpluses means we will be able to better target our resources and to invest and innovate in services that will benefit our patients. Improvements will be introduced more effectively and quickly than is currently possible.
- **Communication** – our membership and Council of Governors will provide more direct and relevant involvement from patients, the public, our staff and stakeholders. Our constituency arrangements will allow for more locally focussed discussions with a wider range of stakeholders and we will gain a much clearer picture of the health issues and how we can play a part in managing those.
- **Accept responsibility** – we will be more accountable for our own decisions and actions and will regularly report on these to Monitor, our members and the public.
- **Leadership and direction** – we will have greater flexibility and responsibility to provide our own leadership and follow our own direction. Patients, the public and staff will have a greater involvement in leadership by being members and/or governors.

## The Council of Governors

- Thirteen public governors elected by the membership of seven constituencies:
    - Six constituencies are mapped to the current commissioning sectors in London;
    - One constituency for Outside London, mapped to the three Strategic Health Authority areas which surround London;
- Three staff governors elected by two classes of staff membership: front line (2 governors) and support (1 governor);
- Eight appointed partner governors representing voluntary agencies (5), local authority (1), primary care trust (1) and the staff council on behalf of the trade unions (1);
- The Trust Chairman will chair the Council of Governors and the vice-chair of the Council will be nominated by the elected governors.

# Story board 7 – how we plan to achieve our strategy

We have identified nine key service development plans that underpin our strategy for the next five years.

## 1. CommandPoint

The current computer aided dispatch system, which handles 999 calls and sends resources to patients, will be replaced in the summer of 2011 by the CommandPoint system.
The scope of the implementation project includes the core system software and hardware and interfaces with existing systems, applications or services. The project includes design, development, testing, training and the actual transition from the old to new system. Once successful transition has been achieved and the implementation project closed there will be a series of initiatives to build upon this new, stable foundation. These will look to develop new business benefits from improved functionality and benefit from developments led by other emergency services that use CommandPoint.

**Benefits:**

- Improved service delivery.
- Improved staff welfare.
- Capacity to accommodate increased service demand.
- Achieve performance targets.
- Reduced corporate risk.

**Timescale:** Short-term: Completion of implementation scheduled for during 2011.

**Costing:** Fully resourced and funded within our budget, includes all technical training staff, premises and equipment. The approved full business case cost (capital and revenue) is £25.5 million.

**Resourcing:** A core team of 10 staff, increasing to 20 as the project moves toward full transition.

**Key Risks:**

- The nature of a software development project, which is more risky than purchasing a totally bespoke application.
- The actual transition of switching from old to new system, risk of potential failure and service degradation.
- The degradation in service that will be anticipated in the first 60 days following transition.

**Mitigation:** The Project is run using the PRINCE 2 project management method. This includes a risk register that is pro-actively managed by the Project Manager and regularly reviewed by the Project Executive and Project Board. The project is also subject to the NHS Gateway review process, the reports from which the Project Executive also shares with the Trust Board.

## 2. Clinical response model

Once this service development plan is implemented, the vast majority of 999 calls will be attended by an appropriately-trained paramedic arriving by car. With additional assessment and decision making skills, paramedics will be the initial response to most emergency calls (there will be some determinants that will still require an immediate response of a car and an ambulance). The solo clinician will assess the patient's needs and select the most appropriate treatment option for the best outcome for the patient. The options may include:

- requesting conveyance to an A&E Department;
- conveying the patient to an appropriate care pathway eg minor injuries unit;
- referring the patient to an appropriate care pathway, for example, their GP;
- advising on self-care (eg nearest pharmacist or rest); or
- treating on scene.

The paramedic will also decide on the best method of transportation, if required, and the appropriate timescale for transportation. This could include an ambulance response or an A&E support vehicle, or they may opt to transport the patient themselves by car. The overall aim will be to treat patients closer to home and target our frontline ambulance fleet to those patients who truly need it.

**Benefits:**

- More appropriate care for patients.
- Improved patient experience.
- Higher skilled workforce.
- Improved staff satisfaction.
- Increased use of alternative care pathways
- Reduced attendance at A&E with associated system cost savings.
- Significantly reduced multiple dispatches with associated improvements in efficiency from better use of existing resources.

**Timescale:** Short-term - the pilot phase is planned to run for three months from September 2010 with rollout in 2011/12.

**Costing:** Not expected to cost any more than the current model, however this needs to be assessed after three-month pilot.

**Resourcing:** Paramedics will receive additional training in enhanced assessment skills and use of alternative care pathways.

**Key Risks:**

- Dependant on the outcome of the pilot, affordability is a potential key risk;
- Implementation of CommandPoint may interfere with timescales for rollout.

**Mitigation:** The pilot will be planned to minimise clinical risk to patients and any arising risks will be identified and managed appropriately as part of ongoing evaluation throughout the pilot. A project is underway to understand the interdependencies and risks within the control room in order to ensure the risk involving CommandPoint are identified and where possible mitigating activity is implemented.

## 3. Clinical transfers

Reconfiguration of healthcare services has resulted in increasing numbers of patients needing onward transportation to tertiary units for specialist intervention and treatment. Based on clinical need there are different transport options currently available which may include:

- Self transfer;
- Transfer by patient transport service provider for hospital (non-clinical);
- Transfer by critical care team (neonatal and children's transfer services); and
- Critical and immediate transfers by LAS.

Where patients do not meet the criteria for a critical or immediate transfer they are referred back to the hospital's patient transport service provider, which can pose a clinical risk. A large number of these journeys do not require medical intervention, however they do require transfer by personnel who are trained beyond a first aid level (ie the current level of our Patient Transport Service staff).

This service development involves us investigating providing a pan-London service to these patients, transferring them in either an A&E support vehicle or a blue-light patient transport service vehicle.

**Benefits:**

- More appropriate care for clinical patients on transfer.
- Appropriate resource use of LAS and acute trust staff.
- Improved patient experience.
- Timely transfers resulting in better patient outcomes.
- Reduction in inappropriate transfers by frontline crews
- Better use of existing resources
- Improvement in Category A performance.

**Timescale:** Short to medium-term: currently in scoping stage, which will include market assessment.

**Costing:** Dependent on demand for service, to be determine in scoping Stage. Anticipate costs would be met by commissioners.

**Resourcing:**

- Decreased use of A&E frontline staff and hospital staff.
- Increased use of A&E support and our Patient Transport Service.
- Increased control (clinical) input.

**Key Risks:**

- Capacity to meet demand.
- Competition from other providers.

**Mitigation:** Currently undertaking scoping stage, involving activity and demand profiling and market analysis to understand what competitors currently provide and how our proposed service would compare.

## 4. Control Rooms

There is currently a single control room at Waterloo, which handles 999 calls, with a cold standby at Bow. In the event of evacuating Waterloo there would be a time delay to achieve the switchover to Bow. Recent disaster recovery scenario testing has assisted in reducing this risk. However at best (ie during the normal working day when all required resources are on duty in London), it would take a number of hours to bring Bow fully on line.

The two data centres (one co-located with each control room) are already full. A third data centre is outsourced and is currently being used to provide additional capacity. Both Waterloo and Bow are at capacity with regards to electrical power and physical space and will be unable to cope with the estimated 20% rise in demand over future years. Bow and Waterloo are also both within the Thames flood plain.

This service development involves replacing the existing single control room at Waterloo with two fit-for-purpose live running control rooms and associated data centres.

**Benefits:**

- Ability to maintain 999 call taking and despatch pan-London in the event of losing one of the control rooms
- Two fit-for-purpose control rooms and associated data centres.

**Timescale:** Three years from point of securing funding.

**Costing:** Indicative costs of £46 million.

**Resourcing:** The following dedicated resources will be required: Project Manager; Deputy Project Manager; Project Support Officer; one LAS operational staff member (drawn from Control Services or Sector); Configuration Librarian; Estates Project Manager; IM&T Project Manager; Project Accountant; HR Specialist; Communications Specialist.

**Key Risks:** Ability to secure additional funding for the project.

**Mitigation:**

- A sequence of exercises have been undertaken to test the existing arrangements, In October there will be full scale test switching all services overnight to Bow.
- The strategic outline business case will be reviewed in October 2010 (once the Government spending review has been announced and the business case for the electronic patient report form has been completed). Decisions can then be taken in relation to the overall affordability of the project.
- Work is being undertaken to consider better utilisation of existing facilities between Waterloo and Bow.

## 5. Coordinating healthcare in London

We want to coordinate healthcare capacity and refer patients to appropriate centres of care through:

- one pan-London phone number for urgent care (possibly 3-digit number - 111);
- a pan-London triage system (possibly NHS Pathways product) ;
- a pan-London referral system, incorporating a capacity management system (CMS) and a directory of services; and
- the provision of emergency and urgent care single point of access services as a way to improve services for patients ensuring fast, efficient and safe streaming and triage of patients to the most appropriate service.

**Benefits:**

- Improved public access to urgent healthcare services.
- Increased efficiency within the NHS as patients are able to quickly and easily access the healthcare services they need.
- Increased public satisfaction and confidence in the NHS.
- The provision of detailed data to support commissioning of more effective and productive healthcare services that are tuned to meet peoples' needs.
- Reduced duplication of service provision across multiple providers.
- Reduction in non-emergency calls to 999 leading to increased efficiency of the 999 emergency ambulance service.
- Increased number of calls closed on phone or by referral, therefore reduced vehicle sends and conveyance.

**Timescale:** Short-term, November 2010 – December 2012

**Costing:** To be quantified - costs of salaries for 111 call handlers and management plus estates to house them. Anticipate costs to met by commissioners.

**Resourcing:** Additional call taking staff would be required to answer 111 calls, plus staff to coordinate and act on information being received through CMS.

**Key Risks:**

- LAS is not the provider of the 111 service.
- Providers do not use the capacity management system to update capacity information.
- Information on the directory of services is not kept up to date and information becomes inaccurate.
- No demand reduction in 999 calls after 111 is introduced.
- Clinical risk to patients who call urgent care number inappropriately.

**Mitigation:** Discussions are underway with NHS London and commissioners. This project is run using the PRINCE 2 project management method, which includes a risk register that is pro-actively managed by the Project Manager and regularly reviewed by the Project Executive and Project Board.

## 6. Electronic Patient Record Form (ePRF)

The ePRF can capture a complete and accurate set of personal, operational and clinical data for each patient encounter and transmit it in real time for immediate access both within the Service and by outside agencies, such as receiving A&E departments and other appropriate care pathways.

Details of the call automatically populates the ePRF 'tablet' (hand portable PC device) and where patient details are known, appropriate medical information is downloaded from the Spine. Mandatory fields ensure 100% data compliance. If the patient is to be transported, then all recorded details are downloaded to the receiving centre (hospital or urgent care centre of some type), estimated time of arrival is automatically calculated, hence reception staff know what to expect and when. The ePRF tablet also acts as information centre for the ambulance staff. It has access to various clinical guidelines and provides basic translation software for deaf people and commonly used languages.

**Benefits**

- Improved clinical outcomes for patients.
- An overall reduction in clinical risk.
- Improvements in service delivery.
- Increased opportunities to review data and performance in a timely manner, to feed back to staff.

**Timescale:** Long-term **-** To be developed and implemented over a 2 to 3 year period, however will not be commenced until after 2012 Games wrap-up.

**Costing:** The ePRF will require approximately £10-12 million over 2-3 years to develop and implementation.

**Resourcing:** A project team composed of: Project Management; Project Support; Communications Lead; IM&T Lead; Technical Support; Fleet QA; Business Change; Trainers; and Finance Support .

**Key Risks:**

- Resistance from A&E departments and appropriate care pathways to accept ePRFs.
- Funding being solely provided by the Service.
- Funding be de-prioritised and redistributed to frontline services.

**Mitigation:** Risks will be closely managed by the Project Board, which reports to Senior Managers Group on a monthly basis. Close and early engagement with acute trusts, appropriate care pathways and the GP community.

## 7. Emergency Planning for London

NHS London Emergency Preparedness (NHS LEP) coordinates emergency preparedness across all of London's acute, mental health and primary care trusts. We will investigate hosting NHS LEP, once NHS London is disestablished.

As we are the only pan-London trust, we are in a unique position to provide this vital service. We are also the emergency arm of health across the capital. As we have worked closely with the NHS LEP since its inception, it makes sense for this partnership to continue and for us to host this function.

**Benefits:**

- More consistent approach to emergency preparedness and closer links across London.
- Emergency planning, preparedness and response strengthened.
- Strengthen ties with wider NHS.
- Reputation and brand strengthened.
- Financial benefits for NHS by hosting within LAS - efficiencies of scale.
- Being able to share roles.

**Timescale:** Short-term: dependant on restructure of SHA (currently to be disbanded by April 2012), and where divisions/units are relocated

**Costing:** Salaries, infrastructure, ancillaries (exercises). Expect to recoup costs from DH/PCTs plus management costs. NHS in London would make economies of scale.

**Resourcing:** Acquire existing team

**Key Risks:**

- Reputational risk if we are unable to follow through with hosting requirements
- Reputational risk if something adverse happens and Emergency Preparedness is questioned
- If NHS LEP moves to an unrelated body, it could damage planning and response across London

**Mitigation:** Proposal to be scoped and discussions to begin with NHS London as soon as possible. The next stage would be to develop a transition plan and implement robust performance indicators on both sides.

## 8. Emergency Preparedness and Specialist Training

We will investigate building on our skills and experience in emergency planning and major incident response by scoping our potential to:

- consult with public and private organisations in relation to business contingency, event and emergency planning;
- host emergency preparedness conferences;
- deliver paramedic and emergency driving training; and
- deliver CBRN awareness training and training in use of specialist equipment.

**Benefits:**

- Reputation, in-house control over clinical training of paramedics.
- Better stakeholder relations.
- Provide staff a more diverse set of skill opportunities.
- Strengthens our brand in the public and healthcare eye.
- Income generation.

**Timescale:** Medium-term:

- Scoping and market testing phase – complete by March 2011;
- Strategic business plan development – complete by mid 2011/12;
- Implementation of plan – from mid 2011/12 onwards.

**Costing:** Cost of additional resources during scoping stage. Further costs would be determined during this stage.

**Resourcing:** Additional resources will be required during scoping stage: three to four people for three months. Further resource implications would be determined during this stage.

**Key Risks:**

- Damage to reputation if not successful.
- Demand outstretch resources.
- Loss of initial investment if scoping stage determines no options are viable.

**Mitigation:** High quality scoping and market testing prior to development of full business case.

## 9. London 2012 Olympic and Paralympic Games (2012 Games)

During the 2012 Games we will:

- deliver an appropriate level of care for all local communities and Olympic and Paralympic related patient populations including athletes, Olympic family, spectators, media and venue workforce prior to and during ; and
- be an active partner in the planning and delivery of a safe and secure 2012 Games.

This will be achieved by:

- addressing capacity issues during the planning phases and ensuring optimal use of health resources to deliver excellent patient care; and
- working in partnership with other stakeholders involved in the planning for the safe and secure 2012 Games and taking an active role in the exercising and testing of plans in a multi-agency environment.

**Timescale:** Medium-term, with five stages: Foundation (Nov 2007 – Aug 2008); Operational Planning and Readiness (Sept 2008 – Dec 2010); Testing, Exercises and Operational Implementation (Dec 2010 – June 2012) and Games-time and Knowledge Transfer (June 2012 – March 2013).

**Costing:** The current identified costs for 2011/12 and 2012/13 equate to £18.5 million. These costs are currently under consideration as part of the Comprehensive Spending Review and a decision is expected in November 2010.

**Resourcing:** The current envisaged resource implications are 419 whole time equivalents for cover against the Olympic competition schedule (excluding command and control, some aspect of the dedicated athlete ambulance provision and the Games-effect) and approximately 70 additional ambulances at the peak of activity. The workforce requirement will be met using LAS and pre-planned aid staff.

**Key Risks:**

- Failure to develop sufficiently strong relationships with external partners.
- Inadequate organisational resource/commitment for programme's full implementation.
- Underestimation of timescales when planning.
- Reliance on resource input from other ambulance trusts nationally.
- Insufficient funding provided to permit the required planning and operation.
- Inability to maintain core business/meet performance targets during Games time.

**Mitigation of risks:** The Project is run using the PRINCE 2 project management method. This includes a risk register that is pro-actively managed by the Project Manager and regularly reviewed by the Project Executive and Project Board.

## 10. Estate changes

Current state of estates:

- 50% of estate is greater than 50 years old
- Estate has been developed incrementally, not strategically
- Current single Control Room is on floodplain

This service development involves actioning the Estates Strategy, which moves to:

- Less but larger stations
    - No prescriptive number for London (greater than 15, less than 70)
    - Estimates per new station: 220 staff; 40 vehicles; building 700m$^2$; site 0.8 hectare
    - Facilities to include: crew rooms; toilets/shower/locker rooms; management offices; meeting rooms; training/computer room; Make Ready; room for expansion; sufficient parking; energy efficient.
- Two independent but linked control rooms
    - Each control room capable of meeting 100% demand
    - Incorporating event control rooms
- Reduce number of workshops
- Hazardous response team – two facilities east and west
- HQ – consolidate existing annexes and align with plan for Control

**Benefits:**

- Aligned with our Strategic Plan.
- Supports clinical response model - increased single responding.
- Supports New Ways of Working, including team-based working, local training.
- Supports workforce development.
- Reduces need for ad hoc, incremental capital spend.
- Improved operating resilience; improve quality of estate facilities.

**Timescale:** Five to 10yrs.

**Costing:** within existing financial envelope.

**Resourcing:** within existing financial envelope.

**Key Risks:** execution to plan and timetable.

**Mitigation:** A well defined project planning environment.

# Story board 8 – Our enabling strategies

- **Human Resources,**
- **IM&T,**
- **Membership,**
- **Estates** (already described in service development plan).

## 1. Human Resources Strategy – 2008/9 to 2012/13

Whilst some of the external context and drivers have changed since its first publication, the direction of travel and associated activity expressed in the strategy remain the same. This reflects the consistent aspiration to provide more appropriate care to patients in London making most appropriate and efficient use of the wider healthcare provision in the capital.

Strategic aims of HR Strategy are to:

- Provide an overall workforce skill mix which meets the need to respond appropriately to the diverse population of London. In addition to our core frontline staff, this will include having the right skills within non-operational roles to appropriately support the provision of excellent patient care.
- Develop a flexible workforce and organisation which is responsive to the changing needs of the service and future developments in healthcare.
- Become an employer of choice.
- Provide a model career framework.
- Develop leadership capacity and capability for the future development of the Service.
- Support our Service Improvement Programme through excellence in Human Resource Management and the Organisation Development and People Programme.

These strategic aims will lead to us being recognised and respected as a fully integrated and vital partner in the wider NHS in London.

Most importantly, our patients will experience a high class delivery of healthcare, in particular (and in line with key national objectives) we will:

- achieve better survival rates for patients who are seriously ill or injured;
- resolve more patients' needs without them having to leave home;
- take patients to the most appropriate place for treatment, which may not be an A&E Department;
- achieve better patient satisfaction;
- achieve high levels of staff satisfaction;
- achieve organisational improvement, including being more efficient and effective in what we do and how we use our resources.

The detail contained within the projects and actions supporting the achievement of the strategy remain dynamic in order to respond to the changing environment. These are

managed through project/programme management methodology with robust governance arrangements contained within the overall Service Improvement Programme.

### Workforce Transformation – growth and re-profiling

| A&E Staff | 2007/8 | 2010/11 | 2015/16 |
|---|---|---|---|
| Team Leader | 156 | 187 | ↑ 232 |
| Paramedic Practitioner | 0 | 30 | ↑ 156 |
| Emergency Care Practitioner | 52 | 74 | ↓ 0 |
| Paramedic | 807 | 1,042 | ↑ 2,406 |
| Student Paramedic | 0 | 743 | ↓ 0 |
| Emergency Medical Technician | 1,507 | 918 | ↓ 259 |
| A&E Support | 47 | 328 | → 354 |
| Clinical Telephone Advisor | 37 | 50 | ↑ 100 |
| **TOTAL** | **2,606** | **3,372** | **3,507** |

### Workforce Transformation – redesign

- Clinical response model
- New Ways of Working (NWoW)
    - Team-based working
    - Locally delivered training and professional development
    - Strengthened clinical leadership through clinical tutors and team leaders
- Move to higher education model
- Finalise clinical career ladder
    - A&E support through to paramedic consultant/practitioner

### Improving productivity and efficiency by:

- Reducing double dispatch.
- Improving sole responder utilisation.
- Improving “hear and treat” and “see and treat” numbers.
- Reducing fleet size over time.
- Absorbing more calls without workforce growth.
- Reducing management costs to nationally benchmarked average.

## 2. IM&T Strategy 2008/09 – 2012/13

### Objectives:

- To set the blueprint for how IM&T will deliver and support the Service over the next five years.
- It is focused to ensure that it supports people and clinical issues, not just IM&T.
- The IM&T Strategy is one of the enablers to support the delivery of the IBP.

### Deliverables:

- The **CommandPoint** project will deliver a new, fully integrated computer-aided dispatch system (CAD),
    - Reliability will improve to 99.9%+ and new functionality will be released twice a year through upgrades
- We will move to **two control rooms**, each with 100% spare capacity for resilience.
- **Airwave** will be fully implemented, with every crew member carrying a digital radio that provides point to point communication for crew members, direct access to the control room and a panic button in case of emergencies.
- **Electronic Patient Record Forms** will be installed in all response vehicles and connect live to the control room and receiving facilities (eg A&E departments and appropriate care pathways).
- All data will be input once, as close to the original collection point as possible, normally via a web browser. Once entered, data will then re-used by a defined suite of systems, thus removing the need for duplicate data entry.
- 'Hot desking' will be common place, with staff having a transportable telephone number and are able to log onto their user accounts and files from any LAS PC.
- All managers who have a justified business requirement will have a laptop computer (or similar device) equipped will full remote access, allowing 24/7 access.
- All staff will have access to basic e-mail (known as web mail) from any internet terminal – essentially giving free access to Trust e-mail from home computers or internet cafés.
- A new suite of services will be made available for people who do not speak English and/or who cannot use the telephone as an able bodied person would. This includes direct internet services and text messaging via translator services that then interact with the control room.
- There will be a single repository for all staff data, the national Electronic Staff Record system, that includes records of personal issue equipment:
    - Application forms will all be electronic and from moment of initial enquiry, the entire employee process is automated.
    - Self service will be fully implemented allowing staff to self-manage certain personal attributes (e.g. Bank details, address, telephone extension).

- Management Information will provided by a suite of reporting tools that reside on all desktop and remote access computers.
    - There are different levels of tools and staff are able to generate reports as and when they require them, according to their access rights.
    - The central Management Department provides expert analysis for the most complex queries, reports on overall trends, provides predictions, continually develops the tools and acts as guardian of data standards.
- There will be a 24/7 IM&T Support desk that acts as a single focal point for ALL IM&T support.
    - Utilising interactive tools, support technicians will be able to remotely access the faulty equipment or service.
    - 70% of the calls will receive a 'fix' at the point of the call being received.
    - Increasingly customers will use 'self service'.
- Staff training and education will evolve:
    - All employees will be required to have a basic level of IM&T literacy, irrespective of their role (e.g. e-mail, basic word processing).
    - Many training modules will be delivered by web-based e-learning packages, including many clinical modules.

**Approach:**

In order to deliver the vision defined above, the actual strategy is delivered in a number of discrete sections, each covering a specific aspect of IM&T.

- There will be a clear focus on IM&T customer service and delivery.
- Compliance to ensure effective Information Governance and Security is rightly mandated.
    - eg any data stored on a PC in a non-secure area or on a portable device such as a laptop, PDA or mobile phone will be encrypted.
- Much work will be undertaken in the early years of this strategy to enhance the underlying technical infrastructure.
    - IPT Telephony Voice/data/video will be the cornerstone, where voice information is managed in the same way as traditional data traffic.
- In terms of new software provision, the starting point will be to gather initial requirements and undertake a feasibility study.
    - Solutions will be delivered through amending an existing system, implementing a third party product, interfacing or by in-house developments, using web technologies where appropriate.
    - There will also be a drive towards working collaboratively with the wider emergency services family to produce joined-up solutions.

## 3. Membership Strategy

Becoming a Foundation Trust will enable patients, members of the public and staff to have an opportunity for increased involvement in our development and delivery of emergency services. For our patients and the population of London this involvement will build on our existing patient and public involvement and public education strategies and established relationships with community groups.

This document describes our strategy to attract, engage, retain and develop a significant representative and diverse membership for London Ambulance Service NHS Foundation Trust. As a public benefit organisation we believe that membership will enable us to deliver health care services more effectively for our patients and the community of London.

**Our membership objectives are:**

- To achieve a membership consisting of the range of diverse communities of London's population and workforce.
- To focus on the development of our membership base and member-relations activities in order to achieve a representative membership for our maiden year as an FT i.e. 2011/12.
- To have a Governing Council reflecting a quality membership.
- To maintain our compliance with our constitution as a foundation trust. This will be achieved by a range of initiatives which will include inputs from our Communications and Governance teams.
- To build our Patient and Public Involvement Strategy and our Public Engagement Strategy so that our members feel involved, engaged and real partners in our future as a public benefit corporation.
- To maintain a membership services function that achieves full compliance with regulatory requirements, including a well-managed membership database and progressive mechanisms to support membership development.

Our membership will be built on a framework that will consist of the following:

- Membership will be open to anyone aged 16 or above.
- A public constituency comprising of seven groups based on London health sectors and its surrounding SHA boundaries.
- A staff constituency comprising two classes: frontline and support.
- A Council of Governors consisting of governors elected by our members or appointed by local and partner organisations, such as local authorities and primary care trusts.
- An accurate and informative members register, managed by an external supplier which will be held on a secure and confidential database, which will be managed in accordance with the Data Protection Act 1998.

Members will be able to:

- become actively involved in our work and help shape our future plans;
- get a better understanding about what we do, and help promote our work;
- be consulted on any major changes that we are proposing to our services;

- receive regular information about what we are doing;
- attend open days, seminars and events;
- take part in focus groups and surveys;
- elect governors to represent your views on our Council of Governors; and
- stand for election as a governor.

We need to ensure that our membership numbers are manageable, can be resourced appropriately, and most importantly, reflect the diverse communities we serve. We aim to have a public membership of 6,000 by March 2011.

## Council of Governors

The Council of Governors will have a key role in supporting, leading and developing our membership. The effectiveness of the Council of Governors will be measured against how it can execute its role and responsibilities which are:

- Advisory: advising the Board or Directors on the strategic approach of the Service
- Guardianship: to act as guardian of the Service on behalf of the local communities that constitutes the population of London.

To enable the Council of Governors to be effective in their role, we will provide induction, training and development.

The Council will meet five times a year including the Annual General Meeting.

## Plans for future membership recruitment

An annual membership recruitment plan is being developed and is designed to deliver the target figures for member recruitment.

## Evaluating success

Although the Membership Strategy is initially put forward by the Trust, the Council of Governors is the most appropriate body to take on the role of developing, monitoring and evaluating it. The Council will need to hold under continuous review the Membership Strategy so that it remains meaningful, accessible and relevant to all of our diverse membership community.

The Council of Governors will evaluate the strategy annually and report on it at its annual meeting with the Board of Directors.

NHS London

Southside
105 Victoria Street
London SW1E 6QT

www.london.nhs.uk

Peter Bradley
Chief Executive
London Ambulance Service NHS Trust
220 Waterloo Road
London, SE1 8SD

5 August 2010

Dear Peter

**Commitment to deliver Foundation Trust Pipeline Trajectory**

I am writing to you in respect of the recent release of the White Paper ('Equity and excellence: Liberating the NHS') and the statement within outlining that 'all NHS trusts become, or are part of, Foundation Trusts by 2013/14'.

A firm commitment has been given by NHSL to this as a top priority, as I am sure it has been within your own organisation. We now need to tighten the management of agreed FT timeline trajectories. At this point in time our record of your planned trajectory is as follows:

| Organisation | Secretary of State submission date | Forecast FT licence date |
|---|---|---|
| *London Ambulance Service* | *1st March 2011* | *1st Sept 2011* |

Note. The above timelines have either been submitted by your organisation (and subsequently reviewed by NHSL ) or have been determined by NHS London (based on its 30th June NHSL submission to DH).

Each SHA is asked on a quarterly basis by DH to confirm their respective trajectories for organisations to achieve this objective, and in the future each SHA will be more tightly performance managed in this delivery. With that in mind I am requesting you to confirm your Board's endorsement of the current planned trajectory or if the above trajectory is not now appropriate you need to agree with your Board (and Sector Chief Executive) a revised trajectory and provide detail of why it has now changed. I will require your clear commitment to the delivery of the agreed trajectory which will be performance managed in line with the quarterly return to the DH.

Further strategic planning guidance will be issued shortly, however in the meantime it will be necessary for NHSL to understand the most significant risks (max 3) that you believe will prevent your organisation from becoming a FT, or part of a Foundation Trust (FT). Risks may include issues such as insufficient commissioning support/unclear commissioning intentions, leadership/Board issues, PFI costs and difficulties in delivering of productivity improvements (CIPs etc). Your formal response to these requests is required by no later than 17 September 2010 to be consistent with the next quarterly return. In addition to writing

to yourself I will also be writing formally to your respective Sector Chief Executive and would like your response to be agreed with the Sector Chief Executive before it is sent.

Once this information is received a review will be undertaken of how these risks may be addressed or mitigated sufficiently to allow progress to be made and what the 'picture' of the provider landscape may look like in the future. This will enable NHSL in conjunction with the Sector and your organisation to support your Trust to articulate a solution(s) across London and ensure that by the due date (2013/14) your organisation is a FT or part of an FT.

May I also take this opportunity to alert you to the recent changes relating to quality governance in the "Guide for Applicants". As expected from the recent Monitor consultation this will feature significantly throughout the assessment process and therefore, I recommend that you become familiar with these changes.

If in the mean time if you have any further questions concerning the above, then please contact either myself or my senior team as appropriate.

Matthew Hopkins – Head of Provider Support (NHSL)

Mark Brice – Head of FT Unit (NHSL)

Andrew Woodhead – Head of Mergers and Acquisitions (NHSL)

I look forward to hearing from you in due course and thank you in anticipation for your continued support.

Best wishes,

Mark Davies – Director of Provider Transformation, NHS London

CC. Ruth Carnall – Chief Executive, NHS London

Mike Spyer Chair, NHS London

Executive Management Team, NHS London

# LAS FT Application Programme Schedule

| | Jul-10 | | Aug-10 | | | | | Sep-10 | | | | Oct-10 | | | | Nov-10 | | | | | Dec-10 | | | | Jan-11 | | | | | Feb-11 | | | | Mar-11 | | | | Apr-11 | | | | May-11 | | | | | Jun-11 | | | | Jul-11 | | | | Aug-11 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 19-Jul-10 | 26-Jul-10 | 02-Aug-10 | 09-Aug-10 | 16-Aug-10 | 23-Aug-10 | 30-Aug-10 | 06-Sep-10 | 13-Sep-10 | 20-Sep-10 | 27-Sep-10 | 04-Oct-10 | 11-Oct-10 | 18-Oct-10 | 25-Oct-10 | 01-Nov-10 | 08-Nov-10 | 15-Nov-10 | 22-Nov-10 | 29-Nov-10 | 06-Dec-10 | 13-Dec-10 | 20-Dec-10 | 27-Dec-10 | 03-Jan-11 | 10-Jan-11 | 17-Jan-11 | 24-Jan-11 | 31-Jan-11 | 07-Feb-11 | 14-Feb-11 | 21-Feb-11 | 28-Feb-11 | 07-Mar-11 | 14-Mar-11 | 21-Mar-11 | 28-Mar-11 | 04-Apr-11 | 11-Apr-11 | 18-Apr-11 | 25-Apr-11 | 02-May-11 | 09-May-11 | 16-May-11 | 23-May-11 | 30-May-11 | 06-Jun-11 | 13-Jun-11 | 20-Jun-11 | 27-Jun-11 | 04-Jul-11 | 11-Jul-11 | 18-Jul-11 | 25-Jul-11 | 01-Aug-11 | 08-Aug-11 | 15-Aug-11 | 22-Aug-11 | 29-Aug-11 |
| FT Project Board meetings | 20 | | | | | | 3 | | | 21 | | | | | 27 | | | | 26 | | 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Trust Board meetings | | | | | | | 31 | | | | 28 | | | | | | | | | 30 | | 14 | | | | | tbc | | | tbc | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SRP meeting (Trust Board in private) | | 27 | | | | | | | | | | | | | | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SMG meetings | 19 | 26 | | **11** | | | | | **15** | **23/24** | | | 13 | | | | 10 | | | | 8 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SSG meetings | | | | | | | | 8 | | | | | | | | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Senior Managers & Managers Conferences | | | | | | | | | 17 | 22 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HDD1 preparation (incl mtg with SHA/GT) | | | | tbc | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Engage commissioners - review IBP&LTFM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Engage commissioners - SD mtgs | | 29 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Allocate Leads for strategies and service developments | 19 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Key strategies agreed by SRP (workforce/fleet/estates) | | 27 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Service Development Plans agreed by SRP | | 27 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Key assumptions agreed by SRP (incl demand, activity) | | 27 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Review and integrate assumptions | | | | 11 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Engage commissioners - SACU MDs mtgs | | | | 10 | | | | | 16 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **LTFM: first draft completed - 24th Aug** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **IBP: first draft complete - 24th Aug** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Engage commissioners - review IBP&LTFM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Engage commissioners - SD mtgs | | | | | | 26 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Develop NEDs understanding of LTFM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PCT letters of support due** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **IBP & LTFM: drafts approved by Board** | | | | | | | **31** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **IBP & LTFM: Review by SHA - 1st Sept** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Prepare Board for Executive Interviews | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Engage commissioners - Sector MD mtgs | | | | | | | | | 15 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IBP & LTFM: Incorporate SHA comments | | | | | | | | | 15 | 23/24 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Executive Interviews by SHA** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Engage commissioners - review IBP&LTFM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Constitution finalised & approved by Board | | | | | | | 31 | | | | 28 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Engage commissioners - SD mtgs | | | | | | | | | | | 30 | | | | 28 | | | | 25 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Executive Interviews by Grant Thornton (HDD1) | | | | | | | | | | | | ★ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **HDD1: Review of business & finance (3wks)** | | | | | | | | | | | | ★ | | 21 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CQC audit (7wks - same time as HDD1) | | | | | | | | | | | | ★ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Engage commissioners - SACU MDs mtgs | | | | | | | | | | | | | 12 | | | | 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Sign-off - Strategic Commissioning Board** | | | | | | | | | | | | | | **22** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Legal review of Constitution completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PCT interviews by SHA (before completion of HDD2) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IBP & LTFM: Update after HDD1 | | | | | | | | | | | | | | | | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Develop HDD1 Action Plan | | | | | | | | | | | | | | | | 2 | | | | 30 | | 14 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Board Observation by SHA** | | | | | | | | | | | | | | | | | | | | | ▲ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **HDD2: Detailed historic due diligence (3wks)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Develop HDD2 Action Plan | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IBP & LTFM: Update after HDD2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mock Board to Board | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IBP & LTFM: Completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Trust Board formal approval of IBP & LTFM** | | | | | | | | | | | | | | | | | | | | | | | | | | | | tbc | | | | | | | | | | | | | | | | | | | | | | |
| **SHA Board to Board** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SHA Board to Board Feedback | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Trust Board formal approval of FT applic.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | tbc | | | | | | | | | | | | | | | | | |
| Council of Governors elections | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SHA Support for application** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SHA Board Approval | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | tbc | | | | 31 | | | | | | | | | | | | |
| SoS review (6-8wks) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1 | | | | 1 | | | | | | | | | | |
| **SoS support for application** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Monitor review (incl HDD3) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Council of Governors appointed** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Monitor Board to Board** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Authorisation** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Cat B 19min Trajectory (YTD)** | 91.9% | | 92.4% | | | | | 92.8% | | | | 93.2% | | | | 93.5% | | | | | 93.2% | | | | 93.3% | | | | | 93.4% | | | | 93.2% | | | | | | | | | | | | | | | | | | | | |
| | **Jul-10** | | **Aug-10** | | | | | **Sep-10** | | | | **Oct-10** | | | | **Nov-10** | | | | | **Dec-10** | | | | **Jan-11** | | | | | **Feb-11** | | | | **Mar-11** | | | | **Apr-11** | | | | **May-11** | | | | | **Jun-11** | | | | **Jun-11** | | | | **May-11** | | | | |
| LEAVE: Erin Heinrich | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| LEAVE: Tracey Freeman | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| LEAVE: Sandra Adams | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| LEAVE: Caron Hitchen | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| LEAVE: Richard Webber | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| LEAVE: Peter Bradley | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| LEAVE: Mike Dinan | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| LEAVE: Lizzy Bovill | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| LEAVE: Peter Suter | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| LEAVE: Fionna Moore | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| LEAVE: Martin Flaherty | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

London Ambulance Service NHS
NHS Trust

# LONDON AMBULANCE SERVICE TRUST BOARD

**31st August 2010**

**PAPER FOR NOTING**

| | |
|---|---|
| **Document Title:** | **Briefing on the process for historical due diligence** |
| **Report Author(s):** | **Sandra Adams** |
| **Lead Director:** | **Sandra Adams** |
| **Contact Details:** | **020 7783 2045** |
| **Why is this coming to the Trust Board?** | **To brief the Trust Board on an essential and important part of the FT application process** |
| **This paper has been previously presented to:** | ☐ Strategy Review and Planning Committee<br>☐ Senior Management Group<br>☐ Quality Committee<br>☐ Audit Committee<br>☐ Clinical Quality Safety and Effectiveness Group<br>☐ Risk Compliance and Assurance Group<br>☐ Other |
| **Recommendation for the Trust Board:** | To note the process and what is required of board members |

**Executive Summary/key issues for the Trust Board**

- Historical due diligence (HDD) is a formal part of the FT application process and dictates the timeline depending upon the outcome of each stage.
- There are 3 stages with 1 & 2 concerning financial reporting and governance and then a corporate finance review, commencing from October 2010 and lasting approximately 3 months depending upon the outcome of each stage. Stage 3 takes place during Monitor's review and leads to the Reported Accountant's Opinion upon which Monitor usually base the final decision.
- HDD is scheduled to commence from 4th October 2010 for 3 weeks. Interviews are being planned with all board members for the 1st week and Grant Thornton (the independent accountants) will feedback to the Chairman, Chief Executive, Director of Finance and Director of Corporate Services in the week commencing 18th October. Following this the Grant Thornton team will present the findings and outcome of HDD stage 1 to a formal board meeting currently being planned for the afternoon of 21st October.
- The outcome of HDD stage 1 will set the timetable for the rest of the process depending upon the findings and the level of action required. This could mean the current timetable remains and action is taken as we progress, or it could mean a delay of 3 – 6 months, or more, if the findings are significant.
- The briefing note outlines the areas that the HDD interviews will cover and what is required of board members. The FT team for NHS London will undertake preparatory interviews in the week prior to HDD.

**Attachments**

Briefing note

**********

**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:

**Briefing on the process for Historical Due Diligence**

**11th August 2010**

The following summary is intended to brief Trust Board members on the process and timeline for the historical due diligence (HDD) assessment that will be undertaken by Grant Thornton, independent accountants, as an essential part of the foundation trust (FT) application. This is based on discussions with the lead assessor and the FT team at NHS London.

## 1. Preparation stage

- Information to be provided 1-2 weeks in advance: documentation covering corporate governance (board structure, committees, membership, recruitment, governance structure, meetings); high level controls (assurance framework, CQC ratings, standards for better health performance and plans for improvement); risk management (risk register, key risks, governance of major capital projects, legal – including SUIs, litigation, disciplinary matters); management reporting framework; financial controls and reporting framework (structure of finance team, services, fitness for purpose, budgeting, procurement, treasury management, service line management, finance dashboard report, working capital, and CIPs); audit arrangements; IM&T(systems, implementation of new/replacement systems, support, disaster recovery, testing, business continuity); IFRS; standards, targets, quality measures within commissioner contracts (performance reporting, forecasting, risk assessment, CPIs, external enquiries, assessments). This represents approximately 180 lines of enquiry. Work is underway to collect and collate this information.
- Pre-HDD meeting: to be held 1-2 weeks prior to HDD commencing. Date to be confirmed.

## 2. 1st stage HDD

This will focus on financial review and financial reporting procedures and governance. The assessment team will spend 2 weeks on site and the following areas will also be covered: the integrated business plan (IBP) and long term financial model (LTFM); governance submissions; committees, pen portrait of the board; high level controls. The financial review from Stage 1 focuses on preparation for Stage 2:

- Interviews are being planned for week commencing 4th October and include all board members, executive directors, and the Heads of Communication and Business Development. The Heads of Internal and External Audit will be interviewed as will Neil Kennett-Brown and the SHA finance director. Our FT finance lead (Tracey Freeman) will need to be available during weeks 1 & 2. I will meet with the assessor at the end of each day to review and make any further plans. We are booking interview dates in for all board members now to ensure that these are in diaries. These may be subject to change.
- Interviews will cover the background around board member roles and responsibilities; Executive directors will be asked about risks and assurance within their own areas and other areas (to ensure corporate understanding).

- Non-executive directors will be expected to demonstrate a good level of challenge, productive working relationships with executive directors, an understanding of the Trust's strategy and performance, and the key risks and issues.
- In preparation for this process the NHS London FT team will run interviews with board members in late September and these are being booked around the September board meeting as far as possible. This will take the form of 30 minutes with each board member with 10 questions each.

## 3. Points to note for this stage

**Financial model**

- All Board members will be expected to understand the financial assumptions and pinch points within the LTFM, for example the current financial position, where we will be in 5 years time, and the planned surplus for years 1 & 5;
- We will need to have a description of the model and process and how we have tested assumptions and affordability, and have details of the mitigation strategy.

**IBP**

- The core strategy needs to be agreed and board members need to be able to articulate the key threads and issues including: the Vision and objectives, how we will deliver and measure achievement/delivery; our enabling strategies such as workforce and governance. Also, the risks, mitigating strategies, and quality.

## 4. 2nd stage HDD (29th November for 3 weeks)

- This is a corporate finance review looking at 2 years history and the current year outturn; income & expenditure; cash flow; EBITDA; CIP; forecast; and risk areas;
- ALE 4 will not have any influence on this stage although we may be able to use some of the evidence;
- There is usually a minimum period of 3 months from commencement of HDD 1 to completion of stage 2.

## 5. Stage 3 HDD (provisionally May/June 2011)

- This is the working capital review and is undertaken in the last 7-8 weeks of Monitor's assessment period;
- This leads to the Reported Accountant's Opinion upon which Monitor usually base the final decision.

**Future briefings**

- SHA assessment process – commencing with the pre-HDD interviews and leading to Board observation (30th November), and Board to Board (late January 2011);
- Governance and constitution – this will be a paper for Trust Board in September.

Sandra Adams
Director of Corporate Services
13th August 2010

London Ambulance Service NHS
NHS Trust

# LONDON AMBULANCE SERVICE TRUST BOARD

**31st August 2010**

**PAPER FOR NOTING**

| | |
|---|---|
| **Document Title:** | **SERVICE IMPROVEMENT PROGRAMME 2012 UPDATE** |
| **Report Author(s):** | **Martin Brand, Head of Planning and Programme Management** |
| **Lead Director:** | **Sandra Adams** |
| **Contact Details:** | **Corporate Services Department, Programme and Change Management Office** |
| **Why is this coming to the Trust Board?** | **To update Trust Board on progress with the SIP** |
| **This paper has been previously presented to:** | ☐ Strategy Review and Planning Committee<br>☒ Senior Management Group<br>☐ Quality Committee<br>☐ Audit Committee<br>☐ Clinical Quality Safety and Effectiveness Committee<br>☐ Risk Compliance and Assurance Group<br>☐ Other |
| **Recommendation for the Trust Board:** | To note the progress made with the three programmes comprising the overall Service Improvement Programme 2012 outlined in the report |

**Executive Summary/key issues for the Trust Board**

The Service Improvement Programme (SIP2012) is the implementation mechanism to achieve the change articulated by the Trust's business plan, attached are the progress reports for the three programmes that comprise it:

- Clinical Development, Leadership and Workforce;
- Performance and Service Delivery;
- Olympics.

The business plan articulates how the three Strategic Goals of the Trust will be achieved through the realisation of corporate objectives expressed in terms of SMART targets represented on the balanced scorecard. The three programmes take their Mandate from the need to fill the gap between SMART target ambitions and what the Trust will achieve if it does not change.

**Attachments**

Programme Summary - Performance and Service Delivery Programme
Programme Summary - Clinical Development, Leadership and Workforce Programme
Programme Summary - London 2012 Olympic and Paralympic Programme

**********

**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:
SIP covered by Equality Impact Assessments and 26 March 2008 PPI event at The Oval

**PROGRAMME SUMMARY – Performance and Service Delivery Programme**

**Programme Progress**

- Development of the programme is bound up with work to develop SMART targets for the Trust to support the IBP. These are being considered by the August SMG meeting following which it will be necessary to undertake a gap analysis to understand whether the Trust's ambitions will be achieved by seeing through to completion the various initiatives now in train or whether more will need to be done. Either way a view on the sufficiency or otherwise of current initiatives and their contribution will provide the programme with a mandate specifying what it is required to deliver over the three years to 2013/14 and a programme plan sequencing activity can be developed.
- Work has been initiated to progress the gap analysis and a proposed approach to completing the work will be presented to SSG on 8th September.

**Project Progress**

- Technology: *CommandPoint*: Following discussions with NG regarding the timescales for delivery of Release 1.1 this has been reviewed and a new transition date will be announced; *TEASHIP*: It is likely that the national trial will become permanent, in-house solution planning needs to focus on CommandPoint.
- Production**:** *Static Defib:* A total of 274 static sites have been located/set-up to date; *Hospital Based Alert and Handover Project:* Whipps Cross site is demonstrating consistently high uses of the web based system since its introduction and they are very pleased with the information it shows. Charring Cross is also showing a steady increase in the use of the system.
- Distribution: *Urgent Care Dispatching*: Utilisation has increased with UOC showing a 2% increase in utilisation (rising to 65%); *Ambulance and FRU activation*: The project has delivered and been closed.
- Infrastructure: *Vehicle fleet procurement:* Build of the next 65 AEU's with MacNeillie is underway, as of 28th July 10 are in service, 13 have been delivered to LAS, a further 3 are at Mercedes, with 2 more scheduled for inspection on 30th July; *Event control rooms*: The project remains on track for completion in October 2010; *Real time fleet management information*: The refresh training is completed at all but two workshops which will be covered in the first week of August. The response from staff has been encouraging, fewer issues are arising with the data that is being put into Tranman and utilisation of the system is improving.
- CPG: *Performance measurement*: ALE submissions made in Performance Accelerator for 2010-11 scoring;
- FT: *Good business strategy***:** The FT application timeline has been revised; The Draft IBP is approximately 75% complete; Market strategies, service developments, Workforce Plan, Fleet Plan and Estates Plan are agreed in principle by the Trust Board but need to be fleshed out and incorporated in the IBP and LTFM; *Financially viable*: key assumptions are being used to complete the strategic financial model; Regular meetings are arranged between LAS FT finance lead and the lead commissioner; the IBP finance chapter is 25% complete; *Well governed***:** preparation for Historical Due Diligence (Stage 1) is underway.

**Upcoming tasks for this period**

- Technology: *CommandPoint:* Review and revise the transition plan for Release 1.1, continue preparation of end user testing and training and commence transition planning; *LARP*: Prepare analogue decommissioning risk assessment for SMG. *TEASHIP*: Set up EOC working group for an in-house solution for control room integration. Scope viability of web based access to emergency SMS and build user awareness.
- Distribution: *Urgent care despatching:* Options paper on changes to UOC and clinical services in Control sent to the Director of Operations for decision on how it should be taken forward.
- Infrastructure: *Vehicle fleet procurement:* Await funding approval to progress the fleet replacement programme.
- CPG: *Asset Tracking*: Resolve the slow progress on the Asset Tracking pilot for HART at Deptford; *Starters, movers and leavers*: SharePoint AFA to be approved.
- FT: *Capable Board to Deliver***:** Independent analysis of Board capability / capacity to be planned along with the start of preparing the Board for observations and interviews; *Local health Economy issues/external relations*: Numerous engagement activities planned with commissioners to help gain

their support for the FT application; implications of the White Paper to be incorporated in the IBP and LTFM.

**Business Changes** (By exception)

- Technology: *LARP:* Amber due to – (i) EOC desk re-organisation, CTAK changes required (ii) Savings - decommissioning of analogue radio can only commence once Risk Assessment has been agreed, (iii) Airwave Despatch and In-Build – on hold with purchasing. *Data warehouse:* Amber - awareness and buy-in needs to improve before scoping of additional work can be achieved. Resource constraints due to CommandPoint integration are also a concern.
- Production *First & Co-responders*: Changes to CTAK are limited and impact on delivery; *Roster Reviews*: The target end date of all rotas being agreed is now slipping and has been escalated to the project board for resolution. 03.00 finishes and 08.00 starts are problematic, these have followed the process and been taken to ADO level. In the West the union representative disagrees with the 03.00 finish time, should this revert to 02.00 the project could be compromised if it led to revisiting already agreed rotas.
- CPG: *PRF improvement*: Technical issues with scanning and character recognition on new PRF currently distorting statistics.

**Key issues, interdependencies and risks to note**

- Technology: *Data Warehousing*: MI resource availability due to CommandPoint development, agreement on the future direction for the next phase of the project. *LARP*: Agreement of funding for the decommissioning stage.
- Distribution: *Urgent care despatching*: Continuing difficulty in obtaining data from MI to allow determination of where the staff and vehicles need to be located and times of shifts.
- Infrastructure*: Vehicle fleet procurement*: Bottle necks in decommissioning LD V's to release sufficient LP12 chargers for use in new ambulances; *New workshop commissioning*: Whilst the site visits have been arranged there is anxiety about turnout particularly given the lack of feedback from staff; *Real time fleet management information:* There has been difficulty in finding a suitable date to arrange a meeting with the logistics manager and the workshop managers who will pilot the stock module. This is due to key staff on rosters. This is now scheduled for Wednesday 4th August.
- CPG: *Starters, movers and leavers:* Compliance with establishment control processes is problematic, especially at senior management level, and is causing grave difficulties for administration of starters, movers and leavers.
- FT: Timeline for FT application is now for submission to Secretary of State by April 2011, aiming for authorisation in August 2011. The SMG needs to coordinate and complete a large amount of work in August in order to stick to the current timeline. The IBP and LTFM need to be 95% complete before we can progress to Historical Due Diligence 1 (HDD1). The outcome of HDD1 will determine the Trust's ability to stick to the proposed timeline. Under performance on Category B19 trajectory may halt the FT application process.

**Benefit Realisation Up-date**

- Benefits Realisation reporting has been included in the programme report for the first time this month in relation to the CPG workstream (see traffic lights summary report). The scope of benefits reporting will expand in future months. The benefits to be focused upon have been agreed with SROs.

- Full Benefit Realisation management (with benefit profiles defined at the outset) is dependent upon a clear Programme Mandate arising from the SMART targets gap analysis work.

# Programme Report: Performance & Service Delivery > Period Ending: 1 August 2010 <

▲=Closed, ▲=On track, ▼=Not on track, ▲=Not on track, in control

## Workstreams

| | | Status | Business Changes | Benefits (workstream level) | Project Benefit & Status |
|---|---|---|---|---|---|
| **Technology** | Command Point 2010 | ▶ pg 2 | | Better flow of information to front line staff | |
| | Data Warehousing | ▶ pg 4 | ▲ pg9a | | |
| | LARP | ▶ pg 5 | ▲ pg9a | Improved access routes for all patients | |
| | PTS data solutions | ▲ pg 6 | | Essential replacement of business critical system | |
| | TEASHIP | ▲ pg 7 | | Improved data collection, analysis and decision making | |
| | e-PRF | ▼ pg 9 | | | |
| **A&E Production** | First and co-responders | ▶ pg 13 | ▶ pg33a | Improved liaison with other NHS organisations | |
| | Static Defibrilator | ▲ pg 14 | ▶ pg33a | | |
| | Hospital turnaround projects | ▲ pg 15 | ▶ pg33b | Increased availability of response resources (crews & vehicles) | |
| | Roster reviews | ▲ pg 15 | ▲ pg33c | | |
| | Annual leave - transferred | | | | |
| | Resourcing to ORH plan across 168 hours | ▲ pg 15 | ▲ | Increased ability to meet targets (clinical & response times) | |
| | Mobile Office | ▲ pg16 | 33d | | |
| | Hospital based alerts | ▶ pg16 | ▶ 33d | | |
| **A&E Distribution** | Performance oversight (CDU/EOC) | ▲ pg18 | | | |
| | Single responders | ▲ pg18 | ▶ pg33e | | |
| | Urgent care despatching | ▲ pg18 | | Increased productivity | |
| | Ambulance activation (30 seconds) | ▲ pg20 | | | |
| | FRU activation (15 seconds) | ▲ pg20 | | Reduced patient waiting times | |
| | Active area cover | ▲ pg20 | | | |
| | Rest breaks | ▲ pg21 | ▶ pg33e | | |
| **A&E Infrastructure** | Vehicle fleet procurement | ▼ pg23 | | Improved management of large scale events | |
| | Event Control | ▼ pg24 | | | |
| | Logistics & fleet review | ▲ pg25 | | | |
| | Emergency preparedness review | ▶ pg25 | | Improved management of resources | |
| | New workshop commissioning | ▲ pg26 | | | |
| | Control Rooms | ▲ pg27 | | | |
| | Real time fleet management info | ▲ pg28 | | | |
| **Corporate Processes** | Staff Administration--Ph 2 | ▶ pg35 | | | |
| | Performance Measurement (phase 3) | ▲ pg35 | ▶ pg34a | Improved Governance | ▶ Improved ALE score (3) |
| | Electronic expenses | ▶ pg36 | ▶ pg34a | Efficiency savings | ▶ 100 hrs of staff time saved processing claims |
| | Inventory management | ▼ pg36 | | | |
| | Asset Tracking | ▲ pg36 | | Reduced lead time for processes | |
| | Starters, movers & leavers | ▼ pg37 | | | |
| | Incident data records-Ph 2 | ▲ | ▶ pg34a | Improved control over expenditure | Decrease in liable collisions per 1k activations |
| | PRF improvement | ▲ | ▲ pg34a | | ▲ 85%+ of PRFs completed on time |
| **Foundation Trust** | Legally constituted & representative | ▶ p 42 | | | |
| | Good business strategy | ▲ p 43 | | | |
| | Financially viable | ▲ p 45 | | | |
| | Well governed | ▶ p 45 | | Achieving Foundation Trust status | |
| | Capable Board to deliver | ▶ p 46 | | | |
| | Good service performance | ▶ p 46 | | | |
| | LHE issues/external relations | ▶ p 47 | | | |

# PROGRAMME PROGRESS REPORT FOR CLINICAL DEVELOPMENT, LEADERSHIP & WORKFORCE

## PROGRAMME SUMMARY

### Project Progress

- OD & People: the final draft of the 24hr Barnehurst trial has been circulated to SMG. This will inform the planning for the extended trial which has been agreed to go-live on the 29th September.
- OD & People: the Talent Management Programme was launched with a LAS New Article at the end of July – the nomination process opened on the 1st of August with a number of nominations received already.
- NWoW: the roll-out plan has been agreed for NWoW that will cover the next 3 years and implementation at all complexes; Camden, Friern Barnet , Bromley and Greenwich have all accepted the invitation to be part of wave 2. The first engagement meeting took place on the 29th July with the core team, ADOs and AOMs. A further complex has been invited to take part in wave 2.
- NWoW: the comms plan is being pushed with an article in the June LAS News as well as a 2-page article in the July edition. The revised glossy document describing the scope and benefits of NWoW has also been distributed to participating complexes.
- HFL: the Clinical Education Steering Group has agreed the materials for the assessment skills training package in principle, detailed content is being worked on. However there are issues with securing training dates for their delivery – see ISSUES for further information.
- HFL: Ipsos MORI have nearly completed the qualitative and quantitative interviews for the perceptions audit and the final report is due at the end of September. An internal review meeting is already scheduled.

### Upcoming tasks for this period:

- OD & People: planning will continue for the extended (2 month) trial of the clinical response model at Barnehurst in the first instance; with the intention to expand this to Bromley and Greenwich to sequence with NWoW roll out. A dedicated operational planning office is to be set up in Bromley.
- OD & People: the pilot of the e-learning site LAS LIVE over the 11 sites is planned for the end of August; Trust-wide roll-out is planned for September.
- OD & People: the talent management programme nomination process will remain open through all of August and close on the 10th of September.
- NWoW: commence the diagnostic work on the wave 2 complexes to inform the detailed project plans. Seek agreement from the fifth complex to take part in the trial.
- HFL: finalise and verify the accuracy of the ACP list in collaboration with the sectors in anticipation of the data up-load to the Directory.

### Business Changes

- The 1st cohort for the coaching and mentoring programme has begun; these training days will take place over the coming months before the 2nd cohort goes live in September. Places have been offered and accepted by SMG members who will be coaches for the talent management programme in the first year.
- A number of NWoW projects have been closed and moved to business change status, these include; the clinical leadership projects at Chase Farm and Barnehurst, as well as Team based Working at Barnhurst.
- Both clinical leadership business changes are amber – this is due to no CPD training being available for delivery as part of phase 2 of roll out of the training.

## PROGRAMME PROGRESS REPORT FOR CLINICAL DEVELOPMENT, LEADERSHIP & WORKFORCE

**PROGRAMME SUMMARY**

**Key issues, interdependencies and risks to note:**

- **INTER-DEPENDENCY** – the planning for the clinical response model project has begun with a number of pilots sites identified in the South. These have been identified because they are current or future NWoW complexes and therefore have had a number of key initiatives implemented that will support their capacity and capability to operate as pilot sites.
    - **ISSUE –** the delay in NWoW Wave 2 roll out may impact upon the delivery of phase 2 of the CRM pilot (Bromley & Greenwich). A dedicated operational planning office is being set up in Bromley to oversee the trial; this will link in closely with NWoW roll out.
    - **ISSUE –** the delay in rolling out the ACP training may impact upon staff training and confidence in the utilization of pathways as part of the pilot (see issue below).
- **ISSUE** - Agreement to include Appropriate Care Pathway (ACP) clinical training within the agenda for the designated training days is yet to be confirmed (it was planned to be confirmed in June). This has resulted in slippage for the pathway training which will have a knock on effect to the completion of stage 1 of the project. The plan is to attempt recovery by exploiting the rostered days for complex based rather than training centre based delivery of the material.
- **ISSUE** – the learning management system project has been traffic-lighted red due to the halt in the project and subsequent work to develop an options appraisal and implementation plan. The options appraisal is being developed and will be presented to the Workstream Lead in September for approval.
- **ISSUE** – the technical issues with the e-learning project have largely been resolved with an agreed plan with IM&T to address identified gaps in infrastructure at the pilot sites. Agreement has also been reached to upgrade to Internet Explore 8 (from 6) to support LAS LIVE. This remains an issue until all PCs at the pilot sites have been up-graded and that this can be replicated across the Trust.
- **ISSUE** – the AFA for the talent advisor post is yet to be agreed which is resulting in no progress for the KSF /PDR project. This is also likely to have an impact on the talent management programme which has been launched in August with no certainty of the advisor being in post to support its delivery.

**Benefit Realisation Up-date**

- OD & people benefits are still in development with a number of changes recently agreed. These should be tabled at the September workstream board for sign off and there after included in the programme report.
- An OD Survey has been distributed to staff during July that will inform a number of the OD & People measurements, specifically around leadership and management, team working and staff attitudes and behaviours. So far the return rate is steady.
- NWoW benefits were agreed at the June workstream board; there are 11 in total with one change to better capture improvements to the patient experience. Next steps are to collect the baseline data to be tabled at the August workstream board and programme board.

# Programme Report: Clinical Development, Leadership & Workforce

## Reporting Period: 12/07/2010- 11/08/2010

Status ▲=Closed project, ▲=On track, ▲=Not on track but in control, ▼=Not on track and not in control,

| | Enabling Projects | Status | | Business Changes | | Benefits (workstream level) | Benefit Status |
|---|---|---|---|---|---|---|---|
| OD&P | Workforce Plan Implementation | ▲ | | ▶ | pg 16 | More access by staff to career progression | |
| | Coaching & Mentoring | ▲ | | ▶ | pg 16 | | |
| | Performance Management | ▲ | Pg 5 | | | More consistent delegation to appropriate levels | |
| | Talent Management | ▶ | pg 5 | | | | |
| | E-learning | ▲ | pg 6 | | | Better leadership at all levels | |
| | Learning Management Systems | ▼ | pg 7 | | | | |
| | Standards of Paramedic Education | ▶ | pg 8 | | | More opportunity for clinical & personal development | |
| | Clinical Response Model | ▲ | pg 8 | | | | |
| | Staff Well-Being | ▶ | pg 9 | | | | |
| | Staff Engagement | ▶ | pg 9 | | | Better management style that supports, empowers, challenges | |
| | Team Working | ▲ | pg 10 | | | | |
| | KSF / PDR | ▲ | pg 11 | | | | |
| NWoW | Chase Farm - Clinical Leadership | ▲ | pg 19 | ▲ | pp25 | Increased used of alternative pathways | |
| | Chase Farm - Leadership Development | ▲ | pg 20 | | | Improved response to patients that need it most | |
| | Chase Farm- Team Based Working | ▲ | pg 20 | | | Improved clinical support & leadership | |
| | Barnehurst - Clinical Leadership | ▲ | pg 21 | ▲ | pp26 | Improved staff confidence to use skills/make decisions | |
| | Barnehurst - Leadership Development | ▲ | pg 22 | | | Improved staff engagement | |
| | Barnehurst - Team Based Working | ▲ | pg 22 | ▶ | pp27 | Improved work life balance | |
| | Barnehurst - Estates | ▶ | pg 23 | | | More engagement with the community | |
| Healthcare for London | Stroke | ▶ | pg 26 | | | | |
| | Major Trauma | ▶ | pg 26 | | | | |
| | Appropriate Care Pathways | ▼ | pg 27 | | | | |
| | Stakeholder Engagement | ▶ | pg 28 | | | | |

**PROGRAMME PROGRESS REPORT FOR LONDON 2012 OLYMPIC AND PARALYMPIC PROGRAMME**

## PROGRAMME SUMMARY: 31 July 2010

**Progress:**

- Exercise Citius Torch took place 15/16 July; attended by Richard Webber, Jason Killens, , Alan Palmer (Exercise Team) and Steve Waspe (Facilitator); debrief expected imminently; subsequent decisions required on co-ordination versus command function of the National Olympic Co-ordination Centre and the consequent requirement for LAS resource
- Liaison with equipment and consumable suppliers regarding contingency plans for Games-time
- Operational decision to use buddy-scheme approach for deployment of pre-planned aid where possible and depending on numbers ie. LAS staff paired with non-LAS staff
- First meeting of zone and venue commanders to ensure standard overview of liaison with LOCOG to date and common approach to working in venues; zone commanders to meet monthly and venue commanders quarterly
- Pre-planned aid working group continuing; agreement of current establishment for all services and production of work plan containing numbers and skill-sets available for Games finalised at end of July for presentation to National Directors of Operations Group in September
- Ongoing development of skills acquisition packages for 2011 training; three e-learning clinical sessions are being developed in-house; consideration of other LAS training priorities during 2011/12 to ensure any overlap managed

**Upcoming tasks for this period:**

- Consideration of initial proposal for Olympic Deployment Centre design and review of hub and spoke deployment option ie. identifying muster points around the capital where staff are picked up from and bussed into
- Further liaison with Staffside about the internal and external selection processes
- Olympic fleet requirement to be factored into LAS fleet plan; agreement by Trust Board
- Ongoing scoping of Tranche 3: Testing, exercises and operational implementation due to commence January 2011

**Key issues, interdependencies and risks to note:**

- Feedback from NHS London regarding proposal for 15% in-year financial cut; 8.1% reduction required, which is being considered by the Olympic Games Planning Office; this will equate to more than a 40% reduction in the funding originally identified for 2010/11
- Agreement with NHS London and North West London Commissioning Partnership that requirement to report into Olympic Safety and Security Programme (and extent) will be determined once decision made on submission in Comprehensive Spending Review (CSR)
- Guidance received from the Department of Health regarding volunteers; staff are able to utilise existing annual leave allocation or alternative leave arrangements to volunteer for the Games; LAS to determine a specific view for the LAS Olympic workforce, which will feed into the selection process

**Communications:**

- Peter Thorpe asked to present at Emergency Services Show (November 2010) and Ambulance Service Network Conference (October 2010)
- Olympic pages on Intranet updated; work commenced on next version of newsletter; remaining pedometers advertised and distributed to staff
- Article about National Ambulance 2012 Games Conference (May 2010) in Ambulance Life newsletter and submitted to Emergency Services Times
- Transcript of LAS (emergency services) session on 09 June at the London Assembly available on website (www.london.gov.uk)

# Programme Report: London 2012 Olympic and Paralympic Programme

## Period Ending: 31 July 2010

# LONDON 2012 OLYMPIC AND PARALYMPIC PROGRAMME

**Project Status Key:**
- ✓ On track
- Not on track but under control
- ✗ Not on track and not in control

**2010**

| JAN | FEB | MARCH | APRIL | MAY | JUNE | JULY | AUGUST | SEPTEMBER | OCTOBER | NOVEMBER | DECEMBER |
|---|---|---|---|---|---|---|---|---|---|---|---|

## T2P1: OPERATIONAL PLANNING
**Project Executive: Peter Thorpe**
**Project Manager: Alan Palmer**
**Status:** ✓

- Command and control structure agreed (FEB)
- LAS Scenario Testing and Exercise Programme designed (MARCH)
- Event demand in urban domain during lockdown period v.2 (APRIL)
- Venue-specific contingency plans for construction phase v.2 (APRIL)
- Operational Plan v.1 (draft) (JUNE)
- Contingency Plan v.1 (draft) (JUNE)
- Plans for deployment of pre-planned aid (JULY)
- Olympic hospitals specific plans (JULY)
- LAS Scenario, Testing and Exercise Programme commenced (AUGUST)
- Complete end stage review and scope next stage (SEPTEMBER)
- Venue-specific operational plans for Games-time v.1 (OCTOBER)
- Venue-specific contingency plans for Games-time v.1 (OCTOBER)
- Operational Plan v.2 (NOVEMBER)
- Contingency Plan v.2 (NOVEMBER)
- Timetable/ approach to LAS attendance at 2011 test events (NOVEMBER)
- Operational plans for Olympic-related events in urban domain v.1 (inc torch relay) (DECEMBER)
- Demand manage-ment outside venues v.1 (DECEMBER)
- Conduct End Project Review (DECEMBER)

## T2P2: WORKFORCE
**Project Executive: Peter Thorpe**
**Project Manager: Sandy Thompson**
**Status:** ✓

- Commence selection process design (JAN)
- Review process of identifying golds/ silvers to ensure on track (FEB)
- All LAS workforce groups and nos identified v.2 (MARCH)
- Accreditation review (APRIL)
- Complete end stage/ scope next stage (APRIL)
- Command and control structure resourced (Zone commanders) (JUNE)
- Agree selection process (JULY)
- Implementation of policy change required (JULY)
- Support/welfare structure for staff - detailed plan (AUGUST)
- HR pre-planned aid issues addressed (AUGUST)
- Selection process commenced (NOVEMBER)
- Command and control structure resourced in entirety (DECEMBER)
- Operational staff support procured/ delivered (DECEMBER)
- Conduct end project review (DECEMBER)

## T1P3: SKILLS ACQUISITION
**Project Executive: Anna Parry**
**Project Manager: Alan Taylor**
**Status:** ✓

- Ongoing development of training/educational sessions (commenced Sept 09) (JAN)
- Feasibility of e-learning packages for Olympic Programme determined (JUNE)
- Timetable for induction for staff from other UK Ambulance Trusts (SEPTEMBER)
- Selection and recruitment of training officers (DECEMBER)
- Conduct end project review (DECEMBER)

## T1P4: INFRASTRUCTURE AND SUPPORT
**Project Executive: Peter Thorpe**
**Project Manager: Anna Parry**
**Status:** ✓

**Oustanding from 2009 action plan to manage**

- Review of IM&T requirements (FEB)
- Gap analysis and option appraisal (IM&T) (FEB)
- Risk and priority analysis (IM&T) (FEB)
- Plan for specification, procurement, secure internal resource (IM&T) (MARCH)
- (LAS) Airwave communication plan (IM&T) (MARCH)
- Confirm vehicle purchasing framework (Operational Support) (MARCH)
- Agree business continuity plan for equipment/consumable suppliers (Operational Support) (SEPTEMBER)
- Agree any alternative equipment/consumable specificity; purchase plans (Operational Support) (SEPTEMBER)
- Detailed design for complex; statutory permissions (Estates) (DECEMBER)
- Transport plan produced (Operational Support) (DECEMBER)
- Conduct end project review (DECEMBER)

## W1: COMMUNICATION AND INVOLVEMENT
**Workstream Lead: Sandy Thompson**
**Status:** ✓

- Plan for communication of information re selection process (JAN)
- UK Ambulance Forum (10 February) (FEB)
- Complete review of communication aids e.g. language line, multi-lingual phrase book etc (MARCH)
- Publication of 2nd edition of 2012 gamesplanning newsletter (APRIL)
- National Ambulance Games Seminar (MAY)

## W2 COMMISSIONING PROCESS
**Workstream Lead: Peter Thorpe**
**Status:** ✓

- Financial reporting (quarterly) (JUNE)
- Business case (financial) re-work (JUNE)
- Progress reporting (monthly: SMG report) (APRIL – DECEMBER)
- Financial reporting (quarterly) (SEPTEMBER)
- Olympic vehicle requirement factored into fleet plan (SEPTEMBER)
- Scope to 'flex fleet' (National) (SEPTEMBER – DECEMBER)
- Financial reporting (quarterly) (DECEMBER)

**Legend**
- Awaiting approval
- Planned milestone
- Milestone achieved
- Minor slippage but under control
- Critical Slippage- requires intervention

London Ambulance Service NHS
NHS Trust

# LONDON AMBULANCE SERVICE TRUST BOARD

**31st August 2010**

**PAPER FOR APPROVAL**

| | |
|---|---|
| **Document Title:** | **Terms of reference for board committees** |
| **Report Author(s):** | **Sandra Adams** |
| **Lead Director:** | **Sandra Adams** |
| **Contact Details:** | **020 7783 2045** |
| **Why is this coming to the Trust Board?** | **Standing Orders** |
| **This paper has been previously presented to:** | ☒ Strategy Review and Planning Committee<br>☐ Senior Management Group<br>☐ Quality Committee<br>☐ Audit Committee<br>☐ Clinical Quality Safety and Effectiveness Group<br>☐ Risk Compliance and Assurance Group<br>☐ Other |
| **Recommendation for the Trust Board:** | To approve the terms of reference for committees reporting to the Trust Board |

**Executive Summary/key issues for the Trust Board**

The Board is required to approve the terms of reference for those committees described in the Standing Orders and Scheme of Delegation that report to the Trust Board. The Audit and Quality committee terms of reference have previously been approved leaving the following for approval:

a) Remuneration committee. These terms of reference have been updated to follow the standardised template for terms of reference. No substantive changes have been made.
b) Strategy Review & Planning group. These terms of reference have been drafted to reflect the new role of the Strategy Review and Planning Group which has replaced the Service Development Committee.
c) Charitable Funds committee. The responsibilities section has been updated to reflect the current role of the Charitable Funds Committee based on best practice.

**Attachments**

Terms of reference for a) – c) above

**********

**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
NHS Trust

**Terms of Reference**
**May 2010**
**Remuneration Committee**

## 1. Authority

1.1 The Remuneration Committee is constituted as a standing committee of the Trust Board of Directors (the Board). Its constitution and terms of reference shall be set out below and subject to amendment when directed and agreed by the Trust Board.

1.2 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

1.3 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

## 2. Purpose

The primary purpose of the Remuneration Committee is to advise the Board about appropriate remuneration and terms of service for the Chief Executive and other executive directors.

## 3. Objectives

3.1 To make such recommendations to the Board on the remuneration and terms of service of the Chief Executive, other Board Directors and such senior managers as the Board may have decided should fall within the Committee's remit, as to ensure that they are fairly rewarded for their individual and corporate contribution to the Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangement for such staff where appropriate.

3.2 To advise on and oversee appropriate contractual arrangements for staff covered by paragraph above, including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

## 4. Responsibility

4.1 In developing recommendations for remuneration packages, the Committee will wish to ensure that they have:

4.1.1. A clear statement of the responsibilities of the individual posts and their accountabilities for meeting objectives of the organisation;

4.1.2. Means of assessing the comparative size of the job by job evaluation;

4.1.3. Comparative salary information from the NHS, other public sector organisations including Trusts, and other industrial and service organisations;

4.1.4. The Board should decide in advance its general policy on Directors' remuneration and terms of service and look to the Committee to ensure that its policy is applied consistently.

## 5. Membership

5.1 The Committee will comprise the Board Chairman and non-executive Directors. Its composition is to be given in the Annual Report. The Chief Executive and Director of Corporate Services/Trust Secretary will normally be in attendance at meetings but will not be present for discussions about their own remuneration and terms of service.

## 6. Accountability

6.1 The Remuneration Committee shall be accountable to the Trust Board.

## 7. Reporting

7.1 The Committee is to report in writing to the full Board specifying the basis for its recommendations. The Board will use the Committee's report as the basis for its discussions on the remuneration and terms of service for those staff falling with its area of responsibility. The minutes of the relevant Board meetings are formally to record decisions taken.

## 8. Administration

8.1 The Committee will meet as directed by the Board. Its proceedings will be formally minuted and it will be serviced by the Director of Corporate Services/Trust Secretary.

## 9. Quorum

The quorate number of members shall be 3 non-executive directors plus the Chair or Deputy Chair.

## 10. Frequency

10.1 Meetings shall be held twice yearly.

## 11. Review of Terms of Reference

11.1 The Trust Board shall review these terms of reference annually.

London Ambulance Service NHS Trust

**Terms of Reference**
**July 2010**
**Strategy Review and Planning Group**

## 1. Authority

1.1 The constitution and terms of reference of the Strategy Review and Planning Group (known hereafter as the Committee) shall be set out below and subject to amendment when directed and agreed by the Trust Board.

1.2 The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all staff are directed to co-operate with any request made by the Committee.

1.3 The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of people from outside the LAS with relevant experience and expertise if it considers this necessary.

## 2. Purpose

The primary focus of the committee is to contribute to the development of the London Ambulance Service NHS Trust strategy through consideration of changes to the external environment, health policy and local health strategy and to ensure that quality and patient safety are at the heart of the strategy and service delivery.

2.1 To review and develop the strategic goals and objectives for a 3-5 year period.
2.2 To monitor progress with the development and implementation of strategic and operational plans to deliver the strategy.
2.3 To consider key initiatives and changes for discussion in a confidential environment before recommending a way forward.
2.4 To consider future developments and market opportunities that may be of strategic interest to the LAS.
2.5 To ensure that quality and safety underpin the strategy and supporting initiatives.
2.6 To make recommendations for the Trust Board to discuss and decide upon in an open and transparent manner.
2.7 To make recommendations to the Trust Board on the consultation process required to ensure patient, public and staff engagement in the Trust's future strategic development.

## 3. Responsibility [Duties]

3.1 The committee will review, on behalf of the Trust Board, the strategic positioning and opportunities for the LAS for a rolling 3-5 year period.
3.2 The committee will seek information and assurance from the executive team and other senior managers on progress with the service improvement programme and other key drivers for the achievement of the Trust's strategic goals.

3.3 The committee will ensure that a programme of consultation and engagement is in place to support major strategic changes and will review the outcomes from such processes, making recommendations to the Trust Board as appropriate.

## 4. Membership

4.1 The Committee will comprise the Trust Chairman, Non-Executive Directors, Chief Executive and executive (voting and non-voting) directors.

4.2 The Committee will be chaired by the Trust Chairman.

4.3 Senior managers and other trust officers may be invited to attend when their presence is considered necessary.

4.4 Representatives from partner organisations may be invited to attend when relevant to the matter under discussion.

4.5 Upon authorisation as an NHS foundation trust, the Trust Board will consider whether to invite governor representation onto the group.

## 5. Accountability

5.1 The Strategy Review and Planning Group shall be accountable to the Trust Board of Directors.

## 6. Reporting

6.1 The minutes of the Strategy Review and Planning Group meetings shall be formally recorded by the Trust's Committee Secretary and the approved minutes submitted to the Trust Board;

6.2 The Chair of the Strategy Review and Planning Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Board or that require executive action.

## 7. Administration

7.1 Secretarial support will be provided by the Trust's Committee Secretary and will include the agreement of the agenda with the Chair of the Strategy Review and Planning Group and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward;

7.2 The Agenda and papers will be distributed 5 days before each meeting;

7.3 The draft minutes and action points will be available to Committee members within 7 days of the meeting;

7.4 Members will ensure provision of agenda items, papers and update the commentary on action points at least 10 days prior to each meeting;

7.5 Papers tabled will be at the discretion of the Chair of the Strategy Review and Planning Group

**8. Quorum**

8.1 The quorum shall be at least four of the board directors, two of whom shall be non-executive directors and two executive directors.

**9. Frequency**

9.1 The Strategy Review and Planning Group shall meet at least four times a year.

9.2 The Chair may request additional meetings if they consider it necessary.

**10. Review of Terms of Reference**

The Trust Board shall review these terms of reference at least annually from the date of agreement.

London Ambulance Service NHS
NHS Trust

**Terms of Reference**
**April 2010**
**Charitable Funds Committee**

## 1. Authority

The terms of reference of the Charitable Funds Committee shall be set out below and subject to amendment when directed and agreed by the Trust Board.

The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

## 2. Purpose

To oversee, on behalf of the trustees of the London Ambulance Service Charitable Funds[1], the management, investment and disbursement of charitable funds within the regulations provided by the Charities Commission and to ensure compliance with the laws governing charitable funds.

## 3. Responsibility

To act on behalf of the Trust in satisfying the duties and responsibilities of trustees in managing the funds;

To ensure that policies and procedures are in place to meet the requirements of the Charities Commission and the laws governing charitable funds;

To establish an investment strategy in accordance with the Trustee Act 2000 and if necessary to appoint fund managers to act on its behalf;

To monitor the performance of investments and of appointed Investment Managers;

To review the charity's reserves policy;

To review the income and expenditure transactions for all funds;

To review legacies received and ensure that the Trust complies with the terms of the legacy;

[1] The Trust Board members shall act as the Trustees of the London Ambulance Services' Charitable Funds. The Trustees shall hold the Trust Funds upon trust to apply for any charitable purpose or purposes relating to the NHS wholly or mainly for the services provided by the LAS NHS Trust.

To examine the financial statements of the charity and approve the annual return and the annual accounts in line with the requirements of the Charities Commission and the laws governing charitable funds;

To approve the charitable funds annual budget;

To authorise the establishment of new funds and new charities.

**4. Membership**

One non-executive director member shall be the Chair of the Committee and, in their absence, another non-executive member shall be nominated by the others present to deputise for the Chair.

The Director of Human Resources and Organisational Development, the Financial Controller and a nominated staff-side representative shall normally attend all meetings.

Other managers/staff may be invited to attend meetings depending upon issues under discussion.

**5. Accountability**

The Charitable Funds Committee shall be accountable to the Trust Board of Directors.

**6. Reporting**

The minutes of Charitable Funds Committee meetings shall be formally recorded by the Trust's Committee Secretary and the approved minutes submitted to the Trust Board;

The Chair of the Charitable Funds Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Board or that require executive action.

**7. Administration**

Secretarial support will be provided by the Trust's Committee Secretary and will include the agreement of the agenda with the Chair of the Service Development Committee and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward;

The agenda and papers will be distributed 5 days before each meeting;

The draft minutes and action points will be available to Committee members within 7 days of the meeting;

Members will ensure provision of agenda items, papers and update the commentary on action points at least 10 days prior to each meeting;

Papers tabled will be at the discretion of the Chair of the Charitable Funds Committee.

**8. Quorum**

The quorate number of members shall be 50% of the full membership.

There shall be one non-executive director, the Director of Human Resources & Organisational development/deputy, and the financial controller or nominated deputy, and a staff-side representative present to make the meeting quorate.

**9. Frequency**

The Charitable Funds Committee shall normally meet once a year.

The Chair may request additional meetings if they consider it necessary.

**10. Review of Terms of Reference**

The Charitable Funds Committee shall review these terms of reference at least annually from the date of agreement.

London Ambulance Service NHS
NHS Trust

# LONDON AMBULANCE SERVICE TRUST BOARD

**31st August 2010**

**PAPER FOR NOTING**

| | |
|---|---|
| **Document Title:** | **Report of the Trust Secretary** |
| **Report Author(s):** | **Sandra Adams** |
| **Lead Director:** | **Sandra Adams** |
| **Contact Details:** | **020 7783 2045** |
| **Why is this coming to the Trust Board?** | **Standing Orders** |
| **This paper has been previously presented to:** | ☐ Strategy Review and Planning Committee<br>☐ Senior Management Group<br>☐ Quality Committee<br>☐ Audit Committee<br>☐ Clinical Quality Safety and Effectiveness Group<br>☐ Risk Compliance and Assurance Group<br>☐ Other |
| **Recommendation for the Trust Board:** | To note the tenders received and opened and the use of the Trust Seal since May 2010 |

**Executive Summary/key issues for the Trust Board**

Two tenders have been received, opened and entered into the tender book since 25th May 2010:

1. Formation of event control at St Andrew's, Bow
2. HART facilities at Cody Road.

There have been two entries to the register for the Use of the Trust Seal:

1. Lease and licence for alterations in respect of 21 Ullswater Crescent.
2. Notice to surrender Unit L, 68 Brewery Road, London N7. Transfer between London Ambulance Service NHS Trust and Arden Estates Ltd.

**Attachments**

Report of the Trust Secretary

**********

**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 of Directors**
**31st August 2010**

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

## 1. Introduction

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

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

## 2. Tenders received

There have been two tenders received since the last Trust Board meeting

2.1 Formation of event control at St Andrew's, Bow
Tenders received and opened on 7th July 2010
TCL Granby
Millane Contract Services Ltd
Coniston Construction
Lakehouse Contracts Ltd.

**2.2 HART facilities at Cody Road**
Tenders received and opened on 30th July 2010
SGG Contracting Ltd
Coniston Construction
WACM Ltd
TCL Granby
Millane Contract Services Ltd.

## 3. Use of the Trust Seal

There have been two entries to the register:

3.1 Lease and licence for alterations in respect of 21 Ullswater Crecent (relating to Purley Ambulance Station) between London Ambulance Service NHS Trust and Jones and Richards Limited.

3.2 Notice to surrender Unit L, 68 Brewery Road, London N7. Transfer between London Ambulance Service NHS Trust and Arden Estates Ltd.

## 4. Recommendation

That the Trust Board notes this report.

**Sandra Adams**
**Director of Corporate Services/Trust Secretary**
**10th August 2010**

London Ambulance Service NHS
NHS Trust

# LONDON AMBULANCE SERVICE TRUST BOARD

**31st August 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<br>☐ Senior Management Group<br>☐ Quality Committee<br>☐ Audit Committee<br>☐ Clinical Quality Safety and Effectiveness Group<br>☐ Risk Compliance and Assurance Group<br>☐ 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**<br>To note the Trust Board forward planner for the coming year and to identify any areas for discussion for future agenda items. | |
| **Attachments**<br>Trust Board forward planner. | |

**********

**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 |
|---|---|---|---|---|---|---|---|
| **28 Sept 2010 TB** | CommandPoint Update (PS) | Being Open Policy (MD) | 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 |
| | Response to Six Lives report (Daryl Mohammed) | | Surge and Winter Pressure Planning Assurance (LB) | Patient Experience Report (GB) | | | |
| *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 | | |
| | | | | SFIs for approval | | | |
| | SIP Update | | | FT constitution for approval | Report from Trust Secretary | | |
| **2nd November 2010 SRP awayday - all day** | External Communications plan and stakeholder analysis (AP) | | Cat A and B Trajectory | | | Martin Flaherty | 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* | Presentation on Cycle Response Unit (RW and Tom Lynch) | | | | 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 possibly attending court | |
| *SMG 8th* | CommandPoint Update (PS) | | | | Report from Finance Director | | |
| | | | | | Report from sub-committees | | |
| | | | | | Clincal Quality and Patient Safety Report | | |

# TB FORWARD PLANNER

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | SIP Update | | | | Report from Trust Secretary | | |
| | | **Presentations** | | | | | |
| | | **Approval** | **FT items** | | | | |
| | | **Compliance** | | | | | |
| January 2011 | Formal IBP and LTFM sign off pre-submission | | | | | | |
| February 2011 | Approve FT application | | | | | | |
| March 2011 | | | | Risk management policy and strategy review<br>Governance structure review | | | |