London Ambulance Service NHS Trust

TRUST BOARD

Meeting to be held at 10.00am on Tuesday 28th September 2010
Conference Room, LAS Headquarters, 220 Waterloo Road, London SE1 8SD

Peter Bradley
Chief Executive Officer

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AGENDA

			TAB
1.	**Welcome and apologies for absence** Richard Webber		
2.	**Minutes of the Part I meeting held on 31st August 2010** To approve the minutes of the meeting held on 31st August 2010		TAB 1
3.	**Matters arising** 3.1 Actions from previous meetings	All	TAB 2
4.	**Report from sub-committees** To receive a report from the following committees:		
	4.1 Charitable Funds Committee meeting on 31st August 2010	CS	Oral
	4.2 Quality Committee meeting on 7th September 2010	BM	Oral
	4.3 Audit Committee meeting on 13th September 2010	CS	Oral
5.	**Chairman's Report** To receive a report from the Trust Chairman on key activities	RH	Oral
6.	**Update from executive directors** To receive reports from Executive Directors on key matters		
	6.1 Chief Executive Officer including balanced scorecard	PB	TAB 3
	6.2 Finance Director including Cost Improvement Plan	MD	TAB 4
7.	**Clinical quality and patient safety report** To receive the monthly report on clinical quality and patient safety	FM	TAB 5
	STRATEGIC AND BUSINESS PLANNING		
8.	**Winter Surge Planning Framework 2010/11** To approve the Winter Surge Planning Framework 2010/11	LB	TAB 6
9.	**Update on 7/7 Action Plan** To provide the Trust Board with assurance surrounding ongoing preparedness for Major Incidents and the lessons identified from the 7/7 London Bombings	JK	TAB 7

10.	**Response to the White Paper: Equity and Excellence: Liberating the NHS** To discuss the formal response from the LAS to the White Paper	PB	Oral
11.	**CommandPoint Update** To provide the Trust Board with an update on the current status of the CommandPoint Project, and to seek approval for the actual transition date	PS	TAB 8

FOUNDATION TRUST PROCESS

12.	**Integrated Business Plan and Long Term Financial Model** To approve the draft Integrated Business Plan and Long Term Financial Model	SA/ MD	TAB 9
13.	**Governance rationale and membership strategy** 13.1 To consider and approve the governance rationale that underpins the constitution for the London Ambulance Service NHS Foundation Trust 13.2 To approve the updated membership strategy that supports the governance rationale and the Integrated Business Plan	SA	TAB 10

GOVERNANCE

14.	**Annual Trust Board Effectiveness Review** To consider the findings of the 2009/10 Trust Board Effectiveness Review	SA	TAB 11
15.	**Audit Committee Annual Report** To note the Audit Committee Annual Report for 2009/10	CS	TAB 12
16.	**Being Open Policy** To approve the Being Open Policy	SA	TAB 13
17.	**Standing Financial Instructions** To approve the revised Standing Financial Instructions	SA	TAB 14
18.	**Forward Planner** To review the Trust Board forward planner and agree items for future meetings	SA	TAB 15
19.	**Questions from members of the public**		
20.	**Any Other Business**		
21.	**Date of next meeting** **The next public Trust Board meeting will be held on Tuesday 30th November 2010 at 10.00am.** *The Trust Board of Directors will hold a Strategy Review and Planning on Tuesday 2nd November 2010, all-day awayday (this is not a public meeting)*		

LONDON AMBULANCE SERVICE NHS TRUST

TRUST BOARD MEETING
Part I

Minutes of the meeting held on Tuesday 31st August 2010 at 10:00 a.m.
in the Conference Room, LAS HQ, 220 Waterloo Road, London SE1 8SD

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Present:	
Richard Hunt	Chair
Peter Bradley	Chief Executive Officer
Mike Dinan	Director of Finance
Roy Griffins	Non-Executive Director
Caron Hitchen	Director of Human Resources and Organisation Development
Brian Huckett	Non-Executive Director
Beryl Magrath	Non-Executive Director
Fionna Moore	Medical Director
Caroline Silver	Non-Executive Director
Sarah Waller	Non-Executive Director
Nigel Walmsley	Non-Executive Director
In Attendance:	
Sandra Adams	Director of Corporate Services
Lizzy Bovill	Deputy Director of Strategic Development
Fiona Carleton	Assistant Director of Operations
Jessica Cecil	Associate Non-Executive Director
Maria Faroque	Senior Financial Analyst
Francesca Guy	Committee Secretary (minutes)
Erin Heinrich	Foundation Trust Project Manager
Angie Patton	Head of Communications
Khaled Kassem-Toufic	Head of Business Development
Richard Webber	Director of Operations
Members of the Public:	
Joseph Healy	Chair of Patients Forum
Neil Kennett-Brown	North West London Commissioning Partnership

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95/10. Welcome and Apologies **Action**

Apologies had been received from Peter Suter and Martin Flaherty.

96/10. Minutes of the Part I meeting held on 29th June 2010

The minutes of the meeting held on 29th June 2010 were agreed.

97/10. Matters Arising

The following matters arising were considered:

54/10: Caron Hitchen reported that the salary costs for work-related injuries amounted to approximately £225,000 last year. Caron Hitchen was undertaking a wider review to gather more comprehensive data. The Chair commented that it would be useful to add this to a broader discussion about Health and Safety at a future Trust Board meeting. **CH**

72/10: Caron Hitchen reported that she was in the process of finalising the budget for the Wellbeing Strategy and would circulate it to the Trust Board by email. **CH**

86/10: Mike Dinan confirmed that the lease for the reprovision of Purley Ambulance Station was fully-repairing.

The Chair asked that the Trust Board be provided with an age profile of the fleet and that this be added to the action schedule. **MD**

98/10. Formal Reports from the sub-committees

Beryl Magrath provided an update on the key discussion points of the Quality Committee meeting held on 26th July 2010 and noted the following:

- An update on the development of a new LAS clinical indicators dashboard would be given to the Committee at its next meeting. The dashboard would measure performance in the areas of patient safety, clinical outcomes and patient experience;
- The Committee noted that a new Director of Health Promotion and Quality, Steve Lennox, had been appointed. Steve would have overall responsibility for infection control and would be a member of the Quality Committee;
- The Committee received updates from the Risk Compliance and Assurance Group (RCAG) and the Clinical Quality, Safety and Effectiveness Committee (CQSE). The CQSE was considering setting up longitudinal patient outcome audits initially at one NWOW site and one other site;
- The Committee received an integrated audit programme which included clinical audit, governance/compliance audits and internal (RSM Tenon) audits for 2010/11. These audits had been mapped to the strategic goals and the strategic risks. The Committee made suggestions for additional areas of focus for local review and audit, namely Make Ready cleanliness, RTCs, Cat B and stroke and trauma PRFs;
- The Committee agreed that the Trust should be assessed at level 1 by the NHSLA in October 2010 with a view to preparing for level 2 assessment next year;
- The Committee received a detailed presentation on all training activities within the Trust. The Committee noting that training arrangements had improved considerably with the advent of practising student paramedics and the introduction of new rotas. A further update would be given in a year's time;
- The Committee also received a presentation on medicines management and noted the considerable progress that had been made over the last six months.

In response to a question from the Chair, Beryl Magrath responded that on the whole the meeting had gone well, but that the Committee now needed to develop a work plan for the year and to focus on areas in detail.

99/10. Chairman's Report

The Chair reported the following:

- The Chair had attended an ambulance service network meeting in July 2010 and had discussed the white paper and its implications for ambulance services;
- Regular meetings with Northrop Grumman had been held to ensure that the relationship was maintained. The Chair had also visited the team at the Southwark Bridge road site;
- LAS had received a visit from the Ambulance Service in Paris;
- The Chair had attended a Patients' Forum meeting;

- The Chair had participated in a ride-out in Isleworth and would continue to do ride-outs on a regular basis;
- Interviews for the Director of Health Promotion and Quality had taken place and Steve Lennox had been appointed and would be joining the Trust on 20th September;
- The appointment of Jessica Cecil as non-executive director had been confirmed by the Appointments Commission. Jessica would replace Sarah Waller at the end of her tenure in November 2010.

100/10. Update from Executive Directors

Chief Executive Officer

Peter Bradley noted the following points:

- A meeting was held with commissioners regarding the introduction of the 111 non-emergency contact number. Paul Woodrow had been seconded to NHS London to work on the implementation of the 111 number for London;
- Performance was good with 94% for Category B for August which was a big improvement on last year. The challenge was to maintain the trajectory throughout September;
- Reducing hospital handover times remained behind target levels. A hospital summit had been held last week;
- A successful Fall Back Control test had been undertaken;
- Five new sites had been selected for the next phase of NWOW and the initial two complexes have now embedded NWOW as normal practice;
- A second and extended pilot of the Clinical Response Model would be undertaken in Barnehurst;
- Preparation for the London Bombings inquest continued;
- The Trust would be making a response to the White Paper and in particular issues relating to the commissioning of ambulance services and outcomes. A draft would be presented to the Trust Board in September;
- Consultation meetings would be starting on 1st September and unannounced rideouts would be undertaken; **PB**
- The Category B trial had been approved by ECPAG and was now awaiting ministers' approval. If approved, it would be implemented across England.

The Chair noted that July 2010 had been the busiest month for the Trust on record and that the performance improvement should be recognised in light of this context.

With regards to the South London PTS contract, Peter Bradley reported that the Trust was working closely with both staff and their union representatives on TUPE provisions with a view to ensuring continuity of service for patients.

The Chair commented that the Trust Board would like to have a highlight report on any issues regarding the Cost Improvement Plan at the next meeting. **MD**

A discussion followed about the Clinical Response Model. Beryl Magrath asked whether any other ambulance service had introduced this type of model and whether it would be trialled in other complexes. Peter Bradley responded that South Central Ambulance Service currently successfully operated in this way and there was no reason why it should not be successful in London as long as clinical support was improved.

Beryl Magrath noted that sickness levels had increased. Caron Hitchen responded that

sickness absence was slightly higher than last year, but was manageable.

Beryl Magrath commented that it would be useful to have data on patients left at home as well as those who were conveyed to non-A&E providers.

Joseph Healy reported that the Patients' Forum had raised concerns regarding the transfer of PTS to Savoy in south London and had suggested that if the local community were involved in commissioning for PTS, it was likely that LAS would win more contracts. Caron Hitchen added that industrial action had been suspended pending future discussions about the contract. The transfer date had been delayed to 1st October 2010.

Director of Finance

Mike Dinan reported the following:

- The in month position for the Trust was a £375k surplus against a planned surplus of £134k;
- CBRN and HART income had now been received and therefore the status of these risks had moved to green;
- The Cost Improvement Plan was behind on agency cost and non-frontline payroll. The CIP would become the QIPP and future reports would reflect this.

Nigel Walmsley asked whether the impairment line could change by the end of the year due to the planned vehicle remount.

The Chair noted that overall the Trust was on track, but the next few months could prove challenging.

101/10. Clinical Quality and Patient Safety Report

Fionna Moore reported the following:

- The Cardiac Arrest annual report for 2009/10 had been published. LAS survival rates for cardiac arrests according to the Utstein template had reached approximately 21.5% and the overall rate was 8%. This represented a significant increase on last year's results;
- ROSC rates were higher at South East Coast Ambulance Service. The LAS would be looking to introduce best practice ways of working;
- Following clinical audit into paediatric care it was proposed that all under 2s be conveyed to hospital. This policy was in line with other ambulance services. Children between the ages of 2 and 5 years who were left at home would have to be referred to a GP within a week;
- LAS had been asked to complete a further safeguarding declaration by the Commissioners. These declarations only refer to safeguarding activity for children. Safeguarding referrals were currently being reviewed by borough to identify any trends;
- Two controlled drugs incidents had occurred since the last Trust Board meeting. The first was the loss of one ampoule of morphine into which an extensive investigation had been undertaken. The second involved a break in at Silvertown Ambulance Station during which an attempt was made to access the controlled drugs safe. This attempt was unsuccessful and had been reported to the Metropolitan Police Controlled Drugs Liaison Officer and the NHS Local Counter Fraud Specialist;
- All paramedics were being issued with a personal pouch in which to keep

morphine;
- The Trust was exploring the possibility of introducing IV paracetamol. This would be trialled in the west area;
- The Trust was exploring options to better differentiate IV glucose and saline to reduce the possibility of errors in administration.

Beryl Magrath asked whether the Trust received any feedback about whether safeguarding referrals were appropriate. Fionna Moore responded that this was difficult as the Trust did not routinely receive feedback.

Sarah Waller asked whether the increase in CPI completion rates had led to any changes in staff behaviour. Fionna Moore responded that staff would receive feedback on performance.

The Chair thanked Fionna for her report and asked that safeguarding be emphasised in future reports.

102/10. <u>Integrated Business Plan and Foundation Trust Application Timeline</u>

Sandra Adams reported that, as requested at the last Strategy Review and Planning meeting, the Trust Board had been provided with storyboards on the IBP. Full copies of the latest version of the IBP would be available on request. Sandra explained that the 8 storyboards summarised individual chapters of the IBP to provide key messages and emphasis. The enabling strategies now needed to be cross-checked with the SIP to ensure there was alignment.

The Chair commented that he found the storyboards to be a helpful way of presenting the information contained within the IBP and asked that the number of locations be added. **SA/EH**

Peter Bradley noted that the long term financial model was a key component of the IBP and that it was still in the process of being developed. It was intended that the long term financial model would be presented to the Trust Board in September for approval. **MD**

A query was raised about the planned changes to the control room and the implementation of e-PRF and whether this was likely to be achieved given the current financial context. Mike Dinan responded that these were necessary developments, but more work might need to be done on how it was resourced. Caroline Silver commented that if a short-term solution for the control rooms was being explored, this needed to be included in the IBP.

A discussion followed about the Clinical Response Model and whether this would be achievable within the timescales. Caron Hitchen responded that an extended three month trial would be conducted and would evaluate a range of impacts. Peter Bradley commented that currently staff were not being utilised to best effect and that the Clinical Response Model was an important part of improving efficiency. However, the Trust needed to ensure clinical safety and improve clinical support.

Caroline Silver asked whether the strategy as outlined in the IBP was aspirational or whether it was something the Trust could realistically achieve. Nigel Walmsley asked whether it was possible to indicate how many of the storyboards would be realistically be achieved and how many were aspirational/optional.

Jessica Cecil asked about the governance framework in the context of the fast moving environment. Peter Bradley responded that it was recognised that the content of the IBP would evolve over time and might change within the next six months.

Sarah Waller noted that the documentation made reference to the possibility of being subsumed by another Foundation Trust and asked whether the Board had given due consideration to this possibility. The Chair responded that the Trust aimed to become a Foundation Trust in its own right and therefore the terminology should reflect this. **SA**

Sandra Adams agreed to circulate the updated versions of the storyboards to the Trust Board members. **SA**

The Trust Board approved the draft IBP subject to the changes to be made to the storyboards.

The Trust Board was asked to identify no more than three significant risks which might impact on the LAS becoming a Foundation Trust. These were agreed as:

- Category B performance
- PCT Funding
- Impact of CSR this year.

Sandra Adams and Peter Bradley would respond to the SHA letter by 17th September 2010. **PB/SA**

103/10. Historical Due Diligence

Sandra Adams reported that Grant Thornton was now unable to conduct the interviews in the week commencing 4th October and were instead available for interviews from 7th October. It was also likely that the planned meeting for 21st October would need to be rearranged. There was a general concern raised about Trust Board members' availability to attend interviews and asked that the interview dates be confirmed as possible. It was suggested that the option of telephone interviews should also be explored. **SA**

Sandra Adams added that the paper provided to the Trust Board gave a briefing on the information that would be required for the interviews.

104/10. Commissioning and the London Ambulance Service Going Forward

Neil Kennett-Brown gave a presentation on the current commissioning arrangements for London, the specific challenges for urgent and emergency care and the commissioning priorities for 2010/11. Neil Kennett-Brown supported the work that had been undertaken to develop the IBP and appreciated the difficulties in developing a strategy in a shifting policy context.

Beryl Magrath noted the emphasis on a whole system approach and therefore the increasing importance on communications. Neil Kennett-Brown responded that opportunities to better link ambulance services with GPs needed to be further explored. There followed a discussion about what impact the introduction of the 111 number would have.

Neil Kennett-Brown noted that the size of the GP consortia could lead to fragmentation and would be reliant on relationships. There would be a lead commissioning role which would commission pan-London services based on the top 10 priorities across London.

105/10. Service Improvement Programme

Sandra Adams noted that the Board had been provided with a summarised update on the

Service Improvement Programme. There were a small number of activities at red and amber, which would be recovered. Sandra Adams also brought the board members' attention to the number of blue flags which indicated that project aims had been met and that projects were moving to business as usual and the benefits realisation stage.

Sarah Waller asked what the status was for the 2012 Olympic and Paralympic funding. Mike Dinan responded that this continued to be a risk and that the budget was not currently ringfenced.

Beryl Magrath noted that union representatives in the west area were objecting to a 3am finish for shifts. Caron Hitchen responded that this was being worked through locally and if no resolution could be found it would be brought to the joint secretaries. Richard Webber added that the issue largely centred around one complex in the west.

The Chair requested that the Trust Board receive a half-yearly update on the Service Improvement Programme. **SA/FG**

106/10. Board Committee Terms of Reference for approval

Sandra Adams reported that these were the final board committee terms of reference which required board approval before they could be added to the Standing Orders.

The Trust Board approved the terms of reference for the Remuneration Committee, the Strategy Review and Planning Group and the Charitable Funds Committee.

107/10. Report from the Trust Secretary

Sandra Adams asked the Board to note the receipt of two tenders and the two entries to the register for the Use of the Trust Seal since May 2010.

108/10. Forward Planner

The Trust Board confirmed that they found it useful for the forward planner to be circulated on a regular basis.

Sandra Adams noted that there were several items which had arisen from this meeting to be added to the forward planner:

- Cost Improvement Plan update (September);
- Response to white paper (September);
- Safeguarding (September)
- Foundation Trust consultation and membership strategy;
- Health and Safety and work-related injuries (November).

109/10. Questions from members of the public

There were no questions from members of the public.

110/10 Any other business

There were no items of other business.

111/10. Date of next meeting

Tuesday 28th September 2010.

The Chair noted that it had been standard practice to hold a pre-meeting with non-executive directors at 9.00. The Chair proposed that Trust Board meetings commence at 9.30/10.00 with the intention of finishing at 13.00/13.30, unless a whole day was required.

It was agreed that the Trust Board meetings for 2011 would also follow this timing and additional time in the afternoon would be arranged as required. It was noted that increasingly more time would need to be devoted to the foundation trust application process.

It was agreed that an update on the Clinical Response Model would be provided to the Trust Board at their away day on 1st November 2010.

ACTIONS
from the Meeting of the Trust Board of Directors of
LONDON AMBULANCE SERVICE NHS TRUST
held on 31st August 2010

Meeting Date	Minute Date	Action Details	Responsibility	Progress and outcome
20/09/09	**101/09**	**LAS Foundation Trust Membership Strategy** 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** 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** 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. 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** 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**	**It was agreed that this should be discussed as part of a wider discussion on Health and Safety which was on the forward planner for 30th November 2010**
25/05/10	**72/10**	**Wellbeing Strategy** 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**	**Caron Hitchen reported that she was in the process of finalising the budget and would circulate it to the Trust Board by email**

31/08/10	**97/10**	**Matters Arising** The Chair asked that the Trust Board be provided with an age profile of the fleet.	**MD**	
31/08/10	**100/10**	**Update from Chief Executive Officer** Draft LAS response to the White Paper to be presented to the Trust Board in September.	**PB**	**On the agenda for the Trust Board meeting on 28th September 2010**
31/08/10	**100/10**	**Update from Chief Executive Officer** The Chair requested that the Trust Board receive a highlight report on any issues regarding the Cost Improvement Plan at the next Trust Board meeting	**MD**	**Included within the Update from the Director of Finance**
31/08/10	**102/10**	**Integrated Business plan and Foundation Trust Application Timeline** Number of Trust sites/locations to be added to the IBP storyboards	**SA/EH**	
31/08/10	**102/10**	**Integrated Business plan and Foundation Trust Application Timeline** Long Term Financial Model to be presented to the Trust Board meeting in September for approval	**MD**	**On the agenda for the Trust Board meeting on 28th September 2010**
31/08/10	**102/10**	**Integrated Business plan and Foundation Trust Application Timeline** Terminology to reflect the fact that LAS aimed to become a Foundation Trust in its own right. Sandra Adams agreed to circulate the updated versions of the storyboards to the Trust Board members.	**SA**	**Complete**
31/08/10	**102/10**	**Integrated Business plan and Foundation Trust Application Timeline** Sandra Adams and Peter Bradley would respond to the letter from the SHA by 17th September 2010	**SA/PB**	**Complete**
31/08/10	**103/10**	**Historical Due Diligence** Interviews to be arranged asap with the possibility of telephone interviews also to be explored.	**SA**	**The majority of interviews have been arranged**
31/08/10	**105/10**	**Service Improvement Programme** The Chair requested that the Trust Board receive a half-yearly update on the Service Improvement Programme.	**SA/FG**	**Added to forward planner for 30th November 2010**

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

31 AUGUST 2010

PAPER FOR NOTING

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

Executive Summary

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

- Areas of risk within the 2010/11 contract remain LAS performance against CAT B and patient handover to green time
- LAS is working closely with NHSL & NHSD on developing the 111 single point of access
- Progress has been made in the review of the balanced scorecard. A work in progress document has been attached to this report. The review of the balanced scorecard will be complete by mid-October 2010
- Strong performance was delivered through August despite increased demand
- September performance is more challenged
- Control Services staff are being consulted regarding the reintegration of UOC staff into EOC
- V12.1 AMPDS was introduced on 2 Sept. A loading error led to 10 calls being misclassified.
- Staffing in August on DCAs was 12% up on last year and the overtime spend decreased c17% assisted by the posting of new Student Paramedics
- Following the HSE visit the Trust has delivered in excess of 3000 hours of training
- Extensive planning activity has been undertaken in readiness for the Papal visit. LAS coordinates the national ambulance service response in relation to the medical contribution to the security and protection arrangements
- NHSL, Commissioners and LAS staff continue to work to resolve handover delays
- Fleet support is showing improvement with extended workshop hours.
- The Make Ready contract is going out to tender this month via OJEU
- PTS are active in various contract submissions
- Various issues regarding the SWLH contract are still being worked through
- Recruitment and deployment of front line staff is on plan and EOC recruitment is complete

- Sickness levels in July are showing a slight increase and staff turnover is stable
- Detailed tables and graphs are presented including revised presentation of adverse incident reporting
- The Trust is on track to meet the 13 key training commitments published in January 2010
- NWOW is being introduced at 5 more complexes
- Planning for the implementation of a full evaluation of the new Clinical Response Model (CRM) is progressing with the evaluation planned to be conducted at Barnehurst complex followed by Greenwich and Bromley.
- A revised H&S policy statement & consultative process comes into effect in the Autumn
- Further work on H&S related issues are detailed
- The trust's excellent cardiac arrest survival figures have received positive media coverage
- The Cycle Response Unit's 10 year anniversary was featured in the Evening Standard
- LBC radio ran special reports on violence in London and our increased workload
- Ambulance News and the Annual Review have been circulated to FT members & key stakeholders
- A variety of Public education & PPI activity is detailed

Attachments
Chief Executive's Report
Balanced Scorecard
Information Pack for Trust Board

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

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

Risk Implications
This paper links to the following strategic risks:

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

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

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

Equality Impact Assessment
Has an Equality Impact Assessment been carried out?
☐ Yes
☒ No
Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST
TRUST BOARD MEETING 28 SEPTEMBER 2010
CHIEF EXECUTIVE'S REPORT

1. COMMISSIONING AND BUSINESS DEVELOPMENT

Areas of risk within the 2010/11 contract remain LAS response time performance against the Category B target and patient handover to green time. Monthly contract performance and service development meetings continue with our lead commissioners from the North West London sector. Currently conversations with the commissioners are focused on developing the appropriate care pathways work, the implementation of the capacity management system tool and the FT application.

LAS have seconded Paul Woodrow, Assistant Director, to the 111 team at NHS London for a 3 month period to support them with the development of the 111 Business case. In addition, we continue to work closely with NHS Direct and NHS London on how this could be delivered across London. This will include the development and utilisation of local single points of access for urgent care services across the capital.

2. BALANCED SCORECARD

Attached is a report presenting progress to date in respect of the Corporate Objectives. The monthly balanced scorecard has expanded reflecting the work undertaken in respect of the five year SMART targets included within the Integrated Business Plan. This is a work in progress that will be completed by mid October 2010.

Key:
Corporate objectives overview – supporting indicators associated with individual corporate objectives.
Act – is the actual for August
Plan – is the target set for the month
RAG – is the allocated manager's forecast for year end
Ind – indicates whether the target has been achieved – red means no, green yes. Direction of arrow indicates trend (this month compared to previous month)

Colleagues are asked to provide explanatory commentary when the target has not been achieved. This has not been fully complied with for August but steps will be taken to ensure that this is undertaken for the next report.

Where the **Ind is shown as** ▷ ? this indicates that data has not been obtained as yet; work is in hand to ensure, where possible, this is achieved by mid October. There are some areas e.g. "% of NWOW staff attending NWOW training" where due to 5/7 NWOW complexes needing to finalise the diagnostic stage, thereby ascertaining complexes' individual training needs, it has not yet been possible to set trajectory target. This will be done once the final training plan has been written.

There are a number of supporting indicators currently shown on the report which cannot be meaningful measured on a monthly basis e.g. the three elements of the corporate objective 6; progress reports will be provided via the outcome indicator report which will be presented at the next meeting of the Trust Board. They appear on the current version of the report for information only.

If members of the Trust Board wish to be given access to the Performance Accelerator (the web based portal) that is being used by the Trust to track progress this can be arranged along with a short introductory session.

3. SERVICE DELIVERY

Accident & Emergency service performance and activity

The table below sets out the A&E performance against the key standards for this financial year (2010/11), the complete validated performance for July, the un-validated performance for August and the first 16 days of September.

	CAT A8	**CAT A19**	**CAT B19**	**CAT C60**
Standard	**75%**	**95%**	**95%**	**90%**
2010/11 yr to date	76.3%	99.4%	92.3%	92.0%
July	76.3%	99.5%	92.7%	92.0%
August	78%*	99.5%*	94.0%*	92.6%*
September (to 16th)	74.0%*	99.1%*	92.0%*	89.4%*

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

It is pleasing to be able to report that both Category A and Category B performance for the year to date are the strongest they have been at this point in the year for many years. Category A performance YTD is above the national commissioned standard whilst Category B performance YTD is 7% above the same position last year demonstrating a significant improvement in delivery against this target. Whilst being marginally behind the trajectory agreed with commissioners in recent months substantial improvement has been made against this target. Category C performance remains strong and in excess of 90% across the period.

Demand on the LAS has continued to remain above the predicted growth level of 3.5% rising by 5.5% YTD against the same period last year. The overall demand increase during August was 6.5% against August 2009 seeing a demand rise in all categories of call. Category A demand was up an average of 47 calls per day during August with a marginal in month increase in Category B demand. Category C workload saw the largest rise with an average of 118 more calls per day as compared to August last year – a rise of 20%.

Ambulance utilisation in July and August remained above the target of 55% at 72%. Utilisation of FRUs fell slightly to 42% in July. Utilisation for August and September are on track for similar month end results.

Emergency call answering within 5 seconds was 94.7% for August – almost back to June's level of 94.8%. This is markedly better than the 92.9% achieved in July. This arises from renewed focus on call taking performance, assisted by a new management information report which allows the call taking managers to view variations within 15 minute periods and account for below service level performance.

Compliance against the quality assurance process in call taking for August sat at 96.21% against the 95% target.

A key focus for Control Services has been the consultation around the reintegration of UOC staff into EOC. This work has had to start now in order that the new process is embedded and in situ prior to CommandPoint training in January. The first phase will be the relocation of staff into EOC, with a second phase seeing the full integration of all sector resources. At the same time, work and focus has been placed upon aligning and reconfiguring EOC working processes in order to support the Clinical Response Model trial.

A new version of MPDS (v12.1) was introduced to the Trust on 2nd September. An error occurred whilst loading of the new data tables and this lead to a small number of emergency calls being wrongly categorised as green calls instead of amber calls. This error was identified swiftly and corrected. Each call was reviewed to identify any potential delays. Of the ten calls involved, only one call received a response outside of the Category B response time. An investigation into the root cause of the coding error has commenced and will report in due course.

A total of 132,851 Ambulance Hours resourcing were produced for August this year which was 13,925 hrs more than for the same period last year. This represents a c12% increase in DCA staffing on the same period last year. FRU hours produced for August decreased by only 1.4% to 51,215hrs compared to 51,924hrs for the same period last year.

Actual overtime spend for August 2010 was 42,000 hrs. This is a decrease of circa 17% compared to the same period last year when we spent in the region of 54k hrs of planned overtime. We have put plans in place to manage a planned reduction in overtime availability from October onwards.

The continued recruitment and posting to Operations of new Student Paramedics contributed to the reduction in the need for overtime. This growth in the in post establishment also assisted with the increase in DCA production.

Over 3000 hrs of training have been completed covering various mandatory training updates stipulated following the HSE visit. This also includes some EMT4-Patient assessment training and two, one day, LUL (London Underground Ltd) trackside safety training events.

Progress continues against the implementation plan for new rosters. During September a total of 11 new rosters will go live making the total number of new rosters implemented 40 against a total of 69. Of the remaining 29 rosters to be implemented, 12 have been agreed and await an implementation date. Of the remaining 17 rosters a number are nearing completion of discussions with staff side and are on track for implementation within the coming weeks. A small number remain open for detailed discussion with staff side.

The Emergency Preparedness Department have been preparing for the State Visit of His Holiness Pope Benedict XVI taking place in mid September. A significant amount of planning time together with operational deployments have been set aside for this four day event. LAS have co-ordinated the national ambulance service response in relation to the medical contribution to the security and protection arrangements.

Preparations are underway for the Emergency Preparedness Board audit of LAS preparedness for major incidents. The audit is scheduled to take place in late

September with a report detailing findings and recommendations to be published in October.

There have been two incidents of note during the period. The first was a call to a Chlorine leak at a school swimming pool in Twickenham where a number of children were treated and taken to 3 separate hospitals. A multi-agency debrief has taken place the results of which are currently being collated. The second being a call to a chemical incident at St Thomas Hospital where the MPS conveyed several contaminated casualties. This resulted in the Emergency Department being closed for a period and a number of persons were decontaminated. A multi-agency debrief has taken place the results of which are currently being collated.

Intensive pre-planning for this year's Notting Hill Carnival concluded with the successful management of the two day event in partnership with St. John Ambulance. Over 500 LAS staff were deployed across both days of the event with in excess of 700 casualties being treated of which 117 were conveyed to local emergency departments.

Unfortunately LAS have experienced an increased number of delayed handovers at hospitals and potential SUIs during recent weeks. This has often been the result of lack of bed capacity problems rather than Emergency Department issues.

These issues have been escalated to the commissioners and the Sector Acute Commissioning Units in order to resolve them as efficiently as possible. To support this the LAS have worked with NHS London to revise the guidance regarding managing emergency department capacity management and are providing training to sectors in how LAS can work with hospitals and commissioners over the winter to ensure delays are minimised.

LAS have also been working with the LAS and Whole Systems Transformation programme to deliver a new capacity management tool across London. This will enable LAS and the whole health economy to have sight of live capacity information from all the acute sites in London. This tool is due to go live this autumn and will enable LAS to work with partners to proactively manage any capacity issues and to reduce the need for hospital redirections and closures which result in delayed patient care as well as reduced LAS performance.

The reduction of the LAS element of hospital turnaround continues to be a priority for the Trust and a specific short life working group has been established to support complexes and staff to reduce our turnaround to 15mins. This resource is in addition to local area improvement plans created following the LAS Hospital Summit held in August. Currently the hospital turnaround time is 19.5mins.

Five fleet workshops on seven day rotas continue to deliver good results in terms of reduced vehicle downtime. A sixth Workshop, Hillingdon, will now support the New Malden and Camden rota's whilst maintaining a core hours service. Five further workshops have agreed rotas and these will be activated once outstanding issues on Bank Holiday working and other allowances are clarified. In the absence of an agreement with Barnehurst Workshop, third party support will be activated to provide weekend cover.

The Fleet Support Services Project Board met in August to consider the final 4 options for the proposed West Workshop site. Sites at Park Royal, Greenford, Hounslow and Isleworth were considered. The Hounslow site narrowly scored the

highest in terms of benefit realisation. A full business case will be tabled at the Trust Board later this year.

MacNeillie's had completed a total of 30 new Mercedes ambulances by the end of August, then had a planned two week shutdown. Delivery has restarted at a rate of three per week from mid September. At the same time the LDV fleet is gradually being withdrawn as equipment is transferred to the new vehicles. A new vehicle specification for the next generation FRU car is being compiled in consultation with operational users.

Following the agreement of outline specifications for the new Make Ready contract preliminary discussions have been held with potential service providers. There has been an encouraging response from a number of major facilities management providers. A competitive dialogue process is to be used for vehicle cleaning to stimulate innovative thinking on behalf of potential suppliers. The tendering process will commence this month with the issue of an OJEU notice.

4 PATIENT TRANSPORT SERVICE

Commercial

The LAS has been invited to present for the Patient Transport Services contract with North West London Hospitals NHS Trust, on 29 September 2010. This includes services to Northwick Park and Central Middlesex Hospitals. This is part of phase 2 of the London Procurement Programme, for PTS.

We have also taken part in a presentation to the Royal Free, Hampstead NHS Trust, with regard its Amyloidosis Service. The next stage is to provide a detailed tender submission followed by further presentation.

The LAS has been successful at the Preliminary Qualifying Questionnaire (PQQ) stage for Phase 3 of the London Procurement Program. Work has now started on the tender submissions and responses are due on 3 November 2010.

A PQQ has been submitted for the tender for UCLH NHS Trust. We wait for confirmation that we are successful to proceed to the next stage.

South London Healthcare NHS PTS Contract

The transfer date was revised to 1 October 2010 following issues which arose around pension provision by the new supplier.

The LAS continues to work with all parties to ensure that the rights of staff, affected by this transfer, are protected.

A number of staff have now been successful in securing posts within other areas of the LAS and consequently will not transfer to the new supplier. To date only 36 staff will currently transfer to Savoy Venture Ltd.

The LAS is also reviewing the original contract award process with South London Healthcare and the London procurement Programme

Performance

Activity in August fell by 2,197 journeys in August to 23,062.

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

- Arrival time: 91%
- Departure time: 92%
- Time on Vehicle: 96%

5. HUMAN RESOURCES

Workforce Plan implementation

The A&E funded establishment for 2010/11 is 3433. Vacancies as at the 31 August 2010 are reported at 171 wte. Recruitment activity continues to be in accordance with the plan. 45 graduate paramedics will commence full time contracts during September; the remaining 21 in October.

In addition 60 A&E Support staff are due to commence employment between September and March 2011 giving 126 future starters in total. Taking anticipated leavers into account this would leave the Trust with approximately 130 vacancies at year end.

The last cohort of Student Paramedics will be posted to operational duties on 27 September following 2 weeks annual leave.

We have offered the opportunity to A&E Support staff with a minimum of 6 months operational experience to apply to undertake the Student Paramedic programme. Two All-in-One recruitment days are planned for 9th and 16th October, with the programmes commencing at Hannibal House on 1st and 22nd November. Each course will be able to accommodate 24 students. As these students will be experienced in ambulance work and driving we are able to shorten the initial course to 18 weeks (from 26 weeks). This means that the students will be back on operational duties by the end of the financial year. We have already put steps in place to ensure that at the beginning of the next financial year we are in a position to fill the A&E Support vacancies that these promotions will create.

Recruitment to the Emergency Operations Centre is now complete. All planned places are allocated and the final course has now commenced.

Workforce information

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

Sickness levels in July are reported at 5.22%. This is higher than June (4.65%) and higher than the same period last year (4.70%).

Year to date absence is currently shown as 5.06% against a target of 4.5%.

Although a small staff group, it is noteworthy that PTS sickness increased from 4.64% to 6.18%, which may be attributable to a level of dissatisfaction with the loss of the South London contract. HR Managers are in the process of further strengthening the monthly attendance audits with local managers to ensure a robust focus on the management of attendance is maintained. Through this process they will also identify any specific trends which may be inform future management requirements.

Staff turnover remains stable and in line with workforce planning projections at 5.65% for the year as at August 2010.

Appeals against dismissal and Employment Tribunals

Since the last Trust Board meeting, no appeals against dismissal have been heard.

Whilst no Employment Tribunal cases have been heard in this period, the Trust has attended an Employment Tribunal cost hearing and was awarded costs of c£9,000 relating to the preparation undertaken to defend a claim which was subsequently struck out. This is the third successful claim by the Trust for costs in the last 18 months totalling c£32,000.

Training and Education

The Trust is on track to meet the 13 key training commitments published in January 2010. In particular, 1185 front line staff have accessed training in Core Refresher Skills (CRS) as at 30 August 2010. This is against a plan of 1330 for the whole year.

A second day programme is being developed for delivery from November onwards. This has been slightly delayed due to changes in the Conflict Resolution Training package which have had to be made in order to achieve national approval of the programme.

Access to training will be further supported by the full implementation of rota changes incorporating training days.

In addition, the Trust continues with its:

- 3 year training programme of over 700 Student Paramedics
- conversion training of 144 Emergency Medical Technicians to Paramedic
- A&E Support training
- Call Taking and Dispatch training
- Health and Safety training for managers

Provision of the “All in One” refresher day for mandatory training of non clinical staff in health and safety, governance and risk management continues.

Application to the Trust’s Talent Management programme has now closed with the assessment process currently underway.

New Ways of Working

The LAS is now progressing its rollout plan for New Ways of Working for A&E frontline staff. Five new Complexes have now begun implementation. These are Friern Barnet, Camden (West), Islington (East), Greenwich and Bromley (South).

Recruitment is underway to the Clinical Tutor posts (two at each Complex) along with establishing the staff forums to lead on projects such as Team based Working.

Workforce transformation

Planning for the implementation of a full evaluation of the new Clinical Response Model (CRM) is progressing.

The evaluation is planned to be conducted at Barnehurst complex followed by Greenwich and Bromley.

Intense work is currently underway to ensure the dispatch model and associated technical capabilities are aligned as closely as possible to CommandPoint without putting either project at undue risk. More detail of the impact of this work on the date of commencement of CRM is expected to be available for the date of the Trust Board meeting.

Partnership working, staff engagement and joint consultative arrangements

Consultation continues via the Operational Partnership Forum on a range of issues, including the roster review, active area cover arrangements, review of the rest break agreement and A&E Support/Urgent Operations Centre with a view to reaching agreement in September 2010.

Consultation continues with staff and staff side representatives in relation to the future TUPE transfer of PTS staff in South London. This process has been extended following delay in the actual transfer of the contract of PTS services.

Health and Safety

Following formal consultation, the revised health and safety policy statement and supporting consultative arrangements have been agreed with the three Trade Unions. A new Operational Partnership Health and Safety Forum will be established specifically to deal with issues relating to operational ambulance staff, allowing the Corporate Health and Safety Group to focus on Trust-wide and strategic issues. The new structures will be launched form the Autumn.

The review of incident-reporting arrangements continue. A trial involving the scanning of incident reports to speed transmission to the Health and safety team has commenced on 3 complexes, resulting in improved reporting. A further pilot is shortly to commence involving radio or telephone reporting of incidents directly into the Emergency Operations Centre. It is hoped that this will enable almost immediate reporting of adverse incidents.

A pilot evaluation of 3 chair transporters has commenced. Staff in each of the seven sectors will have the chance to use and evaluate the chairs over a period of 28 weeks

The NHS Security Management Service has undertaken its annual audit to validate the number of physical assaults reported by staff. This has confirmed a figure of 346 for the period 1 April 2009 to 31 March 2010, down from 433 for the corresponding period in 2008/9.

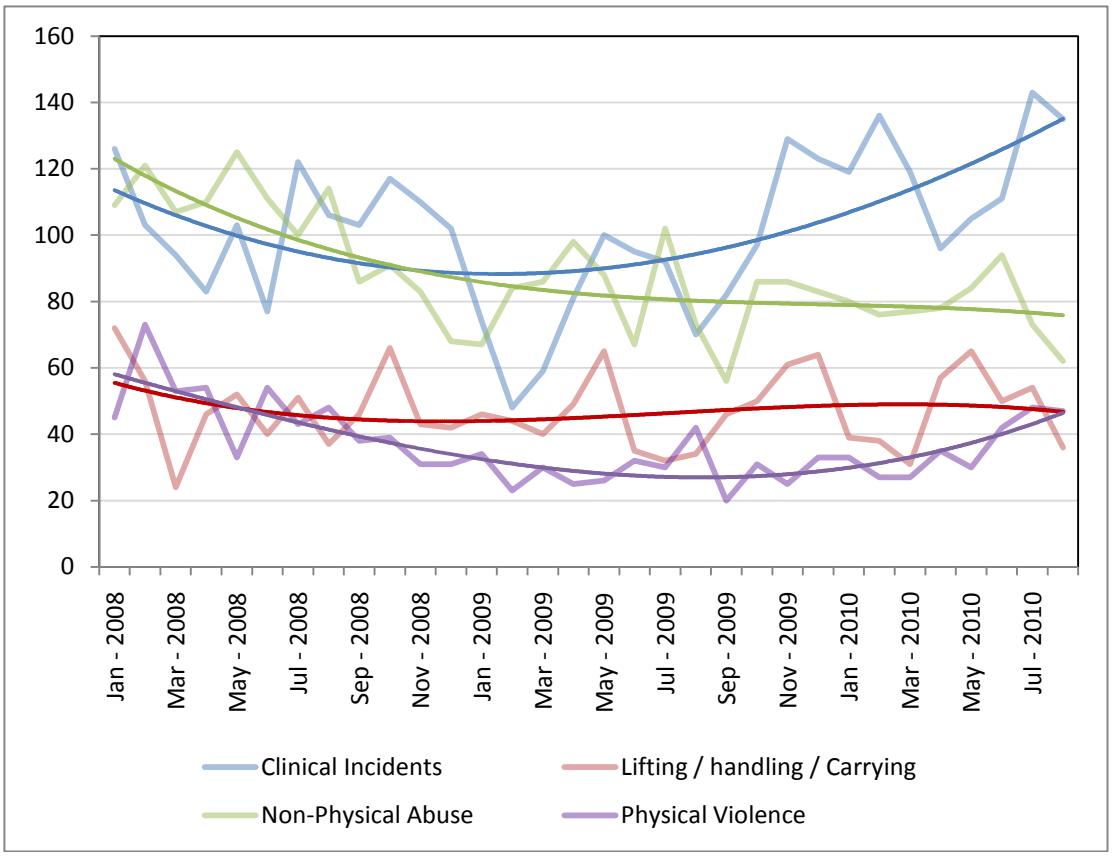
On 13 September Jason Killens and Tony Crabtree undertook a voluntary follow-up visit to meet the Health and Safety Executive (HSE) and update on progress against the inspection report and action plan. The Trust has been congratulated on its progress against the plan. A further, informal visit and ride-out has been agreed, and is likely to take place around March 2011.

The first of a regular (not less than quarterly) health and safety e-bulletin to improve information and awareness for staff has been launched, and includes a request for staff feedback and suggestions as to future topics for inclusion.

Health and Safety Key Category Incident Report

Previous reports of adverse incidents have focussed on simple numerical reporting over a rolling 12 month period of the number of reported incidents in the four categories of greatest risk in terms of volume of incidents. These are clinical incidents, lifting and handling, physical violence and non-physical abuse.

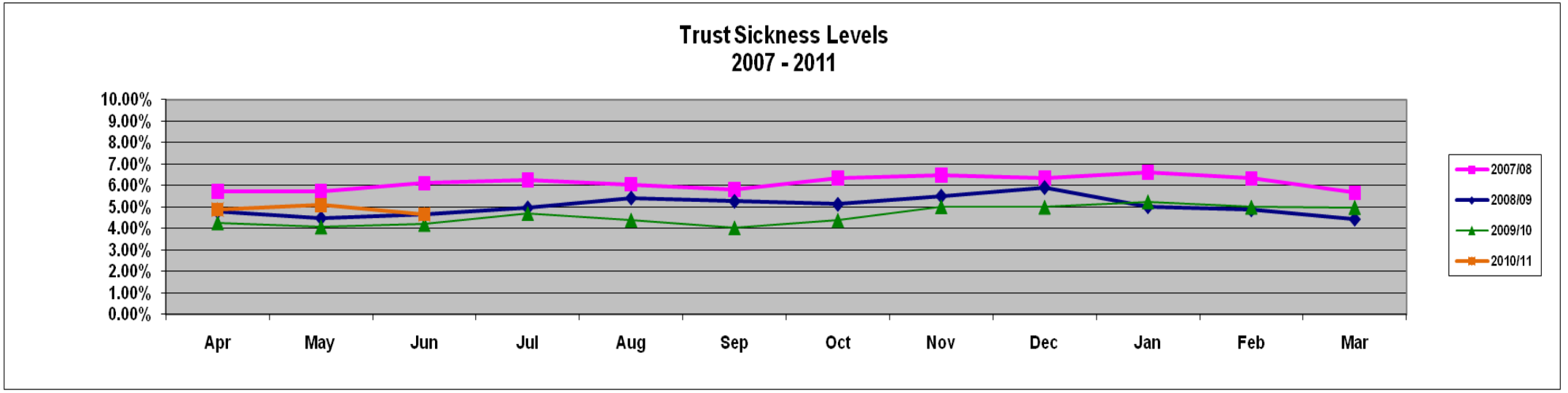
To better illustrate reporting patterns, this data is now shown below in graph format, showing number of incident report forms received monthly from January 2008.



(number of reported incidents shown as the left axis)

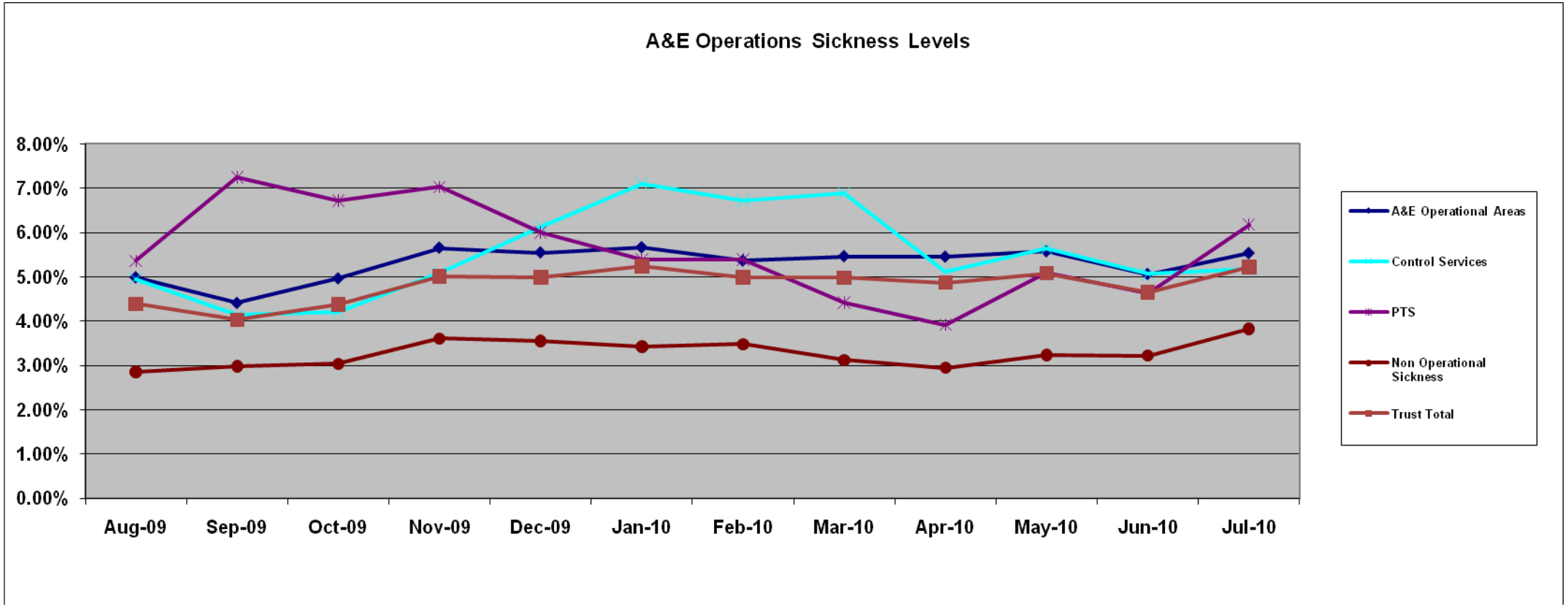
Monthly Trust Sickness Levels

Financial Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2007/08	5.73%	5.73%	6.10%	6.25%	6.05%	5.80%	6.33%	6.47%	6.34%	6.61%	6.32%	5.66%
2008/09	4.79%	4.49%	4.64%	4.96%	5.41%	5.26%	5.12%	5.50%	5.89%	5.01%	4.87%	4.44%
2009/10	4.27%	4.07%	4.19%	4.70%	4.39%	4.03%	4.38%	5.01%	4.99%	5.24%	4.99%	4.98%
2010/11	4.87%	5.08%	4.65%									



A&E Ops Sickness Levels

	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Calendar YTD	Financial YTD
A&E Operational Areas	4.98%	4.41%	4.96%	5.65%	5.55%	5.66%	5.36%	5.46%	5.45%	5.57%	5.06%	5.53%	5.31%	5.40%
Control Services	4.95%	4.14%	4.20%	5.09%	6.14%	7.10%	6.72%	6.89%	5.12%	5.64%	5.07%	5.17%	5.53%	5.25%
PTS	5.36%	7.25%	6.72%	7.03%	6.01%	5.39%	5.39%	4.42%	3.92%	5.10%	4.64%	6.18%	5.63%	4.95%
Non Operational Sickness	2.86%	2.98%	3.04%	3.61%	3.55%	3.43%	3.48%	3.12%	2.95%	3.24%	3.22%	3.83%	3.27%	3.30%
Trust Total	**4.39%**	**4.03%**	**4.38%**	**5.01%**	**4.99%**	**5.24%**	**4.99%**	**4.98%**	**4.87%**	**5.08%**	**4.65%**	**5.22%**	**4.92%**	**5.06%**



Staff Turnover

Staff Groups	Oct-08/Sep-09	Nov-08/Oct-09	Dec-08/Nov-09	Jan-09/Dec-09	Feb-09/Jan-10	Mar-09/Feb-10	Apr-09/Mar-10	May-09/Apr-10	Jun-09/May-10	Jul-09/Jun-10	Aug-09/Jul-10	Sep-09/Aug-10
A & C	9.94%	9.55%	8.70%	8.62%	9.36%	9.38%	9.28%	9.48%	8.86%	9.51%	10.14%	9.68%
A & E	4.49%	4.36%	4.28%	4.29%	4.22%	4.29%	4.61%	4.93%	5.12%	5.02%	5.28%	5.07%
CTA	4.26%	4.35%	3.92%	4.35%	3.77%	4.00%	3.57%	3.64%	3.45%	3.64%	1.79%	1.75%
EOC Watch Staff	9.30%	8.87%	8.91%	8.78%	8.70%	8.54%	8.78%	9.16%	9.48%	8.15%	7.69%	7.31%
Fleet	8.62%	3.45%	1.79%	1.72%	1.79%	5.56%	8.77%	8.62%	10.53%	10.53%	10.53%	12.07%
PTS	7.50%	6.25%	6.84%	6.47%	5.65%	6.14%	6.67%	7.59%	7.62%	7.21%	7.73%	10.29%
Resource Staff	8.33%	8.51%	7.84%	8.51%	8.00%	6.12%	3.77%	5.66%	7.84%	7.55%	7.41%	7.55%
SMP	5.15%	4.92%	4.42%	4.26%	3.37%	3.16%	2.31%	2.74%	2.29%	2.31%	2.30%	2.73%
Trust Total	**5.58%**	**5.28%**	**5.12%**	**5.09%**	**4.95%**	**4.99%**	**5.18%**	**5.54%**	**5.64%**	**5.50%**	**5.69%**	**5.65%**

A&E Establishment as at August 2010

Position Titles	Staff in post(Fte)	Funded Est.	Variance		Leavers Month	Leavers FYD
Team Leader Paramedic	182.45	194.00	11.55		0.00	3.00
ECP	63.96	74.00	10.04		1.00	2.00
Paramedic	886.19	1047.00	160.81		2.92	17.38
EMT 2-4	1080.16	956.00	-124.16		4.00	17.68
Student Paramedic 1	91.00	404.00	-71.00		0.00	12.00
Student Paramedic 2	384.00				2.00	7.00
Student Paramedic 3	222.00	300.00	77.00		0.00	0.00
Student Paramedic 4	1.00				0.00	0.00
EMT 1	20.61	328.00	23.63		0.00	0.00
A&E Support	283.76				2.00	5.31
EMD1	130.00	54.00	-76.00		1.00	7.00
EMD2	118.61	90.55	-28.06		0.00	1.00
EMD3	73.16	100.76	27.60		0.00	0.00
EMD Allocator	64.91	78.00	13.09		0.00	1.00
CTA	47.24	50.00	2.76		0.00	0.00
Total	**3649.05**	**3676.31**	**27.26**		**12.92**	**73.37**

6. COMMUNICATIONS AND ENGAGEMENT

Media

Cardiac statistics: The latest cardiac arrest survival rate (21.5 per cent) received coverage in local papers. Tower Hamlets newspapers focused on a reunion with a 27-year-old survivor from Canary Wharf (with front page coverage in The Wharf newspaper), and local Enfield newspapers covered the story of a teenage survivor accepting a public-access defibrillator on behalf of his tennis club.

Cycle response unit: The team's 10-year anniversary was covered in the Evening Standard, some local London newspapers and the ambulance trade press.

Fatal incident at a water park: A tragic incident, in which an 11-year-old girl was fatally injured at a water park in west London, generated widespread media attention including from ITV London, BBC London and the Press Association. The Service was later asked to comment on claims that the doors of the ambulance involved in this incident would not open on arrival at hospital. The inference was that the patient was stuck in the ambulance for some time, which may have had an impact on her care. This was not the case. Following a misleading BBC report, a revised statement was issued stating that although the doors of the ambulance were jammed, this did not have any impact on the patient's care or treatment, and underlining the fact that she was immediately taken out of the vehicle's side door to waiting hospital staff.

Other stories of note: A journalist from LBC radio joined a single responder for an observational shift on Friday 10 September, to highlight how violence in London increases demand on the 999 system and poses challenges to our staff. Paramedic Martin Carey took the journalist to a number of calls he was sent to, including a shooting and an assault outside a bar. On the following Monday LBC ran two special reports, one three minutes long and the second four minutes long, both reaching an estimated audience of 900,000 Londoners.

Ealing Today (local newspaper) ran a front page story about the theft of equipment from an ambulance. The Sat Nav, stab vests, and even fruit were stolen from the vehicle, which was parked up while a crew were in a nearby house treating a patient. The story also featured on the Ealing Gazette's website.

Stakeholder engagement

Ambulance News and Annual Review: The autumn edition of Ambulance News was published earlier this month and sent to foundation trust members and key stakeholders, as well as GPs surgeries across London. It included the first issue of the Annual Review, reflecting on the key issues and achievements of the 2009/10 financial year.

Staff recognition

Celebration of Service: Over 80 people attended the Celebration of Service event in early September to recognise 21 members of staff completing 20 years of service and six members of staff reaching retirement. Richard Hunt and Peter Bradley made the presentations to staff.

PPI and Public Education activity report

Public education:

- Recent public education activities have included emergency services youth engagement days, community fun days, CPR training, summer school and nursery visits, a coffee morning with mental health service users, “Be Safe” week at the London Transport Museum, a summer festival in East Ham, and a careers event.

Forthcoming events:

- Arrangements are being made to hold a series of community events in each of the Trust’s future FT constituencies, starting with Bexley and Enfield. This approach will replace the annual patient care conference.

- The PPI and Public Education Team is also working closely with the FT Team on the development of a series of Clinical Seminars for FT members.

Peter Bradley CBE
Chief Executive Officer

20 September 2010

Balanced Scorecard Corporate Objectives Overview

PI	PI Actual					
PI Target Name	PI Milestone Name	Plan	Actual	R	V	Comments
CO1. Improved outcome following STEMI						
% of STEMI patients taken to specialist cardiac centres	Jul 10	90	91	G	G	
CO1. Increase in survival rates for stroke patients						
% of appropriate patients taken to specialist centres	May 10	0	57	?	G	2010-09-08 GV: 57% of FAST positive patients were conveyed to a HASU, a further 34% of FAST positive patients were appropriately transported to the nearest A&E. Therefore, 91% of patients were conveyed to an appropriate facility.
CO1. Increase in survival rates for trauma patients						
% of appropriate patients taken to major trauma centres	Sep 10	60		?	?	-
CO1. Survival rate for out of hospital cardiac arrest						
% patients with presumed cardiac aetiology who have a return of spontaneous circulation (ROSC) sustained to hospital (LAS overall)	Jul 10	23	23	G	G	
Number of people trained by the Trust under the community responder scheme	Aug 10	40	42	G	G	CHS 09/09/10: The number of CFRs trained is now back on target and is anticipated to stay that way until the end of the calendar year at least.
Number of people trained to use defibrillators	Aug 10	160	235	G	G	CHS 09/09/10: I anticipate that the number of defib trained people will continue to remain above the target.
CO2. Increased use of appropriate care pathways						
% of complexes with new Clinical Response Model in place	Sep 10	12		?	?	-
% of falls referred to established pathway	Sep 10	100		?	?	-
% of patients referred to a community provider	Sep 10	200		?	?	-
End of Life care target - 50% processed in 72 hours	Sep 10	50		?	?	-
Patient Specific Protocols target -75% processed within 48 hrs	Sep 10	75		?	?	-
The % of total incidents resolved through CTA, NHSD and cases-not-conveyed by year-end.	Sep 10	33		?	?	-
CO3. Meet locally agreed Category C response target						
Meet locally agreed Category C (30 minute ambulance response target)	Aug 10	90	92.60	?	G	
Meet locally agreed Category C (30 minute callback) response target	Aug 10	90	97.50	?	G	
CO3. Meet the Category A (8 and 19 minutes) response time target						
% Calls answered in 5 seconds	Aug 10	95	93.60	?	R	
Achievement of Cat A (8 minutes)	Aug 10	74	77.90	G	G	

PI	PI Actual					
PI Target Name	PI Milestone Name	Plan	Actual	R	V	Comments
Achievement of Cat A (19 minutes)	Aug 10	95	99.51	G	G	
AEU mobilisation from station less than 30%	Jul 10	30	25	?	G	
Ambulance mobilisation <208sec Average	Jul 10	208	114.30	?	G	
Ambulance utilisation of 55%	Jul 10	55	71.70	?	R	
Category A activation of 45 seconds	Aug 10	45	45.50	G	R	
FRU mobilisation <134 sec Average	Aug 10	134	107	?	G	
FRU mobilisation from station less than 25%	Jul 10	25	26	?	R	
FRU utilisation of 40%	Jul 10	40	42.50	?	R	
Job cycle time (incl. hospital turnaround) 51 minutes	Aug 10	51	64	?	R	
Proportion of the year below REAP level 1 & 2 combined	Sep 10	75		?	?	-
Staffing total hours produced as per contract	Sep 10	49287		?	?	-
VOR %	Aug 10	12	11	?	G	
CO3. Meet the Category B (19 minutes) response time target						
Achievement of Cat B (19 minutes)	Aug 10	86.50	93.97	?	G	
Category B activation of 90 seconds	Sep 10	90		?	?	-
CO4. Meet Health & Safety target						
Meet Health & Safety target - H&S incidents reported within 7 days	Aug 10	35	35.93	A	G	AK 7/09/10:The scanning trial has shown positive results so far, with about 2/3 of all submitted incident forms from J3 complex being received within 7 days. If we extrapolate the improvement in figures to the entire Trust, we could expect 320 received within 7 days per month.
CO4. Meet Infection control target - Compliance on Infection Control Audit						
Compliance with guidelines as % of all	Aug 10	85	92.50	?	G	
Infection control audits as per plan - complexes to undertake infection control audit, quarterly returns will be received over the 3 month period	Aug 10	20	2	?	R	TH 2010-09-06: Low numbers of audits returned so far in Q2 - expected large increease for final month.- good response in Q1 but poor so far this month. Low numbers of audits returned Possibly due to time of year (School holidays). Reminder and mid point review sent to complexes and IPC champions
CO4. Meet patient report form completion target						
Meet patient report form completion target - % PRFs received within 7 days	Aug 10	95	99.30	?	G	

PI	PI Actual					
PI Target Name	PI Milestone Name	Plan	Actual	R	V	Comments
CO5. Increase in staff confidence levels						
% of non-operational staff receiving PDR sessions per annum	Sep 10	90		?	?	-
% of operational staff receiving PDR sessions per annum	Sep 10	40		?	?	-
% of operational staff who have a workplace performance review twice per year	Sep 10	40		?	?	-
% of operational staff who have two CPI feedback sessions per yea	Jul 10	95	102	?	G	
Complexes with NWoW in place	Sep 10	2		?	?	-
Compliance with guidelines as a % of all	Jun 10	95	94	A	R	SG 02/08/10. June 2010 compliance data shows that compliance to the CPI aspect of care has remained the same as last month, at 94%.
CPI Completed as % of plan	Jul 10	75	80	?	R	
CO5. Increase in staff skill levels						
% of NW0W staff attending NWoW training days	Sep 10			?	?	-
% of staff attending training courses against places available	Aug 10	70	68.50	G	R	GH 09/09/10 In August we dipped below 70% - seasonal, due to holidays, in addition we had planned a number of days for EMT 4 training which had to be cancelled as either no or too few people were allocated to the places by resources. We are meeting with Resources to find a solution to this in the next couple of weeks. That being said we are still achieving 70% uptake across all courses year to date.
Number of (not qualified) Student paramedics in training	Aug 10	664	704	?	R	
Proportion of annual priority training commitments delivered	Sep 10	111		?	?	-
CO6. Increase representation of staff from minority ethnic ANNUAL MEASURE						
(ANNUAL) Increased proportion of BME staff progressed	Mar 11			?	?	-
(ANNUAL) Increased proportion of BME staff recruited	Mar 11			?	?	-
(ANNUAL) Increased proportion of BME staff retained	Mar 11			?	?	-
CO7. Trust sickness levels						
Reduce sickness levels across the Trust	Jul 10	4.50	5.22	A	R	AB 09/09/10: Operational staff: Current audits of adherence to MAP indicate compliance in terms of sickness absence mngt. Review and revision of audit process being undertaken. Achievement of Trust target is reliant upon A&E figure coming down
CO7. Improve clinical leadership through NWoW implementation						
Proportion of NWoW complexes with full establishment of clinical tutors and team leaders	Sep 10	100		?	?	-

PI	PI Actual					
PI Target Name	PI Milestone Name	Plan	Actual	R	V	Comments
CO7. Lower vacancy rates to 4%						
Control Services staff vacancy %	Aug 10	3	3.97	G	R	AB 09/09/10: Control Services 20 wte above establishment. An additional 9 EMDs began their training on 23/8. No further EMD courses are planned for this financial year
Front-line staff vacancy %	Aug 10	4	4.95	G	R	AB 09/09/10: thsi equates to 170 wte of which 120 are unallocated in the establishment. A&E Support courses commencing Sept, Oct, Nov, are full (45 WTE). 66 graduate paramedics will move to full time work (as EMT3s) during Sept and Oct pending HPC registration.
Support services vacancy %	Sep 10	3		?	?	-
CO8. More efficient use of fleet						
% AEU fleet available to operations	Aug 10	88	89	G	R	
Fleet plan - merceds in fleet	Aug 10	30	30	G	G	
CO8. Reduce carbon footprint						
% of carbon reduction	Sep 10			?	?	-
CO8. Reduction in the cost base (CIP)						
CIP completed as % of plan	Sep 10			?	?	-
CIP realised (£)	Aug 10	5820	5616	?	R	
CO8. Resources ALE ANNUAL MEASURE						
ALE score of Excellent	Sep 10	50		?	?	-
CO8. Resources Estates						
% completion of Estates strategy objectives completed	Sep 10			?	?	-
Estates capital spend as % of plan	Sep 10	47		?	?	-
CO8. Resources Financial						
Capital Cost Absorption rate	Aug 10			?	?	not available yet
Capital Resource Limit (CRL)	Aug 10	16.79	16.99	?	R	
Control Surplus/ (Deficit)	Aug 10	502	526	?	R	
Cumulative Net surplus	Aug 10	-634	1848	?	G	
EBITDA %	Aug 10	6.86	7.23	?	R	

PI	PI Actual					
PI Target Name	PI Milestone Name	Plan	Actual	R	V	Comments
External Financing Limit (EFL)	Aug 10	260000	260000	?	G	
Liquidity Ratio	Aug 10	1.50		?	?	not yet available
Net Surplus/(Deficit) - after Impairments	Aug 10	502	526	?	R	
Return on Assets (RoA)	Sep 10	0.46		?	?	-
To process at least 95% of bills by value within 30 days	Aug 10	95	89	?	G	
To process at least 95% of bills by volume within 30 days	Apr 10	95	84	?	G	
CO8. Resources IM&T						
C9.1 Target availability CTAK core functionality	Aug 10	99.80	99.93	G	G	IBM IDS failure on 24/8 duration .53 hours
C9.2 Target availability CAD environment as a whole	Aug 10	99	99.41	G	G	
CAD System availability (unplanned downtime)	Sep 10	99.80		?	?	-
CommandPoint - CAD 2010 Milestones - % Complete	Aug 10	42	42	?	G	

Legend

RAG Status - Owner Generated

 Red RAG Status represents a high level of concern

 Amber RAG Status represents a possible issue for concern

 Green RAG Status represents on track

 RAG Status Not Set

PI Variance - System Generated

 Red Variance Indicator

 Amber Variance Indicator

 Green Variance Indicator

 Variance Not Set

London Ambulance Service
NHS Trust

Information Pack for Trust Board

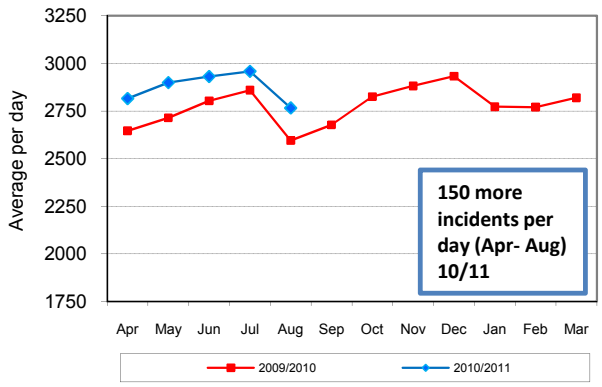
August 10

**Please be aware we are still catching up on PRFs and we have no Hospital Data for August yet (would not be meaningful as limited info)
Utilisation Data is only based on first 10 days of Aug
**Also LAS hours compliant to ORH still awaiting new version

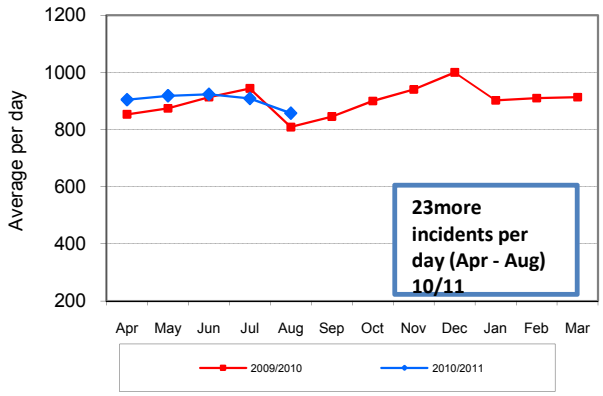
No EBS data available this month

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

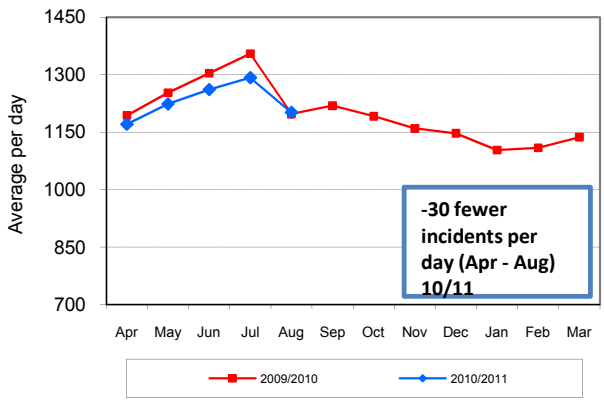
Graph 1
Average number of Cat A, B & C incidents per day



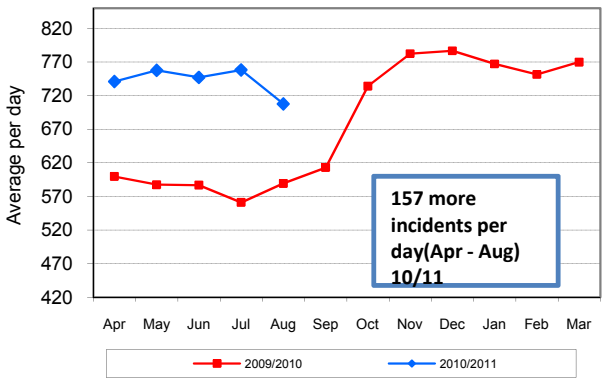
Graph 2
Average number of Cat A incidents per day



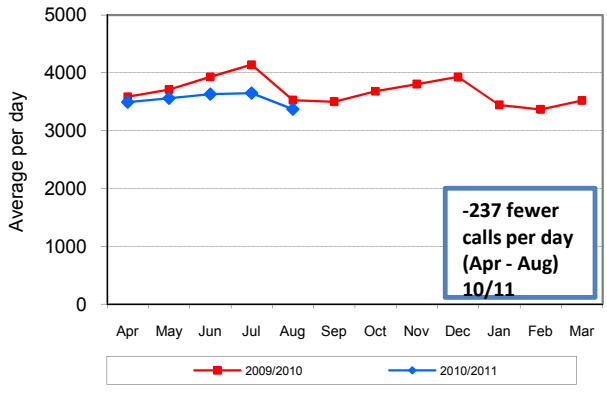
Graph 3
Average number of Cat B incidents per day



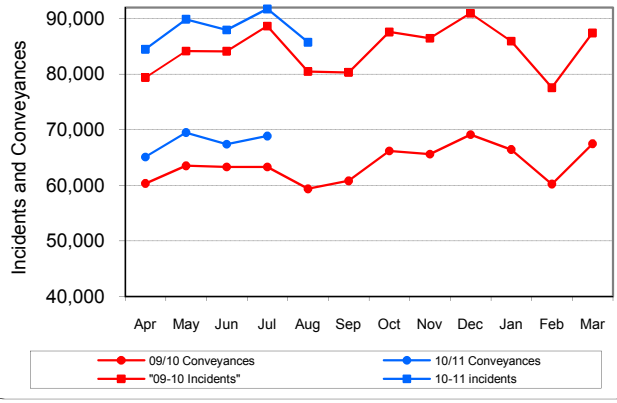
Graph 4
Average number of Cat C incidents per day



Graph 5
Average number of 999 calls received per day

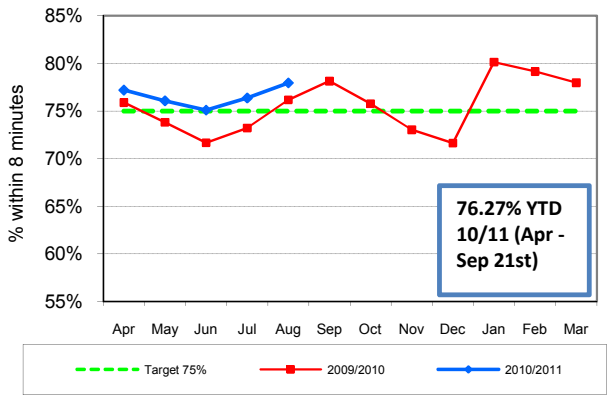


Graph 6
No of incidents conveyed

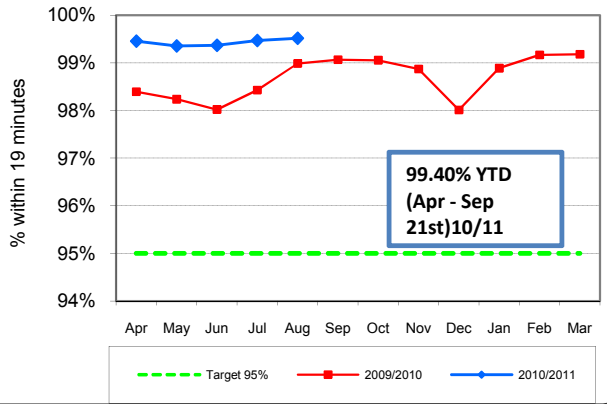


London Ambulance Service NHS Trust
Accident and Emergency Service
Performance - August 2010

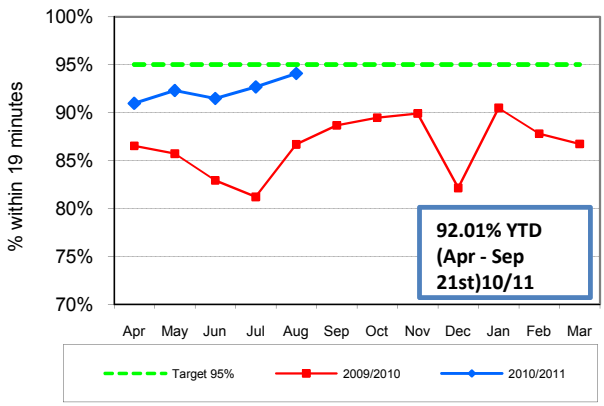
Graph 7
Category A 8 minute performance



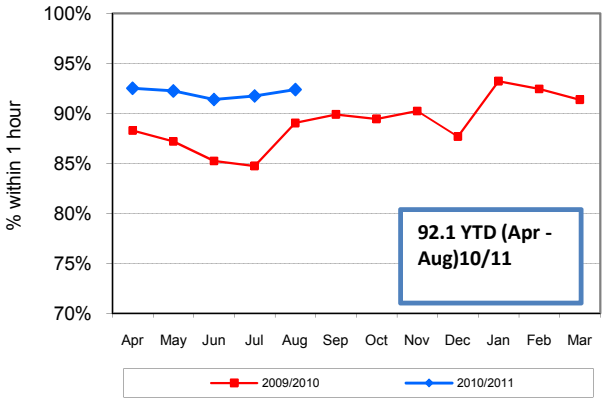
Graph 8
Category A 19 minute performance



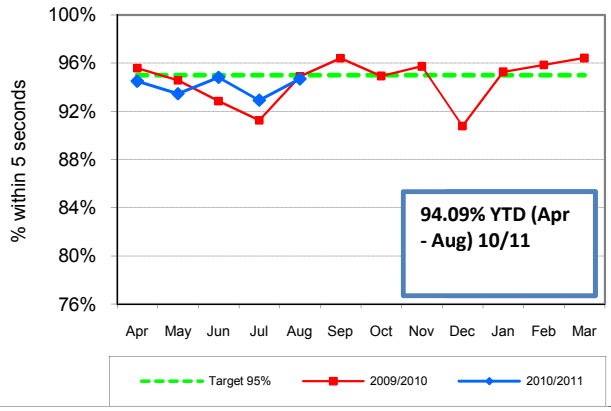
Graph 9
Category B 19 minute performance



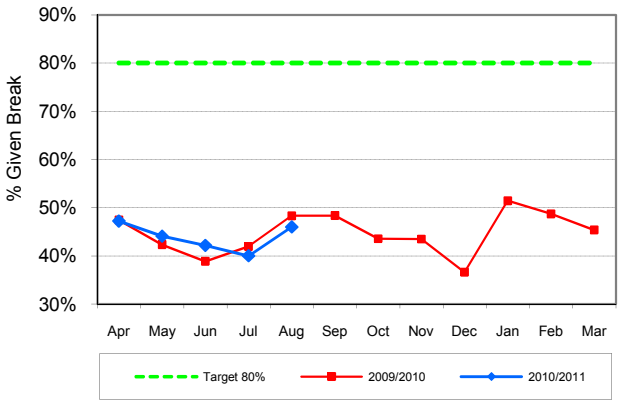
Graph 10
Category C incidents (excluding card 35) responded to within 1 hour (call connect to arrive scene)



Graph 11
Percentage of calls answered within 5 seconds

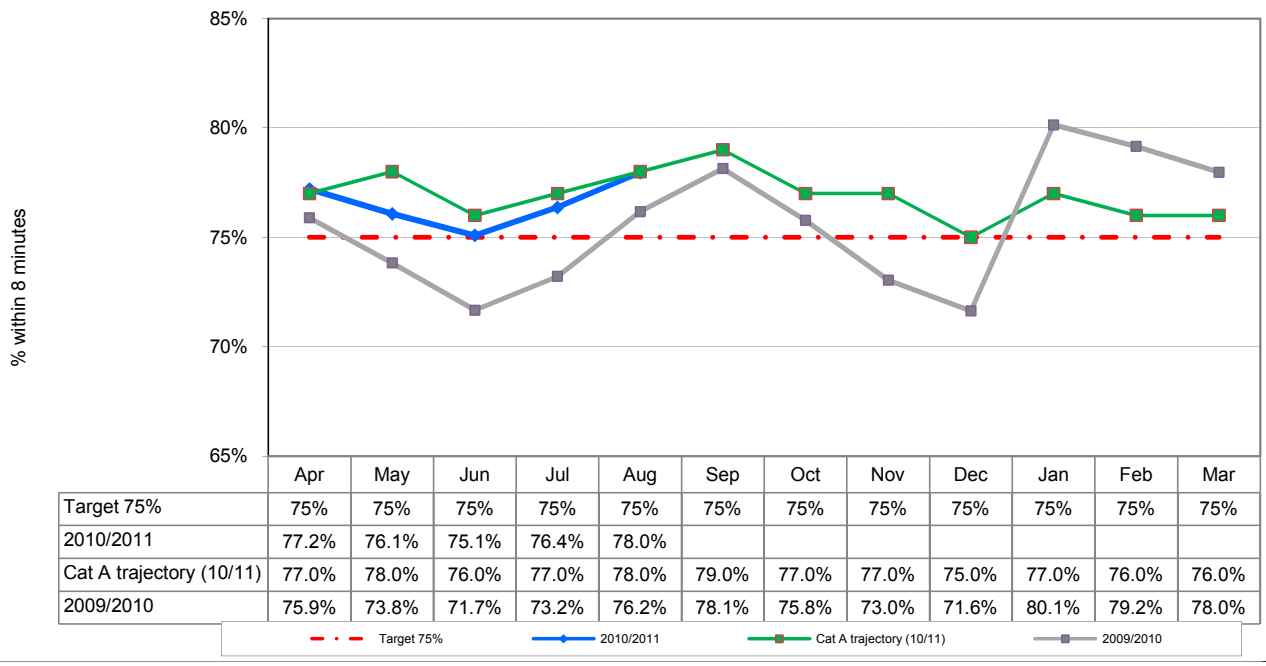


Graph 12
Rest Breaks Given



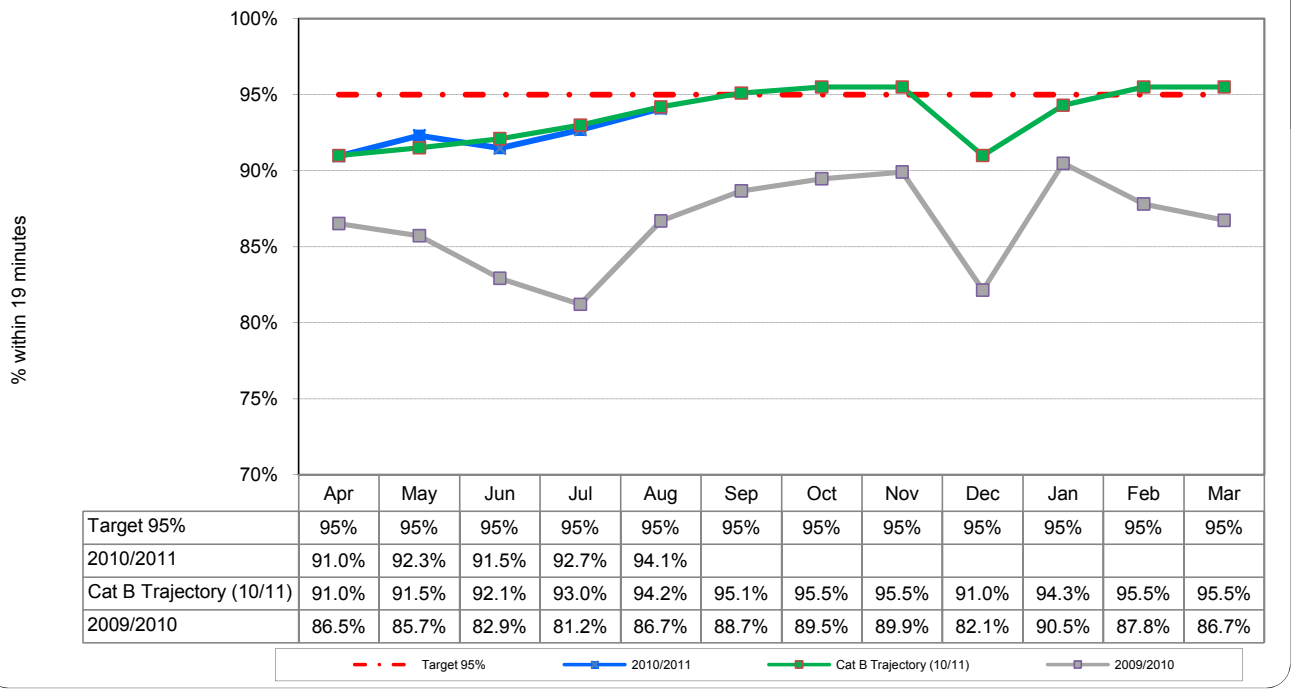
London Ambulance Service NHS Trust
Accident and Emergency Service
Performance - August 2010

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%	76.4%	78.0%							
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%

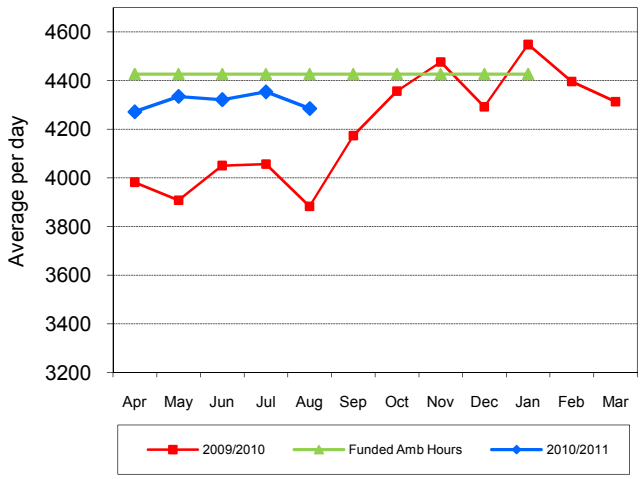
Graph 14
Category B 19 minute performance



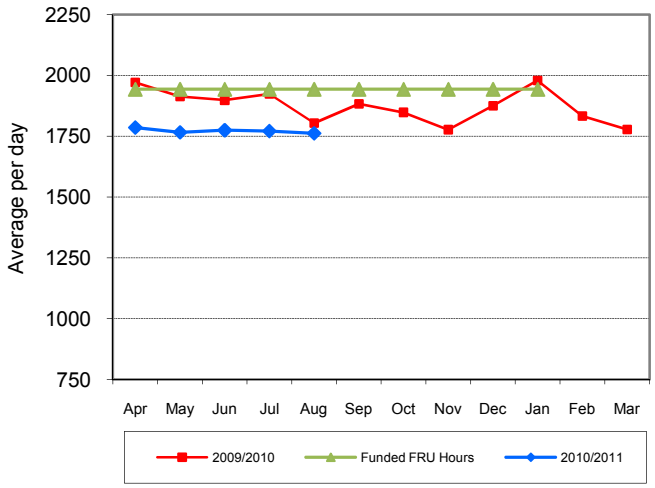
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target 95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
2010/2011	91.0%	92.3%	91.5%	92.7%	94.1%							
Cat B Trajectory (10/11)	91.0%	91.5%	92.1%	93.0%	94.2%	95.1%	95.5%	95.5%	91.0%	94.3%	95.5%	95.5%
2009/2010	86.5%	85.7%	82.9%	81.2%	86.7%	88.7%	89.5%	89.9%	82.1%	90.5%	87.8%	86.7%

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

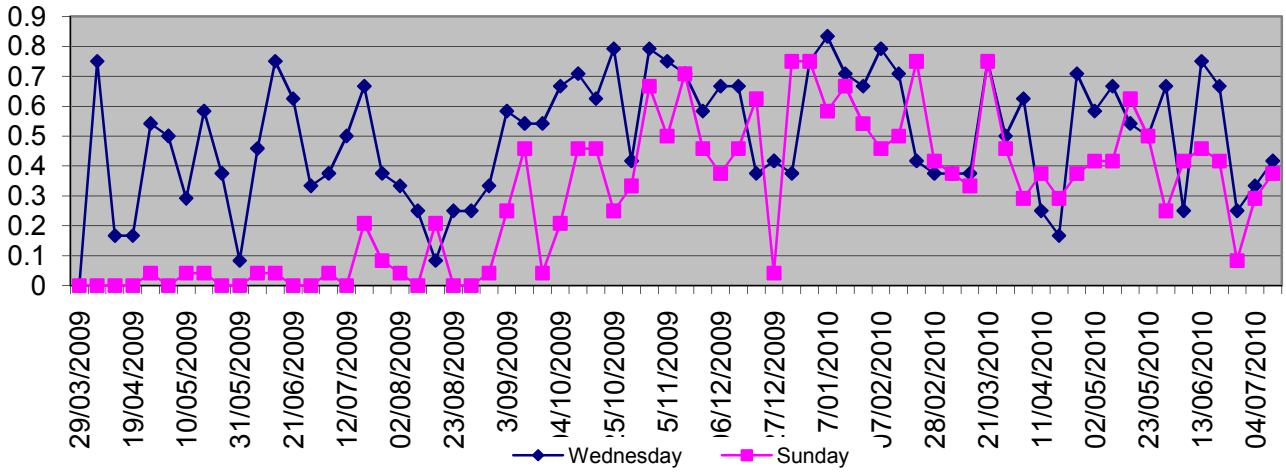
Graph 15
Ambulance Hours average available per day



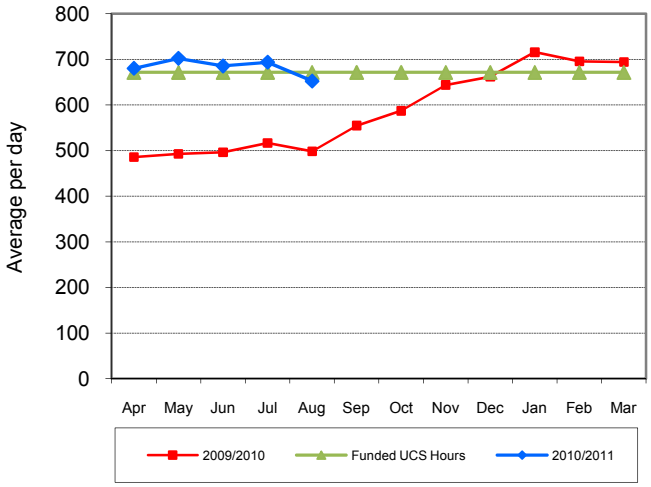
Graph 16
FRU hours average available per day



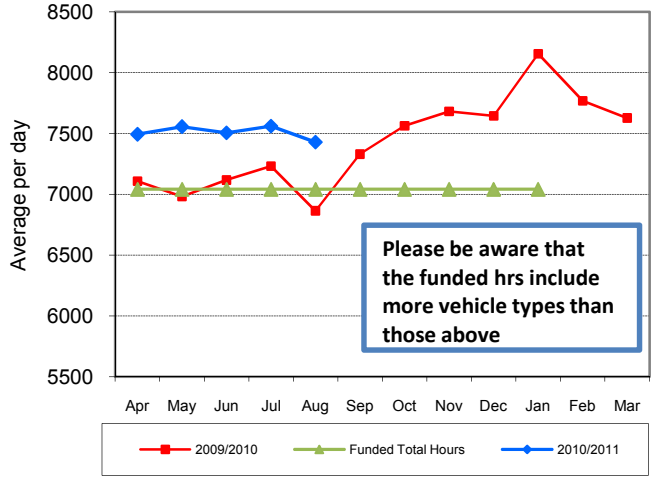
LAS hours in the day Compliant to ORH



Graph 17
UOC Hours average available per day



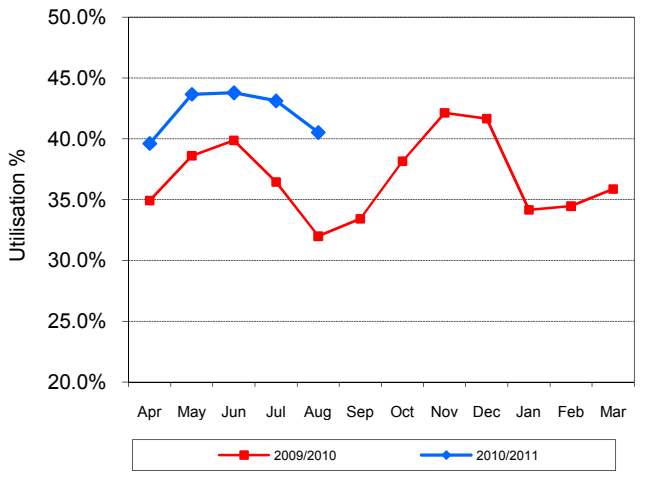
Graph 18
All Vehicle Hours average available per day



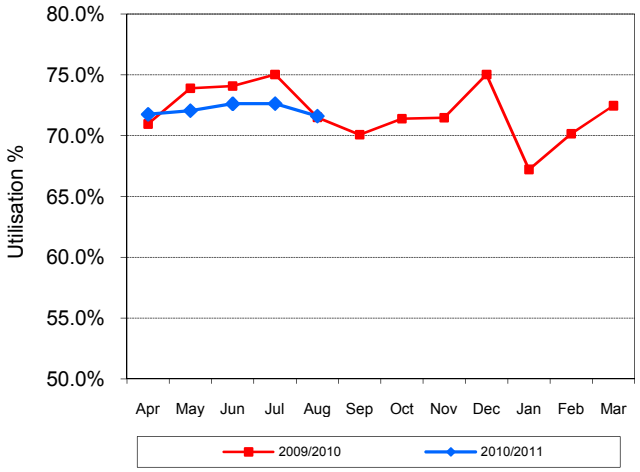
includes other vehicle types other than those above

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

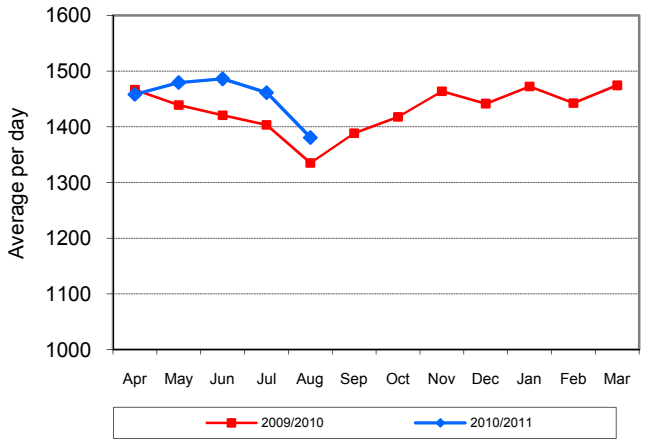
Graph 19
FRU Utilisation



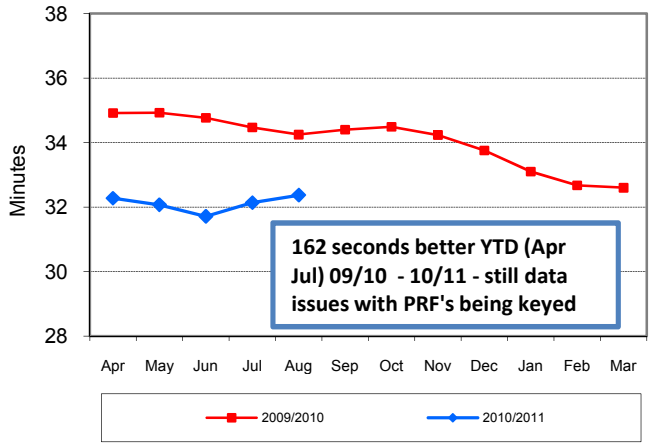
Graph 20
Ambulance Utilisation



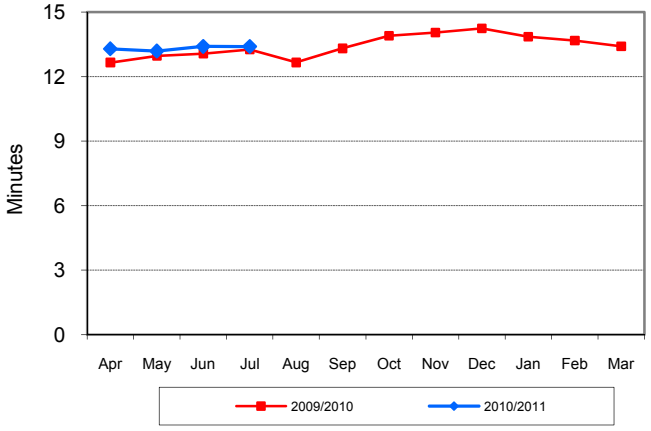
Graph 21
EOC hours staffed per day



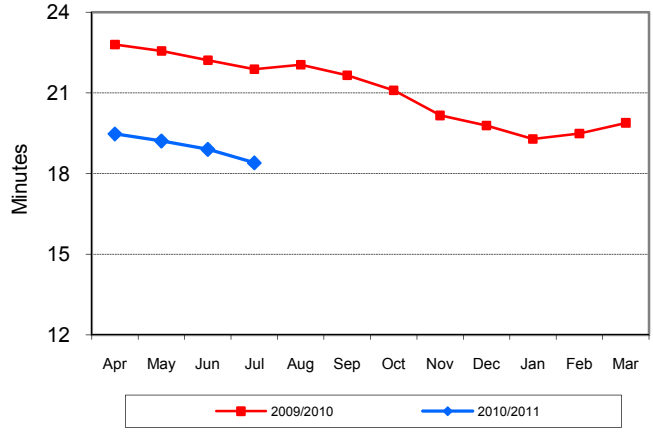
Graph 22
Average hospital turnaround time



Graph 23
Average Arrival at Hospital to Handover (Mins)

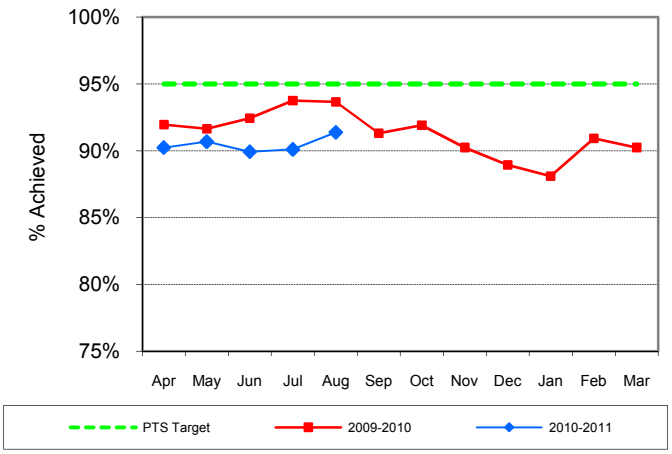


Graph 24
Average Handover to Green (Mins)

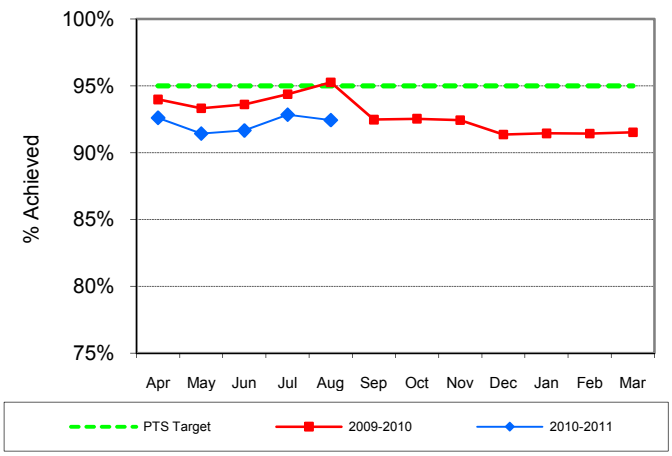


London Ambulance Service NHS Trust
Patient Transport Service
Activity and Performance - August 2010

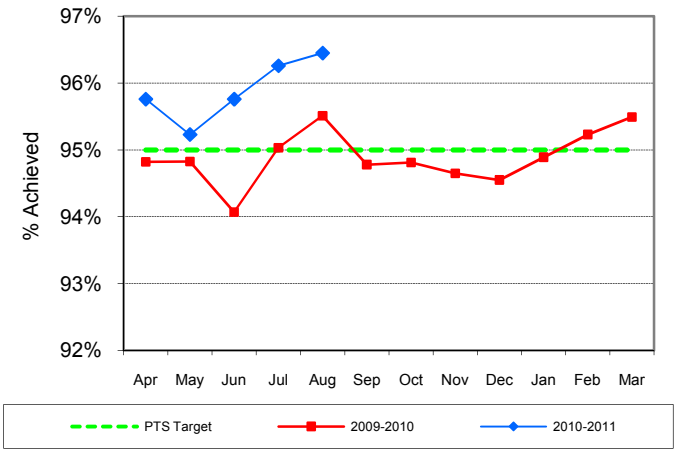
Graph 25
Arrival at Hospital Against Appointment Time



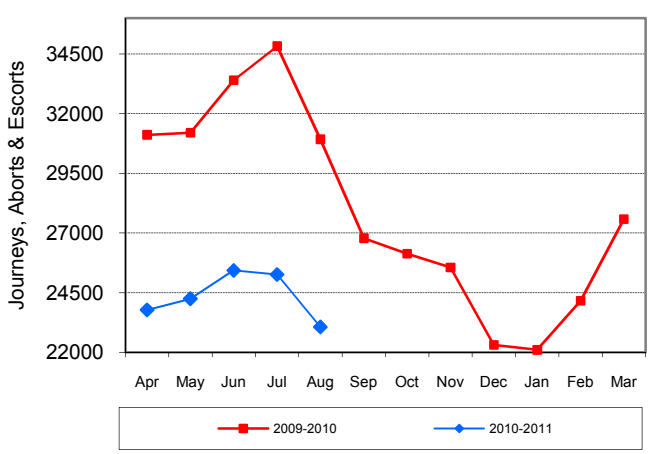
Graph 26
Departure Against Ready Time



Graph 27
Time spent on Vehicle



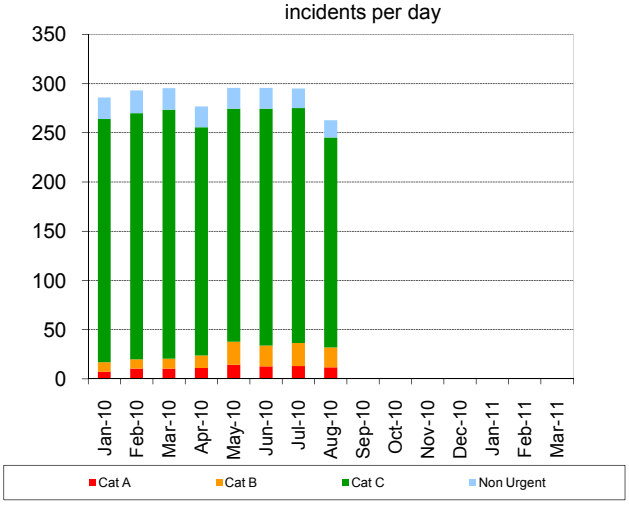
Graph 28
PTS Total Activity



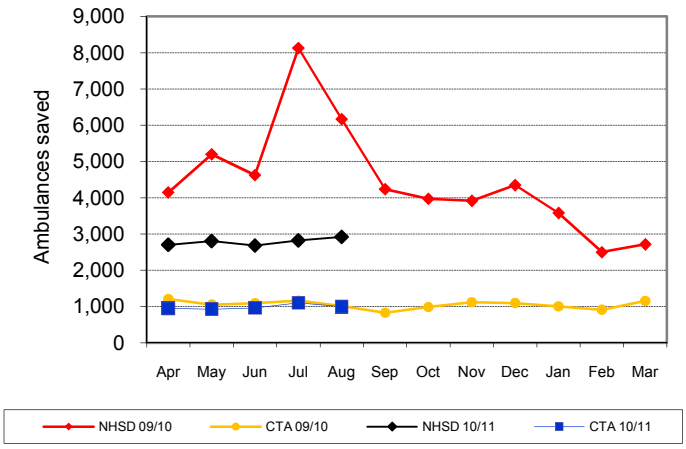
London Ambulance Service NHS Trust
Accident and Emergency Service
UOC Effectiveness - August 2010

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

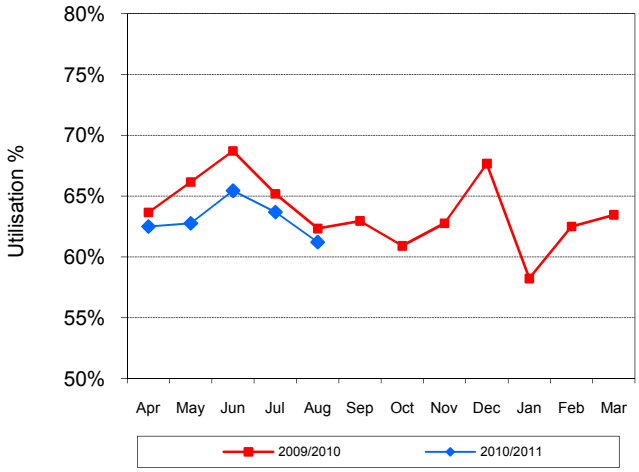
Graph 29
CAT A, B & C Workload by Urgent Care Vehicles average incidents per day



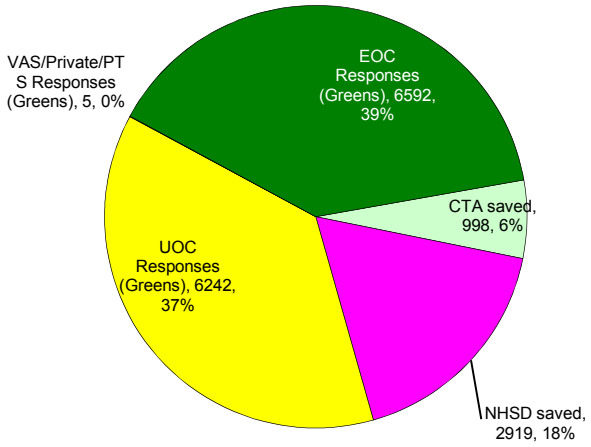
Graph 30
CTA/NHSD Ambulances saved



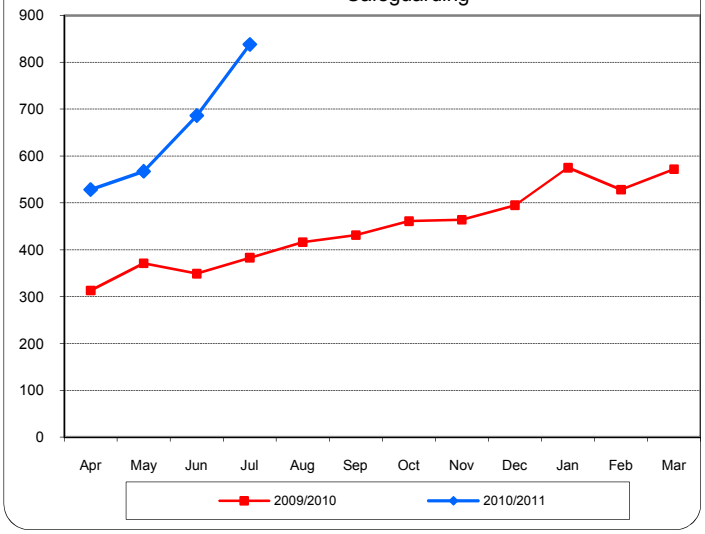
Graph 31
UOC Utilisation



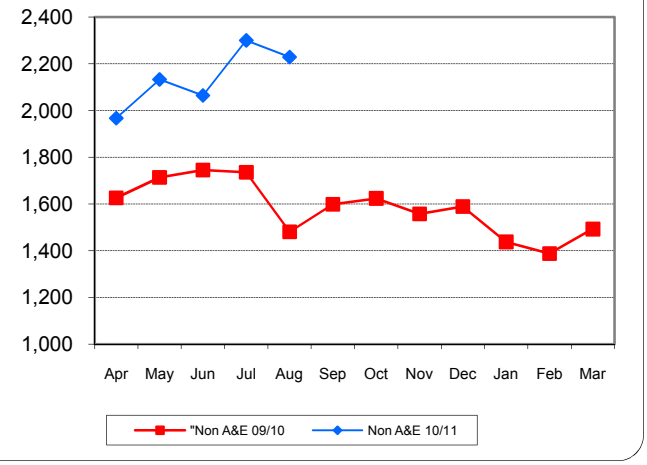
Graph 32
Green resolution - August 2010



Graph 33
Safeguarding



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



London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

M05 August

PAPER FOR REVIEW

Document Title:	**M05 August - 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 £338k surplus against a planned surplus of £38k. The year to date position for the Trust as at 31st August 2010 is a £1848k surplus against a planned surplus of £1338k. The trust currently expects to achieve a forecast position of £526k surplus against a planned outturn of £502k surplus. The trust is on target to meet its financial control figure. Please refer to Page 2 in the board report for further detail.

- The YTD surplus position has improved in month above plan mainly due to additional PTS income due to the cointinuation of activity for South East Hospitals. In addition, a number of non pay items are below the planned level of expenditure (Medical equipment, IM&T and fuel). However, continuing financial challenges will mean that the Trust still expects to achieve its original control total of a £500k surplus.

- 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 has available Capital funding for 2010/11 of £14.23m. The Capital Plan can be found on Page 8 of the board report.

- The current cash position is £2.2m. Please see Page 11 for further information.

- The PTS year to date result is a £260k profit. This is broadly in line with the annual planned profit of £619k.

Attachments

Report Contents

Page 2	Financial Summary
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LAS Financial Review - Financial Summary

Month Ending 31st August 2010 - (Month 5)

Month M05 August				Summary	Ytd M05 August				2010/11			
Act £000	Plan £000	Diff £000	%		Act £000	Plan £000	Diff £000	%	Fcast £000	Plan £000	Diff £000	%
				Income								
21,514	21,578	-64	-0.3%	A&E	107,279	107,888	-608	-0.6%	257,387	258,931	-1,544	-0.6%
1,937	1,847	89	4.8%	Other	11,290	9,236	2,054	22.2%	22,776	22,167	608	2.7%
23,451	**23,425**	**26**	**0.1%**	**Total**	**118,570**	**117,124**	**1,446**	**1.2%**	**280,163**	**281,098**	**-936**	**-0.3%**
				Operating Expense								
17,464	16,814	650	3.9%	Pay	87,230	84,137	3,093	3.7%	205,679	203,292	2,387	1.2%
4,374	4,747	-373	-7.9%	Non Pay	22,762	22,982	-220	-1.0%	55,386	55,386	0	0.0%
21,837	**21,560**	**277**	**1.3%**	**Total**	**109,992**	**107,118**	**2,873**	**2.7%**	**261,065**	**258,678**	**2,387**	**0.9%**
1,614	**1,864**	**-251**	**-13.5%**	**EBITDA**	**8,578**	**10,006**	**-1,428**	**-14.3%**	**19,097**	**22,420**	**-3,323**	**-14.8%**
6.88%	7.96%	-1.08%	-13.6%	EBITDA %	7.23%	8.54%	-1.31%	-15.3%	6.82%	7.98%	-1.16%	-14.5%
1,275	**1,826**	**-551**	**-30.2%**	**Depreciation, Dividend & Interest**	**6,730**	**8,668**	**-1,938**	**-22.4%**	**18,571**	**21,918**	**-3,347**	**-15.3%**
338	**38**	**300**	**790.0%**	**Net Surplus/(Deficit)**	**1,848**	**1,338**	**510**	**38.1%**	**526**	**502**	**24**	**4.8%**
1.44%	0.16%	1.28%	789.0%	Net Margin	1.56%	1.14%	0.42%	36.4%	0.19%	0.18%	0.01%	5.2%
0	0	0	#DIV/0!	Impairment	0	0	0	#DIV/0!	0	0	0	#DIV/0!
338	**38**	**300**	**790.0%**	**Net Surplus/ (Loss) After Impairment**	**1,848**	**1,338**	**510**	**38.1%**	**526**	**502**	**24**	**4.8%**
				Average Capital Employed	**109,135**	**109,578**	**-443**	**-0.4%**	**109,256**	**109,578**	**-322**	**-0.3%**
				Return on Capital Employed	1.69%	1.22%	#DIV/0!	38.7%	0.48%	0.46%	0.02%	5.1%

LAS Financial Review - Financial Performance Indicator

Month Ending 31st August 2010 - (Month 5)

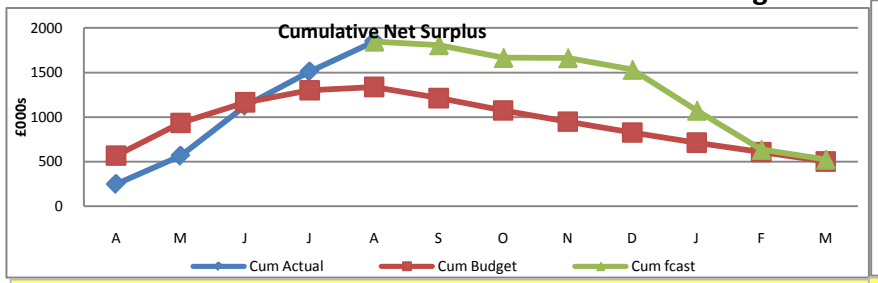
Key Financial Performance Targets	Performance Ytd Position Act £000	Plan £000	Diff £000	%	Forecast 2010/11 Fcast £000	Plan £000	Diff £000	%	Status Current (YTD)	Trend	Forecast
1. EBITDA *Monitor*	8,578	10,006	(1,428)	-14.3%	19,097	22,420	(3,323)	-14.8%	↓	↑	↓
2. EBITDA % *Monitor*	7.23%	8.54%	-1.31%	-15%	6.82%	7.98%	-1.16%	-14.5%	↓	↓	↓
3. Control Surplus/(Deficit) *NHSL*	1,848	1,338	510	38%	526	502	24	4.7%	↑	↑	⇔
4. Net Surplus/(Deficit) - after Impairments *Monitor/DH*	1,848	1,338	510	38%	526	502	24	4.7%	↑	↑	⇔
5. Cost Improvement Program (CIP) *NHSL*	5,616	5,820	(205)	-4%	18,369	18,439	(70)	-0.4%	↓		⇔
6. Return on Assets (RoA) *Monitor*	1.69%	1.22%	0.47%	39%	0.48%	0.46%	0.02%	5.1%	↑		⇔
8. Capital Resource Limit (CRL) *DH*	(2,492)	2,831	(5,323)	-188%	14,227	16,987	(2,760)	-16.2%	↓		↓
9. External Financing Limit (EFL) *DH*	(260)	(260)	0	0%	(260)	(260)	0	0.0%	⇔		⇔
10. Liquidity Ratio *Monitor*	1.10	1.50	(0)	-27%	0.79	1.50	(0.71)	-47.4%	⇔		↓
11. To process at least 95% of bills by value within 30 days *DH*	89%	95%	-6%	-6%	90%	95%	-5%	-5.3%	↓		↓
12. To process at least 95% of bills by volume within 30 days DH	84%	95%	-11%	-12%	86%	95%	-9%	-9.5%	↓		↓
13. LAS Trust Management Costs *DH - Calculated as % of Total LAS Income (Excl. MPET)*	6.9%	7.0%	-0.1%	-2%	6.9%	7.0%	-0.1%	-1.5%	⇔		⇔

- The Reduction against plan of EBITDA % is largely due to increasing Operating cost pressures particularly in non frontline pay and non pay items such as vehicle maintenance. This has eroded the trusts actual EBITDA margin.
- 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

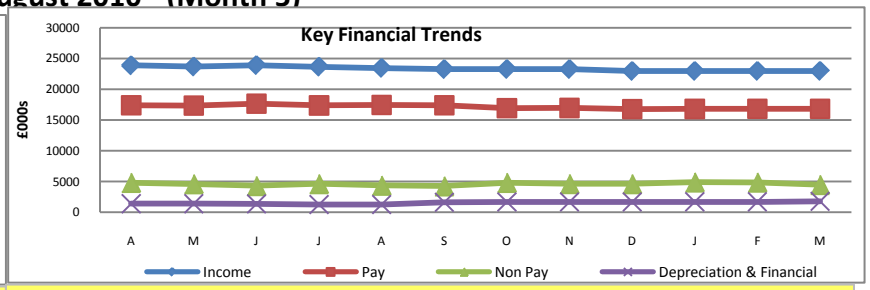
KEY

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

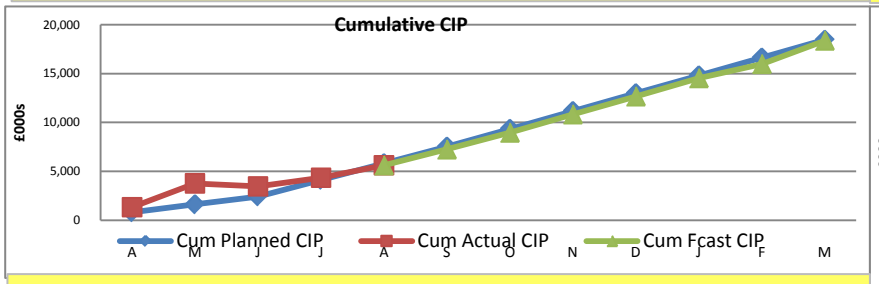
LAS Financial Analysis
Financial Analysis
Month Ending 31st August 2010 - (Month 5)



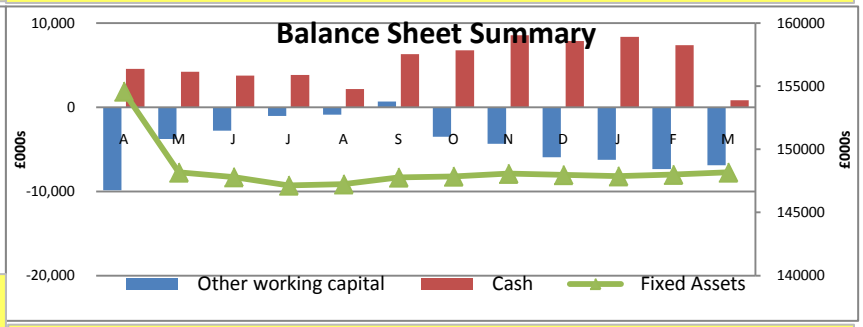
The Trust is currently on track to achieve it's year end surplus position of £502k



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. However, additional savings against budget due to lower than expected spend on A&E staffing has offset this.



The Balance sheet remains in line with expected forecast.

Other Trend Information

	April	May	June	July	August	September	October	November	December	January	Average
A&E Cost Analysis											
A&E Cost per Head per month (£s)	1.7	1.8	1.8	1.8	1.7	1.8	1.8	1.7	1.7	1.7	1.8
EOC Cost Per Call & Response per month (£s)	4.5	4.7	4.4	4.4	4.2	4.3	4.3	4.3	4.0	3.7	4.3
A&E Cost Per Incident (£s) per month	169.5	171.5	171.4	159.2	174.1	179.1	161.4	161.9	154.8	163.1	166.6
A&E Cost Per Day (£000s)	479.2	481.4	496.4	468.9	468.2	497.4	470.2	481.2	468.0	466.0	477.7
Activity Analysis											
Incidents per WTE per month	17.8	18.4	18.5	19.4	17.7	17.6	19.0	18.8	19.8	18.8	18.6
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	1.4
Calls per WTE per month	24.5	26.2	28.3	28.7	31.2	26.8	25.5	28.0	27.6	29.8	27.6
Staffing											
% Overtime to Total Payroll	6.9%	6.9%	7.0%	6.3%	6.7%	6.6%	3.5%	3.6%	3.3%	3.3%	0.1
Total Frontline Staff WTE	3,447	3,410	3,407	3,398	3,377	3,395	3,409	3,411	3,399	3,386	3,404
Total Control Services Staff WTE	472	470	465	476	488	494	491	488	485	482	481
Total Operatioanl Support Staff WTE	93	93	92	92	93	93	93	93	93	93	92
Total Management Staff WTE	222	216	210	221	224	227	227	227	227	227	223
Total Other Corporate Support Staff WTE	523	531	533	528	528	536	535	534	533	532	531
Total Non Frontline Staff	1,309	1,310	1,299	1,317	1,332	1,349	1,345	1,341	1,337	1,333	1,327
Total LAS Staff WTE	4,756	4,720	4,706	4,715	4,709	4,744	4,753	4,752	4,736	4,719	4,731
Ratio of Frontline to Non Frontline Staff Staff	2.6	2.6	2.6	2.6	2.5	2.5	2.5	2.5	2.5	2.5	2.6

LAS Financial Review - Income & Expense Trend

Month Ending 31st August 2010 - (Month 5)

	Apr-10 Actual	May-10 Actual	Jun-10 Actual	Jul-10 Actual	Aug-10 Actual	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	
Income	**(23,877)**	**(23,675)**	**(23,912)**	**(23,655)**	**(23,451)**	**(23,257)**	**(23,265)**	**(23,261)**	**(22,946)**	**(22,948)**	**(22,955)**	**(22,961)**	**(280,163)**	**(281,098)**	**936**	**-0.3%**
Payroll (£k)																
A&E Frontline	10,478	10,460	10,535	10,488	10,468	10,632	10,718	10,750	10,810	10,829	10,833	10,821	127,823	132,786	(4,963)	-3.7%
A&E Overtime	1,048	1,039	1,049	950	1,042	1,011	449	464	464	467	469	472	8,924	5,485	3,439	62.7%
A&E Incentive	3	1	0	0	1	0	0	0	0	0	0	0	5	0	5	#DIV/0!
A&E Management	1,227	1,218	1,175	1,241	1,212	1,164	1,142	1,143	1,144	1,144	1,144	1,144	14,098	13,334	764	5.7%
EOC	950	951	952	959	989	928	923	914	900	894	886	880	11,126	10,555	571	5.4%
Operational Support	297	291	251	289	298	293	293	293	293	293	293	293	3,475	4,023	(548)	-13.6%
PTS	562	543	527	517	531	540	540	540	415	415	415	415	5,963	5,168	795	15.4%
Corporate Support	2,218	2,236	2,400	2,252	2,284	2,292	2,327	2,331	2,334	2,342	2,347	2,362	27,725	29,186	(1,461)	-5.0%
Other Overtime	161	158	189	146	135	140	140	140	96	96	96	96	1,591	765	826	107.9%
Agency	448	442	582	533	503	383	380	380	325	325	325	325	4,950	1,991	2,959	148.7%
Total	**17,390**	**17,339**	**17,662**	**17,375**	**17,464**	**17,384**	**16,913**	**16,955**	**16,781**	**16,804**	**16,807**	**16,806**	**205,679**	**203,292**	**2,387**	**1.2%**
Non Pay																
Staff Related	530	492	655	600	507	659	670	557	544	542	542	542	6,840	6,893	(52)	-0.8%
Consumables, Medical Equip & Drugs	488	631	626	666	370	492	507	514	574	531	561	507	6,466	5,971	495	8.3%
Vehicle Leasing	78	96	120	202	172	137	137	137	128	128	128	128	1,592	2,447	(855)	-35.0%
Fuel & Oil	454	471	454	463	422	455	455	455	444	444	444	444	5,405	6,026	(622)	-10.3%
Vehicle Maintenance	397	804	557	561	613	621	747	669	636	599	572	607	7,382	6,057	1,325	21.9%
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	166	(214)	151	151	151	152	152	151	1,706	1,577	130	8.2%
3rd Party Transport	102	49	64	86	69	57	54	52	34	34	34	34	670	351	319	90.7%
Accomodation & Estates	991	1,094	1,028	1,057	953	1,015	1,008	1,011	1,011	1,011	1,011	1,011	12,200	11,707	493	4.2%
IT & Telecoms	723	717	377	656	624	789	841	841	844	812	802	437	8,462	8,958	(496)	-5.5%
Finance & Legal	752	(144)	(2)	162	239	(23)	(23)	(23)	(23)	(13)	(23)	(23)	856	779	77	9.9%
Consultancy	12	(4)	42	119	108	75	75	75	75	448	448	448	1,923	1,972	(48)	-2.5%
Other	130	184	174	(174)	131	204	206	202	207	207	208	203	1,883	2,648	(765)	-28.9%
Subtotal	**4,830**	**4,614**	**4,317**	**4,628**	**4,374**	**4,267**	**4,827**	**4,641**	**4,626**	**4,895**	**4,879**	**4,489**	**55,386**	**55,386**	**(0)**	**0.0%**
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	868	1,112	1,134	1,135	1,135	1,174	1,174	1,242	12,803	15,283	(2,480)	-16.2%
Subtotal	**992**	**992**	**967**	**877**	**868**	**1,112**	**1,134**	**1,135**	**1,135**	**1,174**	**1,174**	**1,242**	**12,803**	**15,283**	**(2,480)**	**-16.2%**
Financial																
Dividend	314	314	314	294	309	435	435	435	435	435	435	435	4,588	4,588	(0)	0.0%
Interest	101	99	92	97	98	99	99	99	99	99	99	99	1,180	2,047	(867)	-42.4%
Subtotal	**415**	**414**	**406**	**391**	**407**	**533**	**533**	**533**	**533**	**533**	**533**	**533**	**5,768**	**6,635**	**(867)**	**-13.1%**
Total Expense	**23,628**	**23,358**	**23,352**	**23,271**	**23,112**	**23,297**	**23,408**	**23,264**	**23,076**	**23,407**	**23,393**	**23,071**	**279,637**	**280,596**	**(960)**	**-0.3%**
Net Surplus	**(249)**	**(316)**	**(560)**	**(384)**	**(338)**	**40**	**143**	**3**	**130**	**459**	**438**	**110**	**(526)**	**(502)**	**(24)**	**(0)**
Cumulative Surplus	**(249)**	**(565)**	**(1,126)**	**(1,510)**	**(1,848)**	**(1,808)**	**(1,666)**	**(1,663)**	**(1,533)**	**(1,074)**	**(636)**	**(526)**	**(526)**	**(502)**		

LAS Financial Review - Financial Risks

Month Ending 31st August 2010 - (Month 5)

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	m5 ytd activity up 6%
2. A&E Income - CatA8 penalty	4,955	4	2	8	0	G	m5 performance 76% ytd
3. A&E Income - CatB19 penalty	4,955	4	4	16	1,652	R	m5 performance on trajectory. Net penalty based on both proportionality & caliberation
4. A&E Income - CatC (KPI)	4,955	4	2	8	0	G	m5 CTA and NHSD performance well above target
5. A&E Income - LAS Patient handover to green (KPI)	1,635	3	2	6	545	A	m5 performance on revised trajectory
6. A&E Income - Clinical Performance Indicator (KPI)	1,635	3	2	6	0	G	m5 ytd on track
7. A&E Income - New Clinical Model (KPI)	1,635	3	3	9	0	G	m5 planning for SE trials in progress
8. A&E Income - Alternative Care Pathways (CQUIN)	2,973	4	2	8	743	A	m5 dependent on availability of specialist units and falls services London-wide
9. A&E Income - Cardiac, Stroke & Falls (CQUIN)	743	3	2	6	186	A	m5 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	m5 ytd on track. Net based on 5% slippage
11. Economic Cost Pressures (Fuel, Rates, etc)	1,000	3	3	9	0	G	m5 ytd on track
12. PTS Profitability	350	3	3	9	0	G	m5 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 August 2010 - (Month 5)

Key CIP Programs	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	3,024	3,029	(5)	0%	3,024	3,029	(5)	0%	⇔		⇔
2. Agency Cost	639	945	(306)	22%	3,696	4,252	(556)	7%	↓		↓
3. A&E Subsistence	33	374	(341)	237%	777	1,682	(905)	47%	↓		↓
4. Third Party Transport	385	410	(25)	3%	1,631	1,844	(213)	6%	⇔		↓
5. Non Frontline Payroll	16	190	(174)	247%	862	1,605	(743)	36%	↓		↓
6. Non Pay - Major Contract Review	88	285	(197)	80%	957	1,285	(327)	16%	↓		↓
7. Non Pay - Activity Reduction	882	594	288	-18%	2,439	2,673	(233)	#NUM!	↑		↓
8. Non Pay - Other	103	(6)	108	#NUM!	2,574	2,071	503	-56%	↑		↑
9. A&E Pay - Other	447	0	447	-100%	2,409	0	2,409	0%	↑		↑
10. Pay - Other	0	0	0	#DIV/0!	0	0	0	#DIV/0!	⇔		⇔
Total	5,616	5,820	(205)	2%	18,369	18,439	(70)	#NUM!	⇔		↓

- 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.

- The CIP now includes savings made due to the lower than expected increase in A&E Costs projected to the year end. This relates to timing and skill mix recalculations.

- 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 August 2010 - (Month 5)

Projects	Ytd Position 5				Forecast 2010/11				Status
	Act £000	Plan £000	Diff £000	%	Act £000	Plan £000	Diff £000	%	2010/11
1. CommandPoint	7	568	560	99%	1,929	3,406	(1,476)	-43%	↓
2. IM&T - Other	496	214	(281)	-131%	1,526	1,287	239	19%	↑
3. Fleet - DCA	1,891	911	(980)	-108%	6,794	5,467	1,328	24%	↑
4. Fleet - FRU	88	22	(65)	-297%	132	132	0	0%	↔
5. Fleet - Other	192	17	(176)	-1047%	192	101	92	91%	↔
6. Estates - West Workshop	0	0	0	#DIV/0!	140	0	140	#DIV/0!	↔
7. Estates - HART East	24	105	81	77%	631	631	0	0%	↔
8. Estates - Hart West	0	0	0	#DIV/0!	0	0	0	#DIV/0!	↔
9. Estates - Other	757	274	(483)	-176%	1,852	1,647	206	12%	↑
10. Clinical Equipment	0	0	0	#DIV/0!	0	0	0	#DIV/0!	↔
11. Other Projects	0	0	0	#DIV/0!	0	0	0	#DIV/0!	↔
12. Fleet - Finance Lease	0	767	767	100%	4,600	4,600	0	0%	↔
13. Disposals	(5,946)	(991)	4,955	-500%	(6,646)	(5,946)	(700)	12%	↓
14. Unapproved SPPPs	0	944	944	100%	3,076	5,664	(2,588)	-46%	↓
Total	(2,492)	2,831	5,323	188%	14,227	16,987	(2,760)	-16%	↓
Capital Resource Limit (CRL)	2,831	2,831	0	0%	16,987	16,987	0	0%	↔
Variance	(5,323)	0	5,323	#DIV/0!	(2,760)	0	2,760	#DIV/0!	↓

- Plan and CRL figure are based on 2010/11 final FiMs submission
- IM&tT & Fleet forecast has been reduced due to the likelihood of projects not been completed in 2010/11 (amount reduced

KEY:

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

LAS Financial Review - Summary I&E & Balance Sheet

Month Ending 31st August 2010 - (Month 5)

	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	21,514	21,578	-0.3%	107,279	107,888	(608)	-0.6%	103,333	3,946	3.8%	257,387	258,931	(1,544)	-0.6%
Other	1,937	1,847	4.8%	11,290	9,236	2,054	22.2%	12,946	(1,656)	-12.8%	22,776	22,167	608	2.7%
Total	23,451	23,425	0.1%	118,570	117,124	1,446	8002.4%	116,280	2,290	2.0%	280,163	281,098	(936)	-0.3%
Operating Expense														
Pay	17,464	16,814	3.9%	87,230	84,137	3,093	3.7%	84,610	2,620	3.1%	205,679	203,292	2,387	1.2%
Non Pay	4,374	4,747	-7.9%	22,762	22,982	(220)	-1.0%	23,993	(1,231)	-5.1%	55,386	55,386	(0)	0.0%
Total	21,837	21,560	1.3%	109,992	107,118	2,873	3628.2%	108,603	1,388	1.3%	261,065	258,678	2,387	0.9%
EBITDA	1,614	1,864	-13.5%	8,578	10,006	(1,428)	-800.9%	7,676	902	11.7%	19,097	22,420	(3,323)	-14.8%
EBITDA %	6.9%	8.0%	-13.6%	7.2%	8.5%	-1%	-753.0%	6.6%	0.6%	9.6%	6.8%	8.0%	-1.2%	-14.5%
Depreciation, Dividend & Interest	1,275	1,826	-30.2%	6,730	8,668	(1,938)	-22.4%	6,631	99	1.5%	18,571	21,918	(3,347)	-15.3%
						-								
Net Surplus/(Deficit)	338	38	790.0%	1,848	1,338	510	162.3%	1,046	802	10.2%	526	502	24	4.8%
Net Margin	1.4%	0.2%	789.0%	1.6%	1.1%	0.4%	174.4%	0.9%	0.7%	9.6%	0.2%	0.2%	0.0%	5.2%
Impairments	0	0	#DIV/0!	0	0	0	#DIV/0!	0	0	#DIV/0!	0	0	0	#DIV/0!
Net Surplus after Impairment	338	38	790.0%	1,848	1,338	510	162.3%	1,046	802	#DIV/0!	526	502	24	4.8%
Balance Sheet														
Non Current Assets				147,780	152,901	(5,121)	-3.3%	131,406	16,374	12.5%	154,018	152,901	1,118	0.7%
Cash				2,163	2,979	(816)	-27.4%	5,141	(2,978)	-57.9%	836	2,979	(2,142)	-71.9%
Working capital				690	(9,903)	10,593	-107.0%	(1,538)	2,228	-144.9%	(6,256)	(9,903)	3,646	-36.8%
Non Current Liabilities				(40,713)	(36,399)	(4,315)	11.9%	(41,767)	1,054	-2.5%	(39,999)	(36,399)	(3,601)	9.9%
Capital Employed				109,920	109,578	342	0%	93,242	16,678	17.9%	108,599	109,578	(979)	-1%
Average Capital Employed				109,135	109,578	(443)	-0.4%	38,851	70,284	180.9%	109,256	109,578	(322)	-0.3%
Return on Capital Employed				1.69%	1.22%	#DIV/0!	38.7%	2.7%	(0)	-37.1%	0.48%	0.46%	0	5.1%

LAS Financial Review - Balance Sheet

Month Ending 31st August 2010 - (Month 5)

	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*	*Actual*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*
Intangible assets	12,639	12,604	12,604	12,182	12,244	12,273	12,273	12,273	12,273	12,273	12,273	12,273	12,273
Property, Plant and Equipment	131,434	125,054	124,671	124,427	124,450	124,959	125,034	125,251	125,152	125,053	125,173	125,351	131,197
Trade and Other Receivables	10,503	10,513	10,527	10,534	10,544	10,548	10,548	10,548	10,548	10,548	10,548	10,548	10,548
Total Non-Current Assets	154,576	148,171	147,802	147,143	147,238	147,780	147,855	148,072	147,973	147,874	147,994	148,172	154,018
Current Assets													
Inventories	2,783	2,728	2,701	2,686	2,672	2,739	2,739	2,739	2,739	2,739	2,739	2,739	2,739
NHS Trade Receivables	3,122	10,903	9,332	2,886	2,438	11,542	4,888	4,869	4,869	4,837	4,837	4,838	2,750
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	7,599	7,573	7,573	7,573	7,573	7,573	7,573	7,599
Accrued Income	1,897	4,503	4,641	6,138	8,302	4,477	4,477	4,477	4,477	4,477	4,477	4,477	2,944
Prepayments	3,249	1,933	2,775	4,200	3,670	3,355	3,355	3,355	3,355	3,355	3,355	3,355	3,356
Investments	0	0	0	0	0	0	0	0	0	0	0	0	0
Cash and Cash Equivalents	5,141	4,533	4,208	3,737	3,836	2,163	6,319	6,773	8,534	7,857	8,363	7,348	836
Current Assets	24,394	31,195	30,965	27,884	28,472	31,875	29,351	29,786	31,547	30,838	31,344	30,330	20,224
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	31,615	28,534	29,122	32,525	30,001	30,436	32,197	31,488	31,994	30,980	20,224
Total Assets	179,620	180,016	179,417	175,677	176,360	180,305	177,856	178,508	180,170	179,362	179,988	179,152	174,242
Current Liabilities													
Bank Overdraft	0	0	0	0	0	0	0	0	0	0	0	0	0
NHS Trade Payables	336	340	321	242	280	214	357	906	776	742	1,009	1,020	250
Non NHS Trade Payables	7,682	6,786	10,241	8,779	6,727	5,745	6,415	7,085	8,415	9,085	9,755	10,095	7,094
Other Payables	6,854	8,782	9,036	9,020	8,757	8,881	8,877	9,009	9,697	9,954	10,294	10,455	8,879
PDC Dividend Liabilities	200	514	828	1,142	1,436	1,745	0	435	870	1,305	1,740	2,175	0
Capital Liabilities	8,610	4,873	3,190	586	360	416	603	954	990	1,026	1,320	672	6,760
Accruals	1,217	5,044	1,828	2,022	4,646	4,243	4,243	4,243	4,243	4,243	4,243	4,243	2,621
Deferred Income	124	91	306	80	198	4,701	4,028	3,363	2,698	2,033	1,368	703	40
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	2,483	2,042	1,409	1,304	859	647	541	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	26,176	29,672	27,187	28,026	29,615	29,869	30,998	30,526	25,644
Net Current Assets/(Liabilities)	(4,726)	773	1,408	2,706	2,946	2,853	2,814	2,410	2,582	1,619	996	454	(5,420)
Total Assets less Current Liabilities	149,850	148,944	149,210	149,849	150,184	150,633	150,669	150,482	150,555	149,493	148,990	148,626	148,598
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	21,620	21,620	21,620	21,620	21,620	21,620	21,620	21,620
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	11,018	11,094	11,050	11,127	10,195	10,151	10,226	10,304
Total Non-Current Liabilities	40,523	40,617	40,567	40,646	40,602	40,713	40,789	40,745	40,822	39,890	39,846	39,921	39,999
Total Assets Employed	109,327	108,327	108,643	109,203	109,582	109,920	109,880	109,737	109,733	109,603	109,144	108,705	108,599
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	12,686	13,246	13,201	13,539	13,499	13,356	13,352	13,222	12,763	12,324	12,218

LAS Financial Review - Cashflow

Month Ending 31st August 2010 - (Month 5)

	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*	*Actual*	*Actual*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	
Operating Activities													
`	664	730	1,000	462	745	494	391	530	404	75	95	427	6,017
Depreciation and amortisation	992	992	967	877	868	1,112	1,134	1,135	1,135	1,174	1,174	1,242	12,802
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)	(115)	(109)	(113)	(113)	(113)	(113)	(113)	(113)	(113)	(113)	(111)	(1,353)
Dividend Paid	0	0	0	0	0	(2,180)	0	0	0	0	0	(2,610)	(4,790)
(Increase)/Decrease in Inventories	55	27	15	14	(67)	0	0	0	0	0	0	0	44
(Increase)/Decrease in NHS Trade Receivables	(7,781)	1,571	6,446	448	(9,104)	6,654	19	0	32	0	(1)	2,088	372
(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	(45)	26	0	0	0	0	0	(26)	603
(Increase)/Decrease in Accrued Income	(2,606)	(138)	(1,497)	(2,164)	3,825	0	0	0	0	0	0	1,533	(1,047)
(Increase)/Decrease in Prepayments	1,316	(842)	(1,425)	530	315	0	0	0	0	0	0	(1)	(107)
Increase/(Decrease) in Trade Payables	4	(19)	(79)	38	(66)	143	549	(130)	(34)	267	11	(770)	(86)
Increase/(Decrease) in Other Payables	5,182	3,720	(7,020)	(2,406)	(905)	652	788	2,004	913	996	487	(4,590)	(179)
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	(403)	0	0	0	0	0	0	(1,622)	1,404
Increase/(Decrease) in Deferred Income	(33)	215	(226)	118	4,503	(673)	(665)	(665)	(665)	(665)	(665)	(663)	(84)
Increase/(Decrease) in Provisions & Liabilities	94	(50)	79	(44)	51	76	(44)	77	(932)	(44)	75	78	(584)
Net Cash inflow/outflow from operating activities	3,207	2,162	(2,584)	1,067	(396)	6,191	2,059	2,838	740	1,690	1,063	(5,025)	13,012
Cashflows from Investing Activites													
Interest received	27	29	31	30	29	28	28	28	28	28	28	26	340
(Payments) for property, plant & equipment	(3,737)	(2,331)	(3,327)	(1,126)	(1,321)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(2,000)	(1,000)	(19,842)
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)	(1,292)	(972)	(972)	(972)	(972)	(972)	(1,972)	(324)	(12,630)
Net Cash inflow/outflow before financing	(503)	(140)	29	284	(1,688)	5,219	1,087	1,866	(232)	718	(909)	(5,349)	382
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)
Loans received from Salix Finance	0	0	0	0	60	0	0	0	0	0	0	0	60
Capital element of finance lease	(105)	(185)	(500)	(185)	(45)	(441)	(633)	(105)	(445)	(212)	(106)	(541)	(3,503)
Net Cashflow inflow/(outflow) from financing	(105)	(185)	(500)	(185)	15	(1,063)	(633)	(105)	(445)	(212)	(106)	(1,163)	(4,687)
Increase/(decrease) in cash & cash equivalents	(608)	(325)	(471)	99	(1,673)	4,156	454	1,761	(677)	506	(1,015)	(6,512)	(4,305)
Cash, cash equivalents and bank overdrafts at 010410	5,141												

LAS Financial Review - Income Summary

Month Ending 31st August 2010 - (Month 5)

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	103,541	104,315	(774)	-0.7%	248,499	250,357	(1,858)	-0.7%
731	620	17.9%	CBRN	3,213	3,102	111	3.6%	7,704	7,445	259	3.5%
74	94	-21.1%	RTA	525	470	55	11.6%	1,184	1,129	55	4.8%
21,514	**21,578**	-0.3%	**Subtotal**	**107,279**	**107,888**	**(608)**	-0.6%	**257,387**	**258,931**	**(1,544)**	-0.6%
			Specialised Services								
477	581	-17.9%	HART	2,802	2,906	(104)	-3.6%	6,724	6,974	(250)	-3.6%
3	3	-0.3%	HEMS	16	16	(0)	-0.3%	39	39	(0)	-0.1%
480	**584**	-17.8%	**Subtotal**	**2,818**	**2,922**	**(104)**	-3.6%	**6,763**	**7,013**	**(250)**	-3.6%
			Information Services & Research								
92	92	0.0%	EBS	461	461	0	0.0%	1,102	1,106	1	-0.3%
28	13	117.6%	Research	115	65	50	76.3%	255	156	99	63.2%
121	**105**	14.6%	**Subtotal**	**576**	**526**	**50**	9.5%	**1,358**	**1,262**	**100**	7.6%
			Patient Transport Services								
722	598	20.7%	PTS	3,763	2,991	772	25.8%	8,158	7,177	981	13.7%
85	80	6.8%	BETS & SCBU	315	400	(85)	-21.3%	887	959	(73)	-7.6%
38	46	-16.1%	A&E Long Distance	100	229	(129)	-56.2%	296	550	(254)	-46.1%
846	**724**	16.8%	**Subtotal**	**4,178**	**3,619**	**558**	15.4%	**9,341**	**8,687**	**655**	7.5%
			NHS London								
265	213	24.6%	MPET	2,478	1,063	1,416	133.2%	2,536	2,550	(14)	-0.5%
0	0	#DIV/0!	Other Education	0	0	0	#DIV/0!	0	0	0	#DIV/0!
53	70	-24.3%	Olympics 2012	331	348	(17)	-4.9%	767	835	(68)	-8.1%
317	**282**	12.6%	**Subtotal**	**2,809**	**1,410**	**1,399**	99.2%	**3,304**	**3,385**	**(81)**	-2.4%
			Commercial								
92	77	20.7%	Stadia	403	383	20	5.2%	963	919	44	4.8%
52	52	0.0%	BAA	260	260	0	0.0%	625	625	0	0.0%
10	1	733.8%	Training	20	6	14	225.2%	35	15	20	135.5%
155	**130**	19.3%	**Subtotal**	**684**	**650**	**34**	5.2%	**1,623**	**1,559**	**64**	4.1%
18	22	-18.2%	**Other**	226	109	117	107.5%	387	262	125	47.7%
23,451	**23,425**	0.1%	**Total**	**118,570**	**117,124**	**1,446**	1.2%	**280,163**	**281,098**	**(931)**	-0.3%

LAS Financial Review - Expense Summary

Month Ending 31st August 2010 - (Month 5)

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											
21,514	21,578	-0.3%	A&E	107,279	107,888	(608)	-0.6%	103,333	3,946	3.8%	257,387	258,931	(1,544)	-0.6%
1,937	1,847	4.8%	Other	11,290	9,236	2,054	22.2%	12,946	(1,656)	-12.8%	22,776	22,167	608	2.7%
23,451	**23,425**	**0.1%**	**Total**	**118,570**	**117,124**	**1,446**	1.2%	**116,280**	**2,290**	2.0%	**280,163**	**281,098**	**(936)**	-0.3%
			Payroll (£k)											
10,468	10,914	-4.1%	A&E Sectors	52,431	54,383	(1,952)	-3.6%	47,304	5,126	10.8%	127,823	132,786	(4,963)	-3.7%
1,042	453	130.1%	A&E Overtime	5,128	2,270	2,857	125.8%	6,657	(1,529)	-23.0%	8,924	5,485	3,439	62.7%
1	0	#DIV/0!	A&E Incentive	5	0	5	#DIV/0!	2,330	(2,325)	-99.8%	5	0	5	#DIV/0!
1,212	1,116	8.6%	A&E Management	6,073	5,565	508	9.1%	5,317	755	14.2%	14,098	13,334	764	5.7%
989	908	8.8%	EOC	4,800	4,529	271	6.0%	4,468	332	7.4%	11,126	10,555	571	5.4%
298	335	-11.0%	Operational Support	1,426	1,671	(245)	-14.7%	1,389	37	2.6%	3,475	4,023	(548)	-13.6%
531	430	23.6%	PTS	2,681	2,148	533	24.8%	2,785	(105)	-3.8%	5,963	5,168	795	15.4%
2,284	2,445	-6.6%	Corporate Support	11,390	12,304	(913)	-7.4%	10,053	1,337	13.3%	27,725	29,186	(1,461)	-5.0%
135	64	111.3%	Other Overtime	789	319	470	147.4%	1,200	(411)	-34.3%	1,591	765	826	107.9%
503	149	237.6%	Agency	2,508	948	1,559	164.4%	3,106	(598)	-19.3%	4,950	1,991	2,959	148.7%
17,464	**16,814**	**3.9%**	**Total**	**87,230**	**84,137**	**3,093**	3.7%	**84,610**	**2,620**	3.1%	**205,679**	**203,292**	**2,387**	1.2%
			Non Pay											
507	522	-2.9%	Staff Related	2,783	3,240	(456)	-14.1%	2,997	(214)	-7.1%	6,840	6,893	(52)	-0.8%
370	497	-25.5%	Consumables, Medical Equip & Drugs	2,781	2,493	288	11.6%	2,997	(216)	-7.2%	6,466	5,971	495	8.3%
172	204	-15.5%	Vehicle Leasing	669	1,022	(353)	-34.5%	237	432	181.8%	1,592	2,447	(855)	-35.0%
422	502	-15.9%	Fuel & Oil	2,264	2,511	(248)	-9.9%	1,883	381	20.2%	5,405	6,026	(622)	-10.3%
613	499	22.9%	Vehicle Maintenance	2,933	2,565	368	14.3%	2,604	329	12.6%	7,382	6,057	1,325	21.9%
0	0	#DIV/0!	Other Automotive	0	0	0	#DIV/0!	0	0	#DIV/0!	0	0	0	#DIV/0!
166	130	27.4%	Vehicle Insurance	1,012	665	347	52.2%	692	321	46.3%	1,706	1,577	130	8.2%
69	14	392.8%	3rd Party Transport	370	253	117	46.2%	943	(573)	-60.8%	670	351	319	90.7%
953	938	1.6%	Accomodation & Estates	5,122	5,143	(21)	-0.4%	5,201	(79)	-1.5%	12,200	11,707	493	4.2%
624	730	-14.6%	IT & Telecoms	3,098	3,847	(749)	-19.5%	3,572	(474)	-13.3%	8,462	8,958	(496)	-5.5%
239	339	-29.7%	Finance & Legal	1,007	(773)	1,781	-230.2%	1,100	(93)	-8.5%	856	779	77	9.9%
108	160	-32.3%	Consultancy	277	850	(573)	-67.4%	627	(350)	-55.8%	1,923	1,972	(48)	-2.5%
131	212	-38.1%	Other	445	1,165	(721)	-61.8%	1,139	(695)	-61.0%	1,883	2,648	(765)	-28.9%
4,374	**4,747**	**-7.9%**	**Subtotal**	**22,762**	**22,982**	**(220)**	-1.0%	**23,993**	**(1,231)**	-5.1%	**55,386**	**55,386**	**(0)**	0.0%
			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!
868	1,274	-31.8%	Other	4,696	5,903	(1,207)	-20.4%	4,843	(147)	-3.0%	12,803	15,283	(2,480)	-16.2%
868	**1,274**	**-31.8%**	**Subtotal**	**4,696**	**5,903**	**(1,207)**	-20.4%	**4,843**	**(147)**	-3.0%	**12,803**	**15,283**	**(2,480)**	-16.2%
			Financial											
309	382	-19.1%	Dividend	1,546	1,912	(365)	-19.1%	1,400	146	10.4%	4,588	4,588	(0)	0.0%
98	171	-42.6%	Interest	487	853	(365)	-42.8%	388	100	25.8%	1,180	2,047	(867)	-42.4%
407	**553**	**-26.4%**	**Subtotal**	**2,034**	**2,765**	**(731)**	-26.4%	**1,788**	**246**	13.8%	**5,768**	**6,635**	**(867)**	-13.1%
23,112	**23,387**	**-1.2%**	**Total Expense**	**116,722**	**115,786**	**935**	0.8%	**115,234**	**1,488**	1.3%	**279,637**	**280,596**	**(960)**	-0.3%

LAS Financial Review - Divisional Summary

Month Ending 31st August 2010 - (Month 5)

Month Act	Month Budget	%		Ytd Act	Ytd Budget	Diff	%	2010/2011 Fcast	2010/2011 Budget	Diff	%
£000	£000			£000	£000	£000		£000	£000	£000	
			Operations								
			A&E Sector Services								
8,255	13,949	-404%	**- Subtotal**	70,316	68,575	1,741	2.5%	168,690	168,937	(247)	-0.1%
			Control Services								
1,862	1,637	14%	**- Subtotal**	9,398	8,711	687	7.9%	21,204	20,066	1,138	5.7%
			Operational Support								
7,505	1,277	488%	**- Subtotal**	8,015	6,877	1,138	16.5%	18,468	15,821	2,646	16.7%
			Total Operations								
17,622	16,863	4%	**- Subtotal**	87,730	84,164	3,565	4.2%	208,362	204,824	3,537	1.7%
			Patient Transport Services (PTS)								
671	552	21%	**- Subtotal**	3,503	2,942	561	19.1%	7,540	6,819	721	10.6%
			Corporate Directorates								
249	188	32%	**- Subtotal**	1,211	980	231	23.5%	3,157	2,319	837	36.1%
			Corporate Services								
315	282	12%	**- Subtotal**	1,308	1,418	(110)	-7.8%	3,219	3,303	(84)	-2.5%
			Service Development								
68	82	-18%	**- Subtotal**	479	434	45	10.4%	994	965	30	3.1%
			Finance & Estates								
1,366	2,194	-38%	**- Subtotal**	7,193	8,248	(1,055)	-12.8%	19,449	23,112	(3,663)	-15.8%
			Human Resources & Training								
1,257	1,396	-10%	**- Subtotal**	7,360	7,990	(630)	-7.9%	15,572	16,868	(1,296)	-7.7%
			IM & T								
1,122	1,332	-16%	**- Subtotal**	5,730	7,111	(1,381)	-19.4%	15,730	16,399	(669)	-4.1%
			Commmunications								
119	130	-9%	**- Subtotal**	569	666	(97)	-14.5%	1,528	1,579	(51)	-3.2%
			Medical								
92	119	-23%	**- Subtotal**	507	595	(88)	-14.8%	1,237	1,438	(202)	-14.0%
			Total Corporate Directorates								
4,820	5,972	-19%	**- Subtotal**	25,489	28,680	(3,191)	-11.1%	63,735	68,953	(5,218)	-7.6%
			Total LAS								
23,112	23,387	-1%	**- Total LAS**	116,722	115,786	935	0.8%	279,637	280,596	(960)	-0.3%

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

28TH SEPTEMBER 2010

PAPER FOR NOTING

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

Executive Summary/key issues for the Trust Board

Safety: 1 new SUI declared, relating to non conveyance.

Clinical and cost effectiveness:

1. CPI performance now at 80% for the last month (July). Feedback targets for the year to date exceeded.
2. Update on the clinical issues addressed with staff through the annual Chief Executive's Consultation Meetings provided.
3. Interim report on Clinical Audit and Research provided.
4. Revised Safeguarding declaration now submitted.

Governance:

Update provided on medicines management. 1 incident involving Controlled Drugs where 2 ampoules of morphine were broken, having been taken home at the end of shift.

Care environment and amenities:

IP&C update provided to staff through the Consultation Meetings. Staff encouraged to access seasonal influenza vaccinations.

Attachments
Main report with 1 appendix (Interim Clinical Audit report on Obstetric Care)

****

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper links to the following strategic risks:

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

NHS Constitution

This paper supports the following principles that guide the NHS:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☒ No

Key issues from the assessment:

LONDON AMBULANCE SERVICE NHS TRUST

Trust Board 28th September 2010

Clinical Quality and Patient Safety Report

Safety

1.1 Update on Serious Untoward Incidents (SUIs)

One new SUI has been declared since my last report in August 2010. This case relates to a young patient assessed by a London Ambulance Service crew, who was left at home and subsequently deteriorated and died within a short period of time. Concern has also been expressed over the decision not to refer his partner for further investigation given the possibility that he had died of overwhelming infection.

Our Patient Experiences Department has worked closely with the NHS London to review and improve the standard of SUI reports prepared by investigating officers. As a result, opportunities for a number of staff to undertake a 2 day training course in Root Cause Analysis have been offered.

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.

6 alerts were received from 19th August – 9th September 2010. All alerts were acknowledged; none required action.

Clinical and Cost Effectiveness

2.1 Clinical Performance Indicator completion

The current target for CPI completion is **95%.** The July figures show that the dramatic improvement achieved in March and April has been sustained. The fall in completion for the month of June which reflected the increase in the REAP level has been partially recovered.

Diagram 1. CPI completion December to July 2009 / 2010

Area	December	January	March	April	May	June	July
East	20%	23%	77%	86%	77%	78%	83%
South	44%	46%	82%	94%	94%	70%	73%
West	36%	56%	86%	98%	93%	76%	86%
LAS	**36%**	**43%**	**82%**	**93%**	**89%**	**74%**	**80%**

For the year 2010 to date, Team Leaders across the LAS have delivered 1994 feedback sessions, exceeding their target for the year so far. The West Area continues to exceed its target (this figure is based on each member of staff receiving two feedback sessions per year).

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

2.2 Chief Executive's Consultation Meetings

The Chief Executive's yearly Consultation Meetings with staff commenced on 1st September. A Medical Director's Update is included, focusing on areas where clinical care has significantly changed, and those where improvements and changes are needed. These include the resuscitation of patients in cardiac arrest, the management of acute coronary syndromes, stroke and major trauma. There is also a focus on patient and staff safety, including a discussion on the referral of children under the age of 5 years, highlighting recurring themes of complaints and possible litigation against the Trust, the need to take patient's own medication into hospital with them, and the infrequent but potentially serious implications for staff called to patients who have committed 'chemical suicide.'

To date eleven meetings and a Senior Managers' Conference have been held (out of a total of 26 Complex meetings, 3 Control Services meetings, 1 Senior Managers' Conference and 2 Managers' Conferences). The clinical issues which have arisen, so far, have included shortages of equipment, changes in airway management training for paramedics in training, concerns raised by A&E Support staff around their deployment and responsibilities, the challenges staff face in managing patients with mental health problems, feedback on safeguarding referrals, concern around the conveyance of all children under 2 years and the practicalities of referring children to primary care out of hours. The challenges of proposing patients for inclusion on the High Risk Address Register have also been discussed.

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

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

2.3 The management of frequent callers

The Patient Experience Department continues to focus on patients who use the Service very frequently and sometimes inappropriately, to explore opportunities for better care in the community. The following are some examples:

- Caller who placed 1300 calls in 6 month period – resolved via liaison with their local Community Mental Health Trust. The outcome was that the patient was placed in a supervised care facility
- Caller who placed over 500 calls in a 12 month period : Anti Social Behaviour Order (ASBO) granted
- Cross agency networks being expanded in North East and South East sectors with strong support from Commissioners

- Targeted review of Care Homes: to date 2 care homes identified as placing disproportionate call volumes, this has been taken forward through liaison with local Care Homes / Local Authorities.
- Successful conclusion of outreach project with Transport for London (TfL); working with Street Rescue & Metropolitan Police to reduce 'rough sleeper' calls.
- Introduction of crew referral process, identifying 'new' cases
- Continued liaison with St Mungo's hostels in terms of better emergency care management of their residents

2.4 Safeguarding update

The Patient Experience Department has submitted the revised safeguarding declaration. This can be viewed via: http://www.londonambulance.nhs.uk/health_professionals/safeguarding-child_protection/safeguarding_children_declarat.aspx

We anticipate that further revisions to this declaration will be made in the coming weeks as we update training information particularly in relation to those groups and members of staff who have more advanced input to our safeguarding arrangements. We are also considering the practicalities of alerting GPs where a child is not conveyed on clinical grounds.

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 has been one Controlled Drugs (CD) incidents since the last report to the Trust Board. This occurred at Hillingdon Ambulance Station when a member of staff inadvertently left two ampoules of morphine in a uniform shirt. These broke when the shirt was washed. The broken ampoules were returned and the member of staff is aware of the gravity of this occurrence.

The roll out of the new morphine pouches is continuing across the Service. On receipt of the pouch each member of staff also receives a letter reinforcing the practical issues around the care of Controlled Drugs.

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

One of the messages being delivered as part of the Medical Director's Update to staff during the Consultation Meetings is the importance of having this year's seasonal flu vaccination.

Public Health

Nothing further to report

Recommendation

That the Board notes the report

Fionna Moore,
Medical Director
18th September 2010

Appendix 1

Clinical Audit & Research Summary Report for the Trust Board

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

Authors: Stephen Gadd (Clinical Audit Manager) and Gurkamal Virdi (Assistant Head of Clinical Audit & Research), Clinical Audit and Research Unit, Medical Directorate.

Introduction

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

Method

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

The second component of the project was to obtain the women's views on the care they received, their expectations and to ask them the circumstances which led to the ambulance being called, via a questionnaire. As part of writing to the women, their consent to be included in the audit project was sought.

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

Findings

Emergency call tapes were reviewed and found to have an AMPDS case evaluation score of 86%. Emergency Medical Dispatchers (EMDs) had an average customer service score of 99%. A chief complaint of Pregnancy/Birth/Miscarriage was allocated for 96% of the calls in the audit and there was a correlation between calls allocated the highest LAS (Red) response, and cases identified by the crews as being

emergencies. This suggests that LAS EMDs and AMPDS are able to identify both obstetric cases with high specificity and detect obstetric emergencies so they can be given an appropriate response.

The crew assessment of primary observations was very good, although assessment of second observations was less so. The history of pregnancy was only documented for 64% of cases. It is important that this is documented so that it is clear that the history of the woman's pregnancy has informed the crew's decisions.

The audit also found that only 73% of cases were offered entonox when indicated. It should be noted that the complaints review carried out prior to the audit identified incidents relating to pain management. In addition, one of the themes identified in the patient questionnaire was women's appreciation of the analgesia offered to them by crews.

The only obstetric complications in the audit sample were severe haemorrhage and continuous abdominal pain. Management of these patients was good, although the documentation of blood loss volume can be improved.

Patients are generally being conveyed appropriately according to the JRCALC Clinical Practice Guidelines. However, the use of pre-hospital alerts in cases with complications was not consistent. This might be in part due to the lack of dedicated emergency alert lines (blue call lines) in maternity units as found in emergency departments

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

The majority of respondents to the questionnaire stated they called an ambulance for normal presentations of labour: 63% because they were having regular contractions and 52% because their waters had broken. This indicates that a proportion of people are routinely using ambulances for normal presentations of labour. Furthermore, when asked if they were satisfied with the service they received: 85% of respondents stated they were completely satisfied. However, two respondents stated they were not satisfied and their free text descriptions described themes relating to staff attitude. This issue was also identified in the review of obstetrics complaints to the LAS.

Conclusion

Appropriate, professional assessment and management of all obstetric cases, including routine cases, is vital in decreasing the chances that an obstetric emergency is missed. This is critical in supporting the best outcome for the mother and baby. Overall, the clinical audit shows that we are generally providing high quality care for this high risk patient group. This is further supported by the responses to the questionnaires indicating that the majority of the women in the audit were pleased with the care they received. There were a small number of cases where deviations from best practice were identified and the recommendations from the audit are designed to address these gaps in care.

Recommendations

1. Crews should be reminded to exercise caution when attending all obstetrics cases, as ambulance services have only limited capabilities in identifying and managing obstetric abnormalities.
2. Crews should be reminded of the importance of taking more than one set of observations, as time allows, to detect any changes in the woman's condition. This is especially important in cases where the woman presents with frank bleeding and severe, continuous abdominal pain.
3. A memory aide should be produced listing the key questions to ask and document for routine pregnancies, to include: history of the presenting pregnancy, history of previous pregnancies and live births, estimated date of delivery, the pain score and whether entonox administration is required. In addition, it should contain a reminder of when women should be conveyed to their booked maternity unit, the nearest maternity unit or to an emergency department.
4. Crews should be reminded to document an estimated volume of blood loss when a woman presents with bleeding, or a reason why this could not be documented.
5. The LAS continues to work with maternity units and Healthcare for London to ensure dedicated emergency alert lines are placed in each unit.
6. The LAS should explore ways of encouraging the further education of ante-natal women about what constitutes normal signs of labour and what constitutes signs of potential complications to help them to know when to call an ambulance.
7. Crews and call-takers should maintain a positive, polite and kind attitude when dealing with all Service users.
8. Crews and call-takers should be commended that the majority of questionnaire respondents were very happy with the service they received.
9. A further audit focusing on obstetric emergencies cases should be conducted in the future.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

28TH SEPTEMBER 2010

PAPER FOR APPROVAL

Document Title:	**Winter Surge Planning Framework 2010/11**
Report Author(s):	**Jason Killens and Lizzy Bovill**
Lead Director:	**Lizzy Bovill**
Contact Details:	**Lizzy.bovill@lond-amb.nhs.uk**
Why is this coming to the Trust Board?	**NHS London requires LAS Board level assurance of LAS Winter Plan**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☒ Other ADG
Recommendation for the Trust Board:	To approve this winter plan

Executive Summary/key issues for the Trust Board

1.1 London Ambulance Service underwent a strict winter and flu planning assurance process in 2009 under the direction of NHS London and the Department of Health. LAS were given a 'Green' RAG rating for preparedness and this planning framework builds on those preparedness strategies through learning from the pressures experienced during the winter period of 2009/10.

1.2 The Winter Pressure Surge Planning Framework 2010/11 for the London Ambulance Service sets out to maintain optimum levels of service to service users across the capital by deploying, where necessary, innovative and different solutions to demand and capacity management.

1.3 Actions to increase available staffing, capacity management regimes and alternate ways of dealing with requests for emergency ambulances are at the heart of this framework and will, where practicable, maintain a high level of emergency response to those patients in greatest need.

1.4 UK ambulance services are organisations that are structured so that virtually all available resources are routinely deployed to frontline services. Consequently there are few additional assets within organisations that can be released to provide additional capacity.

1.5 The national patient waiting time standards operated within ambulance trusts are very susceptible to subtle increases to demand and reductions in capacity. This framework recognises that vulnerability and sets out a series of considerations that, if faced with demand changes and capacity reduction during the winter period of 2010/11, will, where possible, maintain high levels of emergency ambulance cover

across the capital.

1.6 The framework adopts existing principles for the management of short term increases in demand where this outstrips supply (capacity) and seeks to enhance these arrangements and ensure a whole system approach to protracted periods of unprecedented demand for our services.

1.7 The Framework is under regular review and adopts recommendations and lessons identified from previous events, exercises and incidents as well as best practice from peer organisations.

1.8 The framework is shared with partners in the London health economy and is the result of an assurance process from NHS London (Strategic Health Authority).

Attachments

****

Strategic Goals 2010 – 13
This paper supports the achievement of the following corporate objectives:

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

Risk Implications
This paper links to the following strategic risks:

☐ There is a risk that we fail to effectively fulfil care/safety responsibilities
☒ There is a risk that we cannot maintain and deliver the core service along with the performance expected
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Equality Impact Assessment

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

Key issues from the assessment:

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

28TH SEPTEMBER 2010

PAPER FOR NOTING

Document Title:	**7/7 Action Plan**
Report Author(s):	**Jason Killens**
Lead Director:	**Richard Webber**
Contact Details:	**112085**
Why is this coming to the Trust Board?	**To provide the Trust Board with assurance surrounding on ongoing preparedness for Major Incidents and the lessons identified from the 7/7 London Bombings**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	Note the new actions that have arisen from the 7/7 inquest preparations and our ongoing progress in enhancing overall preparedness

Executive Summary/key issues for the Trust Board

As part of our work to prepare for the inquests into the London Bombings of 2005 the original action plan has been reviewed to ensure continued compliance and improvement. A new plan launched on 15th September 2010 detailing 29 actions now replaces the original document and will be monitored monthly by SMG.

Trust Board are asked to note actions 2, 11, 19 and 22 as those requiring the allocation of resources to achieve. All actions are scheduled to be completed by 31st March 2011.

Attachments

Interim 7/7 action plan

****

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper links to the following strategic risks:

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

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- ☒ 1. The NHS provides a comprehensive service, available to all
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- ☐ 7. The NHS is accountable to the public, communities and patients that it serves.

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

- ☐ Yes
- ☒ No

Key issues from the assessment:

London Ambulance Service NHS Trust
Action Plan: Issues identified from interim report of preparations for 7th July 2005 inquests

Ref	Action	Owner	Delivery date	Progress	Comments
1	It is stated that training vans carry major incident equipment and are available 24/7. Audit the current provision and ensure it is compliant with previous assurances to GLA.	Chris Doyle*	31st October 2010	DSO David Gordedo secured to undertake audit and report on findings	Secure 1 WTE for 4 weeks to do this and items 3 and 10
2	Deliver an ESV replacement programme to enhance the provision of equipment necessary to manage Major Incidents at the incident site	John Pooley	31st March 2011	Nick Pope contacted by John Pooley (14/09) to expedite	Agreed as required at SMG briefing 15/09/10
3	Audit the availability of triage cards to ensure immediate deployment to an incident scene; develop bulk storage options together with deployment capabilities to incident sites; consider the need for additional triage training for frontline staff and explore the market to see if a more efficient system is available	Chris Doyle*	31st October 2010	DSO David Gordedo secured to undertake audit and report on findings	Secure 1 WTE for 4 weeks to do this and items 1 and 10
4	Restrict access to ICR to essential staff only	Paul Tattam	30th September 2010		List of names to be granted access to be agreed with John Pooley. Replace current locking mechanism so that the doors remain secure.
5	Provide a simple and easy log in system for all equipment to be used by staff in ICR during an incident	Paul Tattam	30th November 2010	All EOC logins for CTAK, Avaya phones and ICCS work in ICR/ECR	
6	Develop an electronic command log that is capable of recording critical messages and other information that is viewable by all operational managers both internally and in the remote environment	IM&T	31st December 2010		To be passed to Vic Wynn at the September EP and BC steering group meeting. Named owner to be recorded.
7	Publish direct dial telephone numbers for FBC	Paul Tattam	30th September 2010	Numbers secured and to be made available to EOc and key Ops managers	
8	Audit the availability of command role tabards at station	EPU	30th November		Named owner to be provided by

	level; provide adequate supplies and deployment capabilities in each area		2010		John Pooley by 30th September 2010.
9	Develop a document and statement control process to manage the aftermath of a Major Incident	Paul Gibson	31st March 2011		
10	Audit the provision of blast and major incident equipment held at transport hubs (supplied to DH) to ensure its fitness for purpose and secure replacements where necessary; publish a directory of locations and responsible persons at each site	Chris Doyle*	31st October 2010	DSO David Gordedo secured to undertake audit and report on findings	Secure 1 WTE for 4 weeks to do this and items 1 and 3
11	Deliver a replacement programme for ECVs (new style in light of technical changes) removing from service Red and Blue major	John Pooley	31st March 2011	Nick Pope contacted by John Pooley (14/09) to expedite	
12	Raise awareness of the need to log, record and time all actions and decisions taken by managers/officers during a Major Incident	Jason Killens	31st March 2011		Development of training package by Bond Solon – quotes received.
13	Develop the role of a critical message loggist in the revised Major Incident plan	Liam Lehane	31st December 2010		
14	Raise awareness amongst frontline staff of the safety features provided by 3 whistle blows from LFB	David Williams	28th February 2011	Covered in core EPU training at current time	Ensure covered in EP session of core skills refresher day two
15	Publish guidance to frontline staff on the use of FFP2 and FFP3 masks when working in dusty environments such as underground tunnels	John Selby	31st October 2010		
16	Raise awareness of the need to check the security of proposed RVPs and casualty clearing stations at incident sites to manage the risk of secondary devices	David Williams	28th February 2011		Ensure covered in EP session of core skills refresher day two
17	Review each action within the Trusts initial action plan following the 7th July bombings to provide assurance that each action remains delivered or that it has been superseded (noting this where applicable)	Liam Lehane	15th September 2010	Actions reviewed and those that require further work transferred to this action plan	
18	Review and publish the revised Major Incident Plan including	John	31st December		

	new incident roles, revised communications strategy and scene management requirements providing update training and or awareness where necessary to relevant staff groups	Pooley	2010		
19	Maintain availability and readiness for use of Gold Suite developing fall back arrangements should HQ be compromised	John Pooley	30th November 2010		
20	Submit SPPP for funding, advertise and recruit 1 WTE qualified training officer hosted by and dedicated to EPU for delivery of training and development of Trust wide staff on EP and BC issues	John Pooley	31st December 2010		
21	Develop pop up system for action cards or required actions associated with major incidents within CommandPoint	John Hopson	June 2011		Upon delivery of CommandPoint this functionality will go live
22	Develop and deliver a comprehensive training package for all control services staff with specific attention paid to managers in all aspects of major incident management including ICR use and control requirements of incident management	Fiona Carlton	31stDecember 2010		
23	Scope the reconfiguration of ICR in the light of experience in the use of the current configuration, develop a costed requirements document and submit proposals for funding and development	Liam Lehane	31st March 2011		Multi-disciplinary working group consisting of experienced uses to be established to scope requirement
24	Develop predetermined major incident actions and requirement instructions to crews via MDT	John Hopson	31st December 2010		
25	Agree specification for replacement DSO vehicle programme taking into account major incident equipment requirements, secure funding and deliver a vehicle replacement programme	Jason Killens	31st March 2011		
26	Incorporate a range of suitable call signs for use by PTS during a major incident into OP/022 that are useable within CTAK and CommandPoint	Craig Harman	30th November 2010		
27	Scope the requirement of and procure portable lighting solutions for deployment to incidents in tunnels and	David Hutton	31st December 2010		

	confined spaces				
28	Provide two pairs of suitable debris gloves on each AEU, FRU, MRU and CRU together with sufficient spares in ESVs	David Hutton	30th November 2010		
29	Incorporate departmental response to and support of major incidents into each directorate business continuity plan developing a recall to duty cascade information system	Paul Williams	31st December 2010		

*on behalf of Jason Killens

Key:	Total	Percentage
Off target, will not deliver as expected		
Some slippage, likely to deliver on target		
On target, will deliver as expected		
Delivered		

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

28th September 2010

PAPER FOR APPROVAL

Document Title:	**CommandPoint Update**
Report Author(s):	**Peter Suter**
Lead Director:	**Peter Suter**
Contact Details:	
Why is this coming to the Trust Board?	**The objective of this paper is to update the Trust Board on the current status of the CommandPoint Project, and to seek approval for the actual transition date.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	For the purposes of planning and contract modification, the Trust Board approve the CommandPoint Transition date as 8 June 2011. The actual go-live decision will be subject to separate Trust Board approval.
Executive Summary/key issues for the Trust Board The objective of this paper is to update the Trust Board on the current status of the CommandPoint Project, and to seek approval for the actual transition date.	
Attachments CommandPoint Update	

****

Corporate Objectives 2010 – 13
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Risk Implications
This paper links to the following strategic risks:

☒ There is a risk that we fail to effectively fulfil care/safety responsibilities
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Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☒ No

Key issues from the assessment:

LAS TRUST BOARD SEPTEMBER 2010

COMMANDPOINT UPDATE

1. INTRODUCTION

1.1 The objective of this paper is to update the Trust Board on the current status of the CommandPoint Project, and to seek approval for the actual transition date. This date will then be confirmed contractually; however confirmation does not give approval to commence transition. This will be a separate process to ensure that the Trust Board have control over the final 'go live' decision

2. REVIEW OF THE PROJECT APPROACH.

2.1 The CommandPoint system is designed to replace the existing CTAK Command & Control System. In terms of development and testing it is being delivered by two releases of software. Release 1.0 is the main release delivering all the requirements within the original contract and specification. Release 1.1 is an update that includes six additional pieces of functionality specifically requested by the LAS. It is release 1.1 that is required for go live.

2.2 Only one of the updates in release 1.1 affects what end users will see and therefore impacts upon training. However, the training impact is small and our training team have satisfied themselves that it can safely be delivered using screen shots. This means that end user training can be started using release 1.0. This approach has allowed the software development work for release 1.1 to be decoupled from the overall critical path of the project.

3. PROJECT PROGRESS

3.1 The first formal stage of testing, the Factory Acceptance Test (FAT) for release 1.0 was successfully completed on Monday 14 June. The second stage of testing, Site Integration Testing (SIT) has also now been successfully completed. This was a significant milestone as it involved installing the release 1.0 software on the test systems at Southwark Bridge Road and connecting to the live CTAK interfaces. This was logistically and technically complex, at times requiring A&E Operations to work without normal system facilities. For example in the early hours of one morning while A&E Operations worked using fall back arrangements, the entire MDT infrastructure was successfully connected to, and tested with, CommandPoint release 1.0.

3.2 It is worth referring back to the earlier stages of the project where there were issues with the interface simulators provided by the LAS. At the time this was a difficult issue, however the value of continuing and completing this work has been very influential to the overall success of SIT.

3.3 The third stage of testing is the User Acceptance Testing (UAT). Between 16 August and 10 September the first of three planned iterations of UAT against release 1.0 of CommandPoint ran a total of 249 detailed test scripts covering all areas of user functionality specified in the contracted system requirements. The results obtained by this first iteration were in-line with the expectations for a new system and environment of this size and complexity.

3.4 A second iteration of UAT is scheduled to be run from 27 September to 22 October. A third iteration will be scheduled if required. The detection and resolution of issues with the CommandPoint system prior to its deployment is crucial to the success of the project. The number of issues found at this stage reflects the importance and thoroughness of the UAT procedure to date.

3.5 The work on training materials and the pilot training courses is well advanced. The plan is on schedule for the end user training to commence In January 2011. Once the transition date is approved by the Trust Board, letters will immediately be sent to all Control Services staff confirming their training dates.

4. POINTS TO NOTE

4.1 Risk management remains a key focus for the Project and risks are reviewed weekly by the Project Executive. The highest risks remain in relation to end user training. However there

are no risks that need specifically bringing to the Trust Board's attention at this time. The Senior Management Group is closely engaged with the project, with formal reporting at the monthly meeting.

4.2 As reported previously, work is underway to finalise arrangements for the organisation of the FRU's and UOC within the Control Room. Detailed analysis and planning is currently being undertaken to determine how the Clinical Response Model evaluation will be achieved without putting the CommandPoint transition at risk.

4.3 Consideration needs to be given as to the content of the first post 'go live' development release of CommandPoint. Normal practice would suggest that this would be approximately six months after transition (dependant on complexity). Based upon the original schedule this is currently specified as an interface for PSIAM, that is used for Clinical Telephone Advice.

4.4 NG have made further changes to their Project Management arrangements. NG Project Manager John Hopkins has been relocated back to the USA, but returns to the UK whenever required. A UK Based Project Manager, Donna Ruddell has been moved by NG into the LAS premises at Southwark Bridge Road to ensure continuity. Donna will also have a key role in support after transition. Currently these arrangements are working satisfactorily.

4.5 NG has now delivered their report relating to the performance issues identified during FAT. An Initial review report indicates a satisfactory conclusion to this matter.

4.6 The project is currently within the allocated budget.

5. TIMETABLE

5.1 A previous Trust Board report identified a February 2011 milestone as the projected transition date. This was prior to any testing having started, but it did provide a sound basis for project focus and planning. It is now anticipated that February/March 2011 will provide the milestone for next Gateway Review.

5.2 Given the experiences from testing and finalising additional development work (release 1.1) the project team can now reasonably predict the actual transition date. Based on joint detailed planning with NG, it is proposed that the actual transition takes place between midnight and 07:00 hours on Wednesday 8 June 2011. A high level plan detailing the key milestones is attached at Appendix 1.

6. RECOMMENDATION

6.1 For the purposes of planning and contract modification, the Trust Board approve the CommandPoint Transition date as 8 June 2011. The actual go-live decision will be subject to separate Trust Board approval.

Peter Suter
Director of IM&T
September 2010

APPENDIX 1: Key Milestones.

CommandPoint- High Level Plan		
Description	**Deliverables**	**Date**
User Acceptance Testing	Complete second iteration	22/10/10
Pilot Course	Running the pilot course for End Users. This will trial the course content and training material. Following completion, the training materials will be finalised.	29/11/10
FAT 1.1	Commence FAT of Release 1.1 (Note this is not on the critical path)	13/12/10
Commence Pre Go-Live User Training	15 week programme, to train all control services staff.	6/1/11
Gateway 4	Full gateway review to assess readiness to go live	TBC Feb/Mar/11
Release 1.1	Release 1.1 used in training.	TBC Feb/Mar/11
Complete Pre Go-Live User Training	All staff trained in their primary job function (Call Taking or Dispatch). A number of staff on each watch trained in both Call Taking and Dispatch Functions.	May 11
Final preparation	Final technical and operational preparations for transition to CommandPoint.	21/4/11
Transition Date	The actual go live date for CommandPoint.	8/6/11
+60 Days	Post go live focus to ensure; Bug fixes Embedded working practices Return operational performance back to previous levels	7/8/11
Post Go-Live Training	Follow-up training to ensure that all staff have received training in both Call Taking and Dispatch Functions	TBC
Release 1.2	The current plan has a requirement to build an interface to PSIAM for CTA. The details of this work and timetable have yet to be specified.	TBC
Project closure	Formal closure and handover to in-life team.	TBC

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

28th September 2010

PAPER FOR APPROVAL

Document Title:	**Integrated business plan and Long Term Financial Model**
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 Long Term Financial Model**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	a) To approve the draft Integrated Business Plan and Long Term Financial Model

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 five years. The full IBP is available to board members on request.

At the Trust Board meeting on the 31st August 2010, the Board approved the story boards which were created to summarise the key content within the draft IBP. Work has continued in the past few weeks, to clarify the clinical response model and a few minor issues and to integrate the key assumptions contained within the LTFM into the IBP. Additional story boards have been created to summarise this new content and are attached for review and comment. The financial modelling storyboards will be presented on the day, as they are subject to discussions this week. These storyboards form the basis of the discussion on 28th September and the Trust Board is asked to approve the draft IBP and LTFM 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, as part of the FT application process. The FT support team have undertaken to respond by 8th October 2010 and the formal assurance process will then commence.

The FT timeline is on-track for authorisation in September 2011.

Attachments

Additional story boards on the IBP and LTFM.

****

Strategic Goals 2010 – 13

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Risk Implications

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☒ No

Key issues from the assessment:

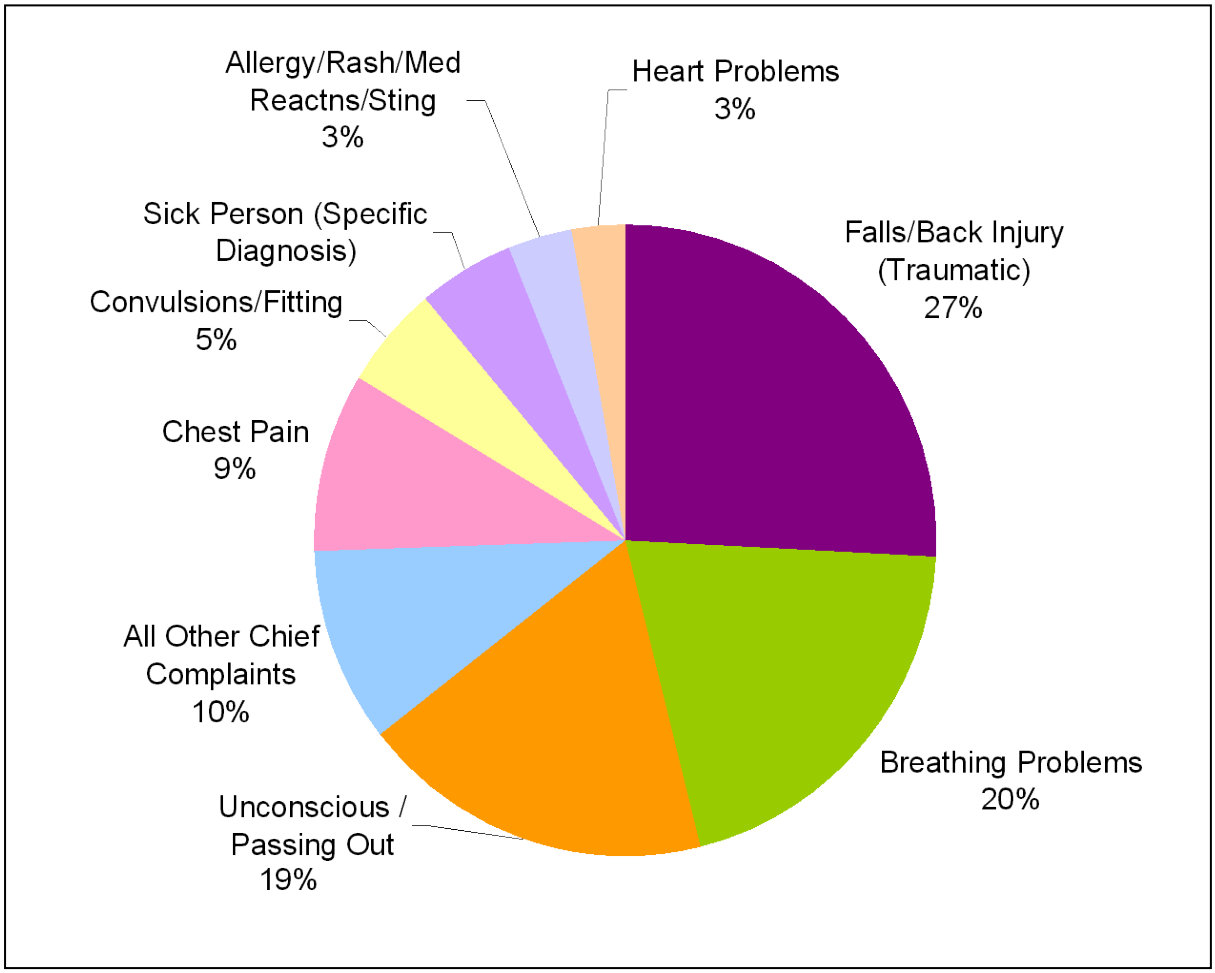
LAS Foundation Trust Application

Additional Story boards

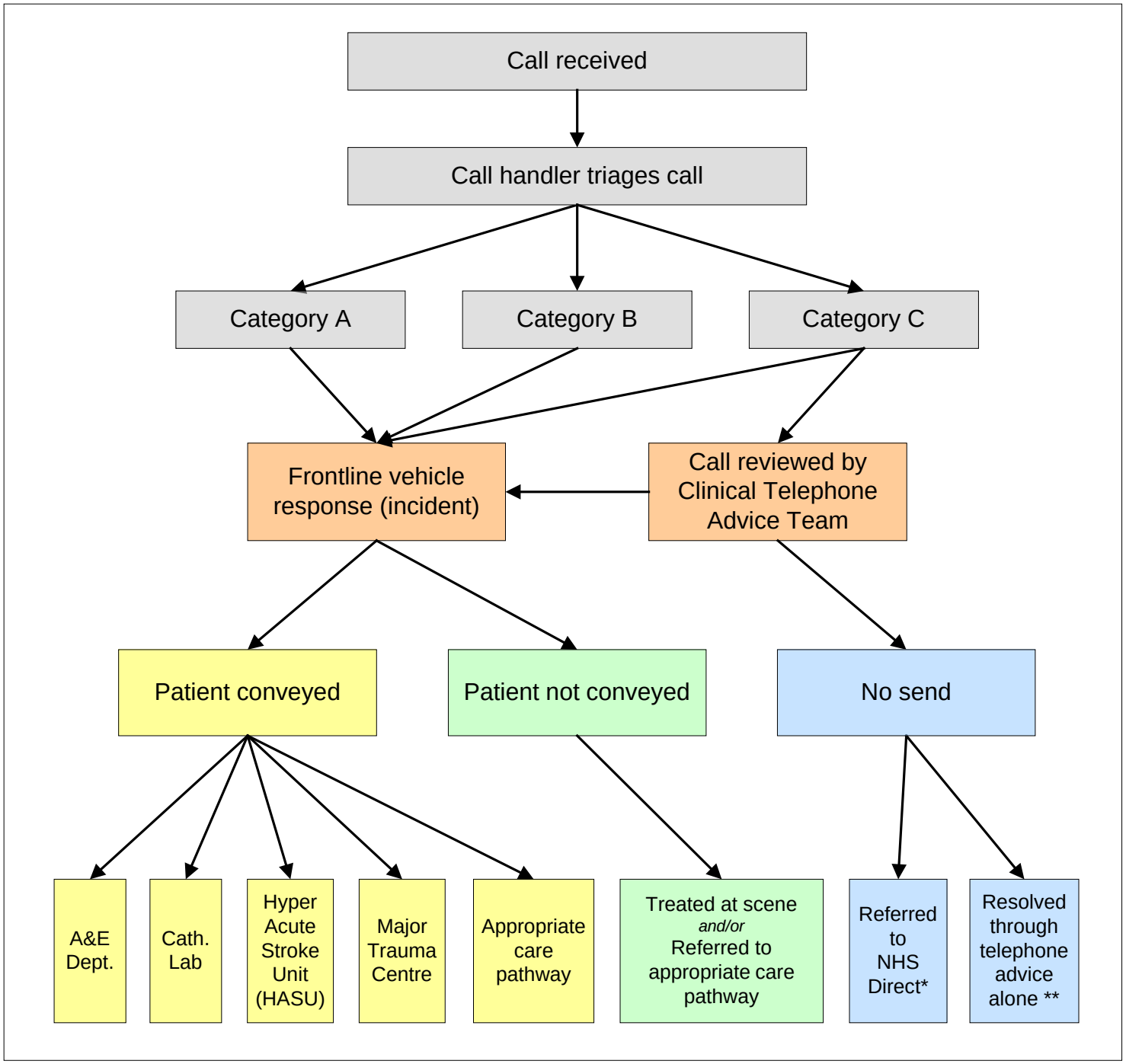
Trust Board Meeting 28th September 2010

Story board A – What are the principle medical complaints presented by our patients?

Figure: Proportion of incidents, by complaint (2007/8)



Story board B – Flowchart of LAS operating model



* In 2009/10, 17% of the calls we referred to NHS Direct (64,301 total) were referred back to the LAS for a vehicle response

** Resolution may include referral to an appropriate care pathway

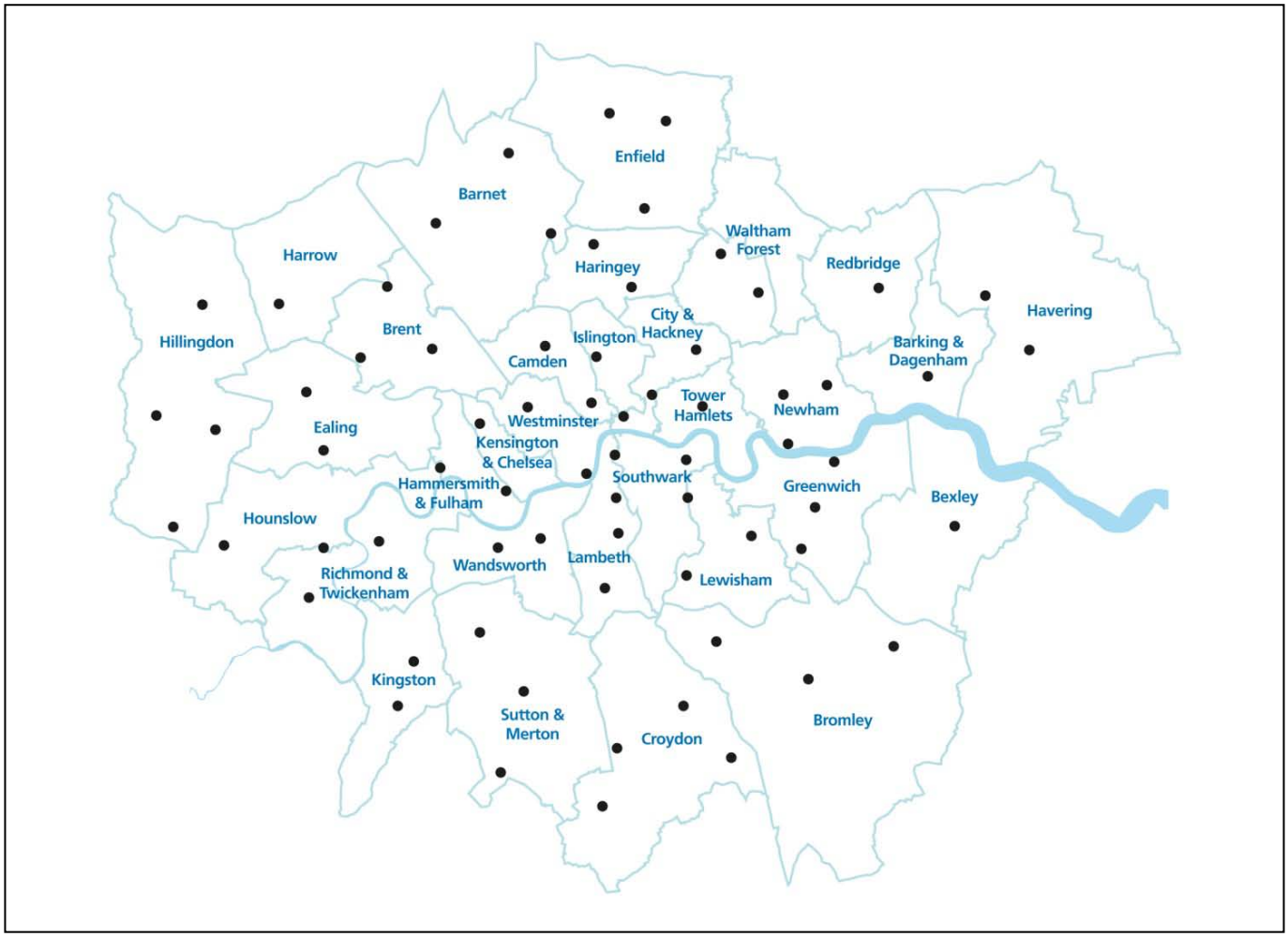
Story board C – Staff make-up and locations

The Trust employs more than 5,000 staff who provide operational and support services across 74 London sites. We manage 71 ambulance stations and provide emergency vehicle responses from 26 complexes (hubs) across London.

Our operational staff make up approximately 80 per cent of our total staff numbers. Current frontline roles are community first responders, A&E support staff, student paramedics, emergency medical technicians, paramedics, team leaders and advanced practitioners.

The majority of our non-operational staff provide support within key areas including fleet and logistics; human resources - including education and training, finance, information management and technology (IM&T), medical support; corporate services and support;, communications, and operational administration and support.

Figure: Location of LAS ambulance stations, across the 31 London PCTs (black dots indicate station)



Story board D – Summary of service development plans

We have identified 10 key service development plans that underpin our strategy for the next five years.

The following five service development plans are already taking shape and form part of our base case:

- **2012 London Olympic and Paralympic Games**
- **Clinical response model**
    - Taking healthcare to the patient: a response appropriate to patient need
    - More efficient and effective use of resources
- **Clinical transfers**
    - Transporting patients between tertiary sites for specialist intervention and treatment
- **CommandPoint**
    - Replacing the current computer-aided dispatch system
- **Estates changes**
    - Moving to fewer but larger station and improving/rationalising other estate

The following additional five service development plans will be reviewed and considered for potential and affordability:

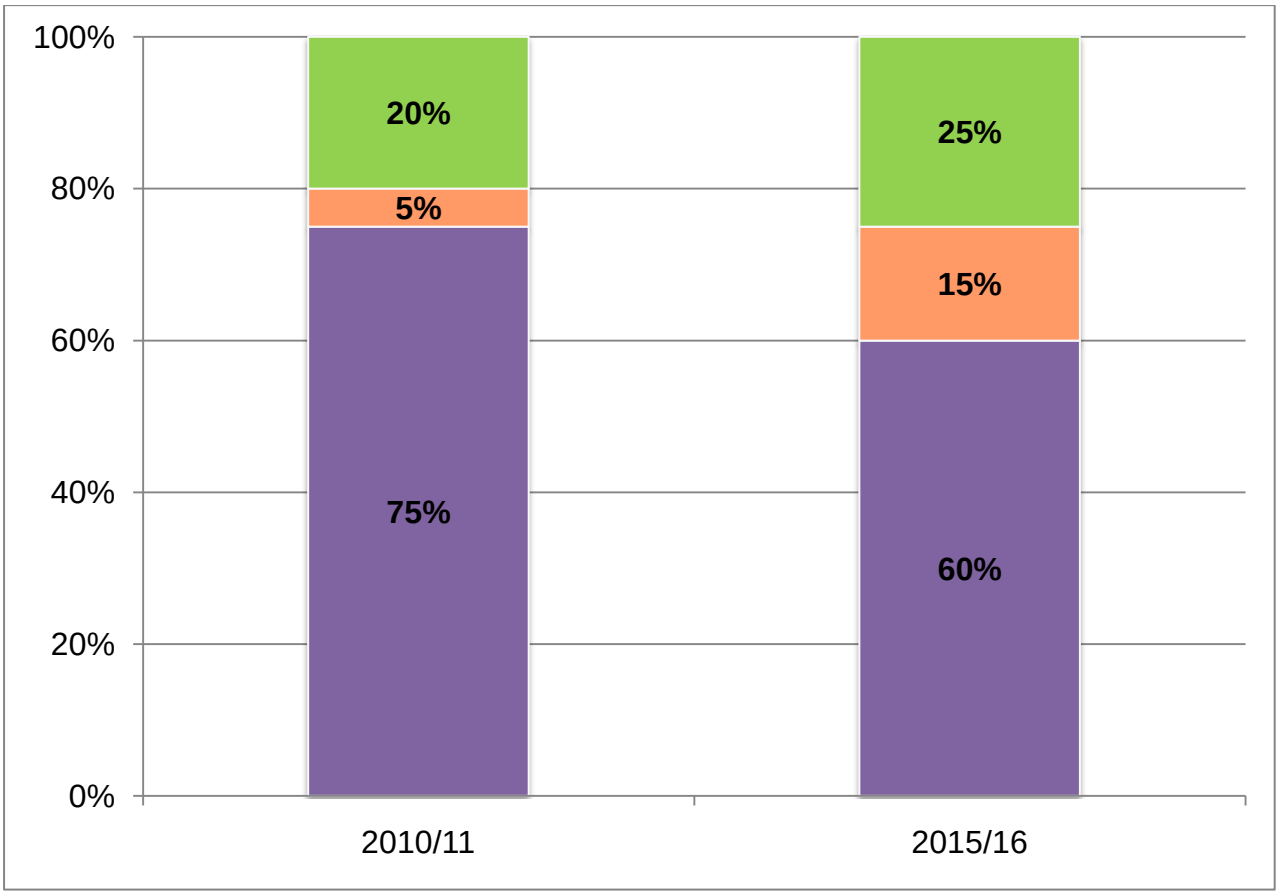
- **Control rooms**
    - Replacing the existing single control room at Waterloo with two fit-for-purpose control rooms
- **Coordinating healthcare in London**
    - Coordinating healthcare capacity and referring patients to appropriate centres of care through a single point of access
- **Electronic patient record form**
    - A complete and accurate set of personal, operational and clinical data for each patient encounter, recorded and transferred electronically
- **Emergency planning for London**
    - Taking over the role currently undertaken by NHS London to coordinate emergency preparedness across London's acute, mental health and primary care services
- **Emergency preparedness and specialist training**
    - Building on our skills and experience in emergency planning and major incident response

Story board E – Clinical response model service development plan

Figure below shows the impact of the clinical response model on incident resolution:

- More patients treated on scene or referred to appropriate care pathway
- Less patients conveyed to A&E
- More patients conveyed to appropriate care pathways.

These percentages will be confirmed during the three-month trial period starting in October 2010.



Incident (non-convey): Patient is treated on scene or referred to appropriate care pathway.

Incident (convey to appropriate care pathway): Patient is conveyed to an appropriate care pathway eg walk-in centre, minor injuries unit.

Incident (convey to A&E): Patient is conveyed to an acute hospital eg A&E department, HASU, catherisation laboratory, major trauma unit.

Story board F – Updates to other service development plans

- **Control rooms**
    - Indicative cost of replacing the existing single control room at Waterloo with two bespoke control rooms is £46 million.
    - Cheaper alternatives are being investigated, including:
        - Costing of "warming" the facilities at Bow.
        - The potential for a joint property development with other emergency service providers.
- **Coordinating healthcare in London**
    - The 3-digit number, 111, will replace the current 0845 NHS Direct number, however services will continue to be provided by NHS Direct.
        - The impact of this national strategy is still to be assessed. A pilot initiative is underway in North West England.
- **Electronic patient record form**
    - Significant investment will be required for this development during the IBP period. Previous funding from NHS London was withdrawn in 2010/11 and the source of funding and the scope of development will be reviewed.

London Ambulance Service NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

28th September 2010

PAPER FOR APPROVAL

Document Title:	**Governance rationale and membership strategy for the London Ambulance Service NHS Foundation Trust**
Report Author(s):	**Sandra Adams/Erin Heinrich/Shirley Rush**
Lead Director:	**Sandra Adams**
Contact Details:	**020 7783 2045**
Why is this coming to the Trust Board?	**This is a requirement of the Trust's application to become an NHS Foundation Trust**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	a) To consider and approve the rationale for the governance arrangements of the London Ambulance Service NHS Foundation Trust b) To approve the membership strategy

Executive Summary/key issues for the Trust Board

The governance rationale forms an appendix to the Integrated Business Plan and will be submitted to the Secretary of State as part of the formal application to become an NHS Foundation Trust. The document describes how the constituencies are defined, how the membership will be managed and how the Council of Governors is comprised. It incorporates the roles and responsibilities of the board of directors, how appointments are made and how meetings are to be managed. The rationale also covers the management of registers (membership, and interests of directors and governors), and the process for appointing the Trust's auditors.

The key issues for the Trust Board to consider are:

- Paragraph 15 and 17: Election rules for public and staff governors;
- Paragraph 28: Appointment of the Chairman and non-executive directors;
- Paragraph 29: Appointment of the Chief Executive;
- Paragraph 31: Remuneration and allowance for non-executive directors;
- Paragraph 35: Meetings of the Council of Governors – deputising arrangements;
- Paragraph 42: Composition of the Board of Directors – minimum and maximum numbers;
- Paragraph 44: Terms of office – transitional arrangements for the board of directors;
- Paragraph 59: Appointment of the Auditor.

The draft constitution will be made available to board members on the day of the board for review if they so wish. The governance rationale summarises the content of the constitution and provides a substantive briefing on the proposed governance arrangements.

The membership strategy was reviewed and agreed by the Trust Board in September 2009. This has been updated and supports key elements of the governance rationale and is therefore being brought back to the Trust Board for final approval. The strategy is a supporting strategy for the Integrated Business plan.

Attachments

1. Summary of key areas for the Trust Board to consider
2. Governance rationale
3. Membership strategy

****

Corporate Objectives 2010 – 13

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☐ 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

28th September 2010

Summary of the key issues described in the governance rationale for the London Ambulance Service NHS Foundation Trust

The following table highlights the key issues contained within the governance rationale document that the Trust Board may wish to consider prior to approval. The full document summarises the constitution and election rules and will be available for board members to take away from the board meeting.

Paragraph	Issue	Details	Rationale
15 and 17	Election rules for public and staff governors	Implement a system of first past the post with the candidates with the highest number of votes becoming governors for a 2 or 3 year period.	In accordance with the National Health Service Act 2006. Preferred method to that of a single transferable voting system.
28	Appointment of the Chairman and Non-executive directors	The first Chairman of the FT will be the current chairman through to completion of his current term of office. The first non-executive directors will be the current directors through to completion of the current term of office or a period of 12 months whichever is the greater and if they so wish. A Nominations Committee will be	These transitional arrangements allow continuity within the governance arrangements and the changes from being an NHS Trust to a foundation trust. This is in accordance with the National Health Service Act 2006. The Nominations Committee

		established by the Council of Governors which will consider whether to recommend the re-appointment of the retiring non-executive or Chairman. This will only apply to the first renewal of appointment. Subsequent appointments will be subject to open competition within the area of the Trust.	will comprise of governors and directors and an independent assessor and it will consider the skill set required by the foundation trust for the board of directors in any subsequent appointment.
29	Appointment of the Chief Executive and Accounting Officer	The first Chief Executive of the foundation trust will be the current Chief Executive. Future appointment to the post will be made by a sub-committee of the Board of Directors chaired by the Chairman and including non-executive directors. The appointment will require majority approval from the Council of Governors.	This is in accordance with the National Health Service Act 2006 and ensures there is continuity from NHS Trust to NHS foundation trust
31	Process to decide remuneration and allowances for non-executive directors	The Council of Governors will establish a committee to manage this process, potentially subject to annual review.	In the current financial climate and the freeze on public sector pay, the recommendation would be to apply the same freeze to non-executive remuneration during the same period.
35	Meetings of the Council of Governors – deputising arrangements	The Chairman of the Board of Directors will be the chairman of the Council of Governors. In his	The Deputy Chairman of the Trust Board will provide continuity overall to

		absence the deputy chairman of the board of directors should deputise at the Council meeting. The Council of Governors shall nominate one of the elected governors as Vice Chair of the Council who will chair the meeting when discussing matters concerning the chairman and non-executive directors, for example on remuneration or appointments.	proceedings, supported by the Director of Corporate Services. The Vice Chair position avoids potential conflict of interest for members of the Trust Board.
42	Composition of the Board of Directors	Trust Chairman Non-executive directors: no less than 5 and no more than 8 Executive directors: Not less than 4 and no more than 6 including: Chief Executive* Finance director* Medical Director* Director of Health Promotion and Quality (registered nurse)* Deputy Chief Executive Director of Human resources and Organisation Development.	*Required as a minimum within the National Health Service Act 2006. Subject to casual vacancies there will always be a majority of non-executive directors. 'The board should be of sufficient size that the balance of skills and experience is appropriate for the requirements of the business and that changes to its composition can be managed without disruption.' Monitor's NHS Foundation Trust Code of Governance 2010.

44	Terms of office for Chairman and non-executive directors	As per paragraph 28. For subsequent appointments/re-appointments the Council of Governors will take account of guidance. This is currently terms of 3 years. Any term beyond 6 years (2 three-year terms) should be subject to rigorous review and terms thereafter could be subject to annual re-appointment.	To reflect best practice in corporate governance 'The board of directors should ensure planned and progressive refreshing of the board.' Monitor's NHS Foundation Trust Code of Governance 2010. Serving longer than these two terms could be a determinant as to whether the non-executive director is still independent.
59	Appointment of the Auditor	The auditor (external) will be appointed by the Council of Governors after a process of competition overseen by the Audit Committee of the Board of Directors.	Current best practice is for a 3-5 year appointment.

Sandra Adams

Director of Corporate Services

21st September 2010

DRAFT GOVERNANCE RATIONALE

	Issue	Details	Rationale
MEMBERSHIP			
Public Membership			
1.	Definition of the public constituencies	The constituencies shall be as follows based on Commissioning Primary Care Trust (PCT) sectors: • **North West London (NWL) -** Including boroughs of: Ealing, Harrow, Brent, Hillingdon, Hounslow, Hammersmith & Fulham, Westminster and Kensington & Chelsea. • **North Central London (NCL) -** Including boroughs of: Barnet, Enfield, Camden, Islington, Haringey. • **Outer North East London (ONEL) -** Including boroughs of: Waltham Forest, Redbridge, Barking & Dagenham and Havering. • **Inner North East London (INEL)** - Including boroughs of: City & Hackney, Tower Hamlets and Newham. • **South East London (SEL) -** including boroughs of: Lambeth, Southwark, Lewisham, Greenwich, Bromley and Bexley. • **South West London (SWL) -** Including boroughs of: Richmond, Kingston, Wandsworth, Sutton, Merton and Croydon. • **Outside London** – includes 126 boroughs within the following three strategic health areas: East of England; South East Coast; and South Central. Additional details are contained in our consultation document, membership strategy and constitution.	As per the National Health Service Act 2006, each of public membership constituency must be made up of one or more electoral area for the purposes of local government elections in England. Based on feedback from the public consultation we have aligned our London constituencies with the commissioning PCT sector boundaries and have an “Outside London” constituency, based on the boundaries of the following three strategic health areas: East of England; South East Coast; and South Central.

2.	How the membership will reflect the full diversity of the potential community and be representative of the community served by the Trust	The details of how we plan to recruit a membership which reflects this diversity are included in our Membership Strategy.	Between and within the areas of our constituencies, socio economic standing, ethnic and cultural diversity varies widely. We intend to recruit a public membership which is fully representative of the communities, reflecting socio economic, ethnic and cultural diversity of the people to whom the Trust provides services. With our consultation process we have developed data and communications tools which we will refine as we progress.
3.	Plans to develop, maintain and grow the membership	Theses details are included in our Membership Strategy.	We are seeking to develop and engage a representative membership. We are identifying levels of involvement and communications tools to support this. The membership strategy will be an integral part of the work of the Council of Governors
4.	Any exclusions to membership that are over and above the legal minimum	None	It would be administratively difficult and inconsistent with our inclusive approach to apply exclusions to our membership. Appropriate exclusions are proposed for Governor and Director Appointments.
5.	Expected minimum number of members in the public constituency	At authorisation we will have a minimum of 1,750 members in the public constituencies, with a year-on-year incremental growth as set out in the Membership Strategy.	Due to London's large population, the incremental growth as defined in the Membership Strategy is a manageable target. This will enable us to target key areas where membership is low in order to maintain a membership representative of London. We have also taken into account the need to keep costs at a reasonable level in setting these targets.
Patient membership			
6.	Will there be a patient or	There will be no separate patient group however	We wish to engage with all communities and to

	service user constituency?	patients and their carers will be encouraged to be part of the public group.	keep the governance process as simple as possible. We believe that current and future patients are part of the community.
Staff constituency			
7.	Definition of the Staff constituency	An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided: • He/she is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or • He/she has been continuously employed by the Trust under a contract of employment for at least 12 months. The Staff group includes those performing functions for the Trust but excludes volunteers and agency contractors (who can be public members).	As per the National Health Service Act 2006.
8.	Plans for sub division of the constituency	The staff constituency will be sub-divided into two classes: Front line and Support. There will be three governor positions available to staff for election to the Council of Governors, as below: 2 x Front line 1 x Support Staff are able to nominate for election any member within the class to which they have been allocated.	The number of staff governors on the Council will be representative of frontline to support staff ratio. We engage all staff at as early a stage as possible about decisions which concern them. We want them involved in the membership and the Council of Governors
9.	Plans to develop,	Theses details are included in our Membership	We have adopted an 'opt-out' system for staff

	maintain and grow the membership. What are the timescales and milestones for growth? How membership will reflect the diversity of staff	Strategy.	membership. We anticipate the staff membership to reflect the numbers and diversity of the workforce profile.
10.	Expected minimum numbers of members in the staff constituency	We expect a minimum of 2,000 staff members. Staff will automatically become members unless they choose to opt-out.	We anticipate that the majority of staff will wish to remain as members. We will monitor opt-out numbers annually against workforce numbers.
11.	Are there any plans to recruit staff members on an opt-out basis? How will you communicate with staff to ensure they are adequately informed?	We will be using an 'opt out' system for staff, anticipating that current and future staff will wish to become members. Further details about communication are provided in the Membership Strategy	Having discussed the options with staff and understanding the pride and commitment the staff show to the Trust we believe that the process whereby all staff automatically become members is the option which best suits the Trust.
Disqualification of membership			
12.	Any exclusions that are to be applied for disqualification of membership	Statutory minimum only, as per the National Health Service Act 2006.	As per the National Health Service Act 2006.
Termination of membership			
13.	Under what circumstances will you terminate membership and how you will enforce it.	Only on the basis of disqualification, as per the National Health Service Act 2006.	Only current staff will be part of the staff constituency. We are keen to maintain the involvement of staff once they leave our employment and will offer public membership if the eligibility criteria apply.
COUNCIL OF GOVERNORS			

14.	The size and composition of the Council of Governors	We have estimated a Council of Governors of 24, made up of the following: • 13 Public governors (elected) • 3 Staff governors (elected) • 1 PCT governor (appointed) • 1 Local authority governor (appointed) • 1 Staff council governor (appointed) • 5 Voluntary sector governors (appointed). And the Chairman of the Board of Directors will be the Chairman of the Council of Governors.	We wish the Council of Governors to be reflective of the communities we serve. These numbers take into account feedback from the public consultation. As per the National Health Service Act 2006, the number of elected governors should be equal to or more than the appointed governors. The Staff Council, PCT (or GP consortia), Local Authority and Voluntary sector governors will represent the interests of partner organisations.
15.	How will you ensure the size of the Council of Governors is manageable?	We believe a Council of 24 governors to be an optimum number to ensure that the agenda and level of engagement is manageable and effective.	Our research indicates that small Councils are more effective. We will work to ensure that dialogue between the Directors and Governors is effective.
16.	What part do you want the Council of Governors to play in the NHS foundation trust and how will you empower them?	The Council of Governors will have an important role to play in the development and implementation of the Trust's integrated business plan, providing a different perspective at times and stimulating the debate.	The public governors will be encouraged to develop particular areas of interest within the service and we will seek ways in which to develop their role. We plan an in depth induction programme for all governors. We will also, through our membership strategy, work with the public governors to support them in engaging with their constituent members.
Public Governors			
15.	The process to be followed for nominating public governors and details of the election process	The process for nomination will be as per the National Health Service Act 2006. The election process will follow the current DH model election rules, using the first-past-the-post model.	As per the National Health Service Act 2006. The first-past-the-post model will be implemented in line with the model constitution and election rules.
16.	Circumstances in which people are not eligible to	In addition to the mandatory circumstances, these will be:	We are proposing these additional restrictions to ensure the integrity of our governors.

	be governors over the mandatory circumstances	• a person who, in the case of a Staff Governor or Public Governor, ceases to be a member of the constituency he represents; • a person who, in the case of a PCT Governor, Local Authority Governor, or other Partnership Governor, has his sponsorship withdrawn by the sponsoring PCT, Local Authority, partnership or organisation; • a person who has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body. • a person whose tenure of office as the Chairman or as a member of Director of a health service body has been terminated on the grounds that his appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest; • a person who is an Executive or Non Executive Director of the Trust, or a Governor, Non Executive Director, Chairman, Chief Executive officer of another NHS Foundation Trust; • a person who has had his name removed, by a direction under any NHS Act or has otherwise been disqualified or suspended from any healthcare profession, and has not subsequently has his name included in such a list or had his qualification reinstated or suspension lifted (as applicable) • a person who is incapable by reason of mental disorder, illness or injury of managing and administering his property and affairs; • a person who has been declared, by a sub-committee of the Council of Governors, to be a	

		vexatious complainant;
		• a governor who has failed to agree to abide by the value of the Trust's CRITICAL values and the Nolan Principles.
		• a Governor who fails to attend any meeting of the Council of Governors, for a period of one year or three consecutive meetings (whichever is the shorter) his tenure of office is to be immediately terminated, unless the other Governors are satisfied that:
		  • the absence was due to a reasonable cause; and
		  • he will be able to start attending meetings of the Trust again within such a period as they consider reasonable.	

Staff Governors			
17.	The process to be followed for nominating staff governors and details of the election process	The process for nomination will be as per the National Health Service Act 2006. The election process will follow the current DH model election rules, using the first-past-the-post model.	As per the National Health Service Act 2006. The first-past-the-post model will be adopted.
18.	Circumstances in which people are not eligible to be governors over the mandatory circumstances	See Section 16 above.	See Section 16 above.
Primary Care Trust Governors			
19.	PCTs that are eligible to appoint governors are selected and details of the appointments process	We have identified one seat for a PCT governor, representing London's 31 PCTs. These PCTs will be asked to nominate a governor at the time the Council of Governors is being convened.	As per the National Health Service Act 2006. It is essential we continue our close working relationship with the PCTs. We will work with them to ensure the role of partner governor is understood and the individual nominated is supported by the Trust and the commissioning

			sectors. These arrangements will be reviewed in light of the introduction of GP Consortia and the disestablishment of PCTs.
Local Authority Governors			
20.	Local authorities that are eligible to appoint governors are selected and details of the appointment process	We have identified one seat for a local authority governor, representing the Greater London Authority (GLA). The GLA will be asked to nominate a governor at the time the Council of Governors is being convened.	As per the National Health Service Act 2006. This will enable the Council of Governors to have a wider perspective of the economic community in which the Trust operates.
University Governors			
21.	The universities that are eligible to appoint governors are selected and details of the appointments process	There will not be a representative of the Universities on the Council of Governors.	We have strong links with Universities through our training and education.
Partnership Governors			
22.	Why those organisations were selected and the process for appointing them	We are seeking to engage representation from voluntary sector organisations that support special interest groups such as Diabetes, Mental Health, Stroke and Cardiac care. We have allocated one partner governor position to the Staff Council that supports the trade union interests of our workforce.	Representation from such patient groups will add value to the work of the Trust. The Trust's management works closely with the Staff Council and wishes to see this reflected in the new governance arrangements ensuring that trades unions are fully engaged.
23.	Are you considering representatives of any organisation who will be allowed to attend board meetings in an official capacity (eg chair of	Not at this stage.	This will be reviewed in the first 3 years.

	neighbouring trust) but who will have no voting rights?		
Terms of Office			
24.	Any cap on the total time serviced for each category of governor (whether elected of appointed) and for non-elected governors the term of office before re-appointment	Elected governors will stand for 2 or 3 years per term for a maximum of 3 terms (9 years). Non-elected governors will stand for a term of one year with confirmation from their sponsoring organisation of any further term at the end of each year.	These arrangements will enable us to achieve the balance between continuity and allowing new people to join. It will enable governors to build up their knowledge and experience to become effective at the table.
Disqualification			
25.	The provisions for the removal of Governors that are intended to apply and any other additional reasons for exclusion	As per the National Health Service Act 2006 and as per Section 16 above.	Where a member has acted against the interests of the Trust as judged by a sub committee of the Council of governors, the member will be excluded
Termination as a governor			
26.	What conditions or requirements apply including the requirements of Schedule 7, paragraphs 8(1) and (2) of the NHS Act 2006	As per the National Health Service Act 2006 and as per Section 16 above.	Where a member has acted against the interests of the Trust as judged by a sub committee of the Council of governors, the member will be excluded
Vacancies			
27.	The process of handling vacancies in the Council of Governors	The Constitution will make allowance for by-elections. Where a vacancy arises for an elected Governor the Trust need not hold a by-election if it is less than six months to the next scheduled election.	The Trust has to be mindful of the resources involved in an election and to make best use of public money.

		Where a vacancy arises for an elected Governor within 6 months of the previous election the Trust may, instead of holding a by-election, fill the vacancy by appointing the highest polling unsuccessful candidate at the most recent election of governors for the constituency or class in respect of which the vacancy has arisen. Any person so appointed shall hold office for the unexpired term of office of the retiring Governor.	
Roles and Responsibilities of Governors			
28.	The process to appoint or remove the Chair and other Non Executive Directors. This may not apply for the initial chief executives and non-executives.	The chairman, other than on the creation of the Foundation Trust, will be appointed by the Council of Governors. The process of selection will start with the Council of Governors agreeing a role profile and person specification. A delegated sub group of the Council of governors comprising two governors, two board directors and an independent assessor will short-list candidates and then interview. The recommendation will be taken to the Council of Governors for approval. The process for appointment of non-executive directors, again other than on the creation of the Trust, will be the same, except that the Chairman will also sit on the appointments panel. The Nominations Committee described above will be a formal committee of the Council of Governors and will be chaired by a public governor (one of the two described above).	As per the National Health Service Act 2006. The first Chairman of the Trust will be the current Chairman who will complete his current term of tenure and must then be re-appointed. This will allow continuity during the transition period. The initial Non Executive Directors will continue to the end of their remaining terms of tenure or a period of 1 2months, whichever is the greater. This allows for continuity within the governance arrangements and will follow current guidance. The Nominations Committee will be empowered by the Council of Governors to undertake the appointments process and to make recommendations to the full Council meeting.

		The process for the removal of the Chairman and the Non Executive Directors will be set out in the Constitution. This will require a three quarters majority of the Council of Governors	
29.	The process to approve the appointment or removal of the Chief Executive put forward for appointment by the Non Executive Directors	The Chief Executive will be appointed by a sub committee of the Board of Directors chaired by the Chairman and including the Non Executive Directors. The panel may include external assessors in an advisory role. The post will be subject to open competition and short listing before a process of interview and assessment that will be determined. It will require the approval of a majority of the Council of Governors in General Meeting. The removal of the Chief Executive will require a majority vote of the Board of Directors, including a majority of Non Executive Directors as set out in the Constitution and in line with the terms and conditions of employment. The motion for his removal will follow the necessary notice period and any disciplinary procedures in place.	As per the National Health Service Act 2006. The first Chief Executive of the Foundation Trust will be the current Chief Executive. It will be important that the future appointment process for this post is by the Chairman and the Non Executive Directors and that approval by the Council of Governors is done as swiftly as possible. The removal process will need to be co-ordinated with the terms and conditions of appointment.
30.	The process to approve or remove the executive directors put forward for appointment by the Chief Executive	The Remuneration and Terms of Service committee of the Trust Board of Directors will appoint the individual executive directors, following an appointment process supervised by the Chief Executive. An advisory external assessor may also to be included in the appointment panel. Appointment to a vacancy will be through public advertisement, short listing and due process and appraisal of candidates.	As per the National Health Service Act 2006. The first executive directors will look to provide continuity with the current Trust, whilst recognising the needs for the new Trust and the new governance arrangements. Specifically first executive director posts include: • Deputy Chief Executive • Director of Finance

		The removal of the executive directors will follow standard HR policies and the terms and conditions of employment.	• Director of HR and Organisation Development • Director of Health Promotion and Quality (registered nurse/midwife) • Medical Director Future appointments must reflect the ability of the Chief Executive to build a team and to involve the Non Executive Directors
31.	The process to decide the remuneration and allowances of Non Executive Directors	The remuneration and allowances of Non Executive Directors, including Chairman will be set by the Council of Governors taking account of any guidance or best practice set out by the Regulator or the Foundation Trust Network	It is important that we ensure we attract and retain high calibre individuals and that decisions relating to remuneration are made as independently as possible. In the current financial climate and a freeze on public sector pay awards; there will be no change to no-executive director remuneration and allowances. This will be reviewed at the point when the pay climate in the public sector changes.
32.	Details of the relationship between the Board of Directors and the Council of Governors.	The Trust will look to foster a constructive working relationship between the Board and the Council for the benefit of the Trust and its patients. This will be on both a corporate level (Board to Council/Council to Board) and individual (Director to Governor/Governor to Director). The specific reporting arrangements will be set out in the respective standing orders. These will include strategic/forward plans and progress against them as a regular item. The role of the Council of Governors is to represent their constituency or stakeholder in advising the Board of Directors, being consulted by them and	The relationship between the Board of Directors and Council of Governors will be critical to the success of the Trust. The constitution and the standing orders will provide a basic framework within which engagement can take place, but the Trust is looking to involve its governors in more ways.

		ensuring that the Trust operates in a way that meets its purpose and complies with its authorisation. The role of the Board of Directors is to exercise the powers of the Trust in meeting its constitutional purpose of providing goods and services for the purposes of the health service delivering healthcare to the population of London. The formal link between the two rests with the Chairman of the Trust and the Non Executive Directors all of whom are appointed by the Council of Governors although only the Chairman attends both meetings. The Trust Board and the Council of Governors must work together in a range of ways so as to provide seamless leadership and direction to the Trust embracing the values and principles which will lead to its success. Members of the Board of Directors will be encouraged to attend some/part or all meetings of the Council of Governors with executive directors reporting on their areas of performance both in terms of past performance and future plans. Key to the relationship will be the work done by both outside formal meetings of the Council of Governors. This will utilise the experience, knowledge and representative skills of the Governors through: • Detailed induction and on-going training for all governors in their roles and the work of the	

		Trust • Involvement in sub groups for specific projects that are appropriate to the Governor's area of interest. These will range from public/patient involvement events to service planning • Opportunity for the governors to shadow directors/senior managers as part of their development • The reporting by governors to their members	
33.	Any other provisions about the Council of Governors. This should outline details of how the Council of Governors intends to maintain a dialogue with the staff and public membership	The Council of Governors will be encouraged to reflect on its performance and operation both formally and also through assistance with organisational development. The Council will seek to use the community newspaper 'Ambulance News', public reports and the Trust website to keep members informed as a whole on its business. In addition support will be given to individual governors to develop a 'workplan' for their involvement with the membership. Broader roles for the Council and individual Governors are: • Provide an advisory role in assisting the Trust to carry out its business and develop its plans for the future as well as be consulted by the Board of Directors on plans for future developments by the Trust and seek to influence but not dictate decisions of the Board of Directors on plans for significant expenditure and the development of services.	The effectiveness and impact of the Council of Governors will depend on the nature of the individuals who come forward to serve but the Trust will encourage active involvement. The responsibilities will be enshrined in a code of conduct for governors that all will be expected to sign.

		• Receive reports, presentations and information from the Chief Executive and members of the Board of Directors on the performance of the Trust. In addition to review reports to the Trust or, specifically, to the Council of Governors from Monitor, the Care Quality Commission or the external auditor and put in place processes to monitor any remedial actions. • Be appointed to and be actively involved in advisory groups, sub committees and other forums as may be set up by the Trust. In carrying out these roles members of the Council of Governors will be made aware of the following responsibilities: • Elected Governors from staff and public groups have been elected to represent the interests of all the members of their group and the local community whether they are members or not. Appointed Governors represent the interests of their stakeholder or partner organisations and the wider community of the capital whose health needs we serve. All Governors have an overriding responsibility to act in the overall interest of the Trust. To this end they are expected to actively participate in the decision making at the Council of Governor meetings and bring their knowledge, experience and perspective to bear. Governors do not have day to day management responsibilities, these powers rest with the Board of Directors. Governors should act at all times for the greater	

		benefit of the public and that their public service should not be carried out for any private gain. It is their responsibility to bring to the attention of the Trust and the Chairman, any change in personal circumstances that might impact on their ability to act as a Governor. Governors should also espouse and act within the highest standards of public service, including respect for confidentiality. Governors act in a stewardship and guardianship role to ensure that the Trust acts and develops for the broader public benefit. As such the actions of the Trust exercised through its Board of Directors and delegated down are accountable to the local community through the Council of Governors. In maintaining and developing the services of the Trust, the Council of Governors is responsible for ensuring that it reflects the needs and expectations of the local community and potential users. Public Governors have a responsibility to actively encourage community engagement through communication with members and taking into account their views so as to both represent and reflect the views of their constituency. Governors should ensure that they are appropriately informed about their role and responsibilities and should commit to keep themselves up to date through training and development that will be facilitated by the Trust. Meetings of the Council of Governors should not be used to raise issues specific to individual cases.	

34.	Details on payment of travel and other expenses (but not remuneration) for Governors	Governors will be reimbursed for travel expenses reasonably incurred as per Trust policy. These will be authorised and monitored by the Director of Corporate Services who will manage the budget.	The overriding objective will be to reimburse Governors for expenditure incurred in carrying out their duties but not to take away money from the delivery of health care. The Trust will be guided by best practice in this area.
Meetings			
35.	Who will deputise in the Chairman's absence at the Council of Governors	The Deputy Chairman of the Board of Directors who will be one of the Non Executive Directors will act as Chairman of the Council of Governors in the event of the appointed Chairman's incapacity. An elected governor will be appointed as Vice Chair of the Council of Governors and will take the Chair when discussing matters concerning the Chairman and Non-Executive directors, such as remuneration and allowances and performance.	The Deputy Chairman of the Trust Board provides consistency. The Vice Chair position avoids potential conflict of interest for members of the board.
36.	Any special reasons as to why meetings of the Council of Governors are not open to the public	Meetings of the Council of Governors will only exclude the public when a motion is carried by a majority of Governors present including a majority of public Governors. The reasons for such meetings shall be due to the sensitivity of the item under discussion at the discretion of the Chairman. Members of the Council of Governors may be required to meet for induction, training and development at other times but events will not be in place of the responsibility to attend the Council of Governor meetings.	The Trust will wish to be as open as possible, but appreciates that there may be instances when the Council of Governors may wish to exclude members and/or the public due to sensitive issues that may have been referred to it by the Board of Directors
37.	The frequency of meetings of the Council of Governors	The constitution will set a minimum of five meetings a year, one of which will be the Annual General Meeting. In addition to formal meetings, governors will be	The formal meetings will coincide with the main events to be considered and an integrated committee schedule will be published annually. Additional formal meetings will be included as

		encouraged to be involved in working groups as requested by the Trust.	required
38.	The number of Governors by type that must be present at any meeting of the Council of Governors	The rules of quoracy will be set out in Standing Orders but will require a majority of public governors, one appointed governor and one third of the total number of governors in post to be present	A **quorum** is the minimum number of members of a deliberative body necessary to conduct the business of that group. Ordinarily, this is a majority of the people expected to be there.
39.	The wording of the declaration for Governors to give the particulars of their qualification to vote as a member of the Council of Governors and for members to vote or stand for election as a governor.	I confirm that to the best of my knowledge I am a member of the public or staff constituency (delete as appropriate) and eligible to be a governor in line with the requirements of the constitution, standing orders and paragraph 7 of Schedule 7 to the 2006 Act.'	The Trust feels that a brief self declaration is sufficient.
Conflicts of interests of governors			
40.	Details of how conflicts of interest should be handled	Governors will be expected to complete a declaration form of interests to be added to the Trust's Register of Interests.	This will be managed in accordance with the Trust's Standing Orders and Standing Financial Instructions.
Committees and Sub Committees			
41.	Any other provisions about committees that may be set up to advise the Council of Governors	The following formal committees will be established under the Standing Orders for the Council of Governors: • Nominations Committee (for the appointment of the Chairman and non-executive directors of the Trust Board of Directors) • Remuneration Committee (for the remuneration and allowances of the Chairman and non-executive directors of the Trust's Board of Directors) • Appointment of the Auditor.	These arrangements will be incorporated into the Standing Orders of the Council of Governors.

		These committees will meet when required. The Council of Governors may establish working groups as required.	
BOARD OF DIRECTORS			
Board of Directors			
42.	The overall membership numbers and constitution of the Board of Directors including the numbers and roles of Non Executive Directors and Executive Directors	The constitution will set out the size of the Board of Directors as being: • The Trust Chairman • Not less than 5 and no greater than 8 Non Executive Directors Subject to casual vacancies there will always be a majority of non Executive Directors (including the Chairman) Not less than 4 and no more than 6 executive directors including: • Chief Executive and Accounting Officer • Deputy Chief Executive • Director of Finance • Director of Health Promotion and Quality (registered nurse) • Director of Human Resources and Organisation Development • Medical Director (qualified medical practitioner). Additional senior executives (non-voting) attend Board of Directors' meetings. These are as follows: • Director of Corporate services/Trust Secretary • Director IM&T • Director of Operations • Deputy Director of Strategic Development	The Trust is looking to embed best corporate governance practice, for example the Intelligent Ambulance Board, as well as the statutory minimum.

		• Head of Communications.	
43.	The eligibility criteria for non-executive director posts	Only a member of a public constituency is eligible for appointment as a non-executive director.	
Terms of Office			
44.	Terms of office for the Chairman and Non Executive Directors	The Chairman and other Non Executive Directors will initially be appointed for the remainder of their current terms or for a minimum of 12 months whichever is the greater. On subsequent appointments/reappointments the Council will take account of guidance currently indicating three years per term of office for the Chairman and Non Executive Directors.	The terms of office will reflect current best practice in corporate governance. Code of Governance, paragraph C.2.2 recommends rigorous review after 2 three-year terms and possible annual re-appointment thereafter. Serving longer than these 2 terms could be relevant to determining whether a non-executive is still independent. 'The board of directors should ensure planned and progressive refreshing of the board.'
45.	Terms and conditions of the Chief Executive and Executive Directors	The terms and conditions will be determined by the Board of Directors' Remuneration and Terms of Service Committee comprising the Chairman and Non Executive Directors	The Trust will reflect best practice in corporate governance
Disqualification			
46.	Any exclusions to the Board of Directors over and above the legal minimum	The constitution will include the standard exclusions	This is considered sufficient
Roles and Responsibilities			
47.	The process for a committee of non Executive Directors to monitor, review and	The Audit Committee is a formal committee of the Trust Board and its terms of reference are incorporated within the Standing Orders of the Board of Directors.	This embeds best corporate governance practice and is based upon the NHS Audit Committee Handbook.

	carry out other audit functions. Proposals for the audit committee's function are also required.	Membership of the Audit Committee comprises of 3 non-executive directors, one of whom is the Chair of the Committee and who has recent and relevant financial experience.	
48.	The process for the non-executive directors to appoint or remove the chief executive and for the committee of chief executive, chair and non-executive directors to appoint or remove other executive directors	The appointment or removal of the Chief Executive shall require the approval of the Council of Governors. A committee of the Chairman, Chief Executive and the non-executive directors shall appoint or remove the executive directors. Any person who is disqualified from becoming or continuing as a Director on any of the grounds set out in the constitution shall resign as a Director of the Trust or if he declines or fails to do so shall be removed forthwith by the Board of Directors and a new Director appointed in his place in accordance with the provisions of the Constitution.	In accordance with best governance practice and the model constitution.
49.	The process for a committee of Non Executive Directors to decide remuneration and allowances for Executive Directors and (if relevant) the provisions on remuneration and allowances that might be set out in the constitution, pending appointment of such a	The Remuneration and Terms of Service Committee is a formal committee of the Trust Board and its terms of reference are incorporated within the Standing Orders of the Board of Directors. The committee comprises of the Chairman and the Non Executive Directors and the Chief Executive attends.	This embeds best corporate governance practice and is based upon the NHS Audit Committee Handbook.

	committee.		
50.	The process for the directors to consult with the Council of Governors on the Trust's forward planning	Standing Orders for the Council of Governors will make clear the process for consultation on forward planning, but the minimum will be the presentation of an annual strategic and operational plan to the Council of Governors. At a previous stage the Council of Governors will be involved in discussing and understanding the key drivers to forward planning and be able to guide the Board of Directors in their work. This may involve work by governors outside the formal meetings.	It will be the role of the Board of Directors to prepare and implement forward plans but the Governors will look to contribute at an early stage rather than 'rubber stamping'. The Trust sees this contribution as ongoing throughout the year by involving governors in working groups so that the formal adoption of the forward plan should be a natural conclusion of their involvement
51.	The process for the Board of Directors to present to the Council of Governors at a general meeting the annual accounts, any report of the auditor on them and the annual report	All members of the Board of Directors will be encouraged to attend meetings of the Council of Governors but particularly the Annual General Meeting. The attendance of the Chief Executive, Director of Finance and Director of Corporate Services / Trust Secretary at the Annual General Meeting will be a minimum requirement. At this meeting the formal business will include presentation and adoption of the annual accounts, annual report and the report of the auditor.	A balance needs to be struck between allowing the Council of Governors to exercise its stewardship function and giving governors freedom to discuss issues between themselves. The formal business of the annual General Meeting will be set out in the constitution
Meetings of the Board of Directors			
52.	Details of how meetings should take place including whether in public or private.	Details of how meetings of the Board of Directors take place will be set out in the Standing Orders. The Trust Board meets in public eight times a year and holds 4 four strategy and board development meetings in private. The Trust Board reserves the right to hold Part II meetings in confidence following a public board	The Trust is committed to transparency and openness and papers for Public meetings will be published on the website..

		meeting.	
Conflict of Interests of Directors			
53.	Details of how conflicts of interest should be handled	All members of the Board of Directors sign up to a code of conduct that includes specific provisions on the avoidance and declaration of conflicts of interest, both financial and other. All potential conflicts of interest will be for the director to declare and absent themselves from any discussion or decision-making that may lead to any conflict or perception of a conflict. The Trust will expect Directors to absent themselves from the part of the meeting where the business involving their potential conflict of interest is discussed. Any canvassing outside the meeting will be regarded as a disciplinary offence.	The Trust will be fully committed to adopting and implementing standards of business conduct based on the Code of Governance and the Nolan Principles.
REGISTERS			
54.	How the register of members will be maintained including admission to and removal from the register	The Director of Corporate Services will be responsible for the maintenance of the register of members, through the Membership Manager. Admission to the register will be through completion of a standard application form which will include a self declaration of eligibility. The amount of detail kept on the register will be kept to a minimum. Requests for removal from the register will be through a standard form or at the instigation of the Director of Corporate Services, through the Membership Manager, should they receive notification from other sources (such as read of the death of a member but not informed).	The Trust has a contract with an external database provider and this database will act as the register and will be covered by data protection requirements. Standard reports will provide the main details with supplementary information maintained that is only retained because of its need. In accordance with model election rule 26, the register will close for the purposes of voting on the closing date for receipt of nominations

		Once a year the Director of Corporate Services / Secretary will review the register for any anomalies and ensure that the details appear reasonable.	
55.	How the register of members of the Council of Governors will be maintained including admission to and removal from the register	The Director of Corporate Services will be responsible for the maintenance of the register of members of the Council of Governors. This will list out the name and contact details for the governors, their constituency or stakeholder and date of appointment and term of office. Once a Governor leaves office or is removed the date and circumstances will be recorded. The register of members of the Council of Governors will link to the register of their interests and they will be asked to confirm this on an annual basis or as soon as circumstances change	This will be maintained in accordance with best practice.
56.	How the register of members of the Council of Governors' interests will be maintained including admission to and removal from the register	The Director of Corporate Services will be responsible for the maintenance of the register of governors' interests. Governors will be expected to register all interests as soon as they are apparent. The Director of Corporate Services will be responsible for obtaining a signed declaration including nil returns. The Register will be updated on an annual basis and a report given in the Annual Report and Accounts. Upon notification from a governor of the interest ceasing, or at the end of the terms of office of a governor, the interest will be removed from the	The Trust is fully committed to upholding standards of business conduct and public values, particularly in ensuring that there are no conflicts of interest, perceived or actual at any level from Governors to staff. In public business there is no place for private gain.

		register.	
57.	How the register of the Board of Directors' interests will be maintained including admission to and removal from the register	The Director of Corporate Services will be responsible for the maintenance of the register of members of the Board of Directors. Directors will be expected to register all interests as soon as they are apparent. The Director of Corporate Services will be responsible for obtaining a signed declaration including nil returns. The Register will be updated on an annual basis and a report given in the Annual Report and Accounts. The register will also include senior posts and a general principle for declarations of interest from all staff. Upon notification of a director or senior manager of the interest ceasing to exist, or on termination of employment with the Trust, the interest will be removed from the Register.	We will use the current system in accordance with Trust Standing Orders.
PUBLIC DOCUMENTS			
58.	How the Trust will make provision for the public to receive the documents set out in the 2006 Act and the charges that will apply (regulations may prescribe circumstances in which there is not to be public access to the register).	The Director of Corporate Services will be responsible for ensuring that documents are appropriately lodged with the Regulator. It is likely that the Director of Corporate Services will have the primary link with the Regulator. Copies of these documents will be made freely available on request to any member or stakeholder. The Trust will reserve the right to charge for additional or multiple copies to cover the costs of production	Links for formal reporting to the Regulator will lie with the Director of Corporate Services

AUDITOR			
59.	Details of the auditor's appointment and roles and responsibilities	The auditor will be appointed by the Council of Governors after a process of competition that will be overseen by the Audit Committee of the Board of Directors in conjunction with the Director of Finance. The full role and responsibilities including a code of audit will follow guidance from the Regulator and best practice. The Audit Committee will review the appointment and related issues such as the level of non audit service. Appointment will usually be for 3-5 years.	The Trust's current external auditor is the Audit Commission. Monitor's Code of Governance 2010 refers to best practice.
ACCOUNTS			
60.	Details of the process to make the accounts available	The Accounts along with the Annual Report and forward plans will be made available on the Trust's website and full copies will be available on request. Summarised copies of the accounts will be included in the annual report and in other documents that are made more widely available. The Trust will look to incorporate reporting its accounts through local media and through positive reporting	The Trust will seek to make the accounts as widely available as possible taking account of cost and environmental considerations. Summarised accounts will be promoted in the first instance.
ANNUAL REPORTS AND FORWARD PLANS			
61.	Details of process to make the annual report and forward plans available.	The standard wording in the template constitution will be adopted in terms of reports to the Regulator. It is anticipated that an annual report will be produced for members which will summarise the	It is our intention to be as open as practicable and to consider different ways of engaging all our stakeholders and the public being mindful of cost and environmental considerations

		detail to the Regulator and produce greater narrative that is more accessible to members. Copies of the full text will be available to members upon request, placed in public locations such as libraries and on the Trust's website	
INDEMNITY			
62.	Details of any indemnity clause	The following will be included in the constitution: 'Members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions save where they have acted recklessly. Any costs arising in this way will be met by the Trust. Financial procedures will be drafted to cover more detailed procedures.' and 'The Trust may also take out and maintain for their benefit insurance against such risks.'	In accordance with the model constitution and best governance practice. The Trust will continue its work in putting in place procedures and in embedding strong corporate governance. It will seek advice regarding professional indemnity insurance for its directors.
DISPUTE RESOLUTION PROCEDURES			
63.	Detail of any dispute resolution procedures in the constitution	The Trust will continue its work in putting in place procedures and in embedding strong corporate governance. This will be described in the constitution and will allow the Chairman, on advice of the Director of Corporate Services/Trust Secretary, to seek to resolve the dispute. If unable to do so, he shall appoint a special committee comprising equal numbers of directors and governors to consider the circumstances and make recommendations to both bodies with a view to resolving the dispute.	In accordance with best governance practice.

		Disputes with members will be through an escalation procedure managed by the Director of Corporate Services/Trust Secretary with the Council of Governors being the ultimate authority on such matters.	
AMENDING THE CONSTITUTION			
64.	Details of the procedure for amending the constitution	The Constitution will be reviewed by the Board of Directors and Council of Governors after one year and every three years after that. The review will take account of any review by the Department of Health, the Regulator or guidance from the Foundation Trust Network or other best practice. Changes will require approval by the Board of Directors and the Council of Governors	The Constitution will need to be maintained and kept up to date and relevant to the needs of the Trust as it develops. Changes to the Constitution other than those of a minor nature will require approval by the Regulator. All changes require approval by the Board of Directors and the Council of Governors

London Ambulance Service NHS Trust

NHS Foundation Trust

Membership Strategy

LOOKING AFTER LONDONERS

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1. The London Ambulance Service as an NHS Foundation Trust

Becoming a Foundation Trust will enable patients, members of the public and staff to have an opportunity for increased involvement in the development and delivery of emergency services by the London Ambulance Service (LAS). 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.

Who We Are

We provide an emergency healthcare service for over seven and a half million people living in London, as well as visitors and commuters to the city. Our service extends over an area of approximately 620 square miles, from Heathrow in the west to Upminster in the east, and from Enfield in the north to Purley in the South.

We are the only London-wide NHS trust, have more than 4,000 staff and an annual turnover of around £260 million. As an integral part of the NHS in London, we work very closely with hospitals and other healthcare providers, as well as other emergency services.

We understand that the process of building a meaningful membership needs time and resources. We are committed to achieving the objectives set out in this document and recognise that this is a long term commitment and investment. It is a learning process for all of us in these early stages, for the public, our staff, our future governors, our partners and our members themselves.

The LAS faces unique membership challenges in developing its membership that are different as an ambulance service from the acute hospital sector. As London's mobile health service these include engagement with a large transient population (800,000) including commuters who visit and leave the capital daily. The LAS has set out its initial response to these challenges in the foundation framework provided by this strategy. It is recognised that a flexibly evolving and multi-faceted approach will need to be part of the vision for our member engagement. The Trust has sought to address these challenges throughout the strategy.

2. Objectives for membership and framework

The membership has a major role in supporting the achievement of the Trust's objectives with a focus on growing an inclusive culture of public engagement within the organisation.

The Trust will set realistic targets, reflecting the need to develop and implement best practices in order to become an exemplar Foundation Trust membership organisation.

Becoming a member of a Foundation Trust offers an individual the opportunity to act as a guardian overseeing the Trust's strategic vision. The needs and health concerns of London's communities will inform the Trust's stated vision. The membership as guardian will determine how we can develop patient-centred services that improve directly our patient's experience.

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.
- A Governing Council reflecting a quality membership
- As an FT we will maintain our compliance with our constitution. 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.
- To ensure the opportunity to become a member of the LAS is accessible to all of the eligible community
- To ensure we take every opportunity to promote membership

Members will be informed of activities and plans, listened to and their views taken into account as the Trust develops plans and delivers its services now and in the future.

However, people will wish for different levels of involvement and engagement and we will recognise, respect and respond to this. For those who wish to be more actively involved there is the opportunity to become a Governor.

Membership does not provide any special access to our services or treatment provided for healthcare purposes. Membership is free and members will not receive any payment.

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

- Membership will be open to anyone aged 16 or above.
- Seven public constituencies based on London's healthcare commissioning sectors.
- A staff constituency comprising two classes: front line 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, and the staff council of the London Ambulance Service.
- 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:

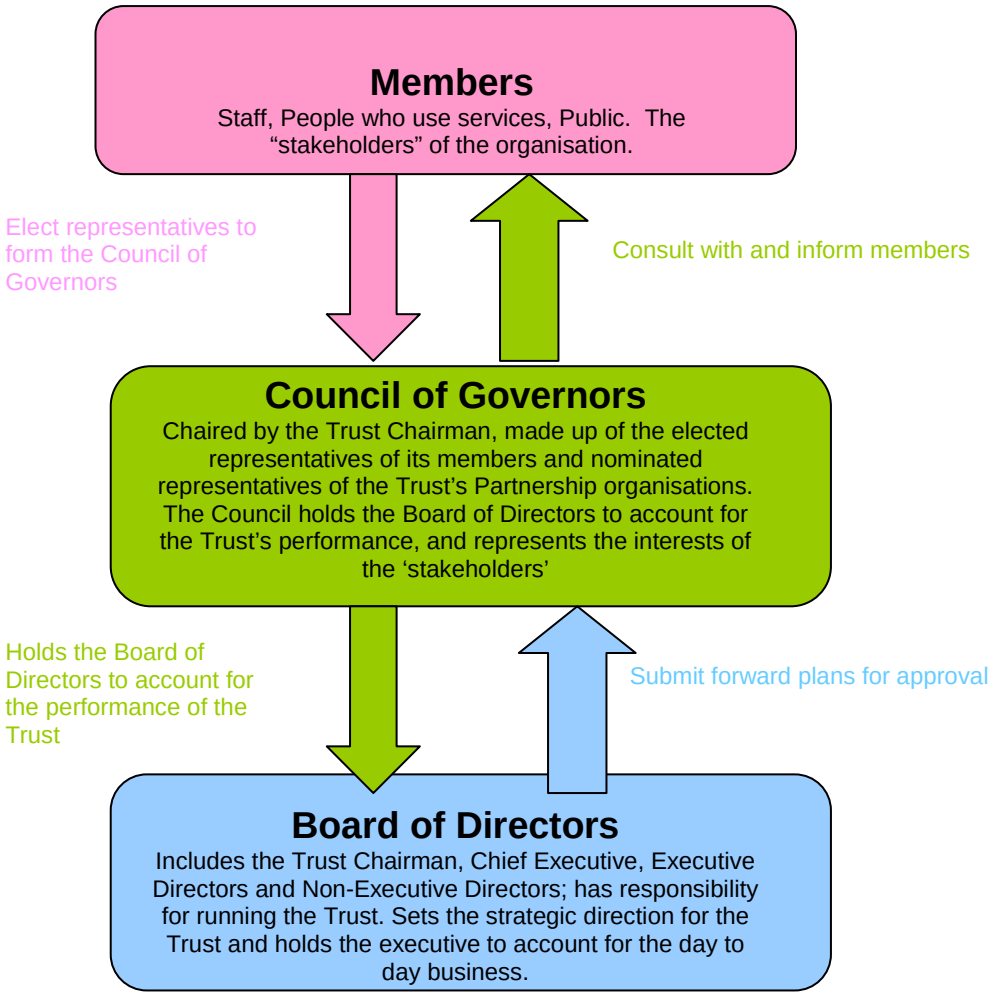
- become actively involved in our work and help shape our future plans
- get a better understanding about what we do, and help promote our work
- be consulted on any major changes that we are proposing to our services
- receive regular information about what we are doing
- attend open days, seminars and events
- take part in focus groups and surveys
- elect governors to represent your views on our Council of Governors
- stand for election as a governor.

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 LAS
- Guardianship: to act as guardian of the LAS on behalf of the local communities that constitutes the population of London.

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



3. Defining the membership community

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 approximately 6,000 by the time we become a Foundation Trust in 2011/12. By the end of our first year as an NHS Foundation Trust we aim to have increased our public membership to 8,000. We have 7 public constituencies each represented by two elected Governors (one for the outside London area). We will be working to ensure that members are distributed across these areas as shown in appendix 1 (page 16).

There will be eight membership constituencies – 7 public and 1 staff (divided into two classes).

3.1 The public constituencies

Public membership is available for any individual member of the public aged 16 and over and resident in a London borough or county in the surrounding SHA boundaries ie East of England: Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk; South East Coast: Surrey, Sussex and Kent; South Central: Oxfordshire, Buckinghamshire, Berkshire, Hampshire and the Isle of Wight.. Members will be invited to join by completing a registration form; this will ensure that we have a group of members who have made a positive choice.

We will have 7 public constituencies, 6 are based on the health sectors of London and one is for members 'Outside London'. See appendix 5 (page 21)

The following tables and graphs (Figure 1 – 6) show the population profile by size, ethnicity, social grade, age and gender.

The table in Figure 1 below shows area breakdown, Governor representation, population size and percentage.

Area	Governors	No of boroughs	Population size	% Population
North West London (NWL) Including Ealing, Harrow, Brent. Hillingdon, Hounslow, Hammersmith & Fulham, Westminster and Kensington & Chelsea	2	8	1,732,020	24.15
North Central London (NCL) Including Barnet, Enfield, Camden, Islington, Haringey	2	5	1,178,447	16.43
Outer North East London (ONEL) Including Waltham Forest, Redbridge, Barking & Dagenham and Havering	2	4	845,168	11.78
Inner North East London (INEL) including City & Hackney, Tower Hamlets and Newham	2	3 plus City	650,006	9.06
South East London (SEL) including Lambeth, Southwark, Lewisham, Greenwich, Bromley and Bexley	2	6	1,488,199	20.75
South West London (SWL) including Richmond, Kingston, Wandsworth, Sutton, Merton and Croydon	2	6	1,278,251	17.83

Total London	**12**	**32 plus City**	**7,172,091**	**100**
Outside London	**1**	**126**	**13,383,317**	**100**
GRAND TOTAL	**13**	**158**	**20,555,408**	

Figure 1 (Source: 2001 Census)

London is a diverse city with 300 languages spoken and 90 different ethnic communities[1]. Sixteen of the 20 most ethnically-diverse local authorities in England are in London[2]. As shown in Figure 2, London's population is predominantly White, with an increasing Black, Asian and Minority Ethnic (BAME) population. Since the 2001 Census, the BAME population proportion is estimated to have increased from 29 per cent to 35 per cent in 2010[3].

There are also similarities in diversity across each commissioning sector, with obvious peaks in ethnicity in certain areas. For example, Inner North East London has a higher footprint of Bangladeshi than other sectors while there is a higher presence of White ethnicity in all other sectors. As a general trend, east London as a whole has a higher percentage BAME population than west London.

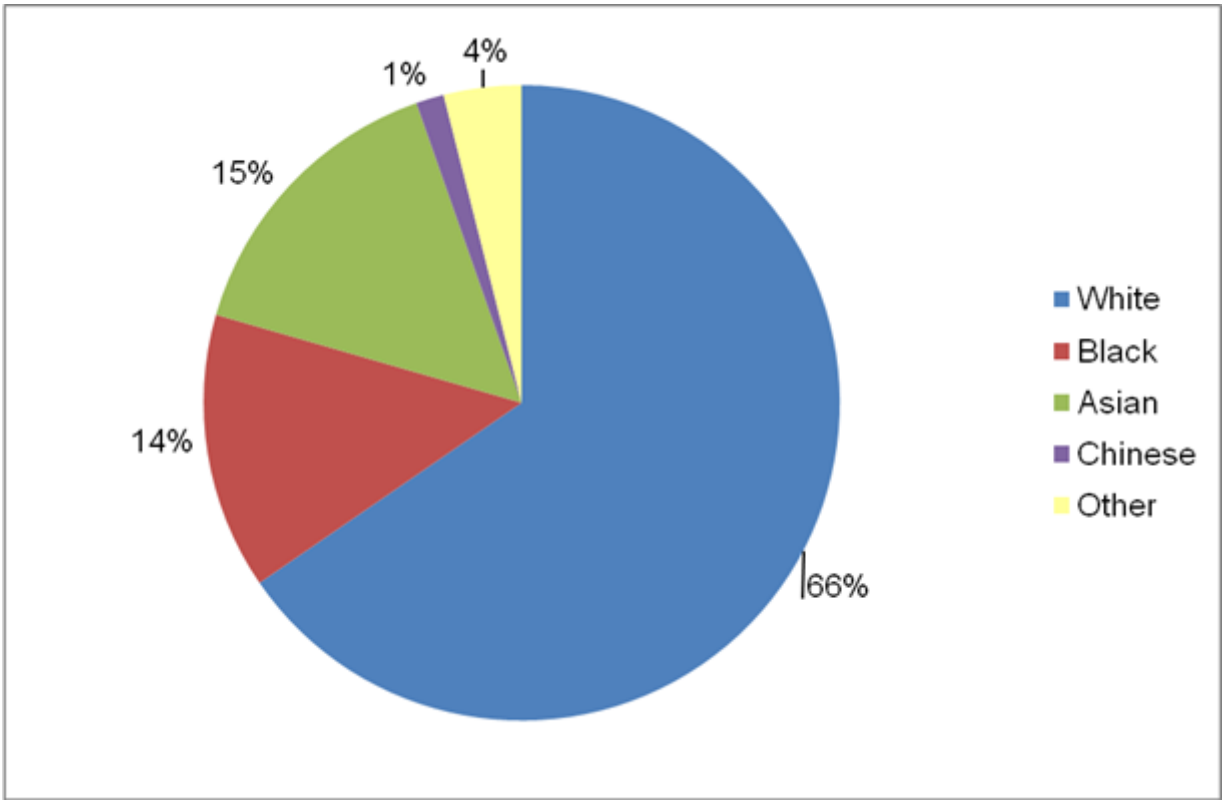


Figure 2 Ethnicity profile of London-wide population, 2010[4]

Map of London showing the London boroughs with the highest and lowest proportion of people from a minority ethnic group.

[1] Source: NHS London (2007) *Healthcare for London: A Framework for Action*.
[2] Ibid.
[3] Source: Greater London Authority (2010) 2009 Round Ethnic Group Projections – SHLAA (revised).
[4] Source: Greater London Authority (2010) *2009 Round Ethnic Group Projections – SHLAA (revised).*

Top 6 indicated:
1 Newham (60% from a minority ethnic group)
2 Brent (55%)
3 Tower Hamlets (49%)
4 Ealing (41%)
5 Harrow (41%)
6 Hackney (41%)

None of the London boroughs have minority ethnic populations in the lowest category shown on the map of United Kingdom (0% to 4%).

Lowest proportions in London are in boroughs of Havering, Bromley, and Bexley (between 4 and 9%)

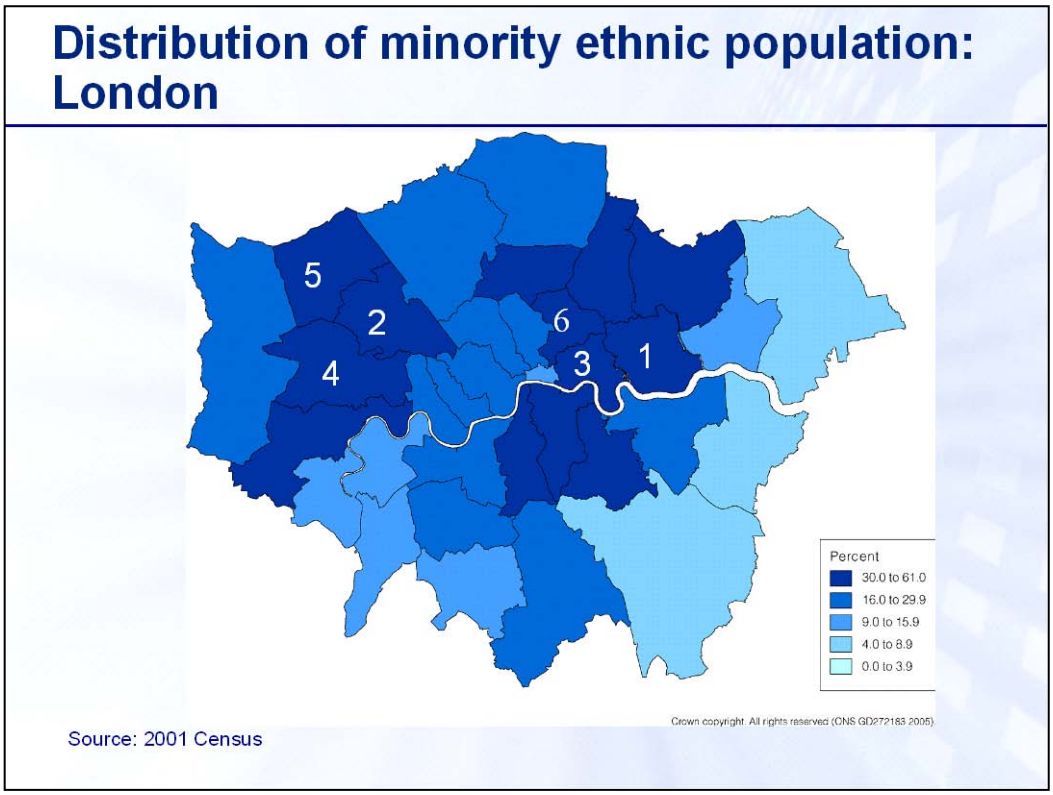


Figure 3 (Source 2001 Census)

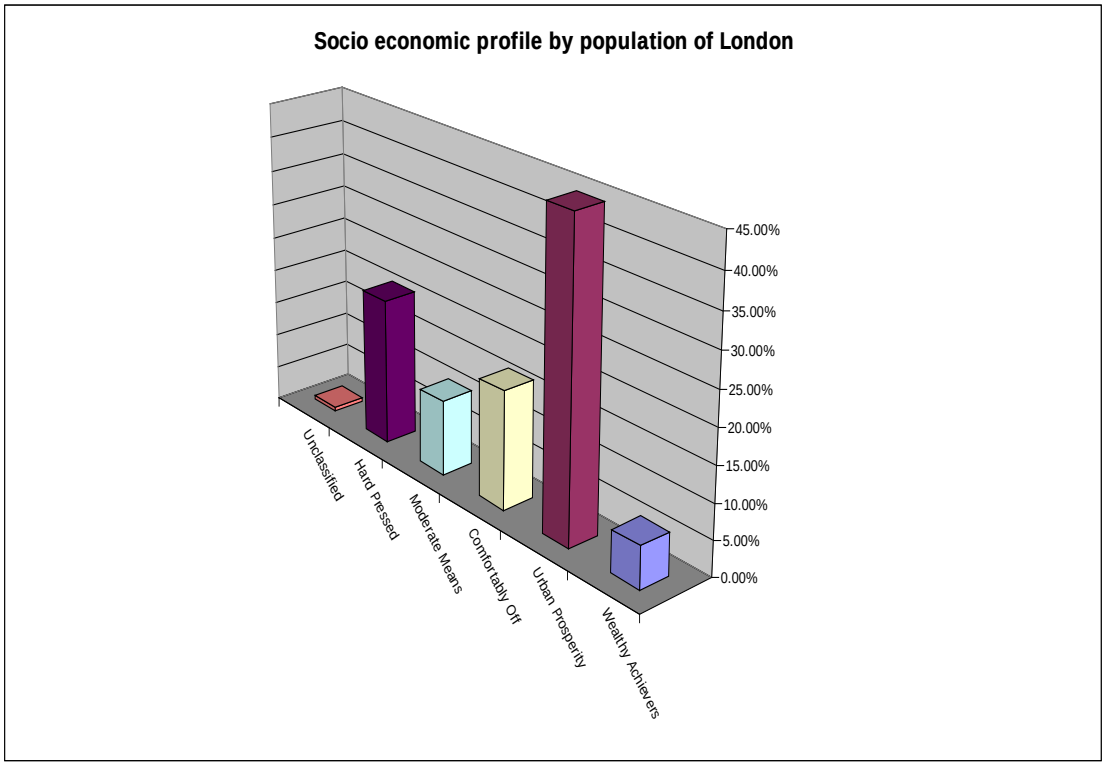
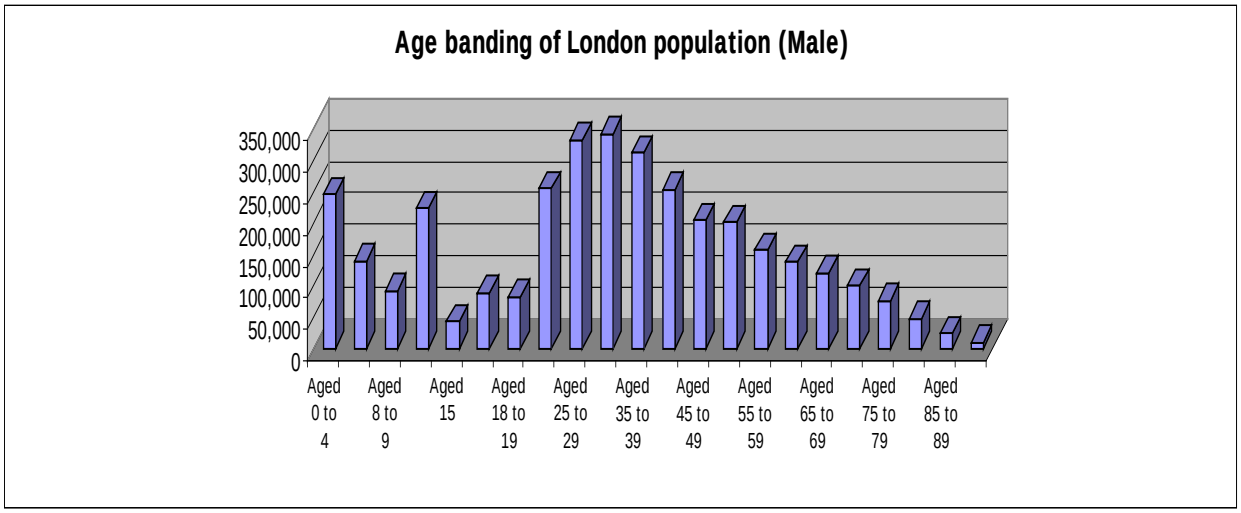
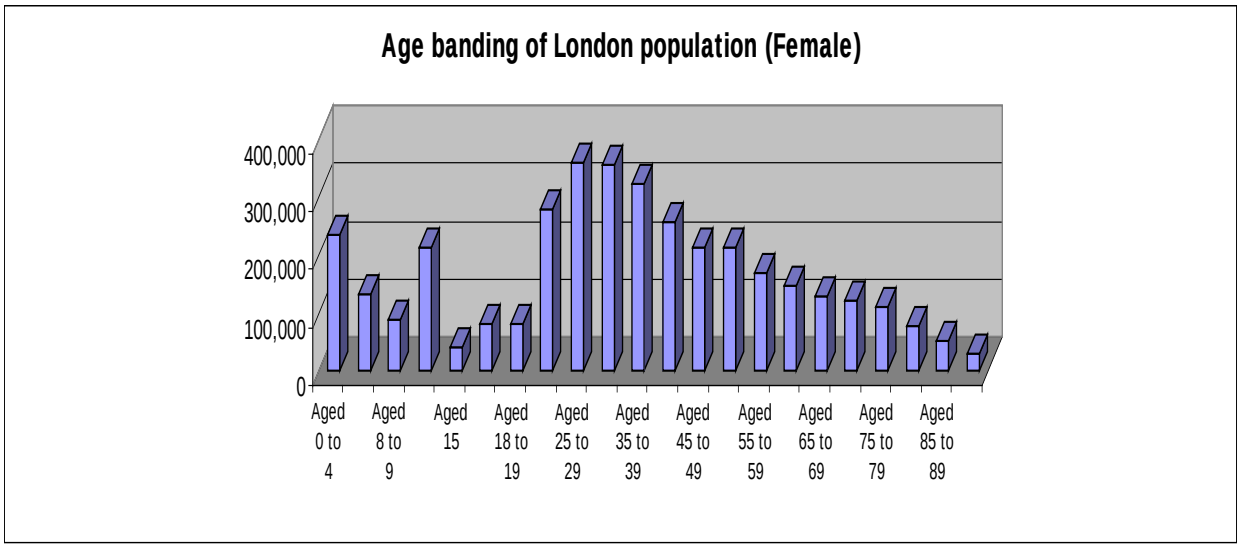


Figure 4 (Source: 2001 Census)




Age banding of London population (Female)
400,000
300,000
200,000
100,000
0
Aged 0 to 4
Aged 8 to 9
Aged 15
Aged 18 to 19
Aged 25 to 29
Aged 35 to 39
Aged 45 to 49
Aged 55 to 59
Aged 65 to 69
Aged 75 to 79
Aged 85 to 89

The staff constituency

The staff constituency is divided into two classes: front line and support staff, to reflect the make-up of the workforce. Staff will be allocated to the class that best fits the description of their role within the LAS.

The Trust plans an inclusive approach to staff membership using the opt-out method, whereby all existing and new staff appointments with a minimum of 12 months service automatically become a member. If an individual employee does not want to become a member they can opt out but they will not be eligible to join another constituency while continuing to work for the Trust. Staff can opt back into membership at any time.

When a member of staff leaves LAS employment their membership of the staff constituency will be terminated. If they remain a resident within the geographical area served by the Trust they will be invited to become public members.

If a member of the public constituency becomes employed by the LAS their membership will revert to staff membership.

Longer-term temporary staff and contractors can join the staff category as long as they have worked for us for at least 12 months. Volunteers and staff with a contract of employment of less than 12 months cannot be staff members, but can join us as public members if they meet the residential criteria.

A staff member may be asked to temporarily cease membership activities during any period of suspension under the Trust's code of conduct and associated staff policies and professional codes.

The staff constituency will have approximately 4,500 members and will be represented by three Governors on the Council, two for front line staff and one for support staff.

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4. Resourcing the membership development

We recognise that the membership strategy can only be effective over the long term if it is properly resourced.

Director of Corporate Services

The Director of Corporate Services/Trust Secretary has the director level responsibility for membership. The membership services function is established within the Corporate Services Directorate and is supported by a dedicated Membership Manager. The Director of Corporate Services will provide guidance and support to the Council of Governors and the Chair of the Trust especially in managing the relationship between the Council of Governors and the Board of Directors.

Financial support for membership and Governor activity is a priority for the Trust and resources are already committed towards the staffing of the membership function, provision of externally commissioned specialist services, and information and activities to support and engage members. Non-pay costs associated with membership governance such as elections, support for Council of Governor meetings, Governor's "surgeries", cover for staff governors, reimbursement for travel of Governors, Members' meetings and events will also be budgeted for and funded.

Currently, the Trust has an internal membership office, as part of the Foundation Trust Application Programme.

Membership Manager

The management and development of the membership is the responsibility of the Membership Manager.

The Membership Manager links proactively with Trust staff and other agencies involved in community engagement and patient and public involvement activities in order to maximise all potential partnerships with local communities and groups, and takes up all opportunities to recruit members and raise awareness of the benefits of membership.

Membership responsibilities will include:

- Setting up systems and processes for the day-to-day management of the membership
- Responding to members' information requirements and any problems or queries they may have about our services
- Ensuring the Trust engages members effectively and actively involving them in Trust business
- Ongoing recruitment of members
- Targeting under-represented groups
- Ensuring effective communication with all members exploiting electronic communication to save costs where appropriate
- Conducting Governors' induction and training
- Running elections using an external provider
- Maintaining ongoing communications with Governors
- Arranging Governor meetings
- Ensuring effective information flows and communication between Governors, members and Trust management
- Assisting Governors to produce a membership development strategy which will be evaluated and analysed in their annual report.

The **Head of Communications** manages the Trust's external and internal media relationships and will provide support in handling public relations issues and production of the members' newsletter.

The Trust contracted an external provider in February 2009 to maintain its membership database for an initial period of two years. The contract will be

reviewed prior to this period and we will evaluate the costs and benefits of maintaining the database internally.

The Trust will review continually the adequacy of its membership support function to ensure that it continues to meet the demands of a growing and increasingly engaged membership, future elections, and the needs of Governors when they are elected.

5. Building the membership base

Staff governors will be encouraged to promote membership and its benefits to new comers through induction days. Once employees are eligible to join as staff members they will receive a letter informing them of the opportunity to opt out if they so wish. This approach will be supported by a programme of staff communications and engagement to highlight the opportunities of NHS Foundation Trust status. This programme will include reference to the benefits of becoming an FT. On leaving the Trust staff will be invited to join our public constituency.

With regard to the public constituency, we will build on existing links with all our stakeholders and take every new opportunity to promote membership.

This will include:

- Local Involvement Networks (LINks)
- Public events
- Patient Experience contacts
- Schools and Events Team contacts and groups
- Community Resuscitation Training Team contacts
- Community Responders
- Patient Transport Services
- Patient & Public Involvement Team contacts
- Community Involvement Officers
- LAS Patient's Forum

Member Constituency	**2009/10**	**2010/11**	**2011/12**
Public	**4,000**	**6,000**	**8,000**
Staff	**4,350**	**4,400**	**4,500**

Whilst the Trust wishes to recruit members in sufficient numbers to adequately represent the local population, the priority is to recruit and support a membership that is engaged and interested in the Trust's activities and in developing its plans.

The management team will:

- Recognise members as a valuable resource in the planning and delivery of services
- Take advantage of trust events as a means to recruit members
- Encourage staff to be active members
- Encourage and support managers to promote the FT message and recruit members through their local area networks as part of their outreach remit

The Council of Governors, within the first 12 months, will:

- Develop an action plan for maintaining and building up the growing membership
- Identify initiatives for raising the profile of membership with staff, service users and communities.
- Seek to achieve a membership that is representative of the diverse communities we serve
- Keep staff, service users, and local communities and the wider public informed about our work in order to promote understanding, partnership working and the recruitment of new members
- Work with partner organisations across local, health and social care communities to promote a co-ordinated approach when communicating with patients and the public

The Council of Governors, within the first 18 months will:

- Review the profile of the membership against demographic information on the communities we serve, and utilise the results to inform future membership recruitment
- Review support arrangements for membership

6. Managing active membership

The effective engagement of members is crucial to our success as a Foundation Trust. We will want to develop activities to make the most of our members and keep them involved, as much as they want to be, with the Trust.

Member activities will include:

- Participating in patient focus groups and other feedback activity
- Standing as a Governor
- Taking part in Governor elections
- Attending Council of Governor meetings
- Attending annual members meeting
- Involvement in special interest/focus groups about service improvement
- Health promotion and education events for their community
- Responding to surveys about service development proposals
- Constituency meetings with Governors

- Members' newsletter contributions

Our member registration forms include a menu of involvement options, enabling us to identify the level of engagement that members are seeking. This allows us to ensure that we can contact the right people quickly when a new initiative is underway regarding any of the above activities. The Council of Governors will receive an annual report on the membership including numbers joining, leaving, demographic analysis and targets for greater involvement.

Governors will play a key role in the success of members' engagement as they are the link between the trust and the members.

The management team will:

- Keep members up-to-date with service development plans through regular newsletters
- Keep the Foundation Trust website updated and active
- Consult members on strategic plans and development plans (eg policy development)
- Invite members to attend events on health issues
- Support members through the election process
- Provide Council of Governors the opportunity to review the annual accounts, auditor's reports and annual report at a general meeting
- Provide Council of Governors the opportunity to express a view about the Trust's forward plans for the NHS FT

The Council of Governors, within the first 12 months, following authorisation by Monitor will:

- Develop an action plan for determining members' interests and involving them in the work of the trust
- Encourage the contribution of members in the planning and delivery of services
- Promote constructive working relationships and dialogue between public members and our staff

The Council of Governors, with the first 18 months, will:

- Map the level of involvement and influence of members in the planning and delivery of services, and utilise the result to inform the membership development strategy in the future
- Review the action plan for members involvement

7. Communicating with members

The Trust is keen to assist all members, Governors, managers and staff as effectively as possible in the development of the organisation and its services. It is essential to establish appropriate and meaningful two-way dialogue. Communications will be in 'Plain English', avoiding the use of jargon, and will

provide information in appropriate and accessible formats to meet the needs of members that are relevant and timely, as well as delivered in their preferred format.

The Head of Communications will lead the development of all communication with members in liaison with the Director of Corporate Services. Our communication and contact with all of London is important to us and we will continue to develop facilities that enable effective engagement.

There will be a planned series of communications throughout the year, hard copy newsletters, event invitations, details of special interest groups etc.

We will use as many feedback mechanisms as possible to encourage members to participate fully in the Trust – hard copy response, e-mail, contact centre, members' website pages etc in accessible formats.

Membership register

A register of public and staff members will be maintained by the Trust. This information about members will be held on a secure and confidential database, which will be managed in accordance with the Data Protection Act 1998. The register will be managed by an external supplier on behalf of the Trust through an agreed and closely monitored contract agreement.

Newsletters

Based on guidance and experience from our consultation event programme delivered at venues in every London borough, we will offer members the means to find out about our service now and our plans for the future. The Trust plans to produce quarterly newsletters, which can be used to spread our public awareness message and educate the public on the range of our services.

Annual General Meeting

This is an opportunity for members to meet their representatives and senior staff and to ask questions. It provides a good opportunity for the Foundation Trust to promote itself. A member who understands the work of the Trust and feels involved and valued is more likely to recruit other members.

Task and Finish Groups

From time to time there may be a need to develop task and finish groups on particular issues and patient and public views can be obtained through the membership.

Working groups/committees

There may be opportunities in the future to invite members, with the appropriate skills, to join a committee or working groups.

eComms

The Trust will encourage the use of electronic media (email, website etc) to communicate with members and encourage them to respond by email. However, hard copy will be available to members, as other Foundation Trusts have found this to be the most popular medium.

The management team will:

- Provide communication channels for members to include:
    - Newsletters (x4) throughout the year
    - Email updates
    - Membership section on website
- Encourage members to vote in elections
- Consult with members and future strategies and plans
- Provide appropriate mechanisms for members and consult with members about future strategies and governors' arrangements
- Organise membership events and meetings presenting items of interest

The Council of Governors, in the first 12 months, will:

- Identify ways and means to inform members about the Trust
- Evaluate the success of their communication approaches with members
- Maintain and develop the programme of events and seminars
- Participate in a well attended annual meeting of the Council

The Council of Governors, in the first 18 months, will:

- Evaluate the success of our communication with our members so that the Head of Communications can use any constructive feedback to develop our Communications Strategy and update our Membership Recruitment Action Plan.

8. Playing a key community role

The Trust is fully committed to being a good corporate citizen; we will endeavour to ensure that we contribute to all the communities in London that we serve. Our aim is to encourage interest and understanding of the London Ambulance Service and promote good relationships.

The Service has strong existing links into the community through a range of initiatives and workstreams including Community First Responders, the Events and Schools team and the Community Resuscitation Training team. The Trust's Public Education Strategy sets out how these links will be developed through increased coordination, recording, evaluation and support. As a foundation trust we will seek to recruit and engage members through all these activities.

The London Ambulance Service has a Patient & Public Involvement Action Plan for 2008-2012, which sets out the current and future priorities for PPI activity. Our approach is to prioritise groups which will benefit most from our involvement in their communities.

The Patient & Public Involvement Manager is responsible for development and implementation of these strategies and ensuring that patients and the public are made aware of and are involved with the work of the Trust.

Some examples of our PPI activity are provided in the sections below.

The Prince's Trust

As part of our commitment to working in the community, the Trust is supporting The Prince's Trust on a programme which helps young people aged between 16 and 25 return to education, gain employment or access to training.

London Ambulance Service staff will be seconded for 12-14 weeks to work with young people involved in the programme, which aims to boost the confidence, motivation and develop the skills of vulnerable young people so they can move on with their lives.

Tower Hamlets Project

Trust staff are involved in a number of projects in the Tower Hamlets area specifically aimed at reducing health inequalities affecting the Bangladeshi community. One such project is teaching emergency life support to young Bengali families. These classes were set up because there is a higher infant mortality rate in this community than any other. The LAS already offers emergency life support in other parts of London through the community resuscitation team.

The Trust also worked with Tower Hamlets Primary Care Trust to produce a health information pack, "Get the Right Treatment." This provided information about which services should be accessed in a variety of situations, and won a London Health & Social Care award.

Through the project in Tower Hamlets, we also aim to engage with children and young people through a range of activities, including skills training and drama.

Children and Young People

The Trust works closely with other emergency services and organisations to deliver public education activities for young people, including knife and gun crime awareness events and the Safe Drive Stay Alive Campaign, a powerful theatre education project involving all the emergency services, exploring the circumstances and consequences of a road traffic collision.

Working in association with Junior Citizens Schemes, the LAS participates in events across London which are aimed at seven to 10-year-olds, educating them about first aid and gives them advice on how to make a 999 call.

Community Involvement Officers

As part of the Trust's organisational development programme (New Ways of Working) a new role of Community Involvement Officer (CIO) has been introduced. The CIO role is to support local management teams to develop valuable local relationships including patients, residents, voluntary organisations and other health and social care partners. There are two CIO posts at present, but this number will increase until we have 26 posts, one for each group of local ambulance stations.

Olympics Planning

The Olympic Games Planning Office (OGPO) plans to work closely with patients, the public and partners to ensure that key messages are delivered and that feedback from these stakeholder groups is contributing to planning work going forward. The Trust is also working closely with the Olympic Delivery Authority (ODA), London Organising Committee for the Olympic Games (LOCOG) and the Olympic Security Directorate (OSD) on issues for delivering the Olympics in 2012 without compromising the care delivered to Londoners, such as transport plans, occupational health and first responder schemes and a medical model of care.

The Trust intends that its engagement with LINks will provide an opportunity for increased networking possibilities, with greater engagement with community and social care organisations. Having relationships with 33 LINks in London will also form a strong basis for recruiting members as well as enabling our members to become more actively involved in their local areas. It is envisaged that these relationships will be made at a strategic level as well as at a local level through each station complex.

The management team will:

- Provide opportunities for local communities to become actively engaged with the Trust:
- Maximise opportunities for joint partnership working
- Consult with partners and communities regarding strategies and plans

The Council of Governors, in the first 12 months, will:

- Develop appropriate mechanisms London wide for engaging with their local communities

- Maximise opportunities for promoting membership and relationships with communities and local people
- Participate in local events to promote Trust membership

The Council of Governors, in the first 18 months, will:

- Review effectiveness of local mechanism for engaging and involving communities groups

9. Working with other membership organisations and partners

The Trust is will appoint Governors from five voluntary sector partner organisations and is currently considering the following organisations as representative of some of the major groups of patients we work with: Age Concern London, British Heart Foundation, Diabetes UK, Mind and The Stroke Association. We will also invite nominated representatives from a PCT and a local authority.

Strong partnerships have been made and developed with aspirant ambulance trusts through membership and project management networks, where colleagues regularly share best practice and learning.

The Trust has also developed links with other local foundation trusts and worked together to maximise opportunities for recruiting local people.

The management team will:

- Establish and continue working relationships with other foundation trusts around membership issues, for example setting up a membership managers network
- Involve other membership organisations, such as LINks, in membership and promote Governor elections to these groups
- Consult with partners and communities regarding strategies and plans

The Council of Governors, in the first 12 / 18 months, will:

- Agree joint approaches, where relevant, on matters such as recruitment and events

10. 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 an annual meeting with the Board of Directors.

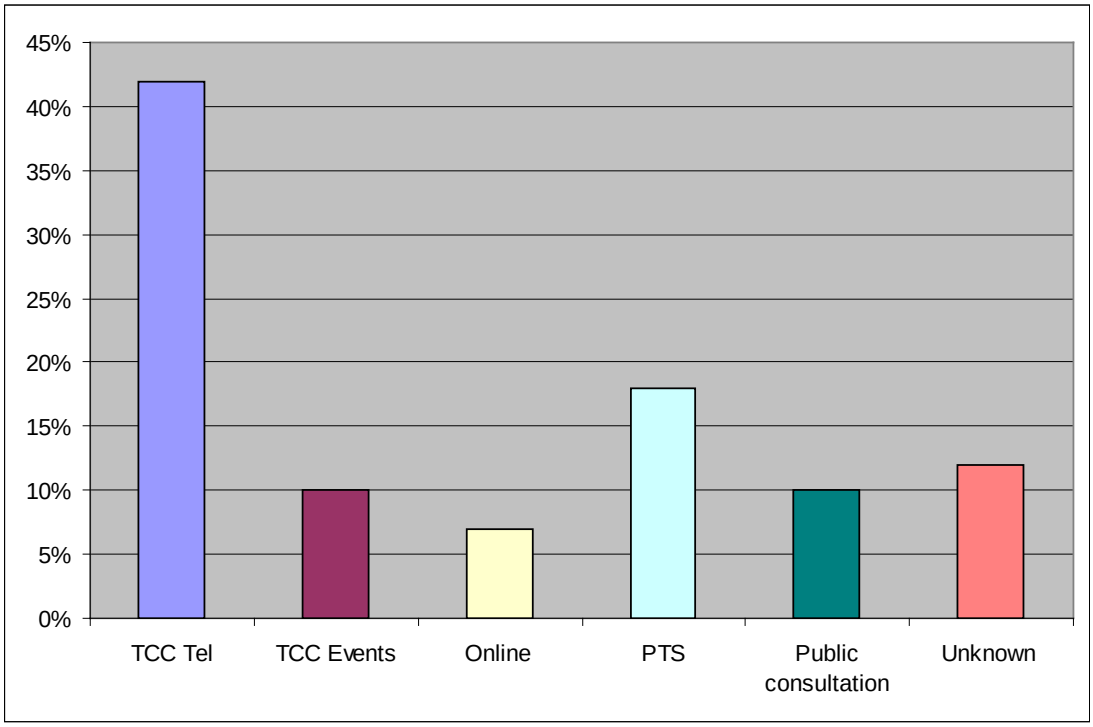
The Council of Governors might wish to evaluate progress in implementing this strategy by:

- Confirming appropriate cross-sectional community representation
- Reviewing the composition of the membership (and focusing recruitment on areas where there is under representation)
- Reviewing the strategy annually ensuring it meets its aims
- Seeking feedback directly from members and governors (and specifically whether members feel they have a real say in the way the organisation is run)
- Monitoring the number of members who have participated in elections
- Setting up a membership engagement sub-committee enhancing the role and function of the Trust's Patient and Public Involvement Committee. The principal objective of the Membership Engagement subcommittee will be to monitor the implementation of this strategy and action plans defined to measure annual progress with our membership approach and targets.
- Assess Council's performance in developing a meaningful membership strategy

11. Membership recruitment to date

To date we have recruited 4,500 public members through a range of activities. Recruitment started in February 2009 in conjunction with our 14 week consultation process.

The following graph demonstrates how members have been recruited.



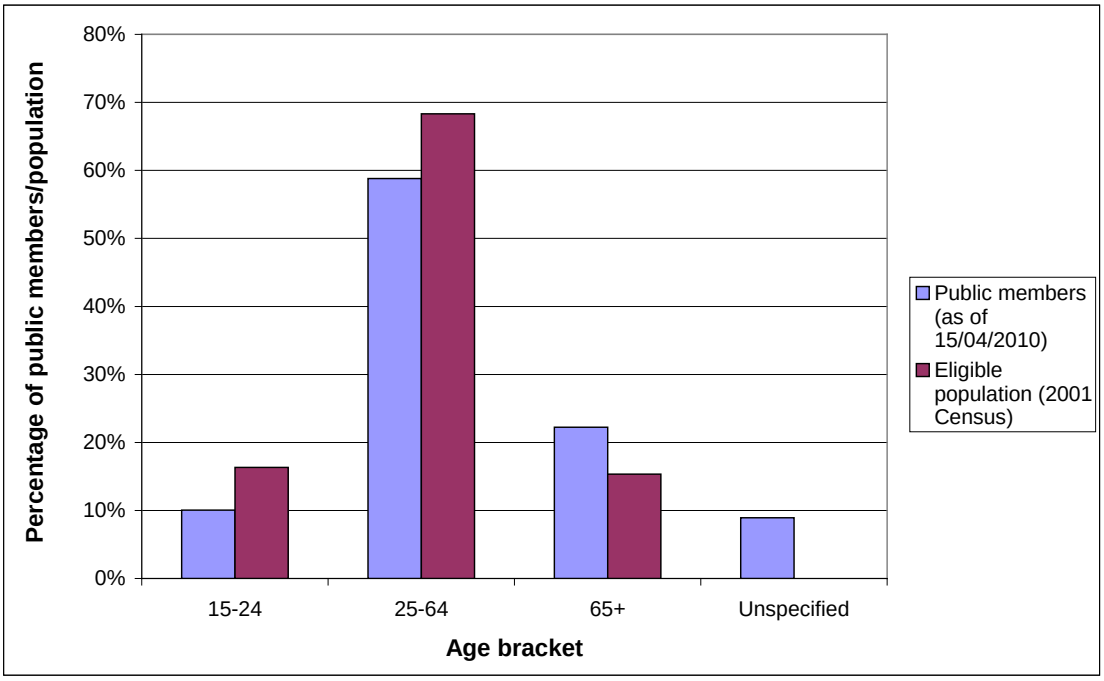
TCC Tel – Telephone recruitment campaign

TCC Events- Face-to-face recruitment campaign

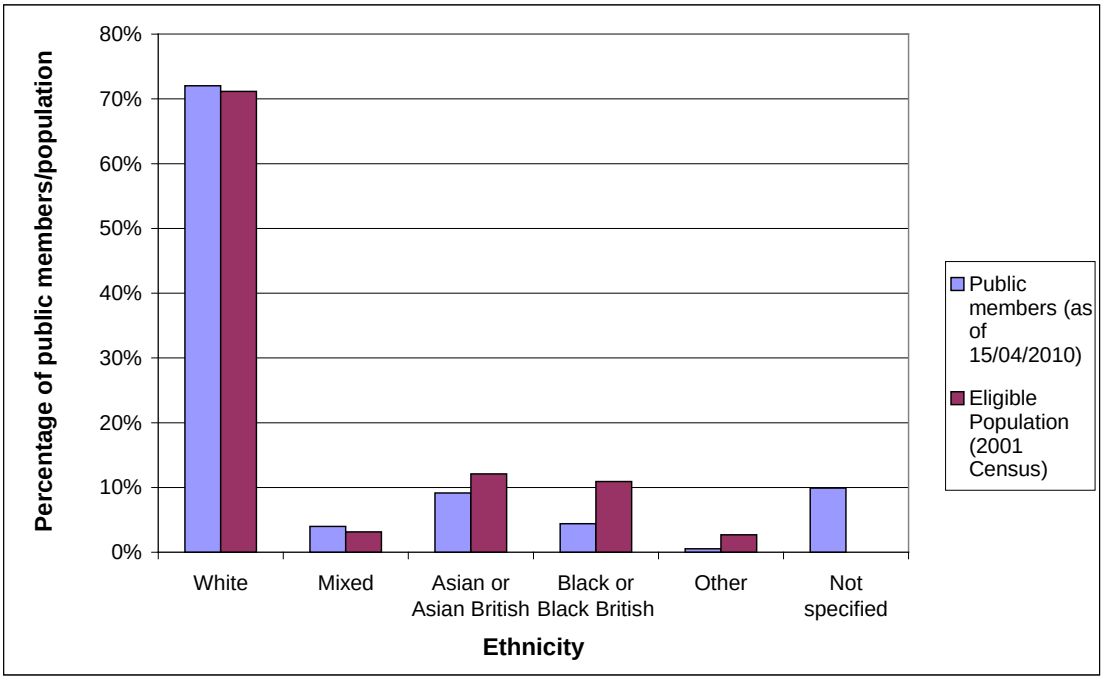
PTS – Mailings to Patient Transport Services patients

The following figures show the public membership profiles in relation to age, ethnicity, social grade, gender and constituency.

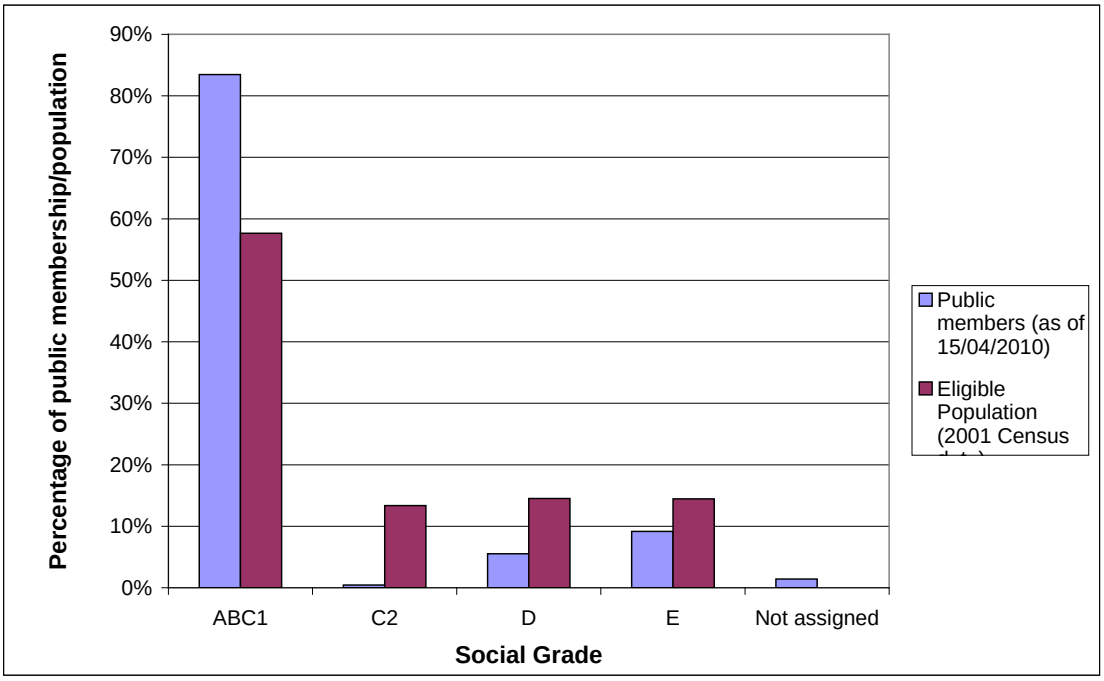
1. **Public membership age profile**



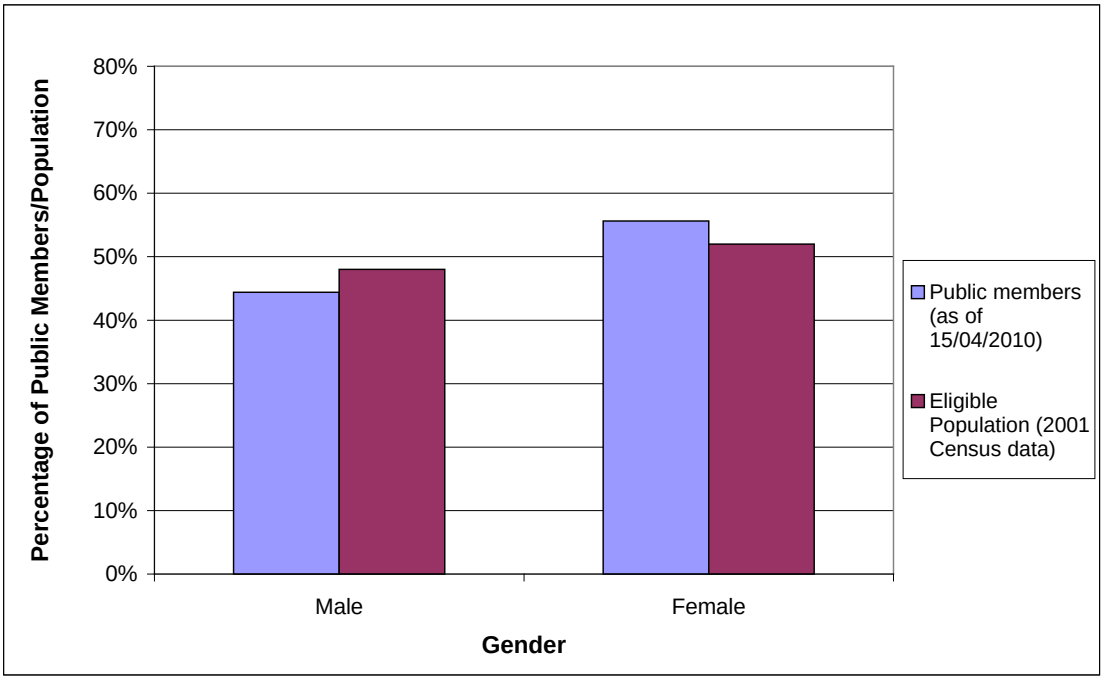
2. Public membership ethnicity profile



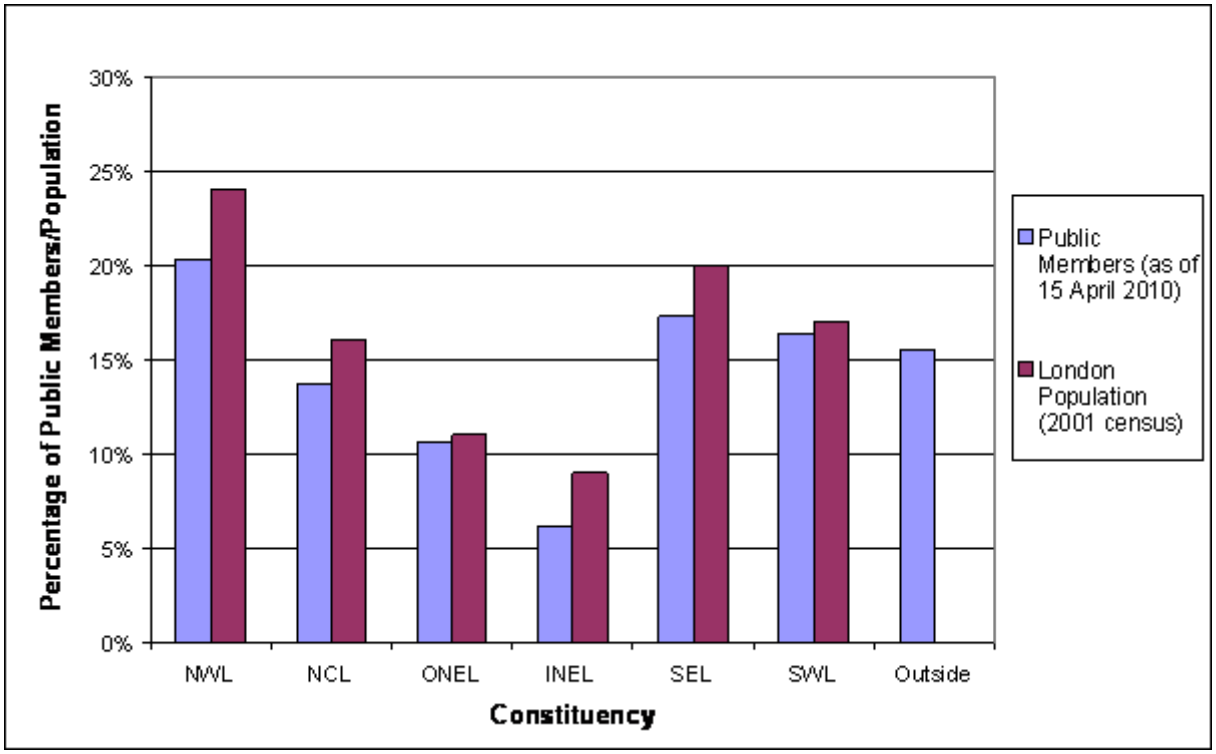
3. Public membership social grade profile



4. Public membership gender profile



5. Public membership constituency profile



(Constituency abbreviations: NWL - North West London; NCL – North Central London; ONEL – Outer North East London; INEL – Inner North East London; SEL – South East London; SWL – South West London; Outside – Outside London)

From these graphs we can see that we are slightly underrepresented in the following categories. The 2009/10 recruitment plan will address this underrepresentation through targeted activity in increase membership from these groups.

- Black or Black British (under by approx 6%),
- C2 social grade persons (under by approx 12%)
- Male persons (under by appox 6%), and
- People North West London (4%), from the Inner North East London (3%) and North Central London (4%).

12. Plans for future membership recruitment

Amembership recruitment plan is produced annually and is designed to deliver the target figures for member recruitment and address any underrepresentation of groups as shown above

These will include:

- recruitment targeted at specific groups or areas
- continued use of our existing contact with London's population

- engaging staff and volunteers in recruiting public members
- engaging local community groups, including youth organisations, and large local businesses
- engaging health and social care community partner organisations
- engaging with local education providers, including the universities
- using local media to promote the campaign
- face-to-face promotional visits
- exploiting electronic media to maximise membership recruitment at minimum cost. (eg using e-vite to sign up new members online, website quizzes to attract people from the home-page)

After authorisation we will support the Council of Governors to develop means to recruit and retain our members.

We will analyse our register of members to identify gaps in representation of London's communities based on the most recent demographic information available to us and take appropriate action to address any gaps.

Appendix 1

Governors & Public constituencies

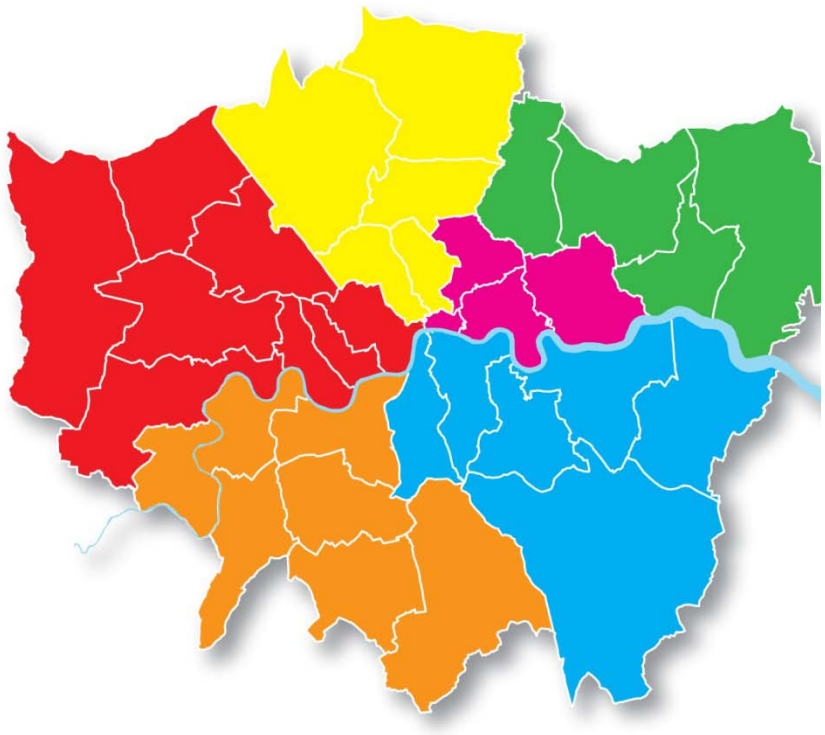
2 **North West London**
Ealing, Harrow, Brent, Westminster, Kensington & Chelsea, Hammersmith & Fulham, Hounslow and Hillingdon

2 **North Central London**
Barnet, Enfield, Haringey, Islington and Camden

2 **Outer North East London**
Barking & Dagenham, Havering, Redbridge and Waltham Forest

2 **Inner North East London**
City of London, Hackney, Newham and Tower Hamlets

2 **South East London**
Bexley, Bromley, Greenwich, Lewisham, Southwark and



	Lambeth	
	❷ **South West London** Richmond & Twickenham, Wandsworth, Kingston, Sutton, Merton and Croydon	
	❶ **Outside London** East of England: Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk South East Coast: Surrey, Sussex and Kent South Central: Oxfordshire, Buckinghamshire, Berkshire, Hampshire and Isle of Wight	

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

28th September 2010

PAPER FOR NOTING

Document Title:	**Annual Trust Board Effectiveness Review**
Report Author(s):	**Sandra Adams/Francesca Guy**
Lead Director:	**Sandra Adams, Director of Corporate Services**
Contact Details:	**02077832257**
Why is this coming to the Trust Board?	**In compliance with governance good practice, NHS Trust Boards should undertake an annual evaluation of its own performance, in addition to that of its committees and individual directors.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	To consider the findings of the 2009/10 Trust Board Effectiveness Review

Executive Summary/key issues for the Trust Board

The Healthy NHS Board Principles for Good Governance recommends that NHS Trust Boards undertake a formal and rigorous annual evaluation of its own performance, in addition to that of its committees and individual directors. This evaluation is intended to assist and enable the Trust Board to assess how it is performing and to identify ways in which to maximise strengths and improve areas of weakness.

Directors and Non-Executive Directors were asked to complete a questionnaire of seven sections, which each contained a series of statements that directors were asked to signify their level of agreement with, from strongly agree to strongly disagree. The questionnaire also included comments boxes for each of the statements for further comments and observations.

Fourteen directors and non-executive directors completed the questionnaire and the results have been collated in the attached document. A scoring system has been used to analyse the results, whereby 'strongly agree' received a score of 5 down to 'strongly disagree' which received a score of 1. This gives a maximum score of 70 and a minimum score of 14 for each statement.

To highlight strengths and areas of weakness, all statements which received a score of 55 and above were rated green, all statements which received a score between 40 and 54 were rated amber and those which received a score below 40 were rated red. The RAG rating gives an indication of strengths and weaknesses, but in reviewing the results, the comments should also be taken into account.

The following statements scored highly, with every answer either 'strongly agree' or 'agree':

1.1 The board has developed a strategy for the Trust that is central to the way it is directed.
1.2 The strategy is well aligned to the Trust's remit, capacity and capabilities.
2.9 Directors attend meetings regularly, and are fully prepared and informed for meetings.
3.2 The balance of Executive Directors to Non-Executive Directors is appropriate.
3.3 the board composition ensures the right mix of knowledge and skills to maximise performance.
3.10 The board has sufficient access to the executive management and officers of the Trust outside of board meetings.
4.1 The board takes collective responsibility for the performance of the Trust.
4.2 The board holds the organisation to account for its performance in the delivery of the strategy.
4.3 The board reviews the performance of the organisation through regular monitoring throughout the year against budgets, financial indicators and strategic milestones.
5.1 The board has sound processes for identifying and regularly reviewing its principal risks, involving all areas of the Trust, and takes necessary action to mitigate these risks.
5.2 The board receives regular reports on the Trust's risk management and other internal control systems for assurance.
6.4 The board takes into account the views of its key stakeholdesr in the decisions that it makes.

One statement received a score of 34 and was rated red:

The board composition reflects the diverse communities that it serves.

Attachments
Trust Board Effectivness Review 2009/10

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

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

	3. COMPOSITION, RELATIONSHIPS AND INTERACTION	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Comments	Score
3.1	The board is the right size.	3	10	1				58
3.2	The balance of Executive Directors to Non-Executive Directors is appropriate.	2	12				With the appointment of the Director of Health Promotion and Quality to a voting executive position	58
3.3	The board composition ensures the right mix of knowledge and skills to maximise performance.	2	12				With recent appointments to both Executive and non-Executive posts the appropriate mix have been greatly strengthened. To be kept under review as we reflect board performance.	58
3.4	The board composition reflects the diverse communities it serves.		1	5	7	1	In some diversity strands the board is representative (in particular, gender). However it is not so at all in relation to race. Much more progress on overall diversity is required.	34
3.5	Appointments place significant emphasis on succession planning both with regard to executive and non-executive directors' positions.	1	5	6	2		A feature in recent recruitment.	47
3.6	The roles and the responsibilities of Executive Directors and Non-Executive Directors are well defined and clearly understood.	3	10	1			Improving with more to do.	58
3.7	The Chair demonstrates effective leadership of the board and allows full and open discussion before major decisions are taken.	3	10	1				58
3.8	The board is cohesive and combines being supportive of management with providing appropriate challenge.	4	9	1			A key focus of the last year and improving from meeting to meeting. This is not consistent but it is starting to improve	59
3.9	Directors contribute actively across the breadth of the board agenda and not only to their functional leadership areas.		9	3	2		On the whole this is the case. Not where we need to be. dependent on individuals	49
3.10	The board has sufficient access to the executive management and officers of the Trust outside of the board meetings.	8	6				Executive managers are open to being contacted outside of board meetings. Personally however, I have experienced very little demand. Now improved.	64
3.11	There is a structured process for induction of new board members.	4	6	2	2			54
3.12	Induction and development programmes ensure board members remain up-to-date throughout their time on the board.	2	8	2	2		This has improved over the last 12-18 months. The FT process is helping progress in this area.	52
3.13	The board undertakes a regular skills audit of its current board members to ensure an effective balance of knowledge, skills and backgrounds.		2	8	4		Informal. Don't know. A more formal process is now required.	40

3.14	Board members undergo an annual appraisal process of their individual contribution and performance which culminates in a personal development plan.	3	9	2			Not sure if all non-executive directors have a PDP. Certainly all executive directors do. 1:1 with the chair for the NEDs. Covered as part of Executive review process Exec Directors undergo regular appraisal meetings with a formal annual assessment and are expected to have a robust PDP. NEDs have an annual appraisal	57
3.15	The time commitment of non-executive directors is about right and NEDs demonstrate flexibility in their commitment over the longer period.	1	9	1	3		Some are more able to be available than others due to other commitments. FT process is placing a considerable burden on NEDs. The time commitment is an increasing challenge and needs to be watched. This varies with individual NEDs	50

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

28th September 2010

PAPER FOR NOTING

Document Title:	**Audit Committee Annual Report 2009/10**
Report Author(s):	**Sandra Adams/Francesca Guy**
Lead Director:	**Sandra Adams, Director of Corporate Services**
Contact Details:	**02077832257**
Why is this coming to the Trust Board?	**As recommended by the NHS Audit Committee Handbook and in line with governance good practice, the Audit Committee should prepare an annual report to the Trust Board that sets out how the Committee has met its terms of reference throughout the year.**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☒ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	To note the Audit Committee Annual Report for 2009/10

Executive Summary/key issues for the Trust Board

As recommended by the NHS Audit Committee Handbook and in line with governance good practice, the Audit Committee is asked to prepare an annual report to the Trust that sets out how the Committee has met its terms of reference throughout the year.

The Audit Committee reviewed the Audit Committee Annual Report at its meeting on 7th June 2010 prior to final approval at its meeting on 13th September 2010.

The Audit Committee complied with good practice and met its terms of reference by:

•Reviewing and agreeing the nature and scope of the external audit and agreeing the external audit plan and audit fee for 2009/10 financial year;
•Agreeing the Annual Audit Letter prior to submission to the Trust Board. An unqualified opinion on the accounts for 2009/10 was given to the Trust in June 2010;
•Reviewing the Trust's system of internal financial controls and agreeing the Statement on Internal Control;
•Reviewing and agreeing the internal audit strategy and programme of work and receiving regular update on progress against recommendations. The key conclusion from RSM Tenon's work for 2009/10 as provided in the Head of Audit Opinion and Annual Report was that significant assurance could be given that controls were generally being applied consistently;
•Completing a self assessment exercise to evaluate the Committee's effectiveness and compliance with requirements;

•Reviewing the work of other committees. The Chair of the Clinical Governance Committee attended Audit Committee meetings as an observer and gave an update on key items of discussion;
•Reviewing the Annual Report and Financial Statements prior to submission to the Trust Board.

One area of particular focus throughout the year was the management of controlled drugs following internal audits which took place in March 2009 and July 2009. The Audit Committee received regular reports on the progress made against recommendations and the Trust Board was provided with a report of progress made in this area which included evidence of compliance against the relevant core standards.

The Audit Committee also reviewed the format of the risk register and board assurance framework and noted the progress that had been made in mapping risks to the Trust's strategic goals. The Audit Committee requested that they receive the full risk register annually and at every other meeting focus on the top ten strategic risks.

The Audit Committee's workplan for 2010/11 includes the review of the Integrated Business Plan and the Long Term Financial Model in preparation for the application for Foundation Trust status, and monitoring the effectiveness of the revised governance structure which was implemented in 2010.

Attachments
Audit Committee Annual Report 2009/10

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

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

ANNUAL REPORT OF THE AUDIT COMMITTEE
2009/10

1. Introduction

1.1 The role of the Audit Committee is to support the Board with regard to its responsibilities for issues of risk, control and governance through providing assurance on risk management, governance and internal control. In addition, the Committee provides a form of independent check upon the executive arm of the Board.

1.2 As defined within the 'Audit Committee Handbook (2007)', the Committee has responsibilities for the review of governance, risk management and internal control covering both clinical and non-clinical areas. In discharging these duties the Committee is required to review:

- Internal financial control matters, such as safeguarding of assets, the maintenance of proper accounting records and the reliability of financial information;
- Risks regarding disclosure statements (Statement on Internal Control and Standards for Better Health) which are supported by the Head of Audit Opinion and other opinions provided;
- The underlying assurances as detailed in the Assurance Framework;
- The adequacy of relevant policies, legality issues and the Codes of Conduct;
- The policies and procedures related to fraud and corruption.

1.3 The conduct of this remit is achieved firstly, through the Committee being appropriately constituted, and secondly, by the Committee being effective in ensuring internal accountability and the delivery of audit and assurance services.

2. Scope of the report

2.1 This report outlines how the Committee has **complied with the duties delegated by the Trust Board** through its Terms of Reference **(See Appendix A)**, and identifies the key actions to address further developments in the Committee's role.

3. Constitution

3.1 In accordance with the terms of reference, the membership of the Audit Committee from 1st April 2010 – 31st March 2010 was four Non-Executive Directors, with a quorum of two, including two with 'recent relevant financial experience'. The Director of Finance was invited to attend all meetings and the Committee requested the attendance of the Chief Executive and other officers of the Trust to answer any points which arose. In addition, the Internal and External auditors and the Local Counter Fraud Specialist were invited to attend. The Chair of the Trust's Clinical Governance Committee was also invited to attend Audit Committee meetings as an observer.

3.2 A schedule of attendance at the meetings is provided in **Appendix B** which demonstrates full compliance with the quorum requirements and regular attendance by those invited by the Committee.

3.3 In accordance with the terms of reference four meetings were held within the last financial year on 8th June 2009, 15th September 2009, 9th November 2009 and 8th March 2010.

3.4 The Committee had an annual work plan for 2009/10 with meetings timed to consider and act on specific issues within that plan.

3.5 The Committee Chair reported to the Trust Board following each meeting.

3.6 A detailed review of the Audit Committee activity for 2009/10 has been included at **Appendix C.**

4. Self Assessment

4.1 During 2009/10 the Committee has complied with 'good practice' by:

- Monitoring the Risk Management Framework of the Trust (set out in its Risk Management Policy) using the Assurance Framework as a tool to measure the mitigation of risks by controls;
- Reviewing the Trust's system of internal financial controls;
- Completing a self assessment exercise to evaluate the Committee's effectiveness and compliance with requirements;
- Conducting private discussions with the auditors;
- Agreeing an annual work programme;
- The Head of Governance attending all committee meetings to keep the committee aware of topical legal and regulatory issues.

5. Internal Processes

5.1 In accordance with the Committee's authority, in addition to the Director of Finance, other officers of the Trust were called to attend the Committee to provide updates regarding progress on implementation of recommendations following audit and other assurance reviews.

5.2 Following receipt of audit reports the Committee has directed audit resources to complete follow-up reviews and to perform detailed reviews into specific issues and high risk areas. Additionally, to support the Committee's control of implementation of key actions, a schedule of follow-up was reported by the Governance and Compliance Team.

5.3 The Committee regularly received the minutes of the Clinical Governance Committee and Risk Compliance and Assurance Group which supports the principles of integrated governance.

5.4 The accounting officer presented the 2009/10 Annual Accounts which were subsequently reviewed by External Audit. Additionally, regular reports were produced by the accounting officer for the Committee's approval of tender waivers and write-offs for Losses and Compensation.

6. Independent Assurances / Audit

6.1 External Audit

6.1.1 The provision of External Audit services was delivered by the Audit Commission. Their work can be divided into two broad headings:

- To audit the financial statements and provide and opinion thereon,
- To form an assessment of our use of resources.

6.1.2 At its meeting on 8th June 2009, the Audit Committee agreed the nature and scope of the audit as set out in the Annual Plan and the audit fee for 2009/10 financial year. The

Committee received regular updates on the progress of work. In addition, reports and briefings (as appropriate) were received from the External Auditors in accordance with the Audit Commission's requirements. Updates were also requested on the requirements and progress regarding the Annual Health Check and implementation of Audit Recommendations.

6.1.3 An unqualified opinion on the accounts for 2009/10 was given to the Trust in June 2010. The work on the 2009/10 accounts commenced in March 2010 and concluded with reports issued in June and September 2010:

- Annual Governance Report 2009/10 June 2010;
- Annual Audit Letter 2009/10 (including ALE Report) September 2009.

6.2 Internal Audit

6.2.1 The Internal Audit service was provided by RSM Tenon, an independent organisation. RSM Tenon demonstrated their compliance with NHS mandatory Internal Audit Standards (as reported within their Director of Audit Opinion and Annual Report). Internal Audit provides an independent and objective appraisal service embracing two key areas:

- The provision of an independent and objective opinion to the Accountable Officer, the Board and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisations agreed objectives;
- The provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

6.2.2 The Audit Committee received and approved the Internal Audit Plan for 2009/10 and the Internal Audit Strategy 2009/12 at its meeting on 9th March 2009. The Committee noted that the Internal Audit Plan and Strategy had been developed with input from the Trust's Director of Finance and was consistent with the audit needs of the organisation as identified in the Trust Board Assurance Framework. The Audit Committee also considered the level of resource and agreed that it was appropriate, given the level of assurance required. The strategy was subsequently updated and the amendments were approved by the Audit Committee at its meeting on 15th September 2009.

6.2.3 Internal auditors were present at all but one of the Audit Committee meetings (9th November 2009) and provided the Committee with key findings from each audit report an update on progress against recommendations made. The Audit Committee was informed that, in order to enhance the audit process, scoping meetings had been held with the lead directors for each of the audits to agree the detailed scope for each review and the timings as to when these reviews would take place.

6.2.4 The Audit Committee received a report, compiled by the Governance and Compliance team, at each meeting on the progress made in implementing outstanding internal audit recommendations. This proved to be a useful management tool and the Audit Committee asked that the format of the report be amended to include both the original deadline for the recommendation to be implemented and the updated deadline. The Audit Committee asked that, where deadlines had not been met, the owners of the audit recommendation should be asked to attend an Audit Committee meeting to explain the cause of the delay.

6.2.5 One area of particular focus throughout the year was the management of controlled drugs following internal audits which took place in March 2009 and July 2009. The Committee received regular reports on the progress made against recommendations and the Trust Board was provided with a report of progress made in this area which included evidence of compliance against the relevant core standards.

6.2.6 The key conclusion from RSM Tenon's work for 2009/10 as provided in the Head of Audit Opinion and Annual Report was that **'Significant Assurance'** could be given that there were generally sound systems of internal control to meet the organisation's objectives and that controls are generally being applied consistently. However, there were some areas of weaknesses that were identified which were drug controls, patient transport services, records management and medical devices. The Audit Committee were assured that the Trust had since taken action to address the weaknesses that were identified.

7. Fraud

7.1 As with the Internal Audit Service, Counter Fraud was provided by RSM Tenon.

7.2 The Committee received a Counter Fraud Work Plan for 2009/10.

7.3 The Audit Committee received reports from the Local Counter Fraud Specialist at all but one meeting. The Committee was pleased to note that more referrals were being reported directly to the Local Counter Fraud Specialist.

8. Other Assurance Functions

8.1 At each of its meetings, the Audit Committee received the minutes of the Clinical Governance Committee and the Risk Compliance and Assurance Group. The chair of the Clinical Governance Committee attended three out of four of the Audit Committee meetings.

8.2 The Audit Committee received updates on the Trust's preparation to undergo assessment for compliance at level 1 of the NHSLA risk management standards in October 2010 and on the progress of the Trust's registration with the Care Quality Commission.

8.3 The Committee received assurance on financial governance through the ALE score of 4: excellent.

9. Financial Reporting

9.1 At its meeting on 8th June 2009, the Audit Committee received and ratified the Audited Annual Accounts, incorporating the Statement on Internal Control, for the year ending 31 March 2009 prior to their submission to the Department of Health on 12th June 2009. The Committee noted that the Trust had achieved the breakeven performance, External Financing Limit and Capital Resource Limit, but not the Capital Cost Absorption Rate. This was due to the fall in value of land and buildings attributable to the current economic downturn.

9.2 The Audit Committee was kept informed of changes in, and compliance with, accounting policies and practices and received presentations on the impact of and compliance with the new International Financial Reporting Standards and on the progress and implementation of the Government Banking System.

10. Risk Management

10.1 The Audit Committee reviewed the format of the risk register and board assurance framework and noted the progress that had been made in mapping risks to the Trust's strategic goals. The Audit Committee requested that they receive the full risk register annually and at every other meeting receive a summary of the top ten highest rating risks.

10.2 The Audit Committee also considered the risk management structure as part of a wider governance review.

11. Audit Committee training

11.1 Audit Committee members attended a risk management workshop on 24th November 2009.

12. Audit Committee Terms of Reference

12.1 The Audit Committee reviewed their terms of reference at their meeting on 8th March 2010.

13. Conclusion

13.1 Whilst the Committee has performed its duties as delegated by the Trust Board and mandated through governance requirements, the focus in 2009/10 was given to developing and responding to the system reforms and risks as detailed below.

- Further development of the Corporate Risk Register and Board Assurance Framework;
- A review of the Trust's committee structure and risk management structure;
- Annual review of the Audit Committee Terms of Reference annually; and
- Review of the membership of the Audit Committee with changes taking effect from April 2010

13.2 The Audit Committee's workplan for 2010/11 includes the Integrated Business Plan and the Long Term Financial Model in preparation for the application for Foundation Trust status and monitoring the effectiveness of the revised governance structure which was implemented in 2010.

APPENDIX A

London Ambulance Service NHS Trust
Terms of Reference
January 2010
Revised 22nd March 2010
Audit Committee

1. Authority

- The Audit Committee is constituted as a Standing Committee of the Trust Board of Directors. Its constitution and terms of reference shall be set out below and subject to amendment when directed and agreed by the Board of Directors.
- 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.
- 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 focus of the Audit Committee shall be the risks, controls and related assurances that underpin the achievement of the Trust's objectives.

- The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities;
- The Committee shall review the adequacy of risk and control related disclosure statements, in particular the Statement on Internal Control, Standards for Better Health, Internal and External Audit reports, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
- The Committee shall review the adequacy of the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- The Committee shall review the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements; and
- The Committee shall review the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, within the context of the Board Assurance Framework, but will not be limited to these audit functions. It will also seek reports and assurances from the Quality Committee, and from directors and managers as appropriate, concentrating on the overarching systems of risk, controls and assurances, together with indicators of their effectiveness.

3. Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

- review and approval of the Internal Audit strategy, operational plan and a more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;

- consideration of the major findings of internal audit work (and management's response), ensuring co-ordination between the Internal and External Auditors to optimise audit resources;

- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;

- undertaking an annual review of the effectiveness of Internal Audit.

4. External Audit

The Committee shall review the work and findings of the External Auditor and consider the implications and management responses to their work. This will be achieved by:

- consideration of the performance of the External Auditor;

- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, the audit fee, and ensure coordination, as appropriate, with other External Auditors in the local health economy;

- discussion with the External Auditors of their local evaluation of audit risks;

- review of all External Audit reports, including agreement of the Annual Audit Letter before submission to the Board and any work carried outside the Annual Audit Plan, together with the appropriateness of management responses;

- discussion and agreement on the Trust's Statement on Internal Control.

5. Other Assurance Functions

The Audit Committee shall review other assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

- To review the work of other Committees, and principally that of the Quality Committee, and the Risk, Compliance and Assurance Group;
- To review the findings of any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc);
- In reviewing the work of the Quality Committee the Audit Committee will wish to satisfy themselves on the assurance that can be gained from the clinical audit function.

6. Financial Reporting

The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- the Statement on Internal Control;

- disclosures relevant to the Terms of Reference of the Audit Committee;

- changes in, and compliance with, accounting policies and practices;

- unadjusted mis-statements in the financial statements;

- significant adjustments resulting from the Audit.

The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness, timeliness and accuracy of the information provided to the Board.

7. Membership

The Committee shall be appointed by the Board from amongst the Non-Executive directors of the Trust and shall consist of not less than three members, all of whom shall have voting rights.

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

The Director of Finance and Director of Corporate Services should normally attend all Audit Committee meetings, with the Chief Executive invited to attend at least annually to discuss with the Audit Committee the process for assurance that supports the Statement on Internal Control.

Other executive directors should be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that director.

The appropriate Internal and External Audit representatives and a Local Counter Fraud representative shall normally attend all meetings. At least once a year the Audit Committee should meet privately with the External and Internal Auditors.

8. Accountability

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

9. Responsibility

The Audit Committee is a non-executive committee of the Trust Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

10. Reporting

- The minutes of Audit 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 Audit Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Board or that require executive action;
- The Committee will report to the Board annually on its work in support of the Statement on Internal Control, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against the Standards for Better Health.

11. 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 Audit Committee and attendees and 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 Audit Committee.

12. Quorum

The quorate number of members shall be 2 which will include the following:

- The Chair of the Audit Committee or the nominated deputy (who must also be a Non-Executive Director);
- In the absence of the Chair, committee members will nominate a deputy chair for the purposes of that meeting.

13. Frequency

- Meetings shall be held at least quarterly;
- The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

14. Review of Terms of Reference

- The Audit Committee will review these Terms of Reference within at least annually from the date of agreement;
- The Chair or the nominated deputy shall ensure that these Terms of Reference are amended in light of any major changes in committee or Trust governance arrangements.

Terms of Reference
20th January 2010
Revised for changes to the Quality Committee and risk management structure – 22nd March 2010

APPENDIX B

AUDIT COMMITTEE ATTENDANCE 2009/10

	08/06/2009	15/09/2009	09/11/2009	08/03/2010
Audit Committee				
Caroline Silver (Chair)	✓	✓	✓	✓
Brian Huckett	✓		✓	✓
Roy Griffins	✓	✓	✓	✓
Sarah Waller			✓	✓
Non-executive Directors				
Dr Beryl Magrath	✓		✓	✓
Trust Officers				
Peter Bradley, Chief Executive	✓			✓
Sandra Adams, Director of Corporate Services		✓	✓	✓
Mike Dinan, Director of Finance		✓	✓	✓
Laila Abraham, Interim Head of Governance	✓	✓	✓	✓
Asif Islam	✓		✓	✓
Michael John, Financial Controller	✓	✓		✓
Martyn Salter			✓	
Andy Bell			✓	
Susan Logan			✓	
Natalie Mabey			✓	
Ken Thompson, Chief Cashier			✓	
Audit Commission				
Phil Johnstone	✓	✓		✓
Dominic Bradley	✓	✓		✓
Internal Auditors				
David Foley	✓			
Chris Rising	✓	✓		✓
Ronak Dashani				✓
Local Counter Fraud Specialist				
Gary Douglas	✓			✓
John Baker		✓		

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

28TH SEPTEMBER 2010

PAPER FOR NOTING

Document Title:	**Being Open Policy**
Report Author(s):	**Sandra Adams**
Lead Director:	**Sandra Adams, Director of Corporate Services**
Contact Details:	**02077832257**
Why is this coming to the Trust Board?	**To approve the policy prior to the NHSLA Level 1 assessment taking place on 13th and 14th October 2010**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☒ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Group ☐ Risk Compliance and Assurance Group ☒ Other Associate Directors Group
Recommendation for the Trust Board:	To approve the Being Open Policy

Executive Summary/key issues for the Trust Board

This policy sets out how the Trust's processes work to implement the National Patient Safety Agency standards for Being Open.

It is intended to support further development of a culture within the service that delivers consistently open, honest and timely communication from trust staff to patients, carers or others involved in a patient safety event. The term patient safety event includes internal and external incidents, complaints, claims and concerns.

This policy is intended to link with policies and procedures for staff to raise concerns eg the Whistleblowing Policy. The Whistleblowing policy is currently under review and any amendments to the Being Open Policy which may arise from this review will be incorporated.

Attachments

TP034 – Being Open Policy

****

Strategic Goals 2010 – 13

This paper supports the achievement of the following corporate objectives:

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

Risk Implications

This paper links to the following strategic risks:

☒ There is a risk that we fail to effectively fulfil care/safety responsibilities

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

NHS Constitution

This paper supports the following principles that guide the NHS:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☒ No

Key issues from the assessment:

London Ambulance Service NHS Trust

Being Open Policy

DOCUMENT PROFILE and CONTROL.

Purpose of the document: To ensure that the Trust meets its obligations to patients, relatives and the public in being open.

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Sponsor Department: Patient Experience Department

Author/Reviewer: Head of Patient Experiences. To be reviewed by xxx 2012.

Document Status: Draft

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
25/06/2010	2.4	Governance lead	
25/06/2010	2.3	Governance lead / Governance & Compliance Manager	
8/06/2010	2.1	Governance lead	Updated process and monitoring requirements
06/10/2008	1.2	Head of Patient Experience	Reformatted. Minor amendments.

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

For Approval By:	**Date Approved**	**Version**
SMG		3.0
SMG	06/10/08	2.0
Chief Executive	01/07	1.0
Agreed by Trust Board (If appropriate):		

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

EqIA completed on	**By**
Staffside reviewed on	**By**

Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**
	Whistleblowing Procedure	
TP004	Complaints and Feedback Policy	
TP013	Claims Handling Policy and Procedure	
TP054	Investigation of Incidents PALS Complaints and Claims Policy	
TP055	Learning from Untoward Incidents, PALS, Claims and Complaints Policy	
TP/006	SUI Policy	
HS011	Incident Reporting Procedure	
	NHSLA Risk Management Standards for Ambulance Services 2010/11	

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

1. Introduction

On September 2005 the National Patient Safety Agency (NPSA) advised that all NHS organisations should implement a “Being Open Policy”. This policy describes how London Ambulance Service NHS Trust (LAS) will demonstrate its openness with patients and relatives when mistakes are made.

Being Open is a general concept the specific delivery of “Being Open” communications will vary according to the severity grading, clinical outcome and family arrangements of each specific event. In exceptional cases information may need to be withheld or specific legal requirements might preclude disclosure. Equally records of communications with patients and families would not normally be shared in the public domain.

The Trust aims to promote a culture of openness, which it sees as a prerequisite to improving patient safety and the quality of healthcare systems.

This policy is to be implemented following all patient safety incidents where serious actual harm has occurred or could have occurred (near miss) .

2. Scope

This document outlines the Trust’s policy on openness and how the LAS meets its obligations to patients, relatives and the public by being open and honest about any mistakes that are made whilst trust staff care for, treat and transport patients

This document is aimed at all staff working within the Trust who are responsible for patient care and for ensuring the infrastructure is in place to support openness between healthcare professionals and patients, their families and carers, following a patient safety event.

3. Aims and Objectives

The Trust’s aim is to evidence a robust risk management system is in place which reflects the following:

3.1 Learning from mistakes with full transparency and openness

3.2 A proactive approach to clinical negligence with the onus on risk management systems and processes identifying incidents which require review and learning.

3.3 working in partnership with all stakeholders

3.4 When mistakes happen, patients/relatives/carers/others should receive an apology and explanation as soon as possible and staff should feel able to apologise at the earliest opportunity. Saying sorry is not an admission of liability. A patient has a right to expect openness from

their healthcare providers. Staff do not intend to cause harm in the majority of cases but unfortunately incidents do occasionally occur. Support for staff should be offered from the Staff Counselling and Occupational Health Services Manager or the Human Resources and Organisation Development Directorate.

3.5 Line managers should know that an individual or team might require support during the investigation and, after discussion should guide them to the appropriate support mechanism. This may involve external agencies.

3.6 Senior managers undertaking SUI investigations must follow the LAS SUI policy guidance (TP?) so that appropriate support is offered to the victim/families/carers/others. A single point of contact will be identified with the victim/carers/relatives to aid communication and feedback of information about the incident,

3.7 The LAS aims to comply with the requirements of the NHS Litigation Authority (NHSLA) Risk Management Standards for Ambulance Services.

The Principles of Being Open are set out in full in Appendix 3.

4. Responsibilities

4.1 Trust Board

The Trust Board will be informed and ultimately assured that the processes work effectively in line with the board level public commitment to implementing the *Being open* principles.

4.2 Chief Executive

The Chief Executive is ultimately responsible for the process of managing and responding to the *Being open* process and for the delegation of this role when required.

4.3 Executive Directors

SMG are responsible for compliance with the *Being open* process. They are responsible to the Trust Board and the Chief Executive for managing an effective *Being open* process.

4.4 Learning from Experience Group

The Learning from Experience Group will have overall responsibility for managing the *Being open* process.

- The Group links with all the other relevant risk management committees and groups: Quality Committee, Risk Compliance and

Assurance Group, Clinical Quality, Safety and Effectiveness Group, and Area Governance Groups;

- The Group is responsible for ensuring continuous development of the *Being open* document in accordance with national guidance;
- In reviewing SUIs and cases of significance to patient care, the Group monitors the *Being open* processes;
- the Group communicates both up to board level, and down to the local management levels; and
- The Group facilitates organisational learning and improvement as a result of effective *Being open* processes by making sure that any lessons learned are disseminated through the Trust; publishing case study examples and SUI reports on the Trust's website; and making any recommendations to the Trust Board.

The terms of reference for the Group can be found at appendix 4.

4.5 Head of Patient Experiences and Assistant Director of Corporate Services

The Head of Patient Experiences is responsible for the overall application of the policy and the Assistant Director of Corporate Services for supporting the Head of Patient Experiences in monitoring compliance and reporting on effectiveness to the Learning from Experience Group as part of the overall monitoring process.

4.6 Head of Legal Services, Head of Safety and Risk, Governance and Compliance Team

These managers are the recognized links with the NPSA.

4.7 It is the responsibility of all **Trust managers** to support staff so that they adhere to this policy

4.8 All **staff** working within the LAS are expected to adhere to this policy and demonstrate the principles of being open when a patient safety incident occurs.

5. Definitions

Definitions of the terms used within this document are consistent with those in the Trust's Incident Reporting Policy and SUI Policy

Patient Safety Incident

'...any unintended or unexpected incident that could have or did lead to harm for one or more patients receiving NHS-funded healthcare' (Seven Steps to Patient Safety, NPSA 2003). This can be identified in the course of an incident report, complaint, and enquiry to Patient Experience Department or a claim.

Serious Untoward Incident
'...a situation in which one or more service users are involved in an event which is likely to produce a significant, legal media, or other interest and which if not properly managed, may result in loss of the Trust's reputation or assets.'(Seven Steps to Patient Safety, NPSA 2003)

Lead Manager ..staff manager who provides tactical level of management at or close to a specific incident whose function is to determine priorities in allocating resources in order to deliver effective resolution of the incident

6. Clinical support and advice

Clinical support and advice for staff involved in a patient safety incident is provided according to how serious the patient safety incident is classified as using the trust risk management matrix (TP035) with support from operational managers and the Medical Directorate as described below:

- The first level of support is provided by local managers (working at station level) for staff in a patient safety incident who will give advice so that they are able to manage the incident in real time as soon as possible after the incident has happened, and includes general advice. This includes advising on the being open process and general enquiries about how to communicate with patients, relatives and carers.
- The second level of support is provided by complex level managers (Ambulance Operations Managers) and may include guidance from clinical tutors and /or Duty Station Officers. Where authority and support is needed from the trust's senior operational managers then the Assistant Director of Operations where the complex is located will be involved by the complex level managers
- The third level of support is provided by the Assistant Medical Directors to the Assistant Director of Operations where they are based in conjunction with the Medical Director. For Control Services support is provided by the Deputy Medical Director. Both Medical and Deputy Directors manage and participate in a 24 hour on call rota so that advice can be provided when the incident happens and action implemented by staff "on scene".

7. Being Open Process

The most appropriate staff are identified to meet with the patient and/or relatives and others.

The nominated lead manager will normally be the Ambulance Operations Manager as the most senior person responsible for the patient's care and/or someone with the experience and expertise in the type of incident that has occurred. This person will be supported by at least one other member of staff within the department or Medical directorate. Links with the Patient

Experiences Department, Legal Services and Risk and Safety Managers must be established at the earliest opportunity. The nominated lead and staff directly involved in the incident will hold a pre-meeting to establish the facts and agree/understand the aims of the meeting with the patient and/or relatives and others; the lead will use this opportunity to determine the needs of the patient and/or relatives in order to ensure that no-one will be disadvantaged in any way. The patients and/or relatives and others may not in all instances be present at this pre-meeting but feedback must be given at the earliest opportunity once the actual facts are known. No communication errors should arise by giving unsubstantiated facts as this can create anxiety.

A letter should be sent to the patient and/or relatives and others inviting them to meet with the nominated staff, offering them a choice of venues and times and advising of the independent advocacy service available to support and assist them (in accordance with the Trusts Complaints and Feedback Policy (TP004), SUI Policy (TP006), and Investigation of Incidents, PALS, Claims and Complaints Policy (TP055)).

The patient and/or the relatives and others should be given the opportunity to choose:

- Whom they would prefer to meet with;
- Where and when the meeting will be held;
- Whether they would like to bring a friend to the meeting.
- The date, time and venue should be confirmed in writing including email

Nominated staff may continue to meet with the patient/relatives and others to support continuity of communication and relationship building.

The meeting is held as soon as possible after the incident, taking into account the patient's and/or the relative's and others' wishes.

Any meeting should be held in deference to the patient/relative/advocate's wishes others. The same applies as to any venue, it is usually for the patient/relative to decide and for the Trust to accommodate.

All learning from the incidents must be cascaded to the whole organisation, via Learning from Experience Group, anonymised Outcome Reports, Area Governance Committees, Trust communications systems including the website .

Details are shared with any other healthcare organisation or relevant stakeholder as appropriate.

7.1 Procedure for the nominated team

At the meeting with the patient and/or relatives and others, the nominated staff from the investigating team should follow the procedure below.

- Apologise for what happened

- If known, explain what went wrong and where possible, why it went wrong.

- Give the patient and/or relatives an opportunity to ask as to why they thought it went wrong.

- Ask the patient and/or carer and others why they thought the error occurred.

- Inform the patient and/or relative(s) and others what steps are being/will be taken to prevent the incident recurring.

- Provide opportunity for the patient and/or relatives and others to ask any questions.

- Agree with the patient and/or relatives and others any future meetings as appropriate.

- Suggest any sources of additional support and counselling and provide written information if appropriate.

- When full investigation is required because the incident has been coded as high or catastrophic, a full Root Cause Analysis will be undertaken (see Trust SUI Policy). The patient, relatives and others should be given this information and a contact person will be agreed with the patient, relatives and others. The contact person will be responsible for keeping the patient, relatives and others up to date with how the investigation is progressing, maintaining a dialogue by addressing new concerns, sharing new information when available and providing information on counselling as appropriate.

- Create a record using the case management system used by the Trust according to the lead department with a complete, accurate record of all communications, including date and time of each entry, what the patient and/or relatives and others have been told, and a summary of agreed action plans.

7.2 Follow-up

The Medical Director or nominated deputy will sent a letter of apology, within the timescales as outlined in TP004/TP006/TP055, explaining how and, if possible, why the error occurred. If this information is not available, they should provide an explanation as to how the error will be investigated and when they can expect to be provided with additional details. This letter will clarify the information previously provided, reiterate key points, and record action points and future deadlines.

8. Documentation

The requirements for documenting all communication are set out below;

8.1 the requirement for written records of discussions with patients/carers is set out in section 7.1.

8.2 Documentation regarding the Being Open discussion

Aside from offering any apologies the aims of the Being Open discussion are principally:

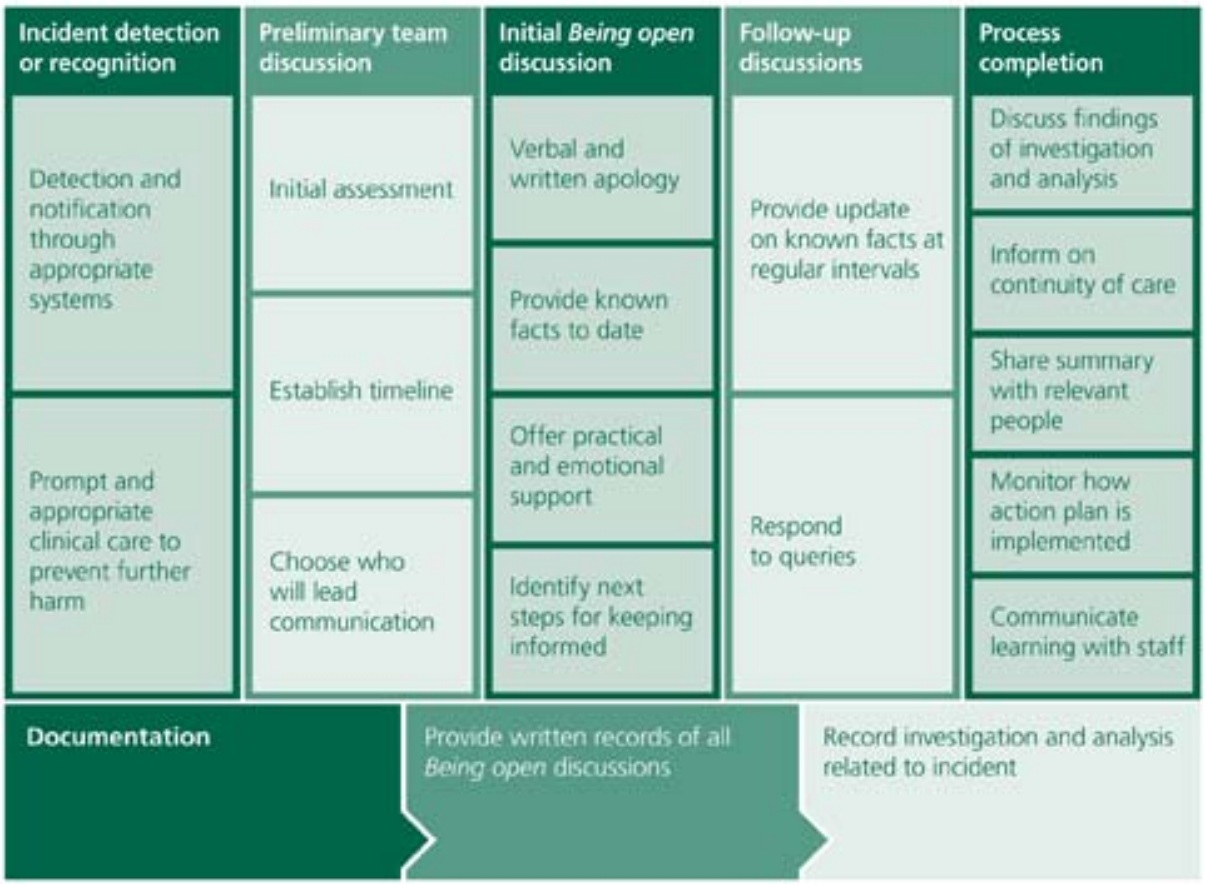
- to share any facts that are known and agreed with the patient/carers
- to explain any likely short and long-term effects of the incident
- to inform the patient/carers that an investigation is being carried out and to agree
- how they will be kept informed of the progress and results of that investigation
- to establish the patient's/carer's understanding of what happened
- to identify what questions, if any, the patient's/carer's have
- to offer appropriate practical and emotional support to the patient/carers

The documentation of the Being Open discussion should reflect the aims of the Being Open process.

IMPLEMENTATION PLAN	
Intended Audience	All LAS Staff
Dissemination	Available to all staff on the Pulse and to the public on the LAS website.
Communications	Revised Policy and Procedure to be announced in the RIB and a link provided to the document.
Training	Staff are encouraged to access the NPSA e-learning toolkit on being open (refer to Appendix 1 for an overview of the stages of the being open process). The trust also provides training on Incident Investigation and Root Cause Analysis with support from the Patient Experience Department.
Monitoring	Adherence to this policy will be monitored through the sample audits of records held by Patient Experiences, Legal Service and Patient Involvement. Reports will be provided for the Learning from Experience Group and any outcomes/ recommendation to RCAG. Appropriate dissemination of reports will also be made to area governance groups. For these reasons monitoring of compliance and effectiveness will be via confidential planned audit of Significant Events based on an agreed methodology using an appropriately sampled population. This audit will be carried out by the Head of Patient Experiences and the Assistant Director of Corporate Services. The results of the Audit will be included in the annual report. If any deficiencies are identified these will be fed back to the appropriate manager who will be responsible for producing and implementing an action plan. The action plans will be monitored by the Learning from Experience Group with any concerns being escalated to the Quality Committee or Risk Compliance and Assurance Group.

Appendix 1

Overview of the *Being open* process



NPSA. (2009). *Being Open. p.3*

- Stage 1: Patient safety event detection or recognition - This covers how patient safety events are recognised; the prompt and appropriate clinical care and prevention of further harm; and who to notify about the patient safety event.
- Stage 2: Preliminary team discussions - This covers the preliminary team discussion to establish the basic clinical and other facts; undertaking the initial assessment to determine the level of response required; the timing of the discussion with the patient, their family and carers; and choosing who will be the lead in communicating with the patient, their family and carers

Grading of patient safety incidents to determine level of response

Incident	Level of response
No harm (including prevented patient safety incident)	Patients are not usually contacted or involved in investigations and these types of incidents are outside the scope of the *Being open* policy. Individual healthcare organisations decide whether 'no harm' events (including prevented patient safety incidents) are discussed with patients, their families and carers, depending on local circumstances and what is in the best interest of the patient.
Low harm	Unless there are specific indications or the patient requests it, the communication, investigation and analysis, and the implementation of changes will occur at local service delivery level with the participation of those directly involved in the incident. Reporting to the risk management team will occur through standard incident reporting mechanisms and be analysed centrally to detect high frequency events. Review will occur through aggregated trend data and local investigation. Where the trend data indicates a pattern of related events, further investigation and analysis may be needed. Communication should take the form of an open discussion between the staff providing the patient's care and the patient, their family and carers. **Apply the principles of *Being open***
Moderate harm, severe harm or death	A higher level of response is required in these circumstances. The risk manager or equivalent should be notified immediately and be available to provide support and advice during the *Being open* process if required. **Apply the *Being open* process**

NPSA. (2009). *Being Open*. p.21

- Stage 3: The initial Being open discussion - This covers the content of the discussion and what should not occur: speculation, attribution of blame, denial of responsibility and provision of conflicting information from different individuals.
- Stage 4: Follow-up discussions - This covers the subsequent discussions with the patient, their family and carers.
- Stage 5: Process completion - This covers repeating the apology; providing feedback on the findings of the investigation into the patient safety event; what the organisation will be doing to prevent occurrence; the ongoing clinical management plan (if appropriate); and communicating with relevant other community care providers what has happened. This also covers monitoring how the recommendations to prevent recurrence have been implemented and communicating with staff the recommendations to spread the learning.

Appendix 2

Being Open Flow Chart

1.Apologise to patient/carer/relative/others

2. Arrange a pre-meeting with all the health and social care professionals involved to ascertain the facts

3. Agree verbal review of the facts, which can be fed back to patient/carer/relatives/others. Reinforce empathy regarding the incident and for incidents coded as low or moderate using the Trust's Risk Matrix (TP035) arrange a meeting with the family in a more formal manner as appropriate, considering all points under responsibilities. Send a letter, within the timescales as outlined in TP004/TP006/TP055, acknowledging the incident and arranging a date and time to discuss this.

4If the incident is coded significant or high patient experience, governance and risk management staff must be involved as early as possible. A RCA investigation should be considered and this process explained to the family. When the investigation is completed a meeting may be arranged with the family with a member of staff attending to feedback or an executive member of the trust , depending on the outcome of the incident review and the patient/carer./relatives' wishes.

4 Within 14 days of the investigation being concluded and the final report formally approved a copy will be sent to the patient/carer/relatives/others with identification of the incident, why the incident occurred, recommendations and any lessons learnt.

6 Legal Services Department must be made aware of any incident that may proceed to litigation

1. All Learning from incidents must be cascaded to the whole organisation via staff meetings electronic bulletins, trust website and intranet and staff conferences.

Appendix 3

The Principles of Being Open

Being Open involves apologising when something has gone wrong, being open about what has happened, how and why it may have happened, and keeping the patient and their family informed as part of any subsequent review.

Principle of Acknowledgement

All patient safety events should be acknowledged and reported as soon as they are identified. In cases where the patient, their family and carers inform healthcare staff that something has happened, their concerns must be taken seriously and should be treated with compassion and understanding by all staff. The Trust recognizes that denial of a person's concerns or defensiveness will make future open and honest communication more difficult.

Principles of Truthfulness, Timeliness and Clarity of Communication

Information about a patient safety event must be given in a truthful and open manner by an appropriately nominated person. This is most usually the Patient Experiences department who receive the vast majority of service-user approaches but is not exclusive. Communication from Operational/Clinical staff must only be from Ambulance Operation manager grade staff or above. Communication should also be timely, informing the patient, their family and carers what has happened as soon as is practicable, based solely on the facts known at that time. It will be explained that new information may emerge as the event investigation takes place and that they will be kept up to date. Patients, their families and carers and appointed advocates should receive clear, unambiguous information and be given a single point of contact for any questions or requests they may have.

Principle of Apology

Patients, their families and carers should receive a meaningful apology - one that is a sincere expression of sorrow or regret for the harm that has resulted from a patient safety event or that the experience was poor. This should be in the form of an appropriately worded agreed manner of apology, as early as possible. Both verbal and written apologies should be given. **Saying sorry is not an admission of liability and it is the right thing to do.** Verbal apologies are essential because they allow face to face contact, where this is possible or requested.. A written apology, which clearly states the organisation is sorry for the suffering and distress resulting from the patient safety event, will also be given.

Principle of Recognising Patient and Carer Expectations

Patients, their families and carers can reasonably expect to be fully informed of the issues surrounding a patient safety event, and its consequences, in a face to face meeting with representatives from the organisation and/or in accordance with the local resolution process where a complaint is at issue. They should be treated sympathetically, with respect and consideration.

Confidentiality must be maintained at all times. Patients, their families and carers should also be provided with support in a manner to meet their needs. This may involve an independent advocate or an interpreter. Information about the Patient Experiences Department and Independent Complaints Advocacy Service is routinely offered accordingly; See also http://www.londonambulance.nhs.uk/talking_with_us/enquiries,_feedback_and_compla.aspx

Information enabling to other relevant support groups will be given as soon as possible and as appropriate

Principle of Professional Support

The Trust has set out to create an environment in which all staff are encouraged to report patient safety events. Staff should feel supported throughout the patient safety event investigation process; they too may have been traumatised by the patient safety event. Resources are available are referred to within the respective Trust policies, (HS011, TP004), to assist ensure a robust and consistent approach to patient safety event investigation. Where there are concerns about the practice of individual staff the relevant professional body and/or Human Resources department can be contacted for advice. Where there is reason to believe a member of staff has committed a punitive or criminal act, the Trust will take steps to preserve its position and advise the member(s) of staff at an early stage to enable them to obtain separate legal advice and/or representation. Staff should be encouraged to seek support from relevant professional bodies. Where appropriate, a referral will also be made to the Independent Safeguarding Authority.

Principle of Risk Management and Systems Improvement

Root Cause Analysis (RCA), or similar techniques should be used to uncover the underlying causes of patient safety events. Investigations at any identified level will however focus on improving systems of care, which will be reviewed for their effectiveness. *Being open* is integrated into patient safety event reporting and risk management policies and processes.

Principles of Multi-Disciplinary Responsibility

Being open document applies to all staff who have key roles in patient care. Emergency care provision is often a component of the totality of total healthcare and can involve multi-disciplinary teams. This is reflected in the way that patients, their families and carers are communicated with when things go wrong. This ensures that the *Being open* process is consistent with the philosophy that patient safety events usually result from system failures and rarely from actions of an individual. To ensure multi-disciplinary involvement in the *Being open* process, especially if working with NHS trusts in other sectors (e.g. acute care or mental health) it is important to identify clinical and managerial leaders who will support this across the health and care agencies that may be involved. Both senior managers and senior clinicians will be asked to participate in the patient safety event investigation and clinical risk management as set out in the respective Trust policies and practice guidance.

Principles of Clinical Governance

Being open involves the support of patient safety and quality improvement through the Trust's clinical governance framework, in which patient safety events are investigated and analyzed, to identify what can be done to prevent their recurrence. It also involves a system of accountability through the chief executive to the board to ensure that these changes are implemented and their effectiveness reviewed. Findings are disseminated to staff so they can learn from patient safety events. Audits are an integral process, to monitor the implementation and effects of changes in practice following a patient safety event.

Principle of Confidentiality

Details of a patient safety event should at all times be considered confidential. The consent of the individual concerned should be sought prior to disclosing information beyond the clinicians involved in treating the patient. The Trust will anonymise any incident it publishes but still seek the agreement of those involved.

Where it is not practicable or an individual refuses consent to disclosure, disclosure may still be lawful if justified in the public interest or where those investigating the patient safety event have statutory powers for obtaining information. Communications with parties outside of the incident lead and those involved in the investigation ill be on a strictly need to know basis and, where practicable, records are secure and anonymised where released. Where possible, it is good practice to inform the patient, their family and carers about who will be involved in the investigations before it takes place, and give them the opportunity to raise any objections.

Principle of Continuity of Care

The Trust recognise that patients are entitled to expect they will continue to receive all usual treatment and continue to be treated with respect and compassion.

Appendix 4

Learning from Experience Group
Terms of Reference
September 2010

1. Authority

1.1 The Learning from Experience Group constitution and terms of reference shall be set out below and subject to amendment when directed and agreed by the Quality Committee.

1.2 The Group is authorised by the Quality Committee 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 Group is authorised by the Quality Committee 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 focus of the Learning from Experience group will be the integrated review of incidents including SUIs, PALs enquiries, complaints and claims, in order to identify actual and emerging risk themes and to recommend changes to practice and for ensuring that the objectives of the Learning from Untowards Incidents, PALs, Claims and Complaints Policy are achieved.

2.1 Oversee the arrangements for investigation and action planning on incidents, claims and complaints.

2.2 Ensure that following investigations and serious case reviews, action plans to address root causes are drawn up and their implementation monitored and reported to the Quality Committee.

2.3 Ensuring arrangements for improvement in practice following serious incidents is implemented and evaluated.

2.4 Oversee and monitor arrangements for the dissemination of learning within the organisation and where appropriate, across the ambulance service network.

3. Objectives

3.1 Examine emerging themes and issues of significance from incidents including SUIs, complaints, claims, and PALs as a mechanism for service user and stakeholder feedback.

3.2 Seek assurance of action taken on, and implementation of, themes and issues and the lessons learnt and improvements made.

3.3 Seek assurance on the effectiveness and outcomes of lessons, improvements and changes to practice.

3.4 Consider ways of involving and engaging patients and the public in learning from issues and assessing the effectiveness of outcomes and improvements made.

3.5 Make recommendations to the Risk, Compliance and Assurance Group on any new risks emerging, or changes to existing risks.

3.6 Make recommendations to the Clinical Quality, Safety and Effectiveness Committee on action, monitoring or assurance required on emerging themes and risks.

3.7 Provide assurance to the Quality Committee.

3.8 Oversee the implementation and review of the following policies:

- Learning from Untoward Incidents, Claims and Complaints
- Investigating incidents, claims and complaints
- Complaints and user feedback policy
- Being Open.

4. Membership and attendance

4.1 The Learning from Experience Group shall comprise:

- Deputy Chief Executive (Chair)
- Assistant Director, Corporate Services (Deputy Chair) / Director of Corporate Services initially
- Head of Patient Experience
- Head of Legal Services
- Head of Safety and Risk
- Head of Patient & Public Involvement
- Deputy Director of Operations
- Assistant Medical Director
- Assistant Director, Employee Relations
- Assistant Director, Professional Education & Development
- Audit and Compliance Manager
- LAS Patient Forum representative.

Other members of staff may be required to attend for specific agenda items.

5. Accountability

5.1 The Learning from Experience Group shall be accountable to the Quality Committee.

6. Reporting

6.1 The minutes of the Learning from Experience Group meetings shall be formally recorded by the Trust's Committee Secretary and the approved minutes submitted to the Quality Committee.

6.2 The Chair of the Learning from Experience Group shall draw the attention of the Quality Committee to any issues that require disclosure to the full Trust Board.

6.3 The Learning from Experience Group shall receive regular reports from the Patient and Public Involvement Committee.

6.4 Recommendations and feedback shall be made to this group as appropriate.

7. Administration

7.1 Secretarial support shall be provided by the Trust's Committee Secretary and shall include the agreement of the agenda with the Chair of the Learning from Experience Group and attendees, collation of papers, taking minutes and keeping a formal record of matters arising and issues carried forward.

7.2 Agenda items shall be forwarded to the Committee Secretary six days before the date of the committee meeting.

7.3 The draft minutes and action points shall be made available to Committee members within seven working days of the meeting.

7.4 Papers shall be tabled at the discretion of the Chair of the Learning from Experience Group.

8. Quorum

8.1 The quorum shall be the Chair or Deputy Chair, and two other members.

9. Frequency of meetings

9.1 The Learning from Experience Group shall meet quarterly before the Senior Management Group and the Quality Committee.

9.2 The Deputy Chief Executive or the Director of Corporate Services may request a meeting if they consider that one is necessary.

10. Review of Terms of Reference

10.1 The Learning for Experience Group shall review these Terms of Reference annually.

10.2 The Chair or the nominated deputy shall ensure that these Terms of Reference are amended in light of any major changes in committee or Trust governance arrangements.

Terms of reference
2nd September 2010

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

28th September 2010

PAPER FOR APPROVAL

Document Title:	**Standing Financial Instructions**
Report Author(s):	**Sandra Adams/Francesca Guy**
Lead Director:	**Sandra Adams, Director of Corporate Services**
Contact Details:	**02077932257**
Why is this coming to the Trust Board?	**As an NHS Trust the Trust Board is required to approve any changes to the Standing Orders and Standing Financial Instructions**
This paper has been previously presented to:	☐ Strategy Review and Planning Committee ☐ Senior Management Group ☐ Quality Committee ☐ Audit Committee ☐ Clinical Quality Safety and Effectiveness Committee ☐ Risk Compliance and Assurance Group ☐ Other
Recommendation for the Trust Board:	To approve the updated Standing Financial Instructions

Executive Summary/key issues for the Trust Board

The Standing Orders and Standing Financial Instructions provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

The Standing Orders, Delegated Powers and Standing Financial Instructions provide a comprehensive business framework. All executive and non-executive directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

The Standing Financial Instructions have been reviewed against current requirements and brought into line with current best practice.

The key changes are the inclusion of the following paragraphs:

3) Security Management (page 8)
4) Resource Limit Control (page 9)
9) Tendering and Contract Procedure (page 14). This section was formerly included within the Standing Orders, however it is more appropriate and in keeping with standard practice to include tendering and contract procedure within the Standing Financial Instructions.
10) NHS Service Agreements for Provision of Services (page 28)
14) Financial Framework (page 37)
19) Risk Assessment (page 43)

The Standing Orders and Scheme of Delegation were last reviewed by the Trust Board in March 2010 and have since been updated with terms of reference for key committees and approved by the Trust Board, to support the new governance arrangements.

Attachments
Standing Financial Instructions

****

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

Standing Financial Instructions

Revisions agreed by the Trust Board November 2008

24/09/2010

PRE-AMBLE

1. The “Directions on Financial Management in England” issued under HC (91)25 in 1991 state that each Board must adopt Standing Financial instructions (SFIs) setting out the responsibilities of individuals.

2. Each Board operates within the statutory framework within which it is also required to adopt Standing Orders. In addition to the Standing Orders, there is a Scheme of Delegation, Financial Procedural Notes and locally generated rules and instructions. Collectively these must comprehensively cover all aspects of financial management and control. They set the business rules which directors and employees (including employees of third parties contracted to the Trust) must follow when taking action on behalf of the Board.

Mike Dinan
Director of Finance
September 2010

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1 Introduction

2 Audit

3 Security Management

4 Resource Limit Control

5 Service Planning, Budgets, Budgetary Control and monitoring

6 Annual Accounts and reports

7 Bank and PGO accounts

8 Income, Fees and Charges and Security of Cash, Cheques and other negotiable instruments

9 Tendering and Contract Procedure

10 NHS Service Agreements for Provision of Services

11 Terms of Service and Payment of Directors and Employees

12 Non-pay expenditure

13 External borrowing and Investments

14 Financial Framework

15 Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

16 Stores and Receipt of Goods

17 Disposal and Condemnations, Losses and Special Payments

18 Information Technology

19 Risk Assessment

20 Patient's Property

21 Charitable Funds

22 Acceptance of Gifts by Staff

23 Retention of Documents

24 Risk Management

1. INTRODUCTION

1.1 GENERAL

1.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Financial Directions issued by the Secretary of State under the provisions of Sections 99(3), 97(A)(4) and (7) of the National Health Service Act 1977; National Health Service and Community Care Act 1990 and other acts relating to the National Health Service or in the Financial Regulations made under the Acts for the regulation of the conduct of the LAS in relation to all financial matters. They shall have effect as if incorporated in the Standing Orders of the LAS.

1.1.2 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the London Ambulance Service NHS Trust (LAS). They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Standing Orders and Scheme of Delegation adopted by the Trust.

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the LAS. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental financial procedure notes. All financial procedures must be approved by the Director of Finance.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance must be sought before action is taken. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders.

1.1.5 Failure to comply with SFIs and Standing Orders is a disciplinary matter that could result in dismissal.

1.1.6 Overriding Standing Financial Instructions – if for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

1.2 TERMINOLOGY

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

(a) "Trust" means the London Ambulance Service NHS Trust;

(b) "Board" means the Board of the LAS;

(c) "Budget" means a resource, expressed in financial terms, proposed by the LAS for the purpose of carrying out, for a specific period, any or all of the functions of the LAS;

(d) "Chief Executive" means the chief officer of the LAS;

(e) "Director of Finance" means the chief financial officer of the LAS;

(f) "Budget Holder" means the director or employee with delegated authority to manage finances and resources for a specific area of the organisation; and

(g) "Legal Adviser" means the properly qualified person appointed by the LAS to provide legal advice.

1.2.2 Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them, subject to the Scheme of Delegation.

1.2.3 Wherever the term "employee" is used it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.3 RESPONSBILITIES AND DELEGATION

1.3.1 The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation Document (EL(94)40 refers)

1.3.2 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation Document adopted by the LAS.

1.3.3 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and, as its Accountable Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the LAS' activities and is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.4 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.5 It is a duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and put in a position to understand their responsibilities within these instructions.

1.3.6 **The Director of Finance** is responsible for:

(a) implementing the LAS' financial policies and for co-ordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the LAS' transactions, in order to disclose, with reasonable accuracy, the financial position of the LAS at any time;

(d) and, without prejudice to any other functions of directors and employees to the LAS, the duties of the Director of Finance include:

(e) the provision of financial advice to the LAS, its directors and employees;

(f) the design, implementation and supervision of systems of financial control;

(g) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the LAS may require for the purpose of carrying out its statutory duties.

1.3.7 **All board members and employees,** severally and collectively, are responsible for:

(a) the security of the property of the LAS;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.8 **Any contractor or employee of a contractor** who is empowered by the LAS, in writing, to commit the LAS to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive Officer to ensure that such persons are made aware of this.

1.3.9 For any and all board members and employees who carry out financial function, the form in which financial records are kept and the manner in which board members and employees discharge their duties must be to the satisfaction of the Director of Finance.

2. AUDIT

2.1 AUDIT COMMITTEE

2.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook (2005), which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services;

(b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial judgements;

(c) Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) Reviewing schedules of losses and compensations and making recommendations to the Board;

(f) Reviewing schedules of debtor/creditors balances over three months old or £100k and explanations/action plans;

(g) Reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

2.1.2 Where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health (to the Director of Finance in the first instance.

2.1.3 It is the responsibility of the Director of Finance to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when an internal audit service provider is changed.

2.2 DIRECTOR OF FINANCE

2.2.1 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an internal audit function;

(b) ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

(d) ensuring that an annual audit report is prepared for consideration by the Audit Committee and the Board. The report must cover:

(i) a clear opinion on the effectiveness of internal control measures in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;
(ii) progress against the annual work plan for the Audit Committee;
(iii) major internal financial control weaknesses discovered;
(iv) progress in the implementation of internal audit recommendations;
(v) strategic audit plan covering the coming three years;
(vi) a detailed plan for the coming year.

2.2.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or employee of the LAS;

(c) the production of any cash, stores or other property of the LAS under a member of the Board and an employee's control; and

(d) explanations concerning any matter under investigation.

2.3 ROLE OF INTERNAL AUDIT

2.3.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the LAS' assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences
(ii) waste, extravagance, inefficient administration,
(iii) poor value for money or other causes.

(e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health.

2.3.2 The plan of work for Internal Audit should be reviewed and approved by the Audit Committee at the beginning of each financial year. This plan should be drawn up with full consideration of all risks as detailed within the risk register.

2.3.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

2.3.4 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee Members, the Chairman and Chief Executive of the LAS.

2.3.5 The Head of Internal Audit shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

2.4 **FRAUD AND CORRUPTION**

2.4.1 In line with their responsibilities, the Trust Chief Executive and Director of Finance shall monitor and ensure compliance with Secretary of State (SofS) Directions on fraud and corruption.

Fraud - any person who dishonestly makes a false representation to make a gain for himself or another or dishonestly fails to disclose to another person, information which he is under a legal duty to disclose, or commits fraud by abuse of position, including any offence as defined in the Fraud Act 2006. Appendix B is a summary of the Fraud Act 2006.

Corruption - where someone is influenced by bribery, payment or benefit-in-kind to unreasonably use their position to give some advantage to another

2.4.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by the Department of Health Fraud and Corruption Manual and guidance.

The contact details for the LCFS are:

Name: Gary Douglas
Telephone: 07917462009
Office: 020 7920 3200
Email: Gary.Douglas@rsmtenon.com
Address: RSM Tenon, 45 Moorfields, London, EC2Y 9AE

2.4.3 The Local Counter Fraud Specialist will provide a written report, at least annually, on counter fraud work within the Trust.

2.4.4 The Local Counter Fraud Specialist shall report to the Trust Director of Finance in accordance with the Department of Health Fraud and Corruption Manual.

2.4.5 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary for Health guidance on NHS security management.

2.4.6. The Trust has a Anti-Fraud and Corruption Policy which is available on the intranet site, the Pulse.

2.5 **EXTERNAL AUDIT**

2.5.1 The external auditor is appointed by the Audit Commission and paid for by the LAS. The Audit Committee must ensure a cost-efficient external audit service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the external auditor and referred to the Audit Commission if the issue cannot be resolved.

3. SECURITY MANAGEMENT

3.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

3.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

3.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.

3.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

4. RESOURCE LIMIT CONTROL

4.1 Not applicable to NHS Trusts.

5. ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

5.1 Preparation and approval of service plans and budgets

5.1.1 The Board must ensure that there is an approved annual business plan before the commencement of the each financial year. The Chief Executive will compile and submit to the Board an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

(a) aims and objectives;

(b) a statement of the significant assumptions on which the plan is based;

(c) details of major changes in workload, delivery of services or resources required to achieve the plan;

(d) the individual and collective responsibilities of directors.

5.1.2 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Annual Business Plan;

(b) accord with workload and staffing plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available income; and

(e) identify potential risks.

5.1.3 The Director of Finance shall monitor financial performance against budget and service plans, periodically review them, and report to the Board.

5.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

5.1.5 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

5.1.6 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

5.2 BUDGETARY DELEGATION

5.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing, in the Scheme of Delegation, and be accompanied by clear definitions of:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service; and
(f) the provision of regular reports.

5.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virements limits set by the Board.

5.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

5.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

5.3 BUDGETARY CONTROL AND REPORTING

5.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year-end position;
(ii) data correlating financial, establishment and activity trends;
(iii) movements in working capital;
(iv) movements in cash and capital;
(v) capital project spend, including commitments, and projected outturn against plan;
(vi) explanation of any material variances from plan;
(vii) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensive advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

5.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;

(b) any potential underspend is highlighted to the Director of Finance (for virement if necessary);

(c) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and

(d) no permanent employees are appointed without the approval of the Director of Human Resources other than those provided for within the available resources and in the budgeted establishment as approved by the Board. Permanent employees must be appointed against recurrent income.

5.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan and a balanced budget.

5.4 CAPITAL EXPENDITURE

5.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure~~.~~

5.5 MONITORING RETURNS

5.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the relevant monitoring organisation.

6 ANNUAL ACCOUNTS AND REPORTS

6.1 The Director of Finance, on behalf of LAS, will:

(a) prepare financial returns for the LAS, in accordance with the accounting policies and guidance given by the Department of Health and the Treasury, the LAS' accounting policies, and generally accepted accounting principles;

(b) prepare, certify and submit annual financial reports to the Department of Health for each financial year in accordance with current guidelines; and

(c) submit financial returns to the Department of Health for each financial year in accordance with the timetable prescribed by the Department of Health.

6.2 The Trust's annual accounts must be audited by an auditor appointed by the Audit Commission. The Trust's Audited Annual Accounts must be presented to a public meeting and made available to the public.

6.3 The LAS will publish an Annual Report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health's Manual for Accounts. The document will include inter alia:

(a) the Annual Accounts of the LAS;

(b) details of relevant directorships and other significant interests held by Board members, as defined in Standing Orders;

(c) composition of the Remuneration and Terms of Service Committee;

(d) remuneration of the chairman, highest paid Director, and other Directors and highly paid employees, in accordance with guidance relating to the NHS.

7. BANK AND PGO ACCOUNTS

7.1 GENERAL

7.1.1 The Director of Finance is responsible for managing the LAS' banking arrangements and for advising the LAS on the provision of banking services and operation of accounts. This advice will take into account guidance/Directions issued from time to time by the NHS and the Department of Health. In line with 'Cash management in the NHS' Trust should minimise the use of commercial banks accounts and consider using the Paymaster General Office (PGO) accounts for all banking services.

7.1.2 The Board shall approve the banking arrangements.

7.2 BANK AND PGO ACCOUNTS

7.2.1 The Director of Finance is responsible for:

(a) bank accounts and Paymaster General Office (PGO) accounts;

(b) establishing separate bank accounts for the LAS' non-exchequer funds;

(c) ensuring payments made from bank or PGO accounts do not exceed the amount credited to the account except where arrangements have been made; and

(d) reporting to the Board all arrangements made with the LAS' bankers for overdraft facilities;

(e) monitoring compliance with DH guidance on the level of cleared funds.

7.3 BANKING PROCEDURES

7.3.1 The Director of Finance will prepare detailed instructions on the operation of bank and PGO accounts which must include:

(a) the conditions under which each bank and PGO account is to be operated;

(b) the limit to be applied to any overdraft; and

(c) those authorised to sign cheques or other orders drawn on the LAS' accounts.

7.3.2 The Director or Finance must advise the LAS' bankers in writing of the conditions under which each account will be operated.

7.4 TENDERING AND REVIEW

7.4.1 The Director of Finance will review the commercial banking arrangements of the LAS at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the LAS' banking business.

7.4.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary for OPG accounts.

8 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

8.1 Income systems

8.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

8.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

8.2 FEES AND CHARGES

8.2.1 The LAS shall follow Department of Health's advice in the 'costing' manual in setting prices for NHS service agreements.

8.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

8.2.3 Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's Commercial Sponsorship – Ethical standards for the NHS (2000) shall be followed.

8.2.4 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

8.3 DEBT RECOVERY

8.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

8.3.2 Income not received should be dealt with in accordance with losses procedures.

8.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated. Overpayments will be reviewed in order that procedures are introduced to prevent recurrence.

8.4 SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

8.4.1 The Director of Finance is responsible for:

(a) approving the form of all receipt books, agreements forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the LAS.

8.4.2 Official money shall not under any circumstances be used for the encashment of private cheques.

8.4.3 All cheques, postal orders, cash, etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

8.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless, exceptionally, such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the LAS is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the LAS from responsibility for any loss.

9 TENDERING AND CONTRACT PROCEDURE

9.1 DUTY TO COMPLY WITH STANDING ORDERS

9.1.1 The Trust shall ensure that competitive tenders are invited for:

(a) the supply of goods, materials and manufactured articles;

(b) The rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);

(c) the design, construction and maintenance of buildings and engineering works (including construction and maintenance of grounds and gardens); for disposals.

9.1.2 Every contract, whether made by the Trust, or by a committee of the Trust or by a nominated officer to whom the power of making contracts shall have been delegated, shall comply with these Standing Orders and, unless the Board has resolved to do otherwise in advance and on a per project/procurement basis, with

any extant Departmental guidance. Where the Board makes such a resolution then it shall take precedence over any provisions to the contrary in these Standing Orders. Copies of such guidance documents can be obtained for reference purposes from either the Director of Finance. No exception from any of the following provisions of these Standing Orders shall be made other than by direction of the Board or, in an emergency, as detailed in paragraph 1.2 of this Appendix.

9.1.3 An exception from any of the following provisions of these Standing Orders may be made by direction of the Board. In an emergency an exception may be made by direction of the Chief Executive, or in his/her absence, the Director of Finance, or in his/her absence, an Executive Director other than the Director directly involved in the issue. In such emergency circumstances, the exception shall only be made after consulting with the Chairman of the Board or, in his/her absence, the Deputy Chairman, in accordance with Standing Order (Urgent Decisions).

9.1.4 The Trust shall comply as far as is practical with the requirements of the Department of Health "Capital Investment Manual" and "Estate Code" in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health guidance. "The Procurement and Management of Consultants within the NHS".

9.2 EU DIRECTIVES

9.2.1 Directives by the Council of the European Union (EU) prescribing procedures for awarding contracts for services, building and engineering works and for the supply of goods, materials and manufactured articles (hereafter referred to as goods and services) shall have effect as if incorporated in these Standing Orders and shall apply throughout.

9.2.3 The EU public procurement thresholds represent contractual value levels above which public authorities must follow EU procedural rules with regard to the issuing of contracts.

9.2.4 Value is defined as the total consideration excluding VAT that is to be paid over the lifetime of the contract or if the lifetime is not defined it is taken to be the equivalent of 48 months' spend. Reference must be made to the extant EU procurement thresholds as set out in the following link: http://www.ogc.gov.uk/procurement_policy_and_application_of_eu_rules_eu_procurement_thresholds_.asp

9.2.5 Where the contract includes options, the value of these options must be taken into account in determining whether the threshold has been reached. In the case of contracts for lease, rental or hire purchase the relevant figure is the aggregate of the consideration that will be paid throughout the duration of the contract. Where the term exceeds 12 months the estimated residual value must also be included. Where the duration is indefinite or uncertain the relevant figure is the monthly contract value multiplied by 48. In the case of regular or renewable contracts the relevant figure is either the aggregate of the consideration to be paid during the anticipated duration of the contract (or over the first 12 months if the duration is indefinite) or the consideration paid by the buyer under similar contracts for goods of the same type during the preceding 12 months (adjusted for any expected changes), whichever is the more appropriate. A single contract providing for a regular supply over a period of time and a series of separate contracts concluded

over a period of time for the same type of goods are both regarded as 'regular' contracts for these purposes.

9.2.6 The thresholds are set bi-annually and with effect from January 1st 2010 (VAT exclusive) are as follows:

Supplies	£101,323
Services	£101,323
Works	£3,927,260

9.3 PROCUREMENT FRAMEWORK

9.3.1 Standard Procurement Method

The Trust's standard method of procurement shall be by competitive tendering. However, as detailed below, the Trust's standard method of procurement shall be affected by the monetary value of the goods and services being purchased.

9.3.2 Purchases below £3,000

9.3.2.1 Standard Trust purchasing procedures shall be followed without the requirement for either competitive tendering to be implemented or competing quotations to be sought.

9.3.2.2 Wherever possible the goods and services being purchased shall be joined together so that the value shall exceed £3,000.

9.3.3 Non-Estates Purchases between £3,000 and £25,000

9.3.3.1 Competing quotations shall be sought, unless the purchase is made through the Trust's supplies agent. Refer to paragraph 5 of this appendix

9.3.3.2 Non-estates purchases are goods and services other than purchases relating to building and engineering works (as detailed in paragraph 4.1.4 of this Appendix).

9.3.3 Estates Purchases between £3,000 and £100,000

9.3.3.1 Competing quotations shall be sought.

9.3.3.2 Estates purchases relate to building and engineering works.

9.3.4 Non-Estates Purchases above £25,000

9.3.4.1 Competitive tendering shall be implemented. Refer to paragraph 4 of this Appendix.

9.3.4.2 Non-estates purchases are goods and services other than purchases relating to building and engineering works (as detailed in paragraph 4.1.4 of this Appendix).

9.3.5 Estates Purchases above £100,000

9.3.5.1 Competitive tendering shall be implemented. Refer to paragraph 4 of this Appendix.

9.3.5.2 Estates purchases relate to building and engineering works (as detailed in paragraph 4.1.4 of this Appendix).

9.4 COMPETITIVE TENDERING

9.4.1 The Board shall ensure that competitive tenders are invited for:

(a) the supply of goods with a monetary value in excess of £25,000;

(b) the supply of materials and manufactured articles with a monetary value in excess of £25,000;

the rendering of services, including consultancy costs, with a monetary value in excess of £25,000;

(c) building and engineering works of construction and maintenance, (including construction and maintenance of grounds and gardens) and for professional design services on works projects, with a monetary value in excess of £100,000, or such other figure as the Department of Health may from time to time determine;

(d) for fee bids which take price into consideration for disposals and for all other projects.

9.4.2 Competitive tendering may be waived under the following circumstances:

(a) where the goods or services are ordered under existing contracts;

(b) as provided for under paragraphs 4.4, 4.6 and 14 (Disposals) of this Appendix;

(c) where so provided in the NHSE Capital Investment Manual - copies of which are held within the Finance and Estates departments for reference purposes as appropriate;

(d) The timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender.

(e) the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(f) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering.

(g) where in the opinion of the Chief Executive and the Director of Finance, the estimated expenditure or income would not warrant formal tendering procedures, or competition would not be practicable taking into account all the circumstances (as detailed in paragraph 5.2 of this Appendix).

9.4.3 In the event of any of the above referenced circumstances where competitive tendering is waived, the reasons shall be set down in a permanent and signed record. A copy of the signed record shall be retained with the associated project working papers and the original signed record shall be retained by the Director of Finance or the Chief Executive.

9.4.4 The provisions of this paragraph apply where EU procurement regulations have been satisfied. Where it is proposed that competitive tendering shall be waived and single tender action is being proposed, the relevant Director shall provide detailed information in writing regarding:

(a) the justification for single tender action;

(b) compliance with public procurement regulations (EU Directives);

(c) the possible effects of not seeking competitive tenders; and

(d) value for money.

9.4.5 Where it is proposed that competitive tendering shall be waived, the information (as detailed in paragraph 4.4 of this Appendix) shall be presented to the Director of Finance, the Chief Executive or the Trust Board as appropriate (as detailed in paragraphs 4.5.1, 4.5.2 and 4.5.3 below). Where the Director of Finance, the Chief Executive or the Trust Board approve the waiving of competitive tendering, the relevant record (as detailed in paragraph 4.3 of this Appendix) shall be authorised. Where the approval to waive competitive tendering is authorised, such decisions shall be reported by the Director of Finance to the Trust's Audit Committee.

9.4.6 Where the proposal to waive competitive tendering relates to goods or services valued at less than £150,000, the authorisation shall be given by the Director of Finance.

9.4.7 Where the proposal to waive competitive tendering relates to goods or services valued at more than £150,000 and less than £400,000, the authorisation shall be given by the Chief Executive.

9.4.8 Where the proposal to waive competitive tendering relates to goods or services valued at more than £400,000, the authorisation shall be given by the Trust's Board.

9.4.9 Competitive tendering is not required where:

(a) The goods or services can be obtained through a pre-tested competitive framework or catalogue arrangement to which the Trust has legitimate access and meets the requirements of public procurement regulations.

9.4.10 Formal tendering procedures may be waived, under the authority of one of the Trust's Executive Directors, without reference to the Chief Executive and the Director of Finance where:

(a) the estimated expenditure is not in relation to building and engineering works, does not exceed £25,000 and is within budget allocation;

(b) the estimated expenditure is in relation to building and engineering works (as detailed in paragraph 4.1.4 of this Appendix), does not exceed £100,000 and is within budget allocation.

9.4.11 Under these circumstances competing quotations are to be sought (as detailed in paragraph 5 of this Appendix).

9.4.12 The Board shall ensure that invitations to tender are sent to a sufficient number of comparable firms to provide fair and adequate competition - taking into account the capacity of the firms to supply the goods or materials or to undertake the services or works required.

9.4.13 Normally, a minimum of three comparable firms shall be invited to tender unless procurement is routed through the Trust's supplies agent. In circumstances where the Trust's supplies agent is being used to secure tenders or quotations, the procurer shall not be specified. In circumstances where at least three tenders are being sought without the use of the Trust's supplies agent, the Trust's supplies agent could also be one of the organisations invited to produce a tender or quotation.

9.4.14 Where approved lists are maintained, the Board shall normally ensure that the firms invited to tender are among those on such approved lists. Such lists, where compiled, will include approved firms which have been subject to appropriate financial vetting (as detailed in paragraph 7 of this Appendix) as well as the separate maintenance list or record for minor works in accordance with ESTMANCODE guidance. Where maintained, the Director of Finance shall keep the list of financially approved firms and the Director of Finance/Head of Estates shall keep the maintenance list and minor works record.

9.5 COMPETING QUOTATIONS

9.5.1 Where formal competitive tendering is dispensed with under paragraph 4 of this Appendix, competing quotations shall be obtained in writing wherever possible, unless procurement is routed through the Trust's supplies agent. In circumstances where procurement is routed through the Trust's supplies agent, the Trust's supplies agent shall abide by LAS Standing Orders at all times. In circumstances where it is not possible to obtain three competing quotations in writing, a file note of three competing quotations secured via telephone shall be maintained as a minimum. The value of contracts allocated without formal competitive tendering shall not exceed £25,000 in the case of non-estates goods or services or £100,000 in the case of building and engineering works (as detailed in paragraph 4.1.4 of this Appendix).

9.5.2 Competing quotations may also be invited directly from any firm, including the Trust's supplies agent, without regard to the provisions of paragraph 5.1 of this Appendix (i.e., where the value of the procurement exceeds £25,000 or £100,000 as appropriate) for the following purposes:

(a) the supply of proprietary or other goods and the rendering of services where such goods or services are of a special or unique character, for which, in the opinion of the Chief Executive and the Director of Finance it is neither possible nor desirable to purchase through competitive tendering;

(b) the supply of goods or manufactured articles of any kind which, in the opinion of the Chief Executive and the Director of Finance are required quickly for the continuance of the provision of the service provided by the Trust and are not obtainable under existing contracts.

9.5.3 In such circumstances, the firms invited to provide competing quotations shall only be those which are deemed suitable in the opinion of the Chief Executive and the Director of Finance.

9.5.4 Unless the Trust's supplies agent is used, a minimum of three competing quotations shall be invited in writing from comparable firms. Where this is not possible the Director of Finance shall be informed, in writing, of the reasons for and the outcome of the limited quotations. A copy of the written record shall also be retained with the associated project working papers.

9.5.7 Similar arrangements to those described in paragraph 5.2 above may be made for specialist services works in connection with building and engineering maintenance, provided that the Director of Information Management & Technology and Director of Finance certifies that the provisions of paragraph 5.2.1 and 5.2.2 above are applicable. The reasons for the decision shall be passed by the Director of Information Management &Technology to the Chief Executive and Director of Finance in writing. The record shall be counter-signed by the Chief Executive and Director of Finance to show their acceptance of the reasons for the decision. A copy of the signed and authorised record outlining the reasons for this decision shall be retained with the associated project working papers.

9.6 STANDARD PROCUREMENT

9.6.1 Where the value of the goods and services to be purchased are less than £10,000, they shall be joined together wherever possible so that the total value exceeds the £10,000 minimum required for purchasing through competing quotations.

9.6.2 Where the provisions of paragraph 6.1 of this Appendix are not possible, the requirement for procurement through either competing quotations or competitive tendering shall be waived, and the goods and services shall be purchased through standard LAS procurement channels in accordance with standard LAS procurement procedures. It should be noted that, in order to maintain procedures of best practice and value for money, it is recommended that at least three telephone quotations shall be sought for expenditure of less than £10,000.

9.7 LIST OF APPROVED FIRMS

9.7.1 The Trust shall maintain, wherever possible, lists of approved firms from who tenders and quotations may be invited, ensuring that the establishment and maintenance of such lists allows for sufficient competition. Such lists shall be maintained as detailed in paragraph 4.8 of this Appendix.

9.7.2 The lists, where maintained, shall be subject to periodic review and re-establishment, where appropriate, by advertising. It is to be noted that Department of Health guidance in CONCODE provides for the list to be re-established by advertisement every five years.

9.7.3 The lists, where maintained, shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Director of Finance is satisfied.

9.7.4 Where the Director of Finance is not satisfied with the technical and financial competence of the firms, the firms are to be removed from the list of approved suppliers, where maintained, and no tenders or quotations are to be accepted or invited from such firms.

9.7.5 Where no lists are maintained by the Trust, the Director of Finance is to be informed of all firms who have been invited to provide tenders or quotations by the Trust and subsequent to the opening of the tenders, shall determine whether such

tenders or quotations received are to be accepted by the Trust by reference to their technical and financial competence (as detailed in paragraph 12.5 of this Appendix).

9.8 INVITATIONS TO TENDER

9.8.1 All invitations to tender on a competitive basis shall be in accordance with the Board's agreed procedures and be submitted in either:

(a) hard copy (as used by the Estates Department);
(b) electronically using the Bravosolution e-tendering portal (as used by the Procurement Department.

9.8.2 For hard copy tender returns it will be stated that no tender shall be accepted unless it is submitted in either the specialenvelope/package provided by the Trust or a plain, sealed envelope/package bearing the word "Tender" followed by the subject to which it relates and the latest date and time for receipt of such tender.

9.8.3 For electronic returns the 'Sealed' option for viewing responses shall be used.

9.8.4 Every tender for goods, materials, services or disposals shall embody the NHS Standard Contract Conditions that the tender shall be awarded under.

9.8.5 Every tender for building and engineering work, except any tender for maintenance work only (where Capital Investment Manual guidance shall be followed) shall be in the terms of the current editions of the Appropriate Standard Forms of Contract. Where appropriate, these base documents shall be modified and amplified to accord with extant Departmental guidance and other instructions and, in minor respects, to cover special features of individual projects.

9.8.6 All invitations to tender shall state in the invitation to tender that no tender shall be accepted unless it includes details of at least three recent referees who can be contacted to provide information on the technical and organisational competence of the tenderer, and the latest set of published financial statements of the tenderer.

9.8.7 All invitations to tender shall require tenderers to submit prices exclusive of VAT. Tenderers shall state the applicable VAT separately.

9.9 RECEIPT AND SAFE CUSTODY OF TENDERS

9.9.1 The Trust Secretary shall be responsible for the receipt, endorsement and recording of competitive tenders in the competitive tendering register and, for hard copy tender returns, for the safe custody of tenders received until the time appointed for their opening.

9.9.2 The competitive tendering register shall be in the form of a bound book with pre-numbered pages. For reference purposes, an example of the type of information held within the competitive tendering register has been included as Appendix B of this Appendix.

9.9.3 The date and time of receipt of each tender by the Trust Secretary shall be endorsed on the unopened tender envelope/package and recorded in the appropriate register (as detailed in paragraph 9.2 of this Appendix).

9.9.4 For electronic tender returns, tenders may not be 'opened' or supplier information viewed until the pre-defined time and date for opening has passed.

9.10 OPENING TENDERS

9.10.1 For hard copy tender returns, as soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two senior officers/managers officers designated by the Chief Executive and not from the originating department. The originating department will be taken to mean the Department sponsoring or commissioning the tender.

9.10.2 All Executive Directors and members of the Trust Board will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

9.10.3 For any tenders with a value greater than £1 million, the tenders must be opened in the additional presence of an Executive Director.

9.10.4 All eligible tenders received shall be opened on one and the same occasion.

9.10.5 Every tender received shall be endorsed with the date of opening and initialled by at least two of those present at the opening, at least one of whom shall be a Director in circumstances outlined in paragraph 10.2 of this Appendix.

9.10.6 A record of the opening of the tenders shall be maintained in the appropriate register (as detailed in paragraph 9.2 of this Appendix). The record is to be signed by at least two persons present at the opening of the tenders, in accordance with paragraph 10.2 of this Appendix as appropriate. The record shall show for each set of competitive tenders:

(a) the name of all firms invited to tender, details of which shall not be supplied to those designated officers responsible for receipt and opening until after the date of return;

(b) the names of firms from which tenders have been received;

(c) the date the tenders were opened;

(d) the price tendered (excluding VAT).

9.10.7 Except as in paragraph 10.8 below, a record shall be retained within the appropriate register (as detailed in paragraph 9.2 of this Appendix) of apparent price alterations within the tender. The record shall take the form of an addendum to the appropriate register and shall be initialled by at least two of those present at the opening, signed in accordance with paragraph 10.5 of this Appendix as appropriate. The addendum shall detail:

(a) all price alterations on the tender;

(b) the final price shown on the tender;

(c) any letter, document or material enclosed with or accompanying the tender.

9.10.8 A record shall be made in the addendum to the appropriate register (as detailed in paragraph 9.2 of this Appendix), if the price alterations are so numerous on any one tender as to render the procedure outlined in paragraph 10.6 of this Appendix unreasonable in the opinion of the Chief Executive or the Trust Secretary.

9.10.9 All records required to be maintained, as outlined within this Appendix, shall be held in the custody of the Trust Secretary.

9.11 ADMISSIBILITY OF TENDERS

9.11.1 Late tenders shall not be considered where other tenders received have already been opened, except in the circumstances described in paragraphs 11.2 and 11.3 below.

9.11.2 Technically late tenders are those despatched in good time but delayed beyond the due time for the receipt of tenders through no fault of the tenderers. Such tenders may be regarded as having arrived in due time by the Chief Executive or the Trust Secretary and a permanent signed record kept of the reasons, where the signed record shall be retained as an addendum to the appropriate register (as detailed in paragraph 9.2 of this Appendix).

9.11.3 Late tenders shall only be considered in circumstances, to be determined by the Chief Executive or the Director of Finance, which would be of advantage to the Trust. Such circumstances may be where significant financial, technical or delivery advantages would accrue to the Trust and the Chief Executive and the Director of Finance are satisfied that there is no reason to doubt the bona-fides of the tenderers concerned. In such circumstances, the tender may be considered and a permanent signed record shall be kept of the reasons, where the signed record shall be retained as an addendum to the appropriate register (as detailed in paragraph 9.2 of this Appendix).

9.11.4 Incomplete tenders are those from which information necessary for the adjudication of the tender is missing. These shall be dealt with in accordance with paragraph 11.6 below.

9.11.5 Amended or re-submitted tenders shall not be considered after the due time for receipt.

9.11.6 If it is considered necessary by the Chief Executive or his/her nominated officer to discuss with a tenderer the contents of his/her tender in order to elucidate technical points before the award of a contract, the tender need not be excluded from the adjudication. A signed record of the nature of the discussion and its outcome shall be kept, where the signed record shall be retained as an addendum to the appropriate register (as detailed in paragraph 9.2 of this Appendix).

9.11.7 Where the examination of tenders reveals errors which, in the opinion of the Chief Executive or his/her nominated officer, would affect the tender figures, the tenderer is to be given details of such errors and given the opportunity of confirming or withdrawing their offer. In such circumstances, the tender need not be excluded from the adjudication and a signed record of the nature of the discussions and their outcomes shall be kept. In these circumstances, the signed record shall be retained as an addendum to the appropriate register (as detailed in paragraph 9.2 of this Appendix).

9.11.8 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration and while negotiations are in progress or re-tenders are being

sought, the tender documents shall be kept strictly confidential and held in safe custody by the Chief Executive or the Trust Secretary.

9.12 ACCEPTANCE OF TENDERS

9.12.1 Non-Competitive Tenders

9.12.1.1 Where only one tender is sought and/or received the Chief Executive or his/her nominated officers shall, as far as is practicable, determine that the price to be paid is fair and reasonable and keep a signed record of the reasons for this decision. In such circumstances, the signed record is to be retained as an addendum to the appropriate register (as detailed in paragraph 9.2 of this Appendix).

9.12.1.2 In circumstances where either no tender is received by the Trust or the Chief Executive or his/her nominated officer determine that the price to be paid is not fair and reasonable, the Chief Executive shall empower the Director responsible for the originating department to approach firms which the Director is aware can provide the relevant goods or services to the Trust. The Director shall report, in writing:

(a) the content and outcome of their discussions with the approached firms;

(b) the agreed prices for the provision of the specified goods or services;

(c) their recommendations as to which firms shall provide the goods or services to the Trust.

9.12.1.3 The Director shall forward the record (as detailed in paragraph 12.1.2 of this Appendix) to the Director of Finance, the Chief Executive or the Trust Board for approval of their recommendations as per the financial limits detailed in paragraphs 4.5.1, 4.5.2 and 4.5.3 of this Appendix.

9.12.1.4 Where this procedure is adopted, the Director of Finance shall maintain the duly authorised record, and report the decisions made to the Trust's Audit Committee.

9.12.2 Building, Engineering and Maintenance Works

If the number of tenders received is insufficient to provide adequate competition, or tenders are late, amended, incomplete, qualified, or otherwise not strictly competitive, in the opinion of the Chief Executive or his/her nominated officer, they shall be dealt with in accordance with Department of Health guidance extant or guidance obtained for the purpose of the particular case. Such guidance can be found, for example, in CONCODE - which can be obtained for reference purposes from the Director of Finance. Competitive tendering cannot be waived for building and engineering construction works, maintenance (other than in accordance with CONCODE) without the Department of Health's approval.

9.12.3 Basis for Acceptance of a Tender

9.12.3.1 The basis for the acceptance of a tender shall be that which is the most economical advantageous to the Trust and this may be, but is not necessarily, that with the lowest price where payment is made by the Trust. If the lowest price is not accepted then the good and sufficient reasons shall be set out in either the contract file or other appropriate record.

9.12.3.2 The possible criteria for acceptance of the tender shall be:-

(i) price

(ii) quality
(iii) delivery date
(iv) capital expenditure implications
(v) revenue expenditure implications
(vi) cost effectiveness
(vii) aesthetic characteristics
(viii) functional characteristics
(viii) technical merit
(ix) after sales merit
(x) technical assistance
(xi) any other relevant criteria.

9.12.3.3 The basis for the acceptance of a tender shall be kept in a signed record, signed in accordance with paragraph 10.5 of this Appendix. The signed record shall be retained as an addendum to the appropriate register (as detailed in paragraph 9.2 of this Appendix).

9.12.4 Tender Other than the Lowest

9.12.4.1 Any tender accepted shall be the most advantageous to the Trust, have the lowest price where payment is made by the Trust or have the highest income where payment is received by the Trust.

9.12.4.2 A tender, other than the lowest where payment is to be made by the Trust or the highest where payment is to be received by the Trust, shall only be accepted for good and demonstrable reasons if the Chief Executive or his/her nominated officer so decide and keep a signed record of that decision. This decision shall then be reported to the Trust Board. The original signed record shall be retained with the Trust Board's relevant working documents and a copy shall be retained as an addendum to the appropriate register (as detailed in paragraph 9.2 of this Appendix).

9.12.5 Financial Competence

Any tender or quotation shall only be accepted by the Trust where the Director of Finance is satisfied with the financial competence of the firms involved. Such assurance shall be sought by the use of financial criteria, to be determined as appropriate by the Director of Finance or his/her nominated officer, to analyse the financial information received with the tender documentation, and any other documentation the Director of Finance or his/her nominated officer consider appropriate. In circumstances where the Director of Finance is not satisfied with the financial competence of the firms, the position shall be discussed by the Director of Finance or his/her nominated officer with the firms in an attempt to be satisfied with the tenderer's financial competence on behalf of the Trust. Only where the Director of Finance is satisfied with the financial competence of the firms shall the tender or quotation be assigned to those firms. A permanent, signed record of the discussions and outcomes shall be retained with the appropriate working papers used to analyse financial competence and retained within the Finance department - where the records can be viewed by appropriate officers of the Trust as appropriate.

9.12.6 Technical & Organisational Competence

9.12.6.1 Any tender or quotation shall only be accepted by the Trust where the Director responsible for the originating department is satisfied with the technical and organisational competence of the firms involved.

9.12.6.2 At least one recent reference shall be taken up from the selection of three provided with the tender documentation of the chosen tenderer. Any tender shall only be

accepted where the references taken up are satisfactory, in the opinion of the relevant Director (as detailed in paragraph 12.6.1 of this Appendix).

9.7 POST-TENDER NEGOTIATIONS

Post tender negotiations with the successful tenderer shall only be carried out with the agreement of the Chief Executive or the Director of Finance and a signed record shall be kept of the reasons for the negotiations and the outcome of the discussions, with the signed record being retained with the associated tender working papers.

9.8 DISPOSALS

9.8.1 Paragraph 4 (Competitive Tendering) of this Appendix shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer.

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items arising from works of construction, demolition or site clearance, which shall be dealt with in accordance with the relevant contract;

(d) land or building concerning which Department of Health guidance has been issued, but subject to compliance with such guidance;

(e) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract.

9.9 IN HOUSE SERVICES

The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

9.10 FORMS OF CONTRACT

9.10.1 Every contract for building and engineering works, except contracts for maintenance work only, where Department of Health Capital Investment Manual guidance shall be followed, shall embody as much of the JCT as are of this Appendix). In the case of contracts for building and engineering works costing more than £100,000 (or such other amount as the Department of Health may from time to time determine), the contract shall be embodied in a formal document executed under seal.

9.10.2 **Cancellation of Contracts** - Except where specific provision is made in model Forms of Contracts or standard Schedules of Conditions approved for use within the NHS and in accordance with Standing Orders, there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the

obtaining or execution of the contract or any other contract with the Trust, or for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the Trust, or if the like acts shall have been done by any person employed by him or acting on his behalf (whether with or without the knowledge of the contractor), or if in relation to any contract with the Trust the contractor or any person employed by him/her or acting on his/her behalf shall have committed any offence under the Prevention of Corruption Acts 1889 and 1916 an other appropriate legislation.

9.10.3 **Determination of Contracts for Failure to Deliver Goods or Material** – There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may without prejudice determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good (a) such default, or (b) in the event of the contract being wholly determined the goods or materials remaining to be delivered. The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

9.10.4 **Contracts involving Funds Held on Trust** – shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Act 2006.

9.11 ADVANCED/PHASED PAYMENTS

Advance/phased payments, except those made for capital building projects as laid down conditions of contract, are only to be made in exceptional circumstances and shall only be made following the agreement of the Chief Executive and the Director of Finance. A signed record shall be kept of the reasons for this method of payment, with the signed record being retained with the associated tender working papers.

9.12 APPLICATION OF LIQUIDATED AND ASCERTAINED DAMAGES ON CONSTRUCTION CONTRACTS

The Chief Executive or his/her nominated officer shall normally enforce the application of liquidated and ascertained damages on construction contracts, except where the Chief Executive or his/her nominated officer determine that they should be waived. In circumstances where such damages are waived the Chief Executive shall note the reasons in a signed record, which will be passed to the Director of Finance and presented to the Audit Committee as appropriate.

9.13 REPORTING OF TENDER ACTIVITY

9.13.1 The Trust Secretary shall report to the Board any tenders received and the names of those organisations tendering.

9.13.2 After the analysis of tenders by the senior manager responsible has completed then the Trust Secretary shall report to the Board for noting in the Part II meeting:

(a) what was being tendered,
(b) the names of those tendering and
(c) the amounts of each tender.

9.13.3 This report is to be presented as soon as practicable after tenders have been opened.

9.13.4 The senior manager responsible for the procurement shall provide the Trust Secretary with sufficient information to enable the reporting required at paragraph 19.2.

9.14 PRIVATE FINANCE INITIATIVE

9.14.1 Where appropriate the Trust will test for PFI when considering capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

9.14.2 The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

9.14.3 Where the sum exceeds delegated limits set by the Department of Health, a business case must be referred to the organisation designated by the DoH for approval.

9.14.4 The proposal must be specifically agreed by the Board.

9.14.5 The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

10. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES

10.1 Service Level Agreements (SLAs)

10.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service commissioners for the provision of NHS services.

10.1.2 All SLAs should aim to implement the agreed priorities contained within the Local Delivery Plan (LDP) and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

(a) the standards of service quality expected;
(b) the relevant national service framework (if any);
(c) the provision of reliable information on cost and volume of services;
(d) the NHS National Performance Assessment Framework;
(e) that SLAs build where appropriate on existing Joint Investment Plans
(f) that SLAs are based on integrated care pathways.

10.2 Involving partners and jointly managing risk

A good SLA will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The SLA will apportion responsibility for handling a particular risk to the party or parties in the best positions to influence the event and financial arrangements should reflect this. In this way that Trust can jointly manage risk with all interested parties.

10.3 A 'Patient Led NHS and 'Practice Based Commissioning'

10.3.1 The Department of Health has published its document 'Creating a Patient'led NHS' and 'Practice Based Commissioning' setting out the basis upon which the Government's major reform agenda will be carried forward.

10.3.2 Every aspect of the new system is designed to create a service which is patient-led, where:

(a) People have a far greater range of choices and of information and guidance to help make choices;
(b) There are stronger standards and safeguards for patients;
(c) NHS organisations are better at understanding patients and their needs, use new and different methodologies to do so and have better and more regular sources of information about preferences and satisfaction.

10.3.3 In order to be patient-led the NHS will develop new service models which build on current experience and innovation to:

(a) Give patients more choice and control wherever possible;
(b) Offer integrated networks for emergency, urgent and specialist care to ensure that everyone throughout the country has access to safe, high quality care;
(c) Make sure that all services and all parts of the NHS contribute to health promotion, protection and improvement.

10.3.4 The NHS will develop the way it secures services for its patients. It will:

(a) Promote more choice in acute care by offering choice to the patient both in number and type of provider;
(b) Encourage development of new community and primary services alongside new practices;
(c) Strengthen existing networks for emergency, urgent and specialist services;
(d) Build on current practices in shared commissioning to create a far simpler contract management and administration system that can be professionally managed.

10.3.5 The NHS needs a change of culture as well as of systems to become truly patient-led, where:

(a) Everything is measured by its impact on patients and type of provider;
(b) The NHS is as concerned with health promotion and prevention as with sickness and injury;
(c) Frontline staff have more authority and autonomy to better support the patient;
(d) Barriers which create rigidity and inflexibility are tackled and codes of conduct and shared values are instilled into the culture.

10.3.6 A patient-led NHS needs effective organisations and incentives, with:

(a) A new development programme to help NHS Trusts become NHS Foundations Trusts;
(b) A similar structured programme to support PCTs in their development of 'Practice Based Commissioning';
(c) Further development of Payment by Results to provide appropriate financial incentives for all services;

(d) Greater integration of all the financial and quality incentives along with full utilisation of new human resources and IT programmes.

10.3.7 Commissioning a Patient-led NHS and Practice Based Commissioning are being rolled out by the Department of Health and full support and latest guidance may be accessed at http://www.dh.gov.uk

10.4 Reports to Board on SLAs

The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA.

11. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EMPLOYEES

11.1 REMUNERATION

11.1.1 In accordance with Standing Orders the Board shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

11.1.2 The Committee will:

(a) advise the Board about appropriate remuneration and terms of service for the Chief Executive, other officer members employed by the Trust and other senior employees including:

i. all aspects of salary (including any performance related elements/bonuses);
ii. provisions for other benefits, including pensions and cars;
iii. arrangements for termination of employment and other contractual terms;

(b) make such recommendations to the Board on the remuneration and terms of service of office members of the Board (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) monitor and evaluate the performance of individual officer members (and other senior employees);

(d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

11.1.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of officer members. Minutes of the Board's meetings should record such decisions.

11.1.4 The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

11.1.5 The Trust will pay allowances to the Chairman and non-officer members of the Board in accordance with instructions issued by the Secretary of State for Health.

11.2 FUNDED ESTABLISHMENT

11.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

11.2.2 The funded establishment of any department may not be varied without the approval of the Director of Human Resources and the Director of Finance. The changes resulting in variation from the annual budget exceeding £500k must be approved by the Trust Board.

11.3 STAFF APPOINTMENTS

11.3.1 No officer or member of the Trust Board may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive Officer; and
(b) within the limit of their approved budget and funded establishment.

11.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

11.4 PROCESSING OF PAYROLL

11.4.1 The Director of Human Resources & Organisation Development is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notification;
(b) the final determination of pay remitted and allowances;
(c) making payment on agreed dates;
(d) agreeing method of payment.

11.4.2 The Director of Human Resources & Organisation Development will issue instructions regarding:

(a) verification and documentation of data;
(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;
(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
(d) security and confidentiality of payroll information;
(e) checks to be applied to completed payroll before and after payment;
(f) authority to release payroll data under the provisions of the Data Protection Act;

11.4.3 The Director of Finance will issue instructions regarding:

(g) methods of payment available to various categories of employee;
(h) procedures for payment by cheque, bank credit to employees;

(i) procedure for the recall of cheques and bank credits;
(j) maintenance of regular and independent reconciliation of pay control accounts;
(k) separation of duties of preparing records and handling cash; and
(l) a system to ensure the recovery from those leaving the employment of LAS of sums of money and property due by them to the Trust.

11.4.4 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Director of Human Resources & Organisation Development's instructions and in the form prescribed by the Director of Human Resources & Organisation Development;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty or fulfil obligations in circumstances that suggest they have left without notice, the Director of Human Resources & Organisation Development must be informed immediately.

11.4.5 Regardless of the arrangements for providing service, the HR Director & Organisation Development shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

11.5 CONTRACTS OF EMPLOYMENT

11.5.1 The Board shall delegate responsibility to the Director of Human Resources & Organisation Development for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

(b) dealing with variations to, or termination of, contracts of employment.

12. NON-PAY EXPENDITURE

12.1 DELEGATION OF AUTHORITY

12.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

12.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services; and
(b) the maximum level of each requisition and the system for authorisation above that level.

(c) the authorised signatories policy; a list of authorised signatories will be held by the Finance Department.

12.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

12.2 CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES

12.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the LAS. In so doing, the advice of the LAS' adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted.

12.2.2 Requisitions are not to be split or otherwise raised in a manner devised so as to avoid the financial thresholds. No requisition is to be raised which would cause a budget, year to date, to become overspent.

12.2.3 The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

12.2.4 The Director of Finance will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed;

(b) prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) a list of directors/employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and that charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for

the use of vehicles, plant and machinery have been examined.

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(iii) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

12.2.5 Pre-payments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cashflows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%, or where in the nature of the business, prepayment is a normal term and condition eg telephone line rental).

(b) the appropriate officer must provide, in the form of a written report to the Director of Finance, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the LAS if the supplier is at some time during the course of the prepayment agreement unable to make his commitments;

(c) the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold); and

(d) the budget holder is responsible for ensuring that all items due under a pre-payment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

12.2.6 Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance;

(c) state the LAS' terms and conditions of trade; and

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

12.2.7 Managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all contracts (except as provided in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU on public procurement

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health.

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Directors or employees, other than;

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

The Standing Orders includes guidance, set out in Appendix VI, the Standards of Business Conduct for London Ambulance Service NHS Trust.

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;

(g) verbal orders must only be issued very exceptionally – by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked “Confirmation Order”;

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) goods are not taken on trial or loan in circumstances that could commit the LAS to a future un-competitive purchase;

(j) changes to the list of directors/employees authorised to certify invoices are notified to the Director of Finance;

(k) purchases from petty cash are restricted in value and by type or purchase in accordance with instructions issued by the Director of Finance;

(l) petty cash records are maintained in a form as determined by the Director of Finance.

(m) purchases using purchasing cards are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance.

(n) Purchasing card records are maintained in a form as determined by the Director of Finance.

12.2.8 The Chief Executive must ensure that the LAS' Standing Orders are compatible with the requirements issued by the NHS in respect of building and engineering contracts (CONCODE) and land and property transactions (ESTATECODE). The technical audit of these contracts shall be the responsibility of the Director managing those areas. The Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within these codes.

13 EXTERNAL BORROWING AND INVESTMENTS

13.1 EXTERNAL BORROWING

13.1.1 The Director of Finance will advise the Board concerning the Trust's ability to pay interest on, and repay, both the originating capital debt and any proposed new borrowing, within the limits set by the NHS. The Director of Finance is also responsible for reporting periodically to the Board concerning the originating debt and all loans and overdrafts.

13.1.2 The Board will agree the list of employees (including specimen of their signatures) who are authorised to make short term borrowing on behalf of the Trust. This must contain the Chief Executive and the Director of Finance.

13.1.3 Any application for a loan or overdraft will only be made by the Director of Finance or by an employee so delegated by him and the Board will be informed of this at the following meeting.

13.1.4 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

13.1.5 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money and comply with the latest guidance from the Department of Health.

13.1.6 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Director of Finance. The Board must be made aware of all short-term borrowings at the next Board meeting.

13.1.7 All long term borrowing must be consistent with the plans outlined in the current Business Plan.

13.2 INVESTMENTS

13.2.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board via the Treasury policy.

13.2.2 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

13.2.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

14 FINANCIAL FRAMEWORK

14.1 The Director of Finance should ensure that members of the Board are aware of the Financial Framework. This document contains directions which the Trust must follow. It also contains directions to Strategic Health Authorities regarding resource and capital allocation and funding the Trusts. The Director of Finance should also ensure that the direction and guidance in the framework is followed by the Trust.

15 CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

15.1.1 The Chief Executive

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for ensuring that there is a system in place to ensure the effective management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) shall ensure that the capital investment is not undertaken without confirmation of purchasers support and the availability of resources to finance all revenue consequences, including capital charges.

15.1.2 For every capital expenditure proposal above the limits set in the Scheme of Delegation the Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the Capital Investment Manual) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest possible ratio of benefits to costs;

The involvement of appropriate Trust personnel and external agencies;

(ii) appropriate project management and control arrangement; and

(b) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

15.1.3 The Director of Finance shall assess on an annual basis the requirements for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

15.1.4 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "ESTATECODE".

15.1.5 The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

15.1.6 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitments against authorised expenditure.

15.1.7 The approval of a capital programme shall not constitute approval for expenditure on any individual scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender.

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "ESTATECODE" guidance and the LAS' Standing Orders.

15.1.8 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall take fully into account the delegated limits for capital scheme included in DH publication "Delegated limits for capital investment'.

15.2 PRIVATE FINANCE

15.2.1 When the LAS proposes to use finance which is to be provided other than through its EFL, the following procedures shall apply:

(a) The Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum involved exceeds delegated limits the business case must be referred to the Department of Health or in line with current guidelines.

(c) The proposal must be specifically agreed by the Board where it exceeds the threshold set for capital schemes for Board approval.

15.3 ASSET REGISTERS

15.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance and, inter alia, the Director responsible for fleet and facilities concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

15.3.2 The LAS shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be designed so as to generate the standard accounting figures to enable the annual accounts to be produced, as set out in the Capital Accounting Manual as issued by the Department of Health.

15.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(c) lease agreements in respect of assets held under a finance lease and capitalised.

15.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

15.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

15.3.6 The value of each asset shall be indexed to current values in accordance with methods specified in the Capital Accounting Manual issued by the Department of Health.

15.3.7 The value of each asset shall be depreciated using methods and rates as specified in the Capital Accounting Manual issued by the Department of Health.

15.3.8 The Director of Finance shall calculate and pay capital charges as specified in the Capital Accounting manual issued by the Department of Health.

15.4 SECURITY OF ASSETS

15.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

15.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset; and

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

15.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

15.4.4 Whilst each employee has a responsibility for the security of property of the LAS, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

15.4.5 Any damage to the LAS' premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

15.4.6 Where practical, assets should be marked as LAS property.

16 STORES AND RECEIPT OF GOODS

General position

16.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stocktake;

(c) valued at the lower of cost and net realisable value.

16.2 Subject to the responsibility of the Director of Finance for the system of control, overall responsibility for the control of stores shall be delegated to the Director of Operations by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of Pharmaceutical stocks shall be the responsibility of the Directors of Operations; the control of fuel and oil of the Fleet Manager.

16.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the Directors of Operations. Wherever practicable, stocks should be marked as health service property.

16.4 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores and losses.

16.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

16.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

16.7 There will be a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable articles. The Directors of Operations shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also 15, Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

17 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

17.1 DISPOSALS AND CONDEMNATIONS

17.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

17.1.2 When it is decided to dispose of a LAS asset, the Director or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

17.2.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;

(b) recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

17.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

17.2 LOSSES AND SPECIAL PAYMENTS

17.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments. These will be authorised by the Audit Committee.

17.2.2 Any employee discovering or suspecting a loss of any kind must immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance or inform an officer charged with the responsibility for responding to concerns involving loss This officer will then appropriately inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved.

17.2.3 In cases of fraud and corruption or of anomalies that may indicate fraud or corruption, the Director of Finance must inform the relevant CFOS regional team in accordance with Secretary of State for Health's Directions.

17.2.4 The Director of Finance must notify the Counter Fraud and Security Management Services and the External Auditor of all frauds.

17.2.5 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial and where fraud is not suspected, the Director of Finance must immediately notify:

(a) the Board, and

(b) the External Auditor.

17.2.6 Within limits delegated to it by the Department of Health, the Board shall approve the writing-off of losses.

17.2.7 The Director of Finance shall be authorised to take any necessary steps to safeguard the LAS' interests in bankruptcies and company liquidations.

17.2.8 For any loss, the Director of Finance should consider whether any insurance claim can be made against insurers.

17.2.9 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

17.2.10 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

17.2.11 All losses and special payments must be reported to the Audit Committee at very meeting.

18 INFORMATION TECHNOLOGY

18.1 The Director of Finance, and the Director of Information Management and Technology, who are responsible for the accuracy and security of the computerised financial data of the LAS, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the LAS' data, programs and computer hardware for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that adequate management (audit) trails exists through the computerised system and that such computer audit reviews as are considered necessary are being carried out.

18.2 The Director of Finance shall be satisfied that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

18.3 The Director of Information Management & Technology shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

18.4 The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

18.5 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

18.6 Where computer systems have an impact on corporate financial systems the Directors of Information Management and Technology and Finance shall be satisfied that:

(a) systems acquisitions, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Directorate of Finance staff have access to such data; and

(d) such computer audit reviews as are considered necessary are being carried out.

18.7 In the case of computer systems which are proposed general applications (i.e. normally those applications which the majority of Trusts in an NHS area wish to sponsor jointly) all responsible directors and employees will send to the Director of Information Management and Technology:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

19 RISK ASSESSMENT

The Director of Finance and the Director of Information Management and Technology shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

19.1 Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Director of Finance shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Management and Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that an audit trail exists;

(c) Director of Finance staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

20 PATIENTS' PROPERTY

20.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients or found in the possession of deceased patients.

20.2 The Director of Finance must provide detailed written instructions on the collection, custody, and safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients.

20.3 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

20.4 The Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

21 CHARITABLE FUNDS

21.1 INTRODUCTION

21.1.1 The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes. The Director of Finance shall ensure that each fund is managed appropriately with regard to its purpose and to its requirements.

21.1.2 This Section of the SFIs shall be interpreted and applied in conjunction with the rest of these Instructions, subject to modifications contained herein.

21.1.3 The Director of Finance will have primary responsibility to the Board for ensuring that these SFIs are applied to charitable funds.

21.2 EXISTING FUNDS

21.2.1 The Director of Finance shall arrange for the administration of all existing charitable funds, in conjunction with the Legal Adviser. They shall ensure that a governing instrument exists for every trust fund and shall produce detailed codes of procedure covering every aspect of the financial management of funds held on

trust, for the guidance of directors and employees. Such guidelines shall identity the restricted nature of certain funds.

21.2.2 The Director of Finance shall periodically review the funds in existence and shall make recommendations to the Board regarding the potential for rationalisation of such funds within statutory guidelines.

21.2.3 The Director of Finance may recommend an increase in the number of funds where this is consistent with the Trust's policy for ensuring the safe and appropriate management of restricted funds, e.g., designation for specific stations or departments.

21.2.4 The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

21.2.5 The Scheme of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion rearing the disposal and use of the funds are to be taken by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

21.2.6 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

21.3 **NEW FUNDS**

21.3.1 The Director of Finance shall, in conjunction with the Legal Adviser, arrange for the creation of a new trust where funds and/or other assets, received in accordance with this Body's policies, cannot adequately be managed as part of an existing trust.

21.3.2 The Director of Finance shall present the governing document to the Board for adoption as required in Standing Orders for each new trust. Such document shall clearly identify, inter alia, the objects of the new trust, the capacity of this Trust to delegate powers to manage and the power to assign the residue of the trust to another fund contingent upon certain conditions, e.g. Discharge of original objects.

21.4 **SOURCES OF NEW FUNDS**

21.4.1 In respect of Donations, the Director of Finance shall:

(a) provide guidelines to officers of the Trust as to how to proceed when offered funds. These to include:

(i) the identification of the donors intentions;
(ii) where possible, the avoidance of new trusts;
(iii) the avoidance of impossible, undesirable or administratively difficult objects;
(iv) sources of immediate further advice; and
(v) treatment of offers for personal gifts; and

(b) provide secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into the LAS' charitable funds and that the donor's intentions have been noted and accepted.

21.4.2 In respect of **Legacies and Bequests,** the Director of Finance shall, with appropriate legal advice:

(a) provide guidelines to officers of the Trust covering any approach regarding:

(i) the wording of wills;
(ii) the receipt of funds/other assets from executors;

(b) where necessary, obtain grant of probate, or make application for grant of letters of administration, where the LAS is the beneficiary;

(c) be empowered, on behalf of the LAS, to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty; and

(d) be directly responsible, in conjunction with the Legal Adviser, for the appropriate treatment of all legacies and bequests.

21.4.3 In respect of **Fund-raising,** the Director of Finance shall:

(a) after consultation with the Legal Adviser, deal with all arrangements for fund-raising by and/or on behalf of the LAS and ensure compliance with all statutes and regulations;

(b) be empowered to liaise with other organisations/persons raising funds for the LAS and provide them with an adequate discharge. The Director of Finance shall be the only officer empowered to give approval for such fund-raising subject to the overriding direction of the Board;

(c) be responsible, along with the Legal Advisers, for alerting the Board to any irregularities regarding the use of the LAS' name or its registration numbers; and

(d) be responsible, after due consultation with the Legal adviser, for the appropriate treatment of all funds received from this source.

21.4.4 In respect of **Trading Income,** the Director of Finance shall:

(a) be primarily responsible, along with the Legal Adviser and other designated officers, for any trading undertaken by the LAS as corporate trustee; and

(b) be primarily responsible, along with the Legal Adviser, for the appropriate treatment of all funds received from this source.

21.5 INVESTMENT MANAGEMENT

21.5.1 The Director of Finance shall be responsible for all aspects of the management of the investment of income and funds held on trust. The issues on which he shall be required to provide advice to the Board shall include:-

(a) in conjunction with the Legal Adviser, the formulation of investment policy within the powers of this Body under Statute and within governing instruments to meet its requirements with regard to income generation and the enhancement of capital value;

(b) the appointment of advisers, brokers, and where appropriate, fund managers and:

(i) the Director of Finance shall agree, in conjunction with the Legal Adviser, the terms of such appointments; and for which

(ii) written agreements shall be signed by the Chief Executive;

(c) pooling of investment resources and the preparation of a submission to the Charity Commission for them to make a scheme;

(d) the participation by this Body in common investment funds and the agreement of terms of entry and withdrawal from such funds;

(e) that the use of NHS Trust assets shall be appropriately authorised in writing and charges raised within policy guidelines;

(f) the review of the performance of brokers and fund managers;

(g) the reporting of investment performance.

21.6 **DISPOSITION MANAGEMENT**

21.6.1 The exercise of the LAS' dispositive discretion shall be managed by the Director of Finance in conjunction with the Board. In so doing he shall be aware of the following:

(a) The objects of various funds and the designated objectives;

(b) the availability of liquid funds within each charitable fund;

(c) the powers of delegation available to commit resources;

(d) the avoidance of the use of exchequer funds to discharge charitable fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer shall be discharged by trust funds at the earliest possible time;

(e) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the LAS; and

(f) the definitions of "charitable purposes" as agreed by the NHS and the Charity Commission.

21.7 **BANKING SERVICES**

21.7.1 The Director of Finance shall advise the Board and, with its approval, shall ensure that appropriate banking services are available to the LAS as corporate trustee. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

21.8 **ASSET MANAGEMENT**

21.8.1 Charitable fund assets in the ownership of or used by the Trust as corporate trustee, shall be maintained along with the general estate and inventory of assets. The Director of Finance shall ensure:

(a) in conjunction with the Legal Adviser, that appropriate records of all assets owned by the LAS as corporate trustee are maintained, and that all assets, at agreed valuations, are brought to account;

(b) that appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;

(c) that donated assets received on trust shall be accounted for appropriately;

(d) that all assets acquired from funds held on trust which are intended to be retained within the charitable funds are appropriately accounted for, and that all other assets so acquired are brought to account in the name of the LAS NHS Trust.

21.9 **REPORTING**

21.9.1 The Director of Finance shall ensure that regular reports are made to the Board with regard to, inter alia, the receipt of funds, investments, and the disposition of resources.

21.9.2 The Director of Finance shall prepare annual accounts in the required manner which shall be submitted to the Board within agreed timescales.

21.9.3 The Director of Finance, in conjunction with the Head of Legal Services, shall prepare an annual trustees' report (separate reports for charitable and non-charitable trusts) and the required returns to the NHS and to the Charity Commission for adoption by the Board.

21.10 **ACCOUNTING AND AUDIT**

21.10.1 The Director of Finance shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

21.10.2 The Director of Finance shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. He will liaise with external audit and provide them with all necessary information.

21.10.3 The Board shall be advised by the Director of Finance on the outcome of the annual audit. The Chief Executive shall submit the Management Letter to the Board.

21.11 **ADMINISTRATION COSTS**

21.11.1 The Director of Finance shall identify all costs directly incurred in the administration of funds held on trust and, in agreement with the Board, shall charge such costs to the appropriate trust accounts.

21.12 **TAXATION AND EXCISE DUTY**

21.12.1 The Director of Finance shall ensure that the Trust's liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

22 ACCEPTANCE OF GIFTS BY STAFF

The Director of Finance shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy should follow the guidance contained in the Department of Health Standards of Business Conduct for NHS Staff.

23 RETENTION OF RECORDS

23.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidelines, currently the Records Management: NHS Code of Practice.

23.2 The records held in archives shall be capable of retrieval by authorised persons

23.3 Records held in accordance with the Records Management: NHS Code of Practice shall only be destroyed at the express instigation of the Head of Records Management within the authority delegated by the Chief Executive. Records shall be maintained of documents so destroyed.

24 RISK MANAGEMENT

24.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board.

24.2 The programme of risk management shall include:

1) a process for identifying and quantifying risks and potential liabilities;

2) engendering among all levels of staff a positive attitude towards the control of risk;

3) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

4) contingency plans to offset the impact of adverse events;

5) audit arrangements including; internal audit, clinical audit, health and safety review;

6) a clear indication of which risks shall be insured.

7) arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make a Statement on the effectiveness of Internal Control (SIC) within the Annual Report and Accounts as required by current Department of Health guidance.

24.3 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk

pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

24.4 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, three exceptions when Trusts may enter into insurance arrangements with commercial insurers. The exceptions are:

1) Trusts may enter commercial arrangements for insuring motor vehicles owned by the Trust including insuring third party liability arising from their use;
2) Where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into; and
3) Where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority.

In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Finance Director should consult the Department of Health.

24.5 Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

24.6 Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.

24.7 All the risk-pooling schemes require members to make some contributions to the settlement of claims (the 'deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

London Ambulance Service NHS
NHS Trust

LONDON AMBULANCE SERVICE TRUST BOARD

28th September 2010

PAPER FOR NOTING

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

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

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

Risk Implications
This paper links to the following strategic risks:

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

NHS Constitution

This paper supports the following principles that guide the NHS:

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

Equality Impact Assessment

Has an Equality Impact Assessment been carried out?

☐ Yes
☒ No

Key issues from the assessment:

TB FORWARD PLANNER

Date	Strategic and Business Planning	Items for approval (eg Policies and Business Cases)	Performance and Other	Governance	Standing Items	Apologies	Committee dates
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	Patient Experience Report (GB)	Report from CEO including balanced scorecards and performance report		8th Audit Committee
SMG 10th	Presentation on Cycle Response Unit (RW and Tom Lynch)			Board assurance framework and corporate risk register - 6 month progress report (SA)	Report from Finance Director		SRP 3rd 2-5pm
	Safeguarding			Q2 finance and governance declaration	Report from sub-committees		
	Six Lives Report (Daryl Mohammed)				Clincal Quality and Patient Safety Report		
	Health and Safety and work-related injuries (CH)						
	SIP Update - half yearly report				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)			Charitable Funds Annual Report and Accounts	Report from Finance Director		
					Report from sub-committees		
					Clincal Quality and Patient Safety Report		
					Report from Trust Secretary		
25 January 2011 TB	Formal IBP and LTFM sign off pre-submission						
SMG 12 Jan							
1 March 2011 TB	Approve FT application						
SMG 16 Feb							

TB FORWARD PLANNER

29 March 2011 TB				Risk management policy and strategy review			
SMG 16 Mar							
26 April 2011 SRP				Governance structure review			
SMG 13 April							

Presentations
Approval
Compliance
FT items